

An investigation of purchasing and supply chain management practices and challenges in state enterprises: A CASE STUDY OF THE HEALTH SECTOR IN ZIMBABWE

Submitted in fulfilment of the requirements of the degree of Doctor of Technology: Public Management and Economics in the Faculty of Management Sciences at the Durban University of Technology

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JANUARY 2017



DECLARATION

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ABSTRACT

The world over, countries are burdened with existing and emerging diseases and while that affected all nations, sub-Saharan Africa carried the heaviest portion. This filtered to Zimbabwe where a myriad of health challenges are faced. Unavailability of medicines coupled with poor inventory management of these medicines has been prevalent. Insufficient financial resources and increasing cost of healthcare costs is one of the pressing matters. It is also important to note that these challenges are occurring at a time when government is realising the crucial role of procurement in addressing health challenges.

Due to the extent, depth, breadth and nature of the health challenges and their criticality in establishing sustainable and affordable health system in Zimbabwe, a case study approach has been adopted where data from questionnaires, interviews, documents and observations were corroborated and triangulated in an effort to bring to the surface deep-seated procurement matters and how they are related to the challenges provided.

Thus, in terms of the research findings, it was first revealed that the procurement legislative frameworks and processes are fragmented and not in one place resulting in multiple accountabilities. It was further shown that the framework is inappropriate in a healthcare set-up where issues of speed and flexibility in addressing requirements are paramount. It was also shown that procurement planning being a critical aspect is regrettably and detrimentally missing in procurements. In addition, the selection criteria as set out in the regulations and practiced by individual state health facilities indicated over-reliance on price and that being the case, key aspects such as quality and supply-lead time are missed and yet are very necessary in terms of evaluation among other factors.

In the findings, the peripheral role of procurement staff with clinicians being also at the epicentre of purchasing decisions was presented. Perhaps related to that was the inadequacy of procurement skills and competences from the procurement personnel.

Last on the findings, financing and the frequency of disbursement was unmatched with hospital requirements and thus resulting in unavailability of adequate medicines and equipment.

Key words: purchasing, supply chain management, purchasing process, purchasing strategy, supplier selection and evaluation, supply chain strategy, supply chain integration and co-ordination, procurement practices and challenges, public procurement, procurement legislative framework, case study, health sector.

DEDICATION

Dedication is directed to my dear family for their tremendous support and encouragement throughout the demanding doctoral programme and part of that encouragement was that we can do all things through Him who gives us strength.

ACKNOWLEDGEMENTS

In the preparation and completion of this thesis, the author would like to sincerely acknowledge and thank the following people who have contributed significantly in terms of professional guidance, assistance, moral support and constructive criticism.

Firstly, the author would like to express profound gratitude to the Supervisor Professor Mohamed Saheed Bayat for professional and continuous assistance rendered from the initial preparatory stages up to the end of the thesis. The unwavering support and timely feedback during our regular meetings have been highly appreciated. I recall quite vividly that I sometimes called him even after normal hours and he was more than willing to assist and made me comfortable to proceed with discussions on the phone sacrificing quality family time. Secondly, the concerted efforts from the academic staff from Public Management and Economics Department and Project Management Section are well acknowledged by the author.

The author's thanks and acknowledgements are also directed to the questionnaire and interview respondents (hospital and suppliers respondents) who provided valuable insights. Also, gratitude goes to the management of hospitals used as the case study for the permission and co-operation in the data collection stage of the research.

The author would also want to extend deepest appreciation to the Statistician, Mr Edwin Demera for assisting in a great way with the statistical data.

Finally, the author would like to thank family members and friends, my brother (Naboth) for great financial assistance, my brother Enock for encouragement, my wife (Elina) and my son (Ethan) for the overwhelming support, inspiration and understanding during long periods of study and compilation of this research. The study could prolong after work and even during weekends hence their support was highly desired.

TABLE OF CONTENTS

DECLARATION.....	i
ABSTRACT.....	ii
DEDICATION	iii
ACKNOWLEDGEMENTS.....	iv
LISTS OF GRAPHS.....	xi
LISTS OF TABLES.....	xii
LIST OF FIGURES.....	xiii
LIST OF ABBREVIATIONS.....	1
CHAPTER 1- INTRODUCTION.....	2
1.1. Background of the Study.....	3
1.2. Health Procurement System in Zimbabwe.....	4
1.3. Statement of the Research Problem.....	5
1.4. Rationale	6
1.5. Research Aim and Objectives.....	7
1.6. Limitations and Ethical Considerations.....	8
1.7. Structure of the research.....	8
1.8. Summary of the Chapter.....	9
CHAPTER 2- PURCHASING AND SUPPLY CHAIN	
MANAGEMENT IN PERSPECTIVE.....	10
2.1. Introduction	11
2.2. Purchasing and Supply Chain Management.....	11
2.2.1. The Purchasing Process	11
2.3. Evolution and Strategic role of Purchasing and Supply Chain	
Management	14
2.3.1. Costs.....	14
2.3.2. Globalisation and Information Technology.....	16
2.3.3. Demanding nature of customers.....	16

2.4. Understanding the Purchasing Environment	18
2.5. Development of Purchasing Strategy.....	19
2.5.1. Management of Supplier Base.....	20
2.6. Supplier Selection and Evaluation	21
2.7. Supply Chain Management	21
2.7.1 Supply Chain Strategy.....	22
2.7.2. Supply Chain Drivers.....	23
2.7.2.1. Facilities.....	23
2.7.2.2. Inventory.....	24
2.7.2.3. Transportation.....	24
2.7.2.4. Information.....	25
2.7.3. Supplier Relationships.....	25
2.7.4. Supply Chain Co-ordination and Integration.....	27
2.7.4.1. Push Strategy.....	27
2.7.4.2. Pull Strategy.....	27
2.7.4.3. Push-Pull Strategy.....	28
2.8. Public versus private sector purchasing-what are the differences?.....	28
Summary of the Chapter.....	30
CHAPTER 3- PUBLIC PROCUREMENT WITH REFERENCE TO ZIMBABWE.....	32
3.1. Introduction.....	33
3.1.1. Political Objectives.....	33
3.1.2. Socio-economic objectives.....	34
3.2. Corruption.....	36
3.3. The role of ethics in Public Procurement.....	37
3.4. Challenges in Public procurement.....	38
3.5. Public Procurement in Zimbabwe.....	39
3.5.1. Historical Background of Public Procurement.....	39

3.5.2. The Regulatory Framework for Public Procurement in Zimbabwe.....	41
3.5.2.1. Key Aspects of the Procurement Act.....	41
3.5.2.1.1. Application of the Act.....	41
3.5.2.1.2. The State Procurement Board (SPB) and its functions.....	41
3.5.2.1.3. Tendering Proceedings.....	42
3.6. Procurement Regulations.....	42
3.7. Global Health Purchasing and Supply Chain Management Issues and Challenges.....	43
3.8. Health Procurement System in Zimbabwe	46
Summary of the Chapter.....	47
CHAPTER 4- RESEARCH METHODOLOGY.....	49
4.0. Introduction.....	50
4.1. Research Paradigm.....	51
4.1.1. Positivism Paradigm	52
4.1.2. Interpretivism Paradigm.....	53
4.2. Case Study Research Method.....	54
4.2.1. Ensuring Validity and Reliability in Case Study Design	56
4.2.2. Ethical Consideration in case Study Design.....	58
4.2.3. Case Study design and Sampling	58
4.2.2. Sampling	59
4.3. Data Collection Methods	61
4.3.1. Guidelines applied in the design and development of interviews.....	61
4.3.1.1. Before Interview.....	63
4.3.1.2. During the Interview.....	64
4.3.1.3. After the interview	65
4.3.2. Guidelines applied in the design and development of Questionnaire.....	66
4.3.2.1. Questionnaire design.....	67

4.3.2.2. Questionnaire Layout	67
4.3.2.2.1. Pilot Testing	68
4.3.2.2.2. Administration of Questionnaire.....	71
4.3.3. Direct Observation.....	71
4.3.4. Document Analysis.....	71
4.4. Data Analysis	72
Summary of the Chapter.....	74
CHAPTER 5: PRESENTATION AND ANALYSIS OF FINDINGS.....	76
5.0 INTRODUCTION.....	77
5.1. QUESTIONNAIRE RESPONSE RATE	77
5.2. INTERVIEW RESPONSE RATE	78
5.3. PROCUREMENT PRACTICES AND CHALLENGES	78
5.3.1. PROCUREMENT PROCESSES AND THE REGULATORY FRAMEWORK.....	78
5. 3.2. Procurement Cycle.....	82
5.3.3. Recognition of the role of Procurement	85
5.3.4. Development of Product Specifications	86
5.3.5. Purchase of Different Medical Equipment	86
5.3.6. Suppliers Symposium.....	88
5.3.7. Selection Criteria	89
5.3.8. Procurement Planning.....	90
5.3.9. Manual Purchasing and Supply Chain Management System.....	90
5.4. Procurement Challenges	91
5.4.1. Procurement Skills and Competences.....	91
5.4.2. Financing Hospital Purchases	92
5.4.3. Corruption.....	95

5.4.4. Stock levels	96
5.4.5. Storage Facilities	96
Summary of the Chapter.....	97
CHAPTER 6: ANALYSIS AND DISCUSSION.....	99
6.0 Introduction.....	100
6.1. Procurement Legislative Framework and Processes	100
6.2. Procurement Planning	102
6.3. Development of Product Specifications	103
6.4. Selection Criteria	104
6.5. Supplier Symposium.....	106
6.6. Recognition of the role of procurement.....	106
6.7. Manual Purchasing and Supply Chain Management System.....	108
6.8. Procurement Skills and Competences.....	109
6.9. Financing Hospital Purchases	110
6.10. Corruption.....	112
Summary of the Chapter.....	112
7. CONCLUSION AND RECOMMENDATIONS.....	114
7.0. Introduction.....	115
7.1. Conclusion.....	115
7.2. Recommendations.....	117
7.3. Procurement legislative framework and processes	117
7.4. Procurement Planning	118
7.5. Development of product specifications	119
7.6. Selection Criteria	119
7.7. Supplier Symposium.....	120
7.8. Recognition of the role of procurement.....	120

7.9. Manual Purchasing and Supply Chain Management.....	121
7.10. Procurement skills and competences	121
7.11. Financing hospital purchases	122
7.12. Corruption.....	122
REFERENCES.....	124
Bibliography.....	134
APPENDICES.....	136
Appendix 1: Letter Requesting Permission from the Hospitals (Sample)...	136
Appendix 2: Research Questionnaire from Hospital Respondents.....	137
Appendix 3: Raw Data on Questionnaires Responses from Hospital Respondents.....	146
Appendix 4: Personal Interview (semi-structured) from Hospital Respondents.	161
Appendix 5: Research Questionnaire for Suppliers of Hospital Commodities.	163
Appendix 6: Raw Data on Questionnaires Responses from Suppliers.....	169
Appendix 7: Personal Interview (unstructured) from Suppliers of Hospital of Commodities.	173
Appendix 8: Government of Zimbabwe Procurement Act.....	175
Appendix 9: Government of Zimbabwe Public Health Act of 1924.....	202

LISTS OF GRAPHS

Graph 5.3.1.5: Pie Chart showing Most Common Tender Type	81
Graph 5.3.5.1: Factors that are resulting in non-functional equipment	87
Graph 5.4.2.4: Factors behind delays in the completion of infrastructural projects.....	95

LISTS OF TABLES

Table 1: Main characteristics of Positivism and Interpretivism	53
Table 2: Interview Protocol	66
Table 5.3.1.1: Questionnaire response to the relevancy of the Procurement System to the health sector	80
Table 5.3.1.2: Questionnaire response to the fairness of the procurement system	80
Table 5.3.6.1: Attendance of a Supplier Symposium (Tender Conference/Training)	88
Table 5.3.7.1: Most Commonly Used Tender Evaluation Criteria	89
Table 5.3.8.1: Realistic supply time	90
Table 5.4.1.1: Receiving of feedback after tendering process	91
Table 5.4.2.1: Inadequate funds from Ministry of Finance	92
Table 5.4.2.2: Frequency of funds disbursements to hospitals	93
Table 5.4.2.3: Impact of frequency on funds disbursements on service delivery	93
Table 5.4.2.3: Number complains received regarding late payments	94

LIST OF FIGURES

Figure 1: Purchasing Cycle.....	12
Figure 2: Costs of a Manufacturing Company	15
Figure 3 : Porter's Five Forces Framework.....	17
Figure 4: Development of Supply Chain Strategy.....	23
Figure 4 : Kraljic's Purchasing Product Portfolio Matrix	26
Figure 5: Web of Public Accountability	29
Figure 6: Relevant Situations for Different Research Methods	55
Figure 7 : Summary of Steps Undertaken to Design the Questionnaire	70

LIST OF ABBREVIATIONS

BEE	Black Economic Empowerment
CIPS	Chartered Institute of Purchasing and Supply
COMESA	Common Market for Eastern and Southern Africa
ECC	European Economic Commission
EDI	Electronic Data Interchange
EDLIZ	Essential List of Medicines in Zimbabwe
FIFA	International Federation of Association Football
GDP	Gross Domestic Product
HSF	Hospital Service Fund
IT	Information Technology
MAD	Multiple Accountabilities Disorder
MCAZ	Medicines Control Authority of Zimbabwe
MOHCC	Ministry of Health and Child Care
NHS	National Health Services
Natpharm	National Pharmaceutical Company
OECD	Organisation for Economic Co-operation and Development
PPPs	Public Private Partnerships
P&SCM	Purchasing and Supply Chain Management
RBV	Resource Based View
RBZ	Reserve Bank of Zimbabwe
RFID	Radio Frequency Identification
RFQ	Request for Quotation
SPB	State Procurement Board
TCO	Total Cost of Ownership
UK	United Kingdom
UNICTRAL	United Nations Commission on International Trade Law
VEN	Vital, Essential and Necessary Drugs
VFM	Value for Money
ZESA	Zimbabwe Electricity Supply Commission

CHAPTER 1- INTRODUCTION

CHAPTER 1- INTRODUCTION

For decades, Purchasing and Supply Chain Management (P&SCM) occupied a peripheral role in most organisations; both private and state-owned. Vries and Huijsman (2011:159) further highlighted that while recognition of this critical function was low in both sectors, it was more pronounced in service sectors like the health. It is only in recent years that P &SCM has evolved to be recognised as a strategic function and a number of developments or factors necessitated that realisation. For example, in the public health sector, the need to ensure availability of medicines and cost-containment led to the desire to establish seamless, dependable, responsive and cost-effective supply chain networks that guarantee uninterrupted flow of hospital commodities (Nicholson 2012: 4; Wilding 2013).

Thus, the focus of this introductory chapter is to set the context of the research through providing the background of the study. This is followed by the statement of the research problem. Next, the rationale or justification for conducting the research is provided. Thereafter, research aims and objectives will also be presented. Finally, the structure of the thesis will be given.

1.1. Background of the Study

Globally, nations are faced with increased burden of diseases and death. Over the past few years, Ebola caused untold suffering and deaths with 28 646 cases recorded and 11 323 deaths up to March 2016 and this was according to World Health Organisation (2016). Not only that but cancer is becoming the leading killer with about 8.2 million people dying from cancer related illness and this was given by World Health Organisation (2015) and corroborated by US Centres for Diseases Control and Prevention (2015). Further, HIV and AIDS pandemic are still claiming lives and statistics indicate that about 1.6million people died in 2012. While diseases have affected the entire globe, Africa specifically the sub-Saharan region has been greatly affected.

It is therefore important to note that despite the pandemic of diseases, there remain serious health delivery challenges faced by governments. First and foremost, is the issue of availability of essential medicines and according to World Health Organisation (2016), availability is very low in low –to-middle income countries which is at 37.7% and 46%. This is exacerbated by the general prices of generic medicines which is twice higher than the international reference prices. In Congo and Philippines specifically, patients at public health facilities pay over 400% more than the stipulated international reference prices (World Health Organisation 2016). Low budget allocation which is less than 5%

of the total budget for the health sector in developing countries worsened challenges in the health delivery system. Unpredictability in timing and disbursement of funds has been also observed as the key financing challenge in the health sector.

Against this background of public health delivery systems, provision of affordable, consistent and quality healthcare services have been central for all governments. Managing healthcare costs so that the cost burden does not extend to patients remains one of the key priorities for public health facilities (Charkraborty, Bhattacharya and Dobrzykowski 2014:677). The issue of affordability and availability of healthcare services have seen the popularity of the "Obamacare" in the United States, for instance. Citizens and patients are increasing becoming sophisticated, more informed and focused on quality health (CGI 2014:4).

In view of the above health challenges in general, purchasing and supply chain management has been singled as one of the key levers in addressing availability of medicines, equipment and also as a tool for cost containment (Arney et al.2014:295; Kanyoma and Khomba 2013:27). The report by World Health Organisation (2011) further noted the centrality and strategic importance of procurement to most of the challenges faced in health delivery particularly issues related to medicines availability and cost.

Coming to the health situation in Zimbabwe, acute and persistent shortages of essential medicines have been reported at major public health institutions (Zimbabwe Independent 2014; Daily News 2014 and Herald 2016). This is further worsened by inadequate, non-functional equipment and infrastructure. For that reason, it is of paramount importance to give an overview of the health procurement system in Zimbabwe.

1.2. Health Procurement System in Zimbabwe

The mandate of providing quality and safe healthcare services is directly given to the Ministry of Health and Child Care. Under the Ministry of Health and Child Care, are health facilities or centres ranging from clinics to referral hospitals that are rendering such services to patients.

Coming to the issue of procurement of medicines, surgical consumables and reagents, a tier system is in place. The first tier is the National Pharmaceutical Company (Natpharm), who procures all the medical products required by the public hospitals and municipal clinics. Previously, Natpharm has been on record of failing to provide a comprehensive solution to hospital medical requirements as most drugs were not in stock. In cases Natpharm does not have the products which is currently the position, the respective hospitals can go tender for those products in line with the Procurement Act and Regulations 171 of 2002. This is the second tier.

Therefore, the procurement system depicts a semi-autonomous position in the sense that there is involvement of Natpharm and state hospitals in making purchases.

1.3. Statement of the Research Problem

The following excerpt from the Herald (2016) regarding the status of medicines in Zimbabwe provided an insight into the extent of the challenges in the health sector:

"An acute shortage of drugs has hit the country's major public hospitals with the situation likely to persist for the next months as the National Pharmaceutical Company await for the completion of the tendering process to replenish its stock".

Despite this shortage of medicines at hospital, there are also situations where drugs are also expiring at some health facilities and the following excerpt from Newsday (2015) indicated:

"Drugs are expiring at rural health centres and district hospitals whilst the central hospitals are in need of the same, and Pharmacy Directorate at the Ministry of Health and Child Care must as a matter of urgency start a workable redistribution system of the distributed drugs to reduce the quantities of drugs expiring". This was further reported by the Auditor and Comptroller General (2015) who highlighted that: "the inventory management system did not generate drug expiry and aged analysis reports. The generation of the expiry reports would help the hospital to monitor the expiry of drugs and slow moving items more effectively and in order to come up with the correct valuation of inventory" and this was part of the audit report regarding one of the major central hospital.

In addition to the above, reports of inadequate funding for the Ministry of Health and Child Care 2015 budget and also increasing cost of healthcare services have been noted. Blood and blood products are beyond reach of many patients and this is further worsened by the fact that some health facilities could not stock blood because of lack of refrigerators, electricity and the general poor infrastructure (Herald 2015). Furthermore, transport remains a challenge with most ambulances being poorly resourced in terms of equipment like oxygen and infusions (Herald 2015).

From the above described situations in the public health sector, it is evident that there are operational challenges mostly in purchasing and supply chain management that require to be explored in considerable depth hence the focus of this research.

1.4. Rationale

Despite various researches conducted in purchasing and supply chain management by a number of authors in different countries, public procurement in general has been perceived to be a neglected or a marginalised area of research academically. In cases of studies or researchers in public procurement conducted, a specific attention to the health sector was not satisfactorily and comprehensively given. It was however noted in the literature review that while studies were done in public management in different states some of the findings and recommendations were limited in application to the Zimbabwean context because of different operating environment hence need to concentrate a spotlight on Zimbabwe procurement practices and challenges in public health facilities.

A number of factors or developments in recent years have redirected the focus to purchasing and supply chain management by state institutions or enterprises. Continuous efforts to reduce costs in purchased commodities signalled the attention to purchasing and supply chain management (Larson et al.2009; Monczka et al.2009; This is further necessitated by the need to ensure consistent and uninterrupted flow of quality goods and services to demanding citizens and these factors heightened the recognition of purchasing and supply chain management as the key lever in the turnaround of service delivery (Program for Appropriate Technology in Health 2011; CGI 2014:2; Arney et al.2014:295).

Thus, in Zimbabwe the research coincided with government realisation of the strategic position of procurement in the turnaround strategy of the affected sectors like health. Further, the gravity, criticality and the persistent nature of the health challenges necessitates the finding of a sustainable and workable solution for the betterment of the general populace.

From the study, a number of stakeholders are set to benefit immensely. First and foremost, the government of Zimbabwe in terms of refining and realignment of procurement policies and practices in public procurement particularly in the health sector when all the operational and strategic gaps are identified. There is going to be a paradigm shift in how procurements are done which will have a net effect on savings and realisation of Value for Money. Second, the patients will also benefit when healthcare services are consistently and continuously provided at a low cost. Third and last, the research will provide a platform for other researches with focus on public health procurement practices and challenges to be conducted.

1.5. Research Aim and Objectives

Aim:

The research aims at investigating the procurement practices and challenges in public health institutions in Zimbabwe.

Objectives:

1. Identifying, reviewing and analysing the public procurement practices and policies in the health sector.
2. Identifying the challenges, operational and strategic gaps and how they can be mitigated or addressed.

Research Questions:

1. How important is procurement to the State Health Institutions and what is the level of recognition of the function?
2. What are the deep-seated procurement issues that are reflecting in the form of the challenges highlighted?
3. Why is the health delivery system encountering these challenges?
4. How are the procurement practices related to the challenges?
5. How then can the purchasing and supply chain management be improved in view of efficiency, effectiveness, competitiveness, transparency and self-sufficiency?

1.6. Limitations and Ethical Considerations

First, the sensitivity nature of the study was noted and appropriate action undertaken. Second, lack of breadth and depth of the existing peer-review journals and white papers to cover extensively purchasing and supply chain management in the health sector but useful framework was extracted from those sources. Time and resources constraints were observed and action taken accordingly.

Then, in terms of ethical considerations, there were very important ethical issues before, during and after the research process and these were addressed in sufficient detail. Thus, access to research sites, consent, anonymity, confidentiality and objectivity were addressed as part of ethical considerations.

1.7. Structure of the research

The research is composed of seven chapters sequentially organised and these are as follows:

Chapter 1: Introduction

This first chapter introduces the background of the research followed by statement of research problem. Rationale for conducting the research is provided and thereafter research aim and objectives as well as the research questions are presented.

Chapter 2: Purchasing and Supply Chain Management in Perspective

The chapter critically evaluate and analyse key concepts, models and academic discussions contained in literature in the field of Purchasing and Supply Chain Management. This chapter provides the theoretical frame work to the study.

Chapter 3: Public Procurement with reference to Zimbabwe

This Chapter is categorised in four sections, and the first discussed Public Procurement from the general perspective, while the second, looked at Public Procurement in Zimbabwe. The third reviewed global health procurement and the fourth, health procurement issues in Zimbabwe.

Chapter 4: Research Methodology

The fourth chapter first present in significant depth the two research paradigms and lays the basis and justification for the selection or adoption of the case study method. Data collection methods and analysis is finally presented.

Chapter 5: Presentation and Analysis of findings

This Chapter mainly presents the qualitative and quantitative findings. Detailed analysis is reserved for the next chapter.

Chapter 6: Analysis and Discussion

Detailed analysis and discussions of findings presented in the previous chapter is done in this chapter.

Chapter 7: Conclusion and Recommendations

The last chapter of this thesis provides first the conclusion; highlighting also the linkage between published literature and findings. Thereafter, recommendations are proposed in light of the analysis and discussion of the findings.

1.8 Summary of the Chapter

Globally all nations are affected by diseases and death but Sub-Saharan Africa is greatly affected. In Sub-Saharan Africa, Zimbabwe specifically has their fair share of challenges that include shortages of medicines, equipment, high healthcare costs and inadequate health financing. In light of those challenges, the study aimed at investigating the purchasing and supply chain management practices and challenges. The justification for conducting the research is premised on insufficient attention given to purchasing and supply chain management in the public health sector. Many stakeholders including the government, both at central and ministerial level can immensely benefit in terms of policies and procedures realignments and most importantly, the patients in terms of improved healthcare services.

CHAPTER 2- PURCHASING AND SUPPLY CHAIN MANAGEMENT IN PERSPECTIVE

CHAPTER 2 - PURCHASING AND SUPPLY CHAIN MANAGEMENT IN PERSPECTIVE

2.1. Introduction

This Chapter provides a detailed theoretical framework of the research by critically evaluating and assessing key concepts, models, theories and academic discussions in the field of Purchasing and Supply Chain Management. From that review, gaps in research will be identified.

2.2. Purchasing and Supply Chain Management

In order to fully and clearly understand the area under investigation, it is deemed imperative to first define key definitions and outline the context.

Definition of Concepts

Van Weele (2005:12) provided a comprehensive and understandable definition of **Purchasing** and it is as follows:

"The management of the company's external resources in such a way that the supply of all goods, services, capabilities and knowledge which is necessary for running, maintaining and managing the company's primary and support activities is secured at the most favourable conditions".

While Simchi-Levi, Kaminsky and Simchi-Levi (2008:1) defined **Supply Chain Management** in detail as:

"A set of approaches utilised to efficiently integrate suppliers, manufacturers, warehouses and stores, so that the merchandise is produced and distributed at the right quantities, to the right locations, and at the right time, in order to minimise system-wide costs while satisfying service level requirements". From this definition, several concepts need to be broken down.

What this means is from the suppliers, manufacturers, distributors, retailers and final customers there are processes which require to be integrated in a manner seamless so that there is minimisation of costs but a systems approach is applied to costs at every stage and facility within the supply chain network. Not only are the costs important to minimise but addition of value in the supply chain network (Christopher 2011).

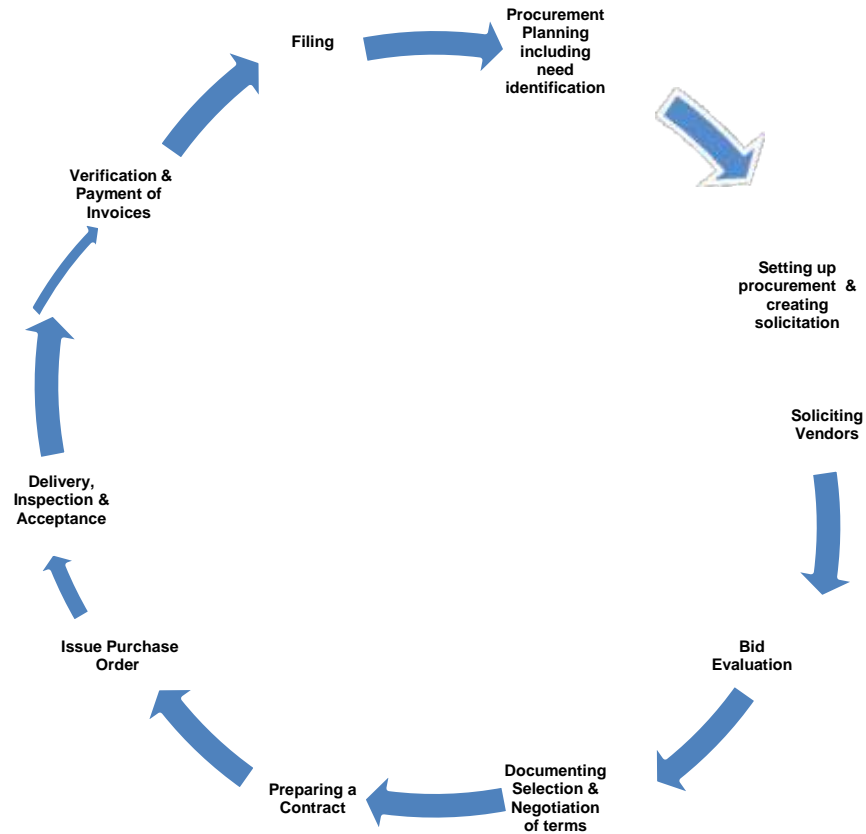
Having provided the definitions of the two key concepts in this study, the next section will first focus on purchasing and thereafter supply chain management in greater detail. Adoption of this format of presentation is premised on the fact that the two functions: purchasing and supply chain management are separate though related and intertwined.

2.2.1. The Purchasing Process

At the onset, it is quite crucial to understand that purchasing as a process involves a series of stages which are in a form of a cycle and these stages can be best presented in the form of the diagram below. Understanding of the sequence and importance of these stages is critical to appreciate how purchasing functions

in organisations. In general, the purchasing cycle differs from organisation to organisation as it is governed by legal requirements, purchasing policies and procedures.

Figure 1: Purchasing Cycle



Source: Authors

From the diagram above, the purchasing cycle start with procurement planning which essentially involves need identification. In literature, many authors do not clearly indicate procurement planning but it is imperative that the cycle begins with it. The procurement or purchasing process begins with determination of requirements (goods and services) which could be for the whole year with particular timelines for each product as specified by the requesting department or user. Following this stage, there is setting up of the procurement and solicitation. In other words, it is the process of coming up with product or service specifications, be it functional or technical type and the appropriate solicitation mechanism that best fulfil the organisation's strategy and internal processes and general guidelines. After that process, the next stage will be tendering which essentially differs if it is public entity or a private organisation because different avenues will be pursued. When bids are received, evaluation of the bids is done and subsequently, awarding of a contract or Purchase Order. Evaluation or selection of an appropriate supplier is quite crucial and this will be extensively discussed in the coming sections. Goods are delivered and inspected. The final

stages are the payment of the goods and services and the filing of the procurement documentation. The last stages are equally important in that failure to pay for the supplied commodities have serious supply chain issues which will be discussed later in the chapter. Also, filing is very important in that the procurement documentation should be properly filed for scrutiny by the Comptroller and Auditor General in the case of public procurement.

From the purchasing cycle, it is quite clear that the core responsibilities of purchasing function in organisations involve:

- **Supporting of the organisation's primary activities (Van Weele 2005:82)**
It is the duty of the purchasing function to ensure uninterrupted flow of commodities. The commodities supplied should be high quality. As Van Weele (2005:82) rightly indicated, failure to discharge this role result in departments bypassing the procurement department and conducting purchases independently and even leading to lack of recognition of the procurement function. In other words, if it is a hospital, it is required that all medicines, reagents and equipment are available to patients and procurement should support that availability.
- **Managing and controlling of purchasing-related Costs (Van Weele 2005:82)**
When purchasing commodities, it is expected that they are secured at the lowest Total Cost of Ownership (TCO) and not just that lowest price. TCO considers both the direct and indirect costs hence it is comprehensive and holistic. It is thus, the responsibility of the purchasing function to ensure that the selection criteria utilised looks at price and non-price factors in their entirety and not myopically.
- **Managing of supply-chain related risks (Van Weele 2005: 83; Wilding 2008; Christopher 2011)**
Given the volatility and turbulence in today's global markets, supply chain risk reduction is the prerogative role of purchasing and supply chain management. It follows that development of appropriate supply chain strategy in line with the product type and market nature is quite important. Product shortages threaten the global supply chain networks.
- **Contributing to Innovation (Van Weele 2005:83)**
Due to constant interface of purchasing and suppliers of commodities, literature had shown that suppliers are a source of innovation in terms of products and services and for that reason, good supplier relations which also tap into the innovation and benefit the organisation is necessary. In motor industry, Toyota has demonstrated that innovation is tapped from suppliers and even in pharmaceutical sector as well.
- **Determination of product specifications**
It is again the responsibility of the purchasing function to come up with correct product specifications that are generic and not brand specific.

Crafting of appropriate specifications requires management of internal relationship with key requesting departments. For example, if it is in a hospital, a seamless approach with the Pharmacy is important in order come up with correct specifications of medicines. Failure to have good relationship may limit the potential of coming up with relevant specifications which encourages competition.

- **Adherence to Legal ,Ethical and Commercial Standards**

This is crucial for both public and private sector organisations. Adherence to legal, ethical and commercial guidelines pose greater impact in the health sector because of its general sensitivity. For instance, the procurement of medicines should ensure that the required medicines are registered in line with local laws.

Therefore, it is not difficult to see that the role of purchasing and supply chain management is no longer a clerical, transactional and administrative role but it has emerged as a strategic, relational function in organisations. It is critical to consider the evolutonal stages and the strategic role of purchasing and supply chain management and to reflect on other broader developments that have shaped the function.

2.3. Evolution and Strategic role of Purchasing and Supply Chain Management

In order to correctly position the role of P&SCM in organisations, both state and private, it is critical to reflect on historical developments that have shaped the functional area.

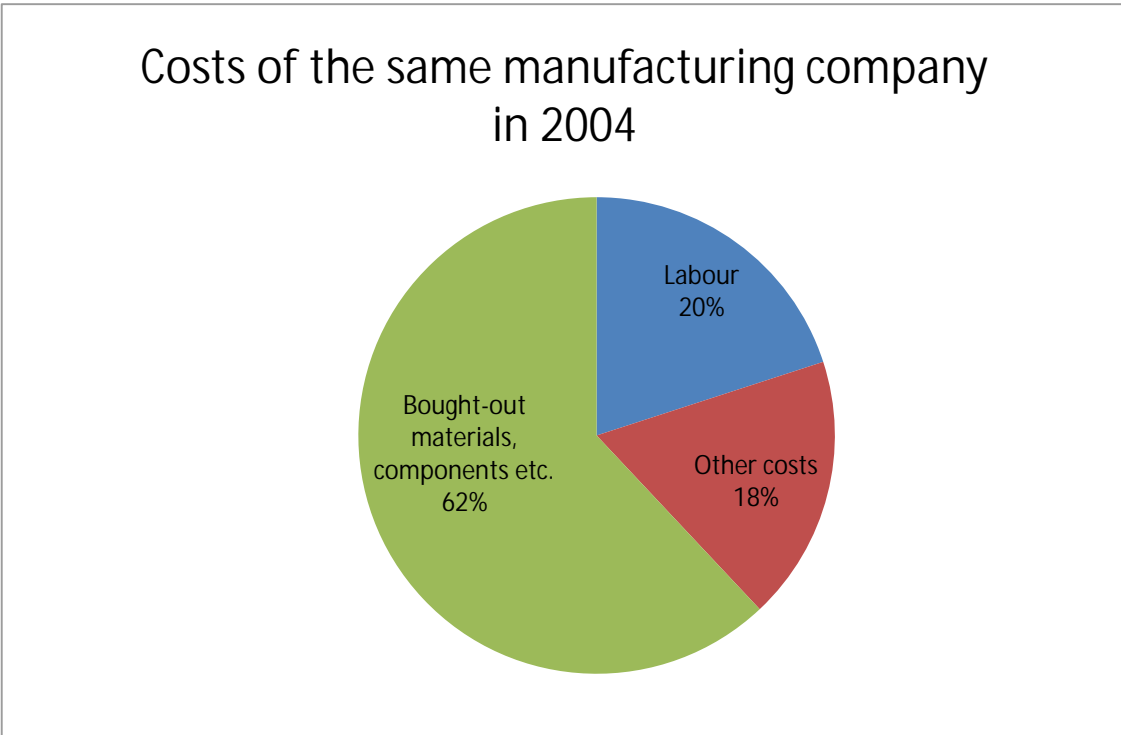
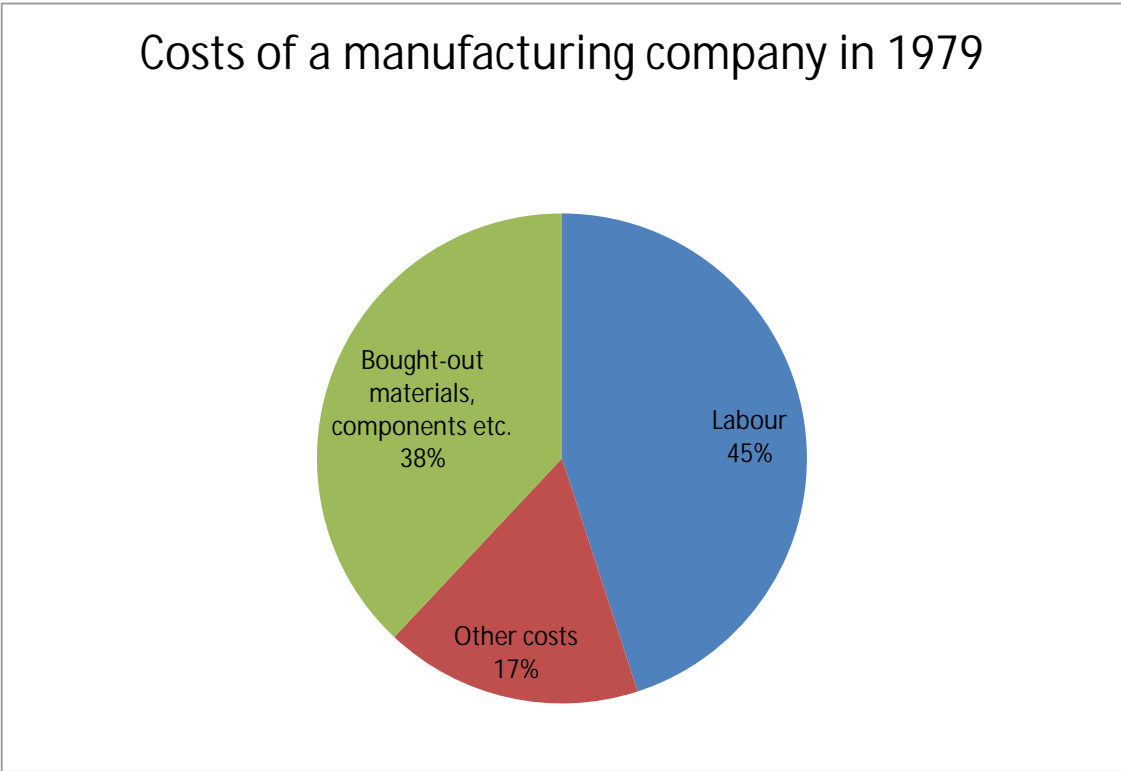
During the industrialisation era, the focus of manufacturing was on mass production and cost reduction. The concern then was to produce more commodities to deal with shortages and customers merely accepted whatever was available. A typical example of the scenario was the famous statement by Henry Ford: "You can have any colour, as long as it is black". This referred to the Model T version of the Ford vehicle which was only available in black irrespective of one's colour preferences. However, rapid developments that have seen the growth of the marketing concept where customer needs became sophisticated and demanding, led to the realisation of the strategic importance of P&SCM in organisations. The situation was further exacerbated by significant inflationary pressures against limited budgets.

It is therefore crucial to analyse in detail the factors or developments that have led to the recognition and establishment of P& SCM as a strategic function.

2.3.1. Costs

To illustrate how the proportion of purchased products have increased relative to other costs of production, a pie chart provided by Lysons and Farrington (2006:19) for periods 1979 and 2004 respectively will be presented as follows.

Figure 2: Costs of a Manufacturing Company



Source: Lysons and Farrington (2006:19)

It is evident from the pie chart above that there is unprecedented increase in costs of purchased products in 2004 by a significant margin relative to the labour costs. Previously, the concern was on labour costs but from 2004, the focus is on procured commodities and that explains why the business and management focus is on P&SCM as the key lever to competitiveness and cost reduction (Larson et al. 2009). This is premised on the fact that P&SCM is the conduit of organisation's expenditure on purchased products. It is therefore not difficult to see why purchasing and supply chain management has been a focal point for cost savings (Monczka et al.2009:7). Suppliers represent the purchasing organisation's largest costs.

2.3.2. Globalisation and Information Technology.

Organisations have been compelled to look beyond traditional sources of supply and demand in search of competitiveness. This precipitated in the growth of outsourcing of non-core activities as business consider low labour cost nations like China. Further, motivation of globalisation is emanating from deregulation by trading governments for example, General Agreement on Tariffs and Trade (GATT), European Economic Community (ECC) and Common Market for Eastern and Southern Africa (COMESA). Increased growth of IT in the form of Radio Frequency Identification (RFID) and Electronic Data Interchange (EDI) has literally made traditional borders obsolete (Van Weele 2005). This has heightened the recognition of the strategic role of P&SCM in effective management of disparate global supply chains markets in a cost effective and responsive manner.

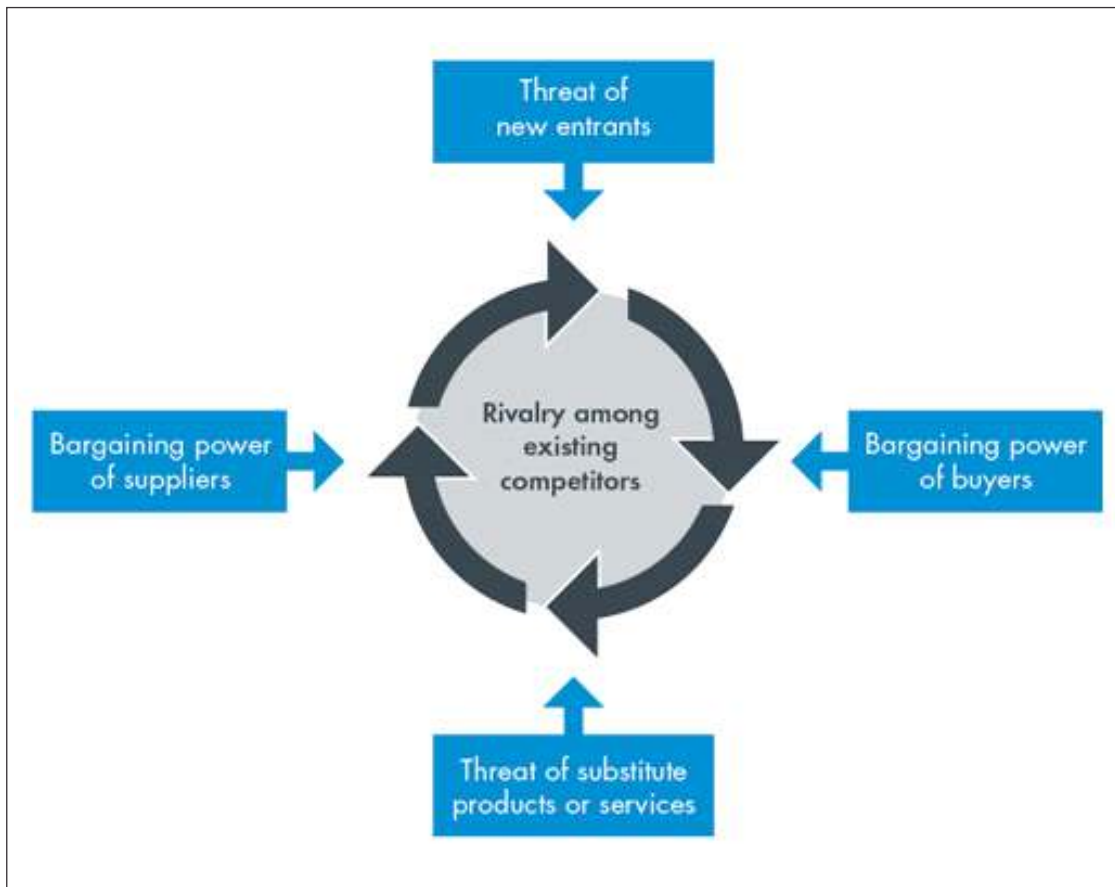
2.3.3. Demanding nature of customers

As indicated in the foregoing paragraphs, the nature of customers has drastically changed from accepting whatever was available to a position of "commanding their first choices in products and services" (Van Weele 2005). As a corollary, organisations do not have the in-house capacity to unilaterally confront the multiple and varied needs hence the strategic role of P&SCM in linking the organisation to boundless potential of suppliers. Suppliers are therefore involved in the previously "sacred" areas of product research, design and development in order to satisfy customer needs in a timely and cost effective way.

Thus, the work of Porter (1980); Five Forces Framework or model, though presented three decades ago is still relevant today in illustrating the importance of P&SCM in today's organisations. The Five Forces Framework as shown in the diagram below are threat of new entrants, bargaining power of buyers, threat of substitute products or services, bargaining power of suppliers and rivalry among existing competitors. As strongly and sensibly argued by Mol (2003:44), three of these forces "involves suppliers of a firm and therefore purchasing management". Organisations continuously find ways of enhancing their bargaining power versus their supplier's perhaps through the aggregation of requirements. The threat of new entrants and substitute products as presented by Mol (2003) emanates primarily from suppliers who are mismanaged by the purchasing organisation. Suppliers may in turn exploit their specialist knowledge to produce perfect substitutes if supplier relations are not well

managed. It is therefore, supply chain management that "provides idiosyncratic inter-firm linkage" that leads to competitiveness (Dyer and Singh 1998:61).

Figure3 : Porter's Five Forces Framework



Source: Porter (1980)

Despite these convincing academic debates that support the importance of P&SCM to sustainable competitive advantage of firms, there are authors like Ramsay (2001) who strongly contended the strategic role of P& SCM applying the Resource Based View (RBV) concept. This is of course raise debate as to whether the concept of RBV is valid to test the strategic role of purchasing and supply chain management. Other authors like Rozemeijer (2008) classified such arguments as "purchasing myopia", meaning that the Purchasing function is, to borrow Monczka et.al (1998) 's words is "much more than mere ordering of pencils"-it is strategic. Other organisations have followed Ramsay's philosophy as evidenced by Zheng et.al (2007) whose studies unearthed the employment of non-purchasing staff who do not sit in a purchasing department. This alone proved lack of recognition for the strategic role of P& SCM.

From discussion of the evolution and strategic role of purchasing and supply chain management, it is also relevant to consider the purchasing environment.

2.4. Understanding the Purchasing Environment

All organisations (public and private) do not exist and operate in a vacuum and that equally apply to the purchasing function. In terms of the operating environment, there is the external and internal and these need to be understood from the perspective of purchasing. This is because the development and crafting of purchasing strategy (which will be discussed in the coming section) is dependent upon it. By definition, external environment which is usually referred to as the macro environment, relates essentially to factors or influences that are outside the control of the purchasing organisation. Internal environment or the micro environment mainly is concerned with factors which are within the organisation, for example, the available resources, the organisational structures, policies and procedures.

As highlighted above, the external environment influences on organisations usually represent the Political, Economic, Social, Technological, Environmental and Legal (PESTE) (Lysons and Farrington 2006: 49). These factors can be explained briefly as:

- **Political-** on this factor the policies and Acts of government as the regulator and sometimes implementer is looked at in terms of both the opportunities and risks they pose.
- **Economic-** this external factor considers aspects such as the monetary and fiscal policies and other economic interventions. A typical example in Zimbabwe was the monetary interventions which were introduced through the Reserve Bank of Zimbabwe (RBZ) that introduced the use of bond notes alongside other major currencies like the United States Dollar, Euro and the South African Rand. This was coupled with restrictions of external payments of goods and services to outside sources. Thus, analysing this factor may mean lengthy procurement process if suppliers are first required to apply for the release of funds from their accounts to a manufacturer in Europe. It may also imply that the general cost of commodities purchased will be high because the foreign currency will be sourced on the parallel or black market.
- **Social-** according to Lysons and Farrington (2006:49), this factor or influence relates to social trends, cultural patterns etc.
- **Technological-** use of Information and Technology and the rate of change impact even on procurement processes, general costs and competitiveness.
- **Environmental-** presently there is pressure about creating a sustainable environment and part of that have culminated into sustainable procurement as well as green procurement. Some chemicals or even reagents have been banned merely for ecological reasons. An understanding of these matters is of paramount importance.
- **Legal-** this applies to laws; national, regional or international and how they impact the organisation. Understanding of how the Procurement Act and Regulations influence purchasing decisions in Zimbabwe, as an example, is critical

Then, internal or micro environment understanding is aimed at the organisation itself and the industry in general.

Various models, tools and strategies such as Porter's Five Forces Framework, SWOT (Strength, Weakness, Opportunities and Threats), Sensitivity Analysis and PESTE Model can be utilised in understanding the purchasing environment. Thus, the overall aim of understanding the environment is mainly to identify variables or factors that are likely to impact the organisation and devise a counter purchasing strategy. In today's global, volatile, unstable and turbulent environments and markets, this is quite critical for organisation survival.

2.5. Development of Purchasing Strategy

It is crucial first to note that the purchasing department in any organisation is at the functional level just as finance department or marketing and they exist to support the corporate level. Bearing this in mind, the development of a purchasing strategy as explained above, is hinged on perfect understanding of the corporate objectives of the organisation, the external and internal forces at play, the available resources and the requirements of the organisation. If the purchasing strategies do not address these pertinent matters, then it will be misfiring. An example of how purchasing strategy can support the corporate objectives of a hospital can be as follows:

Corporate Objective(s)	Purchasing Strategy
Ensure consistent availability of medicines to patients	<ul style="list-style-type: none"> • Establishing alternative sources of supply. • Establishment of strategic partnerships, contracts with key suppliers that included Basic Ordering Contracts. • Management of supplier relationships
Provision of affordable healthcare services to all patients	<ul style="list-style-type: none"> • Adopting a lower cost strategy when purchasing (competitive tendering). • Supplier base broadening to include regional and international suppliers. • Price negotiations

Economical use of scarce resources	<ul style="list-style-type: none"> • Adoption of the Pareto Rule or the ABC Analysis as the basis for identification of priority areas. If for example, there are limited financial resources; prioritisation could be in line with the Vital Essential Necessary (VEN) guidelines that clearly explain which drugs are critical.
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Source: Authors

2.5.1. Management of Supplier Base

Lyson and Farrington (2006:391) described supplier base as the, “number, range, location and characteristics of the vendors that supply the purchaser”. The supplier base can be viewed as broader, narrow, sole-source (monopoly), local, regional and international. Generally, there are number of factors that influence the nature and size of the supplier base and this includes but not limited to, the scope of and nature of organisations' requirements and volatility or stability of the supply market as depicted by Kraljic's(1983) positioning model. In most cases in public procurement, the size of the supplier database is not unilaterally decided by that particular public entity but it is influenced by the procurement laws and regulations that prescribe and encourage competitive tendering.

Thus, supplier base rationalisation which is a process of establishing a manageable number of suppliers commensurate to the organisation's requirements, can provide both advantages and disadvantages which need to be identified and managed (Lysons and Farrington 2006: 391).

Advantages of Supplier Base Reduction

- There is an opportunity to focus on supplier relationships.
- In terms of procurement system integration, it is much easier than a case where there are various suppliers e.g. use of Electronic Data Interchange.
- Lower administrative costs like tendering.

Disadvantages of Supplier Base Reduction

- Reducing the number of suppliers may be a departure from principles of competition and violation of procurement laws in public procurement settings.
- There is supply risk because of a creation of some sort of an oligopoly market structures and potentially can create overdependence on few suppliers which can be exploited to the purchasing organisation's disadvantage.

- In some cases, reducing the number of suppliers entails reduction of purchasing leverage.

2.6. Supplier Selection and Evaluation

Consistent with the foregoing paragraphs, how suppliers are selected and evaluated impact on the organisation's performance in terms of competitiveness, efficiency and effectiveness. While there is a general consensus that price is not everything, purchasing decisions are to a greater extent, hinged on price alone. This limited approach on supplier selection and evaluation was influenced by traditional accounting system that consider price as an overriding factor, ignoring other costs; direct and indirect such as quality, supply lead-time, availability of back-up service and disposal costs (Garfamy 2006).

While there are several approaches available in literature like the Analytical Hierarchy Process, the concept of Total Cost of Ownership (TCO) or Life Cycle Costing (LCC) represents a comprehensive and holistic approach towards supplier selection and evaluation. This is premised on the fact that the TCO method goes beyond price by incorporating other price-related costs associated with the purchasing cycle from acquisition to disposal (Garfamy 2006).

This approach to supplier selection is quite important to be utilised in the procurement of medical equipment as a classical example. This is because, equipment like Chemistry Analyser for example, could be cheaper by merely looking at the purchase price but long –term costs of reagents may far surpass the costs of equipment.

However, the disadvantage of using the TCO approach is that it requires readily available costs data which could be difficult to consolidate accurately at the time of supplier selection. Further, the concept is biased on quantifiable costs issues and neglecting the qualitative aspects which could of paramount importance in the selection of suppliers (Bhutta and Huq 2002).

After looking at purchasing in greater detail, supply chain management can now be discussed and reviewed.

2.7. Supply Chain Management

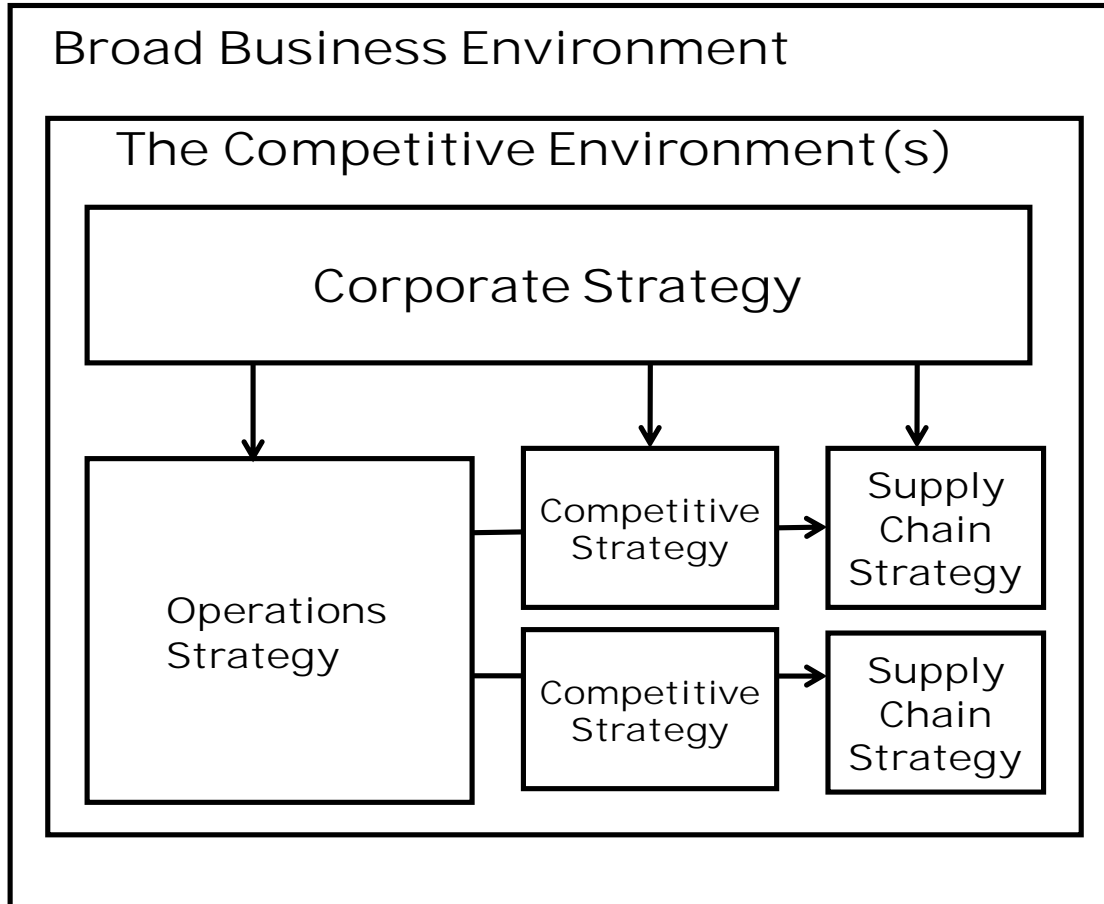
Supply Chain Management is relatively a new concept that was designed following other manufacturing strategies, tools and technologies which sought to reduce costs and enhance competitive advantages (Simchi- Levi, Kaminsky and Simchi-Levi 2008:7). Previously, strategies like Just In Time (JIT) which originated in Japan, Kanban, lean manufacturing, Business Process Re-engineering and Total Quality Management were meant to address issues of costs, effectiveness and competitiveness. Most of the mentioned tools were prominent in the 1980s. However, the complexity, volatility and the disparate nature of the global supply chains and the increasing costs resulted in supply chain management becoming most recent, useful and important strategy in addressing those operational aspects (Simchi- Levi, Kaminsky and Simchi-Levi 2008:7).

2.7.1 Supply Chain Strategy

Chopra and Meindl (2004:1) indicated that the development of the supply chain strategy is derived from the competitive strategy of the organisation. It is the competitive strategy that defines and outlines how the organisation satisfies its customer needs through products and services. In some cases, the organisation may have different competitive strategies for different markets, for example, an organisation based in the United States may have a different competitive strategy in Africa where the customers or consumers value affordability at the expense of responsiveness.

Thus, the diagram below illustrates clearly that supply chain strategy needs to be well synchronised with the competitive strategy (Chopra and Meindl, 2004:30). Thus, the supply chain strategy development and formulation begins with understanding of the influences of the broad business environment which impacts on the operations of the organisation. On the diagram below is the Corporate Strategy which essentially contains the mission as well as the strategic intent of the organisation. After the corporate strategy, is the competitive strategies which are naturally crafted by the marketing people. As sufficiently explained by Wilding (2008), it is the marketing people who know what drive value in the organisation. Therefore, for supply chain strategy to be effective, it should be well synchronised with the competitive strategy. For example, the market served by DHL requires speed, responsiveness and dependability and the competitive strategies are developed around those variables and the supply chain strategy complements that. If for example DHL marketing people's strategies is on swift delivery of parcels and the supply chain strategy is targeting low cost, there is likely to be discord which will suffocate the competitive strategy. Even in a hospital set-up, the clinical strategy is more or less the same as the competitive strategy should be functionally supported by the supply chain strategy. This is exactly what is depicted by the diagram on the next page (Figure 4).

Figure 4: Development of Supply Chain Strategy



Source: Authors

Having explained in detail how the supply chain strategy is developed and the importance of finding a strategic fit, the next section will discuss and review the supply chain drivers.

2.7.2. Supply Chain Drivers

According to Chopra and Meindl (2004:52), the organisation in its supply chain strategy should provide for a good strategic fit between responsiveness and efficiency (cost). In light of that, there are, as highlighted by Chopra and Meindl (2004:52), four drivers of performance within the supply chain and these are: facilities, inventory, transportation, information. The four drivers will be examined and discussed in terms of their relative role in the supply chain in that order. Substantial review of this important concept will be drawn mostly from Chopra and Meindl (2004:52) mainly because of clarity in the presentation of supply chain drivers.

2.7.2.1. Facilities

By facilities, this refers to locations in the supply chain network where products are manufactured, stored and warehoused. The location of the production site and warehouses has wider implications in the supply chain. Chopra and Meindl (2004:52) indicated that it is not only the location but the capacity and flexibility of facilities that are critical in supply chain performance.

Thus, location of the facilities impact on responsiveness and cost in the supply chain and that explain why they are classified as drivers. Taking Bayer Healthcare as an example, production and warehousing facilities may be in Germany and there could be economies of scale which accrue from bulk production at one central facility. This will have the greatest positive impact on costs. However, if Bayer Healthcare for example, has Africa as one of its greatest markets for medicines, it means maintaining facilities in Germany will impact on responsiveness as the company will be unable to respond in a timely manner to demand changes in Africa. In the motor industry that explain why Toyota has production assemblies in many countries including South Africa just to manage the responsiveness. However, in some cases, there could be some trade restrictions in certain countries in the case of opening a subsidiary.

Therefore on this supply chain driver, placement of facilities is not a matter of tossing a coin and decides but it is a careful, strategic matter that has wider implications in terms of responsiveness and cost.

2.7.2.2. Inventory

Inventory is a term that usually refers to finished products, raw-materials, components and sometimes, work-in-progress. The reason, according to Chopra and Meindl (2004:56) why inventory is kept is because of mismatch between supply and demand. Where responsiveness is critical like in the pharmaceutical, holding stock is important but there are also costs associated with that like in the case of medicines or reagents with a shorter shelf-life. If these products are stocked and expire in the warehouses it counts as a cost but again, if a customer requires the product and is out of stock, it also means loss of revenue and potentially a risk to patients. If the competitive strategy established is on responsiveness, it follows therefore that the supply chain strategy should ensure continuous availability of the products and this is more pronounced in the health sector where unavailability of a drug has serious effects on the condition of the patient. In the case of a low cost market being pursued, stock holding is likely to increase costs of products and consequently, stocks should be minimal. Inventory management as a supply chain driver has culminated into concepts like Minimum and Maximum Stock Level, Emergency Order Level, Safe Stock and Re-order level, all in an effort to manage responsiveness and costs.

2.7.2.3. Transportation

Movement of products from the manufacturer, distributor and to the final customer is achieved through transport and there are various modes which include air, road, pipeline, rail, ship and lately electronic. These various modes have different responsiveness and cost implications depending on the type of the market. Where the market is greatly concerned with responsiveness, air route can be employed to deliver the product but there is a cost implication. In the same manner, where costs or affordability is paramount to that specific market, sea route may be considered to address that component.

Related to transportation is the decision concerning routes and networks because they impact significantly on responsiveness and cost and this is with respect to direct and indirect routes. In Zimbabwe, importers of second-hand

vehicles prefer to use Tanzanian port to receive vehicles from Japan as opposed to receive them via Durban, South Africa. The reasons could be a combination of responsiveness, risk and costs.

2.7.2.4. Information

Information as a major supply chain driver may not be positioned as such and Chopra and Meindl (2004:61) point to the fact that information does not have physical presence as facilities, inventory and transportation. This should not lessen the critical role of information as a driver. However, it is important to note that Simchi- Levi, Kaminsky and Simchi- Levi (2008:143) seemed to cover some very important aspects of information.

The major challenge of information sharing within the supply chain network is the unwillingness to share and this could be motivated by the mistrust that exists within the supply chain. Partners in the supply chain network do not know how the information shared is going to be used. Part of the fear is that the information can be extended to competitors. Efficient and effective supply chain network design and planning are mainly based on accurate information shared. Challenges of demand variability (Bullwhip or the Forester Effect) are best addressed through information sharing and as well as forecasting. More importantly co-ordination and integration is enabled by information sharing and hence it becomes of the key drivers in supply chain performance.

As a way of incentivising and facilitating accurate information sharing, Simchi-Levi, Kaminsky and Simchi-Levi (2008:162) proposed use of Capacity Reservation Contracts and Advance Purchase Contracts. This will allow the supply chain partners to release correct and valuable information.

2.7.3. Supplier Relationships

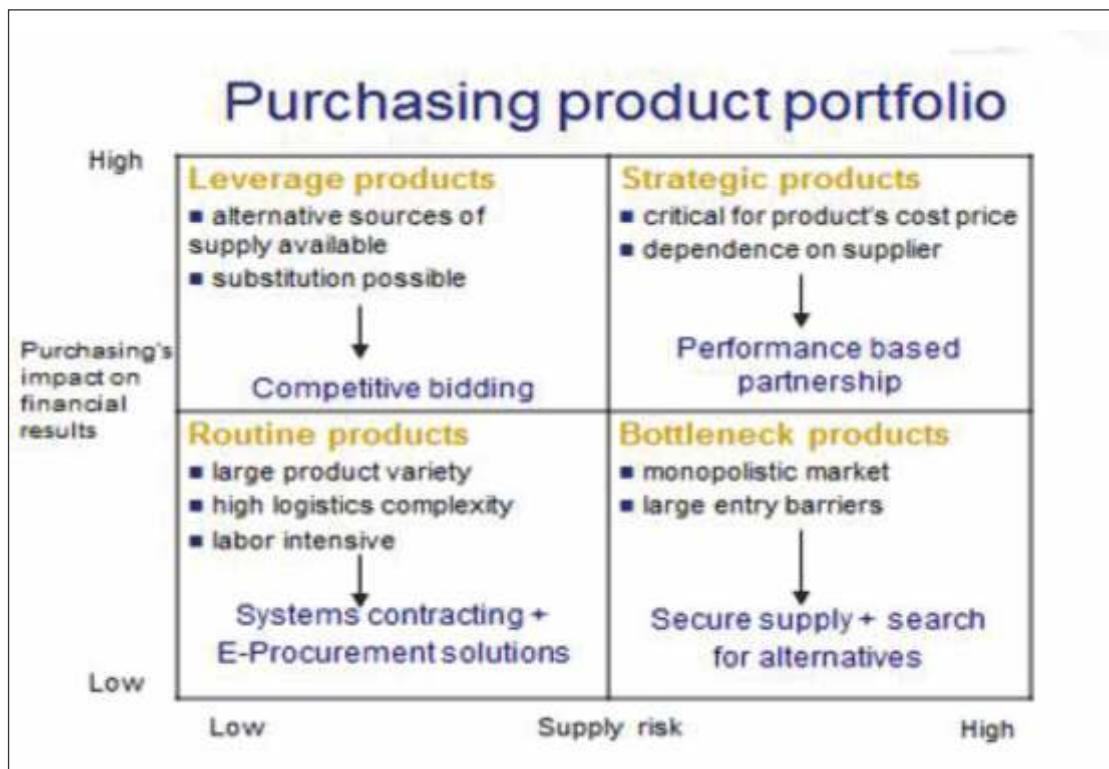
According to Wilding (2008; 2013), the central principle behind Supply Chain management (SCM) is the issue of management of relationships in the supply network. For that reason, the success of an organisation is heavily hinged on the identification, selection and subsequently the appropriate management of suppliers of commodities. The corporate attitude towards suppliers is of strategic importance amid the drastic increases of expenditure in bought –in commodities. The traditional arm's length approach has lost relevance owing to the increasing need for a collaborative, relational approach. Why do relations matter? Kraljic (1983) cited turbulence and instability in the supply markets, resource depletion and product scarcity as necessities for close collaborative relationships with suppliers. A "customer is king" philosophy no longer holds water in light of broad changes in the internal and external business environment.

To illustrate how supplier relationships managed to give competitive edge to procuring organisations, a three year study in automobile industry was conducted. Suppliers were then requested to rate their relationships with customers (purchasing organisations) and Japan's Toyota, Honda and Nissan were rated the highest ahead of Chrysler, Ford and General Motors who were even rated below the median(Monczka 2009:7). Good supplier relationships were cited as their lever in light of cost and quality impact their products have.

Thus, the model by Kraljic (1983) can be applied or utilised by organisations to adopt a correct and relevant P&SCM strategy consistent with the nature of their purchasing requirements. Gelderman and Van Weele (2005) discussed the criticality of the model in differentiating the various mechanisms or approaches for managing supplier relations. A straitjacket approach cannot be uniformly applied to all suppliers hence need to classify the most appropriate relationship to adopt under given circumstances.

The model according to Kraljic (1983) categories an organisation's purchased products or items into four distinct quadrants on the basis of profit impact and supply risk as shown below.

Figure 5 : Kraljic's Purchasing Product Portfolio Matrix



Source: Van Weele (2005)

Each of the four quadrants demands a distinctive approach towards supplier relations or management (Gelderman and Van Weele 2005). For example, the routine quadrant are products that are usually low value items available from a number of suppliers and the focus will be on managing transaction costs. The value of the product is less than the process of acquiring them. Bottleneck matrix represents a high risk and low expenditure products and it is often the case of highly specialised equipment available from a monopoly source. Key in this product category is to secure alternative sources. Leverage quadrant as depicted in the diagram is characterised by low risk and high expenditure where products are available from a number of sources and in addition, substitute products are also available. This is where competitive bidding is most desirable due to the presence of large number of suppliers. Lastly, strategic matrix

signifies commodities that are critical to the organisation and is characterised by high risk and expenditure. There is high dependence on suppliers' innovation and expertise and that calls for a collaborative approach with the few suppliers. Despite the usefulness of the model towards supplier relations, there is a considerable debate in literature in terms of the downside of the approach. First and foremost, some authors strongly contended the sufficiency of just two variables: profit impact and supply risk. This criticism emanated from the complexity of business decisions which may not be practically reduced to these two factors (Gelderman and Van Weele 2005).

Second, the model recommended the exploitation of the suppliers' dependence by trying to avoid unfavourable balance of power- a position which may retard the development of win-win collaborative relationship (Dubois and Pedersen 2002). Maximising profits and reducing risks at the detriment of the other can be frustrating in the supply chain network particularly for suppliers.

2.7.4. Supply Chain Co-ordination and Integration

This section is covered in considerable depth by Simchi-Levi, Kaminsky and Simchi-Levi (2008:188). Failure to co-ordinate and integrate exposes the organisation to greater supply chain risks and challenges. Issues of bullwhip effect and increases costs in the supply chain are typical challenges of lack of integration and co-ordination. The variety and multiplicity of stakeholders in the supply chain network definitely requires some form of co-ordination and integration from the manufacturer's manufacturer, distributors to customer's customers. As explained before, information and communication technology plays a centre stage in terms of co-ordination and integration. Thus, it is the co-ordination and integration of the front end and the back of the supply chain which is critical.

Therefore, in literature there are supply chain strategies aimed at co-ordinating and integrating the supply chain network which includes the push strategy, pull strategy and push-pull strategy and these will be briefly explored in turn.

2.7.4.1. Push Strategy

The push strategy is defined by Lysons and Farrington (2006:335) as "when products are manufactured in anticipation of demand and production is based on long-term forecasts and, therefore uncertain". However, the potential challenges of this strategy is on timely reaction to changes in the market since it is based on forecasts and in some cases, it may lead to product obsolescence particularly in high technology sectors like IT and medical equipment.

2.7.4.2. Pull Strategy

This strategy is the opposite of push strategy in that production and distribution is in response to specific orders from the customers and not necessarily from forecasts. In pull systems, no inventory holding is done as production can only be commenced upon receiving of an order. However, a pull system or strategy work best where there is a highly integrated information and communication technology like the use of Point of Sale (POS) and Electronic Data Interchange (EDI). Thus, using this method, impact positively on cost reduction but the

demerits of the system is on failure to capitalising on bulk production which leads to economies of scale. Also, the pull strategy can be impractical to implement where there are longer lead times to respond to customer demand (Simchi-Levi, Kaminsky and Simchi- Levi (2008:190).

2.7.4.3. Push-Pull Strategy

This is a hybridisation of the push approach in the first stages of the supply chain and the pull system in the last stages of the supply chain and the interface between the two is classified as the push-pull boundary (Lysons and Farrington 2006: 335).

Having looked at these strategies that discussed supply chain co-ordination and integration, which approach from the three can be appropriate? The author accepted and agreed to a larger extent with what Simchi- Levi, Kaminsky and Simchi- Levi (2008:191) highlighted. If it is established that there is high demand uncertainty, then a pull strategy is most relevant. In cases, where there is stability in the supply chain and there is certainty and forecasts can be close to accurate, a push strategy is most applicable.

After reviewing the purchasing and supply chain management concepts, models, theories and strategies, there are significant differences between public and private sector purchasing. It is therefore appropriate to examine these differences and by so doing, the context of purchasing and supply chain management practices and challenges is correctly depicted and set.

2.8. Public versus private sector purchasing-what are the differences?

According to Lian and Laing(2004:247), purchasing environments between the public and private sector differ remarkably and so, are the practices and challenges. The demands and expectations on public sector purchasing are greater than private sector (Arbjørn and Freytag 2012:205).They differ in a number of ways. In highlighting the differences, the researcher will adopt the manner applied by (Arbjørn and Freytag 2012:205) which appears more useful, direct and easier to follow.

- **Nature of funding**

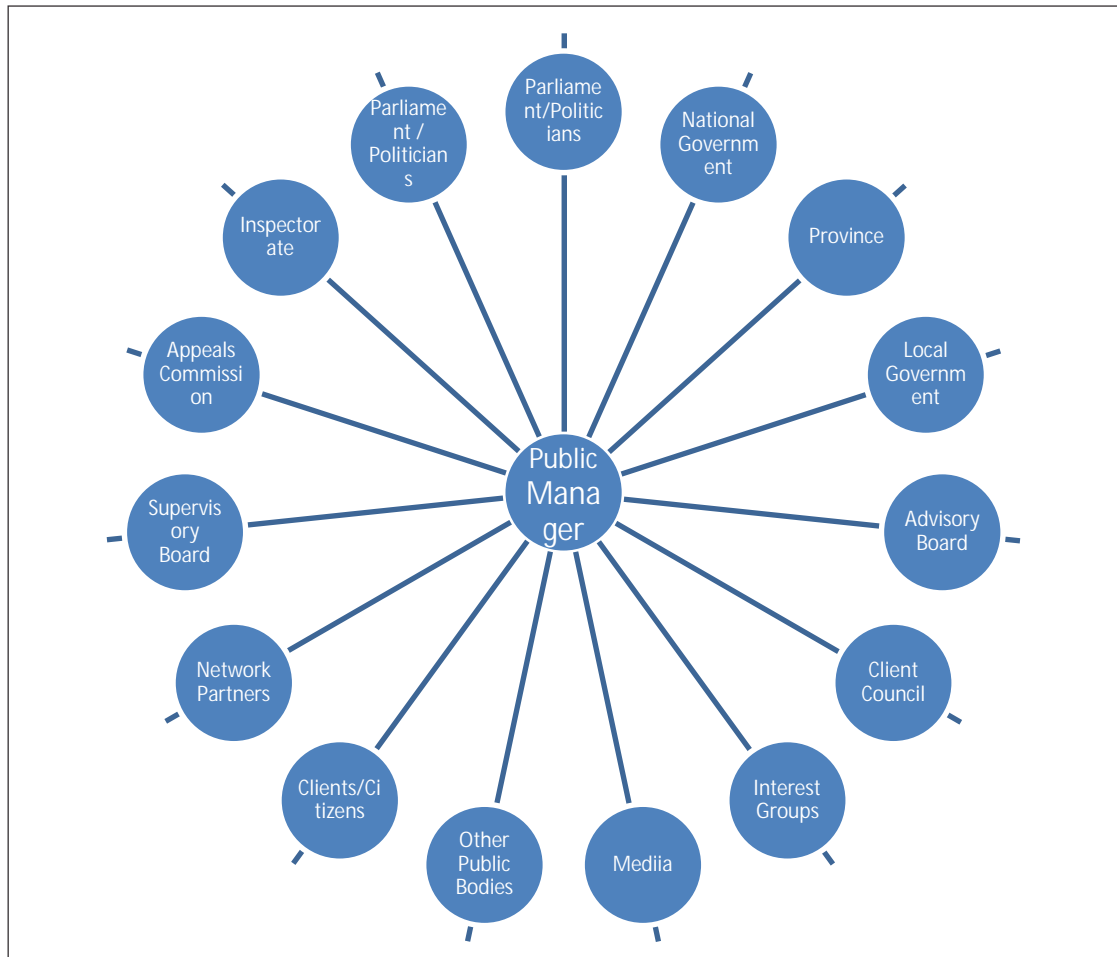
First and foremost, the nature of the funding determines the differences. Public sector purchasing is mostly financed through taxes levied from companies and individuals and for that reason; the funds are classified as public funds. The private sector raises funds through shares mainly and because of that, the purchasing department is answerable to shareholders in most cases.

- **Internal and External Stakeholders**

As explained in the foregoing paragraphs, the source of finances utilised in the purchasing of commodities in public sector is from taxes levied from companies and individuals, it follows that there is need for high public accountability and transparency. Schillemans (2015:433) described the "webs of accountability" in the public sector with public managers as

“spiders” of that complex web, connecting to a variety of stakeholders. The diagram below can be useful in trying to demonstrate the multiplicity and variety of stakeholders in the public sector so that an understanding of the nature of public purchasing can be enhanced.

Figure 5: Web of Public Accountability



Source: Schillemans (2015)

As strongly argued and articulated by Schillemans (2015:436), this web of accountability creates permanent pressure on public sector institutions by forcing them to invest substantially in accountability capacity. Some people could be employed merely to fill in forms as may be required by the Inspectorate. Of all the listed stakeholders above, media has intensified the pressure borne by the public sector; dictating the operating landscape through providing a parochial view of issues. The potential risk of multiple accountability is that public managers or administrators including purchasing personnel, will be grossly indecisive- a phenomenon well described by Koppel (2005) as “Multiple Accountabilities Disorder” (MAD). In an effort to please all the stakeholders, they can lose focus of the most important decisions of the entity. This is the particular circumstance which public purchasing is confined to with respect to public accountability.

- **Multiple Goals**

Unlike in the private purchasing where the ultimate goal is to procure the commodities in order to make profit, public sector purchasing pursues a number of broader objectives which may include political and socio-economic. This is also because of the impact public purchasing has on broader social sectors of the economy. These will be discussed in greater detail later in the chapter.

- **Existence of Rules, Procedures and Regulations**

In the public sector purchasing, there are rules, procedures and regulations aimed at enhancing open competition and achieving best value for money on all purchases. Thus, the nature of rules in the public sector compels competition through invitation of many suppliers but this is quite different with the private sector purchasing because they may reduce the number of supplier to manage risks (Arlbjørn and Freytag 2012:204). National and international procurement regulations influence the purchasing decisions in public sector organisations. Thus, existence of too many rules and regulations result in inflexibility and also confine level of interactions with suppliers to very formal platforms in public sector purchasing.

- **Budget- Driven Purchases**

In public purchasing, it is, to a larger extent, driven by approved budgets and less driven by market innovation (Arlbjørn and Freytag 2012:206). This will also be debated in considerable depth in the coming section but it is a unique characteristic of public purchasing.

- **Supply Chain Relationship Forms**

The form of relationship in the public sector purchasing is mainly market-based, arms-length. The relationship with suppliers is conveniently managed and is not collaborative and sustainable. That being the case, there is little confidential treatment of information from suppliers unlike in the private sector, where such information is the source of competitive advantage. It is from this approach to supplier relationships that the private sector has been able to be competitively afloat.

Summary of the Chapter

The purchasing process or cycle has various stages from procurement planning to filing of procurement documentation and it is from the purchasing cycle and wider business environment developments that the responsibilities of procurement professionals are derived.

Purchasing and supply chain management evolved from a clerical, transactional to a strategic, relational function and this was necessitated by changes in cost structure in terms of procured goods, demanding nature of customers, globalisation and growth of information technology. Further, it is important to understand the purchasing environment and it is from that understanding that the purchasing strategy can be appropriately developed and crafted.

Also, in terms of purchasing, supplier selection and evaluation is quite important as it determines the performance of organisation in view of innovation, competitiveness, effectiveness and efficiency and the concept of Total Cost of Ownership plays a pivotal role in the supplier selection.

Coming to supply chain management, it can be concluded that supply chain management represent the latest management thinking after other tools and strategies like JIT and lean manufacturing were employed in the 1980s to address costs and competitive matters. Related to supply chain management, is the development of the supply chain strategy which should support the competitive strategy of the organisation. More so, there are important drivers of supply chain performance and these are facilities, inventory, transportation and information.

Supply chain co-ordination and integration is strategic in managing costs, enhancing visibility, increasing profitability and various strategies are employed to support that.

Lastly, there are marked differences between public and private purchasing and that naturally means the practices and challenges are also different.

Having looked at the theoretical framework underpinning important purchasing and supply chain management concepts, models, theories, strategies and discussions, the next Chapter 3, will look into public procurement in considerable depth.

CHAPTER 3- PUBLIC PROCUREMENT WITH REFERENCE TO ZIMBABWE

Chapter 3: Public Procurement with reference to Zimbabwe

3.1. Introduction

This Chapter is in four sections. The first section is on public procurement from a general section and the second, addresses public procurement with respect to Zimbabwe. The third component is concentrating on global public procurement challenges and the fourth, examine and discusses public health procurement system in Zimbabwe.

Definition of Terms and Context Setting

In this section, it is important to first note that the term "Purchasing and Supply Chain Management in State Enterprises" will be used interchangeably with **public procurement** or **government purchasing**.

It is imperative to define public procurement first in order to correctly set the context of this literature review and the following definition by Arrowsmith (2010:1) is given as: **"the government's activity of purchasing goods and services which it needs to carry out its functions"**.

The procurement by government or state enterprises signifies a very crucial part of any economy whether developed or developing. This is premised on the idea that procurements by the State Enterprises contribute significantly about 10-15% for developed countries and 20% for developing nations to the Country's Gross Domestic Product respectively (Mukhopadhyay 2011). In Zimbabwe for instance, in 2012 the National Budget was at US\$ 3.4 billion for rehabilitation of infrastructure, purchase of equipment and other related expenditure for line Ministries (Government of Zimbabwe 2012). Due to the magnitude of expenditure, public procurement is utilised as an important policy tool to address the following strategic objectives as highlighted by McCrudden (2007:257) and Arrowsmith (2010:150). For that reason, it is necessary in this academic discussion to review some of the objectives of public procurement.

3.1.1. Political Objectives

In most government purchases, the political objectives influence the purchasing decision. At the same time government institutions need to procure goods and services in an economic manner (Van Weele 2005). An example will be when a government want to construct a large hydro-power plant to generate electricity and it would seem economic to invite potential international bidders in order to obtain Value for Money. This may be contrary to the political objectives of inducing local employment by using local contracting firms. The government may prefer local firms irrespective of high acquisition costs and as argued by Van Weele (2005), political objectives may be at variance with economic rational thinking.

The above is true when reviewing the case of Zimbabwe Electricity Supply Authority (ZESA) where they procured pre-paid meters from South Africa instead of buying locally in tandem with the Indigenisation and Economic Empowerment Policy (Herald 2012). There was a lot of criticism over the company's decision in view of protecting and fuelling local employment.

Further, the political aspirations of a country can also influence the crafting of specific foreign policies (Thai 2001:37) as evidenced by the Zimbabwean Look East Policy where the government through Ministry of Foreign Affairs advocated for trading agreements with Asian based countries like China and Malaysia in what may appear as a political retaliation to economic sanctions imposed by European countries. The relations in general with the European Union have deteriorated drastically. In Zimbabwe, for example, the procurement policy prescribe that the purchase of vehicles by state institutions must be made from Willowvale Mazda Motor Industries- a local company and any purchase apart from the specified company should seek prior approval from the State Procurement Board. The question that remains is whether it is an economic, political reason or a combination of both. It follows therefore that effective purchasing and supply chain management in state institutions demand an understanding of the respective political environment.

3.1.2. Socio-economic objectives.

Not only the political objectives but the socio-economic objectives like wealth redistribution may also be achievable through public procurements (Bolton 2006:194). Notably in Zimbabwe, the Indigenisation and the Economic Empowerment Act (2008) where a fifty-one (51%) percent shareholding is reserved for nationals indicate the encroachment of socio-economic objectives in public procurement generally. This comes against the background that most companies were foreign owned before independence in 1980 and the enacted Indigenisation and Economic Empowerment Act seek to increase the shareholding position of "black Zimbabweans" and even to promote procurements from such firms. This concept is also synonymous with the Black Economic Empowerment policy advocated by the South African government in an effort to address gross imbalances during the Apartheid era. While the Act is good in principle for Zimbabwe situation, it fails to take cognisance of the manufacturing capacity of the local firms resulting in many of them acting as representatives of the foreign firms. This is particularly true with reference to medical equipment suppliers who are still foreign owned but represented with local dealers who will sell the products at high prices (Herald 2014). Not only that, even foodstuffs are still imported in neighbouring countries like South Africa because local manufacturing capacity is still very low. Further, the Indigenisation and Economic Empowerment Act (2008) seem to be at variance with the current Constitution which spells out that there must be equity and equality in handling the procurements- a position that can be used by grieved foreign owned firms to register the complaints. In other words, there is lack of harmonisation of Policies and Acts with respect to public procurement.

Apart from the strategic objectives discussed above, it is also important to critically analyse issue of public accountability and budget policy that underpins government purchases (Van Weele 2005:342). Starting with public accountability, it is paramount to note that the funds utilised in procurement of commodities by government department is levied from income tax, companies tax duties and fines and should flow back to the general public in the form of public goods and utilities like education, infrastructure, sanitation and health (Hui et al. 2011). It is in the interest of the general public to have all expenditure

meticulously checked and verified by the Comptroller and Auditor General for probity because public accounts must be presented also to the relevant parliamentary portfolio committee since the budget approval is done through parliament. Therefore there are many stakeholders in the entire procurement process by virtue of source of funding and some of the stakeholders include politicians, the procuring entity, central and local government hence need for accountability.

Then, on budget policy all fiscal budget allocations made for the current year must be fully utilised in that year failure of which will result in reallocations and obviously a reduction of the next year's budget. Thus, once the budget is approved it is like a "license to spend" as Van Weele (2005:341) described the process and even savings made through strategic purchasing cannot be credited in the next budget to a particular institution. In other words, there is a disincentive to save because of budgetary implications for the coming budget. This budget policy applies to Zimbabwe as well as to other governments.

In light of the above, strict regulatory framework is in place to ensure transparency, accountability and competition, for instance, in Zimbabwe the Procurement Act (2002) is enacted for that reason. Even the European Union (EU) Procurement Directives are established or designed to increase competition and transparency to member states. However, the issue of competition being central to the enactment of the regulations have been greatly disputed by Thai (2009) particularly in view of the type of markets in developing countries. Economic market conditions have a bearing on government efforts to increase competition. In other words, any effort to increase competition is subject to availability of such conditions on the market. It is practical and feasible to discuss competition in pure market conditions where there is a pool of suppliers but in oligopolistic and monopolistic market structures where there are very few sources of supply, competition is difficult to encourage (Thai 2009). In addition, Caldwell et al. (2005) strongly contended the existence of competitive markets in public procurements particularly when they are tested with the economic models that require perfect information and low barriers to suppliers.

Thus, the straitjacket nature of the regulations and extensive authorisation protocols as also highlighted by Potoski (2008:58) and Cabras (2011:189) becomes onerous to the public procurement professionals in the discharge of their duties and even frustrating to competent, reputable suppliers citing bureaucratic rigidities resulting in high cost of products particularly with reference to the objectives of market competition. This also applies to delays in the completion of infrastructural projects (Tadelis 2012:298). In some cases, there could be need to harmonise the national or domestic laws with EU Procurement Directives. Further, the nature of the restrictions alienate public procurement from the entire supply chain network (Larson 2009:224). Also, when the regulations place a particular emphasis on purchasing the lowest product and neglecting the Total Cost of Ownership (TCO) especially the Zimbabwe Procurement Act, it follows therefore that an arm's length approach is adopted at the detriment of long-term strategic supply chain relationships. In terms of product scarcity, such approach is catastrophic (Wilding 2008). Supply

chain management risk is broadened because sustainability is sacrificed by short-term relationships.

Referring back to the issue of transparency highlighted in the foregoing paragraph, corruption in general has crippled many governments and not just Zimbabwe. It is an issue which requires a thorough analysis and discussions.

3.2. Corruption

The commonly and widely used definition of corruption is, "the use of public office for a private gain (Gray and Kauffman 1998:7). Neu, Everett and Rahaman (2015:50) further qualified the definition by incorporating, "illegitimate use of public or communal resources for private gain". The first definition by Gray and Kauffman (1998) is highly debatable because it excludes the private sector but due to incidences of corruption in the private sector like Enron and Adelphia in the United States, it follows that the issue of corruption affects both sectors and should be dealt with holistically (Thai 2009). Corruption has been classified as a multi-headed dragon because of the various forms it takes which include but not limited to, bribery, cartels or collusive tendering.

Corruption has been a global issue that "undermines rule of law and citizens' democratic rights", Lindskog, Brege and Brehmer (2010:167). On an international scale, the latest allegations of corruption in June 2015 regarding fourteen (14) officials of the world governing body, International Federation of Association Football (FIFA) attested to the complexity of corruption even in social sectors. The Organisation for Economic Co-operation and Development (OECD) estimated that about US\$ 2 trillion is used annually by governments world-wide (Transparency International 2010).

The occurrence of corruption is not necessarily because of this sheer magnitude of procurement activities but also a function of unique features of public procurement. One of the unique feature that provides a fertile ground for corruption as logically debated by Neu, Everett and Rahaman (2015:51), is the use of financial resources by the government entities that belongs largely to invisible stakeholders. Unlike in private sector, taxpayers and other beneficiaries are distant stakeholders and are often difficult to image when such purchasing activities are conducted. This leads to a situation where procurement players feel less accountable due to some kind of invisibility of these stakeholders (Neu, Everett and Rahaman 2015).

Raymond (2008:784) further explains that corruption and unethical behaviour is rife in developing countries as compared to developed nations and weak enforcement of the regulations coupled with low income below the poverty datum line were cited as the drivers. The studies carried out by Puiu (2015:606) pointed a correlation which between wages in public sector and corruption level. So, as mitigation measure salary increase reduces corruption but the question is about the sustainability of the approach. Whichever way one may explain or justify the reason, corruption remains an undesirable activity that retards social and economic development.

However, it is regrettable to note that corruption has far-reaching effects. Superficially, it may seem as if the public officials are siphoning funds from government but in essence they are actually hurting and depriving the poor of the necessary public utilities like health and education. According to Transparency International (2010), the exact cost of corruption is difficult to measure quantitatively primarily because of the clandestine environment in which it takes place but it is estimated that it adds 10 to 25% to the contract value. In some cases, it can be 50%. In view of this, it is not just an issue of diverting funds for personal use; lives are resultantly sacrificed and destroyed. Take for an instance, a flawed tender that culminated into a supply of unregistered, counterfeit drugs which do not have the required potency and efficacy. The death toll in Haiti (2010), as another example, resulting from an earthquake was blamed in part to corruption that leads to the construction of sub-standard public facilities (Transparency International 2010).

In dealing with corruption, a clear, holistic and comprehensive regulatory framework for the conduct of public procurement is a fundamental prerequisite. Further, internal checks and balances coupled with audits are indispensable in fostering a responsible, accountable and ethical behaviour among the public procurement professionals.

It is therefore important to acknowledge that a set of rules alone without the correct attitude and ethics will not fundamentally result in good procurement practices. In fact, Lao Tzu highlighted in a poem that: "the more laws and commands there are, the more thieves and robbers there will be". Hence, it is necessary to review the role of ethics in procurement.

3.3. The role of ethics in Public Procurement

Ethics is defined as, "the principles of conduct governing an individual or group; concern for what is right or wrong, good or bad", Lysons and Farrington (2006:655).

The importance of ethics in purchasing has not been central as compared to other established professions such as medicine, surgery, law, accountancy and architecture (Lysons and Farrington 2006). For instance, a medical doctor or registered general nurse, the right to practice is subject to appropriate professional membership. Malpractice in these professions, unlike purchasing, has serious repercussions. Michael Jackson's Physician, Dr Murray's practicing license was revoked when convicted of ethical breach. Of course, there are reasons or developments highlighted below that necessitated the pursuance of ethical codes in purchasing.

- Susceptibility of purchasing professional to corruption because of their position as organisation's representative to the external suppliers and also the volume of financial resources at their disposal.
- Importance of trust and unimpeachable level of integrity in maintaining and sustaining relationships in the supply chain network.
- Demand for accountability and transparency by the stakeholders.

While there are professional bodies in the field of purchasing like the Institute of Supply Management (ISM) in the United States of America and the Chartered Institute of Purchasing and Supply (CIPS) in the United Kingdom that provide enough guidance on ethical issues in procurement, they have not yet developed a comprehensive sanction system for those who deviate from the prescribed code of conduct. Considering purchasing being prone to corrupt activities, it is expected that penalties are attached to malpractice particularly that there are far reaching effects in terms of service delivery.

The other reason given by Lysons and Farrington (2006) is that a conflict of interests may arise in that the professional codes of conduct can be superseded by the organisational ethics standards.

3.4. Challenges in Public procurement.

While commonalities between public and private procurement exists, there are unique challenges that public procurement professionals encounter in the purchase of commodities. Khai (2009) enumerated some the most prevalent challenges. Other studies like the Winter Commission unearthed a number of challenges that were occurring in public procurement (Potoski 2008). The following represent the challenges available in literature.

- **Lack of skilled procurement professionals**

Both Larson (2009) and Uyarra (2014) agreed in the separate studies that public procurement is often conducted by poorly trained professionals with narrow perspective on purchasing and supply chain management tools and techniques commensurate with the complex operating environment. This has cascaded into a number of issues relating to over-specification of tenders through use of highly prescriptive tender methods as opposed to outcome-based tenders, leading to high cost of products (Uyarra 2014). Further, the study unearthed lack of useful supplier feedback by procuring entities which in essence frustrate relations in the supply chain network and obviously competition. This was further compounded by lack of confidentiality when dealing with suppliers.

- **Focus on short-term relationships**

The emphasis by the public procurement professionals is on competitive bidding as also required by the procurement regulations as opposed to negotiation (Larson 2009). In times of product scarcity, short-term relationship will prove to be a disadvantage. When Toyota's factors were destroyed by fire in 1994, burning one of the most essential components used in the assembly, its operations were immediately restored without disrupting its entire supply chain network due to close long-term relationships with its key suppliers (Wilding 2008).

- **Lengthy Procurement Processes**

Following concerns regarding public procurement inefficiencies in the UK government departments, the state appointed a Commission

popularly known as the "Winter Commission" to scrutinise the system and subsequently submit recommendations (Potoski 2008). One of the findings was lengthy authorisation protocols where several signatures have to be appended prior to finalisation of purchases. Requisition pass through multiple layers of approvals and this according to Potoski 2008) made procurement onerous and cumbersome particularly on small purchases. The lengthy procedures resulted in procurers spending more time on **compliance at the expense of delivery**, even constraining well-intentioned procurement professional from pursuing public value.

- **Quality and Cost Trade-Off**

Public procurement purchases are often fraught with difficult especially on issues of quality and cost. For example, Company X offers \$1 million for the supply, delivery, installation and commissioning of medical equipment at a quality of 92%. Another Company Y offers \$1.2million for the same equipment but the quality is at 100%. In as much as cost cannot be considered without regard to quality public procurers are often in a serious quandary when presented with such purchases (Thai 2009). In the United States of America, it has been argued by Bergman and Lundberg (2013:73) that the tight regulation and the buy-low-bid rule has created an atmosphere in which suppliers cut costs by offering the bare minimum acceptable quality- sometimes acceptable only in a formal sense.

- **Timeliness and Cost Trade-Off**

Using the similar example above; assuming that Company X offers \$1million to supply medical equipment in 180 days while Company Y offers \$1.2million to supply the same in 60 days. Which company is likely to get the tender? Cost may be preferred over supply lead-time and this may not be ideal for a medical organisation (Thai 2009).

- **Conflicting objectives; national and international**

More often than not, public procurement professionals face challenges in terms of which regulations to follow; national or international particularly if the national procurement laws violate international guidelines. A good example will be policies that favour local employment and not foreign purchases.

3.5. Public Procurement in Zimbabwe

To fully appreciate the public procurement system in Zimbabwe, it is very necessary and desirable to critically evaluate the procurement law, policy and to reflect on the historical influences that have shaped the adoption of the existing system.

3.5.1. Historical Background of Public Procurement

In general, Africa and Asia experienced various forms of oppression and marginalisation during the colonial era (Chowa and Mukuware 2013). In Malaysia specifically, there was huge disparity between the indigenous Malays and the foreigners that led to the economic reform known as the New Economic

Policy in an attempt to address the gap. Similarly, in South Africa, the apartheid regime created economic imbalances that resulted in the adoption and implementation of the Black Economic Empowerment (BEE) to narrow and manage the Gini co-efficient in that state. Zimbabwe also took the same path in an effort to correct economic discrepancies and inequalities created before 1980-the country's Independence Day. This was to be achieved through a series of policies and Acts. Interestingly, public procurement was employed as one of the strategic tool to address the socio-economic matters and the procurement system resultantly became the product of the historical political and economic developments (Tsabora 2014).

To start with, the Indigenisation and Economic Empowerment Act of 2010 endeavour to ensure that, "fifty one per centum of the shares of every public company and any other business shall be owned by indigenous Zimbabweans". Further, the Indigenisation and Economic Empowerment Act [Chapter 14:33] define Indigenous Zimbabwean as:

"Any person who, before 18th April 1980 was disadvantaged by unfair discrimination on the grounds of his or her race, and any descendant of such person, and includes any company, association, syndicate or partnership of which indigenous Zimbabweans form the majority of members or hold the controlling interest". Accordingly, this definition tends to exclude every white person (Matyszak 2011).

The provisions of the Indigenisation and Economic Empowerment further gives specific guidelines on procurement particularly with reference to Section 3 (1) (f) of the Act which prescribe that "all government department, statutory bodies and local authorities shall **procure at least fifty per centum of their goods and services required to be procured in terms of the Procurement Act [Chapter 22:15] from business in which a controlling interest is held by Indigenous Zimbabwe**". This Act addresses all procuring entities which in principle referred to government entities hence inclusion of all companies under Section 3 (1) (f) is anomalous (Matyszak 2011).

In addition to the above, Section 3 (1) (g) incorporates the issue of sub-contracting by stipulating that any sub-contracting if need be, shall be done to the "prescribed extent in favour of businesses in which a controlling interest is held by indigenous Zimbabweans". The net effect of this approach to public procurement is that it fails to take cognisance of the limited capacity of the local firms and further, by recommending sub-contracting it literally transforms local firms into middlemen business or briefcase companies who in the past have failed to deliver on time and often increased the cost of commodities. The former Zimbabwean Minister of Finance, Tendai Biti attributed the non-completion of infrastructural facilities to incompetent brief case companies (Herald 2012).

Now the public regulatory framework for Zimbabwe can be examined in the following section.

3.5.2. The Regulatory Framework for Public Procurement in Zimbabwe

It is regrettable that from 1980, Zimbabwe has not published or produced a White Paper on public procurement and this should have adequately and correctly guided the course of procurement decisions (Tsabora 2014). Despite the non-availability of a clearly articulated public procurement policy document, the government of Zimbabwe pursued some of the unwritten policy like the Look East Policy where government preferred transactions to be done with countries like China and Malaysia.

However, it is important to note that public procurement is governed by the Procurement Act [Chapter 22:14] and the Procurement Regulations, 2002. For that reason, the next section will scrutinise the key aspects of the Act and the Regulations.

3.5.2.1. Key Aspects of the Procurement Act

3.5.2.1.1. Application of the Act

Section 3 (1) of the Act clearly stipulates that it applies to all procuring entities except (a) such classes of procurement or (b) such procuring entities; as may specified by the President by the Statutory Instrument. By "procuring entities", the Act referred to the State Procurement Board, any Ministry or government department, Statutory Body and local authority. However, the Act remains vague under Section 3(1) (a) and 3 (1) (b) by not specifying the classes of procurements. For the purposes of ensuring total adherence and compliance to this Act, clarity was necessary for those sub-sections.

In terms of administration of the Act, the mandate was given to Ministry of Finance.

Then, the major part of the Act is concentrated on the functions of the State Procurement Board. In light of that, the following section will examine and evaluate the role of SPB.

3.5.2.1.2. The State Procurement Board (SPB) and its functions

Section 4 of the Procurement Act gives the establishment of a Board referred to as the State Procurement Board which "shall be a corporate body capable of suing and being sued in its own name and subject to this Act of doing all things that bodies corporate may do by law". This is very commendable as it fosters corporate governance and of course some sense of accountability on the part of SPB. Further, Section 5 (1) (a) clearly indicate its role in terms of conducting procurements on behalf of procuring entities where procurement is of a class prescribed in the Procurement Regulations. It is critical also to note that the other role of SPB relates to the supervision of procurement proceedings conducted by respective procuring entities.

From the above described functions of SPB, it is not difficult to see that the Board is playing a dual role of being a player and a referee at the same time. SPB is a player in the sense of conducting procurements and referee in view of supervising procuring entities. This scenario puts SPB in a very difficult position

because their supervisory role which is often critical is questionable if it is carried out by an interested party. Ideally, an independent body which is not completely involved in procurements is appropriate to supervise the various procuring institutions.

The Act also states the composition of SPB under Section 6 (1) and the desired qualifications of the members which are under Section 6 (2) which is highly appreciated. However, given the magnitude and complexity of procurements nationwide, one may question the adequacy of 7-10 members of the Board. More so, the Act acknowledged the criticality of ability and experience of the members but did not specify or prescribe the suitable professional qualifications required. Leaving it plain or broad, may give room for the employment of non-purchasing professionals.

It is also crucial to note that the Procurement Act goes a long way in specifying ethics and integrity of the members of the SPB. This is well captured under Section 7.

3.5.2.1.3. Tendering Proceedings

It is very encouraging that the Procurement Act as given under Section 31 (1) requires tender invitations to be published and that invitations should contain total and comprehensive information regarding the nature, quantity and quality of commodities as contained under Section 3 (b) of the Procurement Act (Quinot and Arrowsmith 2013).

Having discussed that, it is critical to note that Section 31 (m) of the Procurement Act confines to a larger extent, the selection criteria based on lowest price. This has a potential of neglecting the crucial concept of Value for Money as a guiding principle when evaluating bids.

In addition, Section 31(n) of the Act prohibits negotiations between procuring entity and the supplier with respect to the bids submitted. This may not reflect well on the best procurement practices. In fact, the Procurement Act gave reference to the 1994 United Nations Commission on International Trade Law (UNICTRAL) Model Law but the current UNICTRAL 2011 Model law have provisions for negotiations which in essence warrant re-alignment of the Procurement in tandem with the UNICTRAL Model Law.

Turning on to the Procurement Regulations of 2002, the Procurement Act gives further reference to the important specifics relating to tender types which various state institutions may apply in the procurement of goods and services. The next section will consider the various tender types.

3.6. Procurement Regulations

Section 4 (1) of the Procurement Regulations of 2002 give clearer guidelines on tender invitations. Basically, there are four types of tenders namely Competitive, Informal, Formal and Special-Formal and these will be explained as follows:

- **Competitive Tender**
Section 5 (1) of the Procurement Regulations provide that where a procuring entity require supply of goods, construction works or services the value of which equals or is less than \$10,000, the procuring entity shall solicit for 3 competitive quotations from suppliers. This type of tender is solely conducted and concluded by the respective procuring entity without the involvement of SPB primarily because of the lower threshold limit.
- **Informal Tender**
According to Section 4 (2) if a procuring entity wish to purchase commodities at a value which exceeds \$10 000 but does not exceed \$50 000, the procuring entity shall follow the Informal Tender subject to the procedure of the tender route as prescribed by Section 6. Section 6 provides that tender advertisement be carried out in a newspaper of wide circulation. Again, the concerned procuring entity finalise the entire process.
- **Formal Tender**
This is an option if the value of the required purchase exceeds \$50 000. Accordingly, Section 4(1) of the Procurement Regulations stipulates that in such circumstances, the invitation of tenders shall be conducted by SPB in line with the procedure for formal tender as set out in Section 8.
- **Special-Formal Tender**
Lastly, this tender route is similar to the Formal Tender and the only difference as clearly set out by Section 7 (2) is the situations that warrant the application of the procedure. First, this tender is applicable if the requirements are urgent to an extent that there is inadequate time for the advertisement in the Government Gazette and prior approval has to be granted by the Chairman of SPB in order to adopt this route. Following that approval, SPB will reach out to pre-qualified suppliers on behalf of the procuring entity.

For detailed review of the Procurement Act and Regulations, please refer to Appendix 8.

After reviewing public procurement from a general point of view and then to the Zimbabwean public procurement framework, it is therefore necessary to briefly examine the global health issues followed by country-specific (Zimbabwe) health context and challenges.

3.7. Global Health Purchasing and Supply Chain Management Issues and Challenges

The world over, provision of affordable and quality healthcare services have always been a top priority for governments. Healthcare costs are increasing on a continuous basis and hospitals are often encountering a difficult task of providing the required services without extending the cost burden to the patients

(Charkraborty, Bhattacharya and Dorbrzykowski 2014:677). In United States of America (USA), the Affordable Care Act popularly known as the "Obamacare" was enacted in an effort to expand and improve the healthcare delivery system. Not only in the USA but also in the United Kingdom (UK), deliberate and concerted efforts have been made by the National Health Services (NHS) to ensure that patients' needs are met in a timely and cost effective manner (Nicholson 2012:4). This is further prompted by ballooning expenditure of health commodities, for instance, the NHS had a health annual budget of £18 billion.

In light of these global challenges, Arney et al. (2014:295) strongly contend that purchasing and supply chain management is pivotal to the availability and cost containment of hospital products. In Malawi, for instance, the research findings unearthed that procurement inefficiencies and lack of competitiveness of the practices were central to the unavailability of medicines (Kanyoma and Khomba (2013:27) .Such medicines unavailability can easily frustrate the Physicians and Surgeons in their effort to deliver service to the patients. Further, the report by World Health Organisation (2011:1) clearly underscored the importance of procurement to the smooth running of hospital operations.

Against this background, one would question the late or slow adoption of Purchasing and Supply Chain Management by public health institutions amid such operational bottlenecks (Charkraborty, Bhattacharya and Dobrzykowski 2014:677). This could however be attributable to the fact that procurement in the health sector is overshadowed by the clinicians who are at the epicentre of purchasing decisions. Ford and Scanlon (2007:194) argued the uniqueness and complexity of public health supply chains as the cause for slow adoption of purchasing and supply chain concept.

Thus, the above necessitates a re-look into the real challenges that are in health sector procurement.

- **Complexity and Uniqueness of Health Sector Procurement**

It is very essential to appreciate the complex nature and the uniqueness of procurement in the health sector. As highlighted by Feander and Dassu(2014:2) one of the issue that make health procurement a challenge is the highly technical component of the requirements and this is further worsened by the dominance of Clinicians who largely influence purchasing decisions. While it may not be expected for procurement professionals to know in great detail the health products, it is imperative to establish formal constructs that enhance joint working between the Clinicians and the procurement professionals in order to develop robust procurement strategies (Feander and Dassu 2014:2).

- **Inadequate use of Procurement Infrastructure**

Use of Information and Communication Technology in the procurement and supply chain networks in the public health is still in its infancy as some of the processes are wholly manual. Simchi-Levi, Kaminsky and Simchi-Levi (2008:407) clearly highlighted that Information and Technology (IT) is the greatest enabler of effective supply chain management. According

to Kanyoma and Khomba (2013:29) forecasting of hospital inventory levels is primarily based on **experience** instead of being **data-generated**. The problem with this approach is that it will generate into excess stock being held and in some cases result in the expiry of costly pharmaceuticals. Use of Radio Frequency Identification (RFID) for enhancing visibility of orders in the supply chain and the application of other web-based tools like Collaborative Planning Forecasting and Replenishment is not widely utilised in public health set-up. It is also of paramount importance to appreciate that the role of Information and Communication Technology is not confined to pharmaceuticals and medical equipment only but to patient logistics. Patient logistics incorporates planning and controlling and this will result in matching supply and demand in the medical supply chain (Vries and Huijsman 2011:160). Some medical institutions could be overwhelmed by patients while in other centre; patients flow will be very low. Therefore, the argument as given by Vries and Huijsman (2011:159) in the late adoption of the approach could be that supply chain management strategies and tools were originally developed in industrial manufacturing setting and extending it to the service sector can be fraught with challenges.

The other factors that could be resulting in difficulties in the use of Information and Communication tools are the existence of multiple stakeholders, dynamic internal and external environment. However, it is also important to note that the private health sector is able to exploit modern methods like Telemedicine and this is because of distinct differences highlighted above.

Besides the impediments to adoption of IT tools mentioned above, some studies have highlighted mistrust challenges in the effectiveness of the supply chain management (Wilding 2008). Trust precedes co-operation and collaboration in the supply chain network.

- **Financing in the Health Sector**

Financing procurements specifically in low-and middle-income countries has been fraught with challenges. Unpredictability in the timing and disbursement of funds proved to be hindrance to effective procurement (Cohen, Reeh and Neroutsos 2011:7). This problem of inadequate funds could be emanating from the fact that some vaccines and pharmaceuticals were classified as donor- funded (Woodle 2000) but because of shifting responsibility to host governments, there are insufficient financial resources to procure the required products. Untimely disbursement of funds has an effect on ordering the appropriate quantities of products and also poses a delay on payment of suppliers. The net effect of late payments is on higher prices and subsequently strained relationships in the supply chain network. In addition, irregular disbursement of funds from Treasury hinder proper procurement planning and execution particularly against the background that some countries like Uganda sufficient funds accumulate at the end of the fiscal year. In view of that, it may be difficult if not impossible, to utilise the funds

effectively and efficiently because of inadequate time for competitive bidding. Again, failure to use the funds within the given fiscal year does not result in the funds carried over to the next year.

3.8. Health Procurement System in Zimbabwe

Provision of safe and affordable healthcare services remains the mandate and priority of Ministry of Health and Child Care (MOHCC), formerly Ministry of Health and Child Welfare (MOHCW). The MOHCC deliver the services to patients through a network of health facilities that include Clinics, District, and Provincial, General and Referral or Central hospitals spread throughout the country.

For period 2000 to 2009, the health delivery system was critically affected and the following key health indicators show the extent of the health challenges (MOHCW 2012-2014).

- Infant mortality and under five mortality rose from 53 and 77 per 1000 live births in 1994, to 6- and 86 per 1000 live birth in 2009. Regrettably, these indicators worsened by 2011 with under 5 mortality at 84 per 1000 live birth per 1000 and infant mortality at 57 per 1000 live birth.
- Maternal mortality levels increased from 29.4 to 35% among children below 5 years.
- Life expectancy drastically fell from 63 in 1988 to 43 years in 2005/6.

Within the same time-frame and specifically in 2008, essential drugs and surgical supplies dwindled with 29% and 58% for Vital items and 22% and 36% for other categories on the Essential Drug List for Zimbabwe (EDLIZ). Further, there was shortage of critical diagnosis and monitoring medical equipment in hospitals; some obsolete and others non-functional. Transport and communication unavailability added to the basket of challenges facing the health sector (MOHCW 2009-2013). In addition, there is inadequate financing in the health sector with the current budgetary allocation approximately at US\$7 per capita per annum versus the World Health Organisation target of at least US\$34(MOHCW 2008-2013).

Having provided this background information regarding the health delivery system, it is crucial to provide an overview of the existing procurement system. Primarily, the procurement of pharmaceuticals is conducted through the National Pharmaceutical Company of Zimbabwe (NATPHARM) and the Medicines Control Authority of Zimbabwe (MCAZ). NATPHARM is a parastatal that procures, warehouses and distribute drugs, reagents and surgical supplies. MCAZ is mainly involved as a regulatory agency for all pharmaceuticals. Registration and licensing of all drugs and surgical consumables is conducted through MCAZ (Osika et al. 2010:83). Thus, all public hospitals are required to procure **all** medical supplies from NATPHARM and can **only** procure from other external suppliers if NATPHARM does not have the needed products in tandem with the Procurement Act and Regulations. It is very important to note that

NATPHARM is selling the medical commodities entirely on a cost-recovery basis.

However, NATPHARM is currently incapacitated in terms of provision of the required medical products and frequent stock-outs resulted in individual public health facilities procuring their own supplies. According to Osika et al. 2010:87, 49 health facilities sampled reported that they have not received the products they ordered from NATPHARM while 48 facilities indicated that the reason why they have not received inadequate medical commodities was attributable to the fact that they were stock-outs at NATPHARM.

Despite these shortages, 59% of the health facilities sampled had expired pharmaceuticals and 81% of the facilities sampled had products approaching the expiry date (Osika et al.2010:90). These situations ignite debate as to whether purchasing and supply chain management is being effectively and efficiently done. What are the re-ordering levels of the concerned institutions? Are there tools in place for inventory management? Who are the stakeholders in the procurement process and were they consulted? These are questions which might be asked.

For detailed review of the Zimbabwe Public Health Act of 1924, please refer to Appendix 9.

Following the review of the health procurement system in Zimbabwe, the summary of chapter is presented below:

Summary of Chapter

This section summarise key issues emanated from the review of the Chapter.

- Public or government procurements are very significant to a country's GDP.
- Government purchasing serves Political, Social and Economic objectives and these shapes the public procurement terrain of a nation.
- Budget policy, transparency and accountability are central to government purchases.
- A comprehensive procurement regulatory framework reduces corruption.
- Corruption impacts on developmental sectors of a country.
- Corruption is more prevalent in developing than developed nations. However, it impacts both private and public organisations.
- Ethics are very important in enhancing a responsible behaviour in public procurement.
- There are serious challenges in public procurement relative to private sector purchasing.
- Public procurement system in Zimbabwe is a product of historical developments and is governed by the Procurement Act and Regulations.
- Increasing healthcare costs are affecting service delivery.
- Purchasing and Supply Chain Management is critical to the availability and cost containment of medical products.

- Health sector lagging behind in the adoption of latest P&SCM tools and strategies.
- Health financing: a notable challenge.
- Provision of healthcare services in Zimbabwe is through Ministry of Health and Child Care.
- The health sector in Zimbabwe requires serious attention in terms of procurement despite remarkable improvements.

From the review of Literature conducted, it is quite evident that purchasing and supply chain management has been extensively explored. However, there are gaps in research which needs to be addressed particularly in view of the latest challenges facing organisations. Further, it is important to note that health procurement is not adequately covered by research as shown the few peer-reviewed journals in this area of research.

The next Chapter will provide the research methodology utilised for this investigation.

CHAPTER 4 - RESEARCH METHODOLOGY

CHAPTER 4: RESEARCH METHODOLOGY

4.0. Introduction

The public hospitals in Zimbabwe which provide affordable healthcare services to patients are experiencing multi-faceted operational challenges that include but not limited to, acute and persistent shortages of essential medicines, expiration of drugs as well as obsolete and non-functional diagnostic and monitoring medical equipment. This is further exacerbated by increasing cost of healthcare services. The shortage of medicines and expiration of drugs is a difficult and ironic situation to understand but what that means is some essential medicines are in short supply while other medicines are ordered in excess and distributed without proper inventory management system. The existence of obsolete and non-functional medical equipment could signal to the availability of technologically old equipment while the non-functional ones are as a result of lack of spare components.

In light of the above, the research aims at investigating the purchasing and supply chain management practices and challenges. This is because the research problem appears to embed serious procurement issues that are manifesting in a number of challenges described.

Thus, under purchasing and supply chain management practices, the author targeted to explore deeper the procurement processes (internal and external), systems, policies, strategies, methods, procurement legislative framework as contained in various Acts employed by the public medical institutions in the acquisition of medicines, surgical consumables, laboratory reagents and medical equipment. Then, on challenges, the researcher intended to establish the real procurement impediments that public health institutions face in their effort to provide healthcare to patients.

In the previous chapter that reviewed available literature in the area of research, it was clearly indicated that there is limited research particularly in purchasing and supply chain management in the public health sector and this underpins the importance of this research.

In view of the above presented research problem, this investigation seeks to provide answers to the following research questions:

1. What are procurement practices and challenges in the health sector?
2. How are the procurement practices related to the challenges?
3. Why are the health institutions using the existing procurement practices, systems and strategies?

Therefore this Chapter identifies and critically discusses the research methodology adopted for this study. First, the research objectives will be provided followed by explanation of the two main research paradigms that underpins the study. An analysis and justification of the chosen case study method or approach is then made. Thereafter, data collection methods used for this study as well as the data analysis procedures will be presented.

The **objectives** of this research are to:

1. Identify, review and critically analyse the procurement practices and policies (processes, systems, legislative framework and strategies) in the public health sector.
2. Identify challenges, operational and strategic gaps and how they can be addressed so that quality and improved healthcare is provided to patients.

4.1. Research Paradigm

It is very important before a critical discussion is done to first provide a comprehensive definitions of "research" first and then "paradigm". In literature, Burns (1997) as quoted by Mackenzie and Knipe (2006:2) provided a comprehensive and full definition of research and it is as follows:

"The systematic investigation or inquiry whereby data are collected, analysed and interpreted in some way in an effort to understand, describe, predict or control an educational or psychological phenomenon or to empower individual in such contexts".

Paradigm is defined as:

"A loose collection of logically related assumptions, concepts or propositions that orient thinking and research (Bogdan and Biklen 1998: 22 as referenced by Mackenzie and Knipe (2006). In other words, it is a philosophical, theoretical or conceptual framework which underpins or guides research (Ponterrotto 2005:127). Creswell (2009:5) described paradigms as "philosophical world-views". All research is generally premised on assumptions and philosophy about

how people perceive the world or reality (Trochim 2006).

The researcher therefore noted that without the selection of a paradigm first, there is no justification or basis for the subsequent choices of research methodology, tools, instruments, participants and research design in this study hence it is indispensable first to consider this (Mackenzie and Knipe 2006). Further, Creswell (2009:5) emphasised that the researcher should explicitly indicate the philosophical idea (s) espoused and that explains why the discussion first concentrated on the research paradigms because of its centrality to the highlighted research aspects above.

Thus, the two main paradigms are **positivism** and **interpretivism** and these will be explored in greater detail.

4.1.1. Positivism Paradigm

This philosophy originated with Aristotle, Francis Bacon, August Comte and Mill in the 19th Century (Bailey, Ford and Raelin 2009; Mackenzie and Knipe 2006). Positivism paradigm is founded on the idea that it is possible and desirable to study human behaviour in the same context natural scientists study the natural world where the world conforms to the fixed laws and rules of causation and happening like the laws of relativity and gravity (Livesey 2006; Aliyu et al.2014:81). Based on that, the role of the researcher is to confine to what is observable because the assumption is knowledge is "something out there awaiting discovery" (Bailey, Ford and Raelin 2009; Trochim 2006).

Thus, the methods under this philosophy are hypothesis-driven in that researchers set to propose a theory or a statement which they endeavour to test and prove (O'Leary 2004).

However, this paradigm attracted criticism in terms of independence and unbiased observation. Both Dash (2005) and Biggam (2005) strongly disputed the feasibility of excluding human influence completely in a bid to avert bias because observation and interpretation are done by humans. Regarding human behaviour as passive, controlled and largely determined by the external environment was underlined as a downside of positivism philosophy (Dash 2005). Also, its assumption of general applicability of findings to the whole population draws criticism.

4.1.2. Interpretivism Paradigm

This paradigm is based on the thoughts of Max Weber(1864-1920) who indicated that in human sciences, the major concern is with “Verstehen” (understanding) the process as opposed to “objective facts” (Hughes 2012). Saunders, Lweis and Thornhill (2008) provided that the world of business and management is generally marred with complexities hence need to deeply understand the **details of situation and perhaps the forces working behind them**. It is in the same view that the researcher aimed at gaining a deeper understanding into the purchasing and supply chain management practices and challenges and how they influence health service delivery in the public sector. Thus, the paradigm embedded a hermeneutical approach which assumes that deeper meaning or reality is hidden and therefore should be unearthed (Ponterotto 2005). The methodology under this paradigm is to describe and explain reality primarily from the perspective of those involved and perhaps the rationale being that the facts are usually context-bound (Livesey 2004).

Therefore the main features of these two research paradigms can be summarised in the table below as follows:

Table 1: Main characteristics of Positivism and Interpretivism

Positivism	Interpretivism
▪ Objectivity	▪ Understanding and interpretation of the process
▪ Measurability	▪ Research is inseparable with the object of research
▪ Predictability	▪ Reality is context -bound and time dependent
▪ Controllability	▪ Uses methods like Case Studies and Ethnographic Studies
▪ Replicability	
▪ Certainty	
▪ Uses methods like experiments and Surveys	

Source: Authors

The selected Paradigm (s)

The choice of one paradigm or a combination of both is generally a decision which is influenced by a number of factors that include but not limited to the

training of the researcher, timescales, research constraints, research aim and objectives (Weber 2004). These variables were considered in the study. Thus, the two paradigms as maturely presented by Weber (2004) can be treated as **complementary** and not necessarily polar opposites and for this study they are considered as such. This is because different methods present different strengths and weakness and consequently a hybrid of both offset some of the weakness of the methods while capitalising on the strengths. In fact, Saunders, Lewis and Thornhill (2009:108-109) simply indicated that they are all better at doing different things depending on the nature of the research problem and objectives pursued. The intricacies and subtleties therefore of the public health delivery system in Zimbabwe demanded the use of both paradigms (positivism and interpretivism) so that a deeper and broader understanding of the challenges is enhanced.

Having laid the foundation of the research through the discussion of the two research paradigms, a particular attention can now be concentrated on the selected Case Study research approach or strategy.

4.2. Case Study Research Method

For this section, the researcher has drawn substantial guidance from (Yin 2009) who is arguably the leading "guru" in case study research design and methods and according to Yin (2009:18) as case study is defined as: 'an empirical enquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined'. Of great note from the definition given, is the ability of the case study as the author's preferred method, to look in considerable and intense depth an on-going phenomenon in its natural setting. The difference of this approach with surveys or experiments being that the research goes to where the phenomenon is and in its context. Experiment artificially engineers an environment. In other words, it works in **controlled environments** as opposed to **natural settings**. Due to the centrality of real-life context of the area under investigation to the research; a case study was subsequently selected.

Broadly, case study can be descriptive, explorative and explanatory but this study, it shall be to a greater extent, confined to the last two types. This is primarily because explanatory type seeks to determine the operational relationship between the procurement practices and service delivery and

exploratory concentrating on understanding the situation in the health delivery system in greater detail.

It is again critical to note that the adoption of this method followed Yin's (2009) guidelines which determined that a case study is most relevant and appropriate under the following conditions or situations.

Figure 6 : Relevant Situations for Different Research Methods

METHOD	Form of Research Question (1)	Requires Control of Behavioural Events? (2)	Focuses on Contemporary Events? (3)
Experiment	how, why ?	yes	Yes
Survey	who, what, where, how many, how much?	no	yes
Archival Analysis	who, what, where, how many, how much?	No	yes/no
History	how, why?	no	no
Case Study	how, why?	no	yes

Source: COSMOS CORPORATION as referenced by Yin (2009:8)

From the above diagram showing relevant situations for different research methods, a case study according to Yin (2009:13) is most applicable is when a "how" and "why" questions are being asked.

Thus, regarding the choice of the case study method, the researcher took into cognisance the following advantages;

- Its ability to investigate in considerable depth and also the capacity to enhance greater understanding of complex issues such as the one under

consideration.

- The capacity of the case study to develop or build up models or theories which can be tested by more quantitative techniques (Chandler 2013).
- It consider the phenomenon in its context as opposed to an artificial controlled environment and the net effect of such an approach is relevance and appropriateness of the solutions to the challenges because in management research, the emphasis is on practical, workable, relevant and useful solutions to the problems identified.
- In addition, the ability of the case study approach in converging different lines of enquiry such as interviews, questionnaires, observation and document analysis in a process of triangulation was noted by the author.

Having highlighted that, the researcher also considered carefully the issues listed below that required to be effectively managed when adopting the case study approach.

- First, there were concerns in research pertaining to the rigour of this research method. To mitigate that potential challenge, the author has religiously and systematically followed the methodological steps as provided for by Yin (2009).
- Second, in relation to generalisability, the author noted and appreciated that statistical generalisation cannot be done when using this method. However, analytical generalisation can be done where models could be constructed for further testing by more quantitative methods (Chandler 2013; Yin 2009).
- Third and most crucial, is the issue of access to the selected cases. The author negotiated access. Letters with clear purpose and persuasive language we sent allaying fears that could be attached to anonymity and confidentiality. Access was indeed fundamental in this study.
- Fourth, since the main tool of the case study is interview as a qualitative technique, the researcher is able to effectively conduct the interviews.
- Fifth and last, resource constraints in terms of time and financial resources were thoroughly considered and that culminated into the selection of three cases.

4.2.1. Ensuring Validity and Reliability in Case Study Design

In case study design, validity and reliability are important research principles that provide a quality benchmark of the research design. These two principles

also provides trust and credibility in the data collected and interpreted. Validity denotes to the accuracy, trustworthiness, authenticity and credibility of the findings from the viewpoint of the researcher, participants and the readers (Creswell 2009:191). However, reliability refers to the consistency, stability and repeatability of the results of the study (Trochim 2006; Yin 2009:40).

In light of the above, the researcher noted that there are four tests which are applied to gauge the quality of the research in terms of validity and reliability and these are well provided by Yin (2009: 41). Thus, the following table extracted from Yin (2009:41) provided in brief how the validity and reliability tests are addressed and the stage of research in which the recommended strategy was be applied.

Table 2: Validity and Reliability tactics

TESTS	Case Study Tactic	Phase of Research in which tactic occurs	Applied Strategy in this research
Construct validity	▪ Use multiple sources of evidence	Data Collection	Questionnaires, Interviews, Document Analysis and Observations were utilised
	▪ Establish chain of evidence	Data Collection	Interview Transcripts recorded, observations written in real time
	▪ Have key informants review draft case study report	Composition	Not applied
Internal validity	▪ Do pattern matching	Data Analysis	Patterns from cases matched
	▪ Do explanation building	Data Analysis	Links between variables identified and explained
	▪ Address rival explanations	Data Analysis	
External validity	▪ Use logic models	Research Design	Not applied
	▪ Use theory in single-case studies	Research Design	Not adopted
	▪ Use replication logic in multiple-case studies	Data Collection	Applied
Reliability	▪ Use case study protocol	Data Collection	Applied
	▪ Develop case study database		Not used

Source: Yin (2009:41)

The tactics explained above that managed validity and reliability concerns of case study design were applied consistently throughout the research. It is imperative, as provided above, to note that the strategies are applied at different

stages of the research, that is, at design, data collection and analysis stages.

Reinforcing validity and reliability in case study design

Apart of the tactics employed by the researcher that were aimed at providing validity and reliability, the questionnaires were piloted and seen, after incorporating the changes, to be appropriate but this will be presented in the coming sections. Further, the nature of the research where hospitals respondents and suppliers of hospital commodities answered separate questionnaires and interviews provided the corroboration that improved on the validity and reliability of the findings.

4.2.2. Ethical Considerations in Case Study Design

In this study, the researcher noted carefully key areas which were critical before, during and after the research process. This was also in tandem with the university ethical guidelines. First and foremost, access to the public institutions was formally negotiated through letters that were signed by Durban University of Technology (DUT). These letters explained in detail the nature of the study, the purpose and the importance to the selected cases and access was granted. However, the actual letters signed by the university could not be scanned and attached as appendices for anonymity and confidentiality reasons which will also be explained in the following paragraphs.

Second, there was free and informed consent on the part of research respondents. No pressure or deception was used on them but it was clearly explained to them the purpose of the research, why they were chosen and how the information obtained from them will be utilised so that there was total understanding of the research process. Thus, at the beginning of questionnaires and interviews for both hospital and suppliers', the above matters were clearly highlighted even further indicating that the respondents are free to withdraw from interviews or leave some questions unanswered should they feel uncomfortable to do so without any consequences. It was purely voluntary.

Third, on anonymity and confidentiality, Fisher et al. (2010:80), explained the former as “not indicating names” and the later as “not revealing the sources of information”. The information provided could not be identified with the respondents and that explained why the public institutions and suppliers were given as A to M. It was some coding to preserve anonymity and confidentiality.

Fourth and last, objectivity was considered as one of the most important ethical research guidelines. The researcher made a commitment of ensuring all facts were correctly presented and free from emotional and rational imbalances (Fisher et al. (2010). The findings were fairly reported and limitations acknowledged in the study. Therefore, the findings were presented in a professional, objective and ethical manner so that the consumers of the researcher will make their independent opinion.

4.2.3. Case Study design and Sampling

Both Trochim (2006) and Yin (2009) concurred on the importance of determining

or establishing "Units of Analysis" when adopting case study method. Units of analysis (cases) refers to the main entities the researcher is analysing or investigating and in this particular instance, are the three major referral hospital that are offering healthcare services to patients in Zimbabwe. The focus on these three referral hospital is on purchasing and supply chain practices and challenges. These referral hospitals are also known as central hospitals and they represent the largest public health institution in Zimbabwe. In addition to these three major public institutions, the researcher focuses on ten Suppliers of medical commodities in an effort to obtain holistic and well-balanced data. Suppliers of these hospitals can provide valuable insights in the area under investigation Therefore, for the purpose of preserving anonymity in this study; they shall be referred to as:

Unit (s) of Analysis	Description	Number of Units
Major Referral Public Hospitals	Hospital A to Hospital C	3
Suppliers of Hospital Commodities	Supplier D to Supplier M	10
Total Number		13

Thus, a **multiple case design** was selected for this investigation. Each case is treated separately and thereafter, a cross-case analysis and comparison made. In selecting a multiple case design, evidence of more cases is generally taken as more compelling and robust. However, the author noted the magnitude of the study and the resources involved hence it explained why it was reduced to thirteen cases.

Having explained on the case study design, the sampling methodology can now be examined.

4.2.4. Sampling

Trochim (2006) defined sampling as, "the process of selecting units (e.g. people, organisations) from a population of interest so that by studying the sample we may fairly generalise our results back to the population from which they were chosen". And so, for this study the researcher categorises all the public health institutions and Suppliers of medical commodities as the "population" and it is from these hospitals that a representative or sample was selected. The rationale

for selecting a sample hinged heavily on the impracticalities associated with collecting data from all the public institutions. Limitations in terms of time, resources (both human and financial) and issues to do with access were very central to that decision.

Broadly, there are two main types of sampling: **probability** (representational) and **non-probability** (judgemental) and they will be briefly analysed in turn. Starting with probability sampling, it is a method which is premised on random selection that is to say, different units within the population have an equal probability of being chosen or selected. In this modern era, computers are now employed to generate random selections. Thus, probability methods include simple, stratified, and systematic and cluster random sampling.

However, there are situations or conditions where the researcher can be uncomfortable with using probability sampling methods primarily due to the impracticalities of the method to the issues under investigation. Like in this case, the author selected non-probability method and specifically the **purposive** sampling method in light of the research issues and objectives (Saunders, Lewis and Thornhill 2009). Further, the choice of this sampling method reflects the assumed knowledge of the research participants in purchasing and supply-chain management practices and challenges where they cannot be randomly selected. The referral hospitals being the largest are the most affected due to the high number of patients they attend to given the broad spectrum services they offer from general to specialist. If a decision was made to select to select clinics, district hospitals and provincial hospitals, some of them are not procuring as standalone entities or facilities hence they will be somewhat inappropriate for this study. In the same vein, it was impractical to reach to all the suppliers of medical products because of time and resource limitations.

Another important consideration is access to these selected public hospitals. Realising the criticality of access, the researcher requested detailed letters from the university that clearly explained the purpose of the research and offset potential suspicions if any. This facilitated access because of high sensitivity of the issue under investigation in hospitals. A sample of the letter is attached under Appendix A.

Further to the above, it is of paramount importance to note that this research is

fixed on time periods that stretch from **February to August 2016**.

After having considered the case study design and sampling methodology adopted, the next section will discuss in greater detail the data collection methods.

4.3. Data Collection Methods

Categorically, data collection methods can be **primary** and **secondary** and these two can be summarised as follows:

- **Primary Data (field research):** Saunders, Lewis and Thornhill (2009:256) described this as new data collected specifically for this investigation and so, it is data from the questionnaires, interviews and observations.
- **Secondary Data (desk research):** This referred to data collected initially for a different purpose like in the form of management reports, memorandum, minutes of meetings policy documents and letters. However, it may be necessary to appreciate that document analysis could fall in the category of primary data and not necessarily secondary if the researcher was the first to analyse them (Saunders, Lewis and Thornhill 2009:256).

For the reason that a case study design allows a triangulation of multiple lines of enquiry and corroboration of findings, the above sources of data, primary and secondary are employed in this study.

Therefore, the author selected four data collection methods namely interviews, questionnaires, observation and document analysis and these will be critically analysed in the following sub-sections respectively.

4.3.1. Guidelines applied in the designing and development of Interviews

The researcher first understood the purpose of interviewing and according to Patton (1990:278), it is to: find out what is in and on someone else's mind. The purpose of open-ended interviewing is NOT put things in someone else's mind (e.g. the interviewer's preconceived categories for organising the world) **but to access the perspective of the person being interviewed. We interview people to find out from them things we cannot directly observe".**

On interviews, Remenyi (2011:1) preferred to use the full name or title: academic research interview and obviously it is for the purpose of clearly distinguishing it

from the ordinary interviews and the author agreed with such an important distinction because of the important consideration or issues that normally package or define academic research interviews. By definition, academic research interview refers to a formal technique of soliciting verbal evidence from a knowledgeable respondent (Remenyi 2011:1).

In light of the above, the researcher selected **semi-structured** and **unstructured** interviews primarily because of the importance of flexibility in following the trajectory in conversation where the researcher may be able to note significant issues which can emerge (Bryman and Bell 2011). Structured interview in this particular investigation may not be very ideal because the topical nature of the research problems requires an in-depth analysis of issues surrounding health service delivery challenges. In fact, Yin (2009:106) recommended flexibility as opposed to rigidity which could be the case of structured interview. The nature of the interview itself relies also on cultivating rapport to ensure the participants persist with the interview hence the relevance of those two types of interviews.

However, before a further discussion is continued the researcher took cognisance of certain challenges or issues that could be associated with interviewing which should be carefully noted and managed.

- It was noted that there is a potential challenge of the researcher inducing bias or influencing the response from the informant. For this challenge, the researcher adopted and maintained an open framework in formulating and articulating questions. Leading questions were as a result, avoided.
- Interviewing is generally time-consuming, first during the interviews and after when transcripts are compiled word for word.
- Interviewing involves a blend of skills that include active listening, quick note taking, careful and meticulous planning and these were also considered (Qu John Dumay 2011:239).
- Further, it was noted that due to the criticality and somewhat sensitive nature of the investigation, participants may be less comfortable with telephone interview hence need to focus solely on face-to-face-one to-one interviewing.
- On the part of the interviewees, it seems that middle to top management level prefers to be interviewed as opposed to completion of questionnaires (Saunders, Lewis and Thornhill 2009).

Thus, in academic research interviewing there are pertinent issues **before**, **during** and **after** interviewing that need to be deeply examined.

4.3.1.1. Before Interview

Thorough preparation is the centre-piece of any successful academic interview. To highlight the criticality of interview preparation, Turner III (2010:757) indicated that the process is a make or break or can alleviate or worsen potentially problematic situations that may happen. Further, Saunders, Lewis and Thornhill (2009:328) gave the five Ps which are: "prior planning prevents poor performance" in an attempt to illustrate the criticality of planning. For the above reasons, the following formed part of the preparatory exercise carried out.

- Remenyi (2011) underscored the importance of field testing of the interview questions with similar people to the one to be interviewed. This is to ensure the questions are interpreted in the same manner intended by the researcher.
- Preparation of the interview schedule or protocol. The diagram shown on table 2 illustrates what should be contained in the interview protocol. Also, the general arrangement of questions should be purposeful made starting with less sensitive and easy to answer questions and as rapport is cultivated, it will be less catastrophic if relatively sensitive matters are asked.
- Securing of quiet, neutral, convenient and uninterrupted interview venue (Saunders, Lewis and Thornhill 2009). This encompassed also setting appointments particularly on clinical staff that may have tight work schedules or may work on a night or day shifts.
- Sending of interviews themes prior to the interview date so that all the necessary information or documents are gathered (Bryman and Bell 2011). This also helps in the event that the intended participant feels that another respondent could be referred or suggested for interview if they determine so upon receipt of the interview themes.
- The issue of being dressed formally cannot be overemphasised because in public institutions, it is the norm. Casual dressing posed a potential of not to be considered seriously. This also included arriving earlier. In fact Remenyi (2011) recommended about 10 to 15 minutes prior to an interview venue to be able to make some observations.
- Introductory statement. This was deemed central to ensure that no suspicion is raised regarding the real intention of the interview. Sufficient

professional and educational background was provided including the rationale behind selecting the respondents. The purpose of conducting the research was clearly articulated. Assurances of confidentiality and anonymity were given including the coding that was to be used on data presentation so that the respondents do not feel unsettled. This was very essential given the nature of the study.

In addition, under the introductory remarks the length of the interview was stated and the researcher endeavoured to adhere to that conscious of the fact that some are busy clinicians who need to go back to their work stations. Consent forms were given to be completed and also the respondents sensitised about their right to withdraw at any given time in the course of the interview should they feel so.

4.3.1.2. During the Interview

This is also a very important stage of the interview and in view of that the issues listed below were thoroughly considered.

- The interviewee should be kept continuously engaged and motivated to continue with the interviewing process and the general atmosphere should be relaxed and unhurried. It is important not to unsettle the informants if the interview process is to be successful. The feeling that the interview is a worthwhile process should be maintained throughout. This could be demonstrated by constantly leaning forward when seated, avoiding crossing arms or legs and maintaining consistent, polite and interested eye contact (Marks and Yardley 2004:3). Further, it is of paramount importance to maintain a non-judgemental attitude for the basic reason that people may feel uncomfortable to provide more details should they suspect being judged.
- It is imperative to keep control of the direction of the interview and even desirable to maintain 80/20 rule concentration on research issues (Remenyi 2011). This could also be achieved by use of a blend of questioning strategies that include but not limited to 'introducing', 'follow-up', 'probing', 'specifying' and 'interpreting' questions (Open University 2013:2).
- Paying closer attention on the informant's body language.
- Noticing the "unsaid".
- Active and not cosmetic listening. If listening is passive and cosmetic, it

has a potential of frustrating the respondent during the interview process. While on this stage, it is essential to deliberate on how data is recorded and stored. Regarding interview recording, the author considered the importance of accurate rendition of the interview information and an audio recorder was used upon consent of the informant (Yin 2009:109). It is also imperative to test proper functionality of the audio-recorder and constantly check the progress of recording in the course of the interview (Marks and Yardley 2004:4). However, there were instances where the respondent appeared uncomfortable in its presence, the author took notes. Thus, Yin (2009:109) outlined situations where use of audio-recorder may not be ideal and these include:

- Where the researcher assumes that the audio recorder is a perfect substitute for active listening during the interview process.
- Where there is no intention of data transcription.
- Where the informant declined to be audio-recorded.

4.3.1.3. After the interview

- Sincere acknowledgement of the interviewee's effort and time sacrificed is very important at the end of the interview.
- Debriefing. Remenyi (2011) reiterated the importance of providing a brief summary of the data supplied because if the researcher misunderstood certain points or details, the informant may correct and changes can be effected. However, care should be taken not to restart the interview as the length of the interview would have been agreed.
- Reflection of how the interview process went. This includes checking if there is anything to be improved or if additional questions should be incorporated (Open University 2013:2).
- Repeating the contact details of the researcher in the event of further details or information requiring to be forwarded (Turner III 2010:757).
- After the interview process, all data recorded was immediately transcribed to avoid mixing of information in the event of another interview. In the case of notes, the information was neatly and logically organised while the details are still fresh in the mind of the interviewer.

Table2: Interview Protocol

Item	Issue	Detail	Notes
1	Research Topic		
2	Research Question		
3	Informant(s)		
4	Location		
5	Gatekeeper		
6	Organisation		
7	Arrival at the premises	Arrive early, observe staff, building etc. and make notes	
8	Pre-Interview	Thank informant, restate research topic, research questions, verify if the informant is willing to provide views, seeking audio-recorder permission, present ethics issues and signing of letter of consent	
9	Interview Schedule	Interviews themes	
10	Interview		
11	Post-Interview	Thank the respondent, debrief and ask permission to ask further points of clarification if necessary	
12	Other data	Collect any relevant data: minutes of meetings, memo, policy documents etc.	
13	Reflection	Assess how the interview was done. Any further need to add more questions.	
14	Transcript	Data compilation and generation of transcript.	

Source: Remenyi (2011:39)

4.3.2. Guidelines applied in the designing and development of Questionnaires

A questionnaire is defined as, “a data or evidence collecting device that consists of a list or series of specific questions which when answered by an appropriate informant or a group of informants, will help lead a researcher to a greater understanding of the research question (s) and provide an insight into possible answers" (Remenyi 2011:91). Having provided that definition, it is imperative to note that the purpose of a questionnaire is to collect the actual or specific data needed to answer the research problem and objectives. The rationale being it is unlikely to have the same opportunity to repeat the data collection using the same instrument to the individuals who chose to remain anonymous, if the initial

data collected failed to answer the research questions and objectives (Saunders, Lewis and Thornhill 2009:360). Hence, issues of questionnaire design, layout, clear explanation of the instrument itself, pilot-testing and administration aspects of the questionnaire are fundamental in terms of determining or impacting the response rate, reliability and validity of data gathered. For that reason, the above issues will be comprehensively explained in the following paragraphs in that order.

4.3.2.1. Questionnaire design

As highlighted in the foregoing paragraphs, the importance of questionnaire design cannot be over-emphasised because of its impact on response rate, reliability and validity of data. In light of that, the crafting or formulation of questions was a careful and deliberate process which started with a thorough review of the research problem, aims and objectives of the research so that only relevant and necessary questions are contained in the questionnaire. Any question which failed to justify its presence in the questionnaire in view of that above was, as a result, removed.

Therefore in designing, the researcher incorporated closed, open, scaled and filter questions but the bulk of the questions concentrated on the first. The reason for such decision was that they (closed questions) are easy to complete and analyse. The researcher slotted an option of "Other" in closed questions to avoid frustrating the respondent by not finding the most appropriate answer and that broadens the respondent's option. Further, on open questions sufficient fill in space was provided so that the respondent is not limited if he or she feels there is need for more details. Also, filter questions though not many were employed to divert respondent where necessary on issues they may not comprehensively answer to where they can. This also reduces the frustration.

Further to the above, use of technical (jargon), abbreviations and colloquial language were avoided in the question(s) formulation and more importantly, the tone of the questions was friendly, courteous, polite and persuasive.

On all questions, an effort was made to ensure that they are single-issue structured to avoid confusing the respondent.

4.3.2.2. Questionnaire Layout

The structure and appearance of the questionnaire was of paramount importance. First, the researcher provided a very brief introductory notes right at the beginning of the questionnaire in the main body of the questionnaire explaining clearly the purpose of the research, the topic, thanking the respondent for the time given to complete the questionnaire, assurances of confidentiality and anonymity and how and when the completed questionnaire will be collected. The researcher selected this layout of inserting the introduction in the main body as opposed to attach a separate covering letter because there was a possibility of the attachment getting lost and that could potentially jeopardise the research when such important notes are missed. In addition, the last part of the questionnaire clearly indicated the "End" and thereafter, thank the respondent for completing the questionnaire. The contact details were again provided for any follow-up issues or point of clarification (Saunders, Lewis and Thornhill 2009).

Furthermore, clear instructions on how to complete each question were provided. In cases where the respondent was required to tick the box it was indicated. Sub-headings were used so that questions and themes sequentially flowed in a logical manner without mixing and the approach being from general to specific and more sensitive towards the end of the questionnaire.

Having said that, the importance of proof-reading to check all spelling and grammatical errors cannot be overlooked because when numerous mistakes are identified, respondents may be unsure if at all they are the real intended recipients of the questionnaire. Essentially it affects their confidence regarding the questionnaire.

4.3.2.2.1. Pilot Testing

The value of pilot testing cannot be underestimated because the researcher need to sure and satisfied that the questions contained are suitable and are correctly asked in order to meet the research objectives. In other words, the questions should be clearly understood or interpreted by the respondent in the same manner intended by the researcher. Similarly, the responses by the informant should be decoded by the researcher in the same way intended by the informant (Saunders, Lewis and Thronhill 2009:372). In real world for instance, it will be a rare scenario to procure an electrical appliance without testing the correct and full functionality of the equipment. Thus, this important research

required to have the data collection instrument tested prior to use.

In light of the above, the draft questionnaire was first given to three knowledgeable people who are experts in the area under investigation and ten individuals who have similar background or knowledge to the ones intended to complete the questionnaire. The following were highlighted and incorporated into the final draft after the pilot testing

- Some of the questions appeared to be vague and so, they were re-written so that the respondent is clear on what is being asked.
- Also, questions that appear to be too technical were re-organised so that the respondent could interpret them in the same way intended by the researcher.
- Additional questions were added to incorporate issues that are pertinent to the research aims and objectives.
- Instructions appeared to be unclear were also corrected.

An Overview of the Final Questionnaire (Hospital and Suppliers)

There were 34 questions in the Hospital Questionnaire and 14 in the Suppliers' Questionnaire. The following sections were incorporated in the Hospital Questionnaire which is provided as Appendix 2:

Before the Section A, a very brief, simple introduction of the research is crafty presented and further providing assurances of confidentiality and anonymity. Stating it clearly that respondent is feel to proceed to questions which he or she is comfortable to answer.

- **Section A: Demographics of the Respondent**
- **Section B: Procurement**
- **Section C. Tendering**
- **Section D: Supplier Selection**
- **Section E: Suppliers Relations**
- **Section F: Financing**

Section A is merely for profiling respondents while Sections B to F are specifically designed to identify the purchasing and supply chain management practices and in the process challenges will be very clear to identify. Even the last open question though not in a section format, asked about challenges affecting health delivery system. This was designed to sort of exhaust key challenges facing hospitals.

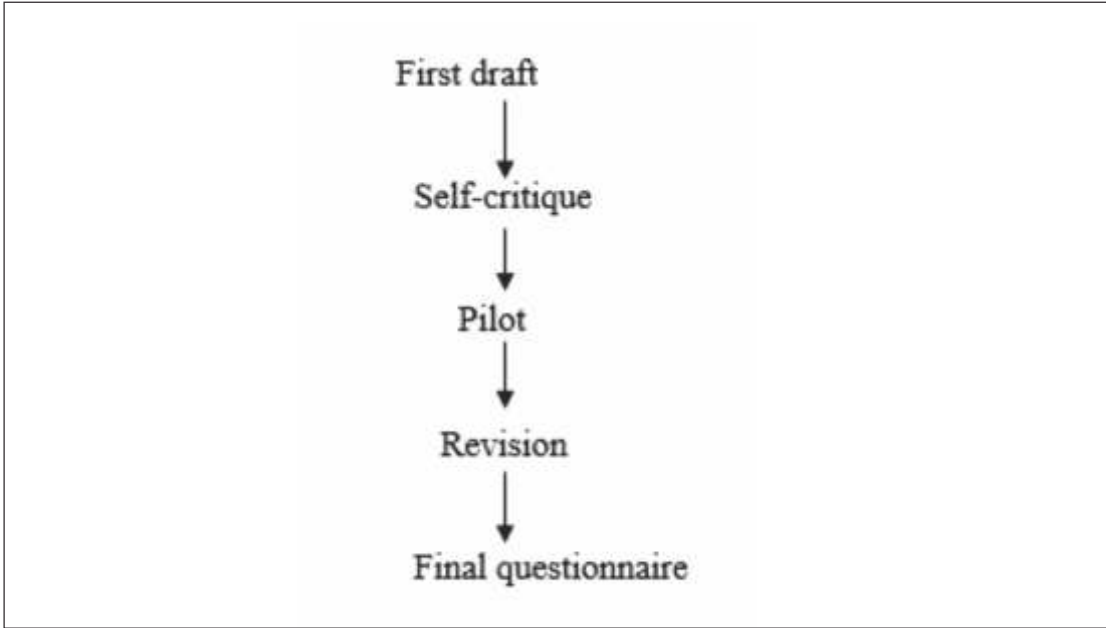
Then, Suppliers' Questionnaires was only composed of 3 sections and it is attached as Appendix 3:

- **Section A: Demographics of the Respondent**
- **Section B: Procurement/Tendering**
- **Section C. Payments**

The last open question was for the recommendations in public procurement in hospitals

From the above, it can be seen that the key stages in designing an effective questionnaire are:-

Figure 7 : Summary of Steps Undertaken to Design the Questionnaire



Source: Authors

Therefore, the purpose of pilot testing is to refine the questionnaire so that it is suitable and reliable in collecting the intended information in fulfilment of the research questions. Without the trial run of the questionnaire, there was no guarantee that it will be useful for the intended purpose (Saunders, Lewis and Thornhill 2009).

4.3.2.2.2. Administration of Questionnaire

The researcher chose to hand deliver the self-completion questionnaire and the rationale being that, the method ensures that the questionnaire is completed by the right respondent and if they are any issues which may require further clarification it will be best done on a face to face interaction. Upon completion which is after two weeks, the completed questionnaire will be hand collected and the reason is that the respondents have no continuous access to internet otherwise, they could have been emailed.

More so, the period of two weeks was given so that the informants will not feel pressurised to complete the questionnaire. However, they will be reminded at the end of the first week so that they will not forget to complete the questionnaire.

4.3.3. Direct Observation

According to Yin (2009:109) and Remenyi (2011), direct observations could be done during interviews or when hand delivering questionnaires. Conditions of infrastructure, population served in the hospital facilities including the general condition of the equipment can be observed. The general impoverishment of the health facility can be seen during the interviews particularly if the researcher arrives in time to allow direct observations while waiting for interview appointment time.

4.3.4. Document Analysis

Document analysis is defined by Bowen (2009:27) as "a systematic procedure for reviewing or evaluating documents-both printed and electronic (computer-based and internet-transmitted material". Documents includes minutes of meetings, memoranda, event programs, letters, emails, background papers, maps and charts, newspapers, press releases, program proposals, strategic and business plans(Yin 2009:103; Bowen 2009:27). While documents may contain valuable information, it is very important that a critical analysis,

examination and interpretation be made in order to make the correct sense out of the documents.

In essence, document analysis should not be done in isolation but should be converged and corroborated with other sources of evidence. It is therefore the idea of providing a confluence of data that should guide document analysis (Bowen 2009: 28).

Thus, Yin (2009) and Bowen (2009) identified advantages of document analysis. (a) Documents are unobtrusive and non-reactive implying that they are produced as a result of the case study; (b) they are also stable and it is as a result of them being non-reactive; (c) documents have a wide coverage in terms of time, events and settings.

However, the disadvantages of document analysis emanate from the fact documents in general are usually meant for a specific purpose and target audience and sometimes may provide insufficient detail (Yin 2009:105; Bowen 2009:31). For that reason, it is imperative for the researcher to analyse the information against that background. Further, there is low retrievability implying documentation may be deliberately made inaccessible particularly if it is deemed sensitive.

Having highlighted the above, the researcher noted the importance of selecting and thoroughly organising relevant organisational documents which are central to the issues under investigation (Yin 2009:105).

4.4. Data Analysis

When data is collected as explained above, it will not be useful either for organisational or research purposes if it is in a raw state. Data and information does not mean the same. It is therefore the conversion of the collected data into information that is important in the analysis stage (Crowther and Lancaster 2012). In fact, Sharp, Peters and Howard (2002) defined the process of data analysis as the, "the ordering and structuring of data to produce knowledge". Researchers and managers in most cases are interested in information that aids the decision-making process rather than voluminous, difficult to understand quantitative and qualitative data.

It is therefore imperative to note that data analysis involves the distillation, classification, identification and finally communication of information (Crowther and Lancaster 2012). These processes will be briefly explained below.

Distillation- is the process of sieving through mass of data so that data is reduced to manageable and relevant data appropriate for the research. It also entails summarising data through use of graphs, tables, diagrams etc. (Crowther and Lancaster 2012).

Classification- is the grouping of data into categories so that data is not mixed in a confusing and illogical manner.

Identification- is the establishment of any relationship between variables.

Communication- represents the final communication of findings after the above processes.

Cognisant of the above fact the data collected is both qualitative and quantitative, it follows therefore that they are also analysed differently. The difference between the two is that qualitative data is data in non-numeric form such as can be found in interviews and open-ended questionnaires (Saunders, Lewis and Thornhill 2009:480) Starting with qualitative data particularly interviews where long full transcriptions and detailed notes were made, there is voluminous data which require to be distilled. In light of that, the process start by working through each interview transcript line by line identifying issues as they emerge from the interview prior to any cross comparisons and data will be organised into major themes. Part of data organisation entailed cutting and pasting sections of data under common themes and coding so that data is reduced to manageable format.

Thus, for qualitative data there are important stages which are essential in the analysis stage which is data reduction, data organisation and interpretation and presentation. Data reduction referred to the using letter codes and assigning them in the margin of interview transcript and a record of the meaning of each code kept for the reason of maintaining consistency when working on other transcripts. Then, the next stage is data organisation which relates putting together sections of similar coded data under one theme from the interviews. Finally, the analysis of what is being highlighted in the interviews will be presented.

For quantitative data, analysis will be aided by use of an excel spreadsheet or

Statistical Package for Social Science (SPSS) to facilitate in the production of tables and graphs. However, for the purposes of compatibility of data to either excel spreadsheet or SPSS, all data is required to be in numeric format particularly that some questionnaire responses will be in words. In light of that need, a process of coding is employed to ensure that it is a numeric form. Post-coding where questionnaires are coded when they are returned after completion was preferred because of the potential confusion that can pose to the respondents who may unsure of what the codes stand for.

Therefore the Chapter can be summarised as follows:

Summary of Chapter

To summarise, the Chapter first explained the research paradigm as a philosophical, theoretical and conceptual framework which underpins research hence the initial focus of the chapter. The two main research paradigms: positivism and interpretivism were deeply explored. On one hand, positivism paradigm is a research philosophy founded on the view that human behaviour can be easily studied in the same manner scientists study natural world mainly through observations. Thus, positivism is hypothesis-driven and the focus is to remove human influence and bias by confining to what is observable and measurable. On the other hand, interpretivism paradigm is premised on thoughts of Max Weber which emphasise understanding of issues as opposed to objective facts .Choice of the research paradigm is the basis for the subsequent selection of the research methodology. Further, the two research paradigms were considered as complementary for the study and not as polar opposites.

The intricacies and subtleties of the research problem coupled with the prominence of a "how" and "why" research questions necessitated the adoption of the case study design in order to have an in-depth understanding of the real issues in the public health delivery system in Zimbabwe. It is also imperative to note that the case study design uses multiple sources of evidence in a process of triangulation and corroboration. A multiple case design was therefore selected where each case is treated separately and thereafter a cross- case analysis and comparison is made.

Out of the two main sampling methods which are: probability and non-

probability, the latter was preferred and subsequently the purposive sampling technique was chosen primarily because of the practicability and relevance of the technique to the area under study.

Coming to data collection which broadly incorporated primary and secondary data, interviews, questionnaires, direct observation and document analysis were employed as methods. In terms of data collection, key research instruments were interviews and questionnaires though other mentioned methods were utilised. Regarding interviews which were semi-structured and unstructured, the main purpose was to find out the real issues from the perspective of the respondents. In addition, there are very pertinent considerations before, during and after interviews which required a particular attention in order to ensure successful use of the instrument. Flexibility and need to get rich and deeper information was the key factor in structuring interviews in that fashion. Also, on questionnaires the design, layout, clear explanation of the instrument itself and administrations aspects were also fundamental to the successful use of the tool.

After data collection, analysis of that data was very crucial because raw data without being converted into information may not be very useful. Various stages of organising and structuring data were necessary from distillation, classification, identification and communication.

CHAPTER 5- PRESENTATION AND ANALYSIS OF FINDINGS

CHAPTER 5: PRESENTATION AND ANALYSIS OF FINDINGS

5.0 INTRODUCTION

This Chapter presents the qualitative and quantitative findings extracted from the questionnaires, interviews, observations and accessed documentation from the public health institutions and suppliers of hospital commodities. The idea of having suppliers of medical products completing questionnaires and being interviewed also is premised on the need to have a comprehensive, holistic and well- balanced view regarding the public procurement practices and challenges because they are also influenced and affected by them. So, there is corroboration of findings.

Therefore, the response rate for both questionnaires and interviews will first be given. This is followed by presentation of findings on an issue by issue basis. Pertinent issues that emanated from the research will be presented in turn. Critical analysis and the subsequent discussion of findings will be done in Chapter 5. The rationale behind this presentation style being adopted is to guide the researcher in the accomplishment of the two objectives of the study which are:

1. Identify, review and critically analyse the procurement practices and policies (processes, systems, procedures, legislative framework and strategies) in the public health sector.
2. Identify challenges, operational and strategic gaps and how they can be addressed so that quality and improved healthcare is provided to patients.

5.1. QUESTIONNAIRE RESPONSE RATE

The questionnaires were in two sets: hospitals questionnaires and suppliers' questionnaires. Seventy (70) questionnaires were distributed to three (3) hospitals and 60 questionnaires were returned fully completed. This represented a response rate of 85.7%. Then, for suppliers, 20 questionnaires were distributed to ten (10) suppliers of hospital medical products and all 20 were returned fully completed translating to 100% response rate.

The high response rate could be attributed to the proper design, layout, pilot-testing, distribution strategy and prior engagement adopted by the author. Ample time (2 weeks) were given to the respondents and often reminded courteously on a weekly basis about the completion of the questionnaires. The questionnaires were collected instead of the respondents troubling about delivering them.

5.2. INTERVIEW RESPONSE RATE

Switching to interviews, the author selected 60 individuals for interview and 50 were successfully interviewed, translating to 85.7% response rate for health institutions. Twenty supplier respondents out of 20 selected were interviewed. Setting of flexible appointments well ahead of the actual interview date could be attributed to the high response rate especially for busy clinical and administration staff. However, the interview process for both hospital respondents and suppliers took close to 3 months. Appointments for some interviews were continuously re-scheduled and the process also coincided with demonstrations that resulted in some respondents staying at home because of the chaotic surrounding environment.

5.3. PROCUREMENT PRACTICES AND CHALLENGES

In light of the first and second objectives of the research, procurement practices will be presented followed by the challenges. Procurement practices section will highlight the systems, policies, procedures, legislative framework and strategies that are applied or utilised in the procurement of healthcare commodities. However, it is imperative to note that in the presentation of the findings some of the procurement practices present themselves as challenges and this will be shown on an issue by issue basis in the following paragraphs and sub-sections.

5.3.1. PROCUREMENT PROCESSES AND THE REGULATORY FRAMEWORK

The procurement of hospital commodities is primarily governed by the Procurement Act [Chapter 22:14) and the Procurement Regulations of 2002. Apart from that, the Indigenisation and Economic Empowerment Act of 2010, Section 3 (1) (f) prescribed that 50% of procurements must be from businesses where Zimbabweans have a controlling stake. Further, there are other policies like the Look East Policy and the Buy Zimbabwe Initiative which is enshrined in

the National Trade Policy of 2012 -2016 which gives other guidelines with regards to public procurement. The Buy Zimbabwe Campaign, for instance, is aimed at promoting local procurement of commodities and this culminated into the enactment of Statutory Instrument 18 of 2016 which banned importation of certain medicines like Aspirin, Cotrimoxazole, Ibuprofen, Metformin and Amoxicillin. So, there are several policies and legislative frameworks which are contained in different Acts that guide procurement by institutions.

In describing the procurement system in general 45 out of 60 questionnaire respondents said it is restrictive and inappropriate for the health sector. This was further corroborated by the supplier's questionnaire that also highlighted it as non-responsive, unfair and not cost-effective. Twenty out of twenty suppliers' respondents agreed on the state of the procurement systems, policies and procedures. The following italicised excerpt indicated that: “the procurement systems and processes are not best for patients and not ideal for hospital. I think they were designed by non-procurement professionals with limited experience in procurement-maybe accountants. It is not customised for health sector. For example, you need Isoflurane for Theatre, the value alone is usually above \$10.000 threshold limit which follows that an informal tender should be floated in the newspaper but the patient with a specific condition which needs surgery within a specified period will be waiting”.

From the perspective of the suppliers, the following italicised excerpt described the existing procurement system as follows:

“Where I say the system is not cost-effective is where they require 5% bid bond of the total tender value and its very expensive to secure that or a bank guarantee. They may even require that each item must be quoted on separate sheets and imagine there are 400 items and how expensive is the tendering process. To make matters worse, the procurement system is manual- you have to drive to collect the tender document in person and return the quotations again. It is also unfair because sometimes you participate in a tender that you feel it is already decided. Let me give you a typical example of another dimension of unfairness. I tendered for 10 000 sharp tins and when the order was issued it was 3000 sharp tins. When I quoted I had negotiated a price with the manufacturer for 10 000 sharp tins and it means the supplier will not give me 3 000 sharp tins at the same price”.

Another respondent from the suppliers' side described the procurement processes as not responsive: "I tendered for x-ray machines some time in November last year and only to be awarded the tender this year in August. They took too long to adjudicate and I think they will be consulting many stakeholders' In response to the questionnaire, below is how suppliers described the procurement system and this is shown from table 4.3.1.1 to table 4.3.1.3 below.

Table 5.3.1.1: Questionnaire response to the relevancy of the procurement system to the health sector

	Frequency	Percent	Valid Percent	Cumulative Percent
No	17	85.0	85.0	85.0
Yes	3	15.0	15.0	100.0
Total	20	100.0	100.0	

The above table indicated that 17 out of 20 suppliers which translate to 85% described the procurement system as not relevant while 15% said it is relevant. The response was showing lack of relevance of the procurement system in tandem with the unique healthcare set-up.

Table 5.3.1.2: Questionnaire response to the fairness of the procurement system

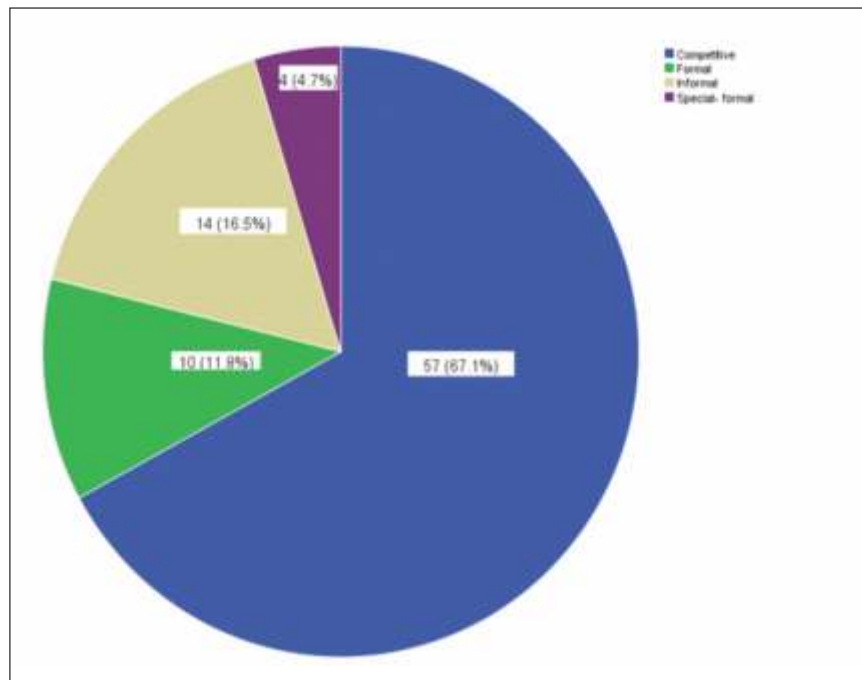
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	20	100.0	100.0	100.0

Table 4.3.1.2 above showed that 20 out of 20 suppliers which represent 100% indicated that the procurement system is not responsive and cost-effective. Lack of responsiveness emanating from the longer time it takes from tendering to the final issuance of a Purchase Order. In terms of the procurement system being not cost-effective, follow-up questions indicated that the cost of tendering is high because the suppliers have to collect physically the Request for Quotations and submit bids in person. Advertising for local tenders is mainly through notice boards. Also, the responses given was that sometimes instructions in the tender stipulate that each item should be quoted on a separate sheet and in the case of many items it become expensive in the preparation of the tender submissions.

Further, the procurement system relies in advertising in government gazette or

in the Herald which could be easily missed. For Competitive Tenders, notice boards are used. It is also very interestingly to note that the Competitive Tenders out of all the tender types, are the most commonly used and this is because they can deal with urgent requirements. That alone signals the need to have a flexible tendering system that is ideal to address the unique and urgent healthcare demands. The pie chart on the next page clearly shows that.

Graph 5.3.1.5: Pie Chart showing Most Common Tender Type



Pursuant to the above tendering system in place as provided for under the Procurement Act [Chapter 22:14] and the Procurement regulations, interview respondents indicated that when Informal Tenders are floated, a sizeable number of respondents submit their quotations but the challenge is that most of them will be briefcase companies who know that by bidding the lowest, they are likely to be awarded the tender. As a result of that, the evaluation process will be fraught with challenges. The following italicised excerpt provided that:

“If you use Informal Tenders, you will receive loads of responses and it is the briefcase companies which provide every requirement and came out cheaper and fails to deliver. If you want to restrict competition, you have to seek approval for that and it is a tedious process which takes longer. As a result you have no control of the size of the supplier database”. This was also substantiated by all suppliers who highlighted that they have been thrown out of business by

briefcase companies who only have the quotation book in their bag but with no offices or registered premises to operate from.

It was also reported that the tendering or market conditions have frustrated the best suppliers resulting in the worst ones who have found it very difficult to sell their products.

5.3.2. Procurement Cycle

The significance of the hospital purchasing cycle is that it affects the responsiveness of the services to the patients against the assumption that sickness cannot be postponed to a later date when all the services and products are available. Thus, the hospital's purchasing cycle has three important stages: Requisitioning, Tendering and Ordering. The following flow chart summarises the purchasing cycle.

5.3.2.1. Flowchart of the Procurement Cycle

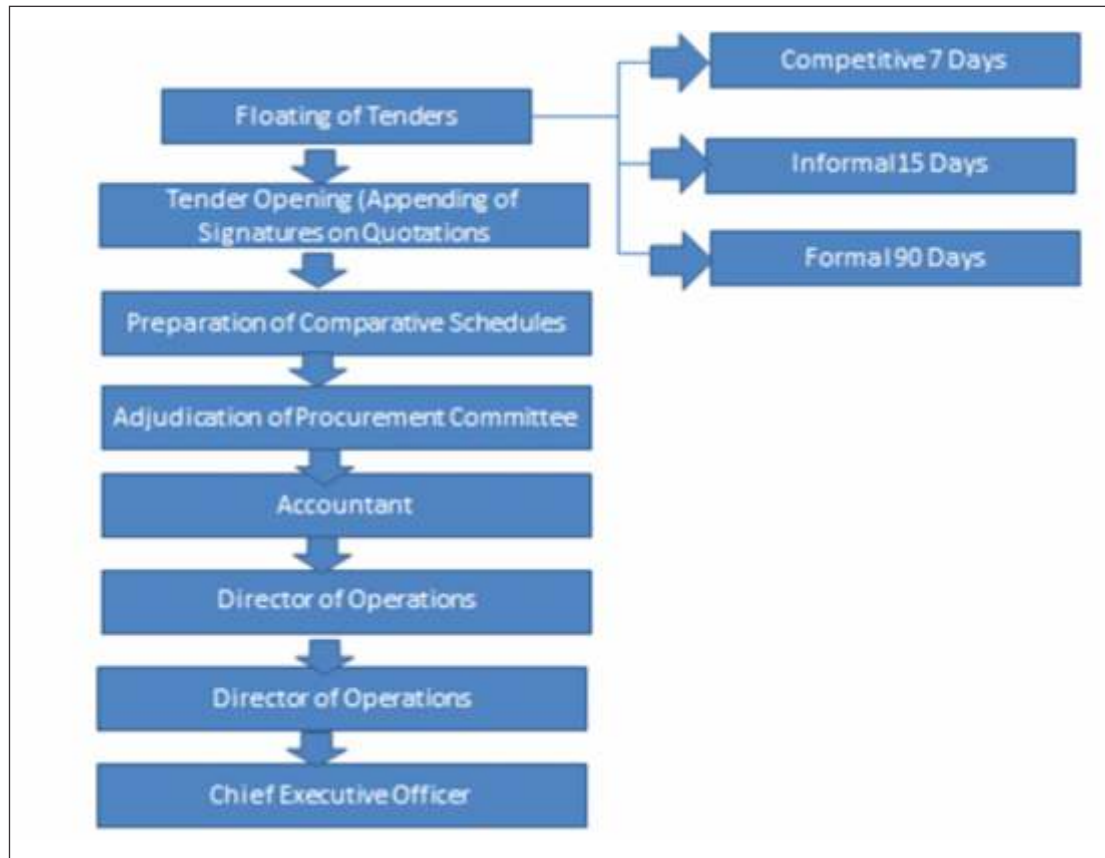
Stage 1: Requisitioning



The flow chart above showed the reviewing and approval process of a purchase requisition. For example, when a need is identified in theatre, the department send a request either to the Pharmacy if it is medicines and the Pharmacist or Pharmacy Technician initiate a requisition which is approved by the Chief Pharmacist which is the head of department. Thereafter, the requisition is

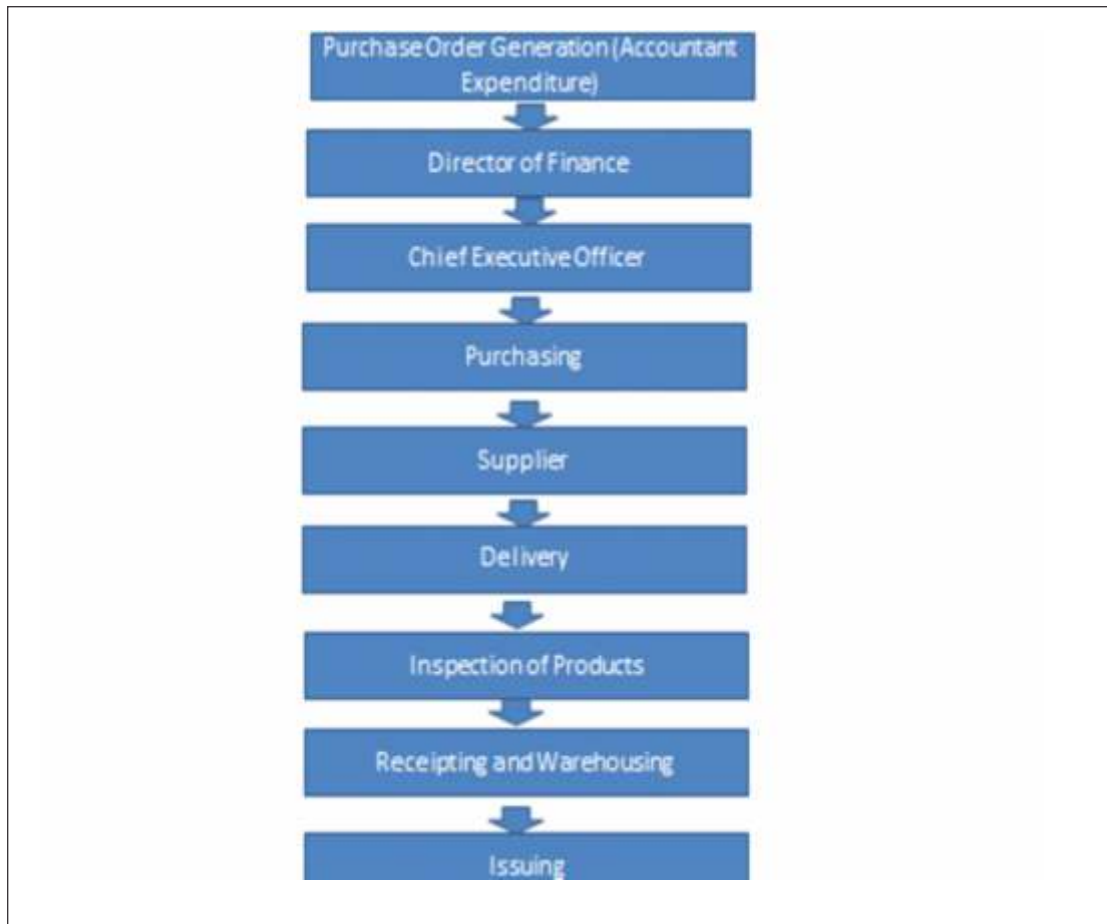
approved by the Accountant and subsequently the Director of Finance before the final approval by the Chief Executive Officer.

Stage 2: Tendering



The Tendering Stage only commences after the approval of the purchase requisition by the Chief Executive Officer. The decision is first need to be made as to whether a Competitive, Informal or Formal Tender is to be used but that much depends on the threshold limit. After closure of the tender, the bids are opened by the Central Buying Office (CBU) and subsequently prepared on comparative schedule for adjudication by the Procurement Committee. When the adjudication is completed by the Procurement Committee, the purchase documents are then reviewed by the Directors of Operations and Finance before approval by the Chief Executive Officer.

Stage 3 – Ordering (Purchase Order Generation and Approval Flows)



Source: Own depiction based on interviews and hospital documentation

On Stage 3 which is the Ordering starts when the purchase documents are approved and the Purchase Order is prepared by Accountant Expenditure and reviewed by the Director of Finance before being approved by the Chief Executive Officer. Following this, the Purchase Order will be send to Procurement Department so that it is issued to supplier(s) for delivery. After delivery goods will be inspected, received, warehoused and issued to user departments.

Starting with Stage 1 (Requisitioning), it is very much clear that for the process to be completed about seven signatures should be appended to give full authorization to be next stage which is the tendering. Again on tendering, the process as indicated above seems long and winding particularly if the tender. Avenue pursued is Informal (15 days) or Formal (90days). The entire process of tendering passes through 8 phases up to the Chief Executive Officer who

approves the adjudication documents. After that, comes ordering which is the final stage.

While recent amendments of the procurement regulations which decentralised Formal and Special-Formal Tenders to hospitals which were initially under the purview of the State Procurement Board, the reviews of these tenders is still being done by the State Procurement Board. There is high probability of lengthening the procurement process unnecessarily because by those reviews, it could imply lack of confidence regarding the capacity of the hospital procurement staff to unilaterally and independently complete the process.

Thus, on average, it took approximately 2 weeks to have the final product delivered for basic products while, for sophisticated purchases like equipment, it took 3-4 months. Having said that, there was no documented Signature Authority Matrix that detail the approvals flow of the procurement processes.

5.3.3. Recognition of the role of Procurement

From the questionnaire responses, it is shown that the role of procurement is recognised. However, observations and interviews made illustrated that in real sense the role of procurement is at the peripheral particularly with respect to the actual contribution to purchasing decisions. First and foremost, the title of procurement professional on the Ministry of Health and Hospital Staff Establishment is indicated as Administration Officers and not Procurement Officers. This scenario tend to cast doubt as to whether they hold correct professional qualifications and that dove-tailed with the research by Raga, Bayat and Ferreira (2012:81). It is again the highest level for a procurement staff. There is no representation at director level or any a senior level at the head office at Ministry of Health and Child Care. Further, it is of paramount importance to understand that these staff establishment were put in place decades ago and as such, no longer reflect the current demands to deliver quality healthcare services in terms of purchasing and supply chain management.

Secondly, during the interviews it was observed at the three case hospitals that the location of Procurement Office is in the back-yard close to the boilers and stores. They are actually not in the Administration Block. Their lack of recognition is further shown by the exclusion in the Procurement Committee and the following italicised excerpt clearly highlighted that point:

“We are in the armpits of the clinicians and accountants and we are excluded from the deliberations of the Procurement Committee. Non-procurement staffs are at the centre of all purchasing decisions and several problems have followed as a result of that. In fact, the perception on procurement staff is demotivating- they regard buyers as thieves and this hurts and probably explains the exclusion in general. We simply take the procurement documents to this Committee and once they adjudicate they give us for us to process. Recognition is very poor”.

While the existence of the Procurement Committee alone is in line with global international best practices on fostering transparency in the public procurement processes, exclusion of the procurement experts in the decision could result in a number of challenges and these will be explored in considerable depth in the next chapter.

5.3.4. Development of Product Specifications

The interviews and questionnaire responses particularly from suppliers', unearthed widespread use of brands in the specifications of medical products. This was most common in medical equipment and suture materials. Notably, the extract from this interview response highlighted: “They use lock-out specifications which are confined to a particular brand and in the case of suture material, they specify SMI brand as if the surgeons are like brand ambassadors of those companies. There are different other good brands apart from SMI sutures. In some cases, the clinicians just stick to what they know even if it is outdated and not currently used”.

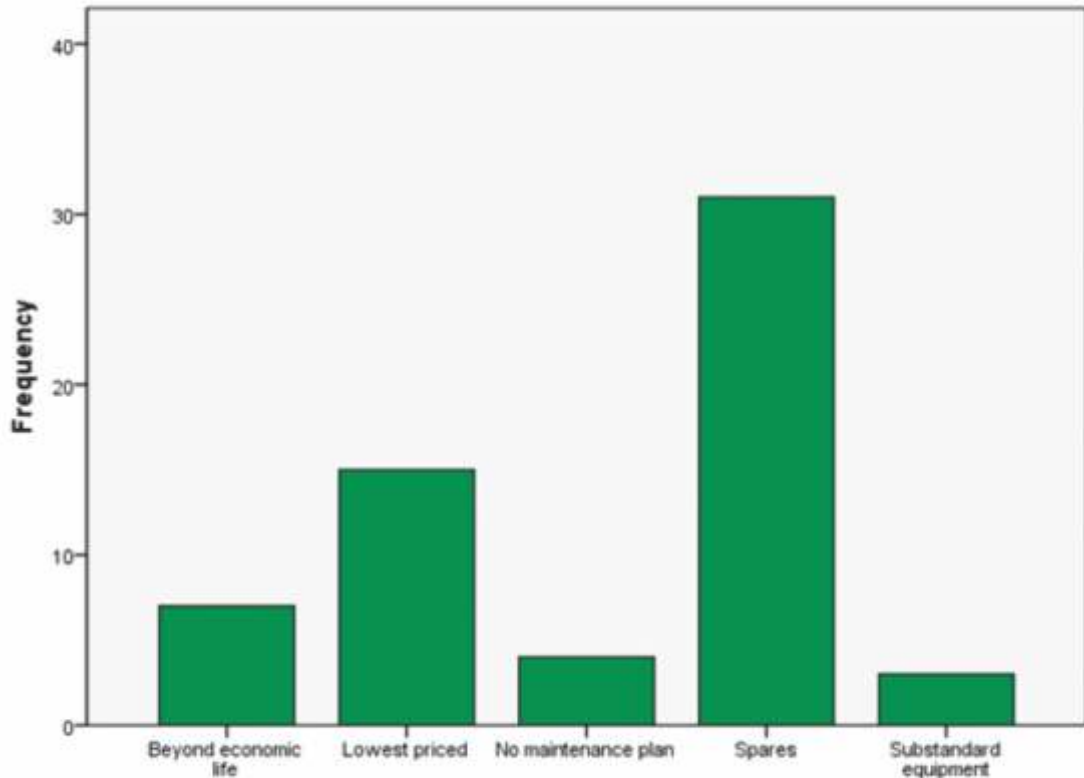
The net effect of brand specificity is on creating artificial oligopolistic and monopolistic market structure because competition is restricted by use of such specifications and Value for Money not realised in such procurements.

5.3.5. Purchase of Different Medical Equipment

It was noted during the interviews that each hospital is purchasing medical equipment which include Intensive Care and Theatre machines independently of each other resulting in total different models and types supplied by different companies." Lack of standardisation of medical equipment even here and as central hospitals means we cannot leverage on consolidation when negotiating procurements". This came out during the interview from hospital respondents.

Related to medical equipment, some machines are not functioning primarily because of lack of spares or components as shown below.

Graph 5.3.5.1: Factors that are resulting in non-functional equipment



The bar graph it is clearly shown that the major reason why some medical equipment is not functional is as a result of lack of spares components. The other important factor being that the equipment purchased could be lowly priced equipment which could not be durable enough. Also, shown quite relevantly is the issue that some of the equipment has surpassed their economic life but still being utilised.

Medical equipment unlike basic goods and services demands a holistic and thorough procurement decision because they are not one-off purchases. Spares or back-up availability is of paramount importance. A classic example at one medical institution was an Ultra-Sound Scan machine which had developed a software vision error and that problem could not a resolved because of unavailability of back-up services. Further, the graph above shows that some of the non-functioning machines were those procured on the basis of the lowest price. It

therefore goes without saying that in procurement, it is not only the purchase price that should be considered. Over-reliance on price as the selection was also picked in the document analysis.

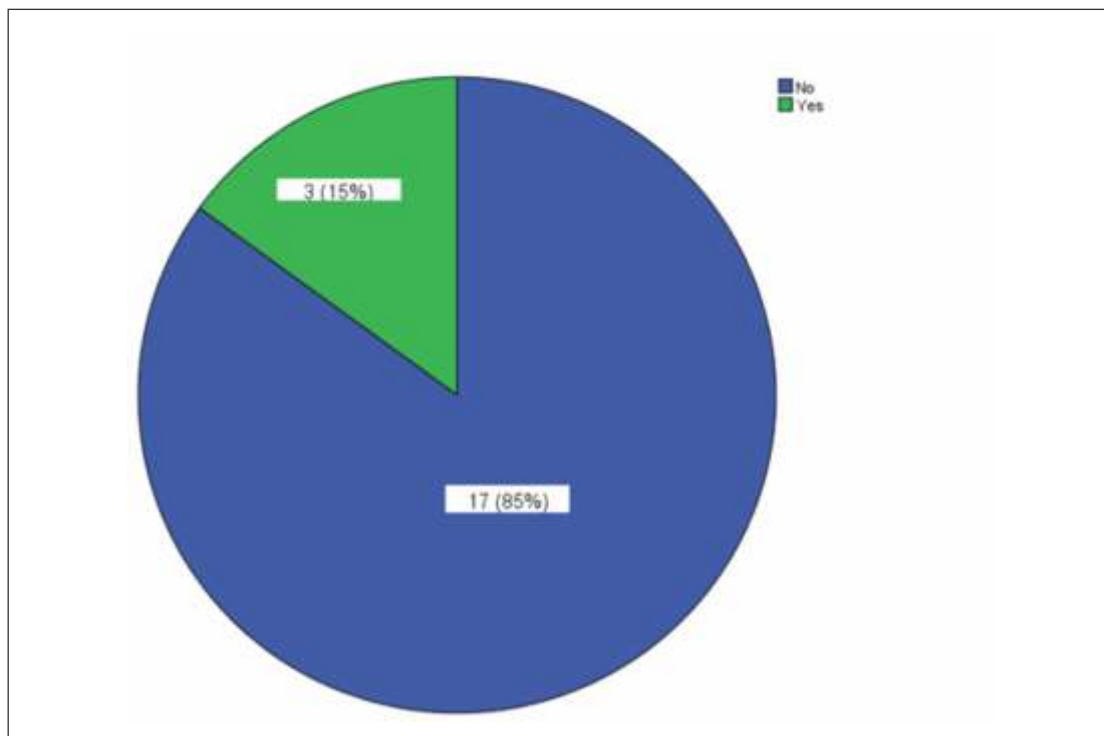
Also, it is very important to notice that some of the non-functionality has surpassed their useful economic life.

In fact, interviews uncovered that some of the equipment are in excess of 15 years hence the continuous break-downs.

5.3.6. Suppliers Symposium

A suppliers' symposium is essentially a conference or a platform where all suppliers are called to be sensitised about the tendering requirements, expectations, terms, conditions and ethical issues so that they are at the same wave-length with the procuring hospital organisations. Lack of that platform could spell out discord, misunderstandings and suspicion within the supply chain network. Regrettably, the table below showed that 95% of the suppliers sampled have not attended that symposium which was also confirmed by all hospitals.

Table 5.3.6.1: Attendance of a Supplier Symposium (Tender Conference/Training)



The pie chart above provide a summary of response from the suppliers who expressed that in most cases they are not aware of tender expectations and it is crucial to note that it is happening at a time when supplier symposium are also not being done by procuring hospital. 85% of the suppliers have not attended supplier symposium. Supplier symposium could have assisted in enhancing understanding of general tender terms, conditions and expectations.

5.3.7. Selection Criteria

Five hundred and thirty-six (536) Procurement Documents were selected between January and July 2016 and out of that, 534 were based on lowest price translating to 99% of the purchases being on lowest price.

One (1) was based on lowest technically acceptable price and it was for the supply and delivery of hospital mattresses. The other one which was for the purchase of Normal Saline, Ringers Lactate, Naloxone 0.02mg and Naloxone 0.4mg could not be signed by the Finance Director because the criteria was not based on lowest price. Section 31 (m) of the Procurement Act stipulated that, “the procuring entity shall accept whichever valid tender offers the lowest price, unless other criteria are specified in the solicitation documents, in which event those criteria shall be followed”. This is done upon solicitation of at least 3 quotations. The issue of 3 quotations, is it a measure of competitiveness or just a mere fulfilment of the number of quotations in line with the regulations? This will be explored in greater detail in the next chapter.

Further, the questionnaire responses indicated the price has the highest weighting and importance in the selection criteria. From the hospital questionnaire, 50 out 60 supported the issue of price being the overriding factor while 90% of suppliers' questionnaires showed price as the main variable and this shown on the table below:

Table 5.3.7.1: Most Commonly Used Tender Evaluation Criteria

Evaluation Criteria	Frequency	Percent	Valid Percent	Cumulative Percent
Brand name	1	5.0	5.0	5.0
Price	18	90.0	90.0	95.0
Sample	1	5.0	5.0	100.0
Total	20	100.0	100.0	

The above table indicated the 18 out of 20 suppliers highlighted that price is the main dominant selection variable.

5.3.8. Procurement Planning

The interviews revealed that procurement planning as a critical function of the procurement professionals is not being done in most cases. An extract from an interview from hospital respondents highlighted:" there is no planning from departments for us to focus on procurement planning. Purchasing is mainly on noisy items which are urgently required and not necessarily following a plan. Planning is frustrated by inadequate funds. Why planning when you cannot purchase?". Lack of planning is further cemented by the questionnaire responses from suppliers who highlighted that in most cases, Purchase Order given to them does not give realistic supply lead-time as stock could have ran out at the time of order placement. Therefore, 100% of their responses indicated that they are not given realistic supply lead-time as shown on the table 4.3.8.1 below.

Table 5.3.8.1: Realistic supply time

	Frequency	Percent	Valid Percent	Cumulative Percent
No	20	100.0	100.0	100.0

This is further exacerbated by delays from banks in transmitting international payments caused by monetary restrictions imposed by the Reserve Bank of Zimbabwe. It technically means longer supply lead-time for imported medicines.

5.3.9. Manual Purchasing and Supply Chain Management System

Questionnaires and interviews both from hospitals and suppliers respondents described the procurement system as manual and paper-based. There is no e-tendering as suppliers have to submit quotations physically and also tender advertisements are not uploaded on websites but in newspapers only. This also applied to the inventory management system which is mainly stock-card based resulting in lack of visibility in the pipeline. The situation starts with Natpharm where some of the drugs are distributed close to expiry and there is irrational distribution of the medicines; some receiving too much in relation to the consumption pattern. Forecasting and planning is fundamentally missing as distribution is being based by experience rather than being informed by the

actual consumption rate.

This is also reflected by some medical commodities are ordered when they are already out of stock. There is no electronic and well-integrated inventory management system.

Further, suppliers' questionnaires and interview strongly highlighted that the manual tendering system increase cost of their businesses.

5.4. Procurement Challenges

This section presents the procurement challenges.

5.4.1. Procurement Skills and Competences

This issue came strongly from both hospitals internal requesting departments, procurement regulatory body as well as from all the suppliers. Topical was the issue of insufficient market intelligence by buyers to an extent that they required requesting departments to search the market for them. Lack of capacity and need for training was highlighted with several interviews emphasising that there is 'mediocrity in the calibre of the procurement professionals- they needed to go beyond adherence to be able to address efficiency and competitiveness. Further, co-ordination and communication issues were pointed out to be lacking between procurement staff and requesting departments. Inadequate professional support and guidance to the clinical sections were reported in the interviews.

To further substantiate the above, 15 out 20 suppliers have indicated that they have not received feedback after tendering and that has negatively affected them.

Table 5.4.1.1: Receiving of feedback after tendering process

	Frequency	Percent	Valid Percent	Cumulative Percent
No	15	75.0	75.0	75.0
Yes	5	25.0	25.0	100.0
Total	20	100.0	100.0	

5.4.2. Financing Hospital Purchases

Unavailability of finances to efficiently run the hospitals was very topical in both interviews and questionnaires from suppliers and hospitals. Three sources of finances: Government annual budget which comes from Ministry of Finance, Hospital Service Fund (HSF) and Donor funds (from Non-governmental organisations and private companies particularly mines) were established. Of the three sources, the hospitals mainly rely on the first two. Donor funds, in most cases are specifically directed towards the purchase of particular medicines for example anti-retroviral drugs and malaria drugs or a specific construction project.

Donors, more often than not, prefer to procure medicines on their own and supply through Natpharm but the issue of needs synchronisation remains a very important matter because if that does not happen, priorities may be missed. The hospitals owed suppliers payments of drugs, surgicals and other consumables for a period of at least 3-4 years. Erratic and insufficient disbursements have greatly affected operations of the hospitals with suppliers unwilling to continue supplying. Late payments may result in suppliers charging a precautionary price which could be higher than the prevailing market price.

The table 4.4.2.1 below illustrated that 100% of the questionnaire respondents agreed that they do receive inadequate finances from Treasury.

Table 5.4.2.1: Inadequate funds from Ministry of Finance

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	60	100.0	100.0	100.0

Funding from the Ministry of Finance annual budget allocation have been inadequate falling short of the Abuja Declaration that stipulated that about 15% of the national budget should be allocated to Ministry of Health and Child Care. In fact, the official statement from the Minister of Health and Child Care, Dr David Parirenyatwa regarding inadequate funding in May 2016 highlighted that, “I have approached Treasury, and Finance Minister is looking at it. What we need is about \$65 million for the year but he can give us in tranches. What I am saying is do not continue prioritising other arms of government without looking at our arm

too. For example, Treasury approved a budget of \$450.000 for Midlands Province but they were given \$3000". This disbursement is less than 1% of the budgeted amount

Table 5.4.2.2.Frequency of funds disbursements to hospitals

	Frequency	Percent	Valid Percent	Cumulative Percent
Irregular	57	95.0	95.0	95.0
Quarterly	1	1.7	1.7	96.7
Yearly	2	3.3	3.3	100.0
Total	60	100.0	100.0	

It is therefore not a matter of figures being allocated because a percentage of more than 15% of the national budget can be allocated to Ministry of Health but the real issue is the translation of figures into the actual disbursements. Thus, in terms of the frequency of disbursement of finances, 95% of questionnaire respondents from the hospital indicated that it is irregular and therefore the timing of receipt of funds is not fixed, for example, on monthly or quarterly. This is shown on table 4.4.2.2 above.

In terms of the impact of the frequency of disbursements of funds on the health delivery system, sixty (60) out of 60 questionnaire respondents from the hospital as indicated in the table 4.4.2.3 below, concurred that the frequency of funds disbursement has a direct impact on the provision of quality and comprehensive healthcare services.

Table 5.4.2.3.Impact of frequency on funds disbursements on service delivery

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	60	100.0	100.0	100.0

Apart from finances from the government and donors, what is the contribution of the Hospital Service Fund (HSF) which is mainly what hospitals collect as revenues from paying patients? While this will be discussed in greater detail in the next chapter, it signals some management issues that deal with prioritisation, innovation and correct utilisation of cash-cow sections like

pharmacy, laboratory and x-ray to generate sufficient revenue for the upkeep of the public medical institutions.

Due to the issue of inadequate financing which culminated into late payments, about 96.7% of complaints received by hospitals from suppliers as shown on table 4.4.2.3 are related payments for medical commodities supplied but not paid for after 3-4 years.

Table 5.4.2.3. Number complains received regarding late payments

	Frequency	Percent	Valid Percent	Cumulative Percent
No	2	3.3	3.3	3.3
Yes	58	96.7	96.7	100.0
Total	60	100.0	100.0	

Lastly, it was observed and noted during scheduled interviews that some of the infrastructural projects, for example, the Laundry building was incomplete. The reason given by the hospitals questionnaire responses was inadequate financing though the others reasons had to do with lengthy procurement process and unreliable suppliers. The table above clearly illustrated

Improvement in general infrastructure at hospital remains a priority against the background that most of the facilities were constructed some before the 1980s and others slightly after and these facilities are no longer able to accommodate increased patient population at hospitals.

Graph 5.4.2.4: Factors behind delays in the completion of infrastructural projects.

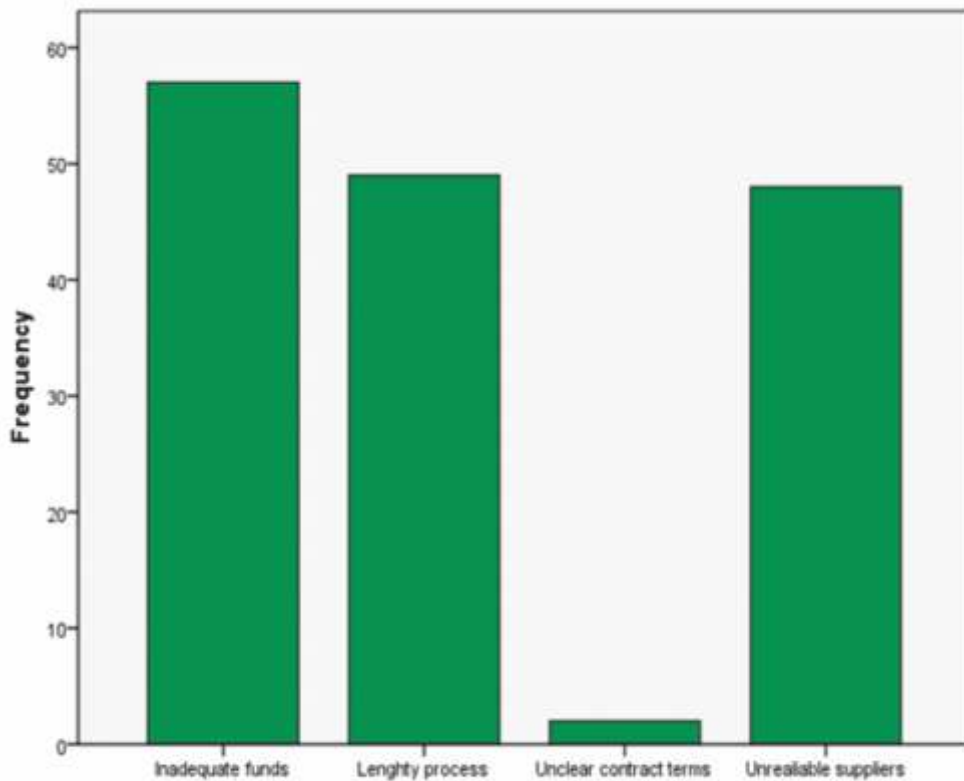


Table 4.4.2.4 above shows that inadequate financing, lengthy procurement process and unreliable suppliers are the major reasons why infrastructural projects take a longer time to be completed.

For detailed data, please refer to Appendices 3,4,6 and 7.

5.4.3. Corruption

The hospital questionnaires and interviews could not establish the existence of corrupt practices. Naturally, corruption is not a practice which concerned individuals will openly discuss particularly with an outsider for obvious reasons. However, responses from suppliers hinted unfairness and lack of best practices in situations where they said they can participate in a tender that they know it is already decided. So, what that implied is that the tendering process in those particular circumstances could only be there to merely fulfil the procurement requirements with no real intention of making it a fully competitive process.

Various cases of corruption have been reported and investigated and most recently is the corruption allegations of Natpharm employees who were selling medicines to private companies and receiving payments which are not accounted for. It is therefore imperative to note with deep concern that the Procurement Act is reflecting lack of understanding on how to deal with corruption. Section 39 of the Procurement Act [Chapter 22:14] primarily deals with suppliers' corrupt tendencies and the corresponding remedies but corruption does not start and end with suppliers alone. Actually, corruption can be initiated by the procuring organisations and for that reason, a balanced approach detailing remedial actions to be taken for both, should be adequately provided.

5.4.4. Stock levels

The average stock levels for medicines and surgical consumables were about 50%. However, according to the VEN which is the classification of medicines and surgical consumables in the Essential List of Medicines in Zimbabwe (EDLIZ), the recommended levels are as follows:

- Vital Drugs means life-saving drugs, non-availability may lead to death/disability, optimum availability to be 100%.
- Essential means non-availability of these drugs lead to pain, optimum availability to be 80%
- Necessary means that these drugs are required but of lower priority than the above drug classification.

5.4.5. Storage Facilities

Regarding sufficient and appropriate storage facilities, it was observed and noted during the interviews that some of the medical equipment and IV Fluids were stored outside; in the corridors close to Pharmacy and Stores. Ideally, IV Fluids are part of medicines and as such requires appropriate storage facilities. In laboratory, inadequate cold-chain facilities were also noted.

SUMMARY OF FINDINGS

SUMMARY OF FINDINGS

Under the procurement practices, the procurement processes done by the public hospitals is government by different policies and Acts which include but not limited to, the Procurement Act, Indigenisation and Economic Empowerment Act and the Buy Zimbabwe Initiative. Generally, the existing public procurement system was categorised as irrelevant, non-responsive, unfair and costly in the health sector. That represented corroborated findings from hospitals and suppliers respondents. The purchasing cycle showed multiple processes and extensive authorisation protocols which could be inconsistent with the nature of the healthcare requirements.

It is also regrettable to note that the role of procurement professionals is at the peripheral and are not core to the procurement committee. In fact, they are excluded. Another procurement practice which relates to the overly use of brand specifications was also presented.

In terms of procurement of medical equipment, each hospital procures independently and hence there is no leverage on consolidation of purchases. It is worrisome that most medical equipment is non- functional primarily because of lack of spares.

Further, it was also presented that suppliers in generally are not aware of the tendering requirements, expectations and some guiding ethical matters. This was because no supplier symposium was conducted. In addition, in most cases suppliers are not receiving any feedback after tendering- a position which greatly affected them. Not only that, the selection criteria is hinged on price upon solicitation of 3 quotations and in most sampled procurement the trend was quite evident. Procurement planning as a key function of the procurement department is not being carried out as purchases a primarily made on the basis of the urgent ones. Apart from that, the purchasing and supply chain management is manual and paper-based.

Lastly, in terms of procurement challenges issues to do with inadequate financing, lack of relevant procurement skills and competences, corruption, inadequate storage facilities and dwindling stock levels for medicines were noted.

CHAPTER 6: ANALYSIS AND DISCUSSION

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6.0 Introduction

Following the presentation of findings in the previous chapter which was mainly descriptive with superficial analysis, this section will analyse and discuss the major findings in considerable depth. The discussion will not be in isolation but will also relate to published work highlighted in literature review. First, the analysis and discussion will concentrate on the procurement practices followed by the challenges in the same manner the findings were presented.

6.1. Procurement Legislative Framework and Processes

On the issue of the procurement legislative framework and the subsequent processes, there are a myriad of issues to analyse and discuss. Critical to note in the first instance, is the existence of different procurement regulations and policies which are scattered in different Acts notably, the Procurement Act, the Indigenisation and Economic Empowerment Act and the Trade Policy which contain the Buy Zimbabwe Initiative. It is not difficult to see that these laws are not harmonised into one document which should guide comprehensively the procurements by state enterprises. There is a chance that some of these regulations may be missed by state procurement professionals unintentionally because they are not in one place. Related to that, multiplicity and variety of procurement regulations could lead to what Schillemans (2015:433) described as "Multiple Accountabilities Disorder (MAD) primarily because there will be too many facets to comply with. There will be again substantial investment in compliance at the expense of performance.

In describing the procurement regulations, research respondents mainly highlighted lack of relevance to the unique public healthcare set-up. The Procurement Act was enacted in 2002 and certain market and economic conditions existed at that time. These regulations apply to almost all sectors of government that include mining, agriculture and health included but a critical analysis of these sectors will evidently unravel that they are not really the same hence need for a customised approach. It appeared that the nature of regulations themselves have a strong basis toward accounting as opposed to actual procurement processes themselves and could signal the involvement of accounting and administrative professionals in the crafting of these regulations.

The other dimension could be that there was an inadequate consultation particularly from procurement professionals.

Further, there are issues to do with increasing the cost of tendering from the perspective of the suppliers. The procurement regulations do not provide or support the use of modern procurement methods like the use of email to send Request for Quotations or Request for Proposals and the receive the bids and other electronic tendering.

Even the platforms which are used to advertise or publicise tenders which are mainly notice boards and newspapers may have limitations in terms of coverage. For example, a tender on the notice board can only be viewed physically by the supplier who visited and in the same context, a potential bidder who missed the newspaper advertisement may not know of that particular tender. Website tender advertisements may be necessary both in terms of coverage and cost containment. Naturally, suppliers will factor in all the costs of doing business including those of tender preparations and submission and consequently, the final product is going to be expensive. Therefore, modern day procurement methods such as e-tendering and use of secured email in receiving bids can be good alternatives in view of the need for efficiency and responsiveness.

In addition to the above, the main objectives of the procurement regulations are to promote transparency and competition which will eventually impact on best value for money principles. While this is generally acceptable, there could be a need to holistically look at those pillars. The issue of transparency and competition is it only the function of the multiple procurement regulations but the existence of other factors like the availability of market conditions which favour competition and other strategies which are targeted at changing the corrupt mind-set to an ethical and accountable one. Rules alone may be inadequate to address those aspects.

Considering the procurement regulations, it also debatable to notice that the enactment of Statutory Instrument 18 of 2016 which banned importation of certain medicines may have missed certain factors like the local manufacturing capacity. This is against the background that some manufacturing companies like Caps Holdings and its subsidiaries; Geddes and Autosterile closed leaving

few companies such as Varichem Pharmaceutical. There could be real good intention from the government to boost local production and to promote employment at the same time but issues to do with sustainability and competitiveness remain central. So, what should start is the increase of local capacity followed by import embargo or ban.

Apart from the analysis and discussions above, the procurement cycle which forms part of the public procurement process is crucial to be deeply analysed. The flow chart on figure 4.3.2.1 showed that there are multiple stages for requisitioning, tendering and ordering. It is a multi-layered process with several reviewing and approving signatures resulting in lengthening unnecessarily the procurement process. While approval layers to be could be a means of checks and balance in the entire procurement process, it may be burdensome and frustrating to well-intentioned procurement officers.

Further, the procurement regulations particularly with reference to the tender types, there appeared to be no provision clearly giving the public procurement professionals to procure without going to tender for a certain threshold limit for example, purchases below a \$1000.00.

Therefore, in the health sector, the procurement policies and procedures should also reflect and guarantee specific operations objectives like speed and flexibility because these are critical in providing healthcare services to patients (Slack, Chambers and Johnson 2010). Sickness cannot be postponed until all the procedures are fulfilled. This is not to suggest that cost and compliance to the regulations is not important.

6.2. Procurement Planning

As presented in the previous Chapter, procurement planning is not being conducted and purchases are done in a haphazard manner with attention being given to "noisy" requirements. Essentially, procurement planning involves the identification of the hospital requirements that need to be purchased, the scope of the commodities, appropriate procurement methods and strategies to be employed and the timelines (Onyango 2014:448). Prior studies indicated a relationship between procurement planning and institutional performance and this is because failure to plan is actually planning to fail. Neglect therefore of this

crucial procurement function which should direct and set the procurement process in motion implies that some of the so-called urgent requirements are not really urgent but normal routine requirements which could have been properly procured using the standard or convectional route (Muhindo, Abada and Brahim 2014:227). Further, when purchases are being handled in piece-meal fashion; there is no leverage on consolidation of bulk orders.

Not only that, there is a probability that an item can be “noisy” and yet not very critical to the smooth running of the hospital and essentially prioritisation should be informed by the actual importance of an item. Further, the reason commonly given during the interviews and questionnaires that procurement planning is discouraged by lack of finances may not hold much water because when there is inadequate finance that is when prioritisation is greatly needed hence procurement planning becomes an integral part of that.

In addition, effects of lack of procurement planning does not end with procuring hospitals alone but can cascade to suppliers who have highlighted that in most cases there were given a Purchase Order to supply items which are already out of stock. This has a bearing on sourcing costs because of insufficient time to conduct market intelligence on the part of the suppliers.

Therefore, lack of a procurement plan revealed inadequate procurement knowledge and skills mainly on the part of the hospital procurement professionals. Ideally, there should be a formal constructs where the procurement staff and the user departments jointly come up with a procurement plan though it is the procurement function that should spear-head the process. From the interviews, it appeared that procurement planning is strange to public procurement and not known.

6.3. Development of Product Specifications

In the findings, widespread use of brand names and “lock-out” specifications was presented. This could mean that the specifications are largely influenced by suppliers of hospital commodities. Suppliers are taking a leading role in informing the needs of the hospitals and those hospitals may not really know what they exactly require (Strong 2013). It may also mean use of the restrictive specifications is intentionally targeted at monopolising the market, favouring one

particular supplier at the detriment of others and suppliers may be forgiven to suspect that the surgeons could have vested interests beyond those of the organisation. In fact, the suppliers highlighted that they felt that some surgeons could be construed as the brand representative of those companies. Use of brands as a method of specification is actually at variance with the principles of enhancing market competition and value for money. Ideally, product specifications should be of generic format so that there is maximum competition. The other issue being that highly prescriptive specifications can hinder innovation and unnecessarily increase the cost of purchase.

Consistent use of brand specifications could reveal lack of proper communication and guidance from the procurement professional who should be the experts guiding correctly the course of purchasing decisions. By asking relevant and clarifying questions to the users departments pertaining to what exactly they require, use of brand names may be substituted with generic specifications. In terms of specifications development, there could be a “silo mentality” –an independent way of working on specifications and not as one functional team.

Then, on the issue of sticking to outdated specifications, it means there is little market research and intelligence in line with global trends. In the case of medical equipment this could have disastrous effects in terms of continuous availability of spare components. Insistence of old specifications may signal issues to do with general training so that the surgeons or requesters of products are comfortable with the new products or machine on the market.

6.4. Selection Criteria

Generally, the performance of the hospitals in terms of ensuring affordable and quality healthcare services hinges heavily on the performance of their suppliers. For that reason, the approach utilised in the selection and evaluation of suppliers has a bearing on the hospital's operations. It is against this background that the selection criteria used in the awarding of tenders is of material relevance to this study in light of this aspect being presented as a finding.

The procurement documents from the state health institutions clearly showed that the selection criteria overly used was the purchase price because 534 out of

536 were awarded based on the lowest price upon solicitation of at least 3 quotations. Even, on 1 document that contains naloxone drugs could not be approved because the Procurement Committee selected basing on the fact that the supplier had an existing stock; maybe to address a potential stock-out. Of course, the Procurement Act seemed to give options to select or award tenders basing on lowest price or other factors specified but the structure and the nature of the section seem to tilt more on the selection based on purchase price. In cases where all product specifications are adequately and satisfactorily met, it may be good to select based on the lowest price but it becomes an issue if other important factors are neglected or overridden. It is however, important as correctly argued by Bergman and Lundberg (2013: 73) that the "buy-low-bid" which naturally create an atmosphere where suppliers will cut their prices only to win a tender but offering bare minimum acceptable quality just in a formal sense. Actually, this was highlighted by several suppliers that they have been requested to re-tender when the lowest bidder failed to supply and that is time-consuming. Side-effects of imbalanced and inadequate supplier selection approach where purchase price is the main decisive factor exhibited serious issues in terms of non-deliveries, cheaper sub-standard products and also unavailability of back-up services like the Ultra-sound machine which could not be repaired after developing just a software vision error. This came out in the findings.

While this is the case, the responsibility lies with the procurement professionals in clearly highlighting the evaluation criteria and the corresponding weight of each factor in the solicitation documents given to suppliers at the time of tendering so that evaluation could be done in line with the criteria specified if it is determined that the variables are important.

Whether, the selection criteria will be based on lowest price alone or on all other variables, suppliers should also be advised in the solicitation documents at the time of tendering.

In terms of procurement, it is therefore not only the purchase price which should influence the purchasing decision but a number of variables that should be carefully considered. In fact, the concept of Total Cost of Ownership (TCO) which looks beyond the purchase price by quantifying and incorporating all the costs from acquisition, possession, use to the actual disposal of the item (Garfamy

2006). This approach manages the myopia associated with basing purchase decision on price.

In addition to the above discussions, the selection criteria based on price upon solicitation of at least 3 quotations seem not to reflect the market or supply situations as well presented by Krlajic's model. This is particularly so with respect to the "Strategic" and the "Bottleneck Matrix". Products available from monopolistic and oligopolistic market structures like narcotics (Pethidine and Morphine Sulphate) may not be found everywhere hence a non-competitive procurement method relevant. Then on "Strategic" matrix products where there is high dependence on the particular supplier(s), an arm's length approach which is solely based on lowest price may not be ideal. The example of this situation is for highly customised diagnostic equipment like the Point of Care (POC) machines for the Early Infant Diagnosis (EID), a partnership approach could be appropriate for the supplier to develop specific machine. As a corollary, it may be stated that each supply context demands a relevant supplier selection model. Using a straitjacket approach to varying supply situations confirmed why respondents indicated that the procurement regulatory framework is irrelevant to the unique healthcare set-up because on the above example, lowest price may be difficult to justify.

6.5. Supplier Symposium

When 95% of suppliers indicated that they have not attended supplier symposium and even indicating that they can only be called for a meeting when "they want to cool us on late payments", clearly indicate the general state of supplier relationship hospitals have. Corporate attitude towards suppliers in general should be positive, mature and strategic because supplier relationships are the centre-piece for organisational performance. It will impact positively on cost-containment, quality and even more desirable in terms of innovative solutions in this volatile economic business environment. Charkraborty, Bhattacharya and Dobrzykowski (2014:677) also highlighted on the need to remove barriers and adopt a collaborative and interactive approach towards supplier relationships.

6.6. Recognition of the role of procurement

As presented in the previous section, the role of procurement professionals in state hospitals is at the peripheral, manifested in a number of ways that include

but not limited to, their exclusion in the Procurement Committee. Use of the title Administration Officers when they are expected to be called Procurement Officers further substantiates lack of recognition for the professionals. It may still be questionable if the incumbents have the correct professional procurement qualifications if they are pronounced as Administration Officers. The italicised excerpt clearly unravels the level of recognition of the procurement professional in state hospitals.

"We are in the armpits of the clinicians and accountants and we are excluded from the deliberations of the Procurement Committee. Non-procurement staffs are at the centre of all purchasing decisions and several problems have followed as a result of that. In fact, the perception on procurement staff is demotivating- they regard buyers as thieves and this hurts and probably explains the exclusion in general. We simply take the procurement documents to this Committee and once they adjudicate they give us for us to process. Recognition is very poor".

Exclusion therefore of the procurement professionals from the deliberations of the Procurement Committee means that non-procurement clinical staff makes procurement decisions. The background of clinicians is not procurement and who could be guiding correctly the course of purchasing decisions? Ideally, the inclusion of the procurement expert even if they may not have voting rights, will mean that the decisions made are sufficiently moderated in line with the best practices and also procurement regulations. It is imperative to appreciate that procurement is a technical speciality in the same manner medicine and surgery are regarded. If a procurement professional is not allowed to perform surgery, for example it follows therefore that purchasing and supply chain management should be equally valued and recognised and even reserved for professional to guide. Procurement is definitely much more than ordering of floor polish and there is marked difference procurement and buying. Buying in simple terms is what everyone can do in the supermarket on groceries and procurement is much more complex and strategic so as to warrant a professional to conduct that.

Considering procurement as unimportant and a function which can be done by anyone belies a total misunderstanding of the criticality of the department. Global developments and increasing pressure to contain healthcare costs and to improve medicines availability in state medical institutions, position correctly the strategic role of procurement.

However, it is very important that the procurement professionals also demonstrate high and unmatched professional procurement standards and articulate strategies so that they are viewed as the reference point on all procurement matters. Overshadowing of this essential role may suggest that in some cases, the calibre of professionals are not confident or are showing their worthy in the organisation. It could be difficult to be considered seriously and importantly when they are not presenting themselves in such a manner.

6.7. Manual Purchasing and Supply Chain Management System

The findings indicated that the state medical institutions' procurement system is mainly manual and paper-based. This system is used at a time when in some cases products are expiring while in others there are stock-outs. Suppliers also of medical products highlighted that the manual procurement system is increasing cost of doing business with the hospitals because they should collect the tender documents physically and submit their proposal in the tender box in person.

In today's world, Information and Technology is actually the greatest enabler in terms of supply chain management and this is attributed to many factors that include but not limited to, globalisation, cost-containment and the need to manage supply-chain related risks. In view of globalisation, the disparate nature of business operations where the network of manufacturers, suppliers and distributors is scattered across the world require some form of co-ordination and visibility in the supply chain network. Disjointed internal and external processes can be seamlessly brought together through IT. The procuring hospital should be in a position to see how the equipment ordered in Germany at Karl Storz, for example, reaches Zimbabwe and Information and Technology is pivotal. Further, sourcing from competitive uses requires extensive use of Information and Technology.

Coming back to the issue of inventory management, Information and Technology is critical. A fully electronic, computerised integrated system should be able to indicate how many of paracetamol tablets are at hospital A and how many vials of Ceftriaxone injection are at hospital B and these can be accessed by a click of a button and by that kind of pipeline visibility is crucial. This system can easily manage expiry of pharmaceutical. Not only that, management of assets like IT equipment, diagnostic equipment and hospital furniture can be barcoded and linked to a central asset and tracking system that can give the location and the

state of an asset by the click of a button instead of hand- writing asset number with a marker and input the details into a hard cover asset register book.

Further, demand forecasting and planning will be made much easier through use of accurate data which can be consolidated and analysed.

In addition, use of Information and Technology should not only be confined to direct procurement matters but broader aspects that have an impact on both procurement and supply chain management. For example, management of patients in most developed countries are now being done through sophisticated cost-effective methods like Telemedicine where a doctor in South Africa can view patient diagnosis online and prescribe the medicines via that system without necessarily coming to Zimbabwe.

Another dimension which can exploit the merits of Information and Technology is in patient allocation. This may seem to be unrelated to procurement but it does because it has an implication on resources hospital require hence the involvement of procurement. If renal patients in Harare are concentrated at one hospital, as an example, it becomes manageable if there is an integrated IT system to reallocate patients to less busy health facilities. This also impact on patient turnaround time.

Having analysed and discussed the procurement practices as part of the findings, the procurement challenges can now be scrutinised in the same fashion.

6.8. Procurement Skills and Competences

As a challenge, this aspect came out clearly and strongly from a number of respondents. Lack of relevant skills and competences commensurate with the expectations of their role was highlighted as detrimentally missing from the calibre of the public professionals. For example, providing feedback to suppliers after tendering can be considered a simple process expected from the procurement professionals. When such procurement deficiencies and inadequacies are evident, it may not be difficult to argue that since the Procurement Officers are referred as Administration Officers in the staff establishment, they do not possess requisite qualifications in the field of procurement. In the case of them having the qualifications, it should be

complemented by adequate training to cement their skills and competences.

There other argument for discussion is that the conditions of service and the structures in procurement do not seem to attract suitably qualified procurement professionals. It could be that at some point there were highly trained and qualified procurement personnel but they could have left to join other organisations and of course, for the remaining procurement professional there was insufficient Knowledge Information Management. They left with their knowledge and skills without being documented and transferred in the forms of Standard Operating Procedures (SOPs), manuals and best practices.

It is therefore imperative to note that the role of procurement is not just to process procurement documentation and order placement but it is so strategic to the smooth operations of the hospitals. Even for that issue of using brand specifications and failure to leverage on order consolidation of medical equipment clearly showed lack of procurement skills and competences. For that reason, it should be manned by suitably qualified procurement professionals to be in a position to effectively communicate and adequately guide the internal non-procurement departments on all matters to do with their requirements.

6.9. Financing Hospital Purchases

The research unearthed that there are three sources of financing hospital purchases and these are: Annual Budget allocation from Ministry of Finance, Donor funds and Hospital Service Fund (HSF) which is generated by the hospital from the services provided to patients. Of the three sources, funds from the Ministry of Finance caters for the major portion of the hospital requirements but presently most drugs are being procured through the donors or Non-Governmental Organisations (NGOs) and supplied through Natpharm. That being the case, donors generally finance a particular line(s) of drugs for example, UNFPA could more interested in supplying reproductive health related drugs like Oxytocin particularly for pregnant mothers and not the other broader ranges of drugs or vaccines. While donor efforts are highly appreciated there could be scenario where the area of interest(s) to finance from a donor perspective may not be the priority for the host government or Ministry of Health and Child Care. For example, a donor may concentrate more financial resources on malaria when the real priority is on HIV and AIDS or even Tuberculosis. In such circumstances, it will ideal to co-ordinate and synchronise

areas of priorities not only with the host government but even among the donors themselves. It is however important that the responsibility of ensuring that the hospital are adequately resourced rests primarily with the government through Ministry of Health and Child Care.

Related to financing from Treasury, it was very clear that the hospitals are not receiving sufficient funds and this has a direct impact on the stock levels of pharmaceuticals, reagents and medical equipment and even more importantly on infrastructural projects. Ideally, all hospitals should be receiving most of their drugs from National Pharmaceutical Company (NATPHARM) which is mandated to procure the medicines on behalf of state hospitals. If hospitals are not supplied by NATPHARM the question is why? It is because they are also under-funded and therefore cannot supply the hospital and that means hospital will end up conducting procurement for almost every drug.

The issue of insufficient funds is exacerbated by erratic disbursements. It is not known when the hospitals will receive the funds and this has greatly affected suppliers with the majority of them closing because of liquidity issues. Some suppliers are owed payments which are between 3-4 years old. Ordinarily late payments like these will attract legal action from suppliers if it was in the private sector but suppliers are not too comfortable fighting this with the government. Of course, most recently at a state hospital, there was an attempt to attach ambulances for non-payment of services provided. So, when payments take such an imaginable period, it is more or less like a donation because there is little business sense in that and there is a high potential of suppliers charging exorbitant prices to hedge against unforeseen late payments. Instead of payment a tin of paracetamol at \$8.00, suppliers may charge \$30.00.

Whilst it can be appreciated that financial resources may be scarce, failure to adequately resource the hospitals financially can be attributable to inefficiencies in the systems ranging from procurement methods and other leakages in the actual products. World Health Organisation (2010) reported that about 20-40% of health financing is wasted through inefficiencies particularly with respect to practices and policies. The percentage of wastage is actually a large sum of financial resources not being put to good use.

Apart from that, it could also need to be looked into if other innovative financing

models or frameworks like the Public Private Partnerships (PPPs) are being explored together with mechanism at increasing the collection of revenue even at hospital level.

6.10. Corruption

In the findings, suppliers of hospital commodities highlighted that they sometimes feel that tendering is merely a fulfilment of the procurement regulations because a bidder could already been identified. This could signal lack of fairness in the procurement system and probably corrupt tendencies. As Lao Tzu hinted:" the more laws and commands there are, the more thieves and robbers there will be". This means that corruption requires not just the laws and systems but a combination of measures. It is again not a matter of the laws exposing corrupt cases but acting on revelations of it.

Having said that, what really are the causes of corruption? If the causes are identified will that justify the existence of corruption? The reason why these questions are asked is because authors like Puiu (2015:606) tried to provide a correlation between wage levels with corruption in developing countries. While there could be notable causes of corruption, highlighting those may be tantamount to justification of corruption. Whatever the cases, corruption remains detrimental to the nation with direct effects filtering to patients through high cost of medicines and services; some dying because they cannot afford. So, it goes beyond bribery because any cost to the supplier will ultimately be extended to the patients.

Therefore in dealing with corruption, a raft of measures will be required not only in terms of the laws but also behavioural mind-set shift to a correct way of doing business. This will be provided in details in the recommendations chapter which is the next section.

Summary of the Chapter

The research embarked on, aimed at investigating in considerable depth the purchasing and supply-chain management practices and challenges in state health enterprises in Zimbabwe upon which a set of research objectives outlined below were extracted. In the opinion of the researcher, all the research objectives were satisfactorily met.

1. Identify, review and critically analyse the procurement practices and

policies (processes, systems, legislative framework and strategies) in the public health sector.

2. Identify challenges, operational and strategic gaps and how they can be addressed so that quality and improved healthcare is provided to patients.

However, limitations of the study undertaken have been critically considered and the following form part of that list:

a) Sensitivity of the research

The nature of the study had the potential of uncovering deep-seated sensitive matters in the public health delivery system such as procurement regulations, policies and financing mechanism. Having noted that, use of audio-recorder during interviews was restricted to ensure that respondents expressed themselves freely. Taking of notes was preferred in most cases. High ethical research standards were upheld to ensure that the source of information is concealed through use of codes.

b) Lack of breath and depth of the existing literature

The researcher noted that in peer-reviewed journals, white papers and other credible publications, there was insufficient coverage with respect to purchasing and supply chain management in the health sector with a strong emphasis in developing countries. Nonetheless, the existing literature provided a useful basis and sound platform for the investigation.

c) Time and Resources

The study focused on 3 central or referral hospital and 10 suppliers of hospital commodities giving a total of 13 units of analysis under the case study approach. This was very time consuming particularly interview component looking at the number of respondents and different times of appointments. Also, in terms of finances, costs of travelling, airtime for phone calls, printing of questionnaires were also noted.

Having highlighted all these limitations, the author's research objectives are met.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

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7.0. Introduction

This Chapter summarises the research findings and further indicating how the two research objectives have been met. Linkages between the findings and the available literature will also be shown. Thereafter, recommendations will be tabled for possible consideration at various levels.

The two research objectives outlined in Chapter 1 were met first through primary and secondary research, explained in Chapter 3. Corroboration of results from the questionnaires, interviews, observations and analysed documentation from hospitals and suppliers of hospital commodities identified, reviewed and analysed the procurement practices as well as challenges. The last component of research objective number will be provided in the next section under recommendations.

7.1. Conclusion

The research findings presented revealed more commonalities with the available published literature covered in Chapter 2. Many aspects of the research findings coincided with existing literature. The following conclusions can be drawn from the study:

It can be concluded that in terms of the procurement processes and regulatory frameworks, there are several different policies and Acts which are not necessarily enshrined in the Procurement Act but prescribe how procurements by state organisations should be. The Indigenisation and Economic Empowerment Act and the Trade Policy being separate legislation from the Procurement Act have certain sections that dictate how procurements should be done. It is therefore clear that the regulations are scattered and not harmonised and the effect of which matches perfectly to a concept well described as Multiple Accountabilities Disorder by Schillemans (2015:33) which is brought about by many facets to comply with.

Under the procurement processes, it can also be concluded that the existing straitjacket procurement system is not relevant, cost-effective and appropriate to the unique public healthcare set-up and this is in line with reviews and discussions on views on the nature of public procurement system by Cabras (2011:189). The issue of the procurement cycle which is unnecessarily longer as

a result of multiple layers of reviewing and approving signatures is in tandem with Potoski (2008:58).

In addition, the procurement and the inventory management system is manual and paper-based and that created challenges in terms of costs of tendering, visibility in the pipeline and management of stocks. On this, there is similarity with what Kanyoma and Khomba indicated (2013:29) as the challenge in the health sector and this also covered extensively under literature review.

Another conclusion drawn from this study is that the role of public procurement professionals in the hospitals is at the peripheral primarily because of the exclusion in key procurement decisions. Their role is overshadowed by the clinicians. The above conclusion is further substantiated by the location of the procurement offices which is at the back-yard at all hospitals and even the use of titles: Administration Officers and not Procurement Officers. This finding dovetailed with what Feander and Dassu (2014:2) highlighted in terms of the need to establish formal constructs upon which the role of the procurement professionals will not be overshadowed by clinicians.

From the study, it can also be concluded that the selection criteria overly used is the purchase price upon solicitation of 3 competitive quotations and that coincided with what Bergam and Lundberg (2013:73) highlighted in the literature review as the buy-low-bid where suppliers reduce price merely to win an order but provides compromised quality of products. Neglect of the Total Cost of Ownership (TCO) explained by Garfamy (2006) which looks at all cost from acquisition to disposal resulted in the failure to address maintenance issues of medical equipment.

Furthermore, the research concluded that there is lack of requisite and relevant procurement skills and competences as evidenced by lack of crucial procurement roles like spearheading the crafting of an Annual Procurement Plan so that all purchases are properly co-ordinated and not haphazardly done on the basis of why products are deemed noisy. Widespread use of brands as a method of product specifications demonstrated lack of those relevant skills required in procurement.

Finally, it can be concluded that there is inadequate financing in the state

hospitals and it is exacerbated by erratic disbursements of the limited funds. This was also reflected by Cohen , Reeh and Neroutsos (2011:7) in the literature review conducted.

7.2. Recommendations

The recommendations prescribed by the author emanated from the findings. Thus, the following recommendations can be very useful and appropriate and consequently, can be considered at institutional, ministerial and central government level where procurement policies are crafted. The format of the recommendations are well synchronised with the findings and are presented in exactly the same order.

Recommendation 1: Procurement legislative framework and processes

From the analysis and discussions, it is recommended that the government public procurement, for example, the Procurement Act, Indigenisation and Economic Empowerment Act and the Buy Zimbabwe Initiative be synchronised and harmonised into one procurement document or Act. This is essential in managing multiple accountabilities. Related to that the Procurement Act should not be under the auspices of the Ministry of Finance but should be under the non-existent Ministry of Procurement and creation of this new ministry will go a long way to paying closer attention on procurement matters.

Further, the procurement regulatory framework should not be a one size fits all in terms of application but should be highly customised to reflect very unique health set-up. The nature of procurement regulations governing the health sector should guarantee speed and flexibility in the provision of services to patients as these have a greater bearing on their welfare. If it is realised that a particular theatre drug is urgently required, that should not be on hold until all the procurement processes are finalised. Clear provisions should be made for example for small purchases below a \$1000.00 to be processed without going to tender upon solicitation of 1 or 2 quotations. This way, emergencies are timeously addressed. Linked to the sense, the regulations should be reviewed on a continuous basis rather than relying on a framework is was designed 14 years ago amid changes in the global business environment.

More importantly, when procurement laws and regulations are enacted, first they require an open, extensive and comprehensive consultation from the

procurement professionals themselves who have the necessary background, experience, skills and qualifications. This will provide the much needed relevancy.

It is also recommended that the existing regulations provide and facilitate the modern use of procurement technology such as cloud-based procurement software like Verian Procurement, use of websites and emails in advertising and receiving bids. Relying on notice board advertising in this age may not be advisable. Use of modern procurement technology will greatly impact on efficiency, responsiveness and cost-effectiveness in all processes.

In response to multiple reviewing and approval signatures within the procurement cycle, it is necessary to reduce to practical and manageable level based on value and risk. It makes little sense for a requisition to procurement 5 reams of bond paper to go up to the Chief Executive Officer. Related to that, it is recommended that a standardised Signature Authority Matric be produced for hospitals which are at the same levels like for all central hospitals.

As part of additional recommendations, capacitation of drug manufacturing companies such as Caps Holdings, Varichem, Autosterile should be a priority. Production incentives should be re-looked because they will have a bearing on costs of medicines. For example, to import 0.9% of Normal Saline which is mainly constituted of water from neighbouring countries can be expensive due to high transport. Health requires a lot of investment for sustainability even in procurement.

Recommendation 2: Procurement Planning

Given the criticality of procurement planning to the smooth, efficient, economic way of conducting purchases, hospitals should come up with an Annual Procurement Plan. This is done through identification of all hospital requirements followed by the tabulation of the applicable method of procurement with timelines per each requirement. In order to come up with a comprehensive Procurement Plan, the process should be jointly conducted with the user departments. The recommended presentation format for the Procurement Plan will be a Gantt Chart with components explained above. In this manner, haphazard purchases are managed further providing leverage on order consolidation.

Finally, for the reason that procurement planning is new to procurement professionals in state hospitals, adequate training should be provided on how to conduct the process effectively.

Recommendation 3: Development of product specifications

In addressing widespread use of brands and restrictive specifications, it is necessary and desirable in the interest of stimulating competition, to use generic specifications. This has a great impact on building a sustainable supplier base, moving away from monopolistic and oligopolistic artificially created scenarios. It is further recommended that the specifications should not be highly prescriptive in nature. Instead, they should be of a functional nature to avoid unnecessary high cost of purchases.

In addition, it remain the role of procurement professional to sensitise correctly the users against use of brands and this can be done through clarifying what exactly is required and for what purpose.

As the last recommendation to the insistence of outdated specifications by clinicians, training on the new modern technology, tools, products, procedures and equipment should be done on a continuous basis. This will also involve sending of selected group of clinicians to supplier conferences where a diverse range of products and equipment will be displayed. Hospital to hospital exchange visits where surgeons for example may be attached to a hospital in developed countries for a short period can provide an invaluable opportunity to learn new methods and products.

Recommendation 4: Selection Criteria

Since the selection or the evaluation method of suppliers has a great impact on how the hospital provide consistent, affordable and quality healthcare service, it is first recommended that the Procurement Act itself be amended so that comprehensive and all-encompassing selection methods are contained rather than confining selection to price alone. In fact, selection based on the lowest price should be provided for situations where common and basic commodities where quality is not distinguishable. Products such general stationery may perfectly fit in this category where a selection for bond paper, for example, to print Patients Front Sheets may be based on price if the specifications are met. It is unlikely if the same method of selection can be used for the procurement of

medical equipment where a variety of factors such as back-up service, delivery period apart from purchase price should be considered in their totality. For equipment and certain products the whole Total Cost of Ownership (TCO) should be holistically considered so that a myopic purchase decision is made based on price alone. A best value method of selection could be appropriate where each variable or factor is attached a weight with the total adding up to 100%. It is the prerogative role of procurement to take a leading role in identifying and determining what is the criterion for selection. Where samples are required as a basis for selection, these should be specified. However, in these two circumstances, it is of paramount importance and also in tandem with best practices of fairness and transparency to specify beforehand right in the tender documents how the bids will be evaluated.

More so, in terms of supplier selection methods the Procurement Act and Regulations should provide circumstance or situations where non-competitive or sole-source justification can be used and this is against the background of the drugs manufacturing companies who have closed. For a example, there is public emergency like Cholera where certain drugs, Intravenous Fluids are urgently required for a crisis, it should be provided in the regulations so that even if the threshold limit of the required drugs is above local procurement procurements, the hospitals should be allowed to procure to have lives. Documentation of such scenario should be adequately provided as part of the procurement package. Another situation is where the product is produced by a sole manufacturer or that after a tendering process only or two respondents tender, they should also be covered by the Act rather than insisting on 3 quotations which could impractical to solicit in such circumstances.

Recommendation 5: Supplier Symposium

The recommendation is for the state hospitals to seriously consider having supplier symposium and this platform sets the tone for a collaborative and interactive relationships.

Recommendation 6: Recognition of the role of procurement

First, there should re-alignment of their titles from being referred to Administration Officers to Procurement Officers. Second, the Procurement Officers should be part of the Procurement Committee, not assuming a passive

role but moderating the discussions on purchases in tandem with the procurement regulations and best practices. Third and last, instead of the procurement waiting to be recognised, they should demonstrate their worth and value to the hospitals.

Recommendation 7: Manual Purchasing and Supply Chain Management

Part of the recommendations was already made under the procurement framework and processes with respect to the electronic procurement system. In terms of addressing the issue of inventory management in order to manage expiration of medicines and distribute drugs rationally, a fully integrated and computerised system should be utilised to improve visibility in the pipeline. Re-order levels should be informed by accurate data and this can be enhanced through use of a computerised inventory management system. This also applies to management of hospital assets.

Recommendation 8: Procurement skills and competences

It is important as part of recommendations that the calibre of procurement professionals at state hospital possess suitable academic and professional qualifications as their private sector counterparts do. For such positions, there should be minimum qualification requirements like A Graduate Diploma with the Chartered Institute of Purchasing and Supply (CIPS). This could be cemented by specialist master degree programme like Master of Science Degree in Purchasing and Supply Chain Management from accredited and reputable universities. Apart from qualifications, there should be periodic training and refresher courses from competent and experienced facilitators in the same manner Non-Government Organisations usually do in sharpening the skills of their professionals through such training.

In addition, conditions of service should be designed in a manner that attract and retain qualified procurement professional. If the career progression ladder stretches to a level of Director or Principal Director of Procurement within the Ministry of Health and Child Care, many may be attracted.

The last recommendation under this section will be centred around the established of a sound Knowledge Information Management Systems where existing knowledge database is correctly tapped through documentation of

procurement manuals and Standard Operating Procedures (SOPs).

Recommendation 9: Financing hospital purchases

In terms of financing from the government, at least 15% of the national budget should be allocated to the Ministry of Health and Child Care and this is in tandem with the Abuja Declaration on health financing. Not only budget allocation is important but the actual disbursement of funds in a timely manner is highly recommended because it should not remain money on paper which will never translate into actual release of the funds. Following this, correct utilisation of these funds with the right priorities coupled with stringent, transparent and accountable financial managements systems where audited financial statements are publicly available will go a long way towards addressing the challenge. When adequate finances are provided, appropriate storage facilities will be constructed for medicines and equipment and even the correct stock-holding levels in line with the VEN guidelines will be feasible to meet.

In relation to the funds from donor organisations, synchronisation and co-ordination is recommended so that priority areas of intervention are jointly addressed.

Lastly, innovative financing models like Public Private Partnerships (PPPs) should be considered coupled with the right institutional framework enshrined in the Procurement Act. This is because the current Procurement Act does not cover the PPPs hence the relevancy of this recommendation. Further, correct positioning and management of hospital generated funds remains important in terms of meeting urgent and immediate needs such as patient food. Mechanisms of revenue collection should be crafted while respecting the government policies of accessibility of health services.

Recommendation 10: Corruption

The procurement system should promote fairness, transparency and predictability in the evaluation and the subsequent awarding of tenders. At any given time, the evaluation criteria should be specified in advance in the tender documents should that it does not come as a surprise to the bidders. What they should submit in order to be responsive to the tender should be clearly indicated. For contract like provision of security services, vehicle services in the

event of contract extension, a provision should be made first in the tender documents so that it becomes fair to all bidders.

Moreover, a balanced legal framework is necessary to be provided where remedial action if a corrupt act is identified or reported. If a public procurement professional violates the regulation, what are the remedial actions available? It is also important to have signed Confidentiality Forms confining procurement details to the correct people by state procurement professionals. Disclosure of sensitive details of suppliers to other suppliers could be viewed unethical. It is recommended that Conflict of Interests Declaration Forms be completed by all members of the Procurement Committee and management members per procurement seating as a strong way of managing corruption in adjudication of tenders.

Finally, as a way of strengthening ethics in procurement, public procurement professionals should subscribe to a membership professional body such as CIPS so that in the case of malpractice membership may be revoked. This is generally the trend with respect to medical professions like all clinicians are members of a relevant body and from time to time, they should renew their membership.

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APPENDICES

Appendix 1: Letter Requesting Permission from the Hospitals (Sample)

22166 Unit K

Seke

Chitungwiza

02 March 2016

The Chief Executive Officer

RE: COVERING LETTER FOR DOCTORAL STUDENT- MR JOHNSON SHONHE

This letter first serves to confirm that Mr Johnson Shonhe is pursuing a doctoral degree with the Durban University of Technology, South Africa. As part of the doctoral requirements, he is required to conduct a research or to write a thesis and his area of focus is to: investigate purchasing and supply chain management practices and challenges in the public hospitals. For this research, the student is under the guidance and supervision of **Professor Mohamed Saheed Bayat** who can be contactable on 08637861326

Thus, in conducting the research the student will mainly use interviews and questionnaires at your institution. Further, please be advised that any information provided will remain **confidential and anonymised**. It is solely for the purpose of this academic research.

Your assistance will be greatly appreciated.

Thank you.

Yours Sincerely,

Appendix 2: Research Questionnaire from Hospital Respondents.

QUESTIONNAIRE

In order to make informed business choices or decisions, people require the necessary information and it is this kind of information I need in order to gain a deep insight in "purchasing and supply chain management practices and challenges in public health" as part of my doctoral research with Durban University of Technology (DUT). This questionnaire is purely academic and data collected will be confined to that purpose ONLY. All data or information given will be treated with strictest confidentiality and anonymity. Should you feel uncomfortable in answering some of the questions, kindly proceed to the ones you are. Your time and effort in completing this questionnaire is highly desired and once you complete, the form will be collected from you after 2 weeks.

Please note instructions on how to complete the questions is contained in each section of the questionnaire.

1. SECTION A: Demographics of the Respondent

(a). Name (Optional)

(b). Institution

(c). Department

(d). Position in the Organisation

2. SECTION B: Procurement

(a). Do you purchase goods or services as an institution? (***Please tick relevant box***)

Yes No

b). To what extent do you agree or disagree with the statement below?

Procurement is a very important function at our organisation and without it; it may be difficult to offer satisfactory services to the patients

5	4	3	2	1
---	---	---	---	---

Please highlight the response which best relates to your opinion. Note: 5=strongly agree, 4= agree, 3=unsure, 2=disagree, 1= strongly disagree.

(c). How do you rate the responsiveness of procurement to your organisation requirements?

5	4	3	2	1
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Please tick in the box that best describe the process. Note: 5= very high, 4=high, 3= average, 2=low, 1= very low.

(d). Please give reason to your answer to the question above.

--

(e). How do you describe the procurement structure at your organisation?
(Please tick relevant box)

Centralised Partially Centralised Decentralised
Partially Decentralised

Other (Please specify).

(f). When you purchase hospital products or equipment do you follow a procurement plan? **(Please tick relevant box)**

Yes No

Please provide reasons for your answer in the space below

--

(g). Which of the following reason can be behind infrastructural completion delays?

(Please tick relevant boxes that suits your answer)

- Inadequate funds or disbursements from Ministry of Finance.
- Lengthy procurement process and approvals.
- Unreliable suppliers without capacity.
- Unclear contract terms.
- Other (Please specify)

(h). In terms of percentage, what is the estimated stock holding level of your medical supplies? **(Please tick relevant box)**

100% 80% 50% 30% 10%

Other (Please indicate)

(i). Do you sometimes receive medical supplies from NATPHARM?
(Please tick relevant box)

Yes

(j) In terms of medical equipment what could be reasons behind obsolete or non-functional equipment?

3. SECTION C: Tendering

(a). All products are purchased through tender. Do you agree? **(Please indicate relevant box)**

Yes No

(b). Are there circumstances or situations where purchases can be done without going to tender? **(Please indicate the relevant box)**

Yes No

(c). If yes, is it provided for in the procurement regulations or policy? Please provide more details in the box below.

(d). Types of tenders **(Please the relevant boxes)**

Competitive Informal Formal Special Formal

Other (Please specify)

(e). From the tender types above, which one is the commonly used one and why? **(Please provide your answer in the space provided below).**

(f) Do you provide feedback after to all suppliers after they submit their quotations in a tender process? **(Please tick the relevant box)**

Yes No

(g) How best can you describe your procurement or tendering system?

Wholly Manual Fully Electronic

Other (**Please Specify**)

(h). How best do you describe the procurement policy and regulations?

(Please tick all relevant boxes)

Restrictive Responsive Slow Relevant

Competitive Efficient Irrelevant

(i) Do you do supplier awareness or sensitisation programmes whereby suppliers are educated on the terms, conditions of tenders and how they should respond to tenders? **(Please tick the relevant box)**

Yes No

(j) How wide is your supplier base for all of your requirements? Does it include regional or international companies?

(k) In terms of percentage, what is the estimate of products supplied by foreign firms? In your opinion what could explain the percentage?

(i) In what way does procurement policy and regulations impact efficiency, competitiveness, transparency and responsiveness?

4. SECTION D: Supplier Selection

(a) **Please rank the following variables in order of importance in the selection or awarding of tenders to suppliers of goods and services, where 1=least important and 5=most important.**

- | | |
|---------------------------------------|-----|
| Back up service or after sale service | () |
| Reputation or previous performance | () |
| Price | () |
| Quality | () |
| Delivery period or Supplier lead time | () |
| Quantity | () |
| Conformance to specifications | () |

5. SECTION E: Supplier Relations

(a). In your view, do you consider supplier relations important? **(Please tick the relevant box)**

Yes No

Please provide reasons for your answer.

(b). In the past few months, did you receive complaint from your suppliers?

Yes No

Please give details for your answer in the space provided below

6. SECTION F: Financing

(a). Do you sometimes receive inadequate funds from Ministry of Finance?
(Please tick relevant box)

Yes No

(b). Can you please indicate the frequency of funds disbursements? **(Please tick relevant box)**

Monthly Quarterly Bi-annually
Yearly

Other (Please specify)

(c) Do you do budget variance analysis whereby you compare the budgeted funds versus the actual spent? **(Please tick the relevant box)**

Yes No

(d). Does the frequency in which funds are disbursed affect service delivery? (Please tick the relevant box)

Yes No

(e). In the event that funds from Ministry of Finance are delayed or inadequate, what are your options in financing your hospital purchases?
(Please provide your answer in the space given below)

(f). Do you have any outstanding debts with your suppliers and what impact does that have on service delivery?

(g). Was your organization audited in the past years and who carried the audit?

(h).When was the last time SPB audited your organization?

In conclusion, what are the critical issues that are affecting health service delivery to the hospital?

That brings to the END of the questionnaire. I thank you for spending time and effort in completing the questionnaire. If you have any issues that need clarity, please feel comfortable to contact Johnson Shonhe on this mobile number : [0772777011](tel:0772777011) or alternatively you can email to this address: mungisho@yahoo.com

Appendix 3: Raw Data on Questionnaires Responses from Hospital Respondents

Purchasing done institutionally	Procurement important to organisation and satisfactory service delivery	Procurement responsiveness to organisation requirements
Yes	5	4
Yes	3	1
Yes	1	3
Yes	5	3
Yes	5	3
Yes	5	5
Yes	5	4
Yes	5	4
Yes	4	3
Yes	5	4
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	2
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	4
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3

Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	4
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3
Yes	5	3

2d	2e	2f	2f 2	2g 1
Reason for given responsiveness rate	Procurement structure	Procurement plan followed	Reason for following procurement plan	Reasons behind infrastructural delays
Fast	Centralised	Yes	Strict requirement	Inadequate funds
Slow	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds
Fast	Centralised	Yes	Strict requirement	Inadequate funds
Fast	Centralised	Yes	Strict requirement	Inadequate funds
Fast	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Risky not to do so	Inadequate funds
Fast	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Partially centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds
Medium	Centralised	Yes	Strict requirement	Inadequate funds

Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	Unreliable suppliers
Inadequate funds	Lenghty process	
Inadequate funds		
Inadequate funds		
Inadequate funds		
Inadequate funds		
Inadequate funds		
Inadequate funds		
Inadequate funds		

2h	2i	2j	3a
Estimated stock level	Receive medical supplies from NATPHARM	Reasons behind obsolete or non-functional equipment	Purchases mainly done through tender
30	Yes	Spares	Yes
30	Yes	Spares	Yes
50	Yes	No maintenance plan	Yes
50	Yes	No maintenance plan	Yes
50	Yes	Spares	Yes
50	Yes	No maintenance plan	Yes
30	Yes	No maintenance plan	Yes
30	Yes	Lowest priced	Yes
50	Yes	Spares	Yes
30	Yes	Spares	Yes
10	Yes	Beyond economic life	Yes
30	Yes	Substandard equipment	Yes

30	Yes	Spares	Yes
50	Yes	Substandard equipment	Yes
30	Yes	Beyond economic life	No
50	Yes	Substandard equipment	No
40	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
60	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
40	Yes	Lowest priced	Yes
40	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Lowest priced	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
50	Yes	Lowest priced	Yes
50	Yes	Lowest priced	Yes
40	Yes	Lowest priced	Yes
40	Yes	Lowest priced	Yes
60	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
30	Yes	Spares	Yes
50	Yes	Spares	Yes
30	Yes	Lowest priced	Yes

30	Yes	Lowest priced	Yes
30	Yes	Beyond economic life	Yes
55	Yes	Beyond economic life	Yes
30	Yes	Beyond economic life	Yes
30	Yes	Beyond economic life	Yes
50	Yes	Beyond economic life	Yes

3b	3d 1	3d 2	3d 3	3d 4	3f
Possibility of no tender	Type of tender	Type of tender	Type of tender	Type of tender	Provide feedback to suppliers after they submit quotations
No	Competitive	Informal	Formal	Special-formal	No
No	Competitive	Informal	Formal	Special-formal	No
No	Competitive	Informal	Formal	Special-formal	No
No	Competitive	Informal	Formal	Special-formal	Yes
No	Competitive	Informal	Formal		Yes
Yes	Competitive	Informal	Formal		No
Yes	Competitive	Informal	Formal		No
Yes	Competitive	Informal	Formal		No
Yes	Competitive	Informal	Formal		Yes
Yes	Competitive	Informal	Formal		No
Yes	Competitive	Informal			No
Yes	Competitive	Informal			No
Yes	Competitive	Informal			No
Yes	Competitive	Informal			Yes
Yes	Competitive				Yes
No	Competitive				No
No	Competitive				No
No	Competitive				No

No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
Yes	Competitive				No
Yes	Competitive				No
Yes	Competitive				No
Yes	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
No	Competitive				No
Yes	Competitive				No
Yes	Competitive				No
Yes	Competitive				No
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Yes	Competitive				No
Yes	Competitive				No
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No	Competitive				No
No	Competitive				No
No	Competitive				No
No					No
No					No
No					No

3g	3h 1	3h 3	3h 5
Description of procurement or tendering system	Description of procurement policy	Description of procurement policy	Description of procurement policy
Electronic	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive

Manual	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Both	Restrictive	Slow relevant	Competitive
Manual	Restrictive	Slow relevant	Competitive
Manual	Restrictive		Competitive
Manual	Restrictive		Competitive
Manual	Restrictive		Competitive
Both	Restrictive		Competitive
Manual	Restrictive		Competitive
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Manual	Restrictive		Competitive
Manual	Restrictive		Competitive
Manual	Restrictive		Competitive
Manual	Restrictive		Competitive
Manual	Restrictive		
Manual			
Manual			

Description of procurement policy	Offer supplier training programs	Back up service or after sale service	Reputation or previous performance
Efficient	No	1	3
Efficient	No	4	4
	No	4	4

	No		
	No		
	Yes	5	5
	No	1	3
	No	1	3
	No	1	1
	No	1	1
	No	1	1
	No	1	3
	No	1	3
	No	1	5
	Yes	1	5
	No	1	
	No	1	
	No	1	
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	No	1	
	No	1	
	No		
	No		
	No		

Price	Quality	Delivery period or Supplier lead time	Quantity	Conformance to specifications	Supplier relations important
1	3	1		5	No
5	5	2	5	5	Yes
5	0	0	0	0	Yes
					Yes
					Yes
5	5	5	3	5	Yes
5	4	1	2	3	Yes
5	4	1	2		Yes
5	5	5	1	5	Yes
5	3	1	4	5	Yes
5	2	1	1	5	Yes
5	2	0	0	1	Yes
5	4	3			Yes
5	1	2			Yes
5					Yes
5					Yes
5					Yes
5					Yes
5		3			Yes
5		2			Yes
5					Yes
5		2			Yes

5		2			Yes
5		2			Yes
5		2			Yes
5		2			Yes
5		5			Yes
5					Yes
5		5			Yes
5					Yes
5					Yes
5					Yes
5		1			Yes
5					Yes
5		1			Yes
5		1			Yes
5		1			Yes
5					Yes
5					Yes
5					Yes
5					Yes
5		5			Yes
5					Yes
5		5			Yes
5					Yes
5		1			Yes
5					Yes
5					Yes
5					Yes
5					Yes
5		4			Yes
5					Yes
5					Yes
5		1			Yes
5					Yes
5					Yes
5					Yes
					Yes
					Yes
					Yes

Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes
Yes	Yes	Yes	Irregular	Yes	Yes

Appendix 4: Personal Interview (semi-structured) from Hospital Respondents.

Question 1: Briefly explain your role in this organisation and for how long have you been serving that capacity?

Answer: My role as the Administration Officer is to procure all requirements for the hospital and of course that includes drugs, surgicals, laboratory and other items. I have been serving in this role for more than 5 years.

Question 2: Can you please explain the organisation's procurement process?

Answer: When we receive a request say from Pharmacy, we first determine if we can use the Competitive, Informal or Formal tender route and these routes are primarily determined by the threshold limit for these tenders. Once, we determine the Informal, for example, because that's what we normally use, we put the tender in the newspaper and after it closes, we do the comparative schedules so that we can send to the Procurement Committee for adjudication.

Question 3: Are you part of the Procurement Committee?

Answer: No, we are not. We are in the armpits of the clinicians and accountants and we are excluded from the deliberations of the Procurement Committee. Non-procurement staffs are at the centre of all purchasing decisions and several problems have followed as a result of that. In fact, the perception on procurement staff is demotivating- they regard buyers as thieves and this hurts and probably explains the exclusion in general. We simply take the procurement documents to this Committee and once they adjudicate they give us for us to process. Recognition is very poor.

Question 4: Y-ah that could be a challenge then. So, when you procure these medical supplies, are you following any procurement plan?

Answer: There is no planning from departments for us to focus on procurement planning. Purchasing is mainly on noisy items which are urgently required and not necessarily following a plan. Planning is frustrated by inadequate funds. Why planning when you cannot purchase.

Question 5: What are the key challenges that you faced which affected greatly your operational efficiency, competitiveness and responsiveness as a public institution?

Answer: Well they could be many. First, structure of the Procurement Committee results in most purchasing decisions based on price and that has several problems like quality and delivery issues. The procurement systems and processes are not best for patients and not ideal for hospital. I think they were designed by non-procurement professionals with limited experience in

procurement-maybe accountants. It is not customised for health sector. For example, you need Isoflurane for Theatre, the value alone is usually above \$10.000 threshold limit which follows that an informal tender should be floated in the newspaper but the patient with a specific condition which needs surgery within a specified period will be waiting.

Second, on finances we have just received the first tranche after about 6 months. We don't know even the schedule of release of these funds. We owe suppliers lots of money in overdue payments and they cant continue supplying us.

Question 6: Do you think the procurement policies, practices and regulations are contributing to the operational challenges you highlighted?

Answer: Yes, in a great way.

7. In your opinion, what are the key factors that are affecting procurement at your institution?

Answer: Not involving procurement professional in the procurement committee is affecting procurement decisions because most purchases will be selected on the basis of price and it us who knows the relative performance of each supplier and hence problems of non-deliveries can follow. Then, erratic disbursement of funds because we only receive the first tranche of the funds end of March. Also, if you look at the regulations, they are not properly structured for use in the health system.

10. Lastly, what is your recommendation for the improvement of the procurement processes?

Answer: Regulations need amendment and also to be tailored to suit health sector. More funds need to be given to health sector and also disbursed consistently. The other issue is to recognise and respect buyers as professionals and not thieves. We should also have our own regulatory body just like what doctors and nurses.

Appendix 5: Research Questionnaire for Suppliers of Hospital Commodities.

SUPPLIERS' QUESTIONNAIRE

In order to make informed business choices or decisions, people require the necessary information and it is this kind of information I need in order to gain a deep insight in "purchasing and supply chain management practices and challenges in public health" as part of my doctoral research with Durban University of Technology (DUT). This questionnaire is purely academic and data collected will be confined to that purpose ONLY. All data or information given will be treated with **strictest confidentiality and anonymity**. Should you feel uncomfortable in answering some of the questions, kindly proceed to the ones you are. Your time and effort in completing this questionnaire is highly desired and once you complete, the form will be collected from you after 2 weeks.

Please note instructions on how to complete the questions is contained in each section of the questionnaire.

1. SECTION A: Demographics of the Respondent

(a). Name (Optional)

(b). Supplier

(c). Category

(d). Position in the Organisation

2. SECTION B: Procurement/ Tendering System

a (i) In your opinion, do you agree that the procurement or tendering system is relevant to the health sector? ***(Please tick relevant box)***

Yes

No

Please provide reason(s) for your answer in the space below

(ii) Procurement or tendering system in public health institution is fair, do you agree?

Yes

No

Please provide reason (s) for your answer in the space provided below

(iii) Procurement or tendering system in public health institutions is responsive and cost effective, do you agree?

Yes

No

Please provide reason (s) for your answer in the space below

(b). How best can you describe the procurement or tendering system in hospitals? (**Please provide your response in the box below**)

(c). Following a tendering process, do you receive feedback? (**Please tick relevant box**)

Yes

No

(d)What will be the importance of feedback after tendering process?

(e). Are you very clear on what are the expectations when responding to a tender (**Please tick relevant box**)

Yes

No

Please provide reasons for your answer in the space below

(f). Have you ever attended a supplier symposium where expectations on tender requirements, conditions and terms are explained? **Please tick relevant boxes that suits your answer)**

Yes

No

(g)In terms of evaluation of tenders, what have you found to be the commonly used criteria and to what extent have that affected you when you submit your bid(s)

(h)Would you agree that a manual procurement or tendering process increase the cost of doing business on the part of your organisation?

Yes

No

(i)In what way will a fully electronic procurement process ease your participation in tenders? **(Please provide your answer in the box below)**

(j) In your opinion, are you given realistic time to source and supply the ordered items?

Yes

No

3. SECTION C: Payments

(a). Do you have any outstanding payments for the commodities supplied
(Please indicate relevant box)

Yes

No

(b). On average, which period of Invoices are still outstanding and in what way is it affecting your operations? **(Please indicate the relevant box)**

4. Lastly, what will you recommend to be change or to be improved in the public procurement system?

That brings to the **END** of the questionnaire. I thank you for spending time and effort in completing the questionnaire. If you have any issues that need clarity, please feel comfortable to contact Johnson Shonhe on this mobile number: [0772777011](tel:0772777011) or alternatively you can email to this address: mungisho@yahoo.com

Appendix 6: Raw Data on Questionnaires Responses from Suppliers

2 a (i)	2a (ii)	2a (iii)
Procurement relevant to the health sector	Procurement system fair	2a (iii) Procurement system responsive and cost-effective
No	Yes	No
No	No	No
No	No	No
No	No	No
No	No	No
Yes	No	No
No	No	No
No	No	No
No	No	No
Yes	No	No
No	No	No
No	No	No
No	No	No
No	Yes	No
No	Yes	No
Yes	No	No
No	No	No
No	No	No
No	No	No
No	No	No
No	No	No

2c	2e	2f	2g
2c Receive feedback after tendering process	Clarity on expectations to tender response	Attended training on tender process	Commonly used tender evaluation criteria
No	No	Yes	Price
No	No	No	Price
No	No	No	Price
No	No	No	Price
No	No	No	Price
No	No	No	Price
No	No	No	Brand name
No	No	No	Price
No	Yes	No	Price
No	No	No	Price

No	No	No	Price
No	Yes	No	Price
No	Yes	No	Price
No	No	No	Price
Yes	No	No	Price
No	No	No	Price
Yes	No	No	Price
Yes	No	No	Sample
Yes	No	No	Price
Yes	No	No	Price

2h	2j	3 a)	4 (i)	4(ii)
Manual system costly	Realistic time to source and supply given	Outstanding payment on commodities supplied	Payments to improve	Specifications to be generic
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes
Yes	No	Yes	Yes	Yes

4(iii)	4(iv)	4 (v)	4(vi)
Delivery period to be realistic	Adjudication to take less time	Ethics - conflict of Interests	Capacitation of Suppliers
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	

4 (vii)	4(viii)	4(viv)	
Training of Procurement Staff	Electronic System	Provide feedback	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
	Yes	Yes	

Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	
Yes	Yes	Yes	

Appendix 7: Personal Interview (unstructured) from Suppliers of Hospital of Commodities.

Theme 1: Challenges in public procurement system

There are several challenges in the system. I don't know where to start but let me begin by saying that the procurement system can be unfair because sometimes you participate in a tender where you feel it's already decided. Not only that, but even the evaluation of the tenders itself by the hospital. Let me give you an example, I participated in a tender where some bidders did not quote for some aspects like installation costs for medical equipment and they were awarded the tender on the basis of the lowest cost. The machines could not be installed because the costs were not included. So these buyers do not know that some costs are hidden and by failing to request for detailed quotations, it becomes unfair to others. Another tender we participate, there items were also mixed and it was a big tender. It was going to be better to group them in lots.

There is also the part of the system being not cost effective. Where I say the system is not cost-effective is where they require 5% bid bond of the total tender value and its very expensive to secure that or a bank guarantee. They may even require that each item must be quoted on separate sheets and imagine there are 400 items and how expensive is the tendering process. To make matters worse, the procurement system is manual- you have to drive to collect the tender document in person and return the quotations again.

Regarding product specifications, they use lock-out specifications which are confined to a particular brand and in the case of suture material, they specify SMI brand as if the surgeons are like brand ambassadors of those companies. There are different other good brands apart from SMI sutures. In some cases, the clinicians just stick to what they know even if it is outdated and not currently used. It also appears that there is a silo mentality in coming with specifications.

The issue of payments is also the biggest challenge. This is affecting us and even with our sources of supply. We are owed payments for drugs we supplied a long time ago and what hurts is when I call the Finance Director he does not tell you the truth. They will dodge you or gave incorrect statements. For us also is the issue of business continuity which is at risk under the prevailing conditions.

Lastly on the challenges, there is a barrier and no collaboration between us and them. The relationship is conveniently managed and that is when it suits them if at all is qualified as a relationship.

Theme 2. Recommendations for Improvement of the procurement systems

Let me start by highlighting importance of modernisation of procurement. You

don't need to drive time and again collecting and delivering tenders-this is costly. Second, there is need for declaration of interests from hospital procurement team so that when they stick to particular brands we don't suspect they are interested parties.

Third, capacitation of the health sector is necessary. Reputable companies have either closed or soon will close and also briefcase companies with quotation book only will survive at present.

Also, buyers need training as well as the clinical staff on efficiency and professional way of doing work. I think there is actual need for Knowledge Management Systems because previously there were some good buyers and they left with their knowledge and skills. Let them plan their procurements as well and not to give us orders when the products are already out of stock. Internally they also need to work in unison as departments.

They also need to provide feedback after we participate in a tendering process.

Appendix 8: Government of Zimbabwe Procurement Act

Cap. 22:14

PROCUREMENT

No. 2/99

PROCUREMENT ACT [CHAPTER: 22:14]

ARRANGEMENT OF SECTIONS

PART I PRELIMINARY

Section

1. Short title and date of commencement.
2. Interpretation.
3. Application of Act.

PART II STATE PROCUREMENT BOARD

4. Establishment of State Procurement Board.
5. Functions of State Procurement Board.
6. Composition of State Procurement Board.
7. Disqualifications for membership of State Procurement Board.
8. Terms of office and conditions of service of members.
9. Limitation on right of chairman to engage in other occupations or business; disclosure of business interests and assets by other members.
10. Vacation of office by members.
11. Suspension of members.
12. Filling of vacancies on State Procurement Board.
13. Vice-chairman of State Procurement Board.
14. Meetings and procedure of State Procurement Board.
15. Committees of State Procurement Board.
16. Members of State Procurement Board and committees to disclose certain connections and interests.
17. Minutes of proceedings of State Procurement Board and of committees.
18. Remuneration and allowances of members of members of State Procurement Board and of committees.
19. Remuneration and allowances of members of State Procurement Board and of committees.
20. Directions to State Procurement Board.
21. Reports of State Procurement Board.
22. Delegation of functions by State Procurement Board.
23. Validity of decisions and acts of State Procurement Board.

PART III Financial Provisions

24. Funds of State Procurement Board.
25. Investment of moneys not immediately required by State Procurement Board.
26. Financial year of State Procurement Board.

Section

27. Accounts of State Procurement Board.
28. Audit of State Procurement Board's accounts.
29. Internal auditor.

PART IV
PROCUREMENT PROCEEDINGS

30. Form of procurement proceedings.
31. Tendering proceedings.
32. Procedure for procurement of services.
33. Procurement regulations.
34. Eligibility of suppliers.
35. Record of procurement proceedings.
36. Public access to regulations, etc.
37. Suppliers to permit access to their books and accounts.
38. Non-liability of procuring entity where all tenders are rejected.
39. Effect of bribery, fraud or collusion by supplier.
40. Effect of failure to disclose interest by member of State Procurement Board or committee thereof.
41. State Procurement Board may declare supplier ineligible to be awarded State contract.
42. Directions to procuring entities by State Procurement Board.

PART V
APPEALS

43. Appeal to Administrative Court.
44. Suspension of procurement proceedings pending appeal.

PART VI
GENERAL

45. State Procurement Board may require information.
46. Investigations by State Procurement Board.
47. Procedure on completion of investigation.
48. Offences relating to procurement.
49. Application of Act to BOOT or BOT contracts.
50. Savings.

ZIMBABWE

ACT

To establish a State Procurement Board and to provide for its functions; to Make provision for the procurement of goods, construction work and Services by the State, statutory bodies and other persons; and to provide for matters connected with or incidental to the foregoing.

ENACTED by the President and the Parliament of Zimbabwe.

Part I PRELIMINARY

1 Short title and date of commencement

- (1) This Act may be cited as the Procurement Act [Chapter 22:14].
- (2) This Act shall come into operation on a date to be fixed by the President by statutory instrument.

2 Interpretation

- (1) In this Act-

"building" includes any man-made structure whatsoever or any part thereof, whether above or below the ground;

"chairman", in relation to the State Procurement Board, means the chairman of the Board appointed in terms of subsection (1) of section six;

"conduct" includes any act or omission;

"construction work" means all work associated with the construction, reconstruction, demolition, repair or renovation of any building or infrastructure, and includes-

- (a) site preparation, excavation work, the installation of equipment or materials, decoration and finishing; and
- (b) incidental services such as drilling, mapping, photography and environmental and seismic investigation, where-
 - (i) the services are provided pursuant to the procurement contract; and
 - (ii) the value of the services does not exceed that of the construction work itself;

"goods" means things of every kind and description, including

- (a) raw materials, products and equipment; and
- (b) things in solid, liquid or gaseous form; and
- (c) electricity; and
- (d) immovable property; and
- (e) services incidental to the supply of goods, where the value of the services does not exceed that of the goods themselves;

"member" means the chairman or any other member of the State Procurement Board;

“Minister” means the Vice-President or Minister to whom the President may, from time to time, assign the administration of this Act;

“procurement” means the acquisition by any means of goods, construction work or services;

“procurement contract” means a contract between a procuring entity and a supplier which results from procurement proceedings;

“procurement regulations” means regulations made in terms of subsection (1) of section thirty-three;

“procuring entity” means-

(a) the State Procurement Board, to the extent that it conducts procurement proceedings on behalf of any person referred to in paragraph (b) or (c) of this definition; or

(b) any-

(i) Ministry, department or other division of the Government; or

(ii) Statutory body;

That engages in procurement; or

(c) any local authority or other person declared in terms of subsection (2) to be a procuring entity;

“services” means any object of procurement other than goods or construction work;

“State Procurement Board” means the State Procurement Board established by section four,

“statutory body” means a body corporate established directly by or under any enactment for special purposes specified in that enactment, the membership of which consists wholly or mainly of persons appointed by the President, a Vice President, a Minister, any other statutory body or by a Commission established by the Constitution.

“supplier” means an actual or potential party to a procurement contract with a procuring entity;

“vice-chairman”, in relation to the State Procurement Board, means the person designated as vice chairman in terms of subsection (1) of section thirteen

(2) The Minister may, by statutory instrument, declare any local authority or other person to be a procuring entity for the purposes of this Act:

Provided that the Minister shall not make any such declaration in relation to-

(a) a local authority, except with the consent of the Minister responsible for local government; or

(b) a person, other than a body corporate wholly owned or controlled by the State, without that person's consent.

(c)

3 Application of Act

(1) This Act shall apply to procurement by all procuring entities except-

(a) such classes of procurement; or

(b) such procuring entities or classes of procuring entities;

as may be specified by the President by statutory instrument.

(2) Nothing in subsection (1) shall be construed as preventing a person who engages in procurement to which this Act does not apply from requiring suppliers to conform with all or any of the provisions of this Act in the course of the procurement proceedings.

PART II

STATE PROCUREMENT BOARD

4 Establishment of State Procurement Board

There is hereby established a board to be known as the State Procurement Board, which shall be a body corporate capable of suing and being sued in its own name and, subject to this Act, of doing all things that bodies corporate may do by law.

5 Functions of State Procurement Board

- (1) Subject to this Act, the functions of the State Procurement Board shall be-
 - (a) to conduct procurement on behalf of procurement on behalf of procuring entities, where the procurement is of a class prescribed in procurement regulations; and
 - (b) to supervise procurement proceedings conducted by procuring entities, in order to ensure proper compliance with this Act; and
 - (c) to initiate investigations in terms of section forty-six and take action pursuant thereon in terms of section forty-seven; and
 - (d) to perform any other function that is conferred or imposed on the State Procurement Board by or in terms of this Act or any other law.
- (2) Except as otherwise provided in the Act, the State Procurement Board shall not be subject to the direction or control of any person or authority in the exercise of its functions under this Act.

6 Composition of State Procurement Board

- (1) The State Procurement Board shall consist of a chairman and not fewer than seven or more than ten other members appointed, subject to this section and section seven, by the President.
- (2) Members shall be chosen for their ability and experience in administration or their professional qualifications or their suitability otherwise for appointment.

Provided that at least one of the members shall be a person who has held a post or posts of a senior grade in the Public Service for periods which in the aggregate amount to at least three years, and at least three members shall be appointed from a list submitted by recognised chambers of business, industry, commerce and other professional bodies.

- (3) Members shall be appointed after consultation with the Public Service Commission.
- (4) The Minister shall ensure that the appointment of every member is notified in the Gazette.

7 Disqualifications for membership of State Procurement Board

- (1) A person shall not be appointed as a member, and no person shall be qualified to hold office as a member, if-

- (a) he is not a citizen of Zimbabwe or ordinarily resident in Zimbabwe; or
- (b) he has been adjudged or otherwise declared insolvent or bankrupt in terms of a law in force in any country, and has not been rehabilitated or discharged ; or
- (c) he has made an assignment to or arrangement or composition with his creditors in terms of a law in force in ay country, and the assignment, arrangement or composition has not been rescinded or set aside; or
- (d) he has been sentenced-
 - (i) in Zimbabwe, in respect of an offence; or
 - (ii) outside Zimbabwe, in respect of conduct which, if committed in Zimbabwe, would have constituted an offence;
 to a term of imprisonment of not less than six months imposed without the option of a fine, whether or not any portion has been suspended, and has not received a free pardon; or
- (e) he has been convicted-
 - (i) in Zimbabwe, of an offence under this Act or of an offence involving dishonesty; or
 - (ii) outside Zimbabwe, in respect of any conduct which, if committed in Zimbabwe, would have constituted an offence involving dishonesty;
 and sentenced to a fine of any amount or to a term of imprisonment of any duration, whether or not any part of the sentence has been suspended, and has not received a free pardon.

- (2) A person who is-
 - (a) a member of Parliament; or
 - (b) a member of two or more other statutory bodies;
 shall not be appointed as a member of the State Procurement Board nor shall he be qualified to hold office as a member.
- (3) For the purposes of paragraph (b) of subsection (2), a person who is appointed to a council, board or other authority which is a statutory body or which is responsible for the administration of the affairs of a statutory body shall be regarded as a member of that statutory body.
- (4) Any person who, knowing that he is disqualified in terms of this section to hold office as a member—
 - (a) attends any meeting of the State Procurement Board as a member; or
 - (b) performs any other act as a member;

Shall be guilty of an offence and liable to a fine not exceeding two thousand dollars or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

8 Terms of office and c onditions of service of members

- (1) A member shall hold office for such period, not exceeding three years, as the President may fix at the time of his appointment.
- (2) On the expiry of the period for which a member has been appointed he shall continue to hold office until he has been re-appointed or his successor has been appointed:

Provided that a member shall not continue to hold office in terms of this subsection for more than six months.

- (3) A person who ceases to be a member shall be eligible for re-appointment.
- (4) Members shall hold office on such conditions as the President may fix.

9 Limitation on right of chairman to engage in other occupations or business; disclosure of business interests and assets by other members

- (1) During his term of office, the chairman shall not engage in any other occupation, service or employment for remuneration, unless the President has consented to his engaging in it:

Provided that the chairman shall be entitled to engage in an occupation, service or employment for which he is entitled only to payment by way of travelling and subsistence allowances and out-of-pocket expenses.

- (2) Before any member, including the chairman, performs any function as a member, he shall disclose in writing to the President the full extent of—
 - (a) every occupation, service or employment which he or his spouse engages in for remuneration; and
 - (b) all assets held by him or his spouse, in excess of such value as the President may specify.
 - (c) As soon as possible after he or his spouse—
- (3) As soon as possible after he or his spouse—
 - (a) commences any occupation, service or employment for remuneration; or
 - (b) acquires any asset in excess of such value as the President may have specified in terms of paragraph (b) of subsection (2);a member shall disclose that fact in writing to the President.

10 Vacation of office by members

- (1) A member shall vacate his office and his office shall become vacant—
 - (a) one month after the date he gives notice in writing to the President, through the Minister, of his intention to resign his office or after the expiry of such other period of notice as he and the Minister may agree; or
 - (b) on the date he begins to serve a sentence of imprisonment, whether or not any portion has been suspended, imposed without the option of a fine—
 - (i) in Zimbabwe, in respect of an offence; or
 - (ii) outside Zimbabwe, in respect of conduct which, if committed in Zimbabwe, would have constituted an offence; or
 - (c) if he becomes disqualified in terms of section seven to hold office as a member; or
 - (d) if he is required in terms of subsection (2) or (3) to vacate his office as a member.

- (2) The President may require a member to vacate his office if—
 - (a) The member has been guilty of conduct which renders him unsuitable to continue to hold office as a member; or
 - (b) The member has failed to comply with any condition of his office fixed in terms of section eight; or
 - (c) The member is mentally or physically incapable of efficiently performing his duties as a member; or
 - (d) The member contravenes section nine or seventeen; or
 - (e) The member or his spouse engages in any occupation, service or employment, or holds any asset, which in the President's opinion is inconsistent with his duties as a member.
- (3) The President, on the recommendation of the State Procurement Board, may require a member to vacate his office if the President is satisfied that the member has been absent without the consent of the chairman of the Board from three consecutive meetings of the Board, of which he has been given at least seven days' notice, and that there was no just cause for the member's absence.

11 Suspension of members

- (1) The President may suspend from office a member against whom criminal proceedings are instituted for an offence involving dishonesty and, whilst that member is so suspended, he shall not carry out any duties or be entitled to any remuneration or allowances as a member.
- (2) The President may suspend a member from office if the President has reasonable grounds to believe that the member's office has become vacant in terms of subsection (1) of section ten but the member has not relinquished his office.

12 Filling of vacancies on State Procurement Board

On the death of, or the vacation of office by, a member, the President may appoint a person to fill the vacancy:

Provided that, if the number of members is fewer than the minimum number of members specified in section six, the President shall appoint a person to fill the vacancy within three months after being notified of the vacancy.

13 Vice- chairman of State Procurement

- (1) The President shall designate one of the members, other than the chairman, to be the vice-chairman of the State Procurement Board.
- (2) The vice chairman may at any time, by written notice to the President, resign his office as vice-chairman.
- (3) Within three months after being notified of a vacancy in the office of vice chairman, the President shall designate a member to fill the vacancy.

- (4) The vice-chairman shall perform the functions of the chairman whenever the chairman is unable to perform them.

14 Meetings and procedure of State Procurement Board

- (1) Subject to this Act, the State Procurement Board shall meet for the dispatch of business and adjourn, close and otherwise regulate its meetings and procedures as it thinks fit.
- (2) The chairman may himself at any time and shall, at the request in writing of not fewer than two members, convene a special meeting of the State Procurement Board, which meeting shall be convened for a date not sooner than seven days or later than thirty days after receipt of such request.
- (3) The chairman or, in his absence, the vice-chairman shall preside at meetings of the State Procurement Board.
- (4) A majority of members shall form a quorum at any meeting of the State Procurement Board.
- (5) All acts, matters or things authorised or required to be done by the State Procurement Board may be decided by a majority vote at a meeting of the Board at which a quorum is present.
- (6) Subject to section seventeen, at all meetings of the State Procurement Board each member present shall have one vote on each question before the Board:

Provided that—

- (i) in the event of an equality of votes, the chairman or person presiding shall have a casting vote in addition to his deliberative vote;
 - (ii) no member shall take part in the consideration or discussion of, or vote on, any question before the Board which relates to his vacation of office as a member.
- (7) Any proposal circulated among all members of the State Procurement Board and agreed to by a majority of them shall have the same effect as a resolution passed at a duly constituted meeting of the Board and shall be incorporated in the minutes of the next succeeding meeting of the Board:

Provided that, if a member requires that any such proposal be placed before the State Procurement Board, this subsection shall not apply to the proposal.

- (8) With the approval of the Minister, the State Procurement Board may co-opt any person to the Board, but a co-opted person shall have no vote in any decision by the Board.

15 Principal officer and staff of State Procurement Board

- (1) The State Procurement Board may employ, on such terms and conditions as it may fix with the approval of the Minister—

- (a) a principal officer; and
 - (b) such other members of staff as may be necessary for the proper exercise of the Board's functions.
- (2) Subject to any directions given to him by the State Procurement Board, the principal officer of the Board shall be responsible for controlling and supervising the Board's staff.
 - (3) The State Procurement Board may engage persons otherwise than as employees, to perform services of a specialised, technical or professional nature of the Board.
 - (4) Any remuneration, allowances, pensions and other benefits to which the persons referred to in subsection (1) or (2) are entitled shall be chargeable to the funds of the State Procurement Board.
 - (5) Notwithstanding subsection (1), if the State Procurement Board so requests and the Public Service Commission so permits, the Minister may assign members of the Public Service employed in his Ministry to perform all or any of the functions of the principal officer and members of staff referred to in that subsection.

16 Committees of State Procurement Board

- (1) For the better exercise of its functions, the State Procurement Board may establish one or more committees in which, with the consent of the Minister, it may vest such of its functions as it thinks fit:

Provided that the vesting of a function in a committee shall not prevent the State Procurement Board from itself exercising that function, and the Board may amend or rescind any decision of the committee in the exercise of that function.
- (2) On the establishment of a committee the State Procurement Board may appoint to the committee persons who are not members of the Board.
- (3) The chairman of the State Procurement Board or of a committee may at any reasonable time and place convene a meeting of that committee.
- (4) The procedure of each committee shall be as fixed from time to time by the State Procurement Board.
- (5) Subject to this section, subsections (2) to (7) of section fourteen shall apply, mutatis mutandis, to committees and their members as they apply to the Board and its members.

17 Members of State Procurement Board and committees to disclose certain connections and interests

- (1) In this section—
 “relative”, in relation to a member of the State Procurement Board or a committee of the Board, means the member's spouse, child parent, brother or sister.
- (2) If a member of the State Procurement Board or of a committee of the Board, or a relative of such a member—

- (a) is a supplier who is participating or has participated in any procurement proceedings that are being considered by the State Procurement Board or by any committee of the Board, whether on appeal or otherwise; or
- (b) knowingly acquires or holds a direct or indirect pecuniary interest in a supplier that is participating or has participated in any procurement proceedings referred to in paragraph (a); or
- (c) owns any property or has a right in property or a direct or indirect pecuniary interest in a company or association of persons which results in the member's private interests coming or appearing to come into conflict with his functions as a member;

the member shall forthwith disclose the fact to the State Procurement Board or the committee, as the case may be.

- (3) A member referred to in subsection (2) shall take no part in the consideration or discussion of, or vote on, any question before the State procurement Board or the committee, as the case may be, which relates to any procurement proceedings, property, right or interest referred to in that subsection.
- (4) Any person who contravenes subsection (2) or (3) shall be guilty of any offence and liable to a fine not exceeding two thousand dollars or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

18 Minutes of proceedings of State Procurement Board and of committees

- (1) The State Procurement Board shall cause minutes of all proceedings of and decisions taken at any meeting of the Board or of a committee of the Board to be entered in books kept for the purpose.
- (2) The State Procurement Board shall without delay send the Comptroller and Auditor General a copy of all minutes referred to in subsection (1).
- (3) Any minutes referred to in subsection (1) which purport to be signed, with the authority of the State Procurement Board or the committee concerned, as the case may be, by the chairman of the meeting to which the minutes relate or by the chairman of the next following meeting, shall be accepted for all purposes as prima facie proof of the proceedings of and decisions taken at that meeting.

19 Remuneration and allowances of members of State Procurement Board and of committees

- (1) Members of the State Procurement Board and of committees of the Board shall be paid from the Board's funds—
 - (a) such remuneration, if any, as the President may fix for members of the Board or members of committees, as the case may be, generally; and
 - (b) such allowances, if any, as the President may fix to meet any reasonable expenses incurred by the member in connection with the business of the State Procurement Board or the committee, as the case may be.
- (2) The remuneration payable to a member of the State Procurement Board shall not be reduced during his tenure of office.

20 Directions to State Procurement Board

- (1) The President may give general written directions of policy to the State Procurement Board and the Board shall take all necessary steps to comply with them.
- (2) If the State Procurement Board has failed to carry out any duty imposed upon it by or under this Act or any other law, the Minister may, in writing, direct the Board to take such action as he considers necessary to rectify the matter with such time as he may specify:

Provided that before doing so, the Minister shall give the Board an opportunity to make any representations it may wish to make in the matter.

- (3) If the State Procurement Board fails to take action in accordance with a direction in terms of subsection (2) within the time specified by the Minister, the Minister may take appropriate action on behalf of the Board to rectify the matter.
- (4) The State Procurement Board shall report to Parliament the nature and substance of every direction given to it, together with any comments the Board may wish to make thereon, either by means of a special report submitted in terms of section twenty-one or in its annual report submitted in terms of that section.
- (5) The President or the Minister, as the case may be, shall ensure that the substance of any direction given to the State Procurement Board in terms of subsection (1) or (2) is published in the Gazette within thirty days after the direction was given.

21 Reports of State Procurement Board

- (1) The State Procurement Board—
 - (a) shall, as soon as possible after the 31st December in each year, submit to the Minister an annual report upon matter the Board has dealt with during the previous year; and
 - (b) shall submit to the Minister a special report where the procurement cost exceeds one per centum of the current year's national budget; and
 - (c) may at any time submit to the Minister a special report on any matter upon which the Board considers it desirable to report; and
 - (d) shall submit to the Minister a monthly report specifying the instances in which tenders have been invited and those in which a procurement contract has been concluded.
- (2) The Minister shall lay before Parliament on one of the fourteen days on which Parliament next sits after the report is received by him—
 - (a) the annual report submitted to him in terms of paragraph (a) of subsection (1); and
 - (b) any special report submitted to him in terms of paragraph (b) or (c) of subsection (1) which the State Procurement Board has requested be laid before Parliament.

22 Delegation of functions by State Procurement Board

- (1) Without derogation from any other law, with the consent of the Minister the State Procurement Board may delegate any of its functions to—
 - (a) any of its members; or
 - (b) any member of its staff referred to in section fifteen.
- (2) A delegation in terms of subsection (1)—
 - (a) may be absolute or conditional and may be withdrawn or amended at any time; and
 - (b) shall not prevent the State Procurement Board from itself exercising the function concerned or from amending or rescinding any decision of the delegate in the exercise of that function.

23 Validity of decision and acts of State Procurement Board

No decision made or act done by or under the authority of the State Procurement Board shall be invalid solely because there were one or more vacancies on the Board when the decision was taken or the act was done or authorised, as the case may be.

PART III

FINANCIAL PROVISIONS

24 Funds of State Procurement Board

The funds of the State Procurement Board shall consist of—

- (a) moneys payable to the Board from moneys appropriated for the purpose by Act of Parliament; and
- (b) any other moneys that may vest in or accrue to Board, whether in terms of this Act or otherwise.

25 Investment of moneys not immediately required by State Procurement Board

Moneys not immediately required by the State Procurement Board may be invested in such manner as the Minister, acting on the advice of the Minister responsible for finance, may approve.

26 Financial year of State Procurement Board

The financial year of the State Procurement Board shall be the period of twelve months ending on the 31st December in each year.

27 Accounts of State Procurement Board

- (1) The State Procurement Board shall ensure that proper accounts and other records relating to such accounts are kept in respect of all its activities, funds and property, including such particular accounts and records as the Minister may direct.

- (2) As soon as possible after the end of each financial year, the State Procurement Board shall prepare and submit to the Minister a statement of accounts in respect of that financial year or in respect of such other period as the Minister may direct.

28 Audit of State Procurement Board's accounts

- (1) The account of the State Procurement Board shall be audited by the Comptroller and Auditor-General, who for the purpose shall have all the functions conferred on him by sections 8 and 9 of the Audit and Exchequer Act [Chapter 22:03] as though the assets of the Board were public moneys and the members, employees and agents of the Board were officers as defined in that Act.
- (2) Any member, employee or agent of the State Procurement Board who—
- (a) fails or refuses to provide the Comptroller and Auditor-General with any explanation or information required by him for the purpose of an audit in terms of subsection (1); or
 - (b) hinders or obstructs the Comptroller and Auditor-General in the conduct of an audit in terms of subsection (1);

shall be guilty of an offence and liable to a fine not exceeding one thousand dollars or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

- (3) Notwithstanding subsection (1), the Comptroller and Auditor-General may appoint a suitably qualified person to audit the accounts of the State Procurement Board and, if he does so—
- (a) subsections (1) and (2) shall apply in respect of the person so appointed as if he were the Comptroller and Auditor-General; and
 - (b) any expenses incurred by the person so appointed in carrying out his audit shall be met from the funds of the State Procurement Board.

29 Internal auditor

Section 19 of the Audit and Exchequer Act [Chapter 22:03] shall apply, mutates mutandis, to the appointment of an internal auditor to the State Procurement Board in all respects as if the Board were a department of the Ministry for which the Minister is responsible.

PART IV

PROCUREMENT PROCEEDINGS

30 Form of procurement proceedings

- (1) Except as otherwise provided in this Act, the procurement of—
- (a) goods or construction work by a procuring entity shall be done by means of tendering proceedings in accordance with section thirty-one;
 - (b) services by a procuring entity shall be done by a method which complies with section thirty-two.

- (2) Where in accordance with this Act a procuring entity adopts a method of procurement other than one specified in subsection (1), the procuring entity shall include in the record of its proceedings a statement of the grounds and circumstances on which it relied to justify the adoption of that method.

31 Tendering proceedings

- (1) Subject to this Act, in any tendering proceedings conducted by a procuring entity—
- (a) the invitation to suppliers to tender shall be published—
 - (i) in the Gazette, where the procuring entity is the State; and
 - (ii) in a newspaper circulating in the area in which the procuring entity has jurisdiction or carries on business, where the procuring entity is not the State; and
 - (iii) in a newspaper of wide international circulation or in a relevant trade or technical or professional journal of wide international circulation, where tenders are invited from suppliers who are not nationals or residents of Zimbabwe;
 - (b) the invitation to suppliers to tender shall contain the following information—
 - (i) the procuring entity's name and address; and
 - (ii) a comprehensive description of the goods to be supplied or, as the case may be, of the construction work to be effected; and
 - (iii) the time within which the goods are to be supplied or, as the case may be, the construction work is to be completed; and
 - (iv) the criteria by which, subject to section thirty-four, suppliers will be evaluated; and
 - (v) the manner in which solicitation documents may be obtained and their price; and
 - (vi) the deadline for the submission of tenders and the place where they are to be submitted; and
 - (vii) such other information as may be prescribed in procurement regulations;
 - (c) an invitation to prequalify shall be published in the manner prescribed in paragraph (a) and shall contain the information referred to in subparagraphs (i) to (iv) of paragraph (b), together with the following information—
 - (i) the manner in which prequalification documents may be obtained and their price; and
 - (ii) the deadline for the submission of prequalification documents and the place where they are to be submitted; and
 - (iii) such other information as may be prescribed in procurement regulations;

- (d) the price charged for solicitation documents and any prequalification documents shall not exceed the cost of printing them and providing them to suppliers;
- (e) solicitation documents shall contain comprehensive information as to—
 - (i) the nature, quantity and quality of the goods or construction work required; and
 - (ii) the manner and time in which tenders are to be prepared and submitted; and
 - (iii) the criteria and procedures by which the successful tender will be determined; and
 - (iv) the manner in which the tender price is to be formulated and expressed; and
 - (v) any tender security required; and
 - (vi) the date, time and place for the opening of tenders and the procedure to be followed at such opening; and
 - (vii) any right on the part of the procuring entity to reject all tenders;]
 - (viii) such other information as may be prescribed;
- (f) any modification of a solicitation document shall be communicated without delay to all suppliers who have received the document;
- (g) any extension of the deadline within which tenders must be submitted shall be communicated without delay to all suppliers who have received solicitation documents;
- (h) tenders shall be submitted in writing and sealed in an envelope or other container so that they cannot be read before the time fixed for the opening of all tenders;
- (i) before the time fixed for the opening of all tenders, the procuring entity shall take all necessary steps to ensure that the contents of any tender is not disclosed to any other supplier;
- (j) any tender that is submitted after the deadline for their submission, or any extension of that deadline, shall not be opened and shall be returned to the supplier concerned;
- (k) if suppliers are required to provide security as a condition of their submitting tenders, the requirement shall apply equally to all suppliers;
- (l) all suppliers that have submitted tenders shall be permitted to witness the opening of the tenders and shall have the right to be informed of the price and other salient terms of each tender opened;
- (m) the procuring entity shall accept whichever valid tender offers the lowest price, unless other criteria are specified in the solicitation documents, in which event those criteria shall be followed;
- (n) no negotiations shall take place between the procuring entity and a supplier with respect to a tender submitted by the supplier;
- (o) if any formalities need to be complied with before a procurement contract is concluded, the successful tenderer shall be given due notice of those formalities.

- (2) Subject to subsection (1), a procuring entity shall conduct its tendering proceedings in accordance with procurement regulations or, in regard to any matter that is not prescribed in such regulations or this Act, in accordance with such procedure as the procuring entity may fix;

Provided that any procedure so fixed shall be such as to ensure that all suppliers are treated fairly and impartially and shall be communicated without delay to all suppliers concerned.

32 Procedure for procurement of services

- (1) Subject to this Act, in any proceedings for the procurement of a service by a procuring entity—
 - (a) a notice requesting suppliers to submit proposals for the provision of the service shall be published—
 - (i) in the Gazette, where the procuring entity is the State; and
 - (ii) in a newspaper circulating in the area in which the procuring entity has jurisdiction or carries on business, where the procuring entity is not the State; and
 - (iii) in a newspaper of wide international circulation or in a relevant trade or technical or professional journal of wide international circulation, where proposals are invited from suppliers who are not nationals or residents of Zimbabwe;
 - (b) the notice referred to in paragraph (a) shall contain at least the following information—
 - (i) the procuring entity's name and address; and
 - (ii) a brief description of the service to be procured; and
 - (iii) how to obtain documents giving details of the service to be procured and the manner in which the successful supplier is to be selected;
 - (c) the documents referred to in subparagraph (iii) of paragraph (b) shall contain the following information—
 - (i) a comprehensive description of the service to be supplied and, where applicable, the time when it is to be provided; and
 - (ii) the criteria and procedures by which, subject to section thirty-four, the qualifications of suppliers will be evaluated; and
 - (iii) the information or evidence, if any, which suppliers must provide to prove their qualifications; and
 - (iv) the deadline for the submission of proposals and the place where they are to be submitted; and
 - (v) the criteria and procedures by which the successful proposal will be ascertained; and
 - (vi) any right on the part of the procuring entity to reject all proposals received; and
 - (vii) the terms and conditions of the procurement contract, to the extent that they are known to the procuring entity; and
 - (viii) such other information as may be prescribed in procurement regulations;
 - (d) an invitation to prequalify shall be published in the manner prescribed in paragraph (a) and shall contain the information referred to in subparagraphs (i), (ii), (iii), (v) and (vi) of paragraph (c), together with the following information—

- (i) the manner in which prequalification documents may be obtained and their price; and
 - (ii) the deadline for the submission of prequalification documents and the place where they are to be submitted; and
 - (iii) such other information as may be prescribed in procurement regulations;
- (e) the price charged for the documents referred to in paragraphs (c) and (d) shall not exceed the cost of printing them and providing them to suppliers;
 - (f) any extension of the deadline within which proposals must be submitted shall be communicated without delay to all suppliers who have received the documents referred to in paragraph (iii) of paragraph (b);
 - (g) any proposal that is submitted after the deadline for their submission, or any extension of that deadline, shall not be considered and shall be returned to the supplier concerned;
 - (h) if suppliers are required to provide security as a condition of their submitting proposals, the requirement shall apply equally to all suppliers;
 - (i) the procuring entity shall treat all proposals submitted in such a manner as to avoid the disclosure of their contents to competing suppliers;
 - (j) the procuring entity shall evaluate all proposals that have been validly submitted in accordance with the procedures and criteria specified in the documents referred to in subparagraph (iii) of paragraph (b);
 - (k) if any formalities need to be complied with before a procurement contract is concluded, the successful supplier shall be given due notice of those formalities.
- (2) Subject to subsection (1), a procuring entity shall conduct all proceedings for the procurement of a service in accordance with procurement regulations or, in regard to any matter that is not prescribed in such regulations or this Act, in accordance with such procedure as the procuring entity may fix:

Provided that any procedure so fixed shall be such as to ensure that all suppliers are treated fairly and impartially and shall be communicated without delay to all suppliers concerned.

33 Procurement regulations

- (1) Subject to this Act, the Minister, after consultation with the Minister responsible for finance and the State Procurement Board, may make regulations providing for all matters relating to procurement by procuring entities.
- (2) Procurement regulations may provide for—
- (a) methods of procurement that may be adopted by procuring entities instead of or in addition to the methods specified in section thirty;
 - (b) classes of procurement in which any of the provisions of sections thirty-one and thirty-two may be dispensed with or applied subject to modification;
 - (c) subject to sections thirty-four and forty, the qualifications that suppliers must possess in order to participate in procurement proceedings;

- (d) the procedure to be adopted by procuring entities and suppliers, and the manner in which they shall conduct themselves, in procurement proceedings;
 - (e) information to be provided to suppliers in procurement proceedings;
 - (f) alterations that suppliers may be permitted to make to their tenders, bids or proposals or to any documents submitted by them in any procurement proceedings;
 - (g) the evaluation, comparison and acceptance of tenders, bids or proposals made by suppliers;
 - (h) measures to ensure that tenders, bids or proposals submitted by suppliers are not disclosed to other suppliers;
 - (i) circumstances in which suppliers may be debarred from participating in, or continuing to participate in, any procurement proceedings;
 - (j) fees, deposits and charges payable by suppliers and other persons in respect of procurement proceedings and anything done by the State Procurement Board in terms of this Act;
 - (k) the monitoring and supervision by the State Procurement Board of the performance of parties to procurement contracts;
 - (l) terms and conditions of procurement contracts;
 - (m) circumstances in which the provisions of the regulations may be departed from or waived.
- (3) Procurement regulations may prescribe requirements by reference to the UNCITRAL Model Law on Procurement of Goods, Construction and Services adopted by the United Nations Commission on International Trade Law at its twenty-sixth session in 1993.
 - (4) Procurement regulations shall not have effect until they have been published in the Gazette.

34 Eligibility of suppliers

- (1) Subject to this section, a procuring entity may require suppliers, before they participate in procurement proceedings, to satisfy the procuring entity as to all or any of the following matters—
 - (a) that they possess the necessary professional and technical qualifications and competence, financial resources, equipment, facilities, personnel and experience to perform the procurement contract;
 - (b) that they have the legal capacity to enter into the procurement contract;
 - (c) that they are not insolvent, in liquidation or under judicial management under the law of any country, and that proceedings have not been instituted in any country for their sequestration or winding up or for placing them under judicial management;
 - (d) that they have paid all taxes, duties and rates for which they are liable in Zimbabwe, together with any contributions or payments due under the National Social Security Authority Act [Chapter 17:04];
 - (e) that they are not ineligible to participate in procurement proceedings in terms of section forty-one;
 - (f) that neither they nor, in the case of a body corporate, any of their directors or officers have in the preceding ten years—

- (i) been convicted in any country of an offence by whatever name called relating to—
 - A. the conduct of their profession or business; or
 - B. the making or a false statement as to their qualifications to enter into a procurement contract;
 - or
 - (ii) been disqualified in any country from taking part in procurement proceedings as a result of any conduct referred to in subparagraph A or B of subparagraph (i).
- (2) Subject to this section, a procuring entity may restrict participation in procurement proceedings to persons who are citizens of or ordinarily resident in Zimbabwe: Provided that a procuring entity shall not impose any such restriction except to the extent that it is authorised to do so by procurement regulations.
- (3) Any requirement in terms of subsection (1) or (2) shall—
 - (a) apply equally to all suppliers for the procurement contract concerned; and
 - (b) be set out in any documents by which tenders, bids or proposals in relation to the procurement contract are sought.
- (4) A procuring entity shall impose no criterion or requirement with respect to the qualifications of suppliers other than those provided for in this section, and shall not impose different criteria or requirements for different suppliers.
- (5) A procuring entity shall evaluate the qualifications of suppliers according to the criteria or requirements set out in the documents by which tenders, bids or proposals in relation to the procurement contract are sought, and according to no other criteria.
- (6) This section shall not be construed as affecting any right a procuring entity may have under procurement regulations to debar a supplier from participating in procurement proceedings on account of any act or omission on the supplier's part in connection with those proceedings.;

35 Record of procurement proceedings

- (1) A procuring entity shall keep a record of its procurement proceedings, which record shall contain—
 - (a) a brief description of the goods, construction work or services sought to be procured; and
 - (b) the names and addresses of—
 - (i) suppliers that participated in prequalification proceedings; and
 - (ii) suppliers that submitted tenders, bids or proposals in relation to the procurement contract;
 and information relating to the qualifications, or lack of qualifications, of those suppliers; and
 - (c) the price, or the basis for determining the price, and a summary of the other principal terms and conditions of each tender, bid or proposal that was submitted in relation to the procurement contract; and
 - (d) the name and address of the supplier with whom the procurement contract was entered into, and the contract price; and
 - (e) a summary of the procuring entity's evaluation and comparison of the tenders, bids or proposals that were submitted in relation to the procurement contract; and

- (f) such other information and particulars as may be prescribed in procurement regulations.
- (2) Except as may otherwise be provided in procurement regulations, a procuring entity shall, on request, disclose—
 - (a) to any person, that part of the record of its procurement proceedings that contains the information referred to in paragraphs (a) and (b) of subsection (1); and
 - (b) to any supplier who submitted a tender, bid or proposal in the procurement proceedings concerned, that part of the record of the proceedings that contains the information referred to in paragraphs (c) to (f) of subsection (1).

36 Public access to regulations, etc

- (1) A procuring entity shall ensure that, whenever it engages in procurement—
 - (a) a copy of any procurement regulations which apply to the procurement proceedings; and
 - (b) where the regulations referred to in paragraph (a) refer to the UNCITRAL Model Law specified in subsection (3) of section thirty-three, a copy of that Model Law; and
 - (c) a copy of any direction issued in terms of section forty-two and applicable to the procurement proceedings concerned; and
 - (d) copies of any other documents regulating the procedure in the procurement proceedings or the qualifications of suppliers therein;
 are available for public inspection at all reasonable times during business hours at the offices of the procuring entity.
- (2) A procuring entity shall either—
 - (a) provide any interested party, for a reasonable charge, with a copy of any document referred to in subsection (1); or
 - (b) permit any interested party, at his own expense, to make a copy of any document referred to in subsection (1).

37 Suppliers to permit access to their books and accounts

- (1) It shall be a condition of every procurement contract concluded with the State or any statutory body after the date of commencement of this Act that—
 - (a) the supplier shall permit the State Procurement Board, or any person authorised in writing by the Board, at all reasonable times to inspect the supplier's books and accounts relating to the contract; and
 - (b) if the State Procurement Board so directs, the supplier shall permit the Controller and Auditor-General, or a person who is registered as a public auditor under the Public Accountants and Auditors Act [Chapter 27:12] and nominated by the Comptroller and Auditor-General, to audit the supplier's accounts relating to the contract.
- (2) The cost of any audit referred to in paragraph (b) of subsection (1) shall be met from the funds of the State Procurement Board.

38 Non- liability of procuring entity where all tenders are rejected

Where a procuring entity, before accepting any tender, bid or proposal, rejects all the tenders, bids or proposals that were submitted in any procurement proceedings, the procuring entity shall incur no liability towards the suppliers that submitted those tenders, bids or proposals.

39 Effect of bribery, fraud or collusion by supplier

- (1) If a procuring entity is satisfied that a supplier, or any employee or agent of a supplier—
- (a) in contravention of section 3 of the Prevention of Corruption Act [Chapter 9:16], has given, agreed to give or offered any consideration to an employee or agent of the procuring entity in connection with any procurement proceedings; or
 - (b) has knowingly misrepresented any material fact in a tender, bid or proposal submitted in any procurement proceedings; or
 - (c) has entered or attempted to enter into a collusive agreement or arrangement, whether enforceable or not, with any other supplier whereby the prices quoted in their respective tenders, bids or proposals are or would be, as the case may be, higher than would have been the case had there been no collusion between the suppliers concerned;
- the procuring entity shall reject any tender, bid or proposal the supplier may have submitted in connection with those proceedings.

- (2) If, after a procurement contract has been concluded with a supplier, it is proved that the supplier, or an employee or agent of the supplier—
- (a) in contravention of section 3 of the Prevention of Corruption Act [Chapter 9:16], gave, agreed to give or offered any consideration to an employee or agent of the procuring entity in connection with the preceding procurement proceedings; or
 - (b) knowingly misrepresented a material fact in a tender, bid or proposal submitted in the preceding procurement proceedings; or
 - (c) entered or attempted to enter into a collusive agreement or arrangement, whether enforceable or not, with any other supplier whereby the prices quoted in their respective tenders, bids or proposals were or would have been, as the case may be, higher than would have been the case had there been no collusion between the suppliers concerned;

the procurement contract shall be void as between the procuring entity and the supplier.

40 Effect of failure to disclose interest by member of State Procurement Board or committee thereof

Without derogation from subsection (4) of section seventeen, if the State Procurement Board or a committee of the Board is conducting procurement proceedings on behalf of a procuring entity and a member of the Board or the committee, as the case may be, contravenes subsection (2) or (3) of that section by---

- (a) failing to disclose any relationship or interest he or a relative of his may have in a supplier in those proceedings; or
- (b) taking part in the consideration or discussion of, or voting on, any question before the Board in proceedings such as are referred to in paragraph (a);

any procurement contract concluded between the procuring entity and the supplier concerned shall be void.

41 State Procurement Board may declare supplier ineligible to be awarded State contract

- (1) Subject to this section, if the State Procurement Board is satisfied that—
 - (a) any supplier has been convicted of contravening section forty-eight or any provision of the Prevention of Corruption Act [Chapter 9:16] in respect of procurement proceedings in which the State or a statutory body was the procuring entity; or
 - (b) any procurement contract between a supplier and the State or a statutory body has been cancelled or otherwise terminated on account of fraud on the part of the supplier;

the State Procurement Board may declare the supplier to be ineligible to participate in procurement proceedings with the State or any statutory body for such period as the Board may specify, which period shall not exceed three years.

- (2) Before making a declaration in terms of subsection 91), the State Procurement Board shall notify the supplier concerned that it is contemplating making the declaration and shall ensure that the supplier is given an adequate opportunity to make representations in the matter.
- (3) The State Procurement Board shall ensure that all Ministries and departments of the State, all statutory bodies and the supplier concerned are notified without delay of the terms of any declaration the Board has made in terms of subsection (1).
- (4) The State Procurement Board, on good cause shown, may at any time amend or revoke a declaration made in terms of subsection (1).
- (5) During the period that a declaration in terms of subsection (1) is in effect, no tender, bid or proposal submitted by the supplier concerned in any procurement proceedings conducted by the State or any statutory body shall be considered, and any procurement contract concluded between the supplier and the State or a statutory body shall be void.

42 Directions to procuring entities by State Procurement Board

- (1) Subject to this Act, the State Procurement Board may issue written directions to any procuring entity providing, in relation to any particular procurement proceedings or class thereof, for any of the matters for which procurement regulations may be made.
- (2) In the event of any inconsistency between a direction issued in terms of subsection (1) and any provision of procurement regulations, the regulations shall prevail.
- (3) A procuring entity shall take all necessary steps to comply with a direction issued to it in terms of subsection (1) and shall inform all suppliers in the procurement proceedings concerned of the terms of the direction.

PART V

APPEALS

43 Appeal to Administrative Court

- (1) Subject to this section, any person who is aggrieved by a decision of the State Procurement Board or any procuring entity—
 - (a) in any procurement proceedings; or
 - (b) in terms of section forty-one;may appeal against that decision to the Administrative Court.
- (2) An appeal in terms of subsection (1) shall be noted by lodging a written notice of appeal with the Registrar of the Administrative Court and the principal officer of the State Procurement Board within twenty days from the date on which the appellant was notified of the decision that is the subject of the appeal.
- (3) In an appeal in terms of subsection (1), the Administrative Court may confirm, vary or set aside the decision appealed against or give such other decision as in its opinion the State Procurement Board ought to have given, and may make such order as to costs as it thinks fit.
- (4) The Administrative Court Act [Chapter 7:01] shall apply in relation to the composition, procedure and powers of the Administrative Court in an appeal in terms of subsection (1).

44 Suspension of procurement proceedings pending appeal

- (1) Subject to this section, where an appeal has been noted in terms of section forty-three—
 - (a) the procurement proceedings concerned shall be suspended for a period of seven days from the date on which the appeal was noted; and
 - (b) the operation of the procurement contract concerned shall be suspended for a period of seven days from the date on which the appeal was noted, where the contract entered into force before or during that period.
- (2) The noting of an appeal in terms of section forty-three shall not have the effect referred to in subsection (1) if—
 - (a) the Administrative Court considers that the appeal is frivolous or vexatious or is noted solely to delay the procurement proceedings or the operation of the procurement contract concerned, and directs that the noting of the appeal shall not suspend the proceedings or the operation of the contract, as the case may be; or
 - (b) the procuring entity concerned certifies in writing that urgent public interest considerations require the procurement to proceed.
- (3) A certificate in terms of paragraph (b) of subsection (2) shall be included in the record of the procurement proceedings concerned kept in terms of section thirty-five.

- (4) The period during which procurement proceedings or the operation of a procurement contract are suspended in terms of subsection (1) may be extended by a president of the Administrative Court.

PART VI

GENERAL

45 State Procurement Board may require information

Every procuring entity shall provide the State Procurement Board with such information as the Board may in writing require regarding procurement engaged in by the procuring entity.

46 Investigations by State Procurement Board

- (1) In this section—

“investigator” means a person appointed in terms of subsection (2) to conduct an investigation under this section.

- (2) If the State Procurement Board considers that such an investigation is necessary or desirable for the purpose of preventing, investigating or detecting a contravention of this Act or any other law, the Board may appoint a person to conduct an investigation into any matter related to the conduct of any procurement proceedings by a procuring entity or the conclusion or operation of any procurement contract.
- (3) For the purpose of an investigation in terms of subsection (2), an investigator shall have the same powers, rights and privileges as are conferred upon a commissioner by the Commissions of Inquiry Act [Chapter 10:07], other than the power to order a person to be detained in custody, and sections 9 to 13 and 15 of that Act shall apply, mutatis mutandis, in relation to an investigation in terms of subsection (2) and to any person summoned to give or giving evidence at that investigation.
- (4) In addition to the powers referred to in subsection (3), an investigator may, for the purposes of an investigation in terms of subsection (2)—
 - (a) at any time during normal office hours, without previous notice, enter any premises of the procuring entity concerned or of any supplier in the procurement proceedings concerned;
 - (b) require any officer, employee or agent of the procuring entity or supplier referred to in paragraph (a) to produce any books, records, accounts or documents;
 - (c) search any premises referred to in paragraph (a) for any books, records, accounts or documents.
 - (d) Examine and make extracts from and copies of any books, records, accounts or documents of the procuring entity or supplier referred to in paragraph (a);
 - (e) Remove any books, records, accounts or documents of the procuring entity or supplier referred to in paragraph (a), for so long as may be necessary for the purpose of examining them or making extracts from or copies of them:

- Provided that the investigator shall give a full receipt for any such books, records, accounts or document so removed;
- (f) require any officer, employee or agent of the procuring entity or supplier referred to in paragraph (a)—
 - (i) to explain any entry in any books, records, accounts or documents;
 - (ii) to provide the investigator with such information concerning the management or activities of the procuring entity or supplier as the supervisor may reasonably require.
- (5) The powers of entry and search conferred by subsection (4) shall not be exercised except with the consent of the procuring entity or supplier concerned or of the person in charge of the premises concerned, unless there are reasonable grounds for believing that it is necessary to exercise those powers for the prevention, investigation or detection of any offence or for the obtaining of evidence relating to an offence.
- (6) Any person who, without just cause, hinders or obstructs an investigator in the exercise of his functions under this section shall be guilty of an offence and liable to a fine not exceeding two thousand dollars or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

47 Procedure on completion of investigation

- (1) On completion of an investigation in terms of section forty-six an investigator shall—
- (a) forward a copy of his report thereon to the State Procurement Board; and send a summary of his findings and recommendations to the procuring entity and to any supplier whose conduct was the subject of the investigation.
- (2) If, after considering an investigator's report sent to it in terms of subsection (6), the State Procurement Board is satisfied that there has been a contravention of this Act or any other law in relation to any procurement proceedings or procurement contract, the State Procurement Board may take such action as in its opinion is necessary to rectify the contravention, including—
- (a) annulment of the procurement proceedings;
 - (b) cancellation of the procurement contract
 - (c) condonation of the contravention;
 - (d) ratification of anything done in relation to the proceedings;
 - (e) a declaration in terms of section forty-one
- and, notwithstanding any other law, the proceedings or contract concerned shall be annulled, cancelled or have effect, as the case may be, accordingly.
- (3) Before taking any action in terms of subsection (2) which may adversely affect the rights or property of any person, the State Procurement Board shall afford that person an adequate opportunity to make representations in the matter.

48 Offences relating to procurement

If any supplier, or any person acting or purporting to act on behalf of a supplier—

- (a) knowingly misrepresents any material fact in a tender, bid or proposal submitted in any procurement proceedings; or
- (b) enters or attempts to enter into a collusive agreement or arrangement, whether enforceable or not, with any other supplier whereby the prices quoted in their respective tenders, bids or proposals are or would be, as the case may be, higher than would have been the case had there been no collusion between the suppliers concerned;

he shall be guilty of an offence and liable to a fine not exceeding fifty thousand dollars or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

49 Application of Act to BOOT or BOT contracts

- (1) In this section—

“BOOT or BOT contract” means a contract or other arrangement under which a person undertakes to construct an item of infrastructure for the State, a local authority or a statutory body in consideration for the right to operate or control it for a specified period, after which period he will transfer or restore ownership or control to the State, the local authority or the statutory body concerned.

- (2) This Act shall apply, mutates mutandis, in respect of BOOT or BOT contracts as if they were procurement contracts, and for that purpose—

- (a) every person who enters or offers to enter into such a contract with the State or a local authority or statutory body shall be deemed to be a supplier; and
- (b) the State or a local authority or statutory body shall be deemed to be a procuring entity in regard to any such contract which it enters into or seeks to enter into.

50 Savings

- (1) In this section—

“former board” means the Government tender board constituted pursuant to instructions issued by the Treasury under section 18 of the Audit and Exchequer Act [Chapter 22:03].

- (2) Anything made, done or commenced by the former board which, immediately before the date of commencement of this Act, had or was capable of acquiring legal effect shall continue to have or to be capable of acquiring, as the case may be, the same effect as if it had been made, done or commenced, as the case may be, by the State Procurement Board in terms of this Act.

Appendix 9: Government of Zimbabwe Public Health Act of 1924

PUBLIC HEALTH ACT OF ZIMBABWE 19 of 1924

Acts 19/1924, 3/1930, 37/1938 (ss. 3 and 22), 10/1945, 4/1948, 1/1953, 18/1957 (Federal), 21/1963, 96/1964, 33/1968, 62/1969, 12/1973 (s. 270), 10/1974; 42/1976 (s. 37), 37/1977 (s. 24), 5/1985, 8/1988 (s. 164), 11/1991 (s. 23), 12/1997 (s. 12) 22/2001 (s. 4); Ord. 6/1980; RGN.s 683/1963, 214/1964, 217/1970, 899/1978.

ARRANGEMENT OF SECTIONS

PART I

PRELIMINARY

Section

1. Short title.
2. Interpretation.

PART II

ADMINISTRATION

3. Ministry responsible for public health.
4. Establishment of Advisory Board of Public Health.
5. Appointment of Chief Health Officer and others.
6. Local authorities in rural areas.
7. Local authorities to appoint medical officers of health.
8. Duties of medical officers to local authorities.
9. Government medical officers to be medical officers of health in rural districts.
10. Local authority to appoint health inspectors.
11. Removal of medical officers and health inspectors.
12. Local authority failing to appoint medical officer of health or health inspector.
13. Combined appointments.
14. Duties of local authorities.
15. Health committees.
16. Defaulting local authorities.

PART III

NOTIFICATION OF INFECTIOUS DISEASES

17. Notifiable diseases.
18. Notification of infectious disease.
19. Notification by medical practitioners.
20. Local authorities to transmit return of notifications.
21. Regulations for the notification of infectious diseases.
Prevention and Suppression of Infectious Diseases
22. Inspection of infected premises and examination of persons suspected to be suffering from infectious disease.
23. Provision of isolation hospitals, mortuaries, disinfecting stations and ambulances by local authorities.
24. Removal to hospital of infected persons.

25. Infected persons sent for treatment from other districts.
26. Measures to be adopted by local authority in case of infectious disease.
27. Power of local authority to order or carry out disinfection.
28. Removal to cleansing stations of dirty and verminous persons.
29. Removal orders.
30. Exposure of infected persons or things.
31. Conveyance of infected persons in public conveyances.
32. Infected dwellings not to be evacuated or let without previous disinfection.
33. Removal of bodies of persons who have died of infectious disease
34. Removal and burial of bodies of persons who have died of infectious disease.
35. Regulations regarding infectious diseases.

Special Provisions Regarding Formidable Epidemic Diseases

36. Formidable epidemic diseases.
37. Notification of suspected cases of formidable epidemic diseases.
38. Notification of sickness or mortality in animals.
39. Local authorities to report notification or formidable epidemic diseases by telegraph.
40. Powers of Minister where local authority fails adequately to deal with any formidable epidemic disease.
41. . . .
42. Regulations regarding formidable epidemic diseases.
43. . . .
44. Appointment of epidemic committees.
45. Advances to local authorities.
46. Refunds to local authorities.

PART IV

VENEREAL DISEASES

47. Venereal diseases.
48. Duties of medical practitioners.
49. Duties of medical officers of health and Government medical officers to report, and powers of district commissioners.
50. Conveyance of infection an offence.
51. Detention in hospital of infected persons.
52. Medical examination of inhabitants in a area where venereal diseases believed to be prevalent.
53. Examination of females by women medical practitioners.
54. Rights of persons detained in hospital.
55. Proceedings to be in camera, and reports not to be published.
56. Publication of advertisements of cures.
57. Contributions and facilities for diagnosis and treatment of venereal disease.
58. Regulations.

PART V

INTERNATIONAL SANITARY REGULATIONS

59. Publication of International Sanitary Regulations and amendments thereto.
60. Power to carry out and apply International Sanitary Regulations.
61. Regulations.
62. Power to apply regulations to any infectious disease.
63. Jurisdiction.

PART VI

WATER AND FOOD SUPPLIES

64. Duty of local authority to furnish water supplies.
65. Water works not to be commenced until approved by State.
66. Local authority to maintain existing water supplies in good order.
67. Powers to inspect water supplies.
68. Regulations.
69. Sale of unwholesome, diseased or contaminated articles of food prohibited.
70. Regulations regarding sale of milk and articles of food.
71. Minister's powers to make orders.
72. . . .

PART VII

INFANT NUTRITION

73. Interpretation in Part VII.
74. Regulations in respect of infant nutrition.

PART VIII

SLAUGHTER-HOUSES

75. Interpretation in Part VIII.
76. Local authority may license slaughter-houses.
77. Local authority may refuse licences and appeals against refusals.
78. Licence required for use of premises as slaughter-house.
79. Cancellation of licence.
80. Prohibition against sale of meat which has not been slaughtered in a slaughter-house.
81. Inspection of meat and fees for inspection.

PART IX

SANITATION AND HOUSING

82. Nuisances prohibited.
83. Local authorities to maintain cleanliness and prevent nuisances.
84. Local authorities to prevent or remedy danger to health arising from unsuitable dwellings.
85. What constitutes a nuisance.
86. Notice to remove nuisance.
87. Procedure where person fails to comply with notice.
88. Penalties in relation to nuisances.
89. Court may order local authority to execute works in certain cases.

90. Examination of premises.
91. Persons making complaint of nuisance.
92. Demolition of unfit dwellings.
93. Prohibitions in respect of back-to-back dwellings and rooms without through ventilation.
94. Regulations.

**PART X
GENERAL**

95. Contributions to cost of laboratories and voluntary associations concerned with public health.
96. Powers and duties of Chief Health Officer and assistant health officers.
97. Reciprocal notification and consultation between Ministry and Veterinary Department.
98. Domicile of persons for purposes of this Act.
99. Contracts in respect of dwellings not to be affected.
100. Savings as to recovery of damages.
101. Protection of State and local authorities.
102. Protection of officers.
103. Powers of entry and inspection of premises and penalties for obstruction.
104. Penalties for fraudulent conduct in connection with certificates under this Act.
105. Penalties where not expressly provided.
106. Burden of proof as to knowledge of infection.
107. Defect in form not to invalidate.
108. Service of notices.
109. Powers of local authority outside its district.
110. Provisions of this Act in relation to other laws.
111. Scope and application of proclamations and regulations.
112. Application of Act to State.
113. . . .

AN ACT to make provision for the public health.
[Date of commencement: 1 January 1925.]

PART I

PRELIMINARY (sections 1-2)

[Chap15:09s1]1 Short title

This Act may be cited as the Public Health Act [Chapter 15:09].

[Chap15:09s2]2 Interpretation

(1) In this Act-

'adult' means a person of sixteen years of age or over;

'appropriate Minister', in relation to a local authority or a body or authority referred to in paragraph (a) of subsection (2), means the Minister responsible for administering the Act by or under which that local authority, body or authority was established;

'approved veterinary surgeon' means a veterinary surgeon approved by the Director of Veterinary Services;

'assistant health officer' means a person appointed to be an assistant health officer in terms of section five;

'building' includes any structure whatsoever for whatever purpose used;

'burial' means burial in earth, interment or any other form of sepulture, or the cremation or any other mode of disposal of a dead body;

'carcass' includes any part of a carcass;

'Chief Health Officer' means the person referred to in subsection (1) of section five;

'child' means a person under sixteen years of age;

'cost' or 'expenditure', when used in connection with the removal, detention, accommodation, maintenance or treatment of persons, means cost calculated in accordance with the tariff of charges approved by the Minister and based as nearly as may be on average cost or, if there is no such tariff, means actual cost;

'district', in relation to-

(a) a municipal council, town council or local board, means the municipal area, town area or local government area, as the case may be;

(b) a rural district council, means the council area or, where the Minister has in terms of subsection (2) declared a greater or lesser area to be a district in relation to such rural district council, such greater or lesser area;

(c) in relation to any other body or authority declared to be local authority in terms of subsection (2), means the area declared in terms of subsection (2) to be a district in relation to such body or authority;

'dwelling' means any house, room, shed, hut, cave, tent, vehicle, vessel or boat or any other structure or place whatsoever, any portion whereof is used by any human being for sleeping or in which any human being dwells;

'food' or 'article of food', other than dairy produce as defined by the Dairy Act [Chapter 18:08], means any animal product, fish, fruit, vegetables, condiments, confectionery, beverages and any other article or thing whatsoever, other than drugs or water, in any form, state or stage of preparation which is intended or ordinarily used for human consumption;

'guardian' means any person having, by reason of the death, illness, absence or inability of the parent or any other cause, the custody of a child;

'health inspector' means a person registered as a health inspector under any law relating to the registration of health inspectors;

'hospital or place of isolation' means any special hospital or any premises or portion thereof set apart and used solely for the admission and accommodation of persons suffering from infectious disease;

'infected', in relation to-

(a) an infectious disease, means suffering from, or in the incubation stage or contaminated with the infection of, that disease;

(b) a sexually transmitted disease, means any form or stage of infection referred to in paragraph (a), whether the disease was transmitted through sexual intercourse or not;

and 'infect' and 'infection' shall be construed accordingly;

[Definition of 'infected' substituted by section 12(a) (i) of Act 12 of 1997 with effect from 7 November 1997.]

'infectious disease' means any infectious or communicable disease specified in section seventeen or declared to be an infectious disease in terms of that subsection;

'International Sanitary Regulations' means the International Sanitary

Regulations adopted by the Fourth World Health Assembly at Geneva on the 25th May, 1951, to which the State is a party and any amendment thereto to which the State becomes a party;

'isolated' means the segregation, and the separation from and interdiction of communication with others, of persons who are or are suspected of being infected;

'land' includes any right over or in respect of land;

'local authority' means(

a) a municipal council or town council; or

(b) any-

(i) a local board; or

(ii) a rural district council; or

(iii) any other body or authority;

designated in terms of subsection (2) to be a local authority for the purposes of this Act;

'medical observation' means the segregation and detention of persons under medical supervision;

'medical officer of health' means any medical officer of health appointed by a local authority;

'medical practitioner' means a person who is registered as such under any law relating to the registration of medical practitioners;

'medical surveillance' means the keeping of a person under medical supervision. Persons under such surveillance may be required by the local authority or any other duly authorized officer to remain within a specified area or to attend for medical examination at specified places and times;

'Minister' means the Minister of Health and Child Welfare or any other Minister to whom the President may, from time to time, assign the administration of this Act;

'Ministry' means the Ministry for which the Minister is responsible;

'notifiable', in relation to any disease, means required to be notified to any person or authority in terms of this Act;

'occupier', in relation to any premises, means-

(a) any person in actual occupation of those premises; or

(b) any person legally entitled to occupy those premises; or

(c) any person having the charge or management of those premises;

and includes the agent of any such person when he is absent from Zimbabwe or his whereabouts are unknown. In the case of premises used as a school, the expression 'occupier' includes the principal or person in charge of the school;

'owner', in relation to any premises, means-

(a) the person in whose name the title to those premises is registered, and includes the holder of the stand licence; or

(b) if such a person or holder is dead, insolvent, mentally disordered or defective or a minor or under any legal disability, the person in whom the administration of that person's or holder's estate is vested, whether as executor, guardian or in any other capacity whatsoever; or

(c) if the premises are under lease, the registration whereof is in law necessary for the validity of such lease, the lessee.

When an owner as herein defined is absent from Zimbabwe or his whereabouts are unknown, the expression 'owner' includes an agent of such owner or any person receiving or entitled to receive rent in respect of the premises;

'parent' means the father and mother of a child, whether legitimate or not;
'premises' means any building or tent, together with the land on which the same is situated and the adjoining land used in connection therewith, and includes any vehicle, conveyance, ship or boat;

'public building' means-

(a) any church, chapel, meeting-house or premises used for divine worship;

(b) any theatre, opera-house, hall, exhibition buildings or premises open to members of the public, whether with or without payment;

(c) any hotel or boarding-house, or lodging-house in which five persons or more, exclusive of members of the family or the servants of the owner or occupier, may obtain meals or sleeping accommodation for payment;

(d) any hospital, school or institution, in which five persons or more are or are intended to be gathered at one time;

'rateable property', in relation to a local authority, means property which under any enactment is liable to be assessed by the local authority for any general rate leviable by it;

'rural district', in relation to a rural local authority, means any area outside an urban district which is under the jurisdiction of that rural local authority, and 'rural area' has a corresponding meaning;

'sanitary convenience' means any-

(a) latrine, urinal, water-closet, aqua-privy, earth-closet, pit-closet, borehole-latrine or chemical-closet; or

(b) other device approved by a medical officer of health;

which is being, has been or is intended to be used for the disposal of human waste;

'Secretary' means the Secretary of the Ministry;

'sexually transmitted disease' means any infectious or communicable disease that is normally transmitted through sexual intercourse;

[Definition of 'sexually transmitted disease' inserted by section 12(a) (ii) of Act 12 of 1997 with effect from 7 November 1997.]

'school' means any public or private establishment for primary or secondary or higher education, and includes a hostel or boarding-house kept for housing the pupils at any such establishment, and includes a Sunday school;

'trade premises' means any premises used or intended to be used for carrying on any trade or business;

'urban district', in relation to an urban local authority, means the area under the jurisdiction of that urban local authority, and 'urban area' has a corresponding meaning;

(2) With the approval of the appropriate Minister, the Minister may by statutory instrument designate a rural district council or local board or any other body or authority to be a local authority for the purposes of this Act, and-

(a) may, in the case of a rural district council, declare a greater or lesser area than the council area to be a district in relation to such rural district council;

(b) shall, in relation to such other body or authority, specify the area which shall be a district in relation to such body or authority.

PART II

ADMINISTRATION (sections 3-16)

[Chap15:09s3]3 Ministry responsible for public health

- (1) The Ministry shall be under the control of the Minister.
- (2) The functions of the Ministry shall, subject to this Act, be-
 - (a) to prevent and guard against the introduction of disease from outside;
 - (b) to promote the public health, and the prevention, limitation or suppression of infectious and contagious diseases within Zimbabwe;
 - (c) to advise and assist local authorities in regard to matters affecting public health;
 - (d) to promote or carry out researches and investigations in connection with the prevention or treatment of human diseases;
 - (e) to prepare and publish reports and statistics or other information relative to the public health;
 - (f) generally to administer the provisions of this Act.

[Chap15:09s4]4 Establishment of Advisory Board of Public Health

- (1) The Minister may, for the purposes of this Act, establish a body to be known as the Advisory Board of Public Health which shall consist of the following members, who shall be appointed by the Minister and who shall, subject to any regulations which may be made under subsection (8), hold office for three years and who shall be eligible for reappointment for like periods-
 - (a) a chairman, who shall not be a medical practitioner and who shall preside at meetings of the Board;
 - (b) a deputy chairman, who shall not be a medical practitioner and who shall preside at meetings of the Board in the absence of the chairman;
 - (c) two members, who shall be medical practitioners, to represent the Zimbabwe Medical Association;
 - (d) one member to represent local authorities;
 - (e) one member to represent bodies who perform the functions of medical aid societies;
 - (f) one member, who shall be a medical practitioner, to represent missionary bodies carrying on activities in the field of public health;
 - (g) one member, who shall be a registered nurse or mid-wife, to represent the Zimbabwe Nurses Association;
 - (h) one member, who shall be a dental practitioner, to represent the Dental Association of Zimbabwe;
 - (i) one member, who shall be a registered pharmaceutical chemist, to represent the Pharmaceutical Society of Zimbabwe;
 - (j) one member to represent the Zimbabwe Red Cross, the Saint John Ambulance Association, the Saint John Ambulance Brigade and other similar bodies;
 - (k) one member to represent trade unions;
 - (l) one member to represent the women's voluntary associations carrying on activities in the field of public health;
 - (m) such additional members, not exceeding four, as the Minister may appoint.
- (2) The Secretary shall be ex officio a member of the Board.
- (3) Before making an appointment in terms of subsection (1) the Minister may, in his discretion, call upon a body which, whether itself or in conjunction with other bodies, is entitled to be represented in terms of that subsection, to nominate such number of persons as the Minister may determine who, in its opinion, are suitable and available for appointment as members of the Board:
Provided that the Minister may-

- (a) appoint a person to be a member of the Board who has not been so nominated and may decline to appoint any person so nominated;
- (b) where he has called for nominations in terms of this subsection in respect of any appointment to the Board and no nominations have been made in respect of such appointment within such period as he may determine when calling for such nominations, appoint any person to be a member of the Board whether or not, in his opinion, the person so appointed is able to represent the views of the body whose nominations were called for.
- (4) On the death of, or the vacation of office by, a member of the Board the Minister may appoint a person to fill the vacancy in accordance with the provisions of subsection (1):
 Provided that a person appointed in terms of this subsection may be appointed to hold office for such period, being less than three years, as the Minister may determine.
- (5) The function of the Board shall be to advise the Minister on all matters relating to public health in Zimbabwe.
- (6) The Board or any committee thereof shall have the power to conduct an inquiry into any matter relating to public health referred to the Board by the Minister and, for that purpose, the powers, rights and privileges of the Board or its committees shall be the same as those conferred upon commissioners by the Commissions of Inquiry Act [Chapter 10:07], other than the power to order a person to be detained in custody, and sections 9 to 13 and 15 to 19 of that Act shall apply, mutatis mutandis, in relation to the conducting of such an inquiry and to any person summoned to give evidence, or giving evidence, before the Board or any of its committees and, in addition, the members of the Board and its committees shall be deemed to be persons authorized by the Minister in terms of subsection (1) of section one hundred and three.
- (7) It shall be the duty of the Board, either by itself or by a committee thereof, to make a full, faithful and impartial inquiry into any matter referred to it in terms of subsection (6) and the Board shall make recommendations to the Minister in accordance with the findings of the inquiry.
- (8) The Minister may make such regulations as he may deem expedient to give force and effect to the provisions of this section and such regulations may provide for all or any of the following matters-
- (a) the procedure of the Board, the convening of its meetings and the quorum thereof;
- (b) the establishment of committees of the Board, their procedure and functions and the manner in which persons with special knowledge or skill may be coopted to serve on such committees;
- (c) the allowances payable to members of the Board and of its committees;
- (d) the circumstances in which a member of the Board shall vacate his office.
- (9) The Minister may appoint a person, who may be an officer in the Public Service, to be legal adviser to the Board.
- (10) For the purposes of this section-
 'Board' means the Advisory Board of Public Health established in terms of subsection (1).
- [Chap15:09s5]5 Appointment of Chief Health Officer and others

- (1) The Secretary shall ex officio be the Chief Health Officer.
- (2) There shall be such Government medical officers, assistant health officers, pathologists, medical inspectors, health inspectors and other officers as may be necessary for the purposes of this Act whose offices shall be public offices and form part of the Public Service.
- (3) Notwithstanding anything to the contrary contained in any law relating to the Public Service, no person shall be appointed as-
 - (a) Secretary unless he-
 - (i) is fully qualified for registration as a medical practitioner in terms of the Health Professions Act [Chapter 27:19]; and
 - (ii) possesses a degree, diploma or certificate in public health or state medicine which has been given after examination and is registrable in Zimbabwe and in the country where it was obtained;
 - (b) a Government medical officer unless he is qualified in accordance with subparagraph (i) of paragraph (a);
 - (c) an assistant health officer unless he is qualified in accordance with subparagraph (i) of paragraph (a) and possesses a qualification referred to in subparagraph (ii) of paragraph (a).

[Chap15:09s6]6 Local authorities in rural areas

- (1) Where no local authority exists for the whole or part of a district, the district administrator, acting under the instructions of the Chief Health Officer shall be regarded for the purposes of this Act as the local authority for that area and may, subject to subsection (2), exercise any powers which a local authority may exercise in terms of this Act.
- (2) A district administrator acting in terms of subsection (1) may not-
 - (a) make any permanent appointment; or
 - (b) incur any capital expenditure;
 without the express approval of the Minister.

[Chap15:09s7]7 Local authorities to appoint medical officers of health

- (1) Every local authority may, and when required by the Minister, after consultation with the appropriate Minister, shall, appoint a medical practitioner as medical officer of health to the local authority, whose appointment shall be subject to the approval of the Minister.
- (2) In the making of such appointment, preference shall be given, except in special circumstances in particular cases, to medical practitioners holding degrees, diplomas or certificates in public health or state medicine granted after examination and registrable in Zimbabwe as well as in the country where they were obtained.

[Chap15:09s8]8 Duties of medical officers to local authorities

Every medical officer of health to a local authority shall keep himself informed as to the public health and sanitary circumstances of his district, and shall make such inspections and inquiries as may be necessary for this purpose. In addition, he shall furnish the local authority with all information in respect of such inspections and inquiries, and shall also furnish to the Chief Health Officer special reports, when required, relating to the public health or sanitation of his district.

[Chap15:09s9]9 Government medical officers to be medical officers of health in rural districts

In any area where no medical officer of health to a local authority has been appointed, a Government medical officer designated by the Secretary by statutory instrument shall be the medical officer of health for the area specified in such notice

and shall carry out the duties imposed by section eight on a medical officer of health, furnishing the information referred to in that section to the Chief Health Officer.

[Chap15:09s10]10 Local authority to appoint health inspectors

Every local authority may, and when required by the Minister, after consultation with the appropriate Minister, shall appoint one or more competent health inspectors to assist in carrying out the provisions of this Act within its district, who shall be subject to the supervision of the medical officer of health.

[Chap15:09s11]11 Removal of medical officers and health inspectors

No medical officer or health inspector appointed by a local authority may, except with his own consent, or in conformity with any enactment relating to retirement on account of age or ill-health, or contract governing his appointment, be removed from office, or have his salary or his emoluments reduced, without the sanction of the Minister first being obtained:

Provided that it shall be competent for a local authority to suspend a medical officer of health or health inspector for incapacity, neglect or misconduct, pending the sanction of the Minister as to dismissal; and in the event of such sanction being granted, the said medical officer or health inspector shall be deemed to have been removed from office from the date of such suspension.

[Chap15:09s12]12 Local authority failing to appoint medical officer of health or health inspector

(1) If any local authority fails to appoint a medical officer of health or health inspector within six months after being required to do so by the Minister, the Minister may appoint a medical officer of health or health inspector, as the case may be, to the local authority, and may fix the remuneration to be paid by the local authority to such officer or inspector; and may, in case of default of payment of such remuneration by the local authority, direct that the same be paid out of the Consolidated Revenue Fund, and that the amount be recovered by deduction from any subsidy or other moneys payable out of the said fund to such local authority.

(2) Where the Minister appoints, in terms of subsection (1), a Government employee to be a medical officer of health or health inspector, as the case may be, to a local authority, he may-

(a) fix the remuneration to be paid to the State in respect of such appointment;

(b) in the case of default of payment of such remuneration by the local authority, direct that the amount be recovered by reduction from any subsidy or other moneys payable out of the Consolidated Revenue Fund to such local authority.

[Chap15:09s13]13 Combined appointments

Nothing in this or any other Act contained shall be construed as precluding any person from holding at the same time an appointment as-

(a) Government medical officer and medical officer of health to one or more local authorities; or

(b) medical officer of health to two or more local authorities; or

(c) health inspector for the State and one or more local authorities or for two or more local authorities.

[Chap15:09s14]14 Duties of local authorities

Every local authority shall take all lawful and necessary precautions for the prevention of the occurrence, or for dealing with the outbreak or prevalence, of any infectious or communicable or contagious diseases, and shall exercise the powers and perform the duties conferred or imposed on it by this Act or by any other enactment.

[Chap15:09s15]15 Health committees

(1) A local authority may establish a committee, to be known as a health committee, for the better administration of the duties imposed on the local authority by section fourteen.

(2) Notwithstanding subsection (1)-

(a) the State and one or more local authorities; or

(b) two or more local authorities; may combine to establish jointly a health committee referred to in subsection (1).

(3) The Minister may, after consultation with the local authority or authorities concerned, make such regulations as he may deem expedient to give force and effect to this section and such regulations may provide for all or any of the following matters-

(a) the membership of a health committee, including the number of members to be appointed and the method of appointment of members by the local authority concerned or, in the case of a health committee referred to in subsection (2), by each local authority concerned and, if the State is a party to the establishment of the health committee, by the Minister;

(b) the power of a health committee to co-opt persons with special knowledge or skill to serve on the committee;

(c) the method of financing the activities of a health committee;

(d) the powers of a health committee.

[Chap15:09s16]16 Defaulting local authorities

(1) Whenever upon the report of the Chief Health Officer it appears to the Minister that the public health of any locality is in danger by the failure or refusal on the part of any local authority to exercise the powers or perform the duties devolving upon it under any enactment, or to take the lawful and necessary steps to obtain powers to deal by by-laws or regulations with the danger, the Minister may, after causing an inquiry to be held, at which the local authority shall have an opportunity of being heard, call upon the local authority forthwith to exercise any such powers or to perform properly any such duties, and if the local authority fails to comply the Minister may exercise such powers or perform such duties, and may authorize any person to take all necessary steps for that purpose in the same manner as if he were the local authority.

(2) Any expenditure incurred by the State under subsection (1) may be recovered-

(a) by action in a competent court against the local authority in default; or

(b) by levying a special rate upon all rateable property within the district of the local authority in default; or

(c) by deduction from any subsidy, grant or other moneys payable by the State to the local authority in default;

or by all three or any two such methods of recovery.

PART III

NOTIFICATION OF INFECTIOUS DISEASES (sections 17-46)

[Chap15:09s17]17 Notifiable diseases

For the purposes of this Act, the term 'infectious disease' includes any of the following diseases-

(a) chicken-pox;

(b) diphtheria;

- (c) erysipelas;
 - (d) pyaemia and septicaemia (puerperal);
 - (e) scarlatina (or scarlet fever);
 - (f) typhus fever;
 - (g) plague;
 - (h) Asiatic cholera;
 - (i) typhoid or enteric fever (including para-typhoid fever);
 - (j) undulant or Malta fever;
 - (k) epidemic cerebro-spinal meningitis (or cerebro-spinal fever or spotted fever);
 - (l) acute poliomyelitis (or infantile paralysis);
 - (m) leprosy;
 - (n) anthrax;
 - (o) glanders;
 - (p) rabies;
 - (q) trypanosomiasis (or sleeping sickness);
- and all forms of tuberculosis, and such other infectious or communicable diseases, including sexually transmitted diseases, as the Minister may declare, by statutory instrument, to be infectious diseases either throughout Zimbabwe or in any part of Zimbabwe.

[Section 17 amended by section 12(b) of Act 12 of 1997 with effect from 7 November 1997.]

[Chap15:09s18]18 Notification of infectious disease

(1) Whenever any child attending any school, orphanage or other like institution, or any person residing in any hotel, boarding-house or other like institution, is known to be suffering from any infectious disease, whether such infectious disease is specified in this Part or not, the principal or person in charge of such school, orphanage or other like institution, or the manager or proprietor or person in charge of such hotel, boarding-house or other like institution shall forthwith send notice thereof to the local authority of the district, and shall furnish to the medical officer of health, on his request, a list of scholars or residents thereat, together with their addresses.

(2) Any person who fails to give any notice required by subsection (1) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(3) In any prosecution under this section the onus of showing that he was unaware that the patient was suffering from a notifiable infectious disease shall be on the person charged.

[Chap15:09s19]19 Notification by medical practitioners

(1) If a patient suffering, to the knowledge of the medical practitioner attending him, from an infectious disease dies therefrom, such medical practitioner shall immediately furnish to the local authority of the district a written certificate containing the appropriate particulars mentioned in subsection (1).

(2) Any medical practitioner who fails to furnish a certificate of notification as required by this section shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment, and in any prosecution under this section the

onus shall be on the medical practitioner charged to show that he was unaware that the patient was suffering from or the deceased had died of an infectious disease. [Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s20]20 Local authorities to transmit return of notifications

Every local authority shall, at the end of each week and on the form prescribed, transmit to the Chief Health Officer particulars of all cases of infectious diseases and of all deaths from infectious diseases notified to it during the week, and all information which it may possess as to the outbreak or prevalence of any infectious, communicable or preventable disease in its district.

[Chap15:09s21]21 Regulations for the notification of infectious

The Minister may, in respect of the notification of diseases, make regulations as to(

a) the duties of owners or occupiers of land, owners or managers of mines, employers of labour and all chiefs or headmen or others in regard to reporting the occurrence of such diseases, whether infectious or otherwise, as may be prescribed in the regulations;

(b) the duties of medical practitioners and other persons in regard to the reporting or notification of such disease, whether infectious or otherwise, as may be prescribed in the regulations;

(c) the circumstances in which notification of particular infectious diseases shall not be required;

(d) the duties of a local authority in respect of the keeping of registers and records of such notifications;

(e) the duties of registrars of deaths in respect of furnishing the local authority with notification of returns of deaths notified with such registrars;

(f) the fees payable to medical practitioners in respect of such notifications, and the circumstances in which fees shall or shall not be payable; the forms to be used and the particulars to be furnished by medical practitioners when making such notifications;

(g) the forms to be used and the particulars to be furnished by local authorities and other persons when transmitting returns and reports to the Chief Health Officer;

and, generally, for the better carrying out and attaining the objects and purposes of this Part. Any person who contravenes any of such regulations shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Section 21 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

Prevention and Suppression of Infectious Diseases

[Chap15:09s22]22 Inspection of infected premises and examination of persons suspected to be suffering from infectious disease

The medical officer of health of any urban or rural area or any medical practitioner duly authorized thereto by the local authority may at any reasonable time enter and inspect any premises in which he has reason to believe that any person suffering or who has recently suffered from any infectious disease is or has recently been present, or any inmate of which has recently been exposed to the infection of any infectious disease, and may medically examine any person in such premises for the purpose of ascertaining whether such person is suffering or has recently suffered from any such disease.

[Chap15:09s23]23 Provision of isolation hospitals, mortuaries disinfecting stations and ambulances by local authorities

Any local authority may, and if required by the Minister after inquiry, at which the local authority shall have an opportunity of being heard, shall, provide and maintain either separately or jointly with another local authority or with a hospital authority or with the State-

- (a) suitable hospitals or places of isolation for the accommodation and treatment of persons suffering from infectious diseases;
- (b) mortuaries or places for the reception of dead bodies pending the carrying out of any post-mortem examination ordered by a lawful authority, or until removal for interment;
- (c) disinfecting and cleansing stations, plant and equipment for the cleansing of persons and the disinfection of bedding, clothing or other articles which have been exposed to, or are believed to be contaminated with, the infection of any infectious disease, or which are dirty or verminous;
- (d) vehicles for the conveyance of persons suffering from any infectious disease or for the removal of any infected bedding, clothing or other articles;
- (e) any other accommodation, equipment or articles required for dealing with any outbreak of infectious disease.

[Chap15:09s24]24 Removal to hospital of infected persons

Where, in the opinion of the medical officer of health, any person certified by a medical practitioner to be suffering from an infectious disease is not accommodated or is not being treated or nursed in such manner as adequately to guard against the spread of the disease, such person may, on the order of the medical officer of health, be removed to a suitable hospital or place of isolation and there detained until such medical officer of health or any medical practitioner duly authorized thereto by the local authority or by the Minister is satisfied that he is free from infection or can be discharged without danger to the public health:

Provided that the cost of the removal of such patient and of his maintenance at the hospital may be recovered by the local authority from the said patient or his estate or, in the case of a minor, from his parent or guardian, if it can be shown that the said patient or his estate or, in the case of a minor, his parent or guardian is in a position to defray such cost.

[Chap15:09s25]25 Infected persons sent for treatment from other districts

In the case of any patient suffering from any infectious disease being sent into the district of any local authority for isolation and treatment in any hospital or place of isolation maintained by such local authority from any other district, whether urban or rural, the first-mentioned local authority may recover from the local authority of the district sending the patient the cost of maintenance, nursing and treatment of the patient, and the cost of burial in the event of the death of the patient.

[Chap15:09s26]26 Measures to be adopted by local authority in case of infectious disease

Where a person suffering from an infectious disease is within the district of a local authority, it shall be the duty of that authority to ensure that adequate measures are taken for preventing the spread of the disease, including, where necessary, provision for the accommodation, maintenance, nursing and medical treatment of the patient in a hospital or place of isolation until he has recovered or is no longer a danger to the public health or, in the event of the death of the patient, provision for the removal and burial of the body.

[Chap15:09s27]27 Power of local authority to order or carry out disinfection

(1) When it appears from the certificate of the medical officer of health or a health officer or any medical practitioner that the cleansing or disinfection of any premises or any article is necessary for preventing the spread or eradicating the infection of any infectious disease, or otherwise for preventing danger to health, the local authority may give written notice to the owner or occupier of such premises or to the owner or person in charge of such article requiring him to cleanse or disinfect such premises or article in such manner and within such time as may be specified by and to the satisfaction of the local authority giving such notice.

(2) If the person to whom such notice is given fails to comply therewith, the local authority shall cause such premises or articles to be cleansed or disinfected, and the costs thereby entailed shall be deemed to be a debt due to the local authority by the person in default.

(3) Where the owner or occupier of any such premises, or the owner or person in charge of any such article, is from poverty or otherwise unable, in the opinion of the local authority, to carry out properly the cleansing or disinfection of such premises or article, the local authority may itself carry out any necessary cleansing or disinfection free of charge.

(4) Where any article dealt with by a local authority under this section is of such a nature that it cannot be disinfected, the local authority may, on the order of a district administrator, district officer or justice of the peace, cause such article to be destroyed and no compensation shall be payable in respect of any article so destroyed.

(5) When any article is damaged during disinfection by the local authority, no compensation shall be payable by the local authority if suitable methods of disinfection have been employed and due care and all reasonable precautions have been taken to prevent unnecessary or avoidable damage.

(6) Compensation shall not be payable in respect of the deprivation of the occupation or use of any premises or the use of any article occasioned by disinfection if no undue delay has occurred.

[Chap15:09s28]28 Removal to cleansing stations of dirty and verminous persons

Where a cleansing station is provided within the district of a local authority or within a reasonable distance therefrom, any person within that district certified by a medical officer of health, school medical inspector or other medical practitioner, or by a certificated health inspector, to be dirty or verminous may, on order of the medical officer of health, be removed, together with his clothing and bedding, to such cleansing station and be cleansed therein.

[Chap15:09s29]29 Removal orders

An order made under section twenty-four or twenty-eight may be addressed to any duly authorized officer of a local authority or any police officer. Any person who wilfully obstructs the execution of, or fails or refuses to comply with, any such order shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Section 29 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s30]30 Exposure of infected persons or things

Any person who-

(a) while knowingly suffering from any notifiable infectious disease, or such other infectious disease as the Minister may declare by statutory instrument to be a disease for the purposes of this section, wilfully or negligently exposes himself in

such manner as to be likely or liable to spread such disease in any street, public place, public building, shop, inn, hotel, church or other place used, frequented or occupied in common by persons other than the members of the family or household to which such infected person belongs; or

(b) being in charge of any person, and knowing that such person is so suffering, so exposes such sufferer; or

(c) knowingly gives, lends, sells, pawns, transmits, removes or exposes, or sends to or permits to be washed or exposed in any public wash-house or washingplace,

or in any laundry or other place at which articles are washed, cleansed or dyed, without previous effective disinfection to the satisfaction of the local authority and in accordance with any regulations in force in the district, any clothing, bedding, rags or other articles or things of any kind whatsoever which have been exposed to or are contaminated with the infection of any such disease; or

(d) while knowingly suffering from any such disease, handles, conveys or otherwise comes in contact with any food, dairy produce, aerated water or other articles intended for consumption by man, or carries on any trade or occupation in such manner as to be likely or liable to spread such disease;

shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment:

Provided that nothing in this section contained shall apply to any person transmitting with proper precautions and in accordance with the instructions of the local authority any bedding, clothing or other articles or things for the purpose of having the same disinfected.

[Section 30 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s31]31 Conveyance of infected persons in public conveyances

(1) No person, knowing that he is suffering from any infectious disease which the Minister may declare by statutory instrument to be a disease for the purposes of this section, shall enter any public conveyance, and no person in charge of any person whom he knows to be so suffering, or of the body of any person who to his knowledge has died of any such disease, or in charge of anything which to his knowledge has been exposed to or is contaminated with the infection of any such disease, shall place in any such conveyance any such person, body, article or thing which to his knowledge has been so exposed or is so contaminated, except in the case of a hearse used for the removal of a dead body, without first informing the owner or driver or conductor of such conveyance of the fact of such infection and obtaining his consent. The owner, driver or conductor thereof shall, as soon as possible after such conveyance has been so used, and before permitting the use thereof by any other person, cause it to be efficiently disinfected to the satisfaction of the local authority and in accordance with any regulations in force in the district.

For the purposes of this section, 'public conveyance' includes any railway coach, tramcar, omnibus, cab, motor car or any vehicle whatsoever, or any boat or other vessel, or any aircraft if the conveyance plies for hire or is used by members of the public.

(2) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment, and may in addition be ordered by the court to pay the owner or driver of the conveyance

concerned the amount of any loss or expense necessarily entailed by the disinfection of such vehicle.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s32]32 Infected dwellings not to be evacuated or let without previous disinfection

No person shall cease to occupy or shall let any dwelling or premises or part thereof in which to his knowledge there is or has recently been any person suffering from any infectious disease without having the same, and all articles therein which are liable to retain infection, efficiently disinfected to the satisfaction of the local authority and in accordance with any regulations in force in the district. This section shall apply to any owner or keeper of a hotel or boarding-house who lets any room or part thereof to any person.

[Chap15:09s33]33 Removal of bodies of persons who have died of infectious disease

(1) In every case of death from an infectious disease it shall be the duty of the occupier of the premises in which the death has occurred immediately to make the best arrangements practicable, pending the removal of the body and the carrying out of thorough disinfection, for preventing the spread of such disease.

(1a) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (1a) inserted by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(2) It shall be an offence against this Act for the occupier of any premises to keep any dead body in any room in which any person lives, sleeps or works, or in which food is kept or prepared or eaten, or to keep the body of any person who is known to the occupier to have died of an infectious disease for more than twenty-four hours in any place other than a mortuary or other place set apart for the keeping of dead bodies, except with the sanction in writing of the local authority first obtained.

(3) Where any person dies of an infectious disease it shall be an offence against this Act to remove the body except for the purpose of immediate burial; and it shall be the duty of any person who removes the body to take it direct to the place of interment for burial.

(3a) Any person who is guilty of an offence in terms of subsection (2) or (3) shall be liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (3a) inserted by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(4) Nothing in this section shall be deemed to prevent the removal by due authority of any dead body from a hospital to a mortuary.

[Chap15:09s34]34 Removal and burial of bodies of persons who have died of infectious disease

(1) When-

(a) the body of a person who has died of an infectious disease is retained in a room in which any person lives, sleeps or works, or in which food is kept or prepared or eaten; or

(b) the body of a person who has died of an infectious disease is retained without the sanction of the local authority for more than twenty-four hours elsewhere

than in a mortuary or other place reserved for the keeping of dead bodies; or
(c) any dead body is retained in any dwelling or place in circumstances which, in the opinion of the local authority, are likely to endanger health; or
(d) any dead body found within the district is unclaimed or no competent person undertakes to bury it;

any district administrator, district officer, justice of the peace, medical officer of health or police officer of or above the rank of assistant inspector may, on a certificate signed by a medical practitioner, direct that the body be removed to a mortuary and be buried within a time to be specified in such order, or if the body is that of a person certified to have died of an infectious disease, may order that the body be buried immediately without removal to a mortuary. Unless the friends or relatives of the deceased undertake to, and do, bury the body within the time so specified, the cost of so doing shall be defrayed by the local authority and may be recovered by it by action in any court of competent jurisdiction from any person legally liable to pay the expenses of interment.

(2) Any person who obstructs the execution of any order or direction given under subsection (1) shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s35]35 Regulations regarding infectious diseases

(1) The Minister may make regulations applicable to all infectious diseases or only to such infectious diseases as may be specified therein regarding the following matters-

(a) the imposition and enforcement of quarantine or of medical observation and surveillance in respect of persons suffering or suspected to be suffering from infectious diseases who are not removed to a hospital or place of isolation, the premises in which such persons are accommodated, those in charge of or in attendance on such persons, and other persons living in or visiting such premises or who may otherwise have been exposed to the infection of any such disease;

(b) the duties, in respect of the prevention of infectious diseases and in respect of persons suffering or suspected to be suffering therefrom, of employers of labour, and of chiefs or headmen and others;

(c) the measures to be taken for preventing the spread of or eradicating cholera, typhoid fever, plague, acute poliomyelitis, tuberculosis or any other infectious disease requiring to be dealt with in a special manner;

(d) the conveyance by rail or otherwise of persons suffering from, or the bodies of persons who have died of, an infectious disease;

(e) the prevention of the spread from any animal, or the carcass or product of any animal, to man of rabies, glanders, anthrax, plague, tuberculosis, trichinosis or any other disease communicable by any animal, or the carcass or product of any animal, to man;

(f) the prevention of the spread and the eradication of malaria, the destruction of mosquitoes and the removal or improvement of conditions permitting or favouring the multiplication or prevalence of mosquitoes and the provision and proper upkeep of mosquito nets in the sleeping apartments of hotels, boarding-houses, lodging-houses and all public buildings where persons are accommodated for payment;

- (g) the prevention of the spread of disease by flies or other insects and the destruction of and the removal or improvement of conditions permitting or favouring the prevalence or multiplication of such insects;
- (h) the destruction of rodents and other vermin and the removal or improvement of conditions permitting or favouring the harbourage or multiplication thereof;
- (i) the prevention of the spread of anchylostomiasis, bilharziasis or other disease in man caused by any animal or vegetable parasite;
- (j) the prevention of the spread of any infectious, contagious or loathsome disease by the carrying on of any business, trade or occupation;
- (k) the prevention of the spread of any infectious disease by persons who, though not at the time suffering from such disease, are 'carriers' of and liable to disseminate the infection thereof, and the keeping under medical surveillance and the restriction of the movements of such persons;
- (l) the prohibition of spitting in public places or in public conveyances, except into receptacles provided for the purpose;
- (m) the regulation and restriction of any trade or occupation entailing special danger to the health of those engaged therein, whether from infectious disease or otherwise, and the institution of measures for preventing or limiting such danger;
- (n) cleansing stations and the cleansing of dirty or verminous persons, the disinfection or fumigation of premises, clothing or other articles which have been exposed to or are believed to be contaminated with the infection of any infectious disease, or which are dirty or verminous, and prohibiting the carrying out of any fumigation which involves the use of poisonous gas except under licence;
- (o) rag flock manufacture and the trade in rags and in bones and in secondhand clothing, bedding or similar article, and requiring the disinfection of any such article before its importation, removal, sale or exposure for sale, or use in any manufacturing process;
- (p) the disposal of any refuse, waste matters or other matter or thing which has been contaminated with or exposed to the infection of any infectious disease;
- (q) the regulation or restriction and, where deemed necessary, the prohibition, of the keeping, transmission or use within, or the conveyance or transmission into or out of, Zimbabwe of cultures or preparations of pathogenic micro-organisms or other material capable of causing disease in man;
- (r) the giving compulsorily of any information or the production compulsorily of any documentary or other evidence required for the purpose of tracing the source or preventing the spread of any infectious disease; and generally for the better carrying out of the provisions and the attaining of the objects and purposes of this Part.

(2) Any person who contravenes any provision of regulations made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (2) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Section 35 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

Special Provisions Regarding Formidable Epidemic Diseases

[Chap15:09s36]36 Formidable epidemic diseases

This Act, unless otherwise expressed, in so far as it concerns formidable epidemic diseases, shall be deemed to apply to plague, Asiatic cholera, epidemic

influenza and any other disease which the Minister may, by statutory instrument, declare to be a formidable epidemic disease for the purposes of this Act.

[Chap15:09s37]37 Notification of suspected cases of formidable epidemic diseases
Medical practitioners, principals of schools, heads of families or householders, employers of labour, owners or occupiers of land or premises, chiefs, headmen and others shall report to the local authority or district administrator, as the case may be, the occurrence of any case of illness or death coming to their notice and suspected to be due to any formidable epidemic disease, or with a history or presenting symptoms or post-mortem appearances which might reasonably give grounds for such suspicion. Any person failing to make such report shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Section 37 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s38]38 Notification of sickness or mortality in animals
Every person who becomes aware of any unusual sickness or mortality among rats, mice, cats, dogs or other animals susceptible to plague or other formidable epidemic disease, not due to poison or other obvious cause, shall immediately report the fact to the local authority. Any person who fails to make such report shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Section 38 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s39]39 Local authorities to report notification of formidable epidemic diseases by telegraph

Every local authority shall immediately report to the Chief Health Officer, by telegraph or other expeditious means, particulars of every notification received by such authority of a case or suspected case of any formidable epidemic disease, or of any unusual sickness or mortality in animals, made under section thirty-eight.

[Chap15:09s40]40 Powers of Minister where local authority fails adequately to deal with any formidable epidemic disease

Whenever upon the report of the Chief Health Officer it appears to the Minister that an outbreak of a formidable epidemic disease or a disease suspected of being such has occurred or is threatened within the district of a local authority and is not being investigated or dealt with efficiently and so adequately to safeguard public health, the Minister, notwithstanding any other provision of this Act, may inform the local authority of the measures which he considers should be taken in connection therewith, and if the local authority fails or is for any reason unable forthwith to carry out such measures to his satisfaction, may authorize the Chief Health Officer or any other local authority to take all necessary steps for dealing with the outbreak, and thereupon such officer or local authority shall, for the said purpose, possess all rights and powers of the local authority in default, subject to the obligations attaching to the exercise thereof, and any portion of the expenditure so incurred which is payable by the local authority may be recovered from the local authority in the manner described in subsection (2) of section sixteen.

[Chap15:09s41]41 . . .

[Section 41 repealed by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s42]42 Regulations regarding formidable epidemic diseases

(1) In the case of the occurrence or threatened outbreak of any formidable epidemic disease, the Minister may make regulations as to all or any of the following matters, namely-

- (a) the imposition and enforcement of quarantine and the regulation and restriction of public traffic and of the movements of persons;
- (b) the closing of schools or the regulation and restriction of school attendance;
- (c) the closing of churches and Sunday schools and restriction of gatherings or meetings for the purpose of public worship;
- (d) the regulation or restriction or, where deemed necessary, the closing of any place or places of public entertainment, recreation or amusement, or where intoxicating liquor is sold by retail, and the regulation or restriction, or, where deemed necessary, the prohibition, of the convening, holding or attending of entertainments, assemblies, meetings or other public gatherings;
- (e) the prevention and remedying of overcrowding or the keeping of any dwelling or other building or the contents thereof in a dirty or insanitary or verminous condition;
- (f) the medical examination of persons who are suspected of being infected with, or who may have recently been exposed to the infection of, such disease, and of persons about to depart from any infected area, and the disinfection of their baggage and personal effects, and the detention of such persons until they have after such examination been certified to be free from any infectious disease and until their baggage and personal effects have been disinfected;
- (g) the keeping under medical observation or surveillance, or the removal, detention and isolation of persons who may have recently been exposed to the infection of, and who may be in the incubation stage of, such disease; the detention and isolation of such persons until released by due authority, the use of guards and force for that purpose, and, in case of absolute necessity, the use of firearms or other weapons, and the arrest without warrant of any person who has escaped from such detention or isolation;
- (h) the establishment of isolation hospitals and the removal and isolation of persons who are or are suspected to be suffering from any such disease, the accommodation, classification, care and control of such persons and their detention until discharged by due authority as recovered and free from infection, and the establishment, management and control of convalescent homes or similar institutions for the accommodation of persons who have recovered from any such disease;
- (i) inquiries into the cause of death of any person, apart from any inquiry by a magistrate under any other enactment; the ordering, when deemed necessary, of post-mortem examinations or of exhumations; the prohibition in special circumstances of the burial of any dead body except on a certificate by a medical officer appointed to grant such certificates or after compliance with any other specified conditions, the regulation of the mode of disposal, the times and places of burial of dead bodies and the manner of conducting removals and burials thereof;
- (j) the regulation and restriction and, if deemed necessary, the prohibition of the removal of merchandise or any article or thing into, out of or within any specified or defined area;
- (k) the provision of disinfecting plant and equipment, and the disinfection or, where disinfection is impossible, the destruction of any article or thing, or the disinfection of any premises which are or are believed to be contaminated with the infection of such disease;
- (l) the inspection of premises and articles and the discovery and remedying of sanitary or other defects likely to favour the spread or render difficult

the eradication of such disease;

(m) the evacuation, closing, alteration or, if deemed necessary, the demolition or destruction of any premises the occupation or use of which is considered likely to favour the spread or render more difficult the eradication of such disease, and the definition of the circumstances under which compensation may be paid in respect of any premises so demolished or destroyed and the manner of fixing such compensation;

(n) in the case of plague, the destruction of rodents and the removal or improvement of conditions likely to favour the harbourage or multiplication of rodents, and the disposal of the carcasses of rodents or other animals believed or suspected to have died of plague;

and such other matters as the Minister may deem necessary for preventing the occurrence of such disease or limiting or preventing the spread thereof or for its eradication, and, generally, for the better carrying out and attaining the objects and purposes of this Part.

(2) Any person who contravenes any provision of regulations made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level six or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) substituted by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s43]43 . . .

[Section 43 repealed by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s44]44 Appointment of epidemic committees

(1) Where it is deemed desirable for the purpose of co-ordinating effort or otherwise for more effectively dealing with or preventing an outbreak of any formidable epidemic disease, the Minister may, by statutory instrument, constitute a committee to be termed an 'epidemic committee' for a defined area to discharge such functions and carry out such duties in connection with such outbreaks, and to administer so much of this Act as may be prescribed in such notice, and may, in like manner, make regulations regarding the appointment of officers of such committee, the conduct of its proceedings, the manner in which accounts shall be kept or any other matter relative to such committee.

(2) Where the area so defined includes wholly or partly the district or districts of one or more local authorities, the composition of an epidemic committee and the manner of allocating and defraying expenditure incurred by it shall be such as may be mutually agreed in advance between the Minister and local authority or authorities concerned or, failing such agreement, as the Minister may, subject to this Act, fix and determine.

(3) In the event of the occurrence or threatened outbreak of any formidable epidemic disease in any district for which the district administrator is the local authority, the Minister may constitute an advisory committee of three or more persons resident in the district to advise and assist the district commissioner in connection therewith.

[Chap15:09s45]45 Advances of local authorities

(1) The Minister may authorize the making of advances, on such terms and conditions as he may fix, to any local authority or epidemic committee for the purpose of dealing with any out-break of any infectious disease, and in default of repayment any such advance may be recovered from such local authority in the manner described

in subsection (2) of section sixteen.

(2) The Minister may also authorize the making of advances, on such terms and conditions as he may fix, to any local authority to enable it to pay any proportion of the capital expenditure incurred by it in providing suitable hospitals or places of isolation for persons suffering from any infectious disease, and may in like manner recover any advances so made.

[Chap15:09s46]46 Refunds to local authorities

The Minister may authorize-

(a) the refund of one-half of the approved net cost actually and necessarily incurred by a local authority, or by two or more local authorities acting jointly, in providing and equipping an isolation hospital or other isolation accommodation for persons suffering from any infectious disease, or detained under medical observation because of exposure to the infection of any formidable epidemic disease:

Provided that the scheme as a whole and the plans, specifications and estimates in connection therewith shall be approved by the Minister before the expenditure or any liability thereof is incurred;

(b) the refund of one-half of the approved net cost actually and necessarily incurred by a local authority, or by two or more local authorities acting jointly, in connection with the management and maintenance of an isolation hospital or other isolation accommodation and the maintenance and treatment therein or in any other hospital or place of isolation of persons suffering or suspected to be suffering from any infectious disease, or of persons detained therein under medical observation because of exposure to the infection of any formidable epidemic disease, such net costs being determined after deduction of any revenue;

(c) the refund of two-thirds of the approved net cost actually and necessarily incurred by a local authority, or by two or more local authorities acting jointly or by an epidemic committee, in preventing, investigating, dealing with or suppressing any outbreak of any formidable epidemic disease or any outbreak suspected on reasonable grounds to be of any such disease, including, where necessary, the provision of temporary isolation hospital accommodation.

PART IV

VENEREAL [sic] DISEASES (sections 46-58)

[Chap15:09s47]47 Application of Part IV

This Part shall apply to all sexually transmitted diseases except such diseases as the Minister may specify by statutory instrument.

[Section 47 substituted by section 12(c) of Act 12 of 1997 with effect from 7 November 1997.]

[Chap15:09s48]48 Duties of medical practitioners

(1) Every medical practitioner who attends or advises any patient in respect of any sexually transmitted disease with which the patient is infected shall-

(a) direct the attention of the patient to the infectious nature of the disease and to the penalties prescribed by this Act for infecting any other person with such disease; and

(b) warn the patient against contracting marriage unless and until he has been cured of such disease or is free from such disease in a communicable form; and

(c) give to the patient such printed information relating to the treatment of sexually transmitted disease and to the duties and responsibilities of persons infected therewith as may be supplied to the medical practitioner by the Ministry.

[Paragraph (c) amended by section 12(d)(i)B of Act 12 of 1997 with effect from 7 November 1997.]

[Subsection (1) amended by section 12(d)(i)A of Act 12 of 1997 with effect from 7 November 1997.]

(2) Every medical practitioner who knows or has reason to believe that any person is infected with a sexually transmitted disease in a communicable form and is not under treatment by a medical practitioner, or is not attending for medical treatment regularly and as prescribed by such medical practitioner, shall report the matter in writing to the medical officer of health of the local authority or to the Government medical officer.

[Subsection (2) amended by section 12(d)(ii) of Act 12 of 1997 with effect from 7 November 1997.]

(3) A medical practitioner who contravenes subsection (1) or (2) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (3) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s49]49 Duties of medical officers of health and Government medical officers to report, and powers of district commissioners

(1) It shall be the duty of every medical officer of health and every Government medical officer in his official capacity who knows or has reason to believe that any person is infected with any sexually transmitted disease in a communicable form and is not under treatment by a medical practitioner, or is not attending for medical treatment regularly and as prescribed by such medical practitioner, to give written notice to such person of the requirements of this Act in regard to attendance for treatment of persons infected with sexually transmitted disease, and if thereafter such person does not comply with those requirements, to report the matter to the district administrator.

[Subsection (1) amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997.]

(2) Upon receipt of any such report, the district administrator shall make such further inquiry, or shall make such order or orders, or shall institute such proceedings, as he may deem necessary for the proper enforcement and for the attainment of the objects of this Part.

(3) An order under this section may require the person named therein-

(a) to furnish a certificate by a medical practitioner as to whether he is or is not infected with a sexually transmitted disease in a communicable form; or

[Paragraph (a) amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997.]

(b) to attend at a specified time and place for examination by a medical practitioner named in the order; or

(c) to attend regularly for medical treatment at times and at a place specified in such order; or

(d) to proceed or be removed to and to remain or be detained under treatment in a special hospital or place of accommodation provided or established under this Part, either for a specified time or until cured or free from the disease in a communicable form; or

(e) to comply with such other requirements as the district administrator may deem necessary for the proper safe-guarding of the health of such person and of the public health.

(4) Any person who fails to comply with any order made under this section, or who escapes or attempts to escape from any hospital in which he has been ordered to remain or to be detained, shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (4) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s50]50 Conveyance of infection an offence

Every person who, knowing that he is infected with a sexually transmitted disease, wilfully or by culpable negligence infects any other person therewith, or does or permits or suffers any act likely to lead to the infection of any other person with any such disease, shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

[Section 50 amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997 and by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s51]51 Detention in hospital of infected persons

(1) Where any person sentenced to imprisonment under this Act or any other law is infected with a sexually transmitted disease in a communicable form, he may, by order of the district administrator, be removed to a special hospital or place of accommodation provided and be detained under treatment therein until the expiry of his sentence; and the district administrator, on the representation of the Government medical officer or medical practitioner treating such person, and if satisfied that the public health cannot otherwise adequately be safeguarded, and that such person when released is unlikely to undergo treatment of a medical practitioner for such disease, may order that he be detained in such hospital or place either for a specified period after the expiry of his sentence or until he is cured or free from the disease in a communicable form.

[Subsection (1) amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997.]

(2) Any person so detained in a hospital or other place of accommodation who escapes or attempts to escape therefrom shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s52]52 Medical examination of inhabitants in areas where sexually transmitted disease believed to be prevalent

Where the Minister, on a report by the Chief Health Officer, has reason to believe that sexually transmitted disease is prevalent amongst the residents in any premises or locality, he may issue an order requiring the examination by a medical practitioner of any person or of persons of any specified class or description residing therein. Any person who refuses to comply with such order or with any lawful instructions given thereunder, or who obstructs any medical practitioner or other duly authorized officer in the carrying out of such order, shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Section 52 amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997 and by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s53]53 Examination of females by women medical practitioners
Where any order is made under this Part requiring the medical examination of any female over the age of twelve years and such female desires to be examined by a woman medical practitioner, such examination shall be made by a woman medical practitioner if one is reasonably available.

[Chap15:09s54]54 Rights of persons detained in hospital

Any person detained in hospital under this Part shall be entitled to arrange, at his own expense, for his examination by any medical practitioner, and a report of such examination shall be furnished to the district administrator, who may thereupon cause to be made any further examination of such person which he may deem necessary. No person shall be detained in hospital under this Part who is not, or is no longer, infected with a sexually transmitted disease in a communicable form.

[Section 54 amended by section 12(e) of Act 12 of 1997 with effect from 7 November 1997.]

[Chap15:09s55]55 Proceedings to be in camera, and reports not to be published

Inquiries and proceedings before a district administrator or any court of law under this Part shall be secret and conducted in camera, and the records thereof shall be kept in the manner and form prescribed, anything to the contrary notwithstanding in any other law. Any person publishing or divulging the name of any person dealt with under this Part or the nature of the charge or evidence or the results of such inquiries or proceedings or the contents of any report, certificate, document or order in connection therewith or any other matter coming to his knowledge in connection with anything arising under this Part to any unauthorized person, and any person who, without lawful justification or excuse, falsely alleges that any person is infected with a sexually transmitted disease, shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Section 55 amended by section 12(f) of Act 12 of 1997 with effect from 7 November 1997 and by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s56]56 Publication of advertisements of cures

(1) No person shall publish any advertisement or statement intended to promote the sale of any medicine, appliance or article for the alleviation or cure of any sexually transmitted disease or disease affecting the generative organs or functions, or of sexual impotence, or of any complaint or infirmity arising from or relating to sexual intercourse.

[Subsection (1) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(2) Any person who publishes any such advertisement or statement by printing it in any newspaper or exhibiting it to public view in any place or delivering or offering or exhibiting it to any person in any street or public place or in any public conveyance, or who sells, offers or shows it or sends it by post to any person, shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment. For the purposes of this section, 'advertisement' or 'statement' includes any paper, document or book containing any such advertisement or statement.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(3) This section shall not apply to publications by the Ministry or by any local authority, public hospital or other public body in the discharge of its lawful duties, or

by any society or person acting with the authority of the Minister first obtained, or to any books, documents or papers published in good faith for the advancement of medical science.

[Chap15:09s57]57 Contributions and facilities for diagnosis and treatment of sexually transmitted disease

The Minister, subject to regulations which he is hereby authorized to make, and which may deal with the procedure to be followed, the conditions to be complied with and any other matters necessary for the proper carrying out of this section, may-

(a) provide in Government or other laboratories for the carrying out of bacteriological or other laboratory examinations for the purpose of ascertaining whether any person is infected with or is cured of any sexually transmitted disease, or is free from any such disease in a communicable form. Such examinations shall be free of charge;

[Paragraph (a) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(b) make provision for the free treatment and, where necessary, the accommodation and maintenance of persons infected with sexually transmitted disease. Such provision shall be made as far as practicable in connection with general or isolation hospitals or similar institutions by arrangement with the Minister or the hospital, local or other authority concerned;

[Paragraph (b) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(c) supply, free of charge, such remedies as may be specified from time to time in the Gazette for use in the treatment of persons infected with sexually transmitted disease who are treated as free patients at any public institution;

[Paragraph (c) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(d) refund to any local authority, or to two or more local authorities acting jointly, two-thirds of the net cost of any approved scheme for providing treatment, including maintenance and accommodation, where necessary, for persons who are infected with sexually transmitted disease;

[Paragraph (d) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(e) establish and maintain special accommodation for the maintenance and treatment of persons infected with sexually transmitted disease who are liable to detention;

[Paragraph (e) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(f) make grants-in-aid, subject to such conditions as the Minister may in each case fix and determine, to local authorities or other public bodies or voluntary societies or associations for the purpose of preventing the spread of or securing the proper treatment of persons infected with sexually transmitted disease.

[Paragraph (f) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

[Chap15:09s58]58 Regulations

(1) The Minister may make regulations-

(a) prescribing forms of certificates, notices, orders or returns and books of record to be used in connection with sexually transmitted disease, and defining the information to be furnished therein, and requiring the furnishing and prescribing the

manner of use thereof by district administrators and district officers, Government medical officers, local authorities, medical officers of health and others;
[Paragraph (a) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(b) conferring powers and imposing duties in connection with sexually transmitted disease on district administrators and district officers, Government medical or other officers, local authorities, medical officers of health, employers of labour and chiefs or headmen;

[Paragraph (b) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

(c) adapting, within such area as may be defined, this Part and the procedure thereunder to the understanding and special circumstances of different classes of persons;

(d) providing for the effective enforcement of this Part as regards different classes of persons, and assigning, where deemed desirable, responsibility in connection therewith to local authorities or employers of labour;

(e) as to the management, maintenance and inspection of hospitals or other institutions for the purposes of this Part and the appointment and duties of persons employed therein or otherwise in connection with the carrying out or enforcement of this Part;

(f) as to the classification, treatment, control and discipline of persons treated or detained in such hospitals or institutions, and prescribing compulsory work for such persons where deemed desirable;

(g) prescribing the precautions to be taken by persons suffering from or attending on or having the care or charge of persons suffering from sexually transmitted disease;

[Paragraph (g) amended by section 12(g) of Act 12 of 1997 with effect from 7 November 1997.]

and, generally, for the better carrying out and the attaining of the objects and purposes of this Part.

(2) Any person who contravenes any regulations made under subsection (1) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

PART V

INTERNATIONAL SANITARY REGULATIONS (sections 59-63)

[Chap15:09s59]59 Publication of International Sanitary Regulations and amendments thereto

(1) The International Sanitary Regulations shall be published in statutory instrument as soon as may be after the 25th July, 1953, and any amendment thereto shall be published in a statutory instrument as soon as may be after Zimbabwe becomes a party to such amendment.

(2) Every amendment to the International Sanitary Regulations to which Zimbabwe becomes a party shall be laid before Parliament on one of the thirty days on which Parliament next sits after the publication of the amendment in a statutory instrument.

[Chap15:09s60]60 Power to carry out and apply International Sanitary Regulations
The President may-

- (a) by statutory instrument, designate any airport in Zimbabwe as a sanitary airport and may, by like notice, cancel any such designation of an airport;
- (b) do such other acts as he may deem necessary or expedient for giving effect to the terms of the International Sanitary Regulations or any regulations which have, in terms of section sixty-two, been applied to infectious diseases to which the International Sanitary Regulations do not apply.

[Chap15:09s61]61 Regulations

(1) The President may by regulation-

- (a) make such provision as appears to him necessary or expedient for the carrying out of and giving effect to the International Sanitary Regulations;
- (b) subject to the International Sanitary Regulations, impose fees and provide for the recovery of any expenditure incurred in giving effect to the International Sanitary Regulations.

(2) Any regulations made under subsection (1) may prescribe penalties for any contravention thereof, but no such penalty shall exceed a fine of level six or imprisonment for a period of one year or both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s62]62 Power to apply regulations to any infectious disease

(1) The President may, by proclamation, apply to any infectious disease to which the International Sanitary Regulations do not apply any regulations made under section sixty-one, subject to such exceptions, adaptations and modifications as he may deem necessary or expedient and as shall be specified in such proclamation.

(2) A proclamation under subsection (1) may be amended or revoked by subsequent proclamation.

[Chap15:09s63]63 Jurisdiction

An offence under any regulation shall, with regard to the jurisdiction of a court to try the offence, be deemed to have been committed in any place where the accused happens to be.

PART VI

WATER AND FOOD SUPPLIES (sections 64-72)

[Chap15:09s64]64 Duty of local authority to furnish water supplies

(1) Every local authority, when required to do so by the Minister, shall provide and maintain, or cause to be provided and maintained as far as may be reasonably possible, a sufficient supply of wholesome water for drinking and domestic purposes, whether such supplies be derived from sources within or beyond its district, and for such purposes it may purchase or otherwise acquire any land, water works, springs, fountains, water rights and premises, or rights incidental thereto, within or outside its district, and may construct, equip and maintain any works necessary for collecting, pumping or storing water.

(2) Where such water supply has been provided, the local authority may by regulation compel the owner of every occupied premises within its district to the boundaries of which the local authority has brought such water to lay on such water to any such premises, and may fix a minimum charge for such water, whether used by the occupier or not; such charges shall be payable by the occupier, except in cases where the water is not laid on, when such charges shall be payable by the owner of the premises.

(3) In the event of the water supply of any district being undertaken by any person or company other than a local authority under any lawful contract or legal agreement whatsoever, this Part shall apply, mutatis mutandis, to such person or company in respect of such water supply as if such person or company were the local authority.

[Chap15:09s65]65 Water works not to be commenced until approved by State

(1) No water works may be commenced and no property purchased or acquired by a local authority until estimates and plans have been submitted and approved by the Minister.

(2) Notice shall be given of any proposed scheme for the purpose of construction of works for the supply of water by the local authority by publication in the Gazette, and such notice shall describe such proposed scheme and state the hour and place where the plans, estimates and other particulars relating to the same may be inspected.

(3) If any person, who is injuriously affected by such scheme, objects to the same and transmits his objections in writing to the Minister within one month after the

date of the last publication of the notice aforesaid, the Minister may appoint a committee to inquire into the expediency of sanctioning the proposed scheme and to hear any such objections thereto and to report to him thereon, and on receiving such report the Minister may make an order disallowing the proposed scheme or allowing it with such modification, if any, as he may think fit.

[Chap15:09s66]66 Local authority to maintain existing water supplies in good order

All water works vested in any local authority shall be maintained by the local authority in a condition for the effective distribution of a supply of pure water for drinking and domestic purposes.

[Chap15:09s67]67 Powers to inspect water supplies

(1) The Chief Health Officer or any person duly authorized by him or any medical officer of any local authority may at all times enter any water works or gathering ground and inspect and examine any sources of water supply or any such water works, and take such sample of water as he may deem fit.

(2) Any person who obstructs such medical officer or any other person as aforesaid in such duty shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s68]68 Regulations

(1) The Minister may make, and impose on local authorities and administrators the duty of enforcing, regulations in respect of defined areas-

(a) prohibiting bathing in, and prohibiting or regulating the washing of clothes or other articles or of animals in, or in any place draining into, any such water supply as is in section sixty-seven mentioned;

(b) prohibiting or regulating the erection of dwellings, sanitary conveniences, stables, cattle kraals, pig sties, ostrich pens, dipping tanks, factories or other works likely to entail risk of harmful pollution of any such water supply, or prohibiting or regulating the deposit in the vicinity of, or in any place draining into, any such supply of any manure, filth or noxious or offensive matter or thing;

and, generally, for preventing the pollution so as to endanger health of any supply of water which the public within its district has a right to use and does use for drinking or domestic purposes and for purifying any such supply which has become so polluted, and for preventing the pollution of streams so as to be a nuisance or a danger to health.

(2) Regulations under subsection (1) shall be made with due regard to the interests of agricultural or any other industries.

(3) Any person who contravenes any provision of regulations made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level six or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (3) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s69]69 Sale of unwholesome, diseased or contaminated articles of food prohibited

(1) No person shall sell, or shall prepare, keep, transmit or expose for sale, any milk, dairy produce, meat or other article of food which is not clean, wholesome, sound and free from any disease or infection or contamination; and no person shall collect, prepare, manufacture, keep, transmit or expose for sale any such article without taking adequate measures to guard against or prevent any infection or contamination thereof.

(2) If any person contravenes subsection (1), he shall be guilty of an offence and liable to a fine not exceeding level six or imprisonment for a period of one year or both such fine and such imprisonment.

[Section 69 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s70]70 Regulations regarding sale of milk and articles of food

(1) The Minister may make regulations regarding all or any of the following matters-

(a) the inspection of animals intended for human consumption, and of slaughter-houses, and of factories, stores, shops and other places where any article of food is manufactured or prepared or kept;

(b) the taking and examination of samples of meat or other articles of food, and the removal or detention, pending examination or inquiry, of animals or articles which are suspected of being diseased or unsound or unwholesome or unfit for human consumption, and the seizure and destruction or treatment or disposal so as not to endanger health of any such article which is found to be unwholesome or unsound or diseased or infected or contaminated, and of diseased animals sold or intended or offered or exposed for sale for human consumption; such regulations may empower a medical officer of health or a medical practitioner or, in the case of meat, an approved veterinary surgeon to detain, seize or destroy any diseased, unsound or unwholesome article of food, but shall not confer on any other person any power beyond that of detention of such article for the purpose of examination by a medical officer of health, a medical practitioner or, in the case of meat, an approved veterinary surgeon;

(c) the inspection and examination of, and the regulation, inspection and supervision of the manufacture, preparation, storage, keeping and transmission of, any article of food intended for sale or for export from Zimbabwe, and the prohibition of the manufacture, preparation, storage, keeping, transmission, sale or export from Zimbabwe of any such article which is, or contains an ingredient which is, diseased or unsound or unfit for human consumption, or which has been exposed to any infection

or contamination;

(d) the establishment, locality, supervision, equipment, maintenance and management of slaughter-houses and the disposal of the waste products of slaughtering and the inspection of slaughter-houses and the animals therein and prohibiting, restricting or regulating the slaughter of diseased animals; prescribing the methods which may be used for the killing or slaughter of animals intended for human

consumption, whether such killing or slaughter takes place at slaughter-houses or elsewhere; and prohibiting the killing or slaughter of such animals except by such methods as may be prescribed; and such regulations may provide an exemption from the provisions thereof for the slaughter of animals by the Jewish or Islamic method, subject to such conditions as may be prescribed;

(e) prohibiting the importation into Zimbabwe of any article of food which is not clean, wholesome, sound and free from any disease or infection or contamination, and the seizure and disposal by destruction or otherwise of any such article so imported;

(f) the preparation, manufacture or importation and the storage and sale of or trade in articles of food which are packed in air-tight receptacles or otherwise preserved, and the marking of any such article with the date of manufacture or preparation;

(g) prohibiting the importation, sale, possession or use of vessels which are intended to contain milk or any liquid or semi-solid article of food and which are rusty or defectively soldered or are made of material containing in any part likely to come in contact with the contents lead or other poisonous or injurious substance in such proportion as to be likely to cause injury or danger to health, and fixing the maximum proportions of such substances which may be used in such vessels;

(h) the keeping of swine and the limitation and suppression of the disease known as cysticercus disease or pig measles or any similar disease in animals; and, generally, for the better carrying out and the attaining of the objects and purposes of this Part.

(2) Any person who contravenes any provision of regulations made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level six or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Section 70 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s71]71 Minister's powers to make orders

(1) The Minister may make orders-

(a) requiring the medical examination of any person in any premises in which any article of food intended for sale is collected, kept, sold or exposed for sale, or of any person who has been engaged in the collection, preparation, keeping, conveyance or distribution of any such article;

(b) prohibiting the employment in connection with the collection, preparation, storage, distribution or sale of any article of food of any person who has proved to be a carrier of the infection of typhoid or enteric fever or other infectious disease.

(2) Any person who contravenes or fails to comply with an order made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such

fine and such imprisonment.

[Subsection (2) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Section 71 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s72]72 . . .

[Section 72 repealed by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

PART VII

INFANT NUTRITION (sections 73-74)

[Chap15:09s73]73 Interpretation in Part VII

In this Part-

'feeding article' means a bottle, teat, measuring device or other utensil or article designed to be used in preparing infant food or feeding infant food to infants;

'health worker' means a person who-

(a) is employed in a hospital, nursing-home, clinic, surgery, creche, nursery or other institution wherein health care, treatment or attention is provided for pregnant women, mothers or infants; or

(b) is a medical practitioner or is employed by a medical practitioner in connection with his practice as such; or

(c) performs any work, whether as a professional or non-professional and whether paid or not, in connection with the health of pregnant women, mothers or infants;

'infant' means a child under the age of seven years;

'infant food' means any food, including dairy produce as defined in the Dairy Act [Chapter 18:08] which is-

(a) sold for consumption by infants; or

(b) represented by its manufacturer or seller as being suitable for consumption by infants;

'label' means any brand, mark or written or pictorial or other descriptive matter that appears on or is attached to or packed with, and refers to, any infant food or feeding article or the package thereof;

'market', in relation to any product, includes to promote, distribute, advertise or sell such product or to provide public relations or informational services in connection with such product;

'package' means anything in or by which any infant food or feeding article is covered, enclosed, contained or packed;

'sell' includes-

(a) for the purposes of sale, to offer, keep, possess, expose, display, transmit, consign, convey or deliver;

(b) to authorize, direct or allow a sale;

(c) to barter, exchange, supply or dispose of for any consideration, direct or indirect.

[Chap15:09s74]74 Regulations in respect of infant nutrition

(1) The Minister may make regulations in respect of all or any of the following matters-

(a) encouraging and promoting the breast-feeding of infants;

(b) standards of composition, quality or other properties of any infant food or feeding article, which standards may be prescribed by reference to any publication or document, whether published inside or outside Zimbabwe;

(c) the sampling and testing of infant food and feeding articles;

(d) regulating or restricting the marketing and sale of infant food and feeding articles, and in that connection-

- (i) regulating the packages in which or from which any infant food or feeding article may be sold;
- (ii) regulating the labels that may be attached to or marked on packages of any infant food or feeding article, and prescribing the matter to be or not to be contained on such labels;
- (iii) regulating, restricting or prohibiting the marketing of any infant food or feeding article to the public generally or any section of the public;
- (iv) restricting or prohibiting any method of marketing any infant food or feeding article;
- (v) regulating, restricting or prohibiting the giving or distribution of donations or samples of infant food or feeding articles;

(e) regulating, restricting or prohibiting the production, sale, distribution or display of informational or educational material relating to infant food, feeding articles or the feeding and nutrition of infants;

(f) regulating or restricting the promotion by health workers of the use of any infant food or feeding article;

(g) regulating, restricting or prohibiting-

- (i) the offering or giving, directly or indirectly, by manufacturers or sellers of infant food or feeding articles, of salaries, wages, gifts or other benefits to health workers; and
- (ii) the receipt by health workers of salaries, wages, gifts or benefits referred to in subparagraph (i);

(h) the establishment of one or more committees to approve labels, packages, informational, educational or promotional material and any other matter or thing that may be regulated or restricted in terms of this Part, and the prohibition of the marketing, sale or use of any such label, package, informational, educational or promotional material, matter or thing that has not been so approved;

(i) powers of entry, search, seizure, inspection and investigation for the purposes of preventing, detecting or investigating offences in terms of the regulations;

(j) the furnishing of returns, particulars and other information by persons who manufacture, market or sell infant food or feeding articles;

(k) generally, any matter which, in the opinion of the Minister, will encourage and promote the proper feeding and nutrition of infants.

(2) Regulations made in terms of subsection (1) may provide penalties for contraventions thereof:

Provided that no such penalty shall exceed a fine of level seven or imprisonment for a period of one year or both such fine and such imprisonment.
 [Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

PART VIII

SLAUGHTER-HOUSES (sections 75-80)

[Chap15:09s75]75 Interpretation in Part VIII

In this Part-

'slaughter-house' includes any abattoir, knacker's yard, slaughtering poles or place set apart for slaughtering animals, the meat of which is intended for sale.

[Chap15:09s76]76 Local authority may license slaughter-houses

(1) Subject to any regulations, a local authority may license such slaughterhouses as it from time to time thinks proper within its district.

(2) Every licence issued in terms of this section shall expire on the 31st December of the year for which it is issued.

(3) Nothing in this section contained shall affect the right of a municipal council or town council to establish, erect and maintain its own slaughter-house.

[Chap15:09s77]77 Local authority may refuse licences and appeals against refusals

(1) A local authority may refuse to grant or renew a licence for a slaughterhouse.

(2) Any person who is aggrieved by the refusal of a local authority to grant or renew a licence for a slaughter-house may, within thirty days of such refusal, appeal in writing to the Minister.

(3) Upon such appeal the Minister may require the local authority to furnish him with the reasons for its action.

(4) When any such appeal is noted against the refusal of the local authority to renew a licence, the Minister may, in his discretion, authorize the continued use of the slaughter-house pending his decision on such appeal.

(5) The Minister may, after due inquiry, make such order in the matter as he may deem fit and the local authority shall comply with any such order.

[Chap15:09s78]78 Licence required for use of premises as slaughter-house

(1) No person shall use any premises as a slaughter-house within the district of a local authority unless he is personally licensed in respect of those premises.

(2) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) added by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Section 78 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s79]79 Cancellation of licence

If the holder of a licence for a slaughter-house is convicted of contravening this Act, the local authority which issued the licence may forthwith cancel the licence held by such person.

[Chap15:09s80]80 Prohibition against sale of meat which has not been slaughtered in a slaughter-house

(1) At the request of a local authority which is a municipal council or town council the Minister shall, by statutory instrument, prohibit within the district of such local authority the sale of fresh meat obtained from animals, other than wild game, unless such animals have been slaughtered in a slaughter-house licensed or approved by such local authority.

(2) Any person who acts in contravention of a prohibition issued in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s81]81 Inspection of meat and fees for inspection

(1) Subject to subsection (4), a municipal council or town council may inspect any meat slaughtered at a slaughter-house licensed by it or any meat intended for sale within its district and may charge fees at a rate approved by the Minister for such inspection:

Provided that if inspection fees have been charged in respect of any inspection of meat by another local authority or inspector appointed in terms of regulations or by such competent authority outside the borders of Zimbabwe as may be prescribed by regulation, no further inspection fees shall be charged.

(2) Subject to subsection (3), the Minister may in regulations-

(a) provide for the compulsory inspection of-

(i) animals which are slaughtered at slaughter-houses specified in the regulations;

(ii) the carcasses of and the meat obtained from animals referred to in subparagraph (i);

(b) provide for the appointment of officers of the Public Service as inspectors for the purposes of the regulations;

(c) prescribe the fees which shall be payable to the State for the inspection of animals, carcasses and meat referred to in paragraph (a), the circumstances in which the fees shall be paid and the persons by whom the fees shall be paid.

(3) The Minister shall not in regulations made in terms of subsection (2) specify a slaughter-house in respect of which a municipal council or town council is exercising the powers of inspection conferred upon it by subsection (1) unless he is requested to do so by the municipal council or town council.

(4) No fees shall be charged for the inspection by a municipal council or town council in terms of subsection (1) of meat slaughtered at a slaughter-house specified in regulations made in terms of subsection (2).

PART IX

SANITATION AND HOUSING (sections 82-94)

[Chap15:09s82]82 Nuisances prohibited

No person shall cause a nuisance, or shall suffer to exist on any land or premises owned or occupied by him, or of which he is in charge, any nuisance or other condition liable to be injurious or dangerous to health.

[Chap15:09s83]83 Local authorities to maintain cleanliness and prevent nuisances

It shall be the duty of every local authority to take all lawful, necessary and reasonably practical measures for maintaining its district at all times in a clean and sanitary condition, and for preventing the occurrence therein of, or for remedying or causing to be remedied, any nuisance or condition liable to be injurious or dangerous to health, and to take proceedings at law against any person causing or responsible for the continuance of any such nuisance or condition.

[Chap15:09s84]84 Local authorities to prevent or remedy danger to health arising from unsuitable dwellings

It shall be the duty of every local authority to take all lawful, necessary and reasonably practicable measures for preventing or causing to be prevented or remedied all conditions liable to be injurious or dangerous to health arising from the erection of or occupation of unhealthy dwellings or premises or the erection of dwellings or premises on unhealthy sites or on sites of insufficient extent, or from overcrowding, or from the construction, condition or manner of use of any factory or trade premises, and to take proceedings under the law or regulations in force in its district against any person causing or responsible for the continuance of any such condition.

[Chap15:09s85]85 What constitutes a nuisance

The following shall be deemed to be nuisances liable to be dealt with in the

manner provided in this Part-

- (a) any dwelling or premises which is or are of such construction or in such a state or so situated or so dirty or so verminous as to be injurious or dangerous to health, or which is or are liable to favour the spread of any infectious disease;
- (b) any stream, pool, lagoon, ditch, gutter, watercourse, sink, cistern, sanitary convenience, urinal, cesspool, cesspit, drain, sewer, dungpit, slop-tank, ashpit or manure heap so foul or in such a state or so situated or constructed as to be offensive or to be injurious or dangerous to health; or any collection of water which may serve as a breeding pool for mosquitoes;
- (c) any well or other source of water supply or any cistern or other receptacle for water, whether public or private, the water from which is used or is likely to be used by man for drinking or domestic purposes or in connection with any dairy or milk-shop, or in connection with the manufacture or preparation of any article of food intended for human consumption which is polluted or otherwise liable to render any such water injurious or dangerous to health;
- (d) any stable, kraal, cow-shed or other building or premises used for the keeping of animals or birds which is so constructed, situated, used or kept as to be offensive or injurious or dangerous to health;
- (e) any accumulation or deposit of refuse, offal, manure or other matter whatsoever which is offensive or which is injurious or dangerous to health;
- (f) any dwelling which-
 - (i) is so overcrowded as to be injurious or dangerous to the health of the inmates; or
 - (ii) does not conform with any regulations or by-laws made under any Act and in force in the area as regards-
 - A. air space or floor space; or
 - B. lighting or ventilation; or
 - C. sanitary conveniences; or
 - D. ablution facilities; or
 - E. cooking facilities
- (g) any public building which is so situated, constructed, used or kept as to be unsafe or injurious or dangerous to health;
- (h) any occupied dwelling for which such a proper, sufficient and wholesome water supply is not available within a reasonable distance as under the circumstances it is possible to obtain;
- (i) any trade premises not kept in a cleanly state and free from offensive smells arising from any drain, sanitary convenience or urinal, or not ventilated so as to destroy or render harmless and inoffensive as far as practicable any gases, vapours, dust or other impurities generated, or so overcrowded or so badly lighted or ventilated as to be injurious or dangerous to the health of those employed therein;
- (j) any trade premises causing or giving rise to smells or effluvia which are offensive or which are injurious or dangerous to health;
- (k) any area of land kept or permitted to remain in such a state as to be offensive or liable to cause any infectious, communicable or preventable disease or injury or danger to health;
- (l) any chimney, not being the chimney of a private dwelling, sending forth smoke in such quantity or in such manner as to be offensive or injurious or dangerous to health;

(m) any cemetery, burial place or place of sepulture so situated or so crowded or otherwise conducted as to be offensive or injurious or dangerous to health;

(n) any other condition whatever which is offensive, injurious or dangerous to health.

[Chap15:09s86]86 Notice to remove nuisance

(1) The local authority, if satisfied of the existence of a nuisance shall serve a notice on the author of the nuisance, or if he cannot be found, then on the occupier or owner of the dwelling or premises on which the nuisance arises or continues, requiring him to remove it within the time specified in the notice and to execute such works and do such things as may be necessary for that purpose, and if the local authority thinks it desirable, but not otherwise, specifying any works to be executed to prevent a recurrence of the said nuisance:

Provided that-

(i) where the nuisance arises from any want or defect of a structural character, or where the dwelling or premises are unoccupied, the notice shall be served on the owner;

(ii) where the author of the nuisance cannot be found and it is clear that the nuisance does not arise or continue by the act or default or sufferance of the occupier or owner of the dwelling or premises, the local authority shall itself remove the same, and may do what is necessary to prevent the recurrence thereof.

(2) In subsection (1)-

'author of a nuisance' means the person by whose act, default or sufferance the nuisance is caused, exists or is continued, whether he is an owner or occupier or both owner and occupier, or any other person.

[Chap15:09s87]87 Procedure where person fails to comply with notice

(1) If the person on whom a notice to remove a nuisance has been served as aforesaid fails to comply with any of the requirements thereof within the time specified, or if the nuisance, although removed since the service of the notice, is in the opinion of the local authority likely to recur on the same premises, the local authority shall cause a complaint relating to such nuisance to be made before a magistrate, and such magistrate shall thereupon issue a summons requiring the person on whom the notice was served to appear before his court.

(2) If the court is satisfied that the alleged nuisance exists or that, although removed, it is likely to recur on the same premises, the court shall make an order on the author thereof, or the occupier or owner of the dwelling or premises, as the case may be, requiring him to comply with all or any of the requirements of the notice, or otherwise to remove the nuisance within a time specified in the order and to do any works necessary for that purpose, or an order prohibiting the recurrence of the nuisance and directing the execution of any works necessary to prevent the recurrence, or an order both requiring the removal and prohibiting the recurrence of the nuisance.

(3) The court may by such order impose a fine not exceeding level five on the person on whom the order is made, and may also give directions as to the payment of all costs incurred up to the time of the hearing or making of the order for the removal or prohibition of the nuisance.

[Subsection (3) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(4) Before making an order the court may, if it thinks fit, adjourn the hearing

or further hearing of the summons until an inspection, investigation or analysis in respect of the nuisance alleged has been made by some competent person.

(5) Where the nuisance proved to exist is such as to render a dwelling unfit, in the judgment of the court, for human habitation, the court may issue a closing order prohibiting the use thereof as a dwelling until in its judgment the dwelling is fit for that purpose; and may further order that no rent shall be due or payable by or on behalf of the occupier of that dwelling in respect of the period in which the closing order exists; and on the court being satisfied that it has been rendered fit for use as a dwelling, the court may determine the closing order, and by a further order declare the dwelling habitable, and from the date thereof such dwelling may be let or inhabited. Notwithstanding any such last-mentioned order, further proceedings may be taken in accordance with this section in respect of the same dwelling in the event of any nuisance occurring or of the dwelling being again found to be unfit for human habitation.

[Chap15:09s88]88 Penalties in relation to nuisances

(1) Any person who fails to obey an order to comply with the requirements of the local authority, or otherwise to remove the nuisance, shall, unless he has satisfied the court that he has used all diligence to carry out such order, be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment; and any person wilfully acting in contravention of a closing order issued under section eighty-seven shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (1) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(2) The local authority may in such a case enter the premises to which any such order relates and remove the nuisance and do whatever may be necessary in the execution of such order, and recover in any competent court the expenses incurred by it from the person on whom the order is made.

[Chap15:09s89]89 Court may order local authority to execute works in certain cases

Whenever it appears to the satisfaction of the court that the person by whose act or default the nuisance arises or that the owner or occupier of the premises is not known or cannot be found, the court may at once order the local authority to execute the works thereby directed, and the cost of executing the same shall be a charge on the property on which the said nuisance exists.

[Chap15:09s90]90 Examination of premises

The local authority or any of its officers or, on the order of a district administrator, any police officer may at all reasonable times enter any building or premises for the purpose of investigating as to the existence of any nuisance therein; and the local authority or any of its officers may, if necessary, open up the ground of such premises and cause the drains to be tested or such other work to be done as may be necessary for the effectual examination of the said premises:

Provided that if no nuisance is found to exist the local authority shall restore the premises at its own expense.

[Chap15:09s91]91 Persons making complaint of nuisance

(1) Any three persons who allege that a nuisance exists may notify the allegation to the local authority, supported by certificates of two medical practitioners,

if two or more are resident in the district, otherwise by the certificate of one medical practitioner, and if the local authority fails within a reasonable time to cause the nuisance to be removed such persons may serve the notice referred to in section eighty-six, and thereupon the like proceedings shall be had with the like incidents and consequences as to making of orders, penalties for disobedience of orders and otherwise as in the case of a complaint relating to a nuisance made by the local authority:

Provided that the court may authorize any police officer or any other person to do all the necessary acts for executing an order made under this section, and to recover the expenses from the person on whom the order is made in a summary manner.

(2) Any police officer or other person authorized under this section shall have the like powers as if he were an officer of the local authority.

(3) Where the court is satisfied that the person making a complaint under this section had reasonable grounds for doing so, the court may, when making an order for the removal of the nuisance, also order the local authority to pay any expenses or costs incurred by such person instead of ordering the author of the nuisance to pay the same. The court may likewise order any person whose complaint appears to it to be frivolous or vexatious to pay the costs and expenses incurred by the person who has answered the complaint.

[Chap15:09s92]92 Demolition of unfit dwellings

(1) Where under section eighty-five a nuisance is proved to exist with respect to a dwelling and the court is satisfied that such dwelling is so dilapidated, or so defectively constructed, or so situated, that repairs to or alterations of the same are not likely to remove the nuisance and make such dwelling fit for human habitation, the court may order the owner thereof to commence to demolish the dwelling and any other structures on the premises on or before a specified day, being at least one month from the date of issuing the order, and to complete the demolition and to remove the materials which comprised the same from the site before another specified day.

(2) The court shall give notice to the occupier of a dwelling in respect of which such an order has been issued requiring him to move therefrom within a time to be specified in such notice, and if any person fails to comply with such notice or enters the dwelling or premises after the date fixed by the court for the commencement of the demolition thereof, except for the purpose of demolition, he shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(3) If any person fails to comply with such an order for demolition he shall be guilty of an offence and liable to and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment, and the local authority may cause the dwelling and any other structures on the premises to be demolished, and may recover from the owner the expense incurred in doing so after deducting the net proceeds of the sale of the materials which the local authority may sell by auction.

[Subsection (3) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

(4) No compensation shall be payable by the local authority to the owner or

occupier of any dwelling or other structure in respect of the demolition thereof as aforesaid, and from the date of the demolition order no rent shall be due or payable by or on behalf of the occupier in respect of such dwelling or structure.

[Chap15:09s93]93 Prohibitions in respect of back-to-back dwellings and rooms without through ventilation

(1) Within every urban area, and also within any rural area to which the Minister may, by statutory instrument, apply this section, it shall not be lawful for any person-

(a) to erect any dwelling constructed on the back-to-back system; or

(b) to erect any room intended to be used as a sleeping or living or work room which is not sufficiently lighted by a window or windows of a total area of not less than one-twelfth of the floor area, and sufficiently ventilated by two or more ventilation openings or by windows capable of being wholly or partly opened, such windows or openings being so placed as to secure through or cross ventilation; or

(c) to erect any dwelling on made ground containing street sweepings, refuse, rubbish or other matter liable to decomposition until the approval of the local authority has been obtained and until also such measures for safeguarding health have been taken as the local authority may require; or

(d) to let or use for habitation any dwelling or room erected anywhere after the 1st January, 1925, in contravention of paragraph (a), (b) or (c).

(2) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Subsection (2) substituted by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s94]94 Regulations

(1) The Minister may make regulations, and may confer powers and impose duties in connection with the carrying out and enforcement thereof on local authorities, district administrators and district officers, owners and others, as to-

(a) the inspection of land, dwellings and buildings, and for securing the keeping of the same clean and free from nuisance and so as not to endanger the health of the inmates or the public health;

(b) the construction of buildings, including matters relating to-

(i) proper lighting and ventilation;

(ii) measures for excluding insects and vermin;

(iii) sanitary conveniences;

(iv) other matters necessary or desirable to safeguard the health of the inmates or the public health;

(c) the prevention of overcrowding in any dwelling or building, including the prohibition of the use of any dwelling or building or any part of a dwelling or building for sleeping purposes;

(d) the regulation, prohibition or control of the cooking, preparation or storage of food in any building or part of a building where the facilities therefor are inadequate;

(e) the periodical cleansing and whitewashing or other treatment of dwellings and the cleansing of land attached thereto and the removal of rubbish or refuse therefrom by the owners of the dwellings;

(f) the drainage of land or premises, the disposal of offensive liquids and the removal and disposal of rubbish, refuse, manure and waste matters;

(g) the standard or standards of purity of any effluent liquid containing waste, sewage or other offensive matter which might be a danger to the public health and the conditions whereunder such effluent may be used for domestic, agricultural, industrial or other purposes so as not to endanger the public health;

(h) the keeping of animals or birds and the construction, cleanliness and drainage of places where animals or birds are kept;

(i) the establishment and carrying on of factories or trade premises which are liable to cause offensive smells or effluvia or to discharge liquid or other material liable to cause such smells or effluvia or to pollute streams or which are otherwise liable to be a nuisance or injurious or dangerous to health, and prohibiting the establishment or carrying on of such factories or trade premises in unsuitable localities or so as to be a nuisance or injurious or dangerous to health.

(2) Any person who contravenes any provision of regulations made in terms of subsection (1) shall be guilty of an offence and liable to a fine not exceeding level six or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) substituted by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

PART X

GENERAL (sections 95-113)

[Chap15:09s95]95 Contributions to cost of laboratories and voluntary associations concerned with public health

The Minister, subject to such conditions as he may in each case fix and determine, may-

(a) contribute towards the cost of construction, or maintenance of laboratories or other institutions engaged in carrying out researches or investigations regarding human diseases or towards the cost of any such researches or investigations;

(b) contribute towards the costs incurred by any local authority or educational institution or any public voluntary society or association in connection with maternity welfare or child welfare, the training of health inspectors or health visitors, instruction in first aid or home nursing or any other matter relating to public health.

[Chap15:09s96]96 Powers and duties of Chief Health Officer and assistant health officers

Every assistant health officer of the Ministry may, with the authority and on behalf of the Chief Health Officer, discharge any of the duties or functions of the Chief Health Officer, and any duties imposed or powers conferred by this Act on Government medical officers may be carried out or exercised by the Chief Health Officer or any assistant health officer of the Ministry.

[Chap15:09s97]97 Reciprocal notification and consultation between Ministry and Veterinary Department

(1) There shall be between the Ministry and the Department of Veterinary Services a system of reciprocal notification as to outbreaks or threatened outbreaks of diseases liable to affect both man and animals, and of consultation as to the making of regulations or the taking of measures in connection therewith.

(2) Whenever under this Act it is necessary to determine the presence or absence of disease in any live animal otherwise than by the bacteriological

examination of secretions, discharges or other material, only the certificate of an approved veterinary surgeon shall be evidence.

[Chap15:09s98]98 Domicile of persons for purposes of this Act

Where any question arises as to the domicile of any person for the purposes of this Act, it shall be referred to the Minister, whose decision thereon shall be final and conclusive.

[Chap15:09s99]99 Contracts in respect of dwellings not to be affected

Except as specially provided in subsection (5) of section eighty-seven and subsection (4) of section ninety-two,

nothing in this Act shall prejudice the remedies of any owner or occupier of a dwelling or premises for the breach, non-observance or non-performance of any contract entered into by an owner or occupier in respect of which dwelling or premises an order has been made by the court or a local authority under this Act.

[Chap15:09s100]100 Savings as to recovery of damage

Subject to section one hundred and one, nothing in this Act shall be construed as depriving any person of any right which he may possess to institute legal proceedings and to obtain damages in any court of law for loss or injury sustained through the neglect of any local authority or any person to perform any duty imposed by this Act or otherwise.

[Chap15:09s101]101 Protection of State and local authorities

Whenever, in the exercise of any power conferred or in the performance of any duties imposed upon the State or any officer thereof or a local authority or any officer thereof under this Act or any other law relating to public health, he or it is alleged to have caused injury to any person or damage to any property or otherwise to have detrimentally affected the rights of any person, whether in respect of property or otherwise, it shall be a defence in any legal proceedings founded on such an allegation and brought against the State or its officer or a local authority or its officer that the defendant or respondent has used the best known or the only or most practicable and available methods in the exercise of the power or the performance of the duties aforesaid. In the case of such proceedings against a local authority a certificate signed by the Chief Health Officer that the defendant or respondent has, when regard is had to all the circumstances, used the best known or the only or most practicable and available methods shall be accepted by the court as prima facie evidence of that fact.

[Chap15:09s102]102 Protection of officers

No report made or action taken or thing done by the Minister or by a Government health officer or medical officer of health or approved veterinary surgeon or health inspector or any generally or specially authorized officer of the State or of a local authority in the exercise of any power conferred or the performance of any duty imposed by this Act shall subject him in his personal capacity to any legal proceedings whatsoever, provided such report was made or action was taken or thing was done in good faith and without negligence.

[Chap15:09s103]103 Powers of entry and inspection of premises and penalties for obstruction

(1) Any health officer or medical or health inspector of the Ministry, or any district administrator or district officer, or any police officer or any other person generally or specially authorized by the Minister, and any medical officer of health or health inspector or other person generally or specially authorized by the local authority, may, at any hour reasonable for the proper performance of the duty, enter any land or premises to make any inspection or to perform any work or to do anything

which he is required or authorized by this Act or any other law to do, if such inspection, work or thing is necessary for or incidental to the performance of his duties or the exercise of his powers.

(2) Any person who fails to give or refuses access to any officer, inspector or person mentioned in or authorized under subsection (1) if he requests entrance on any land or premises, or obstructs or hinders him in the execution of his duties under this Act, or who fails or refuses to give information that he may lawfully be required to give to such officer, inspector or person, or who gives to such officer, inspector or person false or misleading information knowing it to be false or misleading, or who prevents the owner or any of his servants or workmen from entering any land or dwelling or premises for the purpose of complying with any requirement under this Act, shall be guilty of an offence and liable to a fine not exceeding level five or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

[Subsection (2) amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s104]104 Penalties for fraudulent conduct in connection with certificates under this Act

Any person who-

(a) for the purpose of obtaining any certificate under this Act, makes any false statement or is a party to any false pretence or conduct, knowing it to be false; or
(b) forges or falsifies any certificate under this Act or utters any such forged or falsified certificate, knowing it to be forged or falsified; or
(c) uses or attempts to use any document as a certificate under this Act, knowing it to be a forged or falsified document or certificate;
shall be guilty of an offence and liable to and liable to a fine not exceeding level seven or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

[Section 104 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s105]105 Penalties where not expressly provided

Any person guilty of an offence against, or contravention of, or default in complying with, any provision of this Act shall, if no penalty is expressly provided for such offence, contravention or default, be liable to a fine not exceeding level four or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

[Section 105 amended by section 4 of Act 22 of 2001 with effect from 20 May 2002.]

[Chap15:09s106]106 Burden of proof as to knowledge of infection

In any legal proceedings, criminal or civil, under this Act relating to an infectious or communicable disease, or to any article or thing alleged to have been exposed to or contaminated with the infection thereof, whenever it is an issue in the proceedings that the accused or the defendant knew that he or any other person was infected with such disease, or that such article or thing had been so exposed or was so contaminated, he shall be deemed to have had such knowledge unless he satisfies the court to the contrary.

[Chap15:09s107]107 Defect in form not to invalidate

No defect in the form of any notice given or order made under this Act shall invalidate or render unlawful the administrative action, or be a ground for exception to any legal proceedings which may be taken in the matter to which such notice or order relates, provided the requirements thereof are substantially and intelligibly set forth.

[Chap15:09s108]108 Service of notices

Whenever under this Act any notice, order or other document is required to be given to any person, the same shall be deemed to be sufficiently served if sent by registered post addressed to him at his last known place of abode or left thereat with him personally or with some adult inmate thereof; and in the case of a notice, order or other document required to be given to an owner or occupier of land or premises whose abode, after inquiry, is unknown, the same shall be deemed to be sufficiently served if posted up in some conspicuous place on such land or premises. It shall not be necessary in any notice, order or other document given to an owner or occupier of land or premises to name him, but the notice, order or document shall describe him as the owner or occupier of the land or premises.

[Chap15:09s109]109 Powers of local authority outside its district.

Nothing in any law specially governing any local authority shall be construed as preventing such local authority from exercising any power or performing any duty under this Act by reason only that in exercising such power or performing such duty it must do some act or thing or incur expenditure outside its district.

[Chap15:09s110]110 Provisions of this Act in relation to other laws

Save as is specially provided in this Act, this Act shall be deemed to be in addition to and not in substitution for any provisions of any other law which are not in conflict or inconsistent with this Act. If any other law is in conflict or inconsistent with this Act, this Act shall prevail.

[Chap15:09s111]111 Scope and application of proclamations and regulations

(1) Any proclamation, regulation, notice or order issued under this Act may be expressed to be in addition to or in substitution for any like document issued by any local authority.

(2) Any proclamation, regulation, notice or order issued under this Act may be expressed to apply throughout Zimbabwe or any specified or defined part thereof.

(3) Any proclamation, regulation, notice or order issued under this Act may be amended or rescinded by the authority which issued it.

[Chap15:09s112]112 Application of Act to State

Nothing in this Act contained shall be construed as conferring any powers or imposing any duties upon a local authority in respect of any land or premises owned or occupied by the State for military purposes.

[Chap15:09s113]113 . . .

[Section 113 repealed by section 4 of Act 22 of 2001 with effect from 20 May 2002.]