

THE NATIONAL HEALTH STRATEGY

for Zimbabwe

2016-2020



ZIMBABWE



**EQUITY AND QUALITY IN HEALTH:
LEAVING NO ONE BEHIND**



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Foreword

This strategic plan has been developed through a participative and consultative process involving significant contributions and support from various individuals and institutions.

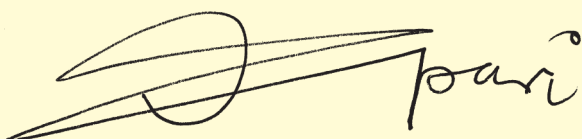
A specific Technical Task Team (TTT) was established to drive preparatory activities towards this strategy. The TTT established Technical Working Groups (TWG) to focus on specific strategic pillars. Various stakeholder workshops were conducted with health workers, community leaders, development partners, government agencies and communities. The TTT also conducted a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis based on the inputs from these stakeholders. The SWOT analysis provided qualitative evidence on the status of the health sector. In addition, a Bottleneck Analysis (BNA) was conducted on selected tracer conditions to unpack the underlying bottlenecks and root causes to observed health system performance challenges. The results of the SWOT analysis and the BNA, together with a comprehensive review of the performance of the previous strategy exploring what worked and what did not was used to identify sector priorities and hence remedial strategies.

The Plan provides the framework that will guide the efforts of the Ministry of Health and Child Care and all stakeholders over the next 5 years in contributing to the attainment of the Zimbabwe Agenda for Socio-Economic Transformation and the Sustainable Development Goals.

The successful implementation of this plan will depend on the continued dedication of staff in the Ministry of Health and Child Care and those of its partner institutions.

As a strategic policy document that we have put together, it is my sincere hope that it will become the single most important point of reference for design of service delivery programmes, resource mobilization and health financing framework, as it outlines how as Zimbabweans we will reach our dream of delivering high quality health services to the citizens.

I therefore wish to extend my sincere appreciation to all those that contributed to the process of developing this plan. I wish to pay special tribute to the members of the technical team and members of the technical working groups for their significant inputs and commitment to this process. On behalf of the Ministry of Health and Child Care, I also wish to acknowledge the financial and technical support rendered to us by our Development Partners. Without the direction and valuable support of our Cooperating Partners, we could not have managed to successfully complete this plan. Finally, I wish to thank all the members of staff of the Ministry of Health, and Child Care, line ministries, Community representatives and NGOs, for their participation, contributions and support to the process of formulating this strategic plan.



Dr P D Parirenyatwa (Senator)
Minister of Health and Child Care

Acknowledgements

The National Health Strategy (2016-2020) is the product of a long and complex process of intensive consultations, teamwork on specific assignments, detailed studies and information gathering. Service providers, civil society groups, community members, the private sector, co-operating partners and other stakeholders were all involved in the process. The Ministry of Health and Child Care is very grateful to those who contributed to the successful development of this strategic plan. The concerted effort of all directorates, programs and other stakeholders is acknowledged. Special thanks go to the Division of Policy, Planning, Monitoring and Evaluation that provided leadership to members of the core team tasked to facilitate the development of this document. The efforts of putting together important information, comments and suggestions have not gone unnoticed. The Government of Zimbabwe would like to appreciate the financial and technical support given by development partners for the development of this document. Last, but not least, the Ministry of Health and Child Care expresses its sincere gratitude to all stakeholders and institutions who continue to contribute one way or the other towards giving quality health services to the citizens of Zimbabwe.



Brig. Gen. (Dr) Gerald Gwinji

Permanent Secretary, Ministry of Health and Child Care

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
ARC	AIDS Related Conditions
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BCG	Bacille de Calmette et Guérin
BEmONC	Basic Emergency Obstetric and Newborn Care
BMI	Body Mass Index
BNA	Bottleneck Analysis
BP	Blood Pressure
BVIP	Blair Ventilated Improved Latrine
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Centre
CHW	Community Health Worker
CORDAID	Catholic Organization for Relief and Development AID
CPR	Contraceptive Prevalence Rate
CT	Computed Tomography
DHE	District Health Executive
DPT	Diphtheria, Pertussis and Tetanus Vaccine
DOTS	Directly Observed Treatment
DR-TB	Drug Resistant Tuberculosis
ECCH	Environmental Control Community Health clubs
EH	Environmental Health
EHB	Essential Health Benefits
EHI	Environmental Health Initiative
EHT	Environmental Health Technician
EHO	Environmental Health Officer
EHT	Environmental Health Technician
EPI	Expanded Programme on Immunisation
ETAT	Emergency Triage Assessment and Treatment
FP	Family Planning
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GPA	Government Programme of Action
GOZ	Government of Zimbabwe
HAB	Hospital Advisory Board
HACCP	Hazard Analysis Critical Control Points
HAT	Human African Trypanosomiasis
HAB	Hospital Advisory Board
HBB	Helping Babies Breathe
HCC	Health Centre Committee

HDU	High Dependency Unit
HIMS	Health Information Management System
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HRH	Human Resources for Health
HTF	Health Transition Fund
HTS	HIV Testing Services
ICD	International Classification of Diseases
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMNCI	Integrated Management of Childhood & Neonatal Illnesses
IPT	Intermittent Preventative Treatment
IRS	Indoor Residual Spraying
KRA	Key Results Areas
LARC	Long-acting Reversible Contraceptive
LF	Lymphatic Filariasis
LLIN	Long Lasting Insecticide Treated Nets
MOHCC	Ministry of Health and Child Care
MDG	Millennium Development Goals
MDR	Multi-Drug Resistance
M&E	Monitoring and Evaluation
MICS	Multiple Indicators Cluster Survey
MIMS	Multiple Indicator Monitoring Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MRCZ	Medical Research Council of Zimbabwe
MRI	Magnetic Resonance Imaging
NAC	National AIDS Council
NCD	Non-communicable Diseases
NHMIS	National Health Management Information System
NHS	National Health Strategy
NIHR	National Institute of Health Research
MTCT	Mother to Child Transmission of HIV
NCD	Non-Communicable Diseases
NGO	Non Governmental Organisations
NMS	National Micronutrient Survey
NTD	Neglected Tropical Diseases
ODA	Overseas Development Assistance
OI	Opportunistic Infections
OJT	On-the-Job Training
OOP	Out of Pocket Expenditure
OPD	Outpatient Department
ORS	Oral Rehydration Salts

PBB	Programme Based Budgeting
PBF	Programme Based Funding
PCN	Primary Care Nurse
PER	Public Expenditure Review
PFM	Public Finance Management
PHE	Provincial Health Executive
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Post Natal Care
PPIUCD	Post-partum Intrauterine Contraceptive Device
PSM	Procurement Supply and Management
RBF	Results Based Financing
RCZ	Research Council of Zimbabwe
RDT	Rapid Diagnostic Test
RRT	Rapid Response Team
TB	Tuberculosis
SCH	Schistosomiasis
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
STH	Soil Transmitted Helminthiasis
STI	Sexually Transmitted Diseases
SWOT	Strengths, Weaknesses, Opportunities and Threats
TTT	Technical Task Team
TWG	Technical Working Group
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
VCT	Voluntary Counseling and Testing
VIDCO	Village Development Committee
VEN	Vital, Essential and Necessary Drugs
VHW	Village Health Worker
VMMC	Voluntary Medical Male Circumcision
WARDCO	Ward Development Committee
WCBA	Women of Child Bearing Age
WDI	World Development Indicators
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZEPI	Zimbabwe Expanded Programme on Immunisation
Zim-ASSET	Zimbabwe Agenda for Sustainable Economic Transformation
ZIPHA	Zimbabwe Public Health Association
ZMPMS	Zimbabwe Maternal and Perinatal Mortality Study
ZNCR	Zimbabwe national Cancer Registry
ZNFPC	Zimbabwe National Family Planning Council
ZSARA	Zimbabwe Service Availability and Readiness Assessment
ZIMSTAT	Zimbabwe National Statistics Agency

Executive Summary

The vision of the Zimbabwe Ministry of Health and Child Care is to have the highest possible level of health quality of life for all its citizens. This National Health Strategy 2016-2020 – Equity and Quality of Health: Leaving No One Behind sets out the strategic direction for the health sector over the next five years in order to attain this vision.

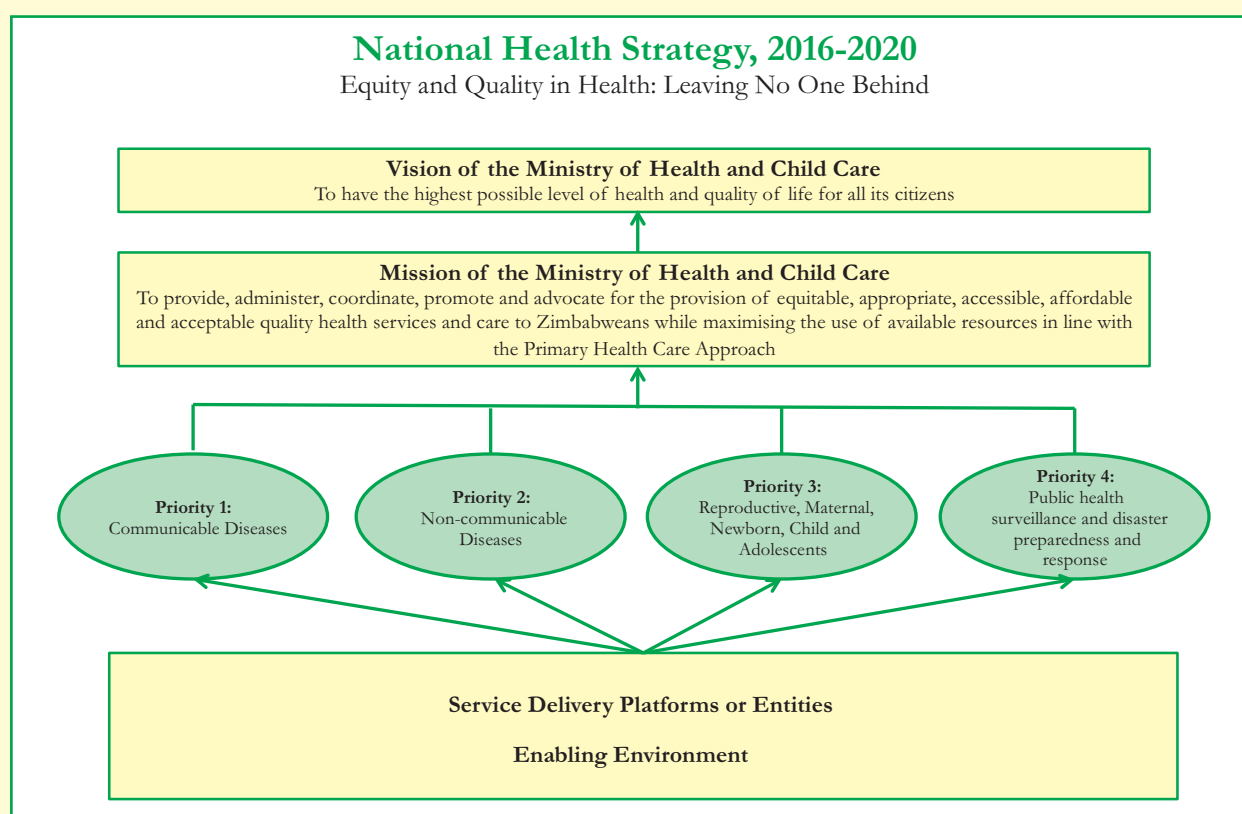
The 2016-2020 National Health Strategy builds on the 2009-2013 strategy and its extension in 2014-15 by addressing existing gaps and, more importantly, seeks to sustain the gains achieved thus far through a comprehensive response to the burden of disease and strengthening of the health system to deliver quality health services to all Zimbabweans. The strategy lays out the health agenda for 2016-2020 taking into account the broader policy context that is largely defined by the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim-Asset) and the Sustainable Development Goals. The current challenges of economic growth worsened by a turbulent global market means that this strategy cannot be business as usual as the country needs to find innovative ways of supporting the health sector. Equally important is the need to ensure that other sectors directly and indirectly linked to health align their programmes and activities to contribute towards a healthy population - hence the ZimAsset's clusters approach.

The 2009-2012 period saw the economy rebounding and beginning to reverse the consequences of near collapse of the health system in 2008. However, the period 2013-2015 saw a dramatic drop in economic growth and the prospects for the next five years are predicted to remain sluggish. Consequently, government fiscal space is likely to shrink thereby increasing the need for external funding to support the health infrastructure, retain health workers, medicines and commodities supply and distribution, amongst others. Improving the quality of health services and ensuring that these services are accessed equitably is the main challenge that this strategy seeks to address under these circumstances.

A systematic review of existing reports, data and evidence regarding the performance of the health sector shows that Zimbabweans still faces a double burden of communicable and non-communicable diseases. Zimbabwe is prone to epidemic diseases including diarrhoeal disease and outbreaks of anthrax and rabies are common, highlighting the critical importance of public health surveillance and a disaster preparedness and response programme. HIV prevalence remain relatively high at 15% amongst adults and gains achieved to date are threatened by the deteriorating indicators and risky behaviors amongst the youth and increasing number of teenage pregnancies. Deaths due to TB remain high due to its twin relationship with HIV and AIDS. Malaria remains a major cause of morbidity and mortality in the country and more so in some geographic areas.

Non-communicable diseases are emerging as major cause of morbidity and mortality amongst both the rich and the poor in the country. The nutrition status of children remains poor. These challenges are compounded by health systems constraints related to shortages of critical health workforce, aging infrastructure and equipment, supply of medicines and other commodities, limited health funding, and considerable challenges with the service delivery platforms or entities and the enabling environment. Addressing the challenges requires strengthened service delivery platforms or entities including primary care and hospital services, and creation of an enabling environment with attention to issues of policy and administration, multi-sectoral partnerships and research and development.

Building on this situation analysis, the strategy is structured as shown below:



This structure is elaborated to include three main goals and twenty one objectives, all with defined Key Results Areas with their baselines and targets, as shown below:

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Goal 1: To strengthen priority health programmes				
Priority 1: Communicable diseases	1. To reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020 and malaria deaths to near zero by 2020	Malaria incidence	39	5
		Malaria deaths	654	0
	2. To ensure timely detection and control of epidemic prone diseases	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	100%
	3. To reduce morbidity due to Schistosomiasis and soil transmitted helminthes and other NTDs by 50% by year 2020.	Prevalence of STH and SCH	22.7% (for SCH/STH)	10%
	4. To prevent new HIV infections and to reduce deaths due to HIV by 50%	% people who are tested and know their status	40.3% (men) 56% (women)	85%
		% of people on ART	TBD	90%
		% of ART patients virally suppressed	TBD	90%
	5. To reduce mortality, morbidity and transmission of tuberculosis by 90%	Mortality rate	10%	< 5%

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Priority 2: Non-communicable Diseases	6. To reduce the incidence of selected Non-Communicable Disease (NCDs) by 50 %	% reduction in NCDs burden	0%	5%
	7. To improve the mental health status of the population	% increase in number of diagnosed mentally ill to the expected mentally ill patients	TBD	90%
	8. To reduce disability and dependence by 50%	% patients under CBR to total rehabilitation patients	TBD	TBD
	9. To improve the quality of life of elderly persons and improve life expectancy from 61.5 to 65 years by 2020	% of older persons that receive geriatric care	TBD	100%
Priority 3: Reproductive, Maternal, Newborn, Child and Adolescents	10. To reduce maternal mortality ratio from 614 to 300 by 2020	MMR	614	300
	11. To reduce Neonatal Mortality Rate from 29 to 20 deaths per 1,000 live births	NMR	29	20
	12. To reduce the under-five mortality rate from 75 to 50 deaths per 1,000 live births	<5 mortality	75	50
	13. To reduce mortality and morbidity due to malnutrition by 50%	Proportion of children under 5 years stunted	28%	19%
Priority 4: Public Health surveillance and disaster preparedness and response	14. To strengthen environmental health services, early detection of disease outbreaks and man-made disasters from 30% to 50% by 2020	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	50%
		% of districts with functional coordination mechanism	50%	100%
		Percentage of household members using improved sanitation facilities which are not shared	35%	50%
		Percentage of household members using improved sources of drinking water	76.1%	TBD
Goal 2: To improve service delivery platforms or entities				
Primary Care	15. To reduce morbidity by at least 50% through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level	Proportion of villages with community based health workers	<60%	>90%
		% districts implementing Essential Primary Health Benefits	0%	100%
Hospital Services	16. To ensure universal access and provision of complementary package of hospital services including emergency and ambulatory curative services	% of hospitals with Quality Management Systems	TBD	
		% of hospitals with functional theatre services	TBD	

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Hospital Services	17. To ensure universal access and provision of quality tertiary specialist curative services	% of tertiary hospitals with specialists	TBD	100%
	18. To promote and support provision of quality palliative care services	% of patients and families needing palliative care who are receiving it	200,000 in need	40% (80,000 people)
Goal 3: To improve the enabling environment for service delivery				
Policy Planning and Coordination	19. To improve health outcomes through facilitation and co-ordination of an effective and efficient health delivery system	% of policies and strategies aligned to the NHS	0	100%
Human Resources		Overall vacancy rate	17%	10%
Finance and Administration		Number of institutions audited against the plan	TBD	82 cost centres
		Number of districts with functional PFMS	0	62
Monitoring and Evaluation		Harmonised M&E policy framework	01	1
Provincial Administration		% of actual to planned PHT reviews convened per year	TBD	100%
Procurement and supply chain management		% availability of essential medicines	42%	80%
Multi-sectoral Partnership	20. To strengthen multi-sectoral collaboration with local and international partners	A policy on public/private and public/public partnerships	0	1
		% of functional national and subnational intergovernmental platforms	TBD	90%
Research and Development	21. To improve uptake of scientific research evidence for decision making and policy development by 70%	% health research informed by the national health research priorities	TBD	70%
		Number of clinical trials on Traditional Medicine conducted	TBD	2

The implementation framework and costing and funding options for the strategy will aid in operationalising the strategy and meeting its targets, towards the vision of having the highest possible level of health and quality of life for all Zimbabweans. Key issues that will be addressed in implementation include provision of an essential health benefits package, investments in health systems strengthening, leveraging multi-sectoral actions, gender mainstreaming specifically targeting women and young girls to improve gender equity, and community participation at all levels. It is important that achievements to date are maintained and indeed improved, otherwise the vision, mission and strategy goals will not be realised by 2020.

Overall Context for the National Health Strategy 2016-2020

1

1.1 Introduction

The Zimbabwe Agenda for Sustainable Economic Transformation (ZimAsset) represents a blueprint for the country's development path from October 2013 to December 2018. It provides the basis and context for all sector strategies and programmes towards the achievement of its vision, namely "Towards an empowered society and growing economy". The National Health Strategy 2016-20 derives from this national vision and provides a framework for attaining health and health related goals and objectives. It assumes the spirit of the Zim-Asset that seeks to attain "quick wins" and is structured around the Results Based Management system that focuses on a clear vision, mission, values, key results areas, goals and objectives. Unlike past strategies, the NHS 2016-20 is complemented by a detailed monitoring and evaluation framework that will be used to assess progress through mid-term and end-term evaluations (Annex I).

1.2 The constitution and its provision for health

The Constitution of Zimbabwe explicitly provides for the right to health care in Section 76, sub-section 1 to 4 that:

- “(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health
- (2) Every person living with a chronic illness has the right to have access to basic healthcare services for the illness
- (3) No person may be refused emergency medical treatment in any health-care institution, and
- (4) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realization of the rights set out in this section”

The Constitution further provides, in Section 77 that every person has a right to safe, clean and potable water, and sufficient food (Food Security, Quality and Safety). These rights are directly related to peoples' health as it not possible to divorce the living conditions of people from their health risks and status. This national health strategy is indeed subordinate to these constitutional provisions and the State has the responsibility to create a conducive environment in which it is possible for all people in Zimbabwe to access basic health services whenever they need them.

1.3 National Health Strategy alignment with Government Programme of Action (GPA)

The Zim-Asset, a Results Based Management agenda, recognizes that socio-economic development requires substantial transformation in all sectors and that change requires multi-sectoral actions and working transversally. The Zim-Asset has four clusters and the Ministry of Health and Child Care (MOHCC) is part of the clusters on Food Security and Nutrition, and Social Service and Poverty Reduction. The outcomes and strategies set for achieving Zim-Asset goals provide a strong basis for this strategy because the MOHCC is mandated to lead and provide these services on behalf of the entire country and contribute to broader socio-economic development. For instance, key outcomes on nutrition include reduction in stunting among children, and improved availability of quality food and nutrition data; and improved enabling legal, food and nutrition policy regulatory environment. With regards to social services delivery, the MOHCC is responsible for several outcomes related to priority health interventions including in the areas of reproductive, maternal, newborn, child and adolescent health; communicable diseases (Human Immunodeficiency Virus - HIV, Tuberculosis - TB, malaria and diarrhoea); non-communicable diseases; and creation of an enabling environment for the delivery of quality services through appropriate policy and regulatory frameworks, reduction of financial barriers, improved procurement and supply of health products and equipment, and improved infrastructures, amongst other things.

The strategies in the GPA are guided by the notion of “quick wins” and this philosophy permeates the NHS 2016-2020. Although the ZIM-Asset planning horizon extends up to 2018, this strategy conforms to that planning trajectory, and also recognizes the importance of mid-term reviews in influencing the assumed trajectory. The strategy comes into effect at a time when Government is implementing Programme Based Budgeting (PBB), a reform process that will not only see alignment of resource budgeting and outcomes, but also necessary reforms to improve the performance of the health system.

1.4 The health sector and global commitments

Zimbabwe still confronts the unfinished Millennium Development agenda as not all of the goals and targets were met. According to the 2014 Multiple Indicator Cluster Survey (MICS), the maternal mortality ratio remains high at 614 deaths per 100,000 live births (versus a target of 174 deaths per 100,000 live births); the under five child mortality rate is at 75 deaths per 1,000 live births (versus a target of 43 per 1000 live births); the nutritional status of children remains problematic, and HIV and AIDS, TB and malaria remain major causes of morbidity and mortality. The strategy is aligned to the Sustainable Development Goals (SDG) agenda, which also takes into consideration the unfinished MDGs agenda. Of the 17 goals, Goal 3 **“Ensure healthy lives and promote well-being for all at all ages”** directly focuses on health, and accordingly, the vision, mission and goals of this strategy relate to it. It is also important to highlight Goal 5 **“Achieve gender equality and empower all women and girls”** which brings to the fore the need to address specific challenges that affect women and girls who tend to be disproportionately affected by poverty, diseases, violence and other social ills. This strategy, as described in the SDG framework seeks to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls.

Importantly, these goals are integrated and indivisible, and balance the three dimensions of sustainable development: the economic, social and environmental. This 2016-2020 Zimbabwe National Health Strategy responds to this call for action in a variety of ways as it seeks to contribute to improving the quality of lives of Zimbabweans.

1.5 Socio-economic and demographic context

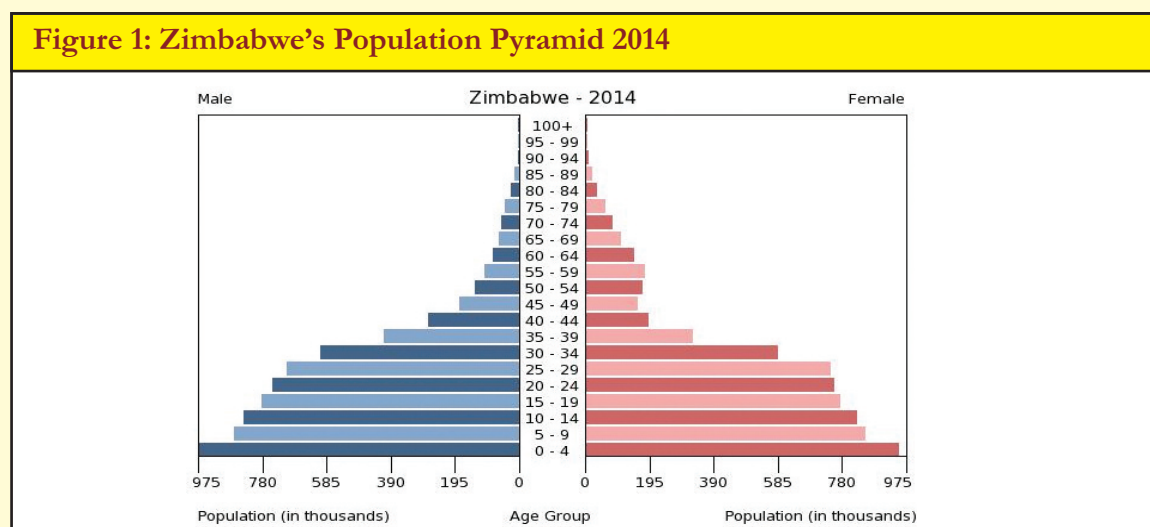
Understanding the socio-economic and demographic context allows for an analysis of what is feasible in the medium to long term, and also identification of population groups that need to be targeted for health services and those that are at risk of various diseases and conditions.

Economic growth slowed down compared to what was projected in the Zim-Asset of 6.2% by 2014, and the prospects over the strategy period are that economy will remain sluggish in the short to medium term, and total tax revenues will generally remain at about 27% of GDP (Public Expenditure Review – PER - 2015). The fiscal trends and projections are important indicators of the government's capacity to allocate financial resources to the health sector. The World Bank revised the economic growth rate for 2015 from the projected 4.2% to 3% due to low investment levels, poor performance of the mining sector and the poor global economic environment. The country has a large debt of nearly \$10 billion that needs to be serviced. Unemployment levels remain high with the majority of the people now in informal employment. This macro-economic environment requires innovation and effective partnerships between government and various partners including communities, in both funding and providing health services to the population.

Population size and structure

Zimbabwe covers 390,757 square kilometres and has 10 provinces and 63 districts. The total population is 13,061,239 translating to the population density of 33. The country has 6,280,539 males and 6,780,700 females. The urban population is 4,284,145 (33%) and the rural population is 8,777,094 (67%). The total fertility rate is estimated at 4.3 children per woman, and the age-specific fertility rate for women aged 15-19 years is 120 births per 1000 women (MICS 2014). The population growth rate is estimated at 2.7% per year. Over 50% of the population is youth (see Figure 1).

Figure 1: Zimbabwe's Population Pyramid 2014



Source: Zim Census 2012

The youth, particularly adolescents, are the future and therefore present both challenges and opportunities for addressing current and future health issues. This particular population group has shown deteriorating health indicators over the last five to ten years in terms of behavior change towards HIV and other sexually transmitted diseases, early sexual debut, unplanned pregnancies, high fertility, increased smoking habits, drugs and substance abuse, worsening perceptions about gender violence and unhealthy eating habits and lifestyles in general. The advent of new communication technologies and sedentary entertainment presents challenges and opportunities. There are now multiple-channels for communicating with the youth, which need to be used as part of the communication strategy. However, the youth are also becoming less active and this is compounded by unhealthy eating habits.

With the majority of the people in rural areas, urban migration remains an ongoing phenomenon resulting in the number of the urban poor increasing. Within the rural areas, resettled farmers are a key target population given the need to improve access to water, sanitation and health services to these populations. The risk of epidemics including cholera remains high because of limited access to clean water and optimal waste management. Effective public health interventions are a priority for these key groups if health services coverage and most importantly outcomes are to improve.

Situation Analysis of Zimbabwe's Health Sector

2

2.1 Health Systems Organisation and Status

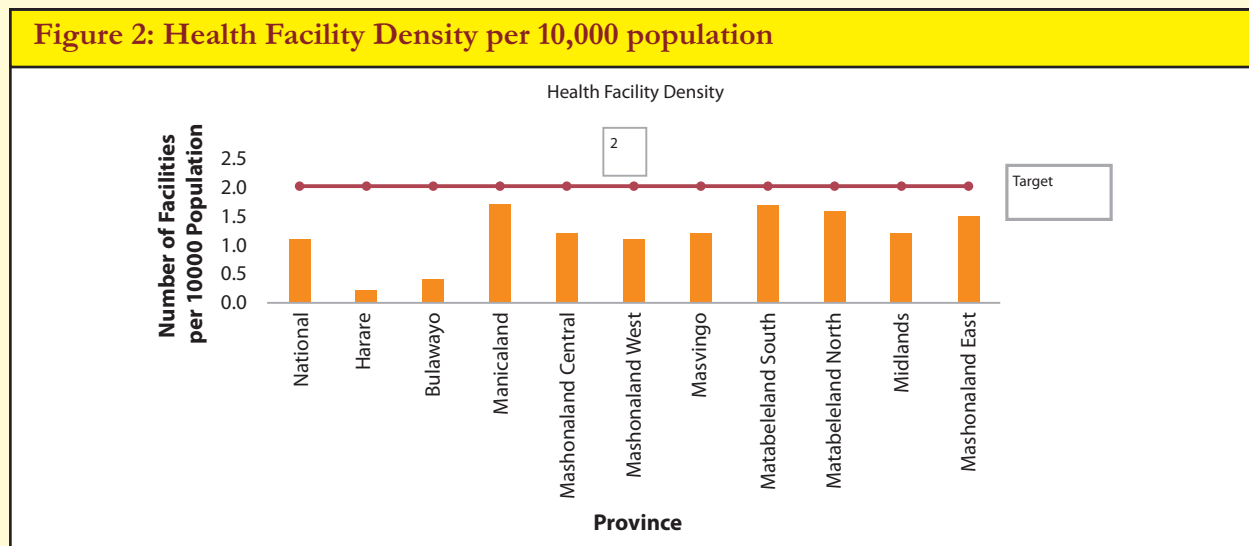
Zimbabwe assumed the Primary Health Care approach in 1980 and its health system is structured accordingly. The health services delivery platforms include primary, secondary, tertiary (provincial) and quaternary (central) facilities and these are shown in Table 1. The majority of these health facilities are at primary care level which refer complicated cases to the next levels of care. Mission and private sector facilities provide considerable services mostly in rural and urban areas respectively.

Table 1: Health facilities profile for Zimbabwe

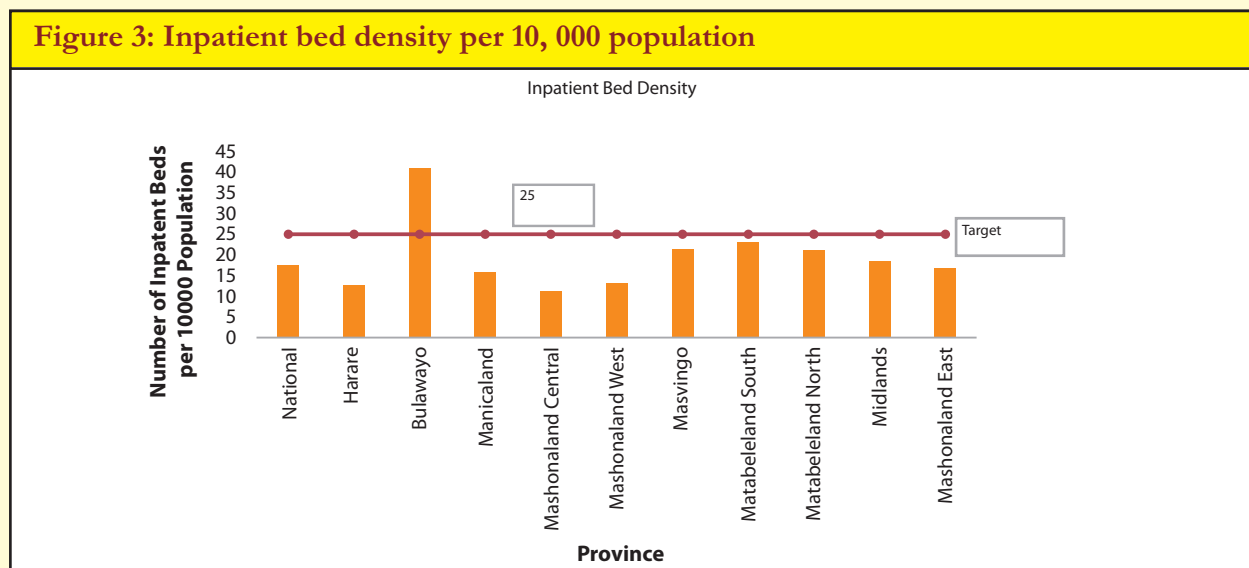
Facility level/ Managing Authority	All facilities	Hospitals	Primary Health Facilities
Central Hospitals	6	6	
Provincial hospitals	8	8	
District Hospitals	44	44	0
Mission Hospitals	62	62	0
Rural Hospitals	62	62	0
Private Hospitals	32	32	0
Clinics	1,122	0	1,122
Polyclinics	15	0	15
Private clinics	69	0	69
Mission clinics	25	0	25
Council/Municipal Clinics/FHS	96	0	96
Rural Health Centre	307	0	307
Totals	1,848	214	1,634

Source: ZSARA, 2015

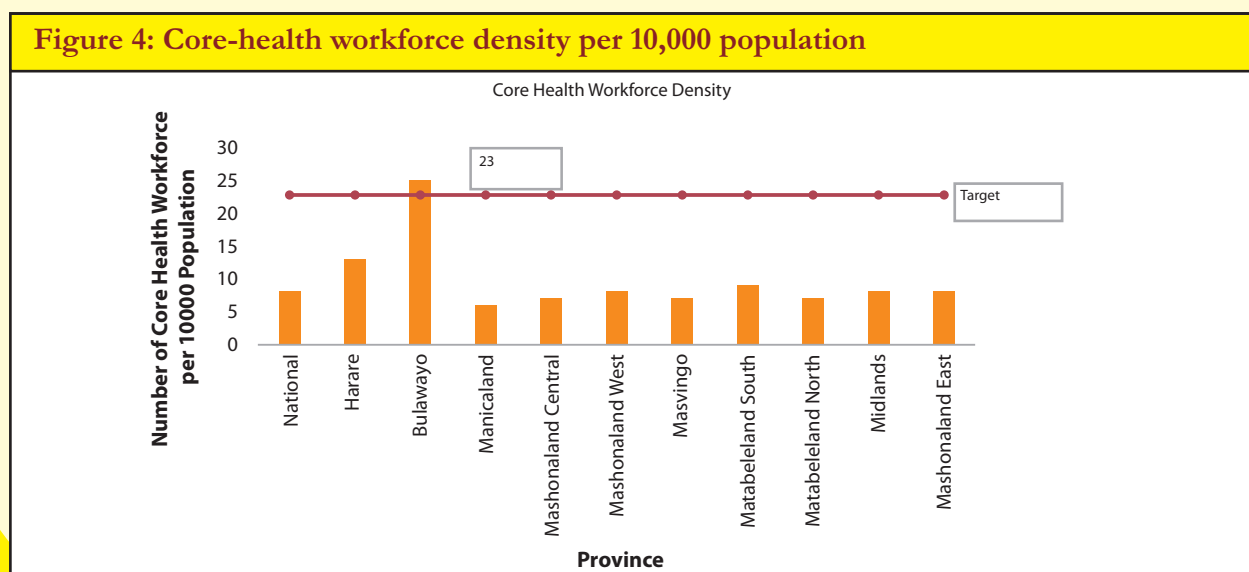
The status of the current health system organization and readiness is aptly described in the recent Zimbabwe Service Availability and Readiness Assessment survey (ZSARA 2015). In the ZSARA survey, general services availability was measured using facility densities such as health facility, inpatient beds, maternity beds, health workers, outpatient visits and inpatients. Three of these metrics – health facility density, core health worker density and inpatient bed density are shown in Figures 2, 3 and 4 respectively. Overall, none of the provinces met the target for health facility density. Bulawayo is the only province that exceeded the core worker and inpatient bed density target.



Source: ZSARA, 2015



Source: ZSARA, 2015



Source: ZSARA, 2015

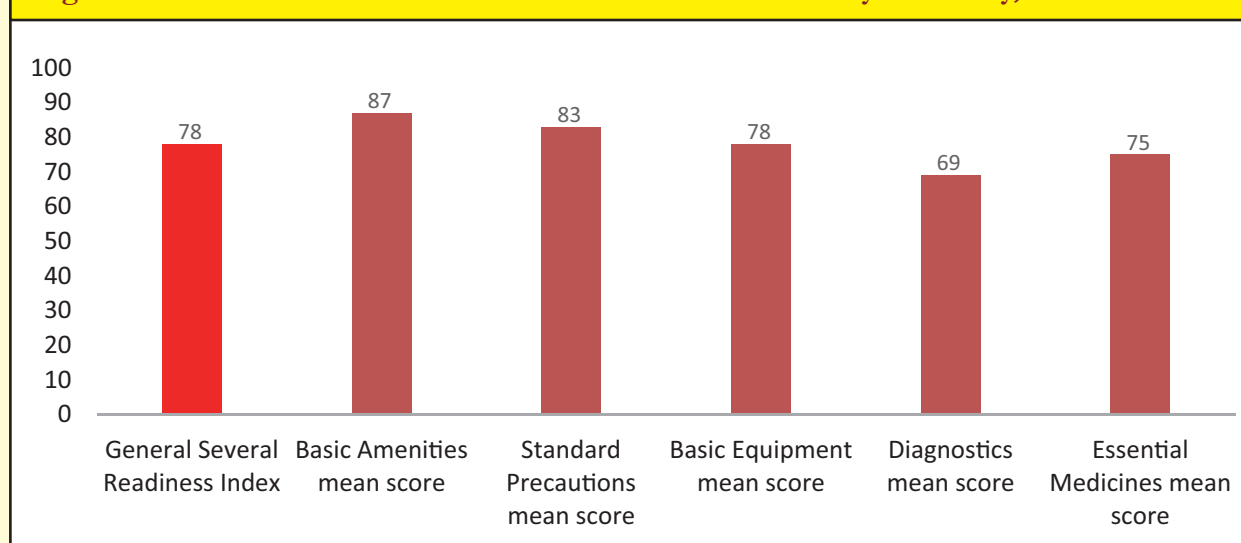
The study also generated evidence on general service readiness on selected basic domains (Box 1), and specific tracer services such as HIV and AIDS, MNCH, TB, malaria, diabetes and others.

BOX 1: General Service Readiness indicators

- Basic amenities: Sanitation facilities were available in all facilities. 96% had access to emergency transportation and an improved water source.
- The item with the lowest availability was the computer with internet/email access, at only 21%.
- Urban locations had a higher availability of basic amenities items compared to rural locations. Hospitals were more likely to have all basic amenities compared to primary care facilities.
- Basic equipment: Thermometers were available across all facilities. Items such as stethoscope, blood pressure apparatus, and adult scale were available in nine of ten facilities nationally. Light source had the lowest availability at 58%. Four in ten facilities had all six basic equipment items.
- Standard precautions: Auto disposable syringes were available in all facilities. Disinfectants, latex gloves and appropriate storage of sharps waste were available in nine out of ten facilities across provinces.
- Six in ten facilities had an appropriate storage for infectious waste. Only one in three facilities had all items for standard precautions.
- Capacity to conduct diagnostic tests on site was relatively high i.e. >70%. Nine in ten facilities conducted malaria rapid tests or HIV rapid tests on site.
- Eight in ten facilities conducted syphilis rapid test and urine dipstick for protein/glucose.
- Less than half (50%) of facilities had tests available blood glucose, urine test for pregnancy and haemoglobin.
- Only 1 in 10 facilities reported having all tests available. There were no major variations between hospitals and primary care facilities in diagnostic capacity.
- Essential medicines: Antibiotics such as oral Amoxicillin were available at almost all facilities (98%). Injectable antibiotics such as gentamycin, ceftriaxone, and ampicillin were the least available (31%)
- Magnesium sulphate and oxytocin were available in 9 out of 10 facilities.

Source: ZSARA, 2015

The study found a general service readiness index of 78% with urban locations having higher overall readiness scores compared to rural locations (Figure 5). Basic equipment scores were generally similar between rural and urban locations (69% rural versus 66% urban). Worth noting was that diagnostics were the lowest at 69%.

Figure 5: General Service readiness index and domain scores by nationally, Zimbabwe 2014

Source: ZSARA, 2015

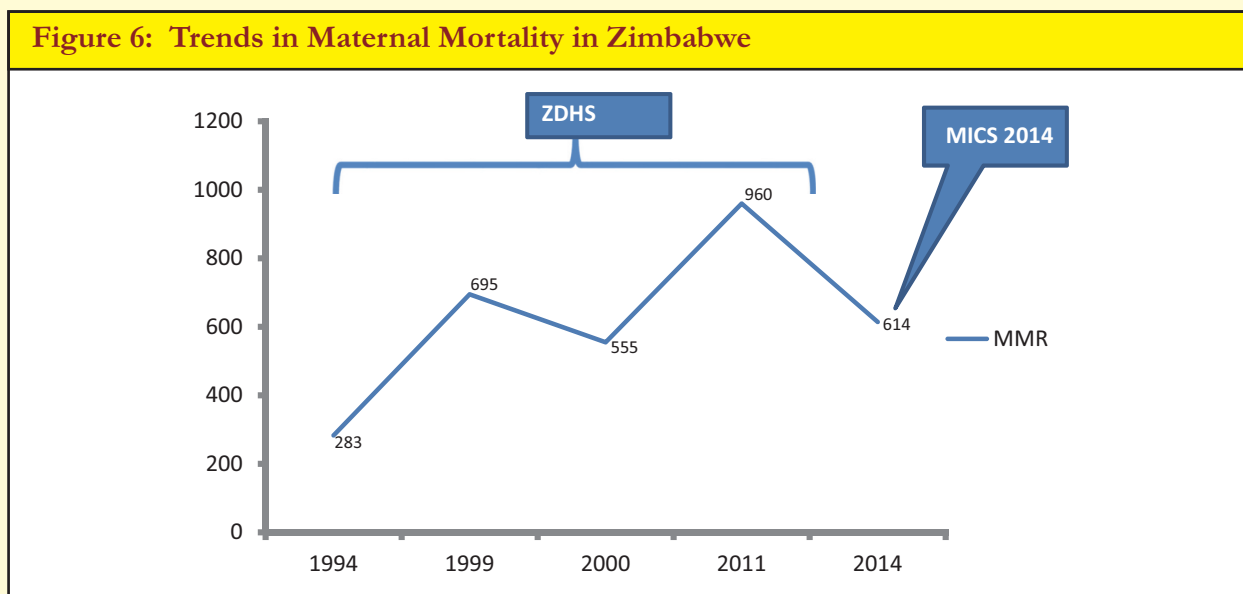
This assessment shows that despite the threat of a near collapse of the health system in 2008, the health system has largely remained resilient enough to provide basic services to the majority of the people. However, challenges remain in terms of service gaps and more importantly quality of services to ensure effective coverage. The other key challenge affecting access is the question of direct payment for health services (Out Of Pocket (OOP) – formal or informal) which presents household hardships especially for those who are poor and vulnerable. Furthermore, improving quality of services and equitable access means that health workers must be available when needed with the right attitudes and work ethics to meet user needs.

Client satisfaction surveys conducted as part of the Results Based Financing (RBF) on Out Patient Department (OPD) visits, family planning, antenatal care, labour, and delivery services showed that the average waiting time was 48 minutes, ranging from six minutes to eight hours (CORDAID 2015). Eighty percent of clients waited for an hour or less, and of these 89% thought the waiting time was reasonable. An equally high percentage (80%) acknowledged that the staff who received them at the facility were friendly. The majority of clients (84%) acknowledged that all the prescribed medicines were available at the facility while 15% said that the prescribed medicines were partially available and 1% stated that medicines prescribed were not available in the facility. 16% of the clients paid for services, and the overall satisfaction level was high at 98%. The caveat to these findings is that this study was done in RBF intervention districts in which health workers had an explicit incentive regime to provide satisfactory services. This strategy seeks to build on the current levels of client satisfaction in these areas and enhance overall health systems responsiveness.

If the Primary Healthcare Approach is to be implemented effectively, strong community systems are essential. Although community structures exist to assist in both health promotion and provision of health services, they need to be strengthened beyond supporting the Village Health Worker (VHW). The role of traditional and local leadership, community structures and community participation needs to be elevated if health interventions are to be effective and sustained over time. Communities play a major role not just in receiving the services they need, but also in co-production of these services and their funding and governance.

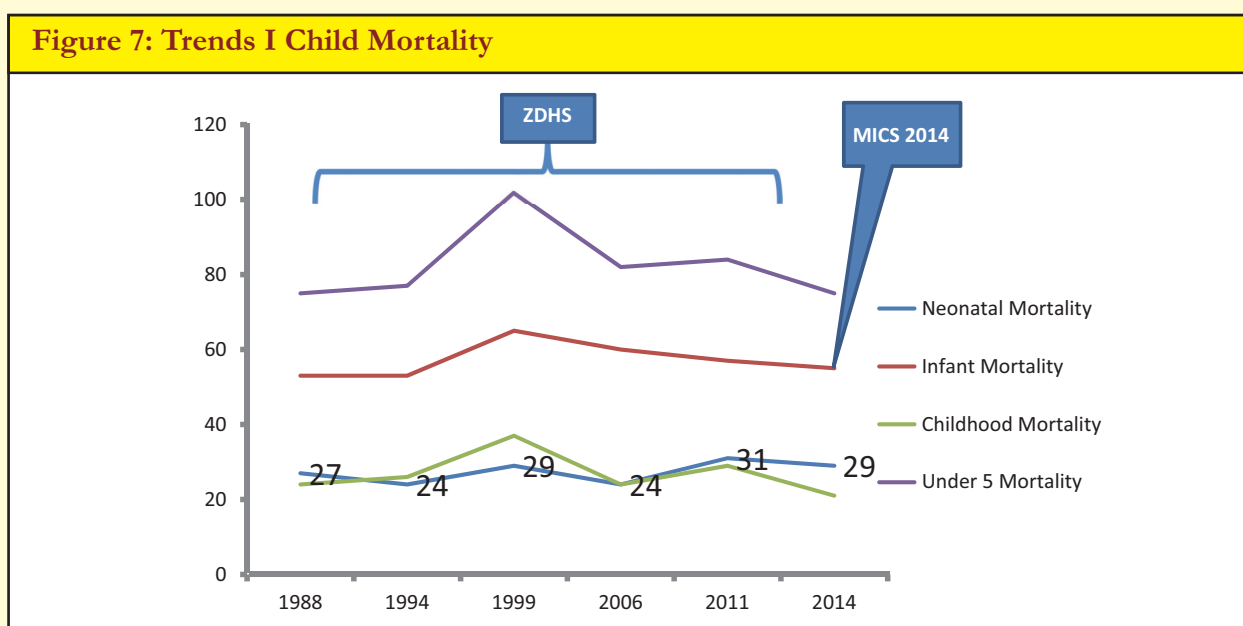
2.2 General performance of the health sector 2009 to 2015

Life expectancy for Zimbabweans increased from 34 years in 2006 to 58.5 years in 2015, with women at 61.3 years compared to men at 56.2 years (WHO 2013). This positive trend is also reflected in the major health indicators such as the maternal mortality ratio which has declined from 960 per 100,000 to 614 per 100,000. However, these figures remain unacceptably high and well below the expired MDG targets (Figure 6).



Source: MOHCC

Child mortality trends do not show any noticeable changes since the early 1980s and it is clear that neonatal and infant mortality remain unacceptably high (Figure 7). The key strategic question is: what is driving this mortality profile?



Source: MOHCC, 2014

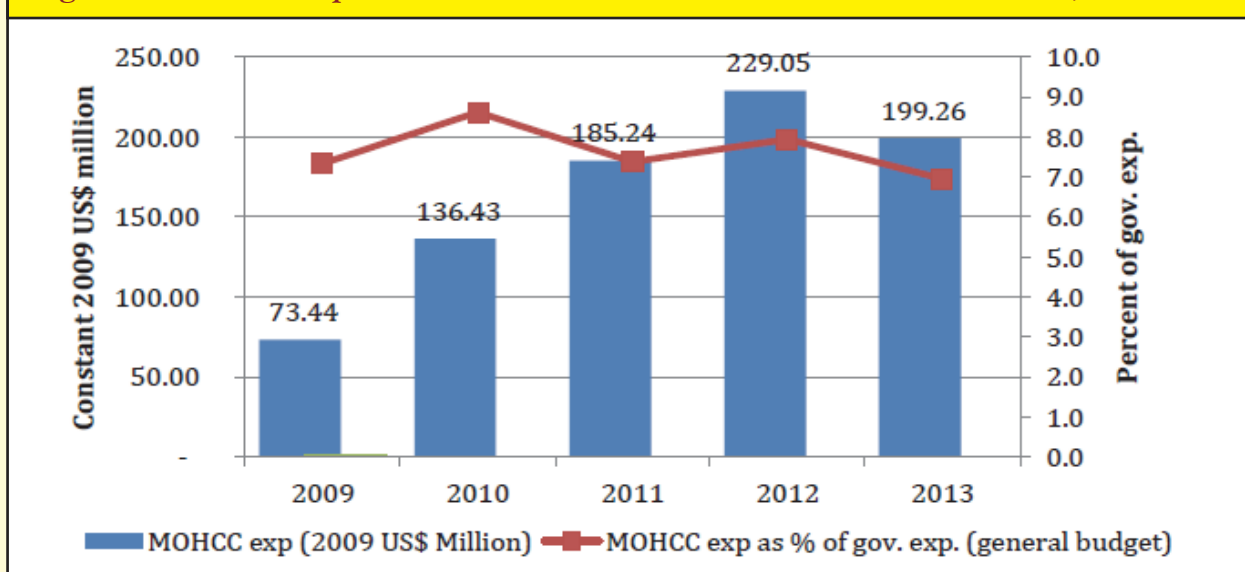
These high mortality figures are occurring in a context in which coverage for maternal and child health services has generally improved (Table 2). The implication is that there are issues to do with the quality of services provided that this strategy seeks to address. Table 2 shows specific indicators related to maternal and child mortality since 2009.

Table 2: Selected Maternal Health Indicators, 2009-2014					
GOAL: To reduce the Maternal Mortality Ratio from 725 to 300 deaths per 100,000 live births by 2015					
Indicator	2009	2013	2014		Target 2015
% pregnant women who have 1st ANC visit in 1st trimester	19.4% (ZDHS 2010/11)		31.2% (MICS 2014)		44.4%
% of pregnant women with at least 4 ANC visits	64.8% (ZDHS 2010/11)		70.1% (MICS 2014)		90%
% of deliveries which are institutional delivery	65.1% (ZDHS (2010/11))		80% (MICS (2014))		80%
% deliveries attended by skilled health personnel	66.2% (ZDHS 2010/11)		80% (MICS 2014)		80%
% of hospitals equipped to provide basic EmONC		45% (MOHCC reports)			85%
% of hospitals equipped to provide comprehensive EmONC		37.6% (MOHCC reports)			80%
% Facilities providing PNC		96.9% (NIHFA 2012)			98%
% PNC attendance	43% (ZDHS 2010/11)		83.5% (MICS 2014)		80%
% of public health facilities providing oral contraceptives		97% (DTTU)			98%

Source: MOHCC, 2014

2.3 Expenditure on health

Government funding for health has generally improved since 2009 reaching a peak in 2012 of 8% of total government expenditure (Figure 8). However, this remains below the Abudja declaration commitment of 15% of total government spend. During the same period external funding significantly increased from \$167 million in 2009 to \$428 million by 2012. Such funding has greatly contributed to the performance of priority health programmes and more recently to the gains made in health systems strengthening, particularly retention of health workers and procurement and distribution of essential health commodities, amongst other things. Out-of-Pocket Expenditure (OOP) contributions remain unacceptably high at 49% (NHA, 2010) given their negative effects on households. In 2009, per capita expenditure was \$9 and this is estimated to have increased to \$24 in 2015. Nonetheless, Cartarm house recommends per capita spend of \$86, meaning that Zimbabwe is still well below this benchmark. The cost per capita for an Essential Health Benefits (EHB) package at primary care level alone is estimated at \$56, which points to the need to double current per capita spend.

Figure 8: MOHCC Expenditure in total and as share of General Government, 2009-2013


Source: Authors using MOFED data

The current public health expenditure pattern shows that 80% goes to salaries, and curative services consume a disproportionate amount of what remains meaning that preventative services and research receive relatively less. Whilst external funding is needed, it tends to target specific programmes at the expense of others creating resource challenges in other areas. Equitable mechanisms for allocating resources across health programmes, service levels and geographies are thus necessary. Equally important is the need to ensure that allocated resources are used appropriately and efficiently to achieve intended results. Performance based funding models (e.g. Results Based Financing - RBF) present opportunities for addressing these issues.

Overall, the health sector is underfunded and largely dependent on external funding for service delivery (over 40% Overseas Development Assistance – ODA - in 2012) given that most of government expenditure on health goes to salaries. This is unsustainable and necessitates looking at other innovative and sustainable ways of funding such as prepayment mechanisms and gradually reducing the share of external funding and OOP.

2.4 Overall burden of diseases

Although significant progress has been made over the last few years, the country still faces a double burden of communicable and non-communicable diseases. HIV prevalence remains relatively high at 15% amongst adults, and gains achieved to date are threatened by risky behaviors amongst youth and increasing number of teenage pregnancies. Deaths due to TB remain high due to its twin relationship with HIV and AIDS. Malaria remains a major cause of morbidity and mortality in the country and more so in some geographic areas. Therefore the focus on major communicable diseases must be sustained. At the same time, non-communicable diseases are indeed emerging as major causes of morbidity and mortality amongst both rich and poor in the country. The nutrition status of children remains poor. Outbreaks of anthrax and rabies are not unusual. The challenges are compounded by health systems constraints related to shortages of critical health workforce, aging infrastructure

and equipment, supply of medicines and other commodities, limited health funding currently \$24 per capita (2015 estimate) versus the recommended \$86 and general challenges with the service delivery platforms and the enabling environment.

Table 3 shows the top causes of OPD utilization in 2014 with Acute Respiratory Infection (ARI) at the top at 31%. Skin diseases, diarrhea, burns and other injuries contribute considerably to the outpatient diseases and conditions.

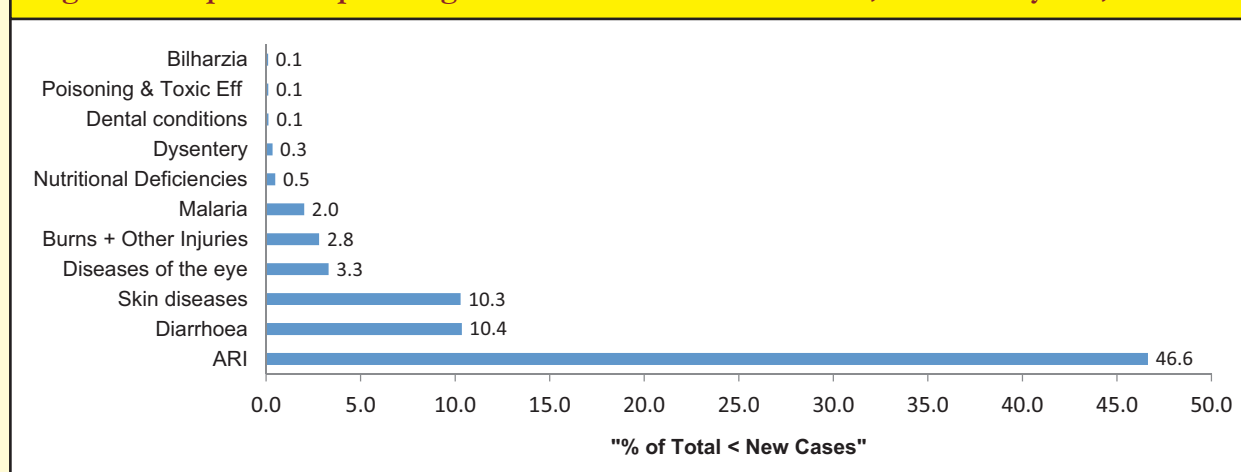
Table 3: Top ten out-patient general new diseases and conditions by all age groups (excluding STIs), 2014

Diseases/Conditions		Numbers	%
1	Acute Respiratory Infections	3,693,350	31.0
2	Skin diseases	959,885	8.1
3	Diarrhoea	763,136	6.4
4	Burns and Other Injuries	570,841	4.8
5	Malaria	535,931	4.5
6	Diseases of the eye	421,620	3.5
7	Dental conditions	178,948	1.5
8	Bilharzia	74,916	0.6
9	Dysentery	49,373	0.4
10	Nutritional Deficiencies	22,648	0.2

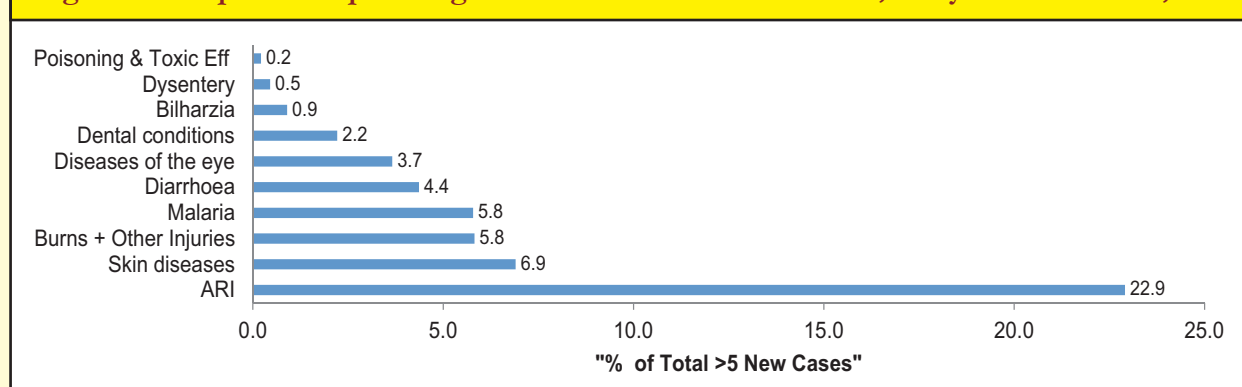
Source: MOHCC, 2014

Outpatient visits broken down by age (see Figures 9 and 10 respectively) show that the top five causes for under-fives visits in 2014 were ARI, diarrhea, skin diseases, diseases of the eye, burns and other injuries. For those five years and above, it was ARI, skin diseases, burns and other injuries, malaria and diarrhea.

Figure 9: Top ten out-patient general diseases and conditions, under-five years, 2014



Source: MOHCC, 2014

Figure 10: Top ten out-patient general diseases and conditions, five years and above, 2014


Source: MOHCC, 2014

Table 4 shows the top inpatient diseases and conditions for all age groups. It is clear that direct and indirect obstetric causes, normal delivery, conditions of the respiratory system, poisoning and toxic effects, ARI and certain conditions originating in the perinatal period contribute the most to this inpatient burden. Slight morbidity patterns are observed for the one to four years age group, and notable differences for those under one year old.

Table 4: Top ten inpatient diseases/conditions, All Age Groups, 2014

Rank	Disease/Condition	Cases
1	Direct & Indirect Obstetric Causes	137,286
2	Normal Delivery	84,940
3	Other Diseases of the Respiratory System	27,575
4	Poisoning and Toxic Effects	21,550
5	Acute Respiratory Infections	20,865
6	Certain Conditions Originating in the Perinatal period	16,554
7	Oral Cavity & Diseases of the digestive system	12,872
8	Parasitic Diseases	11,219
9	Intestinal Infections	10,638
10	Malaria	10,220

Source: MOHCC, 2014

The five major causes of hospital admissions in 2014 were direct and indirect obstetric causes (29.4%), normal deliveries (18.2%), other diseases of the respiratory system (5.9%), poisoning and toxic effects (4.6%), and ARI (4%).

Table 5: Top ten causes of hospital admissions, 2014

Diseases/ Conditions	Cases	%
Direct and Indirect Obstetric Causes	137286	29.4
Normal Delivery	84940	18.2
Other Diseases of the Respiratory System	27575	5.9
Poisoning and Toxic Effects	21550	4.6
ARI: Lower Respiratory Tract Infections & Influenza	18675	4
Certain Conditions Originating in the Perinatal period	16554	3.5
Oral Cavity & Diseases of the Digestive system	12872	2.8
Parasitic Diseases	11219	2.4
Intestinal Infections	10638	2.3
Malaria	10220	2.2

Source: MOHCC, 2014

Table 6 shows the national top twenty causes of mortality amongst Zimbabweans in 2014. The top five causes of death include ARI, conditions originating from perinatal period, TB, HIV and meningitis.

Table 6: National top twenty causes of mortality, all ages

Conditions/Diseases	Total Deaths
1 ARI	2,034
2 Certain conditions originating in the perinatal period	1,812
3 TB	1,134
4 Human immunodeficiency virus (HIV) disease all complications, AIDS and AIDS Related Conditions	853
5 Meningitis	823
6 Diarrhoea and gastroenteritis due to other infectious diseases (bacterial, viral, protozoal)	560
7 Heart failure (congestive and left ventricular)	510
8 Symptoms, signs and abnormal clinical & laboratory findings, not elsewhere	462
9 Other anaemias	455
10 Malaria	441
11 Renal failure	439
12 Other endocrine, vitamin, nutrients and nutritional deficiencies, obesity and metabolic disorders	403
13 Congenital infections and parasitic diseases, excluding HIV	402
14 Other diseases of intestines, including peritoneum	337
15 Cerebral infarction, Cerebrovascular accident (stroke) not specified as hemorrhage or infarction	270
16 Mycoses, including candidiasis	249
17 Intrauterine hypoxia and asphyxia	234
18 Other diseases of liver	223
19 Diabetes mellitus	206
20 Other heart diseases	194

Source: MOHCC, 2014

2.5 Priority Disease Control Programmes

In response to the current burden of diseases the MOHCC has priority disease control programmes namely:

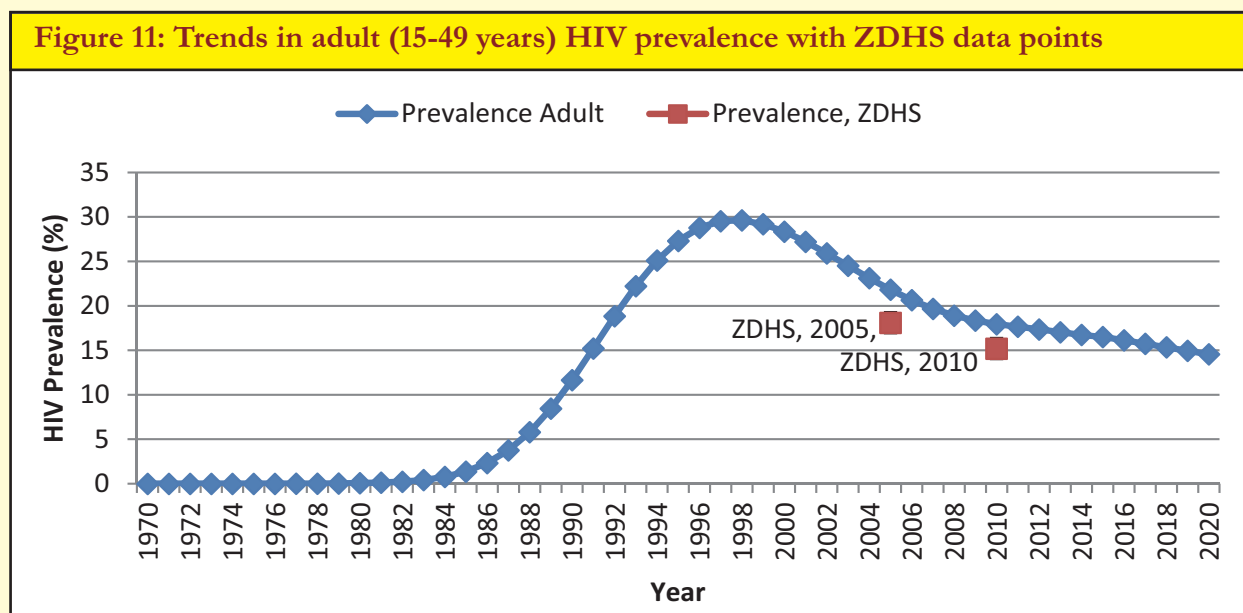
- a) Communicable disease programmes,
- b) Non communicable diseases and conditions programmes,
- c) Reproductive, Maternal, Newborn, Child Health and Adolescent Services, and
- d) Public health surveillance and disaster preparedness and response programme.

The strategy seeks to sustain and improve these flagship programmes as part and parcel of a holistic response to the current disease burden and potential risks of disasters.

2.5.1 Communicable Diseases

HIV and AIDS

HIV and AIDS remains a significant public health problem in Zimbabwe, threatening the socioeconomic fibre of the country and placing a tremendous strain on the capacity of the health sector to respond to the health needs of the population. The HIV prevalence for adults (15-49 years) has declined by 5.6% from 2011, to 15% in 2014 (UNAIDS 2014). A similar trend has been observed in younger adults (15-24 years) both male and female from the period 2011 to 2014 (Figure 11).



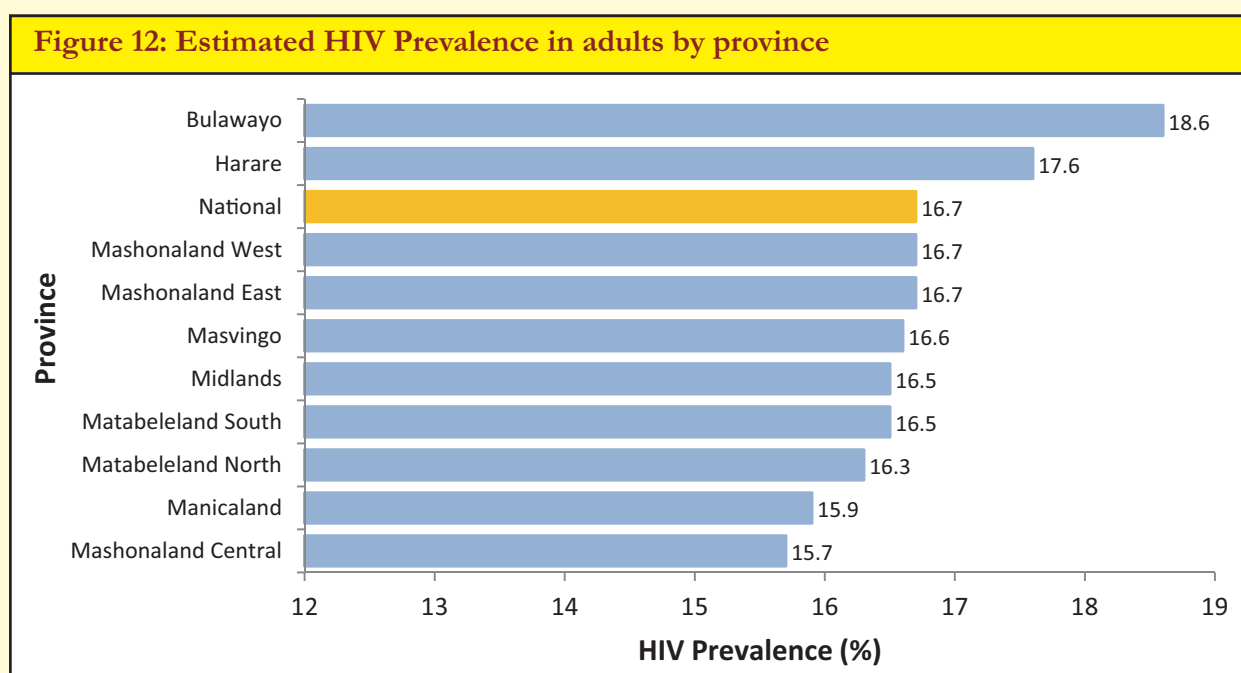
Source: ZDHS, 2005, 2010

HIV prevalence is consistently higher in urban areas compared to rural areas from 2011 to 2014. However, both urban and rural prevalence is gradually increasing (Table 7 below).

Place of residence	2011	2012	2013	2014
Urban	16.63	16.85	17.04	17.23
Rural	15.40	15.56	15.66	15.75
National	17.66	17.36	17.04	16.74

Source: MOHCC, 2015

The estimated HIV prevalence in adults by province is shown in Figure 12. The distribution of adults with HIV across provinces is variable, with Bulawayo having the highest prevalence and Mashonaland Central having the lowest (MOHCC, 2015).



Source: MOHCC, 2015

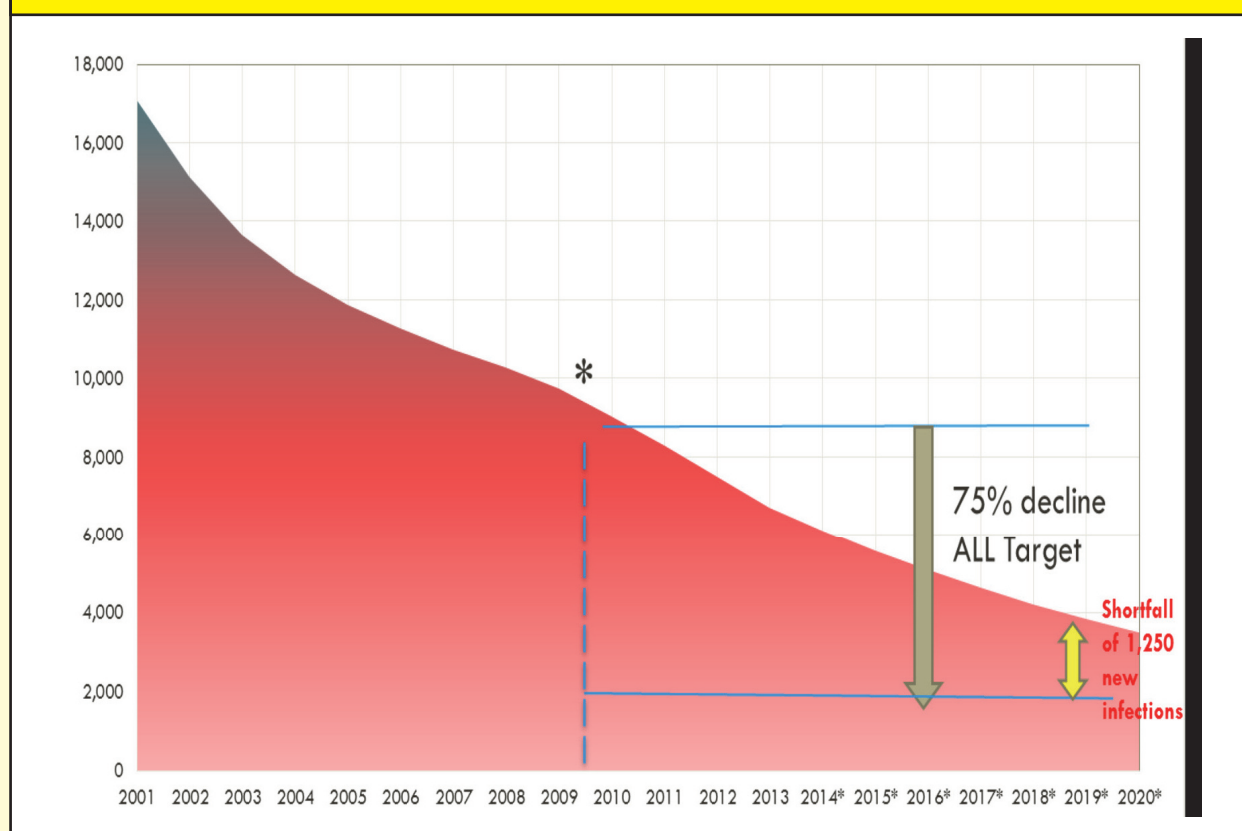
It is estimated that there were 63,848 new HIV infections in 2014 of which 9,086 (14%) were in children 0-14 years old. Generally there is a decline in the number of new HIV infections among both adults and children over the years (Table 8).

Table 8: Estimated number of new HIV infections by year

	2011	2012	2013	2014
Total New infections	80,626 (74,746 - 86,588)	69,177 (63,543 - 74,998)	65,425 (59,325 - 71,866)	63,848 (57,287 - 71,327)
New infections Adults 15+	62,715 (57,630 - 68,048)	59,600 (54,517 - 65,121)	55,437 (49,974 - 61,110)	54,762 (48,774 - 61,392)
New infections (0-14)	17,911 (16,093 - 19,841)	9,577 (8,237 - 11,174)	9,988 (8,518 - 11,609)	9,086 (7,633- 10,622)

Source: MOHCC, 2015

The estimated number of adolescents (aged 15-19) that are expected to have new infections has been declining, and it is anticipated to continue declining in the next five years (Figure 13). However, the decline by 2020 is expected to still be below the target number of 2,000 new infections. Therefore interventions targeting this group are critical.

Figure 13: Estimated number of adolescents (aged 15-19) newly infected with HIV, 2001-2020


It is estimated that 1,550,250 adults and children were living with HIV in 2014. Of the total number of people living with HIV in 2014, 9% (146,824) were children 0-14 years. In the same year, the proportion of women (above 15 years) living with HIV was 54%. The estimated population of adolescents (age 10-19) living with HIV is 108,484 while 117,299 young people (age 20-24) are living with HIV. The majority of adolescents living with HIV are female, and the gender disparities in HIV are wider in the 15-19 and 20-24 age groups.

Based on the total population living with HIV, Antiretroviral Therapy (ART) coverage for both adults and children has increased steadily between 2011 and 2014, from 36.8% to 51.9% and 23.5% to 34.2% respectively (Table 9). However, the number of people on ART in the private sector is unknown. Prevention of Mother-To-Child Transmission (PMTCT) coverage increased from 75% in 2013 to 78% in 2014. The estimated number of adolescents (age 15-19) newly infected with HIV in Zimbabwe has been declining gradually over the years.

Table 9: National ART programme coverage by year

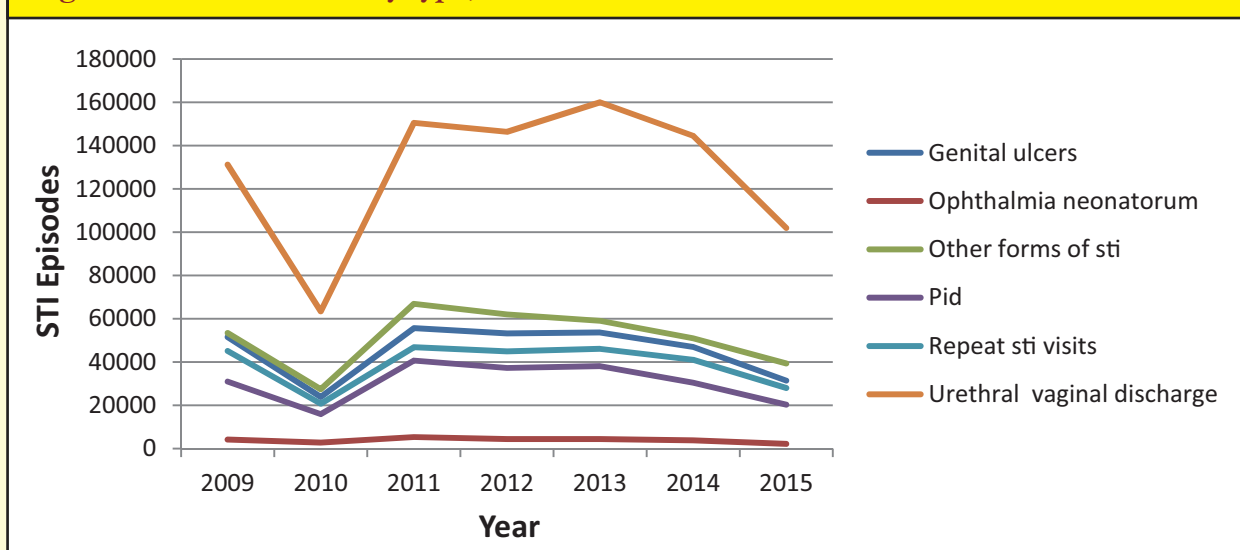
Year	People receiving ART as a percentage of total HIV population (%)				ART Coverage - National HIV Eligibility Criteria (%)				Mothers receiving PMTCT (% Coverage)	
	Adults		Children		Adults		Children		Estimate	95 % C.I
	Estimate	95 % C.I	Estimate	95 % C.I	Estimate	95 % C.I	Estimate	95 % C.I		
2011	36.8	36.7 - 36.9	23.5	23.5 - 23.3	73.8	73.7 - 73.9	55.8	55.4 - 56.2	50	46 - 54
2012	40.5	40.4 - 40.6	28.4	28.4 - 28.2	77.4	77.3 - 77.5	65.8	65.4 - 66.1	78	72 - 84
2013	45.9	45.8 - 46	27.7	27.7 - 27.5	83.6	83.5 - 83.7	57.8	57.4 - 58.1	75	69 - 81
2014	51.9	51.8 - 52	34.2	34.2 - 34	62.7	62.6 - 62.8	63.9	63.6 - 64.3	78	72 - 85

Source: MOHCC, 2015

Sexually Transmitted Infections (STI)

There has been a general decline in the number of clients presenting with STIs (Figure 14). In spite of the downward trend, these remain an important driver of HIV and the country needs a concerted effort to address the high numbers still being recorded. The number of unreported cases treated in the private sector, though unknown, is also a contributing factor to new HIV infections.

Figure 14: Trends in STI by type, 2009-2015

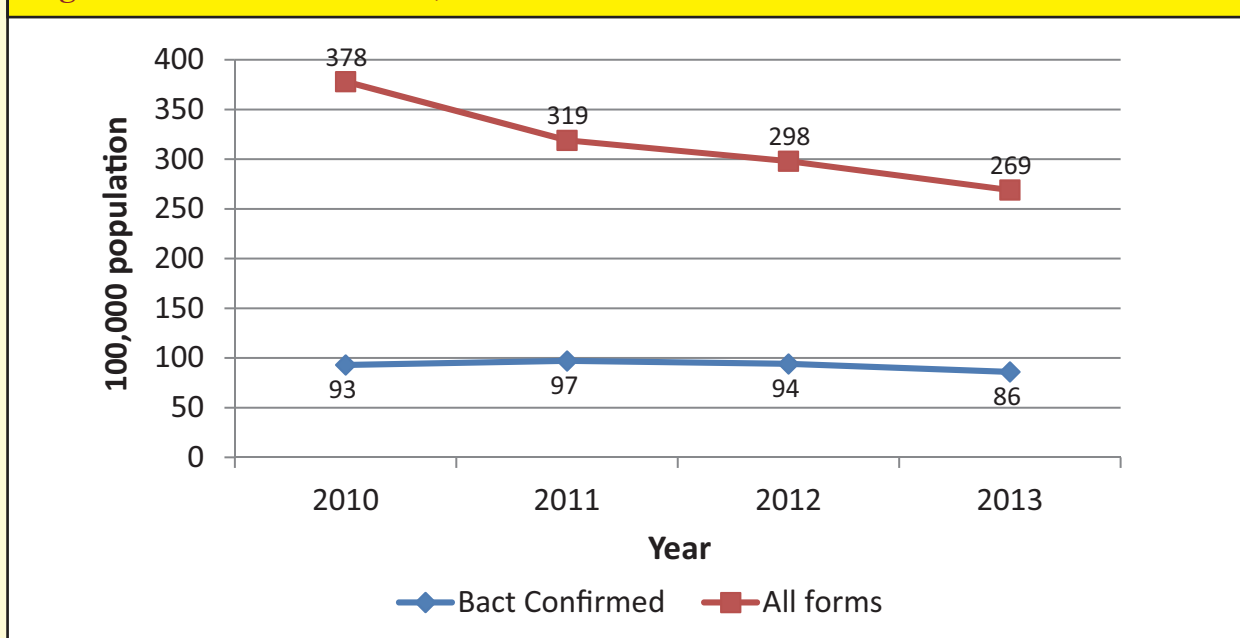


Source: MOHCC, 2015

Tuberculosis (TB)

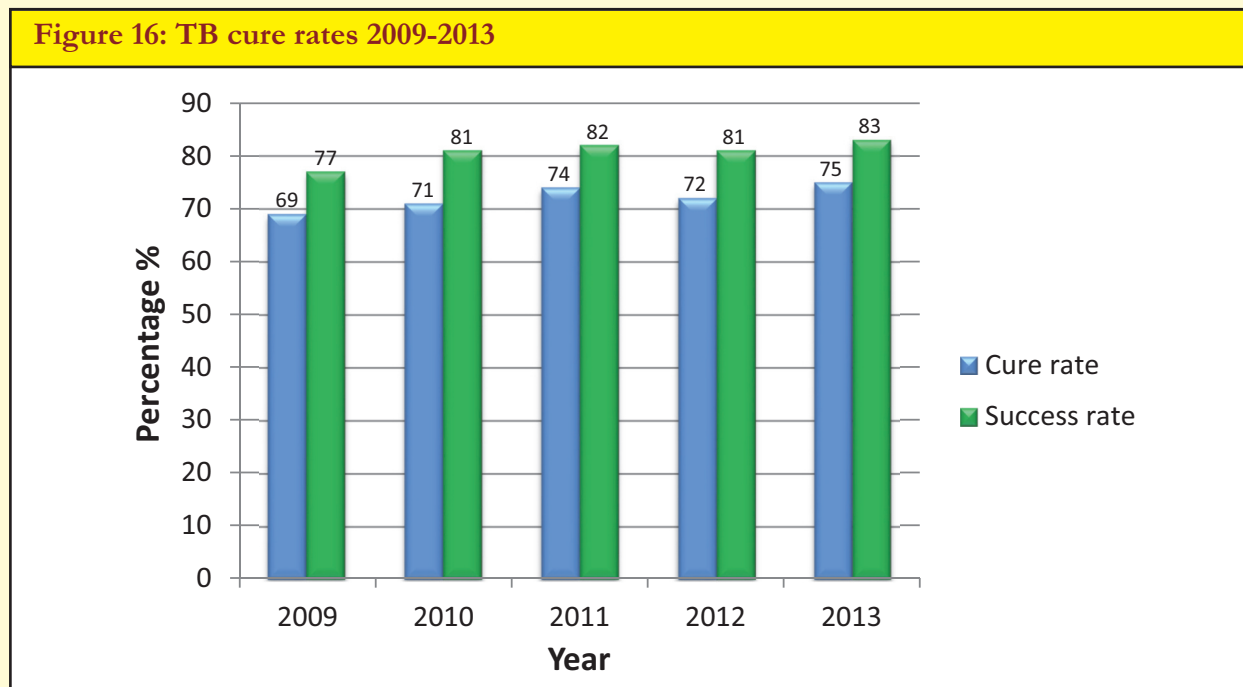
The number of new cases of TB notified has generally declined in the last few years, as seen in Figure 15 below. However, a figure of 269 per 100,000 population is still high by regional and global standards.

Figure 15: Trends in TB cases, 2010-2013

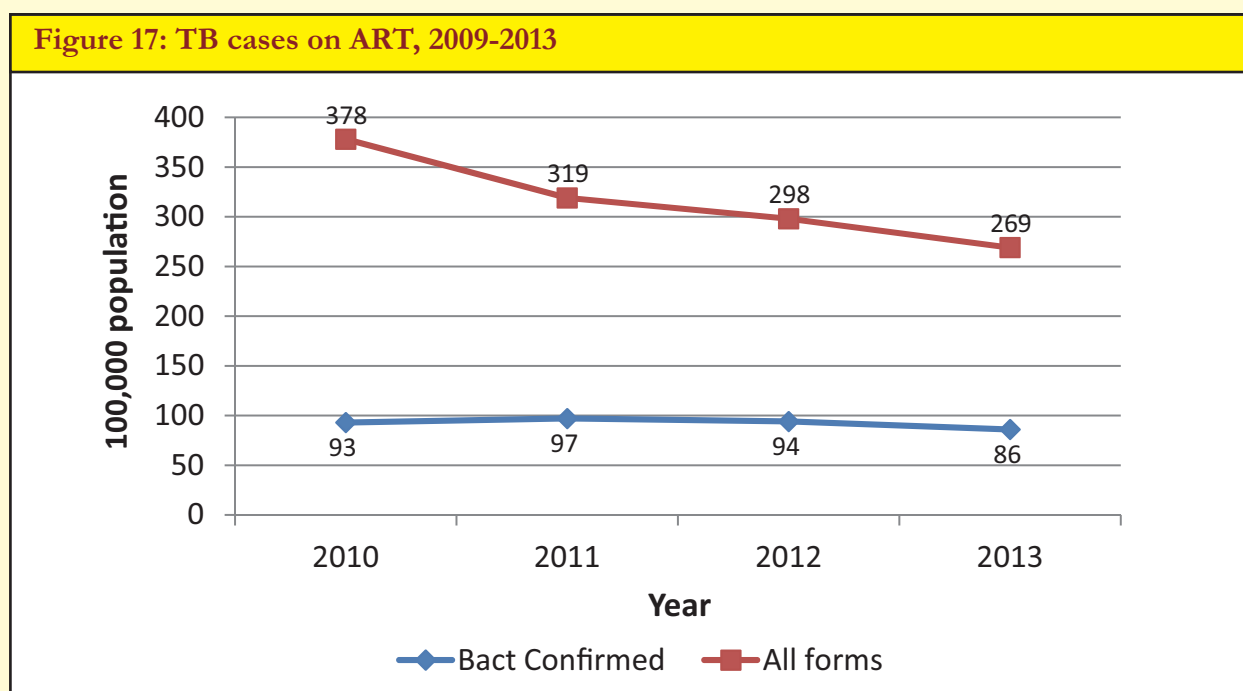


Source: MOHCC, 2015

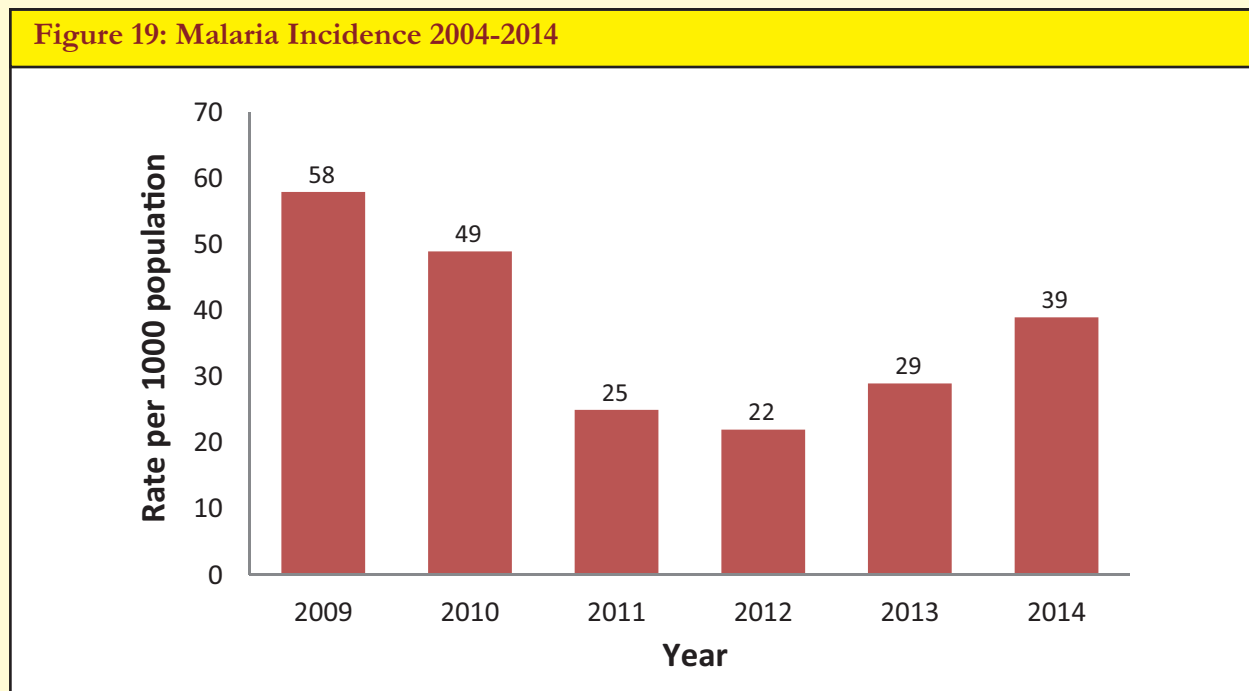
The country has seen an increase in the cure and treatment success rates of TB. However, this is still falls short on the national target of 87% (Figure 16). The mortality from TB remains high at 10%, and may be due to the HIV TB co-infections and rising incidence of drug resistant TB. ART coverage among HIV infected TB patients has improved significantly (Figure 17).



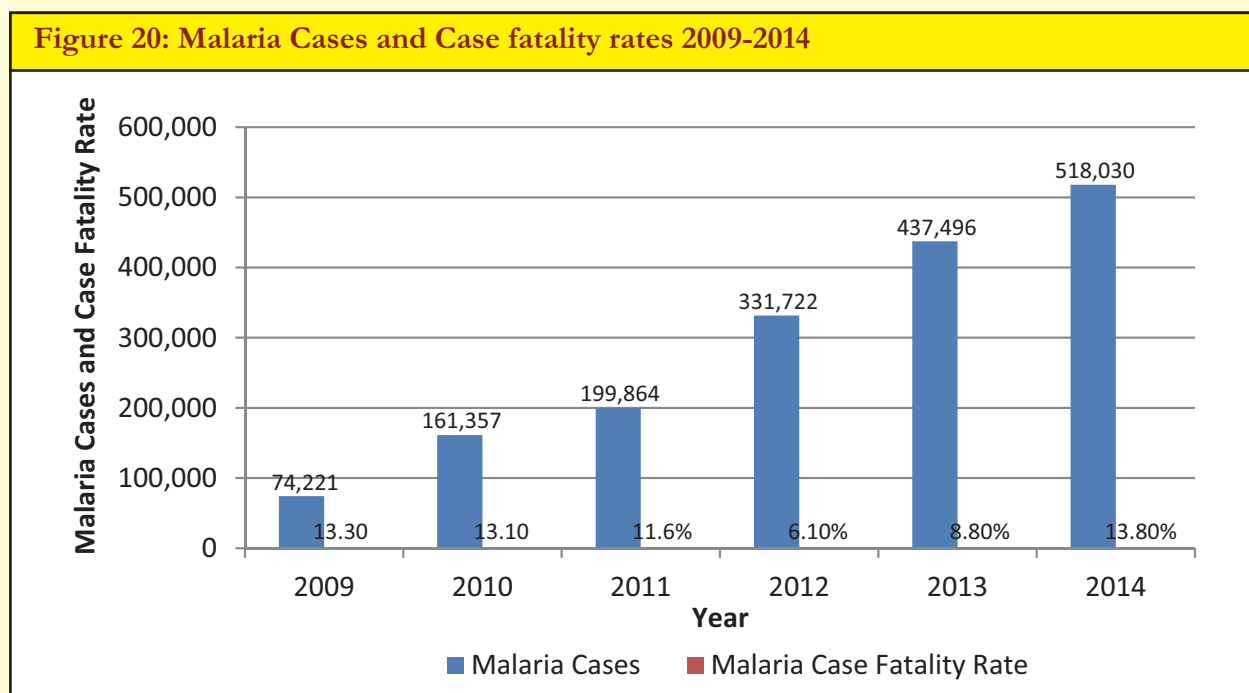
Source: MOHCC, 2015



Source: MOHCC, 2015



Source: MOHCC, 2015



Source: MOHCC, 2015

Other diarrheal diseases

The number of cases for diarrhoea has increased from 554,213 in 2010 to 763,136 in 2014 (Table 10). Annually, over 400 deaths from watery diarrhoea are reported. More than 50% of the deaths occur in children under the age of 5 years.

Table 10: Diarrhoea and Dysentery Cases, 2008-2014

Cases	2010	2011	2012	2013	2014
Diarrhoea	554,213	701,182	779,310	817,787	763,136
Dysentery	36,121	58,154	61,195	61,869	49,373

Source: MOHCC, 2015

Rabies

On average 150 animal cases of rabies are reported every year, though the condition is considered to be under-reported. In humans, cases of rabies have increased from two deaths in 2010 to sixteen in 2014. The challenge with rabies vaccination remains that of responsible pet ownership coupled with the high cost of vaccination and erratic supply of the vaccines.

Anthrax

Outbreaks of anthrax in livestock occur annually in Zimbabwe. The commonest form of anthrax in Zimbabwe is the cutaneous type, which is a zoonotic disease. This is due to the handling of carcasses during skinning and the consumption of infected meat against public health advice. The number of anthrax cases in humans has increased from 76 in 2010 to 135 in 2014.

Hepatitis

Hepatitis is a common cause of chronic liver disease in Zimbabwe but other viral infections are also important. The prevalence of viral hepatitis amongst Zimbabweans has not been systematically updated although the burden of disease is increasing. The WHO estimates that at least 1.5 million people worldwide are killed annually by this 'silent killer'.

2.5.2 Non-communicable diseases

Non-communicable diseases (NCDs), which include cardiovascular disease, cancer and diabetes mellitus, all of which are associated with the common risk factors of poor diet, insufficient physical activity, tobacco use, and alcohol abuse, caused 63% of all deaths globally in 2008 with more than 80% occurring in developing countries. Other common NCDs include injuries, eye and hearing conditions, epilepsy and mental illness. It is estimated that NCDs account for 31% of the total deaths in Zimbabwe (World Development Indicators 2012).

Obesity is a major contributor to NCDs. Initiating and sustaining behavior change related to diet and physical activity is a major challenge facing health professionals, policymakers, and researchers

worldwide in their efforts to reverse global obesity trends. Gathering insights on consumer attitudes and perceptions that affect their behavior, as well as establishing partnerships within communities to influence healthful behavior change, are critical steps.

Previous strategies have disproportionately considered communicable diseases in terms of funding and implementation and neglecting most, if not all of the non-communicable diseases. However, the burden of NCDs has significantly increased over the years and requires corresponding strategies to deal with it. For most of the NCDs, the last baseline study on prevalence was last conducted in 2005, and there has not been a national multisectoral NCDs prevention and control strategy and screening guidelines. This shows the extent of the neglect of these diseases over the last decade or so. Currently there are no health policies with regards to most NCDs and related risk factors such tobacco and alcohol.

Hypertension and Cardiovascular Diseases

According to the 2005 study, the Zimbabwe prevalence rate for hypertension was 27%. Globally 26.4% of the adult population in 2000 had hypertension (26.6% of men and 26.1% of women) and 29.2% were projected to have this condition by 2025 (29% of men and 29.5% of women). The total number of adults with hypertension globally in 2000 was 972 million, with 639 million in developing countries. The number of adults with hypertension in 2025 was predicted to increase by 60% to a total of 1.56 billion. The Global Burden of Disease (GBD) 2010 ranked blood pressure as the leading single risk factor for GBD. It has long been recognised that hypertension is an important risk factor for cardiovascular disease and mortality. Prevention, detection, treatment and control should therefore receive high priority. According to WHO, cardiovascular diseases account for 9% of the total deaths in Zimbabwe.

In 2014, new hypertension cases and follow-ups seen as outpatients amongst those aged 0-24 years were 671 and 3,905 respectively. Higher numbers were seen amongst those aged 25 years and above, with 23,605 new cases and 774,491 follow up visits in the same year. Hypertensive diseases accounted for 0.4% (1254) inpatients of all age groups in 2014. The bottleneck analysis showed that commodities (in particular essential medicines), geographic access and continuity with respect to scheduled reviews are the major bottlenecks on the management of hypertension.

Diabetes Mellitus

According to the 2005 study, the Zimbabwe prevalence of diabetes was 10% and WHO estimates that 1% of total deaths in Zimbabwe are due to diabetes. In 2014, the number of new cases and follow-ups seen as outpatients aged 0-24 years and 25 years plus were 769 and 1,986; and 8,658 and 102,077 respectively. A total of 4,679 cases were seen as inpatients and accounted for 24,633 patient days (MOHCC 2014). The major bottlenecks are commodities (in particular glucostrips and essential medicines), and initial utilisation of services. Proper monitoring of diabetes is crucial to mitigate the rate of complications arising from poorly controlled blood glucose levels. It is essential therefore that the strategies seek to address healthy life style and diet, improve commodities availability and screening services.

Cancer

Cancer is a disease that affects large numbers of people from all walks of life. It is emerging as a major public health concern in sub-Saharan Africa and is expected to double in the next twenty years. Cervical

cancer, though preventable and curable in its early stages, is the leading cause of cancer deaths in this region. In Zimbabwe, cancer is a major cause of morbidity and mortality with over 5,000 new diagnoses and over 1,500 deaths per year. According to WHO, cancers account for 10% of total deaths in Zimbabwe. The number of people developing cancer is expected to increase due to HIV and AIDS and other infections, unhealthy lifestyle choices and an ageing population. Most of the common cancers in Zimbabwe are infection associated.

A total of 3,519 new cancer cases were recorded among Zimbabweans in 2009, comprising 1,427 (40.6%) males and 2,092 (59.4%) females. According to the Zimbabwe National Cancer Registry (ZNCR) 2009 annual report, the five leading causes of cancer among black Zimbabwean men were: Kaposi sarcoma (20.8%), prostate (13.7%), oesophagus (6.3%), non-Hodgkin's lymphoma (6.2%) and liver (5.7%). The five most common cancers among Zimbabwean black women were cervical cancer (33.5%), breast (11.7%), Kaposi sarcoma (8.9%), eye (6.5%) and non-Hodgkin lymphoma (4.9%).

Diagnosis of cancer induces fear both in the individual and in families, and is frequently viewed as a death sentence. Its prevention, diagnosis and treatment poses great challenges particularly in resource constrained environments. There is reason for optimism however, as research indicates possibilities for major strides in its prevention and cure. There have been major improvements in the diagnosis and treatment of cancer, particularly in high income countries. However, adoption of new technologies in cancer diagnosis and treatment will place substantial and diverse pressure on the already overburdened and underfunded health delivery system, and therefore requires careful planning and resource mobilisation. Currently, over 5,000 new cancer cases are diagnosed (all types) in Zimbabwe annually. Experience has, however, shown that this is just the tip of the iceberg as many cancers are not captured by the routine National Health Information System because the patients do not present for treatment, or some deaths are not registered. Of those who do report, the majority are already at an advanced stage of disease due to limited access to screening services. The current cancer treatment and palliation services are unable to meet the existing demand. Additionally, and despite great progress in reducing HIV prevalence in recent years, Zimbabwe remains one of the countries most heavily burdened with HIV with an adult prevalence of 15%. The large number of people living with HIV results in an even higher number of people who will develop cancer in Zimbabwe. Meeting this increased demand and ensuring sufficient quality of services will require early and sustained decisions on investment, human resource planning and the re-organisation of health care services.

The bottleneck analysis revealed that both access to cancer screening services and initial utilization of services are the major bottlenecks in cancer management. Cancer prevention, early detection, control, palliative care and rehabilitation requires a population-wide, integrated and cohesive approach to cancer that encompasses prevention, screening, diagnosis, treatment and support, palliative and rehabilitative care. This calls for strong political, technical, and practical leadership as well as significant investment in terms of infrastructure and equipment, human resources, technologies, medicines and vaccines.

Injuries

WHO estimates that 8% of the total deaths in Zimbabwe are due to injuries. The most common injuries presenting at health facilities are primarily due to road traffic accidents and assaults. This has been compounded by poor prevention strategies, increasing traffic volumes coupled with ageing road infrastructure and uncontrolled animal movement. The challenge has been the proper management of these injuries owing to lack of appropriate skills in trauma management. In addition, pre and inter

hospital management of trauma remains a challenge particularly in rural areas. Imaging diagnosis has not been easy with secondary, tertiary and quaternary institutions lacking functional Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans. It is essential that specialists be availed to manage such cases. The general shortage of personnel at all levels is a contributory factor.

Oral Health

The burden of oral health problems is largely driven by lack of simple preventative measures as communities only seek care when they have specific dental problems. Whilst the school health programme has been effective in addressing oral health issues at schools, the same cannot be said of the wider communities. There still remains an unmet need for oral and dental services at all levels of the health care system. The major challenges facing oral health services include inadequate and inequitable distribution of personal (e.g. maxillo-facial surgeons); shortages of essential dental instruments and supplies especially at district level; inadequate x-ray machines; service vehicles to support supervisions and outreach activities, and the dental school infrastructure needs upgrading.

Rehabilitation

In Zimbabwe, effective coverage for rehabilitation is low at 30% owing to the low rehabilitation practitioner to patient ratio and Community Based Rehabilitation programme which is currently not receiving much attention. Retaining and re-attracting back rehabilitation practitioners remains a huge challenge. Focus should also be directed towards training and improving the availability of rehabilitation equipment and commodities and to strengthening mechanisms for early detection and management of injuries and disabilities. One of the root causes of poor continual utilisation is user fees, particularly when patients present for scheduled reviews. The rise of NCDs has also contributed to the increased demand for rehabilitations services.

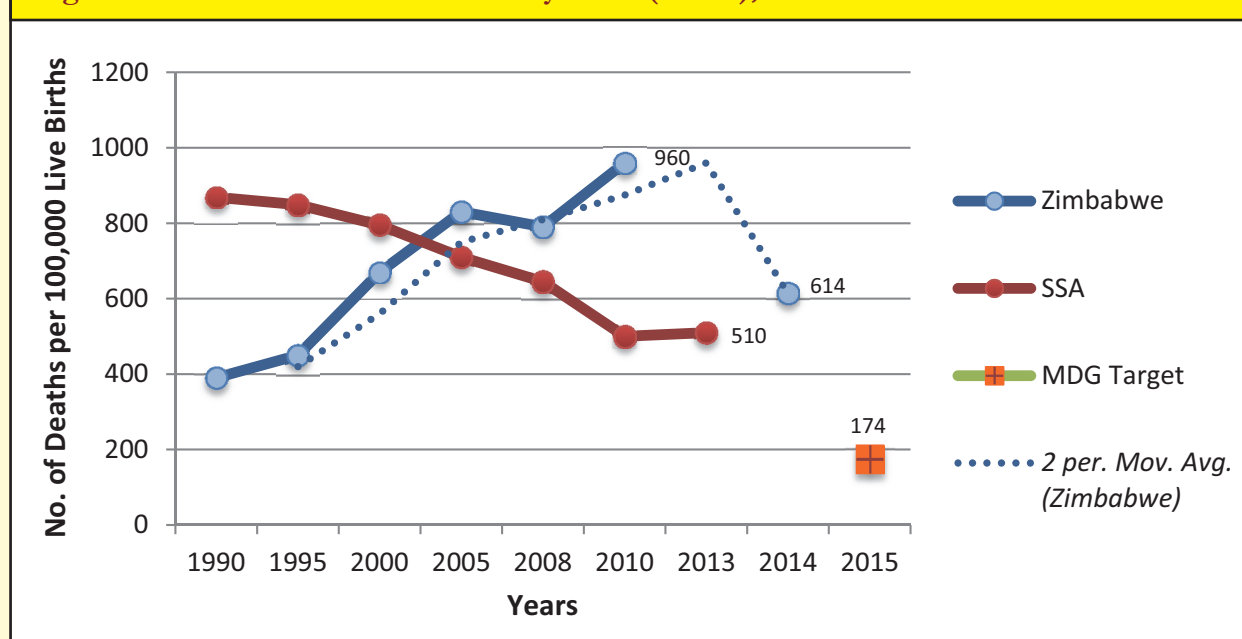
Mental Health

A lot of challenges in managing mental illnesses in the community arise from long standing cultural stigmatization. This directly impacts on the health seeking behavior of the population, and support for the mentally ill from families and communities. The bottlenecks identified are inadequate commodities (40%) and low initial utilization (20%). The low initial utilization is due to the stigma and cultural barriers. The health delivery system has not adequately paid attention to the availability of commodities and specialists personnel (doctors, nurses, clinical psychologists, etc.) to be able to provide quality mental health services.

2.5.3 Reproductive, Maternal, Newborn, Child Health and Adolescents

Maternal and Child Health

Major achievements were made in reducing the Maternal Mortality Ratio (MMR) from 960 maternal deaths per 100,000 live births in 2010-2011 (ZDHS) to 614 in 2014 (MICS) (Figure 21). However this still remains unacceptably high in comparison with the sub-Saharan regional average of 510 (2013) and falls short of the Zimbabwean MDG target of 174.

Figure 21 Trends in Maternal Mortality Ratio (MMR), Zimbabwe and Sub-Saharan Africa


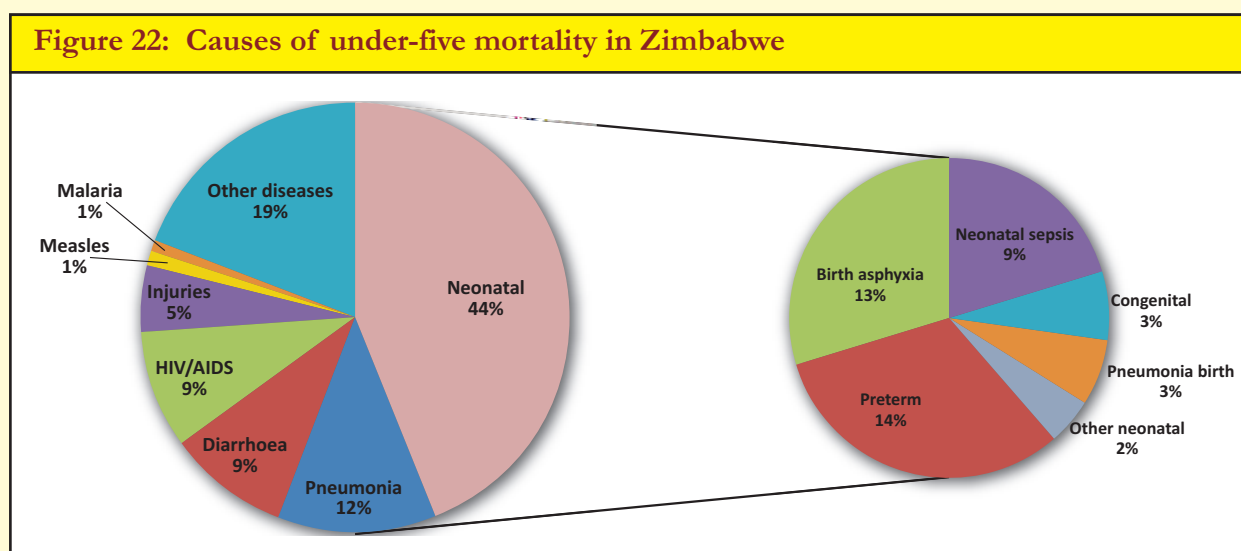
Source: World Bank 2014

Similarly, the under-five mortality rate dropped from 84 deaths per 1,000 live births in 2010/11 to 75 in 2014 but falls short of the 2015 MDG target for Zimbabwe of 25. The infant mortality rate decreased from 57 deaths per 1,000 live births in 2010/11 to 55 in 2014.

According to the World Health Organization Global Health Data (2014), 2,100 maternal deaths reported in Zimbabwe in 2013 were due to causes that are known, preventable and treatable. The major direct causes of maternal deaths were haemorrhage (34%), pregnancy induced hypertension (19%), unsafe abortion (9%), sepsis (9%) and the indirect causes included AIDS defining conditions and malaria (18%), and other direct causes (11%). According to the Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS 2007), the majority of maternal deaths (63%) occur in the postpartum, 24% in the antenatal, and 6.6% in the intrapartum periods. The same study also revealed that successful treatment of direct causes of maternal death could reduce maternal mortality by 46%. The 2013 HMIS data showed that 87% of the reported maternal deaths occurred at health facilities and 13% at home (although the picture could have been distorted by under-reporting of community maternal deaths).

Adolescents and young people contribute significantly to maternal deaths. Zimbabwe has a youthful population, with two thirds of the population below the age of 25 years. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for youth are either deteriorating or remaining high. The adolescent fertility rate in 2014 was estimated at 120 births per 1,000 women aged 15-19 years (MICS 2014). According to 2010/11 Zimbabwe Demographic Health Survey, 20.5% of women aged 20-24 years have had at least one live birth before the age of 18 years. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become a mother as their urban counterparts. The decline of the Maternal Mortality Ratio among women of 15-19 years at 21% is much slower than the average decline of 43% for women of 15-49 (MICS 2014).

The major causes of death among children under one year are respiratory and perinatal conditions; for those between one and four years it is mainly nutritional deficiencies, followed by respiratory conditions. Intestinal conditions are also a major cause of death, ranking third for both age groups. Nearly half (44%) of the under-five mortality is a result of neonatal causes (MICS 2014). Pre-maturity, birth asphyxia and sepsis are the major causes of neonatal deaths (Figure 22).



Source: WHO/CHERG 2014

The gains in health outcomes can be attributed to the implementation of high impact interventions which have seen improvements in key coverage indicators. The number of pregnant women booking for antenatal care is 94% whilst those delivering in facilities with skilled birth attendants is 80%. Immunization coverage has improved in the past years with at least 83% of children being immunized against measles in 2014, up from 76% in 2009. According to the MICS 2014, 92% of children had received BCG vaccination. Despite the high national coverage in utilization, there is still variation in performance by provinces as indicated in Table 11 below.

Table 11: Selected MNCH coverage indicators by province, 2014

Indicators	National	Byo	Manica.	Mash. Central	Mash. East	Mash. West	Mat North	Mat South	Midlands	Masvingo	Harare	Urban	Rural
ANC 1	93.7%	96.0%	91.1%	93.3%	91.2%	93.5%	98.4%	96.4%	93.0%	93.4%	93.7%	95.3%	93.0%
Institutional deliveries	79.6%	94.3%	72.0%	71.0%	80.3%	73.3%	88.7%	84.2%	75.6%	75.1%	89.7%	92.7%	74.2%
BCG	94.7%	96.3%	94.6%	94.6%	91.1%	92.1%	99.3%	95.3%	97.7%	92.6%	96.1%	96.8%	93.9%
Measles	87.6%	90.8%	86.7%	85.2%	86.6%	87.0%	93.0%	92.2%	91.1%	78.1%	89.0%	90.3%	86.5%

Source: MICS data by province

Furthermore, the effective coverage indicators show notable gaps that could explain the mismatch between the high coverage and the impact indicators (e.g. women attending 4 or more ANC visits, 70% - MICS 2014, full immunization coverage, 69%, PNC 6 weeks, 55% - HMIS).

Nutrition

Nutrition is prioritized in Zim-Asset, under cluster one. In addition, the GOZ has endorsed a multi-sectoral Food and Nutrition Security Policy and a National Nutrition Strategy. Commitment IV of the Food and Nutrition Security Policy focuses on Food Safety and Standards, and it commits to the provision of safe and wholesome food to all through monitoring and enforcement of all locally produced and imported foods to meet national Public Health legislation and international standards for quality and safety.

Adolescent and Maternal Nutrition

The nutrition status of a woman before and after pregnancy plays a significant role in ensuring good maternal outcomes. Of concern is the rising trend in overweight and obesity among urban women who according to the National Micronutrient Survey of 2012, were more likely to be overweight (27 percent) and obese (17 percent) compared to their rural counterparts, 19 percent and 11 percent respectively.

Infant and Young Child Nutrition

Recent MICS 2014 results indicate that there is a downward trend in stunting from 35% in 2005/6, to 27.6% in 2014 with noted disparities in Zimbabwe. Stunting remains high in rural areas (30%), compared to 20% in urban areas and there are gender disparities. Of concern is that 10% of children are born already stunted and this points to a need for maternal, pre-pregnancy and adolescent nutrition interventions.

Infant and Young Child Feeding Practices

In Zimbabwe, the majority of babies (98%) are breastfed, but sub-optimal breastfeeding practices put them at risk. The recent MICS survey showed an improving trend in exclusive breastfeeding rates among children zero to five months, from 26% in 2009 (MIMS) to 41% in 2014 (MICS).

Nutritional Status of Men

The 2010 ZDHS reports that 9% of men aged 15-54 years are overweight or obese, while 15.2% are underweight (BMI <18.5) and 75% of men were found to have a normal weight. Overweight and obesity is higher in urban areas (11.4%), compared to 5.7% in rural areas. Zimbabwean men in the highest wealth quintile and those with more than secondary education and older than 30 years of age were found to have a higher prevalence of overweight and obesity.

2.5.4 Public health surveillance and disaster preparedness and response

Building a resilient health system requires an effective public health surveillance and disaster preparedness and response programme. Zimbabwe is prone to man-made and natural disasters such as floods and drought, which have major implications on the health status and survival of the

population. The recent outbreak of Ebola in West and Central Africa and the potential threat of such epidemics to the population points to the need for a robust health surveillance and disaster prepared and response programme across sectors and at national and sub-national levels.

Epidemic prone diseases that are a threat to public health in Zimbabwe include diarrhoeal diseases such as typhoid, dysentery and cholera, and zoonotic diseases such as anthrax, rabies and plague. Outbreaks of malaria particularly in areas that are not known to be malaria prone support the need for a robust surveillance to detect the spread of diseases.

Between August 2008 and July 2009, Zimbabwe faced an unprecedented cholera outbreak that resulted in 98,592 cases and 4,288 deaths. The number of cholera cases reported post 2009 has declined from 1,022 in 2010 to zero in 2014. The case fatality rate of cholera has declined from 2.1% in 2010 to zero in 2014. The country remains at risk for cholera due to low safe water and sanitation coverage. The highest number of cholera cases have been reported in Chiredzi and Masvingo districts in the last five years.

Environmental Health Services

Environmental Health seeks to address all physical, biological, chemical, social and psychosocial factors in the environment. The theory and practice of assessing, correcting, controlling, minimizing and preventing those factors potentially affect the health of present and future generations. The environment in which people live is a key determinant to the levels of exposures, morbidity and mortality. The constitution of Zimbabwe Section 29 (3) mandates the state to take all preventive measures within its limits of resources available to it including education and public awareness programmes, against the spread of diseases. Section 73 reinforces that every person has the right to an environment that is not harmful to their health or wellbeing, and the environment protected for the benefit of present and future generations, whilst Section 77 of the same constitution gives Zimbabweans the right to safe, wholesome, potable water and sufficient food. The following sections of the constitution, Section 28 (Housing Legislation), 32 (Sporting and Recreation facilities legislation), 34 (Domestication of international instruments/conventions) all affect environmental health.

The major challenge facing environmental health services is funding to support training of new and existing environmental health staff, improvement of water and sanitation infrastructure, inspections and outreach visits. Provision of protected water sources and improved sanitation remains a priority as coverage remains low and there are notable rural and urban differences. For example, 47% of households in urban areas and 30% in rural areas used improved sanitation facilities. Environmental health services by their nature require mobility to support supervision, general inspections and health education. Currently, enforcement and compliance with such legislation is limited because of limited resources

Table 12: Water and sanitation

MICS Indicator		Indicator	Description	Value
4.1	MDG 7.8	Use of improved drinking water sources	Percentage of household members using improved sources of drinking water	76.1
4.2		Water treatment	Percentage of household members in households using unimproved drinking water who use an appropriate treatment method	12.0
4.3	MDG 7.9	Use of improved sanitation	Percentage of household members using improved sanitation facilities which are not shared	35.0
		Open defecation	Percentage of household members with no facility	31.7
4.4		Safe disposal of child's faeces	Percentage of children age 0-2 years whose last stools were disposed of safely	57.8
4.5		Place of hand washing	Percentage of households with a specific place for hand washing where water and soap or other cleansing agent are present	50.5
4.6		Availability of soap or other cleansing agent	Percentage of households with soap or other cleansing agent	55.8

Source: MICS, 2014

2.6 Synthesis of Emerging Issues From the Analyses

2.6.1 SWOT analysis

The Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis highlighted key issues for further analysis and indeed broader areas that needed to be addressed by the strategy (see SWOT synthesis report). These are summarized in Table 13 below.

Available information from MICS (2014) showed that 76% of household members had access to improved sources of drinking water (Table 12). Only 35% of household members reported using improved sanitation facilities. Challenges still remain around open defaecation, low use of improved sanitation, safe disposal of faeces and hand washing in the country, which suggests that a significant number of the population is at risk from water and sanitation related diseases. Food monitoring is at 56% according to MICS (2014) (i.e. iodized salt monitoring).

Table 13: SWOT Analysis

Strategic Area	Key Issues for the strategy
Policy and Administration	<ul style="list-style-type: none"> - Enhance Regulatory & Coordination Capacity <ul style="list-style-type: none"> ◆ Practitioners ◆ Health financing <ul style="list-style-type: none"> ● Collection, Pooling, Allocation ◆ Implementing partners - Align & synchronise policies to the National Strategy - HRH Administration, Management & Policy Capacity <ul style="list-style-type: none"> ◆ Training ◆ Recruitment <ul style="list-style-type: none"> ● Posting & Transfer ◆ Retention <ul style="list-style-type: none"> ● Career progression ● Supportive Supervision, Mentorship ● Performance Evaluation & Remediation ◆ Exit from service - Review of the organizational structure of the MOHCC at national and subnational levels & management capacities - Creation of an overall M&E framework - Introduction of quality management systems - Procurement and Supply Chain Management - Core Health Services Package
Public Health	<ul style="list-style-type: none"> - Specific focus on public health emergencies and preparedness including mass casualties - Capacitate environmental health and community nursing services - Government Analyst Laboratory upgrading & linkage with other strategic laboratories e.g. in Ministry of Agriculture laboratories - Enhance infection control strategies - Capacitating Port Health Service & International Health Regulations (IHR) 2005 - Need for an integrated school health care programmes - Integrated communicable and non-communicable disease programmes
Primary Care	<ul style="list-style-type: none"> - Introduce integrated community services through multi-sectoral partnerships - Coordination, capacity building of community based health workers - Decentralization of health services - Capacity building on management of health services - Need to promote and build capacity for health research
Hospital Services	<ul style="list-style-type: none"> - Institutional leadership & governance - Update procurement system guidelines - Invest, maintain, upgrade hospital infrastructure, equipment, transport and communication systems - Promote research and utilization of research findings - Strengthening referral systems

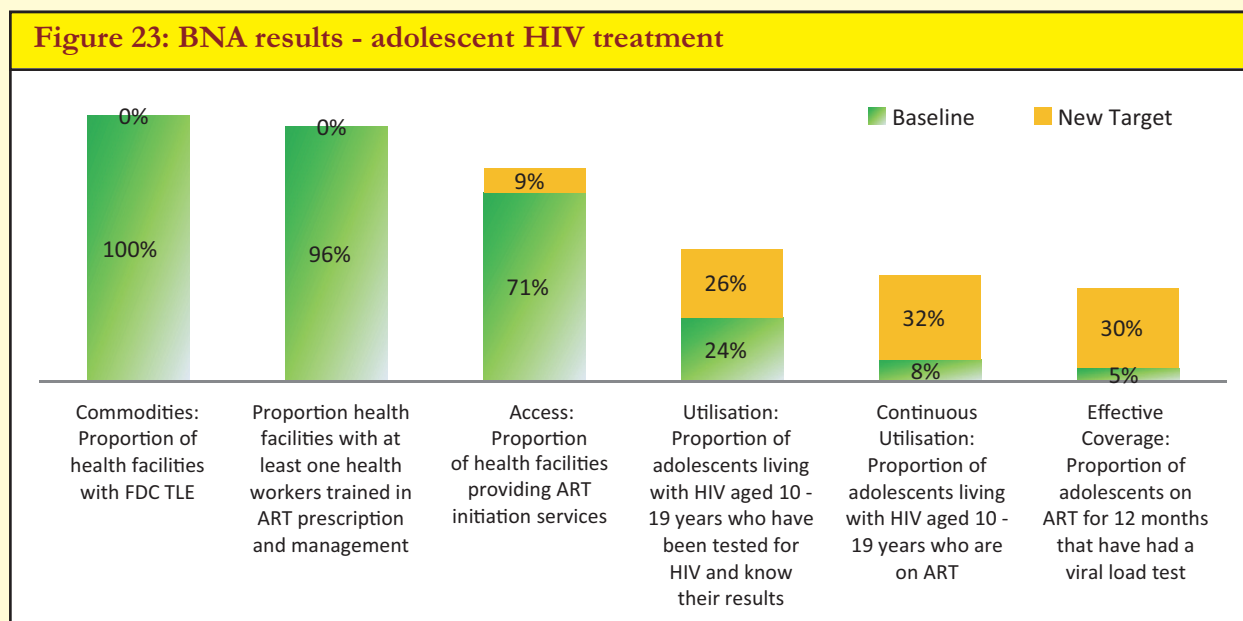
2.6.2 Bottleneck analysis

For a detailed understanding of the existing bottlenecks and indeed root causes to current health sector performance, a Bottleneck Analysis (BNA) was conducted for selected tracer conditions. The tracers were systematically selected to highlight specific programmatic areas that form part of the strategic pillars of this strategy (Table 14).

Table 14: Selected Tracer Conditions for BNA

Tracer Areas	Thematic Interventions	Tracer Areas	Thematic Interventions	Tracer Areas	Thematic Interventions
Health promotion	<ul style="list-style-type: none"> • WASH • Gender based violence • Life skills education/ school health 	HIV and AIDS	<ul style="list-style-type: none"> • STI • PMCT • Adult treatment • Paediatric treatment • Key populations (sex workers) 	Mental Health	<ul style="list-style-type: none"> • Epilepsy • Substance abuse
Maternal and newborn health	<ul style="list-style-type: none"> • Family Planning (Adolescent) • Focused ANC • Skilled delivery • EmONC • PNC/Neonatal sepsis/Asphyxia HBB/Prematurity 	TB	<ul style="list-style-type: none"> • TB treatment • DR-TB • Paediatric TB 	Disability and Rehabilitation	<ul style="list-style-type: none"> • Accident and emergency • Prevention of disability • Rehabilitation
Child Health	<ul style="list-style-type: none"> • Immunization • Community iCCM (Pneumonia, Malaria, Diarrhoea) 	Malaria	<ul style="list-style-type: none"> • LLIN • IRS • ACT treatment 	Elderly	<ul style="list-style-type: none"> • Old age program
Adolescent health	<ul style="list-style-type: none"> • Adolescent pregnancy – SRH (Community/HF) • Adolescent HIV treatment 	Communicable diseases	<ul style="list-style-type: none"> • Epidemic Prone Diseases • Outbreak control (Cholera, dysentery, rabies) 	Cross-cutting health system issues	<ul style="list-style-type: none"> • e-HMIS • Policies
Nutrition	<ul style="list-style-type: none"> • EBF • Minimum acceptable diet • Micronutrient supplementation (Pregnant Women and Adolescents) • Healthy life style/ obesity • Clinical nutrition services • Community IYCF • Growth monitoring • SAM 	NCDs	<ul style="list-style-type: none"> • Hypertension (BP) • Diabetes • Cervical Cancer • Obesity • Eye health • Cardiovascular diseases • Injury and violence • Eye and hearing program 	General Health Services	<ul style="list-style-type: none"> • Pre/eclampsia • Severe malaria

The BNA looked at a number of related dimensions: enabling environment (policy, administration, coordination mechanism, financing etc.); commodities; human resources; access; initial utilization; continuity, and quality. As qualitatively shown in the SWOT analysis, the BNA highlighted the specific bottlenecks in relation to commodities supply and security; the human resource capacity needs; determinants of access issues, and the factors influencing first contacts and follow-up, and more importantly quality. Figure 23 shows the typical BNA results for adolescent health—HIV treatment.



Source: BNA, 2015

Overall, the bottleneck analysis revealed that despite the high service coverage, the quality of care at all levels remained poor or sub-optimal, there was weak programme integration resulting in missed opportunities, and there was lack of continuum of care along the life cycle (newborns, adolescents) and across service delivery levels (community level, tertiary level). Financial barriers impeded access to services, especially by vulnerable groups due to high user fees (at hospital level and in urban areas), as well as inequitable geographical distribution of health facilities especially in new settlement areas. There was significant negative influence of religious and other socio-cultural objectors on care seeking. Limited fiscal space resulted in inadequate allocation of Government resources for service delivery. The main challenge remains of how to mobilise adequate resources to sustain health services, against a national economy that has yet failed to recover and changing donor priorities. The current shortage of qualified staff with the required attitude and skills will continue to compromise quality and equity. These challenges must be addressed over the strategy period.

3.1 Overall Structure of the Strategy

The overall strategy structure is informed by the programme based budgeting format recently assumed by the MOHCC. This structure recognizes the need to link resources to results. The vision and mission are described including the underpinning principles to this strategy. The key results areas that this strategy seeks to achieve are then summarized upfront, and this is followed by the proposed strategic responses by **priority programmes**: Communicable diseases; non-communicable diseases; Reproductive, Maternal, Newborn, Child Health and Adolescents) and Public health surveillance and disaster preparedness and response.

The **services delivery platforms or entities** (Primary Care Services and Hospital Care Services) for implementing the identified strategies are then described followed by a description of the **enabling environment for service delivery** (Policy Planning and Coordination, Human Resources, Finance and Administration, Procurement and Supply Chain Management, Monitoring and Evaluation, Provincial Administration, Multi-sectoral Partnerships, and Research and Development). Cross-cutting issues including quality and equity, gender, and community participation are integrated across the priority programmes and service delivery platforms or entities.

This strategy is informed by the situation analysis, and the need to improve quality of services and enhance equity in access and health outcomes. The strategy implementation framework that demonstrates how these strategies are linked to the desired outcomes is described followed by the estimated costs and funding options for the strategy.

3.2 Vision

To have the highest possible level of health and quality of life for all Zimbabweans

The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all Zimbabweans. This is to be attained through the combined efforts of individuals, communities, organizations and the Government, which will allow Zimbabweans to participate fully in the development of the country. This vision will be attained through guaranteeing every Zimbabwean access to an essential health services package. The Ministry of Health and Child Care has therefore committed to the following Goals or Key Result Areas (KRAs):

- Strengthening priority health programmes
- Improving service delivery platforms or entities, and
- Improving the enabling environment for service delivery

The ultimate goal is to have a healthy population with equitable access to quality services through a strengthened health system.

3.3 Mission

To provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to all Zimbabweans while maximizing the use of available resources, in line with the Primary Health Care Approach

3.4 Principles and values

Underpinning the Ministry of Health and Child Care's vision and mission are the following values:

- Equity in health status and health care
- Gender equality
- Essential quality services
- Cost effectiveness
- Efficiency
- Appropriateness
- Social solidarity
- Affordability
- Client and provider satisfaction
- Transparency and accountability
- Ownership and partnership in health, and
- Continuous Monitoring and evaluation.

Achieving the mission of the Ministry of Health and Child Care will be realised through:

- Strengthening the Primary Care Approach as the main strategy for health development
- Resource mobilization for health to ensure predictable and sustainable resources
- Strengthening multi-sectoral partnerships in health services and care guided by the principle of three ones (one national plan, one coordinating mechanism and one monitoring and evaluation mechanism), and
- An adaptive and reforming health sector

3.5 Key Result Areas

Over the next 5 years, the Ministry of Health and Child Welfare seeks to attain clearly defined performance targets (Table 15). This National Health Strategy defines and explains strategies for attaining these goals and targets for the priority programmes; service delivery platforms or entities, and the enabling environment for service delivery. It presupposes an effective referral system that ensures continuum of care and that clients are seen at appropriate levels of care. The primary care level should be the first contact with the health care system and hence performs the key gatekeeping role and ensures appropriate referrals to higher levels of care. The strategy has three overall strategic goals and twenty objectives.

Table 15: Key Result Areas

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Goal 1: To strengthen priority health programmes				
Priority 1: Communicable diseases	1. To reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020 and malaria deaths to near zero by 2020	Malaria incidence	39	5
		Malaria deaths	654	0
	2. To ensure timely detection and control of epidemic prone diseases	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	100%
	3. To reduce morbidity due to Schistosomiasis and soil transmitted helminthes and other NTDs by 50% by year 2020.	Prevalence of STH and SCH	22.7% (for SCH/STH)	10%
	4. To prevent new HIV infections and to reduce deaths due to HIV by 50%	% people who are tested and know their status	40.3% (men) 56% (women)	85%
		% of people on ART	TBD	90%
5. To reduce mortality, morbidity and transmission of tuberculosis by 90%	% of ART patients virally suppressed	TBD	90%	
	Mortality rate	10%	< 5%	
Priority 2: Non-communicable Diseases	6. To reduce the incidence of selected Non-Communicable Disease (NCDs) by 50 %	% reduction in NCDs burden	0%	5%
	7. To improve the mental health status of the population	% increase in number of diagnosed mentally ill to the expected mentally ill patients	TBD	90%
	8. To reduce disability and dependence by 50%	% patients under CBR to total rehabilitation patients	TBD	TBD
	9. To improve the quality of life of elderly persons and improve life expectancy from 61.5 to 65 years by 2020	% of older persons that receive geriatric care	TBD	100%
Priority 3: Reproductive, Maternal, Newborn, Child and Adolescents	10. To reduce maternal mortality ratio from 614 to 300 by 2020	MMR	614	300
	11. To reduce Neonatal Mortality Rate from 29 to 20 deaths per 1,000 live births	NMR	29	20
	12. To reduce the under-five mortality rate from 75 to 50 deaths per 1,000 live births	<5 mortality	75	50
	13. To reduce mortality and morbidity due to malnutrition by 50%	Proportion of children under 5 years stunted	28%	19%

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Priority 4: Public Health surveillance and disaster preparedness and response	14. To strengthen environmental health services, early detection of disease outbreaks and man-made disasters from 30% to 50% by 2020	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	50%
		% of districts with functional coordination mechanism	50%	100%
		Percentage of household members using improved sanitation facilities which are not shared	35%	50%
		Percentage of household members using improved sources of drinking water	76.1%	TBD
Goal 2: To improve service delivery platforms or entities				
Primary Care	15. To reduce morbidity by at least 50% through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level	Proportion of villages with community based health workers	<60%	>90%
		% districts implementing Essential Primary Health Benefits	0%	100%
Hospital Services	16. To ensure universal access and provision of complementary package of hospital services including emergency and ambulatory curative services	% of hospitals with Quality Management Systems	TBD	
		% of hospitals with functional theatre services	TBD	
	17. To ensure universal access and provision of quality tertiary specialist curative services	% of tertiary hospitals with specialists	TBD	100%
	18. To promote and support provision of quality palliative care services	% of patients and families needing palliative care who are receiving it	200,000 in need	40% (80,000 people)
Goal 3: To improve the enabling environment for service delivery				
Policy Planning and Coordination	19. To improve health outcomes through facilitation and co-ordination of an effective and efficient health delivery system	% of policies and strategies aligned to the NHS	0	100%
Human Resources		Overall vacancy rate	17%	10%
Finance and Administration		Number of institutions audited against the plan	TBD	82 cost centres
		Number of districts with functional PFMS	0	62

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Monitoring and Evaluation		Harmonised M&E policy framework	01	1
Provincial Administration		% of actual to planned PHT reviews convened per year	TBD	100%
Procurement and supply chain management		% availability of essential medicines	42%	80%
Multi-sectoral Partnership	20. To strengthen multi-sectoral collaboration with local and international partners	A policy on public/private and public/public partnerships	0	1
		% of functional national and subnational intergovernmental platforms	TBD	90%
Research and Development	21. To improve uptake of scientific research evidence for decision making and policy development by 70%	% health research informed by the national health research priorities	TBD	70%
		Number of clinical trials on Traditional Medicine conducted	TBD	2

3.6 Strategic Responses

Addressing the current challenges facing the health system and indeed achieving the key result areas highlighted above requires innovation and strengthening of priority programmes and service delivery platforms or entities. The policy and administration framework must be appropriately strengthened to ensure effective policy planning and administration, regulation and compliance with national norms and standards. The health system must be strengthened to respond to the burden of communicable and non-communicable diseases; reproductive, maternal newborn child health and adolescent issues; and public health disease surveillance and disaster preparedness and response. Interventions must be evidence based and supported by robust research and development. Of fundamental importance is strengthening of the primary care system including community systems as the entry point to the health care system. Hospitals at various levels must be capacitated to handle these referrals and other complicated cases to ensure a continuum of care and better outcomes.

Underpinning the proposed strategies is the need to improve quality and equity of services, mainstreaming of gender issues, and working in partnership with all other sectors that contribute to the production and maintenance of health. Each of these strategic components is discussed in turn.

Priority 1: Communicable Diseases

Communicable diseases remain a major contributor of morbidity and mortality in the country. This strategy seeks to address these priority communicable diseases using proven health interventions.

Goal 1: To strengthen priority health programmes		
Objectives	Specific objectives	Strategies
Objective 1: To reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020 and malaria deaths to near zero by 2020	1.1. To increase access of the population at risk to effective and appropriate malaria prevention interventions by 2020	<ul style="list-style-type: none"> • Improve vector control through Indoor Residual Spraying (IRS) and use of Long Lasting Insecticide Treated Nets (LLIN) • Strengthen advocacy, and behaviour change and communication activities • Strengthen demand creation for malaria prevention and control activities • Strengthen Intermittent Preventative Treatment (IPT) and prophylaxis • Strengthen larval source management and personal protection
	1.2. To ensure prompt and appropriate management of all malaria cases by 2020	<ul style="list-style-type: none"> • Strengthen case management (diagnostic, medicines, and supportive care) at all levels of care • Improve surveillance systems, monitoring, evaluation and research
	1.3 To enhance pre-elimination activities	<ul style="list-style-type: none"> • Increase the number of districts in pre-elimination phase (increasing surveillance)
Objective 2: To ensure timely detection and control of epidemic prone diseases	2.1 To strengthen timely detection and control of all epidemic prone diseases	<ul style="list-style-type: none"> • Establish functional Rapid Response Teams • Training in Integrated Disease Surveillance and response (IDSR), and Rapid Response Teams (RRT) • Improve surveillance systems, M&E and research
	2.2 To prevent outbreaks of cholera and other diarrheal diseases, and the occurrence of such diseases	<ul style="list-style-type: none"> • Improve sanitation, water quality and promote hygiene • Strengthen case management
Objective 3: To reduce morbidity due to Schistosomiasis and soil transmitted helminthes and other NTDs by 50% by year 2020	3.1 To reduce the prevalence of Schistosomiasis, STH, LF, and Blinding Trachoma	<ul style="list-style-type: none"> • Establish the prevalence of selected priority Neglected Tropical Diseases (SCH, STH, LF, HAT and Blinding Trachoma) • Conduct Mass Drug Administration (Treatments) • Strengthen advocacy, and behaviour change and communication activities • Strengthen demand creation for NTDs prevention and control activities • Strengthen case management
Objective 4: To prevent new HIV infections and to reduce deaths due to HIV by 50%	4.1 To achieve 90, 90, 90	<ul style="list-style-type: none"> • Improve HIV testing and treatment of those found positive • Optimize HIV prevention activities; <ul style="list-style-type: none"> ◆ BCC ◆ STI control ◆ VMMC ◆ HTS ◆ Condom promotion • Enhance HIV/TB collaborative activities and treatment of other opportunistic infections (OI)
	4.2 To reduce MTCT to less than 5%	<ul style="list-style-type: none"> • Implement PMTCT services • Enhance male involvement

Objectives	Specific objectives	Strategies
Objective 5: To reduce mortality, morbidity and transmission of tuberculosis by 90%	5.1 To increase positive TB treatment outcomes	<ul style="list-style-type: none"> • Increase sputum based diagnosis • Strengthen Directly Observed Treatment (DOTS) programme • Increase in high quality diagnoses and expand use of Gene expert tools • Implement systematic screening of contacts • Provision of support to patients on treatment
	5.2 To integrate TB/HIV services	<ul style="list-style-type: none"> • Enhance ART amongst TB cases • Enhance HIV/TB collaborative activities
	5.3 To effectively manage multi-drug resistant TB	<ul style="list-style-type: none"> • Monitoring of high risk patients • Improve access to early diagnoses of DR-TB including susceptibly • Systematic screening of DR-TB • Strengthen capacity of DR-TB in patients • Strengthen cross boarder collaboration activities

Priority 2: Non-communicable diseases (NCDs)

Prevention and management of non-communicable diseases is critical to reducing the incidence of preventable illnesses, disability and death due to these conditions and diseases. A holistic strategic response requires multi-sectoral partnership in which sector ministries, the private sector and all of society act in concert in promoting healthy life styles.

Goal 1: To strengthen priority health programmes		
Objectives	Specific objectives	Strategies
Objective 6: To reduce the incidence of selected Non-Communicable Disease (cancer, hypertension, diabetes, dental, ophthalmic cases, injuries and oral health) by 50%	6.1 To promote healthy life styles	<ul style="list-style-type: none"> • Strengthen health promotion activities
	6.2 To improve screening and diagnosis of selected NCDs	<ul style="list-style-type: none"> • Promote screening and early detection
Objective 7: To improve the mental health status of the population	7.1 To improve awareness and reduce substance abuse	<ul style="list-style-type: none"> • Promote reduction in substance abuse through multi-sectoral approach (schools, police, churches etc.)
	7.2 To improve management and rehabilitation of addicts	<ul style="list-style-type: none"> • Establishment of drug rehabilitation services
	7.3 To improve management of mental illness and epilepsy	<ul style="list-style-type: none"> • Promote specialization in psychiatry (doctors/nurses/clinical psychologists) • Promote early detection and management of mental illness and epilepsy • Promote reduction of stigma towards mental illnesses in the community

Objectives	Specific objectives	Strategies
Objective 8: To reduce disability and dependence by 50%	8.1 To increase access to quality medical rehabilitation services	<ul style="list-style-type: none"> • Scale-up Community Based Rehabilitation programme • Capacitate training schools for specialised skills • Improve availability of rehabilitation equipment and accessories in health facilities • Strengthen mechanisms for early detection and management of injuries and disabilities (introduce screening programmes for newborn and children in hospitals)
Objective 9: To improve the quality of life of older persons and improve life expectancy from 61.5 to 65 by 2020	9.1 To promote the well-being and quality of life for the elderly.	<ul style="list-style-type: none"> • Improve quality of geriatric care at all levels of care • Implement a support services package for the elderly • Establish community support programmes for the elderly • Establish multi-sectoral linkages for improving the welfare of the elderly in the communities

Priority 3: Reproductive, Maternal, Newborn, Child Health and Adolescents

Reproductive, maternal, newborn, child health and adolescent services remain a priority programme for the country as it addresses a large part of the country's disease burden. The proposed strategies are geared to prevent and avoid unnecessary morbidity and mortality amongst women and children of all age groups.

Goal 1: To strengthen priority health programmes		
Objectives	Specific objectives	Strategies
Objective 10: To reduce the maternal mortality ratio from 614 to 300 by 2020	10.1 To increase early and continuous utilization of ANC services	<ul style="list-style-type: none"> • Advocacy and Communication for maternal health services • Institute client feedback mechanisms • Decentralization of services including infrastructure, health posts and community and supplies • Introduce RBF- pay for service conditional to quality of service (incentivizing VHW/PCN based on referrals) • Set up focused quality improvement systems
	10.2 To increase the consistent provision of quality ANC services	<ul style="list-style-type: none"> • Strengthen on-the-job training (OJT), support and supervision and mentorship
	10.3 To improve outcomes of delivery	<ul style="list-style-type: none"> • Ensure availability of delivery kits • Strengthen quality of maternity waiting home services • Strengthen capacity of health workers in life saving skills including EmONC • Strengthen BEmONC • To strengthen CEmONC services through clinical mentorship and OJT • Strengthen on the job training, support and supervision and mentorship for PNC • Improve access to primary health care facilities

Objectives	Specific objectives	Strategies
Objective 10:		<ul style="list-style-type: none"> • Advocacy and Communication with male involvement • Introduce payment exemption policy • Introduce RBF- pay for service conditional to quality • Establish and upgrade infrastructure (especially maternity waiting homes) • Strengthen continuous quality improvement systems • Strengthen maternal and perinatal death surveillance and response • Strengthening midwifery services • Improve the referral system at all levels • Strengthen transport and communication systems
	10.4 To strengthen Adolescent Sexual Reproductive Health (ASRH)	<ul style="list-style-type: none"> • Improve availability of integrated Youth Friendly Services using appropriate and evidence based inclusive models • Strengthen the school health programme to include comprehensive sexual health education • Implement comprehensive Sexual Education • Advocacy for legislation against child marriage • Enhance community level awareness on ASRH
	10.5 To reduce pregnancy related risks amongst WCBA including adolescents through strengthening Family Planning	<ul style="list-style-type: none"> • Improve the method mix in Family Planning (LARCs including PPIUCDs) • Strengthen integration of FP services with MCH and selected SRH and HIV & AIDS services
Objective 11: To reduce the Neonatal Mortality Rate from 29 to 20 deaths per 1,000 live births	11.1 To scale up high impact child survival interventions for essential new born care	<ul style="list-style-type: none"> • Decentralize mentorship and follow up of trainings to district on management of small and sick newborns • Improve programmes on Helping Babies breath (HBB), KMC, IMNCI, PMTCT (to address asphyxia, sepsis and hypothermia)
Objective 12: To reduce the under-five mortality rate from 75 to 50 deaths per 1,000 live births	12.1 To scale up high impact child survival interventions for under-fives	<ul style="list-style-type: none"> • Strengthen EPI Outreach, maintain cold chain integrity and improve transport availability • Strengthen IMNCI Immunizations, ETAT, Nutrition, and Paediatric ART • Revise pre-service curriculum to include IMNCI, HBB etc.

Nutrition

The proposed strategies focus on adolescent and maternal nutrition, infant and Young Child Nutrition, infant and young child feeding practices; and micronutrient supplementation, amongst other things.

Objectives	Specific objectives	Strategies
Objective 13: To reduce mortality and morbidity due to malnutrition by 50%	13.1 To reduce the prevalence of stunting among children under 5 years of age	<ul style="list-style-type: none"> Promotion of family-focused behaviour change communication on appropriate adolescent, maternal and child care practices Multi-sectoral coordination and collaboration towards an integrated response to stunting Advocacy and resource mobilization for scale up of provision of high impact nutrition interventions throughout the lifecycle Strengthen evidence generation and monitoring of interventions to address stunting
	13.2 To increase exclusive breastfeeding rates in children 0-6 months	<ul style="list-style-type: none"> Promote early initiation of breastfeeding within 30 minutes of delivery Promote exclusive breastfeeding Strengthen advocacy and communication at community level
	13.3 To increase children 6-23 months receiving minimum acceptable diet	<ul style="list-style-type: none"> Promote age appropriate complementary feeding
	13.4 To increase children 6-59 months receiving vitamin A supplementation	<ul style="list-style-type: none"> Promote micronutrient supplementation
	13.5 To reduce prevalence of micronutrient deficiencies (iron in women, Vitamin A in children 6-59 months, iodine in children 5-12 years)	<ul style="list-style-type: none"> Scale up coverage of iron and folate supplementation in women 15-49 years and Vitamin A supplementation in children 6-59 months Capacity building of laboratories and health workers for implementation of National Food Fortification strategy Strengthen food fortification monitoring and surveillance
	13.6 To improve case identification and management of severe acute malnutrition in children 6-59 months	<ul style="list-style-type: none"> Capacity building for screening, identification and management of severe acute malnutrition at community and facility levels Strengthen data quality and reporting for severe acute malnutrition from community to facility levels
	13.7 To reduce prevalence of overweight and obesity among children, adolescents and adults	<ul style="list-style-type: none"> Promote social and behaviour change communication on healthy lifestyles (diversified diets -including consumption of at least 5 servings of fruits and vegetables - decreased consumption of sugary beverages) Promotion of physical exercise of recommended duration using multi-media channels Promote health screening and wellness days through hospital and community based platforms Advocacy and collaboration with stakeholders e.g. CCZ on ensuring food standards are met
	13.8 To increase household access to safe and nutritious food	<ul style="list-style-type: none"> Behaviour change and communication to improve household hygiene, safe sanitation and waster

Priority 4: Public Health surveillance & disaster preparedness and response programme

These environmental health strategies seek to address priority challenges in the management of all physical, biological, chemical, social and psychosocial factors in the environment including compliance with international legislation and conventions.

Goal 1: To strengthen priority health programmes		
Objectives	Specific objectives	Strategies
Objective 14: To strengthen environmental health services, early detection of disease outbreaks and man-made disasters from 30% to 50% by 2020	14.1 To increase access to safe water and sanitation	<ul style="list-style-type: none"> • Improve water and sanitation infrastructure • Promote appropriate water treatment and waste management methods • Monitor water quality
	14.2 To improve management of waste (solid, liquid, chemical, radiation and noise) and reduce pollution	<ul style="list-style-type: none"> • Strengthen waste management systems • Improve Environmental Hygiene through environmental awareness programmes • Increase technical guidance in land use planning • Monitor sanitation and housing standards • Scale-up the healthy villages and healthy towns concept • Enhance water quality and safety inspections
	14.3 To reduce air, water and terrestrial pollution by strengthening public health regulations and awareness on environmental contamination	<ul style="list-style-type: none"> • Resource and strengthen regulating institutions • Ensure institutional and industrial health and safety • Monitor environmental pollution • Regulation of planning and building projects • Enforce the provision of the Public Health Act and its provisions • Ensure compliance with international health laws and regulations • Monitor smoking in public places
	14.4 To enhance safety of food and Food Commodities, and meat	<ul style="list-style-type: none"> • Review food legislation especially for import and export regulations and natural packaged mineral water • Licensing and certification of premises • Ensure Food Quality Monitoring and inspections at all levels • Strengthen the capacity of the Government Analysts and Public Health Laboratory • Conduct public education on food safety, handling and storage • Conduct regular meat inspections
	14.5 To improve climate change awareness	<ul style="list-style-type: none"> • Conduct a climate change and health awareness • Training of Focal Points • Develop a Public Health Adaptation to Climate Change plan
	14.6 To improve awareness on clean and hygiene living conditions	<ul style="list-style-type: none"> • Strengthen Environmental Control Community Health clubs and other community initiative • Promote clean and hygienic conditions at home, public facilities and work places • Promote community participation and involvement in creating a healthy environment
	14.7 To strengthen port health services	<ul style="list-style-type: none"> • Enforce regulatory compliance of imported and exported foods • Conduct regular inspections of points of entry • Strengthen pest/vector control • Screen human remains • Screen travellers at points of entry • Strengthen International Health Regulations (IHR)

Service Delivery Platforms/Entities

The identified strategies will be delivered through primary care and hospital services platforms. Mission and local government facilities will continue playing their traditional roles of partnering with the State in the provision of primary care services. Defining an essential primary care services package is essential to improving access and quality for the majority of the population. Given the existing resource challenges facing the health sector it might not be possible in the short to medium term to guarantee access to comprehensive services to all.

Primary Care Services

Primary care is the basis of the health system in Zimbabwe and will be the major delivery vehicle for implementing the identified strategies. However, the primary care level needs to be strengthened to ensure equitable access to essential health services. To facilitate this process an Essential Primary Care package that focuses on provision of comprehensive preventive and basic diagnostic and treatment services at health center and community level is to be developed, costed and implemented. In addition, the focus will not only be on nurses and VHW but also other community based cadres and professionals working as multidisciplinary teams at this first line level. To enhance the performance of VHW, use of performance based funding needs to be explored to improve coverage, and the levels of household services provided at the community level. The proposed strategies address both the community and the health centre level components of primary care services.

Community level services

Community level services relate to those services provided in the community and at sub-district and even at village or household level as part of community participation in co-production of needed services closer to the families or households.

Goal 2: To improve service delivery platforms or entities		
Objectives	Specific objectives	Strategies
Objective 15: To reduce morbidity by at least 50% through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level	15.1 To Strengthen Community Systems	<ul style="list-style-type: none"> • Strengthen community participation • Increase Community Based Workers: <ul style="list-style-type: none"> ◆ Coverage ◆ Package of services ◆ Household health services ◆ Support / PBF • Strengthen accountability at a) Community level, and b) MOHCC local facility level • Improve number of functional Health centre Committees • Enhance inter-sectoral collaboration at community level
	15.2 To decentralize health care services and increasing autonomy of sub-district level	<ul style="list-style-type: none"> • Introduce Health Posts in communities • Strengthen PBF at sub-district level • Strengthen referral systems between community and primary health care levels • Implement an essential health benefits package at primary care throughout the country
	15.3 To strengthen quality of services (both technical and perceived)	<ul style="list-style-type: none"> • Introduce Quality Management System • Improve supportive supervision and mentorship • Reinforce client feedback mechanisms • Capacitate health care providers on work ethics, ethical practice and public relations • Enhance local monitoring and evaluation

Health Centre Level services

Primary Health Care (PHC) was adopted in Zimbabwe in 1980 to deliver health care to the majority of the population through increased community access to health services. PHC was launched primarily to improve maternal, neonatal and child health (MNCH), and included high impact and cost effective interventions, such as comprehensive antenatal and postnatal care, an expanded programme of immunization (EPI) as well as community level health promotion, child monitoring and surveillance through Village Health Workers (VHWs). By 1990, about 85% of the population had access to basic health services. During the same period, child immunization coverage increased from 25% to 80%, and together with increased coverage of other child health interventions, resulted in an under five mortality rate which dropped by more than 20%, from 104 per 1,000 live births to 81 per 1,000 live births. (UN Inter-agency Group for Child Mortality Estimation, 2010).

The ongoing economic decline has led to diminishing budgets available for health care, resulting in reduced provision at all levels. This system breakdown was characterized by a shortage of skilled professionals, eroded infrastructure, and lack of essential drugs and commodities. Concurrently, demand for services has been undermined by the non-standardised application of user fees. Loss of human resources in the health sector has had a detrimental impact on the availability of services, particularly in rural areas. Vacancy levels are as high as 89% for midwives, 64% for government medical officers and 49% for nursing tutors. Although demand for midwifery training is high, only 13 of the country's 20 midwifery schools are currently functioning, with plans and funding now in place to revive all 20 schools. In an effort to address high vacancy levels, MOHCC has trained over 4000 Primary Care Nurses (PCNs) since 2004. PCNs are deployed to rural health centers following one-year training.

A donor-funded Health Retention Scheme has assisted in retaining some staff, but a long-term solution for retaining qualified health staff is urgently required. To compensate for staff shortages, the Government has also introduced 'task sharing,' allowing health workers to perform new tasks. For example, Primary Counsellors were recently approved to provide HIV testing and counseling, and MOHCC is advocating for nurses to initiate antiretroviral treatment (ART). Currently every district has at least 2 doctors, every primary health care center has at least 2 qualified nurses, 59% of administrative wards are serviced by an Environmental Health Technician and 60% of Villages have access to a village health worker. However, coverage in new settlement areas is lagging and remains a critical gap. Worth noting is that the staff complements described are based on a human resource establishment that has not been reviewed based on current service delivery needs.

In terms of the health information system data capturing at community and PHC levels remains paper based which results in poor data quality. There is no clear definition of disease burden by catchment area and data is not disaggregated by catchment area resulting in low utilization of data for program planning and prioritization. There remains an opportunity for decentralization of the DHIS2 to primary health care center level.

The Service availability and readiness assessment findings show that health facility density in Zimbabwe is less than two primary health facilities per 10,000 population in all provinces, except Bulawayo. Zimbabwe targets 23 health workers per 10,000 population but this target is not being met in all provinces except Bulawayo. Most provinces have less than 10 health workers per 10,000 population which means the majority of primary health care centers are understaffed. In the surveyed areas, outpatient utilization is 0.35 outpatient's visits per person per year, which also falls below the target of 5 outpatient visits per person per year in all provinces (ZSARA 2015).

Despite prioritization of establishment of community health councils in the previous health strategy, there remains a gap at district level. Country wide, first level referral facilities do not have community health councils to support oversight of hospital administration. According to ZSARA 2015, 96% of facilities have access to emergency transport and communication. The NHS performance reports that 67% of the population lives in rural areas, while 33% are in urban areas. Zimbabwe has 1,700 administrative wards covered by 1,630 health facilities. Through funding from the Health Transition Fund, there has been significant improvement in human resources, equipment and medicines. The Results Based Financing approach has supported some improvements in quality of service delivery. However, this improvement has not fully extended to the district hospital and community health worker levels.

Currently all urban facilities are under administration of the local government and usually underfunded to support basic primary health services. The current primary health care package and incentives schemes are skewed towards rural facilities. In addition, peri-urban settlements are growing faster than the health system can cope with provision of primary health services to these areas.

Given the funding situation and the inequities across geographic areas and urban and rural areas, the Ministry seeks to develop and implement an essential health benefits package of services. The notion of promising entitlements to comprehensive services to all Zimbabweans is unattainable in the short to medium term. The Essential Health Benefits package defines the core services that need to be provided at a minimum to all Zimbabweans at primary level. This essential package of services will be continuously reviewed as the fiscal space and hence budget allocations for health services improve over time.

Goal 2: To improve service delivery platforms or entities		
Objectives	Specific objectives	Strategies
Objective 15: To reduce morbidity by at least 50% through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level	15.4 To implement an essential health benefits package at primary care throughout the country	<ul style="list-style-type: none"> Reorganise service delivery platforms including community levels for Essential Health Benefits package
	15.5 To strengthen leadership, governance and management of primary health care	<ul style="list-style-type: none"> Improve integrated coordination and management structures at community level Capacitate Health Centre Committees on governance of health centre activities Delineate roles and responsibilities of the DHE and hospital executives to improve oversight roles
	15.6 To improve infrastructure development	<ul style="list-style-type: none"> Upgrade power sources at facilities to have sustainable and predictable power supply
	15.7 To strengthen the collection and utilization of health information for decision making	<ul style="list-style-type: none"> Adopt appropriate IT technologies for collection, collation of health information and medical records including monitoring of HR, commodities, etc Adopt technologies that facilitate real time monitoring of commodities, equipment, human resources availability at all levels
	15.8 To strengthen Health Financing at the Primary and first referral level	<ul style="list-style-type: none"> Strengthen RBF/PBF including urban primary care facilities and accredited private health providers Adopt innovative mechanisms of addressing user fees as a barrier to access, e.g. vouchers, prepayments/insurance schemes

Hospital Services

Zimbabwe's health referral system is a four-tiered pyramidal system with the lower level primary health facilities (clinics), secondary level (district hospitals), tertiary level (provincial hospitals) and quaternary level (central hospitals). There are six national (central) referral hospitals. Each of the eight administrative provinces has a tertiary (provincial) hospital that acts as a referral centre for other hospitals in that province. There is a district hospital or designated hospital in each of the districts. Mission hospitals contribute a significant number of beds mostly at secondary and primary care level with some being run as designated district hospitals. Hospitals are managed by policy prescribed boards and executives.

For some time now, hospitals have been requesting for autonomy, to be run by statutory independent boards set up by the Minister of Health. To date, hospitals boards have been appointed at central hospital level with none at provincial and district level. Such Boards are "corporate" bodies capable of contracting, owning and disposing of assets, acquiring and disposing of land and buildings, borrowing money for capital investment and retaining fee revenue, among other things. This is different from the Hospital Advisory Boards (HAB) members, who are appointed by the Minister of Health from the local community, whose role is limited to community involvement in the general wellbeing of the hospital. A typical hospital executive consists of a medical superintendent or Chief Executive Officer for central hospitals, clinical director (for central hospitals), a matron, an administrator, a pharmacist and a chief nursing tutor.

Hospitals are an important part of a health care system as they provide essential curative, rehabilitative and supportive services to primary care facilities. However, they consume significant and disproportionate amounts of resources compared to non-curative services. In the financial year 2014, central hospitals accounted for more than 30% of total health expenditure (PER, 2015). Despite this skewed expenditure pattern, problems of hospital cost escalation continue unabated. Claims that public hospitals are under-funded, with very little disbursements from Treasury remain. For example by September 2015, Harare Central Hospital had only received \$560,000 out of a budget application of \$17,500,000. This means that hospitals are primarily operating at very poor cash flow positions funded by charging patients for services and overstressing creditors thereby increasing debts. This also contributes to the inefficiency of hospital services delivery and the low quality of services produced. It is advisable to establish a cost per bed per capita for each diagnostic group by hospital level to determine the real health financing gap for hospitals and better mobilise resources.

Over the last decade patients have been presenting at most hospital out patients department with simple ailments that can easily be managed at primary care level, further straining the available infrastructure, financial, human and other resources. Enforcement of the referral system based on the primary health care approach and patient education are key to ensuring that hospital services are only limited to those who really need them.

The supply chain management of health commodities for hospitals is poor with donor medicines largely skewed to primary health care facilities where availability is over 80%. The average medicine availability in hospitals is at 42% with theatre commodities solely funded by HSF and patients. Most of the hospitals have pharmaceutical manufacturing units for simple compounding of simple formulations such as Glycerine/Ichthammol, Gentian Violet and Silver Sulfadiazine Cream. These are "low hanging fruits" which can further reduce costs at the same time increasing product availability.

However there should be investment in the manufacturing equipment and units layout as these have been idle for a long time. The hospital information systems need to be harmonised and fully computerised with all departments, equipment and patient flow properly linked electronically. The availability of equipment and ambulances/service vehicles is at 52% and 33% respectively.

The vacancy rate for specialists at hospitals is at 65% with significant disparities in institutional or geographical distribution and poor skills mix. For example, 95% of general surgeons are based in Harare whilst there are very few anaesthetists and paediatricians. To address these challenges, it is imperative that performance based standards be set for specialists to train others and that their distribution be equitable.

Patients are currently experiencing long waiting periods for surgeries. For example urology and orthopaedic surgery patients have to wait on average six months with some as long as twelve months. It is therefore important not only to increase the number of specialists but also to capacitate the hospital theatres and health commodities for better hospital service delivery.

Goal 2: To improve service delivery platforms or entities		
Objectives	Specific objectives	Strategies
Objective 16: To ensure universal access and provision of complementary package of hospital services including emergency and ambulatory curative services	16.1 To ensure efficient and effective leadership and corporate governance in hospitals	<ul style="list-style-type: none"> Strengthen oversight on hospital boards according to corporate governance principles Establish Quality Management System
	16.2 To improve generation, mobilization and allocation of resources at hospitals	<ul style="list-style-type: none"> Ensure efficient equitable allocation of available resources Ensure efficient collection of funds owed Improve resource mobilization at hospital level
	16.3 To improve service delivery efficiency	<ul style="list-style-type: none"> Implement Quality Management System and improve patient flow Capacitate and improve hospitals theatre services Improve availability of diagnostic services (laboratory/radiology)
	16.4 To improve hospital patient management	<ul style="list-style-type: none"> Increase availability of functional fixed mechanical equipment, medical equipment and technologies. Establish patient and staff safety programs Hospital Infrastructure refurbishment and increased availability of functional hospital vehicles
	16.5 To promote hospital based research for improved patient outcomes	<ul style="list-style-type: none"> Capacitate management on utilization of IMMIS and DHIS2 Establish and capacitate hospital research committees
Objective 17: To ensure universal access and provision of quality tertiary specialist curative services	17.1 To increase the availability of specialists and targeted skills	<ul style="list-style-type: none"> Set performance based standards for hospital specialists to train others Address disparities in geographical and institutional distribution of specialists
	17.2 To improve hospital patient management	<ul style="list-style-type: none"> Increase the number of functional ICU and HDU at provincial and central hospitals Improve availability of specialist diagnostic services (laboratory/radiology)

Goal 2: To improve service delivery platforms or entities

Objectives	Specific objectives	Strategies
Objective 18: To promote and support provision of quality palliative care services	18.1 To ensure availability of essential palliative care medicines, training and evidence based research	<ul style="list-style-type: none"> • Provide training, mentorship and supervision in palliative care for health professionals and non-health professionals nationally to develop the necessary skills, knowledge and attitudes critical in providing quality palliative care. • To collaborate with other key palliative care stakeholders such as HOSPAZ (Hospice and Palliative Care Association of Zimbabwe) and Island Hospice Service. • Monitoring and Evaluation of all palliative care service provision. • Promote evidence base palliative care research • Make palliative care essential medicines available and accessible to patients.
	18.2 To link palliative care to prevention and treatment	<ul style="list-style-type: none"> • Utilise palliative care, hospice programmes (including all levels of health care facilities, HBC, NAC, palliative care organisations) to identify and refer patients and families to appropriate services for early identification and provision of holistic care.

Enabling Environment for Service Delivery

In order to successfully implement priority programme strategies, an enabling service delivery environment needs to be created. Therefore, investments have to be made in strengthening this environment and the relevant issues and strategies for doing so are explained in turn.

Policy and Administration**Policy, Planning and Coordination**

Policy and administration creates an enabling environment for good governance in the provision of health services. The WHO health systems blocks highlight the importance amongst others of leadership and governance, human resources, health information, procurement and supply of commodities and equipment, infrastructure and financing as critical to the provision of quality health services. During the period under review, the MOHCC had approximately 103 policy and guiding documents, which have to some degree, guided the implementation of health services. However, there was poor synchronization of these strategic documents with the NHS and access to these documents was also limited. This made coordination within the Ministry, inter-ministerial and with other partners a major challenge. Despite the many policy documents, there are still gaps in the guiding documents necessary for creating an enabling environment such as the Health Financing Policy. It was also noted that some of the available policy documents are now outdated and require revision especially the National Health Policy of 1994.

Human Resources for Health

Zimbabwe has improved over the last the last 5 years on its human resources retention with an overall in-post rate standing at 81% as of July 2015 (MOHCC Staff returns, 2015). However, this is based on an outdated staff establishment that was last holistically reviewed in 1996. There are also major

challenges in the equitable distribution of this workforce by region as well as by cadres. According to the Public Expenditure Review, Bulawayo had 18 nurses per 10,000 population while Manicaland had 6 nurses per 10,000 population (World Bank PER, 2012). The working conditions for most of the health workers, as compared to regional conditions including salaries, have remained low creating low motivation resulting in brain drain and failure to re-attract those who left back into the country.

Finance and Administration

The country has failed to meet the Abuja Declaration commitments (spending 15% total government expenditure on health) from the time it was signed up but the GOZ has been making efforts to ensure that health remains a priority Ministry, as it always received the third biggest allocation when compared to other ministries. However, 80% of this has been absorbed mainly by salaries and has fallen short of the WHO recommendation of \$86 per capita. The essential health benefits package estimated required an estimated minimum budget per capita of \$56.84 (Vaughan 2014). Partner support has sustained most of the programmes work with 98% of medicines being procured by partners (NatPharm, 2015). It has been noted that pooled funding gave the advantage of allocative efficiencies, for example, the HTF. Fragmentation and verticalization of program activities has, however, resulted in limited cross-subsidisation and limited value for money.

Procurement and supply chain management

The health sector has seen fragmentation in the procurement of health products as these were largely procured through donor funding. Consequently, there have been inequitable commodities supply and security across referral levels particularly at hospital level. There is therefore need to consolidate and integrate supply chain systems and also introduce electronic systems to improve supply chain visibility, data consolidation and quality. Furthermore, increasing transparency in procurement at all levels is equally important in improving value for money and reducing opportunities of system abuse.

Monitoring and Evaluation

There is currently no harmonized M&E framework policy to ensure that progress is tracked in an integrated fashion. The M&E framework for this strategy is shown in Annex I.

Provincial Administration

Lack of coordination of national and provincial structures largely due to absence of clearly defined roles remains a challenge that is affecting supportive supervision, and effective implementation of programmes and strategies at ground level.

Goal 3: To improve the enabling environment for service delivery

Objectives	Specific objectives	Strategies
Objective 19: To improve health outcomes through facilitation and coordination of an effective and efficient health delivery system	19.1 To create an enabling environment through improved planning and monitoring of health service delivery	<ul style="list-style-type: none"> • Strengthen the governance structures at all levels of the health system • Create regulatory authority for Health Insurers • Strengthen hospital management boards • Develop health financing policy • Revise National Health policy • Streamlining roles and responsibilities between Ministry and HSB • Review organizational structure of the Ministry • Develop a policy framework for Health worker voluntary services. • Align programmatic strategies to the NHS • Harmonise health-related policies and strategies • Gender mainstreaming in all policies • Strengthen quality assurance and improvement across programmes • Re-enforce Risk management processes of resources for health (e.g. performance audits) • Create safety nets through NHI • Develop a traditional medicine policy implementation strategy • Strengthen the protection of Intellectual Property Rights (IPR) of traditional medicine and indigenous knowledge Systems
	19.2 To ensure an efficient and effective health workforce	<ul style="list-style-type: none"> • Develop an HRH Strategy in response to the needs of the NHS - to include the following: <ul style="list-style-type: none"> ◆ Strengthen HR planning and management ◆ Revise staff establishment ◆ Introduce performance based management ◆ Scale up HRIS database at the district level ◆ Create an integrated annual training plan for in-service training in place and development strategy (to address pre-service and in-service training) ◆ Clarify Roles and responsibility for training schools, eg School of nursing (SON) and others. ◆ Strengthen work ethics and practices amongst health workers ◆ Develop an induction manual
	19.3 To implement accountable, effective and transparent management systems at all levels of the health sector	<ul style="list-style-type: none"> • Ensure alignment of MOHCC financial management system to the PFM Act and its regulations • Strengthen coordination of development partner funding • Introduce PBB across districts • Safeguard and ensure optimum use of resources through audits • Introduce a resource allocation formula • Introduce compulsory maintenance plans and budgets for equipment and infrastructure • Conduct National Health Account studies • Continuous resource mobilization for the health sector
	19.4 To improve procurement practices across all levels	<ul style="list-style-type: none"> • Strengthen procurement entities at all levels. • Develop clear guidelines for procurement activities including pooled procurement • Advocate for increased funding for medicines and medical sundries

Objectives	Specific objectives	Strategies
Objective 19:	19.5 To improve supply chain visibility	<ul style="list-style-type: none"> • Integrate and harmonise supply chain systems • Employ technology in logistics and supply chain management to increase visibility and commodity security • Integrate and maintain cold chain supply chain systems
	19.6 To enhance performance and accountability	<ul style="list-style-type: none"> • Develop a harmonized M&E Policy Framework for the MOHCC.
	19.7 To ensure effective policy implementation at provincial level	<ul style="list-style-type: none"> • Strengthen coordination between National and provincial level • Clearly define roles and activities between provincial and national supervision teams • Ensure integrated supportive supervisions per district • Strengthen provincial health team review meetings • Strengthen monitoring and evaluation of RBM

Multi-Sectoral Partnerships

Attaining the highest possible level of health and quality of life for all Zimbabweans cannot be achieved by MOHCC interventions alone. This vision can only be achieved in partnership with other stakeholders – government and non-governmental organizations. Multi-sectoral partnerships entail involving all sectors of society – government, business, civil society organisations and communities. These partnerships are particularly important for effective regulation; improved service delivery, quality, reach and effectiveness; coordination and efficiency in resource use; building ownership and a sense of involvement and participation by all. Global evidence has shown that countries that have effective structures and institutions for partner coordination have realized improved health sector performance and indeed better health outcomes.

Both the National Health Strategy 2009-2013 and its extension 2014-15 strategy, recognized the need for partnerships in health with particular emphasis on partnerships with other government departments and agencies, private sector (both funders and providers), international partners who either fund and or contribute to the delivery of health producing services, and communities.

Partnerships with the private sector

The private sector in Zimbabwe plays an important role in both funding and providing health services, and this role needs to be enhanced. Seizing opportunities within the private sector for public purposes requires an understanding that it is not a homogenous sector. It has, on the one hand, the private-for-profit sub-sector which includes independent providers such as clinics and hospitals, and pharmaceutical, devices and equipment industries, for example. On the other hand, it has the private not-for-profit subsector that includes mission facilities, non-governmental organisations and other charitable organisations, and medical aid societies involved in funding of health care particularly for the middle class.

With regards to partnerships in service provision, missions have a long history of being part of the national health care system; however, over the years support to missions through government grants has been declining in real terms. Furthermore, there has been limited monitoring of the disbursed grants to these institutions because of lack of formal service contracts that define what is expected in

some cases and or limited capacity by the MOHCC to effectively monitor and manage these grants. Some provinces have established these formal management mechanisms and similar actions are necessary country-wide. In some cases mission facilities are designated as district hospitals for instance to support the referral system, however, challenges sometimes exist in the management and coordination functions of such districts due to the dual governance structure of missions—the government and the church.

Local government, like missions, traditionally fund and provide health services in their areas. Recently, local councils have been experiencing funding problems particularly for health services. Their health infrastructure and equipment has deteriorated, health work workers benefits and numbers have shrunk and this has created more inequities in access to essential health services particularly in rural areas. Harmonisation of local government health services and service standards especially primary health care with that of the MOHCC is necessary. Suggestions were made during consultations that the MOHCC takes over local government facilities.

The private for-profit sector presents opportunities for widening access to quality services beyond the middle class but a key challenge is the absence of a defined public-private partnership framework within which to cooperate. The Public Health Act and the Medical Services Act, amongst others, provide the legislative framework for governing the private sector, however there is need to strengthen and develop appropriate institutions to regulate the sector in addition to the current self-regulation that exists, particularly amongst professional groups and independent providers. Wider participation of private providers is likely to be enhanced with the introduction of new forms of health financing such as national health insurance.

Medical Aid Societies and health insurance companies present opportunities for complementary funding to the health sector by tapping into the growing middle class. However, such opportunities depend on the economic prospects and growth in employment levels. With appropriate regulations and governance arrangements such agencies can potentially assist the state in meeting its health objectives of widening access to quality services.

Regulatory function

The MOHCC is the custodian of the principal acts or laws that govern what happens in the health sector. Regulating the health sector is a complex but necessary function to achieve public health objectives. Partnerships are necessary between Medical Aid Societies, Health Insurance companies, and other funding agencies for health for better regulatory compliance. Recent experiences with governance challenges in the medical insurance sector demonstrate the need for effective regulation to ensure that those covered by such schemes get fair health benefits, and that multiple pools are properly managed.

Equally important are partnerships in regulating various health service providers within government including local government, private providers (for-profit and not-for-profit), civil society and communities. In addition, the pharmaceutical industry and other private agencies involved in the production and or procurement of medicines, commodities and equipment necessary for providing health services require regulations to ensure that the appropriate technologies are produced and distributed to where they are needed the most without creating barriers of access. Decisions on which technologies to use and not to use in the health sector need to be based on some form of health technology assessment including economic evaluation.

At the professional level, partnerships with professional bodies for ensuring ethical conduct and processes in the delivery of services is an essential part of ensuring that quality services are provided by both public and private providers and facilities. Creation of norms and standards and institutions that enforce these standards presents another layer of partnership that is not only punitive but also developmental.

Partnerships with other ministries and sectors

The role of other ministries, for example education, agriculture, local government and others, in producing health cannot be minimized. However, such partnerships tend to work well in contexts in which there is not only a single vision but also appropriate governance arrangements to oversee such partnerships. At the national level, the cluster system established under the ZimAsset, provides opportunities for the development of coherent policies that consider health and health related issues (health in all policies). This is particularly important in facilitating a coherent approach to funding and implementing health and health related programmes across sectors.

At the sub-national levels, existing structures such as Provincial Councils, Provincial Development Committees and District Development committees present opportunities for effective inter-sectoral partnership. However, such structures have not been fully functional and need to be revitalized through more funding and capacity building.

Partnerships with development partners

Over the last few years, local and international partners have variously supported the health sector. Depending on which areas have received most support (e.g. HIV and AIDS, malaria, TB and MNCH), health sector performance has been variable and that situation presents challenges. The challenges relate to allocation of resources to priority areas and coordination of activities at all levels to avoid unnecessary duplication and waste, and indeed inequities across programmes and geographically.

Global trends have shown that in countries where resources have been channeled through direct budget support, health care systems have performed better and demonstrated resilience even the context of disruptions. Existing partnership forums such as the bi-annual Ministry and partners meetings (e.g. Development Partners Forum, Country Coordinating Mechanism, HTF steering committee, ZimASSET clusters etc.), various technical cooperation agreements and Memoranda Of Understanding (MOUs) all present opportunities for better coordination. However, as identified in the previous strategy there is still need to review and establish effective coordinating structures. Such structures will not only enhance transparency and accountability but also allow for better targeting of resources and support to where it is needed most.

Partnerships with communities

Communities need not be seen only as beneficiaries of health services but also as co-producers of those services. Their ability to participate in the funding and provision of services depends on the opportunities afforded to them to participate in such activities. Community participation or involvement is the cornerstone of building strong community systems for health. The Constitution defines health care as a right that must be enjoyed by all, and that right requires that the population receives appropriate, acceptable and affordable services. It also means that the health care system must be responsive to their needs and be accountable to them.

Structures for community participation exist at the local levels such as the Village Development Committees (VIDCOs) and Ward Development Committee (WARDCO), and at facility levels through Health Centre Committees (HCC) and Hospital Advisory Boards. However, the challenge has been that these structures are not always functional. Opportunities exist now to use existing PCNs together with the Village Health Workers and Environmental Technicians to improve community engagement activities at the primary care level. The involvement of other community cadres and traditional leadership will enhance demand for services, and also community and individual responsibility for their health status.

Empowering communities to participate in health services planning and providing multiple forums and channels at various levels for community participation is important in building a sense of community ownership and responsibility. The Patient Charter needs to be revived in this regard.

Community consultations showed that communities are concerned about accessing quality services whenever they need them. They raised issues of health worker shortages and attitudes, availability of medicines and equipment, patient transport, inpatient facilities such as beds, food and ablution facilities, amongst other things. The strategy is meant to address these issues.

Systems and structures of accountability across all levels have been reported to be operating sub-optimally. These structures (e.g. Health Advisory Board) need to be empowered to function effectively and establishing a social compact with the community presents opportunities for people to know what to expect from the health care system and more importantly to know what to do in cases of none or poor delivery of services.

Coordination of the multiple partners operating at community level is critical to ensure that the various partners, that is, other government agencies and non-governmental agencies work in harmony towards agreed goals in these communities. Ensuring that health is considered an integral part of other sector programmes will go a long way in addressing the coordination challenges.

Goal 3: To improve the enabling environment for service delivery		
Objectives	Specific objectives	Strategies
Objective 20: To strengthen multi-sectoral collaboration with local and international partners	20.1 To strengthen intergovernmental collaboration	<ul style="list-style-type: none"> • Support existing national and sub-national structures for inter-governmental interactions • Create a framework for funding health and health related activities across ministries • Mainstream “health-in-all” policies across sector ministries • Harmonise of health services at local government level • Improve funding for local government health services
	20.2 To improve public-private sector collaborations in funding and provision of health services	<ul style="list-style-type: none"> • Develop a policy on public/private and public/public partnerships • Develop appropriate regulations to facilitate private sector involvement in providing services for public purpose
	20.3 To enhance collaboration with development partners	<ul style="list-style-type: none"> • Strengthen existing platforms for donor coordination • Develop guidelines for partner involvement in health development

Objectives	Specific objectives	Strategies
Objective 20:	20.4 To strengthen community participation	<ul style="list-style-type: none"> • Develop a policy and strategy for community participation and involvement • Develop a policy and strategy for community participation and involvement • Empower health workers with tools for effective community engagement • Strengthen existing local structures for community involvement • Empower communities through implementation of Patient Charter • Create multi-channels and opportunities for community participation at all levels

Research and Development

Research and development plays a major role in the delivery of quality health services. Research creates opportunities to identify cost-effective interventions to improve results; it makes best or promising practices available or to be better known; it informs policy and programme choices; it allows service provision without waste and duplication, and it facilitates setting of performance standards and facilitate use of performance audits, amongst other things. Research of different types should be seen as an integral part of service delivery at all levels of the health system.

Although funding for health research has remained limited at 2-3% of MOHCC expenditure (PER 2015), over the last few years various agencies in Zimbabwe have conducted several research activities to support various programmes in the MOHCC and associated sectors. Evidence from such studies has largely been generated as part of reviewing programmatic progress, and to inform policymakers and programme managers of the successes and failures of programmes and more importantly attempting to understand the underlying root causes that warrant attention.

In some instances such scientific evidence has not actually been used to inform policy and practice because once published the reports are displaced elsewhere. Whilst it is important to conduct robust studies to generate new knowledge and inform policy and practice, it is equally important to make sure that such evidence is widely shared, and translated into digestible forms for use by the general public, practitioners and indeed policy makers. Translating research evidence into policy, practice and product is critical to the adaptive nature of the health systems, health services and to the changing socio-economic environment that affects service providers and user behaviours. Such research will also include exploring the therapeutic value of traditional medicine.

The National Institute for Health Research (NIHR) is an important agency not only in conducting relevant national health research but in also building capacity for health research at all levels and building partnerships. The institute is largely underfunded to employ and retain competent researchers, to upgrade its laboratories, improve its research infrastructure for diseases surveillance (malaria, schistosomiasis, water borne diseases, etc.), training activities, research communication and knowledge

management generally. The Institute is a strategic asset for coordinating and collaborating with other national and international academic and research institutions in conducting essential national health research that addresses priority issues. However, the challenge is that there is no revised national health research agenda so that various agencies can contribute to its implementation. This strategy seeks to address this by updating the essential national health research agenda that clearly defines national research priorities, suggest possible approaches to addressing those research priorities, strategic research partnerships and how the evidence generated can be utilized at all levels. For instance, all indicators around adolescent health have been consistently poor over the years despite significant investments in targeted interventions. Therefore, finding appropriate solutions to adolescent health requires analysis of existing evidence and testing of new innovative interventions. Traditional medicine continues to play a role in providing services to the public but challenges remain in ensuring use of approved and registered medicines, and promoting evidence based practices.

Within the health sector, there is the challenge of widespread limited use of routinely generated information by practitioners and managers at various operational levels to make informed operational and management decisions. Part of the reason for limited data use is the high workloads, and part because of limited capacity to analyse the collated data that is routinely submitted to higher levels. In order to improve coverage and quality of services provided at all levels of the health delivery system, it is critical that data use and research is mainstreamed down to the community level. The culture of asking questions, collecting data and analyzing it for informed decision making needs to be re-cultivated over the strategy period.

Goal 3: To improve the enabling environment for service delivery		
Objectives	Specific objectives	Strategies
Objective 21: To improve uptake of scientific research evidence for decision making and policy development by 70%	21.1 To develop an essential national health research policy and establish an essential national health research agenda for the country	<ul style="list-style-type: none"> • Develop a national health research policy • Conduct consultative process for reviewing the national health research agenda
	21.2 To develop human capacity for health research development	<ul style="list-style-type: none"> • Build capacity of health research and development (human, material and financial capacity) at all levels (national, provincial, district and community levels)
	21.3 To promote translation of research into policy, practice and product	<ul style="list-style-type: none"> • Establish a Technical Working Group for health research and development that will push the health research agenda and use of research results for evidence based decision making and policy development • Convene results sharing fora or mechanisms at various levels

Objectives	Specific objectives	Strategies
Objective 21:	21.4 To conduct research (including surveys) on priority health issues	<ul style="list-style-type: none"> • Ensure research approval system informed by national health priorities • Encourage collaborative projects with other institutions and investigators including practitioners • Promote research excellence (NIHR, MRCZ, RCZ, ZIPHA, etc.) • Conduct a hepatitis survey that will inform intervention strategies
	21.5 To strengthen research framework for traditional medicine	<ul style="list-style-type: none"> • Conduct research on TM to inform practices • Promote evidence based practices

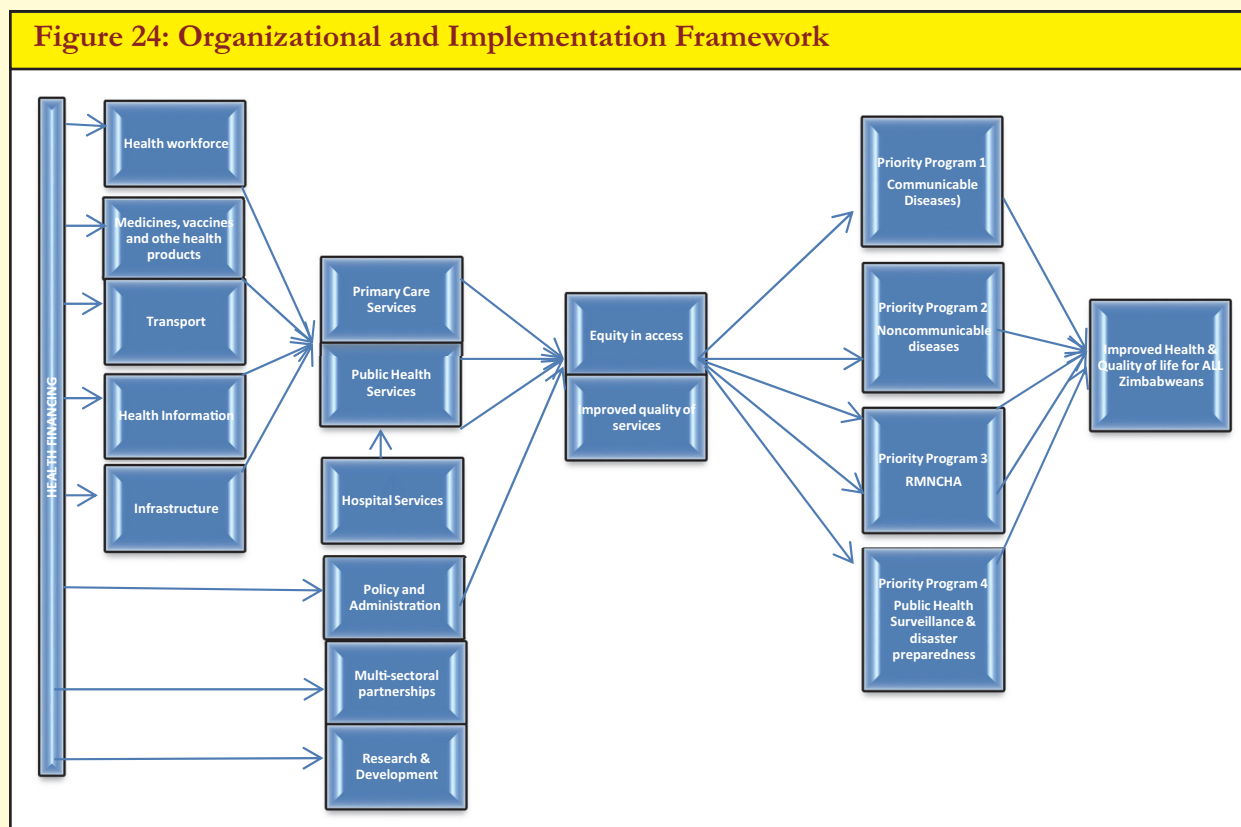
Overall Context for the National Health Strategy 2016-2020

4

4.1 Implementation Framework

Attaining the vision and mission of the NHS 2016-2020 needs enhanced service delivery platforms or entities and an enabling environment in which policy and administration is effectively implemented and coordinated (Figure 24). Underlying all this is the need for a sustainable funding mechanism for health in which people access and use quality services without hardship and are therefore unlikely to fall into financial hardship because of it. Achieving equitable access to health services means that the health system must provide adequate services (essential health package) to all and do so with limited direct costs (including OOP). Introducing an essential services package will facilitate this process and allow appropriate funding mechanisms to be established to deliver it over the next five years. As the fiscal space changes so will the package of essential services with the desire to continuously improve it over time.

Significant investments in health system strengthening are necessary for the health facilities and other service delivery and coordination platforms to function optimally. This is achievable if the health workforce, medicines and other commodities, health information system, transport and infrastructure, and ultimately leadership and governance are strengthened and transformed accordingly. Business as usual will not lead to the desired twin outcomes of equity in access to services, and improved quality of services and indeed to “the highest possible level of health and quality of life for all Zimbabweans”. To date, inequities in access to quality services remain a challenge for the health sector and this strategy seeks to address that by improving efficiencies in the system at all levels, resourcing priority areas, focusing on quality and equity in each programmatic area, and leveraging on mutli-sectoral actions - that is, “all of government and all of society” in implementing health programmes and activities. This means that public-private partnerships for public purposes are an essential strand of this strategy so that government and all its partners work collaboratively at all levels of the health system. As innovative programmes such as RBF and others are scaled up, it important that current gains are sustained and improved, and new innovative programmes such as e-health are implemented to enhance and not to disrupt what has been working so far.



The national level (Head Quarters) needs to respond to this strategy by aligning its organizational structure to achieve the desired results over the next five years. Enhanced and new coordination mechanisms at the national level must cascade to the provincial, district and even the sub-district level so that there is service integration and effective oversight. District management teams need to be strengthened and supported to facilitate more supportive supervisions and engagement with communities, particularly the vulnerable and hard to reach populations. Creation of sub-district level structures that leverage on existing ones is critical to the strengthening of community systems and improving the interface between the health system and communities.

Gender mainstreaming is an inherent and important part of the strategy of addressing inequities in access and health outcomes as women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ because of social (gender) and biological (sex) differences. Implementation of the various strands of this strategy should therefore target women by improving their access to information, prevention and treatment services, and more so services to sexual abuse and violence victims. The Ministry will also facilitate enforcement of appropriate laws on sexual abuse and violence particularly of women. Community participation is viewed holistically as involving appropriate, responsive and accountable utilization of health services. Whilst people must understand their rights to health care, they must also understand their responsibilities to the health system so that the system benefits the greatest number of people. Individuals must also take responsibility for their health status by choosing appropriate lifestyles.

Quality improvement and assurance is essential across service delivery platforms and policy coordination and implementation at national and provincial level. The Quality Strategy as aligned to this strategy will drive the provision of both curative and preventative services. Its focus is holistic in that its basic principles are cross-cutting: a) preventing adverse outcomes for clients (patient harm) through infection control, reducing medical errors, and costs; b) reducing unnecessary or avoidable waste through economic evaluation studies, assessments of duplication, addressing waiting times and unnecessary referrals and treatments; and c) exploring opportunities to foster innovation in how care is delivered, to include coordination between services, reducing overuse of some services, and avoiding underutilization of technology. Overall, the health system must be patient-centred and responsive to their needs. Introduction of quality standards and an institutional arrangement to ensure enforcement of these standards is necessary over the strategy period.

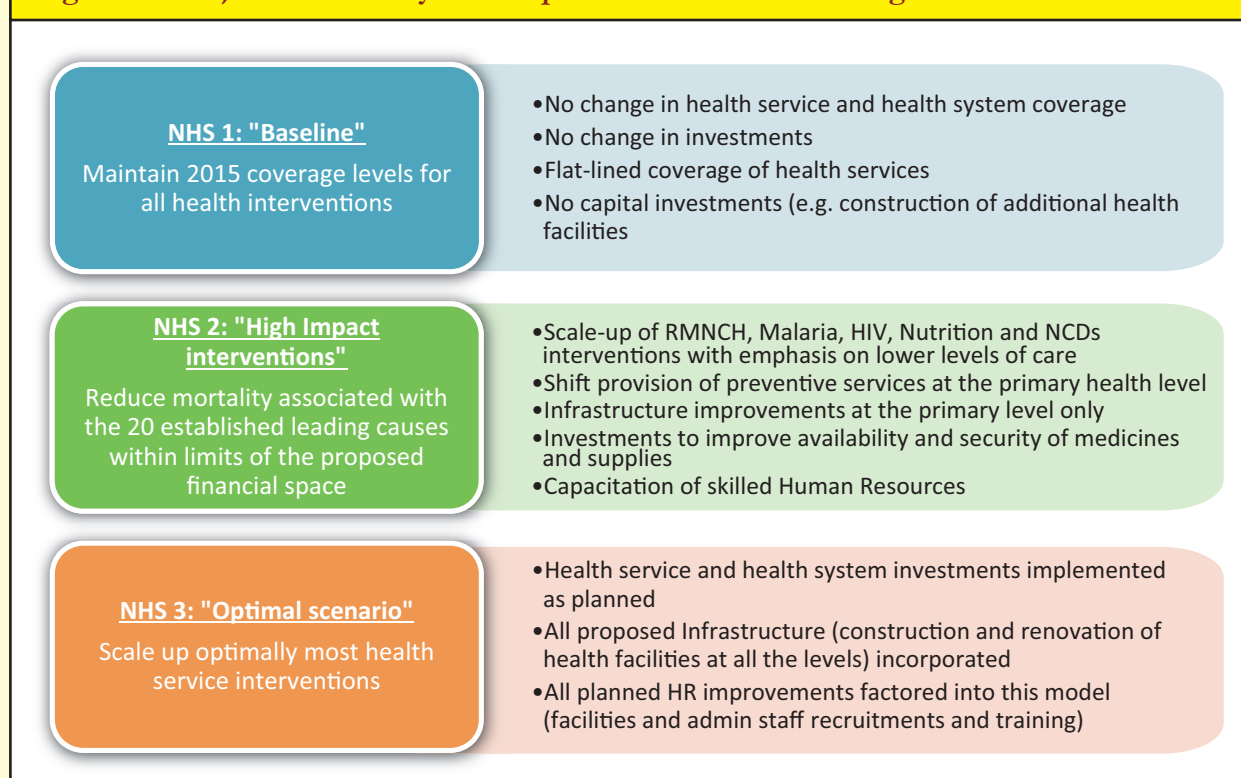
4.2 Costing scenarios and key assumptions

Zimbabwe National Health strategy (NHS) costs estimation was facilitated by the UN OneHealth tool, a unified costing template that estimates the cost of health services and system inputs required to achieve desired health outcomes and impacts. Further details on the tool and costing process are available (MOHCC 2016).

The costing exercise aimed to estimate all costs related to delivering the package of health interventions identified in the NHS for the period 2016 to 2020. Health programs costed include: Reproductive Health Maternal Newborn and Child Health; Immunization; Malaria; TB; HIV/AIDS; Nutrition; Environmental Health and WASH; Non-communicable diseases; Mental Health and Other Communicable Disease (such as Rabies, Anthrax, Other Diarrhoeal Disease). Costs related to health system investments include: Human Resource, Infrastructure, Governance, Health Information System, and Logistics.

Three scenarios were defined to assess how cost and impact differ for alternative scenarios of packages, targets and activities. This allows examining alternative scenarios for reaching targets to make informed decisions and select the policy option scenario and targets to incorporate for final estimation of activities and budgets.

The draft NHS provided an ambitious plan that could not be sustained by current or anticipated financial resources. This ambitious plan corresponds to the NHS3 costing scenario or “Optimal” scenario. The prioritization exercise enabled development of a robust, concise yet feasible NHS within reasonable anticipated resource envelope: this is the NHS2 costing scenario or “High Impact interventions” scenario. The policy direction informing the prioritization centered on the need to address the overarching bottlenecks identified through the bottleneck analysis conducted during the development of the NHS. The thrust was to embrace the primary health care approach (though equally addressing the referral bottlenecks), with a focus on harnessing the principal gains envisaged in preventative programming. Finally, NHS1 costing scenario reflects what it would cost to maintain current coverage level for health interventions: this is the “baseline” scenario (Figure 25).

Figure 25: Objectives and keys assumptions for the three costing scenarios

The entire plan would cost \$6.7bn, \$7.4bn and \$8.3bn for NHS 1, 2 and 3 respectively (Table 16). At the end of the period, the per capita cost would be \$73, \$91 and \$97 for NHS 1, 2 and 3 respectively.

Table 16: Total cost for the three scenarios (million USD)

Scenarios	2015	2016	2017	2018	2019	2020	Total
NHS 1	926.12	1,137.54	1,192.01	1,150.43	1,125.50	1,115.62	6,647.23
NHS 2	926.12	1,187.45	1,302.72	1,316.45	1,348.63	1,364.53	7,445.90
NHS 3	926.12	1,262.98	1,516.87	1,580.66	1,577.39	1,460.60	8,324.63

The preferred scenario (NHS 2), which is expected to have a mean cost per capita of \$88 over the entire period, would have the following impact in 2020: Decline in infant mortality from 45 per 1000 (2015) to 36 per 1000 live births in 2020; Decline in child mortality from 70 per 1000 (2015) to 60 per 1000 live births in 2020; Decline in maternal mortality ratio from 614 (2015) to 514 per 100,000 live births in 2020; and 101,984 life years gained by ART and PMTCT interventions by 2020.

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