THE NATIONAL HEALTH STRATEGY

FOR ZIMBABWE

(2009 - 2013)

EQUITY AND QUALITY IN HEALTH:
A PEOPLE'S RIGHT

PRIMARY HEALTH CARE
A HEALTHY NATION
MINISTRY OF HEALTH & CHILD WELFARE
ZIMBABWE

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Foreword

This National Health Strategy, 2009 – 2013: Equity and Quality in Health-A People's Right, is a successor to the National Health Strategy, 1997 – 2007: Working for Quality and Equity in Health, whose major thrust was to improve the quality of life of Zimbabweans.

The process of developing the Strategy began in 2006 with financial assistance from the World Health Organisation, and was scheduled for completion before the end of 2007. Due to socioeconomic challenges and the political situation in the country which made it difficult to plan long-term, the exercise could not be finalized in 2007 as planned. In 2008 the new strategy should have been launched. However in 2008 the country also experienced the peak of the economic crisis resulting in a sharp decrease in funding for social services by both government and development partners. This directly contributed towards an unprecedented deterioration of health infrastructure, loss of experienced health professionals, drug shortages and a drastic decline in the quality of public health services. Some government central hospitals were completely closed forcing patients to seek health care from the private sector, church run health facilities and traditional health practitioners.

In February 2009, an Inclusive Government was formed and one of its immediate tasks was "Getting Zimbabwe Moving Again". Within a few weeks, the new Government launched the Short-Term Emergency and Recovery Programme (STERP) as a strategy to rehabilitate the country.

The Ministry of Health and Child Welfare, for its part, organized and convened an Emergency Health Summit from 5-6 March 2009, to develop a 100-Day plan to "kick start" the health system under the auspices of the new Inclusive Government. Over 180 stakeholders participated in developing concrete recommendations for action contained in a document, "Getting the Zimbabwe Health Care System Moving Again". This was followed by a ministerial retreat during which Government developed its first 100 day plan. Subsequently, two additional funding proposals were developed and submitted to the Ministry of Finance. Between 2008 and 2009, the Ministry of Health and Child Welfare operated on what one might describe as emergency Annual Plans.

There is an old adage *"Those without a vision, will perish!"*. Thus the country cannot continue operating without a strategic direction, even if it is facing economic challenges and uncertainty over funding. The Ministry of Health and Child Welfare has therefore developed this strategy as part of its mandate, to give strategic direction in health sector development. This five Year National Health Strategy should serve two purposes; first to provide a framework for immediate resuscitation of the health sector and second, to put Zimbabwe back on track towards achieving the Millennium Development Goals.

The Government of Zimbabwe has, in the past, always funded the majority of health activities. Partners have come to fill in the gaps. In the current economic environment, partners are required not only to fill in the gaps, but to assist the country in "lifting off the ground" in the hope that as the economy recovers, government will again be the major funder of health and other social services. Most development partners have committed themselves to fund the Ministry agenda and not their own. It is therefore critical that partners keep this promise and use this document as a reference point to guide all activities in the health sector. The process will be slow, incremental but with a direction.

The document is structured along the following lines:-

- **Context for the National Health Strategy:** Overall context for this health strategy including the mandate, vision and mission of the Ministry of Health and Child Welfare, and Zimbabwe's demography, health status, burden of disease and health system functioning.

- **Part One: Determinants Of Health:** The strategic goals, objectives and proposed strategies to address the determinants of health, including the socioeconomic environmental and behavioural factors, that contribute to the disease burden in Zimbabwe

- **Part Two: Specific diseases affecting Zimbabweans:** The strategic goals, objectives and proposed strategies aimed at addressing specific diseases affecting Zimbabweans. For each disease, condition or population group there is a short description of the Status, Trends and Way Forward. A deliberate effort has been made to make each chapter as comprehensive as possible and as a result, some recurring themes will be noted in most sections as "Key issue to be addressed"

- **Part Three: Health System Strengthening:** The strategic goals, objectives and proposed strategies aimed at addressing the environment that has to be in place for the implementation of the interventions that will lead the nation to its vision.

- **Part Four: Inclusive Implementation:** The strategic goals, objectives and proposed strategies aimed at ensuring the critical and inclusive participation of all stakeholders in successfully implementing this strategy for the health of the nation.

The strategy is based on information from several studies carried out in the last three years (Study on Access to Health Services; Vital Medicines and Health Services Survey; Community Working Group On Health surveys; Zimbabwe Maternal and Perinatal Mortality Survey etc), existing national plans and programmes as well as existing programme specific policy and strategic documents. However it does not cover all details from such policy and strategic documents. Furthermore the strategy has taken into consideration regional and international policies, strategies and commitments made by the country such as the Millennium Development Goals, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, as well as other international, continental and regional health protocols including the African Union (AU) Health Plan; the East, Central and Southern Africa (ECSA) Health Community Agreements, and the Southern African Development Community (SADC) Health Sector Protocol.

Uncertainties over resources have made it difficult to set concrete targets to attain over the life of this strategy; however, a comprehensive Monitoring and Evaluation plan will be developed as an immediate first step to enable integrated monitoring of strategy implementation and impact. The Ministry realizes that the current socio-economic environment, with its limited financial and human resources, also makes it unrealistic to implement the entire five year agenda immediately. As a follow up to this strategy, a "Three Year Rolling Plan" will therefore be developed. This plan will cover priority performance areas where improvements must take place to maintain those activities keeping the health sector "ticking" and thus preventing a complete collapse of the health system. This "Three Year Rolling Plan" forms the basis of the Health Sector Investment Case. In the first year priority will be placed on resuscitating the ailing health system, to address the main health diseases and conditions with the greatest impact on the health of the nation using the Primary Health Care approach.

I therefore urge you all to implement this strategy to secure equity and quality in the health of the nation over the next five years.

Dr Henry Madzorera
Minister of Health and Child Welfare

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Abbreviations

ACT	Artemisinin based Combination Therapy
AFRA	Africa Regional Cooperative Agreement For Research
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ARI	Acute Respiratory Tract Infections
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
AU	African Union
BCG	Bacillus Calmette-Guérin
BMI	Body Mass Index
BSS	Basic Safety Standards
CBNCP	Community Based Nutrition Care Programme
CBDs	Community Based Distributors
CBR	Community Based Rehabilitation
CCZ	Consumer Council of Zimbabwe
CDR	Crude Death Rate
CDC	Centers for Disease Prevention and Control (USA)
CHDs	Child Health Days
CMAM	Community Based Management of Acute Malnutrition
CMED	Central Mechanical Equipment Department
CMR	Child mortality rate
COMESA	Common Market for East and Southern Africa
CSFP	Child Supplementary Feeding Programme
CSO	Central Statistics Office
CWGH	Community Working Group on Health
DDT	Diethly-Dichloro-Triethyline
DOTS	Directly Observed Treatment Short course
EDLIZ	Essential Drugs List of Zimbabwe
EHTs	Environmental Health Technician
EPI	Expanded Programme of Immunisation
ESP	Expanded Support Programme
EU	European Union
FDC	Fixed Drugs Combination
FSAB	Food Safety Advisory Board
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
HBC	High Burden Country
HIV	Human Immuno-deficiency Virus
HOSPAZ	Hospice Association of Zimbabwe
HRH	Human Resources for Health
IAEA	International Atomic Energy Agency
ICT	Information Communication Technology
IDD	Iodine Deficiency Disease
IEC	Information Education and Communication
ILO	International Labour Organisation
IMCNI	Integrated Management of Childhood &Neonatal Illnesses
IMR	Infant Mortality Rate
INFOSAN	International Food Safety Authorities Network
IPR	Intellectual Property Rights
IRHS	Indoor Residual House Spraying
ICT	Information and Communication Technology
ITN	Insecticide Treated Nets
KAPB	Knowledge, Attitude, Practice and Behaviour
LEB	Life Expectancy at Birth

MCAZ	Medicines Control Authority of Zimbabwe
MDGs	Millennium Development Goals
MDR TB	Multiple Drug Resistance Tuberculosis
M&E	Monitoring and Evaluation
MIMS	Multiple Indicator Monitoring Survey 2009
MIS	Management Information Systems
MNH	Maternal & Newborn Health
MOHCW	Ministry Of Health and Child Welfare
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NAC	National AIDS Council
NCPA	National Action Programme for Children
NCDs	Non Communicable Diseases
NGOs	Non Governmental Organisations
NUST	National University of Science
NatPharm	National Pharmaceutical Company of Zimbabwe
NCDs	Non Communicable Diseases
NDTPAC	National Drug and Therapeutics Policy Advisory Committee
NHIS	National Health Information System
NHSP	National Health Strategic Plan
NIDs	National Immunisation Days
NMRL	National Microbiology Reference Laboratory
NPAC	National Programme of Action
OIs	Opportunistic Infections
OVCs	Orphans and Vulnerable Children
PASS	Poverty Assessment Study Survey
PFMS	Public Finance Management System
PHC	Primary Health Care
PHHE	Participatory Health and Hygiene Education
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother To Child Transmission of HIV
PWDs	People With Disabilities
PSIP	Public Sector Investment Program
RBM	Results Based Management
RBZ	Reserve Bank of Zimbabwe
RDC	Rural District Council
RHC	Rural Health Centre
RPAZ	Radiation Protection Authority of Zimbabwe
RTA	Road Traffic Accident
SADC	Southern African Development Community
SAFE	Surgery, Antibiotic therapy, Facial cleanliness, Environmental improvements
SARS	Severe Acute Respiratory Syndrome
SCMLT	State Certified Medical Laboratory Technician
STHs	Soil Transmitted Helminthes
STIs	Sexually Transmitted Infections
SP	Sulfadoxine and Pyrimethamine
TB	Tuberculosis
TBRL	Tuberculosis Reference Laboratory
THP	Traditional Health Practitioners
TM	Traditional Medicine
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Education, Scientific & Cultural Organisation
UNFPA	United Nations Population Agency
UNICEF	United Nations Children's Fund
UZ	University of Zimbabwe
VIA	Visual Inspection With Acetic Acid Solution
VCT	Voluntary Counseling and Testing
VEN	Vital, Essential and Necessary Drugs

VHW	Village Health Worker
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WHO	World Health Organisation
XDR TB	Extremely Drug Resistance Tuberculosis
ZDHS	Zimbabwe Demographic Health Survey
ZDF	Zimbabwe Defence Forces
ZEPI	Zimbabwe Expanded Programme of Immunisation
ZimVAC	Zimbabwe Vulnerability Assessment Committee
ZINQUAP	Zimbabwe Quality Assurance Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNCR	Zimbabwe National Cancer Registry
ZNFPC	Zimbabwe National Family Planning Council

Executive Summary

The National Health Strategy (NHS, 1997 – 2007) set the agenda for launching the health sector into the new millennium. Recognizing that improvement in the health status of the population would not depend on health sectoral actions alone, it sought to pull together all national efforts which had potential to enhance health development into a promising new era.

Whilst the situation analysis carried out at that time showed a worrying decline in health status indicators, the optimism associated with the dawn of a new era provided hope and conviction for improvement. Similarly, the identified weaknesses in the performance of the health system were thought to be temporary, in the hope that the holding capacity of the economy to support a robust health system would improve.

On the contrary: the challenges facing the health sector continued and in fact got worse. During the second half of the implementation period of the National Health Strategy (1997 – 2007), Zimbabwe experienced severe and escalating economic challenges which peaked in the year 2008. The economic decline resulted in a sharp decrease in funding for social services in real terms. This directly contributed to an unprecedented deterioration of health infrastructure, loss of experienced health professionals, drug shortages and a drastic decline in the quality of health services available for the population.

Health Status

Based on data from the Zimbabwe Demographic and Health Survey 2005/6 (ZDHS), Multiple Indicator Monitoring Survey 2009 (MIMS), Maternal and Perinatal Mortality Study and other stidues, the NHS has identified that Zimbabweans are dying from easily preventable and treatable conditions e.g. HIV and AIDS, TB, Diarrhoea, Acute Respiratory Infections, Malaria, Malnutrition, Injuries, Hypertension, Pregnancy Related and Perinatal complications, Mental Health disorders etc. The health status of Zimbabweans can be summarized as follows:

- HIV prevalence continues at an unacceptably high level of 13.7% (15 – 49 year age group) with only 180,000 of an estimated 400,000 persons requiring treatment actually receiving antiretroviral therapy (ART) by mid year 2009
- TB remains a leading cause of morbidity with a notification rate of 434 out of 100,000
- Child health status indicators are worsening, with infant mortality and under five mortality rising from 53 and 77 per 1000 live births in 1994, to 60 and 86 per 1000 live births respectively in 2009 (MIMS)
- The nutritional status of children indicators are unacceptably high with stunting increasing from 29.4 in 1999 to 35% among children under 5 years old
- Maternal mortality levels are at an unacceptably high level of 725 deaths per 100,000 births (Zimbabwe Maternal and Perinatal Mortality Study, 2007)
- Cholera epidemics, exacerbated by a country wide breakdown of sewage and water supply and treatment systems, claimed 4,269 lives out of a total of 97,469 cases by end of April 2009
- It is estimated that over five million people are at risk of contracting malaria annually
- Outbreaks of rabies and anthrax continue being reported in some parts of the country
- There is continued and increasing public health significance of chronic non-communicable conditions such as diabetes and hypertension (Zimbabwe STEPS survey, 2005)
- Life expectancy at birth has fallen from 63 in 1988 to 43 years in 2005/6

Service Delivery

The various studies and surveys carried out in Zimbabwe over the last three years point towards inadequacies in the six health system building blocks (human resources; medical products, vaccines and technology; health financing; health information; service delivery and leadership and governance) that are prerequisites for a functional health delivery system.

There is gross underutilization of public sector institutions, due to non-functionality of the health care system for various reasons:

- Public sector Human Resources for Health vacancy levels (December 2008), are at unacceptable levels of 69% for doctors, 61% for environmental health technicians, over 80% for midwives, 62% for nursing tutors, over 63% for medical school lecturers and over 50% for pharmacy, radiology and laboratory personnel.
- Health management has weakened as a result of high attrition rates of experienced health service and programme managers. This has an impact on supervision and monitoring and is evidenced by reduced quality of service provision.
- Health professionals cannot provide services without adequate medicines and equipment. Access to essential drugs and supplies has been greatly reduced with stock availability ranging between 29% and 58% for vital items and 22% and 36% for all categories of items on the essential drugs list in 2008. Vital items should always be 100% available.
- Medical equipment, critical for diagnosis and treatment is old, obsolete and non-functional.
- The majority of physical health infrastructure is in a state of very serious disrepair. Fixed plant and equipment such as laundry machines, kitchen equipment and boilers are also non-functional. As a result very few public health institutions are able to meet basic hospital standards for patient care and infection control measures.
- As a result of serious shortage and disruption of transport and telecommunications several programs including patient transfer, immunisations, malaria indoor residual spraying, drug distribution, supervision of districts and rural health centres have been compromised.
- The health system is grossly under-funded. The current revised budgetary allocation works out to approximately US$7 per capita per annum against the WHO recommendation of at least US$34.

Besides this gloomy picture of health status and health system, the remaining health professionals have continued providing some limited services with support from both Government and a number of health development partners. The combined effort of the Ministry of Health and Child Welfare, communities, development partners and the private sector, has seen a reduction of HIV prevalence in the 15-49 years age group from 29.3% in 1997 to 13.7% in 2009; the malaria incidence rate has also been declining; the National Immunization and Child Health Days have been a great success resulting in high immunization coverages for selected antigens; occurrences of vaccine preventable conditions have fallen to insignificant levels; all primary care clinics have at least one primary care nurse; the Village Health Worker programme is back on course and the Parliament Portfolio Committee on Health has continued to lobby for more resources for the health sector. All of these successes indicate that with an injection of appropriate resources, health workers can be productive and produce tangible improvements in the health and quality of life of Zimbabweans. It is worth noting that even during these difficult economic times, Government, through the Ministry of Finance, has continued to give priority to the health sector,

The Ministry of Health and Child Welfare remains committed to the vision of ensuring the highest possible level of health and quality of life for all citizens of Zimbabwe. This will be attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socio-economic development of the country. To achieve this vision, the Ministry of Health and Child Welfare has developed this National Health Strategy which has thirty three areas for action and implementation over the next five years. The areas identified go beyond the boundaries of the health sector and are thus the responsibility of the government as a whole, as exposure to some socio-economic and environmental risk factors increases the disease burden of communities.

The Ministry realizes that with the current socio-economic environment it is unrealistic, with its limited financial and human resources, to implement the entire five year agenda at once. As a follow up to this strategy, a "Three Year Rolling Plan" will therefore be developed. This plan will cover priority key performance areas where improvements must take place in order to, at the very least, maintain those activities that are keeping the health sector "ticking" and also prevent a complete collapse of the health system. This "Three Year Rolling Plan" will form basis of the Health Sector Investment Plan

In the first year of the Three-Year Rolling Plan, priority will be placed on resuscitating the ailing health system and making it more functional, in order for it to be able to address the main health diseases and conditions with the greatest impact on the health of the nation.

The main strategy that will be used to address these diseases and conditions will be the Primary Health Care Approach. Zimbabwe, in 2008, joined the rest of the world in re-committing itself to Primary Health Care by signing the Ouagadougou Delcaration. The Primary Health Care Approach will assist the Ministry in not only addressing the health needs of this nation, but will also steer the country towards attainment of the Millennium Development Goals. In 2004, Zimbabwe officially adopted the Millenium Development Goals as the nation's 2015 development vision and since then Zimbabwe has been working towards meeting the MDG targets. From a regional perspective, this document has incorporated some elements of the Africa Health Strategy. Based on the diseases and conditions mentioned above, the following priority programmes will be scaled up:

- HIV, AIDS, STI & TB Programme
- Nutrition Programme
- Environmental Health and Hygiene Programme.
- Maternal Health and Family Planning Programme
- Child Health Programme
- Malaria Control Programme
- Non-Communicable Disease Programme
- Epidemic Preparednes and Response Control Programme
- Mental Health Programme
- Oral Health Programme
- Eye Care Programme
- Heath Promotion Programme, including the School Health Programme

Priority will also be placed on revitalizing the Health Care delivery system based on Primary Health Care including an effective, efficient, referral system and Emergency Services. The health care system covers issues such as the management of common illnesses, emergency services, oral health services, and mental, oral, eye, disability and rehabilitation services amongst other health services.

Health System Strengthening

Adequate resources and an appropriate enabling environment are critical prerequisites for the successful scaling up of the above mentioned programmes. The Ministry has identified the critical success factors for the successful scaling up of health programmes and these are:-

1. Provision of adequate, skilled and well remunerated Human Resources for Health. Efforts will be made to:-
   a. Retain health workers at work by giving them a living income that can be sustained by the current economy.
   b. Increase productivity and professionalism of health workers by providing them with adequate tools of the trade as listed below
   c. Reduce the overall vacancy levels through halting and reversing brain drain, recruiting, training and retaining qualified health staff. The role played by community health workers, as evidenced by their actions during the cholera epidemic, should not be underplayed as one looks at the human resources for health.
2. Continuous supply of medicines and medical supplies:- There will be need to improve the availability of medicines, medical sundries and other hospital supplies, to a level that will enable institutions to provide at least basic services as defined for each level of care.
3. Provision of functional Equipment (Fixed and movable) and Infrastructure:- There will be need to improve the availability and functionality of diagnostic and treatment medical equipment in critical departments (Theatre, Laboratory, Casualty, Maternity, X-ray & renal departments). Water supplies and provision of generators at health facilities shall be given high priority.
4. Provision of Transport:- There will be need to improve the availability of reliable transportation and telecommunication systems to improve and strengthen the referral system.
5. Ensuring a sustainable and predictable Financial Base:- There will be need for advocating and lobbying for a sustainable and predictable financial resource base, to ensure the provision of high quality services to the population.
6. There will also be need to address the issues of leadership and governance at all levels, disease surveillance and health information for decision making including strengthening coordination of health sector players.

These critical success factors are addressed in this strategy under the six pillars of a health system as defined by the World Health Organisation (WHO).

Inclusive Implementation And Monitoring

The thrust and theme of the National Health Strategy is naturally focused on promoting and improving the quality of services and ensuring equity in the delivery of these services. This will be achieved primarily through the meaningful participation and involvement of local communities. In the past, community participation has been interpreted as the provision of free labour by communities for the construction of physical facilities such as clinics and water points. Communities value services when they play a role in their design and development. Relative to their asset base and given the decline in formal health sector funding, communities are likely to be providing a large share of support to health related programmes in their areas through cash and in-kind contributions in the form of labour. This contribution should be officially recognized and evaluated. During the next five years, communities, through health centre committees or community health councils, will be actively involved in the identification of health needs, setting priorities and mobilizing and managing local resources for health.

The action points for the next five years include areas outside the boundaries of the health sector. The current environment in Zimbabwe (characterized by poor and inadequate water supplies; breakdown in the sewer systems; inadequate sanitation in both urban and rural; poor waste management practices; inadequately supervised food preparation processes; and inadequate control of vector borne diseases, coupled with increased urban unplanned overcrowded settlements and poor enforcement of laws and regulations that protect health) has increased the exposure of the nation to hazardous factors in water, air, food and in some cases soil. The picture presented by the top ten outpatient conditions that include diarrhoeal, eye, and skin diseases including asthma and tuberculosis is a reflection of increased exposure to hazardous agents within the environment. Inter-sectoral coordination and collaboration will be necessary to address these major contributors to illness, disability and death in the country.

Improvements in the health status and quality of life of the population do not depend solely on interventions within the health sector. It takes the efforts, contributions and participation of a myriad of stakeholders involved in both financing and direct provision of health services. It nevertheless remains the responsibility of the state, through the Ministry of Health and Child Welfare, to provide leadership and more importantly, stewardship, in harnessing and nurturing these efforts and contributions. Maintaining sustainable partnership frameworks will be an ongoing negotiation process, promoted within an ambit of co-operation and with promotion of equity, quality and access to health care being the focus. Key to implementation of this strategy will be partnerships with Public Health Providers including Missions and Local Authorities; the private sector; traditional international development partners including the United Nations Family and bilateral donors; regulatory bodies of the health professions; institutes of higher learning and other ministries and sectors. Intersectoral collaboration will be based and focused on the common goal i.e. doing those things which improve the quality of life of the population, together. Existing district and provincial structures in the form of Provincial Councils, Provincial Development Committees and District Development Committees will support taking forward the operational agenda of this strategy.

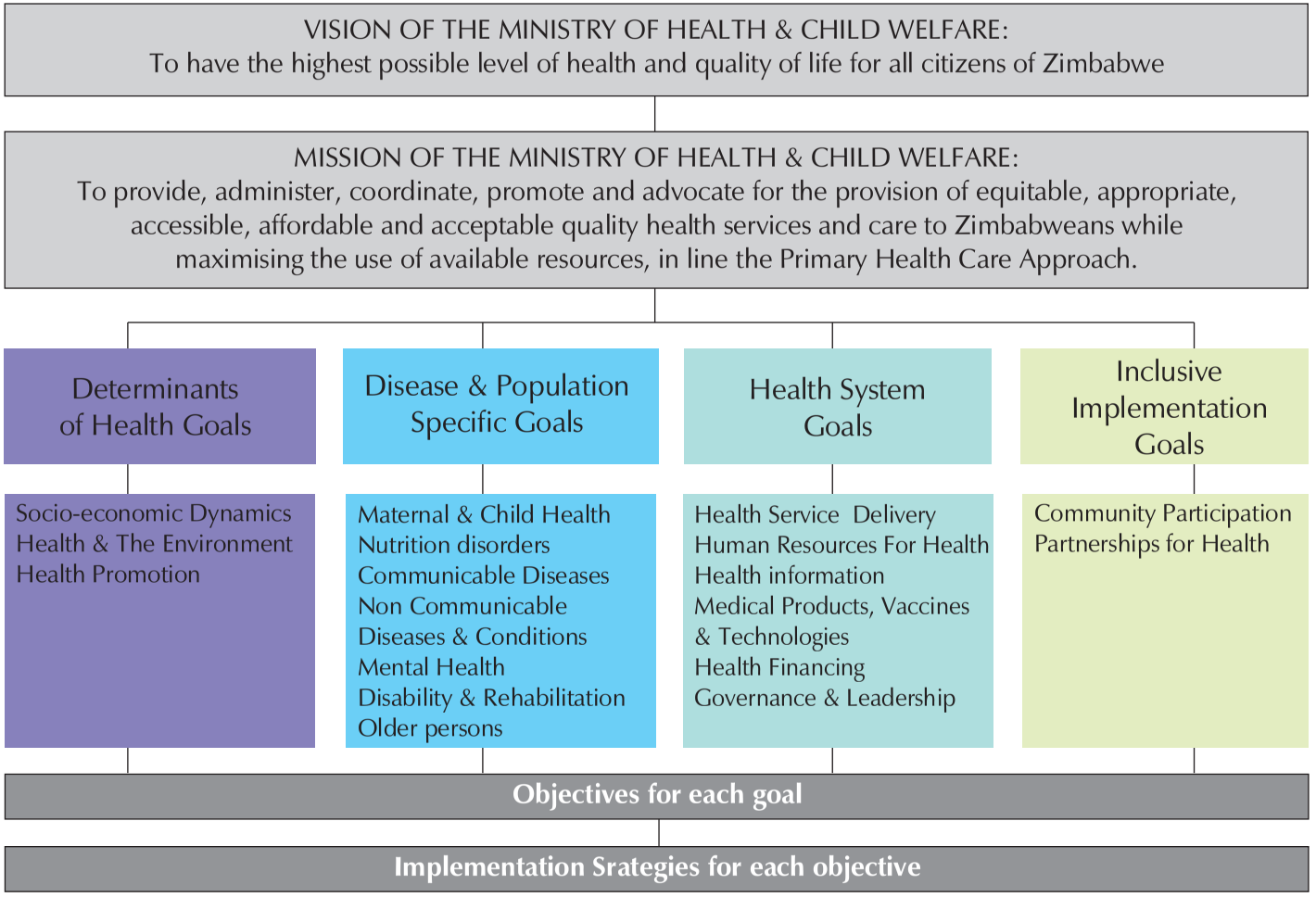
Overall structure of strategy

Based on the situational analysis above, the strategy is divided into four thematic areas. It is anticipated that successful, coordinated implementation within these four areas will lead the nation towards the national vision for health.

- **Determinants of Health:** addressing the factors outside the health sector which have an impact on health
- **Diseases affecting Zimbabweans:** addressing the burden of specific diseases and conditions affecting Zimbabwean's
- **Health System Strengthening:** supporting the overall health system context in which services must be planned, delivered and monitored
- **Inclusive Implementation:** acknowledging and enabling the actions of a wide range of stakeholders towards realising the health of the nation

The strategy develops trends, current status and key issues then articulates goals, objectives and implementation strategies within each of the four thematic areas. A total of **thirty three** goal areas have been identified under these four thematic areas, reflecting the comprehensive nature of an approach required for full health sector revival. This strategic approach is summarized in the figure below, with goals, objectives and implementation strategies detailed in the tables that follow:

Zimbabwe's National Health Strategy 2009-2013: Strategic Approach



2009 -2013 Zimbabwe National Health Strategy Part 1: Determinants Of Health	
Goals	**Objectives**
SOCIO-ECONOMIC DYNAMICS	
1. To increase national awareness on the impact of socio-economic factors such as resource allocation, income, poverty, adult literacy, housing, food availability and working conditions, on the health and quality of life of the population	Advocate for improvement in socio-economic status and living conditions of the population.
	Strengthen inter-sectoral coordination and collaboration with relevant sectors and other organizations, towards improving health and quality of life of the population.
	Increase awareness on and advocate for action by relevant ministries and other stakeholders on the major determinants of health such as water, sanitation, food, hygiene, education and gender amongst others.
HEALTH AND THE ENVIRONMENT	
2. To contribute towards the creation of a safe and healthy environment through strengthening Environmental Health Services in particular, promotion of safe water, appropriate and adequate sanitation, food and personal hygiene	Increase access to safe water and sanitation.
	Increase national awareness and understanding on the impact of environmental factors and living conditions (settlement, factories, agriculture industry, mining, sewage, waste disposal, toxic waste deposal, radiation hazards) on the health and quality of life of the population.
	Promote rural and urban development and housing within an environment where pollution from various types of waste (solid, liquid, chemical, noise, radiation) is reduced to an acceptable minimum.
	Reduce air, water and terrestrial pollution by strengthening mechanisms including regulations that will control and minimize contamination of the environment.
	Strengthen public health measures that ensure food for sale to the public meets standards and is sold and prepared in a manner and in premises that comply with public health regulations. Increase awareness on clean and hygienic living conditions
HEALTH PROMOTION	
3. To promote positive behavioural change through health promotion	Promote positive health behaviours (lifestyles) in 80% of targeted health promotion audiences by 2010.

2009 -2013 Zimbabwe National Health Strategy Part Two: Disease and Population Specific Goals	
Goals	**Objectives**
MATERNAL & CHILD HEALTH	
4. To reduce the Maternal Mortality Ratio from 725 to 300 deaths per 100,000 live births by 2015	Increase the availability and utilisation of youth friendly Family Planning and HIV prevention services.
	Increase the availability and utilisation of quality focused antenatal care including PMTCT services.
	Improve access to skilled attendance at delivery; including EmONC.
	Improve access to quality PNC including PMTCT services.
	Strengthen the capacity of the health system for the planning and management of MNH programmes.
	Improve the policy environment for provision and utilization of quality and equitable MNH services.
5. To reduce the Under Five Mortality Rate from 86 per 1000 live birth to 43 by 2013	Scale up high impact child survival interventions (Immunization, IMCI, etc.).
	Improve coordination and strengthen multi-sectoral approaches to addressing child health conditions.
	Advocate for increased resource allocation to child health programmes.
	Strengthen monitoring and evaluation of child welfare activities and programmes.
NUTRITION DISORDERS	
6. To reduce the incidence and prevalence of nutrition disorders	improve the sustainability of nutrition related programmes.
	Create awareness on the impact of nutrition on health and quality of life through information, education and communication (IEC) on dietary habits.
	Monitor nutritional status of the population for early detection of malnutrition.
	Improve household food security.
	Develop a national programme on control of vitamin and mineral deficiencies.
	Improve the nutritional status and quality of life of people infected and affected by HIV and AIDS.
	Improve nutritional management of malnutrition.
	Improve Infant and Young Child Feeding.
COMMUNICABLE DISEASES	
7. To have halted, by 2015, and begun to reverse the spread of HIV and AIDS (MDG)	Prevent and control HIV and STI transmission.
	Reduce the impact of STI, HIV and AIDS on the individual, community and society.
	Improve coordination and strengthen multi-sectoral approaches to addressing the HIV and AIDS epidemic.
	Advocate for greater resource allocation for STI/HIV and AIDS interaction (extra-budgetary).
	Strengthen STI/HIV and AIDS surveillance and improve research and programme effectiveness.

COMMUNICABLE DISEASES (cont.)	
8. To reduce the mortality, morbidity and transmission of tuberculosis in line with the Millennium Development Goals and the Stop TB Partnership targets	Expand and enhance provision of high quality DOTS.
	Enhance coordination and implementation of TB/HIV collaborative activities.
	Effectively prevent, control and manage multi-drug resistant TB.
	Contribute towards the strengthening of health systems.
	Promote partnerships with other care providers and stakeholders at all levels of the health system.
	Empower people with TB and their communities.
	Promote operations research.
9. To have halted, by 2015, and begun to reverse the increasing incidence of malaria (MDG)	Achieve universal access to malaria prevention and personal protection.
	Improve diagnosis and treatment of uncomplicated and severe malaria.
	Improve detection and timely control of malaria epidemics.
	Strengthen community and other stakeholder participation to maximize achievement of universal access to malaria control interventions.
	Improve coordination, management and monitoring for achieving universal access to malaria control interventions.
10. To improve timely detection and control of epidemic prone diseases (Cholera, dysentery, rabies, anthrax, plague, pandemic influenza, meningococcal meningitis, viral haemorrhagic fevers (VHF) etc.	Strengthen timely detection and control of all epidemic prone diseases through use of Integrated Disease Surveillance and Response.
	Strengthen prevention and timely control of zoonotic diseases.
	Prevent cholera and other diarrhoeal diseases.
	Strengthen detection and control of Viral Haemmorrhagic Fevers (VHF).
	Strengthen detection and control of outbreaks.
	Reduce morbidity due to schistosomiasis and soil transmitted helminthes.
11. To reduce morbidity due to schistosomiasis and soil transmitted helminthes by year 2015	Establish the incidence and prevalence of Schistosomiasis
	Establish the incidence and prevalence of soil transmitted helminthes
NON COMMUNICABLE DISEASES & CONDITIONS	
12. Improve the prevention and management of priority Non-Communicable Disease (NCDs)	Reduce the burden of non communicable diseases by between 15 and 20% by 2013
	Protect women and children against all forms of abuse and violence.
	Increase community participation and responsibility in the promotion of healthy lifestyles and responsible behaviour.
	Research on the social impact of lifestyles on health.
	Increase access to services for clients with NCDs.
	Reduce morbidity and mortality due to cancer.
	Reduce and prevent the incidence of blindness.
	Reduce the incidence of oral health problems.

MENTAL HEALTH	
13. To reduce the incidence of mental illnesses through strengthening and promotion of mental health programs	Increase access to appropriate and effective mental health services, with an emphasis on access; and to reduce the incidence of mental illness.
	Improve the capacity of all levels to achieve national goals.
	Improve outcomes for those with mental illness through the use of proven, effective treatments.
	Create an environment that promotes the mental well being of individuals.
	Strengthen and coordinate forensic services.
DISABILITY & REHABILITATION	
14. Improve the functionality, independence and quality of life of people with disabilities	Increase access to quality medical rehabilitation services to all that need them.
OLDER PERSONS	
15. Improve the quality of life of older persons	Promote the well being and quality of life for older persons.

2009 -2013 Zimbabwe National Health Strategy Part Three: Health System Strengthening	
Goals	**Objectives**
HEALTH SERVICE DELIVERY	
16. To increase coverage, access and utilization of affordable, comprehensive and quality preventive and curative health services	Improve the functionality of Primary Health Care clinics and the referral hospitals (district, provincial and central referral hospitals).
	Improve the quality of care provided in health facilities.
17. To increase availability of transport to at least 75% and communication systems to 100% of the requirements levels	Increase availability of transport at all levels.
	Increase availability of a reliable communication package at all levels.
18. To increase physical access of the population to appropriate health infrastructure for each level of care	Increase the availability of functional infrastructure in underserved areas including deliberate emphasis on developing farm/resettlement area health facilities.
	Regulate the establishment of health facilities.
	Upgrade and rehabilitate health infrastructure.
19. To ensure the delivery of an effective, efficient, accessible, equitable, and affordable national quality assured network of tiered laboratory services	Improve the quality of clinical and public health laboratory service provision.
20. To improve on the quality of the national analytical laboratory services for food, water, toxicology/clinical and industrial inputs/products analysis	Improve the quality of laboratory diagnosis.
	Improve the capacity of the Government Analyst Laboratory.
	Strengthen the administration of the Food and Water Safety and Quality Regulations to ensure availability of safe food and water to the public.
	Improve information collection, gathering and dissemination as National CODEX and INFOSAN Contact Points, SADC, COMESA and FSAB substantive member and secretariat. To be part of the nucleus of the imminent food control authority.
21. To increase access to high quality imaging services	Strengthen the medical imaging services.
22. To reduce radiation exposure of both human beings and the environment	Upgrade Radiation Protection Infrastructure &Services through the implementation of the Radiation Protection Act [Chapter 15:15].
	Ensure safety and security of radioactive sources and contribute towards the fight against illicit trafficking.
	Increase national awareness of radiation hazards and risks.

HUMAN RESOURCES FOR HEALTH	
23. To ensure that the health system based on PHC has appropriate numbers and categories of Human Resources for Health for efficient and effective implementation of the National Health Strategy	Develop and implement a human resources policy and strategy.
	Reduce vacancy levels across all staff categories by 50%.
	Strengthen management at all levels.
HEALTH INFORMATION	
24. To provide reliable, relevant, up-to-date, adequate, timely and reasonably complete information for health managers at facility, district, provincial and national level	Harmonise the functions of the Health Information and Surveillance Systems.
	Strengthen Health Information and Surveillance systems.
	Increase the use of information in decision-making.
	Increase access to information that is ready to use.
	Increase Human Resource capacity in Health information strengthening.
	Improve monitoring and evaluation of HIS.
25. To increase utilization of health research findings for policy development	Strengthen and market the National Institute of Health Research (NIHR).
	Strengthen health research capacity at all levels.
	Conduct Essential National Health Research.
	Develop and transfer appropriate public health technologies to new resettlement areas.
	Promote use of evidence based decisions and policies in the development, facilitation and implementation of health programmes.
	Strengthen national, south-south and north-south research collaborations.
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES	
26. To improve overall availability of drugs, medical supplies and other consumables to 90%	Increase medicines availability in all health institutions to 100% for V, 80% for E and 75% for N.
	Ensure 100% of all medicines entering the health sector are safe, efficacious and of good quality.
27. To increase availability of functional equipment to ensure the delivery of effective curative and preventive services	Increase availability of functional medical equipment and technology for diagnosis, treatment and patient monitoring appropriate for each level of care.
	Implement a preventive maintenance programme.
28. To increase access to and rational use of safe, efficacious and quality traditional medicines	Implement the Traditional Medicine Policy and code of ethics in Zimbabwe.
	Promote the proper use of safe, efficacious and quality Traditional Medicines.
	Educate and train Traditional Health Practitioners (THPs) and Allopathic Health Practitioners (AHPs).
	Strengthen the Protection of Intellectual Property Rights (IPR) of Traditional Medicine and Indigenous Knowledge.
	Contribute to production and conservation of medicinal plants.
	Strengthen the institutional framework for traditional medicine.

HEALTH FINANCING	
29. To increase the levels of sustainable and predictable financial resource base to ensure provision of high quality services to the population	Strengthen the Financial Management system at all levels.
	Improve use of existing resources.
	Mobilize resources for the health sector including to a sustainable financial resource base of at least US$34 per capita.
GOVERNANCE & LEADERSHIP	
30. To improve governance and management of the health sector	Strengthen management and leadership at all levels of the health sector.
	Strengthen the decentralization of health service management to local levels.
	Strengthen the role of regulatory bodies and agencies.
	Provide clear strategic direction for health development.
	Clearly define the appropriate regulatory framework to ensure the various stakeholders fulfill their responsibilities in health.
	Coordinate activities among the different units within the Ministry of Health and Child Welfare.
	Establish a functional mechanism to ensure transparency and accountability in the health sector.
31. To strengthen capacity to formulate, develop and implement health policies and regulations	Create an inclusive health policy development framework.
	Link health service provision to national social development objectives.
	Define role of local authorities in health services development and provision.
	Coordinate activities among the different units within Ministry of Health and Child Welfare.
	Identify and clarify policies which affect and promote the protection of the population's health.
	Strengthen the health policy development framework through coordination, dialogue and collaboration with sectors impacting on health and quality of life.
	Review existing health policies, legislation, and regulations so that they are consistent with changing circumstances.
	Monitor and evaluate the impact of policies on access, equity, efficiency and community satisfaction.

2009 -2013 Zimbabwe National Health Strategy Part Four: Inclusive Implementation	
Goals	**Objectives**
ENHANCING COMMUNITY PARTICIPATION & INVOLVEMENT IN IMPROVING HEALTH & QUALITY OF LIFE	
32. To enhance community participation and involvement in improving health and quality of life and in health development	Make available to all Zimbabwean information on the health status of the nation including determinants and risk factors for health.
	Create an enabling environment and encourage individuals to take responsibility for their own health and secure the health of the others.
	Establish methods for seeking broad based national consensus on priorities to be addressed.
	Make individuals, families and communities aware of their rights and responsibilities.
	Re-vitalize and strengthen the role of the village health worker and other community health workers.
	Provide an enabling implementation framework for community participation.
	Empower communities and ensure their involvement in the governance of health services.
PARTNERSHIPS FOR HEALTH	
33. To enhance collaboration with both local and international development partners	Strengthen partnerships with public health providers.
	Increase and strengthen private sector involvement in the health sector.
	Increase and strengthen intersectoral collaboration and coordination in health development.
	Strengthen partnerships with local and international health partners.
	Strengthen partnerships with health related stakeholders.

Context For The National Health Strategy

INTRODUCTION

Good health and quality of life do not derive only from the health sector, but are influenced by a myriad of other factors which are outside its direct influence. All sectors of the economy impact on the health and quality of life of all citizens through their direct influence on the social determinants of health.

The Ministry of Health and Child Welfare plays a stewardship role in safeguarding the health of the population of Zimbabwe, as well as in direct provision of health services. The Ministry operates within the functions mandated to the office of the Minister of Health and Child Welfare (Restricted: Hand-book on the Functions of the Minister of Health and Child Welfare, March 1993) as well as the provisions of the Public Health Act (Chapter 15:09) and the Health Service Act.

VISION OF THE MINISTRY OF HEALTH AND CHILD WELFARE

The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socio-economic development of the country. This vision will be attained through guaranteeing every Zimbabwean access to comprehensive and effective health services. Guided by its mandate and in line with the Results Based Management framework, the Ministry of Health and Child Welfare has therefore defined the following Key Result Areas (KRAs):

- Improving the health status of the population
- Improving the quality of care
- Health systems strengthening

MISSION OF THE MINISTRY OF HEALTH AND CHILD WELFARE

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

In pursuing this mission, the Ministry of Health and Child Welfare is committed to the following values: -

- Equity in health status and health care
- Comprehensive quality services
- Cost effectiveness (value for money) and efficiency
- Client and provider satisfaction
- Transparency and accountability
- Ownership and partnership in health
- Monitoring and evaluating the performance of the health service to ensure accountability and adherence to national standards and policies.

In broad terms, the mission of the Ministry of Health and Child Welfare will be pursued through:

- Continuously reforming the Health Sector in line with changing needs.
- Strengthening the Primary Health Care Approach as the main strategy for health development.
- Increasing partnership in health services and care whilst maintaining the principle of three ones (one national plan, one coordinating mechanism and one monitoring and evaluation mechanism).
- Ensuring resource availability and sustainability.

Underpinning the Ministry of Health and Child Welfare mission is the need to:

- Achieve equity in health by targeting resources and programmes towards the most vulnerable and needy amongst the population.
- Maintain the Primary Health Care approach as the leading strategy for health development.
- Focus on health as a key component in overall national development policies towards improving the quality of life of all citizens.
- Identify priority health problems and target resources accordingly.
- Develop innovative and new approaches in management and delivery of services in ways which enhance access, community satisfaction and local accountability.
- Aim at high quality health services.
- Give priority to disease prevention, health promotion and protection.
- Widen the participation of stakeholders in the development and implementation of policies for better health and
- Establish wider awareness on the impact of social determinants of health.

The Ministry will therefore ensure that Zimbabweans enjoy the highest possible level of health and quality of life, in line with the vision described above. This aim can be further articulated as:

- To keep as many people as possible in good health in the Community **(A)** through health protection, health promotion and disease prevention strategies
- To provide appropriate quality services for those needing care in the community **(B)** (Primary Care services) and
- To provide high quality hospital services at the appropriate level for those few requiring that form of treatment and care **(C)** (secondary, tertiary and quaternary care).

DEMOGRAPHIC DYNAMICS AND HEALTH STATUS

Demography helps to define those population groups in potential need of health services and those who are vulnerable and at risk. It provides the denominators for comparison of the health status of the same population or against other populations.

There is a close relationship between socio-economic development and the population growth rate. Improved socio-economic development goes hand in hand with improved health status and quality of life, which are in turn associated with a falling birth rate.

Zimbabwe is a landlocked country situated in Southern Africa. The country covers an area of 390,759 km2 and is divided into 10 administrative provinces that include Harare and Bulawayo. The other 8 provinces are mainly rural and are made up of a total of 62 districts.

Zimbabwe's population increased from 10.4 million in 1992 to 11.6 million in 2002 (Central Statistics Office). In 2008, the population was 12,121,565 (Inter-Censal Demographic Health Survey – ICDHS - 2008). The annual population growth rate was 1.1 between 1992 and 2002. According to the 2008 ICDHS, the average rate of natural increase has declined to 0.7.

The male/female ratio in 2008 was 0.93, meaning there are slightly more females than males in the total population, whilst the dependency ratio has dropped to 0.81 (ICDHS 2008) from 0.94 in 1992. This means that for every 100 adults in the age group 15 – 64, there are 81 children and elderly people who should be looked after.

Table 1: Selected demographic indicators.

Indicator	1982 CSO	1988 ZDHS	1992 CSO	1999 ZDHS	2002 CSO	2005/6 ZDHS	2008 ICDHS
Crude birth rate (CBR)	44	-	34.5	30.8	30.3	31	25
Total Fertility Rate (TFR)	6.2	5.5	-	4	-	3.8	3.3
Crude death rate (CDR/1000)	10.8	-	9.5	-	17.2	-	20
Infant Mortality Rate/1000	86	53	65	58	-	55	63
Life expectancy at Birth	57.4	63	61	-	45	43	43
Annual growth rate	1969-82= 3	-	1982-92= 3	-	1.1	1992- 1.1	0.7
Sex ratio: male-Female	96:100	-	95	-	94	2002 = -	93
Rural/Urban population	R74%:U26%	-	R69%:U31%	-	R65%:U35%	-	R74/U26
Dependency ratio	101:3	(103.7)	94.4	87.4	80	-	81

The age structure of the population has remained young, with 41% of the population aged below 15 years. Both in the 2002 Census and 2008 ICDHS, 41% of the population was below 15 years of age, 55% was between the ages 15 and 64 years, and a very small proportion (4%) was 65 years of age or more.

3.6% of the population were under one year old in 1992, with a figure of 3.3% in 2008, according to projections from the 2002 census. The proportion of 5-14 year olds has remained stable at the 1992 figure of around 30%. For planning purposes it is important to note that there is a large dependent proportion of the population (45%) made up of children under 15 years (41%) and those over 65 years (4%). It is also important to note that women and children comprise over 70% of the population.

There has been a drastic decrease in the Life Expectance at Birth (LEB) from above sixty years in 1990, to 41 years for males and 46 years for females according to the Inter-Censal Demographic Health Survey (ICDHS).

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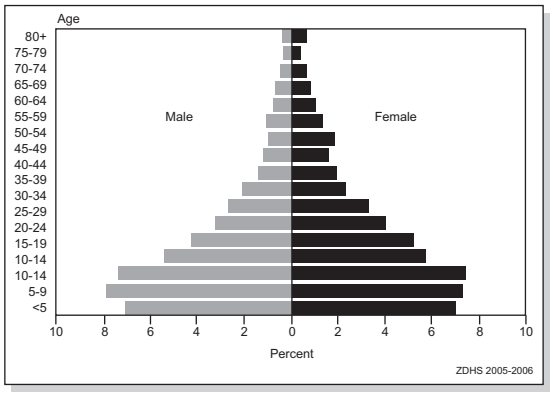
Population structure

Zimbabwe has a broad based population pyramid and a narrow top, reflecting a youthful population with a large proportion of children. This youthful population results from a relatively high fertility and increased adult mortality. However, the structure of the 2005/6 population pyramid is consistent with a population experiencing a decline in fertility. The number of children under five is less than the number aged five to nine years, a finding that is consistent with a recent fertility decline.

Figure 1: Zimbabwe population pyramid10



The total fertility rate has been declining over the years, from 7.9 children per women in 1969 to 6.5 in 1984. It further declined from 5.5 to 4.3 in the period 1985 to1994 and the ZDHS 2005/6 and ICDHS 2008 surveys reported the fertility rate to have further declined to 3.8 and 3.3 births respectively. The table below shows trends in current fertility rates based on successive ZDHS reports. Fertility declined by 1.7 births between 1988 and 2005-6 surveys.

Table 2: Trends in total fertility rates, Zimbabwe 1984-2006

Age Group	1998 ZDHS 1984-1988	1994 ZDHS 1991-1994	1999 ZDHS 1996-99	2005-06 ZDHS	2008 ICDHS
TFR 15-49	5.5	4.3	4.0	3.8	3.3

The 2003 Poverty Assessment Study Survey (PASS) reported that nationally, 30% of all children aged 0 to 17 years were categorized as Orphans and Vulnerable Children (OVCs), of whom 75% were orphans. The study estimated the overall prevalence of orphans within the same population to be 22% giving a total of 1,207,645 children below the age of 18 years. According to the ZDHS 2005/6, close to a quarter of children under the age of 18 years were orphaned, that is, one or both parents were deceased. A dramatic increase was noted in orphan-hood on comparing the 1994 and 2005/6 surveys with the proportion of children orphaned more than doubling between the two surveys, from 9% to 22%. The proportion of all children with both parents deceased also more than doubled, from <1% to 6%. The 2003 study also noted that orphans, particularly double orphans, had a higher prevalence of being underweight (23%) as compared to non-orphans with the 2005/6 ZDHS confirming the same (21% of OVCs underweight, compared with 16% of other children). Urban OVCs, particularly those living in Harare, were particularly disadvantaged with respect to their nutritional status compared with the rural children. The most recent study, MIMS found, 37% of all children aged 0 to 17 years were categorized as Orphans and Vulnerable Children (OVCs), with 25% of all children being orphans. It can therefore be concluded that there are a great number of Orhans and Vulnerable Children in Zimbabwe, who are generally more vulnerable to poverty, food insecurity, malnutrition and HIV & AIDS.

The population living in urban areas has increased from 26% in 1982, to 31% in 1992 and 35% in 2002. With an area of 390,757 km2, the population density of the country was 29 persons per square kilometre (2002 census); an increase from 27 persons per square kilometre in 1992. The highest population densities are found in the cities, with the lowest density being in Matebeleland North due to national parks which

are sparsely populated. However, recent internal migration has resulted in a change in the settlement patterns and therefore population densities. This has a bearing on service provision and utilization, as well as the basic determinants of health.

An unplanned rural–to–urban drift has negatively affected the environment of urban local authorities. Urban infrastructure, specifically the maintenance of environmental standards including for housing, safe water, sanitation and refuse disposal, is deteriorating. There is also increasing pressure for expansion and creation of new infrastructure in the rural growth points and rural service centers, as well as the high density areas of towns and cities. Urban health care thus requires specific focus and attention. Raising awareness about the relationship between population dynamics and health will continue to be a major challenge for the future.

The PASS suggests that an additional urban-to-rural migration of specific populations could be due to job loses or HIV and AIDS as the jobless, retired and critically ill tend to move back to rural areas.

From 2000 there was also a rural-to-farming area migration due to the land reform programme, which saw people moving into designated farms where there were no social amenities. At the national level, 3.2 percent of the population migrated out of the country.

It must be noted that besides the urban – rural differences in some indicators, such as access to health services, there are also differences within the urban and rural areas themselves. There are sub-areas within the rural areas that are particularly far from health facilities; others have high incidences of specific conditions, whilst others are hard to reach for reasons of geography and infrastructure. Of particular note is the growth in the number of unplanned peri-urban settlements without water, sanitation, health and other amenities. These issues need to be considered in programme planning.

Key demographic issues considered in the development of this National Health Strategy were thus:

- 70% of the population lives in the rural areas
- Over 70% of the population is made up of women and children
- 41% of the population are children under 15 years of age
- Older persons make up 4% of the population
- A very large and increasing number of orphans and vulnerable children within the total population of all children.
- Unplanned peri-urban settlements without social services
- Resettled farmers without social services

Burden of disease

Morbidity and mortality trends in Zimbabwe show that the population is still affected by common preventable and treatable diseases and conditions including nutritional deficiencies, communicable diseases, pregnancy, childbirth and new born related conditions.

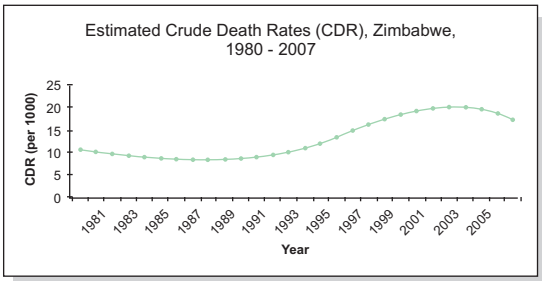
Mortality

Mortality figures are key indicators for assessing the quality of life of a population. Despite the earlier recorded successes of the early 1990s, most health indicators have either remained unchanged or have deteriorated. Multiple factors have affected the capacity of the public health sector to maintain the achievements of the first decade since Independence.

Crude Death Rate

The crude death rate dropped from 10.8 in 1982 to 6.1 in 1987 and then rose to 9.49 in 1992. The overall crude birth rate for the country was estimated at 17 deaths per 1000 population in the 2002 census and 20 deaths per 1000 in 2003. The 2008 Inter-Censal Demographic Health Survey (ICDHS) gives a crude birth rate of 25. The Crude Death Rate decreased from a high of 20.1/1000 population in 2003 to 17.2/1000 population in 2007. TheICDHS (2008) gives a crude death rate of 20.

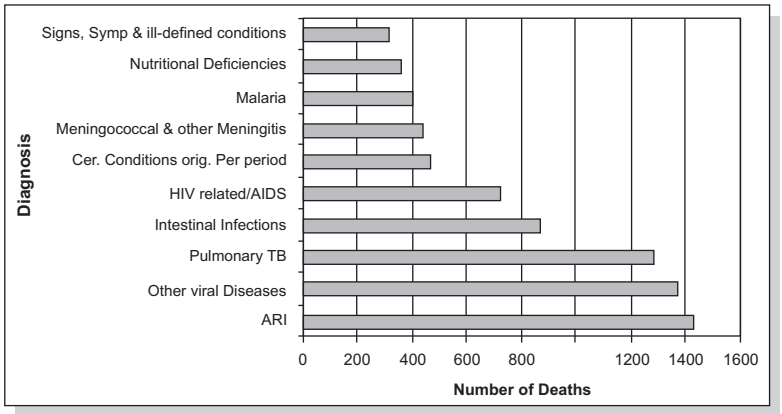
Figure 2: Crude Death Rate Trends



The HIV and AIDS epidemic has greatly affected the national crude death rate. The crude death rate is expected to rise in tandem with an expected rise in the age specific death rates of the 15-45 year olds and the under-fives, due to HIV and AIDS.

Causes of Illness and Death in Zimbabwe
The main causes of illness and death in Zimbabwe have been identified through the routine National Health Information System (NHIS) data as well as various studies as: HIV and AIDS; TB; Diarrhoea; Childhood Illness; Malaria; Malnutrition; Injuries; selected non-communicable diseases; and Reproductive Health & Pregnancy related conditions, as shown in Figure 3.

Figure 3: Causes of death 2008



Source: National Health Profile 2008

Gains have been made in the fight against the above mentioned communicable and non-communicable diseases. However, problems related to health transition in Zimbabwe (the shifting of disease burden from infectious disease to chronic illness in line with industrialized countries) have continued to increase the burden against a backdrop of limited resources (Human Resources for Health, material, equipment and technology).

Of advantage today is the huge knowledge base of 'what works'. Experience over the last ten years has made the health sector aware of high impact and low cost strategies that can be used to combat the diseases and conditions responsible for most illness and deaths in communities. It is therefore logical not to re-invent the wheel but immediately implement those good practices or interventions that represent good value for money in terms of impact on health status.

Priority Programmes For Scale Up
Based on the diseases and conditions mentioned above, the following priority programmes will be scaled up over the next five years:

- HIV, AIDS, STI & TB Programme
- Nutrition Programme
- Environmental Health and Hygiene Programme.
- Maternal Health Programme
- Family Planning Programme
- Child Health Programme
- Malaria Control Programme
- Non Communicable Disease Programme
- Epidemic Preparednes and Response Control Programme
- Mental Health Programme
- Oral Health Programme
- Eye Care Programme
- Heath Promotion Programme including the School Health Programme

Addressing The Burden Of Disease: The Primary Health Care Approach
The main strategy that will be used to address these diseases and conditions, scale up the priority programmes and ensure quality institutional care will be the Primary Health Care Approach (PHC). This implies a healthcare delivery system based on Primary Health Care with an effective and efficient referral system including Emergency Services, and critical health systems support. In 2008, the Government joined the rest of the world in reaffirming its commitment to the PHC approach as signatory to the Ouagadougou Declaration on PHC and Health System in Africa: Achieving better health for Africa in the new millennium.

Meeting The Millennium Development Goals
Critically, the Primary Health Care Approach will also steer the country towards attainment of the Millennium Development Goals. In 2004, Zimbabwe officially adopted the Millennium Development Goals as the nation's 2015 development vision and since then Zimbabwe has been working towards meeting the MDG targets. From a regional perspective, this document has also incorporated some of the elements of the Africa Health Strategy.

The priority diseases and conditions were selected on the basis that they together are responsible for 70% of illnesses and deaths; most are the MDG related target diseases and conditions; furthermore effective cost effective evidence based interventions to reduce the burden of illness and deaths are already known. Operationalising the eight PHC

elements and focusing on the MDG targets will thus address most of the disease burden in Zimbabwe. It therefore follows that a major thrust of the new national health strategy is meeting the PHC and MDG goals which are complementary and aligned with Zimbabwe's disease burden and programme priorities, as shown in the table below:

Table 3: Relationship Between Priority Diseases, MDGs and PHC elements

PRIORITY PROGRAMMES BASED ON BURDEN OF DISEASE			
Priority diseases	Millennium Development Goals	The 8 Primary Health Care Elements	Programmes
HIV, AIDS,TB, STI	MDG N°6: Halt / reverse the spread of HIV/AIDS, Malaria, TB	Education concerning the diagnosis, prevention and control of locally prevalent health problems	HIV, AIDS & TB Programme Heath Promotion Programme
Nutritional deficiencies, hunger	MDG N°1: Eradicate extreme poverty and	Food supply and security (nutrition)	Nutrition Programme
Diarrhoeal diseases	MDG N°7: Ensure environmental sustainability	Drinking water and sanitation	Environmental Health Programme
Maternal illneses and conditions	MDG N°5: Reduce maternal mortality ratio by three quarters;	Maternal and Child Health care including family planning	Maternal Health Programme Family Planning Programme
Child Health illness (Acute Respiratory Infections)	MDG N°4: Reduce under five child mortality rate by two thirds;	Immunization against major infectious diseases	Child Health Programme
Malaria and other epidemic prone diseases	MDG N°6: Halt / reverse the spread of HIV/AIDS, Malaria, TB;	Prevention and control of locally endemic diseases	Malaria Control Programme Epidemic Preparednes and Response Control Programme Health Information and Surveillance Programme
Non Comminicable diseases including Injuries and disabilities		Appropriate treatment of common diseases and injuries	Provision of health care services including Emergency Services Non Communicable Disease Programme Oral Health Programme Eye Care Programme
Mental Disorders			Mental Health Programme
SUPPORTIVE HEALTH SYSTEMS PROGRAMMES			
All above mentioned diseases required treatment		Provision of essential drugs	Essential Medicines Programme
Health information system	Implementation of best practices (IBM)	National Health information system	National Health information system
Research for health	Implementation of best practices (IBM)	All elements	National Health research agenda
NOTE: Zimbabwe incorporated three essential elements of mental health, oral health and NCDs to the original eight elements of the Alma Ata declaration of 1998 and reaffirmed by the Ouagadougou declaration 2008 on PHC and Health Systems: Achieving better health for Africa in the new millennium.			

From the available data (DHS 2006; census 2002, VAS 2003), programme evaluation and annual profiles 1998 – 2006, there is clear evidence that programme management can be improved. Programmes need to be based on health needs. The following measures need to be taken into account in the fight against communicable and non-communicable conditions. Specific objectives of targeted diseases and conditions need to be developed where they do not exist.

Key issues around disease burden considered in development of this National Health Strategy were thus:

- Ensuring that health programmes are based on health needs and problems as evidenced by the National Health Profiles
- Identifying new cost effective approaches for tackling morbidity and mortality, arising from existing and re-emerging communicable and Non Communicable Diseases (NCDs)
- Adequately training all health care staff for various roles in health promotion, disease prevention, case management, follow up and rehabilitation
- Promoting environmental health measures that will reduce the transmission of diseases
- Encouraging individuals, families and communities to be more responsible for their own health and care
- Preventing the spread of diseases through early detection, effective case holding and adequate treatment of all cases
- Strengthening and equipping both public health and clinical laboratories
- Ensuring availability of emergency medicines and commodities
- Improving the quality of life of chronic patients through a continuum of care after discharge
- Improving health protection programmes
- Promoting and encouraging multi-sectoral approaches to disease prevention and control, health promotion and protection
- Strengthening a functional health information system that will monitor health status and services to ensure that the information collected is used in decision making at all levels
- Strengthening information, education and communication strategies

SERVICE DELIVERY AND HEALTH SYSTEM STRENGTHENING

Adequate resources and an appropriate enabling environment are critical prerequisites for the successful implementation of all health programmes and thus delivery of services. The Ministry has identified six critical success factors for successful scaling up of health programmes as follows:

1. **Health Workforce:** Provision of adequate, skilled and well remunerated Human Resources for Health
2. **Medicines and Supplies:** Continuous supply of medicines and medical supplies
3. **Equipment and Infrastructure:** Provision of functional equipment (fixed and movable) and infrastructure
4. T**ransportation:** Provision of Transport
5. **Financial Resources:** Ensuring a sustainable and predictable financial base
6. **Governance and Leadership:** At all levels

However, various studies and surveys carried out in Zimbabwe over the last three years point towards the inadequacies of the six health system building blocks (human resources; medical products, vaccines and technologies; health financing; health information; service delivery; and leadership & governance). Challenges and constraints include:

- Inadequate funds allocated for service delivery
- Poor access to health care, especially by vulnerable groups
- Dilapidated infrastructure for the delivery of health services
- Frequent stock outs of essential supplies
- Poor quality of care in both public and private sectors
- Low salaries for health staff in the public sector and lack of incentives to work in remote areas
- Inadequate capacity for management and leadership
- Inadequate capacity in human resources development, including training and personnel management
- A weak health delivery system in terms of planning, budgeting and management
- Poor inter-sectoral action and partnership in service delivery
- Poor community participation and involvement in health issues.
- Poor availability of costing data for some aspects of the plan.

The current status in the Ministry indeed presents major challenges that require to be addressed within a resource constrained environment. This may require that the nation does *"business unusual"* but always keeping sight the beacon provided by the National vision described above (pg 22). As such, the health sector must strive to increase its capacity in the areas of Human Resources, Medicines, Medical Supplies and Medical

Equipment, Infrastructure, Transport and communication, Governance, Health Information and Financial Resources. The current status of each of these enabling factors is not encouraging due to the socioeconomic challenges being faced by the country (pg 33). However, improvement and coordinated application of the enabling environment will lead towards effective prevention and management of the priority diseases and health conditions eventually leading to the reduction of morbidity and mortality in the country. Implementing vertical programmes targeting the disease burden in isolation will not result in widespread health improvement, as the underlying health delivery system will remain ailing. Furthermore, addressing only one of the enablers will not solve the current crisis in the health sector: **all of the identified priorities need to be addressed.**

Key issues around health system strengthening considered in the development of this National Health Strategy were thus:

- **Health Workforce:** Efforts will be required to:
  - Retain health workers at work by giving them a living income that can be sustained by the current economy.
  - Increase productivity and professionalism of health workers by providing them with adequate tools of the trade as listed below
  - Reduce the overall vacancy levels through halting and reversing brain drain, recruiting, training and retaining qualified health staff. The role played by community health workers, as evidenced by their actions during the cholera epidemic, should not be underplayed as one looks at the human resources for health.
- **Medicines and Supplies:** Improvement of the availability of medicines, medical sundries and other hospital supplies, to a level that will enable institutions to provide at least basic services as defined for each level of care.
- **Equipment and infrastructure:** Availability and functionality of diagnostic and treatment medical equipment in critical departments (Theatre, Laboratory, Casualty, Maternity, X-ray & renal departments) will need to be improved. Water supplies and provision of generators at health facilities shall be given high priority.
- **Transportation:** Availability of reliable transportation and telecommunication systems to improve and strengthen the referral system will need to be improved.
- **Financial resources:** There will be need to advocate and lobby for a sustainable and predictable financial resource base, to ensure the provision of high quality services to the population.
- **Governance and Leadership:** There will be need to address the issues of leadership and management at all levels, disease surveillance and health information for decision making including strengthening coordination of health sector players.

INCLUSIVE IMPLEMENTATION AND MONITORING ARRANGEMENTS

Implementation of the Five Year Strategy will be the responsibility of all stakeholders under the leadership of the Secretary for Health and Child Welfare and the Top Level Management Team.

Institutional Arrangements of MoHCW

Overall, the National Health Strategy will be operationalised, monitored and evaluated in the context of the regular Ministry of Health and Child Welfare activities. The overall responsibilities of the different levels of care in the management of this plan are clearly defined.

Role of MoH&CW Head Office

By facilitating in the development of the National Health Strategy, the head office has assumed one of its key functions of setting policy and guidelines based on the information generated by the operational level.

The Secretary for Health and Child Welfare shall appoint a committee that will oversee the implementation and monitoring of the 5 Year Plan. One of the immediate tasks of this committee will be to disseminate the National Health Strategy for Zimbabwe as widely as possible and develop a comprehensive Monitoring and Evaluation strategy so that everybody is aware of:

- The proposed roadmap towards revitalization of the health sector (3 year plan and targets)
- The roles of the different stakeholders in making it a success.

The Secretariat of the Committee to monitor the implementation of the National Health Strategy will be the Policy, Planning Monitoring and Evaluation Division (PPMED) whose main functions will be to monitor concrete achievements through annual assessment of plans, programmes and projects and to give inputs to the Top Management Team and other senior managers through quarterly reports, minutes of meeting, feedback, follow ups and other relevant documents. More specifically, the role of PPMED in the context of the 5 Year Plan is to:-

- Devise and design clear mechanisms for accountability and ensure they are adhered to
- Co-ordinate the planning, monitoring and evaluation process of all health activities proposed in this strategy
- Co-coordinate capacity building in planning, monitoring and evaluation.
- Develop and apply monitoring instruments and ensure timely submission of reports

Role Of MoH&CW Provincial Level

There is need to distinguish between the Provincial Medical Director's office from the Provincial Hospital:

- The Provincial Medical Director's office is the local representative of the Ministry of Health and Child Welfare and is therefore accountable to the Ministry and Government in ensuring that health services in the province are delivered in accordance with the national health priorities.
- The Provincial Hospital is one of the operational areas.

The Provincial level has to make sure that all stake-holders in a Province are fully aware of the National Health Strategy and their roles in making it a success. Whilst all plans must comply with the National Health Strategy guidelines, the provincial office has to ensure that "specific area peculiar concerns" receive due attention and resources are provided.

Role of MoH&CW Operational Level (Central, Provincial and District hospitals)

The success of the 5 Year Plan will to a large extent depend on the commitment of the operational level. It is at the operational level where practical implementation of the 5 Year Plan is organised and managed.

Once the resource envelope is known, the operational level should prepare a detailed implementation programme with special emphasis on the first year of the 5 Year Plan.

The MoH&CW Planning System and Guidance For Implementation And Monitoring

The Ministry of Health and Child Welfares' planning guidelines will continue to be used. The MODO or National Planning Forum will also be used to monitor implementation progress.

The National Planning Forum shall continue to meet twice per year. The Mid Year National Planning Forum shall focus on performance review of the first six months of the year and decide on what activities to roll out until the end of the year. At this forum, the bottlenecks in the implementation process will be identified and ways in which they can be dealt with suggested. The product of the Mid Year MODO shall be an agreement of the priorities for the next 6 months of the year.

The second National Planning Forum for the year (to be held in November) shall focus on what GOZ has allocated to the health sector and what

our development partners pledge and will give to the health sector so that the Ministry can decide list of activities for implementation in the coming year. The product of the November National Planning Forum shall be a contract between Ministry of Health and Child Welfare and the operational levels as to how the allocated funds will be used in addressing the annual plans.

It is now a requirement, in line with Results Based Management, that a contract be signed between the operational level and the province or head office in the case of central hospitals. The contract will specify what activities will be carried out, when, where, how and at what cost. Included in the contract will also be monitoring and review processes. Indicators for monitoring will also be included in the contract.

Role of Communities
One of the key elements of the Primary Health Care approach is community participation. In the past, community participation has been interpreted as the provision of free labour by communities for the construction of physical facilities such as clinics and water points. However, during the next five years, communities, through health centre committees or community health councils, will be actively involved in the identification of health needs, setting priorities and mobilizing and managing local resources for health.

Role Of Other Stakeholders
The importance of inclusive participation by all stakeholders for successful implementation of this strategy cannot be over-emphasised. Stakeholders may include, but are not limited to:

- Community (see above)
- Health Services Board
- Urban Local Authorities
- Mission Hospitals
- Civil Society (local and international Non-Governmental Organizations)
- Business sector
- Private medical services
- Training Institutions
- Bilateral and multilateral donors
- United Nations Family
- Regulatory bodies
- Other Government Sectors

Stakeholder representatives will be included in the Implementation Monitoring Committee described above. All stakeholders will also be responsible for familiarizing themselves with the National Health Strategy and ensuring their plans, activities and results are aligned, communicating and contributing to the nationally identified priorities outlined in the strategy. Of necessity, different elements of this strategy will require prioritization by Government and Ministry depending on resources available. Critically therefore, stakeholders should also use this plan to work with Ministry to identify gaps and thus focus support on addressing unfulfilled implementation areas of the strategy.

Key issues around inclusive implementation arrangements considered in the development of this National Health Strategy were thus:

- The need to inform and mobilize all stakeholders in the health sector around the National Health Strategy
- The need to foster, encourage and facilitate meaningful community participation in the health sector
- The need to strengthen mechansisms for partnership, collaboration and funding of health sector activities to implement the wide National Health Strategy

OVERALL STRUCTURE OF STRATEGY

Based on the situational analysis above, the strategy is divided into four thematic areas. It is anticipated that successful, coordinated implementation within these four areas will lead the nation towards the national vision for health.

- **Determinants of Health:** addressing the factors outside the health sector which have an impact on health
- **Diseases affecting Zimbabweans:** addressing the burden of specific diseases and conditions affecting Zimbabwean's
- **Health System Strengthening:** supporting the overall health system context in which services must be planned, delivered and monitored
- **Inclusive Implementation:** acknowledging and enabling the actions of a wide range of stakeholders towards realising the health of the nation.

The strategy develops trends, current status and key issues then articulates goals, objectives and implementation strategies within each of the four thematic areas. A total of thirty three goal areas have been identified under these four thematic areas, reflecting the comprehensive nature of an approach required for full health sector revival. A deliberate effort has also been made to make each chapter as comprehensive as possible and as a result some recurring themes will be noted in most sections as "Key issues to be addressed".

Part 1:
Determinants Of Health

1.1 SOCIO-ECONOMIC DYNAMICS

Trends and current status

Good health and quality of life are influenced by several factors, including but not limited to food availability, security, housing, safe water and sanitation, hygiene and employment. Most of these variables are outside the normally understood boundaries of the health sector. However, it is the responsibility of the health sector to identify and inform both the general public and our policy makers of the factors that affect health and quality of life: the social determinants of health. It is therefore crucial that such factors are considered and included in the planning and implementation of government-wide strategies to promote and improve the health and quality of life of the population.

Poverty

Zimbabwe has been experiencing an economic downturn over the last ten years, escalating over the recent past due to recurring droughts, floods, absence of balance of payment support, withdrawal of lines of credit and disinvestment by foreign firms, foreign currency shortages for the importation of raw materials, equipment, fuel and electricity, and the devastating impact of the HIV and AIDS epidemic. Some of the challenges on the macroeconomic front included hyperinflation and low foreign exchange reserves.

The decline in the economy impacted negatively on the well being of the population both directly and indirectly. Directly, the economic downturn meant less revenue generation therefore decreased funding for most Government programmes. Recently, real decreases in public health expenditures and other resources have contributed towards a drastic decline in the quality of public health services, from which the heath system is yet to recover.

Indirectly, one of the major hindrances to increasing the achievement of better health is the increasing level of poverty. From a public health point of view, poverty becomes an impediment when individuals or groups become unable to enjoy the minimum standard of living. Closely linked to poverty is unemployment, whose consequences lead to increased vulnerability in the absence of properly targeted safety nets. Both unemployment and poverty are strongly linked to economic development. The economic contraction culminated in unemployment and inflation rates of over 80% and 231 million percent respectively by 2008. The high inflation rate grossly eroded the purchasing power of the Zimbabwe dollar, and coupled with the high unemployment rate, aggravated poverty (a known negative determinant of health) within the population.

This is significant as the poor tend to have more health problems and poorer access to care. According to the 2003 Poverty Assessment Study Survey (PASS), poverty in Zimbabwe increased considerably between 1995 and 2003. The study found that the proportion of households below the Food Poverty Line (very poor) increased from 20 percent in 1995 to 48 percent in 2003, representing an increase of 148 percent. The proportion of households below the Total Consumption Poverty Line (very poor and poor), increased from 42 percent in 1995 to 63 percent in 2003.

The PASS also found that proportionally, urban area households were increasingly becoming poorer, due to the deteriorating macroeconomic environment. Although there has been a higher increase in poverty incidence in urban areas, rural households have remained worse off.

During the period 2000 to 2008, the country's manufacturing, mining, tourism, and commercial farming sectors were not generating sufficient employment and were operating below capacity. At the same time, real wages from formal employment continued to decline. This decline in formal sector real wages, combined with sluggish employment growth, translated into a decline in average household incomes in real terms and an increase in the percentage of households living below the poverty line, and therefore exposed to more health problems.

Food Insecurity

Coupled with the recurrent droughts, which occurred in 1990/91, 1994/95 and 2000-2002, the decline in economic performance led to food insecurity in the population. This, in turn, led to high levels of malnutrition. The Zimbabwe Demographic and Health Survey showed that the underweight prevalence for under-fives increased from 13 percent in 1999 to 16.6 percent in 2005/6; and the prevalence of stunting, the chronic form of under nutrition, rose from 26.5 in 1999 to 29.4 in 2005/6.

Education

Education is a basic human right which enables a population to make informed decisions about its economic, social and political well-being. It is one of the areas where Zimbabwe has made great achievements, with a literacy rate of well over 95%. The more literate people become, the more they understand health and their responsibilities in securing their health and that of others.

Gender Issues and Violence Against Women
The government of Zimbabwe has made remarkable strides in addressing gender inequalities through legislation and a focus on addressing adverse socio-cultural norms. In the Health Sector, data capture has for a long time been disaggregated by sex and age, making it possible to understand gender barriers in access to healthcare and develop gender specific programmes. In 2001 the Ministry developed a strategy for integrating gender perspectives into the health sector.

Violence against women in the form of domestic violence, sexual coercion and rape, remains common in the lives of many women in Zimbabwe. A number of initiatives to curtail violence against women have been started by women's groups and NGOs, providing local safety nets and counseling services. In addition to these efforts, the health care system should continue to create more focus on issues of violence against women having not adequately focused on these issues to date, though Ministry of Health and Child Welfare has started working in this area through training of health workers in the management of Sexual and gender Based Violence (SGBV). The Ministry has also reviewed the gender and health training manual and Training of Trainers for gender mainstreaming has been done. Other initiatives in this area include rape victim friendly clinics.

Sexual Abuse and Vulnerable Children
An increasingly reported cause of child morbidity, though not captured in the official statistics, is child abuse. The National Programme of Action (NPA) Unit of the MOHCW stated that 2 000 children of all age groups and sexes were reported as being sexually abused in 2005. The perpetrators were reported to be mostly close relatives and neighbours of the abused children. Child sexual abuse carries with it the increased risk of HIV transmission. This increasing phenomenon also indicates the breakdown of child care practices which needs to be attended to in any comprehensive health strategy.

The problems of street children, commercial sex work and vagrancy are on the increase as the social safety net fails to protect a large number of those affected by economic insecurity.

Zimbabwe goes down in history as one of those countries with clear evidence of a linkage between the health status of a nation and its social, physical and economic environment. The major challenges, linked to economic performance and directly affecting the health service delivery system can be summarized as follows:

Key Issues
- Economic decline leading to hyperinflation and resulting in unaffordable commodities, unemployment and rising levels of poverty amongst the general population;
- Increasing negative social health determinants and risk factors for poor health and poverty;
- Drastic reduction in the purchasing power of the health budget, resulting in insufficient resources to procure essential drugs, including antiretroviral therapy, for people in urgent need, as well as basic health services equipment, medical and non medical supplies;
- The income of health workers does not meet their basic needs, resulting in very high attrition rates ranging from 20% to 80%.
- Inadequate foreign currency for health sector requirements

The economic challenges the country is experiencing are adversely affecting the health and quality of life of all Zimbabweans. The health sector should therefore strive to identify and inform both the general public and policy makers of the socioeconomic risk factors that affect health and quality of life.

Goal 1: To increase national awareness on the impact of socio-economic factors (resource allocation, income, poverty, adult literacy, housing, food availability and working conditions) on the health and quality of life of the population.	
Objectives	**Strategies**
To advocate for improvement in socio-economic status and living conditions of the population	• Develop and publish a simple-to-understand document spelling out the adverse effects on health of socioeconomic determinants of and risk factors for health. • Advocate for increased allocation of resources to activities that will reduce the adverse effects of socioeconomic determinants on the vulnerable population groups (e.g. social protection safety nets). • Advocate for the incorporation of education on the impact of socio-economic factors at an early stage in schools. • Monitor the impact of changing socio-economic conditions on health. • Institutionalize health equity analysis into the health sector. • Increase awareness among policy makers and other stakeholders on issues of equity in health and healthcare.
To strengthen inter-sectoral coordination and collaboration with relevant sectors and other organizations, towards improving health and quality of life of the population	• Advocate for the inter-sectoral development and strengthening of regulations and policies tackling the socio-economic inequalities that adversely affect women, children (see pg 81) and those in rural areas and high-density areas. • Identify and clearly spell out the impact on health and quality of life of policies, plans and activities of outside the health sector and advocate for their action to improve health.
To increase awareness on and advocate for action by relevant ministries and other stakeholders on the major determinants of health such as water, sanitation, food, hygiene, education and gender amongst others	• Advocate for the clear definition of the roles and responsibilities of the various players in reducing the adverse health effects of the socioeconomic social determinants on health and advocate for their appropriate action. • Advocate for the strengthening of policies that aim to reduce poverty levels in the country and provide social security services for the poor. • Promote community participation and involvement in activities that will reduce the adverse effects of major socioeconomic determinants.

1.2 HEALTH AND THE ENVIRONMENT

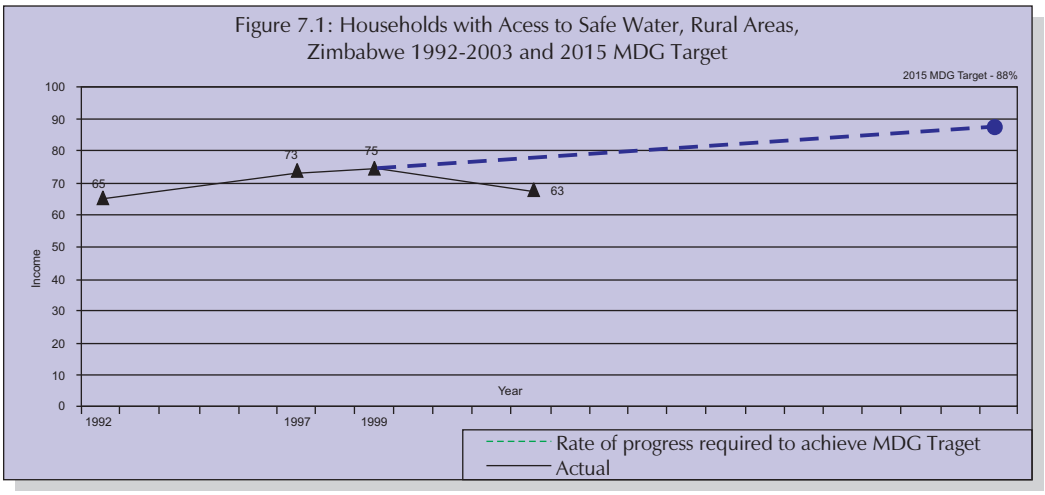
Trends and current status

Healthy environments and living conditions are essential requirements for a healthy people. The current economic decline is now affecting essential infrastructure such as housing, transport, water and waste disposal, causing outbreaks of diseases and other health problems. This economic challenge has led to the expansion of informal sector manufacturing industries as a survival strategy for most in the population. Food production in unregistered premises and consumption of unsafe foods including meat, meat products and milk, are on the increase. This makes it difficult for the few environmental health practitioners to inspect and assess these food processing sites, including 'backyard abattoirs'.

A review of the legal framework is needed in order to empower law enforcement agencies and local authorities to harness their efforts and support growth of informal sector trading (building standards etc), in order to safeguard hygiene and healthy living conditions.

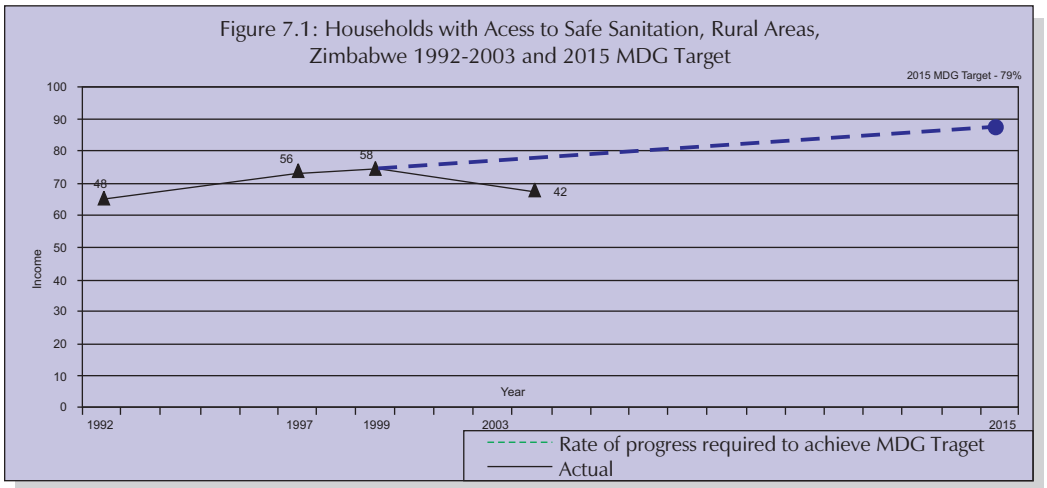
The provision of safe water and sanitation is critical to improving the living standards of the population. It also contributes significantly to the reduction in morbidity and mortality from diarrhoeal diseases. Zimbabwe invested and made great progress in water and sanitation programmes, post independence. According to the Labour Force Survey the proportion of rural households with access to safe water declined from 75.1 in 1999 to 66.5 in 2004. The 2008 ICDHS reports that 75 percent of households had access to safe water. With the recurrent problems in provision of water and sanitation in urban areas, it has been shown that some of the piped water is not safe.

Figure 4: Households with access to safe water in rural areas



Only 42 percent of rural households had access to safe sanitation in the form of Ventilation Improved Latrines. 43 percent of households in rural areas did not have any sanitation at all. This percentage might now be higher, considering the fact that new settlements have recently been established in areas without adequate sanitary and safe water provision. According to the 2008 ICDHS 31 percent of households had no toilet facility at all.

Figure 5: Households with access to safe sanitation, rural areas



Furthermore, in 2000, Cyclone Eline damaged many water points and sanitation facilities in some parts of the country, and most have still not been repaired. According to the 2008 Malaria Indicator survey, most households in rural areas used borehole water (40.9%), or unprotected water sources (22.5%). The bush was the commonest form of sanitation, followed by the Ventilation Improved Latrines (VIPs) (36.0%). Poor sanitation, hygiene and inadequate safe water supplies in rural and peri-urban areas thus remain a matter of great concern, needing priority attention especially in light of the recurrent cholera outbreaks.

A situation where urban coverage was nearly 100% for safe water supply and sanitation services is rapidly changing for the worse. There is need to replace and maintain old water and sanitation systems in the cities, towns and peri-urban areas. The rapid growth of urban populations calls for an urgent need to expand or revamp the water and sanitation systems.

The frequent power outages have led to water cuts, thus forcing urban dwellers to resort to alternative and less safe sources of water. Compounded by the deteriorating capacity to treat domestic and industrial effluent effectively, this has resulted in increased pollution of rivers and lakes, increasing the cost of purifying the water for domestic use.

Entrepreneurs have taken advantage of these shortcomings as evidenced by the proliferation of bottled drinking water and repackaged scarce food products, some of which have failed to meet national food and hygiene standards. This, naturally, calls for continuous monitoring and surveillance by the Government Analyst Laboratory and Environmental Health

Department of both bottled water and every stage in the 'farm to fork' food continuum (farming, manufacturing, processing, packing, labeling, distribution, retailing and catering). This is not always possible, due to limited availability of staff, transport and fuel.

A study on waste management commissioned by the Ministry of Health and Child Welfare in 2007 noted that most sewerage reticulation systems and treatment works were in a state of disrepair. This situation is conducive to the transmission of diarrhoeal diseases including cholera. Diarrhoeal disease outbreaks have occurred in a number of urban settings. Such situations are a threat to public health and need rectification as a matter of urgency, especially given the recurrent cholera outbreaks.

The safe and efficient collection, removal or disposal of industrial, domestic and medical waste, is one of the most important responsibilities of local authorities. The same study noted that local authorities were failing to provide efficient waste management systems, which has resulted in the non-collection and accumulation of refuse in the Central Business Districts, residential areas, markets, industrial areas and other public places. These situations have resulted in fly breeding, generation of offensive odours and breeding of vectors and vermin including rodents, which are known to be responsible for the transmission of plague and diarrhoeal diseases.

Lack of decent habitats remains a major concern. According to 2003 PASS, at national level, a comparison with the 1995 data revealed that for all poverty categories, the percentage of households who owned dwelling units had increased from 55 percent in 1995 to 69 percent in 2003. In rural areas, the percentage of households who owned dwelling units had increased from 67 to 82 percent.

In the urban areas, there is however the problem of overcrowding. According to the PASS study, nationally, the average occupation per room was 1.89 persons, which is nearly double the recommended average of one person per room. It was however observed that this was a slight improvement from 1995, where the average was 2.1.

Environmental health services and others in the health promotion and preventive services outside the health sector, such as schools, have played a major role in increasing health literacy through health promotion. Efforts in this area need to be further strengthened, as it is now well-documented that hand hygiene, together with improved water supply and sanitation, contribute significantly to reducing illness and deaths from diarrhoeal diseases.

The World Health Organization describes environmental health as comprising of those aspects of human health, disease, and injury that are determined or influenced by factors in the environment. It is a well known fact that exposing human beings to environmental factors that are hazardous to health is one of the major contributors to the increase in the disease burden. Half of the top ten leading causes of illness and deaths in Zimbabwe can be directly or indirectly linked to the environment.

The current environment in Zimbabwe (characterized by poor and inadequate water supplies, breakdown in the sewer systems, inadequate sanitation in both urban and rural, poor waste management practices, inadequately supervised food preparation processes and inadequate control of vector borne diseases coupled with increased urban unplanned overcrowded settlements and poor enforcement of laws and regulations that protect health) has increased the exposure of the nation to hazardous factors in water, air, food and in some cases soil. The picture presented by the top ten outpatient conditions that include diarrhoeal, eye, skin diseases, asthma and tuberculosis is a reflection of increased exposure to hazardous agents within the environment. Intersectoral coordination and collaboration will be necessary to address these major contributors to illness, disability, and death in the country. There is also need to adapt, adopt and implement the provisions of the Libreville Declaration on Health and Environment which Zimbabwe signed in 2008 and other local, regional and international initiatives on climatic change.

Key Issues

- Shortage of financial resources to provide safe water and sanitation, especially water treatment chemicals.
- Inadequate access to safe water and sanitation, in both urban and rural areas.
- Mushrooming of unplanned settlements in both the urban and peri-urban areas.
- Inadequate decent housing especially in urban areas.
- Air and water pollution.
- Shortage of skilled human resources for health especially public health practitioners.
- Weak enforcement of public health regulations.
- Promotion of hygienic practices.
- Inadequate capacity in waste management.
- Natural disasters (droughts and floods).
- Increased burden of environment related diseases.

Goal 2: To contribute towards the creation of a safe and healthy environment through strengthening Environmental Health Services and in particular, promotion of safe water, appropriate and adequate sanitation and promotion of food and personal hygiene.	
Objectives	**Strategies**
To increase access to safe water and sanitation	• Strengthen water and sanitation programmes. • Promote simple home treatment of drinking water.
To increase national awareness and understanding on the impact of environmental factors and living conditions (settlement, factories, agriculture industry, mining, sewage, waste disposal, toxic waste deposal, radiation hazards) on the health and quality of life of the population	• Advocate for the institutionalization of environmental impact assessment in national development projects. • Intensify awareness and sensitization of communities to reduce environmental pollution. • Develop and publish a simple to understand document on the impact of human activity on the physical environment. • Strengthen the lobbying and advocacy skills of the health sector in promoting environmental health. • Strengthen and promote integrated planning, implementation and monitoring on environmental health issues. • Strengthen inter-sectoral collaboration and coordination in the area of environmental health.
To promote rural and urban development and housing within an environment where pollution from various types of waste (solid, liquid, chemical, radiation and noise) is reduced to an acceptable minimum	• Advocate for clear definition of the roles and responsibilities of the various players in reducing the adverse health effects of environmental factors and poor living conditions. • Increase compliance with standards in the construction of housing and other public facilities that is compatible with healthy living. • Intensify health education on the importance of proper safe disposal of solid and liquid wastes, and measures that can be taken at community and family levels to encourage this. • Strengthen waste management systems (improving safe and efficient collection, removal or disposal of waste including clinical waste). • Identify, support, and strengthen programmes aimed at improving the living conditions of people in rural, urban and commercial farms. • Resuscitate and promote the concept of healthy villages and healthy towns.
To reduce air, water and terrestrial pollution by strengthening mechanisms including regulation that will control and minimize contamination of the environment	• Review and amend existing public health requirements and regulations to provide the legal backup to enforce control measures. • Institutionalize the International Health Regulations. • Adapt, adopt and implement the provisions of the Libreville Declaration on Health and Environment. • Review and strengthen the roles of regulating institutions. • Enforce the provisions in the Public Health Act and regulations. • Develop appropriate programmes to monitor environmental pollution.
To strengthen public health measures that ensure food for sale to the public meets standards and is sold and prepared in a manner and in premises that comply with public health regulations	• Strengthen the administration of the Food and Water Safety and Quality Regulations to ensure availability of safe food and water to the public. • Strengthen inspection food manufacturing, processing and storage premises. • Strengthen food sampling and analysis. • Strengthen the capacity of both Government analyst and Public Health Laboratory. • Increase education activities to the public on food safety including correct food handling and storage.
To increase awareness on clean and hygienic living conditions	• Strengthen Participatory Health and Hygiene activities. • Promote clean and hygienic conditions at home, public health facilities and work places. • Promote community participation and involvement in activities to create a healthy environment.

1.3 HEALTH PROMOTION

Trends and current status

Education concerning prevailing health problems and methods of preventing and controlling them is one of the pillars of the Primary Health Care approach.

The government has shown commitment to increasing health literacy levels through supporting health promotion activities over the years. The Health Promotion unit originally organized and directed from central and provincial levels has been further decentralized to the district level though the establishment of district health promotion officers. Realizing that health promotion officers cannot do everything on their own, the unit has maintained the objective of developing communication capabilities in all health workers to enable them to disseminate health education in the most appropriate and acceptable manner in the community. They have championed the development of support materials across the various health programmes which are used by health staff in health education.

Areas of documented health promotion success include HIV and AIDS, condom use, Expanded Programme on Immunisation (EPI), breast feeding, control of diarrhoeal diseases using Sugar-Salt-Solution (SSS), institutional deliveries and utilization of health facilities and family planning.

The reduction in the HIV prevalence in Zimbabwe has been partially attributed to heavy investment in information, education and communication by government, NGOs and the private sector. An epidemiological review commissioned by the MOHCW , Zimbabwe and published in November 2005 gathered data from several studies that supported that the decline in HIV prevalence had started in the late 1990's. This decline was further supported by data from the Zimbabwe Demographic and Health Survey of 2005/06 that showed HIV prevalence was 18.1% in the general population (15-49 years). The 2009 ANC HIV Estimates Technical Working Group Zimbabwe reports a further decrease to 13.71% in the same age group. The main conclusions of the epidemiological review were that a decrease in incidence (occurring mainly due to a change in sexual behavior, specifically a decrease in number of sexual partners and reported condom use) and mortality have combined to contribute to a decline in HIV prevalence. This is evidence that the high HIV literacy rate is being translated into action by individuals.

The 2009 Assessment Survey of Primary Health Care in Zimbabwe ("Health where it matters most") reaffirms that information is fundamental in disease prevention and control. The assessment found that people have a reasonable knowledge of common health conditions, but lack the specific knowledge needed to act in an informed way to promote and protect their health, (such as how to make and use Sugar Salt Solution (SSS) to manage dehydration). The Assessment reaffirms the need for communities to have consistent, regular, specific information flows and recommends that ad hoc and one-off information to communities needs to be integrated into a more comprehensive health literacy programme, as is currently being implemented in the districts supported by the Community Working Group on Health (CWGH). Support for the functioning of Village Health Workers (VHWs) and other community based health workers, person-to-person health information and mass media also provide a means to improved health information flows. The assessment notes that high levels of radio ownership mean radios are currently an under-utilised resource for health, also given gaps in transmission coverage and perceived poor quality programming. Addressing this and also promoting health information flow through community newspapers, community radio and schools would significantly enhance people's role in health if appropriately designed and disseminated. Technologies such as cell-phones are found to be widely available and SMS messages through cell-phones can send specific targeted messages on health actions. This was widely used to good effect during the 2008/9 cholera epidemic.

Information, education and communication have also been successfully used in Family Planning services. Knowledge of family planning methods is almost universal in Zimbabwe, meaning that men and women in the country have information about the options available for regulating births and planning their families. The 2005/6 ZDHS notes that the level of knowledge of at least one modern method of family planning among all women age 15-49 years is also almost universal at 98 percent, and for currently married women it is 99 percent.

The above examples are overwhelming evidence that health promotion can lead to changes in population risk factors and prevalence of both communicable and non-communicable diseases/conditions. However, more emphasis has traditionally been placed on information, education and communication around epidemic prone diseases. Since the risk factors for both communicable and non-communicable diseases are

known, investing in health promotion can also be expected to substantially reduce hypertension, cardiovascular disease, diabetes mellitus, dental caries, liver cirrhosis and accidents (see Non Communicable Diseases pg 66). Health promotion can thus play a significant role in reducing morbidity and mortality due to communicable and non-communicable diseases. It is therefore imperative that the fight against the underlying causes of these diseases be given priority for action.

There are number of missed opportunities for health promotion. The school health programme is a known effective strategy for increasing health literacy. The Child to Child Programme has not gained ground in Zimbabwe. Strengthening Participatory Health and Hygiene activities will go a long way in reducing diarrhoeal diseases. Workplace health promotion activities are on the increase but mainly limited to STI, HIV and AIDS activities.

Key issues

- Strengthening Participatory Health and Hygiene Education
- Obsolete equipment for the development and production of IEC materials.
- Lack of mobile units equipped with public address systems
- Lack of support to VHW and other community based health workers.
- Missed opportunities in utilization of mass media especially radio.

Goal 3: To promote positive behavioural change through health promotion	
Objectives	**Strategies**
To promote positive health behaviours (lifestyles) in 80% of targeted health promotion audiences by 2010	• Develop a National Policy and Strategy on Health Promotion. • Finalize the development of the School Health Promotion Policy. • Develop communication strategy. • Strengthen the management and coordination of health promotion activities. • Strengthen health promotion interventions for epidemics and seasonal conditions. • Promote planned health promotion activities at schools, workplaces and health training schools. • Train service providers in interpersonal communication for the improvement of patient care. • Conduct relevant KAPB studies to generate evidence for targeted health promotion interventions. • Strengthen production capacity for multimedia campaign materials. • Mobilize communities for greater involvement and participation in activities that promote good health. • Coordinate health promotion activities of all sectors including the private sector. • Strengthen Participatory Health and Hygiene Education.

Part 2:
Specific Diseases Affecting Zimbabweans

2.1 MATERNAL AND CHILD HEALTH

In Zimbabwe, the female population and children under 15 years constitute about 70% of the total population. This sector of the population is highly vulnerable to malnutrition, infectious diseases including HIV, reproductive health challenges etc. To address the challenges faced by women and children, the Ministry of Health and Child Welfare, as early as 1983, formulated a comprehensive Maternal and Child Health care programme. The objective of the programme was to provide comprehensive and effective health care to the mothers and children on a continuing basis throughout the entire pregnancy, growth and development.

The integrated and comprehensive Maternal and Child Health package was and is still defined to include:-

- Care and supervision during pregnancy
- Supervision and care of home and institutional deliveries.
- Provision of postnatal care.
- Child growth and development monitoring.
- Surveillance of nutrition status of mothers and young children.
- Specific education on care of the nutritionally at risk children 1- 4 years.
- Immunization against the six killer diseases.
- Provision of Child Spacing and Family Planning advice and services.
- Provision of Health Education directed to mothers and school going children.
- Provision of referral mechanism by which complicated or serious cases can have access to higher levels of health care specialist services.
- Collection and compilation of basic MCH service statistics for programme monitoring.

A number of complementing elements make up the comprehensive health package including the Nutrition programme, Health Education programme, Control of Diarrhoeal Diseases programme, School Health Services, Expanded Programme on Immunization, Community Nursing and Child Spacing and Family Planning services. It is this comprehensive package of Maternal and Child Health care that has seen the health and quality of life of women and children improve over the last 20 years.

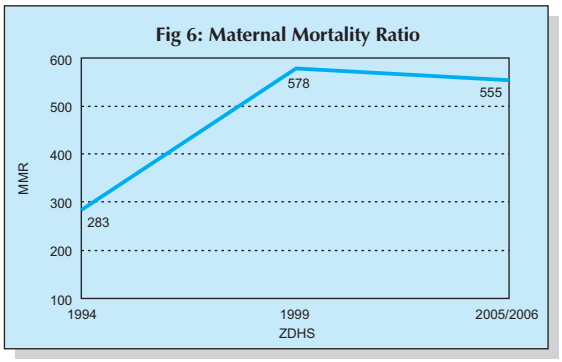
2.1.1 MATERNAL HEALTH

Trends and current status

The maternal mortality ratio (maternal deaths per 100 000 live births), is one of the indicators which sheds some light on a country's health status, quality and access to health care delivery services, especially for women. It is influenced by general socio-economic conditions, nutrition, access and coverage of maternal health care services. The 2007 Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS) has for the first time established that mortality levels are at an unacceptably high level of 725 deaths per 100,000 births.

Over the last 20 years, there have been six estimates of the national maternal mortality ratio in Zimbabwe. Because these estimates have been analyzed using different methodologies, it has been difficult to give trends on the basis of surveys (although all estimates are unacceptably high). Attempts have been made to track maternal deaths using the ZDHS as shown below:

Figure 6: Maternal Mortality Ratio



Based on the Zimbabwe Demography and Health Survey, maternal mortality has been rising from 283 per 100,000 live births in 1994 reaching a peak of 578 per 100,000 live births in 1999.

However, according to ZMPMS (MOHCW 2007) the maternal mortality rate is now reported to be 725/100 000. The methodologies used to obtain the data are different, thereby making trend analysis difficult. As this situation does not yet give us a trend, it is proposed to repeat the 2007 ZMPMS study after five years as this method is more focused and more reliable.

Maternal mortality therefore remains a cause for concern as most maternal deaths are preventable through increased access to antenatal, delivery and post natal care. Furthermore, effective interventions to treat the leading causes of maternal deaths, namely HIV & AIDS, haemorrhage, hypertension/eclampsia, sepsis, malaria and obstructed labour, already exist. The 2007 Zimbabwe Maternal and Perinatal Maternal study further notes that successful prevention and treatment of haemorrhage,

hypertension/eclampsia and sepsis, the three leading direct causes of obstetric deaths, have a potential of reducing maternal deaths by 46%.

Whilst HIV and AIDS is a major contributor to maternal deaths, the 2007 ZMPMS noted that only 34% of pregnant mothers had been tested for HIV; furthermore only 1.8% were taking ARVs. More recently, the 2009 Multiple Indicator Monitoring Survey (MIMS) reported that 58% of women aged 15-49 year had been tested for HIV. Regardless, maternal mortality will remain high, vertical transmission will not be brought down, and childhood mortality from HIV will continue to increase unless more women are tested and appropriate action taken before, during and after pregnancy.

Appropriate care during prenatal, pregnancy, delivery and postnatal care are important for the health of both the mother and the baby. Whilst the 2005/6 ZDHS reported an increase in women attending at least one antenatal care visit from 81% in 1999 to 94% in 2006, the 2007 ZMPMS shows a decrease in ANC attendance to 91% (93%, MIMS 2009). Coverage of antenatal care is slightly higher in urban areas than in rural areas. Skilled attendance at delivery declined from 73% in 1999 to 69% in 2006 and has further declined to 67% (60% MIMS 2009). Institutional deliveries declined from 72% to 68% over the same period (ZDHS 1999, 2005/6) and have remained constant at 68.7% (61%, MIMS 2009), according to in the 2007 Zimbabwe Maternal and Perinatal Mortality study.

Both the 2004 Maternal and Neonatal Health Services Assessment and the 2007 Zimbabwe Maternal and Perinatal Maternal Study used the "three delay model" (described below) to highlight the challenges women face with reproductive health issues. In the 2007 Zimbabwe Maternal and Perinatal Maternal Study, the three delays altogether contributed to 72.8% of all maternal deaths.

The first delay, identified as the time lost in recognizing the seriousness of the situation and deciding whether or not to seek medical attention, was found to be contributing to 56.4% of all maternal deaths (ZMPMS 2007). The second delay, covering the time needed for reaching a health facility or a trained service provider, once a decision was taken to seek care, was found to be responsible for 5.3% of all maternal deaths (ZMPMS 2007). The study also confirmed that lack of communication facilities, lack of transport and financial constraints were contributing to delays in receiving care. User fees have become a significant factor in decreasing use of health services by women at risk. The third delay, which looks at receipt of appropriate and effective treatment once the referral challenge was overcome, contributed to 11% of all maternal deaths (ZMPMS 2007). The study noted that the third delay was caused almost entirely by health system deficiencies, the most important being shortage of personnel, lack of skills and inadequate drugs and supplies.

The Government has made efforts to create an enabling policy environment for the implementation of various maternal, neonatal and child health programmes. Reproductive Health Policy and Guidelines have been developed. In 2004, the MOHCW carried out a comprehensive Maternal Neonatal Health (MNH) Assessment whose findings formed the basis for the MNH Road Map (2007-2015). For the successful implementation of the MNH Road Map, it is necessary to adopt a multi-sectoral approach, which includes males as essential partners of the MNH programme, mainstreaming gender, fostering community involvement and participation, and promoting behavioural change.

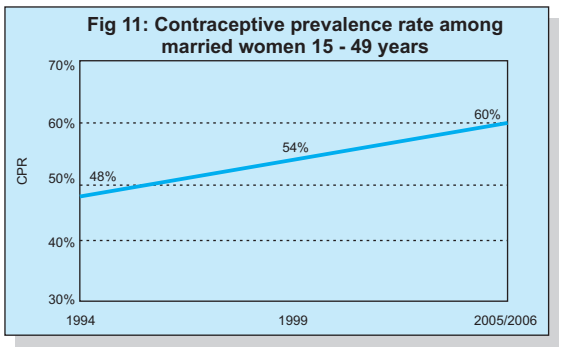
The MOHCW has led several initiatives to mitigate the human resource issues facing the health sector. Confronted with the worsening "brain drain" of general nurses and midwives, the Ministry introduced a new generic cadre, the Primary Care Nurse. These nurses are trained specifically to function at primary health care level. In order to increase the number of nurses who go for midwifery training, qualified midwives receive a substantial allowance for their services. These initiatives are being complemented by a strategy designed to retain medical doctors at district level.

Family Planning

Perhaps the most important intervention to reduce maternal and neonatal morbidity and mortality is to develop and sustain a strong national Family Planning programme, designed to prevent unwanted pregnancies and to encourage child spacing. The Contraceptive Prevalence Rate (CPR), or the percentage of currently married women using a family planning method in Zimbabwe, has increased steadily from 48% in 1994 to 60% in 2006. According to the MIMS 2009 report, the CPR has further increased to 65% (63% of all women were using the modern method of contraception whilst 2% were using the traditional method). The family planning method most commonly used was the pill (43% of all women). The CPR was higher in urban areas

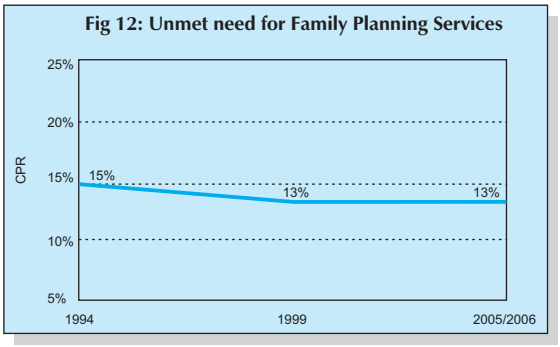
(69%) compared to rural areas (63%). This is now one of the highest rates in Sub-Saharan Africa. The Total Fertility Rate has declined from 4.0 in 1999 to 3.8 in 2006 (ZDHS, 2005-6).

Figure 7:



However, the estimated unmet need for contraception has remained static at 13% for the period 1999 to 2006 as shown below.

Figure 8:



Key issues

- Addressing the three delays in seeking medical care, receiving care, referral to the next level of care, shortages of transport and equipment for emergency obstetric care.
- Mobilizing resources for the provision of Essential and Emergency obstetric care services
- Increasing skilled human resources for health and retain them in the current socio-economic environment.
- Increasing physical and financial access to health services (transport, communication, waiting mothers shelters, removing fees)
- Reversing the HIV and AIDS epidemic and mitigating its impact on maternal health through HIV testing with the provision of antiretroviral drugs and other measures.
- Maternal malnutrition
- Negative cultural and traditional practices that influence health seeking behaviour.
- Access to family planning services
- Gender and male involvement.
- Poor collection of maternal mortality data.

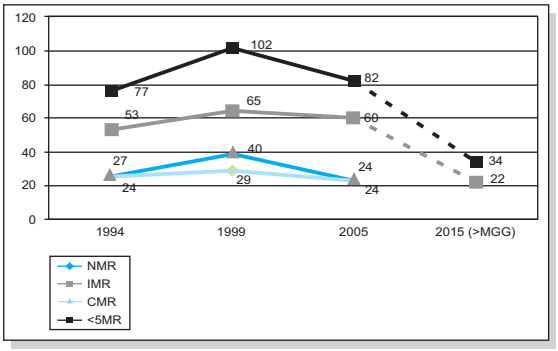
Goal 4: To reduce the Maternal Mortality Ratio from 725 to 300 deaths per 100,000 live births by 2013	
Objectives	**Strategies**
To increase the availability and utilization of youth friendly Family Planning and HIV prevention services	• Capacity building of health service providers on Sexual Reproductive Health, Family Planning and comprehensive HIV Prevention Services. • Strengthen gender sensitive youth friendly Sexual Reproductive Health services provision through training of service providers and production of BCC material on Adolescent Sexual Reproductive Health. • Expanding Community Based Distribution systems. • Integrating STI/HIV/AIDS, and FP programs and services. • Community mobilization to increase demand and use of Sexual Reproductive Health and family planning services.
To increase the availability and utilization of quality focused antenatal care including PMTCT services	• Capacity development on focused ANC including male involvement and comprehensive PMTCT (including ART for treatment eligible pregnant women). • Promotion of male/female condom use. • Dissemination and facilitating use of updated guidelines and clinical protocols. • Operations research as a monitoring and evaluation tool. • Expansion of the mother/baby friendly hospitals initiative. • Community mobilization to increase demand and use of PMTCT.
To improve access to skilled attendance at delivery; including EmONC	• Community mobilization to increase demand and use of maternal and neonatal health services. • Strengthening transport and communication systems for effective referrals.
To improve access to quality PNC including PMTCT services	• Capacity development of facility and community based health service providers in EmONC. • Strengthening the waiting mothers' shelters. • Capacity development on comprehensive post-natal care including PMTCT. • Promotion of dual protection. • Dissemination of updated guidelines and clinical protocols. • Operations research as a monitoring and evaluation tool. • Expansion of the mother/baby friendly hospitals initiative. • Community mobilization to increase demand and use of PNC and PMTCT services.
To strengthen the capacity of health systems for the planning and management of MNH programmes	• RH commodity security. • Availability of skilled human resources. • Functional health management information systems. • Improved health management capacity at all levels. • Improved financing of the MNH programme.
To improve the policy environment for provision and utilization of quality and equitable MNH services	• Review and dissemination of the RH policy. • Development of an SRH strategy. • Development of a human resource development strategy. • Establishment of partnerships to advocate for increased demand for and supply of quality services, and the funding for MNH services. • Lobbying for increased government expenditure for MNH. • Advocacy for integrated SRH services and linkages with the HIV and AIDS strategies. • Implement the findings of the 2007 Maternal and Perinatal Mortality study.

2.1.2 CHILD HEALTH

Trends and current status

The child mortality rate is a sensitive indicator of the level of socioeconomic development of a country. The under five mortality rate (<5MR) rose from 77 per I 000 live births in 1994 to 102 per I 000 live births in 1999 and thereafter decreased to 82 per I 000 live births in 2005. The infant mortality (IMR) followed the same trend. The neonatal mortality rate decreased from 29 per 1000 live births in 1999 to 24 live births per 1000 in 2006. The perinatal mortality rate was 29 per 1000 live births, a figure that is higher than the estimate of 25 per 1000 live births reported in the Zimbabwe Demographic and Health Survey report of 2005/6. The MIMS survey (2009) reports an increase in the under five mortality rate to 86 per 1000 live births compared to 82 in 2005. The rise in mortality is mainly attributed to the direct and indirect impact of the HIV and AIDS epidemic and the concomitant rise in poverty levels.

Figure 9: Trends in Infant and Child Mortality Rates



Source: ZDHS and World fit for Children

Table 4: Zimbabwe IMR and CMR 1978 – 1990

Zimbabwe IMR and CMR 1978 – 1990						
	Infant Mortality Rate			Child Mortality Rate		
Year	Rural	Urban	Total	Rural	Urban	Total
1978	88	64	83	40	25	37
1981	85	59	79	38	22	34
1984	77	50	69	33	17	28
1986	72	47	64	30	15	25
1988	69	46	61	28	15	23
1990	71	55	66	30	20	26
1999ZDHS	65.3	47.2	59.7	36.7	22.8	32.5
2005-06	51	47		22	18	

According to the Child Health Situation Analysis Study conducted in 2006 (MOHCW/UNICEF/WHO), it is reported that the decline in <5, NMR and infant mortality rates could be linked to the overall decrease in HIV prevalence, increased access to opportunistic infection treatment for children using cotrimoxazole, the prevention of acute malnutrition, and the scaling up of Vitamin A supplementation. In addition, the focus of the malaria programme on under fives and pregnant woman is thought have contributed to this improvement.

However, the unfavourable macro-economic and social trends experienced in recent years are likely to reverse these positive trends. The 2007 Maternal and Perinatal Mortality study noted a low percentage of pregnant women who were tested for HIV (34%) with more rural women not being tested. This presents missed opportunities to reduce the vertical transmission of HIV with the consequent rise in childhood mortality from HIV infection. Furthermore, child care practices in the country are currently not optimal because of household constraints (lack of income, food insecurity, lack of mosquito nets, lack of access to safe water and poor access to effective health services).

Up to 78% of all perinatal deaths can be attributed to preterm birth, intrapartum asphyxia & trauma, and unexplained intrauterine death. In addition to these three, infections and conditions related to multiple pregnancies are recorded as the major causes of death in the neonatal period. Both the 2006 National Health Profile and the analysis of the 2006 Child Health Situation in Zimbabwe give the major causes of infant and child mortality as respiratory infections, malaria, diarrhoea, AIDS, tuberculosis and malnutrition.

Table 5 : Causes of mortality 1-4 Years, 2007

Rank	Disease / Conditions	Deaths
1	Nutritional Deficiencies	258
2	ARI	140
3	Intestinal Infections	123
4	Other viral Diseases	37
5	Pulmonary TB	35
6	HIV related / AIDS	31
7	Malaria	28
8	Anaemias & Blood forming Organ Dis.	26
9	Oral Cavity & Digestive System	22
10	Endocrine & Metabolic Dis. & Immunity Dis.	21

Source: MOHCW 2007 Health profile

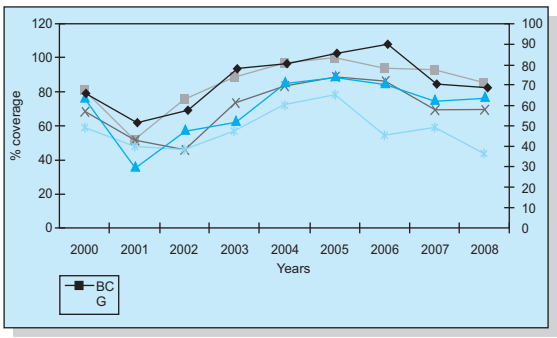
Over the years, the Ministry of Health and Child Welfare has adapted and adopted a number of high impact and low cost strategies aimed at reducing the unacceptably high rates of childhood deaths. One such intervention is the Integrated Management of Childhood and Neonatal Illnesses (IMCNI), adopted and institutionalized in 1999 to address child health problems and ensure maximum development of the child. The overall objective of the strategy is to contribute towards the reduction of child morbidity and mortality.

IMCNI, as an integrated approach to child health, combines improved management of common childhood illnesses with aspects of nutrition, immunization and other important factors influencing child health, including maternal health. It has three components, covering health worker skills development, health systems performance improvement and a third component involving the household and community in child survival issues.

The implementation of the IMCNI strategy followed the WHO guidelines which included an introductory phase, early implantation phase and expansion phase. Implementing the strategy required collaboration between programmes and between different levels of the health system. Prevention of the major childhood killer diseases through immunization is another key strategy of reducing childhood morbidity and mortality. The Zimbabwe Expanded Programme on Immunisation (ZEPI) was introduced in 1982, with the aim of increasing coverage of all ZEPI vaccines to 90% by the year 2000.

Despite the economic hardships immunizations were given a priority by the Ministry of Health and Child Welfare and the community. Immunization coverage for various vaccines gradually increased between 2001 (BCG at 60% and DPT3 at 30%) to 2006 (BCG at 75% and DPT3 at 70%), before declining to less than 60% as shown in the graph (figure 10) The 2005/6 ZDHS confirms that 21% of children in the 12-23 months age group had not received any vaccinations at all, while the 2009 MIMS Survey recorded only 49% of children aged 12-23 months being fully immunized.

Figure 10: Immunisation coverages



The reported decline in routine immunization coverage has been mitigated through Child Health Days (CHDs) that have been conducted twice a year since 2005. Those who are missed by both routine immunization and by the CHD are usually netted through National Immunisation days (NIDs) that are held periodically for poliomyelitis and measles. NIDs have been held every four to five years, starting in 1998 and aim at vaccinating those not reached by routine immunization, and also to boost overall vaccination coverage as part of the strategy to reach the eradication and elimination goals. NIDs held in June 2007 achieved an immunization coverage rate of 80.4% for children between 6 – 59 months. The coverage of selected antigens was also very high with BCG recorded at 96.5%, DPT 96.7%, Measles at 92.3% and vitamin A supplementation being

85.5%. Vitamin A supplementation was integrated into the EPI programme in 2002. It is however of concern to note that vitamin A supplementation has also declined in the past three years, according to the MIMS 2009 report.

The occurrence of vaccine preventable conditions has fallen to insignificant levels over the years, due to sustained high immunization coverage rates. No epidemics of EPI target diseases (except measles in the mid 1990s) were reported due to timely public health interventions that include Child health days, National immunization days, community participation including VHW programme and high health literacy rate on immunization. The investment in the ZEPI has led to the elimination of maternal and neonatal tetanus and polio.

Until the current economic problems, the EPI programme was almost fully funded by Government. However, since 2001, most of the programme commodities (vaccines, cold chain equipment and gas), which require foreign currency, have been funded by partners with personnel and running costs being financed by government.

The ZEPI programme faces its own challenges. The Child Health Situation Analysis (2006) gives a picture of resource constraints which can be generalized across the country. There are problems with outreach activities due to transport shortages, unreliable vehicles and lack of fuel. Gas supplies for refrigerators to maintain the cold chain have also been erratic.

The commitment by Government to the welfare of children is demonstrated through the re-designation of the Ministry to include the Child Welfare component. A National Plan of Action (NPA) for children was developed covering the decade 1990 – 2000. Children's hospitals were established at Harare and Mpilo Central Hospitals. Other initiatives towards improving child health practices include the Kangaroo Mother Care, the expansion of comprehensive services to prevent vertical HIV transmission (PMTCT – Prevention of Mother to Child Transmission); the Baby-Friendly Hospital Initiative; the promotion of exclusive breast feeding in the first six months and the Child Supplementary Feeding Programme. Furthermore, a Child Welfare Health Unit was established at the national level.

However the programme has faced difficulties in its implementation due to fragmentation of responsibility among major stake holders. There is need to redefine the roles, and responsibilities of the various stakeholders and strengthening of coordination and collaboration mechanisms.

Key issues

- Ensuring universal immunization against all child killer diseases.
- Limited outreach activities due to transport shortages, unreliable vehicles and lack of fuel.
- Problems and erratic gas supplies for refrigerators to maintain the cold chain.
- Reversing the HIV and AIDS epidemic, as well as reduce the incidence of other child killer diseases such as acute respiratory infection, malnutrition, malaria and diarrhoeal diseases and pulmonary tuberculosis.
- Reducing vertical transmission of HIV.
- Reducing Malnutrition including the resourcing of child-feeding programmes.
- Ensuring education of the girl child and ensuring access to information on childcare for all mothers.
- Provision of safe drinking water and adequate sanitation.
- Reducing adolescent pregnancies.
- Training and retaining a skilled health workforce.

Goal 5: Reduce the under five mortality rate from 86 to 43 by 2013	
Objectives	**Strategies**
To scale up high impact child survival interventions	• Increase under five immunization coverage through routine child health days and outreach services. • Strengthen surveillance of vaccine preventable disease. • Increase availability of vaccines (including new & underutilized vaccines),cold chain equipment, gas supplies, Vit A , essential drugs including ARVs. • Increase exclusive breast feeding rates. • Improve diagnosis and case management of under five conditions through training and capacity building. • Expand, strengthen and enforce the use of all components of the IMCNI strategy. • Increase number of institutions with child friendly clinics. • Increase access to comprehensive HIV prevention and care services for women including ART and ARV prophylaxis to prevent vertical transmission of HIV. • Improve availability of essential paediatric drugs including ARVs. • Increase provision of safe water and sanitation. • Strengthen the diarrhoeal disease control programme (IEC, home use of ORS, case management training and re-training, ensuring availability of supplies and other commodities). • Improve household security. • Strengthen supplementary feeding programs.
To improve coordination and strengthen multi-sectoral approaches to addressing child health conditions	• Develop a comprehensive child survival strategy. • Strengthen community surveillance. • Improve collaboration between departments (governmental and non-governmental). • Ensure implementation of EPI and IMCI communication strategy. • Strengthen the implementation of community IMCI. • Ensure the implementation of the maternal and neonatal steering committee. • Increase the human resource base for the care of abused children. • Increase community participation in child care.
To advocate for increased resource allocation to child Health problems	• Advocate for human resource management. • Plan and mobilize resources. • Advocate for more funds allocation to child health programmes from the national budget.
To strengthen monitoring and evaluation of child welfare health activities	• Monitor the observance of children's rights. • Monitor the quality of care. • Conduct surveys/ researches.

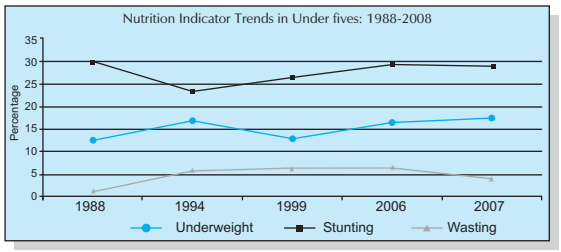
2.2 NUTRITION

Trends and current status

Malnutrition (a composite indicator for both acute and chronic under nutrition) remains a common problem and leading cause of many deaths including those related to HIV. Limited progress will be made in reducing illness and death unless nutritional issues are considered as essential aspects of human well being.

High levels of malnutrition depict food insecurity in the country. Despite achievements in nutrition improvement that have been made in the past through food security, much of this progress has been eroded by recurrent droughts, poor economic environment and HIV & AIDS.

Figure 11: Nutrition Trends



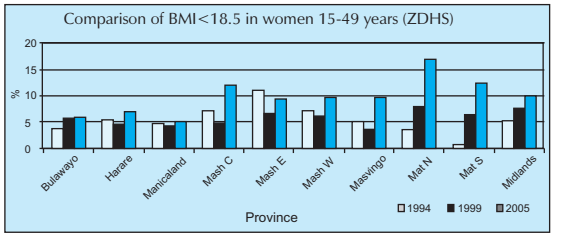
Sources: Demographic and Health Surveys 1988, 1994, 1999; Ministry of Health 2003; ZDHS results 2005-06, Zimbabwe National Food security Assessment 2007
Note: Values for 1988 and 1994 represent children 3-35 months old. Values after 1999 represent children six months to less than five years old.

The under-weight prevalence for under fives increased from 13 percent in 1999 to 16.6 percent in 2005/6; the prevalence of stunting, the chronic form of under nutrition, rose from 26.5% in 1999 to 29.4% in 2005/6, and the prevalence of wasting, the acute form of under nutrition, stayed stable at about 6 percent. More recent data from the Zimbabwe National Nutrition and Food Security Assessment of October 2007 shows that the prevalence of underweight has slightly increased to 17.4 percent. Wasting is given as 4.1 percent and stunting as 28.9 percent. The MIMS 2009 survey shows reductions in underweight and wasting (12% and 2% respectively) but an increase in stunting (35%).

A more detailed analysis of the National Nutrition and Food Security Assessment report reveals that both acute and chronic forms of malnutrition are increasing with some parts of the country more affected than others. The situation in the current economic environment has been worsening. The Zimbabwe Vulnerability Assessment Committee (ZimVAC) found that the food security situation for the majority of the urban population in high density and peri-urban areas has been worsening for a number of reasons. The ZimVAC 2009 urban food security assessment found 33% of the assessed households to be food insecure compared to 24% in November 2006.

Malnutrition is also manifesting itself in adults as evidenced by the Body Mass Index (BMI) that measures the thinness or fatness of adults and also by the levels of anaemia.

Figure 12: Body Mass Index



The trends show a general increase in malnutrition in women, as measured by the prevalence of a Body Mass Index (BMI) of less than 18.5 points, from 1999 to 2005/06. This is an indication of increasing chronic food insecurity.

The increasing levels of malnutrition are associated with the continuing economic downturn, accompanied by increasing levels of poverty, adverse weather patterns, food insecurity and the impact of HIV and AIDS. A tragic outcome of the HIV and AIDS pandemic is the growing orphan crisis. HIV and AIDS has left over one million children without parents, resulting in increased vulnerability to neglect and abuse. As indicated above (pg 24) orphans, and particularly double orphans, were reported in the PASS study to have a higher prevalence of underweight (23 percent), followed by maternal and paternal orphans (20 percent) as compared to non orphans. Urban OVCs, particularly those living in Harare, were particularly nutritionally disadvantaged compared with rural children. The increasing frequency of diarrhoeal disease epidemics has not helped the situation either, as these are also associated with acute malnutrition.

To address child malnutrition, there is a Child Supplementary Feeding Programme (CSFP) that goes back to the early 1980s, and has been resuscitated as and when needed. With the prolonged droughts of the 2000s, CSFP has been almost continuous since 2002, though it might have been suspended at certain times of the year, such as immediately after the harvest. To ensure quality is maintained and children are protected, all the food that is distributed in the CSFP is tested. In conjunction with CSFP, Community Based Growth Monitoring has been promoted in most feeding centres. The slight decrease in wasting observed in the ZDHS 2005/6 could be attributed to the CSFP since districts that conducted CSF recorded lower levels of wasting.

For severely malnourished children who require more intensive support, there is a therapeutic feeding programme which is carried out at health facilities. Hospitals are encouraged to make their own therapeutic milks from raw ingredients (milk, water, cooking oil and cereal) based on a standard recipe and similar to F-75 and F-100. The only imported component needed to make hospital-prepared therapeutic milk is Combined Mineral and Vitamin mix (CMV). However, hospitals are finding it difficult to obtain the raw ingredients, the most difficult of which has been milk.

A Community Based Nutrition Care Programme

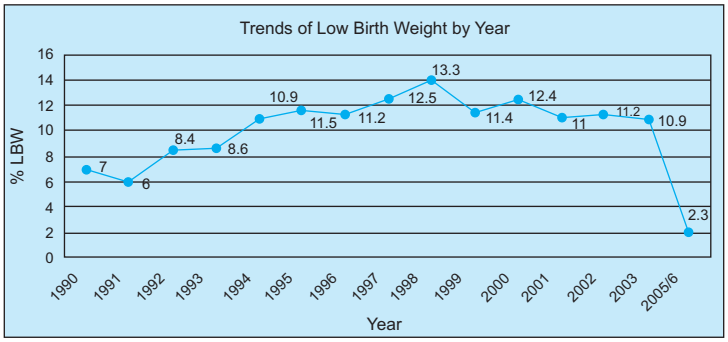
(CBNCP) has been established in 8 districts, 2 major cities and 3 central hospitals, with the first phase of implementation being the introduction of Community Based Management of Acute Malnutrition (CMAM), as an entry point to the wider, more preventative CBNCP. The main aim of CMAM is to decentralise treatment of acute malnutrition, so that clients are able to access treatment without having to stay for long periods in hospitals. Only cases with complications are admitted to the wards.

Partly through the Baby Friendly Hospital initiative, exclusive breast feeding for infants below six months has been widely promoted. Studies have shown that exclusive breastfeeding reduces the risks of diarrhoeal diseases. The benefits of breastfeeding in early infancy even extend for up to 2 years. In 1999, exclusive breast feeding for infants below 4 months was 40% and the 4 – 6 months was 6.2%. Exclusive breast feeding below 6 months was 22% in the 2005/6 ZDHS, with the June 2007 National Nutrition and Food Security Assessment again showing 22%. In general, exclusive breast feeding has declined from the 1999 levels of 46% to 22% in 2007.

In recognition of the specific needs of people living with HIV and AIDS (PLWHA) a nutrition and HIV programme has been established. Partnerships have been built so that the programme works closely with the national ART rollout programme, together with the National AIDS Council. Guidelines on nutrition for people living with HIV have been developed and published. A strategy on nutrition and HIV is in the process of being finalized.

Low birth weight, an indicator of maternal under nutrition and foetal development, (real pre-term and small-for-gestational age) influences the chances of survival of the baby. In 1987, according to a recent, Maternal and Child Health report, the national average was 5.1%. Facility based data, through the National Health Information System, showed a consistent deterioration of the situation from 7 % of all live births occurring in health institutions in 1990 to 8.4% in 1992 and to 11.5 % in 1995. There was a peak in low birth weight in 1998 after which the trend was maintained between 12.4% in 2000 and 10.9% in 2003. However, in the ZDHS in 2005/6, the magnitude of Low Birth weight recorded was very low.

Figure 13: Low Birth Weight by years



Low birth weight can be attributed to the poor nutrition status of the mother before and during pregnancy. Under nutrition can also manifest as anaemia resulting from chronic infection and malaria. HIV and AIDS related opportunistic infections have recently become the most common causes of recurrent infections in the mother. It is also worrying to note that iron supplementation to pregnant women, a critical component of comprehensive maternal and child health care (pg 42) has decreased from 59.7% to 42.9%, during the period between 1999 and 2006.

The elimination of iodine deficiency disorders is one of the successes of the health sector in Zimbabwe. Following a 1988 national goitre survey that showed severe iodine deficiency in the form of goitre in over 50% of the 50 districts surveyed (MOHCW , 1988), a universal salt iodisation programme was established in 1992 resulting in the elimination of IDD by 1999 (National Micronutrient Survey, 1999).

Table 5: Trends in Urinary Iodine and Households accessing Iodised Salt

Year	Median µg/L	Proportion of households accessing iodised salt
I99I	240	-
I993	228	-
I995	430	93 %
I996	450	-
I999	245	97 %
2002	230	87 %
2005	220	89 %
2007	210	94.6 %

The proportion of households accessing iodised salt ranged between 87% and 97% between 1995 and 2007 despite the unavailability of salt in the formal market. There was a rapid increase in urinary iodine from 1993 to 1995 due to the introduction of mandatory iodization of salt nationwide. The increase resulted in reports of transient hyperthyroidism and because of an efficient monitoring system, the problem was quickly

identified and adjustments made to the level of iodation from 33 to 99ppm to the current 25 to 55ppm. The urinary iodine levels decreased from 450 to 245µg/l between 1996 and 1999 and have continued decreasing to 210µg/l in2007. The current levels are now approximating the WHO recommended level of 100 to 200µg/l and showing adequate iodine nutrition in the population.

The 1999 National Micronutrient Survey showed a prevalence of vitamin A deficiency of 35.8% in children between 12 – 71 months and 7% in women of child bearing age. Starting in 2002, vitamin A supplementation using capsules given to children aged between 6 to 59 months has been integrated into the EPI programme as a short term strategy. The long term strategy is to fortify commonly consumed foods with vitamin A. The MIMS 2009 report notes a decline in Vitamin A supplementation, with 23% of children aged 6-59 months receiving Vitamin A compared to 47% in the ZDHS 2005/6.

The goal of nutrition programmes will be to improve health and quality of life by reducing the incidence and prevalence of nutrition disorders. Provision of food supplements to vulnerable children under the age of five years and medically selected groups, including pregnant and lactating mothers, will continue.

Key issues

- Increasing levels of both acute and chronic malnutrition.
- Continued droughts/flooding are increasing food insecurity.
- Increasing economic challenges and poverty.
- Promoting exclusive breast feeding.
- Addressing malnutrition with limited resources under the HIV and AIDS pandemic.

Goal 6: To reduce the incidence and prevalence of nutrition disorders.	
Objectives	**Strategies**
To improve the sustainability of nutrition related programmes	• Assess the nature, magnitude and extent of nutrition problems as well as their causes, and recommend or take appropriate action. • Strengthen on-going nutrition programmes by having them planned and managed by communities. • Revive and capacitate the multi-sectoral Food and Nutrition Committees at all levels.
To create awareness on the impact of nutrition on health and quality of life through information, education and communication (IEC) on dietary habits	• Develop programmes to address nutrition concerns of specific target groups (nutrition in pregnancy, nutrition in school children etc). • Strengthen existing programmes in addressing nutrition at different points in the life cycle.
To monitor nutritional status of the population for early detection of malnutrition	• Strengthen the monthly monitoring and reporting system. • Strengthen clinic and community based growth monitoring.
To improve household food security	• Advocate for food and nutrition security strategies. • Strengthen port health food surveillance and inspection activities. • Strengthen community based food and nutrition programmes.
To develop a national programme on control of vitamin and mineral deficiencies	• Regularly assess the magnitude of micronutrient deficiencies in Zimbabwe. • Conduct KAP study to inform the development of a communication strategy. • Document food consumption patterns in Zimbabwe. • Develop and set quality control system for food fortification in Zimbabwe in line with regional international standards.
To improve the nutritional status and quality of life of people infected and affected by HIV and AIDS	• Build capacity on Nutrition Care and Support for PLWA at all levels. • Motivate males and significant others in maternal, infant and Young child Feeding and HIV. • Develop an Integrated Communication Strategy on Nutrition and HIV & AIDS. • Standardize the data collection tools and reporting format for Nutrition and HIV & AIDS. • Conduct operational research on nutrition and HIV & AIDS.
To improve nutritional management of malnutrition	• Build capacity for the management of acute malnutrition. • Initiate supplementary feeding programme to all under 5s in areas with Global Acute Malnutrition of 7% and above. • Establish local production of Ready to Use Therapeutic Food (RUTF). • Evaluate and revise strategies for the management of malnutrition.
To improve Infant and Young Child Feeding	• Develop Comprehensive Policy and Strategy on Infant and Young Child Feeding. • Integrate HIV and Infant Feeding counseling into pre-service Nursing, Nutrition , HFSS and Medical training. • Increase exclusive breast feeding rates for infants. • Strengthen the Baby Friendly Hospital Initiative in the context of HIV in all institutions offering maternity services. • Integrate EBF monitoring into routine nutrition surveillance. • Develop strategies to address maternal malnutrition.

2.3 COMMUNICABLE DISEASE PREVENTION AND CONTROL

In this document, communicable diseases are presented in four parts, namely 1) STI, HIV and AIDS; 2) TB; 3) Malaria; and 4) other Epidemic Prone diseases. The goal of the communicable diseases programme is to reduce morbidity, disability and mortality due to selected high profile diseases.

Applicable to all the communicable diseases is the need to:

- Strengthen health promotion, disease prevention and control activities
- Strengthen disease surveillance
- Increase availability of medicines and other medical commodities
- Strengthen case management skills
- Strengthen community involvement
- Strengthen inter-sectoral collaboration
- Strengthen the health System

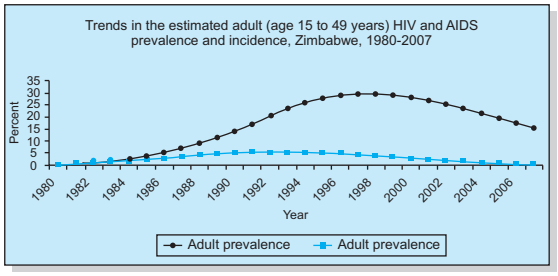
2.3.1 STI, HIV and AIDS

Trends and current status

HIV and AIDS remains a significant public health problem in Zimbabwe, threatening the socio-economic 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.

According to 2007 National HIV and AIDS Estimates , from a prevalence of <1% in 1986, HIV prevalence in Zimbabwe peaked at 29.3% around 1997, before gradually declining to 26.5% in 2001, 23.2% in 2003, 19.4% in 2005 and 15.6% in 2007. The 2009 ANC HIV estimates the HIV prevalence in the age groups 15 to 49 year olds to have further dropped to 13.71%. It is also estimated that new HIV infections peaked at 5.6% in 1993 and have since then continued to decline to the present 0.4%. This information is summarized in Figure 14 below.

Figure 14: Trends in HIV&AIDS Adult Prevalence and incidence (1980-2007)



However, a total of 1.2 million (adults and children) are currently estimated to be living with HIV. Of these, about 343,460 adults and 35,189 children aged less than 15 years of age are in urgent need of life saving ARV drugs. However, only 110,000 were receiving treatment at the end of 2008.

The National Response dates back to 1987 when the National AIDS Control Programme was established within MOHCW. The Programme's main tasks were to increase public awareness about AIDS, monitor the spread of the disease and strengthen HIV screening services at the Blood Transfusion Services.

HIV prevention has been the mainstay of the National Response to fight HIV and AIDS. Early prevention interventions included Behaviour Change Communication focusing on youth, women and People Living With HIV and AIDS (PLWA); prevention and treatment of Sexually Transmitted Infections (STIs); condom promotion and surveillance of the epidemic. The declining trend of HIV prevalence can be largely and directly attributed to this approach which continues to date.

Through a broad consultative process begun in 1997, the national HIV Policy was developed and eventually launched in 1999.The need to broaden the National Response beyond the Health Sector gave rise to the creation of the National AIDS Council (NAC). The objective of NAC was to lead and coordinate the country's multi-sectoral response to AIDS in a more concerted and unified manner. Through an Act of Parliament, NAC was established in 1999 and became operational in 2000.

An intensive Information, Education and Communication campaign, involving all sectors, has been and continues to be carried out across the country. The National AIDS Council is now at the fore-front of coordinating this effort and recently launched a Behaviour Change Communication Strategy for the prevention of sexual transmission of HIV (2006 – 2010), providing guidance to all stakeholders on their contributions to behaviour change promotion.

Voluntary Counseling and Testing (VCT) centres were established across the country from 1998. Intensive multimedia campaigns were used to increase access and uptake of these Voluntary Counseling and Testing services. By the end of 2007, more than a million people had utilized these services across the country and an increasing

emphasis was being placed on encouraging routine offer of HIV testing by healthworkers in health institutions. At the same time, condoms have been made widely available at affordable prices in public health institutions, workplaces, formal markets and other places.

The training of health workers to improve their STI diagnostic and management skills has continued at Genito-Urinary Centres (GUC) in Harare and Bulawayo, while on the job training in syndromic management, targeting mainly nurses, also continues at facility or service delivery levels. Various treatment guidelines/ algorithms were developed during this period and have been distributed widely. STI drugs are available at low cost through the National Pharmaceutical Company of Zimbabwe (NatPharm) and various partners. To ensure patients were exposed to safe and efficacious treatment regimens, periodic STI drug resistance studies have been carried out and the results guided the recommendations of the National Drug and Therapeutics Policy Advisory Committee (NDTPAC) on treatment and management of STIs.

From the initial three pilot sites in 1999, the PMTCT programme has expanded to more than 1300 Family & Child Health sites across the country, with a target of all health facilities (1415) to be providing PMTCT services by 2010.

An important statutory instrument (SI 202 of 98), was developed and passed in 1998, to improve and provide a conducive environment, free from stigma and discrimination, at workplaces.

The Domestic Violence Act of 2007, Criminal Procedures and Evidence Act (Amended) and the Sexual offences Act, were also enacted to curb sexual abuse and gender based violence.

In 2002, Government declared AIDS an Emergency in order to mobilise and increase efforts to make the treatment of AIDS a reality. This, together with the development of generic formulations of ARVs, and decreased prices of ARVs globally, made it possible for MOHCW to establish systems to introduce ART in Zimbabwe. Opportunistic Infections (OI) clinics were established in 2003, in preparation for the introduction of ART. ART was introduced in 2004, in a phased approach, from 5 initial sites, to all central and provincial hospitals and has now been expanded to a number of mission and district hospitals. By the end of 2008 110,000 patients were on ART countrywide. The introduction of a budget line item for ARVs and the commitment of a significant amount of resources from the NATF (AIDS Levy), have been critical and sustainable sources of funding for the ART programme. However, the sector has also received much support from bilateral partners, the Global Fund, UN Agencies, NGOs and the private sector.

The government remains committed to ensuring that PLHWA have access to social services and that they are protected from human and social rights abuse. This is well enunciated in the National AIDS Policy and this commitment is further strengthened by various pieces of legislation. Furthermore, through NAC, different support services are available for PLHWA such as BEAM (for OVCs), CHBC, food and nutritional support programmes and psychosocial support services. ZNNP+ and groups affiliated to it, are well supported and recognized by the Government. To further show this commitment, Meaningful Involvement of People Living with HIV and AIDS (MIPA), was established by NAC in 2004. Other social support activities are well supported by various AIDS service organizations, NGOs, UN Agencies etc, with full government backing. In 2004, the Ministry of Health and Child Welfare launched the National Home Based Care Standards, to harmonise activities of NGOs across the country. Other important strategic plans that have been drawn up to improve programme coordination, include the Draft National PMTCT and Paediatric HIV and AIDS Strategic Plan; National Plan for Orphans and Vulnerable Children (OVC); National Behaviour Change Strategy (2006 – 2010) and the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) – 2006 -2010.

The Business Council on AIDS has been instrumental in mobilizing resources for HIV and AIDS within the workplace, to complement Government efforts as well as influence business attitudes, towards those infected / affected – especially the workforce. The introduction of workplace HIV and AIDS Programmes, which offer VCT, PMTCT, OI, ART, as well as support activities, has taken some strain off Government programs and hence public expenditure, while also assuring the country of a constant and healthy labour supply. Awareness programmes, coupled with school health programmes, have meant that the youth are targeted early, imparting positively on labour supply from the various schools and training institutions.

The Zimbabwe National HIV and AIDS strategic Plan (ZNASP) 2006 -2010, was developed and launched in July 2007, by His Excellency, the

President of the Republic of Zimbabwe, Cde R. G. Mugabe, following recommendations made at the June 2004 National HIV and AIDS conference. The strategy gave focus to Zimbabwe's commitment to the " Three Ones", Universal Access, evidence and results based strategies among others.

There has been an ongoing programme to train and capacitate staff in order for them to deal with various issues related to HIV and AIDS, in such areas as advocacy and lobbying. Furthermore, a number of sensitization workshops have been held for politicians, policymakers and planners on the effects of the AIDS pandemic, with successful buy-in from the targeted audiences.

Government has supported the commissioning of various research studies on vaccines, traditional medicines, infant nutrition etc and some studies are currently ongoing. The ministry of Health and Child Welfare, together with the University of Zimbabwe and the Africa University are involved in vaccine trials. One of the recent research findings in the area of global HIV prevention is the significant impact of adult male circumcision on prevention of HIV transmission; the Ministry of Health have therefore been developing plans to scale up this intervention country wide as another component of a comprehensive HIV prevention response.

Key issues

- Increasing access to essential medicines, including ARVs in a foreign currency constrained environment.
- Meeting the needs of a growing number of orphans.
- Shortage of skilled health professionals.
- How to sustain the behaviour change momentum.

Goal 7: To have halted, by 2015, and begun to reverse the spread of HIV and AIDS	
Objectives	**Strategies**
To prevent and control HIV and STI transmission	• Increase preventive counseling services (including PMTCT). • Promote safer sexual behaviour through an intensive IEC campaign to be implemented by all sectors. • Make condoms widely available. • Promote male circumcision. • Prevent vertical transmission of HIV (see pg 43, 48). • Improve diagnostic and management skills of health workers to prevent complications and improve their management. • Ensure STI Drugs are available at all times. • Monitor STI drug resistance. • Create awareness on sexual abuse and rape and provide for stiffer penalties for offenders.
To reduce the impact of STI, HIV and AIDS on the individual, community and society	• Provide access to treatment, case and psycho-social services for PLWHA. • Protect Human Rights and social services for persons infected and affected by HIV. • Implement National Action Plan for OVCs. • Strengthen political commitment for affective action by leaders at all levels. • Universal access to HIV prevention and treatment.
To improve coordination and strengthen multi-sectoral approaches to addressing the HIV and AIDS epidemic	• Implement the Zimbabwe National Strategic HIV and AIDS strategic Plan (ZNASP) 2006-2010. • Implement the "three ones" principle.
To advocate for greater resources allocation for STI/HIV and AIDS interaction (extra-budgetary).	• Earmark greater resources specifically for STI/HIV and AIDS intervention in the National Budget. • Promote local manufacturer of ARVs and explore the role of traditional medicines.
To strengthen STI/HIV and AIDS surveillance and improve research and programmed effectiveness	• Build research capacity.

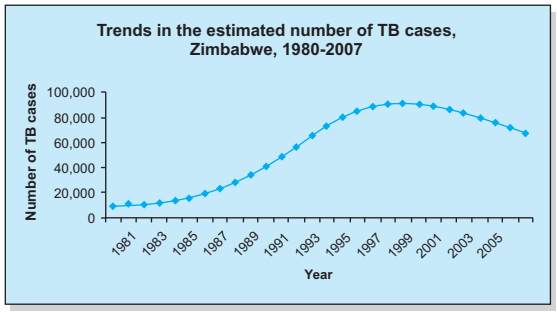
2.3.2 Tuberculosis

Trends and current status

The National Tuberculosis Programme was established in the sixties. In 1983, the government developed a policy of integrating all TB activities into the general health services. The National Tuberculosis Programme officially adopted the Directly Observed Treatment Short-course (DOTS) strategy in 1997. Staff training continues in order to improve diagnostic and case management skills.

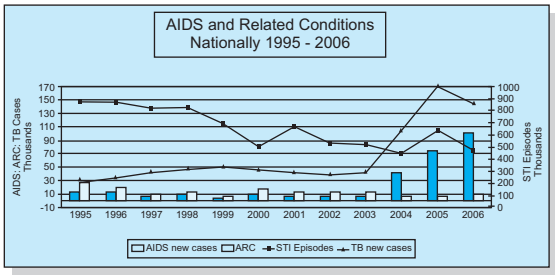
Tuberculosis, once thought to be on the decline, almost trebled in incidence from 96.9/100 000 in 1990 to 267.5/100 000 in 1995. This trend, heavily influenced by HIV, continued to increase to 402/100 000 in 2000. In 2007, the country reported 138,866 cases of tuberculosis (new and relapse), and had an incidence of all cases of 1136 per 100 000 population (WHO, 2008). As shown in fig.15, TB case load expanded exponentially, mainly as a result of the high HIV burden but indications show that the TB epidemic may have passed its peak i.e. the incidence rate for 2005-2006 period showed a decline of 6.8%. HIV affects up to 80% of all TB patients. There were an estimated 1 390 000 people living with HIV and AIDS in 2005, with these people having an annual risk of 5-10% for developing TB. It is probably likely that even more cases of TB should be diagnosed than is currently the case.

Figure 15: Trends in estimated number of TB cases



Tuberculosis, thus, remains a major public health problem for Zimbabwe, a member of the 22 so-called high burden countries responsible for 80% of the Global TB caseload. TB is the second leading cause of death nationally and is among the top five leading causes of hospital admission and outpatient consultation (Health Information Department, 2004). Patients with HIV and AIDS-related conditions occupy up to 70% of all hospital beds, constituting the majority of hospital deaths. TB is the commonest cause of death among PLWHA. The parallel relationship between AIDS cases and TB cases is shown in the graph below:

Figure 16: AIDS and related conditions

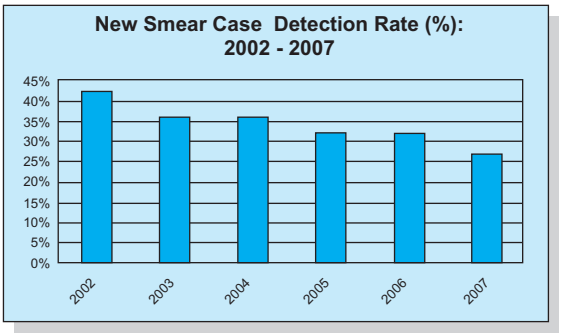


Zimbabwe is currently in the process of strengthening the integration of TB and HIV activities in health care settings. In 2006, a committee on TB and HIV Collaborative activities was formed to report to the National HIV and AIDS partnership forum. The National TB manual was finalized in 2006, to incorporate TB and HIV collaborative activities. The implementation of provider initiated testing and counselling in health care settings started in July 2007 in 10 learning sites. It is envisaged that all TB patients will be offered an HIV test, while suspected and confirmed TB cases will also be able to access HIV testing.

Age and sex specific notification data for 2004 indicated that TB affects more men than women. Just as HIV, the reproductive and economically productive age group is most affected by the disease and is also the same age group bearing the burden of HIV.

The notifications of TB rose markedly during the nineties, from less than 5,000 to a high of over 50,000 in the late nineties. From then on, the notification rate has been on the decline.

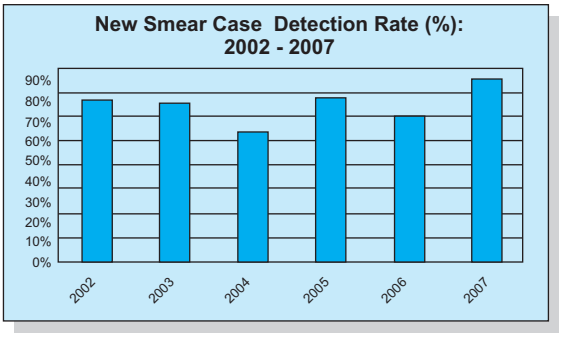
Figure 17: Case Detection Rate over years



Estimated case detection of smear-positive cases was only 42% in 2006 and has remained stagnant over several years (see fig 17 above). However, no nationally representative TB prevalence survey has ever been conducted to validate the TB case estimate by the WHO. Similarly, over the past 25 years, no tuberculin surveys were ever conducted and therefore data on estimates of annual risk of TB infection could be inaccurate. A lot of work will be required to improve case detection to meet the global benchmark standard of 70%.

The treatment success rate has gradually declined over the years and is almost stagnant (see fig.18). The low rate of treatment success (Global Benchmark -- 85%) is an indicator of programmatic inadequacy and the impact of the HIV disease burden. The implications are a high risk of MDR generation and transmission.

Figure 18: Treatment success rate trends



The country has had reasonable stocks of TB drugs at all times. FDCs (Fixed Drug Combinations) are being introduced in a phased manner to replace single dose regimens. The TB manual was thus revised in 2007 to include FDCs. DOTS remains the primary strategy being used by the TB control programme. A good laboratory network for TB diagnosis is well established but is not fully utilized, due to shortages of manpower, reagents and functional equipment.

The monitoring of TB drug resistance continues to be carried out at the TBRL (Tuberculosis Reference Laboratory) in Bulawayo. The laboratory is in the process of being strengthened so that it can monitor cases of MDRTB (Multiple Drug Resistance Tuberculosis) and XDR TB (Extremely Drug Resitance Tuberculosis). In line with DOTS, sputum smear microscopy is being used as the primary TB diagnostic test at district, provincial and central hospitals.

The Government is the major funder of all activities. Significant support is provided by bilateral agencies such as CDC in the area of laboratory strengthening and TB and HIV collaborative activities, whilst the European Union supports the provision of first line anti-TB drugs. Two main sources of multilateral support come as management and technical assistance, from WHO and programmatic support from the Global Fund, with a Round 5 Grant worth US$ 9.2 million with further substantial funding expected from a Round 8 grant recently awarded.

The proposed strategies for the 2008-2013 National TB Control programme are based on the WHO recommended New Stop TB Strategy, introduced in 2006. The vision is to have a TB free Zimbabwe with the following targets:-

- By 2010, detect at least 70% of new sputum smear-positive TB Cases and cure at least 85% of these cases.
- By 2010 all TB patients should have access to comprehensive HIV care and support services including HIV testing, cotrimoxazole therapy and ART.
- By 2012, reduce TB prevalence and death rates by 50% relative to1990.
- By 2030, eliminate TB as a public health problem (<1 case per million population).

Key Issues

- Resources for the National TB programme activities have remained inadequate.
- The case detection rate of new smear-positive cases is still only 42%, just above half the global target of 70%.
- There is over-reliance on chest x-rays for diagnosis.
- Inadequate availability of, access to and use of diagnostic facilities e.g. inadequate capacity at National TB laboratory.
- Inadequate management and supervision due to human resources shortages.
- There is still no national external quality programme in most public laboratories.
- The national treatment success rate of 67% is very far from the global target of 85%.

Goal 8: To reduce the mortality, morbidity and transmission of TB in line with the Millennium Development Goals and the Stop TB Partnership targets.	
Strategic Objectives	**Strategies**
To expand and enhance provision of high quality DOTS	• Increase political commitment for increased and sustained financing. • Improve diagnosis of TB cases through quality assured bacteriology. • Develop and enhance mechanisms for patient support. • Strengthen procurement and supply management systems for TB drugs and other commodities. • Strengthen M/E systems and Impact measurement. • Strengthen Human resource capacity for TB.
To enhance coordination and implementation of TB/HIV collaborative activities	• Scale up TB/HIV collaborative activities.
To contribute towards the strengthening of health systems	• Introduce the Practical Approach to Lung Health.
To effectively prevent, control and manage multi-drug resistant TB	• Prevent and control MDR TB. • Address TB in high risk groups i.e. prisoners. • Strengthen infection control of TB.
To engage all care providers in TB control include Public-public mix, Public-Private mix approaches	• Develop and enhance collaboration for TB control with all stakeholders.
To empower people with TB and their communities	• Strengthen ACSM activities. • Strengthen Community based TB care and DOTS.
To enable and promote operational research	• Implement relevant Identified research priorities.

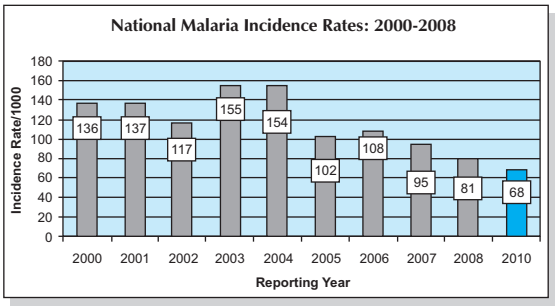
2.3.3 Malaria

Trends and current status

Malaria remains a major public health problem in Zimbabwe, with over five million people estimated to be at risk of contracting the disease annually. It is estimated that 50% of the country's population resides in malarial areas.

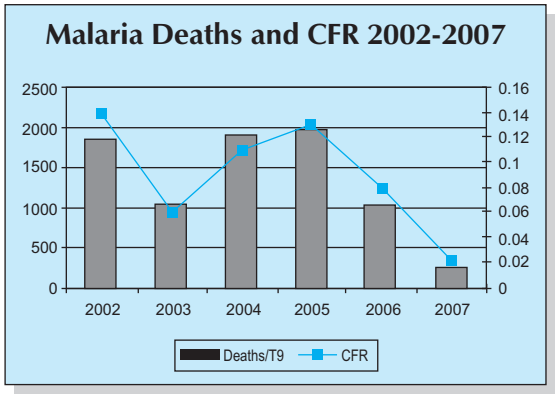
Since 2004, malaria incidence has been declining with a decrease in the number of reported cases from 1.8 million cases in 2006 to 1,315,132 in 2007. This has been mainly attributed to changing weather patterns (drought), use of DDT (Diethyl-Dichloro-Triethyline) in indoor residual house spraying (IRHS), increased use of insecticide treated nets (ITN) and improved treatment regimes.

Figure 19: National Malaria Incidence rates



The number of malaria deaths declined from I 200 to I 000 during the same period as shown in figure 20 below. Improved malaria case management training for health workers continues to play an important role in reducing malaria case fatality rate.

Figure 20: Malaria deaths and CFR 2002-2007



Specific programmes to improve health worker management of malaria cases include Integrated Management of Childhood Illness (IMCI), Integrated Disease Surveillance and Response (IDSR), the Basic Epidemiology course, as well as the inclusion of malaria case management in pre-service training. IDSR has strengthened the use of epidemic thresholds at the Rural Health Centre level and has also led to an increase in outbreak detection rates.

In vivo sentinel studies have been carried out each year to determine malaria drug efficacy. As a result, malaria treatment guidelines were reviewed twice in the past 10 years, transitioning from the use of chloroquine only to the use of the free combination of chloroquine and Sulfadoxine and Pyrimethamine (SP), and now to fixed combination of artemether and lumefantrine (co-artemether), an artemisinin based combination therapy (ACT). Bioassays continue to be done to ascertain the effectiveness of chemicals used for indoor residual house spraying (IRHS). DDT, which has been found to be very effective against predominant vector mosquitoes, has been re-introduced into the malaria spraying programme with good results. A malaria indicator survey (MIS) is planned for the year 2008. The results of the MIS will indicate the progress that has been made in the malaria control programme in the past decade.

Community participation in malaria control is now considered as an integral part of malaria control activities and therefore needs to be actively promoted. This needs to be strengthened with greater involvement in the IRHS programme, bed nets production and larviciding and environmental manipulation to reduce mosquito breeding as well as promoting the adoption of personal protection measures. Epidemic preparedness committees have also been very effective in malaria and other epidemic prone disease control activities in districts such as Binga in Matebeleland North Province.

The involvement of other state agencies such as the Zimbabwe Defence Forces (ZDF), Local Government, Rural District Councils (RDC) and the private sector, especially in IRHS, should create a formidable partnership that will go a long way in ensuring the success of malaria control programme. The pooling of resources such as fuel, vehicles and technical expertise, to complement those provided within the health sector, will achieve economies of scale. Private companies also continue to play a significant role in providing drugs, IRHS chemicals, training and other commodities. Voluntary Service Organisations (VSO) have been very active at the community and district hospital levels. Technical and financial support continue to be received from the UN family.

The decentralization of malaria control activities to the district level was successfully implemented in the past decade, resulting in greater program efficiency as the roles of each level are now clearly defined. The shortage of resources and brain drain, among other challenges, continues to negatively affect the smooth running of the malaria control programme, despite all the effort that has been put towards its re-organization. Successful applications to Global Fund under round I, 5 and more recently 8, are largely expected to ease these challenges.

Despite the economic challenges experienced in the last few years, Treasury allocations for malaria control have continued to increase each year. However, due to hyperinflation and other macro-economic difficulties, coupled with crippling foreign currency shortages, these allocations remain insufficient to meet the obligations of the programme.

The referral system plays an important role in reducing malaria deaths and can only function optimally where there is adequate and efficient transport and telecommunications.
Health promotion campaigns, particularly during commemorations of key malaria health calendar days, continue to be carried out to raise community malaria awareness. Intermittent Presumptive Treatment (IPT), using SP, is an integral part of ante-natal care (ANC). This is actively promoted for all pregnant women in malaria transmission areas.

Key issues

- IEC Materials and drugs availability.
- Human resources.
- Improving the communication and transport network.
- Sustainable funding.

Goal 9: To have halted, by 2015, and begun to reverse the increasing incidence of malaria	
Objectives	**Strategies**
To achieve universal access to malaria prevention and personal protection	• Reduce the transmission of malaria by scaling up effective vector control interventions (IRS and ITNs) to 90% of the population. • Achieve at least 85% of intermittent preventive treatment (at least IPT2) in pregnant women attending antenatal care in all medium to high transmission areas of Zimbabwe.
To improve diagnosis and treatment of uncomplicated and severe malaria	• Provide access to malaria treatment within 24 hours of onset to 85% of fever cases. • Confirm and correctly treat all malaria cases.
To improve detection and timely control of malaria epidemics	• Detect and effectively manage at least 95% of malaria epidemics within two weeks of onset. • Increase malaria free zones in Zimbabwe.
To strengthen community and other stakeholder participation to maximize achievement of universal access to malaria control interventions	• Increase community participation and competence on correct malaria prevention and control measure to 85%. • Strengthen the participation of other stakeholders in malaria.
To improve coordination, management and monitoring for achieving universal access to malaria control interventions	• Strengthen malaria surveillance, monitoring, evaluation and operational research. • Strengthen planning, partnership building and coordination. • Strengthen the management of malaria control programming through adequate financial and human resource management, logistics support and procurement and supply management.

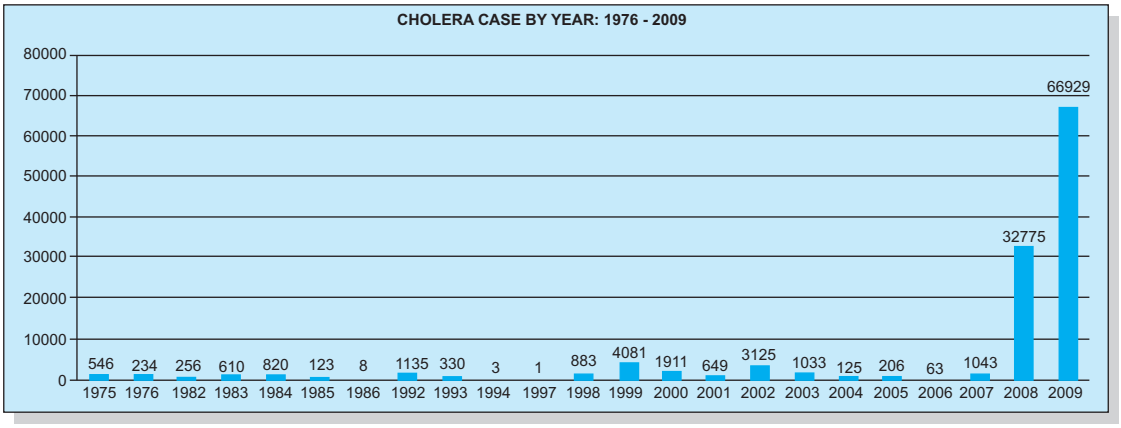
2.3.4 Other epidemic prone diseases

Other epidemic prone conditions that are a threat to public health in Zimbabwe include diarrhoeal diseases such as dysentery and cholera, and zoonotic diseases such as anthrax, rabies, plague, avian influenza, influenza A HINI and SARS.

Cholera

The first recorded case of cholera in Zimbabwe was in 1972. Since then the country has been experiencing sporadic minor outbreaks. Initially the outbreaks were mostly along the eastern and northern borders of the country. From the year 2000 onwards, outbreaks stated occurring in some urban areas. In 2002, the country reported 3125 cholera cases and 192 deaths. The cases decreased in 2003 to 1033 and 36 deaths whilst in 2004, 125 cases and 9 deaths were reported. In 2008 and 2009, Zimbabwe experienced a very serious outbreak starting from Chitungwiza and Harare spreading to 55 out of the country's 62 districts, infecting 99 704 people and killing 4 420. This outbreak occurred at the height of the economic crisis with a very weak health system.

Figure 21: Cholera cases



Although cholera spreads rapidly and can have high case fatalities, it is probably the simplest outbreak to control. The control of cholera requires speedy detection and availing of resources and experienced staff in affected areas. While most outbreaks were controlled within three weeks, the 2008/2009 outbreak continued for many months due to resource constraints, general breakdown in water and sanitation systems, and inexperience on the part of health workers in managing cholera outbreaks.

Key issues

- Making key ministries aware of their roles in Cholera prevention.
- Improving clean water supply coverage.
- Improving sanitation facilities coverage.
- Improving hygienic practices by vulnerable communities.
- Regulation of vending practices.
- Monitoring large gatherings such as funerals, congregations etc.
- Encouraging religious health objectors to protect their own health and that of others.

Rabies and dog bites

Since the major 1994 and 1995 outbreak, there were sporadic minor rabies outbreaks until 2007, when another major outbreak occurred in Mashonaland Central Province. The general macro-economic situation since 2000, characterized by crippling foreign currency shortages, resulted in the virtual breakdown of the routine public dog vaccination programmes. Anti rabies vaccines are imported but against a background of foreign currency shortages, this has resulted in sporadic shortages.

Key Issues

- Vaccination of dogs
- Human anti rabies vaccine
- Activation of zoonotic committees

Anthrax

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. Drought, lack of fodder, overstocking, intensive pasture rotation and dusty crowded pens, are proven risk factors for animals to contract anthrax. Prolonged droughts induce animals to graze closer to soil, which is potentially infected with infective anthrax spores.

Like all zoonotic diseases, the control of anthrax is spearheaded by the veterinary department. Due to resource constraints and lack of stakeholder coordination, anthrax outbreaks that occurred in 2006 and 2007 were prolonged, with human cases reported.

Key Issues

- Vaccination of cattle
- Activation of zoonotic committees

Plague

The last reported Plague outbreak was in Gokwe and some districts in Matebeleland North in 1994, with 554 clinical cases including 48 laboratory confirmed and 29 deaths. Whilst no cases have been reported since 1994, there is need to maintain active surveillance so that the disease will not fall into the group of neglected diseases.

Key Issues

- Maintain plague surveillance

Goal 10: To improve timely detection and control of epidemic prone diseases (Cholera, dysentery, rabies, anthrax, plague, pandemic influenza, meningococcal meningitis, Vital haemorrhagic fevers (VHF) etc.)	
Objectives	**Strategies**
To strengthen timely detection and control of all epidemic prone diseases through use of Integrated Disease Surveillance & Response	• Improve health worker's capacity to detect and manage outbreaks through training in and utilization of Integrated Disease Surveillance & Response (IDSR) principles. • Mobilize adequate resources for timely detection and control of epidemic prone diseases. • Strengthen the health information system to enable it to support effective surveillance. • Strengthen inter sectoral coordination at national , provincial and district level through Civil Protection Unit structures. • Develop and/or revise disease specific Outbreak Management guidelines periodically. • Develop and/or revise disease specific Standard Operating Procedures for managing epidemics. • Establish Rapid Response Teams (RRT) at national, provincial and district levels.
To strengthen prevention and timely control of zoonotic diseases	• Raise community awareness of zoonotic diseases through Information, Education Communication and Advocacy. • Re-activate zoonotic subcommittees to integrate/coordinate the prevention and management of zoonotic diseases through integrated Rapid Response Teams (RRT). • Advocate for vaccination of eligible animals e.g. dogs and cattle by Dept of Veterinary Services. • Support the efforts of key ministries in vaccination of animals.
To prevent cholera and other diarrhoeal diseases	• Advocate for improvement in water and sanitation coverage. • Address Food, Water and Sanitation issues. • Water quality monitoring. • Water chlorination or super chlorination. • Food inspection. • Temporary toilets construction where there are no standard facilities. • Supervise burials. • Establish cholera treatment centres (CTC) or Oral Rehydration Points (ORP). • Promote standard hygiene practices to reduce risks of contracting diarrhoeal diseases e.g. commemorating National Hand Washing days. • Establish Cholera Command & Control Centres (C4) at all levels to direct coordinated response of epidemics.
To strengthen detection and control of Viral Haemmorrhagic Fevers (VHF)	• Utilise Integrated Disease Surveillance & Response guidelines to timely detect and control VHF.
To strengthen detection and control of outbreaks	• Strengthen the health information system with special emphasis on surveillance.

2.3.5 Schistosomiasis and soil transmitted helminthes

Trends and current status

The prevalence and epidemiological distribution of schistosomiasis has continued to increase. Since no large scale control programmes followed the previous National Schistosomiasis Surveys about two decades ago, the current schistosomiasis prevalence may have increased throughout the country as a result of increase in water development projects in response to persistent droughts.

A recent report on a study investigating polyparasitism among primary school children living in rural and commercial farming areas in Zimbabwe, has confirmed high prevalence of schistosomiasis (56% and 66%) in Mutare and Shamva districts respectively (Midzi et al, 2008). According to the World Health Organization treatment guidelines, the prevalence reported in these two areas indicate high level of transmission of the schistosomiasis parasite that warrants regular annual treatment of children in schools and access of the adult population living in these areas to essential drugs for schistosomiasis treatment (WHO 2002).

Although some reports from small scale studies indicate occurrence of soil transmitted helminthes (STHs) in certain parts of Zimbabwe with prevalence ranging from 21-70% (Chandiwana et al 1983, 1989, Midzi et al 2008), data regarding the national distribution of STH is still lacking. There is therefore a need to determine the distribution of STHs in order to plan for their control.

The Government of Zimbabwe has prioritized the control of schistosomiasis on its agenda. Given the absence of prominence in the program in the last ten years a national multi-sectoral team including UN agencies was set up in 2005. A National Plan of Action for the control of schistosomiasis and STHs was approved in 2006. Due to high inflation, the budgeted funds for activities (including for the baseline survey) failed to enable implementation.

Little attention has been given to schistosomiasis control over the past years in Zimbabwe also due to the compelling competition from more life threatening diseases including Malaria, HIV and AIDS, and TB, compounded by floods and droughts that demanded more national funding and human resources leaving schistosomiasis with little of either. However, the patent on praziquantel, the only drug of choice for treatment of schistosomiasis, has expired resulting in reduced drug costs. This condition will make it feasible for large scale procurement of praziquantel and implementation of the national schistosomiasis control programme.

Key issues

- Schistosomiasis programme neglected.
- Unavailability of schistosomiasis drugs.
- School health programme neglected.
- Community participation in environmental management.

Goal 11: To reduce morbidity due to schistosomiasis and soil transmitted helminthes by year 2015.	
Objectives	**Strategies**
To establish the incidence and prevalence of Schistosomiasis	• Conduct schistosomiasis baseline survey. • Stratify the country using baseline data. • Develop treatment policy and strategy.
To establish the incidence and prevalence of soil transmitted helminthes	• Monitor and evaluate program. • Conduct soil transmitted helminthes baseline survey. • Develop treatment policy and strategy. • Monitor and evaluate program.

2.4 NON COMMUNICABLE DISEASES AND CONDITIONS

Trends and current status

Zimbabwe like several other developing countries and in line with the so-called "epidemiological transition" is being faced by a triple burden of communicable, re-emerging and non-communicable diseases and conditions. The country has put at lot of emphasis and resources on the first two. Non-communicable diseases are however bringing with them unnecessary demands on available health resources that if prevented would see these resources channeled to other health needs.

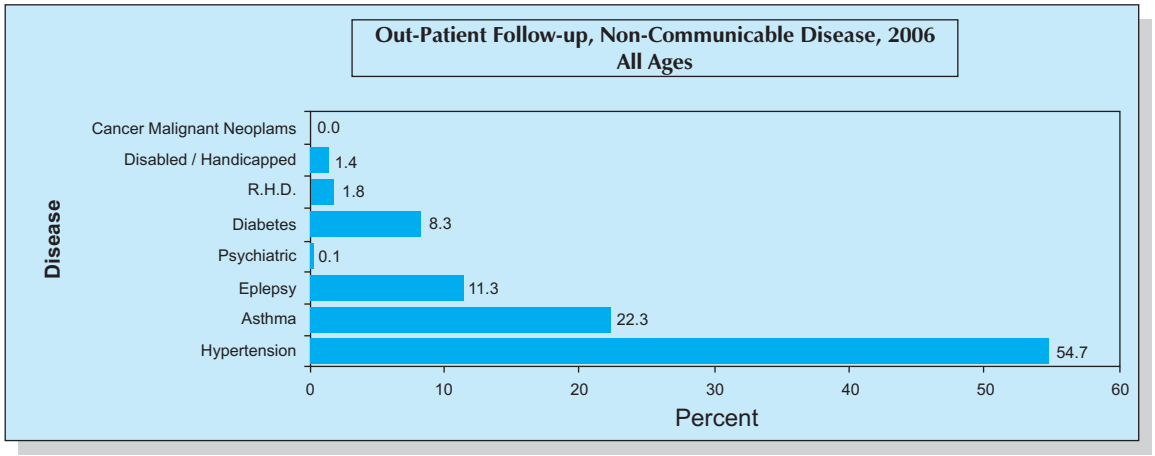
Whilst evidence exists that there is an increase in the prevalence of lifestyle related diseases such as cardio-vascular diseases especially hypertension, diabetes mellitus, various cancers, avoidable and preventable blindness, liver cirrhosis, dental caries, injuries and some of the psychiatric conditions, not much effort is being made in making communities understand the role of social or personal determinants of health such as lifestyles, education, culture, behavior and even earnings on health and quality of life. The best that has been done is to prohibit smoking in public places, prohibition of under age (18 years) drinking and awareness campaigns on the effects of drug abuse to school children and the general public.

Of greater concern is the low level of attention directed towards the risk factors associated with lifestyle diseases, such as excessive alcohol consumption, tobacco use, lack of physical exercise, obesity, drug abuse and social disintegration. It is worth noting that the majority of non-communicable diseases namely diabetes, cardiovascular diseases, cancers, and chronic obstructive lung diseases have common modifiable risk factors namely tobacco use, obesity, dietary factors and physical inactivity; and therefore share intervention strategies.

Evidence exists confirming that a sizeable number of Zimbabweans have adopted poor habits and behaviours which affect their health by increasing their risk of developing non-communicable diseases. The Zimbabwe STEPwise survey (2005) shows that there is a high prevalence of modifiable risk factors of non-communicable diseases. It also reveals that current alcohol consumption and tobacco consumption is very high especially among males. The survey noted that current alcohol consumption was 58 percent in males and 13.5 percent in females in the study population. Tobacco consumption was 33 percent in males and 5 percent in females. Both alcohol and tobacco are causes of cancer.

The prevalence of both diagnosed and undiagnosed hypertension and diabetes mellitus was found to be very high in the Zimbabwe STEPwise survey (2005). Other lifestyle factors such as overweight and central obesity were also noted to be high especially in females. Overweight and central obesity have not traditionally been classified as malnutrition because malnutrition has traditionally been falsely associated with children and not adults. Strengthening people's ability to understand and cope with these problems and promoting appropriate preventive programmes and protection regulations can reduce these lifestyle related illnesses (pg 38).

Figure 22: Out-patient visits for Non Communicable Diseases: 2006



Currently all levels of care contribute to the management of non-communicable, diseases with the lower levels mostly playing the role of identifying and treating cases as provided in the management protocols, if available. Some medicines for some non-communicable diseases can only be initiated at high levels of care with lower levels mostly monitoring and re-supplying medicines. To that end, it has been the practice that each lower level health facility keeps a chronic disease register for the purpose of patient tracking, and also ordering of patient specific medicines. Non-availability of medicines has seen the collapse of this best practice of managing some of the non-communicable conditions as near the patient as possible.

2.4.1 Cardio Vascular Diseases

Cardio Vascular Diseases are a major cause of mortality in adults. Hypertension accounts for 50% of all cardio-vascular diseases and its complications including strokes. In the Zimbabwe STEPwise survey the prevalence of hypertensions was found to be as high as 27%, while in 2006 hypertension accounted for 25% of all out-patient visits for chronic conditions. Strokes are responsible for a significant portion of disabilities and attendances at medical rehabilitation units. Effective management of cases, follow-up and screening of at risk persons depends on specialist guidelines, which are yet to be developed and put into wider use.

2.4.2 Diabetes Mellitus

Diabetes mellitus and its complications are on the increase. It is among the top five chronic conditions seen in the outpatients clinics. The 2005 STEPwise survey noted that the prevalence of diabetes among the adult population is 10%, with a large number of people not being aware that they had raised blood sugar levels.

2.4.3 Chronic obstructive lung diseases

Chronic obstructive lung diseases, especially asthma, are one of the more frequently seen conditions in outpatient clinics. In both adults and children, asthma has become a disease of public health concern. Asthma and the Acute Respiratory tract Infections (ARI) contribute significantly to the high levels of morbidity, mortality and disability, particularly among the under 5 years in Zimbabwe. ARI itself is a major cause of deaths in children under five years. In 2006, new acute respiratory tract infections cases accounted for 37 percent of all outpatient diseases. There were 148,322 new cases for under five years (2006) giving an incidence rate of 394 per 1000 (2006).

2.4.4 Preventable and avoidable blindness

Preventable and avoidable blindness remains a major public health problem in Zimbabwe. Eye conditions have continued to appear amongst the top reasons for OPD attendances in the course of the last decade. Cataracts, trauma and glaucoma are the major reasons for eye admissions. It is estimated that I percent of the population is blind, with half of these cases due to treatable cataracts. It is further estimated that some 80% of the causes of blindness are avoidable. There is however a huge backlog in cataract surgery because of few ophthalmologists in the country largely due to the brain drain. In addition, equipment and supplies need repair and re-supply respectively.

The National Prevention of Blindness Committee provides expert guidance and leadership in the Prevention of Blindness programme. Some of the major activities of programme implementation include development of the SAFE (Surgery, Antibiotic therapy, Facial cleanliness, Environmental improvements) strategy for the elimination of trachoma, training of ophthalmologists, post basic training of nurses in ophthalmology, and ophthalmology outreach services.

Key Issues

- Supply of affordable equipment, technology and spectacles.
- Human resources.
- Improving case management.
- Building national blindness prevention programmes, with a strong community approach, as well as individual approach to eye care.
- Improving physical facilities for both service and training at central and provincial levels. There is need to make effective and efficient use of the available provincial eye care institutions at Bindura, Gwanda, and Victoria Falls.

2.4.5 Cancers

Cancer is an increasingly important public health problem in Zimbabwe. By 1997, cancers accounted for 2% of OPD follow-ups and 8 -10% of all hospital mortality. In 2004 cancers accounted for 0, 4% of OPD visits. In 2005, a total number of 4,015 new malignant cancer cases were recorded among Zimbabweans with I 762 (43.9%) being

males and 2 253 being (56.1%) females. Kaposi's sarcoma (KS) was the leading cause of cancer among Zimbabwean black men accounting for 26.4% of the new cases registered in 2005.

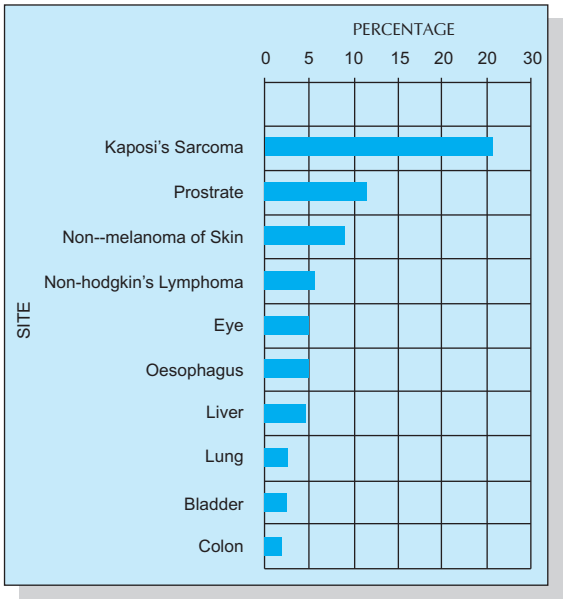
This was followed by prostate (11.4%), non-Hodgkin's lymphoma (NHL) (6.8%), oesophagus (6.0%), liver (5.8%), eye (4.2%), lung (3.0%), non-melanoma of skin cancer (3.0%), connective and soft tissue tumours (2.6%) and colon (2.3%).

The most frequent cancers among Zimbabwean black women were cervix uteri (32.1%), breast (11.1%), KS (10.9%), eye (5.4%), NHL (3.9%), ovary (3.2%), liver (3.0%), stomach (2.5%), oesophagus (2.3%) and non-melanoma of skin cancer (2.2%).
A cancer Age standardized mortality rate of 122 per 100 000 population, for both sexes was reported in 2004 (WHO).

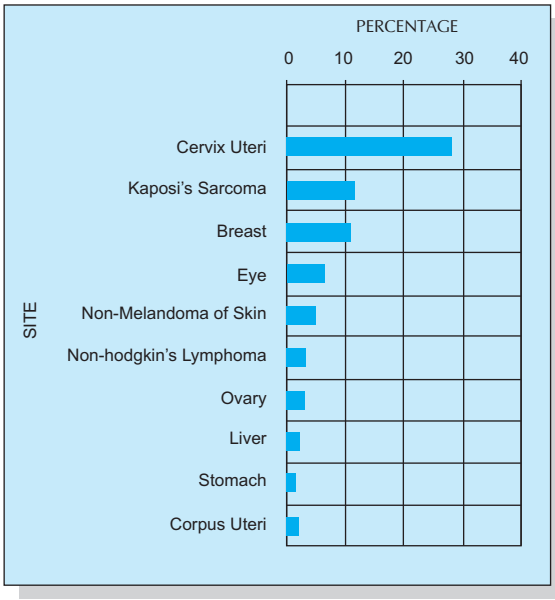
The advent of HIV and AIDS has seen a striking increase in the incidence of certain cancers that are associated with the epidemic. The most notable of these cancers are Kaposi's sarcoma, Non-Hodgkin's Lymphoma and squamous cell carcinoma of the conjunctiva.

Figure 21: Most common malignant cancers: 2005: Males and Females

All Zimbabwean males



All Zimbabwean women



The cancer control programme boosts of one of the best cancer registries on the African continent, the Zimbabwe National Cancer Registry. Registry is an integral part of the overall national cancer control effort and has also become an internationally respected institution that offers reliable cancer statistics. Indigenous and international researchers and the Ministry of Health and Child Welfare, extensively utilize the data produced by the registry for programme planning and management and cancer control programmes. Increased funding will enable the registry to maintain its high standards, upgrade equipment, train personnel, achieve national coverage, conduct more research and produce publications and reports.

The cancer control programme of Zimbabwe has, in the last decade, placed emphasis on early identification of cancers, and raising awareness and training health workers in palliative care for advanced cases.

Key Issues

- Funding of the ZNCR and its activities.
- Human Resource for Health including the training of oncology specialists in country.
- Resources for conducting operational research.
- Maintenance of radiotherapy equipment and drug availability.

2.4.6 Oral health

Little attention has been given to oral health outside the school health programme. However, it is known that a lot can be done to reduce its contribution to the burden of disease through simple preventive measure. Communities have also tended not to seek preventive oral health care, instead waiting until they have a dental problem. One preventive measure of high effectiveness that is not being given adequate attention is the fluoridation of drinking water as a means of preventing dental caries. The 1995 National Oral

Health survey revealed that there is an unmet treatment need for both periodontal related conditions and dental cavities. The University of Zimbabwe (UZ) started the Dental Practitioners degree programme to augment the Dental Therapists and Technologists programmes run by the Ministry of Health and Child Welfare.

Efforts to meet the oral health care needs of all Zimbabweans have included:

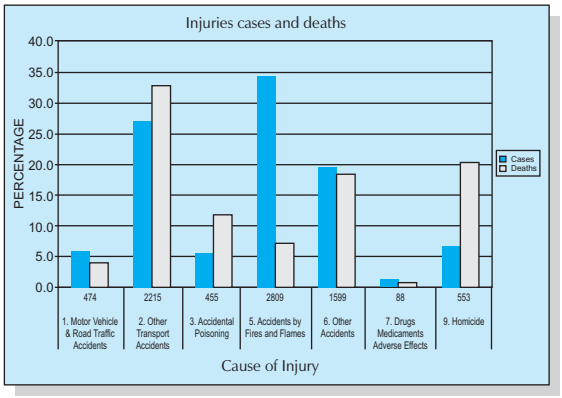
- Initiating the process to develop the oral health policy and strategy for Zimbabwe.
- Equitable deployment of Dentists and dental therapists to central hospitals and provinces and to districts, which has progressed well.
- The inclusion into the PCN Training Regulations of oral health issues and care.
- Continued efforts towards commencing the training of Dental Assistants.
- Strengthening the institutionalization of oral health as a component of PHC.

Efforts in this strategy will be further guided by the findings of the oral health policy, strategy and a survey that will be conducted in due course. The major challenges in oral health are the shortage of dental equipment and supplies.

2.4.7 Injuries

Injuries are reported to be among the top five causes (Figure 24) of out-patient visits. Injuries account for 50% of all newly reported disabilities. Transport accidents and accidents by fires make up a significant proportion of all injuries.

Figure 24: Causes of injuries



Key issues around all NCDs

- The development of NCDs Strategy including updating guidelines and protocols, management of each of the conditions.
- Inadequate human and financial resources necessary to prevent and control NCDs and their risk factors.
- Limited or lack of systematic screening for NCDs or their risk factors at all levels of care.
- High prevalence of hypertension, diabetes, obesity in women compared to men.
- Lack of prioritization of care and management of cancers.
- High level of substance abuse.
- Inadequate rehabilitation services for patients with complications of NCDs.
- Negative perception of some interventions targeted at reducing NCDs and their risk factors.
- Increasing awareness in NCD risk factors.
- Institutionalising NCDs into the PHC and CHBC activities.

Goal 12: Improve the prevention and management of priority Non-Communicable Disease	
Objectives	**Strategies**
To reduce the burden of non communicable diseases by between 15 and 20% by 2013	• Develop and implement a national health policy and plans for the prevention and control of non-communicable diseases. • Reduce the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases (namely tobacco use, unhealthy diet, physical in activity, and the harmful use of alcohol) and their determinants. Available international and regional recommendations on the control and management of NCDs (MPOWER package on tobacco, Global strategy on Diet, Physical activity & Health etc shall be referenced to during the development of policy documents). • Protect and safeguard children and minors from the effects of tobacco, alcohol and drug abuse. • Strengthen and maintain an integrated surveillance system aimed at quantifying the burden and trends of NCDs, their risk factors as well as details of some other major determinants. • Strengthen healthcare services for people with NCDs by developing evidence based norms, standards and guidelines for cost effective interventions. • Provide competence and skills to health workers to cost-effectively manage NCDs and their complications. • Institute accident control and prevention programmes aimed at the reduction of all forms of accidents. • Revive and sustain community-based rehabilitation programmes; • Advocate for active involvement of line ministries to initiate and support legislature designed at creating an NCD prevention and control friendly environment. • Strengthen NCD program coordination structures at all levels of care with each level having a minimum level of appropriate staffing and equipment to effectively coordinate and monitor the implementation of all activities. • Promote primary prevention through community based interventions targeted at promoting positive behavioural changes at the community level using integrated multidisciplinary, multi-sectoral and private/public mix approaches (focal sites being schools, workplaces, church organization etc). • Develop and implement a behavioural change communication (BCC) strategy that seeks to reduce NCDs risk factors as well as increasing awareness towards health life styles and promoting the health seeking behaviour for regular measurement of blood pressure, screening through pap smear, testing and assessing severity of haemophilia, detection of proteinuria etc. • Define and implement a minimum package of cost effective clinical preventive screening interventions such as urinalysis, measurement of blood pressure, blood sugar, body weight and height as well as screening for some common and easily detectable cancers, mental illnesses, blindness and chronic respiratory diseases in health facilities, in schools and workplaces as a strategy for early case detection. • Facilitate treatment, care and support beginning at community level and move up the ladder of the health care delivery system using an effective bidirectional referral system (reintroduce clinic registers to facilitate targeted supply of medicines that are normally not kept at that level).

	• Develop and implement strategies that will help people with non-communicable diseases manage their own conditions better, and provide education, incentive and tools for self management (include supporting organized community based associations for the management of NCDs e.g. Diabetic Association, Haemophilia Association). • Promote and preserve traditional norms that are compatible with the maintenance of healthy lifestyles. • To assess the role efficacy and safety of traditional medicines in the management of non-communicable diseases.
To protect women and children against all forms of abuse and violence	• Contribute to the prevention and reduction of domestic violence and sexual abuse, support victims and stiffer penalties for offenders. • Train health workers and specialist agencies in the identification of abuse of women and children and what to do about it. • Increase awareness in the population of agencies that can assist the victims of abuse and violence.
To increase community participation and responsibility in the promotion of healthy lifestyles and responsible behaviour	• Intensify health education campaigns on promoting healthy lifestyles. • Organize competitions that highlight the importance of healthy lifestyles. • Advocate for greater community participation, particularly in planning and decision-making on issues/matters that promote healthy lifestyles. • Strengthen people's ability to understand and cope with self-created problems, notably alcoholism, STIs, affluence-related diseases, social disintegration and road traffic accidents. • Develop and introduce clinical preventive services starting with the reintroduction of annual medical examinations for health workers.
To research on the social impact of lifestyles on health	• Strengthen research capacity on the social impact of unhealthy lifestyles. • Explore why knowledge of risk factors does not bring behaviour change. • Develop and adopt a standard list of health education priorities.
To increase access to services for clients with NCDs	• Train HCWs to detect NCDs early and treat NCDs effectively utilizing available protocols and algorithms and personal cards. • Acquire equipment and materials for basic diagnostic procedures and investigations. • Ensure NCD vital drugs and consumables availability. • Re-introduce chronic disease registers at the primary care facilities and supply the necessary drugs as per register.
To reduce morbidity and mortality due to cancer	• Review the 10 Year National Cancer Control Programme Plan of 1994 – 2004. • Review and finalize the oncology care for Zimbabwe manual in line with new EDLIZ 2006 and treatment protocols. • Mobilize resources for training HCWs in palliative care and CHBC in liaison with relevant departments and MAC, HOSPAZ and its members. • Rollout the VIA project to all districts in the country. • Strengthen cervical cancer and prostate cancer screening at district levels.
To reduce and prevent the incidence of blindness	• Determine the magnitude and causes of the burden of eye conditions (present findings of the survey on common eye conditions in government health institutions). • Develop programmes on common eye conditions. • Implement vision 2020.

	• Develop curriculum on refraction. • Train HCWs/ ophthalmology nurses in refraction. • Develop dissemination IEC material on the prevention of blindness. • Establish school eye health care programme for refraction and squint problems. • Establish eye centres in the remaining provinces and at selected district hospitals.
To reduce the incidence of oral health problems	• Develop oral health programmes. • Develop an oral health policy with focus individual responsibility for care and treatment. • Disseminate policy to HCWs, stakeholders individuals and families. • Advocate for the in corporation of oral health component into the elements of PHC. • Revamp the school oral health component. • Evaluate the national plan for oral health emphasizing the 16 goals set in 1990. • Develop the oral health strategy based on the findings of the evaluation. • Update IEC material based on information on oral services including HIV and AIDS. • Strengthen surveillance system on oral health.

2.5 MENTAL HEALTH

Trends and current status

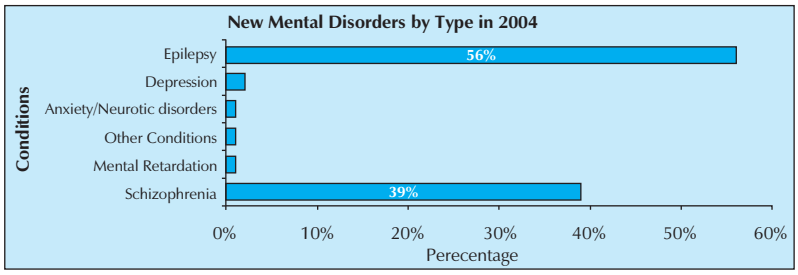
The provision of mental health activities is guided by the Mental Health Act of 1996, the Mental Health Regulations of 1999, and the National health policy of 2005. The Mental Health programme includes care for the mentally ill, forensic care and care for mentally retarded (learning disabilities).

Mental illness remains amongst the major public health concerns in Zimbabwe. The objective to be achieved over the last ten years was to create an environment that promotes the mental well being of individuals. The last ten years, especially the immediate last five years, have seen the development of an environment completely working against this objective due to the socio-economic challenges the country has been going through.

Stress associated with life in Zimbabwe is more pronounced as reflected by increased emotional and mental illnesses resuling from several factors including: HIV and AIDS morbidity and mortality and the subsequent increase of orphans; socioeconomic challenges with its accompanying increasing unemployment and poverty levels; and effects of natural disasters, in particular the droughts and floods. However no studies have been done to show the extent of this stress and the new burden of mental ill health due to the current socio-economic environment. Furthermore the national health information system is not capturing stress disorders.

In 2004, the commonest causes for admissions in Psychiatric Institutions were Schizophrenia and Epilepsy. While epilepsy is not a mental illness, it is captured together with mental illness. The large number of epilepsy patients admitted is the result of lack of specific services for epileptic patients, in particular the community or outreach services, which remain undeveloped and the stigmatization of epileptic patients remains a problem.

Figure 25: New Mental Disorders by Type: 2004



Depression is amongst the top five mental health illnesses seen in public health institutions. For a long time, the breakdown of family structures and social values have been reported as the contributory factor to depression, leading to abuse of alcohol and use of illicit drugs (Brudtland 2001).

While it has been believed that Zimbabwe was a transit state for illicit drugs/ substances, this is no longer the case as these drugs are now sold and consumed in the country. Various surveys have shown that the problem of both alcohol and drug abuse are increasing (WHO, Mental Health ATLAS - 2005).

The first point of contact of mentally ill patients is the primary care level with possible referral upwards as and when the need arises. This was made possible through in-service training of nurses and integrating mental health care into primary care activities. Support to the primary level was provided by a psychiatric-trained nurse found at each district hospital and also by the provincial psychiatric nurse. Psychiatrists provided the specialists care of treatment and are found at provincial and specialists tertiary institutions. Recently this well designed mental health delivery system has not functioned well.

Forensic/detained mentally ill patients are catered for in Special Mental Institutions, Chikurubi Prison in Harare, and Mlondolozi Prison in Bulawayo and these have been similarly negatively affected to the extent that the Mental Health Review Tribunal and the Special Mental Health Boards were not able carry out their duties regularly.

The provision of adequate care and support for the mentally ill requires multi-disciplinary, multi-sectoral, community and corporate involvement and participation. Many stakeholders support and complement the ministry's efforts in advocacy and service provision. There is however need to strengthen partnerships for maximum benefit. There is also need to strengthen community based mental health services with the aim of reducing the custodial concept of psychiatric care.

Community based psychiatric rehabilitation and occupational therapy contributes to the continued care at home and has been noted to play a pivotal role in reducing re-admissions.

However, the existing facilities remain under resourced. The Mental Health and psychiatric services provide expert guidance and leadership in the care of the mentally ill. Training of Psychiatric Nurses, Psychologists, Clinical Social Workers and Psychiatrists is undertaken in country, but there remains a critical shortage of these cadres with a 50% vacancy rate amongst psychiatry trained nurses and over 90 percent of the available psychiatry trained nurses employed at Ingutsheni Central Hospital. While the need to train mental health professionals is clearly essential, empowering existing general health professionals with basic mental health skills is critical. Integration of the programme with the mainstream PHC activities remains the best option.

Zimbabwe has participated in the implementation of the WHO – Assessment Instrument for Mental Health Systems (WHO - AIMS), a new tool for collecting essential information on mental health information systems of a country. Similarly, the implementation of the WHO- Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST V3.0) will enable the country to ascertain the burden of abusers and to detect the problems early and to intervene promptly.

The main focus of the mental health activities for the duration 2008 –2013 will be on prevention of mental illnesses, promotion of good mental health, provision of curative and rehabilitative services for those already affected by mental disorders, and ensuring specialists drug and equipment availability.

Key issues

- Review and revision of the Mental Health Act no 15 of 1996 and its Regulations.
- Erratic availability specialist medicines and equipment.
- Human resources for mental health care.
- Standards and guidelines for the management of common mental health disorders.
- Destigmatization of mental illness and epilepsy.
- Mental health services for the children and the adolescent
- Specialized institutions for alcohol and substance abuse
- Reestablishment and integration of community based mental health rehabilitation programmes including half way homes for the mentally ill.

Goal 13: To reduce the incidence of mental illnesses through strengthening and promotion of mental health programs.	
Objectives	**Strategies**
To increase access to appropriate and effective mental health services, with an emphasis on access; and to reduce the incidence of mental illness	• Increase the number of institutions offering comprehensive mental health services. • Conduct a baseline survey on the Epidemiology of mental disorders. • Develop treatment protocols and guidelines on management of psychiatric and substance abuse conditions. • Improve case management capacity at all levels. • Develop discharge guidelines for patients with mental disorders • Develop psychiatric substances and alcohol policy. • Advocate for appropriate numbers of mental health professionals; i.e. clinical psychologists, psychiatrists nurses, social workers to increase the staff population ratios. • Increase public awareness through mass media, districts and provincial commemorations. • Improve programme management, collaboration and governance by implementation of the acts and regulations. • Resuscitate establishment of treatment and rehabilitation centres for Drug and Alcohol Abuse. • Increase Community Based Mental Health Care program. • Review and strengthen enforcement of the Mental Health Act, Regulations and Policy. • Develop Psychoactive Substance and Alcohol Policy. • Develop mental health services for children and the adolescent.
To improve the capacity of all levels to achieve national goals	• Increase the capability of all levels to provide appropriate and effective mental health services through training. • Develop community based mental health staff. • Reestablish community based mental health rehabilitation programmes including half way homes for the mentally ill. • Advocate for increase of training schools for Mental Health Personnel. • Increase public awareness of the prevalence of mental health and of risk and preventive factors.
To improve outcomes for those with mental illness through the use of proven, effective treatments	• Increase the capacity to provide effectively mental health support in response to disasters. • Promote the detection, early intervention, and treatment of the mental illnesses. • Increase consumer and family input and participation in the treatment planning process.
To create an environment that promotes the mental well being of individuals	• Strengthen Mental Health Education on Prevention of Mental Illness and Substance Abuse, and Promotion of Mental Health in schools. • Design a Mental Health Program specifically for the youths and adolescents. • Address alcohol and substance abuse through IEC strategies. • Establish specialized institutions for alcohol and substance abusers.
To strengthen and coordinate forensic services	.• Strengthen the management and coordination of mental health services. • Strengthen collaborative approaches with other stakeholders to assure integrated, accessible and effective treatment services for those with serious emotional disturbances.

2.6 DISABILITY AND REHABILITATION

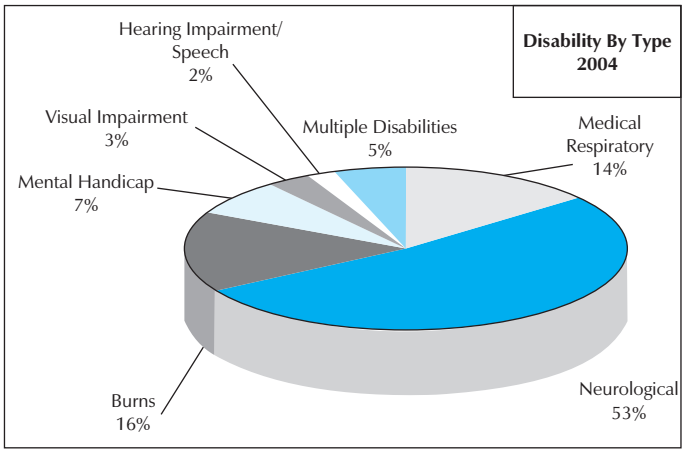
Trends and current status

The Rehabilitation and Disability Program seeks to improve the quality of life for the people of Zimbabwe by promoting healthy living and prevention and management of disabilities and injuries, through a process of rehabilitation empowerment and inclusion into society. Acute injury care services continue to be provided at all health care facilities and rehabilitation care plays a crucial role in the continuum of care in line the PHC approach.

According to the Zimbabwe Population Census of 2002 (CSO), approximately 350 000 People With Disabilities (PWDs) were identified, a figure which equates to 29% of the population. This figure is further validated by the Poverty Assessment Study Survey (PASS) 2003 which showed that nationally, 3% of people were disabled. The rural areas had a slightly higher prevalence of persons with disability than urban areas. The main disability found at the national level in the study was difficulty in moving, followed by difficulty in seeing. About 68% of disabled persons were prevented from maintaining significant economic activity or going to school due to the disability.

The last decade has seen a change in the epidemiology of disability, from those arising as a result of polio, leprosy, and land mines for example, to those related to birth trauma including cerebral palsy, road traffic accidents, spinal cord injuries, amputations, mental illnesses, age related impairments, multiple disabilities and home accidents, especially among children.

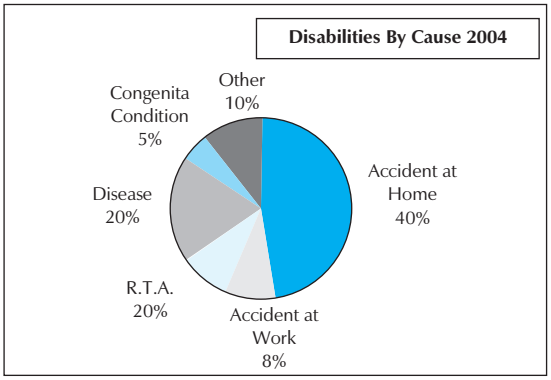
Figure 26: Disability by type



Source: National Health Profile

Injuries are reported to be among the top ten causes of outpatient visits (pg 69) and account for 50% of all newly reported disabilities. Of particular concern are injuries resulting from Road Traffic Accidents, Domestic Accidents and Work Related Accidents, which constitute 10 - 15% of all registered deaths. The most important cause of injury related deaths, are road traffic accidents followed by suicide. In children under 5 years, burns are the most common form of injury. Domestic violence has also become a course of concern. There is also an increase in reported violent injuries such as homicide, suicide and rape.

Figure 27: Commonly reported disabilities: 2004



Accidents in the home are significant and affect all age groups. These are followed by disease related disabilities.

Occupational injuries are also significant, with the highest rates reported in the transport sector followed by the mining and forestry sectors. The work environment in both the formal and informal employment sectors is causing a range of acute and chronic illnesses and injuries that are, in some areas, not detected, reported or managed. Only a small fraction of occupational diseases are identified. The prevention and management of home related injuries is generally inadequate, fragmented and poorly provided for.

Rehabilitation services have over the last decade expanded across the country with almost every district having purpose built rehabilitation department. Both rehabilitation technicians and physiotherapist are being trained locally. Zimbabwe has a very strong Community Based Rehabilitation (CBR) programme, which is now constrained by lack of transport in particular motor cycles, which enable the rehabilitation assistants to get to the hard to reach areas for the purposes of patient screening.

The focus of care is integration, focusing on mainstreaming management of disability into all health programmes including Community Home Based Care, HIV & AIDS, mental health and Reproductive Health programmes, and inclusiveness of People with Disability (PWDs) in decisions and programmes that affect them. There is need to provide Information, Education and Communication (IEC) to meet the needs of specific disabilities including Braille material. There is therefore a need for comprehensively addressing the needs of PWDs, using a human rights' approach.

The prevention and early identification and referral of children and persons with disability, coupled with early intervention for conditions such as birth asphyxia, will avoid the development of permanent complications and remain central to care.

Key issues

- Inability of Health care workers to communicate effectively with persons with hearing disability.
- Failure to transform existing facilities to Centers of Excellence.
- The increasing burden of injuries with limited accident control and prevention.
- Strengthening of / development of efficient Accident and Emergency Services at all levels of care.
- Increasing collaboration with multi stakeholders involved in injuries and accidents.
- Limited access to mobility aids such as prosthesis and walking sticks.
- Lack of skills by health workers to correctly identify and refer clients early for further/ specialist management.
- Non functionality of Rehabilitation Villages as centers of excellence.
- Non ratification of the convention of the Rights of Persons with Disabilities on the rights to health and rehabilitation (Articles 25 to 26, 2006, UN General Assembly).
- Weak multi-sectoral collaboration among stake holders.
- Fragmentation of efforts in dealing with injuries and accidents across sectors and departments.
- Lack of knowledge and information on first aid at home.

Goal 14: To improve the functionality, independence and quality of life of people with disabilities.	
Objectives	**Strategies**
To increase access to quality medical rehabilitation services to all that need them	• Conduct survey to determine magnitude, consequences and types of disabilities in the country. • Contribute towards development of broad based national data on disability and rehabilitation. • Create awareness on the needs of the disabilities among Health Community Workers and general public. • Improve access to health and rehabilitation services to PWDs especially women and children with disabilities. • Update National Community Based Rehabilitation (CBR) guidelines and resuscitate and expand CBR programme to all districts. • Increase awareness on occupational health. • Strengthen mechanisms for early detection such as the "At Risk" programme and early treatment of disabilities. • Promote production of appropriate technology and assistive devices, strengthening training of personnel and equipment for persons with all types of disabilities. • Advocate development of national policy on the provision of assistive devices. • Strengthen accident and emergency services. • Increase awareness on occupational health. • Create awareness on injuries on children in the home, at school and on the road. • Create awareness on work place injuries in the health sector and develop appropriate preventive measures. • Train HCWs to provide appropriate counseling to victims and families. • Identify hazards in the health sector and develop appropriate preventive measures. • Develop and revise protocols and guidelines for management of various RTA and other accident related conditions. • Train HCWs to provide appropriate counselling to victims and families.

2.7 CARE OF OLDER PERSONS

Trends and current status

Over the past ten years, the health sector has sought to concentrate its focus on specific population groups, rather than the wider issues of population growth in itself. The Primary Health Care Strategy adopted by Zimbabwe has had positive results especially for children and the reproductive age group. However, little has been done to address the growing needs of older rpersons. Older persons continue to represent a small proportion of the entire population, but their health and other needs should be considered in the perspective of the gradual expansion of geriatric services. Priority should now not only be given to infants, children, adolescents, but must include the well and sick older persons.

Nothing has caused more alarm with respect to these groups as the effects and impact of the HIV and AIDS epidemic. The vulnerability levels for these groups has increased as social structures continue to collapse due to the death of breadwinners and the rural-urban rural migration, resulting in the loss of family assets, savings, family and community support systems. Whereas in the past when there was a breakdown of traditional structures, the immediate family usually took care of older persons, this is now not always possible.

The accompanying disintegration of households has also led to the burden of family care, shifting to grandmothers and other members of the extended family (where they still exist), leading in some cases to family disunity and child neglect. The health consequences that arise include emotional deprivation, pscho-social problems, isolation, maladjustment behaviour, malnutrition and homelessness and its consequences.

The harsh economic situation experienced from

the dawn of the new millennium has wiped out coping mechanisms to ameliorate this situation. Whilst older persons, who now care for their grandchildren, did not warrant attention ten years ago, the situation has substantially changed, increasing their vulnerability and that of the children they care for and those that are homeless or living in the streets throughout the country. For now, the prospect of a secure old age for the majority of people remains bleak and uncertain. This results partly from the traditional belief that the "elderly will be looked after by their own folk", and that they would have purchased medical aid cover during their working life. Unfortunately however, medical aid has something to offer only to a rich minority. Medical Aid Premiums are high, and likely to remain beyond the reach of many older persons, even if prices become more realistic.

There are no mechanisms to help those who are "asset rich" but cash poor, with all their "wealth" tied up in the value of their homes and perhaps livestock. There are also no means to reassure those who are already old and in immediate need of a variety of services. The long-term care needs of the older persons are currently provided by the voluntary old people's home system, originally developed for minority groups. Continuity of care in their own homes is traditionally what older persons deserve. Exemption from fee payment, at the time of need, falls short of this expectation.

There is now need for both the Ministry of Health and Child Welfare, the Department of Social Welfare and other stakeholders, to engage on this matter. Roles and responsibilities need to be clarified. The care of older persons, whether they are sick or not, requires special skills in order to ensure their continuous comfort. As the care of older persons has not been a priority for reasons mentioned above, the training of human resources in this area has also not been a priority. As a result, the country has neither geriatricians nor geriatric nurses.

Public hospitals and other voluntary old peoples' homes have no capacity to support long term residential care for the majority of older persons. They also lack capacity in the area of home-based care support to the older persons. These observations bring to the fore the necessity to develop a comprehensive, needs driven, policy framework that takes into account the factors enabling older persons to enjoy long and healthy lives.

Opportunities exist for beneficial collaboration between the government, the voluntary and private sectors, local authorities, missions and families, to develop and design a living package for the elderly. The inevitability of ageing, as it affects all, should motivate stakeholders to adopt a balanced approach towards attending to this need. In this collaboration, the crucial principle is that both the well and sick older persons should receive the right care when they need it.

The main challenge for supporting the needs of older persons is to design a programme explicitly to meet the needs of both the well and sick older persons

These needs are necessitated by the early death of the older person's own children, who traditionally cared and provided for them mostly in the older person's rural home environment.

Key issues

- Roles ambiguity among stakeholders.
- Non availability of both geriatricians and geriatric nurses.
- Lack of resources to support long term residential care to the majority of older persons.
- Lack programme to support home and community-based care.

Goal 15: To improve the quality of life of older persons	
Objectives	**Strategies**
To promote the well being and quality of life for older persons	• Conduct rapid health needs assessment for the older persons. • Define package of support required by older persons looking after orphans. • Develop IEC material on older persons and the services available for them. • Develop formal and short time training programme for HCWs on geriatric care to create awareness amongst HCWs in older persons and their needs. • Establish wellness clinics/Geriatric clinics for older persons where they can attend. • Extend the supplementary feeding programmes to older persons in need (based on the determined inclusion criteria).

PART 3:
Health Systems Strengthening

3.I HEALTH SERVICE DELIVERY

3.I.I Clinical Care And Quality Of Services

Trends and current status

The Government of Zimbabwe, in line with the Primary Health Care strategy of organizing services, aims at ensuring the provision of quality and safe health services that meet the needs of the people through a network of health facilities organized to function on the basis of increasing levels of sophistication. Patients with more complex health problems are expected to be referred up the referral chain. Each level of care is expected to provide a package of well defined services provided by appropriately trained health professionals. The public health delivery system consists of four levels of care: primary, secondary, tertiary and central levels. Core health services have been defined for the primary and secondary levels but have not been costed. Work on defining the core health services for the tertiary level has started.

Primary Level

The primary level consists of a network of health centres and community health workers. Village Health Workers, the first amongst community health workers, are the key link between the organized village community and the local health services. The role of Village Health Workers is fundamentally promotive, educative, and preventive, mobilizing the community and the individuals for preventive health activities. Village health workers are the first line health workers for treatment of simple conditions, disease surveillance and for enhancing health information systems. On-going technical supervision of Village Health Workers is provided by the local staff of the rural health centres, which keep the village health workers supplied with medicines and equipment at government expense. Village Health Workers refer and also encourage communities to seek treatment early from a rural health centre or clinic. The original plan was to have one village health worker for every 100 households. The Assessment of Primary Health Care in Zimbabwe (2009) notes that less than half of the households (46%) reported having access to a Village Health Worker in their wards. Furthermore, they are no longer being supplied with basic medicines as the clinics have nothing to give out. With the advent of new challenges and opportunities in the health sector, there is need to enhance the training programme of VHW to embrace community maternal and neonatal health, cholera, influenza and NCDs.

The other key community health worker is the Community Based Distributor (CBD). The Community Based Distributor's main function is to promote family planning services including the re-supply of appropriate contraceptives to eligible clients. However, only 332 CBDs are in post compared to an establishment of 900. In response to epidemics a number of other community health workers such as the "Chloroquine/SP holders" have also been established.

The primary level incorporates the first point of contact between the people and the formal health sector, the Rural Health Centre or clinic. This is the most peripheral unit of the health delivery system i.e. the Primary Care facility. Each Rural Health Centre is expected to cover a population of 10,000 and should be accessible to the community. The expectation is that no person should be more than 8 kilometres of walking distance of a RHC. Both the Access the Health Services Study (2008) and the Assessment of Primary Health Care in Zimbabwe (2009) note that physical access to health facilities is still a challenge as some people have to travel more than 10 kilometres to reach a health facility. The "outreach mobile services" that used to serve them are no longer functional.

The Rural Health Centres (RHC) provide basic but comprehensive promotive, preventive, curative and rehabilitative care, concentrating on mother and child care including antenatal care, delivery of uncomplicated births, family planning, child health and nutrition, routine immunization for children and anti-tetanus immunization for child-bearing women, environmental sanitation, especially in relation to small-scale water supplies and excreta disposal systems, control of communicable diseases, other specified problems including mental illness, eye diseases and physical and mental handicap, and general curative care including oral health. Health and nutrition education form part of all the above activities. Rural Health Centres provide support and supervision for community health workers. Health centres are staffed by two nurses, one of whom should be a midwife and an Environmental Health Technician. Unfortunately midwives are not available in most of these primary care facilities. This has compromised the quality of care given to expecting mothers. The establishment of two nurses at the RHC is no longer adequate given the increase in work load. Environmental Health Technicians are very few with a high national vacancy rate of over 50%. This negatively affects the provision of environmental health services.

Overlooked over years is the role of general practitioners and nurses in running primary care services mostly in urban settings. They concentrate on providing curative services. There is now need to look at the possibility of involving these groups in the provision of selected public health services over and above TB and immunization.

Secondary Level
Rural health centres refer patients to District Hospitals (secondary care facilities). Each district is supposed to have a district hospital and should save a population of approximately 140,000 people. The district hospital provides referral and supervisory support to the network of clinics and Rural Health Centres in the district. They also provide comprehensive preventive and curative services. Patients have their first contact with a medical doctor at this level within the health delivery system. District hospitals refer to Provincial Hospitals (tertiary care facilities) where patients meet a specialist. There are currently a few districts without a district hospital or designated district hospital. Some of the district hospitals train nurse and midwives.

Tertiary and Quaternary Level
Most provinces have a provincial hospital except Matabeleland North where the provincial hospital is under construction. The provincial hospital level provides referral support to district hospitals. There are a limited number of specialists at the provincial and general hospitals. Provincial hospitals refer to Central (Quaternary) Hospitals in Bulawayo, Chitungwiza and Harare that provide, together with private for profit hospitals, the more sophisticated type of services within the country. All provincial hospitals train nurses and/or midwives.

The referral chain works best when the patients referred from the lower levels receive the benefit of specialist opinion. In reality, because of the shortage of mid level doctors, a patient referred by an experienced Government Medical Officer at District Level, or, worse still, by a Specialist from a provincial hospital, is often being seen by a very junior medical officer at the central hospital. This is compromising the quality of care being given to patients.

The planned decentralization of specialist services to the provincial level in the 1997 -2007 Strategy did not succeeded to a significant extent. Availability of specialists at the provincial hospitals would have facilitated the training of intern doctors and trainee medical specialists at this level. Again, because of the shortage of specialists, this has not been possible. Support to doctors in district hospitals by specialists is limited and in some instances, non-existent.

In theory, patients are required to present at the primary level first and then be progressively referred to the Secondary, Tertiary or Quaternary levels depending on the complexity of illness. In practice, the experiences of the past decade have shown that the referral chain has broken down, with all referral hospitals replicating the work of the Primary level. At Harare and Mpilo Central Hospitals, it is estimated that about 75% of patients presenting are self referred. This, in itself, is indicative of the gross misuse of resources in the health sector.

This is partly associated with the failure to apply administrative measures to enforce the referral chain. However, more fundamental is the fact that availability of funds for maintenance, upgrading and essential supplies have decreased in real terms across the system. This, coupled with increases in demand, has led to the deterioration of the quality of services, particularly primary care services. The result is that people simply bypass this level because services are perceived to be of poor quality. Whilst in the past, the referral facilities were better resourced hence more functional than the primary care facilities, the situation has changed. Central hospitals are experiencing the same challenges of limited resources. Basic medical equipment and consumables are very often not available. Most of the fixed equipment such as elevators, boilers and heating systems have reached their end of life and are therefore not functional. Specialist professionals in all fields are in short supply. The few staff that are available are overworked and demoralized.

In the meantime, teaching at all levels is suffering. The quality of health personnel trained is heavily dependent on the clinical activity schedule of the institutions. The heavy staff attrition has taken away experienced manpower leaving recently qualified staff to train students.

The environment within which heath workers perform their work is key in cementing their relationships with patients. The present state of infrastructure does not create a healthy environment for both patients and staff to enjoy the healing process. Both patients and staff expect that facilities and equipment, essential to support recovery paths, are up to standard and functioning. This is a source of disgruntlement among health workers, who feel that their work environment does not further their professional growth and job

satisfaction. On the other hand, patients continue to express disgruntlement over the poor quality of services arising from this situation.

Communities, patients, their families and staff, are the best placed to judge quality because of their personal or communal experiences. Ignoring this and failing to involve them may result in the health system not responding to the actual needs of the population. In the Access to Health Services Study (2008), patients and communities rated the service quality they receive at health centres/hospitals as satisfactory or fair, whilst in the Assessment of Primary Health Care in Zimbabwe (2009) less than half of households in the study were satisfied with the performance of the health system (service quality and outcomes). People could have been reflecting the hardships experienced in 2008.

The 2003 Poverty Assessment Study Survey (PASS) revealed, and the 2007/8 Study on Access to Health Care Services reaffirmed, that in the event of illness most people seek treatment from public health institutions. However, communities complained about the long waiting time they have to endure before being treated. They were also unhappy with chronic shortages of supplies and drugs, poor water and sanitation services at health institutions and lack of electricity, resulting in them being requested to bring candles if they need attention at night. They also complained of shortages of staff leading to long waiting times, shortages of food and poor hospital diet, and lack of ambulances services. Even if ambulances were available, community members were at times requested to provide their own fuel for emergency services. They were also very unhappy with what they view as a much longer and costly referral system, where basic medicines are not available at local peripheral clinics and they have to be referred to district or provincial hospitals. Communities wanted to see doctors visiting peripheral facilities, so that they can be attended to nearer home and avoid high transport costs.

According to the same study, communities expect to be treated well by committed and motivated staff, with readily available drugs and equipment. They expect good client care, quick service, from adequate numbers of staff working in a clean, safe and hygienic environment. They also expect respect for confidentiality, as well as the availability of adequate and nutritious food at health institutions. Most public health institutions are far from meeting these expectations.

The Ministry of Health and Child Welfare has continued to work with various consumer organizations to identify the needs of consumers and to educate them about their rights. The patient's charter was one of the first coordinated steps towards informing consumers of what to expect. More needs to be done to incorporate the consumer's perception of the quality of care in the process of service delivery.

The MOHCW has been encouraging an environment in which stakeholders develop and implement a range of quality assurance tools, such as treatment protocols, management and standard operating procedures, clinical audits and reviews that ensure that all communities have access to quality core health services. The MOHCW has delegated quality assurance responsibilities to appropriate bodies such as professional bodies and technical agencies, operating from the national, provincial and district levels. However, quality assurance programmes are not yet an integral part of health care.

Health services in Zimbabwe are delivered by a multiplicity of players, both public and private, involved in direct service provision and financing, or in some cases, both. This raises the question of how to ensure that their conduct is in the public interest. This has become a concern because of the tensions existing between public interest and private gain. The work of health professionals is regulated through self regulatory mechanisms, as has been the tradition in many countries. The professional councils which regulate their training, accreditation and professional conduct, are created for and run by them. Traditionally, this has been based on the belief that the professionals themselves know best, and are better placed to ensure that standards are maintained based on service or professional ethics, written or assumed. The belief amongst health professionals that the practicing licenses granted to them gives them the right to pursue professional interests without being questioned should be discouraged. Licensing is in fact the basis of a social contract between society and health professionals, in pursuance of the public interest and good. This arises out of the acknowledgement of the nature of their relationship with those they serve, in that the latter surrender their power of judgment to the professional.

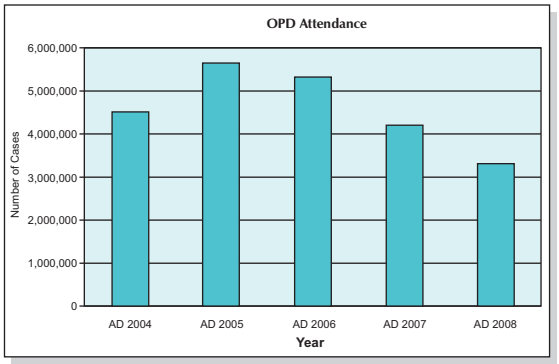
The context has changed. New pressures and opportunities have emerged over the last few years, creating new and perverse professional values which emphasise private gain at the expense of the public good. Within the public sector, this "cultural" change has been fuelled by policies

which have encouraged private provision and subcontracting, in efforts to improve efficiency and quality.

This has also had the effect of reinforcing the belief and view that public sector provision is inferior to private provision. Human resource strategies, which focus on individual incentives and private activities, may also influence the shift from the public sector ethos towards a culture of individualism. Health professionals will no doubt find moral justification for this shift in their low salaries and poor conditions of service, and to a certain extent this is understandable. However, clearly the current means, in the form of self regulatory structures, are weak to deal with these pervasive behaviours.

The utilization of health services is also being affected by the low incomes people are earning. In a bid to raise funds to purchase vital and essential medicines and supplies, some institutions have been charging user fees for services that normally would be free. The Maternal and Perinatal Mortality Study (2007), the Health Services Study (2008), the Assessment of Primary Health Care in Zimbabwe (2009) studies note that user fees for services are considered unaffordable by the community, and are contributing to reduced access to services especially for poor and vulnerable communities. Figure 28 shows this gradual decrease in utilisation of services.

Figure 28: OPD and Inpatient admissions



Subsequent sections in this document including those addressing human resources for health, health infrastructure, transport, communications, medical equipment and supplies, highlight the challenges in most health facilities. The major challenge in all the above is the unavailability of funds. Most medical equipment is obsolete and vital medicines are no longer available at health institutions. The few remaining well trained health professionals are frustrated as they are rendered helpless as they are not able to answer to their callings. It is not possible to provide quality care without the tools of the trade.

Improving the supply side capacity response at all levels, in order to improve quality, remains a major activity for the future. The key to success lies in achieving an appropriate balance between resources devoted to Primary Care and hospital services. To this end, the initiative to make hospital services more efficient and responsive to the needs of lower levels and referred patients remains a major goal for the health sector. Secondary and tertiary health facilities need to be revitalized for them to provide the much needed referral, teaching and supervisory services.

Key issues

- Mapping of coverage of RHCs.
- Improving coverage, access and utilization of health service delivery.
- Institutionalizing quality of care initiatives.
- Increasing the number of qualified health professionals.
- Strengthening professional ethics through the schools and professional councils.
- Strengthening professionals associations and councils.
- Strengthening the referral system.
- Adequately resourcing each level of care and ensuring minimum stock levels at all times for all strategic supplies.
- Re-enforcing the Primary Health Care Approach.
- Strengthening the secondary and tertiary service delivery.
- Strengthening the health system in a resource constrained environment.
- Redefining core health services for each level of care.
- Operations research.

Goal 16: To increase coverage, access and utilization of affordable, comprehensive and quality preventive and curative health services.	
Objectives	**Activity/Strategies**
To improve the functionality of Primary Health Care clinics and the referral hospitals (district, provincial and central referral hospitals)	• Redefine, cost and lobby for the funding of an Essential Package of Health Services that covers both clinical and public health interventions for each level of care (Core services for each level of care). • Revitalize, strengthen and ensure the implementation the comprehensive Primary Health Care approach. • Revitalize and strengthen referral Health Facilities (district, provincial and central hospitals). • Rehabilitate existing health facilities and only construct new ones in exceptionally needy areas. • Train additional health workers with special emphasis on critical shortage areas. • Increase coverage through involving private health providers. • Train more and equip community health workers with special emphasis on Village Health Workers and Community Based Distributors. • Resuscitate mobile outreach clinics in the hard to reach areas. • Increase the availability of medicines, medical supplies and other health facility strategic supplies. • Adequately equip all health institutions in accordance with the Core health services as defined for each level of the health care system. • Create a transparent and accountable procurement system to achieve value for money. • Ensure the availability of adequate and relevant support service facilities at all levels of the health services including laboratory services. • Strengthen the referral system by providing adequate ambulances and radio or telecommunication means. • Strengthen and enforce compliance with the referral system. • Strengthen supportive supervision, monitoring and reporting mechanism.
To improve the quality of care provided in health facilities	• Develop and implement a National Quality Assurance Programme in the Health Sector particularly in the areas of infection prevention and control, patient safety and clinical audits. • Develop SOPs for the hospitals and various levels of services delivery. • Review and develop (where necessary) clinical management policies, standards, guidelines and protocols. • Strengthen clinical audits at all levels of care. • Continuously train and update the diagnostic and case management skills of health workers. • Carry out periodic patient satisfaction surveys including operational research. • Review and implement the provisions of the Patients Charter. • Improve efficiency of hospital management teams. • Improve hotel services in hospitals. • Develop a strong information, education and communication programme aimed at improving the attitude and behaviour of health workers towards their clients.

3.1.2 Transport And Communications

Trends and current status

Transport
Transport and telecommunications form the essential physical link between the different levels of care both in terms of the referral of patients, supervision, outreach services and the supply of commodities. Both are important components of the health care delivery system. The Ministry of Health and Child Welfare aims at providing a complete transport and communication package for each level of care. To that end, a transport policy has been defined and is being implemented.

With the aim of meeting the transport standards for each level of care, a number of ambulances, service vehicles and motor cycles, have been directly purchased by the Ministry. The Ministry's efforts have been complemented by partners, who have also purchased a number of programme vehicles. However, the Health Service is far from meeting its target of vehicle availability as stated in the policy. Lack of transport has been found through a number of studies to be a major barrier to access and quality of health services.

A study on the maternal and neonatal services in Zimbabwe (2004), identified transport and communications as one reason for the delay in reaching treatment centres for pregnant mothers and children, thus contributing to increasing morbidity in this group of the population.

The 2005 Districts Management Study in 25 districts cited transport shortage as a major obstacle to service provision, contributing to breakdown of the referral system and delays in transportation of commodities (food, vaccine, dugs etc). A child health situation analysis study (2006) indicates that the "referral system, supervision and support to lower level health facilities and outreach for community work" have all been compromised by the shortage of transport. The Maternal and Perinatal Mortality Study (2007) noted that only 52% of rural women delivered in health facilities compared to 94% in urban areas. This difference was caused mainly by the difficulty rural women faced in reaching a health facility.

The Access to Health Care Services Study (2008) revealed that most people in rural areas, living far from health institutions, are using wheel barrows and scotch carts to ferry the sick to health facilities. This is because of the very high transport costs (when transport is available), as well as the lack of public transport due to poor road networks. Communities are equally concerned about the transport system. The Access to Health Care Services Study (2008), noted that most rural communities feel that because of the importance and centrality of health in their lives, the solution to ambulance problems requires the urgent injection of funds from central government.

In an effort to improve the management of vehicles, the ministry de-linked its fleet from the Central Mechanical Equipment Department (CMED) to Riders for Health and private garages. The objective of this transition has however not been realised as noted by the Access to Health Care Services Study (2008). The study noted that vehicle repairs and maintenance of the fleet needs urgent attention, as there are currently ambulances and health programme supervisory vehicles that are off the road because of none repair and lack of spare parts.

The few available vehicles are paradoxically under-utilised, due to difficulties in accessing fuel from CMED and the general shortage of fuel in the country. To ensure constant availability of fuel for critical services, some institutions installed fuel tanks and purchase fuel direct from NOCZIM, when available.

Having realized that transport is a key pillar of the health system, not only for service delivery but also for transportation of health workers, and also having noted the breakdown of the public transport system, the Ministry of Health and Child Welfare has actively been sourcing for buses and vehicles. The major obstacle in fulfilling this task has been the shortage of foreign currency. However Government, through the critical staff retention scheme, is complementing the ministry's initiatives by availing vehicles to selected health staff, as well as buses for others.

Transport thus remains a major challenge in the provision of services. Immunization, malaria indoor residual spraying, drug distribution, supervision of districts and clinics, have all been compromised due the shortage and poor maintenance of transport and telecommunications. Inadequate ambulances, high maintenance costs, erratic fuel supply and poor communication systems in health facilities, limit outreach activities and contribute to adverse outcomes, particularly in maternity care, acute care and emergencies.

Telecommunication
A functional health facility connectivity package (telephones, cellular phones, two-way radios and

internet) is essential for emergency referrals to higher levels of care. This is essential for the transmission of important data, epidemic alerts, administrative and management support. Remote areas benefit from clinical advice communicated through various means.

In areas where there is telephone connectivity, some telephones have been installed, whilst in areas without, either radios or cellular communication has been provided. At all levels of care, with the exception of Rural Health Centre level, computers have been acquired, thus improving the efficient production of information and its flow through e-mail. Linked to telephones, some institutions now have fax machines and access to e-mail and internet services through HealthNet. In addition, the ministry has established its own web site.

However, a lot more work needs to be done as shown by the Access to Health Care Services Study (2008) and the Vital Medicines and Health Service Survey. The 2008 study noted that with the exception of very few rural institutions, telecommunication services are now nonexistent and in a state of disrepair due to lack of maintenance. This has made communication in cases of emergency and referrals extremely difficult, with the inevitable unnecessary loss of life in some instances. At many institutions covered by the study, phone or radio equipment is available but what repair and rehabilitation of the networks is required.

Key issues

- Inadequate numbers of ambulances and service vehicles.
- Poor transport management of systems.
- Poor connectivity and communication systems.

Goal 17: To increase availability of transport to at least 75% and communication systems to 100% of the requirements levels	
Objectives	**Activity/Strategies**
To increase availability of transport at all levels	• Vehicles and motor cycles procured in line with the transport package for each level care. • Transport management systems strengthened.
To increase availability of a reliable communication package at all levels	• MOHCW IT policy and strategy developed. • Radios, phones, computers etc in line with the communication package for each level care.

3.1.3 Health Infrastructure

Trends and current status

Distance from the nearest facility is an important factor in planning for health care services. Health facilities must be located within a reasonable distance, and the cost of seeking service should be affordable for equitable health care delivery. In the rural areas where transport is less accessible and a higher proportion of people live, the importance of geographical proximity of health services cannot be over-emphasized.

The standard practice in health infrastructure planning and development has been to ensure one rural health centre per 10 000 population; one district hospital per 140 000 population; and one provincial hospital per province. By 1997, 85% of the population lived within 8 km of a primary care facility. Population movements, as a result of the agrarian reform programme and natural population growth, have reduced geographic accessibility in some parts of the country. The just completed Access to Health Care Services Study (2008), found that most communities live within a 5km radius of their nearest health facilities, 23% between 5 to 10 km, and 17% over 10km from the nearest health centre.

The Access to Health Care Services Study (2008), found that most people walk (85%) to the nearest health facility, whilst a considerable proportion use wheel barrows and scotch carts. Very few people use public transport when visiting their nearest health facility. The study noted that access for those living far from health facilities is extremely difficult, due to lack of transport in the rural areas, where most roads are in disrepair. In the Maternal and Perinatal Mortality Study (2007), distance to a health facility and lack of transport were found to be major barriers to access to institutional deliveries. The study recommends the construction of "waiting mothers shelters" at strategic health facilities to overcome these two challenges.

To increase physical access, a number of construction projects were initiated over the last ten years. However, whenever funds have been

made available, construction activities have been very slow, resulting in some of the projects taking up to 10 years to complete. There are currently a number of projects that have come to a standstill as a result of inadequate funding, but also due to poor management of contracts. A position of hospital engineer has been created in the Ministry to address this situation and institutions have also been encouraged to resuscitate commissioning committees to manage new projects. Some institutions have established their own posts for hospital engineers or an equivalent, to oversee the maintenance and refurbishment of health facility infrastructure including estate management duties.

Resources being allocated for maintenance under the "maintenance vote" (budget line item) are grossly inadequate to meet all the refurbishment requirements of the dilapidated infrastructure and obsolete equipment. This chronic under-funding for maintenance has resulted in some buildings being abandoned due to cracked and leaking roofs.

Lack of accommodation has contributed to the inability to retain health professionals in most institutions. To that end, the Ministry has continued to have accommodation constructed on site where possible.

It is worth noting that health infrastructure capital investment has not kept pace with population expansion; notably, a big gap continues to exist in secondary care facilities in urban areas. This situation has resulted in Provincial and Central Hospitals being used as first referral centres leading to congestion and a fall in the quality of services offered (pg 83). It is in this area that opportunities for Private Sector participation should be vigorously examined and exploited. However, there is also need to construct additional secondary facilities in large urban areas.

In order to identify the gap in meeting the health infrastructure development standards and improve physical access to health services for the underserved, a comprehensive audit of availability and condition of infrastructure was undertaken in the year 2000. Out of this audit, a 15 year health Infrastructure development plan was developed. The infrastructure development plan aims to produce a minimum package of infrastructure per level of care. However, the 15 year health Infrastructure development plan is not backed by an investment plan. Furthermore, there is need to update it.

Table 5: Public Health Facilities as at 30 April 2006

Provinces	Primary level	1st Referral level	2nd Referral level	3rd Referral level	Total
Harare	45	0	0	7	52
Manicaland	253	36	1	0	290
Mashonaland Central	130	15	1	0	146
Mashonaland East	168	22	1	0	191
Mashonaland West	128	22	1	0	151
Matebeleland North	92	17	0	0	109
Matebeleland South	105	18	1	0	124
Midlands	206	28	1	0	235
Masvingo	170	23	1	0	194
Bulawayo	34	0	0	7	41
Total	**1331**	**181**	**7**	**14**	**1533**

Key
Primary level = Clinics and Rural Health Centers
1st Referral level = District, Mission and Rural hospital
2nd Referral level = Provincial Hospital
3rd Referral level = Central hospital and infectious diseases hospital

Challenges

- Brain drain of technical staff for construction and supervision of projects.
- Limited physical access for some communities, especially the newly resettled areas.
- Inadequate funding for infrastructure development.
- Poor maintenance and repair services.
- Delays in completing infrastructure projects.
- Poor contract management.

Key issues

- Strengthen management of Public Sector Investment Programme (PSIP).
- Staff accommodation.
- Maintenance of existing infrastructure.
- Improving estate management

Goal 18: To increase physical access of the population to appropriate health infrastructure for each level of care	
Objectivess	**Activity/Strategies**
To increase the availability of functional infrastructure in underserved areas including deliberate emphasis on developing farm/resettlement area health facilities	• Update data base of available health facilities and their distribution. • Construct secondary level facilities in urban areas. • Construct on-site staff accommodation. • Complete 50% of all ongoing construction projects. • Update the data base for training schools and improve facilities at training schools.
To regulate the establishment of health facilities	• Develop policy guidelines.
To upgrade and rehabilitate health infrastructure	• Rehabilitate health facilities. • Perform regular maintenance of facilities.
To improve availability of water and electricity services at health institutions	• Establish alternative water and electricity supplies for all health facilities.

3.1.4 Laboratory Services

Trends and current status

Laboratory services are an integral part of the health delivery system, essential in diagnosis, treatment, monitoring and control of disease. As a result of the change in disease pattern, there has been a huge increase in demand for laboratory services to support national programmes including HIV, AIDS & TB. The laboratory is also required to provide timely confirmation of outbreaks if appropriate control measures are to be instituted early at lower levels of health care service provision.

The Laboratory services are comprised of public and private components, and are further differentiated by the type of services they provide. Clinical laboratories, the majority of which are found in and managed by health institutions, are the diagnostic laboratory services geared towards personal health care. Public Health Laboratories mainly focus on disease control and prevention. The major public health laboratories in the country are the National Reference laboratories, Government Analyst Laboratory, National Institute of Health Research and the National Blood Service. Both the private and University laboratories provide clinical and public laboratory services, and actively support research activities in the country. One of the specialized laboratories especially critical to the health of the nation is the National Blood Service. The laboratory is mandated to provide safe blood and blood products to whole health sector.

The National Reference Laboratories (Specialized Referral Centres and Services) include the National Microbiology Reference Laboratory (NMRL), the National TB Reference Laboratory (NTBRL), National Virology Laboratory

(WHO-Polio and Measles Laboratories at the College of Health Sciences- Department of Medical Microbiology) and the Zimbabwe Quality Assurance Programme (ZINQAP), which provides quality control and quality assurance to all the registered laboratories focused on patient clinical and quality care.

Laboratory services are organized to function on the basis of increasing levels of sophistication. Each level of care is expected to provide a package of well defined laboratory services by appropriately trained laboratory health professionals. For each level, minimum standard requirements for equipment, reagents and supplies have been defined. There is however need to finalize and adopt the Zimbabwe Medical Laboratory Standards which have not been implemented, despite having been developed in the late nineties.

Appropriate legislation to make participation in external quality assurance mandatory for medical laboratories needs to be developed and put into place, to ensure that public, private, research laboratories etc, can only provide services when their performance is deemed acceptable by the regulatory authority (the Medical Laboratory and Clinical Scientist Council). This is critical as wrong or poor quality laboratory results lead to mismanagement of patients and wastage of resources.

To improve case management at the clinic and hospital ward levels, simple diagnostic tests are being carried out. This has been achieved, for example, through the training of nurses in rapid HIV and malaria diagnostic tests at rural health centre level. The Ministry has also been training Laboratory Assistants /Microscopists, and reintroduced the State Certified Medical Laboratory Technician (SCMLT) cadre in 2007 to perform rapid HIV, malaria and TB smear microscopy to service the first point of entry (the clinic or rural health centre).

For the second level, the Ministry of Health has re-introduced the State Certified Medical Laboratory Technician (SCMLT) training programme. The State Certified Medical Laboratory Technician is expected to provide services for the level of work carried out at district level. The higher laboratory levels (provincial and national) are to be serviced by laboratory scientists.

There has been a general deterioration of laboratory services where the tiered system has failed to provide the standard package of supportive laboratory tests at each level of healthcare. This has resulted in patients seeking services from the private sector where the costs are prohibitive for the majority of the population. However, support from the Global Fund (GF), Expanded Support Programme (ESP) and other partners have however seen an improvement in the provision of CD4, chemistry and haematological services in some hospitals.

Human resources remain a major challenge, as experienced Medical Laboratory Scientists and those graduating from the Department of Medical Laboratory Sciences at the University of Zimbabwe College of Health Sciences, continue to leave the country for the region and overseas.

The procurement and supply chain management of laboratory logistics including equipment needs strengthening. National reference laboratories (the National Microbiology Reference Laboratory, the National TB Reference Laboratory and the National Virology Laboratory) need to have their activities harmonized so they are responsive to the needs of the MOHCW.

Key issues

- Weak supply chain management of laboratory logistics and commodities.
- Unavailability of a framework for the coordination of laboratory support and management.
- Absence of policy and strategy.
- Shortage of human resources.
- Weak service delivery.
- Weak monitoring and evaluation of laboratory services.

Goal 19: To ensure the delivery of an effective, efficient, accessible, equitable, and affordable national quality assured network of tiered laboratory services.	
Objects	**Strategy**
To improve the quality of clinical and public health laboratory service provision	• Develop National Laboratory Policy and Strategy. • Revitalize the laboratory health system with special emphasis on the reference laboratories. • Develop and implement an M&E system for laboratory services. • Define and provide a package of laboratory services for each level of care. • Review and provide guidelines for each level of care. • Strengthen the management capacity and coordination of laboratory services. • Strengthen human capacity development. • Increase the availability of laboratory supplies at each level of care. • Strengthen quality management systems for laboratory services. • Strengthen public-private partnerships. • Strengthen support and supervision of laboratory services. • Increase diagnostic capacity to diagnose MDR and XDR TB and other emerging conditions.

3.1.5 Government Analyst Laboratory

The Government Analyst Laboratory (GAL) offers analytical services to the MOH&CW (Environmental Health, Port Health Authority, Nutrition Unit, Hospitals and National Institute of Health and Research), other ministries and private sector. The range of services includes scientific and technical analytical support to Food and Drinking Water Safety Programmes, Control of Exposure to Toxic and Harmful Substances Programmes. It has capacity to analyze the food, drinking and effluent water, industrial products, agro- products and clinical, anatomical (post mortem) spacemen as listed below:

Foods and Waters

- Food samples according to the provisions of the Food and Food Standards Act (CAP 321).
- Food samples to provide a quality control service to industry and in cases of suspected contamination.
- Water samples to determine suitability for human consumption and effluent water for pollution control.
- Food and Water samples to provide technical information on matters related to food composition, quality, legislation and sources of water pollution and treatment.
- Urine and salt samples for iodine levels to monitor Iodine Deficiency Disorders.

Toxicology, Clinical and Industrial

- Post-mortem specimens for toxic substances as a service to the Ministry of Home Affairs (ZRP) and Forensic Science Laboratory investigating sudden death cases.
- Clinical samples for therapeutic drug monitoring, emergency toxicology; heavy metals, pesticides and muti poisoning and for blood alcohol determination as a support service to health care delivery institutions.
- Customs samples for tariff classification.
- Mutilated currency to assist the Reserve Bank of Zimbabwe with valuation of its currency claims.
- Pesticides formulations for active ingredient levels.

The laboratory has close links with other laboratories both within and outside the country involved in analytical chemical analysis and research. These include the National Research Institute, Public Health Laboratories, Standards Association of Zimbabwe, Tobacco Research Board, Research and Specialist Services, Forensic Science Laboratory, Medicines Control Laboratory, Water Research Laboratory, Harare Municipality Analytical laboratory, Universities and others.

The Government Analyst Laboratory is the Secretariat to the Food Standards Advisory Board (FSAB) that deliberates on Food Safety issues nationally and participates in regional and international Food Safety Control initiatives such as SADC / COMESA Sanitary and Phytosanitary Measures and CODEX meetings and sessions.

The challenges faced by the Government Analyst laboratory are adequately described under the laboratory section of this document.

Key issues

- High workload due to increasing demand for services
- Non ISO 17025 compliance.
- Poor coordination of laboratory services

Goal 20: To improve on the quality of the national analytical laboratory services for food, water, toxicology / clinical and industrial inputs/products analysis.	
Objectives	**Strategies**
To improve the quality of laboratory diagnosis	• Analyze submitted samples according to ISO 17025 quality standards timely and proffer expert technical advice that will assist decision making by stakeholders. • Incrementally improve the quality of analytical service delivery from 55% to 90% of ISO 17025 quality standards requirements by 2013.
To improve the capacity of the Government Analyst Laboratory	• Improve the equipment and instrument base to meet ISO 17025 standards requirements from 40% to 90% by 2013. • Advocate for the improvement of lab infrastructure. • Continuous human resource development.
To strengthen the administration of the Food and Water Safety and Quality Regulations to ensure availability of safe food and water to the public	• To review the Food and Food Standards and water Regulations as necessary jointly with FSAB and adhere to international Sanitary and Phytosanitary Food Safety Regulations. • Craft the National Food Safety Policy and steer the FASB activities. • To contribute towards the establishment of the Food Control Authority.
To improve information collection, gathering and dissemination as National CODEX and INFOSAN Contact Points, SADC, COMESA and FSAB substantive member and secretariat. To be part of the nucleus of the imminent food control authority	• Compile and share analytical and legal information of non-complying analyses results with the National Taskforce for Contagious and Infectious Diseases and Natural Disasters. Liaise with Plant and Animal Health labs, Water Quality Lab, Forensic Science lab, Regional Drug Control lab, Public Health lab, NIHR, Local Authority labs, Tertiary Institution labs and private labs.

3.1.6 Medical Imaging (Radiography) And Other Support Services

Trends and current status

The public health sector has a well established medical imaging system that is "available" in all district, provincial and central hospitals. However, most of the equipment is either obsolete or non-functional due to the shortage of spare parts.

Because of the need for specialist services, Radiotherapeutic services are centralized in Harare and Bulawayo. Nuclear medicine, which is only appropriate in large referral hospitals is only offered in Harare and Bulawayo.

The shortage of imaging professionals is being addressed through the training of radiographers at Parirenyatwa and National University of Science & Technology (NUST) in Bulawayo, and X-ray operators being trained in provincial hospitals. The public health sector has no single radiologist. These are trained outside the country.

A personnel monitoring service assessing individual radiation exposure and catering for both the private and public sectors existed before, but is no longer serving the purpose it was created for due to shortage of staff.

Key issues

- Lack of personnel monitoring service for individual radiation exposure.
- Inadequate numbers of imaging health professionals being trained.
- Poor maintenance of basic imaging equipment.
- Obsolete imaging equipment.

Goal 21: to increase access to high quality imaging services	
Objectives	**Strategies**
To strengthen the medical imaging services	• Update the imaging equipment data base. • Procure imaging equipment for every district, provincial and central hospital. • Revamp the Radiotherapy facilities in BYO and Harare are fully functional. • Revamp the Nuclear medicine facilities in BYO and Harare are fully functional. • Scale up training and retain staff.

3.1.7 Radiation Protection Unit

Trends and current status

The Radiation Protection Unit has the role of ensuring safety and security of radioactive sources, proper management of radioactive waste and the protection of people and the environment from the hazards of ionizing and non-ionizing radiation, through the effective regulation and use and management of radioactive and nuclear materials for beneficial peaceful purposes. The Unit has to ensure a balance of the benefits of radiation uses against the risks of adverse health effects.

The country utilizes nuclear and radiation technologies in the areas of:

- Human health - diagnostic and interventional radiology, radiotherapy, nuclear medicine, nutrition and isotope molecular techniques in diagnosis and treatment of HIV and AIDS, TB and malaria.
- Agriculture - diagnosis and control of veterinary diseases, tsetse eradication, improvement of livestock productivity through artificial insemination, crop breeding, combating desertification.
- Water - dam safety, underground water aquifers development, water treatment.
- Industry - industrial radiography e.g. for non-destructive detection of internal defects or cracks in materials or welds.
- Sterilization- high intensity radiation sources are used to sterilize medical, blood and pharmaceutical products, insect control or for the preservation of food stuffs
- Security e.g. electrically generated x-rays used in airports and other locations to check the contents of packages, mail, baggage etc
- Teaching, Research and Development Laboratories and Universities.

Radiation Protection fell under the Hazardous Substances Control Act Chapter 322 of 1972 until August 2004. This Act also provided for the safe use of other hazardous substances such as industrial chemicals, their mixtures and compounds. In order to comply with the International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources (BSS), a bill was drafted to separate ionizing radiation issues from other hazardous substances.

The Radiation Protection Act [Chapter 15:15] passed through parliament in August 2004 and was operationalised on 1 July 2005. The Act provides for establishment of national regulatory infrastructure for nuclear and radiation safety that meets international standards as set by the International Atomic Energy Agency (IAEA).

The Unit has not been spared from the challenges affecting the health sector including human resources attrition and dwindling financial resources.The activities that the Unit should carry out (authorization, review and assessment, inspection and enforcement, development of regulations and guides, radioactive waste management and personnel monitoring) have been hampered by the prevailing challenges thereby seriously compromising safety.

Loss of institutional memory has adversely affected progress and implementation of the Radiation Protection Act. The initial Radiation Protection Board that was appointed in 2006 could not manage to put in place the Radiation Protection Authority of Zimbabwe owing to these challenges. The Minister of Health and Child Welfare strengthened the Board in May 2008 by making new appointments and there are renewed efforts to see the full implementation of the Radiation Protection Act.

The Unit aims to develop structures that will see the achievement of all five thematic safety areas within the next five years.

Key issues

- Setting up of the Radiation Protection Authority of Zimbabwe.
- Training of Radiation Safety Officers.
- Creation of synergies with other Governmental Departments that have responsibilities in the safety and security of nuclear and radioactive materials.
- Radiological protection in occupational exposure, medical exposure and environmental radiological protection.
- Emergency preparedness and response to radiological accidents.

Goal 22: To reduce radiation exposure of both human beings and the environment	
Objectives	**Strategies**
To upgrade Radiation Protection Infrastructure &Services through the implementation of the Radiation Protection Act [Chapter 15:15]	• Sharpen staff research and technical skills through relevant post-graduate educational and technical programmes. • Establish laboratories for research activities and quality control and quality assurance. • Strengthen collaborative networks with other regulatory authorities through participation in AFRA and IAEA activities. • Strengthen cooperation with regional regulatory authorities through exchange programmes.
To ensure safety and security of radioactive sources and contribute towards the fight against illicit trafficking	• Implement robust radioactive waste management programmes. • Train key partners on safety and security of radiation sources at ports of entry. • Source for detection equipment for ports of entry. • Sign MOUs with strategic partners. • Collaboration with international organizations and partners.
To increase national awareness of radiation hazards and risks	• Increase awareness and understanding on the adverse health consequences of radioactive substances.

3.2 HUMAN RESOURCES FOR HEALTH

Trends and current status

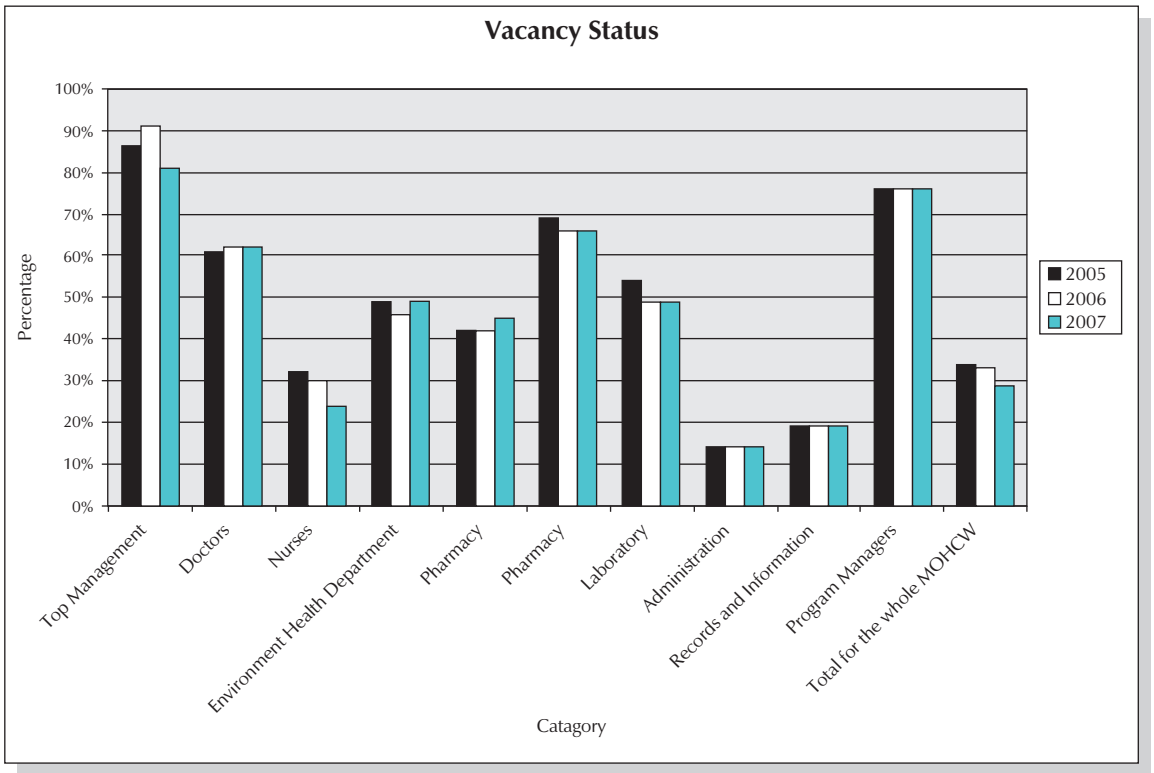
Human resources for Health (HRH) are arguably the most critical component of a health delivery system. An appropriately trained, skilled and well motivated workforce is a critical component required for the efficient delivery of health services. The Ministry of Health and Child Welfare has therefore given human resources high priority, in order to increase access trained human resources and to achieve both the National Health and Millennium Development goals.

Zimbabwe has a physician density of 0.16, a nurse density of 0.72 and an overall density of 1.23 health staff per 1 000 population. According to the World Health Organization (WHO), in order to be able to achieve its MDGs Zimbabwe should achieve a health worker density of at least 2.5 per 1 000 population, i.e. a health worker density of at least 250 doctors, nurses and midwives per 100 000 population. There is evidence that lower maternal, infant and under-five mortality go hand in hand with higher human resource density (physicians, nurses and midwives per 1,000 population.)

After the initial successful local production of a high quality work force, Zimbabwe's health delivery system has over the past few years been hampered by a massive internal and external brain and skills drain. This has resulted in the loss of experienced qualified health professionals from the public health sector. The remaining health professionals are now spread out thinly, to the extent that some institutions are now staffed by untrained cadres. This has reduced access for the population to treatment by trained and experienced health workers. The exodus has also reduced capacity to train and mentor additional health professional,

Figure 28 below shows the vacancy status from 2005 to 2007. For certain categories of staff training efforts have been doubled, and show a steady increase in the vacancy occupancy rates. However the newly recruited staff lack adequate experience to deliver the core health services.

Figure 29: Vacancy status



The national vacancy status in the table above hides the shortage of critical cadres, for example midwives and theatre nurses in the nursing profession, and pathologists and radiologists in the medical profession. Central and provincial hospitals do not have adequate specialists and middle level doctors. Out of the 63 specialist medical established posts eleven are occupied. The objective of decentralizing specialist services to provincial and district hospitals through manpower development has not succeeded to a significant extent. These specialists would have assisted in further training and supervision of health professionals at provincial and district levels. Newly qualified doctors deployed to the districts are therefore receiving inadequate clinical and supportive supervision from specialist doctors. The high vacancy rates of 73% amongst consultants at central hospitals is affecting the quality of services and training programmes. A very high failure rate was recorded amongst medical graduates in 2006 and 2007, which can be directly attributed to the shortage of consultants whose additional responsibilities include training and supervision of health professionals.

Figure 29 also does not show the existing gross inequitable distribution of health professionals, both between urban and rural areas and within provinces. Staff inducement and retention outside major cities has remained a challenge since independence.

Management capacity has been found wanting at all levels as experienced hospital, ward, and programme managers have left the health service. Figure 29 above suggests an average vacancy rate of 81% among the senior positions in the MOHCW. This means that the Ministry of Health and Child Welfare, as at December 2007, was operating with 19% of its approved establishment of senior management positions.

The vacancy levels in the various categories are a cause for concern and have serious implications for the ability of the Ministry to meet its mandate. Doctors, nurses and other health professionals have left the health sector for greener pastures, citing poor conditions of service, an unconducive working environment, lack of requisite tools of the trade and the prevailing compromised economic environment. The shortage of staff as a major concern has been confirmed through key informant interviews with health workers unanimous in citing this as a problem (Access to Health Care Services Study 2007). The study noted that many vacancies remained unfilled at the district hospital level, with junior personnel standing in for senior professional cadres.

Whilst recognizing the common "push" factors fuelling the brain drain in various professional groups in Zimbabwe, the lack of recognition of the extra professional burden peculiar to the health worker has not been sufficiently understood as one of the major factors, despite the creation of the Health Service Board as a "pull factor". The work heathworkers do goes beyond merely fulfilling the basic requirements of a particular job. The relationships that health workers forge with users are qualitatively different from other jobs, where the interaction between client and service provider is less interdependent and intimate. Heath workers across the globe are very sensitive to this lack of recognition, from both the system itself and the public in general.

Zimbabwe is capable of training most of its health human resources both at under and post graduate levels. Training of health professionals is mainly done by the Ministry of Education and the Ministry of Health and Child Welfare. There are a few private institutions offering training in human resources for health.

Increasing the numbers of trained health professionals has been one of the strategies of counteracting the brain and skills drain. In the last three years, the vacancy occupancy rate for trained nurses of 40% at the rural health centers has been reduced to the extent that approved establishment has been reached. This has been achieved through the scaling up of general nurse training and the introduction of the Primary Care Nurse (PCN) programme. However, the challenge of continuing to follow this strategy is the lack of both lecturers and tutors across all fields, with the vacancy rate for tutors at a high level of 68%. This cadre is critical in the training of nurses and midwives. This has led to the observed high failure rate in the nurse training schools particularly in midwifery. The College of Health Sciences in the University of Zimbabwe in late 2007 had a lecturer vacancy rate of up to 57%. Some disciplines, such as anatomy and physiology, had only one lecturer in post as opposed to an establishment of between 20 and 25. Similarly the high failure rate of students was experienced.

The shortage of lecturers and tutors makes it difficult to increase training output in order to reduce vacant posts. As a result, the number of graduates from some training programmes has declined over the years and there will be very few specialists graduating from the medical school during the period of this strategy. Recruitment of expatriate specialists, as a way of alleviating the shortage of critical specialist skills, will be one way of meeting this challenge.

Innovative approaches in training have recently been introduced, including the scale up of generic health worker training programmes such as X-ray Operators, Laboratory Technicians, Pharmacy Technicians, Environmental Health Technicians and Primary Care Nurses. This however is being compromised by absence of formal country-to-country recruitment agreements.

To strengthen the planning and management of human resources, a Human Resources for Health Policy and Strategy, as well as Personnel Information Systems are at an advanced stage of development.A Directorate of Human Resources has now been established at national level in order to coordinate and manage the human resources for health strategy.

Retention of the remaining skilled health professionals has been a priority for both the Ministry of Health and Child Welfare and the Health Service Board. In the last few years, the Ministry of Health and Child Welfare, together with the Health Service Board and the Ministry of Finance has been mobilizing resources to provide incentives to motivate and retain health professionals. The Health Service Board was established in 2005 through an Act of Parliament, with the mandate to create, develop and promote a conducive working environment in the public health sector, in order to overcome brain drain from the health sector.

With the support of Government and Development partners, there have been efforts to manage the brain drain through incentive schemes meant to retain health workers. In the last quarter of 2008 most health institutions were reporting an average staff presence of about 50% across the board, with Harare Hospital reporting the lowest turnout rate of 15% in September/October 2008. Currently however turnout is over 80% of expected staff, and is expected to reach nearly 100% as staff are attracted and assisted to come back to work by the donor funded health worker retention scheme which provides an allowance to health staff in US dollars as well as the dollarization of government salaries.

Key Issues

- Failure to contain and manage brain and skills drain.
- Inequitable distribution of health professionals within the sector.
- Unattractive retention incentive measures at all levels of care and management.
- Poor succession planning
- Low outputs from specialist training areas.
- Absence of bilateral/international agreements relating to HRH recruitment.

Goal 23: To ensure that the health system based on PHC has appropriate numbers and categories of Human Resources for Health for efficient and effective implementation of the National Health Strategy.	
Objectives	**Activity/Strategies**
To develop and implement a human resources policy and strategy	• Finalize the human resources policy and strategy. • Develop a detailed implementation plan for the human resource strategy. • Develop a monitoring system for human resources. • Strengthen the Human Resources department at all levels. • Establish functional human resources information system (Computerized personal information management system).
To reduce vacancy levels across all staff categories by 50%	• Improve salary levels, working conditions and other non-monetary incentives to be comparable with the SADC region. • Increase capacity of training schools including support and supervision. • Secure training places for specialties that are not offered locally. • Continue external recruitment for specialist shortages areas. • Scale up cadetship programme. • Decentralize medical specialists, internship and other specialists' programmes to selected provincial and other hospitals with resources capacity. • Develop and implement a succession planning strategy. • Enter into bilateral/international agreements relating to HRH recruitment.
To strengthen management at all levels	• Adapt the performance appraisal system to fit with clinical work. • Resuscitate the training and management development programmes for all management professional and technical personnel. • Improve professional ethics. • Develop and implemented an orientation programme for all new employees. • Strengthen clinical audits.

3.3 HEALTH INFORMATION

3.3.1 Health And Management Information System And Research

A good health information system provides the information necessary to provide and manage good health services, while it strengthens the organizational system that provides these services in accordance with the principle of Primary Health Care (PHC). This implies that information is collected, collated and analysed at different levels and used for action at that level. At each level it serves specific goals, broadly categorized as follows:

• At the patient level (clinical care): This information is necessary for optimal patient management, i.e. for individual clinical care of both curative disease episodes as well as preventive services. This level of health information is often not considered in the development of a Health Information policy but is left to health workers (clinicians) and managers who are charged with the delivery of optimal medical care.

• At the Health Facility level, it serves operational objectives: the information is gathered to optimize Clinic and Hospital management as well as operational issues of public health management. The objectives are related to good management of the institution and of the management of the services offered to the community (epidemiological, public health considerations). Insights gained through information gathered at this level allow health workers to make operational choices.

• At administrative (District and Provincial) level health information serves a strategic objective: Where it concerns epidemiology and disease control, it may partially overlap and include elements of the operational level. Because of the larger scale and supervisory responsibilities of the provincial level, the resulting actions are more of a strategic nature: distribution of resources over

larger areas (one district versus another), wider scope of institutions (support for govt. clinics or council/mission clinics), choices of alternative resource allocations, etc. These choices involve calculation (or, more often estimations) of cost-effectiveness.

- At National (and international) level, health information should also contribute to policy choices and action which are of a more all encompassing nature than the previous levels. Apart from strictly public health concerns, policy will be shaped by additional inputs from policy makers and often rises above the technical cost-benefit levels of public health interventions.

From operational through to policy level, data gathered from the levels below is progressively more aggregated and complemented with inputs from special surveys, scientific research and international best practice and policy experiences.

Reliable data is required on types of health services provided, coverage of health services, categories of people benefiting from those services, incidence and prevalence of diseases, disease outbreaks, and availability of human, financial and material resources to support the delivery of health services. The data should be accurate, timely and complete in order to guide health managers to effectively plan, implement, monitor and evaluate health services according to their level of responsibility.

Trends and current status

In response to emerging calls for increased availability of data for planning, implementation and monitoring of health programmes, the Ministry of Health and Child Welfare designed and piloted a national health information and surveillance (NHIS) system in 1985. The NHIS system was rolled out nationwide in 1988 followed by a joint evaluation of the system conducted in 1999 by MOHCW and WHO. Some challenges in data collection, analysis, reporting and uniformity were identified and recommendations for improving the system were made. Despite these challenges, the NHIS was awarded a SADC trophy for being the best surveillance system in the region in 2004.

A lot of effort has gone towards improving the NHIS in the past ten years. Posts for Health Information Assistants were created at district and mission hospital levels. Data collection tools have been constantly adapted to suit new information needs. Software packages have been developed for data capture and storage. Health Information assistants training was established at Harare Polytechnic, while IDSR and basic epidemiology courses were introduced for staff at all levels. This training was designed to equip staff at these levels with skills to enable them to use health information for decision making. This training has proved to be very useful and has enabled operational levels to detect and respond to outbreaks early.

Weekly sentinel surveillance data is being used to a limited extent at the local levels, especially by those trained in IDSR and basic epidemiology. Others are collecting data only for transmission to higher levels. This has resulted in some outbreaks being detected at the provincial or national levels, with the district or health facilities unaware of the outbreak. This problem has been compounded by on-going brain-drain, as increasing numbers of inexperienced staff take up posts at the operational level. Furthermore, completeness of information returns remains a challenge, while no success has been achieved towards monitoring the private sector.

A lot of effort has gone towards providing Information Technology support for the districts, provincial and National levels. Most NHIS departments at the various levels have access to computers as well as access to telephone and e-mail facilities. Telephone facilities have however been unreliable especially at the rural health centre level. Radio communication equipment linking Rural Health Centres and Districts hospitals, has largely been vandalized and is now unreliable.

Apart from information generated through the NHIS, the ministry also relies on information generated through research. The National Institute of Health Research (formerly Blair) is mandated to champion this function.

The institute was active in the first half of the past decade, generating research based evidence that has influenced policy changes, for instance in the drug management of malaria, training of staff at provincial and districts levels on operational and health systems research. This latter activity has largely died out and due to brain drain, research activities at the provincial and district levels have virtually stopped.

Recognizing the challenges being faced by the systems designed to provide information to the health delivery system for decision making, monitoring and evaluation, in 2005, the Ministry with the support of UNICEF, commissioned a study to assess the causes of the problems and identify the most effective rectification measures.

The assessment noted that the structures required for the proper functioning of the national health information and surveillance systems are in place. Generally, the information at the points of collection - in all types and levels of health facility - is complete. However, it was noted that the information is increasingly less complete at District, PMD and headquarters respectively, because of failure to update with late returns received at lower levels. The extent of analysis and use of information was noted to vary from programme component to component and facility to facility. The factors affecting the proper functioning of the information system were noted to be multiple and that they were related to management procedures, use of technology and design of the system.

Key issues

- Inadequate analysis and use of information.
- Inadequate focus on performance indicators and targets.
- Inadequately designed software.
- Lack of access to communication facilities.
- Lack of proper data archival/retrieval systems.
- Irrelevant details and gaps in data collection.
- Poor selection of sentinel surveillance sites.
- Weak human resource and management of information.

Goal 24: To provide reliable, relevant, up-to-date, adequate, timely and reasonably complete information for health managers at facility, district, provincial and national level	
Objectives	**Strategies**
To harmonise the functions of the Health Information and Surveillance Systems	• Establishment of a broad-based HIS stakeholders forum. • Selection of core and common health indicators. • Development of the Health Information Strategy. • Operationalisation of the Health Information strategy. • Develop e-health framework and guidelines. • Establishment of a central health information repository. • Development of standard operating procedures (SOP) for data management encompassing both public and private health sectors.
To strengthen Health Information and Surveillance systems	• Adaptation/development of ICT based tools for supporting the business processes of the Ministry of Health and Child Welfare. • Improvement of data collection tools. • Capacity building in health information management and utilization encompassing both public and private health sectors. • Strengthen disease surveillance system in both the public and private health sectors. • Strengthen health information system operations research strategy.
To increase the use of information in decision-making	• Promotion of health information utilisation at all levels.
To increase access to information that is ready to use	• Improved information access and dissemination.
To increase Human Resource capacity in Health information strengthening	• Strengthen HR base in line with HIS strategy.
To improve monitoring and evaluation of HIS	• Regular performance assessment of the HIS.

3.3.2 National Institute Of Health Research

The National Institute of Health Research, formerly Blair Research Institute, is a national centre for research, training and service in the fields of disease control, biomedicine and public health. The Institute comprises the former Blair Research Laboratory (established 1939) in Harare and the De Beers Research Laboratory (established 1965) in Chiredzi. Both units form the research arm of the Ministry of Health and Child Welfare.

The overall objective of the Institute is to carry out scientific research that promotes health development to improve the health of the people of Zimbabwe through effective disease control and solving problems associated with health care delivery.

The National Health Strategy for Zimbabwe 1997 to 2007 stipulated priority areas of health that required strategizing, including planning for disease management, control and prevention. It is the disease control and prevention area that much of the research conducted at the National Institute of Health Research focused on.

Selected key performance areas that posed major challenges and which the Institute's activities covered were:

1. Health Sector management and organization
The Institute, through its Health Systems Research Unit carried out a number of projects aimed at finding ways of improving the quality of Health Service Delivery.

2. High HIV prevalence and AIDS burden
A number of projects were carried out to find out more about the prevalence of HIV and AIDS disease burden and ways of reducing the impact of the disease on the Zimbabwean population.

3. Continued burden of preventable diseases

Malaria
During the past ten years various research projects were carried out on both the malaria parasite and the vector mosquito. The projects covered parasite diagnostics, drug resistance, immunology, malaria interactions with other parasites, mosquito behaviour, evaluation of new insecticides (both synthetic and herbal) and insecticide resistance.

Schistosomiasis
The studies conducted focused on finding alternative ways of reducing the disease burden of schistosomiasis. These included biological control of bilharzias using indigenous ducks, fish and plant molluscicides. Other studies looked at the interactions between schistosomiasis and other diseases such as HIV/AIDS and intestinal worms.

4. Water and Sanitation
The Institute embarked on a number of projects related to water and sanitation technology development, transfer and implementation.

Key issues
- Retention of highly skilled research scientists.
- Unavailability of equipment, chemicals and consumables.
- Reduced support from donors.
- Declining GOZ budgetary allocation (real terms).
- Repositioning of NIHR as a node of research excellence in the SADC region.
- Addressing areas of priority research for informed decision and policy formulation.
- Strengthening collaborative links with other local, regional and international research institutions.

Goal 25: To increase utilization health research findings for policy development	
Objectives	**Strategies**
To strengthen and market the National Institute of Health Research (NIHR)	• Strengthen the capacity and institutional framework of the National Institute of Health Research. • Review and create an enabling environment for implementation national health research. • Redesign the NIHR web page and continue to update it. • Design and produce pamphlets to market NIHR's research activities.
To strengthen health research capacity at all levels	• Identify areas of priority health research (including operational research). • Develop training modules. • Train various levels of health workers in health research.
To conduct Essential National Health Research	• Identify priority health research areas. • Develop proposals for approval and funding. • Implement the research projects.
To develop and transfer appropriate public health technologies to new resettlement areas	• Develop prototype models of appropriate technology. • Test performance of models and modify accordingly. • Develop appropriate public health technologies training modules. • Train communities on how to construct and use the technologies. • Roll out the technologies to new resettlement areas.
To promote use of evidence based decisions and policies in the development, facilitation and implementation of health programmes	• Present research reports to stakeholders including policy makers. • Develop policies and programmes based on evidence from research.
To strengthen, national, south-south and north-south research collaborations	• Write collaborative research proposals for research grants. • Run exchange programs that allow training of collaborative Institutions' staff and also technology transfer. • Strengthen collaborative network through e-groups and e-mail.

3.4 MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

3.4.1 Drugs And Medicines

Trends and current status

Availability of medicines is an important element in shaping perceptions of the quality of services among users of health services. The aim of all in the health sector should therefore be to ensure that all health institutions have an adequate and constant supply of safe and efficacious medicines, surgical sundries and other supplies such as diagnostic and laboratory reagents.

The national Government Medical Stores was commercialised to form the National Pharmaceutical Company of Zimbabwe (NatPharm), with the aim of improving efficiency in the supply of medicines and other medical supplies to public health institutions. The company, a non profit making organization, became operational in December 2001. NatPharm is the major supplier of pharmaceuticals and medical supplies to the nation through the public health system. The Essential Drugs List for Zimbabwe (EDLIZ) guides NatPharm's procurements.

The performance of NatPharm depends on adequate financial resources, especially foreign currency, for it to be able to provide an efficient service to public health institutions. The organization has not been able to obtain the foreign currency it requires to purchase those medicines that are not manufactured locally.

Medicines and other pharmaceutical supplies are sold to public health facilities on a cost recovery basis. NatPharm is the procurement agent for the health sector, with priority being given to public health institutions, who are expected to procure from NatPharm in the first instance. Only in cases where NatPharm does not have the items in stock

can public institutions approach private suppliers. The concept of setting up NatPharm was to ensure that the health sector benefits from the resulting economies of scale.

This should in turn translate into significant savings and mileage for the country's medicines budget. Such savings are however not being realized due to the very low stock levels at NatPharm emanating from foreign currency shortages. Institutions therefore continue ordering from the private sector at exorbitant prices. For example, a mini-survey of prices in the public and private sectors conducted in November 2007 indicated that one unit of 1000 aspirins was 56 times more expensive in the private sector as compared to NatPharm. The exorbitant prices in the private sector resulted from differentials rates in the purchase of foreign currency.

Foreign Currency allocations to NatPharm declined over the years making it difficult for the company to achieve 100% self reliance in the procurement of pharmaceuticals. The foreign currency shortages also negatively impacted on the local pharmaceutical industry, which has to procure raw materials from outside for manufacturing medicines and other medical supplies.

Currently, NatPharm requires approximately US$65m annually for the public sector. However, in the period 2004 to 2007, Natpharm only received 3% of this amount. This is far below the company's requirements and has crippled the company's operations over the years. As a result of the unavailability of foreign currency, stock holdings had drastically declined to 20% capacity by December 2007. Below is the Average Stock Availability from 2004 to 2008.

Table 6: Stock Status of VEN Items at NatPharm

	2004	2005	2006	2007	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08.	May 08	June 08	Sept 08	0ct 08	Nov 08
Vital	63%	72%	82%	42%	22%	29%	35%	32%	36%	38%	42%	52%	58%	42%
Essential	21%	56%	62%	23%	16%	16%	18%	16%	16%	28%	34%	34%	38%	40%
All drugs	41%	65%	68%	31%	18%	22%	22%	25%	26%	26%	35%	43%	45%	36%

Availability for the first half of 2008 shows a declining trend.The VEN stock classification system in the Essential Drug List of Zimbabwe of medicines and surgical sundries was made on the following criteria:
Vital items - life saving, non availability may result in serious disability or death, optimum availability to be 100%;
Essential items – non availability may result in pain or discomfort to the patient, optimum availability to be 80%;
Necessary items – required but of a lower priority than V and N, optimum availability to be 60%.

The stock outs of much-needed essential medicines, vaccines and medical supplies in the system have limited the population's access to wholesome services, because they cannot afford to purchase medicines from private sources. The Access to Health Care Services Study (2008) confirms the unavailability of medicines in the country. The study found out that most people get their medicines from health centres (72%) whilst 27% buy medicines from private pharmacies and one percent from private surgeries. The study however further noted that medicines are often not available (52%) at public institutions, where most communities should conveniently access them. If available, the medicines are for a fee in most instances. The fee at most public institutions is however often a fraction of the actual cost, although many clients stated that this was still unaffordable. The study noted that 50% of clients at times go home without prescribed medicines as they cannot afford to pay the cost price at health institutions.

It is worth noting that although the majority of clients in the study stated that patients should not pay for medicines, almost a third stated that medicines should be paid for, to enable health centres to replenish stocks. This attests to a paradigm shift from one that expects all health services to be provided for free by Government.

In the private sector, medicines and other medical supplies including gloves, cotton wool etc, are so expensive that they are generally unaffordable. More often than not, the medicines are also not available as this sector is also affected by foreign currency shortages. This has forced some patients to purchase medicines from across the borders or from unlicensed vendors, further exposing themselves to the possible dangers of sourcing medicines of unproven quality.

Support has been extended to NatPharm in the form of occasional capitalization grants. To improve medicines distribution, NatPharm purchased five delivery trucks to service all public health institutions. Furthermore, NatPharm has

computerized all its provincial branches and is now producing regular availability reports. Support has also been extended to local pharmaceutical medicines manufacturing companies that supply generic medicines. One such company is now producing ARVs.

Zimbabwe has received a lot of support from a number of partners in ensuring the availability of essential medicines, especially at the grassroots levels. Since 2002, The European Union (EU), has been providing one third of all medicines and surgical supply requirements for the public sector through NatPharm. Over the years, the proportion of EU supplies has been increasing in comparison to those directly purchased by NatPharm. The National AIDS Council (NAC), the Global Fund, USAID, DFID, ECHO, Irish Aid, Canadian International Development Agency (CIDA), UNICEF and other UN agencies, have also been providing medicines to the public sector.

At the beginning of 2009, resources for the procurement and distribution of 5,060 Primary Health Care Package (PHCP) were secured from the Joint Donor Support programme for a period of one year. With this support, drug availability at the primary care level has greatly improved. There is however a critical shortage of medicine at the referral facilities as the Primary Care Package of drugs does not cover specialists' drugs for provincial and central hospitals.

Rational use of medicines has been promoted through the establishment of medicines therapeutic committees, training and deployment of pharmacists and pharmaceutical technicians. The Essential Drugs List of Zimbabwe (EDLIZ) remains the standard for prescribing medicines, and has since been reviewed twice in the past 10 years to keep up with new developments and knowledge. This process is spearheaded by the National Drug and Therapeutics Policy Advisory Committee (NDTPAC). Rational prescribing of medicines is further strengthened by the development, distribution and use of treatment protocols. A number of pharmaceutical, medicines supervision and management programmes have been conducted as indicated above. NatPharm produces a monthly medicines status report. In turn, large institutions have also been producing quarterly medicines status reports.

During the last ten years, greater autonomy was given to the Medicines Control Authority of Zimbabwe (MCAZ), as a way of improving drug quality assurance systems, thereby guaranteeing that medicines reaching the consumers are safe, efficacious and of good quality. The MCAZ has ensured that all medicines used in both the public and private sectors are of good quality through registration of medicines and licensing of pharmaceutical premises. Together with the ministry, the Authority has being enforcing the National Drug Policy. The national drug policy is an essential instrument for regulating the importation, production, and distribution of essential and other medicines.

Management of pharmaceuticals at institutions has also been of great concern. Experienced pharmacists have left the country for greener pastures and this skills flight has not spared the Ministry. There is a very high attrition rate of pharmacy personal, making it difficult to efficiently manage the supply chain for medicines and other medical supplies. For instance, trained pharmaceutical staff were available in only 5% of all health facilities according to the Vital Medicines and Health Service survey of 2009. Recurrent stock outs and lack of management capacity has made it difficult to determine the consumption rates, hence poor quantification of national requirements. A study carried out in 2006 noted that those districts with pharmacy personnel had a more consistent supply of pharmaceuticals than those without. This is believed to be due to better management of the available supplies.

Unavailability of medicines remains a major challenge. The challenge has become so severe that life-saving procedures are being postponed due to the shortage of vital medicines. Furthermore, the allocated resources were being affected by the hyperinflationary environment. A more recent and worrying development is the pilfering of medicines and purchase of unregistered drugs from unapproved vendors. Major challenges are therefore being faced.

Key issues

- Inadequate funding and poor performance of the Public Finance Management System.
- Failure to arrest the high attrition of pharmacists and pharmacy technicians.
- Failure to improve the security of supplies at distribution and storage at Institutions.
- Weak monitoring and evaluation systems.
- Weak supply chain management of medicines and surgical sundries.
- Failure to adequately recapitalize NatPharm.
- Failure to increase capacity for local production.
- Failure to assure quality of donated medicines before shipment.

Goal 26: To improve overall availability of drugs, medical supplies and other consumables to 90%	
Objectives	**Activity/Strategies**
To increase medicines availability in all health institutions to 100% for V, 80% for E and 75% for N	• Strengthen management and capacity of the Department of Pharmacy. • Review and update policies (EDLIZ, Drug Donation). • Provide adequate resources to purchase medicines and supplies as per standard for each level of care. • Continue Drug Monitoring and surveillance. • Continuous training in rational drug use and management of the supply chain of medicines and other related supplies. • Continue actively supporting NatPharm. • Promote and support local manufacture of pharmaceuticals and other medical supplies. • Lobby Ministry of Finance for increased budget allocation for medicines. • Encourage communities to set up security teams at district health centres. • Develop and expand the Medicines Information Systems and integration with NHIS. • Strengthen rational drug use at all levels. • Ensure availability of category C medicines to support PHC. • Improve and strengthen the disposal of expired medicines.
To ensure 100% of all medicines entering the health sector are safe, efficacious and of good quality	• Monitor adherence to pharmaceutical policies for all medicines. • Strengthen Medicines Control Authority of Zimbabwe.

3.4.2 Medical Equipment

Trends and current status

Medical equipment for diagnosis, treatment and monitoring of patients is essential and is required in all hospitals. This includes equipment for laboratories, research activities, and fixed plant such as boilers and autoclaves. Currently available equipment is old, obsolete and non-functional. Lack of regular of maintenance and replacement of medical equipment is compromising client care and leading to demotivation of staff and deficiencies in the basic training of health workers.

Policy has been to include procurement, installation and commissioning of medical equipment in one package for all new health facilities. All the Family Health Project built hospitals and clinics came with equipment and other medical supplies. The Family Health Project built hospitals were equipped based on a standard list of equipment depending on the level of care. There has therefore been a Rural Health Centre and district hospital standard list of equipment derived from the Family Health Project rooming and equipping lists. With the many manufacturers and suppliers of medical equipment, it is now necessary to revisit and update the standard list (with specifications) of equipment for each level of care.

The last bulk purchase of medical equipment for public health facilities was in 1997; this saw a number of institutions benefiting from diagnostic medical equipment. There has been no further bulk purchasing of medical equipment to replace the obsolete equipment in health facilities due to lack of financial resources. In a bid to resuscitate the available equipment, an audit of the state of equipment requiring spares was carried out in 2005 and this was followed by the purchase of the identified spare parts. However, the audit noted that the ministry was using and repairing equipment that was no longer supported by any manufacturer. The Ministry has thus not kept a data bank on the life of available medical equipment and is also not up to date with new medical technologies.

Some institutions have however managed to purchase or receive donations from different sources. A large consignment of emergency obstetric care equipment was received from

UNFPA in 2007. Laboratory items have been received under the Global Fund and CDC. In 2007, state of the art medical diagnostic ultrasound equipment was bought for each central and provincial hospital. These supplemented other existing high tech equipment in the form of Magnetic Resonance Imaging (MRI), Computed Tomography, Digital Subtraction Imaging machines, although these have been in service for some time. However, lack of foreign currency for spare parts and equipment replacement has seen some of these expensive technologies lying idle, or hospitals continuing to use obsolete equipment, some of which might not be safe for patients.

Equipment repairs have been carried out both internally and externally using the maintenance budget line item. The Ministry trained, equipped and deployed a number of equipment technicians to support provincial and central hospital purpose-built equipment workshops. However most, if not all, of the 41 Equipment Technicians trained both in and outside the country have left the service. The equipment technician training programme was discontinued some years ago. Whilst institutions have a maintenance budget line item, this has not been very useful in that the private companies contracted to repair equipment also required foreign currency to purchase spare parts. Foreign currency was not being availed regularly through the formal channels.

Efforts have been made to share the high tech equipment in the private and public sector including scanning machines. However, the diagnostic equipment testing charges are beyond the reach of the majority of the population.

The contracting out of services has received mixed reactions for various reasons. In some situations, companies contracted out to provide services to public institutions have done an excellent job whilst others have provided shoddy services. This is also due to poor contract management practices. There are new efforts promoting private-public partnership in the area of hospital diagnostic equipment

A number of studies and supervisory visits have been commissioned and conducted to check the status of medical equipment in public health institutions. The findings of the National Medical Equipment inventory of 1999 were confirmed by the Maternal and Neonatal Health Services study of 2004 and TMT provincial visits in 2007. An assessment of eight hospitals carried out in 2003/2004 as part of an "Assessment of Quality of Care" study revealed that seven of the eight hospitals did not have 40% of essential equipment. The 2004 Maternal and Neonatal Health Services study noted that institutions did not have basic equipment, including basic operating theatre equipment.

The 2008 and 2009 provincial visits by the Top Management Team (TMT), the Minister of Health and Child Welfare and the Office of the Deputy Prime Minister noted the shortage of functional basic theatre equipment in all provincial and district hospitals. It was noted that besides x-ray machines, laundry machines, kitchen equipment and boilers, some essential pieces of laboratory equipment were non-functional.

The Access to Health Care Services Study (2008), confirmed the status of equipment described above and describes the equipment at most health institutions surveyed as "dismal". Key informants in the study "complained of lack of basics like working blood pressure machines, thermometers, x-ray machines, autoclaves, incinerators, laundry machines, etc. Many of these had broken down and become unserviceable. However, they had not been repaired or replaced for years on end. It is next to impossible to provide health services of an acceptable and effective standard under these conditions."

The Ministry of Health and Child Welfare Equipment Department has also been inadequately staffed for it to manage both the coordination of purchase and repair of medical equipment in hospitals. At national level, the administration and oversight of medical equipment management has left a lot to be desired. As indicated above, the existing network of provincial and central hospital medical equipment workshops is mostly without technicians and spare parts to effect regular maintenance of equipment.

A number of challenges are being faced in the area of technology and equipment. The most serious challenge is the cancellation of clinical procedures, resulting in referral of patients outside Zimbabwe for procedures that could easily be done locally, if only the required piece of equipment was available or functional. In Maternal Health, the third obstetric delay was mainly due to lack of drugs and medical equipment.

More recently, energy and water supplies have become a major challenge. Institutions have in the past reported that some procedures, such as surgical operations, are done using a torch or candle light at night, a situation that was confirmed by the Access to Health Care Services

study. Some generators need to be repaired and new ones bought for those institutions without. There is also need to rehabilitate boreholes in a number of the institutions, as erratic water supplies are a major concern at health facilities.

Noting that most of the diagnostic and clinical monitoring medical equipment is old and some obsolete, the Ministry developed a comprehensive list of equipment required by hospitals. This list now needs updating as more and more equipment is reaching the end of its usefulness or new and better technology is now available. Again, due to unavailability of financial resources, the Ministry has not been able to start procuring and replacing the obsolete equipment. In the meantime, the Ministry has developed a health technology policy, which will facilitate equipment management and purchase of appropriate medical equipment when funds allow.

Key issues

- Lack of technical capacity in bio-medical equipment management.
- Lack of basic medical equipment for service delivery.
- Poor procurement systems.
- Lack of planned preventive maintenance, including poor contract management.
- Shortage of equipment technicians and no training programme in place.
- Updating standard list of equipment for each level of care.
- Lack of a health technology policy.

Goal 27: To increase availability of functional equipment to ensure the delivery of effective curative and preventive services.	
Objectives	**Strategies**
To increase availability of functional medical equipment and technology for diagnosis, treatment and patient monitoring appropriate for each level of care	• Updated standard list of equipment and technology for each level of care. • Each institution has an inventory for medical equipment. • Short and long term equipment replacement strategy developed. • Phased purchasing of equipment and technology. • Private - public partnership strategy in medical equipment technology developed.
To implement a preventive maintenance programme	• Equipment workshops resuscitated. • Phased rehabilitation and refurbishment of equipment. • Increase compliance with equipment maintenance services schedules.
Build capacity both in the public and private sector	• Medical equipment technician training programme resuscitated.

3.4.3 Traditional Medicine

Trend and current status

In some developed and developing countries, Traditional Medicine (TM) has been integrated into the public health delivery system at various levels and is receiving official attention and funding, with clear legislative and operational frameworks that ensure that TM is accessible and available to those who need the service. In Africa, some Research Units in TM have been developed. In Zimbabwe, several institutions and individuals are carrying out research on TM ranging from laboratory studies to clinical evaluations but this is individually driven, uncoordinated and lacks a national agenda.

Many Zimbabweans consult traditional health practitioners (THP) at some point in their lives, indicating that traditional health practice is an important component of Zimbabwe's health care delivery system at both the individual and community level. Progress towards promoting traditional medicine (TM) with regards to formulation, rational use, safety, efficacy and quality and improving access has been made. The Traditional Medical Practitioners Act of 1981 is the legal framework for the coordination and regulation of TM. The Traditional Medical Practitioners Council (TMPC) oversees all matters related to Traditional Medicine.

The government subscribes to the various World Health Assembly (WHA) resolutions including WHA Resolution 56.31and the SADC resolutions on Traditional Medicine. Government has taken some steps to implement some of these resolutions. At the regional level, Zimbabwe is the convener of the Traditional Medicines Coordinating Committee of the SADC.

Despite the early official recognition, Zimbabwe now lags behind, partly because of the limited functionality of the National Directorate of Traditional Medicine to develop, promote and coordinate the TM programme.

Key issues

- The need to adapt, adopt and implement, where appropriate, WHO's traditional medicine strategy as the basis for national traditional medicine programmes or workplans.
- Formulation and implementation of national policies and regulations.
- Limited recognition of the role of traditional medicine as an important component of primary health care.
- Non availability of drug safety monitoring systems for herbal medicines.
- Paucity of research on traditional remedies.
- Lack of protection of intellectual property rights in Traditional medicine.
- Limited documentation of traditional medicine and practice.
- Lack of National standards for safety, efficacy and quality of herbal medicines.
- Lack of role clarity between council, the professionals and the TM department.

Goal 28: To increase access to and rational use of safe, efficacious and quality traditional medicines	
Objectives	**Activity/Strategies**
To implement the Traditional Medicine Policy and code of ethics in Zimbabwe	• Develop and implement a traditional medicine strategy. • Lobby government and communities on specific TM policy issues including inclusion of TM into education curriculum.
To promote the proper use of safe, efficacious and quality Traditional Medicines	• Establish appropriate supportive mechanisms for research, manufacture, processing, distribution, sale, import, export and use of traditional medicines. • Establish safety standards which assure patient's right to safe medical treatment. • Promote the use of safe and effective traditional medical treatment through information, education and communication to health practitioners, the public and consumers.
To educate and train Traditional Health Practitioners (THPs) and Allopathic Health Practitioner (AHPs)	• Increase the knowledge of Traditional Health Practitioners in primary health care. • Increases awareness and knowledge of allopathic health practitioners (AHP) in the role of traditional medicine in the health system. • Develop and disseminate information, education and communication on the role of traditional medicine.
To strengthen the Protection of Intellectual Property Rights (IPR) of Traditional Medicine and Indigenous Knowledge	• Develop an appropriate legal framework for protection of traditional health practitioners, traditional health knowledge, traditional medicines and practices. • Increase awareness on Intellectual Property Rights (IPR) system and legal framework. • Participate in regional and international agreements regulating access to medicinal plant resources for pharmaceutical research.
To contribute to production and conservation of medicinal plants	• Participate in ITC on Biodiversity. • Collaborate with relevant institutions on education and training of THP and consumers on conservation. • Collaborate in developing guidelines on GAP, GMP, GPP, GLP and GCP.
To strengthen the institutional framework for traditional medicine	• Strengthen and capacitate the traditional medicine department. • Review existing legislation to create an enabling environment for implementation of traditional medicine activities. • Strengthen the capacity for research and development including local production of traditional medicines. • Strengthen the capacity of the ministry to coordinate the various aspects of traditional medicine such as, practice control, research and information, regulation of medicines, local production and distribution. • Lobby for increased allocation of resources for the promotion of traditional medicine. • Establish partnerships and networks with relevant regional and international organizations.

3.5 HEALTH FINANCING

Trends and current status

The main objectives of the Health Sector are to ensure the prevention of disease among the population, as well as the provision of care and treatment services to the sick. Adequate financial resources and the existence of efficient and effective financial management systems are imperative if health sector objectives are to be realized.

The National Health Strategy (1997 – 2007), set the agenda for launching the health sector into the new millennium. Recognizing that improvement in the health status of the population will not depend on sectoral actions alone, it sought to pull together all national efforts which had potential to enhance health development into a promising new era.

Whilst the situation analysis carried out then showed a worrying decline in health status indicators, the optimism associated with the dawn of the new era provided hope and conviction for improvement. Similarly, the identified weaknesses in the performance of the health system were thought to be temporary, in the hope that the holding capacity of the economy, to support a robust health system, would improve.

On the contrary: the challenges facing the health sector continued and even got worse. During second half of the implementation period of the National Health Strategy (1997 – 2007), Zimbabwe experienced severe and escalating economic challenges which peaked in the year 2008. The economic downturn meant less revenue generation, thereby decreasing funding for all Government activities.

During the period of a functional economy, the Government of Zimbabwe has always given priority to the social sector. Though the budget allocation to the health sector has been below the levels required to for the delivery of quality health services, health has maintained its ranking in the top five ministries in allocation of Government funding.

Health care services have been financed from several sources including government allocations, private voluntary organisations, medical aid /health insurance schemes, direct out of pocket payments and development assistance from both bilateral and multi lateral partners. Government has remained the major source of health financing in the public sector with taxation being the major source of revenue. The 2001 National Health Accounts estimated government's contribution to total healthcare expenditure to be 39%, while the contribution by households was 29% against 10.8% by employers.

The Private Sector has continued to contribute to the mobilisation of resources for the Health Sector through one-off donations and adoption of wards at health institutions. Tax relief measures have been implemented to provide incentives for corporate and individuals to contribute to the funding of Health Sector inputs. However, less and less assistance has been coming from this source as the private sector was equally affected by the economic decline.

The declining performance of the economy has meant less funding for the health sector. The situation has been further exacerbated by the fact that direct development assistance, which used to augment expenditure on health services by availing the much needed foreign currency, has declined from US$71 million in 1997 to US$7 million in 2002. While donor financing was 13% of the total national health expenditure in 1999, by 2002 it had gone down to only 1%, a trend which reflects the almost total absence of bilateral assistance in terms of direct budget support. The picture has however changed in the recent past.

Over the last twelve months, Government has not been able to raise enough revenue to support the health sector meet its mandate. Most private voluntary employer based medical schemes/health insurance were not functional during the recent economic environment. In essence, health services in Zimbabwe over the past 12 months have been running on material provisions from the donor community.

To achieve the MDGs Zimbabwe should be spending at least US$34 per capita per annum on health. This is the minimum required to provide an essential package of health services. The 2009 revised budgetary allocation works out to about US$7 per capita per annum on health, leaving a deficit of about US$27 per capita per annum. By the third quarter of 2009, the Ministry of Health and Child Welfare had received 10 percent of the 2009 allocation

While there has been a serious decline in the level of direct bilateral funding coming to Zimbabwe as mentioned above, the country has continued to receive support from UN Agencies such as the World Health Organisation (WHO), UNICEF, UNFPA, as well as the European Union (EU) and the Global Fund for HIV and AIDS, TB and

Malaria. Bilateral donors have also continued to make substantial funding contributions channeled through implementing partners and other pooled funding mechanisms.

Concerted efforts will need to be made to offset the decline in revenue flows to the Health Sector by improving the efficiency of existing expenditures, as well as to ensure that there is greater allocative efficiency (see below).

Financial Management
A number of instruments have been introduced in recent years to strengthen financial management capacity in the Public Sector, including the Public Finance Management System (PFMS), which was introduced in the Ministry of Health and Child Welfare in 2004. This system is still experiencing implementation challenges. The introduction and implementation of the Results Based Management (RBM) concept in 2005 has also had an added impact in terms of enabling managers at all levels to link finances to service level activity. Attention has also been given to the improvement of financial management skills for health managers.

National Surveys were conducted in 1999 and 2001 as part of the National Health Accounts initiative. The process documented the flow of resources from Financing Agencies to providers of Health Care Services, and health expenditures from all sources were documented and tracked to their ultimate use. Results of these studies have been used to inform policy, budgeting and the allocation processes in the public health sector.

Allocative Efficiency
There is still considerable concern that despite the government's commitment to Primary health care, a disproportionate amount of public spending continues to go to tertiary (curative services) and higher levels of care. It is believed that this benefits a minority of the population (urban and better off) and provides less cost effective treatment in terms of health gain per dollar spent. This argument is based on the figures that appear in the "Blue Book" (national annual budget) where the medical care services sub-vote, which funds institutional based activities, gets much more than the preventive services Sub-vote III, which caters more for community and preventive health services.

While the need to redirect resources from hospital based curative services to disease prevention and health promotion activities is generally acknowledged, efforts to achieve this have met with limited success, largely due to diminishing financial resources in real terms as well as the failure to extensively and exhaustively identify and quantify prevention and promotion activities that are undertaken in the hospital setting. Until the latter is undertaken, the size of the problem will remain unknown, while movement of resources in the absence of additional funding in real terms can only take place at the risk of affecting the viability of some of these institutions.
An analysis will therefore need to be undertaken to identify and quantify the proportion of funding that is used for preventive services such as immunization, screening, health education and promotion, counselling etc, which are provided and funded through institutional budgets.

Resource Allocation
In an effort to achieve a more equitable distribution of budgetary allocations, several Resource Allocation Formulae have been developed, piloted and availed for wider use. There is some doubt however as to whether there has been consistent and persistent use of the different formula and, where this has happened, final allocations have still needed to be moderated. Special care will therefore need to be taken to ensure that in seeking to achieve the ideal, the Ministry does not exacerbate existing inequities.

User Fees
It has always been acknowledged that existing resources on their own would never be enough to meet the requirements of the health care system, especially in the light of an increasing disease burden. Measures have therefore been taken to improve the efficiency of collection procedures, as well as to mobilize additional resources. The Health Service Fund was established in 1996 to create an incentive for improved billing and collection. Retention of fees at the local level, as well as the flexibility that this provides in terms of responding to emergencies and other exigencies, has gone some way towards making the various levels of care more responsive.

At its inception, various partners contributed to the Health Service Fund. While the extent to which this is happening has diminished in recent years, the Ministry of Finance has continued to make allocations to the Fund in the form of what one could call an "equalisation grant", for use in those districts whose capacity to generate revenue may not be as high as other districts. However, the current economic environment has continued to render this allocation valueless. At its inception it was agreed that at least 40% of the revenues generated by the Health Service Fund would be used for promotion and prevention activities in the district.

One of the reasons often cited for the existence of a huge financing gap is the provision of what, to all intents and purposes, is an unlimited package of free services, while the financing base has continued to shrink to levels where it is impossible to sustain this seemingly noble objective. It is therefore felt that the time may have come for government to review the effectiveness of this policy. The Assessment of Primary Health Care Study in Zimbabwe (2009) is proposing that a package of essential services and resources be defined and costed at primary level and that priority be given to ensuring that this basic level of provision is funded and universally delivered by all providers of primary care clinics (central, local government, mission and other private).

The Access to Health Care Services Study (2008) provides some insight into the user fee subject. The study found that the majority of communities in the study (59%) paid to access health care services especially in the urban areas, commercial farming areas and mines. In rural areas, people are paying user fees at the district hospital level and also in most rural health centres/clinics. The study also found that most people (66%) could afford to pay the fees charged, while the other 36% could not. However, only 38% of the respondents felt that they should pay user fees, whilst 62% did not believe that they should pay to access health services. Key informants in the study perceived the consultation and user fees as being affordable and strongly believe that patients should pay to access health care services to enable the institutions to replenish stocks and maintain health facilities and equipment. They also argued that since the government could no longer afford to adequately finance health services, users should pay; otherwise the whole system would collapse leaving the users worse off.

This argument is now being used by health authorities who are now charging for services that would normally be free (Government policy provides for free health services for the under five years, pregnant women, the above 65 years of age and a few selected special conditions). The impact of re-introducing user fees in some of these areas has affected the utilization of health services. In the Maternal and Perinatal Mortality Study (2007) user fees were the commonly mentioned reason for lack of access. The study noted that user fees had adverse effects on maternal health in Zimbabwe as it is responsible for decreased use of health services by women at risk. The study recommends an urgent review of the user fee policy in order to remove it as a barrier to access for pregnant women. Both the Access to Health Care Services Study (2008) and the Assessment of Primary Health Care Study in Zimbabwe (2009) recommend abolition of user fees at the primary level.

The Access to Health Care Services Study (2008) corroborates the findings of operational research studies undertaken in the Ministry, which concluded that some communities are indeed willing to pay for services provided the revenues generated are used to improve the quality of services offered at their institutions. This is clearly an area in which further work will need to be undertaken to inform the policy review processes.

While in theory it has always been acknowledged that those who can afford to pay should pay for health care services, implementation of this policy has been difficult. The low tariffs that are applied in revenue collection in the Ministry of Health and Child Welfare institutions, as well as difficulties in implementing an efficient "exemption system" have also created a disincentive. The National Social Security Authority (NSSA) has completed the development of a Social Health Insurance Scheme, which is now ready for implementation. Once operationalised, the scheme will combine fee for service and community initiatives (e.g. payment in kind), as well as regular and timeous review of tariffs, and should go some way towards contributing to the mobilisation of additional resources for the health sector. These initiatives will need to be accompanied by improvements in the quality of the service, as well as the actual care offered at institution level. Research has shown that patients are generally not averse to paying for health care, as long as the quality of such service is commensurate with the fees being charged.

Key issues

- Equitable distribution of resources.
- Strengthening Financial Management Systems.
- Costing the core package of health services.
- Inadequate financial resources for the health sector.
- Inefficient use of existing resources.
- Existence of financial barriers to access to health and Safety nets.

Goal 29: To increase the levels of sustainable and predictable financial resource base to ensure provision of high quality services to the population	
Objectives	**Strategies**
To strengthen the Financial Management system at all levels	• Improve the implementation of the Public Finance Management System (PFMS) at all levels of care. • Strengthen financial management and accounting skills for health workers at all levels of care. • Monitor and evaluate resource utilization.
To improve use of existing resources	• Institutionalize implementation of the Results Based Management (RBM) Concept. • Undertake regular National Health Accounts (NHA) audits and disseminate results widely. • Conduct Research to identify and quantify all preventive and promotion activities that take place within hospitals institutions. • Ensure adherence to referral chain through the use of a mandatory by-pass fee. • Review, redefine and cost packages of core health services for each level of care and prioritize allocation of resources accordingly. • Define and publish a health service package that will be provided for free including the clearly defining the beneficiaries. • Revisit policy on outsourcing non-core services e.g. security, cleaning and ground maintenance at provincial level. • Reduce leakages of hospital supplies. • Monitor the operation of funding agencies to ensure that the interests of providers and subscribers are protected. • Commission a study to map out partner areas of work. • Ensure that infrastructure Development and technology Acquisition is consistent with the country's economic capacity. • Strengthen institutional capacity to coordinate Donor Inputs.
To mobilize resources for the health sector including to a sustainable financial resource base of at least US$34 per capita	• Develop a national health care financing policy and strategy. • Explore and establish community health financing mechanism. • Redefine cost and guarantee every Zimbabwean an essential package of health services. • Review user fees with the view to abolish them at relevant levels. • Review and update policy of central government funding for local government and other public health providers. • Lobby for the early introduction of an effective Social Health Insurance scheme. • Improve the effectiveness of existing social safety nets. • Conduct further research into practical exemption criteria. • Lobby for increased external technical and financial assistance to plug the financing gap. • Lobby for the attainment of the Abuja Declaration target of 15%of the National Budget. • Lobby for an increase in health expenditure to at least US $34 per capita to ensure the provision of high quality services to the population. • Explore the possibility of increasing private sector contribution to the provision of health sector funding including the use of legislation and tax relief measures. • Ensure that there is universal billing at all hospitals.

3.6 LEADERSHIP AND GOVERNANCE

3.6.1 Governance and Management of the Health Sector

Trends and current status
Governance in our situation is concerned with issue of organizational structures, management structures, policy and regulatory frameworks, coordination and partnerships with stakeholders, information for decision making and fair resource allocation.

The Zimbabwe health sector is comprised of public and private components, including traditional medicine practices.

The public sector provides health services through facilities under the Ministry of Health and Child Welfare, Ministry of Local Government, Ministry of Education, Ministry of Defence, Ministry of Home Affairs and the Prison Service.

The categories of local authorities include Rural District Councils (RDCs) and Urban Local Authorities. The Private Medical sector includes the Private for Profit Medical Sector (Private Industrial Clinics, Private Hospitals, Maternity Homes and General Practitioners), Traditional Health Practitioners and Complementary Health Practitioners.

The Not-for Profit Private Sector providers include church related and other NGOs. The Zimbabwe Association of Church Related Hospitals (ZACH) represents church related hospitals.

The Code of Professional practice for all health practitioners in Zimbabwe is regulated by the Health Professions Act Chapter 27:19 (2000) whilst that of traditional healers is regulated through the Traditional Practitioners Act (1981), providing a framework for practice and regulation of its members.

The Health Service Act provides for the establishment and the operations of both public and private hospitals and Medical Aid Societies. Minimum standards of practice for both hospitals and medical aid societies are also provided for in the Act. The Health Service Act provides for the establishment of the Health Service Board, Community Health Councils and Hospital Management Boards at Central and Provincial Hospitals.

The Ministry of Health and Child Welfare operates within the functions mandated to the office of the Minister of Health and Child Welfare (Restricted: Hand-book on the Functions of the Minister of Health and Child Welfare, March 1993) as well as the provisions of the Public Health Act (Chapter 15:09) and the Health Service Act amongst others.

National Health Policy Implementation Framework
The health sector activities have been guided by two policy documents, Planning for Equity in Health of the early 1980s and the National Health Strategy, "Working for Quality and Equity in Health" (1997-2007).

The National (Central) Level
The Zimbabwe health care system consists of four graded levels of health care, each engaging in an appropriate mix of promotive, preventive and curative activities, with the higher levels providing support, supervision and referral facilities for the levels below. Each of these levels has a link with corresponding structures in the socio-political system, to ensure political and community inputs and intersectoral collaboration with health related agencies.

Health is part of development and as such it is a dynamic process. Accordingly, the functions and structure of the Ministry of Health and Child Welfare continuously change to meet the ever-changing demands and challenges. The Ministry of Health and Child Welfare has been restructured twice in the last ten years with the aim of not only accommodating new programmes but as part of continued improvement in efficiency.

The Ministry of Health and Child Welfare's headquarters role is regulatory, policy setting and provision of a legally enabling environment for the operations of the various health service providers and funders.

A number of institutional arrangements in the form of Minister's policy making meetings, Permanent Secretary weekly meetings, the Planning Pool and the Top Management Meetings are in place to guide the operations of the Ministry of Health and Child Welfare. A further development in the health sector has been the establishment of the Health Service Board which is mandated to deal mainly with issues pertaining to the conditions of service for members of the public health sector.

Provincial level
The Provincial Medical Directorate (PMD) is a functional extension of the national level. The Provincial Medical Directors have the responsibility to co-ordinate the planning and management of the health delivery system in the provinces. The PMD also ensures that government policy is adhered to and that national policies and goals are being implemented. Community and other sectors' health inputs are captured through the Provincial Development Committees.

District level
The District Health System is the operational level of the health delivery system. Its goal is to provide a comprehensive range of promotive, preventive, curative, rehabilitative and palliative health services, to all the sectors of the community, in line with national and provincial policies and guidelines. Community and other sectors' health inputs are captured through the District Development Committees.

Primary level
The Primary Health Level provides the first point of contact between the community, village health workers and the formal health delivery system. The level comprises of a network of clinics and rural health centres, which provide comprehensive promotive, preventive, curative and rehabilitative services.

The 1997-2007 strategy identified opportunities for strengthening the functioning of the health system through the implementation of a cocktail of health sector reforms including issues such as decentralization, Public and Private Sector Collaboration, strengthening management and organisational development etc. Although most planned activities were carried out in these areas, no further attempt was made to institutionalise them.

Zimbabwe, as other developing countries, has a national health system which is based on three essential pillars.

1. Priority in health care is based on the development of comprehensive and integrated preventive and curative primary level services, starting with the provision of services to those in greatest need; primary health care services which are supported by increasingly specialized higher levels of care, in a coherent national health system. (Primary Health Care Strategy)
2. Communities participating actively in the planning and organization of primary care services.
3. Actions being taken in economic and social sectors that address the non-health determinants of health development.

The biggest challenge is overcoming the perception that ascribes failures in the health system to internal defects of policy, whilst disregarding the external environment with which the health system has contended within the last ten years. In Zimbabwe, real decreases in public health expenditure have resulted in deteriorated health facilities, drug shortages and a drastic decline in the quality of public health services from which it is yet to recover. There is greater awareness now than ten years ago of the need to improve the responsiveness of the health system. Therefore, to ascribe failures in the health system to a weakness of regard for demand when in fact the political economy has starved it of resource supply, is to blame the victim.

Over the past decade, structures and managerial processes driving service development have moved far ahead of the national political and administrative processes and structures. From a health sector point of view, this progress has been most welcome, in that most decisions which local managers should make have been decentralized to the service delivery level. However, bottlenecks still exist, particularly in those areas where local health managers need their counterparts in other sectors to make decisions which affect service development and provision. This continues to be a source of frustration as more often than not, it delays progress. This progress has however had its own internal challenges. The local managers, responsible for making the decisions at each level, are no longer there due to the high attrition rate of the experienced professionals across all disciplines. In December 2007, over 80% of management posts in the Ministry of Health and Child Welfare were vacant (pg 97).

A management culture that did not focus strongly enough on clear objectives, performance and accountability was identified as one of the indicators of poor managerial performance in the health system in the 1997-2007 National Health Strategy. Ten years down the line, cries of the need for better communication and support continue to resonate throughout the health system. This is a clear testimony that the national objectives being pursued by, and the performance expected from, the operational level are not being clearly communicated. New approaches need to be developed in the future, perhaps with the full participation of the workforce. The introduction of the Results Based Management Systems by Government is one such avenue of addressing this deficiency.

The Results Based Management System requires that objectives be worked out after carefully identifying client's needs and/or problems, and the extent and/or seriousness of the problems/needs. Client needs are best addressed by involving them in the planning and management of health services. The existing institutions, such as the Health Centre Committees, Community Health Councils, and the Public Health Advisory Board, can go a long way in meeting this requirement; they are however not fully functional.

The issue of centralized planning and decision making resulting in the inefficient deployment and use of resources has been dealt with through the on-going empowerment and decentralization process. The challenge that still exists is whether local managers have the technical and managerial capacity for running decentralized health systems. The flight of experienced managers soon after the process of implementing the 1997 – 2007 health strategy began, coupled with increased attrition, has not helped the situation. In addition, the management development programmes running then were suspended in 2001 due to funding constraints.

The 1997 -2007 Strategy note the absence of customer focus as a challenge. Whilst tools such as the patients charter were developed and training on their use delivered, not much progress has been observed. However, what is often ignored is that health workers are people first, and as such, the environment they work in influences their relationship with patients. Their work environment does not induce good relations, particularly the sporadic stock outs of essential inputs and poor maintenance of infrastructure. It is next to impossible to provide health services of an acceptable and effective standard under these conditions. With the above situation, morale, motivation and performance of health workers are low and attitudes to patients poor.

The 1997 – 2007 Strategy did not say much about internal audit. Ministry of Health and Child Welfare has over the past five years shown more interest on this subject. Internal Audit function plays a key role in assessing and reporting on an organization's governance, risk and compliance. The Ministry of Health and Child Welfare (MOHCW) has since 2002 given Internal Audit a high priority by creating a deliberate policy of supporting its activities geared towards the objectives of risk management. The Ministry is currently introducing risk management in all departments.

Key issues

- Developing a management culture that focuses strongly on objectives and accountability.
- Decentralization of decision making authority to service delivery levels.
- Development of accepted performance indicators and criteria for performance audit, to achieve improved levels of accountability by managers for their performance.
- Management and organizational development, including training.
- Supporting the operational levels to develop and maintain systems, methods and procedures, which allow health services to respond to local needs.
- Recognizing that systems, methods and procedures, work best with competent staff, hence the need to integrate training and development into wider human resource and organizational objectives.
- Strengthening the audit functions of the Ministry.

Goal 30: To improve governance and management of the health sector.	
Objectives	**Activity/Strategies**
To strengthen management and leadership at all levels of the health sector	• Strengthen Ministry's capacity to formulate, develop and implement policies. • Continuously review and update the skills of managers at all levels. • Resuscitate the management development and leadership training programmes. • Strengthen and improve audit skills. • Develop and introduce the concept of health risk assessment and management into the health sector. • Develop mechanisms for enforcing and improving compliance with existing legislation. • Build partnership between political leaders and providers. • Mobilize political and religious leaders for health.
To strengthen the decentralization of health service management to local levels	• Adapt and implement the provisions of the Ouagadougou declaration. • Consolidate and strengthen the decentralization process in the health sector. • Facilitate community participation in health matters through hospital and community management boards. • Strengthen self-managing units at district, provincial and central levels. • Build capacity to manage the decentralized health system. • Strengthen community participation and involvement in health service planning and management.
To strengthen the role of regulatory bodies and agencies	• Review and where necessary amend the role of existing regulatory bodies. • Create an enabling environment for regulatory authorities.
To provide clear strategic direction for health development	• Improve and strengthen planning, implementation and monitoring function at all levels of care. • Institutionalize the principle of "three ones" (one plan, one coordinating board and one monitoring mechanism).
To clearly define the appropriate regulatory framework to ensure the various stakeholders fulfill their responsibilities in health	• Review and update health legislation to ensure that legislative gaps are filled on areas that need improvement. • Strengthen capacity in health legislation and regulation. • Develop strong health advocacy skills within the MoHCW.
To coordinate activities among the different units within the Ministry of Health and Child Welfare	• Review and redefine the roles, functions, lines of accountability and decision making at each level of the health system. • Redefine the work of the different units and departments. • Strengthen the role of the planning pool. • Review and strengthen internal and external communication with stakeholders.
To establish functional mechanism to ensure transparency and accountability in the health sector	• Undertake and publish annual audits in the health sector. • Develop mechanisms and processes that allow citizens to participate and influence health policies and decisions and also monitor health providers. • Establish mechanisms to improve public accountability.

3.6.2 Policy Development And Legislation Related To Health

Trends and current status

The policy framework of any sector is intended to set the development agenda, by translating the priorities of the body politic into comprehensive policy objectives and actions to carry the objectives through. The implementation of the actions so identified is influenced by the dynamics of the external environment, at times given to unexpected shocks and change. This, in itself, creates problems, even conflict, in selecting and maintaining priorities.

Experience in the last ten years has shown beyond doubt that setting priorities does not lend itself to a quick technical fix. It is in fact a complex process, essentially political and ethical in character, involving the interplay of a number of considerations among which are notably those of equity and efficiency. These are not always compatible.

The current situation, where gross inequalities in health persist, has ensured that equity has remained a dominant factor in health investment. However, experience has also shown the complexity of a process that seeks to balance various conflicting claims for priority status. This suggests the need for a fresh approach that abandons the quest for a simple set of rules and figures, but instead emphasises the importance of the decision making process itself. In this regard, priority setting decisions, whatever they may be in a particular context, must be transparent and based on fair, reasoned and defensible grounds, which must be accessible to the public.

The 1997 – 2007 National Health Strategy emphasized the need for a coherent national policy development and planning framework, as a pre-requisite for improving health and quality of life. Unfortunately, this requirement was understood from a health sector point of view, to the exclusion of broader political imperatives, which naturally affect the performance of the health sector and its capacity to contribute to overall human development.

In other words, this policy framework was understood as the sole responsibility of the Health Sector. It is not surprising therefore, that the influence and impact of economic and social policies on the livelihoods of the people and the performance of the Health Sector were underplayed. The external determinants of improved health were mentioned in passing, without serious analysis of the potential adverse problems they might cause.

The importance of improving the health and quality of life of the population is a national political agenda, which cannot be understood purely from a sectoral point of view. The allocation of resources for health and its supportive components is probably not an exercise in numbers, undertaken during the annual budgetary process. At best, it is possibly a concerted political effort, which blends together a cocktail of public investments influencing improvement in the quality of life of the population; health service provision being one of these elements, amongst many.

The negative indicators describing the health of the population, and the perennial shortages of inputs in the sector, are a result of this oversight. No corrective strategies or measures were developed or anticipated. A current example, in many countries in the region and afar, in ignoring these external factors is the promotion of the production of bio-fuels. This is not an unwelcome development, but it has potential to decrease food production and increase food prices, if not properly designed with people in mind. Access to affordable healthy foods is pivotal in maintaining health in general, and the nutritional status of the population in particular.

The 1997 – 2007 strategy further emphasized the need for decisions to be made as close as possible to the people. As far back as 1983, the then Prime Minister's directive on the process of local governance and development recognized this need. However, evidence shows that without a legal framework compelling state institutions, agencies and their partners to adopt an inclusive approach to programme design and management, local needs are often likely to continue to be side lined in preference for sectoral technical interests. In this respect, indicators of performance and improvement are reduced to an annual ritual of numbers, often without any relevance to the local human condition.

Zimbabwe has recorded some successes in identifying an appropriate legal and regulatory framework with potential to promote collaboration and conformity. The balance is however tilted in favour of the regulator. The challenge is to transform these institutions into empowerment tools for the beneficiaries i.e. communities.

The 1997-2007 National Health Strategy, further recognised that the Ministry of Health and Child Welfare, as a state institution, had a responsibility to provide expertise in the design of national development policies which are known to sustain the continuous improvement of the health status and quality of life of the population. This was in recognition of the fact that the relationship between the population's health status and the actual delivery of health care will probably remain a complex one and contestable at times. Social and economic factors are at least as important, and probably far more so, in the equation.

The question which needs to be dealt with is what the health service's contribution to improving the population's quality of life could and should be. Many pieces of legislation exist under the administration of various sector ministries, intended to secure the wellbeing of the population and also to offer opportunities for individuals and others in society, to take responsibility for their actions in this regard.

Recent local, regional and international epidemiological events clearly indicate that securing the health and safety of the population is a matter of national security. The recent promulgation of the International Health Regulations is testimony to this recognition internationally. As stated elsewhere in this document, achieving this goal requires a framework, led by government, within which other stakeholders will participate. A situation where private individuals and others in society devise their own plans, often ignoring the public interest, should be discouraged. Poor coordination amongst state organs breeds this kind of behaviour.

Whilst it is inevitable and indeed proper, that the health service should be dynamic and move with the changing times, the past decade witnessed an increasing pre-occupation with initiatives to re-engineer the health system in the form of health sector reform. Reform dominated the platform for health development debate. The key ingredients were, amongst others, decentralization, public/private collaboration, hospital autonomy (self managing units), new financing mechanisms, priority setting and resource allocation, patient satisfaction and incentives for health workers. Though little understood then, there were also emerging external pressures, such as the general public sector reforms and globalization, amongst others, which brought with them unforeseen impacts on the process of reform.

These changes created tensions and contradictions in the delivery of health services. For a start, some of the reforms have brought confusion in the organizational processes of the health system. For instance, the practice of integrating vertical programmes into the on-going health system has been shown to be at odds with the requirements of international responses to major diseases. Funding mechanisms such as the Global Fund (TB, AIDS, and Malaria) GAVI etc, are a case in point. The development of multiple parallel systems of funding, provision and accountability, has brought with it new pressures on the health system. The various proposals for selective incentive regimes for staff has added to these pressures and tensions.

It is important for the country, at the policy and planning levels, to avoid the "take all" culture in terms of resources potentially offered, as this is tantamount to promoting short term solutions to long term problems. The consequences might work against public policy and interest and may even lead to loss of control.

Health is a core aspect of human well being. The capacity to achieve a long life in good health is one of the key determinants of quality of life. Ill health and lost years of potential life create a huge dividing line between the poor and the rich. The policy implications arising out of the current situation probably requires focusing on;

- Institutionalising an effective mechanism for financing primary health care. The policy issue is about the institutional structure which will create and sustain accessible primary care services. The challenge is that of re-building decent public primary care services.

- Maintaining public hospitals is important because they are the lifeline for the poor when faced with severe illness. The quality of services which they deliver is key to the behaviour of the health system as a whole. The major challenge is in creating political and institutional incentives for the progressive allocation of resources.

Despite the development and publication of clear policies, it is clear that the health service still pays far too much attention to supply problems, as opposed to demand challenges. This situation is thought to partly arise from the lack of a critical mass in all the disciplines necessary for advancing health policy research and analysis. In addition, there is excessive duplication of efforts, especially in relation to fashionable research areas. The few skilled researchers that are still in the country are

overloaded and frustrated, as they feel that the policy and service environment is not conducive to implementing their research findings.

The National Health Strategy (1997-2007) strongly supported the need for an inter-sectoral collaboration structure at the national level, which would form a platform for state agencies, whose work directly influences improvements in health status and quality of life. The rationale was that interventions which had potential to improve health status and reduce health risks, required a structured approach, which recognised the multiplicity of societal needs in terms of;

- All understanding the interventions i.e. their objectives and impacts.
- Collaboration from others, also recognising the value placed on their needs.
- Design of interventions, towards increasing net benefit to society.
- Implementation plans and monitoring mechanisms, consistent with the above.
- Resources (Now and future), their deployment and tracking.

Some progress has been made, in that ad-hoc consultations do take place. The difficult times the country is going through demand a robust and coherent policy and planning framework to guide the deployment of scarce resources. The changes which have taken place so far and those proposed, have potential to improve the responsiveness of the health service. In addition, the stewardship role of the Ministry of Health and Child Welfare will be clarified and better understood, in a context stakeholders have confidence in.

At the end of the day, providing health services is essentially a political process. Deciding who has access to which services, is indeed to make a political decision. This must be clearly understood. Further, it must also be understood that good public health policy should be tested at the level of service delivery, particularly to the weakest in society.

Key Issues

- Gross in-equalities still exist in the health sector.
- Health considered a sectoral issue instead of making it a national issue.
- Community participation in decision process still very low.
- Weak analytical skills before adoption of external driven agendas.
- Re-enforcing the Primary Health Care Approach.
- Better use of research findings in policy formulation.
- Strengthening inter-sectoral collaboration.

Goal 31:To strengthen capacity to formulate, develop and implement health policies and regulations	
Objectives	**Strategies**
To create an inclusive health policy development framework	• Strengthen the role of the Public Health Advisory Board in proposing, reviewing and agreeing appropriate health policies and monitoring their implementation. • Strengthen institutional capacity of the ministry for health policy analysis and development. • Review and strengthen the work/role of existing planning structures. • Formulate appropriate regulatory framework that will ensure various stakeholders that have activities that impact on health fulfill their responsibilities in health. • Establish a mechanism to involve all stakeholders in the development of health policies, rules and regulations. • Develop strong health advocacy skills within the MOHCW.
To link health service provision to national social development objectives	• Contribute and participate in the development of social protection mechanisms. • Develop tools for measuring impact of social protection initiatives. • Simplify access to health and other social services for vulnerable groups.
To define role of local authorities in health services development and provision	• Amend Public Health Act to place a duty for service development/ provision on local authorities. • Develop appropriate funding arrangements (including service contracts).
To coordinate activities among the different units within Ministry of Health and Child welfare	• Review the terms of reference for the various coordination/ monitoring structures (planning pool, minister's meeting, secretary's meeting, TMT meetings etc.).
To identify and clarify policies which affect and promote the protection of the population's health	• Review the effectiveness and impact of policies on health of the population. • Assess the effectiveness of the public health act and other related legislation on health. • Develop a comprehensive and participatory policy development framework (role clarification of the state and other players inside and outside the health sector important factor).
To strengthen the health policy development framework through coordination, dialogue and collaboration with sectors that have an impact on health and quality of life	• Make other sectors aware of the implications of their policies on health and quality of life. • Strengthen a common planning framework with other stakeholders whose activities have a bearing on the health of the nation. • Strengthen inter-sectoral cooperation and coordination at all administrative levels.
To review existing health policies, legislation, and regulations so that they are consistent with changing circumstances	• Review and amend policies on free health and exemption. • Review and amend policies on health services provision. • Review the public health Act. • Commission a study on the legal framework binding stakeholders. • Advocate for the protection of health rights in the constitution. • Map and monitor health policy research efforts to identify gaps and imbalances (liaising with stakeholders in identifying health policy research issues).
To monitor and evaluate the impact of policies on access, equity, efficiency and community satisfaction	• Evaluate the impact of policy changes as they are implemented. • Undertake corrective measures to meet set objectives. • Publish and disseminate policy documents.

PART 4:
Inclusive Implementation

4.1 ENHANCING COMMUNITY PARTICIPATION AND INVOLVEMENT IN IMPROVING HEALTH AND QUALITY OF LIFE

Trends and current status

The ability and capacity of communities to participate in health development activities depends on the decision making space they enjoy and the degree to which they control the resources for them to carry through those decisions. In practice, their ability to make these decisions will also depend on the quality and availability of the necessary information they require.

Since 1983, when the then Prime Minister's directive established local governance structures, communities have at least in theory enjoyed political control over issues which affect their lives at the local level. It is in view of this that the health service has placed community participation squarely on the health development agenda.

However, experience has shown that the knowledge gap between communities and service providers remains wide, to the extent that community contributions have not always been taken on board. In other words, the creation of participatory structures, on its own, is not enough. For example, the district is the basic planning unit in matters of local development and administration, under the direction of the District Development Committees. However, success has been limited, largely because the District Development Committees do not control local development resources. These remain firmly in the hands of local officials, controlled by their line ministries, there by stifling synergy between the direction of planning and financing, and ultimately implementation. Sadly, this situation has often resulted in community needs and interests being sidelined.

The Study on Access to Health Care Services noted that Communities are willing to support their local health institutions in cash or in kind. However, they remain uncertain as to how they should volunteer their assistance and contribution, saying they need guidance. In light of this, there is need to develop together with the community a Community Level Health Package which clearly defines how communities can contribute to their own health and also to health development including community health financing.

The study further noted that health workers at the periphery claimed they that they have no parameters to guide them in mobilizing communities to support health and health related activities. They felt that the current regulations did not allow them to solicit help from communities. The study also confirmed that dialogue between health workers at the periphery and communities is minimal.

An avenue to get communities to contribute to the health sector exists through local level management structures. Village Development Committees (VIDCOs) and Ward Development Committees WADCO), are expected to take part in decision making and management of health facilities at the community and district levels. However, a number of districts report that in many instances, these committees are not meeting regularly and in certain instances they have been disbanded. In contrast, Health Centre Committees meet regularly. Even so, the high levels of staff turnover tend to weaken health facility managerial structures as new inexperienced staff often replace those that leave for greener pastures.

At the service level, success has been recorded through the re-integration of the village health worker into the health system thereby recreating the vital link between an organized village community and the local health service. This together with the Environmental Health Technician and the recent introduction of the primary care nurse will strengthen the primary level team.

However, an under-utilization of primary care services in general has been observed in the recent past. This is thought to be related to supply side inadequacies, in terms of shortages of drugs, equipment and trained staff, particularly midwives and environmental health technicians. In addition, the community's ability to make choices depends on their level of literacy. Investing in the education of the population, particularly women, is an important component in the exercise of community health rights. The basic elements which form actions communities can take to secure their own health should be part of the education agenda. It is only when the key players in health development have a common understanding of what needs to be done and its meaning, that progressive participation and collaboration can take place. Health promotion and education in school curricula, in such areas as nutrition and lifestyles and the role these play in the causes of diseases, is, for example, a good start.

It is important to recognize that getting communities on board is not an incidental matter – it takes time and effort. The establishment of Community Health Councils, and the introduction

of the Patients' Charter, was meant to provide formal mechanisms for the voice of communities to be heard. The Patients Charter set out clearly a person's rights to care within the health service, and the standards of service which the Government intended to see achieved.

The Charter had a very mixed reception, coming as it did at a time when the performance of the health system was declining. No study has been carried out to ascertain the impact of the Charter. The assumption is that if the Charter has had any impact, patients should be receiving what they are entitled to. There should also be visible improvements in service standards. The public should also be more aware of their rights, and know what to expect from the health service. Information from communities however, shows otherwise. The fact that no system of monitoring or enforcing national compliance was established and followed up, did not help development in this area.

In the case of Community Health Councils, the majority of institutions and districts have not been able to establish one. It is thought that at present, only five districts and institutions have functional Councils.

In addition, the majority of districts, institutions and indeed the general public are not aware of the fact that Hospital Advisory Committees were abolished and replaced with Community Health Councils. The Councils were meant to widen the scope of participation beyond the hospital walls.

There is considerable evidence that ambiguity, limited authority, lack of information and poor quality of representativeness, have contributed to poor results in community participation and involvement in health issues. The major outcry from communities and health workers is for policy making and mechanisms for its implementation to be accountable to them. This demand goes beyond the usual perception of community participation, as a simple act of assembling stakeholders in a workshop in order to gather their views. Building participation in the development of health services, is, by its very nature, a social and political process, which will ultimately demand the achievement of visible results.

Policy accountability at the national level most likely depends on the extent to which structures such as the Public Health Advisory Board, the Health Services Board and the Parliamentary Portfolio Committee on Health, are able to facilitate wider public participation and consultation. This suggest ensuring that the public's voice is heard and brought to bear on policy decisions taking place in and outside the health sector, including oversight over the performance of the health sector as a whole. The Parliamentary Portfolio Committee on Health has been very active in facilitating wide public participation and consultation. On the other hand the Public Health Advisory Board has not been functional.

Though not explicit in the principal law, the values enunciated by the public health system imply that health care is a human right, and therefore cooperation in meaningful ways between providers and those they serve is of paramount importance. All individuals and groups providing access to services have a continuing duty and responsibility to promote and improve the quality of services which people need. In this regard, community participation should be considered as an appropriate means of dealing with health problems, which should be defined in collaboration with the communities and the workforce which serves them. Organizing communities for this purpose should be considered as a goal in its own right.

This 2009-13 National Health Strategy should therefore prioritize people's concerns on services as identified by the Study on Access to Health Care Services, District Health Services assessment 2005/6 and other relevant studies, as the health system exists to address people's concerns. The Study on Access to Health Care Services, noted the need for adequate staff, medicines, shortages of ambulances, electricity, water supplies, telecommunications and quality of food, as concerns most people wanted addressed. These people needs should therefore be the core business of this health strategy.

It is expected that Community participation will further be strengthened through the introduced Results Based Management system that requires that the needs and problems of clients be clearly identified and addressed with their involvement.

Key issues

- Limited information to community on health status, determinants of health and risk factors.
- Non involvement of communities in health planning and management.
- Non functional Public Health Advisory Board.
- Legal status of Health Centre Committees.
- Non involvement of local level structures in monitoring and reporting to the public on the implementation of health policies.
- Lack of authority by communities to manage locally available resources.

Goal 32: To enhance community participation and involvement in improving health and quality of life and in health development	
Objectives	**Strategies**
To make available to all Zimbabweans, information on the health status of the nation including determinants and risk factors for health	• Improve public health reporting. • Publish and disseminate an annual national health profile that is understandable to the general public. • Develop and publish a simple document defining the determinants and risk factors for health and how individuals, families and communities can enhance their own health. • Develop and publish a simple document on health promoting and early health care seeking behaviours. • Work closely with the media to facilitate dissemination of information.
To create an enabling environment and encourage individuals to take responsibility for their own health and secure the health of the others	• Define and agree with individuals, families, communities, schools and church organizations their responsibilities in service provision. • Make greater use of existing grassroots structures in health planning. • Work very closely with community social groups after defining clearly the scope of their work.
To establish methods for seeking broadly based national consensus on priorities to be addressed	• Strengthen joint health and civic planning structures at all administration levels. • Strengthen the role of the Public Health Advisory Board. • Encourage opinion leaders such as church and traditional leaders to participate in national health programmes.
To make individuals, families and communities aware of their rights and responsibilities	• Progressively develop the Patients Charter. • Create system for enforcing the Patients Charter. • Create an effective mechanism for dealing with grievances and complaints.
To re-vitalize and strengthen the role of the village health worker and other community health workers	• Sensitize policy makers, planners and communities on the importance of VHWs. • Redefine the work of the VHW and other community health workers.
To provide an enabling Implementation framework for community participation	• Develop a policy and strategy to strengthen community participation and involvement. • Resuscitate and strengthen community health councils and community health centre committees. • Elaborate a policy framework for community participation. • Review and disseminate guidelines for the establishment and functioning of the community health structures. • Develop a clear institutional framework for intersectoral support to community interventions. • Develop participatory tools for community involvement in health planning and development.
To empower communities and ensure their involvement in the governances of health services	• Identify and map out the key community stakeholders. • Create an environment for empowering communities in the governance of health services through appropriate capacity building. • Redefine the key roles and functions of the community stakeholders and community structures. • Provide appropriate funding for community activities.

4.2 PARTNERSHIPS FOR HEALTH

Trends and current status

Improvements in the health status and quality of life of the population do not depend solely on interventions within the health sector. It takes the efforts, contributions and participation of a myriad of stakeholders involved in both financing and direct provision of health services. It nevertheless remains the responsibility of the state, through the Ministry of Health and Child Welfare, to provide leadership and more importantly, stewardship, in harnessing and nurturing these efforts and contributions.

Experience has shown that maintaining sustainable partnership frameworks should be an ongoing negotiation process, promoted within an ambit of co-operation in which other strategic options have to be considered. Promoting equity, quality and access to health care should be the focus. Without this focus, buttressed by the state, partners will tend to gravitate towards the satisfaction of their own needs, including the pursuit of private gain above public interest.

Partnerships with Public Health Providers

The 1997-2007, National Health Strategy, emphasized the need for the wider social participation of all sectors, communities and individuals themselves, in health care provision, financing, service standards setting, regulation, monitoring and evaluation of performance. Over the past years, there is evidence (some of it anecdotal), that despite this call, the responsibility for improving the health status of the population remains perceived as a sectoral issue. In addition, the sustainability of partnership frameworks depends on the capacity of the principal (the state) to meet agreed obligations. For example, the deficiency in the relationship between the Ministry of Health and Child Welfare and local authorities, as well as with missions, is largely due to the absence of a definite commitment from the state on the level of grants or support to be provided to these stakeholders.

This weakness is worsened by poor technical capacity, on the part of the Ministry of Health and Child Welfare, to monitor and link the usage of grants or support to desired health outcomes. In the case of mission hospitals, the report of the Review Commission into the Health Sector stated "as of now, there are no service contracts between the government and mission hospitals. The working relationship between the government and mission hospitals needs to be clarified through negotiated contracts". Whilst service contracts were developed, these were not implemented, except in Matebeleland North, Mashonaland West and East provinces.

As the case with missions, local authorities provide and finance health services to people in their areas of jurisdiction. Their statutory duties are stated in the Public Health Act as follows; "Every local authority, shall take all lawful and necessary procedures, for the prevention of the occurrence or for dealing with the outbreak or prevalence of any infectious or communicable or contagious diseases". In practice, this means the provision of mainly environmental health services relating to water supply (until recently), sanitation, prevention of pollution, control of communicable diseases and food hygiene. However, both the Public Health Act and the Urban Councils Act, do not place a duty on local authorities to provide personal health services such as, for example, curative and mother and child health services.

As with missions, local authority health services are partly funded from grants from the state, disbursed through the Ministry of Health and Child Welfare but increasingly, from local revenues. With regard to grants from the state, the report of the Review Commission into the Health Sector, stated "However, the proportion provided by the government has declined to the extent that it represents for Bulawayo and Harare, only 4% of the costs incurred by the local authorities on personal health services. In addition, there is no formula used for the allocations, which are completely unpredictable. This makes planning for services difficult for local authorities. User fees "are prescribed by government and local authorities have no say in the matter". Grants for Bulawayo and Harare are now estimated to have fallen to 0.01% of their total health expenditures.

Missions and local authorities have been important traditional partners in service provision and financing. They have however continued to provide and finance services on the basis of an informal "agreement" with the Ministry of Health and Child Welfare. Although they may receive substantial resources from the state through the Ministry of Health and Child Welfare in the form of grants, audits on the use of these grants have not been conducted systematically. In addition, information on the use of resources and the provision of services has not been regularly provided to the Ministry of Health and Child Welfare.

Private and Public Partnerships

The private sector in Zimbabwe has potential to contribute meaningfully to the process of achieving national health objectives. Though cooperation between the private and public sectors has existed for a long time, this has been ad-hoc and informal. This potential needs to be tapped and coordinated. Opportunities exist in increasing the capacity of local manufacturers to produce essential supplies for the health sector (e.g. drugs, equipment and sundries).

However, initiatives in this direction require a national approach, as they cannot be solely sectoral because of the wider implications involved in designing and managing public and private sector partnership frameworks. The stewardship role of the state and the Ministry derives credibility and visibility from and to the extent to which the contributions of stakeholders are recognized and acknowledged.

In participating in both the provision and financing of health services, the private sector should really be complementing the work of the public sector. The private sector frees space to allow the public sector to concentrate on the needs of majority of the population, particularly the vulnerable groups. Their work is regulated partly through the Medical Services Act, which was intended to create a level playing field for patients, providers and funders. The challenges resulting from the performance of the economy have strained this relationship, putting the health of patients at risk.

The growth of the black middle class over the years immediately after independence brought with it extended growth in private medical insurance. These events also triggered the rise in the number of private medical practitioners, since their economic survival depends on the existence of an assured revenue base. This rapid growth under the present economic situation has given rise to new tensions, which, at times, have led to unfair practices. The patient bears the burden of these practices and this has begun to generate pressure on the government for increased regulation to protect patients, funders and providers, from financial and medical hardship.

Medical Aid Societies have limited funds for hospital care. They therefore have an interest in employing techniques that will reduce inpatient use. It is not unusual, for example, for Medical Aid Societies to refuse re-imbursing providers for certain types of care. On the part of providers, fearing non reimbursement, they might, for instance, discharge patients earlier, introduce perverse rationing, or worse, deny them care altogether. Private funders and providers have not fully supported calls for increased regulation, fearing that government will begin to recommend appropriate treatment and therapy for various conditions. Issues of clinical freedom have also been raised.

Some of Zimbabwe's traditional international partners suspended cooperation and direct development support in 2002. A number of them, however, continue to channel development resources through Private Voluntary Organisations, International Non Governmental Organisations and the United Nations family. Since some of these resources do not flow through government channels, there have been obvious difficulties in tracking them and monitoring their use. Support is mostly for HIV and AIDS and programmes related to nutrition, children and mothers. Difficulties have been experienced in accessing resources from global initiatives such as the Global Fund in the past.

However, the bi-annual Ministry and partners meetings have continued to be held, with willing partners participating. Bilateral agreements or memorandum of understanding have also been signed with partners and countries supporting working with the Ministry. There is however need to revisit the existing MOUs and coordinating structures in order to make them more useful.

Beneficial cooperation has grown over the past years, with a number of countries. The principle remains that partners are welcome to support the national health development plan. The structures for the transparent management of development support, in use up until 2002, are still appropriate for use today.

Partnerships with other ministries and sectors

Intersectoral collaboration should be based and focused on the common goal i.e. doing those things which improve the quality of life of the population, together.

This is by no means an easy task but one which cannot be ignored because the primary purpose of intersectional collaboration is to ensure that national resources are allocated in ways that maximise benefit to society. At the district and provincial levels, opportunities exist for taking this approach forward. The structures are there in the form of Provincial Councils, Provincial Development Committees and District

Development Committees. Perhaps, the issue to deal with is how to organise the flow of sectoral funds, in order to achieve the common goal.

Elsewhere in the document (pg 33) it has been indicated that poverty is a known negative determinant of health. Tackling poverty remains a top priority. Reduction in poverty will positively influence the health and quality of life of communities.

The development of gender-sensitive health policies is of high priority, and a whole range of reproductive health strategies have been implemented as a package aimed at improving the lives of women.

Educational opportunities, especially for women, have been shown to have a major impact on the improvement of health standards of countries the world over. The health sector will continuously identify new opportunities for strengthening health literacy together with Ministry of Education.

The health sector has continued to play its role in the promotion of safe water supply and sanitation facilities and has worked closely with the Ministry of water in ensuring the safety of drinking water. The health sector has also continued to work with relevant authorities in promoting food security. Collaboration with the Nutrition council has been maintained. Other intersectoral committees include the Country Coordinating Mechanism, Roll Back Malaria, the Epidemic Prevention and Control etc. There is however a lot that needs to be done to promote intersectoral collaboration with other government agencies.

Organisations representing various health professions have continued to work in partnership with the Ministry of Health, in providing the regulatory framework for all health care providers and purchasers. Professional bodies in partnership with the MOHCW have been responsible for setting and monitoring standards and regulations governing the conduct of various health professionals.

The institutions of higher learning have not been given their rightful positions in the health system. The various activities they perform in improving health and quality of life seems to have been unnoticed. Ministry of Health and Child Welfare needs to work more closely with College of Health Science in patient care, training, laboratory services research etc.

Partnership with the community deserves a special attention and has therefore been dealt with separately in the previous section.

Key issues

- Wider social participation of all sectors, communities and individuals on health issues.
- Service contracts with health service providers.
- Review the Public Health Act, Rural District Councils Act, Urban Councils Act.
- Agreements or Memorandum of understanding with health partners.
- Enhancing multi-sectoral collaboration in health in issues.
- Central Government financing obligations to local government.

Goal 33: To enhance collaboration with both local and international development partners	
Objectives	**Strategies**
To strengthen partnerships with public health providers	• Review and strengthen guidelines for working with public health providers. • Increase funding/grants to public health providers.
To increase and strengthen private sector involvement in the health sector	• Develop a policy on public/private mix and regulation of the private sector. • Develop as system for coordination the operations of public and private sectors.
To increase and strengthen intersectoral collaboration and coordination in health development	• Elaborate a policy framework for intersectoral collaboration and coordination. • Revisit and advocate for the resuscitation of the intersectoral Cabinet committee on social services. • Develop a mechanism of making other ministries and sectors aware of their responsibilities in health. • Develop intersectoral action plans that address major determinants of health. • Develop a clear institutional framework for intersectoral support to community interventions.
To strengthen partnerships with local and international health partners	• Adapt to local conditions and implementing decisions taken by multilateral organizations of which Zimbabwe is a member state. • Strengthen regional and international cooperation on health issues. • Strengthen donor coordination.
To strengthen partnerships with health related stakeholders	• Determine the size and scope of different providers (Mapping). • Define the roles and responsibilities of stakeholders. • Establish a mechanism to involve all stakeholders in issues concerning health and quality life. • Review and improve Memorandum of Understanding with the different stakeholders.

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