

# Zimbabwe National Healthy Ageing Strategic Plan 2017-2020

*Ministry of Health and Child Care in Partnership with World Health  
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## List of Abbreviations

AMTO	Assisted Medical Treatment Orders
ART	Anti-Retroviral Treatment
AU	Africa Union
CEDAW	Convention on Eradication of all forms of Discrimination against Women
CVAs	Cerebrovascular Accidents
CSOs	Civil Society Organisations
DHIS	District Health Information Management System
DHS	Demographic Health Surveys
GMOs	Government Medical Officers
GSAP	Global Strategy and Action Plan on Ageing and Health
HCCs	Health Centre Committees
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
MoHCC	Ministry of Health and Child Care
NGOs	Non-Governmental Organizations
NHAS	National Healthy Ageing Strategy
NHS	National Health Strategy
NSSA	National Social Security Authority
NCDs	Non- Communicable Diseases
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
UN	United Nations
ICESCR	United Nations (UN) International Covenant on Economic, Social and Cultural Rights
WHO	World Health Organization
ZHRC	Zimbabwe Human Rights Commission

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## Executive Summary

### Introduction

Zimbabwe's population showed that the older persons' population was increasing against a background of minimal overall population growth. Healthy Ageing has become a major public health concern especially in low income countries where infectious diseases continue to occur at epidemic levels. The World Health Organization (WHO) developed a global strategy and action plan on ageing and health (GSAP) in 2015. The GSAP aimed at ensuring that ageing populations worldwide receive quality health for purposes of maintaining their functional status. The Africa Union (AU) Protocol on human rights of older persons in Africa also recommends interventions for member states to improve the provision of social services to older persons. Zimbabwe has robust legislation that promotes access to health for older persons. With 20% of all disabled people in Zimbabwe being older persons and a growing epidemic of non-communicable diseases, the need for a healthy ageing strategy was critical.

### Statement of Need for Older Persons in Zimbabwe

The 2012 National Census Report showed that a quarter of the disabled people in Zimbabwe were older people, and the majority of older persons (82%) lived in rural areas. Access to social services was low mainly due to the severe socio-economic challenges facing the country, and the low functional ability of older people, partly due to musculoskeletal disorders, poor vision and the inability to travel unaccompanied. The most common diseases affecting older persons in Zimbabwe were cancers of the prostate and cervix, cardiovascular diseases, diabetes and stroke. Complicating the access to social services were unavailability of medicines in health facilities and low access to income for basic daily living such as inability to pay for transport costs to health facilities, payment for health services at higher level facilities due to severe socio-economic challenges affecting Zimbabwe.

### Healthy Ageing Strategy

The WHO recommends five key strategic objectives to promote healthy ageing and delay functional inability among older persons. The objectives include:

1. Commitment to action, which is measured by the country's readiness to enact laws and create governance structures that guarantees the provision of social services;
2. Alignment of health systems to the needs of older persons. As people age, their health needs tend to become more chronic and complex which affect their accessibility to health care services;
3. Age-friendly environments that promote the creation of opportunities for collaboration and coordination across multiple sectors and with diverse stakeholders;
4. Strengthening of long-term care through reducing the effects of ageing on functional ability using the life course approach; and
5. Improvement of measurement, monitoring and research and use of evidence based programming for older persons.<sup>1</sup>

### The Strategy Development Process

This Strategy was developed using a participatory approach in three phases, a situational analysis, a strategy development and a validation workshop. The rapid situation analysis was conducted in four districts and at national level. Interviews with key informants and focus group discussions with older

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<sup>1</sup> The WHO. Global Health and Ageing Report, 2011

persons were conducted. Published and unpublished literature was reviewed to inform questions used during interviews. Relevant permissions from the Ministry of Health and Child Care and local authorities were obtained before field work was done. A strength, weaknesses, opportunities and threats (SWOT) analysis tool was used to identify potential barriers to implementation of the Zimbabwe National Health Ageing Strategy (NHAS).

### Key Findings on SWOT Analysis

<b>Strengths</b> <ol style="list-style-type: none"> <li>1. Available legal and policy framework</li> <li>2. Institutionalised implementation framework through the Ministry of Labour and Social Welfare</li> <li>3. The national health strategic plan and public health act have clear strategies that address the needs of older persons</li> <li>4. Availability of partners willing to support healthy ageing will catalyse the development and implementation of the healthy ageing strategic plan</li> <li>5. Willingness of the Zimbabwe government to support the development of a national healthy ageing strategy will stimulate the development of a broader national policy framework for older persons in Zimbabwe.</li> </ol>	<b>Weaknesses</b> <ol style="list-style-type: none"> <li>1. Current health information management systems do not collect data on older persons thus, negatively affecting the estimation of the health needs of older persons</li> <li>2. Practising health care workers do not have training in Geriatric medicine affecting the quality of care for older persons</li> <li>3. Current infrastructure, including Government departments are not user friendly to older persons and this has affected access to the few social services that are available</li> </ol>
<b>Opportunities</b> <ol style="list-style-type: none"> <li>1. Availability of three medical training schools that have the capacity to introduce new courses including Geriatric Medicine.</li> <li>2. The availability of the WHO global strategy and action plan (GSAP) and other regional policy documents on older persons which encouraged countries to develop country specific strategic plans</li> <li>3. The HIV epidemic has changed the demographic characteristics of most countries. Funding towards activities linked to older persons, like orphans and vulnerable children (OVCs) creates potential for resources to be made available to older persons and fund cross cutting activities like coordination meetings for older persons.</li> </ol>	<b>Threats</b> <ol style="list-style-type: none"> <li>1. The continued depressed macroeconomic conditions in Zimbabwe will continue to negatively affect funding towards the health sector</li> <li>2. Under the depressed economy, prioritisation of resources will be towards acute infections, maternal and child health and emergencies.</li> <li>3. The prevailing socioeconomic challenges have affected the quality and quantum of support to older persons.</li> <li>4. The increased number of orphans and vulnerable children who are delinquent worsened the mental health of older persons</li> </ol>

## Zimbabwe National Healthy Ageing Strategy (NHAS)

The vision and goals of the Zimbabwe NHAS were developed during the validation workshop including the key indicators for monitoring progress in the implementation of the strategy. The table below summaries the goals, strategic objectives and key priority actions for the NHAS.



Table 2. Summary of Goals, Strategic Objectives and Priority Areas for Zimbabwe

Goals	Strategic objective	Strategic Actions
<b>Goal 1:</b> Create an enabling age friendly environment for the provision of quality and integrated health services for older persons	Strategic Objective 1: Commitment to action on healthy ageing	<ul style="list-style-type: none"> <li>• Develop a multi-sectoral policy document that guides the provision of social services to older persons in Zimbabwe.</li> <li>• Review legislation for older persons to develop a law on universal pensions for all older persons.</li> <li>• Review and amend the Constitution to adopt 65 years as the definition of older persons in Zimbabwe. Align the Older Persons Act of 2012 to the Constitution to include the rights of older persons.</li> <li>• Advocate for Zimbabwe to ratify and domesticate the AU Protocol on Healthy Ageing.</li> <li>• Set up an accountability framework to enhance the participation of older persons in national institutions within all sectors</li> <li>• Create formal structures to enable active participation of older persons in health promotion, for example, include older persons in health centre committees.</li> <li>• Advocate for the creation of a line budget for older persons' care and support within the Ministry of Health and Child Care.</li> </ul>
	Strategic Objective 4: Strengthen long-term care	<ul style="list-style-type: none"> <li>• Harmonise training of community health workers and other community volunteers to include long term care;</li> <li>• Develop a programme that supports long term care of older persons based on an explicit partnership with families, communities, other care providers, and the private sector and reflect the concerns and perspectives of these stakeholders;</li> <li>• Develop and disseminating care protocols or guidelines that address key issues in the provision of quality long term care for older persons; and</li> <li>• Scale up and formalise community initiatives that include Older Persons Community (OPC) structures and groups that act as a resource for caregiving and other community development activities.</li> </ul>
<b>Goal 2:</b> The provision of quality and integrated health services for active ageing	Strategic Objective 2: Align health systems to the needs of older persons	<ul style="list-style-type: none"> <li>• Increase older persons' access to evidence based health interventions that promote good health by ensuring availability of: <ul style="list-style-type: none"> <li>○ Medicines and commodities</li> <li>○ Skilled health care workers</li> <li>○ Research and development.</li> </ul> </li> <li>• Strengthen Health Sector Leadership and Governance at all levels of care through involving older persons in governance structures of the health care system</li> <li>• Advocate for Health Centre Committees to include older persons, with a focus on gender and</li> </ul>

		<p>particularly the needs of older women.</p> <ul style="list-style-type: none"> <li>• Improve human resources for health through pre- and in-service training of HCW in geriatric medicine.</li> <li>• Train Community Healthcare Workers (CHWs) so that they are able to offer quality home based care service to chronically ill persons including older persons</li> <li>• Improve access to health services through leveraging the National Health Strategy (2016-2020). For example, the National Health Strategy (2016-2020) plans to create health posts that will provide health care services at lower level than the clinic. This will improve access to health care for older persons by reducing the distance travelled for health care.</li> <li>• Advocate for improved access to social services by implementing a universal grant for older persons.</li> </ul>
	Strategic Objective 3: Develop age-friendly environments	<ul style="list-style-type: none"> <li>• Improve advocacy on older family support mechanism for vulnerable population groups especially older persons;</li> <li>• Engage all sectors such as Transport, Education, Health, Industry and ICT to develop an older persons national policy to facilitate the mainstreaming of older persons' needs (social protection, sanitation, housing, water and health) in both urban and rural areas</li> <li>• Re-engage older persons and tap into their wisdom, skills and knowledge;</li> <li>• Promote healthy behaviours for the prevention and control of non-communicable diseases (NCDs) through raising awareness to adopt the life course approach for preventing NCDs</li> <li>• Strengthen self-care and family and community support for healthy ageing, including linking with the disability agenda.</li> <li>• Facilitate a psychological support programme for older persons caring for orphans.</li> </ul>
	Strategic Objective 5: Improve coordination, measurement, monitoring, and research	<ul style="list-style-type: none"> <li>• Use the available mechanisms to collect health data on older persons. These include the DHIS2, census, DHS, and National Health Accounts.</li> <li>• Develop a research agenda to provide evidence on healthy ageing and effectiveness policy and programmatic interventions.</li> </ul>

# 1 Introduction

## 1.1 The Concept of Healthy Ageing

Ageing has become an important health and social subject that requires capital investment to mitigate the effect of increased ageing and low fertility worldwide.<sup>3</sup> With the improving public health services, the proportion of people aged 60 years and above is estimated to increase at a faster rate than any other age-group. There has been a significant transition from high to low mortality and fertility due to improved socioeconomic development. This epidemiologic transition means there has been change in the leading causes of disease and death from acute infectious diseases to chronic and degenerative diseases. High death rates from infectious diseases are commonly associated with the poverty, poor diets, and limited infrastructure found in low income countries like Zimbabwe. The multi-country Global Burden of Disease study estimated that in 10 to 15 years from 2011 all geographical regions would suffer more death and disability from non-communicable diseases than from infectious diseases. The WHO World Report on Disability (2011) showed that developing countries had a higher burden of NCDs than developed countries (Figure 1).

	Developed countries (millions)	Developing countries (millions)
Visual impairment	15.0	94.2
Hearing loss	18.5	43.9
Osteoarthritis	8.1	19.4
Ischaemic heart disease	2.2	11.9
Dementia	6.2	7.0
Chronic obstructive pulmonary disease	4.8	8.0
Cerebro-vascular disease	2.2	4.9
Depression	0.5	4.8
Rheumatoid arthritis	1.7	3.7

**Figure 1: Prevalence of NCDs among adults over 60 years**  
*Source: UNFPA (2012)<sup>2</sup>*

The World Health Organization (WHO) recommends that older persons should receive quality health, actively participate and must have adequate security in order to enhance quality of life as people age.<sup>4</sup> Healthy Ageing is therefore one of the three components in developing and maintaining the functional ability that enables participatory wellbeing in older age. Functional ability is determined by the interaction between the person's intrinsic (physical and mental) capacity and his or her environment to function independently. The definition of health, which is a state of physical, mental and social wellbeing, means that social determinants significantly affect the state of one's health. Social determinants of health include knowledge and skills, economic standards of living, civil and political rights, social connectedness, cultural identity, leisure and recreation, safety and physical environment. These social determinants act as risk factors to occurrence of health events and if they are not in favour of mankind cause disease. Healthy ageing cannot be achieved by addressing physical and mental well-being alone without addressing the social determinants of health.

## 1.2 Description of the Zimbabwean Demographic Situation

The global population of older persons is estimated to increase from 500 million to 1.2 billion from 2002 to 2025<sup>5</sup>. For Africa the rate is estimated to increase from 6% in 2012 to 10% in 2050 while in Zimbabwe the population of older persons will grow from 6% to 12.4%<sup>6</sup>. The population of older persons for Zimbabwe increased marginally from a total of 3.6% in 2002 to 4.1% in 2012. In the 2012 census, there were 531,704 older persons in Zimbabwe, majority of them being female (56%) and

<sup>2</sup> UNFPA and HelpAge International (2012) Ageing in the Twenty-First Century: A Celebration and A Challenge.

<sup>3</sup> The WHO. Global Health and Ageing Report, 2011

<sup>4</sup> The WHO, Active Ageing; A policy framework 2002

<sup>5</sup> The WHO. Global Health and Ageing Report, 2011

<sup>6</sup> UNFPA and HelpAge International (2012) Ageing in the Twenty-First Century: A Celebration and A Challenge.

about 82% were living in rural areas. Matabeleland South Province had the highest population of older persons, 5.9%, followed by Matabeleland North with 5.0%. Older persons in Zimbabwe are defined as those aged 65 years and above. The data described in the 2012 census was therefore an under-estimation if the United Nations recommended age of 60 years and above, had been used.

### 1.3 Description of the Zimbabwe's health system

The health system in Zimbabwe is divided into four levels of care, namely tertiary; provincial; district; and primary. The primary care level comprises mainly clinics and rural health centres.<sup>7</sup> There are about 1,650 primary health care facilities. Primary care facilities offer basic outpatient services that include health promotion, preventive, curative and rehabilitative services and community based health care. In urban areas, the local authority owned clinics charge a service charge except for children under five years and patients receiving treatment for infectious diseases like Tuberculosis, human immunodeficiency virus (HIV) infection. The service charge in urban clinics serve to improve income generation under reduced central government spending on social services. Health care services in rural clinics are free of charge to the patient. Complicated cases requiring surgical care are referred to the next level, the district or mission hospital level. There are about 50 District and 49 Mission hospitals in Zimbabwe. These facilities are staffed by Government Medical Officers (GMOs), nurses, laboratory scientists, environmental health officers, pharmacists, health information assistants, nutritionists and health promotion officers. Additional services offered at this level include surgical procedures (caesarean section, safe blood transfusion), comprehensive emergency obstetric and new-born care, and comprehensive management of illness including emergency care. The third level of care is the provincial hospital where services not offered at the district are available. Central or tertiary level of care is the fourth level of care where more complicated specialised services are provided. Payment for services starts from district level upwards for all patients outside the category exempted from paying. Older persons are exempted from paying for health services provided at all levels except at urban clinics where a service charge is levied on all patients except under five year children.

### 1.4 Statement of Need for Healthy Ageing in Zimbabwe

The 2012 national census report showed that 38% (about 199,647) older persons were living with some form of disability, almost double the 20% proportion in 2002. Of the 531,704 older persons reported in 2012, 56% were female and majority, 82%, were living in rural areas. Majority of female older persons had never been formally employed and therefore not eligible to pension benefits. Almost a quarter, 24% of all disabled people were older persons. The 2012 census, the 2015 Zimbabwe Human Rights Commission (ZHRC) Baseline Survey and the assessment of access to social protection and health services in Africa conducted by Help Age International in 2016 confirmed that there was low access to health care and social security (pension, social grants and insurance) for older persons. Households with older persons had lower access to social services than households not living with older persons. This could have been attributed to the high proportion of disability among older persons and the reduced functional ability to access services. A majority of older persons living with a disability had no national identity cards. The group of older persons that was mainly affected are those of foreign origin who migrated to work in mines and farming areas. Without a national identity card it is not possible for any person to access social services. The continued high prevalence of communicable diseases in the African region resulted in more resources being channelled towards the prevention and control of infectious diseases at the expense of the chronic illnesses which are common in older persons. Medicines for chronic non-

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<sup>7</sup> Ministry of Health and Child Care (MoHCC). Final National Integrated Health Facility Assessment Report - Oct 2012

communicable diseases were not readily available at health facilities and older persons were presenting to hospitals with complicated chronic diseases like cerebrovascular accidents (CVA) and complicated diabetes. The WHO reported that prostate cancer, cervical cancer, stroke, coronary heart disease and hypertension were the top 10 causes of age adjusted death rates for Zimbabwe in 2014. Physical access to local health facilities remained a challenge for older persons living in rural areas, where more than 80% of the older persons lived in 2012.

Zimbabwe has robust legal and policy statements on health rights of older persons<sup>8</sup>. The definition of older person is described differently in the different legal instruments of Zimbabwe. According to section 82 of the Zimbabwean Constitution, an older person is a person who is above the age of seventy (70) years. However, the Older Persons' Act defines an older person as "a citizen of Zimbabwe aged sixty-five years or above, who is ordinarily resident"<sup>9</sup>. United Nations and Africa Union guidelines refer to older person as someone who is sixty (60) years and above. The Thesaurus English Dictionary defines old age as a particular period of life at which a person becomes naturally or conventionally qualified or disqualified for anything. The use of different definitions for older persons between the Constitution and the Older Persons Act of 2012 has not affected access to health and social services. However, there are potential challenges related to asserting the rights of older persons guaranteed in the Constitution.

The socio-economic challenges affecting Zimbabwe have resulted in low investment to health and social protection sectors. Health financing has shifted to curative from preventive services compromising the integrated primary health care concept that is the foundation of the Zimbabwe National Health Strategy (NHS). The most affected population groups from the weakened health systems are the extremes of age, women of child bearing age and people with chronic illnesses. Older female persons are often worst affected by poverty, economic challenges and disease burden, mainly because they are not eligible for social security pension and medical aid contributions since they were generally never formally employed. Majority of women work in the informal sector as cross-border traders, vendors, smallholder farmers and unpaid carers. The hyper-inflationary environment experienced during the years 2000-2010 eroded the savings of older persons' pensions and social security. Low access to health care and social security (pension, social grants and insurance) for older persons and unavailability of medicines for chronic non-communicable diseases at public health facilities in Zimbabwe increased health related expenditure among older persons. The Ministry of Health and Child Care (MoHCC) commissioned a Healthy Ageing Strategy development process to respond to the deficiencies noted in the evidence generated from studies in Zimbabwe.

### 1.5 The WHO Policy Framework

The World Health Organization developed a policy on healthy ageing that is guided by three fundamental assumptions that ageing is a life course phenomenon. The life course phenomenon states that the way people age is influenced by genetics, upbringing, and healthy experiences during both younger and adult years and environmental exposures like poor housing, pollution, workplace discrimination and family violence. The goal of the healthy ageing strategy is to delay loss of functional capacity as one ages, through modification of the environment, access to health services and access to long term care services.<sup>10</sup>

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<sup>8</sup> Government of Zimbabwe. National Constitution, 2013

<sup>9</sup> Government of Zimbabwe. The Older Persons Act, 2012

<sup>10</sup> The WHO. Global Report on Ageing, 2015

This Strategy was developed through adaptation of the WHO Global Strategy and Action Plan on Ageing and Health (GSAP) which has five key strategic goals, namely<sup>11</sup>:

#### 1.5.1 Commitment to action

Majority of low income countries do not have programmes to allow operational research that will provide evidence for appropriate interventions. The United Nations (UN) policies and guidelines (Madrid Declaration) and the WHO global strategy and action plan on ageing and health (GSAP) outline the legal requirements for member states to ensure older persons remain functional through provision of adequate health care services. The Africa Union (AU) Protocol on human rights of older persons in Africa also recommends interventions for member states to improve the provision of social services to older persons. Enactment of legislation, creating governance structures and budget lines for the provision services to older persons are used to measure commitment to action by member states.

Although Zimbabwe has not ratified the AU protocol, the country has legislation on the rights of older persons and their social protection. These rights are clearly articulated in Sections 21 and 82 of the national Constitution of Zimbabwe Amendment No. 20 of 2013, and in various other pieces of legislation, namely the Older Persons Act [Chapter 17:12] of 2012 and the Social Welfare Assistance Act [Chapter 17:06] of 1988. Zimbabwe, therefore has created an enabling environment for all partners, government and non-governmental organizations (NGOs), to participate in the provision of services to older persons.

#### 1.5.2 Align health systems to the needs of older persons

As people age, their health needs tend to become more chronic and complex. Health systems should be designed in such a way that services are affordable, accessible and integrated to ensure the needs and rights of older persons are met at all times. Health care workers must be trained to have competencies for managing older persons' health needs. The healthy ageing strategic plan should outline how the Government of Zimbabwe will improve the provision of health services to older persons through a multi sectoral approach.

The Situation Analysis findings, conducted as part of the strategy development process, showed that there was weakening of both community and family based care systems in Zimbabwe, despite these being the most effective means of managing long term care of older persons. The Government through the Department of Social Welfare erratically provided food provisions to homeless older persons accommodated in older people's homes. Free medical services for older persons were limited to consultation only with medicines and medical investigations being offered at a cost. Physical access at health care facilities was a challenge as none of the facilities were built to accommodate patients with disabilities. With about 24% of all disabled persons being older persons, these were the most affected by the absence of ramps for wheelchairs, toilets that are not age-friendly, and poor lighting for older persons with reduced eye sight.

#### 1.5.3 Develop age-friendly environments

This involves creating opportunities for collaboration and coordination across multiple sectors and with diverse stakeholders. This strategic objective complements the one on commitment to action. Governments should develop strategic plans that guide the collaboration and coordination as well as coordinate the collaboration through national stakeholders' meetings. The strategy will recognize that provision of health care to older persons is not the responsibility of the health sector alone, but of all state parties.

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<sup>11</sup> The WHO. Global Strategy and Action Plan on Ageing and Health

Assessment of country level situation showed that formal social security, family and community support were unavailable. Majority that were formally employed and made contributions to pension funds had investments eroded by hyperinflation. Older persons had limited knowledge of how to access pension benefits post-employment. In addition, older persons without identification particulars had challenges accessing social security services including placement into homes, resulting in increased risk of destitution, especially those who were of foreign origin.

Analysis of older persons in Zimbabwe found an emerging issue of delinquency among children under the care of older persons who abused drugs, alcohol and other intoxicating substances. The associated stress of caring for such children increased the risk of some non-communicable diseases among the older persons. Older women were disproportionately affected by this stress as they are more likely to be the primary caregivers.

#### 1.5.4 Strengthen long-term care

The long-term health and ageing needs of older persons require sustained support to reduce the negative impacts of ageing. This can only be achieved if the health of older persons is addressed using the life course approach. The life course approach recognizes that the health of individuals at different age range requires appropriate age-specific interventions. In addition, access to health care from conception to older age determines the state of health of older persons. In Zimbabwe, palliative care services were mainly available in urban settings, yet 82% of the older persons lived in rural areas in 2012. Whilst the National Health Strategy for Zimbabwe outlined the strategies for managing chronic diseases under the non-communicable diseases Unit of the MoHCC, treatment of chronic diseases was not universally available. Training in Geriatric Medicine was not available in Zimbabwe at all levels of care making access to quality health care services for older persons not possible.

#### 1.5.5 Improve measurement, monitoring, and research

Majority of low income countries do not have programmes to allow operational research that will provide evidence for appropriate interventions. The WHO recommends that countries should incorporate mechanism to collect programme data for measuring, analysing and monitoring healthy ageing. Analysis of the Zimbabwe health information system showed that Zimbabwe has a robust health information management system that collects routinely collected data at all facilities. The data is submitted to national level through the district health information system via the web based system of district health information management system (DHIS). In addition to the routinely collected data, the country collects data through population based surveys like the demographic and health survey, malaria indicator survey and multiple indicator cluster surveys. Key gaps were the inability of the surveillance system to collect disaggregated data by age and sex as older women and men face different challenges with ageing.

### 1.6 The Strategy Development Process

This strategy was developed using a participatory approach that encompassed a situational analysis, a strategy development and a validation workshop. The rapid situation analysis was conducted in four districts with interviews with older persons and stakeholders working with older persons. Visits to the four districts were supported with in-depth review of existing studies on old age, health and social protection in Zimbabwe, the region and internationally; and legal instruments including the new constitution on older persons in Zimbabwe. Combining these approaches resulted in a detailed description of healthcare provision and the wider operating environment for older persons' health. Current national health care provisions were compared to the needs of older persons to determine gaps that need to be addressed to improve healthy ageing.

A Strengths Weaknesses Opportunities and Threats (SWOT) analysis was undertaken during the strategy development workshop with stakeholders. Table 1 summarises the findings of the SWOT analysis.

**Table 1: Summary results of the SWOT analysis**

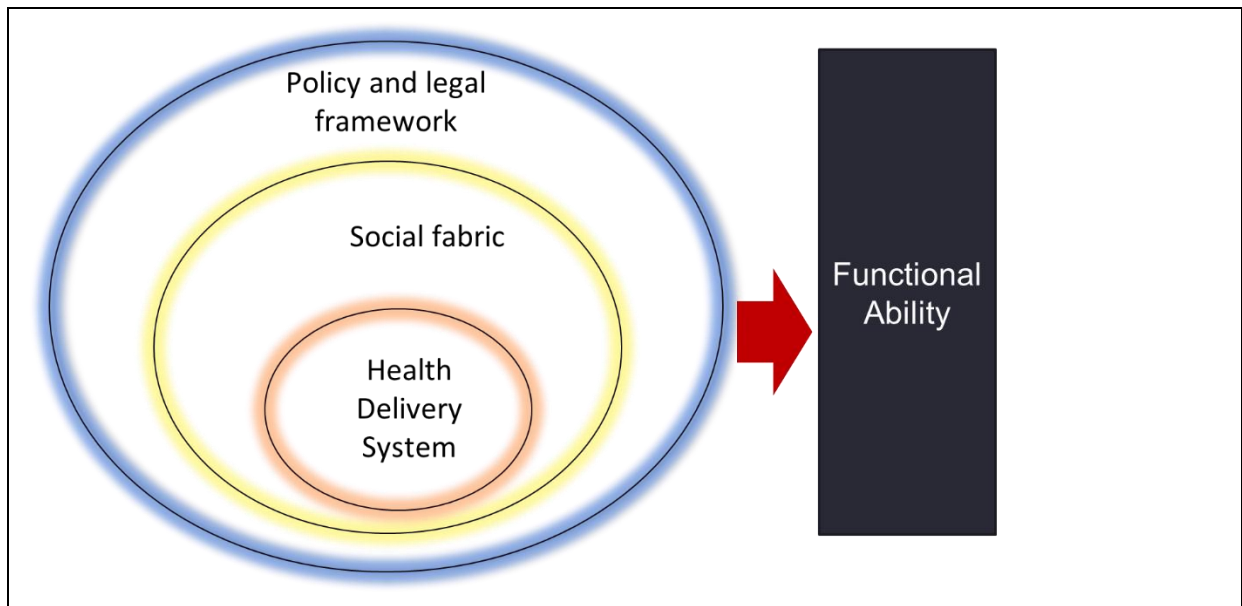
<b>Strengths</b> <ol style="list-style-type: none"> <li>1. Available legal and policy framework</li> <li>2. Institutionalised implementation framework through the Ministry of Labour and Social Welfare</li> <li>3. The national health strategic plan and public health act have clear strategies that address the needs of older persons</li> <li>4. Availability of partners willing to support healthy ageing will catalyse the development and implementation of the healthy ageing strategic plan</li> <li>5. Willingness of the Zimbabwe government to support the development of a national healthy ageing strategy will stimulate the development of a broader national policy framework for older persons in Zimbabwe.</li> </ol>	<b>Weaknesses</b> <ol style="list-style-type: none"> <li>1. Current health information management systems do not collect data on older persons negatively affecting the estimation of the health needs of older persons</li> <li>2. Practising health care workers do not have training in Geriatric medicine affecting the quality of care for older persons</li> <li>3. Current infrastructure, including Government departments are not user friendly to older persons and this has affected access to the few social services that are available</li> </ol>
<b>Opportunities</b> <ol style="list-style-type: none"> <li>1. Availability of three medical training schools that had capacity to introduce new courses including Geriatric Medicine.</li> <li>2. The availability of the WHO global strategy and action plan (GSAP) and other regional policy documents on older persons encouraged countries to develop country specific strategic plans</li> <li>3. The HIV epidemic has changed the demographic characteristics of most countries. Funding towards activities linked to older persons, like orphans and vulnerable children (OVCs) creates potential for resources to be made available to older persons and fund cross cutting activities like coordination meetings for older persons.</li> </ol>	<b>Threats</b> <ol style="list-style-type: none"> <li>1. The continued depressed macroeconomic conditions in Zimbabwe will continue to negatively affect funding towards the health sector</li> <li>2. Under the depressed economy, prioritisation of resources will be towards acute infections, maternal and child health and emergencies.</li> <li>3. The prevailing socioeconomic challenges have affected the quality and quantum of support to older persons.</li> <li>4. The increased number of orphans and vulnerable children who were delinquent worsened the mental health of older persons</li> </ol>

### 1.6.1 Theoretical framework

The Theoretical framework underpinning the strategy development is described in Figure 1. It assumed that if policies and legislations were in place, functional to support health entitlements of older persons and there is an age-friendly social environment where health delivery was aligned to needs of older persons, this would ensure functional ability of older persons would be maintained at optimum level. Using results from the situation analysis and the theory of change assumptions, the goals, strategic objectives and strategies were developed during two critical meetings with stakeholders who were familiar with the needs of and actively working with older persons in Zimbabwe.

**Figure 1: Theory of Change for the Healthy Ageing Strategy**





## 2 Strategic Plan 2017-2020

### 2.1 Vision

The vision of the NHAS is: **An environment where healthy ageing is guaranteed to achieve functional ability of older persons.**

The vision acknowledges that action for healthy ageing must take place across the life-course and also across sectors, ensuring an environment that supports older people to remain healthy, active, empowered and socially engaged. This vision commits to building health systems that are oriented to provide older people with integrated services and information that meet their needs.

#### 2.1.1 Goals

There are two overarching goals.

- 1. Create an enabling age friendly environment for the provision of quality and integrated health services for healthy ageing.**

Although Zimbabwe had robust legal instruments guiding provision of social services to older persons, these were not harmonized. In addition, there is need to strengthen the legislation and ensure health is guaranteed as a right in both the constitution and Act. The legislative and policy framework should provide a basis for health system reforms that improve responsiveness to the health needs of older persons and support prioritization of emerging health challenges that undermine healthy ageing. Age-friendly community and family environments constitute important spheres for older persons to live an engaging life. Such an environment sees older persons as an opportunity and the health of older people as a resource for society.

- 2. Strengthen the provision of quality and integrated health services for healthy ageing.**

A health system that provides quality and integrated services and information that meets needs of older persons facilitates healthy ageing. Through this goal the strategy will support measures to build capacity of health workers within the Primary Health Care model to care for older persons and supply of commodities and technologies that enhance their care.

### 2.2 Strategic Objectives

The strategy will be implemented through five strategic objectives aligned to the WHO GSAP:

- Strategic Objective 1: Commitment to action on healthy ageing;
- Strategic Objective 2: Align health systems to the needs of older persons;
- Strategic Objective 3: Develop age-friendly environments;
- Strategic Objective 4: Strengthen long-term care; and
- Strategic Objective 5: Improve measurement, monitoring, and research.

Table 2 describes the logic link between the goals and the strategic objectives.

**Table 2: Link between goals and strategic objectives**

Goals	Strategic objective
<b>Goal 1:</b> Create an enabling age friendly environment for the provision of quality and integrated health services for active ageing	<ul style="list-style-type: none"> <li>• Strategic Objective 1: Commitment to action on healthy ageing</li> <li>• Strategic Objective 4: Strengthen long-term care</li> </ul>
<b>Goal 2:</b> The provision of quality and integrated health services for active ageing	<ul style="list-style-type: none"> <li>• Strategic Objective 2: Align health systems to the needs of older persons</li> <li>• Strategic Objective 3: Develop age-friendly environments</li> <li>• Strategic Objective 5: Improve measurement, monitoring, and research</li> </ul>

## 2.3 Priority Areas for Zimbabwe

### 2.3.1 Commitment to action on healthy ageing

Generally, Zimbabwe has adequate legal and policy framework that provides for a conducive enabling environment at all levels that enable healthy and positive ageing. This framework is anchored on the international and regional legal instruments that include the United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR); International Covenant on Civil and Political Rights (ICCPR); Convention on Eradication of all forms of Discrimination against Women (CEDAW); and Convention on the Rights of Child. At the regional level, there is the African Charter on Human and Peoples' Rights; the Protocol to the African Charter on Women; and SADC Protocol on Gender and Development. There are non-legally binding frameworks such as the Madrid Declaration and WHO GSAP. The Zimbabwe's Constitution has domesticated these legal instruments. At the national level, the main statute that deals with the older person is the Older Persons Act. However, this Act is not yet aligned with the Constitution and international and regional human rights instruments. It is administered and implemented by the Ministry of Labour, Public Service and Social Welfare. Other statutes that address older persons' issues include the Public Health Act that is administered and implemented by the Ministry of Health and Child Care. The National Social Security Act is administered by the Ministry of Labour, Public Service and Social Welfare and implemented by National Social Security Authority (NSSA). The various legislation and their implementation bodies represent a fragmented institutional framework for addressing the health needs of older persons. This presents challenges in implementation resulting in uncoordinated interventions.

Despite this elaborate framework, there remains insignificant funding for older persons health. The limitations in funding have resulted in very few non-governmental organisations such as HelpAge International, Island Hospice, and Centre for Community Development Solutions (CCDS) implementing programmes for older persons. Efforts to increase focus on older persons are hamstrung by the inadequacies of the legal framework whose language is not framed in a rights language (to facilitate legal enforcement) and thus devoid relevant bodies of delivering on entitlements for older persons. The Older Persons Act has not been fully implemented due to lack of financial resources.

There are also inconsistencies in the legislative framework. The Constitution and Older Persons Act provide different definitions of older persons. An older person is defined by the Zimbabwe Constitution as a person aged from 70 years while the Older Persons Act defines an older person as a

person aged 65 years and above. These definitions are not aligned with the UN, WHO and AU definitions of an older person which is 60 years and above.

Zimbabwe is still to ratify and domesticate the AU Protocol on Healthy Ageing. Such an action will enhance efforts to refine the legal and policy framework to be more responsive to the needs of older persons.

#### *2.3.1.1 Strategic actions for strategic objective 1*

- Develop a multi-sectoral policy document that guides the provision of social services to older persons in Zimbabwe.
- Increase older persons' access to evidence based health interventions for promoting health:
  - Medicines and commodities
  - Skilled health care workers
  - Research and development.
- Review legislation for older persons to develop a law on universal pensions for all older persons.
- Review and amend the Constitution to adopt 65 years as the definition of older persons in Zimbabwe. Align the Older Persons Act of 2012 to the Constitution to include the rights of older persons.
- Advocate for Zimbabwe to ratify and domesticate the AU Protocol on Healthy Ageing.
- Set up an accountability framework within the context of enhancing the functional ability of older people that puts the individual in the centre and serves to unify disease or condition specific targets and those across multiple sectors.
- Create formal structures to enable active participation of older persons in health promotion, for example, include older persons in health centre committees
- Advocate for the creation of a line budget for older persons' care and support within the Ministry of Health and Child Care.

#### *2.3.2 Align health systems to the needs of older persons*

The provision of access to integrated services that meet the needs of older persons is supported by: 1) health workers with appropriate skills; 2) affordable services and financial protection; and 3) access to needed health technologies of assured quality. These are dependent on the effective functioning and support of the health sector leadership and governance.

The country's health delivery system is premised on the Primary Health Care (PHC) approach. The national health strategy (NHS) operationalise the PHC approach for the MoHCC. The major focus of the NHS has remained prioritising preventive services. Health services are provided at all levels from community level through village health workers who refer clients to clinics. Clinics refer patients to tertiary hospitals through the district and provincial hospitals. At the various referral levels, the care for older persons varies with minimal care provided to older persons at clinic level. Key health care system challenges include shortage of human resources, lack of capacity for health service providers to deal with older persons' health needs and lack of medicines for most NCDs affecting older persons. In rural areas, older persons rely on services provided by Government and rural primary healthcare centres. In urban areas, older persons heavily depend on City Council Clinics for health

care but these facilities are underfunded. Palliative care services are available mainly in urban settings. The WHO reports that malignancies and other chronic debilitating illnesses were major causes of death among older persons in rural and urban Zimbabwe. Community health workers remain programme specific focused on specific programmes e.g. immunisations, reproductive health, provision of Anti-Retroviral Treatment (ART). They lack training in the provision of comprehensive care for older persons.

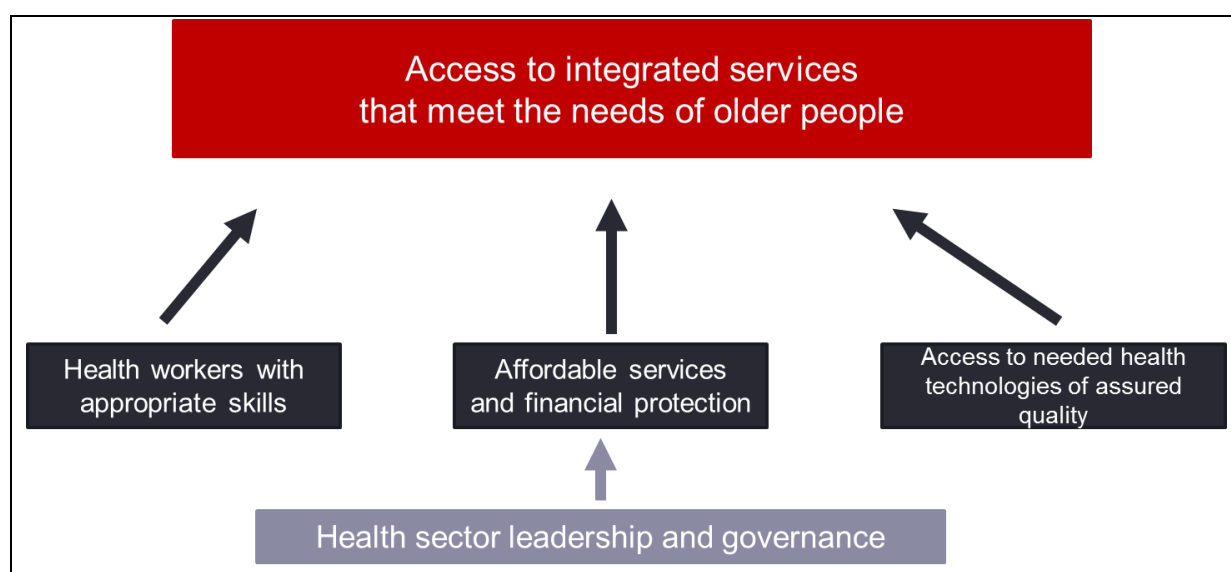
There is no training of medical personnel on Geriatric medicine to enable provision of the primary health care for older persons. Though treatment for chronic diseases is available, it is not universally affordable. The situational analysis noted insignificant funding for Geriatric medicine, that few health centres offered preventative, curative and health promotion services for most common diseases afflicting older persons such as cataracts, cancers, arthritis, hypertension, diabetes and depression.

Older persons did not participate in the health planning system at local to national level. In the health centres visited for the situation analysis, it was noted that the Health Centre Committees (HCCs) and other community development committees do not involve older persons in their activities. This is reinforcing a feeling of neglect among older persons. Perceptions of stigma and discrimination by nursing staff at health facilities are evident among the older persons.

#### 2.3.2.1 Strategic actions

In order to align health systems to needs of older persons, there are several critical elements that need to be put in place. A strong health governance and leadership system that incorporates and prioritises needs of older persons needs to be established. This becomes the anchor on which the other element (health worker capacity, affordability of services and financial protection and access to needed health technologies) are built on. Health worker capacity in Geriatric medicine is critical to support quality health service delivery for older persons. Combined with affordability of services for older persons, especially universal free service or through health insurance or other social protection measures, such strategies improve access to health. Embracing technologies that improve access to health information and services for older persons can also greatly contribute to access and utilisation of such services and information. Figure 2 summarises the conceptual framework.

**Figure 2: Strategies for increasing access to integrated health services and information**



### **Health Sector Leadership and Governance**

- Put in place measures that ensure older persons participate in planning of the health service delivery and programmes that support them. Attention to gender dimensions of access to health will be incorporated in the planning systems.
- Review health information systems to collect data on older persons presenting at public health facilities.
- Enhance the quality of service delivery by tailoring services to the specific health needs of older persons and stimulate quality assessment and exchange of good practices on ways to bridge care interfaces, including in the areas of self, family and community care.

### **Health Workers with Appropriate Skills**

- Motivate the training of Geriatric medicine in Zimbabwe at all levels of the health care delivery system.
- Enhance health workforce capacity to respond to the health needs of the ageing population, by addressing the quantity and skill mix of workers, enhancing their understanding of the link between healthy behaviours across the life-course and good health in older age, and upgrading their skills and capacity to care for Older persons who are frail, ill or disabled.

### **Affordable services and financial protection**

- Government should increase funding towards nutrition programmes and target all older persons regardless of drought prone risk.
- Re-engineer primary health care services to reduce referral of older persons to tertiary facilities.
- Integrate nutrition and health care programmes through introducing a nutritionist at every primary health care facility.
- Advocate for greater inclusion of older persons in current social protection instruments such as the Harmonised Social Cash Transfer.

### **Access to needed health technologies of assured quality**

- Support capacity building and availability of technologies that enable screening of the most common diseases that affect older persons.
- Enable the Older persons to maintain their independence and to access care at home and in communities by promoting innovative health technologies, including in eHealth and mHealth.

#### **2.3.3 Develop age-friendly environments**

The current infrastructure, including Government Departments, are not user friendly to older persons and this has affected access to the few social services that are available. There is a policy that promotes preferential treatment for older persons especially the older persons do not stand in

queues at banks, healthcare facilities, public delivery centres and for buses. Few health centres have patient flow arrangements that allow for prioritisation of older persons.

The signs at most healthcare centres are legible but the assumption is that the older persons are both literate and good eye sight for them to read these signs. It was established that some health centres had wheelchair ramps and rails for easy access by older persons. They also had waiting areas with benches where the older persons could sit while waiting for their turn to be attended to. However, the waiting areas in the rural areas had only roof coverings this resulted in older persons exposed to elements such as wind and rain. Other healthcare centres had no waiting areas for patients that include older persons. The public toilets that were available were not age friendly. In most rural health facilities the toilets had squatting holes, and not enough lighting for them to see. Though the toilets were separated by sex they are not wheel chair accessible.

The healthcare facilities are offering integrated management of sexual and gender based violence into service provision. Some healthcare centres used CHWs to follow up older persons with chronic illnesses. The follow ups were to monitor their health status, promote adherence to treatment and to provide basic nursing care. However, there were no records for the follow ups.

#### *2.3.3.1 Strategic actions*

- Improve advocacy on older family support mechanism for vulnerable population groups especially Older persons;
- Engage all sectors such as Transport, Education, Health, Industry and ICT to develop an Older persons national policy that will address all the needs of Older persons;
- Re-engage older persons and tap into their wisdom, skills and knowledge;
- Mainstream health for older persons in all national policies and sectors to ensure age friendly environments such as social protection, transport, employment, housing, water and sanitation and urban and rural planning
- Advocate for Health Centre Committees to include older persons including the needs of older women.
- Promote healthy behaviours for the prevention of targeted specific conditions through raising awareness that healthy behaviours adopted early on in life can improve health in old age.
- Strengthen self-care and family and community support for healthy ageing, including linking with the disability agenda.
- Facilitate a psychological support programme for older persons caring for orphans.

#### *2.3.4 Strengthen long-term care*

The situational analysis conducted established that the potential sources of care for older persons include formal social security, family and community support. The majority of older persons that were formally employed and made contributions to pension funds had their investments eroded by hyperinflation prevailing in the country until 2008. Older persons have limited knowledge of how to access pension benefits post-employment. Not all older persons that are in need of the government harmonised social cash transfer received the transfer. Older persons with disabilities have challenges in collecting cash from the Post office. It was noted that older persons without identification

particulars had challenges accessing social security services including placement into homes resulting in increased risk of destitution. Older persons living as destitute were mainly those never employed or employed without any pension contributions, such as smallholder farmers, farm workers. Deteriorating socio-economic conditions have collapsed the “Ubuntu” spirit that spurred care of the less privileged in the community including older persons.

Old age was associated with witchcraft especially if the older persons had wrinkles. Due to dementia, some older persons are found with no clothes raising alarms that they may be witches. Those that were victimized and neglected were mostly females. The allegations undermined the care of older persons by relatives and the community.

The care of older persons was complicated by the orphan burden. Due to the AIDS pandemic, the burden of care for OVC was left on older persons with limited government support. Age difference between older persons and OVC in their care hampers adequate parental care. The situational analysis identified an emerging issue of increased delinquency among children under the care of older persons as compared to those under the care of younger caregivers. The associated stress of caring for these children increases the health risk of older persons. Older persons with orphans were associated with poor health. The WHO case study for Zimbabwe found out that 66% of older persons were in poor and very poor health. The caregivers for older persons suffer from emotional and physical illnesses such as worry/stress, high blood pressure, headache, dizziness, chest pains, heart problems, asthma and stomach problems.

Despite weakening of the community and family based care system in Zimbabwe, they represent one of the most effective systems for managing long term care of older persons. Government policy and culture practices promote the use of family and community based systems to care for older persons and orphans and vulnerable children. However, the caring of older persons under the family and community system is viewed as burdensome and may lead to caring fatigue and burn out. Perceptions on institutionalising older persons from key informants suggested that the available older persons’ homes required supporting before coming up with new ones. In addition, the national practice of ensuring older persons are taken care of from their homes was the most preferred method in Zimbabwe.

The majority of homeless older persons who are institutionalised in Older People’s Homes were of foreign origin especially from Malawi, Zambia and Mozambique who provided labour during the Federation in 1957 – 1965. Given their lack of citizenship status they are excluded from benefiting from the framework for care of older persons.

There is a policy of free medical consultation and vital medicines for persons aged 65 and above that promotes access to services. However, the absence of some services undermines health seeking behaviour. Medicines for chronic diseases such as diabetes, hypertension, cardiovascular accidents (stroke), arthritis, poor eye sight from cataracts, human immunodeficiency virus (HIV) and malnutrition are not always available at the local public health facilities. Assisted Medical Treatment Orders (AMTO) to be used for health for the indigent, are accessible to older persons, 65 years and above. However, the AMTO cannot be used in private health facilities or pharmacies where medicines are found. Older persons are also exempted from standing in queues in banks and health facilities.

Older persons experience limited access to health services due to long distances to public health facilities and lack of money to pay for key health services and medication such as X-rays, blood tests



and other investigations especially in local authority facilities. This is evidence of a health system

- Harmonise training of community health workers and other community volunteers to include long term care;
  - Develop a programme that supports long term care of older persons based on an explicit partnership with families, communities, other care providers, and the private sector and reflect the concerns and perspectives of these stakeholders;
  - Develop and disseminating care protocols or guidelines that address key issues in the provision of quality long term care for older persons; and
- that does not respond to the holistic older persons' health needs.

#### 2.3.4.1 Strategic actions

- Scale up and formalise community initiatives that include older persons community structures and groups that act as a resource for caregiving and other community development activities.

#### 2.3.5 Improve measurement, monitoring, and research

In general, Zimbabwe has a robust health information management system which comprises the District Health Information System (DHIS2) and health surveys (Demographic Health Surveys (DHS), malaria indicator survey, Health accounts etc.). However, data on older persons is not routinely collected affecting estimation of health needs of older persons.

##### 2.3.5.1 Strategic actions

- Use the available mechanisms to collect gender and age differentiated health data on older persons. These include the DHIS2, census, DHS, and National Health Accounts.
- Develop a research agenda to provide evidence on gender sensitive healthy ageing and effectiveness policy and programmatic interventions.
- Use evidence from research to review and formulate policies and programmes for healthy ageing.

## 3 Implementation of the Strategy

### 3.1 Coordination

The strategy will be coordinated by the Ministry of Health and Child Care through the Department Epidemiology and Disease Control.

The MoHCC will be responsible for the day to day coordination of strategy implementation. Progress on the strategy implementation will also be closely monitored by the Older Persons Board created by the Older Persons Act of 2012.

A strategy coordination committee, the Healthy Ageing Committee, will be established to oversee implementation of the strategy. The committee will be chaired by the MoHCC through the Department of Epidemiology and Disease Control. It will comprise: MoHCC, representatives from the Older Persons Board, representatives from CSOs, representatives from Ministry of Labour Public Service and Social Welfare, Ministry of Gender, Community Development and Women's Empowerment, International Labour Organisation, and NSSA.

The Healthy Ageing Committee, will be responsible for the following:

1. Oversight on strategy implementation;
2. Oversee development of strategy implementation plan and its costing;
3. Policy and legislative recommendations and advocacy to support healthy ageing;
4. Commissioning of evidence gathering on healthy ageing; and

5. Monitoring and evaluation of strategy.

### 3.2 Monitoring and Evaluation Framework

Monitoring and evaluation of this strategy will be integrated within the current health information system. Current tools will be revised to capture health information for the aged. Indicators to measure performance of the strategy are presented in Table 3.

**Table 3: Performance measures for the strategy**

Result level	Indicators	Source	Responsibility for reporting	Frequency of
<b>Goals</b>				
<b>Goal 1:</b> Create an enabling age friendly environment for the provision of quality and integrated health services for active ageing	Number of laws and policies that support healthy ageing that are functional <sup>12</sup>	Older persons Board	MoHCC	Annually
	Proportion of community health workers with knowledge of care for older persons <sup>13</sup>	Baseline survey, mid-term and end of strategy evaluation	MoHCC	YR 1, Y3 and YR5
	Proportion of households caring for older persons with knowledge on how to care for older persons <sup>14</sup>	Mid-term review and Demographic Health Survey	MoHCC	Every five years
	Funding provided by government for older persons <sup>15</sup>	National budget	MoHCC	Annually
<b>Goal 2:</b> The provision of quality and integrated health services for active ageing	Proportion of health facilities offering integrated services <sup>16</sup>	DHIS2	MoHCC	Quarterly
	Number of health workers in-post trained in	DHIS2	MoHCC	Quarterly

<sup>12</sup> Functionality is defined by full resourcing of institutions administering provisions of the law with annual plans fully implemented

<sup>13</sup> Community workers demonstrating geriatric and gerontological competencies

<sup>14</sup> Knowledge is based on a positive response to three scenarios of older persons care.

<sup>15</sup> Budget lines specific for older persons will be reviewed for responsible ministries: MoHCC, MoLPSSW, MWAGCD etc.

<sup>16</sup> A package of services for older persons will be determined and used to determine the indicator

Result level	Indicators	Source	Responsibility for reporting	Frequency of
	geriatric and gerontological competencies			
	Number of Older persons visiting health facilities for care	DHIS2	MoHCC	Quarterly
<b>Strategic objectives</b>				
Strategic Objective 1: Commitment to action on healthy ageing	Legislation pertaining to older persons aligned to the new constitution	Older Persons Board	MoHCC	Annually
Strategic Objective 2: Align health systems to the needs of older persons	Number of health colleges training on Core geriatric and gerontological competencies	Health Training Colleges	MoHCC	Annually
	Proportion of Health Centre Committees with older persons' representatives.	DHIS2	MoHCC	Quarterly
	Proportion of primary health centres with no stock outs of key medicines for older persons <sup>17</sup>	DHIS2	MoHCC	Quarterly
Strategic Objective 3: Develop age-friendly environments	Proportion of health facilities with appropriate facilities for older persons <sup>18</sup>	DHIS2	MoHCC	Quarterly
	Proportion of older persons able to pay for medicines all the time	DHS	MoHCC	Every five years
	Average distances travelled by older persons to receive health care	DHS	MoHCC	Every five years
Strategic Objective 4: Strengthen long-term care	Number of districts with community based care	Older persons Community Based Care Programme records	MoHCC	Annually

<sup>17</sup> Minimum schedule of medicines for older persons to be determined

<sup>18</sup> An index will be developed to measure appropriate facilities.

Result level	Indicators	Source	Responsibility for reporting	Frequency of
	Number of community health workers trained in long term care of Older persons	Training Records for community health workers	MoHCC	Quarterly
	Quality of care standards in place	MoHCC	MoHCC	Annually
Strategic Objective 5: Improve measurement, monitoring, and research	Proportion of health facilities collecting age disaggregated data	DHIS2	MoHCC	Quarterly
	Number of regular, nationally representative population surveys of older people that assess functional ability; intrinsic capacity; need for health; long-term care; need for broader environmental changes in Zimbabwe	ZIMSTAT	MoHCC	Annually

### 3.1.1 Reporting

Disaggregated data for older persons will use available data collection systems. The MoHCC, Epidemiology and Disease Control (EDC) will review and modify the current data collection tools to include disaggregate age groups up to more than 60 years. The monitoring system of the strategy shall comprise two reports:

1. Quarterly Report
2. Annual Report

#### Quarterly Reports

The quarterly report will provide information on utilisation of health services by older persons disaggregated by age and sex. It will highlight the availability of key medicines for older person and skills and knowledge among health workers at facilities. Challenges and opportunities for entrenching healthy ageing will be identified.

#### Annual Report

An annual report which provides a summary of the progress on key indicators in Table 3 will be provided. As with the quarterly report the annual report will provide information on challenges, opportunities and threats for the success of the strategy.

### 3.1.2 Evaluation Framework

The Zimbabwe National Healthy Ageing Strategy shall be evaluated. A Mid-term evaluation will be implemented midway during implementation with a Final Evaluation at the end of the strategy period.

Special evaluative studies will also be commissioned by the Healthy Ageing Committee such as impact and value for money assessment of promising models of care to build evidence for scale up.

## Annexe 1. Participating organizations During the Strategy Development Process

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