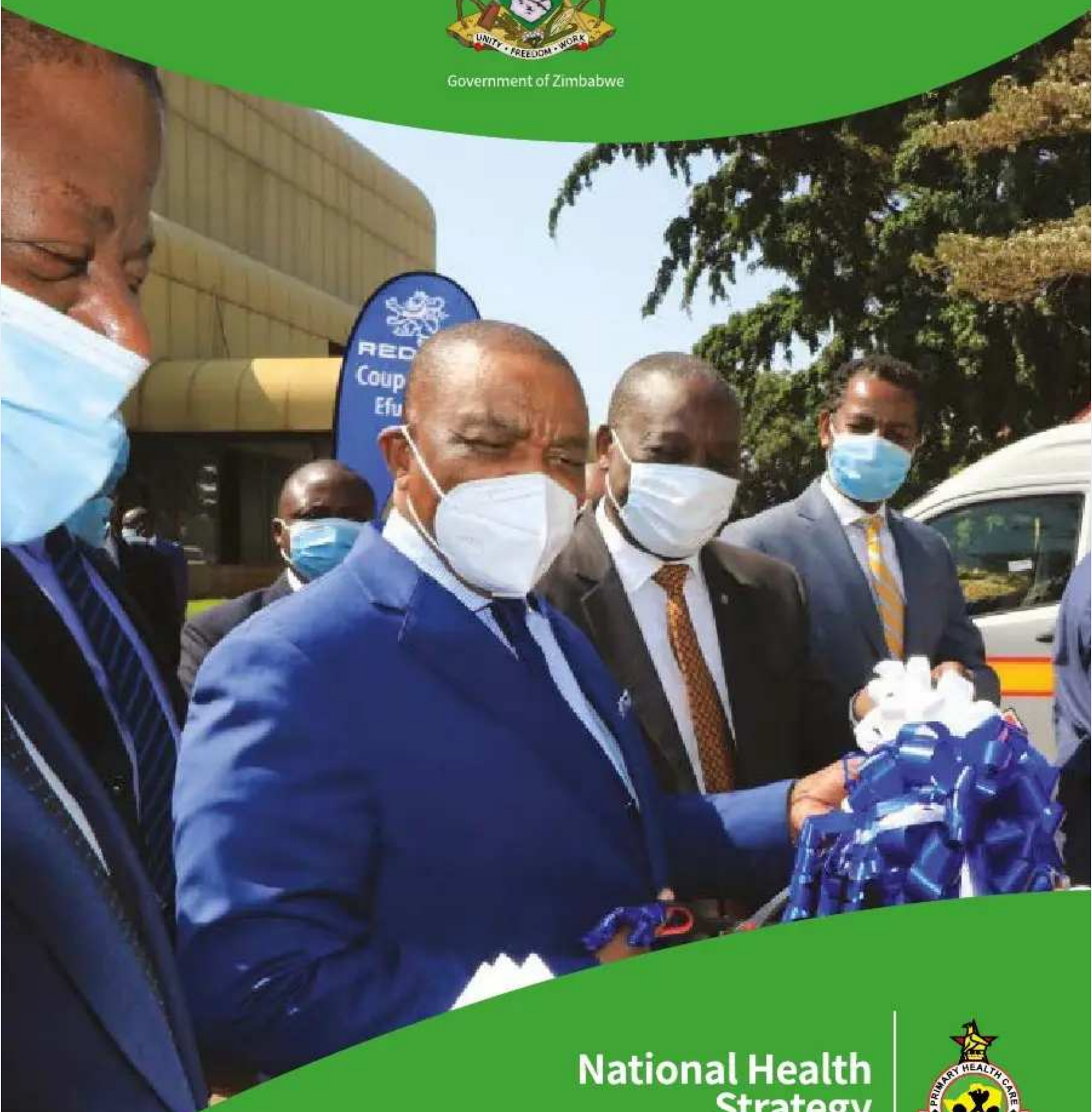
Government of Zimbabwe



National Health Strategy 2021-2025

Ministry of Health and Child Care

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Foreword

The National Health Strategy (NHS) 2021-2025 is a deliberate effort by Government of the Republic of Zimbabwe to improve the health and wellness of the population and eventually ensure universal access to health services. The Strategic focus is on building a resilient and sustainable health system premised on a health in all policies approach by Government. The Health Sector is expected to be a pillar of national development, that is, the National Development Strategy 1: 2021-2025 (NDS1) recognised health as an investment priority.

This National Health Strategy (NHS) 2021-2025 seeks to consolidate the gains made by the previous investments by government, development partners, the private sector, and communities at large. I am aware of the emerging threats that could easily erode the gains made, but this National Health Strategy (NHS) 2021-2025 presents an opportunity to all stakeholders to reset the health sector in the sustainability and resilient mode.

The National Health Strategy (NHS) 2021-2025 identified eleven (11) investment priorities, the successful implementation of which, will result in marked public health and wellness improvement.

The success of this Strategy hinges on sincere and committed participation of all stakeholders. My Ministry commits to create the enabling environment for health service delivery. Implementation of health sector reforms will remain a priority. Addressing determinants of health remains a priority for government.

The public health emergencies experienced in recent years allowed us to realise the urgent need to increase the scope of the health sector. Health is broader than the Ministry responsible for health. To this effect my Ministry will ensure that the Health Sector Coordination Framework is implemented.

I wish to recognise and acknowledge the tremendous support by all stakeholders in the sector. Investment by development partners and support towards public health is well appreciated and I expect that to continue. Let me assure you that Government for the next years to 2030 seeks to increase domestic funding towards health. Evidence from our resource mapping exercise is already pointing to a positive trend.
I thank you.

HON. GEN. (RETD). DR. C. G. D. N. CHIWENGA 'GCZM'
Vice President and Honourable Minister of Health and Child Care

Acknowledgements

The success of putting together this National Health Strategy (NHS) 2021-2025 was a result of the coordination efforts of the various stakeholders in the health sector. Without their invaluable commitments and participation, this milestone would not have been achieved. The Ministry gratefully acknowledges the support and participation from various Government Ministries and Departments, Development Partners, Non-Governmental Organisations, Academia, Health Professional Associations and the Civil Society Organisations.

Appreciation is rendered to the Ministry of Health and Child Care Directorates. Much appreciation is rendered to the Division of Policy Planning Monitoring and Evaluation (PPM&E) under the strategic leadership of the Chief Director PPM&E who through the Directorate of Policy and Planning led the whole process from its initial stages up to the end. Special mention goes to the Monitoring and Evaluation Directorate for the immense effort they made for spearheading the development of the Monitoring and Evaluation Framework of the strategy.

The technical team led by Officers from the Policy and Planning department's efforts are greatly appreciated as they dedicated their time and efforts in the coordination and putting together of this document.

The Ministry would also like to acknowledge the contribution of technical members from various, departments and agencies for their dedication and expertise to the whole exercise. The Ministry would also like to thank its technical partners for their role in the development of this document. More specifically the Ministry is grateful to WHO for the technical and financial support they provided. Special mention is also extended to UNICEF for the technical and financial support provided through the Health Development Fund donor pool and other development partners.

Air Commodore (Dr) Jasper Chimedza
Secretary for Health and Child Care

Acronyms

AHFOZ	Association of Health Funders of Zimbabwe
AMTO	Assisted Medical Treatment Order
ART	Antiretroviral Therapy
CHS	Community Health Strategy
COVID-19	Coronavirus Disease 2019
CSOs	Civil Society Organisations
CSV	Child Sexual Violence
DHIS2	District Health Information Software version 2
EDLIZ	Essential Medicines List of Zimbabwe
EHR	Electronic Health Records
EPI	Expanded Programme for Immunisation
GAVI	Gavi The Vaccine Alliance
GDP	Gross Domestic Product
GF	Global Fund
HDF	Health Development Fund
HN	Health and Nutrition
HMIS	Health Management Information System
HRH	Human Resources for Health
HSB	Health Services Board
HSSP	Health Sector Strategic Plan
IACCH	Inter-Agency Coordination Committee on Health
IHR	International Health Regulations
JEE	Joint External Evaluation
LMIS	Logistics Management Information System
MASCA	Medicines and Allied Substances Control Act
MCAZ	Medicines Control Authority of Zimbabwe
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOFED	Ministry of Finance and Economic Development
MOHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council of Zimbabwe
MTR	Mid-Term Review
NAC	National AIDS Council
NATPHARM	National Pharmaceutical Company of Zimbabwe
NCDs	Non-Communicable Diseases
NDS	National Development Strategy
NHA	National Health Accounts
NHI	National Health Insurance
NHS	National Health Strategy

Acronyms

NIHR	National Institute of Health Research
NMTPAC	National Medicines and Therapeutic Policy Advisory Committee
NRRT	National Rapid Response Team
NTDs	Neglected Tropical Diseases
PEN	Package for Essential NCDs
PEPFAR	President's Emergency Plan for AIDS Relief
PHEOC	Public Health Emergency Operations Centre
PLHIV	People Living with HIV
PPM&E	Policy Planning Monitoring and Evaluation
RBF	Results Based Financing
RMNCAHN	Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition
SARA	Service Availability and Readiness Assessment
SARS COV2	Severe Acute Respiratory Syndrome Coronavirus type 2
SDGs	Sustainable Development Goals
SGBV	Sexual Gender Based Violence
TGHE	Total Government Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Emergency Fund
VAC	Violence Against Children
VHW	Village Health Worker
VIAC	Visual Inspection with Acetic Acid and Camera
VRAM	Vulnerability Risk Assessment and Mapping
WHA	World Health Assembly
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Needs
ZACH	Zimbabwe Association of Church Related Hospitals
ZAPS	Zimbabwe Assisted Pull System
ZDHS	Zimbabwe Demographic Health Survey
ZIMSTAT	Zimbabwe Statistics Agency
ZNASP	Zimbabwe National HIV/AIDS Strategic Plan

Executive Summary

The Country's Health Sector Strategic focus is guided by the overall Vision 2030 that seeks to transform Zimbabwe into a middle income economy by 2030 and the National Development Strategy 1: 2021-2025 (NDS1). The National Development Strategy 1 [2021-2025] identified health as being central to human happiness and well-being making it an important contributor to economic progress, as healthy populations live longer, are more productive, and save more. The National Health Strategy (NHS) 2021-2025's vision is to ensure the highest possible level of health and quality of life for all citizens of Zimbabwe by 2030 and this is anchored on the NDS1 [2021-2025] identified Ten (10) health outcomes. These 11 outcomes will provide the strategic direction for the strategy over the five-year period.

This NHS [2021-2025] builds on the NHS [2016-2020] by addressing identified existing gaps following the Mid-Term Review of the NHS [2016-2020] and, more importantly, seeks to sustain the gains achieved thus far through a comprehensive response to the burden of disease and strengthening of the health system to deliver quality health services to all Zimbabweans. This strategy aims to strengthen the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Zimbabweans. It targets to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of specific health impact targets. The strategic directions are structured around 10 outcomes, and 4 key result areas.

Leadership and governance are critical factors in ensuring efficient and effective direction and management of the health sector. In the context of this strategy, leadership is understood to mean stewardship, while governance refers to the systems and structures for sector coordination, participation, transparency and accountability. The performance of the sector in the area of leadership and governance is analysed along the following key areas: public policy, legislation and regulation; organisation and management; planning and resource mobilisation; transparency and accountability; and monitoring and evaluation.

The main sources of health care financing in Zimbabwe are, government budget appropriations and donor funding with household health expenditure coming through out-of-pocket expenditure. Although government funding has been the largest contributor to total health funding, however the funding still falls short of the requirements of the sector. Total government health expenditure (TGHE) as a proportion of total expenditure has been slightly improving over the years from 2015. External support is currently targeted towards vertical programs such as HIV and AIDS, malaria and TB. Vertical donor support is characterised by certain rigidities and cannot be moved to other priority areas less favored by donors. The private health insurance is also in existence in Zimbabwe and is characterised by several employer based and voluntary medical schemes. To bridge the financing gap, the Government is currently working on the establishment of a National Health Insurance (NHI) as a complimentary source of health financing.

The 2014 and 2019 Multiple Indicator Cluster Surveys (MICS 2014 & 2019) have shown that despite the remarkable rise in institutional delivery from 79.6 in 2014 to 85.5% in 2019, the neonatal mortality rate has risen from 29 per 1000 live births in 2014 to 32 per 1000 live births in 2019.

However, other child mortality indicators, infant mortality rate and under five mortality rate have shown some signs of declining over the same period. Generally, the coverage of Reproductive, Maternal, New-born, and Child Health (RMNCH) interventions have been improving over the 5-year period from 2014 to 2019 and has varied from 71.4% (4 ANC visits) to 82% for mothers and 91% for new born baby (PNC) (MICS 2019). However, despite this high PNC coverage, there is minimal adherence by health facilities to the national post-natal care guidelines which stipulate that postnatal mothers and babies should be monitored in a health facility for at least 72 hours. MMR declined from 651 maternal deaths per 100 000 live births in 2014 to. 462 per 100 000 live births (MICS 2019). There is need to accelerate this decline as it is still high.

The causes of maternal mortality remain bleeding after delivery, pregnancy induced high blood pressure and infection (puerperal sepsis) with HIV being the leading indirect cause. Family Planning services have seen notable inequities (geographical, demographic and socio-economic) and poor method mix, highly skewed towards the short-term methods especially the pill with mCPR at 68% and the unmet need for family planning being at 8.6% against the target of 6.5% by 2020.
National immunisation coverage has shown that the proportion of children who received Penta 3 below one year rose from 89% (ZDHS 2015) to 90.6% (MICS 2019). Districts with DTP3 coverage >80% increased to 59/63(93.6%) in 2018 up from 54/63 (86%) in 2017. Dropout rates for all antigens remained below 10% in all antigens except for MR1 – MR2 that was 11%.

Communicable diseases still constitute a major share of the disease burden affecting Zimbabweans. HIV and AIDS still remain the main burden, with HIV prevalence rate of 12.8% among adults aged 15-49 years (15.4% among females and 10.1% among males) (UNAIDS 2018). Among pregnant women in antenatal care (ANC), HIV prevalence is 14.2%. Zimbabwe as a country has made significant progress towards the 95-95-95 targets. In 2019, 91% of people living with HIV (age 15 years and older) knew their status, 93% of these were on antiretroviral therapy (ART) and 86% of those on ART were virally suppressed. The estimated TB incidence in 2018 was 210 per 100,000 population (Global TB Report 2019). Two thirds (62%) of notified patients were co-infected with HIV in 2018. Males bear the brunt of disease burden, particularly the economically productive 25-44-year age category due to smoking behaviour and work environment.

Malaria continues to be a key driver of morbidity and mortality rates in Zimbabwe. Malaria transmission intensity has seasonal and geographic variation corresponding closely with the country's rainfall patterns and topography. Transmission is perennial in malarious areas, seasonal increases occur annually, with most transmission occurring during or just after the November to April rainy season. There is higher malaria transmission in the northern and eastern border regions, with more limited transmission in the central and south-western portions of the country. At the national level, annual incidence (cases per 1,000 population) has decreased substantially over the last 15 years, from 153 in 2004 to 19 in 2018.

Non-Communicable Diseases (NCDs) affect people of all ages and classes, and are currently the leading cause of deaths in the world. NCDs have similar risk factors, which are mainly attributable to lifestyles, such as physical inactivity, unhealthy diets, tobacco use, drugs and alcohol abuse. There is need to conduct comprehensive epidemiological studies to ascertain the burden of most NCDs in the population. However, hospital data indicate that NCDs are an emerging problem and requires urgent attention. In response to the challenges posed by non-communicable diseases, government has set up a NCDs Department at the Ministry of Health and Child Care.


NEVER
GIVE
UP

1 Introduction

HON. GEN. (RETD). DR. C. G. D. N. CHIWENGA 'GCZM'
Vice President and Honourable Minister
of Health and Child Care

Hon. Dr. John Chamunorwa Mangwiro
Deputy Minister of Health and Child Care

Air Commodore (Dr) Jasper Chimedza
Secretary for Health and Child Care

1.1 Background

The National Health Strategy (NHS) 2021-2025 was developed taking into consideration the challenges that the country has gone through. These include the economic instability since 2008, the change over from the first Republic, and the onset of the COVID 19 pandemic. These challenges had a negative bearing on the health sector. This confirms the intricate link between health and its social and economic determinants. The adoption of the 17 Sustainable Development Goals at the United Nations in 2015, paved the way for the historic adoption of the Political Declaration on Universal Health Coverage in September 2019. The SDGs provided the broad parameters by which Zimbabwe developed her health system with the objective of achieving UHC by 2030. This is a recurring theme throughout this National Health Strategy (NHS) 2021-2025.

Furthermore, the National Development Strategy 1: 2021-2025 (NDS1), provided the national perspective to health and wellness in Zimbabwe. The NDS 1 [2021-2025] identified ten (10) national outcomes for the National priority on Health and Wellbeing. These ten outcomes formed the basis of the priorities in the National Health Strategy (NHS) 2021-2025. The other national priorities established the much needed basis for addressing the key determinants for health and the reaffirmation of the Primary Health Care approach.

1.2 National Health Strategy 2021-2025 development process

The NHS [2021-2025] was developed in a participatory and scientific way ensuring that all views are represented. The Mid Term Review of the previous National Health Strategy complimented by other reviews formed the basis for the strategic interventions. A nationwide stakeholders consultative exercise was conducted to solicit the baseline and views of the Zimbabwean population.

Furthermore, important considerations were taken on board to guide development of the NHS [2021-2025]. Firstly, that objectives be set at a strategic level and that targets and Indicators be aligned to the SDGs and UHC and based on sector outputs and outcomes. Secondly, was to ensure person centred services and integrated service delivery. Thirdly, was to establish equity and access enhancing approaches targeting improvements among the rural and vulnerable populations. Fourthly, was that the NHS [2021-2025] would be developed in a participatory and inclusive process, and that it should meet international standards.

It was in that context that appropriate structures were set up to manage the process. The Steering Committee role was to oversee the development of the NHS [2021-2025]. It was chaired by the Permanent Secretary, with membership from Health Development Partners Group, six Ministries that have key roles in the health sector, Dean Medical School, Representative of UN Agencies and Health Services Board. The Task Team was put in place and its responsibility was to run the day-to-day work regarding development of the HSSP.

The eleven (11) Technical Working Groups identified were Communicable Diseases, Non-Communicable Diseases, RMNCAHN, Emergency preparedness, Service delivery includling community, HRH, Leadership, Governance and Accountability, Research, Innovation and Knowledge Management, Health Financing, HMIS and M & E, PSM. Their role was to do a situational analysis and proposed strategic interventions. These were then reviewed by the broader group of Stakeholders through an iterative process in developing the NHS [2021-2025].

The Stakeholders involved in the process were

- **Medical Schools and other Health Training Institutions.**
- **Government Ministries with key roles in the health sector.**
- **Local Authorities.**
- **Parliamentary Portfolio Committee on Health.**
- **Zimbabwe Association of Church related Hospitals and Elders.**
- **Health Professionals Authority and other Professional Councils (including Traditional Medical Practitioners Council).**
- **Health Services Board.**
- **Professional Associations.**
- **Private Sector Health Providers.**
- **Health Schemes (Medical Aid Societies).**
- **Non-Governmental Organizations/CSOs.**
- **Traditional Leaders.**
- **Health Development Partners.**

1.3 Geography and demography

The population of Zimbabwe is estimated to be 15, 473, 818 million (ZimStat medium scenario projection from 2012 Census) with 52% being female. This gives the country 0,19 percent of the global total population and ranked 74th in the world. Two thirds of the population is below the age of 25. The total fertility rate is 3,9 per woman. Life expectancy is 60 years (61 years for females and 58 for males).

Those who live in urban areas comprise 38 per cent of the population. Population density on average is 38 people per square kilometre.

1.4 Health Policy, Strategies and Health Service structure

In 1980 Zimbabwe adopted its health policy, 'Planning for Equity in Health' (MoH 1980). This was in response to the inequitable socioeconomic situation that existed in the country then. This policy has guided health development since then. This policy laid the foundation for Primary Health Care philosophy in the country.

This has been supported by five-year National Health Strategies, with the last two covering the periods 2011-2015 and 2016 to 2020. The Vision for the 2016-2020 National Health Strategy is to have the highest possible level of health and quality of life for all citizens. And the Mission is 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 (MoHCC 2016).

The health system has a five (5) tier structure, fundamentally based on the referral system, bottom to the top and top to bottom.

The first and lowest level is the Primary Care Level. This has a network of Health Centres/ Clinics/Rural Hospitals each serving a ward in rural areas and Polyclinics in urban areas. In addition, we now also have private clinics on farms and commercial entities such as industry or mines. The network of doctors and nurses' private surgeries falls under this level as well. This level coordinates the community health work.

The second is the Secondary Care level made up of a network of District Hospitals and equivalent hospitals such as Municipal Referral hospitals, mission hospitals among others. They offer emergency, ambulatory, and inpatient services. There is one such Hospital in each district.

Third is the Tertiary level made up of a network of Provincial Hospitals, one each per Province (except Harare and Bulawayo which are urban Provinces). These offer emergency, ambulatory and specialist inpatient services. The fourth level is the Quaternary level offering specialist inpatient services as well as University teaching facilities.

The highest newly introduced level is the high-level cutting edge Quinary level. This level was introduced to spearhead research and development with linkages with Higher and Tertiary Institutions, the manufacturing sector and the MOHCC new divisions of Biomedical Engineering Science and Pharmaceutical /Biopharmaceutical Production.

The number of facilities at each level are as shown in the table.

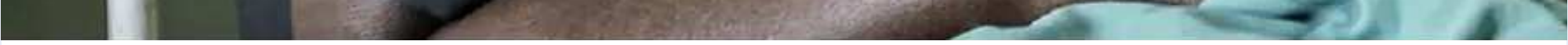

Table 1:Health Facilities by Category

Health Facilities		
Facility Level	Type and ownership of Health Facilities	**All facilities**
Quaternary	Government Central Hospitals	6
Tertiary	Government Provincial Hospitals	8
Secondary	Government District Hospitals	44
	Mission Hospitals	62
	Private Hospitals	32
Primary	Government Rural Hospitals	62
	Municipal Polyclinics	15
	Private Clinics	69
	Mission Clinics	25
	Local Authority Clinics	1122
	Urban Council/Municipal Clinics/FHS	96
	Government Rural Health Centre	307
TOTALS		**1848**

(MoHCC 2019)

1.5 Health status

The top causes of disease burden are as reflected in the diagram below. Communicable diseases occupy the top three places, followed by NCDs.

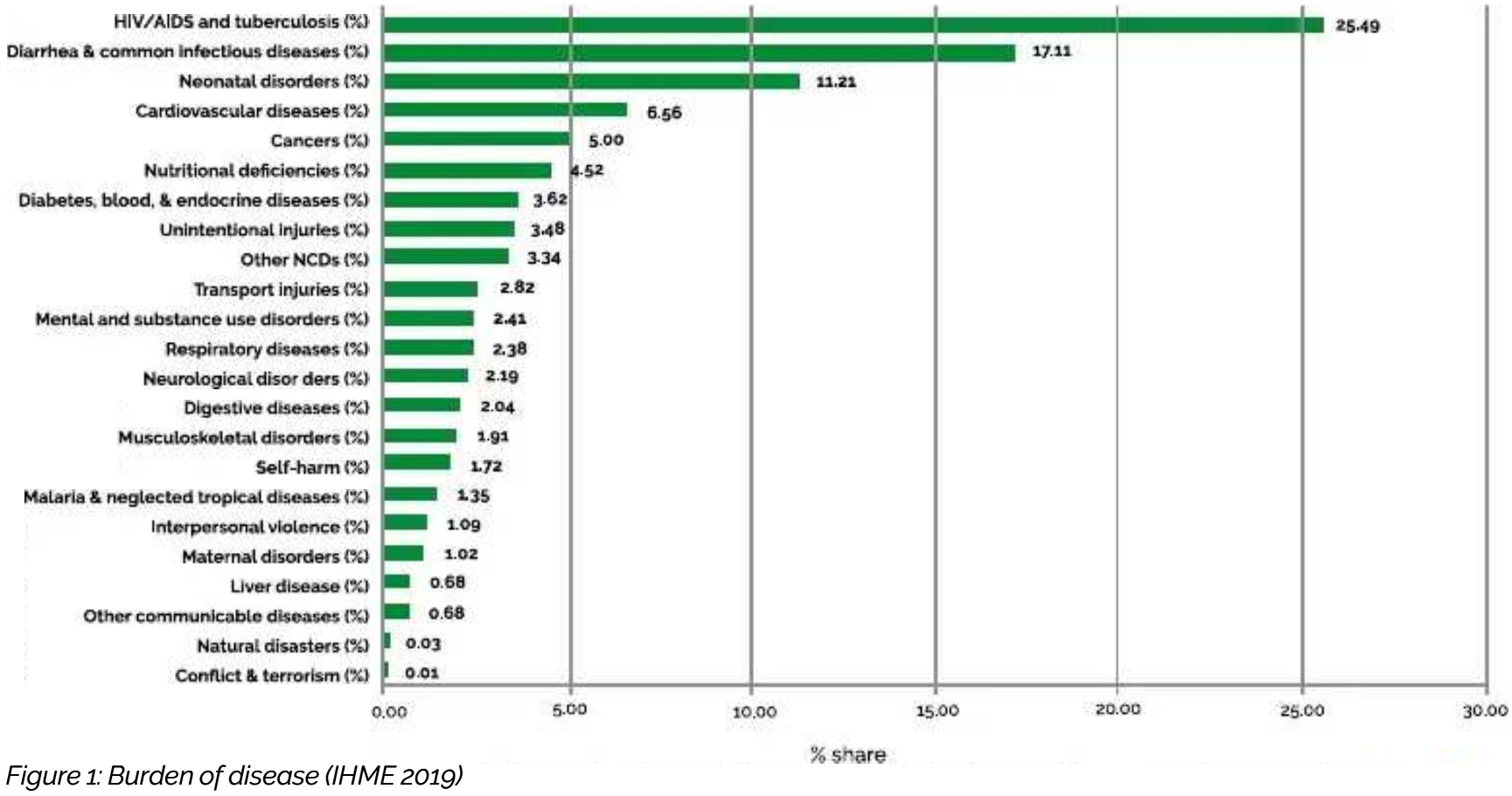

Figure 1: Burden of disease (IHME 2019)

The top ten causes of death are HIV, Lower respiratory tract infections, TB, Ischaemic Heart disease, Neonatal disorders, diarrheal diseases, Stroke, Malnutrition, Diabetes, Road Injuries and self-harm. Of note is that 50% of these are due to NCDs.

1.6 Health sector profile

The health facility density for metropolitan provinces is 0.2 and 0.4 health facilities per 10,000 people in Harare and Bulawayo respectively, with most provinces around 1.6 while the National Average is 1.1. This is well below the country's target of 2 health facilities per 10 000 people. Provincial and Central hospitals are in urban areas. Except for Mabvuku (Eastern District) in Harare Metropolitan Province, there are no District Hospitals in Harare and Bulawayo, resulting in primary care facilities referring patients requiring secondary level care to quaternary institutions. Lack of appropriately skilled human resources, medicines or equipment results in incapacity by lower-level facilities across the country and results in unnecessary referrals.

Currently, there is a defined essential health package for community level, primary and secondary levels of care. A defined package of services for the community level was adopted through the Community Health Strategy 2020-2025 (MoHCC 2019 CHS). Provision of health services is guided by the essential health package for the primary and secondary levels of care as outlined in the District Core Health Services document of 2012 (MoHCC 2012). According to the District Core Health Services Package, most services for normal deliveries should be provided at the district level and lower.

There is need to define a package for tertiary and quaternary levels of care. Implementation of these defined packages was to some extent compromised by weak health systems blocks.

1.6.1 Antenatal care services

The proportion of pregnant women with at least 4 ANC visits has risen from 70.1% in 2014 to 71.4% in 2019. However, the proportion of pregnant women booking early (below 16 weeks gestation) is low, at 29% (MoHCC DHIS2 2019), and that of pregnant women with at least 8 ANC contacts is also low at 10.2 %. The MoHCC will put in place a standardised approach to detect pregnancy early in a proactive manner.

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1.6.2 Intrapartum care services

The proportion of deliveries in health facilities rose from 79.6% in 2014 to 85.5% in 2019 (MICS 2014 - 2019). The proportion of deliveries conducted in health facilities has remained above 80% over the past 4 years.

Despite the high coverage of institutional deliveries and skilled birth attendants, the delay in receiving appropriate care at both BEmONC and CEmONC health facilities (3rd delay) is the most significant contributor to maternal and perinatal deaths. The Caesarean Section rate is high in Central Hospitals. This is expected because these offer referral services. However, in the Provinces, these rates are consistently below 10 per cent, except for Manicaland. An increase in Caesarean Section rates in those countries where they are below 10 per cent is associated with improved maternal and neonatal outcomes (WHO 2015). Therefore, rates below 10 per cent are an indication of limited access to CEmONC.

Table 3: Caesarean Section Rates per provincial Hospital, 2015 – 2018

Province/Facility	Caesarean Section Rate (%)			
	2015	2016	2017	2018
Mpilo Central Hospital	28	26	32	31
United Bulawayo Hospitals	33	29	33	56
Chitungwiza Central Hospital	16	29	20	20
Sally Mugabe Central Hospital	25	24	25	21
Parirenyatwa Central Hospital	35	36	30	35
Manicaland Province	8	10	11	12
Mashonaland Central Province	4	4	5	6
Mashonaland East Province	4	4	4	4
Midlands Province	6	6	6	6
Matabeleland North Province	6	7	8	8
Matabeleland South Province	5	7	7	7
Masvingo Province	6	6	7	6
Mashonaland West Province	4	4	4	5
Total	**7**	**8**	**8**	**9**

1.6.3 Perinatal care services

Despite the remarkable rise in institutional delivery from 79.6 in 2014 to 85.5% in 2019, the neonatal mortality rate has risen from 29 per 1000 live births in 2014 to 32 per 1000 live births in 2019 (MICS 2014, 2019). This reflects the low quality of care in maternity services. Other child mortality indicators are improving, but NNMR is increasing. The diagram below is showing the trends.

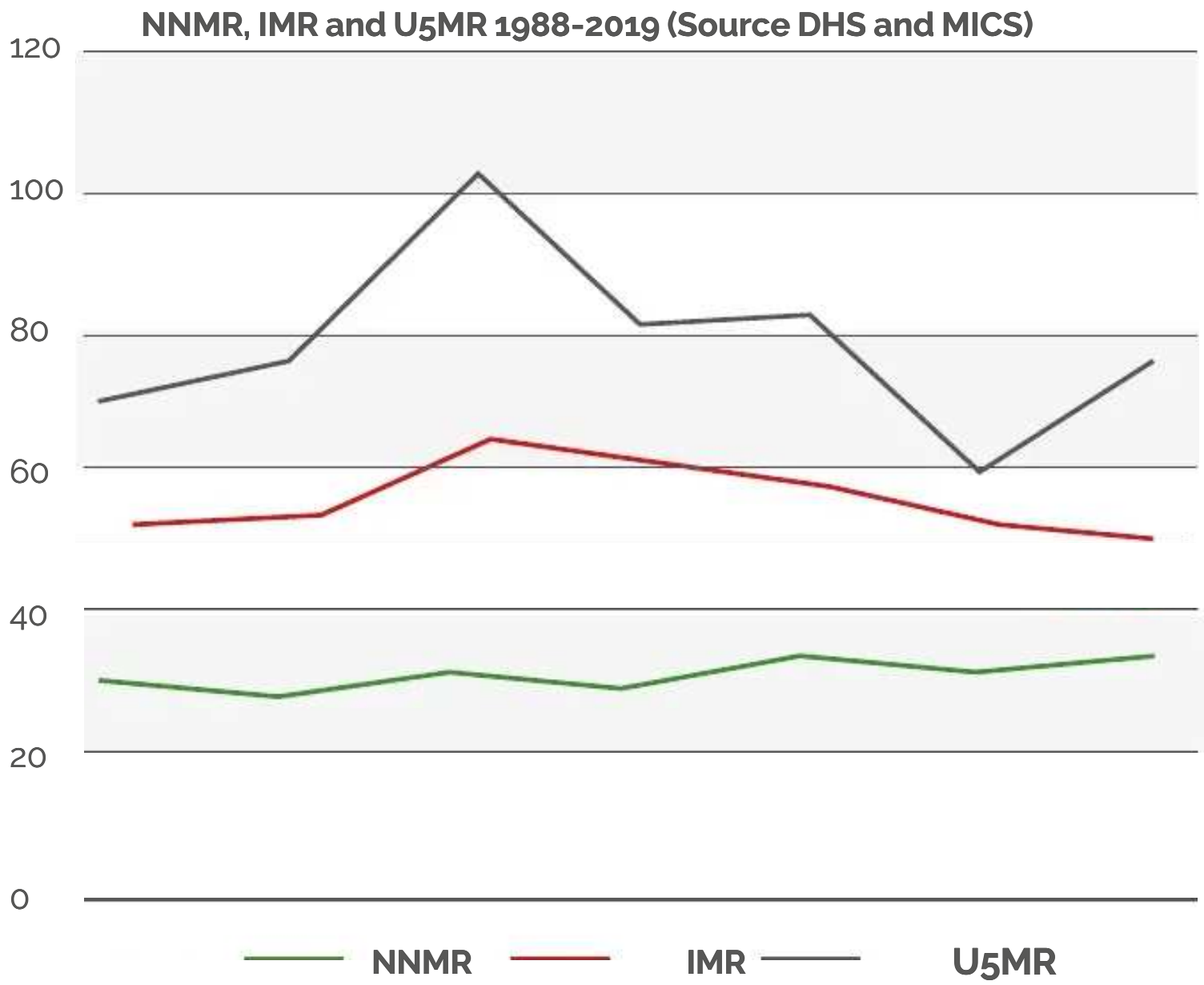


Figure 2:NNMR, IMR and U5MR 1988-2019 (Source DHS and MICS

1.6.4 Postnatal care services

PNC coverage for the mother has risen from 77.3% in 2014 to 82% in 2019. PNC Coverage for the new-born baby has also risen from 85% to 91% in the same period (MICS 2014, 2019). Despite high PNC coverage, there is minimal adherence by health facilities to the national post-natal care guidelines which stipulate that postnatal mothers and babies should be monitored in a health facility for at least 72 hours.

1.6.5 Trends in Maternal Mortality

The diagram below shows the trend in Maternal Mortality Ratio

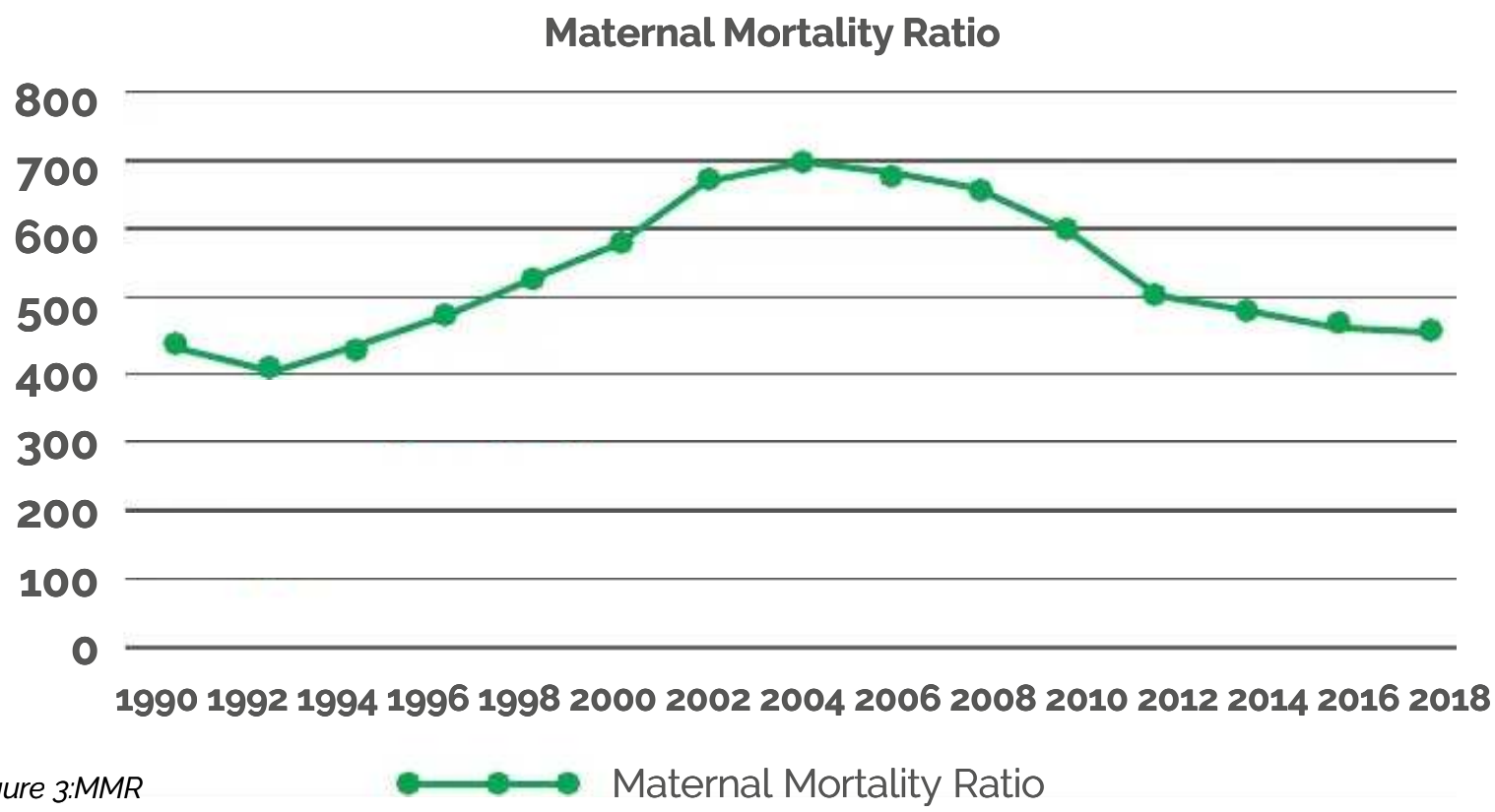


Figure 3:MMR

MMR remains very high at 462 per 100 000 live births, though this is a decline from 651 maternal deaths per 100 000 live births in 2014. The causes of maternal mortality remain bleeding after delivery, pregnancy induced high blood pressure and infection (puerperal sepsis). HIV is a leading indirect cause. The Lifetime Risk of Maternal Mortality reflects chances of a woman dying from maternal causes over the course of her 35-year reproductive life span. This was computed to be 22 per 1000 (ZimStat 2017). The MMR decline is not commensurate with the significantly high ANC coverage (93.3%), institutional delivery (85.5%) and skilled birth attendance (86%), (MICS 2019).

1.6.6 Childhood Illnesses

The major issues affecting access to appropriate quality care include geographical and economic factors, poor knowledge, attitudes, harmful social practices, and religious beliefs of the communities on house- hold practices for child survival. Zimbabwe has just adopted the nurturing care framework for early childhood development. The Integrated Community Case Management predominantly excludes management of pneumonia but is however strong on management of diarrhoea, malaria, and malnutrition. There used to be a vibrant school health programme, unfortunately this was negatively affected by the economic challenges. The program is currently being revitalized.

1.6.7 Immunization

In Zimbabwe, the proportion of children who received Penta 3 below one year rose from 89% (ZDHS 2015) to 90.6% (MICS 2019). Districts with DTP3 coverage >80% increased to 59/63(93.6%) in 2018 up from 54/63 (86%) in 2017. Dropout rates for all antigens remained below 10% in all antigens except for MR1 – MR2 that was 11%. Analysis of the data by District shows that there are children who remain under vaccinated or unvaccinated. There are performance gaps, such as not vaccinating children at every opportunity, hence some Districts are consistently underperforming.

The life course approach to immunisation calls for providing immunisation beyond children, but also to adolescents, women of childbearing age and to adults and the aged. This is done to prevent emerging and re-emerging infectious diseases and protection of the aged. Zimbabwe is practising this through immunisation against HPV to adolescent girls, Tetanus Toxoid to women of childbearing age, flu vaccine in winter to prevent flu outbreaks and typhoid and cholera vaccines during disease outbreaks. Some of the interventions carried out using these vaccines are described in relevant sections in this NHS.

1.6.8 Child health

Delay in accessing appropriate quality care for common childhood illnesses such as cough, fever, diarrhoea, and malnutrition is the most significant contributing factor to mortality. Care seeking behaviour for diarrhoea and fever for under 5 children is only 35.2% and 34.5% respectively (MICS 2019)

1.6.9 Adolescents and young people

Adolescents (10-19 years) are a diverse group, not only in terms of age, gender, and area of residence, but also in terms of ability, beliefs and the nature of circumstances and vulnerabilities they experience. These adolescents face many sexual and reproductive health challenges such as:

- **High rates of unintended pregnancies, maternal morbidity & mortality, early marriage, sexual and gender-based violence and new sexually transmitted infections and HIV.**
- **Adolescent birth rate is declining (from 120 births per 1000 women in 2015 to 108 births per 1000 women in 2019: MICS 2019), however, the unmet need for contraception among adolescents is still higher at 12.6% among adolescents than adults at 10% (ZDHS 2015).**
- **Though there is limited data, substance abuse, mental and nutritional health are some of the problems affecting adolescents and young people.**

1.6.10 Family Planning

Modern Contraceptive Prevalence Rate (mCPR) was at 68% in 2019. Unmet need for Family Planning was at 8.6% in 2019 against a target of 6.5% by 2020. However, there are notable inequities (geographical, demographic and socio-economic) and poor method mix, highly skewed towards the short-term methods especially the pill. The proportion of women using implants as a method of contraception increased from 17% in 2015 to 32% in 2018 and the proportion of women using Intra-Uterine Contraceptive Devices (IUCDs) also increased from 1% in 2015 to 4% in 2018. Permanent methods remain below 1% (both male and female) (HMIS). The Unmet need is highest in the rural hard to reach areas, the urban poor settlements, women with low education, the adolescents and youth.

1.6.11 Sexual and Gender Based Violence

Thirty-nine percent of women reported that they had experienced either physical or sexual violence at some point in their lives (ZDHS, 2015).

1.6.12 Nutrition

Figure 4 below shows the trends of nutrition indicators in Zimbabwe for the period 2012 to 2019.

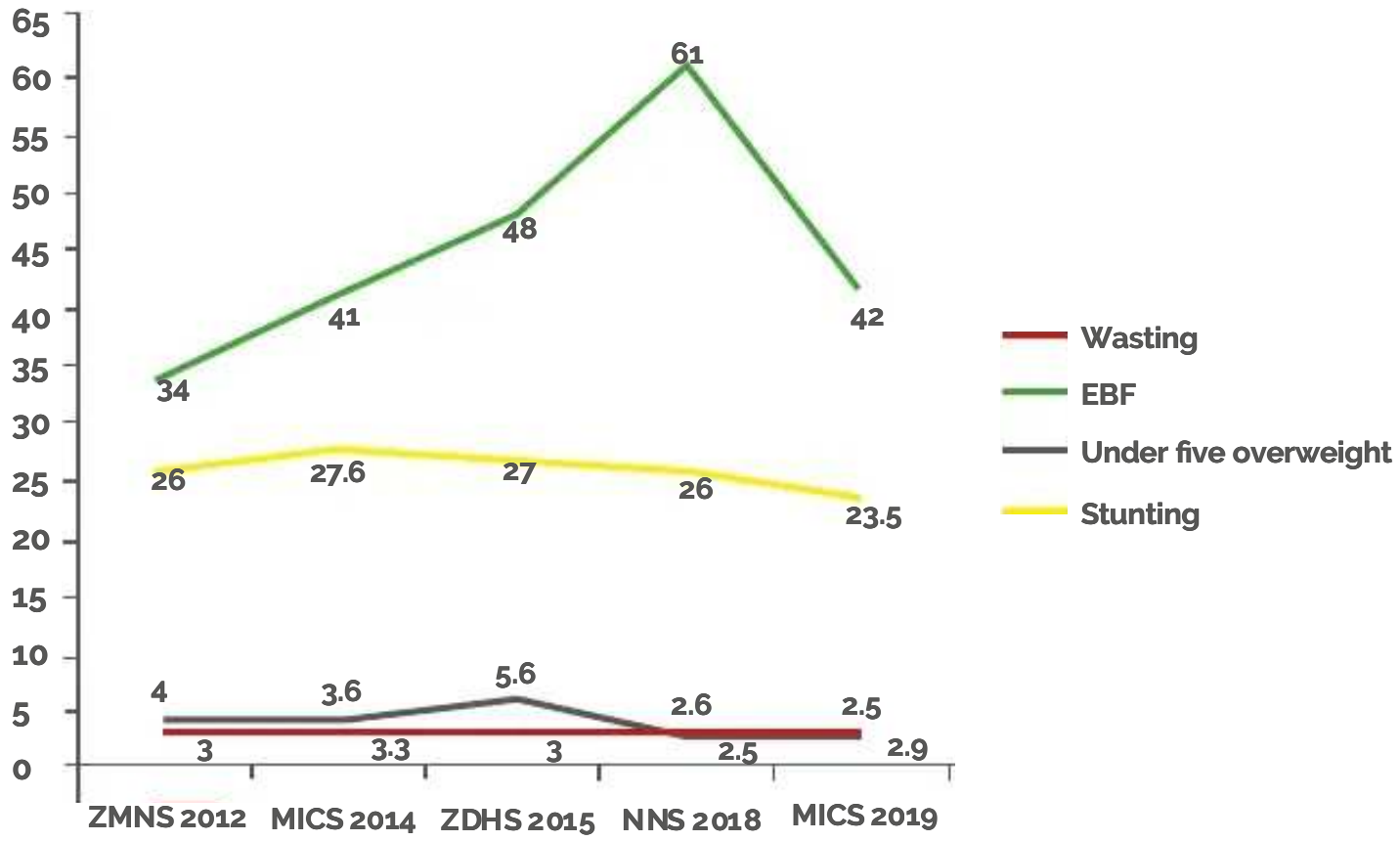


Figure 4: Trends for Global Nutrition Targets for Zimbabwe

The Multiple Indicator Cluster Survey (MICS) of 2019 shows that stunting in Zimbabwe is at 23.5 % which is still high prevalence according to WHO prevalence cut off values of 20% - <30% for public health significance. From the MICS of 2014 and 2019, there has been 3.1% decline in stunting. Using the same percentage decrease to project to 2025 the prevalence of stunting will be approximately 20%, which will be short of the target of approximately 16%.

Overweight has gradually decreased from 4% according to the Zimbabwe Micronutrient Survey (ZMNS) 2012 to 2.5% according to MICS 2019. This is a welcome trend as the global target on overweight children states that they should be no increase of the prevalence.

The exclusive breastfeeding target is at least 50 % of infants between zero to six months should be fed on the mother's breastmilk alone without giving any other foods or fluids except for medicines as prescribed by a medical practitioner. The rate of exclusive breastfeeding has been gradually increasing over the years picking at 61% in 2018 according to the National Nutrition Survey report though the 2019 MICS result shows a decrease to 42%.Global target is to reduce wasting to less than 5% and Zimbabwe has been able to maintain wasting below 5% over the years and from different survey reports.

Micronutrient deficiencies are a problem of public health concern and, are a contributing factor to stunting, poor health and impaired development among the children in Zimbabwe. Micronutrient deficiencies among children 6-59 months is high, with iron deficiency at 72%, anaemia at 31% and vitamin A deficiency at 21%. Vitamin A deficiency, iron deficiency and anaemia in women of childbearing age are also high at 24%, 62% and 26% respectively. Current strategies to improve micronutrient status among children and women include increasing the variety of foods in the diet (dietary diversification and modification), individual supplementation, mandatory industrial food fortification and biofortification.

1.6.13 Communicable Diseases

1.6.13.1 HIV

In 2020, Zimbabwe had 1.4 million people living with HIV (PLHIV), including 1.3 million adults and 84,295 children (UNAIDS 2019). HIV prevalence is 11.8% among adults aged 15-49 years (14.8% among females and 8.6% among males) (ZIMPHIA 2020). Among pregnant women in antenatal care (ANC), HIV prevalence is 14.2%. The gender disparity is most pronounced among young women aged 20-24 years; whose HIV prevalence is three times greater than their male peers (8.1% vs. 2.7%).

There is significant geographic variance in Zimbabwe's HIV epidemic. At the provincial level, HIV prevalence is higher in Matabeleland North (16.7%), Chitungwiza (17.15%), and Matabeleland South (19.6%) than in the other seven provinces, which are all below 15% (UNAIDS 2019). This is explained by early sexual debut, low condom use, multiple sexual partners, and low male circumcision in provinces that show higher prevalence levels. Significant progress had been made towards the 95-95-95 targets. In 2020, 86.8% of people living with HIV (age 15 years and older) knew their status, 97.0% of these were on antiretroviral therapy (ART) and 90.3% of those on ART were virally suppressed (ZIMPHIA, 2020).

This figure below shows gender and 95-95-95 status (NACP 2019a).

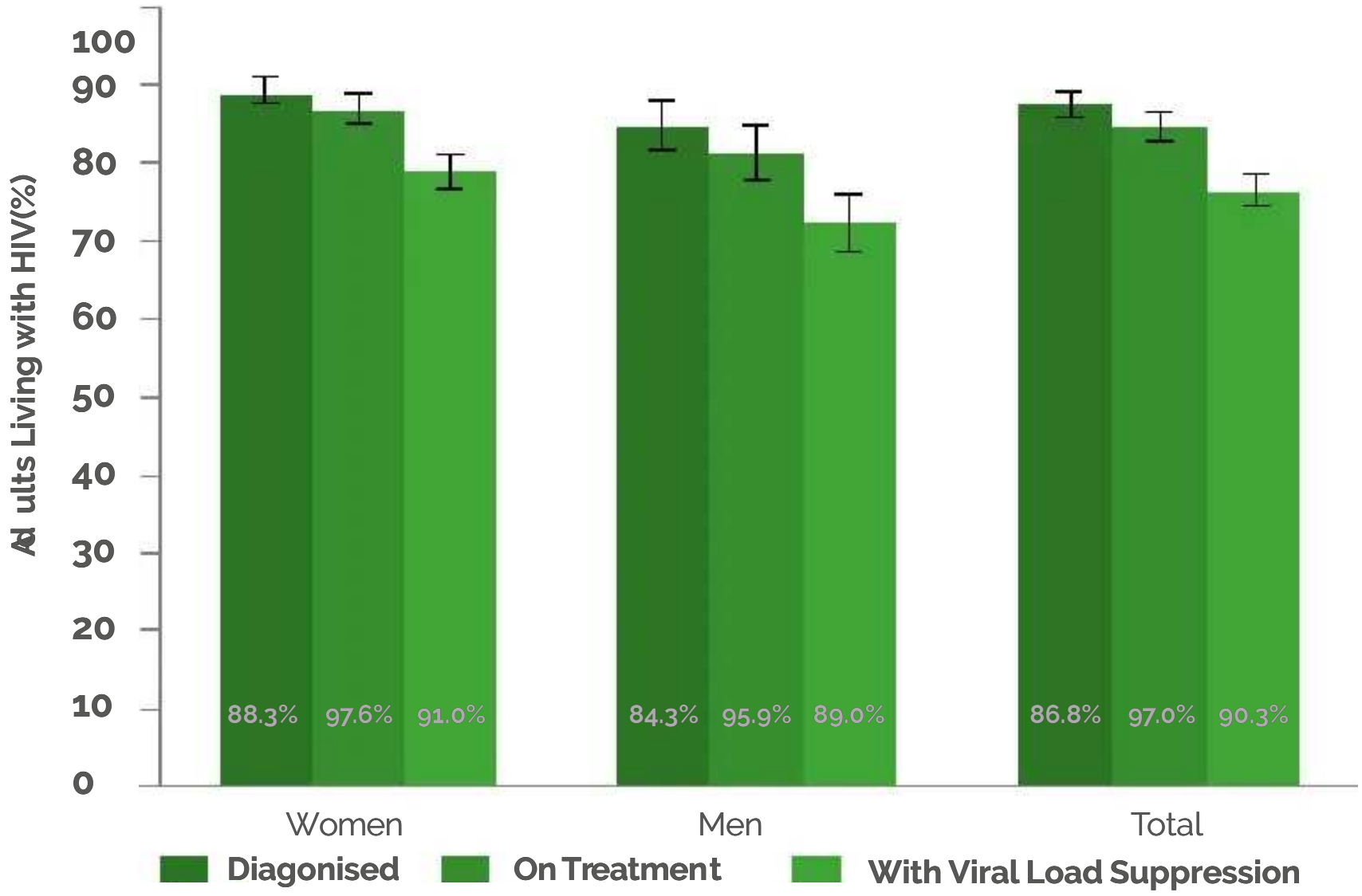


Figure 4:Progress towards the 95-95-95 targets, sex:

Since the inception of ART programme in Zimbabwe in 2004 significant numbers of deaths have been averted. In 2019, an estimated 52000 deaths were averted by ART in both adults and children (UNAIDS, 2019). It is worth noting that late initiation of ART, loss to follow up and poor quality of services are persistent challenges. Treatment coverage, social and behaviour change communication, combination prevention, and prevention of mother-to-child transmission services have helped to reduce new infections. New HIV infections among adults reduced by 15.1% whilst in children it reduced by 19.6% from 2016 to 2019 (UNAIDS, 2019). The mother to

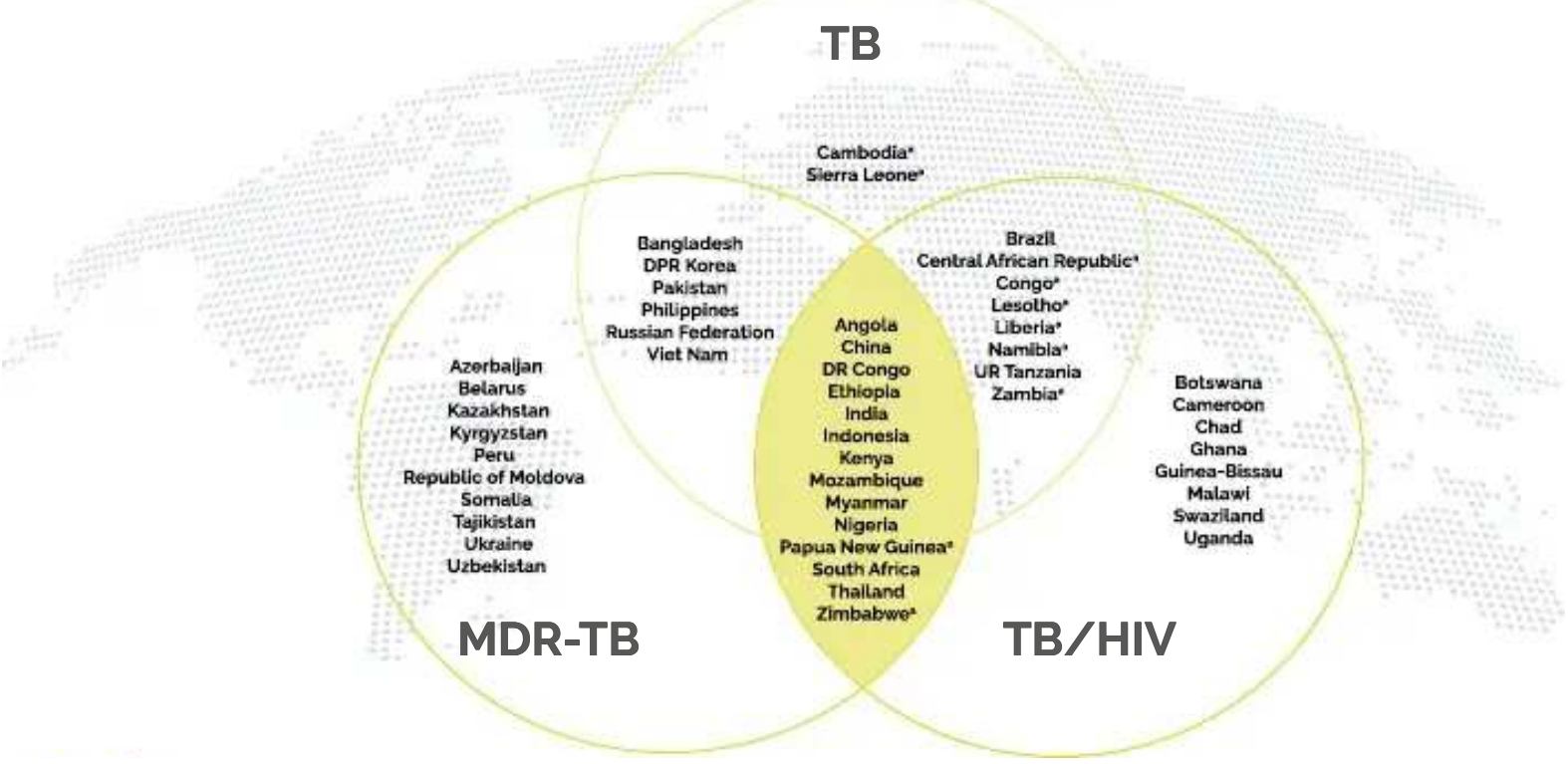
child transmission rate of HIV has come down from 9.41 percent in 2016 to 8.17 percent in 2019.

While there is a generalized HIV epidemic, it is characterized by distinct sub-epidemics that require targeted responses. ZNASP IV defines HIV key populations as sex workers in their diversity, transgender people, men who have sex with men (MSM), people who use drugs and prisoners, and includes AGYW as a priority population (NACP 2019 ZNASPIV).

The HIV and AIDS Strategy for the Informal Economy 2017-2020—which includes sex work as one of eight target sectors—ensures that partnerships with the private sector and key CSOs are established to increase and expand HIV integrated service delivery points, (NACP 2019a).

1.6.13.2 TB

Zimbabwe remains one of top 8 countries in Africa on world's top 30 list of countries heavily burdened by **TB, TB/HIV and MDR-TB**

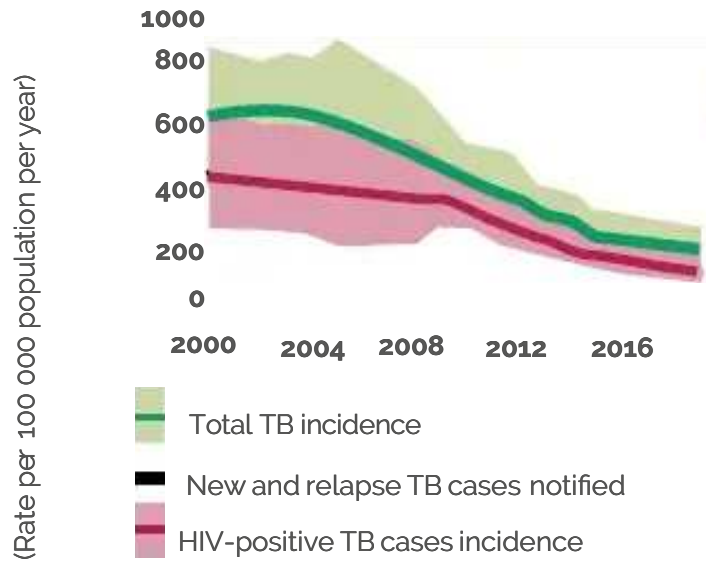


The estimated TB incidence decreased from 242 /100,000 population in 2015 as compared to 199/100 000 population in 2019 (2015 and 2019 GTB reports). Between 2015 and 2019, the incidence rate fell by 18% from 242 per 100,000 population, while the TB mortality rate (including HIV) declined by 40%, to 24 per 100,000 population.

TB incidence and the notified TB patients show a steady decline. WHO has acknowledged Zimbabwe as one of the countries with an impressive decline of between 4-8% between 2015 and 2019. The estimated proportion of TB patients and their households who faced catastrophic costs during treatment was at 80% in 2019 (GTB report) An estimated 8,273 TB cases were undetected in 2019, finding these cases is a top priority for the national response (GTB report

2020). ART uptake among co-infected patients increased from 72% in 2015 to 91% in 2019. The significant incidence decline is attributed to the expansion of the TB prevention and care services, and universal ART coverage. Males bear the brunt of TB disease burden, particularly the economically productive 25-44-year age category.

Men are more likely to work in occupations that place them at risk and are more likely to smoke (around 31-33% of men smoke, compared to less than 5% of women) (MoHCC 2019). Women face greater barriers to TB care, due to gender-related barriers such as access to financial resources (MoHCC 2014). The adoption of innovative tools and strategies has contributed to sustained gains on key outcome and impact indicators with possibility of meeting 2020 global targets as shown in the diagram below (MoHCC 2017).



Drug Resistant Tuberculosis: Drug resistant TB remains a threat to public health in Zimbabwe with estimates from the Global TB Report of rifampicin resistant TB among TB patients at 3% for new and 14.2% among previously treated patients. Treatment success rates for drug-susceptible TB was 84% (2018) and 54% for DR-TB (2017).

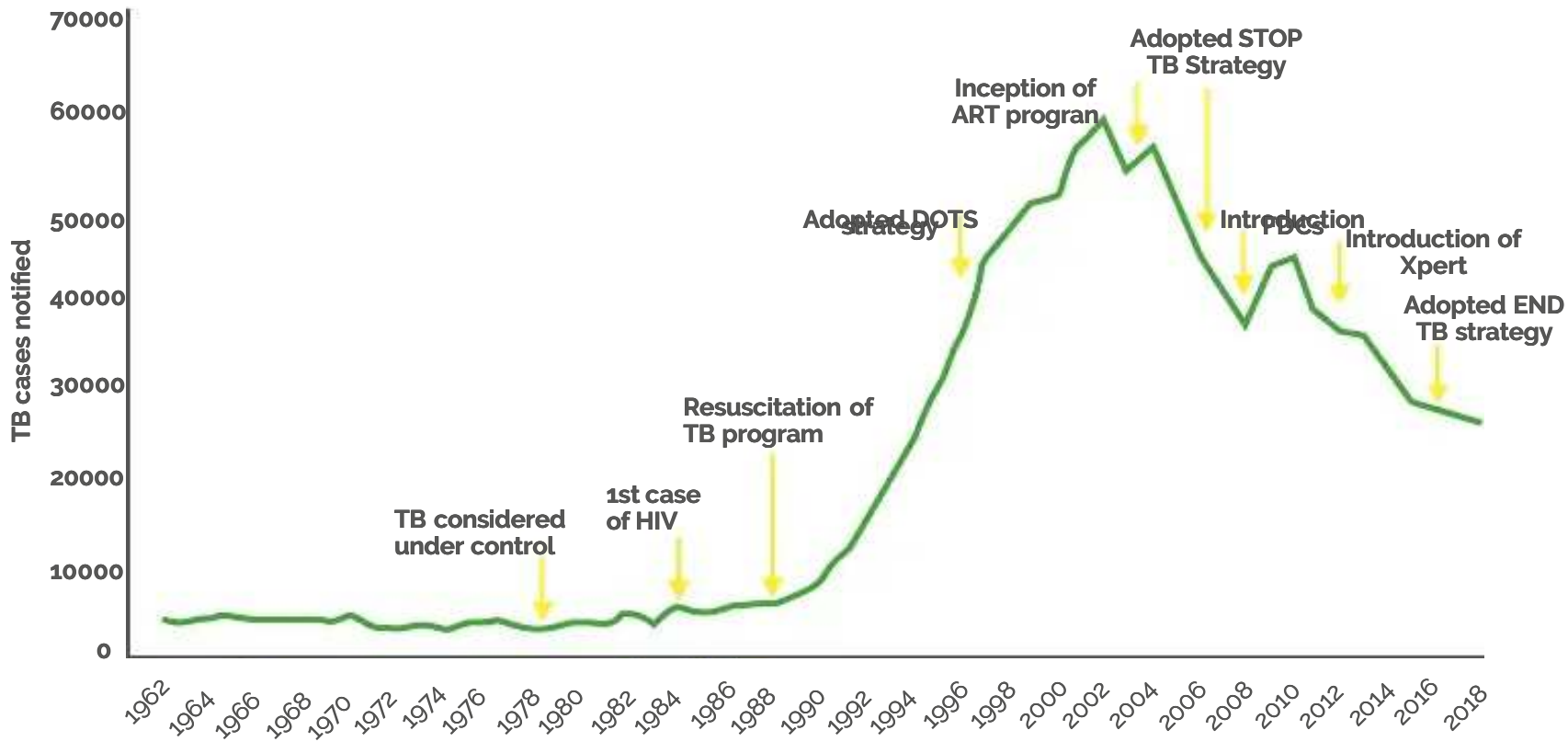


Figure 5: Case notifications (all forms of TB) and key programmatic milestones in Zimbabwe, 1963-2018

TB diagnostic capacity has greatly improved. There are 230 microscopy sites and 128 GeneXpert MTB/Rif (ultra) sites and 2 sites offering culture services. (WHO report 2020) However, there is a need to improve on the use TB-LAM for PLHIV, and to ensure service level agreements for Xpert machines exist given high breakdown levels (MoHCC 2017).

Among 139,914 people with presumptive TB in 2019, 13% had no laboratory investigations done while 9% did not receive results. Uptake of TB preventive therapy (TPT) is suboptimal.

Key and vulnerable populations for TB include PLHIV, children, men, miners and ex-miners, prisoners, mobile populations, the elderly, healthcare workers, and people living in slum settlements. Artisanal small-scale miners (ASMs), who constitute a significant part of the economically active population, have high rates of TB and HIV infection. Other important risk factors for TB in Zimbabwe include HIV, diabetes mellitus (DM), tobacco smoking, alcohol use and undernutrition. The National TB response is increasing and targeting its focus on high risk groups for efficiency and effectiveness.

According to the TB prevalence survey conducted in 2014, at least 10% of presumptive and prevalent TB cases had consulted private practitioners and only 16% of them had been appropriately investigated for TB through sputum examination. PPP will strengthen the access to high quality TB services.

Sub-optimum treatment outcomes have been compounded by documented patient delays in seeking health care, high death rate among TB in the southern region (Bulawayo, Matabeleland South and Matabeleland North, pre-treatment loss to follow-up and not evaluated among, diagnosed TB patients.

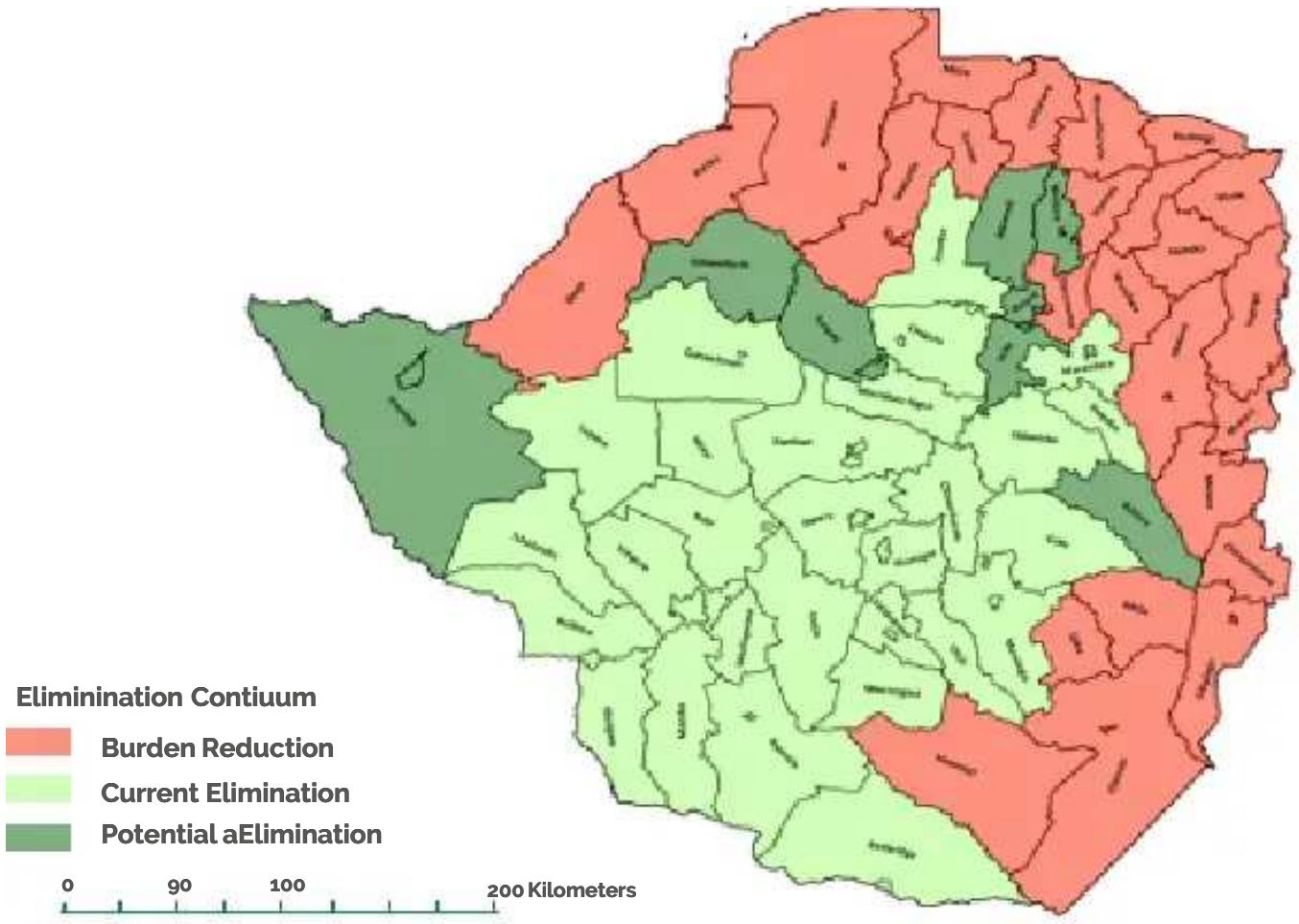
1.6.13.3 Malaria

Malaria transmission intensity has seasonal and geographic variation corresponding closely with the country's rainfall patterns and topography. Transmission is perennial in malarious areas, seasonal increases occur annually, with most transmission occurring during or just after the November to April rainy season. There is higher malaria transmission in the northern and eastern border regions, with more limited transmission in the central and south-western portions of the country. Populations considered to be high risk in the malarious areas include artisanal miners, farm workers, mobile migrant populations including border communities.

Standard Malaria Interventions are used in the prevention and control program. For Vector Control, there is entomological surveillance, LLINs distribution (mass and continuous) and IRS. Intermittent Preventive Treatment in Pregnancy (IPTp) is implemented in 26 high burden districts In malaria case management, testing is mandatory for all suspected cases and ACTs are used for treatment. Community case management by mostly VHWs is implemented in some districts. Effectiveness of the drugs is monitored through Therapeutic Efficacy studies. Supply chain issues and malaria strategic information are considered important components of the program.

The country selected a subnational approach to malaria elimination starting with 7 districts in 2012, then 20 in 2015 and 29 in 2020.The malaria incidence for elimination target for these districts was 2/1000 by 2020.

Zimbabwe: Malaria Elimination Contiuum (2021-25)



The country failed to reach malaria target of 5/1000 in 2020 for control and elimination in all the elimination districts combined as per the NHS. Contributing factors include funding gaps/ and poorly timed release of funds for key control activities namely IRS,poor uptake in some areas, delayed response to outbreaks in 2020 because of intensified covid19 response and decreased time allocated to malaria activities.

1.6.14 NTDs

Seventy per cent of the population is at risk of NTDs. The common NTDs are Schistosomiasis, soil transmitted Helminths, Lymphatic Filariasis, Trachoma, Rabies, Snake bite, cysticercosis and scabies. The country is also endemic to Human African Trypanosomiasis and Leprosy which are more focalised. These diseases can cause disability and affect economic activity in affected communities. Children are prevented from going to school and adults prevented from working.

The interventions against NTDs included improvement in Water and Sanitation, Vector control, Health promotion and community engagement, Preventive Chemotherapy, Intensified and innovative Disease Management and Morbidity Management and Disability prevention

The country has conducted mapping for the four prevalent Preventive Chemotherapy Neglected Tropical Diseases (PC-NTD), Schistosomiasis, solid transmitted Helminthiases, Lymphatic filariasis and trachoma and as a result Mass Drug Administration has been ongoing since the mapping exercise. After six successive annual MDAs for schistosomiasis and soil transmitted helminthiases, an impact assessment was carried out in 2018 which showed a great reduction of the two conditions as well as shrinking of the prevalence map. This calls

for a review of the implementation of the MDA in the country against these two conditions. Vector control for control of NTDs has been employed mainly in Human African Trypanosomiasis (HAT) for the control of Tsetse by the department of Tsetse control. Other vector control interventions still must take shape for the interruption of transmission of NTDs.
Health workers in target hot spots have been trained in the management of HAT, Leprosy and there is need for continuous supportive supervision.
Morbidity Management and Disability prevention has not quite taken shape in the country with activities for Trachoma Trichiasis surgery recently introduced in target districts.

While programs exist for several NTDs in the country there is still need for concerted efforts to introduce targeted programmes for others including snake bite, scabies and cysticercosis. While most of the conditions are prevalent in the country their distribution is not quite known because of insufficient data from routine health information system. For other conditions targeted mapping may be required to understand their burden and distribution.

1.6.15 Public Health Emergencies

Rapid and uncontrolled urbanization, with attendant pressure on old and dilapidated infrastructure, and climate change are factors that have contributed to the occurrence of public health emergencies in Zimbabwe.

A Joint External Evaluation (JEE), as part of the IHR 2005 Assessments, was undertaken in 2018 (WHO 2018) (WHO 2005). It made observations on progress in strengthening IHR Core Capacities as well as identifying areas requiring further attention. Based on the JEE recommendations, a draft National Action Plan for Health Security (NAPHS) has been developed. In addition, tools to conduct the Vulnerability Risk Assessment and Mapping (VRAM) have been developed, and these will be used to carry out a national assessment to gather information for the development of the National All Hazard Preparedness and Response Plan.

The COVID -19 pandemic revealed several health systems gaps that require attention in the next five years. Continuity of other services was compromised and there is need to integrate and harmonise COVID-19 response into the mainstream health response.

1.6.16 NCDs:

The burden of NCDs has been increasing. This is compounded by limited investments to prevent and control them. NCDs caused 33 percent of deaths made up as follows in 2016, Cardiovascular diseases 11 per cent, Other NCDs 10 per cent, Cancers 7 per cent, Diabetes 3 per cent, and Chronic respiratory diseases 2 per cent while injuries caused 12 per cent and Communicable diseases, maternal, perinatal, and nutritional conditions caused 55 per cent (WHO 2018).

1.6.16.1 Adult Risk Factors for NCDs

NCDs share common risk factors. Individuals who have these risk factors are more likely to develop the four common NCDs which are Cardiovascular Disease, Diabetes, Cancer and Chronic obstructive lung disease. The estimated prevalence of these risk factors is as shown in the table below based on 2016 WHO projections data. The STEPS survey in Zimbabwe was undertaken in 2005.,

Table 4:Mean population salt intake among adults aged 20 years or more is 8 g per day.

Indicator	Male (%)	Female (%)	Total (%)
Current tobacco smoking, adults aged 15+ years	28	1	14
Total alcohol per capita consumption, in litres of pure alcohol, adults aged 15+ years	9	1	5
Raised Blood Pressure, adults aged 18+ years	20	21	20
Obesity, adults 18+ years	4	21	12
Raised blood glucose, adults aged 18+ years	4	5	5
Physical inactivity, adults aged 18+ years	21	29	25

(WHO 2018).

There is a Directorate of NCDs at the Ministry of Health Headquarters. The multisectoral National NCD Strategy is still to be developed and its absence o makes implementation difficult. For example, enabling legislation lags behind global standards. Examples include gaps in regulating sugar, saturated fats, and salt content in foods, legislation on harmful use of alcohol, among others. In the health sector, primary prevention interventions such as Hepatitis

B vaccination and HPV vaccination are undertaken.

Secondary prevention through screening happens but is not always linked to medical intervention. Examples are screening for cancers of the cervix, breast, colon and prostate. Case management takes place but has not been adjusted to conform with global guidance. For example, correct assessment and treatment requires intervention by medical practitioners. However, most people's first point of call when they get sick is the primary care nurse.

These health workers need capacity strengthening to assess patients for NCDs and prescribe appropriate treatment. The Ministry of health with support from WHO has developed protocols that will be used to strengthen provision of NCDs at the primary care level using the WHO package for Essential NCDs management (PEN) guidelines.

In recognition of the importance of reducing injuries especially related to Road traffic accidents, a road safety preparedness assessment was carried out in 2019. The findings have been used to develop interventions to address gaps identified. The Rehabilitation program which was set up decades ago has been facing financial hardships. So, its reach is now limited.

17 PSM for essential medicines and commodities

The PSM has been significantly streamlined in recent years, with the vast majority of health commodities now being stored and distributed through the national systems. Following a successful pilot in 2015, Zimbabwe's Assisted Pull System (ZAPS) is now being rolled out to all facilities. Challenges remain managing multiple procurement systems, creating difficulties with visibility and commodity security. The main issue is low availability of health commodities and equipment in both the public and private sector. When the commodities are available, access is often limited because of high prices. This situation is worse for chronic diseases and specialized interventions such as surgery or radiotherapy. Resources to procure public sector health commodities is heavily donor dependent.

17.1 Product Selection, Policy & Governance

There are different product selection processes with the National Medicines and Therapeutics Policy Advisory Committee (NMTPAC) responsible for medicines. The Medical Laboratory and Clinical Scientists Council is responsible for laboratory reagents selection. For vaccines and nutrition commodities, the selection is based on global recommendations without much input from local requirements. Selection for family health products is largely based on donor offering.

17.2 Quantification, Procurement, Warehousing, LMIS and Distribution

17.2.1 Quantification

There is harmonised quantification and forecasting of all commodities except for EPI commodities which are quantified separately. Poor data quality of product consumption particularly for chronic diseases affects quantification accuracy. Information on consumption from the private sector is unknown, this makes it difficult to provide a complete national picture.

17.2.2 Procurement

There is low value for money in the procurement systems for those commodities bought using Government resources due to lack of foreign currency causing delays which frequently results in price changes by suppliers. Health facilities using both Health Services Fund and Results Based Fund funds have been sourcing commodities at high prices as the quantities procured are small.

17.2.3 Warehousing

There is inadequate storage space at both central warehouses and health facilities resulting in poor inventory practices including poor temperature controls. Cold chain maintenance at health facilities remains a challenge with increased power outages and poor supply of LP gas.

17.2.4 Distribution

There remain parallel distribution systems for a few health commodities, such as nutrition and contraceptives; laboratory commodities; vaccines and consumables in the public sector.

Distribution systems, for example for some commodities provided through external support, are heavily donor dependent making sustainability a challenge.
LMIS – There is a manual LMIS system in the public sector. Private sector data is not centrally captured. Visibility of stock across the supply chains has been a challenge resulting in inefficiencies.

17.3 Quality Assurance, Regulatory and Pharmacovigilance

There is a strong and well respected national regulatory authority, Medicines Control Authority of Zimbabwe (MCAZ). However, the poor economic environment has resulted in the mushrooming of illegal selling points of commodities with poor quality assurance as counterfeits which are not only harmful to the public but promote increased development of antimicrobial resistance. The fines in national statutes meted to offenders are too low and not deterrent. The revision of Medicines and Allied Substances Control Act (MASCA) has been slow to give enhanced teeth to the punitive measures to deter potential offenders.

17.4 Local Manufacturing and Wholesaling

There is low-capacity utilization (<30%) and inefficiencies in production resulting in uncompetitive local prices. Local companies are now supplying less than 2% (it used to be 40% in 2000) of requirements in the public sector which is not sustainable for the country in the long term.

17.5 Rational Use and Community engagement

Treatment guidelines published under Essential Medicines List for Zimbabwe (EDLIZ) to promote rational medicines use are reviewed every 4 years with individual programme guidelines updated more frequently. The balance between product effectiveness and affordability is always an issue for public health. There is an increase in counterfeit medicines and unregistered medicines on the parallel market coupled with irrational prescribing in the private sector resulting in harmful effects that promote development of antimicrobial resistance. The high price of accessing medicines from formal sources is pushing patients to access medicines from the informal sector where the quality and effectiveness is not assured. In addition, this is contributing to an increase in drug abuse particularly among the youth.

1.8 Human Resources for Health (Health Workforce);

1.8.1 Human resources stock

Based on the Zimbabwe Human Resources for Health Profile (2014-2018) the total public and private sectors health workforce in December 2018 was 80 457. Of these, medical practitioners, nurses, and midwives were 36 274, giving an SDG composite index of 2.34 per 1000 population compared to the SDG composite index threshold of 4.45 per 1000 population. This corresponds to the estimated number of skilled health workers needed to reach the minimum proportion of achievement of 80 per cent or more coverage for 12 selected health indicators. For calculation of this SDG composite index, the 12 tracer indicators, 5 for infectious diseases; 3 for maternal, new-born and child health; and 4 for NCDs are used (WHO 2016).

Sixty-six per cent of the health workers are female. Seven per cent of the health workers are aged less than 30 years, 40 percent are between 31 and 40, 35 percent between 41 and 50, while 18 per cent are 51 years and above. The low numbers of health workers below age 30 may reflect the recruitment policies over the last decade when there was a freeze in posts and recruitment was based on replacement rather than creation of new positions. Harare, Manicaland, Midlands and Masvingo have more health workers compared with other Provinces. However, these provinces also have more people resident there. On a health worker per population basis, one cannot see a definite trend. Seventy-five per cent of health workers are in the government public sector, while 17 per cent are in the private sector, and 6 per cent are in the faith based and not for profit sectors (MoHCC 2018 HR).

1.8.2 Training of health workers

There are 32 Nursing and Midwifery training schools, 6 Environmental Health training schools and four each for Pharmacy and Medicine training schools. In addition, there are several other training schools for other categories of health workers. Government owns 50 health worker training schools while faith-based organisations own 13. There is limited private sector involvement in health worker training. For Diploma courses, syllabuses are the responsibility of the respective Directorates at MoHCC and the relevant Council at Health Professions Authority. For University degree and postgraduate programs, the Ministry of Higher and Tertiary Education, Innovation, Science and Technology Development moderates training

while allowing each University to produce graduates that can meet requirements of the competitive market.

There are increasing concerns of the quality of training considering performance of the graduates of some health training programs. There has also been several major policy changes or challenges that have arisen over the last twenty years and these have had implications on health worker training, especially with regards to nurses and doctors. Normally reviews should have been undertaken and appropriate measures put in place after each major change in order to maintain quality of graduates of the training institutions. Examples of these major policy changes or challenges are as follows:

i) **Upgrading of SCNs to RGNs and consequent abolition of SCN positions and training.**
ii) **Establishment of Primary Care Nurse training (this has now been discontinued).**
iii) **Training of RGNs in institutions other than the four Central Hospitals i.e., Provincial Hospitals and Mission Hospitals vis a vis quality of trainers including leadership by Clinical Specialists.**
iv) **Recruitment procedures of trainees, especially nurses, which resulted in compromising strict adherence to educational qualification as an entry requirement.**
v) **Unavailability of clinical specialists in hospital wards (due to dual practice and other issues) to provide leadership for both nurse training and medical students.**
vi) **Recurrent industrial action by junior doctors and nurses.**
vii) **Unavailability of basic equipment, medicines and supplies required to run the health service.**
viii) **Creation of Health Professions Authority Councils with individual Councils having regulatory authority over their professions yet there has not been sufficient oversight to ensure these functions are carried out e.g., inspection of health facilities.**
ix) **Governance challenges in the health sector.**

In addition, there has been major changes in the age structure of the population, meaning that chronic diseases have become an important cause of illness and death. There have been new infectious diseases as well as re- emerging infections and new disease outbreaks such as Ebola, SARS, and now COVID-19. This requires a relook at the curriculum of different training programs. Therefore, there are strong reasons for undertaking a review of health training starting with nurses and doctors.

1.8.3 The Work environment

There are many concerns about the work environment. These have resulted in industrial action especially by junior doctors and nurses. Reasons for the work stoppages are many but predominantly revolve around low remuneration packages that do not keep up with inflation. These are described in the Zimbabwe HRH Profile 2014-18 and include: Low funding of the health sector; outdated, unavailability or dysfunctional medical equipment; inadequate numbers of human resources; outdated staff establishments; long recruitment procedures; low remuneration; expensive institutional accommodation; and unavailability of medicines and medical supplies. With the COVID-19 pandemic, the issue of PPEs has been included among these grievances.

Government has responded, sometimes with support of its Partners, by offering retention packages and purchasing equipment and medicines. However, the situation has not improved. For example, vacancy levels for medical specialists were 46 per cent, for pharmacists was 48 per cent and pharmaceutical assistants was 40 per cent in 2018.

Significant numbers of health workers leave the public sector every year. Some go and set up rooms for private practice. Consequently, there has been an upswing in establishment of private health institutions, these include hospitals, surgeries, and pharmacies. In 2018, the private sector employed 17 per cent of the health workforce.

Many health workers emigrated especially to countries in Southern Africa, UK, USA and Australia. Two different staff incentive schemes have been introduced. The Results Based Financing scheme plus retention scheme supported by Global Fund (GF) and Health Development Fund (HDF). The Results Based Financing (RBF) scheme is performance based, and pays on a quarterly basis, with 75 percent of payment going to institutional strengthening and 25 per cent shared among all staff at the institution. A Health Worker Retention Scheme with Global Fund started in 2014 gives a fixed amount targeting mid-level staff and higher in rural areas.

A review of RBF and the HWRS concluded that a way forward could be combining the strengths of the two schemes into one scheme. A major lesson learnt has been that removal of these incentives results in suboptimal performance by staff. However, there are sustainability issues to address concerning source of funding (UNDP/Global Fund 2016).

1.8.4 Workload Indicators of Staffing Need (WISN) study.

A WISN study was undertaken starting 2016. It covered health facilities at all levels including missions' hospitals. It included doctors, nurses, pharmacy, radiography and laboratory staff. Its findings confirmed that staff establishments were not in keeping with workload needs at most health facilities. However, most facilities had enough or too many general nurse posts but none for midwives. For implementation, it recommended correcting the staffing levels at primary care and secondary care level first. A dysfunctional system at the lower levels makes it difficult to make sense of results of the study at provincial and central level (HSB 2017).

1.9 Health Financing

1.9.1 Resource mobilisation:

The health system is financed through a mixture of domestic and external funding sources. Government public health financing is the largest proportion, however the contribution is below recommended levels. The current financial crisis and challenging macroeconomic environment offers limited potential for expanding the fiscal space.

Total health expenditure decreased from USD1,4bn in 2015 to USD1,3bn in 2017 and went up to USD1.7bn in 2018. Total government health expenditure (TGHE) as a proportion of total expenditure shows an increase between 2015 and 2018.

There was a 29% increase from 2015 to 2017 and a 42% increase from 2017 to 2018 which translates to nominal spending of USD438million and USD763million respectively for the years 2017 and 2018. Government Health expenditure as a percentage of total government health expenditure dipped from 8.7% in 2015 to 6.7 in 2017 and increased to 10.1% in 2018. Per

capita health expenditure declined from USD103 in 2015 to USD90.8 in 2017 and increased to USD115 in 2018. Total health expenditure as a percentage of nominal GDP declined from 10.3% in 2015 to 5.9% in 2017 and increased to 7.1% in 2018 (MoHCC 2015 NHA, MoHCC 2018 NHA).

Government remains the single largest funder of the health system with a 44% contribution of total health spending in 2018 compared to the Rest of the World which had 27%, Households 13% and Corporations with 16%.

Good use has been made on innovative financing whereby the AIDS Levy (3 percent income tax), the Health levy (tax on airtime and data) are important sources of health funding. The Health Services Fund is made up of funds generated through fees and grants accruing to health facilities in the public sector. It was projected this would raise USD 35 m in 2018. Other possible sources that have been discussed with the Ministry of Finance are taxes on alcohol, mining, tobacco, fuel, and sugar. Third party vehicle insurance cover is another possible source (MoHCC 2017).

1.9.2 Pooling:

The Government contribution in theory goes into a single major pool. However, there are several pools, these are the consolidated revenue fund; Health Services Fund; AIDS Trust Fund; Local Government, Missions, and Local authorities' salaries fund.Most the contribution from it goes into paying for salaries in the civil service and for approved positions in the mission health facilities.

The funding from partners, though most of it comes through Government and is mostly earmarked, primarily for medicines, medical products and reagents and equipment required to support specific programs. Therefore, these funds are not free funds available for pooling. They also belong to different pools, the biggest ones being the PEPFAR, Global Fund and Health Development Fund.

The Association of Health Funders of Zimbabwe (AHFoZ) is composed of Medical Aid Societies. There is legislation administered by MoHCC to regulate the operations of Medical Aid Societies. This provides for a minimum package of services they should provide. They are also required to submit reports to the regulator. In 2018 there were 32 AFHOZ registered members. AHFoZ members' total expenditure on claims for 2018 was $353 023 812.94.

There is often controversy around setting tariffs or prices for payment of health services between the medical insurance industry, the medical association, and the private hospitals. Disagreement around these tariffs not only affects the private health care industry, but it also affects the public sector as the agreed tariffs influence what public hospitals charge to private patients. Furthermore, pricing is not only about covering costs but also providing the right incentives to pursue public health goals. Pricing, payment systems, and their regulatory frameworks can be powerful tools to drive broader health system goals. A systematic and consultative price setting mechanism is required to cure these challenges.
The government is pursuing the development of National Health Insurance (NHI). A road map guiding the process of establishing the NHI Road Map is in place and it is being gradually implemented.

1.9.3 Purchasing:

There are multiple complex funding flows through Government and through External Partners. Funding is largely allocated to staff salaries and specific programs such as HIV & STI's. AIDS accounts for the highest disease burden estimated at 25.49 per cent, but NCDs which include cardiovascular diseases, cancers along with injuries accounted for 42 percent of disease burden. Despite this, NCDs receive less than 10% of the funding. It goes without saying that NCDs, likely to generate high future costs of care and undermine the economically productive age groups, need to be invested in.

As shown in the diagram below, Government funding is mostly allocated towards salaries, while Partners contributions go towards medicines, medical supplies, and other commodities (MoHCC 2019 MTR). There are differences in budget execution by cost category which imply inefficiencies in allocation and expenditure of health resources. There is a need to balance the administrative control at National Level vs knowing the right combination of interventions for efficiency and quality.

Domestic & External Fund Allocations

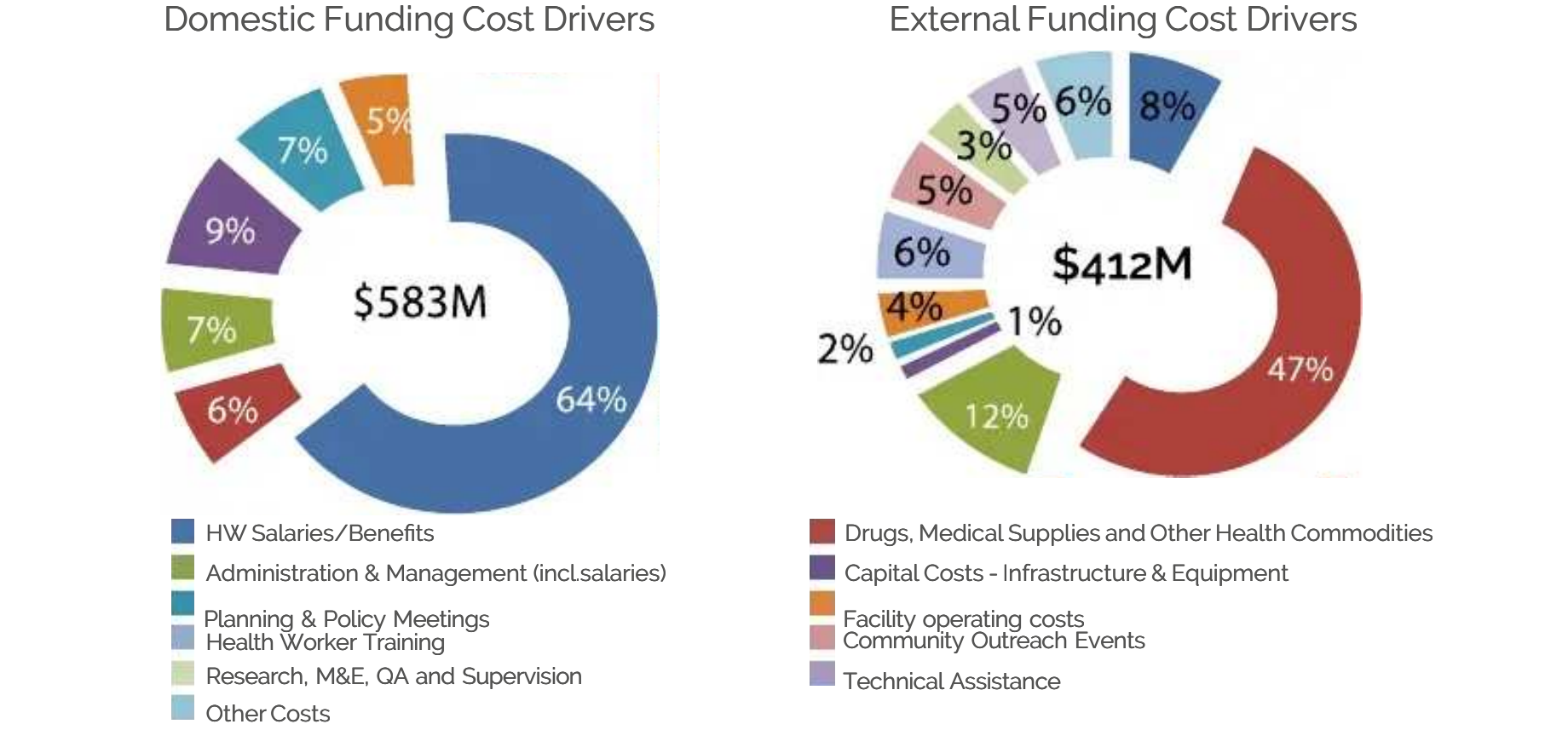


Figure 7: Domestic vs External funding sources

An analysis by level of care shows that more DALYs are averted through health expenditures at community, primary care level and first referral care levels as shown in the diagram below (World Bank 2019). It also showed that HIV and AIDS, Tuberculosis and maternal and child health interventions averted more DALYs than the other interventions. Interventions provided at lower levels demonstrate allocative efficiency in that services can be provided at lower costs than at higher levels. Thus, available resources can be used to provide services to more people. This understanding should guide resource allocation policies in future.

Expenditure and Intervention Impact - DALYS averted:

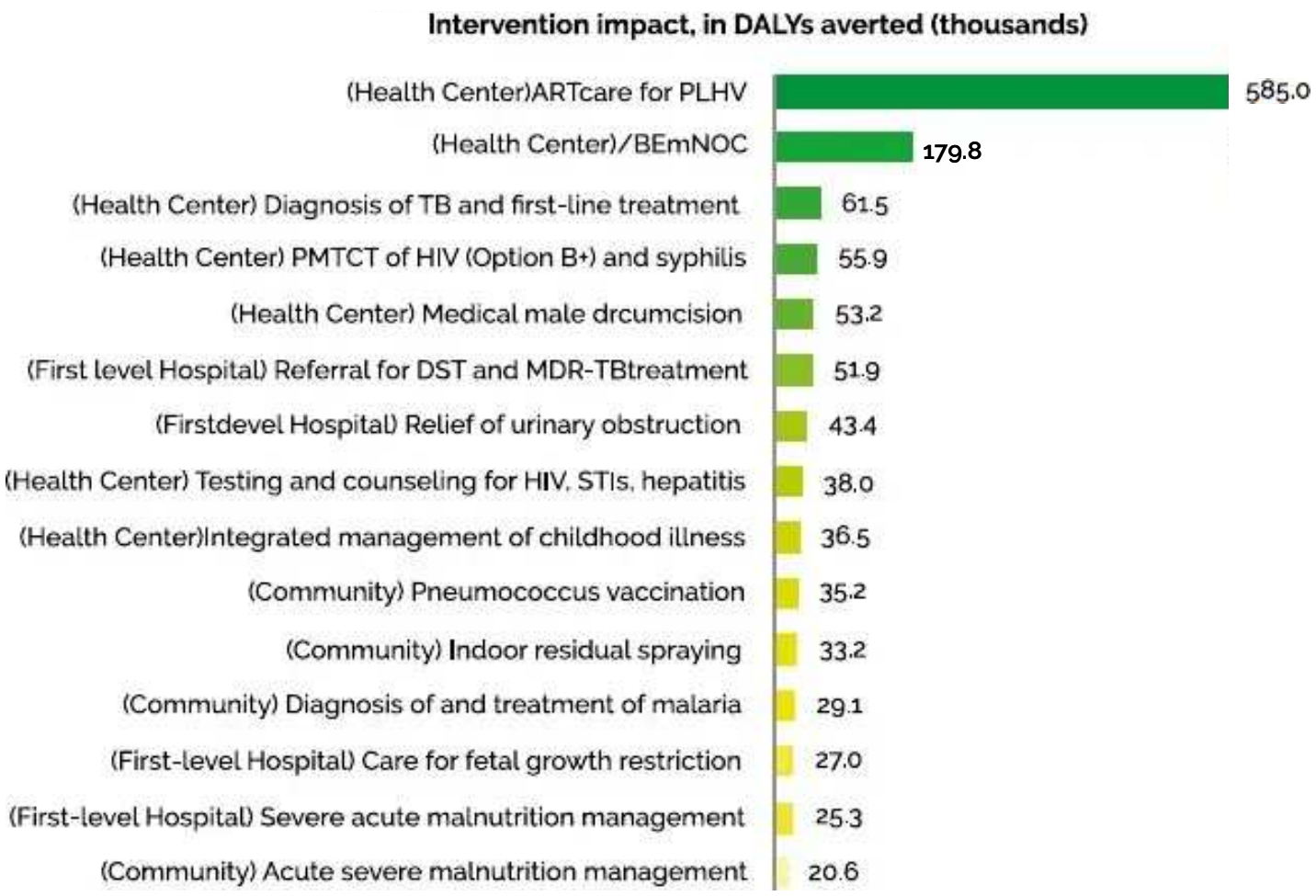


Figure 8:Intervention impact , in DALY averted ***Source:*** *World Bank, 2019*

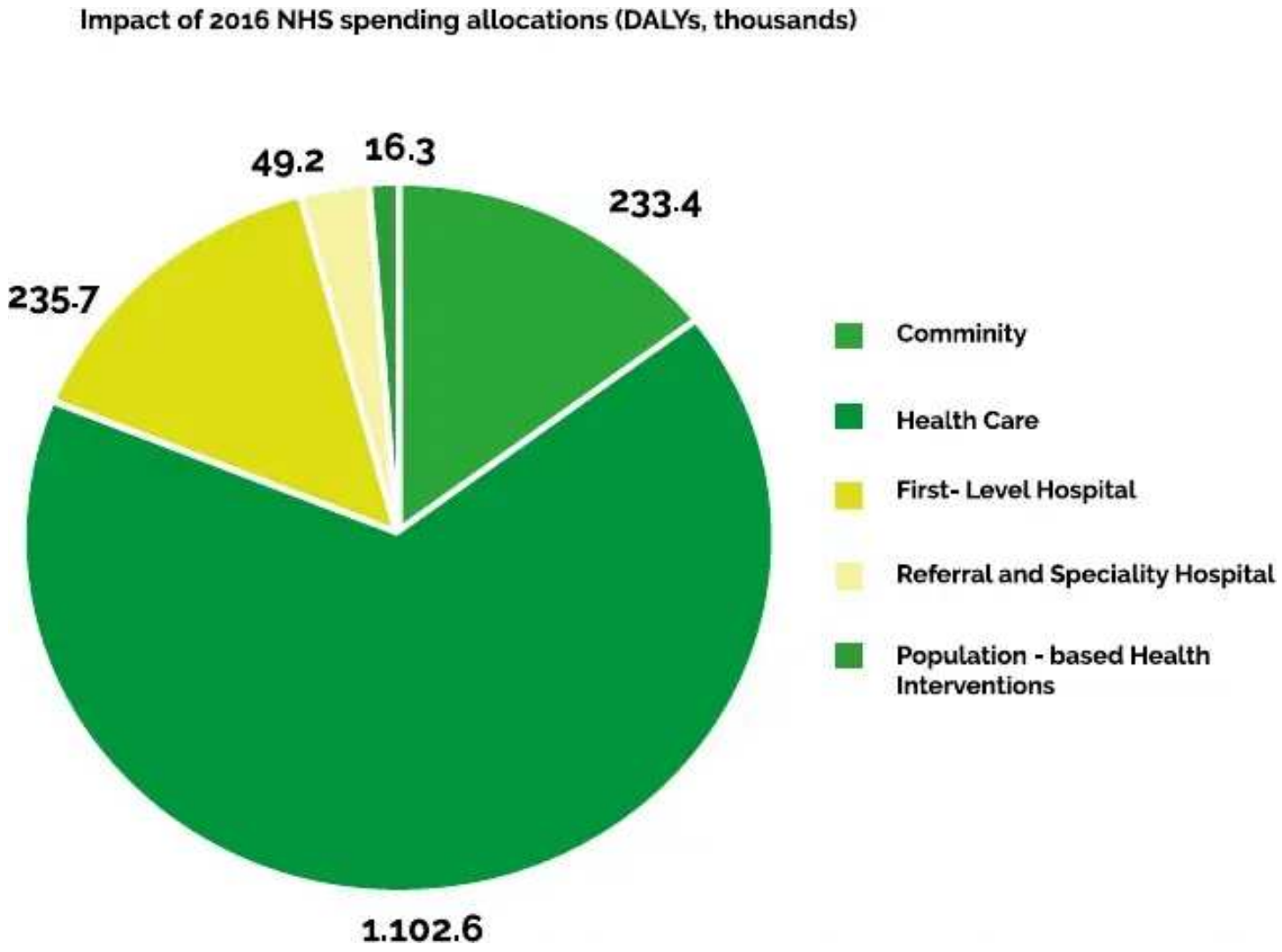


Figure 9: Impact of 2016 NHS spending allocations ***Source:*** *World Bank, 2019*

1.9.4 Results Based Financing:

Results Based Financing (RBF) was introduced with support from the World Bank. It has three objectives which are to strengthen supply of quality maternal and neonatal services to the poor rural communities and in low-income urban districts; increase the utilization of maternal and neonatal care services among the urban poorest quintile; and reduce the out-of-pocket expenditure and catastrophic expenditure on maternal and neonatal care among the urban poorest quintile. Implementation has been adjudged a success as there is evidence that some of these objectives were met. Sustainability remains the biggest challenge with respect to source of funding (MoHCC 2020).

1.9.5 Health User Fees Policy:

A new user fees policy was put in place in 2007. This exempted child under 5 years, maternity care, those above 65 years old and the disabled.

1.9.6 Assisted Medical Treatment Order (AMTO):

This is administered by the Department of Social Welfare. It is meant to cushion the poor, so it pays bills for those designated as poor. Assessment is done by Social Welfare. However, it excludes those exempted through the User Fees Policy.

1.10 Health Leadership, Governance and Accountability

The obligation to ensure provision of basic health services is spelt out in the constitution. This is supported by almost 20 pieces of legislation administered by the MoHCC, and supplementary legislation administered through other sector Ministries.

The national health policy enunciated in 1980 has over time been supported by successive national strategic plans. There are also strategic plans and Guidelines to support implementation of most health programs. All these give directions to the national health service, which is explicitly based on PHC and has a referral relationship between different levels of the system.

The MoHCC through its organizational structures at Headquarters, the Provinces and Districts is expected to oversee and operationalize these legal provisions as well as strategic plans.

The MoHCC has the following statutory bodies; The Health Services Board, The Health Professions Authority, The National Pharmaceutical Company (NatPharm), The National Family Planning Council, and the National AIDS Council, Medicines Control Authority of Zimbabwe (MCAZ) and Medical Research Council of Zimbabwe (MRCZ). These have very important roles to play to ensure implementation of the national health strategies.

The Ministry will continue to strengthen regulation of Medical aid societies to protect their members who pay subscriptions so that they do not pay at point when they consume health services. For instance, the Medical Aid Societies are required to submit financial reports at the end of every financial year and those who do not submit these reports to the regulator, their certificates are cancelled as stipulated in the regulations. The enabling regulations will be reviewed with a view to establish a regulatory authority for health insurance.

There is need to review and align health service provision by local authorities. City Health Authorities' facilities do not operate after hours, thereby leaving their communities with no access to services.

Private practice by public sector health care providers resulting in staff members being absent from their stations. Focus will be on reviewing the private practice policy with a view to improve

quality of services in both public and private health care settings.

Some key sector programmes still operate in silos, with separate funding mechanisms. These "silos" were partly a result of partners' attempts to resuscitate the health sector following the hyperinflation period. Consequently, this means some programs are well funded whilst others remain unfunded (dubbed orphans). Focus will be on integrating and harmonising all health programmes. Management and leadership capacity development to complement improvements in coordination and performance accountability was identified as requiring attention. Linked to the above is the issue of a weakened performance management and accountability system.

> The Ministry will continue to strengthen regulation of Medical aid societies to protect their members who pay subscriptions so that they do not pay at point when they consume health services. For instance, the Medical Aid Societies are required to submit financial reports at the end of every financial year and those who do not submit these reports to the regulator, their certificates are cancelled as stipulated in the regulations.

2. Health Sector Outcomes

The National Development Strategy 1: 2021-2025 (NDS1) identified Health and Wellbeing as one of its Thematic areas, and improved quality of life as one of the national outcomes. eleven Outcomes to be achieved are:

1. **Improved leadership and governance of the health sector.**
2. **Improved Reproductive, Maternal, New-born, Child and Adolescent health and Nutrition.**
3. **Improved health infrastructure and access to medical equipment for quality health service delivery.**
4. **Reduced Morbidity and Mortality due to Communicable and Non-Communicable Diseases.**
5. **Improved access to Primary, Secondary, Tertiary and Quaternary and Quinary care health services.**
6. **Improved access to essential medicines and commodities.**
7. **Increase access to Water, Sanitation and Health Environment.**
8. **Improved Human Resources Performance in the Health Sector**
9. **Increasing domestic funding for health services.**
10. **Improved Public Health Emergency Preparedness and Response Capacities.**
11. **Improved health research and development**

These Outcomes capture the thrust of the targets in SDG 3 and other health related targets such as on water, sanitation, housing and food and nutrition.

SDG 3 goal is to Ensure Health Lives and Well-being for All at All Ages. The foundation of this goal is Universal Health Coverage (UHC) whose aim is that everyone be able to access promotive, preventive, curative, rehabilitative and palliative health services they need, that these services should have sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. Goal 3 also includes a bold commitment to achieve SDG targets on Maternal and Child Health as well as to end the epidemics of AIDS, tuberculosis, malaria, and other communicable diseases by 2030. Targets are also set to prevent and control NCDs.

SADC has a health policy framework whose aim is to raise the regional standard of health for all citizens to an acceptable level by promoting, coordinating, and supporting member states' efforts to improve access to high-impact health interventions. This framework proposes policies, strategies, and priorities in the following areas: Health research and surveillance; Health information systems; Health promotion and education; HIV and sexually transmitted diseases; Communicable and Non-Communicable Diseases; Disabilities; Reproductive health; Health human resources development; Nutrition and food safety; and Violence and substance abuse.

2.1 Goal

To improve quality of life.

2.2 Vision

The highest possible level of health and quality of life for all citizens and permanent residents of Zimbabwe by 2030.

2.3 Mission

To 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 locally available resources in line with the Primary Health Care Approach.

2.4 Guiding principles

a) **Equity – provision of health care services according to need.**
b) **Quality – provision of appropriate services meeting the expectations of clients.**
c) **Efficiency –allocative and productive efficiency.**
d) **Confidentiality – utmost regard to the dignity of clients and patients.**
e) **Professionalism – abide to the dictates of the calling of a profession.**
f) **Partnerships and Multi-sectoral collaboration-strengthening partnerships and collaborating across sectors on health matters.**

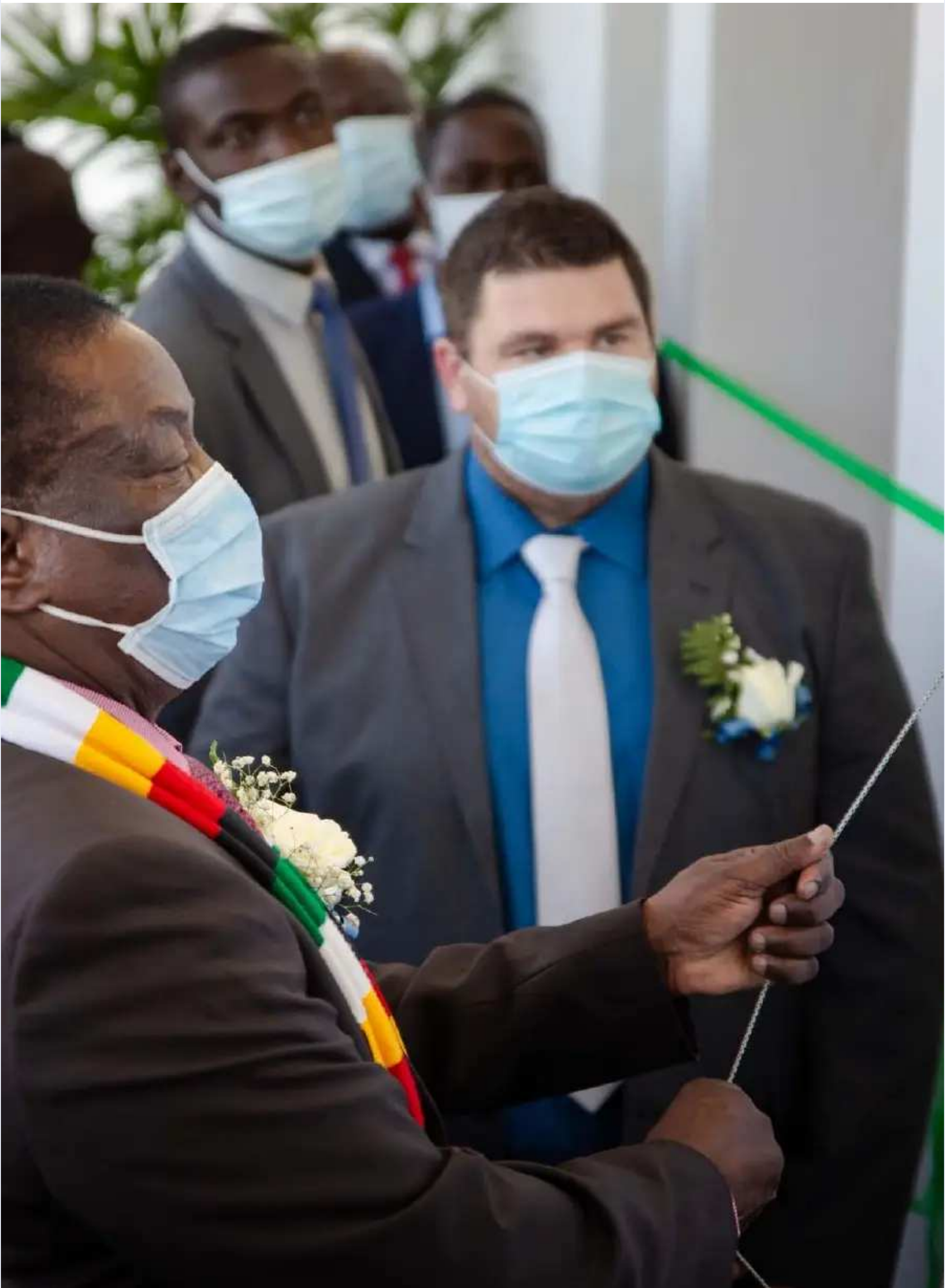
2.5 NHS 2021 – 2025 Planning and Implementation Linkage/ Flow

The Health sector derives its strategic focus from the outcomes stated for the Health and Well-being thematic area in the National Development Strategy 1: 2021-2025 (NDS1). The national outcomes become priority areas of focus for the health sector. The Results based management (RBM) planning framework is customised into four programs or key result areas (KRA) in the health sector. Each of the programs addresses priorities. The implementation plan for the health sector strategic plan is a three-year rolling plan that directs strategic intervention for the service delivery levels and the enabling environment for service delivery.
Figure 1 below illustrates the symbiotic linkages.

Table 1 below shows the sector links between the sector programs according to the Integrated Results Based management framework and the strategic direction of each of the programs/ KRA's and the priorities of the sector that addressed within the program. Each priority is supported by one or more Strategic Directions and the respective Strategic intervention to be implemented to realise the goal. What follows now are the NHS priorities, these have been harmonised with the NDS 1 [2021-2025] priorities or Outcomes. Each priority is supported by one or more Strategic Directions and the respective Strategic Interventions to be implemented to realise the Goal.

Table 5: KRA, Outcomes and PBB linkages

Goal	TO IMPROVE QUALITY OF LIFE		
KRA REF	**KRA**	**Strategic Objective**	**Sector Priority Areas**
1	Policy and Administration	To strengthen enabling environment for health services delivery	1) Improved leadership and governance of the health sector
			2) Increased Domestic Funding for Health
			3) Improved human resource performance in the health sector
			4) Improved Access to Essential Medicines and commodities
			5) Improved Health infrastructure and medical equipment for Health Service Delivery
2	Public Health	To strengthen preventive services and promoting healthy lifestyles (Scale up coverage of public health interventions)	6) Increased access to water, sanitation and healthy environment
			7) Reduced morbidity and mortality due to communicable and Non-Communicable Diseases
			8) Improved Reproductive, maternal, new-born, child and adolescent health and Nutrition
			9) Improved public health surveillance and disaster preparedness and response
3	Curative Services	To strengthen quality of primary and hospital care services (Improved access to quality primary and hospital care)	10) Improved access to primary, Secondary, Tertiary, Quaternary and Quinary health care services
4	Biomedical Sciences and Technology	To improve local manufacturing capacity for health commodities and medical equipment as well as health research and innovations	11) Improved health research and development



3. Health Sector Priorities

3.1 Improved leadership and governance of the health sector

Strategic Direction 3.1.1
Development and implementation of policies and strategies to improve accountability and transparency in the health service.

Strategic Intervention 3.1.1.1:
Strengthen the policy, strategies and guidelines for implementing the mandate of the MOHCC.

The MOHCC in collaboration with the PSC and OPC will capacitate departments and platforms to develop strategies and implementation matrices that are aligned to the Integrated Results Based Management (IRBM).

Strategic Intervention 3.1.1.2:
Strengthen the implementation of the health-related legislation in the Public and Private sector.

There are numerous policy documents on governance of the health sector supported by legislation however implementation and enforcement remain weak for example; the Public Health Act: Non actioning for PHA implementation matrix framework, Health Services Act: Non-existence of Hospital Management Boards (HMBs) at District & most Provincial Hospitals including Health Centre Committees and even regulations for private health sector involvement and reporting in providing health care.

MOHCC will prioritise the operationalisation of the recommendations in the Public Health Implementation matrix framework. The MOHCC will focus on strengthening the one health or multisectoral approach as a way of ensuring the enforcement of the legislation.

Strategic Intervention 3.1.1.3:
Strengthen the Monitoring, Evaluation, Accountability and Learning (MEAL) processes for health programs.

The MOHCC will review the M&E department establishment to accommodate the workload and achieve equitable M&E personnel coverage for all programmes and health system units.

MOHCC will also establish a policy to enforce one harmonised M&E platform for the health sector. Progress, and performance of the NHS, health system components and programs will be tracked. Monitoring, evaluation and review provide the basic measurement systems and accountability mechanism to plan, manage and account for objectives and targets of the NHS

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Strategic Intervention 3. 1.1.4:

Implement the Digital Health Strategy.

The National Digital Health Strategy 2021-2024 will support the establishment of the requisite Health ICT infrastructure and broadband connectivity at all levels, support the deployment of the electronic health record (Impilo) system, accelerate the digitization of business processes within the Ministry, begin the digitization of the community health strategy and strengthen governance and capacity building of digital health in Zimbabwe.

Strategic Intervention 3.1.1.5:

Institutionalise Integrated Results Based Management (IRBM) and the Whole of Government Performance Management approach in implementation and monitoring of all policies programs and strategies.

The Ministry plans to ensure capacitation of every leader in the IRBM system of management, which is the chosen performance management tool for the GoZ. This system institutionalises accountability among all leaders and personnel for the outputs and outcomes of their departments and units, and their linkage to the NHS goals and objectives.

The MTR of the 2016-2020 NHS found a weak performance management and accountability system in the health sector, where leaders report activities which are not well linked with results expected in the NHS. Institutionalising IRBM will also help enhance health sector capacity in planning, budgeting and resource reallocation synchronisation across management levels.

In the same vein, institutionalisation of the GoZ 100-day cycle programme will help improve implementation of Ministry priority projects in the NHS.

Strategic Intervention 3.1.1.6:

Implement strategic Rebranding of the Health Sector.

The NHS will, during the period of its implementation foster a strategic rebranding of the Public Health System.

This will be achieved through several measures that include:

- Implementation of a reviewed structure that maximises efficiencies and equity.

- Transformative and responsive leadership of health sector.

- Motivation of health care workers through comparative remuneration, adequate tools of trade and non-monetary incentives;

All this with a view of improving service availability and readiness with improved client satisfaction.

Strategic Direction 3.1.2:
Strengthen Health Sector Research to better inform policy and development decision making.

Strategic Intervention 3.1.2.1:

Promotion of research and evidence generation for effective program development and policy.

MOHCC will develop an integrated research and development plan that will speak to capacity building of skills in the system. It will work on strengthening partnerships to support the health research agenda, such partnerships include partnering with academic institutions. There will be a need to ring fence funds for research ensuring a repository is accessible.

Strategic Direction 3.1.3: Strengthen health sector coordination, Leadership and management capacities.

Strategic Intervention 3.1.3.1:

Develop and implement leadership and management capacity development plan for all levels.

Organizational leadership, management and operational planning have been observed to be deficient across management levels compromising on institutional pro-activeness and efficiency. There is need for leadership and management training programmes to building and strengthen capacities of MOHCC staff at all levels. Particular attention will be given to provincial and district health management teams.

Strategic Intervention 3.1.3.2:

Operationalize health sector coordination framework.

There is overlapping, unclear roles and function between local authorities and MOHCC; MOHCC and other government departments, uncoordinated partners, poor communication among MOHCC depts and programmes. The ministry will prioritise the implementation of the Health Sector Coordination Framework. The framework focuses on strengthening inter-ministerial coordination, intra-ministerial coordination, intersectoral collaboration, health development partners collaboration and private sector collaboration.

Strategic Direction 3.1.4: Promote health in all policies.

Strategic intervention 3.1.4.1:

Institutionalize health promotion, disease prevention & preparedness in other sectors.

Engage parliamentarians, regulators in non-health sectors, health advocates, NGOs, civil societies and other stakeholders to promote and implement health in all policies that would help address the social determinants of health as well as prevention of accidents, injuries and poisoning.

Engage the education sector to review and update policies and curricula in primary and secondary education. Incorporate in the curricula health promotion, prevention of communicable and non-communicable diseases and reproductive health.

Support the education sector in capacitating schools to promote health, nutrition and sanitation and to prevent and control diseases of public health importance.

3.2 Improved Reproductive, Maternal, New-born, Child and Adolescent health and Nutrition

Strategic Direction 3.2.1. Address gaps in access and quality of RMNCAHN and Child Care services.

Strategic Intervention 3.2.1.1:

Address gaps in access, quality and Improve RMNCAHN and Child Care service availability and service readiness.

The main gap in maternal, neonatal and child health is limited access in some locations and poor quality of services. This will be addressed through enhancing and scaling up access to RMNCAH services. RMNCAHN is a good indicator to measure access based on expected utilisation projected from population figures. Examples are Antenatal care, number of deliveries, maternal deaths, and immunisation. These will be used to measure and monitor progress in improving access, performance of health facilities as well as monitor equity.

There are standard service availability and service readiness requirements as reflected in the SARA 2015. The requirements for RMNCAHN, especially for BEmOC and CEmOC will be prioritised for Primary Care and Secondary Care health facilities. This is consistent with making primary and secondary care fully operational as already discussed. The objective will be to reach 90 per cent for both service availability and service readiness.

Strategic Intervention 3.2.1.2:

Enforcement of a standards based RMNCAHN and Child Care quality services improvement program.

There are standard guidelines for all aspects of service delivery that have been in use for a long time in RMNCAHN and Child Care. There are also new guidelines for antenatal and intrapartum care being adopted such as the one which recommends 8 gestational age appropriate ANC contacts and early ultrasound scan; monitoring progress in labour using the partogram; postnatal care; integrated management of childhood illness, and child immunisation among others.

These guidelines should be strictly followed. Managers will be required to ensure this happens, including through development and use of tools such as the Standards Based Management and Recognition approach. Managers will be held accountable for noncompliance. Mechanisms such as Results Based Financing will be used to reinforce compliance through reward for good performance. Staff trained in Public Health will play a more prominent role in analysing performance of the programs in the Provinces, Districts and Local Authorities. Similar such

Public Health support will be provided to Central Hospitals through creation of positions or secondment of staff.

Prioritising quality improvement in RMNCAHN and Child Care Services is a low hanging fruit, and all elements required are already in place. That explains the prioritisation being given to this.

Strategic Intervention 3.2.1.3:

Engage and work with communities in improving RMNCAHN and Child Care Services outcomes.

Pregnancy, Child birth and Child rearing are societal responsibilities, at least according to our culture. It is common knowledge that some of the reasons for the delays in seeking care are a result of decisions made in the family or community on behalf of the pregnant woman. More effort will be put into explaining program expectations and how family and community can support pregnant women and children to access health services timely in order to get good outcomes. The support will be expected in terms of quick decision making, social support and logistics to facilitate access to services.

Particular attention will be paid to those religious sects that teach followers to not use health services so that they change these practices. Communities and their leaders will be encouraged to play a role in monitoring outcomes against targets set for their areas of jurisdiction. Community Health Committees should be assigned targets towards reduction of maternal mortality in their jurisdiction, based on population projections to increase community's ownership or accountability towards maternal and child health outcomes. It is expected that these committees should assist or trigger communities to identify challenges in access and develop action plans to address them.

Involvement of health centre committees in building of maternity waiting homes and contracting of local transport owners to ferry pregnant women to health facilities can be encouraged so that the second delay can be eliminated as a cause of both maternal and perinatal adverse outcomes. Such approaches ensure participation by all in the community, starting from family members, village leaders to councillors and members of parliament.

Strategic Intervention 3.2.1.4:

Contribute to improving Africa Programme on Accelerated Improvement of CRVS coverage.

Civil Registration and Vital Statistics caters for Birth Registration, Marriage Registration and Death Registration. These interventions contribute immensely to maternal and child health.

With respect to maternal mortality, this will enable us to compute MMR on an as we go basis rather than rely on estimates or special surveys. For these reasons, the Health Sector will play a more significant role towards improvement of at least Birth registration and Death registration. Coverage is now down to about 48 per cent for birth registration. Objective would be to get it back to where it was, around 80 per cent or more.

Negotiations with the Registry Department on CRVS that can be further devolved to health facilities should be undertaken and be provided for in law to enable deployment of this intervention.

Strategic Intervention 3.2.1.5:

Improving youth friendly services so that a comprehensive adolescent health minimum service delivery package that includes SRH, immunisation, mental health, menstrual hygiene, HIV and nutrition is offered at health facilities.

The high rates of unwanted pregnancies, early marriage and sexually transmitted diseases remain of concern. Efforts will be made to ensure unmet needs of contraception especially among adolescents are addressed. Innovative, age appropriate school, family and community based and balanced health education, advocacy, life and livelihood skills-oriented empowerment initiatives for adolescents will be developed and rolled out. HPV and Tetanus toxoid vaccines will be included in this package of services.

Strategic Intervention 3.2.1.6:

Improve sexual and reproductive services to cater for victims of sexual abuse and gender-based violence.

There is great need to ensure that victims of sexual abuse receive prompt psychological and clinical care at earliest possible time, this will ensure that adverse impact of the events are minimised. Secondary health facilities need to have 24hr adult rape clinics whilst primary health facility staff need to capacitate to offer the psychological support and administer post exposure prophylaxis

Strategic intervention 3.2.1.7:

Strengthen Child Care services.

Child Care seeks to ease the effects of rights violations on women and children by enhancing care and support services. This will offer an important continuum of care by contributing to quality Child Care services and state party reporting. Interventions that reduce susceptibility will be rolled out to deliver holistic care. Child Care's central strategy is to strengthen existing structures and improve their capacity to afford comprehensive services to women and children. Child Care will strengthen existing structures and systems from community, district and provincial levels, resulting in more children and women receiving basic services (health, education, justice and social protection).

At community level Child Care will work with women and children, their households and community cadres to provide a protective, stable and safe environment. The major focus will be on scale up interventions in child rights governance, minimum package for violence against children and GBV management. At Government level, this will entail supporting the quality of service delivery through strengthening coordination, monitoring and reporting function of the state party. In addition, Child Care will support SGBV forensic training of health service providers.

Strategic Intervention 3.2.1.8:

Strengthen nutrition program so that it caters for needs from infancy to adulthood.

The program will address issues in maternal, infant and young child feeding, micronutrient deficiency, as well as address overweight and obesity. The program will also address regulatory actions, policies, and strategies related to maternal, infant, young child and adolescent nutrition.

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Strategic Intervention 3.2.1.9:

Improve early identification and prevention of childhood disabilities by upscaling the 'At Risk' Surveillance System (ARSS), and strengthening of the Children's Rehabilitation Program.

About 1 in 10 of children age 2-17 years were reported to have at least one functional difficulty (MICS 2019). Children with disabilities are among the most marginalized groups in society, they face daily discrimination in the form of negative attitudes, and lack of adequate policies and legislation. They are often likely to be among the poorest members of the population and are often barred from realizing their rights to health, education, and even survival. (MICS 2019)

This strategic intervention therefore will enhance early identification of childhood disabilities to promote early intervention. This will curtail most of the challenges faced by children with disabilities. This will help Zimbabwe to meet the standards of the Convention on the Rights of the Child (UNICEF, 1998) and the Convention on the Rights of Persons with Disabilities (UN, 2006)

> At community level Child Care will work with women and children, their households and community cadres to provide a protective, stable and safe environment.


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3.3 Improved health infrastructure and access to medical equipment for quality health service delivery

Strategic Direction 3.3.1:
Expand equitable access to improved health infrastructure that is appropriately equipped.

Strategic Intervention 3.3.1.1:

Establish new health infrastructure to serve underserved areas, prioritizing.

Primary and Secondary Care.

There are inadequate Primary and Secondary Health Care facilities in both rural and urban areas. The focus will be on establishing new facilities in these areas and this will include the construction of health posts at community level. District hospitals will be constructed in Harare and Bulawayo to decongest the Central hospitals in these cities. In the meantime, Primary Care facilities will be established at the referral centres. The health sector infrastructure development plan will be developed to guide implementation of this strategy.

Strategic Intervention 3.3.1.2:

Improve health infrastructure for tertiary and quaternary care infrastructure.

The service delivery platforms referral system is constraining intensive care unit and high depends care unit service at tertiary and quaternary levels due to infrastructure and equipment gaps at secondary care referral facilities. The strengthening of service availability for ICU/HDU at the later will ensure optimisation of the service delivery platform reducing unnecessary referrals.

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Strategic Intervention 3.3.1.3:

Develop new health infrastructure for quinary care services.

In addition to the existing health care services currently offered in the country, there has been an increasing need for quinary services to cater for super specialist medical services and research. This will include the establishment of a quinary hospital that offers super specialist services and conducts research as the highest level of health care. In the interim, available tertiary and quaternary health facilities will be equipped to provide "low hanging" super specialist services where feasible.

Strategic Intervention 3.3.1.4:

Strengthening and equipping ambulance and referral management system.

The referral system is strongly dependent on the transport system between health facilities. The transport system most appropriate to a specific area is dependent on several factors. Although in the Zimbabwean context, the road network is widely used for networking between health facilities, the MOHCC will include air and water ambulance systems to complement the road network. The fleet of ambulances within the MoHCC is no longer adequate to cater for the population at the different levels of care.

The MoHCC will strengthen the ambulance management system by appropriately equipping available ambulances and procuring additional well-equipped ambulances. The recruitment of ambulance technicians who have a critical role in the ambulance management system will be given priority for available ambulances. The MoHCC will ensure that the procured ambulances are well distributed across the country

Strategic Intervention 3.3.1.5:

Procure, rehabilitate and maintain hospital equipment.

The MOHCC will define a minimum equipment standard package for each level of care. The equipment package will be aligned to the basic package of services offered at that level. Within each category, different types of equipment will be identified according to use.

The MoHCC will establish MoHCC vehicle and equipment maintenance workshops. Hospital equipment engineering team will be strengthened and capacitated to provide the required support. To realise this, a health sector equipment procurement and maintenance plan will be developed.

> "District hospitals will be constructed in Harare and Bulawayo to decongest the Central hospitals in these cities. In the meantime, Primary Care facilities will be established at the referral centres."

Expanding Critical Health Infrastructure

Medical Equipment

3.4 Reduced Morbidity and Mortality due to Communicable and Non-Communicable

Diseases

Strategic Direction 3.4.1:
Reduced Morbidity and Mortality due to Communicable diseases and accelerating towards elimination.

Strategic Intervention 3.4.1.1:

Implement the 95-95-95 HIV Strategy.

Standard effective HTS and other HIV Prevention interventions will continue.
Targeted approaches are required to find the remaining 10 percent of PLHIV who do not know their status. This is challenging because the yield from testing services has declined from as high as 20 per cent in 2011 to around 6 per cent in 2018. Innovative approaches such as use of screening tools, index testing and HIV self-testing will be introduced or scaled up. Screening tools help to identify high risk clients.
HIV Index testing involves provision of HTS to sexual contacts and family members of known PLHIV (index clients) who are at increased risk of HIV infection such as sexual partners and children under 15 years. These approaches will be expanded to cover the whole country.

For effective treatment monitoring, viral load (VL) and HIV drug resistance (HIV DR) testing will be prioritized, along with external quality assessment (EQA) for machines and capacity building of health facility staff on VL and HIV DR data collection, reporting, and interpretation of results. Observance of the agreed frequency of VL testing will be made an integral part of program management.

Adolescent Girls and Young Women continue to be the hardest hit by new infections. For this reason, efforts will be made to ensure wide access to prevention interventions such as PrEP which are known to be effective. However, there is limited access to such services. Access to PrEP will be improved to enable those who need it to access it especially those at high risk. Advocacy for interventions in other sectors such as Education, Labour, Small and Medium Enterprises, Social Welfare, Industry and Commerce among others, to address structural determinants that increase risk to AGYW will be undertaken. It will be important to agree upfront the priority interventions and how progress will be monitored.

Known effective interventions focussing on adolescent boys such as male circumcision, and on male masculinity issues will be advocated for and interventions deployed. Effective interventions for high risk groups such as sex workers, and men who have sex with men will be scaled up.

Strategic Intervention 3.4.1.2:

Strengthen implementation of End-TB strategy.

The goal of Ending the TB epidemic will be met by accelerating efforts of increasing the treatment coverage which entails dramatically expanding TB awareness, prevention, high quality care and treatment. The high proportion of patients who have negative outcomes above the desired thresholds will be addressed though various efforts which include; Differentiated service delivery models; Rollout of defaulter tracking tools; Optimization of treatment regimens; Quality Improvement; Decentralization of third line medication to provincial hospitals; and multi-month dispensing will be deployed.

Ensuring availability of commodities as well as improving service quality are important components. Offering differentiated service models to men, adolescents, and mobile populations is known to be an effective way to retain people on treatment. Further expansion of this approach will be prioritised, including focussing on border areas with Botswana and South Africa. A multi-stakeholder approach is required for an effective and sustainable response and this will see expanded implementation of PPP models as well as increased community health care workers and civil society engagement and capacitation. To improve access to care and treatment community based TB screening will be rolled out to all districts with two rounds of screening per district per year. Community based TB screening will be intergrated with screening for NCDs, common cancers and Covid-19.

Strategic Intervention 3.4.1.3:

Strengthen the implementation of the malaria elimination strategy.

Strengthen surveillance as a core intervention and engage other sectors and communities at risk to accelerate and sustain progress towards malaria elimination and prevention of re-establishment of malaria transmission. Improve micro-stratification of malaria risks areas for better planning and targeting of interventions.

The deployment of IRS in areas where Annual Parasite Index of 5 per 1000 and above reaching 95 per cent of targeted population, and LLINs at 2 -4 per 1000 reaching 85 percent of targeted households will continue with adjustments as control measures show effectiveness or otherwise.

This will be supported by the necessary entomological monitoring looking at the vector prevalence and resistance pattern as is standard in the program. There is also a need to widen the scope of interventions to include non-chemical based options. This will help address environmental concerns and resistance issues. Ensuring access to prompt and appropriate management of all malaria cases within 24 hours of onset of symptoms will continue to be the key objective. This will be achieved through Strengthening quality assurance of RDTs and microscopy; Maintaining quality-assured treatment of all uncomplicated malaria cases; Capacitating health facilities to effectively manage severe malaria; and Ensuring quality-assured supply chain management.

The provision of LLINS at first antenatal care (ANC) visit, intermittent preventive treatment for pregnant women (IPTp) to all pregnant women in malaria endemic area starting at 13 weeks gestational age, for a minimum of three doses, and effective case management of malaria will continue. The MOHCC will accelerate morbidity reduction by increasing the number of districts implementing malaria elimination activities. Districts will be capitated with resources to improve operational efficiency in relation to case and foci investigation.

Strategic Direction 3.4.2:
Strengthen Prevention and control of NTDs.
The common approaches including preventive chemotherapy, transmission control, mass drug distribution, vector ecology and management and WASH will be deployed according to the programmatic requirements of each NTD.

Strategic Intervention 3.4.2.1:
Development of NTD master plan.

The NTD master plan will be updated taking into consideration the ongoing efforts in the control and elimination of NTDs and to include the new NTDs.

Strategic Intervention 3.4.2.2:
MDAs for PC-NTDs.

Efforts will be made to improve coverage of MDAs for the four priority PC-NTDs, lymphatic filariasis, soil transmitted helminthiases, schistosomiasis and trachoma.

Strategic Intervention 3.4.2.3:
Enhancing Vector Control interventions.

The Trypanosomiasis Control efforts will need continuous support to maintain vector control in the targeted hot spots Snail control as part of schistosomiasis will need to be scaled up.

Strategic Intervention 3.4.2.4:
Health facility management of common NTDs.

Guidelines for the management of common NTDs will be developed and disseminated and health workers' capacity for the management of these conditions built.

Strategic Intervention 3.4.2.5:
Morbidity Management and Disability Prevention.

Routine and organised morbidity management and disability programmes will be set up for conditions that cause disability which include leprosy, trachoma, lymphatic filariasis
Strategic Intervention 4.2.6: Scaling up Rabies Vaccination
Reactive and proactive vaccination for rabies will be supported in collaboration with the veterinary department.

Strategic Direction 3.4.3:
To reduce preventable disease burden due to NCDs through multisectoral collaboration while taking guidance from global commitments.

Strategic Intervention 3.4.3.1:
Develop the National NCD Strategy and Strengthen coordination of NCD programs prioritising Cardiovascular Diseases, Diabetes, Cancer, Chronic Obstructive lung diseases, Oral Health, Injuries and Mental Health.

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First Lady Auxilia-Mnangagwa (Ambassador Of Health). Waiting to be screened for cervical cancer during her nationwide tour to raise awareness on cervical cancer.

The NCDs share common risk factors, this facilitates a common approach to their prevention. The nine voluntary global targets and 25 indicators as defined in the Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020 provide good guidance on intervention areas (WHO 2013). Furthermore, the prevention and control efforts require a multisectoral approach.

Thus, a well-coordinated structure putting together all NCD related units to coordinate this work will be set up. Priority will be those NCDs that affect the nation. Based on information currently available, this includes Cardiovascular Diseases, Diabetes, Cancer, Chronic Obstructive lung diseases, Injuries and Mental Health.

The first and urgent task for this program will be to develop the National NCD Strategy. This should further elaborate NCDs prevention and control interventions which must be consistent

with commitments made through the UN political declaration on NCDs as well as the World Health Assembly Global strategy for the prevention and control of NCDs. Key aspects relate to tobacco as defined in the FCTC; Harmful use of alcohol; diet, physical activity and health; and sustainable health financing and universal health coverage.

Strategic Intervention 3.4.3.2:

Undertake surveillance of NCDs risk factors as well as the NCDs themselves through routine data gathering mechanisms already in place or special surveys such as STEPs, and National Oral Health Surveys.

To address the limited data availability on NCDs, surveillance on NCD risk factors and the NCDs themselves will be undertaken as a matter of urgency. This will for example be through the MICS, STEPs surveys or CRVS. This will provide up to date data required for planning. This will help expand or narrow the range of conditions to be prioritised. Surveillance of NCD risk factors will be a continuous activity rather than a one-off intervention.

Strategic Intervention 3.4.3.3:

To prioritise primary and secondary prevention in addressing NCDs through multisectoral effort.

Primary prevention will be prioritised to address common risk factors for NCDs. These are to do with use of tobacco, harmful use of alcohol, and advocating for use of healthy diet and physical activity. There are common approaches to this. This includes informing and educating the public, enacting and enforcing restrictions on commercial or public availability of the commodity through legislation, and policy. These provide measures to prevent easy access to harmful products. Another approach is to enforce bans or restrictions to advertising, sponsorship or promotion. This restricts exposure to them which brings about public health benefit. Another complementary intervention is to raise prices through excise taxes and pricing policies. This reduces use, brings about awareness and raises additional revenue to governments. Road traffic injuries will be prevented through education and enforcement of appropriate legislation that will be developed. An example will be to enact strict drink driving counter measures.

Primary prevention through vaccination such as HPV and Hepatitis B will be part of this effort. Other vaccinations will be incorporated as they become available. A systematic improvement will be made on the screening programs especially for cancers but always linked to case management options that will be available.

Strategic intervention 3.4.3.4:

To promote access to affordable mental health and allied services, reducing dependence on institutional-based care increase.

The primary intervention will be to build the capacity of health workers at primary and community level to identify and provide mental health services. This will be done through in service and preservice training.

Strategic Intervention 3.4.3.5:

To reduce the excessive use of alcohol and harmful drugs and to curtail the trafficking of illicit drugs especially among the youth and young people

The primary intervention will be to strengthen advocacy activities through dissemination of messages using mass media and testimonies from people with lived experiences, especially celebrities. This will be supported by provision of support for withdrawal services and appropriate enforcement of legislation in place.

Strategic Intervention 3.4.3.6:

To provide guidance on NCDs case management and its integration into primary care level.

The Primary Care level will play a more prominent role in case management rather than just dispensing medicines prescribed at higher levels. Only cases that require higher level assessment and initiation of treatment should be referred up the system. To enable this to happen clear guidelines on assessment of patients and initiation of treatment at Primary Care level will be developed. This is important because currently it is difficult for primary care workers to assess patients and initiate treatment as there are too many complicated options to choose from. For example, there are many different types of medicines the primary care nurse has to choose from for treatment of high blood pressure. This can be confusing. Often some of the medicines are not available.

A guideline which limits the range of such medicines and ensures whatever is included is always available will improve case management at primary care level. These guidelines will also include palliative care and rehabilitation services where appropriate. A clear guidance on referral up and down the health care system will be provided.

The WHO Package of Essential NCD (WHO PEN) interventions are feasible for implementation even in low-resource settings with a modest increase in investment. They can be delivered by primary care physicians and nonphysician health workers in primary care. The interventions are for detection, prevention, treatment and care of CVD and risk factors (heart disease, stroke, hypertension) diabetes, chronic respiratory disease (asthma and COPD) and cancer (WHO 2018).

The WHO PEN will be adapted and used to guide selection of interventions for prevention, detection, treatment and care of people with NCDs especially at primary and secondary care levels. The equipment to be purchased, the medicines to be deployed and the risk charts to be used will be identified using this guidance.

Strategic intervention 3.4.3.7:

To reduce the burden of oral health diseases in the community.

Oral health conditions have a high prevalence and low mortality. We do not have baseline data as the last National Oral Health Survey was conducted in 1995. According to WHO estimates, Zimbabwe has 38.2% unmet oral disease burden with dental caries contributing 25.9%.

There is a need to integrate oral health into the NCDs framework using the common risk factor approach and increase access through training other health cadres to be proficient in carrying out basic oral health examinations and refer appropriately.

Strategic intervention 3.4.3.8:

To reduce the burden of disability due to Communicable/Non-Communicable Diseases and injuries through improving medical rehabilitation services package at all levels of care.

The National Disability Survey (2013) showed that in Zimbabwe people with disabilities constitute 7% of the population. This translates to 1.12 million people with disabilities. Improving medical rehabilitation services package should be a priority for this NHS.

Strategic intervention 3.4.3.9:

Implement the Community Based Rehabilitation (CBR) program in all districts as a primary health care strategy to increase universal health coverage and inclusion for people with disabilities (PWDs).

There are great unmet health needs for people with disabilities. The WHO recommends Community Based Rehabilitation (CBR) as a cost-effective strategy to address disability challenges in communities

Strategic intervention 3.4.3.10:

Strengthen the identification of geriatrics and engagement of communities in supporting care.

Primary Care levels should be fully equipped to be able to identify geriatrics within their communities through their community level support. The WHO PEN will be adapted and used to guide selection of interventions for prevention, detection, treatment and care especially at primary and secondary care levels.

Strategic Direction 3.4.4:
To reduce preventable disease burden due to consumption of unsafe food and water.

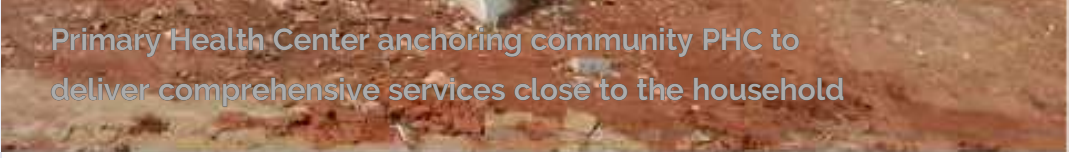
Strategic intervention 3.4.4.1:

Strengthen food quality monitoring in the market.

Ensuring food safety to the population of Zimbabwe through strengthened monitoring will be a priority. Enforcement of the Public Health Act Chapter 15:17, and the Food and Food Standards Act Chapter 15:04 will be strengthened. Special focus will be on strengthening monitoring food fortification, strengthening food analytics, inspection of food imports and exports as well as strengthening monitoring of food poisoning. Strengthening port health management system at Points of Entry and capacitating the Government Analysts Laboratory will be prioritised.

Quatenary hospital for higher specialist services
bridging to quinary super specialist care

Secondary level hospitals bridging primary health care
to the tertiary specialist level at province



3.5 Improved access to Primary, Secondary, Tertiary, Quaternary and Quinary care health services.

Strategic Direction 3.5.1:

Expand equitable access to quality health services with priority being given to Primary Care and Secondary Care to enable higher levels of care to play their roles effectively and efficiently according to the design of the health system in the country.

Strategic Intervention 3.5.1.1:

Capacitate Primary Care and Secondary Care facilities currently in place to fully functional and accountable for service provision.

The Ministry will increase access to health services at community level by establishing health posts below the clinic level. Each health post serves three hundred and fifty households and every district will coordinate with the communities and local implementation partners to establish these health posts at low cost.

The current situation is such that Primary Care and Secondary Care infrastructure is not fully functional partly because of limited Human Resources, Medicines and medical products and equipment. This denies the population access to needed services. This must be addressed as priority. Details on how to address HR, medicines and equipment issues are dealt with in relevant sections in this Strategy. The discussion below focuses on public health services facilities and excludes privately owned facilities as the challenges they face are different.

In this context Primary Care infrastructure includes all such facilities owned by Government, Local Authority, Municipal or Mission authorities. For Secondary Care, priority should be those that are District Hospitals or designated as such first, and then the other hospitals to follow. This includes Mission Hospitals and Local Authority Hospitals. This will ensure fairness in access to health services and in distribution of resources.

What is important here is to prioritise allocation of resources to Primary Care and Secondary Care needs. It is required to first agree what proportion of the budget should go to these two levels, and then ring fence such allocations and ensure procurements and distribution are undertaken accordingly and that ring-fenced resources are used only for this purpose. This means that when resource allocations are made there must be an understanding as to what proportion goes to each level of care, and that this must be respected by managers at all levels.

Each administrative area (i.e ward, district) performance will be monitored based on set service delivery targets and indicators for Primary Care and Secondary Care facilities These could

be selected from among the targets and indicators that will be identified for Monitoring and Evaluation of this plan. Each facility will be required to report and account for its performance.

Strategic Intervention 3.5.1.2:

Provide differentiated service delivery models to cater for special/key/mobile populations

The health system will establish appropriate health infrastructure to cater for temporary communities to ensure access to needed services.

These may be in the form of outreach services supported by local implementing partners including philanthropy.

Strategic Intervention 3.5.1.3:

Revise, update and implement Essential Package of Health Services (EPHS)/UHC benefit package at different levels for achieving UHC.

A Comprehensive Essential Package of Health Services that details interventions to be offered at Community level, Primary and Secondary Care facilities will be developed. The starting point could be the current Core Health Services Package. Thereafter, similar work for defining the Service Packages for Community, Tertiary and Quaternary levels will be undertaken.

This must follow the principle that these levels are there to support the lower levels. However, these higher levels could be allowed to offer referral services beyond what is in the package, but on a full cost recovery basis. This is because they have responsibility for training and research and at the same time require additional funds to run their operations.

Once the service packages are agreed and approved, every effort must be made to ensure all interventions included are provided, all the time, at the right quality level.

In most cases secondary level facilities are providing primary level services in the same OPD area as the secondary level services. This removes the core focus of the referral facility congesting the operations of the secondary level facility operations on primary care services. In other instances, the health services fund is directed to support the primary care services. It is therefore imperative that there be a separation of these services for facilities that do not have a primary care facility within a 5km radius of the hospital. Where a primary care facility exists, there should be redirection of clients to the primary care centre with appropriate health seeking information.

Strategic Intervention 3.5.1.4:

Capacitate Secondary care facilities so that they can undertake Comprehensive Surgical care including CEmOC.

Only 35 percent of hospitals can provide CEmOC and only 55 percent can provide comprehensive surgical care.

This means most hospitals are no different from Primary Care facilities. While the infrastructure is there, service availability is hampered by -limited human resources and low utilization. This implies facilities do not meet people's expectations. Service readiness is hampered by inadequate basic amenities including water and power, essential medicines and medical

supplies, basic precautionary measures including Infection Prevention and Control, diagnostic facilities and basic equipment. Designated district hospitals should be capacitated so that they can do Caesarean Sections, Laparotomy, and treat open fractures at a minimum, the so-called Bellwether surgical conditions. This situation should be monitored through i) population within 2 hours travel distance to facility that can undertake Bellwether Surgical Interventions; ii) surgical, anaesthetic and obstetric provider density; iii) numbers of surgical interventions per 1000 population; iv) perioperative mortality; v) protection of population from catastrophic and impoverishing expenditure. (ref WHO Surgical care systems)

Strategic Intervention 3.5.1.5:

Increase investment on tertiary, quaternary and quinary care service delivery commensurate with cost of service delivery.

Health care facilities should be able to determine the quantum of services they will be able to provide given a defined resource envelope. It is therefore ideal to ensure adequate resourcing of health care facilities to respond to the burden of disease they manage as well as fully equip them for their functions. The Government has a responsibility towards the population and as such should play a role in increasing investment for these levels of care.

Strategic Intervention 3.5.1.6:

Develop medical tourism facilities.

Reorient the business model for quaternary and quinary care level to ensure focus on core specialist services and quality of care standards and make the services affordable, accessible and attractive and competitive. Specialised services in the country have been outsourced in the previous years increasing the health care bill in a country that is struggling financially. Capacitation of the available tertiary and upgrading of some to quinary level will cut on the health care bill and the funds can be channelled back to maintain the facilities.

Strategic Direction 3.5.2
Develop and implement the Health Sector Infrastructure Development and Maintenance Plan.

The story for the health sector equipment mirrors that of the infrastructure. The equipment is old, obsolete and defective due to inadequate maintenance. There is inadequate maintenance staff as the current available staff are only at central hospitals and provincial level. The situation is worsened by a lack of a comprehensive and integrated equipment inventory and that there is no equipment maintenance and replacement plan. In addition, electricity and water supply and proper waste management will be improved in all health facilities.

Strategic Intervention 3.5.2.1:

Capacitate institutions to maintain their own equipment with skilled and equipped personnel.

New residential areas have been created in urban areas throughout the country but especially in the major cities. Most of these areas do not have Primary Care facilities to serve them.

The same applies to resettlement areas opened following land reform. There are also areas where there are large pockets of people, say above 10 000 living more than 20 km from the nearest Primary Care facility. Provincial Health Authorities will be asked to make a quick assessment to come up with information on such areas. All these areas will be prioritized in putting up Primary Care facilities. If there are too many facilities to be established and there are fiscal constraints, then a ten-year plan could be developed to address this gap. In this context 162 health facilities are targeted for construction during the next 5 years.
The development of Mabvuku Polyclinic in Harare to offer surgical services, and function as a district type hospital is innovative and similar approaches must be encouraged. The objective must be to establish Secondary Care facilities so that they can help decongest the tertiary and quaternary hospitals. .

Within this context, the agreements with Local Authorities (1978) must be reviewed so that grey areas such as on funding and accountability in Municipal areas between central Government and the Local Authority are addressed.

Strategic Direction 3.5.3: Enhancing and Strengthening quality of health care services delivery

Strategic Intervention 3.5.3.1:

Develop and implement a quality improvement program.

A major shortcoming in the service today is the absence of a comprehensive quality improvement program. The Quality Improvement/ Quality Assurance Directorate should be strengthened to work on setting quality standards, undertaking quality assessment and supporting quality improvement. This should be a comprehensive program encompassing the work of the Health Professions Authority, Private and Public Sector, and all levels of health facilities.

Quality Standards for Primary Care facilities and Secondary Care facilities in Government, Missions, Local authorities and the Private sector will be developed first. These standards could be based on the IOM Framework (or any other framework) for quality assessment, viz Safety, Effectiveness, Patient centred, Timely, Efficient, and Equitable (IOM 2001). Health facilities should then be assessed and graded. A quality improvement plan would then be developed for the health facility, and progress measured against that.

Strategic Intervention 3.5.3.2:

Invest in public health training schools

Training institutions need to be well resourced for their purpose. Provision of a conducive learning environment that has modern services and resource centres for students need to be availed.

Strategic Direction 3.5.4:
Integration of traditional and complementary medicine into mainstream health services delivery to promote Universal Health Coverage

This strategic direction seeks to exploit existing opportunities while addressing challenges in relation to national policies, laws and regulations, quality, safety and effectiveness of T&CM, universal health coverage and the integration of T&CM into health systems. Strategies being proffered seek to address barriers to integration of T & CM into the health system such as weak collaboration between traditional and conventional health care practitioners, lack of mechanism to monitor safety of T & CM practice, lack of standards, lack of education and training for T & CM providers. Many pressing social and economic issues serve as an incentive for using T&CM such as the predicted increase in the global burden of chronic diseases as well communicable diseases. This calls for the development of a policy framework focusing on strengthening collaboration between conventional and T&CM health sectors.

Strategic intervention 3.5.4.1:

Promote safe and effective use of T&CM through regulation and research.

There is high patronage of the Traditional and Complementary Medicine (T & CM) for many reasons including belief, trust, proximity and cost and mode of payment. The main problems affecting the practice of Traditional Medicine include the lack of information on practitioners including their qualification, registration, educational background, location, number and the products used in their practices.

Other problems include inappropriate premises for practice, inadequate record keeping by practitioners, inadequate facilities for diagnosis and the use of un-standardized products. Furthermore, there are varied and unknown TM practices in the country. There are, also too many hawkers and peddlers practicing in the system without adequate regulation and control.

Research into TM is hampered by the lack of funds, personnel and facilities. Researches that are carried out is uncoordinated nationwide with little or no prioritization. There is very little interaction between scientists and practitioners and generally, there is a worrying lack of recognition of the need for the benefits of research and development towards improving practice.

The following initiatives will be taken;

- **National census of THPs.**
- **All TMPs shall be required to register with relevant councils.**
- **Traditional health information system (as a sub-system to HIMS).**
- **Setting of appropriate standards of practice.**
- **Establish a T & CM research unit within NIHR.**
- **Global Networking and Collaboration**

- **Global Networking and Collaboration.**

Strategic intervention 3.5.4.2:

Develop and implement practitioner regulations for T&CM education and training, skills development, services and therapies.

There is lack of adequate education and training for traditional health practitioners. There are no established institutions for training THPs and their trainers. There is no TM component in the syllabi for the training of conventional health practitioners. Consequently, Traditional Health Practitioners Council (THPC) has been excluded from the Health Professions Authority. Development and implementation of education and training programs is therefore required to professionalize the practice of traditional medicine. This will allow therapeutic communication between traditional and conventional health practitioners thereby enhancing collaboration.

Currently, there is an apparent lack of understanding by T& CM practitioners on legislation covering patenting with respect to traditional medicine products and procedures. Among practitioners there is ignorance about the meaning, implication and workings of patent laws and rights as well as the availability of trademark registers and protection. Generally, there is a lack of knowledge among THPs on the need for intellectual property rights protection.

There is inadequate knowledge among a section of the general public of the capabilities and benefits of T & CM. Thus, a section of the public has some misgivings about T & CM practices and products. These problems are not helped by the fact that very little documentation exists on the practice and products of T & CM.

Public education shall be intensified on the values, benefits and dangers associated with T & CM practices. Guidelines for advertising T& CM products should be developed taking into consideration national guidelines on advertising drugs. There should be training and orientation programmes for media houses and personnel on advertising of T & CM products.

The following will be implemented;

- **Education and training programmes for T & CM practitioners.**
- **THPs practitioners training in research methods to enable them carry out research and documentation of results of their practices.**
- **TM practitioners shall be educated on all aspects of patent, copyright and trade mark laws.**
- **T & CM integrated into curricula of health science students.**
- **Public Awareness for safe use of T & CM and self-health care.**
- **TMPC incorporated under the HPA for easy collaboration, regulation and control of the practice..**
- **An information, Education and communication strategy.**

Strategic intervention 3.5.4.3:

Standardization, quality assurance and large-scale production of T & CM products

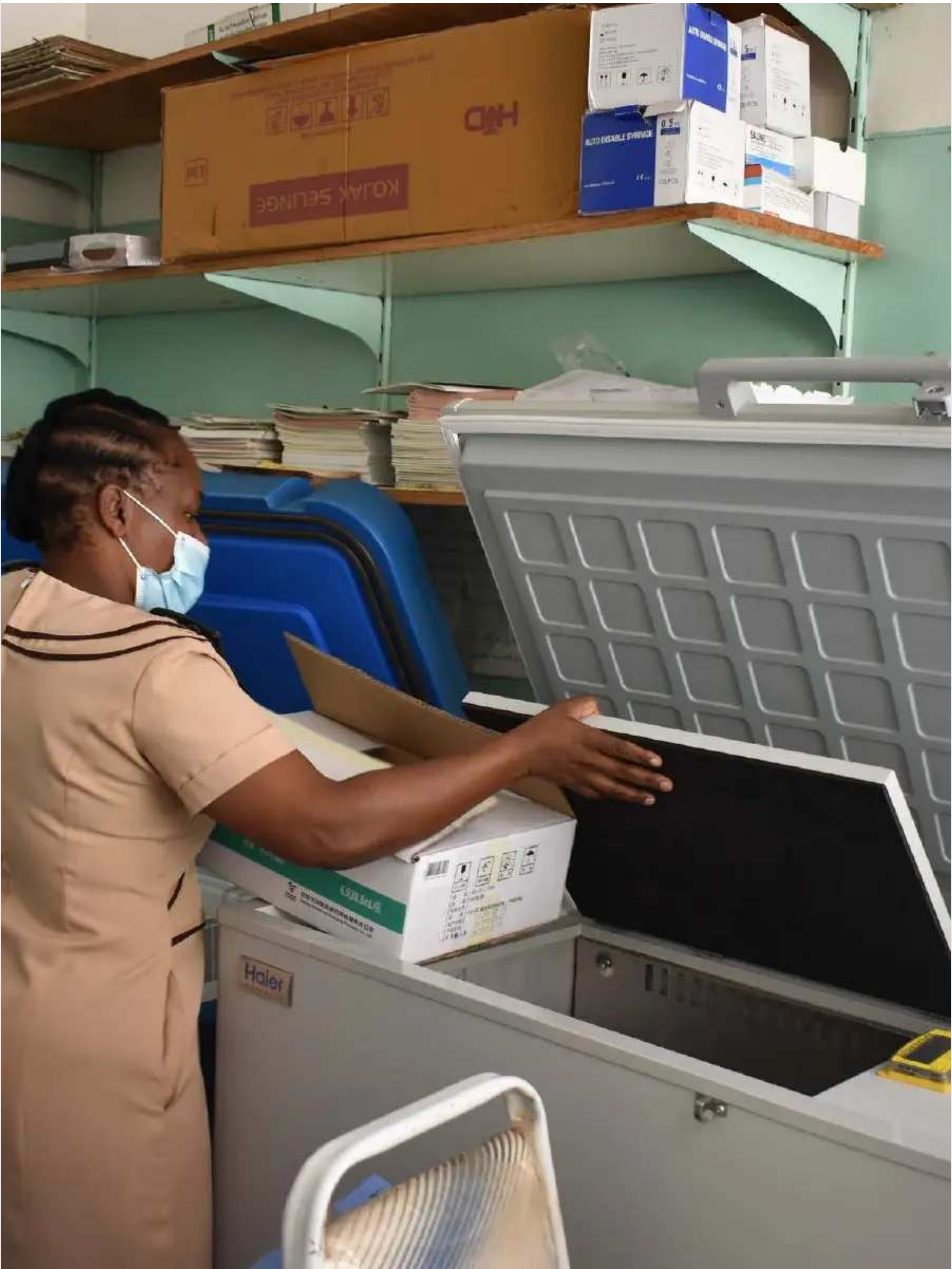
To ensure safe use of traditional medicine there is a need to create appropriate standards for T & CM. Zimbabwe currently does not have a national herbal pharmacopoeia as such this forms

the thrust of this strategic intervention.

Traditional medicines are being dispensed to patients. Some products are being sold to the public without established evidence of safety and efficacy. Production of traditional/plant medicine product do not meet the standards of Good manufacturing practices (GMP) and they lack standardization. Some practitioners are not willing to comply with Medicines Control Authority of Zimbabwe (MCAZ) requirements to disclose the identity of the plants they use for their product preparation.

Sustainability of T & CM use depends on the existence of a robust cultivation and production model to generate enough raw materials for the herbal medicine industry. The following initiatives will be put in place to improve and avail the use of traditional and complementary medicines;

- **Research and Product Development.**
- **Technology transfer and commercialization of best products and practices.**
- **Implement PPPs model to foster production and processing of T & CM.**
- **Strengthen and establish new partnerships with countries with advanced T & CM.**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3.6 Improved access to essential medicines and commodities

Strategic Direction 3.6.1:
Improve transparency, effectiveness and efficiency of the Procurement Supply Chain Management system with built in accountability measures.

Strategic intervention 3.6.1.1

Harmonise quantification, procurement, warehousing and distribution through introduction of electronic LMIS which would also include critical private sector functions.

a) Product selection

The MOHCC will establish a technical committee for product selection for pharmaceutical commodities separate from the National Medicines and Therapeutic Policy Advisory Committee (NMTPAC).

b) Quantification

The MOHCC will accelerate implementation of the electronic logistics management information system to improve end to end data visibility, timely reporting of accurate data, accurate quantification and reduced stock losses. The Electronic Logistics Management Information System linked to eHR and DHIS2 and develop a link with all private sector health facilities to have private sector health consumption linked separately to eLMIS/DHIS2. This will be coupled with several initiatives to facilitate implementation. These will include;

- **To strengthen coordination between the Procurement Directorate (MOHCC) and the Pharmaceutical Services Directorate, Supporting partners and procurement specialists at Central Hospitals, Provinces and Districts.**
- **Establishment of more workable long-term agreements to reduce procurement cycles as well as protect health facilities.**
- **Utilise the new procurement regulations that stipulate the use of district designated procurement entities through the dispensary assistants at Primary Care facilities as a way of improving value for money.**
- **Explore regional collaborative procurements with increased transparency among participating countries including sharing prices and supplier information. Where possible use joint tenders and contract awards through a centralized body acting on behalf of countries (hospitals). This helps reduce costs through economies of scale.**
- **Explore and execute in country joint price negotiation and supplier selection by both public and private sector particularly on imported commodities.**

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C) Warehousing

Construction and/or refurbishment of warehouses at NatPharm and its branches countrywide and health facilities. Installation of solar backup power as well as Solar Direct Drive refrigerators and cold rooms at selected facilities

d) Distribution

Integrate all distribution systems including chains of communication as much as possible for sustainability

Strategic Intervention 6.1.2: Consolidate the work of the regulator, MCAZ, through reviewing of the MCAZ Act.

Public information will be increased to bring awareness on the dangers of procuring and consuming commodities from unregistered sources. Deterrent fines for selling counterfeit medicines, selling unregistered medicines and selling from unregistered premises will be instituted. A delegated function of the MCAZ should be put in place in the provinces while setting up permanent MCAZ offices. A tracing mechanism for all commodities flowing through both the public and private sector supply chains will help to easily identify falsified products.

A strategy and implementation roadmap on the traceability of health products moving through the supply chain is already under development. Product registration timelines will be reduced significantly through accelerated registration for local manufacturers as well as regional collaborative registrations.

Strategic Intervention 3.6.1.2:

Promote local manufacturing of medicines and medical products.

MOHCC will facilitate capacity building for local pharmaceutical manufacturing. Several other initiatives will be explored as follows;

- **Develop the Local Manufacturing Strategy and resuscitate hospital pharmacy manufacturing units for simple hospital formulations.**
- **Strategic procurements by manufacturers and wholesalers of raw materials through category management i.e. classifying and managing commodity categories as strategic business units rather than as a collection of individual products.**
- **Improve technical capacity on current Good Manufacturing Practices (cGMP) and research and development of manufacturers through special arrangements with WHO and other UN agencies building on the GMP roadmaps between manufacturers and MCAZ.**
- **Introduce specialized undergraduate and postgraduate programs at tertiary institutions in regulation and manufacturing as part of building specialized technical skills required in research and manufacturing of medicines and commodities.**
- **Facilitate government to government technology transfers, toll manufacturing and affordable dossier acquisitions.**
- **Facilitate the introduction of special Export Incentives such as; Tax rebates for R&D and Capital Investments; designation of the health manufacturing industry into**

Special Export Zones (SEZ) to increase utilization and new companies and widen products being manufactured.

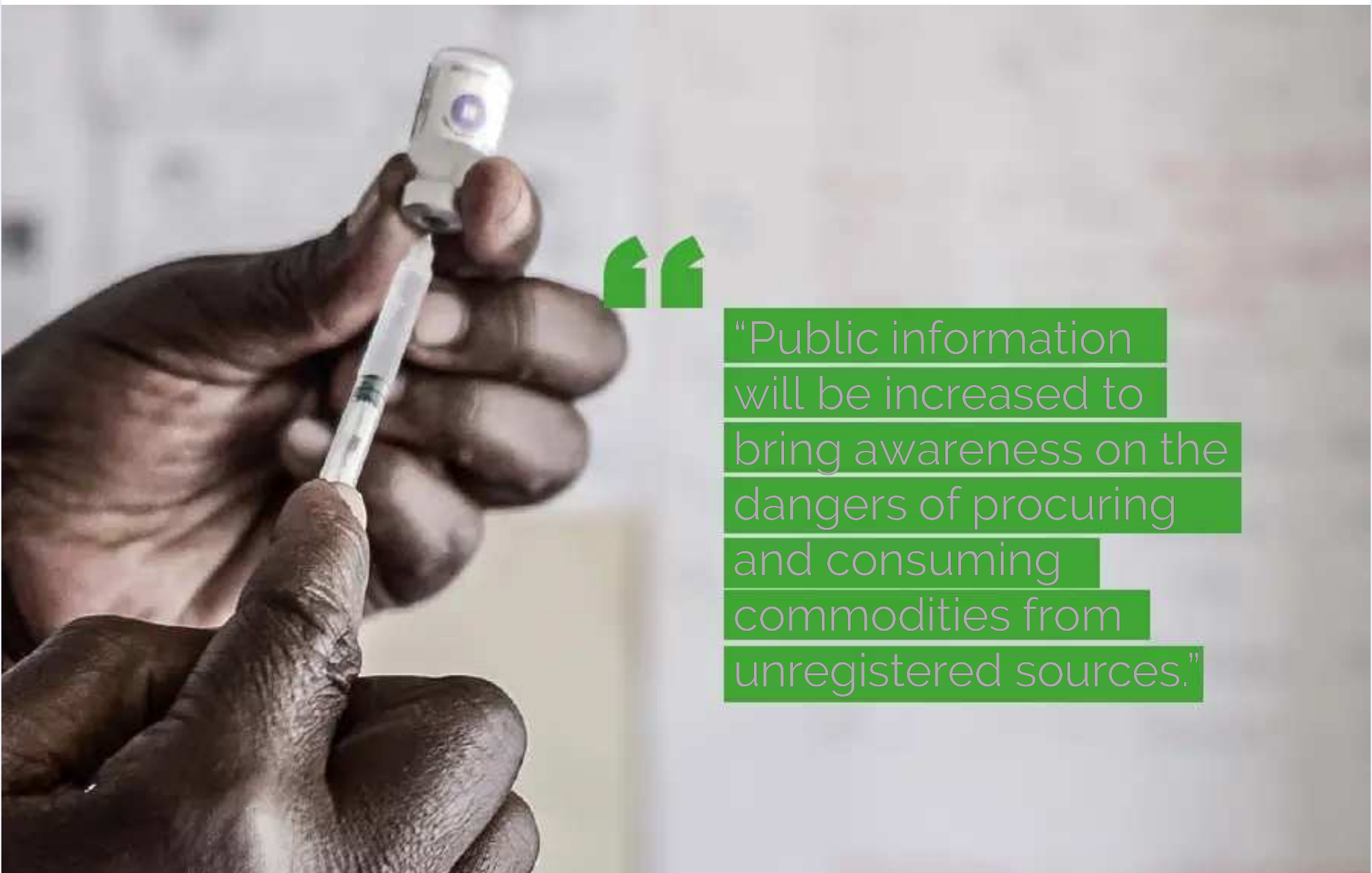
Strategic Intervention 3.6.1.3:
Promote rational use of medicines and commodities.

Initiatives to improve rational use will include;

- **Capacitate Hospital Therapeutic Committees and enforce rational prescribing, dispensing and use of pharmaceutical commodities at all levels.**
- **Increase pharmacovigilance and adverse reactions surveillance**
- **Increase public awareness on dangers of drug abuse.**
- **Strengthening of antimicrobial stewardship programmes.**
- **Enforce generic prescribing and use of STGs in private sector.**
- **Strengthening regular review of treatment guidelines.**

Strategic Intervention 3.6.1.4:
Capitalisation of National Pharmaceutical Company

MOHCC will avail funding to recapitalise and enable NatPharm to perform its mandate and reduce dependency on donor funding



3.7 Increase access to Water, Sanitation and Health Environment

Strategic Direction 3.7.1:

Increased access to potable water, sanitation and a health environment.

Strategic Intervention: 3.7.1.1

Reduction of open defecation through strengthening demand led Sanitation activities.

Open defaecation is still prevalent in Zimbabwe due to limited access to improved sanitation services. Increasing access to sanitation services will reduce open defecation and reduce contamination of drinking water sources

Strategic Intervention: 3.7.1.2:

Strengthen water quality monitoring.

Besides access to improved drinking water sources, its quality should always be monitored to rule out possible contamination and to ensure safety of the drinking water. Drinking Water quality monitoring should be strengthened across the country to ensure drinking water quality complies with WHO standards and where necessary, other corrective interventions are put in place (household water treatment)

Strategic Intervention: 3.7.1.3:

Strengthen participatory health and hygiene education for positive behaviour change.

Communities require continuous health education for positive behaviour change and for them to make informed decisions about their health such as prioritising sanitation activities and adopting hygienic practices. Engage education sector to strengthen knowledge and practices on health and hygiene.

Strategic Intervention: 3.7.1.4:

Increase protection of primary drinking water sources.

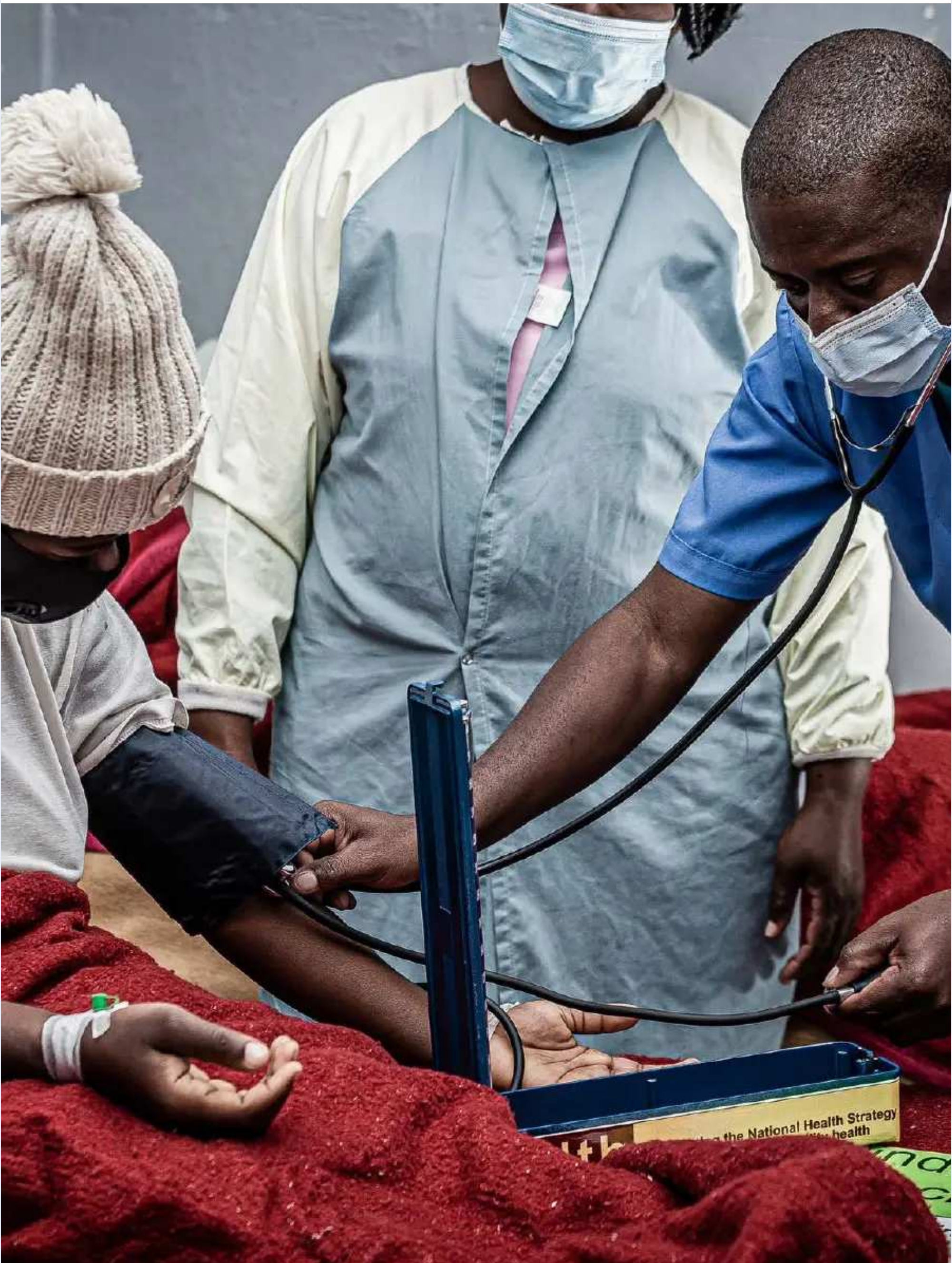
Primary drinking water sources are usually located within homesteads providing easy access to drinking water. They significantly contribute to the provision of drinking water to communities and some of them are not protected. These require protection to minimise contamination through multi-sectoral and community engagement.

Strategic Intervention: 3.7.1.5:

Increase awareness on health care waste management and disposal at health institutions.

Part of Healthcare waste is infectious. Most health institutions lack functional healthcare waste disposal facilities. It is of paramount importance that it is disposed of using recommended methods to safeguard the health of the public. Adequate knowledge on management of healthcare waste should be imparted to healthcare workers both in public and private sectors. Collaborate with local administrative authorities and other sectors for proper health care waste

management.



3.8 Improved Human Resources Performance in the Health Sector

Strategic Direction 3.8.1:
Strengthen Professionalism and ethics in health service delivery.

Strategic Intervention 3.8.1.1:

Review of health worker training programs.

The Health Sector through its structures such as MoHCC, Health Services Board, Health Professions Authority and Professional Associations will engage the Ministry of Higher and Tertiary Education, Innovation, Science and Technology structures, including Colleges and Universities on career guidance, including qualities of graduates expected from health training programs. The objective will be to come up with the right mix in terms of numbers, diversity and competencies of the eventual graduates from training programs.

In view of the many policy shifts that have taken place it is arguable that there has been both positive and negative outcomes in health worker training over the last two or three decades. In addition, there has been a change in the epidemiology of diseases affecting the population.

A review will be undertaken to identify strengths and weaknesses of current training programs, including assessing the need to change their curriculums, develop strategies to address the weaknesses and implement them. Substantial shifts should be anticipated considering the many changes that have taken place as well as questions being raised on performance of some of the graduates. It will also be necessary to look at the role that can be played by the private sector and private health worker training schools. This is important on one hand to enable them to contribute resources to training and on the other hand to create new schools and thus increase the number of training positions for different types of training programs.

It will be necessary to substantially increase (in some cases at least double or even treble) intakes into the training programs in order to address shortages. Special attention in this regard will be paid to medical doctors, pharmacists, radiographers, Nurses, and specialised training among all these professional groups. A dedicated manpower development plan will be developed.

Strategic intervention 3.8.1.2:

New staff orientation and deployment driven by desire to strengthen Primary Health Care Approach.

The need to ensure the health system is strengthened from bottom up, in keeping with the Primary Health Care Approach will influence decisions and action on deployment and orientation of new staff. This will ensure staff are made aware of the importance of ensuring high quality services which in turn will help improve access at primary care level, then secondary care level then at higher levels in the health system. If lower levels are dysfunctional, higher levels will not work well. Staff induction procedures will emphasise this in order to ensure new staff once deployed stay in their positions.

The same thinking will influence addressing disparities in staff geographical and level of care distribution. Disparities in distribution of specialised types of health workers such as specialist nurses and doctors will be addressed as priority. The distribution of staff as published in the national human resources for health profiles will guide deployment to address inequity and specialised staff shortages.

Strategic Intervention 3.8.1.3:

Improving behaviour and competencies of health workers.

The behaviour of health workers has been highlighted as one of the issues that needs to be addressed. This is a cross cutting issue which is addressed through different interventions starting from training, through recruitment and deployment, to management of the workforce, to conditions of service. Behaviour and competencies development trainings will be conducted and provided to health care workers.

Strategic Direction 3.8.2:
Improving the health worker conditions of services.

Strategic intervention 8.2.1:

Implement the single spine remuneration system

Based on what has been happening over the last two decades, this is an area that needs to be addressed if the country is to restore goodwill, performance and confidence of the health workforce. There are several issues requiring redress. A job evaluation exercise will be conducted. A job evaluation will closely look at the value/worth of a job in relation to other jobs in an organization. It tries to make a systematic comparison between jobs to assess their relative worth for the purpose of establishing a rational pay structure.

Strategic intervention: 3.8.2.1

Awarding of Non-Monetary Incentives.

Noting the inadequacy of the levels of remuneration non-monetary incentives will be used to augment the current efforts to adequately remunerate employees. These include but not limited to housing loans, vehicle loans and availing of residential stands. Other areas where there have been some interventions include improving social amenities for staff, treating staff with dignity and sound management practices, and staff development. Clear policies will be put in place and access to all these by all staff should be transparent and fair.

Strategic Intervention: 3.8.2.2:

Provide adequate tools of trade.

Ensuring availability of tools of the trade is an important issue, however this is covered in relevant sections of the Strategic Plan.

Strategic Intervention: 3.8.2.3:

Fully implement Integrated Results Based Personnel Performance Management System (IRBPPMS).

Staff training will be undertaken to strengthen the Personnel Performance System and link it

to a system which rewards good performance and has sanctions against poor performance. This is linked to Governance, Leadership and Accountability which is discussed under the Governance pillar.

Strategic intervention 3.8.2.4:

Strengthening of the Community Health Worker program.

The National Community Health Strategy 2020-2025, intended to address the fragmented management, lack of a regulatory framework and standard operating procedures, and inconsistent allowances for community health workers (MoHCC 2019 VHW). Conditions for the engagement of Community Health Workers such that there be one VHW per village will be put in place.

This requires negotiation and agreement not only on budget issues but also on their reporting structures. Their role in improving access to health care is unquestionable and supported by evidence from different sources as well as country experience especially in sub-Saharan Africa and Asia. This is especially with respect to prevention, early referral and treatment of some common ailments.

Strategic intervention 8.2.6: Review Dual employment and private practice guidelines

Despite guidelines in place on dual employment and private practice, it is clear there have been challenges in enforcing these. Some of the original safeguards such as not allowing dual employment for those in control positions are no longer being followed nor enforced. A review will be undertaken, and new guidelines issued. It is recognised that given current staff shortages it might be unrealistic to ban dual practice completely. These will be enforced with the understanding that those who want to work in the public sector must comply.

Strategic Direction: 3.8.3
Restructure the Health Service.

The MOHCC restructuring exercise was aimed at aligning the establishment to the strategic direction to ensure efficiency and effectiveness of the ministry in delivering the identified 10 strategic priorities. Focus will be on capacity building of the structures and key actors at all levels and strengthening accountability systems on strategy execution.

Strategic Intervention 3.8.3.1:

Review of staff establishments.

The current establishment was last comprehensively updated in the 80s and has become obsolete and no longer matches the current workload. There is a need to rationalise the staff establishment informed by globally acceptable scientific processes.


+10.3
+12.0
+22.6
+41.9
+83.0

3.9 Increasing domestic funding for health services

Strategic Direction 3.9.1: Implementation of the Health Financing Strategy.

Strategic Intervention 3.9.1.1:

Increased efficiency gains from existing resources

- **Place greater emphasis on investment in and implementation of interventions targeted at primary care and prevention.**
- **Strengthen planning and governance around procurement for infrastructure development and equipment.**
- **Improve operational efficiency of existing private voluntary health insurance schemes**
- **Review of structures of the MOHCC to stimulate greater efficiency.**
- **Increase non-wage expenditure on supplies and equipment necessary for quality service delivery.**

Strategic Intervention 3.9.1.2:

Increased reliance on public resources for the health sector.

Implement evidence-based advocacy for increased allocation of government resources to health at central and local government

Strategic Intervention 3.9.1.3:

Develop a National Health Insurance Scheme.

A commitment towards the implementation of a National Health Insurance scheme is consistent, among others, with Zimbabwean Constitution, National Health Strategy (NHS) 2016-2020,2021-2025, Health Financing Policy, Strategy, Abuja commitment 2001 and Astana declaration on Primary Health Care.

Strategic Intervention 3.9.1.4:

Pooling of Health Funds from private and government.

In line with Health financing policy, efforts will be made to pool resources both public and private sector to:

- **Strengthen equalisation mechanism across local authorities to ensure equitable allocation of resources.**
- **Strengthen integration of monitoring and reporting of funds.**
- **Establish a virtual basket of all public funds (including those from church related missions).**
- **Strengthen the regulation of the medical scheme's environment**

Strategic Intervention 3.9.1.5:

Employ strategic purchasing mechanisms.

Strengthening the capacity for strategic purchasing within MOHCC and a dedicated purchasing unit will be established

purchasing unit will be established.

3.10 Improved Public Health Emergency Preparedness and Response Capacities

Strategic Direction 3.10.1:
Meet requirements for International Health Regulations (IHR) 2005 for Preparedness, Prevention, Detection and Responding to Public Health Emergencies.

Strategic Intervention 3.10.1.1:

Full implementation of National Action Plan for Health Security (NAPHS).

The HSSP will support implementation of NAPHS and will aim to:

- **Strengthen Legislation, coordination and prevention of public health emergencies**
- **Strengthen laboratory system and surveillance.**
- **Strengthen response and operations of Public Health Emergency Operations Centre.**
- **Supporting after action reviews (audits), post health emergency or health response in an emergency.**
- **Strengthening health information systems (HIS) and event-based reporting**
- **Strengthen Risk Communication and community engagement.**
- **Strengthen the detection and response to chemical and radiation hazards.**

Strategic Intervention 3.10.1.2:

Develop Post COVID -19 COVID -19 health systems recovery plan and strengthen health systems resilience for future epidemic and pandemics – accepted.

In line with NAPHS, Post COVID -19 health systems recovery plan will be developed to mobilize resources and contribute to building health sector resilience

4 Implementation

Framework For The NHS

4.1 Regulatory framework

As stated earlier, the National Health Policy, Planning for Equity in Health, was published in 1981. This has guided Health Development since then. The Health Policy statement was relevant to the needs at the time and it guided the reconstruction and later development of the national health system. The 10 to 15 years post 1980 saw impressive improvements in health outcome indicators. Since then, there has been developments that require the National Health Policy to be reviewed. Some of these are the change in epidemiology of diseases that affect the population such as aging and NCDs, emerging and reemerging infectious diseases, HIV and TB, and outbreaks of new conditions such as COVID 19. The developments in medical commodities and medical equipment which require a strong regulatory environment to protect the population, ensure efficient use of resources and guide deployment of what the new technology offers.

Furthermore, there has been major social, political and economic changes in the country. These include the acceptance of the contribution that can be made to Health Development by the Private Sector both in terms of funding and provision of health services. A new Health Sector Policy will be developed during the strategic period guided by the National Development Strategy 1: 2021-2025 (NDS1) and global policy frameworks. Furthermore, health sector legislations will be reviewed and new Acts will be enacted to ensure that the enabling environment is conducive for health service delivery.

4.2 Results Based Framework

An enhanced Performance Accountability System is now in place, through the Permanent Secretary's Performance Contract, with the Permanent Secretary at its apex, and focuses on the heads of budget centres at National and Provincial levels and district level. This include simple formats for quarterly Operational plans linked to Departmental Integrated Program Agreements (DIPAs), Ministry Annual Strategic plan and National Health Strategy (NHS) indicators.

Quarterly and Annual Sector review with participation of stakeholders should continue to be held, to review progress and agree high level plans for the next twelve months in the life span of the National Health Strategy (NHS) 2021-2025.

Priority/critical targets/indicators should be identified for each type of Budget Centre to be monitored at regular intervals as part the Monitoring and evaluation function; including monitoring dashboards to provide regular reportage.

4.3 Health Sector Coordination Framework

The Health Sector Coordination Framework identified the four (4) coordination fronts to guide the health sector. These are as follows:

- **Intra MOHCC coordination involving Health Sector State Owned Enterprises, Provinces, Public Health service providers such as ZACH and Local Authorities (and between Provinces and Districts).**

- **Partners and Donors coordination and engagement.**
- **Engagement of other Government Sectors, parliament and State Institutions on Health-related matters.**
- **Coordination with other stakeholders including "Private for Profit" Sector, CSO/NGOs.**

These will be supported to play their roles which include those of communication and engagement; joint planning; resource mobilization and allocation; reporting and sector performance assessments; services delivery monitoring and accountability. This will help ensure that all national, program and donor strategies clearly address their contribution to National Health Strategy goals and UHC/SDG3.
To make this possible requires expanding the capacity of the external partnership and private sector units at the MOHCC.

4.4 Mitigating risks

Economic stability.

Economic stability translates into social stability and availability of funding for health. This will contribute to improving service delivery. Lessons learnt over the last two decades are ample proof of the importance of economic stability. This will translate into Health budget availability and stability. Priority will be on improving allocative and operational efficiencies.

4.5 Natural disasters and health emergencies

Cyclone Idai and other natural disasters, COVID-19, Cholera and Typhoid outbreaks have demonstrated how these can wreak havoc on health service delivery. It is hoped the investments made in preparedness will help should disasters or outbreaks occur.

4.6 Financing the National Health Strategy

i. Projected funds availability based on MTEF.

The full analysis of comparable current funding levels is available from 2018 NHA report. The diagram below shows that data.

NHA indicators	2015	2016	2017	2018
Total population	13, 943, 242	14, 262, 236	14, 588, 528	14, 922, 285
Total nominal GDP	14,007,108,087	20548,678,073	22,466,000,000	24,311,560,544
Total Government Exp	3,937,497,855	4,779,811,474	6,568,065,601	7,552,803,626
TGE	309,699,620	321,324,576	437,890,000	762,840,000
THE	1,447,785,505	1,386,239,947	1,324,694,390	1,729,670,220
THE per capita	103.8	97.2	90.8	115.9
THE as % of GDP	10.3	6.7	5.9	7.1
GHE as % TGE (target is 15%)	8.7	6.7	6.7	10.1

The indicators show that per capita expenditure is above USD 86 which is the recommend level for realizing UHC for a country at the level of development as Zimbabwe. The same can be said about THE as percentage of GDP. However, if we only consider Government contribution the situation changes drastically. Per capita expenditure becomes only USD 51. This reflects the amount Government can fully plan on. However, when we consider 93 per cent of this goes to pay salaries, it shows how inadequate the funding is. Distribution of Government health expenditure can be used as an indication of Government priorities.

4.7 Projected cost of the National Health Strategy and gap

The Strategy will be costed and costed scenarios will guide financing options. A Health sector investment case will be developed to direct investments based on the identified gaps and national health priorities.

5 Monitoring And Evaluation

5.1 Monitoring And Evaluation

Monitoring and evaluation (M&E) are essential functions to ensure that priority health interventions outlined in the NHS are implemented as planned, and that desired or targeted results are attained. All M&E of Government policies, strategies, programs and projects in Zimbabwe is guided by the National Monitoring and Evaluation Policy (NMEP), as well as the National Monitoring and Evaluation Guidelines (NMEG) developed by the Office of the President and Cabinet in 2020.

Until now, M&E in the health sector had been directed by the Zimbabwe Health Sector Performance M&E Policy Guidelines and Strategy, developed in 2018. Going forwards, this document will be split into a Zimbabwe Health Sector M&E Policy, and a separate Zimbabwe Health Sector M&E Plan 2021-2025 that is responsive to the requirements of both the NMEP and NMEG.

5.2 Integrated Results Based Management System

Implementation, monitoring and evaluation of the NHS will be anchored on the Integrated Results Based Management (IRBM) system, a management tool adopted by the Government of Zimbabwe (GoZ) for the implementation of its programmes.

The IRBM system institutionalises accountability among all leaders and personnel for the outputs and outcomes of their departments and units, and their linkage to the NHS goals and objectives.

In addition to planning and budgeting, health sector performance reporting will fully comply with the GoZ Programme-Based Budgeting (PBB) system. This will see a move away from siloed disease-specific planning, budgeting and reporting, towards a functions-based Program and Sub-Program based system.

Institutionalisation of the PBB system will facilitate reporting under the mandatory newly established Whole of Government Performance Management System (WoGPMS), an online platform for electronically reporting and tracking the performance (outputs and outcomes) of Government Ministries, Departments or Agencies (MDAs).

5.3 One Single Country-led M&E Platform

Monitoring and Evaluation of the NHS 2021-2025 will use an integrated and comprehensive health systems approach that is built firmly under a single country-led M&E platform, the MoHCC Directorate of Performance Monitoring and Evaluation (DPME).

Working closely with the other essential units such as the Health Management Information System, this platform will meet all the data needs of the country and allow progress towards attaining the goals and objectives specified in the NHS, as well as national, regional and international commitments such as the SDGs. The entire health sector, including development partners and CSOs are expected to unite under this single-M&E platform.

5.4 M&E Framework

An abridged M&E Framework (a.k.a. Performance Framework), which outlines a selection of core indicators, their baselines and yearly targets to track the performance of the NHS, has been developed, and appears at the end of this document.

It is important to note that the NHS indicators are only indicative of reality, i.e. they are tracer indicators, and therefore not intended to describe the totality of what is happening. A more detailed M&E framework which includes the indicator definitions, data sources and means of verification will be included in the M&E Plan. Hence the M&E Plan essentially operationalises the M&E Framework

5.5 Health Sector M&E Plan

Full details of how the NHS and entire health sector will be monitored and evaluated are described in the costed Zimbabwe Health Sector M&E Plan (2021-2025), which is under development.

It will include the set of core indicators to track NHS performance, as well as other priority indicators such as the SDGs. In addition to indicator definitions and data sources, the M&E plan will specify plans for addressing data gaps and weaknesses, and for conducting data quality assessments. It will also specify analytical outputs and plans for reporting, communication and dissemination of M&E results.

The M&E Plan also aims to ensure effective utilisation of M&E findings and recommendations at both national and sub-national levels. Individual PBB Programmes, units and disease-specific programs in the MoHCC and entire health sector, are expected to develop their own unit-specific M&E frameworks and/or plans which clearly show linkage to the national priorities, objectives and plans specified in the NHS.

5.6 Approaches to Monitoring

There are various monitoring and reporting systems within the health sector that include routine and non-routine systems. On the routine systems there are patient level reporting systems like ePMS and Impilo Electronic Health Record, as well as aggregate systems like the DHIS2, LMIS, eLMIS, NEAMS, PFMS and HRIS.

The DPME will also coordinate the non-routine systems where surveys, assessments, studies and sentinel surveillance will be conducted.

5.7 Reporting and Reviews

Regular data analysis, performance reviews and reporting will be held at various levels (programme, sub-national, national), with recording of recommendations and tracking of their subsequent implementation.

The frequency of performance reporting will be stipulated in the M&E Plan, guided by the needs of the health sector and the requirements of the WoGPMS. The participation of other stakeholders in performance reviews is greatly encouraged, as it demonstrates transparency, and leaves no-one behind.

5.8 Evaluation

In line with the requirements of the NMEG special emphasis will be placed on evaluations, going forwards. In compliance with the NMEP, a costed five-year rolling Zimbabwe Health Sector Evaluation Plan will be developed, which will outline all the policies, programs and strategy evaluations planned under the NHS.

A mid-term evaluation of the NHS is planned halfway through the implementation period. The findings will inform any required revision of the interventions and the indicator targets. An end-line evaluation is planned at the end of the NHS implementation period to determine the overall achievement of the strategy against the intended goals and objectives. The findings will also serve as a situation analysis to inform the development of the next NHS.

6 Conclusion

The NHS will run for a period of 5 years from 2021- 2025. A mid- term evaluation of the NHS will be conducted in 2023 to assess the extent of implementation of the NHS in line with the 5year targets that have been set. This mid-term review will inform the next NHS.

Ministry of Health & Child Care Republic of Zimbabwe

KEY RESULT AREA	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR	Baseline (Year)
Policy and Administration	Increased Domestic Funding for Health	Total Government health expenditure per capita	$30.29 (2020)
		Proportion of total health expenditure paid directly out of pocket of households	24% (2015)
		Proportion of total Government budget that is allocated to health	10.10% (2018)
	Improved human resource performance in the health sector	Overall vacancy rate	8% (2020)
		Health worker density (SDG)	0.1 (2014)
	Improved leadership and governance of the health sector	% implementation of a clearly defined Ministry of Health and Child Care organogram	30% (2020)
		% Implementation of the Health Sector Coordination Framework	10% (2020)
		% Operationalization of Public Health Act Implementation Framework	20 (2020)
		Timeliness of reports (average for key reports)	61% (2020)
		Number of audit reports with adverse observations	0 (2019)
	Improved access to essential medicines and commodities	% Availability of selected tracer medicines	51% (2020)
	Improved health infrastructure and access to medical equipment for quality health service delivery	Proportion of secondary (district) level health institutions with functional theatres	43% (2020)
		Proportion of institutions with tracer equipment (incinerator)	20% (2020)
		Proportion of Primary Health facilities with critical equipment as per defined minimum package (SDG)	70% (2019)
		% Implementation of the Local Production Roadmap	0 (2020)
		Number of newly established Health Facilities	10 (2020)
		Proportion of population living within a radius of 10 km of a health facility	83% (2009)
		Health facility density (Public Facilities)	Public HF: 1.1

	TARGET 2021	TARGET 2022	TARGET 2023	TARGET 2024	TARGET 2025
	$35	$46	$57	$69	$86
	20%	19%	18%	16%	15%
	13%	14%	15%	15%	15%
	6	5	5	5	<5
	0.2	0.5	0.7	0.9	1
	60	70	100%	100%	100%
	25%	50%	70%	80%	100%
	30%	70%	80%	80%	80%
	80%	80%	80%	80%	80%
	0	0	0	0	0
	55%	62%	70%	74%	80%
	55%	72%	86%	99%	100%
	34%	48%	68%	82%	100%
	75%	80%	90%	95%	100%
	40%	50%	70%	80%	100%
	15	25	30	42	50
	85%	86%	87%	88%	90%
	1,115	1,116	1,117	1,118	1,119

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KEY RESULT AREA	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR	Baseline (Year)
Public Health	Increased access to water, sanitation, and healthy environment.	Sanitation coverage (SDG)	67 (2019)
		Proportion of population using safely managed drinking water sources (SDG)	77 (2019)
	Reduced morbidity and mortality due to Communicable and Non-Communicable Diseases	AIDS mortality per 100,000 population	126.72 (2019)
		HIV incidence per 1,000 uninfected population (SDG)	2.81 (2019)
		TB Mortality per 100,000 population	42 (2019)
		TB incidence per 100,000 population (SDG)	199 (2019)
		Malaria incidence rate per 1,000 persons per year (SDG)	0.56 (2019)
		Malaria deaths per 100,000 population	1.9 (2020)
		Covid-19 Case fatality	3.8% (2021)
		Cholera case fatality rate	<0.5 (2018)
		Bilharzia prevalence	0.23 (2020)
		Soil transmitted helminths prevalence	5.5% (2020)
		Incidence of hypertension (per 100,000 population)	232 (2020)
		Incidence of Diabetes (per 100,000 population)	50 (2020)
		NCDs mortality rate (cervical cancer) (SDG)	>15% (2020)
		Cervical cancer incidence	25 (2020)
		Suicide mortality rate per 100,000 population (SDG)	19.1 (2016)

	TARGET 2021	TARGET 2022	TARGET 2023	TARGET 2024	TARGET 2025
	69	73	75	78	80
	79	83	85	87	90
	120	113	99.98	90.95	86.57
	1.23	1.07	0.94	0.76	0.57
	29	26	23	21	less than 20
	185	167	154	142	132
	0.18	0.1	0.05	<0.03	0.01
	1.34	1.12	0.89	0.67	0.5
	<1%	<1%	<1%	<1%	<1%
	0	0	0	0	0
	18%	13.5%	9%	4.5%	<1%
	4.1%	2.8%	1.40%	1%	<1%
	184	161	150	140	132
	48	45	41	37	35
	13.50%	11%	9.50%	7.10%	<5%
	23	19	14	11	8
	17.6%	16.10%	14.60%	13.10%	11.60%

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KEY RESULT AREA	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR	Baseline (Year)
	Improved Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition	Maternal Mortality Ratio (SDG)	462 (2019)
		Under 5 Mortality Rate (SDG)	65 (2019)
		Neonatal Mortality Rate (SDG)	32 (2019)
		Prevalence of stunting among children under 5 years of age (SDG)	24 (2019)
		Proportion of births attended by skilled health personnel (SDG)	86 (2019)
		Institutional Maternal Mortality Ratio	102 (2018)
		Proportion of children under 1 year covered by all vaccines included in their national program (PENTA 3 vaccine proxy)	91 (2019)
		Perinatal Mortality Rate	29 (2019)
		Modern Contraceptive Prevalence Rate (SDG)	67 (2019)
		Adolescent Birth Rate (SDG)	108 (2019)
		Cure rate for children with severe acute malnutrition	69 (2019)
		Proportion of sexual violence survivors who access health services within 72 hours	20 (2019)
		% of 'At Risk' under-five children screened for disabilities	30 (2018)
	Improved public health emergency preparedness and response capacities	Proportion of outbreaks detected within 48 hours in line with IDSR guidelines	90 (2020)
		IHR core capacity index (SDG)	44 (2020)
		Proportion of outbreaks controlled within 2 weeks in line with IDSR guidelines	43 (2020)

	TARGET 2021	TARGET 2022	TARGET 2023	TARGET 2024	TARGET 2025
	388	351	314	277	240
	57	53	49	45	41
	28	26	24	22	20
	22	22	21	20	19
	88	89	90	91	92
	98	86	73	60	51
	93	93	93	93	93
	26	25	23	22	20
	68	70	73	75	80
	103	100	98	95	93
	70	75	80	85	90
	24	30	39	45	60
	40	50	60	70	80
	100	100	100	100	100
	47	49	51	53	55
	60	70	75	86	95

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KEY RESULT AREA	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR	Baseline (Year)
Curative Services	Improved access to primary , secondary, tertiary, quaternary and quinary health care services	Client satisfaction index	75% (2020)
		General service readiness index	50% (2019)
		General service availability index	42% (2020)
Bio- Medical Engineering, Bio- Medical Science, Pharma-ceuticals, Bio-Phar-maceutical Production	Improved health research and development	% implementation of the equipment local production roadmap	0 (2020)
		% implementation of the pharmaceutical local production roadmap	0 (2020)
		% implementation of the diagnostics local production roadmap	0 (2020)
		% food samples analyzed	90 (2000)
		% implementation of the national health research agenda	0 (2020)

	TARGET 2021	TARGET 2022	TARGET 2023	TARGET 2024	TARGET 2025
	76%	77%	78%	79%	80%
	70%	80%	85%	90%	95%
	50%	57%	62%	70%	75%
	10%	20%	30%	40%	50%
	10%	20%	30%	40%	50%
	10%	20%	30%	40%	50%
	100%	100%	100%	100%	100%
	10%	20%	40%	60%	80%