# THE NATIONAL HEALTH STRATEGY

## FOR ZIMBABWE

## (2009 - 2013)

### A Summary

**EQUITY AND QUALITY IN HEALTH: A PEOPLE'S RIGHT**

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# Introduction

The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socioeconomic development of the country. This vision will be attained through guaranteeing every Zimbabwean access to comprehensive and effective health services. Extending from this vision, the mission of the Ministry of Health & Child Welfare (MoHCW) 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.

As part of its mandate to give strategic direction in health sector development, the MoHCW has developed this National Health Strategy, 2009 – 2013, "Equity and Quality in Health - A People's Right". This document is a successor to the National Health Strategy, 1997 – 2007 "Working for Quality and Equity in Health", whose major thrust was to improve the quality of life of Zimbabweans and set the agenda for launching the health sector into the new millennium. Recognizing that improvement in the health status of the population would not depend on health sectoral actions alone, the 1997 National Health Strategy sought to pull together all national efforts which had potential to enhance health development into a promising new era.

Whilst the situation analysis carried out at that time showed a worrying decline in health status indicators, the optimism associated with the dawn of a new era provided hope and conviction for improvement. Similarly, the identified weaknesses in the performance of the health system were thought to be temporary, in the hope that the holding capacity of the economy to support a robust health system would improve. On the contrary: the challenges facing the health sector continued and in fact got worse. During the second half of the implementation period of the National Health Strategy (1997 – 2007), Zimbabwe experienced severe and escalating economic challenges which peaked in the year 2008. The economic decline resulted in a sharp decrease in funding for social services in real terms. This directly contributed to an unprecedented deterioration of health infrastructure, loss of experienced health professionals, drug shortages and a drastic decline in the quality of health services available for the population.

The main thrusts of the 2009-2013 National Health Strategy are therefore firstly to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and secondly, to put Zimbabwe back on track towards achieving the Millennium Development Goals.
The strategy is based on information from several studies carried out in the last three years (Study on Access to Health Services; Vital Medicines and Health Services Survey; Community Working Group On Health surveys; Zimbabwe Maternal and Perinatal Mortality Survey etc), existing national plans and programmes as well as existing programme specific policy and strategic documents. However it does not cover all details from such policy and strategic documents. Furthermore the strategy has taken into consideration regional and international policies, strategies and commitments made by the country such as the Millennium Development Goals, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, as well as other international, continental and regional health protocols including the African Union (AU) Health Plan; the East, Central and Southern Africa (ECSA) Health Community Agreements, and the Southern African Development Community (SADC) Health Sector Protocol.

## SITUATIONAL ANALYSIS

### Determinants of Health

Good health and quality of life are influenced by several factors, including but not limited to poverty, food availability, security, education, gender issues including violence and abuse against women and children, housing, safe water and sanitation, hygiene and employment. The economic challenges the country is experiencing are adversely affecting the health and quality of life of all Zimbabweans through difficulty in accessing preventive and curative healthcare, adequate nutrition and stress resulting from household financial concerns. The current physical environment (characterized by poor and inadequate water supplies, breakdown in the sewer systems, inadequate sanitation in both urban and rural, poor waste

management practices, inadequately supervised food preparation processes and inadequate control of vector borne diseases coupled with increased urban unplanned overcrowded settlements and poor enforcement of laws and regulations that protect health) has increased the exposure of the nation to hazardous factors in water, air, food and in some cases soil. These exposures result in increased rates of diseases such as cholera and other diarrhoeas, malaria, tetanus, asthma and other chest conditions.

Most of these variables are outside the normally understood boundaries of the health sector. However, it is the responsibility of the health sector to identify and inform both the general public and our policy makers of the factors that affect health and quality of life: the social determinants of health. It is therefore crucial that such factors are considered and included in the planning and implementation of government-wide strategies to promote and improve the health and quality of life of the population. Inter-sectoral coordination and collaboration will be necessary to address all of these major contributors to illness, disability, and death in the country and actively implement health education and promotion activities with communities across the country.

### Demographics and Specific Diseases Affecting Zimbabweans

Demography helps to define those population groups in potential need of health services and those who are vulnerable and at risk. Improved socio-economic development goes hand in hand with improved health status and quality of life, which are in turn associated with a falling birth rate. Key demographic issues to be considered for this National Health Strategy include:

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

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

- HIV prevalence continues at an unacceptably high level of 13.7% (15 – 49 year age group) with only 180,000 of an estimated 400,000 persons requiring treatment actually receiving antiretroviral therapy (ART) by mid-year 2009
- TB remains a leading cause of morbidity with a notification rate of 434 out of 100,000
- Child health status indicators are worsening, with infant mortality and under five mortality rising from 53 and 77 per 1000 live births in 1994, to 60 and 86 per 1000 live births respectively in 2009 (MIMS)
- The nutritional status of children indicators are unacceptably high with stunting increasing from 29.4 in 1999 to 35% among children under 5 years old
- Maternal mortality levels are at an unacceptably high level of 725 deaths per 100,000 births (Zimbabwe Maternal and Perinatal Mortality Study, 2007) with skilled attendance at birth declining from 73% in 1999 to 60% in 2009, and institutional delivery declining from 72% to 60% (MIMS) over the same period
- Perennial cholera epidemics, exacerbated in urban areas by breakdown of sewerage and water supply treatment systems, and compounded by declining water and sanitation coverages in rural areas resulting in a loss of over 4,269 lives out of a total 98,000 cases by end of June 2009
- With malaria incidence at 9.4%, it is estimated that over five million people are at risk of contracting malaria, with an average of 1.5 million reported cases and over 1,000 deaths annually
- Outbreaks of rabies and anthrax continue being reported in some parts of the country (RDNS routine data)

- There is continued and increasing public health significance of chronic non-communicable conditions including mental illness, diabetes (10%, hypertension (27%) (Zimbabwe STEPS survey, 2005) and cancers of the reproductive system (29.4% of all cancers in women are cervical cancer and 11.1% are breast cancer, while prostate cancer accounts for 11.4% of all cancers in men) (National Cancer Registry 2009 Annual Report)
- Mental health
- Life expectancy at birth has fallen from 63 in 1988 to 43 years in 2005/6

Most health indicators have deteriorated during the last decade. Consequently, the country is off-track in most of its health targets including the Millenium Development (MDGs) targets, as shown in table 1 below.

*Table1: Progress towards selected health related MDGs*

| Indicator | 1999 | 2005 | 2009 | MDG target |
|---|---|---|---|---|
| Infant Mortality Rate (per 1000 live births) | 65 | 60 | 63 | 22 |
| Under Five Mortality Rate (per 1000 live births) | 102 | 82 | 119 | 34 |
| Stunting in children under 5 (percentage) | 27 | 29 | 35 | 7 |
| Exclusive breastfeeding during the first 6 months (percentage) | 27 | 22 | 26 | 70 |
| Children 12-23 months fully immunised (percentage) | 67 | 53 | 46 | 90 |
| Maternal Mortality Ratio (per 100,000 population) | 578 | 555 | 725 | 145 |
| Skilled attendance at delivery (percentage) | 72.5 | 68 | 65 | 100 |
| HIV and AIDS prevalence (adults aged 15-49) | 28 | 18.1 | 13.7 | 9 |
| Adult ART coverage | 0 | 4 | 54 | 100 |
| Paediatric ART coverage | 0 | <1 | 57 | 100 |
| TB Incidence (notifications per 100,000 population) | 355 | 1047 | 782 in 2007 | 178 |
| Malaria incidence (cases per 1000 population) | 122 | 124 | 94 in 20088 | 62 |
| TB treatment success rate | | | 78% in 2007 | |
| Crude death rate (deaths per 1000 population) | 17.2 | - | 20 | |
| Life expectancy at birth | 45 | 43 | 43 | |

## Service Delivery and Health System Strengthening

Adequate resources and an appropriate enabling environment are critical prerequisites for the successful delivery of health services. Various studies and surveys carried out in Zimbabwe over the last three years point towards the inadequacies of the six health system building blocks (human resources; medical products, vaccines and technology; health financing; health information; service delivery and leadership and governance) that are prerequisites for a functional health delivery system, resulting in the public shying away from public health institutions. As a result there is gross underutilization of public sector institutions, due to non-functionality of the health care system for various reasons:

- Public sector Human Resources for Health vacancy levels have been at unacceptable levels of 69% for doctors, 61% for environmental health technicians, over 80% for midwives, 62% for nursing tutors, over 63% for medical school lecturers and over 50% for pharmacy, radiology and laboratory personnel (December 2008)
- Health management has weakened as a result of high attrition rates of experienced health service and programme managers. This has an impact on supervision and monitoring and is evidenced by reduced quality of service provision.
- Health professionals cannot provide services without adequate medicines and equipment. Access to essential drugs and supplies has been greatly reduced with stock availability ranging between 29% and 58% for vital items and 22% and 36% for all categories of items on the essential drugs list in 2008. Vital items should always be 100% available.
- Medical equipment, critical for diagnosis and treatment is old, obsolete and non-functional.

- The majority of physical health infrastructure is in a state of very serious disrepair. Fixed plant and equipment such as laundry machines, kitchen equipment and boilers are also non-functional. As a result very few public health institutions are able to meet basic hospital standards for patient care and infection control measures.
- As a result of serious shortage and disruption of transport and telecommunications several programs including patient transfer, immunisations, malaria indoor residual spraying, drug distribution, supervision of districts and rural health centres have been compromised.
- The health system is grossly under-funded. The current revised budgetary allocation works out to approximately US$7 per capita per annum against the WHO recommendation of at least US$34.

Based on available evidence, the Zimbabwea health system is not performing to a level that will enable it to address the country's burden of disease.

### Inclusive Implementation and Working Together

A healthy nation can only be achieved through the meaningful participation and involvement of local communities. Community contributions should be officially recognized and evaluated and health centre committees or community health councils should be actively involved in the identification of health needs, setting priorities and mobilizing and managing local resources for health. Health often remains perceived as a sectoral issue, but intersectoral collaboration is crucial in securing the health of the nation by ensuring that national resources are allocated in ways that maximise benefit to society. Missions and local authorities have been important traditional partners in service provision and financing, but have continued to provide and finance services on the basis of informal agreements with the Ministry of Health and Child Welfare. The private sector in Zimbabwe also has potential to contribute meaningfully to the process of achieving national health objectives, although cooperation between the private and public sectors remains ad-hoc and informal. This potential needs to be tapped and coordinated.

Some of Zimbabwe's traditional international partners suspended cooperation and direct development support in 2002. A number of them, however, continue to channel development resources through Private Voluntary Organisations, International Non Governmental Organisations and the United Nations family. Since some of these resources do not flow through government channels, there have been obvious difficulties in tracking them and monitoring their use. Support is mostly for HIV and AIDS and programmes related to nutrition, children and mothers. Difficulties have been experienced in accessing resources from global initiatives such as the Global Fund in the past. However, the bi-annual Ministry and partners meetings have continued to be held, with willing partners participating. Bilateral agreements or memorandum of understanding have also been signed with partners and countries working with the Ministry, but there is need to revisit the existing MOUs and coordinating structures in order to make them more useful. The institutions of higher learning have not been given their rightful positions in the health system and the Ministry of Health and Child Welfare needs to work more closely with College of Health Science in patient care, training, laboratory services research etc.

There is therefore need to inform and mobilize all stakeholders in the health sector around the National Health Strategy and encourage wider social participation of all sectors, communities and individuals on health issues along with strengthened mechanisms for partnership, collaboration and funding of health sector activities to implement the wide National Health Strategy..

**Summary of Current Challenges and Constraints in the Health Sector 2009**

The challenges facing the health status of the nation and service delivery in the health sector in 2009 can therefore be summarized as follows:
- High infant, child and maternal mortality
- High morbidity and mortality due to HIV&AIDs, malaria, and vaccine preventable diseases
- Household food insecurity and resultant malnutrition
- Poor access to safe water and sanitation with consequent increase in diarrhoeal diseases including cholera
- Inadequate Health Information, Education and Communication
- Inadequate funds allocated for service delivery

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

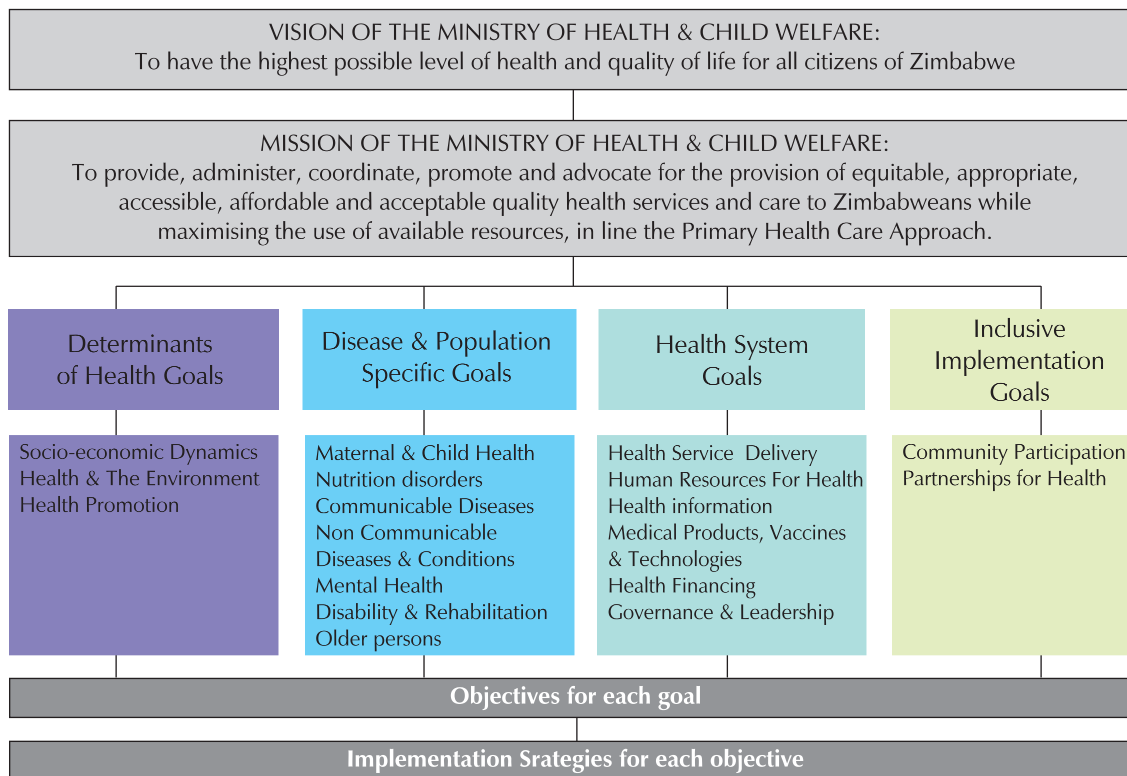
**Summary of Health Sector Successes to 2009**

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

## A COMPREHENSIVE STRATEGIC APPROACH

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

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


Zimbabwe's National Health Strategy 2009-2013:
Strategic Approach
VISION OF THE MINISTRY OF HEALTH & CHILD WELFARE:
To have the highest possible level of health and quality of life for all citizens of Zimbabwe
MISSION OF THE MINISTRY OF HEALTH & CHILD WELFARE:
To provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximising the use of available resources, in line the Primary Health Care Approach.
Determinants of Health Goals
Disease & Population Specific Goals
Health System Goals
Inclusive Implementation Goals
Socio-economic Dynamics
Health & The Environment
Health Promotion
Maternal & Child Health
Nutrition disorders
Communicable Diseases
Non Communicable Diseases & Conditions
Mental Health
Disability & Rehabilitation
Older persons
Health Service Delivery
Human Resources For Health
Health information
Medical Products, Vaccines & Technologies
Health Financing
Governance & Leadership
Community Participation
Partnerships for Health
Objectives for each goal
Implementation Srategies for each objective

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

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

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

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

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

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

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

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

## PRIORITIES FOR THE IMMEDIATE FUTURE

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

**Focus on Revitalising Primary Healthcare**

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

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

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

## HEALTH SYSTEM STRENGTHENING

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

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

## IMPLEMENTATION AND MONITORING ARRANGEMENTS

Implementation of the Five Year Strategy is the responsibility of **all stakeholders** under the leadership of the Secretary for Health and Child Welfare and the Top Level Management Team. The action points for the next five years include areas outside the boundaries of the health sector. Improvements in the health status and quality of life of the population do not depend solely on interventions within the health sector. It takes the efforts, contributions and participation of a myriad of stakeholders involved in both financing and direct provision of health services. It nevertheless remains the responsibility of the state, through the Ministry of Health and Child Welfare, to provide leadership and more importantly, stewardship, in harnessing and nurturing these efforts and contributions.

Maintaining sustainable partnership frameworks will be an ongoing negotiation process, promoted within an ambit of co-operation and with promotion of equity, quality and access to health care being the focus. Key to implementation of this strategy will be partnerships with Public Health Providers including Missions and Local Authorities; the private sector; traditional international development partners including the United Nations Family and bilateral donors; regulatory bodies of the health professions; institutes of higher learning and other ministries and sectors. Inter-sectoral collaboration will be based and focused on the common goal i.e. doing those things which improve the quality of life of the population, together. Existing district and provincial structures in the form of Provincial Councils, Provincial Development Committees and District Development Committees will support taking forward the operational agenda of this strategy.

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

A full operational plan will also be developed to guide practical implementation of this strategy.

**Conclusion**

There is an old adage "Those without a vision, will perish!". Thus the country cannot continue operating without a strategic direction, even if it is facing economic challenges and uncertainty over funding. The Government of Zimbabwe has, in the past, always funded the majority of health activities. Partners have come to fill in the gaps. In the current economic environment, partners are required not only to fill in the gaps, but to assist the country in "lifting off the ground" in the hope that as the economy recovers, government will again be the major funder of health and other social services. Most development partners have committed themselves to fund the Ministry agenda and not their own. It is therefore critical that partners keep this promise and use this document as a reference point to guide all activities in the health sector.

Improvement in the quality and life and health of Zimbabweans requires multi-sectoral action and cannot be achieved by the MoHCW alone. While the MoHCW focuses on priority interventions identified in the strategy, continuing efforts will be made to interest other stakeholders and partners whose activities have an impact on health to play their part in improving health and quality of life.

The fuller version of this document presents a comprehensive five-year strategic plan. The process of implementing it will be slow, incremental but with a direction. All stakeholders are urged to implement this strategy to secure equity and quality in the health of the nation over the next five years.

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