

ZIMBABWE

GLOBAL HEALTH INITIATIVE

STRATEGY

February 2012

GHI Strategy for Zimbabwe

I. Introduction

The sharp economic decline Zimbabwe experienced over the last decade resulted in a dramatic decrease in public funding for basic services and a severe deterioration of the health delivery system. At the end of 2008, the public sector health services had virtually collapsed. By 2009, national government expenditure on health was a mere US\$15 million against the proposed national health budget of US\$150 million or 10% of the estimated requirement for health programming in the country. Since 2009, Zimbabwe's public health system is slowly regaining functionality but this progress has required significant support from the United States and other donors. The Ministry of Health and Child Welfare (MOHCW) is using donor assistance to strengthen preventative and clinical services in Zimbabwe at both the health facility and community levels. Thus, health services and systems are in the process of being rebuilt (see the Health Sector Profile in Appendix A) and the GHI strategy can play an important role toward this end.

Existing US Government (USG) assistance has been mainly oriented around specific diseases and largely vertical national programs structured to mitigate those diseases. The basic premise used in formulating the GHI strategy was to identify effective approaches to accelerate progress in reducing preventable deaths and lessen the burden of disease within Zimbabwe, with a particular focus on women and girls (see the strategy to incorporate women, girls and gender equality into USG programming in Appendix D), through an effort to improve the integration of a set of essential health services and systems. Development of the strategy considered the major causes of deaths in the country and new assistance platforms that could help save more lives. Additionally, the strategy applies GHI principles within the identified initiatives to achieve greater public health impact in the general population.

II. Country Ownership and Investment in Country-Led Programs

A fundamental aspect of the GHI strategy is its clear placement within the latest country-led health strategies and specific national plans for Zimbabwe's health programs to the extent permissible by U.S. policy and statute. This fact reinforces country ownership of all components and clearly demonstrates investment in nationally defined health goals. Thus, the strategy is fully aligned with national health priorities and contributes to the overall goal "to have the highest possible level of health and quality of life for all citizens of Zimbabwe".

The development of the GHI strategy drew upon the Ministry of Health and Child Welfare's (MOHCW) 2009-2013 ambitious health strategy and several other MOHCW health plans, such as the Zimbabwe National AIDS Strategic Plan II 2011-2015 (ZNASP), the Maternal and Newborn Road Map and the National Child Survival Strategy. Therefore, the GHI strategy is founded upon the Government of Zimbabwe's (GOZ) own priorities for improvement of the health sector. All proposed activity areas are designed to be implemented in concert with host-country programs and contribute to MOHCW-led efforts to achieve specific national objectives for disease mitigation and improved essential health services. In doing so, the strategy provides a foundation for working closely with the MOHCW, local non-governmental organizations

(NGO) and other domestic stakeholder groups. The strategy supports the GOZ's commitment to improved health outcomes and strengthens national capacity to sustain health systems improvements into the future.

Top priority health goals for the MOHCW include to:

- reduce the maternal mortality rate from 725 to 300 deaths per 100,000 live births by 2015;
- reduce the under-five mortality rate from 86 per 1000 live births to 43 by 2013;
- have halted, by 2015, and begun to reverse the spread of HIV and AIDS;
- reduce the mortality, morbidity and transmission of tuberculosis in line with the Millennium Development Goals and the Stop TB Partnership targets; and
- have halted, by 2015, and begun to reverse the increasing incidence of malaria.

III. Current USG programs

The following briefly outlines current USG programs by health technical area. A more detailed "Health Sector Profile" for Zimbabwe is provided in Appendix A.

HIV/AIDS: The USG has supported a range of interventions that correspond to prevention, care and treatment for HIV/AIDS. This includes the provision and distribution of condoms, behavior change promotion, prevention of mother to child transmission (PMTCT), voluntary counseling and testing, provider-initiated testing, anti-retroviral treatment, palliative care, orphan and vulnerable children services, strengthening laboratory systems, improving health information systems and logistics system support.

Family Planning: The USG has used modest family planning (FP) resources to integrate voluntary family planning/reproductive health services into other health services, particularly PMTCT, HIV counseling and testing, and palliative care services. The overall goal of the country-led integration effort has been to reduce the spread of HIV/AIDS through the prevention of unintended pregnancies. Activities include training service providers, designing dual protection health-communication campaigns, and, more recently, building local capacity to deliver a range of FP services via mobile clinical outreach teams. Consistent with current USG regulations, family planning resources will not assist the central government.

Maternal and Child Health: MCH funds were recently leveraged to design a new MNCH program to improve service delivery in two districts in the Manicaland province. The USG has also collaborated with donors and partners at the national level to improve pre-service and in-service training packages pertaining to neonatal resuscitation, and has supported a Maternal and Newborn Health Quality of Care component into a National Health Facility Assessment (HFA) that is being planned with the MOHCW this year.

Tuberculosis: Zimbabwe has the second highest TB mortality rate in the world, as TB is the leading cause of death in HIV positive individuals, particularly those in the 15-49 age groups. In 2009, the USG received funding to improve case identification, services and program management. At the national level, the USG has supported the development of management

tools and TB control guidelines. At the provincial level, the USG initiated a TB pilot program in the Midlands Province and expanded into a second province (Masvingo) to train health workers in TB control and management, including DOTS.

Malaria: Zimbabwe received USG malaria funding in FY2011 as part of the President's Malaria Initiative. The USG (in coordination with other national and international partners including Roll Back Malaria Partnership, the Global Fund, and NGOs) will support a package of prevention and treatment interventions within the highest risk districts in support of Zimbabwe's National Malaria Program. This includes expanding the distribution of insecticide-treated mosquito nets, improving coverage of indoor residual spraying with insecticides in high-risk districts, and strengthening service delivery and supervision for the diagnosis of malaria and treatment with artemisinin-based combination therapy (ACTs).

IV. GHI Strategic Goals and New Approaches

In the past, most of the USG assistance for the health sector was primarily focused on the HIV/AIDS epidemic in the country with limited coordination and synergy efforts across other disease-specific programs. The recent availability of other funding sources besides the President's Emergency Plan for AIDS Relief (PEPFAR) and the dawn of the Global Health Initiative provide new opportunities for greater integration of a variety of assistance efforts that can combine to strengthen health delivery platforms and systems in Zimbabwe more holistically.

The basic goal of the GHI strategy is to achieve improved health for Zimbabweans (see the Zimbabwe Global Health Results Framework in Appendix B). With this goal, the expected impact is to reduce morbidity and mortality related to HIV, tuberculosis (TB), malaria, reproductive health and maternal, newborn and child health (MNCH) conditions. The strategy focuses on increasing the integration of services at levels where most people first access health care and for those health problems that are the leading causes of mortality and morbidity in the country. A key priority of the strategy is also to respond to the needs of women and girls who: are the most affected by the HIV epidemic (almost 60% of Zimbabwean adults living with HIV are women); have a lower life expectancy than men; and; carry the greatest responsibility in caring for the sick.

The GHI strategy in Zimbabwe identifies two areas of focus: (1) **integrated health service delivery with a particular emphasis on women and children; and (2) health systems** to build capacity for sustainable programming. These areas were identified based on GOZ and USG health priorities, available resources and key opportunities for USG leveraging and expected impact. The USG in Zimbabwe will make a concentrated effort to leverage its resources and harmonize its efforts to attain greater impact. Progress towards this goal and in these focus areas will involve increasing the availability of and public access to quality basic health services and improving health outcomes resulting from those essential health services selected for assistance. At the goal level, the strategy will be contributing to: reducing maternal mortality; reducing infant and child mortality; improving the timing and spacing of pregnancies for better health outcomes; reducing the incidence/prevalence of HIV/AIDS; increasing the quality and length of lives for those affected/infected with HIV/AIDS; and, reducing TB morbidity and mortality.

The strategy is designed to assist in the re-establishment, initiation or expansion of key basic health services. Increasing the use of essential services by vulnerable segments of the population is an expected outcome of each component of the strategy to address the inequities in access that exist particularly in rural areas. The strategy, therefore, will support accelerated progress towards Zimbabwe's Millennium Development Goals (MDG) for health and improve health service delivery options for Zimbabweans.

The GHI Strategy incorporates a Learning Agenda with a focus on reducing maternal, neonatal and child mortality and reducing morbidity and mortality from the top three infectious diseases in Zimbabwe. The orientation of the Learning Agenda is the implementation of a comprehensive and integrated package of services in selected geographic areas, utilizing resources from USG agencies, the Government of Zimbabwe and other development partners. The strategy's Learning Agenda will be implemented within a context of country leadership and ownership.

The strategy recognizes that the GOZ already has in place many policies and strategies for improving maternal, neonatal and child health and for mitigating the main infectious diseases in Zimbabwe. These national policies, strategies and programs will form the context within which USG assistance is provided. The strategy also includes support of joint efforts with the GOZ to develop evidence-based processes for improving basic health care.

Successful accomplishment of components of the strategy should lead to more Zimbabweans experiencing better essential health services and improved health outcomes. Accordingly, the expected impact of implementing the GHI strategy includes:

- Increased utilization of key integrated essential (prevention and treatment) services, control services, diarrhea treatment, pneumonia detection and treatment;
- Enhanced quality of integrated essential health services;
- Increased availability of integrated essential services and basic health commodities;
- Strengthened health systems that support integrated health service delivery.

The Learning Agenda will focus on geographic areas where USG agencies are currently working at different levels of health service delivery and include additional locations in the country as needed to realize opportunities for increased public health impact or more integrated planning and programming synergies. Whenever possible, existing USG agency and country platforms will be utilized to implement comprehensive cross-cutting evaluations exploring the effectiveness and feasibility of current and new interventions. The intent also is to apply a more comprehensive integrated annual planning process that cuts across policy, health systems and services and engages key stakeholders within the GOZ, the donor community, and civil society.

V. GHI Strategy Focus Areas and Elements

Under GHI, the USG will focus in two areas: 1) health service delivery through enhanced integration and quality of health services; and 2) health systems. Focus in these areas provides the USG an opportunity to maximize program impact through strategic coordination and capitalize on synergies within USG-supported programs. The strategy will build on the considerable resources and achievements the USG and other development partners attained thus

far. Initially, efforts under service delivery will concentrate in one province and then expand to include other provinces as additional resources are made available. The first province will be Manicaland, chosen because it: has high malaria-incidence districts; has a history of above-national-average mortality and disease burden levels; and, is a province where the range of USG programs is already present (allowing a rapid start-up).

Health system-strengthening efforts will be at the national and sub-national level in order to support USG assistance in service-delivery. All proposed activity areas are designed to be implemented in concert with host-country programs and contribute to MOHCW-led efforts to achieve specific national objectives for disease mitigation and improved essential health services.

FOCUS AREA 1: Health Service Delivery

Under GHI, the USG will improve health services by strengthening: (1) the integration of selected health services and (2) the quality of health services. USG efforts in these areas will complement the work of other development partners to improve the availability of and access to a quality comprehensive package of health care. Innovation is an integral component of the USG's support under GHI particularly in health service delivery in the areas of new vaccine introduction (e.g. pneumovaccine) and scale up of voluntary medical male circumcision.

1.1 Integration of health services

The bulk of Zimbabwe's primary health care is intended to occur at the lowest level with a focus on Rural Health Centers (RHC). This primary level is supposed to refer all cases it cannot handle to the secondary level (district hospitals) which in turn refers to the tertiary and quaternary levels (provincial and central hospitals). It is at the level of primary care where the greatest benefits of integrated health services can be realized, resulting in improved health outcomes in Zimbabwe.

At present, rural health centers (RHCs), the preferred source of primary care, are not functioning optimally, including their associated referral system. The primary level and, to some extent, secondary level facilities often lack essential commodities such as basic equipment and some drugs. Basic integrated services are not always available. People seeking primary care frequently bypass the health center level all together and go to a secondary health facility (such as the district hospital) or higher where more services are perceived to exist. Additionally, inconsistent fee schedules particularly for Maternal and Child Health services at public health facilities nationwide deter patients from seeking preventative interventions, early diagnosis and care. These factors effectively limit access to basic health services for many communities in Zimbabwe.

Given that most USG assistance to the health sector over several years has been oriented to supporting vertical national programs focused on a single disease or specific health risk, the recent availability of multiple types of health funding through USG channels and GHI presents the USG with new opportunities to approach the improvement of health service delivery holistically. The use of established partnerships creates tremendous new opportunities for synergy and efficiency in the provision of integrated services.

Data on the burden of disease and the leading causes of mortality in the country supports the USG decision to prioritize and strengthen the integration of key health services (namely, HIV/AIDS, TB, malaria, MNCH and FP/RH) at the district and community levels under GHI. By leveraging its technical assistance and resources, the USG expects to improve the ability of health facilities to provide basic and comprehensive maternal, neonatal and child health services to women and children. For example:

- The USG will expand and further strengthen the integration of a variety of voluntary family planning services – including counseling – into other health services such as prevention services for HIV positive individuals, PMTCT and ANC.
- The USG will further strengthen NGO-operated mobile-outreach teams within targeted provinces to improve access to an integrated package of health services such as HIV testing and counseling, TB case detection, treatment of sexually transmitted diseases and voluntary family planning counseling and services.
- Given the health risks that malaria poses during pregnancy and the latest DHS data that reveal only 7 percent of women received intermittent preventive treatment for infants (IPTp) during an antenatal visit, the USG will support the GOZ's efforts to integrate malaria prevention and control measures into the package of maternal health services offered at primary and secondary facilities. This will entail integrating malaria prevention and treatment standards and protocols into training modules, training service providers and strengthening outreach services and supervision. The USG will support pilot activities that link the distribution of treated mosquito nets with antenatal care services in high-burden malaria areas of the country.
- Through USG support, the integration of HIV/AIDS and TB services at the health facility level will be expanded and strengthened (through training, technical assistance and formative supervision) to better respond to the needs of patients who are both HIV-positive and have TB.
- The USG has improved PMTCT services in more than 50 percent of the health facilities in Zimbabwe. Part of the PMTCT effort is to scale-up the availability of more efficacious regimen (MER) of antiretroviral drugs for PMTCT across the country. Under GHI, the USG will expand the number of sites that offer MER – integrating ART into PMTCT programs. The USG will support health communication efforts to promote knowledge of HIV status as the entry point to PMTCT. In general, the USG will support mass media campaigns that promote a range of health messages for a multidimensional audience.

USG efforts in integration will increase the availability and access to comprehensive health services by creating opportunities for vertical health services to co-locate and integrate with related services and with longer-standing USG-assisted efforts (such as the prevention of mother to child HIV transmission (PMTCT) services) and better serve the clients. The USG will also have new opportunities for shared investments in improving service-delivery and attain greater efficiencies that spans across disease-specific activities. The strategy is to increase the USG's leadership role with the GOZ and other development partners to ensure greater coordination

across national, vertical health initiatives and across the various levels of service delivery in the country. Through the newly-established GHI coordination mechanisms (such as the GHI Country Team and the combined USG data quality assurance team), the USG will engage in regular dialogue around the focus areas to ensure its investment is strategic and coordinated in supporting the GOZ goals in health.

USG efforts in health-service integration will benefit both the health care user and service provider. For example, for the health care user, integrated health services produces an environment in which health care is more seamless, smooth and easy to access; minimizes the number of steps required during a single visit to a health facility; and, reduces the number of separate visits a client needs to make to a health facility to achieve a successful health outcome. For health care providers, integration can result in distinct health services (along with their management and logistical support systems) being provided, managed and evaluated together or in a closely coordinated way. Such integration will lead to better coordination of services and produce greater continuity of care for clients. Improved integration at lower levels of health care will bring services closer to women and their families. Realizing the potential contributions from greater integration and coordination of services is especially important for Zimbabwe due to the combination of health risks that feed the national patterns of morbidity and mortality.

Interventions:

- Expand and further strengthen voluntary FP counseling services and other services in PMTCT and ANC sites.
- Further strengthen mobile outreach teams to improve access to an integrated package of health services (HIV/AIDS, TB, STI, and FP).
- Strengthen service delivery for intermittent preventive treatment for pregnant women (IPTp), as part of improving antenatal care services.
- Expand access to integrated TB/HIV services and improve the management of TB/HIV co-infection.
- Increase access to and improve the quality of PMTCT services in the public health care system by introducing ART services into PMTCT platforms.

1.2. Quality Health Care Services

Zimbabwe's GHI strategy recognizes that quality of care is a critical ingredient for improved health outcomes in the country and the Ministry of Health and Child Welfare's vision includes the improvement of the quality of integrated health care. The strategy acknowledges that families have a right to expect a high standard of health care and that poor standards of care act as a deterrent to seeking both preventative and curative services. National health policies and plans call for full adherence to WHO-recommended protocols for essential health services and these recommended protocols form the basis for standards of quality.

To achieve improvements in quality, the health system will need to achieve positive change in a range of factors that contribute to overall health care quality. For example, increasing the effectiveness of care will require a focus on results in improved health outcomes for individuals and communities. Improvements in efficiency can improve quality by delivering health care in a manner that maximizes resource use and avoids waste. Quality also includes the dimension of

being patient-centered, delivering health care which takes into account the preferences and aspirations of individual service users and their communities. Additionally, quality care is safe and delivers health services which minimize risks and harm to clients and health care workers.

The USG supports the GOZ efforts to improve the quality of services under its current program through pre and in-service training, formative supervision and quality assurance and control. Under GHI, these efforts will be enhanced through better consultation among the USG, the GOZ and other development partners. The USG approach to improving the quality of care will be holistic and not fragmented by disease areas in order to serve the beneficiaries with a range of quality health services. For example, quality assurance measures (such as using the Standards-Based Management and Recognition methodology) include protocols and supervision tools for improving both reproductive and child health services including HIV, while also improving infection control procedures and management of all services at a health facility. Such measures also are integral to the effective use of laboratory services for effective and efficient diagnosis and treatment.

Each service-delivery assistance area under the GHI strategy will include a set of activities designed to assure that services across all disease areas are carried out to set standards and to monitor adherence to those standards within host-country service-delivery networks. Assistance will also include support for the processes for measuring quality, analyzing any deficiencies discovered and taking action to improve performance followed by further measurement to determine whether quality improvements have been achieved. Other activities will include:

Interventions:

- Updating clinical practice protocols for compliance with the latest WHO guidance within an integrated service delivery context.
- Training health care providers and managers in quality assurance techniques for integrated care.
- Enhancing quality-of-care monitoring and data collection systems for integrated services.
- Supporting the introduction or expansion of quality assurance measures or tools such as the Standards-Based Management and Recognition (SBMR) methodology for integrated services.

FOCUS AREA 2: Health Systems

The USG currently supports the GOZ in several health system areas such as supply chain, human resources, monitoring and evaluation through technical assistance at the national level, and through training and material support. To build upon its comparative advantage in health system strengthening and to maximize investments to date, the USG, under GHI, will improve its approach to strengthening Zimbabwe's (1) health commodity logistics systems, (2) laboratory system, (3) human resources for health, and (4) district level health information systems by coordinating better internally among USG agencies and externally with the GOZ and other development partners. Through existing coordination mechanisms, the USG will: dialogue and coordinate its assistance in these areas to ensure its assistance aligns with national priorities and needs; better leverage its resources with other development partners; and, increase

complementarity with the implementation work of other donors. In doing so, the USG expects to attain greater efficiency and impact in the utilization of health services.

2.1: Improved Logistics and Supply Chain Management:

This element of the GHI strategy is designed to help assure that Zimbabweans seeking essential health services find all the critical drugs and supplies available so that they receive optimal basic health care. The strategy supports creating an integrated approach to logistics within the MOHCW. To do so, the strategy is to strengthen both the MOHCW's Directorate of Pharmacy Services (DPS) and the National Pharmaceutical Company (NatPharm), who together manage the procurement and distribution of the other drugs and commodities for the national system. Such strengthening efforts will build on successes achieved in logistics systems for FP and HIV/AIDS supplies. Envisioned assistance will help build a single, integrated health logistics management system characterized by high efficiency, low stock-outs and fully integrated logistics information. Through collaborative efforts of the GOZ and other donors, the integrated logistics system has been expanded to support distribution of commodities procured by non-USG sources of funding. USG support is also working to leverage the resources and increase the reach of the multilateral Global Fund, the newly established multi-donor Health Transition Fund and the World Bank (WB)-administered Multi-Donor Trust Fund.

The GHI strategy envisions a three-phase approach to strengthening a health logistics system in support of the provision of integrated essential services. Phase one will focus on getting existing components of the health logistics systems functioning fully to achieve progress towards the greater availability of essential drugs and other supplies at MOHCW outlets. The second phase will accelerate the integration of disparate logistics channels and mechanisms into a single national logistics system with consistent standards and a shared infrastructure. It is anticipated that the second phase will consume most of the GHI strategy period. The final phase will focus on strengthening evaluation and monitoring functions of the new system's operations to help maintain efficiencies as well as to better inform logistics management processes.

Interventions:

- Assess each component of the existing national logistics system to identify strengths, weaknesses and opportunities to realize improvements.
- Work with the national TB program to conceptualize and help launch a quarterly pull system for TB drugs in conjunction with the provision of commodities for other care.
- Introduce procurement and distribution mechanisms that integrate different health program approaches obtaining needed drugs and health commodities.
- Provide technical assistance to develop new management structures for integrated day-to-day operations of the logistics system.

2.2: Strengthened Laboratory Systems:

Despite the high burden of disease in Zimbabwe, the provision of health care is complicated by the lack of resources, the high cost of effective medications and the limited availability of efficient laboratory services. A major emphasis has been put on laboratory strengthening because of the central role of the laboratory in supporting all HIV program activities.

Under GHI, the focus will be on optimal utilization of laboratory support in providing quality care and reliable diagnostic support for all disease areas. It is important to institute quality systems in the functioning of laboratories since diagnosis, initiation of treatment and proper management of people on antiretroviral therapy depends upon reliable laboratory results. The quality system refers to the organizational structure, procedures, processes and resources needed to implement quality across other health areas. There is also an opportunity to bring CD4 testing closer to women as part of ANC services. The key elements of a quality system are: organizational structure and management, standards, training, documentation and assessment.

Interventions:

- Strengthen the role of laboratories in testing and patient monitoring within an integrated service-delivery context.
- Improve sample transport systems and turnaround time for communication of results from integrated care facilities.
- Develop and implement a national quality assurance system.
- Improve laboratory diagnostic capacities.

2.3: Strengthened Human Resources for Health:

The health sector in Zimbabwe, for some time, has been burdened with a serious shortage of skilled health workers – due largely to substantial out-migration of health professionals. This shortage affected all categories of health workers. The out-migration from the public health services has been exacerbated by several factors but most were related to economic and political instability issues. Among other reasons, health workers leave to: find better opportunities; seek higher incomes; experience work environments with a better health infrastructure; and, secure jobs where they can apply professional skills more fully. The total number of health care providers in the work force is more an issue of retention than an insufficiency in the rate of production of new health professionals.

Donor and partner efforts to reduce staff shortages have resulted in a greater reliance on newly graduated doctors and nurses in the public health system. Although vacancy rates are on the decline, the work force is increasingly typified by young and inexperienced health staff, specifically in rural areas, with sub-optimal practical skills training and a lack of experience to handle complicated and unusual health procedures. The need for in-service training and strengthened supervision systems, therefore, is substantial.

The GHI strategy allows for a more strategic approach to strengthen human resources for health particularly in the area of training. Most of the specific assistance areas affecting service-delivery include training for in-service health personnel that is related to a particular health risk or health-care-delivery protocol. For example, assistance for TB control may include training for currently serving clinical staff on TB case detection and management. In addition, some support is also envisioned for pre-service training to help increase the numbers of new health care workers entering the health work force. The strategy will enhance host-country capacity to train health workers both in-service and pre-service, with a particular emphasis on the integration of services.

The support of training initiatives, therefore, is designed to build human resource capacity for effective delivery and management of integrated services. Clinical focus areas in FY 2012, for example, included male circumcision, revised WHO PMTCT guidelines, pediatric care and treatment, including early infant diagnosis, infection control and prevention, maternal, newborn and child health and ART/OI management. USG resources will also support up-dating training modules for strengthening various national in-service training programs for a variety of health care providers as well as direct support for in-service training of health workers. USG efforts complement those of other donors working closely with the GOZ on HR policy issues, including salary and retention schemes.

Interventions:

- Up-dating training modules for strengthening in-service training programs related to integrated service-delivery for a variety of health care providers.
- Support for in-service training of health workers in selected health care service delivery areas.
- Support of pre-service training of health workers for selected health degree areas or cadres.

2.4: Strengthened and Harmonized Health Information Systems:

The current national health management information system (HMIS) needs strengthening. Because the GOZ is receiving some support from the Global Fund at the national level, the USG, under GHI, will strengthen district-level recording and reporting for HIV, and other health conditions and services provided. Improvements in the district level health information system can, in turn, strengthen the national health information system. The USG will also provide training and technical support to make the information system more relevant and useful to health workers.

In addition, interventions for improving service delivery include robust monitoring and evaluation components that support national health information systems. These monitoring and evaluation activities are designed to use common national health indicators that are part of the Zimbabwean health information systems. Data quality is a key element of health information support for service delivery and is one of the emphasis areas for monitoring efforts for improvements in integrated HIV/AIDS, malaria, MNCH, FP/RH and TB service-delivery.

Interventions:

- Provide mentoring and capacity-building to MOHCW to improve health data collection, use, analysis, and dissemination for and from integrated service-delivery sites.

VI. Women, Girls and Gender Equality (WGGE)

Operations in the Health Sector are guided by The Zimbabwe National Health Strategy; 2009 – 2013 whose theme is ‘Equity and Quality in Health - A People's Right’. Therefore, assistance activities are designed to support this concept of equal access to quality health care. The USG recognizes that women and children are central to the achievement of the majority of the MDGs, such as goals 4 and 5 on child survival and maternal survival respectively. A core component of the GHI strategy in Zimbabwe is therefore for a greater focus on women, girls and gender

equality and the USG team will work closely with the MOHCW, other donors, UN agencies and NGOs in this regard.

Specific details of the WGGE principles to be addressed in this GHI strategy are outlined in Appendix D. These program components have been identified based on both internal and external assessments that have been undertaken including the Demographic Health Survey (2010/2011), a DFID gender and social exclusion assessment (June 2011) and the GOZ/ UNICEF “A Situational Analysis on the Status of Women’s and Children’s Rights in Zimbabwe, 2005 – 2010: A Call for Reducing Disparities and Improving Equity.” Over the course of this GHI strategy further gender analyses, either as part of smaller pieces of operational research or national and USG program assessments will be undertaken.

Specifically, interventions will address some of the disparities that women face that include: a higher risk of HIV infection particularly at younger ages such that 7.45% of women 15-24 years are HIV positive, compared to 3.54 per cent of their male peers; and lower condom use during high risk sex which varies markedly between young women and men (15-24 years) with 42 per cent of young women reported using a condom the last time they had sex with a high-risk partner, compared with 68 per cent of young men (ZDHS2005/6).

Women aged 15–24 also report lower use of modern contraceptive methods than women in other age groups. The proportion of adolescents reporting current pregnancy rises from 2% at the age of 15 to 41% at the age of 19 years, demonstrating the limited reach of youth-targeted FP services. Societal gender imbalances and economic disparities between women and men in Zimbabwe increase the vulnerability of young women and they often engage in cross generational sexual relationships in which they have limited ability to negotiate condom use. These imbalances place these young women at high risk for unintended pregnancies and acquisition of sexually transmitted infections (STIs) including HIV as well as increasing their risk of having a complicated pregnancy. The USG MNCH efforts will also respond to the rural to urban disparity seen in accessing skilled attendance at the time of delivery with 48% of deliveries occurring at home in rural areas compared to 7% seen in urban communities.

In summary, some of the key program areas that address WGGE will be:

- Several programmatic interventions e.g. FP outreach with a focus on improving access for rural women and adolescents, integrated VCT services bringing a range of services closer to communities, targeting of sexually active and reproductive age men and women with communication, health services and FP products and provision of essential maternal and child health (MCH) care services. In particular, the responsible role of men in reproductive decision-making and family planning choices is an emphasis within community outreach efforts.
- Greater effort will be made to integrate voluntary family planning with prevention of mother-to-child transmission of HIV, enabling both HIV+ and HIV- women who do not wish to become pregnant increased access to contraception to prevent unintended pregnancies.

- The USG will support culturally appropriate, gender- and age-specific social and behavior change communication to support healthier attitudes and encourage uptake of health services particularly in the areas of HIV including OVC, FP and MNCH.
- Efforts will continue to have more male involvement in what are traditionally viewed as female programs e.g. MCH, FP and PMTCT. HIV counseling and testing programs will place more emphasis on couple counseling compared to counseling individual partners as it is known to have more impact on positive behavior change.
- Expanded immunization coverage, malaria control and improvements in logistics systems are all designed to provide improved access for women and children. Child survival services strive to equally reach male and female children. Although women continue to be the primary care-givers for children less than 5 years of age, men receive child survival communications and will be encouraged to participate in both preventive and curative health care.
- The USG and its partners regularly collect gender disaggregated data in all the programs. Where there are disparities, targets will be set to correct these disparities.

VII. Learning Agenda

Due largely to social, economic and political circumstances, Zimbabwe has been characterized by rapid change and un-predictable developments. Consequently, maintaining health services in the face of massive change has required constant innovation. Zimbabwean health professionals typically strive to bring the latest technologies to bear in meeting health care needs. Learning and innovation are critical to the overall success of the GHI strategy. The learning agenda will support innovations that promote a results-oriented rather than expenditure or input-based approaches to system strengthening. The objective of the learning agenda is to bring innovation to the process that defines and demonstrates more effective health care solutions to Zimbabwe's health sector problems. Pilot programs and creative approaches to maximize popular participation and better health outcomes are encouraged within the strategy.

The GHI strategy incorporates a more deliberate approach to integrated USG and host-country planning and measurement across PEPFAR, PMI and other USG health assistance areas in order to realize improved health outcomes for Zimbabweans. Drawing upon already existing health activities and programs being implemented by USG agencies, there is currently a group of health intervention platforms that are generating valuable lessons-learned that can inform future efforts to improve health care in Zimbabwe. Past experience will help evaluate the potential of new approaches to accelerate positive change in health service delivery.

Operations research and application of the latest technical findings from the international health arena are also keys to the learning agenda. Zimbabwe's Ministry of Health and Child Welfare has proven very willing to be pioneers in utilizing the latest health care technologies available. Consequently, the GHI strategy may support pilot programs that experiment with new service modalities or new clinical protocols that may result in greater health care efficiencies or better public health outcomes.

To support the learning agenda, the GHI strategy incorporates a vibrant component (also see the section below) for collecting precise and relevant metrics needed to measure and compare

alternative approaches to achieve the desired impact on GHI targets. Cross-cutting evaluations may be needed to explore the effectiveness and feasibility of current intervention formats. The learning agenda approach calls for the USG agencies and the GOZ to work together to: measure current program effectiveness; share lessons learned from implementation experience; collaboratively strive to create new program efficiencies; and, acquire knowledge through the use of rigorous yet practical learning protocols.

VIII. Monitoring and Evaluation

Monitoring and evaluation (M&E) are integral to all aspects of the strategy. GHI brings together a number of programs and presidential initiatives each of which has an M&E system currently in place to measure progress towards reaching GHI goal area targets. Evidence has shown that robust M&E systems that provide timely and useful data about program performance can lead to evidence based decision making and cost effective service delivery towards expected results. The sixth GHI principle of improved metrics, monitoring and evaluation acknowledges this fact and will be applied across all GHI program activities in Zimbabwe to bring us closer to achieving sustainable results.

Until recently, monitoring and evaluation of health assistance was done independently by each USG agency through its own respective channels. Lessons learned or information realized was applied largely within the specific sphere of assistance managed by the USG agency concerned. Under this GHI strategy, USG agencies will now share M&E plans and performance monitoring protocols. Joint USG data quality assessments have already begun to achieve a more common level of data reliability and similar systems of data verification. New systems for M&E are envisioned that will allow USG agencies to maintain individual reporting requirements, give the program adequate data for decision making as well as create opportunities to monitor and evaluate the various “learning agendas” through operations research.

Information gained from monitoring and evaluation and the lessons learned through implementation will inform yearly action plans and become part of the experience base available to Zimbabwe’s national health programs. Information gathered and findings will also be used for wider learning, systems strengthening, and continuous quality improvements within the country’s health sector. The strategy calls for quantifiable progress indicators and objectively verifiable measurement of change in goals and objectives. Within each intervention area and component, monitoring and evaluation efforts will be financed with USG resources. Determination of results will be evidence based and program implementation choices will be derived from the application of monitoring data.

The application of GHI principles is expected to accelerate progress towards sustainable results in HIV and AIDS, malaria, MNCH, FP/RH, TB, nutrition and neglected tropical diseases (NTD). Yearly progress towards the achievement of improved health service delivery will be measured. The impact of the whole GHI approach will be seen in the change in the rate at which Zimbabwe is moving towards achievement of goal area targets. In compliance with USAID’s evaluation policy, this kind of impact evaluation often requires rigorous study design and careful planning prior to implementation of GHI approaches to ensure successful measurement of the net contribution of the GHI approach among other program factors.

The country GHI team will form an inter-agency USG working group on M&E which will work closely with the GOZ to ensure data collection efforts are harmonized and to maximize the use of common indicators in tracking the progress of health programs. USAID has developed an extensive data base to track its programs. The USG interagency M&E group will develop a common GHI tracking matrix within this data base so that all agencies can work together to identify joint indicators and results.

IX. Strategic Coordination, Integration and Partnering

Collaboration and coordination is envisioned at all levels, from downstream point of contacts with individual patients to upstream joint programming with national health counterparts, among U.S. government agencies and with other donor partners. Through the envisioned integration, the GHI strategy will help to better meet the holistic health needs of individuals and increase efficiency and effectiveness in Zimbabwean health systems. Health assistance will support and promote the integration of health services, particularly as they are offered at the primary care and community levels. Partnering between USG-supported implementers and local organizations for better integration within the essential services package will improve the continuum of care for poor and vulnerable populations and ultimately increase the accessibility to and impact of services.

For example, the new strategy promotes the integration of PMTCT and MCH services and builds on the work that the Zimbabwe ART and MCH Task Forces have begun. Using a variety of funding sources, the integration of voluntary family planning within HIV/AIDS services will also build on past work and, under the new strategy, will be strengthened and expanded. The USG will continue to work closely with NGOs, government technical counterparts, and other donors to ensure that synergies among programs are captured and resources optimized.

This strategy is closely linked with the latest Zimbabwean plans to accelerate progress toward achieving the health-related Millennium Development Goals for the country. Virtually all components of the strategy are designed to be undertaken, not only utilizing an integrated and coordinated cross-USG-agency effort, but also in close collaboration with other bilateral and multilateral donors. The strategy expects to maximize opportunities for joint programming and complementary implementation of assistance among donors active in the health sector. Other donors were consulted during the development of the strategy and opportunities have already been identified for joint programming in common intervention areas with DfID, UNFPA, UNICEF, the Global Fund and UNDP. For example, the USG team will work closely with DfID, SIDA and UNFPA on a joint sexual and reproductive health and HIV prevention program, to improve coordination and ensure the most efficient use of combined resources. Similarly, the USG will participate on a high level steering committee managing a multi-donor Health Transition Fund with a focus on improving maternal and infant mortality.

Other efforts to improve collaboration and coordination among donors and GOZ include participating in regular health partner meetings and participating in national review and planning meetings. Increasing the involvement of the private sector in health service delivery also is one of the components of the strategy.

X. Challenges for GHI in Zimbabwe

In many respects, Zimbabwe remains a fragile state that is in transition. The national economy continues to struggle and the amount of domestic resources allocated to the health sector remains limited. National health plans and health service delivery efforts rely heavily on donors to supply the means for the realization of progress. USG funding for health sector assistance in Zimbabwe historically has been low relative to the country's population size and disease burden. Funding for non-HIV health elements (family planning, maternal and child health, etc.) has been especially limited. Therefore, the GHI strategy is designed to realize progress within relatively modest annual funding amounts. The strategy also assumes opportunities for joint donor funding of priority health initiatives with a specific focus on strengthening maternal and child health services will continue. Shifts in health sector assistance levels by other donors could affect the speed of progress in achieving GHI goals and objectives in the country.

The Global Fund is an important donor for the Ministry of Health and Child Welfare's programs. However, there have been issues related to the use and flow of Global Fund resources in Zimbabwe and at present UNDP serves as the Principal Recipient for Global Fund activities. The USG and other donors are offering support to country coordination mechanisms for the Global Fund to help make Global Fund resources more effective in helping to realize national health goals. Recent trends (as indicated in the notifications around round 11 submissions) show diminishing resources within the Global Fund worldwide. This suggests future funding for Zimbabwe from the Fund may be on a smaller scale. Questions remain over how Zimbabwe will be able to fully finance the wide range of health system improvements it envisions for its people.

Zimbabwe's troubled economy also continues to impact the retention of skilled, professional staff, especially midwives and doctors some of whom still look for opportunities abroad. Uncertainties about the economy and future changes in the economy could affect the current retention rates for health personnel. Similarly, there are uncertainties concerning what future political environment may emerge. During the elections in 2008, unrest in some parts of the country affected delivery of health services and the implementation efforts of some NGOs. A resurgence of such unrest could impact health program efforts and overall progress toward the GHI strategy's goal.

U.S. Government assistance to Zimbabwe also is affected by a number of legal limitations, such as Brooke and Section 620q loan default provisions and provisions found in the annual appropriations act. Currently, USAID/Zimbabwe relies on a combination of legal authorities permitting certain types of assistance notwithstanding other provisions of law, waivers, and other exceptions included in statutes to carry out its activities in Zimbabwe. If new limitations on assistance to Zimbabwe are included in appropriations acts in the future, legal authorities are removed or if annual waivers are not approved, it may affect USAID/Zimbabwe's ability to implement some of the activities contemplated herein.

Despite these challenges, the health sector in Zimbabwe has demonstrated that progress still can be made in reducing morbidity and mortality when strategic investments are made. This GHI strategy lays the foundation for expanding and integrating effective interventions to accelerate improvements in health outcomes with a renewed focus on women and girls. Strategic coordination and leveraging of resources will enable the USG to support the MOHCW to

identify efficiencies and increase impact of health sector investments over the five year period of the strategy.

Zimbabwe GHI Strategy – Appendix A: Health Sector Profile

Demographic Information: Although there has not been a national census since 2002, the total population of Zimbabwe is estimated to be around 12 million. About 41% of the population is less than 15 years of age. Individuals between 15 and 64 years of age comprise 55% of the population. Urban residents constitute 38% of the population with the result that the majority of Zimbabweans continue to live in rural areas of the country. The 2002 census estimated the crude birth rate to be around 30 per thousand population and the crude death rate at 17 per thousand. Female-headed households make up 38% of all homes in Zimbabwe. Female-headed households are more common in rural areas (43%) than in urban locations (29%). Among all Zimbabwean households, 35% include foster children who are under the age of 15 years and have no natural parent in the household. The average size of a household in the country is 4.5 persons (2002 Census).

Health Sector and Health Systems: The sharp economic decline Zimbabwe experienced over the last decade resulted in a dramatic decrease in public funding for basic services and a severe deterioration of the health delivery system. At the end of 2008, the public sector health services had virtually collapsed. By 2009, national government expenditure on health was a mere US\$15 million against the proposed national health budget of US\$150 million or 10% of the estimated requirement for health programming in the country. Since 2009, Zimbabwe's public health system is slowly regaining functionality but this progress has required significant support from the United States and other donors. The Ministry of Health and Child Welfare (MOHCW) is using donor assistance to strengthen preventative and clinical services in Zimbabwe at both the health facility and community levels.

Nevertheless, the health sector still is plagued by human resource challenges, insufficient supplies of essential drugs or materials, dilapidated equipment, decaying public infrastructure and disrupted transportation and telecommunication systems. In 2009, the mean annual vacancy rate for all cadres of health workers in the public sector was nearly 40%. Zimbabwe has taken proactive steps to reduce vacancies and build the nation's health work force. Progress is being made, as evidenced by the fact that the mean annual vacancy rate for all health cadres has dropped to slightly less than 20% in 2011. While numerous health workers have returned to their posts, critical vacancies still remain and public sector wages are generally perceived as inadequate.

The economic decline has also affected NGO-based and mission health services (a major health care source for rural populations) and employer-based health insurance schemes. In addition, the dollarization of the economy (since January, 2009) has impacted the cost of health care and the ability of the poor (particularly in rural areas) to access health services. Obtaining sufficient currency can be difficult for the poor and the cost of transportation from rural locales can be high. Fees for health services are not standardized and many facilities set their own rate structures for consultation fees, laboratory tests and prescription drugs. City health facilities, for example, can charge between \$1.00 and \$5.00 for an adult consultation and between \$10.00 and \$50.00 for lab tests. When the composite fees are combined, a visit to a health center for a simple complaint can easily produce a total cost well beyond the means of

many households. Utilization rates of some health facilities are down and effective access to public health services is incomplete.

Maternal and Child Health: The maternal mortality rate (MMR) in Zimbabwe is high and has risen, going from 555 in the 2005/06 Zimbabwe Demographic and Health Survey (ZDHS) to 725 according to a 2007 MOHCW survey. The upward trend in maternal mortality is alarming having more than doubled since 1994. Two to three thousand women die each year in or around childbirth with HIV, postpartum hemorrhage, infection and eclampsia being the commonest causes of mortality. A significant contributing factor to maternal mortality is the number and timing of pregnancies. Although modern contraceptive use is fairly high, the contraceptive prevalence rate (CPR) has remained basically unchanged between 2005 and 2010 (60% vs. 59%). This static period for CPR stands in contrast to the steady increase in the CPR from 38% in 1984 to 60% 2005. While CPR among rural women is similar to what it was five years ago, CPR has fallen from 70% in 2005 to 62% in 2010 among urban women. Unmet need for family planning has remained at about 13% for several years.

Under-5 mortality in children has also increased, rising by nearly 30% since 1988. Infant mortality rose by 26% over the same period. Around 30,000 to 33,000 under-5 year old children die each year, primarily from acute respiratory infection, diarrheal disease and HIV/AIDS, although this also includes 8,000 to 10,000 neonatal deaths. Basic vaccination coverage has increased by 11% since the 2005-06 ZDHS estimate of 53% but still remains well below desired levels. Overall, 12% of children in Zimbabwe have not received any vaccinations. Full vaccination coverage ranges widely regionally, with the least being 46% in Manicaland (which has a large Apostolic population, many of whom refuse vaccination on religious grounds) and low coverage in some areas has contributed to periodic measles outbreaks (as seen in 2009).

The incidence of low birth weight, a proxy indicator of maternal under-nutrition, has also consistently increased over the years with an estimated 10% of newborns having a low birth weight according to the last Demographic and Health Survey (DHS) 2005/6. Low birth weight can be attributed to the poor nutrition status of the mother before and during pregnancy. Under-nutrition can also manifest as anemia resulting from chronic infection and malaria. HIV- and AIDS- related opportunistic infections have recently become the most common causes of recurrent infections in the mother. It is also worrying to note that iron supplementation to pregnant women, a critical component of comprehensive maternal and child health care has decreased from 42.9% to 27.8% from 1999 to 2006.

According to the 2010/11 DHS, levels of malnutrition (wasting) in children are relatively low (3%). Small differences are observed by sex and urban-rural residence, with 4% of boys being wasted compared with 2% of girls and 3% of children in rural areas versus 2% in urban areas. A higher percentage of children were found to be wasted in Matebeleland North (6%) than any other region. Wasting is highest among children of mothers with only a primary-level education (4%) and lowest among children of mothers with more than secondary education (1%). While levels of acute malnutrition have remained relatively stable at 2.1%, the Zimbabwe National Nutrition Survey in 2010 found that one in every three Zimbabwean children suffers from chronic malnutrition (stunting). Globally, maternal and child under-nutrition contributes to 35%

of all child deaths and 11% of the global disease burden. Applying these estimates to Zimbabwe, under-nutrition is likely to contribute to more than 12,000 child deaths each year.

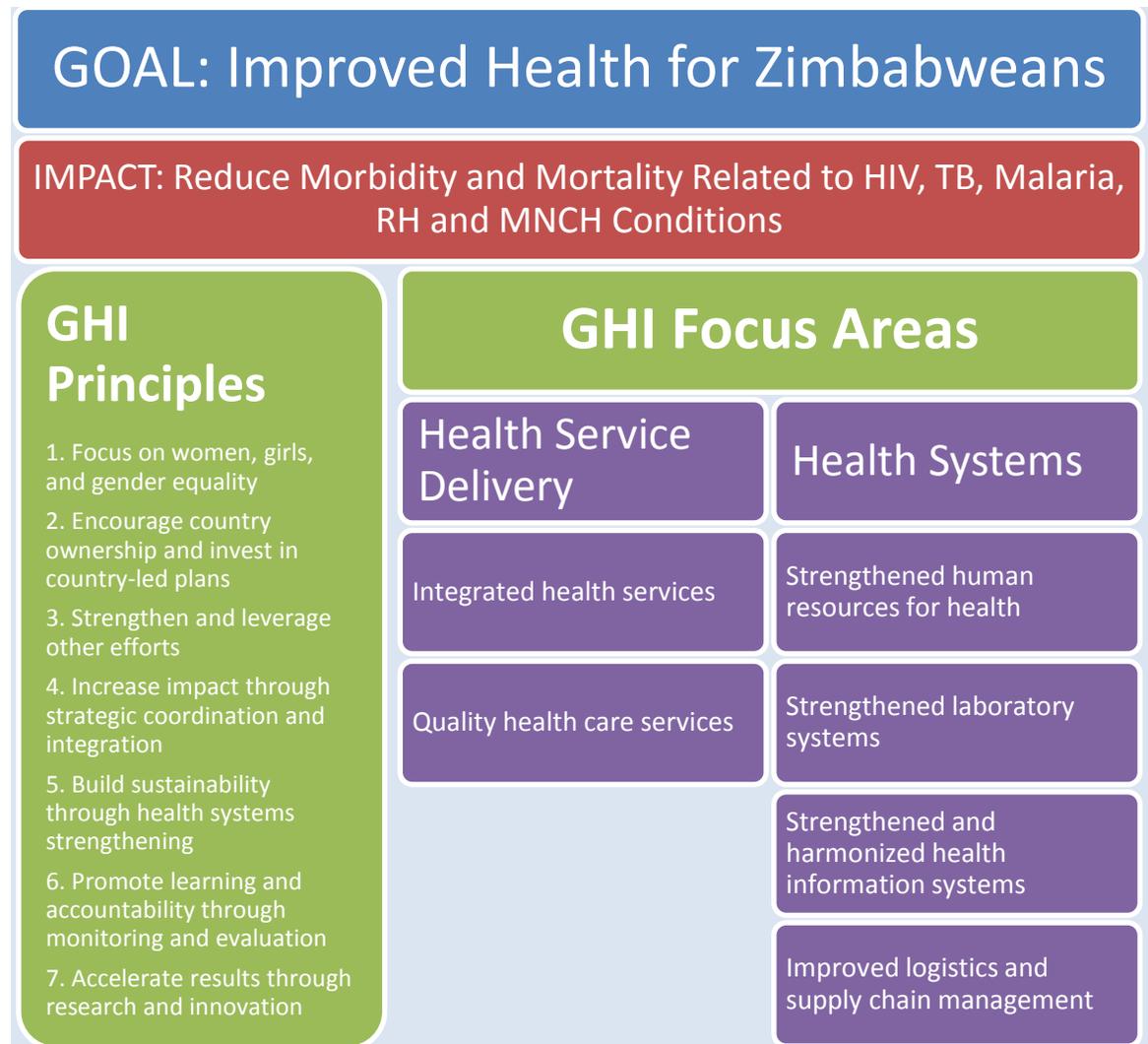
Health Risks and Infectious Disease: The top three major public health threats to life in Zimbabwe today are AIDS (approximately 60,000 adult and about 12,000 child deaths per annum) and TB (with 32-35,000 deaths each year) and malaria (around 600,000 suspected cases in 2010, although malaria deaths are low). Recent surveillance data (2010) estimates adult HIV prevalence at 13.3% compared to 20.5% in 2005 and 25.3% in 1997. An estimated 1,102,864 adults and children are living with HIV. While Zimbabwe remains a high-burden country, it has been recognized for recording a notable decline in prevalence that has been attributed to both high mortality and a decline in HIV incidence, resulting from adoption of safer sexual behaviors. Behavioral surveillance suggests that Zimbabweans are changing their behaviors, including increasing condom use and reducing the number of sexual partners. The annual number of AIDS deaths in Zimbabwe has declined as the number of persons on anti-retroviral therapy (ART) has increased. By October 2011, a total of 470,000 people (approximately 441,000 adults and 29,000 children) were receiving ART through the national health system. This figure represents an ART coverage rate of 65% (at CD4 <350).

Zimbabwe is ranked 17th on the list of 22 high-burden TB countries in the world. According to the World Health Organization's (WHO's) Global Tuberculosis Control Report 2009, Zimbabwe had an estimated 71,961 new TB cases in 2007, with an estimated incidence rate of 539 cases per 100,000 population. The number of new reported TB cases in Zimbabwe declined 2.6% between 2006 and 2007. However, the DOTS (the internationally recommended strategy for TB control) case detection rate declined from 46% in 2002 to 27% in 2007. The treatment success rate also declined from 71% in 2001 to 60% in 2006. Zimbabwe has the second highest TB mortality rate in the world. The TB-HIV/AIDS co-infection rate is high. According to data from WHO, nearly 69% of new adult TB patients are HIV positive. National data suggest the actual estimate is slightly higher, around 80%; accordingly, there is increasing HIV surveillance in TB patients.

Around 4 million people in Zimbabwe are at risk each year of contracting malaria. The most vulnerable groups to this preventable disease are children below the age of 5 years, pregnant women, the elderly and people living with HIV and AIDS. The magnitude of malaria transmission in Zimbabwe varies from year to year but the areas of highest transmission tend to be along the country's northern and eastern borders. While Zimbabwe has 10 provinces and 62 districts, malaria transmission is considered likely to take place in 45 or 73% of districts. About 50% of the country's population resides in the, mainly rural, malaria-endemic areas.

Inadequate provision of safe water and sanitation has contributed to the spread of water-borne diseases. Cholera epidemics or outbreaks have been occurring every year in Zimbabwe since 1998. In the last half of 2008 and early 2009, there was a massive increase in cholera cases and deaths. By the end of 2009 and during 2010, cholera cases had returned to pre-2008 levels. The regularity of the appearance of cholera over the past 12 years suggests that the disease is now endemic in Zimbabwe.

Zimbabwe GHI Strategy – Appendix B: Results Framework



APPENDIX C: Zimbabwe GHI Matrix

Key technical area	Relevant Key National priorities/initiatives from National Health Strategy Zimbabwe 2009-2013	Key Priority Actions/activities likely to have largest impact	Baseline Info/country specific GHI targets	Key GHI principles	Current Key Partners
OVERALL GOAL: Improved health for Zimbabweans					
STRATEGIC FOCUS AREA 1: Health Service Delivery: Improve the integration of five health services (HIV/AIDS, TB, malaria, MNCH and FP/RH) at provincial- and district-level health facilities and the quality of health services at all levels.					
Integrated Health Services:	To have halted, by 2015, and begun to reverse the spread of HIV MDGs 6	Strengthen voluntary FP counseling services and expand clinical FP service availability in PMTCT sites.	# of ANC sites offering or referring for FP. # of FP counseling visits	Focus on women, girls, and gender equality	MCHIP, MOHCW, PSZ, PSI, SCMS, ZACH, JSI, TBCARE,
	To reduce the maternal mortality ratio from 725 to 300 by 2015 MDG 5	Strengthen mobile outreach teams to improve access to an integrated package of health services (HIV/AIDS, TB, STI, FP)	% of HIV tested clients receiving TB screening and diagnosis % of HIV tested clients receiving FP counseling	Encourage country ownership and invest in country-led plans	
	Reduce the mortality, morbidity and transmission of TB in line with the MDG 6 and the Stop TB Partnership	Strengthen service delivery for intermittent preventive treatment for pregnant women (IPTp), as part of improving antenatal care services.	% of ANC bookings receiving IPTp	Increase impact through strategic coordination and integration	
	To have halted, by 2015, and begun to reverse the increasing incidence of malaria	Expand access to integrated TB/HIV services and improve the management of TB/HIV co-infection	% of TB patients tested for HIV and initiated on ART % of HIV patients tested for TB and initiated on TB treatment		
		Increase access to and improve the quality of PMTCT services in the public health care system, by introducing ART services into PMTCT platforms.	% of eligible HIV infected pregnant women initiated on ART in MCH		

Quality Health Care Services:	Improve the quality of care To improve governance and management of the health sector	Up-dating clinical practice protocols for compliance with the latest WHO guidance within an integrated service delivery context.	# of clinical protocols updated		
		Support the introduction and expansion of quality assurance measures or tools such as the Standards-Based Management and Recognition methodology for integrated services.	% of health facilities meeting the minimum SBMR standard.		
		Training health care providers and managers in quality assurance techniques for integrated care.	# of health care workers trained in QA techniques		
FOCUS AREA 2: Health Systems – to sustain delivery of integrated, quality health care services at the sub-national level.					
Improved Logistics and supply chain management	To improve overall availability of to 90% drugs, medical supplies and other consumables MDG 4,5,6	Assess each component of the existing national logistics system to identify strengths, weaknesses and opportunities to realize improvements.	SWOT Analysis conducted	Increase impact through strategic coordination and integration Build Sustainability through health system strengthening Encourage country ownership and invest in country led plans	SCMS, DELIVER, JSI, PSI MOHC W
		Work with the national TB program to conceptualize and help launch a quarterly pull system for TB drugs in conjunction with the provision of commodities for other care.	Integrated quarterly pull system for TB drugs launched.		
		Introduce procurement and distribution mechanisms that integrate different health program approaches obtaining	% of essential drugs managed (procured, distributed, accounted for) through a single national logistics management agency.		

		needed drugs and health commodities.			
		Provide technical assistance to develop new management structures for integrated day-to-day operations of the logistics system.	New management structure for integrated logistics system		
			# and duration of stock-outs of essential drugs and health commodities for integrated service-delivery.		
Strengthened Laboratory systems:	To ensure the delivery of an effective, efficient, accessible, equitable, and affordable national quality assured network of tiered laboratory services	Improve laboratory diagnostic capacities.	% of labs meeting WHO standards criteria.	Encourage country ownership and invest in country led plans. Build Sustainability through health system strengthening.	ZINQAP MOHC W
		Improve sample transport systems and turnaround time for communication of results from integrated care facilities.	Turnaround time for communication of lab results		
		Develop and implement a national quality assurance system.	% of labs successful in EQA.		
		Strengthen monitoring and evaluation systems for lab functions.			
Strengthened Human Resources for Health (HRH)	To improve governance and management of the health sector	Up-dating training modules for strengthening in-service training programs related to integrated service-delivery for a variety of health care providers.	# of health care training curricula for integrated services updated or developed.	Encourage country ownership and invest in country led plans. Build Sustainability through health system strengthening.	DCM; JSI; PSI; MOHC W TBCARE; MCHIP; TBD
		Support for in-service training of health workers in selected health care service delivery areas.	# of in-service health care workers trained (disaggregated by sex) in integrated services.		
		Support of pre-service training of health workers for selected health degree areas or cadres.	# of pre-service trainees graduated (disaggregated by sex) with substantial USG support.		
Strengthened and	To improve governance and	Provide mentoring and capacity-building to	# of personnel at targeted regional, district, and	Encourage country	RTI, MOHC

Harmonized Health Information Systems	management of the health sector	MOHCW to improve health data use, analysis, and dissemination for and from integrated service-delivery sites.	national health facilities trained in health data analysis for integrated service-delivery.	ownership Build Sustainability through health system strengthening	W MACRO, JSI, PSI, TBCARE, MCHIP, PSZ, TBD MOHC W
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Zimbabwe GHI Strategy – Appendix D: Incorporating the Principles on Women, Girls and Gender Equality (WGGE)

Background

During the development of the Global Health Initiative, the Zimbabwe USG team has been mindful of the opportunity that the GHI presents to strengthen the health program to respond more directly to the needs of women, girls and address gender equality. The health program already addresses and responds to many of the inequities in gender that exist in the country, and works closely with the MOHCW, other donors, UN agencies and stakeholders in this regard. However areas of existing programs would be strengthened by a greater focus on women, girls and gender equality to improve the impact of the interventions that the USG supports. Therefore using a more focused gender lens, the USG team has highlighted program areas that will embrace the principles on WGGE and will be mainstreamed into activities as the GHI strategy is operationalized.

1. Ensure equitable access to essential health services at facility and community levels – Key objective within the health program.

Program areas to be implemented under GHI:

- Major efforts to strengthen the integration of services will be undertaken, such as offering ART in MCH services, expanding the integration of STI, FP, HIV services at the New Start and New Life HIV/AIDS testing and counseling centers etc. These initiatives will bring a range of health services closer to women and children; enhance retention to care; and will reduce the number of women/children who are ‘lost in the system,’ e.g. This is a high priority given that approximately 30% of women referred to ART sites from ANCs do not go in for treatment. The GHI will support outreach activities particularly in FP, EPI, and HIV testing and counseling addressing the health needs of remote populations. Women in rural areas are less likely to have access to key health services, which is associated with poorer health outcomes for women and children in a variety of health indicators.
- USG will engage with other donors to support the abolishment of MCH user fees, through participating in the new multi-donor Health Transition Fund. This effort is addressing one of the major barriers to care for women and girls. The USG health program will support training of health workers utilizing a new quality of care approach in 2 Districts. This approach will focus on providing minimum standards of care for MNCH services, which includes addressing health provider attitudes, knowledge and practices. This process will help to improve the quality of care, therefore providing greater reassurance to women and girls that they will receive the appropriate level of care that they seek.
- The New Start and New Life HIV testing and counseling network program as well as USG-supported PMTCT efforts will work to strengthen People Living with HIV/AIDS (PLHIV) support groups, which provide support to pregnant women and their families to help them cope with living with HIV and address their health priorities. Currently there is a very well established PMTCT peer support program in Harare and based on this, a rural model will be designed and scaled up.

- The health program will revitalize the village health worker (VHW) system to strengthen linkages between the community and public health facilities. This is an important component of the PMTCT program to follow-up HIV-exposed infants and strengthens the continuum of care for MNCH activities, especially pregnant women and newborns. VHW will not only start providing more direct maternal, newborn and child health services to women, girls and families but will also mobilize communities to seek preventive and curative services at public health facilities. Not only will this bring services closer to home but the program will ensure greater community participation in health.
- Support the delivery of a wide range of FP commodities, long-lasting insecticide treated bed nets, and both male/female condoms for improving access to family planning as well as HIV prevention methods, in addition to addressing malaria in pregnancy.

2. Increase the meaningful participation of women and girls in the planning, design, implementation, monitoring and evaluation of health programs.

Program areas to be implemented under GHI:

- Routinely collect information from both male and female clients visiting New Start and New Life services on client experiences, health knowledge, attitudes, and behavior as well as socioeconomic information to tailor program approaches to address inequities in health and respond more effectively to the needs of clients.
- Carry out intermittent baseline surveys such as the FP baseline in June 2011 looking at men and women's knowledge, attitudes and FP practices in order to adapt program approaches to be more responsive to the particular needs of men, women and adolescents.
- Work in collaboration with MOHCW and other stakeholders on a large national health facility assessment with a focus on equality and MNCH service delivery. A component of this will include asking care-givers about the quality of services they have received and their perspectives of what can be improved. Results from this national survey will help to identify and prioritize high impact initiatives that will be required to respond to the needs of women and girls.

3. Gender-based violence is a significant issue in Zimbabwe, and is associated with unequal gender roles which affect women disproportionately.

Program areas to be implemented under GHI:

- Design a joint sexual-reproductive-health/HIV program with DFID, SIDA and UNFPA to focus on coordinating a joint GBV strategy, to strengthen the impact of donor-supported interventions addressing GBV.
- The USG health team will participate in updating the National Reproductive Health policy which presents a clear opportunity to reinforce the importance of addressing GBV. This important national process will provide a platform to address GBV, and will support greater coordination of efforts to in address the needs of women and girls.
- USG has been capitalizing on its existing network of partners to integrate GBV community mobilization response activities and behavior change programs. Examples include: provision of post-exposure prophylaxis (PEP) and emergency contraception (EC) through the New Life and New Start centers as well as follow-on psycho-social support provided to women, girls and men.

4. Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets.

Program areas to be implemented under GHI:

- Building on its current investments, there is an opportunity for the USG health team to strengthen initiatives to provide appropriate services to address the needs of adolescent in the new design of USAID's follow-on orphan and vulnerable children (OVC) program. Currently achievements have already been made in addressing the needs of both in-school and out-of-school adolescents (Children First Mid-Program review 2011). The USG health program will continue to work closely with the National Reproductive Unit within the MOHCW, the Zimbabwe National Family Planning Council and SAFAIDS to support a sexual and reproductive health program for adolescents. The focus will be on scaling up successful approaches that address the needs of adolescents, such as a current model that uses schools as an entry point to discuss issues related to SRH using different toolkits such as the Aunty Stella kit and Kids for Real (these toolkits provide different age-appropriate messages relating to SRH issues, which peer educators use to lead discussions).
- Other initiatives to be expanded will include the establishment of more 'Youth Friendly corners' and encouragement will be given to use sport as a successful social mobilization tool to attract more youths to the centers and creatively integrate SRH education into the games.
- Life skills interventions will be supported through OVC programming to strengthen community systems and social networks to provide young people with constant guidance to make safe, healthy and confident decisions throughout this phase of their lives. Already over 15,000 youths have been enrolled in this program. The USG OVC program will however continue to work closely with not only well established grass root organizations, but also religious and community leaders to implement life skill initiatives that are developed for and by the community.
- The planned follow-on OVC program will pay special attention to children who are not part of the formal education school system. This group is mostly composed of girls, who are highly vulnerable and often hard to reach, and therefore often excluded from assistance and accessing basic services. Based on assessments that have been carried out on the out-of-school program, our call for proposals will highlight the need to target out-of-school youth as a critical area to address in the new program design.
- Using lessons learned from the mid-program review of the current OVC program, a focus of the new OVC program will be to promote the linkages between health, education and livelihoods programs and the opportunity exists to strengthen USG current support in this area.
- Finally the follow on OVC program may work to strengthen child protection services in Zimbabwe by building the capacity of government structures within the Department of Social Services (DSS). A pilot project in this area has already been started and findings from this will inform the future direction of the program. USG investment in this area will complement other efforts being led by the DSS and implemented through UNICEF as part of a multi-donor effort.

5. Engage men and boys as clients, supportive partners, and role models for gender equality.

Program areas to be implemented under GHI:

- Efforts will be made to raise awareness within communities on the importance of male involvement particularly within the PMTCT, HIV, FP and MNCH programs. As a component of this, tracking of couples testing in ANC will be monitored. Achievements particularly within the PMTCT program have already been made with an increase in the number of men accompanying their partners to be tested within an ANC setting. However greater efforts in this area continue to need to be made.
- Campaigns around male circumcision will be implemented particularly focusing on boys and male adolescents. Currently, the MC program is strongly integrated within HIV prevention and SRH activities and provides an opportunity to address greater involvement of men/boys in health related programs.
- Community mobilization campaigns will engage with both traditional and religious leaders to raise the importance of male involvement utilizing innovative and context-appropriate methodologies such as community meetings, training or sensitization activities, theater and other cultural activities; and mass-media campaigns using radio, television, billboards.

6. Promote policies and laws that will improve gender equality, and health status, and/or increase access to health and social services.

Program areas to be implemented under GHI:

- The USG health program in Zimbabwe has aligned its activities to support the MOHCW national strategic plan, which is heavily focused on equality with core priority areas addressing the needs of women and girls. USG agencies will actively participate in policy development at a national level through the revision of the RH policy, and the nutrition policy which will explicitly promote women and girls' health.
- Work closely with the MOHCW on the development of national strategies and implementation plans particularly focused on improving access to services for women and girls. Particular focus will be on operationalizing the child survival, PMTCT and nutrition strategies, all of which are due to be revised in 2012.
- Zimbabwe already has many laws in place to protect women including the Marriage Act; Sexual Offences Act 2003; Domestic Violence Act 2006; National Gender Policy 2004; Policy on HIV testing 1999; and Male Circumcision Policy 2010. The USG health teams will ensure that implementing partners are disseminating information to increase knowledge and appropriate action regarding these important laws.

7. Address social, economic, legal and cultural determinants of health through a multisectoral approach.

Program implementation areas under GHI:

- Work towards operationalizing the national Food and Nutrition policy which explicitly calls for a multi-sectoral response to link efforts between economic growth, livelihoods, nutrition and health. As a start, the USG health team will work with the national nutrition

unit to develop a national nutrition strategy and implementation plan that will highlight these linkages and help to prioritize interventions that will support women and children.

- USG health programs will review national surveys e.g. DHS 2010/2011 to ensure all that all programs incorporate special measures to reach women and girls in the lowest economic quintiles either through strengthening the community health delivery system or by providing outreach services.

8. Utilize multiple community-based programmatic approaches, such as behavior change communication (BCC), community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls.

Program implementation areas under GHI:

- USG partners, particularly EGPAF and PSI who are both involved with HIV prevention have been engaging with community leaders including religious/traditional leaders, to increase knowledge about the health consequences of specific behaviors, to encourage them to serve as advocates for change in the community as well as strengthen linkages to health services, such as male circumcision and voluntary family planning. These BCC components of the programs will continue to be supported under the GHI strategy.
- In addition, the USG will strengthen its coordination with other donor initiatives to harmonize BCC approaches and strengthen their collective impact and an opportunity to do this exists in the development of a joint Sexual Reproductive Health and HIV program with DFID, SIDA and UNFPA.

9. Build the capacity of individuals, with a deliberate emphasis on women, as health care providers, caregivers, and decision-makers throughout the health systems, from the community to national level.

Program implementation areas under GHI:

- Significant elements of the health program will focus on improving both pre-service and in-service training to recruit and retain women health care workers who make up the majority of the health work force.
- Training activities include support for University of Zimbabwe MPH program and leadership management training for all district health teams.

10. Strengthen the capacity of institutions -- which set policies, guidelines, norms and standards that impact access to, and quality of, health-related outreach and services -- to improve health outcomes for women and girls and promote gender equality.

Program implementation areas under GHI

- The USG health program will be supporting the MOHCW to strengthen the overall Health Management and Information system including developing tools/registers to enable collection of gender disaggregated data. USG support will both help ensure availability of data at all levels and strengthen capacity of health workers to use data effectively.
- Along with other donors, support will be provided to revise the national Reproductive Health policy and develop a Reproductive Health strategy. These developments will

provide an opportunity to ensure that national programs focus initiatives to address gender inequities and improve health outcomes for women and girls.

Zimbabwe GHI Strategy – Appendix E: Acronyms List

AIDS	- Acquired immune deficiency syndrome
ANC	- Antenatal care
ART	- Anti-retroviral therapy
ARV	- Anti-retroviral
BCC	- Behavior change communication
CD4	- Cluster of differentiation 4
DCM	- Department of Community Medicine, University of Zimbabwe
DfID	- Department for International Development (United Kingdom)
DHS	- Demographic and Health Survey
DPS	- Directorate of Pharmacy Services
DSS	- Department of Social Services
EC	- Emergency contraception
EGPAF	- Elizabeth Glazer Pediatric AIDS Foundation
EID	- Early infant diagnosis
EmONC	- Emergency obstetrical and neonatal care
EPI	- Expanded Program of Immunization
EQA	- External quality assurance
FP	- Family planning
GBV	- Gender based violence
GHI	- Global Health Initiative
GOZ	- Government of Zimbabwe
HBC	- Home-based care
HIV	- Human immunodeficiency virus
HRIS	- Human resources information system
IPTp2	- Intermittent preventive treatment during pregnancy
MC	- Male circumcision
MCHIP	- Maternal Child Health Integration Project
MDG	- Millennium Development Goal
M&E	- Monitoring and evaluation
MER	- More efficacious regimens
MNCH	- Maternal, neonatal and child health
MOHCW	- Ministry of Health and Child Welfare
NAC	- National AIDS Council
NatPharm	- National Pharmaceutical Company
NGO	- Non-governmental organization
NHIS	- National health information and surveillance system
NTD	- Neglected tropical diseases
OVC	- Orphans and vulnerable children
PEP	- Post-exposure prophylaxis
PLHIV	- Persons living with HIV
PMI	- President's Malaria Initiative
PMTCT	- Prevention of mother to child HIV transmission
PSZ	- Population Services Zimbabwe
PSI	- Population Services International

RH	- Reproductive health
RHC	- Rural health center
SAFAIDS	- Southern Africa HIV and AIDS Information Dissemination Service
SBMR	- Standards based management and recognition
SIDA	- Swedish International Development Agency
SRH	- Sexual and reproductive health
STI	- Sexually transmitted infections
TBCare	- Tuberculosis Care Project
TBD	- To be determined
UN	- United Nations
UNDP	- United Nations Development Program
UNFPA	- United Nations Population Fund
UNICEF	- United Nations Children's Fund
USG	- United States Government
VCT	- Voluntary counseling and testing (HIV)
VHW	- Village health worker
VMMC	- Voluntary medical male circumcision
WB	- World Bank
WGGE	- Women, girls and gender equality
WHO	- World Health Organization
ZACH	- Zimbabwe Association of Church Hospitals
ZNASP	- Zimbabwe National AIDS Strategic Plan
ZINQAP	- Zimbabwe National Quality Assurance Program