MINISTRY OF HEALTH AND CHILD CARE

ANNUAL REPORT 2016

The Honourable Minister of Health and Child Care

Dr D.P. Parirenyatwa (Senator)

Sir,

I have the honour to present the annual report for the Ministry of Health and Child Care for the year ending 31st December 2016.

Accordingly, I commend this report to you, Sir, for your attention

Brigadier General (Dr) G Gwinji

SECRETARY FOR HEALTH AND CHILD CARE

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Executive Summary

The vision of the Zimbabwe Ministry of Health and Child Care is to have the highest possible level of health quality of life for all its citizens. The main objective is to safeguard the health of all Zimbabweans

through increasing coverage, access to, and utilization of basic preventive, curative and rehabilitative services and care for the poor and vulnerable groups with emphasis of scaling up implementation of comprehensive Primary Health Care services and its corresponding referral facilities.

- The 2016-2020 National Health Strategy aims at addressing the gaps identified during the life of the 2009 to 2015 NHS, and more importantly, sustain the gains achieved thus far (2009-2015), through a comprehensive response to the burden of disease and strengthening of the health system to deliver quality health services to all Zimbabweans.
- Since 2010, Zimbabwe has made significant strides in reducing infant mortality rates (IMR) and Maternal Mortality Rates (MMR), but did not manage to meet the Millennium Development Goals (MDGs). MMR declined from 960 per 100,000 live births in 2010-2011 to 651 per 100,000 live births in 2015. Similarly, the under-five mortality rate dropped from 84 deaths per 1,000 live births in 2010/11 to 69 deaths per 1,000 live births in 2015. The infant mortality rate decreased from 57 deaths per 1,000 live births in 2010/11 to 50 deaths per 1,000 live births in 2015(Zimstat 2016).
- In an effort to build a more sustainable health financing system to move the country towards Universal Health Coverage (UHC), the Ministry of Health and Child Care embarked on the development of a comprehensive health financing policy in 2016.
- Government fiscal space is likely to shrink thereby increasing the need for external funding to support the health infrastructure, retain health workers, medicines and commodities supply and distribution, amongst others. Improving the quality of health services and ensuring that these services are accessed equitably, will be top of the agenda for the ministry.
- A systematic review of existing reports, data and evidence regarding the performance of the health sector in 2016, shows that Zimbabweans still face a double burden of communicable and non-communicable diseases. The prevalence of HIV among adults, ages 15 to 64 years in Zimbabwe is 14, 6%: This corresponds to approximately 1.2 million people living with HIV (PLHIV) ages 15 to 64 years. Prevalence of viral load suppression among HIV-positive adults, ages 15 to 64 years is 60, 4%: (ZIMPHIA 2015-2016). The ratio of the prevalence rate to the notification rate (P/N ratio) of the smear-positive TB was 0.45, very low compared with other countries (2-3).
- Non-communicable diseases are emerging as a major cause of morbidity and mortality in the country. The nutrition status of children remains poor. Outbreaks of diarrheal diseases are becoming more frequent. These challenges are compounded by health systems constraints related to dis-functioning system of determinants of health, shortages of critical health workforce, aging infrastructure and equipment, supply of medicines and other commodities and limited health funding. The total health expenditure (THE) in Zimbabwe in 2015 was estimated at US$1.49 billion. This accounted for 10.32 % of gross domestic product (GDP). Per capita total health expenditure was estimated at $103, 83. The government health expenditure as a percentage of total government expenditure was 8.72%.Table 1 below shows top ten causes of death amongst Zimbabweans.

Table 1: Top 10 causes of death amongst Zimbabweans as at 31stDecember of 2016.~~: Top 10 causes of~~

Rank	Disease/Condition
1	ARI
2	Slow foetal growth, foetal malnutrition, disorders related to short gestation and low birth weight
3	Human immunodeficiency virus (HIV) disease all complications, AIDS and ARC
4	All meningitis, encephalitis, myelitis & other inflammatory diseases, excluding meningococcal meningitis & HIV disease related
5	Diarrhoea and gastroenteritis due to other infectious diseases (bacterial, viral, protozoal)
6	Heart failure congestive and left ventricular
7	Respiratory infections
8	Congenital infections and parasitic diseases, excluding HIV
9	Anaemia
10	Other endocrine, vitamin, nutrients and nutritional deficiencies, obesity and metabolic disorders

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Executive Summary

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10	Other endocrine, vitamin, nutrients and nutritional deficiencies, obesity and metabolic disorders

Source: MOHCC Health Management Information System 2016

Key program achievements during 2013 to 2016 include:

- Since 2010, Zimbabwe made significant strides in reducing infant mortality rates (IMR) and Maternal Mortality Rates (MMR). IMR decreased from 57 deaths per 1,000 live births in 2010/11 to 50 deaths per 1,000 live births in 2015, and MMR declined from 960 per 100,000 live births in 2010-2011 to 651 per 100,000 live births in 2015
- Seventy-eight percent of women report that their last live birth in the last 5 years was delivered by a skilled provider or health professional, an increase from 66% in the 2010-11 ZDHS. Seventy-two percent of births were delivered in a health facility, an increase from 65% in the 2010-11 ZDHS
- HIV prevalence is still higher among women at 16.7% as compared to men (10.5%). HIV prevalence among young people aged 15-24 is also higher among young women. HIV prevalence is 6.7% among young women and 2.9% among young men age 15-24.The country's HIV transmission rate at the end of eMTCT risk period declined from 12.11% in 2014 to 6.39% in 2016.
- The ANC and HIV testing coverage for 2016 was above 95%, meeting the eMTCT validation process coverage target rates.
- Eight four percent of women and 88% of men know that HIV can be prevented by using condoms during sexual intercourse and 92% of women and 94% of men say that limiting sexual intercourse to one uninfected partner can reduce the chances of getting HIV (ZDHS 2015)
- Coverage of prior HIV testing has increased since the 2010-11 ZDHS. Among women, the percentage who were tested for HIV in the past 12 months and received the results has increased from 34%in 2010-11 to 49% in 2016
- Owing to a combination of robust HIV prevention programmes that included social marketing, massive community mobilisation and awareness campaigns combined with HIV-counselling and testing, condom promotion and distribution, prevention of mother to child transmission and others, Zimbabwe has become a global example in HIV prevention.

Challenges and Constraints:

- Limited funding (reduced donor resources, weak National economy).
- Sub-optimal quality of care resulting from inadequate human resource capacity (numbers, knowledge and skills) and poor health worker attitude (non-accountability for results, work overload, low remuneration).
- Weak referral services (poor ambulance services, user fees at referral centers).
- Lack of resources at lower levels

Lessons Learnt and Opportunities:

- Mapping out key interventions using the life-cycle approach provides better opportunities for integration and complementarity.
- Building individual and institutional capacities within MOHCC will ensure value for money and better sustainability.
- Preventive measures should be complementary to the treatment of disabilities resulting from complications of medical conditions (e.g. strengthening EmONC to prevent obstetric fistulae, early and appropriate treatment of childhood illnesses to prevent childhood disabilities, etc.).

Introduction

This report presents the activities implemented, results achieved, and challenges encountered by the Ministry of Health and Child Care in implementing various programmes, in collaboration with its implementing and development partners, for the period January to 31st December 2016. Table 2 below shows the profile of health facilities in Zimbabwe.

Table 2: Health facilities profile for Zimbabwe as at 31 December 2016

Facility level/ Managing Authority	All Facilities	Hospitals	Primary Health Facilities
Central Hospitals	6	6	
Provincial hospitals	8	8	
District Hospitals	44	44	0
Mission Hospitals	62	62	0
Rural Hospitals	62	62	0
Private Hospitals	32	32	0
Clinics	1,122	0	1,122
Polyclinics	15	0	15
Private clinics	69	0	69
Mission clinics	25	0	25
Council/Municipal Clinics/FHS	96	0	96
Rural Health Centre	307	0	307
Totals	**1,848**	**214**	**1,634**

Source: MOHCC Health Management Information System 2016

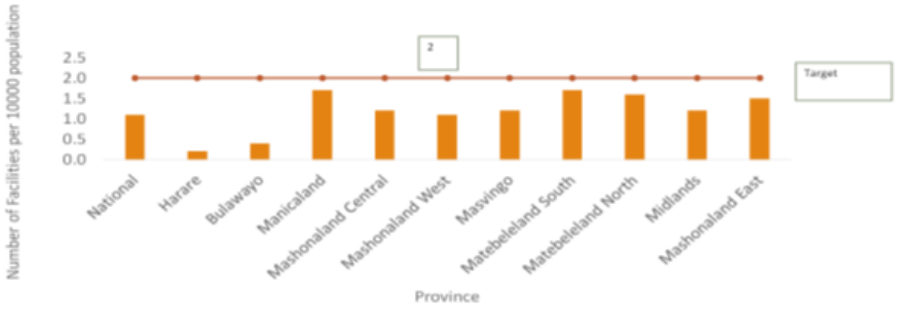

Figure 11: Health Facility Density per 10,000 Population

Source: ZSARA 2016

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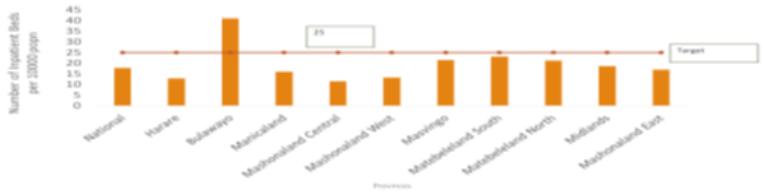

Figure 2: Inpatient bed density per 10,000 population
Source: ZSARA, 2015

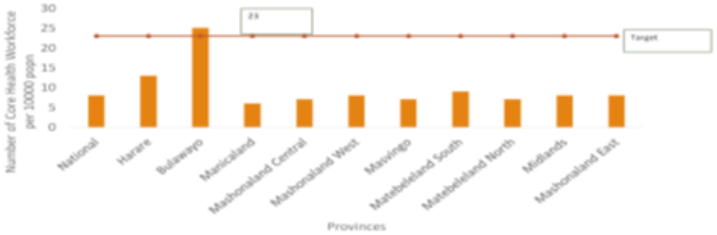

Figure 3: Core-health workforce density per 10,000 population ZSARA, 2015
Source: ZSARA, 2015

Programme Based Budgeting

The Ministry of Health and Child Care started implementing the Programme Based Budgeting in 2015 and was able to fully plan according to the PBB in 2016. The Programmes and Sub-programmes are:

Programme 1: Policy and Administration

Sub-programmes:

1. Minister and Permanent Secretary
2. Policy, Planning and Coordination
3. Human Resources
4. Finance and Administration
5. Monitoring and Evaluation
6. Q/I and Q/A
7. Provincial Administration

Programme 2: Public Health

Sub-programme:

1. Communicable Diseases
2. Non-Communicable Diseases
3. Environmental Health
4. Family Health
5. Research and Development

Programme 3: Primary Health Care and Hospital Care

Sub-Programme:

1. Rural Health Care and Community Care
2. District/General Hospitals
3. Provincial Hospitals
4. Central Hospitals

The Ministry successfully planned the 2017 budget according to the PBB format in November 2016.

CHAPTER 1

1. Policy and Administration

1.1 Policy and Coordination

1.1.1 Policy and Planning

Table 3: Activities carried out to create an enabling environment through improved planning and monitoring of health service delivery

2016 Output	2016 Target	Achievement by 31 December 2016
National Health Strategy 2016-20	Launched NHS 2016-2020	Printing in progress
National Health Financing Policy	Launched NHFP	Printing in progress
Medical Aid Regulatory Authority	Medical Aid Regulatory Authority Established	Layman's draft in place
Reviewed Health Services Act	Health Services Act Reviewed and aligned to the constitution	Consultations with stakeholders in progress: Northern Region done and Southern Region to be done before end of 2nd quarter in 2017
Resource Mapping round 2 completed	Results for resource mapping disseminated	Results available and to be disseminated in January 2017

Source: MOHCC Health Management Information System 2016

1.1.2 Quality Improvements

Quality Assurance and Quality Improvement Policy and Strategy was finalised and made available in all health facilities throughout the country by 31st of December 2016.

Table 4: Provincial Health Executives equipped with skills and knowledge on how to administer Quality checklists using electronic quality application tablets

	NAT	MAN	MC	ME	MW	MASV	Mat N	Mat S	MID	BYO	CH	HRE
Achieved	28	3	3	4	3	3	3	3	4	1	0	1
Target(Jan-Nov)	70	8	9	10	8	8	8	8	9	1	0	1
Variance (%)	60%	63%	67%	60%	63%	63%	63%	63%	56%	0	0	0

Source: MOHCC Health Management Information System 2016

~~*Source: MOHCC Meeting of Donors 2016*~~

Table 5: Districts implementing full cycle of Quality improvement using MNCH indicators

	MAT	MAN	MC	ME	MW	MASV
Achieved	5	1	1			1
Target	5	1	1			1
Variance%	0%	0%	0%			0%

Source: MOHCC Health Management Information System 2016

~~*Source: MOHCC Meeting of Donors 2016*~~

1.2 Human Resources for Health

Table 6: Posts in the public Health Sector as at 31st December 2016.

Ownership	Authorised Establishment	In-Post	Vacant	% In Post	% Vacant
MOHCC	37,603	29,891	7,712	79%	21%
Missions	4,561	4,156	405	91%	9%
Rural District Council	3,196	2,665	531	83%	17%
Urban Municipalities (Bulawayo & Harare)	2,038	1,434	604	70%	30%
Total	**47,398**	**38,146**	**9,252**	**80%**	**20%**

Source: MOHCC Health Management Information System 2016

Table 7: Summary of establishment strength (Selected professionals) as at 31st December, 2016

Category & Designation	Authorised Establishment	In-post	Vacant	% In-post	% Vacant
Top Management	83	44	39	53%	47%
Doctors	1,668	1,173	515	69%	31%
Nurses	12,983	12,057	926	93%	7%
Pharmacists	589	409	180	69%	31%
Laboratory	644	385	259	60%	40%
Radiography	511	252	259	49%	51%
Research	25	13	12	52%	48%
Environmental Health	2,494	1,667	827	67%	33%

Source: MOHCC Health Management Information System 2016

Table 8: Summary of establishment strength (support staff) as at 31st December 2016

	In-post	Vacant Posts	% In-post	% Vacant
Human Resources Officer	92	79	13	86%
Human Resources Assistant/Administration Assistant	561	354	207	63%
Executive Assistant (Private Secretary/Typing Pool Supervisor/Medical Secretary)	342	214	128	63%
Assistant Librarian/Librarian/Senior Principal	16	15	1	94%
Chief Internal Auditor/(Internal Audit Manager)	2	0	100%	0%
Auditor Senior/Principal	11	3	79%	21%
Audit Assistant	4	3	57%	43%
Account Senior/Principal	81	9	90%	10%

Accounting Assistant (Executive Officer Accounts)	272	65	81%	19%
Accounts Clerks/Paralegal	145	45	76%	24%

Source: MOHCC Health Management Information System 2016

Table 9: Summary of establishment strength (support staff) as at 31st December 2016

	Authorised Establishment	In post	Vacant Posts	% In post	% Vacant
Provincial/Senior Health Services Administrator Health Services Admin 1	12	7	5	58%	42%
Health Services Administrator 11	56	35	21	63%	37%
Administrative Officer Senior/Principal	19	15	14	79%	21%
Administration Assistant (Clerk Upgraded/Stores Officer 1/11)	289	216	73	75%	25%
Ambulance Driver/Senior	522	423	99	81%	19%
Driver 1/11/111 coxswain	118	89	29	75%	25%
General Hand/Senior	3020	2927	93	97%	3%
Hospital Hand/Senior	277	245	32	88%	12%
Hospital Hand Theatre	181	142	39	78%	22%
Home/Lady Warden	27	23	4	85%	15%
Laundry Hand/Senior	171	117	54	68%	32%

Source: MOHCC Health Management Information System 2016

Table 10: New RHCs/Clinics which are requiring an establishment as at 31st December 2016

Province	GOZ	RDC	Mission	Total
Mashonaland West	6	25	2	33
Mashonaland Central	2	23	0	25
Matabeleland North	6	24	0	30
Manicaland	0	4	7	11
Masvingo	6	19	1	26
Mashonaland East	1	1	0	2
Midlands				
Matabeleland South	1	2	1	4

Source: MOHCC Health Management Information System 2016

Table 11: Registered General Nurse Training Intakes for 2016 as at September 2016

Number of Training Schools	Jan 2016 intake	May 2016 intake	Sept 2016 intake	Total intake for 2016
25	263	259	314	836

Source: MOHCC Health Management Information System 2016

INTAKE	№ of students who sat for the examinations	№ of students who passed	№ of students who failed	Percentage of students who passed
March 2016	352	327	25	92.89%
July 2016	352	330	22	93.7%
November 2016	353	277	76	78.4%
Total numbers of students	**1057**	**934**	**123**	**88,42%**

Source: MOHCC Health Management Information System 2016

Table 13: Examination Statistics for State Certified Midwives (2016)

Intakes	№ of students who sat for the examinations	№ of students who passed	№ of students who failed	Percentage of students who passed
March 2016	254	214	40	84.7%
August 2016	279	275	4	98.5%
December 2016	161	153	8	95%
Total number of students	**694**	**642**	**52**	**92.5%**

Source: MOHCC Health Management Information System 2016

Table 14: Number of VHWs Trained as at 31st December 2016

Province	District	No of New VHWs Trained			
		Q1	Q2	Q3 & Q4	Total No Trained
3	14	240	600	761	1601

Source: MOHCC Health Management Information System 2016

1.3 Finance and Administration

1.3.1 2016 Budgets and Expenditure

Table 15: Government of Zimbabwe Budgets and Expenditure for 2016

2016			
Economic Classification		Total Funds Allocated	Cumulative Releases
1	Employment Cost	197,855,938	182,430,351
2	Goods and services	2,715,370	1,496,136
3	Maintenance	364,683	180,461
4	Current transfers	84,210,832	79,461,593
5	Programmes	3,916,000	3,609,255
6	Acquisition of fixed capital assets	8,487,959	136,300

7	Medical supplies and services	14,082,654	13,773,353
8	Hospitals and Rural Health Centre	14,113,403	15,021,470
9	Capital transfers	3,515,000	2,373,200
Total		**329,261,839**	**298,482,119**

Source: MOHCC Health Management Information System 2016

Table 16: Health Services Fund income and expenditure for 2016

Health Services Fund income and expenditure for 2016		
	PROVINCES	CENTRAL HOSPITALS
INCOME	14,550,717.29	11,780,400.00
EXPENDITURE	14,202,645.19	10,154,802.08
GRAND TOTAL		
INCOME	26,331,117.29	
EXPENDITURE		24,357,447.30

Source: MOHCC Health Management Information System 2016

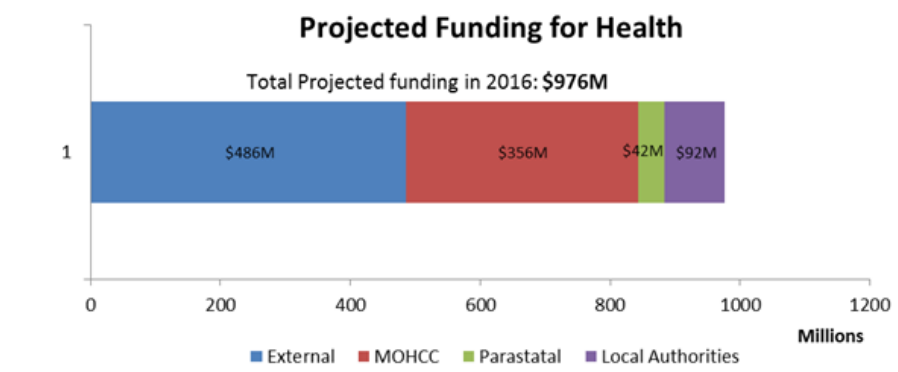

Figure 4: 2016 Projected funding for Health from the MoHCC Resource Mapping Report
Source: MoHCC Resource mapping 2016)

2. Public Health

Table 17: Notifiable diseases

Notifiable Disease	Cases	Deaths	CRF (%)
Cholera	10	1	10.0
Typhoid	85	9	10.6

Dysentery	42,727	84	0.2
Common Diarrhea	521,458	435	0.1
Anthrax	279		0.0
Rabies	12	10	83.3
Snake Bites	5,605	38	0.7
Hepatitis(confirmed)	3	2	66.7
Dog Bites	25,744		

Source: MOHCC Health Management Information System 2016

The following notifiable disease were not reported in the country from January to 31 December 2016:.Meningococal Meningitis, Plague, Yellow Fever, Typhus Fever and Viral Haemorrhagic Fever
Notifiable diseases: Epidemic – Prone Diseases, Deaths and Public Health Events: 2016

Table 18: Epidemic-prone diseases and deaths as at 31 December 2016

Condition	Cumulative cases	Deaths	CFR
Dysentery	42,727	84	0.19%
Malaria	227,894	235	0.19%
Typhoid	2,352 (85 confirmed)	9	-
Cholera	10 suspected (3 confirmed)	1	-
Common Diarrhoea	521,458	435	0.08%
Snake bites	5,605	38	0.7%
Anthrax	279	Nil	-
Rabies	12	10	83%

Source: MOHCC Health Management Information System 2016

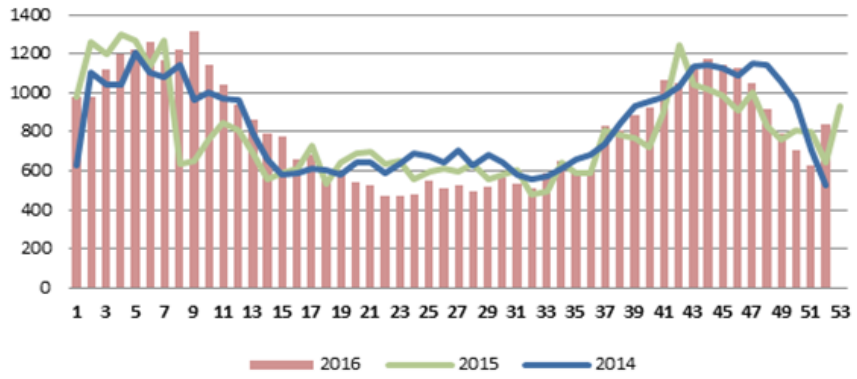

Figure 5: Trends of dysentery cases as at 31st December 2016
Source: MOHCC Health Management Information System 2016

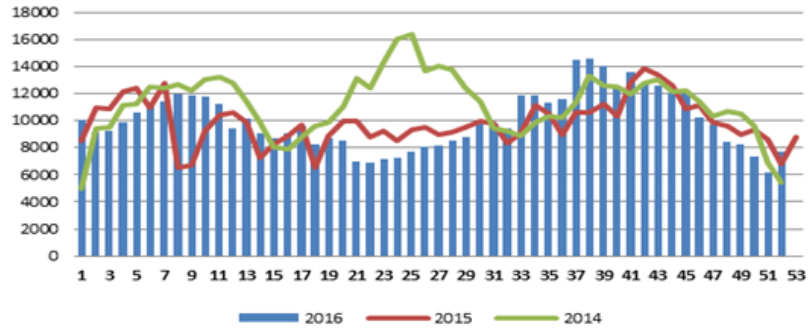

Figure 6: Trends of Diarrhea cases-2014-2016
Source: MOHCC Health Management Information System 2016

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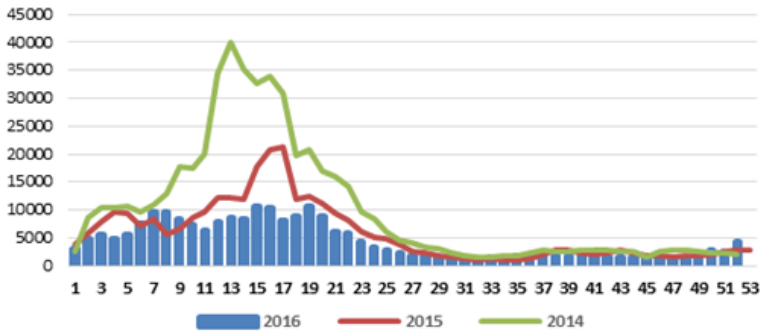

Figure 7: Trends of Malaria cases-2014-2016
Source: MOHCC Health Management Information System 2016

2.1 Communicable Disease

2.1.1 Malaria

Top 20 districts: Malaria incidence: Jan- Dec 2016

Figure 8 below shows top 20 districts by malaria incidence. The districts constituting the top 20 list were concentrated in Manicaland (7), Mash Central (6), Mash East (4) and the remaining 3 shared between Masvingo and Mash West.

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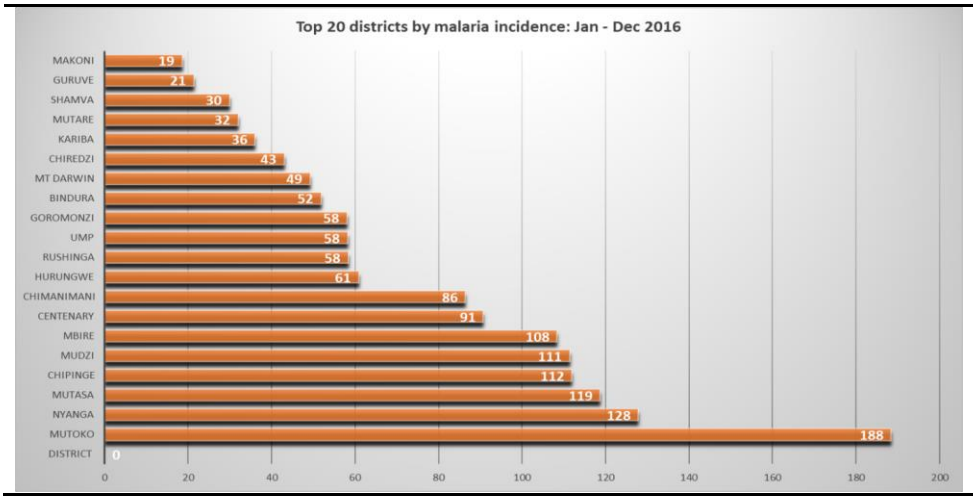

Figure 8: Top 20 districts: Malaria incidence: Jan- 31 Dec 2016 (MoHCC HMIS 2016)
Source: MOHCC Health Management Information System 2016

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Mortality

Figure 9 below shows malaria death by age by province in 2016. In total 235 malaria deaths were reported by hospital facilities in 2016. The majority of malaria deaths occurred in the above 5 years' age group (81%) with 45 (21%) being among the under 5 age group. All the reported deaths went through a mortality investigation and were audited as malaria deaths. The admitting institutions submitted the death investigation forms for further analysis at national level. The graph below shows the number of malaria deaths by province/ institution. Amongst the rural provinces Manicaland recorded the highest number of deaths (76) followed by Masvingo (34) and Mat South had the least of 2 deaths in 12 months. Of the total deaths 20% was among the under 5 age group

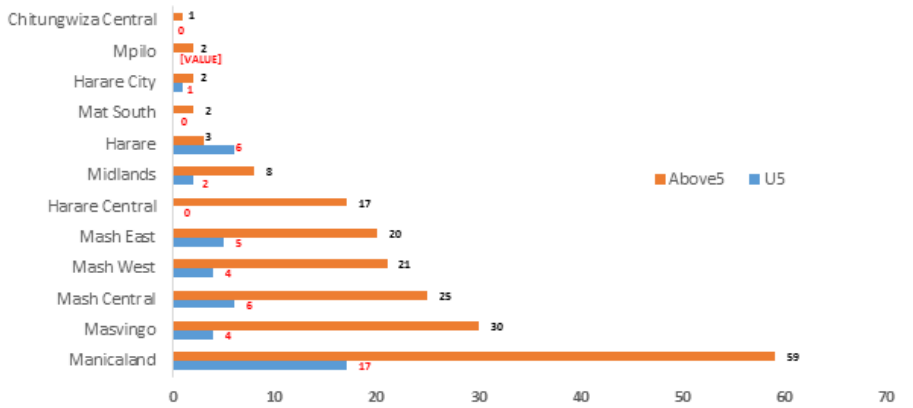

Figure 9: Number of malaria deaths by age by province January to 31 December 2016
Source: MOHCC Health Management Information System 2016

Further analysis to understand the impact of inpatient malaria deaths per 1000 population yielded an annual malaria death rate of 0.017 showing a reduction in malaria mortality from 2013 baseline of 0.03 to 0.017 in 2016.

Vector control:

Synopsis of vector control: 2016

The main objective of malaria vector control is to reduce significantly the incidence and prevalence of both parasite infection and confirmed malaria. The two approaches to malaria prevention by mosquito control deployed in 2016 were Indoor Residual Spraying (IRS) and Long Lasting Insecticidal Nets (LLINs). IRS was carried out is 45 districts and LLINs in 26 districts that lay in moderate and high malaria receptive areas of the country. National targets set for these interventions were 95% targeted populations protected by IRS and

100% targeted people covered by LLINs respectively. To maximise on efficiency gains and effectiveness of the interventions, NMCP adopted the WHO recommendation of ceasing the overlaying of the two interventions in one area. In other words, the beneficiary communities either received IRS or LLINs during the season under review. (The figure below shows the wards covered by either off the interventions).

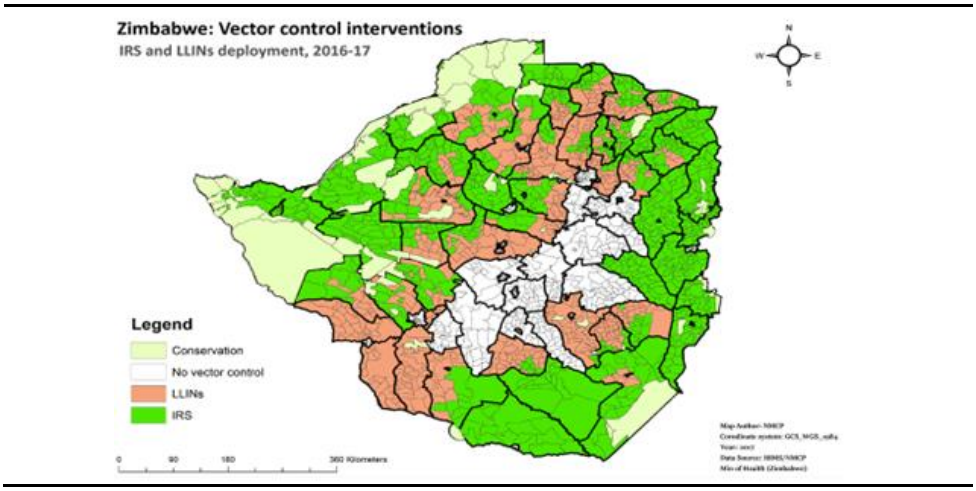

Figure 10: Map showing wards targeted for IRS and LLINs for 2016
Source: MOHCC Health Management Information System 2016

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Table 19: Indoor Residual Household Spraying, 2016

Province	Targeted Rooms	Rooms Sprayed	% Rooms Sprayed	Targeted Population	Population Protected	% Population Protected
Manicaland	760,418	685,528	90%	996,408	944,962	95%
Mashonaland Central	387,709	274,975	71%	566,845	417,899	74%
Mashonaland East	392,066	374,437	96%	495,465	494,604	100%
Mashonaland West	283,772	259,353	91%	373,998	374,179	100%
Matabeleland North	251,453	224,875	89%	435,640	367,185	84%
Matabeleland South	93,424	69,134	74%	122,916	95,874	78%
Masvingo	369,394	360,433	98%	538,525	539,037	100%
Midlands	328,976	317,844	97%	447,691	441,192	99%
Total	**2,867,212**	**2,566,579**	**90%**	**3,977,488**	**3,674,932**	**92%**

Source: MOHCC Health Management Information System 2016

Table 20: Overview of national program performance indicators, 2016

Indicator/s	National Target	Result 2016
Impact		
Confirmed malaria cases (microscopy or RDT) per 1000 persons per year	15	21
Inpatient malaria deaths per 1000 persons per year	0.02	0,017
Outcome/ coverage		
Proportion of population protected by Indoor Residual Spraying within the last 12 months	95%	95%
Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	1,582,085 (100%)	1,752,855 (111%)
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	100%	100%
Proportion of suspected malaria cases that receive a parasitological test in the community	85%	96%
Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national policy at public sector health facilities	80%	83%
Percentage of confirmed cases fully investigated (malaria elimination phase)	85%	78%

Source: MOHCC Health Management Information System 2016

2.1.2 HIV and AIDS Programme

The HIV epidemic in the country remains generalized, feminized and homogenous and continues to decline in new infection rates, prevalence and AIDS related mortality. However, there are areas of high HIV transmission which includes border districts, growth points, small scale mining areas, fishing camps and commercial farming settlements. (

HIV Testing and Counseling (HTC)

HIV Testing Services (HTS) is a crucial first step in the cascade of HIV treatment and an entry point to other prevention and care interventions including male circumcision, prevention of mother-to-child HIV transmission, and treatment of opportunistic infections. Currently a total of 1,460 health care facilities are providing integrated HIV Testing services through Antenatal Clinic (ANC), OI clinics, standalone Testing and Counseling centers, outreach centers, TB clinics and STI clinics. HT services are available to all citizens inclusive of key populations.

HIV Testing Services campaigns were conducted in all districts with more extensive campaigns conducted in the Matabeleland region because of high incidence of HIV in the region. The main focus of the campaigns was to serve the hard to reach populations who included children, adolescents and workers especially those in the informal sector and artisanal miners.

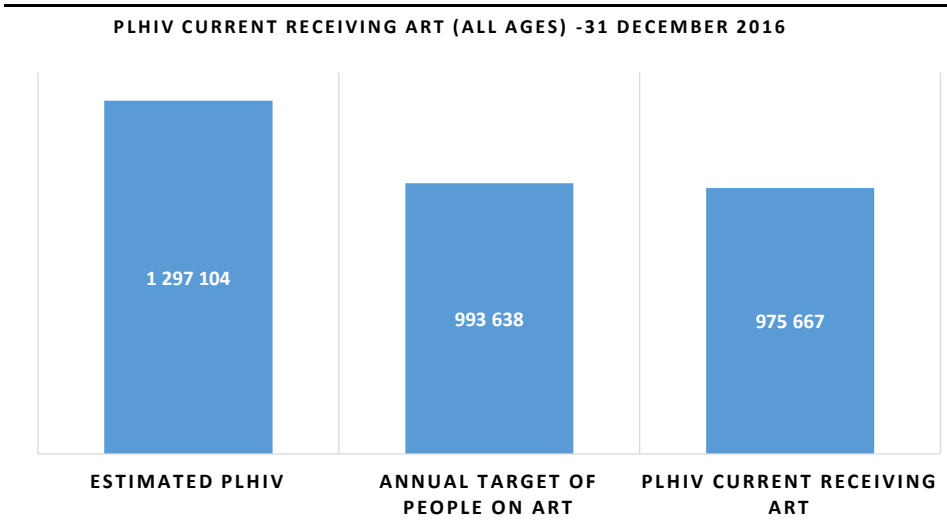

Figure 11: PLHIV currently receiving ART (all ages)-31 December 2016
Source: MOHCC Health Management Information System 2016

~~*Figure 12: PLHIV currently receiving ART (all ages)-31 December 2016*~~

- ~~75% of the PLHIV currently receiving ART of the estimation~~
- ~~98% of the targeted PLHIV currently ART~~

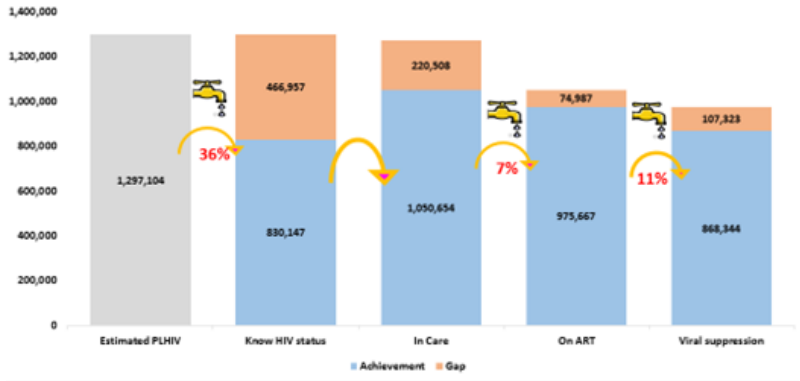

Figure 12: PLHIV currently receiving ART (all ages)-31 December 2016

- 98% of the targeted PLHIV currently ART

Source: MOHCC Health Management Information System 2016

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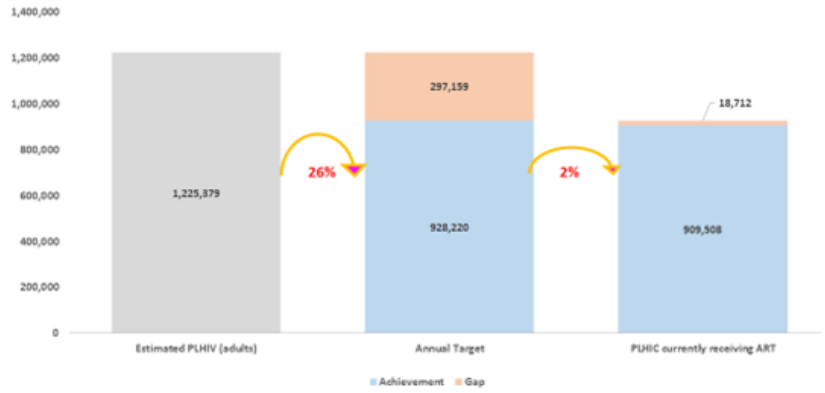
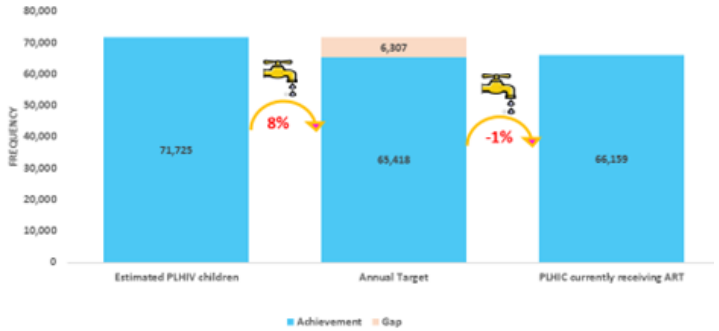


Figure 13: PLHIV currently receiving ART (15+years)-31 December 2016
Source: MOHCC Health Management Information System 2016



- 92% of the estimated PLHIV (children) currently receiving ART whilst 101% of the targeted PLHIV (children) currently receiving ART

Figure 14: PLHIV currently receiving ART (0-14years)-31 December 2016
Source: MOHCC Health Management Information System 2016

Viral load suppression (VLS) among HIV-positive people, by age and sex

Table 21: Viral load suppression among HIV positive people by age and sex

Prevalence		
Older adults	Female 45-54 years	78.7%
	Males 55 and above	71,1%
Young adults	Females 15-24 years	48,6%
	Male 15-24	40,2%

Source: ***ZIMPHIA 2016***

Prevalence of viral load suppression among HIV-positive people in Zimbabwe is highest among older adults 78, 7% among HIV –positive females ages 45 to 54 years and 71, 1% among HIV-positive males age 55 years or older, in contrast, prevalence of VLS is directly lower among younger adults: 48, 6% among HIV positive females and 40, 2% among HIV-positive males ages 15 to 24 years, (ZIMPHIA 2016)

2.1.3 TB

Table 22: TB Prevalence

Prevalence Per 100 000 people	ZIMPHIA	WHO
	292	409

Source: ZIMPHIA 2016

Table 23: Trends of Sensitive TB

TB Notification	2016
	27,343

Source: ***ZIMPHIA 2016***

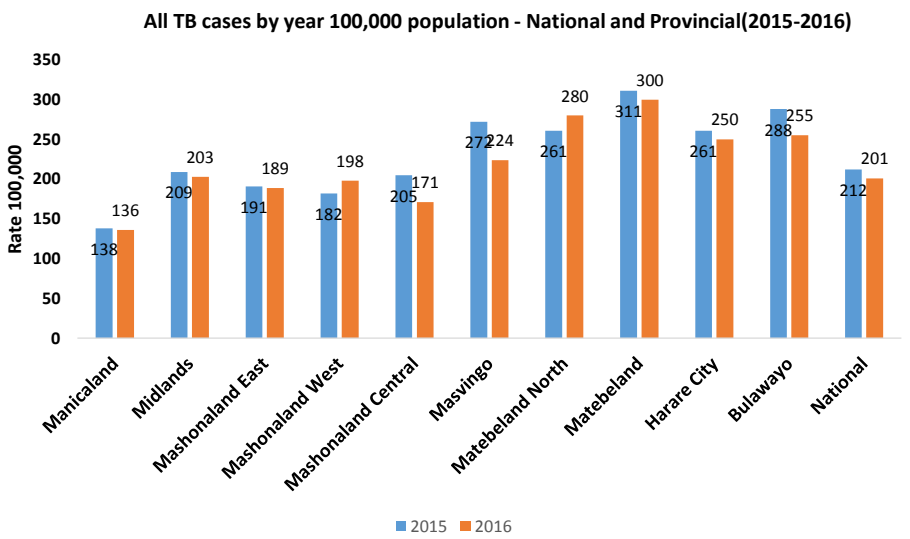


Figure 15: All TB cases by year per 100,000 population-National and Provincial (2015-2016)
Source: MOHCC Health Management Information System 2016

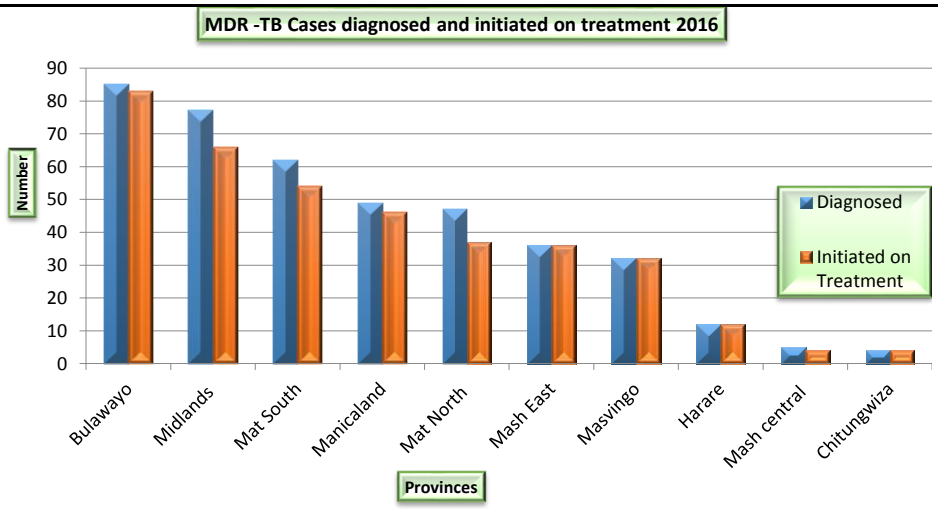


Figure 16: MDR-TB Cases diagnosed and Initiated on Treatment 2016
Source: MOHCC Health Management Information System 2016

Government of Zimbabwe has consolidated the need to strengthen TB HIV collaboration between TB and National AIDS programs. At provincial level, a designate medical officer responsible for TB/HIV has been appointed to coordinate TB/HIV collaborative response at sub-national. Both programs continue to convene joint planning and review sessions as well as periodic TB/HIV partnership fora with partners, to minimize duplicity in program delivery. The response has continued to promote TB/HIV integrated "One Stop Shop" service delivery at facility level. Selected high volume primary care facilities have undergone site renovations to improve ventilation and patient flow to facilitate co-location of both TB and HIV services under one roof.

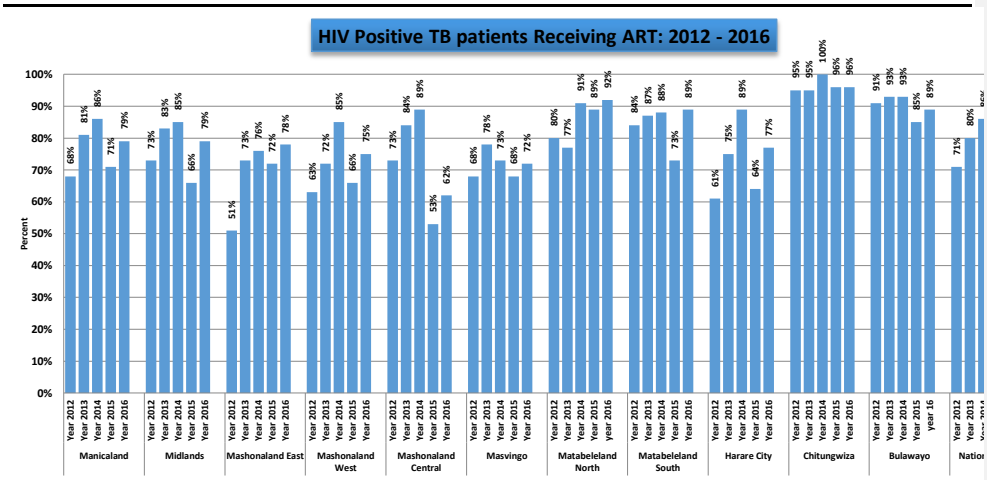


Figure 17: HIV positive TB patients Receiving ART: 2012-2016
Source: MOHCC Health Management Information System 2016

2.2 Non-Communicable Diseases

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Table 24: Selected Registered Non-Communicable Diseases as at 31 December 2016

Condition	2016
Asthma	120,738
Diabetes	111,597
Hypertension	742,188
Mental Diseases	147,382
Breast Cancer	2,505

Source: District Health Information System (DHIS2)

Output	Target	Achieved
Basic Ear , Nose and Throat ,Audiology Equipment Distributed	20 Sites	18 Sites
Ear Nose and Throat ,Audiology Training of Nurses (RGN)and Rehabilitation Technicians	32 RGNs and 16 Rehabilitation Technicians	18 RGNs and 8 Rehabilitation Technicians
Psychosocial Support Training in Childhood Cancers for Nurses	6 Central Hospital = 80 RGNs	3 Central Hospitals =40 RGNs
Childhood Cancer Training (KIDZCAN)	20 Sites	20 sites
Cataract Case Identification Training Project by Seeing is Believing (CBM)	2 Provinces =14 Sites	14 Sites
Cataracts Surgeries **Increased** in 2016	7000	4327 (Jan-Oct 2016)

Source: MOHCC Health Management Information System 2016

~~***Source MOHCC Meeting of Donors (MODO) 2016***~~

Table 26: Cataract Surgeries carried out as at 31st December 2016.

Byo City	UBH	CHIT	Mash E	Mash C	Mash W	Masv	Manica	Mat S	Mid	SKH HRE	HRE CITY	National
74	359	329	209	110	824	1,042	384	119	415	94	368	4,327

Source: MOHCC Health Management Information System 2016

~~***Source MOHCC Meeting of Donors (MODO) 2016***~~

Raising Awareness on NCDs

Table 27: Activities raised awareness on NCDs in 2016 by the 31st of December.

2016 Output	Target	Achieved
Cancer action plan Developed	Finalised and approved	Final draft in place
World Cancer Day 2016	Finalised and approved	Zero draft in place
World Health Day 2016	Commemoration 4 February	Commemorated 4 February2016
World Diabetes Day 2016	Commemoration 7 April 2016	Commemorated 7 April 2016
NCD Strategy	Commemoration 14 November 2016	Commemorated 14 November and 25 November 2016
World Sight Day 2016	Commemoration 13 October 2016	Not Commemorated due to No Funds
National Prevention of Blindness (NPBC) Committee Meetings	4	3 (28th April ,25th August and 24th November 2016)

Source MOHCC Meeting of Donors (MODO) 2016

The Mental Health Services Department continued its role of coordinating provision of mental health and psychiatric services (promotive, preventive, curative and rehabilitative) including substance abuse (Drug, Alcohol and Tobacco Control).

Highlights for 2016 included:

- Hosting of the Multi-Country Workshop on the Protocol to Eliminate Illicit Trade in Tobacco Products,
- Conducted Mental Health Gap trainings for non-specialised health personnel to ensure that patients are managed within the community with referral of those in need of expert help.
- Launched and disseminated of the Zimbabwe Global Youth Tobacco Survey (GYTS) Report in January 2016. Results of the survey indicated that 20% youths smoke tobacco.
- The Mental Health Discharge Plan was developed and is awaiting launching.
- Concluded the Intersection of Alcohol, Gender Based Violence and HIV Policies.
- The final draft of the National Alcohol Policy was completed and awaits cabinet approval.

Table 28: Number of facilities routinely screening and appropriately managing selected Mental Disorders – 8 facilities by December 2016.

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	BYO	CH	HRE
Achieved	8	-	-		1	1	-	-	1	2	-	3
Target	8	-	-		1	1	-	-	1	2	-	3
Variance (%)	0%				0%	0%			0%	0%		0%

Source: MOHCC Health Management Information System 2016

~~***Source MOHCC Meeting of Donors (MODO) 2016***~~

Table 29: Number of facilities offering integrated mental health services by province by December 2016

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	CH	HRE	
Achieved	25	1	1	2	1	1	1	1	1	1	13	Achieved
Target	26	1	1	2	1	2	1	1	1	1	13	Target
Variance (%)	0%	0%	0%	0%	0%	50%	0%	0%	0%	0%	0%	Variance (%)

Source: MOHCC Health Management Information System 2016

~~***Source MOHCC Meeting of Donors (MODO) 2016***~~

2.3 Environmental Health

Table 30: Environment health activities as of 31st December 2016

Environmental health services	Target	Achievements	Percentage
Protected wells	1,500	1362	91%
Collection of food samples	2,400	1677	70%
Collection of water samples	8,000	6764	86%
Inspection of business premises	80,000	63726	80%
screening of travellers at all ports of entry	100%	100%	100%
Collection of cosmetic and industrial samples	200	230	115%
Inspection of food imports at points of entry	100%	100%	100%

Source: MOHCC Health Management Information System 2016

~~*Source MOHCC Meeting of Donors (MODO) 2016*~~

2.4 Family Health

2.4.1 Reproductive, Maternal, New-born, Child and Adolescents

2.4.1(a) Maternal and Child Health Services

The Maternal and Child Health Program apart from the Government of Zimbabwe, has been receiving support from the following:

- Health Development Fund-pooled funding coordinated by UNICEF (HDF)
- Integrated Support Program-pooled funding coordinated by UNFPA (JSP)
- Results Based Financing (RBF) Program a coordinated by Cordaid
- Absolute Return for Kids (ARK) supported ELMA Philanthropies and ARK International
- Maternal and Child Health Integrated Program (MCHIP) a USAID supported program
- H4+ Initiative through UN agencies led initiatives in Maternal and Child Health
- Programme Performance Indicators

Within the frameworks of the HDF, ISP, H4+, RBF and other funding modalities, the Ministry has been implementing interventions to ensure that every pregnancy is safe, intended and results in a positive outcome.

Table 31:The interventions implemented as at 31st of December 2016

Frameworks	Interventions implemented
HDF,ISP,H4, RBF	Improving reproductive health commodity security;
	Strengthening of EmONC service provision;
	Strengthening adolescent sexual and reproductive health;
	Rolling out the cervical cancer programme;
	Revitalization of the maternity waiting homes (MWHs);
	human resource capacity strengthening; improving emergency referral systems;
	Strengthening the coordination, planning, monitoring and evaluation of the Maternal Neonatal Health programme.

Source: MOHCC Health Management Information System 2016

~~*Source MOHCC Meeting of Donors (MODO) 2016*~~

Table 32: Teenage pregnancies by province as at 31st of December 2016

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	BYO	CH	HRE
Baseline (Jan-Dec 2015)	7,011	1,175	898	819	891	805	527	515	732	88	128	433
Target (Jan-Dec 2015)	6,450	1,082	826	754	820	740	484	474	674	80	118	398
Achieved (Jan-Oct 2016)	4,756	771	626	571	563	526	393	369	500	107	42	288
Variance	-26%	-28%	-24%	-24%	-29%	-29%	-19%	-22%	-26%	3%	-64%	-28%

2016 target reduction on teenage pregnancies from 7011 to 6450 was not met, with a variance of *-26%*. Way forward: The Ministry is to come up with innovative ways (egg harness mobile technologies) to strengthen interventions to reduce teenage pregnancies

Table 33: Number of pregnant women who booked 1st ANC before 16 weeks by province

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	BYO	CH	HRE
Baseline (Jan-Dec 2015)	104,707	20,465	14,344	10,831	13,907	17,034	6,283	5,266	12,823	563	687	2,504
Target (Jan-Dec 2015)	115,178	22,512	15,778	11,914	15,298	18,738	6,912	5,792	14,106	620	756	2,754
Achieved (Jan-Oct 2016)	97,841	19,226	14,517	10,234	12,751	15,727	5,130	5,224	11,765	751	665	1,851
Variance (%)	-15%	-15%	-8%	-14%	-17%	-16%	-26%	-10%	-17%	21%	-12%	-33%

Source: MOHCC Health Management Information System 2016

Target was not met with variance of -15%.Achieved 85 % of the target. Recommendation: Strengthen initiatives (e.g. the VHW programme) to encourage/mobilize pregnant women to book early (within 12 weeks gestation) for ANC.

Table 34: Proportion of pregnant women with at least 4 ANC visits by province

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	BYO	CH	HRE
Baseline (Jan-Dec 2015)	446,762	55,568	53,395	45,840	48,793	66,620	29,617	30,065	53,347	11,672	13,289	38,556
Target (Jan-Dec 2015)	469,100	58,346	56,064	48,132	51,232	69,952	31,098	31,568	56,014	12,256	13,954	40,484
Achieved (Jan-Oct 2016)	360,952	41,637	48,001	37,567	41,505	53,400	24,851	25,442	38,983	10,300	8,553	30,778
Variance	-23%	-29%	-14%	-22%	-19%	-24%	-20%	-19%	-30%	-16%	-39%	-24%

(%)												

Source: MOHCC Health Management Information System 2016

~~*Source MOHCC Meeting of Donors (MODO) 2016*~~

The MoHCC is to strengthen community component of the programme (VHW programme) to encourage/mobilize pregnant women to book for ANC

Table 35: Number of institutional deliveries by province

	NAT	MAN	MC	ME	MW	MSV	MN	MS	MID	BYO	CH	HRE
Baseline (Jan-Dec 2015)	363,733	49,083	33,658	35,794	42,152	41,224	20,201	17,242	42,508	19,018	13,846	49,007
Target (Jan-Dec 2015)	381,920	51,537	35,340	35,784	43,286	43,286	21,212	18,104	44,634	19,968	14,538	51,457
Achieved (Jan-Oct 2016)	304,690	41,190	29,260	31,754	33,690	33,690	17,022	14,213	33,803	16,019	16,019	40,797
Variance (%)	-20%	-20%	-17%	-16%	-22%	-22%	-20%	-21%	-24%	-20%	-35%	-21%

Source: MOHCC Health Management Information System 2016

~~*Source MOHCC Meeting of Donors (MODO) 2016*~~

Target was not met with a variance of -*23%*. 77% of pregnant women had at least 4 ANC visits
Recommended the strengthening of community component as above.

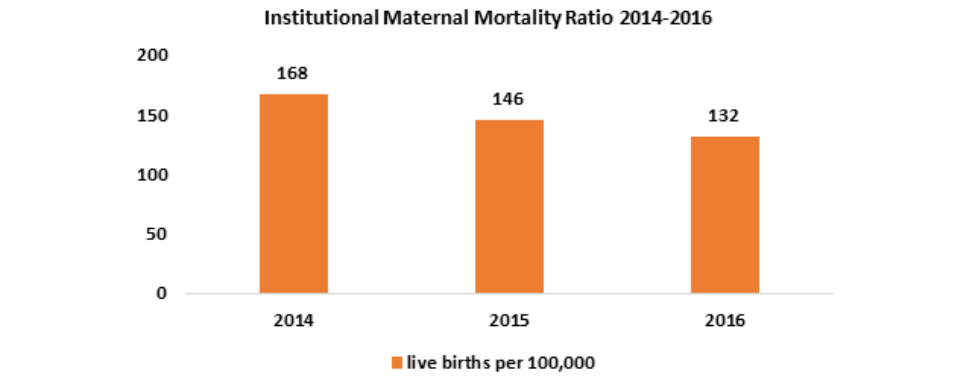


Figure 18: Institutional Maternal Mortality Ratio 2014-2016
Source: MOHCC Health Management Information System 2016

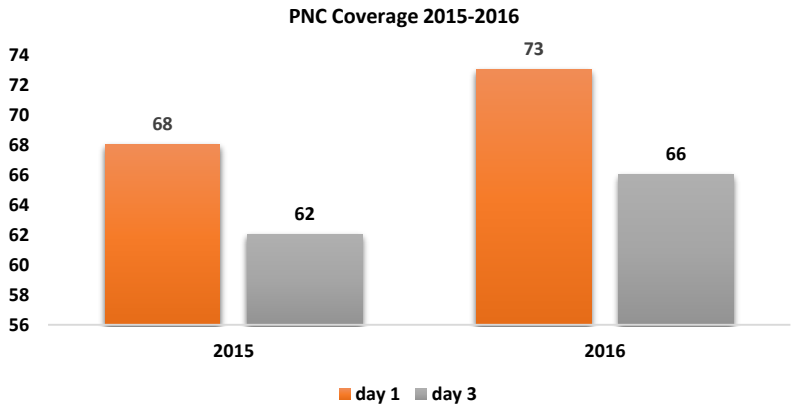


Figure 19: PNC coverage 2015-2016

Source: District Health Information System (DHIS2)

2.4.1 (b) Expanded Programme on Immunization

Table 36: Children fully immunized by province (MoHCC MODO 2016)

	NAT	MAN	MC	ME	MW	MN	MS	MID	MSV	BYO	CH	HRE
Target Jan-Dec	379,110	52,156	36,508	45,310	45,466	19,616	17,368	46,762	42,144	16,682	11,182	45,916
Achieved Jan-Dec	287,224	38,972	24,578	33,407	35,361	15,151	12,552	28,234	31,863	12,158	9,390	45,478
Variance (%)	-24%	-25%	-33%	-26%	-22%	-23%	-28%	-40%	-24%	-27%	-16%	-1%

Source: MOHCC Health Management Information System 2016

Routine Immunisation

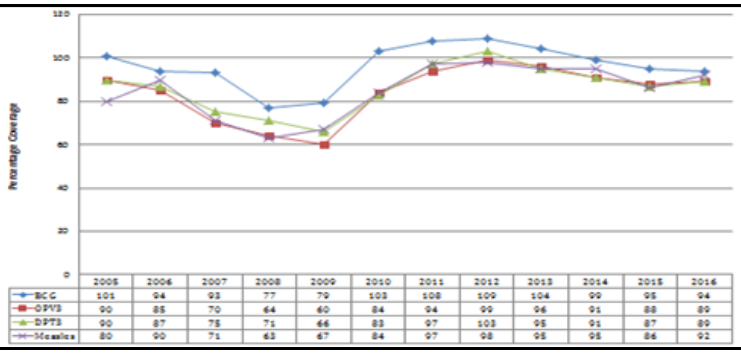
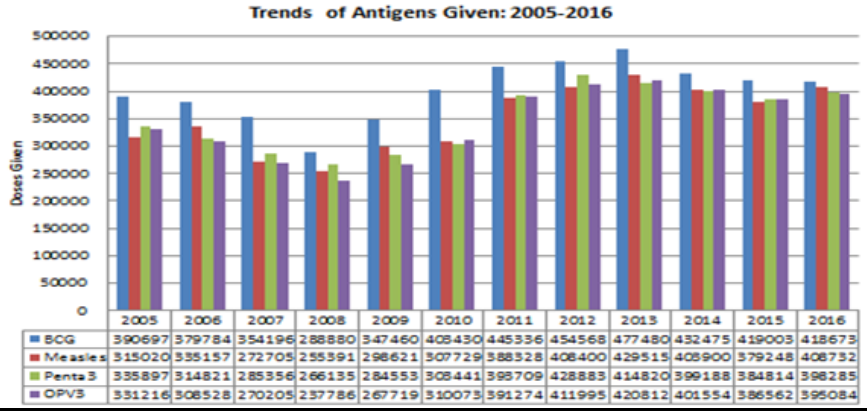


Figure 20: EPI Coverage Trend 2005 – 2016

Source: MOHCC Health Management Information System 2016

- Immunization trends showed that coverage for Penta3 seems to be faltering slightly starting at 95% in 2013, down to 87% in 2015 but rose slightly to 89% in 2016.
- Polio is to be eradicated by 2018, and coverage target is 90% at national and 90% districts to have coverage above 80%. OPV3 coverage absolute figures showed a slight increase of (8 522) from 386 562 in 2015 to 395 084 in 2016 and the coverage stood at 89% in 2016 up from 88% in 2015.
- Expected national measles coverage for 2016 was >95% and target is elimination by 2020. MeaslesRubella1 showed a huge increase in absolute figures and coverage (29 484) (6%) and coverage from 379 248 (86%) in 2015 to 408 732 (92%) in 2016.
- Primary Course Complete (PCC) below one year showed an increase of (14 990) (3%) in both absolute figures and coverage from 363 918 (82%) in 2015 to 378 908 (85%) in 2016. 42/63 (67%) districts had PCC coverage above 80%.
- Rota 2 and PCV3 coverage also showed slight increases in coverage from 87% each in 2015 to 89% for both in 2016. Babies born protected from Neonatal Tetanus also showed a great improvement in coverage from 74% in 2015 to 84% in 2016 way above TT2+ coverage of 63%. Majority of districts had coverage above 80% only 10 districts had coverage below 80%.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BCG	390697	379784	354196	288880	347460	408430	445336	454568	477480	432475	419003	418673
Measles	315020	335157	272705	255391	298621	307729	388328	408400	429515	405900	379248	408732
Penta3	335897	314821	285356	266135	284553	308441	393709	428883	414820	399188	384814	398285
OPV3	331216	308528	270205	257786	267719	310073	391274	411995	420812	401554	386562	395084

Figure 21: Absolute number of children reached with DTP3 from 2005 – 2016(MoHCC HMIS)
Source: MOHCC Health Management Information System 2016

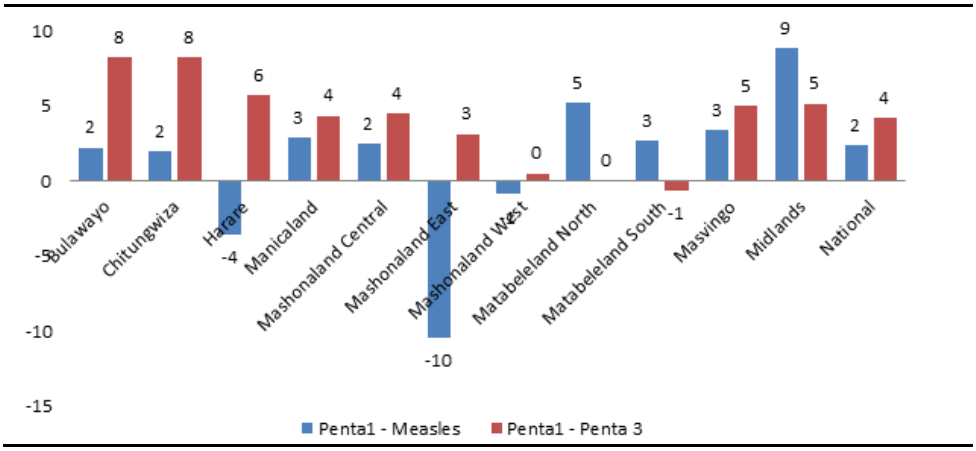


Figure 22: Drop Out Rates by Province/City (MoHCC HMIS 2016)
Source: MOHCC Health Management Information System 2016

Dropout rate between Penta1 and Penta3 dropped from 32 424 (5.8%) in 2015 to 19 018 (4.5%) in 2016 while overall dropout rate between Penta1 and Measles was 8.5% in 2015 and greatly reduced to 2% in 2016 which is commendable. All the 3 cities had high Penta1-3 dropout rates, followed by Masvingo, Midlands, Manicaland and Mashonaland Central. For Penta1-Measles dropout rate, Midlands had 9%, followed by Matabeleland North at 5% while Mashonaland East was at -10% and Harare at -4%. Provinces reporting negative dropout rates need to be engaged to check on where the problem could be emanating from.

Table 37: EPI District Performance by Antigen and PCC 2016

Antigen	<50%	50 -79%	80 – 89%	90-95%
PAB	0	10	12	20
OPV3	0	8	28	15
Penta3	0	6	29	16
PCV3	0	7	27	14
Rota2	0	12	22	12
MR1	0	10	28	11
MR2	14	43	4	1
PCC	0	21	27	11

Source: MOHCC Health Management Information System 2016

Table 37 below shows districts with less than 80% OPV coverage. Most of the districts were in Midlands Province. Although the immunizations improved in 2016, the set target of OPV3 90% at national level was not reached. Target of having 80% districts with target above 80% was achieved in all the antigens.

Table 38: Districts with below 80% OPV3 coverage

Districts with OPV3 coverage below 80%	OPV3 coverages	Province
Buhera	76%	Manicaland
Mutare	76%	Manicaland
Murehwa	67%	Mash East
UMP	67%	Mash East
Masvingo	75%	Masvingo
Mwenezi	75%	Masvingo
Gokwe South	68%	Midlands
Gokwe North	69%	Midlands
Kwekwe	73%	Midlands
Mberengwa	78%	Midlands

Source: MOHCC Health Management Information System 2016

Achievements

Solar direct drive fridges were installed in all the provinces. All the provinces are meeting the target recommended polio certification standards. Less than one MNT elimination status per 1000 live births per district was maintained. Vaccines and supplies availability was at 98% in all the health facilities. Forty-five vehicles eighty- six lap-tops were procured for the programmes

2.4.2 Integrated Management of Neonatal and Childhood Illnesses

Ninety percent of Health Facilities have at least two health workers trained in IMNCI. 20% of referral institutions have at least 4 health workers trained in ETAT.

2.4.2 (c) Child Welfare

Child friendly institutions were established in Lupane and Marondera. Apostolic Church Leaders in Mahusekwa were trained on Child Rights. The ministry managed to develop standardised guidelines on management of sexual abuse. Sensitisation of key stakeholders on Article 31 of UNCRC (Right for leisure, recreational and cultural activities was successfully done.

2.4.1 (d) Nutrition

Trends in Child Malnutrition

- According to the February 2016 Zimvac Rapid assessment report
  - 5.7% children under the age of 5 years have global acute malnutrition
  - 2.1 percent have severe acute malnutrition
  - 3.6% have moderate acute malnutrition.
- An overall increase in severe acute malnutrition (SAM) caseload expected due to the overall food insecurity situation

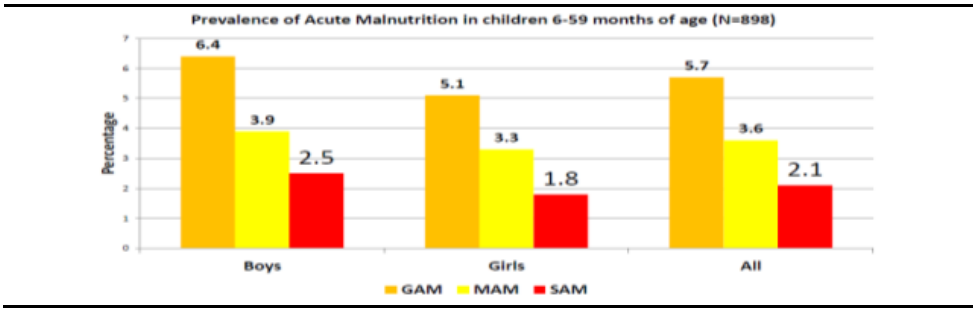


Figure 23: Prevalence of Acute Malnutrition
Source: MOHCC Health Management Information System 2016

Infant and Young Child Feeding (IYCF) Practices

Initiation of Breastfeeding

Trends: The percentage of infants breastfed within an hour of birth has steadily decreased from 68% in 2005-06 to 65% in 2010-11, and then to 58% in 2015, (ZDHS 2015)

Exclusive Breastfeeding

Forty-eight percent of infants under the age of 6 months are exclusively breastfed, (ZDHS 2015)

Table 39

Table 39: Proportion of patients who defaulted in the IMAM programme decreased to less than 15% by province

	NAT	BU	HA	MA	MC	MD	ME	MN	MS	MV	MW
Target	≤15	≤15	≤15	≤15	≤15	≤15	≤15	≤15	≤15	≤15	≤15
Achieved	16%	39%	15%	17%	17%	12%	10%	13%	8%	19%	19%
Variance	-1%	-24%	0%	-2%	-2%	3%	5%	2%	7%	-4%	-4%

Source: MOHCC Health Management Information System 2016

~~*Source MOHCC Meeting of Donors (MODO) 2016*~~

Prevalence of Malnutrition in Children

The 2015 ZDHS data show that 27% of children are stunted, 3%t are wasted, 8% are underweight, and 6% are overweight.

2.5 Research and Development

2.5.1 Government Analyst Lab

The department of Government Analyst Lab provides laboratory analysis, generate scientific and technical information and participate in health preventive and support programmes.

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The lab managed to analyze (5695) samples in 2016 compared to 2015, (5002). The increase was funded from the Health Services Fund, which accrued to $38,788.78 compared to $52,987.37 for the previous year. There were defaulters worth ($48,594) in 2016.
Harare province provided the most number of samples (30.6%) of the total workload followed by Mashonaland East (12.2%), Mash Central (8.7%) and Mash West (6.1%).

Observed Trends: There was a systematic increase of samples received during the past five years. There is more proactive and reactive monitoring and surveillance of food, water and industrial sample quality and safety. More players are seeking registration of their products as required by law.
Food Standards Advisory Board (FSAB)

The FSAB held 5 Technical Committee meetings that considered eight Products Permit Waiver applications, eleven Product Permits applications and twelve Certification applications. It also discussed some CODEX issues of concern that included the FAO initiated Technical Cooperation programme (TCP 3503) that sought to strengthen the National Codex Contact Points, National Codex Committees and Technical Committees of Zimbabwe, Swaziland and Lesotho

2.5.2 Primary Health Care

Table 40: T5 Selected conditions at primary health care facilities by province from January to 31 December 2016

Province	Mild (coughs & cold) female, under 5 years	Moderate (pneumonia) female, under 5 years	moderate (pneumonia) male, under 5 years
Bulawayo Province	14,735	12,979	13,216
Chitungwiza City	4,267	975	1,070
Harare Province	67,544	79,241	79,523
Manicaland Province	24,257	35,658	35,265
Mash Central Province	29,836	34,557	34,235
Mash East Province	27,649	27,315	26,396
Midlands Province	24,970	20,095	20,004
Mat North Province	12,969	11,201	11,495
Mat South Province	10,979	6,245	6,484
Masvingo Province	29,413	29,877	29,825
Mash West Province	30,738	26,950	27,994

Source: MOHCC Health Management Information System 2016

Table 41: T5 Selected conditions at primary health care facilities by province from January to 31 December 2016

Province	severe (pneumonia) female, under 5 years	severe (pneumonia) male, under 5 years	malaria - confirmed cases female, 5 years +	malaria - confirmed cases female, under 5 years	malaria - confirmed cases male, 5 years +
Bulawayo Province	764	960	28	9	36

Chitungwiza City	103	115	48	6	63
Harare Province	5,347	5,085	691	89	843
Manicaland Province	1,295	1,576	21,209	4,426	20,376
Mash Central Province	1,652	1,756	16,653	3,096	16,120
Mash East Province	1,868	1,926	17,876	3,022	18,443
Midlands Province	1,105	1,329	383	44	482
Mat North Province	307	325	587	88	571
Mat South Province	398	413	212	39	361
Masvingo Province	856	1,045	5,776	664	6,503
Mash West Province	1,314	1,525	9,247	1,282	10,850

Source: MOHCC Health Management Information System 2016

Table 42: T5-Malaria conditions at primary health care facilities by province from January to 31 December 2016

Province	malaria - confirmed cases male, under 5 years	Malaria suspected cases female, under 5 years	Malaria suspected cases male, under 5 years	Malaria cases treated by rdt or blood slide female, under 5 years
Bulawayo Province	8	586	666	579
Chitungwiza City	10	36	36	52
Harare Province	131	2,792	3,224	2,794
Manicaland Province	4,502	28,688	29,723	28,632
Mash Cent Province	3,004	23,513	23,680	23,548
Mash East Province	2,917	22,067	22,689	22,069
Midlands Province	39	6,425	6,731	6,428
Mat North Province	91	6,513	6,898	6,512
Mat South Province	31	3,676	3,898	3,677
Masvingo Province	718	10,805	11,338	10,808
Mash West Province	1,377	9,889	10,438	9,862

Source: MOHCC Health Management Information System 2016

Table 43: T5 Selected conditions at primary health care facilities by province from January to 31 December 2017

Province	Cases treated by rdt or blood slide male, under 5 years	Diarrhoea - with dehydration female, under 5 years	Diarrhoea - with dehydration male, under 5 years
Bulawayo Province	652	211	222
Chitungwiza City	47	350	404
Harare Province	3,224	542	606
Manicaland Province	29,696	1,166	1,236
Mash Cent Province	23,723	1,411	1,456
Mash East Province	22,523	1,605	1,680
Midlands Province	6,732	1,301	1,561

Mat North Province	6,897	340	379
Mat South Province	3,899	289	337
Masvingo Province	11,335	1,156	1,271
Mash West Province	10,427	1,399	1,651

Source: MOHCC Health Management Information System 2016

3.1 Rural Health Centres and Hospitals

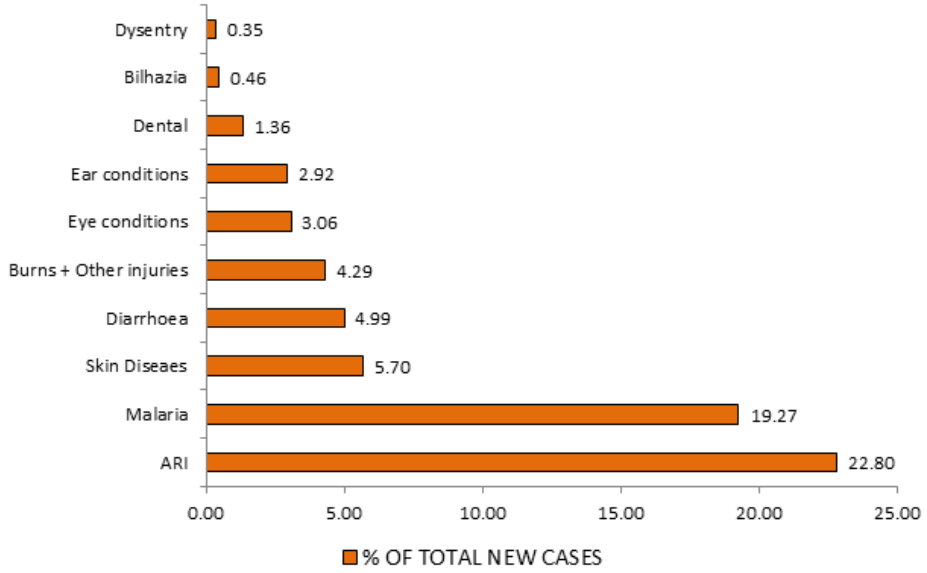

Figure 24: Top Ten Outpatient General Diseases/Conditions
Source: MOHCC Health Management Information System 2016

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2.5.3
~~3.2~~ Hospitals (Districts/General/Provincial/Central)

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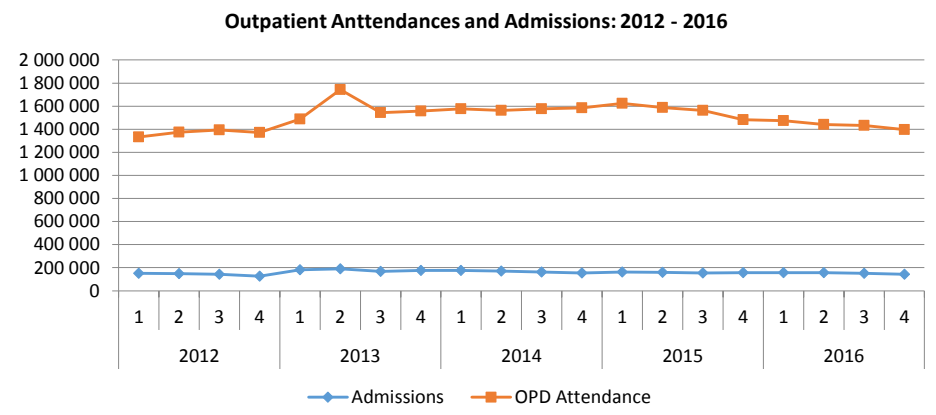

Figure 25: Outpatient Attendances and Admissions: 2012-2016
Source: MOHCC Health Management Information System 2016

Table 44 shows the top ten causes of hospital deaths in 2016. ARI Slow fetal growth, fetal malnutrition, disorders related to short gestation and low birth weight, HIV/AIDS were the major contributory conditions of death.

Table 44: Top ten causes of hospital deaths as at 31st December 2016 (MoHCC HMIS 2016)

Rank	Disease/Conditions	Total
1	ARI	619
2	Slow fetal growth, fetal malnutrition, disorders related to short gestation and low birth weight	466
3	Human immunodeficiency virus (HIV) disease all complications, AIDS and ARC	367
4	All meningitis, encephalitis, myelitis & other inflammatory diseases, excluding meningococcal meningitis & HIV disease related	322
5	Diarrhoea and gastroenteritis due to other infectious diseases (bacterial, viral, protozoal)	251
6	Heart failure congestive and left ventricular	239
7	Respiratory TB	227
8	Congenital infections and parasitic diseases, excluding HIV	222
9	Anaemia	186
10	Other endocrine, vitamin, nutrients and nutritional deficiencies, obesity and metabolic disorders	165

Source: MOHCC Health Management Information System 2016

~~*Source: MoHCC HMIS 2016*~~

Table 45: HS3 by Province for 2016

Province	Beds General	Beds Maternity	Beds Paediatric	Direct Admission General	Direct Admission Maternity	Direct Admission Paediatric	Lab Services Tests Performed Default
Bulawayo Central Hospitals	19,206	2,998	4,200	14,770	12,563	5,919	421,340
Bulawayo	2,160	0	720	0	0	0	18,651
Harare Central Hospitals	20,227	4,040	6,049	25,846	30,670	16,210	1,400,830
Harare	778	0	0	310	0	0	5,457
Manicaland	21,003	7,426	6,280	25,540	32,452	10,474	279,569
Mash Central	9,085	3,332	2,960	18,617	20,442	6,857	174,154
Mash East	12,882	4,947	3,785	13,507	17,107	5,572	158,227
Midlands	23,571	6,743	4,567	31,012	25,329	7,778	229,649
Mat North	7,045	2,363	2,577	11,764	14,358	4,260	78,567
Mat South	11,258	3,484	3,462	10,476	14,817	4,309	73,279
Masvingo	23,620	5,912	6,503	27,929	25,781	9,047	339,750
Mash West	14,647	5,109	4,571	22,133	27,504	7,205	439,639

Source: MOHCC Health Management Information System 2016

Table 46: HS3 by Province for 2016

Province	maternal deaths general	maternal deaths maternity	mortuary services (bodies received default)	other deaths general	other deaths maternity	other deaths paediatric	patients/ clients ANC+PNC
Bulawayo Central Hospitals	29	24	5,425	2,800	0	266	6,288
Bulawayo	0	0	0	0	0	0	0
Harare Central Hospitals	52	137	11,586	5,992	18	963	10,845
Harare	0	0	13	8	0	0	0
Manicaland	7	19	5,555	2,295	110	502	38,006
Mash Central	3	22	3,351	1,302	86	287	16,223
Mash East	2	15	2,551	1,318	12	314	23,928
Midlands	11	23	4,424	2,099	13	314	23,928
Mat North	2	12	1,565	885	39	130	13,301
Mat South	3	5	2,422	951	45	121	17,497

Masvingo	8	32	3,180	1,818	238	296	33,989
Mash West	11	25	4,294	1,733	185	381	22,282

Source: MOHCC Health Management Information System 2016

Table 47: HS3 by Province for 2016

Province	patients/ clients child clinic	patients/ clients family planning	patients /clients general	radiology services (ct scans) default	radiology services (ultrasound scans) default	referrals out general	referrals out paediatric
Bulawayo Central Hospitals	4,302	3,496	125,845	0	12,681	127	66
Bulawayo	0	0	0	0	0	45	1
Harare Central Hospitals	46,009	8,822	124,309	4,848	13,680	19	9
Harare	13	29	15,927	0	0	79	0
Manicaland	133,782	25,885	360,429	4	1,948	2,869	566
Mash Central	107,524	5,567	194,331	57	9,969	613	182
Mash East	78,893	10,595	196,676	13	2,338	1,370	244
Midlands	60,205	15,389	214,498	0	45,430	1,833	355
Mat North	47,364	8,492	114,700	0	3,964	804	297
Mat South	38,188	9,845	179,559	5	5,055	1,312	358
Masvingo	104,356	18,572	344,230	0	4,930	2,101	369
Mash West	98,572	9,394	224,610	8	6,765	1,732	359

Source: MOHCC Health Management Information System 2016

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Table 48: HS3 by Province for 2016

Province	rehabilitation services attendances default	repeats ANC+PNC	repeats child clinic	repeats family planning	repeats general
Bulawayo Central Hospitals	9,422	11,477	3,390	2,545	189,956
Bulawayo	0	0	0	0	0
Harare Central Hospitals	22,529	23,566	27,082	14,900	176,986
Harare	737	1	540	350	4,555
Manicaland	10,372	56,977	21,480	59,261	102,210
Mash Central	13,882	43,116	28,292	26,719	102,897
Mash East	9,675	39,126	64,099	31,487	71,985
Midlands	10,291	38,675	7,874	32,585	137,819
Mat North	11,350	26,921	12,274	16,058	55,195

Mat South	5,592	34,522	6,292	17,651	37,537
Masvingo	10,750	55,541	18,450	57,979	170,818
Mash West	9,093	45,337	22,846	27,286	113,010

Source: MOHCC Health Management Information System 2016

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