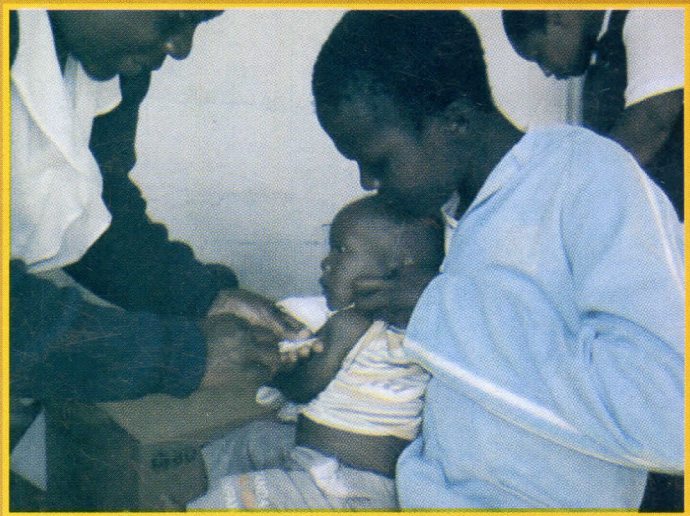




ZIMBABWE

National Child Survival Strategy for Zimbabwe 2010 - 2015



NATIONAL CHILD SURVIVAL STRATEGY FOR ZIMBABWE

2010-2015

Harare, Zimbabwe

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Ministry of Health and Child Welfare

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Acronyms

ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BEmOC	Basic Emergency Obstetric Care
CEmoC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CSSC	Child Survival Steering Committee
CSTWG	Child Survival Technical Working Group
DDF	District Development Fund
DOT	Directly Observed Treatment
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
ETAT	Emergency Triaging and Treatment
FST	Family Support Trust
GAVI	Global Alliance for Vaccine and Immunization
GMO	Government Medical Officer
Hib	Haemophilus Influenza B
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IGME	Inter-agency Group for Child Mortality Estimation
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
ITN	Insecticide Treated Nets
IPT	Intermittent Presumptive Treatment
IYCF	Infant and Young Child Feeding
MCH	Maternal and Child Health
MNCH	Maternal Neonatal and Child Health

MDG	Millennium Development Goals
MER	More Efficacious Regimen
MIMS	Multiple Indicator Monitoring Survey
MNCH	Maternal Neonatal and Child Health
MOHCW	Ministry of Health and Child Welfare
NIDs	National Immunization Days
MNCHSC	National Maternal, Newborn and Child Health Steering Committee
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNC	Primary Care Nurse
SdNVP	single dose Nevirapine
SP	Sulfadoxine/ Pyrimethamine
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNICEF	United Nations Children's Emergency Fund
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey

Foreword

Zimbabwe, like most Sub-Saharan African countries, bears a heavy burden of high neonatal and child mortality when compared to countries in other regions of the world. The under-five mortality rate according to the Zimbabwe Demographic and Health Survey of 2005-6 is 82 deaths per 1,000 live births. The infant mortality rate is 60 deaths per 1,000 live births compared to 82 in 1999. Related to this is the neonatal mortality rate which was 36 per 1,000 live births in 2004 (State of the World's Children 2009, UNICEF) compared to 29 per 1000 live births in 1999. The Multiple Indicator Monitoring Survey (MIMS) of 2009 estimates under five mortality rate and infant mortality rates at 94 and 67 deaths per 1000 live births respectively. These indicators are unacceptably high. This demonstrates the need for us to scale up high impact interventions urgently, in order to reverse this trend and achieve Millennium Development Goal (MDG) number four.

Neonatal conditions are the leading causes of mortality in children under five years in Zimbabwe. The HIV epidemic continues to be a major challenge to child health. Approximately 105,740 children are living with HIV. Ninety percent of these infections are result of mother-to-child transmission. It is therefore imperative that efforts to prevent vertical transmission and rapid scale up of infant diagnosis are redoubled, so that infants are protected from acquiring HIV infection, and those infants who are infected are detected early offered life saving Anti-Retroviral Therapy (ART).

The country has made efforts to address child health issues in the context of several international agreements aimed at improving child health. The first International declaration underlining the importance of primary health care (PHC) was the 1978 Alma-Ata Declaration. The declaration expressed the need for urgent action by all governments, health and development partners, and the world community, to protect and promote the health of all people of the world. Zimbabwe has re-affirmed its commitment to the Ouagadougou Declaration on Primary Health Care Approach, to facilitate the delivery of high impact, low cost interventions at high population coverage rates in order to reduce under-5 mortality by two thirds by 2015.

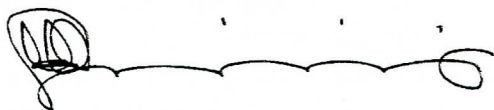
This Child Survival Strategy provides a framework for addressing child health challenges currently facing Zimbabwe. It is an over-changing strategy for scale up of the national response to reduce the current levels of child mortality and morbidity in line with the MDG health related targets. The life cycle approach and continuum of care concept, starting with care from the home environment to health facility, guided the development of this strategy.

The strategy will help bring together all national stakeholders to support one national Child Survival programme, one national Child Survival coordination mechanism, and one national Child Survival Planning, Monitoring and Evaluation Framework.

The Ministry of Health and Child Welfare would like to acknowledge the generous technical and financial contributions from all organizations and institutions that participated in the development of the Child Survival Strategy. The ministry of health would also like to extend its gratitude to all past and current donor partners who have offered specific support for child health activities, as well as financial and technical assistance for other aspects of health service delivery.

Most importantly the Ministry of Health and Child Welfare would like to acknowledge the dedicated service and hard work of all health personnel at all levels of service delivery, who are at the forefront of efforts to improve child survival in the country.

I therefore urge you all to implement this strategy and secure the health of our children over the next five years.



Brigadier General (Dr) Gerald Gwinji
Permanent Secretary
Ministry of Health and Child Welfare

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Executive Summary

Zimbabwe has a high estimated HIV prevalence of 13.7%, a weakened health system in the midst of poor economic performance, and recurrent droughts. These factors predispose the Zimbabwean child to poor health outcomes. One in every eleven Zimbabwean children dies before their fifth birthday each year (approximately 35,500 children per year). In order to develop a comprehensive child survival strategy for the country, a situation analysis on maternal, newborn and child health was carried out to guide the process and content of strategy development.

The Zimbabwean infant mortality rate is estimated at 67 per 1,000 live births. The under-5 mortality is estimated at 94 per 1,000 live births, and the neonatal mortality rate is 36 per 1,000 live births (MIMS 2009). The perinatal mortality rate is 29 per 1,000 live births (Zimbabwe Maternal and Perinatal Mortality Study, 2007). Of these perinatal deaths 50 percent occur within the first 24 hours. These indicators are unacceptably high. About 80 percent of deaths among under-5 children are caused by four mostly preventable causes: Neonatal causes (29 percent); AIDS (21 percent); pneumonia (13 percent) and diarrhoea (9 percent). Measles has resurfaced having an 8 percent contribution to mortality. Malnutrition is an underlying cause for most of these conditions. Most of these deaths can be prevented by providing universal coverage with proven high impact low cost interventions.

The Ministry of Health and Child Welfare of the Government of Zimbabwe has developed this strategy in order to deliver these proven interventions, reaffirming its commitment to significantly reduce early child mortality as promoted in the Millennium Development Goals (MDGs). The Child Survival Strategy was developed in the context of the existing National Health Strategy, and will complement other documents, including the Maternal and Neonatal Roadmap launched in 2009. Although the policy and legal environment is well developed, child survival integration at operational level lacks the capacity to deliver these interventions.

The goal of the strategy is to achieve MDG 4, to reduce under-5 mortality by two thirds: for Zimbabwe this translates to a reduction from 79 per 1,000 live births in 1990 to 27 per 1,000 live births by 2015. The mission of the strategy is to provide comprehensive and integrated maternal, newborn and child health services by scaling up proven cost effective interventions at high population coverage through family/community, outreach and facility level care. The mission will be realized through the successful, integrated implementation of nine strategic objectives focused on 1) increasing coverage of key interventions for universal access; 2) strengthening the capacity of the health system; 3) strengthening the capacity of individuals, families and communities; 4) mobilizing and diversifying the resource base; 5) strengthening supervision, monitoring and evaluation; 6) establishing and sustaining partnerships for implementation; 7) strengthen logistics and supply chain systems; 8) establishing a coordination mechanism; and 9) strengthening multisectoral collaboration in health.

Continuum of care, equity, partnerships and the multi-sectoral approach will be the major guiding principles of this strategy. The strategy will be anchored on the Primary Healthcare Approach, health systems strengthening and empowering families and communities especially the poor and marginalized. A phased implementation plan with timelines and benchmarks will allow for realistic attainment of the targets.

Advocacy, through operational partnerships at all levels, will be paramount in promoting increased resource mobilization and allocation towards those interventions that will lead to the intended reduction in maternal, newborn and child mortality. The organizational structure of the MOHCW will be realigned in order to integrate the main child health programmes and give child health clear visibility within the ministry. There is need for rapid recruitment, training/orientation and deployment of village health workers who will be a catalyst for enhanced community mobilization and participation in MNCH activities including community case management of selected childhood conditions.

A National Maternal, Newborn and Child Health Steering Committee (MNCHSC), chaired by the Honorable Minister of Health and Child Welfare, will promote the implementation of the Child Survival Strategy and create national awareness of the need for universal access to high impact maternal, newborn and child health interventions. From a child health perspective, the MNCHSC will be technically supported by national Child Survival Technical Working Group (CSTWG). Government ministries, development partners; civic society, FBOs, research and training institutions have well defined roles in the strategy.

A set of relevant indicators will be collected systematically from all levels of the health system in Zimbabwe. The National Maternal, Newborn and Child Health Steering Committee will task the CSTWG to develop standard operational definitions for indicators, as well as the numerators and denominators to be used while measuring each indicator. The MNCHSC will also monitor progress in implementation of the child survival strategy as part of its efforts to ensure attainment of the strategic goals and objectives. The partnerships shall also assist government in the developing the appropriate tools and mechanisms for tracking progress of implementation of the strategy. The Child Survival Technical Working Group will develop a research agenda in collaboration with training and research institutions on coverage, quality, utilization and compliance with interventions and impact of these interventions.

Chapter 1: Context for Strategy

1.1 Background

One out of every eleven Zimbabwean children dies each year before their fifth birthday (approximately 35 500 children per year). With an under-5 mortality rate estimated at 94 per 1,000 live births (MIMS 2009), Zimbabwe ranks within the top 50 countries in the world for high early childhood mortality. Over 65% of these deaths occur within the first year of life, as estimated by an infant mortality of 60 per 1,000 live births (MIMS, 2009). Within the first month, 24 neonates out of 1,000 live births die each year. This represents about 40% of the infant mortality and 28% of the under-5 mortality. In order to effectively reduce the childhood mortality trends in the country, a child survival strategy outlining the major target killers, key intervention strategies and actions, coupled with a well defined monitoring and evaluation framework, required development. This child survival strategy should be used in conjunction with the maternal and neonatal roadmap, infant and young child feeding policy, comprehensive multiyear strategic plan, HIV and AIDS strategic documents and other policy documents pertaining to child survival.

1.2 Geography, and demographic situation

Zimbabwe is a landlocked country in central Southern Africa, with a total land area of 390,757 square kilometers and a population density of 30 people per square kilometers. It shares borders with Zambia, Mozambique, South Africa, Botswana, and Namibia. The country's population was estimated to be 13,300,000 in mid-2007, of which 41 percent are children under 15 years of age. 1,706,000 people (13 percent of the total population) are children under-5 years.

According to the World Health Report of 2009, the life expectancy at birth in Zimbabwe for both sexes was estimated at 45 years. The healthy life expectancy i.e. an estimate of how many years a person might live in good health, was estimated at 39 years. Females have a lower healthy life expectancy of 38 years compared to 40 years for males.

The total fertility rate i.e. the number of children a woman would have by the end of her childbearing years in the ages 15-49 years was estimated at 3.2 in 2007. The total fertility rate has declined from 5.2 in 1990 to 3.2 in 2007. Approximately 21 percent of women aged 20-24 have their first child at 18 years. The median birth interval in Zimbabwe is 41.6 months. About one in ten children are born after too short an interval (less than 24 months) (ZDHS 2005/6).

1.3 Socio-Economic Context

Delivery of quality Maternal, Neonatal and Child Health (MNCH) services and improvement in the health status of women and children not only rest with immediate environmental and health systems, but also with socioeconomic factors including the performance of macroeconomic factors which have a bearing on health access, improvement in education levels, women's empowerment and optimization of public financing mechanisms. Since the late 1990s the country's economy, which is mostly agriculture based, began to decline. In subsequent years the country's real economic growth rates declined to negative values estimated at -12.1 percent in 2003 to the lowest rate of -14.1 percent in early 2009, ranking 215th in the world. The negative

economic growth resulted in the highest inflation record in the country's history, massive devaluation of the currency, low productive capacity, and loss of jobs, food shortages, poverty, massive de-industrialization and general despondency. The hyperinflation officially ended in February 2009 when the country changed the Zimbabwean dollar for a multi-currency economy based mainly on the United States dollar and the South African rand. The economic decline has had a profound effect on child survival through a strained health delivery system due to shortage of both human and material resources, failing health delivery infrastructure, community inability to pay for health services and general household level food insecurity.

The recent economic situation has also seen a decline in the country's expenditure on health in real terms. The general government expenditure on health as a percentage of general government expenditure did not change significantly from 7.3% in 2000 to 8.9% in 2006 (World Health Report 2009). This is not reflective of meaningful funding in health as all sectors were being affected by a hyperinflationary economic environment.

1.4 Organization of the Health System

Zimbabwe's public health delivery system is organized into a hierarchical system of four tiers namely (from the least specialized to the most specialized).

- **Level 1: Primary Health Care (Clinics / Rural Health Centers and Village Health Workers):** There are approximately 1,000 primary health care facilities comprising rural clinics and urban municipal clinics. The level comprises of a network of clinics, rural health centers assisted by village health workers, providing comprehensive promotion, preventive, curative and rehabilitative services and community based health services. The rural health centers have an establishment of 2 nurses one of whom must be trained in midwifery. These centres must be able to deliver the essential package of MNCH services which include:
 - Focused antenatal care including PMTCT
 - Postnatal care including early detection and timely referral of women/neonates with complications
 - Normal delivery using the partogram
 - Ensuring appropriate breastfeeding practices
 - Full immunization growth monitoring and promotion
 - IMNCI Services Community based health services

- **Level 2: District /Mission Hospitals.** There are 41 Government District Hospitals. These are complemented by 6 designated mission hospitals in

those districts without a government hospital. Services offered at this level are:

- Surgical procedures including caesarian section
- Safe blood transfusion
- Comprehensive emergency obstetric and newborn care
- Comprehensive management of childhood illness including paediatric emergency care

A major concern is that urban centres such as Harare do not have district or provincial level hospitals. This means patients are often referred directly to tertiary institutions which may become overburdened with conditions that can be dealt with at a lower level.

- **Level 3: Provincial Hospitals.** There are 7 provincial hospitals. They are the highest levels of referral at Province level with posts for specialized health services. However, these posts are largely vacant meaning these centres currently provide similar services to district level hospitals. Child Survival Services offered include:
 - Caesarian section
 - Blood transfusion
 - Comprehensive emergency obstetric and newborn care
 - Comprehensive management of childhood illness including paediatric emergency care
 - Management of complicated paediatric, adult medical and surgical cases referred from the district level

- **Level 4: Central Hospitals.** There are six Central Hospitals in the country, two in Harare, two in Bulawayo, Inguthseni Hospital and one in Chitungwiza. These provide specialized levels of care with specialty services for both maternal and child health. These specialties include: obstetricians and gynaecologists, neonatologists, pediatricians, and paediatric surgeons. Services offered include
 - Comprehensive emergency obstetric and newborn care especially management of complicated maternal and newborn cases
 - Specialist medical and surgical management of complicated paediatric cases such as paediatric cancer

In addition to government provided services (both central and local government), there is also an active for-profit private sector.

The Access to Health Care Services Study (2008) found that 60% of communities live within a 5km radius from the nearest health facilities, 23% live between 5 to 10 km

and 17% are over 10km. The study noted that access to health services was extremely difficult owing to lack of transport in the rural areas, and most roads were in a poor state.

1.5 Initiatives to improve maternal, newborn and child health in Zimbabwe

1.5.1 Promotion of Primary Health Care

At independence in 1980, Zimbabwe adopted the Primary Health Care (PHC) approach as the main strategy for delivering healthcare to the majority of the population, with a focus in increasing community access to health services.

The initiatives to improve MNCH within the PHC approach included: a comprehensive antenatal and postnatal care program, a well supported Expanded Program in Immunization (EPI), and community level child monitoring and surveillance through Village Health Workers (VHWs). Health care services were provided through a “supermarket approach”, where preventive and curative maternal, newborn and child health services were accessed at a single visit. Together, these initiatives resulted in a decline of early childhood mortality rates. The period of 1983 to 1988 recorded an under-5 mortality rate of 75 per 1,000 live births compared to the preceding period (1978-1982) with a rate of 104 per 1,000 live births (ZDHS/1983). The infant mortality rate declined in the same time periods, from 64 to 53 per 1,000 live births. These were early indicators of the success of the various MCH interventions being carried out.

Major gains were documented from 1980 up to the mid 1990's. Access to health facilities increased remarkably, so that 85 percent of the population was living within 8-10 kilometres of a facility. The infant mortality rate decreased by 50 percent between 1980 and 1990, from 100 per 1,000 live births to 50 per 1,000 live births. During the same period childhood full immunization coverage increased from 25 percent to 80 percent. In 1983 Zimbabwe established a Child Survival Foundation which was instrumental in advocating for a focus by government, partners and the public at large on valuing the welfare of the child. In these years child survival was supported by a health delivery system that performed well after independence but has started to show signs of decreased performance in recent years.

Zimbabwe remains committed to the PHC approach as reaffirmed in the Ouagadougou declaration on PHC and Health Systems strengthening of 2009. Zimbabwe is also party to the 2015 Millennium Development Goals (MDGs) which includes a specific target for reduction of child mortality. The Zimbabwe Maternal and Neonatal Roadmap was launched in December 2009 and is expected to help harness resources targeted towards maternal and neonatal health. Concerted efforts to prevent vertical transmission of HIV have been initiated. The PMTCT programme was launched in 1999 under the framework of the national HIV and AIDS policy of 1999, based on single dose Nevirapine. Owing to the limited effectiveness of this regimen the More Efficacious Regimen (MER) was piloted and is in the process of being rolled out, along with prioritization of pregnant women with CD4<350 to receive ART. The Nutritional Sentinel Site Surveillance System was established in November 2004 by the Government of Zimbabwe to monitor the nutritional status of

children and women. The child survival strategy is part of the ongoing efforts to improve on the health and welfare of children in Zimbabwe.

1.5.2 Creating a favourable policy and legal environment

Since 1980, health sector activities have been guided by two policy documents: “Planning for Equity in Health” of the early 1980s, and the National Health Strategy, “Working for Quality and Equity in Health” (1997-2007). The guiding policy since 2009 has been the National Health Strategy for Zimbabwe (2009-2013) - Equity and Quality in health: A People’s Right. The key principles enshrined in these documents include protection of the poor and vulnerable through exemption of user fees for all health services in the public sector, the Primary Health Care approach, and integration of preventive and curative services through the supermarket approach and use of village health workers for community mobilization. In addition the Public Health Act provides for the support and well-being of maternal and child welfare.

The Government of Zimbabwe is a signatory to a number of important international legal instruments that bind governments to create an enabling environment for delivery of maternal, neonatal and child health services. These include:

- The UN Convention for the Rights of the Child (1989)
- The International Conference on Population and Development (ICPD) Programme of Action (1994)
- The Millennium Declaration (2000)
- The Abuja Declaration (2000)
- The Regional Child Survival Strategy for the African Region developed by WHO, UNICEF and the World Bank and adopted by the 56th Regional Committee of Health Ministers in August 2006
- The Maputo Plan of Action (2006)
- Ouagadougou Declaration (2008) on Primary Health Care and Health Systems in Africa
- Africa Health Strategy

There are a number of national policies and strategies that promote child health and welfare. These include:

- The National Health Strategy for Zimbabwe 2009-2013
- Scaled Action Plans for Zimbabwe (UNICEF) 2007-2015
- Maternal and Neonatal Health Road Map 2007-2015
- Plan for the Nationwide Provision of antiretroviral therapy 2008-2012
- Zimbabwe National Programme of Action for children
- National Orphan Care Policy
- Reproductive Health Policy
- National HIV and AIDS Policy
- Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010
- National Gender Policy
- National Adolescent Health Strategy
- National Infant and Young Child Feeding Policy
- Breast-milk Substitutes and Infant Nutrition Regulations, Nutrition and HIV strategy