MINISTRY OF HEALTH AND CHILD CARE

ANNUAL REPORT 2017

Foreword

MINISTRY OF HEALTH AND CHILD CARE

ANNUAL REPORT 2017

The Honourable Minister of Health and Child Care

Dr O. Moyo

Sir,

I have the honour to present the annual report for the Ministry of Health and Child Care for the year ending 31st December 2017.

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

Major General (Dr) G. Gwinji (Rtd)

SECRETARY FOR HEALTH AND CHILD CARE

Contents

List of Tables

List of Figures

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 01 January to 31st December 2017. The profile of health facilities is presented in Table 1.

Table 1: Health Facilities Profile for Zimbabwe as at 31 December 2017

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	65	65	0
Rural Hospitals	62	62	0
Private Hospitals	32	32	0
Clinics	1,160	0	1,160
Polyclinics	15	0	15
Private clinics	69	0	69
Mission clinics	48	0	48
Council/Municipal Clinics/FHS	96	0	96
Rural Health Centre	307	0	307
Totals	**1,912**	**214**	**1,695**

1. Program Based Budgeting

The Ministry of Health and Child Care started implementing the Programme Based Budgeting (PBB) in 2015 and was able to fully plan and budget according to the PBB in 2017. The programmes and sub-programmes are shown in Table 2 below:

Table 2: Program Based Budgeting Programs and Sub-Programmes

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

Programme 1: Policy and Administration

1.1 Policy Planning and Coordination

The department is responsible for general policy development and review. The department works with other departments to develop, review, amend and update policies, legislation and regulations. The department also provides support and advice to the Office of the Minister, Permanent Secretary (PS) and other Ministry directorates in terms of preparing Cabinet papers and briefs, responses to various issues including Parliamentary queries and questions. The department has to ensure that all the laws administered by the Ministry of Health and Child Care (MOHCC) are up-to-date.

In the year 2017, the Directorate had a target to implement two of the Key Results Areas of the National Health Strategy (NHS) 2016-2020 namely:

1. Strengthening the enabling environment for service delivery
2. Improving service delivery platforms or entities

The Directorate had one outcome and ten outputs. About 80% of the outputs progressed well in 2017. Table 3 below shows the outcome and outputs for 2017.

Table 3: Summary of 2017 Performance: Department of Policy Planning and Coordination

Outcome	Output	Performance
To create an enabling environment through improved planning and monitoring of health service delivery	Medical Insurance Act	The Bill was drafted and stakeholder consultations were made. The Bill is expected to be completed in 2018.
	Health Financing Policy	The Policy was finalized and awaits launching
	Health Financing Strategy	The strategy was finalized
	Revised Health Policy	
	Donor Coordination Strategy	Donor mapping was conducted and a donor database was created though it requires improvement. A draft strategy is anticipated to be completed in 2018.
	MoHCC and HSB roles streamlined.	Stakeholder consultations were conducted countrywide. Principles of the Health Services Act Amendment Bill were drafted and to be presented to Cabinet.
	Public Private Partnership Policy.	The National PPP framework was launched and principles for the health sector specific policy is expected to be completed in 2018.

	Policies harmonised to the National Health Strategy	More than 60% of the existing policies were aligned to the NHS and all new policies and strategies in 2017 are aligned to the National Health Strategy.
	Community Participation and involvement Policy	The policy was not developed in 2017. However, a community health framework was developed in 2017 and the Village Health Workers' Strategy was finalized. The plan in 2018 is to develop the Community Health Policy.

1.2 Human Resources for Health (HRH)

The HRH directorate's main purpose is provide effective leadership and partnership in planning, leading, organizing, controlling, developing, implementing and administrating HRH function. The HRH directorate directs HRH efforts towards the corporate and strategic objectives of the MOHCC line with the NHS. The Directorate focuses on the following four major HRH priority areas:

1. HRH Information Management and Research
2. Production, Training and Development
3. Recruitment, Selection, Deployment, Retention, Management, and Utilization
4. HRH Policy, Planning and Financing

The HRH Strategic Plan 2017-2020 was developed, with the MOHCC Induction Manual finalized. The overall staff vacancy rate in the MoHCC was at 19% in April, reduced to 17% in July and was at 16% as at 31 Dec 2017. There were 2,250 posts (2000 nurses and 250 doctors posts created in 2017). The total number of staff on retention scheme in 2017 was 21472. All 63 districts in the country had a functional Human Resource Information System (HRIS) as at 31 December 2017.

Table 4: Posts in the Public Health Sector as at 31st December 2017

Ownership	Establishment	In Post	Vacant
MOHCC	37,691	31,682(84%)	6,009(16%)
Missions	5,024	4,635(92%)	389(8%)
RDCs	3,428	2,913(87%)	515(13%)
Total	**46,143**	**39,176**(87%)	**6,913**(15%)

The Ministry of Health and Child care had 84% of the total establishment filled with only 16% vacant posts. Missions had the least vacancy rate of 8% followed by RDCs at 13%. Nationally there was a vacancy rate of 15% as at December 31St 2017.

Table 5: Summary of establishment strength (Selected professionals) as at 31st December 2017

Category and Designation	Authorised Establishment	In Post	Vacant
Top Management	82	50 (61%)	32 (39%)
Doctors	1,851	1,324 (72%)	527 (28%)
Nurses	20,876	18,784 (90%)	2,092(10%)
Pharmacists	589	361 (61%)	228 (39%)
Laboratory	644	359 (56%)	285(44%)
Radiography	512	263 (51%)	249 (49%)
Environmental Health	2,494	1,706 (68%)	788 (32%)

Radiography had a vacancy rate of 49% as of December 31st 2017, followed by laboratory with a 44% vacancy rate. The lowest vacancy rate came for nurses, which exhibited a 10% vacancy rate as of December 31st 2017, followed by doctors with a 28% vacancy rate.

Table 6: Summary of Establishment Strength (support staff) as at 31st December 2017

Designation	Establishment	In Post	Vacant
HRO	92	81 (88%)	11 (12%)
HRA	561	359 (64%)	202 (36%)
Executive Assistant	342	219 (64%)	123 (36%)
Accounting Assistant	337	280 (83%)	57 (17%)
Audit Assistant	7	6 (86%)	1 (14%)
Accounts Clerks	190	147 (77%)	43 (23%)

In terms of established positions for support staff, Human Resource Assistant (HRA) and Executive Assistants had the highest vacancy rate of 36% a piece, followed by Accounts Clerks with 23% vacancy rate as at December 31st 2017.

Table 7: Summary of establishment strength (support staff) as at 31st December 2017

Designation	Establishment	In Post	Vacant
PHSA	12	8 (67%)	4 (33%)
HSA	56	40 (71%)	16 (29%)
Admin Officer	19	15 (79%)	4 (21%)
Admin Assistant	289	222 (77%)	67 (23%)
Ambulance Driver	522	423 (81%)	99 (19%)
General Hand	118	89 (75%)	29 (25%)
Laundry Hand	171	121 (71%)	50 (29%)
Hospital Hand	458	381 (83%)	77 (17%)

Provincial Health Services Administrator (PHSA) had a vacancy rate of 33% as of December 31st 2017 while Health Service Administrator (HSAs) and Laundry Hands had 29% vacancy rates a piece. The ambulance drivers had the least vacancy rate of 19% as of December 31st 2017.

Table 8: New Rural Health Centres/Clinics Requiring an Establishment as at 31 December 2017

	GOZ	RDCs	Missions	Total
Mash East	0	11	0	11
Mash West	6	26	1	33
Mash Central	1	24	0	25
Manicaland	9	9	3	21
Midlands	3	28	1	32
Masvingo	6	19	2	27
Mat North	1	18	1	20
Mat South	2	10	1	13

The newly established Rural Health Centres (RHCs)/ Clinics requiring an establishment are 33 in Mashonaland West followed by 32 in Midlands, 27 in Masvingo and 25 in Mashonaland Central. In total 182 new posts are required to staff the new facilities throughout the country as of December 31st 2017.

1.3 Finance and Administration

The total budget allocation for 2017 was $351,244,754, of which Treasury releases were $346,368,329. In 2017, Treasury made an effort to honor all the releases in cash, however, outstanding cash was $6,250,660. Furthermore the budget allocation for the Ministry was insufficient to cover hospital operations. The expenditure and the relevant analyses are presented below.

Table 9: Government of Zimbabwe Budgets and Expenditure for 2017: Economic Classification

Economic Classification	Total Funds Allocated	Cumulative Releases
Employment Costs	206,058,714	205,748,149
Goods and Services	7,985,412	6,280,738
Medical Supplies and Services	29,130,865	29,112,863
Maintenance	376,140	260,389
Current Transfers	86,529,836	86,299,596
Special Initiatives	-	-
Hospitals and health Centres	13,137,513	11,919,669
Acquisition of Fixed Capital Assets	6,916,274	5,950,315
Capital Transfers	100,000	57,610
Total	**350,234,754**	**345,629,329**

In Table 10 below, the expenditure by Program Based Budgeting (PBB) classification is presented. The bulk of the budget was allocated to Primary Health Care and Hospital Care.

Table 10: Expenditure by PBB Classification

Programmes	Total Funds Allocated	Cumulative Released
Programme 1: Policy and Administration	18,539,607	16,727,057
Programme 2: Public Health	11,131,356	10,539,465
Programme 3: Primary Health Care and Hospital Care	320,563,791	318,362,806
Total	**350,234,754**	**345,629,329**

The bulk of the budget allocation was for Programme 3, which constituted 92% of the total budget. However, much of the expenditure was meant to cover employment costs. The other expenditure was mainly for Administration and Management (including salaries).

Table 11: 2017 Cash Releases from Treasury: Operation Only

Programme Summary	Cash Applied	Cash Received	Outstanding Cash
Programme 1: Policy And Administration	12,558,270	11,842,521	715,749
Programme 2: Public Health	8,225,468	7,801172	424,296
Programme 3: Primary Health Care And Hospital Care	277,744,922	272,634,307	5,110,616
Grand Total	**298,528,661**	**292,278,001**	**6,250,660**

Most of the cash applied for in 2017 from Treasury was honored. A large amount of outstanding cash was for Programme 3. The difference between the total expenditure and the cash expenditure comes from the direct payments, (set offs and salaries paid directly to SSB). Table 12 below summarizes the funds allocated and the cumulative releases per cost category.

Table 12: Expenditure Trend Analysis

Economic Classification	2016		2017	
	Total Funds Allocated	Cumulative Releases	Total Funds Allocated	Cumulative Releases
Employment Cost	200,310,000	214,334,752	206,058,714	205,748,149
Goods and Services	1,983,000	2,840,277	7,985,412	6,280,738
Maintenance	356,000	292,778	376,140	260,389
Current Transfers	80,809,000	84,273,264	86,529,836	86,299,596
Programmes*	2,525,000	1,854,869	-	-
Acquisition of Fixed Capital Assets	20,109,000	5,177,805	6,916,274	5,950,315
Medical Supplies and Services	8,305,000	7,385,334	29,130,865	29,112,863
Hospitals and Rural Health Centres	11,771,000	9,957,129	13,137,513	11,919,669
Capital Transfers	4,621,000	2,992,138	100,000	57,610
Total	**330,789,000**	**329,108,346**	**351,244,754**	**346,368,329**

*Following the adoption of the new chart of accounts, programs are not recognized as economic classification. Thus the line items previously classified as Programs now fall under Goods and Services.

Employment costs continue to consume the largest share of the budget (58% of the allocation). In comparison to 2016, in 2017, $20,825,865 more was allocated for medical supplies and services. Most of the budgeted funds were utilized in 2016 as compared to 2017 in which $4,876,425 of the budgeted funds were not utilized.

Table 13: Per Capita & Budget Allocation Trend Analysis

Year	2018	2017	2016	2015	2014	2013
Per Capita GDP Allocation	26.9	21.69	25.45	23.15	25.92	24.44
Budget Allocation /Total Government Budget	9.04%	6.88%	7.46%	6.57%	8.18%	8.23%

In Table 13 above, the Per Capita & Budget Allocation Trend Analysis is presented. The budget allocation as a proportion of the total budget for the years 2013 to 2018 is presented in Figure 1 below.

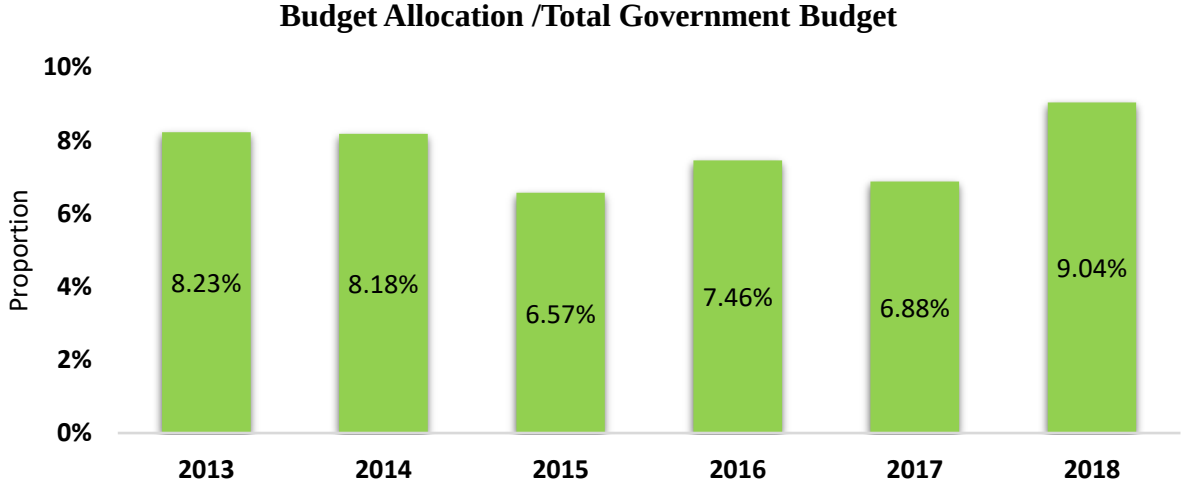


Figure 1: Budget Allocation/Total Government Budget 2013-2018 (Abuja ratio)

The 2017 Abuja ratio was 6.88% which remains below the target, and is also less than the ratio for the previous year. Based on the NHS Scenario 2, which requires the Ministry to be funded up to $1.3bn, our ideal per capita would be $96.2, giving a difference of $69.3 with the expenditure target received from Treasury.

Table 14: Budget Utilization Update, Global Fund as at 31 December 2017

Grant	Total Budget	Cum Budget – As at 31 Dec 2017	Cum Expenditure as at 31 Dec 2017.	Burn Rate
TB	38,789,239	28,734,805	25,305,516	65 %
Malaria	67,663,405	57,837,583	53,070,620	78 %
HIV	50,464,724	39,041,073	37,640,601	74 %
Total	**156,917,370**	**125,613,462**	**116,016,738**	**74 %**

The three Global Fund grants performed well, however TB had a lower burn rate. This was because some procurements that took place late in 2017 spilled into 2018. In addition, there were competing activities as well as deferred implementation of some of the activities.

Table 15: Budget utilization update: Partners (Head Office) as at 31 December 2017

Donor	Cash Disbursement	Expenditure
HDF	63,465,845	52,124,575
Sightsaver	18,399	19,389
WHO	31,400	31,178
END Fund	866,343	643,886
Total	**64,381,988**	**52,819,029**

Most of the donor budget provided was utilized in the period under review.

Ministry's Revenue Sources (Domestic Resource Mobilisation)

The Health Services Fund, is a Ministry of Health fund for collections from the health fees paid by eligible patients. The funds collected in 2017 are presented in Table 16.

Table 16: Debtors as at 31 December 2017

Station	Budget	Collections	Expenditure	Projections
Parirenyatwa	13,000,000	13,634,603	13,328,970	17,079,000
Central Hospitals	12,874,000	12,267,608	11,280,062	12,395,000
Provinces	10,501,000	13,607,781	12,560,236	14,262,500
Government Analyst	35,000	51,374	49,914	32,000
Harare Dental	102,000	84,193	82,528	72,500
Total	**36,512,000**	**39,645,561**	**37,301,712**	**43,841,000**

Outstanding Creditors

Outstanding creditors as at 31 December 2016 were $67m, and $54m as at 31 December 2017. There is slow recovery of debts, which may necessitate their writing off and use of ICT platforms for debt collection. This is presented in Table 17.

Table 17: HSF Cashflow Statement as at 31 December 2017

Station	Balance As At 31 December 2016	Debtors Raised 2017	Payments	Balance As At 31 December 2017
Parirenyatwa	56,000,000			48,778,175
Central Hospitals	80,453,079			90,048,040
Government Analyst	48,594			48,106
Harare Dental	56,636			72,8534
Provinces	26,827,974			38,686,617
Totals	**163,386,283**			**87,585,752**

Port Health Services

In line with government policy regarding ease of doing business, the Zimbabwe Revenue Authority (ZIMRA) is now collecting Port Health fees on behalf of the MOHCC. The collected fees from all ports of entry are remitted to Head Office on weekly basis. Head Office retains 35%, while the beneficiary hospitals and PMDs get 40% and 25% respectively of the fees collected from border posts within their jurisdictions. Head Office has opened a Health Services Fund (HSF) account, primarily for purposes of managing the Port Health fees remittances from ZIMRA.

Total fees collected as at 31 December 2017 amounted to $331,153 Income and expenditure from Port Health fees is accounted for under the HSF.

Health Fund Levy

The Health Fund Levy (HFL) is a government levy of 5% on every dollar purchase of airtime and mobile data. Of the total 10% duty collected from airtime, half (5%) is retained by the Ministry of Finance and the other half (5%) goes to the MoHCC as the HFL.

The Finance Act (No. 2) 2017 explains the HFL as follows: "*The rate of special excise duty on airtime shall be ten per centum of the sale value of airtime, five per centum of which shall be designated as a Health Fund Levy and be credited to a fund established under section 18 of the Public Finance Management Act [Chapter 22:19] for the purchase of drugs and equipment for Government hospitals, provincial hospitals and district and general hospitals as defined in the Health Services Act [Chapter 15:16].*"

The PS constituted a health committee to manage the fund. The committee resolved to focus on high impact interventions and areas not funded by partners. These areas included procurement of blood and blood products; non communicable disease medicines; medicines used in anesthesia; any other significant public health commodities; and to support renal service through procurements of consumables and servicing of equipment. In addition, there was a deliberate effort to target the secondary level facilities upwards, which are not covered by Health Development Fund (HDF) for medicines.

The available funding under the HFL as at 31 December 2017 was US$22,701,863. This amount was used as indicated in Table 18 below.

Table 18: Summary of Health Levy Utilization

Actual Cash Transferred to Suppliers	
	Amount US$
Natpharm - Drugs and Medicines	3,025,093
GAVI- Rubella Pre-Financing	276,255
UNICEF- Drugs	7,600,000
GAVI- Co-financing	600,000
Datlabs- Central Hospitals Drugs	230,000
National Blood – Subsidy	4,700,000
Total Payments Made	**16,431,349**
Allocated Pending Payments	
Medicines	1,789,214
Laboratory reagents	3,341,000
Laboratory Equipment	286, 500
Blood Coupons: Maternal Health	840,000
Blood Coupons Printing	4,800
Total Pending Payments	**6,270,514**
Total	**22,701,863**

When it came to the US$3,025,093.96 allocated to Natpharm, it was used as follows: As at 31 December, US$1,512,362 worth of commodities had been distributed across the country, leading to a notable improvement of medicine availability. A stock holding of US$1,414,303 was at NatPharm. There was apparent low utilization of the HFL due to the unavailability of foreign currency, so committed procurements could not be paid on time. In addition, suppliers are being adversely affected by liquidity challenges and regulatory issues, lengthening the process of payment to primary manufacturers outside the country, resulting in increases in delivery lead times. The MoHCC continues to lobby the Reserve Bank of Zimbabwe (RBZ) for prioritisation in foreign currency allocations to the Health Levy.

1.4 Monitoring and Evaluation

Although it was only activated in September, when the first employee, (i.e. the director) was hired, the Department of Performance Monitoring and Evaluation managed to develop a draft Health Sector Performance M&E Policy Guidelines and Strategy. In coming up with this draft document, the department hired a consultant to develop the M&E Policy guidelines and strategy through a rigorous situational analysis and stakeholder consultative meetings. The department also developed the NHS Performance Framework, being the much awaited Annex to the National Health Strategy 2016-2020. Figure 2 below show the status of the M&E department deliverables as at December 31st 2017.

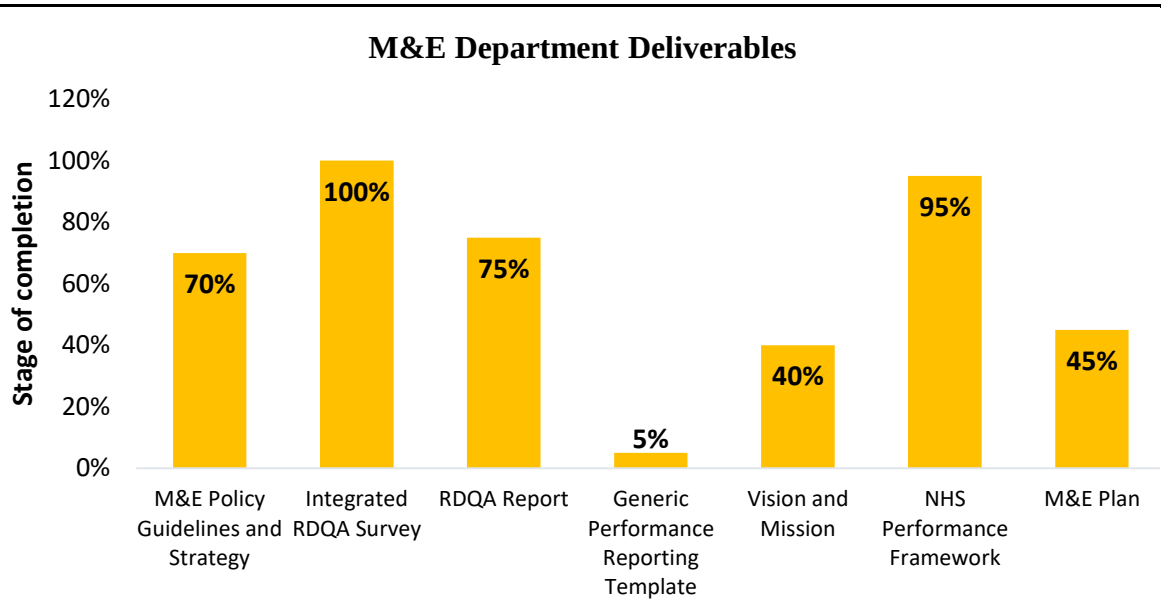


Figure 2: M&E Department Deliverables

The data in Figure 2 above shows that the M&E department has managed to develop a draft M&E Policy Guidelines and Strategy, which was at 70% completion by December 2017. Furthermore, the department successfully commissioned a Routine Data Quality Assessment (RDQA), while the RDQA draft report was at 75% completion as at December 2017.

The M&E department managed to initiate the process of developing a performance reporting template which was at 5% by the end of 2017. The departmental vision and mission development was at 40% while the performance NHS tracking performance framework was at 80%. The M&E plan for the MoHCC was at 90%.

Health Information and Surveillance:

The District Health Information System 2 (DHIS2) system was customised to accommodate community data reported by Village Health Workers (VHWs). The generic report, which is produced monthly, was also customised to be reported through DHIS2. The unit is also working closely with Harare Polytechnic, which is offering a health information management course at certificate, diploma and higher national diploma levels. Discussions are underway to have a Bachelor of Technology in the same course. Training in DHIS2 was conducted for national office managers. There was production and sharing of the weekly disease surveillance bulletin for all the 52 weeks in 2017. The 2018 to 2022 National Health Information Strategy is under development.

Reporting Coverage: For any data to be used, it has to be measured against its quality. Completeness and timeliness are some of the key dimensions of data quality. Below is a set of key reports that are submitted on a monthly or quarterly basis, with the corresponding reporting rates (completeness) achieved in 2017.

Table 19: Reports that are Submitted on a Monthly or Quarterly Basis

Name	ART	HS3/5	OPD	Psych	TB	VHW
Bulawayo Central Hospitals	74.1	45.8	43.1	25.0	0	
Bulawayo Province	40.6	50.0	88.2	7.5	98.9	8.3
Chitungwiza City	62.2		97.9	0	100	0
Harare Central Hospitals	70	25.8	71.7	15.7	50	
Harare Province	82.7	14.1	90.0	0	85	0
Manicaland Province	89.4	99.3	99.2	50.5	95.4	91.6
Mashonaland Central Province	80	100	96.7	64.0	98.7	51.0
Mashonaland East Province	80	59.3	98.3	78.3	97.5	73.2
Midlands Province	98.2	95.1	99.4	70.5	99.2	69.3
Matabeleland North Province	84.2	84	97.8	89.6	98.1	59.8
Matabeleland South Province	94	81.1	99.3	72.8	98.8	83.9
Masvingo Province	98.8	84.2	97.7	66.8	94.8	52.9
Mashonaland West Province	98.8	95.1	95.3	83.3	99.1	62.6
Zimbabwe Ministry of Health	81.0	69.9	90.4	48.0	92.9	50.2

Key: %

85-100		75-84		0-74		N/A	

The most affected report is the VHW, which is a report submitted by VHWs to the clinic/hospital. This is followed by the psychiatry services report. Other reports are doing relatively well. Hospitals are the most affected institutions.

Challenges: Poor Internet bandwidth remains one of the key challenges. This compromises access to data. Most of the Health Information Systems are implemented through web based platforms, making it a requirement that internet be available to support access to the online resources. The Inpatient Mortality and Morbidity Information System (IMMIS) regularly malfunctions, resulting data on in-patients not being reported. This has impacted negatively on the key consumers of the data who have since failed to measure their performances.

Opportunities: More functionality in DHIS2 has offered more solutions to problems in data management to include customisation of several reports. Having started as entirely an aggregate based system, DHIS2 has been scaled up to include case based data. Users are now able to incorporate tracking of events and patients within the system. The Electronic Patient Management Systems **(**ePMS) and Electronic Health Record (EHR) are similar systems, which, if integrated, will provide a good opportunity to improve management of health records. In addition, they can assist in the reduction of workload on health care workers, as they offer services at various levels of health care.

Recommendations: Integration and linking of systems, for example, through an interoperability layer, harmonized data collection tools and improvement of internet bandwidth at all levels.

1.5 Quality Assurance / Quality Improvements

The Quality Assurance (QA) and Quality Improvement (QI) department endeavours to improve the entire MOHCC performance. This will be achieved through implementing a quality management system that will be based on addressing critical success factors. Top most is the establishment of a documented system, training and allowance for implementation, evaluation and taking of corrective action. Through a collaborative approach with other departments, the department hopes to epitomize processes for quality service continuity through customer engagements, supply chain management, staff training, information management, document control, safety evaluations, audits and performance evaluations. The directorate has set itself several goals to be able to track the effect of the organizational efforts for informed decision making in future. Table 20 shows the departmental performance for 2017.

Table 20: Summary of QA/QC 2017 Performance

Outcome	Outputs
Quality Improvement and Quality Assurance program institutionalized across health facilities and institutions	5S program implemented in 12 hospitals (3 Central, 8 Provincial and 1 General) and the hospitals are quarterly supervised and provided with cameras and laptops
	DHEs in 18 rural and 2 urban districts and PHEs in 8 provinces successfully administering quality checklists using tablets
	MNCH focused CQI being implemented in a DH and 5 RHCs per district in each of the 5 provinces and the facilities receive quarterly coaching visits by provincial and district coaching teams
	Pocket guide for QI produced and distributed
Coordination and monitoring mechanism for Quality Improvement and Quality Assurance strengthened	Provincial level QI coaching teams established in 5 provinces. The teams are composed of PHEs members and co-opted members
	The coaches were given Training of Trainers (ToT) and tools to conduct coaching, and have managed to conduct quarterly visits to hospitals implementing CQI programs
Quality Component of RBF program strengthened	In the revised PIM for RBF, the proportion of contribution of quality to RBF subsidies is increased to 50% and 60% at Primary and Secondary level, respectively
	In the revised PIM for RBF, it is highlighted that CSS will be conducted by CBOs in all the 60 districts and a mix method of exit and tracing mechanism will be utilized interchangeably, quarterly.
	CSS will be conducted using mobile phones by CBOs

Key Recommendations: From a quality perspective, the QA/QI Department believes team work needs to be improved in terms of transparency and accountability. This should start from the top and cascade down to lower levels. For sustained continuous improvement this needs to start with:

- Performance management and target setting at departmental and individual level
- Introduction of internal audits and sharing of audit findings
- Leadership commitment to close identified gaps

Programme 2: Public Health

In 2017, there were reported cases and deaths from diseases that are classified as notifiable in Zimbabwe, as shown in Table 21 below. Typhoid was the notifiable disease with the highest number of cases reported in 2017, while rabies had the highest number of deaths and case-fatality rate.

Table 21: Notifiable Diseases Reported in January to December 2017

Notifiable Disease	Suspected	Confirmed	Deaths	CFR (%)
Typhoid	2032	155	0	0
Cholera	6	1	3	42.9
Rabies	16	---	16	100
Anthrax	124	---	3	2.5
Poliomyelitis	169	0	0	0
Measles	608	0	0	0
Neonatal Tetanus	3	0	0	0
Meningococcal Meningitis	5	---	0	0

Key: --- Information not available.

There were no reported cases of the following notifiable diseases in the country from January to December 2017: Meningococcal Meningitis, Plague, Yellow Fever, Viral Haemorrhagic Fever, Diphtheria, Hepatitis and Typhus fever.

Epidemic-prone diseases, Deaths and Public Health Events for 2017 were also documented as shown below.

Table 22: Epidemic-Prone Diseases and Deaths as at 31 December 2017

Condition	Suspected	Confirmed	Deaths	CFR %
Malaria	394 235	394 235	524	0.13
Dysentery	29 941	29 941	133	0.45
Anthrax	124	---	3	2.5
Rabies	16	---	16	100
Meningococcal Meningitis	5	---	0	0
Cholera	6	1	3	42.9
Common Diarrhoea	556 086	556 086	1457	0.26
Hepatitis	11	0	0	0

Source: (MoHCC HMIS 2017)
Key: --- Information not available.

2.1 Communicable Disease

The Communicable Diseases Unit in 2017 had to deal with a cholera emergency in Manicaland Province, as well as a typhoid outbreak in Harare City and other areas. In 2017 the Unit coordinated the 6th Mass Drug Administration (MDA) for schistosomiasis and intestinal worms, 2nd MDA for lymphatic filariasis in 39 Districts and 2nd MDA for Blinding Trachoma in 3 districts.

Timely detection and control of epidemic prone diseases

Cholera: In 2017 two cholera outbreaks were reported in Zimbabwe, with Mutare and Chipinge districts having a cumulative figure of 6 suspected cases, 2 confirmed cases and 1 death. The death was a result of an imported cholera case from Mozambique detected at Forbes Border Post. These cholera outbreaks were detected within 48 hours, reported to the next level within 24 hours and controlled within 2 weeks.

Typhoid Fever: Zimbabwe experienced a typhoid outbreak in October, which started in Harare City and spread to other provinces. Harare was the most affected area accounting for 68.1 % of the total cases. The outbreak was also experienced in Hurungwe district (Mashonaland West) specifically in Bashungwe rural area. The following table shows areas where cases of typhoid were reported in Zimbabwe in 2017.

Table 23: Typhoid Fever Suspected and Confirmed Cases by Province, 21 Oct-19 February 2017

Province	District/ Hospital	Date of Onset of Outbreak	Suspected Cases	Confirmed Cases	Deaths
Harare	Harare City	13-Oct-16	1270[1]	74	4
	Harare Central Hospital		276	3	2
Mash Central	Mazowe Shamva	1-Dec-16	99	1	0
Mash West	Hurungwe	13-Dec-16	170	5	0
Mash East	Marondera Murehwa	22-Jan-17	25	0	0
Manicaland	Mutare	Unknown	8	2	0
Masvingo	Bikita	13-Nov-16	9	0	0
Total			**18,985**	**85**	**8**

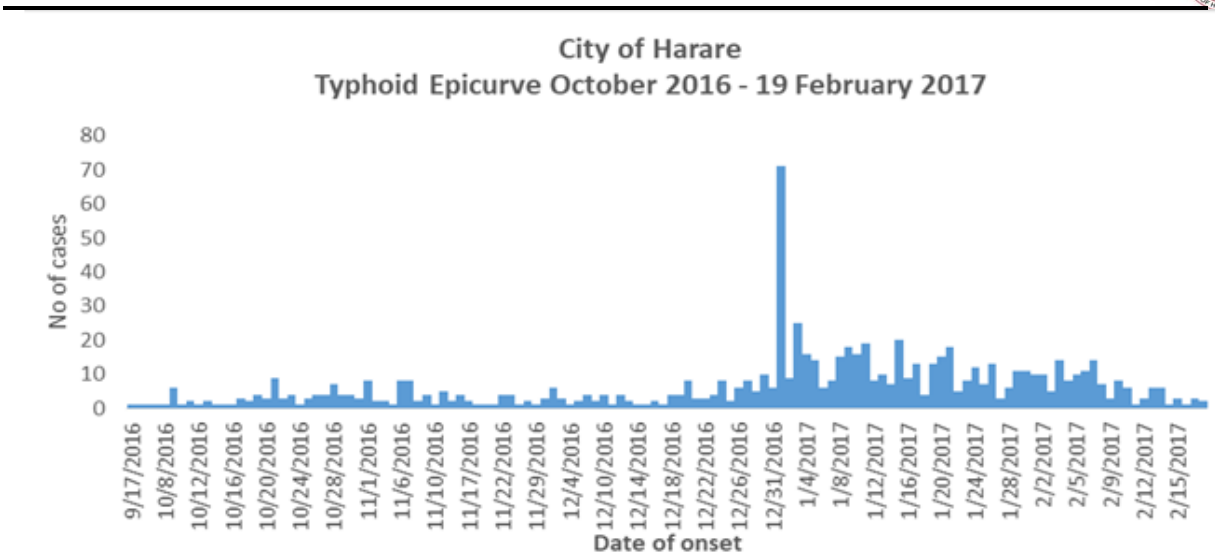


Figure 3: Epicurve of Suspected and Confirmed Cases of Typhoid Fever in Harare City, Oct 2016-19 February 2017

Response to Typhoid Outbreaks in 2017 and Emergency Preparedness and Response (EPR)

The unit coordinated the formation of an Inter-Ministerial Committee on typhoid to coordinate outbreak response at national level, which was chaired by the Hon. Minister of Health. It comprised of Minister Local Government, Public Works and National Housing; Minister Small to Medium Enterprises; Minister of Environment and Water and Climate; Ministry of Defence; State Security, Office of the President and the Minister of Information. Other departments were also co-opted into the committee. The Communicable Disease Unit activated emergency response mechanisms and the National Command Centre through the National Rapid Response Team (NRRT). This coordinated the typhoid control activities and offered advice to the Ministerial Taskforce Committee. The NRRT met on a daily basis during January and February 2017 to coordinate typhoid control activities.

The following graphs and tables illustrate other epidemic diseases reported in 2017

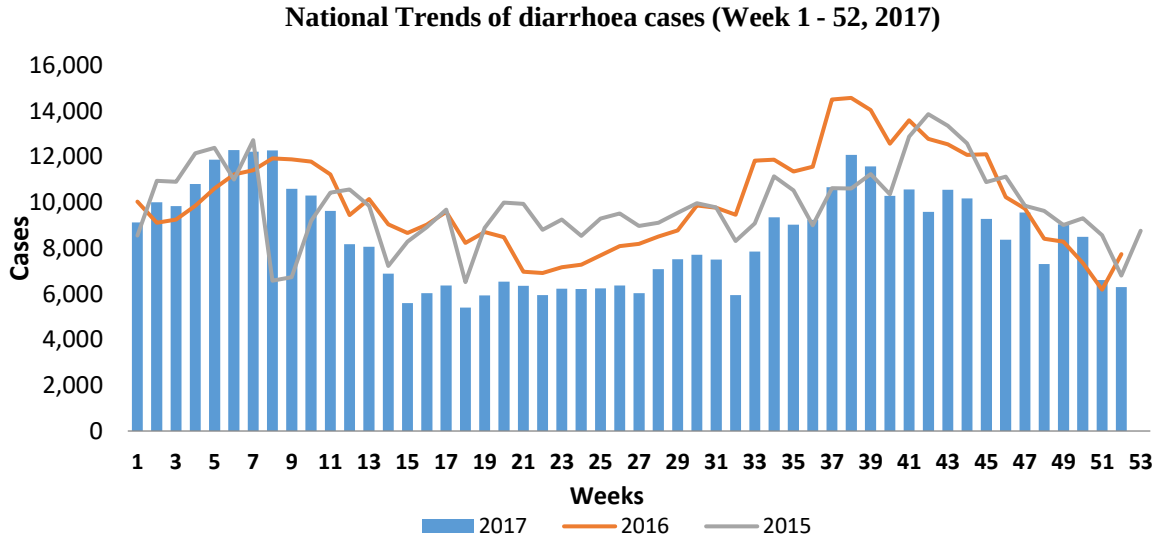


Figure 4: National Trends of Diarrhoea Cases

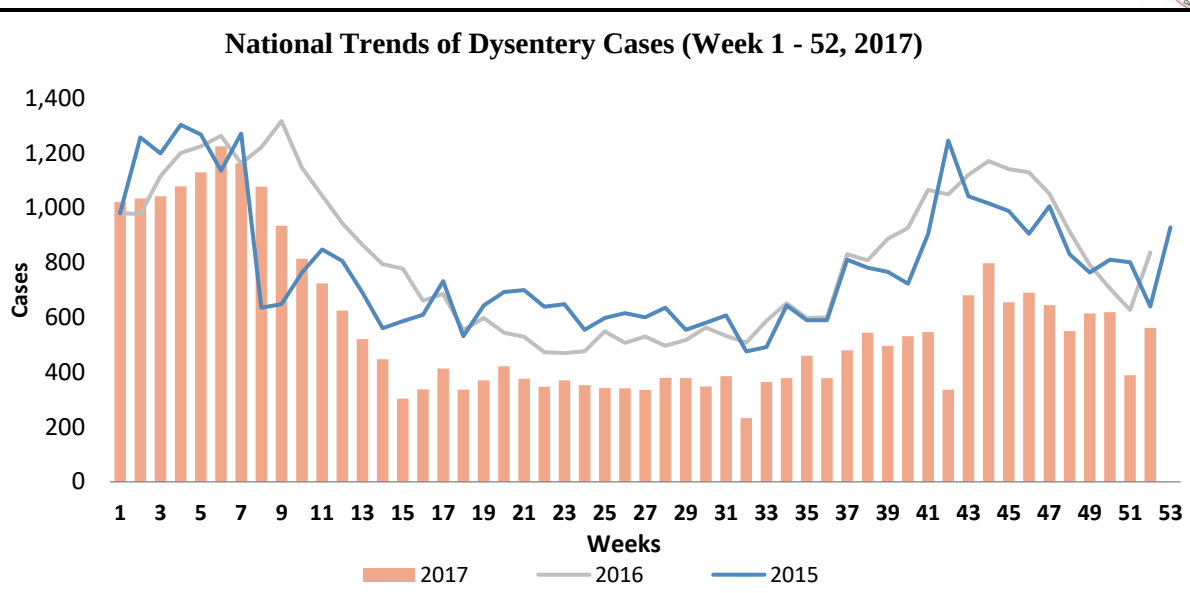


Figure 5: National Trends of Dysentery Cases

Table 24: Anthrax Cases and Deaths 2017

District	Cases	Deaths
Buhera District	9	0
Mutare District	1	0
Mazowe District	13	0
Shamva District	1	0
Gokwe North District	12	0
Gokwe South District	2	0
Binga District	13	1
Lupane District	3	0
Hurungwe District	3	0

Table 25: Rabies Cases 2017

Province	Cases	Deaths
Manicaland	1	1
Mashonaland Central	1	1
Mashonaland East	5	5
Mashonaland West	1	1
Masvingo	3	3
Parirenyatwa Hospital	1	1
Chitungwiza Central Hospital	3	3

Schistosomiasis, Soil Transmitted Helminths and other NTDs

The mapping of Neglected Tropical Diseases (NTDs) in Zimbabwe was first done in 2010-2011 nationwide for Schistosomiasis (SCH) and soil transmitted helminths (STH), which was followed by the first ever Mass Drug Administration (MDA) in 2012 for the two diseases mentioned above. The country has 57 out of 63 districts which are endemic for SCH, and 46 districts endemic for STH.

The MDA for SCH and STH conducted in 2017 was the 6th round of MDA for the 2 diseases, targeting school aged children (SAC) 5-15 years for SCH and pre-school, and SAC 1-15 for STH. For SCH, the program reached a total of 2,789,926 of a targeted 3,434,714, resulting in a coverage of 81.2%. Coverage of 64% was reached from a targeted 4,225,010 children for STH.

The National Lymphatic Filariasis (LF) survey conducted in 2014 in all 63 districts in Zimbabwe revealed that 39 districts were endemic for the disease. The 2nd round of LF MDA (2017) reached a total of 3,605,650 people out of 6,974,488 (51.7% coverage). Due to the low coverage, there is an ongoing exercise in the 32 districts that failed to reach 65% coverage.

A trachoma survey was conducted in 2014-15, and out of the 63 districts, only 16 were mapped due to resource constraints. The results indicated that 11 districts were endemic, 3 of which had active trachoma also called follicular trachoma (TF), or inflammatory trachoma; of between 10.0 and 29.9%; whilst 8 had TF of between 5% and 9.9%. The first Trachoma mass drug administration, (MDA) using oral Azithromycin and Tetracycline eye ointment was conducted in Binga District in Matabeleland North Province in 2016. In 2017, with additional funding, the Trachoma MDA was conducted in 3 more districts namely Centenary (Mashonaland Central), Lupane (Matabeleland North), and Gokwe South (Midlands) that require 3 rounds of MDA. Zimbabwe is planning to map an additional 20 districts in 2018.

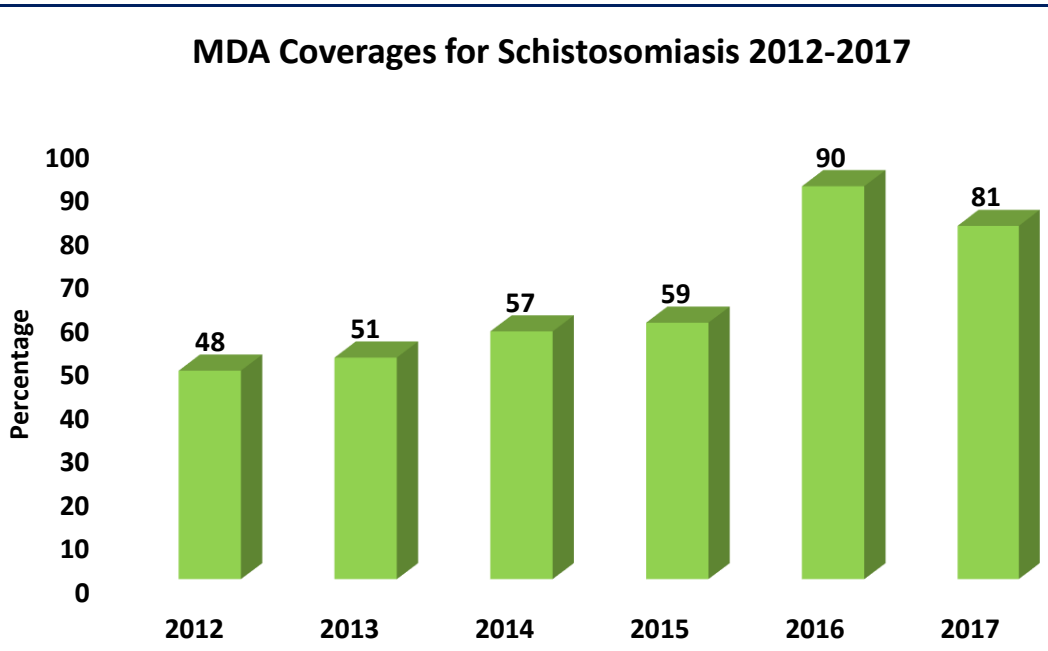


Figure 6: MDA Coverage for Schistosomiasis 2012-2017

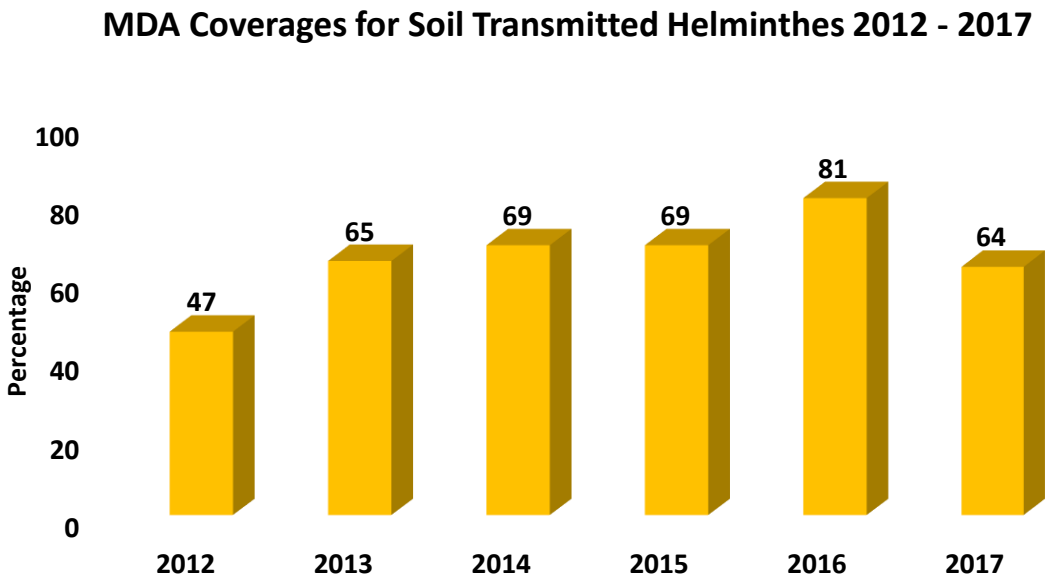


Figure 7: MDA Coverage for Schistosomiasis 2012-2017

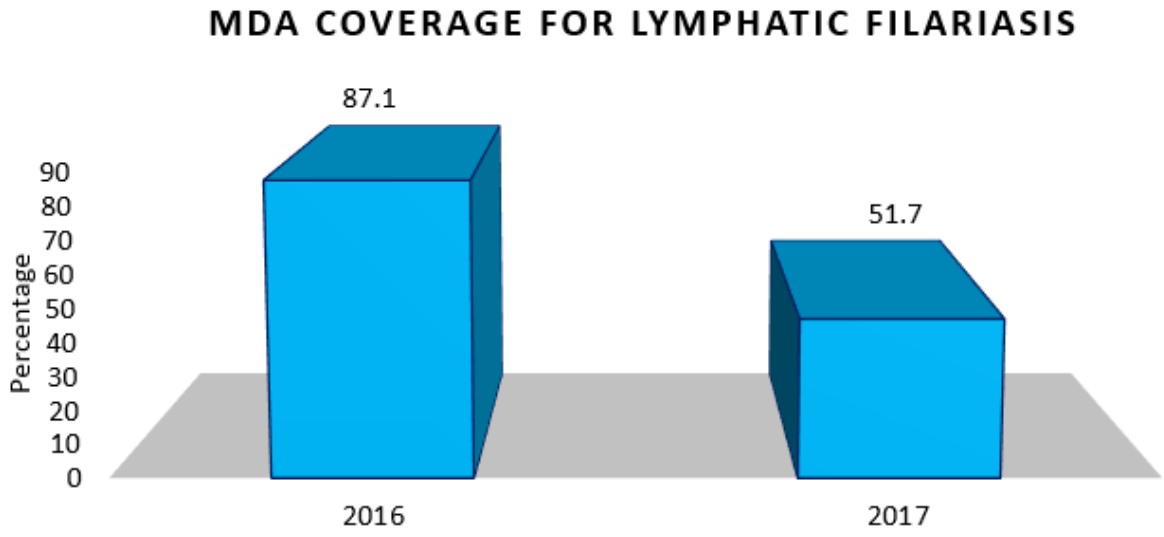


Figure 8: MDA Coverage for Lymphatic Filariasis 2012-2017

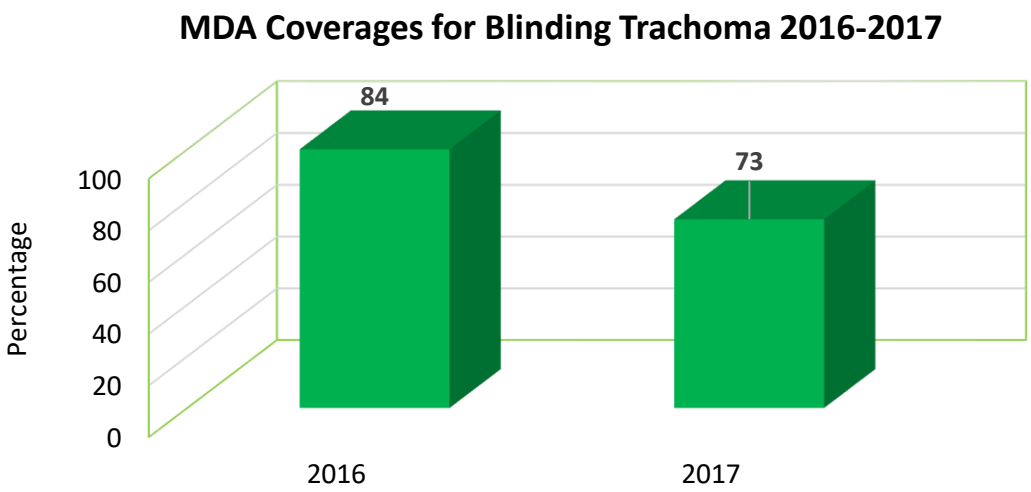


Figure 9: MDA Coverage for Blinding Trachoma 2016-2017

Performance Self-evaluation in the NTD Program

The initial 2017 MDA implementation was held in Manicaland as the program had to utilize the medicines that were about to expire. Training of Trainer (TOT) activities at national, provincial and district levels were conducted successfully. A multi-sectorial approach was utilized for communication during the program implementation. This included the use of village health workers to carry out interpersonal communication, distribution of Information, Education and Communication (IEC) material, electronic and print media such as press, TV and radio. This was done to ensure comprehensive communication and social mobilization. The incorporation of Vitamin A supplementation into the MDA campaign enabled funds to be pooled together from UNICEF.

Challenges in Epidemic Disease Control Activities

1. There is need for a multi-sectoral strategic approach to improve the water supply, hygiene and sanitation in the country.
2. There is insufficient communication between districts and national level for better case reporting. The situation in the provinces out of Harare is not well documented, resulting in discrepancies between data reported in DHIS2 and Line lists.
3. There is lack of laboratory capacity to support epidemiological surveillance, especially in remote areas.
4. Some areas were not accessible due to floods, and this resulted in extension of the implementation period.
5. There was political uncertainty and political gatherings which coincided with the MDA implementation.
6. Competing programs in health that coincided with the implementation MDA activities resulted in some of the targeted population not being reached.
7. The integration of Vitamin A supplementation with the MDA campaign resulted in healthcare workers being overwhelmed, as they had to execute multiple tasks for both programs.
8. Religious objectors/ Medicine objectors in some areas limited participation in the program.

Recommendations:

1. Support is needed for the strengthening of laboratory capacity of provincial hospitals in the affected provinces for early diagnosis and rapid response**.**
2. There is need to cconduct a case-control study to identify other risk factors associated to typhoid fever in the country in Harare.

2.1.1 Malaria

The routine malaria surveillance system in districts of Zimbabwe has enabled the National Malaria Control Program (NMCP) to identify places within districts that have ongoing transmission, the seasonality of malaria transmission and populations at risk in these areas. The transmission of malaria is heterogeneous in the low burden districts, with some areas continuing to have malaria transmission despite preventative interventions being deployed.

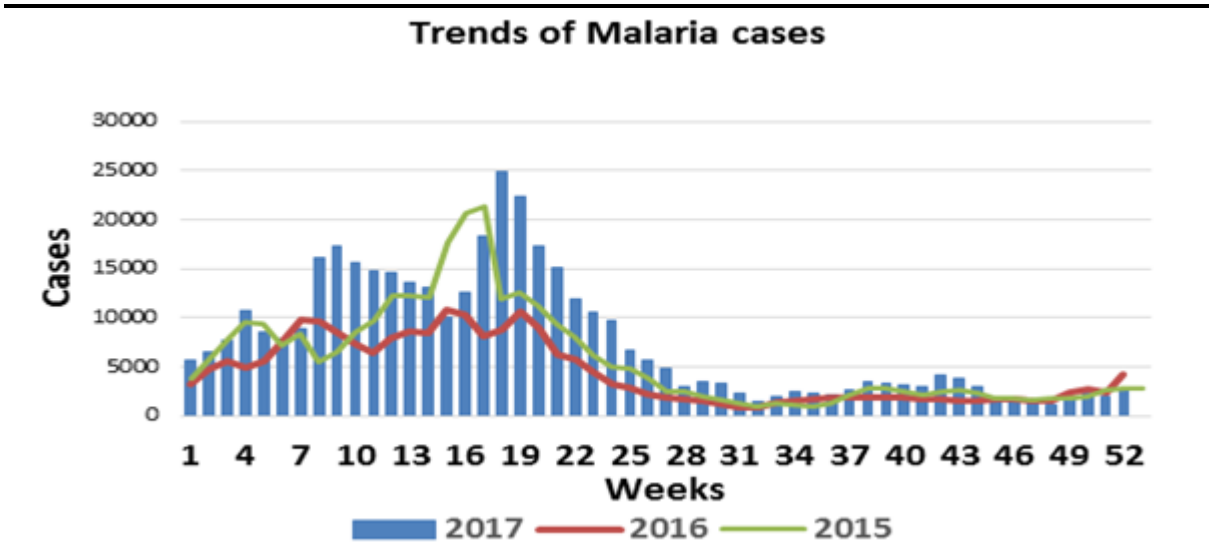


Figure 10: Trends of Malaria Cases

Malaria is an epidemic prone disease that is tracked through the weekly disease surveillance system. The cumulative figures for malaria in 2017 were 467,964 cases and 534 deaths reported nationally. The annual case load was highest in 2017 compared to 2015 and 2016. Eighty percent of the cases were reported from Manicaland, Mashonaland Central and Mash East.

Roadmap to 2020

The WHO developed a Global Technical Strategy (GTS) for malaria 2016-2030, reflecting on the progress achieved in the fight against malaria. The strategy sets global targets which include elimination of indigenous malaria in at least 35 countries that had malaria transmission in 2015 by 2030. The GTS approach is based on three pillars and two supporting elements that guide how countries design their malaria programs to achieve the set targets (WHO, 2015). Pillar 1 deals with ensuring universal access to malaria prevention, diagnosis and treatment; Pillar 2, focuses on accelerating efforts towards elimination and attainment of malaria-free status; Pillar 3, addresses issues of transforming malaria surveillance into a core intervention. The two supporting elements are harnessing innovation, expanding research and strengthening the enabling environment.

The country malaria collaborative adopted a comprehensive new roadmap which directs efforts to eliminate malaria in some parts of the country by 2020. Thus the roadmap outlines a pathway to

eliminate malaria incidence and mortality, and prevent its transmission in some of the districts and provinces by 2020.

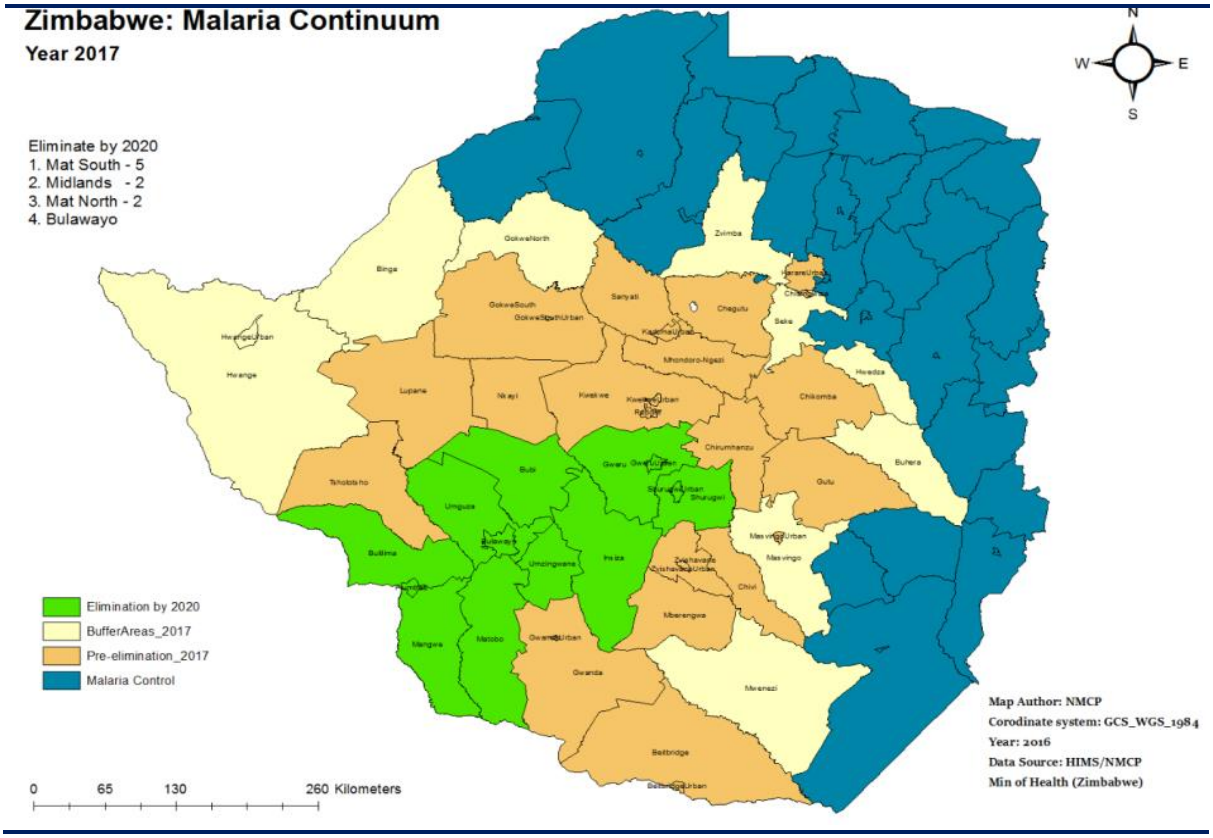


Figure 11: Zimbabwe Malaria Continuum

In a transitional process, the milestones are to have 30 districts *(48%)* in malaria control zones, 16 districts (25%) pre-elimination, 8 buffer districts (13%) *and* at least nine districts (14%) earmarked for zero indigenous malaria transmission by 2020. In order to achieve this malaria elimination drive, there is necessity for increased domestic funding and commitments that will help the country to sustain the shift from control to elimination.

Malaria Burden

Malaria incidence trends: The goal is to reduce malaria incidence to 5/1000 and malaria deaths by at least 90% by 2020. Progress towards the goal is tracked by determining the incidence of malaria (per 1000 population at risk) calculated annually. During the year under review, a total 467,964 confirmed malaria cases were reported against the population of 13,727,473 (with a growth rate factor 1.1%), giving a calculated incidence of 34 cases per 1000 population. This result constituted a specific increase in incidence compared to previous years which had 29/1000 in 2015 and 20.5/1000 in 2016. The graph below shows the trends of malaria incidence over the past 8 years. The upsurge in 2017 was largely due to occurrence of outbreaks even in low malaria transmission settings, resulting in an increased malaria burden.

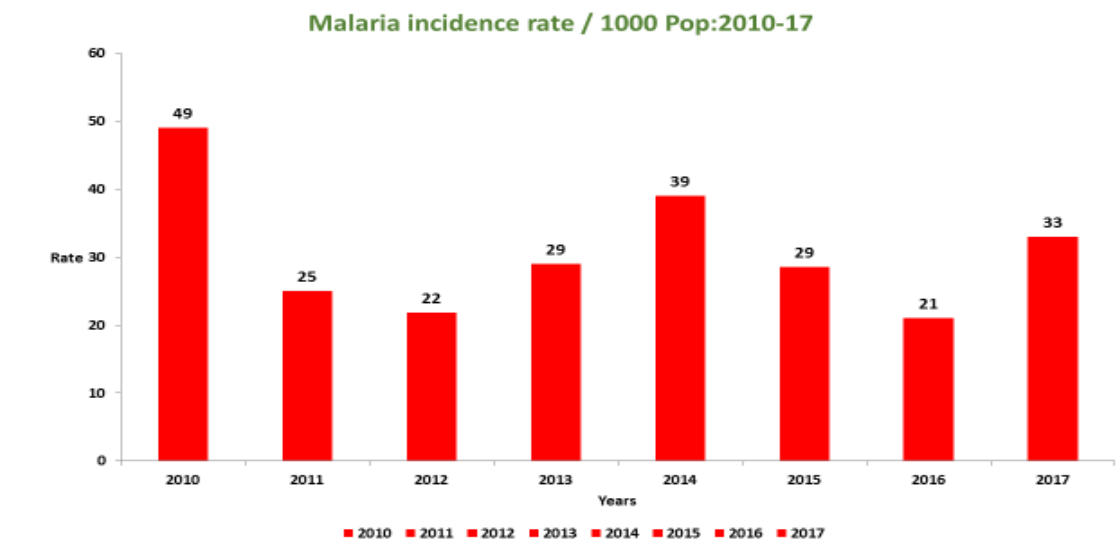


Figure 12: Malaria Incidence in Zimbabwe 2010-2017

On the back of malaria incidence reduction over the years (2015, 2016) and the rise in 2017, the NMCP identified the contributing factors, and remained on course to put in place intervention measures at all levels. The impact of the outbreak could have been worse were it not for the malaria epidemic management, the responsive funding under the Global Fund New Funding Model Grant and support from other partners which capacitated the provinces and districts to fight and control the malaria outbreaks.

Distribution of Malaria Incidence by Province, 2017

The intensity of malaria burden varied across geographical areas with the three Northern provinces contributing about 80% of the national case load.

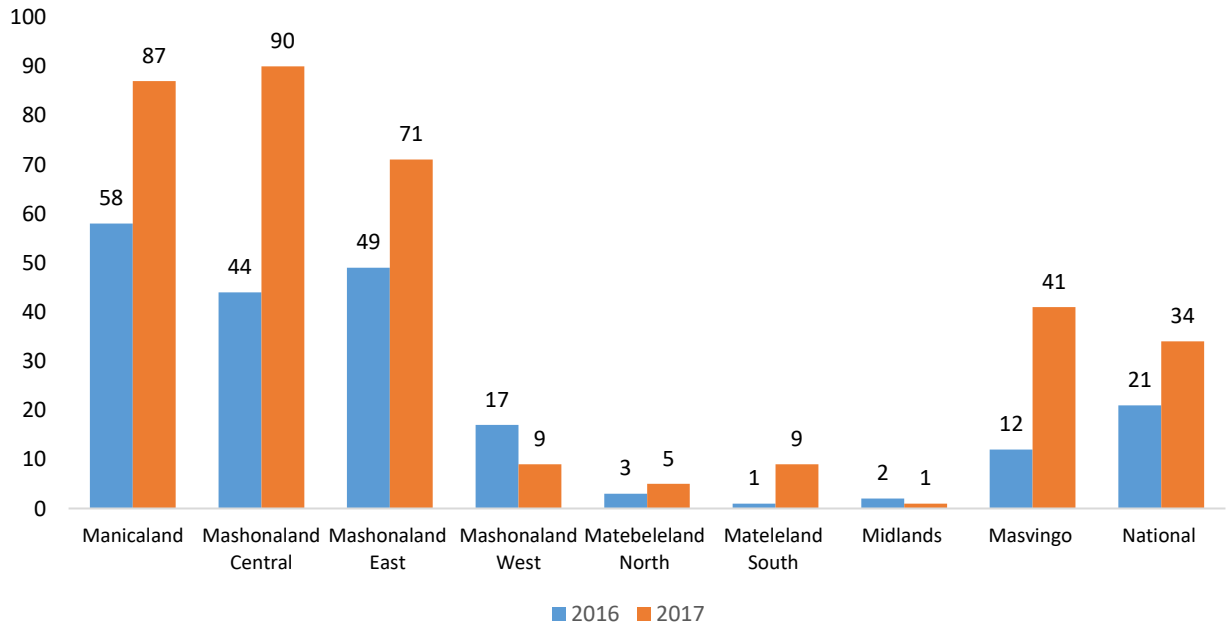


Figure 13: Malaria Incidence Rate by Province, 2016-2017

Malaria Deaths

Status in 2017:

In 2017, there was a spike of 534 deaths from malaria compared to 265 deaths in 2016. Three provinces (Manicaland, Mashonaland Central, and Masvingo) accounted for more than 80% of the total deaths reported in 2017. The graph in Figure 14 shows an observed sharp increase of non-malaria deaths from 2016. Similarly a minimal increase was observed on trends on malaria deaths, with little effect on the overall increase of non-malaria deaths between 2015 and 2017.

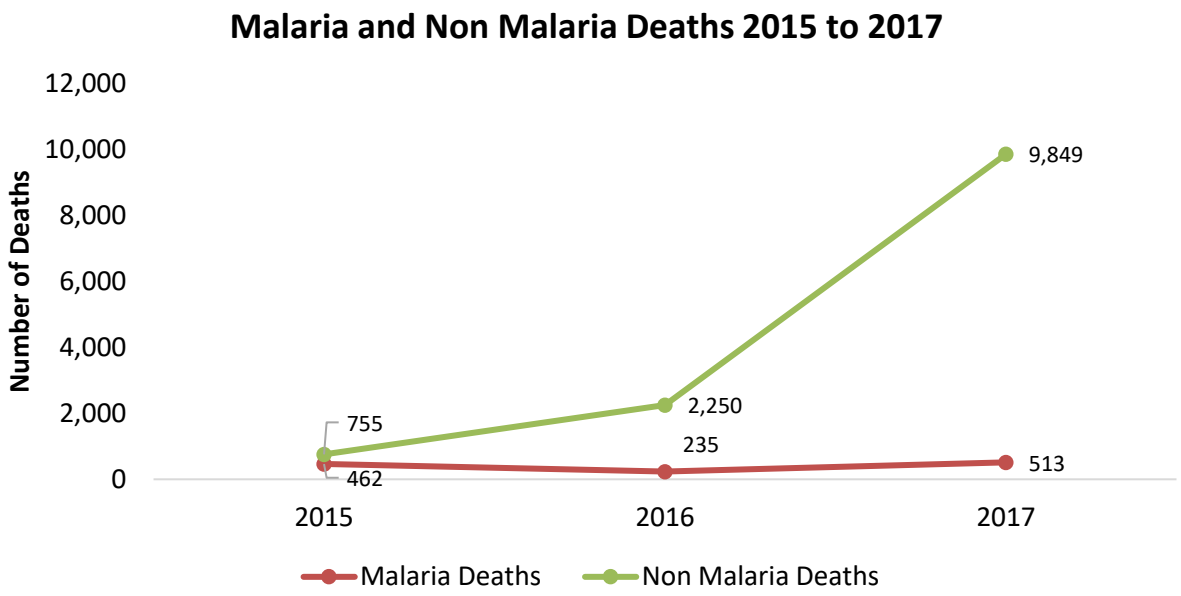


Figure 14: Malaria and Non Malaria Deaths 2015-2017

Malaria Deaths Investigations

Investigation of all malaria deaths is a requirement at all admitting institutions. In 2017, at least 67% (358) of the deaths (534) were investigated, which was a notable increase from 53% investigated in 2016. Notably, the target of 100% was not met due to competing activities and human resources constraints. Some of the reasons identified as contributing to malaria deaths included late presentation of patients and unavailability of key medical supplies, including diagnostic kits at health facilities. The low death investigation from admitting institutions calls for a recommendation to conduct a detailed investigations to understand the causes, so as to inform a mitigatory plan of action.

Malaria Deaths in the Population

Computed against the population based indicator (malaria deaths/ 100000 population), the program attempts to measure quality of improvements in case management. Using 2012 census population (with annual projection of 1.1) an annual malaria death rate of 0.039% was attained. This was an increase in malaria mortality from the 2013 baseline of 0.03 in 2017. The results directly corresponded to the malaria incidence, which had an upward picture for the year under review. The impact of outbreaks resulted in increased hospitalisation due to malaria disease.

Vector Control

Vector control is the mainstay to prevent and reduce malaria transmission in Zimbabwe. The proven strategies in use are Indoor Residual Spraying (IRS) and Long Lasting Insecticidal Treated Nets (LLINs). Both strategies are conducted through mass net campaigns and continuous LLIN distribution, with limited larval source management. If coverage of vector control interventions within a specific area is high enough (above 80% WHO benchmark), then a measure of protection will be conferred across the community.

During the 2016/2017 malaria season, the programme completed the planned activities for IRS resulting in a total of 3,671,843 people being protected against a target of 3,9745,53 people resulting in 92% of the population protected against malaria. The spraying operational campaign coverage of 92% (2,820,231 rooms) was achieved against the annual targeted 3,079,986.

Table 26: IRS Coverage by Province 2017

Province	2017 Targeted Rooms	Rooms Sprayed In 2017	% Sprayed	2017 Targeted Population	Population Protected In 2017	% Protected
Manicaland	765,170	661,010	86	1,025,126	922,098	90
Mash Central	368,705	342,453	93	490,893	456,070	93
Mash East	409,219	399,360	98	519,197	497,159	96
Mash West	355,003	338,587	95	496,998	471,136	95
Masvingo	405,774	373,276	92	564,944	539,687	96
Mat North	282,929	265,637	94	466,745	396,802	85
Mat South	111,512	80,335	72	133,354	110,644	83
Midlands	381,586	360,573	94	290,658	279,715	96
National	**3,079,898**	**2,821,231**	**92**	**3,987,915**	**3,673,311**	**92**

LLINs distribution, 2017

In most settings, the WHO recommends LLIN coverage for all people at risk of malaria. To achieve this, Zimbabwe adopted a cost-effective way of providing LLINs free of charge through mass net campaigns and continuous distribution strategies to ensure equal access for all.

Mass LLINs campaigns:

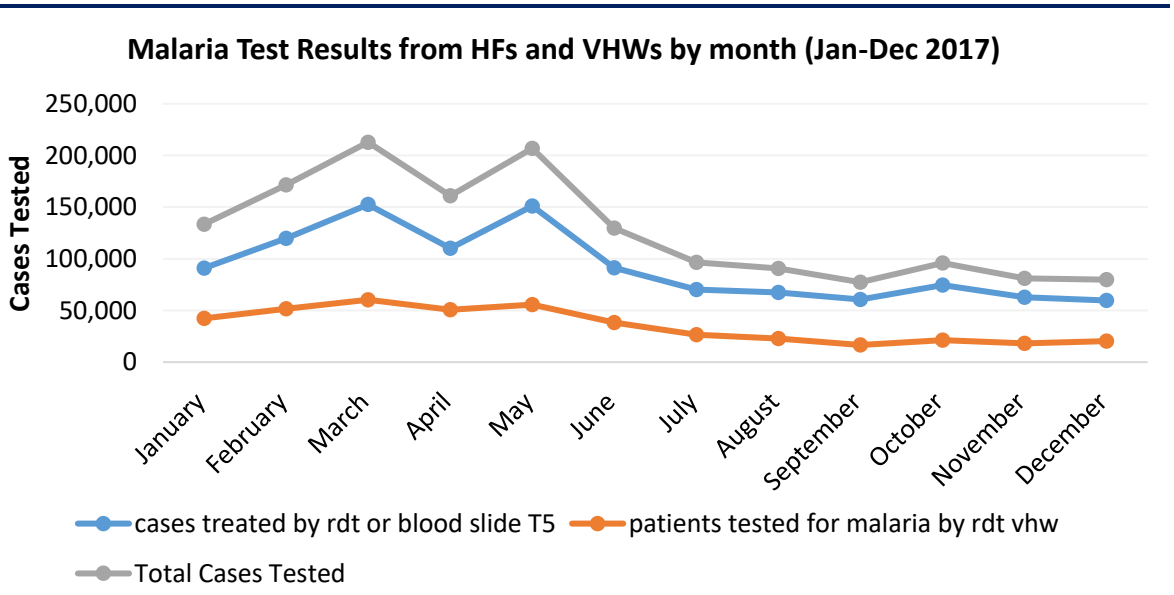
Between July-December 2017, a total of 294,350 (100%) LLINs were distributed through mass campaigns to **5** districts namely Bulilima, Matobo, Mangwe, Umguza and Bubi). The nets (293,350 LLIN) were funded by Global Fund and 1000 by Isdell Flowers. Plan International and PSI supported with the implementation process of the mass campaign approach.

Continuous LLIN distribution (CD)

The objective of continuous LLIN distribution is to maintain high net coverage after mass campaign in the targeted communities in areas of annual parasite index of less than 5/1000 population. The roll out of CD started in 2017 preceding the pilot projects done in Mashonaland Central province in 2015-2016 with support from Zimbabwe Assisted Project in Malaria (ZAPIM). It is a keep-up intervention that resulted in a total of 219,641 LLINs being distributed in 2017 through ANC, EPI and community channels in 26 districts (ZAPIM -10 districts, Plan international - 16 districts) of in all the 8 rural provinces except Manicaland province. CD was supported by Global Fund through Plan International in 16 districts and PMI in districts in 10 districts.

Malaria diagnosis, testing and treatment

Prompt diagnosis and treatment is the most effective way of preventing mild cases of malaria from developing into severe disease and death. Improving the quality of malaria case management services remains key in ensuring decreased morbidity, mortality and neurological sequeale. Despite the malaria prevention strategies implemented during the course of the year, a national total of 1,574,090 suspected malaria cases were seen at both health facility and community level. With a recorded test rate of 98%, the total number of cases confirmed positive and treated at these two levels (health facility and community) of malaria service provision stood at 467,964 compared to the 2016 figure of 63,299



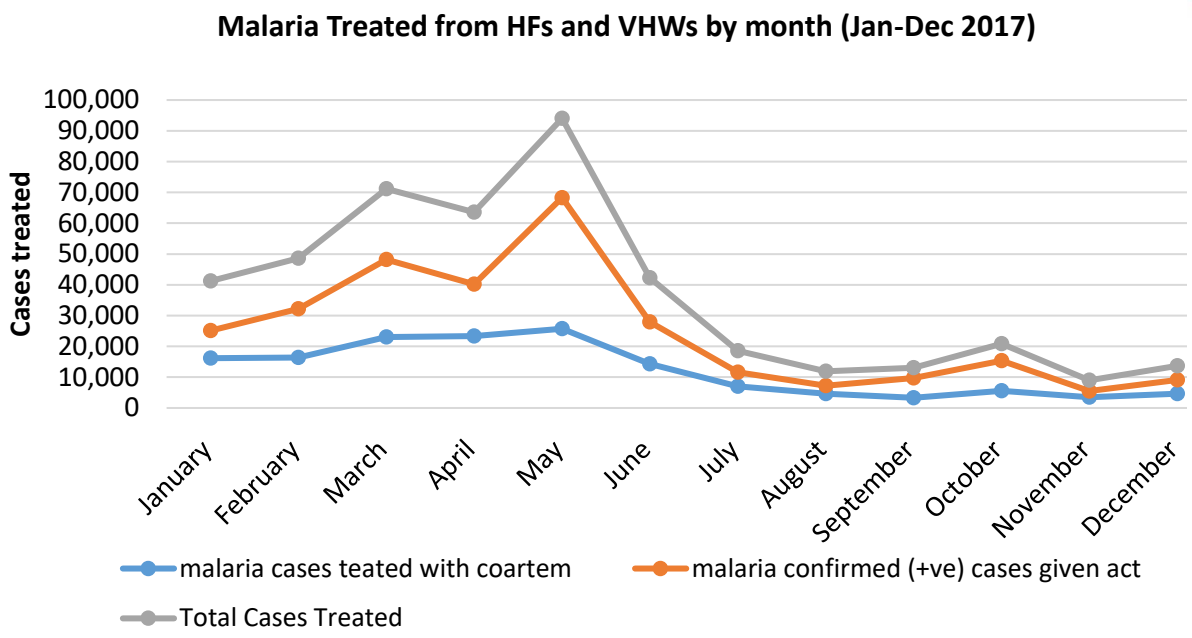


Figure 15: Monthly Trends of Test Rate and Treatment by HFs and VHWs, 201

Deliverables for Malaria Commodities

Stock availability: Artemether/ Lumefantrine tablets, Artesunate injection, Artesunate Amodiaquine, quinine injection and tablets were in full supply in 2017. Due to delays of Global Fund and PMI shipments for RDTs, there were reported stock outs of RDTs in some districts in Q2 2017. Commodities were distributed through the Zimbabwe Assisted Pull System (ZAPS) to the rest of the country. There were some noticeable delays in the Q1 and Q2 deliveries especially from the NatPharm Harare branch.

Quantification: Annual quantification for the period January 2017-December 2020 was conducted in March 2017. After consolidating commitments from partners and projected needs, there was no gap for ACTs, RDTs and medicines for severe malaria. The only gap was for artesunate suppositories 50mg and 200mg values at USD 8,000 which has since been taken up by the Ministry and procurement underway through NatPharm. The quantification also considered the Global Fund gap analysis and

Procurement: Procurements of malaria medicines was two pronged through GHSC-PSM using USAID/PMI Funds, and through Pooled Procurement Mechanism using Global Funds. Notably, RDTs were not received on time with Global Fund shipment being late by four months and PMI by close to two months. Quinine injection and tablets, Clindamycin procured under GF and Artemether Lumefantrine 6x1 under GHSC-PSM had not been received by 31 December 2017. This picture posed a difficult situation to meet equitable distribution of anti-malaria commodities. The table below show all the antimalarial received from January –December 2017

Table 27: Quantities of Antimalarial Received January-December 2017 by Partner

Product	Quantity Received 2017		Grand Total
	GF NFM	USAID	
Artemether/Lumefantrine (6x1), Blister	41,670	9,650	91,320
Artemether/Lumefantrine (6x2), Blister	56,880		56,880
Artemether/Lumefantrine (6x3), Blister	39,120		39,120
Artemether/Lumefantrine (6x4), Blister	174,210		174,210
Artesunate injection 60mg, Ampoule	43,665		43,665
Artesunate/Amodiaquine 100/270mg all ages, Blister	4,650		4,650
Artesunate/Amodiaquine 25/67.5mg, Blister	1,850		1,850
Artesunate/Amodiaquine 50/135mg, Blister	1,250		1,250
Primaquine 15mg (base), tablets	36,200		36,200
Rapid Diagnostic Tests (PAN/COMBO), test	289,700		289,700
Rapid Diagnostic Tests(Malaria) Pf only, test	1,158,825	1,398,300	2,557,125
Sulphadoxine/Pyrimethamine 500/25MG, Tablets	387,000	469,600	856,600

Regional Cross Border Collaboration: With recognition that malaria knows no boundaries, the Malaria Strategic Plan stresses the need for regional collaboration with neighbouring countries Mozambique, South Africa, Zambia and Botswana synchronize interventions and messages to effectively fight malaria from all fronts.

Elimination 8 Regional Collaboration: Zimbabwe is a member of the Elimination 8 (E8) countries (Swaziland, South Africa, Botswana and Namibia Angola, Mozambique, Zambia and Zimbabwe) that are working towards malaria elimination. The countries have been divided into 2groups. The four front runner countries (Swaziland, South Africa, Botswana and Namibia) have a target of achieving zero local transmission by 2020 and the four second line countries (Angola, Mozambique, Zambia and Zimbabwe) by 2030.

Through E8 the country has managed to establish 5 health posts along the border and within the communities that have limited access to health care services.

Figure 16: Map Showing the Location of the Health Posts Supported by E8

Zimbabwe signed its first malaria cross border agreement with Zambia (ZamZim) in April 2017. The significance of the agreements between the countries were to operationalize malaria joint work plans, share data, harmonize interventions and messages for the benefit of communities on both sides and ultimately working together towards realizing the regional common goal of eliminating malaria.

Elimination 8 regional collaboration: In collaboration with NMCP the E8 through regional Global Fund grant committed to support the setting up 5 Health Posts in border districts namely Rushinga, Beitbridge, and Mutasa. One static clinic along the border with Mozambique and one mobile clinic along the border with South Africa to increase access to health services by mobile among cross border communities.

Social Behaviour Change Communication: The Malaria Communication Strategy Implementation Guide 2013 was updated in line with the Malaria Communication Strategy 2016-2020. The commemorations of the World Malaria Day (WMD) and SADC malaria day commemorations worked as both advocacy and social mobilization tools.

Epidemic Preparedness and Response Management: The 2017 year witnessed changes in population movements for travel and trade, increased rainfall, cross border issues and community behaviours that increased the risk of malaria outbreaks, their spread and implication into epidemics.

Distribution of reported outbreaks by district by Health facility, 2017: The maps below enable the display and visualisation of space and time data that helped understand the entirety of the outbreak events of 2017 and the context of their occurrences in different places.

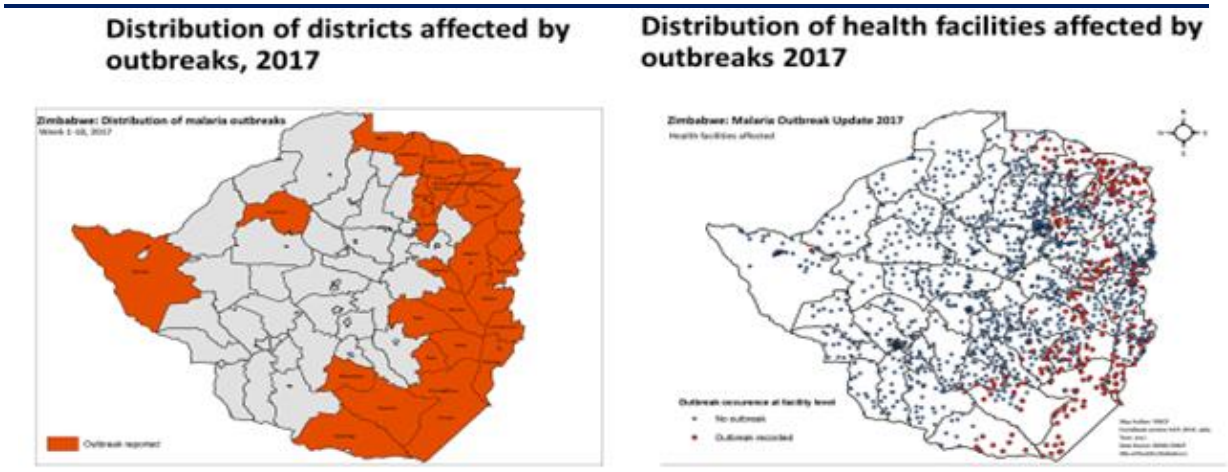


Figure 17: Distribution of Districts and Health Facilities Affected by Outbreaks in 2017

Tracking outbreak events: The management of data and information for malaria epidemic control by documenting the events was critical, for tracking progress and decision making for immediate action. Weekly surveillance data, information systems for provinces and districts, tools and data sets were analysed during outbreaks, and further strengthen the responses. It also increased visibility for the outbreaks control at all levels.

Table 28: National Picture of Outbreaks Reported in 2017

Indicator	Manica	Mash C	Mash E	Mash W	Masvingo	Mat North	Mat South	Midlands	National
Districts reported outbreaks	7/7	6/8	6/8	1/7	6/7	2/7	1/7	2/8	31/62
Total no of HFs	279	150	150	13	178	148	21	243	1182
Reported outbreaks	65	42	105	3	78	2	6	13	314
Date last outbreak reported	Week 36	29/07/2017	Wk 36	Mar-17	On going	Week 11	06/07/2017	25/06/2017	
Outbreaks detected within 1 wk	65	42	81	3	78	2	6	5	282
Variance (%) & color code									
Outbreaks controlled in 2 weeks	16	12	30	0	61	2	0	0	121
Variance(%) & color code									

A total of 364 health facilities from 34 districts had cases surpassing the threshold limit values. Out of the, 282 outbreaks detected within one week 121 outbreaks were controlled in 2 weeks. The highest number of reported outbreaks (N=105) was in Mashonaland East province and the least in Matabeleland North provinces (N=2). The performance of key indicators tracking epidemics is summarized in the graph below;

Proportion of outbreaks detected & controlled within national target, 2017: While the malaria outbreak control efforts were tracked on weekly basis each province was able to submit weekly reports on the status of the outbreak (ongoing, controlled, action required, resources needed, etc.). Nationally 90% of the outbreaks recorded were detected within 1 week. Of these, 39% were controlled within two weeks. Fifty six districts had their updated EPR plans in place. The strong partnership support was evidenced by different support given to the provinces and districts to fight the outbreaks However, one of the lessons learnt was that malaria outbreaks are not infrequent hence preparedness measures are key at all cost.

Malaria Monitoring and Evaluation

Monitoring and evaluation includes monitoring program outputs, such as whether intervention coverage and quality was achieved and evaluation of impact. An important part of M&E involved analysis and swift feedback to the periphery, which could theoretically improve program response, clearly M&E needs to be undertaken with a spirit of surveillance and response. This include weekly malaria surveillance to detect outbreaks, case based surveillance and entomological surveillance.

Table 29: Performance on Key Indicators 2017

Indicator	Target	Result
Confirmed malaria cases (microscopy or RDT) per 1000 persons per year	10	34
Inpatient malaria deaths per 1000 persons per year	0.01	0.039
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	95	98
Proportion of suspected malaria cases that receive a parasitological test in the community	90	95
Percentage of confirmed cases fully investigated (malaria elimination phase)	80	79
Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national policy at public sector health facilities	95	90
Proportion of population protected by Indoor Residual Spraying within the last 12 months	93	92
Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	100	111

Malaria integration and firming with DHIS2

- **Instituting electronic routine net distribution reporting**

While most of the malaria data elements are configured in the DHIS2, efforts were underway to improve data quality and to lay the ground work to incorporate reporting of new indicators for the 2017 widely rolled out routine net distribution intervention. The persuasion is to have the reporting and track routine net distribution through the accredited channels of ANC, EPI. This approach will ensure the capturing of data at source to monitor availability and prevent stock out nets.

- **A distinctive feature in Zimbabwe : The DHIS2 Tracker**

One of the noteworthy and significant aspects in the year under review was that of firming a home-grown, user-friendly, national, Web-based online electronic case based project monitoring system i.e. the DHIS2 Tracker. The system supports the real time case based surveillance reporting system that has grown from strength to strength over the years with 100% functionality in the 20 pre-elimination districts. The year under review also saw the creation of the DHIS2 Tracker Dash Board to track the implementation progress and results of the elimination indicators. The system provides access to project information on an indicator basis. The system helps to identify bottlenecks, delays, issues, and constraints in the implementation of malaria elimination projects/ activities and any additional needs of the executing entity, (province, district or partner). The program emphasizes the capture of data at source.

- **Performance on malaria indicators, 2017**

Overall, the national data highlighted the results of monitoring that exhibited programme achievements of the coverage or quality targets set for 2017. However, there was noticeable increases of cases in about 5 out of the 8 provinces resulting in national incidence of 34/1000 pop in 2017 compared to 21 /1000 pop in 2016. Three highly burdened provinces namely Manicaland, Mashonaland Central and Mashonaland East contributed about 80% of the national case load. These circumstances were ably explained by the wide spread outbreaks that transpired in 2017, whereas 2016 was free from outbreaks and lessened community suffering due to malaria disease. The table below shows some of the coverage indicators with performance results per province.

Table 30: Containment Indicators by Province 2017

Province	Indoor Residual spraying, 017			Cases treated with ACTs, 2017			Incidence 2016-2017	
	IRS Target-pop	IRS actual-pop	Result (%)	Target	Actual treated	Actual result (%)	Cases/1000 pop-2016	Cases/1000 pop-2017
Bulawayo	NA	NA	NA	161	112	70	0	0
Harare	NA	NA	NA	3,167	2,049	65	1	1
Manicaland	1,025,126	922098	90	153,522	112,783	73	58	83
Mashonaland Central	490,893	456,070	93	108,801	102,297	94	44	91
Mashonaland East	519,197	497,159	96	112,285	103,211	92	49	79
Mashonaland West	496,998	471,136	95	13,469	11,737	87	17	9
Masvingo	564,944	539,687	96	64,587	59,873	93	12	41
Matabeleland North	466,745	396,802	85	3,827	3,755	98	3	5
Matabeleland South	133,354	110,644	83	6,430	5,528	86	1	9
Midlands	290,658	279,715	96	2,066	1,783	86	2	1
National	**3,987,915**	**3,673,311**	**92**	**468,243**	**403,200**	**86**	**21**	**34**

- **Malaria elimination indicators**

For the 20 districts in elimination phase electronic case based surveillance and reporting system through the DHIS2 Tracker appeared to be the main tool for monitoring and evaluation. The original paper based system was not thrown away but used as backup system in the pre elimination areas. Case based reporting appeared to be the main tool of evaluation. The elimination reporting system was integrated in the NHIS for reaching elimination. A toll-free hotline for elimination was operated at national level for trouble shooting and follow up of issues impeding progress in implementation of the electronic case based surveillance system based on DHIS Tracker used for real time reporting of case and entomological investigations carried by the field based personnel (environmental health practitioners) in the 20 districts.

Expanding of Elimination Areas in Zimbabwe: Following the success of the past years, particularly in southern parts of the country, and recognizing the growing regional and global momentum towards elimination, the Zimbabwe National Malaria Control Programme (NMCP) has announced an ambitious goal for the national reduction of malaria incidence to 5 per 1,000 by 2020, and to accelerate towards zero through the adoption of a progressive sub-national plan for malaria elimination. In 2018 at least 4 districts are expected to start implementation of malaria sub-national elimination bringing to a total of 24 of the 62 in the country.

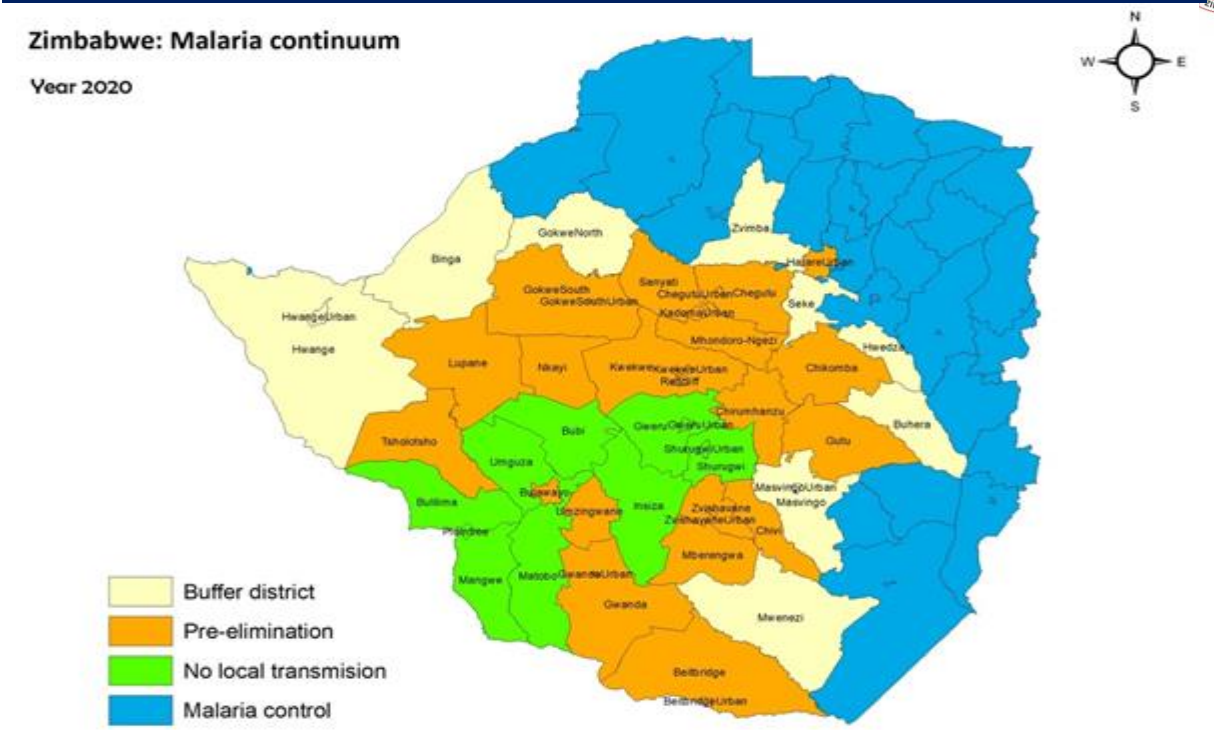


Figure 18: Zimbabwe Malaria Elimination Roadmap 2018-2020

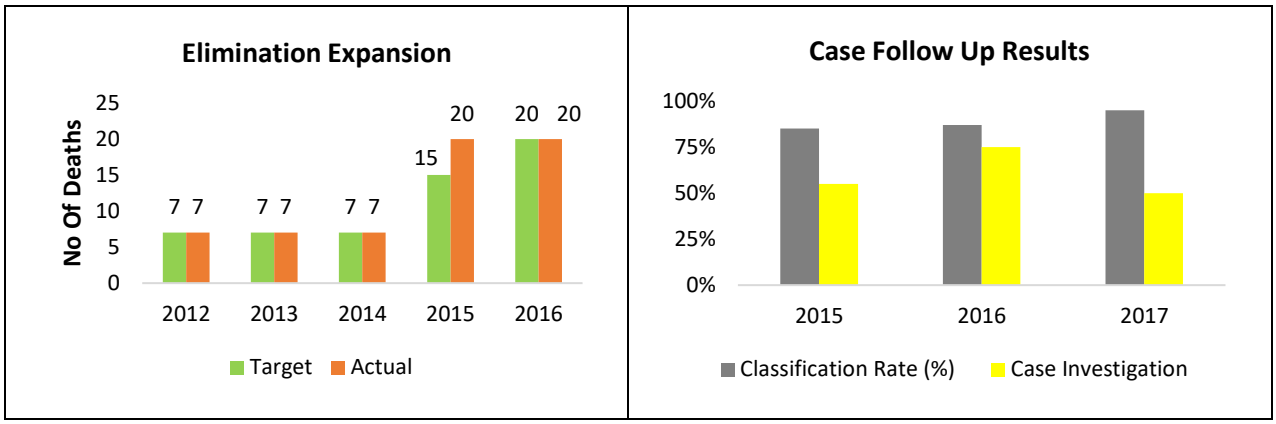


Figure 19: Case Investigation and Classification

The graph above shows progress on strategic targets for transitioning malaria districts to pre elimination in the past 5 years (2012-2016). The districts in elimination agenda increased from 7 in 2012, which increased to 15 in 2015 and went up to 20 districts in 2016 through to 2017.

The graph on case follow-up results -2017 shows the trends of case investigation and case classification. Of the year on year reported cases the case classification was higher than case investigations. Field case investigation is a resource intense activity and was affected by low field level HR coverage and also exacerbated by occurrence of outbreaks which resulted in rise of malaria cases. The increase of malaria situation made it difficult to attain optimal case investigation in 2017.

Operational Research

One of the recommendations of the MIS, 2016 was to find out the reasons for low and declining LLIN utilization. LLIN utilization for children under 5 and pregnant women declined from 50% to 33% and from 49% to 36% respectively despite increase in ownership. The NMCP with funding support from the Global Fund New Funding Model grant and technical support from Clinton Health Initiative (CHAI)

and the World Health Organization (WHO) conducted a qualitative study in 10 districts entitled '*Understanding Long Lasting Insecticidal Net Utilization Amongst Households In Malaria Transmission Districts Of Zimbabwe'*

*The b*road objective of the study was to have an in-depth understanding of why the LLIN utilization is falling against an increase in LLIN ownership. In-depth interviews (IDI), Focus group discussions (FGD) and Key informant interviews (KII) were used to collect the data.

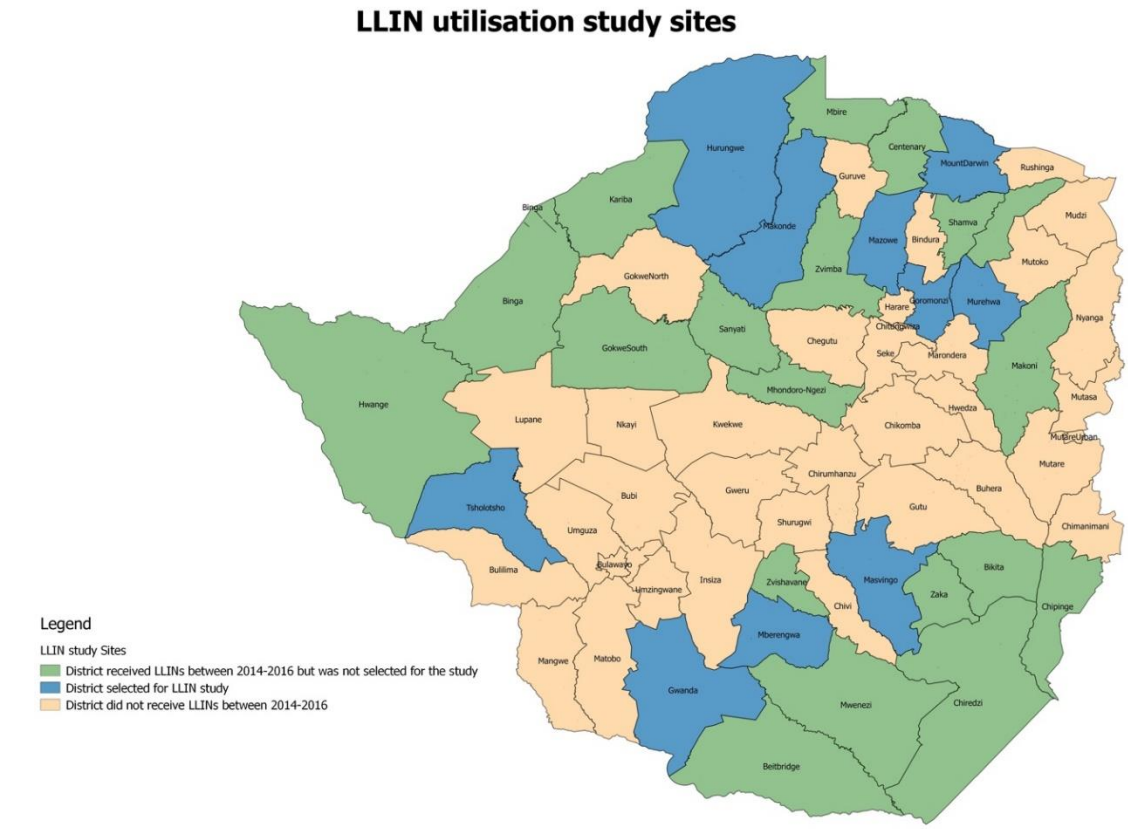


Figure 20: LLIN Utilisation Study Districts

Financial Summary

The main sources of funding for malaria program are GOZ and external partners. In the past three years the programme received significant funding although there was a slight reduction in 2017. Out of the 2017 strategic requirements of $56,935,831.00 the programme managed to get $44,979,307.00. In 2015 the programme was able to fund 92% of its strategic needs, 82% in 2016 and 79% in 2017. Vector Control remains the major consumer of the budget with an average spending of 58% of the total budget. Although the programme's financial performance is pleasing, the major challenge is that more than 90% of the recurrent expenditure was from external funders which are mainly GFATM and USAID. The government of Zimbabwe still remains the major funder in terms of infrastructure and human resources but the contribution to recurrent expenditure remains subdued due to the dwindling fiscal space.

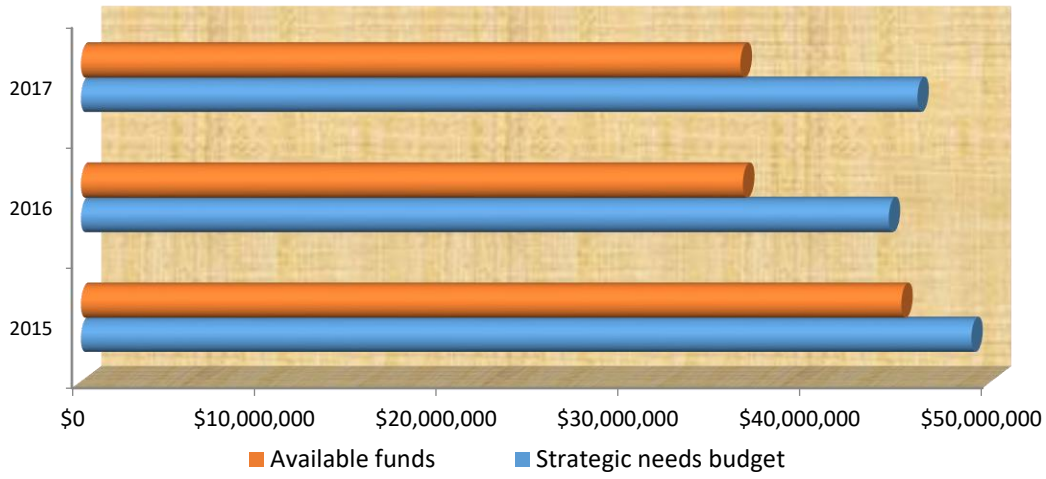


Figure 21: Strategic Plan Needs vs Availed Funding for 2015 to 2017

2.1.2 HIV and AIDS and Tuberculosis Programme

HIV and AIDS

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 transmission, and these include border districts, growth points, small scale mining areas, fishing camps and commercial farming settlements. In 2017, an estimated 1,323,639 adults and children were living with HIV. The number of children 0-14 years living with HIV has significantly declined from 81,400 in 2013 to 74,460 in 2017. Figures below show a summary in terms of HIV mortality and morbidity.

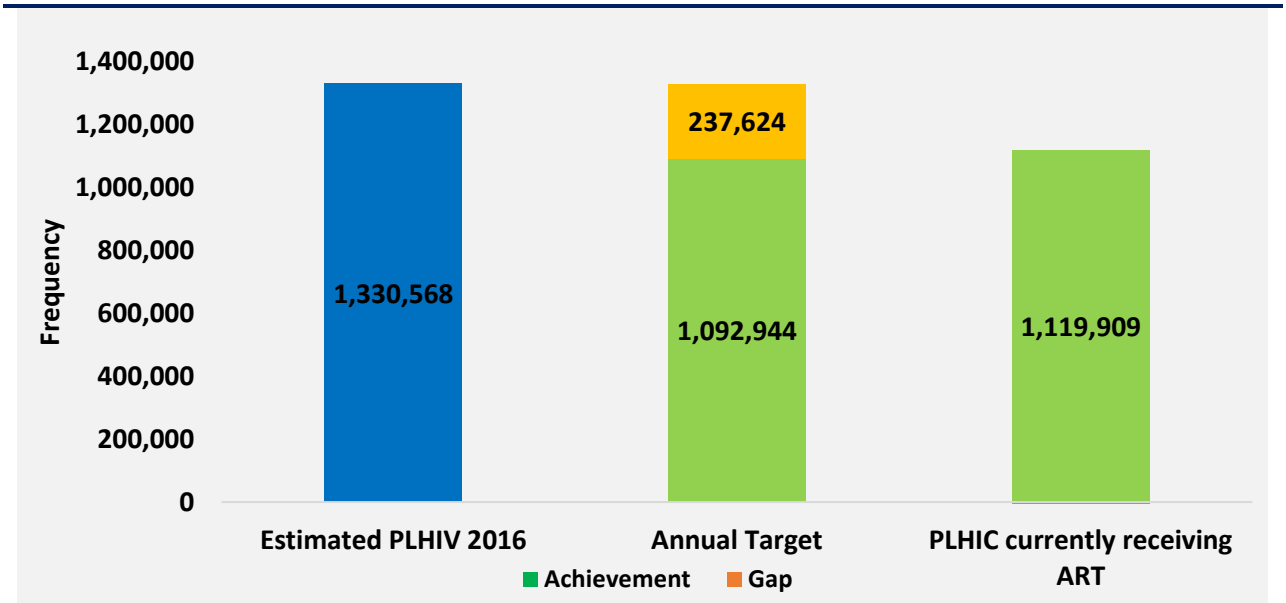


Figure 22: PLHIV Currently Receiving ART (All Ages)

Eighty-four percent of PLHIV are currently receiving ART. There are ongoing efforts including differentiated HIV services to get all clients on care and also retained in care.

Achievement towards 90-90-90 (all ages) 31 December 2017

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

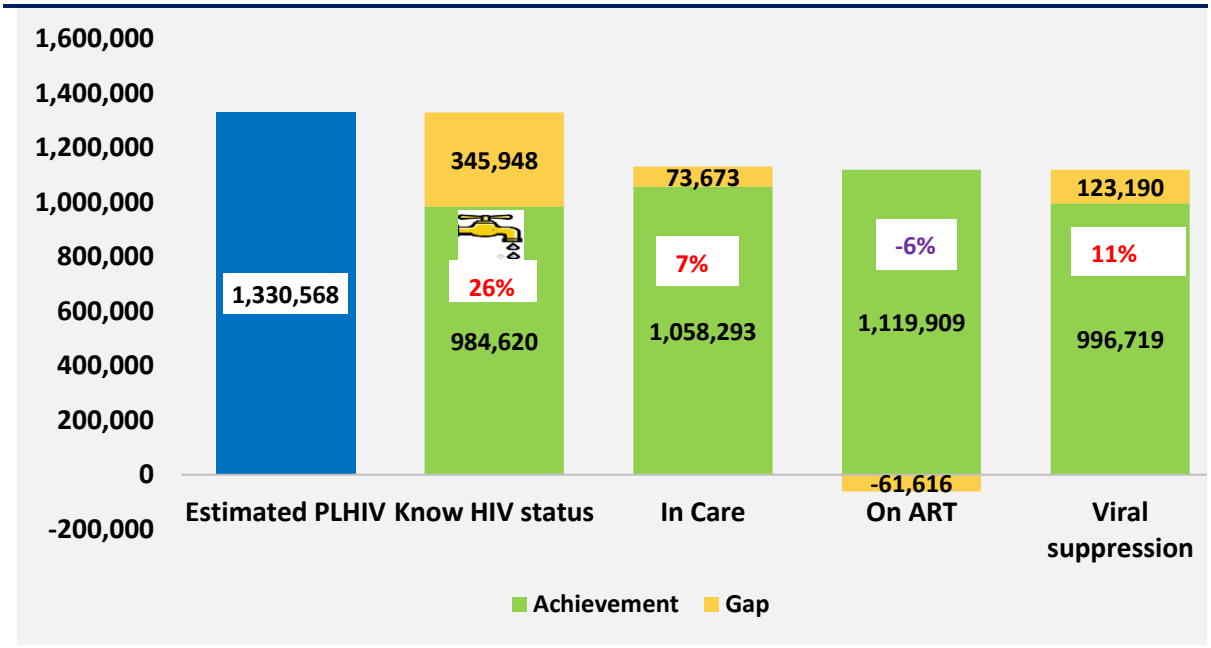


Figure 23: PLHIV (15+) Actively Receiving Art as at End of 2017

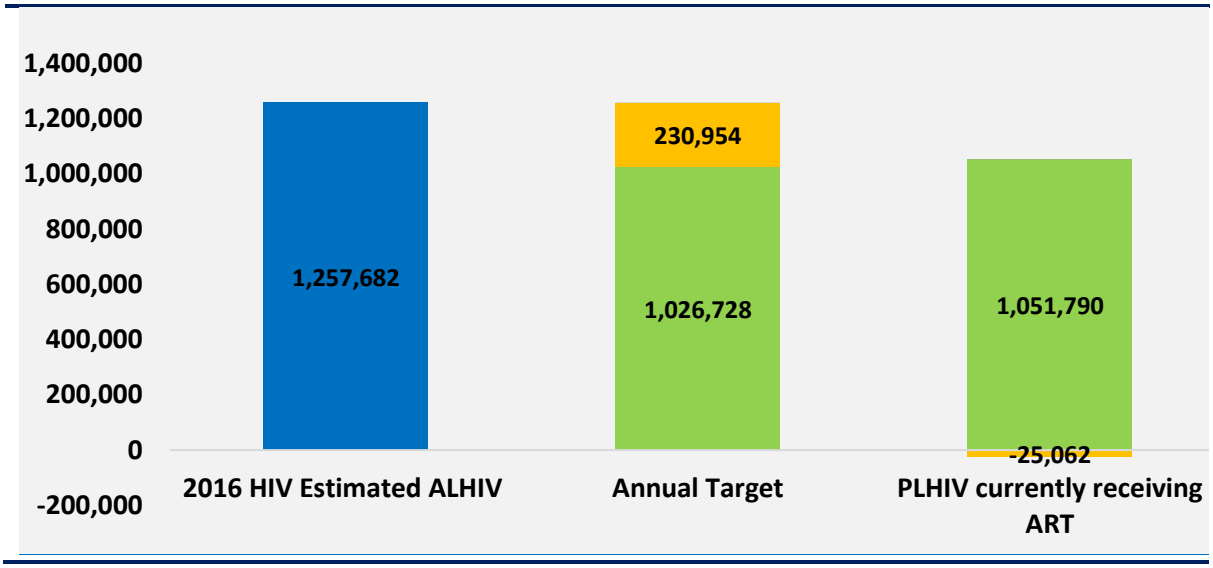


Figure 24: PLHIV (15+ years) Actively Receiving ART as at end of 2017

Eighty-four percent of the Estimated ALHIV were receiving ART

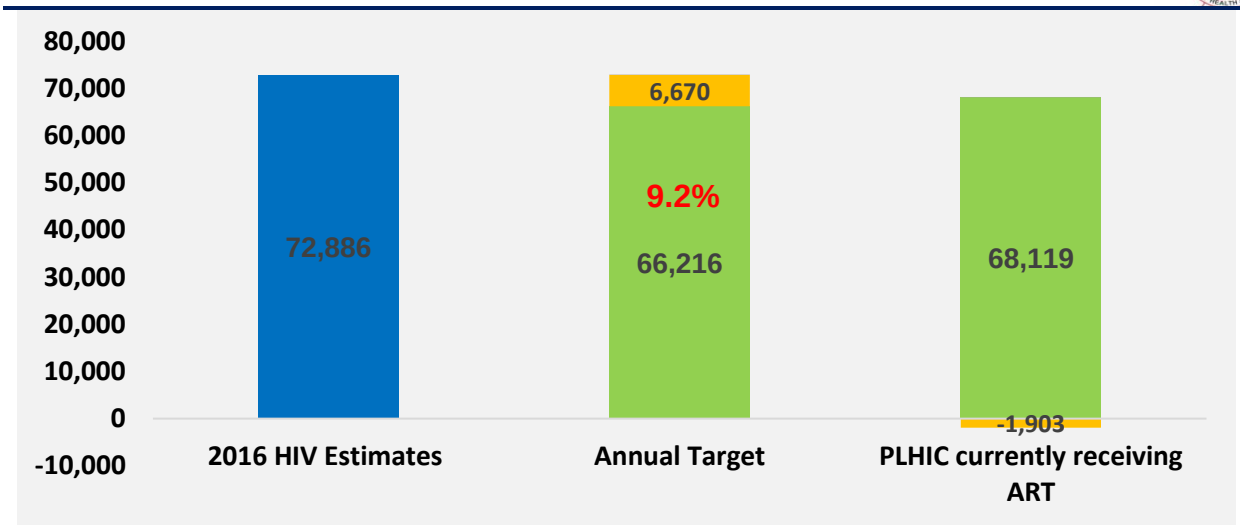


Figure 25: PLHIV Currently Receiving ART (0-14years)-31 December 2017

Ninety-three percent of the Estimated CLHIV were receiving ART. 103% Targeted CLHIV were currently receiving ART.

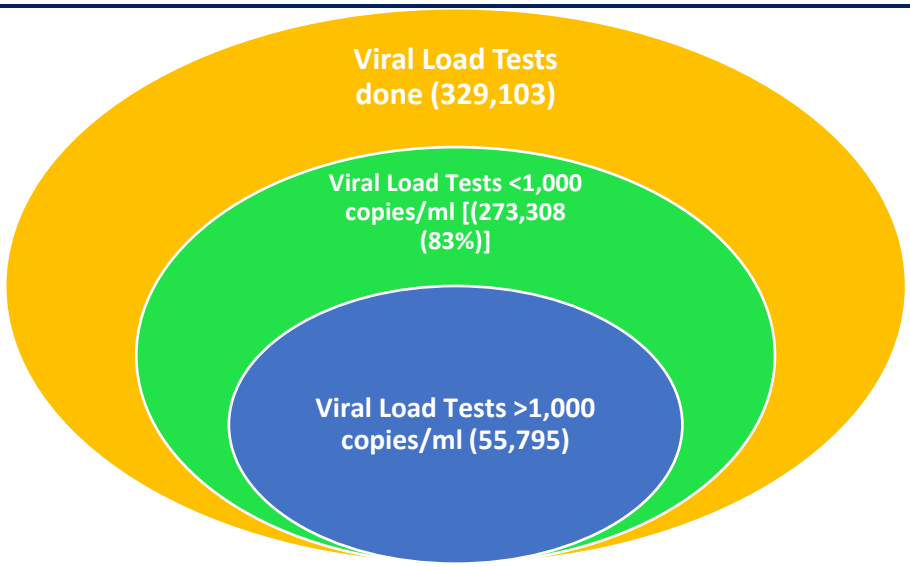


Figure 26: Viral load suppression (VLS) among HIV-positive people, 31 December 2017

Eighty-three percent of the all PLHIV were virally suppressed in 2017. The main reason for non-suppression in the 17% is poor adherence to treatment. The programme continues to strengthen adherence counseling and peer support to improve this.

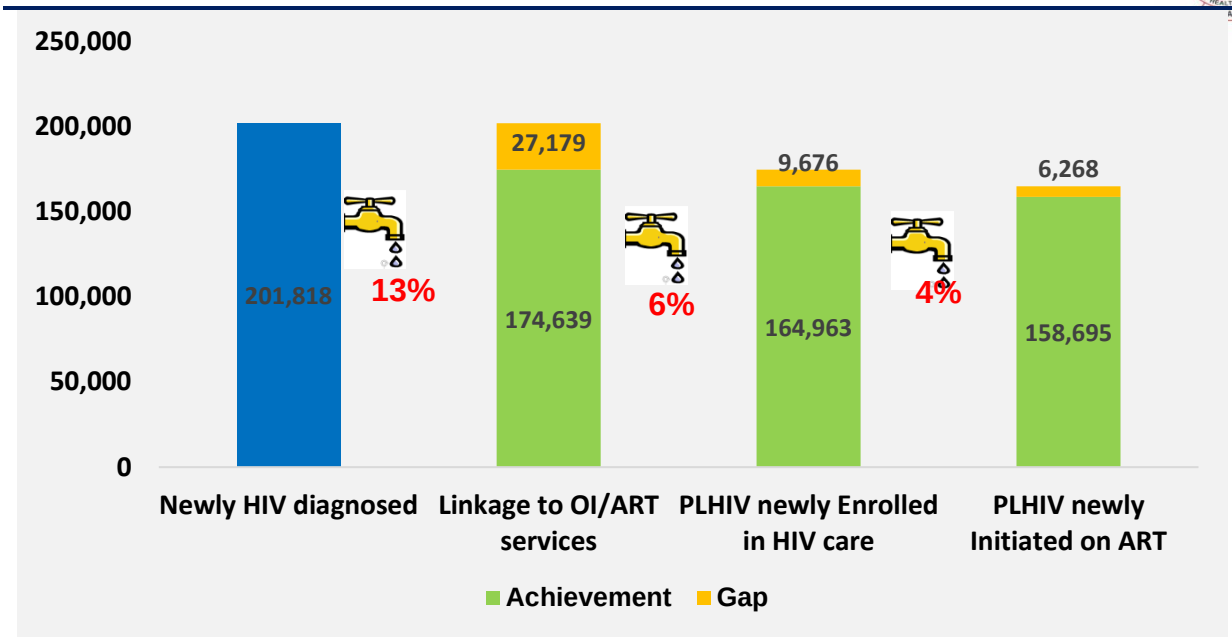


Figure 27: National ART Initiation Cascade 2017.

Of the people newly diagnosed to be HIV positive, 13% were not linked for OI/ART services. Of the people linked for OI/ART services, 6% were not enrolled into HIV care. Of the PLWHIV newly enrolled in HIV care, 4% were not initiated on ART. The 4% who were not initiated on ART are being followed up by Community and Clinic Referral Facilitators. In addition, Village Health Workers also help to track clients and bring them back to care.

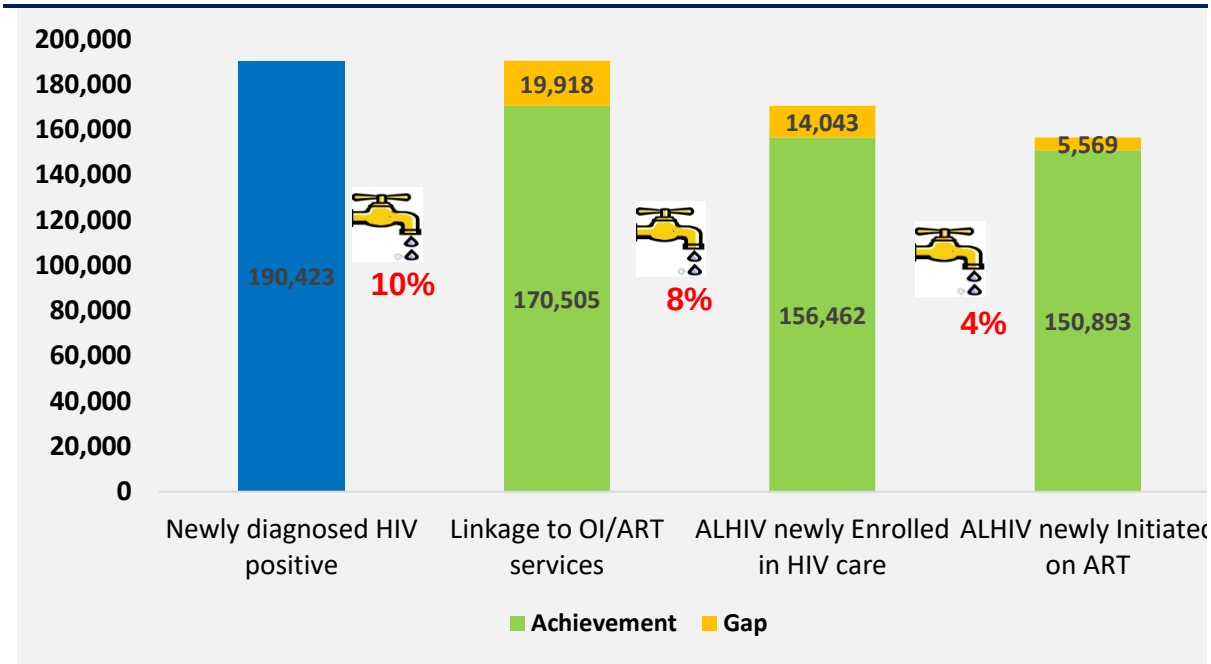


Figure 28: National Adults ART Initiation 2017

Ten percent (10%) of the adult people newly diagnosed with HIV were not linked to OI/ART services. Of the adult people with HIV linked to OI/ART services, 8% were not enrolled into HV care, and of those who did get enrolled, 4% were not initiated on ART. For the 4% who were not initiated on ART are being followed up by Community and Clinic Referral Facilitators. In addition, Village Health Workers also help to track clients and bring them back to care.

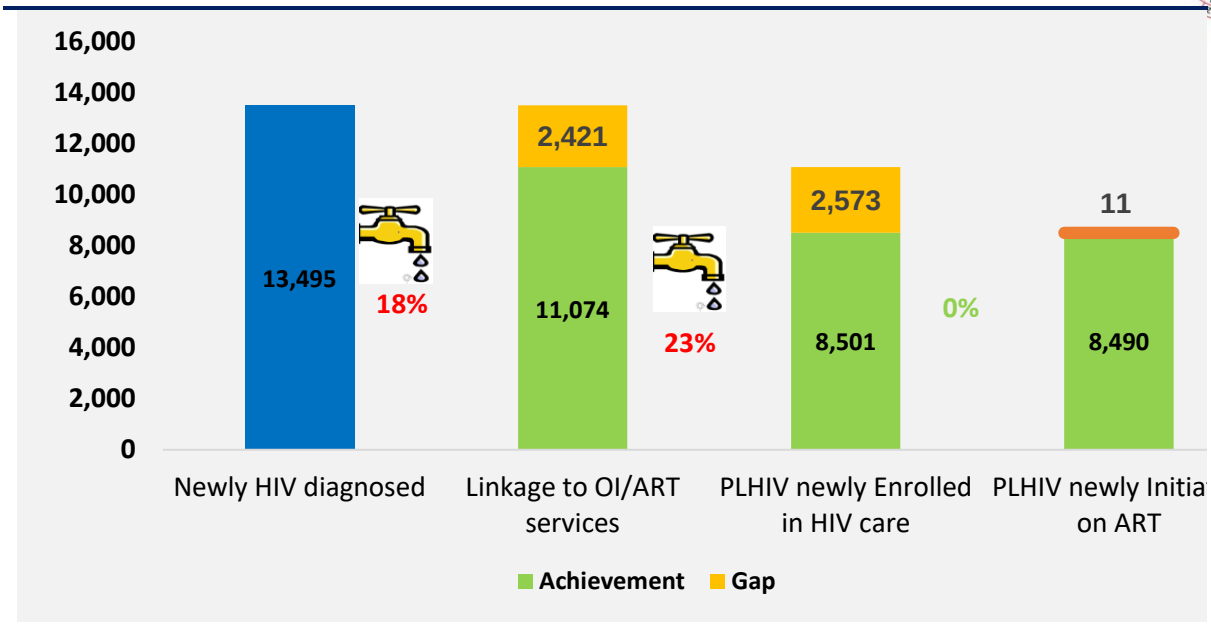


Figure 29: National Children Initiated on ART in 2017.

Out of all children newly diagnosed with HIV, 18% were not linked for OI/ART services in 2017. Twenty-three percent (23%) of the children linked for OI/ART services were not registered into HIV care. Nearly all (100%) of the children enrolled into HIV care were initiated on ART. Community and Clinic Referral Facilitators and Village Health Workers help to track clients and bring them back to care.

Elimination of Mother to Child Transmission of HIV Program Performance, Jan-Dec 2017

The PMTCT programme continues to move in line with the global guidance towards elimination of mother to child transmission of HIV and Syphilis. Its goal is to have the program validated on the path to elimination for both HIV and syphilis in Zimbabwe. In line with the agenda the programme capacitated District Managers on PMTCT cascade analysis for Bulawayo, Mat South, Mat North, Midlands and Manicaland. An analysis on the Early Infant Diagnosis (EID) DBS samples rejected by three laboratories between January and June in 2017 was done. Provinces with high rejection rates were Midlands, Mash West, Mash East and Mash Central. The PMTCT programme trained 270 Health Workers in EID DBS collection from these provinces to reduce rejections. This was followed by post training support in 2 of the provinces (Mash West and Midlands) reaching out to Health Workers in 31 sites with the highest rejection rates.

After piloting the Mother Baby Pair register, four (4) provincial TOTs for 8 provinces were conducted and a total of 100 HCWs were trained. A total of 5 provinces and their respective districts were capacitated through training to do PMTCT data analysis and utilization at the local level.

A multimedia campaign was conducted in the run up to the launch of the 5 year EMTCT plan. A total of 29 radio slots were aired all in all. Key messages focused on dual elimination of HIV and Congenital Syphilis. This also included messages on integrated SRH and nutrition services. The 5-year Plan for EMCT of HIV and Syphilis in Zimbabwe (2018-2022) was finalized, printed and launched at a colorful event in Bulawayo on the eve of 2017 World AIDS Day commemorations.

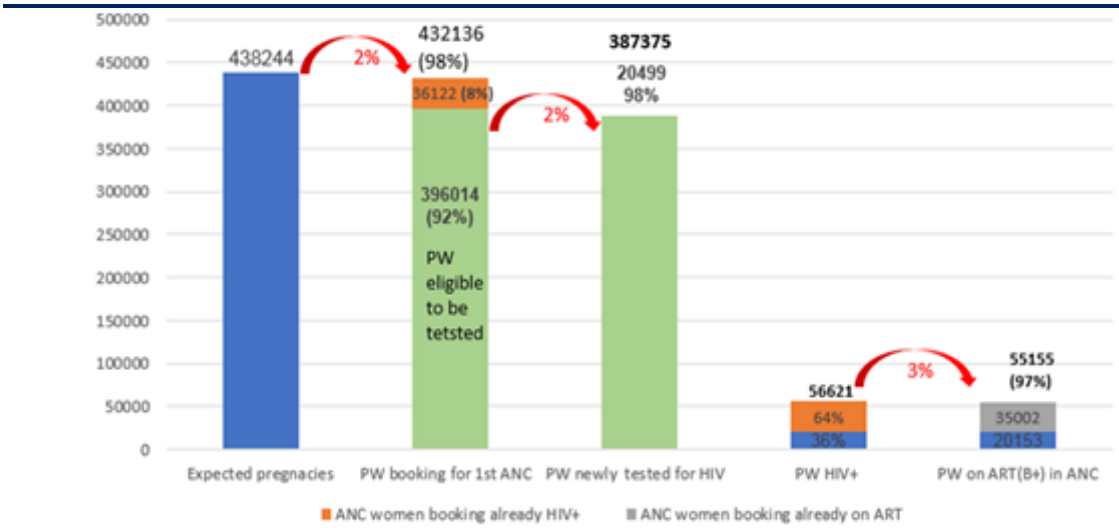


Figure 30: ANC Cascade, Jan-Dec 2017

The expected pregnancies were 438,244 and 92% (396,014) pregnant women were eligible for testing during the 1St ANC booking while 8% (36,122) were already HIV positive at booking, resulting in 2% leakage in 1st ANC boooking. 98% (20,499) pregnant women were newly tested giving a leakage of 2% . Three percent (3%) of the pregnant women who tested positive for HIV were not intiated on ART, mainly because some women still needed the consent of their partner to start taking ART

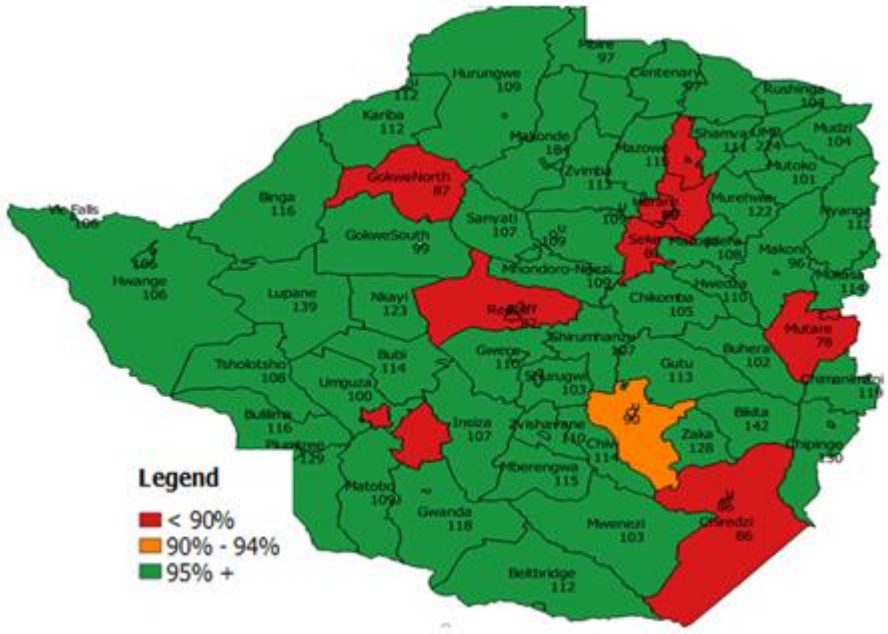


Figure 31: ANC Coverage, Jan-Dec 2017

Most of the districts were above 95% antenatal care coverage. Eight of the district reported less than 90% ANC coverage. More resource mobilization is need for the district below 95% to conduct early ANC booking community awareness campaigns and sensitization meetings.

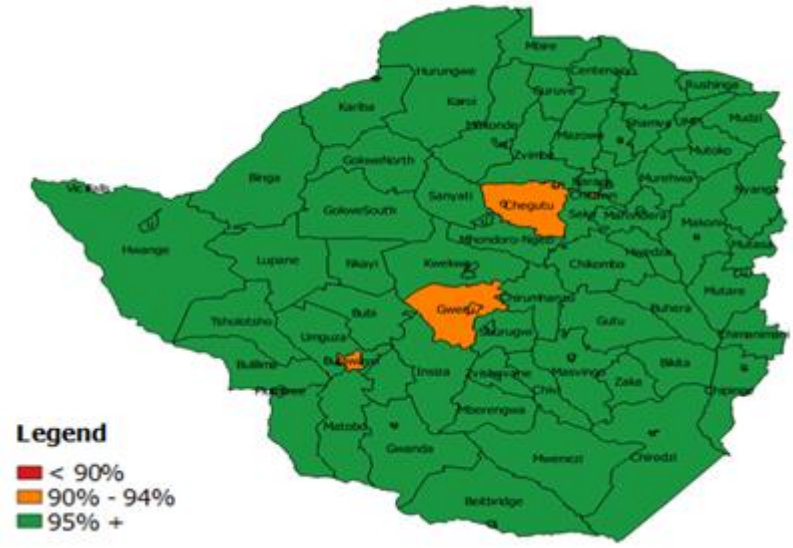


Figure 32: HIV Testing in ANC, Jan-Dec 2017

Most of the districts performed well in HIV testing in ANC except four districts which were the least, and these were Chitungwiza, Chegutu, Gweru and Bulawayo.

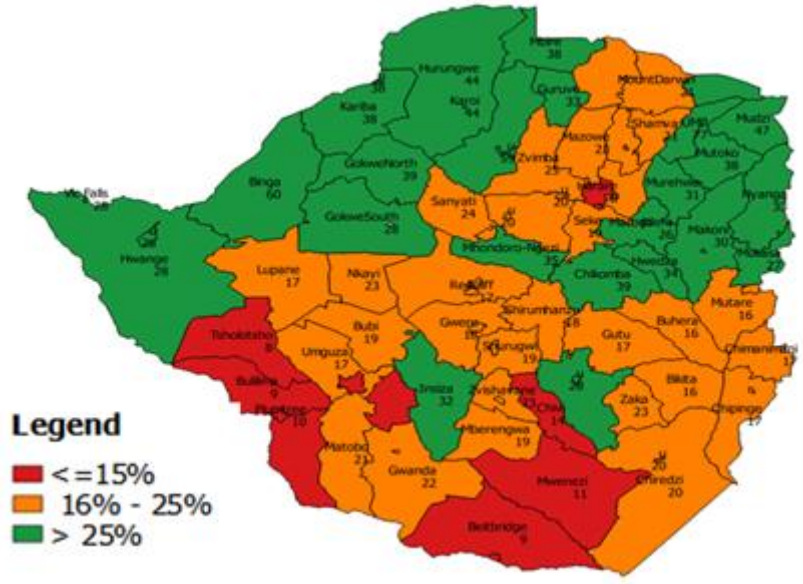


Figure 33: Male Partner Testing, Jan-Dec 2017

Male participation in PMTCT remains a challenge with many districts performing below 15% and between 16 to 25% respectively. The reasons include poor health seeking behaviour among men, non-male friendly services rendered by many health facilities, and fear of the unknown.

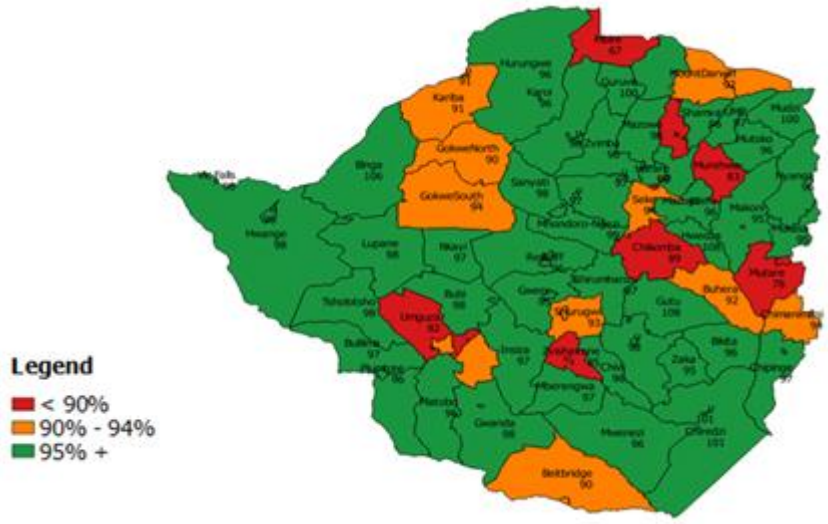


Figure 34: Women Receiving ARVs in ANC, L&D and PD, Jan-Dec 2017

ARVs coverage in pregnant and lactating women was good, with many districts achieving above 95%. Seven districts were below 90%, and these were Mbire, Bindura, Murehwa, Chikomba, Mutare, Zvishavane and Umguza.

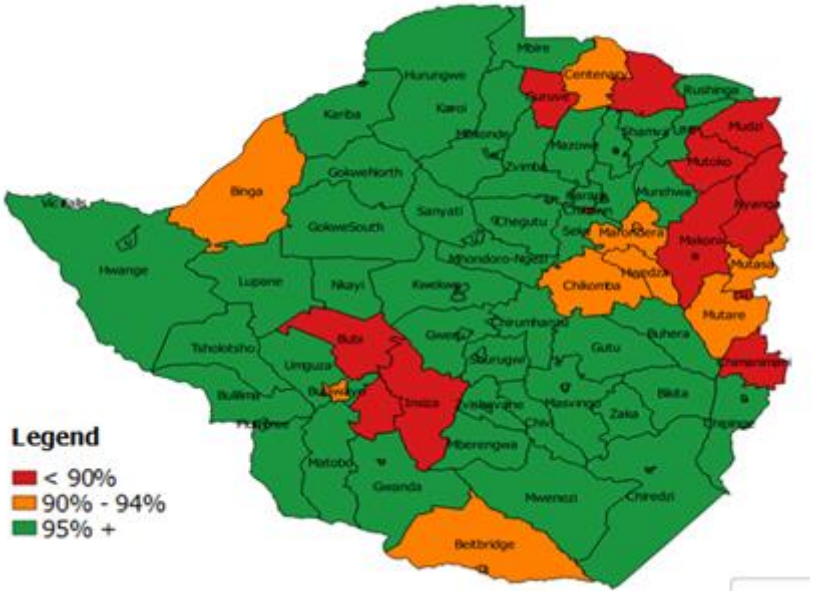


Figure 35: HIV Exposed Infants Initiated on NVP, Jan-Dec 2017

Most of the districts were above 95% for initiation of HIV-Exposed Infants (HEI) on Nevirapine (NVP). A total of 96% of the identified HEI received NVP, resulting in 4% leakage. This was due to stock out of NVP in most of the districts.

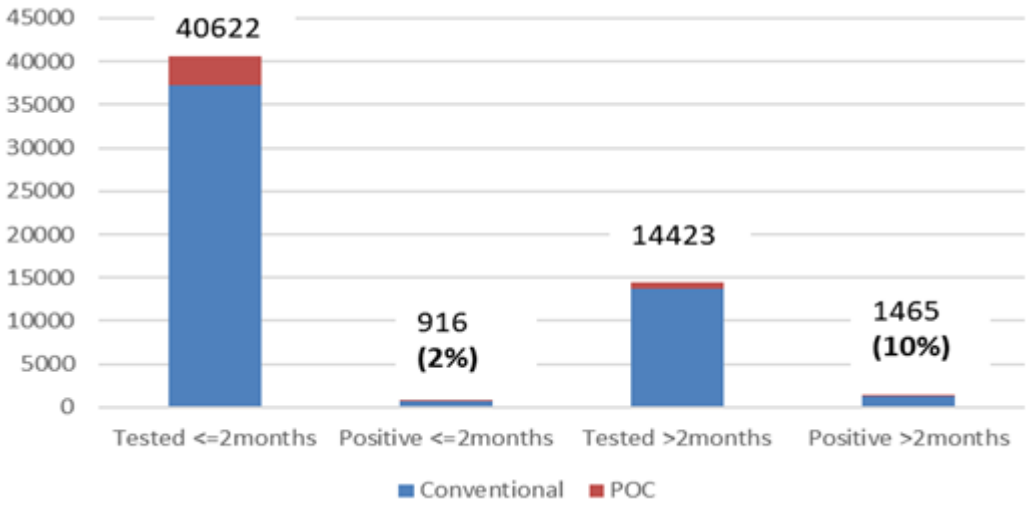


Figure 36: EID Sample Testing

Early Infant Diagnosis (EID) sample testing done on conventional machines is going down due to the introduction of Point of Care (POC) machines. There was higher positivity (10%) among children above the age of two months possibly because of longer exposure period to HIV and the fact that they represent previous missed opportunities.

Prevention Programmes

HIV Testing Services (HTS)

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 out of 1,912 health care facilities are providing integrated HIV Testing services through antenatal clinics, Opportunistic Infection clinics, stand-alone Testing and Counseling centers, outreach centers, TB clinics and STI clinics. HT services are available to all citizens inclusive of key populations.

HTS campaigns were conducted in all districts, and more extensively 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.

STI Programme Highlights

The total number of STI cases reported in 2017 decreased, compared to same period in 2016 for most STI syndromes except other forms of STIs. The major STI syndromes reported were Vaginal Discharge Syndrome (VDS) followed by Urethral Discharge Syndrome UDS, other STIs not classified by syndrome then Genital Ulcer Disease GUD. The increase in non-classified STIs could be a sign of poor diagnosis which could be strengthened through clinical mentorship. According to results of the Aetiology Study of 2015/16, gonorrhoea and chlamydia accounted for 24% and 14 % of VDS infections whilst Trichomonas vaginalis recorded 19% and M genitalium 7 %. Among men presenting with UDS: gonorrhoea and chlamydia accounted for 73% and 22.5 % of infections and few were due to T vaginalis (4%) and M Genitalium (3.5%).The presence of gonorrhoea in UDS is indicative of high risk sexual behaviour. The major cause of GUD was Herpes Simplex Virus 66.6% and Treponema pallidum 22.5%. There is need to strengthen syphilis testing and condom promotion. Coverage for syphilis testing and

treatment in ANC achieved 91% and 78% respectively against the yearly target of 95% for period under review. Poor data capturing, stock-out of Benzathine penicillin and laboratory based syphilis testing in some institutions contributed to low testing and treatment coverage.

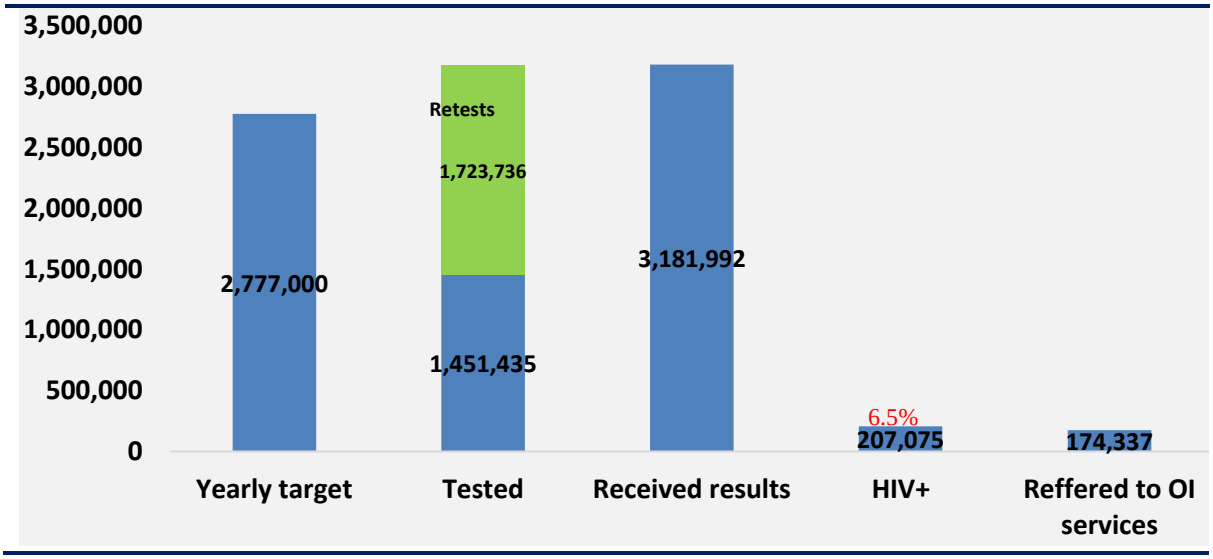


Figure 37: HTS Cascade, Jan-Dec 2017

A total of 3,175,171 clients were tested for HIV during the period under review, resulting in a performance achievement of 115%% against a yearly target of 2,777,000. Disaggregated by province, the highest number of HIV tests and received results Mashonaland West had a highest achievement rate of 135% (429,972) against a target of 319,355. Out of the total tested, 3,181,992 clients received their test results, indicating some -0.02 % leakage in the testing cascade between the total number tested and those that received test results. Out of the 207,075 patients who tested HIV positive, 174,337 (84%) were referred for HIV Care and Treatment services, indicating a 16% leakage in the cascade.

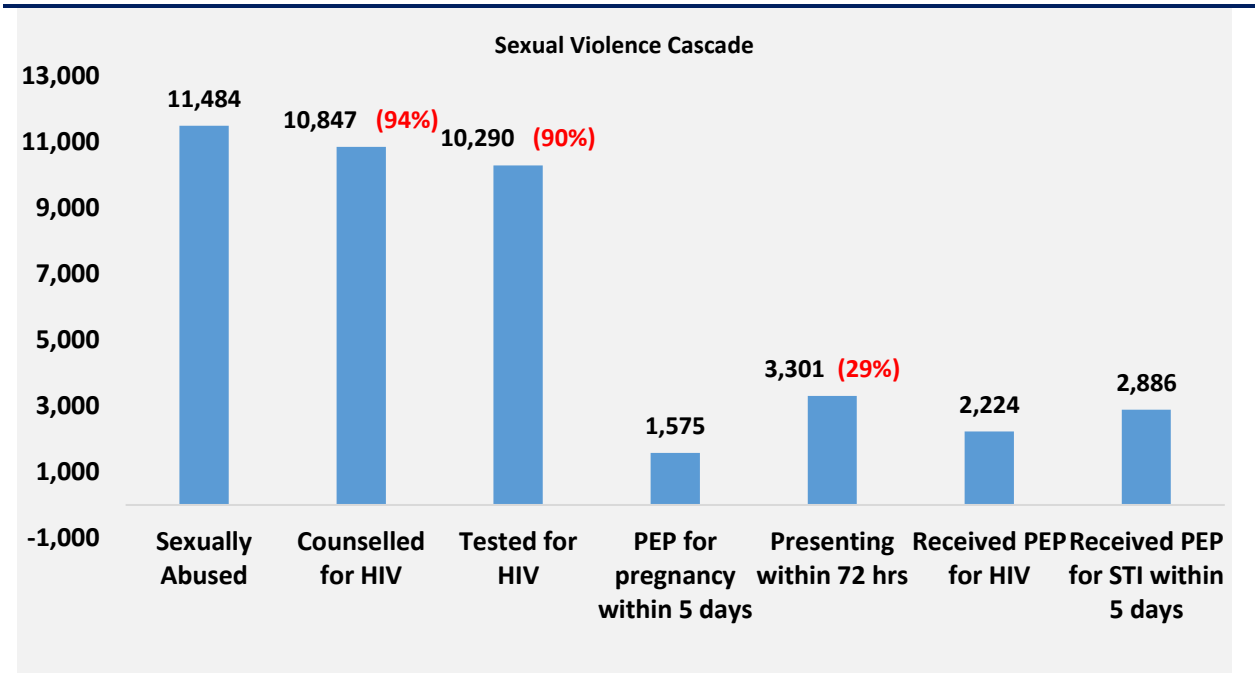


Figure 38: Sexual Violence Cascade Jan-Dec 2017

A total of 11,484 cases of sexual abuse were recorded country wide in Jan-Dec 2017, 94% (10,847) of the sexually abused clients were counselled for HIV and 10,290 (94%) of these were tested for HIV. A total of 3,301 (29%) of the sexually abused clients managed to present within 72 hours.

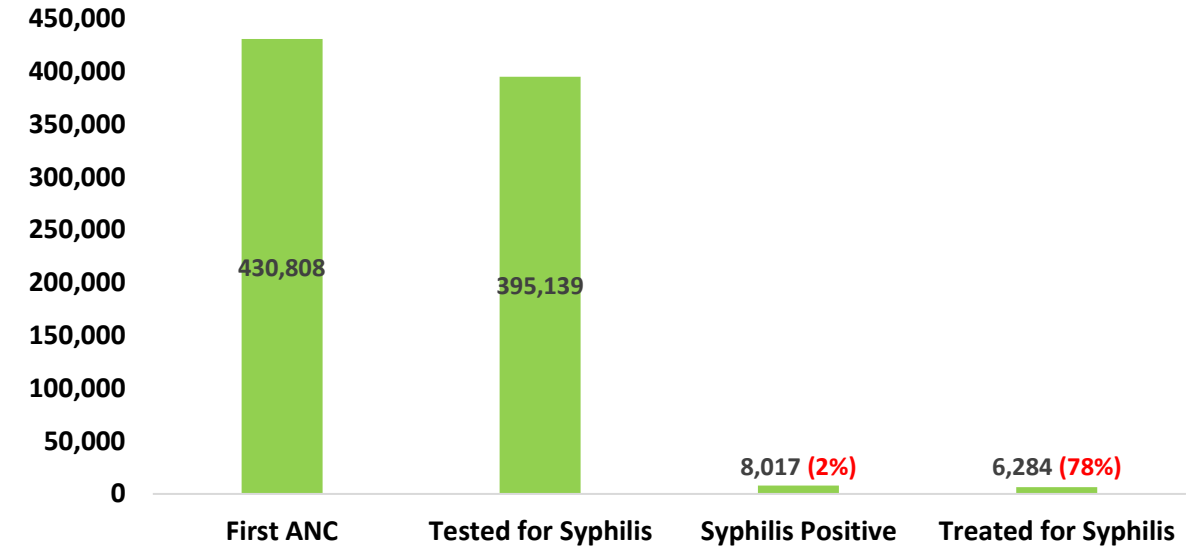


Figure 39: Syphilis Testing and Treatment in ANC Jan-Mar 2017

During the period under review, a total of 430,808 pregnant women attended 1st ANC, and 395,139 (90%) were tested for Syphilis in ANC, out of whom 8,017 (2%) were Syphilis positive. The syphilis treatment coverage was 78 % (6,284). Poor recording and stock-out of benzathine penicillin contributed to low treatment coverage. In some district hospitals syphilis testing in ANC is laboratory based and this results in failure to issue same day results as recommended.

Male circumcision services 2017 cascade (10 – 29 years)

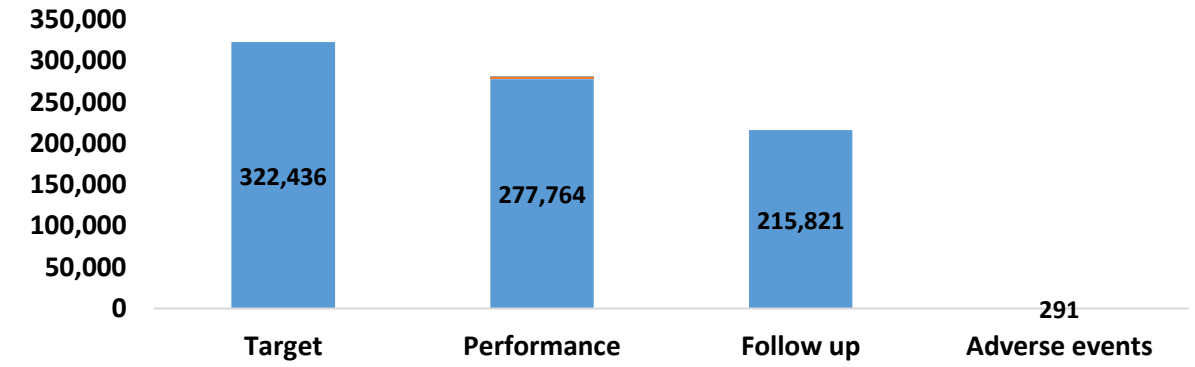


Figure 40: Male Circumcision Cascade, 2017

In the 10 – 29 years age category, the VMMC program performed well with an 87% performance rate, 77% of the clients circumcised returning at least once in 14 days for review. The adverse event rate was 0.1%. The adverse events include bleeding and infections.

HIV Quality Improvement Programme

This initiative jointly coordinated by the HIV/AIDS and the Quality Assurance / Quality Improvement directorates aims to improve the quality of HIV service delivery in the country. Implementation is guided by the QA/QI Policy and Strategy.

In line with the first phase outlined in the QA/QI Strategy of building capacity on QI in selected priority areas, the programme trained an additional 54 health workers from facilities in Mashonaland East. At the end of the training, plans had been developed by each of the facility representatives on how they would implement the programme at their facility.

For the facilities trained previously on the programme, cluster review meetings were convened to glean lessons learnt during programme implementation. Participation was from multidisciplinary teams like nursing managers, OI nurses, quality improvement coaches and district health executives. The objectives of the meeting were to,

1. Share QI implementation experiences, including coaching and performance Measurement.
2. Peer learning platform for participating facilities.
3. Update on national HIV QI activities and future strategic direction
4. Review implementation progress of HIV QI at implementing facilities since training.
5. Identify bottlenecks and challenges with implementation
6. Develop strategies for improvement in implementation
7. DSD update, integration with QI

In addition to sharing best practice, noting common challenges during peer learning there was a planning session in the end in which multidisciplinary teams problem-solved common challenges affecting quality of care at their sites. The following table summarizes the common challenges as well as the best practice seen at facilities as well as recommendations in the OSDM.

Table 31: Common Challenges and Recommendations in the OSDM

Area of focus	Recommendations/Best Practice
Retesting prior to initiation	-Co-locating the PC doing testing with the nurse initiator -Correct documentation of retesting through appropriate use of the columns in the HTS register -Ordering and use of the latest HTS tools
Retention in Care	-Using ePMS to generate list of patients expected for clinical visits. Facilities without ePMS can use appointment diaries. -Using SMS to remind patients of their visits -Using ePMS to identify those that missed visits -Use phones and/or community volunteers to actively search for and bring back to care those that miss visits -Reinforcing adherence issues as well as importance of clinic visits during health education. -More thorough assessment of clients for readiness prior to initiating ART.
VL monitoring and suppression	-Stock management of consumables like syringes, EDTA tubes

	-Using ePMS to identify those that have not yet received VL testing, and to also generate -To prioritize pregnant and lactating women, children, adolescents as well as clients reaching six months on ART for VL.

There has since been a widening of the scope of the program beyond PMTCT and Treatment and Care that had been monitored since the pilot of the programme in 2013. The service areas being monitored for quality of care now include the HTS programme, Treatment and Care, TB/HIV, Lab as well as Pharmacy.

Tuberculosis

Tuberculosis (TB) is a significant public health problem in Zimbabwe with high morbidity and mortality rates. Zimbabwe is one of the eight countries in Africa that appear in all 3 of the World Health Organization (WHO) lists of top 30 countries with high absolute numbers and / or per capita incidence of TB, TB/HIV and Multi – Drug Resistant TB (MDR-TB). These countries contribute 80% of the world's burden of TB. Zimbabwe conducted a TB prevalence survey in 2014, which led to a more accurate estimate of the burden of TB. The estimated TB incidence rate in 2015 was 242 cases per 100 000 population per year, and in the same year about 8 000 deaths were attributed to TB alone. The NTP carried out various activities during the year under review. These include; training at the health facility and community level, active and passive case finding, and treatment of identified cases as well as HIV/TB collaborative activities.

Monitoring and Evaluation / Surveillance: Quality data/information for decision making in planning, implementation, monitoring and evaluation at all levels were generated at all levels. The programme conducted support and supervision, programme performance review, routine data quality assessments and capacity development on quality data collection, analysis and utilisation in the year under review. The program implementation milestones are illustrated in Figure 41.

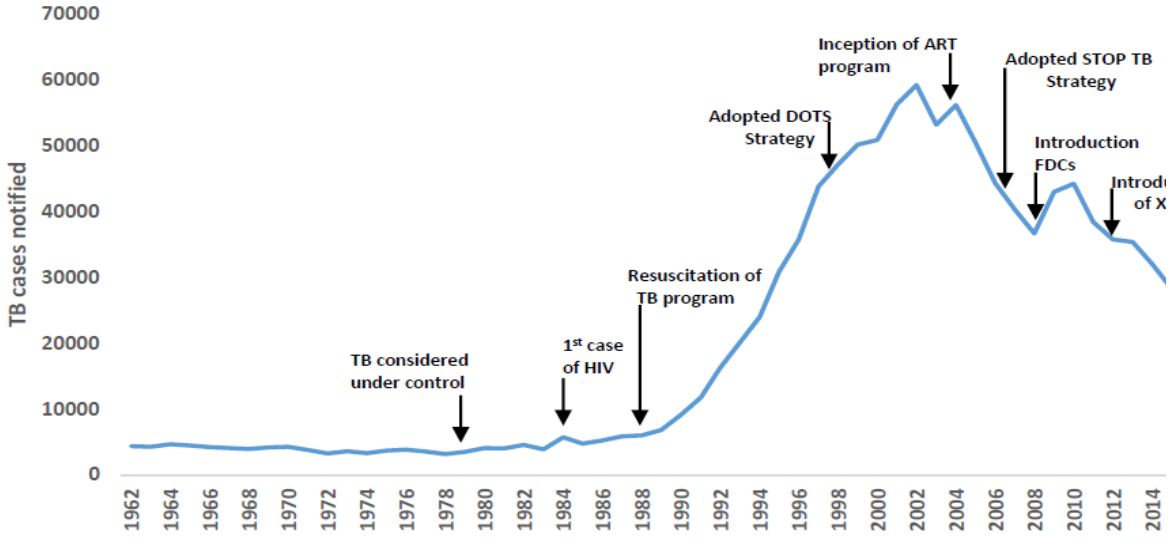


Figure 41: Programme Implementation Milestones

In 1997 the Ministry of Health and Child Care officially adopted the WHO-recommended, Directly Observed Treatment Short-course (DOTS) strategy, and introduced Fixed Dose Combinations for the management of drug susceptible TB in 2004. In 2006, the Stop TB Control Strategy was adopted, which emphasized on the integration of TB and HIV/AIDS control services. Post 2015, the End TB Strategy was also adopted which is addressing the three pillars: Integrated, patient-centered TB care and prevention; Bold policies and supportive systems; Intensified research and innovation.

TB Notifications: Although health care workers have been capacitated and mentored in early TB diagnosis and early treatment of diagnosed TB cases, we continue to lose cases who do not have their specimens sent to the laboratories for testing, or results not collected from the laboratories. Specimen transportation system challenges are a major contributor to the problem of specimens not being sent to the laboratories. When the courier fails to turn up to collect the specimen, the specimens are thrown away.

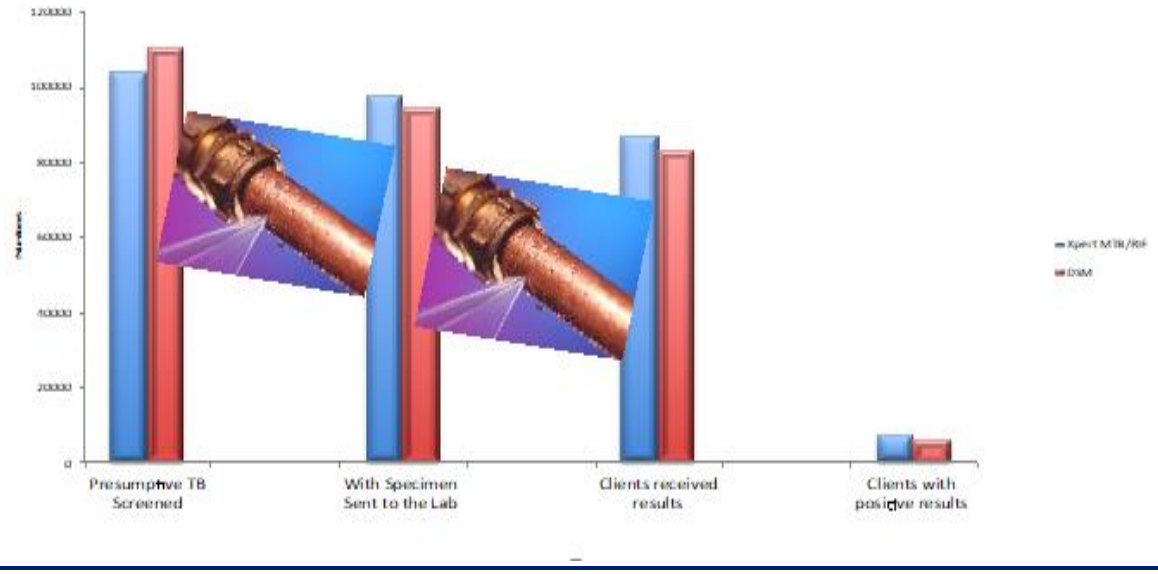


Figure 42: TB National Screening Cascade 2017

A total of 13,058 bacteriologically diagnosed TB cases were recorded in the laboratories, compared to 13, 263 cases reported through programme routine reporting system. The difference is attributed to cases which were diagnosed from central hospitals and referred to the provinces for further management.

2017 Provincial Trends

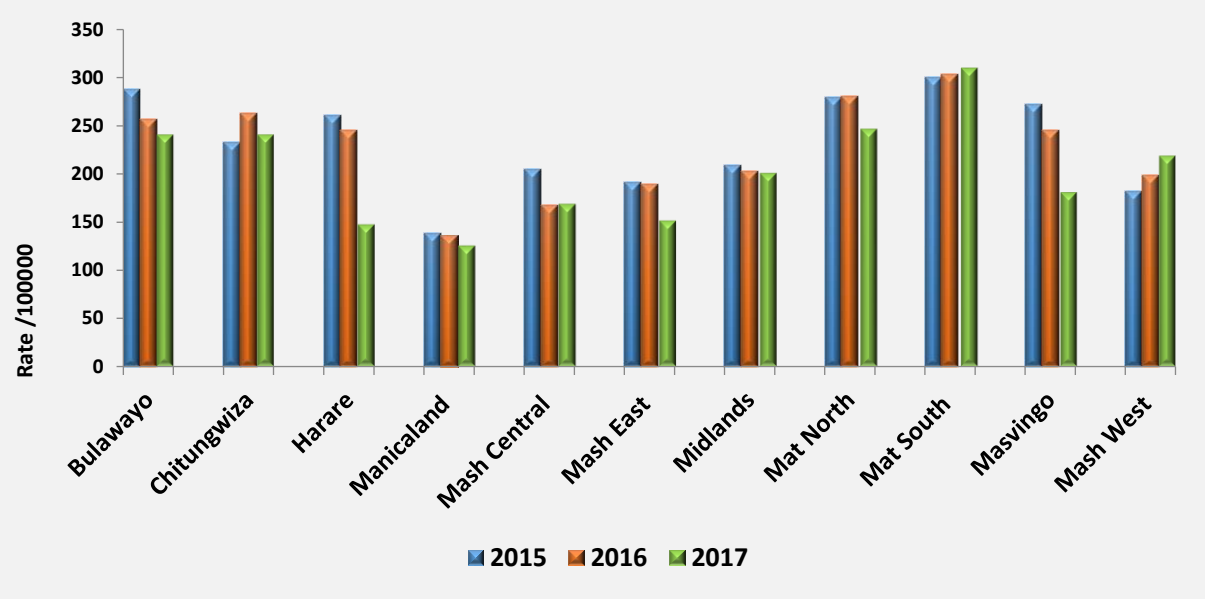


Figure 43: Comparison of 2015 -2017 TB Case Notification by Province

All provinces are experiencing a steady decrease in TB notification rates except for Matabeleland South and Mashonaland West, as shown in Figure 43. Matabeleland South, one of the provinces which were supported by Challenge TB, is known for accurate recording and reporting of TB cases. Matabeleland South conducted strong support and supervision visits to the districts, mentoring, and thorough routine data quality assessment. Mashonaland West TB programme leadership is performing well with accurate reports, updated registers and data validation.

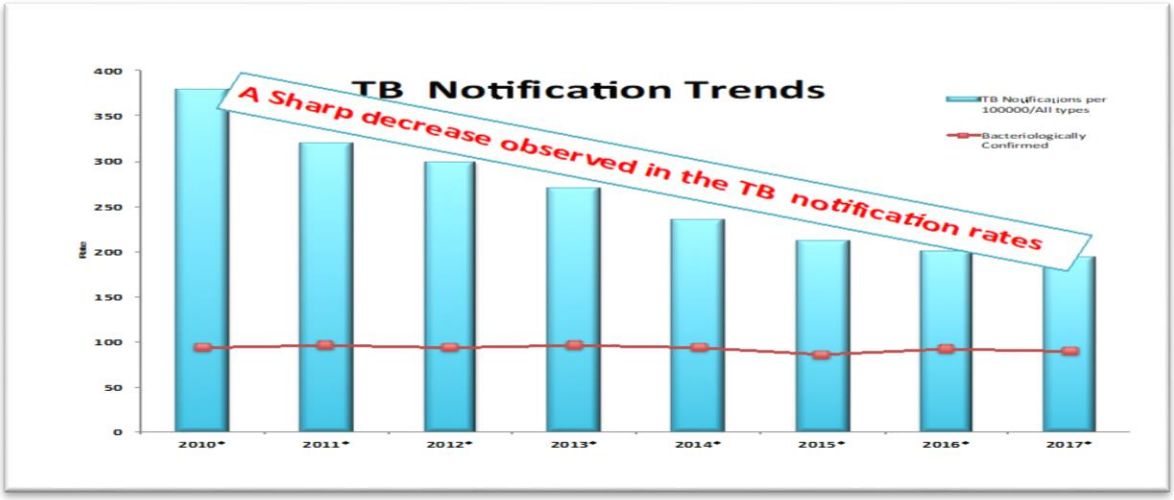


Figure 44: TB Notification Trends per/100000 from 2010 to 2017

Despite the wide coverage of the installation of Gene X pert machines in the country and changing of TB diagnosis algorithm from Direct Sputum Microscopy (DSM) as first choice of TB diagnosis to Xpert MTB/ RIF, the trend of declining of TB notifications remained the same, compared to previous years . The following strategic interventions were employed to improve TB case notifications; Use of Xpert MTB/Rif as a first test for TB diagnosis has been adopted and the programme disseminated the new guidelines and algorithms; Targeted TB screening among high risk groups has been ongoing, and included scaling up bi-directional screening of TB and Diabetes. Mentorship activities have been

ongoing in provinces and the programme continued to support the TB-HIV collaboration activities; Capacity building of HCWs to diagnose childhood TB through knowledge and skills for clinical judgment, performing and interpreting Mantoux; conducting sputum induction and gastric lavage and sustained supply of respective consumables was done; Strengthened specimen transportation system and contact investigation with support from Challenge TB in 21 selected priority districts based on low notifications and poor treatment outcomes through provision of enablers, resources, and motor cycle service and maintenance.

Treatment Outcomes for Drug Sensitive Tuberculosis

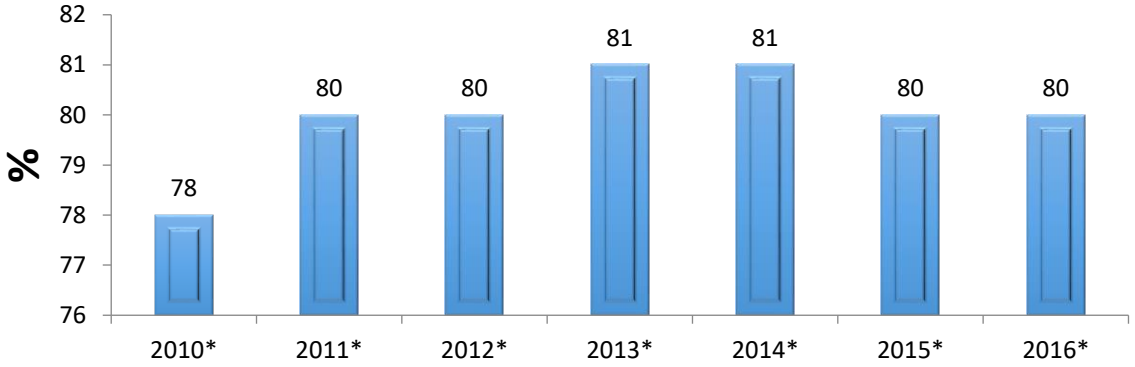


Figure 45: Tuberculosis Treatment Success Trend 2010 - 2016

The programme is struggling to achieve the expected target of 90%. The most contributing factor is high death rates on the southern part of the country. Poor health seeking behavior leading to delayed presentation and delayed initiation of ART contribute to the death rates.

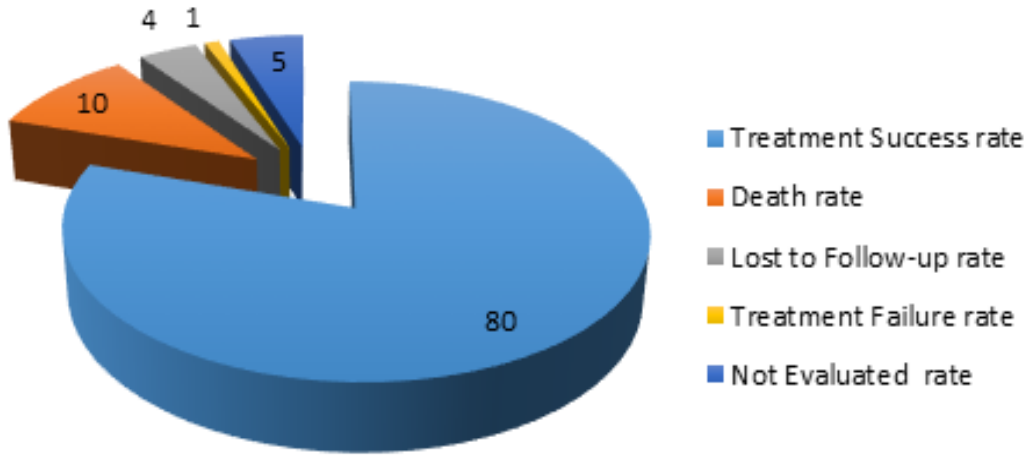


Figure 46: Tuberculosis Treatment Outcomes: National Picture 2016

Table 32: Tuberculosis Treatment Outcomes, Provincial Picture 2016

Province	Treatment Success rate %	Death rate %	Lost to Follow –Up %	Treatment failure rate %	Not Evaluated %
Bulawayo	81	16	2	1	0
Chitungwiza	93	3	2	0	2
Harare	85	6	5	1	3
Manicaland	77	13	4	0	6
Mashonaland Central	82	7	5	1	5
Mashonaland East	78	8	8	0	6
Mashonaland West	80	8	4	1	7
Masvingo	79	8	4	1	8
Matabeleland North	73	16	3	1	7
Matabeleland South	72	19	5	1	3
Midlands	76	12	5	0	7

Some patients presented late in their illness and died whilst on treatment. The top causes of death were anaemia, renal failure, liver failure and opportunistic infections as a result of ART failure. Some patients were deferred ART due to illness.

Program Performance against set targets

TB case notification was below target throughout 2017, as shown in Figure 47 below.

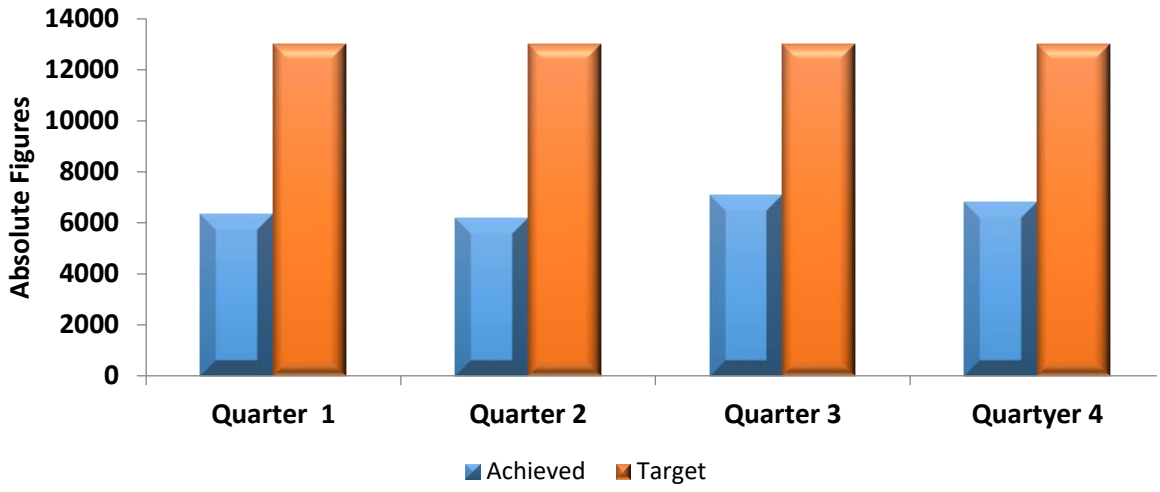


Figure 47: National Notification of TB Cases Against Set Targets

It is important to note that the targets were set based on WHO estimates, which were very high, compared to figures found in the National TB Prevalence Survey conducted in 2014. The National TB Prevalence Survey results showed that TB prevalence in the general population was 320,000/100,000 as compared to 630,000/100,000 from WHO estimates projected before the general survey. Therefore there is a need to set the performance target according the results of the National TB Prevalence Survey results.

Drug Resistant Tuberculosis

The National TB Programme embarked on strengthening case detection on DR-TB cases through training on programmatic management of drug resistant TB; and targeted mass TB screening campaigns in prison settings, densely populated communities, mines, refugees and displaced communities using two mobile trucks that are also fitted with Gene X pert machines. There is also TB screening using X pert MTB/Rif at Zimbabwe's two main borders (South Africa and Botswana).

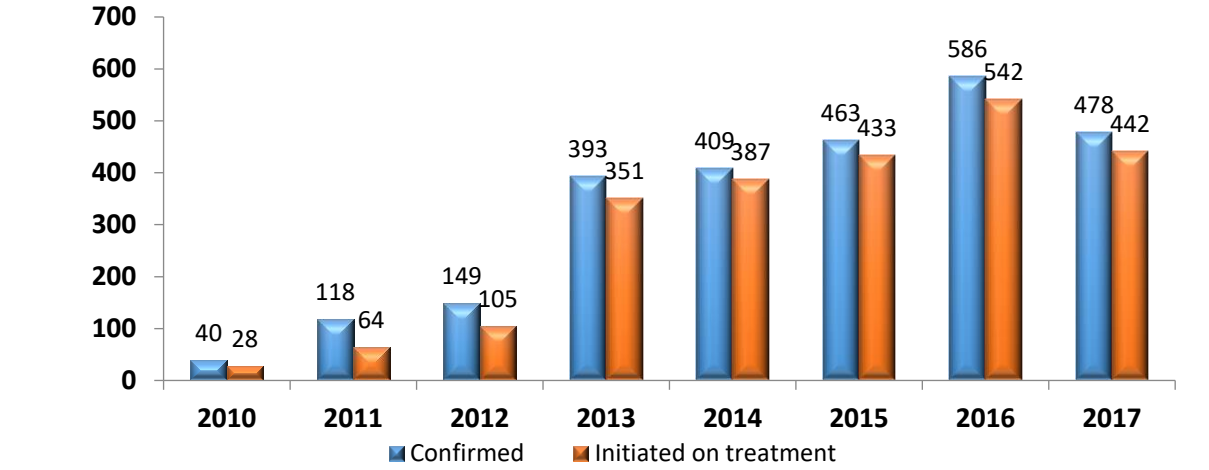


Figure 48: Trends of Drug Resistant TB 2010 – 2017

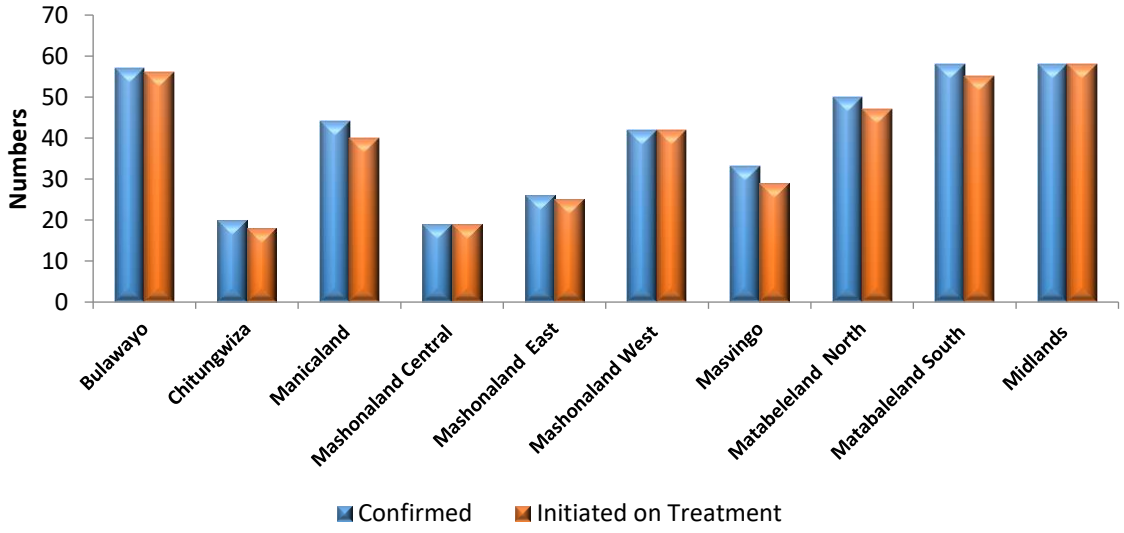


Figure 49: 2017 Confirmed Drug Resistant TB and Compared with Treatment Initiation

The indicator performance was affected by low utilization of X pert machines and the underperforming specimen transportation system. During the period under review the programme strengthened the case finding of MDR-TB cases by coming up with the following strategies: Revised algorithm where the GeneXpert will be used as the first line of TB diagnosis; Continuing with on-job trainings with emphasis on data driven support and mentorship; Strengthening DR TB cases detection through improving specimen transportation system; Training health workers on the new PMDT guidelines.

Treatment Outcome Drug Resistant Tuberculosis

The MDR –TB Success rate continues to decrease despite the monthly allowance given to DR-TB patients to sustain attending assessment reviews and buy food.

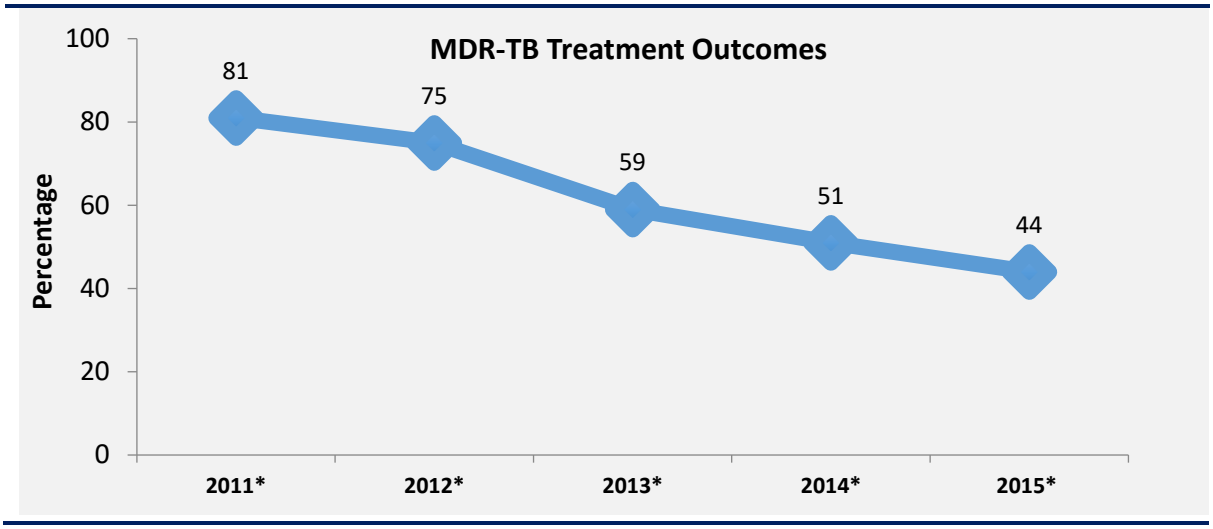


Figure 50: MDR-TB Success Rate Trends 2011 – 2015

The main drivers are negative treatment outcome indicators such as high death rate, lost to follow –up, not evaluated, and data quality issues such as recording and reporting of cases. The solution that is likely to work best is to have a DR-TB electronic patient tracker.

Table 33: National 14 Months Treatment Outcome Report 2015

	Total Registered	Cured	Treatment Complete	Failed	Died	Lost To Follow Up	Not Evaluated	Total Analyzed
RR	354	86	49	3	68	68	80	224
MDR	73	31	19	5	5	4	9	64
XDR	6	4		0	2	0	0	6
Total	**433**	**121**	**68**	**8**	**75**	**72**	**89**	**294**
Treatment Outcomes In %								
%		**44%**		**1%**	**17%**	**17%**	**21%**	

Table 34: Provincial 24 Months Treatment Outcome Report 2015

Province	Treatment Success rate %	Death rate %	Lost to Follow-up rate %	Treatment Failure rate %	Not Evaluated %
Bulawayo	74	15	8	0	3
Chitungwiza	44	21	21	7	7
Harare	69	12	0	0	19
Manicaland	55	23	9	9	4
Mashonaland Central	92	8	0	0	0
Mashonaland East	80	0	0	0	20
Mashonaland West	59	26	11	0	4
Masvingo	76	8	4	2	34
Matabeleland North	28	34	2	2	34
Matabeleland South	40	42	11	2	4

Midlands	63	14	6	6	11

Among the drug resistant TB cases death rate remained high in 2017. Some patients presented late in their illness and died whilst on treatment. The top causes of death being anaemia, renal failure, liver failure and opportunistic infections as a result of ART failure. Some patients were deferred ART due to illness. The TB programme is strengthening community awareness on TB/MDR-TB to ensure that patients seek treatment early. This is being done through training of community health workers, distribution of IEC materials and community TB care M&E tool.

Program Performance against Set Targets

The indicator performance was affected by low utilization of X pert machines and the under-performing specimen transportation system. During the period under review the programme strengthened the case finding of MDR-TB cases by coming up with the following strategies:

- Revised algorithm where the GeneXpert will be used as the first line of TB diagnosis.
- Continuing with on-job trainings with emphasis on data driven support and mentorship,
- Strengthening DR TB cases detection through improving specimen transportation system and training health workers on the new PMDT guidelines.

TB/HIV Collaborative Indicators

TB/HIV indicators showing a trend of patients initiated on ART, Patients with results and proportion of TB patients with HIV positive results.

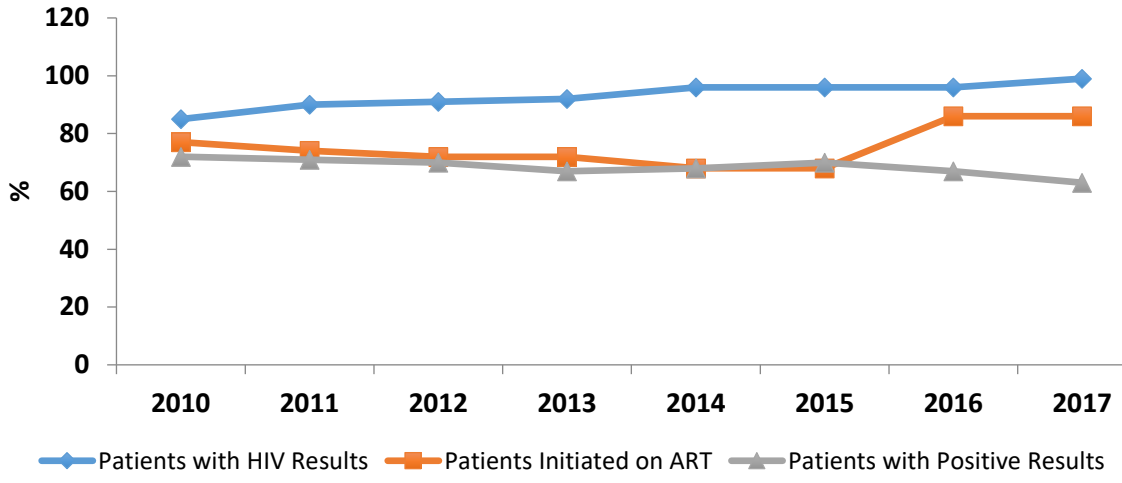


Figure 51: TB/HIV Collaborative Indicators

Scaling up of the provider initiated testing and counselling to all health facilities as well as continued efforts to strengthen TB-HIV integration could to explain the good performance of this indicator. The programme is also supporting the training and on the job mentorship of Health Care Workers using the HIV Integrated Training curriculum to further strengthen TB/HIV collaboration. A one-stop-shop model of care successfully implemented in Integrated TB-HIV Care sites continue to act as centres of excellence from which Health Care Workers carry out clinical attachments to sustain the significant success achieved in integrating TB-HIV integrated services.

Table 35: Provincial Picture on TB/HIV Collaboration Indicators

Province	TB patients with HIV results	TB patients with positive HIV results	Patients initiated on ART
Bulawayo	99	71	90
Chitungwiza	99	58	93
Harare	100	77	64
Manicaland	100	51	84
Mashonaland Central	99	58	94
Mashonaland East	100	65	75
Mashonaland West	99	61	93
Masvingo	100	60	88
Matabeleland North	96	68	87
Matabeleland South	99	71	90
Midlands	99	62	87

The indicator performed well most likely due to the fact that the majority of health centres are now ART initiation sites (decentralization of ART services). The programme is supporting the training of Health Care Workers using the HIV Integrated Training curriculum to further strengthen TB/HIV collaboration. Nurses are seconded for practical attachments to sites that have established a high level of TB/HIV integration such as the Integrated TB and HIV Care sites. This model of integration has been instrumental in promoting ART uptake among TB patients with services for both TB and HIV being provided under one roof (one stop shop concept).

Community Engagement: These activities included annual commemoration of the World TB Day to raise awareness on TB. Initially the commemorations were centralized and with mobilisation of more resources for this activity, commemorations were then decentralized to provinces and lower levels. There was training of community based health workers and volunteers to support treatment at community level (Community DOT). Engagement of Civil Society Organisations in the implementation of community TB care programme. To standardize communication on TB in the country, ACSM guidelines were developed, printed and disseminated to all health facilities and stakeholders. To harmonies the work amongst CSOs, MoHCC and communities on TB, Guidelines on community engagement in TB were developed. There was training of community health workers through CSOs to improve TB case detection at community. For year 2015, about 13% notified TB cases nationally were referred through community structures. There was also Training of journalists to improve on accurate media coverage for TB programme and raising awareness. This has significantly improved the relationship between the programme and the media houses

2.2 Non-Communicable Diseases

2.2.1 Mental Health Services

The Mental Health Services Department (MHSD) continued coordinating provision of mental health and psychiatric services (promotive, preventive, curative and rehabilitative) including substance abuse (Drug, Alcohol and Tobacco Control). The programme goal is to ensure that comprehensive mental health services are available throughout the country. Challenges include Inadequate supply of psychotropic medication; inadequate human and financial resources to effectively and efficiently

implement the planned activities; inadequate of rehabilitation centres for drug abusers in the country. Access to mental health services varies across provinces, as shown in Figure 52.

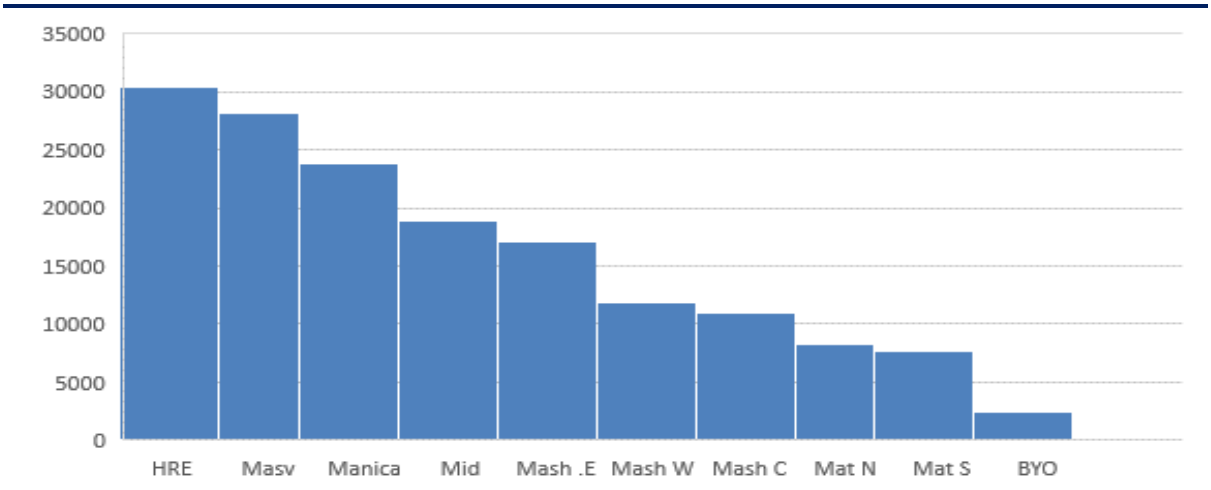


Figure 52: Access to OPD Mental Health Services in 2017 by Province

Highlights for 2017 included the appointment of the Mental Health Review Tribunal, and completion of the final draft of the National Alcohol Policy. Awareness activities on Mental Health and Substance Abuse were conducted. These included commemoration of the World No Tobacco Day, World Mental Health Day, and World Suicide Prevention Day. MOHCC collaborated with the Ministry of Agriculture on a WHO Framework Convention on Tobacco Control Article 17 & 18 survey on alternative crops. The results showed that most tobacco farmers also grew some other crops to diversify food sources, and ensure other income sources. The MHSD continued giving psycho-social support to returning Kuwait victims. Kuwait victims are Zimbabwean citizens who were trafficked from Zimbabwe to Kuwait where they had been promised better jobs and salaries, but on arrival in Kuwait they were treated as slaves. They were used as housemaids in some cases without pay, were ill-treated (abused), worked for very long hours daily, and were psychologically traumatised.

Challenges faced by MHSD included inadequate supply of psychotropic medication, and lack of rehabilitation centres for drug abusers in the country.

2.3 Environmental Health

As a core public health discipline, environmental health interventions fundamentally focus on preventing disease and creating healthy, supportive environments. Programmes undertaken include, Food Safety, Port Health, WASH, Waste Management, Training, and participation in Disease Control programmes which include; the National Malaria Control Programme, the Tuberculosis Programme, Outbreak control, Communicable diseases, International Health Regulations, and Disaster Preparedness.

Promotion of Community Involvement in Community Health Programmes: Each province was targeted to have 400 Community Health Clubs (CHC) formed. CHCs are instrumental in community mobilisation. Mashonaland Central, Midlands, and Masvingo provinces formed more than 400 clubs each. Nationally, 2629 CHCs were formed out of a planned 3200, signifying an achievement of 82%. There has not been any funding for formation and sustaining of CHCs, and Environmental Health Technicians use their initiative to form and sustain these clubs.

Promotion of Construction of Community Blair Latrines: The programme targeted to facilitate construction of 25 000 Blair latrines. The community managed to construct 19 825 (79%) latrines at household level. Each province had a target of 3 125, but only Midlands achieved this, largely due to the support given by Zvitambo. The achievement has pushed the national coverage of families with access to unshared safe sanitation to 33%.

Protected Family Wells: Whilst the coverage of safe water is above 65%, the distance to the protected water has influenced families to provide protected individual family wells. Nationally a total of 2046 family wells were protected in 2017, surpassing the target of 2020. This has improved access to safe water.

Food and Water Safety: Food safety covers a wide range of activities, which include regulation, food inspections, and inspection of premises, food sampling, and interpretation of food laws. Food sampling was targeted as an indicator of food quality monitoring. There were plans to collect 2000 food samples but only 1404 samples (79%) were collected. However provinces like Masvingo and Mat South exceeded their targets, whilst Mat North didn't collect a single sample. Zimbabwe as a country started mandatory food fortification in July 2017, which saw a number of companies fortifying the four main food vehicles namely maize meal, wheat flour, cooking oil and sugar. A monitoring and sampling framework for these commodities was developed. The MoHCC procured food sampling and monitoring equipment from the EU through the Sanitary Phyto-Sanitary Committee.

A total of 13182 water samples were collected against a target of 10 000. Each province targeted 1000 water samples, and 6 provinces exceeded their targets, with Midlands and Manicaland trebling and doubling their targets respectively.

Premises Inspections: Only Mashonaland East and Mashonaland West did not achieve the 10 000 premises they were targeted to inspect. The rest of the provinces exceeded the target, with Midlands doubling its target.

Port Health: There are 15 ports of entry where port health is functional in the country. These ports of entry are Robert Gabriel Mugabe International Airport, Joshua Mqabuko Nkomo International Airport, Victoria Falls International Airport Forbes, Chirundu, Nyamapanda, Espungabeira, Kariba, Beitbridge,

Mpoengs, Plumtree, Maitengwe, Victoria Falls, and Mukumbura. Important border posts like, Sango, Kazungula and Pandamatenga have no functional port health services. Three border posts (Victoria Falls, Forbes and Beitbridge) are targeted for upgrading to One Stop Border Posts.

Food Safety Project: The MoHCC commenced a national food safety programme entitled "Strengthening the National Food Control System in Zimbabwe" that will run from October 2016 to September 2018, and is funded by FAO. The Project includes a thorough review of existing legislation and recommendations, the development of new legislation or amendments of existing legislation as required, strengthening the food control system as well as training which is needed at all levels in order to develop capacities and competencies needed to implement an effective food control system.

International Health Regulations: A Joint External Evaluation of the country was conducted in 2017 using the Joint External Evaluation Tool developed by the Joint External Evaluation (JEE) process as part of the International Health Regulations (2005) Monitoring and Evaluation framework. The JEE

tool is intended to assess country capacity to prevent, detect, and respond to public health threats independently of whether they are naturally occurring, deliberate, or accidental..

Challenges: The Environmental Health Department needs more EHTs as there is 41% vacancy, EHOs 34% DEHOs 41% and port Health 60%. Inadequate staff has left most of the population not accessing environmental health services. The current freeze by Treasury affecting new appointments impacts severely on effective service delivery. Poor funding has affected achievement of set targets like in food safety, WASH, water quality monitoring. The country lags behind in terms of use of new innovations and technologies in food safety (rapid test kits, modern machinery).

Recommendations

1. Increase the employment rate from around 50% currently to 90-100% to ensure improved access to environmental health services by communities.
2. All ports of entry should remit a proportion of their user fees to national level to enable equitable repositioning of resources to all identified levels
3. To build collaborations/ partnerships to monitor pollution in identified area, e.g. Harare, Bulawayo, Chitungwiza, major mines and other major centers

2.4 Family Health

The main objective of the Family Health Department is to safeguard the health of Zimbabweans through the provision of maternal and child health services, including nutrition and the utilization of basic preventive, curative and rehabilitative services especially for the poor and vulnerable groups with an emphasis on scaling up implementation of Primary Health Care services and corresponding referral facilities.

Nutrition

The Nutrition Program in the MOHCC seeks to improve the quality of life of the people of Zimbabwe by promoting Healthy Living through preventing and reducing Nutrition Related Disorders.

Growth Monitoring: The MoHCC conducts monthly growth monitoring of children 0-59months.

Table 36: Children 0-59 Months Measured in 2017.

Province	Measured	Moderate Stunted	Severe Stunted
Bulawayo	18,467	720	273
Harare	80,611	901	227
Manicaland	73,226	2,296	692
Mashonaland Central	50,242	1,943	513
Mashonaland East	48,673	2,081	814
Midlands	44,886	1,742	692
Matabeleland North	24,607	878	146
Matabeleland South	25,948	898	276
Masvingo	62,617	1,011	272
Mashonaland West	54,823	1,489	468
National	**484,100**	**13,959**	**4,373**

Source: HIMS (2018)

Nationally 484,100 Children U5s were measured for stunting in 2017, and 13,959 were moderately stunted, while 4,373 were severely stunted. Mashonaland East had the highest number of severely stunted children, followed by Manicaland and Midlands.

Table 37: Children 0-59 Months Weighed in 2017.

Province	Weighed	Moderate Underweight	Severe Underweight
Bulawayo	21,344	684	269
Harare	83,762	859	243
Manicaland	89,943	2,437	534
Mashonaland Central	54,654	1,851	472
Mashonaland East	57,201	2,383	570
Midlands	49,630	1,727	539
Matabeleland North	27,593	1,165	181
Matabeleland South	27,752	815	236
Masvingo	66,887	810	164
Mashonaland West	59,791	1,481	371
National	**538,558**	**14,211**	**3,578**

Source: HMIS (2018)

A total of 538 558 were weighed in 2017, and 14 211 were found to be moderately underweight, while 3, 578 were severely underweight. Four of the provinces (Manicaland, Mashonaland Central, Mashonaland East and Midlands) had high number of severely underweight children ranging from 472 to 570.

Integrated Management of Acute Malnutrition (IMAM): The majority (25 348) of IMAM admissions were for the 6-59 months age-group (Table 38). The under 5s are at risk from the moment they are introduced to other foods mainly due to issues of food insecurity at household level. Inadequate nutrition education is also another contributing factor hence the need to invest in advocacy and communication. The burden of severe acute malnutrition is still high as shown by the increase in admitted cases from 28 875 in 2016 to 36 278 in 2017.

Table 38: IMAM Admissions in 2017

Province	0-5mnths	6 -59mnths	relapse	U5s	5 yrs+
Bulawayo	35	737	41	813	659
Harare	128	2,162	162	2,452	2,749
Manicaland	326	3,605	112	4,043	327
Mashonaland Central	158	3,494	171	3,823	432
Mashonaland East	154	2,173	96	2,423	661
Midlands	333	4,986	133	5,452	701
Matabeleland North	124	1,991	124	2,239	967
Matabeleland South	88	1,550	62	1,700	225
Masvingo	129	1,883	128	2,140	813
Mashonaland West	127	2,767	113	3,007	652
National by age	**1,602**	**25,348**	**1,142**	**28,092**	**8,186**
National total admissions				**36,278**	

Source: HMIS 2018

Table 39: IMAM Outcomes in 2017

Outcome	Number (No.)	Percentage (%)
Cured	15,313	67%
Defaulted	3,666	16%
Died	598	3%
Non-recovered	3,275	14%

Source: HMIS (2018)

The IMAM programme is doing well, although it failed to reach the national cure rate target of 75% and only achieved 67% in 2017. There were 3% deaths (national target 5%).

Severe Acute Malnutrition (SAM): The cases of SAM are still very high in the country, with 16, 753 SAM cases being recorded in 2017 Table 40). There is need to expand the active screening to all rural districts to ensure that all SAM cases are detected and treated.

Table 40: SAM Cases in 2017

Province	Bilateral Oedema	Marasmus	Pellagra	SAM
Bulawayo	534	315	40	**889**
Harare	1,186	84	136	**1406**
Manicaland	1,830	778	282	**2890**
Mash Central	1,373	759	53	**2185**
Mash East	1,323	507	104	**1934**
Midlands	1,756	676	130	**2562**
Mat North	552	447	136	**1135**
Mat South	364	324	96	**784**
Masvingo	675	260	136	**1071**
Mash West	1,229	477	191	**1897**
National	**10,822**	**4,627**	**1,304**	**16,753**

Source: HMIS 2018

Vitamin A Supplementation: A total of 932 479 children received their Vitamin A during the first half of 2017 against a national target of 1,500,000. This translates to 69% of the children, a marked improvement from 60% over the previous two years. A total of 981 203 received their Vitamin A in the last half of 2017 against a national target of 1,500,000 under 5s aged 6- 59months. To improve Vitamin A coverage, there is need for community supplementation using VHWs.

Baby Friendly Hospital Initiative: The Ministry of Health and Child Care and its development partners have committed to the implementation of Baby-friendly Hospital Initiative (BFHI) as one of the child survival strategies. In line with the strategy a BFHI Assessor Training was done, and 7 hospitals were assessed.

Hospital Food Services: The HFSS Training School has undertaken a study of prison catering services nationwide which showed low cases of SAM in prisons. The school also undertook anthropometry measurements at Health Expos, and the results showed that most women were overweight, which is a worrying trend. There is need for inter-departmental collaboration between Nutrition and NCDs departments.

Constraints and Recommendations: Although 2017 was generally a successful year, some the programme faced several constraints, including the following:

- Nutrition Ward Coordinators needed motorbikes or bicycles for better reach out as the distance between some wards was big and it would be tiresome.
- Lack of coordination among partners and the MoHCC resulted in some communities not wanting to cooperate in some programmes.
- There is a general misconception that Nutrition is a stand-alone programme, and therefore behaviour change was difficult as some think that Nutrition personnel are parallel to Health Promotion Officers
- Some facilities did not have enough register thus leading to poor data quality

Best practices/ Opportunities

- Nutrition and HIV Integration was a success
- The Development of a Mother-Baby Pair Register was one of the best practises as we discovered that the mother baby pair register was important in making work easier and reducing the workload for nurses at health facilities

Recommendations

- There is need for the integration of BFHI steps in reproductive health protocols.
- Partners to work and plan together with relevant sectors to achieve more and to standardise the information shared and reported.

CHILD HEALTH

Major Programme Outputs in 2017

1. Launched the Child Survival Strategy
2. Reviewed community RMNCH register and VHW reporting form that was piloted in Manicaland.
3. Conducted ETAT trainings and post training follow up visits.
4. Developed Vitamin A implementation guidelines by VHWs
5. Commemorated jointly the World Pneumonia and World Prematurity days
6. Monthly child mortality meetings being coordinated and conducted through PAZ
7. Conducted monthly child survival meetings

Figure 53 below shows that perinatal death rate fell down from 38% in 2013 to 29% in 2017(HMIS, 2018).

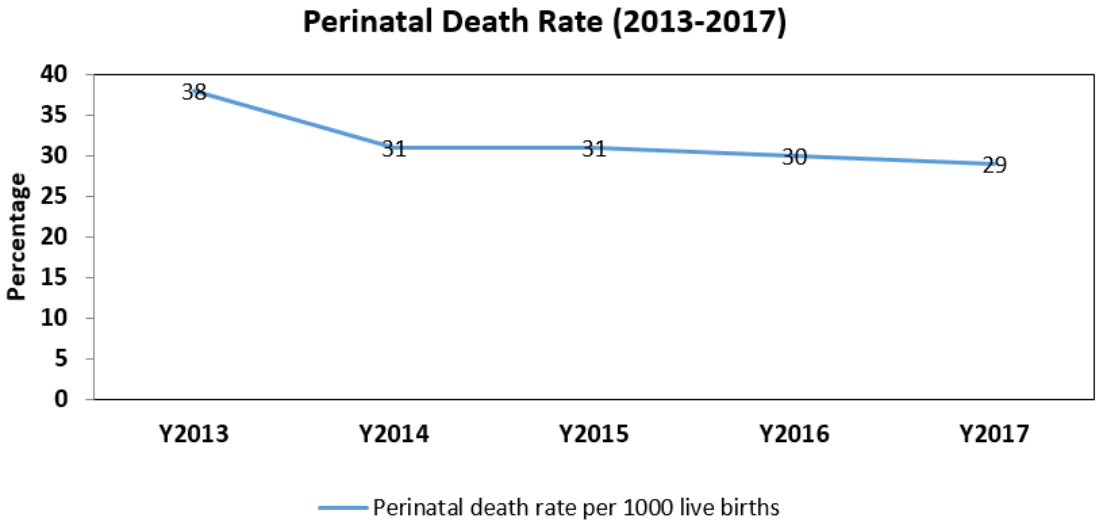


Figure 53: Perinatal Death Rate by Year

Figure 54 below also shows that fresh still birth rate declined from 8% in 2013 to 6% in 2017 and seems to have stagnated (HMIS, 2018).

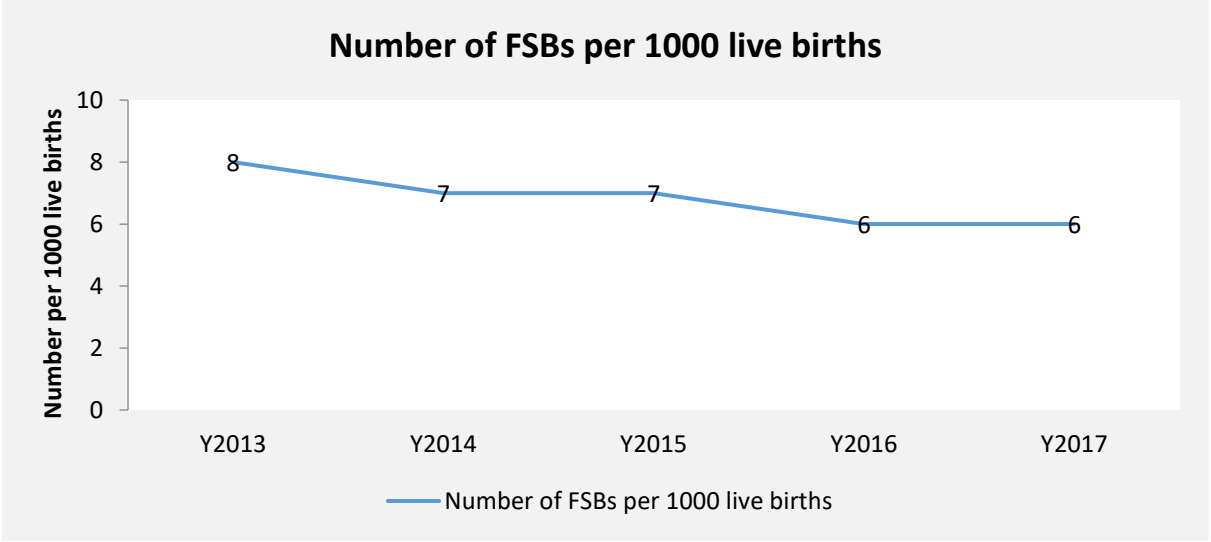


Figure 54: Fresh Still Birth Rate by Year

Figure 55 below shows that early neonatal deaths declined by a percentage point from 14% in 2016 to 13% in 2017(HMIS, 2018).

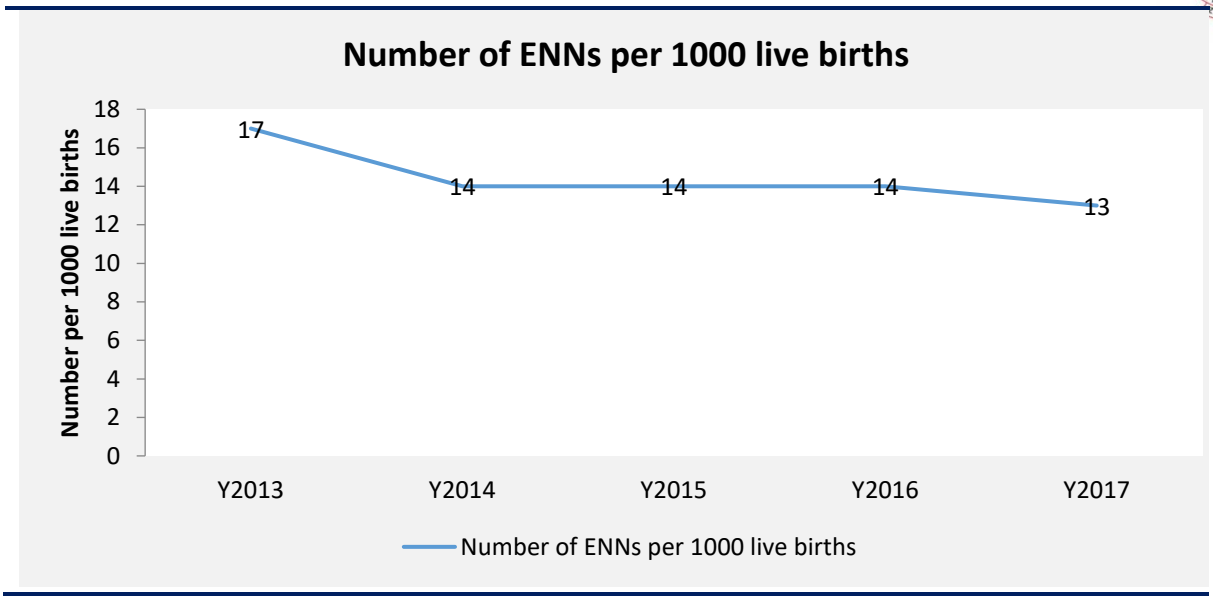


Figure 55: Early Neonatal Deaths by Year

Other indicators

According to the Vital Medicines Availability and Health Services (VMAHS) report availability of benzyl penicillin was at 96.4% in the last quarter of 2017 with PHC showing a higher availability rate of 96.9% compared to 91.6% for the secondary and higher level facilities. However according to the DHIS2 the proportion is 67.7%.

1. By end of 2017, only 2 rural provinces were still awaiting ETAT training compared to 5 in 2016.
2. The Ministry of Health and Child Care (MoHCC) set ambitious targets that at least 2 health workers at every health facility be trained in IMNCI. By 2017 the MOHCC has achieved 87.6% of health facilities with at least 1 IMNCI trained health worker and 49.8% of health facilities with at least 2 IMNCI trained health workers
3. Proportion of U5 Diarrhoea cases treated with ORS and Zinc sulphate in 2017 was 5.4%. In 2016 this indicator has no data on the HMIS however the ZDHS for 2015/6 estimated this at 14.9%. This raises questions on the quality of data on this indicator on DHIS-2

Other programme performance indicators can only be measured through surveys and these were not done in 2017.

Recommendations

1. Scale up Community RMNCH Register and report community deaths through DHIS2. This will strengthen community management of neonatal and childhood illnesses.
2. Conduct death audits for children. Notify all deaths for children under five years and analyse data. Currently, an analysis of key causes of childhood deaths cannot be done.
3. Conduct assessment for training approaches, needs and available skills in IMNCI and ETAT. There is need to take stock of the best approaches for training and skills development.
4. Improve quality of care (through clinical mentorship and on job trainings).
5. Define package of services and equipment for neonates for all levels and conduct assessment of the status. This will be important to improve quality of care for newborns.

6. Review data collection tools and data elements in order to collect vital child morbidity and mortality data in appropriate age groups. Critical activity to have improved data for decision making.

REPRODUCTIVE, MATERNAL, NEWBORN AND ADOLESCENT HEALTH

Major Programme Outputs for 2017

- Developed and piloted an ePartograph as a component of the Delivery module in the Electronic Health Records (EHR)
- Deployed the ePartograph to 8 RHCs in Uzumba-Maramba-Pfungwe District
- Procured and distributed essential MNH commodities (including blood 11,000 units of blood and more than 4 100 women benefited from the blood)
- Adopted WHO recommendations on 8 ANC contacts
- Launched the national Obstetric Fistula program in Gweru
- Conducted post-training follow up and on-the-job training of service providers in EmONC
- Capacitated 580 health workers in providing LARCs (IUCD and Implanon NxT)
- Launched and disseminated the National ASRH Strategy II
- Established 11 new VIAC sites
- Launched the national Cervical Cancer Prevention and Control Strategy
- Finalized development of national guidelines for improving neonatal outcomes
- Rolled out KMC to 20 district hospitals
- Rolled out the electronic maternal and perinatal death notification system (eMPDNS) to Midlands.
- Conducted assessments in RMNCH- Ambulance services availability and functionality, Community linked maternal death surveillance and response (CLMDSR).
- Produced and published the quarterly RMNCAH&N scorecards.

.

Performance on Key Programme Indicators

Results below provide a snapshot of the status of key programme indicators in 2018.

Antenatal Care Coverage (First Visit)

A total of 435,829 pregnant women were booked for ANC in 2017. Figure 56 shows that ANC coverage increased by one percentage point from 78% in 2016 to 79% in 2017(HMIS, 2018).

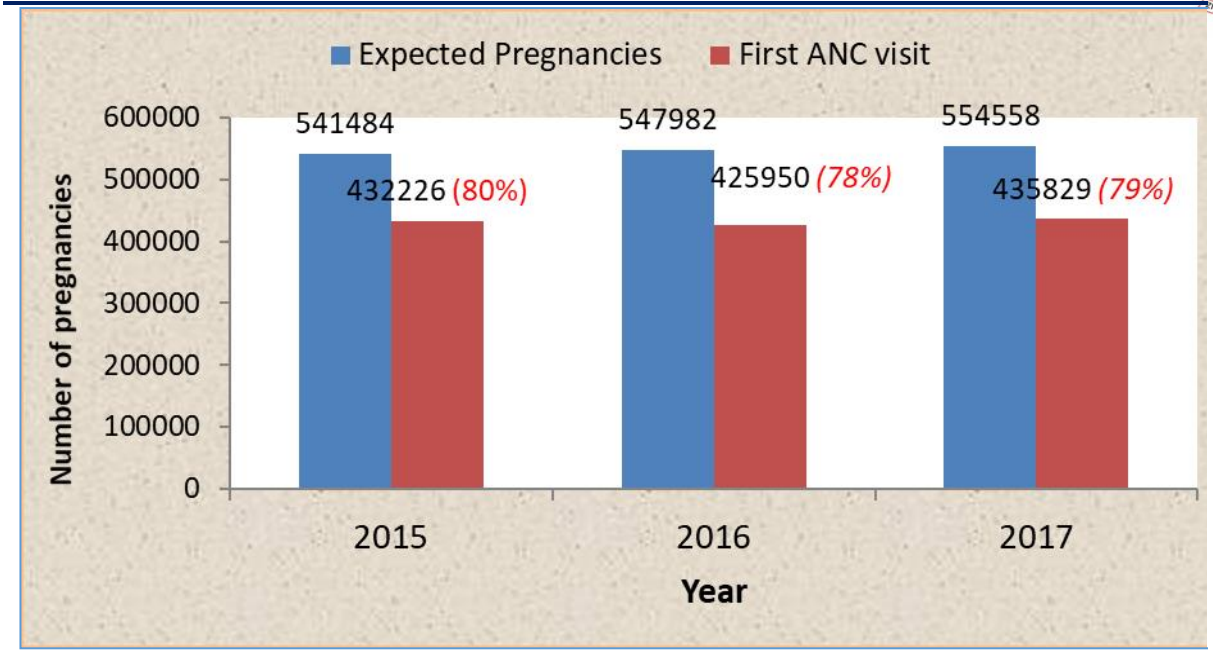


Figure 56: Antenatal Care Bookings by Year

Gestational Age at Booking

The proportion of pregnant women who booked early (below 16 weeks gestation) increased by 6 percentage points since 2014 (figure 57).

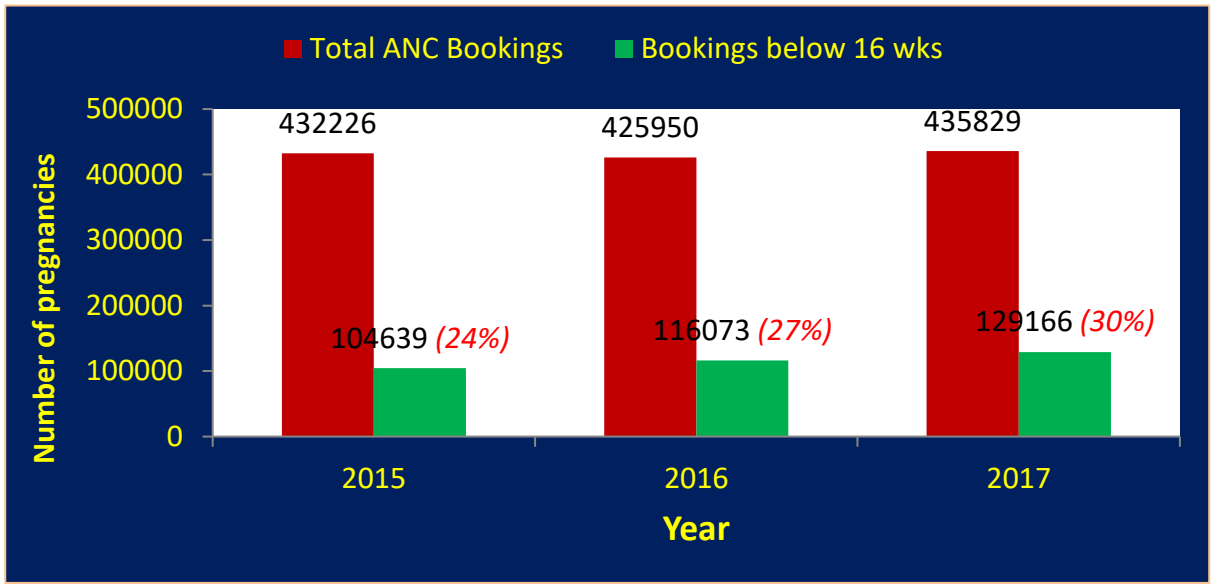


Figure 57: Booking Below 16 Weeks Gestation

Antenatal Care Coverage (Fourth Visit)

The proportion of pregnant women with at least four antenatal care visits increased from 78% in 2016 to 81% in 2017 (Figure 58). (HMIS, 2018).

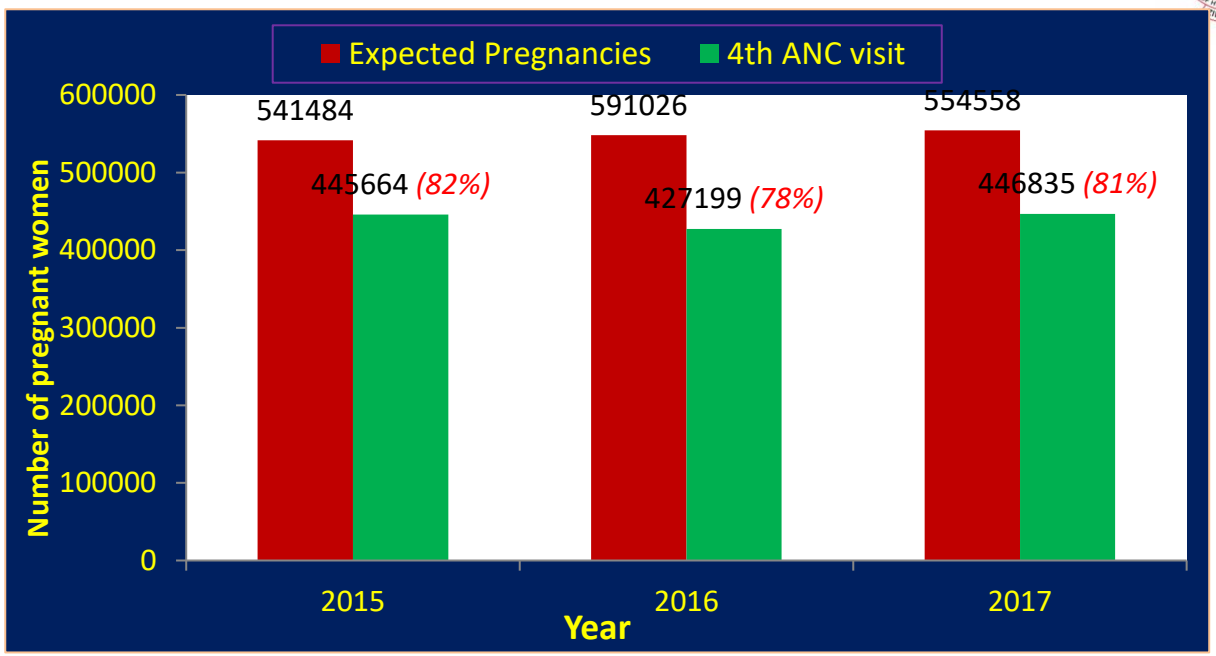


Figure 58: Fourth Antenatal Care Visit by Year

Institutional deliveries

The proportion of institutional deliveries remained stagnant at 83% between 2016 and 2017, after having declined from 84% in 2015 (Figure 59). (HMIS, 2018).

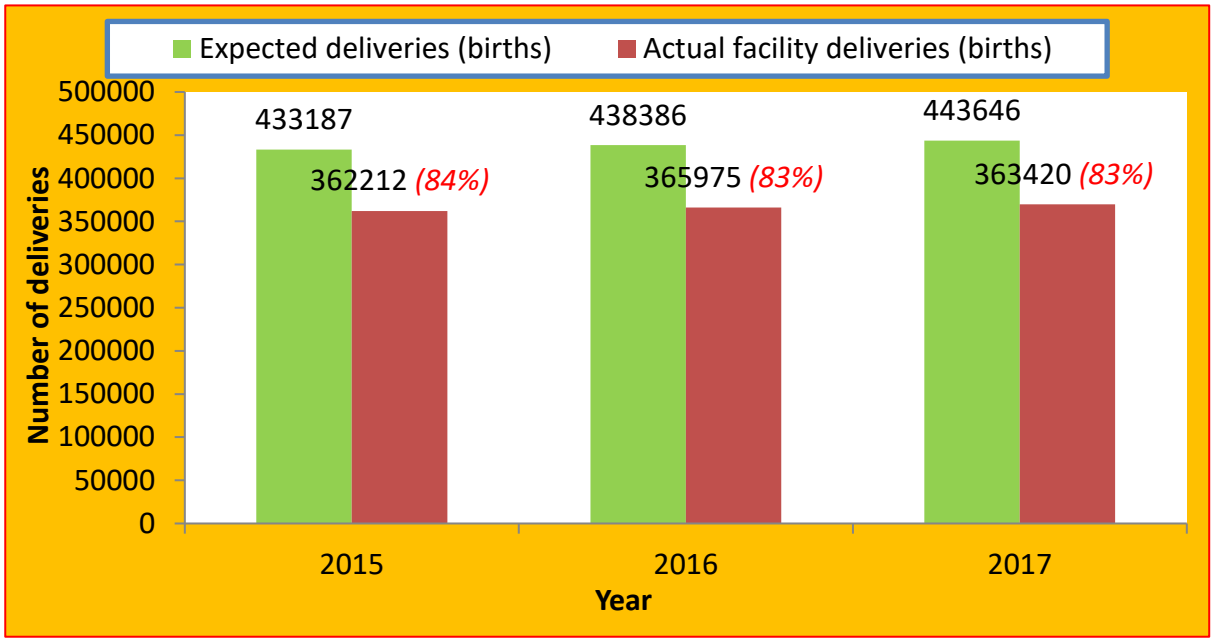


Figure 59: Institutional Deliveries by Year

Deliveries by Caesarean Section

Caesarean section rate has increased by almost 2% since 2013 (Table 41). Debate is currently ongoing on country specific targets for caesarean section. (HMIS, 2018).

Table 41: Deliveries by Caesarean Section in 2017

Year	Number of c/sections done	Total births	C/section rate	Target
2013	26,546	411,861	6.4%	10%
2014	27,328	390,403	7%	10%
2015	28,953	394,701	7.3%	10%
2016	31,841	394,741	8.1%	10%
2017	32,877	396,808	8.3%	10%

Post-natal Care

Post-natal care coverage has been increasing since 2013. PNC coverage at day 1 increased by 10% since 2013; and PNC at day 3 increased by 6 percentage points (Figure 60). (HMIS, 2018).

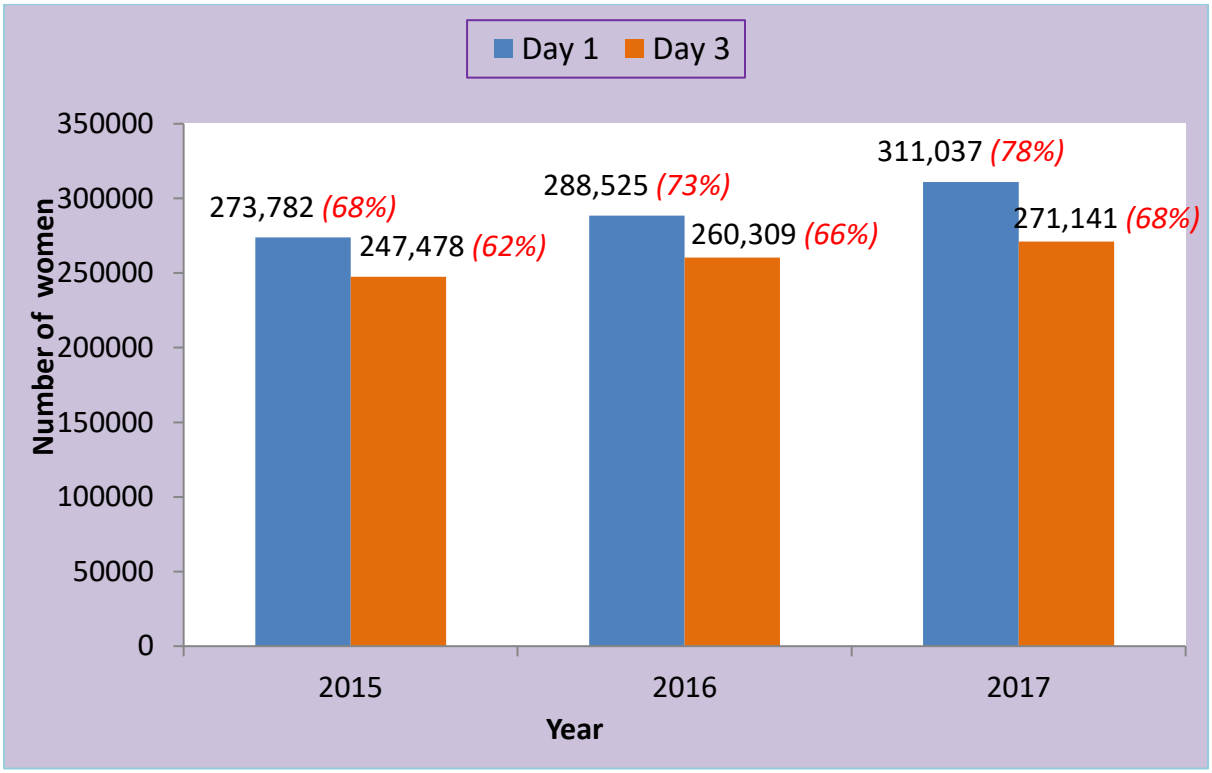


Figure 60: Post-Natal Care by Year

Maternal deaths

The total number of maternal deaths as reported by health facilities through the HMIS/T5 remained almost constant at 528 in 2016 and 529 in 2017. However, there was a significant improvement in the notification of maternal deaths through the maternal death notification form between 2016 and 2017 from 70% to 80% (HMIS, 2018).

Table 42: Distribution of Maternal Deaths by Province, Year and Source of Data

Province	Number of Maternal Deaths and Live Births							
	2016				2017			
	Live births	Maternal deaths			Live births	Maternal deaths		
	HMIS (T5)	HMIS (T5)	Death notification forms received	Notified as (%) of T5	HMIS (T5)	HMIS (T5)	Death notification forms received	Notified as (%) of T5
Bulawayo[2]*	19,836	63	39	62%	18,380	83	79	95%
Harare[3]*	62,910	193	114	59%	59,522	172	134	78%
Manicaland*	52,257	44	26	59%	52,736	62	49	79%
Mashonaland Central	38,465	34	29	85%	38,903	25	8	32%
Mashonaland East	42,303	28	31	111%	40,409	33	29	88%
Midlands*	43,280	48	45	94%	45,113	53	36	68%
Matabelelaland North	21,628	23	18	78%	22,539	14	13	93%
Matabelelaland South	18,146	13	13	100%	18,593	6	4	67%
Masvingo*	42,078	39	27	69%	44,438	33	36	109%
Mashonaland West*	49,271	43	25	58%	49,476	48	33	69%
Total	**390,174**	**528**	**367**	**70%**	**390,109**	**529**	**421**	**80%**

Data seems to suggest that notification of maternal deaths from the provinces that are implementing the eMPDNS has improved over the two year period (2016 and 2017) when compared to those that are notifying through hard copies of the maternal death notification forms.

The major direct causes of maternal mortality in 2017 were post-partum haemorrhage (22%), eclampsia (16%), and infections (14%), (Figure 61). AIDS related conditions accounted for 10% of the deaths, mainly due to cryptococcal meningitis, pulmonary TB, atypical pneumonia and chronic diarrhoea.

[2] Include Bulawayo city, United Bulawayo Hospitals and Mpilo Central Hospital
[3] Include Harare city, Parirenyatwa Group of Hospitals, Harare Central Hospital and Chitungwiza Central Hospital
* Provinces notifying maternal deaths through the eMPDNS – Harare Central Hospital, UBH, Mashonaland West, Midlands, Manicaland and Masvingo

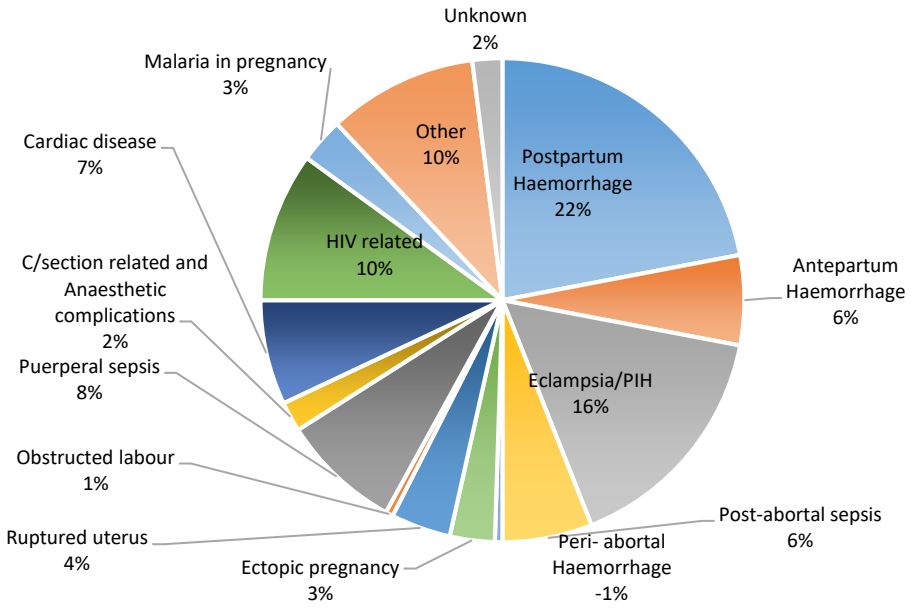


Figure 61: Percentage distribution of deceased women by cause of death (n=421)

Cause of death among women aged 15 - 24 years (n= 98). The major direct causes of maternal mortality among women aged 15 – 24 years in 2017 were puerperal sepsis (16%), eclampsia/PIH (16%) and post-partum haemorrhage (14%), as shown in Figure 62. Other conditions accounted for 13% of the deaths and these include medical conditions such as diabetes mellitus, embolism etc.

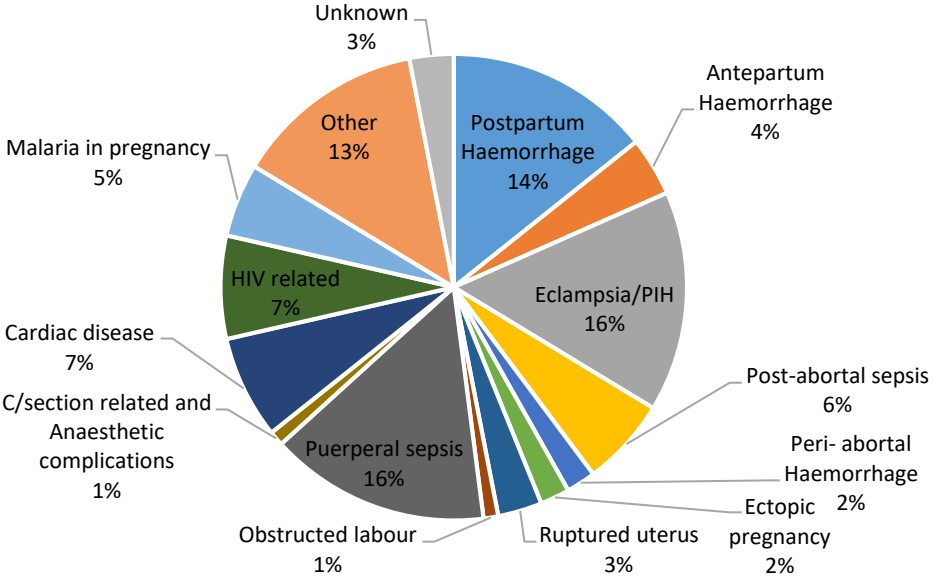


Figure 62: Percentage distribution of deceased women (15-24 years) by cause of death (n=98)

Perinatal deaths, fresh still deaths and early neonatal deaths

Figure 63 shows that perinatal death rate fell down from 38% in 2013 to 28.6% in 2017 (HMIS 2018).

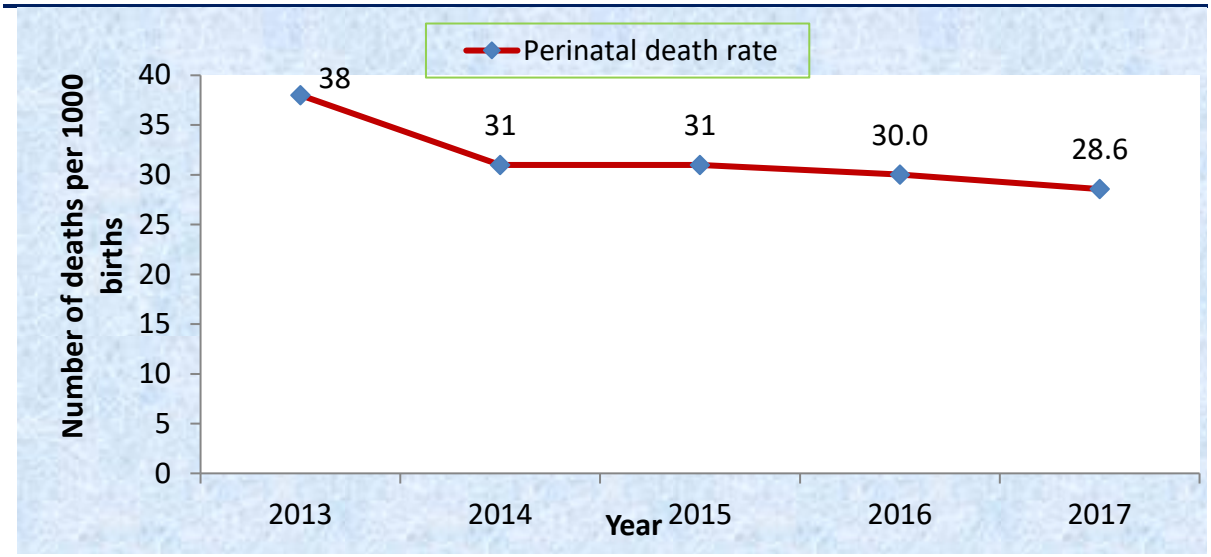


Figure 63: Perinatal Death Rate by Year

Figure 64 also shows that fresh still birth rate declined by a percentage point from 7% in 2015 to 5.9% in 2017(HMIS 2018).

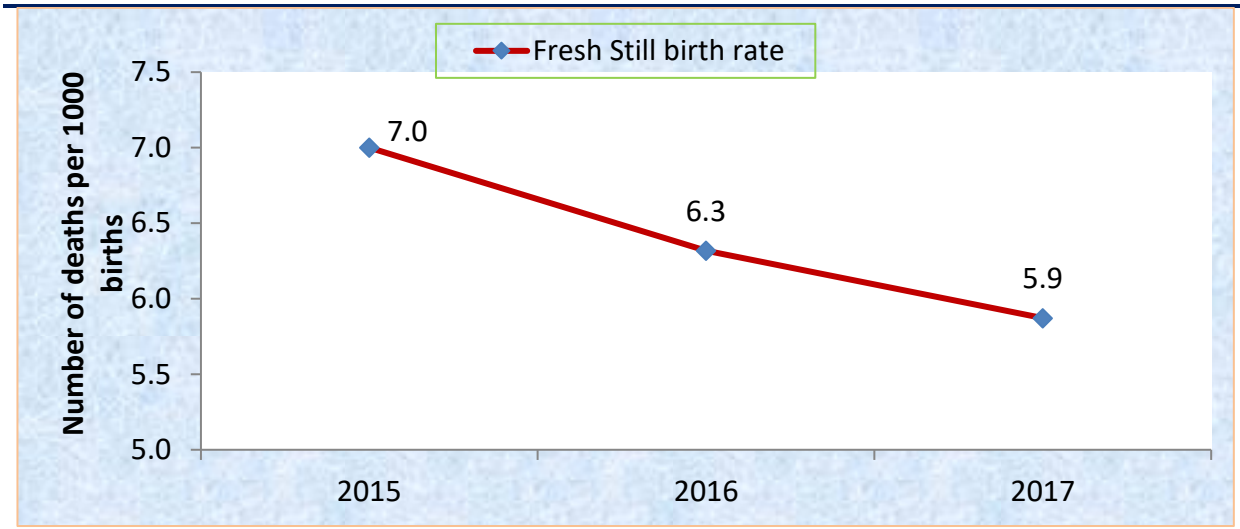


Figure 64: Fresh Still Death Rate by Year

Table 43 below shows that early neonatal deaths declined by 12 percentage points from 5719 in 2015 to 5058 in 2016(HMIS 2018).

Table 43: Number of Early Neonatal Deaths by Organizational Unit and by Year

Province/Organizational unit	Number of early neonatal deaths		
	2015	2016	2017
Bulawayo Central Hospitals	559	523	553
Bulawayo Province	11	12	17
Chitungwiza City	5	10	0
Harare Central Hospitals*	1589	1554	1482
Harare Province	25	28	21
Manicaland Province	621	480	457
Mashonaland Central Province	421	443	383
Mashonaland East Province	351	332	299
Midlands Province	668	547	580
Matabeleland North Province	197	202	149
Matabeleland South Province	169	233	166
Masvingo Province	492	516	384
Mashonaland West Province	611	534	567
Total	**5,719**	**5,414**	**5,058**

Summary of Achievements on Specific Programme Objectives

- A total of 119 health facilities now have at least one cadre trained in IUCD insertion and removal.
- Developed and piloted an e-Partograph as a component of the delivery module in the Electronic Health Records
- Adopted WHO recommendations on 8 ANC contacts
- Established 11 new VIAC sites against a target of 25 (achieved 44% of the target).
- Launched the national Cervical Cancer Prevention and Control Strategy
- VIAC logistics and supply chain management now integrated into the national system
- Launched and disseminated the National ASRH Strategy II.
- Launched and disseminated results of the adolescent fertility study. Printed and distributed 2000 copies of the ASRH Training Manual, 5000 Participant handbooks and 5000 YFSP Guidelines
- Strengthened collaboration with the gender department in the Ministry of Women Affairs, Gender and Community Development.
- Rolled out the electronic maternal and perinatal death notification system to Midlands province.
- RMNCAH scorecards were produced quarterly and shared with partners and all health managers.
- Data from the maternal and perinatal death notification forms received captured and analyzed. Results are yet to be shared with stakeholders

Table 44: VIAC Screening Cascade, 2017

Province	Clients screened	No. VIAC Positive	VIAC Positivity Rate	Clients treated with Cryo	Clients treated with LEEP	Total Clients Treated	% Treated with Cryo/LEEP
Bulawayo	8,594	659	7.7	116	185	301	45.7
Harare	15,105	1,063	7.0	424	236	660	62.1
Manicaland	7,972	401	5.0	168	20	188	46.9
Mashonaland Central	6,045	301	5.0	105	24	129	42.9
Mashonaland East	10,625	878	8.3	414	133	547	62.3
Mashonaland West	11,363	358	3.2	194	2	196	54.7
Masvingo	11,331	748	6.6	543	21	564	75.4
Matabeleland North	1,931	89	4.6	21	3	24	27.0
Matabeleland South	4,295	361	8.4	105	20	125	34.6
Midlands	8,925	688	7.7	193	10	203	29.5
Grand Total	**86,186**	**5,546**	**6.4**	**2,283**	**654**	**2,937**	**53.0**

NATIONAL PROGRAMME OF ACTION FOR CHILDREN (NPAC)

Zimbabwe remains committed to her obligations in terms of international and regional child rights instruments and norms. The National Programme of Action for Children (NPAC) as the national coordinating body for the implementation, monitoring, evaluation and reporting on International and Regional Treaties and related Protocols has the honor to share the efforts being made by the Government in promoting, protecting and observing the rights of the Child. NPAC's vision is for a Zimbabwe in which every child's best interest, development, survival, protection and participation are guaranteed. The goal is to promote the realisation of children's rights in safe, secure child friendly environments.

Status of Draft Child Rights Policy: The Draft Child Rights Policy was submitted to the Cabinet Committee on Legislation in 2015 for the Committees' consideration before Cabinet assessment and possible approval. The year 2016 saw the Draft Child Rights Policy briefly discussed on at the Working Party of Officials.

Day of the African Child: In June 2017, the Day of the African Child (DAC) was commemorated alongside the inauguration of the Child Parliamentarians.

MoHCC successfully wrote and timeously submitted the DAC report as required to the African Union Expert Committee on the Rights and Welfare of the Child. The report covered areas around Legislative and Administrative Measures and National Plans of Action taken to align national policies and programmes with the Charter and the SDGs.

Services for Survivors of Sexual Violence: Following an intensive analysis of service provision for survivors of sexual gender based violence and child sexual violence, provincial sensitization and consultative meetings were carried out to assist in the development of a National Strategic Implementation Plan towards provision of quality service provision for survivors of sexual violence.

Major successes

- Completion of provincial consultative meetings which resulted in clear roadmap for achieving goal
- Development of a Costed National Plan for implementation of activities
- Identification of & carrying out capacity building of NPAC/SGBV provincial & institutional coordinators
- Identification and training of potential trainers on care and management of survivors of abuse
- Development of: Training manuals; Competency booklets; Checklist for centers of excellence for clinical attachment
- Revisited DHIS data elements to be user friendly, with clear disaggregation for correct statistical data for child and adult
- Incorporation of GBV & Child Violence into nursing curriculum
- Training of one nurse educator from each of the schools of nursing.
- Padare & Ministry of Youth & Women Affairs incorporated in trainings.
- DAC Report compiled and to be submitted to AU Committee on Child Rights

Challenges: Non-assessment of centers of excellence for attachment, non-printing of: training manuals, competency booklets. This was due to lack of timeous release of funds.

The following activities of child governance (child care/child rights) were not done: completion of National Implementation Plan of Action for the AU & UN recommendations towards the realization of child rights in accordance to the presented country reports to the relevant Treaty Body drafting, Initial Optional Protocol on Child Sale, Child Prostitution & Child Pornography (OPSC), Report drafting Initial Optional Protocol on Children in Armed Conflict Report, drafting of the Second Periodic Report for the AU African Charter on the Rights and Welfare of the Child (ACRWC) , Capacity building, dialogue, commemorations on child rights. The major reason was non-funding.

PROGRAMME 3: PRIMARY HEALTH CARE AND HOSPITAL CARE

3.1 Hospital Statistics

Table 45: Total bed Occupancy Days in 2017

Province	Occupied Bed Days
Bulawayo Central Hospitals	458,304
Harare Central Hospitals	642,262
Bulawayo Province	4,043
Harare Province	4,518
Manicaland Province	278,325
Mashonaland Central Province	182,241
Mashonaland East Province	167,259
Midlands Province	252,884
Matabeleland North Province	136,206
Matabeleland South Province	132,777
Masvingo Province	290,006
Mashonaland West Province	215,395
Nationally	**2,764,220**

Source: DHIS 2 (as at 15 June 2018)

The data shows that the Harare Central Hospitals (Parirenyatwa, Harare Central Hospital and Chitungwiza Central Hospital) had the highest number of days (642262 days) hospital beds occupied followed by Bulawayo Central Hospitals (Mpilo, UBH and Ingutsheni) which had 458304 days occupied. The days are cumulative figures of the 6 Central Hospitals throughout the year 2017. Bulawayo as a province had the least number 4,043 days hospital beds occupied followed by Harare province 4,518 days. Nationally, the beds were occupied for 2,764,220 days which is a cumulative figure for all the admitting facilities throughout the country.

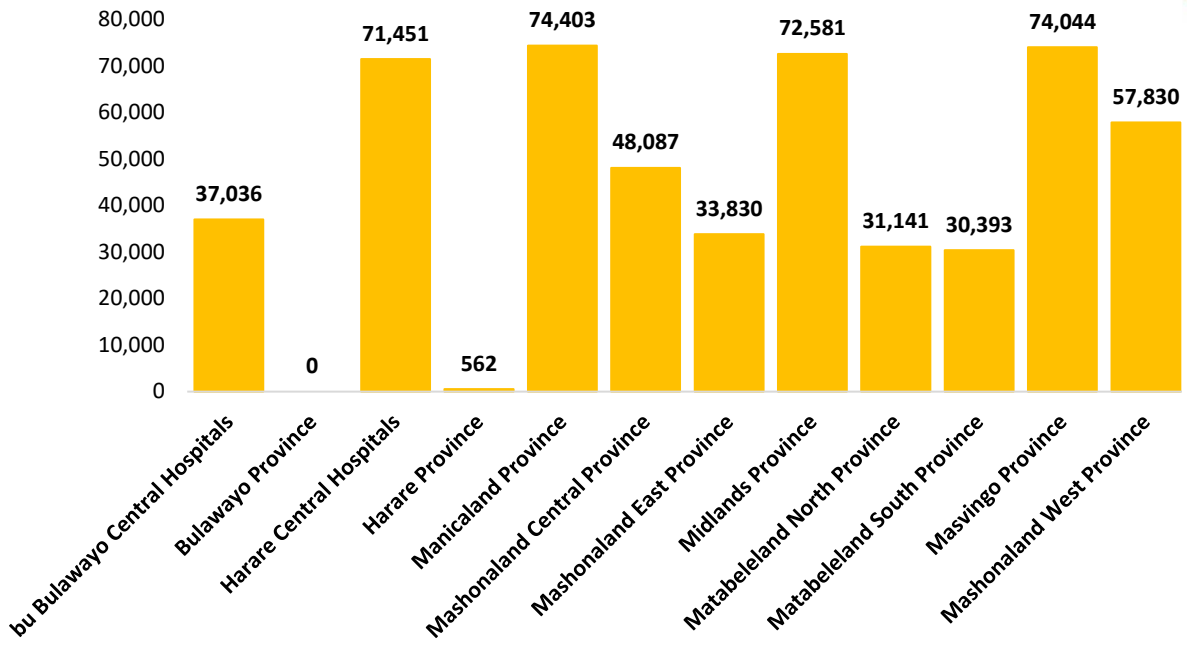


Figure 65: Total Patients who were Directly Admitted in 2017.
Source: DHIS 2 (as at 15 June 2018)

The data from the provinces and Central Hospitals show that Manicaland province had the highest number of direct admissions 74,403 patients followed by Masvingo Province with 74043 patients directly admitted in 2017. However, Bulawayo province had no direct admissions of patients followed by Harare province which directly admitted 562 patients.

Table 46: Caesarian Sections Conducted in 2017

Province	Operations
Bulawayo Central Hospitals	20,438
Bulawayo Province	0
Harare Central Hospitals	35,523
Harare Province	17
Manicaland Province	18,991
Mashonaland Central Province	13,848
Mashonaland East Province	8,805
Midlands Province	15,506
Matabeleland North Province	6,976
Matabeleland South Province	3,957
Masvingo Province	11,694
Mashonaland West Province	22,703
Nationally	**158,458**

Source: DHIS 2 (as at 15 June 2018)

Data from DHIS 2 show that Harare Central Hospitals conducted the highest number of 35,523 operations in 2017. This was followed by Mashonaland West province which conducted 22,703 operations in 2017. There is need to establish the unique features in Mashonaland West which enabled the province to conduct so many operations. On the other hand, there were no operations conducted in Bulawayo provinces whilst on 17 operations were conducted in Harare Province.

Table 47: Hospital fees Collected in 2017

Province	Other Cash Collected	Hospital Fees Collected
Bulawayo Central Hospitals	141,407	4,778,566
Bulawayo Province	0	2356
Harare Central Hospitals	4,766,664	15,950,2453
Harare Province	0	120
Manicaland Province	525,745	1,517,852
Mashonaland Central Province	376,124	614,154
Mashonaland East Province	880,297	1,234,733
Midlands Province	1,270,518	1,608,812
Matabeleland North Province	20,220	264,025
Matabeleland South Province	180,206	581,435
Masvingo Province	107,198	610,848
Mashonaland West Province	149,607	1,499,491
Nationally	**8,417,987**	**172,214,843**

Source: DHIS 2 (as at 15 June 2018)

In terms of Hospital fees collected and other cash collected, Harare Central Hospitals had the highest figures collected in excess of US$20 million. This was followed by Midlands province which collected over US$2 million.

Table 48: Total Hospital Deaths in 2017

Province	Maternal Deaths	Other Deaths
Bulawayo Central Hospitals	73	3,441
Harare Central Hospitals	153	7,537
Bulawayo Province	0	67
Harare Province	1	17
Manicaland Province	39	3,020
Mashonaland Central Province	14	1,734
Mashonaland East Province	14	1,678
Midlands Province	34	2,564
Matabeleland North Province	8	1,029
Matabeleland South Province	4	962
Masvingo Province	21	2,279
Mashonaland West Province	34	2,261
National	**395**	**26,589**

Source: DHIS 2 (as at 15 June 2018

The data show that Harare Central Hospitals had the highest number of maternal deaths of 153 in 2017 followed by Bulawayo Central Hospitals 73 maternal deaths, Manicaland Province 39 maternal deaths and 34 maternal deaths for Midlands and Mashonaland west respectively. The central hospitals had the highest number of other deaths which were over 10 000 followed by Manicaland province with 3020 deaths. Notably, Bulawayo Province had no maternal death while Harare Province had only 1 maternal death in 2017.

3. 2 Nursing

Primary Care Nurse Up-skilling Programme in Obstetrics and Maternity Care

In 2017 a total of 886 Primary Care Nurses did their up-skilling course in Obstetrics and Maternity Care.

Registered General Nurse and Midwifery Training Intakes for 2017

A total of 886 Registered General Nurse and 575 midwifery students were enrolled in the training schools in 2017 (Table 49).

Table 49: Registered General Nurse and Midwifery Training Intakes for 2017

Type of Training	Number Of Training Schools	Jan 2017 Intake	May 2017 Intake	Sept 2017 Intake	Total Intake For 2017
Registered General Nurse	25	250	295	341	886
Midwifery	22	159	207	209	575

Post-Basic Nursing

There were 287 nurses who enrolled into post-basic training at various institutions in 2017, as shown in Table 50.

Table 50: Enrolment of Nurses in Various Qualifications

Course	Number of Students
Diploma in Nursing Administration	16
Diploma in Community Nursing	28
Operating Theatre Nurse Diploma	44
Diploma in Psychiatric Nursing 18 Months Programme	37
Diploma in Ophthalmic Nursing	24
Diploma in Nurse Anaesthetist	39
Three year Diploma in Psychiatric Nursing	31
Intensive Care and Coronary Care Nurses Diploma	29
Renal Nursing Diploma	10
Advanced Neonatal Intensive Care and Paediatric Nursing	18
Oncology and Palliative Care Nursing	11
Total	**287**

2013 – 2017 Statistics for Registered General Nurses

Table 51: Pass Rates for Registered General Nursing Students

Intake Year	№ of students who sat for the examinations	№ of students who passed	№ of students who failed	Percentage of students who passed
Total for 2013	1618	1209	409	75%
Total for 2014	1182	793	389	67%
Total for 2015	887	742	146	84%
Total for 2016	1057	934	123	88%
Total for 2017	1167	914	253	78%

The Ministry of Finance unfroze 2,000 posts for nurses which are to be filled in stages in 2017. As of December 2017 there were 1,647 unemployed Registered General Nurses awaiting deployment.

2013 – 2017 Statistics for State Certified Midwives

Table 52: Pass Rates for State Certified Midwives

Intake Year	№ of students who sat for the examinations	№ of students who passed	№ of students who failed	Percentage of students who passed
Total for 2013	893	808	85	90%
Total for 2014	874	779	95	89%
Total for 2015	937	835	102	89%
Total for 2016	694	642	52	93%
Total for 2017	676	590	86	87%

In 2016, a total of 694 student midwives sat for their final examination and 642 passed giving a pass rate of 92.5%. In 2017 some 676 students sat for their final examinations and 590 passed, giving a pass rate of 87%.

2010 - 2017 Statistics for Primary Care Nurses

As of December 2017 a total of 403 Primary Care Nurses were unemployed and awaiting deployment.

Table 53: Results of Post Basic Nursing Students Examinations

	Diploma	№ of students who sat for the examinations	№ of students who passed	Pass rate
May 2017	Operating Theatre Nurses Diploma	29	27	93%
	Renal Nurses Diploma	5	4	80%
	Diploma in Nurse Anaesthetist	12	12	100%
	Diploma in Intensive Care and Coronary Nursing	22	21	95%
	Psychiatric Nurse 18 months Diploma	19	19	100%
	Psychiatric Nurse 3 years Diploma	1	1	100%
July 2017	Diploma in Ophthalmic Nursing	12	12	100%
	Diploma in Oncology and Palliative Nursing	9	9	100%
Nov 2017	Advanced Neonatal Intensive Care Paediatric Nursing	14	14	100%
	Renal Nurses Diploma	1	1	100%
	Diploma in Oncology and Palliative Nursing	1	1	100%
	Diploma in Psychiatric Nursing	33	18	55%
Dec 2017	Operating Theatre Nurses Diploma	14	11	79%
	Diploma in Intensive Care Nursing and Coronary Care Nursing	1	0	0
	Diploma in Ophthalmic Nursing	9	9	100%
	Diploma in Nursing Administration	16	16	100%
	Diploma in Community Nursing	28	28	100%
	Diploma in Nurse Anaesthetist	18	17	94%

The Village Health Worker (VHW) Programme

In 2017 a total of 1 560 additional VHWs were trained. The programme continued to play a critical pivotal role in strengthening community health services and improving the quality of health service delivery at community level. More than 1,489,592 (75%) of households countrywide have access to integrated community based health services delivered through VHWs.

UNICEF and UNDP through Ministry of Health and Child Care supported the enrolment of VHW into an electronic database and about 96% have been enrolled. The database will ensure timely disbursement of VHW stipends and overall management of VHWs.

UNICEF and UNFPA supported a learning visit to Ethiopia where best practices to be adopted by the country were identified. These include defining a service package, curriculum, selection and deployment of the rightful cadres, re-engineering Primary Health Care, drafting a road map and plans to advocate and pioneer reforms required for a viable community health system that contributes to achievement of universal health coverage. The recommendations and best practices learnt are going to

guide planning and implementation modalities for 2018 including advocacy processes to strengthen community systems in Zimbabwe.

Challenges

As of December 2017, 1 647 Registered General Nurses and 403 Primary Care Nurses who completed their training were yet to be employed. The Ministry of Finance is addressing the problem in stages. Filling in of Tutor's posts has also been a challenge.

3.3 Pharmacy Services

Through the Directorate of Pharmacy Services (DPS) the MoHCC endeavours to improve the health of the citizens of Zimbabwe through appropriate procurement, promotion of local production of essential medicines, storage, distribution and management of medicines ensuring, safety and accessibility.

Commodity Availability

Stock availability per province according to Vital (V), Essential (E) and Necessary (N) (VEN) classification of drugs for 2017 is indicated in Table 54 below. The targets were set at 80% and 60% for the Vital and Essential classifications respectively.

Table 54: VEN Availability at Provinces in 2017

Province	Midlands	Mashonaland Central	Mashonaland West	Manicaland	Masvingo	Matebeleland South	Mashonaland East	Matebeleland North	Harare City	Bulawayo City
Average vital stock status (%)	51.7	70.4	55	66.9	68.4	58.6	87.6	85.5	73.8	87.9
Average essential stock status (%)	38.8	59.1	48	44.4	59.4	46.2	74.3	76.8	73.7	75
NatPharm "V" stock status	36.5%									
NatPharm "E" stock status	22%									

Thirty percent (30%) of the provinces surpassed the target for the Vital while, 50% were on or above target for the Essential category.

One of the main drivers of availability of commodities at health facilities is distribution. Therefore, DPS rolled out the Zimbabwe Assisted Pull System (ZAPS) which seeks to integrate several systems that various programmes have been using to deliver different health commodities to the same health facilities. The DPS developed indicators that look at the performance of ZAPS, which are discussed below:

Table 55: ZAPS performance: Stockout Rates of Selected Commodities by Province.

(Products highlighted in red had stock outs above the target range of ≤5%)

Provinces	Male Condom	Control Pill	Jadelle	Oxytocin	Misprostol	Zinc/ORS co pack	Amoxycillin 250mg	TDF/ 3TC/ EFV	AZT/ 3TC/ NVP	RHZE	AL 1X6	AL 4X6	Determine
Bulawayo Province	0%	30%	0%	33%		95%	60%	0%	5%	4%	13%	25%	3%
Harare Province	3%	4%	3%	34%	50%	9%	14%	0%	0%	3%	40%	41%	1%
Manicaland	1%	8%	4%	9%	18%	10%	42%	1%	4%	2%	8%	8%	2%
Mashonaland Central	3%	6%	6%	12%	56%	2%	12%	1%	3%	2%	18%	20%	3%
Mashonaland East	1%	2%	4%	8%	71%	0%	8%	0%	2%	2%	30%	52%	3%
Mashonaland West	1%	1%	4%	12%	38%	18%	36%	1%	8%	4%	27%	21%	4%
Masvingo	1%	3%	3%	5%	3%	5%	21%	0%	3%	1%	9%	36%	1%
Matabeleland North	1%	11%	7%	10%	42%	23%	29%	1%	7%	2%	44%	30%	5%
Matabeleland South	0%	13%	11%	19%	73%	13%	18%	1%	12%	2%	23%	17%	2%
Midlands	2%	8%	5%	9%	56%	3%	15%	0%	3%	1%	12%	24%	2%
National	1%	6%	5%	11%	42%	10%	24%	1%	4%	2%	20%	26%	3%
Source:	**TopUp**												

The stock out rate at primary health care facility is directly related to ZAPS as most if not all commodities at this level are dependent on one or all processes to do with ZAPS. The major driver of the observed stock outs was funding gaps leading to inadequate quantities being supplied to health facilities. For commodities that have been in full supply there were no significant stock outs noted.

Table 56: Loss Rate of Selected Commodities by Province

(Losses due to expiry were within the acceptable range of ≤5% except for those highlighted in red).

Provinces	Male Condom	Control pill	Jadelle	Oxytocin	Misprostol	Zinc/ORS co pack	Amoxycillin 250mg	TDF/ 3TC/ EFV	AZT/ 3TC/ NVP	RHZE	AL 1X6	AL 4X6	Determine
Manicaland	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%
Mashonaland Central	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mashonaland East	0%	0%	0%	0%	12%	0%	0%	0%	0%	0%	0%	1%	0%
Mashonaland West	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	0%
Masvingo	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Matabeleland North	0%	0%	0%	0%	0%	0%	4%	1%	0%	0%	5%	3%	0%
Matabeleland South	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	3%	2%	0%
Midlands	9%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	9%	0%
National	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	1%	1%	0%
Source:	**TopUp**												

There were very low expiries in the tracked commodities due to improved stock management and the roll out of a pull system which is more sensitive to user requirements.

Table 57: Stocking Levels of Selected Commodities at Primary Care Level

	Stocking Levels												
	Stocked According to Plan												
Provinces	**Male Condom**	**Control pill**	**Jadelle**	**Oxytocin**	**Misoprostol**	**Zinc/ORS co pack**	**Amoxycillin 250mg**	**TDF/ 3TC/ EFV**	**AZT/ 3TC/ NVP**	**RHZE**	**AL 1X6**	**AL 4X6**	**Determine Tests**
Manicaland	31%	22%	11%	25%	7%	21%	50%	42%	25%	14%	20%	25%	29%
Mashonaland Central	23%	32%	6%	5%	0%	24%	32%	25%	23%	21%	22%	20%	24%
Mashonaland East	33%	34%	12%	13%	0%	17%	30%	38%	29%	18%	14%	19%	27%
Mashonaland West	49%	33%	19%	11%	0%	26%	17%	40%	32%	17%	6%	12%	27%
Masvingo	33%	39%	23%	38%	0%	35%	35%	66%	51%	16%	28%	25%	26%
Matabeleland North	43%	48%	14%	15%	2%	19%	23%	52%	38%	11%	18%	14%	13%
Matabeleland South	37%	33%	16%	10%	2%	22%	13%	55%	38%	20%	16%	12%	16%
Midlands	33%	14%	13%	14%	0%	16%	34%	44%	34%	14%	6%	27%	18%
National	34%	29%	14%	17%	1%	22%	31%	44%	32%	17%	16%	20%	24%
Source:	**TopUp**												

All products were not stocked according to plan because of delays in deliveries whilst some were rationed by NatPharm because supplies were limited. The acceptable range is ≥90%.

Table 58: Stock Availability at NatPharm

Provinces	*Male Condom*	*Control Pill*	*Jadelle*	*Oxytocin*	*Misoprostol*	*Zinc/ORS co pack*	*Amoxycillin 250mg*	*TDF/ 3TC/ EFV*	*AZT/ 3TC/ NVP*	*RHZE*	*AL 1X6*	*AL 4X6*	*Determine*
Manicaland	100%	84%	93%	90%	70%	58%	14%	98%	97%	97%	89%	37%	98%
Mashonaland Central	69%	88%	81%	88%	0%	20%	35%	72%	55%	15%	14%	35%	18%
Mashonaland East	77%	76%	79%	66%	4%	84%	66%	91%	71%	14%	24%	58%	44%
Mashonaland West	86%	84%	93%	80%	5%	88%	90%	88%	61%	28%	78%	14%	50%
Masvingo	88%	92%	95%	65%	100%	90%	36%	97%	97%	96%	61%	28%	53%
Matabeleland North	89%	72%	85%	95%	62%	88%	76%	88%	98%	70%	78%	66%	88%
Matabeleland South	75%	60%	85%	85%	25%	90%	79%	82%	85%	51%	94%	56%	82%
Midlands	93%	81%	90%	76%	0%	67%	48%	92%	90%	90%	95%	93%	45%
National	85%	80%	87%	80%	27%	71%	51%	90%	81%	60%	60%	51%	60%
Source:	**TopUp**												

The acceptable range is ≥90%. The low order fill rates were due to the following:

(1) Delays in procurements resulting in rationing of stocks

(2) Limited availability of commodities resulting in rationing of stocks

(3) Poor data quality resulting in wrong order quantities.

Financial Performance:

Guided by the annual quantification in February 2017 and an update in August 2017, Table 59 outlines the funding gap per product category. The annual quantification planned for February 2018 which will take into account the performance achieved between July – December 2017 will result in changes to programme targets thus affecting the gaps for 2018 – 2020.

Table 59: Funding Gaps for Procurement of Commodities (Quantification Report August 2017)

Category	2017	2018	2019	2020
Anti-retroviral medicines (ARVs) (Adults)	$0	$49,993,600	$10,556,009	$25,621,025
Anti-retroviral medicines (ARVs) (Paeds)	$0	$0	$0	$0
HIV Test Kits	$0	$2,484,918	$4,710,032	$6,548,861
Syphilis Test Kits	$0	$669,848	$669,848	$1,088,503
Voluntary Male Medical Circumcision	$0	$3,009,351	$1,747,933	$2,108,770
Tuberculosis	$0	$0	$0	
Tuberculosis Diagnosis in Children	$101,376	$110,436	$126,964,44	$127,824
Isoniazid Preventive Therapy (IPT)	$0	$1,777,445	$1,091,302	$1,091,302
Opportunistic Infections (OI)	$445,532	$5,156,917	$588,620	
Reproductive Health (RH)	$704,090	$593,594	$991,311	$716,803
Sexually Transmitted Infections (STI)	$0	$883,633	$604,102	$591,836
Anti-malarials	$0	$8,195	$8,195	
Selected Anti-cancer medicines	$0	$29,316	$44,011	$126,440
Other Essential Medicines	$8,589,198	$8,396,656	$11,953,98	$14,355,236
Nutrition	$6,745,338	$4,698,624	$10,508,004	$10,516,068
VIAC	$43,370	$159,110	$0	$0
Condoms and Contraceptives	$0	$0	$150,070	$196,560

Note: Gaps were observed for ARVs and Test Kits in the August Update due to a change of targets after reviewing performance between January and June 2017.

Table 60: Challenges and Proposed Solutions

Category	Challenges	Proposed Solutions
Procurement	Delayed procurements	Monitor the pipeline and engage procurement partners
	Funding gaps for some commodities	Mobilize resources to cover funding gaps Prioritise procurement of medicines under various available funding streams
Storage and Distribution	Storage constraints at central and facilities	Mobilise resources to expand and improve storage space for commodities at all levels
	Delays in order processing and deliveries	Increase order processing and throughput
	Delays in disbursements and acquittals of ZAPS funds.	Closely work with partners and provinces to ensure timely disbursements and acquittals
	Limited availability of ordering vehicles	Expedite delivery of all ordering vehicles

Rational Medicines Use	All facilities did not manage to conduct board of surveys	Train and support districts and hospitals to conduct board of surveys twice a year
	Accumulation of expired commodities due to backlog in destructions	Expedite the commissioning of the procured incinerators
Human Resources for Pharmacy	Low absorption of pre-registration pharmacists in public sector	Create training posts for pre-registration pharmacists
	Retention of pharmacists in districts	Engage the government and partners on ways of attracting and retention of pharmacists beyond the Global Fund support ending December 2017
	Establishment not in line with current workload	Lobby for the creation of additional posts
	Lack of dedicated procurement and supply chain (PSM) cadres at clinic level	Lobby for the establishment of procurement and supply management cadres at lower level facilities

Below is the dashboard from the Feb 2018 Vital Medicines Availability and Health Services survey (VMAHS), whose overall objective is to assess over time the availability of essential maternal, new-born and child health services and medicines and the functionality of these essential maternal, new-born and child health services, in approximately 1,400 health facilities with a focus on primary care level services.

DASHBOARD

Indicator	Baseline	Milestone 1	2017												2018
			Q1			Q2			Q3			Q4			Q1
			Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	
Output 1.1 Increased capacity to provide ANC services															
1.1.1 Proportion of health centres with at least one upskilled Primary Care Nurse	80% in 2014	82% in 2016	97.0%	96.8%	99.8%	97.0%	96.6%	99.6%	98.0%	96.1%	98.1%	98.0%	94.0%	95.9%	92.4%
1.4.1 Proportion of health facilities charging user fees for ANC	7.70%		6.0%	7.2%	120.0%	6.0%	5.2%	86.7%	6.0%	5.0%	83.3%	6.0%	3.2%	53.3%	1.3%
Output 1.2. Increased capacity to provide EMOC services at primary and secondary levels															
1.2.2 Proportion of PHCs providing the 6 selected signal functions of basic emergency obstetric and newborn services.	57% VHMAS in 2014	65% by 2016	25.0%	39.7%	158.8%	25.0%	32.1%	128.4%	28.0%	28.2%	100.7%	30.0%	19.9%	66.3%	7.6%
1.2.3 Proportion of district hospitals with at least 3 doctors.			80.0%	69.6%	87.0%	80.0%	66.8%	83.5%	85.0%	68.3%	80.4%	90.0%	66.7%	74.1%	60.0%
1.2.4 Proportion of district hospitals performing Caesarean Section on pregnant women who require it.	87% in 2015 (VMAHS)	95% by 2016	95.0%	94.4%	99.4%	95.0%	93.4%	103.5%	97.0%	91.3%	94.1%	98.0%	91.7%	93.6%	91.7%
1.2.5 Proportion of District hospitals having at least two health professional who can do C/S	80% by 2014 (Administrative report)	82% by 2016	90.0%	92.7%	103.0%	90.0%	83.3%	92.6%	93.0%	91.5%	98.4%	94.0%	91.7%	97.6%	91.7%
1.2.6 Proportion of district hospitals with at least two health professionals who can provide anaesthesia for emergency obstetric surgery	80% by 2014 (Administrative report)	82% by 2017	55.0%	51.2%	93.1%	55.0%	55.3%	100.5%	59.0%	62.7%	106.3%	60.0%	61.7%	102.8%	71.7%
1.2.7 Proportion of district hospitals with fully functional operation room to perform emergency obstetric surgery.	91% in 2014	94% in 2016	75.0%	78.3%	104.4%	75.0%	70.4%	93.9%	78.0%	84.6%	108.5%	80.0%	78.3%	97.9%	75.0%
1.2.8 Proportion of health facilities with fully functional communication equipment for emergency referral	90% in 2014	92% in 2016	76.0%	82.0%	107.9%	76.0%		119.0%	80.0%	78.2%	97.8%	85.0%	79.1%	93.1%	79.1%

Indicator	Baseline	Milestone 1	2017												
			Q1			Q2			Q3						
			Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	Q4
1.2.9 Proportion of district hospitals with the capacity to provide blood transfusion for emergency obstetric care	71% in 2014	75% in 2016	92.0%	91.3%	99.2%	92.0%	93.4%	94.9%	96.0%	96.6%	100.6%	98.0%	96.7%	98.7%	91.7%
Output 1.3. Increased availability of postnatal care															
1.3.1 % of health facilities offering postnatal care services	97%		99.0%	99.6%	100.6%	99.0%	99.9%	100.9%	99.0%	99.8%	100.8%	100.0%	99.9%	99.9%	99.9%
Output 2.1. Increased capacity of health facilities to manage common newborn child illnesses including HIV/AIDS and severe acute malnutrition by 2020												-			
2.1.1 Proportion of health centres having at least one Health Worker trained on IMNCI	60 % in 2014	70% by 2017	90.0%	90.2%	100.2%	90.0%	88.5%	98.3%	90.0%	88.5%	98.3%	95.0%	87.6%	92.2%	88.3%
2.2.2 Proportion of health facilities offering paediatric ART services.	39% in 2014	70% in 2016	97.0%	96.4%	99.4%	97.0%	97.7%	100.7%	97.0%	97.1%	100.1%	98.0%	96.9%	98.9%	97.8%
1.3.2 Stock out rate for essential medicines (need to specify the medicines)	80% in 2014		0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%
Output 2.2. Increased availability of immunization and pediatric ART services															
2.2.1 Proportion of health facilities with 100% availability of functional cold chain equipment	96.% in 2014 VMAHS	97% by 2016	100.00%	96.50%	96.50%	100.00%	97.30%	97.30%	100.00%	97.70%	97.70%	100.0%	97.8%	97.8%	96.2%
2.2.2 Proportion of health facilities with at least 80% availability of ARVS for children	51% in 2015	75% in 2016	75.0%	71.6%	95.5%	75.0%	77.8%	103.7%	75.0%	82.7%	110.3%	80.0%	82.8%	103.5%	83.1%
2.2.3 Proportion of health facilities with at least 80% availability of selected antibiotics			80.0%	88.7%	110.9%	80.0%	85.4%	106.8%	80.0%	90.2%	112.8%	80.0%	85.5%	106.9%	91.9%
2.2.4 Proportion of health centres with at least 70% availability of traditional vaccines throughout the year			95.0%	96.9%	102.0%	95.0%	98.9%	104.1%	95.0%	95.6%	106.2%	95.0%	96.8%	101.9%	97.2%

Indicator	Baseline	Milestone 1	2017												
			Q1			Q2			Q3			Q4			
			Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	Target	Result	% of target	
Output 3.1. Increased capacity of districts to provide comprehensive nutrition services															
3.1.2 Proportion of health facilities with no stock out of critical nutrition supply (vitamin A, IFA, RUTF)			98.0%	99.6%	101.6%	98.0%	99.8%	101.8%	98.0%	97.9%	99.9%	98.0%	88.1%	89.9%	97.3%
Ferrous and Folic Tablets			98.0 %	77.10%		98.0%	89.4%	91.2%	98.0%	93.2%	95.1%	98.0%	93.0%	94.9%	95.2%
RUTF			98.0%	88.4%		98.0%	90.9%	92.8%	98.0%	91.2%	93.1%	98.0%	92.0%	93.9%	91.6%
3.1.4 Proportion of primary health care centres assessing and managing children with severe acute malnutrition as per the global standard.	70% 2015	80 % 2016	75.0%	85.0%	113.3%	75.0%	86.9%	115.9%	85.0%	84.1%	98.9%	85.0%	89.1%	104.8%	88.2%
Output 4.1 Increased capacity to provide HIV prevention services among children, women and men especially young people and key populations															
4.1.7. Proportion of Health facilities reporting no stock outs of selected STI drugs				97.40%			98.90%			99.8%	105.1%	95.0%	99.6%	104.8%	99.5%
Output 5.1. Increased availability of and access to voluntary family planning, especially long acting family planning methods															
5.1.1. Percentage of health facilities providing IUCD insertions and removals in the last 3 months.	0 in 2014	3% by 2016								16.7%			39.2%		39.2%
5.1.6. Percentage of health facilities with no stock out of long acting contraceptives (Implants, IUCDs) for the past 3 months	0.98	98%				63.6%				73.20%			58.9%		74.6%

As presented in the dashboard, the Ministry managed to achieve most of its targets as reflected by the green on the dashboard. These targets were measured across a wide spectrum of indicators ranging from human resources for health, availability of infrastructure to the services being provided.