THE ZIMBABWE HEALTH SECTOR INVESTMENT CASE (2010 - 2012)

Accelerating progress towards the Millennium Development Goals

Equity And Quality In Health
A People's Right

March 2010

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Acronyms

ACT  Artemisinin-based Combination Therapy
AIDS  Acquired Immunodeficiency Syndrome
ANC  Antenatal Care
ARI  Acute Respiratory Infection
ART  Antiretroviral Therapy
ARV  Anti Retroviral Drug
BEmONC  Basic Emergency Obstetric and Newborn Care
CBD  Community Based Distributor
CD4  Cluster Differentiation 4
CEmONC  Comprehensive Emergency Obstetric and Newborn Care
Chn  Children
CHW  Community Health Worker
CPR  Contraceptive Prevalence Rate
CWGH  Community Working Group on Health
DFID  United Kingdom Department for International Development
DHE  District Health Executive
DMO  District Medical Officer
DPT  Diphtheria, Pertussis and Tetanus Vaccine
EC  European Commission
EHT  Environmental Health Technician
EPI  Expanded Programme of Immunization
FP  Family Planning
GDP  Gross Domestic Product
GOZ  Government of Republic of Zimbabwe
HIV  Human Immunodeficiency Virus
ICU  Intensive Care Unit
IFA  Iron Folate Supplements
IM  Intramuscular
IMNCI  Integrated Management of Neonatal and Childhood Illnesses
IMR  Infant Mortality Rate
IRS  Indoor Residual Spraying
IV  Intravenous
LLIN  Long lasting insecticide treated mosquito net
MBB  Marginal Budgeting for Bottlenecks
MCH  Maternal and Child Health
MCV  Measles Vaccine
MDG  Millennium Development Goal
MDR  Multi Drug Resistant Tuberculosis
MIMS  Multiple Indicator Survey
MOHCW  Ministry of Health and Child Welfare
MRP  Manual Removal of Placenta
NGO  Non Governmental Organisation
NHS  National Health Strategy
ORS Oral Rehydration Salts
PCN Primary Care Nurse
PHC Primary Health Care
PMD Provincial Medical Director
PMTCT Prevention of Mother-to-Child Transmission of HIV infection
PROM Premature Rupture of Membranes
RHC Rural Health Centre
RRP Removal of Retained Placenta
SAM Severe Acute Malnutrition
STI Sexually Transmitted Infection
TARSC Training and Research Support Centre
TB Tuberculosis
U5MR Under 5 Mortality Rate
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
VHW Village Health Worker
WHO World Health Organisation
ZDHS Zimbabwe Demographic and Health Survey
MDG Millennium Development Goal
MDR Multi Drug Resistant Tuberculosis
MIMS Multiple Indicator Survey
MOHCW Ministry of Health and Child Welfare
MRP Manual Removal of Placenta
NGO Non Governmental Organisation
NHS National Health Strategy
ORS Oral Rehydration Salts
PCN Primary Care Nurse
PHC Primary Health Care
PMD Provincial Medical Director
PMTCT Prevention of Mother-to-Child Transmission of HIV infection
PROM Premature Rupture of Membranes
RHC Rural Health Centre
RRP Removal of Retained Placenta
SAM Severe Acute Malnutrition
STI Sexually Transmitted Infection
TARSC Training and Research Support Centre
TB Tuberculosis
U5MR Under 5 Mortality Rate
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
VHW Village Health Worker
WHO World Health Organisation
ZDHS Zimbabwe Demographic and Health Survey
Equity And Quality In Health - A People’s Right
The recent Multiple Indicator Monitoring Survey (MIMS) and the Maternal and Peri-natal Mortality study as well as administrative data sources indicate a consistent pattern. The Zimbabwean health system has been in decline for more than a decade and the result is a systematic decrease in coverage of most basic services and a rising maternal and child mortality rate. This decline is most noticeable in key areas of maternal and child health, such as the Expanded Programme on Immunization and obstetric care for pregnant women, once high-performing core elements of Zimbabwe’s Primary Health Care System. In addition, even in sub-sectors such as access to anti-retroviral treatment for HIV, where overall progress has been solid, coverage for critical groups such as pregnant women or children is either unknown or very low. Finally, the disparities between urban and rural access continue to grow.

Support to the health sector is one of the top priorities of the Inclusive Government of Zimbabwe. Support to the sector has been emphasized in the Short Term Emergency Plan (STERP) and the soon to be released, Mid-Term Plan, 2010-2015. The Inclusive Government has indicated its commitment to reaching the Abuja target of 15% of total government expenditures going towards the health sector. In addition, an ambitious National Health Strategy is now in place that covers the period 2009-2013. Building upon these documents, the Health Sector Investment Case, 2010-2012, outlines the key package of health services, the key health system bottlenecks to be overcome, the desired coverage targets, the incremental costs and the expected achievements in relation to the health MDGs.

The investment case validates the historical focus of the Ministry of Health and Child Welfare on Primary Health Care, with a strong focus on community-based approaches, complemented by robust referral systems and facilities. Under the most ambitious scenario in the investment case, an additional investment of 700 million USD over 3 years or around 19 USD per capita is required to achieve a reduction in under 5 and maternal mortality of 38% and 17% respectively. The Ministry is currently undertaking a mapping exercise to determine the current resources available, mostly through the support of bilateral and multilateral partners, in order to determine the precise financing gap. Concerted efforts will then need to be made in order to expand the fiscal space available for the health sector through internal and external sources.

Further efforts will now be made to ensure that both government resources and external aid are focused on the national health packages and priorities outlined in the investment case. While it is clear that more aid is required, it is also clear that there are risks of fragmentation of the assistance for the health sector, unless the health system is supported more broadly to deliver on the health MDGs in Zimbabwe. We call on all partners to support our efforts in this regard.

Dr Henry Madzorera

Minister of Health and Child Welfare
March 1, 2010
1. Rationale

The consummation of the Government of National Unity together with the stabilization of the economy in 2009 has created an environment that has allowed the health sector to move from emergency planning mode to the completion of an ambitious five year National Health Strategy (2009-2013) (NHS). Based on data from the Zimbabwe Demographic and Health Survey, 2005/6 (ZDHS), Multiple Indicator Monitoring Survey, 2009 (MIMS), Maternal and Perinatal Mortality Study and other studies, the NHS has identified that Zimbabweans are dying from easily preventable and treatable conditions e.g. HIV and AIDS, malaria, pregnancy related complications, diarrhoeal diseases etc. As a result most health indicators have stagnated or deteriorated. Consequently, the country is off track in most of its health targets including the Millennium Development Goals (MDG) targets (Table 1). The health system, which is supposed to assist in improving these health indicators, has almost collapsed. The MOHCW has therefore made a deliberate decision to catch-up on lost ground in meeting its targets with special emphasis on the MDGs. The MOHCW realises that it is impossible under the current economic environment to implement all the provisions of the NHS. The major challenge facing the health sector is lack of resources - financial, human and material. If the current funding levels and weak capacity of the public health system persist or deteriorate, Zimbabwe will not achieve health related MDGs.

Table 1: Progress towards selected health related MDGs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1999</th>
<th>2005</th>
<th>2009</th>
<th>MDG target</th>
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<tbody>
<tr>
<td>Infant Mortality Rate (per 1000 live births)</td>
<td>65</td>
<td>60</td>
<td>60</td>
<td>22</td>
</tr>
<tr>
<td>Under Five Mortality Rate (per 1000 live births)</td>
<td>102</td>
<td>82</td>
<td>86</td>
<td>34</td>
</tr>
<tr>
<td>Stunting in children under 5 (percent)</td>
<td>27</td>
<td>29</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>Exclusive breastfeeding during the first 6 months (percent)</td>
<td>27</td>
<td>22</td>
<td>26</td>
<td>70</td>
</tr>
<tr>
<td>Children 12 -23 months fully immunised (percent)</td>
<td>67</td>
<td>53</td>
<td>49</td>
<td>70</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (per 100,000 population)</td>
<td>578</td>
<td>555</td>
<td>725</td>
<td>145</td>
</tr>
<tr>
<td>Skilled attendance at delivery (percent)</td>
<td>72.5</td>
<td>68</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>HIV and AIDS prevalence in adults aged 15 - 49 (percent)</td>
<td>28</td>
<td>18.1</td>
<td>13.7</td>
<td>9</td>
</tr>
<tr>
<td>Adult ART coverage (percent)</td>
<td>0</td>
<td>4</td>
<td>54</td>
<td>100</td>
</tr>
<tr>
<td>Paediatric ART coverage (percent)</td>
<td>0</td>
<td>&lt;1</td>
<td>57</td>
<td>100</td>
</tr>
<tr>
<td>TB Incidence (notifications per 100,000 population)</td>
<td>355</td>
<td>1047</td>
<td>782</td>
<td>178</td>
</tr>
<tr>
<td>Malaria incidence (cases per 1000 population)</td>
<td>122</td>
<td>124</td>
<td>94</td>
<td>62</td>
</tr>
<tr>
<td>TB treatment success rate (percent)</td>
<td></td>
<td></td>
<td>78%</td>
<td>78% in 2007</td>
</tr>
<tr>
<td>Crude death rate (deaths per1000 population)</td>
<td>17.2</td>
<td>-</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>45</td>
<td>43</td>
<td>43</td>
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In a deliberate attempt to mobilize resources to implement the three-year plan, the MOHCW has developed this Health Sector Investment Case. The audience of this document includes but is not limited to (i) government of Zimbabwe (GOZ), (ii) development partners, (iii) technical partners, (iv) private sector, (v) civil society and (vi) the general public. The major thrust of the investment case is to revitalize the health sector, identify high impact priority interventions and mobilize additional resources to scale up progress towards attainment of MDGs, which are currently lagging behind. It is anticipated that the benefits of scaling up MDG related interventions should positively impact on the wider health system. Whilst every effort was made to ensure wide consultation and inclusivity in the preparation of this investment case, the MOHCW acknowledges that the document may have omitted some health interventions and current and/or planned inflows into the health sector. Such omission was not intended, but may be due to the document’s key focus on health MDGs.

1The National Health Strategy for Zimbabwe (2009 - 2013), Equity and Quality in Health: A People’s Right, MOHCW
2. Process of developing the investment case

The investment case was developed through consultation of key stakeholders (Annex 1) in health including government, development and technical partners, civil society, programme managers and the private sector. UNICEF, World Bank and WHO provided joint technical support. The investment case draws from the NHS, which is based on information from several studies carried out in the last two years (Study on Access to Health Services, Vital Medicines and Health Services Survey, CWGH surveys, Zimbabwe Maternal and Perinatal Mortality Study etc) and also the existing national plans and programmes. The NHS and consequently the investment plan takes into account regional and international commitments made by the country including but not limited to (i) the Millennium Development Goals (MDGs), (ii) the Ouagadougou declaration, (iii) the Africa Health Strategy and (iii) other regional health commitments and protocols.

The Marginal Budgeting for Bottlenecks (MBB) tool was used to guide development of the investment case. Figure 1 outlines the process of developing the investment plan using the MBB tool.

Figure 1: Steps in MBB: Results-Based Planning, Costing & Budgeting

The MBB tool helps to: a) plan and forecast the potential cost and impact of scaling up investments to remove health system constraints; b) prepare evidence-based expenditure programmes and health budgets; and c) assess allocative and input efficiency of various resource utilization scenarios. The tool is premised around the results framework (or expanded logical framework approach) where resource inputs are translated into outputs, outputs into outcomes, and outcomes into impact. The resulting conceptual framework disaggregates the health outcome production process into service production and health production functions. The service production function captures how inputs (investment) transform into health services, and includes costing and coverage indicators. The health production function translates the health services into health outcomes, focusing on the epidemiological process, i.e. mortality and/or morbidity reduction. This translates to a return on investment into the health sector.

Data was mainly obtained from several key documents and expert opinion where reliable data was unavailable. A three-day workshop of the Three-year Plan Taskforce was organized in Harare in November 2009 to identify three year priorities from the NHS, orient members on the MBB tool and gather preliminary baseline country data. A second workshop, attended by Provincial Medical Directors (PMDs), was held from 7-11 December 2009 in Harare to (i) complete baseline data collection and validation, (ii) conduct an analysis of bottlenecks in achieving the three year priorities, (iii) discuss and agree on technical and policy strategies to address identified bottlenecks, (iv) based on agreed strategies, set targets for three investment options (modest, medium and comprehensive), (v) estimate additional funding per capita required for each option, and (vi) assess the financing gap for each of the three options. The ensuing report and proposed investment options were further discussed with and verified by MOHCW programme managers and development partners.

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1 MBB is an analytical costing and budgeting tool developed by teams from UNICEF, the World Bank, and Ministry of Health of several countries.
3. Analysis of the health system

The MOHCW is focussed on revitalizing the Primary Health Care Approach (PHC) to address the health needs of the nation. The same was reinforced in the Assessment of Primary Care in Zimbabwe (2009) which clearly articulated the need to “Put in place a national PHC strategy, backed by clear service entitlements, with resources effectively applied to community and primary care levels of the health system” as “an entry point to wider PHC oriented changes”. In this context the NHS identifies three important objectives of the health system in Zimbabwe - (i) to keep as many people as possible in good health in the community through health protection, health promotion and disease prevention strategies, (ii) to provide appropriate quality services for those needing care in the community (Primary care) and (iii) to provide high quality hospital services at the appropriate level for those few requiring that form of treatment and care (Secondary, Tertiary and Quaternary care).

The World Health Organisation (WHO) advises that inadequate health systems are one of the main obstacles to scaling-up interventions to secure better health outcomes and further identifies six essential building blocks to strengthen health systems. The MBB tool allows the assessment of health system performance by identifying bottlenecks at specific points in the service delivery process using selected high impact interventions. The interventions used in the development of this investment case were selected from the different packages of services at each level of the health system taking into account the national disease burden, existing national programmes and the WHO health systems building blocks. The following coverage indicators were used to assess the performance of the system in delivering the selected interventions: (i) availability of essential commodities, (ii) availability of human resources, (iii) physical accessibility, (iv) utilization (initial and continuous utilization), and (v) quality of service. The following sub-sections discuss the current situation, possible causes and proposed strategies to address identified bottlenecks in providing the selected services at three levels of care - household (community), clinic (primary) and hospital (secondary, tertiary and quarternary).

Each level of care is expected to offer a package of clearly defined services provided by appropriately trained health professionals. **Whilst careful selection of interventions at each level of service delivery was done, the performance of the system using the selected interventions may not, in some instances, be entirely generalizable to all the core package of services provided or planned at each respective level. However the strategies proposed to address the identified bottlenecks are not limited to the selected interventions but are meant to address gaps in the broad service delivery at each level.**

3.1 Primary level

The primary level consists of a network of community health workers and health centres. The community level of health services includes all actions that families and communities can take to maintain and improve their health and nutrition status. The primary level also incorporates the most peripheral unit, and first point of contact between the people and the health delivery system, the Rural Health Centre or clinic.

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1. Primary health care was initially declared in Alma Ata in 1978 and reaffirmed in Ouagadougou in 2008, as a strategy that seeks to respond equitably, appropriately, and effectively to basic health needs. It includes the following eight elements (i) education concerning prevailing health problems and the methods of preventing and controlling them; (ii) promotion of food supply and proper nutrition; (iii) an adequate supply of safe water and basic sanitation; (iv) maternal and child health care, including family planning; (v) immunization against the major infectious diseases; (vi) prevention and control of locally endemic diseases; (vii) appropriate treatment of common diseases and injuries; and (viii) provision of essential drugs.


3.1.1 Community health

In line with the Primary Health Care approach, which calls for a conscious acceptance by the community of the responsibility for its own health, the tradition of community involvement in health has been preserved. There are a number of home or community based health practices or behaviors that can be carried out by households or communities themselves after receiving guidance. The role of the health system, in this situation, is to empower communities through information, education and other communication strategies, as well as other forms of support, for instance, in the form of provision of insecticide treated mosquito nets, provision of safe drinking water and sanitation and provision of oral rehydration sachets etc.

Community health workers are often the key link between communities, especially rural, and local health services. These cadres mobilize households and communities in activities that foster promotive, educative, and preventive, preventive health behaviour. In Zimbabwe Village health workers (VHWs) are the commonest community health worker in rural areas where they are usually the service provider in the prevention of locally endemic conditions, treatment of simple conditions and disease surveillance. Rural health centres supply appropriate medicines and commodities and provide on-going technical supervision and support to VHWs. Ideally one village health worker should serve 100 households or a village. The equivalent of VHWs in urban centres are called Health Promoters.

Community Based Distributor (CBD), whose main function is to promote family planning services including the re-supply of appropriate contraceptives, is another key community health worker. The growing range of community health workers includes former chloroquine holders, depot holders and home-based caregivers. Community health workers are not intended to be full-time health workers on salaries but receive variable monetary stipends and material incentives. They are often supported by local authorities, NGOs, government ministries and parastatals in collaboration with the MOHCW.

The investment plan will support the critical role of communities in activities to determine their health. Long-lasting insecticide-treated nets (LLINs), exclusive breastfeeding and oral rehydration therapy for managing diarrhoea were used to assess coverage of services and constraints at the community level. The output of the analysis from the MBB application is shown in Figure 2 and summarized below.

Figure 2: Coverage at community health level
(a) **Availability of essential commodities**
It is estimated that only 19% of districts have required LLINs according to national need while oral rehydration salts are available to 10% of villages countrywide. The critical shortage of essential commodities for the selected household and community level health interventions is a result of inadequate stocks of LLINs at national and district level, inadequate capacity to ensure efficient distribution of commodities to community level and weaknesses in inventory management among relevant community health workers. In some instances national policy does not enable or has not been revised to encourage wide distribution of basic commodities at community level e.g. use of zinc containing ORS, which was recently introduced as part of new clinical guidelines.

(b) **Availability of human resources**
Nineteen percent of villages countrywide are estimated to have active village health workers. The causes of the shortage of community health workers include the cessation of the VHW training programme in most districts, poor remuneration and internal competition arising from non-harmonisation of incentives.

(c) **Physical accessibility**
The availability of VHWs was used as proxy for physical accessibility at community health level. The Assessment of Primary Health Care in Zimbabwe (2009) found that less than half of households have access to a VHW in their wards and existing VHWs are no longer being supplied with basic medicines since clinics do not even have sufficient stock for their own use. The study also noted low coverage of malaria spraying and TB contact tracing and 20% of facilities were reported to lack refrigeration for the cold chain undermining routine immunization. Gaps in availability of resources and support for prevention and promotion activities by environmental health technicians (EHTs), VHWs and clinics leave communities susceptible and dependent on curative care. Environmental Health Technicians are very few with a high national vacancy rate of over 50%. This negatively affects the provision of environmental health services.

(d) **Utilization – initial and continuous**
Initial and continuous utilization of LLINs in high malaria districts are estimated to be 27% (ownership of at least one net per household) and 23% (percentage of children under 5 year sleeping under a net) respectively. Similarly initial utilization of various types of fluids to manage acute watery diarrhoea at household level is estimated to be 58% whereas 12% of children are given more fluids and continued feeding during an episode of acute watery diarrhoea. 98% of children aged 6-9 months are ever breastfed.

Low utilization of most services and activities targeted at community level is due to low level of knowledge and compounded by socio-cultural and religious beliefs that discourage conventional techniques e.g. religious objectors who do not accept immunization and cultural beliefs against exclusive breastfeeding. In the Assessment of Primary Care in Zimbabwe (2009) households were “found to lack the correct knowledge or accessible resources to manage dehydration” and suggested “that health literacy programmes need to give people reasonably wide knowledge and reinforce this with more frequent repeat of information for common endemic diseases and that VHWs and EHTs should continue to play an important role in this”.

(e) **Quality of services**
Effective use of selected community level interventions was used as a proxy of quality of services. Only (i) 17% of children under 5 sleep under an LLIN, (ii) 26% of children are exclusively breastfed and (iii) 8% of children with acute watery diarrhoea receive ORS and continuous feeding.
3.1.2 Health centre level
Health centres are staffed by two nurses, one of whom should be a midwife and an Environmental Health Technician. Each Rural Health Centre is expected to cover a population of 10,000 and should be accessible to the community within no more than 8 kilometres of walking distance. Given the fact that women and children under 15 years constitute about 70% of the total population, the NHS highlights the importance of maternal and child health in Zimbabwe. These population groups are particularly vulnerable to malnutrition, HIV and AIDS, other infectious diseases and adolescent and reproductive health challenges. In 1993 the MOHCW developed a comprehensive Maternal and Child Health care programme to provide a continuum of maternal, newborn care and child health. For purposes of this investment case, family planning (FP), antenatal care (ANC), prevention of mother-to-child transmission of HIV infection (PMTCT) and expanded programme on immunisation (EPI) were selected as tracer services to assess the performance of the health system at clinic level. The output of the analysis from the MBB tool is shown in Figure 3 and summarized below.

Figure 3: Coverage at health centre level

(a) Availability of essential commodities
As of October 2009, 56% of health facilities were estimated not to have had stock-out of IFA for ANC and 70% of primary health centres had no stock-out of vaccines and injection materials during the previous 3 months. Availability of essential commodities for EPI is erratic due to national shortage, inadequate distribution capacity and lack of/or poorly maintained cold chain equipment. Rapid HIV test kits and ARVs for PMTCT have also been in erratic supply largely due to inadequate funding and weak distribution capacity.

(b) Availability of human resources
Ninety-three percent of the nursing establishment in government health institutions is filled. This high staffing level is a result of expanded training and deployment of a generic cadre of nurse, the Primary Care Nurse (PCN). However PCNs have limited midwifery orientation and general institutional experience. Only 38% of health facilities offer comprehensive PMTCT services. Thirty-three percent
of villages countrywide have access to facilities with nurses or midwives providing ANC according to national standards. Similarly only 33% of families have access to family planning services. Currently there are only 332 CBs instead of 900 countrywide. The shortage of experienced registered nurses and midwives is mostly due to poor remuneration and conditions of service, general harsh macro-environment and inadequate training capacity.

(c) **Physical accessibility**
The NHS states that distance from the nearest facility is an important factor in planning for health care services and the health facility must be located within a reasonable distance, and the cost of seeking service should be affordable for equitable health care delivery. In rural areas, where transport is less accessible and the majority of people live, the importance of the foregoing cannot be over emphasized. 60% of pregnant women have ANC access, 58% of villages countrywide have access to static or outreach PMTCT services and 60% of villages can access EPI static and outreach services. The Study on Access to Health Care Services in Zimbabwe, (May 2008) and the Assessment of Primary Health Care in Zimbabwe (2009) both noted that physical access to health facilities remains a major challenge in most districts as thousands of people have to travel more than 10 kilometres to reach a functional health facility. Outreach mobile services that were previously well-established in all districts are now extremely weak. Physical inaccessibility is accentuated by lack of health facilities in hard to reach rural areas and most resettlement areas, unavailability and/or unaffordable transport and user fees.

(d) **Utilization – initial and continuous**
The Maternal and Perinatal Mortality Study (2007), Study on Access to Health Care Services in Zimbabwe, (May 2008) and the Assessment of Primary Health Care in Zimbabwe (2009) all identified user fees as a significant barrier to accessing services especially among poor and vulnerable communities. Initial uptake and continued utilisation of rural health centre services is estimated below:

- 87% of married couples have ever used FP and 60% are currently using FP
- 88% of pregnant women attend at least one but 69% attend at least four ANC visits
- 66% of pregnant women receive HIV counseling and testing during ANC
- Only 53% of HIV positive pregnant women are referred and receive CD4 screening before they deliver. This service is available at district hospital level.
- 85% of children aged 12-23 months receive DPT1 immunisation but only 67% receive DPT3 and the measles vaccination

The causes of low utilization of services at clinic level include lack of knowledge, religious and cultural barriers, user fees and poor male involvement.

(e) **Quality of services**
According to the NHS and as stated in the Patient Charter, communities, patients, their families and staff, are the best placed to judge quality, because of their personal or communal experiences. Both the Study on Access to Health Care Services in Zimbabwe, (May 2008) and the Assessment of Primary Health Care in Zimbabwe (2009) reported the community perception of quality of services at health centres and hospitals as satisfactory with less than half of households satisfied with the performance of the health system (service quality and outcomes). In the preparation of this investment case, the following estimates of effective coverage of selected health centre services were used as a proxy of quality:

- 58% of married couples are currently using modern FP (CPR is estimated to be 65%)
- 36% of pregnant women attend at least 4 ANC visits during pregnancy
- 29% of HIV positive pregnant women receive a complete course of ARV prophylaxis
- 49% of children aged 12-23 are fully immunized by the age of 18 months

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5Study on access to health care services in Zimbabwe, May 2008
Maternal and Perinatal Mortality Study 2007, MOHCW