



Financing Alliance for Health

Country Fact Card - Zimbabwe

2019

Macro context of Zimbabwe

Health Landscape

Health Financing

Community health system



Political landscape

Current Government

- President: Emmerson Mnangagwa
- Government in transitional period, following the resignation of Pres. Robert Mugabe in 2017, after 37 years in power
- Consistent budget deficits (want to reduce budget deficit to 4% of GDP in 2019, down from an 11%)

Country priorities

- Mining is the largest industry in Zimbabwe, though agriculture employs the most people
- Revival of Zimbabwe's ailing economy through investment in agriculture, strengthening the currency, attracting FDI etc.

Risks

- Zimbabwean economy is now in recession and anticipated by WB to shrink by 3.1% in 2019
 - Violent protests were witnessed due to fuel shortages, price hikes of basic commodities, and electricity outages
- The health care sector, is under-resourced; doctor strikes are common due to poor pay and working conditions
 - There is a shortage of health workers – ratio of 8:10,000 population, which is against the target of 23:10 000
- A third of the population, would need food aid this year following the El Nino-induced drought

Macroeconomic Indicators

• Population	16.9M
• GDP per capita (current USD, 2014)	\$1,650
• GDP CAGR, 2012-2016	xxx
• Unemployment (total)	11.2%
• Youth unemployment (rate)	17.6%
• Inflation	66.8% or 98%
• Credit rating	C
• Interest rate	xx
• Current account deficit	-1.3% (\$300M)
• Population growth rate	1.4%

Geographic context:

- Mostly rural country: there 10 provinces (8 rural and 2 metropolitan) and 63 districts; 33% of the population lives in urban areas
- ~3M households with an average household size of 4.2 persons

Epidemiologic context:

- HIV and AIDS, TB and malaria remain a significant public health problem even though there has been decreases in both incidence and prevalence
- NCDs are also on the rise and account for 33% of the total deaths in Zimbabwe
- Diarrheal diseases including typhoid and cholera have been on the increase due to deteriorating water and sanitary conditions

State of health care:

- 8 core health workers ((doctors, nurses, pharmacists) per 10 000 population, only a third of the WHO-recommended target of 23 per 10 000
- The primary level is comprised of CHWs and rural health centers or clinics that offer basic maternity, preventive, and curative services



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Health system indicators

• HIV Prevalence (2017)	13.6%
• Unmet need for contraception	11%
• Maternal mortality ratio/100k (2015)	443
• Neonatal mortality rate/1k live births	29
• Infant mortality rate/1k live births	50
• Under 5 mortality rates/1k live births	69

• Community health workers per 1,000 citizens	0.04
• Physicians per 1,000 citizens	0.1
• Life expectancy at birth	61
• DALYs per 1,000 citizens	111
• Maternal mortality rate per 100,000 births	443
• Under-five mortality rate per 1,000 births	46.2

Causes of maternal mortality

- Haemorrhage
- Hypertension
- Puerperal sepsis
- Obstetric embolism
- Abortion

Causes of child mortality*

• HIV/AIDS	29%
• Lower respiratory infections	11.7%
• Diarrheal diseases	6%
• Tuberculosis	4.2%
• Malaria	3.6%

*Malnutrition is also a leading underlying causes of under-five deaths; 27% of children are stunted, 3% are wasted, 8% are underweight, and 6% are overweight



Macro context of Zimbabwe

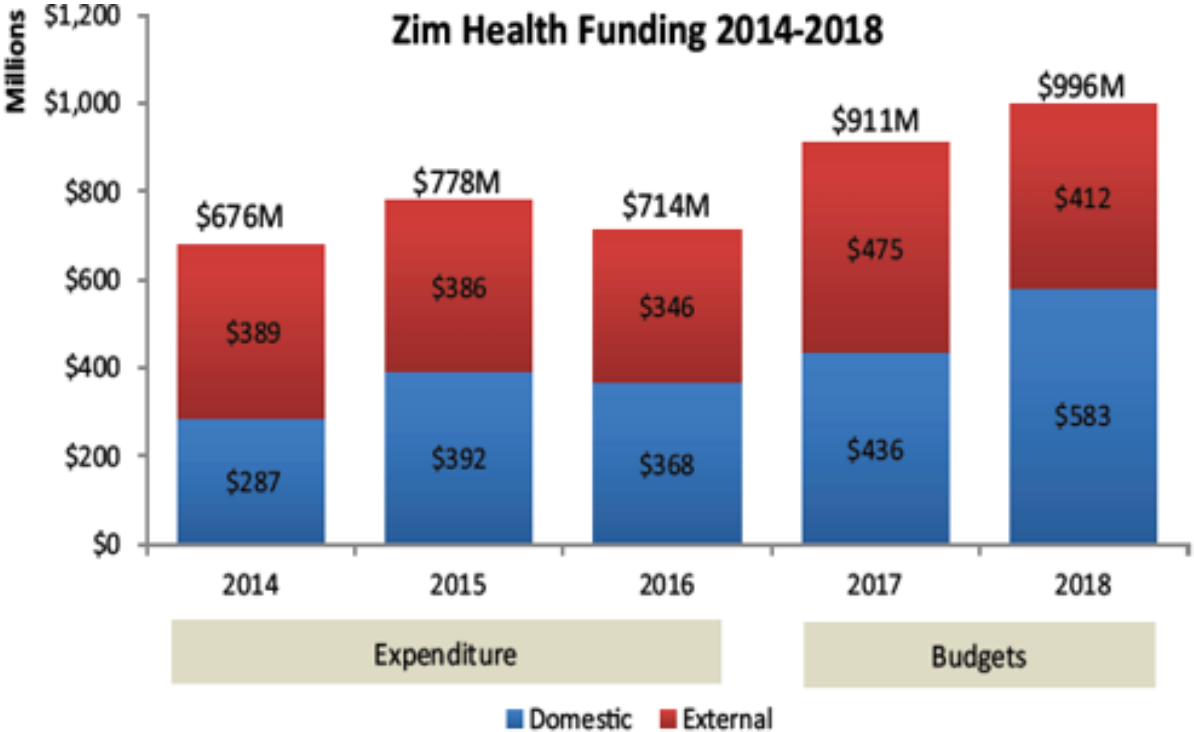
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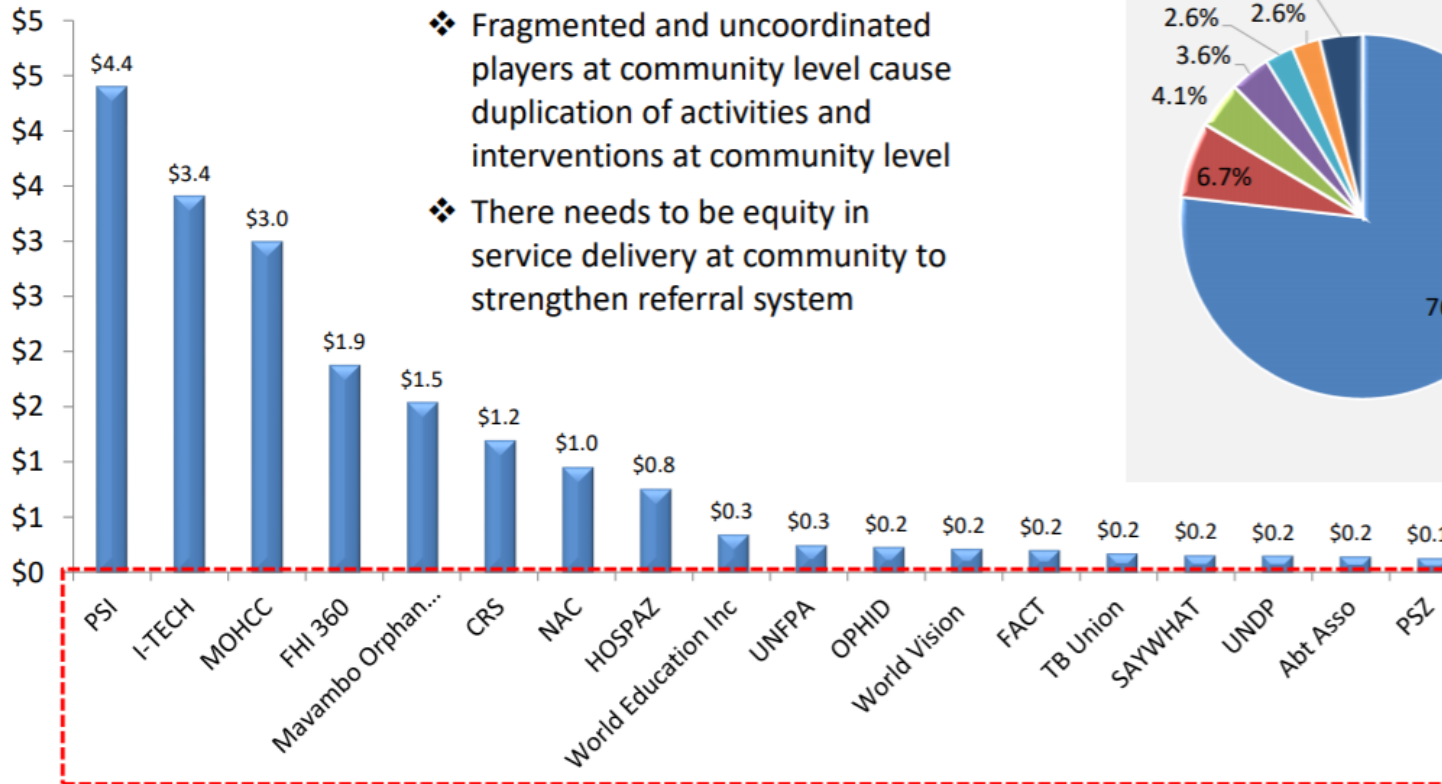


Health funding in Zimbabwe



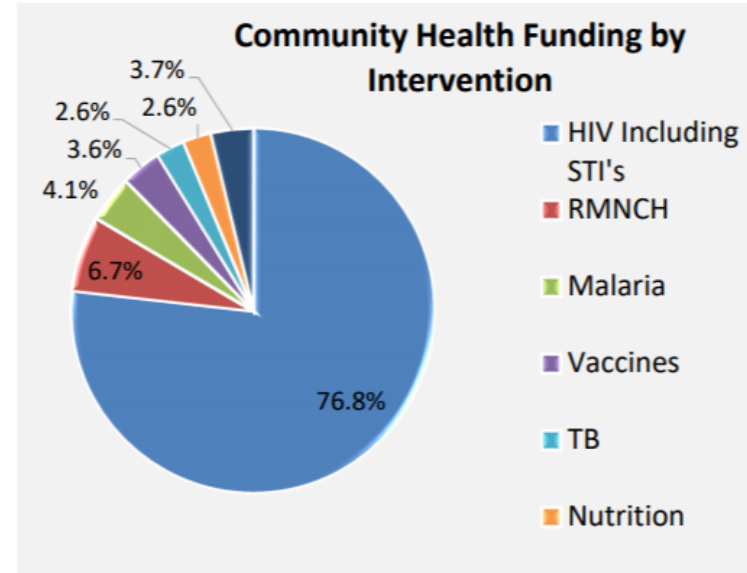
- Currently, the government of Zimbabwe contributes ~50% of the national health budget
- While internal funding dominates the resource envelope for health, ~80% of funding is allocated towards health systems costs, specifically towards salaries and benefits

Split of Community Health Funding Across Implementing Partners



- ❖ Fragmented and uncoordinated players at community level cause duplication of activities and interventions at community level
- ❖ There needs to be equity in service delivery at community to strengthen referral system

Community Health Funding by Intervention





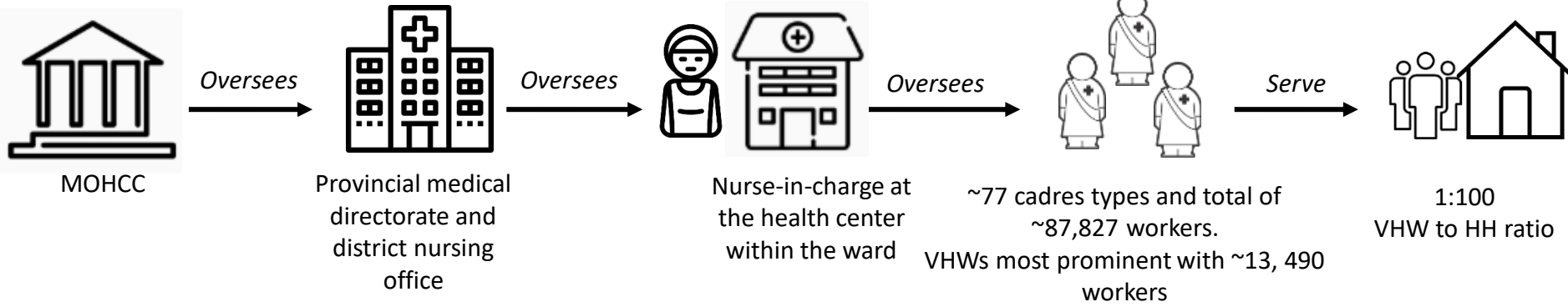
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National Community health worker structure: Zimbabwe has a legacy CH program, which was launched in 1981



Time spent • Spend 4-6 hours per day, 3 days per week, and visit ~20 households per day

Interventions

- Services include: prevention, health promotion and treatment of common conditions (~23 service). VHWs are trained on wider scope of services, other cadres receive verticalized training

Selection

- Selected by the community following a recruitment request from the health center
- Has to be >25, married, literate, of good character etc.
- Only an estimated 19% of villages had active VHWs, based on a Unicef 2010 study)*

Training

- MOHCC conducts an initial 8-week VHW training. Refresher trainings are conducted as needed/when funds are available

HS linkage

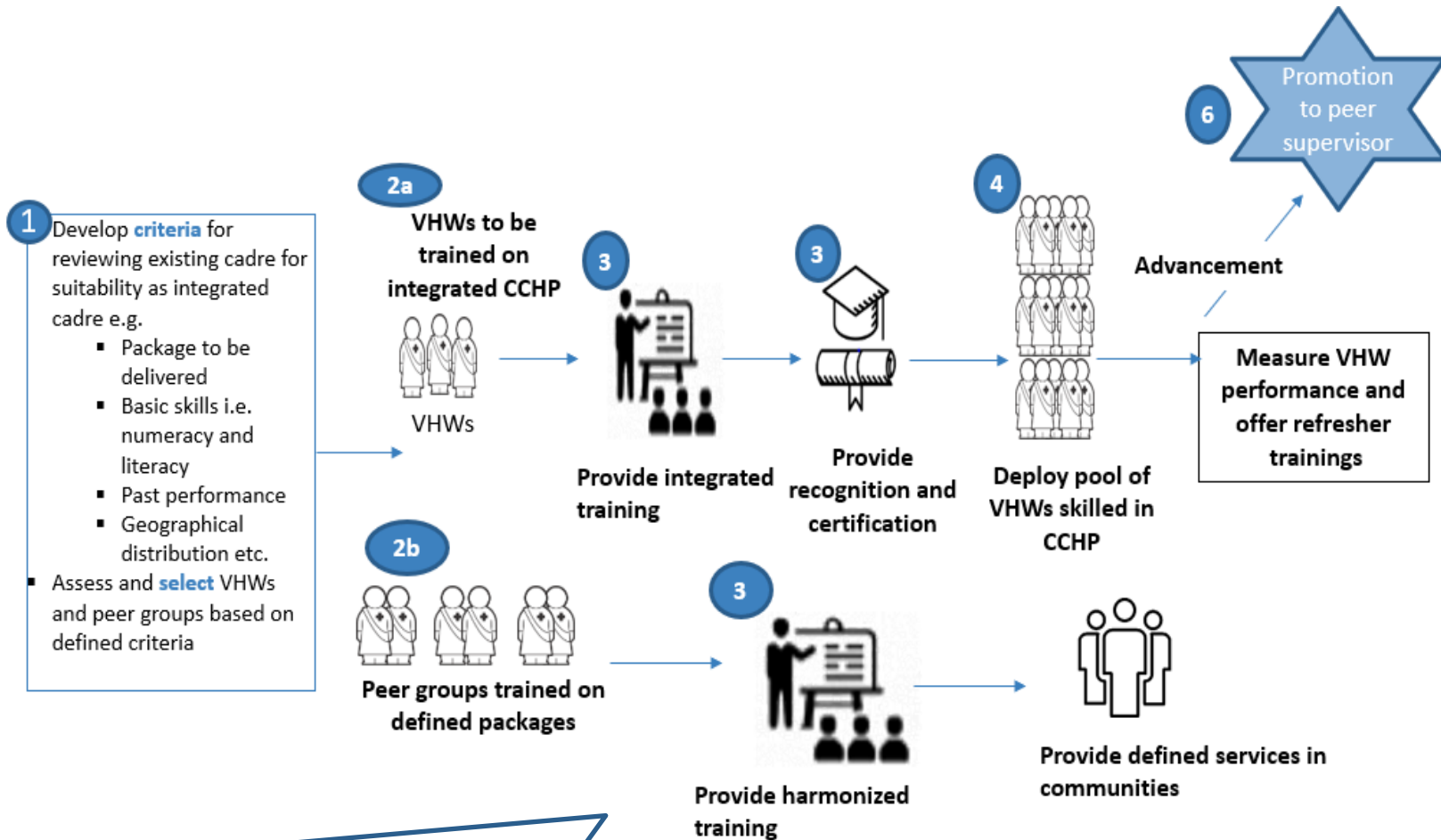
- Reporting lines include: Director for Nursing Services > Provincial Nursing Officers > District Nursing Officer > Nurse-in-charge at the health center
- VHWs are expected to attend monthly meetings at the rural health center
- Poor linkage of community data to DHIS

Incentives

- VHWs receive a quarterly allowance of \$42, though remuneration is often irregular
- They are also provided with a bicycle and a medical supply kit – stock outs are regular

*Shortage of VHWs community health workers attributable to the cessation of the VHW training programme in most districts, poor remuneration and internal competition arising from non-harmonization of incentives.

Revised community health programme structure



Community health services will be provided by:

- VHWs** that are selected and trained to provide the entire integrated community health package
- Peer groups/networks** selected and trained to provide specific service packages to special groups as defined by the TWG, to broaden the base and reach of the integrated CHW cadre