



INVESTMENT CASE FOR THE National Health Strategy 2021-2025



Investment Case for the **National Health Strategy** **2021-2025**

"Accelerating investments towards Universal Health Coverage"

Foreword

Accelerating investments towards Universal Health Coverage

In line with vision 2030 and the National Development Strategy (NDS 1), the Ministry of Health and Child Care seeks to accelerate the attainment of Sustainable Development Goals, the African Agenda 2063 and ensure Universal Health Coverage (UHC). The Zimbabwean Health Sector has made significant progress in improving health outcomes and responding to population health needs. The latest UHC service coverage index for Zimbabwe stands at 54 above the Sub-Saharan Africa average of 43.89. To ensure progress towards Universal Health Coverage, the Government of Zimbabwe (GoZ) through its Ministry of Health and Child Care has therefore developed the National Health Strategy (NHS) 2021-2025 whose goal is "To improve the quality of life" for all Zimbabweans. Eleven health sector priority outcomes have been identified for this goal to be realized which require intensive investments in the health sector.

To that effect, the GoZ seeks to increase Domestic Funding for Health to meet the 15% Abuja Declaration and ultimately the USD84 per capita World Health Organisation threshold in demonstration of its commitment to the health of its population. According to the latest Resource Mapping and National Health Accounts reports, the GoZ budgetary allocations have been on an upward trajectory. The MoHCC will therefore continue to advocate and lobby with treasury for more resources to the health sector. Strategies have been put in place to increase population coverage and scope of services as the country moves towards Universal Health Coverage. The period 2021-2025 will mark the establishment of the National Health Insurance Scheme (NHIS) for Zimbabwe. Further to that, the benefit packages for the various levels of care are being developed to guide investments.

Given the considerable gap between the costs of the proposed set of interventions and strategies and the resources available, the MoHCC has therefore come up with this National Health Strategy Investment Case to ensure available resources are directed towards prioritized high impact interventions. Investing in health has enormous benefits societally and economically and this is well elaborated in this document. The ongoing COVID-19 pandemic has disrupted essential health services and threatens to reverse hard-earned gains obtained from years of health investments from government and development partners to the sector. In light of this, concerted and smart investments are needed to ensure Zimbabwe reclaim any gains lost and accelerate progress towards Universal Health Coverage.

Implementation of this Investment Case to the NHS 2021-2025 calls for efficiencies in the utilisation of available resources during implementation of the high impact prioritised strategic interventions. The need for collaboration and coordination can therefore not be



over emphasized as enunciated in the NDS1 and the National Development Cooperation Strategy. The coordination in the health sector will be guided by the recently developed Coordination Framework for the Health Sector.

The Minister of Health and Child Care appreciates the investments by development partners and private sector to date, and implores for continuity as their investments complement the GOZ efforts in financing this investment case to accelerate the implementation of the NHS 2021-2025 as Zimbabwe progresses towards Universal Health Coverage.



HON. Gen (RETD) DR. C. G. D. N. CHIWENGA 'GCZM'

Vice President and Minister of Health and Child Care

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I therefore look forward to this continued coordinated close collaboration during the implementation, monitoring and evaluation of this Investment Case for the NHS 2021-2025.



Air Commodore (Dr) Jasper Chimedza

Secretary for Health and Child Care



Acronyms

AG	Auditor General
AHFoZ	Association of Healthcare Funders of Zimbabwe
AMTO	Assisted Medical Treatment Order
ANC	Ante Natal Care
API	Annual Parasitic Incidence
ARSS	At Risk Surveillance System
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEO	Chief Executive Officer
CHAI	Clinton Health Access Initiative
CHE	Catastrophic Health Expenditure
CHIS	Community Health Information System
CQI	Continuous Quality Improvement
CSOs	Civil Society Organisations
DAH	Development Assistance for Health
DALYs	Disability Adjusted Life Years
DHIS	District Health Information System
DHT	District Health Team
DNA	Deoxyribonucleic Acid
DP	Development Partners
DPC3	Disease Control Priorities
DTP3	Pentavalent Immunisation
EDC	Epidemiology and Disease Control
EBP	Essential Benefits Package
EHTs	Environmental Health Technicians

EmONC	Emergency Obstetric Newborn Care
ENND	Early Neonatal Death
EPI	Expanded Programme on Immunisation
ETAT	Emergency Triage Assessment and Treatment
FBOs	Faith Based Organisations
FCH	Family Child Health
FP	Family Planning
FY	Financial Year
GAP	Global Action Plan
GDP	Gross Domestic Product
GoZ	Government of Zimbabwe
HAT	Human African Trypanosomiasis
HBS	Helping Babies Survive
HCWs	Health Care Workers
HDF	Health Development Fund
HDPCG	Health Development Partners Coordination Group
HDU	High Dependency Unit
HIP	Health Intervention Prioritisation
HIS	Health Information System
HMIS	Health Management Information System
HPA	Health Professions Authority
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSB	Health Services Board
HSIDP	Health Sector Investment Development Plan
HSS	Health Systems Strengthening
HSWG	Health Sector Working Group
HTF	Health Transition Fund
ICU	Intensive Care Unit
IDRS	Infectious Disease Reporting System



IHME	Institute of Health Metrics and Evaluation
IMAM	Integrated Management of Acute Malnutrition
IMF	International Monetary Fund
IMNCI	Integrated Management of Newborn and Childhood Illness
IMR	Infant Mortality Rate
IPTs	Intermittent Preventive Therapies
IRBM	Integrated Results Based Management
IRS	Indoor Residual Spraying
IST	Integrated Sample Transportation
ITNs	Insecticide Treated Nets
JRM	Joint Review Mission
KMC	Kangaroo Mother Care
KRAs	Key Result Areas
LiST	Lives Saved Tool
LLINs	Long Lasting Insecticide Nets
LMIS	Laboratory Management Information System
MCAZ	Medicines Control Authority of Zimbabwe
mCPR	modern Contraceptive Prevalence Rate
MDA	Mass Drug Administration
MDR-TB	Multi Drug Resistant Tuberculosis
MDSR	Maternal Death Surveillance and Response
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal and Child Health
MODO	Ministry of Health and Donor Planning meeting
MoFED	Ministry of Finance and Economic Development
MoHCC	Ministry of Health and Child Care
MOLG	Ministry of Local Government
MOPSE	Ministry of Primary and Secondary Education
MTCT	Mother to Child Transmission
MTR	Medium Term Review

NATF	National AIDS Trust Fund
NatPharm	National Pharmaceutical Company of Zimbabwe
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
NHA	National Health Accounts
NHI	National Health Insurance
NHS	National Health Strategy
NHS-IC	National Health Strategy Investment Case
NMR	Neonatal Mortality Rate
NPAs	National Priority Areas
NDS1	National Development Strategy 1
NSOAP	National Surgical Obstetric and Anesthetic Plan
NTDs	Neglected Tropical Diseases
OHT	One Health Tool
OJTs	On Job Trainings
OOP	Out of Pocket
OPC	Office of the President and Cabinet
ORS	Oral Rehydration Solution
PBB	Programme Based Budgeting
PCC	Parent to Child Communication
PEN	Package of Essential Non-communicable Disease Interventions
PEPFAR	President's Emergency Plan for AIDS Relief
PFMS	Public Finance Management System
PHEOC	Public Health Emergency Operations Center
PHT	Provincial Health Team
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPM&E	Policy Planning Monitoring and Evaluation
PPPs Public	Private Partnerships
PROGRESS	Place of Stay, Occupation, Gender, Religion, Education, Socio-Economic Status and Social capital



PSCM	Procurement and Supply Chain Management
PSMAS	Premier Service Medical Aid Society
Q2	Quarter 2
QA	Quality Assurance
QI	Quality Improvement
QSS	Quality Support and Supervision
RBF	Results Based Financing
RMNCAH-N	Reproductive Maternal Newborn Child Adolescent Health and Nutrition
ROI	Return on Investment
RTA	Road Traffic Accident
SBCC	Social Behaviour Change Communication
SBMR	Standards Based Management and Recognition
SBU	Special Business Unit
SCH	Schistosomiasis
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
STH	Soil Transmitted Helminths
TAT	Turn Around Time
TB	Tuberculosis
THE	Total Health Expenditure
TOC	Theory of Change
TSCZ	Traffic Safety Council of Zimbabwe
TSP	Transitional Stabilisation Programme
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

US	United States
US\$	United States Dollar
VHWs	Village Health Workers
VIAC	Visual Inspection with Acetic Acid and Camera
VMAHS	Vital Medicines Availability and Health Services Survey
WASH	Water Sanitation and Hygiene
WB	World Bank
WCBA	Women of Child Bearing Age
WHO	World Health Organisation
WHO-CHOICE	World Health Organisation Choosing Interventions that are Cost Effective
ZDHS	Zimbabwe Demographic Health Survey
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZWL	Zimbabwe Dollar



Executive Summary

The Government and stakeholders in the health sector aspire to realize improved health outcomes for all, including the vulnerable and marginalized, to enhance Zimbabwe's human capital development towards a prosperous and empowered upper-middle income society. Zimbabwe's National Health Strategy (2021- 2025) was therefore developed, not only to advance its vision and goal for the next 5 years, but to also act as a guide on priority health interventions in the sector in order to improve the country's economy and overall wellbeing of the citizens. As such, the strategy is aligned with the National Development Strategy 1 (2021-2025). Chief among the NDS 1 priorities will be sustainable economic growth, anchored on sector specific growth enablers – such as infrastructure, human resources, technology, macroeconomic stability, financial stability, and sustainable public debt management. Focus on transformational value chains, international re-engagement, enablers for improved social welfare and inclusive growth (such as health, food security, effective governance and community and youth participation) complete the priority list of the NDS 1 2021-2025. The NHS 2021-2025 also considers a number of programme specific strategies in the health sector. These include the Human Resources for Health Strategy, National Infrastructure Development Plan, the HIV and AIDS Strategy, the Non-Communicable Disease Strategy, Mental Health Strategy, and the Community Health Strategy.

The NHS 2021-2025 is anchored on the concept of an Investment Case. The NHS investment case outlines how the Government of Zimbabwe (GoZ), in partnership with donors, will efficiently save lives, improve health and nutrition outcomes and accelerate the attainment of national goals in line with the Sustainable Development Goals (SDGs). The NHS investment case considered the results and lessons learnt from the Mid Term Review of the National Health Strategy 2016-2020 and the Multiple Indicator Cluster Survey (MICS) 2019.

NHS Investment Case used the World Health Organization (WHO)'s One Health Tool, which focuses on estimating the cost of Health Services and Health Systems Strengthening while the effectiveness of health interventions was estimated using the disease specific Impact Models and the Lives Saved Tool (LiST). Results were customized to the Ministry's Programme Based Budgeting format, which required that programmes be grouped first into 4 broad categories; Policy and Administration, Public Health; Curative Services and Bio- Medical Science Engineering and Pharmaceutical Production.

The development of the National Health Strategy Investment Case was spearheaded by a taskforce led by MoHCC with technical assistance from its development partners. Technical Working Groups (TWGs) on Investment Case and Health Financing were set up to support the costing of the NHS. These TWGs drew membership from the MoHCC, MoFED, Development Partners and NGOs and Civil Society Organisations. These technical working groups identified the interventions and activities to be costed and also assisted in the prioritization of the interventions.

The following three costing scenarios were generated based on an agreed set of targets and assumptions:

- (1) **Scenario 1 (Full NHS Scenario) – based on the full implementation of the 289 NHS interventions as guided by the NHS Strategic Interventions.**
- (2) **Scenario 2 (Moderate Coverage Scenario) – maintained the same number of interventions as the Full NHS scenario but had moderate scale up of target coverages by between 1-10% of the NHS baseline targets; and**
- (3) **Scenario 3 (Primary Health Care Scenario) – scenario was based on an identification of a set of high impact cost-effective interventions informed by the WHO OHT and the Health Prioritisation Analysis. The scenario streamlined a set of primary care interventions that would advance Universal Health Coverage (UHC).**

The Full NHS Scenario - is the highest cost scenario requiring US\$7.8 billion for five years. It is the highly ambitious scenario and costs more than all the other two scenarios. Scenario 2 – the Moderate Scenario, allowed for moderate increases in intervention coverages of between 1% -10% and maintained the same set of interventions as the full NHS. This requires about US\$6.2 billion for the five-year period. Scenario 3 - Primary Health Care Scenario, prioritised the costing of a set of high impact and cost-effective maternal and child health interventions. It is the least costly scenario and it requires at least US\$5.2 billion to fund the plan for the five-year period.

The programme based budgeting framework was applied in the costing of the investment case. Overall, curative services account for most of the resource requirements for all the 3 scenarios. The programme accounts for 74%, 70% and 66% for the Full NHS scenario, Moderate coverage scenario and Primary Health Care scenario. Estimated funding for the Public Health programme is 9% for the full NHS, 11% for the moderate scenario and 13% for the Primary Health Care scenario respectively. Due to the focus on Bio-Medical Sciences Engineering and Pharmaceutical Production programme (which currently is just focusing investment on infrastructure and equipment) resources meant for recurrent costs would appear to be crowded out. However, while all scenarios will focus on investment and rehabilitation of infrastructure and equipment, the Primary Health Care scenario will focus on a limited set of high priority infrastructure and equipment that responds to the growing population and to the needs of the newly resettled people. Other critical investments will include the construction of health posts, district hospitals and installation of solar backup power as well as Solar Direct Drive refrigerators and cold rooms at selected rural health facilities.

The demographic dividend resulting from the Primary Health Care scenario is the estimated economic growth resulting from the reduction in fertility, mortality for under 5s and for women of childbearing/reproductive age. Fertility rates are expected to decrease from

3.27 in 2021 to 2.35 in 2025. The demographic transition as a result of reduced mortality and fertility will see a shift in age structure to the more productive/working age group. Investment in child health interventions such as case management of neonatal sepsis/pneumonia, PMTCT, oral rehydration solution will yield comparably more additional lives saved than the other interventions. Overall, investments in child health interventions will

result in 16 680, 7 281 and 7 628 additional lives saved for the 5-year period for the Full NHS, Moderate Coverage and Primary Health Care Scenario respectively. Additional maternal lives saved would be 1 420, 880 and 956 for the Full NHS, Moderate Coverage and Primary Health Care Scenario respectively.

While the strategy gives the country the strategic direction on the types of health services to be provided and the estimated cost and coverage targets for the entire health sector, the financing of the strategy will largely come from the public sector. The estimated public funding from Government and its partners is assumed to be US\$4.13 billion for next 5-years. Given this estimated cost of the plan - this would result in gaps of 47%, 33% and 22% for the full NHS, the Moderate coverage and the Primary Health Care scenario respectively.

The 2015 and 2017/2018 National Health Accounts showed that on average a total of US\$1.5 billion is spent annually in the entire health sector by both public and private sectors. The US\$1.5 billion spent in the health sector translates to almost US\$103 per capita and is more than the US\$86 per capita that is needed to promote universal access to core primary health care services in most low-income countries as recommended by WHO. Such an amount would cover the entire needs of the moderate coverage scenario and the Primary Health Care scenario. It would also cover 96% of the estimated costs for the full NHS Scenario. A greater share of the US\$103 per capita expenditure comes from the external partner financing, and the private sector whose mandates maybe different from the government's mandate. Furthermore, private health funds only cover about 10% of the population, while household Out of Pocket funds are not risk pooled. The assumption is that at least US\$60 per capita is pooled and public so that it can efficiently purchase the basic package. Hence, without a re-configuration of private sector funding by reforming the prepaid insurance schemes and reducing the household out-of-pocket expenditures, these funds would largely remain outside the purview of the MoHCC, perpetuating the current inefficient funding status quo. Multistakeholder policy dialogues need therefore to focus on how the public and private sector can reorganize the financing of the sector in order to reduce the inefficient fragmentation in the current health financing structure.

However, the need for financing unexpected emergencies such as the COVID-19 response would add to the above financing gaps, as the pandemic is expected to linger on for some years to come. However, the COVID-19 relief funds are enabling the government to purchase new equipment and refurbishment of hospital wards which is strengthening of the Health System.

Furthermore, Zimbabwe's current competing needs offer limited potential for expanding fiscal space for health. Earmarking of specific health taxes/levies has shown potential in adding fiscal space for health. Earmarking of specific taxes for health in addition to allocations through the budget have contributed significant earmarked funds towards health. AIDS Levy contributions have since risen from US\$5.7 million in 2009 to close to US\$52 million in 2018 (NAC). In 2017, the GoZ also introduced the Health Levy, 5% tax on mobile airtime and data. This was ring-fenced for procurement of hospital medicines and medical commodities. The levy generated more than US\$50 million in three years. Another potential source of revenue for the sector would be earmarking a portion of VAT. A study done in 2013 on earmarking of at least 1-2% of VAT showed that earmarking of 1% tax on VAT would generate approximately US\$138 million annually for the health sector. However, the

return of the Health Funds to the Consolidated Revenue Fund/general revenue has proved how difficult the concept and implementation of earmarking taxes is in general. For the Ministries of Finance, however, trade-offs to the general economy as a result of earmarking funds may generate some inefficiencies of revenue sources and budget allocations.

Achieving efficiency gains to maximize the current level of resources flowing to the sector is the most urgent and plausible option given the limited fiscal space. In addition to exploring the above fiscal measures, this NHS investment strategy is expected to not only facilitate policy dialogue around the following proposals, but to also translate these proposals into actionable reforms. These proposals are;

- i. **Reprioritizing health in total government spending in order for the Government Health Expenditure to either meet the Abuja Target of 15%, or spend at least US\$86 per capita or at least 5% of the country's Gross Domestic Product. The 2015/2017/2018 National Health Accounts show that on average Zimbabwe spends about US\$103 per capita. Whilst this per capita health expenditure is comparatively higher than the US\$86 per capita, a greater share of it comes from external sources and the private sector. The assumption is that at least US\$60 per capita is pooled and public so that it can cover the basic package.**
- ii. **Harmonization and alignment of current external funding to national priorities to reduce fragmentation and enhance efficiencies for better health outcomes.**
- iii. **Defining realistic, viable and cost-effective intervention packages at all levels of the country's health care system. This should be complemented by the development of a unit cost database that will enable realistic estimation of budgets for the MoHCC.**
- iv. **Establishing a needs-based and cost-effective resource allocation formula that will result in more efficiency gains and effective implementation of the NHS.**
- v. **Enhanced focus and financing of community health interventions will not only improve access to health services – but will do so at a very low unit cost. However, if the suggested set of interventions are not implemented and monitored properly, this could lead to unnecessary trade-offs between access to health services at community level and quality of care.**
- vi. **Decentralisation and implementation of the PFMS to all cost centres for all government entities will result in improved budgeting, expenditure, planning, execution, and auditing of health funds by helping turn allocated funds into inputs.**
- vii. **This NHS Investment case proposes a more focused attention on the provision of appropriate inputs at the appropriate levels of care – the human resources, medicines and supplies, infrastructure and equipment.**
- viii. **Reconfiguring of the private sector health services provision and funding model so that the private complements rather than competes with public sector in both service provision and funding. Lack of adequate public funding has led to the charging of user fees as cost recovery measure, but this has often led to high OOPs and reduced access to health services.**

According to Xu et al (2003) 'A 1% increase in the proportion of total health expenditure provided by out-of-pocket payments is associated with an average increase in the proportion of households facing catastrophic payments of 2.2%'.

As part of the implementation of the NHS, the governance structure to oversee its implementation will rely on existing platforms that have been set up by MoHCC in the Coordination Framework for the Health Sector. The government of Zimbabwe is implementing the Whole of Government Approach to monitoring and evaluation. The Division of PPM&E, specifically the Directorate of Monitoring and Evaluation housed in this division, will take lead in this aspect. Monitoring and evaluation of the NHS will ensure compliance with the principle of one plan, one implementation and one monitoring and evaluation framework.

Contents

Foreword	4
Acknowledgements	6
Acronyms	7
Executive Summary	13
1 Introduction	20
1.1 Background	20
1.2 Economic Status	20
1.3 The NHS Investment Case	20
2 Situational Analysis	24
2.1 Health status	24
3 Health Financing	26
3.1 Health Financing Reforms	26
4 Theory of Change for the NHS Investment Case	30
4.1 Sector Aspirations and Theory of Change	30
4.2 Results Framework for the National Health Strategy Investment Case	32
5 Methodology and Approach to the costing of the NHS-IC	36
5.1 NHS Costing Process	38
5.2 NHS Prioritisation and Costing Scenarios	39
6 Results of the NHS Costing	41
6.1 Full NHS Cost Scenario	41
6.1.1 Cost Analysis by PBB Pillars and Level of Care and Programme	42
6.2 Moderate Coverage Scenario	44
6.2.1 Cost Analysis by PBB Pillars and Level of Care and Programme	44
6.3 High Impact Scenario	46
6.3.1 Primary Care Focus	47
6.3.2 Cost Analysis by PBB Pillars and Level of Care and Programme	48

7	Return on Health Sector Investment	50
7.1	Mortality Rates and Deaths Averted	50
7.2	Additional Lives saved	51
7.3	Demographic Transitions	54
8	Financing of the NHS Investment Case	56
9	Implementation Framework for the NHS Investment Case	60
9.1	Country Coordination Platforms	60
9.2	Monitoring and evaluation	61
10	Appendix 1: NHS Implementation Matrix used for Costing	62

1 Introduction

1.1 Background

There is documented evidence that Zimbabwe has made great strides towards improving its health outcomes. The proportion of pregnant women with at least four (4) ANC visits has risen from 70.1% in 2014 to 71.4% in 2019. The proportion of deliveries conducted in health facilities has remained above 80% over the past 4 years. The proportion of deliveries in health facilities rose from 79.6% in 2014 to 85.5% in 2019 (MICS 2014 - 2019). PNC coverage for the mother has risen from 77.3% in 2014 to 82% in 2019. PNC coverage for the newborn baby has also risen from 85% to 91% in the same period (MICS 2014, 2019). MMR remains unacceptably high at 462 per 100 000 live births, though this is a decline from 651 maternal deaths per 100 000 live births in 2014. In Zimbabwe, the proportion of children who received Penta 3 below one year rose from 89% (ZDHS 2015) to 90.6% (MICS 2019). Districts with DTP3 coverage >80% increased to 59/63(93.6%) in 2018 up from 54/63 (86%) in 2017. Infant mortality rate fell from 52/1000 to 47/1000 in 2019. Under 5 mortality rates declined from 69/1000 in 2015 to 65/1000 in 2019. However, neonatal mortality rate has risen from 29 per 1000 live births in 2015 to 32 per 1000 live births in 2019 (MICS 2014, 2019).

1.2 Economic Status

The investment case describes a set of funding scenarios and the rationale for how the Government of Zimbabwe (GoZ), in partnership with its Development Partners, proposes to efficiently save lives, improve health and nutrition outcomes and accelerate the attainment of national goals in line with the Sustainable Development Goals (SDGs). The NHS investment case considered the results and lessons learnt from the Mid Term Review of the National Health Strategy 2016-2020 and the Multiple Indicator Cluster Survey (MICS) 2019. Global and regional guidance on public health related issues and lessons learnt from ongoing programmes were also utilized. Key actions to be undertaken in Zimbabwe for the next five years were identified. These actions will accelerate, and support sustained and resilient changes in health systems strengthening. This will ensure the attainment of humanitarian development in a coordinated and inclusive way with one plan, one implementation and one monitoring framework. The guiding principle for the NHS Investment Case will be the NHS Health Sector Strategic Direction as specified in the NHS 2021-2025.

1.3 The NHS Investment Case

In October 2018 at the 40th anniversary of the Alma Ata Declaration on Primary Health Care (PHC), United Nations (UN) member states including Zimbabwe renewed their commitment to strengthening PHC systems as an essential step to achieving Universal Health Coverage (UHC) by "enabling every person everywhere to exercise their fundamental right to health" (Dr. Tedros Adhanom Ghebreyesus, 2018)



Globally, about 930 million people worldwide are at risk of catastrophic health expenditure, yet scaling up PHC interventions across low and middle-income countries could save 60 million lives and increase average life expectancy by 3.7 years by 2030. Primary Health Care is therefore widely recognized as one of the important means to achieving the Sustainable Development Goal (SDG) No.3.

WHO and UNICEF have issued the following harmonized definition to facilitate coordination of PHC efforts at global, national and local levels, and to guide implementation; "A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" ¹.

According to the WHO, PHC is the most inclusive, equitable, cost-effective, and efficient approach to enhance people's physical and mental health, as well as social well-being through implementation of three interrelated and synergistic PHC components², i.e.,

- 1) Primary care and essential public health functions as the core of integrated health services;
- (2) Multisectoral policy and action for health, and;
- (3) Empowered people and communities.

The 8 essential elements of PHC delivered across service level from community to quaternary facilities include;

- **Health education on prevailing health problems and the methods of preventing and controlling them.**
- **Nutritional promotion including food supply.**
- **Supply of adequate safe water and sanitation.**
- **Maternal and child health care.**
- **Immunization against major infectious diseases.**
- **Prevention and control of locally endemic diseases including communicable and non-communicable diseases (NCDs).**
- **Appropriate treatment of common diseases and injuries; and**
- **Provision of essential drugs**

In addition to these components, PHC is also critical to making the health systems more resilient to situations of crisis, more proactive in detecting early signs of epidemics and other emergencies; more prepared to act early in response to surges in demand for services³, and better capacity for recovering from an emergency situation. A PHC approach is therefore an

¹WHO and UNICEF. *A vision for primary health care in the 21st century: Towards UHC and the SDGs*

²World Health Organization. *Framework on integrated people-centred health services: an overview. 2018* (http://www.who.int/service-delivery-safety/areas/people-centred-care/Overview_IPCHS_final.pdf, accessed 10 October 2018).

³ <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

essential foundation for health security, emergency, and risk management, and for building community and country resilience.

Zimbabwe's health service delivery is established at five levels: primary, secondary, tertiary, quaternary, and the recently added quinary level as per National Health Strategy 2021-2025, with PHC being the main vehicle through which health care programmes are implemented⁴. While the country has made significant progress in improving health outcomes for the population, including women, children and adolescents, significant inequities still exist, resulting in some population groups not having access to services of the necessary quality for achieving national and global public health targets. Whereas many centrally located facilities have achieved good quality of care standards, the large geographic area of the country and its widely dispersed population renders these services out of reach for a large proportion of the population that is faced with potentially impoverishing out of pocket opportunity costs. Even where service points are close to the populations, inequity in availability of skilled personnel, medical equipment and essential medical supplies makes quality services unavailable to additional sections of the population.

The demonstrated links of PHC to better health outcomes, improved equity, increased health security and better cost-efficiency, make PHC the cornerstone of health systems strengthening. Because PHC integrates services in health, nutrition, early childhood development, HIV and AIDS, and WASH into a package delivered through community, outreach and facility-based strategies and multisectoral approaches, investing in PHC is critical to the availability and provision of quality affordable essential health interventions necessary for achievement of Universal Health Coverage. Relatively low investments into PHC have potential to expand access for the most vulnerable populations, women, children, and adolescents.

Added value of investing in PHC has been demonstrated during recent emergency situations such as the Cyclone Idai when community based PHC interventions contributed to the reduction in excess mortality related to constrained access to vital social services that could exacerbate disease outbreaks, morbidity, and mortality. Equally, PHC interventions have constituted one of the central components of the COVID-19 pandemic response in Zimbabwe, including surveillance activities, Risk Communication and Community Engagement (RCCE), operating isolation facilities, implementing Infection Prevention and Control (IPC) activities, community case management, and facilitating continuity of essential health service provision.

Health systems which are oriented towards PHC are more likely to have better health outcomes and greater public satisfaction at lower costs and true access^{5,6}. Consequently, WHO recommends that countries must increase spending on PHC by at least 1% of their GDP in order to close the coverage gaps against SDG targets.

⁴National Health Strategy 2021-2025

⁵Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Serv Res.* 2003;38(3):831-65

⁶Sepulveda MJ, Bodenheimer T, Grundy P. Primary care: can it solve employers' health care dilemma? *Health Aff (Millwood).* 2008;27(1):151-8

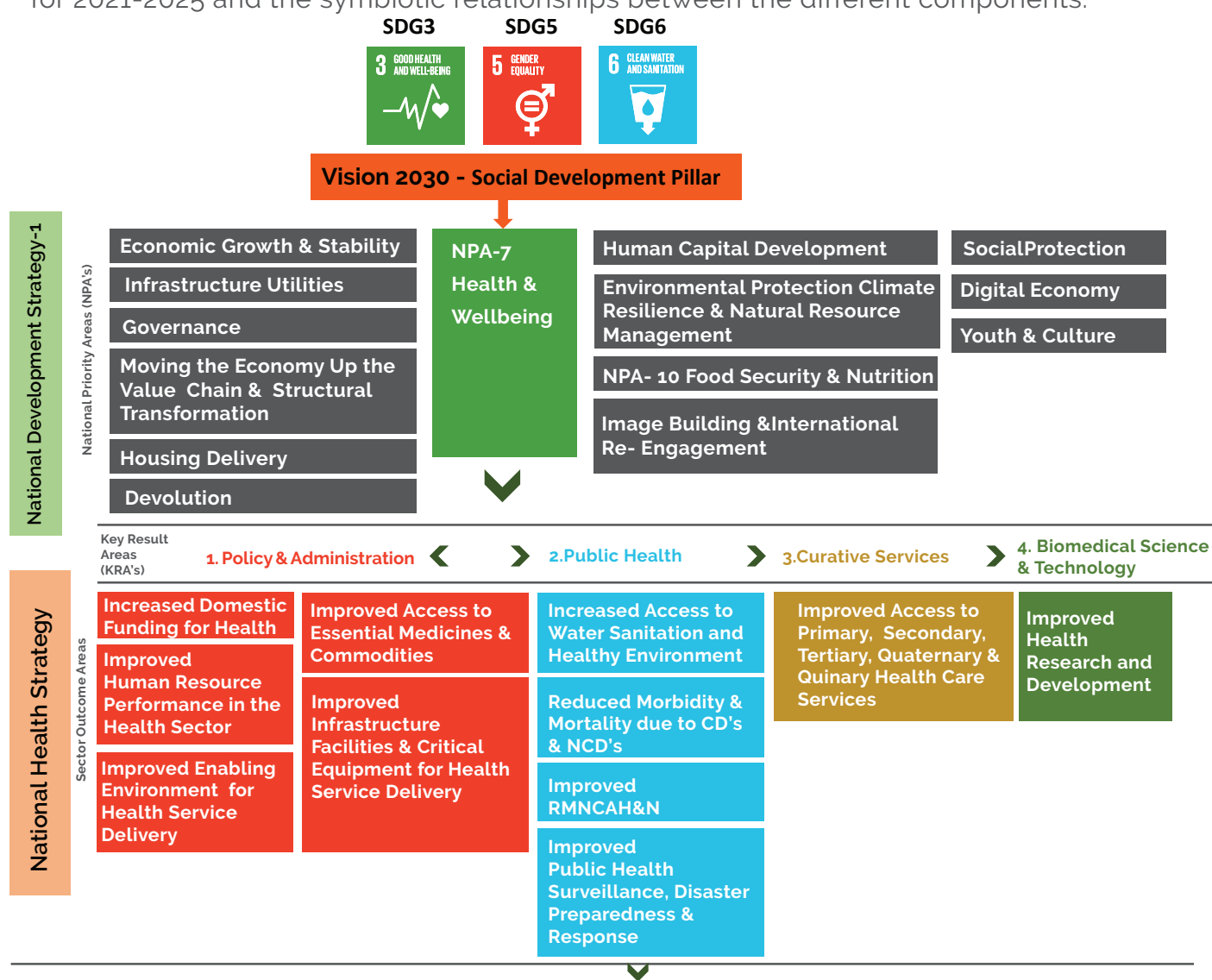


Hence the investment case scenario No.3 of the NHS 2021-2025 strategy prioritizes more cost effective PHC-oriented health systems approach as the "Primary Health Care" scenario which is intended to prioritise and scale up PHC activities and achieve the highest attainable level of health with a reasonable resource package, while maximizing efficiency, equity and solidarity.

1.4 Health sector Strategic Direction 2021-2025

The Global Action Plan (GAP) for Healthy Lives and Well-being for All was launched at the United Nations General Assembly on 24 September 2019 to guide member states moving forward through enhanced stronger collaboration at country level. This was to ensure the attainment of Sustainable Development Goal 3. Zimbabwe as a member state also ratified this GAP at the highest level.

Zimbabwe as a signatory to the global international health commitments strives to accelerate progress towards Universal Health Coverage. To that extent the Ministry of Health Child Care (MoHCC) developed a National Health Strategy to guide the 2021-2025 implementation of all the health sector strategies. Figure 1 shows the MoHCC's National Strategic Direction for 2021-2025 and the symbiotic relationships between the different components.



Annual Work Plans– Indicating Ministry, Programme and Sub - Programme Level Outcome, Outputs, and Strategies

Figure 1: National Strategic Framework



2 Situational Analysis

This section provides a summary of the situational analysis which is explained in much detail in the National Health Strategy 2021-2025 document.

2.1 Health status

- Poor quality of services has been noted as the major driver of the dissonance between the coverage of services and poor outcomes. Adolescent birth rate remains unacceptably high although the rate declined from 120 births per 1000 women in 2015 to 108 births per 1000 women in 2019 (MICS 2019). There is therefore need to address the root causes through a multisectoral approach.
- New-born mortality contributes to the majority of under-5 deaths. NMR has gone up from 29 (ZDHS 2015) to 32 (MICS 2019) deaths per 1000 live births and this attests to poor quality of care within the health system. In addition to neonatal mortality, most under-5 deaths are occurring in the community and are as a result of preventable causes.
- Child undernutrition, including stunting, wasting and deficiencies of essential vitamins and minerals in Zimbabwe, is high. Stunting has remained high among children under 5 years of age in Zimbabwe although it has declined from 27% (2015 ZDHS) to 23.5% (MICS 2019). While the national trends show an overall reduction in the burden of under-five stunting in Zimbabwe, a previous survey by ZIMVAC (2016) showed variation between districts. However, this was more pronounced in rural (29 %) versus urban (22 %) areas.
- Working closely with health development partners and NGOs, the MoHCC mounted one of the most successful HIV interventions in Africa. Once one of the hardest hit countries by HIV, Zimbabwe has shown the world that determination, smart partnerships at global and community level using evidence-based interventions are key in combating HIV. As of 2020, 90% of people living with HIV in Zimbabwe now know their status, whilst 97% of PLHIV are on lifelong Anti-retroviral therapy and for those on ART, 90.3% achieved viral load suppression.
- TB is one of the public health challenges regionally, but Zimbabwe is experiencing a downward trend on the incidence of TB, which indicate the effectiveness of interventions to the extent that Zimbabwe is no longer being considered a high burdened TB country.
- Overall, the incidence of malaria has decreased by 34% from 29/1000 population to 19/1000 population. However, the incidence remains a concern in 32 rural districts where the Annual Parasitic Incidence (API) ranges between 5/1000 and 153/1000 population.
- Annual Malaria incidence is particularly high in areas close to the borders with Mozambique and Zambia. This is related to challenges with cross-border collaboration in malaria control with these countries. In 2018 the three provinces of Manicaland, Mashonaland Central and East contributed approximately 80% of the confirmed malaria cases nationwide. However, the strategy of implementing tailored packages of malaria surveillance activities based on classifying districts into control, buffer and elimination

districts has resulted in the increase of elimination focus districts from 7 in 2012 to 28 in 2018.

- Gender based violence and access to services have remained a concern. The childhood prevalence of sexual violence was 9.1% among females and 1.1% among males ages 18-24 (Violence Against Children Study, 2017). Thirty six percent (4 130) of sexual violence survivors reported within 72 hours at their nearest health facility. According to the gender analysis report⁸;
- The different gender norms, roles and relations of men and women present variations in exposure to risks, access and utilization of health services as well as social impacts of illness
- Empowerment gradient between men and women, as well as exposure to sexual and gender violence (SGBV) limit health service utilization and heighten the risk for disease for girls and women
- Zimbabwe has not been spared from the unprecedented COVID-19 pandemic since the first case was reported in March 2020. While the Government's response has been remarkable – access to some essential services has been disrupted especially by the public health control measures such as lockdowns. Furthermore, in response to the pandemic some of the general response capacities at all levels of care have been strengthened through acquisition of equipment, personal protective equipment.

⁸Health and Gender Equity Policy Brief: Key Considerations for Zimbabwe's Health Sector

3 Health Financing

3.1 Health Financing Reforms

The Ministry of Health and Child Care has started implementing important reforms to enhance Universal Health Coverage and efficiencies in the sector. These reforms include the National Health Insurance reform, institutionalisation of the Results Based Financing, HRH staff rationalization, creation of an authority to oversee the Private Medical Aid Societies, the rejuvenation of the Assisted Medical Treatment Orders and decentralization of the public financial management system (PFMS) through the Ministry of Finance and Economic Development.

Other reforms to be implemented include the re-definition of the Essential Benefits package (EHB), the definition of health intervention packages at all levels of care, the full institutionalisation of expenditure tracking mechanisms e.g. Resource Mapping and the National Health Accounts. Resource Availability

The public health system has however, remained consistently financed by a mixture of domestic and external funding sources. The Resource Mapping exercise has shown that between 2014 and 2019, government (domestic) funding has been fluctuating between 42% and 60% of total public financing - with Development Assistance for Health (DAH) contributing the difference. Figure 3 below shows the total public financing for health since 2014 (2020 and 2021 figures are estimates)

The 2015/2017/2018 National Health Accounts show that on average Zimbabwe spends about US\$103 per capita on health. Whilst the country's average per capita health expenditure is comparatively higher than the US\$86 per capita, a greater share of it comes from external sources and the private sector.

Furthermore, some of the donor funds are earmarked for certain population groups hence are not available to all the country's citizens. On the other hand, voluntary health insurance only covers less than 10% of the population in Zimbabwe and out of pocket expenditure is undesirable as it could push households into catastrophic health expenditure. The assumption is that at least US\$60 per capita is pooled and public so that it can efficiently purchase the basic package.

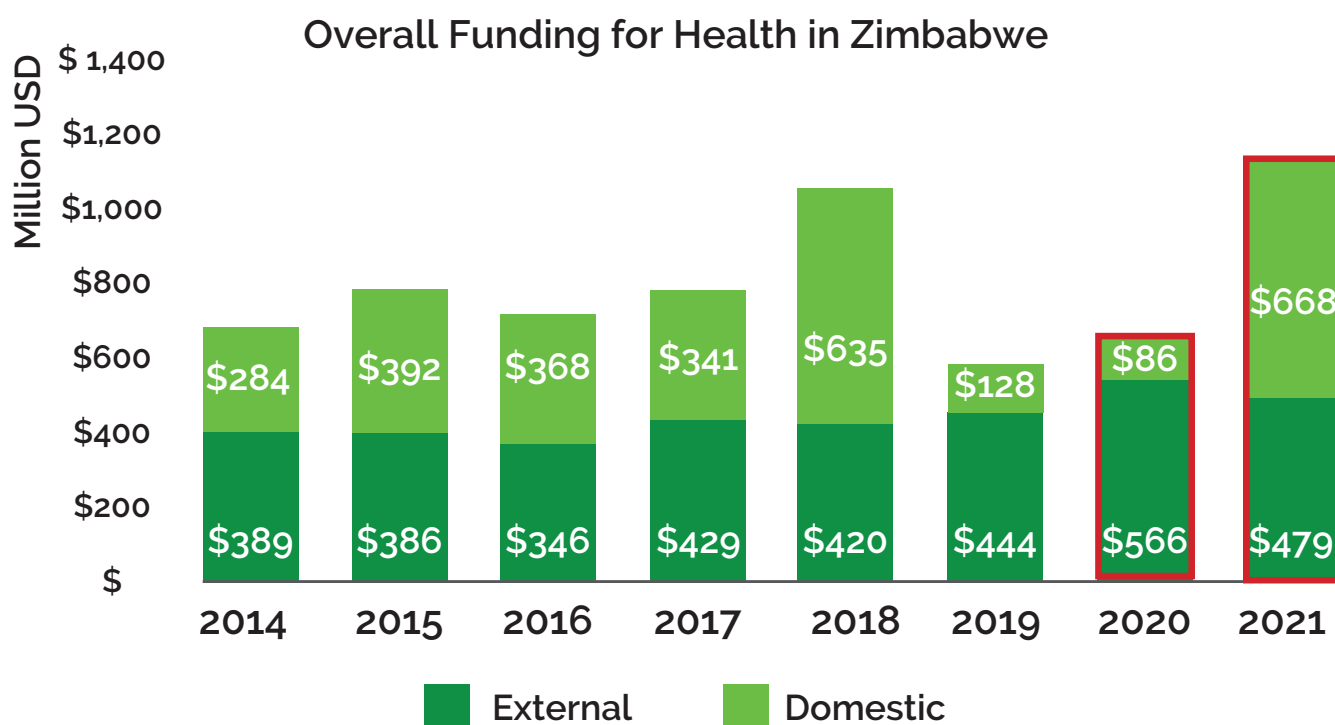


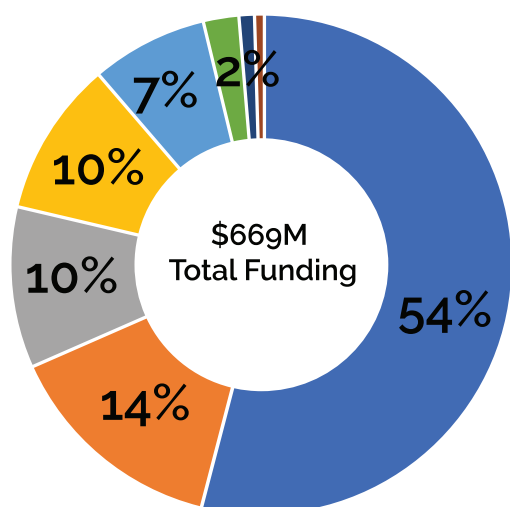
Figure 3: Zimbabwe Health Financing from Government and Donors

Source: Resource Mapping Report 2019.

There has been a significant decline in total household contribution to health. Overall household contribution to health expenditure (including through insurance schemes) has decreased from 25.04% in 2015 to 16% and 13% for the years 2017 and 2018 respectively. Subsequently household out of pocket (OOPs) expenditure declined from 24 % in 2015 to 11% and 9% in 2017 and 2018 respectively. This could be attributable to various reasons, which include; effective performance of prepayment mechanisms at the primary care level such the free user policy supported by various funding mechanisms such as Results Based Financing, the Assisted Medical Treatment Order and reimbursement of maternity services at hospital levels. Reduction in OOPs could also have been as a result of people forgoing care and opting for other alternatives such as faith healing.

However, throughout this period, disbursements to health remained unpredictable and below budget allocation with only over 80% of the budget allocated being disbursed. In 2021, 54% of the Government of Zimbabwe budget allocation for MoHCC was for salaries (Figure 5).

2021 Domestic Funding by Cost Category



2021 External Funding by Cost Category

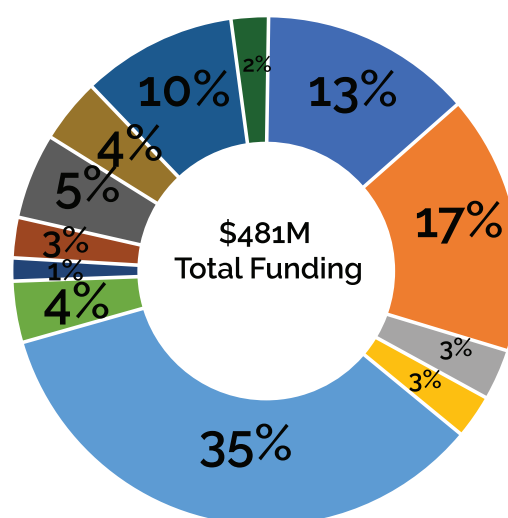


Figure 5: Domestic and External Funding Cost Drivers

Donor spending remains relatively large, although off-budget. Global Fund, PEPFAR and Health Development Fund remain the major sources of external funding. Global Fund and PEPFAR have largely focused on HIV/AIDS, Tuberculosis and Malaria, while the Health Development Fund has focused on RMNCAH-N. As shown in the figures above donor spending has also largely gone towards pharmaceuticals and other medical commodities, while government spending has gone towards employment costs.

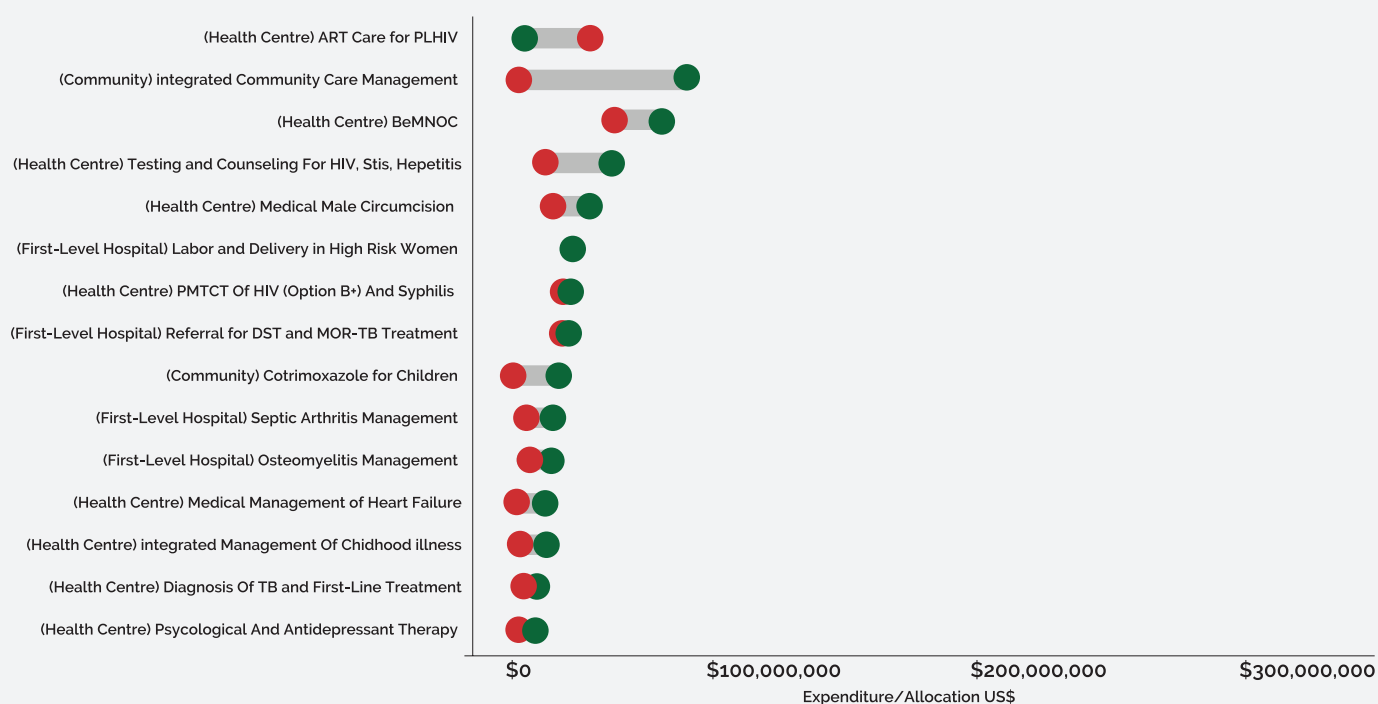
Zimbabwe has room to improve efficiency of its public spending on health.

An analysis of expenditures across health interventions in relation to the Disability Adjusted Life Years (DALYs) averted for 2016 versus a prioritized scenario showed that more DALYs can be achieved for the same amount spent (Figure 7), through;

- A shift of resources from low-level interventions at hospitals to community and rural health centres.
- Using an integrated community approach to further reduce the NCD, HIV/AIDS, TB and Malaria
- Investing more resources in Maternal Newborn and Child Health (MNCH) interventions that can be offered at the community and primary care level particularly Basic Emergency Obstetric and Neonatal Care interventions.
- Improving the capacity of health centres to manage NCDs

Figure 7: Comparison of Actual Expenditure vs. Optimized Allocation of Resources to Interventions⁹

Comparison of 15 Optimized interventions with the Highest Expenditure, US\$, 2016
Showing Actual (Red) vs Optimized (Green) Spending in 2016



⁹ Data used to construct the graph was sourced from World Bank (2016) Health Intervention Prioritisation (HIP) Analysis for Zimbabwe, Washington DC

4 Theory of Change for the NHS Investment Case

4.1 Sector Aspirations and Theory of Change

The Government and stakeholders in the health sector aspire to realize improved health outcomes for all, including the vulnerable and marginalized, to enhance Zimbabwe's human capital development towards a prosperous and empowered upper-middle income society. Zimbabwe's human capital index of 0.47 (from 0.41 in 2010), which is lower than the Sub-Saharan Africa average of 0.56 (WB, 2020), presents opportunities for improvement particularly for the health sector. Government's Vision 2030 Strategy outlines how this goal will be realized through five strategic clusters: (a) Governance; (b) Macro-economic Stability and Re-engagement; (c) Inclusive Growth; (d) Infrastructure and Utilities; and (e) Social Development which includes investments to improve coverage and quality in health service delivery.

Inputs and Strategic Interventions

Provision of financial and materials resources from Domestic and ODA sources

1

Implementation of priority health system strengthening reforms and Domestic Resource Use and Mobilisation (DRUM) Strategy

2

Implementation of priority strategic interventions to complement the delivery of an essential benefit package of services in the health sector.

Outputs

Improved numerical adequacy in skilled and motivated workforce, distributed appropriately

Financial resources allocated efficiently across interventions, within programs and target groups

Increased supply of medicines and commodities supported by an efficient PSM mechanisms

Adherence to governance and accountability mechanisms. Culture of data and evidence driven decision

1

3

Fidelity in implementation and compliance to target outputs for interventions under:
Communicable and Non Communicable Diseases Service Delivery Platforms including Community Health RMNCAH-N Health Emergencies and Health in Emergencies

Assumptions

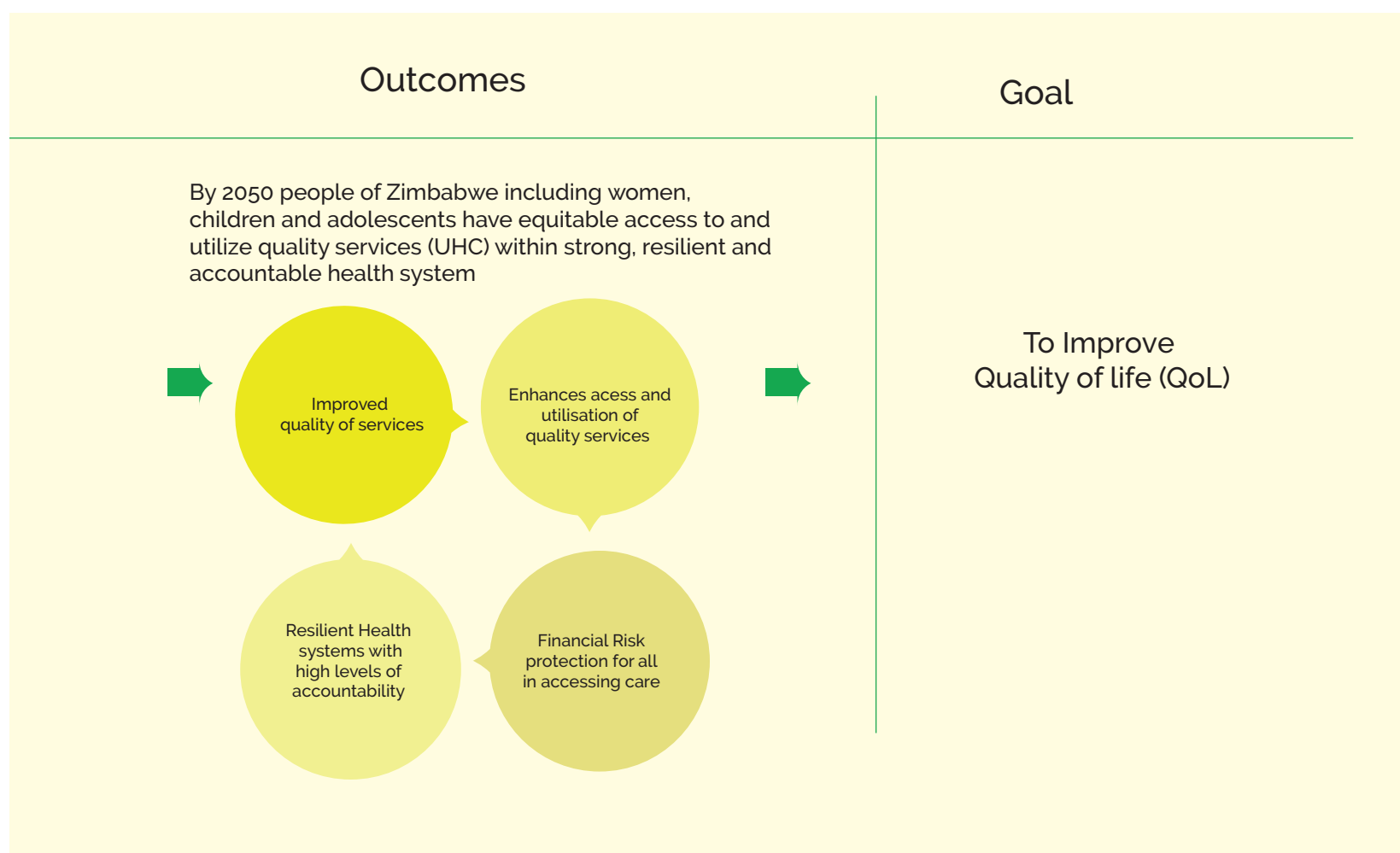
- 1) Sustained commitment to prioritise the sector in Government financial allocation and partnerships for ODA are maintained
- 2) Political will for technical reforms is high at Ministry and higher levels
- 3) Minimal disruptions to service delivery due to stability in macro-economic and political conditions

Figure 8: Investment Case Theory of Change



The mission for the transition towards desired results in the health sector is underpinned on the SDG Agenda and principles of UHC. Guided by a set of results that are aligned to the SDGs, the overarching transformation agenda will consider the key facets of leaving no one behind for a shared prosperity, building on the gains realised to date and ensuring a sustained and resilient response. The situation analysis as described in Section Two provides a basis upon which key identified gaps will be targeted to realise improved health outcomes.

Potential socio-political and economic enablers and barriers to the realisation of envisaged results have shaped the pathways of change as articulated in this NHS-IC's Theory of Change (TOC). The implementation of priority health system reforms in the short to medium term is anticipated to provide an enabling environment for the implementation of identified high impact interventions aimed at addressing communicable, non-communicable and emergency conditions burdening the country. More specifically, a numerically adequate skilled and motivated workforce that is complemented by efficiently allocated financial and material resources including pharmaceutical commodities, operating in a well governed system with high accountability and evidence driven decision making is likely to productively implement high impact preventive and curative interventions with optimal quality. Informed and empowered communities that are aware of their rights, entitlements and responsibilities are likewise expected to access and utilise quality health services without financial distress, regardless of their PROGRESS (Place of Stay, Race, Occupation, Gender, Religion, Education,



Socio-Economic Status and Social Capital) status. The realisation of these expected results in the short, medium to long term is however underpinned on a set of assumptions that include the stability in the macro-economy and political environment as well as strengthened collaboration and coordination between Government and development partners. To this end the NHS recognises the need to address crosscutting social inclusion themes including having a gender sensitive lens in programming and mainstreaming disability to ensure equity in access to services and realisation of positive health outcomes Figure 8 provides an illustration of IC Theory of Change, while Figure 9 provides a summary of the NHS-IC Results Framework.

4.2 Results Framework for the National Health Strategy Investment Case

All Investments in the sector will be directed at ultimately improving quality of life for Zimbabweans. Figure 9 below shows the results framework for the NHS Investment case. Adequate financing of the health sector ensures the achievement of the NHS eleven (11) prioritized outcomes. During the course of this investment period, adequate resources need to be mobilized and efficiently utilize in delivering identified investment outputs.



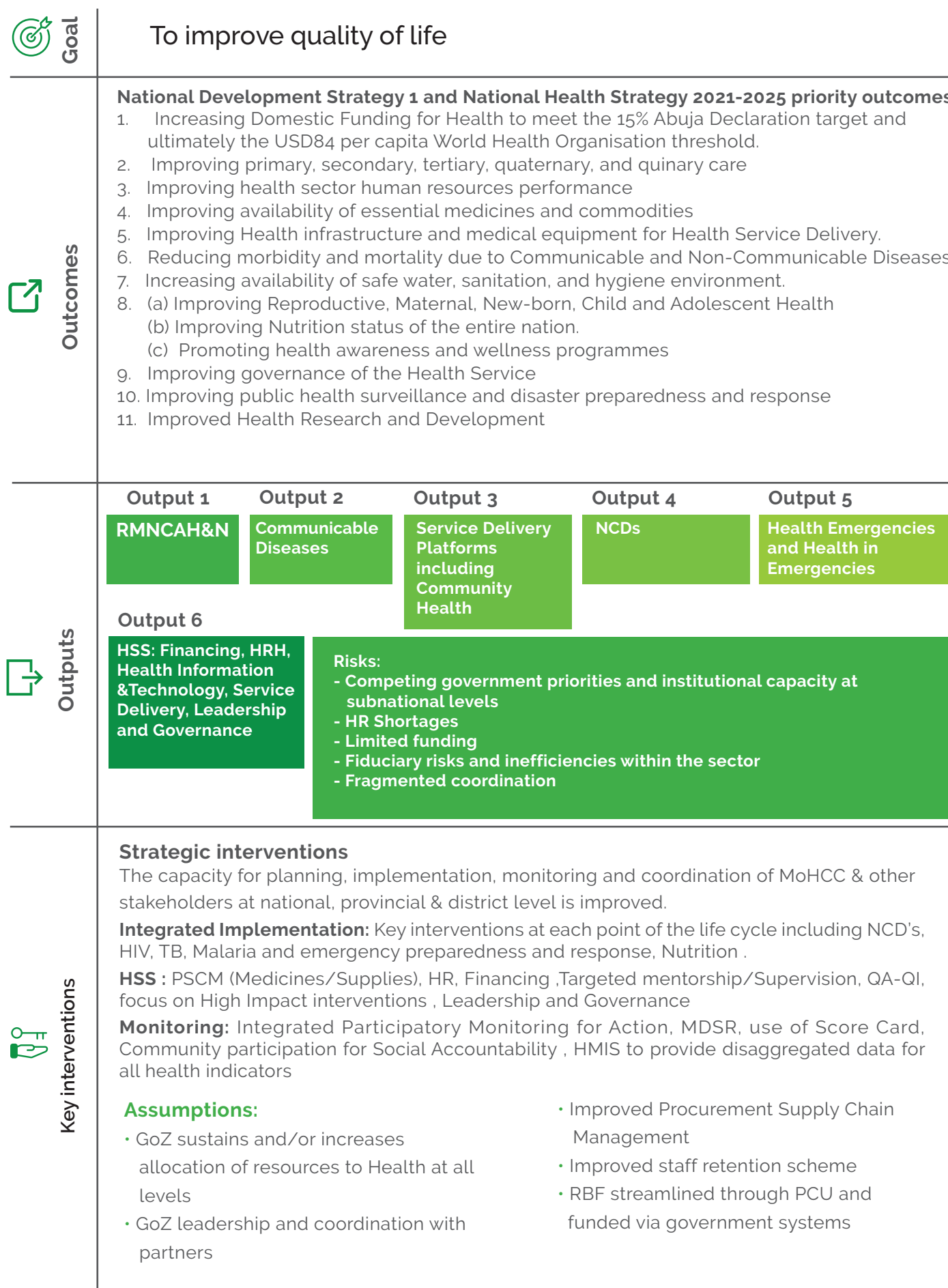


Figure 9: NHS-IC Results framework

Achieving the outcomes and the ultimate goal as outlined in the Results framework above will require the implementation of among other activities listed in Figure 8 – the following key priority activities;

- **Development and implementation of policies, strategies and coordination in order to improve accountability and transparency in the health service**
- **Addressing gaps in access and quality of RMNCAHN and Child Care services through the provision of appropriate services, tools of trade and constant quality monitoring.**
- **Provision of immunization services will go beyond the traditional target groups. The life course approach to immunisation calls for providing immunisation beyond children, but also to adolescents, women of child bearing age and to adults and the aged.**
- **Reduced morbidity and mortality due to communicable diseases and accelerating towards elimination by for example;**
 - Implementing the 95-95-95 HIV strategy
 - Implementing the end-TB strategy through a deliberate focus on differentiated service delivery models, rollout of defaulter tracking tools, optimization of treatment regimens, quality Improvement, decentralization of third line medication to provincial hospitals and multi-month dispensing.
 - Strengthening the implementation of Malaria elimination strategy through targeting of households for IRS, provision of ITNS (LLINs) and prompt and appropriate management of all malaria cases within 24 hours by appropriate laboratory and radiographical/radiological services.
 - **Development of an NCD Strategy and the multi-sectoral coordination framework of which one of the key interventions will be the treatment and management of NCDs as well as the improved surveillance of the risk factors.**
 - **Strengthening of the provision of NTD interventions and WASH (Water Sanitation and Hygiene services).**
 - **Expand access to quality health services with priority being given to Primary Care and Secondary Care in order to enable higher levels of care to play their roles effectively and efficiently according to the design of the health system in the country.**
 - **Expand equitable access to improved health infrastructure that is appropriately equipped**
 - Construction of District hospitals including in Harare and Bulawayo in order to decongest the Central hospitals in these cities.
 - Rehabilitation of hospital and health centre infrastructure and equipment
 - Strengthening of the MoHCC's ambulance management system by appropriately



- equipping available ambulances and procuring additional well equipped ambulances.
- Recapitalisation and enable NatPharm to perform its mandate and reduce dependency on donor funding.
- Construction and/or refurbishment of warehouses at NatPharm and its branches countrywide and health facilities.
- **Increased focus on higher level hospital level care through;**
- **The strengthening of service availability for ICU/HDU at the later will ensure optimisation of the service delivery platform and reduce unnecessary referrals.**
- **Acceleration of the implementation of the Electronic Health Records (EHR) to improve end to end data visibility, timely reporting of accurate data, accurate quantification and reduced stock losses.**
- **Apart from adjusting HW salaries in line with cost of living - focus on non monetary incentives in order to improve the conditions of service for the health workers will motivate them to stay.**
- **Strengthening the Community Health interventions – in particular the requirement of one Village Health Worker per village will be emphasised.**

These strategic interventions and activities, among the many more mentioned in the NHS document will seek to reduce the incidences of diseases such as HIV/AIDS, Tuberculosis, Malaria, Non-communicable Diseases etc. - and associated mortalities. To achieve these the NHS 2021 -2025 has planned to scale up coverage of a number of interventions in order to achieve some of the target results listed in the Table 1 below.

Table 1: Key Performance Indicators for Selected Impact Indicators

Key Performance Indicators	Baseline	Target (2025)
HIV Mortality rate per 100 000	126.72	86.57
TB Mortality rate per 100 000	42	< 20
Malaria Mortality rate per 100 000	1.9	0.5
NCDs Mortality rate	> 15%	< 15%
Maternal Mortality rate per 100 000	462	240
Under 5 Mortality rate per 1000	65	41
Neonatal Mortality rate per 1000	32	20
Stunting prevalence Under 5	24	19

5 Methodology and Approach to the costing of the NHS-IC

The costing of the NHS was built on the methodology that was used to cost the National Health Strategy for 2016-2020 (MoHCC, 2016). Specific changes were made on the methodology to align the costing and results to the MoHCC's Programme Based Budgeting Approach. The costing of the NHS relied on the already developed Monitoring and Evaluation Framework, results of the Resource Mapping exercise, the draft Investment Case for Health and the Health Public Expenditure Review. For the actual costing the NHS Investment case relied on World Health Organisation (WHO) OneHealth Tool. The impact and effectiveness of health interventions was estimated using the disease specific Impact Models and the Lives Saved Tool (LiST).

Figure 10 below shows the health service programs, the levels of service delivery, health system components that were included in the NHS costing, as well as the intended outcomes. Accordingly, there were two types of costs to that were estimated under OHT; the health programs/services (i.e., RNMCH, Nutrition, HIV, TB program, Malaria program, etc.) Health systems (i.e., building health infrastructure, recruiting human resources, strengthening supply chain, etc.).

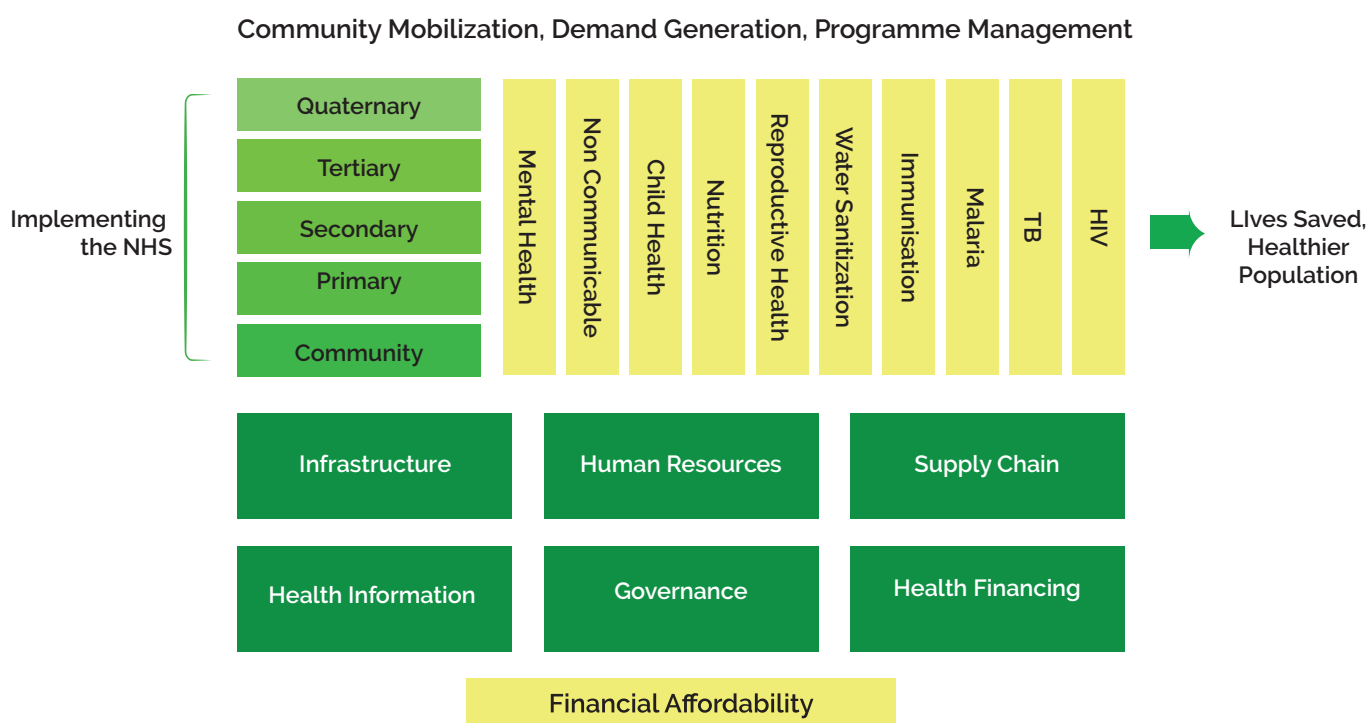


Figure 10: OneHealth Framework



the costing of the health interventions programmes was based on the ingredients approach – where the cost of an input is estimated as the 'product of the quantity used multiplied by the value of each unit'. Unit costs for each input were then used to calculate the total service cost as shown in the equations in Figure 11 below.

cost of services = number of service * unit cost of the service

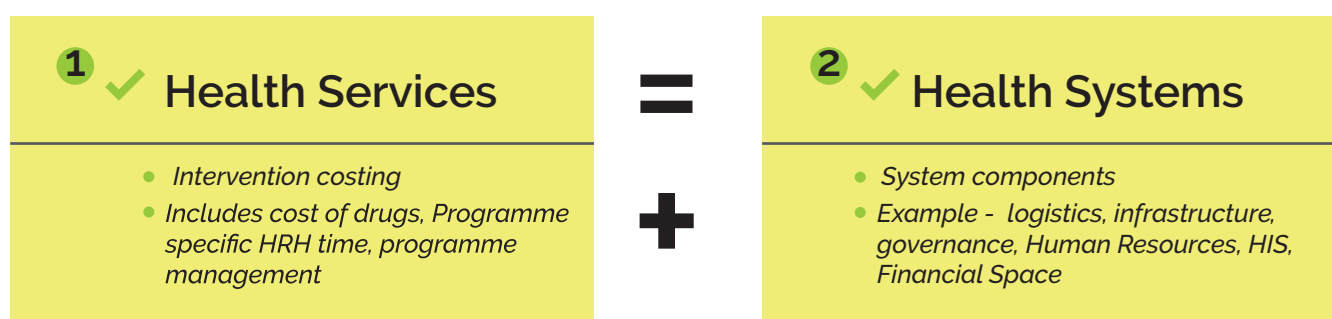
where the number of services required in the tool was determined using the formula:

number of services = target population * population in need * coverage

Estimating the cost for strengthening health systems used the ingredient approach as shown in equations above. The number of inputs for each pillar of health systems was obtained from NHS directly or interviews with key informants. The figure below shows the two broad interfacing components of the NHS investment case costing.

TWO BROAD INTERFACING COMPONENTS

Zimbabwe's NHS Costs 2021 - 2025



cost of Services = number of service X unit cost of the service
number of services = target population X population in need X coverage

Figure 11: OHT Intefacing components

Customisation of the OHT followed the Ministry's PBB Format – which required that programmes be grouped first into 4 broad categories as shown in Figure 12; Policy and planning, Public Health; Curative Care and biomedical Engineering. These were further divided into several sub-programmes as shown in the schematic below. Public health activities that are provided by health facilities were mapped and included in the service delivery platform while activities (e.g. surveillance) implemented at the central level were included under programme costing or under the health systems strengthening components.

Health Services & Systems Customised to Program Based Budgeting (PBB) Format

“The costing approach”

1 Health Systems Strengthening			2 Service Delivery Platform
1. Governance (PS & Min; PMDs; Policy; M&E; F& Admin Audit; Legal Services)	2. Health Financing (RBF Co-Financing & Management of AMTO, PSMAS)	3. Human Resources for Health (HRH) —(Distributed by Delivery Channel)	1. Customised Programmes (mapped to PBB format)
4. Logistics (Drug cost Including HQ and Natpharm infrastructure and management cost)	5. Infrastructure & Equipment (Hospitals, & management costs) Health Posts, etc)	6. HIS (Part of M&E)	2. Population and Service Coverage
			3. NCDs (Injuries); RNMCH (added higher hospital interventions)

Figure 12: Costing Approach

5.1 NHS Costing Process

The development of the National Health Strategy was spearheaded by a taskforce led by MoHCC with technical assistance from the Partner Organisations. Technical Working Groups (TWGs) on Investment Case and Health Financing were set up to support the costing of the NHS. These TWGs drew membership from the MoHCC, MoFED, Development Partners and NGOs and Civil Society Organisations – and were chaired by the MoHCC costing sub-group constituted by the MoHCC and partners to advance the costing, prioritization and selection of scenarios. This sub-group assisted with technical backup and validation of the NHS costing process and results. The NHS costs were collected in both US\$ and in local currency and a blended rate (an average of the official and unofficial rates) was used to convert some of the local costs. For the actual costing unit costs were analysed in constant terms – but the costing results were presented and adjusted for inflation (US\$ inflation rates).

The data collection process and analysis for the costing was divided into three (3) phases. In Phase 1 high level meetings with MoHCC Policy, M&E department and Programme Managers, Development Partners and Technical Working Group on Health Financing and CSOs were carried out to agree on the methodology. Phase 2 involved the following activities.

- i. Document/Literature review: (1)
- ii. Mapping of past costing studies: (2)
- iii. Development of tools and validation: (3)
- iv. Discussion of investment strategies: (4)
- v. Data collection: (5)
- vi. Development of Coverage targets (M&E framework: (6)
- vii. Discussion on costing scenarios: (7) and
- viii. Identification of funding gaps.

In Phase 3 analysis and validation of results was carried out. The main activities included: (1) holding a workshop to validate collected data on costs and coverage targets; (2) validation of cost assumptions; (3) validation of cost scenarios and investment scenarios; and (4) Fiscal space review. The validation workshop was attended by government officials from MoHCC and its Partner organisations. However, the validation workshop focused mostly the costs, while coverage targets and fiscal space analysis were done as separate activities with relevant programmes and experts respectively.

5.2 NHS Prioritisation and Costing Scenarios

The three costing scenarios were formulated based on the prioritisation processes and these are summarised in the main NHS Strategy document. Programme documents and sub-sector strategic plans such as for HIV/AIDS, TB and Malaria were also used for the costing and prioritisation. Consultation with the Technical working Group on Health Financing, programme managers, monitoring and evaluation officers and national experts helped shape the prioritisation of the strategic interventions.

Further discussions with officials from MoHCC and the Health Financing Technical Working Group generated three (3) costing scenarios. The scenarios were premised on: (1) funding the Full NHS (all the 289 identified interventions) based on the targets set in the NHS. (2) moderate scale up of intervention coverage (with all the 289 interventions moderately scaled up baseline target); and (3) primary health care scenario – based on a set of high impact and cost-effective interventions (of which a set of 174 interventions were selected). For the moderate coverage NHS scenario, the costing assumed final year target coverage scale-up of between 1%-10% of the baseline coverages.

The Primary Health Care scenario was based on set of interventions were derived from a prior health intervention prioritization study that was done in 2016 in Zimbabwe. The study provided a list of cost-effective primary health care-oriented interventions – which were in fact a sub-set of the Full NHS (2021-2025) list of interventions. Table 2 below provides a summary of all the three scenarios.

Table 2: Prioritisation Assumptions

Scenario	Description	Number of Interventions	Intervention Coverage
Full NHS	Costing of the full National Health Strategy. Interventions as derived from the NHS (2021-2025) list of strategic interventions	289 interventions costed.	Scale of intervention coverages as guided by the NHS (2021-2025) and programmes.
Moderate	Moderate scale of the Full NHS (2021 -2025) Interventions	289 interventions costed.	Assumed that target coverage scale - up of between 1%-10% of the baseline coverages. Interventions with low baseline coverages were scaled up by a higher factor than those with high baseline coverages.
Primary Health Care	A set of high impact and cost- effective interventions selected from a list of interventions as identified in the full NHS. Focus on Primary Health Care interventions	174 interventions costed. For the LiST impact assessment - 75 interventions mainly focused on maternal and child health were used. Targeted infrastructure investments	Maintained the same scale up in target coverages for the corresponding interventions as selected from the full NHS Scenario

The estimated costs for each of the three scenarios were subsequently compared to the available funding for health from the government and its partners to ascertain any financial gaps.

6 Results of the NHS Costing

This section provides a summary of results from the costing of all the scenarios with a further sub-section on financing gap analysis. The Full NHS scenario is the highest cost scenario requiring an estimated US\$7.8 billion for five years.

The full intervention menu for the scenario included a total of 289 interventions with coverage, and infrastructure and equipment acquisition targets as specified in the NHS 2021-2025 document. The moderate coverage scenario had the same number of interventions as the Full NHS Scenario – albeit with a moderate scale up of intervention as described in the table above.

This scenario requires about US\$6.2 billion for all the five years. This scenario only allowed for moderate increases in coverage – but maintained the same targets for infrastructure and equipment requirements. The Primary Health Care requires US\$5.2 billion for the same period. This scenario – as noted in earlier sections focused on a selected package of cost-effective interventions and strengthening of health systems through funding specific infrastructure and equipment as specified in the MoHCC's Infrastructure Development Plan. Table 3 below shows a summary of the estimated NHS costs for all the three scenarios by year.

Table 3: Estimated Costs - NHS Investment Case

Investment Case Scenarios	Estimated cost (in Billion USD)					
	2021	2022	2023	2024	2025	2021-2025
Full NHS	1.284	1.400	1.539	1.700	1.872	7.8
Moderate	1.081	1.131	1.230	1.331	1.438	6.2
Primary Health Care	0.972	1.000	1.051	1.102	1.147	5.2

6.1 Full NHS Cost Scenario

The full NHS requires a total of US\$7.8 billion (Figure 13) to achieve the NHS targets, with costs increasing to 45% by 2025 as a result of increasing scale up of coverage, increased focus on infrastructure and maintenance and increasing costs as a result of inflation. Per capita expenditure would rise from US\$86.90 in 2021 to US\$120.7 by 2025.

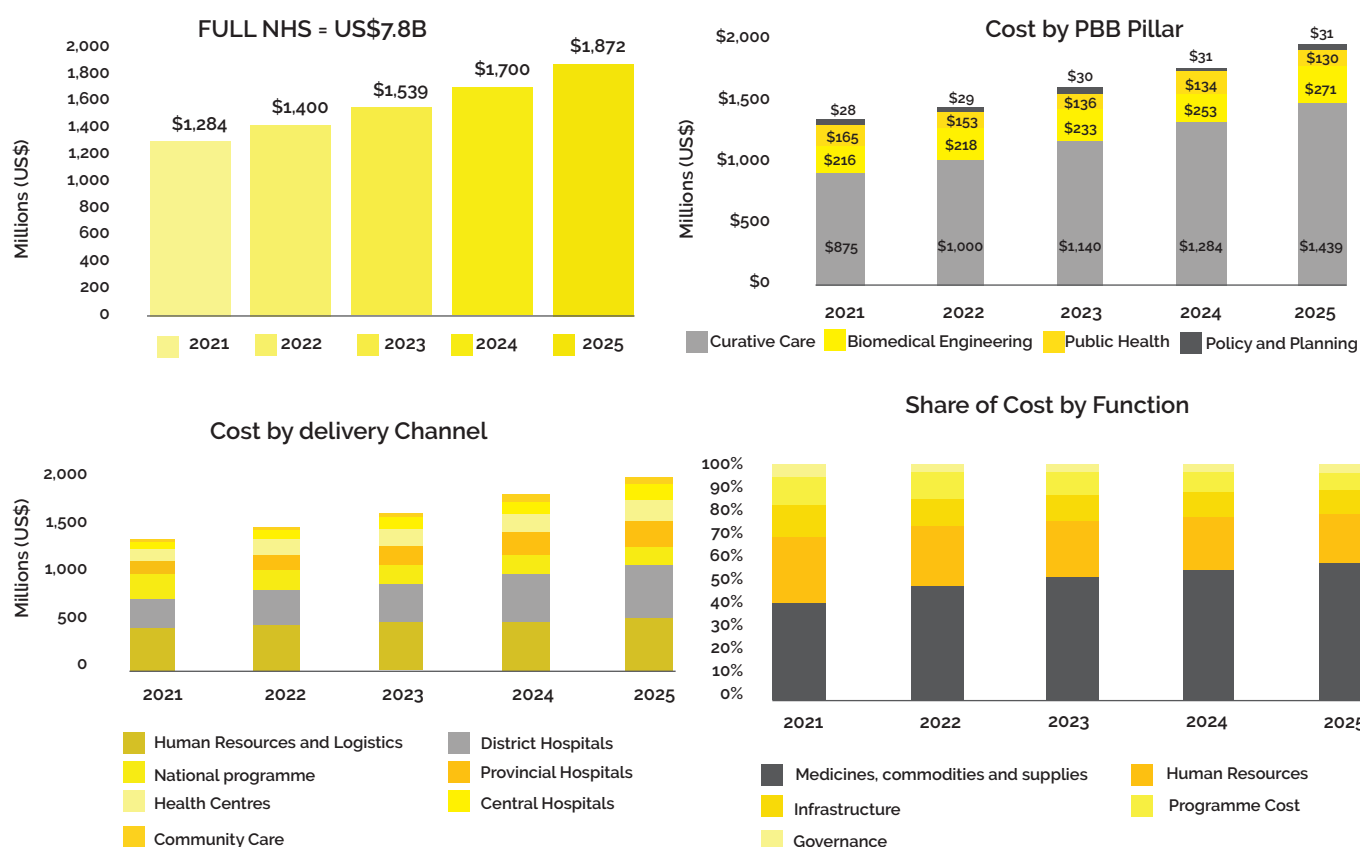


Figure 13: Estimated Full NHS Costs

6.1.1 Cost Analysis by PBB Pillars and Level of Care and Programme

The Programme Based budgeting framework has four programmes;

- i. **Policy and Administration programme** which has the following eight (8) sub-programmes; Ministers and Permanent Secretary's office, Policy and Planning, Human Resources, Finance and Corporate Services, Monitoring and Evaluation, Internal Audit, Logistics and Asset Management and Legal Services.
- ii. **Public Health** – which has the following four (4) sub-programmes; communicable diseases, Family Health, Non-Communicable diseases and Environmental Health
- iii. **Curative Care Programme** – which has the following six (6) sub-programmes; Quinary Care (Research Hospital), Quaternary care (all central hospitals and national support services such as laboratories and dental services); Tertiary Care (all Provincial Hospitals); Secondary care (all district and general hospitals); Primary care (all rural health centres), and Traditional Medicine.
- iv. **Bio-medical Science, engineering and Pharmaceutical Production** – which has five (5) sub-programmes; Bio-medical engineering, bio-pharmaceutical engineering and production, Bio-medical research, Bio-analytics and Health Research.

Curative services programme accounts for most of the budget requirements at 74% due to pharmaceuticals and costs for human resources. This is followed by Bio-Medical Sciences Engineering and Pharmaceutical Production, which accounts for 15%, while Public Health and Policy and Planning Programmes account for 9% and 2% respectively (Figure 14). In order

to strengthen health services provision, the Bio-Medical Engineering programme has been given high priority – and a lot of infrastructure construction, maintenance and rehabilitation has been proposed for the next five years. This would naturally crowd out expenditures for other programmes; hence the lower estimated resources for the Public Health and Policy and Planning Programmes. Cost by function shows that medicines, commodities, and supplies will need more resources in the next 5 years as result of the anticipated increase in intervention coverages.

An analysis of cost by delivery channel shows that district hospitals and health centres still account for the majority of the resources - with medicines and human resources as the major cost components. Central Hospitals and Community care account for the least resources.

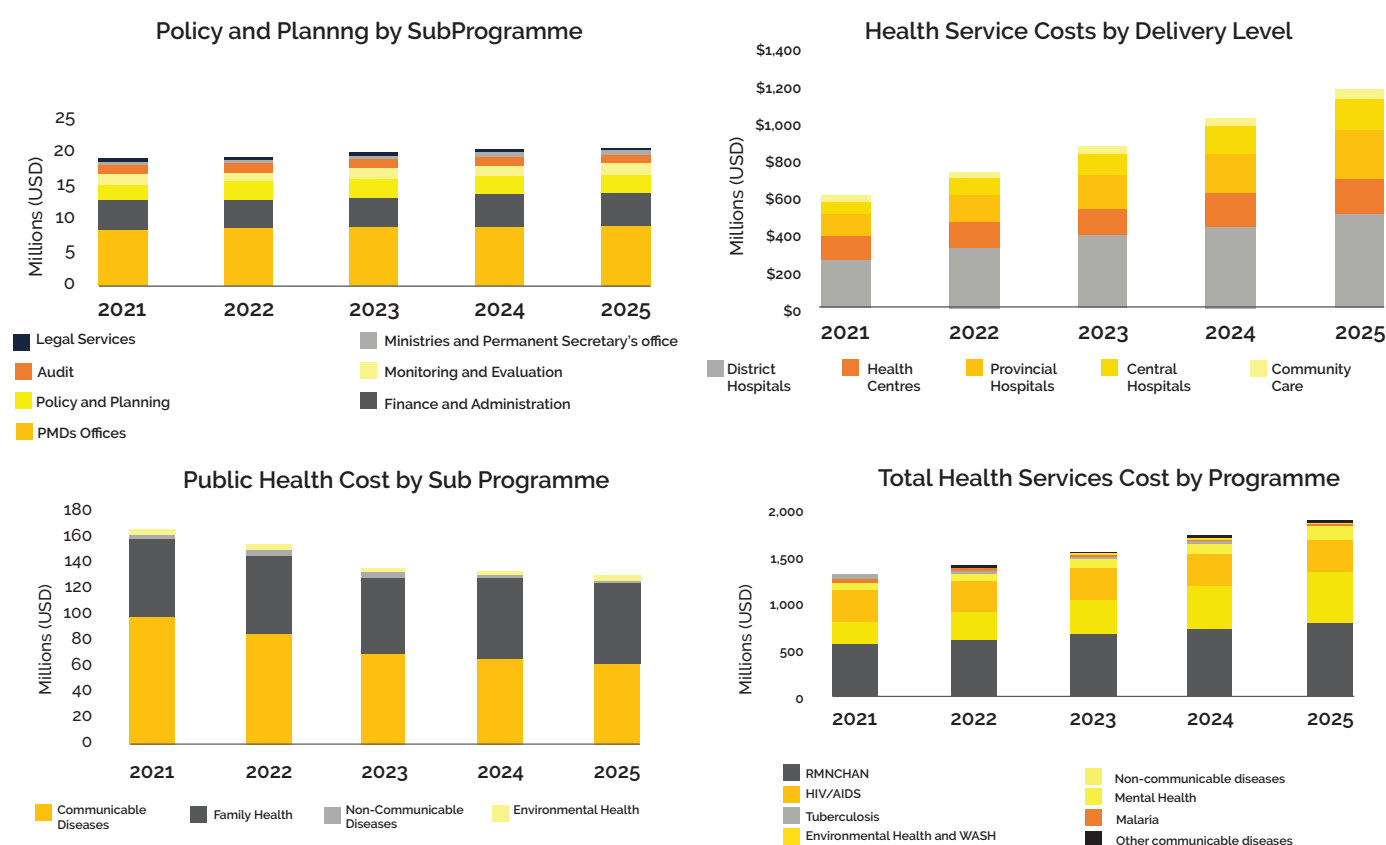


Figure 14: Full NHS Costs by Sub-Programme

Development partners have consistently spent above US\$400 million over the past 5 years on HIV/AIDs, Tuberculosis, Malaria and Reproductive Health interventions – representing in some instances – more than 50% of the combined Government and Development Partners¹⁰ total public resources. Most of the Development Partners' resources went towards pharmaceutical and medical supplies and equipment at the primary and secondary levels of care. Combined with the government contribution – total resource envelope for the five-year from 2021-2025 would be US\$4.13 billion; hence it is envisaged that an estimated 53% of the plan will be publicly funded by Government and its Partners, leaving an unfunded gap of 47%.

¹⁰This is inclusive of Global Fund for HIV/AIDS, Tuberculosis and malaria and PEPFAR funding as estimated in the MoHCC Resource Mapping and GF funding estimates up to 2023.



6.2 Moderate Coverage Scenario

Under this scenario and similar to the Full NHS Scenario - all the 289 interventions were included and costed, except that the target coverages were modestly increased as explained in the following assumptions.

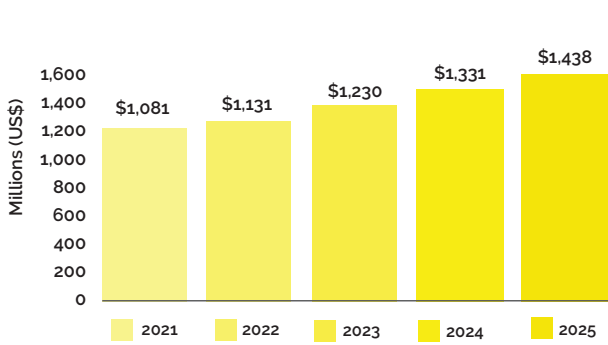
- **all interventions that had baseline coverages of <75% were increased by a factor 10% for the target year 2025. The years in between were interpolated.**
- **all coverage interventions between 75% and 95% were increased by 5% for the target year 2025, while the years in between were interpolated.**
- **all coverage >94% were increased by 1% for the target year 2025.**
- **Community interventions, HIV/AIDS, Tuberculosis and Malaria interventions coverages were based on the respective sector strategies.**
- **An assumption for delivering of more than 50% of the services (interventions) at the lower level (district and below) was also made.**

The annual cost for the moderate coverage Scenario is US\$6.2 billion for the five-year period. The estimated per capita expenditure rises from US\$73.13 to US\$96.76 in 2025 (Figure 15). Furthermore, assuming a resource envelope of US\$4.13 billion from Government and its Partners for a five-year period - an estimated 66% of the plan will be publicly funded leaving an unfunded gap of 33%.

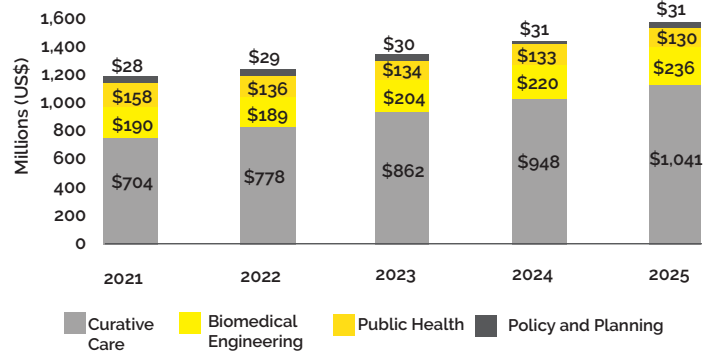
6.2.1 Cost Analysis by PBB Pillars and Level of Care and Programme

Under moderate funding scenario – the curative services programme accounts for 70% while the remaining 30% will go to Bio-Medical Sciences Engineering and Pharmaceutical Production, Public Health and Policy and Administration Programme. Medicines and Human resources are the major cost drivers for the curative services programme.

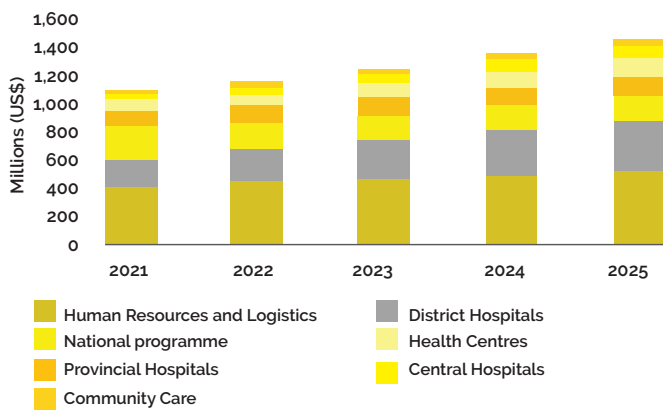
NHS COST MODERATE COVERAGE = US\$6.2B



Cost by PBB Pillar



Cost by delivery Channel



Share of Annual costs by Function

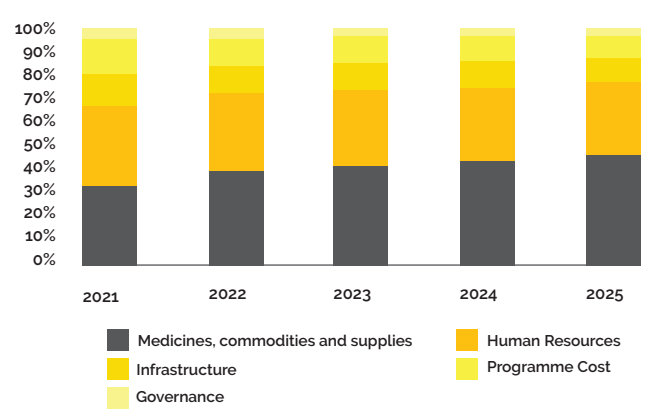


Figure 15: Moderate Coverage Scenario

Cost by delivery channel shows that district hospitals account for the largest share of the resources, followed by Health centres, with the community care level accounting for the smallest share.



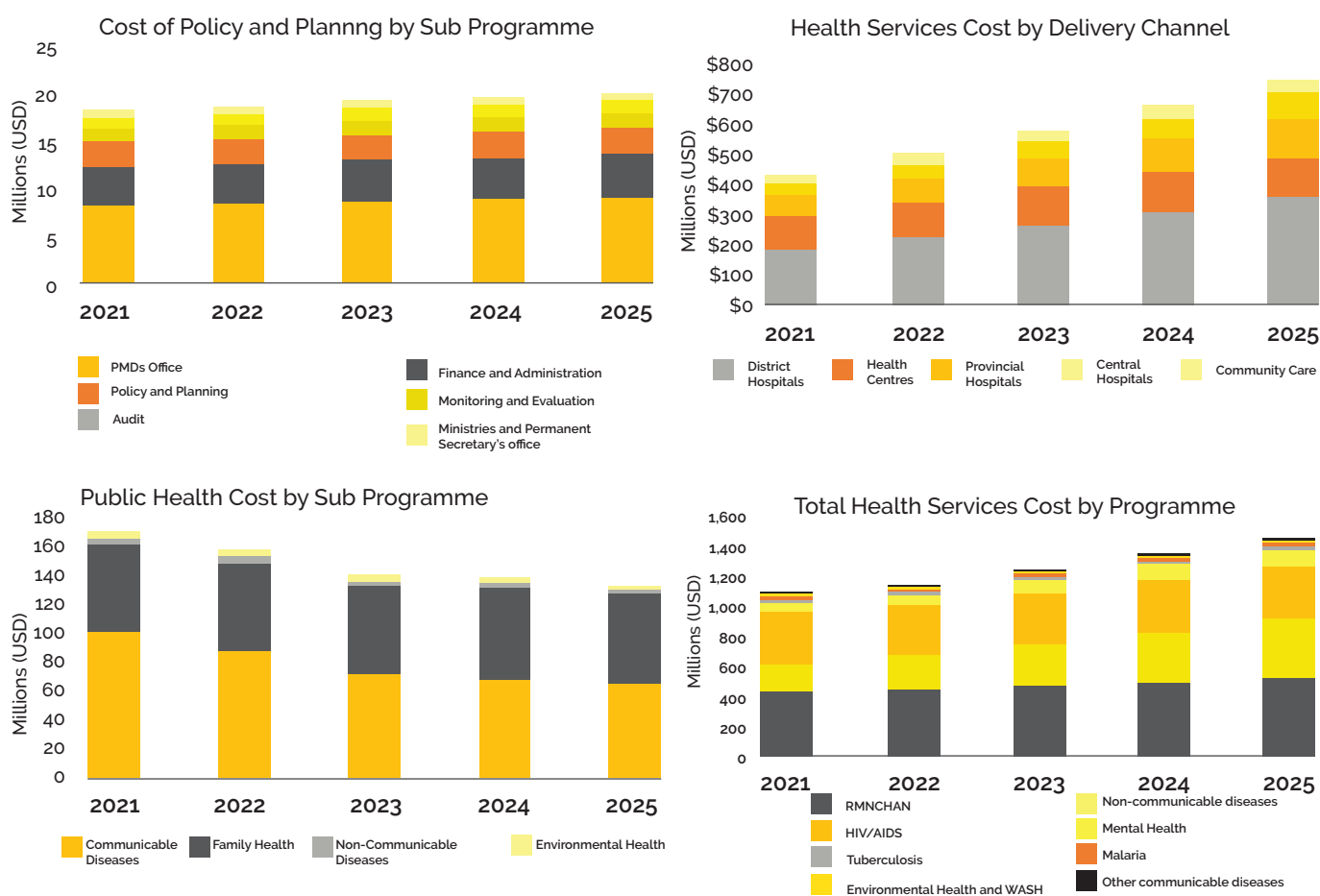


Figure 16: Moderate Scenario costs by Sub-Programme

6.3 High Impact Scenario

The Primary Health Care Scenario is based on a package of selected interventions from the NHS list of interventions. A total of 174 interventions were selected based on the WHO OHT and Health Intervention Prioritisation Study/Analysis as explained in **section 2.12**. It also focused strongly on cost effective Primary Health Care Interventions. According to the WHO, PHC is the most inclusive, equitable, cost-effective, and efficient approach to enhance people's physical and mental health, as well as social well-being through implementation of three interrelated and synergistic PHC components,¹¹ i.e., (1) Primary care and essential public health functions as the core of integrated health services; (2) Multisectoral policy and action for health; and (3) Empowered people and communities.

¹¹World Health Organization. Framework on integrated people-centred health services: an overview. 2018 (http://www.who.int/servicedeliverysafety/areas/people-centred-care/Overview_IPCHS_final.pdf, accessed 10 October



6.3.1 Primary Care Focus

Zimbabwe's health service delivery is established at four levels: primary, secondary, tertiary, quaternary, and the recently added quinary level as per National Health Strategy 2021-2025.

The following figure provides a five (5) year summary of estimated annual costs of the primary care level per scenario. The investment at the primary level of care for the Primary Health Care Scenario is slightly lower compared to the Full NHS scenario, but slightly higher when compared to the middle scenario.

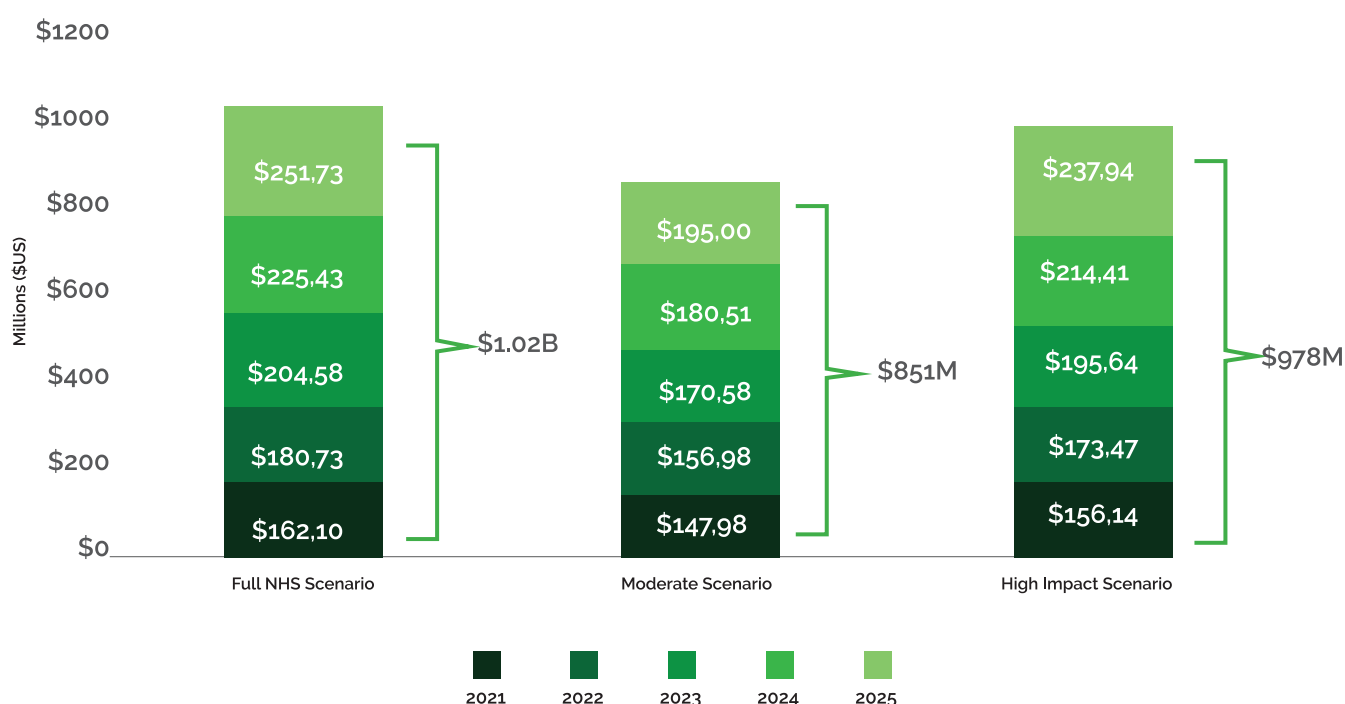


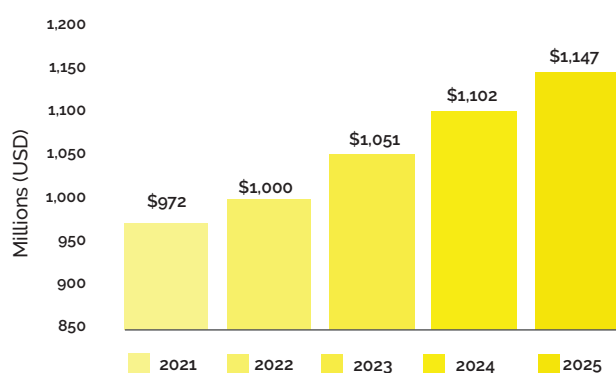
Figure 17: Estimated Costs NHS at the Primary Level

The estimated cost for the Primary Health Care Scenario is US\$5.2 billion (Figure 18). The estimated per capita expenditure for 2021 is US\$65.79 in 2021 and this will rise to US\$73.99 by 2025. Based on the estimated resource envelope of US\$4.13 billion for five years – the estimated public funding from Government and its Partners would cover 78% of the Primary Health care Scenario. This would leave an unfunded gap of 22%. An estimated US\$978m (Figure 18) is the cost of providing primary health care at the health post and Health Centre/ Clinic level. This represents 19% of the overall Primary Health Care costs. This implies that either the bulk of the Primary Health Care interventions are being provided at the higher levels of care or the cost of primary health care interventions provided at the higher levels are more costly.

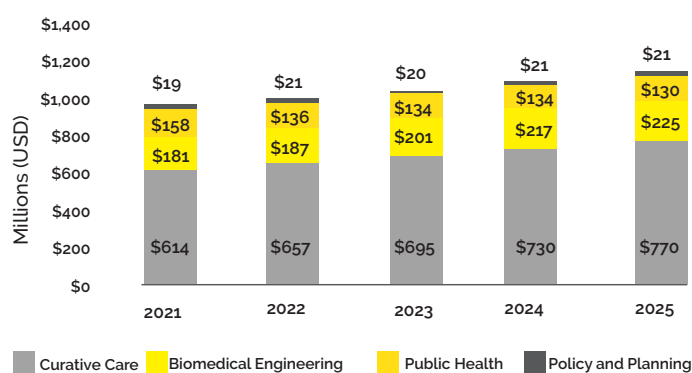
6.3.2 Cost Analysis by PBB Pillars and Level of Care and Programme

Curative Services accounts for most of the resources (66%) of the total of all PBB programmes followed by Bio-Medical Sciences Engineering and Pharmaceutical Production (19%), Public Health (13%) and Policy and Administration Programme (2%). The assumption under the high impact scenario is that the Bio-Medical Sciences Engineering and Pharmaceutical Production programme will be prioritised to account for infrastructure construction, maintenance and rehabilitation of health facilities and associated infrastructure, although the selection of the investments would be strategically focused on maternal and child health care. Cost by function shows that medicines, commodities and supplies will need more resources in the next 5 years as result of increased intervention coverages.

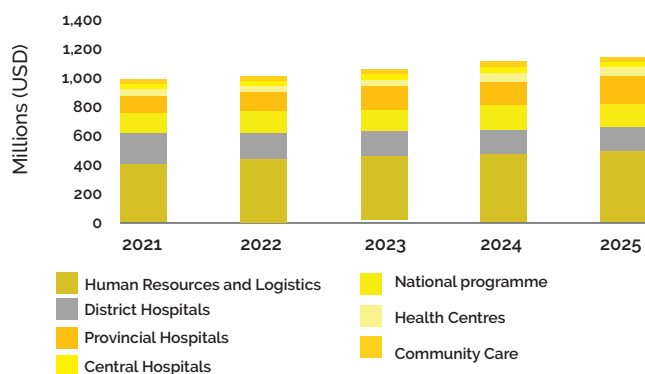
High Impact Scenario = US\$5.2B



Cost by PBB Pillar



Cost by delivery channel



Share of Annual costs by Function

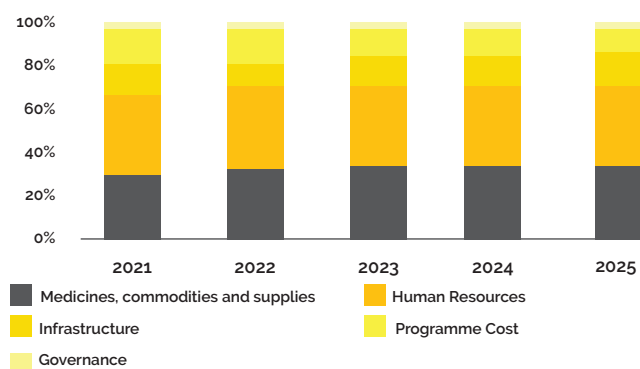


Figure 18: Estimated Costs NHS High Impact Scenario

Similar to the other two scenarios - district hospitals and health centres still account for the majority of the resources - with medicines and human resources accounting for more than the other cost components. Central Hospitals and Community care account for the least resources.



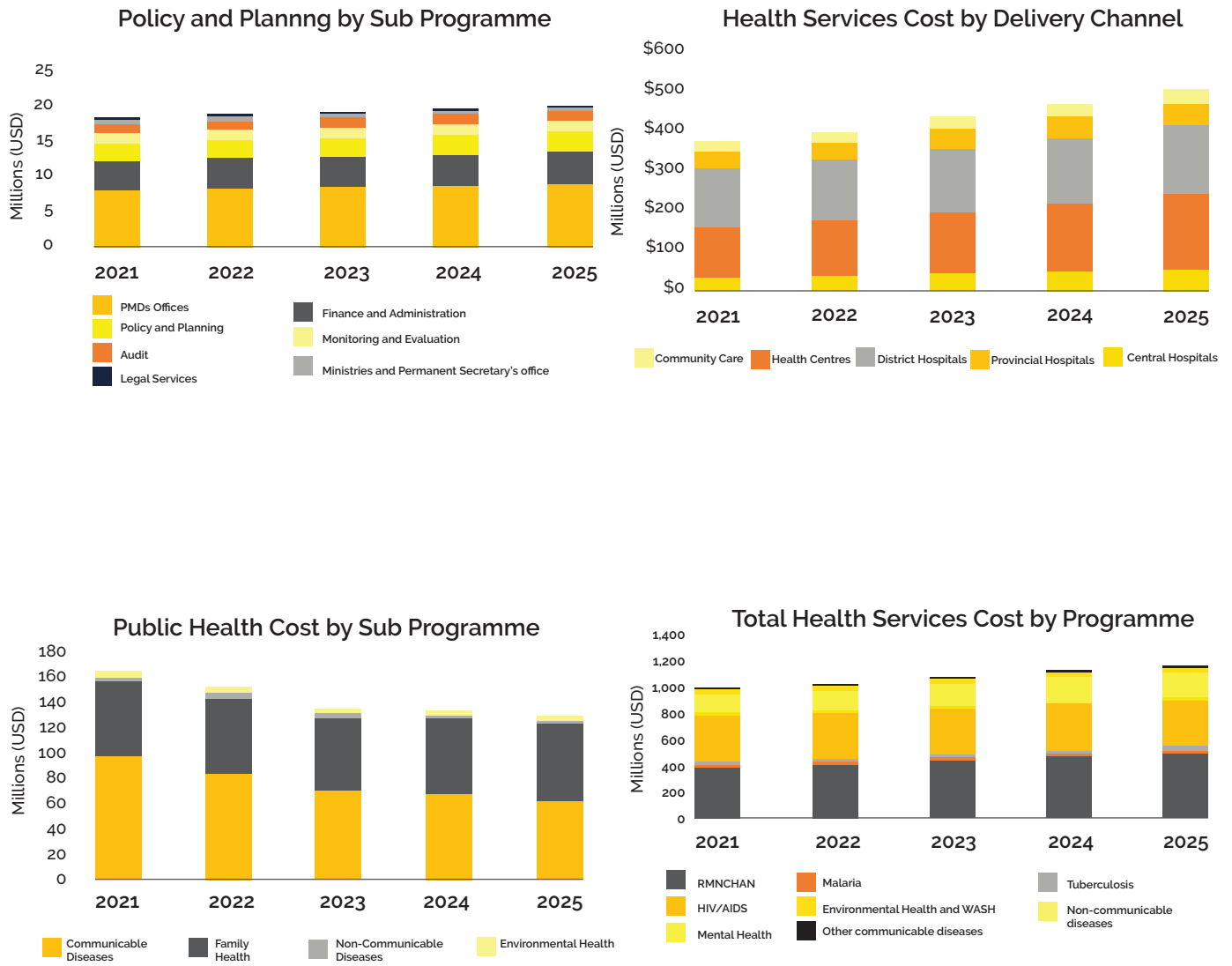


Figure 19: High Impact Scenario costs by Sub-Programme

7 Return on Health Sector Investment

The return on investment for the NHS costing was evaluated based on the following benefits parameter:

•Extended life cycle benefits (lives saved/morbidity and mortality averted and the demographic dividend).

In assessing the mortality impact and the demographic dividends that accrue as a result of investing in key maternal and child health interventions, the LiST tool was used. The LiST Tool is one of the impact models in the OHT that were developed to evaluate the impact of scaling up key interventions. In estimating the impact – it combines with the Demographic, AIDS impact and Family Planning models. To avoid double counting – the model first estimates the impact of prevention and the treatment interventions. The constant coverage, although not presented in this analysis was used as the counterfactual scenario; hence results presented in the analysis show additional lives saved for the full NHS scenario, the Moderate Coverage scenario and the High Impact Scenario.

7.1 Mortality Rates and Deaths Averted

The following section shows the impact of the different funding scenarios in terms of the reduction in mortality/lives saved. Tables 4,5 and 6 show the reduction in mortality ratio/rates for maternal and child health indicators for all the scenarios. Naturally the Full NHS shows a sharper reduction in both the maternal and child health mortality indicators. However, the calculated end period indicators for 2025 are still higher than the target those set by the MoHCC for 2025. While model targeting for MoHCC was informed by other consideration, OneHealth Tool used its targeting model which could have resulted in these differences.

Table 4: Mortality Rates and Deaths Averted Full NHS Scenario

Full NHS Scenario	2020	2021	2022	2023	2024	2025	NHS Target
Maternal mortality ratio (deaths per 100,000 live births)	462	470.66	440.41	409.11	376.82	343.6	240
Neonatal mortality rate (deaths per 1,000 live births)	32.04	31.97	29.54	27.19	24.91	24	20
Under five mortality rate (deaths per 1,000 live births)	64.99	61.78	58.12	54.27	50.72	48.52	41
Stillbirths Averted		142	142	266	372	459	
Deaths Averted (0-4 years)		618	2122	3529	4633	5069	

Table 5: Mortality rates and Deaths Averted Moderate Coverage Scenario

Full NHS Scenario	2020	2021	2022	2023	2024	2025	NHS Target
Maternal mortality ratio (deaths per 100,000 live births)	462	455.98	446.73	437.03	427	420.97	240
Neonatal mortality rate (deaths per 1,000 live births)	32.04	31.52	30.96	30.41	29.86	29.31	20
Under five mortality rate (deaths per 1,000 live births)	64.99	61.68	60.98	59.86	58.85	58.16	41
Stillbirths Averted		68	150	220	280	277	
Deaths Averted (0-4 years)		485	805	1166	1447	1524	

Table 6: Mortality Rates and Deaths Averted Primary Health Care Scenario

Full NHS Scenario	2020	2021	2022	2023	2024	2025	NHS Target
Maternal mortality ratio (deaths per 100,000 live births)	462	455.44	446.05	436.27	426.15	415.77	240
Neonatal mortality rate (deaths per 1,000 live births)	32.04	31.53	30.97	30.41	29.87	29.33	20
Under five mortality rate (deaths per 1,000 live births)	64.99	61.6	60.92	59.83	58.83	56.73	41
Stillbirths Averted		70	155	229	290	340	
Deaths Averted (0-4 years)		691	1011	1458	1810	2082	

7.2 Additional Lives saved

Tables 7 and 8 below show the additional lives saved for all the three scenarios. Generally for all the three scenarios the following maternal health interventions; micronutrient supplementation, caesarian section, prevention of malaria in pregnancy and maternal sepsis case management have relatively larger gains in additional lives saved.

Investing in the full NHS will obviously bring positive dividends by way of additional lives saved for the listed maternal health interventions. However, given an environment of tight fiscal space for health, smart investments through funding for targeted high impact interventions based on a PHC approach will bring comparatively more dividends as is the case with the High Impact Scenario. Also - merely tweaking the target coverages and maintaining/implementing the same number of interventions as is the case with the

moderate coverage scenario will not increase the number of lives saved relative to the High Impact Scenario.

Table 7: Additional Maternal Lives Saved

Intervention (Maternal Health)	Additional Lives Saved by Scenario and by Intervention		
	Full NHS	Moderate Coverage	High Impact
Preconceptual/Contraceptive use			
Safe abortion services	196	36	38
Post abortion case management	54	33	35
Ectopic pregnancy case management	25	7	8
Pregnancy			
TT - Tetanus toxoid vaccination	3	2	2
Prevention of malaria in pregnancy	53	50	53
Micronutrient supplementation (iron and multiple micronutrients)	584	496	539
Hypertensive disorder case management	150	26	29
Malaria case management	33	30	33
Child Birth			
Clean birth environment	30	6	8
MgSO ₄ for eclampsia	5	31	34
Antibiotics for preterm or prolonged PROM	78	15	16
Assisted vaginal delivery		14	15
Parenteral administration of uterotronics	9	39	43
Caesarean delivery		55	59
Curative after Birth			
Maternal sepsis case management	200	40	44
Total	1420	880	956

For child health interventions – generally case management of neonatal sepsis/pneumonia, PMTCT, oral rehydration solution will yield comparably more additional lives saved than the other interventions. Overall, investments in child health interventions will result in 16 680; 7 281 and 7 628 additional lives saved for the 5-year period for the Full NHS, Moderate Coverage and Primary Health Care Scenario.

Table 8: For Under 5 health interventions

Intervention	Additional Lives Saved by Scenario and by Intervention		
	Full NHS	Moderate Coverage	High Impact
Pregnancy			
TT - Tetanus toxoid vaccination	88	59	66
Prevention of malaria in pregnancy	323	302	328
Syphilis detection and treatment	83	22	23
Micronutrient supplementation (iron and multiple micronutrients)	43	56	61
PMTCT - Prevention of mother to child transmission of HIV (including breastfeeding choices)	623	589	619
Maternal age and birth order	28	34	30
Childbirth			
Clean birth environment	70	16	18
Clean cord care	161	128	140
Antibiotics for preterm or prolonged PROM	412	74	81
Assisted vaginal delivery	17	257	278
Neonatal resuscitation	247	222	241
Caesarean delivery		295	320
Breastfeeding			
Age-appropriate breastfeeding practices due to promotion	358	112	120
Preventive			
Change in stunting prevalence	1399	1399	1399
Vitamin A supplementation	375	250	257
Zinc supplementation	1465	386	394
Basic sanitation	234	8	9
Point-of-use filtered water	74	259	268
Piped water	392	112	115
Hand washing with soap	49	34	34

Table 8: For Under 5 health interventions (contd)

Intervention	Additional Lives Saved by Scenario and by Intervention		
	Full NHS	Moderate Coverage	High Impact
Vaccines			
DPT vaccine	57	38	40
Pneumococcal vaccine	95	14	15
Rotavirus vaccine	21	6	6
Measles vaccine		22	23
Curative after birth			
Case management of premature babies	1635	300	327
Case management of neonatal sepsis/ pneumonia	4647	953	1035
ORS - oral rehydration solution	1297	547	566
Antibiotics for treatment of dysentery		50	51
Zinc for treatment of diarrhea		105	108
Oral antibiotics for pneumonia	2328	598	620
Vitamin A for treatment of measles	159	34	36
Total	16680	7281	7628

7.3 Demographic Transitions

For all the scenarios, fertility rates are expected to decrease from 3.27 in 2021 to 2.35 in 2025. These reductions in mortality rates and fertility rates have a positive impact on economic growth. The demographic transition will see a shift in age structure to the more productive age group as shown in the population pyramids for base year 2020 and the end year 2025.

Table 9: Demographic Dividend (Transition)

High Impact Scenario	Population 0-14	Population aged 15-64	Population aged 65+
2021	0.42	0.55	0.03
2022	0.41	0.56	0.03
2023	0.40	0.57	0.03
2024	0.39	0.58	0.03
2025	0.38	0.59	0.03



Population by age and sex (Percent)

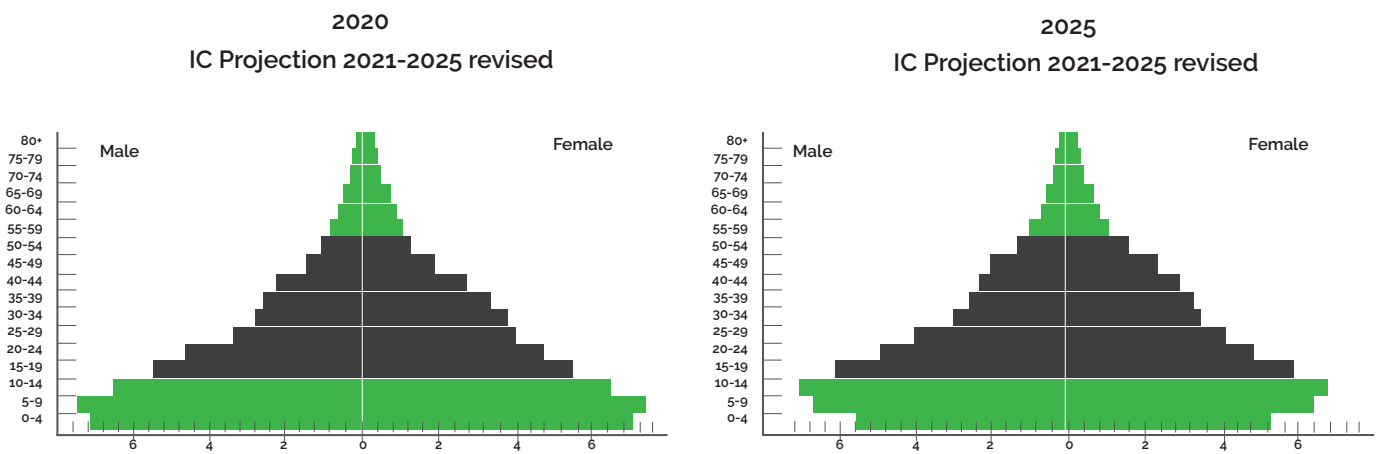


Figure 20: Dependency Pyramid

This positive shift to the more productive age group will result in less dependency as shown in Figure 20 – which shows a decline in the dependency ratio from 0.83 in 2020 to 0.70 in 2025



8 Financing of the NHS Investment Case

Financing of the NHS remains critical given the estimated resource requirements for the three scenarios. While the strategy gives the country the strategic direction on the types of health services to be provided and the estimated cost and coverage targets for the entire health sector, the financing of the Strategy will largely come from the public sector. As estimated earlier - Government and partner funding of the NHS is assumed to be US\$4.13 billion for next 5-years. Given the estimated cost of the plan this would result in gaps of 47%, 33% and 22% for the full NHS, the Moderate coverage and the Primary Health Care scenarios respectively (Figure 22). The Primary Health Care Scenario costs less than all the other scenarios because of its focus on a select package of high impact and cost-effective maternal and child interventions.

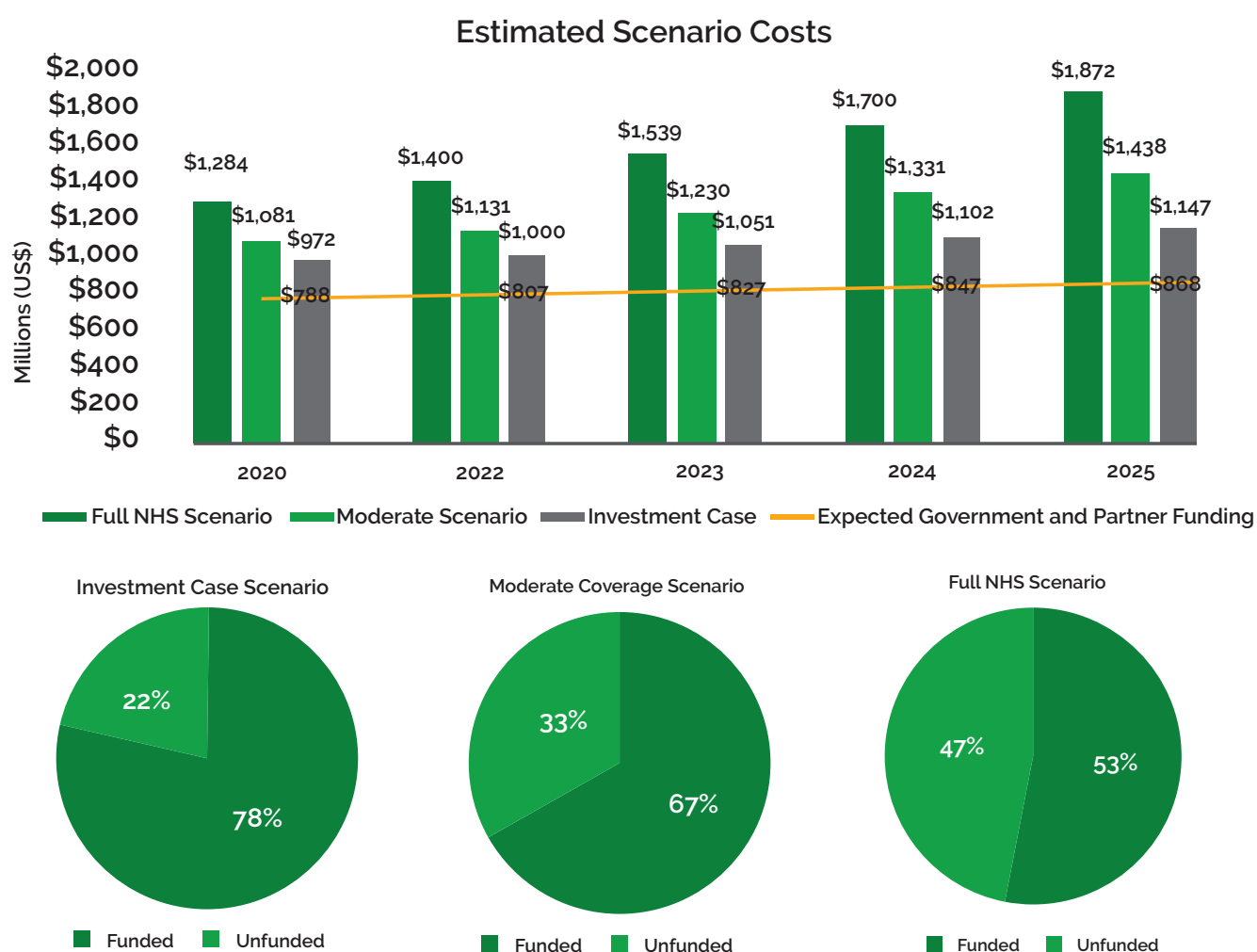


Figure 22: Summary Estimated Scenario Costs



The 2015 and 2017/2018 National Health Accounts showed that on average a total of US\$1.5 billion is spent annually in the entire health sector by both public (Government and donors) and private sources (companies, households and others) of funds. Such an amount would cover the entire needs of the moderate coverage scenario and the Primary Health Care scenario.

It would also cover 96% of the estimated costs for the full NHS Scenario. However, without a re-configuration of private sector funding by reforming the prepaid insurance schemes and reducing the household out-of-pocket expenditures, these funds would largely remain outside the purview of the MoHCC, perpetuating the current inefficient funding status quo. Multistakeholder policy dialogues need therefore to focus on how the public and private sector can reorganize the financing of the sector in order to reduce the inefficient fragmentation in the current health financing structure.

Zimbabwe's current competing needs offer limited potential for expanding fiscal space for health. The need to finance the COVID-19 response would add to the above financing gaps, as the pandemic is expected to linger for some years to come. The competing needs for financing the COVID 19 response will likely crowd out the growth in the financing of the general health budget. While the IMF recommends broadening the tax base, particularly the VAT, and improving tax administration (e.g., simplifying procedures and addressing areas where collection efficiencies can be improved), other socioeconomic challenges such as rising unemployment and growth of the informal sector will further restrict the available fiscal space.

Earmarking of specific health taxes/levies has shown potential to adding fiscal space for health. Earmarking of specific taxes for health in addition to allocations through the budget have contributed significant earmarked funds towards health. AIDS Levy contributions have risen from US\$5.7 million in 2009 to close to \$US52 million in 2018 (NAC). In 2017, the GoZ also introduced the Health Levy, 5% tax on mobile airtime and data which was ring-fenced for procurement of hospital medicines and medical commodities.

The levy generated more than US\$50 million in three years. Another potential source of revenue for the sector would be the earmarking a portion of VAT. In a study done in 2013 on earmarking of at least 1-2% of VAT – the study showed that earmarking of 1% tax on VAT would generate about US\$138 million annually for the health sector. However, the return of the Health Funds to the Consolidated Revenue Fund/general revenue against it being earmarked specifically for health has shown us the lesson of how difficult the concept of earmarking taxes is - as it has the potential to generate trade-offs in the general economy and other inefficiencies in resource allocation. In a similar study in 2013 as part of set of studies on innovative health financing - consideration of pro-health taxis such as for Alcohol, Tobacco and Sugars were considered but the subsequent Fiscal Space Analysis in 2016 indicated that this may not open up the fiscal space significantly. however, these taxes have the potential to lessen the long-term health effects of relevant foods contributing to lessening the burden on NCDs.

In addition to earmarking health specific taxes/levies - achieving efficiency gains to maximize the current level of resources flowing to the sector is the most feasible option. Increasing fiscal space for health requires both efficiency gains and reprioritizing health in

total government spending. Harmonization and alignment of current external funding to national priorities, will enhance efficiencies and better health outcomes.

Further to the above- enhancing efficiency may require a new pooling and purchasing arrangement framework. The National Health Insurance (NHI) has been mentioned as a possible solution to pooling and purchasing of health. While in the short-term introducing an NHI remains a difficult task given the current economic situation - a more comprehensive and broader National Health Insurance (NHI) funded from tax earnings from the formally employed and complemented with public sources such as earmarked VAT would be a more acceptable and feasible model. Importantly, both the formally and informally employed pay VAT when they purchase goods and services – and VAT payments in Zimbabwe are not essentially regressive as a number of basic goods that are commonly accessed by poor population groups are either zero-rated or subsidized.

Significant focus on infrastructure development and rehabilitation. Current infrastructure being utilized in the health sector is old and inadequate in number, space and design. Furthermore, this infrastructure lacks adequate maintenance for optimal use. Focusing on high impact investments on infrastructure development and rehabilitation would not only improve service provision and access, but also improve efficiency resulting in increased fiscal space for health. The investment case will for example focus on constructing health posts, district hospitals and installation of solar backup power as well as Solar Direct Drive refrigerators and cold rooms at selected rural health facilities.

Emphasizing cross-programmatic efficiencies through integration of programmes or services. This could be done through, for example, encouraging integration of programmes and services, one Monitoring and Evaluation system for all programmes, combined support and supervision guidelines.

Task shifting has also been identified as a potential game changer – While it is important to put staff at appropriate levels of care and retain skilled personnel at all levels – in instances of inadequate personnel or increased provision of services - benefits can be realized by shifting tasks to lower level cadres. For example, having more Primary Care Nurses manning primary healthcare facilities, pharmacy technicians, X-ray operators and other such technicians at the district hospitals has afforded the respective populations constant access to care. Targeted upgrading/upskilling courses could then be reinvigorated to fill the skills gaps in order not to compromise on quality of care in the long run.

Reinforcing the Primary Health care concept in service provision will not only improve access to health services – but will do so at a very low cost. The Costed Community Health Strategy showed that the country could provide accessible health services at community level at lower prices. The use of VHWs to complement preventive services offered has improved access to care. However, as noted above training and monitoring and supervision of the VHW would need to be constantly done in the next five-years.

The MoHCC's proposal on use of a scientifically grounded resource allocation formula will result in more efficiency gains and effective implementation of the NHS-IC. This will definitely reinforce the MoHCC's Primary Health Care approach. The burden of disease, in particular that of the most vulnerable, should drive the allocation of public funds to the health sector. Looking at the disease profile and health seeking behaviors of the poorest,



it is necessary to reallocate more resources to the lowest levels of care, where most of the vulnerable go and where the majority of cases can be treated at a lower cost. Pulling out some resources from curative to preventive services will lead to a reduction of the burden on health systems and health financing by reducing the incidence of NCDs and communicable diseases which are costly to treat. The High impact scenario which places more emphasis on primary care interventions has shown that it is possible to reduce the cost of curative care in the long run.

Defining realistic and viable and cost-effective intervention packages at all levels of the country's health care system. This should be complemented by the development of a unit cost database that will enable realistic estimation of budgets for the MoHCC.

Implementation of the PFMS at all levels of care and for all government will result in improved budgeting, expenditure, planning, execution and auditing of health funds by helping turn allocated funds into inputs. Expediting the decentralisation of the 'All Government' planning and implementing recommendations from the Auditor General's (AG) reports related to budget control procedures, accounting procedures, governance and the procurement system will be critical to moving toward greater technical efficiency. Strengthening programme-based budgeting and moving away from line-item budgeting will allow monitoring of progress and tying of resources to specific and clearly defined programmes would allow for increased accountability.

Implementation of the public wage bill reforms and focused Human resources recruitment will result in substantive efficiency gains. The large wage bill represents a major constraint. While the share of employment cost has gone down from 64% in 2018 to the current 54% in 2021 of the MoHCC budget, there are still rigidities that are still affecting the funding of critical health programmes such as infrastructure and equipment. In parallel though, MoHCC reports show significant shortages of some categories of human resources for health.

The Mid-term review of the NHS 2016-2020 highlighted the importance of improving efficiencies at hospital level. While hospitals are a critical component of the health system in Zimbabwe, their efficiency remain uncertain in the absence of a comprehensive hospital efficiency study. However, limited evidence reveals that hospitals at all levels have reported low bed occupancy rate.

The Investment case has proposed a more focused attention on the provision of appropriate inputs at the relevant levels of care. Currently the efficiency of the health sector is impeded by poor availability of major inputs in health care facilities. The health system is lacking the basic inputs (human resources, drugs, equipment) required to deliver quality health services. There is evidence that RBF can help address some of those structural issues as demonstrated by the recent evaluation of RBF.

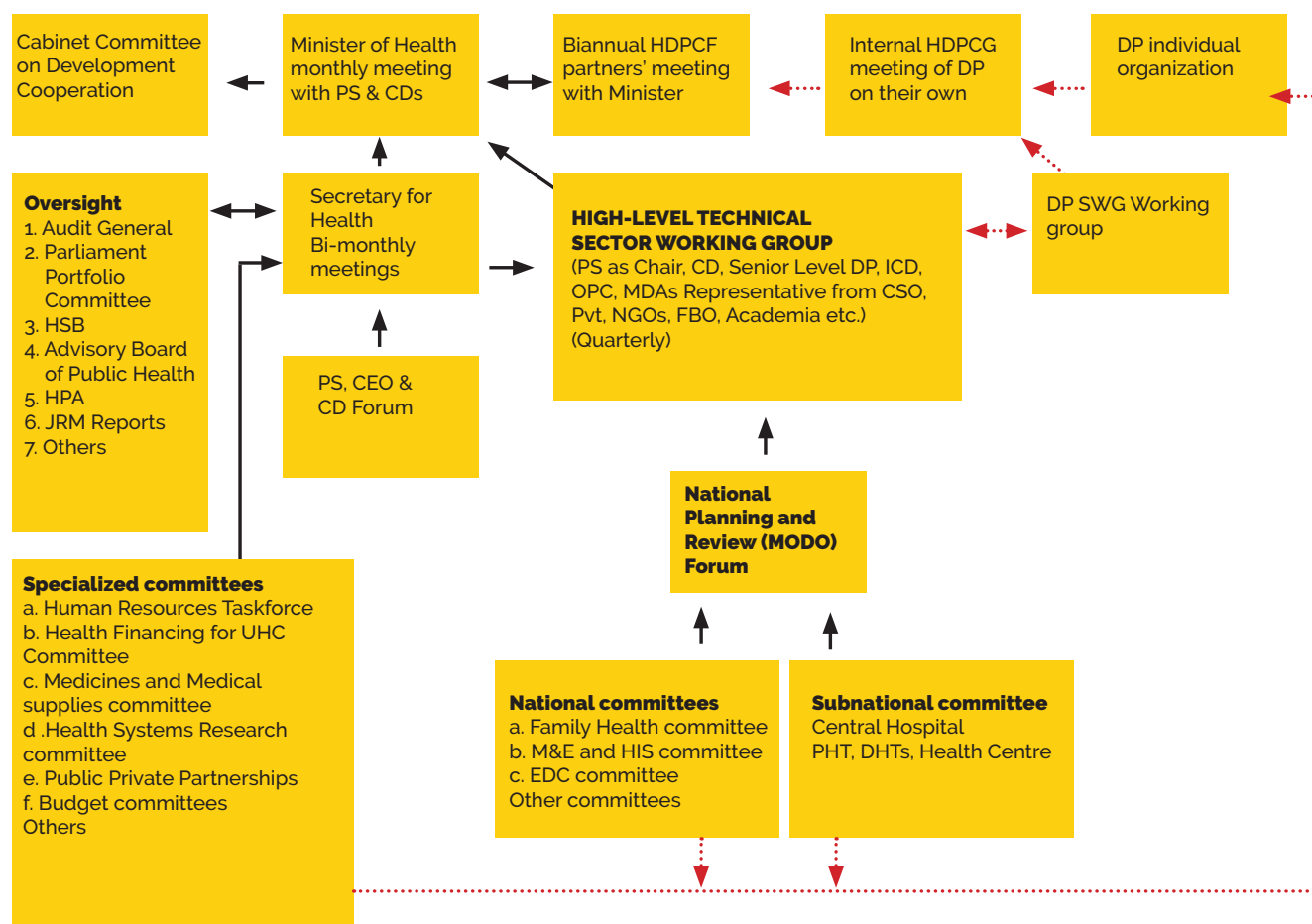
Addressing issues affecting the supply chain would allow achieving major efficiency gains. The existence of parallel distribution systems has a direct impact on costs and availability of drugs.

Vertical programs tend to fund drugs in an uncoordinated way which creates parallel distribution systems. Merging such systems in the medium-term would result in significant efficiency gains.

9 Implementation Framework for the NHS Investment Case

9.1 Country Coordination Platforms

The governance structure to oversee implementation of this NHS will therefore rely on existing platforms that have been set up by MoHCC in the Coordination Framework for the Health Sector as shown in the figure below. The MoHCC has developed the Coordination Framework for the Health Sector whose overall objective is "To coordinate efforts by the MoHCC and all stakeholders in financing, planning, implementation including monitoring and evaluation of all health-related interventions, to maximize health outcomes among the people of Zimbabwe".



MOHCC internal reporting: → Linkages: ↔ Partner reporting line starting from TWG: ⋯→

Figure 23: Consolidated Health Sector Partner Coordination Structure¹²

The Health Sector Working Group platform in its terms of reference has a mandate to provide oversight on the implementation of the NHS. As outlined in the structure above and in the coordination framework the Health Sector Working group chaired by the Secretary for Health and Child Care brings together all the relevant stakeholders at a policy technical level. MoHCC has also set up various TWGs whose deliberations bring to the attention of the HSWG any technical issues for consideration during the implementation phase. Therefore, that HSWG (being supported by the various technical working groups and committees) will routinely review the NHS implementation and make recommendations for course corrections for technical issues. Above the Health Sector Working group is the Health Development Partners Coordination Forum (HDPCF) which is chaired by the Minister of Health and Child Care. This platform is responsible for policy direction. Therefore, if there are any issues requiring policy direction these will be brought to the attention of this platform by the HSWG.

The Directorate of PPM&E will take the lead in strengthening coordination of the financing of the NHS. The capacity of the office of the Chief Director PPM&E will be strengthened in fulfilling its role of effectively coordinating health activities¹³. This entails the setting up of a functional Health Economics and Policy Unit, which is in the new structure of the MoHCC. The Directorate of Policy and Planning, who are the custodian of all policy and strategic documents in MoHCC will be responsible for ensuring constant review meetings by the HSWG and TWGs as stipulated in the MoHCC Coordination calendar.

9.2 Monitoring and evaluation

Monitoring and evaluation of the IC will rely on existing MoHCC systems for monitoring and evaluation to ensure compliance with the principle of one plan and one monitoring and evaluation. The government of Zimbabwe is implementing the Whole of Government Approach to monitoring and evaluation. The Division of PPM&E will take lead in this aspect and specifically the Directorate of Monitoring and Evaluation housed in this division. In addition to the constant monitoring activities at national and sub-national levels, a mid-term and end line evaluation of this NHS will be led by the MoHCC making reference to the NHS Monitoring and Evaluation framework.

¹²Source -Health Sector Coordination Framework 2019.

¹³Source-Health Sector Coordination Framework

10 Appendix 1: NHS Implementation Matrix used for Costing

Table 32: NHS and IC 2021-2025 Implementation Matrix

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
1	Implementation of the Corporate Governance Frameworks	1.1	Development of the Health Sector Specific framework	1.1	Policy planning & Coordination	✓	✓	✓	✓	✓
			Implementation	1	Policy planning & Coordination	✓	✓	✓	✓	✓
			Monitoring	1	Policy planning & Coordination	✓	✓	✓	✓	✓
		1.1	Audit of current institutional management boards registration with Institute of Board Directors	1	Policy planning & Coordination	✓	✓	✓	✓	✓
		1.1	Submissions of prospective board members to the Minister for hospitals and parastatals	1	Policy planning & Coordination	✓	✓	✓	✓	✓
2	Strengthening health budget and expenditure tracking accountability systems	9.1	Development of the resource allocation formula	9.1	Policy planning & Coordination.	✓	✓	✓	✓	✓
			Training of The Budget Committee on the resource allocation formula	9.1	Policy planning & Coordination	✓	✓	✓	✓	✓
			Conduct annual Resource Mapping and National Health Accounts.	9	Policy planning & Coordination.	✓	✓	✓	✓	✓
			Establish the Medical Aid Regulatory Authority	9	Finance and Admin	✓	✓	✓	✓	✓
			Scale up of the RBF in urban areas			✓	✓	✓	✓	✓
		1.1	Conduct a Regular training and Monitoring of the PFM systems	1	Internal Audit	✓	✓	✓	✓	✓
			Conduct routine Audits	1	Internal Audit	✓	✓	✓	✓	✓
	Implementation of audit recommendations and risk assessments	1.1	Implement Audit tracking tools	1	Finance and Admin & Audit	✓	✓	✓	✓	✓
			Capacitate risk and Audit Committees	1		✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
3	Implementation of the new structure	1.1	Filling in new posts	1	Human resources					
			Management capacity building of all structures		Human resources					
			Strengthening decentralized structure		Human resources					
			Institutionalising performance management							
4	Review Health Service Board to match the mandate of other Public Service Commissions.		Draft a Health Services Act Amendment Bill	1	Legal services	✓	✓			
					Minister and PS office	✓	✓			
5		1.1		1	Logistic and asset management	✓	✓	✓	✓	✓
6	Implementation of strategies that improve Reproductive, Maternal, Neonatal and Adolescents Health	2.1	Enforcement of standards based RMNCAHN and quality service improvement programme	2	Family Health	✓	✓	✓	✓	✓
			Community engagement on RMNCAHN	2	Policy planning and Coordination	✓	✓	✓	✓	✓
			Adolescent Sexual and Reproductive Health	2	Family Health	✓	✓	✓	✓	✓
			Scaling up Implementation of the Adolescent health minimum service delivery package							
			Training of districts in implementing the Parent to Child Communication (PCC) package		Family Health	✓	✓	✓	✓	✓
			Training of health providers on WHO's 9 standards on youth friendly		Family Health	✓	✓	✓	✓	✓
			Integration of Facility Assessments as youth friendly into existing QAs such as RBF		Family Health	✓	✓	✓	✓	✓
			Family Planning		Family Health	✓	✓	✓	✓	✓
	Develop and integrate Quality indicators for FP into HMIS		Family Health	✓	✓	✓	✓	✓		

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
			Track quality indicators routinely		Family Health	✓	✓	✓	✓	✓
			Development of a Family Planning Investment Case		Family Health	✓	✓	✓	✓	✓
			Procurement of simulation models for central, provincial and district hospitals for On the job training of health care workers in FP		Family Health	✓	✓	✓	✓	✓
			Develop package of fertility services to be offered at different levels of care including SBCC		Family Health	✓	✓	✓	✓	✓
			Training of Specialists and other staff in comprehensive management of sub-fertility		Family Health	✓	✓	✓	✓	✓
			Develop legal framework governing provision of fertility services		Family Health	✓	✓	✓	✓	✓
			Capacitation of central hospitals to provide specialized fertility services		Family Health	✓	✓	✓	✓	✓
			VIAC Services		Family Health	✓	✓	✓	✓	✓
			Training of health care workers on screening and treatment		Family Health	✓	✓	✓	✓	✓
			Expansion of screening services		Family Health	✓	✓	✓	✓	✓
			Mentorship and QA meetings		Family Health	✓	✓	✓	✓	✓
			Procurement of appropriate equipment for treatment		Family Health	✓	✓	✓	✓	✓
			Conduct HPV DNA screening pilot in selected sites		Family Health	✓	✓	✓	✓	✓

STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
					2021	2022	2023	2024	2025
		Expand HPV DNA screening pilot to other sites and include HIV negative patients		Family Health	✓	✓	✓	✓	✓
		Mapping of sites for second HPV DNA screening pilot		Family Health	✓	✓	✓	✓	✓
		Conduct second HPV DNA screening pilot in selected sites		Family Health	✓	✓	✓	✓	✓
		Sexual and Gender Based Violence		Family Health	✓	✓	✓	✓	✓
		service providers trained in care SGBV patients/survivors		Family Health	✓	✓	✓	✓	✓
		development of SBCC interventions		Family Health	✓	✓	✓	✓	✓
		SGBV data capturing integrated into HMIS		Family Health	✓	✓	✓	✓	✓
		Early Booking		Family Health	✓	✓	✓	✓	✓
		procurement of pregnancy test kits		Family Health	✓	✓	✓	✓	✓
		development of SBCC interventions		Family Health	✓	✓	✓	✓	✓
				Family Health	✓	✓	✓	✓	✓
		update job aids such as clerk sheets to include pregnancy surveillance		Family Health	✓	✓	✓	✓	✓
		ANC 8 contacts		Family Health	✓	✓	✓	✓	✓
		sensitization of health workers on the new ANC protocol		Family Health	✓	✓	✓	✓	✓
		implementation of the RMNCAH-N quality improvement guidelines		Family Health	✓	✓	✓	✓	✓
		conduct Client Satisfaction Surveys		Family Health	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
			utilize data from Client Satisfaction Surveys at SDPs level		Family Health	✓	✓	✓	✓	✓
			document learning stories		Family Health	✓	✓	✓	✓	✓
			procurement of USS scans		Family Health	✓	✓	✓	✓	✓
			accredit and recognize health facilities		Family Health	✓	✓	✓	✓	✓
			sensitization of health workers on the new MWHs guidelines		Family Health	✓	✓	✓	✓	✓
7	Strengthen maternal and perinatal death audits.	2.1	Maternal and Newborn Mortality reduction	2	Family Health	✓	✓	✓	✓	✓
			Conduct Maternal and Perinatal Deaths Audits							
			On job training of health workers on EmONC plus	2	Family Health	✓	✓	✓	✓	✓
			Conduct integrated mentorship in RMNCAH-N		Family Health	✓	✓	✓	✓	✓
			establish functional skills laboratories to the number required		Family Health	✓	✓	✓	✓	✓
			Procurement of simulation models for 63 District Hospitals, and 8 provincial hospitals and upgrade for 5 central hospitals		Family Health	✓	✓	✓	✓	✓
			Capacitate health workers in safe obstetric anaesthesia		Family Health	✓	✓	✓	✓	✓
			Provision of BEmONC-1 at appropriate health facilities		Family Health	✓	✓	✓	✓	✓
			Provision of CEmONC at appropriate health facilities timely implement the New Born Action Plan		Family Health	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
			Implement standards of new born care as outlined in the New-born Care package- include these on the QSS for all levels including central hospitals		Family Health	✓	✓	✓	✓	✓
			Strengthen community post-natal care initiatives		Family Health	✓	✓	✓	✓	✓
			Child Health		Family Health	✓	✓	✓	✓	✓
			roll out community IMNCI		Family Health	✓	✓	✓	✓	✓
7			train health workers in IMNCI		Family Health	✓	✓	✓	✓	✓
			train health workers in ETAT (district, provincial and central hospitals health workers working in FCH and paediatric wards)		Family Health	✓	✓	✓	✓	✓
			implement IMNCI/ ETAT guidelines in the management of under fives		Family Health					
			advocate for increased contribution of domestic funding towards immunization		Family Health	✓	✓	✓	✓	✓
			capacitate health worker to offer integrated screening for 4Ds		Family Health	✓	✓	✓	✓	✓
8	Implementation of a National Nutrition policy	4.3	Coordinate maternal infant and young child feeding program	2	Family Health	✓	✓	✓	✓	✓
			Develop a micro nutrient deficient program	2	Family Health	✓	✓	✓	✓	✓
			Growth monitoring (stunting and obesity assessment plan)	2	Family Health	✓	✓	✓	✓	✓
						✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
			Procurement of equipment and training of VHWs to conduct Growth Monitoring		Family Health	✓	✓	✓	✓	✓
			Training of doctors and nurses on community IMAM		Family Health	✓	✓	✓	✓	✓
			Promote good nutrition		Family Health	✓	✓	✓	✓	✓
			Food fortification monitoring activities		Family Health	✓	✓	✓	✓	✓
			Iron and folate supplementation activities		Family Health	✓	✓	✓	✓	✓
					Family Health	✓	✓	✓	✓	✓
					Family Health	✓	✓	✓	✓	✓
					Family Health	✓	✓	✓	✓	✓
9	Implement a comprehensive National Healthy Lifestyle	4.3	Development of the comprehensive National Healthy Lifestyle framework	4	NCD	✓	✓			
	Programme		Conduct wellness programmes	2	NCD	✓	✓	✓	✓	✓
10	Strengthen Child Care services	3.2		3	Family Health	✓	✓	✓	✓	✓
				3	Family Health	✓	✓	✓	✓	✓
11	Improve early identification and prevention of childhood disabilities	3.2	Scaling up the 'At Risk' Surveillance System (ARSS)	3	NCD	✓	✓	✓	✓	✓
			Review the Children's Rehabilitation Program	3						

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
12	Implement Health Sector Infrastructure Development Plan	3.3	Inventory of the MoHCC infrastructure		Logistics and asset management	✓	✓	✓	✓	✓
			Develop the Health Sector Investment Development Plan (HSIDP)	3	Logistics and asset management	✓	✓	✓	✓	✓
			Construction of new hospitals, clinics and health posts	3	Logistics and asset management	✓	✓	✓	✓	✓
			Polyclinics upgraded to district hospitals in each urban	3	Logistics and asset management	✓	✓	✓	✓	✓
13	Improve health infrastructure for tertiary and quaternary care infrastructure	3.1	Upgrade and Refurbish of central and provincial hospitals	3	Logistics and asset management	✓	✓	✓	✓	✓
14	Develop new health infrastructure for quinary care services	3	Establish a quinary hospital that offer super specialist services	3	Logistics and asset management	✓	✓	✓	✓	✓
			Equip tertiary and quaternary health facilities	3	Logistics and asset management	✓	✓	✓	✓	✓
15	Strengthening and equipping ambulance and referral management system	3	Procure adequately equipped ambulances	3	Logistics and asset management	✓	✓	✓	✓	✓
			Equitably distribute ambulances							
			Recruit ambulance technicians	3	Logistics and asset management	✓	✓	✓	✓	✓
16	Capacitate lower levels of care to minimize referrals	3.1	Establishment of Health Posts	3	Logistics and asset management 3	✓	✓	✓	✓	✓
17	Implement the 95-95-95 HIV Strategy	4.1	Initiating new patients on ART	4	Communicable Diseases	✓	✓	✓	✓	✓
			Increased testing	4	Communicable Diseases	✓	✓	✓	✓	✓
			Differentiated models for HIV services	4	Communicable Diseases	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
18	Strengthen Implementation of End-TB strategy	4	Expanding TB awareness	4	Communicable Diseases	✓	✓	✓	✓	✓
			Roll out defaulter tracking tools	4	Communicable Diseases	✓	✓	✓	✓	✓
			Optimization of treatment regimens	4	Communicable Diseases	✓	✓	✓	✓	✓
			Implementation of Integrated Sample Transportation (IST) plan		Communicable Diseases	✓	✓	✓	✓	✓
					Communicable Diseases	✓	✓	✓	✓	✓
			Redistribution of GeneXpert machines		Communicable Diseases	✓	✓	✓	✓	✓
			Procurement of GeneXpert machines		Communicable Diseases	✓	✓	✓	✓	✓
			Integration of GeneXpert machine maintenance into the Health Sector Equipment Maintenance framework		Communicable Diseases	✓	✓	✓	✓	✓
			Conducting the TB Mortality Study		Communicable Diseases	✓	✓	✓	✓	✓
			Review of the TB treatment guidelines to include other service delivery models eg TB refill groups		Communicable Diseases	✓	✓	✓	✓	✓
			Training of HCWs in childhood TB case detection		Communicable Diseases	✓	✓	✓	✓	✓
					Communicable Diseases	✓	✓	✓	✓	✓
		Communicable Diseases	✓	✓	✓	✓	✓			
19	Strengthen the implementation of the malaria elimination strategy.	4.1	Deployment of IRS in targeted areas	4						
			Entomological monitoring	4	Communicable Diseases	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
		4.1	Prompt and appropriate management of all malaria cases	4	Communicable Diseases	✓	✓	✓	✓	✓
			Increasing malaria elimination districts	4	Communicable Diseases	✓	✓	✓	✓	✓
			Distribution of LLINs to target populations	4	Communicable Diseases	✓	✓	✓	✓	✓
					Communicable Diseases	✓	✓	✓	✓	✓
			Conduct larviciding		Communicable Diseases	✓	✓	✓	✓	✓
			Revitalization of cross-border Malaria control programs		Communicable Diseases	✓	✓	✓	✓	✓
20	Develop and Implement Neglected Tropical Diseases master plan.	4.2	Increase MDAs coverage for four priority PC-NTDs		Communicable Diseases	✓	✓	✓	✓	✓
			Develop and disseminate guidelines for the management of common NTDs		Communicable Diseases	✓	✓	✓	✓	✓
			Multisectoral NTD Response Meetings		Communicable Diseases	✓	✓	✓	✓	✓
			Setting up of morbidity management and disability programs		Communicable Diseases	✓	✓	✓	✓	✓
			Scaling up of rabies vaccination programme		Communicable Diseases	✓	✓	✓	✓	✓
			Enhancing Vector Control interventions		Communicable Diseases	✓	✓	✓	✓	✓
21	Multisectoral approach to primary and secondary prevention of NCDs	4.3	Develop the National NCD Strategy and strengthen coordination	4	NCD	✓	✓	✓	✓	✓
			Development and implement guidelines for NCDs case management	4	NCD	✓	✓	✓	✓	✓
			Establish halfway homes and drug and alcohol detox centers	4	NCD	✓	✓	✓	✓	✓
			Adoption and adaptation of the WHO Package of Essential NCDs (WHO-PEN) interventions and integration into the EHB	4	NCD	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
			Integration of the NCD management equipment into the Health Sector Equipment Framework		NCD	✓	✓	✓	✓	✓
			Procurement of NCD management equipment		NCD	✓	✓	✓	✓	✓
			Integration of NCD training materials into existing training modules		NCD	✓	✓	✓	✓	✓
			Development of the NCD E-HR module		NCD	✓	✓	✓	✓	✓
			Robust NCDs data gathering	4	NCD	✓	✓	✓	✓	✓
22	Strengthen the provision of mental health services	4.3	Build capacity of health workers at lower levels of care	4	NCD	✓	✓	✓	✓	✓
			Advocate for the reduction of the excessive use of alcohol and harmful drugs	4	NCD	✓	✓	✓	✓	✓
23	Reduce preventable disease burden due to consumption of unsafe food and water	4.4	Inspection of food imports and exports	4	Environmental Health	✓	✓	✓	✓	✓
			Scale-up food quality monitoring.	4	Environmental Health	✓	✓	✓	✓	✓
			Capacitate government analyst laboratory	4	Bio Analytics	✓	✓	✓	✓	✓
24	Strengthen port health systems	10.1	Increasing the staffing levels	10	Environmental Health	✓	✓	✓	✓	✓
			provide adequate port of entry tools of trade	10	Environmental Health	✓	✓	✓	✓	✓
25	Implement community Health Strategy	5.1	Harmonize community Health worker manual	5	Policy planning and coordination	✓	✓	✓	✓	✓
			Recruit, train, equip and incentivize VHW	5	Human resources	✓	✓	✓	✓	✓
			Harmonize the data collection tools	5	Monitoring and evaluation	✓	✓	✓	✓	✓
			Capacitate community Health structures e.g HCC	5	Policy planning and coordination	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)					
						2021	2022	2023	2024	2025	
26	Implement essential packages for Health Services	5.1	Define Hospital service packages	5	All program 3 sub programs	✓	✓	✓	✓	✓	
			Capacitate Health Institutions to deliver the defined packages	5	All program 3 sub programs	✓	✓	✓	✓	✓	
			Development of the National Surgical Obstetric and Anaesthetic Plan (NSOAP)			✓	✓	✓	✓	✓	
			Dissemination of the NSOAP			✓	✓	✓	✓	✓	
			roll out an electronic asset register			✓	✓	✓	✓	✓	
			monitoring of adherence to maintenance schedules								
			Implement the Solar for Health plan			✓	✓	✓	✓	✓	
27	Strengthen specialist services	5.1	Increase the number of specialist Health professionals	5	Human Resources	✓	✓	✓	✓	✓	
			Provide supportive medical equipment and infrastructure	5	Logistics and asset management	✓	✓	✓	✓		
28	Develop and Implement quality improvement programme	5.2	Conduct Quality Assessments	5	Quality assurance	✓	✓	✓	✓	✓	
			Institutionalize quality improvement in Health Institutions			Quality assurance and patient care	✓	✓	✓	✓	✓
			Implement Quality focused RBF in provincial and central hospitals			Quality assurance and patient care	✓	✓	✓	✓	✓
			Institutionalize clinical mentorship and on the job training			Program 3 all sub programs	✓	✓	✓	✓	✓
29	Integrate TACM into main stream health services	5.2	Develop framework for collaboration	5	Traditional medicines	✓	✓	✓	✓	✓	
			Promote safe use of TCAM	5	Traditional medicines	✓	✓	✓	✓	✓	

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
30	Develop and Implement a comprehensive strategy on the bio-medical	6.1	Resuscitate hospital pharmacy manufacturing unit	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
			Build technical capacity on current best manufacturing practice	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
	pharmaceutical production		Introduce specialised undergraduate and post graduate programmes at tertiary Institutions in manufacturing	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
	Strengthening procurement regulations and supply chain management of medicines and commodities	6.1	Reviewing of MCAZ Act	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
			Implement the electronic Logistic Management Information System	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
			Capacitate NATPHAM	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
			Pharmaceutical production at Natpharm SBU	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
			Capacitate Natpham	6	Bio-Pharmaceutical Engineering and production	✓	✓	✓	✓	✓
31	Mitigate against pharmaceutical pilferage and losses	6.1	Full roll out of Elmis	6	Policy Planning and Coordination	✓	✓	✓	✓	✓
			Roll out electronic Health Record(eHR)	6	Policy Planning and Coordination	✓	✓	✓	✓	✓
			Conduct regular stock monitoring	6	Policy Planning and Coordination	✓	✓	✓	✓	✓
32	Implementation of key WASH polities and action plans	7.1	Develop WASH facilities in both urban and rural areas	7	Environmental Health	✓	✓	✓	✓	✓
			Reduction of open defecation	7	Environmental Health	✓	✓	✓	✓	✓
			Conduct water quality monitoring	7	Environmental Health	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)					
						2021	2022	2023	2024	2025	
32	Implementation of key WASH polities and action plans	7.1	Mainstream WASH emergency preparedness and response into national planning and resource allocation process	7	Environmental Health	✓	✓	✓	✓	✓	
33	Improve Human Resources Performance	8.1	Review Health worker training programmes	8	Human Resources	✓	✓	✓	✓	✓	
		8.2	Provide adequate tools of trade	8	Human Resources	✓	✓	✓	✓	✓	
			Decentralized IRBM training to all facilities		Policy & Planning	✓	✓	✓	✓	✓	
			Development and submission of individual IRBM performance contracts		Policy & Planning	✓	✓	✓	✓	✓	
			Fully implement IRBPPMS	8	Human Resources	✓	✓	✓	✓	✓	
			Map the current distribution of the various cadres in the country according to the skills mix	8	Human Resources	✓					
			Create a comprehensive database for all cadres based on training institutions output	8	Human Resources	✓					
			8.3	Review staff establishment	8	Human Resources	✓	✓	✓	✓	✓
			Review of remuneration structure		Human Resources	✓					
34	Full implementation of the Health Financing Strategy	9.1	Establish Health Funding virtual pooling mechanisms	9	Policy Planning and Coordination	✓	✓	✓	✓	✓	
			National Health Insurance Roadmap	9	Policy Planning and Coordination	✓	✓	✓	✓	✓	
			Develop and Implement a PPP framework		Policy Planning and Coordination						
			Scale up urban voucher program		Policy Planning and Coordination						

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
35	Implement National Action Plan for Health Security Action plan	10.1	Improve community Health information systems and evidence reporting	10	Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Strengthen response and operations of PHEOC	10	Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Strengthen coordination and prevention of public health emergencies	10	Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Develop post Covid19 Health Systems Recovery Plan	10	Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Lobby regulatory authorities to require reporting as criteria for license renewal		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Incentivize private institutions that report		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Training of trainers (10 per province) to decentralize IDSR		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Decentralized IDSR Training of health workers		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Health Emergency Response Reviews		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Implementation of the Cholera Elimination roadmap		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Conducting regular simulation exercises targeting institutions and communities on disaster response		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Lobby for revitalization of the ward health teams		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓
			Adopt, adapt and implement local disaster risk reduction strategies in line with the Sendai Framework for Disaster Risk Reduction 2015-2030		Communicable Diseases & Environmental Health	✓	✓	✓	✓	✓

	STRATEGIC ACTION	NHS STRATEGIC DIRECTION REFERENCE	KEY ACTIVITIES	OUTCOME REFERENCE	PROGRAMME	TIMELINES (2021)				
						2021	2022	2023	2024	2025
35	Implement National Action Plan for Health Security Action plan	10.1	Development of trauma response protocols		Curative services	✓	✓	✓	✓	✓
			Implementation of the National toll free number for RTAs and other health emergencies		Curative services	✓	✓	✓	✓	✓
			Construction of emergency response centers at hospitals along major highways		Curative services	✓	✓	✓	✓	✓

The funding in reference is for public financing (does not cover private and household financing).



Ministry of Health & Child Care Republic of Zimbabwe