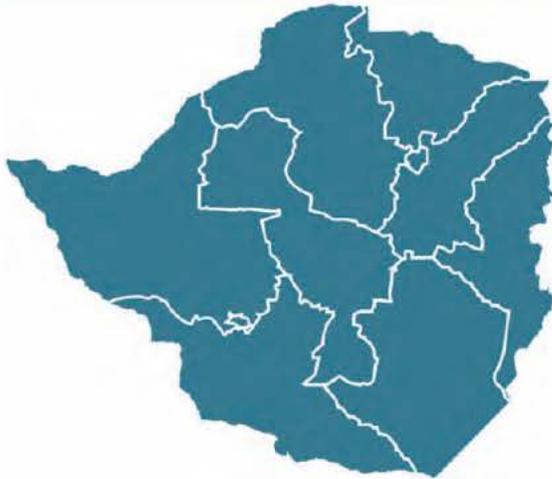


MCHIP Country Brief: Zimbabwe



Health Areas:

- Maternal Health
- Newborn Health
- Child Health
- Immunization
- Malaria
- Nutrition

Selected Health and Demographic Data for Zimbabwe	
Maternal mortality ratio (deaths/100,000 live births)	960
Neonatal mortality rate (deaths/1,000 live births)	31
Under-5 mortality rate (deaths/1,000 live births)	84
Infant mortality rate (deaths/1,000 live births)	57
Contraceptive prevalence rate	57
Total fertility rate	4.1
Skilled birth attendant coverage	66%
Antenatal care, 4+ visits	65%

Sources: Zimbabwe Population Census, 2012; World Bank; Zimbabwe Demographic and Health Survey, 2010–2011.



Program Dates	October 1, 2010–May 31, 2014					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of provinces	10%	No. of districts	7	No. of facilities	277
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INTRODUCTION

The USAID-funded Maternal and Child Health Integrated Program (MCHIP)/Zimbabwe was launched in 2010 as a strategic response to the alarming increase in levels of maternal, newborn, and child deaths in the country. MCHIP/Zimbabwe's vision was to significantly contribute to accelerated and sustainable improvements in maternal, newborn, and child health in Zimbabwe through scaling up of evidence-based, high-impact, integrated public health interventions. The goal of the program was to support Zimbabwe's Ministry of Health and Child Care (MOHCC) in its ultimate aim of attaining the Millennium Development Goals, particularly the ones related to maternal and child health and nutrition.

From 2010 to 2014, MCHIP/Zimbabwe's activities were informed by the following objectives (which were refined during the course of the program):

- *Objective 1:* Support for national policies, strategies, and guidelines
- *Objective 2:* Improve maternal, newborn, and child health (MNCH) at health facilities in learning sites and support national-level scale-up plans
- *Objective 3:* Improve MNCH/family planning at community level by village health workers (VHWs) and other agents
- *Objective 4:* Increase routine immunization coverage in Manicaland and support nationwide introduction of pneumococcal conjugate (PCV13) and rotavirus vaccines

As such, MCHIP/Zimbabwe's key technical areas included:

- *Maternal health/postpartum family planning/prevention of mother-to-child transmission of HIV (PMTCT):* to reduce morbidity and mortality associated with pregnancy, labor and delivery, and the postpartum period
- *Newborn health:* to reduce illness and death associated with newborn asphyxia, prematurity and low birth weight, and infection
- *Child health:* to reduce morbidity and mortality associated with the most common causes of childhood illness
- *Immunization:* to reduce illness and death in children associated with vaccine-preventable diseases through support for activities to improve routine immunization coverage as well as national introduction of new vaccines
- *Malaria:* to reduce illness and death in pregnant women and children caused by malaria
- *Nutrition:* to help reduce stunting and underweight in children
- *Cross-cutting/health systems strengthening:* including quality of care improvement; capacity-building and training; monitoring and evaluation (M&E), health management information systems (HMIS), and research; and health promotion, communication, and advocacy initiatives

MCHIP's MNCH interventions were guided by the MNCH priorities laid out in the National Health Strategy. MCHIP's activities were designed using the continuum-of-care approach, from the antenatal care period up to a child's fifth year of age, spanning the prevent-protect-treat continuum, and implemented at policy, health facility, and community levels.

MCHIP began work in Manicaland, a seven-district province with the highest under-five mortality rate reported in the country.¹ Over the life of the program, MCHIP extensively supported 22 health facilities in two learning districts in Manicaland (Mutare and Chimanimani) to deliver high-quality MNCH services, and scaled up immunization interventions across all seven Manicaland districts. MCHIP also supported various community-based activities throughout Manicaland, with a specific focus on strengthening the quality of community-based health services in Mutare and Chimanimani districts.

MCHIP/Zimbabwe worked hand in hand with the MOHCC and other partners to support activities at the national level as well as at selected provincial and district levels. MCHIP/Zimbabwe's strategic approach was guided by key principles, including: 1) scaling up proven, evidenced-based interventions; 2) maximizing resources through strategic integrated programming; 3) building on existing efforts of programs and partners; and 4) focusing on program learning.

Critical to the success of many of MCHIP's activities was the forging of key strategic partnerships within the Zimbabwean public health community. From 2010–2014, the MCHIP team built strong relationships and formed close collaborations with numerous departments/units within the MOHCC, as well as with other key partners and stakeholders, including other United States Agency for International Development (USAID)-supported projects and partners, nongovernmental and community-based organizations, other technical partners, and key professional societies and associations.

Through focused and consistent cooperation, coordination, and collaboration with these stakeholders, as well as strategic leveraging of resources for maximum efficiency, MCHIP realized several important program successes over the life of project. Life-of-project (LOP) performance is shown below for selected project indicators.

Summary of Life-of-Project Performance, by Key Project Indicator

KEY PROJECT INDICATOR	BASELINE (JANUARY–DECEMBER 2009)	LIFE OF PROJECT PERFORMANCE (OCTOBER 2010–MARCH 2014)	NOTES
Facility-based maternal mortality ratio	296/100,000 live births (data from 79 health facilities (HFs) in the 2 learning districts) (Jan–Dec 2009 data; source: MOHCC, 2009)	246/100,000 live births	Life of project (LOP) figure is from the two districts, Mutare and Chimanimani, representing the average over the period Oct 2010–Mar 2014. There were challenges in completeness of data at baseline.
Facility-based early neonatal mortality rate	63/1,000 total births (data from 79 HFs in the 2 learning districts) (Jan–Dec 2009 data; source: MOHCC, 2009)	37/1,000 total births	LOP figure is from the two districts, Mutare and Chimanimani, representing the average over the period Oct 2010–Mar 2014. There were challenges in completeness of data at baseline.
% of MCHIP Standards-Based Management and Recognition (SBM-R)-supported facilities achieving set target for maternal and newborn health (MNH) clinical standards	0% of HFs reached at least 80% of MNH standards	76% of HFs (13/17) reached at least 80% of MNH standards	LOP data figure is from the two districts, Mutare and Chimanimani, covering the period Oct 2010–Mar 2014 and represents performance measured in the August 2013 assessment.

¹ Zimbabwe Demographic and Health Surveys Key Findings 2010/11.

KEY PROJECT INDICATOR	BASELINE (JANUARY–DECEMBER 2009)	LIFE OF PROJECT PERFORMANCE (OCTOBER 2010–MARCH 2014)	NOTES
% of MCHIP SBM-R-supported facilities achieving set target for child health (CH) clinical standards	0% of HFs reached at least 60% of CH standards	71% of HFs (15/21) reached at least 60% of CH standards	LOP data are from the two districts, Mutare and Chimanimani, covering the period Oct 2010–Mar 2014 and represents performance measured in the 2013 assessment.
Number of pregnant women receiving first antenatal care (ANC) visit	17,215 (data from 79 HFs in the 2 learning districts) (Jan–Dec 2009 data; source: MOHCC, 2009)	68,021	LOP data are from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010–Mar 2014. There were challenges in completeness of data at baseline.
Number of pregnant women receiving at least four ANC visits (ANC 4+)	9,139 (calculated given 71% utilization rate for ANC 4+ reported in ZDHS* 2005/06, multiplied by ZIMSTAT† 2011 expected pregnancies for Mutare and Chimanimani)	65,518	LOP data are from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010–Mar 2014. There were challenges in completeness of data at baseline.
% of pregnant women receiving two doses of intermittent preventive treatment (IPTp2) for malaria during ANC	14% (Source: national estimate, MIMS‡ 2009)	52%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2011–Mar 2014.
Number of deliveries with a skilled birth attendant	10,460 (data from 79 HFs in the 2 learning districts) (Jan–Dec 2009 data; source: MOHCC, 2009)	47,484	LOP data are from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010–Mar 2014. There were challenges in completeness of data at baseline.
% of low birth weight newborns admitted in Kangaroo Mother Care (KMC)	0%	24%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2011–Mar 2014.
% of children less than 12 months of age who received 3 doses of the Pentavalent vaccine	52.1% (Source: Manicaland provincial estimate, ZDHS 2010/11)	94%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010–Mar 2014.
% of children less than 12 months of age who received measles vaccination	64.5% (Source: Manicaland provincial estimate, ZDHS 2010/11)	92%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010–Mar 2014.
<p>* ZDHS = Zimbabwe Demographic and Health Survey † ZIMSTAT = Zimbabwe National Statistics Agency ‡ MIMS = Multiple Indicator Monitoring Survey</p>			

KEY ACHIEVEMENTS

With the support of MOHCC stakeholders and other implementation partners, MCHIP/Zimbabwe facilitated major MNCH-related accomplishments during the life of the project. These included:

- **MCHIP/Zimbabwe served as a major catalyst for improved national policies in support of MNCH.** For example, MCHIP supported the updating, review, development, and/or finalization of several key MNCH policies and guidelines; mobilized/leveraged critically needed resources for priority MNCH activities at national and sub-national levels; and strengthened the leadership and stewardship role of the MOHCC at national, provincial, district, and community levels.
- **MCHIP/Zimbabwe raised national awareness of the importance of delivering high-quality health care services and improved the quality of MNCH care at district and community levels through implementation of quality improvement models.** On average, among the 22 MCHIP-supported health facilities in Mutare and Chimanimani districts, a majority met or exceeded quality of care standards for key MNCH interventions. In Mutare and Chimanimani communities, the quality of services provided by VHWs was also improved through implementation of an innovative community-based performance-quality improvement approach.
- **MCHIP/Zimbabwe introduced an innovative, skills-based training approach to improve effectiveness of MNCH clinical training.** MCHIP introduced a comprehensive MNCH training approach at provincial/district level, which emphasized acquisition of skills/competencies (not just knowledge) and included developing training materials, preparing trainers, and orienting MNCH supervisors to plan for and conduct post-training follow-up and to provide supportive supervision. Between 2010 and 2014, MCHIP trained nearly 3,500 health care workers at all levels in a wide variety of key MNCH topics.
- **MCHIP/Zimbabwe supported scaling-up of under-utilized and newer MNCH interventions in Manicaland.** MCHIP supported national-, provincial-, and district-level MOHCC stakeholders to introduce and/or revitalize several evidence-based, high-impact MNCH interventions including: KMC for managing low birth-weight babies; Helping Babies Breathe for newborn resuscitation; and Integrated Management of Newborn and Childhood Illnesses (IMNCI) for managing sick infants and children.
- **MCHIP/Zimbabwe supported revitalization of routine immunization in Manicaland and the introduction of new and under-utilized vaccines nationally.** MCHIP supported the Manicaland Expanded Programme on Immunizations unit to roll out the Reach Every District approach in all seven districts and supported successful national-level planning, introduction, and roll out activities for the new pneumococcal conjugate vaccine (PCV13) in 2012 and the rotavirus vaccine in 2014.
- **MCHIP/Zimbabwe strengthened integrated community-based MNCH.** At community level, MCHIP piloted a quality improvement approach that, for the first time in the history of community-level MNCH care, measured the quality of care provided by VHWs during ANC, postnatal care, and community case management for sick children and adults using a structured approach. Results from Chimanimani, where VHWs were included in the program, showed a statistically significant improvement in the quality of MNH care provided at community level when compared against VHWs who did not receive the quality improvement package.

- **MCHIP/Zimbabwe supported “program learning” activities, with results documented and dissemination plans under way by the project’s end.** Designed as a “learning project,” MCHIP identified a handful of priority operations-research-type topics early on in the project and developed standard program learning protocols for each. By early 2014, each of these studies had been completed and results were disseminated (or are being planned for dissemination) as appropriate.

It may not be possible to directly attribute health outcomes seen in Manicaland from 2010 to 2014 to MCHIP/Zimbabwe’s interventions, but some positive trends in maternal, newborn, and child health outcomes have been observed, including:

- Decreasing facility-based, early neonatal and intrapartum deaths per 1,000 births, by month, for the period October 2010 to March 2014 for the 17 SBM-R-supported facilities.
- Decreasing number of facility-based deaths among children under five years of age due to pneumonia and malaria: pneumonia-case fatality rates decreased from 7.4% in 2012 to 5% in 2013 and to 3% during January–March 2014. Case fatality rates from malaria decreased from 6.9% in 2012 to 1.6% in 2013, a 77% reduction. These gains coincided with the interventions supported by the project in scaling up IMNCI trainings, expanding quality-improvement activities for child health, introduction of PCV13, and the improvement in community case management for malaria by VHWs.
- There was a 25% reduction in the total number of severe pneumonia cases in Mutare and Chimanimani between 2011 and 2013, potentially related to PCV13 introduction in 2012 and other MCHIP-supported interventions at facility and community levels.
- The proportion of diarrhea cases in children under five with dehydration decreased from 11.8% in 2011 to 7.6% in 2012 and then to 6.5% in 2013, which might be due to early treatment in the community as well as expanded access to oral rehydration solution and zinc at MCHIP-supported facilities.

WAY FORWARD

Zimbabwe, while showing some encouraging data gains in combating mortality and morbidity, still has a long way to go to reverse the unacceptably high mortality levels among women and children under five. In early-2014, MCHIP/Zimbabwe will transition to a new three-year, USAID-funded associate award, and, as during the October 2010–May 2014 period, will continue supporting the Zimbabwe MOHCC’s MNCH efforts. During this next phase of the project, MCHIP/Zimbabwe will incorporate the following recommendations into its programmatic design.² The MCHIP team is confident that doing so will increase the odds of success in the future, with the ultimate project goal remaining improving the health of the country’s women, children, and families.

At National Level, Recommendations for MCHIP’s Way Forward Include:

- Continue to advocate for/support provision of high-level coordination for MNCH activities within the MOHCC to strengthen national-level strategic planning, coordination, and program implementation.

² Many of these recommendations originate from a USAID external evaluation that was conducted by USAID/Zimbabwe in late 2013.

- Continue to support the MOHCC’s efforts in developing key, evidence-based national policies, standards, guidelines, and training packages.
- Continue to advocate for a “beyond the numbers” approach to providing high-quality health care nationwide and assist the MOHCC to identify a single national approach to quality improvement.
- Advocate for inclusion and standardization of high-impact MNCH packages and competency-based training approaches in pre-service education curricula.
- Improve MNCH service integration by working with partners and providing technical support to MOHCC counterparts to ensure that current national ANC and postnatal care platforms are used to strengthen malaria in pregnancy, maternal nutrition and anemia, infant and young child feeding, PMTCT, and postpartum family planning/intrauterine contraception devices interventions.
- Continue to provide support to the MOHCC in the area of health information systems and M&E.
- Continue technical assistance and support for national MNCH advocacy, communication, and social mobilization activities.

At Provincial/District Level, Recommendations for MCHIP’s Way Forward Include:

- Improve, expand, and maintain facility-based MNH SBM-R activities in Manicaland, including:
 - Expand coverage of SBM-R activities to new districts to equip health workers to deliver evidence-based, integrated services that are humanistic, respectful, and client-centered.
 - Increase focus on provincial hospital and high-volume referral sites (i.e., non-learning site district hospitals in Manicaland). Prioritize all Manicaland district hospitals and Mutare provincial hospitals for additional targeted interventions.
 - Seek ways to simplify SBM-R tools/reduce the number of SBM-R performance standards/verification criteria without compromising the resulting quality of care. Adapt SBM-R tools such that they have a greater focus on the main causes of maternal and newborn mortality and morbidity (for example, greater focus on critical pathways).
 - Revise the SBM-R scoring system to make it less punitive and more encouraging.
 - Change the SBM-R approach such that participating health workers are recognized in an appropriate manner earlier in the process to increase motivation and retention.
 - Continue to revise/improve the SBM-R approach as piloted in Zimbabwe for child health, for example, make tools more responsive to changes in the quality of care delivered to children. Pilot new quality improvement tools to address quality of services provided to sick children at provincial/district hospital level. In addition, work with Mutare Provincial Hospital, specifically, to improve in-patient care for sick children.
 - Involve more partners and engage more policymakers in the quality improvement process to facilitate national-level adoption, scale-up, and rollout.
 - Test new ways to link quality of care improvements to maternal, newborn, and child mortality/outcome data.
- Prioritize support for districts with high maternal, newborn, and child mortality and morbidity, and within these, prioritize support for high-impact MNCH interventions and activities such as emergency obstetric and newborn care, KMC, Helping Babies Breathe, malaria case management, and Reach Every District.

- Continue to utilize a competency-based training approach for capacity-building at sub-national level, with a sustained emphasis on post-training follow up, on-the-job training, and supportive supervision.
- Continue to support strategic planning, coordination, data review/M&E, and evidence-based decision-making at provincial/district/facility levels. Continue focus on providing technical assistance to the MOHCC and seeking opportunities to leverage partner resources in order to amplify MCHIP's technical reach within the province/districts.

At Community Level, Recommendations for MCHIP's Way Forward Include:

- Scale up community-based child survival interventions (e.g., early care seeking for pneumonia, reducing indoor air pollution, community infant and young child feeding, malaria community case management, use of long-lasting insecticide-treated bed nets), in conjunction with strengthening health facility service provision. A key recommendation is to continue, refine, and expand the community performance-quality improvement approach to one or more additional Manicaland districts and further assess results in six to 12 months.
- Prioritize civil society capacity-building by partnering with local civil society organizations and strengthening their capacity to mobilize communities for improved knowledge about, access to, and utilization of MNCH services. Working with civil society organizations will foster further community engagement and facilitate sustainability and local ownership of community interventions.