

# A spotlight the Zimbabwe National Health Policy (2016-2020)

Takudzwa Bakasa

Bindura University of Science Education, Zimbabwe.

Email: takubakasa@gmail.com

Copyright © 2020 Bakasa. This article remains permanently open access under the terms of the [Creative Commons Attribution License 4.0](https://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Received 24th February, 2020; Accepted 6th April, 2020

**ABSTRACT:** This study examines the national health strategy employed by the Zimbabwean government for the period 2016-2020. The study is structured in a manner that it provides a conceptualisation of the issues under discussion then probes into the situation under which the strategy was adopted, the priority areas identified by the strategy in conjunction with the implementation strategy. The study also probes into the challenges that have constrained the implementation of the strategy thus far and highlights the recommendations under which Zimbabwe's health system may achieve its objectives. From a snapshot, the context involves transformation from a highly centralised, segregatory and urban based health care systems to a more equitable health care system with presence in rural communities. The priority areas under discussion include, communicable and non-communicable diseases, disaster preparedness, prevention and risk mitigation. The paper is a desk-based review of the Zimbabwe National Health Strategy as well as other government documents, academic literature, information published on audio-visual, paper-based and online media platforms. The use of key words was fundamental in conducting the study, and online articles dating back to 2016 were reviewed. In addition, academic literature was mainly used to discuss the broader public health context in Zimbabwe, during the period under review. From evidence gathered the article is inclined toward the view that the Government of Zimbabwe has lost track in the implementation of the ZNHS, and unless drastic measures are taken, the targets set-forth within the strategy remain far from being realised.

**Keywords:** Disaster, disease, health care, mortality, national health strategy, prevention, Zimbabwe.

## INTRODUCTION

Health policy gathers its definition from the umbrella concept of social policy. Social policy is defined as the intentional measures taken by the state to respond to both existing and forecasted social problems. Mutokosi (2015) defines health policy interventions as programme solutions to health problems. The National Health Strategy 2016-2020, is a four-year strategic plan adopted by the government of Zimbabwe to address challenges in health care, which have become so rampant. The plan coordinates socio-economic blueprints such as the Zimbabwe Agenda for Socio-Economic Transformation and Global Goals in the name of the Sustainable Goals in setting targets and contexts under which health care interventions will be carried out. The World Health Organisation (<https://www.who.int/about/who-we-are/constitution>) defines health as a state of physical, mental and social wellbeing and not merely the absence of disease and

infirmity. This definition is propounded by Nobile (2014) and Putera (2017) who independently imply that; health is a state characterized by anatomic, physiological, and psychological integrity which consequently translates to the ability to perform personally valued family, work, and community roles as well as the ability to deal with physical, biological, psychological, and social stress. Therefore, the objective of the research is to analyse the Zimbabwe National Health Strategy from 2016 to 2020. The analysis looks into the priority areas set forth within the strategy, basing on the extent to which they reflected the foreseeable comprehensive needs of Zimbabweans during the period of implementation. Furthermore, the extent to which structures have been set up to support the strategy is another object of analysis within this paper. This is based on the discovery often reiterated in literature that the government of Zimbabwe, like other African Govern-

ments make it a habit to gazette policy instruments, which are never followed up by adequate socio-economic structures and implementation acumen to facilitate the realisation of goals set within policy instruments. The result-based approach is the main theoretical framework utilised to support conclusions of analysis. This entails a pedantic approach which focuses on the linkages between inputs, activities and overall impacts realised in the implementation of programmes and projects under the auspices of the Zimbabwe National Health Strategy 2016-2020. The overall impacts of the strategy.

## ZIMBABWE NATIONAL HEALTH STRATEGY

In analysing the Zimbabwe National Health Strategy, one may find the background of the Zimbabwe national health system noteworthy: Health policies in colonial Zimbabwe were mainly segregatory and directed towards cementing colonial interests (Nyazema, 2010). Health provisions within the colonial era, placed black people at a disadvantage, therefore resulting in high mortality and morbidity amongst the native population. In response, the newly formed government adopted the plan for equity in health, 1980-1992. The plan was done so as to reduce inequalities in healthcare, and the focus of this plan was to make health care more accessible to formerly marginalised populations (Mutokosi, 2015). Therefore, health care was heavily subsidised and provided for free for those earning less than Z\$150, at the same time, medical centres were established in rural areas. Government expenditure on health was however cut short during the period 1992-1996 under the Economic Structural Adjustment Programmes (ESAPs). Following the realisation that the ESAPs caused more harm than good the government of Zimbabwe, employed several strategies to mediate the effects of ESAPs, these were embedded in National Health Strategies; 1997-2007; 2009-2013; 2014-2016. The national health strategy 2016-2020 forms the most recent health policy initiative developed by the Zimbabwean government to strengthen the health system. Furthermore, it is noteworthy that the National Health Strategy 2016-2020, was adopted in an environment in which the country had failed to meet Millennium Development Goals (MDGs) yet facing new targets under the Sustainable Development Goals (SDGs).

### Priority areas identified by the NHS

The first priority area identified by the NHS, 2016-2020 refers to communicable diseases. According to WHO (2011), a communicable disease is an illness caused by a specific infectious agent or its toxic products. It arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a

susceptible host, either directly or indirectly (through an intermediate plant or animal host, vector, or the inanimate environment). Therefore, it is an infectious disease, transmissible as from vector-person or person to person by direct contact with an affected individual or discharges or by indirect means. In the context of this priority area, the National Health Strategy 2016-2020 has a strong focus on a number of goals ranging from the prevention of malaria, diarrhoeal diseases (cholera and typhoid), tuberculosis and HIV/AIDS among other diseases. Targets set forth in this priority area include, the reduction of malaria incidence, from 39/1000 in 2014 to 5/1000 in 2020, and malaria deaths to Zero in 2020, reduce Schistosomiasis related morbidity by more than 50% and prevent new HIV infections at the same time reduce HIV related deaths by half. The commitment of the NHS to manage communicable diseases is iterated in various strategies concerning the timely detection and control of epidemic prone diseases. In order to achieve goals pertaining to the prevention of communicable diseases, the NHS 2016-2020, suggests a number of strategies chief among which is the strengthening of priority disease control programmes. This is also supported by the setup of public health surveillance systems for the early detection of risk factors leading to epidemics. In addition to this, the strategy also places emphasis on improving vector control through Indoor Residual Spraying (IRS) and use of Long-Lasting Insecticide Treated Nets in prevention of malaria and monitoring of water quality and hygiene promotion as well as screening of travellers at points of entry to prevent the spread of cholera.

The second priority of the NHS, 2016-2020, refers to non-communicable diseases (NCDs), which refer to a medical conditions or diseases that are non-infectious or non-transmissible (Costich, 2015). NCDs can refer to chronic diseases which last for long periods of time and progress slowly. Major NCDs in Zimbabwe resulting in rapid deaths include, heart diseases, stroke, cancers, diabetes, chronic kidney diseases, whilst prolonged illnesses include osteoporosis, Alzheimer's disease and cataracts. In relation to this priority area, the NHS emphasises the need to reduce the incidence of non-communicable diseases by half during the period of implementation. The strategy also aims to improve mental health outcomes among the general population, reduce disability and dependency by half and improve the quality of life especially for the elderly and consequently improve life expectancy from 61.5 years to 65 years in 2020. In attaining these goals, the national health strategy suggests the need to improve diagnosis and management of selected NCDs and promote reduction in substance abuse through multi-sectorial approach.

Moving on, the third pillar of the ZNHS focuses on health and nutrition at varying levels. The strategy focuses on reproductive health, maternal health, new-born, child and adolescent health. Goals set within this priority area include the reduction of maternal mortality ratio from 614

to 300 by 2020. Further goals include; the reduction of neonatal mortality from 29/1000 to 20/1000 live births, reduce under 5 mortality from 75 to 50 deaths per 1000. The strategy also seeks to reduce mortality, morbidity and malnutrition by half by 2020. According to this strategy the objectives are as follows; to increase early and continuous utilization of ANC services, to increase the consistent provision of quality ANC services. Kadzere (2017) maintains that in order to achieve this, there is need for advocacy and communication for maternal health services, to decentralize the services including infrastructure, health posts and community supplies especially in remote areas as well as strengthening job training, support and supervision and mentorship. Johnson (2014) maintains that in order to reduce maternal mortality, women should seek health services early. The ministry of Health and Child Care is progressing has managed to decentralize health services and they are using community health workers to disseminate information on ANC in the communities that pregnant women are encouraged to seek health services in their early months. Civil societies such as AIDS Counselling Trust are also conducting programs which provides knowledge on ANC so as to reduce maternal care. Thus, by so doing this will reduce the neonatal mortality since child survival interventions for essential new born babies will be increased. Thus, from the above, another component of third priority is to reduce maternal mortality.

In addition, reducing the under-five mortality is one of the major goals of the third priority area. Kadzere (2017) postulates that there is need for scaling up high impact child survival interventions for under-fives. Ministry of health and child care concurs that under-five mortality can be as a result of malnutrition, micronutrient, poor breastfeeding. According to ZNHS 2016-2020, this is to be done by strengthening IMNCI immunisations, ETAT, nutrition and Paeds ART. Nutrition can be defined as the organic process by which an individual assimilates food and uses it for growth and maintenance. Johnson (2014) maintains that a child can be underweight or overweight. Hence, the need to promote family focused behaviour change communication on appropriate adolescent, maternal and child care practices. From this, early initiation of breastfeeding and exclusive breastfeeding. Kadzere (2017) maintains that promotion of social and behaviour change on healthy lifestyles helps individuals to maintain the required weight. This entails eating a balanced diet and also giving room for exercise for physical fitness. Apart from this, the third priority includes sexual reproductive health for adolescents. On this, a number of civil societies has promoted sexuality education so as to reduce sexual risk behaviour among adolescents. Nundwe (2012) maintained that a number of parents in Africa has found it difficult to openly discuss issues of puberty with their children. Therefore, the Ministry of Health and Child Care has improved the availability of integrated youth friendly services, enhanced community level of awareness and

advocated for legislation against child marriages.

The fourth priority of the ZNHS of 2016-2020 is public health surveillance and disaster preparedness and response programme. According to the strategy, the goal is to contribute towards the creation of a safe and healthy environment through strengthening environmental health services in particular promotion of safe water, appropriate and adequate sanitation food and personal hygiene. The objective of this priority is to improve management of waste that is solid, liquid, chemical, radiation and noise and reduces pollution in order to have an environment which is healthy which can guarantee fewer disasters. According to Kadzere (2017) the strategy of the priority 4 is to strengthen waste management systems and improve environmental hygiene through environmental awareness programmes and promote water treatment and waste management tools. This helps in the promotion of health in individuals and help to prevent and mitigate disasters in the country. However, due to the cholera outbreak of 2018 it can be critiqued that the priority 4 of the ZNHS was not fully implemented if not at all. Dickson (2018) and Matswetu (2018) independently imply that the cholera outbreak in Zimbabwe in September 2018 was largely caused by untreated water and uncollected waste in the towns just as the one in 2008.

Apart from the above, the ZNHS of 2016-2020 talks about service delivery platforms and entities. At this section it focuses on the primary care services and hospital services. The goal is to reduce morbidity through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level and also to ensure access and provision of complementary package of emergency and ambulatory curative services. The primary care services should be strengthened to ensure community participation, improving support and supervision and also improve the care facilities (Kadzere, 2017). This will help to reduce morbidity in primary care services and increase quality service delivery which will promote the health of the people. Also monitoring of hospitals boards and ensures efficient equitable allocation of available resources is essential since it will help in the delivery system. Therefore, the ZNHS is concerned with the health facilities and improve their quality in order to promote good health to the people in the country.

The National Health Policy seeks to promote enhanced health wellbeing through the promotion of an enabling environment. An enabling environment entails a conducive environment made up of ethical considerations, assisted financial medical schemes to the vulnerable, and a comprehensive multisectoral approach as an intervention to responding to challenges faced in service delivery. This also includes mainstreaming gender and disability sensitivity in health facilities and service delivery. The goal of this priority is to improve health outcomes through facilitation and co-ordination of an effective and efficient health delivery system. Ethics such as informed consent,

confidentiality and regard of importance of human dignity are some of the tools enhancing the creation of an enabling environment. Access to health services is heightened by an environment that has some established staff management personnel with roles and responsibilities well defined within health policies. The enabling environment also re-enforces risk management processes of resources for health such as performance audits to foster accountability and transparent service delivery that is egalitarian as proposed by the National Health Strategy. The National Health Strategy is a bedrock promoting a conducive environment for health delivery and coordination.

### Evaluation of the Implementation of the ZNHS

The implementation environment of the ZNHS is of particular interest. This is because the strategy has been implemented by two separate administrations, with the latest claiming to have shed off characteristics of the last. When the ZNHS was first in 2016, it was supported by one of the best and well-rounded policies the then Zimbabwean Government had ever come up with, the "Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET)". In a not so surprising move, the incoming administration scrapped off the ZIMASSET and set up the Medium Term Plan 2017-2020, which emphasised a transformative agenda for Zimbabwe. Therefore, the successes or shortcoming of the ZNHS are largely influenced by these policy contexts. It is also worth mentioning that during the period of implementation, the country changed its health minister who was directly involved in the development of the strategy, for one who had to and is still grappling with questions toward his credentials and suitability to run the ministry.

Zimbabwe has had mixed progress in dealing with communicable diseases over the recent years. The country has made tremendous strides in the fight against malaria. Sande et al. (2017) aver that Zimbabwe has engaged in intensive efforts to eliminate malaria since 2003, and the results of such intensive efforts have begun to show. Vector Control Programmes and IRS protection has increased from around 26-28% in 2003 to 95% in 2015 (Sande et al., 2015) and this has further increased in 2019. This is further supported by Tapera (2019) who argues that the utilisation of other control measures such as the long-lasting insecticidal nets (LLIN) had increased among household in malaria prone areas, thus demonstrating the positive impact of the ZNHS. However, communicable diseases remain among the top causes of mortality in Zimbabwe, HIV/AIDS is the leading cause of death within the country (Centre for Disease Control, 2019) despite resources being pooled to fight this pandemic. Kharsany and Karim (2016) explain that HIV/AIDS has remained a problem in the country mainly because the provision of free ART has not yet reached a universal status, rather roughly

84% of those in need have been receiving ART. Furthermore, the country faces a trend whereby a generation of consisting of many children born with HIV/AIDS are reaching the adolescence stage, leading to peer to peer transmission through sexual experimentation. Furthermore, the CDC (2019) highlights that tuberculosis and diarrhoeal diseases remain among the major causes of mortality within the country. Against this background, one may argue that the investment of tremendous effort is called for if the country is to realise the goals set forth in the ZNHS by the end of 2020.

The country has also made great strides in the reduction of non-communicable diseases. However, they remain among the top causes of mortality within the country. According to data from the CDC (2019), ischemic heart disease is among the top 5 causes of mortality in Zimbabwe, followed by stroke and protein-energy deficiency. The ZNHS also sought to improve the general mental health of Zimbabweans, however Dlodlo (2019) highlights that mental health outcomes among people in the country have been worsening. This can be largely attributed to harsh economic conditions which have exposed individuals to the pre-conditions of stress, anxiety and depression. Further, evidence showing that the mental health status of the country is declining is shown in the increase of suicide cases within the nation. Pembere (2019) highlights that the increase in suicide cases across the country may be as much as 42%, having highlighted that in the first three months of 2019 a total of 129 cases of suicide were reported as opposed to 91 during the same period in the previous year. This demonstrates that the country still has a long way to achieve the set goals. Furthermore, in terms of the third priority area, data from UNICEF (2019) indicates that under-five mortality in Zimbabwe has been decreasing from 54.3 in 2015 to as low as 46.2 in 2018. This is further supported by data from Geoba (2020) which indicates that Zimbabwe's under five mortality stood at 37.61 per 1000 live births in 2019. Furthermore, the Multiple Indicator Cluster Survey (2019) in Health Times (2019), indicates a 24% decrease in maternal mortality in Zimbabwe, dropping from 614 per 100,000 live births in 2014 to 462 per 100,000 in 2019. Nevertheless, the mortality rate remains quite high, and way behind the target set forth within the ZNHS (to reduce maternal mortality rate to 300 per 100,000).

### Shortfalls within the Zimbabwe Health System

Shortfalls remain persistent within the Zimbabwe Health System despite the adoption of the ZNHS 2016-2020. During the period 2016-2018, the country has battled several diarrhoeal disease outbreaks ranging from dysentery to typhoid. On the 6th of September, the Zimbabwe Ministry of Health and Child Care, confirmed a cholera outbreak, which was then declared as a state of emergency five days later (WHO, 2018). The Zimbabwean

Government was quick to acknowledge that it did not have the capacity to deal with the outbreak, for it did not have funds set aside for disaster reduction, thus began a process of establishing a pooled fund for disease control. The international donor community, local non-governmental organisations and enterprises have been leading the charge against the outbreak. Burke (2018) states that cholera is a medieval disease which does not have a place within modern society. The cholera outbreak proved the fallacy of the surveillance and disaster reduction aspects of the strategy. This proved that community health risk assessments were not being conducted, therefore in as much as the policy has many provisions on paper, they are not being put into practice.

Furthermore, corruption has crippled most of Zimbabwe's institutions and this is quite notable within the health sector. Corruption refers to the abuse of public office in pursuit of self-interests. Mudzingwa, (2018) highlights that Zimbabwe is ranked 158 out of 190 countries on the global corruption index. Corruption within the health sector has led to many citizens being robbed of opportunities to access the best possible care. Laiton (2014) highlights a growing trend at government hospitals where doctors are conspiring with other medical staff to move medicines and other medical equipment to their private surgeries. Therefore, at the end of the day government hospitals are stripped off their capacity to provide access to medication for the public. Furthermore, Kidia (2018) notes that corruption has led to Zimbabwe being a pariah state, isolated from the rest of the world. This has had implications in the extent to which the country receives development aid. Most donor societies have begun to shun the Zimbabwean government, as they have realised that most aid is embezzled for private use or misrepresented for political leverage. This has fundamentally reduced the extent to which the health sector in Zimbabwe has been open to funding opportunities. To make matters worse, Bräutigam and Knack (2004) also note that it is extremely difficult to get African governments to agree to implementation guidelines set forth by donor organisations. Resistance is often faced when funding partners try to enforce value for money programming and impact oriented-results frameworks. The Zimbabwean Government is no exception, and this has limited the extent to which the health sector in Zimbabwe has received support.

In addition, during the year 2017, major and the majority of medical aid societies were entangled in a scandal in which they were accused of taking advantage of the populace, by advertising benefits which would then never materialise. This negates the ideals set forth by the NHS 2016-2020 in which it drives for universal medical through the use of medical aid societies. Furthermore, the embezzlement of funds by government officials has left the health sector among other sectors in a dilapidated state. The Zimbabwean Government appears to have misplaced priorities upon which it purchases vehicles for ministers

and service chiefs whilst the health sector is in distress. The MoHCC declined the initial allocation of US\$408 million to the health sector citing it as insufficient and not even close to 15% of the annual budget as reinforced by the Sustainable Development Goals. Katongomara (2018) notes that the health budget was later revised to US\$520, which nevertheless remains significantly below the estimated US\$1.1 billion needed to revitalise the health sector. In 2018 Zimbabwe also experienced a major strike by junior doctors and nurses demanding a raise in their allowances as well as protesting over the lack of basic medication in their institutions. Therefore, the fact that the nation's health sector is underfunded, defeats the effectiveness of the national health strategy 2016-2018. The recommendation would be fight against corruption, pursue human development and create an enabling environment for the pursuit of positive health outcomes.

Population dynamics within the Zimbabwean landscape have also proved to be a hurdle in the implementation of the ZNHS. In 2012, a census conducted by the Zimbabwe Statistical Office ZIMSTAT indicated that Zimbabwe has a population of 14 million of which the majority of the population lives in rural areas. The fact that most Zimbabweans live in rural areas has a dual implication to the ZNHS. First, most people in rural areas are unaware of the existence of the policy framework, and are even more ignorant of issues relating to health insurance, which the policy purports to be the key strategy toward achieving universal health coverage in Zimbabwe. In addition, the population in rural areas if not ignorant of health insurance, sees no use in having health insurance, as most live far from health institutions. Against this background, the use of alternative medicine has remained rampant in rural areas. Furthermore, demographic information in Zimbabwe indicates that 95% of the population within the country is without employment, therefore access to medical aid or comprehensive health insurance policies is elusive. Most people within the country's towns live on a hand to mouth basis, whilst the majority live in rural areas. Those living on a hand to mouth basis do not have the financial resources to engage health insurance service providers and neither do they see health insurance as a priority.

## CONCLUSION

In a nutshell, the Zimbabwe National Health Strategy is a comprehensive policy document which seeks to address the major health challenges which the country has been facing. The strategy is oriented towards the principles of the Alma Ata declaration in that it sees the attainment of primary health care as the major area of intervention so as to promote positive health outcomes among the populace. The study has focused on discussing the priority areas set forth by the strategy, which include, communicable and non-communicable diseases, reproductive, maternal, new

born, child and adolescent health as well as public health surveillance and disaster preparedness and response. The interventions proposed by the strategy are centred around the theme 'equity and equality in health care; leaving no-one behind, thus demonstrating inclinations towards universal access principles set forth in the Alma Ata declaration as well as the sustainable development goals. The foregoing study has also highlighted that although the strategy looks good on paper, its practical implementation is hindered by the lack of political will, corruption and the lack of capacity.

## CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

## REFERENCES

- Bräutigam, D. A., & Knack, S. (2004). Foreign aid, institutions, and governance in sub-Saharan Africa. *Economic Development and Cultural Change*, 52(2), 255-285.
- Burke, J. (2018). 'Medieval' cholera outbreak exposes huge challenges in Zimbabwe. Retrieved 12th November, 2018 from <https://www.theguardian.com/global-development/2018/sep/20/medieval-cholera-outbreak-exposes-zimbabwe-problems>.
- Centre for Disease Control (CDC) (2019). *Global Health- Zimbabwe*. Retrieved from <https://www.cdc.gov/globalhealth/countries/zimbabwe/default.htm>.
- Costich, J. (2015). PHSSR findings on 21st century approaches to communicable disease. *Frontiers in Public Health Services and Systems Research*, 4(3), 51-54.
- Dickson, M. (2018). Threats and Problems on Public Health: The Case of Zimbabwe's Harare CBD and the Inner-city. *International Journal of Public Health & Safety*, 3(4), Article 168.
- Garusa, T. (2019). *Zimbabwe records decrease in infant mortality rate*. New Zimbabwe. Retrieved from <https://www.newzimbabwe.com/zimbabwe-records-decrease-in-infant-mortality-rate/>
- Geoba (2019). *Zimbabwe- selected rankings 2019*. Retrieved from <http://www.geoba.se/country.php?cc=ZW&year=2019>.
- Health Times (2019), *Zimbabwe's maternal mortality rate drops*. New Zimbabwe. Retrieved from <https://www.newzimbabwe.com/zim-maternal-mortality-rate-drops/>
- Johnson, M. A. (2004). Hype and hope about foods and supplements for healthy aging. *Generations*, 28(3), 45-53.
- Kadzere, T. (2017). *An over-view of Zimbabwe National Health Strategy 2016-2020*. Zimbabwe Ministry of Health and social welfare.
- Katongomara, A. (2018). *Health Budget Increased*. Retrieved 18th November, 2018 from <https://www.chronicle.co.zw/health-budget-increased>.
- Kharsany, A. B., & Karim, Q. A. (2016). HIV infection and AIDS in sub-Saharan Africa: current status, challenges and opportunities. *The open AIDS Journal*, 10, 34-38.
- Kidia, K. K. (2018). The future of health in Zimbabwe. *Global health action*, 11(1), Article 1496888.
- Laiton, C. (2014). *Four nurses 'steal drugs', operate private clinic*. Retrieved 13th November, 2018 from <https://www.newsday.co.zw/2014/10/4-nurses-steal-drugs-operate-private-clinic/>
- Matswetu, P. (2018). *An assessment of knowledge, attitudes and practices related to typhoid and its management strategies in Mbare high density suburb in Harare, Zimbabwe* (Doctoral dissertation, BUSE).
- Mudzingwa, F. (2018). *Zimbabwe one of the hardest places to conduct business on earth: Zimbabwe more corrupt than Nigeria*. Retrieved 12th November, 2018 from <https://www.techzim.co.zw/2018/06/zimbabwe-one-of-the-hardest-places-to-conduct-business-on-earth-zim-more-corrupt-than-nigeria>.
- Mutokosi, L. (2015). *Major health policy interventions in post-independent Zimbabwe*. Harare; University of Zimbabwe.
- Nobile, M. (2014). The WHO definition of health: A critical reading. *Medecine and Law*, 33 (2014) 33
- Nundwe, C. S. (2012). *Barriers to communication between parents and adolescents concerning sexual and reproductive health issues: A case study of Kinondoni Municipality, Tanzania*. Muhimbili University of Health and Allied Science; Tanzania.
- Nyazema, N. Z. (2010). The Zimbabwe crisis and the provision of social services: Health and education. *Journal of Developing Societies*, 26(2), 233-261.
- Pembere, K. (2019). *Suicide cases reach alarming rates in Zimbabwe*. Health Times. Retrieved from <https://healthtimes.co.zw/2019/06/21/breaking-suicide-cases-reach-alarming-rates-in-zim>.
- Putera, I. (2017). Redefining health: Implication for value-based healthcare reform. *Cureus*, 9(3), e1067.
- Sande, S., Zimba, M., Mberikunashe, J., Tangwena, A., & Chimusoro, A. (2017). Progress towards malaria elimination in Zimbabwe with special reference to the period 2003–2015. *Malaria Journal*, 16(1), 295.
- Tapera, O. (2019). Determinants of long-lasting insecticidal net ownership and utilization in malaria transmission regions: evidence from Zimbabwe Demographic and Health Surveys. *Malaria Journal*, 18, Article number 278.
- UNICEF (2019). Country profiles- Zimbabwe- Key demographic indicators. Retrieved from <https://data.unicef.org/country/zwe/>.
- WHO (1946). Constitution of the World Health Organization. Retrieved from <https://www.who.int/about/who-we-are/constitution>.
- WHO (2011). *World Health Organization's guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries*. Geneva, WHO.
- WHO (2018). *Cholera – Zimbabwe*. Retrieved from <https://www.who.int/csr/don/20-september-2018-cholera-zimbabwe/en/>