By 30 May, the cumulative number of cases reported with cholera stood at 98,424 and 4,276 deaths*. On the whole the outbreak continues to take a downward trend, with the cumulative crude case fatality rate now down to 4.3%. 61.4% of the deaths reported occurred outside health facilities. 89% of the districts and all 10 provinces have reported cholera cases.

This week (22) 60 cases and 1 deaths were reported compared to 140 cases and 2 death during week 21.

Harare accounted for about 41 (60.3%) of the cases reported. Matabeleland North and South reported no new cases for the eighth cumulative week and Bulawayo for the fifth cumulative week.

The number of districts submitting daily reports declined from 97.7% during week 21 to 85.2% this week. Mberengwa and Gokwe North districts and Masvingo province had poor compliance in terms of reporting this week. Mudzi and Mt Darwin both back reported cases this week, 12 and 1 respectively.

The cholera command and control centre (C4) has pre-positioned cholera kits in 8 provinces and 57 districts (see the map below). The C4 is gathering information about cholera supplies available to other agencies/NGOs in order to enhance outbreak preparedness plans.

* A number of cholera deaths were denotified by districts, hence a lower figure in this bulletin compared to the previous one.
Community Based care of mothers and newborns: by Shelly E Chitsungo, Specialist Maternal and Newborn Health, UNICEF

One of the indicators that best reflect a country’s state of health is its child mortality rate (deaths of children under 5 years of age per 1,000 live births). In this respect the Millennium Development Goal (MDG) number 4 calls for the reduction of mortality among children below five years by two thirds (2/3) by 2015. In order to achieve this goal and considering death within the first month of life accounts for almost half of all child deaths each year, there is need to design special programmes and materials for providing essential care to mothers and newborns in health facilities and in the community.

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery therefore early and quality post natal care is important for both the mother and the newborn to treat complications arising from the delivery as well as to provide the mother with important information on how to care for herself and her baby. Mothers who deliver in health facilities are sometimes discharged as early as six hours post natal due to inadequate human and material resources.

In Zimbabwe, the current practice is to provide immediate post natal care to mothers and babies following institutional delivery and then follow them up ten days later. It was noted in the 2005-6 Zimbabwe Demographic and Health Survey (ZDHS) that 45% of mothers did not receive a post natal check up, with only 30% of mothers receiving a Post Natal Checkup (PNC) within the first 48 hours after delivery. The mother and baby therefore have no care and support during for the first 7 days after birth when most maternal and neonatal deaths occur.

Maternal and neonatal mortality can be reduced by community based interventions delivered through non midwife community based workers. Since hospital care is limited and sometimes not available to parents, new born care can be provided at home through linkages with community based Integrated Management of Childhood Illnesses (iMCI) and by training community based workers on specific mother and newborn home based care practices. The main interventions would be support for the family and community based new born care through home visits to support for, optimal feeding, thermal care, cord care and early recognition of complications and referral.

Guided by the Maternal and Neonatal Health Roadmap for Zimbabwe (2007-2015) and informed by the Zimbabwe Maternal and Perinatal Mortality Study (2007), UNICEF is supporting initiating evidence based and integrated low cost interventions that help reduce maternal and neonatal morbidity and mortality at community level with effective referral for clinical management. The innovation is to explore and extent the continuum of maternal and neonatal care which have always been health facility based from the health facility to the community and household level, with effective referral for medical care for sick mothers and neonates. Furthermore scaling up interventions with the highest effect on reducing neonatal deaths will reduce maternal deaths resulting in progress towards MDG 5.

The Ministry of Health and Child Welfare is leading the implementation of the programme with technical guidance from UNICEF, in collaboration with UNFPA and WHO. Partnerships have been formed with community based NGOs such as Zvitambo and Goal Zimbabwe in mobilizing communities for safe motherhood initiatives. The programme is being implemented in 10 districts with plans for a rapid scale up into a national programme. Strengthening of emergency obstetric and neonatal care and improving the overall quality of maternal, neonatal and child health services will be supported as part of the programme.

Some of the objectives of the programme are to:

1. Train community based workers on community management of the mother and the newborn, home based care of the premature and low weight babies, support for initiation of early feeding including exclusive breastfeeding where appropriate, management of neonatal illnesses and referral for mothers and newborns that are sick.

2. Conduct health education for mothers and other significant others like grandmothers and traditional birth attendants on appropriate newborn care

Through a consultative process, the community based care programme for mothers and newborns is being implemented within the broad context of primary health care and Village health Workers (VHW) have been identified as the community based worker who will implement the programme. The VHW be capacitated to provide essential maternal and newborn care at community level.
A community based maternal and neonatal care training module which will be an addendum to the Village Health Worker Training manual has been developed and will be used in the training of VHW in community based care of mothers and newborns. A generic Community based care of mothers and newborns manual for community based workers has also been adapted to be used by VHW as reference material in the field. A total of 54 trainers from 11 districts have participated in a community based care for mothers and newborns Training of Trainers Workshop to enable them to train VHW in the new concepts. UNICEF is in the process of procuring essential equipment and supplies for VHW and these include weighing scales, thermometers, torches and visibility items for VHW. It is anticipated that all the ten districts will start training VHW mid June 2009. The training will focus on pregnancy and danger warning signs, delivery and the first week of life after delivery.

Monitoring and evaluation for the community based care for mothers and newborns programme will be linked to existing health information systems and specific indicators relevant to monitoring neonatal health care services been identified. Best practices in integration identified during monitoring and evaluation will be documented to capture critical incidences and experiences which would be used in scaling up services.

Adolescent Sexual Reproductive Health (ASRH) in Zimbabwe: an overview
By Dr. T. Kanyowa (WHO), T. Chinhengo (UNFPA)

Worldwide it is acknowledged that the sexual and reproductive health needs of adolescents differ from those of adults, and remain poorly understood and inadequately served in many parts of the world. Addressing the needs of young people, and promoting healthy sexual and reproductive development, maturation and behaviour, undoubtedly represent a considerable challenge for many countries.

According to the Zimbabwe Demographic and Health Survey of 2005-6, the HIV prevalence rate stands at 18.1%, while the maternal mortality ratio is estimated at 555 deaths for every 100,000 live births. The country is also faced with growing levels of unwanted teenage pregnancies and abortions, and the burden of Sexually Transmitted Infections remains high. Approximately 50% of HIV infections are occurring during adolescence and young adulthood, with girls and young women being especially vulnerable. The major vector for HIV transmission to the young generation is sex between young women and older men (5+ years older). HIV prevalence (ZDHS ’05) in the 15 - 19 age group is: F 6.2% and M 3.1% and in the age group: 20 - 24: F 16.3% M 5.8%. Only 36% of sexually active married girls in the age group 15-19 use any form of modern contraception method.

According to the UNFPA/UNICEF/WHO Framework for action (1995), the main health needs for adolescents and youth are:

- Information and Life Skills
- Services and Counselling
- Safe and Supportive environment
- Opportunities to contribute and participate

Providing young people with sexual and reproductive health information and services is therefore key to enable them to make well-informed choices about their reproductive health and decrease their risk of HIV infection. Efforts to increase the availability of reproductive health and HIV prevention services, such as access to family planning methods, treatment for STIs and VCT need to be combined with IEC activities that aim to increase young people’s awareness and demand for services. Furthermore, youth participation in planning for their needs has been recognized as paramount in the endeavour to improve ASRH.

In the public sector, the Zimbabwe National Family Planning Council has been providing ASRH services in 16 districts around the country. It has also been noted that the response to ASRH needs has been varied due largely to many players responding in their own unique ways, in an uncoordinated manner. The country is making efforts to improve this response.

A forum of key stakeholders in adolescent sexual and reproductive health (ASRH) has therefore been established to provide a coordinated approach to ASRH. The forum will serve to improve effective and efficient ASRH programme implementation to secure the right of young people to good sexual and reproductive health. The ASRH Coordination forum will be closely linked to the already existing National Reproductive Health Steering Committee.
The Strategic Partnership Programme (SPP) is collaboration between UNFPA and WHO to improve the quality of sexual and reproductive health care through utilization of consensus-driven, evidence-based practice guidelines. It was established in 2003 and launched in the African Region in September 2004.

Zimbabwe among the seven (7) countries of intensified focus in the region, together with Benin, Cameroon, Nigeria, South Africa, United Republic of Tanzania and Zambia. The country Zimbabwe participated in the SPP Regional launch meeting in Tanzania in 2004, and following that meeting, decided to update Sexually Transmitted Infections (STI) and Family Planning (FP) Guidelines.

The following were the reasons for adapting/updating STI & FP Guidelines;
- FP guidelines had not been reviewed regularly
- STIs trend was going downward but the burden remained high
- Contraceptive prevalence rate (CPR) then was 53%, with an unmet need of 13%
- HIV and AIDS prevalence rate (PR) then (24.6%) was still very high

The strategy will also effectively be a resource mobilisation document and thus forms the backbone to the successful response to key ASRH issues in the country.

Strategic Partnership Programme in Zimbabwe
by Dr T. Kanyowa (WHO: NPO/CAH)

The Strategic Partnership Programme (SPP) is collaboration between UNFPA and WHO to improve the quality of sexual and reproductive health care through utilization of consensus-driven, evidence-based practice guidelines. It was established in 2003 and launched in the African Region in September 2004.

The strategy will focus on five thematic areas:
- Policy and advocacy
- Service provision
- Life skills and Livelihoods
- Co-ordination
- Monitoring and evaluation, and research

The strategy will also provide guidelines to policy makers, various line ministries, non-governmental organisations and communities, and defines their roles and responsibilities in providing SRH services to young people. This strategy is going to be implemented in line with the National Health Strategy, the Maternal and Neonatal Health Road Map (2007 - 2015), National Reproductive Health Policy, National Reproductive Health Service Delivery Guidelines, Zimbabwe National HIV & AIDS Strategic Plan (ZNASP 2006-2010) and the Sexual and Reproductive Health Strategy for the SADC Region: 2006 - 2015, among others.

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2. Advocacy meeting with senior managers and key stakeholders to introduce the revisions and agree on the changes to be made. Technical group then carry out adaptations to existing national guidelines.

**STI Guidelines**

1. Step by step reviewed general information on syndromic treatment, training manual, guidelines on male and female examination, flow charts of different Syndromes
2. Reviewed Zimbabwe flow charts and incorporated information from WHO guidelines
3. Adopted first choice treatment from WHO and adapted Zimbabwe choice of drugs as effective substitutes. Added some conditions e.g. pubic lice, which are not in WHO guidelines

**Family planning guidelines**

Adopted WHO eligibility criteria
- A condition for which there is no restriction for the use of the contraceptive method.
- A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- A condition which represents an unacceptable health risk if the contraceptive method is used.
- Other methods not currently available e.g. combined injectable contraceptives, patch were also included

The STI guidelines have already been printed and disseminated for use. Printing challenges in the changing economic environment resulted in failure to have the Family Planning guidelines printed. This challenge needs to be overcome before implementation of the new guidelines by service providers.

**Outstanding activities**

- Printing of family planning guidelines
- Training of service providers
- Review RH guideline incorporating the updated FP and STI guidelines

**Lessons learnt and recommendations**

There is need for active mobilisation of resources to ensure adequate programme implementation

It is important to work in collaboration with other programmes/units to maximize on resources

**Partnerships fostered**

Partnership has been fostered between the following:

1. Ministry of Health and Child Welfare
2. UNFPA and WHO
4. City Health Departments
5. City of Harare Health Services Department

The following are targeted to come on board;
- Zimbabwe Medical Association
- Zimbabwe Nurses Council
- Population Services International (PSIZ)
- National Aids Council
- Other partners, i.e. USAID, UNICEF, UNAIDS

**Conclusion**

Zimbabwe is grateful for the support from WHO/UNFPA for the assistance given in establishing the SPP. The national STI guidelines have been produced and are in use. The country hopes to be able to print the Family Planning guideline and disseminate for implementation at service provider level.

**Update on social mobilization working group epidemic preparedness & response activities**

As part of their remit, the joint health-WASH social mobilization working group is carrying out community health promotion with an emphasis on putting in place community epidemic preparedness and response mechanisms.

In order to do this, trainer of trainer workshops were planned for health promotion focal persons at provincial level. Two workshops were carried out, in Harare for the Northern Provinces and Bulawayo for the southern ones.
Between 29 April and 31 May, 400 resource persons were trained at district level (all districts) in the following provinces: Matabeleland North and South, Masvingo, Mashonaland Central, Midlands, Manicaland, Mashonaland East and West.

In order to further support community epidemic preparedness and response mechanisms, the working group is strongly advocating for the revitalization of the village health worker (VHW) program. This shall include the following activities: updating of training modules, carrying out an inventory of existing VHWs, selecting and training the VHWs and the provision of kits which shall include antiseptic, bandages, analgesics, condoms, personal protective equipment, Oral Rehydration Salts, scales, Mid Upper Arm Circumference (MUAC) Tapes, Antimalarials, Information Education and Communication (IEC) materials, reporting forms/record books and pens/pencils. Discussions between the working group, Ministry of Health & Child Welfare and other stakeholders regarding revitalization are underway.

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Please send contributions for next edition by COB on each Wednesday to Ida-Marie Ameda at amedai@zw.afro.who.int

For more information on the cholera outbreak, see the WHO and OCHA websites listed below:
http://www.who.int/hac/crises/zwe/en/

More information on the Health Cluster may be accessed online at;

### Donor response to the cholera crisis

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