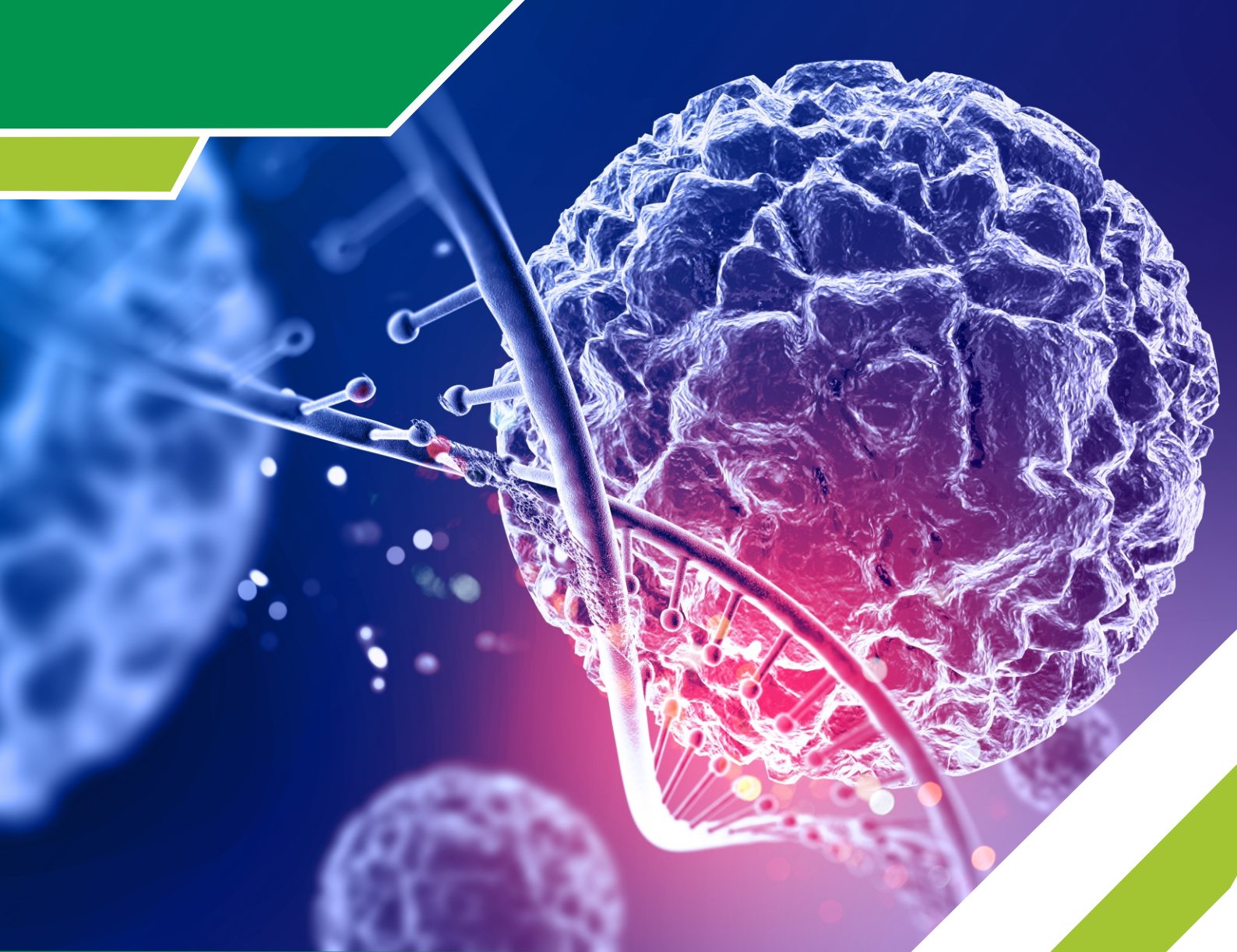




MINISTRY OF HEALTH AND CHILD CARE

National Cancer Control Plan

2025 - 2030





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National Cancer Control Plan

2025 - 2030

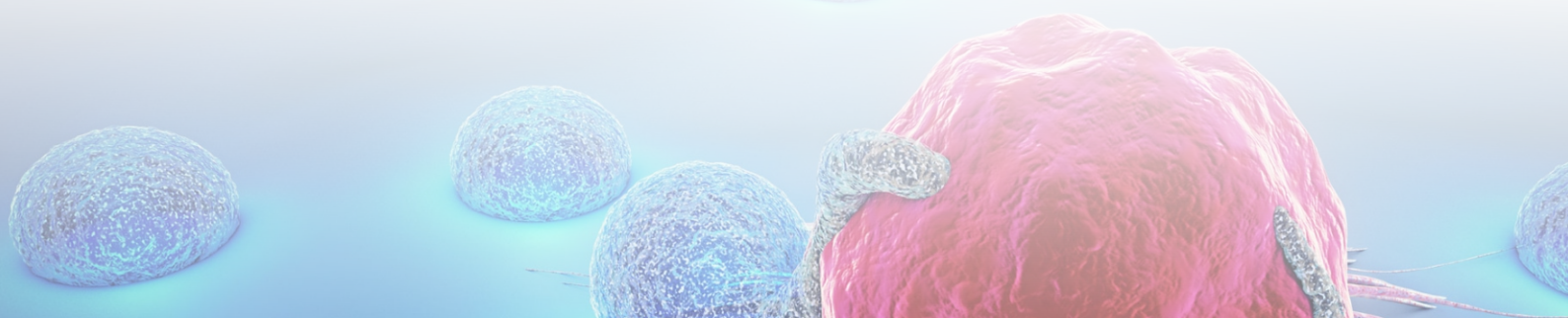


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FORWARD

In Zimbabwe, the Health Sector is guided by the National Health Strategy (NHS) 2021-2025. The NHS feeds into the Health and Wellbeing Thematic area in the National Development Strategy (NDS). The vision of the NHS is to have “The highest possible level of health and quality life for all citizens and permanent residents of Zimbabwe by 2030”.

There has been a growing burden of non-communicable diseases in Zimbabwe, notably cancer. According to the Zimbabwe National Cancer Registry (ZNCR), Zimbabwe has registered over 7000 new cancer cases annually since 2014. To address the growing cancer burden, the National Cancer Control Plan (NCCP) is aligned with the national priorities highlighted in the NHS and advocates for a comprehensive cancer control policy and programme. The plan has also been aligned to the Sustainable Development Goals (SDGs) and global cancer initiatives for priority cancers.

Cancer prevention and control requires a population-wide integrated and cohesive approach that encompasses prevention, early detection, diagnosis, treatment, palliative and rehabilitative care. This calls for strong political commitment, technical, and practical leadership as well as significant investment in terms of infrastructure, equipment, human resources, technologies, medicines, and vaccines. The NCCP seeks to reform and re-organise the way cancer services are delivered in Zimbabwe, to ensure equitable and accessible quality cancer services. It is envisaged that this will address the fragmentation of cancer services in line with the Coordination Framework for the Health Sector and consequently reduce the burden of cancer in the country.

My Ministry will not leave anyone and no place behind without access to quality cancer control services towards attaining the SDG3 targets by 2030 and the ultimate vision of achieving Universal Health Coverage. I would therefore urge our health development partners and relevant stakeholders including the private sector to rally behind and complement the Government of Zimbabwe efforts in reducing the cancer burden in the country.

Hon. Dr. D.T. Mombeshora (MP)



Minister of Health and Child Care.

This National Cancer Control Plan (NCCP) 2025-2030 updates the National Cancer Prevention and Control Strategy (2014 -2018). The success of putting together this strategic document was a result of wide consultation, dedication and coordinated efforts of the various stakeholders in the health sector.

I would like to applaud the Ministry of Health and Child Care (MoHCC) directorates and the subnational levels who came together throughout the development process to ensure this document became a reality. Appreciation is extended to our development partners, Non-Governmental Organisations (NGOs) and Associations namely World Health Organization (WHO), International Atomic Energy Agency (IAEA), International Agency for Research on Cancer (IARC), United Nations International Children's Emergency Fund (UNICEF), World Bank, United Nations Population Fund (UNFPA), Clinton Health Access Initiative (CHAI) and Bristol Myers Squibb Foundation through Jointed Hands Welfare Organisation (JHWO) for technical and financial support throughout the whole process.

Dr.A.J.V.Maunganidze



Secretary for Health and Child Care

ACRONYMS

AFRONET	AFRICA RADIATION ONCOLOGY NETWORK
AORTIC	AFRICAN ORGANISATION FOR RESEARCH AND TRAINING IN CANCER
ART	ANTI-RETROVIRAL THERAPY
AU	AFRICAN UNION
BMSF	BRISTOL MYERS SQUIBB FOUNDATION
BCR	BULAWAYO CANCER REGISTRY
CHAI	CLINTON HEALTH ACCESS INITIATIVE
COVID-19	CORONAVIRUS DISEASE (COVID-19)
CP	COUNTERPARTS
CT	COMPUTERISED TOMOGRAPHY
DHIS	DISTRICT HEALTH INFORMATION SYSTEM
DNA	DEOXYRIBONUCLEIC ACID
DPS	DIRECTORATE OF PHARMACY SERVICES
EDLIZ	ESSENTIAL DRUG LIST IN ZIMBABWE
EHR	ELECTRONIC HEALTH RECORD
EMA	ENVIRONMENTAL MANAGEMENT AGENCY
GICC	GLOBAL INITIATIVE ON CHILDHOOD CANCER
GLOBOCAN	GLOBAL CANCER INCIDENCE, MORTALITY AND PREVALENCE
HBV	HEPATITIS B VIRUS
HDR	HIGH DOSE RATE
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HOSPAZ	HOSPICE AND PALLIATIVE CARE ASSOCIATION OF ZIMBABWE
HPA	HEALTH PROFESSIONS AUTHORITY ZIMBABWE
HPV	HUMAN PAPILLOMAVIRUS
HR	HUMAN RESOURCES
IACR	INTERNATIONAL ASSOCIATION OF CANCER REGISTRIES
IAEA	INTERNATIONAL ATOMIC ENERGY AGENCY
IARC	INTERNATIONAL AGENCY FOR RESEARCH ON CANCER
IEC	INFORMATION, EDUCATION AND COMMUNICATION
IKS	INDIGENOUS KNOWLEDGE SYSTEMS
IT	INFORMATION TECHNOLOGY
JHWO	JOINTED HANDS WELFARE ORGANISATION
KPI	KEY PERFORMANCE INDICATOR
LMIC	LOW TO MEDIUM INCOME COUNTRIES
MDPCZ	MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF ZIMBABWE
MEL	MONITORING, EVALUATION AND LEARNING
MOF	MINISTRY OF FINANCE
MOHCC	MINISTRY OF HEALTH AND CHILD CARE
MOU	MEMORANDUM OF UNDERSTANDING
MRI	MAGNETIC RESONANCE IMAGING

ACRONYMS

NBSZ	NATIONAL BLOOD SERVICES OF ZIMBABWE
NCCP	NATIONAL CANCER CONTROL PLAN
NCD	NONCOMMUNICABLE DISEASES
NCI	NATIONAL CANCER INSTITUTE
NGO	NON-GOVERNMENTAL ORGANISATION
NHMIS	NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM
NHS	NATIONAL HEALTH STRATEGY
NSOAS	NATIONAL SURGICAL OBSTETRIC AND ANAESTHESIA STRATEGY 2022-2025
PACT	PROGRAMME OF ACTION FOR CANCER THERAPY
PSA	PROSTATE SPECIFIC ANTIGENS
PC	PALLIATIVE CARE
PCI	PALLIATIVE CARE INTEGRATION
PGH	PARIRENYATWA GROUP OF HOSPITALS
PHRTC	PARIRENYATWA HOSPITAL RADIOTHERAPY CENTRE
PVO	PRIVATE VOLUNTARY ORGANISATION
RPAZ	RADIATION PROTECTION AUTHORITY OF ZIMBABWE
RT	RADIOTHERAPY
SADC	SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
SDG	SUSTAINABLE DEVELOPMENT GOALS
SI	STATUTORY INSTRUMENT
SPECT	SINGLE-PHOTON EMISSION COMPUTERISED TOMOGRAPHY
SSA	SUB SAHARAN AFRICA
STI	SEXUALLY TRANSMITTED INFECTIONS
SWOT	STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS
TOT	TRAINER OF TRAINERS
UHC	UNIVERSAL HEALTH COVERAGE
UN	UNITED NATIONS
UNICEF	UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND
UNFPA	THE UNITED NATIONS POPULATION FUND
USD	UNITED STATES DOLLAR
USPSTF	UNITED STATES PREVENTIVE SERVICES TASK FORCE
USS	ULTRASOUND
UZ	UNIVERSITY OF ZIMBABWE
VIA	VISUAL INSPECTION WITH ACETIC ACID
VIAC	VISUAL INSPECTION WITH ACETIC ACID AND CERVICOGRAPHY
VMS	VARIAN MEDICAL SYSTEMS
WHO	WORLD HEALTH ORGANIZATION
ZDHS	ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY
ZNCR	THE ZIMBABWE NATIONAL CANCER REGISTRY

EXECUTIVE SUMMARY

Government-led efforts to control cancer began in 1994 with the development of the first 10-year National Cancer Control Plan (NCCP) for Zimbabwe. The overall aim was to formulate, plan and implement a coordinated programme for the prevention and control of cancer in Zimbabwe. This was followed by the National Cancer Prevention and Control Strategy (2014-2018) that was developed to address highlighted gaps recommended following an integrated mission of Programme of Action for Cancer Therapy, otherwise referred to as an imPACT Review on Zimbabwe in 2010. The imPACT Review was coordinated by the International Atomic Energy Agency (IAEA) and conducted jointly with the World Health Organization (WHO) and the International Agency for Research on Cancer (IARC).

The Government of Zimbabwe through the Ministry of Health and Child Care provided appropriate leadership in the implementation of that strategy. However, significant weaknesses and gaps were noted in the various components of the strategy including cancer policy, regulatory, institutional and organisational frameworks, coordination, partnerships, and monitoring and evaluation frameworks. Additionally, the strategy was not costed. Hence, major reforms will be required to ensure successful implementation of the Zimbabwe National Cancer Control Plan (2025-2030). Below is a snapshot of a situational analysis on health systems pillars for cancer prevention and control in Zimbabwe.

Cancer services are offered at all levels of the healthcare system with care concentrated at tertiary and quaternary levels. Several gaps exist in access, availability, affordability, and quality of services that need to be addressed. Prevention offers the most cost-effective strategy for control of cancer. Integration of screening and early detection in other existing health programs will give optimal public health benefits with minimal cost implication and long-term cancer control benefits.

There are on-going government efforts to train healthcare workers in cancer services subspecialties, but the numbers trained fall short of meeting the country's requirements. There is a need to address gaps in numerical adequacy of service providers, conditions of service, knowledge gaps in cancer management and safety concerns for the health workforce.

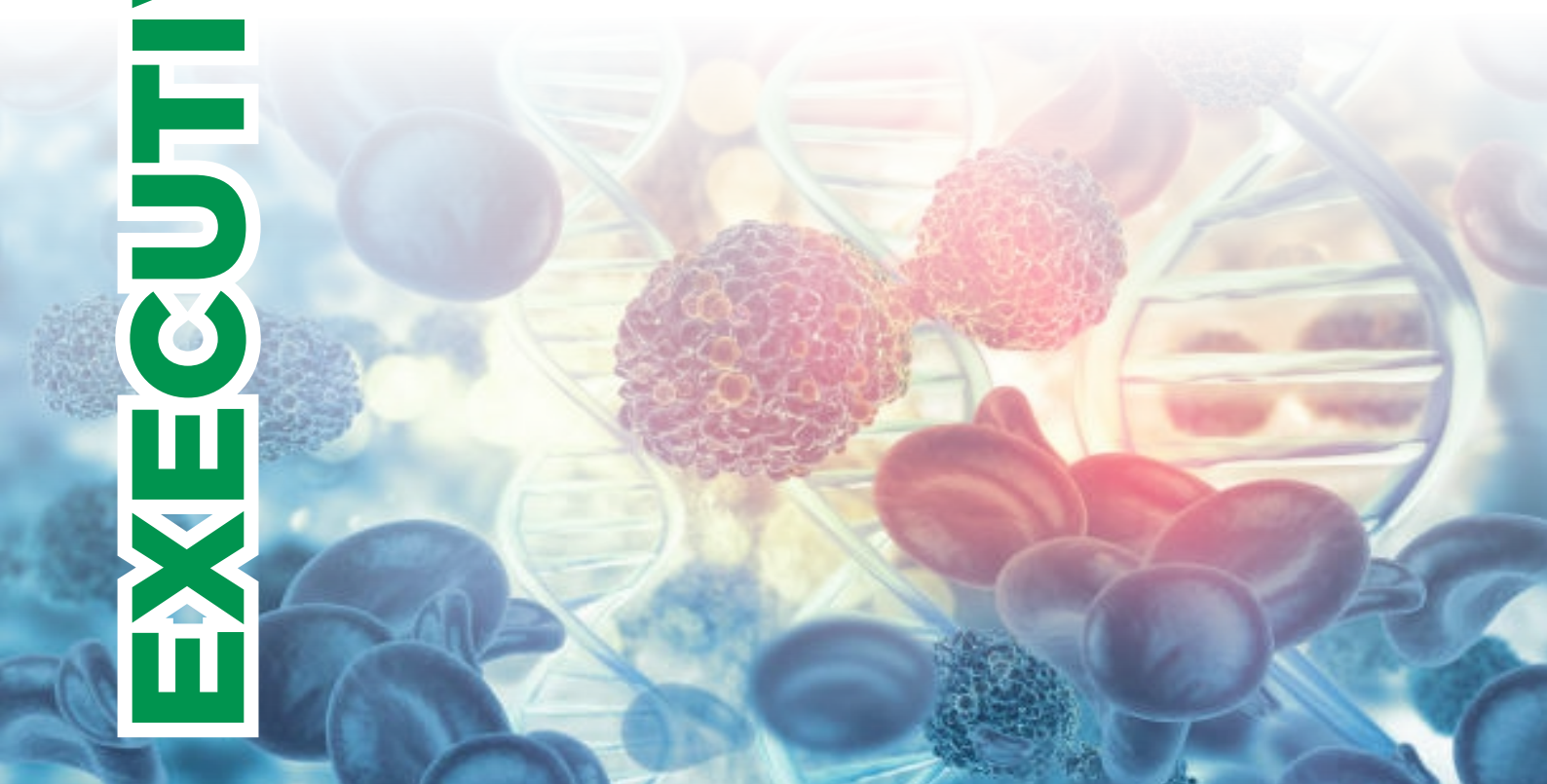
Financing for cancer remains a challenge for Zimbabwe with preceding efforts being underfunded due to competing priorities. Deliberate efforts will be made to ensure adequate and sustainable funding for cancer prevention and control. Notable gaps in supply chain, equipment, infrastructure, and specific budgetary allocation for cancer need to be addressed.

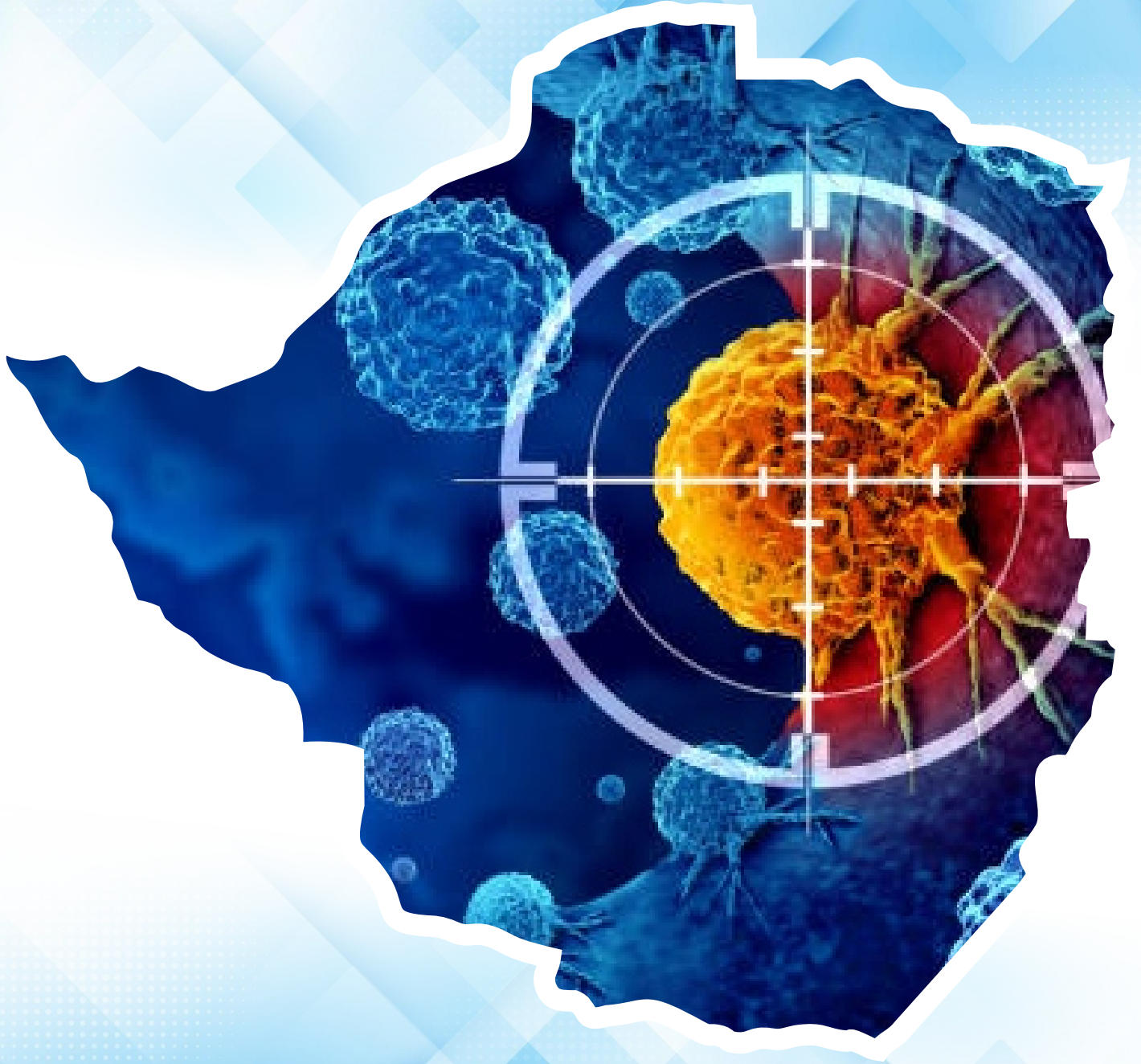
To enhance efficient and effective implementation of the strategy Monitoring, Evaluation and Research are key elements. There is a need to strengthen the systematic collection of quality cancer data in a timely and cost-effective manner to enable informed decision and policy making. Furthermore, there is a need to strengthen systems in monitoring and evaluation of cancer intervention programs, as well as strengthening cancer research, evidence generation and dissemination.

EXECUTIVE SUMMARY

The Government of Zimbabwe has implemented several health sector reforms with the aim of strengthening governance of the health sector among other pillars. The goal of these reforms is to improve the health status of the nation. The Ministry of Health and Child Care provided appropriate leadership in the implementation of preceding NCCP. However, there is a need to develop and strengthen policy, strategies and guidelines for cancer services and enforce their implementation as well as strengthen cancer coordination mechanisms at national and sub-national levels.

Cancer screening, diagnostic and treatment services in Zimbabwe are affected by inadequate infrastructure and equipment as well as inconsistent supply of medicines and sundries. There is a need to address identified gaps in infrastructure and equipment as well as the supply of medicines and sundries for cancer services. This strategy seeks to address the identified gaps and further strengthen cancer services with the overall goal of reducing the cancer burden in the country.





1 SITUATIONAL ANALYSIS

BACKGROUND

Globally, cancer is among the leading causes of morbidity and mortality. In 2020 about 20 million new cases and 10 million deaths were recorded worldwide (GLOBOCAN,2020). These figures are projected to increase to 26 million cases and 17 million deaths annually by 2030 (GLOBOCAN,2020). The projected increase is due to several factors including growth and ageing of populations, fewer resources to allocate to cancer prevention and control, improvements in life expectancy from reduced infectious disease mortality, unhealthy lifestyle such as smoking tobacco, physical inactivity, and unhealthy diets and slower decline in cancer causing infections: Human Immunodeficiency Virus (HIV), Human Papilloma Virus(HPV), and Hepatitis B Virus (HBV) among others.

Low to Medium Income Countries (LMIC) bear the heaviest burden of cancer and Zimbabwe is not spared. Approximately 70% of world-wide cancer deaths in 2020 occurred in low- and middle-income countries (GLOBOCAN,2020). Over the years Africa has recorded more cancer deaths as compared to HIV related deaths (GLOBOCAN,2020).According to GLOBOCAN 2020 estimates, the most common cancers were breast (11,7%), lung (11,4%) Colorectal (10%), Prostate (7,3%), and stomach (5,6%) (GLOBOCAN,2020). Cervical cancer is the leading cause of cancer deaths in the region despite it being preventable through vaccination, screening and treatment (GLOBOCAN,2020).

Latest estimates indicate that there were around 1.1 million new cancer cases in Africa in 2020 and 700,000 cancer related deaths each year (GLOBOCAN,2020). Africa accounts for 5.7 percent of global cancer incidence, but has a larger share of deaths, at more than 7 percent. This is probably due to the unique distribution of cancer cases and the higher cancer fatality rate in the region. Cancer death rates in Africa are projected to exceed the global average by 30% in the next 20 years.

The World Health Organization has projected an increase in cancer particularly in early transitioning nations including Zimbabwe. GLOBOCAN 2020 cancer estimates for Zimbabwe indicated 16083 new cases and 10 676 deaths (GLOBOCAN,2020).According to the Zimbabwe National Cancer Registry (ZNCR) Zimbabwe has recorded over 7000 new cancer cases and over 3 000 cancer deaths annually since 2014 (ZNCR,2022) (Figure 1). Both new cancer cases and deaths are expected to double in the next twenty years. Prioritising cancer prevention and control will have a great impact on reducing the projected cancer burden in Zimbabwe.

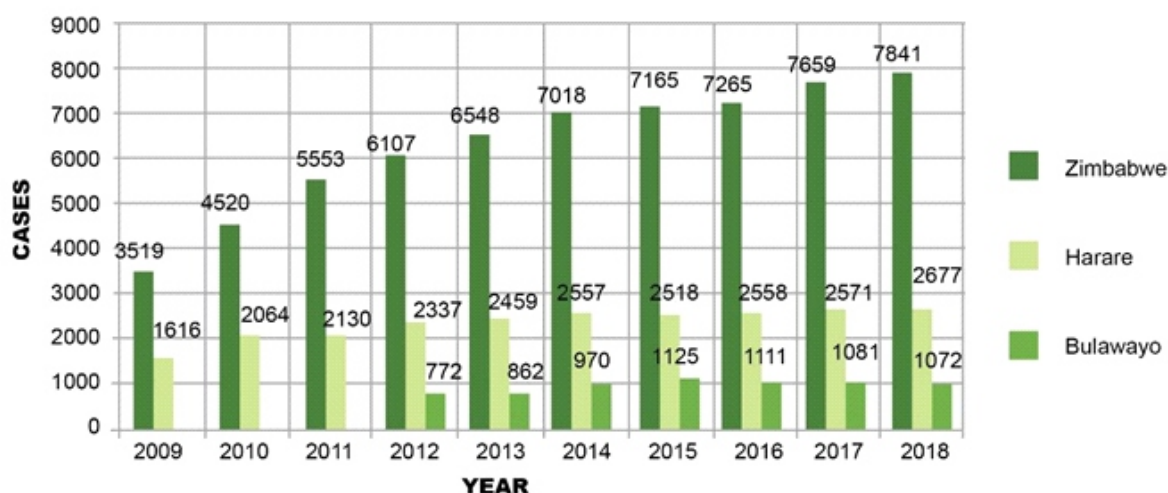


Figure 1: Registration of cancer data: 2009-2018.

According to the ZNCR 2018 annual report (ZNCR, 2022), 7841 new cancer cases comprising 3,301 (43%) males and 4,540 (57% females) were registered in Zimbabwe. Overall, the leading causes of cancer mortality were cervix (13%), prostate (10%), breast (7%), oesophagus (7%), liver (7%), Non-Hodgkin Lymphoma (6%), stomach (5%), lung (5%) and colorectal (4%).

Among black Zimbabwean men the most common cancers were prostate (27.8%), Non-Hodgkin Lymphoma (8.0%) Kaposi sarcoma (6.8%), oesophagus (6.2%) and liver (5.1%). The five most common cancers among Zimbabwean black women were cervical cancer (38.1%), breast (13.3%), oesophagus (3.7 %), Non-Hodgkin Lymphoma (3.5%) and stomach (3.3%).

In non-black men the most frequent cancer was prostate (25.8%), followed by colon (11.3%), lung (8.6%) and rectum (6.6%). In non-black women the most common cancers were breast (36.1%), lung (6.9%), melanoma skin cancer (6.2%) and corpus uteri (6.2%).

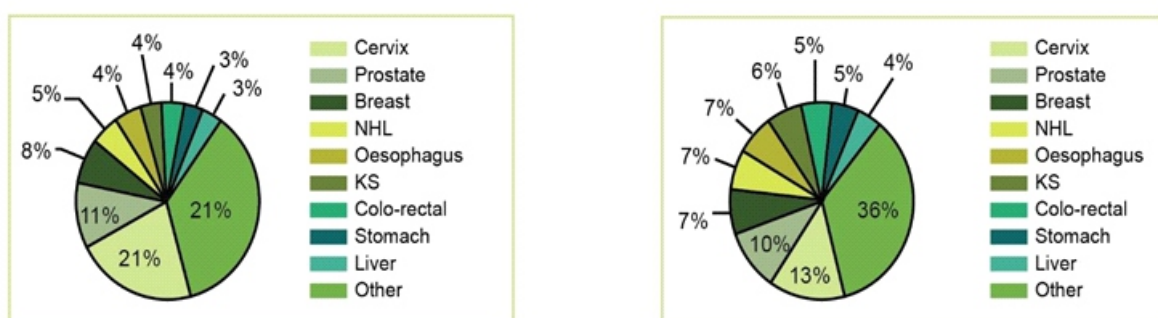


Figure 2: From left to right, Zimbabwe 2018 Cancer Incidence: N=7841 and Mortality: N=2743

About half of the new cancer cases diagnosed annually in Zimbabwe are in the cities of Harare and Bulawayo where cancer management services (diagnostic and treatment) are located as shown below. However, it is important to note that in some cases, individuals coming from the rural sometimes provide urban addresses upon registration.

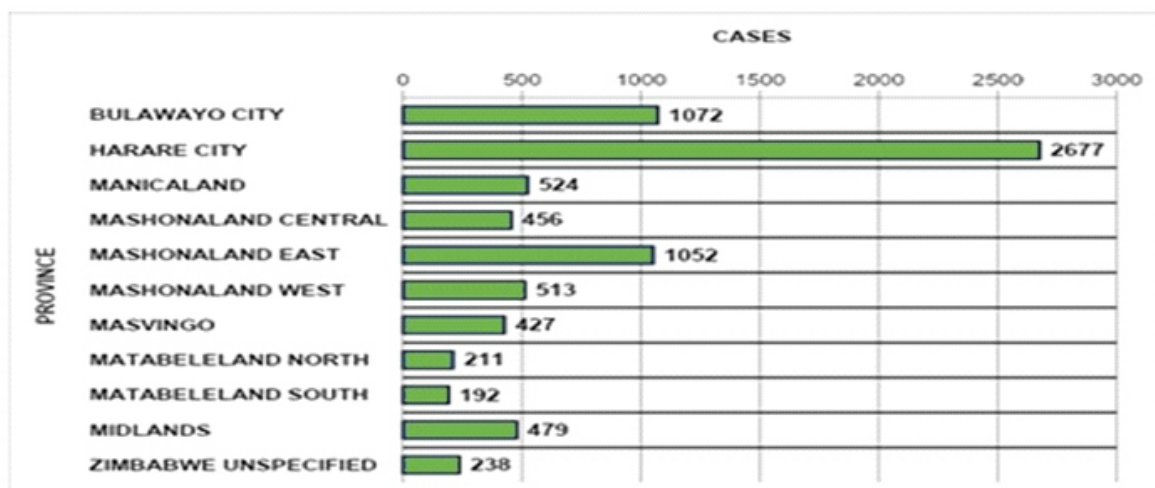


Figure 3: Geographic distribution of total cancers registered in 2018 by province.

1.2 High Impact or Priority Cancers in Zimbabwe

To improve Cancer Prevention and control in the country there is need to focus on certain cancers. These include childhood, cervical, prostate, colorectal, lung and breast cancer. Prioritization of these cancers is based on prevalence and high impact of cancer prevention and control measures and availability of global funding for programming. However, highly preventable cancers such as lung and liver cancers also require special and urgent consideration due to availability of funding.

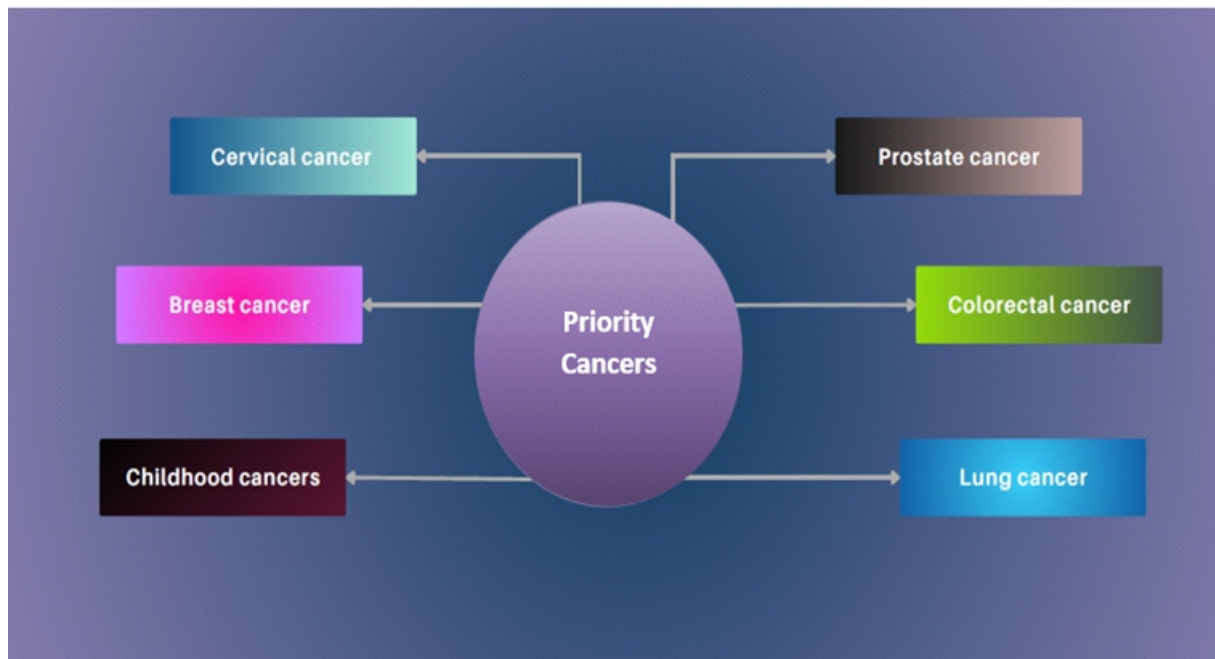


Figure 4: Priority Cancers

1.2.1 Cervical Cancer

Cervical cancer is the fourth most common cancer among women worldwide and according to GLOBOCAN 2020 the incidence was about 600 000 with an estimated mortality of 340 000. Cervical cancer is the most frequent malignancy in Zimbabwean women with an estimated burden of 19% (ZNCR, 2022). It is estimated that 2270 women develop cervical cancer in Zimbabwe annually and a mortality rate of 64% has been recorded. The burden and mortality of cervical cancer is most likely higher than those recorded in the National Cancer Registry.

1.2.2 Prostate Cancer

According to the Zimbabwe National Cancer Registry 2018 Annual report (ZNCR, 2022), prostate cancer is the most diagnosed malignancy and the leading cause of cancer-related mortality among Zimbabwean men. About 20% of men diagnosed with prostate cancer die from the disease while the other 80% die with the disease rather than from it (Jacklin et al., 2021). Unfortunately, in Zimbabwe most patients with prostate cancer present at an advanced stage leading to poor treatment outcomes.

1.2.3 Breast Cancer

Breast cancer is the commonest cancer in women worldwide and leading cause of new cancer cases (2.26 million) (GLOBOCAN, 2020). However, in Zimbabwe, breast cancer is the second most common cancer in women after cervical cancer (ZNCR, 2022). Data from the cancer registry report also shows a consistent increase in the number of cases diagnosed. Peak incidence was noted between the ages of 30 and 60 years when most are in their prime.

1.2.4 Colorectal Cancer

According to 2020 GLOBOCAN estimates Colorectal cancer is the 3rd most common cancer globally, and the 6th most common cancer in Africa (GLOBOCAN, 2020). According to the United States Preventive Services Task Force (USPSTF) regular screening beginning at the age of 45 years is key to early detection of colorectal cancer. In Zimbabwe colorectal cancer accounts for 3% of all cancers and 5% of all cancer deaths (ZNCR, 2022). Over the past three decades, Zimbabwe has witnessed a gradual increase in the incidence of colorectal cancer. This can be attributed to changes in diet, lifestyle, and to improvements in diagnostic capabilities.

1.2.5 Childhood Cancers

Globally about 400,000 new cases of childhood cancers are reported annually and 85% of these children live in LMIC. The survival of children with cancer in high income countries has increased to over 80% in the last decades, whereas estimated survival in many countries in sub-Saharan Africa is below 20%.

In Southern Africa, estimates of 5-year net survival among diagnosed cases were only 19% in Southern Africa and 8% in both East and West Africa. Although higher quality data are urgently needed, several conclusions can still be drawn: the burden of childhood cancer in Sub-Saharan Africa (SSA) is substantial, the incidence in some parts of the region might exceed that of high-income countries, and survival across much of the continent is dismal. Current projections show that Africa will account for nearly 50% of the global childhood cancer burden by 2050, necessitating immediate efforts to confront this challenge (WHO African Region, 2023). In 2018, WHO launched the Global Initiative for Childhood Cancer with an initial focus on six common and highly curable index cancer types: Acute Lymphoblastic Leukaemia, Retinoblastoma, Nephroblastoma, Hodgkin Lymphoma, Non-Hodgkin Lymphoma and Low-Grade Glioma. The target is to increase survival worldwide to 60% by 2030.

In Zimbabwe, 293 childhood cancers (among children less than 15 years) recorded in 2018, 176 were in boys (60.0%) and 117 were in girls (40.0%). Childhood cancers accounted for 3.7% of the cancers registered in 2018. The most frequently occurring cancers in boys were leukaemia (18.9%), lymphoma (18.4%), retinoblastoma (16%), Wilms Tumour (16%) and Brain Nervous System (9.2%). In girls, the most common cancers were Wilms tumour (20.9%), retinoblastoma (18.3%), leukaemia (15.5%), Brain, nervous system (9.4%) and bone (7.8%) (ZNCR, 2022).

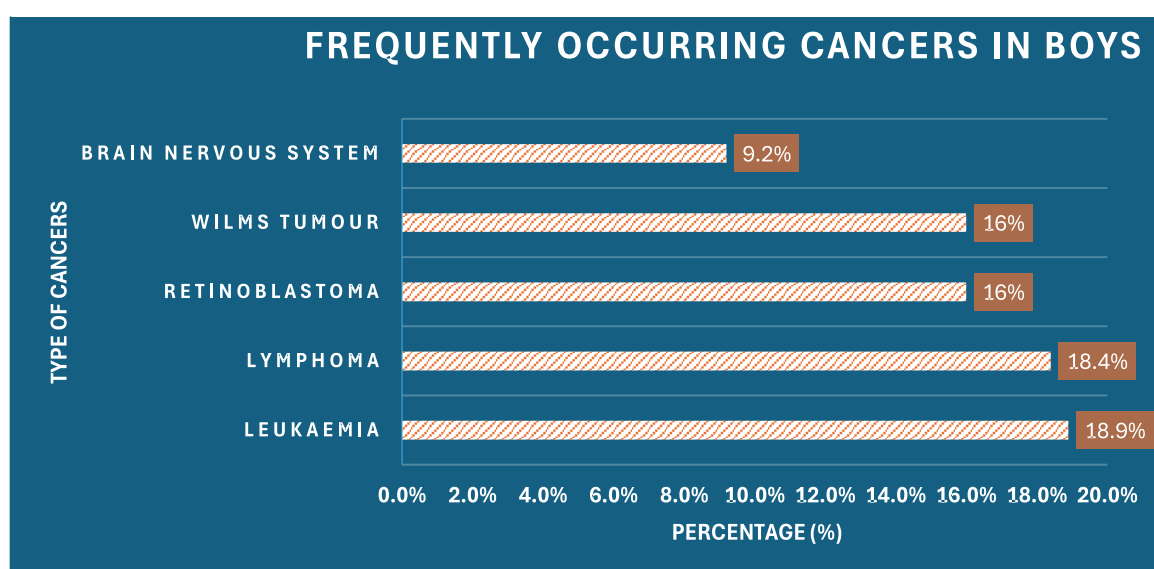


Figure 5: Frequently Occurring Cancers in Boys.

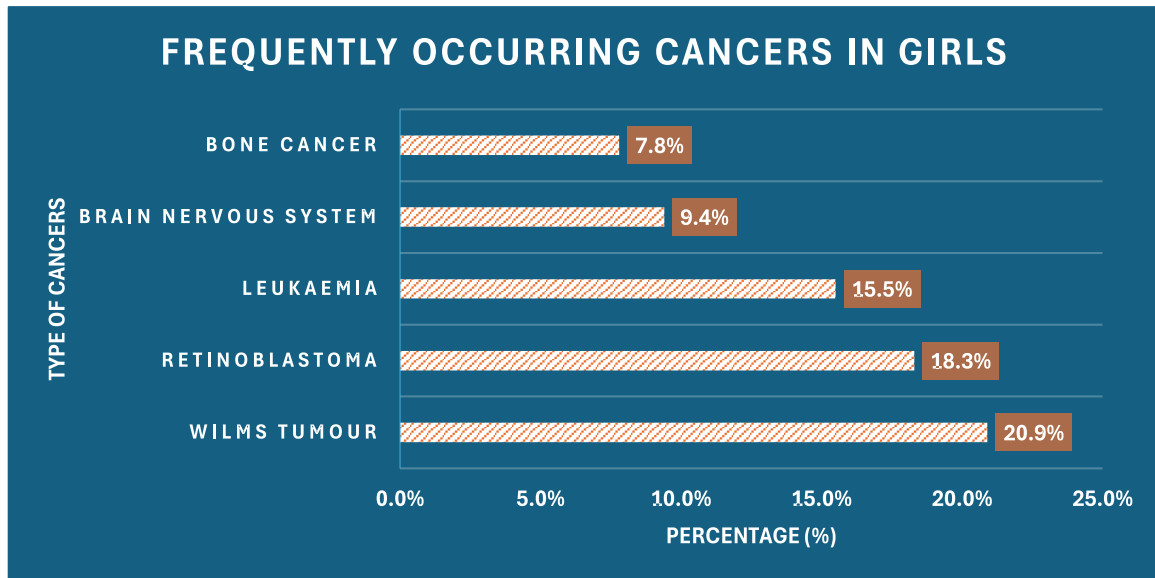


Figure 6: Frequently Occurring Cancers in Girls.

1.2.6 Lung cancer

Lung cancer is a significant public health concern, causing a considerable number of deaths globally. GLOBOCAN 2020 estimates of cancer incidence and mortality produced by the International Agency for Research on Cancer (IARC) show that lung cancer remains the leading cause of cancer death, with an estimated 1.8 million deaths (18%) in 2020. Smoking tobacco (including cigarettes, snuff and pipes) is the leading risk factor for lung cancer, accounting for approximately 85% of diagnosed cases. However, lung cancer can also affect non-smokers through prolonged exposure to second-hand smoke. Other risk factors for lung cancer include exposure to toxic occupational hazards (such as asbestos, radon gas, and certain toxic industrial chemicals), air pollution, hereditary cancer syndromes, and a history of chronic lung diseases. Lung cancer is often diagnosed at advanced stages, which can limit treatment options and affect prognosis. Primary prevention (such as tobacco control measures and reducing exposure to environmental risk factors) can reduce the incidence of lung cancer and save lives. Lung cancer in most cases, it is diagnosed in late stages due to its overlap with the diagnosis of TB.

According to a study by Mazhindu et al, (2024) conducted at Parirenyatwa, it showed that 53% of patients with pathologically confirmed primary lung cancer had been diagnosed with pulmonary TB in the preceding 12 months. The median diagnostic delay for lung cancer was 8.37 months, with 77% of patients presenting at stage 4 (Mazhindu, et al., 2024). The study revealed that screening high risk individuals has the potential to allow early detection and to dramatically improve survival rates.

Thematic Area	Strengths	Weaknesses	Opportunities	Threats
Service Delivery	- Successful HPV & HBV vaccination programs. -Established HIV/AIDS program. -Cervical cancer VIAC screening at district level.	- Lack of integration with other programs. - Low funding for HPV DNA and cervical cytology. -Limited multidisciplinary approach in cancer care. - Misdiagnosis of some cancers e.g. lung cancer as TB.	- Regional and international benchmarks. - Use of HIV infrastructure for cancer control. - WHO Cervical Cancer elimination initiatives. -Partner Projects including Hope for Lungs Project.	- Emerging pandemics (e.g., COVID-19). - Competition for funding. - Program sustainability issues. - High dropout rates due to stigma and misconceptions.
Health Workforce	- Availability of local pathology training. - Core surgical expertise. - Specialist training locally available.	- Limited number of qualified pathology workforce. - Low uptake of specialist training. - Skills flight and long turnaround times.	- Regional trainings and task shifting. - Partner-supported regional training. - Global training and online resources.	- High attrition rate. - Limited resources and funding for training. - Poor recognition in public sector.
Infrastructure, Equipment, and Products	- Existing basic infrastructure for diagnostic radiology. - Availability of essential medicines list and EDLIZ.	- Poor maintenance of infrastructure. - Limited advanced imaging equipment in public sector. - Erratic supply of essential medicines.	- Partner support and evolving technology. - Public-private partnership. -Cancer Access Programs. - Enrolling for regional clinical trials.	- High cost of technology. - Limited funding and sustainability. - Skills flight.
Monitoring, Evaluation, and Research	- Well-established national cancer registry. - Increased uptake in research. - Digital platforms available.	- Lack of public sector funding for research. - Limited grant writing skills. - Poor coordination.	- Availability of donor funding. - Support from IARC and African Cancer Registry Network. - International initiatives on digital use.	- Skills flight. - Sustainability issues. - Competing priorities.
Healthcare Financing	- Government funding availability. - Support from international organizations.	- Lack of dedicated funding for radiotherapy equipment. - High out-of-pocket spending.	- Public-private partnerships. - Coverage by private insurance. - Increased number of partners in cancer space.	- Competing priorities. - Donor dependency for cancer prevention funding.
Leadership and Governance	- High political will. - MoHCC NCD Department in place.	- Harsh economic environment. - Fragmented implementation of programs.	- Commitment to UN SDGs. - Bilateral support. - E-health infrastructure development.	- Competing government priorities. - Poor economic performance. - Change in government policy.



2

OVERVIEW OF CANCER SERVICES IN ZIMBABWE

2.1 Service Delivery

Cancer services are offered at all levels of the healthcare system with cancer care services concentrated at Tertiary and Quaternary levels.

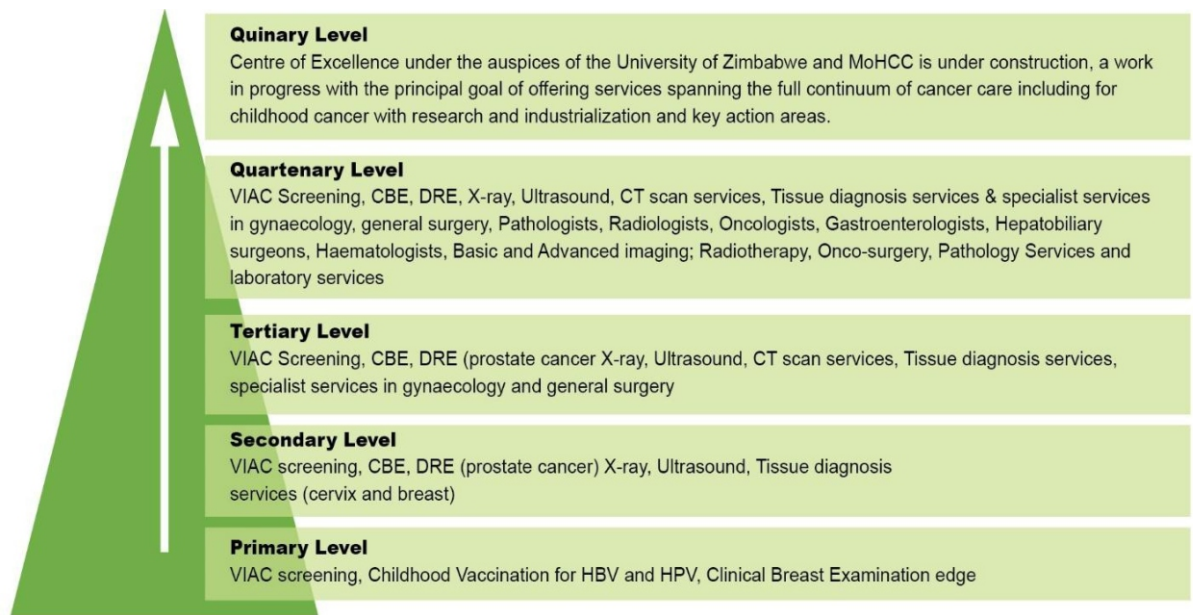


Figure 7 Levels Of Cancer Services In Zimbabwe.

2.1.1 Cancer Service Delivery

Cancer service delivery will focus on the following areas: cancer prevention, early detection, diagnosis, treatment, palliative care, rehabilitation, and survivorship. Integrating cancer prevention, screening, and early detection into other programs is crucial for optimal public health benefits and long-term cancer control. Potential integration areas include sexual and reproductive health initiatives, existing HIV/AIDS programs, national immunization efforts for HPV and Hepatitis B and C, occupational and environmental health initiatives, maternal and child health programs, and lifestyle modifications.

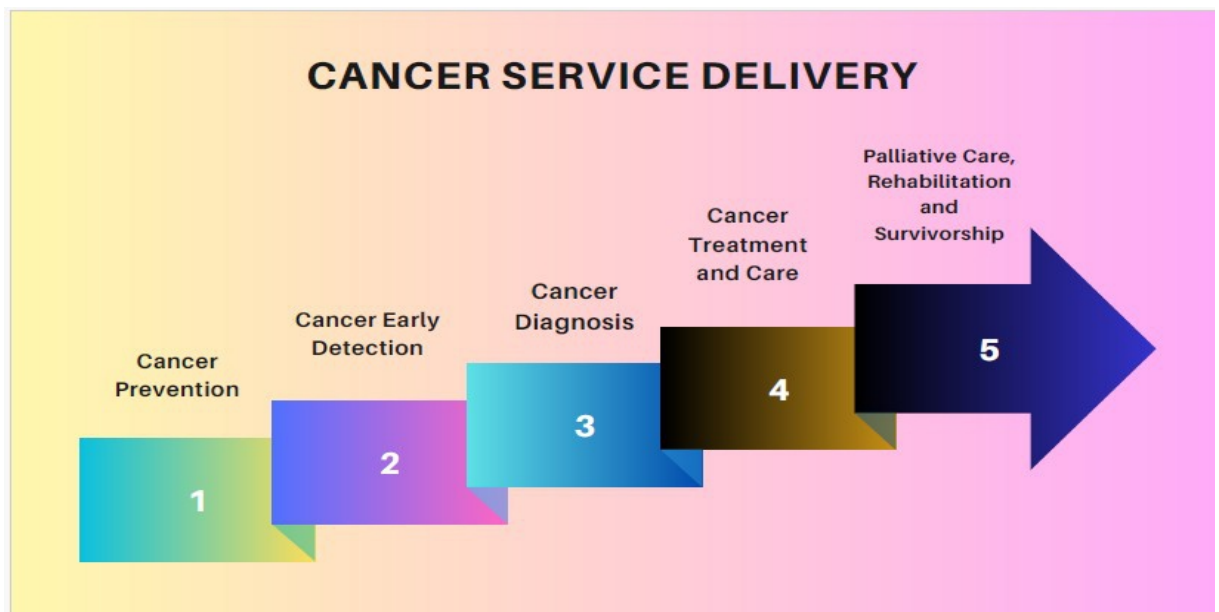


Figure 8: Cancer Service Delivery.

2.1.1.1 Cancer Prevention

Prevention is the most cost-effective intervention, especially in resource-constrained environments like Zimbabwe. Thirty to forty percent of cancers are preventable by avoiding known risk factors. The main factors contributing to the increasing incidence of cancer in Zimbabwe include infectious agents, tobacco use, alcohol use, unhealthy diets, physical inactivity, and environmental factors. Over the next five years, a multifaceted approach will be adopted - focusing on reducing exposure to infectious agents, tobacco, alcohol, unhealthy diets, physical inactivity, and environmental hazards. Key strategies will include community education and awareness campaigns, integration of cancer prevention into school curricula or occupational health programs, and promotion of healthy diets through local food initiatives.

Additionally, physical activity programs, stronger tobacco control policies, and alcohol use reduction initiatives will be implemented. Vaccination drives for HPV and HBV will be organized, alongside regular screening programs for high-risk populations. Environmental health initiatives will aim to improve living conditions, safer mining practices, while collaboration with traditional and faith-based healers will enhance community engagement in cancer awareness. Finally, advocacy for supportive strategic policies and investment in research will ensure a comprehensive framework for cancer prevention, ultimately reducing the burden of cancer and improving public health outcomes in Zimbabwe.

A Cancer Communication Strategy will be developed to promote healthier lifestyle and social behaviour changes, prioritizing the reduction of exposure to cancer risk factors.

2.1.1.2 Cancer Early Detection

Eighty to ninety percent of cancer patients present at an advanced stage when treatment is costlier, and outcomes are poorer (ZNCR, 2022). This is due to a lack of access to early detection, compounded by resource constraints, inadequate health professional education, and low awareness. The NCCP focuses on strategies for detecting early signs of cancer and intervening before it fully metastasizes. This includes scaling up existing and introducing new screening programs to identify individuals at risk and treat precancerous lesions. Key actions include improving cervical cancer screening through HPV DNA testing, decentralizing treatment of precancerous lesions, and increasing awareness of early warning signs among families and health workers. Training healthcare providers on early detection and improving the referral system for cancer patients will be prioritized. Efforts to encourage asymptomatic patients to embrace screening must be matched with access to diagnosis, treatment, palliative care, survivorship, and rehabilitation.

Zimbabwe can also utilize Low Dose CT scans for cancer screening, focusing on high-risk populations for early detection of lung and other cancers. The advantages include improved detection rates of early-stage cancers, reduced mortality through timely intervention, and enhanced overall treatment outcomes, ultimately leading to a more effective cancer management strategy.

These strategies can significantly enhance cancer screening efforts, particularly for lung cancer, which is increasingly becoming prevalent in the region. By targeting high-risk populations, Low Dose CT scans can facilitate the early detection of malignancies when they are most treatable. This proactive approach aligns with WHO recommended screening and diagnostic tests which research has shown that Low Dose CT screening can reduce lung cancer mortality by up to 20% compared to standard chest x-rays.

2.1.1.3 Cancer Diagnosis

Despite improvements in cancer prevention and early detection, there is a gap in cancer diagnosis. Early detection efforts must be matched with the capacity to diagnose and treat cancer. Currently, cancer diagnosis services are inaccessible to most of the population due to centralized services, high costs, inadequate skilled personnel, and equipment limitations. The NCCP focuses on building human resource capacity and skills retention, decentralizing services, reducing diagnosis costs, and ensuring infrastructure, equipment, and products availability.

Cancer diagnostic services include tests and procedures to confirm or rule out cancer, enabling definitive treatment if diagnosed. These services include diagnostic pathology and imaging. Pathology involves examining tissue samples from tumours, bone marrow or lymph nodes. Imaging services are essential for establishing the disease stage and include x-ray, ultrasound, CT, MRI, and nuclear medicine. Treatment services include surgical oncology, radiotherapy, chemotherapy, hormonal therapies, and targeted therapies. The current infrastructure, equipment, and products for cancer diagnosis and treatment do not meet the country's cancer burden.

2.1.1.4 Cancer Treatment and Care

Clinical oncology services such as Oncological Surgery, Radiation Oncology, Medical Oncology, Haematology and Paediatric Oncology are primarily available at quaternary (central hospital) levels, including Parirenyatwa Group of Hospitals, Sally Mugabe Central Hospital, Mpilo Central Hospital, United Bulawayo Hospital, and Chitungwiza Central hospitals. The NCCP prioritizes upgrading existing services and decentralizing cancer treatment.

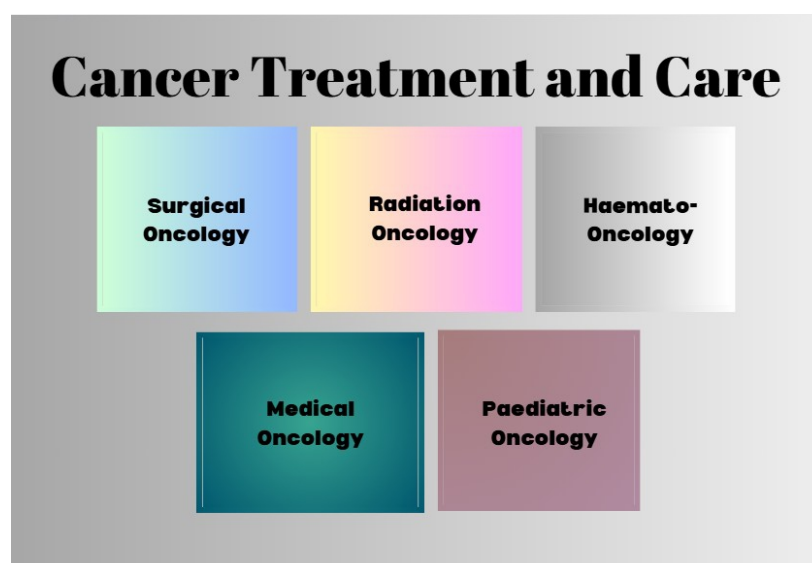


Figure 9: Cancer Treatment and Care.

2.1.1.4.1 Surgical Oncology

There are various surgical specialties available in Zimbabwe at central and provincial hospital level. Surgical specialties include general surgery, neurosurgery, cardiothoracic surgery, urological surgery, ophthalmology, otolaryngology, gynaecological and paediatric surgery. Cancer patients mostly get surgical services in the public health sector and advocacy for strengthening of surgical capacities at the secondary, tertiary and quaternary level is a priority. Further details are available in the National Surgical Obstetric and Anaesthesia Strategy (NSOAS) 2022-2025.

2.1.1.4.2 Radiation Oncology

The recommended number of radiotherapy machines is one per million population. Ideally, one radiation oncologist can serve about 200-250 patients per year, and each machine requires at least three medical physicists and two radiotherapy technicians per shift. However, Zimbabwe faces a critical shortage of cancer management personnel in all key areas of cancer treatment, including radiation oncologists, medical physicists, dosimetrists, radiotherapy technologists, oncology and palliative care nurses. Despite local training, the numbers remain insufficient, compounded by skills flight to high-income countries. Over the next six years, plans must include replacing old machines with new technology and developing a skilled human resource retention strategy. Centralized radiotherapy services at major referral hospitals create barriers for patients due to high transport and accommodation costs, making private radiotherapy services inaccessible for most who must pay out of pocket thereby incurring catastrophic costs.

2.1.1.4.3 Haemato-Oncology

The Haematology specialty provides diagnostic and clinical treatment services for haematological malignancies like leukaemia and lymphomas. These services are centralized and available only at Parirenyatwa Group of Hospitals. Currently, there are four Clinical Haematologists in Zimbabwe. Local training of Haematologists started under the University of Zimbabwe postgraduate program in 2022. Building specialist capacity through on-the-job training locally or abroad is essential. Chemotherapy, the main treatment modality for haematological malignancies is largely unavailable in the public sector. However, partner support provides some anti-cancer medicines like Imatinib for specific cancers. Highly specialized treatments like bone marrow transplantation are not yet available in-country. Blood and blood products, critical for managing haematological cancers, are often in short supply, leading to competition with maternity and other medical emergencies and resulting in treatment delays and poor outcomes.

Blood and other blood products are critical commodities in the management of haematological cancers. Blood transfusion services, run by the National Blood Services of Zimbabwe (NBSZ) which collects blood from voluntary and non-remunerated donors supply the whole country, and frequently struggle to meet demand. With increase in the cancer burden there will be an increased demand for blood and blood products by cancer patients who will have to compete with needs for maternity and other medical emergencies. This may result in treatment delays for cancer patients and contribute to poor outcomes.

2.1.1.4.4 Medical Oncology

Medical Oncology involves treating cancer with chemotherapy, hormonal therapy, biological therapy, and targeted therapies. The increasing complexity of medical oncology necessitates sub-specialization. Currently, radiation oncologists practice this field in Zimbabwe. Most chemotherapy agents are unavailable in the public sector, requiring patients to purchase medicines from private pharmacies. However, most patients cannot afford these medicines. Public patients access chemotherapy services at Parirenyatwa and Mpilo Radiotherapy Centres and the Kaposi Sarcoma and HIV management clinic at Parirenyatwa Hospital. Integrating oncology with HIV services, especially for HIV-related malignancies, presents an opportunity. Trained oncology and palliative care nurses provide an opportunity for decentralizing chemotherapy services.

2.1.1.4.5 Paediatric Oncology

Paediatric oncology services are centralized, with a dedicated unit at Parirenyatwa Group of Hospitals led by Paediatric Oncologists. Management includes surgery, chemotherapy, and radiotherapy, supported by regional and international collaborations, such as St Jude's Children's Cancer Research Hospital. Local Private Voluntary Organizations have improved access to cancer diagnosis and anti-cancer medicines for children. Training Paediatric Oncology specialists at the University of Zimbabwe, was initially intended to commence in 2023, with the intention to expand services for facilitation of early diagnosis and improve on survival rates. However, due to the non-functionality of the cancer machines, students with the intention to train as oncology specialists have not managed to complete the training as at 2024 as the practical component to the training could not be done.

Over the next five years, improvements in medicine availability, staff complement, and partner support are anticipated, along with new centres for childhood cancer management which will also serve as centres of excellence.

2.1.1.4.6 Paediatric Oncology Services

Paediatric haemato-oncology services are primarily situated at Parirenyatwa Group of Hospitals (PGH), the main referral hospital, with services for children aged 0 to <15 years. Three trained Paediatric Oncologists currently manage childhood cancers. At Mpilo Central Hospital, paediatric oncology services focus on treating solid tumours with surgery, radiotherapy, and chemotherapy. Data on paediatric oncology services in the rest of the country is unavailable.

2.1.1.4.7 Paediatric Radiation Oncology Services

Radiation therapy is crucial for managing childhood cancers. Children needing radiotherapy are referred to Parirenyatwa and Mpilo Radiotherapy Centres. However, these machines frequently break down. Neither centre has child-friendly facilities, such as immobilization accessories or sedation equipment. There are no radiation oncologists specialized in paediatric oncology, though ongoing capacity building is assisted by Implementing Partners.

2.1.1.5 Cancer Palliative Care, Rehabilitation and Survivorship

A Palliative Care Policy and Strategy are both in place. The policy addresses pain management and the psycho-social and cultural needs of all people living with cancer including children. There is need to improve access to palliative care country-wide through essential medicine provision, training of service providers, research and integrated teamwork. Since 2017, Zimbabwe embarked on an initiative to integrate Palliative Care into the public health system, across all pillars and anchored on having health care workers and institutions capacitated and mentored on palliative care. This ensures coverage and sustainability of palliative care, which would contribute to the attainment of Universal Health Coverage (UHC). There is no expertise in paediatric palliative care.

2.1.2 Cancer Diagnosis – Pathology, Laboratory Services and Medical Imaging

2.1.2.1 Laboratory Services

Basic laboratory services are offered in Zimbabwe's public health care sector. At the level of Districts and Mission Hospitals, the haematology, clinical chemistry and medical microbiology are available. Specialist laboratory services are available at specialist levels of care and in some private laboratory settings. These specialist laboratory services include histopathology, immunochemistry, endocrinology, etc and are limited mainly in Harare and Bulawayo where specialist services are offered. Major challenges to providing specialist laboratory services include a limited range of services, lack of modern equipment, frequent machine breakdowns, high maintenance costs, and suboptimal quality assurance procedures. The absence of dedicated molecular laboratories and inadequate training in newer techniques are significant gaps.

2.1.2.2 Medical Imaging - Diagnostic Radiology and Nuclear Medicine

Accurate cancer staging requires various imaging modalities. Plain x-rays and ultrasonography are the most widely available methods, accessible at most health centres, including district hospitals. CT and MRI imaging services are largely unavailable in the public sector, compounded by machine breakdowns and a shortage of skilled manpower. Parirenyatwa Group of Hospitals has had an MRI installed and available for providing services for the public. Interventional radiology services are only available in the private sector and are prohibitively costly for most cancer patients. Zimbabwe has two state-owned nuclear medicine departments, one at Parirenyatwa Group of Hospitals in Harare and the other at Mpilo Central Hospital in Bulawayo. The Nuclear Medicine Unit at Mpilo is currently the only functional nuclear medicine centre, offering radionuclide imaging with a gamma camera. As of December 2024, the SPECT machine's gamma camera has not been functional since December 2022.

Equipment	Mpilo	Functional Status	PGH	Functional Status
Linear accelerators (DMX linac, Unique, 600 C)	2	Non-Functional	3	Functional
Bebig High Dose rate brachytherapy	1	Non-Functional	2	Non-Functional
Varian X-ray simulator	1	Non-Functional	1	Non-Functional
C-arms (Siemens, General Electric)	1	Functional	2	Non-Functional
Oncology Information System	1	Non-Functional	1	Functional
Eclipse Treatment planning system x 1	1	Non-Functional	1	Functional
Toshiba CT scanner	1	Functional	1	Functional

Table2: Current status of equipment for cancer services in Zimbabwe as of March 2025

2.2.2 Service Contract for Radiotherapy Equipment

Radiotherapy services are inconsistent due to equipment breakdowns and the absence of service contracts. The two public centres lack service contracts for their radiotherapy equipment, leading to significant downtimes. Upfront payments are often required, delaying service provision. Equipment such as the Aria OIS v 11.0 and 600 C linear accelerator are out of support and therefore require replacement. As new equipment is being procured, service contracts are currently being factored in.

2.3 Health Workforce

Significant strides have been made in training radiation oncologists, radiologists, medical physicists, radiation therapists, oncology, and palliative care nurses. However, the numbers fall far short of national requirements. The preservice curricula need to be reviewed to strengthen oncology training and multidisciplinary team management. Rotation, post-service training, and mentorship can enable the decentralization of services like chemotherapy and palliative care. Incentives are needed to retain specialized healthcare workers. Increasing the scope and number of professionals trained in oncology, including Oncology Pharmacists, Paediatric Oncology Nurses, and Community Healthcare Workers, is essential. The table below is an overview of the health workforce status of some of the members of the multidisciplinary team required to provide comprehensive care.

Specialties	Currently available		Ideal number	Gaps # required
Gynaecological Oncologists	2		10	8
Gynaecologists	108		128	20
Oncologists	15		64	49
Haemato-oncologists	5		-	-
Paediatric Oncologists	4		10	6
Surgical Oncologists	0 (2 in training)		-	-
Pathologists	10		64	54
Nuclear Medicine Physician	1		6	5
Radiologist	17		64	47
Oncology and palliative care nurses	73		128	55
Medical Physicists	10		20	10
Palliative care specialists	6		64	58
Radiation therapists	30		60	30

Table 3: Overview of Cancer Health Workforce in Zimbabwe (as of June 2024).

2.4 Healthcare Financing

Zimbabwe's health financing landscape comprises domestic and external resources. The MoHCC Resource Mapping Report of 2021 indicates increased domestic resource allocation towards health, though competition for resources remains high. There is no data on cancer control funding, resulting in low funding for cancer prevention and control. Recent inclusion of cancer and non-communicable diseases in the MoHCC budget is encouraging. Currently, there is no national health insurance in place and most patients must pay out of pocket for cancer services, leading to financial catastrophe. Currently, Zimbabwe has no national health insurance that covers individuals in need - as a result, cancer patients incur out-of-pocket expenditure for cancer services culminating in patients incurring catastrophic costs. Furthermore, the government has promulgated the sugar tax which was ring fenced for NCDs and Cancer care. Private insurance covers less than 10% of the population and rations certain services. For some cancers, NGO support provides free screening and pre-cancer treatment, however, invasive disease treatment is costly and limited. Zimbabwe joined the UHC Partnership (UHC-P) in 2018, despite that, there is no Universal Health Coverage package for cancer. However, the Bristol Myers Squibb Foundation (BMSF) recently started supporting the country for the Multiple Myeloma and Lung Cancer grants through MoHCC, JHWO and the CAZ. This support has been extended towards Multiple Myeloma diagnostic and patient management equipment as well as towards Lung Cancer policy design and support programs.

2.5 Leadership and Governance

The Government of Zimbabwe has implemented health sector reforms to strengthen governance. Since 2017, Zimbabwe has integrated Palliative Care into the health system, contributing to UHC. In 2022, the MoHCC started implementing the Health Sector Coordination Framework, providing new opportunities to strengthen governance, including cancer services through the Hospital Service Technical Working Group. While the MoHCC has provided leadership in implementing the NCCP, there is a need to develop and enforce policies, strategies, and guidelines for cancer services and strengthen coordination mechanisms at all levels.

2.6 Monitoring, Evaluation and Research

2.6.1 Routine Monitoring and Reporting

The M&E system for cancer prevention and control supports the collection of credible data to inform decision-making. The system is results-oriented, tracking achievements across the results chain from inputs and activities to outputs, outcomes, and impact. Priority output and outcome indicators are included in a Performance Framework, with baseline data and targets set. Progress will be measured and reported during NCCP implementation through appropriate existing and new mechanisms as shown in figure 10 below.

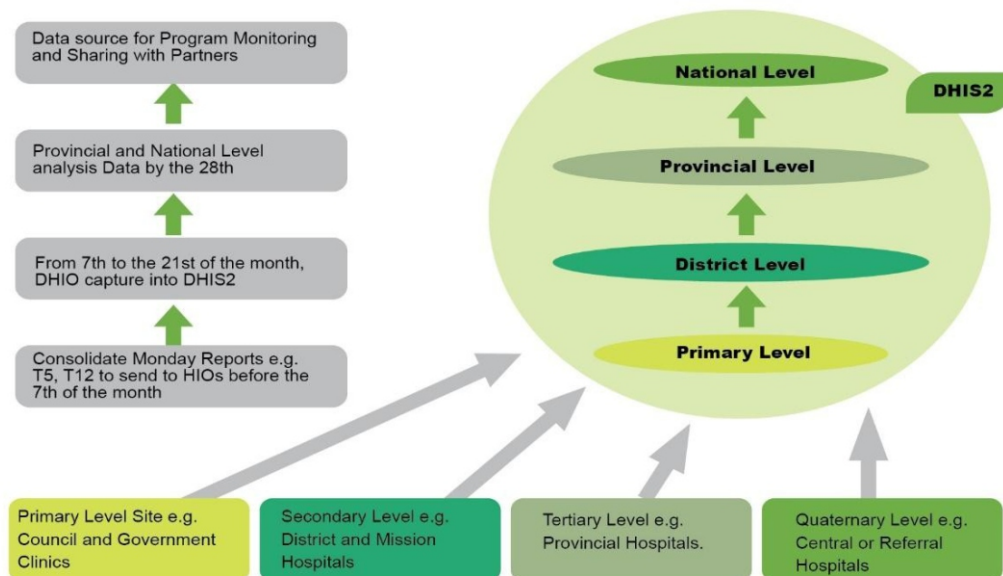


Figure 10 : Cancer Data Flow

2.6.2 Non-routine (Evaluations/Assessments/Surveys)

Non-routine processes will be conducted to generate and validate data generated from the cancer prevention and control processes. Rapid Assessments, Process Evaluations, Mid-term and End-term evaluations will be conducted during the life of this strategy under the guidance of the Directorate responsible for M&E. Some of the key assessments earmarked include incorporating the NCDs (Cancer) module in ZDHS, DHIS 2, STEPwise approach to Non-Communicable Diseases risk factor surveillance (STEPS), School Based Health Survey, and continuation of Sentinel surveillance. It is important to note that the focus of measurements and analysis for this section is at the outcome and impact level whilst routine monitoring is typically focused on tracking of the lower-level results – processes and outputs.

2.6.3 Data Analysis Dissemination of M&E Products

Information generated during the implementation of this strategy will be shared with all stakeholders in line with the Ministry guidelines. Information will be analysed using modern qualitative and quantitative software to produce informative reports that will be shared both physically and electronically. Dashboards will be developed for tracking and sharing of information. Portals and Websites will also be used for dissemination alongside dedicated dissemination workshops and meetings.

2.7 Cancer Surveillance and Research

2.7.1 The Zimbabwe National Cancer Registry

Zimbabwe has a well-established and productive population-based cancer registry, which is currently considered a model for sub-Saharan Africa. It provides technical support to other registries in the region on behalf of the International Agency for Research on Cancer (IARC), WHO/Afro, International Atomic Energy Agency (IAEA), the International Association of Cancer Registries (IACR) and the African Cancer Registry Network (AFCRN).

The Zimbabwe National Cancer Registry (ZNCR) was established in 1985 and achieved adequate population coverage for the population of Harare City by 1990. Since then, it has extended its activities to the provinces with the aim of achieving complete national coverage. The history, surveillance methods, data quality and completeness of registration have been described in detail elsewhere (annual reports, peer-reviewed medical journals etc.). Briefly, the registry performs active and passive case-finding based on public and private hospital in-patient and out-patient records, public and private histology reports, radiotherapy records and death certificates. The Registry now receives notifications from provincial, district, rural and mission hospitals.

The ZNCR is central in monitoring and evaluating the National Cancer Control Plan. Results from the Registry have been extensively published in high impact medical journals and cited in other scientific publications. ZNCR has provided data to important international publications including five successive volumes of the 'Cancer Incidence in Five Continents' series (Volumes VII, VIII, IX, X and XI). It was also the source of data for national estimates of cancer incidence, mortality and prevalence for GLOBOCAN 2020 published by the IARC. In recent years, it has also contributed data to 'Cancer in Sub-Saharan Africa' (Volumes II and III) and 'Cancer of Childhood in Sub-Saharan Africa' published by the AFCRN.

The Bulawayo Cancer Registry (BCR) is now fully functional following its reactivation in 2012. This important development has contributed significantly to improved national coverage by the ZNCR. Despite the successes mentioned above, the ZNCR is severely underfunded and understaffed. This NCCP focuses on strengthening the existing cancer registry's financial, human resource and technical capacities among others. Moreover, phased decentralisation for cancer services will enable further expansion of cancer surveillance.

2.7.2 Other Data Sources

There are other sources of data related to cancer in Zimbabwe including the National Surveillance Systems (T5 and T9), a hospital-based surveillance system that captures cancer data among other diseases within the integrated disease surveillance system. The DHIS-2 system of the National Health Management Information System (NHMIS) also collects data on selected cancers (cervix, breast and prostate). There are also plans in place to ensure that the DHIS-2 captures other cancer modalities such as lung cancer, multiple myeloma, and childhood cancers. Special surveys also capture critical cancer data, for example the Zimbabwe STEPS surveillance studies sponsored by WHO which captures data on risk factors for cancer and other non-communicable diseases.

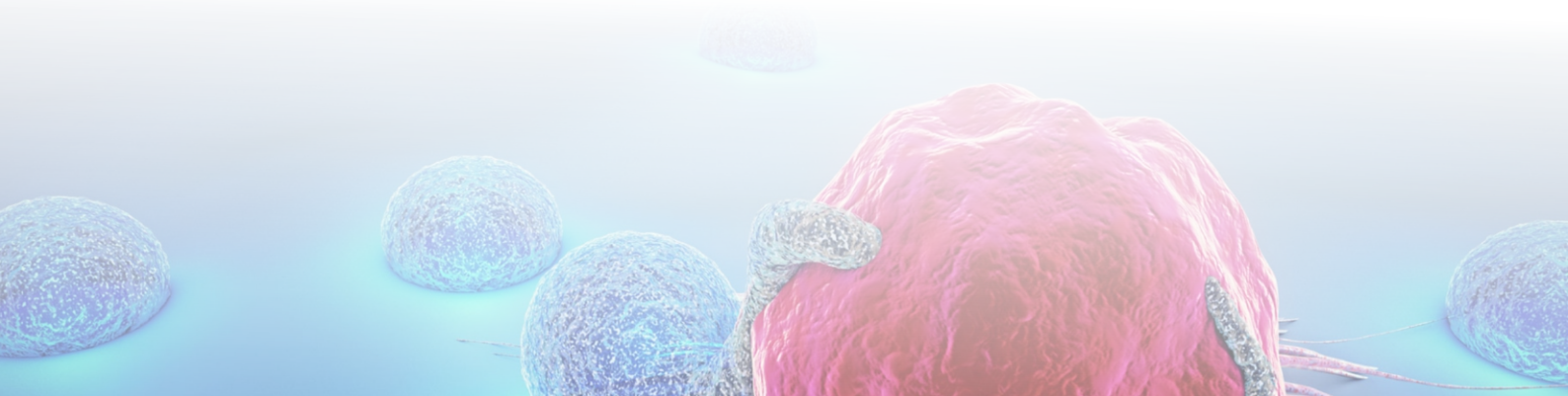
2.7.3 Research Needs

Of the 19.3 million cases of cancers that occurred worldwide in 2020, about 70% of them were in developing countries. In Sub-Saharan Africa, research has been dedicated to agriculture and infectious diseases as well as HIV and AIDS at the expense of non-communicable diseases such as cancer. The limited research on cancer in the country results in limited local evidence to guide policy and cancer management guidelines. Inadequate resources both human and financial hamper efforts to decentralise cancer research within the country. Sub-optimal collaboration between relevant stakeholders involved in cancer research efforts hampers progress in this area. This NCCP seeks to address these gaps through development of a clear, targeted funded, coordinated non-communicable diseases research plan by the MoHCC in collaboration with multiple stakeholders including universities and non-governmental organisations. Cancer research is a priority area for the National Research Agenda under formulation, which is being led by MOHCC through the Health Research Technical Working Group. Ongoing adoption of e-health technology by the MoHCC and strengthening of Monitoring and Evaluation directorate as well as development of human resource capacitation and retention plan will facilitate implementation of the formulated surveillance and research plan.





3 Strategic Direction



3.1 Vision

Quality cancer control services for all by 2030.

3.2 Mission

To create an enabling environment for evidence-based cancer prevention, early detection, diagnosis, treatment, palliative care, rehabilitation, survivorship, surveillance and research with a view to reduce cancer burden in Zimbabwe.

3.3 Goal

Reduction of cancer morbidity and mortality through implementation of quality cancer services and evidence-based cost-effective prevention and control interventions.

3.4 Guiding principles

Principle	Expectations of the Client
Quality services	Provision of appropriate services meeting the expectations of clients.
Equity	Provision of health care services according to need.
Affordability	Universal health coverage ensuring no one is left behind.
Integration	Combining services of multiple interrelated diseases to increase overall efficiency of the health system and patient convenience.
Partnerships	Strengthening partnerships and collaborating across sectors on health matters.
Ethical conduct /professionalism	Abide by the dictates of the Patient's Charter and the Health Professions Act (Chapter 27:19).

Table 4: Guiding principles in the provision of appropriate cancer services in meeting the expectations of the client.

3.5 Services Priorities/Outcomes

This NCCP will focus on the implementation of strategic actions that fall under the following pillars:

- ☑ Service Delivery
- ☑ Health Workforce
- ☑ Infrastructure equipment and products
- ☑ Monitoring Evaluation and Research
- ☑ Healthcare Financing
- ☑ Leadership and Governance
- ☑ Priority Cancers
- ☑ Cervical cancer
- ☑ Prostate cancer
- ☑ Breast cancer
- ☑ Colorectal Cancer
- ☑ Childhood cancers
- ☑ Lung Cancer

The following outcomes and objectives were identified;

- a) To scale up and improve access to quality cancer services throughout the continuum of cancer care by 2030.
- b) To increase the number of competent human resources for cancer throughout the cancer continuum of care by 2030.
- c) Expand equitable access to improved cancer prevention, management, and cancer care infrastructure.
- d) To provide accurate and reliable cancer related data for policy making, cancer prevention, management, and research in a cost-effective manner by 2030.
- e) To ensure increased sustainable funding for comprehensive cancer services by 2030.
- f) To strengthen leadership and governance for comprehensive and integrated cancer services at all levels.



4 STRATEGIC INTERVENTIONS

4.1 Service Delivery

4.1.1 Strategic Objective

4.1.1.1 To scale up and improve access to quality cancer service throughout the continuum of cancer care by 2030.

4.1.2. Strategic Direction

4.1.2.1 Address gaps in availability, affordability and quality in cancer services.

4.1.2.2 Strengthen standards-based cancer quality services.

4.1.2.3 Raise awareness on cancer.

4.1.2.4 Integrate prevention, screening and early detection interventions into existing or new programs.

4.2 Health Workforce

4.2.1 Strategic Objective

4.2.1.1 To increase the number of competent human resources for cancer throughout the cancer continuum of care by 2030.

4.2.2 Strategic Direction

4.2.2.1 Address numerical adequacy gaps of cancer service providers.

4.2.2.2 Addressing knowledge gaps in cancer management.

4.2.2.3 Build and expand human resource capacity for cancer services.

4.2.2.4 Improve conditions of service, bonding and retention.

4.2.2.5 Ensure a safe working environment.

4.2.2.6 Promote task shifting to increase availability and decentralisation of oncology services.

4.3 Infrastructure Equipment and Products

4.3.1 Strategic Objective

4.3.1.1 Expand equitable access to improved cancer prevention, management, and cancer care infrastructure.

4.3.2 Strategic Direction

4.3.2.1 Provide sustainable and appropriate infrastructure and equipment needed for prevention, screening, diagnosis and treatment of cancer.

4.3.2.2 Ensure availability of quality and affordable supplies for safe cancer prevention and management services

4.3.2.3 Provide IT infrastructure and software.

4.4 Monitoring, Evaluation and Research

4.4.1 Strategic Objective

4.4.1.1 To provide accurate and reliable cancer related data for policy making, cancer prevention, management, and research in a cost-effective manner by 2030.

4.4.2 Strategic Direction.

4.4.2.1. Systematically collect quality cancer data in a timely and cost-effective manner to provide information for decision making.

4.4.2.2. Monitor and evaluate cancer intervention programmes.

4.4.2.3. Facilitate cancer research and dissemination including publications.

4.4.2.4. Strengthen the national health information management system to provide regular data on cancer associated risk factors.

4.5 Healthcare Financing

4.5.1 Strategic Objective

4.5.1.1. To ensure increased sustainable funding for comprehensive cancer services by 2030.

4.5.2 Strategic Direction

4.5.2.1 Advocate for taxation on unhealthy foods and drinks, and other harmful substances associated with cancer.

4.5.2.2 Strengthen equipment, medicines, reagents and consumables supply chain to mitigate disruption of services.

4.5.2.3 Increase financial support for cancer services throughout the continuum of care including palliative and survivorship care.

4.5.2.4 Increase financial support for cancer surveillance and research.

4.6 Leadership and Governance

4.6.1 Strategic Objective

4.6.1.1 To strengthen leadership and governance for comprehensive and integrated cancer services at all levels.

4.6.2. Strategic Direction

4.6.2.1 Recognition and support of cancer subspecialties.

4.6.2.2 Develop, strengthen, and implement policies and strategies to improve cancer services at all levels.

4.6.2.3 Advocate for the implementation of guidelines and regulations for environmental, radiation and occupational carcinogenic agents.

4.6 Priority Cancers

4.7.1 Strategic Objective

4.7.1.1. To improve and expand access to equitable prevention, early detection, diagnosis and management of prioritised cancers in Zimbabwe.

4.7.2 Strategic Direction

4.7.2.1 Cervical Cancer

4.7.2.1.1 Increase awareness on cervical cancer risk factors, signs and symptoms and services.

4.7.2.1.2 Improve HPV vaccination coverage in line with attaining 90% coverage by 2030.

4.7.2.1.3 Expand the screening coverage to attain 70% coverage by 2030.

4.7.2.1.4 Expand treatment coverage to attain 90% by 2030.

4.7.2.1.5 Improve management of women with invasive cancer to attain 90% coverage by 2030.

4.7.2.2 Prostate Cancer

4.7.2.2.1 Increase awareness on prostate cancer risk factors, signs and symptoms and services.

4.7.2.2.2 Improve access to screening, early detection, early diagnosis and treatment of prostate cancer.

4.7.2.2.3 Improve management of people diagnosed with prostate cancer.

4.7.2.3 Breast Cancer

4.7.2.3.1 Increase awareness on breast cancer risk factors, signs and symptoms and services.

4.7.2.3.2 Improve access to screening, early detection, timely diagnosis and treatment of breast cancer.

4.7.2.3.3 Improve management of people diagnosed with breast cancer.

4.7.2.4 Colorectal Cancer

4.7.2.4.1 Increase awareness on colorectal cancer risk factors, signs and symptoms and services.

4.7.2.4.2 Improve access to screening, early detection, early diagnosis and treatment of colorectal cancer.

4.7.2.4.3 Improve management of people diagnosed with colorectal cancer.

4.7.2.5 Childhood Cancers

4.7.2.3.4 Increase awareness on childhood cancer risk factors, signs and symptoms and services.

4.7.2.3.5 Improve access to screening, early detection, early diagnosis and treatment of childhood cancer.

4.7.2.3.6 Improve case management of Children diagnosed with cancer.

4.7.2.3.7 Strengthen training for healthcare providers on childhood cancer care and treatment protocols.

4.7.2.3.8 Foster partnerships with implementing partners to support families affected by childhood cancer.

4.7.2.3.9 Promote research initiatives focused on childhood cancers to improve treatment options and outcomes.

4.7.2.3.10 Establish support networks for parents and caregivers of children with cancer to provide emotional and practical assistance.

4.7.2.6 Lung Cancer

4.7.2.6.1 Determine the local cancer risk profiles and increase awareness on these risk factors.

4.7.2.6.2 Improve access to screening, early detection, early diagnosis and treatment of lung cancer.

4.7.2.6.3 Improve management of people diagnosed with lung cancer.

4.7.2.6.4 Enhance access to diagnostic services, including imaging and pathology.

4.7.2.6.5 Provide specialized training for healthcare professionals on the latest lung cancer treatment protocols, diagnostic techniques and patient management strategies to improve care quality.

4.7.2.6.6 Integrate lung cancer care into primary healthcare services.

4.7.2.6.7 Promote smoking cessation programs and tobacco control policies.



5 Implementation Framework For National Cancer Control Plan

Implementation Framework For National Cancer Control Plan

The implementation of this Plan will be guided by the Integrated Results-Based Management Framework. This results-based framework enhances Performance Accountability across the government, led by the Permanent Secretary's Performance Contract. The framework includes quarterly Operational Plans linked to Departmental Integrated Program Agreements (DIPAs), Ministry Annual Strategic Plans, and the National Health Strategy, into which this strategic plan will feed. An implementation plan (see annex) has also been developed to ensure effective execution.

The governance structure for overseeing the implementation of this strategic document will rely on existing platforms established by the MoHCC under the Health Sector Coordination Framework. The MoHCC has developed this framework to coordinate efforts in financing, planning, implementing, monitoring, and evaluating all health-related interventions to maximize health outcomes for the people of Zimbabwe.

Clear governance structures for cancer services are critical for the successful implementation of this strategy. These structures will integrate into the existing MoHCC frameworks for sustainability and effective coordination. To operationalize the Health Sector Coordination Framework, the MoHCC has established Technical Working Groups, including a Cancer Technical Working Group. This group will comprise representatives from the MoHCC, Professional Associations, Private Sector, Health Development Partners, and UN Technical Agencies.

Table 5: NCCP Implementation Framework

Objective	Strategic Direction	Interventions	Period						Primary Responsible Institution or Organization
			2025	2026	2027	2028	2029	2030	
To scale up and improve access to quality cancer services throughout the continuum of cancer care by .2030	Address gaps in availability, affordability and quality in cancer service	Build capacity for all levels of healthcare to carry out relevant cancer services in compliance with the NCCP	X	X	X	X	X	X	MoHCC NCDs HR
		Strengthen and integrate cancer services into other Health Services	X	X	X	X	X	X	MoHCC, Partners
		Integrate cancer services into existing Ministry Outreach Programme	X	X	X	X	X	X	MoHCC, Partners
		Strengthen and integrate palliative care into cancer services at all levels	X	X	X	X	X	X	MoHCC, Partners
		Decentralise cancer services	X	X	X	X	X	X	MoHCC, Partners
		Strengthen the periodic screening and monitoring of individuals exposed to occupational	X	X	X	X	X	X	MoHCC, Partners

		hazards associated with cancer							
	Strengthen standards-based Cancer services	Develop, adapt, and disseminate cancer treatment guidelines	X	X	X	X	X	X	MoHCC, Partners
		Strengthen compliance to standard cancer guidelines.	X	X	X	X	X	X	MoHCC
		Establish and strengthen multidisciplinary teams in cancer management at all cancer centres	X	X		X	X	X	MoHCC
		Strengthen cancer referral system and patient navigation pathways	X	X	X	X	X	X	MoHCC, Partners
	Raise awareness on cancer	Develop a cancer communication strategy	X			X	X	X	MoHCC
		Promote educational and information campaign on physical activity and healthy diets	X	X	X	X	X	X	MoHCC, MoPSE, MoIPBS, partners
		Continuous provision of health education on universal infant immunisation	X	X	X	X	X	X	MoHCC, Partners
		sensitise policy makers on the need to support cancer services	X	X		X	X	X	MoHCC

To increase the number of competent human resources throughout the continuum of care by 2030.	Address numerical adequacy gaps of human resources for health	Ensure availability and equitable distribution of trained and qualified cancer health workforce at all levels	X	X	X	X	X	X	MoHCC
	Addressing knowledge gaps in cancer management	Train cancer health workforce at all levels of care on cancer risk factors, early signs and symptoms and services including referral and follow up mechanisms.	X	X	X	X	X	X	MoHCC
	Build and expand human resource capacity for cancer services	Prioritize training of critical cancer personnel (radiotherapists, medical physicists, medical doctors, surgical oncologists, oncology pharmacists, and oncology and palliative care nurses, oncologists)	X	X	X	X	X	X	MoHCC, IAEA, Partners
		Support and capacitate training institutions and trainers (pathologists, laboratory scientists, radiologists, adult and paediatric oncologists, haematologists, laboratory scientists, physicists, radiographers, oncology, and palliative care nurses)		X	X	X	X	X	MoHCC, MoHTE

		Develop technical capacity development plan for cancer services at all levels	X	X	X	X	X	X	MoHCC
		Develop a roadmap for strengthening of public-private partnerships/cooperation to enhance training and employment opportunities for cancer health workers		X	X	X	X	X	MoHCC, MoFED
		Ensure of the quality standards of education and practice	X	X	X	X	X	X	MoHCC
		Improve pre-service training in the curriculums of medical, nursing & allied medical personnel in oncology	X	X	X	X	X	X	MoHCC
		Expand the staff establishment to provide positions that will meet the demand for cancer services	X	X	X	X	X	X	MoHCC,HSC MoFED
		Revise establishment for health facilities to enable attainment of ideal cancer provider densities	X	X	X	X	X	X	MoHCC

	Improve conditions of service, bonding and retention	Implement mechanisms to ensure cancer providers with specialised skills are placed on appropriate salary scales	X	X	X	X	X	X	MoHCC HSC
		Offer competitive Locum rates	X	X	X	X	X	X	MoHCC
	Ensure safe working environment	Provide workplace education on reducing risk of exposure		X	X	X	X	X	RPAZ MoHCC
		Ensure provision of radiation protection measures		X	X	X	X	X	RPAZ MoHCC
		Develop comprehensive Quality Assurance Programme		X	X	X	X	X	RPAZ MoHCC
		Limit exposure and mitigate effects of exposure to carcinogens in the workplace	X	X	X	X	X	X	RPAZ MoHCC
		Initiate and sustain periodic screening and monitoring of individuals exposed to occupational hazards associated with cancer.		X	X	X	X	X	RPAZ MoHCC
	Promote task shifting to increase availability and decentralisation of	Develop and implement a composite strategy that includes task sharing			X	X	X	X	MoHCC MoHTE

		Include cancer infrastructure in the construction of quinary cancer care services			X	X	X	X	MoHTE MoHCC
		Advocate for provision of transport for cancer patients on treatment	X	X	X	X	X	X	MoHCC
		Prioritise rehabilitation and maintenance of equipment and infrastructure for cancer prevention and management	X	X	X	X	X	X	MoHCC
		Evaluate donated cancer equipment for usability prior acceptance and distribution.	X			X	X	X	MOHCC
		Include service level and maintenance contract at the time of purchase and ensure compliance with service level agreements by suppliers	X			X	X	X	MOHCC MOFED
		Provide rehabilitation equipment in all health facilities			X	X	X	X	MOHCC
		Expand cancer screening coverage equipment for cancers		X	X	X	X	X	MoHCC

		Adopt simple, inexpensive and effective technologies for cancer services that are scalable to primary health care settings	X	X	X	X	X	X	MoHCC
		Provide chemotherapy biosafety cabinets		X	X	X	X	X	MoHCC
		Improve and secure office space for Zimbabwe National Cancer Registry main offices in Harare and provision of office space in other provinces	X			X	X	X	MoHCC
		Advocate for waiting hostels for outpatients on treatment	X			X	X	X	MoHCC
	Ensure availability of quality and affordable supplies for safe cancer prevention and management services	Ensure adequate cancer medicines and commodities	X			X	X	X	MoHCC
		Establishment of a standalone oncology pharmacy		X	X	X	X	X	MoHCC
		Strengthen supply chain of essential diagnostic and therapeutic medicines and other consumables	X			X	X	X	MoHCC

	Provide infrastructure and IT software	Strengthen the availability of IT infrastructure and software to ensure world class services to optimise technical output Ensure upgrading of equipment software digitalize the cancer management service provision expand internet connectivity at all levels			X	X	X	X	MoCTCS
To provide accurate and reliable cancer related data for policy making, cancer prevention, management, and research in a cost-effective manner by 2030.	Systematically collect quality Cancer data in a timely and cost effective manner to provide information for decision making	Advocate for cancer to be a reportable disease by 2025 through improved reporting, especially by private sector facilities.		X		X	X	X	MoHCC
		Strengthen and expand existing cancer registries		X	X	X	X	X	MoHCC
	Strengthen the national health information management system to provide regular data on cancer associated risk factors.	develop a network of national data sources including Vital Statistics, cancer screening, HIV and AIDS registers and national health databases (DHIS2 and EHR)		X	X	X	X	X	MOHCC
		Improve access to internet connectivity at all levels			X	X	X	X	MoHCC

	Monitor and evaluate cancer intervention programmes	Strengthen routine monitoring and evaluation of cancer interventions		X		X	X	X	MoHCC
	Facilitate cancer research and dissemination including publications	Improve and coordinate cancer research including clinical trials			X	X	X	X	MoHCC
		Enable periodic publication of cancer data and other ad hoc cancer publications			X	X	X	X	MoHCC
		Promote research on role of Indigenous Knowledge Systems (IKS) on cancer management		X	X	X	X	X	MoHCC
		Participate in regional and global cancer research forums and other cancer initiatives		X	X	X	X	X	MoHCC
	Promote research and evidence generation for effective cancer program development and policy	Establish the true burden of Non-Communicable Diseases (NCDs).	X			X	X	X	MoHCC
To ensure increased sustainable funding for comprehensive cancer services by 2030.	Advocate for taxation on unhealthy foods and drinks, and other harmful substances associated with cancer	Advocate for allocation taxes levied on harmful substances associated with cancer to the cancer control program			X	X	X	X	MoHCC MoFED

	Strengthen equipment, medicines, reagents and consumables supply to mitigate equipment breakdown	Establish and coordinate a ring fenced sustainable multi sectoral funding mechanism for key cancer management equipment			X	X	X	X	MoHCC MoFED
		Ring fence funds in foreign currency for external service support, repairs and upgrades to mitigate equipment breakdown	X	X	X	X	X	X	MoHCC, MoFED
	Increase financial support for cancer services throughout the continuum of care including palliative and survivorship care	Allocate an adequate budget for palliative care opioids at MoHCC			X	X	X	X	MoHCC, MoFED
		Ensure availability of cost-free palliative care opioids at primary healthcare level.		X		X	X	X	MoHCC
	Increase financial support for cancer surveillance and research	Advocate for increased funding for cancer surveillance and research in program budgeting in the MoHCC		X		X	X	X	MoHCC
To strengthen leadership and governance for comprehensive and integrated cancer services at all levels.	Recognition and support of cancer subspecialties	Review the regulatory frameworks regarding recognition and registration of sub specialties in cancer services.			X	X	X	X	MoHCC

		Identify and equip facilities to carry out sub-speciality cancer services.	X			X	X	X	MoHCC
	Develop, strengthen and implement policies, strategies and guidelines to improve cancer services at all levels	Initiate and sustain discussions for the establishment of a national cancer institute including legislation			X	X	X	X	MoHCC
		Advocate for inclusion of cancer services in health legislation, policies, and strategies				X	X	X	
		Ensure implementation of policy, strategies and guidelines for cancer services.	X			X	X	X	MoHCC
		Improve accountability in resources allocated to cancer control programs	X			X	X	X	MoHCC
		Strengthen cancer coordination mechanisms at national and sub-national levels.	X			X	X	X	MoHCC
		Develop and implement national guidelines for cancer screening and early diagnosis, treatment and palliative, rehabilitative and	X			X	X	X	MoHCC

		Design, print and distribute IEC material in all the official local languages in Zimbabwe with key messages on cervical cancer	X	X	X	X	X	X	MoHCC, MoPSE, MoIPBS
		Distribute the IEC material using the existing distribution channels (health facilities, community meetings, outreaches, mass media campaigns) Establish advocacy groups to lobby for resources for cervical cancer prevention, control and treatment targeting policy makers	X	X	X	X	X	X	MoHCC MoPSE
		Integrate cervical cancer into sexuality education in schools through collaboration with the ministry of primary and secondary education.	X	X	X	X	X	X	MOHCC MoPSE
		Integrate cervical cancer prevention into the HIV Communication and Behavioural change strategies	X	X	X	X	X	X	MOHCC

	Improve HPV vaccination coverage to attain 90% coverage by 2030.	Expand HPV vaccination to attain 90% coverage among girls before the age 15 by 2030	X	X	X	X	X	X	MoHCC
	Increase utilization of services for prevention, control, diagnostics and treatment of cervical cancer	Demand creation in the community	X	X	X	X	X	X	MoHCC
		Integrate cervical cancer prevention services into primary health care – adopt WHO guidance to strengthen HPV DNA screen at primary health care	X	X	X	X	X	X	MoHCC
		Provide cervical cancer prevention and control services in a cultural acceptable and cost that is affordable to all the women in Zimbabwe	X	X	X	X	X	X	MOHCC
		Government to increase funding for cervical cancer prevention and control at all levels of care	X	X	X	X	X	X	MOHCC
		Strengthen SRH – HIV linkages in relation to cervical cancer	X	X	X	X	X	X	MOHCC

	Improve HPV vaccination coverage to attain 90% coverage by 2030.	Policy development on HPV vaccination for girls aged 9 to 14	X	X	X	X	X	X	MOHCC
		Expand HPV vaccination to attain 90% coverage among girls before the age 15 by 2030	X	X	X	X	X	X	MOHCC
		Forecasting, procurement and distribution of HPV vaccinations within the expanded program on immunization	X	X	X	X	X	X	MOHCC
		Cold Chain Maintenance	X	X	X	X	X	X	MOHCC
		Train health workers at all levels of care in HPV vaccination	X	X	X	X	X	X	MOHCC
	Expand the screening coverage to attain 70% by 2030.	Cascade cervical cancer screening to primary health facilities and communities.	X	X	X	X	X	X	MOHCC
		Develop the implementation framework to scale up screening with recommended high-performance tests.	X	X	X	X	X	X	MOHCC

	coverage by 2030	Strengthen the referral system and follow up mechanisms	X	X	X	X	X	X	MOHCC
		Increase capacity for the Pathology lab for Histology for central and provincial level- including procurement of equipment and	X	X	X	X	X	X	MOHCC
		Train specialist gynaecologists at provincial and central hospital to provide radical surgical treatment for cervical cancer	X	X	X	X	X	X	MOHCC
	Increase awareness on prostate cancer risk factors, signs and symptoms and services	Provide health education on prostate cancer risk factors, signs and symptoms at all levels including within communities		X	X				MoHCC, MoIPBS
		Promote educational and information campaigns on benefits of lifestyle changes, screening, early detection, early diagnosis, and early treatment of prostate cancer.	X						MoHCC MoIPBS

		Improve visibility of prostate cancer services to the public		X					MoHCC MoIPBS
	Improve access to screening, early detection, early diagnosis, and treatment of prostate cancer.	Build and expand human resource capacity for prostate cancer screening, detection, diagnosis, treatment and management	X	X	X				MoHCC
		support the piloting of population based prostate cancer screening, detection and diagnosis initiatives		X	X				MoHCC
		decentralise prostate screening, detection and diagnosis to low level facilities.			X				MoHCC
		Increase access to treatment of prostate cancer.	X	X	X				MoHCC
	Improve management of people diagnosed with prostate cancer.	Increase access to palliative, rehabilitation, and survivorship care	X						MoHCC
		Strengthen the referral system and follow up mechanisms		X					MoHCC
	Increase awareness on breast cancer risk	Provide health education on breast cancer risk factors, signs and	X	X	X				MoHCC MoIPBS

	factors, signs and symptoms and services	symptoms at all levels including within communities							
		Promote educational and information campaigns on benefits of lifestyle changes, screening, early detection, early diagnosis, and early treatment of breast cancer.	X	X	X				MoHCC MoIPBS
		Increase awareness for self-breast examination.	X						MoHCC MoIPBS
		Improve visibility of breast cancer services to the public		X	X				MoHCC
	Improve access to screening, early detection, timely diagnosis, and treatment of breast cancer.	build and expand human resource capacity for breast cancer screening, detection, diagnosis, treatment and management	X	X	X				MoHCC
		support the piloting of population-based breast cancer screening, detection and diagnosis initiatives			X				MoHCC

		decentralise breast cancer screening, detection and diagnosis to low level facilities.			X				MoHCC
		Increase access to treatment of breast cancer.	X						MoHCC
	Improve management of people diagnosed with breast cancer	Increase access to palliative, rehabilitation, and survivorship care	X	5					MoHCC
		Strengthen the referral system and follow up mechanisms	X						MoHCC
	Increase awareness on colorectal cancer risk factors, signs and symptoms and services	Provide health education on colorectal cancer risk factors, signs and symptoms at all levels including within communities	X	X	X				MoHCC MoIPBS
		Promote educational and information campaigns on benefits of lifestyle changes, screening, early detection, early diagnosis, and early treatment of breast cancer	X	X	X				MoHCC MoIPBS
		Improve visibility of colorectal cancer services to the public		X					MoHCC

	Improve access to screening, early detection, timely diagnosis, and treatment of colorectal cancer	Build and expand human resource capacity for colorectal cancer screening, detection, diagnosis, treatment and management	X						MoHCC
		Strengthen and increase coverage of colonoscopy services in Zimbabwe		X					MoHCC
		decentralise colorectal cancer screening, detection and diagnosis to low level facilities			X				MoHCC
		Increase access to treatment of colorectal cancer.	X						MoHCC
	Improve management of people diagnosed with colorectal cancer	Increase access to palliative, rehabilitation, and survivorship care		X					MoHCC
		Strengthen the referral system and follow up mechanisms	X						MoHCC
	Prevention	Strengthen smoking cessation programs and enforce anti-smoking legislation	X	X	X	X	X	X	MoHCC Partners

	Prevention	Implement nationwide education programs to raise awareness about lung cancer risk factors, symptoms, and the importance of early detection.	X	X	X	X	X	X	MoHCC Partners
	Improve early diagnosis	Introduce low-dose CT screening programs for high-risk populations to facilitate early diagnosis and improve treatment outcomes	X	X	X				MoHCC Partners
	Improve early diagnosis	Enhance access to affordable and effective lung cancer treatments, including chemotherapy and targeted therapies, through public health facilities.	X	X	X	X	X	X	MoHCC
	Integration of palliative care services for improved quality of life	Expand palliative care services specifically for lung cancer patients, focusing on pain management and quality of life improvements, ensuring that these services are accessible in both urban and rural settings.	X	X	X	X	X	X	MoHCC Partners

	Capacity Building	Provide specialized training for healthcare providers on lung cancer management, including diagnosis, treatment options, and palliative care.	X	X					MoHCC Partners
	Research and Data Collection	Invest in research to better understand lung cancer epidemiology in Zimbabwe and establish a robust cancer registry for monitoring trends and outcomes.	X	X	X	X	X	X	MoHCC Partners ZNCR
	Policy development	Enforce policies aimed at reducing air and environmental pollution and exposure to carcinogens, including regulations on industrial emissions and tobacco control measures	X	X	X	X	X	X	MoHCC Partners
	Improve early diagnosis	Launch mobile screening units to reach underserved areas, ensuring that high-risk populations have access to lung cancer screening and education.	X	X	X	X	X	X	MoHCC Partners
	Integration with the HIV/AIDS program	Leverage existing HIV care frameworks to include lung cancer screening and treatment,	X	X	X	X	X	X	MoHCC Partners

		recognizing the overlap in risk factors and improving overall health outcomes.							
	Research and Data Collection	Support research focused on lung cancer prevention, treatment efficacy, and survivorship, aiming to develop localized strategies that address the unique challenges faced in Zimbabwe	X	X	X	X	X	X	MoHCC Partners
	Collaboration through PPPs	Partner with non-governmental organizations to enhance community outreach and support services for lung cancer patients, including counselling and financial assistance programs.	X	X	X	X	X	X	MoHCC
	Increase awareness on childhood cancers risk factors, signs and symptoms and services	Provide health education on colorectal cancer risk factors, signs and symptoms at all levels including within communities	X						MoHCC, Partners
		Promote educational and information campaigns on benefits of lifestyle changes, screening, early detection, early	X						MoHCC, Partners

		diagnosis, and early treatment of childhood cancers							
		Improve visibility of childhood cancers services to the public	X						MoHCC
	Improve access to screening, early detection, timely diagnosis, and treatment of childhood cancer	Strengthen partnership with non-governmental organisations and promote and support their activities.	X	X					MoHCC WHO
		Ensure that health workers are trained on early detection of childhood cancers particularly the 6 index cancers, acute lymphoblastic leukaemia, Wilms' tumour, Burkitt lymphoma, Hodgkin lymphoma, retinoblastoma and low-grade glioma.	X	X	X				MoHCC
		Harmonise international treatment guidelines and national guidelines.	X						MoHCC
		Establish accommodation for children from out of town		X					MoHCC

		to reduce treatment abandonment.							
		build and expand human resource capacity for childhood cancers screening, detection, diagnosis, treatment and management		X					MoHCC MoHTE
		Increase access to treatment of childhood cancers.	X	X	X				MoHCC
		Establish Centres of Excellence and care networks		X	X				MoHCC
	Improve management of people diagnosed with childhood cancers	Increase access to palliative, rehabilitation, and survivorship care	X	X	X	X	X	X	MoHCC, Partners
		Strengthen the referral system and follow up mechanisms	X	X	X	X	X	X	MoHCC



6

Coordination Of The National Cancer Control Plan Implementation

The implementation framework clearly outlines the roles and responsibilities of all stakeholders involved in cancer control in the country. The framework is designed to be resilient and responsive to the ever-growing burden of cancer in the country. It also provides the coordination of cancer prevention and control in the country at both national and sub-national level.

6.1 Coordination of the NCCP Implementation Framework

Public Health Level	Stakeholders	Roles and Responsibilities
National	Ministry of Health & Child Care	Aligns cancer control with the broader health agenda in the country
		Develop policies, strategies and guidelines
		Build partnerships for effective cancer control
		Mobilizes resources for cancer control
		Coordinate training programs for healthcare workers for effective service delivery
	Cancer TWG	Provide technical expertise on cancer control
		Provide expertise on clinical guidelines, protocols, and quality standards for cancer services.
	National Cancer Forum (to be formed)	Promotes evidence-based research on cancer
Coordinates cross-sectorial collaboration among diverse stakeholders		
Province	MoHCC	Monitors NCCP performance, and addresses challenges
		Implements decentralization of cancers services
		Oversee integration of cancer services with general health services in primary, secondary, and tertiary facilities
		Provides training programs for healthcare providers to improve cancer

Table 6: Coordination of the Zimbabwe National Cancer Control Plan

6.2 Roles and Responsibilities

State Actors	Responsibilities
Ministry of Health and Child Care (NCD Department)	Lead the development, dissemination, and implementation of the National Cancer Control Plan (NCCP) Coordinate partnerships and collaborations with key stakeholders involved in cancer control efforts. Build and enhance capacity among healthcare workers for cancer prevention and control
Other Ministry of Health and Child Care Departments	Oversee the operationalization of the M & E Framework of the NCCP Participate in and contribute technical expertise to Cancer TWG meetings Integrate cancer prevention and control into different departments specific programming, in alignment with the guidance the Cancer TWG Support use of digital health platforms in cancer control Mobilize and allocate adequate financial resources for cancer prevention and control Integrate cancer prevention and control into the broader health sector plans Collect and report cancer data and support the national cancer registry
Other government ministries and agencies	Collaborate with the Ministry of Health & Child Care in cancer control and embed cancer control in all policies Support the implementation of the NCCP through a whole-of-government, whole-of-society approach
Non- State Actors	Responsibilities
Civic Society Organizations	Support cancer advocacy, communication and social mobilization activities in the country. Advocate for resources towards implementation of the NCCP. Support provision of cancer prevention and control services.

Private Health Sector	Complement MoHCC on cancer service delivery. Support local manufacturing of quality, health products and technologies. Contribute to evidence generation in cancer control. Capacity building of health care workers in the private sector.
Development Partners and International Non-Governmental Organizations	Provide technical assistance with the Cancer Strategy, national guidelines and policy development. Mobilize financial and other resources for implementing the cancer control plan. Convening Multidisciplinary Team (MDT) meetings. Lung Cancer Guidelines/SOP & Strategy Finalization/Validation. Sensitization and capacitation of healthcare workers on cancer prevention, screening and control services. Lung cancer community awareness raising and demand creation. Support Cancer Registry Strengthening Support research through risk mapping and needs assessment surveys. Lung cancer Community Awareness Strengthen the referral pathway protocol for radiology, oncology services.
Regulatory Bodies	Regulate and enforce aspects of the NCCP related to their respective bodies. Establish and update mechanisms for recognition, certification and registration of oncology professionals.
Professional Associations	Provide technical guidance on cancer control Support the implementation of the NCCP.

Professional Associations	Collaborate with MoHCC in technical support areas. Support the professional development of their constituencies.
Academia	Conduct cancer education and training of professionals. Conduct cancer research to inform and guide the NCCP. Collaborate with MOHCC to develop mechanisms for research data sharing. Establish biobanks and undertake cancer genomics and pharmacogenomic research to inform treatment decisions Conduct clinical trials and research to inform and guide the NCCP Collaborate with MOHCC to develop mechanisms for research data sharing in the country and in the region.
General Public	Adopt healthy lifestyles and positive health seeking behavior. Support efforts to reduce stigma and discrimination. Actively participate in patient support groups.
Media	Disseminate accurate cancer data and information to the public.
Cancer Advocates	Champion cancer prevention and control measures. Contribute expertise to strategy development.

Table 7: Roles and responsibilities of key sectors and stakeholders

6.3 Cancer Prevention And Control M&E Framework

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target						
								2025	2026	2027	2028	2029	2030
Service Delivery	Reduced mortality due to cancer	Cervical Cancer mortality rate- (SDG)	Number of cervical cancer deaths	Impact	>15% (2020)	NHS PF	>20%	7.1%	9.5%	11.5 %	15%	18%	20%
		Mortality rate attributed to cardiovascular diseases, cancers, diabetes, and chronic respiratory infections	Number of deaths caused by cardiovascular diseases, cancers, diabetes and chronic respiratory infections	Impact	>36% (2024)	DHIS 2	>35%	15%	18%	20%	25%	30%	35%
		Prostate cancer mortality rate	Number of prostate cancer deaths	Impact	(11%) 2018	National Cancer Registry		9.6%	9.3%				
		Child mortality due to cancer (<i>Retinoblastoma</i>)	Number of child-related cancer deaths	Impact	2018 (20%	NCDs Programme Reports		19.8 %	19.7 %				

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		Lung Cancer mortality rate	Number of lung cancer deaths per 100,000 population	Impact	146.7: 100,000	National Cancer Registry	<140	140	130	120	110	100	<100
	Reduced cancer incidence	Cervical cancer incidence	Percentage of new cases of cervical cancer diagnosed annually	Impact	25% 2020	NHS PF	23%	10%	11%	15%			
		Prostate cancer incidence	The number of new cases of prostate cancer diagnosed annually	Impact	11% 2018	National Cancer Registry	11.1%	11.3 %	11.4 %				
		Childhood cancer incidence (<i>Retinoblastoma</i>)	The number of new cases of retinoblastoma diagnosed in children aged 0-14 annually	Impact	16% 2018	National Cancer Registry	16.1%	16.3 %	16.4 %				

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		Lung cancer incidence	Number of new cases of lung cancer diagnosed per 100,000 population per year	Impact	202.5: 100,000	National Cancer Registry							
	Improved cancer treatment outcomes	Treatment rate for VIAC positive women	Percentage of women who test positive for Visual Inspection with Acetic Acid (VIAC) and subsequently receive appropriate treatment for precancerous lesions	Outcome	2020	DHIS2	90%	90%	90%	91%	92%	93%	93%
		Treatment completion rate for Prostate cancer	Percentage of patients diagnosed with prostate cancer who complete their prescribed	Outcome	33% 2020	NCDs Program Reports	35%	30%	30.5 %	31%	33%	33.8 %	35%

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
			treatment regimen										
		Treatment completion rate for childhood cancer (<i>Retinoblastoma</i>)	Percentage of children diagnosed with retinoblastoma who complete their prescribed treatment regimen	Outcome	33% 2020	NCDs Program Reports	35%	15%	18%	22%	25%	30%	35%
		Treatment completion for lung cancer	Percentage of lung cancer patients who complete the prescribed course of treatment (e.g., surgery, chemotherapy, radiotherapy, or targeted therapy) annually	Outcome	2020	Retrospective study	55%	35%	37%	39%	42%	45%	55%

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		% availability of radiotherapy services (Pari & Mpilo)	Proportion of time radiotherapy equipment is operational and accessible to patients annually	Process	2020	MOHCC Reports	80%	30%	40%	50%	60%	70%	80%
		% availability of Chemotherapy services	% time period of months that chemotherapy services are available and operational annually	Process	<55% 2020	MOHCC Reports	57%	55.1 %	52.1 %	53%	54%	55%	57%
	Improved case identification	Number. of specialist oncologists	Total number of practicing oncologists within the healthcare system, including those specializing in various fields of oncology (medical oncology, radiation	Process	15% 2021	MOHCC HR Returns/ MDPCZ	10	3	5	6	8	9	10

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
			oncology, surgical oncology)										
		Number of new cervical cancer cases diagnosed through screening	Percentage of cervical cancer cases identified as a result of organized screening programs (such as Pap smears or HPV testing)	Output	3375 2024	DHIS2, MoHCC Reports, Cancer Registry, ZDHS	90%	62%	65%	70%	75%	80%	90%
		Number of new prostate cancer cases diagnosed	Proportion of newly identified prostate cancer cases annually	Output	3083 2020	DHIS2, MoHCC Reports, Cancer Registry, ZDHS	90%	80%	85%	90%	90%	90%	90%
		Number of new lung cancer cases diagnosed	New cancer cases per 100,000 population per year	Output	11.4% 2020	Cancer Registry	25%	15%	18%	20%	22%	23%	25%

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
	Improv ed capacity to manage cancer	% facilities with no stock-outs of morphine	Proportion of healthcare facilities that have a continuous supply of morphine available for patient use, without any interruptions or shortages, over a specified time period	Process	(51%) 2020	DPS reports	80%	60%	65%	70%	75%	80%	80%
		Proportion of health care workers trained in cancer management services (prevention, screening, diagnosis,	% of healthcare workers who have completed training programs focused on cancer	Output	(15%) 2020	NCDs Program Reports	30%	18%	20%	22%	25%	28%	30%

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		treatment and care) (disaggregated by type of cancer)	management services										
		Proportion of health care workers trained in early warning signs of childhood cancers (<i>Retinoblastoma</i>)	% of primary health care workers who have completed training programs specifically addressing the early warning signs of retinoblastoma	Output	(15%) 2020	NCDs Program Reports	30%	17%	20%	22%	25%	28%	30%
		Number of health care facilities offering continuation of cancer treatment services (Including paediatric oncology) (Targeting 1 facility per province)	Total count of healthcare facilities that are equipped to provide continuation of cancer treatment services.	Output	2 2021	MOHCC Reports, Facility readiness report	6	3	3	4	4	5	6

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		Proportion of patients in need of palliative care who have received care from a PC trained provider. (disaggregated by type of cancer)	%	Output	40% 2020	MOHCC Reports	60%	42%	45%	50%	53%	58%	60%
		Number of healthcare workers trained in palliative care		Output	493 2020	Island Hospice Reports	600	500	530	550	565	580	600
		Proportion of health facilities with IEC material on cancer prevention and management (disaggregated by type of cancer)	% of health facilities with IEC material on cancer prevention and management	Output	21% 2020	Health Promotion Reports	60%	30%	40%	45%	50%	55%	60%
	Standards-based	Proportion of Cancer Guidelines developed	Proportion of Cancer Guidelines developed	Output			2	2	0	0	0	0	0

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
	cancer quality services	Number of Cancer guidelines Reviewed					2	2					
	Improved Cancer awareness	Cancer Communication Strategy/package developed		Output	0	Progress Reports	3	2	1				
		Number of community members reached with Cancer awareness (disaggregated by type of cancer)	Total count of individuals within a defined population engaged through cancer awareness activities	Output	1816204 2024	DHIS 2	2000000	1900 000	1900 200	1900 400	1900 600	1900 800	2000000
Health Work force for Cancer	Trained health force	Number of trained and Qualified cancer care professionals.	Oncologist, Haematologist, Radiotherapist, etc	Output	283 2024	NCCP, HRH records	618	300	350	400	480	550	618

[illegible]

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		Salary scale for cancer care professionals				HRH records							
	Capacity Building of health professionals training institutions	Number of Training institutions capacitated				Progress Reports							
Infrastructure equipment and products	Adequate infrastructure , equipment and products	Number of certified cancer screening facilities	Total number of certified cancer screening facilities	Output	260 2023	WHO records	315	265	275	280	290	295	315

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target						
								2025	2026	2027	2028	2029	2030
		Number of Key Cancer Equipment Procured	Radio-therapy, imaging machines etc	Output	12 2015	Inventory reports	25	12	14	16	18	22	25
		Number of Functional radiotherapy Equipment	Counting functional key cancer equipment	Output	4 2024	Inventory reports	10	5	6	7	8	9	10
		Number of Provincial hospitals with available essential cancer medicines	Essential cancer medicines availability	Output	0.1%	MoHCC- Pharmacy	90%	10%	10 %	15%	15%	20%	20%
Monitoring, Evaluation and Research	Cancer research and dissemination	Number of Cancer related operational research conducted/ articles published		Output	0	Journals	4	2	2	3	3	4	4

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target						
								2025	2026	2027	2028	2029	2030
		Number of cancer research articles published in peer reviewed journals		Output	0	Journals	3	1	2	3			
		Number of National Non-Communicable Diseases Risk survey carried out		Output	1	Progress Reports	1	0	1				
	Quality cancer data to provide information for decision making	Data bases successfully linked to cancer registry database	Vital Statistics, screening, HIV and AIDS, national health databases (DHIS2 and EHR)	Output	1	Progress Reports	2	1	0	1			
		Number of cancer types including childhood cancers considered reportable diseases by 2030	Cancer types appearing MoHCC T5 Forms and DHIS2	Output	0 2022	MoHCC databases, T5 Forms	5	0	5				

[illegible]

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target						
								2025	2026	2027	2028	2029	2030
	Social Protection for vulnerable cancer patients	Number of Cancer patients assisted through patient social protection models	Counting number of patients assisted (free drugs and/or other services and needs)	Outcome	0	-	>100	5	10	20	30	50	>100
Leadership and Governance	Improved oncology service delivery	Reviewed regulatory frameworks regarding recognition and registration of sub specialities	Framework review										
	Cancer coordination mechanisms	Number of National Cancer Forum Meetings held		Output	-	-	4	1	2	3	4		

PILLAR	OUTCOME DESCRIPTION	KEY PERFORMANCE INDICATOR (KPI)	KPI Definition	Type of Indicator	Baseline (Year)	Data Source	Overall Target	2025	2026	2027	2028	2029	2030
		Number of cancer stakeholders' coordination meetings held		Output	1 2024	Progress reports	8	1	2	3	4	6	8
	Cancer Legislative framework	National Cancer Policy developed											
		National Cancer Guidelines Developed (disaggregated by type of cancer)		Output	2 2020		2	1	1	2			
		Number of Higher-level meetings that discussed Zimbabwe Cancer Institute Act	Number of Higher-level meetings that discussed Zimbabwe Cancer Institute Act during the implementation period of the Plan	Outcome	0 2024		2	0	1	0	1		

Table 8: Cancer prevention and control M&E Framework

Institutions that contributed to the NCCP Development

1. Ministry of Health and Child Care (MoHCC)
2. Ministry of Energy and Power Development
3. International Atomic Energy Agency (IAEA)
4. International Agency for Research in Cancer
5. World Health Organization (WHO)
6. United Nations International Children's Emergency Fund (UNICEF)
7. The United Nations Population Fund (UNFPA)
8. Bristol Myers Squibb Foundation (BMSF)
9. Cancer Association of Zimbabwe
10. KidzCan Zimbabwe
11. CancerServe Trust
12. Environmental Management Agency (EMA)
13. Island Hospice and Health Care
14. Jointed Hands Welfare Organisation (JHWO)
15. Newlands Wellness Pharmacy
16. Programme of Action for Cancer Therapy (PACT)
17. Radiation Protection Authority of Zimbabwe (RPAZ)
18. University of Zimbabwe (UZ)
19. Clinton Health Access Initiative (CHAI)
20. Talk Cancer Zim
21. Zimbabwe National Cancer Registry
22. Parirenyatwa Group of Hospitals
23. Mpilo Central Hospital
24. Organisation for Public Health Interventions and Development (OPHID)
25. Biomedical Research and Training Institute (BRTI/ThruZim)

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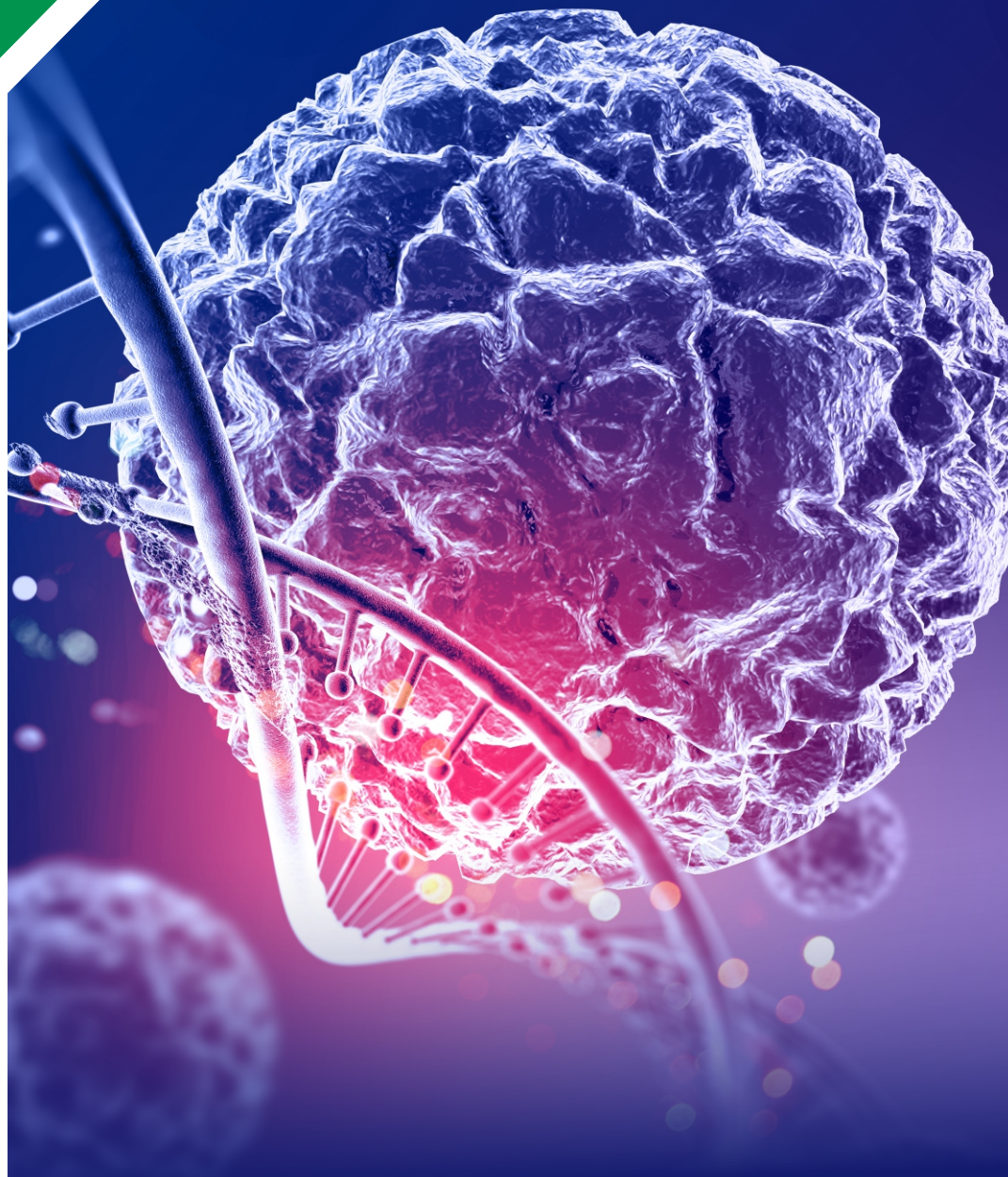
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2025 - 2030