

CBM UK PROJECT EVIDENCE BRIEF #12

Improving vision for communities in Zimbabwe's Midlands Province

A health systems strengthening approach

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Project snapshot

Improving Vision for Communities in Zimbabwe's Midlands Province

Locations:

All eight districts of Midlands Province, Zimbabwe.

Timeframe:

July 2023 - September 2025.

Project partners:

CBM Global, HelpAge Zimbabwe and The Ministry of Health and Child Care Zimbabwe.

Project funders:

UK government through UK Aid Match.

Project context

The Midlands Province is predominantly rural and faces high levels of rapid urbanisation. It has limited primary and tertiary eye care services and major human resource and infrastructure gaps. All eight district hospitals lacked sufficient equipment, drugs and other consumable supplies. The Provincial Eye Unit in Gweru required urgent repairs as well as accessibility improvements for people with disabilities. Primary healthcare workers often lacked knowledge about eye health conditions and although trained ophthalmic nurses were available in district hospitals, their ability to deliver a full range of diagnostic and refractive services was constrained by inadequate equipment and limited referral support systems.

Project outcomes

8
district hospitals equipped with functional eye health equipment.

1,483
health workers trained in inclusive eye health.

2,557
cataract surgeries performed.

54,101
people accessed eye health services during the project

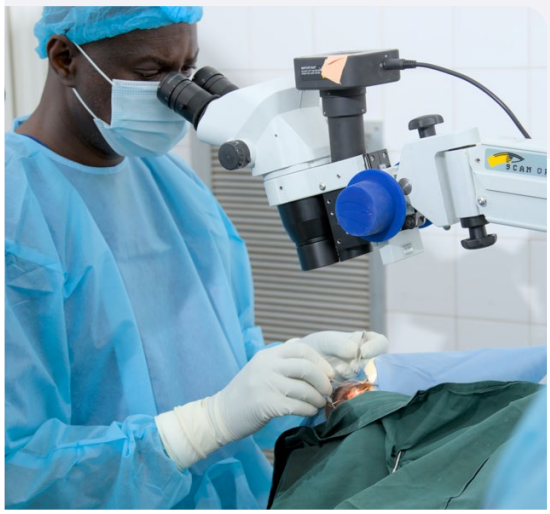


Image caption: A cataract surgery taking place. ©CBM UK/Thabani

Overview

The World Health Organization (WHO) and United Nations have called for stronger integration of eye health within Universal Health Coverage (UHC) and national health systems, recognising its importance for achieving the Sustainable Development Goals (SDGs).[1] The WHO also stresses the importance of primary eye care as the basis of a strong healthcare system and for health equity. This brief applies the WHO Health Systems Building Blocks Framework to share evidence and key lessons from the project that guide funders, policy makers and implementing partners planning eye health investment.

Zimbabwe faces high levels of preventable blindness and limited availability of quality eye health services.[2] In Midlands Province in western Zimbabwe, eye health services have been severely under-resourced, leaving many unable to access timely diagnosis and treatment. Using the WHO's Health System Strengthening Framework, CBM worked with Zimbabwe's Ministry of Health and Child Care (MoHCC) and HelpAge Zimbabwe to strengthen eye care across all eight districts. There are now standalone eye health services in all eight hospitals of Midlands Province and 54,101 people accessed eye health services during the project.

Introduction

Globally, over 90% of people with visual impairments have conditions that can be prevented or treated.[3] Many face avoidable vision loss because they lack access to timely and affordable care, such as cataract surgery or glasses. Visual impairment can significantly reduce quality of life and hinder access to education and job opportunities, leading to significant national and global productivity loss.[4]

In Zimbabwe a lack of awareness of eye health conditions, high treatment costs, and mistrust of formal health services limits access to early diagnosis and treatment, leaving many with avoidable blindness and at risk of falling into poverty. The country faces substantial workforce shortages that are exacerbated by the emigration of skilled healthcare professionals. In Midlands Province, a rapid assessment of avoidable blindness (RAAB) found that 94.7% of bilateral blindness was considered avoidable and 55.8% was considered treatable, identifying significant potential for interventions to reduce avoidable blindness.[5]

This project demonstrated how tailored system strengthening efforts and decentralised service delivery can increase access to eye health services. Mobile health camps delivered 2,557 cataract operations across the province, while investing in low-cost technologies and training of primary healthcare staff in inclusive eye health, enabled eye health examinations and referrals to take place at primary level. This strengthened workforce capacity and improved health infrastructure and technology, leading to improved service delivery and reduced burden on limited tertiary services.

1 WHO. 2022.
2 IAPB Vision Atlas. Country Data.
3 WHO. 2019.
4 Marques et al. 2021. Global Economic Productivity losses from vision impairment.
5 Mashaka and Machek, 2021 Rapid Assessment of Avoidable Blindness.

Methodology

This brief draws on data from a mixed methods endline evaluation, a baseline assessment, a Rapid Assessment of Avoidable Blindness (RAAB), routine monitoring, evaluation and learning (MEAL) data, referral records, and programme documentation. Quantitative data assessed changes in eye health service utilisation, referral patterns, and access to care. Qualitative insights revealed how involving traditional healers shaped referral pathways and connections between communities and contemporary eye health services.

What the evidence tells us

The Midlands project was designed using the WHO Health Systems Building Blocks Framework, which comprises six components: service delivery, health workforce, health information systems, medical products and technologies, financing, and leadership and governance.[6] Effective health system strengthening requires different levels of investment across these components depending on local needs. The following section demonstrates the key findings from the project and how this framework was applied to the context of Midlands Province. One of the key contributors to the success of the project was shifting tasks to primary healthcare, supported by the Arclight. a low cost ophthalmic device. The Arclight is a low-cost ophthalmic device which with training can enable eye health services to be integrated into primary healthcare systems.[7]



Image caption: Someone using the Arclight tool.

[6] WHO 2017. Monitoring the Building Blocks of health systems.
[7] Blaikie, A. Arclight: a pocket ophthalmoscope for the 21st century.

Balancing short-term and long-term investment

Key finding:
Short-term measures like eye health outreach camps can fill critical resource gaps while longer term investments in health system strengthening. are secured.

"Previously, we did not have an eye unit here and we were all over the place but now we have a standalone eye unit."
Female, key informant

The integration of medical technologies into hospital infrastructure is an essential foundation of successful eye health delivery. It supports the entire pathway of care from prevention to diagnosis, treatment and ongoing management.[8] Midlands Province faced severe medical technology and infrastructure gaps, reducing the availability of eye health services and cataract operations. A 2021 RAAB highlighted a high surgical backlog and found that 55.8% of bilateral blindness in Midlands was caused by cataracts.[9]

While longer-term solutions were being developed, the project set up 36 outreach camps to meet urgent needs for cataract operations. This outreach model reduced travel and cost barriers enabling 42,081 eye health consultations to take place closer to patients' homes and 2,557 cataract operations to be delivered. This demonstrates that flexible, decentralised service models can meet urgent gaps in care.

To meet longer-term needs, the project provided essential eye health equipment to all eight district hospitals in the province. It also identified and addressed infrastructural accessibility barriers for people with disabilities. That investment means that every district hospital now has a visible, stand-alone eye unit. For example, the Mberengwa Hospital now has a dedicated operating space for its ophthalmic nurse. This replaced the previous system where services were offered in outpatient departments.

Longer term solutions require continued domestic financing and investment from local and national authorities. Motivating political will for eye health required continued advocacy and partnership alongside local organisations, this was supported by CBM's partnership approach which worked alongside local OPDs and local governments throughout the project.

[8] UK Government. 2024. Medical Technology Strategy
[9] Mashaka and Machek, 2021 Rapid Assessment of Avoidable Blindness.

Strengthening the primary health workforce

Key finding:
Strengthening the capacity of primary and community health workers can shift tasks to primary level and ease the burden on limited specialist services.

Strong primary healthcare systems are fundamental to achieving Universal Health Coverage. In low- and middle-income countries, strong primary care is critical to eye health access and coverage, because ophthalmic imaging equipment is typically limited to tertiary hospitals or private facilities. In Zimbabwe, this is exacerbated by workforce shortages which makes early detection of eye health conditions difficult. The project trained primary healthcare staff on how to do routine eye checks, using the Arclight, and refer eye conditions to specialist services where necessary. This helped shift tasks to primary level and ease the burden on limited specialist services. [10]

The Arclight is a low-cost alternative to conventional ophthalmoscopes that can be used for basic eye and ear examinations in primary healthcare settings. Training primary care nurses and ophthalmic nurses (OPNs) to use the Arclight enabled nurses and other primary healthcare staff to detect and refer eye conditions at primary level. This training also covered parts of the WHO Primary Eye Care curriculum, including recognising common red eye disorders and conditions such as cataract and retinoblastoma. This improved diagnostic capacity with knowledge scores increasing from 67% to 89% and clinical skills from 24% to 92% from baseline to endline conditions.

Regular refresher and competency-based training is critical for the effective use of the Arclight. Virtual learning platforms and real-time peer support on WhatsApp enabled ongoing professional growth and knowledge exchange. Shifting tasks to primary care level must be backed up by policies, training and the proper integration of community health workers.

[10] Blakie et al. The Arclight Device: Frugal imaging for eyecare.

Engaging traditional and faith healers

Key finding:
Engaging traditional and faith healers in referral pathways can increase uptake of contemporary eye health services.

"I've stopped using substances such as snuff and mubvagazi (bloodwork tree bark) on people's eyes. Now, they refer anyone with eye problems to the hospital."
Focus group discussion participant

Cultural beliefs and health-seeking behaviours strongly shape health outcomes.[11] The WHO increasingly recognises the value of culturally responsive health systems and acknowledges that traditional medicine can enhance service delivery. In many African settings, including Zimbabwe, the cause of disease is deemed spiritual, so traditional and faith healers are often the first point of contact for care.[12] They are often easier to reach, less expensive and more trusted.

The project discussed safe eye health practices with traditional and faith healers. This enabled them to refer people to appropriate services, using referral cards. In two pilot districts alone, traditional and religious leaders referred 6,205 people within six months of training, leading to referrals surpassing project targets by 369%. Structured engagement and partnership with traditional and faith healers helped identify more cases, expand service reach, improve referral efficiency and reduce harmful eye health practices.

Lessons from the project show the value of community-based referral systems and provide an alternative model of engagement that other districts and settings can replicate. They also highlight the need to plan resources carefully, while generating increased demand. This should be supported by robust health information systems that monitor the impact of strengthening one building block of the health system on other blocks.

[11] Nambi, H. 2025. The impact of cultural practices of health outcomes.
[12] Asante, P. 2023. Medical Pluralism Healthcare Utilization and patient wellbeing.

Community mobilisation

Key finding:
Eye health champions (EHCs) helped address gender norms that discourage people from seeking care.

Misconceptions about contemporary healthcare are widespread in Zimbabwe, and fears surrounding cataract surgery and anaesthesia can stop people seeking treatment. A network of EHCs, many of whom had received cataract surgery through the project, shared their personal stories to encourage people to seek care.

Men often ignore early disease symptoms and delay seeking medical care.[13] Peer-to-peer advocacy by male eye health champions was especially effective, encouraging men to seek care sooner while female champions leveraged their strong community networks leading to a higher rate of referrals. This enabled earlier detection of eye health conditions.

These activities were supported by community dialogues and radio programmes and contributed to a substantial increase in service use. Consultations rose from 11,358 in Year One to 28,480 in Year Three, with community mobilisation activities contributing significantly to increased service uptake. This is a critical insight because the WHO Building Blocks Framework does not explicitly recognise community mobilisation as part of health system strengthening.

[13] Abdulla, N et al., (2022) Men health seeking behaviour. A literature review

Leadership and governance

Key finding:
Implementing eye health initiatives in partnership with local authorities fosters political commitment and institutional ownership.

Embedding eye health within provincial and district planning processes strengthens accountability, clarifies leadership, and creates the conditions for continued investment beyond the project. In Midlands Province, successful service delivery created momentum for institutionalising eye health within government health systems. This helped to support policy change and increased investment in eye health across the province.

The project improved collaboration between the MoHCC, district authorities, universities, researchers and implementing partners, which led to the development of a Provincial Eye Health Policy Position Paper. This named the MoHCC as lead coordinator for eye health, and outlined priorities for budgeting, workforce development and service coordination. At district level, increased prioritisation and investment into eye health led to service improvements. The Zvishavane district hospital now has a dedicated clinical space for eye health, and Gweru district committed to finance a bi-annual rural outreach programme for cataract operations.

By generating and sharing evidence of local needs and project impact over three years, local authorities increasingly began to prioritise eye health. This shifts system strengthening efforts from donor-supported interventions to a recognised government priority with defined leadership and increased budget. Linking project implementation with policy engagement allowed for successful models for eye health to be institutionalised within existing health systems.

Learning from experience

1. Domestic financing is the foundation of sustainable health system strengthening efforts.

External funding can catalyse system strengthening efforts, but for services to be sustained, governments must progressively embed eye health into their regular planning and budgeting systems. This project demonstrated political commitment and institutional ownership can be built through a partnership approach, continued advocacy and a strong policy framework.

2. Strengthening primary eye care is essential for removing barriers and bringing services closer to where people live.

Equipping primary healthcare staff to detect and refer eye conditions, using low-cost tools such as the Arclight, reduces reliance on scarce specialist services and removes the distance, time and cost barriers that often prevent people from seeking care. This brings eye health services as close to people's homes as possible.

3. Community mobilisation is a critical building block of health system strengthening.

Community mobilisation was essential to the success of the health system strengthening approach. In settings characterised by low levels of trust in contemporary healthcare, respecting local cultural practices around health seeking behaviour and engaging trusted local actors are essential for improving service uptake. Involving traditional and faith healers can expand service reach and improve referral pathways. Rather than viewing traditional and contemporary healthcare systems as competing structures, mutual engagement and recognition are crucial to the success of the health system strengthening approach.

4. Improvements to referral processes must be balanced with levels of available support.

Demand generated by improved referral processes must align to the capacity of the health system to respond. Future programmes should improve referral pathways in parallel with investments in capacity strengthening. Regular capacity assessments, communication between referral agents and service providers, alongside feedback mechanisms can help match referral volumes with available services. The phased implementation of system strengthening interventions can also improve service alignment. Phase Two, launched in 2025, will support local authorities to strengthen health infrastructure and monitoring systems.

Recommendations

1. Advocate for sustainable domestic financing to integrate eye health into national health financing mechanisms.

Increased government investment and integration into national health financing policies enables long-term institutionalisation of eye health services. This underpins the success and sustainability of health system strengthening.

2. Strengthen collaboration between communities, health facilities, and health authorities.

Sustainable health system strengthening requires stronger connections among community groups, healthcare providers, and government systems. This can improve referral pathways, strengthen accountability, and encourage local ownership. Programme design and investment should build on existing community and government structures. Stakeholder roles and responsibilities must be clearly defined.

3. Invest in workforce development alongside health technologies.

Investments in low-cost technologies for primary healthcare can improve early detection, diagnosis and referral. However, their impact depends on an appropriately trained workforce. Programme implementers should pair technology investments with competency-based training, supportive supervision, maintenance systems and integration into routine primary healthcare.

4. Invest in community mobilisation to strengthen service uptake and referral pathways

Building trust is essential for improving service uptake in contexts where fears about contemporary healthcare are prevalent. Programme implementers should invest in local champions and trusted community members, including traditional and faith healers where appropriate, to support health promotion, strengthen referral pathways and reduce harmful practices.

5. Apply the WHO Health Systems Building Blocks Framework as an interconnected system, informed by evidence-based learning.

The Building Blocks Framework should not be treated as a set of isolated or equally weighted components. Continuous monitoring, evaluation, accountability and learning (MEAL), supported by routine health information systems and referral pathway data, should be used to identify system bottlenecks, monitor progress and direct resources to the areas of greatest need.

Conclusion

The Midlands project demonstrates that sustainable improvements in eye health are achieved by coordinated investments across multiple parts of the health system. Progress was driven by interactions across the WHO system strengthening building blocks rather than isolated investments. Investments in medical products and technologies and the health workforce were prioritised to provide the foundation for improved service delivery. This was supported by community mobilisation, including engagement with traditional and faith leaders and investments at primary healthcare level that enabled earlier diagnosis, improved referral pathways and reduced pressure on limited tertiary services. The introduction of the Arclight alongside training supported frontline health workers to detect eye conditions and improve access to care. Integrated actions strengthened service delivery and eye health coverage across the province, catalysing health system strengthening efforts which aim to reduce avoidable blindness.



Nurse helps a patient during an eye consultation. ©CBM UK/Thabani

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