

BIENNIAL REPORT OF THE WHO COUNTRY OFFICE IN ZIMBABWE



2014–2015



World Health
Organization

REGIONAL OFFICE FOR
Africa

BIENNIAL REPORT OF THE WHO COUNTRY OFFICE IN ZIMBABWE, 2014–2015

WORLD HEALTH ORGANISATION
REGIONAL OFFICE FOR AFRICA
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FOREWORD



The WHO Country Office (WCO) in Zimbabwe is once more pleased to share this 2014-2015 biennial report with stakeholders and partners. The report highlights key contributions made by WHO to health development efforts in Zimbabwe. We wish to point out from the outset that the report does not purport to present all the results of a wide range of WHO technical activities for the period. Rather, it is a synopsis of significant achievements, the challenges encountered, and lessons learnt, that will be used to improve the work of WHO in the coming years. The report is, in part, one way of giving practical effect to our efforts to strengthen accountability, in line with the Transformation Agenda of the WHO Secretariat in the African

Region. More importantly, it aims to enhance the culture of evaluation and reporting, and to improve strategic communication.

Although Zimbabwe continues to face numerous challenges emanating from a depressed economy, some very positive signals emerged in the course of the biennium that promise to reverse the negative trends. We congratulate the Government of Zimbabwe for its re-engagement efforts, begun in 2015, with the Bretton Woods institutions and bilateral partners. Notably, an agreement was reached in Lima, Peru, between the Government of Zimbabwe, the World Bank, IMF and the African Development Bank, on debt rescheduling. This important agreement, concluded on the sideline of the IMF/World Bank annual meeting, has the potential to lead to new financing arrangements and loans from the international financing institutions. The re-engagement is a positive signal that will create a healthy environment for sustained economic revival.

In spite of the difficult economic situation, WHO maintained its focus on strategic engagement with the Government, and continued to strengthen collaboration with development partners in health, first, by paying special attention to the objectives of the MDG agenda, and second, by initiating processes towards adaptation of the new

Sustainable development goals (SDGs). To this extent, WHO helped to document and report on progress made in implementing the MDGs. A Zimbabwe final progress report on MDGs is available, and presents a full overview of progress and challenges. Progress on the MDG impact indicators will serve to inform programming for the new Sustainable development goals. Of strategic importance, and working with other partners, WHO helped initiate the development of the new National Health Strategy (NHS 2016–2020) that has incorporated critical issues in the SDGs. Drawing from, and ensuring complete alignment with, the new NHS, the Country Office also initiated the development of the third generation Country cooperation strategy (CCS 2016–2020).

The visibility of the Country Office was heightened during the biennium, partly because the United Nations country team (UNCT) in Zimbabwe formally adopted WHO premises as the venue for all commemorative functions and major events involving the UN system. For instance, the commemorative functions celebrating the UN at 70+, which attracted diplomatic missions in Zimbabwe and high-level Government officials, were held at the WHO Country Office premises. On that occasion, we were proud to host the Vice President and Minister of Justice, Legal and Parliamentary Affairs of the Republic of Zimbabwe, Hon Emmerson D. Mnangagwa, on 23 October 2015. Improvement of the roads network and parking bays, as well as roof repairs and a coat of paint on the buildings, have given all of us the feeling of a new lease of life. We have received many gratifying remarks from our partners on the 'new look' of the WHO workplace.

Another key highlight of this biennium was WHO support to a successful hosting of the 18th Session of the international conference on sexually transmitted infections (STIs) and AIDS in Africa (ICASA 2015) in Harare from 29 November to 4 December 2015. The conference ran under the theme *AIDS in post-2015: linking leadership, science and human rights*. It was attended by close to 5,000 delegates, including some health ministers from the Region.

With regard to work on specific programmes, WHO played a critical role in identifying priorities for the Global Fund, GAVI, CIDA, DfID, the Bill & Melinda Gates Foundation (BMGF), the President's Malaria Initiative (PMI) and other donor-supported projects in health. WHO helped in preparing the necessary grant applications, and actively supported programme implementation. We carried out brokerage functions to untangle operational bottlenecks, to lead negotiations between donor agencies and local implementing teams, and to ensure timely and accurate reporting to donors. For example, the national HIV/AIDS, TB and malaria programmes that are heavily

supported by WHO, have scored very good performance indicators. These indicators are key pre-conditions for funding renewals that the country continues to enjoy. Zimbabwe has not received any negative audit queries. In fact, as a matter of pride, Global Fund projects in Zimbabwe are now a showcase of success.

We believe that the health sector made major gains, both in terms of programmatic work, and in efforts to access the required resources from partners to support programme activities. However, the gains made remain fragile and may not be sustainable, as they continue to be heavily dependent on external support. We urge the Government to redouble its efforts in exploring new avenues for sustaining programmes that are funded by partners. For the donors, we believe it is risky to reduce or withdraw funding at this time. The country still needs greater support to ensure that the gains made are not reversed by sudden cuts of support.

Moving forward, a key lesson learnt from the 2014-2015 biennium is the need to strengthen coordination, in order to ensure that the efforts of partners are focused on government-led priorities that are spelt out in the NHS. Accountability remains critical, not only to satisfy donor requirements, but also for the people in remote communities and in peri-urban congregate settlements, who are in dire need of improved service delivery. We should revitalize primary health care and community engagement in matters of health, paying particular attention to disease prevention and health promotion efforts that are targeted at risk factors to disease outbreaks and non-communicable diseases (NCDs). Above all, however, more needs to be done to make Universal health coverage a reality, and, in the spirit of SDGs, to *'leave no one behind'*.

We sincerely hope that this synopsis of WHO work in Zimbabwe for the 2014-2015 biennium will shed some light on the contributions of the Organization to health development efforts in the country.



Dr David O. Okello
WHO Representative

1. HIGHLIGHTS OF THE BIENNIUM

- (a) WHO hosted key UN commemorative functions;
- (b) Supported Zimbabwe to host the 18th international conference on AIDS and STIs in Africa (ICASA);
- (c) Supported development of an operations and service delivery manual to orient implementation of ARV guidelines;
- (d) Supported the development and costing of the new National health strategy (NHS 2016–2020);
- (e) Facilitated preparation of applications submitted to GAVI for the introduction of new vaccines;
- (f) Supported HIV drug resistance surveillance activities;
- (g) Supported containment of Ebola virus disease outbreaks in West Africa, and managed associated local anxiety and fear of possible Ebola importation to Zimbabwe;
- (h) Supported the national TB prevalence survey (TPS);
- (i) Supported Zimbabwe to accede to the WHO Framework convention on tobacco control (FCTC);
- (j) Supported the first-ever service availability and readiness assessment;
- (k) Supported the revision of the 6th edition, and the development of the 7th edition of the Essential Medicines List for Zimbabwe (EDLIZ);
- (l) Introduced Emergency triage assessment and treatment (ETAT) to improve care of sick children in referral hospitals.

In October 2015, the United Nations country team in Zimbabwe joined the rest of the world in celebrating the 70th anniversary of the United Nations. The celebrations were an opportunity for the UN to reflect on and take stock of its achievements, and to review strategies on how to meet current and future global challenges in major areas such as development, human rights, peace, and security. The celebrations were hosted by the WHO Country Office at its Highlands premises in Harare. The guest of honour was the Vice President and Minister of Justice, Legal and Parliamentary Affairs, Hon. Emmerson D. Mnangagwa. In the statement he presented on that occasion, the Vice President paid tribute to the excellent relations of cooperation and collaboration that exist between the Government and the UN country team. He also emphasized that the

UN would need to continue to assist Zimbabwe in its efforts to attain the SDGs. Just before the function, the Vice President met with Dr David Okello, WHO Country Representative for Zimbabwe, Mr Parajuli, UN Resident Coordinator, and Mr R Hossaini, UNICEF Country Representative. He signed the Visitors' Book and left memorable remarks on the role of the UN in sustaining peace and development efforts in the world. The WHO Country Office premises have been a favourite venue for hosting United Nations commemorative events for the last few years.

The UN at 70 commemorations with the Vice-President of Zimbabwe as guest of honour

Figure 1: The Hon Vice President, Dr E. D. Mnangagwa, meets Dr D Okello (WR, Zimbabwe), Mr Parajuli (UN Resident Coordinator in Zimbabwe) and Mr R Hossaini (UNICEF Country Representative) in the WR's Office during celebration of the UN at 70



Figure 2: The Hon. Vice President, Dr E D Mnangagwa, with Dr D Okello (WR, Zimbabwe), Mr Parajuli (UN Resident Coordinator in Zimbabwe) and other delegates follow proceedings at the commemoration of the UN at 70



18th International conference on AIDS and STIs in Africa (ICASA) in 2015

Zimbabwe successfully hosted the International conference on AIDS and STIs in Africa (ICASA 2015) from 29 November to 4 December 2015. The conference ran under the theme AIDS in post-2015: linking leadership, science and human rights. Close to 5,000 delegates attended the conference, including health ministers from the Region. The Country Office, in collaboration with the Inter-country support team for eastern and southern Africa (IST/ESA), was part of the local scientific and organizing committees of ICASA; there was additional support from the Regional Office and the WHO headquarters. Zimbabwe was highly commended for hosting ICASA 2015 on short notice. One of the key contributions of WHO at ICASA was the launch of the 2015 revised guidelines on the use of ARVs, for the prevention and treatment of HIV infection.

Figure 3: ICASA Opening ceremony with the Hon Vice President of Zimbabwe, Dr E. D. Mnangagwa; Dr Matshidiso Moeti, WHO Regional Director for Africa; Dr D. Parirenyatwa, Minister of Health and Child Care, Zimbabwe; Mr A Musiwa, Deputy Minister of Health and Child Care, Zimbabwe; Mr M. Sidibe of UNAIDS; and the regional directors of UNFPA, UNICEF and UNODC



Figure 4: Dr Matshidiso Rebecca Moeti, WHO Regional Director for Africa, at the launch of the 2015 WHO ARV guidelines at ICASA



Figure 5: ICASA launch of the WHO Report on the global health sector response to HIV, 2000–2015



Figure 6: Dr Chombo, Minister of Home Affairs, Zimbabwe; Dr David Okello, WHO Country Representative for Zimbabwe; Dr Magda Robalo, Director, CDS at the Regional Office, and others, following proceedings at ICASA



2. KEY ACHIEVEMENTS

Health system strengthening

The World Health Organization Country Office continued to support the Government of Zimbabwe in its efforts to strengthen the health system. The National health strategy (NHS) guides the country's health development agenda. During the biennium, WHO supported the extension of the 2009–2013 NHS to 2015. Furthermore, WHO provided technical assistance to the Ministry of Health and Child Care (MOHCC) during the evaluation of NHS 2009–2015. The lessons learnt from the exercise were utilized in the development of the new NHS for 2016–2020. WHO staff members and other partners were actively engaged in the costing of the new NHS, using the *One Health* tool.

Following the identification of key priorities in the new NHS, and to ensure close alignment with it, the Country Office embarked on the process of developing the new Country cooperation strategy (CCS) for 2016–2020. The CCS defines WHO's role in Zimbabwe and provides a broad framework for collaboration between the Organization and the Republic of Zimbabwe. The strategy took into consideration the aspirations of various national development strategies as outlined in the Zimbabwe Agenda for Economic and Social Transformation (Zim-Asset), the Zimbabwe United Nations Development Assistance Framework (ZUNDAF 2016–2020), and other relevant national development policy papers.

Health financing is a key pillar of the health system that WHO supports. In this regard, WHO has been building the capacity of MOHCC in National health accounts (NHA), using the new version of System of health accounts (SHA 2011). This will enable MOHCC to monitor and track the flow of funds in the health sector, from both public and private sources. WHO is supporting Zimbabwe to complete the 2013–2014 NHA. The findings of this exercise will feed into the 2016–2020 NHS. WHO, in conjunction with other key stakeholders, also supported MOHCC to initiate the development of a health financing strategy to be concluded in 2016.

In order to address the growing disparity between the ever-increasing disease burden and available human resources, WHO introduced the new version of the human resources for health (HRH) management and planning tool known as *Workload*

indicator of staffing needs (WISN). The tool will be used by MOHCC and the Health service board (HSB) to address workforce needs at different levels. The Country Office, in collaboration with the Inter-country support team, provided technical assistance for conducting pilot tests for the adoption of the WISN tool in the country. The main national WISN study will be carried out in 2016. It is envisaged that the findings from the WISN study will form a scientific basis for convincing Treasury to review upward the current HRH establishment to cope with the current workload.

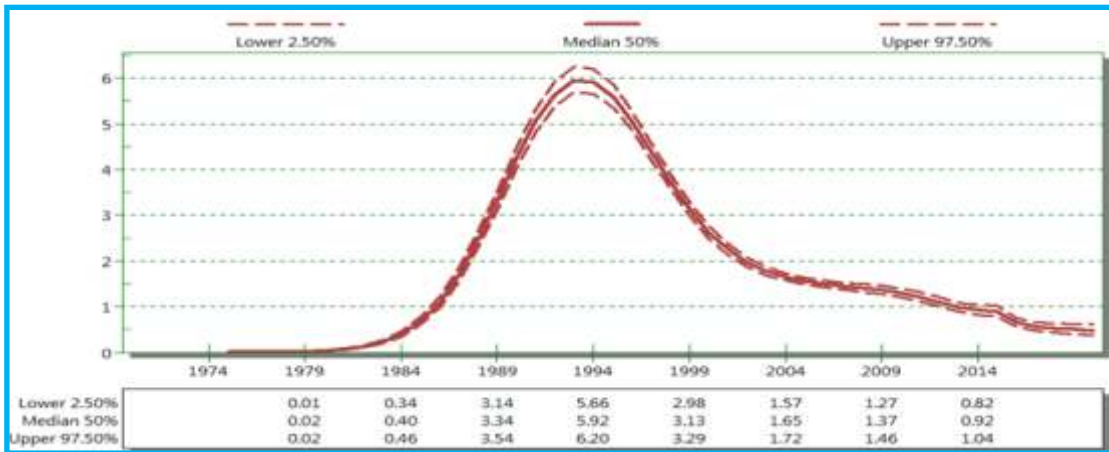
In collaboration with IST/ESA, the Country Office supported the newly-established Department of quality assurance and quality improvement (QA/QI) in promoting the *Hand hygiene* and *Safe surgery saves lives* initiatives, and health care waste management. WHO and MOHCC trained at least 58 health facility managers and quality assurance officers as trainers of trainers in basic patient safety and hospital management. This will be followed by cascade training to include other health institutions. In addition, 10 pharmacists from 4 hospitals were trained in the local production of alcohol-based hand rubs that will be used to promote hand hygiene in health care settings. WHO also facilitated the inclusion of two central hospitals (Harare and Parirenyatwa) in the African partnership for patient safety (APPS) network. This will enable the exchange of experiences in various areas of patient safety.

Funding from the EU/ACP/WHO renewed partnership grant enabled WHO, in line with one of its core mandates of setting norms and standards, provided technical and financial support to facilitate revision of the 6th edition of the Essential medicines list for Zimbabwe (EDLIZ). This led to the publication of the 7th edition of EDLIZ (2016–2020). WHO also continued to support capacity building in the Medicines control authority of Zimbabwe (MCAZ) in order to meet its objective of providing quality-assured medicines to the population.

HIV and AIDS

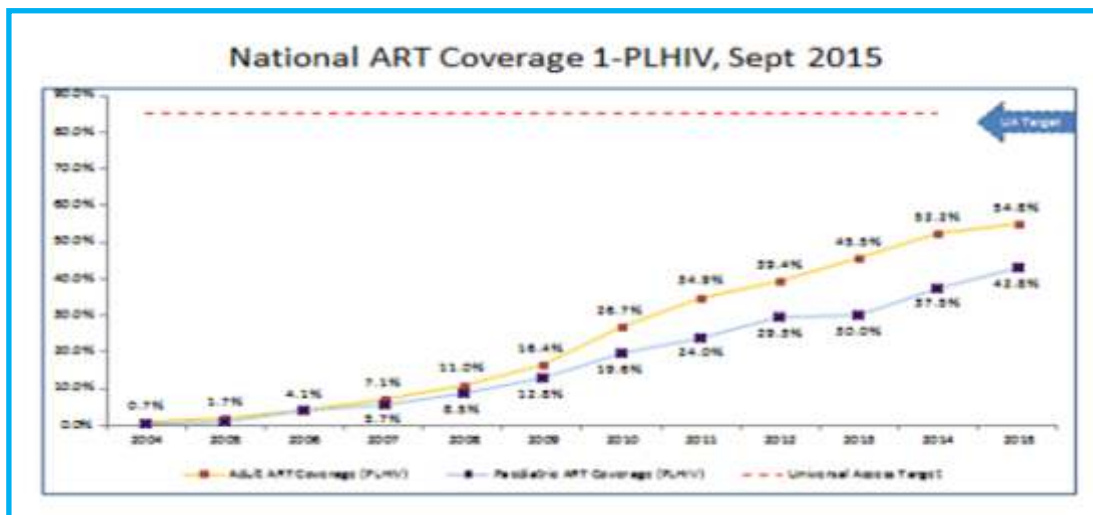
HIV continues to be one of the major public health problems in Zimbabwe. The country has seen a decline in the HIV incidence rate among adults aged 15 to 49, which now stands at 0.92% for 2014, down from 2.63% in 2000. HIV prevalence remained stable at 16.7% according to 2014 HIV estimates.

Figure 7: HIV incidence among persons 15–49 years of age



During this biennium, the Country Office contributed to the scaling up of HIV treatment and care services in the country, first, through provision of technical support for the adaptation and dissemination of the 2013 ARV and HIV testing and counselling (HTC) guidelines, and second, for the development of the Operation and services delivery (OSD) manual and job aides. For some time, paediatric and adolescent HIV care and treatment lagged behind. However, WHO and partners jointly supported MOHCC to develop an accelerated pediatric and adolescence strategic plan to address these inequities. As of December 2015, coverage for ART was 61% for adults and 44% for children.

Figure 8: National ART coverage 1-PLHIV, September 2015



During the period under review, the Country Office also continued to support the country's efforts in resource mobilization for HIV. In 2014, the Office supported negotiations with the Global Fund that resulted in the release of an additional US\$150 million towards HIV care and treatment. This helped to scale up the ART programme. In 2015, the Country Office provided technical support for the development of the successful US\$ 40 million Global Fund incentive funding concept note. The Office continues to advise the Government on technical matters, through its participation in the Country coordinating mechanism (CCM) and its various sub-committees.

With the rapid scale-up of ART programmes, prevention of the emergence of HIV drug resistance (HIV DR) has taken on paramount importance. In an effort to mitigate resistance, the Country Office supported annual Early warning indicator (EWI) surveys, as well as HIV DR (PDR) pre-treatment surveys. EWI survey results indicate that some facilities need to strengthen such programmatic components as on-time drug pick-up, and retention of patients on ART. Due to delays in the processing of specimens, the results of the PDR are expected only in 2016. As for the acquired HIV DR (ADR) survey, the protocol was developed with guidance from WHO, and approved by the local Ethics board (MRCZ). The actual survey will be conducted only in 2016.

WHO and ILO supported MOHCC to launch the public-private partnership (PPP) framework, with full support from the private sector. In 2015, draft memoranda of understanding (MOUs) were developed to establish relations with four PPP entities that were assessed and accredited. It is encouraging to note that strengthening of PPPs for health is on the agenda of the 2016–2020 National health strategy.

With regard to the generation of evidence for HIV programming, the Country Office supported the following research activities: the INSPIRE PMTCT implementation research project; the ASRH/VMMC project; initiation of the first phase of the mortality study (impact study); documentation of Zimbabwe's experience in the adaptation and implementation of the 2013 ARV guidelines; the survey to enumerate the number of patients on ART within the private-for-profit sector in Zimbabwe; and the STI gonococcal antimicrobial susceptibility project (GASP), among others. WHO also supported the generation of strategic information for HIV programmes. The country is now able to generate outcome analysis for its facilities.

Programme on tuberculosis

Tuberculosis (TB) remains a major public health problem in Zimbabwe, with high morbidity and mortality rates. The country is among the 22 high-TB-burden countries in the world. Together, these countries account for over 80% of the global TB burden. For a long time, the country has planned its interventions based on estimates of the disease burden. However, a nationwide prevalence survey is the best way of setting baseline indicators that can enable the country to understand the true epidemiology of TB.

Accordingly, the Country Office, in collaboration with other partners, and with funding from the Global Fund, provided technical assistance to Zimbabwe to conduct a national TB prevalence survey (TPS) aimed at determining the prevalence of bacteriologically confirmed pulmonary TB among the population aged 15 years and above. The TPS was designed and conducted in line with international recommendations developed by the WHO Global taskforce on TB impact measurement.

Figure 9: TB prevalence survey field data collection in 2014



The findings of this survey indicated that the epidemiology of TB in Zimbabwe was different from that previously estimated using routine surveillance data. The results revealed a lower prevalence of smear-positive TB (82.2 per 100 000) and bacteriologically confirmed TB (343.7 per 100 000) among persons 15 years of age and older. Using the findings from the 2014 TPS, the estimated TB prevalence for all forms of TB in persons of all ages in Zimbabwe, is 275 per 100 000 (95% CI: 217–334). The results of the TB prevalence survey will be submitted to the Minister of Health and Child Care, and disseminated to senior management in early 2016, followed by dissemination to the general public.

Figure 10: Members of the Parliamentary portfolio committee on health at the TB advocacy meeting



The Global TB Caucus was launched at the 45th Union conference on lung health in October 2014 in Barcelona, Spain. That conference brought together parliamentarians from all over the world. A landmark was achieved here in Zimbabwe in August 2015, when the WHO Country Office, in collaboration with the TB Union, supported the national TB programme to engage, for the first time, local parliamentarians to join the Global TB caucus in the fight against TB. A two-day TB advocacy meeting was held in Kadoma, where 28 members of parliament and journalists came together to gain more insight into TB control in the country. The Office helped MOHCC to sensitize MPs on the newly-adopted *End TB* strategy. This strategy emphasizes the first pillar, namely, political commitment to bold policies and supportive systems. The country's political

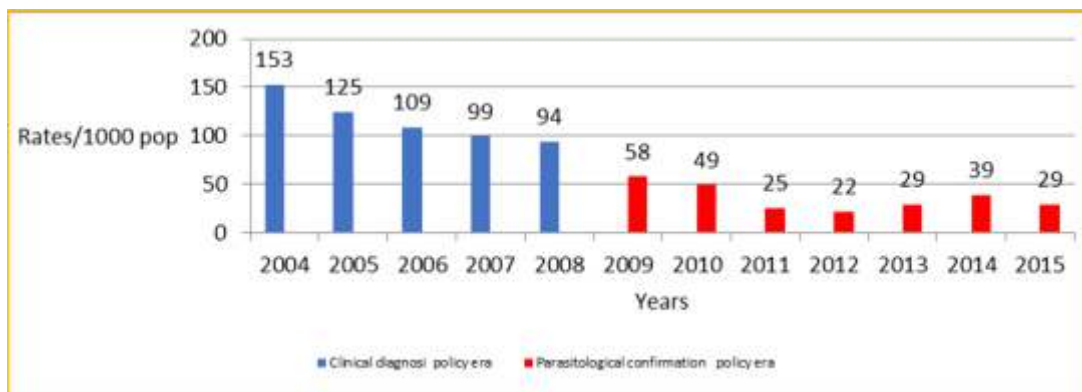
commitment to fighting this curable epidemic is pivotal for all efforts to *End TB*. At the end of the two-day TB advocacy meeting, 14 members of parliament signed the Barcelona Declaration as part of their commitment to advocate for an end to TB. It is expected that more parliamentarians will eventually support this initiative.

Malaria programme

The WHO Country Office supported various, but integrated, efforts against malaria in Zimbabwe. The joint efforts have resulted in a dramatic decline in the number of new malaria cases reported in the country – bringing hope to the possibility of eliminating the disease by 2030. There was a general decline in the number of new cases recorded annually, from 153 cases for every 1000 people in 2004, to 49 cases for every 1000 people in 2010. There was a further decline to 29 cases for every 1000 people in 2015.

WHO provided new and up-to-date policy and strategic guidance, technical assistance, and evidence, and shared good practices. Between 2014 and 2015, the Country Office specifically supported MOHCC and partners in the areas of behaviour change communication (BCC), indoor residual spraying to fend off the malaria vector, and case management – all in line with the Global malaria strategy and other related WHO guidelines.

Figure 11: Malaria incidence rate per 1000 population

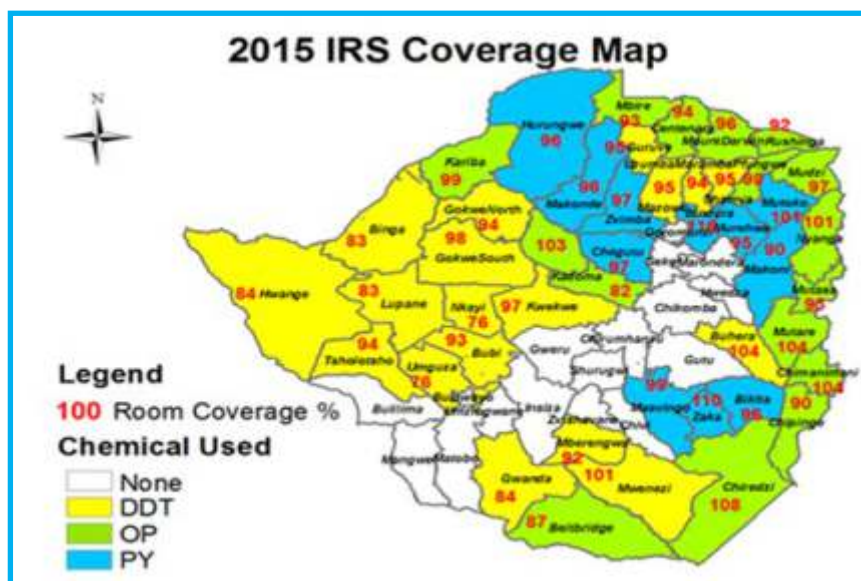


We supported MOHCC to conduct a survey on malaria medicines therapeutic efficacy testing (TET). The results from the TET indicated that Artemisinin-based combination therapies (ACTs) were still effective in Zimbabwe. During the biennium, the Country Office supported revision of the National malaria treatment guidelines, as well as malaria case management guidelines, in accordance with the latest WHO directives.

The major features in the new Malaria treatment guidelines were the introduction of Primaquine in districts earmarked for malaria elimination, and the use of parenteral artesunate for treatment of severe malaria. Continuous monitoring of resistance to insecticides in use revealed some levels of resistance to pyrethroids and carbamates, and to a lesser extent, to DDT also. With Country Office support, MOHCC replaced pyrethroids with more effective organophosphates. This resulted in a significant reduction in malaria incidence in the affected districts, particularly in Manicaland Province. Figure 12 shows the distribution of insecticides by class during the period under review.

The population protected, and number of structures sprayed, have remained above the recommended 85%.

Figure 12: Malaria incidence rate per 1000 population



Distribution of long-lasting insecticidal nets (LLINs) continued throughout the period. Four channels of LLIN distribution were adopted, commencing in November 2014, namely, during ante-natal care (ANC) visits (1st booking) and EPI campaigns (targeting measles), in schools (grades 3 and 6), and in the community (through village health workers and health facilities). The graph below shows the number of nets distributed by channel of distribution.

Figure 13: Trends in IRS coverage 2012 to 2015

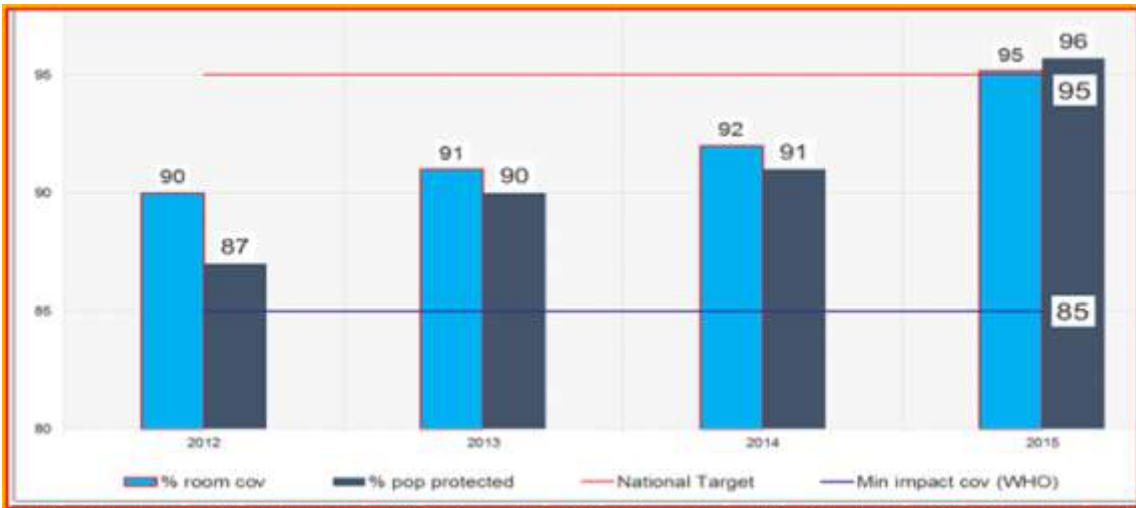
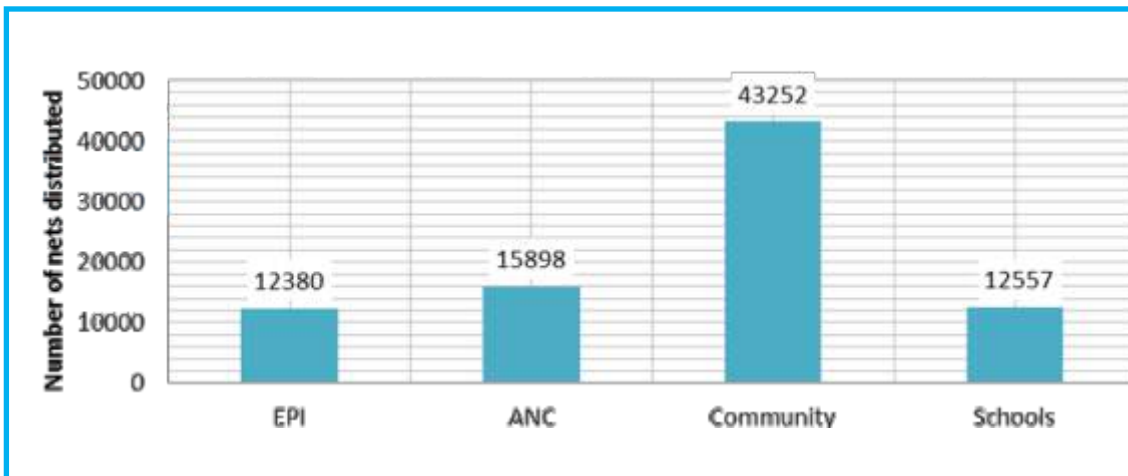


Figure 14: Routine LLINs distributed in 2014 to September 2015



With Country Office support, the National malaria control programme (NMCP) increased the number of districts targeted for malaria elimination from 7 to 20 in the current malaria strategic plan. All managers from the 13 additional districts were trained in malaria elimination techniques, with Country Office facilitation. The map in Figure 15 indicates the number of districts earmarked for malaria elimination. Enhanced surveillance has been scaled up in these districts.

Zimbabwe Country Office, were trained at the WHO Regional Office in Brazzaville, Congo, on emergency preparedness and response for Ebola virus disease.

This core team held subsequent training sessions on EVD preparedness and response for health staff working at the central, provincial and district levels throughout the country. Similar training sessions were organized for port health officers, other stakeholders working at points of entry (international airports and ground crossings), and workers at funeral parlours. Training focused on case management, surveillance, laboratory diagnosis, infection control, safe burial practices, and safe handling and transportation of EVD victims. The Country Office, with support from the Inter-country support team, procured 1500 units of personal protection equipment (PPE), some of which were used for demonstrations during training sessions. The national taskforce on EVD preparedness and response, with technical assistance from the Country Office, supported three designated institutions to be ready to manage any suspected EVD cases. These were the Wilkins Infectious Disease Hospital in Harare, the Thorngrove Infectious Disease Hospital in Bulawayo, and Gweru Provincial Hospital. In addition, other urban centres were made ready through intensive training, to identify quarantine facilities for detaining suspected cases while evacuation arrangements are being made. All local authorities were provided with skills to identify separate burial sites for EVD victims.

Figure 17: Cholera Treatment Centre in Beitbridge



The Country Office also actively supported MOHCC in the development of a national Ebola preparedness and response plan. At the same time, we provided guidance to the UN country team (UNCT) to develop a specific Ebola preparedness and response plan to cater for UN staff and their dependants.

At the peak of the Ebola virus disease outbreak in West Africa, the Zimbabwe Country Office received a request from the Regional Office to send technical teams to Ebola hot spots, and to beef up WHO response to this deadly outbreak. Indeed, the Country Office was one of the very first contributors to this international drive. But there were mixed feelings on these deployments as many people were worried about the risk of contracting the deadly Ebola disease.

The concern was not just about the risk of contracting a deadly disease with no known cure. The general perception among the public in the country was that individuals deployed to support Ebola outbreak activities, and visitors from affected countries, would be the likely sources of any importation into the country. We wish to cite here the deployment of Dr Lincoln Charimari, who was one of the very first staff members from the Zimbabwe Country Office to be sent to Sierra Leone. We had to inform and obtain the concurrence of the host Government to secure his deployment. Of course, he served his term and came back more energized, with invaluable experience that earned him recognition to be considered for international deployment elsewhere.

The Country Office was, throughout the period of the peak of the disease outbreak in 2014 and 2015, heavily occupied with responding to wide-spread anxiety, fear and near-panic reactions to rumours of importation of the disease into the country. The media was awash with rumours, particularly among health workers. The spouses of staff members deployed for Ebola work in West Africa were especially fearful of contracting Ebola. In spite of the thorough briefings given to our staff on personal protection and infection control measures, the fear still persisted. The Country Office was involved in much public education on the measures to be taken in response to Ebola threats, and in helping institute screening measures at ports of entry. Fortunately, none of our staff members on deployment to West Africa contracted the disease, and there was never to be a single case of Ebola imported to Zimbabwe. But many lessons were learnt on ways of handling rumours of a deadly disease in a country that never experienced any real outbreak.

Another notable event during the biennium was support for the timely identification and control of cholera outbreaks in Beitbridge District, Matabeleland-South Province, in March, 2015. A total of 8 cases were reported in this district. According to IDSR

guidelines, a single case of cholera, of course, constitutes an outbreak. Therefore, this called for all structures to be rapidly activated. The Inter-agency coordination committee on health (IACCH) quickly assumed its coordination role, and a national rapid response team (NRRT) was immediately dispatched to support the District. The district and provincial rapid response teams which were trained by WHO investigated and responded to the outbreak within 24 hours of the initial notification. A cholera treatment centre was set up at a site outside the Beitbridge District Hospital, and prepositioned emergency stocks supplied by the Country Office, were used to treat patients. Infection control activities, as well as health care waste management at the site, were conducted according to WHO guidelines.

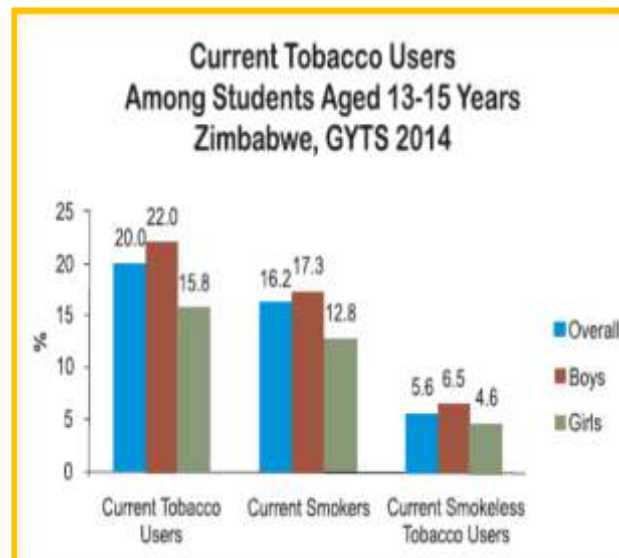
The status of International health regulations (IHR) 2005 remains a concern. Zimbabwe was unable to fully comply with the global requirements for putting in place core capacities for its implementation after the first secured extension at the end of 2014. A second and final application for extension to 2016 was submitted, and the country received the Director General's approval for a further extension, as the present report was being prepared. There is therefore urgent need to take action to ensure that IHR (2005) core capacities are met before the end of the extension. To that effect, the Ministry of Health has reviewed the IHR action plan and developed strategies on the way forward. This was followed by a situation analysis at eight main ports of entry to the country, to assess the level of IHR preparedness. The Ministry also conducted workshops to build the capacity of inter-sectoral teams, partners and port health officers. All the information gathered from the situation analysis, together with interactions with partners, will feed into updating and completing the IHR monitoring tool in early 2016.

Health promotion and social determinants of health

Accession to the WHO Framework convention on tobacco control (FCTC) was one of the key landmarks of the 2014-2015 biennium. The Government of the Republic of Zimbabwe finally acceded to the WHO FCTC in December 2014. The accession took effect on 5 March 2015, when Zimbabwe became the 180th party to the Convention. This success was a result of years of concerted advocacy and lobbying, and persistent technical and resource support from the WHO Country Office.

Following this accession, Country Office and WHO Regional Office teams, in collaboration with MOHCC, hosted an orientation workshop on the responsibilities of parties to the WHO/FCTC, and on the tobacco control plans and activities of the Government. To further inform national actions on tobacco control, WHO and the

Centres for Disease Control (CDC) in Atlanta also supported the Government to conduct the Global youth tobacco survey (GYTS) in 2014; a country report was subsequently produced. The survey revealed that 2 in 10 (20%) young people aged 13 to 15 years who are in school, currently use tobacco products, despite the fact that the country has laws that prohibit tobacco product sales to minors.



WHO also continued to support advocacy and awareness raising activities on tobacco, through commemoration of world no-tobacco days, and during campaigns on international days against drug abuse and illicit trafficking. We also supported related campaigns that highlighted the need for tobacco control, such as the high-level cancer advocacy of 2014, and World Cancer Day commemorations in 2014 and 2015.

Moving forward, there is need to review the laws governing tobacco in Zimbabwe, including Statutory instrument 264 of 2002, and public health (control of tobacco) regulations, to bring them in line with the provisions of the WHO/FCTC. Strengthening enforcement of existing and future laws and regulations is equally important, and success will depend on concerted multi-sectoral efforts.

Immunization and vaccine development

Pursuant to the Global vaccine action plan (GVAP) of 2011–2020, the WHO Country Office continued to play a significant role in the Expanded programme on immunization (EPI) in the country. It disseminated updated information on new vaccines, technologies and vaccination standards, and provided guidelines, information, and financial and technical support for monitoring and evaluating the immunization programme.

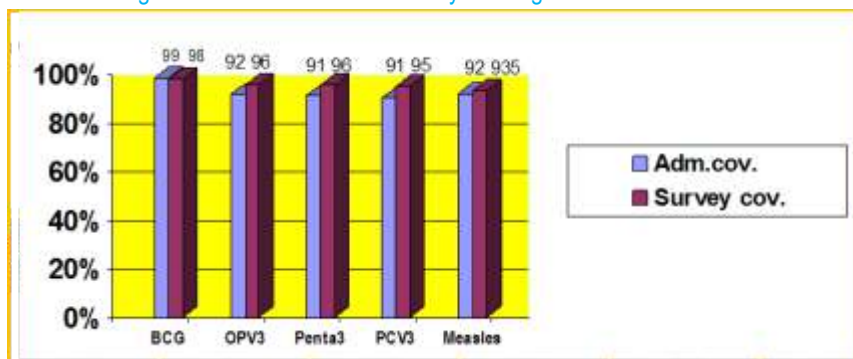
MOHCC, with technical assistance from the Country Office, successfully implemented the introduction of the human papilloma virus (HPV) vaccine in the two demonstration project districts of Beitbridge and Marondera in September 2014. Lessons learnt and experiences gained from these two districts will be utilized during the anticipated national roll-out of the HPV vaccine.

The vaccines storage capacity of the country was increased with the installation of cold rooms at the new Central vaccines store in Harare, and in each of the 11 provincial vaccine stores of the country. This was a joint effort of the WHO and UNICEF country offices. The country now has one of the best central vaccines stores in the Region. Expansion of the vaccine storage capacity will go a long way in maintaining the potency of vaccines, thus improving the overall quality of immunization services in Zimbabwe.

The Country Office played a key role during application processes made to GAVI for the introduction of new vaccines, namely, the rotavirus and measles/rubella (MR) vaccines. The rotavirus vaccine was rolled out in May 2014, while the MR vaccine was rolled out in September 2015, through a campaign targeting all children from 9 months to 14 years of age. Apart from technical support for these activities, the Country Office funded and led the post-introduction evaluation of the rotavirus vaccine, the results of which were used to take corrective action needed to improve the introduction of new vaccines in future.

Besides the introduction of the rotavirus vaccine, the Country Office facilitated the post-MR campaign coverage survey, concurrently with the long-awaited routine EPI coverage survey. WHO funded and provided a consultant to lead the two surveys that yielded a validation of administrative data. The national MR campaign attained validated vaccination coverage of 94%, which is quite a high coverage rate that will sustain the country's measles elimination status and contribute to achieving the SDG on child mortality in Zimbabwe. The country has now also validated data for both the MR campaign and routine EPI, as depicted in Figure 19. Besides attaining high vaccination coverage, the country also managed to meet the standard performance indicators for polio, measles and NNT.

Figure 18: Administrative vs survey coverage for EPI vaccines in 2015



The Country Office also facilitated dissemination of information and training of health workers on the Polio endgame strategy, with particular emphasis on the polio switch from tOPV to bOPV. As a result, the country is now a participant in the Global polio endgame strategy. A switch plan has been developed, and 1 May 2016 was set as the national switch date.

Programme on family and reproductive health

Although Zimbabwe was still fairly far from attaining Targets 4 and 5 of the Millennium development goals at the end of 2015, the reversal of the upward trend in maternal and under-5 mortality was a high point in maternal and child health during the biennium. Apart from monitoring health-related MDG trends, the WHO Country Office was also involved in national discussions on and adoption of Sustainable development goals (SDGs).

WCO work during this biennium was mainly in the areas of strategy and guideline development, building capacity for integrated care at facility level, and supporting the generation of evidence for improved programming. This included development of distance IMCI modules, of a nutrition surveillance training manual, of nutrition surveillance guidelines, of a basic paediatric emergency triage assessment and treatment (ETAT) protocol, and of the Child survival strategy 2015–2020.

The Country Office was influential in the design and implementation of alternative methods of learning, given the financial constraints facing traditional methods of capacity building. This was highlighted by the introduction of computerized IMCI for medical students, a distance IMCI course for training already qualified health workers, and the mentorship programme for maternal and new-born health care. This will enable health workers to have more time to manage their patients, instead of attending many workshops.

Figure 19: Health worker assessing a sick child, using the Integrated management of newborn and childhood illness (IMNCI) approach



Emergency triaging of sick children was upgraded through strengthening of the capacity of a core group of health workers that include paediatricians, government medical officers, and registered nurses working in casualty wards. The Country Office was also instrumental in strengthening the management skills of managers in child health programme management. It is anticipated that these achievements will greatly improve child survival in the country.

Considerable effort was also put into revising key indicators in sexual and reproductive health, making sure these are incorporated into the health management information system (HMIS). Worthy of further note was the development and review of a scorecard which monitors selected maternal and child health indicators. As a result of this initiative, reporting has improved, and remedial actions taken on key indicators for reproductive, maternal, newborn and child health (RMNCH).

WHO was part of the coordination mechanism for the UN H4+ initiative. In 2015, a total of US\$ 6 433 218 was mobilized jointly with UNAIDS, UNFPA, UNICEF, and UNWOMEN to support catalytic and strategic actions to improve RMNCAH. The initiative was jointly implemented, with joint monitoring and reporting.

In the area of research, WHO led two key studies: the Zimbabwe service availability and readiness assessment (SARA), and the first-ever micronutrient survey. SARA provides an overall picture of the current status of both public and private facilities, with respect to available services and their readiness to deliver them, in view of the resources invested. The micronutrient survey, for its part, provides key information for improving nutrition activities in the country. A child survival study was also, among others, undertaken as part of a larger study on the African continent that provided the basis for revision of the child survival strategy for 2016–2020.

Finance and administration

Perhaps the most significant activity of the Finance and administration unit during the period under review was the total refurbishment of our office premises in Highlands, Harare. Working together with the Inter-country support team, we managed to fill potholes on the roads network, rehabilitate parking bays, repair leaking roofs and apply a coat of paint on the buildings. We continue to appreciate the offer of the Government of Zimbabwe to house WHO in these premises. The best we can do is to ensure full maintenance of the facilities placed at our disposal. There is a lot of pride among staff members in the outcome of the refurbishment work done. We have received many pleasant remarks from partners on the new look of WHO offices.

Based on a request from the Parirenyatwa group of hospitals, the Regional Office authorized the refurbishment and hand-over to the Government of Zimbabwe of unused offices at the WHO-Annex building. The offices handed over are now being used by the Ministry of Health and Child Care as facilities to train nurses and midwives.

Figure 20 (a) : Parts of the renovated WHO premises at Highlands,



Figure 20 (b) : Parts of the renovated WHO premises at Highlands, Harare



The Country Office provided both technical and administrative support to Liberia and Sierra Leone, in response to Ebola virus disease outbreaks in those countries. We provided support in the areas of procurement, finance management, travel, human resources, and office administration. This support was very well appreciated by WHO Liberia and WHO Sierra Leone, as well as the WHO Regional Office for Africa.

Partnerships and collaboration

On major events related to the *UN Delivering as One* initiative (working together with other UN agencies), the Country Office was fully represented on UNCT, Operations management team (OMT), and UN communications group (UNCG) meetings. The WHO Country Representative and the Operations Officer were among the key persons who initiated the *UN Delivering as ONE* approach in Zimbabwe. The OMT, led by the WHO Operations Officer, consolidated and produced the 2015 annual work plan, the mid-term review report, and worked on the 2016–2020 UN Country team strategic operation framework (SOF) that was adopted unanimously by all the UN agencies in the country. With the location and generous facilities that WHO offers, the WHO Country Office hosted such major UN commemorative events and celebrations as the UN Day and wellness days.

The Country Office also worked closely with the College of public health physicians, and actively supported the launch of the Zimbabwe public health association in a colourful function on 15 August 2015.

3. CRITICAL CHALLENGES OF THE BIENNIUM

The WHO Country Office budget remains low and inadequate to cover key posts and office operation activities. In particular, we experienced challenges meeting UN shared costs under resident coordinator functions – especially for security services and UN Clinic operations. Even though there have been suggestions to charge centrally costs related to UN Resident Coordinator functions, there are many residual nuances that will continue to increase local costs almost annually. Fortunately for the Zimbabwe Country Office, the presence of IST/ESA in Harare has greatly cushioned some of our expenses.

In spite of the financial constraints of WHO, the Country Office continues to play its valuable technical role in response to old and new challenging health situations. We

still have to deal with the lack of a common understanding of the role of the World Health Organization. Many partners, particularly among NGOs and CSOs working in health, will expect WHO not only to provide technical support functions, but also to fund some of their activities. Of course, WHO remains active in negotiations with donors, and sometimes directly helping to put together grant proposals for donor funds. The Organization also monitors progress on implementation of grants, which information is used to strengthen required accounting reports prepared for donors.

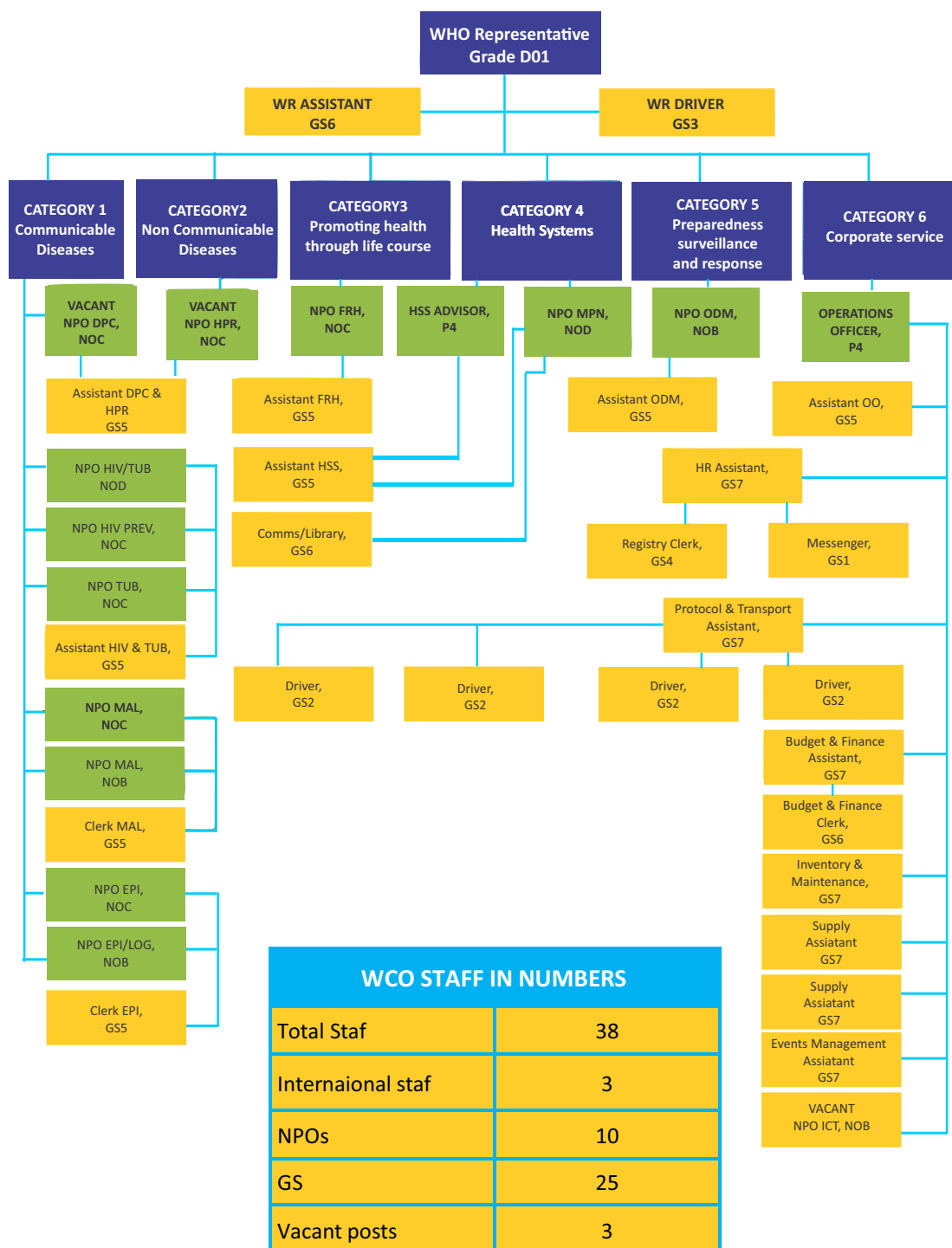
Finally, we remain extremely concerned about the emerging non-communicable disease (NCD) onslaught on the country. Unfortunately, the exact burden of NCDs is not well quantified, making it difficult to design appropriate remedies. And while risk factors – such as cigarette smoking, alcohol abuse, unhealthy diets, and physical inactivity – are known, we are concerned about the role industries are playing in aggressively marketing some of the risk factors that have serious health consequences.

4. PERSPECTIVES FOR THE NEXT BIENNIUM

The agenda for the next biennium will be guided by the strategic priorities highlighted in the Country cooperation strategy 2016–2020 which will focus on, but not exclusively on, the unfinished MDG agenda, the SDGs, and the Twelfth General Programme of Work (GPW 2014–2019) aligned to Zimbabwe’s National health strategy 2016–2020. In particular, the three identified key result areas of critical importance will revolve around strengthening priority programmes, improving service delivery platforms and entities, and improving the enabling environment for service delivery. These will be aligned to the following broad strategic priorities:

- # Health systems strengthening for universal health care (UHC) in the context of SDGs, and embracing advocacy for workforce retention; development of a new workforce strategy; support for MOHCC in human resource management, using results from the Workload indicators of staffing needs (WISN) study; support for combating antimicrobial resistance (AMR); strengthening of the pharmaceuticals system to incorporate Good governance for medicines principles; and building capacity for the institutionalization of National health accounts (NHA), using the SHA 2011 and resource mapping tools;
- # Reproductive, maternal, newborn, child and adolescents health: this will involve supporting the generation of evidence for monitoring trends in RMNCAH; and developing and updating relevant strategies, policies, guidelines and tools for maternal, newborn and child survival;
- # Communicable diseases: the focus will be on HIV/AIDS, TB, malaria, and NTDs; there will be need to continue with the communicable disease control agenda, especially contributing towards attainment of the 90-90-90 target in the HIV programme; the problem with emerging hepatitis in people living with HIV (PLHIV) and the general population will need to be addressed; effective support for surveillance of TB and drug resistant TB will have to be provided; research to generate scientific evidence to inform policy and strategic decisions will have to be conducted; and support for the implementation of MDAs will be needed, as will impact surveys;
- # Noncommunicable diseases: the WHO STEPWISE survey will guide the development of an NCD strategy, and of clinical guidelines for priority NCDs;
- # Public health surveillance, disaster preparedness and response: support to MOHCC in reviewing IHR (2005) implementation will be crucial, as will the coordination of disease outbreak response, including response to other public health emergencies; for this, it will be important to strengthen capacity in IDSR, and the capacity of rapid response teams.

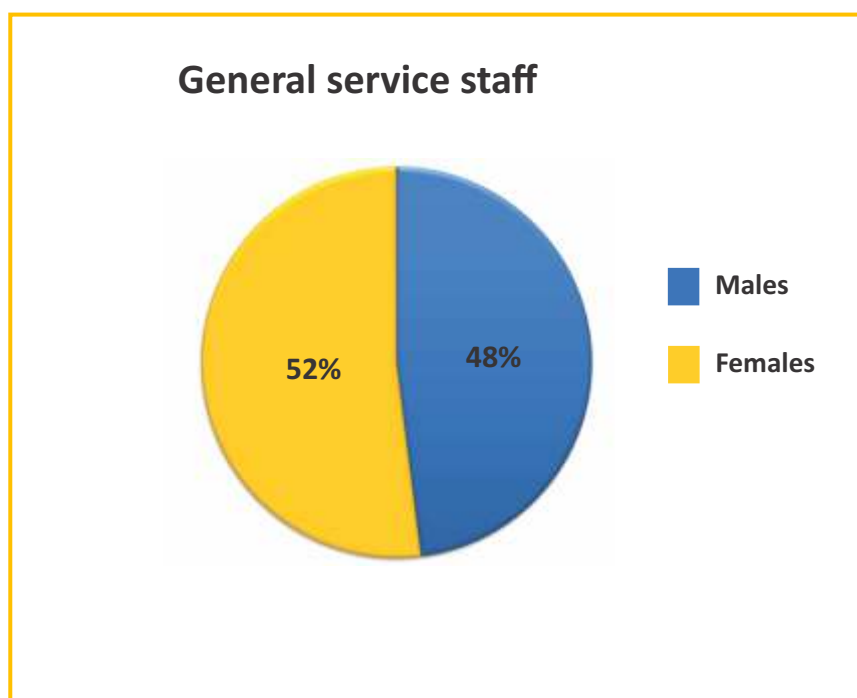
STRUCTURE OF THE WHO COUNTRY OFFICE IN ZIMBABWE AS AT 31 DECEMBER 2015



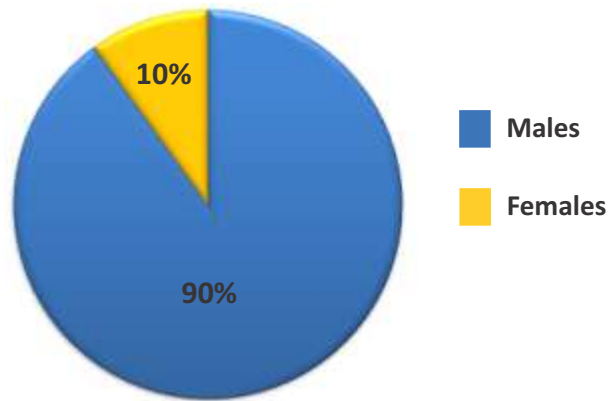
ORGANIZATIONAL STRUCTURE AND STAFFING

ZIMBABWE COUNTRY OFFICE STAFF ON 31 DECEMBER 2015

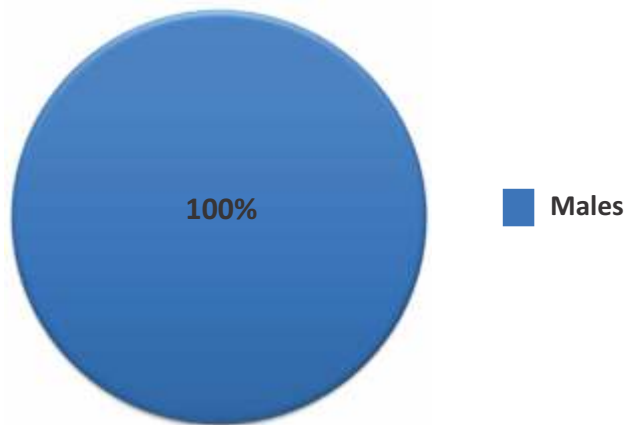
GRADE	MALE	FEMALE	TOTAL	% MALE	% FEMALE
General service staff	12	13	25	48	52
National Professional Officers	9	1	10	90	10
Internationally recruited staff	3	0	3	100	0
TOTAL	24	14	38	63%	37%



National professional staff



Internationally-recruited staff



STAFF MOVEMENTS

NAME	REASON FOR LEAVING
Dr. Charimari	Appointment to a higher position in South Sudan
Mrs Munyoro	Retirement
Mr. V. Kausiyo	Resignation for personal reasons
Mr. Chinjekure	Resignation to take up a higher position



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