WHO COUNTRY COOPERATION STRATEGY

2016–2020

ZIMBABWE

World Health Organization

REGIONAL OFFICE FOR AFRICA

WHO COUNTRY COOPERATION STRATEGY

2016–2020

ZIMBABWE

WORLD HEALTH ORGANIZATION
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MAP OF ZIMBABWE

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ZAMBIA
Zambezi River
MOZAMBIQUE
Mashonaland Central
Mashonaland West
Harare
Mashonaland East
Matabeleland North
Midlands
Manicaland
Bulawayo
Masvingo
Matabeleland South
BOTSWANA
Limpopo River
SOUTH AFRICA
0 45 90 180 km

ABBREVIATIONS AND ACRONYMS

AFRO	WHO Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ARI	acute respiratory infection
ASRH	adolescent, sexual and reproductive health
AU	African Union
CBR	crude birth rate
CCM	Country Cooperation Mechanism
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CDR	crude death rate
CHAI	Clinton Health Access Initiative
COMESA	Common Market for Eastern and Southern Africa
CRC	Convention of the Rights of the Child
CSO	civil society organization
DFID	Department for International Development
DFATD	Department of Foreign Affairs Trade, & Development (Canada)
DHIS	District Health Information Software
DRM	disaster risk management
DTP3	diphtheria-tetanus-pertussis
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EM	essential medicines
EPI	expanded programme on immunization
EPR	emergency preparedness and response
ERF	Emergency Response Framework
ESP	Expanded Support Programme
EU	European Union
FAO	Food and Agriculture Organization
GAVI	Global Alliance for Vaccines, and Immunization
GDP	gross domestic product

GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	German Society for International Cooperation
GOZ	Government of Zimbabwe
GPW	General Programme of Work
GSRRS	Global Status Report on Road Safety
HDF	Health Development Fund
H4	Partnership for Women and Child Health
HIV	human immunodeficiency virus
HQ	headquarters
HTF	Health Transition Fund
IACCH	Inter-Agency Coordination Committee on Health
ICASA	International Conference on AIDS and STDs in Africa
ICATT	IMCI computerized adaptation and training tool
ICCM	integrated community case management
ICT	information communication technology
IDSR	integrated disease surveillance and response
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IUTLD	International Union against Tuberculosis and Lung Disease
JSI	John Snow International
JUNTA	Joint UN Team on AIDS
MCHIP	Maternal & Child Health Immunization Programme
MDG	Millennium Development Goals
M&E	monitoring and evaluation
MICS	Multiple Indicator Cluster Survey
MMR	maternal mortality rate
MNCAH	maternal newborn child adolescent health
MOHCC	Ministry of Health and Child Care
MTP	Medium Term Plan
MTSP	medium-term strategic plan
NATF	National AIDS Trust Fund
NCD	noncommunicable disease
NGO	nongovernmental organization

NHA	national health accounts
NHS	National Health Strategy
NORAD	Norwegian Agency for Development Cooperation
NTD	neglected tropical diseases
ODA	official development assistance
OOPE	out-of-pocket expenditure
PHC	primary health care
PHEIC	public health events of international concern
PLWHIV	people living with HIV
PMI	President's Malaria Initiative
PMT	Programme Management Team
PMTCT	prevention of mother-to-child transmission
PoE	point of entry
PPP	public-private partnerships
QoC	quality of care
RHA	rapid health assessments
RMNCAH	reproductive, maternal, newborn, child and adolescents health
SADC	Southern African Development Community
SDA	Seventh Day Adventist
SIDA	Swedish International Development Agency
SOPs	standard operating procedures
SDG	Sustainable Development Goals
SRH	sexual and reproductive health
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women

USAID	United States Agency for International Development
VTPA	Virtual Team of Policy Advisors
WCO	World Health Organization Country Office
WDI	World Development Indicators
WISN	workload indicator for staffing need
WFP	World Food Programme
WHO	Word Health Organization
WR	WHO Representative
Zam-Zim	Zambia-Zimbabwe cross border malaria initiative
ZDHS	Zimbabwe Demographic and Health Survey
Zim-Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

PREFACE

The WHO third generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthening WHO capacity and making its deliverables more responsive to country needs. It reflects the WHO 12th General Programme of Work at country level and aimed at achieving greater relevance of WHO's technical cooperation with Member States. In addition it also focuses on identification of priorities and efficiency measures in the implementation of WHO reform and of the Transformation Agenda in the African Region. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

This third generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The strategy takes into account the global health context and the move towards universal health coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on aid effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the Organization's country workplan; advocate for and mobilize resources as well as coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government of Zimbabwe in the conduct of this important exercise of

developing the CCS. I also request the entire WHO staff, and particularly the WHO Country Representative to double efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

Dr Matshidiso Moeti
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The development of the third generation CCS for Zimbabwe for the period 2016-2020 was guided by the WHO 2016 *Guide for the Formulation of the Country Cooperation Strategy*.[1] The 2016-2020 CCS is a result of intensive and extensive consultation with a wide range of organizations and individuals. These include officials from the Ministry of Health and Child Care; UN agencies; bilateral and multilateral agencies; civil society and nongovernmental organizations (CSOs & NGOs); organizations representing vulnerable and marginalized communities; collaborating centres; and the private sector. The development of this strategy was also guided by the unfinished agenda of the UN Millennium Development Goals (MDGs), the UN Sustainable Development Goals (SDGs), the WHO global priorities, the WHO African Region orientations, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF), and other relevant regional and subregional initiatives. It also takes into consideration the importance of national development strategies as outlined in the Zimbabwe Agenda for Sustainable Socioeconomic Transformation (Zim-Asset), the new National Health Strategy (NHS 2016-2020) and standards on the right to health ratified by the country.

Based on the outcome of the various consultations undertaken, WHO will concentrate its broad strategic agenda over the next five years in five priority areas: (a) achieving and sustaining universal health coverage (UHC) through a revitalized primary health care (PHC) approach and sustainable service delivery through strengthening of health systems. (b) accelerating achievement of the unfinished MDGs relating to reduction of maternal, newborn, child and adolescent mortality; and strengthening sexual and reproductive health; (c) reducing further the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases; (d) strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC; and (e) strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security.

1. Guide for the Formulation of a WHO Country Cooperation Strategy. Guide 2016

The macroeconomic environment in Zimbabwe remains weak, resulting from multiple factors at play — such as inadequate external inflows, low international commodity prices that keep liquidity conditions tight, and an appreciating US dollar. All these have contributed to a slowed economic growth and rising unemployment. At the moment, most programmes that are showing positive trends are heavily dependent on support from development partners. This raises serious concerns about the sustainability of critical health programmes when the external support ends. The next CCS will assist the Government to find ways of improving health-care financing that shield patients from catastrophic expenditure — e.g. by helping to design appropriate health insurance schemes that work for those in gainful employment, and also for the unemployed and the poor.

Rising poverty remains a major concern, and with the current widespread droughts and lack of inputs into agriculture, the socioeconomic outlook for Zimbabweans is likely to worsen over the short to medium term. The negative macroeconomic situation has impacted on the health sector in the country in a variety of ways. For example, the majority of families and individuals cannot afford health services; whilst Government cannot adequately fund health services. There is limited information on the contributions made by the private health sector. The new CCS will advocate for and help put in place a public-private-partnership framework that will at least gather relevant health information from the private sector for national planning and management purpose.

Beyond maintaining focus on the unfinished MDGs agenda, noncommunicable diseases and conditions continue to pose a growing public health challenge. Diabetes, hypertension, cardiovascular conditions, cancer and mental health conditions continue to afflict a growing number of Zimbabweans. Efforts are underway to improve the capacity of public health facilities to screen and diagnose these conditions and diseases through the training of health workers, procurement of diagnostic equipment and consumables as well as advocacy towards healthy lifestyles. Government is also planning to continue investing in low cost high impact primary care interventions which focus on community health and preventive care.

Human resources for health (HRH) remain the bedrock of effective and efficient health-care systems. The country has remarkably stabilized the brain drain phenomenon of the last decade - mainly by training more health personnel. Nearly all the public sector posts which were established in the early 1980s have been filled up. Increasingly though, there is a surplus of

trained health professionals who cannot be immediately absorbed when they are released from the training institutions. With adequate consultations involving all Government ministries and other sectors, the surplus health workforce could still be absorbed to serve the needs of the population.

WHO lacks resources to adequately engage skills to support critical programmes such as disease prevention and control, response to emergencies, and fulfil responsibilities under the International Health Regulations (IHR). On the other hand, Zimbabwe is surrounded by four countries and due to population movement, issues related with cross-border activities is a permanent challenge concerning control of epidemics of international concern that requires intercountry collaboration. These issues will be addressed in the new CCS.

In the context of this CCS, WHO remains committed to supporting the Ministry of Health and Child Care (MOHCC) and partners in addressing the major health and developmental challenges facing Zimbabwe over the next five years. The strategic priority actions identified here are aligned to the MOHCC mission of achieving equity and quality in health through UHC. WHO's actions are hinged on provision of advisory and technical support to the MOHCC within the spirit of universality in the SDGs and their strong emphasis on equality — frequently referred to as "leaving no one behind" — as well as promoting a multisectoral approach with regards to health; recognizing that health is represented not only in the 13 targets under SDG 3, but also in 35 additional health-related targets under the other SDGs. The new CCS ensures that social and economic determinants of health, including gender equality and women's empowerment are periodically monitored and the results widely communicated and discussed at national level.

The CCS document is structured as follows: Chapter 1 provides the introduction, national context and overview of WHO policy framework. Chapter 2 outlines the health and development situation in the country — including the current socioeconomic situation in Zimbabwe, and details of the country's main health achievements and challenges. This is followed by a description of Zimbabwe's landscape of development cooperation, partnerships, and financial allocations to the health sector, collaboration with the UN as well as the country's obligations under regional resolutions, agreements, and commitments. Chapter 3, reviews the WHO's cooperation over the past CCS cycle. Chapter 4 presents the strategic agenda of WHO's cooperation for the period 2016–2020 and linkages to other local and international goals and targets. Chapter 5 addresses the implementation of this strategic agenda, including its implications on the entire Secretariat. The section also analyses how to improve resources for implementation. This will be achieved through wide dissemination of the strategy in the country and within the WHO system. Finally, Chapter 6 looks at how the CCS will be evaluated.

As required by WHO internal management, the CCS will be reviewed and evaluated mid-term and again near the end of the cycle. This exercise will be linked with the biennial workplan monitoring, assessment of the ZUNDAF and with the WHO country performance assessment that looks at WHO's influence at country level based on the strategic priorities identified here.

CHAPTER 1:

INTRODUCTION

The CCS is WHO's key instrument to guide its work in and with a country, in support of the country's national health policy, strategy or plan. It is the main process for harmonizing WHO's collaboration in countries, with that of other United Nations (UN) bodies and with its development partners. WHO uses the CCS to develop current and future biennial country workplans.

The Government of Zimbabwe (GOZ) and the WHO Country Office (WCO) have implemented the second generation CCS for the period 2008–2015, which responded to the needs and priorities in the health sector at the time. This third generation CCS constitutes WHO's business plan for the period 2016-2020. It takes into consideration the evaluation of the previous CCS, and is informed by a systematic assessment of recent national health development focus, emerging health needs, government policies and expectations, current issues and challenges facing the country. It is anchored to ensure continued relevance of health-related goals and targets as outlined in the various Government policy documents for the implementation of the Sustainable Development Goals (SDGs) — which have clearly defined health priorities. The policy documents also identify specific strategies to achieve the unfinished MDGs, which the new CCS will seek to address.

The CCS is aligned with WHO's medium-term vision for health, as defined in the 12th General Programme of Work (GPW) 2014–2019, and focusing on selected priorities for WHO cooperation in Zimbabwe. It provides a broad framework to build country-level priorities and bottom-up planning process; and ensures that both WHO's global and regional priorities, as well as national health priorities, inform the biennial workplan. The CCS will guide the country-level programme budget and resources allocation. Furthermore, it should help advocate WHO priorities in the country, and also mobilize resources for the health sector.

This CCS is also aligned with the AFRO Transformation Agenda, which makes a commitment to positive change for accelerating the

implementation of WHO reforms within the African Region.[2] To this extent, it is informed by values of the transformation agenda, with emphasis on producing results, smart technical focus, responsive strategic operations, effective communications and partnerships in response to country needs.

In formulating this country cooperation strategy, the focus remained on WHO's mission and functions as well as its role as a neutral broker and policy advisor. The CCS will serve as a reference document for WHO's work in Zimbabwe. It is the tool to inform the biennial planning exercise and will be part of a continuum that includes the new results chain of the GPW and regional strategic plans, resolutions or mandates. There is also greater complementarity and information sharing between the CCS and the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) process and vice versa, in order that the two processes are mutually reinforcing and identified priorities are aligned. The development and implementation of this strategy will lead to maintaining existing partnerships and building new ones at the country level, while ensuring national and local ownership of the processes involved. It will also ensure complementarity and synergy among stakeholders and development partners in the health sector.

During the period 2016–2020 WHO will focus its efforts in Zimbabwe on the following five broad strategic agenda:

(a) Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems;

(b) Accelerating the achievement of the unfinished MDGs relating to reduction of maternal, newborn, child and adolescent mortality; and strengthening sexual and reproductive health;

(c) Reducing further the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases;

(d) Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC;

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2. The Transformation Agenda of the WHO Secretariat in the African Region 2015-2020

and

(e) Strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security.

In formulating this CCS, the Zimbabwe WCO followed the global guideline for the formulation of the WHO Country Cooperation Strategy. An external consultant was engaged to conduct a comprehensive evaluation of the second generation CCS, which was carried out and completed in September 2015. Lessons learnt from this evaluation fed into the formulation of third generation CCS which is closely aligned to the new National Health Strategy 2016–2020.

The product of this new CCS resulted from inclusive dialogue and consultation with a wide range of organizations and individuals. These included officials from the Ministry of Health and Child Care, as well as other UN system organizations; bilateral and multilateral agencies; civil society and nongovernmental organizations (CSOs & NGOs); community groups; academic institutions; collaborating centres; and the private sector. Inclusive dialogue also involved consultation with representatives from socially excluded or disadvantaged sub-populations, as well as national human rights and women's bodies. These dialogues contributed to ensuring broad support and to the maximization of complementarity and synergies with partners throughout the CCS process.

CHAPTER 2:

HEALTH AND DEVELOPMENT SITUATION

This chapter deals with the current situation in the country and comprises two sub-sections, detailing: (a) the country's main health achievements and challenges; and (b) the country's landscape of development cooperation, partnerships and collaboration with the UN and obligations under regional and global resolutions, agreements and commitments.

2.1 Main health achievements and challenges

Under this section we summarize the analysis of the country's main health and development issues based on a comprehensive review of key national reference documents and country intelligence; and application of a gender, equity and human rights framework. The political, social, and macroeconomic context of the country is highlighted as well as the health situation, and the country's progress in the six WHO leadership priorities.

Political, social and macroeconomic context of Zimbabwe

The political environment in Zimbabwe remains dynamic, characterized by a vibrant media, independent judiciary and parliamentary democracy. Though the country has been ruled by a single party since independence in 1980, regular general elections are held every five years. In 2013, Zimbabwe adopted a new constitution and launched the Zimbabwe Agenda for Sustainable Socioeconomic Transformation (Zim-Asset) which replaced the Medium-Term Plan.[3] The Zim-Asset will guide the economic development of the country until 2018. It makes provision for strategies to improve social services, physical infrastructure and food security with key drivers for growth comprising mining, agriculture, tourism, and enhanced support for small to medium scale enterprises. The SDGs have a high priority in the political agenda, i.e. influencing the public policies of the country. The existing national development plans and strategies, including sectoral plans and strategies and other related plans, all reflect the SDGs and unfinished MDGs.

Zimbabwe enjoys membership to the Southern African Development

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3. Zimbabwe Agenda for Socioeconomic Transformation 2013-2018 (ZIMASSET). Government of Zimbabwe, Ministry of Finance and Economic Development, Harare 2013. See also www.zimtreasury.gov,zw/zim-asset www.zimtreasury.gov.zw/index.php/zim-asset

Community (SADC), the Common Market for Eastern and Southern Africa (COMESA), as well as the African Union (AU).The country is a signatory to several international conventions that promote gender equality. These include the Convention on the Elimination of all Forms of Discrimination Against Women (1991); the Beijing Declaration on the Platform for Action (1995); the Convention on Civil and Political Rights; the Equal Remuneration Convention; the Convention on Prohibition of Discrimination in Occupations, Convention on the Elimination of the Worst Forms of Child Labour and the Convention on Economic, and Social and Cultural Rights. According to MOHCC the country has been meeting deadlines for some reports on these conventions.

There is a Ministry of Women Affairs, Gender and Community Development and a national gender policy (2013–2017). Zimbabwe has made impressive strides in addressing gender disparity, particularly with achieving gender parity in both primary and secondary education. There has been tremendous improvement in tertiary education enrolment, with the Gender Parity Index (GPI) increasing from 60% in 2000, to 95% in 2012. The country has also effectively integrated gender, equity and human rights into public policies, strategies and operational planning. Social and economic determinants of health, including gender equality and women´s empowerment are periodically monitored and the results widely disseminated and discussed at the national level. However, challenges still remain in the unfinished business in terms of achieving gender balance in political and economic decision-making, and economic participation at all levels, and eliminating domestic violence.[4]

The economic situation in Zimbabwe is characterized by a weak macroeconomic environment. For example, according to a recent IMF report,[5] capital expenditure has declined from about 13% of total expenditure in 2012 to 7% in 2015; and total investment as a share of GDP dropped by 2% points, from 13% in 2013 to 11% in 2015. The same IMF analysis notes that inflow of official development assistance (ODA) as a share of GDP declined from 7% in 2013 to just over 3 % in 2015; and GDP growth which was 10% in 2012 declined to 3.8% in 2014 and down to

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4. Zimbabwe Millennium Development Goals 2000-2015. Final Progress Report, UNDP/ Zimbabwe. www.zw.undp.org/content/zimbabwe/un/home/library/mdg-final-progress-report-2000-2015.html
5. Zimbabwe Country Report No.16/109. Published by the International Monetary Fund (IMF), May 2016.

1.1% in 2015. This implies that the Zimbabwean economy is operating well below capacity. The official unemployment rate in 2014 rose to 11.3%, from 10.7% in 2011.[6] People below 30 years of age constitute 65% of the unemployed population. Total tax revenues accounts for barely 27% of the GDP.

Zimbabwe is saddled with a huge debt burden. The total public and publicly guaranteed debt, including arrears as at September 2015 was estimated at US$ 8.368 billion, of which US$1.290 billion was domestic debt, whilst US$7.078 billion was external debt.[7] The debt burden affects the country's ability to borrow from the Bretton Woods Institutions and the African Development Bank. The gap between income and expenditure continues to widen with revenue estimated at 16% below budget. Zimbabwe's economic output is constrained by infrastructure bottlenecks, among them shortage of electricity, water and transport as well as high cost of doing business, low productivity and uncompetitive manufacturing sector. Inflation remains in negative territory (-.2.5% in 2015) because of the appreciating US dollar (which currently is the main currency in use), and lower commodity prices which has worsened the country's competitiveness relative to its main trading partners, namely mainly South Africa and regional partners. Moreover, the continued depreciation of the rand against the US dollar has undermined the competitiveness of the country's exports. The rand has lost over 13% of its value against the US dollar since January 2015, a development which has also seen Zimbabweans increasingly preferring the US dollar over the rand in conducting business transactions and as a store of value.

The country remains prone to man-made and natural disasters such as floods and drought which have impacted negatively on health. Outbreaks of cholera and other diarrheal diseases in the past, together with the threat of transnational importation of deadly diseases point to the need for a robust health surveillance and disaster preparedness and response programmes.

6. Zimbabwe Poverty Atlas 2015. Published by Zimbabwe National Statistics Agency. Harare, 2015. ISBN 978-92-806-4823-2.

7. The 2016 National Budget Statement — "*Building a Conducive Environment that Attracts Foreign Direct Investment*", Presented to the Parliament of Zimbabwe on 26 November 2015 by Hon. P. A. Chinamasa, MP, Minister of Finance and Economic Development.

Health situation analysis

The right to health care is enshrined in the Constitution of Zimbabwe[8] which commits the State to "take all practical measures to ensure the provision of basic, accessible and adequate health services throughout the country". The country has made some progress in achieving the MDGs. The Zimbabwe Demographic and Health Survey (ZDHS, 2015)[9] and the Multiple Indicator Cluster Survey (MICs)[10] reports both show that the country made some progress in achieving the MDGs. The percentage of pregnant women accessing antenatal care visit increased from 64.8% in 2009 to 75.7% in 2015. The percentage of deliveries attended by trained health personnel increased from 66% in 2009 to 78.1% in 2015. Maternal mortality ratio declined from 960 per 100 000 in 2010-2011 to 651 per 100 000 live births in 2015. Under-five mortality dropped from 84 deaths per 1000 live births in 2010 to 69 deaths per 1000 live births in 2015. According to the same 2015 ZDHS, Zimbabwe has a youthful population, with two thirds of the population below the age of 25 years. Twenty-two per cent of female adolescents aged 15–19 years have children. However, child bearing increases with age, from 3% among women aged 15 years, to 48% among those aged 19 years. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become a mother as their urban counterparts. This can be attributed in part to cultural and religious practices in rural areas that promote and accept early sexual debut.

Zimbabwe has demonstrated its commitment to child survival as evidenced by ratification of international and regional treaties including the Convention of the Rights of the Child (CRC) and the African Charter. The nutritional status of children however remains of concern. One out of every three children in the country is malnourished, 11% of children less than 5 years

8. Zimbabwe Constitution. Government of Zimbabwe. Published by Fidelity Printer and Refiner (Harare) 2013
9. Zimbabwe National Statistics Agency and ICF International 2016. Zimbabwe Demographic and Health Survey 2015
10. Zimbabwe National Statistics Agency (ZIMSTAT), 2015. Zimbabwe Multiple Indicator Cluster Survey (MICS) 2014. Final Report, Harare, Zimbabwe

of age are underweight and more than a quarter of children (27.6%) are stunted.[11] There is a clear rural/urban disparity — for example, 28% of children under the age of five years in rural areas are stunted compared to 21% in urban areas.[12] The recent El Nino weather phenomenon which was associated with severe droughts in many parts of the country resulted in food insecurity and a negative impact on rural livelihoods. Food insecurity is likely to have a major impact on the nutritional status of children in particular if the current mitigation measures are not sustained. Regular assessments to monitor the nutritional trends of children in the most affected districts will be required.

The country has experienced a gradual decline in HIV prevalence among adults aged between 15 and 49 years, from a peak of 29.7% in 1997, to 18.1% in 2006; and 16.7% in 2014, predominantly as a result of behaviour change. Despite these gains, the current prevalence rate is unacceptably high. The HIV prevalence has consistently been higher in urban areas (16.85%, 17.04% and 17.23%) compared to rural areas (15.56%, 15.66% and 15.75%) in 2012, 2013 and 2014, respectively.[13]

Figure 2-1 depicts the HIV epidemic trend since 1983. There was a sharp increase in prevalence from 1986, reaching a peak in 1997. This was followed by a sharp decline until 2007, but the latter has since has been gradual. The ZDHS 2010 and 2015 show a similar trend in decline of HIV prevalence.

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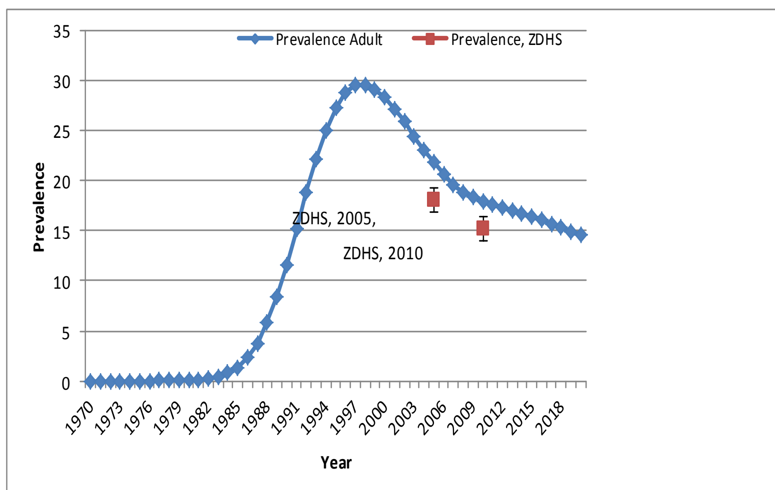
11. Zimbabwe Zero Hunger Strategy Review Report. Published by the World Food Programme (WFP). Delma Printers 2015.
12. Zimbabwe National Micronutrient Nutrition Survey Report, 2015. Zimbabwe Ministry of Health Child Care, 2015.
13. Ministry of Health and Child Care: Zimbabwe National and Subnational HIV/AIDS Estimates 2014.

Figure 2–1: Trends in adult (15-49 years) HIV prevalence with ZDHS data points



The same ZDHS data shows that HIV incidence declined from a peak of 5.92% in 1994 to 0.92% in 2014. In Zimbabwe, HIV and AIDS affects women disproportionately with HIV prevalence among women at 18% compared to men at 12%. In 2014, 78 % of HIV positive women had access to PMTCT care and the rate of mother to child transmission was 9.6%.[14]

In terms of the number of people living with HIV (PLWHIV) accessing ART, Zimbabwe has made impressive strides; and as of December 2015, the coverage for ART was 61% for adults and 44 % for children. According to data from a prospective cohort study at sentinel sites monitoring development of HIV resistance, the overall prevalence of any drug resistant

14. Ministry of Health and Child Care (MOHCC): Zimbabwe National and Subnational HIV/ AIDS 2014 MOHCC H HIV estimates 2014.

mutations at baseline for patients initiating first line antiretroviral therapy was 6.6% (95% CI 5.2–8.2) in the period 2009–2010.[15] Also from the same study, at 12 months after initiation of ART, 89.9% of the PLWHIV on ART achieved viral suppression of below 1000 copies/ml; highlighting treatment success and achievement of HIV drug resistance (HV DR) prevention. However, as the country continues to scale up ART, there is need to strengthen its strategy for the prevention and emergency of HIV drug resistance.

A nationwide TB Prevalence Survey 2014[16] reported a TB prevalence of 292 cases per 100 000 population. Zimbabwe remains one of the 30 countries with the highest burden of TB, TB-HIV and Drug resistant TB.[17] HIV remains the main factor fuelling the TB epidemiology in the country, with about 70% coinfection of all newly registered TB cases annually. Case notification has been steadily declining since 2010 from around 43 000 to 29 600 population in 2014, and this trend is in line with global trends. Treatment success rate of notified TB cases is 81% against a target of 95%, while the death rate is as high as 18% in some regions in the country against a target of less than 10%. Through collaborative TB-HIV services Zimbabwe has achieved 90% HIV testing among TB patients, and 86% ART on all TB patients. The actual burden of multidrug resistant TB (MDR TB) is still unknown, but will be informed by the ongoing TB drug resistant survey. The WHO TB Global Report estimates MDR TB burden at around 950 cases annually. With the introduction of new diagnostic technology, there has been a marked improvement on detection of MDR TB from 40 cases in 2012 to 413 in 2014 (based on an estimated 43% detection rate). Of these 92% are enrolled on treatment.

Due to the country's unfavourable macroeconomic environment, there has been a lot of mobility by Zimbabweans within the subregion in search of employment opportunities. This predisposes people to the risk of contracting and spreading HIV and tuberculosis, and also to the spread of MDR/TB. Currently there is no cross-border harmonization of treatment regimens for HIV and TB in the SADC region posing a challenge for patients already on treatment as they cannot access the same treatment across the border. This is further compounded by the fact that some

15. Report on the National HIV drug resistance monitoring at sentinel sites 2009-2011. Ministry Health and Child Care (MOHCC), Harare.
16. Zimbabwe National TB Prevalence Survey 2014 (report to be published MOHCC).
17. WHO Global TB Report 2015 (WHO/HTM/TB/2015.22) Geneva.

countries in the region do not offer HIV and TB services to migrants. To this effect there is need for further discussions between countries on how to deal with cross-border HIV and TB.

Zimbabwe is endemic to four preventive chemotherapy neglected tropical diseases (PC NTDs) — i.e. soil-transmitted helminthiasis (STH), schistosomiasis (SCHISTO), lymphatic filariasis (LF) and blinding trachoma. Recent NTD mapping results show that of the 63 districts in the country, 56 are endemic for SCHISTO, 47 are endemic for STH and 39 for LF.[18] Mass drug administration (MDA) started in 2012 for SCHISTO and STH obtaining coverages of 47% for STH and 48% for SCHISTO in 2012, and increasing to 58% for STH and 69% for SCHISTO against a target of 75%. MDA for LF and Trachoma are expected to start in 2016. No mapping has yet been done for other NTDs, although Zimbabwe is known to be endemic for rabies and human African trypanosomiasis (HAT).

The incidence of malaria declined from 58 per 1000 population in 2009 to 39 per 1000 population in 2014.[19] The decline has been more marked in the central and southern part of the country giving the country the drive to embark on pre-elimination activities in those parts of the country. Zimbabwe has met the Abuja target of a malaria incidence rate of 68 per 1000 people. However, the disease remains a significant cause of morbidity and mortality, especially in the summer months, in the low-lying areas of the country. While there has been an overall decline in incidence, there was no corresponding decline in mortality for the age group above five years. There seems to be a challenge in case management for this age group which will need further research. Of the 63 districts of Zimbabwe, 47 are malaria endemic. The eastern and northern border districts remain considerably highly burdened due to the mobility of population groups from high burdened countries across the borders. Cross-border collaboration in the control of malaria has become a critical strategy for malaria control. The emergence of vector-resistant strains to three of

18. Report on Lymphatic Filariasis Mapping in Zimbabwe, MOHCC (unpublished) 2014. See also Midzi N, Mduluza T, et al. (2014) Distribution of Schistosomiasis and Soil Transmitted Helminthiasis in Zimbabwe: Towards a National Plan of Action for Control and Elimination. PLoS Negl Trop Dis 8(8): e3014. doi:10.1371/journal.pntd.0003014
19. Ministry of Health and Child Care (MOHCC): National Health Information Systems NHIS Harare 2015

the four classes of insecticides is a major concern. The alternatives are very expensive, which could result in reduced coverage for targeted areas.

Although Zimbabwe seems to be facing a double burden of communicable and noncommunicable diseases (NCDs), there are no current statistics on the burden of NCDs in the country. The last WHO stepwise approach to surveillance (STEPS) for NCD risk factors survey was done in 2005. However, evidence from health facility-based surveillance data suggests that NCDs and conditions continue to pose a growing public health challenge. Diabetes, hypertension, cardiovascular conditions, cancer, road traffic injuries and mental health conditions continue to afflict a growing number of Zimbabweans. The 2014 National Health Profile reported that there were 1420 deaths out of 14 983 road traffic injuries, compared to 2042 deaths out of 14 759 road traffic injuries in 2014. Of the deaths in 2014, 89% were passengers and 8% pedestrians. For the injuries, 66% were passengers and 29% pedestrians.[20] It is estimated that NCDs account for 31% of total deaths in Zimbabwe.[21] The prevalence of smoking remains high at 22% for youths in school.[22] Efforts are underway to improve the capacity of public health facilities to screen and diagnose these conditions and diseases through the training of health workers, procurement of diagnostic equipment and consumables as well as advocacy towards healthy lifestyles. Government is also planning to continue investing in low cost high impact primary care interventions which focus on community health and preventive care.

Zimbabwe has adapted the AFRO Integrated Disease Surveillance and Response (IDSR) 2010 guidelines which include IHR (2005). The country is monitoring implementation of IHR core capacities through the MOHCC focal point and IDSR reporting through the MOHCC/HMIS. However, the country has yet to meet the minimum core capacity requirements for implementation of IHR (2005) in the context of IHR/IDSR strategy; and to prepare public health emergency contingency plans at the designated ports of entry (PoEs) which are regularly tested and updated.

20. National Health Profile. Ministry of Health and Child Care (MOHCC) 2014
21. World Development Indicators. Published by the World Bank. Washington D.C. 2012
22. Zimbabwe 2014 Country Report: Global Youth Tobacco Survey. Published by Ministry of Health and Child Care, (MOHCC) 2014

The health system in Zimbabwe

A strong health system is important for the implementation of health interventions to reduce morbidity and mortality. Zimbabwe has experienced two decades of poor economic performance that has resulted in the weakening of virtually all the six pillars of a functional health system.

The Health Services Act[23] guides the organization of the public health system. The public health-care system of the country operates at primary, secondary, tertiary and quaternary levels and in line with primary health care principles (PHC). Annex 2 summarizes the number and type of health facilities within the country

The National Health Strategy (NHS2016-2020) makes provision for dealing with the unfinished MDGs agenda, and for implementation of SDGs. Of the 17 SDGs, Goal 3 — '*Ensure healthy lives and promote well-being for all ages*' — directly focuses on health and the vision and goals of the latest NHS. Key SDG targets have been selected and adapted as national sustainable development goal targets (e.g. reducing premature mortality from NCDs, mental health, road safety, prevention of substance abuse, etc.). The NHS explicitly spells out ways for advancing UHC, and UHC is part of broader national efforts to deal with extreme poverty, social exclusion and gender inequity.

The new NHS also outlines the country's commitment to realizing the human rights of all and to achieve gender equality through the empowerment of all women and girls. With the majority of the people living in rural areas, urban migration remains an ongoing phenomenon resulting in the number of the urban poor increasing. Within the rural areas, resettled farmers are a key target population given the need to improve access to water, sanitation and health services to these populations. This priority will integrate SDG Goals 3 and other health-related goals. Unlike past strategies, the new NHS encompasses a detailed monitoring and evaluation framework which will be used to assess progress through mid-term and end-term evaluations. The key result areas and goals outlined in the NHS are detailed in Annex 3.

Although there is no comprehensive health information flow from private health-care providers, the sector seems to be making significant

23. Health Services Act. Published by the Ministry of Health and Child Care (MOHCC), Harare 2004

contributions to health provision. There is currently no policy on public-private partnerships for health; but some work has started to encourage this partnership on HIV/TB and EPI programmatic areas. Most health-care specialists in the country run private practice under a well-organized Private Hospital Association located largely in urban settings. It is estimated that more than 95% of the specialist doctors are concentrated in Harare, the capital city, leaving other major cities and provincial hospitals largely under-serviced.[24]

The human resources for health (HRH) situation in Zimbabwe has stabilized in the past five years after experiencing unprecedented levels of attrition in the first decade of the millennium. Efforts put in place through the introduction of staff retention allowances and targeted training of critical categories of staff that were well supported by health development partners (e.g. GF and HDF) have greatly contributed to the stabilization of the HRH situation.[25] However, this stability will remain artificial as long as government is unable to sustain the gains made by providing incentive remuneration packages. Of concern is that the current HRH establishment that was put in place in the early 1980s has since not been revised. This is in spite of the doubling in population size and significant increase in the disease burden over the years. The current freeze on recruitment of new staff adversely affects placement of many qualified personnel who could be immediately absorbed into services. Presently, WHO is supporting the Workload Indicator of Staffing Needs (WISN) survey which will provide a realistic HRH establishment. Furthermore, one of the legacies of the brain drain syndrome is that new recruits into services are unable to access mentorship of more experienced hands hence increasing concerns about the quality of healthcare services.

The health-care system in Zimbabwe is largely financed by the government with contributions from the private sector, bilateral and multilateral agencies, NGOs, and households. Government budget allocation to health has risen significantly from a low of US$ 9 per capita in 2009, to US$ 25 per capita in 2015. However, current levels of Government funding for

24. www.herald.co.zw/shortage-of-medical-specialists-hits-zim/
25. Zimbabwe Human Resources for Health (HRH) Profile. Ministry of Health and Child Care (MOHCC) 2013

health care still falls short of WHO's recommendation of US$ 86 per capita.[26] In the 2016 national budget the Ministry of Health & Child Care was allocated US$ 330.7 million compared to the US$ 449.6 million bids, which misses the 15% Abuja target by 5.3%. Of this allocation, 84% is allotted to salaries, leaving very little for actual programme implementation. A summary of key findings of the 2016 health resource mapping exercise shows that donor funds, as a share of the total resource envelop (i.e. about US$ 2.477 million), make up 57.6%, 50% and 54.5% for 2014, 2015 and 2016, respectively. In present circumstances, therefore, the health-care system is heavily dependent on external support, particularly for HRH retention, essential medicines and procurement of health technologies.

The National Health Information and Surveillance System that had deteriorated during the hyperinflationary era started showing some recovery during the second CCS era. This is exemplified by the performance of the weekly rapid diseases notification system which has consistently maintained above 90% completeness and timeliness since 2013. This improved performance is largely due to the adoption and use of the District Health Information Software (DHIS). The weekly rapid disease notification system has been backed by a public telecommunication service enabling health centres to report by short messages services. However, of concern are the inadequate financial resources for supporting the National Health Information System (NHIS). There is also inadequate compilation of information emanating from the private health sector.

2.2 Development cooperation, partnerships & contributions of the country to the global health agenda

Partnership and development cooperation

The key development and funding partners in the health sector comprise multilateral and bilateral institutions, international NGOs, and humanitarian

[26] WHO, Health in 2015 from MDGs to SDGs, Geneva 2015

and faith-based organizations. Funding partners comprise the European Union (EU), United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC) and the United Kingdom's Department for International Development (DFID), Irish Aid, SIDA, GIZ, BMGF, World Bank, Swiss Embassy, NORAD, French Aid, and the UN family.

Other mechanisms through which Zimbabwe has received funding include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Expanded Support Programme (ESP) and Global Alliance for Vaccines, and Immunization (GAVI) and the multi-donor funded Health Development Fund (HDF). Government through Zim-Asset and in partnership with the UN family through the Zimbabwe UN Development Assistance Framework (ZUNDAF) provides partners with regular information on the national development agenda. There are regular strategic and yearly planning and half-yearly monitoring and review meetings, during which the MOHCC provides partners with guidance on areas where development assistance is required.

However, there is a growing concern that some donors no longer see Zimbabwe as requiring humanitarian assistance and have expressed unease about extending support to the country. As a result, increasingly we are witnessing the reduction of external support for some critical health programmes – perhaps due to competing global priorities and sluggish global economy. There is therefore need for a fundamental rethink of the engagement of partners to sustain their support in building a resilient and sustainable health system that offers quality comprehensive care and aims to progressively achieve universal health coverage. Moreover, today we continue to face an emerging additional health burden. Instead of diseases vanishing as living conditions improve, socioeconomic progress is creating unintended conditions that favour the rise of noncommunicable diseases. The role of the WCO as arbitrator between the MOHCC and partners remains critical. The WCO is still trusted as an honest broker to provide empirical evidence on areas of genuine need.

As indicated already, the MOHCC relies heavily on support from donors — including the Health Development Fund and the Global Fund particularly for recurrent expenditure. Even though a complete tabulation of partners' support levels are not provided because of limited information, Annex 4

already indicates a total of US$ 646 781 064 coming from partners. These mechanisms will remain essential until such a time when the country has a functional macroeconomic environment in place. However, there is need to explore other approaches and strategies for mobilizing financial, material and human resources from national and local stakeholders, including the community. The completion of the national health accounts remains a priority. The country will require support in strengthening national health accounts analysis, health sector financing options and the possibilities that exist in the public-private partnerships (PPPs).

In an attempt to mainstream the SDGs in the country the government together with the UN system organized stakeholder workshops to raise awareness, prioritize goals and domesticate targets. Specific strategies to achieve the unfinished MDGs and SDGs have been put in place, putting emphasis on health in all sectors. Specific strategies to prepare local governments for the “localization” of SDGs at subnational level are being worked out. Stakeholder analysis of health and health related SDGs support areas is reflected in Annex 4.

Collaboration with the UN system at country level

The United Nations in Zimbabwe works in support of the Government of Zimbabwe and in collaboration with development partners. The United Nations Country Team (UNCT) is the highest-level inter-agency coordination and decision-making body in Zimbabwe, which is led by the United Nations Resident Coordinator. The UNCT arrangement enables all UN entities with activities in Zimbabwe to work as a team in formulating common positions on strategic issues, ensuring coherence in action and advocacy. The UNCT values its engagement with all stakeholders, including government, bilateral and multilateral donors, nongovernmental organizations, civil society organizations and the private sector. The agencies working in health include: UNFPA, UNICEF, UNAIDS, UNDP and WHO. Also, ILO, World Food Programme and UN Women contribute to health through their programmes that address some social dimensions of health.

The 2016–2020 ZUNDAF was designed at a strategic level to provide the Government of Zimbabwe and the UN Country Team with a flexible and agile framework and responds in a holistic manner to the evolving national context. Increased effectiveness through UN coherence and stronger partnerships are key underlying principles for the operationalization of the ZUNDAF. The ZUNDAF provides the Government of Zimbabwe and the

United Nations Country Team with enhanced perspectives to advance the recovery and development agenda. Accordingly, in order to ensure coherent and strategic action in contributing to this agenda, a Joint Implementation Plan for the 2016–2020 ZUNDAF was developed, to serve as a tool for improved programming, planning, implementation, monitoring and evaluation and accountability. Within the plan, a set of flagship programme for each ZUNDAF national priority areas have been jointly elaborated with government. These are: (a) equal access to justice for all; (b) promoting economic recovery through enhanced entrepreneurship and employment for youth and women in Zimbabwe; (c) strengthening the capacity of national statistical systems and timely production of statistical data; (d) community action programme for adaptation and mitigation of climate change; (e) prevention and treatment of malnutrition in Zimbabwe; (f) eliminating new paediatric HIV infections and keeping children and parents alive; and (g) strengthening the multisectoral approach to gender based violence prevention and response.

The above priority areas integrate several Sustainable Development Goals (e.g. SDGs 1, 2, 3, 5, 8, 13, and 16). These are the critical areas of social determinants of health. WHO's contribution has been through informing policy, strategy and guideline formulation, building core institutional capacity, monitoring trends according to the WHO mandate and resource mobilization for key programmes. As a member of the UNCT Programme Management Team (PMT) and Virtual Team of Policy Advisors (VTPA), the WCO has been actively involved in monitoring the implementation of the ZUNDAF through active participation in annual review meetings where issues pertaining to the achievement of ZUNDAF are tabled.

Country's contributions to the global health agenda

Zimbabwe's President chaired both the SADC[27] and the 54-nation continental body, the African Union, in 2015. Zimbabwe's Minster of Health chaired the SADC health ministers' fora where several key resolutions were taken. In 2015 Zimbabwe organized and hosted the International Conference on AIDS and STDs in Africa (ICASA) under the banner "AIDS in Post-2015 Era: Linking Leadership, Science and Human Rights"

Another key initiative that has contributed positively to health development

27. SADC's members are: Angola, Botswana, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

in other countries is Zimbabwe's efforts toward meeting the Roll Back Malaria's Global Malaria Action Plan goals and targets. Zimbabwe was instrumental in cementing the Zambia-Zimbabwe (Zam-Zim) cross border malaria initiative. This, coupled with strong partnerships between countries, with corporates, UN Agencies, among others, has resulted in gains for malaria control and prevention.

The national response to HIV and AIDS in Zimbabwe is financed through the National AIDS Trust Fund (NATF) resourced through the AIDS Levy, Global Fund, bilateral and multilateral institutions. The NATF is administered by Zimbabwe's National AIDS Council. The Global Fund, bilateral and multilateral funds and resource are administered by selected agents or institutions identified by the respective funders. Given Zimbabwe's success in decreasing the HIV/AIDS burden there are lessons that can be learnt from this mechanism to fight the disease. Zimbabwe has shared with other countries its experience in establishing and implementing the AIDS Levy as a mechanism to enhance local financial resource mobilization.

CHAPTER 3:

REVIEW OF WHO'S COOPERATION OVER THE PAST CCS CYCLE

The second generation CCS covered the period 2008–2015. The key strategic agenda of this CCS comprised of the following components: (a) improving health systems performance; (b) reducing the burden of the major communicable and noncommunicable diseases; (c) enhancing health promotion to reduce the major risk factors, including the promotion of healthy environments; and (d) addressing the vulnerability of the country to emerging health issues such as natural and man-made disasters, disease outbreaks and different risk factors through the strengthening of the emergency preparedness and response (EPR) capacity of the health sector.

An external evaluation of the CCS was undertaken between August and September 2015. The main thrust of the evaluation was to provide information on the successes and challenges in its implementation; as well as lessons learnt that could be taken up in the next CCS covering the period 2016–2020.

The specific objectives of the evaluation were: (a) to assess the level of achievement of the goals in the CCS 2008-2015; (b) to document challenges encountered during the implementation of the CCS 2008-2015; (c) to assess knowledge and awareness of WCO staff and partners including MOHCC on the CCS and their perception of its relevance; and (d) to recommend key actions to be considered by WCO during the development of third generation CCS 2016-2020.

The methodology involved secondary research comprising of a comprehensive literature review of developments within the four strategic areas and qualitative approaches, including self-assessments from WCO staff and key informant interviews. The review was undertaken at a point when the country was heavily engaged in SDGs development processes. The focus for WHO was to advocate for adapting the SDGs to the national context and integrating national sustainable development priorities into the NHS, and into the new CCS priorities and focus areas. Efforts were made to ensure that the new CCS captures the spirit of universality in the SDGs and their strong emphasis on equality — frequently referred to as '*leaving no one behind*' — as well as promoting a multisectoral approach with regards to health; recognizing that health is represented not only in the 13

targets under SDG 3, but also in 35 additional health-related targets under the other SDGs.

It was acknowledged and noted that WHO cannot do everything, hence the need for its technical cooperation with the country to be strategic and focused in order to maximize the effectiveness of its efforts at country level.

Given that the second generation CCS was implemented over a seven-year period when there was significant staff attrition at both the MOHCC and the WCO, there was some degree of recall bias on the part of the key informant participants. Moreover, no mid-term evaluation was conducted to inform the final evaluation.

The review identified some key achievements for WHO. In spite of the political, economic and major epidemiological events that had significant impact on the status of health of Zimbabweans during the period covered by this CCS, WHO still played a significant role in resource mobilization, advocacy and policy development; as well as in technical advice and assistance in the best global practices in health. Implementation of HIV, TB and malaria programmes; the expanded programme on immunization; as well as maternal and child health programmes received much attention. WHO's efforts to monitor progress in these programmes as part of tracking health related MDGs was commendable. WHO was also critical in supporting the strengthening of the pharmaceutical systems in the country, including timely revision of the essential medicines list. The development and extension of the National Health Strategy and undertaking of national health accounts was led by WHO. In addition, WHO played a leading role in responding to health emergencies and disasters that occurred during this period. This included responses to the measles, malaria and typhoid outbreaks; and to the unprecedented cholera outbreak in 2008-2009, and as well as responding to the health humanitarian situation of internally displaced people following floods.

However, the analysis identified some constraints which are summarized here. The CCS was not fully known, utilized, and appreciated as the reference point for the work of WHO in the country, by some stakeholders (some MOHCC staff, development partners' and nongovernment sector). Detailed analysis of the resources committed for implementation of the specific priority areas identified in the CCS was limited because the strategy was not costed. Noteworthy though, the CCS document functioned as reference guidance for the development of the biennial programme workplans and budgets. The capacity of the country office to

implement the biennial programme of work was highly constrained by inadequate financial and human resources. It should be pointed out here that the Biennial Programme Budget for each biennium did not change dramatically throughout the period of the CCS – in all cases not exceeding US$15 million per biennium; far less than a minimum of at least US$ 30 million expressed by the country office.

Approximately 40% of the allocations provided were spent on salaries; and of the remaining balance, 47% went to programme support — administered through Direct Financial Corporation (DFC) agreement with the Ministry of Health. Some critical and strategic MOHCC requests for support (e.g. request for STEPS survey and the National Health Accounts studies) were not responded to adequately because of budgetary constraints. No funding was allocated for emergencies, and whenever emergencies occurred, the WCO had to trigger emergency resource mobilization through the Regional Office, or through the UN Central Emergency Response Fund (CERF) — which processes were considered very slow; and responses always inadequate and late for the emergency.

On human resource capacity in the country office, staffing levels during this period varied from 39 to 40 for each biennium. Of this, 92% were mainly locally recruited staff. Professional staff who offered technical support to the Ministry of Health constituted 25–30% of the existing staff level. International staff complement was limited to the Head of the WHO Office in the country and the Administration Officer. Absence of critical technical capacity to deal with key programmes such as disaster preparedness and response, reproductive health, disease prevention and control, health promotion, health financing and essential medicines affected the full potential of WHO operations. Support for health systems strengthening which is considered central for the achievement of all health programmes was perceived to be insufficient. Because of the inadequate human resource base in the office, some programme officers became overloaded by taking on extra responsibilities which compromised their overall efficiency.

Looking ahead, it is important to create more awareness about the CCS to enable stakeholders to appreciate WHO's mandate and its role in health development in the country. It is noted that the last CCS paid more attention to specific diseases and conditions because of selective partner funding streams. Nevertheless, WHO's collaboration with donor organizations such as Global Fund is facilitating mobilization of resources

to implement its normative role at country level and also to enhance additional technical capacity in the country office. For instance, 2 technical staff members at WCO are supported through the Global Fund. Public-Private Partnership arrangements were weak to effectively address the gaps in health care service delivery. This is an area that needs further policy elaboration. The CCS did not also give adequate attention to the role of communities in addressing disease prevention and health promotion efforts that are targeted to disease outbreaks and noncommunicable diseases. These issues should be adequately explored in the new CCS.

It is further proposed that the CCS be fully utilized as a guiding tool in the biennial programme planning, as well as an instrument for resource mobilization. The country office should ensure that the next CCS (and future ones) is widely disseminated and regularly referenced as the guiding roadmap of WHO's work in the country. Appropriate measures should be taken to ensure that the WCO is fully resourced to play its central role in health development. Furthermore, adequate attention should be given to the revitalization of primary health care and community engagement on matters of health.

CHAPTER 4:

4. Strategic agenda for WHO cooperation

This strategy is guided by the unfinished business from the UN Millennium Development Goals (MDGs), the UN Sustainable Development Goals (SDGs), the WHO global priorities (MTSP & GPW), the WHO African Region Orientations, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF), and other relevant regional and subregional initiatives. It takes into consideration the importance of national development strategies as outlined in the Zimbabwe Agenda for Economic and Social Transformation (Zim-Asset) — the Government of Zimbabwe's blueprint for socioeconomic development over the period 2014–2018, and responds to the health needs of the country as defined in the new National Health Strategy (NHS 2016–2020).

The 2016–2020 CCS strategic agenda is aligned with the MOHCC mission of achieving equity and quality in health through universal health coverage (UHC). The strategic priorities, focus areas and related goals and targets within this CCS hinge on provision of advisory and technical support to the MOHCC within the spirit of universality in the SDGs and their strong emphasis on equality — frequently referred to as "leaving no one behind" — as well as promoting a multisectoral approach with regards to health; recognizing that health is represented not only in the 13 targets under SDG 3, but also in 35 additional health-related targets under the other SDGs.

The Zimbabwe NHS 2016–2020 in particular, identified three key result areas of critical importance, namely: strengthening priority programmes; improving service delivery platforms/entities; and improving the enabling environment for service delivery. The CCS is primarily aligned to these key result areas. In addition, the CCS priorities focus on outcomes of consultations with key stakeholders, lessons learnt from the review of the past CCS cycle and WHO's comparative advantage, added value and core functions; taking into account the Organization's financial and human resources (present and future).

The CCS strategic priorities and the corresponding focus areas, and their linkages to GPW outcomes, NHS targets, SDGs targets and ZUNDAF

outcomes are elaborated in Annex 5. In order to support the implementation of the NHS the WCO will need to address the specific internal constraints relating to human resource capacity and programmatic funding; and both of these issues are further elaborated in Chapter 5.

In the sections that follow, we give the illustrative examples of each strategic priority, detail the focus areas within each strategic priority and provide some illustrative interventions with corresponding indicators. The specific interventions at this stage remain illustrative; but they will be adjusted according to the evolving needs and prevailing realities of the MOHCC during the implementation period.

4.1 Strategic Priority 1 : *Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems*

The pursuit of universal health coverage in Zimbabwe faces considerable obstacles because of the inherent weaknesses in the health systems — organization of the health systems, shortcomings in health delivery approaches, inadequate financing schemes and problems associated with available HRH. The new CCS therefore, emphasizes the importance of health systems strengthening as the foundation of any improvements in health delivery in Zimbabwe. The strategic focus areas under this priority include:

Strategic Focus Area 1.1 — Strengthen HRH to ensure appropriate recruitment into services to match workload, training that responds to contemporary needs, equitable deployment and appropriate retention schemes (including remuneration, motivation, and improved work environment).

Strategic Focus Area 1.2 — Support efforts to improve access to and rational use of safe, effective quality medical products (medicines, vaccines, diagnostics and other procedures, systems and health technologies); to strengthen national health regulatory authority; and to ensure that mechanisms for coordination with stakeholders have been established to increase access to essential, high-quality, effective and affordable medical products.

Strategic Focus Area 1.3 — Support MOHCC to make a case for appropriate health-care financing- through regular NHA studies, resource mapping exercises, cost effectiveness analysis of healthcare programmes, finalization of the health financing policy, advocating for the

implementation of a national health insurance, and supporting the budget process for achieving universal health coverage.

Strategic Focus Area 1.4 — Strengthen health information systems to ensure availability of high-quality, timely and reliable data disaggregated by income, gender, age, rural-urban disparity, as well as periodic reviews of the National Health Information & Surveillance Strategy to generate evidence to monitor trends in priority health programmes for both public and private health sectors.

Strategic Focus Area 1.5 — Support national efforts to improve access to comprehensive, person-centred, integrated health services based on primary health care, quality and continuity of care, and to effectively integrate gender, equity and human rights into public policies, strategies and operational planning.

The strategic focus areas for Priority 1, together with illustrative interventions and corresponding indicators are shown in Table 4.1.

Table 4.1: Strategic Priority 1 focus areas, illustrative interventions and corresponding indicators

Focus Areas	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 1.1	Support development of new HRH strategy.	HRH strategy (2016-2020) in place
	Advocacy for HRH retention in HDF forum.	
	Sharing best practices on HRH retention	Number of best practices reports shared.
	Support the MOHCC in human resource management using the Workload Indicators of Staffing Needs (WISN) study.	Capacity to conduct WISN study developed.
Strategic Focus Area 1.2	Support the revision and updating of Standard Treatment Guidelines and EDLIZ	New STG and EDLIZ in place
	Support development and implementation of interventions for improving transparency and good governance of the pharmaceutical sector	Good Governance for Medicine (GGM) framework in place
	Support antimicrobial resistance monitoring (AMR) to curb growing antimicrobial resistance	AMR National Action Plan (NAP) in place
	Support improved medicines selection, prescribing , dispensing and use	National Medicines Survey produced
	Support updating of Pharmaceutical Country Profile	Updated Pharmaceutical Country Profile in place
Strategic Focus Area 1.3	Support MOHCC in strengthening effective Health Development Partners Group coordinating mechanisms.	Streamlined and effective coordination mechanisms in place.
	Support MOHCC to build capacity for effective leadership, management and governance (LMG) at all levels of the health delivery system including community level.	Number of WHO supported LMG capacity building trainings/ workshops held
		LMG materials and TA provided by WHO
	Support MOHCC to enhance partnerships and their coordination at all levels of the health delivery system with a particular focus on public- private partnerships (PPPs)	Policy on PPPs in place
		MOUs for PPPs in place
		Number of partnerships developed
	Support development of National Health Financing Policy and Strategy	National Health Financing policy and Strategy in place
	Capacitate the development of periodic national health accounts	Periodic national health accounts in place
Strategic Focus Area 1.4	Support development of new NHIS strategy	NHIS Strategy in place
Strategic Focus Area 1.5	Support development of people-centred policies and programmes.	NHS updated

4.2: Strategic Priority 2: *Accelerating achievement of the unfinished MDGs relating to reduction of maternal, newborn, child and adolescent mortality; and strengthening sexual and reproductive health*

Diseases and conditions associated with pregnancy and child birth remain a major cause of morbidity and mortality in Zimbabwe. Despite significant progress during the period covered by the second generation CCS, the country failed to meet its RMNCAH-related MDG targets. For example, maternal mortality remains unacceptably high, well above the regional average for Africa. The NHS still places high priority on RMNCAH. In response to this situation, the new CCS has selected RMNCAH as a priority area guided by the Global Strategy for Women's, Children's and Adolescents' Health.

The strategic focus areas under this priority include:

Strategic Focus Area 2.1 — Strengthen MOHCC capacity to implement quality and affordable interventions to contribute to the reduction of maternal mortality in the country.

Strategic Focus Area 2.2 — Strengthen the MOHCC capacity to implement quality and affordable interventions to end preventable deaths of neonates and children below five years of age.

Strategic Focus Area 2.3 — Support MOHCC to ensure universal access to sexual and reproductive health-care services particularly for adolescents, and the integration of reproductive health and gender into national strategies and programmes.

Strategic Focus Area 2.4 — Support MOHCC efforts to end all forms of malnutrition, including stunting and wasting in children under five years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

The specific strategic focus areas, together with illustrative interventions and corresponding indicators identified for the period of the new CCS under this priority are outlined in table 4.2

Table 4.2: Strategic Priority 2 focus areas, illustrative interventions and corresponding indicators

Focus Areas	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 2.1	Support development and updating of relevant strategies, policies, guidelines and tools for maternal health.	Availability of adapted or updated QOC standards, guidelines and protocols
	Support QOC assessments and use results to improve maternal health	Number of QOC assessments supported
Strategic Focus Area 2.2	Support implementation of innovative health worker training methods for acceleration of child survival (e.g. ICATT, distance IMCI)	Innovative approaches adopted
Strategic Focus Area 2.3	Support implementation of adolescent, sexual and reproductive health (ASRH) across the country (e.g. strengthen school health programme, advocate for legislation against child marriage, enhance community awareness on ASRH)	Number of ASRH initiatives supported
Strategic Focus Area 2.4	Support the MOHCC and other stakeholders in efforts to reduce stunting by providing guidelines and international best practices	Number of nutrition guidelines adapted

4.3 Strategic Priority 3: *Reducing further the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases*

Communicable diseases remain the leading cause of ill-health and mortality in Zimbabwe and WHO will support the country as it aspires to end the HIV, TB and malaria epidemics by 2030; and prevent vaccine preventable diseases. There is also an emerging epidemic of hepatitis especially among PLHIV and this will need to be addressed. Malaria remains an endemic problem in low-lying areas of the country. Other communicable diseases like diarrhoeal conditions, respiratory tract and sexually transmitted infections and zoonoses remain a major public health problem in Zimbabwe. Efforts are also underway to control NTDs — soil transmitted helminths (STH), schistosomiasis (SCHISTO), lymphatic filariasis and blinding trachoma.

The strategic focus areas under this priority include:

Strategic Focus Area 3.1 — Support national efforts towards attainment of HIV '*90-90-90 targets*[28] by 2020.

[28]' HIV 90-90-90 targets' refer to fast track targets to ensure that 90% of PLWHIV are diagnosed, 90% of those diagnosed receive sustained anti-retroviral therapy, and 90% of those on treatment have durable viral load suppression by 2020.

Strategic Focus Area 3.2 — Reduce TB burden in the country as well as introduce new diagnostic and treatment approaches for MDR TB.

Strategic Focus Area 3.3 — Reduce malaria incidence and support efforts to move towards malaria elimination.

Strategic Focus Area 3.4 — Reduce morbidity due to NTDs especially STH and SCHISTO.

Strategic Focus Area 3.5 — Reduce morbidity and mortality due to vaccine preventable diseases.

The specific strategic focus areas, together with illustrative interventions and corresponding indicators identified for Priority 3 are outlined in Table 4.3.

Table 4.3: Strategic Priority 3 focus areas, illustrative interventions and corresponding indicators

Strategic focus areas	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 3.1	Provision of technical assistance to strengthen paediatric and adolescents HIV prevention, treatment and care Development or updating normative guidelines for prevention, treatment and care. Review of policies and strategies on HIV. Support to programme management including programme reviews Provide technical assistance in the introduction and implementation of new technologies for early diagnosis and monitoring of treatment of HIV and hepatitis Support to MOH in preventing and monitoring the emergence of drug resistance associated with scaling up of HIV programme Advocate to have hepatitis back on the health agenda before it reaches epidemic levels Resource mobilization	Increased coverage of ART to 90% by 2020 among children and adolescents, pregnant women, general population Number of guidelines, SOPs and training materials that are developed by 2020 Number of policies and strategies reviewed and updated Drug resistance surveys conducted
Strategic Focus Area 3.2	Strengthen implementation of the national TB programme guided by normative documents which have been developed in accordance and aligned with the WHO END TB strategy Strengthen provision of quality, comprehensive and universally accessible diagnostics, and treatment and care services for programmatic management of MDR TB. Strengthen national TB surveillance, recording and reporting of quality TB data for monitoring implementation progress	National TB Strategic Plan 2017 - 2020 developed National TB manual updated National TB laboratory Operational Plan developed GeneAlert introduced National policy on the use of Gene Xpert revised M &E tools revised TB Drug resistance survey completed

Table 4.3: Strategic Priority 3 focus areas, illustrative interventions and corresponding indicators (continued..)

Strategic focus areas	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 3.3	Support the development of malaria policies and strategic plans in line with WHO guidance Provide technical support in programme implementation for the further reduction of malaria burden and creation of malaria free zones Support in monitoring the performance of the NMCP Support in carrying out malaria therapeutic efficacy testing Support in resource mobilization for malaria control and elimination	Malaria policy updated Malaria strategic plan developed Proportion of population at risk of malaria protected against malaria maintained above 95% Malaria programme reviews conducted Therapeutic efficacy monitoring carried out Programmatic and financial gap analysis tables updated and concept notes developed
Strategic Focus Area 3.4:	Capacity development in NTD control Facilitate procurement and distribution of PC-NTD preventive chemotherapy medicines Provide technical support and guidance in prevention and control NTD stakeholder coordination Facilitate monitoring, evaluation and quality assurance activities in the implementation of NTD prevention and control activities Advocate for the integration of preventive chemotherapy as a front-line intervention to control morbidity due to NTDs. Support community and social mobilization to overcome neglected tropical diseases Facilitate development, updating and dissemination of national NTD guidelines and protocols	2 yearly Trainings in NTD prevention and control 100% PC-NTD medicines required, supplied. Quarterly steering committee meetings held Annual NTD reports completed Post-MDA surveys Preventive Chemotherapy integrated as front-line intervention for NTD control Improved community awareness on neglected tropical diseases Guidelines for major NTDs developed/ update
Strategic Focus Area 3.5:	Provision of technical support to polio eradication activities as stated by the Global Polio Eradication Initiative (GPEI) Supporting neonatal tetanus (NNT) and Measles elimination activities including related surveillance activities Supporting the MOHCC in achieving and maintaining high immunization coverage Mobilizing resources for new vaccines introduction Supporting operational research including periodic assessments, programme reviews and evaluations	AFP surveillance indicators (non-polio AFP case detection rate and % stool adequacy) Measles surveillance indicators (non-measles febrile rash detection rate and % of districts with at least one case with blood specimen per year) Measles vaccination coverage nationally and by district Percentage of districts with 80% or greater coverage with third dose of diphtheria-tetanus-pertussis containing vaccine Number of new vaccines introduced

4.4 Strategic Priority 4: *Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC*

The push on NCDs will be to reduce mortality due to NCDs in line with the Global NCD Action Plan 2013–2020. This will be achieved chiefly through efforts on reduction of incidence of the major NCDs and related risk factors.

The strategic focus areas under this priority area include:

Strategic focus area 4.1 — Improved access *to* prevention and control of NCDs in line with the global action plan through policy dialogue and implementation of sound intersectoral strategies for the prevention of NCD risk factors.

Strategic focus area 4.2 — Improve the mental health status of the population through the development and implementation of national policies and plans.

Strategic focus area 4.3 — Support the implementation of multisectoral actions to reduce injuries and violence, in particular gender based violence, and violence against children.

Strategic focus area 4.4 — Support provision of services for disabled people through more effective policies and integrated community-based rehabilitation.

Examples of specific interventions to be undertaken are illustrated in Table 4.4.

Table 4.4: Strategic Priority 4 focus areas, illustrative interventions and corresponding indicators

Strategic focus area	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 4.1	Support the development of strategies and guidelines for NCD prevention and control	NCD Strategy and action plan developed Ear and hearing health services strategy developed Adaptation and dissemination of WHO PEN guide on NCD control National CBR guidelines developed
Strategic Focus Area 4.2	Increase access to services for mental, neurological and substance use disorders.	Mental health strategy developed mhGAP intervention guide adapted MH capacity developed
Strategic Focus Area 4.3	Development and implementation of injury multisectoral plans Development of policies and plans against gender-based violence	Injury multisectoral plans developed Policies and plans against gender-based violence developed
Strategic Focus Area 4.4	Development of policies to support disabled people especially for the visually impaired and those with hearing loss	Policies to support disabled people developed

4.5 Strategic Priority 5: *Strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security*

WHO will support the MOHCC in strengthening capacities for public health surveillance, epidemic and pandemic prone diseases, as well as emergency risk and crisis management. The focus areas identified for the new CCS for this priority include:

Strategic focus area 5.1 — Improved alert and response capacities through strengthened coordination mechanisms, capacity building in IDSR, IHR (2005) and the development and maintenance of IHR core capacities including Port Health capacities.

Strategic focus area 5.2 — Enhanced capacity for early detection and prompt response to epidemic and pandemic- prone diseases through development and implementation of operational plans, in line with WHO recommendations on strengthening national resilience and preparedness

covering pandemic influenza and epidemic and emerging diseases; setting up systems support for expert guidance in connection with disease control, prevention, treatment, surveillance, risk assessment and risk communications.

Strategic focus area 5.3 — Improve capacity for emergency risk and crisis management through maintenance of Inter-Agency Coordination Committee on Health (IACCH), strengthened national capacities for all-hazard emergency and disaster risk management for health, development and implementation of health sector strategy and plan, including reporting by an in-country network of qualified and trained WHO emergency staff.

Strategic focus area 5.4 — Support efforts to reduce risks to food safety through development and implementation of food safety standards and guidelines; and enhanced multisectoral collaboration.

Strategic focus area 5.5 — Improve capacity to respond to threats and emergencies with public health consequences guided by the WHO's Emergency Response Framework in acute emergencies with public health consequences.

Table 4.5 shows illustrative interventions and the corresponding indicators under this priority area.

Table 4.5: Strategic Priority 5 focus areas, illustrative interventions and corresponding indicators

Strategic focus areas	Illustrative Interventions	Corresponding Indicators
Strategic Focus Area 5.1	Capacity-building in IDSR, disaster risk management (DRM) and strengthening of rapid response teams at all levels.	Rapid response teams trained in IDSR and DRM
	Advocate for introduction of pre-service training in all multidisciplinary public health training institutions	Multidisciplinary public health training institutions supported to incorporate IDSR training in their curricula
	Advocating for improvement of IHR core capacities and strengthening of IHR implementation, as well as strengthening Port Health capacity and cross-border collaboration at all points of entry (PoE).	Number of points of entry implementing all 12 IHR core capacities.
Strategic Focus Area 5.2	Capacity building for early detection and response to disease outbreaks and other public health emergencies.	Reports on outbreaks and other public health emergencies identified and responded to within 48hrs.
Strategic Focus Area 5.3	Support MOHCC in coordination of disease outbreak response, including other public health emergencies.	Coordination mechanism established and maintained
	Support MOHCC in the review of their EPR Plans and development of contingency plans.	Reviewed EPR Plans. Developed Contingency plans.
	Provide technical support to MOHCC in conducting rapid health assessments during disease outbreaks and other public health emergencies.	Rapid health assessment reports produced.
	Provide technical support MOHCC in monitoring and evaluation of field operations during emergencies.	Monitoring and evaluation Reports produced.
Strategic Focus Area 5.4	Advocate for the establishment of food safety regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards.	Food safety regulatory frameworks established.
Strategic Focus Area 5.5	Capacitate the MoHCC in the application for the Emergency Response Framework (ERF) from Regional Office in crisis situations.	Number of graded emergencies meeting ERF criteria.

CHAPTER 5

IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR THE ENTIRE SECRETARIAT

The implications for the WHO Secretariat involve capacity, pooling of resources and application of standard operating procedures for emergencies. Efforts will be made to ensure that the strategic agenda is adequately rooted in an understanding of the country context, paying attention to the socioeconomic challenges and how they affect health development efforts. In particular, attention will be paid to ensuring that implementation of the strategic agenda does not lead to weakening of the state capacity and/or legitimacy, neither should the uneven distribution of technical support lead to an unintentional widening of social disparities.

The central focus for the Secretariat will remain strengthening the capacity for national health development. To this extent, periodic and systematic analysis of risks will be carried out in a sustained manner to ensure that interventions are not patchy but planned within the overall strategy for health system rebuilding with a special focus on capacity-building for sustainability. Recognizing the links between political and development objectives, every effort will be made to support integrated whole-government approaches and seek the required buy-in across the various relevant sectors through inclusive dialogue and consultations. Above all, WHO will ensure alignment of the CCS strategic agenda with national health priorities, including health and health-related national sustainable development goal targets; as well as deepening alignment in strategic agenda implementation through the use of country systems for example in monitoring and evaluation. WHO will also ensure that agreed priorities and focus do not foster fragmentation, but rather seek to promote coordination of partner support for government plans and programmes. While acting fast, the Secretariat will stay engaged long enough to give success a chance; employing a mixture of strategic priorities that can meet immediate needs as well as those that assure the country of medium-term predictability of technical support based on jointly agreed benchmarks.

5.1 Core capacity of WCO

It is clear from the analysis of the WCO that additional core capacity (in

terms of human and financial resources, infrastructure – including information and communication technology) and other resources will be required to implement the CCS Strategic Agenda. Without adequate human resource capacity in particular, it will not be possible to achieve the expected results. In line with the current review of the WCO core capacities under the Transformation Agenda, efforts should be made to beef up the human resource capacity needs specifically for: (a) noncommunicable diseases (NCD) — to fill skills gaps for dealing with mental health and substance abuse and nutrition; (a) providing health through the life course (FRH) — to fill skills gaps for dealing with gender, equity and human rights mainstreaming and social determinants of health; (a) health systems (HSS) — to fill skills gaps for dealing with access to essential medicines and other health technologies and strengthening regulatory capacity, as well as health systems information and evidence; (d) health security and emergencies (HSE) — to fill skills gaps for dealing with issues of food safety; and to fill gaps in health promotion efforts.

There is also need to stabilize the contracts of ICT staff who are presently all on SSA contracts. Critically though, filling HRH gaps in the WCO is linked to the budgetary provisions made available to the country office, which remain grossly inadequate.

5.2 Office space and meeting rooms

The WCO has ample office space made available, courtesy of the Government of Zimbabwe to house its entire staff. It has adequate meeting rooms and good ICT capability. This advantage affords WCO an opportunity to hold/host many of the training, workshops and meetings that are in the CCS at WCO at a lower cost than holding meetings in hotels, which tends to be expensive. Therefore, wherever possible, the WCO will hold planned meetings in WHO facilities. Similarly, the WCO could also offer its space to MOHCC to hold their meetings. A critical need for WCO is to ensure budgetary provisions for regular maintenance and repairs of the office infrastructure.

5.3 WCO information and communication technology needs to implement the CCS

Although the current ICT infrastructure and capacity is very good, there are frequent breakdown of servers, and some computers require replacement. A master plan for ICT infrastructure upgrading and maintenance for the duration of the new CCS is required, and there should be adequate

budgetary provision for this.

Several activities in the CCS involve training of health workers at various levels of the health delivery system (national, provincial and district) and community levels. The current ICT infrastructure is not geared towards supporting national level distance learning. WCO will explore possibilities and feasibility, and in consultation with other partners on the ground, to assist in the installation of the necessary technology to support long distance learning for health workers at provincial and district levels.

5.4 Interactions with MOHCC

Currently WCO technical officers are active participants in several programme level technical working groups some of which they co-chair. Adequate mechanisms will be put in place to further strengthen cooperation between WHO and the MOHCC, through regular assessment of the implementation of the CCS and the annual workplans.

5.5 Interactions with other development partners

Successful implementation of the CCS will depend on close collaboration between WHO and other development partners active in the health sector. As part of its global leadership in health, WHO will support activities that are implemented by other partners by availing technical guidance and stimulating and supporting the development of appropriate policies. This has implications for not only the WCO in Zimbabwe, but also AFRO and HQ. Every opportunity should therefore, be seized to not only offer WHO technical support, but also to mobilize resources to enable WCO to play its supportive role to MOHCC and its brokerage and coordination role.

5.6 Support from IST, AFRO and HQ

In implementing this CCS, technical support, guidance and catalytic funding will be expected from IST, AFRO and HQ. Specifically, we are referring to funds needed for programming and technical assistance (TA) to the Ministry of Health — given that there are many other partners who have funds but inadequate TA capacity. If the HRH gaps identified here cannot be immediately filled, the country office will rely on the entire Secretariat to fill the gaps, especially for priority-setting, programming and responsibility. Fortunately, IST/ESA is housed together with the WCO in Harare, therefore the WCO will take full advantage of this proximity, and when necessary solicit additional support from other levels of the Organization to bolster the CCS implementation, including overseeing the mid-term review and the final evaluations.

CHAPTER 6:

EVALUATION OF CCS

This chapter indicates how the CCS will be monitored and evaluated during the course of implementation and at the end of the CCS cycle; and how the lessons learnt and recommendations from the final evaluation will be shared within WHO and with the government, national stakeholder and development partners.

6.1 Purpose of the monitoring and evaluation

The WCO, under the leadership of the Head of WHO Office in the country (HWO), with the support of AFRO and HQ, and in full coordination with the MOHCC, health-related ministries, national stakeholders and other partners, will ensure the monitoring and evaluation of the CCS. The proper monitoring and evaluation of the CCS will be the first step towards assessing WHO's performance in the country.

6.2 Timing

The CCS will be monitored regularly during the course of implementation, evaluated halfway into, and again near the end of the CCS cycle, and as much as possible coinciding with other national review processes in the country (as relevant). This exercise will be linked with the biennial workplan monitoring, assessment of the ZUNDAF (if feasible) and with the WHO country performance assessment that looks at WHO's influence at country-level based on the CCS strategic priorities.

6.3 Type of monitoring and evaluation

The mid-term review will be process-oriented and will be used to assess progress towards the achievement of the strategic priorities and strategic focus areas (i.e. to find out if CCS implementation is going as planned); and to correct the implementation of the CCS as well as revise as necessary the strategic orientations of the CCS. The end term evaluation will focus on determining whether the strategic priorities have been achieved, and whether their achievements have contributed to the National Health Plan. The findings of the evaluation will inform the formulation of the next CCS.

The evaluation process will be led by the HWO, who will designate a CCS

evaluation working group drawn from the country office staff (which can include an external element — such as hiring of an external consultant and involvement of stakeholders especially for the final evaluation).

Regular, on-going monitoring

The main focus of the regular ongoing monitoring is to continuously review whether the CCS priorities and strategic focus areas are reflected in the WCO biennial workplan; and if the core staff of the country office has the appropriate core competencies needed in the country for delivering the WHO technical cooperation required by the CCS priorities and strategic focus areas.

The regular, ongoing monitoring will function as an early warning system to alert the HWO to the need for refocusing the biennial workplans and adjust as feasible the country office staffing patterns, or seek additional technical support through contracting mechanisms or from IST, RO or HQs to meet the technical support requirements.

Mid-term evaluation

The main focus of the mid-term evaluation is to determine the progress of strategic focus areas; whether the expected achievement(s) required to reach the strategic priority is/are being achieved. In short the evaluation procedure will be guided by the strategic priorities highlighted in the CCS (2016–2020) and in particular, the five identified key priority result areas will be analysed.

For example, Health Systems Strengthening for Universal Health Care (UHC) in the context of the SDGs will be evaluated in relation to WCO advocacy for HRH retention, development of new HRH strategy; support to MOHCC in human resource management using the Workload Indicators of Staffing Needs (WISN) study, support to combating of antimicrobial resistance (AMR), strengthening pharmaceutical systems incorporating good governance for medicines principles and building capacity for the institutionalization of NHA using SHA 2011 tool and resource mapping tools.

Regarding reproductive, maternal, newborn, child and adolescents health the evaluation will address trends in RMNCAH development, the amount of relevant strategies, policies, guidelines and tools for maternal, newborn and child survival provided by WHO.

Communicable diseases: HIV/AIDS, TB and malaria, NTDs will be evaluated in terms of how WCO has contributed towards attainment of the '90-90-90 target in HIV programme'; addressing emerging hepatitis in people living with PLHIV and general population; the support given by WCO for an effective surveillance of TB and DR TB, research to generate scientific information to inform policy and strategic decisions and, support to the implementation of MDAs and impact surveys.

Noncommunicable diseases: The extent to which WHO STEPS survey has guided the development of NCD strategy and clinical guidelines for the priority NCDs.

Public health surveillance, disaster preparedness and response will be evaluated in terms of the level of support MOHCC has received in reviewing its IHR (2005) implementation, and coordination of disease outbreak response, including other public health emergencies. Furthermore, the strengthening of capacity in IDSR and rapid response teams will be assessed

The evaluation will therefore be guided by the indicators for the key result areas as indicated in Annex 5. The mid-term evaluation will also identify impediments and potential risks that might demand attention and which might warrant changes in the strategic priorities or areas of focus; and identifies actions required to improve progress during the second half of the CCS cycle.

Final evaluation

The main focus of the final evaluation, which will be a more comprehensive assessment than what is required in the mid-term, will be to measure the achievement of selected national sustainable development goal targets linked in the CCS strategic agenda (see Annex 5); to identify the main achievements and gaps in implementing the CCS strategic agenda in terms of its contents and in relation to the NHS performance areas; to identify the critical success factors and impediments; and to identify the principal lessons to be applied in the next CCS cycle.

The final evaluation report will be prepared, describing the main achievements, gaps and challenges and noting the lessons learnt and the appropriate recommendations. The report will be shared for comments with regional office and HQ.

ANNEXES

Annex 1: Key socioeconomic, health and demographic Indicators for Zimbabwe

Variable/Indicator	Value	Period	Source
Population	14 600 000	2014	World Bank: Human Development Report 2015
Population growth rate	2.8%	2014	op. cit. p. 236
Total fertility rate	4.0 birth	2015	Zimbabwe Demographic and Health Survey (ZDHS) 2015
Crude birth rate (CBR)	32 /1000 pop	2015	ZDHS op. cit p.9
Crude death rate (CDR)	35/1000 pop	2014	http://beta.data.worldbank.org.indicators/data
Life expectancy at birth (years)	61 (females) 56 (males) 59 (both sexes)	2015	NHS 2016
GDP growth	3.8%	2014	http://beta.data.worldbank.org.indicators/data
Inflation	-2.4%	2015	http://beta.data.worldbank.org.indicators/data
Population living on less than $1.25 per day	72%	2014	https:www.wfp.org/countries/Zimbabwe 2014.
Human Development Index Rank out of 188 countries	155	2015	UNDP
% Population under 15	42%	2014	Zimbabwe Multiple Indicator Cluster Survey (MICS) 2015
% Population over 60	5.7%	2014	MICS 2015
Neonatal mortality rate per 1000 live births	29	2015	NHS 2016
Under-five mortality rate per 1000 live births	69	2015	NHS 2016

Annex 1: Key socioeconomic, health and demographic Indicators for Zimbabwe (continued)

Variable/Indicator	Value	Period	Source
Maternal mortality ratio per 100 000 live births	651	2015	Zimbabwe Demographic and Health Survey (2015)
% DTP3 immunization coverage among 1-year-olds	83	2014	Health Development Fund (HDF) Report 2015
% Births attended by skilled health workers	80	2014	Health Development Fund (HDF) Report 2015 p.16
Density of physicians per 1000 population	0.083	2015	Zimbabwe Demographic and Health Survey (2015)
Total expenditure on health as % of GDP	6.4%	2014	World Bank Group: Health Public Expenditure Review, Zimbabwe, 2015
General government expenditure on health as % of total government expenditure	9.7	2016	National Budget: Blue Book 2016
Adult (15+) literacy rate total	84	2007-2015	UNDP: Human Development Report, 2015
Population using improved drinking-water sources (%)	80 (total) 69 (rural) 97 (urban)	2015	Zimbabwe Demographic and Health Survey (2015)
Population using improved sanitation facilities (%)	40 (total) 32 (rural) 52 (urban)	2015	Zimbabwe Demographic and Health Survey (2015)
Poverty head count ratio at national poverty lines (% of population)	72%	2015	Zimbabwe Poverty Atlas 2015

Annex 2: Health facilities profile for Zimbabwe[29]

Facility level	Types of facilities	Number of facilities
Hospitals	Central hospitals	6
	Provincial hospitals	8
	District hospitals	44
	Mission hospitals	62
	Rural hospitals	62
	Private hospitals	32
	Total hospitals	214
Primary health facilities	Clinics	1122
	Polyclinics	15
	Private clinics	69
	Mission clinics	25
	Council/municipal clinics/FHS	96
	Rural health centre	307
	Total Primary health facilities	1634
Total of all facilities		1848

29: *Zimbabwe Service Availability and Readiness Assessment (SARA), 2015*

Rural hospitals are a category of hospitals that were built in the old colonial period to cater for the African population. They are located mostly in rural areas, growth points and small towns. They are small hospitals with a limited number of beds (20–30). They offer simple outpatient services, inpatient care for simple cases. They do not have operating theatres. They are staffed by nurses only. They are no longer being built.

District hospitals are large hospitals that were/are built by Government. They are the first referral levels for primary health care facilities (including rural hospitals). District hospitals generally have a bed capacity of more than 100; however, some can have over 200 beds. They offer operating theatre services. They are staffed by doctors. Every district has a district hospital. In districts where there is no government-built hospital, a mission hospital is designated as the district hospital.

The 1122 clinics are owned by rural district councils. They are thus found in rural areas. Municipal clinics are found in urban areas where the local authority is a "municipal council" as opposed to rural district councils. Both rural council clinics and municipal council clinics offer primary ambulatory health services with a large focus on maternal and child health services. Please note that large cities like Harare and Bulawayo have polyclinics that are large and cater for large numbers of people. They offer maternity related in-patient services.

Annex 3: Key result areas and goals of the Zimbabwe NHS 2016– 2020[30]

Key Result Area	Goal
Communicable diseases	1. To reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020 and malaria deaths to near zero by 2020
	2. Timely detection and control of epidemic prone diseases
	3. To reduce morbidity due to schistosomiasis and soil transmitted helminths and other NTDs by year 2020.
	4. To prevent HIV new infections and to reduce deaths due to HIV by 50%
	5. To reduce the mortality, morbidity and transmission of tuberculosis
NCDs	6. Reduce the incidence of selected noncommunicable disease (NCDs)
	7. Improve mental health status of the population
	8. Reduce disability and dependence
	9. Improve the quality of life of older persons
Reproductive, maternal, newborn, child and adolescent health	10 Reduce maternal mortality ratio from 614 to 300 by 2020
	11. To reduce neonatal mortality rate from 29 to 20 deaths per 1000 live births
	12. To reduce the under-five mortality rate from 75 to 50 deaths per 1000 live births
	13. To reduce mortality and morbidity due to malnutrition
Public health surveillance & disaster preparedness and response	14. To contribute to the creation of a safe and healthy environment through strengthening environmental health services in particular promotion of safe water, appropriate and adequate sanitation food and personal hygiene
Primary care	15. To reduce morbidity through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level.
Hospital services	16. To ensure access and provision of complementary package of hospital services including emergency and ambulatory curative services
	17. To ensure access and provision of quality tertiary specialist curative services
Policy planning and coordination	18. To improve health outcomes through facilitation and coordination of an effective and efficient health delivery system
Multisectoral partnership	19. To strengthen multisectoral collaboration with local and international partners
Research and development	20. Conduct scientific research that promotes evidenced based decision-making and policy development.

30. Government of Zimbabwe, National Health Strategy 2016-2020

Annex 4: Stakeholder analysis of health and health-related SDGs support areas

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
Global Fund	Funding	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 3c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	HIV, AIDS, TB , malaria, health systems strengthening (HRH retention)	HIV US$ 469m; TB US$ 39m; Malaria US$ 60m (2014-2016)
GAVI	Funding	3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births. 3b: Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	Vaccines, health systems strengthening	US$ 6.8m (2013-2017)

Annex 4: Stakeholder analysis of health and health-related SDGs support areas (continued)

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
BMGF	Funding	3.6; 3.7 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	NCDs, NTD	US$ 274 848 (2015)
DFID	Funding	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births	Child health, nutrition, maternal health; HIV, AIDS, TB, malaria; WASH	US$ 7 081 063 (2015)
USG: (USAID, JSI, CDC,PMI PEPFAR, MCHIP)	Funding and technical support	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births	Reproductive, Maternal and child health, medicines; HIV, AIDS, TB, Malaria; STIs	US$140 418 766 (2015)
EGPAF	Funding and technical support	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases	HIV, AIDS, eMTCT	US$8 147 651 (2015)

Annex 4: Stakeholder analysis of health and health-related SDGs support areas (continued)

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
CHAI	Funding and technical support	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	Health systems (financing); HIV/ AIDS, TB, Malaria,	$1 922 893 (2015)
DFATD (CIDA)	Funding	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases	Maternal and child health; HIV Prevention (eMTCT); Nutrition	TBD $580 000 (2016 eMTCT)
SIDA	Funding and technical support	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Rights (RMNCAH & Rights)	$3 020 052 (2015)
UNDP	Funding and technical support	1, 2, 3, 5, 16, 3a. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	Maternal, child, adolescent health; HIV, AIDS,	TBD

Annex 4: Stakeholder analysis of health and health-related SDGs support areas (continued)

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
UNFPA	Funding and technical support	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.7 By 2030, ensure universal access to sexual and reproductive health -care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes 5.1;5.2; 5.3;5.6;	Reproductive, Maternal, new born, child, adolescent health; Gender	TBD
UNICEF	Funding and technical support	1 End poverty in all its forms everywhere 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births 4, 5, 6	Maternal, child health, nutrition, WASH, Vaccines; HIV/AIDS; Health Systems, Education; Children's rights	US$1 535 791 (2015)
World Bank	Funding and technical support	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births 3.2 By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Health Finance and Health systems strengthening	US$ 8 million (2016)

Annex 4: Stakeholder analysis of health and health-related SDGs support areas (continued)

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
World Bank		3c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States		
UNAIDS	Funding and technical support	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	Multisectorial coordination of HIV response; HIV, AIDS	TBD
IUTLD	Technical and Funding	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.4 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being	TB; TB challenges, STOP TB, Global Drug Facility,	TBD
ILO	Funding and technical support	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 8.5 By 2030 achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value. 8.8 Protect labour rights and promote safe and secure working environments of all workers, including migrant workers, particularly women migrants, and those in precarious employment	Strengthening partnership in HIV in the world of work; Health systems (HRH)	TBD
UNWOMEN	Funding and technical support	5 Achieve gender equality and empower all women and girls	Gender rights	TBD

Annex 4: Stakeholder analysis of health and health-related SDGs support areas (continued)

Name of Agency	Roles fulfilled by development partner	Health and health related SDG targets	Major programmatic area of support within Country	Net Contribution (US$)
UNESCO	Funding and technical support	4. Ensure inclusive and equitable quality education and promote life-long learning opportunities for all	Education	TBD
FAO	Funding and technical Support	2.1 by 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round 2.2 by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	Food security and Nutrition	TBD
WFP	Funding and technical support	2.1 by 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round 2.2 by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	Food security and Nutrition	TBD

TBD = To be determined: Some contributions by identified stakeholders during this CCS life-span is difficult because projections can only indicate aspiration

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes*
Strategic Priority 1 Achieving and sustaining UHC through a revitalized PHC approach and sustainable service delivery through strengthening of health systems	Strategic Focus Area 1.1 Strengthen human resources for health to ensure appropriate recruitment into service to match workload, training that responds to contemporary needs, equitable deployment and appropriate retention schemes (including remuneration, motivation and improved work environment).	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Reduce vacancy rate to 10% by 2020 Increase the coverage of specialists in tertiary (provincial) hospitals to 100% by 2020.	3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least -developed countries and small island developing States	Key public sector institutions mobilize, manage and account for resources effectively for quality service delivery.
	Strategic Focus Area 1.2 Ensure availability of affordable quality assured essential medicines and appropriate health technologies effective procurement and supply systems backed by strong/ improved regulatory mechanisms.	Improved access to, and rational use of safe, efficacious and quality medicines and health technologies	% availability of essential medicines (42-80%)	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.	Key institutions provide quality and equitable basic social services Key public sector institutions mobilize, manage and account for resources effectively for quality service delivery
	Strategic Focus Area 1.3 Strengthen health information system to ensure availability of high-quality, timely and reliable data disaggregated by income, gender, age, rural-urban disparity; and revitalize PHC approach in support of priority programmes to deliver quality health-care services.	All countries have properly functioning civil registration and vital statistics systems	% health research informed by the national health research priorities	17.18 By 2020, enhance capacity-building support to developing countries, including for least-developed countries and small island developing States, to increase significantly the availability of high-	Government and its partners generate and utilize data for development

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
				-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability.	Government and its partners generate and utilize data for development
	Strategic Focus Area 1.4 Support MOHCC to make a case for appropriate health-care financing- through regular NHA studies, resource mapping exercise, cost effectiveness analysis of health-care programmes, finalization of health financing policy, advocating implementation of a national health insurance, and supporting the budget process for achieving universal health coverage.	Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Periodic publication of NHA and Resource Mapping	3. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	Key public sector institutions mobilize, manage and account for resources effectively for effectively for quality service delivery
Strategic Priority 2: Accelerating achievement of the unfinished MDGs relating to reduction of maternal, newborn, child and adolescent mortality; and strengthening sexual and reproductive health;	Strategic Focus Area 2.1: Strengthen MoHCC capacity to implement quality, affordable interventions to contribute to the reduction of maternal mortality in the country	Increased access to interventions for improving health of women, neonates, children and adolescents	Reduce maternal mortality ratio from 614 to 300 by 2020	3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Outcome 6.2: Key institutions provide quality and equitable basic social services
	Strategic Focus Area 2.2: Strengthen the MoHCC capacity to implement quality affordable interventions to end preventable deaths of neonates and children under five years of age	Increased access to interventions for improving health of women, neonates, children and adolescents	To reduce Under-five mortality rate from 75 to 50 deaths per 1000 live births	3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1000 live births and under-five mortality to at least 25 per 1000 live births	Outcome 6.2: Key institutions provide quality and equitable basic social services

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
	Strategic Focus Area 2.3. Support MOHCC to ensure universal access to sexual and reproductive health-care services, and the integration of reproductive health and gender into national strategies and programmes.	Increased access to interventions for improving health of women, neonates, children and adolescents	Reduce maternal mortality ratio from 614 to 300 by 2020	3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	Outcome 6.1:Vulnerable populations have increased access and utilization of quality basic social services
	Strategic Focus Area 2.4. Support MoHCC efforts to end all forms of malnutrition, including stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.	Reduced nutritional risk factors	Reduce mortality and morbidity due to malnutrition by 50%	2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	Outcome 6.1: Vulnerable populations have increased access and utilization of quality basic social services
Strategic Priority 3 Further reducing the burden of AIDS, tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases	Strategic Focus Area 3.1: Attain the 90-90-90 targets by 2020, through policy dialogue, technical support, adaptation and implementation of most up-to-date norms and standards in preventing and treating paediatric and adult HIV infection, integrating HIV and other health programmes, prevention of	Increased access to key interventions for people living with HIV	Reduce HIV deaths by 50%	3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	All adults and children have increased HIV knowledge, use effective HIV prevention services, and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic 90% of all people living with HIV know their HIV status, at least 90% of HIV positive people receive sustained

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
	emergence of drug resistance, strengthening strategic information and research and reducing inequities				antiretroviral therapy, 90% of those on treatment have durable viral load suppression Key institutions from Government and civil society effectively and efficiently manage a multisectoral AIDS response
	Strategic Focus Area 3.2: By 2025 to have reduced mortality of all forms of TB by 80% from 132/100000 in 2012 to 26/100 000 and to have reduced the incidence of all forms of TB by 80% from 562/100000 in 2012 to 112/100 000 through scale up care and control, with focus on reaching vulnerable populations, and strengthening surveillance, as well as updating policy guidance and technical guidelines on HIV-related tuberculosis, delivery of care for patients with MDR TB, introduction of new tuberculosis diagnostic and MDR TB treatment approaches, tuberculosis screening in risk groups and integrated community-based management of tuberculosis	Increased number of successfully treated tuberculosis patients	Reduce mortality due to TB from 10% to less than 5%	3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	
	Strategic Focus Area 3.3: Reduce malaria incidence and support efforts towards malaria elimination through updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response as well as implantation of malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy monitoring and surveillance through capacity strengthening	Increased access to first-line antimalarial treatment for confirmed malaria cases	Reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020	3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
	Strategic Focus Area 3.4: Reduce morbidity due to schistosomiasis and soil transmitted helminthiases and other NTDs implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines technical support	Increased and sustained access to essential medicines for neglected tropical diseases	Prevalence of STH and SCH from 22.7% to 10% in 2020	3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	
	Strategic Focus Area 3.5: Reduce morbidity and mortality due to vaccine preventable diseases through implementation and monitoring of the global vaccine action plan as part of the Decade of Vaccines Collaboration strengthened with emphasis on reaching the unvaccinated and under-vaccinated populations; intensified implementation and monitoring of measles and rubella elimination, and hepatitis B control strategies	Increased vaccination coverage for hard-to -reach populations and communities No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	To reduce the under-five mortality rate from 75 to 50 deaths per 1000 live births	3.2: By 2030, end preventable deaths of neonates and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births. 3.b Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	Vulnerable populations have increased access to and utilization of quality basic social services

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes
Strategic Priority 4: Strengthening and re-orienting health and health-related systems to address the prevention and control of NCDs, including disabilities, injuries and mental health disorders, and the underlying social determinants through people-centred primary health care and UHC	Strategic Focus Area 4.1: Improved access to prevention and control of noncommunicable diseases in line with the global action plan on NCDs (2013–2020) through policy dialogue and implementation of sound intersectoral strategies for the prevention of NCD risk factors	Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors	NCDs burden reduced by 5%	3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	
	Strategic Focus Area 4.2: Mental health status of the population improved through development and implementation of national policies and plans in line with the 2013–2020 global mental health action plan; mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services; expansion and strengthening of country strategies, systems and interventions for disorders due to alcohol and substance use	Increased access to services for mental health and substance use disorders	90% increase in number of diagnosed mentally ill to the expected mentally ill patients	3.4: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
	Strategic Focus Area 4.3: Risk factors for violence and injuries reduced through development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020); development and implementation of programmes and plans to prevent child injuries; development and implementation of policies and programmes to address violence against women, youth and children	Reduced risk factors for violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth	Reduce disability and dependence by 50 %	3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation 16.1: Significantly reduce all forms of violence and related death rates everywhere 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children	
	Strategic Focus Area 4.4: Disability and dependence reduced through strengthening the provision of services to reduce disability due to visual impairment and hearing loss through more effective policies and integrated services including community-based rehabilitation	Increased access to services for people with disabilities	Reduce disability and dependence by 50%	3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 4.a: Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all	

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes
Strategic priority 5: Strengthening preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters in order to improve health security	Strategic Focus Area 5.1: Improved alert and response capacities through strengthened coordination mechanisms; capacity building in IDSR, IHR(2005) and the development and maintenance of IHR core capacities including Port Health capacities	All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	
	Strategic Focus Area 5.2: Enhanced capacity for early detection and prompt response to epidemic and pandemic prone diseases through development and implementation of operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases; setting up systems support for expert guidance with in connection with disease control, prevention, treatment, surveillance, risk assessment and risk communications	Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes *
	Strategic Focus Area 5.3: capacity for emergency risk and crisis management improved through accelerated response to threats and emergencies with public health consequences and implementation of the WHO Emergency Response Framework in acute emergencies with public health consequences; maintenance of Inter-Agency Coordination Committee on Health (IACCH), strengthened national capacities for all-hazard emergency and disaster risk management for health, development and implementation of health sector strategy and plan including reporting by an in-country network of qualified and trained WHO emergency staff	Countries have the capacity to manage public health risks associated with emergencies All countries adequately respond to threats and emergencies with public health consequences	100% of districts with functional coordination mechanism 100% of outbreaks detected within 48 hours and controlled within 2 weeks	3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	
	Strategic Focus Area 5.4: Prevent and mitigate risks to food safety through development and implementation of food safety standards, guidelines and recommendations; multisectoral collaboration to reduce foodborne public health risks, including those arising at the animal–human interface; and improved national capacity to establish and maintain risk-based regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards	All countries are adequately prepared to prevent and mitigate risks to food safety	100% of districts with functional coordination mechanism	3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking-water to all	Communities are equipped to cope with climate change and build resilience for household food and nutrition security.

Annex 5: Summary of WHO support to Zimbabwe Health sector during the period 2016–2020 (continued)

Strategic Priorities	Strategic Focus Area	GPW Outcome	National (NHS) Target	SDG Targets	ZUNDAF Outcomes*
	Strategic Focus Area 5.5: Capacity to respond to threats and emergencies with public health consequences improved through implementation of the WHO's Emergency Response Framework in acute emergencies with public health consequences	All countries adequately respond to threats and emergencies with public health consequences	100% of outbreaks detected within 48 hours and controlled within 2 weeks 100% of districts with functional coordination mechanism	3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	

* ZUNDAF outcomes were not specified for some CCS Focus Areas