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REGIONAL OFFICE FOR Africa

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ZIMBABWE

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ZIMBABWE

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

ACRONYMS

AC	:	Assessed Contributions
ACT	:	artemisinin-based combination therapy
AFP	:	acute flaccid paralysis
AFRO	:	WHO Regional Office for Africa
AIDS	:	acquired immunodeficiency syndrome
ANC	:	antenatal care
ARI	:	acute respiratory infection
ART	:	antiretroviral therapy
ARVs	:	antiretrovirals
CAP	:	Consolidated Appeal Process
CBR	:	crude birth rate
CCM	:	Country Coordinating Mechanism
CCS	:	Country Cooperation Strategy
CDR	:	crude death rate
CEHI	:	Children's Environmental Health Indicat ors
CERF	:	Central Emergency Response Fund
CFI	:	Country Focus Initiative
CFR	:	case fatality rate
CHD	:	Child Health Days
CIDA	:	Canadian International Development Agency
CRS	:	Catholic Relief Services
CSO	:	Central Statistical Office
DDT	:	dichlorodiphenyltrichloroethane
DFID	:	Department for International Development
DOTS	:	directly-observed treatment short-course
DPT	:	diphtheria pertussis tetanus
EBF	:	Extra-Budgetary Funds
ECHO	:	European Commission Humanitarian Office
EDLIZ	:	Essential Drugs List for Zimbabwe
EGPAF	:	Elizabeth Glaser Pediatric AIDS Foundation
EPI	:	Expanded Programme on Immunization
ESAP	:	Economic Structural Adjustment Programme
ESP	:	Expanded Support Programme
EU	:	European Union
FPL	:	Food Poverty Line

GAVI	:	Global Alliance for Vaccines and Immunization
GDP	:	Gross Domestic Product
HDPCG	:	Health Development Partners Coordination Group
HIV	:	human immunodeficiency virus
HMIS	:	Health Management Information System
HMN	:	Health Metrics Network
HQ	:	Headquarters
HRH	:	human resources for health
IDSR	:	Integrated Disease Surveillance and Response
IMAI	:	Integrated Management of Adolescent and Adult Illnesses
IMCI	:	Integrated Management of Childhood Illness
IPT	:	intermittent preventive treatment
IRS	:	indoor residual spraying
IST/	:	Intercountry Support Team for Eastern and Southern Africa
ITNs	:	insecticide-treated nets
IYCF & C	:	infant and young child feeding and counselling
JICA	:	Japanese International Cooperation Agency
JRF	:	Joint Reporting Form – WHO/UNICEF
MCAZ	:	Medicines Control Authority of Zimbabwe
MDGs	:	Millennium Development Goals
MDR/TB	:	multi-drug resistant tuberculosis
MDTF	:	Multi-donor Trust Fund (World Bank coordination mechanism)
MERP	:	Millennium Economic Recovery Programme
MOHCW	:	Ministry of Health and Child Welfare
MPSLSW	:	Ministry of Public Service, Labor and Social Welfare
MTSP	:	Medium-Term Strategic Plan
NatPharm	:	National Pharmaceutical Company
NCDs	:	noncommunicable diseases
NEPAD	:	New Partnership for Africa's Development
NERP	:	National Economic Recovery Programme
NGO	:	nongovernmental organization
NHA	:	national health accounts
NHS	:	national health strategy
OPD	:	Outpatient Department
ORS	:	oral rehydration salts
OVC	:	orphans and vulnerable children
PASS	:	Poverty Assessment Study Survey
PCN	:	Primary Care Nurse
PEP	:	Post Exposure Prophylaxis

PHAST	:	Participatory Hygiene and Sanitation Transformation
PITC	:	Provider Initiated Testing and Counselling
PMTCT	:	prevention of mother-to-child transmission
PRA	:	Principal Recipient Agent
PSI	:	Population Services International
RB	:	Regular Budget
RBZ	:	Reserve Bank of Zimbabwe
RDTs	:	rapid diagnostic tests
RED	:	Reach Every District
SIDA	:	Swedish International Development Agency
SP	:	sulphadoxine-pyrimethamine
STI	:	sexually-transmitted infection
TB	:	tuberculosis
UN	:	United Nations
UNICEF	:	United Nations Children's Fund
UNFPA	:	United Nations Population Fund
UNV	:	United Nations Volunteers
USAID	:	United States Agency for International Development
VC	:	Voluntary Contributions
VCT	:	voluntary counselling and testing
WCO	:	WHO country office
WHO	:	World Health Organization
WHR	:	World Health Report
ZDHS	:	Zimbabwe Demographic and Health Survey
ZEDS	:	Zimbabwe Economic Development Strategy
ZIMPREST	:	Zimbabwe Programme for Economic and Social Transformation
ZIM VAC	:	Zimbabwe Vulnerability Assessment Committee
ZNFPC	:	Zimbabwe National Family Planning Council
ZUNDAF	:	Zimbabwe United Nations Development Assistance Framework

EXECUTIVE SUMMARY

This second generation Country Cooperation Strategy defines WHO's role at country level and the broad framework for collaboration between the Organization and the Republic of Zimbabwe for the period 2008-2013.

The macroeconomic environment in Zimbabwe has shown consistent negative growth over the last ten years with levels of poverty worsening steadily. The increase in poverty can be attributed to the decline in economic performance, low productivity in agriculture due to recurrent droughts and lack of inputs, which have resulted in high unemployment and underemployment.

This strategy is guided by: the Millennium Development Goals (MDGs), the WHO global priorities, the WHO Medium-Term Strategic Plan (MTSP), the WHO African Region orientations, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF 2007-2011), and other relevant regional and subregional initiatives. It takes into consideration the importance of national development strategies as defined in the Zimbabwe Economic Development Strategy (ZEDS 2009-2013) and responds to the health needs as defined by the National Health Strategy (NHS 2008-2013).

The definition of the strategic agenda for the period 2008-2013 was driven by an in-depth analysis of the implementation of the first generation of the CCS 2004-2007, taking into consideration the unfinished agenda, as well as the recognition of the existence of new issues and challenges.

The CCS, by taking into consideration WHO's mission and functions and its comparative Advantage, provides an opportunity to reiterate the Organization's commitment to continue supporting the Ministry of Health and Child Welfare (MoHCW) and the partners in addressing the major health and developmental challenges. The priorities agreed for WHO country cooperation constitute part of the strategic agenda with the following components:

(i) Improving health systems performance;

(ii) Reducing the burden of the major communicable and noncommunicable diseases;

(iii) Enhancing health promotion to reduce the major risk factors, including the promotion of healthy environments; and

(iv) 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.

The significant macroeconomic challenges, compounded by the critical human resources for health shortage, are impacting negatively the implementation of all programmes. It is expected that the reinforcement of the different coordination mechanisms will bring about more synergy and improvement of the health system performance. The implementation of the recommendations of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa will result in accelerated actions towards the achievement of the health-related Millennium Development Goals.

The timeframe of the second generation Country Cooperation Strategy is aligned with the Medium-Term Strategic Plan (MTSP). Its operationalization will therefore be done through three consecutive biennial Plans of Action: 2008-2009, 2010-2011 and 2012-2013. To achieve the strategic agenda, WHO will strengthen its country office performance and ensure that its support to the country is of good quality, strategic, well targeted and coordinated. Issues like leadership, staffing, continuous learning, good management and other administrative concerns will be addressed. Concerted approach among t he three levels of the Organization will be reinforced.

PREFACE

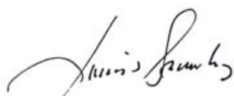
The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.



Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) is the expression of WHO's corporate strategy at country level and it takes into consideration the organization's policies, guiding principles, the global and regional directions and balances these with the needs of the country.

The first Country Cooperation Strategy document was developed to guide the Organization's cooperation with the Government of Zimbabwe during the period 2004-2007. This second generation of the CCS constitutes the business plan for the period 2008-2013. It takes into consideration the analysis made on the implementation of the first CCS and the need to respond to the current issues and challenges facing the country.

This strategy is guide d by: the Millennium Development Goals (MDGs), the WHO global priorities, the WHO Medium-Term Strategic Plan (MTSP), the WHO African Region orientations, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF 2007-2011), and other relevant regional and subregional initiatives. It takes into consideration the importance of national development strategies as defined in the Zimbabwe Economic Development Strategy (ZEDS 2009-2013) and responds to the health needs as defined by the National Health Strategy (NHS 2008 - 2013). The timeframe of the second generation of the Country Cooperation Strategy is aligned with the Medium-Term Strategic Plan (MTSP). Its operationalization will therefore be done through three consecutive biennial Plans of Action: 2008-2009, 2010-2011 and 2012-2013.

In formulating this cooperation strategy, the focus was on WHO's mission and functions as well as its role as broker and policy adviser. The CCS will serve as a reference document for the work of the entire Organization in Zimbabwe. The development process and the implementation of the CCS encourage building partnerships at country level by ensuring complementarity and synergy amongst different stakeholders in health and other development partners.

In view of the foregoing, WHO will concentrate its efforts on the following broad strategic agenda:

(i) Improving health systems performance;

(ii) Reducing the burden of the major communicable and noncommunicable diseases;

(iii) Enhancing health promotion to reduce the major risk factors, including the promotion of healthy environments; and

(iv) 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 capacity of the health sector.

The Country Cooperation Strategy for Zimbabwe for the period 2008-2013 is a result of intensive consultation involving the three levels of WHO, the Ministry of Health and Child Welfare, other government ministries, the UN agencies, multilateral and bilateral organizations, nongovernmental organizations, civil society, private sector, training and research institutions and other relevant stakeholders.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 DEMOGRAPHY AND SOCIAL ENVIRONMENT

The Zimbabwe population was estimated at 12.2 in the year 2007, with forty-one percent of the population below 15 years of age, 55% between the ages of 15-64 and only 4% in the age group 65years and above.

The macroeconomic environment in Zimbabwe has shown consistent negative growth over the last ten years with levels of poverty worsening steadily. The increase in poverty can be attributed to the decline in economic performance, low productivity in agriculture due to recurrent droughts and lack of inputs, which have resulted in high unemployment and underemployment. This has been compounded by the devastating impact of HIV and AIDS and the general increase in the cost of living.[1]

Several policies have been put in place to redress the economic decline: the Economic Structural Adjustment Programme, the Zimbabwe Programme for Economic and Social Transformation, the Millennium Economic Recovery Programme, the National Economic Revival Programme, the Macroeconomic Policy Framework 2005-2006 and, recently, the Government of Zimbabwe has embarked on the development of the Zimbabwe Economic Development Strategy, the ZEDS for the period 2009-2013. The main socioeconomic and demographic indicators are summarized in Table 1.

Table 1 - Key Socioeconomic and Demographic Information

Variable/Indicator	Value	Period	Source
Population	12.2million	2007	Population projections 1992-2007, CSO
Population Growth rate	1.1%	1992-2002	Census 2002
Total fertility rate	3.8 birth	2005-6	ZDHS 2005-6
Crude Birth Rate (CBR)	30/1000 pop	2002	Census 2002
Crude Death Rate (CDR)	15/1000 pop	2002	Census 2002
Life expectancy at birth	43 yrs	2008	World Health Statistics
Literacy rate	97%	2003	
GDP	-4.6%	2007	ZEDS
Inflation	›100 000%	Dec 2007	CSO
Food poverty line	58%	2003	Zimbabwe 2003 PASS
Total Consumption Line	72%	2003	Zimbabwe 2003 PASS

[1] Zimbabwe Millennium Development Goals 2005 Progress Report.

Despite all the policies, the country has continued to experience macroeconomic instability, characterized by hyperinflation, shortages of essential commodities, high unemployment rate,and a contraction of basic social services including health, education and housing.

2.2 REVIEW OF THE FIRST GENERATION CCS AND ITS CHALLENGES

The Zimbabwe first generation CCS covered the period 2004-2007 and was guided by the WHO General Programme of Work (2002-2005), WHO AFRO Strategic Framework (2002-2005), the Health-for All Policy for the 21st Century in the African Region (Agenda 2020). It was in line with the national priorities as defined by the Zimbabwe Vision 2020 and the National Health Strategy Working for Quality and Equity in Health covering the period 1997-2007. In selecting the strategic agenda, importance was given to alignment with the MDGs and the Zimbabwe United Nations Development Assistance Framework (ZUNDAF). The three strategic components identified as priorities for the work of WHO in Zimbabwe were:

(a) Rebuilding and sustaining the national health capacity;

(b) Reducing the HIV/AIDS explosion and responding to it as an emergency with humanitarian and long-term consequences;

(c) Reducing the disease burden, not only for HIV/AIDS but for other emerging and re-emerging priority diseases.

2.2.1 Rebuilding and Sustaining National Health Capacity

During the life of the first generation CCS, health service performance in Zimbabwe continued to decline. Some of the major reasons for this decline in performance included staff shortages; insufficient resources to procure essential medicines and medical supplies; decreased donor support; introduction of user fees at district level and above; poor maintenance of infrastructures and equipment; and an increased disease burden on an already weakened health system. Rebuilding and sustaining national health capacity was therefore identified as a priority for WHO support.

2.2.1.1 Advocacy and Resource Mobilization

While the proportion of government funding for health continued to increase in absolute figures, due to the hyperinflationary environment, local funding for health declined significantly in real terms. A national accounts study which indicated a significant increase in household out-of-pocket expenditure on health was undertaken; however the results are yet to be released. Efforts to ensure adequate funding for priority health programmes were intensified during this period, with proposals successfully submitted to the Global Fund, GAVI, HMN, CAP and some bilateral partners.

2.2.1.2 Health Policies and Systems

Strengthening district health systems, the cornerstone of the Zimbabwe health delivery system, continued to take centre stage, with an emphasis on planning, implementation and monitoring of district health performance. Revision of the 1997-2007 National Health Strategy and the development of the successor health strategy, 2008-2013 were critical to ensure access to health care by all people of Zimbabwe. Many other policies were developed or reviewed including the ART policy, Traditional medicine policy, EPI policy and ITN policy, among others. As government capacity for providing services diminished due to the harsh economic environment, the role of partners increased. Coordination of these partners however remained a challenge.

2. ealth Management Information System

The national health information system, once a model in the Region, continued to face many challenges. A detailed evaluation of the system in 2005[2] revealed many structural and managerial challenges that needed to be addressed and will continue to be tackled in the second Generation CCS. Training in Integrated Disease Surveillance and Response (IDSR) continued to be strengthened, with the majority of provinces having conducted training of trainers (TOTs) and having initiated district-level training. Subdistrict training will remain a priority.

2.2.1.4 Human Resources for Health Development

Shortage of qualified and experienced health personnel, high staff attrition and low morale with resultant frequent strikes continued to plague the health system. Work on development of a comprehensive human resources for health (HRH) policy has be gun in earnest but is yet to be completed. Local training institutions have not been fully functional as tutors/lecturers in all categories of health staff are the group most affected by staff attrition.

Fellowships for priority areas as identified by the Ministry continued, however the rate of return of the fellows after training remained low. As part of the health sector recovery plan, training of generic health workers (primary care nurses, pharmacy and X-ray technicians and village health workers) has been encouraged and saw increased support from various partners.

2.2.1.5 Health System Strengthening – the unfinished Agenda

The health system continues to suffer from a critical shortage of human resources for health. Vacancy rates for the major health professions continue to increase. The underlying causes of the crisis are varied and include the brain drain due to the harsh socioeconomic environment, loss from the public to the private sector, movement from the health to other sectors, mal-distribution, and the effects of the HIV/AIDS pandemic. The policy and strategic plan for human resources for health need to be finalized and implemented. The local training institutions need to be strengthened. Generation, analysis and use of quality and timely information for evidenced-based planning and decision-making is limited. Strengthening the national health information system and generation of information from locally-conducted research will be critical in providing an evidence base. The National Health Strategy expired in 2007. Development, implementation and dissemination of the new national policy document will be the focus of the first biennium of this CCS.

Following the principles of PHC reiterated in the Ouagadougou Declaration, the district remains the centre of the health system and therefore district health system strengthening will be critical to improving service delivery. Other important areas of focus will be :

(i) Continued advocacy for increased resource mobilization;

(ii) Dissemination and appropriate use of results of the national health accounts study;

(iii) Regular monitoring of implementation of the National Health Strategy;

(iv) Strengthen capacity to estimate, procure and monitor distribution of essential drugs, vaccines and other medical commodities;

(v) Strengthening government's role in partner coordination in the health sector.

2 Zimbabwe National Health Information and Surveillance System–*An Assessment and Recommendations May 2005, MoHCW/UNICEF 2005.*

2.2.2 Reducing the HIV/AIDS explosion

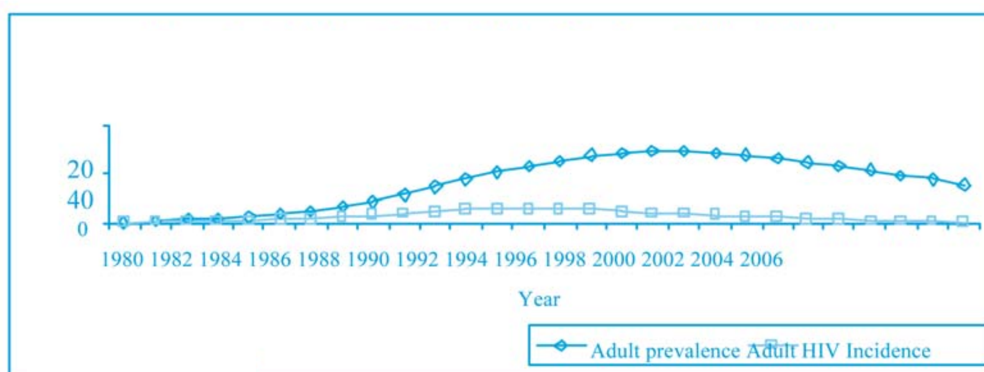
2.2.2.1 Trends in HIV and AIDS Prevalence and Incidence

With a national prevalence of 24.6% in 2003 and widespread high prevalence in both urban and rural areas, HIV/AIDS was recognized as an emergency and a major threat to national development.

During the life of the first CCS (2004-2007), Zimbabwe witnessed a significant drop in the prevalence of HIV from 24.6% to 15. 6% in adults aged 15 to 49 years (see figure below). This prevalence is still unacceptably high and the response to the epidemic must be intensified to sustain the decline and to address the impact of increasing AIDS-related morbidity and mortality, including orphans and vulnerable children (OVC), in all economic and population sectors.

The decline in HIV prevalence has been attributed to behaviour change, including delayed sexual debut, decreasing the number of sexual partners, and increased condom use. The country has also experienced an increase in mortality due to AIDS over the same period. The HIV incidence has also declined over the years and was estimated to be 0.4% in 2007.[3]

Figure 1: Trends in the estimated adult (age 15 to 49 years) HIV and AIDS prevalence and incidence, Zimbabwe, 1980-2007



Source: MoHCW, 2007

2.2.2.2 Prevention and Management of HIV and AIDS

HIV prevention remains an important mainstay of the HIV programme. Based on review of the HIV and AIDS programme in 2005 a National Behaviour Change Communication Strategy focusing on the drivers of the epidemic was developed and is being rolled out. In 2007, the MoHCW developed the Health Sector HIV Prevention Strategic Framework, 2007-2010 to strengthen the health sector contribution to HIV prevention.

Zimbabwe made considerable progress in scaling up PMTCT services to all districts with a total of 1560 health facilities able to deliver PMTCT services[4]. More than 94 % of pregnant women were attended to by a trained health worker at least once during pregnancy[5] and of the

3 MOHCW HIV and AIDS Estimates 2007.
4 MOHCW Annual report 2007.

HIV- positive women seen at the health facilities, over 68% received nevirapine for PMTCT.[6] The programme is in the process of introducing the more efficacious regimen (AZT/3TC and Nevirapine) to further reduce chances of transmission of the virus from mother to baby.

The country developed policy, strategic and technical guidelines to support scaling up of HIV testing and counselling services for both adults and children, through Provider Initiated Testing & Counselling (PITC) which complements the Client Initiated Testing and Counselling (VCT). The number of health facilities providing integrated PITC services increased to 710 by end of 2007 (National HTC Strategic Plan 2008-2010). This contributed to a significant increase in the number of adults accessing testing and counselling services. The proportion of adults who know their HIV status was about 20% by end of 2007.

The OI/ART programme was established in the public sector in 2004 and coverage with treatment services has significantly increased to over 90% of the districts. The number of people living with HIV (PLHIV) in need of treatment who access it increased from about 5 000 in 2004 to over 116 000 by mid-2008.

Sixty percent (60%) of those accessing ART are females and about over 10 000 are children. Initiation of ART services is down to the district level with decentralization to primary health centres for follow up of patients on ART. To improve quality of services provided and to monitor and reduce emergence of resistance to ARV medicines, the ART programme has established an HIV drug resistance surveillance system[7].

2.2.2.3 Reducing the HIV/AIDS explosion - the unfinished Agenda

Though a lot has been done, even more remains to be addressed. This includes:

(i) increasing coverage of counselling and testing services to reach 80% of the population by 2010;

(ii) improving the quality of PMTCT services and mobilizing communities to support and use the services, emphasizing population-based targets and aiming at reducing the MTCT of the virus to single digits; establishing systems for early infant diagnosis and ensuring early infant treatment ;

(iii) scaling up collaborative HIV/TB interventions; strengthening coordination of CHBC services and establishing sustainable linkages with the health system; establishment of a strong system for management of major HIV/AIDS complications, improving quality of care and treatment services supported by a robust HIVDR surveillance systems;

(iv) establishing policies that support scale up and decentralization of services such as task shifting;

(v) strengthening local production of HIV medicines and other HIV/AIDS drugs; and

vi) establishing programme-based.

(vii) result-oriented operational research.

The major challenges that the programme will face in addressing the above unfinished agenda include the hyperinflationary environment and unstable human resource base, arising from high staff attrition.

5 ZDHS 2005-2006, Chapter 9.
6 MoHCW Annual report 2007.
7 MoHCW OI/ART Review Report 2008.

2.2.3 Reducing the Disease Burden

Under the framework of the first generation CCS, in seeking to reduce the priority disease burden, focus was given to both communicable and noncommunicable diseases, integrated disease surveillance and response, reproductive, child and adolescent health as well as environmental health issues.

2.2.3.1 Communicable Diseases:

Continued to be a major public health problem in Zimbabwe. This was further compounded by the challenges imposed by the threat of emerging and re-emerging infections. Cholera, which used to occur in 10-year cycles, has been occurring annually since 1998. Cholera control was strengthened by way of training in case management, setting up management of cholera camps, health education and surveillance.

A national human and avian influenza preparedness plan, SOPs and IEC materials were developed. Personal Protective Equipment (PPE) were also procured. Vaccine-preventable diseases, in particular polio, neonatal tetanus and measles, have been drastically reduced. However, their surveillance towards elimination (measles and neonatal tetanus) and eradication (polio) should be strengthened. Zimbabwe's disease surveillance system and routine immunization coverage activities are adversely affected by inadequate resources.

Tuberculosis continues to be one of the leading causes of morbidity and mortality in the population. In 2006, the TB notification rate was 434/100 000 population[8]. The case detection rate for sputum positive cases was 42% and treatment completion rate 66% against WHO standards of 70% and 85% respectively. It is estimated that between 70% and 80% of people with TB are co-infected with HIV and this therefore makes the implementation of collaborative TB/HIV activities crucial. The current continued expansion of HIV prevention, treatment and care services and the introduction of fixed dose combination drugs for TB (FDC) is also likely to improve the management of TB/HIV.

While DOTS coverage remains high with all districts practising it, there are challenges in carrying out direct sputum microscopy, irregular support and supervision and monitoring and evaluation, including reporting of outcomes. The surveillance of MDR TB is poor mainly because the national TB reference laboratory has been severely under-resourced in terms of manpower, equipment, reagents and funding in recent years. Establishment of a sound surveillance system for MDR and XDR TB within the TB programme remain a priority.

It is estimated that half of the twelve million Zimbabwean population lives in malaria-prone areas. Transmission of malaria is largely unstable exposing all age groups at risk of malaria; however, under-fives and pregnant women remain at greatest risk particularly in the 17 highest burdened districts. Indoor residual spraying using DDT and pyrethroids remains an important mainstay of the national malaria control programme. DDT was reintroduced in 2004 and is used in accordance with the Stockholm Convention. In 2007, the national IRS coverage was 57.3% with varying provincial coverage. The country has introduced the Rapid Diagnostic Test (RDT) and the use of ACTs for case management.

2.2.3.2 Chronic Noncommunicable:

Diseases, and mental, neurological and psychosocial problems are perceived as emerging causes of public health concern in Zimbabwe. These include cardiovascular disease, diabetes,

[8] WHO Global TB Report 2007.

various cancers, violence and injuries, mental and substance abuse disorders as well as oral health conditions. The absence of reliable data means that the burden of most noncommunicable diseases is not precisely known, although cancer of the cervix and Kaposi sarcoma occur frequently. In a survey carried out in 2005, the prevalence of diabetes in the country was found to be 10% while that of hypertension stood at 26.7%. The high prevalence of HIV has also meant that oral health conditions, in some cases even Noma, are on the rise. Road traffic and occupational accidents and forms of violence also account for some morbidity and mortality in the country. Following the survey to measure the burden of NCDs using the STEP approach, guidelines for management of diabetes and hypertension were developed, and an intersectoral committee to advise on matters of diet and physical activity was established.

During the first generation of the CCS the concept of Integrated Disease Surveillance and Response (IDRS) was largely disseminated and its implementation promoted in Zimbabwe. The dissemination process was done through training of health workers in different settings such as government institutions, local authorities and uniformed forces as well as through the adaptation of technical guidelines for use at the sub-district level. The capacity for outbreak response was strengthened through provision of emergency drugs, supplies and equipment using CAP and CERF funds; the rapid disease notification system (weekly surveillance system) was revised and strengthened; and the International Health Regulations 2005 (IHR) were introduced through training of national and provincial focal persons including Port Health officers.

2.2.3.3 Reproductive, Child and Adolescent Health

The country witnessed a decline of the under-five mortality rate from 102 deaths per 1000 live births to 82 deaths per 1000 live births between 1999 and 2006. The neonatal mortality rate stands at 24 per 1000 live births in 2006. Efforts have been made to improve the quality of care at community, primary and referral health centres in support to the Expanded Programme on Immunization (EPI), IMCI, and Young Child Feeding and Counselling. The current socioeconomic challenges have impacted negatively on the coverage of EPI DPT3 which declined from 89% in 2005 to 75% in 2007. The maternal mortality ratio has declined from 695 deaths in 1999 to 555 deaths per 100 000 live births in 2005/6. However, this remains significantly high. The contraceptive prevalence rate in Zimbabwe has increased steadily from 38% in 1984 to 60% in 2006. The total fertility rate has declined from 4.0 in 1999 to 3.8 in 2006. There was an increase in women attending at least one antenatal care visit from 81% in 1999 to 94% in 2006. Skilled attendance at delivery declined from 73% in 1999 to 69% in 2006 while institutional deliveries declined from 72% to 68% over the same period (ZDHS 1999, 2005/6). Gender-based violence remains a challenge; 25% of women aged 15 - 49 years have experienced sexual violence (ZDHS 2005/6).

During the period under consideration, several activities were carried out to move the country to the achievement of the targets for MDGs 4 and 5. In that line, an assessment of Maternal and Neonatal Health Services was carried out, with the subsequent development of a national MNH Road Map. Key activities were the training of health workers in Emergency Obstetric and Neonatal Care, Manual Vacuum Aspiration and implant insertion. Facility-based IMCI was implemented in 23 out of the 61 districts with every first level health facility manned by a health worker trained in IMCI. This was made possible through the introduction of IMCI in the pre-service training for the Primary Care Nurse. Community IMCI is being implemented in 8 out of the 61 districts. Advocacy has been carried out for the inclusion of women and child health issues on the agenda of partners. This was done through representation in various task forces, steering committees, partnerships that advocate for

increased funding for Maternal and Neonatal Health services from partners and advocacy for integrated services. The country managed to carry out a review of laws, policies and strategies related to Gender-based Violence, Adolescent Sexual and Reproductive Health.

2.2.3.4 Protection of Healthy Environments

The deterioration of the water and sanitation situation in urban and rural areas remains an important concern for the protection of healthy environments. The national water coverage index stands at 70% and the sanitation coverage at 26%[9]. In a bid to achieve the targets for MDG 7, the country, with the support of its partners, has implemented health promotion activities using the health education targeting vulnerable communities and settings approach (schools and village competitions); the policy and strategic framework was established through the development of the environmental health policy as well as the Children's environmental health indicators and technical guidelines.

2.2.3.5 Reducing the Disease Burden - the unfinished Agenda

A lot still needs to be done to address the challenges posed by communicable and noncommunicable diseases. The outstanding work remains in the development of strategic plans for both TB and malaria, creation of a malaria database at all levels and establishment of a programme for the management of MDR-TB in the country. Much still needs to be done in strengthening the routine surveillance of NCDs, promotion of healthy lifestyles, revision of the mental act and production of management guidelines for common mental health conditions, prevention of injuries and promotion of good oral healthcare.

To improve emergency preparedness and response, it is important to establish or revitalize the existing rapid response teams at national, provincial and district levels. Although training in IDSR has been carried out during the last four years, the high staff turn-over and attrition has impacted negatively on the implementation of integrated disease surveillance and response, hence the need to continue training and incorporate the information on IHR 2005.

The attainment of MDGs 4 and 5 is compromised; the unfinished agenda includes addressing the decline in routine immunization coverage using the expansion of the RED approach and outreach services; improving AFP surveillance and data management of vaccinepreventable diseases including polio eradication and measles elimination; costing and implementation of the Road Map for the reduction of maternal and neonatal mortality; expansion of all components of IMCI to all districts; development of a functional maternal, neonatal and child health forum and the development of an ASRH policy, a child survival strategy, a comprehensive adolescent health strategy; and development of service delivery guidelines for implementation.

The strengthening of crossborder dialogue on the management and control of diseases would contribute to a better and coordinated implementation of the International Health Regulations among the neighbouring countries.

The deterioration of the water and sanitation situation in urban and rural areas remains an important concern for the protection of healthy environments. Although an effort was made in the development of an environmental health policy and child environmental health Indicators, their implementation needs to be pursued.

9 Wash Inventory Atlas Zimbabwe. March 2006. UNICEF.

The country remains extremely vulnerable to natural (drought and floods) and manmade disasters and disease outbreaks. It is therefore important to continue to support the MOHCW and the partners using two main approaches: emergency and humanitarian approach as well as support in recovery. Support for coordination of the health cluster for humanitarian response and strengthening of emergency preparedness and response remain part of the unfinished business.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 OVERVIEW AND TRENDS IN DEVELOPMENT ASSISTANCE

Zimbabwe has, in the past eight years, gone through severe economic recession, floods and cyclones and droughts which have led to severe food deficits. These factors, compounded by high rates of HIV infection and repeated cholera and other outbreaks, have caused a humanitarian crisis in the country. Political differences with major donor nations have resulted in changes in approach by many donors who now direct their assistance to humanitarian needs such as food, shelter and epidemic response at the expense of health development needs. These funds are now increasingly being channelled through either NGOs or the UN agencies rather than given directly to government.

3.2 MAIN DEVELOPMENT PARTNERS IN THE HEALTH SECTOR

3.2.1 Main areas of development assistance and partnerships

The main development partners in the health sector are a cross section of both multilateral and bilateral institutions, international NGOs, and humanitarian and faith-based organizations.

They include the European Union (EU), United States Agency for International Development (USAID), the Center for Disease Control (CDC) and the UK's Department for International Development (DFID). The UN agencies working in health are UNFPA, UNICEF, UNAIDS and UNDP. Other mechanisms through which Zimbabwe is receiving funding include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Expanded Support Programme (ESP), the consolidated appeal process (CAP), Global Alliance for Vaccines and Immunization (GAVI) and the Health Metrics Network.

3.2.2 Other Funding Mechanisms

The Global Alliance for Vaccines and Immunization (GAVI) has provided support from 2002 in immunization services strengthening, injection safety, pentavalent vaccine support and technical support to EPI during the formulation of the financial sustainability plan and the costed EPI multi-year plan. Further support in EPI has been received from Helen Keller International and Rotary International.

The Health Metrics Network (HMN) has given support for strengthening various aspects of the national health information system.

The MoHCW has been engaging non-traditional donors for support in recent years. This has been done through government-to-government agreements. The South Koreans, Russians, Iranians, Chinese, Egyptians and Cubans have provided support in various areas of health care delivery that include malaria control, traditional medicine and curative services.

Table2: Main areas of Development Assistance and Partnerships

Partner or funding mechanism	Type of Partnership	Principal Area of Intervention	Funding (millions)	Period
The EU	Bilateral	Health Systems Strengthening, HIV/ AIDS, Reproductive health, malaria control, water and sanitation,	Euro 150	2005–2007
USAID	Bilateral	HIV/AIDS and Family planning,	USD 176.9	2000–2007
CDC	Bilateral	HIV/AIDS and Tuberculosis,	USD 50	2001–2008
DFID	Bilateral	HIV/AIDS, maternal and newborn health, malaria control, immunization, emergency and vital medicines support,	£ 45	2007–2008
UNFPA	Multilateral	Reproductive health, population and development, gender mainstreaming,	USD 40.5	2007–2011
UNICEF	Multilateral Multilateral	Young child survival and development, water, sanitation and hygiene, HIV/AIDS,	USD 91	2007–2011
UNAIDS		HIV/AIDS,	USD 58	2006
The Global Fund		HIV/AIDS, Tuberculosis and Malaria,	USD 125	2004–2007
The ESP		HIV/AIDS,	USD 36	2007–2008
CAP		Cholera control, provision of ARVs, Emergency Preparedness and Response,	USD 1,5	2006–2008

3.3 COORDINATION OF DEVELOPMENT ASSISTANCE

Government, through it's economic development strategies and partnership with the UN family through the Zimbabwe UN Development Assistance Framework (ZUNDAF), provides partners with information on the national development agenda. Through its strategic and yearly plans, the MoHCW in turn provides its partners with guidance on the areas of development assistance. There is a Donor Section in the MoHCW that coordinates all donor funds that are channelled through the ministry. It's functionality needs to be improved.

A number of mechanisms have been put in place to allow for receiving, disbursing, tracking and reporting on the use of donor assistance. The GF resources are managed by the Country Coordinating Mechanism (CCM) while the Expanded Support Programme (ESP) Working Group coordinates ESP funding.

The ZUNDAF provides a forum for coordination of government and UN activities in Zimbabwe Working groups and clusters have been established and they are functional. Through the Resident Coordinator with technical advice from the Office for the Coordination of Humanitarian Affairs (OCHA) all humanitarian activities are coordinated. The Interagency Humanitarian Coordination mechanism has been constituted as well as the Donors group. In the context of improving coordination among the different sector partners, the Cluster approach has been recently adopted and WHO is leading the health Cluster. Under the World Bank, the Multi-donor Trust Fund (MDTF) is being created, with health as a component of the Basic Services group.

The Health Development Partners Coordination Group (HDPCG) was formed in 2007 in recognition of the need for better information sharing and coordination of efforts among donors and development partners in the health sector. The HDPCG aims to adopt a coordinated approach and, possibly, joint actions in areas such as essential drugs supply and support to human resources in health. The group is currently chaired by the EU and WHO is vice-chair.

SECTION 4

WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, including the achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO corporate strategy[10]

4.1 GOAL AND MISSION

The mission of WHO remains the attainment by all peoples, of the highest possible level of health (Article 1 of WHO Constitution). The corporate strategy and the Strategic Orientations for WHO Action in the African Region 2005-2009 outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States, including the Millennium Development Goals.

4.2 CORE FUNCTIONS

The work of the WHO is guided by core functions, which are based on its comparative advantage[11]. These are:

(a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;

(b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

(c) Setting norms and standards, and promoting and monitoring their implementation;

(d) Articulating ethical and evidence-based policy options;

(e) Providing technical support, catalyzing change and building sustainable institutional capacity;

(f) Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas. These include:

(a) Investing in health to reduce poverty;

(b Building individual and global health security;

[10] WHO EB 105/3. A corporate strategy for the WHO Secretariat.
[11] Eleventh General Programme of Work 2006-2015. A Global Health Agenda.

(c) Promoting universal coverage, gender equality, and health-related human rights;
(d) Tackling the determinants of health;
(e) Strengthening health systems and equitable access;
(f) Harnessing knowledge, science and technology;
(g) Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda as follows:

(i) Health Development;
(ii) Health Security;
(iii) Health Systems;
(iv) Evidence for Strategies;
(v) Partnerships;
(vi) Improving the Performance of WHO.

In addition, she has indicate d that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The global priority areas have been outlined in the Eleventh General Programme of Work. They include :

(a) Providing support to countries in moving to universal coverage with effective public health interventions;
(b) Strengthening global health security;
(c) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
(d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
(e) Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account, the global documents and the resolutions of the WHO governing bodies, the health Millennium Development Goals, and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives which are outlined in the Medium Term Strategic Plan 2008- 2013.[12] These regional priorities have been expressed in the Strategic Orientations for WHO Action in the African Region 2005-2009. They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing,

[12] Medium-Term Strategic Plan 2008-2013, Strategic Direction 2008-2013, p4.

technologies and laboratories), governance and partnerships, and management and infrastructure.

In addition to the priorities mentioned above, the Region is committed to supporting countries to attain the health MDGs and assisting in tackling its human resource challenge. In collaboration with other agencies, the problem of how to assist countries source financing for the goals of the countries will be done under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may benefit maximally from the technical support granted to them.

To effectively address the priorities, the Region is guided by the following strategic orientations[7]:

(a) Strengthening the WHO country offices;

(b) Improving and expanding partnership for health;

(c) Supporting the planning and management of district health systems;

(d) Promoting the scaling up of essential health interventions related to priority health Problems;

(e) Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO corporate strategy at country level will vary from country to country depending on the country specific context and health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization, as outlined in section 4.2, may be adjusted to suit each individual country needs.

[7] Medium-Term Strategic Plan 2008-2013, Strategic Directions 2008-2013, P.4 Paragraph 28.

SECTION 5

CURRENT WHO COOPERATION IN ZIMBABWE

The relationship between WHO and the Republic of Zimbabwe started in 1980 following the country's independence. To respond to the increasing demands for WHO to support the country, the composition of the country team as well as budget allocation were regularly revisited. Zimbabwe is also hosting the recently established Intercountry Support Team for East and Southern Africa (ESA/IST). WHO's contribution during the first generation CCS is described below.

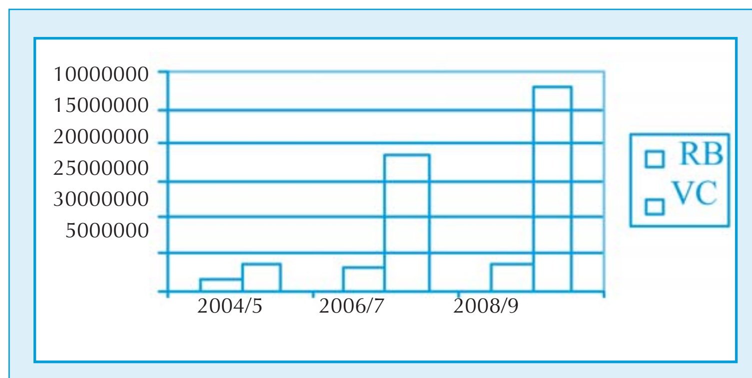
5.1 HUMAN RESOURCE S

The WCO professional staff in Zimbabwe provides direct support to the country. It has a complement of 39 staff members of whom 11 are technical, 6 are administrative, 9 are secretarial and 13 constitute other support staff. According to the recently developed Human Resources Plan, the country office is still understaffed and regularization of the proposed positions needs to be finalized. The WCO will need to complete the reprofiling exercise started in 2004 to ensure a structure that would provide adequate support to the country. The revised organization chart is in Annex 1.

5.2 WCO BUDGET DISTRIBUTION AND MAIN AREAS OF WORK

The WHO budget consists of assessed and voluntary contributions. The assessed contributions (AC) are assured while voluntary contributions (VC) need to be mobilized. During the period 2004 to 2007 WCO received biennial funds ranging from US$ 1 576 000 to US$ 2 967 000 from the assessed contributions and US$ 3 689 000 to 18 746 000 from voluntary contributions. The 2008-09 biennium has US$ 3 152 000 from AC and US $ 28 098 509 from VC funds, which will also include locally-mobilized funds to support various programmes. Figure 2 below shows the flow of funds from 2004 to 2008/9.

Figure2: Funds flow into the WCO from RB and EB Trends in budgetary contributions for WCO Zimbabwe (US$)



There has been a marginal increase in the amount of the assessed contributions while voluntary contributions increased several folds between 2004 and 2008. The AC fall way below the country office's needs and are commonly used for salaries and operational costs, leaving very little for programme support. The unpredictability of VC funding creates uncertainty in planning and execution of programme activities.

5.3 PRIORITY AREAS OF TECHNICAL SUPPORT

The implantation of the first generation CCS was done in two bienniums: 2004-2005 and 2006-2007.

For the Programme Budget 2004-2005, twenty areas of work (AoW) were selected[13]. The estimated budget for the biennium was US$ 5.3 million of which 3.6 million was on resource gap, and only 1.6 million was secured from the regular budget.

For the Programme Budget 2006-2007, Knowledge Management and Information Technology, and Health Financing and Social Protection AoWs were added to the previous biennium making them twenty-two, to be implemented with only US$ 1.09 million from the regular budget as against 18.4 million from VF. The fact that the MoHCW relies on contribution from WHO made it very difficult to reduce selected AoWs from one biennium to another. This situation remains a challenge as WHO is increasingly perceived as donor partner.

Using the WHO functions at country level[14], it was possible to support the MoHCW in its effort s to achieve the health goals as stated for the period under review. Different policy documents were developed; appropriate strategies and guidelines were adapted to the country context; various activities pertaining to capacity building in the different programmes were undertaken; research activities were implemented and support in monitoring progress towards the achievement of the health-related MDGs was provided. There was a strong commitment in reinforcing partnerships within the United Nations family, in the context of the ZUNDAF, and collaboration with other development partners was strengthened.

5.4 ESA/IST, WHO REGIONAL OFFICE AND HEADQUARTERS SUPPORT

The WHO core functions define the technical support that the organization is providing to the country. Where competencies are not available within the WCO team and within the country, ESA/IST is the first port of call. The Regional Office (AFRO) and HQ are providing policy and technical advice, resource mobilization, information sharing, and capacity building. They are also ensuring a balance between global and regional initiatives and country priorities. All support to the country is guided by the CCS and coordinated by the country office.

13 Communicable disease surveillance; Malaria; Tuberculosis; Surveillance, prevention and management of noncommunicable diseases; Health promotion; Child and adolescent health; Research and programme development in reproductive health; Making pregnancy safer; Women's health; HIV/AIDS; Health and environment; Emergency Preparedness and Response; Essential medicines; Immunization and vaccine development ; Organization of health services; Blood safety and clinical technology; Tobacco; Mental health and substance abuse.

14 The following are WHO's functions : F1 Supporting routine, long-term implementation; F2 Catalysing adoption of technical strategies and innovations; F3 Supporting research and development; policy experimentation; development of guidelines; F4 Sharing information: generic policy options and positions, guidelines and standards; case studies of good practice; advocacy; F5 Providing specific high-level policy and technical advice.

5.5 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS ANALYSIS OF THE WCO

The SWOT analysis was used for the identification of Strengths, Weaknesses, Opportunities and Threats that can influence the implementation of the CCS in Zimbabwe. These are conditions related to the overall environment as well as the WHO itself. The summary is illustrated in Table 3.

Table 3: SWOT Analysis

Strength	Close consultation with the MoHCW during the planning process Good working relationships with MoHCW officials Creation of IST to provide timely support to countries and the potential for additional support from RO and HQ Decentralization of funds to countries Increased delegation of authority to WHO country representatives
Weaknesses	Inadequate staffing of a number of priority programmes Inadequate funding for a number of critical programmes. Overall zero growth of the Regular budget. Weak resource mobilization and advocacy capacity at country level Poor coordination systems among the various partners including the UN agencies, leading to competition, duplication and poor implementation performance in some programmes
Opportunities	Increased confidence and reliance on WHO by other partners as the leading agency in health Increasing opportunities for resource mobilization for some programmes: GF, ESP, EC, DFID, GAVI, HDPCG; RBM, Stop TB among others The presence of the IST/ESA in Zimbabwe The UNDAF process as a platform for dialogue in the United Nations family The existence in Zimbabwe of internationally recognized centres of excellence, WHO collaborating centres and training institutions.
Threats	Diminishing donor confidence in the managerial capacities of the government with a decrease of external funding being channelled through the government institutions. Unfavorable social and economic environment characterized by a rapidly deteriorating economy Extreme weather patterns (droughts versus floods) In some programmes, increasing number of partners with competing technical inputs in health in a context of weak coordination mechanisms

SECTION 6

STRATEGIC AGENDA: PRIORITIES AGREED FOR WHO COOPERATION WITH THE COUNTRY

The definition of the strategic agenda for the period 2008-2013 was driven by an in-depth analysis of the implementation of the first generation CCS, taking into consideration the unfinished agenda, as well as the recognition of the existence of new issues and challenges. The Global and Regional priorities as defined by the 11th GPW and the MTSP 2008-2013 constitute the institutional framework. The importance of linking with the national priorities as defined by the National Health Strategy 2008-2013 and alignment with the ZUNDAF 2007-2011 and partners mapping is a fundamental guiding principle.

To respond to Zimbabwe's needs and priorities in the health sector, WHO will continue to use its comparative advantages and focus on a strategic agenda that is composed of:

(a) Improving health systems performance;

(b) Reducing the burden of major communicable and noncommunicable diseases;

(c) Enhancing health promotion to reduce the major risk factors, including protection of healthy environments;

(d) Addressing the vulnerability of the country to emerging health issues such as natural and man-made disasters and disease outbreaks through the strengthening of emergency preparedness and response.

6.1 IMPROVING HEALTH SYSTEM PERFORMANCE

WHO has proven to have technical expertise in

(i) development of national health policies and strategic plans;

(ii) capacity building and development;

(iii) health systems performance; (iv) development of national health accounts and evidence for justification for investing in health;

(v) health information system development; and

(vi) health systems research. The Government of Zimbabwe and its partners need to address the decline in the functioning of its health system as a precondition to achieving the health goals.

6.1.1 Human Resources for Health

WHO will use the following strategies to support the heath sector in addressing its HRH needs:

(a) Development and operationalization of the HRH policy and strategic plan;

(b) Support capacity building and development in priority health areas;

(c) Development of relevant research protocols in HR issues (impact of HIV/AIDS on staff, stress and burn-out of staff);

(d) Promote task shifting as a strategy to address the human resources challenges.

6.1.2 Health Financing

WHO will focus on:

(a) Advocacy for increased expenditure on health from both government and partners;

(b) Disseminating best practices on health financing schemes;

(c) Providing technical support to undertake the national health accounts exercise and advocate for the use of evidence to influence policy;

(d) Strengthening WCO and MoHCW capacity for resource mobilization;

(e) Strengthening resource management capacity at all levels;

(f) Providing technical advice on macroeconomics and health.

6.1.3 Policy Formulation, Monitoring and Evaluation

WHO will focus on:

(a) Assisting in formulating, implementing, monitoring and evaluating relevant policies;

(b) Advocating for the use of evidence to influence policy.

6.1.4 Partnerships and Coordination

(a) Strengthening existing partnerships in health and advocating for new ones;

(b) Reinforcing the capacity of the MoHCW to coordinate development partners in health (the Stewardship role).

6.1.5 Health System Performance

In line with the Ouagadougou Declaration of 2008, WHO will strengthen PHC as the strategy for health services delivery through:

(a) Strengthening health management at all levels with emphasis on the district level;

(b) Advocating for equity in the delivery of health services;

(c) Providing technical support for quality assurance for health programmes;

(d) Sharing best practices in health service delivery;

(e) Advocating for health to be put at the centre stage of national development and poverty reduction strategies.

6.2 DISEASE PREVENTION AND CONTROL

WHO will continue to use its technical expertise in disease prevention and control, to promote the scaling up of proven interventions and programmes. It will also strengthen epidemiological surveillance and capacity to measure progress towards the achievement of the Millennium Development Goals.

6.2.1 Scaling Up and Strengthening Key Interventions

WHO will focus on providing technical support to the MOHCW to:

(a) Strengthen the management of health programmes (communicable and noncommunicable)

(b) Advocate for community involvement in prevention, treatment, care and support;

(c) Promote the use of new medicines and technologies;

(d) Scale up effective public health interventions;

(e) Support the implementation of the Maternal and Newborn Road Map and the Child Survival Strategy to reduce maternal, newborn and child mortality;

(f) Strengthen drug resistance surveillance systems;

(g) Monitor insecticide resistance;

(h) Address mental health challenges and the prevention and control of alcohol and substance abuse;

(i) Scale up blood safety services.

6.2.2 Strengthening of Epidemiological Surveillance and Response

WHO will focus on:

(a) Providing technical support for the implementation of Integrated Disease Surveillance and Response (IDSR) nationwide;

(b) Providing technical support for the implementation of the International Health Regulations;

(c) Supporting preparedness and response for diseases caused by emerging dangerous Pathogens;

(d) Strengthening surveillance of diseases targeted for eradication and elimination.

6.3 HEALTH PROMOTION AND PROTECTION OF HEALTHY ENVIRONMENTS

Diseases that can easily be prevented by health promotion strategies such as behaviour change and promotion of healthy lifestyles are on the increase. Health promotion programmes such as Healthy Cities; Healthy Markets, Health Promoting Schools Initiative, Tobacco Free Initiative, Participatory Health and Hygiene Education (PHHE), prevention of road traffic accidents among others have been implemented in Zimbabwe.

6.3.1 Under health promotion WHO will:

(a) Provide technical support to the MoHCW for the finalization and implementation of the health promotion policy and strategy;

(b) Use the different opportunities to advocate for health as a fundamental requisite for development;

(c) Promote integration of health promotion into different programmes (cross cutting);

(d) Advocate for coordinated involvement of the communities in decision making on health-related matters;

(e) Provide technical support to the MoHCW in assessing and implementing promotive adolescent health programmes;

(f) Provide technical support to the MoHCW to strengthen its communication strategies such as advocacy and lobbying skills;

(g) Advocate for promotion of healthy lifestyles (healthy diet; physical activity, among others).

6.3.2 Environment and Health

WHO will focus on:

(a) Supporting the MoHCW and local authorities to strengthen awareness activities for waste management;

(b) Providing technical support to the MoHCW for the development and implementation of occupational health policy and strategies;

(c) Advocating for increasing coverage of rural sanitation;

(d) Supporting provision of safe drinking water and appropriate sanitation, especially in cholera-prone areas and resettled areas;

(e) Supporting water quality monitoring in rural and urban areas;

(f) Advocating for health impact assessments of developmental programmes;

(g) Building capacity on identification of environmental health risks, hazard mapping and general operation procedures;

(h) Advocating for improved Children's Environmental Health.

6.4 EMERGENCY PREPAREDNESS AND RESPONSE

The health sector profile is characterized by a mix of acute and emergency needs and a chronic deterioration of the health system. In response to the country's vulnerability to natural (drought and floods) and man-made disasters and disease outbreaks, WHO will support MOHCW and its partners using two main approaches: emergency and humanitarian approach and support in recovery. Important actions to be taken include:

(a) Support vulnerability assessment;

(b) Advocate for the inclusion of disaster risk reduction measures into developmental; programmes;

(c) Strengthen emergency preparedness and response;

(d) Support coordination for humanitarian action;

(e) Support in resource mobilization using the CAP, CERF facilities and other mechanisms;

(f) Strengthen surveillance and early warning systems;

(g) Provide technical support in the implementation of the emergency preparedness and response component of the 2005 International Health Regulations.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The implementation of the Country Cooperation Strategy has a number of implications in the way the Organization operates. This calls for a better coordination among the three levels of the Organization and strengthening of the concept of *"One WHO"*, improvement of partnerships within the United Nations system and with health development partners as well as reinforcement of coordination mechanisms and stewardship role of the MoHCW. Specific implications include:

7.1 HUMAN RESOURCES

Country Office

For implementation of the CCS, it is important to have the adequate competencies and skills to respond to the selected strategic agenda. In this regard, the human resources plan was updated, a reprofiling exercise was undertaken and a proposed organization chart was developed. Implementation of the proposed chart will be critical for the successful implementation of the strategic agenda. To address the need for improvement of the performance of the country team, the Organization will ensure an enabling environment for continuous learning.

WHO/AFRO and IST Level

In view of the shortage of expertise in the country office in some key areas, the Regional Office and the IST should provide technical support in the implementation of the strategic agenda. AFRO should equally provide more opportunities for country office staff members to participate in regional/international training courses, workshops and meetings to keep abreast with latest technical developments.

WHO HQ Level

In collaboration with AFRO, HQ should provide staff development and training opportunities to the WHO country staff. HQ is requested to consider the provision of additional funding in line with the Country Focus Initiative for strengthening the country office capacity to implement the CCS.

7.2 FINANCIAL RESOURCES

Country Level

The successful implementation of the CCS needs adequate financial resources. However, trends show that the AC have been inadequate to cover the planned activities and VC budget is unpredictable. There is need therefore for increased resource mobilization by WHO and firm commitment from the donor community.

AFRO Level

AFRO should commit resources within the Country Focus Initiative and support the mobilization of additional resources to reinforce the implementation of the CCS strategic agenda.

WHO HQ Level

HQ should continue the mobilization of the extra budgetary resources especially in view of the current humanitarian situation.

7.3 PARTNERSHIPS

WHO will need to strengthen its leadership role in health and ensure high visibility by excelling in areas where it has a comparative advantage. WHO will continue to be the lead agency of the Health Cluster in the UN country team.

SECTION 8

MONITORING AND EVALUATION

The CCS will be operationalized through the existing managerial mechanisms, namely the Programme Budget and the three consecutive biennial Plans of Action for 2008-200915, 2010-2011 and 2012-2013. Quantitative and qualitative targets will be set to undertake monitoring and evaluation of the CCS implementation.

The indicators to be formulated in this connection will measure issues relate d to the selection of strategic objectives and Organization-wide expected results that address the concerns of the agreed strategic agenda for Zimbabwe. The Global Management System (GSM) once operational will be an important tool for the overall managerial process.

[15] SO1 (Immunization and Vaccine Development and Epidemic Alert and Response); SO2 (Malaria; Tuberculosis; HIV/AIDS); SO3 (Surveillance, Prevention and Management of Chronic Noncommunicable Diseases and Mental Health); SO4 (Making Pregnancy Safer and Child and Adolescent Health); SO5 (reducing the health consequences of emergencies); SO6 (Health Promotion; Mental Health and Substance Abuse); SO9 (Nutrition); SO10 (Health Systems Policies and Service Delivery; Health Financing and Social Protection and Human Resources for Health); SO11 (Health Technologies and Laboratories); SO12 (Country Analysis and Support, including Partnerships); and SO13 (WHO's Core Presence in Country).

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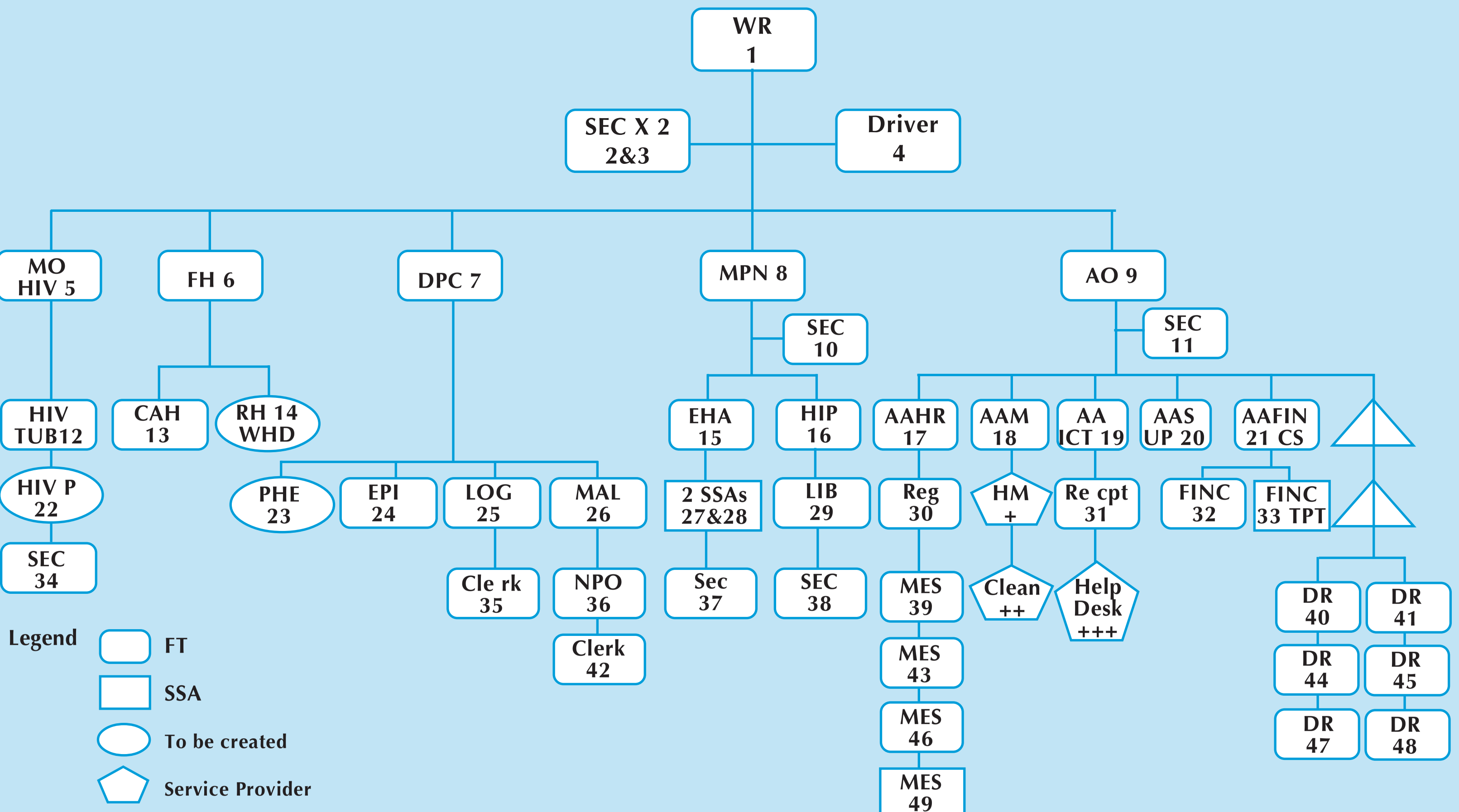

Annex 1
WCO ZIMBABWE CHART 2008
WR 1
SEC X 2 2&3
Driver 4
MO HIV 5
FH 6
DPC 7
MPN 8
AO 9
SEC 10
SEC 11
HIV TUB12
CAH 13
RH 14 WHD
EHA 15
HIP 16
AAHR 17
AAM 18
AA ICT 19
AAS UP 20
AAFIN 21 CS
HIV P 22
PHE 23
EPI 24
LOG 25
MAL 26
2 SSAs 27&28
LIB 29
Reg 30
HM +
Re cpt 31
FINC 32
FINC 33 TPT
SEC 34
Cle rk 35
NPO 36
Sec 37
SEC 38
MES 39
Clean ++
Help Desk +++
DR 40
DR 41
Clerk 42
MES 43
DR 44
DR 45
MES 46
DR 47
DR 48
MES 49
Legend
FT
SSA
To be created
Service Provider
Common Services

Annex 2 : Elaboration of Second Zimbabwe Country Cooperation Strategy document for the period 2008-2013 - *timeframe*[16]

Step	Activities	Responsible	Milestone	Timeline
Creation of multidisciplinary team	Proposal of membership of Development Team	MPN	List submitted to WR	29/10/2007
	Elaboration of TOR	MPN	TOR submitted to WR	29/10/2007
	Reminder Letter to MoHCW to inform on process and confirm DME Dr Dlakama as Govt. representative on team	MPN/WR	Letter sent to MoHCW	30/10/2007
	Letters to other health partners and UN Agencies to inform on process. UN Agencies to request representation	MPN/WR	Letters dispatched to UN Agencies, Bilateral agencies	31/10/2007
SWOT Analysis	In-depth assessment of strategic agenda items of current CCS 2004-2007	CST	Concise individual briefs on achievements, gaps, challenges, and unfinished agenda	5/11/07 to 12/11/07
	Peer review of briefs	WR /MPN	Consolidated brief	
	Consultative sessions with MoHCW and key partners on outcomes of SWOT analysis	WR /MPN	Consensus on SWOT outcomes	
Gap Analysis of Office and Health Partners' Competences	Analysis of office competence	WR	Map of office competences	4/02/08 to 15/02/08
	Assessment of donor assistance to health sector	MPN	Donor and partner map	
Definition of Strategic Agenda	Elaboration of strategic agenda	CST	Draft strategic agenda	12/02/08 to 4/03/08
Consensus Building	Consultative meetings with Government and partners	MPN/WR	Consensus on strategic agenda	05/03/08
Draft the document using the proposed generic outline	Desk review; members of the development committee coordinate the submissions for consolidation	Members of the Group/MPN	Availability of Draft one of the CCS	05/03/08 to 10/04/08
Discussion with Government and Partners	Organization of a retreat to review the document before submission to AFRO peer review	MPN/WR	Solid amendments on the draft document	15/7/08 to 16/7/08
Peer Review by AFRO	Submission of the Draft to DPM's Office for review	MPN and WR	Comments received from the review committee and incorporated	16/7/08 to 20/8/08
Government and Partner endorsement	Dissemination of the improved draft to Government and other partners and organization of a consensus meeting	WR and MPN	Document discussed and endorsed at country level	09/10/08
Final Draft sent to RD for approval	Submission of the consensus document to RD's Office	WR	Document approved by RD and forwarded to DG	end October 2008
Publication and dissemination of CCS Document	Contract for printing of document	AO	Document printed	November 2008
	Advocacy meeting to introduce document to Government, partners and general public	WR	Widespread awareness (launch) and acceptance of CCS document	November 2008
	Production of policy briefs	WR	Policy briefs	December 2008

[16] Updated on 20th October 2008