World Health Organization

Country Cooperation Strategy at a glance

Zimbabwe

http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Low-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (2015)	48
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2015)	83
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	60.7 (Both sexes) 59.0 (Male) 62.3 (Female)
Population (in thousands) total (2015)	15602.8
% Population under 15 (2015)	41.6
% Population over 60 (2015)	4.4
Poverty headcount ratio at $1.25 a day (PPP) (% of population) ()	
Literacy rate among adults aged >= 15 years (%) (2007-2012)	84
Gender Inequality Index rank (2014)	112
Human Development Index rank (2014)	155
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	6.44
Private expenditure on health as a percentage of total expenditure on health (2014)	61.70
General government expenditure on health as a percentage of total government expenditure (2016)	9.7
Physicians density (per 1000 population) (2011)	0.083
Nursing and midwifery personnel density (per 1000 population) (2011)	1.335
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2015)	23.5 [16.8-33.8]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)	69
Maternal mortality ratio (per 100 000 live births) (2015)	651
Births attended by skilled health personnel (%) (2015)	78.1
Public health and environment	
Population using improved drinking water sources (%) (2015)	97.0 (Urban) 76.9 (Total) 67.3 (Rural)
Population using improved sanitation facilities (%) (2015)	49.3 (Urban) 30.8 (Rural) 36.8 (Total)

Sources of data:
Global Health Observatory May 2017
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

The country has realised improvements in service delivery. The percentage of pregnant women accessing antenatal care visit increased from 65% in 2009 to 76% in 2015. Maternal mortality ratio declined from 960 in 2010-2011 to 651 per 100 000 live births in 2015. Under-five mortality dropped from 86 deaths in 2010 to 69 deaths per 1000 live births in 2015. Twenty-two per cent of female adolescents 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 are 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.

The country has experienced a gradual decline in HIV prevalence among adults aged between 15 – 49 years, from a peak of 29.7% in 1997, to 18.1% in 2006; and 14.7% in 2015, predominantly as a result of behaviour change. HIV prevalence has consistently been higher in urban areas compared to rural areas. Zimbabwe continues to scale up its HIV prevention; treatment and care programmes and the country adopted the Treat All Policy in December 2016. As of 31 March 2017, the ART coverage among children was 98.3%; while for adults it was 76.2%, based on the 2016 HIV Estimates and Projections. Zimbabwe remains one of the 30 countries with the highest burden of TB, TB-HIV and Drug resistant TB; with an estimated TB prevalence of 292 cases per 100,000 populations. HIV remains the main factor fuelling the TB epidemiology in the country. The incidence of malaria declined from 58 in 2009 to 39 per 1000 population in 2014 and the country met the Abuja target of a malaria incidence rate of 68 per 1000 people. Zimbabwe is also endemic to 4 preventive chemotherapy neglected tropical diseases – i.e. soil transmitted helminthiasis, schistosomiasis, lymphatic filariasis and blinding trachoma. The country seems to be facing a double burden of communicable and non-communicable diseases (NCDs), although there are no current statistics on the burden on NCDs. 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, cancers, road traffic injuries and mental health conditions continue to afflict a growing numbers of Zimbabweans. It is estimated that NCDs account for 31% total deaths in Zimbabwe. Furthermore, the country is prone to natural and man-made disasters - including frequent disease outbreaks, acute public health emergencies and other health-related humanitarian disasters.

HEALTH POLICIES AND SYSTEMS

The right to health care is enshrined in the 2013 Constitution of Zimbabwe which commits the state to "take all practical measures to ensure the provision of basic, accessible and adequate health services throughout the country". The Health Service Act guides the organisation 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 healthcare principles (PHC). The National Health Strategy (2016-2020) makes provisions for dealing with the unfinished MDGS Agenda, and for implementation of SDGs. Of the 17 SDGs, Goal 3 - "to ensure healthy lives and promote well-being for all ages" – directly focuses on health and the vision and goals of the new NHS. Key SDGs 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 realising the human rights of all, and to achieve gender equality throughout empowerment of all women and girls. WHO supported the Workload Indicator of Staffing Needs (WISN) survey provided a new realistic HRH establishment. One of the legacies of the brain-drain syndrome n Zimbabwe is that new recruits into public health services are unable to access mentorship of more experienced hands, hence increasing concerns of quality of healthcare services.

Current level of government funding of healthcare (US$25 per capita in 2015) still falls short of WHO's recommendations of USD86 per capita, and the healthcare system remains heavily dependent on external support – particularly for HRH retention, essential medicines and procurement of health technologies.

COOPERATION FOR HEALTH

Funding partners comprise the European Union (EU), United States Agency for International Development (USAID, the Centre for Disease Control and Prevention (CDC), and the United Kingdom's Department for International Development (DFID), Irish AIDS, SIDA (Sweden), the Canadian Department of Foreign Affairs, Trade and Development (DFATD), GIZ, BMGF, World Bank, Swiss Embassy, NORAD, French Aid and the UN family through Zimbabwe United Nations Development Assistance Framework (ZUNDAF) under a Joint Implementation Matrix (JIM).

The Global Fund continues to be one of the major funding partners for HIV/AIDS, TB, malaria programmes and related health systems strengthening - in terms of human resource retention, health information and service delivery. The Ministry of Health and Child Care (MOHCC) has been the Principal Recipient (PR) for TB and malaria grants since January 2015, while UNDP continues to be the PR for the HIV grant. The Health Development Fund (HDF) that was launched on 8 October 2015 (to succeed the Health Transition Fund) targeted raise US$ 682 million in five years (2016-2020). It is now supporting 7 thematic areas: maternal, new-born and child health and nutrition; sexual reproductive health rights; medical products, vaccines and technologies; human resources for health; health financing; health policy, planning, M&E and coordination; and technical support, operations research and innovation. The country successfully included RMNCAH&N in the Global Fund concept note for 2018-21 funding support. The Inter Agency Coordination Committee on Health (IACCH) is a coordination mechanism for health emergency preparedness and response under the MOHCC that continues to function efficiently with support from the WCO as Secretariat backed by DFID grant.

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Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2016–2020)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: Achieving and sustaining UHC through a revitalised PHC approach and sustainable service delivery through strengthening of health systems.	• Strengthen HRH to ensure appropriate recruitment into services to match workload, training that responds to contemporary needs, equitable deployment and appropriate retention schemes. • Support efforts to improve access to and rational use of safe, effective quality medical products; 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. • 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, and advocating for the implementation of a national health insurance. • Strengthening health information systems. • Support national efforts to improve access to comprehensive, person-centred, integrated health services based on PHC.
STRATEGIC PRIORITY 2: Accelerating the achievement of unfinished MDGs relating to reduction of maternal, new-born, child and adolescent mortality; and strengthening sexual and reproductive health.	• Strengthen MOHCC capacity to implement quality and affordable interventions to contribute to reduction of maternal mortality in the country. • Strengthen MOHCC capacity to implement quality and affordable interventions to end preventable deaths of neonates and children below 5 five years of age. • Support MOHCC to ensure universal access to sexual and reproductive health care services. • 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.
STRATEGIC PRIORITY 3: Reducing further the burden on HIV, AIDS, Tuberculosis, malaria, neglected tropical diseases, hepatitis, and other communicable diseases.	• Support national efforts toward attainment of HIV “90-90-90 targets”. • Reduce TB burden in the country as well as introduce new diagnostic and treatment approaches for MDR/TB. • Reduce malaria incidence and support efforts to move towards malaria elimination. • Reduce morbidity due to NTDs especially STH and schistosomiasis. • Reduce morbidity and mortality due to vaccine preventable diseases.
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 underlining socio-economic determinants through people-centred primary health care and UHC.	• Improve access to prevention and control of NCDs in line with the global action plan. • Improve the mental health status of the population through the development and implement of appropriate national policies/strategies and plans. • Support the implementation of multi-sectoral actions to reduce injuries and violence, in particular gender-based violence and violence against children. • Support provision of services for disabled people through more effective policies and integrated community based rehabilitation.
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.	• Improve 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. • Enhance capacity for early detection and prompt response to epidemic and pandemic prone diseases. • Improve capacity for emergency risk and crisis management. • Support efforts to reduce risks to food safety. • Improve capacity to respond to threats and emergencies with public health consequences.

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