WHO Zimbabwe Country Office is pleased to share with its partners and stakeholders its 2014 Annual Report which showcases its contribution to the health sector in Zimbabwe. The country made progress in 2014 both politically and in program work that WHO supports.

Politically, the re-engagement of Western countries which is envisioned to stimulate further ties with partners and begin to erase the negative impact of sanctions that the country bore for many years, was a major step in the right direction for the country.

We congratulate the Government of Zimbabwe for the successful engagement with the Global Fund, where Zimbabwe was used as an early applicant in 2013 under the new funding mechanism, and the country started receiving the funds in 2014 for the 2014 – 2016 funding period; as well as the successful signing of the WHO Framework Convention on Tobacco Control, (WHO/FCTC), which was a major boost of our efforts to control tobacco use, despite a lot of resistance from tobacco growers.

We have witnessed maternal and child health parameters come down dramatically from 960 per 100,000 live births five years ago to about 614 per 100,000 live births in 2014; and there is growing excitement about the possibility of achieving a major dent in the maternal, new-born and child health parameters by the end of 2015. Routine immunization coverages are also on an upward trend with almost all antigens at above 85% coverage (MICS 2014). The net outwards exodus of health care workers seen in the past years has halted, and there is a steady revamping of the health workforce through various staff retention schemes supported by partners.

Although Zimbabwe did not have any cases of Ebola in 2014, the EVD outbreaks in the three West African countries of Liberia, Guinea and Sierra Leone created major anxiety and near panic situation on what to expect if a case was to be imported. The media was caught in a frenzy of rumours, false and alarmist stories of Ebola cases at health facilities in Harare City mainly. WHO was heavily involved in Ebola preparedness in the country as well as quelling the media and public anxiety on Ebola.

We believe the health sector made major gains, both in terms of programmatic work and in the efforts to access the required partners’ resources to support programme activities. However, the gains registered, remain fragile and may not be sustainable. Zimbabwe’s fiscal space remains constrained and more effort is needed to sustain programmes that are funded by partners. To our partners, our message is - address the sustainability question jointly with Government. This is not the time to reduce or withdraw funding. The country still needs a lot of support to ensure that the gains made are not reversed by sudden cuts of support.

We would like to thank the Government of Zimbabwe, partners and our donors for their support during 2014. WHO Zimbabwe Country Office is committed to playing its role in technical support, partnership brokerage, networking and building capacity of national teams to deal with the health problems facing the country.

We are, therefore, pleased to share with you this 2014 annual report that summarises our contributions to the results registered during the year.
NATIONAL CONTEXT: POLITICAL, ECONOMIC AND SECURITY ENVIRONMENT

Despite the continued economic and political challenges felt throughout the year, the situation in Zimbabwe in 2014 can be described as having been generally stable and peaceful with some positive trends in the social sectors.

On the political side, the country remained stable, although there was increased party based factionalism. Factional fighting within the ruling party (ZANU-PF) continued to affect government business. Moreover, the ruling party’s constitution was amended, bestowing on the President increased powers of appointment for party members. In December 2014, the Vice President, 16 Ministers and several other prominent party members were relieved of their government and party posts amidst accusations of corruption. On the other hand, the main opposition party has undergone another split, further challenging its position in the political arena within the country.

Despite some of these challenges, the Government did make some progress in improving the development landscape. An implementation plan for the 2013-2018 Zimbabwe Agenda for Sustainable Socioeconomic Transformation (Zim Asset) was developed in an inclusive manner. In addition, some reform measures were introduced, including ring-fencing high value social spending, targeted tax compliance operations, as well as a framework for the establishment of special economic zones.

Notably, the Government remained committed to strengthening its engagement with key international partners. Investment projects were signed with China and Russia amounting to over USD 8 billion in September 2014. Likewise, the EU has decided to resume direct engagement with the country in November 2014 and high profile economic and political missions from the UK and Denmark were held. Moreover, Zimbabwe reached an agreement with the IMF on Phase 2 of the Staff Monitored Programme. This agreement covers issues of fiscal and budget stability, re-engaging creditors, and providing clarification on key national policies. Combined, these important steps are major milestones which could provide added confidence in the country and the economy going forward.

CRITICAL EVENTS IMPACTING ON HEALTH

The epidemiological situation at the close of 2014 was characterized by localized outbreaks of typhoid fever in the suburbs of Harare and in Manicaland province. Other epidemic diarrhoeal diseases such as dysentery and watery diarrhoea also continued to sporadically occur from all the provinces.

From the 2015 National Budget presented by the Minister of Finance, the Health Budget was allocated 6.57% of the consolidated revenue fund, representing the 7th largest allocation and a reduction from the 4th in 2014. At 6.57% of the national budget, the Health Budget suffers a further slide from the 15% of the Abuja Declaration target. This gradual sliding away from the Abuja target is a worrying development. The overall challenge for the budget allocations in recent years has been the slow disbursement of the allocated figures for programme implementation.

The rains of the 2014 – 2015 agricultural seasons were delayed and erratic, but became more consistent in some areas by the close of 2014. However, most areas received less than normal rains and there are indications of another drought and failed agricultural season. This will worsen the humanitarian situation, and draw the country back from recovery and return it to the humanitarian mode.
OVERVIEW OF PROGRAMMES FOR 2014

Getting to zero – the Zimbabwe HIV/TB journey

HIV continues to be one of the major public health problems in Zimbabwe. Indeed Zimbabwe remains one of HIV high burden countries in sub-Saharan Africa. According to the 2013 HIV Estimates of the Ministry of Health & Child Care, the HIV prevalence was at 14.7%, with an estimated 1.2 million people living with HIV. The recent 2010/2011 Zimbabwe Demographic Health Survey (ZDHS) indicated a drop of HIV prevalence in the general population from 18% in 2005/2006, to 15% in the 2010/2011. The WHO Country Office (WCO) provided technical support in the following areas: development of the operations and service delivery manual and job aides to facilitate the implementation of the 2013 ARV guidelines that the country adapted; revision and harmonization of the national HIV testing and counselling (HTC) guidelines; interim review of the Option B+ Operational plan; PMTCT INSPIRE Implementation research projects; documentation of Zimbabwe’s experience in the adaptation of the 2013 WHO guidelines and implementation progress during 2014 as part of the WHO/GF Partnership; development of the framework for public private partnerships in HIV and TB; prevention and minimization of HIV drug resistance through development of the pre-treatment HIV DR protocols, among others. We also spearheaded further negotiations with the GF for the increase in HIV grants allocations for Zimbabwe. The country was granted an additional USD150 million in 2014. WHO continues to support all GF activities within the country and in 2014 was nominated to be a member of the CCM Oversight Committee - a new prerequisite by GF starting in 2015. However, the dual epidemic of TB/HIV continues to fuel the TB and HIV epidemics in the country, with 60 to 80 % of all newly registered TB patients being dually infected. The initiation of ART among TB/HIV co-infected patients has improved to 77%, from 45% in 2012. WHO supported the roll out of intensified case finding and Isoniazid preventive therapy (ICF & IPT) among people living with HIV (PLHIV). The country has also made commendable progress in the provision of comprehensive HIV/TB prevention, treatment, and care and support services.

The emergence of multi-drug resistant TB poses a challenge to TB control. The country continues to build capacity for TB culture and drug-susceptible test (DST) for first line drugs in two National Reference Laboratories, but there is still no capacity for DST of second line medicines, thus limiting the capacity for the diagnosis of XDR/TB. To address access to MDR/TB treatment, WCO supported the country in putting efforts to decentralize diagnosis and management to district level where MDR/TB management teams are being trained and mentored to equip health workers with appropriate knowledge and skills. This decentralization is also creating challenges of providing quality treatment, care, monitoring and recording.

The country started rolling out the introduction of new TB diagnostic tools – the Gene Xpert for TB diagnosis among risk groups and MDR/TB diagnosis. The availed access to MDR/TB diagnosis is leading to detection of many new MDR/TB cases which is also creating programmatic challenges to ensure that all patients are timely enrolled on treatment and that adequate second line medicines are available for the identified patients.

Overall, there was good progress made in dealing with TB care in the country in 2014, both in terms of enhanced care of HIV/TB co-infection and improved diagnosis. The scale-up of Gene Xpert tool has improved the diagnosis of MDR and XDR/TB. WCO supported the conducting of the first ever TB prevalence survey in the country and results of this survey will be available towards the end of 2015. In the same year WCO provided technical support in the development of the GF/TB Concept note which was approved for funding by the GF Board.
**Malaria**

Malaria is one of the major health problems of public health concern in Zimbabwe. The whole population is at risk of malaria but transmission is mainly seasonal, peaking up in summer (January to May) with the rest of the year having relatively low transmission. Malaria high transmission is mainly along the periphery of the country with high temperature and erratic rainfall. Transmission becomes less but epidemic prone towards the centre of the country. Malaria Control in Zimbabwe is led by the Ministry of Health and Child Care supported by various partners. The Zimbabwe Government remains the main financier of Malaria control supported mainly by the Global Fund and US Presidential Malaria Initiative (PMI). WHO provides the much needed technical support on policy issues, training, programme management, monitoring and evaluation. WCO continued to provide technical support in drafting and revising guidelines, training materials, drafting Global Fund grant proposals, providing leadership and support in assisting the country to adopt and adapt new WHO guidelines, and brokering cross border malaria control initiatives.

**Maternal, new-born and child health**

Results from the recently concluded Multiple Indicator Cluster Survey (2014) show an encouraging improvement of key maternal, new-born and child health (MNCH) and nutrition indicators. The report shows Maternal Mortality Ratio (MMR) has declined from 960 to 614 deaths per 100,000, while under-five mortality rate is now 75 deaths per 1,000 live births (a drop from 86 deaths per 1,000 in 2010). Infant mortality rate is 55 deaths per 1,000 live births (a drop from 58 per 1,000).

Breastfeeding is nearly universal in Zimbabwe, and exclusive breastfeeding rates have improved from 31% to 41%. Stunting rates amongst children under five have improved from 31% to 27.6% (MICS 2014). The percent of children 12-23 months fully immunised increased from 65% to 69% and those immunised for measles increased from 79% to 83%. Neonatal conditions, pneumonia and diarrhoea remain the leading causes of mortality in children under five years in Zimbabwe, with HIV and malnutrition being important underlying causes.
The WCO continued to participate in the routine coordination mechanisms with MoHCC and other UN partners (H4+, Health Transition Fund, Child Survival, Adolescent and Sexual Reproductive Health (ASRH), Gender Theme Group, and Reproductive Health Steering Committee). WCO also continues to support the building of capacity on using the WHO Growth Charts for growth monitoring and assessment for health workers working directly with children at health facilities; and training of health workers (Hospital matrons, district nursing officers, sisters in charge and some government medical doctors) on the WHO Package on Managing Programmes to Improve Child Health.

These gains in child health have been complimented by gains in the EPI programme whose main objective is to reduce under-five morbidity and mortality from vaccine preventable diseases in line with MDG 4. An upward trend has been noted in EPI coverages of all antigens with DTP3 coverage for January to July 2014 at 93%, in line with the GVAP targets. The high vaccination coverage and low drop-out rate of less than 10% for DTP1-DTP3 signify good access and utilization of immunization services. WCO conducted an HPV vaccine preparedness assessment that led to the introduction of HPV vaccine in 2 demonstration project districts, and provided technical and financial support during the successful expansion of the Central Vaccine Stores and installation of cold rooms at both National and provincial levels. Through WHO technical support, the country successfully applied for GAVI New Vaccine Introduction (NVI). The vaccines applied for are IPV, MSD in the form of MR and MR campaign to target 9 months to 14 years children. The applications were conditionally approved by GAVI Board pending some clarifications.

**Promoting healthy lifestyles**

The role of health promotion is increasingly being recognised in Zimbabwe. This is evidenced by the improved resource support towards the Health promotion unit in the MoHCC as well as increased involvement of the Health Promotion unit in emergency preparedness and response; and prevention and control of NTDs among other areas. Significant attention was also given towards the implementation of a Social Determinants of Health (SDH) and Health in All Policies (HiAP) approach. The national health promotion response however remains fragmented and weakly coordinated. This is attributable to the limited breadth and depth of human resources at central level as well as limited financial resources at all levels. Direct budget
support from government remains very limited. This is compounded by the fact that WCO did not receive any funding for HPR and could not adequately support MoHCC in this area. Despite the glaring challenges, a lot of milestones were achieved. The Government of Zimbabwe acceded to the WHO FCTC with the accession tool being registered with the Depository at the UN Treaty Section in December. This followed protracted advocacy, lobbying and support from WCO and AFRO. WCO also successfully lobbied for the endorsement (signing) of the National Health Promotion policy for Zimbabwe by the Minister of Health and Child Care. The policy which was endorsed in April 2014 was developed with support from WHO in 2011, but had not been endorsed by the Government of Zimbabwe. MoHCC was also successfully supported to establish a national level SDH Working Group, comprising focal persons from 10 ministries in the Government of Zimbabwe, including the Office of the President and Cabinet and the MoHCC. In addition, WCO provided technical and financial support towards convening of meetings for the Working Group where a review of national policies, legislation and regulations in relation to SDH in Zimbabwe was also done. A case study on ‘Alcohol policy development and implementation in Zimbabwe’ was jointly submitted by WCO and MoHCC, and was accepted for presentation during the 2nd meeting of the global network of WHO national counterparts for implementation of the global strategy to reduce the harmful use of alcohol in Geneva.

**Tackling the threats of Communicable & Non Communicable Diseases**

Zimbabwe continues to have challenges in the provision of water and sanitation particularly in urban and peri-urban areas, and this has resulted in persistent reports of sporadic cases of typhoid and outbreaks of diarrhoea in Harare and Chitungwiza cities. Inadequate funding and persistent human resource challenges at the MoHCC continue to hamper progress. The national capacity for implementation of the International Health Regulations (IHR) and Integrated Disease Surveillance and Response (IDSR) remains weak. The Government has once again applied for extension of the period required to put in place the required IHR capacity.

The renewed global thrust on the NCDs front has been taken up by the country although a comprehensive NCDs strategy is yet to be developed. Good progress was made in tackling some neglected tropical diseases (NTDs) endemic in the country, with the completion of lymphatic filariasis and blinding trachoma mapping. But IDSR training continued to be faced with severe resource constraints. WCO supported the MoHCC to train health staff in Manicaland, Mashonaland East and Central Provinces in IDSR, to carry out lymphatic filariasis and blinding trachoma mapping; and to produce the National Eye Health Strategy 2014 to 2018, as well as the draft protocol for NCD risk factor surveillance.

**Dealing with Disease outbreaks and other health Humanitarian situations**

In outbreak and disaster management, WCO focused mainly on providing technical guidance on reforms in the coordination of humanitarian response, response to floods, (particularly the Tokwe-Mukosi flood disaster,) health assessments, preparedness for Ebola, capacity building for health staff, and monitoring of communicable disease trends. Following the declaration of Ebola Virus Disease (EVD) outbreaks in West Africa, the country moved very fast to prepare for Ebola with the production of the Ebola Preparedness and Response Plan and training of health workers in EVD with the support of WCO and IST/ESA. Laboratory supplies for EVD diagnosis and personal protection equipment (PPEs) for all strategic health institutions were received and promptly distributed to the relevant national institution for immediate use, while the viral transport media stocks were made available at the NMRL cold room. Zimbabwe has, however, not yet recorded any cases of Ebola importation, but there were several cases of Ebola scare stories reported mainly in the media. WCO assisted the Ministry of Health
and Child Care to move swiftly and quell the rumours and allay the fears of the public. WCO also participated directly in supporting the outbreaks in Sierra Leone and Liberia. One of the very first teams of WHO staff to be mobilised to support the outbreak were from WCO/Zimbabwe. Furthermore, WCO dealt with and addressed major issues surrounding pre-deployment preparation of the first team to go to West Africa; and how to handle them on their return. Spouses and co-workers of returning staff were not fully prepared on handling the returning staff, and remained extremely anxious of what to expect on return of the staff on deployment. Some of them came to WR for explanations to allay the anxiety surrounding the health of these staff. Suffice to mention here that attainment of full IHR (2005) core capacity requirements remained unfulfilled by the time of the June 2014 extended deadline and an application for a second extension to 2016 was submitted to WHO. IHR core capacity is critical in helping the country respond to public health conditions of international concern.

Transforming the Health Cluster into the Inter Agency Coordination Committee on Health (IACCH)

When the decision to transform the Health Cluster into the Inter Agency Coordination Committee on Health (IACCH) was made, WCO provided technical guidance in drawing up terms of reference of the new coordination mechanism. Under the new coordination system, WCO became the secretariat to ensure that it became fully operational. Regular IACCH meetings were held throughout the year. WCO participated and provided technical support to other coordination mechanisms like the National Taskforce on Epidemic Prone Diseases and the National Civil Protection Committee throughout the year. Zimbabwe successfully applied for AFRO public health emergency funds (APHEF) and received US$65,000 which was used to respond to the Tokwe Mukorsi Flood Disaster. Rapid Health Assessments and monitoring missions were conducted to the flood disaster affected areas, and technical as well as material support in the form of medicines and camping equipment were provided by WCO and IST.

Achieving environmental health

Public Health and Environment (PHE) activities lacked financial support throughout the year, and as a result very little was accomplished in this area. A proposal to carry out the Situation Analysis and Needs Assessment (SANA) was submitted to AFRO early 2004, but there was no support received. WCO supported the training of health workers from Parirenyatwa and Harare Central Hospitals in Health Care Waste management (HCWM). Health staff trained included nurses, nurse aids, ambulance crews and general staff. With financial support from WHO/AFRO, WCO supported training on the use of the Urban Health Equity Assessment and Response Tool for health staff and other partners in Bindura Town. A Task Team was established, and this task team will conduct the assessment. A roadmap was drawn up, and the Urban HEART Tool will be implemented in 2015.
Rebuilding Zimbabwe’s health system

Zimbabwe’s health system, as outlined along the WHO six building blocks, remain relatively weak following a decade of unprecedented socio-economic decline characterised by a global record hyper-inflation that resulted in exodus of experienced health workers from the public health sector. Staff exodus was either to local private sector or NGOs, but more considerably to regional neighbouring countries as well as to far off continents. The introduction of the multi-currency regime in addition to several other measures to stabilize the economy resulted in an immediate halt of further decline. The country’s Medium Term Plan (MTP) (2011-2015) marked the return to strategic development planning after the Short-Term Emergency Recovery Programme (STERP) had established macro-economic stability. The implementation of MTP programme then resulted in the restoration of economic stability and growth. The MTP was succeeded by a new socio-economic blueprint, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset) that is now guiding all development.

The health sector has benefited from this economic stabilization and turn around. However, the level of investment in the health by government has worryingly continued to decline since 2013 when MOHCC was allocated $380m ranking 2nd highest, followed by a decline in 2014 to $337m.

Rising poverty levels have also increased vulnerabilities in the general populace against considerable fiscal constraints. Challenges remain in health service delivery with increasing reliability on donor support – raising concerns of sustainability. Efforts to reverse the decline will require more than ordinary concerted efforts to turn around the health sector.

The MOHCC prioritized areas to invest with the few available resources namely Human Resources for Health (HRH); Health Information; Medicines, Vaccines & Medical technology and Leadership and Governance (stewardship). There have been notable achievements already.

WCO provided technical support in conducting the National Health Accounts (NHA) survey using the new Systems of Health Accounts (SHA 2011) tool in June 2014. This is in line with building capacity for institutionalizing NHA. Technical support is being provided on four block release basis by a consultant recruited by WHO/HQ who has undertaken two visits already between August and Dec 2014. WCO is also supporting the implementation of National Health Information and Surveillance Strategy through active involvement in Technical Working Group (TWG). WCO also supported the revision of Essential Medicines List for Zimbabwe (EDLIZ 2011) and Standard Treatment Guidelines based on WHO list of prequalified medicines which culminated in the production of the 7th edition of EDLIZ, as well as other guidelines and strategies, and mobilized resources for health systems strengthening. WCO is also an active member of the UNCT and participates in all UNCT programmes and sits in various UNCT committees.

WHO Promoting Evidence Based programming through Research

Food Consumption Patterns Survey

WHO has been actively promoting generation of evidence through various research. WHO supported the first ever Food Consumption Patterns Survey in May 2014. Nutrition is an important factor in preventing and managing protein-energy malnutrition, micronutrient deficiencies and the diet related chronic diseases. Assessing dietary intake is vital in identifying the inadequacies of the diets consumed. Inadequate diets predispose the people to nutritional problems which may have lifelong effects on
individuals and communities. The results of the survey will inform the design, targeting and implementation of nutrition intervention programmes in Zimbabwe.

Taking Health to the People

WHO promotes healthy behaviours through various commemorations. World Breast Feeding Week is held every year in the first week of August. The theme for 2014 was “Scoring the winning Goal for life”. The World Breastfeeding Week campaign was launched 22 years ago to focus and facilitate actions to protect, promote and support breastfeeding. Since then, each year, the spotlight has been on various breastfeeding issues. This year’s theme helps us to remember the importance of breastfeeding for a child’s healthy growth and development. WHO supported this year’s commemorations which were taken to the community with plays and music to promote breastfeeding.

What enabled the work of WCO in 2014

The success of the different programmes was brought about by a number of facilitating factors such as existing partnerships and effective coordination mechanisms which helped to strengthen collaboration and streamline partner support to MoHCC. Other factors include continued funding support from the Global Fund, and the availability of additional resources like the Health Transition Fund (HTF), and the PMI. These made it possible to implement activities in a financially constrained environment. In the WCO, all programs work in an integrated approach when supporting the MoHCC, and WCO enjoys good working relations with MoHCC and other partners. WHO remains the key technical partner of MOHCC applying its leverage as the UN agency mandated as the leading authority on health; and as co-Chair of the Health Development Partners Group in 2014, WHO also utilized its close relationship with MOHCC to push the national health development agenda with partners. Above all, the greatest facilitating factor was working with a Government which showed commitment to health issues.
Outstanding challenges to WCO work in 2014

A number of challenges were encountered which hampered progress. One of the major challenges is the progressive decline of government allocation of the budget to MoHCC from a high of $380m in 2013 to $300m in 2015, plus the declining releases against these allocations that have continued to range between 40-65%. Linked to this, is the government’s inability to pay for vaccine procurement and to timely meet GAVI co-financing requirements. This threatens the reversal of the gains made in the EPI program. Another challenge for 2014 was the prevailing WHO financial constraints which hampered our ability to provide adequate support to the MoHCC on planned activities.

The Role of the Operations Cluster

The Operations Cluster remains the foundation which supports both Technical Programmes and Administration to achieve the WHO mandate in the country. The Operations team which comprises the Finance, Budget, Human Resource, Procurements, Events and Meetings, Assets Management and Control, Transport, Travel, Protocol, and Security, has been responding on a daily basis to various issues affecting the Programmes, operations, the professional life and the conditions of working environment in the field. This has been made more complex in the context which the WCO hosts the Inter-Country Support Team for Eastern and Southern Africa (IST/ESA), a presence which involves a huge volume of transactions and logistics supports. It is also worth mentioning that the Operations followed with special attention the WHO Regional restructuring initiated by the Regional Director at the beginning of the biennium 2012-2013 with the introduction of the Country Support Unit (CSU). The Admin Cluster supported the smooth flow of programme work through the introduction of innovative and cost cutting ways like printing rationalization and centralization which enabled the WCO to reduce printing volumes by 90%; the installation of CCTV which contributed to reducing by 50% the budget allocated to security; and the introduction of the Straight to Bank payment system which has been very efficient and cost saving in that it reduced the error margin in terms of banking details and also reduced by 70% the printing volume as well as logistics (vehicles, fuel and drivers) between the office and the banks and also facilitated daily imprest reconciliations.

The operations team also managed to raise additional funds for the day to day running of the office through the disposal of obsolete assets for 2014. Following the approval obtained from the Property Survey Committee in AFRO to dispose the selected obsolete assets, an auction was held. The funding raised has been useful for office maintenance and operations. They also designed a template for the monitoring of DFCs which was distributed to all secretaries and programme assistants. Subsequently, we have good returns that show that there is no DFC without at least a partial clearance and none of the DFCs has more than 90 outstanding days required to close them. Regionally, Zimbabwe is one of the countries in the green category on DFC reporting. The Operations Cluster also maintained the working environments at Highlands and Annex, and also complied on MOSS and MORSS upgrades for the vehicles and WHO compound to ensure the safety of staff at all times.

Staffing

The total number of staff as at 31st December 2014 was 38, with women making up 39.5%, and men 60.5%. Of the 38, there are 2 International staff, 10 National Professional Officers (NPOs), and 26 General Service (GS) staff.
EVENTS IN PICTURES

WR presenting a farewell gift to Dr Charimari who left WCO Zimbabwe for WCO South Sudan

NPO ODM inspecting a makeshift clinic at Chingwizi Holding Camp following the Tokwe Mukosi floods

WR signing an MOU with the Principality of Monaco for malaria control activities in Zimbabwe

Staff undergoing Zumba fitness training during the 2014 Wellness Days

Staff at an end of year function hosted by the Staff Association

Representatives of the Staff Association presenting blankets donated by staff to a children’s home