This action is funded by the European Union

ANNEX 1

of the Commission Decision on the Annual Action Plan 2015 in favour of Zimbabwe to be financed from the 11th European Development Fund

Action Document for Improving Health Outcomes for the Population of Zimbabwe

1. Title/basic act/ CRIS number	Improving health outcomes for the population of Zimbabwe CRIS number: ZW/FED/038-192 Financed under the 11th European Development Fund			
2. Zone benefiting from the action/location	Zimbabwe The action shall be carried out in all areas of Zimbabwe while the project team will be located in Harare			
3. Programming document	National Indicative Programme for Zimbabwe, 11th European Development Fund			
4. Sector of concentration/ thematic area	Focal Sector 1: Health			
5. Amounts concerned	Total estimated cost: EUR 436 000 000 Total amount of EDF contribution EUR 55 000 000 This action is co-financed in joint co-financing by the following potential donors for an indicative amount of EUR 381 000 000 - United Kingdom, Sweden, Ireland, Canada and Norway.			
6. Aid modality and implementation modality	Project Modality Indirect Management with an international organisation – UNICEF			
7. DAC code(s)	12220			
8. Markers (from CRIS DAC form)	**General policy objective**	**Not targeted**	**Significant objective**	**Main objective**
	Participation development/good governance	☐	☒	☐
	Aid to environment	☒	☐	☐
	Gender equality (including Women In Development)	☐	☒	☐
	Trade Development	☒	☐	☐
	Reproductive, Maternal, New born and child health	☐	☐	☒

	RIO Convention markers	Not targeted	Significant objective	Main objective
	Biological diversity	☒	☐	☐
	Combat desertification	☒	☐	☐
	Climate change mitigation	☒	☐	☐
	Climate change adaptation	☒	☐	☐
9. Global Public Goods and Challenges (GPGC) thematic flagships	None			

SUMMARY

After a decade of decline, the Zimbabwean health sector initiated a steady recovery in 2011, which has resulted in an improvement on the most critical indicators. The proposed European Union (EU) assistance to the health sector under this action aims at further improving health outcomes for the population. This objective will be achieved through a three pronged strategy that builds on the successful coordinated approach that health development partners have adopted in Zimbabwe since 2011. The action will in the first place implement high impact activities that will allow the primary care health system to protect the population against the most important health threats, in particular those at the root of maternal and child mortality. In the second place the action will strengthen national health systems by improving organizational and managerial skills at provincial and district level, and by strengthening the capacity of human resources for health and ensuring their availability, particularly in rural areas. Finally, the action will promote equal access to health services by supporting the necessary reforms on health financing and governance, both by rolling out a result based financing approach to health structures countrywide and by contributing to the development of appropriate policies and strategies, including enhancing community participation in governance structures.

In order to achieve the desired impact, the action will be co-financed with other development partners by pooling resources into the Health Transition Fund (HTF) administered with UNICEF and into the Health Development Fund (HDF), which will succeed the former in 2016.

1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

Following a decade of negative growth, the Zimbabwean economy has been on a positive trajectory since the inception of the Inclusive Government in February 2009 and the adoption of measures to restore economic stability and growth. However, growth slowed down in 2014 to 3.1% from 10.6% in 2012 and 4.5% in 2013. The slowdown is due to underperformance in the agricultural sector together with other structural challenges such as a huge infrastructure deficit, high external debt burden, liquidity constraints, lack of access to international lines of credit, and low foreign direct investment levels.

The period 2000–2008 also witnessed increased poverty levels, worsened by frequent droughts among other shocks. A poverty report on the 2011-2012 PICES Survey[4] reveals that 72.3% of Zimbabweans are poor, whilst 16.2 % of the households are in extreme poverty. Poverty is most prevalent in rural areas, where 84.3% of people are deemed poor and 30.4% extremely poor. The

[4] Poverty, Income, Consumption and Expenditure Survey, ZimStat 2013

2013 United Nations Human Development Index (HDI) ranks Zimbabwe among low human development countries: 172nd out of 186 countries compared to 1998, when it ranked 130th out of 174 countries. The estimated Gross Domestic Product (GDP) per capita in 2013 was USD 953.8, which classes Zimbabwe as a low income country.

Although both GDP and HDI are still low, some of Zimbabwe's social indicators have improved in the last four years. The Zimbabwe health system in particular has shown a steady recovery since 2011. This has resulted in critical health indicators such as maternal and child mortality showing a significant improvement. Maternal mortality has decreased for the first time in twenty years. While in 2010, the estimated annual maternal deaths were 3,840, this figure has come down to 2,456[5], using 400,000 as the total annual live births. This implies that, within the last couple of years, the country has managed to avert a total of 1,384 maternal deaths annually. Under-5 child mortality is also decreasing; in 2009 there were around 37,600 deaths of children less than 5 years of age annually but this figure has come down to 30,000 in 2014. This again means the country is now able to avert a total of 7,600 deaths of children less than 5 years of age annually.

The key elements assisting this recovery have been:

- A sound National Health Strategy well developed into annual working plans;
- Development Partners' (DPs) support in addressing key bottlenecks;
- Institutional framework and memory still in place throughout the health system, with evidence of strong resilience;
- Available and motivated, albeit weakened, professional staff;
- Focus on essential, high impact interventions based on the key health system pillars;
- Good health seeking behaviour in the population;

In spite of the recovery, Zimbabwe will still be unable to achieve the health related Millennium Development Goals (MDGs) in 2015 with the notable exception of HIV/AIDS. The restoration of an effective health care system is still far from complete, and failure to consolidate and build upon the progress made in the last 5 years would lead to a risk of a decline of the system particularly in view of sluggish economic growth.

1.1.1 Public Policy Assessment and EU Policy Framework

Zimbabwe's economic blue print, the "Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset)" covers the period from October 2013 to December 2018. The plan aims at accelerating growth and prosperity around four strategic clusters and two sub-clusters: Food Security and Nutrition; Social Services and Poverty Eradication; Infrastructure and Utilities; Value addition and Beneficiation; Fiscal Reform Measures; and Public Administration, Governance and Performance Management. While Zim Asset's proposed interventions have been positively assessed by international institutions (World Bank, International Monetary Fund (IMF), United Nations (UN)), the feasibility of their implementation raises a number of questions, particularly in relation to the Government's ability to raise sufficient resources to fund them in the absence of a major international investment effort. Nonetheless, Zim Asset is the basis on which Government will engage with donors in the future and underpins a number of specific sector strategies, including the National Health Strategy.

Zimbabwe has adopted a National Health Strategy for 2009-2015 (NHS) and is currently finalizing a new version covering the period 2016-2020. The NHS is consistent with the EU's policy goals. It aims at providing access to quality and equitable health services to Zimbabweans, with a specific focus on achieving the MDGs directly related to health. The NHS adopts a

[5] All data in the paragraph from Multiple Indicator Cluster Survey – MICS 2014. ZIMSTAT/UNICEF

Primary Health Care approach and intends to strengthen the health system by systematically addressing the World Health Organization (WHO) six building blocks[6]. The NHS was formulated in consultation with DPs and civil society and is considered to be a sound document that provides a clear strategy for improving health outcomes for the population of Zimbabwe. DPs are also involved on the formulation of the follow up 2016-2020 strategy, which is expected to be approved in the last quarter of 2015.

Health makes part of the EU development policy priorities as established in the Communication on "Increasing the impact of the EU Development Policy: an agenda for change"[7]. The NHS' goals are consistent with the Communication on the "EU role in Global Health"[8], as they focus on increasing protection against health threats, on strengthening the national health system and on increasing equitable access of the whole population to quality health services.

1.1.2 Stakeholder analysis

The main sector stakeholder is the Government of Zimbabwe, specifically the Ministry of Health and Child Care (MoHCC) which, in addition to defining the sector's National Policy and Strategy, oversees their implementation and coordinates Development Partners. The MoHCC also supports the annual planning process and provides supporting supervision to the Provincial level.

The UN Agencies involved in the health sector (UNICEF, UNFPA, UNDP and WHO) provide technical assistance, financial management and secretariat support for major external funds such as the Global Initiatives (Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), Global Vaccine Alliance (GAVI)) and the Health Transition Fund (HTF).

The World Bank has conducted a number of studies on health sector financing and is implementing a programme to pilot a Result-Based Management (RBM) approach to the financing of health structures in 18 districts.

A number of bilateral donors provide funding to the sector and are actively contributing to the definition of annual plans and the decision making process through their participation in the HTF steering committee. These include Canada, UK, Ireland, Norway, Sweden, and the EU. The US Government Agencies (USAID, CDC (US Centers for Disease Control and Prevention)) are mainly supporting interventions related to HIV/AIDS, tuberculosis, malaria and sexual and reproductive health. They also attend the HTF steering committee.

The private sector, although gaining relevance, is still scarcely represented in the health sector since the downturn of the economy in 2007, when many industries/companies and the insurance system collapsed. A number of church-related organizations are providing health services within the National Health System.

Non Governmental Organisations (NGOs) have a role in prevention and mitigation actions and in supporting quality assurance. The civil society organisations participate in the major sector's coordination platforms, while local health committees keep the health facilities accountable to the community.

All of the above mentioned stakeholders have been consulted during the identification and formulation phase of this programme and have participated in its design through formal and informal consultations aimed at ensuring that the programme responds to the needs and demands of the various stakeholders in the sector.

The action will support the Zimbabwe national public health service, therefore targeting the whole population of Zimbabwe (13.1 million) with special attention to women, the new-born and

[6] The six building blocks are service delivery, health workforce, information, medicines, financing and governance.
[7] COM(2011)637
[8] COM(2010)128

children, who represent 70% of the population[9]. In addition the HTF targets with allowances, training and capacity building approximately 19,000 public service health staff essential to the delivery of health services.

1.1.3 Priority areas for support/problem analysis

The scope of this action is to support the Zimbabwe's health sector to continue recovering in order to improve health outcomes for the population. There are palpable signs that the health system is recovering. For the first time, Zimbabwe has managed to bend the alarmingly high maternal mortality curve after twenty years of continuous incline[10]. Under-5 and infant mortality rates have also decreased, although the number of deaths remains comparatively high with under-5 mortality rate at 75 deaths per 1,000 live births (compared to the 2009 rate of 94/1000), and infant mortality at 55/1000 (compared to the 2009 rate of 65 per 1000). Maternal mortality at 581/100,000 live births in the five years preceding the survey is still well above the regional average.

The NHS highlights four major sector weaknesses in Zimbabwe: deficit of medical and managerial health professionals; irregular availability of essential medicines and medical supplies; inadequate provision and maintenance of equipment and infrastructure especially at peripheral level; and disrupted basic utilities and services. Furthermore, it recognizes that "user fees" continue to be a barrier to access health care for the majority of the population, particularly women and vulnerable groups. In 2010, the MoHCC produced a "Health Sector Investment Case" that analysed both the costs of the package of health services needed to achieve the MDGs and the existing financial gap. It concluded that human resources for health and essential health commodities were the major supply side bottlenecks and that maternal and child health were the most underfunded programmes in the sector, as other critical areas such as HIV/AIDS, malaria and tuberculosis were covered by ongoing programmes funded by the Global Fund and USAID.

While the support provided by DPs in the last four years, in particular through the "Health Transition Fund (HTF)", has partially addressed the system weaknesses and contributed to the system recovery, there is a need to focus on improving the quality of health services provided to mothers and children if maternal and child mortality are to be further reduced. This requires the continuation of the HTF's comprehensive approach, which addresses all health system building blocks that are crucial for the health system to be fully functional. In addition, the health system still needs to address the disparities due to geography, wealth, religion and other socio-cultural factors, and age. User fees at the different levels of health care limit access to health care for poor people who are not able to pay. The following are priority areas for support:

On Maternal, New-born and Child Health (MNCH), and Nutrition an adequate volume of services is now being delivered at the appropriate levels, but there is a need to focus on the continuum of care across the life cycle, on greater quality of care and on more equitable service accessibility.

On Medicines and Commodities much of the infrastructure and equipment is already in place, but there is a need to support their service and maintenance, linked to the Results-Based Financing mechanism that is being rolled out since mid-2014. The current high levels of availability of shortlisted essential supplies have to be maintained, and a more efficient and appropriate supply chain mechanism needs to be established

On Human Resources for Health, the critical staff retention scheme is still required to ensure that adequate numbers of appropriately trained staff are in place, although a more cost effective

[9] The National Health Strategy for Zimbabwe 2009-2013
[10] Multiple Indicator Cluster Survey – MICS 2014. ZIMSTAT/UNICEF

system needs to be developed. Critical training needs have mostly been addressed in the past years but mentorship and supervision capacities need to be strengthened in order regularly assess the level of quality of care.

On Health financing, a Result-Based Financing mechanism or RBF was introduced for rural health centres in mid-2014. As this mechanism is still in the process of being established and tested across the country, there is a need to ensure that an effective and efficient system is in place, looking in particular into the extent to which the use of resources is performance related. The full removal of user fees continues to pose a challenge in a few places, mainly in those facilities run by local government as well as at higher referral levels, which causes delays in clients reaching hospitals.

On Health Policy, Planning, Monitoring and Evaluation (M&E) and Coordination, there is a need to strengthen the management capacities of provincial and district teams of the MoHCC in order to ensure comprehensive and inclusive governance of the health sector and establish an appropriate level of decentralisation.

Funding remains a critical problem underlying the health sector. The national macroeconomic situation remains uncertain, and the rate at which government can increase its expenditure on health is still limited, but there is some space for the proportion of public expenditure allocated to health to be increased from the current 8% of the National 2015 Budget towards the 15% Abuja target to which Government has committed. DP funding is still required in the mid-term, although a progressive shift needs to take place from support to recurrent costs (that need to be increasingly funded by government) to a combination of necessary recurrent support and investments that make funds from all sources more effective.

2 RISKS AND ASSUMPTIONS

Risks	**Risk level**	**Mitigating measures**
<u>Government policy and capacity</u> Weak sector coordination capacity between and among health development partners Ministry of Finance (MoF) and MoHCC EU Delegation not sufficiently resourced to lead coordination of bilateral donors and Global Health Initiatives effectively	**Level L**	Harmonize and integrate existing different information sharing and coordination platforms and mechanisms. Ensure availability of technical assistance. Manage 2015 transition of both health specialist and head of sector effectively. Relevant European Commission services to consider options for improving effectiveness of staff rotation. (forecasting, maintaining cadre of health specialists, rotation management by thematic directorates)
<u>Environmental and climate change</u>: -Possible negative environmental impact of new health infrastructure works.	**Level L**	An environmental impact assessment will be carried out in line with EU guidelines in case of major infrastructure works.

Finance -Macroeconomic environment not stable enough for MoHCC to be able to drive the implementation of the National Health Policy. -Budget allocation to the health sector remains insufficient not reaching 15% as per Abuja Declaration. -Human resources for health salary scale and non-financial benefits insufficient to retain staff in their working stations. - Global Health Initiatives (Global Fund, GAVI) and other major donors of health aid considerably reduce their allocations to Zimbabwe	**Level M**	-Engage with Government to help overall national economic recovery. -Enhance dialogue between Government, EU, and other donors about equitable national budget redistribution in favour of social services. Support Human Resources for Health (HRH) policy implementation and sustainability. -EU Support to Public Financial Management and the elaboration of a medium term financial framework. The European Commission relevant service follows up on the board of Global Fund and GAVI that resources continue to be channelled to effective programmes in countries most in need.
Assumptions		
-Key government planning documents and strategies are in place. They are defined with a transparent and consultative approach and they are shared with all relevant stakeholders. -NAO and MoHCC are committed to engage in identification and implementation of the activities. -Human and financial resources are available and gradually increase. -All identified thematic areas are indivisible/interdependent and need to be supported in order to achieve the overall objective of the programme.		

3 LESSONS LEARNT, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

Most of the EU support to the health sector has been channelled through the Health Transition Fund (HTF) since its inception in 2011. This is a sector pooled funding mechanism administered by UNICEF which supports the implementation of the NHS 2009-2015. The HTF has undergone a mid-term review, as well as annual joint reviews from which the following lessons can be drawn:

- The implementation at scale of a critical mix of demand and supply side interventions, largely supported through the HTF and other initiatives, has been successful in strengthening the health system and in generating demand for services.
- There is a need to improve quality of care. Most of the under-5 deaths reported in Zimbabwe occur during the neonatal period. There are enormous opportunities for the health system to capture most of the deliveries and of the new-borns at risk at facility level; therefore, the identification of gaps in quality of care, the assessment of human resources competencies and the introduction of mechanisms for quality improvement are essential to maximize the benefits of the investments done so far to restore the availability of services at all levels of the system.
- DP support to the health sector through the HTF has been key in contributing to the availability of essential services throughout the health systems, thanks to its sustained, horizontal investment in supplies and commodities, the health worker retention scheme and

the decentralization of funding towards peripheral health structures. Future donor support to the health sector should include an exit strategy with regard to procurement, the health worker retention scheme and the health services fund, to avoid shocks or discontinuity of essential services.

- Future support to the health sector should include an acceleration plan targeting high priority areas of Zimbabwe where most of the child mortality occurs.
- Focused, evidence-based investments are required to further enhance the quality of essential maternal, new-born and child health services mortality outcomes in Zimbabwe are to be improved.
- Systems should be put in place and/or strengthened to monitor and improve the quality and effectiveness of the training and its relevance and applicability in the work place and for health worker performance.

3.2 Complementarity, synergy and donor coordination

This programme is complementary with ongoing and previous EU funded actions in the health sector. The action will provide both a last contribution to the HTF that the EU has funded since 2011, and initial funds to support the "Health Development Fund (HDF)", that will run from 2016 to 2020 aiming at consolidating and improving the gains made. The HDF is the continuation of the work currently supported through the HTF. Both the HTF and the HDF are sector-pooled funding mechanisms, their aid method and the action management modality remain the same and there will be no disruption between the two. In addition, this programme complements the ongoing "Revitalizing Maternity Waiting Homes and Other Related Services" programme, which was funded under the MDG initiative and aims at reducing maternal mortality.

Both HTF and HDF are complementary to programmes fighting HIV/AIDS, malaria and tuberculosis that the US (about USD 100 million per year) and the GFATM (USD 535 million for 2014-2016) are funding. They are also complementary to the Integrated Support Programme funded by UK, Norway, Ireland and Sweden, which focuses on improving sexual and reproductive health, and to the USD 15 million provided by the GAVI Alliance for Vaccines and Immunisation every year. EU contributions from EDF and GPGC to the Global Fund account for roughly 5-6% of all Global Fund resources (at GAVI about 2%). This means that the EU share of Global Fund and GAVI resources provided to Zimbabwe every year are roughly equivalent to the amounts provided through its bilateral programme. It is therefore in the EU’s interest to ensure that both investments are mutually reinforcing each other.

There is a strong coordination among the health sector stakeholders in various groups with varying scope and overlapping memberships. Development partner and Government policy dialogue takes place through the Health Partners Development Forum chaired by the Minister, which brings together all the sector stakeholders on a bi-annual basis. The Health Development Partners Coordination Group (HDPCG) meets every two months and facilitates coordination and information sharing among development partners. MoHCC Annual Plans are discussed in bi-annual meetings organized by the MoHCC, chaired by the Permanent Secretary and attended by all Provincial Health Executives (PHEs), development partners, and other stakeholders including relevant state and para-state institutions, and civil society organizations. In addition, there are programme specific coordination platforms such as the GFATM Country Coordination Mechanism, the HTF Steering Committee, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) meetings, and the Integrated Support Programme Steering Committee. The EU Delegation has so far ensured good coordination between the various coordination groups through regular attendance and information exchange. However, more effective coordination structures and processes across the various groups will be necessary.

3.3 Cross-cutting issues

Across these thematic areas, there will be specific attention paid to:

Gender: Barriers (including fees) to health care in pregnancy are a critical factor in girls' vulnerability and inequality in society. The action will promote gender equality and women and girls' empowerment through a national scale programme that alleviates those barriers. In addition it will provide gender sensitive training for male and female community health workers including skills to tackle social issues facing women, and communication skills to support good maternal nutrition and exclusive breastfeeding. The action will also ensure age and sex disaggregated data in all stages of the programme cycle (analysis, implementation, monitoring, and evaluation) wherever required.

HIV/AIDS: HIV/AIDS direct interventions are not a direct focus of this action, because of the existence of other financing mechanisms in Zimbabwe. However, HIV is inextricably linked to maternal and child health. Improving maternal neonatal and child health overall will also strengthen the continuum of HIV prevention, care and treatment for women and children.

Good Governance: The action includes specific activities aimed at improving the governance of the health systems. Specific support will be provided to develop management and organizational capacities, especially at MoHCC provincial and district levels. In addition the action will facilitate community participation in the governance of health structures.

Environment: In case the rehabilitation of some of the health structures is required, emphasis will be put on using environmental friendly techniques for construction. Appropriate environmental practices will also be promoted in ensuring safe disposal of medical products wastes.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results

The overall objective is to contribute to the improvement of health outcomes for all the population of Zimbabwe.

The action will have the following specific objectives:

Specific Objective 1. To increase the protection of both women and men against health threats.

Result 1.1: Increased population access to maternal, neonatal and child health services in quantity and quality, including a comprehensive approach to sexual and reproductive health.

Result 1.2: Epidemic diseases timely detected and controlled and burden of non communicable diseases (NCD) reduced.

Result 1.3 Increased Population coverage related to preventable conditions/diseases.

Result 1.4 Reduced percentage of under-5 children wasted and/or stunted.

Specific Objective 2. To strengthen and further develop the national health system.

Result 2.1 Improved organization and management of services.

Result 2.2 Improved quality and availability of services provided by health facilities.

Result 2.3 Human resources for health numbers, skills and distribution optimized.

Specific objective 3: To reduce inequalities in access to quality health services.

Result 3.1 Improved access to and better utilization of health services by the most at risk groups of the population.
Result 3.2 Better health sector governance, management and financing.
Result 3.3 Sound policies, strategies and regulations for the health sector in place.
Result.3.4 Enhanced community participation and involvement in improving health and quality of life.

4.2 Main activities

In order to achieve the above results and objectives, this action will provide funding to the ongoing sector pooled fund administered by UNICEF, the Health Transition Fund, as well as to its successor, the Health Development Fund, which will be launched in 2016. Both Funds will include the following activities:

Activities linked to Result 1.1: Improvements achieved in obstetric and new-born care under the HTF will be consolidated by targeting with additional support geographical areas with the worse performing records, strengthening the referral systems and support to referral points, supporting further human resources capacity building through clinical mentorship and targeted on-the-job training, improving quality of antenatal care and supporting the implementation of the national policy on postnatal care; and improving essential new-born care by ensuring that all health facilities conducting deliveries are equipped and trained in essential new-born care and management of birth asphyxia, and improving the management of neonatal sepsis. Concerning sexual and reproductive health-care services, the action will focus on enhancing the skills of health workers in communicating effectively with youth and providing youth-friendly services and supporting village health workers (VHWs) to work with youth in communities and facilitate their access to appropriate services.

Activities linked to result 1.2: Supporting the preparedness and response to communicable diseases outbreaks through the overall health system strengthening by improving communication networks and alert systems for disease outbreaks.

Activities linked to Result 1.3: Substantial progress has been made under the HTF on introducing new vaccines, expanding coverage of immunization, and conducting integrated management of neonatal and childhood illnesses (IMNCI) training. The present action will focus on targeting geographical areas showing the weakest performance in service coverage, particularly reaching out to those mothers and children not accessing services due to geographical remoteness or religious/ social beliefs. Activities will aim at finding innovative ways of reaching the hardest-to-reach populations; consolidating and strengthening the triaging system (fast-tracking the clinical care of very sick children); strengthening the link with the community health system and the work of VHWs; and improving awareness in health staff about ensuring good overall health in children, and actively seeking illness with each contact point.

Activities linked to Result 1.4: The action will build the national capacity in maternal, infant and young child nutrition by enhancing the implementation of growth monitoring and promotion using WHO growth standard guidelines; improving the quality and care for children with severe acute malnutrition*;* increasing micronutrient coverage for young children and pregnant women; strengthening capacity of nutrition managers and implementers in knowledge transfers, skills development and supportive supervision through differential strategies; improving quality of the nutrition information system at all levels; and demonstrating multi-sectoral community based approach models to reduce stunting in selected vulnerable districts

Activities linked to result 2.1: Improving supervision, monitoring and quality reporting by establishing a quality assurance system; introducing MNCH quality score cards within the regular supervision system; and strengthening facility based Maternal and Neonatal death reviews and audits and the use of audit data to improve decision making and action by managers.

Activities linked to result 2.2: Procurement of essential medical products, vaccines and technologies (medicines, nutrition commodities and consumables); supporting the ongoing transition from a push to an assisted pull system of ordering of medicines and other commodities, further linking and integration of HIV-related services to the general health system and facilitate a comprehensive approach to antiretroviral supplies and overall health of mothers and children

Activities linked to result 2.3: Completing a staff workload need assessment and supporting the implementation of findings within the national human resources planning framework; reviewing the approach to post-basic in-service training at national level so that there is a nationally coordinated, and provincially implemented, training programme covering all appropriate subjects; ensuring continued retention of key staff by providing critical post allowances; and supporting the current review of the retention system at national level to ensure a gradual move towards a comprehensive, nationally driven, fair system of provision of fair wages and benefits to all health workers.

Activities liked to result 3.1: Ensuring full abolition of user fees for key MNCH services through the RBF mechanism;

Activities linked to result 3.2: Improving the financing of the health system by completing the rolling out the RBF mechanism in rural health centres, including training at all levels; considering performance-based strategies for other funding support; ensuring adequate learning from the RBF experience to inform a future plan for performance-based strategies in the health sector.

Activities linked to result 3.3: Providing technical support to the MoHCC to generate the necessary evidence in order to develop strategic and annual work plans; strengthening the routine health sector M&E system, strengthening the routine health management information system, supporting national and provincial review and planning meetings, establishing a programme of provincial health teams and district health team meetings.

Activities linked to result 3.4: Strengthening the effectiveness of health centre committees by supporting ongoing capacity building activities and monitoring their impact; strengthening and supporting a system to facilitate and monitor the VHWs in the implementation of their roles, initiation of integrated Community Case Management (iCCM) by supporting newly trained VHWs to improve community awareness about services; reviewing and developing appropriate guidelines on community management of illness; and ensuring adequate support for VHWs from the health staff in the RHCs.

4.3 Intervention logic

The intervention logic behind the identified results and activities is based on the analysis of the status of the health sector in Zimbabwe undertaken during the preparation of the National Indicative Programme, with the additional input provided by the evaluations, studies and surveys carried out in the second half of 2014, in particular the Multiple Indicator Cluster Survey 2014 and the HTF mid-term review.

The analysis concludes that coordinated interventions by DPs in the health sector in support of the NHS, notably through the HTF, have significantly contributed to the health sector recovery

after many years of decline. However, there is a risk of stagnation if past interventions focused on ensuring appropriate quantitative levels of primary health care do not evolve into actions aimed at improving the quality of care and if the current inequality in access to health is not reduced. This is particularly true for maternal and child care indicators, which are still very high compared to regional averages.

The action assumes that supporting public health service delivery in a comprehensive manner is the most effective approach to enhance equal access to quality health services. This will in turn result in achieving the overall objective of improving the health outcomes for all the population of Zimbabwe. In order to achieve that a three pronged strategy is proposed:

- The action will in the first place support high impact interventions in primary health care structures in order to ensure their capacity to protect the population against the main health threats. Taking into account that there is alternative and complementary funding available for HIV/AIDS programmes, the action will focus in particular on maternal and child health, including a nutrition component. Activities will target all peripheral health structures with a special focus on geographical areas showing the worst indicators in this regard.
- The action will in the second place strengthen national health systems by improving organizational and managerial skills at provincial and district level, strengthening the capacity of human resources for health and ensuring their availability, particularly in rural areas, so that peripheral structures are able to provide quality services to the rural population.
- Finally, the action will promote equal access to health services by supporting the necessary reforms on health financing and governance (rolling out a results based financing approach to health structures countrywide), the development of appropriate policies and strategies and enhancing community participation in governance structures.

In order to provide such a comprehensive approach successfully, there is a need to pool donor resources in support to the government's National Health Strategy. The Health Transition Fund administered by UNICEF has done that with remarkable success since 2011. The action will therefore continue to support both the HTF in its last year of implementation and its successor, the Health Development Fund, which will run from 2016 to 2020. This will also be the approach that other development partners currently supporting the HTF will take.

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country, referred to in Article 17 of Annex IV to the ACP-EU Partnership Agreement.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.1 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date of entry into force of the Financing Agreement.

Extensions of the implementation period may be agreed by the Commission’s authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute a non-substantial amendment in the sense of Article 9(4) of Regulation (EU) 2015/322.

5.3 Implementation modalities

5.3.1 Indirect management with an International Organization

This component will be used for the implementation of all activities listed under section 4.2 from 1 April 2015 to 31 December 2015.

This action will be implemented in indirect management with UNICEF in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012 applicable by virtue of Article 17 of Regulation (EU) 2015/323. This implementation entails the management of the implementation of the last phase of the Health Transition Fund. This implementation is justified because of UNICEF's specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of maternal and child health. Moreover, UNICEF in Zimbabwe has proven to have a strong capacity to manage pooled funds, such as the HTF, the Education Transition Fund, and the Child Protection Fund. UNICEF has been an efficient and appropriate HTF manager since the Fund was set up in the last quarter of 2011.

The entrusted entity would carry out the following budget-implementation tasks: undertaking the tendering, selection and concluding contracts of grants and supply, service and works and making payments resulting from those contracts. UNICEF will use the combined resources of all donors to the actions for the funding of these contracts. They are awarded and implemented in accordance with the procedures and standard documents lay down and published by UNICEF. While UNICEF will provide technical know-how, UNICEF staff will be mostly involved in the management of the above mentioned contracts.

The entrusted international organisation is currently undergoing the ex-ante assessment in accordance with Article 61(1) of Regulation (EU, Euratom) No 966/2012 applicable by virtue of Article 17 of Regulation (EU) 2015/323. The Commission’s authorising officer responsible deems that, based on the compliance with the ex-ante assessment based on Regulation (EU, Euratom) No 1605/2002 and long-lasting problem-free cooperation, the international organisations can be entrusted with budget-implementation tasks under indirect management.

The Commission authorises that the costs incurred by the entrusted entity may be recognised as eligible as of 1 April 2015 because even including the commitments from other donors including previous ones by the EU, a significant funding gap remains for the year 2015. A request by UNICEF has been received on 9 March 2015.

5.3.2 Indirect management with an International Organization

This component will be used for the implementation of all activities listed under section 4.2 from 1 January 2016 to 31 December 2020.

This action will be implemented in indirect management with UNICEF in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012 applicable by virtue of Article 17 of Regulation (EU) 2015/323. This implementation entails the management of the implementation of the Health Development Fund. This implementation is justified because of UNICEF's specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of maternal and child health. Moreover, UNICEF in Zimbabwe has proven to have a strong capacity to manage pooled funds, such as the HTF, the Education Transition Fund, and the Child Protection Fund. UNICEF has been an efficient and appropriate HTF manager since the Fund was set up in the last quarter of 2011.

The entrusted entity would carry out the following budget-implementation tasks: undertaking the tendering, selection and concluding contracts of grants and supply, service and works and making payments resulting from those contracts. UNICEF will use the combined resources of all donors to the actions for the funding of these contracts. They are awarded and implemented in accordance with the procedures and standard documents lay down and published by UNICEF.

While UNICEF will provide technical know-how, UNICEF staff will be mostly involved in the management of the above mentioned contracts.

5.4 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility in accordance with Article 22(1)(b) of Annex IV to the ACP-EU Partnership Agreement on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.5 Indicative budget

Module	**EU contribution (EUR)**	**Indicative third party contribution (EUR)**
5.4.1 – Indirect management with UNICEF: Health Transition Fund for period: April to December 2015	12 000 000	42 000 000
5.4.2 – Indirect management with UNICEF and Health Development Fund for period: 2016 to 2020	42 900 000	339 000 000
5.10 – Audit	100 000	
Totals	55 000 000	381 000 000

5.6 Organisational set-up and responsibilities

A Project Steering Committee will be responsible for the oversight and decision making of the HTF/HDF. The HTF/HDF Steering Committee will be composed of MoHCC, funding partners to the HDF, UNICEF, World Bank, USAID, CDC, WHO, UNFPA, UNDP, UNAIDS, Civil Society representatives (local and international NGOs) and the Health Services Board. UN agencies will also serve as technical advisors and UNICEF will a serve as the Secretariat.

The Steering Committee will be co-chaired by the Permanent Secretary of the MoHCC and a Funding Partner. Funding partners will select a funding partner who will serve as Co-Chair of the HTF/HDF steering committee. The HTF/HDF steering committee will meet monthly. If necessary, this could be changed to every other month or quarterly as implementation progresses.

UNICEF will have two distinct roles in the HDF - as fund holder and programme manager, and as a potential implementing partner in areas in which it has a comparative advantage as determined by the steering committee. A number of safe-guards will be put into place to ensure transparency and segregation of duties as necessary.

The majority of the HTF/HDF activities are executed by the MoHCC, but contracted and paid for by UNICEF. Other specific components are delivered by academic or research institutions, private sector companies, UN agencies, or non-governmental organizations using UNICEF tender or partnership cooperation agreement procedures. The Terms of Reference for subcontractors will be approved by the HTF/HDF Steering Committee, with contracts awarded based on comparative advantage, ability to deliver results and value for money. Key comparative advantages will be

considered in areas where a national programme and provider are already engaged and performing successfully.

5.7 Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.8 Evaluation

Having regard to the importance of the action, a mid-term evaluation and a final evaluation will be carried out for this action or its components via independent consultants contracted by the implementing partner. The mid-term evaluation will be carried out for problem solving and learning purposes, in particular with respect to future EU interventions in the sector. The final evaluation will be carried out for accountability and learning purposes at various levels, including for policy revision.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

5.9 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

Indicatively, one contract for audit services shall be concluded under a framework contract in 2020

5.10 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU.

This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.5 above. However, no budget is foreseen in this programme for communication and visibility as these measures will be funded through the Health Development Fund budget managed by UNICEF.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities.

Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.

Partners' visibility plan will be included every year in the HDF Annual Plan and approved by the HDF Steering Committee. The HTF logo is going to be redesigned for the implementation of the HDF ensuring that funding partners are well represented. More in detail the EU visibility will be enhanced through specific visibility events at the contracts' signature, reports' presentation on mid-term reviews and impact evaluation results. Further, UNICEF will ensure that EU support will be always mentioned during meetings with health personnel at various levels and at community level.

APPENDIX - INDICATIVE LOGFRAME MATRIX[11]

The activities, the expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and may be updated during the implementation of the action without an amendment to the financing decision. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for listing the activities as well as new columns for intermediary targets (milestones) when it is relevant and for reporting purpose on the achievement of results as measured by indicators.

	Intervention logic	Indicators	Baselines (incl. reference year)	Targets (incl. reference year)	Sources and means of verification	Assumptions
Overall objective: Impact**	**CONTRIBUTE TO THE IMPROVEMENT OF HEALTH OUTCOMES FOR ALL THE POPULATION OF ZIMBABWE**.**	-Maternal Mortality Ratio (MMR) -Under-5 Mortality Rate (U5MR) -Neonatal Mortality Rate -Prevalence of Stunting Children under 5	614 per 100,000 live births (2014) 75 X 1,000 live births (2014) 29 X 1,000 live births (2014) 28% (2014)	<100 X 100,000 live births (2020) < 40 X 1,000 live births (2020) 20 X 1,000 live births (2020) 19% (2020)	-Demographic and Health Survey (DHS) -Multiple Indicator Cluster Survey (MICS)	-Government remains committed towards health -Health Development Partners continue to support technically and financially the sector

[11] Indicators aligned with the relevant programming document are marked with '*' and indicators aligned to the EU Results Framework with '**'.

Specific objective(s): 1.Outcome(s)*	**S.O.1 To increase the protection of both women and men against health threats*.**	-% of Children under 5 with pneumonia treated with antibiotics -% of Children under 5 with diarrhoea treated with ORT and Zinc	34% (2014) 14% (2014)	60% (20220) 50% (2020)	-DHS - MICS	-The overall country socio-economic situation improves
Specific objective(s): 2. Outcome(s)S	**S.O.2 To strengthen and further develop the national health system**.**	-Status of Quality Assurance Policy and Tools -% of District Hospitals with at least two doctors -% of District Hospitals with the capacity to provide blood transfusion for EmOC -Number of Health Facilities with working communication equipment - Number of districts accessing the District Health Information System 2	Under Review 80% (2014) 60% (2013) 1.165 (2013) 7 (2013)	QA Policy and Tools in use at all Health Facilities 90% (2020) 90% (2020) 1.597 (2017) 63 (2017)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS -National Integrated Health Facility Assessment (NIHFA)	- Availability of basic services is regular (electricity, water, etc.) -Trained and qualified health personnel retained -Equipment available and in good working condition
Specific ** objective(s): 3. Outcome(s)	**S.O.3 To reduce inequalities in access to maternal and child quality health services**.**	- % of national budget allocation to health - % of hospital institutions not charging user fees for maternal and child health care	8% (2014) 0% (02014)	15% (2020) 50% (2020)	Blue Print – National Budget estimates and Expenditures - National Integrated Health Facility Assessment (NIHFA)	As Above

Outputs S.O.1 **	**1.1: Increased population access to maternal, neonatal and child health services in quantity and quality, including a comprehensive approach to sexual and reproductive health.**	-% of institutional deliveries -% of facilities providing 6 selected signal functions of basic emergency Obstetric and newborn services -% of facilities Implementing IMNCI -% of women using modern methods of contraception.	65.1% (2013) 57% (2014) 41% (2009) 58.7% (2013)	85% (2020) 100% (2020) 95% (2017) 70.0% (2017)	-National Health Information System -Provincial Medical Directors' Reports - DHS - MICS -NIHFA	As Above
	1.2: Epidemic diseases timely detected and controlled and burden of Non Communicable diseases (NCD) reduced.	-% of cholera outbreaks detected within 48h and controlled within 2 weeks; -Number of women at risk screened for cervical cancer at least once in a given year.	100% 60,000 (2013)	100% 240,000 (2017)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS	As Above
	1.3: Increased Population coverage related to preventable conditions/diseases.	-Number of 1-year-old fully immunised (Penta 3 Coverage) -Number of 1-y Year-old immunized against measles; -% of population who slept under Long Lasting Insecticidal Net the previous night of the survey.	56% (2013 84% (2013) 94.5% (2013)	80% (2020) 90% (2020) >95% (2020)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS	As Above
	1.4: Reduced percentage of under-5 children wasted and/or stunted.	-Prevalence of acute malnutrition (weight/height).	3.0% (2011)	1.5%(2020)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS	As Above
Outputs S.O.2 **	**2.1: Improved organization and management of services.**	-Health information system compliance on completeness.	82% (2013)	95% (2020)	-National Health Information System -Provincial Medical Directors' Reports	As Above
	2.2: Improved quality and availability of services provided by health facilities.	-Percentage availability of vital medicines.	65.7% (2013)	100% (2020)	-National Health Information System -Provincial Medical Directors' Reports	As Above
	2.3: Human resources for health numbers, skills and distribution optimized.	-Human Resources for Health vacancy rates.	15% (2013)	< 5% (2020)	-National Health Information System -Provincial Medical Directors' Reports	As Above

Outputs S.O.3 **	**3.1: Improved access to and better utilization of health services by the most at risk groups of the population.**	-Number of Out Patient (OPD) new cases in a given year.	8,735,514 (2013)	To be defined	-National Health Information System -Provincial Medical Directors' Reports	As Above
	3.2: Better health sector governance, management.	-% of Health Facilities providing user fee free services for mothers, children under 5 and elderly	40% (2014)	100 % (2020)	-Provincial Medical Directors' Reports -DHS -MICS	As Above
	3.3: Sound policies, strategies and regulations for the health sector in place.	-Availability of updated National Health Policy/Strategy.	NO (2014)	Yes (2016)		As Above
	3.4: Enhanced community participation and involvement in improving health and quality of life.	Number of primary care facilities applying Results Based Financing (RBF) and having an active Health Centre Committee.	320 (2013)	1,106 (2017)	Result Base Financing Reports	As Above