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This action is funded by the European Union

ANNEX

of the Commission Decision amending Commission decision C(2015) 5386 on the Annual Action Programme 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, all regions. The action shall be carried out in all areas of Zimbabwe while the project team will be located in Harare.			
3. Programming document	11th EDF National Indicative Program 2014-2020			
4. Sector of concentration/ thematic area	Focal Sector 1: Health			
5. Amounts concerned	Total estimated cost: EUR 697 000 000 Total amount of EDF contribution EUR 75 685 000 This action is co-financed by the following potential donors for an indicative amount of EUR 621 315 000: - United Kingdom, Sweden, Ireland, Canada and Norway (for the Health Transition Fund - HTF); - United Kingdom, Sweden, Ireland and GAVI (for the Health Development Fund, HDF).			
6. Aid modality(ies) and implementation modality(ies)	Project Modality - Indirect Management with UNICEF - Indirect Management with UNFPA			
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			
10. Sustainable Development Goals (SDGs)	Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages Sustainable Development Goal 5: Achieve gender equality and empower all women and girls			

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 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 administered by UNICEF and into the Health Development Fund, 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 initiated a positive trajectory following 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 the World Bank revised the economic growth for 2015 from the projected 4.2% to 3%. The slowdown was due to low investment levels, poor performance in the mining sector, under performance in the agricultural sector, due to a prolonged drought, 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 2016 United Nations Human Development Index (HDI) ranks Zimbabwe among low human development countries: 154 out of 188 countries compared to 1998, when it ranked 130th out of 174 countries. The estimated GDP per capita in 2016 was USD 979, 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 five 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 five 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' (DP) support in addressing key bottlenecks;
- Institutional framework and memory still in place throughout the health system, with evidence of strong resilience;

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

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

- 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 was still unable to achieve the health related Millennium Development Goals (MDGs) in 2015 with the notable exception of HIV/AIDS. Lack of 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 and non-attainment of the Sustainable Development Goals (SDGs).

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)"*[6] 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 (WB, IMF, 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 2016-2020[7] (NHS).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 SDGs directly related to health. The NHS adopts a Primary Health Care approach and intends to strengthen the health system by systematically addressing the World Health Organization (WHO) six building blocks[8]. 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.

The New European Consensus on Development[9] defines affirms the importance of health as central to people's lives and a key element of equitable and sustainable growth and development, including poverty eradication and reaffirms the commitment of the EU and its Member States reaffirm to protecting and promoting the right of everyone to enjoy the highest attainable standard of physical and mental health, so as to promote human dignity, well-being and prosperity. In particular it states that in support of this commitment the EU and its Member States will continue to support partner countries in their efforts to build strong, good quality and resilient health systems, by providing equitable access to health services and universal health coverage.[10] The NHS' goals are consistent with the Communication of the "EU role in Global Health"[11], as they focus on increasing protection against health threats, on strengthening the

[6] Endorsed by the cabinet in October 2013
[7] Launched on 23 January 2017
[8] The six building blocks are service delivery, health workforce, information, medicines, financing and governance.
[9] OJ, C 210, 30.6.2017, P. 1-24
[10] Ibid.
[11] COM(2010)128

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, oversights 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 (GFATM, GAVI) and the Health Transition Fund /Health Development Fund (HTF/HDF).

The World Bank has conducted a number of studies on health sector financing and is implementing a programme of Result Based Management (RBM) approach to the financing of health structures in 18 districts at primary and secondary level while the HDF is implementing the same in the 42 districts only at primary care level.

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/HDF steering committee. These include GAVI, UK, Ireland, Sweden, and the EU (additionally Canada and Norway for HTF). The US Government Agencies (USAID, CDC) are mainly supporting interventions related to HIV-AIDS, tuberculosis, Malaria and sexual and reproductive health. They also attend the HTF/HDF 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.

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 program and have participated in its design through formal and informal consultations aimed at ensuring that the program 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 children, who represent 70% of the population[12]. In addition the HTF/HDF targets with allowances, training and capacity building approximately 20,700 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

[12] The National Health Strategy for Zimbabwe 2016-2020

maternal mortality curve after twenty years of continuous incline[13]. Under-5 and infant mortality rates have also decreased, although the number of deaths remains comparatively high with under-five mortality rate at 69 deaths per 1,000 live births (compared to the 2009 rate of 94/1000), and infant mortality at 50/1000 (compared to the 2009 rate of 65 per 1000). Maternal mortality at 651/100,000 live births in the five years preceding the survey is still well above the regional average.

The NHS highlights the emergence of the non-communicable diseases as a major cause of morbidity and mortality as well as the poor nutritional status of children. These are further compounded by the shortage of critical health workforce, aging infrastructure and equipment, limited supply of medicines and other commodities, limited health funding and considerable challenges with service delivery platforms and the enabling environment... The NHS 2016-2020 highlights the four closely interlinked priorities for the health sector namely (i) communicable diseases, (ii) non-communicable diseases, (iii) reproductive maternal, newborn child and adolescents' health and (iv) public health surveillance and disaster preparedness and response. Furthermore the main thrust of the NHS 2016-2020 is improving quality of health services and ensuring that these services are accessed equitably. 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 six years, in particular through the "Health Transition Fund (HTF) and HDF", 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 necessitated the continuation of the comprehensive approach, which addresses all the health system building blocks that are crucial for the health system to be fully functional. The HDF is supporting all the six health building blocks as well as a component on research and innovation. 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, 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

[13] 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 or RBF was introduced for rural health centres in mid-2014. For secondary level, an input based financing is being used. 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 Ministry of Health and Child Care 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 7.2% of the National 2016 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.

1.2 Other areas of assessment

N/A.

2 RISKS AND ASSUMPTIONS

Risks	Risk level	Mitigating measures
Government policy and capacity There is a room for improvement in the sector coordination capacity between and among health development partners Ministry of Finance (MoF) and MoHCC	**L**	Harmonize and integrate existing different information sharing and coordination platforms and mechanisms. Ensure availability of technical assistance.
Environmental and climate change: -Possible negative environmental impact of new health infrastructure works.	**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.	**M**	-Engage with Government to help overall national economic recovery. -Enhance dialogue between Government and EU about equitable national budget redistribution in favour of social services.

-Budget allocation to the health sector remains insufficient not reaching 15% as per Abuja Declaration. -HRH salary scale and non-financial benefits insufficient to retain staff in their working stations.		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
Assumptions		
- National Authorising Officer 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 National Health Strategy 2009-2015. The HTF underwent an end 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-five 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 was 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 Health Transition Fund (HTF) that the EU has funded since 2011, and 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 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 "Revitalizing Maternity Waiting Homes and Other Related Services" programme (UNFPA), 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 and the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) have currently approved at technical level the new country funding request for a current GF allocation recommendation of USD 483 million. They were also complementary to the Integrated Support Programme funded by UK, Norway, Ireland and Sweden, which focuses on improving sexual and reproductive health.

There is a strong coordination among the health sector stakeholders. 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 (MODO) 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/HDF Steering Committee, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) meetings.

The EU has conducted a Health System Assessment (2016) in order to analyse the performance of the three key pillars of the sector (Human Resources, Health Financing and Pharmaceuticals), which contributed to the sector dialogue.

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 major focus of this action, because of the existing 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[14].

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-five 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.

[14] The EU remains committed to the promotion, protection and fulfilment of all human rights and the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development (ICPD) and the outcomes of their review conferences and remains committed to sexual and reproductive health and rights (SRHR), in this context. All references to sexual and reproductive health and rights should be read in conjunction with the new European Consensus on Development (paragraph 34).

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 (partly administered by UNFPA on its component 2), which was 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/HDF 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 services, the action will focus on enhancing the skills of health workers in communicating effectively with youth and providing youth-friendly services, improving family planning availability especially the long acting methods, cervical cancer screening and treatment; multisectoral coordination of gender based violence prevention 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, strengthening of the coordination platforms 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. The action will also incorporate updated IMNCI training package into the preservice curricula for primary care nurses and

registered general nurses, explore the possibility of introducing i-IMNCI for the country at village level and explore integration of ETAT+[15] into preservice medical training.

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 improving IYCF[16] practices both at community and facility level*;* increasing micronutrient coverage for young children and pregnant women (Ion and Folic Acid, vitamin A, zinc with Oral Rehydration Solutions); 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; improving quality of care for children with SAM[17] both enrolled for inpatient and outpatient programme integrating with HIV; 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 Maternal Newborn and Child Health 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. Strengthen forecasting, procurement, storage, distribution and monitoring of Reproductive Maternal, Newborn and Child Health (RMNCH) drugs, vaccines, blood products and health and nutrition commodities and strengthening of the logistical management information systems and reporting of all health commodities.

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

[15] ETAT+ Emergency Triage, Assessment and Treatment plus admission care
[16] IYCF Infant and Young Child Feeding
[17] SAM Severe Acute Malnutrition

sector and use RBF to influence priorities and continuously review indicators that it rewards and consideration of phasing out of RBF from being managed by external partners to be managed within Ministry of Health and Child Care thus making it more sustainable.

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 MICS 2014 and the HTF end-term review.

The analysis concludes that coordinated interventions by DPs in the health sector in support to the NHS and the Health Financing Policy, notably through the HTF/HDF, 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 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 (implementing 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 UNICF has done that with remarkable success since 2011. The action will therefore continue to support, the Health Development Fund, which runs from 2016 to 2020. This will also be the approach that other development partners 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 **64** 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 the Annex to Regulation (EU) No 323/2015.

5.3 Implementation modalities

5.3.1 Indirect management with UNICEF

This component will be used for the implementation of all activities listed under section 4.2 from 1 April 2015 to 31 December 2015 in the framework of the support to the Health Transition Fund (HTF).

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 the Annex to Regulation (EU) No 323/2015. 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: concluding grants and supply, service and works contracts and payments resulting from those contracts necessary to implement the action.

They are awarded and implemented in accordance with the procedures and standard documents lay down and published by UNICEF. UNICEF tenders' term of references will be defined by a task force representing relevant HDF partners. Terms of References will be presented and approved by the HTF Steering Committee. Similarly, "ad hoc" appointed tenders' evaluation committees will submit the assessment results for the "No objection" by the HTF Steering Committee. Although Art. 96 of the Cotonou Agreement has been lifted, UNICEF will continue

to ensure that implemented activities are directly paid without financial resources being n channelled via the Government treasury.

The Commission authorises that the costs incurred by the entrusted entity may be recognised as eligible as of 1 April 2015. A request by UNICEF has been received on 09 March 2015.

5.3.2 Indirect management with UNICEF

This component will be used for the implementation of all activities listed under section 4.2 from 1 January 2016 to 31 December 2020 in the framework of the support to the Health Development Fund (HDF).

A part of 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 the Annex to Regulation (EU) No 323/2015. 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/HDF, the Education Transition Fund, and the Child Protection Fund. UNICEF has been an efficient and appropriate HTF/HDF manager since the Fund was set up in the last quarter of 2011.

The entrusted entity would carry out the following budget-implementation tasks: concluding grants and supply, service and works contracts and payments resulting from those contracts necessary to implement the action. They are awarded and implemented in accordance with the procedures and standard documents lay down and published by UNICEF.

The Commission authorises that the costs incurred by the entrusted entity may be recognised as eligible as of 1 April 2015. A request by UNICEF has been received on 9 March 2015.

5.3.3 Indirect management with UNFPA

A part of this action may be implemented in indirect management with UNFPA in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012 EDF applicable by virtue of Article 17 of Regulation (EU) No 323/2015. This implementation entails the management of the implementation of the component 2 of the Health Development Fund related to Sexual Reproductive Health and Rights. This implementation is justified because of UNFPA's specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of family planning, youth health, reproductive rights and gender equality.

The entrusted entity would carry out the following budget-implementation tasks: .concluding grants and supply, service and works contracts and payments resulting from those contracts necessary to implement the action. They are awarded and implemented in accordance with the procedures and standard documents lay down and published by UNFPA.

In both direct and indirect management, the Commission will ensure that the appropriate EU rules, including those in respect of providing financing to third parties, are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures affecting Zimbabwe.

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 in EUR	Indicative third party contribution, in EUR	TOTAL
5.4.1 –Indirect management with UNICEF: Health Transition Fund	12 000 000	303 000 000	**315 000 000**
5.4.2 –Indirect management with UNICEF: Health Development Fund	62 585 000	318 315 000	**380 900 000**
5.4.3 –Indirect management with UNFPA: Health Development Fund	1 000 000	-	**1 000 000**
5.10 – Audit	100 000	-	**100 000**
Totals	**75 685 000**	**621 315 000**	**697 000 000**

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, EU, 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 nature of the action, a mid-term evaluation and a final evaluation will not be carried out for this action or its components via independent consultants contracted by the implementing partner.

In case an evaluation is not foreseen, the Commission may, during implementation, decide to undertake such an evaluation for duly justified reasons either on its own decision or on the initiative of the partner.

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.

The financing of the evaluation shall be covered by another measure constituting a financing decision.

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 2021.

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.

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.

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 respectively UNICEF and UNFPA.

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 and UNFPA will ensure that EU support will always be mentioned in line with the new EU-UNICEF partnership during meetings with health personnel at different levels and at community level.

6 PRE-CONDITIONS

N/A.

APPENDIX - INDICATIVE LOGFRAME MATRIX[18]

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	614 per 100,000 live births (2014) 75 X 1,000 live births (2014) 29 X 1,000 live births (2014)	<350 X 100,000 live births (2020) < 48 X 1,000 live births (2020) 25 X 1,000 live births (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

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

		Children under 5	28% (2014)	19% (2020)		

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)	45% (2020) 30% (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	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 (2020) 63 (2020)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS - Vital Medicines and Health Services survey (VMAHS)	- Availability of basic services is regular (electricity, water, etc.) -Trained and qualified health personnel retained -Equipment available and in good working condition

		Health Information System 2				
Specific ** objective(s): 3.	**S.O.3 To reduce inequalities in access to maternal and child quality health services**.**	- % of national budget allocation to health - % of health institutions not charging user fees for maternal and child health care	8% (2014) 0% (2014)	15% (2020) 50% (2020)	Blue Print – National Budget estimates and Expenditures - VMAHS	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) 80% (2020) 95% (2020) 70.0% (2020)	-National Health Information System -Provincial Medical Directors' Reports - DHS - MICS -VMAHS	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 (2020)	-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 immunised against measles;	56% (2013 84% (2013) 94.5% (2013)	80% (2020) 90% (2020) >95% (2020)	-National Health Information System -Provincial Medical Directors' Reports	As Above

		-% of population who slept under Long Lasting Insecticidal Net the previous night of the survey.			-DHS -MICS	
	1.4: Reduced percentage of under-5 children wasted and/or stunted.	--% of children under five years with Severe Acute malnutrition (SAM) who received standard treatment for SAM .	65% (2014)	75%(2020)	-National Health Information System -Provincial Medical Directors' Reports -DHS -MICS	As Above
Outputs S.O.2 **	**2.1: Improved organisation 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)	80% (2020)	-National Health Information System -Provincial Medical Directors' Reports	As Above
	2.3: Human resources for health numbers, skills and	-Human Resources for Health vacancy rates.	15% (2013)	< 5% (2020)	-National Health Information System	As Above

	distribution optimised.				-Provincial Medical Directors' Reports	
Outputs S.O.3 **	**3.1: Improved access to and better utilisation 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)	Signed off documents available and accessible	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 PMD reports	As Above