ANNEX

of the Commission Decision on the

Action Document for Contribution to Health Transition Fund IV

1. IDENTIFICATION

Title/Number	**ZIMBABWE** **CONTRIBUTION TO HEALTH TRANSITION FUND IV** CRIS number: ZW/FED/031-013		
Total cost	Total estimated cost: EUR **304 735 610 (Year 2011-2015)** Total amount of EDF contribution: EUR 12 350 000 This action is jointly co-financed by other donors Previous commitments to December 2013: EUR 97 460 000 *Ireland for an amount of EUR 3 460 000* *Norway for an amount of EUR 3 310 000* *UK for an amount of EUR 52 310 000* *Canada for an amount of EUR 6 930 000* *Sweden for an amount of EUR 1 150 000* *EU for an amount of EUR 30 300 000*		
Aid method / Method of implementation	Project Approach Component 1 - *Indirect Management with UNICEF* Component 2 - *Indirect Management with UNFPA*		
DAC-code	12220	Sector	Basic Health Care

2. RATIONALE AND CONTEXT

2.1. Summary of the action and its objectives

The main component of this Action Document proposes to channel EU support to health services delivery to the population of Zimbabwe through the Health Transition Fund (HTF). The Health Transition Fund is a pooled fund mechanism administered by UNICEF, which was established during the recovery period following the 2008 crisis. It has established itself as a robust brand and has contributed to alignment with Government priorities, promoting ownership, building confidence, delivering tangible benefits nationwide and reducing aid fragmentation.

A smaller second component will complement the first by funding health national surveys and specific assessments.

The overall objective of the action is to improve access to basic health services to all Zimbabweans, thus supporting Zimbabwe to achieve health Millennium Development Goals (MDGs) 1c, 3, 4, 5, 6 and 8e.

The purpose of the action is to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact maternal, neonatal and child health (MNCH) interventions through support to the health sector.

2.2. Context

2.2.1. Country context

Since the adoption of appropriate measures under Article 96 of the revised Cotonou Agreement by Council Decision 2002/148/EC as last amended by Council Decision 2012/96/EU, based on the conclusion of Article 96(2) consultations with the Republic of Zimbabwe on 11 January 2002, EU assistance to Zimbabwe has been reoriented mainly to programmes and projects in direct support of the population, in particular in social sectors such as health and education (and since 2010 to projects in support of the reforms contained in the Global Political Agreement). The EU contribution to the HTF included in this Action Document is thus already compliant with these conditions and will not be affected by a suspension or lifting of the current limitations to the cooperation with the Government of Zimbabwe.

Following the suspension of the application of Cotonou Agreement's Article 96, appropriate measures by the European Council Decision of 24 July 2012, Zimbabwe and the EU launched the 11th EDF programming exercise in August 2012. The exercise's first phase was completed in October 2012 with the submission of a draft Country Strategy Paper (CSP) 2014-2020 agreed by the EU Delegation and the National Authorizing Officer (NAO). The CSP identified three focal sectors of concentration for the 11th EDF in Zimbabwe: health, agriculture based economic development, and governance and institution building.

The three focal sectors identified were approved by the Commission and European External Action Services (EEAS) on May 2013, following which the preparation of a National Indicative Plan (NIP) started in July. The process was interrupted during the electoral period, but has meanwhile resumed and the submission of the draft NIP is expected in the course of 2014. The support to the HTF proposed in this Action Document is consistent with the priorities for the health sector agreed with the Government during the programming process.

2.2.1.1. Economic and social situation and poverty analysis

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, real gross domestic product (GDP) growth decelerated to 6.8% in 2011 and further to 4.4% in 2012, from 9.0% in 2010. The trend has continued in 2013 with estimates ranging from 1.5 % (former Finance Minister) to the Government's 3.5%. 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 lack of clarity on the implementation of the indigenization policy. Prospects for 2014 are not good, the slowdown of the economy has accelerated in the second half of 2013, commodity prices have gone down, private investment has not picked up and the weakness of the banking sector persists[1].

While the economic policy outlined by the new Government in the last quarter of 2013 has been positively received by the World Bank (WB) and the latest International Monetary Fund's (IMF) staff monitored programme mission, there are serious doubts about the Government's capacity to generate enough revenues to cover the 2014 National Budget's USD 4.2 billion projected expenditures.

Together with negative economic growth, the period 2000-2008 witnessed increased poverty levels, worsened by frequent droughts among other shocks. The recent poverty report on the 2011-2012 PICES Survey[2] reveals that 72.3% of Zimbabweans are poor, whilst 16.2 % of the

[1] African Development Bank monthly updates.
[2] Poverty, Income, Consumption and Expenditure Survey, ZimStat 2013.

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 2013 United Nations Human Development Index (HDI) ranks Zimbabwe among the low human development countries: 172nd out of 186 countries compared with 1998 when it ranked 130th out of 174 countries. Zimbabwe has had the steepest HDI fall ever. The estimated GDP per capita in 2012 was USD 714.2, 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 two years. These include indicators pointing to a revitalization of the health services delivery at district and rural level and to an increase in pupils' early learning in primary schools. However, this is an improvement not mirrored in other key areas for poverty reduction. The food security situation is still a matter of particular concern, as the latest analysis shows that 2.2 million Zimbabweans are expected to be food insecure in the 2013/2014 consumption year. This represents 25% of the rural households and is a 6% (32% increase) higher compared to the previous consumption year[3].

2.2.1.2. National development policy

The Government approved in December 2013 a new economic development blueprint, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset), which will drive the national development agenda over the next five years. The Zim Asset identifies four priority areas of intervention: food security and nutrition, social services and poverty eradication, infrastructure and utilities, and value added and beneficiation. While Zim Asset's proposed interventions have been positively assessed by international institutions (WB, IMF, UN), its analysis of the causes of the deteriorating economic and social environment that Zimbabwe has experienced since 2000 appears to be quite simplistic as "illegal economic sanctions imposed by Western Countries" are identified as the main and only cause. Also, the feasibility of Zim Asset implementation raises a number of questions, particularly in relation to the Government's ability to raise sufficient resources to fund it in the absence of a major international effort. Public service delivery, which has progressively improved since 2010, is very likely to continue to be heavily dependent on the donor community for the duration of Zim Asset.

The Delegation's selected sectors of concentration for the 11th EDF are aligned to Zim Asset's priorities. Two of the EU selected sectors (health an agriculture based economic development) are aligned to three of the Zim Assets priorities (food and nutrition, social services and value addition), while the EU third sector (Governance and Institutional Development) is aligned to one of the Zim Asset sub-clusters (Public Administration, Governance and Performance Management).

The Government has clearly stated that Zim Asset is the basis on which it will engage with donors in the future. Line Ministers have indicated that they will be reviewing sector policies in order to make them consistent with it.

2.2.2. Sector context: policies and challenges

Health and other social services deteriorated drastically in the past decade, reaching a state of effective collapse at the end of 2008 / early 2009. The downturn of the economic situation severely affected the capability of the public system to deliver health services to the population, especially to the most at risk groups such as women and children. The health system was characterized by: 1) Deficit of medical and managerial health professionals; 2) Irregular availability of essential medicines and medical supplies; 3) Inadequate provision and maintenance of equipment and infrastructure; and 4) Disrupted basic utilities and services.

[3] Rural livelihoods assessment 2013, ZimVAC (Zimbabwe Vulnerability Assessment Committee) 2013.

Furthermore, the forced reintroduction of "**user fees**" was a barrier to health care and contributed to greater disparities in access, effectively excluding poorer people from the formal health care system.[4] As a consequence, life expectancy at birth declined from 62 years in 1990 to 52 years in 2011. The Zimbabwe Demographic and Health Survey (ZDHS) 2010-2011, showed that other key health indicators had also deteriorated: under-five mortality and infant mortality rates sharply increased while maternal mortality has more than trebled from 283 per 100,000 live births in 1994 to 960 in 2010-11. Births delivered by a skilled provider decreased from 94% in 2005 to 66% in 2010-11.

The situation has improved since 2011. Surveys[5] and surveillance[6] reports are showing initial evidence of the revitalization of the health sector, such as the increase of the national coverage of fully immunised children from 53%[7] to 65%[8] and the coverage of single antigens (BCG, OPV3, DPT3 and measles), which has increased from 70% in 2009 to a current 95-100%. Zimbabwe did not report a single case of measles during 2012 and up to September 2013. The Vitamin A supplementation coverage is at 99%. Fees for services have been eliminated at rural clinic level.

The key factors in the recovery of the health sector have been the ability of the public system not only to retain current staff but also to increase health worker capacity at health facilities; the increased ability of training institutions to form health cadres; the availability of vital medicines and medical supplies (now at 97% availability of the Primary Health Care Package[9]); and the decentralization of funding to rural clinics and district hospitals. All 1,200 Rural Health facilities in Zimbabwe are receiving an average of USD 750 per month to cover running costs.

International development partners have been instrumental in funding the above through the HTF, a mechanism that pools donor funds in support of the National Health Strategy and the Ministry of Health and Child Care (MoHCC) annual plans.

2.3. Lessons learnt

The EU was a key contributor to the design and initial funding of the HTF since it was established in 2011. The EU's objective was to link relief and rehabilitation aid delivered through quick impact projects from 2008 to 2010 with wider support to the health system aligned to the Government's National Health Strategy.

Actions funded by the EU and other development partners to mitigate the impact of the collapse of the health system in 2008/2009 were mainly project based and uncoordinated. While they helped tackling the crisis in the short term, they had limited mid term impact and were often unsustainable. The HTF was set up to overcome these issues by enhancing alignment with the National Health Strategy, strengthening Government ownership and harmonizing development partners' aid.

While it is still soon to measure the impact of the HTF, the evidence collected so far indicates that it is resulting in an improvement of the health situation in Zimbabwe. According to the conclusions of the "Independent Evaluation of the Health Transition Fund (HTF)" performed by the Liverpool School of Tropical Medicine in 2013, the HTF is contributing significantly to address major health system constraints, which include human resources for health, health

[4] See Zimbabwe's Association of Doctors for Human Rights Annual Report, 2009. http://www.zadhr.org/.
[5] - Independent Evaluation of the Health Transition Fund in Zimbabwe – 2012 Annual Report - LSTM.
- Vital Medicines Availability Health Survey (VMAHS).
- National Integrated Health Facility Assessment (NIHFA) 2011.
[6] - Health Management Information System (HMIS).
- Provincial Medical Director's reports (PMDs Reports).
[7] 2005-2006 Demographic and Health Survey (DHS).
[8] 2012 UNICEF HTF Annual Report.
[9] Vital Medicines Availability Health Survey (VMAHS).

commodities including medicines and vaccines, health financing, and monitoring and evaluation of the health sector. The evaluation concludes that as a result of these combined positive changes, provinces and districts have started witnessing improvement in both the outpatient and inpatient utilization rates and overall improvement in health care utilization across all health service delivery levels.

Outputs delivered by the HTF in 2013 included the following:

- Implementation of a harmonised retention allowance which, together with the provision of a critical posts allowance, has made it possible to attract young doctors to work in district hospitals (there are now three doctors in each of the 62 Rural Health Districts) and drastically reduce to less than 5% the vacancy rates of nurses, midwives, PCNs[10] and other health cadres posts.
- Training health cadres: Midwifery/Nursing Schools enrolment up to 500 Register Nurses per annum and 600 PCNs per annum; 40% health cadres trained in Emergency Obstetric and Neonatal Care, and Integrated Management of Neonatal and Child Illness (IMNCI).
- Further than ensuring 97% availability of medicines and medical supplies, the HTF has increased availability of newborn care equipment and of midwifery kits (50% availability). A voucher system for making blood available to pregnant women, including related laboratory reagents, is in place.
- The HTF Steering Committee, which is chaired by the Permanent Secretary of the MoHCC, has become the most important platform for dialogue and coordination among health partners including donors, technical agencies and Government.

The independent evaluation makes a number of recommendations for the HTF to focus on from 2014 onwards. These include supporting the improvement of the health information system, training and supporting nurse anaesthetists as soon as possible, establishing a quality assurance system and initiating a new mentorship programme at district level, and assessing coverage and impact of maternity waiting homes.

At outcome level, the EU will fund in the first quarter of 2014 the new round of the Multiple Indicators Cluster Survey, which will provide information on a wide range of health and other MDGs related indicators, thus allowing the EU to measure the impact of its support on the health status of the Zimbabwean population.

The current economic stagnation implies that health sector financing will still require external aid in the next years if the incipient recovery is to continue. Lack of funding for the health sector would halt progress on reducing maternal and child mortality in Zimbabwe, as it would not be possible to maintain the current of level of coverage for essential medicines, vaccination, available blood at peripheral facilities, and presence of doctors and nurses at, respectively, district hospitals and rural clinics. In addition, funding covering current expenditures in peripheral facilities through the Health Service Fund would be significantly reduced and result on user fees for maternal and child healthcare being imposed again. This would in turn result in exclusion of the most deprived from access to health care. Development partners need therefore to maintain in 2014 and 2015 the level of funds contributed to the HTF in previous years (an average of USD 60 million per year). The EU has so far provided EUR 30.3 million to the HTF, which results in an average of EUR 12 million per year from mid 2011 to end 2013.

It is equally important that the Government gradually increases the share of the budget allocated to the health sector (currently at 8%) up to the 15% Abuja target. The dialogue between development partners and Government on development issues, which is now ad hoc and informal, needs to be strengthened so that financing for health, and for social expenditure in general, is more thoroughly discussed.

[10] Primary care Nurses (PCNs).

2.4. Complementary actions

This contribution complements three previous 10th EDF "ad hoc" allocations to the HTF. It is also complementary and in synergy with the "EU MDGs Initiative" programme for Zimbabwe, the objective of which is "Revitalizing Maternity Waiting Homes and Related services". The programme is implemented by UNFPA (United Nations Population Fund).

The HTF directly complements Government resources for the health sector. HTF annual plans are both aligned with the NHS goals and developed on the basis of the annual MoHCC "Performance Contract[11]" signed with the Ministry of Finance. As current Government resources are largely below the health system requirements identified in the "Health Investment Case", capital investment and recurrent expenditures mostly rely on external support. The Government is now preparing a sustainability plan that should map the way for it to assume most of the public health system costs in the mid-term.

Further than the HTF, the other major funding mechanisms for the health sector in Zimbabwe are the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the PEPFAR[12] initiative. They are complementary with EU funding as their focus is on major transmissible diseases that are not central to HTF's scope.

2.5. Donor coordination

The EU Delegation in Zimbabwe is a key stakeholder in the health sector. It is currently co-chairing the HTF Steering Committee and is one of the most active participants in the "***Health Development Partners Coordination Group***" (HDPCG), which is an informal group composed of bilateral and multilateral development partners that meets every two months. The Delegation also participates regularly in the GFATM Country Coordination Mechanism.

Further to the HDPCG, a "***Health Coordination Forum***" (HCF) chaired by the Minister of Health and Child Care has been established and should lead sector coordination. Although it should meet on a quarterly basis, meetings have not been taking place regularly, as Government has in fact used the HTF Steering Committee as its preferred platform for sector coordination.

The HTF steering committee is co-chaired by the Permanent Secretary of the MoHCC and by one of the HTF donors (currently the EU). It is further composed of the other HTF donors, the UN Agencies active in the health sector (WHO, UNICEF, UNFPA, UNAIDS, UNDP), and the Civil Society represented by one international and one national NGO. Non HTF donors such as USAID, CDC[13] and World Bank are "associated" participants to the steering committee and regularly present or update the committee on their initiatives. The steering committee meets every month and has become the "de facto" sector coordination group thanks to both the active leadership on the Government side and to the committee's wide membership.

Health and Water and Sanitation Clusters under the UN Office for the Coordination of Humanitarian Affairs are still active and in charge of providing coordinated responses to possible outbreaks (cholera and other diarrheal diseases, anthrax, etc.).

[11] The MoHCC Performance Contract is the MoHCC annual implementation plan.
[12] President's Emergency Plan for AIDS Relief (PEPFAR).
[13] CDC: Centre for Diseases Control, Atlanta, US.

3. DETAILED DESCRIPTION

This Action Document proposes to channel EU support to health services delivery to the population of Zimbabwe through the Health Transition Fund. The HTF is a pooled fund mechanism administered by UNICEF, which was established during the recovery period following the 2008 crisis. It has established itself as a robust brand and has contributed to alignment with Government priorities, promoting ownership, building confidence, delivering tangible benefits nationwide and reducing aid fragmentation.

3.1. Objectives

The overall objective of the action is to improve access to basic health services to all Zimbabweans, thus supporting Zimbabwe to achieve health MDGs 1c, 3, 4, 5, 6 and 8e

The purpose of the action is to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact maternal, neonatal and child health (MNCH) interventions through support to the health sector.

3.2. Expected results and main activities

Component 1: Health Transition Fund

The EU will support the implementation of the NHS 2009-2015, with a particular focus on helping achieve the maternal and child health targets of the strategy, as well as those related to the strengthening of the health systems. The preferred mechanism for the delivery of aid will continue to be the HTF. The EU has so far provided EUR 30.3 million to the HTF under three previous Decisions, while the ongoing implementation progress is satisfactory. The HTF has four major thematic areas of intervention, which are the following:

Thematic Area 1: Maternal, Newborn and Child Health, and Nutrition

The expected result is **improved Obstetric and Newborn Care**, **Community Health service delivery, and strengthened Expanded Programme for Immunization (EPI) and IMNCI and Nutrition.**

Key activities will focus on intervention during the peri-natal period where rates of both maternal and newborn death are highest.[14] Capacity building, training, procurement and distribution of essential equipment and supplies and supportive supervision of critical cadres of health workers are included. This thematic area also includes advocacy for abolishing user fees for pregnant and lactating mothers and children under-five in particular.

Thematic Area 2: Medical Products, Vaccines and technologies (Essential Medicines and Commodities)

The result is **to ensure the availability and access to essential medicines and commodities including vaccines and injection equipment, cold chain equipment and nutrition commodities in health facilities across Zimbabwe**.

Key activities within this thematic area include the provision of selected essential medicines and medical supplies, the procurement of vaccines, injection materials and cold chain equipment for immunization, emergency obstetric care equipment, newborn care supplies, including early infant HIV diagnosis, ready to use therapeutic and supplementary nutrition commodities, and potentially micro-nutrient sprinkles and lipid-based supplements[15].

[14] Munjanja, S. Maternal and Perinatal Mortality Study, 2007, MoHCC Zimbabwe (http://www.UNICEF.org/zimbabwe/ZMPMS_report.pdf).

[15] There is an estimated 40 per cent gap in Dried Blood Spot and PCR supplies for 2012 and 2013, with larger gaps in subsequent years up to 2015.

The HTF will finance the strengthening of the National Pharmaceutical Company (NatPharm) and Ministry counterparts in integrated management of essential medicines and health and nutrition commodities (Drug and Logistic Management Information Systems) with a view to increasing access, use and quality of primary health care services across Zimbabwe.

Thematic Area 3: Human Resources for Health (including Health Worker Retention Scheme)

The result is **to ensure that all health management offices and health facilities are staffed with the minimum standard of qualified health professionals by 2015.**

Key activities in this thematic area include ensuring that the Health Worker Retention Scheme is resourced, coordinated and effectively administered within a framework that enables an affordable harmonized national retention allowance that complements government salaries and helps retain critical health sector workers. In addition, technical assistance will be provided to support MoHCC in Human Resources strategic management and planning and demand driven capacity building (training, supervision and orientation).

Thematic Area 4: Health policy, planning and finance (Health Services Fund)

The result is **to improve national capacity for policy, planning and financing system across all health service delivery levels with special emphasis on the financing of most peripheral health facilities.**

Key activities include financial support to peripheral health facilities through the Health Services Fund, Monitoring, Evaluation and Operational Research, and provision of Technical Assistance. The technical assistance will focus on governance, management, Health Information System (HIS) and policy development. It will also support demand driven human resources capacity development across the four HTF thematic areas. A programme of technical assistance will be developed with the MoHCC and relevant parastatal institutions.

Component 2: Studies, national surveys

The result of this component is **increased availability of reliable information concerning access to health services in Zimbabwe**.

Key Activities

Activities will be defined in the related studies and national surveys' protocols developed jointly and/or by key partners and the relevant Ministries. The activities will be in addition and complement those already defined within the HTF thematic areas. Terms of Reference (ToR) will be defined according to needs.

3.3. Risks and assumptions

The following table summarises major risks and mitigation measures to address them:

Risk	Mitigation Measures
Political and economic situation worsen to civil conflict or collapse of service sectors.	Donors and UN Agencies and NGOs will work closely with government Ministries, district and local authorities responsible for social service sectors to ensure good relations and delivery at central, district and local levels. In particular, they advocate for separation of politics from provision of social services and conduct regular field monitoring.
UNICEF's internal procurement and contracting systems are not able to effectively expedite and manage large scale programmes.	Donors and UNICEF are to agree on the realistic in-country technical and operational capacity required to effectively implement and monitor the programme's progress.

Government does not have capacity to facilitate policy reform quickly and contribute adequate domestic financial resources.	The HTF will allow government appropriate flexibility in implementation across different components. Policy and strategic planning support and technical assistance will assist in strengthening government capacity.
Liquidity constraints in the financial system may hamper access to funds transferred by HTF to individuals and health institutions.	The MoHCC and the HTF Steering Committee have set up a specific task force, which is regularly monitoring the recovery of funds by Health Institutions. Weaker local banks are being identified and MoHCC has requested employees and health facilities to open new accounts in stronger commercial banks.

Key to success will be UNICEF's long term relationship with government in the health sector and their ability to navigate demanding circumstances that are likely to emerge, especially in relation to the country economic situation. During the first two years of the HTF implementation, UNICEF has showed appropriate institutional skills to achieve results in the current political environment.

3.4. Cross-cutting issues

For the **health component**, the HTF takes into consideration cross cutting issues such as gender, water and sanitation, HIV-AIDS, communication, good governance and human rights protection. Pregnant women are focal beneficiaries of the intervention, which includes the promotion of HIV counselling and voluntary testing, preventing mother to child transmission (PMTCT) and exclusive breast feeding.

HIV-AIDS direct interventions are not a major focus of this pooled fund, because of the existing financing mechanisms in Zimbabwe (HIV-Levy, GFATM, etc.). However, HIV is inextricably linked to maternal and child health. Improving MNCH[16] overall will also strengthen the continuum of HIV prevention, care and treatment for women and children.

3.5. Stakeholders

Core stakeholders of the programme include:

- **Bilateral Donors** which have already contributed to the Health Transition Fund. These are Canada, EU, Ireland, Norway, Sweden, and UK. They are all part of the HTF Steering Committee.
- **MoHCC** nationally, which provides policy direction. Provincial and District levels will provide support, supervision and, within their resources, contribute to the implementation of foreseen activities, to their supervision and to monitoring. Other relevant Government agencies collaborating in the implementation of the action include the *Health Service Board* (HSB), the national pharmaceutical company *NatPharm*, the national statistical company *ZIMSTAT*; the *Public Service Commission* and the *Ministry of Finance*.
- **UNICEF**, which provides coordination, technical assistance and financial management of the HTF, including the secretariat.
- **Implementing Partners,** (e.g.: UNICEF, WHO, UNFPA, Crown Agents, WB, Non-Governmental Organisations, Universities, etc.) support the Ministry in the implementation of high-impact interventions. Implementing partners are selected on the basis of their comparative advantages in relation to the activities to be implemented.

The HTF programme supports the Zimbabwe national public health service, therefore targeting the whole population of Zimbabwe (13.1 million)[17] with special attention to women,

[16] Maternal, Neonatal and Child Health.
[17] 2012 Census

the newborn and children, who represent 70% of the population[18]. 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.

Formal engagement with civil society takes place through the local and international NGOs representation in the HTF steering committee. Further, several ongoing EU financed NGO projects address aspects complementary and in synergy with the HTF in the areas of sexual and reproductive health, HIV, and community accountability.

4. IMPLEMENTATION ISSUES

4.1. Financing agreement

In order to implement this action, it is **not** foreseen to conclude a financing agreement with the partner country, referred to in Article 17 of Annex IV to the Cotonou Agreement.

4.2. Indicative operational implementation period

The indicative operational implementation period of this action, during which the activities described in sections 3.2. and 4.3. will be carried out, is **36 months** from the date of entry into force of the financing agreement or, where none is concluded, from the adoption of this Action Document, subject to modifications to be agreed by the responsible authorising officer in the relevant agreements. The relevant Committee shall be informed of the extension of the operational implementation period within one month of that extension being granted. The HTF as currently supported by the Government of Zimbabwe and the donors will end by December 2015.

4.3. Implementation components and modules

Indirect management with an international organisation: UNICEF for Component 1 and UNFPA for Component 2.

4.3.1. Indirect management with an international organisation

Component 1: Health Transition Fund

This action with the purpose to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact maternal, neonatal and child health (MNCH) interventions through support to the health sector, may be implemented in indirect management with UNICEF in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012. 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 be responsible for concluding all 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.

[18] The National Health Strategy for Zimbabwe 2099-2013.

The entrusted entity is currently undergoing the ex-ante assessment in accordance with Article 61(1) of Regulation (EU, Euratom) No 966/2012 EDF [applicable by virtue of Article 17 of the Annex to Regulation (EU) No 567/2014]. The responsible authorising officer of the Commission 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 entity 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 01 March 2014 because, taking into account the existing commitments from other donors including previous ones by the EU, a significant funding gap remains for the year 2014. The request by UNICEF for funding starting in March 2014 was received by the Delegation on 10 February 2014.

Component 2: Studies, national surveys

This action, the objective of which is to increase availability of reliable information concerning access to health services in Zimbabwe, will be implemented in indirect management with UNFPA in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012. This implementation is justified because of UNFPA's specific international mandate and its proven technical capacity to identify and implement population based surveys and investigations and provide related technical assistance. Moreover, in the past years, UNFPA has shown strong capacity to manage donors' funds for the implementation of the 2010 Demographic Health Survey, the 2012 Zimbabwe Population Census, the National Integrated Health Facility Assessment, and others. UNFPA will be responsible for managing the implementation of surveys and investigations through pooled funds. UNFPA will act as a pooled fund manager with an oversight and coordination role, entering into contract with research institutions such as ZimStat[19], the University of Zimbabwe and others according to their comparative advantages. UNFPA is currently managing the EU funded programme "Revitalising Maternity Waiting Homes" to the EU's satisfaction.

The entrusted entity would be responsible for concluding all 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. There will be no sub-delegation

The entrusted entity is currently undergoing the ex-ante assessment in accordance with Article 61(1) of Regulation (EU, Euratom) No 966/2012 EDF [applicable by virtue of Article 17 of the Annex to Regulation (EU) No 567/2014]. The responsible authorising officer of the Commission 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 entity can be entrusted with budget-implementation tasks under indirect management.

4.4. Scope of geographical eligibility for procurement and grants

N/A.

4.5. Indicative budget

The HTF multi-donor pool fund programme covers a five-year programme period, 2011-2015 for a total estimated budget of EUR **304 735 610**, of which EUR **12 350 000** shall be financed from the EDF Bridging Facility Allocation in the framework of the revised ACP-EU Partnership Agreement.

[19] ZimStat: Zimbabwe National Statistics Agency.

Previous EU commitments to the HTF amount to a value of **EUR 30 300 000**, out of a total donors' commitment of EUR **97 460 000** as of December 2013.

Component	Amount in EUR
Component 1: Health Transition Fund Indirect Management with UNICEF	12 000 000
Component 2: Studies, national surveys and *ad hoc* technical assistance Indirect Management with UNFPA	250 000
Evaluation and audit	100 000
Total	**12 350 000**

4.6. Performance monitoring

Under the agreement, UNICEF will be responsible for the project financial management, coordination and monitoring. Donors will have an oversight role through the Steering Committees and will participate in the HTF annual review. Robust baseline statistical and early primary learning assessment data has been collected in early 2012; this is informing the internal and external monitoring and evaluation processes. The first is done by UNICEF in conjunction with Development Partner and the MoHCC, the second one is performed by the Liverpool School of Tropical Medicines.

With reference to component 2, the performance monitoring will be defined according to the expected results and activities specified in the related ToR or action description and the selected implementation modality.

4.7. Evaluation and audit

In addition to the evaluations managed by UNICEF in line with the Financial and Administrative Framework Agreement (FAFA), joint external reviews will be carried out in collaboration with senior government staff and external independent evaluators (Liverpool School of Tropical medicines) directly appointed by the main development partners.

Financial verifications will be carried out. They will respect specific arrangements with the Indirect Management Delegation Agreement as relevant.

UNICEF verification activities are foreseen through the Results Oriented Monitoring (ROM) mission.

4.8. 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 before the start of implementation and supported with the budget indicated in section 4.5 above.

The measures shall be implemented either (a) by the Commission, and/or (b) by the partner country, contractors, grant beneficiaries and entrusted entities. Appropriate contractual

obligations shall be included in, respectively, financing agreements, 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.

The cost of the Communication and Visibility will be included in the Indirect Management Delegation Agreement.