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ANNEX 2

of the Commission Implementing Decision on the financing of the annual action plan in favour of the Republic of Zimbabwe for 2022

Action Document for Improving Health Outcomes for the Population of Zimbabwe

ANNUAL PLAN
This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and action plans in the sense of Article 23(2) of NDICI-Global Europe Regulation.

1. SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Improving Health Outcomes for the Population of Zimbabwe NDICI AFRICA/2022/043-392 OPSYS ref .: ACT-60560 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	The action will contribute to the TEI: 'Gender equality through women's empowerment'
3. Zone benefiting from the action	Zimbabwe
4. Programming document	Multiannual Indicative Programme (MIP) for Zimbabwe (2021-2027).
5. Link with relevant MIP(s) objectives/expected results	Priority Area 3: Social Recovery and Human Development Specific Objective 3.1 (SO3.1): To improve protection of children, adolescents, adults, including people with disabilities, against health threats in interventions with consideration of specific gender needs Specific Objective 3.2 (SO3.2): To improve accountability and transparency of quality health services and increase outreach and capacity at system level Expected result (ER) 3.1.1. to ER 3.1.4 and ER 3.2.1 to ER 3.2.2
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Basic Health (122); Population Policies/Programmes & Reproductive Health (130); Social Infrastructure and Services (160)
7. Sustainable Development Goals (SDGs)	Main SDG: SDG 3: Good health and well-being

	Other significant SDGs : SDG 2: Zero hunger SDG 5: Gender Equality SDG 10: Reduced inequality SDG 13: Climate Action			
8 a) DAC code(s)	122 (Basic Health) 130 (Population Policies /Programmes & Reproductive Health) 12240 Basic Nutrition 13020 Reproductive Health Care 13030 Family planning (Sexual Reproductive Health and Rights (SRHR) 13040 STD control incl. HIV/AIDS (SRHR) 15180 Ending violence against women			
8 b) Main Delivery Channel @	41000 - United Nations agency			
9. Targets	☐Migration ☒Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☐ Education ☐ Human Rights, Democracy and Governance			
10. Markers (from DAC form)	**General policy objective @**	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☐	☒	☐
	Aid to environment @	☐	☒	☐
	Gender equality and women's and girl's empowerment	☐	☒	☐
	Trade development	☒	☐	☐
	Reproductive, maternal, new-born and child health	☐		☒
	Disaster Risk Reduction @	☐	☒	☐
	Inclusion of persons with Disabilities @	☐	☒	☐
	Nutrition @	☐	☒	☐
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity @	☒	☐	☐

	Combat desertification @	☒	☐	☐
	Climate change mitigation @	☐	☒	☐
	Climate change adaptation @	☐	☒	☐
11. Internal markers and Tags:	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation @ Tags: digital connectivity digital governance digital entrepreneurship job creation digital skills/literacy digital services	☐	☒ ☒ ☐ ☐ ☐ ☒ ☒	☐ ☐ ☐ ☐ ☐ ☐ ☐
	Connectivity @ Tags: transport people2people energy digital connectivity	☐	☐ ☐ ☐ ☐ ☒	☐ ☐ ☐ ☐ ☐
	Migration @ (methodology for tagging under development)	☒	☐	☐
	Reduction of Inequalities (methodology for marker and tagging under development)	☐	☒	☐
	Covid-19	☐	☒	☐
BUDGET INFORMATION				
12. Amounts concerned	Budget line(s) (articles, item): BGUE-B2022-14.020122-C1-INTPA Total estimated cost: provisional EUR 84 850 000[1] Total amount of EU budget contribution: EUR 41 000 000[2] This action is co-financed in joint co-financing through a pool fund by: - United Kingdom for the provisional amount of GBP 37 000 000 - Ireland: EUR 9 000 000			
MANAGEMENT AND IMPLEMENTATION				

[1] The total cost will be defined at the start of the action
[2] Out of this amount, an estimated 28.7 M EUR (70%) contributes to the TEI on Gender Equality and Women's Empowerment

13. Type of financing[3]	**Indirect management** with UNICEF

1.2 Summary of action

This action will support high impact interventions to save lives and protect the health of the most vulnerable (especially women, new-borns, children and people with disabilities), with full consideration of specific gender needs. This includes strengthening primary health care (PHC) structures, and enhancing health security measures, in order to protect the population against the main health threats. Activities will target district health facilities in the country as the most effective approach to maintain access to quality health services, through the Health Resilience Fund (HRF) (which will replace the current Health Development Fund (HDF)). The HDF contributed to impressive results in maternal and child mortality over the past decade but the gains made are threatened by ongoing economic instability, the impact of COVID-19, and the risk of a funding gap for the first semester of 2022. Other donors to the HDF are the UK's Foreign, Commonwealth & Development Office (FCDO), Swedish International Development Cooperation Agency (SIDA), Irish Aid and the Global Alliance for Vaccines and Immunisation (GAVI).

The action is closely aligned to the Constitution, the national priorities set out in the National Development Strategy (NDS-1) and the Government of Zimbabwe's National Health Strategy 2021-2025. In line with the implementation of the MIP (2021-2017), the action will ensure meaningful interaction with civil society for improving health outcomes and addressing vulnerabilities. In addition, this intervention will contribute to the Sustainable Development Goals (SDGs) on the eradication of poverty (SDG-1), zero hunger (SDG-2), good health and well-being (SDG-3), gender equality (SDG-5), reduced inequality (SDG-10) and climate action (SDG-13).

Key elements of gender, disability, conflict sensitivity and do-no-harm approaches, human rights and democracy will be mainstreamed in the action. **In addition, the action will contribute to the Team Europe Initiative (TEI) 'Gender equality through women's empowerment**'. Approximately 70% of the action's budget (circa. amount of EUR 28 000 000) should target gender-based activities under the TEI. These activities are synergistic with the Spotlight Initiative in Zimbabwe to which the EU has contributed USD 30 000 000. The Spotlight Initiative aims to eliminate sexual and gender-based violence (SGBV) and harmful practices (HP) through the consolidation of a broad partnership with civil society, Government, private sector, media and development partners. The HRF could complement and build on the successes of the Spotlight Initiative because the latter creates awareness in communities about women's rights, which in turn, could increase utilisation of services.

Furthermore, the action will seek to enhance climate resilience and environmental sustainability through the promotion of sustainable waste disposal and management of renewable (solar) energy within primary health facilities.

In order to provide such a comprehensive approach successfully, it is important to pool resources and ensure that the package of services is designed to respond to the needs of the targeted population. Therefore, services delivered will be adaptable to emerging health and nutrition situations, including emergencies such as epidemics and cyclones and emerging infectious diseases.

With this action, the EU will retain the role of one of the main Development Partners (DP) for promoting equitable access to quality health care and will have a lead role in coordination among the other donors and the Ministry of Health and Child Care (MoHCC). This role will include steering priority activities and ensuring comprehensive governance and oversight of the Fund.

[3] Art. 27 NDICI

The duration of the action is indicatively 48 months. The total amount of the EU contribution is estimated at EUR 41 000 000 and will be executed through indirect management with United Nations Children's Fund (UNICEF) as Fund Manager and implemented by UNICEF, The United Nations Population Fund (UNFPA), World Health Organisation (WHO) and Civil Society Organisations (CSOs). The Global Alliance for Vaccination and Immunisation (GAVI) may contribute towards the pool fund in the future.

2 RATIONALE

2.1 Context

Zimbabwe is a low-income country[4] with a population estimated at 15.5 million in 2020. With a low score of 0.571 in the human development category of the Human Development Index (HDI) in 2019, Zimbabwe ranked 150 out of 189 countries and territories worldwide. In recent years the country has been exposed to economic, climate and pandemic shocks. Zimbabwe's National Adaptation Plan[5] has also indicated that the health sector is one of the country's sectors that are highly vulnerable to climate change. The economic and financial legacy is complex with the debt level unsustainable with limited fiscal space for increased domestic funds for health.

Poverty levels are high, with an estimated 70.5 % of all households living in poverty in 2017. The country remains vulnerable to a wide range of health hazards including cholera, typhoid, HIV, tuberculosis (TB), malaria, measles, rabies, viral haemorrhagic fever, gastrointestinal diseases, road traffic accidents, drought, cyclones and floods. Impacts on health from heat-stress are increasing as a result of extreme temperatures, inadequate sanitation, and waterborne diseases. These problems add additional stress on the health sector. Two years of drought and low harvests (2018/19) followed by Cyclone Idai (2019) put a strain on government capacity. High-inflation and exchange rate devaluation in 2019 significantly reduced overall budgets for health. The economic and financial crisis was aggravated by the COVID-19 pandemic, resulting in an acceleration of poverty and vulnerability, and a negative cycle of health service deterioration.

Health outcomes were affected between 2018 and 2020. For example, still births increased by 5 % from 2018 to 2019 and maternal mortality rose by 27 % between December 2019 and December 2020. An increase in teenage pregnancies and child marriages was reported during the COVID-19 pandemic.

Gender disparities in health are highly prevalent and slowing down progress towards the country's health related development goals. Maternal and child health mortality rates remain notably high relative to peers in the Sub-Saharan African region. This is partly due to the fact that the prevalence of child marriages and teenage pregnancies is high. Early pregnancies contribute to poor maternal health and high child mortality thus perpetuating a vicious cycle for the poorest and most vulnerable girls. A closer look at the health conditions that disproportionately affect women, such as malnutrition and HIV, shows that empowerment imbalances and exposure to Sexual Gender Based Violence (SGBV) are strong mediating factors in the attainment of negative health outcomes for women and girls.

A major problem with quality of health care is staff attrition due to dissatisfaction with the remuneration and working conditions. High inflation and exchange rate devaluation in 2019 resulted in a nine-month long strike of healthcare workers. There was a shortage of medicines and equipment in public hospitals and maternity clinics. In 2018, there were 1.6 physicians and 7.2 nurses per 10 000 population, which is a long way from the WHO's recommendation of the minimum threshold of 23 doctors, nurses, and midwives per 10 000 population. The COVID-19 pandemic also resulted in attrition of health workers and further deterioration of quality in the health services.

Over the period 2016-2020, external financing accounted for 65 % of overall health financing against 35 % from domestic resources. Part of the external funds for health came from the multi-donor HDF. This Fund is led by the Ministry of Health and Child Care (MoHCC), in partnership with UNFPA and UNICEF. The EU is its main donor along with the Foreign Commonwealth and Development Office, FCDO (UK), Government of Ireland (Irish Aid),

[4] Global Health Observatory, May 2017

[5] Zimbabwe Revised Nationally Determined Contribution 2021 Final

Swedish International Development Agency, SIDA (Sweden) and the Global Alliance for Vaccines and Immunisation (GAVI). The total contribution from the HDF was USD 340 000 000 over six years (2016-2021) and the EU provided a total of EUR 126 000 000 under the 11th European Development Fund to this Fund.

Zimbabwe benefits from a range of other external funding commitments including over USD 440 000 000 from the Global Fund to fight HIV, TB, Malaria (GFATM) (2018-2020), USD 25 000 for the World Bank's Global Financing Facility (GFF), in 2019 and USD 200 000 000 from the United States Agency for International Development (USAID) in 2020. These funds focus on chosen disease areas but do not provide significant technical support for key healthcare building blocks and reforms.

Government financing to the health sector is growing. The balance between donor funds and domestic funds changed considerably in 2021, with domestic financing constituting 58% and external financing 42% i.e. the budget in 2021 increased to USD 1 150 000 000 from USD 668 000 000 in 2020. In 2021, Zimbabwe received USD 960 000 000 from the IMF Special Drawing Rights (SDR) in 2021. Part of these funds have been used to support recovery from the COVID-19 pandemic, for example, for COVID-19 vaccine acquisition, research and development in the pharmaceutical sector, and the revamping of six referral hospitals. At present, it is not known how much of these SDR will be allocated to health as the government indicated that other sectors, such as mining and agriculture, will also benefit. Since 2019, budget allocation for health has generally improved, reaching a peak in 2021 of 13 % of the budget[6], excluding emergency funding for COVID-19. However, the current spending is still below the Abuja Declaration target of 15 % and any increases could be significantly eroded if high inflation and exchange rate devaluation return.

The HDF will come to an end in December 2021 and the EU has agreed to a no-cost extension until June 2022 to ensure there is a bridge to the next phase of EU support. In the coming years, major donors (EU, UK, Ireland and Sweden) plan to reduce their financial support to the health sector. The EU is planning to contribute over a four-year period, starting in 2021, up to a total of EUR 41 000 000 (approx. 40% less than for the preceding three-year period under the HDF). Therefore, domestic resource mobilisation is needed to ensure sustainability and a phasing-out plan in the long run.

In this complex context, a new multi-donor health programme, provisionally called the Health Resilience and sustainability Fund (HRF) 2021-2025, will replace the HDF. The aim of the new HRF is to continue supporting basic health in ways that will complement government funding. The focus will be on four critical strategies to (i) securing the gains achieved through the HDF by maintaining a focus on essential health services, with consideration of gender needs; (ii) improving accountability and transparency in the provision of quality health services (iii) strengthening health security, including promoting digital tools to increase efficiency (iv) ensuring environmentally sustainable PHC facilities. These activities will contribute to SDGs 2, 3, 5 and 10, deliver on key priorities in Zimbabwe's National Health Strategy 2021-2015, and support the EU's gender equality and disability inclusion priorities. An estimated 70 % of the EU contribution to this action will support the TEI on Gender Equality and Women's Empowerment.

Advocacy and leveraging domestic funding for sustainability and gradual exit from the HDF is a priority for the government to decrease its dependency on donors. At a high-level policy dialogue, that took place on 3rd November 2021, the Ministry of Finance and Economic Development announced that the government is committed to increasing public expenditure in health per capita by 2025 to USD 160 from the current USD 80 per capita. The post-HDF programme Theory of Change (ToC) is that the government will gradually take over the funding of the health sector, but external support is still needed in the medium term to propel the health system towards a 'programmatic tipping point' beyond which local resources could be used to sustain results.

Therefore, under the new Health Resilience Fund (HRF), sustainability includes institutional elements (e.g. integrated planning); financing elements (e.g. innovation to expand fiscal space); and technical elements (e.g. leveraging technologies to enhance efficiency).

[6] This is below the Abuja target of 15 %.

2.2 Problem Analysis

Despite improvements in the health sector, over the past decade, systematic challenges persist, especially in relation to quality of care. **Current levels of government allocations are significantly lower than the needs of the health sector**. Therefore, Zimbabwe remains heavily dependent on external donor support to provide services to the poorest people in Zimbabwe, especially in the context of the economic crisis and Covid-19 pressures.

The role of Development Partners (DPs) is key to sustain quality service delivery in the country and strengthen the health system. **If donor funding for the HDF is terminated there is a risk that the gains made over the past decade, such as reduction in maternal and child mortality, will be reversed**. The MoHCC has also recognised, in the government's draft Programme Document for a Multi-Donor Pooled Fund for Health in Zimbabwe 2022-2025 **that continued external support remains necessary, to sustain results achieved over the past decade**, and to propel the health system towards a 'programmatic tipping point' beyond which local resources could be used to sustain results.

Although other financing instruments (including EU supported Global Fund to Fight HIV, TB, Malaria (GFATM) and the Global Financing Facility (GFF), and bilateral funds from other donors such as USAID), provide investment in specific disease areas, a pooled donor fund, such as the HRF, is still needed to strengthen the wider aspects of the health system, build sustainability, and get the best results from these financing facilities and bilateral funds.

An evaluation of the HDF **recommended an improved design to address gender-based issues that affect women of reproductive age and adolescent girls at community level** including human resources for health (HRH) and Nutrition. In response to this, the MoHCC developed priorities for health in the coming period, including institutionalising community-based primary health care (PHC) systems through the development of a costed community health strategy. Donor support is needed to implement this strategy.
As donor funds cannot cover all health needs, the future programme (HRF) must prioritise investment and strike a balance between health systems strengthening and provision of essential services to the most vulnerable.

Given that Zimbabwe has high maternal and child mortality rates, maintaining quality packages of care, during and after pregnancy, in rural areas, is a high priority especially since there is pressure on the MOHCC to concentrate services in the bigger urban centres. Evidence shows that maternal and neonatal deaths arise from the risks attributable to pregnancy and childbirth, low coverage, and poor-quality health services. **Scaling up high impact interventions and essential health services packages at the primary level has the greatest impact on the burden of disease[7].** If these routine essential services are not maintained, Zimbabwe will not meet the Sustainable Development Goals (SDG) for mothers and children by 2030.

The new HRF will also contribute to the TEI on "Gender Equality and Women's Empowerment' to which Sweden, Netherlands and Ireland are contributing.

Women and girls will be targeted though provision of services (maternal health services, family planning, Sexual Reproductive Health and Rights (SRHR), Gender Based Violence (GBV), and nutrition service) to improve outcomes for women and girls. These activities build upon and complement Pillar 2 (Institutional Strengthening) of the Spotlight Initiative[8]. This Initiative aims to eliminate sexual and gender-based violence (SGBV) and harmful practices. Integrated health/ GBV/SRHR services will be delivered at community level, especially through mobile health teams in rural areas, enhancing the protection of women thus contributing to the goals of the Spotlight Initiative.

Gender inequality will also be tackled in the planning and delivery of health services to ensure that female healthcare staff are recruited in every healthcare facility. Measures will be taken to ensure that women and girls

[7] A cost-effectiveness analysis of maternal and neonatal health interventions in Ethiopia, Solomon et al. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6661540. Health Policy and Planning 34(3) May 18 2019
[8] Technical Guidance Note on the Six Pillars of Spotlight Theory of Change, Spotlight Initiative, Guidance Note (undated), https://endvawnow.org/uploads/browser/files/spotlight_initiative_pillar_guidance_note.pdf

are effectively represented in health sector governance, in particular, primary health care settings. This is important to challenge deeply rooted traditional/religious beliefs held by communities that increase maternal and new born deaths. In addition, gender disaggregated data will be collected to assess whether the programme is equitably reaching women and girls and meeting their specific needs.

Motivating and retaining healthcare workers is a huge challenge in Zimbabwe. Zimbabwe's health professionals are well trained and well regarded. However, **donor funded efforts are needed to prevent the continuous migration ('brain drain') of medical personnel** (to the private sector, to other countries, to other professions) which has put much strain on the health sector in Zimbabwe. Without such support, the quality of services will continue to deteriorate. The HRF will deploy technical assistance and ensure political engagement to lead on key health sector reforms such as addressing public sector wages and other policies to retain health workers.

Zimbabwe's progress to meet the International Health Regulations (IHR) of 2005 is not just a national health security issue but a global one. The country is vulnerable to a wide range of health hazards and has a long way to go to build full capacity to effectively prevent, detect and respond to health threats. **Donor support is needed for crisis preparedness and response capability to respond to health emergencies and emerging health threats.** This includes supporting an effective COVID-19 response and maintaining preparedness for other critical threats such as cholera and typhoid. Crisis preparedness will also be built into the HRF to ensure resources are immediately channelled to respond to a health crisis if needed**.**

Digital health tools and strategies are increasingly recognised as enablers of health system strengthening and crucial to overcome health system bottlenecks[9]. Digital tools deployed for COVID-19, such as certification of vaccination, show a strong potential for scale-up. Investment in such tools is consistent with the action document 'Accelerating the COVID-19 response and strengthening health systems through digital health tools' in the sub-Saharan Africa region[10]. In the context of primary health care (PHC) special attention to the modernisation of the District Health Information System (DHIS) using digital solutions, is justified.

Accountability and transparency including strong and independent monitoring and evaluation systems, is crucial. **The HRF will have a strong focus on independent monitoring and evaluation to ensure performance data are brought together to ensure that resources are utilised efficiently and transparently.** This includes supporting the engagement of civil society organisations (CSOs) to hold health service providers to account. Monitoring will be carried out with full involvement of Health Centre Committees and with adequate representation from CSOs, especially those representing women's health and women's rights. A results-based financing system (RBF) will strengthen primary health services in the poorest districts by providing rewards to individuals or institutions after agreed-upon results are achieved and verified. RBF in Zimbabwe has contributed to improved health service delivery. For example, only 2 % of health facilities in Zimbabwe charge user fees for maternal and child health services via RBF. RBF, if mainstreamed, is a strategic vehicle to improving quality, service availability and financial protection.

The National Health Strategy (NHS) 2016-2020 aims to advance universal health coverage (UHC). Zimbabwe joined the UHC Partnership (UHC-P) in 2018. The UHC-P is supported and funded by the World Health Organization (WHO), the European Union, and other donors (Luxembourg, France, Ireland, UK, Japan, Germany, Belgium and Canada) A Health Systems expert, funded by the Partnership is based in the WHO Zimbabwe office, supports capacity building for human resources and health information systems. These activities could complement the HRF and contribute to improvement of quality of health services delivery.

Promoting safe disposal and management of waste and supporting renewable energy services (Solar for health) **will ensure climate resilient and environmentally sustainable primary health care facilities.**

[9] Concept Note Team Europe Initiative on Digital Health

This action will be aligned with the 2010 Communication and Council Conclusions on the EU role in Global Health[11], the European Consensus on Development (2017)[12]; the joint communication 'Towards a comprehensive Strategy with Africa'[13]; and the Gender Action Plan III[14].

Working with other development partners (UK, Ireland, Sweden and GAVI) over the next four years will not only provide a platform to strengthen the health system but reduce the need for bilateral funding. The previous partnership for the HDF and its predecessor the Health Transition Fund (HTF), has provided DPs with a strong platform for engagement and influence in the sector. The benefits of a pooled funding arrangement included avoiding duplication of effort; increasing influence with the government; and strengthening coordination in the sector.

Related to the programme's sustainability, the UNICEF evaluation report highlights that even though there was no functional HDF exit strategy, the government would like to decrease donor dependency. As the context is uncertain, the report suggests a more flexible programme design be adopted in the future (as an alternative to the more fixed design model of the HDF). The report also suggests a detailed governance structure based on a Central Oversight Committee for policy-setting, risk management and decision-making supported by several thematic committees or technical working groups.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action:
The main sector stakeholders are the Government of Zimbabwe, specifically the MoHCC which, in addition to defining the sector's National Health Strategy, oversees implementation and coordinates development partners. The Health Development Fund (HDF) donors include the EU, FCDO (UK), Irish Aid, SIDA, Sweden and GAVI. The new HRF will aim to continue building collaboration among these partners.

The UN Agencies involved in the health sector (UNICEF, UNFPA, UNDP and WHO) provide technical assistance, financial management support, and secretariat support for major external funds such as the Global Initiatives (GFATM, GAVI and the GFF).

These activities will also complement the support provided by other donors in health care, including the US Government agencies (USAID, Centres for Disease Control (CDC), the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund (GFATM) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), mainly supporting interventions related to HIV-AIDS, Tuberculosis, Malaria, and sexual and reproductive health and the support provided by the World Bank mainly via the Global Financing Facility (GFF).

The World Bank has conducted a number of studies on health sector financing and is implementing the Results-Based Financing (RBF) programme, financing health structures in 18 districts, now handed over to the government. The US Government Agencies (USAID, CDC and PEPFAR) are mainly supporting interventions related to HIV-AIDS, Tuberculosis, Malaria, and sexual and reproductive health. They also attend the HDF steering committee.

CSOs, particularly those representing women's health and women's rights, have a role in prevention and mitigation actions and in supporting quality assurance, monitoring and accountability. CSOs participate in the major sector's coordination platforms, while local health committees keep the health facilities accountable to the community.
70 % of the Action will contribute to the TEI on Gender Equality and Women's Empowerment.
The two EU bilateral donors (namely Sweden and Ireland) with a country programme are developing their own programming exercise to be finalised in 2022 and therefore their definite contribution is still to be established.

The Action also closely coordinates with the Gender Based Violence (GBV) component with the ongoing Spotlight Initiative. The Spotlight Initiative aims to eliminate SGBV (Sexual and Gender Based Violence) through

[11] COM(2010)128 final of 31.03.2010
[12] OJ C 210 of 30.6.2017
[13] JOIN(2020) 4 final of 9.3.2020
[14] JOIN(2020)17 final of 25.11.2020

strengthening the legal and policy framework on SGBV. Activities include institutional capacity development in Ministries of Health, Justice and Social welfare; addressing women's economic empowerment through training and financial support; and strengthening data collection for planning, policy formulation and evidence-based advocacy for the eradication and prevention of SGBV and HPs at national, subnational and community levels. The Spotlight will thus complement the new support to health programme by promoting an enabling environment for the tackling of SGBV and addressing all other factors surrounding it such as social norms, promoting reporting and treatment for survivors and ultimately contributing to its elimination.

It is assumed that the activities of HRF and Spotlight will be mutually reinforcing. As UNICEF and UNDP are also implementing partners of the Spotlight Initiative, duplication will be avoided.

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The general objective (impact) of the action is to save lives and improve health outcomes.

More specifically, the action has the following specific objectives:

1. To save lives, leaving no one behind, with a strategic focus on the most vulnerable in society as an entry point to improve protection of children, adolescents, women and adults, and people including those with disabilities and those forcibly displaced, with full consideration of specific gender needs.
2. To improve accountability, good governance, transparency and sustainability in the provision of quality essential health services and increase devolution to ensure appropriate outreach and capacity at all system levels.
3. To strengthen health security to prevent, detect and respond to health threats, including strengthening health sector preparedness against emerging diseases.
4. To strengthen climate resilient and environmentally sustainable primary health facilities.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives (Outcomes) are also outlined in the Logical Framework. These outcomes and outputs are linked with those of the TEI's Action on Gender Equality and Women's Empowerment.

For SO 1:
Output 1.1: Geographical access maintained to the full range of quality, integrated Reproductive, Maternal, Neonatal, Child, Adolescent and Nutrition (RMNCAH) services, disaggregated by location.
Output 1.2: Increased availability essential medicines and commodities for mothers, new-born's and children.
Output 1.3: Access, within 72 hours, to health interventions for survivors of Gender-based Violence (GBV) complementing the Spotlight Initiative (SI).
Output 1.4: Access maintained to Nutrition services for babies, children, adolescents, and women throughout their life cycle of reproductive age.
Output 1.5: Improved access to youth friendly nurses at primary health facilities.

For SO 2:
Output 2.1: Technical assistance to improve accountability and transparency in health financing systems through Results-Based Financing (RBF).
Output 2.2: Training on the use of Digital Tools, such as District Health Information Systems (DHIS-2) in Health Financing systems to improve data collection and analysis.
Output 2.3: Promotion of gender balance in managerial positions through revision of job descriptions.

For SO 3:
Output 3.1: Support for a strong platform and network for an effective alert and response system for critical health threats
Output 3.2: Promotion of vaccine update including COVID-19 vaccination uptake
Output 3.3: Support to improve capacity indicators of IHR 2005 to be tracked though the State Party Annual Report

For SO 4:
Output 4.1: Training for safe disposal of healthcare waste in PHC facilities.
Output 4.2: Monitoring of sustainable energy services (solar for health) through tracking implementation of efforts to provide solar energy to health centres.
The outputs related to GBV and SRHR will complement those of the Spotlight Initiative. It is assumed that MS's TEI activities on Gender Equality and Women's Empowerment will also have an impact on these outputs. When the contributions from MSs become clear, the outputs will be revisited.

With the EU aiming to phase gradually out its funding for the health sector in Zimbabwe, an exit strategy together with the Government of Zimbabwe, along with an Oversight Committee will be set up to address in a timely manner bottlenecks in the health sector and to respond to upcoming challenges during the exit strategy. This phase will be an excellent opportunity to scale up various digital health management tools, which will contribute to the capacity of the Government of Zimbabwe to manage efficiently the health sector after the this programme has been completed.

3.2 Indicative Activities

Activities related to Outputs 1:
Activity 1.1.1: Development/Re-enforcement of a strong and well-defined referral system between primary and secondary/tertiary will be promoted to ensure continuum of care and effective implementation of PHC as first point of care (including screening for cervical cancer, mental health).
Activity 1.1.2: Commodities and associated supply chain support for maternal and child health services (Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAN) including life-saving nutrition commodities (including family planning commodities for all and privacy to be respected at health facilities, no user fees for young girls for family planning).
Activity 1.3.1: Private and confidential health services for sexual and reproductive health and rights (SRHR) and GBV prevention, complementing activities funded by the Spotlight Initiative in the provinces where it is being implemented
Activity 1.4.1: Breast-feeding advocacy programmes increased to promote breastfeeding, realigning breastfeeding policy directives as well as community attitudes and values towards the exclusive breastfeeding.
Activity 1.4.2: Nutrition services at district level will be strengthened by scaling up high impact critical nutrition interventions through a multisectorial community-based model approach, an improved coordination mechanism between health facility and community system, and through "closing the gap" in referral systems to improve case follow up.
Activity 1.5.1: Adolescent and youth-friendly health services including comprehensive sexual reproductive health and rights (SRHR) education and services for women, men, adolescent boys and girls (including in schools), involving youth friendly nurses.

Activities related to Outputs 2:
Activity 2.1.1: Training provided for resource tracking and financial management linked to Integrated Results Based Management (IRBM).
Activity 2.2.1: Rollout of the Demographic and Health Information Survey (DHIS-2) combined with capacity building for the relevant health staff in district facilities, with a special emphasis on rural facilities.
Activity 2.2.2: Implementation of innovative digital tools to strengthen health systems and overcome bottlenecks.
Activity 2.3.1: Adaptation of recruitment processes at district facility level to ensure increased gender balance.

Activities related to Outputs 3:
Activity 3.1.1: Creation of a network to ensure early reporting of diseases
Activity 3.2.1: Mobile health teams to increase vaccination rates in rural areas.
Activity 3.3.1: Introduction/strengthening of digital tools and alert systems for disease outbreaks including communication systems.

Activities related to Outputs 4:
Activity 4.1.1: Support to staff at PHC facilities to implement health-care waste management guidelines through capacity development.
Activity 4.2.1 Tracking system to be developed to monitor use of solar energy at health facilities and action to be taken to ensure all primary health facilities have support to maintain solar systems.

3.3 Mainstreaming

Climate change and environmental protection.
Zimbabwe faces many problems related to food security, water and energy, including those linked to its climate and vulnerability to droughts, floods and high temperatures. The HRF will be consistent with Zimbabwe's Nationally Determined Contributions (NDC) and will not engage in fossil fuel combustion. This programme will help fight climate change by encouraging investments in energy-efficient power generation for health clinics and providing increased access to clean, affordable energy technology such as solar power systems at health facilities. However, support from the HRF will be limited to tracking and maintenance of solar systems and not installation. This is because of the reduced budget and the fact that other donors (e.g. Sweden) support installation of solar power systems.

Climate risks related to health and possible climate adaptation and mitigation measures (e.g. solar energy, waste management) to make the health system more resilient, will be included in policy discussions and raised at health policy forums (such as the Health Development Partners Group (HDPG), HDF/HRF Steering Committee) and technical working groups, including those on human resource management and healthcare financing. Investment by the government, private sector and other donors will be encouraged and this issue can be raised at meetings with the government and donors. As donor funding for the HRF has been reduced compared with the amount for the HDF, solar installations will not be supported, only the monitoring and tracking of these installations.

Gender equality and empowerment of women and girls
A Health and Gender Equity analysis[15] informed the design of the action. In addition, a draft Joint Needs Assessment on Gender and Youth[16] was taken into account. Gender is fully mainstreamed with emphasis given to maternal and child health including sexual and reproductive health, family planning, gender-based violence and recruitment of female health workers. Additional gender analyses will be completed during the inception phase to get more precise baselines data and reinforce stakeholder analysis to ensure gender issues are fully considered.

The new HRF will also contribute to the TEI 'Gender Equality and Women's Empowerment'. Women and girls will be targeted though provision of maternal health services, family planning, reproductive health and nutrition service. Gender inequality will be tackled in the planning and delivery of health services to ensure interventions are accessible and appropriate to help improve outcomes for women and girls, and are inclusive of people with disabilities. This will include risk screening and diagnosis of disability at birth

Gender based violence (GBV) health responses and treatment protocols will be implemented. These activities **complement the Spotlight Initiative in Zimbabwe which** contributes to the elimination of sexual and gender-based violence (SGBV) and harmful practices (HP) by strengthening mechanisms at the district level to deliver on various GBV/SGBV and SRHR mandates. Victims of gender-based violence will be supported and protocols implemented. Gender inequality will be tackled in the planning and delivery of health services to ensure interventions are accessible and appropriate to help improve outcomes for women and girls, and are inclusive of people with disabilities. Measures will be taken to ensure that women and girls are effectively represented in health sector governance, in particular, primary health care settings. This is important to challenge deeply rooted traditional/religious beliefs held by communities that increase maternal and new born deaths. In addition, gender disaggregated data will be collected to assess whether the programme is equitably reaching women and girls and meeting their specific needs.

Human Rights

[15] Health and Gender Equity Policy Brief, The World Bank, June 2019.
[16] Draft Joint Needs Assessment on Gender and Youth, UNFPA, Zimbabwe, 2021.

The action will ensure the implementation of the Human Rights Based Approach principles: Respecting all rights, non-discrimination, transparency, participation and accountability. Interventions will be designed 'to leave no one behind' in line with the human rights-based approach to programming. All categories of the community, with a special attention to vulnerable populations living in the most vulnerable situations such women and girls, will have access to health service under this action. The awareness of Village Health Workers (VHW), as well as clinic and hospital staff, will be raised on the fact that vulnerable groups such as those living in poverty, the disabled and people living in hard-to-reach communities should be considered as priority groups to be included in service delivery. Public institutions will be considered as duty bearers and the action will aim to reinforce their capacities to realise their responsibilities. The public will be considered as rights-holders and will be represented by the CSOs. These organisations will be involved in the action.

Disability
Physically and mentally disabled people will be given easier access to health services. A strong health system would enable more disabilities to be detected at birth. An addition, disaggregated data will be collected to assess whether the programme is equitably reaching people with disabilities and meeting their specific needs.

Democracy
Health services will be provided to all specifically vulnerable groups such as women, children and people with disabilities, and those living in the most vulnerable situations. Conflict sensitivity and do-no-harm approaches should be considered in relation to: targeting/selection of beneficiaries, geo-focus and corruption risks. In particular, anti-corruption mitigation measures need to be considered when it comes to service delivery and interventions with a resource transfer as they may create competition, divisions and conflict.

Disaster Risk Reduction
Sustained investments in primary health systems, such as in infrastructure, solar energy systems, mobile health teams, will make the health system more resilient to respond to the impacts of disasters. The HRF will have flexible funding to respond to emergencies and disasters such as outbreaks of disease e.g. cholera, a new Covid variant, and droughts or cyclones.

3.4 Risks and Lessons Learnt

Category	**Risks**	**Likelihood (High/ Medium/ Low)**	**Impact (High/ Medium/ Low)**	**Mitigating measures**
1	Weak governance and political buy-in (possibly worsened by COVID-19 pandemic and upcoming elections in 2023)	High	High	- Close cooperation with CSOs and UN - Close cooperation with Government of Zimbabwe at sub-national (District-) level Increased political and policy dialogue on appropriate governance reform at national and sub-national levels, technical assistance for the MOHCC on internal management of the HRF.
2	Weak sector coordination between and amongst health DPs, Ministry of Finance and Economic Development (MoFED) and MoHCC	Low	Medium	- Establishment of DPs/UN/Government of Zimbabwe oversight mechanism, regular monitoring mechanism and flexible programming approach
3	Deterioration of medical supply, including family planning commodities and outflow of skilled medical and nursing staff (brain drain)	Medium	Medium	- Close collaboration with other DPs and inter-non-governmental organisations active in the sector to achieve/maintain quality health care as well as expertise on sustainable financial solutions suitable for the situation and context.

				Policy dialogue with the government and UN partners for a proper retention scheme for medical and nursing staff. Policies to enhance recruitment and deployment with a gender lens
1	MSs initially committed to funding the HRF or TEI withdraw	Low	Low	Technical and financial monitoring of the implementation of the action will be a continuous process and transparency will be ensured. Donors will working closely with the MoHCC and ensure a sustainable exit strategy including increasing financial support for the HRF from the government.
2	More COVID-19 waves and limited vaccination	High	Medium	Government aims to vaccinate 60% of population by December 2021. Vaccine stocks are adequate but more measures are needed to be to address vaccine hesitancy. The government and partners have plans to address this and the EU is involved in policy dialogue.

Lessons Learnt:

In spring 2021, a UNICEF-initiated evaluation of the HDF concluded that the HDF's objectives and strategies were consistent with and relevant for Government of Zimbabwe's health sector policies and plans in terms of prioritizing and addressing community healthcare and nutrition needs.

Over the past decade, health sector support through the HDF (and the predecessors Health Transition Fund/Extended Support Programme (ESP)) made significant gains in the financing, management and delivery of basic health services, including progress towards reducing user fees especially at primary health care (PHC) level; increasing availability of essential medicines and commodities; and increasing coverage (above 80%) of the community-based health care services through the establishment of community health workers nationwide.

The HDF succeeded, to some extent, to slow down the breakdown of the health system that had been underway since the early 2000s and that was significantly accelerated during the economic and financial crisis of 2007-2008. Notable progress on several key health indicators was achieved over the past decade. For example, between 2014 and 2019, maternal mortality decreased by 25 % and under 5 mortality decreased by 3 % (Multiple Indicator Cluster Survey - MICS 2019). Stunting declined from 32 % in 2011 to 24 % in 2019 (MICS, 2019). Between 2016 and 2021 over one million adolescents and youth were reached with sexual and reproductive health rights (SRHR) and HIV services in 20 targeted districts, which contributed to a reduction in adolescent pregnancies.

The HDF accelerated innovative technology use for healthcare services, which did help improve results. For instance, the Village Health Worker (VHW) use of mobile application/devices for registration and reminders for mothers for antenatal and post-natal care did work in improved rates for antenatal care visits. Similarly, the online/remote specialist consultations (via phone - under mentorship interventions) proved useful, and merits replication wherever possible.

In addition, the HDF provided DPs with a strong platform for engagement and influence in the sector. Benefits of the pooled fund have included avoidance of duplication of effort; the ability to strengthen the health system in coordination with other donors and the government; and the opportunity to use resources flexibly for emergency response while protecting essential services. For example funds were allocated for response interventions to health emergencies such as Cyclone Idai in 2019 and the COVID-19 pandemic.

However, despite the success of the HDF and general improvements in health service delivery, a deeper investigation of health indicators shows a less satisfactory picture. The programme faced the challenge of a continuous outflow of trained healthcare workers (especially doctors & nurses) due to low salaries/compensation. This is causing serious disruption, impacting the quality of care, and is disproportionally affecting women.

The triple role of UNICEF as (i) the administrator of the HDF, (ii) its main implementer and (iii) its main negotiator/interlocutor with the MOHCC has resulted in a diminished steering capacity by the lead donors of the HDF. This in turn has led to a situation that interventions under the HDF continued though their effectiveness had been limited, as the end evaluation report of the HDF has demonstrated.

A substantial, direct and reliable dialogue between Development Partners (DPs) was also not continuously achieved, which, as a consequence, led to uncertainties related to important policy decisions by the Government of Zimbabwe. This included a clear government exit strategy including reduced reliance on DPs.

The main instrument for coordination has been the Steering Committee, which was not sufficient to provide a regular platform for a substantial policy dialogue, especially during the COVID-19 pandemic. Finally the impact of the COVID-19 pandemic and the direct consequences of the lockdown measures as well as the pressure on the health systems has had a negative impact on the key health indicators which were (until recently) improving mainly due to the HDF.

The HDF model needs to be modified, to strengthen the interaction between the donor community and the Government of Zimbabwe, to ensure that EU investment, and investment by other donors in the health sector, is utilised more efficiently.
As outlined in section 4.7 -Organisational Set-up and Responsibilities, measures will be taken to address these problems. A Strategic Leadership and Accountability Group, chaired by the UNRCO will support the donor high-level representation and better communication with the Government. A substantial change between the HDF and the HRF would be that a new independent Programme Monitoring Unit (PMU) to be based in the MoHCC, in the Health Policy Division, with a co-ordinating and monitoring role. These activities will ensure that the new HRF integrates a realistic transition and exit strategy from Zimbabwe's health sector by the EU over the coming period. The government has already indicated that they want to reduce donor dependency and have already increased spending on health over the past few years. The government's commitment will be closely monitored and will be a key objective during the mid-term review of the HRF, as well as a condition of more support from the EU.

3.5 The Intervention Logic

he intervention logic for this action, including the identified outputs and activities, is based on the analysis of the burden of disease in Zimbabwe, the evaluation of the HDF 2016-2020, the National Health Strategy 2021-2025, and the MoHCC's Post HDF programming document. For the latter document, a Technical Working Group (TWG) comprising personnel from all key units of the MoHCC, DPs (including the EU) and UN agencies (UNICEF, UNFPA and WHO) undertook a priority setting exercise. The **specific objectives (outcomes), outputs and activities**, for this Action are based on this exercise.

The underlying intervention logic is that supporting public health service delivery at district level in a comprehensive manner is the most effective approach to ensure the provision of equal access to quality health services. This in turn will contribute to the achievement of the overall objective of this action, i.e., to save lives, improve health outcomes and to foster equitable socio-economic inclusion for all citizens of Zimbabwe. The intervention logic will reinforce the intervention logic of the TEI.

To achieve this goal a four-pronged strategy is proposed:

- High-impact cost-effective and evidence-based interventions will be maintained at primary level with a special focus on geographical areas showing the worst health indicators. If activities, such as integrated Reproductive, Maternal, Neonatal, Child, Adolescent and Nutrition (RMNCAH) services, target rural health structures, and if user fees are removed, pregnancy complications can be prevented and maternal and neonatal mortality rates can be reduced. Full access to the full range of comprehensive services for Women's Health (including to GBV services, family planning services for all women, including teenagers) is key to the action's contribution to the TEI on Gender Equality and Women's Health.
- Secondly, capacity development and engagement of civil society, at district level, is key to improving accountability and transparency. As a priority of the action is preventing the high attrition of skilled healthcare staff, especially nurses, it is important that staff, especially females, are adequately trained and represented both in the workforce and in governance structures (e.g. Health Centre Committees, Village Development Committees). This in turn will strengthen the health system not only by improving organisational and management skills, but by motivating healthcare workers. Health workers can also be motivated by delivering Results-Based Financing (RBF) and ensuring a supportive workplace environment. This is turn will improve the quality of care and reduce preventable deaths. These activities are also key to the action's contribution to the TEI on Gender Equality and Women's Empowerment.
- Thirdly, capacity development, better coordination, and investment in digital tools and alert systems for disease outbreaks, will strengthen the country's preparedness and response capacity for health hazards (e.g. cholera) and emerging threats (e.g. COVID-19) and ensure the Country's compliance with the International Health Regulations (IHR 2005). This is turn will reduce preventable deaths.
- Fourthly, systems to monitor solar energy and implementation of hazardous waste management guidelines will ensure that PHC facilities are environmentally sustainable and are better able to adapt to the effects of climate change.

A number of **assumptions** underpin the new HRF design. These include the expected gradual take-over of financing of the HRF by the government. This assumes that economic volatility will not constrain fiscal space and that the government will meet its obligations in health, including increasing public expenditure per capita by 2025 to USD 160.

Other assumptions include continued synergies with relevant stakeholders on their specific disease areas (e.g. GFATM, GFF, bilateral donor projects); and the development of innovative approaches to improve efficiency in the healthcare systems e.g. use of innovative digital technology.

The action will also support the implementation of a realistic Exit Strategy aimed at enhancing the government's capacity to fund and manage health services at primary level after the end of EU support. For this purpose, the action will enhance organisational and managerial skills at national, provincial and district level, strengthening the capacity of human resources for health and ensuring their availability.

3.6 Logical Framework Matrix

At action level, the indicative logframe should have a maximum of 10 expected results (Impact/Outcome(s)/Output(s)).
It constitutes the basis for the monitoring, reporting and evaluation of the intervention.
On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage. In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

- At inception, the first progress report should include the complete logframe (e.g. including baselines/targets).
- Progress reports should provide an updated logframe with current values for each indicator.
- The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.
The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision

Results	Results chain (@): Main expected results (maximum 10)	Indicators (@): (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To contribute to saving lives, improving health outcomes for the population of Zimbabwe	1. a. Institutional Maternal Mortality Ratio (SDG 3.1.1) (MMR). 1.b. Maternal Mortality Ratio 2. Under Five Mortality Rate (U5MR) (SDG 3.2.1)* 3. Prevalence of stunting in children under five years of age (SDG2.2.1)* 4. Adolescent Birth Rate 5. Cervical cancer incidence 6. Perinatal mortality rate	1. 102 per 100 000 (2018) 1.b. 462 per 100 000 (2019) 2. 65 per 1000 live births (2019) 3. 23.5 % (2019) 4. 108 per 1000 live births (2019) 5. 25 per 100 000 (2020) 6.29 (2019)	1 60 per 100 000 (2024) 2. 277 per 100 000 2024 2. 45 per 1000 live births (2024) 3.20% (2024) 4. 95 per 1000 live births (2024) 5.11 per 100 000 (2024) 6. 22 (2024)	1. DHIS 2 2. MICS/Zimbabwe Demographic Health Survey (ZDHS) 3. MICS/ZDHS 4. MICS/ZDHS	Not applicable
Outcome 1	1.1 To save lives, leaving no one behind, with a strategic focus on the most vulnerable in society as an entry point to improve protection of children, adolescents, women and adults, and people including those with disabilities and those forcibly displaced, (with full consideration of	1.1 Proportion of the population living within a radius of 10 km of a health facility 1.2 Proportion of deliveries attended by a skilled birth attendant 1.3 **EU Results Framework (EURF) 2.33 Number of women of reproductive age using modern contraception methods with EU support	1.1 83 % (2009) 1.2 86 % (2019) 1.3TBD 1.4 TBD	1.1. 88 % (2024) 1.2. 91 % (2024) 1.3. TBD 1.4 TBD	1.1.DHIS 1.2 DHID 1.3 UNICEF reports 1.4 UNICEF	2. The overall country socio-economic situation will improve 3. The Government will meet commitments to increase domestic resources for health 4. Availability of basic services e.g. electricity, water, communications etc. 5. Skilled health workers will be retained

	specific gender needs).	1.4 **EURF 2.32 Number of women of reproductive age, adolescent girls and children under 5 reached by nutrition related interventions supported by				6. Equipment will be available and in good working order 7. Health emergencies will be managed and not disrupt the health system 8. Synergies will be maintained with other donors (e.g. GFF) to increase efficiency and effectiveness 9. Innovative digital technology will improve efficiency in the health system
Outcome 2	2.1 To improve accountability, good governance, transparency and sustainability in the provision of quality essential health services, and increase devolution to ensure appropriate outreach and capacity at all system levels.	2.1 Proportion of participating health facilities that meet their performance targets	2.1 TBD A	2.1 92 % (2024)	2.1 RBF Admin report	
Outcome 3	3.1 To strengthen health security to prevent, detect and respond to health threats, including strengthening health sector preparedness against emerging diseases.	3.1 Proportion of outbreaks detected within 48 hours in line with IDSR guidelines 3.2. Certification of COVID-19 vaccination, testing and recovery status using digital tools i.e. number of digital vaccination certificates	3.1 43 % (2020) 3.2 TBD during Inception, disaggregated by sex	3.1 75 % (2024) 3.2 TBD	3.1 DHIS-2 3.2 MoHCC /Country reports	As above Countries and regions are prepared to adjust their laws and regulations to enable the adaptation process of respective platforms to the Digital Covid-19 vaccination certificate and report regularly

						on the roll-out of the programme.
Outcome 4	To strengthen climate resilient and environmentally sustainable primary health facilities.	4.1 Proportion of health facilities implementing IPC (Infection, prevention and Control) guidelines. ’ 4.2 Proportion of HRF health facilities using solar energy	4.1 TBD 4.2 TBD	4.1 T**BD** **4.2 TBD**	4.1 MoHCC/ UNICEF/WHO reports 4.2 MoHCC/ UNICEF/WHO reports	As above
Results	**Results chain (@): Main expected results (maximum 10)**	**Indicators (@): (at least one indicator per expected result)**	**Baselines (values and years)**	**Targets (values and years)**	**Sources of data**	**Assumptions**
Output 1 related to Outcome 1	1.1. Geographical access maintained to the full range of quality, integrated Reproductive, Maternal, Neonatal, Child, Adolescent and Nutrition (RMNCAH) services, disaggregated by location. 1.2 Increased availability of essential medicines 1.3Access to health-related GBV services 1.4 Improved access to youth friendly health services	1.1.1 Number of health facilities, supported by the HRF, providing comprehensive emergency obstetric and new-born care services 1.2.1 % availability of selected tracer medicines (inc family planning commodities) at HRF facilities 1.3.1 Proportion of SGBV survivors who access health services within 72 hours at hospitals and clinics funded by the HRF 1.4.1 Proportion of HRF facilities providing adolescent and youth-	1.1.1 TBD 1.2.1 51 % (2020) 1.3.1 20 % (2020) 1.4.1 78 %(2020)	1.1.1 94 % (2024) 1.2.1 74 % (2024) 1.3.1 45 % (2024) 1.4.1 88 %	1.1.1VHMAS Report /MOHCC 1.2.1 DHID 1.3.1 UNFPA report 1.4.1 UNFPA report 1	As above 1. Skilled health workers will be retained 2. Equipment will be available and in good working order 3. Health emergencies will be managed and not disrupt the health system 4. Synergies will be maintained with other donors (e.g. GFF) to increase efficiency and effectiveness 5. Supplies of commodities and medicines will not be disrupted

		friendly services that meet national standards in supported provinces				
Output 2 related to Outcome 2	2.1 Technical assistance to improve accountability and transparency at HFs through RBF 2.2 Training in use of digital tools for DHIS 2.3 Promotion of gender balance in managerial positions	2.1.1 Proportion of primary health care facilities, supported by the HRF, with functional Health Centre Committees 2.2.1 Number of HRF staff trained with support of the EU-funded intervention with increased knowledge and/or skills in use of digital tools, disaggregated by sex 2.3.1 Proportion of HRF facilities providing training sessions for HR to enhance recruitment and deployment with a gender lens	2.1.1 100 % (2020) 2.2.1 TBD 2.3.1 TBD	2.1.1- 100 % 2.2.1 TBD 2.3.1 TBD	2.1.1 MOHCC reports 2.2.1 MOHCC/UNICEF/ Health Information Management Systems (HIMS) reports Pre- and post- training information 2.3.1. MoHCC/UNICEF reports 2.4.1 UNICEF/ DHIS reports	As above
Output 3 related to Outcome 3	3.1 Support for a strong platform/ network to deliver an effective infectious disease alert and response system 3.2. Promotion of vaccine uptake Support to improve capacity indicators of IHR 2005 to be	3.2.1 Number of health agencies/ Non-Governmental Organisations (NGO's) part of network 3.2.1 Proportion of children under 1 year covered by PENTA 3* (Pentavalent) in HRF supported hospitals and clinics	3.1.1 TBD 3.2.1 TBD 3.2.1 TBD	3.1.1 TBD 3.2.1 TBD 3.3.1 TBD 3.6.1 TBD 3.6.2 3.3.1 TBD	3.1.1 MOHCC admin /UNICEF/ WHO reports 3.2.1 Country progress reports 3.3.1. WHO reports	As above

	tracked through State Party Annual Report	Proportion of districts with HRF supported clinics and hospitals implementing a multihazard/multisector forecasting early warning system including use of digital tools				
Output 4 related to Outcome 4	4.1 Training for safe disposal of healthcare waste for PHC facilities 4.2 Monitoring of sustainable energy (solar for health) through tracking	4.1.1 Number of staff, working in HRF facilities, trained in health care waste management guidelines (IPC guidelines)* 4.2.1.Number of HRF health facilities implementing guidelines on healthcare waste management 4.3.1 Proportion of HRF health facilities tracked for solar energy cold chain functionality	4.1.1 TBD 4.2.1 TBD 4.3.1 TBD	4.1.1 70 % 4.2.1 TBD 4.3.1 TBD	4.1.1 Pre- and post-training information from MOHCC admin /UNICEF/ WHO reports 4.2.1 UNICEF/MohCC reports 4.3.1 UNICEF/MoHCC reports	1. Skilled health workers will be retained 2. Equipment will be available and in good working order 3. Health emergencies will be managed and not disrupt the health system 4. Synergies will be maintained with other donors (e.g. GFF) to increase efficiency and effectiveness 5. Supplies of commodities and medicines will not be disrupted

4 IMPLEMENTATION ARRANGEMENTS

4.1. Financing Agreement

In order to implement this action, it is envisaged to conclude a financing agreement with the Republic of Zimbabwe.

4.2. Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in Section 3, will be carried out and the corresponding contracts and agreements implemented, is 48 months from the date of entry into force of the financing agreement.
Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements

4.3. Implementation of a Budget Support Component

N/A

4.4. Implementation modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[17].

4.4.1 Indirect management with an international organisation

This action may be implemented in indirect management with UNICEF.

The envisaged entity has been selected using the following criteria:

- relevant expertise, experience and presence in the country;
- specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of maternal and child health, particularly integrated health and nutrition packages at community level;
- proven delivery experience and capacity to manage a fund of this size and complexity having managed the HDF (and its predecessor the HTF) since 2010. UNICEF have an established relationship with the MoHCC and staff is already in place to manage financial resources.
- strong technical networks and proven capacity in convening the HDF Steering Committee. This has been important in bringing influence from the HDF and increasing the impact with the government and other stakeholders.

UNICEF has developed comprehensive plans in line with the MoHCC National Health Strategy, 2021-2025, focusing on the most prioritised areas of activities in primary health care (PHC), which is targeted under this action. In addition, the MoHCC has outlined the organisation set-up and responsibilities for the post-HDF programme[18]. This document has recommended that the programme be implemented under the management of UNICEF in coordination with UNFPA and WHO. UNFPA has technical expertise in SRSH and adolescent health and WHO

[17] www.sanctionsmap.eu. Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.
[18] MoHCC Post HDF Programming document, November 2021

has technical expertise in global health security. All agencies have technical expertise in health systems strengthening and have access to international markets for procurement of supplies and equipment.

Exception to the non-retroactivity of costs
The Commission authorises that the costs incurred may be recognised as eligible as of 1st July 2022. This is because the current HDF will end on 30 June 2022 and a funding gap could arise between July 2022 and adoption of the Decision. If funds are not available to cover such a gap, the gains made of the past few years could be reversed and maternal and child mortality could increase, especially in the context of the COVID-19 pandemic and the economic crisis. The Government does not have sufficient funds to cover the full gap, however Development partners have prioritised the sub sectors in health in urgent needs for ad hoc Government support.

4.5. 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 on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.6. Indicative Budget

Indicative Budget components	**EU contribution (amount in EUR)**	**Third-party contribution, in currency identified**
Implementation modalities – cf. section 4.4		
Indirect management with UNICEF – cf. section 4.4.1	41 000 000	GBP 37 000 000
Evaluation – cf. Section 5.2 **Audit –** cf. Section 5.3	N/A	N/A
Totals	41 000 000	GBP 37 000 000

4.7. Organisational Set-up and Responsibilities

A Strategic Leadership and Accountability Group, chaired by the UNRCO will support the Donor high-level representation. This group will be composed of the funding partner heads, the United Nations Resident Coordinator (UNRC), the Permanent Secretary for Health and implementing partner's representatives. The main role of this group will be to examine the medium and longer term broader health objectives and strategically and holistically assess the sector in order to influence the HRF Project implementation to ensure it is efficient.

The Strategic Leadership and Accountability Group could also offer opportunities for more funding partners' visibility.

A Project Steering Committee (PSC) will be responsible for technical oversight and HRF decision making. The HRF Steering Committee will be composed of MoHCC, funding partners to the HRF and to the health sector in general, UN implementing agencies (UNICEF, UNFPA, WHO), the World Bank, Civil Society representatives (local and international NGOs) and the Health Services Board. UN agencies (WHO, UNFPA) would also serve as technical advisors and UNICEF would a serve as the Secretariat. The PSC would meet quarterly and would be co-chaired by the Permanent Secretary of the MoHCC and one Funding Partner.

UNICEF would have two distinct roles in the HRF, as fund manager and, as implementing partner in areas where the agency has a comparative advantage as determined by the PSC. A number of safeguards would be put into place to ensure transparency and segregation of duties as necessary.

Under the HDF, there was insufficient focus on sustainability and an exit strategy. There is a need to work more closely with the MoHCC. A substantial change between the HDF and the HRF would be a new independent Programme Monitoring Unit (PMU) based in the MoHCC, in the Health Policy Division, with a co-ordinating and monitoring role. This would give strength to the role of the government as this Unit would ensure that the HRF is aligned with the National Health Strategy 2021-2015 and with other significant global health programmes (GFATM and GFF), which are also based in the Ministry. The role of such a Unit would also include consolidation of all narrative reports (annual reviews, quarterly updates) and submitting these reports to the donors, UNRCO and the PSC, for approval. This would ensure a link between Monitoring & Evaluation data and management decisions.

The majority of the HRF activities will be executed by the MoHCC but contracted and paid for by UNICEF. Other specific components would be delivered by academic or research institutions, private sector companies, UN agencies, or non-governmental organisations using UNICEF tender or partnership cooperation agreement procedures. The Terms of Reference for these specific components would be approved by the HRF Steering Committee, with contracts awarded based on comparative advantage, ability to deliver results and value for money. Key comparative advantages would be considered in areas where a national programme and provider are already engaged and performing successfully.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in governance structures such as the Steering Committee and the Oversight Committee to ensure and effective implementation of the action.

5 PERFORMANCE MEASUREMENT

5.1 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. This will be coordinated with the monitoring of actions under both the TEI on Gender Equality and Women's empowerment and the Spotlight Initiative.

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 (for project modality) and the partner's strategy, policy or reform action plan list (for budget support).

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).
Roles and responsibilities for data collection, analysis and monitoring:

To increase accountability, monitoring will assess gender equality results. Measures will be taken to ensure that women and girls are effectively represented in health sector governance, in particular, in primary health care (PHC) settings. This is important to challenge deeply rooted traditional/religious beliefs held by communities that increase maternal and new-born deaths. An addition, gender-sensitive and sex-disaggregated indicators will be collected to assess whether the programme is equitably reaching women and girls and meeting their specific needs.

Additionally a yearly Joint Monitoring field visit with the implementing partners will evaluate the quality of health services provides at rural, district and provincial levels in order to guide the annual MoHCC, Implementing Partners' and Development Partners' (DP) planning processes.

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 mid-term and final reports, 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).

5.2 Evaluation

Having regard to the importance of the action, mid-term and final evaluations will be carried out for this action or its components via independent consultants contracted by the Commission.

If feasible, evaluations will be coordinated with those carried out by Member States to evaluate the impact of the TEI on Gender Equality and Women's Empowerment.

They will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact that the programme should gradually transfer some components of this action to be led and eventually financed by the Government and its line ministry, the MoHCC.

The Commission shall inform the implementing partner at least 2 months in advance of the dates foreseen for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination 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 evaluation will be gender and human rights sensitive, assessing gender equality and human rights results and implementation of rights-based approach working principles (participation, non-discrimination, accountability and transparency).

Evaluation services may be contracted under a framework contract.

5.3 Audit and Verifications

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 audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

It will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programs are in principle no longer required to include a provision for communication and visibility actions promoting the programs concerned. Communication activities will be coordinated with MS involved in the TEI on Gender Equality and Women's Empowerment.

These resources will instead be consolidated in Cooperation Facilities established by support measure action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale

Appendix 1 REPORTING IN OPSYS

The present action identifies as

Action level		
x	Single action	Present action: all contracts in the present action