EN

THIS ACTION IS FUNDED BY THE EUROPEAN UNION

ANNEX 1

of the Commission Decision on the financing of the Annual Action Programme 2019 in favour of the Republic of Zimbabwe

Action Document for Improving Health Outcomes for the Population of Zimbabwe II

1. Title/basic act/ CRIS number	Improving Health Outcomes for the Population of Zimbabwe II CRIS number: ZW/FED/042-236 financed under the 11th European Development Fund (EDF)	
2. Zone benefiting from the action/ location	All provinces, Zimbabwe	
3. Programming document	National Indicative Programme (NIP) 2014-2020 for Zimbabwe	
4. Sustainable Development Goals (SDGs)	Main SDGs: 2, 3 (nutrition/health) Other significant SDGs : 5, 6, 7 (gender, water and sanitation, renewable energy)	
5. Sector of intervention/ thematic area	Health sector	DEV. Assistance: NO[1]
6. Amounts concerned	Total estimated cost: EUR 160 000 000 Total amount of EDF contribution EUR 38 000 000, 11% of the NIP This action is co-financed in joint co-financing by: - United Kingdom for an amount of GBP 53 140 000[2] - Ireland for an amount of EUR 2 000 000 - Sweden for an amount of Kroner 50 000 000[3] - Global Alliance for Vaccinations and Immunization for an amount of USD 13 456 090[4]	
7. Aid modality and implementation modality	Project Modality Indirect management with UNICEF and UNFPA	
8 a) DAC code	Main DAC code:122 Basic Health – Sub code 12220 Basic Health care	
b) Main Delivery Channel	UNICEF - 41122; UNFPA - 41119	

[1] Official Development Assistance is administered with the promotion of the economic development and welfare of developing countries as its main objective.
[2] InfoEuro rate (October 2019) : EUR 59 857 171.82
[3] InfoEuro rate (October 2019) : EUR 4 672 460.52
[4] InfoEuro rate (October 2019) : EUR 12 305 523.55

9. Markers (from CRIS DAC form)[5]	**General policy objective**	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☐	X	☐
	Aid to environment	X	☐	☐
	Gender equality and Women's and Girl's Empowerment [6]	☐	X	☐
	Trade Development	X	☐	☐
	Reproductive, Maternal, New born and child health	☐	☐	X
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity	X	☐	☐
	Combat desertification	X	☐	☐
	Climate change mitigation	X	☐	☐
	Climate change adaptation	X	☐	☐
10. Global Public Goods and Challenges (GPGC) thematic flagships	None			

SUMMARY

The social impact of Zimbabwe's new Government's fiscal reform programme has aggravated the existing challenges faced by the health sector, impacting negatively on health services delivery, availability of pharmaceuticals and motivation and training of the workforce.

The action aims at enhancing support to the health sector with the objective of improving health outcomes for the population. It is based on the Ministry of Health and Child Care's (MoHCC) strategy 2016-2020 of achieving equity and quality of health and builds on the experience of past interventions.

Public health service delivery will be supported in a comprehensive manner with a three pronged strategy:

- support high impact interventions in primary health care structures to ensure their capacity to protect the population against the main health threats;

- strengthen national health systems by improving organisational and managerial skills at provincial and district level, strengthening the capacity of human resources for health;

- support the necessary reforms on health financing and governance, the development of appropriate policies and strategies and enhancing community participation in governance structures.

The action will be co-financed with other development partners (DPs) by pooling resources into the Health Development (HDF) administered by UNICEF and UNFPA.

[5]When a marker is flagged as significant/principal objective, the action description should reflect an explicit intent to address the particular theme in the definition of objectives, results, activities and/or indicators (or of the performance / disbursement criteria, in the case of budget support).

[6] Please check the Minimum Recommended Criteria for the Gender Marker and the Handbook on the OECD-DAC Gender Equality Policy Marker. If gender equality is not targeted, please provide explanation in section 4.5.Mainstreaming.

1 CONTEXT ANALYSIS

1.1 Context Description

Zimbabwe has a legacy of a well-functioning health system, though it suffered huge disinvestment and loss during 2000s. With the current economic and financial crisis, the health system faces significant challenges including insufficient resources to offer a basis package of care; domestic resources almost fully devoted to paying salaries; and over-reliance on external financing.

The new Government sworn in in September 2018 faces severe fiscal constraints, aggravated by debt arrears and an unsustainable debt level, prompting implementation of measures aimed at fiscal stabilisation including currency reform. While critical in the current economic environment, these measures, compounded by the El-Nino-related drought and the devastating effect of Cyclone Idai, disproportionately impact the poorest and most vulnerable in society.

In order to support the population and promote continuous reforms the allocation of the National Indicative Programme (NIP) will be increased by EUR 53 million (from EUR 234 million to EUR 287 million) and the amount of focal sector 1 "Health" by EUR 38 million (from EUR 88 million to EUR 126 million). Substantial support has been provided over the past years to the health system and mitigate the impact of economic and environmental shocks. The HDF and its predecessor, the Health Transition Fund (HTF), succeeded in mitigating the impact of the economic and financial crisis of 2007-2008 and subsequent economic and fiscal constraints on the health system.

The social pressure resulting from the recently introduced spending and fiscal reforms have resulted in scarcity of pharmaceutical and additional burden to the population with increasing level of poverty. In addition, significant worsening of working conditions and occupational unrest amongst medical personnel has already led to further brain-drain from the sector. New support to health provisions, with a focus on maternal and child health care, and pharmaceuticals will be channelled through the HDF. The support will embed a phasing out approach for government to gradually take over responsibility for sustaining these services.

The current National Health Strategy (NHS) 2016-2020 aims to advance universal health coverage (UHC) as part of broader national efforts to tackle extreme poverty, social exclusion and gender inequity. In response to the current fragility of the health system, this action will enable the Ministry of Health and Child Care (MoHCC) to offer adequate basic health services for all with quality improvement and availability of essential medicines, among others.

1.2 Policy Framework (Global, EU)

The programme will carry forward and deepen the reforms of health and social protection sectors promoted under earlier EU interventions, with a direct and beneficial impact on the most marginalised and, in line with the Agenda for Change, 'build the foundations for growth and ensure that it is inclusive'.

The European Commission communication 'The EU Role in Global Health'[7] of 2010 highlights that the preferred framework for providing EU support should involve joint donor processes following the UHC 2030 principles and affirmed EU and EU Member States' commitment to achieving 'equitable and universal coverage of quality health services' and supporting countries to 'put in place fair financing of health systems and develop or strengthen social protection mechanisms in the health sector'.

[7] COM(2010) 128 final of 31.3.2010.

The new European Consensus on Development of June 2017[8] reaffirms the commitment to supporting partner countries in their efforts to build strong, good-quality and resilient health systems, by providing equitable access to health services and universal health coverage, as well as continue promoting cross-sectoral initiatives at international, regional and local levels. The Consensus further re-affirms its support to partner countries in their efforts to build resilient and quality health systems, including the strengthening of the Global Health Workforce, the prevention and treatment of communicable and non-communicable diseases.

The action aligns with the Gender Action Plan[9], more specifically with objective no 10 'Equal access to quality preventive, curative and rehabilitative physical and mental health care services for girls and women'.

1.3 Public Policy Analysis of the partner country/region

*The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (*ZimAsset) – *(2013-2018)* guided the preparation of the current National Health Strategy 2016–2020.

The Transitional Stabilisation Programme (October 2018 - December 2020) provides for investment in health services to be guided by the 2016-2020 National Health Strategy.

Zimbabwe has adopted a National Health Strategy (NHS) *for 2016-2020* which is consistent with the EU's policy goals.

In 2018, Zimbabwe has adopted a *Human Resource for Health Strategy and Policy* which is soon to be disseminated and implemented.

The National Gender Policy (2013-2017).

These policies address adequately the challenges of the concerned sector.

1.4 Stakeholder analysis

The main sector stakeholder is the Government of Zimbabwe, specifically the MoHCC which, in addition to defining the sector's National Policy and Strategy, oversees their implementation and coordinates DPs.

The UN Agencies involved in the health sector (UNICEF, UNFPA, UNDP and WHO) provide technical assistance, financial management and secretariat support for major external funds such as the Global Initiatives (GFATM, GAVI) and the HDF which include the EU, DFID (UK), Irish Aid, and SIDA Sweden.

The World Bank has conducted a number of studies on health sector financing and is implementing the Result Based Financing (RBF) programme of financing of health structures in 18 districts which are now in the process of being handed over to the government following an institutionalisation roadmap. There are ongoing discussions on further support to the health sector in Zimbabwe by the World Bank-managed Global Financial Facility (GFF), which will be coordinated with the HDF.

The US government agencies (USAID, United States Agency of International Development, CDC (Centers for Disease Control and Prevention) and PEPFAR (President's Emergency Plan for AIDS Relief)) are mainly supporting interventions related to HIV-AIDS, tuberculosis, malaria and sexual and reproductive health. They also attend the HDF steering committee.

[8] OJ C 210 of 30.6.2017.

[9] Gender Equality and Women's Empowerment: Transforming the Lives of Girls and Women through EU External Relations 2016-2020, SWD(2015)182 final of 21.9.2015.

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

The action will support the Zimbabwe public health service, therefore targeting the whole population of Zimbabwe estimated at 17.3 million with special attention to women, the new-born and children, who represent 70% of the population[10]. Special attention will be given to young women and women of child bearing age.

1.5 Problem analysis/priority areas for support

The national macroeconomic situation remains uncertain. The rate at which government can increase its expenditure on health is still limited but there is some space for the proportion of public expenditure allocated to health to be increased from the current 8% of the National 2019 Budget towards the 15% Abuja target to which government has committed.

Additional support to the health system will also allow the EU and the other HDF donors to prepare a transition for some activities currently supported by DPs to the government. A step by step phasing out strategy is currently being discussed with the government, in line with the 2018 Mid Term Review of the HDF.

The recently approved IMF Staff Monitored Program (SMP) includes government's commitment to increase social spending on health, education and social protection programme for people living in the most vulnerable situations.

The scope of this action is to support the Zimbabwe's health sector to continue on a recovery path in order to improve health outcomes for the population. For the first time, Zimbabwe has managed to bend the alarmingly high maternal mortality curve after twenty years of continuous incline[11].

The National Health Strategy (NHS) 2016-2020 highlights four major sector weaknesses in Zimbabwe: (i) deficit of medical and managerial health professionals; (ii) irregular availability of essential medicines and medical supplies; (iii) inadequate provision and maintenance of equipment and infrastructure especially at peripheral level and (iv) disrupted basic utilities and services. Furthermore, it recognises that ‘user fees’ continue to be a barrier to access health care for the majority of the population, particularly women and vulnerable groups.

The sector faces the following main constraints:

- Barriers to accessing services of maternal, new-born and child health due to demand and supply side bottlenecks;
- Growing burden of non-communicable diseases (NCDs);
- The health work force presents numerous challenges;
- The assisted pull system[12] (facilities that order commodities based on their needs) is highly donor dependent. Donors are the main funding sources for the procurement;

[10] The National Health Strategy for Zimbabwe 2009-2013.

[11] Multiple Indicator Cluster Survey, MICS 2014. ZIMSTAT/UNICEF.

[12] The Zimbabwe Assisted Pull System (ZAPS) is an integrated procurement and supply management (PSM) system for key RMNCAH programs that has been fully rolled out over the last two years. The ZAPS includes consolidated management of four existing health commodity distribution systems for the primary health care facility level: (i) Delivery Team Topping Up (DTTU); (ii) Zimbabwe Informed Push/Primary Health Care Package (ZIP/PHCP); (iii) Zimbabwe ARV Distribution System (ZADS); and (iv) Essential Medicines Pull System (EMPS). For the hospital level, the ZAPS consolidates the DTTU and the malaria and tuberculosis portions of the ZIP/PHCP, while the ZADS and EMPS continue to operate as separate systems.

- The Health and Management Information System (HMIS) is fragmented at the facility level;
- Public financing remains low but inefficiencies also exist in managing available resources.

The independent mid-term evaluation (MTE) of the HDF done in 2018 as well as a Joint Monitoring Mission (JMM) conducted in March 2019 by key stakeholders, recognised key achievements through the support from HDF and identified gaps in achieving effective coverage of Maternal New-born Child Health (MNCH) and immunisation services.

In coordination with government, donors and key stakeholders developed an operational plan to implement key recommendations from the MTE and JMM. These interventions from the operational plan will be considered across the strategic areas of support (Maternal, New-born and Child Health, and Nutrition, Medicines and Commodities, Human Resources for Health, Health financing, Health Policy, Planning, Monitoring and Evaluation and Coordination).

2 RISKS AND ASSUMPTIONS

Risks	**Risk level H/M/L**	**Mitigating measures**
Government policy and capacity Weak sector coordination capacity between and amongst health DPs Ministry of Finance (MoF) and MoHCC.	**L**	Harmonise and integrate existing different information sharing and coordination platforms and mechanisms. Ensure availability of technical assistance.
Environmental and climate change: -Possible negative environmental impact of new health infrastructure works. Possible increase of natural disasters (cyclones, drought, flooding).	**L**	An environmental impact assessment will be carried out in line with EU guidelines in case of major infrastructure works.
Socio-cultural barrier: Socio-cultural resistances to promote gender equality and to address health services from a rights-based approach perspective.	**L**	Awareness-raising at management level.
Finance - Macroeconomic environment not stable enough despite the SMP/IMF support for MoHCC to be able to drive the implementation of the National Health Policy. - Budget allocation to the health sector remains insufficient not reaching 15% as per Abuja Declaration.	**M**	- Engage with government to help overall national economic recovery. - Enhance dialogue between government and EU about equitable national budget redistribution in favour of social services. - Support Human Resources for Health (HRH) policy implementation and sustainability.

- HRH salary scale and non-financial benefits insufficient to retain staff in their working stations. - Chronic fuel and gas shortage may lead to disruption of certain health services and furthermore lead to civil unrest.		- EU Support to Public Financial Management and the elaboration of a medium term financial framework.

Assumptions

- Key Government planning documents and strategies are in place. They are defined with a transparent and consultative approach and they are shared with all relevant stakeholders.
- NAO and MoHCC are committed to engage in identification and implementation of the activities.
- Human and financial resources are available and gradually increase.
- All identified thematic areas are indivisible/interdependent and need to be supported in order to achieve the overall objective of the programme

3 LESSONS LEARNT AND COMPLEMENTARITY

3.1 Lessons learnt

Most of the EU support to the health sector has been channelled through the HTF (2011-2015) and the HDF (2016-2020).This is a sector pooled funding mechanism administered by UNICEF, implemented by UNICEF and UNFPA, which supports the execution of the NHS 2009-2015 and 2016-2020. The HDF has undergone a mid-term review, as well as annual joint reviews from which the main following lessons can be drawn:

- The implementation at scale of a critical mix of demand and supply side interventions has been successful in strengthening the health system and in generating demand for services;
- There is a need to improve quality of care. Most of the under-five deaths reported in Zimbabwe occur during the neonatal period;
- DPs' support to the health sector through the HDF has been key in contributing to the availability of essential services throughout the health systems;
- HDF pool funding provides a coordinated and cost effective modality to address MoHCC priorities;
- Future donor support to the health sector should include an exit and sustainability strategy with regard to procurement and the financing of health services to avoid shocks or discontinuity of essential services.
- Triangulation and use for decision making in analysis of data for monitoring and evaluation could be further enhanced.

A second phase of the HDF is planned starting from 2020.

3.2 Complementarity, synergy and donor coordination

The action is complementary with ongoing and previous EU funded actions in the health sector and will provide additional funds to support the implementation of the HDF, aiming at consolidating and improving the gains made. In addition this programme complements the former 'Revitalising Maternity Waiting Homes and Other Related Services' programme, which was funded under the MDG initiative and aims at reducing maternal mortality.

HDF is complementary to programmes fighting HIV/AIDS, malaria and tuberculosis that the US and the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) are currently funding. They are also complementary to the Integrated Support Programme funded by UK, Norway, Ireland and Sweden, which focuses on improving sexual and reproductive health as well as ongoing discussions as Zimbabwe has been selected to join the Global Financial Facility (GFF).

DPs and government policy dialogue has taken place through a High-level Policy dialogue, The Health Development Partners Coordination Group (HDPCG) meets every two months and facilitates coordination and information sharing among DPs. MoHCC Annual Plans are discussed in bi-annual meetings, chaired by the Permanent Secretary and attended by all Provincial Health Executives (PHEs), DPs, and other stakeholders, including relevant state and para-state institutions, and CSOs.

In addition, there are programme-specific coordination platforms such as the GFATM Country Coordination Mechanism (CCM), the HDF Steering Committee, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) meetings, and the Integrated Support Programme Steering Committee. There are ongoing discussions with the MoHCC to revitalise all statutory coordination committees with revised terms of references.

This action will also closely coordinate with the World Health Organisation (WHO) Country Office, Zimbabwe, as the EU has provided a new grant to WHO as of 1 July 2019. Through this EU-WHO 'Health Systems Strengthening for Universal Health Coverage Partnership' programme, which covers all countries of the African Caribbean and Pacific Group of States, i.e. including Zimbabwe, the EU is enabling the WHO to support the health policy dialogue with the Ministry of Health of Zimbabwe and help building capacities of the health authorities in health system strengthening.

This action will therefore seek synergies with the WHO programme, especially to strengthen the specific objectives 2 and 3 under this action.

4 DESCRIPTION OF THE ACTION

4.1 Overall objective, specific objective(s), expected outputs and indicative activities

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

The action will have the following **specific objectives**:

Specific Objective 1 - To increase the protection of women, men and children against health threats

Result (output) 1.1: Increased population access to maternal, neonatal and child health services in quantity and quality, including access to comprehensive sexual and reproductive health services;

Result (output) 1.2: Enhanced communication systems for prevention, detection, control and case management of epidemic prone diseases;

Result (output) 1.3: Enhanced capacity for community social mobilisation and health promotion for non-communicable disease (NCDs) and preventable disease;

Result (output) 1.4: Enhanced national capacity in maternal, infant and young child nutrition.

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

Result (output) 2.1: Improved capacity for organisation and management of services;

Result (output) 2.2: Improved availability of quality services provided by health facilities;

Result (output) 2.3: Human resources capacity for health numbers, skills and distribution enhanced.

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

Result (output) 3.1: Improved access to health services by the most at risk groups of the population;

Result (output) 3.2: Enhanced capacity for health sector governance, management and financing;

Result (output) 3.3: Enhanced capacity for development of Sound policies, strategies and regulations for the health sector;

Result (output) 3.4: Enhanced community participation and involvement in improving health and quality of life;

Result (output) 3.5: Ensure a smooth transition from donor-funded activities to GoZ support funding.

Indicative activities:

Activities linked to SO 1:

1.1: Improvements achieved in obstetric and new-born care under the HDF will be consolidated by targeting with additional support geographical areas with the worst performing MNCH indicators, strengthening the referral systems and support referral institutions via capacity building to health workers.

1.2: Supporting the preparedness and response to communicable diseases outbreaks through the strengthening overall health system by improving communication networks and alert systems for disease outbreaks including pre-positioning of essential medicines and supplies. Specific attention will be given to equal access to all information for all target groups involved (reaching out to remote areas, communication in different languages, sensitisation, etc).

1.3: Substantial progress has been made under the HDF on introducing new vaccines, expanding coverage of immunisation, and conducting integrated management of neonatal and childhood illnesses (IMNCI) training. The present action will focus on targeting geographical areas showing the weakest performance in service coverage and performance indicators, particularly reaching out to those mothers and children not accessing services due to geographical remoteness or religious/social beliefs. Coordination and capacity building will be provided to prevent and treat none communicable diseases including vaccination such as the HPV vaccines against cervical cancer.

1.4: The action will build the national capacity in maternal, infant and young child nutrition at all levels; and demonstrating multi-sectoral community based approach models to reduce stunting in selected vulnerable districts.

Activities linked to SO 2:

2.1: Improving supervision, monitoring and quality reporting by establishing a quality assurance system; rolling out MNCH quality score cards to district and community levels within the regular supervision system; and strengthening facility based Maternal and Neonatal death reviews and audits; use of those data's which will improve the decision making and action by managers (with specific attention for the participation of among the managers).

2.2: Transparent procurement processes for essential medical products, vaccines and technologies (medicines, contraceptives, nutrition commodities and consumables); supporting the overall distribution system and ordering of medicines and other commodities, further linking and integration of HIV-related services to the general health system and facilitate a comprehensive approach to antiretroviral supplies and overall health of mothers and children. Review of the ZAPS (Zimbabwe Assisted Pull System) and explore ways of curbing the leakages in the distribution system.

2.3: Review the recommendations from the staff workload need assessment and support the implementation of findings within the national human resources planning framework; reviewing the approach to pre and post-basic in-service training at national level so that there is a nationally coordinated, and provincially implemented, training programme covering all appropriate subjects; ensuring continued retention of key staff by providing critical post allowances; and supporting the current review of the retention system at national level to ensure a gradual move towards a comprehensive, nationally driven, fair remuneration system and benefits to all health workers. A gender balance among participants in all different activities will be assured.

Activities linked to SO 3:

3.1: Ensuring full abolition of user fees for key MNCH services through effective and transparent implementation of the government MoHCC user fee policy through mechanisms such as the RBF.

3.2: Improving the financing of the health system by improving/harmonising the performance-based RBF mechanism in rural health centres, including training at all levels. Coordination for evidence generation to improve allocative and operational efficiencies for the scarce resources put at the disposal of the health sector.

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

3.4: Strengthening the effectiveness of health centre committees by supporting ongoing capacity building activities and monitoring their impact; strengthening and supporting a system to facilitate and monitor the village health workers (VHWs) in the implementation of their roles, initiation of integrated Community Case Management (iCCM) by supporting newly trained VHWs to improve community awareness about services; reviewing and developing appropriate guidelines on community management of illness; and ensuring adequate support for VHWs from the health staff in the rural health centres (RHCs). A gender balance among participants in all different activities will be assured.

3.5: recent efforts to strengthen the sector dialogue at higher level have included an initial working session (May 2019) with MoHCC on post 2020 perspectives with recommendations. Part of the RBF scheme is covered by government funds in 18 districts with an institutionalisation roadmap to gradually take over; same applies for the procurement of essential medicines for which need to strengthen the ZAPS system has been identified; the

drafted human resources for health strategy need to be operationalised. Key interventions post 2020, will be designed with an exit and sustainability strategy ensuring key elements of the programme are gradually transferred to government.

4.2 Intervention Logic

The intervention logic behind the identified results and activities is based on the analysis of the status of the health sector in Zimbabwe undertaken during the addendum of the National Indicative Programme, with the additional input provided by the evaluations, studies, surveys carried out and the HDF mid-term review.

The analysis concludes that coordinated interventions by Development Partners in the health sector in support to the NHS, notably through the HDF, have significantly contributed to the health sector recovery after many years of decline. However, there is a risk of stagnation if past interventions focused on ensuring appropriate quantitative levels of primary health care do not evolve into actions aimed at improving the quality of care and if the current inequality in access to health is not reduced.

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

- The action will in the first place support high impact interventions in primary health care structures in order to ensure their capacity to protect the population against the main health threats. Activities will target all peripheral health structures with a special focus on geographical areas showing the worst indicators in this regard.
- The action will in the second place strengthen national health systems by improving organisational and managerial skills at provincial and district level, strengthening the capacity of human resources for health and ensuring their availability, particularly in rural areas, so that peripheral structures are able to provide quality services to the rural population.
- Finally, the action will promote equal access to health services by supporting the necessary reforms on health financing and governance, the development of appropriate policies and strategies and enhancing community participation in governance structures.

In order to provide such a comprehensive approach successfully, there is a need to pool donor resources in support to the government's national health strategy. The HDF, administered by UNICEF since 2016, has done that with remarkable success. The action will therefore continue to support the HDF in its last year of implementation and its successor, beyond 2020.

4.3 Mainstreaming

Key elements of gender, resilience, conflict sensitivity and climate change and human rights will be mainstreamed in the design, implementation, and monitoring of the programme:

Gender: the programme design is **strengthening systems** in order to reach scale and sustainability. Large numbers of women and girls will be reached for maternal care and nutrition. To empower the girl child, sensitisation will be given to women and adolescents on issues linked to child marriage, education using health platforms such as ante-natal care visits and outreach activities. Women will also be considered as active right-holders, entitled to know and enjoy their (sexual and reproductive) rights and to be able to claim them in case these rights are not provided (on an equal basis). Both UNFPA and UNICEF have strong

approaches to gender equality and human rights. These will be mainstreamed in the project cycle management (PCM).

Resilience: working across the key building blocks for Health System Strengthening (HSS) will re-enforce the system and provide resilience in order to overcome shocks due to health emergencies (outbreaks) or health in emergencies (cyclone, drought, etc). Additionally, Community Health Workers already trained and equipped are easily mobilised. Under this funding, the system will be further strengthened and made more resilient.

Climate change: appliances and supplies procured for the programme will be environmentally friendly e.g. installation of solar panels and procurement of solar energy driven refrigerators for the cold chain in health facilities, support will be provided for medical waste disposal and treatment.

Human rights: interventions will be designed 'to leave no one behind' in line with the rights-based approach to programming. Community health workers, as well as health staff, will be sensitised on key groups such as the poor, people living with impairments, hard-to-reach communities as key priority groups to be included in service delivery. The right-based approach (RBA) will strengthen the respect, protection and realisation of human rights for rights-holders, through a systematic attention to the 5 principles (applying all rights, non-discrimination, participation, accountability and transparency) during procedures and processes the project is applying (throughout the whole project cycle management).

4. 4 Contribution to Sustainable Development Goals (SDGs)

This intervention is relevant for the United Nations 2030 Agenda for Sustainable Development. It contributes primarily to the progressive achievement of SDGs 2, 3; 5, 6 and 7.

Zimbabwe has committed itself to implementing all the SDGs with emphasis on the following 10 SDGs (2, 3, 4, 5, 6, 7, 8, 9, 13 and 17). The prioritisation exercise was guided by the country's vision, the need to focus on enabling goals, resource availability and unfinished business in the MDGs[13]. Interventions under this proposal '*improving Health Outcomes for the Population of Zimbabwe'* will contribute primarily to the progressive achievement of SDGs 2 and 3 and by extension to SDGs 5, 6 and 7 which are all interlinked.

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4 will be carried out and the corresponding contracts and agreements implemented, is 36 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 Decision and the relevant contracts and agreements.

[13] Zimbabwe Voluntary National Review (VNR) of SDGs For the High Level Political Forum July 2017.

5.3 Implementation of the budget support component

N/A.

5.4 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[14].

5.4.1 Indirect management with an international organisation

A part of this action may be implemented in indirect management with UNICEF. This implementation entails the management of the implementation of the Health Development Fund II. This implementation entails (i) increasing the protection of women, men and children against health threats and furthermore promoting an environment for these populations to thrive and transform; (ii) strengthening and further developing the national health system; (iii) reducing inequalities in access to quality health services. All results described under section 4.1.

The envisaged entity has been selected using the following criteria: specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of maternal and child health. Moreover, UNICEF in Zimbabwe has proven to have a strong capacity to manage pooled funds, such as the HTF, HDF, the Education Transition Fund, and the Child Protection Fund. UNICEF has been an efficient and appropriate HTF manager since the Fund was set up in the last quarter of 2011 and has effectively managed the HDF since first quarter of 2016.

5.4.2 Indirect management with an international organisation

A part of this action may be implemented in indirect management with UNFPA. This entails the implementation of the Health Development Fund II and to increase the protection of women, men and children against health threats and furthermore promote an environment for these populations to thrive and transform. Their activities will contribute to the following objectives/results under section 4.1: objective 1 - results 1.1, 1.3 / objective 2 - result 2.2 / objective 3 - results 3.1, 3.3, 3.4. UNFPA will mainly participate in increasing the quality and quantity of comprehensive sexual and reproductive health services, countrywide.

The envisaged entity has been selected using the following criteria: UNFPA's specific international mandate and its proven technical capacity to identify and implement high impact interventions in the area of family planning, youth health, reproductive rights and gender equality. Additionally, UNFPA in Zimbabwe has proven to have a strong capacity to manage EU funds, such as EU-MDG project 'Maternity waiting homes' and the '2015 Health Demographic Health Survey'. Moreover, UNFPA has been an efficient partner in supporting all specific activities related to sexual and reproductive health (SRH) with the support of DFID UK, Irish Aid and SIDA since the beginning of HDF implementation.

[14] 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.

5.5 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, subject to the following provisions.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realization of this action impossible or exceedingly difficult.

5.6 Indicative budget

	EU contribution (in EUR)	**Indicative third party contribution (in EUR)**
5.4.1 Indirect management with UNICEF, including communication and visibility	35 900 000	88 000 000
5.4.2 Indirect management with UNFPA, including communication and visibility	2 000 000	34 000 000
5.9 Evaluation, 5.10 Audit/Expenditure verification	100 000	N.A.
5.11 Communication and visibility	Already covered under phase I of the programme	N.A.
Totals	**38 000 000**	**122 000 000**

5.7 Organisational set-up and responsibilities

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

The PSC will meet quarterly and will be co-chaired by the Permanent Secretary of the MoHCC and one Funding Partner.

UNICEF will have two distinct roles in the HDF - as fund holder and programme manager, and as a potential implementing partner in areas in which it has a comparative advantage as determined by the PSC. UNFPA will be an implementing partner mainly in SRH as well as in cross-cutting activities under thematic areas detailed in the timetable. A number of safe-guards will be put into place to ensure transparency and segregation of duties as necessary.

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

money. Key comparative advantages will be considered in areas where a national programme and provider are already engaged and performing successfully.

5.8 Performance and Results monitoring and reporting

Quarterly monitoring reports are coordinated by UNICEF as programme manager, covering Vital Medicines Availability and Health Services survey (VIMAHS) results, which will be discussed during the PSC meetings as well as during ad hoc technical meetings. UNICEF and UNFPA are contributing to a joint annual report on HDF activities, including follow up of SDGs indicators.

Additionally a yearly Joint Monitoring field visit with CCM will evaluate the quality of health services provides at rural, district and provincial levels in order to guide the annual MoHCC and DP planning meeting (MODO).

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix. Specific attention will be given on a regular basis, regarding the progress made in terms of gender equality and the realisation of human rights.

The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

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

5.9 Evaluation

Having regard to the importance of the action, a final evaluation will be carried out for this action or its components through a joint mission contracted by the Commission. Human rights and gender expertise will be part of the evaluation mission.

It 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, MoHCC.

The Commission shall inform the implementing partner at least 3 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. 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.

Evaluation services may be contracted under a framework contract.

5.10 Audit

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

It is foreseen that audit services may be contracted under a framework contract.

5.11 Communication and visibility

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

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and contribution agreements.

The Communication and Visibility Requirements for European Union External Action (or any succeeding document) shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.

This action shall contain communication and visibility measures, which shall be based on a specific and joint Communication and Visibility Plan of the Action, to be elaborated at the start of implementation by UNICEF and UNFPA and budgeted under each respective contractual agreement. Specific attention will be given to gender sensitive communication and visibility actions (avoiding stereotyping in visibility material for example).

APPENDIX - INDICATIVE LOGFRAME MATRIX (FOR PROJECT MODALITY) [15]

	Results chain: Main expected results (maximum 10)	Indicators (at least one indicator per expected result)	Sources of data	Assumptions
Impact (Overall Objective)	**CONTRIBUTE TO THE IMPROVEMENT OF HEALTH OUTCOMES FOR ALL THE POPULATION OF ZIMBABWE**	1. Maternal Mortality Ratio (MMR) 2. Under Five Mortality Rate (U5MR) (girls/boys) 3. Neonatal Mortality Rate (girls/boys) 4. Prevalence of stunting children under five years (girls/boys)	1. Multiple Indicator Cluster Survey (MICS 2019) 2.MICS 2019 3. MICS 2019 4. MICS 2019 and Demographic and Health Survey (DHS 2020)	*Not applicable*
Outcome(s) (Specific Objective(s))	**SO1 To increase the protection of women, men and children against health threats.***	1.1 -% of children under five with diarrhoea treated with ORT and Zinc (girls/boys) 1.2 -Proportion of children aged (0-6 months) exclusively breastfed (girls/boys) 1.3 -Proportion of deliveries attended by a skilled birth attendant.	1.1 MICS 2019 & DHS 2020 1.2 MICS 2019 & DHS 2020 1.3 MICS 2019 & DHS 2020	The overall country socio-economic situation improves
	S.O.2 To strengthen and further develop the national health system*	2.1 -Proportion of health facilities with an RBF quality score of above 80%	2.1 Vital Medicines and Health Services (VMAHS) reports	- Availability of Basic Services is regular (Electricity, Water, Communication, etc) -Trained and qualified health personnel retained -Equipment available and in good working condition Health emergencies managed timely with minimum disruption of the health system

[15] Mark indicators aligned with the relevant programming document mark with '*' and indicators aligned to the EU Results Framework with '**'.

	S.O.3 To reduce inequalities in access to maternal and child quality health services**	3.1 - % of national budget allocation to health 3.2 - % of traditional vaccines procured by Government funds 3.3 - Proportion of health facilities charging user fees for ante-natal clinic (ANC)	3.1 Yearly national Budget estimates and Expenditures 3.2 MICS 2019 & DHS 2020 3.3 VHMAS	Trained and qualified health staffs retained. - Regular monitoring of health facilities
Outputs S.O.1 **	**1.1: Increased population access to maternal, neonatal and child health services in quantity and quality, including access to comprehensive sexual and reproductive health services.**	1.1.1-Number of facilities providing 5 selected signal functions of basic emergency Obstetric and newborn services with the support of the Action 1.1.2-Number of districts hospitals with capacity to provide comprehensive emergency obstetric and newborn care (CEmONC) services (C/S and blood transfusion) with the support of the Action 1.1.3-Number of women 16-49 years using long acting family planning methods (Implants and IUCD). ** (EURF 2.6) 1.1.4-Number of children age 6-59 months (boys and girls) receiving vitamin A supplementation with the support of the Action	1.1.1 VHMAS, HMIS, ZDHS, MICS 2019. 1.1.2 VHMAS, HMIS, ZDHS, MICS 2019. 1.1.3 VHMAS, HMIS, ZDHS, MICS 2019. 1.1.4 VHMAS, HMIS, ZDHS, MICS 2019.	- Trained and qualified health staffs retained. - Regular monitoring of health facilities
	1.2: Enhanced communication systems for prevention, detection and control and case management	1.2.1-% of cholera outbreaks detected within 48 hours and controlled within 2 weeks	1.2.1 -National Health Information System-Provincial Medical Directors' Reports -DHS -MICS	
	1.3: Enhanced capacity for community social mobilisation and health promotion for non-communicable disease (NCD's) and preventable disease	1.3.1-Number of women screened for cervical cancer with the support of the action 1.3.2-Number of 1-year-olds fully immunised (Penta 3 Coverage) with the support of the Action ** (EURF 2.5) 1.3.3-Number of 1 Year-old immunised against measles with the support of the Action	1.3.1 VHMAS reports 1.3.2 MICS 2019 1.3.3. MICS 2019	- Trained and qualified health staffs retained. - Regular monitoring of health facilities
	1.4: Enhanced national capacity in maternal, infant and young child nutrition	1.4.1-Proportion of children with severe acute malnutrition cured and discharged (girls/boys)	1.4.1 -National Health Information System -Provincial Medical Directors' Reports -DHS 2020- -MICS 2019	- Trained and qualified health staffs retained - Regular monitoring of health facilities

Outputs S.O.2	**2.1: Improved capacity for organisation and management of services**	2.1.1-Number of districts staffs trained to provide reports using the standard core indicators of the HMIS	2.1.1. -National Health Information System -Provincial Medical Directors' Reports	- Trained and qualified health staffs retained
	2.2: Improved availability of quality services provided by health facilities	2.2.1-Percentage availability of vital medicines. 2.2.2-Long Term Agreement (LTA) for coordinated procurement of supplies by health centre using RBF resources finalised	2.2.1 VHMAS 2.2.2 VHMAS -National Health Information System -Provincial Medical Directors' Reports	- LTA at Ministry of Health and Child Care way of procurement in place
	2.3: Human resources capacity for health numbers, skills and distribution enhanced	2.3.1-Comprehensive retention scheme for HRH finalised by MoHCC and on Government budget 2.3.2-% of District Hospitals with at least three doctors	2.3.1 MoHCC annual report 2.3.2 -National Health Information System -Provincial Medical Directors' Reports	- Human Resources for Health policy/strategy adopted and implemented
Outputs S.O.3	**3.1: Improved access to health services by the most at risk groups of the population**	3.1.1-Proportion of districts with at least 80% DPT3 vaccination coverage	3.1.1 -National Health Information System -Provincial Medical Directors' Reports	- Quality health services available - sufficient trained and qualified health staffs at health delivery points retained
	3.2: Enhanced capacity for health sector governance, management and financing	3.2.1-Number of provincial planning and review meetings conducted annually	3.2.1 -Provincial Medical Directors' Reports -	- sufficient trained and qualified health staffs at health delivery points retained
	3.3: Enhanced capacity for development of sound policies, strategies and regulations for the health sector	3.3.1-Status of development of updated National Health Policy/Strategy with the support of the Action.	3.3.1 HDF annual reports and Minutes of HDF SC	
	3.4: Enhanced community participation and involvement in improving health and quality of life	3.4.1-Proportion of health facilities with functional Health Centre Committees	3.4.1 Result Based Financing findings in HDF annual reports	- Community health strategy adopted and operationalised

	3.5: Ensure a smooth transition from donor-funded activities to Government support funding	3.5.1 Gradual increase of Government commitment into HDF annual budget	3.5.1 - HDF annual work plans and reports - Minutes of High level sector dialogue meetings with Minister of Health and Child Care	- Ministry of Health and Child Care strong advocacy during the budgetary exercise