Health Transition Fund

A Multi-donor Pooled Transition Fund for Health in Zimbabwe

Supporting the National Health Strategy to improve access to quality health care in Zimbabwe

December 2011
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<tr>
<td>HTF Name</td>
<td>Health Transition Fund (2011 - 2015)</td>
</tr>
<tr>
<td>Initial Donors</td>
<td>Governments of Ireland, Sweden, Norway, and the United Kingdom as well as the European Commission delegation to Zimbabwe</td>
</tr>
<tr>
<td>Funds Required</td>
<td>Approximately US$ 435,336,586 - total amount over 5 years</td>
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<tr>
<td>Duration</td>
<td>2011 - 2015</td>
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**Objective**

Reducing maternal and child mortality through abolishing user fees and supporting high impact interventions and health system strengthening

**Goal:** to contribute to reduced maternal mortality (by 3/4) and under-5 mortality (by 2/3) (MDGs 4 and 5) and eliminate user fees for children under-5 and pregnant and lactating women by 2015.

The programme also aims to contribute to halving the prevalence of underweight in children under-5 (MDG 1c) and combat, halt and reverse trends in HIV and AIDS, Malaria and other diseases (MDG 6) by 2015.

**Purpose:** to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector.

**Expected Results**

- National coverage of focused ANC (4 visits) increased to 90% by 2015
- National skilled birth attendance rate increased to 80% by 2015
- Access to comprehensive emergency obstetric and newborn care increased to 80% by 2015
- National coverage of postnatal care (at least 3 visits in the first week after delivery) increased to 80% by 2015
- MNCH program implementation is monitored quarterly in all districts by 2015
- 80% of health centers have a fully functional health committee by 2015
- Community based preventive and selected curative MNCH services are provided for 80% of villages by 2015
- National full immunization coverage increased to 90% by 2015
- New vaccines (Pneumococcal and Rota-virus vaccine) introduced at the national level by 2013
- The proportion of sick newborns and children under-5 treated appropriately for common childhood illnesses (neonatal sepsis, pneumonia, diarrhoea, pediatric HIV, SAM and malaria) increased to 80% by 2015
- National coverage of exclusive breastfeeding rate increased to 50% by 2015
- The national coverage rate of timely and appropriate complementary feeding increased to 50% by 2015
- The national coverage rate of twice a year Vitamin A supplementation for children 6-59 months of age increased to 90%
- Access and compliance of routine Iron/folate supplementation for pregnant women increased to 80% by 2015
- The national coverage rate of Vitamin A supplementation for mothers within the first 42 days after delivery increased to 80% by 2015
- Availability of essential medicines (the selected package based on WHO recommendations applicable to Zimbabwe) and health commodities is maintained at 80% in all health facilities across Zimbabwe by 2015
- Availability of vaccines (antigens), vaccine supplies and cold chain equipment maintained at 100% in all health facilities across Zimbabwe by 2015
- 95% of health facilities and health management offices are staffed with the minimum standard required and qualified health professionals by 2015
- Health system capacity in policy making, planning and financing developed across all health services delivery levels by 2015
- 80% of health facilities received financial support through the HSF to cover their running cost
- Zero Open Defecation (ZOD) rate 100% by 2015 (output level)

**Geographic Focus Area**
National

**Focus population**
Women and Children (in particular pregnant and lactating women and children under-5)

**UNICEF Zimbabwe**

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- Aboubacar Kampo, Chief of Young Child Survival and Development (Health and Nutrition)
  Email: akampo@UNICEF.org
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AU</td>
<td>African Union</td>
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<tr>
<td>CARMMA</td>
<td>AU Campaign on Accelerated Reduction of Maternal Mortality in Africa</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CIFF</td>
<td>Children's Investment Fund Foundation</td>
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<td>CMAN</td>
<td>Community based management of Acute Malnutrition</td>
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<tr>
<td>CCORE</td>
<td>Collaborating Centre for Operational Research and Evaluation</td>
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<td>CPF</td>
<td>Child Protection Fund</td>
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<tr>
<td>CSO</td>
<td>Country Situation Overview (WASH)</td>
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<td>DFID</td>
<td>Department of International Development (UK Aid)</td>
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<td>DHET</td>
<td>District Health Executive Teams</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DPPME</td>
<td>Division of Policy, Planning, Monitoring and Evaluation (MoHCW)</td>
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<td>DPS</td>
<td>Directorate of Pharmacy Services</td>
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<td>DRR</td>
<td>Disaster Risk Reduction</td>
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<td>EPI</td>
<td>Expanded Programme of Immunization</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>ESP</td>
<td>Expanded Support Programme (for Immunisation)</td>
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<td>ETF</td>
<td>Education Transition Fund</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria (also referred to as Global Fund)</td>
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<td>HFA</td>
<td>Health Facilities Assessment</td>
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<td>HIS</td>
<td>Health Information System</td>
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<tr>
<td>HIV</td>
<td>Human-Immuno Deficiency Virus</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>HMIS</td>
<td>Health Management and Information System</td>
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<td>HTF</td>
<td>Health Transition Fund</td>
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<td>INMCI</td>
<td>Integrated Management of Maternal, Newborn and Childhood Illnesses</td>
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<td>LATH</td>
<td>Liverpool Associates for Tropical Health</td>
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<td>LMIS</td>
<td>Logistics Management Information Systems</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MICS</td>
<td>Multiple Indicators Cluster Survey</td>
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<td>MIMS</td>
<td>Multiple Indicator Monitoring Survey</td>
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<td>MLM</td>
<td>Mid Level Management (for immunization)</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MoHCW</td>
<td>Ministry of Health and Child Welfare</td>
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<td>MPMS</td>
<td>Maternal and Perinatal Mortality Study</td>
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<td>NCHDs</td>
<td>National Child Health Days</td>
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<td>NHS</td>
<td>National Health Strategy (2009 - 2013): Equity and Quality in Health - A People's Right</td>
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<tr>
<td>PAC</td>
<td>Post Acute Care</td>
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<td>PEPFAR</td>
<td>U.S Presidents Emergency Funds for AIDS Relief</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PoS</td>
<td>Programme of Support (to the National Action Plan for Orphans and Other Vulnerable Children)/Child Protection Fund</td>
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<td>PMD</td>
<td>Provincial Medical Director</td>
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<td>PRP</td>
<td>Protracted Relief Programme</td>
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<td>RED</td>
<td>Reach Every District (Approach)</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>USD/US$</td>
<td>United States Dollars</td>
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<tr>
<td>UZ</td>
<td>University of Zimbabwe</td>
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<tr>
<td>VHSSP</td>
<td>Vital Health Services Support Programme</td>
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<td>VMAHS</td>
<td>Vital Medicines Availability and Health Facility Survey</td>
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<tr>
<td>VHWs</td>
<td>Village Health Workers</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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The Health Transition Fund (HTF) is a multi-donor pooled fund, managed by UNICEF, to support the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe to achieve planned progress towards 'achieving the highest possible level of health and quality of life for all Zimbabweans'. Zimbabwe’s recent history of severe deterioration in infrastructure, lack of investment, low wages, decreasing motivation and capacity of the civil service, and absolute shortage of essential supplies and commodities, resulted in the near-collapse of the health sector in late 2008, and early 2009.

The HTF will support the efforts to mobilize the necessary resources for critical interventions to revitalize the sector and increase access to care through eliminating the payment of fees for services for mothers and children under-5 as foreseen by national policy. As such, critical, high impact interventions will reduce maternal and under-5 mortality (MDGs 4 and 5) and reduce prevalence of underweight in children less then 5 years old (MDG 1 c) and assist in combating HIV, Malaria and other diseases (MDG6).

Support to key goals outlined in the Zimbabwe National Health Strategy and the Health Investment Case will be provided in a coordinated and streamlined way and will be aligned with the MoHCW annual operating plan/annual Performance Contracts and review processes. The pooled fund supports the continuation of national-scale health services delivery in critical areas. The mechanism provides strengthened capacity in government to take on sector budget support should the situation improve, while mitigating risks and enhancing preparedness, should humanitarian situations require response.

Based on gaps analysis, principles of aid effectiveness and coordination, the HTF recognizes that health MDG outcomes cannot be achieved without adequate investment in the health systems that underpin health service delivery; that investment in health needs to be embedded in broader development planning and needs long-term predictable funding from donors as well as mechanisms to hold all partners accountable.

The HTF initially focuses on the following four thematic areas, but according to the burden of diseases and available financial resources this could be extended to other areas included in The National Health Strategy for Zimbabwe (2009-2013).

The initial first year focus areas are the three core health system reforms required to support the removal of user fees, and a comprehensive programme implementation area on maternal, newborn, and child

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1 In particular applying the Paris Declaration on Aid Effectiveness to the Health Sector to improve complementarily and coordination of funding partners to support harmonization and alignment efforts at the country level.

2 Outlined in the work plan for the “Health 8” agencies: The Gates Foundation, GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, UNFPA, UNICEF, World Health Organization and the World Bank
health and nutrition to support quality of care improvements.

**The initial four core thematic areas are therefore:**

1. **Maternal, Newborn and Child Health and Nutrition;**
2. **Medical Products, Vaccines and Technologies** (Medicines and Commodities);
3. **Human Resources for Health** (including Health Worker Management, Training and Retention Scheme); and
4. **Health Policy, Planning and Finance** (Health Services Fund Scheme and Research).

Together these pillars provide comprehensive support to the health system and provide the necessary foundation and recurrent revenues to alleviate the collection of service fees from patients. The HTF includes enhancing the health workforce, upgrading essential equipment and logistics, providing equitable financing solutions, ensuring quality of care, improved health practices through social mobilization and integrating community-based strategies.

The HTF will also provide integrated support to monitoring and evaluation and technical expertise in the roll-out of activities. The HTF requires a pooled donor contribution of approximately US$80 million per year over five years. The pooled mechanism significantly reduces overhead costs in operations, reporting and fund administration ensuring that funding is channeled toward achieving direct programme impact. Further, the HTF scale will allow achievement of results against national scale indicators at the 5 year stage and reduces potential duplication of efforts by development partners.
2.1 Brief Situation Overview

In the 1980s and early 1990s, Zimbabwe had one of the best primary health care systems in sub-Saharan Africa. Zimbabwe was at the forefront of regional and global initiatives on child survival, with the government launching the first child survival revolution in 1988. Economic challenges faced by the country in the last decade however, have led to a chronic under-investment in the health sector and a significant deterioration in the health indicators. This period also saw the introduction of user fees which have presented an additional barrier to health care, impacting the most vulnerable in particular.

Maternal and Child Health

Today the maternal mortality ratio is 790 per 100,000 live births (compared with 390 in 1990)\(^1\) and the under-5 mortality is 94 per 1,000 live births (compared with 78 in 1990). See figure 1.

This means that in Zimbabwe, eight women die every day of pregnancy-related complications, and 100 children die every day, mainly due to preventable causes such as common newborn disorders, pediatric HIV, diarrhea, pneumonia and the underlying cause of malnutrition (see figure 2).

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\(^1\) UN Inter-agency group for Child Mortality Estimation, 2010
Newborn disorders

Newborn disorders are the most important cause of under-5 deaths which are also intrinsically related to maternal health and nutrition. About 75 per cent of maternal and neonatal deaths occur in the first week after delivery due to lack of basic care in the immediate postnatal period. As such, timely identification and appropriate intervention for high risk mothers is critical to prevent large numbers of mothers dying and to improve neonatal outcomes and survival. Currently less than 30 per cent of women and their babies receive immediate postnatal care, with the majority of mothers sent home immediately after delivery. Follow up postnatal care is delayed for approximately 10 days. This delay misses the critical window for maternal newborn health and nutrition interventions, such as promotion of exclusive breastfeeding (currently at an alarmingly low coverage rate of 5.8 per cent).

AIDS related conditions

Despite progress made on access to anti-retroviral treatment (ART) for adults, AIDS-related conditions remain the number one cause of maternal deaths and the second major cause of child deaths. Currently only 978 of the 7,000 HIV positive children under the age of two receive ART. The identification of HIV infected infants who require treatment is a significant challenge due to a) weak community postnatal follow up for HIV positive mothers and their HIV-exposed infants resulting in only 30 per cent receiving Early Infant Diagnosis (EID), b) limited health worker training in EID, c) a weak referral chain; only a small proportion of those who are tested and receive Polymerase Chain Reaction (PCR) results being initiated on ART, and d) loss to follow up due to the centralized pediatric HIV management system. Although the MoHCW is working on decentralization, patients are referred to higher level health facilities which often may be a distance away, and where the availability of pediatricians may be limited.

4 Current National Guidelines recommend 10 day period. Part of the HTF activities aims to support MoHCW in revising these guidelines.
6 UNICEF Briefing note (Sherman and Kitabire) - Data on PMTCT/Pediatric HIV and Maternal ART, based on 2010 National Estimates; MoHCW statistics, and GFATM Round 10 Proposal.
The improvement of Prevention of Mother to Child Transmission of HIV (PMTCT) services is vital in order for fewer babies to be infected and should include scaled up interventions to meet the 2010 WHO Pediatric HIV treatment guidelines for health facilities. While PMTCT is not a specific component of this proposal, an integrated approach to MNCH will be pursued.

**Pneumonia and Diarrhoea**

Pneumonia is the third leading killer disease of children under-5 in Zimbabwe (after HIV and AIDS and neonatal disorders). Pneumonia contributes to 14 per cent of under-5 deaths. In the MIMS survey of 2009, only 16 per cent of children under-5 suspected of having pneumonia in the two weeks preceding the survey had received the necessary antibiotics.

Diarrhoea is the fourth leading cause of mortality among under-5s in Zimbabwe, contributing to 9 per cent of childhood deaths. MIMS 2009 demonstrated that 11 per cent of children at national level in this age group had suffered from diarrhoea in the last two weeks preceding the survey, with no sex or urban and rural differentials. According to this report, 58 per cent of children under-5 who had diarrhoea in the two weeks preceding the survey were given homemade salt and sugar solution. This rate represents a decline from 61 per cent using solutions reported in the 2005/6 ZDHS.

The HTF is focusing on improvement in case management capacity of health workers to treat pneumonia and diarrhoea. It will also work to improve the health care seeking behaviors of families and communities.

**Undernutrition**

Global analysis confirms nutrition-related disorders including stunting, severe wasting, intrauterine growth restriction and deficiencies of key micronutrients (zinc, vitamin A and iron), are responsible for about 35 per cent of child deaths globally and 11 per cent of the total global disease burden. These nutrition-related disorders are highly prevalent in Zimbabwe and are estimated to contribute to approximately 12,000 under-5 child deaths every year (a third of all under-5 deaths).

Child undernutrition in Zimbabwe is a result of an interaction between poor dietary intake and disease. This interaction is driven by suboptimal feeding and care practices, especially during the critical periods of pregnancy, infancy and young childhood (0 to 24 months), an unhealthy household environment, and lack of health and nutrition services.

The rate of exclusive breastfeeding and complementary feeding (the corner stone for child survival and development), is alarmingly low with less than 6 per cent of infants under the age of six months exclusively breastfed and less than 10 per cent of those 6 - 24 months accessing optimal complementary feeding.

Child undernutrition is also partly related to maternal nutritional status. In Zimbabwe, about 10 per cent of children are born with a Low Birth Weight, indicating...
intrauterine growth restriction. In addition, an estimated 9 per cent of women of reproductive age are thin (BMI less than 18.5) of which 2 per cent are considered very thin (BMI less than 17). Access to and utilization of key maternal nutrition services is very low. Regardless of high attendance rates for ANC (93 per cent) and facility level delivery (58 per cent) coverage of maternal micronutrient supplementation (Iron/Folate during pregnancy and vitamin A postpartum) is less than 30 per cent.

User fees

After independence (and with the exception of Parienyatwa Hospital and a small number of higher level referral facilities) Zimbabwe did not charge user fees for health services in public facilities. User fees were introduced and then increased during the 1990’s as part of the Zimbabwe Economic Structural Adjustment Program (ESAP). Generally, in the 1990s fees increased (with some exceptions in rural areas) and were collected centrally. Although designed to improve service quality to ensure access to health for poor people and vulnerable groups, the application of user fees have not improved quality of care and have had a negative impact on equitable access in Zimbabwe. Further, the Poverty Assessment Study Survey in 2003 showed that a lack of available money was the main reason for patients not seeking treatment for illness/injuries.

Provisions in the user fee policy have included free access for children under-5, pregnant women and the elderly. Provision of ART is free but there are charges for consultations and laboratory tests. Despite the exemptions outlined in policy, pressures from the economic crisis have reduced resources to frontline services. Furthermore, the application of exemption policies has been impacted by lack of knowledge of individual rights under the policy and the ad hoc collection of informal payments. The policy is also widely misunderstood (one example is that fees are widely charged for referral consultations which should be exempt) and establishing eligibility for exemption of fees on the basis of poverty has been difficult.

Efforts to abolish user fees for mothers and children under-5 are also complicated by the limited ability to monitor and enforce the legal implementation of the policy and by the different ministerial portfolios covering health. Health facilities at provincial level (managed by MoHCW) are subject to the policy whereas district level facilities (managed by the Ministry for Local Government) are not necessarily covered.

The user fee policy includes some ‘flexibility’ in that urban local authorities are not bound by fee levels in the public sector but require ministerial approval to adopt any revised fee structures. The implementation of the user fees policy has been erratic, administratively complicated and has lead to equity in service use being compromised (the introduction in user fees in 1993 resulted in a 30 per cent decline in use of Rural Health Centres). Even when user fees were 'abolished,' the low capacity of the Health Services Fund to cover running costs in facilities resulted in a non-standardised system of fees, levies, registration payments and incentives being charged.

For example, the provisions for women, children under-5 and the elderly are not always being realised in practice. The Vital Medicines and Health Services Surveys suggest that only about 53 per cent of health facilities provide a full maternity service free of charge. Other facilities charge fees with prices varying from US $3 to US$50; with higher prices in urban locations. User fees are also charged on an ad hoc basis for emergency services (such as C-sections, for blood transfusion and post acute care (PAC)).

Generally, user fees present a barrier to health care and contribute to greater disparities in access, effectively excluding poorer people from the formal

11 MIMS
14 Normand, C et al Resource Mobilisation for the Health Sector in Zimbabwe, December, 1996
15 The comprehensive user fee policy for public health facilities was introduced in January 2002. This policy includes: No fees to be charged at Government RCH and RDC clinics, no fees to be charged for maternity services, free health services for children under-5, free TB treatment: public and private sector, and free treatment for pensioners
17 Zigora el al 1997 personal communication in in Pauingus Lingani Ncube Sikosana, 2009
18 Also see www.ipsnews.net/africa/nota.asp?idnews=52272 for press comment on fees for a routine delivery.
health care system.\textsuperscript{19,20} The Maternal and Perinatal Mortality Study (2007)\textsuperscript{21} cited user fees as the main reason for lack of access to ante, post-natal and institutional delivery services. These data also suggest that demand for health services is higher in those facilities that do not charge fees.

Generally, user fee income in Zimbabwe is being used to cover non-salary recurrent costs and is pooled and re-distributed through the Health Services Fund (see discussion in section 4). Consensus statements such as the Principles on Cost Sharing in Education and Health in Sub-Saharan Africa\textsuperscript{22} stress that fees should be considered at best as a stepping stone to more equitable financing mechanisms and not for funding routine resource requirements.

If user fees are abolished then support for the running costs of facilities will be critical to ensure fees are not charged informally. Also facilities will need to be strengthened to effectively cope with the subsequent increases in demand. To effectively remove user fees Zimbabwe will need to:

1. Reduce and cover overhead running costs of facilities (see thematic area 4) channelling financial resources directly to health facility level through the reactivation of the Health Service Fund. This must be done in a timely manner as removal of fees is likely to increase the pressures on these facilities.

2. Cover essential medicines and equipment (particularly for routine maternal and child health interventions).

3. Support human resources with skills in maternal and child health and ensure their retention and motivation (see thematic area 1 and thematic area 3).

4. Develop an effective communication strategy and public information campaign around user fees to ensure reduction in informal charges and knowledge of rights (integrated activity in thematic area 1).

The four thematic areas proposed in the HTF aim to adequately address these aspects and resource needs in order to effectively abolish user fees for pregnant women and children under-5. Further, research on the total cost of the package of care at different service delivery levels, as requested by MoHCW, will help support and inform evidence-based advocacy strategies.

## Health Financing

Health financing in Zimbabwe has had implications for equitable access to services. The public health sector operations rely mainly on tax revenues allocated by the Ministry of Finance (MoF) to the MoHCW. More recently sector operations rely on donor development aid, user fees and to some extent on health insurance income.

The recent improvement in the economic climate and the significant support of the donor community have made human resources for health, essential medicines and medical supplies more available. However, health facilities are not yet functioning effectively. Facilities remain unable to cover costs for basic services (such as electricity, water, communications,) as well as for regular maintenance of infrastructure and equipment.

Since mid-2009, the relative stabilization in the national context has facilitated sector recovery with a move from an emergency planning mode towards completion of an ambitious five year National Health Strategy (2009-2013).\textsuperscript{23} The MoHCW has recognized that the major challenge in implementing the national strategy is a lack of resources (financial, human and material). Although the 2011 government budget for the health sector is US$ 256 million (9 per cent of the total budget), the actual disbursement depends on the

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\textsuperscript{20} Yates, 2009 Universal health care and the removal of user fees Lancet, 2009:373:2078-81 Published online http://download.the-lancet.com/pdfs/journals/lancet/PIIS0140673609602580.pdf?d=ref16241398bd8eb460-46867125.12e76956375.4d851299071951328


\textsuperscript{22} 1997 Addis Ababa Consensus on Principles on Cost Sharing in Education and Health in Sub-Saharan Africa

\textsuperscript{23} The National Health Strategy for Zimbabwe (2009 - 2013), Equity and Quality in Health: A People’s Right, MOHCW
availability of resources. For example, in 2009 only US$15 Million (10 per cent) of the originally allocated budget of US$150 Million was disbursed to the MoHCW for service delivery. As such, significant external financing is required to restore and maintain service delivery and improve health outcomes.

If the current funding levels and weak capacity of the public health system persist or deteriorate, Zimbabwe will not achieve the health related Millennium Development Goals (MDGs). In this respect the ‘Health Sector Investment Case’ identified priority areas that need urgent attention over the next 3 years (2010-2012). This plan aimed to revitalize the health sector and scale up high impact interventions that will assist the country to ‘catch up’ to MDG targets. In order to achieve the MDGs, Zimbabwe should be spending at least US$34 per capita per annum on health. This per capita amount is the minimum required to provide an essential package of health services. The 2009 revised budgetary allocation, including donor contributions, allocated about US$7 per capita per annum on health.

It is clear that a focused effort is required to decentralize financial resources and strengthen accounting processes in order to better facilitate the effective running of primary level facilities. The HTF is responding to the findings in the Health Sector Investment Case with a comprehensive programme that aims to ‘build back better’ the health system including addressing health financing needs while also addressing issues of equitable access and user fees. The HTF activities and priority areas were selected as areas that will have the highest impact towards achieving key MDG targets.

**Medicines and medical supplies**

The Health Investment Case outlined the critical need for ensuring the availability of essential medicines and medical supplies, adequate professional staff and a need to decentralize financial resources for day to day management of primary level health facilities.

A multi donor fund has provided support to the Vital Medicines and the Vital Health Services Support Programme (VHSSP) to supply more than 75 per cent of the country’s selected package of essential medicines and surgical needs at primary and secondary level facilities.

Over the last 2 years this programme has achieved the following substantial results:

- No health facilities assessed in Round Six of the VHMAS had complete stock outs of selected essential medicines;
- Health facilities with at least 50 per cent of the selected essential medicines rose to high levels (99 per cent) in Round Six from 44 per cent in Round One; and
- Health facilities with at least 70 per cent of the selected essential medicines in stock rose to 87.9 per cent in Round Six from less than 20 per cent in Round One.

**Figure 3: Trends in availability of essential medicines in Zimbabwe Health Facilities**

**Source:** VHMAS, Round Six


25 VHSSP November 2008 Mission monitoring report and the Vital Medicines Availability and Health Services Survey (VMAHS May-October 2009)
The increase in availability and equitable distribution of essential medicines at peripheral health care centres can be attributed to the push allocation strategy introduced in 2009, in parallel to the pull system already in place. On-going support to the essential medicines programme is included in the HTF under thematic area 2.

Disparities in Access

In addition to user fees and financial constraints presenting barriers to adequate health care, other physical (such as distance, transport, restricted opening hours) and socio-cultural barriers exist in Zimbabwe. These barriers are more pronounced for people in rural areas, the poor and those belonging to particular religious communities.

Joint analysis conducted by Equinet and the Collaborating Centre for Operational Research (CCORE) in 2010 shows that disparities in maternal health have increased in the past decade; access to critical services across the continuum of maternal health care have deteriorated more for the poorest women than for women of higher socio-economic status. This trend is depicted in the differences in coverage of skilled birth attendance in Figure 4.

Similar disparities and trends have been noted for prevalence of chronic undernutrition (stunting), seen in figure 5. These trends reflect low exclusive breastfeeding rates and poor complementary feeding, as well as poor sanitation and poverty.

In addition, although the majority of the population is highly literate and demands health services, other socio-cultural barriers exist for some religious communities, such as the Apostolic communities, which represent an increasing proportion of the total population. These groups exhibit poorer acceptance and coverage of health interventions (see figure 6 overleaf).

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26 See details of the CCORE here: http://ccore-zw.org.dnpserver.com/
Human Resources and Health Systems

The deterioration in MNCH and nutrition indicators is also due to diminished institutional capacity due to limited health spending, infrastructure deterioration, commodity shortages and outmigration of health workers. This situation has limited the health system’s ability to deliver quality services and presents challenges in enforcing user fee policies. For example, there are around 500 midwives practicing in Zimbabwe today; it is estimated that around 2,500 midwives with enhanced training are needed to scale up necessary life-saving services. Vacancy rates in facilities and for those providing vocational training are high across all cadres of health workers, for example:

- Doctors - 69 per cent,
- Environmental Health Technicians - 61 per cent
- Midwives - 80 per cent
- Nursing Tutors - 62 per cent
- Medical School Lecturers - 63 per cent

Although it is expected that the impact of vacancy rates will be mitigated by current efforts improving the skills of 550 Primary Care Nurses (PCNs) in midwifery and training of 500 environmental health assistants, most of Zimbabwe’s health institutions are understaffed and operate with a skeleton staff burdened with heavy workloads. The shortage is most critical in rural areas where the staff is generally less qualified and vacancy rates are higher. Migration from rural to urban areas is common due to inadequate resources. As such access to care is better in urban areas, where private facilities (at a cost to the patient) provide another alternative care option. In addition, migration of workers within the health system from public to private sector often represents a stepping stone for moving out of Zimbabwe.

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28 Estimates are based on MoHCW Administrative Report (2010) reported vacancy levels of 89 per cent midwives, 64 per cent government medical offices and 59 per cent medical tutors.
29 MoHCW Administrative Report, 2008
30 This includes perceived lack of adequate measures for protection against HIV, combined with heavy workloads (see Chikanda 2004 for example).
The sub-optimal availability and distribution of human resources for health is compounded by inadequate HR management systems. The staff in place are not integrated into a system operating with adequate infrastructure, a working information system, laboratory systems and a functioning procurement and supply system for medicines and equipment. Supervision and referrals between different levels of the health system have also deteriorated with need for enhanced coordination, training and teamwork practices. The working conditions, leadership of health managers, salaries, benefits and career development along with national scale workforce planning and human resources databases need to be improved to address further attrition and skill deficiencies at all levels.

Extreme shortfalls in monitoring human resources are linked to weakened health information systems on a broader scale. Significant investment is needed in rigorous and coordinated planning, coherent policy dissemination, monitoring and evaluation. The weakened system has negatively impacted service delivery and otherwise effective interventions. It has also increased reliance on the informal health care sector due to high fees charged by private clinics and ad hoc introduction of fees in public institutions.32

The Human Resources for Health Retention Scheme (HHRS) was launched at the end of 2008 in response to the decline in health delivery services and major outbreaks of cholera. The situation in 2008 was compounded by a low rate of staff turnover and a high percentage of skilled workers seeking alternative livelihoods and leaving the public health institutions. In response to this situation, funding partners and the MoHCW created the HRRS, as an emergency intervention to attract public health workers back to work and to retain skilled workers by providing them with temporary allowances.

The HHRS was successful in motivating staff to return to work and improving attendance rates by paying health workers allowances. The intervention resulted in a decrease in vacancy rates, with some institutions reporting no vacancies by September 2009. Between 2008 and 2011 the HRRS has enabled the return and retention of between 16,527 to 20,555 health workers.33 34

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32 See CCORE, Vital Medicines and Health Services Survey, Round 6 September 2010
33 UNDP HRRS Verification exercise report Dec 2009
34 Administrative data from the Human Resource Board March 2011
2.2 Rationale for the HTF pooled-fund model

Despite the priority given to MNCH in the Ministry of Health and Child Welfare’s Health Investment Case, the elaboration of the new national Child Survival Strategy and the Reproductive Health Roadmap, there is currently no coordinated national-scale initiative to address the rising maternal, neonatal and child mortality rates, to support the MoHCW in implementing these important policy priorities and to ensure user fees are removed for key groups.

In recent years and despite a resource constrained environment, health partners have been working together to support the MoHCW in technical, policy and operational areas related to maternal, newborn and child survival and health systems as well as many other areas. Although several donors have already made commitments or are planning to increase their efforts in these areas, and despite the increased global (such as G8 Muskoka Initiative, UN Secretary General’s Initiative and the EU initiative on the health MDGs) and regional focus on MDGs 1c, 4 and 5 (Such as CARMMA and AU nutrition and maternal health initiatives), Zimbabwe will not meet any of the health and nutrition related MDGs without a major new concerted effort. Success on MNCH outcomes as well as related nutrition and HIV goals is entirely dependent on the functioning of critical health system building blocks. These foundations include human resources for health (including the health worker retention scheme); reliable and adequate supplies of essential medicines; and decentralization of financial resources to the most peripheral health facility level. However, funding for these types of support has been inadequate and unpredictable.

A pooled fund will support government implementation of the national health sector strategy, including policy development, planning and monitoring. MoHCW will lead in determining priorities, rather than coordinate a multiplicity of efforts. Pooling funds will assist in providing coherence for existing donors under one national initiative and set of objectives while also ensuring gaps unable to be met by one donor are covered by another and therefore helping to mitigate risks. Coordinated use of resources will maximize impact and reduce both transaction costs, and the risk of duplication of efforts.

While the fund is a transitional mechanism aimed at bridging towards sector financing, it will also allow for continuity of critical health system functions under all contingencies, including humanitarian funding should the need arise. The initial focus will be on the four core areas but the fund will be flexible enough to focus on additional areas in the future. Other pooled funds - including ESP, ETF, Child Protection Fund (formally Programme of Support) and PRP - have demonstrated that it is possible to galvanize a national scale, coordinated multi-donor response, and a similar approach is proposed for MNCH and the health sector. Coordination across programmes, such as, sharing direct programme support costs where possible, will ensure effectiveness, accountability, transparency and benefits from economies of scale.
3.1 Goal/Purpose/Objectives

**Goal:** to contribute to reduced maternal mortality (by 3/4) and under-5 mortality (by 2/3) (MDGs 5 and 4) and eliminate user fees for children under-5 and pregnant and lactating women by 2015. The programme also aims to contribute halving the prevalence of underweight in children under-5 (MDG 1c) and contribute to combating, halting and reversing trends in HIV and AIDS, Malaria and other prevalent diseases (MDG 6) by 2015.

**Purpose:** to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact MNCH interventions through support to the health sector.

**Objectives:** (by Thematic Areas)
Within the MoHCW vision and MoHCW thematic goals of Disease and Population, Health Systems, and Determinants of Health, the HTF covers objectives in four key thematic areas. The specific objectives and linked MoHCW goals are provided in section 5 and in the logical framework at Annex I (see separate document).

3.2 Scope of the HTF
Achievement of these goals is anticipated to assist Zimbabwe in reaching MDGs 1 (Target c), 4, 5 and contribute to MDG 6 over five years. In particular, the fund aims to facilitate the delivery of a primary health care package free of charge to pregnant and lactating women and children under-5 years. In the longer term other groups such as those above 65 years of age and those with selected special conditions could be included, as indicated in Government policy.35

The HTF takes its design from the key objectives and strategies outlined in the pillars of the National Health Strategy (2009-2013): Equity and Quality in Health - A People's Right (NHS, 2009) and the related Annual Planning for expansion of the fund to support these areas will be in consultation with MoHCW and funding partners 35

### The Four Key HTF Thematic Areas

1) Maternal, Newborn and Child Health, and Nutrition
   - Enhance Obstetric and Newborn Care Capacity of the Health System
   - Improve the Community Health Services System for MNCH and Nutrition
   - Improve Child Health through Strengthening the EPI and Integrated Management of Newborn and Childhood Illnesses
   - Strengthen National Capacity for Maternal, Infant and Young Child Nutrition.

2) Medical Products, Vaccines and Technologies (Medicines and Commodities)

3) Human Resources for Health (including Health Worker Management, Training and Retention)

4) Health Policy, Planning and Finance (including support for the Health Services Fund)
Work Plans/Performance Contracts. The HTF also draws on the Child Survival Strategy (2010-2015) and aligns to priorities identified in both the Health Investment Case (2010-2012) and the Reproductive Health Road Map (2007-2015). The HTF design, objectives and strategies stem from these MoHCW plans and will be reviewed by the HTF Steering Committee at critical points.

An overview of the MoHCW vision is provided in Figure 7. Those areas initially prioritized by the HTF are highlighted.

Within the MoHCW overall strategy for health there are 33 specific goal areas identified. Of these 33 areas, the HTF will work towards addressing 20-23 (directly and indirectly) within the first year of implementation (2011-2012). Although no other major national donor-funded pooled fund has an explicit emphasis on maternal and child survival, this fund will complement and coordinate with other existing related initiatives supported by the MoHCW, bilateral, multilateral, and civil society organizations.

HIV interventions are not a major focus of this pooled fund initially, because of the existing financing mechanisms in Zimbabwe (such as the HIV-Levy and Global Fund). However, HIV is inextricably linked to maternal and child health and support will be given to the MoHCW to strengthen service integration. Strengthening MNCH overall will also strengthen the continuum of HIV prevention, care and treatment for women and children. In addition it is important to note that a complementary initiative is being developed through UNFPA on neglected issues on women's health. However, in future, the HTF could include support for strategic high impact HIV-related initiatives should the need arise.

Interventions related to the water sector, particularly infrastructure-related programmes, are currently not supported through the HTF. They are, rather, supported by other sector specific financing mechanisms and incorporated in complementary programmes such as the WASH Emergency Rehabilitation and Risk Reduction initiative, with which the HTF will coordinate.

Nonetheless, health promotion activities are included, particularly those that fall within the responsibilities of the Village Health Workers, such as demand-led hygiene and sanitation campaigns (relevant to Zimbabwe National Health Strategy 'Determinants of Health' goals), with an emphasis on hand washing with soap and zero open defecation in village level interventions.

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36 Focus areas of the HTF were also informed by supporting research in Zimbabwe Demographic and Health Survey 2005/6, Multiple Indicator Monitoring Survey 2009 (MIMS), Maternal and Perinatal Mortality Study 2007 (MPMS).


38 Note that Health Promotion under determinants of health goals in the NHS focuses on WASH and school based strategies. Health promotion activities as they relate to IYCF however, are included in the HTF in the MNCH and Nutrition thematic area.

39 This figure taken from goals relevant to the HTF thematic areas outlined in the National Health Strategy for Zimbabwe (2009-2013). It should be noted however, although aligned, these goals do not directly correlate to objectives in the MoHCW performance contract.
4.1 Thematic areas description

A broad overview of key intervention areas by thematic area is outlined below.

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

Objectives

Related National Health Strategic Plan (NHSP) Goals:40
Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate (MDG4). Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio (MDG5). Halve the prevalence of underweight in children under-5 years of age by 2015 (MDG1c)

The objectives for Thematic Area 1 focus on outcomes in Obstetric and Newborn Care, Community Health service delivery, and strengthening the Expanded Programme for Immunization (EPI) and IMNCI and Nutrition.41 In particular, these objectives support MoHCW capacity to introduce, improve, implement, supervise, monitor and evaluate national evidence-based, cost effective interventions and best practices in order to raise minimum standards of health services for mothers, newborns and children. This thematic area also includes advocacy, communication and awareness campaigns that aim to increase knowledge about user fees policies and access to healthcare, particularly in rural areas.

Key Activities

A major focus is on the perinatal period where rates of both maternal and newborn death are highest.42
Capacity building, training, procurement and distribution of essential equipment and supplies and supportive supervision of critical cadres of health workers required for this scale-up are included.
Activities for year 1 are linked to the MoHCW performance contract43 and will continue, with review, over the five year programme period. Linked to all interventions, including research and facilities support, this thematic area also includes advocacy for abolishing user fees at all facilities for pregnant and lactating mothers and children under-5 in particular.

Activities within the sub-sets of this thematic area include:44

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40 Sub-objectives with targets for year one are indicated in performance contract. Related goals to Thematic Area 1 ZNHS: p. 14
41 See Annex I for full logical framework matrix, including expected results relating to these actions.
43 The performance contract is derived from the Zimbabwe National Health Strategy and is a one year work plan signed off by the MoHWC. The HTF takes its key strategies and areas of intervention from this document.
44 See Performance Contract for more detail on activities planned.
4.1.1.1 Enhancing Obstetric and Newborn Care Capacity of the Health System

Activities aim to significantly improve access to ANC (to 90 per cent), skilled birth attendance (to 80 per cent) and relevant emergency obstetric and postnatal care. Implementation of these activities will be monitored regularly through support to the MoHCW systems.

The programme aims to achieve a minimum standard of at least one midwife for every 5,000 people. For Zimbabwe, a total of 2,000 to 2,500 midwives would need to be deployed in all health facilities including rural health centers. Currently, there are around 500 midwife nurses practicing in the country; therefore an additional 2,000 midwives are required to fill the remaining gap. Trainees will be drawn from the pool of Registered Nurses currently practicing. They will be recruited nationally and enrolled into midwifery training schools for a period of one year.

Initially the capacity of midwifery training schools will be strengthened to enable the schools to provide competency-based midwifery training. This will be achieved through:

- Revising the current midwifery training curriculum (for RGNs and PCNs) to provide competency based comprehensive midwifery education that produces fully qualified midwives;
- Increasing the number of fully functional midwifery schools from 13 to 20. The existing 13 midwifery schools that are functional are seriously understaffed, with only two to three midwifery tutors in each school. There are an additional seven potential schools which can provide fully fledged competency based training if support is provided in selected areas, such as human resources, teaching materials and supplies. Therefore the HTF will support a total of 20 midwifery schools which require varying levels of support in different areas of capacity in order to render them fully functional. Each school is expected to produce around 25 midwives per year;
- Ensuring availability of five midwifery tutors for each midwifery school; that is 100 tutors. There are 30 midwifery school tutors currently in practice who require only on-the-job type refresher training. The remaining 70 new tutors will be recruited primarily from the pool of current practicing midwives and from outside the country. Where necessary, they will receive training on teaching methodology and selected refresher trainings;
- Provision of regular refresher training on maternal and newborn life-saving skills, including neonatal resuscitation for all currently practicing midwives; and
- Strengthening policies for retention of midwives. After graduation, midwifery nurses will be bonded to an equivalent year of service for each year of training received. Together with the national health worker retention scheme and improving the skills of other health workers (such as PCNs, PGNs and VHW), this plan is expected to support a conducive working environment for health workers to keep them motivated to work for longer periods, especially in rural health centers.

Conducting regular supportive supervision is critical to reinforce the skills of already deployed midwives and PCNs. The supervision will also assess overall client satisfaction and identify problems related to stock-outs of essential supplies and consumables. Client satisfaction will be measured through exit interviews of women attending care with their infant(s) to assess their level of satisfaction with the service.

Regular supportive supervision will remain one of the most important mechanisms for quality assurance for the provision of standard MNCH services. Current efforts to improve supportive supervision will be streamlined and an integrated and standardized tool for supportive supervision will be developed in consultation with partners.

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45 There is a global shortage of midwifery tutors. This strategy helps to produce more midwives with the capacity to tutor. Other schemes and potential partners in Zimbabwe and the region working to increase the available pool of tutors will be explored by the HTF, this will include teamwork training, twining and regional partnership arrangements, improving access to training and teaching (such as those outlined in the Scaling Up, Saving Lives Task force for Scaling Up Education and Training for Health Workers (Global Health Alliance, WHO, GHWA 2008) Report.)
Based on priorities and gap analysis, the HTF will consider support to revitalize the Maternity (Mother/Baby) Waiting Homes (MWHs), to make them fully functional. These homes are vital to ensure increased access to Emergency Obstetric and Neonatal Care (EmONC). This strategy will also ensure all high risk mothers are in contact with health facilities before and after delivery to address problems related to the ‘three delays’ in order to allow for early identification of and intervention for life threatening complications for both the mother and the newborn. As most mothers stay an average of three to four weeks in MWHs, the MWHs provide an excellent opportunity to introduce key maternal and newborn health practices, such as early initiation and exclusive breast feeding, thermal care, hygiene, family planning and early care seeking behaviors for danger signs for her and the newborn. Postnatal care will also be strengthened through training and supportive supervision of all health workers.

It is widely recognized that family planning contributes to reducing maternal mortality by reducing the number of births and, thus, the number of times a woman is exposed to the risk of mortality. Family planning reduces maternal mortality directly through reducing exposure to unintended pregnancy and indirectly, through reducing high-risk births as a consequence of timing, spacing, and parity. Recognizing the significant role of family planning in reducing maternal mortality, if required the HTF will complement other support in this area to improve the national contraceptive prevalence rate over the next five years.

Advocating for the enforcement of the existing user fees policy is imperative to mitigate demand side bottlenecks and barriers that impact equitable access. A comprehensive advocacy strategy and awareness campaign that explains the costs of healthcare, promotes transparent understanding of investments in the health system through the HTF and promotes rights to health care will increase demand for abolishment of user fees for vulnerable groups at all levels.

There is also a need to address barriers to maternal, neonatal and child health for specific groups of the community such as Apostolic sects, for whom the problem goes beyond financial and geographical barriers. There will be a need to design special implementation approaches to address issues of maternal and neonatal health with these communities.

The HTF will complement ongoing essential equipment and supplies for maternal and newborn health initiatives with special emphasis on providing supplies, equipment and consumables to all primary health centres. This includes upgrading operation rooms.
laboratories and blood banks as well as training and recruitment of key health professionals.

In addition, in order to strengthen the key referral systems the HTF will support:

- Review, standardization and introduction of referral guidelines and tools for facility and community MNCH and nutrition; and
- Procurement and distribution of ambulances to all district hospitals as well as communication equipment for health facilities.

4.1.1.2 Strengthening the community health service delivery system for MNCH and Nutrition

The HTF will support activities that will revitalize health committees in all districts and strengthen community-based and targeted case management services. To ensure the continuum of care from the household level to the health facility, empower families to take care of their own health and strengthen the health care seeking behavior of the community, the HTF will focus on the following activities:

- A Village Health Worker (VHW) situation analysis will be conducted to assess the geographical distribution of VHWs and their scope of work;
- VHW training materials on MNCH and Nutrition and utility kits will be revised, updated and standardized. In-service and pre-service training for approximately 17,000 VHWs will be provided in line with the updated materials. Community-based case management training for VHWs on selected MNCH problems will also be included;
- Revitalization of health centre health committees;
- Social mobilization efforts to engage Apostolic communities and other religious groups using purposefully designed programmes and approaches;
- Social mobilization and community based awareness campaigns on user fees policy and right to health care; and
- Capacity development of VHWs to promote hygiene and sanitation in order to increase hand washing with soap at critical times from 10 per cent to 80 per cent and to achieve Zero Open Defecation (ZOD) in all villages (100 per cent).

4.1.1.3 Improving Child Health Through Strengthened EPI and Integrated Management of Newborn and Childhood Illnesses.

Activities in this area contribute to an increase in full immunization coverage (including new vaccines). They also aim to increase the proportion of newborns and children treated for key neonatal and childhood illnesses.

Building on existing WHO and UNICEF support to EPI, activities to strengthen routine EPI services include:

- Revise, update and standardize training materials for Reach Every District (RED) approach and for Mid Level Management for immunization (MLM), such as microplanning and cold chain management etc. and conduct associated training with relevant health personnel and managers;
- All EPI vaccines (antigens), injection supplies and related consumables will be procured and distributed, with logistics and financial support for regular monthly outreach services;
- Support the development of a proposal to GAVI for the inclusion of new vaccines (pneumococcal and rotavirus) into the routine EPI system; and
- Support the MoHCW in the preparation to introduce and roll out new vaccines according to the GAVI recommendations for new vaccines.

In order to build health workers capacity to assess and manage common childhood illnesses (including HIV, neonatal sepsis, pneumonia, diarrhea, severe acute malnutrition and malaria) the following activities will be undertaken:

- Revising and standardizing the Integrated management of newborn and childhood illnesses (IMNCl) training material (integrated with updated
management of early newborn problems, Ped-ART and management of acute malnutrition);  

- Training on IMNCI (facilitators, course directors, clinical facilitators and health workers) at primary health centre level;  

- Incorporation of the updated IMNCI training package into pre-service training of the Primary Clinical Nurses (PCNs) and Registered General Nurses (RGN); and  

- Training on 'follow up after training' to district and provincial health managers and master trainers (supervisory skills); and development and distribution of IMNCI drug kits.

4.1.1.4 Strengthen National Capacity (at all levels) in Maternal, Infant and Young Child Nutrition

In order to expand high impact nutrition interventions47 (that give priority to increasing exclusive breastfeeding, complementary feeding, micronutrients supplementation and treatment) at facility and community level, nutrition activities supported by the HTF will focus on integration of these interventions into MNCH services, by strengthening the capacity of nutrition managers and implementers through knowledge transfer, skills development, supportive supervision, provision of policy, strategies and guidelines and evidence based advocacy.

Activities supported by the HTF will include:

- Comprehensive analysis of gaps and development and dissemination of key policy and related strategies/guidelines including the national food and nutrition policy,48 comprehensive national nutrition strategy and national nutrition communication strategy;  

- Ensure improved and integrated materials and tools for scaling-up effective interventions on optimal breastfeeding and complementary feeding -

practices for use at all levels of health professionals;  

- Conduct relevant training to all facility and community health workers;  

- Review, update and standardize the national growth monitoring system and standards (using most recent WHO recommendations) and conduct the relevant trainings;  

- Assess gaps, update guidelines/tools and conduct refresher training on micro-nutrition supplementation to health workers in all health facilities (prioritizing prenatal and postnatal Vitamin A supplementation to women, Vitamin A supplementation to children 6 to 59 months and supplementation of Zinc during diarrhea);

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47 Including: Maternal Iron/folate supplementation, immediate breastfeeding, Exclusive breastfeeding, timely introduction of appropriate complementary foods, zinc in treatment of diarrhea, vitamin A supplementation, treatment of acute malnutrition, deworming of children  
48 The development of the national food and nutrition policy is being supported by UNICEF, WFP, WHO and FAO, and WHO.
Further adapt and finalize guidelines and protocol for treatment of acute malnutrition and ensure that treatment of Severe Acute Malnutrition is routinely provided in all facilities;

Integrate IYCF counseling, supplementation of micronutrients and treatment of severe acute malnutrition into routine child and maternal health services, including ANC, PNC, PMTCT, IMNCI, Pediatric HIV and others; and

Strengthen capacity of the nutrition system nationally to ensure integration and supportive supervision of direct nutrition interventions (mainly through the health sector) as well as intersectoral linkages/indirect interventions (such as through Agriculture, WASH).

The HTF also includes a comprehensive review of the status of high impact nutrition interventions to date as well as formative research to define barriers and facilitators of optimal breastfeeding, complementary feeding and maternal nutrition practices. A comprehensive assessment of the national nutrition system's ability to support direct interventions (mainly through the health sector) and inter-sectoral linkages will also be conducted. Furthermore, where gaps do exist, capacity development of key nutrition personnel will be pursued at all levels.

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

Objectives

Related NHSP Goal: Increase access to and utilisation of quality primary health care services and referral facilities through health systems strengthening and ensuring availability of essential health commodities

The objective for Thematic Area 2 is to maintain the availability of 80% of essential medicines and commodities (the selected package based on the WHO recommendations applicable to Zimbabwe) and 100% of vaccines and injection equipment, cold chain equipment and nutrition commodities in all health facilities across Zimbabwe by 2015. In particular those supplies required to scale-up interventions for accelerating MDGs 1, 4 and 5 are included.

Key Activities

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

Reproductive health commodities may also eventually be included as well as essential supplies for National Child Health Days (NCHDs) and for tertiary facilities.

Provision of essential capital equipment for MNCH and nutrition activities covered in this area includes:

- Comprehensive inventory of needs for capital health facility equipment at all levels through the Integrated Health Facility Assessment;
- Procurement and distribution of capital health facility equipment as needed;
- The maintenance and repair of equipment; and
- Annual reviews of capital equipment functionality.

The HTF will finance the strengthening of NatPharm and MoHCW counterparts in integrated management of essential medicines and health and nutrition commodities to increase access, use and quality of primary health care services across Zimbabwe. The recent NatPharm System Assessment noted that NatPharm capacity for distribution of essential medicines is limited and continued support for the harmonisation of distribution resources would make the most efficient use of available resources and ensure

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Sub-objectives with targets for year one are indicated in performance contract. Related goals to Thematic Area 2 ZNHS: p 18

There is an estimated 40 per cent gap in Dried Blood Spot and PCR supplies for 2012 and 2013, with larger gaps in subsequent years up to 2015.
equitable distribution. The HTF will work together with stakeholders within the existing Harmonization Taskforce to support capacity building efforts.

The national Vital Medicines Programme currently managed by UNICEF is included in this thematic area. The Vital Medicines Programme works with government to provide all health care facilities with at least 80 per cent stocks requirements of agreed selected essential medicines and supplies and to strengthen supply chain management.

The HTF will also provide support to the quarterly Vital Medicines Availability and Health Services Survey (VMAHSS) that has proved essential in ensuring sufficient monitoring coverage for a programme of this magnitude. Spot checks will also be carried out. A Drug Information System which will focus on collecting information on stock at hand, consumption and any losses or adjustments to the system will be set up as well as support provided to Logistics Management Information Systems.

To ensure that availability is not affected by irrational prescribing or dispensing habits, the HTF plans to support the MoHCW DPS drug management training exercises for district pharmacy managers and rural health worker staff as well as to continue to distribute the 2010 revised Standard Treatment Guidelines (EDLIZ) to health workers for reference.

Training of rural health workers is a key step in transitioning from the push to the pull system for determining medicine requirements at the decentralized level. The curricula focuses on calculation of minimum and maximum medicine stock levels, calculation of reorder levels and how to place requisitions. The training strategy, with support to the DPS supervisory activities, will promote good drug management practices such as the use of stock cards to manage stock, determination of average monthly consumption for quantification purposes and minimum and maximum stock levels at facilities to avoid expiry of commodities and to make effective use of resources.

4.1.3 Thematic Area 3: Human Resources for Health (including Health Worker Management, Training and Retention)

Objectives

Related NHSP Goal: To reduce the vacancy levels across all staff categories by 50%

The objective for Thematic Area 4 is to ensure that 95% of health management offices and health facilities are staffed with the minimum standard of qualified health professionals by 2015.

Key Activities

This thematic area will also support MoHCW in Human Resources management and planning. Activities in this thematic area ensure the Health Worker Retention Scheme (HWRS) is resourced, coordinated and effectively administered within a framework that enables an affordable harmonized national retention allowance that complements government salaries and helps retain critical health sector workers. The HWRS (direct cash transfers to workers) will be administered by an appropriate contractor to support key strategic positions within the MoHCW, approved by the HSF Steering Committee, through ‘top-up’ salary payments. Support for Human Resources for Health is linked to all system strengthening work supported by the HTF and sits across the four thematic pillars (see Figure 8).

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51 Sub-objectives with targets for year one are indicated in performance contract. Related goals to Thematic Area 4 ZNHS: p 18
52 This objective links to the ZNHS goal: To ensure that the health system based on PHC has appropriate numbers and categories of Human Resources for Health for efficient and effective implementation of the National Health Strategy (Goal 23 NHS).
Further, considering these areas of support for Human Resources across the HTF pillars, the relationship between scaling up support for the health workforce and MDG health outcomes is described in Figure 9.

The diagram shows how immediate steps can lay the foundation for longer term outcomes and achieving the MDGs within the 5 year programme. For example, the rapid scale up of large numbers of community health workers and supervisors in a well managed health system can significantly improve access to preventative and curative interventions for child health and communicable diseases (MDG 1c, 4 and 6). Increases in mid-level cadres including midwives and midwifery tutors/assistants, will also help reduce maternal mortality (MDG 5). The HTF focuses on medium term and quick win interventions as the foundation for comprehensive support. Further, the focus on Human Resources will help counter the increased workload for staff as demand for services increases with the realization of the user fee policy.

The HTF’s support to human resources under thematic area 3 (the health worker retention scheme and technical assistance) are outlined in figure 9.

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**Figure 9: Impact of scaling up Health Workforce on Health Outcomes: Adapted from figure in WHO/GHWA Scaling Up, Saving Lives report, 2008 page 12**

<table>
<thead>
<tr>
<th>CRITICAL SUCCESS FACTORS</th>
<th>WORKFORCE PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political commitment</td>
<td>Sustained govt and donor involvement and support</td>
</tr>
<tr>
<td></td>
<td>Collaborative planning around the national strategic plans</td>
</tr>
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<td></td>
<td>Significant financial investment</td>
</tr>
</tbody>
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**EDUCATION AND TRAINING STRATEGIES**

- **Quick wins**
  - e.g. payment incentives for workers

- **Medium term**
  - Short and long term workforce planning
  - Commitment to produce appropriately trained personnel to meet health needs
  - Significant expansion of pre service training

- **Longer term**
  - Strengthened information systems for health workforce and education
  - Effective management
  - Ability to absorb and support health workers (adequate retention scheme)

**Strategies**

- **Scale - up outcomes**
  - More community health workers
  - More mid level cadres
  - More high level cadres

**Health Outcomes**

- MDG6
- MDG 4
- MDG 5 Chronic disease management

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53 See Global Health Workforce Alliance, 2008. Scaling Up, Saving Lives Task force for scaling up Education and Training for Health Workers
4.1.3.1 Health Worker Retention Scheme (cash payments to workers)

The Health Worker Retention Scheme aims to ensure that the health system, based on Primary Health Care principles, has appropriate numbers and categories of Human Resources for Health for effective and efficient implementation of the National Health Strategy. In particular, the scheme aims to provide salary incentives that reduce clinical and managerial turn-over and vacancy rates of essential staff nationwide, targeting areas and levels of critical need. Priorities for support include the Human Resources Directorate (with view to improving capacity in overall data analysis to better inform policy decisions) as well as front line professionals and village health workers.

The HWRS has been successful in returning health workers to facilities and improving vacancy rates. Since its inception the scheme has steadily increased the number of workers receiving top-up payments (see Figure 10).

The HTF support to the HWRS aims to complement and work with existing initiatives supporting Human Resources for Health, with a view to coordinating, aligning and where possible streamlining other funding mechanisms, such as the Expanded Support Programme, bilateral donor institutions and Global Fund Round 8 commitments.

Over the next five years the scheme will be co-financed by the HTF contributions from donors and the government with a phased-down approach. The HTF commitment will initially support 94 per cent of the scheme’s costs in the second half of 2011 with a phased out approach to zero per cent in 2015 as government resources become increasingly available. Over the five years government will increase wages for health workers as well as take on full payment of salaries by 2015. Table 1 shows the tentative scheme arrangements and exit strategy. Although the HTF and government current commitments will fund the majority, a seven per cent shortfall currently remains unfunded.

The scheme aims to support a projected quota of 22,065 workers in the public system over the next five years. Any additional health workers will be fully supported by government (rather than the HTF).

The allowances will be paid in line with the grades and conditions set out in the MoHCW Reviewed Short-Term Human Resources Retention Policy (April 2009) and 2011 MoHCW projections. These costs, presented in Table 1, include all positions C5 and above as well as adjustments for rural workers incentives. Rural incentive payments are critical to retain and attract staff in areas where vacancy rates are higher and health care coverage is lower.

Payments of HTF funds to health workers will be made directly into employees’ bank accounts through a contracted service provider. The terms of reference for this contract will be agreed within the HTF Steering Committee.

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54 Zimbabwe National Health Strategy page 96 - 101
55 C5,D1,D2,D3,D4,E1,E2,E3,E4,E5 (1), E5(2), F and F+. Deployed workers (Cuban) do not come under the scheme, however are included for rural incentive adjustments.
In addition to the details outlined in the Health Worker Retention Policy the HTF proposes to also support key strategic positions within the MoHCW. These positions will be proposed by the Human Resources Taskforce and other MoHCW stakeholders including the Director of HR and the MoHCW finance team. Support to these positions will be co-financed from the MoHCW and the Human Resources for Health phased commitments from the HTF. These key staff will support timely and accountable financial liquidation, monitoring of health transition progress and outcomes, and resource management, particularly at the district level.

The communication and planning processes in the HTF will ensure that posts supported by donors and funding mechanisms are coordinated and harmonized across the MoHCW. This harmonization will occur at various levels of implementation, ensuring no duplication or gaps in key roles.

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**Government will also introduce additional wage increases to ensure incremental salary increases for employees over the five years.**

**This plan assumes additional health workers (beyond the assumed fixed number of 22,065 minimum standard) will be supported by government and not HTF funding.**
In addition to incentive 'top-up' payments through the HWRS, the MoHCW will be supported with technical assistance in health workforce planning and development and implementation of a staged National Human Resources Strategy and strengthened management capacity. The development and implementation of the human resources strategy will include the following considerations:


- Strategic targeting for scaling up education and training for health workers, including consideration of 'institution twinning' and regional partnerships arrangements.

- Use of health information systems for modeling current and future health needs and health worker requirements as a basis for developing strategic plans.

- Indicators and targets relating to health workforce planning and development including monitoring of health labour market absorption capacity (such as considering quantitative indicators on deployment and retention).

- A sub-strategy on communication that helps to attract and retain health workers (considering the impacts of migration of workers within the sector).

The HWRS will be a key component of the Human Resources Strategy, including monitoring progress towards the phased-down approach in HTF funding.

In addition to the Human Resources Strategy and related plans, management systems will also be strengthened through provision of technical support. Such work will include improving ethics policies, appraisal systems and clinical audits. Technical support will also assist in future planning for the HWRS.

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

Objectives

Related NHSP Goal: Increase access to and utilisation of quality primary health care services and referral facilities through health systems strengthening

The objective for Thematic Area 4 is to improve national capacity for policy, planning and financing across all health service delivery levels, with special emphasis on the most peripheral health facilities by 2015.

Key Activities

Interventions in health policy, planning and finance include financial support to peripheral health facilities through the Health Services Fund and external Monitoring and Evaluation and Operational Research and provision of Technical Assistance.


99 Sub-objectives with targets for year one are indicated in performance contract. Related goals to Thematic Area 3 ZNHS: p 129

100 This objective links to the ZNHS goals: to increase the levels of sustainable and predictable financial resources to ensure provision of high quality services to the population (Goal 29 NHS), and to strengthen capacity to formulate, develop and implement health policies and regulations (Goal 31 NHS).
Evidence from other countries show that three health systems reforms are required to facilitate the removal of user fees - namely adequate essential medicines, motivated and equipped personnel, and funding for maintenance and running costs of health facilities. The International Health Partnership, for example, recommends that funds be set aside for monitoring performance, evaluation, operational research and strengthening health system information systems.61

Human resources, routine activity and output monitoring and essential medicines are addressed through other HTF thematic areas. Complementing other system reforms included in the HTF design, activities under this thematic area will support vital health facility maintenance costs through support for the Health Services Fund and a robust monitoring, evaluation and research framework.

4.1.4.1 Revitalising the Health Services Fund

The Health Services Fund was initially established in September 1996 to expand and improve service delivery through decentralized funding to District Hospitals (DHs) and Rural Health Clinics (RHCs). The HTF aims to revitalise the existing financing mechanism to cover selected running costs and maintenance expenses of health facilities. In particular, through increasing and decentralising financial resources using the Service Fund procedures it is envisaged that the support from the HTF will facilitate the delivery of a primary care health package free of charge for all children under-5 years, pregnant women, people over 65 years of age and a few selected additional groups, as indicated in government policy.

The types of costs covered by the Health Services Fund are primarily non-capital investments and include utilities (such as water, electricity, communication, transport), basic commodities and maintenance (such as soap and cleaning products, electrical bulbs, bed sheets and blankets, fuel, minor repairs) and funding to support community based interventions (such as health outreach activities).

A 2010 World Bank mission confirmed that the Services Fund structure and system are used by the District Health Executive Teams (DHET) for the financial management of the user fees revenues under the supervision of the Provincial Medical Directorates (PMDs). 62 The assessment found the system and structure to be sound and relevant for decentralised health financing. However, because of the low income base, facility maintenance has been constrained. The increased revenue for the HSF aims to provide the income necessary to enable MoHCW to enforce the user fees policy, mitigating motivations to charge fees.

Impact on User Fees

The 'Access to Health Care Services Study' 63 provides insight into the issue of user fees in Zimbabwe. The study found that the majority of communities in the study (59 per cent) paid to access health care services especially in the urban areas, commercial farming areas and mines. In rural areas, people paid user fees at the district hospital level and in most rural health centres. The study also found that most people (66 per cent) said they could afford to pay the fees charged and 36 per cent said they could not. However, 62 per cent of respondents did not believe that they should have to pay for basic health services.

Those key informants in the study that perceived the fees to be affordable strongly believed that patient fees were necessary to enable health institutions to replenish stocks and maintain facilities and equipment. They also argued that since the government could no longer afford to adequately finance health services, patients should pay; otherwise the whole system would collapse. As such, motivated by the need to cover recurrent costs, health facility managers are charging for services that would normally be free.

The impact of re-introducing user fees has affected the use rate of health services. The "Assessment of Primary Health Care Study in Zimbabwe" (2009) recommends that a package of essential services and resources be defined and costed at primary level and

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62 PMD is the provincial office of the health system, which major task is to provide technical assistance and supportive supervision for the correct implementation of national health policy, strategies, technical and administrative procedures.
that this basic level of service provision is funded and universally delivered by primary care clinics (central, local government, mission and other private). The costing of the primary health package is being supported as one of the advocacy and planning strategies in the HTF.

The HTF aims to provide the support necessary to ensure this primary health package is available nationally over the next 5 years; government support includes all costs not covered by the HSF as well as incremental support to the Health Worker Retention Scheme. The HTF support to the Health Service Fund addresses those recurrent costs that are directly linked to facility-based rationale for charging user fees. Along with a tailored advocacy strategy, the revitalised HSF will enable MoHCW to enforce the user fee exemptions in MoHCW policy and increase the population’s access to health care.

As part of the final programme evaluation, the processes contributing to the success of user fee removal will be reviewed. The medium term economic prospect of the country is optimistic and therefore the government’s fiscal revenues will increase modestly in the medium term. The HTF will advocate for pro-health budget allocations, with a view towards achieving fiscal self-sufficiency while also acknowledging limited economic growth, competing demands for social services, and aid dependency.

HTF support to the Health Service Fund

Funds will be allocated to peripheral health facilities according to the "HSF Financial and Accounting Procedures Manual" which contains procedural and accounting information specific to government hospital operations. The manual will be revised to outline adapted modalities such as the disbursement of funds directly to RHC and DH bank accounts. The funds transfer will be coordinated by MoHCW and facilitated by a service provider contracted by UNICEF.

Lessons learnt from the two ‘front runner’ districts (Marondera Rural and Zvishavane) as part of the 2011 World Bank Results Based Financing programme will be taken into account in yearly review and coordination meetings and future programme design. DHETs are expected to aggregate and approve health facilities’ plans/reports and provide supportive supervision and technical guidance where necessary. These officers will also be responsible for reporting on funds utilization to both the MoHCW and the HTF contracted service provider. The terms of reference for the contracted service provider for this component of the HTF will be agreed by the HTF Steering Committee.

In addition to monitoring the removal of user fees by 2015, other key results to be outlined in the ToR include:

- Consolidation and revision of the Health Services Fund procedures including exploration and consideration of Result Based Financing models implemented in World Bank ‘front runner’ districts. This may involve participatory workshops with key stakeholders and reorientation/training of MoHCW accountants and financial officers directly involved in the management of the HSF at central and peripheral levels.

- Each health facility has a prioritized and costed Annual Plan of Action approved and monitored by DHETs as well as a sound information system recording data on services provided and available.

- HSF financial resources are readily available in each peripheral health facility and are used effectively according to agreed criteria.

The service provider will transfer funds on a regular basis to each peripheral health facility across eight provinces (excluding Harare and Bulawayo cities) according to the MoHCW list of countrywide health facilities. As presented in Table 2, the HTF will support the Health Services Fund over the next five years according to the estimated indicative amount in the following table. Government will continue to incrementally support the Health Worker Retention scheme and facility costs not covered by the HSF.

The service provider will report to UNICEF and the HTF Steering Committee in order to monitor implementation and to ensure effective coordination among the different stakeholders. The service provider will provide relevant information on implemented HSF procedures, funds disbursement and utilization, and will implement any recommended improvement measures. The service provider will also provide an annual audit of MoHCW expenditures at different levels and design and implement relevant visibility activities that are coordinated with related HTF advocacy strategies.
4.1.4.2 Operational Research, Evaluation and Monitoring Framework

The HTF monitoring and evaluation framework will provide the basis for tracking progress and addressing challenges in implementation. This framework will rely on MoHCW systems, structures and processes that will be strengthened through various HTF interventions. Accountability for outcomes in the HTF will be measured against indicators outlined in the MoHCW yearly Performance Contracts (AWPs) and the HTF logframe, which outlines tools to track progress at various levels. This initial monitoring and evaluation framework (to be developed at the outset of programme action) is presented in the logical framework matrix (Annex I).

Three distinctive elements are considered in this section. These are:

a) Routine monitoring
b) Impact evaluation
c) Operational research

Routine monitoring of HTF activities have been integrated within descriptions of HTF thematic areas. Routine monitoring will be based on existing national systems, particularly the Health Management Information System (HMIS). Further, tools and procedures, such as UNICEF’s Field Monitoring System that captures outcomes of monitoring trips and the Vital Medicines and Health Services Surveys (VMAHSS) will complement the MoHCW Health Information System. The comprehensive quantitative and qualitative Integrated Health Facility Assessment planned for 2011 along with other government data collection will be used to confirm baselines and inform programme planning. Other key sources of information include the DHS/MICS Administrative Report and data collected by ZimStats (formally CSO).

Specific activities included within routine monitoring of the HTF include:

- Routine monitoring reports
- Periodic surveys
- MOHCW/health sector quarterly administrative reports
- Regular supportive supervision; an important mechanism for quality assurance in the provision of standard MNCH services and the management of health commodities. Current efforts to improve supportive supervision will be streamlined in the HTF and an integrated and standardized tool for supportive supervision will be developed in consultation with different programmes within the MoHCW.
- Regular review meetings to assess the status of programme implementation will also be strengthened, focusing on particular technical components of MNCH and Nutrition
- Quarterly and annual review meetings that provide updates on programme progress and planning needs.

The HTF will seek to strengthen national monitoring systems including the HMIS. Specifically, the HTF will strengthen national health information through the use of new information technologies, revitalizing systems

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### Table 2: Support to the Health Services Fund over five years

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Number of facilities</th>
<th>Monthly cost per facility US$</th>
<th>Year 1 (6 mths) costs US$</th>
<th>Year 2 costs US$</th>
<th>Year 3 costs US$</th>
<th>Year 4 costs US$</th>
<th>Year 5 costs US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/Rural Centres</td>
<td>1,2524</td>
<td>750</td>
<td>5,634,000</td>
<td>11,268,000</td>
<td>11,268,000</td>
<td>11,268,000</td>
<td>11,268,000</td>
</tr>
<tr>
<td>District and Mission Hospitals</td>
<td>181</td>
<td>1,500</td>
<td>1,629,000</td>
<td>3,258,000</td>
<td>3,258,000</td>
<td>3,258,000</td>
<td>3,258,000</td>
</tr>
<tr>
<td>DHEs Office</td>
<td>62</td>
<td>1,500</td>
<td>558,000</td>
<td>1,116,000</td>
<td>1,116,000</td>
<td>1,116,000</td>
<td>1,116,000</td>
</tr>
<tr>
<td>Total Required for Health Services Fund (funded by HTF)</td>
<td>1,495</td>
<td>7,821,000</td>
<td>15,642,000</td>
<td>15,642,000</td>
<td>15,642,000</td>
<td>15,642,000</td>
<td>15,642,000</td>
</tr>
</tbody>
</table>

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4 Excluding Harare and Bulawayo health facilities
such as the logistics management system that will enhance reporting on key health commodity consumption rates and the maternal and newborn deaths audit system. Ongoing routine programme monitoring will further develop institutional capacity within various levels of the MoHCW by strengthening the current information collection and reporting systems for the selected core indicators included in the national HMIS. Registration books will be standardized, printed and distributed for coherent data collection and reporting. Supportive supervision and in service training on the new HMIS will be conducted in all health facilities, targeting staff and health managers at all levels.

Monitoring data will be analysed to generate conclusions and recommendations aimed at adjusting and improving programme implementation. The programme manager will ensure that conclusions and recommendations from routine monitoring are followed up effectively.

b) Impact Evaluation of the HTF
Impact evaluation activities will be managed independently from the implementation of the HTF, although the independent contractor will work closely with the HTF Steering Committee. Independence of such evaluations is considered as part of OECD DAC’s key norms and standards for evaluating development assistance65. Four aspects of independence66 are considered here:

1. Organizational independence - given the size of the HTF and the involvement of multiple funders, it is proposed that the impact evaluation elements be managed by an independent evaluation contractor. It is also proposed that this contractor report to the HTF Steering Committee through an evaluation sub-committee established specifically for this purpose. It is proposed that this sub-committee be formed of three to five independent professionals drawn from academic institutions, civil society organisations and the private sector. This work is provided for as a separate, earmarked line within the overall HTF budget. The evaluation contractor would have free access to all information that they consider relevant.

2. Behavioural independence - items for inclusion in elements of the impact evaluation will be selected by the evaluation contractor and the evaluation sub-committee of the HTF Steering Committee. Although these items - and detailed terms of reference - may be discussed with the full HTF Steering Committee, they do not necessarily need to be approved by all individual members of the Steering Committee. The evaluation contractor will be encouraged to produce candid, uncompromising, high quality reports, containing well-evidenced findings and clear conclusions and recommendations. These reports will be submitted to the Evaluation Sub-Committee of the HTF Steering Committee. Evaluation findings will be made freely and proactively available to all HTF stakeholders, including beneficiaries and the general public.

3. Protection from outside influence - the independent evaluation contractor will be recruited through an open and transparent process, based on agreed recruitment criteria. The independent evaluation contractor and the evaluation sub-committee of the HTF Steering Committee will be responsible for the design and execution of all elements of the impact evaluation. This will include design of a suitable evaluation framework. The independent evaluation contractor will be responsible for all reports generated from the impact evaluation. Comments from stakeholders, including the HTF Steering Committee will be welcomed but the evaluation contractor will be responsible for determining how these comments should be addressed in terms of revising the report. The evaluation sub-committee will determine whether or not the report submitted by the contractor meets required quality standards.

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65 OECD DAC Network on Development Evaluation - Evaluating Development Cooperation: Summary of Key Norms and Standards
4. Avoidance of conflicts of interest\(^{67}\)- the evaluation contractor will operate a conflicts of interest policy which will ensure that no individual involved in the evaluation have a conflict of interest relating to the HTF.

**Elements of the impact evaluation include:**

- **A baseline assessment** that considers and reviews potential indicators for assessment of indicators, selects those to be used and identifies baseline levels for them.

- **Annual reviews** that assess programme achievement, challenges and opportunities. These annual reviews will feed into\(^{68}\) the programmatic reviews and planning processes described above and will produce annual reports which will feed into the Mid-Term Review (MTR) and final evaluation.

- **A Mid-Term Review (MTR)** of technical programme achievement and the effectiveness of HTF management arrangements will be undertaken. The MTR will inform all stakeholders on progress, challenges and opportunities. It also provides an opportunity to reorient priorities if required in order to achieve key programme goals.

- **A final impact evaluation** will be undertaken in the final year of the HTF linked to regular MDG status reporting for 2015 and following the guidelines set forth in ‘UNICEF Evaluation Report Standards’. Existing data collection efforts in line with government and global MDG monitoring will be used. The Multiple Indicators Cluster Survey (MICS/MIMS) planned for 2013 will provide mid-programme results and the next round of Demographic Health Survey (DHS) will also provide result data at the end of the HTF funding period.

The Independent Evaluation Contractor and the Evaluation Sub-Committee of the HTF Steering Committee will determine the timing, terms of reference and composition of annual review missions, the MTR and final evaluation. The timing of the annual reviews will be coordinated carefully with the government planning cycles to ensure that the information is of maximum benefit to the MOHCW.

c) Operational Research

Based on the current situational analysis on health and programme roll out, health information gaps will be identified. Accordingly, an operational research agenda will be developed for approval by the HTF steering committee. Subsequently, suitable institutions and individual candidates will be identified. The CCORE (Collaborating Centre for Operational Research) and all other relevant academic and research institutions will be considered according to their comparative advantage. UNICEF, supported by the HTF monitoring team, will ensure that findings are well disseminated to all stakeholders and used to inform decision making and future programme direction.

### 4.1.5 Technical Support and Indirect Outcomes through HTF Planning and Approach

A subsidiary objective in each thematic area is to assist donor harmonization and alignment as interest grows in scaling-up actions for MDGs 1c, 4, 5 and 6. A programme of technical assistance will be developed with the MoHCW and relevant para-statal institutions in relation to all thematic areas of support under this fund. The HTF includes technical assistance in areas of governance, management, HMIS, and policy development as well as technical assistance for its prioritized thematic health care areas. Providers of technical assistance will be identified according to the criteria of comparative advantage and value for money.

The management and governance arrangements of the HTF will work to strengthen and support government processes, systems and accountability in health programming. The design of the HTF as a sector wide approach helps prepare government structures for future receipt and direct management of donor funds. It also assists in disaster risk reduction and preparation for humanitarian action should the situation deteriorate or in the event of complex disasters.

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\(^{67}\) Potential conflicts of interest include:

- Official, professional, personal or financial relationships that might cause an evaluator to limit the extent of an inquiry, limit disclosure, or weaken or slant findings
- Preconceived ideas, prejudices or social/political biases that could affect evaluation findings
- Current or previous involvement with a programme, activity or entity being evaluated at a decision-making level, or in a financial management or accounting role; or seeking employment with such a programme, activity or entity while conducting the evaluation
- Financial interest in the programme, activity or entity being evaluated
- Immediate or close family member is involved in or is in a position to exert direct and significant influence over the programme, activity or entity being evaluated

\(^{68}\) Options to be considered include (i) holding these annual reviews prior to the annual programmatic review so that findings and conclusions can be considered in that process (ii) the external evaluation contractor contributing personnel to the annual programmatic review.
The strategies presented in the table below will be mainstreamed in various aspects of the Health Transition Fund. The programme will develop analytical tools, programming guidelines and standards to inform the choice of appropriate interventions and appropriate instruments to monitor the extent to which the programme adequately addresses cross-cutting issues.

The specific issues and considerations in the programme are presented below. The issues are divided into those that will be fully mainstreamed into HTF-supported programmes and those with which linkages with HTF-supported programmes will be made.

### Cross cutting issue (mainstreamed) | Mainstreaming (across the explicit activities outlined in the HTF logframe and proposal)
--- | ---
Gender and Human Rights[^69] | Realization of the ‘Right to Health’ is inherent in the HTF programme goals. The programme goal to eliminate user fees, in particular, is a key challenge in ensuring universal access to health care protected under Article 25 of the Declaration of Human Rights, with particular reference to motherhood and childhood[^70] as well as specific Children's Rights (the Convention of the Rights of the Child, article 24).

The entitlements in the Right to Health are advocated, provided for and supported in the HTF including:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- The right to prevention, treatment and control of diseases;
- Access to essential medicines;
- Maternal, child and reproductive health;
- Equal and timely access to basic health services;
- The provision of health-related education and information; and
- Participation of the population in health-related decision making at the national and community levels.

[^70]: Article 25 of the Declaration of Human Rights includes: 1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. 2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
<table>
<thead>
<tr>
<th>Cross cutting issue (mainstreamed)</th>
<th>Mainstreaming (across the explicit activities outlined in the HTF logframe and proposal)</th>
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<tbody>
<tr>
<td></td>
<td>The HTF also recognizes and aims to prevent issues related to disability, ensuring</td>
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<td></td>
<td>equitable access to health care without discrimination.</td>
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<td></td>
<td>Gender considerations in maternal and young child survival and development include</td>
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<tr>
<td></td>
<td>the issue that maternal health and survival is socially determined, women's status</td>
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<tr>
<td></td>
<td>and access to resources and services powerfully affect child health outcomes, the</td>
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<tr>
<td></td>
<td>gender division of labour, and the role of boys and men in sustaining young child</td>
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<tr>
<td></td>
<td>and women's development.71</td>
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<tr>
<td></td>
<td>The HTF includes a focus on:</td>
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<tr>
<td></td>
<td>- Promoting gender equality and women and girls' empowerment through a national</td>
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<tr>
<td></td>
<td>scale programme that alleviates barriers (including fees) to health care in pregnancy</td>
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<tr>
<td></td>
<td>as a critical factor in girls' vulnerability and inequality in society;</td>
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<tr>
<td></td>
<td>- Men's role in MNCH (such as through male champions) is emphasized;</td>
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<tr>
<td></td>
<td>- Gender sensitive training for male and female community health workers including</td>
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<td></td>
<td>skills to tackle social issues facing women and communication skills to support</td>
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<td></td>
<td>good maternal nutrition and exclusive breastfeeding;</td>
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<tr>
<td></td>
<td>- Gender-based violence and sexual violence are recognised as public health issues</td>
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<tr>
<td></td>
<td>and a child protection priority affecting girls, boys and women, requiring support for</td>
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<td></td>
<td>forensic examination recognised by the courts, access to treatment for HIV, emergency</td>
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<tr>
<td></td>
<td>contraception and referral for welfare and legal services; and</td>
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<tr>
<td></td>
<td>- Ensuring age and sex disaggregated data in all stages of the programme cycle</td>
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<tr>
<td></td>
<td>(analysis, implementation, monitoring, evaluation) wherever required.</td>
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<tr>
<td>HIV and AIDS</td>
<td>- Integration of HIV across the life cycle of health care and across all health</td>
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<tr>
<td></td>
<td>service delivery; and</td>
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<tr>
<td></td>
<td>- Reducing HIV associated stigma through national scale and holistic programmes.</td>
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<td></td>
<td>For example, exclusive breastfeeding programmes will focus on all mothers, and will</td>
</tr>
<tr>
<td></td>
<td>reduce the problematic association of HIV with exclusive breastfeeding prevailing in</td>
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<tr>
<td></td>
<td>parts of Zimbabwe.</td>
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<tr>
<td>Communication</td>
<td>- Integrated communication, awareness and advocacy strategies (especially around user-</td>
</tr>
<tr>
<td></td>
<td>fees) cut across all interventions, especially at community-based levels:</td>
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<tr>
<td></td>
<td>- Operational research will inform evidence-based advocacy and special social</td>
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<tr>
<td></td>
<td>mobilization efforts, particularly related to behavior change such as household</td>
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<td></td>
<td>level promotion of exclusive breastfeeding and engagement with religious groups; and</td>
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<tr>
<td></td>
<td>- Interventions involving a number of strategies including face to face motivation,</td>
</tr>
<tr>
<td></td>
<td>posters and IEC material, focus group discussions and private/public partnerships.</td>
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<tr>
<td>Governance</td>
<td>The focus of the HTF is on health system strengthening and support for the MoHCW</td>
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<tr>
<td></td>
<td>to ensure financial systems and accountability are improved, within the working</td>
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<tr>
<td></td>
<td>context and safeguards of the Cotonou Agreement Article 96, the MDGs as well as the</td>
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<td></td>
<td>Paris Declaration on Aid Effectiveness and the Accra Agenda for Action72.</td>
</tr>
</tbody>
</table>

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71 UNICEF DRAFT Operational Guidance on Gender Analysis and Programming for Young Child Survival and Development, Version 1 April 2010

<table>
<thead>
<tr>
<th>Cross cutting issue (mainstreamed)</th>
<th>Mainstreaming (across the explicit activities outlined in the HTF logframe and proposal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to the MoHCW systems and processes, particularly in human resources and health sector financing, will strengthen sector governance, financial monitoring and coordination. The emphasis on integrated and supportive supervision also aims to improve performance, accountability and governance within key areas of MoHCW, particularly maternal, newborn and child health as well as the MoHCW financial directorate. Interventions in the HTF pooled funding arrangement aim to bridge towards sector financing by strengthening government accounting and financial monitoring processes. The pooled mechanism allows for continuity and improvements in critical health system functions under all contingencies, including preparations in the scenario of humanitarian funding channels becoming dominant once more. Finally decentralized flow of resources, client satisfaction surveys and support to community level health committees aim to increase community ownership and ultimately accountability of health services to those whom they intend to serve.</td>
<td></td>
</tr>
</tbody>
</table>
| Environment                       | - Impacts of WASH activities on young child survival and maternal health are considered in the context of MDG 7 (environmental sustainability). Impacts on climate change are monitored by UNICEF globally. UNICEF is a party to new UNEP global agreements to monitor the environmental footprint in programming, and wherever possible will reduce the impact and increase efficiency in resource use including through innovative new technologies.  
- Behavior change promoted in the HTF within the VHW programme, for example, addresses water conservation and efficiency in use.  
- Funding to health facilities will facilitate safe disposal of medical waste according to MoHCW protocols. The handling of all medical waste will utilize universal precautions, treating all blood and other potentially infectious materials (OPIM) as potentially infectious. At minimum, rubber gloves shall be worn when there is the potential for the hands to have direct skin contact with blood or OPIM. All medical waste shall be collected, stored and shipped in leak-proof bags or containers and labeled as medical waste. Disposable syringes, needles, scalpel blades or other sharp items shall be placed in puncture-resistant containers for disposal. |

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73 Medical waste includes (but is not limited to) sharps (needles, scalpels, etc.), laboratory cultures and stocks, blood and blood products, body fluids, bandages, dressings, and pathological wastes, as well as solid waste.
<table>
<thead>
<tr>
<th>Key related issues (for linkages)</th>
<th>Consideration of key linkages with the programme themes</th>
</tr>
</thead>
</table>
| Disaster Risk Reduction (DRR)    | ● DRR is embedded within all HTF activities. Focus is on reducing vulnerabilities and mitigating the impacts of disasters and related disease outbreaks. Particularly vulnerable groups are targeted to ensure reduced exposure to risks. The HTF will support institutional and community capacity to:  
- identify, assess and monitor disaster risks and enhance early warning;  
- use knowledge, innovation and education to build a culture of safety and resilience at all levels; and  
- reduce underlying risk factors and strengthen disaster preparedness for effective response at all levels. |
| Protection                       | ● Linkages with services working to improve birth registration (such as through health facility based registration facilities) so that appropriate legal, civil status and health documents are provided to vulnerable women and children (especially children under-5) in particular. This includes strengthening the maternal death audit system.  
● Mechanisms for monitoring and reporting instances of abuse and exploitation are in place and health staff are trained to refer patients to, or directly provide (if capable) appropriate care services and gender-sensitive counseling, particularly for people who have experienced rape, domestic violence, sexual exploitation, forced or child marriage, forced prostitution, trafficking and those suffering psychological trauma. Such referral mechanisms and staff capacity will be strengthened through activities in HTF.  
● Efforts to discourage or eliminate harmful traditional practices are done in a culturally sensitive way (those practices that are helpful for healing will be researched and respected and interventions will be supported at all levels).  
● Linkages to health insurance schemes and social protection programmes (cash transfer etc) |

74 Based on Minimum Agency Standards for incorporating Protection into Health Programmes (Physical, Mental and Social Aspects of Health)
A summary matrix of the risk management strategy is provided below. Risks and assumptions are also included in Annex I, specific risks (such as those that relate to the Retention Scheme, impact of increased demand due to user fees advocacy etc will be outlined separately in workplans). The existing strengths of the Zimbabwe health system should be noted as important foundations for the feasibility of the HTF. Such strengths include:

- Key government planning documents and strategies are comprehensive and in place;
- A strong network of partners exists in Zimbabwe working to improve health;
- The MoHCW has working groups for technical components, aid coordination and planning with which the HTF will interact;
- Key research has been completed such as the Maternal and Perinatal Mortality Study, 2007; and
- Importantly, with the exception of certain religious groups, demand for a quality health system is still high. People in Zimbabwe remember when the healthcare system was functioning well and continue to demand health services; the challenge is improving utilization and the quality of services.

Risks and assumptions will be addressed by the HTF partners and UNICEF.

### Risks and Assumptions

<table>
<thead>
<tr>
<th>Planned Risk Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF and other UN agencies are working closely with government Ministries responsible for social service sectors to ensure good relations and delivery. UNICEF was able to support the provision of services through various mechanisms over the past years and does not anticipate this changing in the near future. The UN system has risk mitigation strategies to continue support should security phase increase.</td>
</tr>
</tbody>
</table>

- Political and economic situation does not worsen to civil conflict or collapse of service sectors.
- UN security phase does not rise to level 3 or above
<table>
<thead>
<tr>
<th>Risks and Assumptions</th>
<th>Planned Risk Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>● UNICEF is able to effectively work with all partners, including Government, as well as having full access to implement and monitor its programmes. UNICEF is able to maintain programme focus on intended strategic outcomes for women and children.</td>
<td>UNICEF is cluster lead for WASH, Nutrition and Education as well as fully engaged with other sectors. It maintains close links with government structures and the donor community, ensuring close coordination and consultation. In particular, UNICEF engages with key ministries to advocate for separation of politics from provision of social services and conducts regular field monitoring of programme activities to report operating risks and programme activities.</td>
</tr>
<tr>
<td>● UNICEF’s internal procurement and contracting systems are able to effectively expedite and manage large scale programmes.</td>
<td>HTF donors and UNICEF are to agree on the realistic in-country technical and operational capacity required to effectively implement and monitor the programme’s progress.</td>
</tr>
<tr>
<td>● Overall costs of procurement of goods and services do not escalate beyond reasonable levels</td>
<td>UNICEF has a comprehensive procurement process which aims at supplying the best services and goods at the best cost and can access global markets to ensure economies of scale where necessary. Nevertheless as a principle local procurement is encouraged to develop the local economy wherever possible - but not at the risk of compromising implementation or quality.</td>
</tr>
<tr>
<td>● Collaboration between implementing organisations and councils will be problem free and devoid of politics.</td>
<td>MOUs between implementing partners should emphasize the need to work together, commit to a transparent process free of politicisation. Interventions are designed to support national strategic plans, coordinated by Government and implemented through government systems whenever possible.</td>
</tr>
<tr>
<td>● Government has capacity to facilitate policy reform quickly and contribute adequate domestic financial resources, especially for health worker payments.</td>
<td>The HTF pooled-fund mechanism will allow government appropriate flexibility in implementation across different components of the health performance contract (including the health worker retention scheme). Policy and strategic planning support and technical assistance will assist in strengthening government capacity.</td>
</tr>
<tr>
<td>● All 4 thematic areas are indivisible/interdependent and need to be supported in order to achieve the overall objective of the Health Transition Fund</td>
<td>The HTF provides realistic funding projections and a pooled mechanism with reduced transaction costs to encourage all four interdependent pillars to be pursued. An integrated proposal has been presented to donors.</td>
</tr>
</tbody>
</table>
The Health Transition Fund is a multi-donor pooled fund with UNICEF serving as a common programme and fund manager. The roles and responsibilities for programme management and coordination of the HTF are outlined below, and further detailed in Annex II (Terms of Reference, HTF Steering Committee.) A detailed operations manual for the fund is also being developed. The management structure of the HTF is presented in Figure 11 below.

Figure 11: HTF Management Structure
7.1 Ministry of Health and Child Welfare (MoHCW)

It is the role of the MoHCW to take leadership in directing the health sector through national planning and review processes which articulate national priorities, strategies and operational objectives. The Directorate of Policy, Planning, Programming, Monitoring and Evaluation (PPPME) within the MoHCW convenes a consultative meeting each December that involves all Departments, with national and provincial health staff, and funding and technical partners. The participants review the status of health for all Zimbabweans and determine a set of prioritised actions for the following year. These actions are detailed and costed in a Performance Contract that the MoHCW signs with the Office of the Prime Minister and the Ministry of Finance. The Performance Contract is otherwise known as the MoHCW Annual Plan.

Broad policy dialogue and aid coordination are addressed within the Health Sector Review and Planning Group, chaired by the Minister of Health and Child Welfare, with a funding partner as Vice Chair. The Health Sector Review and Planning Group is composed of senior-level representatives from bi-lateral and multi-lateral agencies and development banks. The Group’s mandate is to (i) support MoHCW ownership and leadership in the health sector, and encourage strong MoHCW-led coordination of funding partners; (ii) promote coordinated sector-wide policy dialogue and technical support on strategic issues in health; and (iii) ensure that the support of funding partners to health is provided to MoHCW in a regular, predictable, harmonised and coordinated manner.

In regards to the HTF, the MoHCW Directorate for Policy and Planning will provide leadership in the development of annual implementation plans. An HTF Coordinator position will be established based in the MoHCW Directorate for Policy and Planning, with responsibility to ensure that the programme is fully implemented, and to assist in coordination and communication with HTF partners. The implementation of the HTF will be further supported by the National Maternal, Newborn and Child Health Steering Committee (MNCHSC), chaired by the Honorable Minister of Health and Child Welfare. The MNCHSC will be technically supported by the national Reproductive Health Steering Committee (RHSC) and the Child Survival Technical Working Group (CSTWG). The RHSC and CSTWG are comprised of Government ministries, development partners, civic society, and research and training institutions.

7.2 HTF Steering Committee

The HTF Steering Committee will be responsible for the oversight and decision making of the HTF. The HTF Steering Committee will be composed of MoHCW, funding partners to the HTF, a representative organisation from Civil Society, UNICEF, WHO and UNFPA. The latter three agencies will also serve as technical advisors and UNICEF will serve as the Secretariat. The steering committee may invite individuals or representatives of other organisations to participate in discussions. All efforts will be made to reach decisions through consensus. If agreement cannot be reached by consensus and a vote is required, only the MOHCW and the major financial stakeholders (donors to HTF and the fund manager) will be eligible to vote.

Funding partners to the HTF will provide pooled financial support, with the exception of financial resources already allocated in 2010/2011, necessary to fully implement the coordinated interventions set out in the HTF Programme Document, and make timely transfers of funds through the agreed-upon pooled funding mechanisms. Funding partners will strive to ensure the predictability of their financial support by informing the MoHCW and other partners of the support they anticipate providing.

The Steering Committee will be co-chaired by the Permanent Secretary of the MoHCW and a Funding Partner. Funding partners will select, annually, a funding partner which will serve as Co-Chair of the HTF Steering Committee. The HTF Steering Committee will initially meet monthly (this could be changed to every other month or quarterly as implementation progresses).

The role of the HTF Steering Committee includes, but will not be limited to:

- Approving funding allocations to thematic areas and related activities in accordance with the framework of the agreed HTF objectives
Ensuring alignment of HTF allocations with the MoHCW Performance Contract/Annual Plan within the thematic areas agreed upon in the Programme Document

Approving terms of reference for implementing partners

Participating in tender review committees and approving selection of implementing partners in accordance with UNICEF rules and regulations

Reviewing and approving annual, mid-term and end-of-programme programmatic and financial progress reports submitted by UNICEF. The programme report will present results-based progress against the log frame indicators

Appointing an evaluation sub-committee consisting of three to five independent professionals who will have responsibility for managing all aspects of the impact evaluation conducted by the independent evaluation contractor. These elements include the baseline assessment, joint annual reviews, mid-term review and final evaluation. This management role will include determining areas of enquiry, agreeing terms of reference, and approving reports and other products in terms of meeting quality standards.

7.3 UNICEF

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

As fund manager and programme manager of the HTF, UNICEF, under the oversight of the Steering Committee and supported by the HTF Coordinator, will be responsible for ensuring overall financial management and attainment of programme results across all thematic areas. This role will include legal responsibility for the appropriate use of funds as well as the performance of contractors and HTF implementing partners. Using the in-country management HTF budget line, UNICEF will ensure sufficient technical and operations capacity exists to manage risk, supervise contractors and ensure accountability for the HTF resources and results. UNICEF will also support the MoHCW with the minimum level of technical and implementation capacity in each thematic area as required and in building capacity for overall financial and programme management of such funding mechanisms. The HTF Coordinator will be a Zimbabwean national based in the MoHCW who will play a key liaison role between the MoHCW, the Steering Committee and UNICEF. He/she will assist in coordination, trouble shooting and in real time updates and communication. An HTF financial officer will assist both UNICEF and MoHCW with overall financial management of the programme.

UNICEF will sign a Contract or Memorandum of Understanding with each funding partner setting out the terms and conditions governing the receipt and administration of contributions, and will report on the use of funds pursuant to parameters established within the Contract or Memorandum of Understanding signed with each funding partner. UNICEF will prepare and maintain a treasury plan to ensure timely replenishment of the HTF account, showing likely cash-flow requirements for the programme over the course of the year.

As part of the consolidated report and as an annex to the narrative report, UNICEF will submit to Donors by 31 March an annual financial utilisation report, showing funds received from all sources and expended for the HTF. The financial utilisation report will follow the format set out by the contributing donors and will be in line with key institutional agreements such as the
Ensuring Transparent Governance in the Health Transition Fund

- The HTF programme is developed through a highly consultative process (including MoHCW planning and reviews, aid coordination unit discussions and collaborative work planning).
- Donor and UNICEF Agreements outline commitment to logframe and budget allocations within the programme budget allotment (PBA) and corresponding proposal.
- Only the Steering Committee has the authority to make changes to the log frame and budget allocations.
- UNICEF will recuse itself from Steering Committee decisions regarding selection of implementing partners in which UNICEF is a potential partner.
- An HTF co-coordinator based at MoHCW will ensure alignment with MoHCW plans and assist in sharing information with all partners.
- Contractors will be selected through a transparent and competitive tender process. Terms of Reference will be approved by the Steering Committee, and MoHCW and donor representatives will participate on the review committee.
- Independent reviews will occur throughout implementation, including: Regular joint annual reviews, a mid-term review, a final evaluation
- Transparent communications strategy will ensure public availability of key documents, including web-based materials.

Financial and Administrative Framework Agreement (FAFA) with the EC. It will cover the period, in any one year, up to 31 December. In addition, UNICEF will provide quarterly and six monthly budget and programmatic updates for in-country review and discussion by the HTF Steering Committee. A certified financial statement will be produced by 30 June.

Annual Reviews, a Mid-Term Review in year 3, and a Final Evaluation of the HTF programme will be conducted as detailed in the Programme Document and as agreed by the HTF Steering Committee. The findings of the reviews will inform GoZ, Donors, and UNICEF on progress, challenges and opportunities, including recommendations to reorient priorities if required in order to achieve key programme goals and objectives.

UNICEF will arrange for its financial records to be audited in accordance with the established procedures and appropriate provisions of the financial regulations and rules of the United Nations and UNICEF. Procurement of goods and services under the HTF programme will be in accordance with UNICEF’s Procurement Rules and Regulations. The HTF Steering Committee will be invited to participate in tender review committees and to approve selection of implementing partners in accordance with UNICEF’s Procurement Rules.

7.4 Implementing Partners

Non-UN Partners

Although the majority of the HTF activities will be implemented by the MoHCW, specific components may be delivered by academic or research institutions, private sector companies, UN agencies, or non-governmental organizations using UNICEF tender or partnership cooperation agreement procedures. The Terms of Reference for subcontractors will be approved
by the HTF 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. Partnerships and outsourced contracts will be subject to a capped cost recovery rate of seven per cent.

UNICEF will sign a Contract Agreement with implementing partners and contractors will provide standard quarterly, semiannual and end of year narrative and financial reports. Implementing partners will submit their final financial report no later than six months following the financial closing of programme activities. Rules and guidelines for contracting partners will be detailed in the HTF Operations Manual.

UN Partners

Should the Steering Committee select UN agencies other than UNICEF as implementing partners, provision will be made for pass-through or bilateral agreements, with consideration for funding agency requirements. In both cases standard UN agreements between UN partner agencies or between donors and UN agencies will be utilised.75

7.5 Financial Assurance

Policies and procedures for making and accounting for payments to implementing partners will be detailed in the HTF operations manual, currently being drafted.

7.6 Statement of Intent Guiding the HTF Partnership

MoHCW, the HTF funding partners, UNICEF, and other relevant agencies will be governed by a Statement of Intent to guide the partnership for the Health Transition Fund in Zimbabwe (see Annex III).

8 Resources

Please see separate document for HTF Budget

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75 In the pass-through mechanism, UNICEF would charge 1% administration fee for administering funds and UN agencies receiving funds would charge a 7% recovery rate. Should the funding to UN partners exceed a to-be-determined amount, then a bilateral arrangement between the donor partner and UN partner would ensue with recovery rates based on UN partners’ agreements with donor governments.
ANNEX 1: HTF Logical Framework Matrix

The logical framework is provided as Annex I in a separate document. Please contact UNICEF for a copy of the matrix.

ANNEX II: Terms of Reference - Steering Committee

Health Transition Fund Steering Committee: Terms of Reference

Background
The Health Transition Fund (HTF) is a multi-donor pooled fund aimed to support the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe to achieve planned progress towards 'achieving the highest possible level of health and quality of life for all Zimbabweans'. These Terms of Reference serve to guide the management of the HTF through a HTF Steering Committee.

Purpose
The HTF Steering Committee will be responsible for definition of priority interventions within the four selected thematic areas and allocation of related financial resources.

Guiding Principles
The Steering Committee will be guided by the principles laid out in the Statement of Intent to Guide the Partnership for the Health Transition Fund in Zimbabwe.

Specific Roles and Responsibilities
The Steering Committee's specific roles and responsibilities include the following:

- Approving funding allocations to thematic areas and related activities in accordance with the framework of the agreed HTF objectives
- Ensuring alignment of HTF allocations with the MoHCW Performance Contract/Annual Plan within the thematic areas agreed upon in the Programme Document
- Approving terms of reference for implementing partners
- Participating in tender review committees and approving selection of implementing partners in accordance with the UNICEF rules and regulations
- Reviewing and approving annual, mid-term and end-of-programme programmatic and financial progress reports submitted by UNICEF. The programme report will present results-based progress against the log frame indicators
- Appointing an evaluation sub-committee consisting of three to five independent professionals who will have responsibility for managing all aspects of the impact evaluation conducted by the independent evaluation contractor. These elements include the baseline assessment, joint annual reviews, mid-term review and final evaluation. This management role will include determining areas of enquiry, agreeing terms of reference, and approving reports and other products in terms of meeting quality standards.

Membership
The HTF Steering Committee will be composed of MoHCW, funding partners to the HTF, a representative organisation from Civil Society, UNICEF, WHO and UNFPA. The latter three agencies will also serve as technical advisors and UNICEF will serve as the Secretariat. The steering committee may invite individuals or representatives of other organisations to participate in discussions. The agreed quorum for meetings is over 50 per cent of membership. All efforts will be made to reach decisions through consensus. If agreement cannot be reached by consensus and a vote is required, only the MOHCW and the major financial stakeholders (donors to HTF and the fund manager) will be eligible to vote.

Chair
The steering committee will be co-chaired by the Permanent Secretary of the MoHCW and an HTF funding partner. The HTF funding partners will select, annually, a funding partner which will serve as co-chair on an annual rotation basis.
Secretariat
UNICEF as the programme and fund manager will serve as the Secretariat to the steering committee. The Secretariat will convene meetings of the steering committee; prepare and circulate the meeting minutes; and perform other functions necessary to ensure the smooth functioning of the steering committee.

Frequency of meetings
The HTF steering committee will meet initially on a monthly basis, unless otherwise determined by a consensus of the steering committee. The agenda and minutes of previous meetings will be circulated by the Secretariat one week prior to the meeting.

ANNEX III: Statement of Intent
A Statement of Intent to Guide the Partnership for the Health Transition Fund in Zimbabwe

1 Introduction
This Health Transition Fund (HTF) Statement of Intent (hereinafter the SI) provides a specific framework of collaboration, cooperation and coordination between the Government of Zimbabwe (hereinafter the GoZ), the Donors and UNICEF in the implementation of the HTF. The SI provides a Code of Conduct and information on the programme management, administration and reporting of the HTF.

2 Goal
To harmonise, align and coordinate support by GoZ and donors in the implementation of the UNICEF-managed HTF.

3 Purpose
The GoZ, Donors and UNICEF recognize the importance of addressing the needs of the Zimbabwean people in the field of health and commit themselves to the goals and objectives articulated in a number of key policy papers, including the GoZ National Medium Term Plan (2010-2015), the Health Sector Investment Case (2010), and the National Health Strategy for Zimbabwe: Equity and Quality in Health - A People’s Right (2009-2013). This SI defines the principles and mechanisms to guide, coordinate and facilitate productive relations between the GoZ, Donors and UNICEF in the pursuit of those goals and objectives, and to deliver an effective framework of support, under a set of guiding principles, utilising standardised operational procedures.

4 Background
The HTF is a multi-donor pooled fund aiming to support the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe to achieve planned progress towards ‘achieving the highest possible level of health and quality of life for all Zimbabweans.’76 The HTF will support efforts to mobilize the necessary resources for critical interventions to revitalize the health sector and increase access to care through eliminating the payment of fees for services for mothers and children under-5. As such, critical, high impact interventions will reduce maternal and under-5 mortality; reduce prevalence of underweight in children less than 5 years old, and assist in combating HIV, malaria and other diseases.

Support to key goals outlined in the Zimbabwe National Health Strategy and the Health Investment Case will be provided in a coordinated and streamlined way and will be aligned with the MoHCW annual review processes and operating plans (performance contracts.) The HTF will initially focus on the following four thematic areas, but could be extended to other areas in accordance to disease burden and available financial resources.

The four core thematic areas are:
1. Maternal, Newborn and Child Health and Nutrition
2. Medical Products, Vaccines and Technologies (Medicines and Commodities)

76 National Health Strategy (2009-2013)
3. Human Resources for Health

4. Health Policy, Planning and Finance

The pooled funding mechanism will significantly reduce overhead costs in operations, reporting and fund administration, ensuring that funding is channelled towards achieving direct programme impact. Further, the HTF scale will allow achievement of results against national scale indicators at the five-year stage, and reduce potential duplication of efforts by development partners.

This SI represents a common understanding between the GoZ, Donors and UNICEF, and does not constitute an international treaty, a legally binding instrument, or an obligation on the part of the signatories to commit funds. This SI does not supersede any legally binding Contribution Agreement between Donors and UNICEF. Where there is a conflict between this SI and a legally binding agreement, the terms of the legally binding agreement shall govern.

The signatories agree to the principles of transparency, openness and accountability, including the observance of universal respect for human rights and the principles of gender equity. Any suspected breach of these principles during implementation of HTF will be subject to thorough investigation and review.

5 Partners

The initiating partners to this SI are the Government of Zimbabwe; UNICEF; the Governments of the United Kingdom of Great Britain and Northern Ireland ("the United Kingdom") represented by the Department for International Development (DFID); the Government of Ireland represented by Irish Aid; the Government of Sweden; the Government of Norway; and the European Commission represented by the Delegation of the European Union to Zimbabwe. These partners will be collectively referred to as Signatories. Any new funding partner wishing to participate in the Health Transition Fund should do so in accordance of the provisions of this SI.

6 Code of Conduct

6.1 The Code of Conduct takes into consideration regional and international policies, strategies and commitments such as the Millennium Development Goals and the 2005 Paris Declaration on Aid Effectiveness. The GoZ, Donors and UNICEF recognize this Code of Conduct as a mechanism for facilitating donor harmonisation, allowing for greater government ownership and leadership, aligning donor activities with sector programmes and budgets, and linking sector support to national policies and poverty reduction support.

The GoZ, Donors and UNICEF recognize that the GoZ has the leadership role in directing the health sector. The GoZ should co-ordinate all health care providers, funding and implementation partners, including communities, to ensure that health services are efficient, effective and equitable.

The GoZ, donors and UNICEF understand that progress towards achieving the goals laid forth in the National Health Strategy is largely dependent upon the assurance and effective and efficient utilisation of both national and international resources. For this reason, the GoZ, Donors and UNICEF agree that a pooled funding approach is an important mechanism to:

a) Promote a common vision for health development;

b) Establish priorities and improve the allocation of resources to achieve those priorities;

c) Improve the efficiency and accountability of utilisation of resources; and

d) Rationalise and maximize the efficient use of resources in the health sector.

6.2 The Code of Conduct will be guided by the following principles:

i. The need to raise the health status of all Zimbabweans through an efficient and effective health delivery system;

ii. The commitment to national ownership and leadership with the Government setting health
priorities, using national planning and budgeting processes;

iii. A climate of transparency, openness and accountability. All parties bear the responsibility to share relevant information and to keep other parties informed so as to ensure full and equal opportunity to participate in and contribute to health development in Zimbabwe through established institutions;

iv. The observance of health-related resolutions entered into by the Government at both regional and international levels; and

v. The observance of universal respect for human rights, including reproductive and health rights, and the respect for principles of gender equity, democracy, transparency, rule of law, good governance and protection of the environment.

6.3 The Government agrees to:

i. Maintain and steadily augment contributions to the health sector; and

ii. Undertake a joint annual review and planning process that is decentralized and collaborative. The process will produce a Performance Contract that will present priorities and resources, including allocations from the State Budget.

6.4 Donors agree to:

i. Align funding support to MoHCW priorities;

ii. Communicate with the GoZ regarding their annual and multi-annual commitments in order that the GoZ can plan and provide services accordingly;

iii. Recognize the importance of timely disbursement of funds and work towards ensuring that financial disbursements are made according to a schedule agreed with the GoZ;

iv. One system for technical reporting, procurement, financial accounting, and auditing of programme expenditure;

v. Build the capacity of MoHCW personnel in the areas of project planning, design, budgeting, implementation, monitoring and evaluation, and reporting;

vi. Conduct joint missions related to the HTF in order to minimise the burden on MoHCW; and

vii. Review and approve annual budgets and workplans by end of December each year for implementation the following year.

7 Programme Management, Administration and Reporting

7.1 The HTF is a pooled fund in which donor contributions are allocated according to the Programme Document and annual work plans approved by the HTF Steering Committee.

7.2 UNICEF is prepared to receive and administer contributions of varying amounts from Donors for the implementation of the HTF.

7.3 As part of the consolidated report and as an annex to the narrative report, UNICEF will submit to Donors by 31 March an annual financial utilisation report, showing funds received from all sources and expended for the HTF. The financial utilisation report will follow the format set out by the contributing donors and will be in line with key institutional agreements such as the Financial and Administrative Framework Agreement (FAFA) with the EC. It will cover the period, in any one year, up to 31 December. In addition, UNICEF will provide quarterly and six monthly budget and programmatic updates for in-country review and discussion by the HTF steering committee. A certified financial statement will be produced by 30 June.
7.4 Annual Reviews, a Mid-Term Review, and a Final Evaluation of the HTF programme will be conducted as detailed in the Programme Document and as agreed by the HTF Steering Committee. The findings of the reviews will inform GoZ, Donors, and UNICEF on progress, challenges and opportunities, including recommendations to reorient priorities if required in order to achieve key programme goals and objectives.

7.5 The Signatories will meet at minimum quarterly within the HTF Steering Committee to review progress of on-going activities and to plan for the next phase in the programme, as further detailed in the Steering Committee Terms of Reference.

7.6 UNICEF will arrange for its financial records to be audited in accordance with the established procedures and appropriate provisions of the financial regulations and rules of the United Nations and UNICEF.

7.7 Procurement of goods and services under the HTF will be done in accordance with UNICEF’s Procurement Rules and Regulations. The HTF Steering Committee will be invited to participate in tender review committees and to approve selection of implementing partners in accordance with UNICEF’s Procurement Rules.