HEALTH DEVELOPMENT FUND

Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020)

A Coordinated Effort by the Government of Zimbabwe and Development Partners in supporting the Ministry of Health and Child Care to improve equitable access and quality of health care in Zimbabwe, with special emphasis on Women, Newborns, Children and Adolescents

August 2015




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

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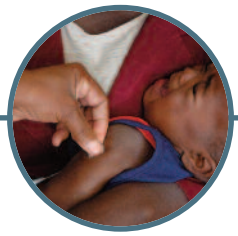


Health Development Fund

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

Foreword

A Coordinated Effort by the Government of Zimbabwe and Development Partners in supporting the Ministry of Health and Child Care to improve equitable access and quality of health care in Zimbabwe, with special emphasis on Women, Newborns, Children and Adolescents

We the undersigned pledge our commitment to realizing the targets which we have set in this document for the improved access and equity for quality of health care for the mothers and children of Zimbabwe.

The HDF comes at a time when a good baseline has been created by the Health Transition Fund and the Integrated Support Programme among the other Programmes which have worked to reduce the maternal mortality ratio (MMR) and the infant mortality rate (IMR). These achievements though significant, have not yet reached the targets which the country requires to be called a healthy nation and as such the Health Development Fund has new targets which are in line with the National Health Strategy 2016- 2020. The target for MMR by 2020 is set at 350 maternal deaths for every 100,000 live births. This is ambitious, but we are hopeful that should the resources be made available this can be achieved in the coming five years. In addition to this, Sexual and Reproductive Health an important and critical component of the National Health Strategy is included in the HDF. It is targeted to reduce the unmet need for family planning to 6.5% by the end of 2020 as the main tracer indicator for the efforts that will be put into Sexual Reproductive Health Rights in Zimbabwe.

Brigadier General (Dr) G. Gwinji
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Contents

Summary of Contribution

Country	Zimbabwe
Title of Proposal	Health Development Fund (2016-2020)
Proposed Donors (currently involved in the HTF)	Governments of Canada, Ireland, Norway, Sweden, United Kingdom, European Union, and GAVI. (It is envisaged that additional donors will also become involved).
Project Duration	5 years - 2016 to 2020
Funds Required	US$ 681.91 Million (total amount for 5 years)
Objective	**Aim:** To support the Ministry of Health and Child Care in the context of the 2016-2020 National Health Sector Strategy to achieve its goals of improving the quality of life of its citizens, through guaranteeing every Zimbabwean access to comprehensive and effective health services. **Goal:** To contribute to reducing maternal mortality (by 50%) from 614 and under-5 mortality (by 50%) from 75, by ensuring equitable access to quality health services for women and children by 2020; and to contribute to the reduction of the unmet need for family planning to 6.5%, halving the prevalence of stunting in children under-5 from 28% and eliminating MTCT by 2020, combating HIV and AIDS, Malaria and other prevalent diseases **Purpose:** To continue to consolidate and improve on gains made in maternal, new born child and adolescent (young people) health by strengthening health systems and scaling up the implementation of high impact Reproductive Maternal New born Child and Adolescent Health (RMNCH-A); and nutrition interventions through support to the health sector.
Expected Results	**Thematic Area 1, Maternal, Newborn and Child Health and Nutrition** • National coverage of focused ANC (4 visits) increased to 80% by 2020 • National skilled birth attendance rate increased to 85 % by 2020

Expected Results	• Access to comprehensive emergency obstetric and newborn care increased to 85 % by 2020 • 90% provinces and districts conducting quarterly maternal death reviews by 2020 • National coverage of postnatal care (at least 2 visits in the first week after delivery) increased to 85% by 2020 • The proportion of sick newborns treated appropriately for sepsis according to national guidelines increased to 60% by 2020 • The proportion of sick children under-5 treated appropriately for common childhood illnesses (pneumonia, diarrhoea and malaria) increased to 45%, 30% and 90% respectively by 2020 • National full immunization coverage increased to 75% by 2020 • National coverage of exclusive breastfeeding rate increased to 60% by 2020 • The national coverage rate of timely and appropriate complementary feeding increased to 70% by 2020 • The national coverage rate of twice a year Vitamin A supplementation for children 6 -59 months of age increased to 90% by 2020 • National coverage for Antiretroviral treatment for children 0 – 14 years increased to 91% by 2020
Expected Results **Geographic Focus Area** **Focus population** **Strategic Partners**	**Thematic Area 2, Sexual Reproductive Health Rights** • Percentage of users of long acting methods of contraception increased from 1% to 5% • Unmet need for family planning among females aged 15-19 reduced from 17% to 8.5% • Unmet need (Limiting) for family planning (age 40-44) reduced from 12.9% to 6% • Percentage of sexually active HIV positive women who use a modern method of contraception (Contraceptive Prevalence Rate, CPR) increased from 63.8% to 68% • Percentage of women aged 15-49 accessing cervical cancer screening services increased from 9% to 35%. • Percentage of facilities offering youth friendly services that meet national standards increased from 6% to 25% • Percentage of young people among users of minimum package of SRH services increased (to be defined and baselines to be determined) • Adolescent fertility rate reduced from 120 to 115 per 1000 • Percentage of young women 15-19 who have ever experienced physical violence decreased from 23% to 15%

Expected Results	• Percentage of women and girls who report having used services after being abused increased from 15% to 20% (police) and 2.2% to 10% (Social service) • 400 fistula repaired in supported sites by 2020.
	Thematic area 3, Medical Products, Vaccines and Technologies (Medicines and Commodities) • Availability of essential medicines including contraceptives (the selected package) and health commodities is maintained at 80% in all rural health facilities across Zimbabwe by 2020 • Availability of vaccines (antigens), vaccine supplies and cold chain equipment maintained at 90% in all health facilities across Zimbabwe by 2020 • Percentage of rural health facilities with a stock out in the last three months on the essential medicines.
	Thematic area 4, Human Resources for Health • 95% of Health facilities and health management offices are staffed with the minimum standard required and qualified professionals by 2020
	Thematic area 5, Health Financing • Result Based Health Financing implemented in all rural health facilities of Zimbabwe by 2020
	Thematic area 6, Health Policy, Planning, M & E and Coordination • 100% of rural health centres have a fully functional health centre committee by 2020 • Health system capacity in policy making, planning and financing developed across all health service delivery levels by 2020
	Thematic area 7, Technical Support, Operations Research and Innovation • At least one operations research conducted on innovation on inter sectoral collaboration and building of synergies in RMNCH-A and SRHR in the country by 2020.
Geographic Focus Area	National
Focus population	Women, Children and Adolescents (in particular pregnant and lactating women and children under-5)
Strategic Partners	Ministry of Health and Child Care, Funding Development Partners, UN agencies, Civil Society Organisations and other health development partners, Local Authorities and local leaders.

Abbreviations and Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASRH	Adolescent Sexual Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BCG	Bacille Calmette Guerin (vaccine against Tuberculosis)
CCORE	Collaborating Centre for Operational Research and Evaluation
CDC	Centre for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHERG	Child Health Epidemiological Review Group
CIDA	Canadian International Development Agency (now DFATM-Canada)
CMAM	Community based management of Acute Malnutrition
CS	Caesarean Section
CSOs	Civil Society Organizations
CVS	Central Vaccine Stores
DFATM	Department of Foreign Affairs, Trade and Development (of Canada)
DFID	Department for International Development (UK Aid)
DHEs	District Health Executives
DHIS	District Health Information System
DHIS 2.0	District Health Information Software version 2.0
DHS	Demographic and Health Survey
DHT	District Health Team
DHMT	District Health Management Team
DPs	Development Partners
DPT	Diphtheria Pertussis Tetanus (combined vaccine)
DPPME	Department of Policy, Planning, Monitoring and Evaluation (of the MoHCC)
EBF	Exclusive Breast Feeding
EC	European Commission
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Programme on Immunization
EU	European Union
FAFA	Financial and Administrative Framework Agreement
FP	Family Planning
FANC	Focused Antenatal Care
GAVI	Global Alliance on Vaccines and Immunisation
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria (also referred to as Global Fund)
GPRHCS	Global Programme on Reproductive Health Commodities and Security
GOZ	Government of Zimbabwe
H4+	UN Partnership for women and child health (UNAID, UNFPA UNICEF, WHO and WB)

HDF	Health Development Fund
HCC	Health Center Committee
HIS	Health Information System
HIV	Human-Immuno Deficiency Virus
HMIS	Health Management and Information System
HRH	Human Resource for Health
HSB	Health Services Board
HTF	Health Transition Fund
ICCM	Integrated Community Case Management (of common childhood illnesses)
ICF	ICF International
IFA	Iron and Folic Acid
IGMME	Interagency Group on Maternal Mortality Estimates
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPV	Inactivated Polio Vaccine
ISP	Integrated Support Programme
ITN	Insecticide-Treated Net
IUCD	Intrauterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JRM	Joint Review Mission
LAM	Long Acting Method
LEEP	Loop Electrosurgical Excision Procedure
LSTM & H	Liverpool School of Tropical Medicine and Hygiene
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MIMS	Multiple Indicator Monitoring Survey
MLM	Mid-Level Management (training for immunization)
MNCH	Maternal and neo natal and child Health
MODO	Ministry of Health and Development Organizations (planning and review meetings)
MoF	Ministry of Finance
MoHCC	Ministry of Health and Child Care
MPMS	Maternal and Perinatal Mortality Study
MTCT	Mother to Child Transmission (of HIV)
MTR	Mid-Term Review
MWH	Maternity Waiting Home
NCDs	None Communicable Diseases
NIHFA	National Integrated Health facility Assessment
NHS	National Health Strategy
OCP	Oral Contraceptive Pills
OF	Obstetric fistula
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy (Treatment)
PCNs	Primary Care Nurses
PCV	Polio-Containing Vaccine
PEPFAR	U.S. Presidential Emergency Funds for AIDS Relief
PHC	Primary Health Care
PHEs	Provincial Health Executives
PHT	Provincial Health Team
PMDs	Provincial Medical Directors
PMI	U.S. Presidential Malaria Initiative

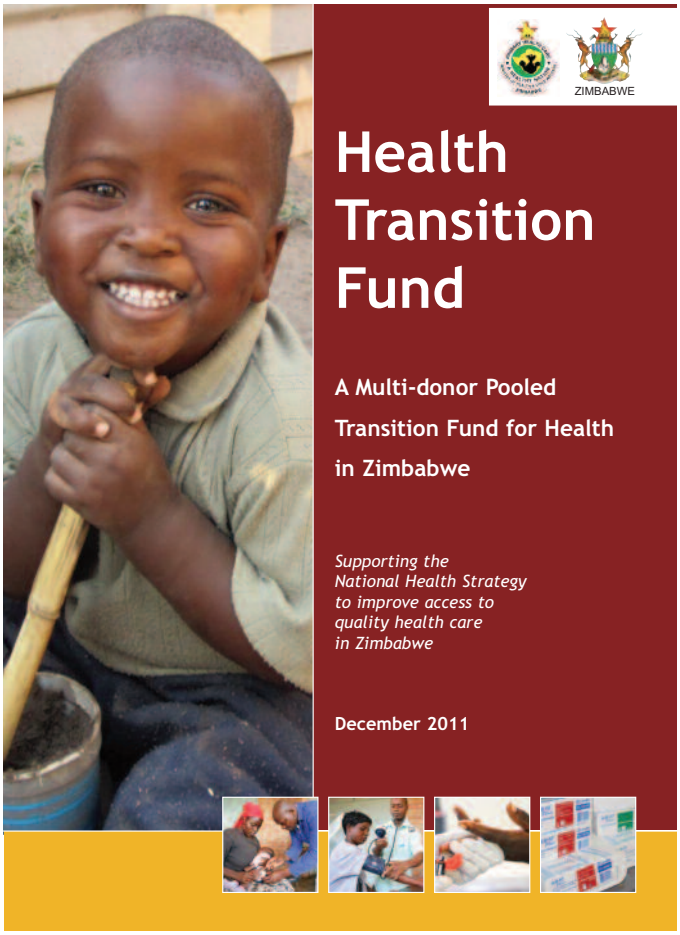
PNC	Postnatal Care
PPPs	Public-Private Partnerships
PPPME	Policy, Planning, Programming, Monitoring and Evaluation (Directorate of the MoHCC)
QoC	Quality of Care
RBF	Results-Based Financing
RTIs	Reproductive Tract Infections
RBM	Results-Based Management
RED	Reaching Every District (with immunisation services)
RHCs	Rural Health Centres
RMNCH-A	Reproductive Maternal New born Child and Adolescent Health
RTIs	Reproductive Tract Infections
SAM	Severe Acute Malnutrition
SIDA	Swedish International Development Agency
SRH	Sexual & Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHWs	Village Health Workers
VIAC	Visual Inspection with Acetic Acid and Cervicography
VMAHS	Vital Medicines Availability and Health Services Survey
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WISN	Workload Indicator of Staffing Needs
YFHS	Youth Friendly Health Services
ZDHS	Zimbabwe Demographic and Health Survey
ZimAsset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

Executive Summary

This programme document titled, 'Health Development Fund 2016 to 2020, is intended to be financed by the current Health Transition Fund donors, namely the Governments of Canada, Ireland, Norway, Sweden, United Kingdom; the European Union and other prospective donors. This programme takes forward some of the work currently supported through the Health Transition Fund (HTF), H4+ Programme, EU MDG initiative, Integrated Support Programme (ISP), and Global Programme on Reproductive Health Commodities & Security (GPRHCS) These funding mechanisms were established to support and revitalize Zimbabwe's health sector which was near collapse as a result of the economic challenges experienced in the country during the period 2008/9. The proposed Health Development Fund (HDF) aims to continue consolidating and improving on gains that Zimbabwe has made in reproductive, maternal, new born and adolescent health and nutrition. It aims at further strengthening the health system and scaling up the implementation of high impact reproductive, maternal, new born, child and adolescent (young people) health and nutrition. The Ministry of Health and Child Care sees this document a vehicle to further strengthen the health system especially for the maternal mortality ratio and infant mortality rate reduction. The proposed programme is drawn from the National Health Sector Strategy and will continue to be implemented under the leadership of the Ministry of Health and Child Care (MoHCC) with all partners contributing to one plan, one coordinating mechanism and one monitoring framework. The 2016 -2020 National Health Strategy will be the main guiding document for all the interventions supported under the HDF.

During the 1980s and the 1990s, a highly effective health system was in place in Zimbabwe. Key characteristics were: Efficacy of organizational structure based on national governance, provincial leadership, and district management of the health system; adequate public expenditure on health (in excess of US$40 per capita); public/community support for health interventions by a well-educated population; well prepared and supervised health professional staff; and functioning information and logistical support systems.

The economic challenges of the past decade progressively undermined this system and contributed to an eventual rapid deterioration in maternal, new born, child and adolescent health indicators thus putting Zimbabwe off-track in achievement of the Millennium Development Goals (MDGs). The period also saw rapid spread of HIV and significant challenges with availability of Anti-Retroviral Therapy, with increased HIV/AIDS mortality and morbidity amongst mothers and children and reduction in life expectancy of the general adult population.



The Health Transition Fund (HTF) among other funding modalities was set up in 2011, in a highly polarized political environment. At that time, development partners were willing to come together to support the health sector based on the findings of the Health Sector Investment Case which analyzed the various bottlenecks that impeded health care provision. The specific findings established that human resources for health and essential health commodities were the major supply side bottlenecks. The HTF was therefore set up as a national programme with a focus on the primary health care level. Around the same time, several other initiatives, such as H4+, ISP, MWH and GPRHCS also came forward to support MoHCC on Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH-A). The analysis at the time did show that among the priority areas for the Government of Zimbabwe, maternal and child health were the most underfunded programmes in the health sector.

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In the period 2012 – 2015, the following 4 core thematic areas have been supported through the HTF mechanism.

- Maternal, newborn and child health and nutrition (scaling up the implementation of high impact Maternal Newborn and Child Health (RMNCH-A) and Nutrition interventions)
- Medical products, vaccines and technologies (Medicines, blood and commodities)
- Human resources for health (Health worker management, training and retention)
- Health policy, planning and finance (Health Services Fund and research)

In addition, other implementing partners supported Integration of sexual reproductive health services (Family Planning, HIV, GBV and Cervical Cancer), Health Information System and M&E, Demand and Community Participation, and Communication and Advocacy.

In terms of achievement the HTF together with other initiatives have contributed significantly to the removal of critical health system bottlenecks and thus strengthening the Health System, mainly through::

- Human Resource for Health resulting in key personnel now being retained in the system
- Ensuring availability of essential medicines, vaccines and commodities
- Strengthening the M&E system, including strengthening of supervision and monitoring efforts

- Covering the routine and running costs of primary health centres in the rural areas. This helped to reduce user fees for pregnant women and children less than five years of age in 94% of Primary Health Care (PHC) facilities.
- Promotion of integration of sexual reproductive health and all other services to achieve efficiency of service delivery

There are palpable signs that the health system is recovering, resulting in increased coverage of key RMNCH-A high impact interventions. For the first time after almost twenty years of continuous deterioration recent data (MICS 2014) shows that, Zimbabwe has managed to bend the curves of the alarmingly high maternal and under 5 mortality.

However, in order to push the maternal and child mortality curve further down there is need to focus on improving the quality and equity of health services provided to mothers, children and adolescents while still continuing and increasing the momentum of the current interventions. Nutrition is a critical component for pregnant women and children and it will be focused on in the HDF. In addition to maintaining the coverage achieved in some areas, special attention to voluntary Family Planning (FP) programme, Youth Friendly Health Services (YFHS) and Sexual and Reproductive (SRH) and HIV service integration is necessary. Targeted approach to reach specific vulnerable populations such as newborns, adolescents and people living in hard to reach communities, including those with particular religious and socio-cultural leanings with quality services and correct information can further accelerate the achievement. This means that the health system building blocks which are crucial for the health system to be fully functional, and which have been supported by the HTF and other initiatives should continue to be supported until and unless secure and alternative funding and programming mechanisms are put in place.

Therefore, the financing partners of the HTF, H4+, MWH, and ISP, UNICEF and UNFPA agreed to collaborate under the leadership of the Ministry of Health and Child Care on a further phase of support to the people of Zimbabwe through a “Health Development Fund”, and are seeking to mobilise partner support. Furthermore, it has been proposed that GAVI funding support for the EPI programme will subsequently be channelled through the HDF.

The key guiding principles of this programme are as follows:

Firstly, it is emphasized that without continued economic recovery and political stability, any gains made in the health sector will remain fragile. Further to this, if government is to achieve its objectives for the health of the people of Zimbabwe, the proportion of public expenditure allocated to health needs to be increased and other innovative ways of financing the sector in a sustainable manner need to be explored. In addition, more effort is needed in scaling up the health financing initiative that the MoHCC has started. With this in mind the change of name from Health Transition Fund (HTF) to Health Development Fund (HDF) reflects a progressive shift from support for recurrent costs (increasingly funded by government) to a combination of necessary recurrent support and health systems investments that make funds from all sources more effective.

Secondly, the cohesion and coherence achieved through the Ministry of Health and Child Care leadership of the HTF needs to be maintained, and where possible extended across the whole health sector interventions. However, the leadership, coordination and accountability arrangements need to be strengthened at the provincial level and below, through the full restoration of effective Provincial Health Team (PHT) and District Health Team (DHT) arrangements. It is noted that strengthening of management at these decentralized levels will allow for increased delegation of responsibilities from the national level.

Thirdly, a motivated workforce will provide the basis for continued availability of health care services. In order to restore services, all health workers are receiving a retention allowance added to their salaries while staff on “critical posts” receive additional payments supplementing their salaries hence enabling them to stay in post and arresting the hemorrhage of trained

professionals from the health system especially in rural areas. In addition, the Results Based Financing (RBF) schemes provide bonus payments based on improved performance of health facilities. These payments have been crucial in retaining skilled health staff and remain highly justified. However, it is important that these interventions are eventually harmonized into a single salary system in the public sector. In consultation with the Ministry of Health and Child Care, a target date (such as January 2018) could be proposed for transitioning to this system aiming to have full government funding by the agreed target date. Existing service-specific incentives such as VMMC will be evaluated and integrated into the current human resource support in a coordinated manner.

Fourth, a professional and skilled workforce will be a key assurance that quality of services will be improved. Investment will be made in continuing to support: training of staff in key shortage areas, clinical mentorship and supportive supervision, and continued professional development. . However, a review of the approach to post-basic in-service training is essential at national level. This should result in a nationally coordinated, provincially implemented training programme covering all appropriate competencies. It should seek to ensure appropriate numbers of adequately trained staff at all levels, while minimizing duplication and time away from station.

Fifth, support will continue to be given to a pharmaceutical supply system that includes selected commodities and contraceptives (free and fully funded) to the client for specific groups (among them mothers and children under five including malnourished children) and low cost and good quality commodities for other clients made available on a timely basis through a "pull" system.

Sixth, as the current HTF provided funds to Rural Health Centres through the RBF facility, patients referred from this level to the district and provincial level should have a voucher system to allow them to be attended to. The voucher system design will be incorporated into pillar 7. Ideally, although RBF should be implemented at district level, due to limited resources, the focus will be at the rural health facility. Should resources permit, this can be scaled upwards to cover the district hospitals. District Hospitals and provincial hospitals will continue to receive input financing through Health Services Fund support.

Seventh, to increase effectiveness of resource utilization, support will be provided to a flexible fund to improve key aspects of health service delivery, focused on reducing mortality and morbidity in the "hardest to reach" client groups and geographical areas. This fund will provide technical assistance, support innovations and advance their implementation and evaluation. The fund will be available to government and non-government organizations and may also be useful in schemes that will help to maximize the impact of health services funded through other initiatives (e.g. HIV/AIDS; TB; Water and Sanitation projects; etc.).

Eighth, the programme will capitalize on the gains of the ISP programme to further strengthen the integration of Sexual Reproductive Health information and services, especially those which directly impact on maternal mortality reduction, such as Family Planning. Focus will be given to the most vulnerable groups of the population including adolescents, youth and key populations and strive towards enhanced partnership with social sector programmes, in areas such as education and gender. For Nutrition, lessons learned from the current pilot inter-sectoral programme in four districts will be built on.

Contributing to the National efforts, the HDF will support the Ministry of Health and Child Care to achieve its goals and strategies that aim at improving the quality of life of Zimbabweans, attained though guaranteeing every Zimbabwean access to comprehensive and effective health services.

The Goal of the HDF will be To contribute to reducing maternal mortality (by 50%) and under-5 mortality (by 50%), by ensuring equitable access to quality health services for women and children by 2020; and to contribute to the reduction of the unmet need for family planning to 6.5%, halving the prevalence of stunting in children under-5 and eliminating MTCT by 2020,

combating HIV and AIDS, Malaria and other prevalent diseases.

The Purpose is to continue to consolidate and improve on gains made in maternal, new born and child health by strengthening health systems and scaling up the implementation of high impact Reproductive Maternal Newborn Child and Adolescent Health (RMNCH-A) and nutrition interventions through support to the health sector.

The HDF will provide support across the full range of health services whilst continuing to provide key support to RMNCH-A and nutrition services, as well as enhancing equity in health care availability, through targeting newborns, adolescents, hard to reach communities and specific sections of society either poorly reached or unreached by health system. The focus will be on consolidating gains made at the primary care level and in district hospitals, with a move to selected support at provincial level. Development partners will be encouraged to allocate the majority of their health sector support to a pooled fund under the guidance of the Ministry of Health and Child Care.

Within this context the following seven thematic areas which provide continuity and build on existing foundations are proposed.

- Thematic Area 1: Maternal, Newborn, Child Health and Nutrition
- Thematic Area 2: Sexual and Reproductive Health and Rights *(SRHR) (including Adolescents)*
- Thematic Area 3: Medical Products, Vaccines and Technologies *(Medicines and Commodities)*
- Thematic Area 4:Human Resources for Health *(including Health Worker Management, Training and Retention)*
- Thematic Area 5: Health Financing *(Result-Based Financing or RBF)*
- Thematic Area 6 : Health Policy, Planning, M&E and Coordination
- Thematic Area 7: Technical Support and Innovation

The governance of the pooled fund will be through the HDF Steering Committee. This will be led by the Ministry of Health and Child Care with representation from all key stakeholders (whether pool funders or not) and co-chaired by the funding partners who rotate on an annual basis. The Steering Committee will have representation from funding partners, Civil Society, Private sector, United Nations Agencies and the Ministry of Finance. The Ministry of Health and Child Care in consultation with stakeholders will determine the best means of achieving strong coordination and efficiency, and will build on the success of the Joint Review Mission (JRM) and other key accountability and coordinating mechanisms.

Table 1 overleaf illustrates the resource requirements for the period 2016 to 2020. The budget is based on resources expected to sustain momentum and which would provide a realistic chance of achieving the new health targets in the draft National Health Strategy 2016 to 2020 which is still under preparation. In the event that that only a portion of these funds is mobilized, it will be important to pursue allocating resources in all the seven thematic areas.

Table 1: HDF resource requirements for seven thematic areas (US$ in Millions)

Thematic Area	2016	2017	2018	2019	2020	Total
HDF PILLARS						
1. RMNCH-A Service Delivery	7.97	8.57	8.45	7.80	6.62	39.41
2. SRHR	37.00	54.00	51.00	22.00	21.00	185.00
3. Medicines, Commodities (including Nutrition commodities) and Technologies	39.09	40.57	41.79	43.02	44.27	208.74
4. Human Resources for Health	14.53	13.28	11.92	14.11	16.39	70.23
5. Finance (RBF)	11.07	11.32	11.42	11.51	11.58	56.90
6. Policy, Planning, M&E and Coordination	4.97	4.87	3.99	3.02	1.94	18.79
7. Technical Support and Innovation	4.50	5.12	4.74	4.37	4.50	23.23
Sub-Total for Thematic areas	119.13	137.73	133.31	105.83	106.30	602.30
Programme Management Costs	7.00	7.00	7.00	7.00	7.00	35.00
Total Programmable Budget	126.13	144.73	140.31	112.83	113.30	637.30
Recovery Costs	8.83	10.13	9.82	7.90	7.93	44.61
Total HDF Budget	134.96	154.86	150.13	120.73	121.23	681.91
1 a) Pediatric HIV and AIDS*	2.6	3.5	3.1	3.0	2.7	14.9

Notes

The total budget for HDF is USD681.91 Million

The recovery costs and programme management costs include those for both UNICEF and UNFPA

A detailed budget with the split between UNICEF and UNFPA is in Annex 2

**This budget is not funded through HDF and thus not included in the total figures*

Chapter 1

Background

In the 1980s and 1990s, the Zimbabwe Health System was arguably one of the best on the African continent. However, economic challenges of the past decade progressively undermined the health system and contributed to an eventual rapid deterioration in maternal, new born, and child health indicators. The expenditure on health per capita deteriorated significantly from US$42 in 1991 (which was the highest in sub-Saharan Africa) to just under US$6 in 2009.

As a consequence, major challenges were faced in the health sector including; loss of professional staff, dysfunctional health infrastructure, lack of drugs and equipment, outdated policies and procedures and facilities being unable to cover their running costs. By 2008/ 2009, the health system was in a state of near collapse, manifested in emerging disease epidemics, and a huge cholera outbreak in 2008 which the system was unable to contain, resulting in the loss of 4,000 lives. A measles outbreak in 2009 claimed the lives of 1,600 young children. The impact of these crises was a rise in maternal mortality from 390/100,000 live births recorded in 1990 to 960/100,000 live births in 2010 (ZDHS-2010). Under five mortality also increased from 74/1,000 live births to 94/1,000 live births (MIMS-2009).

At the same time the rapid spread and lack of widely available treatment for HIV and AIDS increased mortality and morbidity amongst mothers and children and reduced the life expectancy of the adult population. The HIV prevalence increased steadily through the 90s to an estimated peak of 29% in 1997 and life expectancy dropped from to 60.1 years in 1990 to just 47 in 2000. Non-communicable disease prevalence also rose steadily with an estimated 1,855 women were being diagnosed with cervical cancer and 1,286 dying annually from the disease (WHO/HPV Centre 2010 estimates). Amongst the poorest, all of this was further exacerbated by poor nutrition as Zimbabwe continued to face nutritional challenges with an estimated 35% of all children under the age of 5 experiencing stunting in 2010 and more recent estimates at 28% (MICS, 2014). The weakened health system is still no well positioned to cope with the growth in non-communicable diseases.

In the period from 2009 to 2014, the beginnings of recovery has been observed and the key elements contributing to this recovery have been:

- Clarity of overall Government and Ministry strategies;
- Development Partner support in addressing key health services delivery bottlenecks mainly through harmonized aid modalities (pooled funding mechanisms);

- Strong institutional framework, experience, capacity and institutional memory still in place and evidence of strong resilience of systems;
- Available and motivated, professional staff;
- Focus on essential, high impact interventions based on the key health system pillars;
- Good health seeking behavior in the population;
- Economic recovery.[1]

The key Development Partners supporting the Government of Zimbabwe in the health sector are UK DFID, European Union, CIDA, Irish Aid, SIDA, Norwegian Government (focusing on women and children), the Global Fund; partnership of the United Nations organizations, USAID/PEPFAR (focusing on HIV/AIDS, TB and Malaria treatment) and the World Bank (focusing on Results Based Financing). All these partners are providing coordinated support through different programmatic funds such as the Health Transition Fund (HTF) which is managed by UNICEF, the ISP (pillar 2), H4+, MWH, and GPRHCS, which are managed by UNFPA. All different programmatic funds are aligned to the National and Sectoral Policies and are led by the Ministry of Health & Child Care.

The Health Transition Fund (HTF) was set up in 2011 by a coordinated effort of the Ministry of Health and Child Care and key health development partners. This was in response to the challenges facing the health sector. The development partners were willing to support the health sector in a coordinated manner to address the system wide challenges at the time. The analysis that led to the development of the Health Investment Case was used to identify the priorities within RMNCH-A area. It was established that human resources for health and essential health commodities were the major bottlenecks and that maternal and child health interventions were the most underfunded areas in the sector. The HTF was a comprehensive programme that aimed to 'build back better' the health system by primarily addressing constraints in human resources, commodities, monitoring and evaluation, and financing while also addressing inequitable access especially made worse by user fees. While the fund was transitional in nature, it was designed to enhance continuity of critical health system functions under all contingencies, including humanitarian situations.

The HTF was focused on four core thematic areas:

- Maternal, newborn and child health and nutrition (scaling up the implementation of high impact RMNCH-A interventions such as EmNOC, IMNCI, EPI etc.)
- Medical products, vaccines and technologies (provision and distribution of vital medicines, blood and commodities)
- Human resources for health (Health worker management, training and retention)
- Health policy, planning and finance (Health Services Fund and research).

The HTF is a pooled fund in support of the implementation of the National Health Strategy of the Government of Zimbabwe and managed by UNICEF with technical and financial contributors being; DFID, EU, CIDA, Irish Aid, Norwegian Government, and Swedish Government. The Ministry of Health and Child

[1] Between 2009 and 2012 GDP growth has averaged 10.5% http://www.imf.org/external/pubs/ft/scr/2014/cr14202.pdf , and this has enabled more expenditure by government and households to go towards health

Care (MoHCC) is the implementing agency and in consultation with the different departments and subnational management bodies, takes the lead in identifying priority areas of the health system that need to be supported through the HTF. The HTF Steering Committee is responsible for the oversight and decision.

The support to the National Health Strategy also included the following interventions managed by UNFPA: The Integrated Support Programme (ISP) which started in 2012 with an aim to strengthen integrated SRH information and services, such as family planning, cervical cancer, Gender Based Violence and HIV through funding support of DFID, SIDA and Irish Aid. The H4+ also initiated in 2012 as a coordinated UN effort in six districts to strengthen maternal health through a focus on health system strengthening funded by SIDA and CIDA. The MDG initiative to revitalize the Maternity Waiting Homes (MWHs) to address the second delays throughout the country through EU support, and the Global Programme on Reproductive Health Commodities and Security (GPRHCS) which provides strategic support to strengthen commodity security for FP and Maternal Health and to enhance choice and quality of FP.

In addition to the above, other key Development Partners funding the health sector include: USAID/PEPFAR (focused on HIV/AIDS, TB and Malaria treatment), the Global Fund, GAVI, PMI and other multilateral and bilateral funding modalities. The HTF due to its national implementation, focusing on primary health care facilities and systems strengthening has been instrumental in catalyzing the overall effort in resuscitating the health sector.

KEY ACTIVITIES AND ACHIEVEMENTS ATTAINED THROUGH THE HTF

The HTF activities include the training and deployment of more than 2,500 midwives and the provision of critical post allowances which has helped to increase the number of doctors at the district hospital level from 70 in 2011 to 139 in 2014. Today, each district hospital has at least one doctor who can perform cesarean section. More than 85% of primary health care facilities are stocked with essential medicines at any given time (Vital Medicines Availability and Health Services Survey or VMAHSS). Through Results Based Financing, the HTF provides a monthly grant to 1,500 health facilities to cover their running costs. User fees were removed in 94% of the rural primary health centers and 83% of the urban health facilities which are now providing services free of charge to pregnant women and children aged five years of age and below.

The HTF has contributed significantly to removing the critical health system bottlenecks mainly in the areas of:

- Human Resource for Health resulting in key personnel now being retained in the system
- Ensuring availability of essential drugs, vaccines and commodities
- Strengthening the M&E system with supervision and monitoring efforts being put in place or strengthened
- Covering the routine and running costs of primary health centres, which helped to remove user fees for pregnant women and children under five year.[2]

KEY ACTIVITIES AND ACHIEVEMENTS ATTAINED THROUGH OTHER MAJOR INITIATIVES

H4+: It is a joint UN initiative with UNICEF, WHO, UN Women and UNAIDs coordinated by UNFPA. Since inception in 2011, H4+ has strengthened RMNCH-A programme delivery in the country by contributing to the development and revision of several RMNCH-A guidelines, and strengthening health systems by enhancing capacity, ensuring availability of essential medicines and supplies, providing infrastructural support, reinforcing community and firming up monitoring and supervision mechanisms. Through the programme, 1) 48 health facilities were supported to

[2] Vital Medicines Availability and Health Services Availability Services Survey, Round 19 (Jan-Mar 2014).

offer EmONC services in 6 H4+ supported districts including provision of EmONC equipment, supply and essential RH medicines. 2) Key national RMNCH-A policies, guidelines and protocols were revised or developed, such as PNC guidelines, Revised WHO National HIV guidelines (Option B+), National Nutritional Strategy, National Infant and Young Child feeding Strategy, Emergency Triage Assessment and Treatment (ETAT) guidelines, and clinical mentorship guidelines, etc. 3) Extensive health care providers trainings were supported, including 317 Health workers trained on BEmONC; 632 on IMNCI; 371 on IYCF; 589 on Pediatric ART / Option B+; and 371 on Growth Monitoring. 4) Maternal Death Review meetings were conducted in all supported provinces. 5) Contraceptives were provided to 5,542 new young girls in Youth Friendly Health Facilities in Hurungwe and 6). 121 community groups or rural committees were established on RMNCH-A/HIV/IYCF issues and 114,316 persons exposed to community dialogues on RMNCH-A/HIV issues.

MWH: UNFPA has supported MOHCC to revitalise 103 Maternity Waiting Homes (MWHs) across the country, procured 63 ambulances for all the district hospitals and equipment and nutritional supplies for the MWHs. To date, about 90,000 women have been admitted into the MWHs and 600 health workers have been trained on provision of EmONC services. The districts and provinces have also been supported in conducting maternal death review meetings. IEC and promotional materials for MWHs have also been developed.

ISP: Led by UNFPA (Pillar 2), the Integrated Support Programme (ISP) has contributed to the improvement of women and girl's SRH through the provision of family planning (FP) services, cervical cancer screening and treatment, HIV prevention and GBV prevention and response. Key achievements of the ISP are: 1) Supported MOHCC to setup 56 health facilities that are offering cervical cancer screening services using VIAC. 94,000 women have been screened for cervical cancer in the public health sector from 2012 to 2014. 2) 700 service providers trained and 258 health facilities supported to offer FP services including implant insertions. 3) 397,160 households were reached through home visits aimed at generating integrated and specific demand for SRH/HIV/GBV services with 434,937 referrals made to various services. 4) 121,876 person exposures by girls aged 10-19years through Sista2sista clubs, 64,565 young people 16-24years accessed FP at supported sites and 80,000 person exposures (young people 10-24years) to SRH information, including through social media. 5) Supported 6040 GBV survivors to access and receive services at shelters and one stop centres, 5,856 community leaders, health personnel, police officers, court officers were trained on GBV management.

GPRHCS: Managed by UNFPA, the Global Programme on Reproductive Health Commodities and Security (GPRHCS) programme contributes to strengthening national capacity for coordinating the joint efforts in the country for achieving FP2020 commitments made by the government of Zimbabwe and contributes to commodity security of essential reproductive medicines and supplies. It has supported national efforts on strengthening contraceptive method mix, especially long acting methods by building capacity of 700 service providers and strengthening policy environment for integrated FP information and services. The government was supported to develop a national family planning strategy (2015-2020). The following RH commodities and drugs have been procured under the GPRHCS: implants, emergency contraceptives, syphilis test kits, oxytocin, magnesium sulphate and calcium gluconate.

INDICATIONS OF IMPROVEMENT

There are palpable signs that the health system is recovering, resulting in increased coverage of key RMNCH –A high impact interventions (Multiple Indicator Cluster Survey - MICS2014). For the first time after twenty years of continuous incline, Zimbabwe has managed to bend the alarmingly high maternal mortality curve as evidenced by the 2012 Census findings, the 2013 Inter Agency group for Maternal Mortality Estimate and the 2014 Multiple Indicator Cluster Survey (Fig 1).

In 2010, the estimated annual maternal deaths were 3,840. According to the MICS 2014, this figure has come down to 2,456, using 400,000 as the total annual live births. This implies that, within the last couple of years, the country has managed to avert a total of 1,384 maternal deaths annually. Similarly , in 2009, there were around 37, 600 deaths of children less than five years of

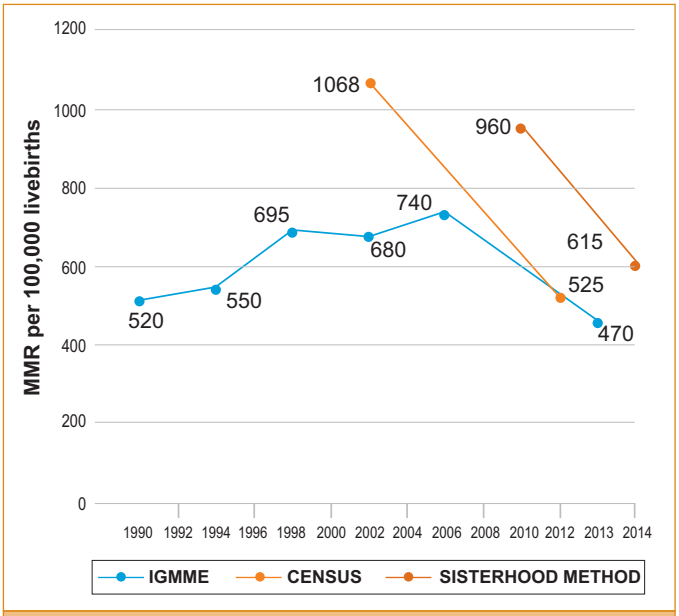


Figure 1: Maternal mortality trends

Source: MICS, 2014

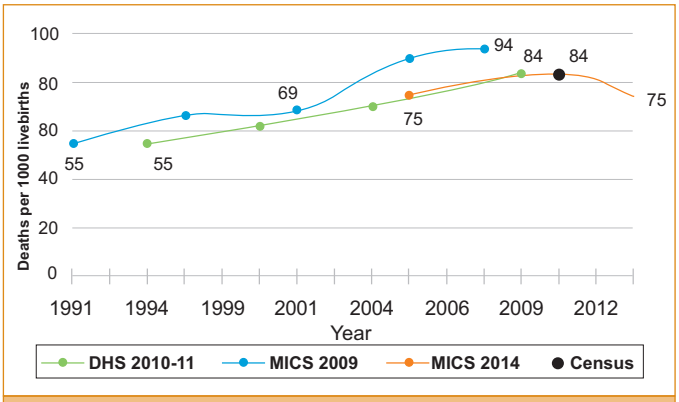


Figure 2: U5 Mortality trends

Source: MICS, 2014

age annually but this figure has come down to 30,000 in 2014 (MICS-2014). This again means the country is now able to avert a total of 7,600 deaths of children less than five years of age annually (figure 2).

However despite the declining maternal and child mortality, the number of deaths remains unacceptably high. In order to push the maternal and child mortality curve down further, there is a need to focus on improving the quality and equity of health services for mothers (including Family Planning), newborns and adolescents. In addition, hard to reach communities, religious and other socio-cultural objectors should be prioritized. The impact of HIV on reproductive health outcomes necessitate the need for prevention of HIV among women and girls of reproductive age as a critical approach to reducing child mortality and improving maternal health. This will entail more comprehensive programming, better coordination and maximizing on efficiencies among all actors especially those addressing SRHR and HIV needs. It also means the four health system blocks that are crucial for making the system fully functional and that have been supported through the HTF should continue to be funded until and unless alternative funding mechanisms are put in place.

It is further noted that the national macroeconomic situation remains uncertain, and the rate at which government can increase its expenditure on health is still limited and shows no sign of being able to pick up in the foreseeable future. However, efforts will continue to be made to advocate for better health sector allocations and disbursement from the national revenue budget, but it is clear that continued partner support is essential for a further period of at least 5 years. Thus the foundations have been laid, but the restoration of an effective health care system is still far from complete, and failure to consolidate and build upon progress made would lead to a risk of a rapid decline of this fragile system. Therefore health Development Partners agree on a further phase of support through a "Health Development Fund" (HDF) and now seek to mobilise financial resources around this programme following the one plan, one coordination mechanism and one monitoring framework principle to enhance coordination led by the MoHCC. It has been proposed that GAVI funding support for the EPI programme will subsequently be channelled through the HDF.

The key guiding principles of this programme are as follows:

First, First, it should be emphasized that without continued economic recovery and political stability, any gains made in the health sector will be fragile. It is also clear that if government is to achieve its objectives for the health of the people, the proportion of public expenditure allocated to health needs to be increased. With this in mind the change of name from Health Transition Fund (HTF) to Health Development Fund (HDF) reflects a progressive shift from support to recurrent costs (increasingly funded by government) to a combination of necessary recurrent support and capital

investments to the sector that make funds from all sources more effective.

Secondly, the cohesion and coherence achieved through Ministry of Health and Child Care leadership of the HTF needs to be maintained and if possible extended across the whole health sector to achieve a more integrated approach to Maternal Health and Child Health programmes and to further strengthen FP. The leadership, coordination and accountability arrangements need to be strengthened at the provincial level and below, through the full restoration of effective Provincial Health Team (PHT) and District Health Team (DHT) arrangements. Strengthening of management at these levels will allow for increased delegation from the national level.

Third, a well-motivated workforce will provide the basis for continued availability of health care services. In order to restore services all health staff have been provided with a retention allowance added to their salary and additional payments have been made for selected "critical positions" for ensuring effective and efficient RMNCH-A services delivery. In addition the RBF schemes are providing bonus payments based on performance. These payments have been crucial in retaining health staff and remain highly justified. However, it is important that these interventions are eventually harmonized into a single salary system in the public sector. It is proposed that a target date be set (such as 1st January 2018) for transition to this system with the aim of full government funding by the agreed target date.

Fourth, a professional and well skilled workforce will be the main assurance that quality of services will be improved. Investment will be made in training of staff in key shortage areas, clinical mentorship, supportive supervision, and in continued professional development. A review of the approach to post-basic, in-service training is essential at national level. This should result in a nationally coordinated, provincially implemented training programme covering all appropriate competencies; it should seek to ensure appropriate numbers of adequately trained staff at all levels, while minimizing duplication and time away from station.

Fifth, support will continue to be given to a pharmaceutical supply system that includes a "push" system for selected commodities to specific client groups (free and fully funded for mothers and children under five) and low cost and good quality commodities for other clients, made available on a timely basis through a "pull" system.

Sixth, as the current HTF provided funds to RHCs and District Hospitals, and introduced a RBF approach for RHCs in 2014, building on the experience in 18 districts supported by the World Bank, the next phase will need to ensure that an effective and efficient system is in place. It is proposed that, whilst support will continue to be given to other non-staff running costs at the primary and first referral levels through the RBF system, this subsidy should be focused on all the Primary Health Care facilities. Special consideration will be made to hard to reach districts.

Seventh, to increase effectiveness of resource utilization, support will be provided to a flexible fund to improve key aspects of health service delivery focused on reducing mortality and morbidity in the "hardest to reach" client groups and geographical areas. This fund will support technical assistance and vanguard implementation and evaluations. The fund will be available to government and non-government organizations and may also be useful in schemes that will help to maximize the impact of health services funded through other initiatives (e.g. HIV/AIDS; TB; Water and sanitation projects; etc.).

Eighth, the programme will capitalize on the gains of the ISP programme to further strengthen the integration of SRH information and services, especially those which directly impact on maternal mortality reduction, such as FP. Focus will be given to the most vulnerable groups of the population including adolescent and youth and strive towards enhanced partnership with programme in other sectors, such as education and gender.

Chapter 2 of this programme document describes the current position on maternal, newborn, and child health; the progress made; and the challenges still being faced.

CHAPTER 2

Situation Overview of Reproductive, Maternal, Newborn and Child Health

CHILD HEALTH

The 2014 MICS survey reports **Under-five mortality rate** at 75 deaths per 1,000 live births (compared to the 2009 MIMS rate of 94/1000 LB), and **Infant mortality** at 55/1000 (compared to the 2009 MIMS rate of 65 per 1000)[3] (see Table 2 below). Under 5 and IMR vary in by regions of the country, urban and rural areas, between boys and girls, and between the richer and the poorer. This is depicted in Figure 3, 4 and 5 below.

Table 2: Early Childhood Mortality Trends, Zimbabwe

Indicator	Description of Indicator	ZDHS 2010	MICS 2014	% Decline
Neonatal Mortality Rate (NMR) per 1,000 live births	Probability of dying within the first month of life.	31	29	6%
Infant Mortality rate (IMR) per 1,000 live births	Probability of dying between birth and the first birthday.	57	55	4%
Under-Five Mortality rate (U5MR) per 1,000 live births	Probability of dying between birth and the fifth birthday.	84	75	11%
Indicator values refer to the five-year period before the survey.				

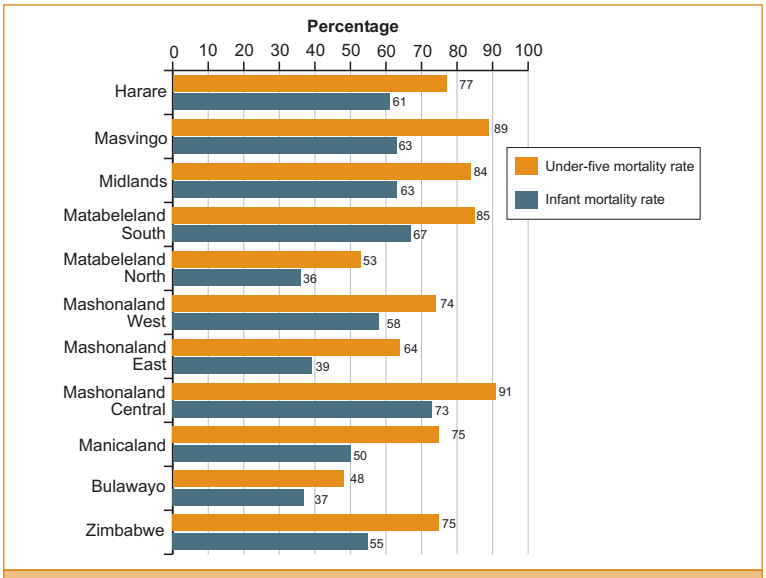


Figure 3: Under five mortality and Infant Mortality by Province

Source: MICS, 2014

[3] For the MICS, infant and under-five mortality rates were calculated from the mother's birth history information using the direct method of estimation.

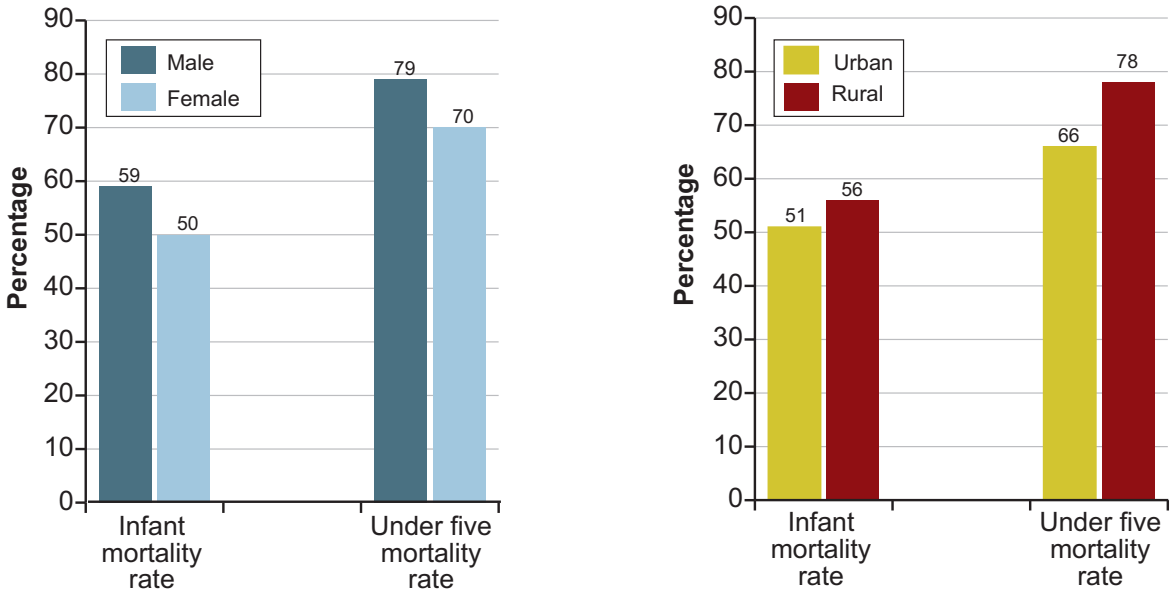


Figure 4: Under-five and Infant Mortality Rates, Rural and Urban Areas, Male and Female Children, Zimbabwe, 2014

Source: MICS, 2014

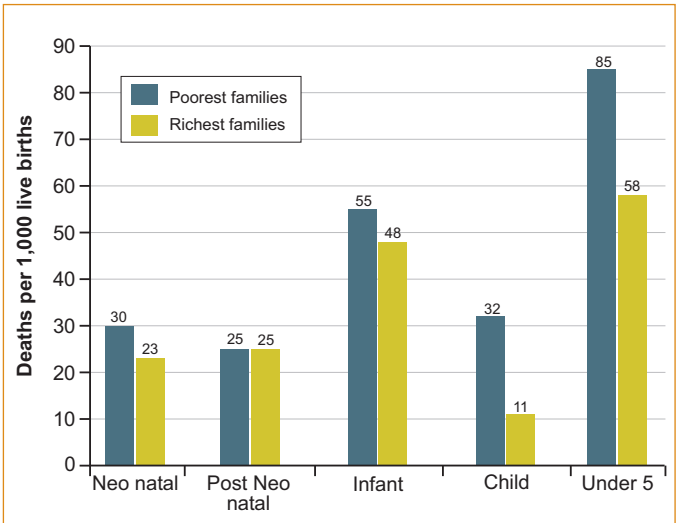


Figure 5: Difference of mortality rates between richest and poorest families, Zimbabwe, 2011

Source: 2011 ZDHS (ZIMSTAT and ICF International, March 2012)

Causes of Child Deaths

According to different sources, the causes of death of children under the age of 5 in Zimbabwe are related to: neonatal deaths, AIDS, pneumonia, malaria and diarrhoea (Child Health Epidemiological Review Group, 2013). Malnutrition is considered an underlying factor in about 30% of these deaths. Figure 6 below depicts an approximation on how each cause contributes to overall under-five deaths in the country.

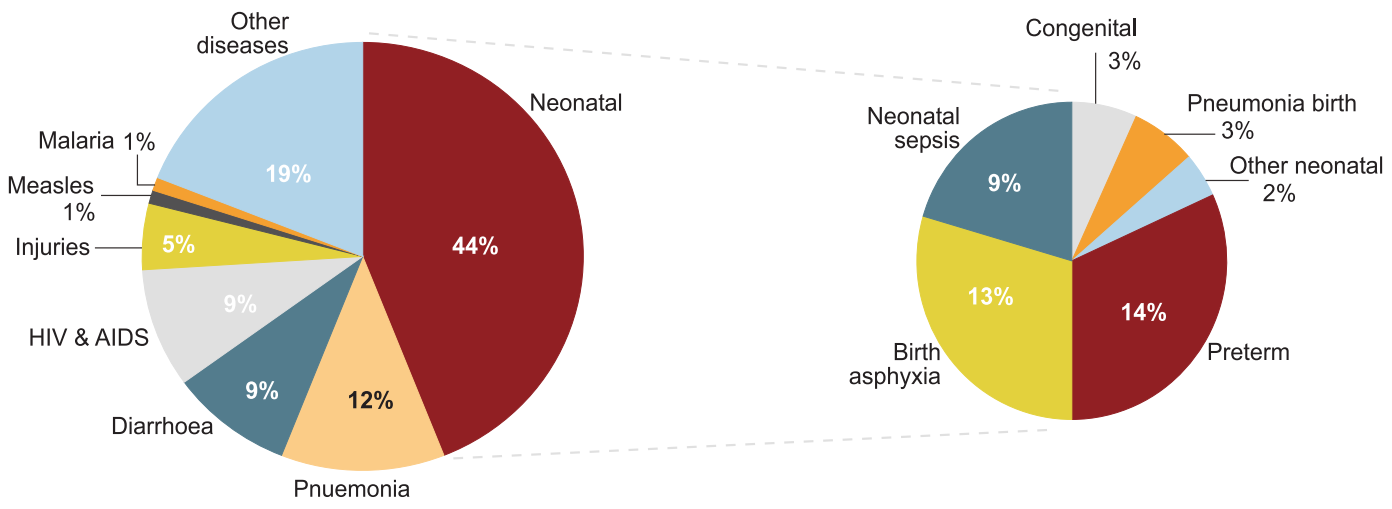


Figure 6: Causes of Under-five Deaths in Zimbabwe, 2012

Source: WHO/CHERG 2014[4]

Neonatal deaths

Most of the under five deaths happen during the neonatal period (within the first month of life of the child). According to the 2014 MICS, the neonatal mortality rate is 29/1000 live births, contributing to 39% of under five deaths. The Zimbabwe Health Management Information System for 2013[5] (Ministry of Health and Child Care, 2013) indicated that there were 8,601 neonatal deaths in Zimbabwe, the majority (78%) occurred in the first week of life, and based on the Perinatal Death Notification reports, 48% of the deaths were due to complications of prematurity, 41% due to birth asphyxia and 11% due to neonatal sepsis.

Diarrhoea

Results from the 2014 MICS survey show that 15.5% of children under age 5 had suffered an episode of diarrhoea in the two weeks preceding the survey. Episodes of diarrhoea are more common in urban settlements than rural areas. According to the Zimbabwe DHS 2011, 15% of the children in urban areas had diarrhoea in the two weeks preceding the survey, in comparison with 12.5% in rural areas.

MICS-2014 data shows that among those children that presented with diarrhoea, 41.8% sought advice or treatment from a healthy facility or health service provider. Only about 14% of the children with diarrhoea were treated with a combination of oral rehydration salts (ORS) and zinc, while 56.4% received ORT and continued feeding (ZIMSTAT and UNICEF, Aug 2014).

Acute Respiratory Infection (ARI)

Acute Respiratory Infections accounted for 25.2% of all cases of patients seen in health institutions in Zimbabwe in 2012[6]. The 2014 MICS shows that 5.3% of children under-five years of age had had ARI symptoms in the two weeks preceding the study, and of these, almost 53% were treated at a health facility or by heath service provider. Among those treated, 34.3% received antibiotics.

According to the 2014 MICS, 73.9% of households in Zimbabwe use solid fuels as the primary source of domestic energy to cook. Using WHO calculations to determine the burden of disease from Household Air Pollution, the ARI risk for Children if there is 73.9% of population using solid fuels, equates to 58%[7].

[4] Data available at Countdown to 2015 website: http://www.countdown2015RMNCH.org/country-profiles/zimbabwe accessed on September 18, 2014.

[5] Country administrative data system.

[6] 2013 Health Bulletin, Q1. Data does not differentiate children from adults.

[7] http://www.who.int/phe/health_topics/outdoorair/databases/HAP_BoD_methods_March2014.pdf?ua=1

Fever/Malaria

During the two weeks preceding the 2014 MICS survey, 27% of the children had experienced episodes of fever. Among these, 43.6% sought treatment in a health facility or provider, and 3% were treated with anti-malarial medicine.

In the non-endemic areas, malaria happens between the months of February and May, and cases are more concentrated in Mashonaland West and Mashonaland Central, Masvingo and Manicaland Provinces. According to UNDP report (May 2013), in total, 45 of Zimbabwe's 61 districts have conditions that support moderate to high transmission of Malaria.

The malaria incidences have been on a downward trend since 2011. See figure 8 below.

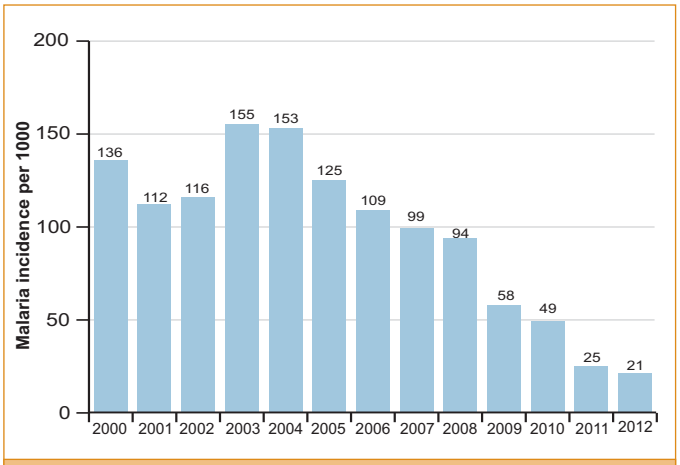


Figure 7: Trend of Malaria Incidence, Zimbabwe

Source: (UNDP, Malaria Indicator Survey, May 2013)

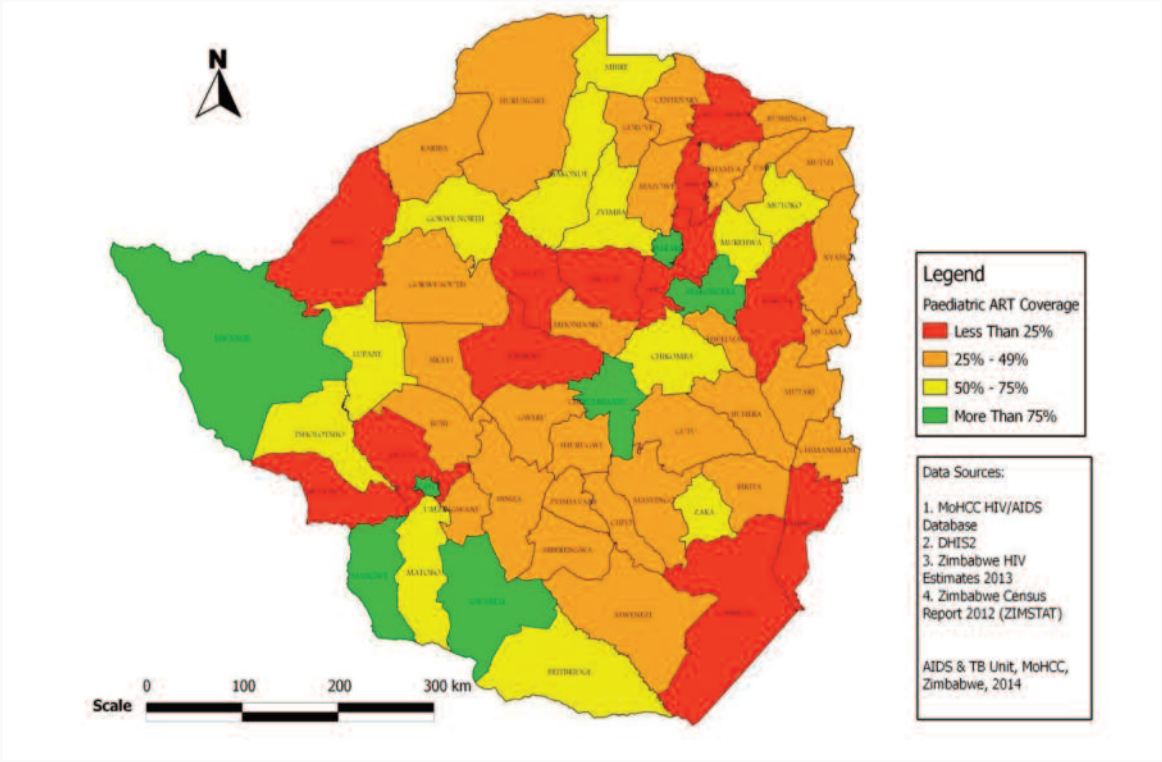


Figure 8: Paediatric ART Coverage by District

Source: 1994 ZDHS, 1999 ZDHS, 2005-06 ZDHS, 2010-11 ZDHS and 2014 MICS

[8] By 2020, the cascading targets are to have at least 90 percent of all people living with HIV know their diagnosis; 90 percent of those people to be receiving antiretroviral treatment; and 90 percent of those on HIV treatment to have an undetectable viral load..

Achieving the 90:90:90[8] targets in line with the Fast-Track strategy to end the AIDS epidemic by 2030 (UNAIDS) requires acceleration of the implementation of HIV prevention and treatment interventions for children and adolescents. The MoHCC has developed a 2015 to 2018 acceleration plan for children and adolescents that aims at reducing the prevention and treatment gaps where targeted interventions and investments will be based on high yield results.

Nutrition

MICS results indicate that there is a downward trend in stunting prevalence from a peak of 35% in 2005/6 to 27.6% in 2014 with noted disparities (ZIMSTAT 2014[9]). Stunting remains high in rural areas (30%), compared to 20% in urban areas. Also worth noting are the gender disparities with boys having a higher stunting prevalence of 31.1% compared to girls at 24.1%. Underweight and wasting remain stagnant at 11% and 3% respectively (ZIMSTAT 2014). Figure 3 below further highlights trends in stunting, underweight and wasting since 1999. Furthermore, there is not much change in Global Hunger Index (GHI) for Zimbabwe, it was 20.5 in 2005 and in 2013 it has reduced to 16, which is ranked under "serious category" (GHI report 2013).

In terms of trends in micronutrients, the typical diet in Zimbabwe is deeply deficient in vitamins and minerals required for health, development and survival. The national micronutrient survey of 2012 showed that the prevalence of iron deficiency among children aged 6 to 59 months in Zimbabwe was 72%. The results of the survey further showed that children less than three years of age were the most affected by iron deficiency with the age group of 6 to 11 months having a prevalence of 81% and those aged 12 to 35 months having a prevalence of 74%. 31% of children aged 6 to 59 months had anaemia and the younger children 6 to 11 months had the highest levels at 55%. Among the children who had anaemia, 67% also had iron deficiency.

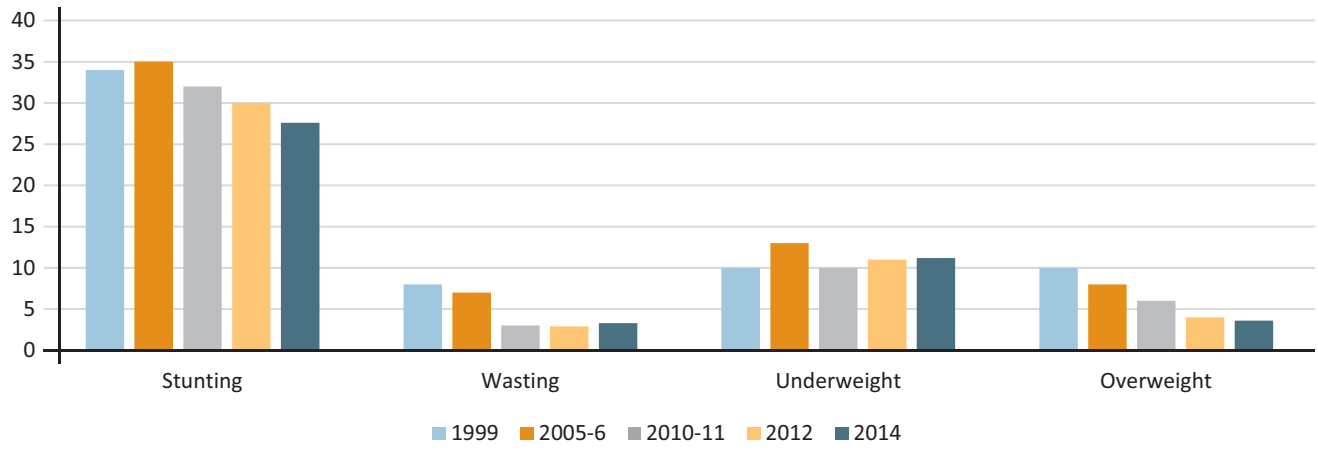


Figure 8: Trends in stunting, underweight and wasting prevalence 1999-2012

ZDHS 1999, 2005/6, 2010/11, MNS 2012, MICS 2014

[9] MICS

Immunization

According to the 2014 MICS, overall, 69% of children between 12 to 23 months of age were fully vaccinated[10] by their first birthday. Despite the fact that recent rates show that the country has been in a positive trend in terms of vaccination, there is still a significant number of children that are not being fully vaccinated by their first year. See figure 9 below.

This positive trend is also seen in other vaccines. MICS 2014 shows that about 92% of children had received BCG vaccination, 84.9% polio 3, 85.4% DPT3, 82.6% measles vaccine. The positive trend can be attributed to the well-supported and well-coordinated Expanded Programme on Immunisation (EPI) programme that involves all major stakeholders, and a robust vaccine and cold chain management system. According to the 2013 EPI Annual Report (Ministry of Health and Child Care, 2013b), there were no significant stock outs of vaccines at the Central Vaccine Stores. This was confirmed by the VMAHS report of 2014 where 83.2% of the facilities – both rural and urban - had all the required vaccines in stock (CCORE and UNICEF, 2014).

Zimbabwe was also successful in introducing new vaccines. The pneumococcal vaccine that targets one of the major killers, Pneumonia, was introduced in July 2012 and Rotavirus vaccine that is targeting Rotavirus diarrhoea was introduced in August 2014.

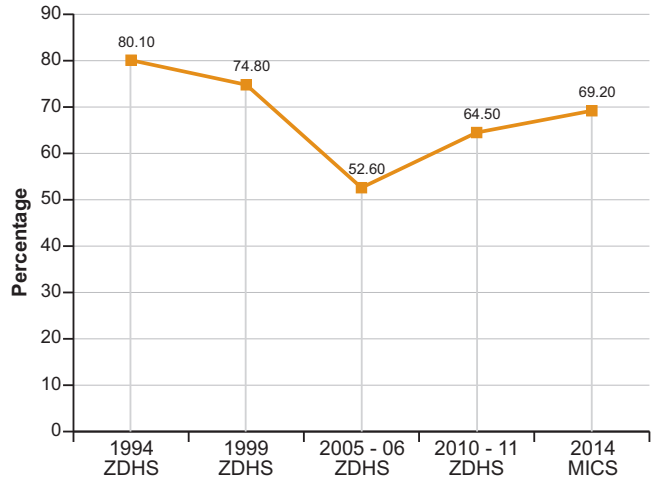


Figure 9: Trends in % of children with all basic vaccination, Zimbabwe

Source: 1994 ZDHS, 1999 ZDHS, 2005-06 ZDHS, 2010-11 ZDHS and 2014 MICS

Childhood disabilities

Disability, as a consequence of poor health and nutritional status of children, often tends to be overlooked when designing health and nutrition programmes. The three top causes of disabilities in Zimbabwe according to the 2013 disability survey[11] conducted by MOHCC with support from UNICEF were diseases (42% of disabilities in males and 19% of disabilities in females), congenital/ perinatal causes (28% of disabilities in males and 19% in females) and accidents (15% of disabilities in males and 9% in females). The known predisposing factors to disabilities during pregnancy include intake of certain medicines, drugs and chemical abuse including tobacco and alcohol) that may be harmful to the unborn baby, micronutrient dietary deficiencies, and maternal illness during pregnancy (such as rubella). During delivery, prolonged obstructed labour and foetal asphyxia are major predisposing factors to childhood disability. Unborn babies exposed to these conditions are at risk of developing disabilities. Similarly, newborn and childhood illnesses (such as neonatal jaundice, febrile convulsions, ear and eye infections, measles and polio) are well known potential causes of childhood disabilities. It is noted that most of the causes of disability are preventable and the health sector should play a key role. MICS 2014 found that the coverage of interventions to manage disabilities are relatively high, although quality needs to be further improved and a focus on prevention is needed. The key findings of the disability survey revealed that the prevalence of disabilities in Zimbabwe stands at 7%, which is relatively low as compared to other countries in similar settings but further research is necessary to clarify preventive measures.

[10] Full vaccination includes the following: BCG, Polio, Pentavalent (DPT, HepB, Hib) and measles.

[11] Living Conditions among Persons with Disabilities Survey: Key findings report; MOHCC, UNICEF (2013).

WOMEN'S HEALTH

Maternal Mortality and Morbidity

According to the 2014 MICS, Zimbabwe's Maternal Mortality Ratio for the country stands at 581/100,000 live births in the five years preceding the survey and 614/100,000 in the seven years preceding the survey (see Table 3).

The Maternal Mortality Ratio, which had previously been on a steady increase from an estimate of 520 in the early 1990s doubling to 1,068 (census 2002) and 960 per 100,000 live births (DHS 2010), began showing a downward trend for the first time in 2012. The UN interagency group for maternal mortality estimates[12] indicated that Zimbabwe's MMR has gone down to 470 per 100,000 live births in 2013 from 740 per 100,000 live births in 2005. A similar downward trend is seen in the estimates according to the census results, declining to 525 per 100,000 live births (census 2012). The latest estimates from MICS 2014 stands at 614 per 100,000 live births. The variations in these figures are due to the differences in data collection methodology, but they all fall within the same statistical range. While the decrease in maternal mortality rate is commendable, the rate is far above the global high MMR cut off of 300[13] per 100,000 live births and way above the Zimbabwe MDG target of 1990s level (174 per 100,000 live births). The National Health Strategy gives the MDG target as 145 per 100,000 live births. In depth analysis of MMR figures from 2002 and 2012 censuses shows that the slowest decline in MMR has been for the age group of 15-19 years (13%) compared to overall decline of 49% for 15-49 year age group[14].

The WHO estimates that for every maternal death, there are 20 to 50 cases of severe maternal morbidity, one of which is Obstetric Fistula (OF). Obstetric Fistula usually afflicts the most marginalized women and girls i.e., young, poor, often illiterate living in rural areas. Prolonged or obstructed labour without access to emergency obstetric care is the most immediate cause of Obstetric Fistula. Obstetric Fistula is one of the most devastating consequences of a neglected childbirth and is a glaring example of health inequity in any society. A 2009 Fistula Needs Assessment carried out in Zimbabwe revealed that Manicaland, Matabeleland

Table 3: Maternal Mortality Indicators for Zimbabwe, 2014

MICS Indicator	Indicator	Description	Value
5.13	Maternal mortality ratio	Deaths during pregnancy, childbirth, or within two months after delivery or termination of pregnancy, per 100,000 births within the 7-year period preceding the survey	614
	Maternal mortality ratio	Deaths during pregnancy, childbirth, or within two months after delivery or termination of pregnancy, per 100,000 births within the 5-year period preceding the survey	581

Source: MICS 2014 (ZIMSTAT and UNICEF, Aug 2014)

North and Mashonaland West provinces are affected more by Obstetric Fistula compared to others. According to the Zimbabwe Maternal and Perinatal Mortality Study (Ministry of Health and Child Welfare, 2007) the majority of maternal deaths (63%) occurred in the postpartum period, 24% in the antenatal, and 6.6% in the intrapartum periods. Based on the 2013 HMIS[15] data , 87% of the reported maternal deaths occurred in health facilities and 13% occurred at home, although the picture could have been distorted by under-reporting of community maternal deaths.

[12] UN Interagency Maternal Mortality Estimates, 2014. Available at http://data.unicef.org/maternal-health/maternal-mortality. Accessed on October 11, 2014.

[13] Trends in Maternal Mortality 1990-2010; WHO, UNICEF, UNFPA & The World Bank Estimates

[14] Thematic Analysis of Census Data (not published)

[15]Ministry of Health and Child Care, Health Management Information System, 2013. Data from this system comes from administrative records. Despite being a good source of information, data from this system has to be used carefully since it does not take into consideration those cases that are not notified at hospital. Therefore, chances are high that they hide cases that happened at home or in other facilities. That is one of the reasons why some indicators using HMIS are different from those using survey methods such as ZDHS and MICS, for example.

Leading Causes of Maternal Deaths

The major direct and indirect causes of maternal deaths continue to be the same through different years. The World Health Organization Global Health Data (2014[16]) reported 2,100 maternal deaths in Zimbabwe in 2013 due to causes that are known, preventable and treatable (see Figure 10 below). According to the organization, major causes of maternal deaths were haemorrhage (34%), pregnancy induced hypertension (19%), unsafe abortion (9%), sepsis (9%), indirect causes including AIDS defining conditions and malaria (18%), and other direct causes (11%). According to the Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS 2007) majority of maternal deaths (63%) occur in the postpartum, 24% in the antenatal, and 6.6% in the intrapartum periods. The same study also revealed that successful treatment of direct causes of maternal death could reduce maternal mortality by 46%. 2013 HMIS data showed that 87% of the reported maternal deaths occurred at health facilities and 13% at home, (although the picture could have been distorted by under-reporting of community maternal deaths). The Zimbabwe Maternal and Perinatal Mortality Study (Ministry of Health and Child Welfare, 2007) showed AIDS defining conditions as being the highest indirect cause of maternal deaths. Although no local more recent data on this is available, the above 2013 WHO global report points at HIV as a significant contributor to maternal deaths that cannot be ignored.

These observations emphasise the need for strengthening the basic and the comprehensive emergency obstetric and neonatal care (BEmONC and CEmONC) services along with the delivery of integrated SRH-HIV services in the country to reduce maternal and neonatal mortality and morbidity. The fact that majority of maternal deaths occur at facilities suggest a possible delay in arrival at the facility (second delay) including the quality of care as a major associated factor leading to deaths. For preventing and minimising maternal deaths due to second delay, especially in rural areas, ZMPMS 2007 recommended that all pregnant women in rural areas in Zimbabwe should stay at Maternity Waiting Homes (MWH) for 3 weeks before and three days after delivery to increase their access to skilled birth attendance and BEmONC services.

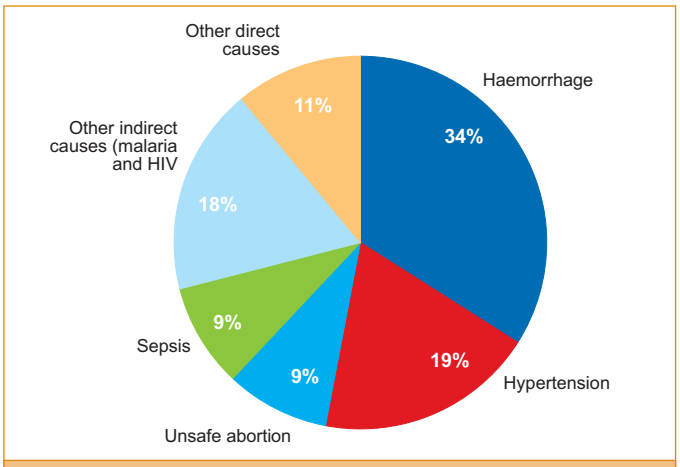


Figure 9: Causes of Maternal Death, Zimbabwe

Source: WHO Global Health Data (2014)

Quality of Care of Maternal Health Services

The most recent key maternal health indicators (MICS 2014) shows that Zimbabwe has a high ANC coverage (94%), high institutional delivery (80%), high level of skilled birth attendance (80%) and high contraceptive prevalence rate (67%). Despite this high coverage, MMR remains high. Although the high MMR can be partly explained by high prevalence of HIV, the findings of the most recent national integrated health facility assessment conducted in 2012 (NIFHA 2012), identified quality of care of maternal and neonatal health services as an area of concern. These findings emphasise the need to focus on continuing skills development, mentorship and supportive supervision.

The Quality of Care component of NIFHA 2012, which included a component on direct observation, points to the low coverage of BEmONC (6%) and CEmONC (7%) services across the country (providing all 7 and 9 signal functions respectively) along with poor quality of ANC, delivery and postnatal services. 'Lack of money to pay for treatment' also explains part of high maternal mortality and morbidity, especially for the vulnerable girls and women in the society. ZDHS 2010-11 highlighted that this was a major concern for women living in rural areas (59%), in lowest wealth quintile (70%) and ones who had no education (75%).

[16] WHO Global Health Data, 2014, available at http://apps.who.int/gho/data/node.country.country-ZWE?lang=en

The quality of care component of NIFHA 2012 assessment also pointed to the gaps in the knowledge and skills of health providers on key maternal and neonatal health care. 47% midwives, 67% SRN and 70% PCNs were not trained on EmONC. Only 21% health providers knew about all the three components of Active Management of the Third Stage of Labour (AMTSL). Complete knowledge on comprehensive newborn care was lacking as on average a health worker could answer only 41% questions on comprehensive new born care.

Due to inadequate quality of care, Zimbabwe has reported 88 referred fistula cases of which only 59 were repaired and more cases were not referred according to the fistula needs assessment conducted by the Ministry of Health and Child Care in 2010.

Maternal Death Surveillance & Response (MDSR)

An efficient MDSR system to identify and notify each individual maternal death and to take appropriate action to avert similar deaths in future has an important role to play in reducing maternal mortality and improving overall maternal health. A recent MDSR Assessment[17] in four provinces in the country identified the gaps in the existing MDSR system in the country, which were related to weak structures and capacity at facility and community levels to conduct maternal reviews. In addition, the assessment identified lack of resources for MDSR system and weak capacity to take appropriate action. With support from UNFPA (H4+) to MoHCC, efforts are underway to develop an electronic database for maternal deaths to strengthen MDSR system by ensuring real-time reporting of maternal deaths leading to prompt action. The existing DHIS2 platform used for national HMIS is being used for developing the database for maternal deaths so that this system can be fully integrated within existing HMIS and scaled up across the country.

Antenatal Care

The 2014 MICS data shows that 93.7% of pregnant women 15-49 years of age were seen at least once by skilled health personnel, and 70% attended four[18] or more antenatal visits[19]. This represents an improvement from 93.4% and 56.8% respectively from the MIMS 2009 data. The increased access to ANC services can further improve maternal health if quality of care can also be improved. The NIFHA 2012 found that only 14% health workers surveyed met the standard to identify danger signs in pregnancy with only 4% and 2% inquiring for fever and convulsions respectively. Only about 2% screened for pre-eclampsia signs. Of the observed health workers, less than half (46%) provided all routine preventative medicines (Iron / Folic acid). Slightly more than a third (36%) provided education on birth preparation, while only 12% provided adequate counselling on danger signs in pregnancy.

Despite the improvement in terms of access to antenatal care, according to the 2013 HMIS, most of the women in the country have their first visit late in pregnancy. While the recommendation is that the first visit should occur before 16 weeks of gestational age, only 15% had their first visit during this period, 54% booked between 16 to 27 weeks, and 31% booked after 28 weeks.

The national standards and protocols for Focused Antenatal Care (FANC) that are in place, indicated that

[17] An Assessment of Maternal Death Surveillance and Response in Mashonaland Central, Manicaland, Midlands and Matabeleland North Provinces of Zimbabwe (Draft Report): 2014; conducted by MoHCC with support from H4+, UNFPA

[18] The World Health Organization (WHO) recommends a minimum of four antenatal care visits as the standard for the countries.

[19] The country Target is 90% by 2015.

over 90% of all facilities offered key components of routine ANC, but of the level 1 facilities only 31% tested for anaemia and only 16% carried out routine urinalysis for pregnant women, as compared to 73% of hospitals testing for anaemia and 57% of hospitals doing urine analysis (MoHCC, 2012).

Despite improvements, a large number of women still do not receive the four recommended ANC visits. Social and cultural practices and beliefs from different groups in Zimbabwe contribute to a large group of women not attending ANC. A second determinant is related to financial access for those that seek ANC services. Despite the current policy which advocates for free access, there are still places that charge for some services, and access to adequately staffed services is still an issue. Hospital facilities are not accessible for all, particularly for those that live in the most isolated and vulnerable areas. Further transport cost and its availability also impair access.

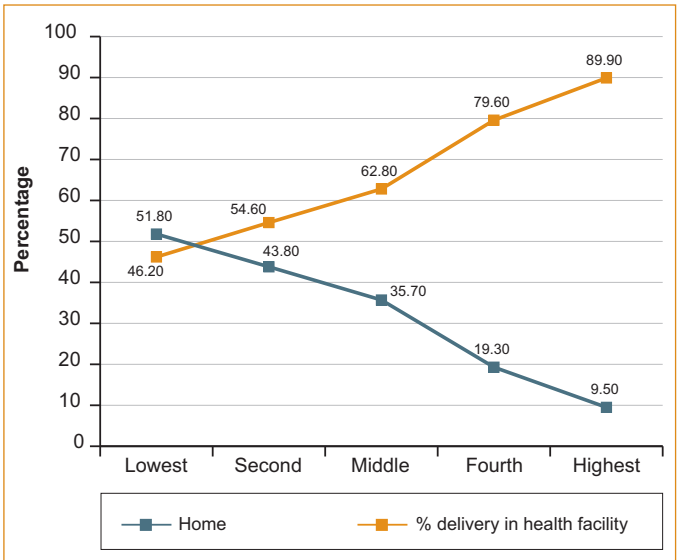


Figure 11: Comparison of home deliveries and health facility deliveries by wealth quintile, Zimbabwe, 2011

Source: ZDHS 2011

Delivery

According to the 2014 MICS, almost 79.6% of births happen in health facilities, presenting an improvement when compared with numbers from the 2011 ZDHS that indicated that 65.1% .Also according to the 2011 ZDHS, home deliveries are more common in rural areas (43% of the time) as compared to urban areas (15% of the time). According to HMIS, home deliveries significantly decreased from 39% in 2012 to 24% in 2013 (See Figure 11 below). There is a social-economic component related to home deliveries: the poorer a mother is, the higher the chance that the delivery is going to happen at home.

Skilled Attendant at birth

The 2014 MICS data shows that 80% women age 15-49 years with a live birth in the last 2 years preceding the survey were attended to by skilled health personnel at delivery of their most recent live birth (See Figure 12 below). On the other hand, the 2011 ZDHS found that only 66.2% of the births take place under the supervision of a skilled provider. This number is very close to the one found in the 2013 HMIS system that showed that 68% of the deliveries were conducted by skilled personnel in health facilities. The Zimbabwe 2011 Demographic and Health Survey (ZIMSTAT and ICF International, March 2012) shows that the socio-economic status is one determinant for being attended by a skilled health provider during delivery (See Figure 13 and 14 below). 91% of the mothers in the richest families of the country had the help of a qualified health worker against 48% of the women in the poorest families. Richest mothers-to-be in the country also have access to more skilled health workers during delivery than any other wealth quintile.

Midwifery

The HTF supports midwifery schools to improve pre-service training and increasing the number of trained midwives in the country. However, gaps still remain in strengthening midwifery regulation and association, where strategic support can be provided to MoHCC and the Zimbabwe Confederation of Midwives (ZICOM).

Access to a qualified health worker also varies according to rural or urban area, as well as by province. 86% of women in the urban areas had access to skilled

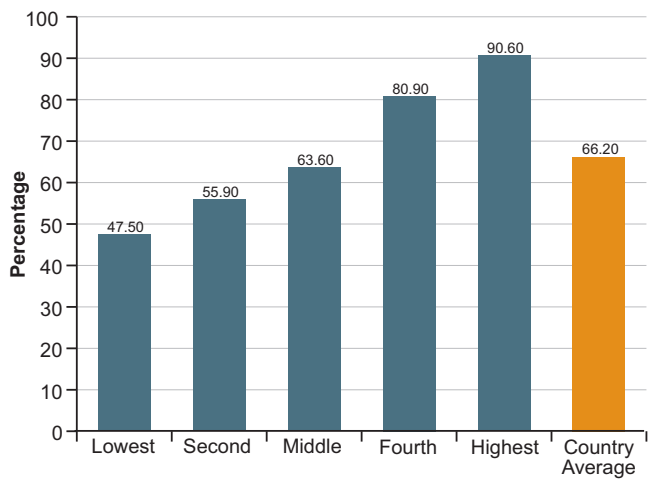


Figure 12: % delivered by skilled provider by wealth quintile, Zimbabwe, 2011

Source: ZDHS 2011

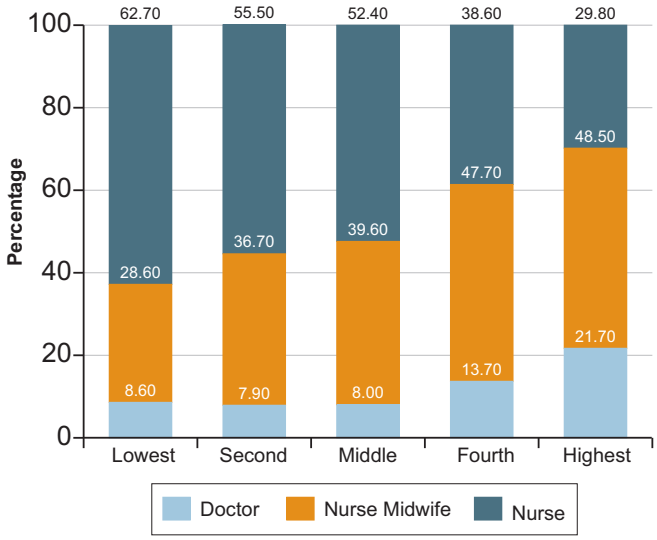


Figure 13: Type of skilled provider assisting during delivery by Wealth Quintile (%), Zimbabwe, 2011

Source: ZDHS 2011

providers during delivery in contrast with 58% in the rural areas. NIFHA 2012 highlighted that only 9% health workers took complete history during labour to identify all the danger signs and about 11% assessed for pre-eclampsia/eclampsia (testing urine for protein) during labour and delivery. The figure below (Figure 14) shows how the provinces vary in terms of deliveries supported by qualified providers, and by traditional birth attendants.

The VMAHS 2014 (Ministry of Health and Child Care, 2014) reported varying levels of availability of basic EmONC services according to type of facility and location. In the urban areas, 100% of the Government facilities, 40% of the local authority facilities and 33% of the mission facilities provided basic EmONC services. In the rural areas, only 66% of the local authority facilities, 57% of the Government facilities and 42% of the mission facilities provided EmONC services.

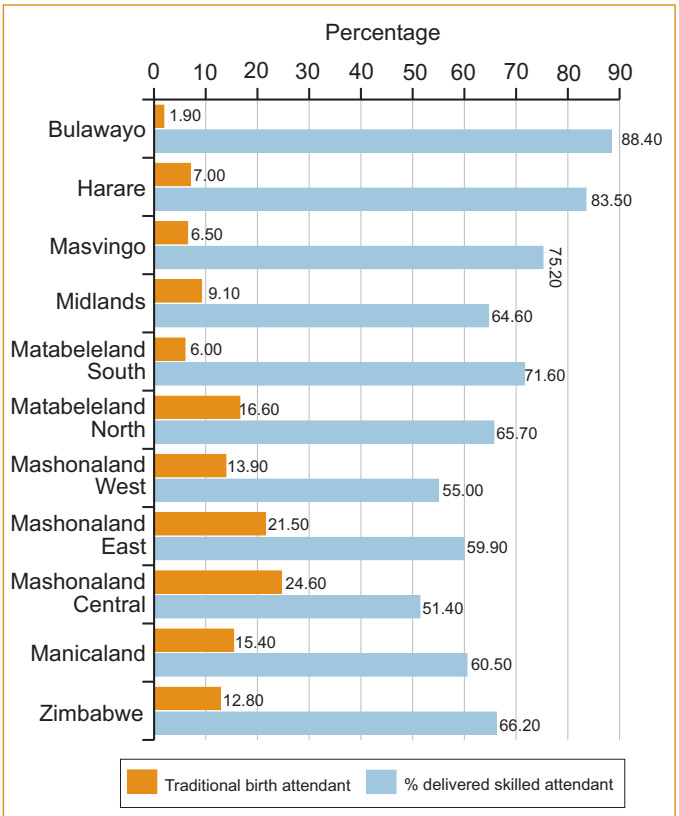


Figure 14: % Delivery by Traditional Birth Attendant and % Delivery by Skilled Provider, Zimbabwe and Provinces, 2011

Source: Data for graph derived from ZDHS 2011

The proportion of facilities with mothers' waiting homes also varied widely, with 100% of mission district hospitals, 89% mission hospitals, 68% Government rural hospitals and 63% Government district hospitals having obstetric waiting homes.

The availability of ambulances for referrals was fairly good according to the VMAHS 2014 (CCORE and UNICEF, 2014). Although none of the Government primary health care facilities had a functional ambulance, 100% of central and provincial hospitals, 98% of district hospitals, 95% of urban facilities and 85% of rural hospitals had functional ambulances.

Postnatal Care

According to the 2014 MICS, 77% of the mother's age 15-49 years had received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live birth in the last 2 years. This number shows an improvement when compared to previous years (according to ZDHS, 43% of the mothers would have a post-natal care visit).

Despite an improvement in post-natal care, 23% of the mothers still do not receive a health check after delivery, and only 39% of mothers and 48% of babies delivered at home receive PNC (MICS 2014).

Remaining challenges in Maternal, Newborn, Child Health, Nutrition and HIV

Although the MICS 2014 results showed significant gains in the revitalization of the health system, and remarkable improvement in the key maternal, newborn and child health, nutrition and HIV and AIDS indicators, continued efforts are required to sustain the gains, and to avoid the risk of the health system lapsing back again.

- The fact that 87% of reported maternal deaths occur in health facilities is just one example to show that despite the improvements in coverage of the interventions, and despite the good health seeking behaviour of the Zimbabwean population, quality of care and equity of access still remain major challenge that need to be addressed.
- Newborns continue to contribute significantly to under-five mortality, and adolescents are not provided equal opportunity of access to health care.
- Significant gains have been made in adult ART uptake, but the area of Paediatric ART, although improved, still lags behind.
- Health services at the rural health facilities has greatly improved over the years, but the charging of user fees and the poor quality of services at the Provincial and tertiary hospitals has resulted in non-compliance to referral and increasing number of deaths reported at the higher level health facilities.
- Despite consistently high immunisation coverage for all traditional antigens, the completion rate of primary immunisation for infants has stagnated at around 70%.

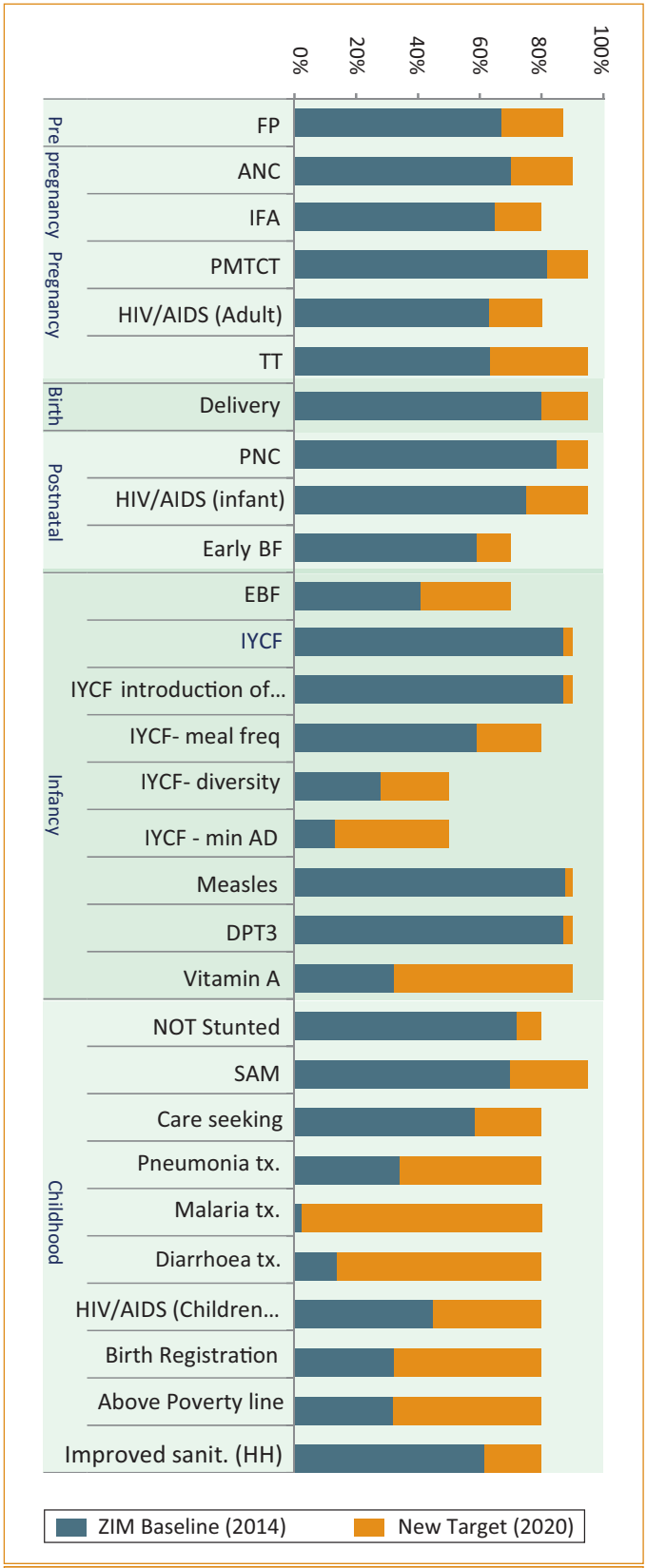


Figure 15: Health Indicators by life cycle, baseline and target

- The coverages of health and nutrition interventions across the life cycle demonstrates a glaring of missed opportunities that still need to be addressed.
- Sustainability for the supply of essential drugs, commodities and retention of human resources still remain a challenge.
- Ensuring sustainable financing of the health sector.

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

Family Planning

MICS 2014 shows that the contraceptive prevalence rate has improved to 67% from 64.9% in 2009, accompanied by a reduction of unmet need from 13% to 10.4% for the same period. This trend however does not correspond to the increase in Total Fertility Rate from 3.8 in 2006 to 4.1 in 2011. While the society in general has a higher number of children wanted, MICS 2014 pointed out to a few challenges in provision of family planning services and promoting choice. First, family planning method mix is heavily tilted towards short term methods, such as pills which sit at 43.9%. Second, unmet needs for youth (15-19) is higher than the average indicating a gap in promoting information and quality services for young people. Third, unmet needs for adults above 35 years old is among the highest, meaning a lack of access to long acting and permanent methods.

Adolescent Sexual and Reproductive health (ASRH)

Zimbabwe has a youthful population, with 2/3 of the population below the age of 25. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for youth are either deteriorating or remaining high, but also one of the key solutions to the problem the society faces taking into consideration the demographic dividend they can bring.

The adolescent fertility rate is estimated at 120 births per 1,000 women aged 15-19 years which is the highest rate recorded since 1984. According to 2010/11 Zimbabwe Demographic Health Survey, 20.5% of women aged 20-24 years have had at least one live birth before the age of 18 years. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become a mother as their urban counterparts. The adolescent also has a high unmet needs for family planning at 17% and low Contraceptive Prevalence Rate at 10%. The decline of Maternal Mortality Ratio among women of 15-19 at 21% is much slower than the average decline of 43% for women of 15-49. HIV prevalence among young women aged from 15 to 24 is 6.4%, nearly twice as high than that among young men. Longitudinal data from the national sex work programme indicates that young female sex workers of the same age group experience an HIV incidence of more than 10%, ten times as high as the general population. All of these call for targeted and integrated sexual reproductive health information and service for young people.

HIV and AIDS

Despite significant improvements over the past 15 years, HIV remains a major cause of mortality, morbidity and maternal deaths in Zimbabwe. HIV prevalence among the adult population declined steadily to the currently estimated 15%, accompanied by a decline in incidence from an estimated 3.5% in the late 1990s to currently 0.98% in the general population. Young women experience higher HIV prevalence and incidence than young men at 6% prevalence and 1% incidence (2013 HIV estimates) in the age group between 15 and 24, indicating that innovative and comprehensive HIV prevention interventions remain a key element of ASRH programmes and require strengthening both at health system and community level. Longitudinal data from young key populations (CeSHHAR[20] programme data) indicates even higher HIV risk, with HIV incidence rates above 10% observed among young female sex workers, arguing that specific interventions to reach these vulnerable populations are required but not yet in place.

Zimbabwe is currently rolling out voluntary medical male circumcision (VMMC) as a high-impact intervention for preventing new infections among young men in an intense effort to circumcise the sexually active age group between 15 and 29 years. The gains achieved through this programmed need to be maintained beyond this so-called 'catch-up' phase and capacity built in the public health system to provide VMMC to new age cohorts as well as other age groups based on national policy and guidelines.

[20] Centre for Sexual Health and HIV AIDS Research Zimbabwe

While HIV services are widely available in the country with e.g. HIV testing available in all health facilities, service uptake needs to be strengthened to achieve ambitious targets like the 90-90-90 approach to testing and ARV treatment adopted recently in the ZNASP III which aims at increasing the percentage of diagnosed PLHIV to 90% by 2020, and halving HIV incidence in the same period.

Cervical cancer

In Zimbabwe, 4.37 million women in reproductive age are at the risk of developing cervical cancer. Current estimates indicate that every year 2,270 women are diagnosed with cervical cancer and 1,451 die from the disease. (WHO/HPV 2014 estimates).

Cervical cancer ranks high among the most frequent cancers in women in Zimbabwe. Under the ISP, the Ministry of Health and Child Welfare has been supported to introduce and scale up Visual Inspection with Acetic Acid (VIAC) based cervical cancer screening services. In the past 3 years over 80,000 women have been screened. The coverage of services however remains low. Only half of the districts currently have cervical cancer screening services. In addition only about 60% of VIAC positive women received treatment (cryotherapy or LEEP). There is need to accelerate expansion of VIAC services, strengthen treatment of precancerous lesions and link with treatment and palliative care services.

Gender Based violence (GBV)

Zimbabwe has made strong commitments towards eradicating violence against women and girls, especially rape and sexual violence. The National Action Plan to End Rape and Sexual Violence launched in 2014 and the 2010-2015 National Gender-Based Violence Strategy were designed to improve the efforts of the Government and its development partners to prevent and respond to violence against women through an effective and coordinated multi-sectoral response. Despite these efforts, according to ZDHS 2010-11, 30% of women age 15-49 have ever experienced physical violence since age 15 and 18% of women experienced it within the past 12 months. The most common perpetrator of physical violence against women is the woman's current or former husband or partner. 2010-2011 ZDHS shows that women from all socio-economic and cultural background in Zimbabwe are subject to violence. Early and forced child marriages as manifestations of violence against girls are on the increase in Zimbabwe. The impact of this on girls and young women are early pregnancies, high maternal mortality and high rates of school drop outs. Despite availability of key policy guidelines, critical programming gaps like poor coordination and weak monitoring and evaluation system still exist. In addition, services for the survivor of GBV, like post-exposure prophylaxis, medical services, psychosocial support, legal assistance and shelters are still very scarce in the country. A 2012 study showed that only 3% women who suffered GBV received any kind of professional help.

Remaining challenges in improving RMNCH-A

Although these data indicate increasing coverage of essential RMNCH-A services, there are areas of concern regarding quality of care. For example:

- The percentage of women who had their blood pressure measured and gave urine and blood samples during the last pregnancy are reported at 52%.
- Tetanus toxoid protection is estimated at 64%, and intermittent prophylaxis treatment for malaria at 6.4%, indicating missed opportunities to provide a full package of services to pregnant women attending ANC services.
- According to the MTR Health Facility Survey, in 2014 only 44% of Primary Care Nurses (PCNs) in Level 1 facilities have been trained in focused ANC. The target of the HTF is to train 80% of PCNs by December 2015.
- The new Post Natal Care recommended schedule of PNC visits on days 1, 3 and 7, and after 6 weeks of delivery is not yet being reported by facilities
- Treatment of children who have ARI/pneumonia symptoms with antibiotics is only 34%

- Treatment of children who have diarrhea with ORT is only 56%, while treatment with ORT and zinc is 14%
- Total fertility increased from 3.8 in 2006 to 4.1 in 2011. Unmet need for family planning for young people (15-19 years of age) at 11% is higher than the national average. There is also high unmet needs for women above 35 years.
- The demand for cervical cancer screening exceeds the availability of services in public health facilities, only 9% of women of RH age screened up to now comparing with the target of 35% to achieve an impact.
- There are numerous fistula cases in the country of which only a minority has been repaired (from 88 cases reported to hospitals only 59 repairs were done 12 months before the MOHCC fistula survey 2010, but many women have not even reached the referral level).
- The adolescent fertility rate is estimated at 120 births per 1,000 women aged 15-19 years which is the highest rate recorded since 1984. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become mothers as their urban counterparts.
- 30% of women aged 15-49 have ever experienced physical violence since age 15. Also, the high rate of early and forced child marriages at 31% according to 2012 Census is a manifestation of violence against girls. Multi-sectoral service to survivors remain limited in programme supported areas.
- Access to comprehensive sexual reproductive health and HIV prevention and treatment services by key populations, such as female sex workers, remain limited especially in public health facilities.

It is important for the programme to address these challenges in order to sustain the gains made so far in improving the health care for children and women in the country.

Chapter 3 describes the overall aims and objectives of the HDF within the context of the Ministry's emergent strategic plans from 2016 to 2020.

CHAPTER 3

The Health Development Fund - Overall Goal and Purpose

The Government of Zimbabwe within the overall framework of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) seeks to improve the quality of health care of its people. Within this framework, the Ministry of Health and Child Care is developing its Strategic Plan (2016 to 2020). t is envisaged that the overall priorities will continue from the previous Strategic Plan (2010 to 2015) and that there will be opportunity to build upon the existing achievements. The National Health Strategy (NHS) is therefore expected to have an emphasis on RMNCH-A and Nutrition, SRHR, HIV, TB, and Malaria. The Ministry of Health and Child Care sees the NHS as a vehicle to further strengthen the health system especially for the reduction of maternal and child morbidity and mortality. In addition the MoHCC is likely to give additional emphasis to the following:

- Burden of non-communicable diseases;
- Strengthening of district and provincial hospitals;
- Enhancing quality of services;
- Preparedness for medical emergencies (such as Ebola, Cholera);
- Implementation of Results Based Management (RBM); and
- Enhancing Community participation.

In order to respond to the commitments above, there is need for the Government of Zimbabwe to establish a clear long term framework for health financing. The overall objective needs to be that of financial viability of good quality services, implementation of high impact low cost interventions and strong sector coordination. It is also clear that if government is to achieve its objectives for the health of the people of Zimbabwe, the proportion of public expenditure allocated to health needs to be increased to the Abuja target of 15% of the state's national budget, and seek innovative ways of funding the sector more sustainably.

The HDF will contribute to the efforts of the Ministry of Health and Child Care in achieving the goals set in its National Strategy.

The Health Development Fund

Aim: To support the Ministry of Health and Child Care in the context of the 2016-2020 National Health Sector Strategy to achieve its goals of improving the quality of life of its citizens, through guaranteeing every Zimbabwean access to comprehensive and effective health services.

Goal: To contribute to reducing maternal mortality (by 50%) and under-5 mortality (by 50%), by ensuring equitable access to quality health services for women and children by 2020; and to contribute to the reduction of the unmet need for family planning to 6.5%, halving the prevalence of stunting in children under-5 and eliminating MTCT by 2020, combating HIV and AIDS, Malaria and other prevalent diseases.

Purpose: To continue to consolidate and improve on gains made in maternal, new born child and adolescent (young people) health by strengthening health systems and scaling up the implementation of high impact Reproductive Maternal New born Child and Adolescent Health (RMNCH-A); and nutrition interventions through support to the health sector.

Thematic Areas

Within this context the thematic areas of support will also reflect continuity and build on the strong foundations that have been restored and improved through the HTF and other programmes. These are defined as follows:

Thematic Area 1: Maternal, New-born and Child Health, and Nutrition

Thematic Area 2: Sexual Reproductive Health and Rights

Thematic Area 3: Medical Products, Vaccines and Technologies (Medicines and Commodities)

Thematic Area 4: Human Resources for Health (including Health Worker Management, Training and Retention)

Thematic Area 5: Health Financing (Result-Based Financing)

Thematic Area 6: Health Policy, Planning, M&E and Coordination

Thematic Area 7: Technical Support and Innovation

Chapter 4 provides more detailed description of the intended areas of support within the Health Development Fund.

CHAPTER 4

Thematic Areas - Detailed Description

THEMATIC AREA 1: MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION

The main priorities in terms of Maternal, Newborn and Child Health, and Nutrition are to consolidate the gains made through key high impact cost effective interventions, and gradually shift from ensuring that an adequate volume of services are delivered at the appropriate levels, to focusing on the continuum of care across the life cycle, greater quality of care and more equitable service accessibility.

These areas comprise the following interventions: enhancing Obstetric and Newborn Care; strengthening the Community Health Service delivery system; improving the Expanded Programme on Immunization (EPI) and Integrated Management of Newborn & Childhood Illnesses (IMNCI); and strengthening national capacity in Maternal, Infant and Young Child Nutrition. These interventions support ongoing capacity building of MoHCC to improve, implement, supervise, monitor and evaluate national evidence based and best practices in order to raise minimum standards of health services for mothers, newborns and children. The main interventions remain similar to those supported by the HTF but with an appropriate change of focus to ensure that the successes achieved to date are maintained and enhanced. Key activities in each intervention are as follows:

1.1 Consolidating improvements in Obstetric and Newborn Care

A substantial number of midwives have now been trained or upgraded; therefore, the focus will now be on ensuring adequate coaching and mentoring support for those staff to promote high quality of care and appropriate referral when required. District hospitals now have at least one doctor who can perform Caesarean Section, so the focus will be on continuing to ensure that all appropriate supportive systems are in place for management of complicated obstetric emergencies. Specific activities will include:

- Ensuring those geographical areas and in particular districts hospitals if necessary showing the lowest performance in service coverage are targeted with additional support as these are likely to include segments of the population most at risk.
- Strengthening the referral systems and support to referral points by:
  - Improving the communication system and establishment of a two-way referral system among each health service delivery level
  - Considering the application of e-health technology, and
  - Ensuring that deterrents at the referral level such as user fees and transport are effectively addressed
- Supporting further human resources capacity building by:
  - Consolidating the clinical mentorship programme and targeted on-the-job training to ensure that health staff provide adequate quality of care at the appropriate level and refer quickly when needed
  - Improving quality of antenatal care and supporting the implementation of national policy on postnatal care
  - Support the training of nurse anaesthetists
- Support innovation and application of ICT in maternal health
  - Using M-Health for a pregnancy life cycle management approach and integrated RMNCH-A/SRH/HIV services

With the number of mobile and smart phone users rising fast the potential that mobile communication technology (m-health) has in improving RMNCH-A programming in the country is huge. This covers a wide range of interventions including awareness generation, community mobilization and promotion, appointment scheduling and reminders, mobile telemedicine to support staff in rural health centres, health management & information services, health survey and surveillance, patient monitoring, establishing Health call centres/Health care telephone help line, and Emergency toll-free telephone services. Once operational, m-health can reach a large number of people with earmarked services in real time and in a very cost effective manner, including improving programme management. Based the priority, in the initial phases of HDF implementation, together with GoZ, the specific m-health interventions will be defined have to be agreed.

- Supporting midwifery association, regulation and education to strengthen quality
- Improving quality of supervision, monitoring and reporting by:
  - Establishing a quality assurance system

- Introducing RMNCH-A quality score cards within the regular supervision system, and
- Strengthening facility and community based Maternal and Neonatal death surveillance and response, including identification, reporting reviews and audits and the use of audit data to improve decision making and action by managers

- Improving essential newborn care at all health service delivery levels including at community level by:
  - Ensuring that all health facilities conducting deliveries are equipped and staff trained in essential newborn care and management of birth asphyxia
  - Improving management of neonatal sepsis by appropriate training and awareness-raising of VHWs and ensuring rapid management or referral at primary care level

1.2 Further strengthening the Community Health Service delivery system for RMNCH-A and nutrition

Strengthening Community based health service delivery will continue to be a strong focus of the programme that empower communities to claim their rights and increase demand for appropriate quality services. A substantial amount of training to Health Centre Committees (HCCs) has been carried out and the country currently has about 11,000 VHWs who are now in place to support community based service delivery and improve communication between communities and health facilities. This has been done by the Global Fund and HTF, among other partners. The impact of these inputs will only be realised with strong efforts to consolidate, strengthen their capacity and cascade the communities' demands to national policy advocacy. This will be done through community system strengthening of Global Fund and through support to districts by the HDF. Specifically for Nutrition, further training will be given under the nutrition component of the HDF. Activities will include the following:

- Continuing to strengthen the effectiveness of HCCs by supporting ongoing capacity building activities and monitoring their impact focusing more on the use of patients charter and Ministry of Health and Child Care standards of quality services and satisfaction indexes
- Strengthening and supporting a system to facilitate and monitor the VHWs in implementation of their roles,
- Support broader community consultations on the development of health services operational plans and review the frequency of community feedback on the progress made, feeding into the accountability mechanisms of RBF funding.
- Strengthening advocacy role of HCC and how this can cascade to national policy advocacy through the CSOs leading the programme.
- Support the development of conflict handling mechanisms that track the conflicts and resolutions raised from the local, district,

provincial and national level.

- Strengthen the use of social accountability tools in order to improve the demand of quality services and accountability at local health centres.
- Initiation of integrated Community Case Management (iCCM) by:
  - Supporting newly trained VHWs to improve community awareness about services
  - Review/ develop appropriate guidelines on community management of illness and clarify tasks, responsibilities and authority of VHWs
  - Ensuring adequate support for VHWs from the health staff in the RHCs
  - Strengthen community maternal death surveillance and response

1.3 Improving Child Health through continued strengthening of EPI, IMNCI and ETAT+

Substantial progress has been made on introducing new vaccines, expanding coverage of immunization, and conducting IMNCI training. The next phase will build on the successes in increasing vaccination availability and coverage, and continue to strengthen IMNCI implementation, specifically focusing on:

- Ensuring those geographical areas, in particular district hospitals if necessary showing the lowest performance in service coverage are targeted with additional support, and particularly reaching out to those mothers and children not accessing services due to geographical remoteness or religious/ social beliefs
- Finding innovative ways of reaching the hardest-to-reach populations
- Consolidating and strengthening the triaging system (fast-tracking the clinical care of very sick children).
- Strengthening the link with the community health system and the work of VHWs described above
- Improving awareness in health staff about ensuring good overall health in children, and actively seeking illness with each contact point.
- Incorporation of the updated IMNCI TRAINING package into pre service training into pre-service training for the primary, clinical nurses and registered general nurses.
- 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
- Explore the possibility of introducing i-IMNCI for the country at village level.
- Scale up ETAT+ trainings targeting referral hospitals
- Explore integration of ETAT+ into pre service medical training

It has been proposed that GAVI in support of the EPI programme funding will subsequently be channelled through the HDF. This will not only complement the GAVI vaccine support that is currently procured by UNICEF through the HTF and provide additional resources for the Health Systems Strengthening, but will also ensure better coordination. Under this arrangement, GAVI will subsequently be included among the funding partners of the HDF, and the oversight of GAVI funding support will fall under the HDF Steering Committee. This is still subject to Government approval.

1.4 Consolidating gains in Paediatric HIV and AIDS and accelerating ART for Children and Adolescents

Evidence based interventions that ensure service integration and equity will be scaled up with a focus on results based management. These will be supported in line with the national acceleration plan for ART for children and adolescents. The key focus areas will be;

- Improve the policy environment to facilitate accelerated and sustainable scale up of infant, paediatric and adolescent HIV care and treatment towards universal coverage in Zimbabwe
- Expand the provision of quality and comprehensive integrated Infant, paediatric and adolescent HIV and AIDS testing, care and treatment

- Strengthen the Human Resource Capacity at national, provincial, district and facility level for the accelerated scale up and universal provision of paediatric and adolescent HIV care and treatment
- Strengthen paediatric and adolescent community systems for the provision and support for HIV care and treatment services
- Ensure the continuous availability of good quality ARV medicines and commodities for the identification, treatment and monitoring of HIV among children and adolescents
- Expand and improve generation, dissemination and use of strategic information for infants, children and adolescents
- Strengthen infant, paediatric and adolescent ART program management, coordination and supervision

1.5 Enhancing National Capacity in Maternal, Infant and Young Child Nutrition

Critical evidenced based nutrition interventions, scaled up across the country through HTF have resulted in improvement in nutrition service delivery system, contributing to progress in optimal infant and young child feeding practices, improved micronutrient supplementation coverage in children and mothers, and management of severe acute malnutrition among young children.

The next phase will build on the successes and specifically focusing on:

- Improving IYCF practices (IBF, EBF, Minimum Acceptable diet) both at community and facility level. Continuing to enhance implementation of growth monitoring and promotion using WHO growth standard guidelines integrated with IYCF
- Implementation of the National Nutrition Communication strategy.
- Improving the quality and care for children with SAM both enrolled for inpatient and outpatient program integrating with HIV
- Increasing micronutrient coverage for young children and pregnant women (IFA, vitamin A, zinc with ORS , scaling up food fortification interventions)
- Strengthening capacity of nutrition managers and implementers (VHWs, district and provincial nutritionists) in knowledge transfers, skills development and supportive supervision through differential strategies which will include mentorship program, monthly review meetings with corrective actions and feedback system and training on identified gaps)
- Improving quality of Nutrition information system at all levels
- Demonstrating multi sectorial community based approach model to reduce stunting in selected vulnerable districts with a special focus on:
  - Addressing context specific drivers of stunting through the capacitated coordination structures at community level and with the involvement of the communities themselves

- Interventions to be targeted at the nutritionally-at risk households (i.e. vulnerable pregnant and lactating women, children under 2 years of age, adolescent girls)
- Integrated response to stunting through convergence of multi-sectoral services (health, agriculture, WASH, social protection, education gender) provision at the household level for greater synergy between services
- Effective use of available resources and leveraging additional resources for improved nutrition outcomes
- Capacity building of existing multi-sectorial government structures as identified in the Food and Nutrition Security Policy and National Nutrition strategy

1.6 New possible activity areas:

If additional funds are available, the following activity areas will be supported:

- Supporting the preparedness and response to communicable diseases outbreaks through the overall health system strengthening work of the HDF through:
  - Improving communication networks and alert systems for disease outbreaks
  - Strengthen service providers capacity to apply minimum initial service package for reproductive health during emergency (MISP)
- Provision of selected high impact intervention on Non-Communicable Diseases (NCDs), for example:
  - Early detection and treatment of hypertension and diabetes
- Addressing a range of cross-cutting factors that influence RMNCH-A outcomes, for example:
  - Addressing patient, maternal and child rights: ensuring free access to health services.
  - Making birth registration available within health facilities.
  - Addressing violence and abuse - prevention and care
  - Child Marriages
  - Improving geographical access: considering task shifting and task sharing, and paying particular attention to those areas that are performing below target in achievement of key indicators
  - Promoting health seeking behaviour, addressing factors impeding access and acceptance of health services (religious and other socio-cultural groups) through targeted awareness-raising with local leaders and key stakeholders
  - Addressing emerging urban health challenges and those of peri-urban poor, and seeking to disaggregate data from these groups compared to the overall urban population.
  - Childhood disabilities: There will be further support to improve timeliness and quality of antenatal care, skilled delivery, prevention and early treatment of childhood illnesses as key interventions for preventing childhood disabilities. At risk babies exposed to conditions that predispose them to childhood disabilities will be followed up and provided with special care to prevent progression to disabilities. Special attention will be given to early identification of developmental delays and referrals to appropriate community based rehabilitation services. Those who may eventually develop disabilities will be referred to specialized services for rehabilitation.

THEMATIC AREA 2: SEXUAL REPRODUCTIVE HEALTH RIGHTS

This pillar seeks to strengthen availability of and access to voluntary family planning services, especially long acting contraceptive methods (LAM), improve and expand post-abortion care and post abortion FP services, strengthen integrated information and services in MWHs, strengthen cervical cancer prevention. Fistula prevention, treatment and social re-integration will be added. Provision of youth-friendly sexual reproductive health services and scale up of integrated SRH-HIV

services, especially for adolescents and key populations will be strengthened. , It will also support the catch-up as well as the sustainability phase of VMMC. The pillar will also continue to strengthen demand generation and behaviour change communication for key SRH issues, especially through further integrating community interventions for SRH such as Behavior Change Facilitators (BCFs) programme. It will consolidate gains made under the Integrated Support Programme, the Global Programme for Reproductive Health Commodity Security and other SRH programmes. Lessons learned from ISP will be applied through both public and private sector service delivery in the different areas.

2.1 Family Planning

One cost-effective and key intervention in reducing maternal mortality and neonatal mortality and morbidity is family planning. Focus of the programme will be on increasing coverage and quality of FP information and services for hard-to-reach and marginalized populations including adolescents, promoting choice and strengthening method mix, especially to enhance the availability of long acting methods (LAMs) of family planning, including during postpartum and post-abortion periods. In line with the unmet need for spacing among young women and girls and the unmet need for limiting among women above 35 years of age, efforts will be made to make appropriate FP methods more accessible to them. Proposed interventions include:

- Support to implement, monitor and report on the FP strategy and the national action plan.
- Support to strengthen capacity of relevant national institutions to be fit-for-purpose and to effectively lead, regulate and coordinate family planning programmes and services for achieving FP2020
- Provision of family planning commodities and diversifying choices of contraceptives, taking into account specifics in unmet need and diverse age groups.
- Strengthening supply chain management, through support to the DTTU and a transition from push to pull system
- Support to the revision of relevant protocols and guidelines for FP, especially for LAMs
- Supporting FP trainings, complemented by supportive supervision to increase the number of trained and skilled FP service providers at primary health care level, especially on LAM
- Improving access to FP services for HIV positive women by better integrating SRH and HIV services, e.g. increasing FP service provision in OI/ART settings.
- Improving access to a minimum package of high quality youth-friendly SRHR services by young people at health facilities as per the principles of continuum of care. The minimum package, delivery modality and specific targeting of SRHR services will be informed by the ongoing national adolescent fertility study and the ASRH interventions review. Reducing unmet need for FP among adolescents aged 15-19 will require multi-sectoral efforts beyond the health system which are further elaborated in the Joint Programme on Youth currently being developed by the UN agencies in Zimbabwe (see ASRH section).
- Outreach services – to reach closer to the client subject to availability of evidence especially from religious objectors.

2.2 Post Abortion Care

In addition to ensuring that unmet needs for family planning are addressed, post- abortion care services will be focused on in terms of improving the quality of service provision.

With the overall goal of reducing maternal mortality in the country, the focus of support is to 1) prevent abortion through greater investment in programmes for elimination of teenage pregnancy and child marriage complemented by specific family planning programmes targeted towards young boys and girls; 2) advocate to simplify the legal and bureaucratic procedures governing legal abortion; and 3) improve the quality of post abortion care services, especially through:

1. Aligning post abortion care services in accordance with the internationally agreed expanded package of post abortion care[21] that comprises the following components:
    a. Treatment of incomplete and unsafe abortion and complications;
    b. Counselling to respond to women's emotional and physical health needs;
    c. Contraceptive and family planning services;
    d. Reproductive and other health services;
    e. Community and service provider partnership to prevent abortion and respond to abortion needs
2. Revising post-abortion national guidelines
3. Building capacity of health service providers to provide post abortion services (especially on the use of Manual Vacuum Aspiration - MVA)
4. Ensuring the availability of medical supplies, including MVA kits in health facilities

[21] Post abortion Care Consortium Community Task Force. Essential Elements of Postabortion Care: An Expanded and Updated Model. Postabortion Care Consortium. July, 2002

2.3 Strengthening maternity waiting homes services

Building on the revitalization of maternity waiting homes, supported under the EU MDG Initiative, maternity waiting homes services will be strengthened. Key activities will include:

- Scale up refurbishment of MWHs in hard to reach areas
- Enhance the use of maternity waiting homes to link communities with the health system to achieve quality continuum of care.
- Support quality integrated SRH/HIV/GBV information and services at MWHs, especially for adolescents who are pregnant.
- Men involvement and improvement of their role in the Maternity Waiting Homes

2.4 Cervical Cancer Prevention

Based on the success and lessons learnt in the Integrated Support Programme, the MOHCC will be supported to scale up the VIAC based national cervical cancer screening programme and treatment of pre-cancerous lesions. Referral mechanisms to advanced care at tertiary hospitals will be enhanced. The programme will promote integrated SRH service using the VIAC centres established. Key activities will include:

- Development or revision of guidelines and protocols on cervical cancer prevention
- Capacity building of health workers on screening using VIAC and treatment of pre-cancerous lesions with cryotherapy and LEEP
- On the job support and mentorship
- Procurement and distribution of VIAC equipment and consumables to establish additional VIAC services with the aim of at least two hospitals in each district providing VIAC
- Integration of cervical cancer services with HIV, RMNCH-A and FP
- Strengthening linkages with other cervical cancer prevention activities like HPV vaccination
- Strengthening referral mechanisms to advanced

care at tertiary hospitals and addressing barriers to access

2.5 Adolescent Sexual and Reproductive Health

Support to ASRH requires a multi-sectoral response, such as health, education, vocational skills and work with communities. The UN is drafting a joint programme that will act as a vehicle for multi-sectoral engagement around youth development. While the joint program is still to be finalised, the proposed focus is on outcomes such as reducing adolescent fertility and child marriage. The support to strengthen ASRH information and services through the HDF will focus on health sector interventions and the community for improving the overall wellbeing of young people and reducing teenage pregnancies. Specific focus will be on:

- Establishing standards for YFHS based on international/regional standards
- Enhancing skills of health workers in communicating effectively with youth and providing youth-friendly services
- Supporting community workers and gatekeepers to work with youth in communities and facilitate their access to appropriate services, including FP
- Link with HPV vaccination services.

In addition, the SRHR component for adolescent and youth will cut across different thematic areas, such as family planning, HIV, GBV, etc. As new evidence is being generated through the joint review of ASRH interventions and the teenage pregnancy study in 2015, the HDF will support new interventions and innovations for adolescents and youth beyond the three proposed interventions above.

2.6 Obstetric Fistula

Fistula prevention, treatment and social re-integration will be supported. Prevention of obstetric fistula is mainly through improving quality of maternal health care, including EmONC and addressing the three delays. Quality maternal health care is covered under the RMNCH-A thematic area. The overall objective under this pillar is to support treatment and re-integration through increasing availability of obstetric fistula repair services to vulnerable women, and mitigating the effect of obstetric fistula. Key activities will include:

- Refurbishment of theatre facilities to provide obstetric fistula services at selected hospitals
- Obstetric Fistula Camps for affected women
- Develop a training programme for doctors and nurses on simple obstetric fistula repair and post-operative management
- Work with community cadres to increase awareness of available services in communities and among affected women, facilitate access to services and socially re-integrate women following obstetric fistula repair

2.7 SRH-HIV integration

The focus of this area will be on a) roll-out of the service provider SRHR and HIV linkages capacity building to ensure that SRHR and HIV integration is part of day-to-day service provision in both (SRH and HIV) settings, and b) scale-up of an integrated SRHR and HIV linkages model focusing on STI and HIV prevention among pregnant and postpartum women in maternal health services, and building on the current initiatives under the maternity waiting homes.

Key activities

- Strengthening use of maternity waiting homes to link communities with the health system continuum of care, health promotion and SRH-HIV services (ANC, PMTCT, HTC, delivery, post-partum family planning, cervical cancer).
- Strengthening prevention of unintended pregnancies among women living with HIV (prong 2 of PMTCT), and HIV prevention among HIV negative young women in ANC settings (Prong 1 of PMTCT)
- Scale up of an integration model developed under the ISP and Linkages programmes into health facilities at district level including urban facilities

- Service provider capacity strengthening on the syndromic STI and RTI management approach, condom promotion and safer sex negotiation, management of SGBV, provision of integrated youth -friendly SRH and HIV services
- Strengthening service provider capacity to provide stigma-free and appropriate integrated SRHR services to key populations, where indicated in innovative settings.
- Capacity building of managers in facilitative supervision and mentorship

2.8 Voluntary Medical Male Circumcision

HDF will continue to support the remaining catch-up effort of VMMC through private sector interventions in the initial phase of the HDF. Meanwhile, to ensure continued availability of VMMC services beyond the catch-up phase, capacity of the public health system will be strengthened to provide surgical and device-led VMMC services to targeted males, based on national policy and strategic recommendations. This requires

- Support for national programme coordination
- Support for policy development and stakeholder engagement especially the education sector
- Integration of VMMC into male-friendly SRH and other PHC services as well as PNC for EIMC (to be determined based on currently outstanding policy decisions)
- Training and refresher training of health workers in all districts including urban areas
- Support for quality assurance and cascaded supervision
- Maintaining functional referral systems for adverse events
- Replacement of reusable instruments and where indicated procurement of devices
- Mass media for demand generation for MC during the transition period from private sector to public sector delivery models
- Support for generation of evidence as well as modelling based on emerging information

2.9 Gender Based Violence

Similar to ASRH interventions being multi-sectoral, the support to eliminate GBV will be provided through a multi-sectoral GBV prevention and response programme. The programme will focus on elimination of sexual and gender-based violence as well as child marriage through 1) improve GBV and child marriage prevention mechanisms; 2) strengthen access to and availability of integrated, comprehensive and survivor centered GBV services; 3) strengthen GBV multisectoral coordination and 4) enhance monitoring, evaluation and knowledge management. Key interventions include the following.

- Support the Ministry of Women Affairs Gender and Community Development to coordinate a multi-sectoral gender-based violence prevention and response programme at national, provincial and district level, with special attention to sexual violence and child marriage. It will promote three Ones through strengthened coordination, namely, One GBV response framework, One GBV coordinating body and One M&E framework;

- Further integrate prevention of gender-based violence and child marriage in community-based demand generation programmes with community leaders, faith-based organizations and other community gate keepers.
- Seek opportunity to integrate prevention of GBV and child marriage in the comprehensive sexuality education programme for young girls and boys and the newly launched parent-to-child communication programme.
- Support the national campaign to end child marriage including enhanced advocacy for policy change and alignment and enforcement of age of marriage to the new constitution.
- Build the capacity of national institutions, mechanisms and civil society organizations to provide quality, integrated and survivor centered services as per national guidelines, which include but not limited to legal aid, police and health services.
- Support will be provided to strengthen and scale up one-stop centers and community shelters for integrated services, integrate GBV and SRH services in Maternity Waiting Homes, and integrate GBV services for key populations. The programme will scale up support to capacity building of service providers in the referral pathway on the survivor centered principles and approaches. It also aims at fostering team spirit among service providers to enable a coordinated and seamless referral process, guided by the same principles. The programme will strengthen collaboration and build capacity among police and judiciary to improve survivors' service access and case management including improved access to legal abortion;
- Health sector response which was lacking in the past will now be scaled up. Key activities include, among others, capacity building of health care workers in clinical care and management of GBV including sexual violence with the aim of making the services available at least in each district and provincial hospital; Sensitization of Health workers at primary health care centres, including local government clinics on screening for GBV and making appropriate referrals; Provide support to establish/enhance One Stop Centre at provincial hospitals; Strengthen the referral pathway to enhance integration of services in health facilities through training and mentorship; Support procurement of essential commodities such as pregnancy and HIV test kits, PEP kits; and Strengthen routine M&E system in reporting cases of GBV in health sector through reviewing existing tools and then providing capacity building to address gaps.
- Last but not least, the programme will build the capacity of national institutions, mechanisms and civil society organizations to monitor the national gender-based violence strategy with a focus on confidential data management and harmonized data collection. It will also support the Ministry of Women Affairs and Gender to strengthen knowledge management on GBV through training, research and regular dissemination of programme results and experiences.

2.10 Community interventions

Community interventions under the SRHR theme will aim at generating demand for HIV & SRH services and creating an enabling environment for service uptake especially for young people and key populations through existing community based cadres[22].

The HIV&SRH community interventions will include:

- Continuation of the home visit approach implemented under the ISP, with additional emphasis on reaching young people
- Support for task shifting and community-based service delivery of key SRH services through the community cadres engaged in home visits.
- Enhanced outreach and mobilisation for key populations, especially young sex workers, combined with appropriate models of service delivery and programme evaluation.

[22] A study to map community cadres across health and GBV interventions is under way and will make recommendations towards a comprehensive community systems strengthening approach. Currently proposed roles of community cadres will be revised based on the findings of the study.

- Engagement of community leaders as agents of change through training and promoting their active leadership in reducing cultural and social access barriers to SRHR service uptake.

The HDF will facilitate dialogue and programming with concerned Ministries which host different community cadres with an aim to integrate community workers through one service package for RMNCH-A, one coordinating body, one budgetary framework, one performance management system and one M&E system to achieve efficiency and effectiveness of voluntary health extension workers in the communities. This will influence the design and implementation of pro poor health policies.

2.11 Advocacy work

Advocacy interventions around all aspects of SRHR but prioritizing child marriage, access to legal rights for SGBV survivors, and improving service access for young people and key populations have been ongoing and will continue under the HDF involving partners such as the National AIDS Council, MOHCC, MWAGCD, and civil society. Support will be provided to work with law makers as well as judiciary, police and health service providers, complemented by interventions at community level targeting gatekeepers such as traditional and religious leaders.

THEMATIC AREA 3: MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES (MEDICINES AND COMMODITIES)

The objective for Thematic Area 3 still remains 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. Reproductive health commodities will be included.

Medical products, vaccines and technologies (medicines, blood products, health commodities including nutrition supplies) will continue to be a main area of support in the consolidation phase. Although much of the infrastructure and equipment is already in place there is need to support their service and maintenance, linked to the Results-Based Financing mechanism that is being rolled out since mid-2014. Selected medical equipment will be procured only in case of acute shortage, as most of the supported health facilities at primary level have already been equipped to provide basic RMNCH-A and nutrition services under the current HTF and other UNICEF interventions (including EmONC, neonatal resuscitation and newborn corner equipment (including kangaroo care), walk-in cold rooms, programme vehicles, solar refrigerators, quality assurance and testing equipment, bicycles for Village Health Workers). Apart from the procurement of vaccines, the GAVI support through the HDF will be utilised for supporting EPI cold chain, logistics and other equipment, as well as their routine maintenance.

UNFPA will continue to support medicines and commodities for programmes such as the Maternity Waiting Homes (refurbishment), the H4+ (maternal health drugs, MVA kits and other equipment e.g. anaesthetic machines) and the Global Programme for Reproductive Health Commodity Security (family planning commodities, oxytocin and magnesium sulphate). Additional commodities to be procured through UNFPA will include STI medicines stipulated in the revised national guidelines on syndromic management of STIs and Reproductive Tract Infections (RTIs), but have not traditionally been included in the primary health care kit.

The main objective for the next phase is to ensure the current high levels of availability of essential supplies is maintained, and a more efficient and appropriate supply chain mechanism is established.

Key activity areas include the following:

- Explore the possibility of a single harmonised supply chain management system for the country.
- Continue the procurement of essential medical products, vaccines and technologies (medicines, nutrition commodities and consumables
- Support the ongoing transition from a push to an assisted pull system of ordering of medicines and

other commodities, following up on the results of the pilot implementation in Manicaland and scaling up good practices across the country

- Consider expanding the current bulk items to provide adequate amount of EmONC medicines and consumables, and second line and emergency maternal and paediatric drugs that are required to manage critically conditions for both the mother and the child.
- Encourage further linking and integration of HIV-related services to the general health system and facilitate a comprehensive approach to antiretroviral supplies and overall health of mothers and children
- Strengthen forecasting, procurement, storage and distribution and monitoring of RMNCH –A drugs, vaccines, blood products, health and nutrition commodities.
- Strengthen Logistics Management Information System (LMIS) and reporting for all health commodities
- Strengthen product selection, forecasting, procurement, storage and distribution and monitoring of RMNCH –A drugs, vaccines, blood products, health and nutrition commodities.
- Strengthen Rational Medicines Use, Rational Blood Use and Rational Nutritional Commodities Use.
- Support the ongoing quality assurance activities including pharmacovigilance, reporting on adverse drug reactions (ADRs) and adverse events following immunisations (AEFI).

THEMATIC AREA 4: HUMAN RESOURCES FOR HEALTH (HRH) (INCLUDING HEALTH WORKER MANAGEMENT, TRAINING AND RETENTION)

With an economy that is still ailing and with no immediate likelihood of wage increases, it is clear that the critical staff retention scheme will remain as another major area that requires support to ensure adequate numbers of appropriately trained staff are in place. The possibility of financing the HRH retention packages through RBF is an area the government and partners may wish to consider, with a view to developing a more cost effective system.

There will be less focus in future on the in service training of midwives, since the 'manageable quota' for midwives has almost been reached in the current HTF. Similarly, there will be less focus on the training of prescribers on clinical IMNCI, and any further gaps will be filled by WHO and other partners. However, a national assessment of remaining training needs is required in order to assess overall progress to date, so that remaining priorities are identified and only specific targeted needs will be addressed in the extension phase.

Therefore, the key objectives of the next phase will be to ensure that the current trend in reducing vacancy rates is maintained and improved, and that health staff are able to provide a minimum level of quality of care that is regularly assessed.

Key activity areas include the following:

- Completing the Workload Indicators of Staffing Need (WISN) assessment and support implementation of findings within the national Human Resources planning framework and the revision of the national health strategy.
- Reviewing of the approach to post-basic, in-service training at national level so that there is a nationally coordinated, provincially implemented training programme covering all appropriate subjects; it should seek to ensure appropriate numbers of adequately trained staff at all levels while minimising duplication, time away from station, and concentration of knowledge in a few cadres.

- In consultation with the schools or universities, effort will be made to incorporate the in-service training into pre-service training and revision of curricula to include changes and new developments in RMNCH-A and SRHR.
- Ensuring continued retention of key staff and increase dialogue for fiscal space for government contribution.
- Supporting the current review of the retention system at national level to ensure a gradual move towards a sustainable, comprehensive, nationally driven, equitable system of provision of fair wages and benefits to all health workers driven by the Government of Zimbabwe. This will include and will not be limited to consideration of what can be reduced, increased or phased out. This will ensure that there is more value addition to the investment. Consideration of linking with thematic area 5 on the possibility of paying for staff based on performance will also be explored.
- Ensuring adequate mentoring to health staff and regular supportive supervision to health facilities.
- Mentorship programmes will continue to be supported on all thematic areas and include all levels of service delivery, from community level to referral centres. During the first year of the implementation of the HDF a Cost Benefit Analysis which includes quantitative and qualitative analysis of the benefits attained by the Programme will be conducted.

THEMATIC AREA 5: HEALTH FINANCING (RESULT-BASED FINANCING AND OTHER INNOVATIVE HEALTH FINANCING MECHANISMS)

The objective for this Thematic Area is to improve national capacity for health financing across all health service delivery levels with special emphasis on the most peripheral health facilities, primary health centers and district hospitals.

The current HTF provided funds to RHCs and District Hospitals on a regular basis, but introduced a RBF approach for RHCs in mid-2014. As this mechanism is still in the process of being established and tested across the country, building on the experience in 18 districts supported by the World Bank. In consultation with World Bank, the next phase will need to ensure that an effective and efficient system is in place. It is proposed that, whilst support will continue to be given to other non-staff running costs at the primary and first referral levels through the RBF system, this subsidy should be focused on the Primary Care facilities. The extent to which the use of these resources is performance related, and at what level, requires further consideration including consistency with overall RBM and Health Financing policies.

At the rural clinics there is almost full coverage of free services but patients referred to the higher levels still have to pay for these services. The full removal of user fees continues to pose a challenge for higher level facilities since the available funds are not sufficient to cover their running costs. This issue still needs to be addressed. A voucher mechanism is proposed as a possible solution for referrals. Notwithstanding the Government policy, Urban Health Centres are more likely to charge fees. However, where there are pockets of vulnerable populations within the urban and peri-urban centres, innovative ways could be used to address accessibility issues.

Key activities include:

- Use the findings of a process evaluation to be conducted in 2015 on the current PIM to improve the implementation modalities of the RBF and also possibility of implementation of RBF in the district hospitals and the referral chain.
- Enhance the RBF mechanism in RHCs including closing the gaps in training at all levels based on the RBF Project Implementation Manual and the disadvantage of low volume and remote clinics.
- Considering performance-based strategies for other funding support, e.g. District Health Executive Teams, Provincial Health Executive Teams
- Ensuring adequate learning from the RBF experience to inform a future plan for performance-based strategies in the health sector

- Supporting the overall approach of government-led Results Based Management (RBM) and Health Financing.
- Consider a voucher system for referrals from clinic level and building on lessons learnt from existing voucher systems in the country, for example the World Bank RBF project.
- Use RBF to influence priorities and continuously review indicators that it rewards.
- Linking RBF to strengthening community participation component so that there is disclosure of resources to communities, progress on the use and future ambitions.
- Consideration for phasing of out RBF from being managed by external partners to be managed within the Ministry of Health and Child Care thus making RBF more sustainable.

THEMATIC AREA 6: HEALTH POLICY, PLANNING, M&E AND COORDINATION

The cohesion and coherence of direction achieved through the HTF needs to be continued, and if possible extended across the whole health sector. The leadership, coordination and accountability aspects of these arrangements need to be strengthened at the provincial level and below through the full restoration of effective Provincial Health Team (PHT) and District Health Team (DHT) arrangements, and such strengthening of management at these levels that will permit increased delegation from the national level. Thus, the key objective of this thematic area is to ensure comprehensive and inclusive governance of the health sector with an appropriate level of decentralisation established and accountability mechanisms

Key activities

- Providing technical support to the MoHCC to generate the necessary evidence in order to develop evidence based strategic and annual work plans
- Support provided to further strengthen the routine Health sector M&E system, to strengthen the routine HMIS (DHIS-2), PMD generic report, National MODO and provincial review and planning meetings, and the annual joint review missions.
- Providing support to a full programme of PHT and DHT Meetings
- M and E planning and consolidation of the different M and E strategies within the Ministry
- Data generation including the linkage of DHIS and the RMNCH-A scorecard
- Support for the national task force teams which have a direct influence to RMNCH-A and provide guidance to good governance in the task forces
- Revision of policies, strategies and guidelines as guided by the 2016-2020 National health strategy e.g. HR, Health Financing, Quality Assurance and Improvement strategies, RBF national guidelines
- Revise the current Vital Medicines and Health Services Availability Survey to include the SRHR commodities and to make the survey more relevant in the HDF.
- Coordination of the supply chain management and data generation.
- Consolidate the quality improvement, quality assurance and infection control activities as guided by the national health policy and strategy for quality in health.

The progress so far achieved, for the women and children's health status indicate that any further progress will require more support especially in supervision, quality standards and monitoring. It also requires that the health facilities and the health system be robust, with a two way referral system at each level of the health system and identifies the most efficient ways and new ways of doings things. Technical support and innovation as described in the subsequent section will be critical to achieve this.

THEMATIC AREA 7: TECHNICAL SUPPORT, OPERATIONS RESEARCH AND INNOVATION

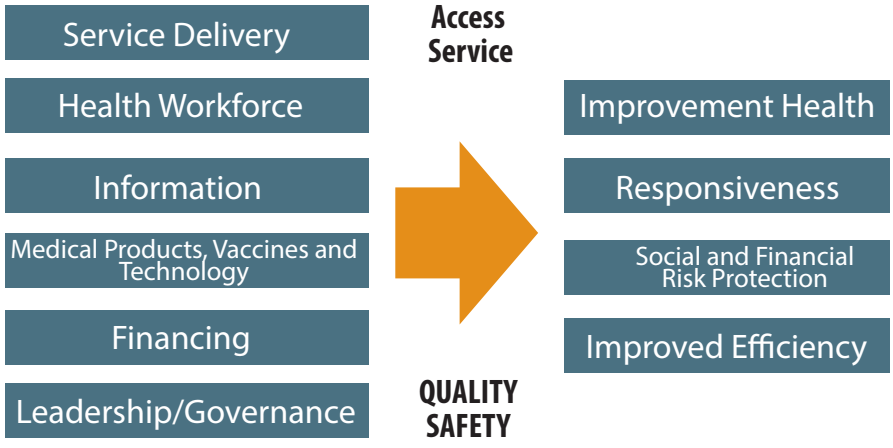
It is envisaged that a small flexible fund will be available to support improvement in key aspects of health service delivery with a commitment to reduce mortality and morbidity particularly in the "hardest to reach" client groups and geographical areas. This fund will support technical assistance and vanguard implementations and evaluation. The fund will be available to government and non-government organisations and may also be useful in schemes that will help to maximise the impact of health services funded through other initiatives (e.g. HIV / AIDS; TB; Water and sanitation projects; etc.) including spatial mapping of partnerships.

Key activities:

- Support interventions to address issues and recommendations arising from Joint Review Missions.
- Provide support in the design and roll out of operational research on key RMNCH-A areas where there is paucity of information to facilitate innovative responses and approaches
- Provide technical support to generate evidence base from local and global sources that can be used for policy dialogue
- Innovations around inter-sectoral collaborations and building of synergies in line with HDF objectives
- Provision of short term technical assistance for key areas
- Facilitate the development of Public-Private Partnerships
- Incentivise and reward innovations
- Operations research on linking health care financing policy and RBF
- Innovative approaches to learning and mentorship, e medicine, e-learning.
- Design methods and ways of reaching the populations in peri-urban settings.
- Setting up a near real time monitoring system under the Multi sectoral Community based programme to reduce stunting.

Health Systems Blocks

It should be noted that the thematic areas seek to follow the health systems blocks as given by WHO with thematic area 1 and 2 being the services, thematic area 3, covering the medicines and technologies, thematic area 4 covering the Human resources for Health, thematic area 5 covering Health Financing and Health Information strengthening, thematic area 6 for leadership and governance and thematic area 7 for information.



The WHO Health System Framework

Source: Adapted from the World Health Organisation

CHAPTER 5

Cross Cutting Issues

Across these thematic areas, there will be specific attention paid to:

Focus on Quality: In spite of the quantitative improvements that the health sector has documented over the last two years, improving effective quality coverage still remains as a major challenge. Therefore it will be important to focus on consolidating the gains realized so far in order to improve the quality of health services provided to the community. There is need to start focusing on targeted capacity building of government, with particular emphasis on improving the knowledge, attitude and skills of health and administrative workers at the district and provincial hospital level through on the job training, clinical/ technical mentorship and regular supportive supervision. At the primary care level, there is a need to accelerate progress in training PCNs to address the quality gaps observed in ANC/PNC services. This process has started and needs to be fully implemented and consolidated. The attitude of health workers has been presented as a major concern in several annual review meetings and at this juncture this requires urgent attention. To begin with, it may be wise to start providing an in-service training on medical ethics and professional orientation to all practicing health workers and administrators at all levels. This would be complemented by the strengthening of HCCs, client satisfaction assessments, and the use of community accountability mechanisms, such as the community score cards.

Focus on Equity: The health system still needs to address the disparities due to: geography, wealth, religion and other socio-cultural factors, and age. There is limited geographical access to health care for certain communities due to distance, terrain/rainy season. Most of the service coverages are lower in rural areas as compared to the urban areas. User fees at the different levels of health care limit access to health care for poor people who are not able to pay. The problem of religious and other socio-cultural objectors to health services continues to persist, especially among the Apostolics who constitute about 30% of the population. There are inadequate specially designed services for new-borns and adolescents who are the most vulnerable and underprivileged and are the greatest contributors to morbidity and mortality. Therefore it will be imperative to design a tailored health service delivery system to address those sections of the society through: task shifting/sharing, strengthening the outreach programs, designing a more responsive and innovative health service delivery system for new-borns and adolescents and for the religious objectors. Most importantly, abolishing user fees for pregnant women and children of less than five years will be desirable. While this has been largely achieved at the primary care level, fees are often still charged at higher levels in the referral chain which is a major deterrent to seeking further care.

Continuum of Care: Disparities have been observed in coverages of interventions across health service delivery levels as well as across the life cycle. Although the lower health facilities usually provide fewer services in terms of quantity and quality for various reasons including; human resource gaps, skills gaps, attitude gaps among the different levels, there is a realisation that the peri-urban poor communities have limited financial access to the urban and tertiary health facilities, and are resorting to other unorthodox care seeking behaviours. For similar reasons, clients referred from the lower health facilities for tertiary care do not comply because they are usually required to pay for services at these facilities. Therefore, it may be necessary to extend the support from the HTF to urban and tertiary facilities so that the free maternal and child care policy can be effected at these levels as well. There is need to further explore other mechanisms to mitigate the effect of user fees at the referral centres, including the possibility of using vouchers for referred clients. Similarly, the current implementation of community level interventions remains weak, and needs to be strengthened to improve the coverage of evidence-based cost effective interventions to complement the facility level interventions. Across the life cycle, it has been observed that newborns and adolescents who contribute significantly to infant mortality and maternal mortality respectively, are not receiving adequate health care the along the continuum of care, and therefore need to be prioritised. It is also necessary to work on program integration, to be more effective and to obtain better value for money. Integrating training and service guidelines, developing comprehensive supportive supervision tools, and providing integrated RMNCH-A services are some of the areas whereby program integration can be realized.

Further strengthening of infrastructure: Most of the health facilities lack reliable water supply and sanitation facilities, and electricity, and this could be included as another possible area of further support, although there is scope to coordinate better with other sources of support and funding; for example, through WASH activities and through Global Fund and GAVI support for health systems strengthening. In addition, strengthening communication and the referral system across all health service delivery levels, including with the village health service program is necessary. The use of solar energy could be scaled up through partnerships with the private sector and NGOs.

Community strengthening: Further strengthening of the role and operation of Health Centre Committees will be an important focus in the next phase so that health care providers are held to account but also supported in their work, and form stronger links with the communities they serve.

Gender: The HDF will focus on:

- Promoting gender equality and women and girls' empowerment through a national scale programme that alleviates barriers (including fees) to health care in pregnancy as a critical factor in girls' vulnerability and inequality in society
- Men's role in RMNCH-A (such as through male champions) is emphasized
- Gender sensitive training for male and female community health workers including skills to tackle social issues facing women, and communication skills to support good maternal nutrition and exclusive breastfeeding
- Gender-based violence and sexual violence are recognised as public health issues, and a child protection priority affecting girls, boys and women, requiring support for forensic examination recognized by the courts, access to treatment for HIV, emergency contraception and referral for welfare and legal services
- Ensuring age and sex disaggregated data in all stages of the programme cycle (analysis, implementation, monitoring, and evaluation) wherever required
- Cultural and Religious beliefs on early marriages and non-use of contraceptives that will increase the spread of HIV and AIDS, pregnancy complications to young women, psychosocial challenges and human rights abuses.

Environmental conservation and Waste Management: Assist the sector to improve its waste disposal systems.

CHAPTER 6

Feasibility, Risks and Value for Money

A summary matrix of the risk management strategy is provided below. The existing strengths of the Zimbabwe Health system should be noted as important foundations for the feasibility of this programme. These include:

(a) Key government planning documents and strategies are in place

(b) A strong network of health partners exists in Zimbabwe working to improve the health sector

The risks to the programme will be addressed by the HDF partners, UNICEF and UNFPA.

	Risk	Probability	Impact	Mitigation Strategy
1	Increased political uncertainty could lead to disruption of Programme implementation.	Low	High	The UN and HTF donors have been able to maintain good relations with the MOHCC during previous instability and will continue to engage in regular dialogue. The UN will continue to support service delivery even during periods of crisis, as proven during 2007-9. The UN system will apply risk mitigating measures[23] to continue support should political uncertainty lapse into political instability.
2	Deterioration in the economy, resulting in further reduction in government contribution to the health sector.	Medium	High	The HDF will support the core functions of the health system. The development partners and the UN will continue to advocate that the Government of Zimbabwe allocates more resources to health sector. Utilize the national policy advocacy of CSOs under community accountability theme.

[23] The UN system uses an Enterprise Risk Management system that clearly defines the risk levels for all its operations in the country.

	Risk	Probability	Impact	Mitigation Strategy
3	GOZ fails to implement required health reforms, in particular elimination of user fees by facilities in the urban areas and referral facilities.	Medium	Medium	The DPs, UN and civil society will advocate for GOZ to provide funding to the urban and referral facilities so that they are able to offer free services. The HDF will pursue the use of voucher system for referrals to higher level facilities.
4	GOZ fails to implement required health reforms, in particular implementation of the recommendations that will come from the WISN study	Low - Medium	Low	
5	Further outward migration of Human Resources for Health.	Low	High	HDF will support strategic HRH management and reform including workforce planning and review of the retention scheme to ensure that incentives target key cadres of health sector. HDF will continue to strengthen policies for retention of midwives, and training of cadres willing to provide services in the hard to reach populations of the country. HDF will continue to support RBF, retention scheme, reliable supplies, and improved supportive supervision which will increase staff motivation.
6	Government institutions have limited capacity to implement programme components effectively	Low	High	Targeted technical assistance and capacity building will be built into the HDF.
7	Persistent low utilisation of services by religious and other socio-cultural objectors.	Low - Medium	Low	Targeted community mobilization, engagement with opinion leaders, and gate keepers, targeted outreach services. HDF will support operational research to understand and address the barriers to access for these socio cultural groups.
8	Corruption, fraud and misuse of funds	Low	High	The UN's financial controls and accounting procedures will be applied to provide adequate safeguards. Make use of hybrid social accountability tools to root out corruption through the community participation theme.

	Risk	Probability	Impact	Mitigation Strategy
9	Overall costs of procurement of goods and services escalate beyond reasonable levels.	Low	High	The UN will apply the comprehensive procurement process which aims at procuring the best services and goods at the best cost across local and global markets.
10	Insufficient funding to cover all the HDF pillars.	Medium	High	The HDF will advocate for additional funding by other partners, and will encourage more donors to join the fund.
11	Industrial action or strikes by the health workers	Low	High	Assessment and clarity on the salaries, retention allowances and remaining transparent in the different programmes. Advocacy for adequate remuneration for the staff
12	Negative publicity on public health interventions, e.g. Immunisation, key populations, mass drug administration	Low	Medium	Capacity to anticipate and respond to these reactions. Orient media for anticipated events, prepare fact sheets in readiness to response, and prepare media response, training media on reporting on health.
13	Transition of supply chain management systems	Low - Medium	Low	Careful planning, close monitoring, contingency fund to close the gaps
14	Adverse weather conditions and natural disasters e.g. el nino leading to disruption of services or increase in malnutrition	Low	Medium	Disaster and risk management and preparedness, multi sectoral responses at both national and community level.

VALUE FOR MONEY

The HDF is building on the successes and lessons learnt from two major programmes which were implemented between 2012 and 2015 (HTF and ISP). Both programmes ensured that they had value for money precepts in them i.e. economy, efficiency, effectiveness and equity.

For the HDF these will be addressed as follows:

Economy

UNICEF and UNFPA will be responsible for procurement of essential medicines and equipment in the HDF. This will build on UNICEF's track record of procurement for the HTF Medicines. UNICEF uses competitive tendering processes to obtain value for money in procurement of drugs and commodities. Procurement of goods and services under the HDF will be done in accordance with UNICEF's procurement rules.

UNICEF and UNFPA will use its regular competitive procurement process for sub-contracting additional implementing partners. There is a wide range of research institutions, private sector companies and non-government organisations in Zimbabwe, which could respond to any competitive procurement process initiated by UNICEF, in order to ensure competition on cost and innovation in delivery.

Efficiency

The HDF will mobilise additional resources for the National Health Strategy, ensure coordinated use of resources, and reduce duplication of efforts and transaction costs for donors and the MOHCC. The HDF will strengthen alignment of donor support for national priorities, and allow restrictions that some donors may have on funding government staff, technical assistance, incentives or capacity building. The HDF is also in line with Paris Declaration on aid effectiveness principles of harmonisation and alignment.

The procurement of medicines and commodities by UNICEF and UNFPA will have the economy of scale advantage as they will procure almost the national requirements for the country. This will have the potential of generating savings which can be ploughed back into the Programme.

Effectiveness

The pooled fund will allow national-scale health services delivery to continue in critical areas despite the political context. The mechanism provides strengthened capacity in government to take on sector budget support should the situation improve, while mitigating risks. The activities to be funded by the HDF will be directed by the national health strategy and implemented using national guidelines thus ensuring the resources are used to support country priorities.

UNICEF and UNFPA will establish baseline data and monitor unit costs at the key levels of the value for money results chain.

Financial and value audits will be undertaken within the UN parameters of internal audits. The terms of reference for the external evaluator of the HDF will include consideration of value addition and value for money.

Equity

The Programme is based on a situational analysis which has reflected the gaps in access and quality of health services for the mother and the child especially for RMNCH-A activities. The focus of the HDF is to provide equitable services particularly to the hard to reach and to districts performing below expected targets.

The thrust of the value for money under the HDF will be on preservation of the gains which have been made by the earlier programmes. If these gains are not sustained they will be eroded. Any other Programme which seeks to support the health sector will have to start from where the other two programmes started in 2012. Currently there is limited fiscal space for the government to take over and fund the activities which have resuscitated the health systems for the country and improved the well-being of the Zimbabwean communities.

The framework and indicators for the VFM will be developed and adopted before the start of the HDF.

CHAPTER 7

Monitoring, Evaluation and Reporting

A robust and realistic program monitoring system in support of the Health Development Fund (HDF) is essential for successful program management and implementation. The HDF will be monitored using the logical framework given in Annex 3. This reinforces evidence-based management principles, and empowers health sector managers at District, Provincial and National levels to collect and use data to track results and improve services. The framework identifies key questions to be answered, the data to be collected at specific points in time, and guidance on processing and analyzing the data.

The logical framework will further be refined to align with the National Health Sector Strategy. The indicators will be prioritized and rationalized by identifying most critical indicators (tracer indicators), thus ultimately reducing them to a manageable number. The cross-cutting issues (gender, social-equity, etc.) will be included in the log frame and gender disaggregation in some of the indicators will be incorporated.

An M and E framework will be developed with the operational work plan. These will have clear timelines and milestones and should be ready before implementation starts. The purpose of the HDF M and E framework will be to monitor implementation progress and provide continuous feedback to the MoHCC and HDF Steering Committee in order to strengthen, refine and improve program implementation. This will be done using indicators tracked through DHIS II and administrative reports. The framework will ascertain whether program objectives are on track, annual targets are being reached, services are reaching the target groups, will also identify any geographic variances, and assist HDF and health sector managers to identify and ameliorate implementation problems, making necessary changes to increase efficiency and effectiveness.

HDF monitoring will involves the following steps:

In principle there is no parallel monitoring structure which is specifically designed for HDF. The HDF will use the existing M&E system of the health sector. It will also continue supporting the national monitoring system and further strengthening the routine HMIS. The HDF has got a logical framework (see Annex 2). The sources of information and data to feed into the logical framework will include:

- **PMD's report, HMIS and other administrative reports**

  The main data and information sources are: the monthly PMDs report and the routine HMIS. The PMDs monthly reporting format will be further improved to capture the information on HDF implementation status,

including achievements challenges and opportunities. Within the existing HMIS core indicators, those relevant to monitoring HDF implementation status will be extracted regularly and analyzed.

- **Vital Medicines Availability and Health Services Survey**

  These health facility based surveys are conducted quarterly to assess the status of medicines and supplies and services. The current VMAHS will be revised to accommodate SRHR, commodities and services and the indicators that are tracked by the system and find ways of linking this survey to the DHIS II system.

- **Reports of Bi- annual and Annual review meetings**

  The HDF annual implementation plan will also be monitored using the routine 6 monthly and annual "plan and implementation review", also known as the "MODO," which is conducted by the Planning, Policy and M&E Department of the MoHCC.

- **Reports of a Joint Review Missions (JRM)**

  Once a year, a Joint Review Mission composed of HDF Steering Committee members and other relevant stakeholders will be conducted as part of the quality assurance system. Joint Review Mission members will be divided into different groups and go out to all provinces of the country for a minimum of three days each to assess the HDF implementation status. JRM members will visit randomly-selected health facilities and will also conduct desk reviews with MoHCC health management officials at different levels. A standard check list will be utilised and the findings of the JRM will be shared at the annual planning and review meeting by the HDF coordinator.

- **Regular integrated supportive supervision**

  Moving from traditional, hierarchical supervision systems to more supportive ones requires innovative thinking, national buy-in, and time to change attitudes and practices. A cornerstone of supportive supervision is working with health staff to establish objectives, monitor performance, identify and correct problems on-site, and proactively improve the quality of service through mentoring and on-the-job training. At each level of health service delivery a supportive supervision team will be formed with a specific task using the standard quality check list that the MoHCC has developed.

- **Annual Reviews, Mid-term review and Final Evaluation**

  On an annual basis the HDF will be reviewed. Midterm Review and a final evaluation will be conducted by an independent evaluator in the second half of 2018 and 2020. These reviews will use data from MICS 2018 and ZDHS 2020. Information from the reviews will provide guidance respectively for planning the second half of the programme and its impact.

  Targets for the HDF have been set in consultation with the Ministry of Health and Child Care, in alignment with the Health Sector Strategic Plan which is currently being developed. While aiming high, due considerations have been made for committing to realistic and achievable targets, within the confines of financial and human resource availability and other enablers such as a conducive policy environment and ongoing efforts to combat the negative influence of religious and other socio-cultural objectors.

Reporting

A reporting plan will be developed to outline key reporting events in the HDF cycle. The plan will include annual reporting to donor's quarterly HDF Steering Committees updates, as well as joint and independent reviews. UNFPA will submit to UNICEF a report on thematic area 2 and the other related areas, for consolidation in the annual report for the HDF. All contributing donors will receive one consolidated annual narrative donor report each year covering the period in any one year up to 31 December. This annual narrative donor report will include an annexed annual financial utilisation report which will follow the format set out by

the current HTF reporting format. Templates for the HDF annual report as well as for the quarterly HDF Steering Committee updates will follow the current HTF format. Each report will be drafted by UNICEF in consultation with MoHCC, UNFPA and key stakeholders.

In addition to the reports generated within UNICEF with inputs from UNFPA, the Mid-Term Review, independent evaluation, regular joint review mission reports will be consolidated and disseminated by UNICEF.

Ensuring visibility of the HDF and its partners through communication and advocacy.

A comprehensive communication strategy and plan to maximize the visibility of the HDF interventions, demonstrate the program's vision of change and highlight its positive results achieved in improving the health system in Zimbabwe will be developed. The strategy will continue to provide a coherent overview of HDF support to the Zimbabwe health sector as the transition is made from the Health Transition Fund to Health Development Fund. It will aim at improving the knowledge, perceptions, and practices of key target audiences with regards to the programme objectives by:

- Sharing with program stakeholders and beneficiaries a common vision and understanding of the program goals, objectives, and expected results;
- Actively mobilizing program stakeholders and beneficiaries to support and engage with program activities;
- Sustainably adopt and apply new processes, protocols and behaviors promoted by the program;
- Promoting increased government of Zimbabwe engagement and capacity to implement and sustain project activities in future.
- Sources of funding to be acknowledged in all communication and advocacy which makes reference to the HDF.

Target audiences will include:

1. The government of Zimbabwe policy makers, managers and service providers - focusing on both National and Decentralized levels
2. Development partners and donors to the health sector
3. Direct programme beneficiaries and the general Zimbabwean public;
4. Audiences abroad to provide a balanced view on HDF development in Zimbabwe
5. The media for behavior change communication.

In addition to this it will make a concerted effort to bring visibility to the whole sector and include other partners who are working in health but not necessarily in the same areas as covered by the HDF.

Each target audience has different stake/level of interest in the HDF programme and the content and tone of communication materials developed will be tailored to address key messages to each audience. Various media channels will be used including popular social media, print media, TV and radio, technical and policy briefs. Other channels will be considered as deemed appropriate for the message. As well as taking advantage of high profile national events, HDF will organize special launch events, exhibitions and press conferences. Messages will also be developed as stickers on materials supplied by the HDF. A specific visibility five year plan for visibility will be developed in the first six months of the HDF implementation.

CHAPTER 8

Programme Management[24]

It is proposed that the Health Development Fund will mainly be a multi-donor pooled fund. The HDF will provide support across the full range of health services whilst continuing to provide key support to RMNCH-A, SHRH and nutrition services, and enhance equity in health care availability. The focus will be on consolidating the gains made at the primary care level and in district hospitals, with a possible move to selected support at provincial level. Development partners will be encouraged to apply the majority of their health sector support to a pooled fund under the guidance and leadership of the Ministry of Health and Child Care and all other partners with the same objectives willing to work under one strategic plan, one coordination mechanism and one monitoring and evaluation plan. The MoHCC will build on the success of the current HTF Steering Committee and establish a HDF Steering Committee that incorporates representation from all key stakeholders (whether pool funders or not).

The modalities of governance are indicated in the box below.

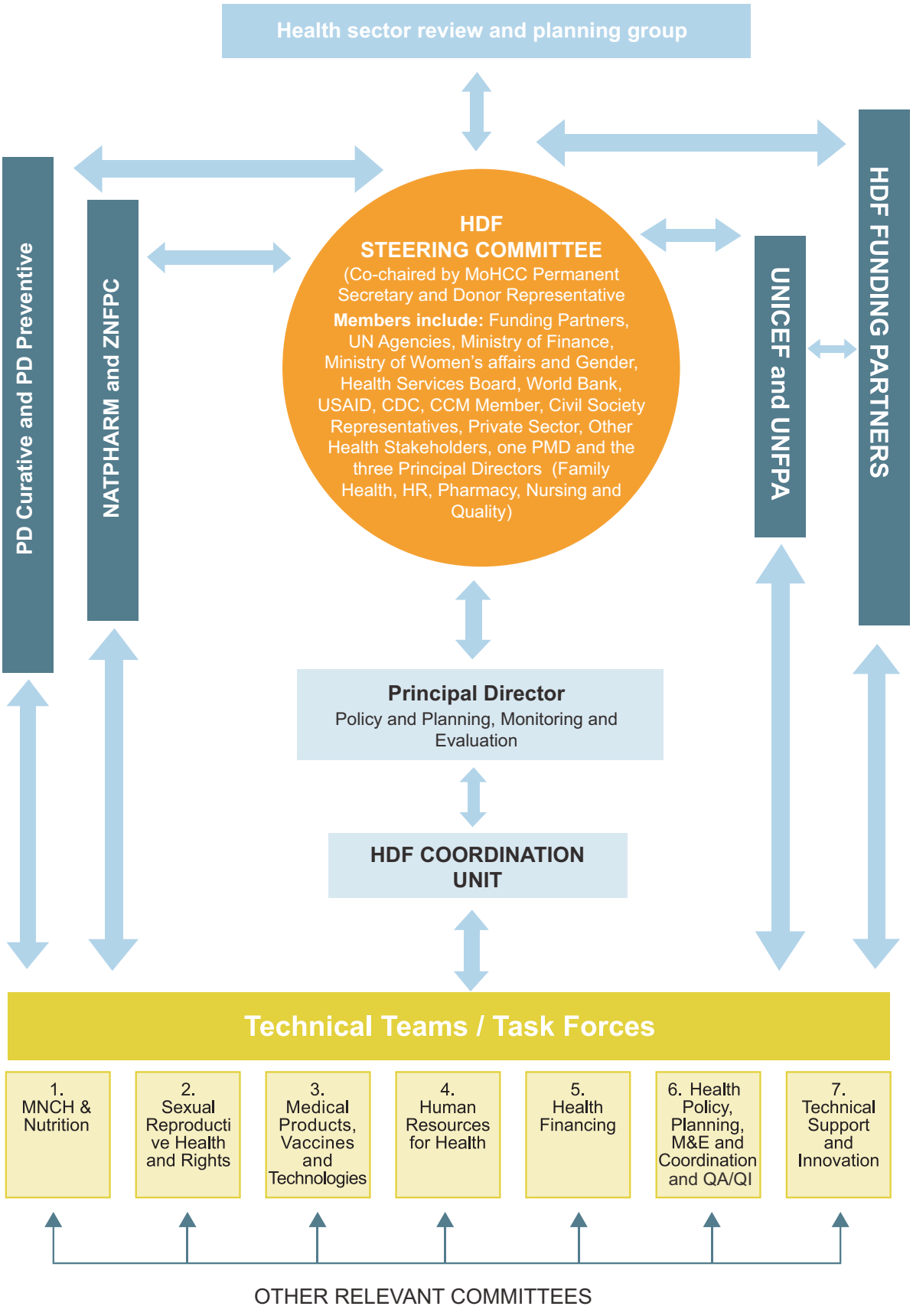
ENSURING TRANSPARENT GOVERNANCE IN THE HEALTH DEVELOPMENT FUND

- The HDF programme is developed through a highly consultative process (including MoHCC planning and reviews, aid coordination unit discussions and collaborative work planning).
- Donor and UN Agreements outline commitment to log frame 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.
- A technical team/task force per each thematic area will support the Steering Committee decision making process.
- A coordination unit will be established at the MoHCC, with One HDF co-coordinator and one HDF assistant coordinator to ensure alignment with MoHCC plans and assist in sharing information with all partners.
- Contractors will be selected through a transparent and competitive tender process guided by UNICEF. Terms of Reference will be approved by the Steering Committee. A review panel selected from the HDF SC members will be requested to review the bids. The contracting of implementing partners will be done by UNICEF.
- 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.

The outline of the management structure of the HDF is presented in the Figure below.

[27] See Annex 3 for the strategic roles of HDF partners

HEALTH DEVELOPMENT FUND GOVERNANCE OUTLINE



The diagram above provides the management structure for which the HDF will be coordinated and managed with the HDF Steering committee taking a central role in the decision making processes. In summary, the technical committees will work with the respective Directorates listed in the diagram, to ensure that all the technical input and knowhow is built into the decision makers of the Ministry. It is planned that the Directors contribute to the monthly steering committee meetings of the HDF. The technical committees are considered as critical in the running of the HDF will be supported by the HDF to ensure that they are functional where this is necessary under the planning component of the HDF. The Funding Partners, UNICEF and UNFPA will contribute to the technical discussions in the technical committees. This will assist in ensuring that when the Steering Committee meets, discussion will be limited to strategic issues. In addition to this, the Funding Partners, UNICEF and UNFPA will attend the Steering Committee meetings. The Partners, together with UNICEF and UNFPA will be able to meet outside the Steering Committee to discuss implementation and funding issues. The Funding Partners will also be able to hold separate meetings to guide on funding possibilities. The roles of the Policy and Planning, Monitoring and Evaluation Division of the Ministry of Health and Child Care, will ensure that the activities funded under the HDF follow the guidelines and strategies of the Ministry of Health and Child Care and ensure that the activities are monitored within the MoHCC structures. The Division will also be expected to house the coordinator and the assistant coordinator of the HDF and provide guidance where necessary. It is the role of the HDF Steering Committee to take the issues and challenges which need the Minister's input to the Health Sector Planning and Review meetings.

The specific roles for each of the stakeholders in the management and coordination of the HDF are outlined below:

8.1 Ministry of Health and Child Care (MoHCC)

It is the role of the MoHCC 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, Monitoring and Evaluation (PPPME) within the MoHCC convenes a consultative meeting at the end of the year 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 prioritized actions for the following year. These actions are detailed and costed in a Performance Contract that the Permanent Secretary MoHCC signs with the Office of the President and the Ministry of Finance. The Performance Contract is in-built into the MoHCC 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 Care with the deputy chair appointed from among development partners. The Health Sector Review and Planning Group is composed of senior-level representatives from bi-lateral and multilateral agencies and development banks. The Group's mandate is to (i) support MoHCC ownership and leadership in the health sector, and encourage strong MoHCC-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 MoHCC in a regular, predictable, harmonized and coordinated manner.

The Permanent Secretary of the MoHCC will chair the HDF Steering Committee, co-chair jointly with one of the HDF Funding Partners. The MoHCC Principal Director, Policy and Planning, Monitoring and Evaluation, will provide leadership in the development of annual implementation plans and the monitoring of the outputs of the HDF as part of his role in the MoHCC planning, monitoring and evaluation. The three principal directors shall be members of the Steering committee and so will be the executive director of the HSB, executive director of NatPharm and ZNFPC. The following directors will also be members of the steering committee: Family Health, Human resources, Pharmacy and Nursing.

The implementation of the HDF will be further supported by the National Maternal, Newborn and Child Health Steering Committee (RMNCH-A SC), chaired by the Honorable Minister of Health and Child Care. The RMNCH-A SC 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.

8.2 HDF Funding Partners

Funding partners to the HDF (Currently: Canada, DFID, EU, Irish Aid, Norway and Sweden and other new funding partners including GAVI) will provide un-earmarked financial support necessary to fully implement the coordinated interventions set out in the HDF 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 MoHCC and other partners of the support they anticipate providing.

Within their capacity Funding Partners will provide technical support in the different thematic areas and eventually "ad hoc" financial resources for specific intervention related to monitoring and evaluation, population surveys, financial reviews.

On an annual rotation basis the Funding Partners will select a HDF Steering Committee Co-chair.

All Funding Partners irrespective of their financial participation quota have the same rights and duties within the HDF decision process and visibility.

The role of HDF Funding Partners includes, but will not be limited to:

- Align funding support to MoHCC priorities;
- Communicate with the GoZ regarding their annual and multi-annual commitments in order that the GoZ can plan and provide services accordingly;
- 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;
- One system for technical reporting, procurement, financial accounting, and auditing of programme expenditure;
- Conduct joint missions related to the HDF in order to minimise the burden on MoHCC; and
- Review and approve annual budgets and work plans by end of December each year for implementation the following year.
- Ensure all contracted implementing partners in RMNCH-A comply with HDF planning and reporting requirements

8.3 HDF Steering Committee

The HDF Steering Committee will be responsible for the oversight and decision making of the HDF. The HDF Steering Committee will be composed of MoHCC, Principal directors and directors relevant to the programme components, one provincial medical director, Funding partners to the HDF (Canada, DFID, EU, Irish Aid, GAVI, Norway and Sweden), UNICEF, UNFPA, WHO and other UN agencies, Ministry of Finance, Ministry of Gender,Women's affairs and Community Development, Health Services Board, NatPharm, Zimbabwe National Family Planning Council, World Bank, USAID, CDC and a civil society representative for the local NGOs and for the international NGOs, UNICEF, WHO and UNFPA will serve as technical advisors with UNICEF as the Secretariat.

The Steering Committee will be co-chaired by the Permanent Secretary of the MoHCC and a Funding Partner. Funding partners will on an annual basis select a funding partner to serve as co-chair of the HDF steering committee. The HDF steering committee will initially meet monthly (this could be changed to every other month or quarterly as implementation progresses).

The role of the HDF steering committee includes, but will not be limited to:

- Approving funding allocations to thematic areas and related activities in accordance with the HDF annual plan and budget.
- Ensuring alignment of HDF allocations with the MoHCC Performance Contract/Annual Plan within the thematic areas agreed upon in the Programme Document.
- Approve reallocation of funding across thematic areas, across agencies, between implementing partners, among activities based on shifting priorities and performance
- Approving terms of reference for implementing partners.

- Participating in tender review committees and approving selection of implementing partners in accordance with UN rules and regulations.
- Review and approve the terms of reference, scope of the mid-term review, including the report
- Reviewing and approving the end-of-year programmatic and financial progress report submitted by UNICEF and UNFPA. The programme report will present results-based progress against the log frame indicators.
- Agreeing on the scope and timing of the Joint Annual Reviews.

8.4 UNICEF

UNICEF will have two distinct roles in the HDF- as fund holder and programme coordinator/manager. A number of safe-guards will be put into place to ensure transparency and segregation of duties as necessary.

As fund manager and programme coordinator/manager, UNICEF, under the oversight of the Steering Committee will be responsible for:

Ensuring overall financial management and attainment of programme results across all thematic areas. This role will include responsibility for the appropriate use of funds as well as the performance of contractors and HDF implementing partners. Using the in-country management HDF budget line, UNICEF will ensure sufficient technical and operations capacity exists to manage risk, supervise contractors and ensure accountability for the HDF resources and results.

UNICEF as Administrative Agent will sign an inter agency agreement with the participating organization (UNFPA) enabling UNICEF to transfer funds to UNFPA and allocating technical and reporting responsibilities to UNFPA for the pillars that are going to be implemented with UNFPA support.

UNICEF and UNFPA will support the MoHCC with technical and implementation capacity in respective thematic areas as required and in building capacity for overall financial and programme management of such funding mechanisms.

UNICEF will sign a standardized agreements 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 agreements signed with each funding partner. UNICEF will prepare and maintain a treasury plan to ensure timely replenishment of the HDF account, showing likely cash-flow requirements for the programme over the course of the year.

A reporting plan will also be developed to outline key reporting events in the HDF cycle. The plan will include annual reporting to donors, 6 monthly donor updates, as well as joint and independent reviews. By 31 January of every year, UNFPA will submit to UNICEF a report on thematic area 2 and parts of thematic areas 3 and 7, for consolidation in the annual report for the HDF. All contributing donors will receive one consolidated annual narrative donor report each year covering the period in any one year up to 31 December to be circulated to the donors. This annual donor report will include an annexed annual financial utilisation report. The financial utilisation report will follow the format set out by the contributing donors and will be in line with key institutional agreements. Templates for the HDF annual report as well as for quarterly Steering Committee updates will follow the current HTF format. Each report will be drafted by UNICEF in consultation with key stakeholders and MoHCC colleagues and will be submitted to the donors by the 31st April of every year.

In addition to the reports generated within UNICEF, Mid-Term Review (report with recommendations), and independent evaluation as well as regular joint annual review reports will be reviewed and disseminated by UNICEF.

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 HDF programme will be done in accordance with UNICEF's Procurement Rules.

The HDF Coordinator and an assistant will be based in the MoHCC they will play a key liaison role between the MoHCC, the HDF Steering Committee and UNICEF, UNFPA and the Funding Partners. The HDF Coordinator will assist in coordination, smooth communication and real time updates.

8.5 UNFPA

UNFPA will be responsible for thematic area 2, SRHR and any other areas where they have a comparative advantage identified by the HDF Steering Committee. UNFPA will have the oversight of the financial management and attainment of programme results on the designated thematic area. This role will include responsibility for the appropriate use of funds as well as the performance of contractors and HDF implementing partners. UNFPA will also support the MoHCC with technical and implementation capacity in the designated thematic area as required and in building capacity for overall financial and programme management of such funding mechanisms.

Participating partners have appointed UNICEF as Administrative Agent. This means that the Administrative Agency and the participating UN organization (UNFPA) will sign the standard inter agency agreement with UNICEF 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 in the programme document.[25] UNFPA will prepare and maintain a cash flow plan to ensure timely replenishment of the thematic area 2 and other relevant pillars, showing likely cash-flow requirements for the programme over the course of the year.

A reporting plan including a financial report will be provided for thematic area 2, and other relevant pillars outlining key reporting events in the HDF cycle. The plan will include annual reporting to donors, quarterly Steering Committee updates, as well as joint and independent reviews. UNFPA will submit to UNICEF a report on thematic area 2 and on other activities undertaken by UNFPA under other relevant pillars, for consolidation in the annual report for the HDF. All contributing donors will receive one consolidated annual narrative donor report each year covering the period in any one year up to 31 December. This annual donor report will include an annexed annual financial utilisation report. The financial utilisation report will follow the format set out by the contributing donors and will be in line with key institutional agreements. Templates for the HDF annual report and the quarterly updates will follow the current HTF. Each report will be drafted by UNFPA in consultation with key stakeholders and MoHCC colleagues and this should be submitted to UNICEF by 28 February of every year.

UNFPA will participate and contribute to the Mid-Term Review, independent evaluation as well as regular joint annual review activities as directed by the HDF Steering Committee.

UNFPA 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 UNFPA. Procurement of goods and services for thematic areas 2, and the other relevant areas will be done in accordance with UNFPA's Procurement Rules.

8.6 Implementing Partners

Although the majority of the HDF activities will be implemented by the MoHCC, specific components may be delivered by academic or research institutions, private sector companies, UN agencies, or non-governmental organizations using the UN tender or partnership cooperation agreement procedures.

8.7 Non-UN Implementing Partners

UNICEF and UNFPA will enter into agreement with implementing partners as per their programme and financial policies and procedures to manage specific components of the HDF, as agreed upon by the HDF Steering Committee. Contractors will provide standard quarterly, semiannual and end of year narrative and financial reports. HDF will follow UN procedures for all the activities to be implemented in the HDF.

8.8 UN Implementing Partners

Should the Steering Committee select additional UN agencies other than UNICEF and UNFPA as implementing partners, provision will be made for pass-through or bilateral agreements. In both cases standard UN agreements between UN partner agencies or between donors and UN agencies will be utilised.[26]

[25] In the pass-through mechanism, UNICEF would charge 1% administration fee for administering funds

[26] In the pass-through mechanism, UNICEF would charge 1% administration fee for administering funds and UN agencies receiving funds would charge the prevailing recovery rate.

CHAPTER 9

Programme Co-ordination

Inter Sectoral Coordination and building synergies: The links with other programmes and support to the health sector are well recognized, particularly in HIV and AIDS; TB; Malaria; Nutrition; Sexual and Reproductive Health; Water, Sanitation and Hygiene (WASH), Education and Social Protection. The HTF to date has encouraged strong links across sectors and sub-sectors and will continue to do so while extending this coordination to a more formal approach that is more inclusive and encourages greater participation of other key stakeholders through the governance mechanism that has been so effective.

The HDF will use the multi-sectoral community based nutrition model as a practical example of working across sectors.

All the members of the Steering Committee will make a concerted effort to report at the beginning of each year the activities that they are funding including those that are being implemented through NGOs. The technical committees under the

MoHCC will be required to provide a summary of the activities which NGOs are doing in the specific areas covered by the technical committees.

The HDF internal coordination will be carried out by the HDF Coordinator, with the responsibility to monitor, that approved plans and related actions are fully implemented. The HDF Coordinator will also be responsible for the communication with HDF Funding and Non-funding Partners. He/She will facilitate the coordination of the different partners of the HDF including UNFPA, UNICEF and the donor agencies on behalf of the Ministry of Health and Child Care. The HDF Coordinator will also be responsible for writing the minutes of the HDF Steering Committee meetings and for organizing the logistics of the Joint Annual Review. Due to the increased thematic areas covered by the HDF, he/she will be supported by a HDF Assistant Coordinator.

The Coordinators will be based in the Ministry of Health and Child Care where they will have a coordination unit. The terms of reference including the resourcing for the coordination unit, will be established before the HDF starts functioning. The terms of reference will be based on the HDF structure and lessons learnt from other pooled funding mechanisms.

The HDF, like the HTF, is by "de facto" one of the major health co-ordination platforms of the health system in Zimbabwe. For this reason the HDF Steering Committee in addition to its core members (MoHCC, Funding Partners, UNICEF, and UNFPA) is open to the participation of other relevant health sector stakeholders. The following institutions/bodies are currently participating in the HTF Steering Committee and they are expected to also be represented in the HDF Steering Committee: The Ministry of Finance, Health Services Board, WHO, UNDP, UNAIDS, World Bank, USAID, CDC, GF-CCM, RBF-national steering committee, Civil Society Representatives and Private Sector representative.

The wide participation of the health stakeholders in the HDF Steering Committee meetings ensures the flow of information especially in relation to the HDF adopted strategies and implemented actions. It will also share with partners challenges and lessons learned. In addition during all steering committee meetings, partners non-financing the HDF are requested to provide a short presentation of their plans and achievements.

The Global Fund due to the common areas of support that it has with the HDF will have a standing item on the HDF agenda through the CCM, and it the same way HDF will be a standing item on the agenda of the CCM. In this way coordination and information flow between two of the major funding streams in health will be effected. GAVI funding will be managed through the HDF, and will therefore be monitored by and reported to the HDF Steering Committee.

The HDF aid modality being similar to a SWAP mechanism and fully aligned and embedded to the Zimbabwe National Health Policy represents the basis for a model of the whole health sector co-ordination.

Resourcing the Health Development Fund

Government health expenditure in Zimbabwe has recovered significantly since the near economic collapse in 2008/9. Since 2008, total government expenditure on health has increased from less than US$60m, to US$313.6m in 2014. This is an increase in government health per capita spending from just over US$5 to about US$23 in 2014, and shows strong commitment to health, especially at a time where fiscal space remains very tight.

Although the commitment from the Government of Zimbabwe to continue strengthening the health system is commendable, there are challenges that continue to hinder sustainable public sector health financing over the short to medium term. Some of these include: Lack of policy clarity, low investment levels into the economy, significant levels of national debt, and a general slowdown in regional and global economic performance. These factors, and others, have continued to constrain fiscal space and have made it difficult for the government to fund non-wage expenditures in critical social sectors such as health, or to fund health priority areas such as medicines and medical supplies, maternal and child health, NCDs and nutrition. Zimbabwe's current health expenditure per capita thus remains far below what would be necessary for the health sector to meet its basic health MDG targets. At the current level of expenditure of around US$23/capita, increased spending is still required to meet the WHO recommended spending level. In 2009, The WHO Task Force on Innovative Financing revised the US$34 per capita recommended by the Macroeconomic Commission in 2001 to US $ 44. This would have to increase to US $ 60 in 2015. In view of the heavy burden of HIV, TB and NCDs, this upward revision is particularly relevant for Zimbabwe. Using the projected population, in 2015, Zimbabwe should be spending about US$ 930m annually on health which is three times the current level of expenditure. Despite this, the calculation of resource requirements is undertaken taking into account the historical spending levels, the absorptive capacity, the constrained fiscal space and what can realistically be raised by donor partners and sustain the significant impact achieved so far.

[27] MoF Budget Statement, November 2014.

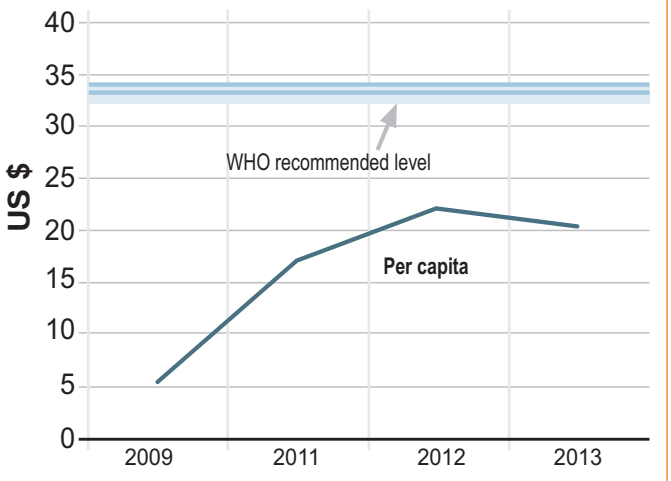


Figure 14: Trends in per capita spending in health

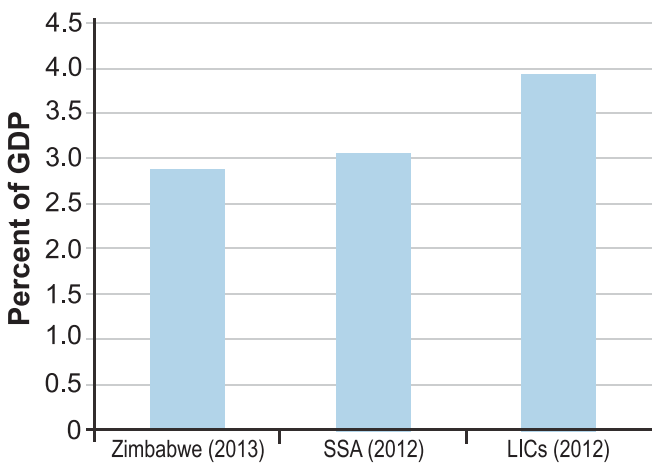


Figure 15: Health sector expenditure comparisons

Despite the increased expenditure from 2008; as a percentage of GDP, government health expenditure in Zimbabwe still lags behind that of sub-Saharan Africa and of other low-income countries, as depicted in figure 15 above. The current proportion of health expenditure also falls significantly below the Abuja declaration agreement, where Zimbabwe and other signatories pledged to increase the proportion of government expenditure towards health to 15% of total budget. These are major advocacy issues being taken up with the Ministry of Finance by MOHCC and will continue to be discussed and flagged by the HDF Steering committee and the Review and Planning group for discussion in parliament.

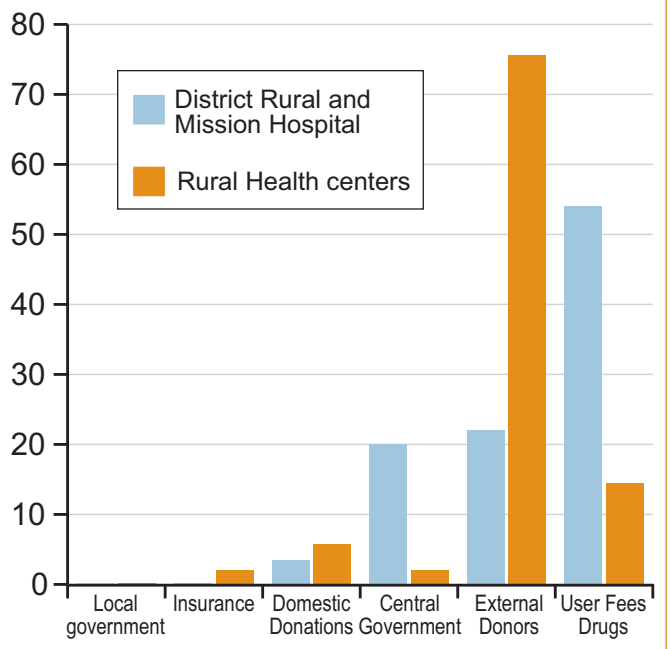


Figure 16: Sources of Health Sector Revenue

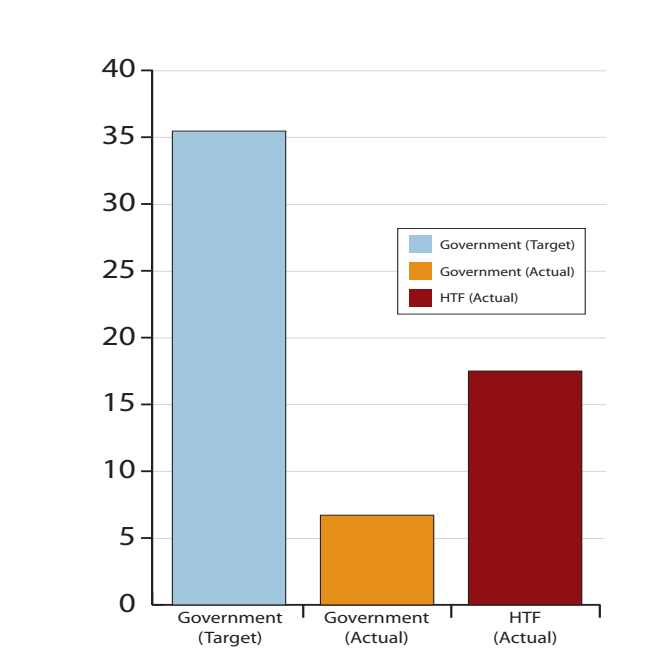


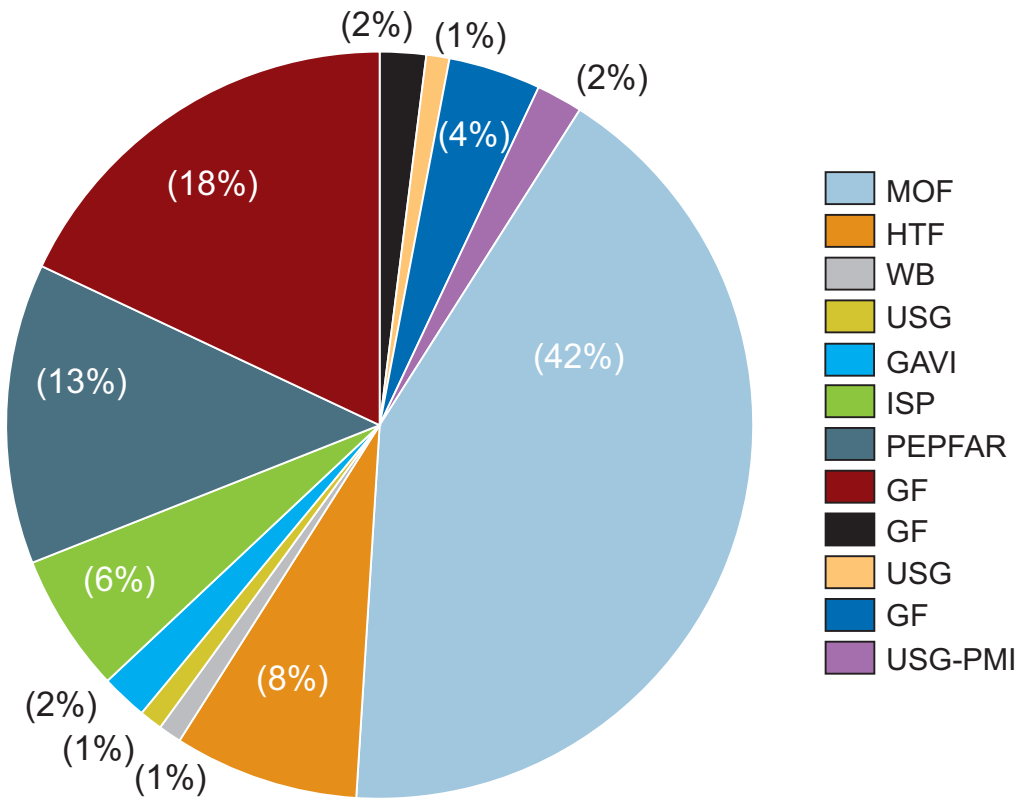
Figure 17: Medical Supplies and Services Expenditure

More than 70% of rural district and mission hospitals revenue, excluding salaries, is provided for by donors; and in 2013, central government was able to provide US$6.7m towards medical supplies and services expenditure, compared to donor contributions of $17.5m. Donor funds and out of pocket expenses largely from poor households continue to be a critical input is sustaining the gains made in reducing maternal and child mortality. Therefore, despite the commendable commitment by GoZ towards improving the health sector through increasing investment in the sector within a constrained fiscal environment more still need to be done to sustain the gains. It is necessary still vital that donor funds continue to flow into the sector in the short to medium term to safeguard the investment in health and preserve the gains realized in the sector thus far. In this way out of pocket expenses for the vulnerable groups can reduced.

Estimating total health expenditure requirements in Zimbabwe in 7 thematic areas, 2016-2020

To estimate the required spending on key interventions, health expenditure needs were determined based on the level of spending per capita necessary to catch up on basic health. A total health expenditure target of US$42/capita in 2020 (from GoZ and DPs) is projected. This target is still far below the expected per capita of US$60.00. Under this scenario, health expenditure in Zimbabwe will initially rise to approximately US$42/capita in 2020 and then as DP contributions start to be phased out, total health spending per capita will trend towards the WHO recommended level and be largely funded by GoZ.

The total health funding requirements are assumed to increase smoothly from 2014 levels to the level required to achieve the macro target of US$42/capita in 2020.



2014 Health Sector Funding - showing proportions of the different partners to the health sector in 2014

For this target of US$42/capita to be achieved, total expenditure on health in Zimbabwe would need to be approximately US$597m[28]. In 2014, public health expenditure was reported as US$313.6m and DP[29] contributions were US$181.6m[30]. Of this combined expenditure, between 63% and 67% of this was incurred in the six thematic areas by GoZ and selected DP. Based on this macro expenditure, target expenditure amounting to approximately US$597m in 2020, and that approximately 63-67% of this will go towards the 6 thematic areas addressed in the first phase of HTF. The total required expenditure in the 6 thematic areas, 2016-2020 is shown in table 4 below. This calculation is based on the total health expenditure needed to achieve a per capita expenditure of US$42 in 2020, apportioned to the 6 thematic areas based on their share of total health expenditure in 2014.[31] The figures in the table include all of the salary budget, most of the commodities[32] and expenditure in capital required to improve M&E systems in the short term.

Resource requirements for seven HDF thematic areas 2016-2020

The financial resource requirement for the HDF for the seven thematic areas between 2016 and 2020 is based on what is estimated to be the funding gaps in the sector. The total financial envelope required to meet the set targets is USD681.91 Million and the detailed budget is given in Annex 2.

This works on a central assumption that the resource requirements can be pooled fund in 2016 to 2020 and will maintain the momentum so far built by the different programmes mentioned in this document moreso the HTF and the ISP. It has a realistic chance of achieving the targets described earlier and summarized in Annex 1 below. On average, the pooled fund requires US$136m per annum to deliver the targets. Should this not be mobilized, it will be necessary to revise the targets.

Table 4: Estimated total required health expenditure in the thematic areas, 2016-2020

Thematic Area	2016	2017	2018	2019	2020	Total
Commodities and Technologies	$67.96	$70.00	$72.10	$74.27	$76.49	$360.82
Sexual reproductive health[33]	50	50	50	50	50	250.00
RMNCH-A Service Delivery	$17.79	$18.32	$18.87	$19.44	$20.02	$94.44
Human Resources for Health	$183.43	$188.93	$194.60	$200.44	$206.45	$973.85
Finance (RBF)	$18.87	$19.44	$20.02	$20.62	$21.24	$100.19
Policy, Planning, M&E and Coordination	$46.07	$47.45	$48.88	$50.34	$51.85	$224.59
Technical Support and Innovation	$4.00	$4.12	$4.24	$4.37	$4.50	$21.23
Total	**$388.13**	**$398.27**	**$408.72**	**$419.48**	**$430.55**	**$2,045.12**

[28]Projected population in 2020 is 14.2m. This is based on a historical annual population growth average of 1.1% witnessed between the 2002 and 2012 national census.

[29]Official Development assistance

[30]MoF annual budget statement, December 2014

[31]These six thematic areas constituted approximately 67% of the total health expenditure in 2014. This ratio was then applied to the total health expenditure in 2020 sufficient to achieve a per capita expenditure of $42 from Goz and official development assistance.

[32]It is assumed that adequate commodities funding for the HIV / AIDS, TB, and Malaria programmes will be available from multilateral funds and non-pooling DPs.

[33]Estimated figures not readily available

ANNEX 1: MIMS 2009, DHS 2010 AND MICS 2014 INDICATOR TRENDS AND HDF BASELINES

Indicator	MIMS 2009	DHS 2010-11	MICS 2014 (HDF baseline)	HDF Log frame target 2020
Maternal Mortality Ratio (MMR) per 1000,000 live births	-	960	614[35]	350
Neonatal Mortality Rate (NMR) per 1,000 live births	-	31	29	25
Infant Mortality Rate (IMR) per 1,000 live births	67	57	55	8
Under-Five Mortality Rate (U5MR) per 1,000 live births	84	84	75	65
Proportion deliveries with Skilled Birth Attendance (SBA)/ facility deliveries	60%	66%	80%	85%
Proportion of pregnant women attending at least 4 ANC visits	57%	65%	70%	80%
Proportion of women who received PNC within 2 days of delivery	-	27%	77%	80%
Unmet need for family planning	-	13%	10.4%	6.5%
Adolescent fertility rate	-	124	120	115[36]
Percentage of infants aged 12-23 months fully immunized	36%	65%	69%	75%
Percentage of infants exclusively breastfed (EBF) (0-6 months)	26%	31%	41%	45%
Prevalence of stunted children	-	32%	28%	19%
Proportion of under-5 children with ARI symptoms treated with antibiotics	-	31%	34%	45%
Proportion of under-5 children with diarrhea treated with ORT	-	63%	56%[37]	60%
Proportion of under-5 children with diarrhea treated with ORT and zinc	-	-	14%	30%

[34] Some of the targets have been adjusted slightly downwards in view of the diminishing donor funding contributions. The HDF targets will be revised and only finalized in alignment with the National Health Sector Strategy targets once the latter has been completed towards the end of the year.

[35]Deaths during pregnancy, childbirth, or within two months after delivery or termination of pregnancy, per 100,000 births within the 7-year period preceding the survey; the value was 581 for deaths within the 5-year period preceding the survey

[36] Subject to revision according to new ASRH strategy

[37]Treated with ORT and continued feeding

ANNEX 2: DETAILED BUDGET

Thematic Area	2016	2017	2018	2019	2020	Total
UNICEF COMPONENT						
1. RMNCH-A Service Delivery	4.97	5.07	4.95	4.8	4.62	24.41
3. Medicines, Commodities (including Nutrition commodities) and Technologies	26.09	27.57	28.79	30.02	31.27	143.74
4. Human Resources for Health	14.53	13.28	11.92	14.11	16.39	70.23
5. Finance (RBF)	11.07	11.32	11.42	11.51	11.58	56.9
6. Policy, Planning, M&E and Coordination	4.97	4.87	3.99	3.02	1.94	18.79
7. Technical Support and Innovation	4	4.12	4.24	4.37	4.5	21.23
Sub-Total for Thematic areas	65.63	66.23	65.31	67.83	70.3	335.3
Programme Management Costs	5.5	5.5	5.5	5.5	5.5	27.5
Total Programmable Budget	71.13	71.73	70.81	73.33	75.8	362.8
7% Recovery Cost	4.98	5.02	4.96	5.13	5.31	25.40
UNICEF Total	**76.11**	**76.75**	**75.77**	**78.46**	**81.11**	**388.20**
UNFPA COMPONENT						
1. RMNCH-A	$3.00	$3.50	$3.50	$3.00	$2.00	$15.00
2. SRHR	$21.00	$23.00	$23.00	$22.00	$21.00	$110.00
2a unfunded MC programme catch-up phase	$16.00	$31.00	$28.00			$75.00
3. Medicines, Commodities and technologies	$13.00	$13.00	$13.00	$13.00	$13.00	$65.00
7. Technical Support and Innovation	$0.50	$1.00	$0.50	-	-	$2.00
Sub-total for Thematic Area	**$53.50**	**$71.50**	**$68.00**	**$38.00**	**$36.00**	**$267.00**
Programme Management Costs[1]	**$1.50**	**$1.50**	**$1.50**	**$1.50**	**$1.50**	**$7.50**
Total Programmable Budget	**$55.00**	**$73.00**	**$69.50**	**$39.50**	**$37.50**	**$274.50**
7% Recovery Cost	$3.85	$5.11	$4.87	$2.77	$2.63	$19.22
UNFPA Total	**$58.85**	**$78.11**	**$74.37**	**$42.27**	**$40.13**	**$293.72**
GRAND TOTAL	**$134.96**	**$154.86**	**$150.13**	**$120.73**	**$121.23**	**$681.92**
1a) Paediatric HIV and AIDS*	2.6	3.5	3.1	3.0	2.7	14.90

***This budget line is provide for information, its not included in the total budget for the HDF**

****GOZ to provide its commitment in the Health Development Fund.**

ANNEX 3: LOGICAL FRAMEWORK

Attached separately