UNICEF ZIMBABWE

Sectoral Report for Health for the period January to December 2016

Submitted in March 2017

unicef | for every child

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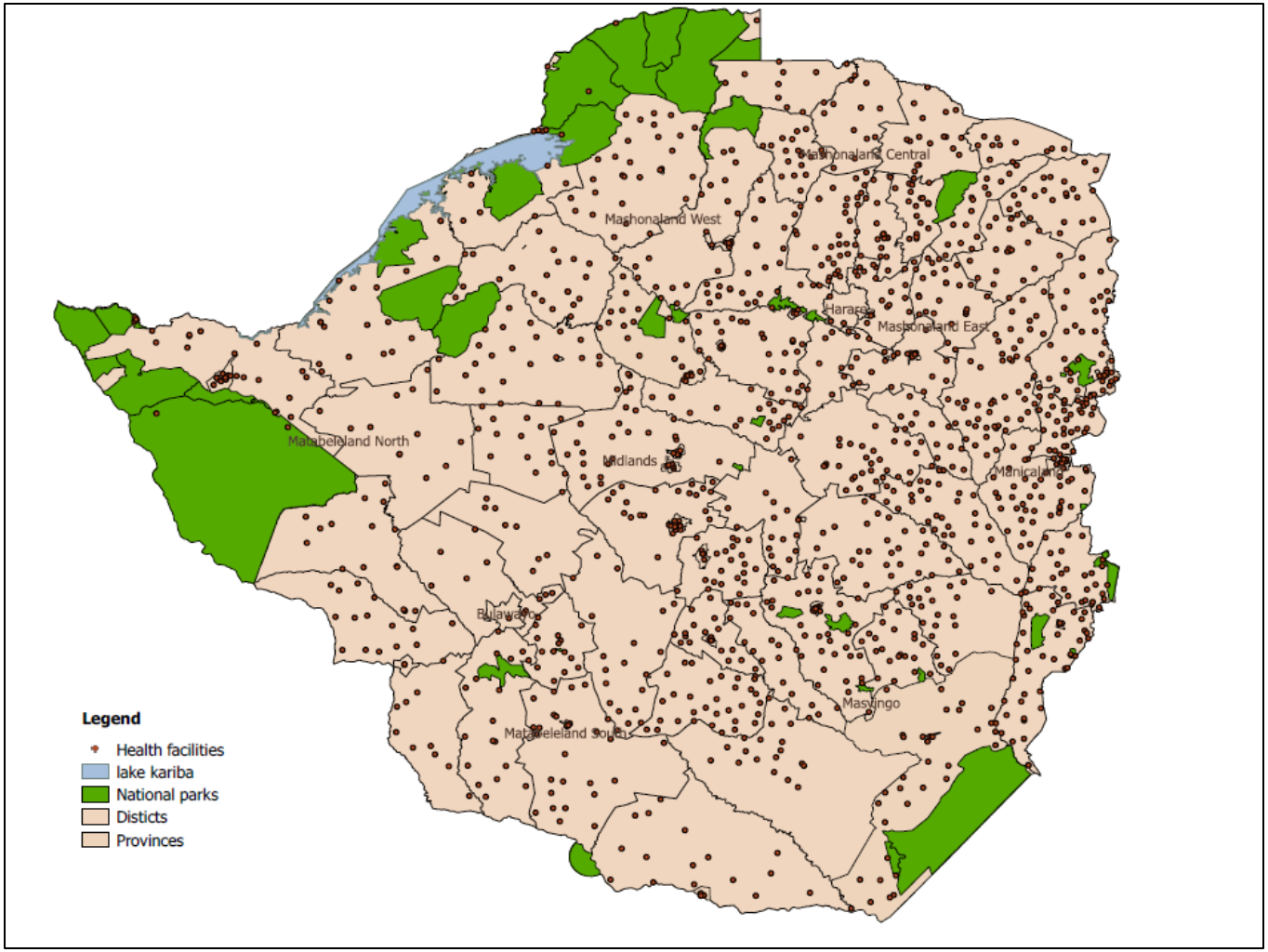
Cover Photo: *Members of the apostolic sect with their babies at Murambinda Hospital Zimbabwe. The apostolic sect is a religious sect known for shunning health services. This is however gradually changing as illustrated in this cover photo.*

Caption: *UNICEF Zimbabwe, 2016.*

Map showing health facilities in Zimbabwe



1.0 Executive Summary

UNICEF's health programme is guided by the UNICEF Strategic Plan (2014 to 2017), the Convention on the Rights of the Child (CRC) and Core Commitments for Children in Emergencies. At a national level, the health programme is guided by the Ministry of Health's National Health Strategy (2016 to 2020), the Zimbabwe United Nations Development Assistance Framework (ZUNDAF 2016 -2020) priority area on social services protection, the Government of Zimbabwe's (GoZ) economic blueprint - the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset 2013 – 2018) and the UNICEF Zimbabwe Country Programme (2016 to 2020). The programme is also guided by the Sustainable Development Goals (SDGs 2016 – 2030) particularly goal 3 (Good Health), but also putting under consideration elements of goals 5 (Gender Equality) and 13 (Climate Action) (https://sustainabledevelopment.un.org/post2015/transformingourworld).

Zimbabwe is still recovering from the deterioration of the health system and the overall social services from 1999 to 2008, and still very far from reclaiming its 1990's status as one of the best health systems in the whole of Africa. In the past five years, the health system was beginning to show tangible signs of recovery with health service coverage indicators showing progressive improvements. The Maternal Mortality Ratio (MMR) showed a confirmed downward trend, decreasing by 36% from the 960 per 100,000 live births (2010 ZDHS) to 614 maternal deaths per 100,000 live births (MICS 2014) and 651 maternal deaths per 100,000 live births (DHS 2015). Under-Five Mortality Rate (U5MR) decreased by 25% from 102 under-five deaths per 1,000 live births in the 1999 (ZDHS) to 75 under-five deaths per 1,000 live births in 2014 (MICS) and most recently to 69 under-five deaths per 1,000 live births (DHS 2015). However this positive progress is in danger of regressing due the deteriorating macroeconomic environment epitomised by the liquidity crises. This has been exacerbated by the El Nino induced drought and subsequent La Nina induced floods.

The key efforts and interventions planned and implemented in 2016 continued to build on the results demonstrated in the 2014 MICS and 2015 DHS and included technical and financial support to the Ministry of Health and Child Care (MoHCC) in enhancing health workers capacity, ensuring availability of essential drugs, vaccines and nutrition commodities and strengthening the monitoring and evaluation system for the health care system. The Government of Zimbabwe (GoZ) sought to continue with the non-payment of user fees by pregnant women and children below five years of age as this was a barrier to service utilisation. There has been continued improvements in key health outcomes for mothers and under 5 children. Immunisation coverage had been on a slow decline since 2013, there however have been signs of a reversal of this decline during 2016.

This report details the results achieved in 2016 using all sources of funding available to support the Health outcome area. UNICEF would like to thank the Swedish Government for providing country specific thematic Funds that have enabled flexible programming to optimise results. UNICEF would also like to thank all the other donors who contributed to these achievements in 2016, and look forward to working together in 2017 to achieve even better results for the women and children of Zimbabwe.

2.0 Strategic Context of 2016

The Health Development Fund (HDF 2016 - 2020) was established in 2016 as a direct continuation of the Health Transition Fund (HTF 2012 - 2015) which in the previous five years had been so instrumental in supporting the Ministry of Health and Child Care (MoHCC) implement the National Health Strategic Plan and address the identified bottlenecks that had brought the health system to a near-collapsed status in 2008/2009. The successes of the HTF in providing support towards the revitalisation and resuscitation of Zimbabwe's health system was well demonstrated in 2015. The Health Transition Fund directly contributed to reduced maternal mortality and under-5 mortality (MDGs 5 and 4), contributed to halving the prevalence of underweight in children under-5 (MDG 1c) and contributed to combating, halting and reversing trends in HIV and AIDS, Malaria and other diseases (MDG 6). In the post 2015 era, the HDF has taken over as a dynamic pool of funding aligned with the Sustainable Development Goals (SDGs 2016 – 2030) and the New National Health Strategy (2016-2020).

The main focus of the HDF 2016 – 2020 is to sustain the gains achieved in the previous five years, while also looking at issues of quality and equity, further building on the successful scaling up maternal, new-born, child health (MNCH), nutrition interventions and the three core health system reforms required to support the removal of user fees, regular supply of essential health commodities, vaccines and technologies, support for human resources for health and support for health policy, planning, monitoring and evaluation and health financing (HSF). Because of the remarkable successes scored and the confidence gained, UNICEF continued to serve as a common programme and fund manager for the HDF. In addition to continuing to implement activities meant to sustain the gains achieved to date more focus was placed on improving quality of services through providing on-the-job trainings, supportive supervision and mentorship support to health workers and implementation of the quality checklist as part of the Results Based Financing (RBF) mechanism, as opposed to the traditional classroom trainings.

The programme also provided support to the Ministry of Health and Child Care (MoHCC) in the development of the new National Health Strategy (2016-2020) ensuring that it is aligned to the Sustainable Development Goals (2016 – 2030) as well as to the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) agenda. The programme focused on building national, sector-wide systems to provide high-impact interventions targeting the most vulnerable children, in response to high prevalence of poverty (72%) and low economic growth (3.4%), while also addressing social norms, such as gender inequity and harmful religious practices (early marriage and refusal to use modern health and education services). The programme reflected on the principles of aid effectiveness, emphasizing on building mutual trust, transparency, risk-sharing, use of country systems, strengthening national capacity, and timely and predictable aid.

The ensuing progressive recovery of the health system in Zimbabwe can be credited to the collaborative contributions of the Ministry of Health and Child Care (MoHCC), the HDF partners, who from 2016 included the Global Alliance on Vaccines and Immunisation (GAVI). Other partners include the World Bank and the Global Fund. In addition to country specific thematic funding, the Government of Sweden provided a direct contribution of SEK 199,000,000 to the HDF. In 2016, the HDF faces diminished funding as some donors such as Canada and Norway who were part of the HTF are no longer part of

the HDF. Thematic Funding ensured that there was little disruption in the provision of key programme activities such as clinical mentorship, training of health workers in IMNCI as well as EPI out-reach activities. It was critical in facilitating programming flexibility to ensure holistic achievement of planned results.

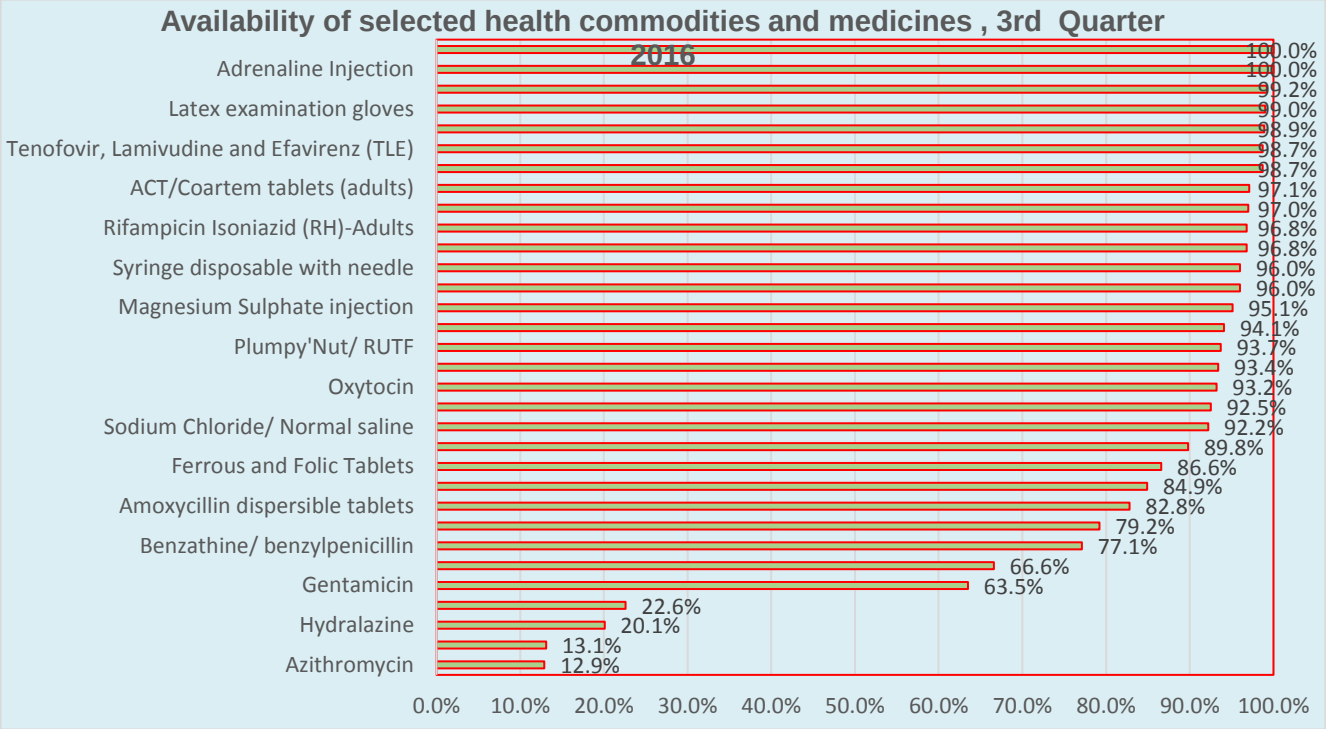
3.0 Results in the Outcome Area

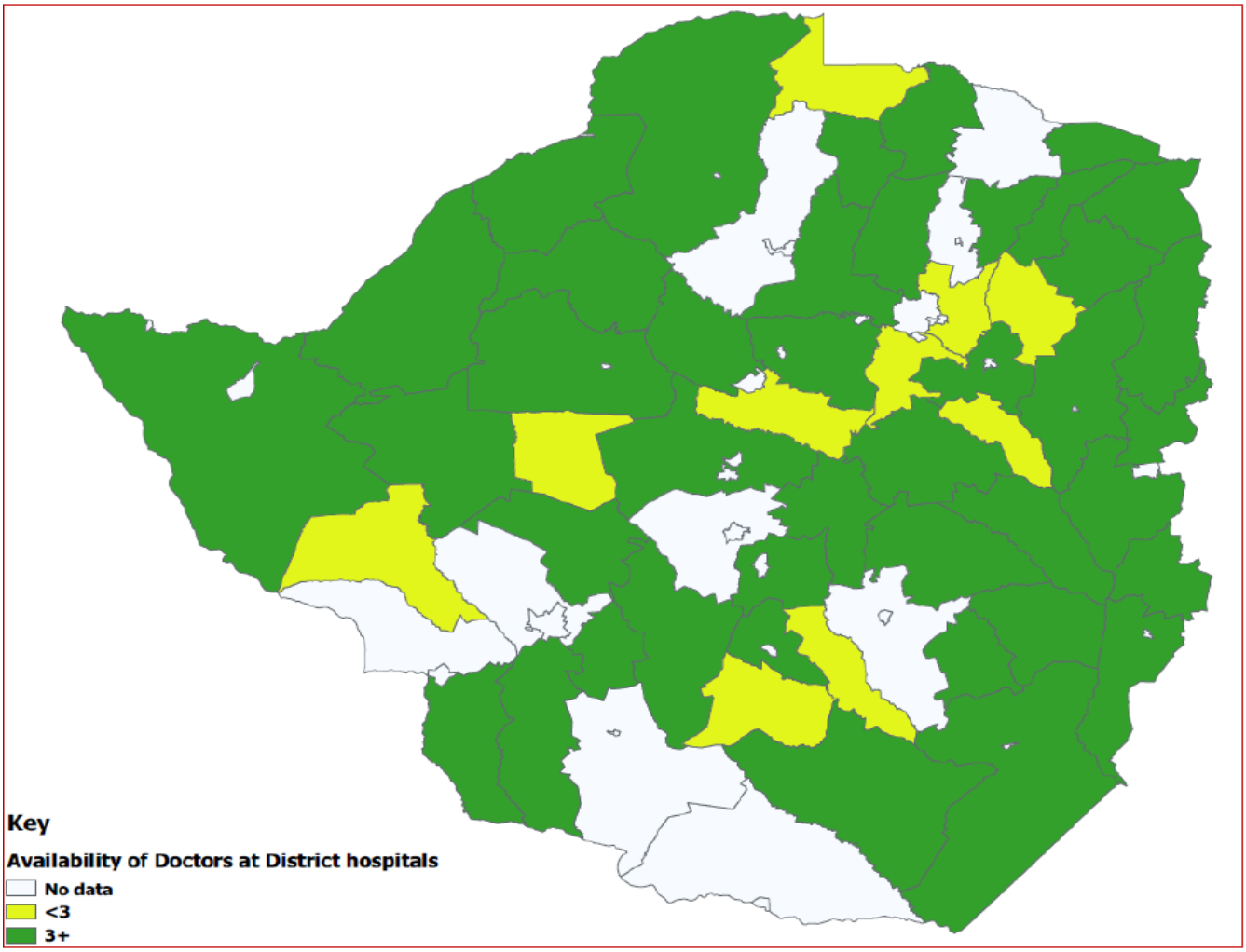
During 2016, although the country faced a very challenging funding climate, most of the results for the Maternal, Newborn, Child Health (MNCH) and Systems Strengthening programmes have progressed fairly well during the year. With reduced donor funds and a national economy that is still showing a downward trend, UNICEF's focus has been on maximising on the limited resources, ensuring optimal resource efficiency. Scenarios for prioritization of HDF spending were developed and implemented to ensure availability of essential pharmaceuticals and human resources, while at the same time not losing focus on sustaining the programmatic gains on the major MNCH areas. UNICEF also focused on resource mobilization and optimization by the HDF Coordination Unit engaging with donors (EU Ambassadors and UNICEF National Committees Offices) and monitoring performance. The HDF partnership was expanded in 2016 bringing GAVI on board as a major funder for the EPI Programme. Further, the HDF was implemented as a joint programme with UNFPA being a participating UN agency focussing on the component of Sexual and Reproductive Health Rights (SRHR). Donor resources were mobilised outside the HDF from sources such as the Thematic Funds from the Government of Sweden and the UNICEF National Committees (Natcoms) for the MNCH Programme.

Health Systems Strengthened

With the available HDF and other programme funds, UNICEF has continued with the Health Systems Strengthening approach, focusing on health commodities, human resources for health and Results-Based Financing as well as service delivery.

UNICEF, UNFPA, JSI Deliver and Global Fund procured and distributed medicines including the 13 essential MNCH commodities, ensuring increased availability of the tracer essential medicines in health facilities from 65% to 78%. This is illustrated in the first figure below. UNICEF and the Global Fund contributed to the health worker retention scheme, resulting in low staff turnover and increased proportion of District Hospitals with at least three doctors from 50% to 67.9% as shown in the second figure below.

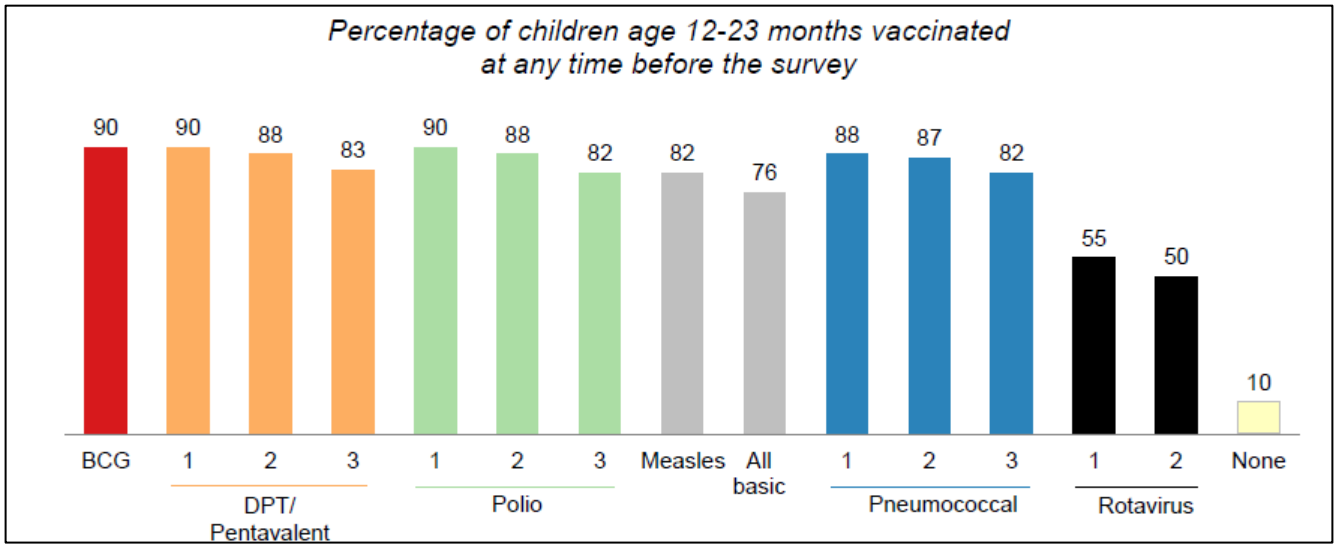

Availability of selected health commodities and medicines , 3rd Quarter
2016
Adrenaline Injection 100.0%
Latex examination gloves 100.0%
Tenofovir, Lamivudine and Efavirenz (TLE) 99.2%
ACT/Coartem tablets (adults) 99.0%
Rifampicin Isoniazid (RH)-Adults 98.9%
Syringe disposable with needle 98.7%
Magnesium Sulphate injection 98.7%
Plumpy'Nut/ RUTF 97.1%
Oxytocin 97.0%
Sodium Chloride/ Normal saline 96.8%
Ferrous and Folic Tablets 96.8%
Amoxycillin dispersible tablets 96.0%
Benzathine/ benzylpenicillin 96.0%
Gentamicin 95.1%
Hydralazine 94.1%
Azithromycin 93.7%
93.4%
93.2%
92.5%
92.2%
89.8%
86.6%
84.9%
82.8%
79.2%
77.1%
66.6%
63.5%
22.6%
20.1%
13.1%
12.9%
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

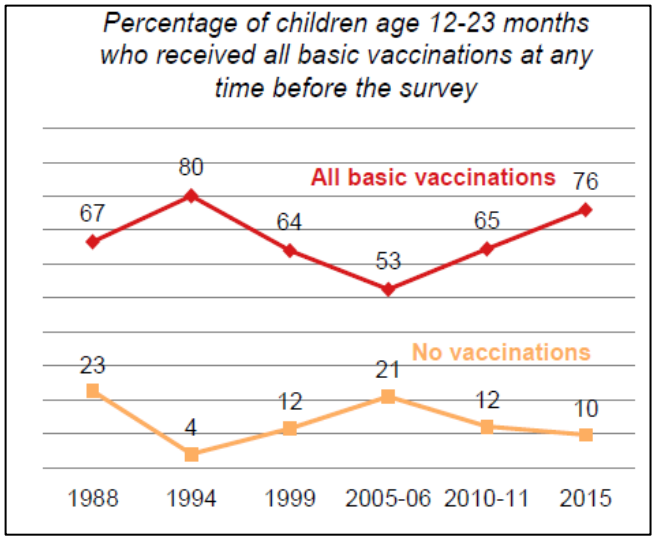

Key
Availability of Doctors at District hospitals
No data
<3
3+

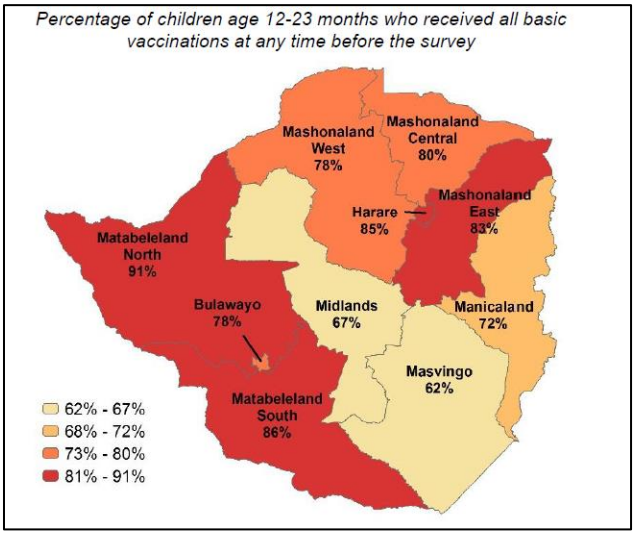
With support from UNICEF, the World Bank and other partners, a costed National Health Strategy 2016-2020 and a Child Survival Strategy 2016 - 2020 are now in place. UNICEF in collaboration with ALMA supported the MOHCC to develop the Zimbabwe RMNCHA scorecard which is now being used at National and Provincial level for programme monitoring and feedback for action.

High Immunization Coverages Maintained

Thematic funding together with funding from the HDF contributed to maintenance of high immunisation coverages achieving 85% fully immunized infants against a target of 85% for the year 2016 according to routine administrative data. Support to the immunisation programme included technical, financial and logistic support to the Ministry of Health and Child Care (MoHCC) in forecasting, procurement and distribution of vaccines and other immunisation supplies, maintenance of the cold chain system through regular servicing and repairs, ensuring constant back-up power supply of LP gas and generators, and the installation of 107 solar drive refrigerators, resulting in 98.1% of health facilities having functional cold chain refrigerators throughout the year, hence ensuring availability of vaccines for the immunisation. The solar drive refrigerators contributed to reduction of running costs as well as conservation of the environment.







MOHCC administrative reports from routine EPI data show that immunization coverages have begun to pick up again from 2016, with BCG at 93%, DTP_3 at 89% (falling 1% below the GVAP target of 90%), measles-rubella at 92%, and fully immunized at 85%. However, there are disparities of coverage among the different Provinces. Improved immunisation coverages was achieved through support to static immunisation at health facilities as well as over 1,600 immunisation outreaches targeting the hard to reach communities, and specific programmes targeting the religious and other socio-cultural objector groups including the urban elite. These are groups that often resist immunisation due to their beliefs and ideologies, misconceptions or just not being available during the immunisation sessions. There was intense social mobilisation and engagement towards promoting and enhanced understanding of the value of immunisation. This has resulted in reduced morbidity and infant mortality for these groups.

Quality Maternal and Newborn Health Services Provided

Universal access to antenatal care (ANC) and postnatal care (PNC) was at 99.7% and 99.9% respectively, with ANC first booking coverage at 95%. There was however loss to follow up for ANC with only 76% of pregnant women attending the recommended minimum of 4 ANC visits.

Proportion of primary health care facilities providing basic emergency obstetric and newborn care (BEmONC)	79%	90%	September 2016	77.5%	VMAHS (3rd quarter 2016)
Proportion of district hospitals performing Caesarean section	85%	90%	September 2016	88.5%	VMAHS (3rd quarter 2016)
Number of district hospitals with new born corners established	20	40	September 2016	40[4]	MoHCC reports

The proportion of District Hospitals able to perform Caesarean Section was 88.5% resulting from the support that UNICEF provided in the deployment and retention of doctors in districts hospitals and the provision of blood coupons to enable hospitals to provide free blood to pregnant women who needed it.

This has been complemented by the Clinical Mentorship Programme, and the support Absolute Return to Kids (ARK) has provided to train and deploy Nurse Anaesthetists to District Hospitals especially where the doctors are not able to administer anaesthesia.

Although there was good coverage for most of the MNCH indicators, an enabling environment including availability of skilled health professionals, commodities and essential medicines including blood, a worrying concern is that mothers and newborns continue to lose their lives. A decline of 8.9% in institutional MMR (from 146 per 100,000 live births in 2015 to 133 per 100,000 live births in 2016) has been noted, based on the number of maternal deaths by end of September 2015 as compared to the same period in 2016. Nevertheless, there is still great concern as mothers continue to die from preventable and manageable conditions. In effort to address this, UNICEF will continue to support Quality of Care improvement through the Clinical Mentorship Programme in 5 Provinces while UNFPA supported 3 Provinces (Midlands, Matabeleland North and Mashonaland West).

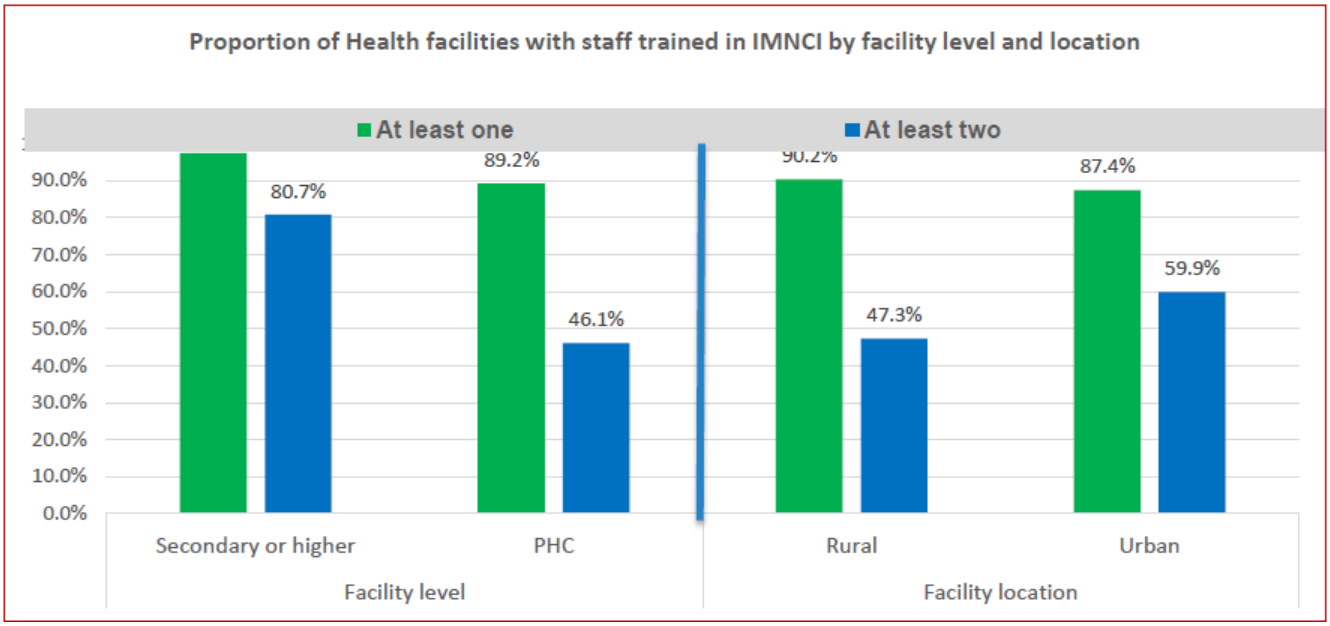
Common Childhood Illnesses Prevented and Treated Appropriately

Data from MICS 2014 and DHS 2015 showed that the number of children who slept under an insecticide treated net or were treated with ORS plus zinc for diarrhoea or were treated with antibiotics for pneumonia was low as shown in the table below.

Outcome	Baseline 2014 (MICS)	Progress 2015 (DHS)	Target 2020	Achieved 2016	Data source
Proportion of children aged 0-59 months with diarrhoea treated with ORS & Zinc tablets	14%	20%	30%	No data	MICS, DHS
Proportion of children aged 0-59 months with suspected pneumonia treated with appropriate antibiotics	34%	40%	45%	No data	MICS, DHS
Proportion of children aged 0-59 months with malaria treated with ACTs or other appropriate antimalarial	79%	82%	95%	No data	MICS, DHS
Proportion of children aged 0-59 months in malaria endemic districts sleeping under an LLITN	27%	35%	60%	No data	MICS, DHS

By the end of November 2016, there was no new data on the proportion of under-five children sleeping under an insecticide treated net, nor on appropriate treatment of fever, diarrhoea and pneumonia. The country has adopted the Integrated Management of Newborn and Childhood Illnesses (IMNCI) as a strategy to improve the coverage of these services. Community IMNCI, which is yet to be introduced, promotes early detection and early treatment and/or referral of these common childhood illnesses thereby avoiding complications and improving treatment outcomes.

Sick newborns and under-5 children have access to the integrated management of newborn and childhood illnesses (IMNCI) in 86.4% of health facilities where at least one health worker is trained. 43% of the health facilities have at least two health workers trained. The very sick under-fives now access improved referral care in 16 (25%) of the District Hospitals where Emergency Triaging Assessment and Treatment (ETAT) programme was successfully introduced in 2016.



UNICEF, WHO, MCHIP and Save the Children have continued to support the MOHCC to scale up the proportion of health facilities managing sick children using the IMNCI approach by introducing the long-distance learning module which aims to capacitate a larger number of health workers with the available limited resources. A total of 223 health workers have been trained in the 8 Provinces and Bulawayo City. To improve timely and appropriate management of sick children referred to the higher levels facilities, UNICEF and WHO in collaboration with the Paediatric Association of Zimbabwe introduced the Emergency Triaging Assessment and Treatment (ETAT) programme as part of the referral chain for the IMNCI programme in 16 District Hospitals. A follow up assessment conducted by the MOHCC and partners revealed good achievements in terms of quality of care and improved treatment outcomes including intraosseous insertion.

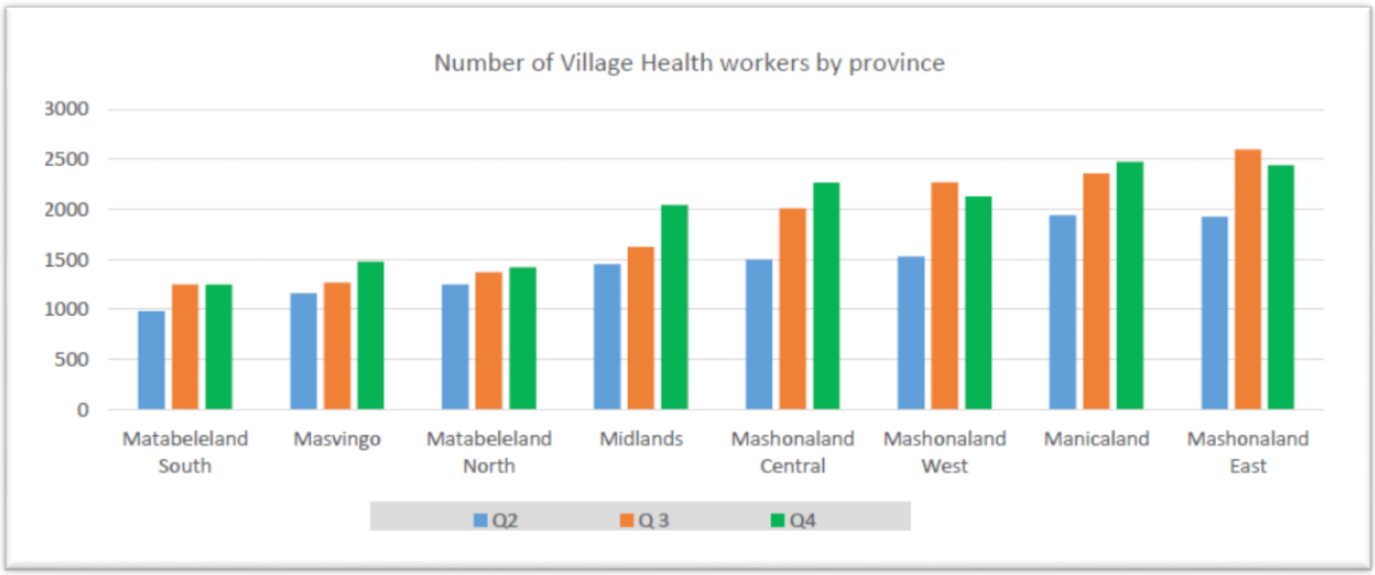
Strengthened Community Systems

Health Centre Committees (HCCs) are core community structures in the governance, monitoring of health services, feedback for action and citizen's accountability. The proportion of facilities with functional Health Centre Committees (HCCs) remained at 100%. Community Working Group on Health and Save the Children continue to play an important role in trainings and review of the HCCs training manual.

UNICEF played a critical role in improving the package and quality of health service delivery at the community level by supporting a comprehensive review of the village health worker programme including the training materials and its management systems. The proportion of villages with trained

Village Health Workers (VHWs) increased from 61% in 2015 to 72.6% in 2016. At least 60% of households in the rural districts that had lowest coverages can now access the services of a VHW, an improvement from 39% at the beginning of the year. Overall, more than 70% of households countrywide now have access to community health services delivered through VHWs, whereby one VHW is responsible for 100 households in communal areas. UNICEF through the HDF has continued to provide evidence based support to increase the number of VHWs in districts with lowest coverages through targeted three week trainings. An additional 3,002 VHWs were capacitated with knowledge and skills to provide a comprehensive package of basic preventive, promotive and curative Health, Nutrition and HIV services during the year.

UNICEF also continued to provide refresher trainings to capacitate mentor/ peer 3,000 VHWs supervisors in supportive supervision at community level. As by quarter two of 2016, UNICEF also paid the token allowances to incentivize the 5,886 VHWs, complemented by 7,440 paid by the Global Fund. The DHIS 2.0 data shows that VHWs contributed significantly to demand creation for services within their communities as shown by an increase in the number of pregnant women being identified and referred from the community to the health facilities for antenatal care booking before 14 weeks, increased proportion of care givers with first contact with VHWs who seek treatment for childhood illnesses at the health facility, and increased institutional deliveries at facilities previously recording high number of home deliveries.



In addition, UNICEF through the HDF has also supported the capacity enhancement of Community-Based service providers on Community Dialogue to mobilise communities for services, and has supported the ongoing development of an a Reproductive, Maternal, Newborn, Child and Adolescent (RMNCHA) Communication Strategy.

Outcome	Baseline	Target	Date	Achieved	Source
Children < 1 year receiving DTP-containing vaccine at national level	87%	92%	September 2016	89.8%	DHIS
Children < 1 year receiving measles-containing vaccine at national level	88%	92%	September 2016	93%[1]	DHIS
District or equivalent administrative unit with at least 80% coverage of DTP-containing vaccine for children < 1 year receiving	47	55	August 2016	58	MOHCC - routine EPI data Jan-Aug 2016)
District or equivalent administrative unit with at least 80% coverage of measles-containing vaccine for children < 1 year receiving	43	55	August 2016	53	MOHCC - routine EPI data Jan-Aug 2016)
Women attended at least four times during their pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy	70%	81%	September 2016	75.6%	DHIS
Proportion of children fully immunised by the age of one year.	69%	72%	September 2016	64.4%[2]	DHIS
Output 1.1					
Health care facilities with functioning basic water, sanitation and hygiene facilities	88%	92%	September 2016	92.7%[3]	VMAHS (3rd quarter 2016)
Proportion of primary health care facilities providing basic emergency obstetric and newborn care (BEmONC)	79%	90%	September 2016	77.5%	VMAHS (3rd quarter 2016)

Outcome	Baseline	Target	Date	Achieved	Source
Proportion of district hospitals performing Caesarean section	85%	90%	September 2016	88.5%	VMAHS (3rd quarter 2016)
Proportion of health facilities with availability of functional cold chain in the previous year	96%	98%	September 2016	98.1%[5]	VMAHS (3rd quarter 2016)
Proportion of health facilities that have 80% availability of selected MNCH medicines	89%	92%	September 2016	90.5%	VMAHS (3rd quarter 2016)
Proportion of district hospitals staffed with at least 3 doctors	50%	60%	September 2016	75%	VMAHS (3rd quarter 2016)
Output 1.2					
Proportion of rural health facilities implementing RBF.	85%	90%	September 2016	100%	Programme reports
Proportion of rural health facilities with functional health centre committees.	100%	100%	September 2016	100%	VMAHS (3rd quarter 2016)
Availability of a costed National Health Strategy that includes RMNCH programmes	None	Strategy completed and disseminated	September 2016	The strategy was finalized and awaiting launch	Programme reports
Output 1.3					
Proportion of villages with at least one Village Health Worker capacitated to promote the utilisation of integrated community health services.	61%	65%	September 2016	72.6%	MOHCC administrative reports

3.1 Strategic Partnerships and Inter-Agency Collaboration

The HDF 2016 – 2020 programme has promulgated an expanded partnership that has resulted in enhanced synergies and complementarity between stakeholders resulting in progressive change. The main strategic partners in 2016 were the Ministry of Health and Child Care (MoHCC), the traditional HDF partners (DfID, EU, Irish Aid and the Government of Sweden). In 2016, additional partners came on board the HDF wagon - the Global Alliance on Vaccines and Immunisation (GAVI), the World Bank, and the Global Fund.

WHO has been a major partner in IMNCI and ETAT, UNFPA in Maternal and Adolescent Health, and UNDP has been a major partner in the area of community health. The World Bank has been a strategic partner in the areas of Health Systems Strengthening/ Health Financing and the costing of the 2016-2020 National Health Strategy. There are also strategic partnerships with a number of NGOs including MCHIP, ALMA, Save the Children, Community Working Group on Health and ARK in different aspects, and the private sector including Crown Agents and Cord Aid.

3.2 Value for Money

As in the previous years, UNICEF while implementing activities in 2016 has continued to ensure that funds are effectively and efficiently utilized to improve access to health care and improve health status of the mothers and children as well as preventing them from being impoverished by medical expenses. UNICEF continued to support high impact cost effective interventions in maternal and child health that have resulted in the health outcomes of mothers and children improving tremendously without inputting huge investments in the programme. By focusing on key health systems strengthening activities, the support provided through UNICEF has ensured that the Zimbabwe public health system is able to function and deliver quality services for HIV/AIDS, nutrition, TB and malaria. The focus on primary health level has ensured that support is targeted to improve quality of services at the primary health which is usually the first point of call. The introduction of results based financing has resulted in a more effective and efficient delivery of quality health services.

UNICEF ensured transparency and value for money by using UNICEF's procurement processes and procedures in the procurement of medicines and most of the equipment and supplies required for the programme. This was because UNICEF was able to achieve economies of scale and efficiencies through open competition and applying international competitive bidding procedures. Due to its robust procurement systems and its global reach, UNICEF was able to contract the best possible suppliers on the market at competitive prices for essential commodities. UNICEF's innovative contracting terms as well as expanded and diversified supplier base contributes to price reductions and savings thereby delivering value for money.

3.3 Constraints, Challenges and Lessons Learned

The primary challenge in 2016 was that of limited and reducing funding for the health programme, against an increasing need for sustaining the gains, improvement in quality and equity. As a result of reduced funding, there was among other things a reduction of health worker retention allowances which

has culminated in some degree of demotivation, and in a few instances attrition of doctors from the District Hospitals. UNICEF has made efforts at resource rationalisation and optimisation, focusing on integration and value for money, as well as mobilisation of additional resources including engaging the global fund and thematic funding from the Government of Sweden to address the gaps

Other programmatic challenges included the growing population of religious and other socio-cultural objectors including the urban and peri-urban elite, competing priorities including the drought emergency. This has impacted mainly on immunisation coverages, which in 2015 fell below the (GVAP) of 90% but rose in 2016 to 89%, but also on the uptake of other MNCH services. The programme has worked with colleagues from Communication for Development (C4D) section to tackle the issue of objectors.

At the community level, there has been weak coordination of community health services, with multiple Community Service Providers working in an uncoordinated way, including some playing multiple roles. It has been difficult to establish a reliable VHW database, despite previous efforts to support the Districts and Provinces towards this. UNICEF is working with UNDP to support the MOHCC establish an electronic VHW database that will also streamline the electronic payment of their allowances. UNICEF, UNFPA and UNAIDS took the lead in supporting the MOHCC to speed up the finalisation of the VHW Strategic Direction Document which will enhance the coordination, planning and synchronised management of the community health work, and the finalisation of the Community Systems Strengthening Framework to guide community health services programming.

During the earlier part of 2016, the country was affected by a period of prolonged El Nino induced drought that mainly affected food production resulting in malnutrition, but also in health related effects including an increase in diarrhoeal diseases and acute respiratory infections. Further, during 2016, the country started to experience a liquidity crisis. UNICEF Country Office has engaged the banks on availing cash for priority programme implementation at the lower level facilities.

During the course of 2016, it was learnt that it is possible to achieve the desired results with careful prioritisation and rationalisation of resources. It is also possible to influence and change the behaviour of objector groups by engaging positively with them. There is also the need to further explore other domestic sources of funding as well as engage the Government of Zimbabwe (GoZ) to invest more in health. Only then will achievements be consolidated and the sustainability of the current investment by the partners assured.

3.4 Risk Assessment and Risk management

The programmatic risk included inability or lack of capacity to implement the planned programme, and non-adherence to the planned programme. To mitigate this risk, UNICEF implemented the programme mainly through the Ministry of Health and Child Care (MoHCC), ensuring through the Health Systems Strengthening (HSS) approach that adequate capacity is built and maintained. The programme was managed through the HDF Steering committee, chaired by the Permanent Secretary in the Ministry of Health with participation of funding partners, UNICEF and other implementing partners. Priority areas to support within the programme were discussed and agreed during the development of the annual work plan which was approved by the HDF Steering Committee at the beginning of the year before

implementation began. Programme monitoring was done throughout the year by the HDF Steering Committee during the quarterly, mid-year and annual reviews, as well as during the Joint Review Mission, and adjustments made as required. Feedback was also derived from independent evaluations. Delivery of the programme through the MoHCC ensures ownership and builds on sustainability through capacity enhancement which is critical for continued quality health service delivery.

The financial risks included inadequacy of funds to manage the programme in time, and possible misappropriation of the funds by the implementing partners. To mitigate these, UNICEF in 2016 embarked on a resource prioritization and optimization strategy. UNICEF also used the Harmonized Approach to Cash Transfers (HACT) approach which focused closely monitoring the utilisation of funds while also focusing on strengthening national capacities for management and accountability. The adoption of the harmonized approach is a step in implementing the Rome Declaration on Harmonization and the Paris Declaration on Aid Effectiveness, which call for a closer alignment of development aid with national priorities and needs. The HACT approach initially conducts a micro assessment of the implementing partners' financial management systems with a view to first facilitate capacity development where weaknesses of the implementing partners are and secondly assists in the establishment of appropriate cash transfer modalities, procedures, and assurance activities to be applied by UNICEF. Spot checks where financial verification visits were conducted at intervals determined by the results of the Micro-Assessment. Finally in cases where more than $500,000 was expected to be transferred per year the implementing partners undergoes a 'special audit' of its financial management systems. This is similar to a Micro-Assessment but provides a much more in-depth analysis of the IPs systems.

Risk Analysis Matrix:

Risk	Impact	Likelihood	Mitigation
Deterioration in the economy, resulting in further reduction in government contribution to the health sector.	high	medium	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.
The liquidity crisis in the country persist and continues to impact on programme implementation especially at the sub-national level.	medium	high	Continued negotiations with the Ministry of the Finance and the National Bank of Zimbabwe to ensure that priority is given to institutions delivering humanitarian services. Negotiate with the mobile cash transfer companies for their support in transferring cash to sub-national service delivery points.
GOZ fails to implement required health reforms, in particular elimination of user fees by facilities in the urban areas and	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

Risk	Impact	Likelihood	Mitigation
referral facilities. Children and pregnant women are the primary beneficiaries of the free services, therefore are the ones affected when the policy is not implemented.			voucher system for referrals to higher level facilities.
GOZ fails to implement required health reforms, in particular implementation of the recommendations that will come from the Workload Indicator of Staffing Needs (WISN) study.	low	medium	The Health Service Board has been given the overall responsibility of coordinating and managing the human resource retention scheme, to lobby with the Government for lifting the recruitment ban and to provide additional funding for salaries and wages.
Further outward migration of Human Resources for Health.	medium	medium	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.
Increased political uncertainty could lead to disruption of Programme implementation.	medium	Low to medium	The UN and HDF 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[1] to continue support should political uncertainty lapse into political instability.
Industrial action or strikes by the health workers. Children and pregnant women are the most vulnerable members of	medium	high	Assessment and clarity on the salaries, retention allowances and remaining transparent in the different programmes. Advocacy for adequate remuneration for the staff

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

Risk	Impact	Likelihood	Mitigation
the communities and the main beneficiaries of the health services, and therefore would be worst affected.			
Adverse weather conditions and natural disasters e.g. El Nino leading to disruption of services or increase in malnutrition. Children are the most vulnerable members of the communities and always first to be affected by food shortages.	medium	medium	Disaster and risk management and preparedness, multi sectoral responses at both national and community level.
Unsafe disposal of sharps and other medical wastes contaminating the environment, posing risks especially children who are more exposed to injuries from these wastes.	low	medium	Most health facilities have waste disposal sites disposal sites that were constructed with support from the HTF/HDF.
Breakdown of the cold chain system leading to ineffective vaccines.	low	high	Almost all health facilities have functional cold chain systems with back–up power supply, and all health facilities have well developed contingency plans for managing cold chain failure including timely transfer of vaccines to the nearest functional cold chain.
Negative publicity on public health interventions, e.g. Immunisation, key populations, mass drug administration. These interventions mostly target children, and naturally most affected when the services are disrupted.	low	low	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.
Persistent low utilisation of services by religious	Low to Medium	Low	Targeted community mobilization, engagement with opinion leaders, and gate keepers,

Risk	Impact	Likelihood	Mitigation
and other socio-cultural objectors, mainly affecting women and children, who are prevented from accessing the modern life-saving interventions, with punitive measures sometimes meted out to mothers who take their children for these services.			targeted outreach services. HDF will support operational research to understand and address the barriers to access for these socio cultural groups.
Government institutions have limited capacity to implement programme components effectively.	Low	medium	Targeted technical assistance and capacity building will be built into the HDF.
Corruption, fraud and misuse of funds.	Low	medium	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.
Overall costs of procurement of goods and services escalate beyond reasonable levels.	Low	low	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.
Insufficient funding to cover all the HDF pillars.	Medium	medium	The HDF will advocate for additional funding by other partners, and will encourage more donors to join the fund.

4.0 Financial Analysis

This section provides information on the financial resources that were available to support results implemented in the health outcome area in 2016. A large part of the health outcome area was funded through the Health Transition Fund (HTF 2012 - 2015) which spilled over into 2016 and the Health Development Fund (HDF 2016 – 2020) which commenced in January 2016. Data for the tables provided in this section has been generated from UNICEF's Performance Management system, which is a resource planning system that monitors management and programme performance across the organization. In 2016, the planned budget for Health from UNICEF's Regular Resources, and Other Resources (Regular and Emergency) amounted to **US$60,250,301** as shown in table 1 below.

Table 1: Planned Budget for Outcome Area 1: Health Zimbabwe

Output Areas	Funding Type[2]	Planned Budget[3] (US$)
01-05 Health systems strengthening # General	RR	1,000,000
	ORR	59,250,301
Total Budget		**60,250,301**

Table 2 below illustrates that there were no country specific thematic funds received in 2016 for outcome area 1. This is because the funds used for achieving the 2016 results had been received in 2015 as illustrated in table 4. Total expenditure on thematic funds amounted to **US$1,194,643.00.**

Table 2: Country-level thematic contributions to Outcome Area 1 in 2016 Zimbabwe

Donors	Contribution Amount[4] (US$)	Programmable Amount[5] (US$)
Government of Sweden	0.00	0.00
Total	**0.00**	**0.00**

Thematic funding enabled UNICEF Zimbabwe to respond to priority areas within the programme. This was instrumental to the delivery of quality health services for women and children in Zimbabwe. Regular engagement with the local Swedish Embassy enabled UNICEF to discuss first hand its programme in Zimbabwe and demonstrate the results that the programme is undertaking to enable the equitable and sustained realization of rights for the children of Zimbabwe.

The greatest expenditure incurred in the Health Outcome area in 2016 was in health systems strengthening. Expenditure under this organizational target accounted for 86% of the total expenditure for the outcome area as shown in table 3 below. The funds were mainly spent on procurement of essential medicines and retaining critical staff through the human resources for health scheme.

[2] RR: Regular Resources, ORR: Other Resources – Regular, ORE: Other Resources – Emergency
[3] Planned budget for ORR and ORE does not include estimated recovery cost.
[4] Contribution amount: This is the total amount received from SIDA - Sweden
[5] Programmable amount: This is the amount available for programming which is derived from contribution amount less cost recovery

Table 3: Expenditures in the Outcome Area 1 by Programme Area
Zimbabwe

Organizational Targets	Expenditure Amount[6] (US$)			
	Other Resources - Emergencies	Other Resources - Regular	Regular Resources	All Programme Accounts
01-01 Immunization		2,078,128	597,745	2,675,874
01-03 Maternal and Newborn health		1,104,169	4,052	1,108,221
01-04 Child health	47,461	1,887,493	544,518	2,479,472
01-05 Health systems strengthening		42,894,402	298,071	43,192,473
01-07 Health # General		477,979	1,875	479,854
Total	**47,461**	**48,442,172**	**1,446,261**	**49,935,894**

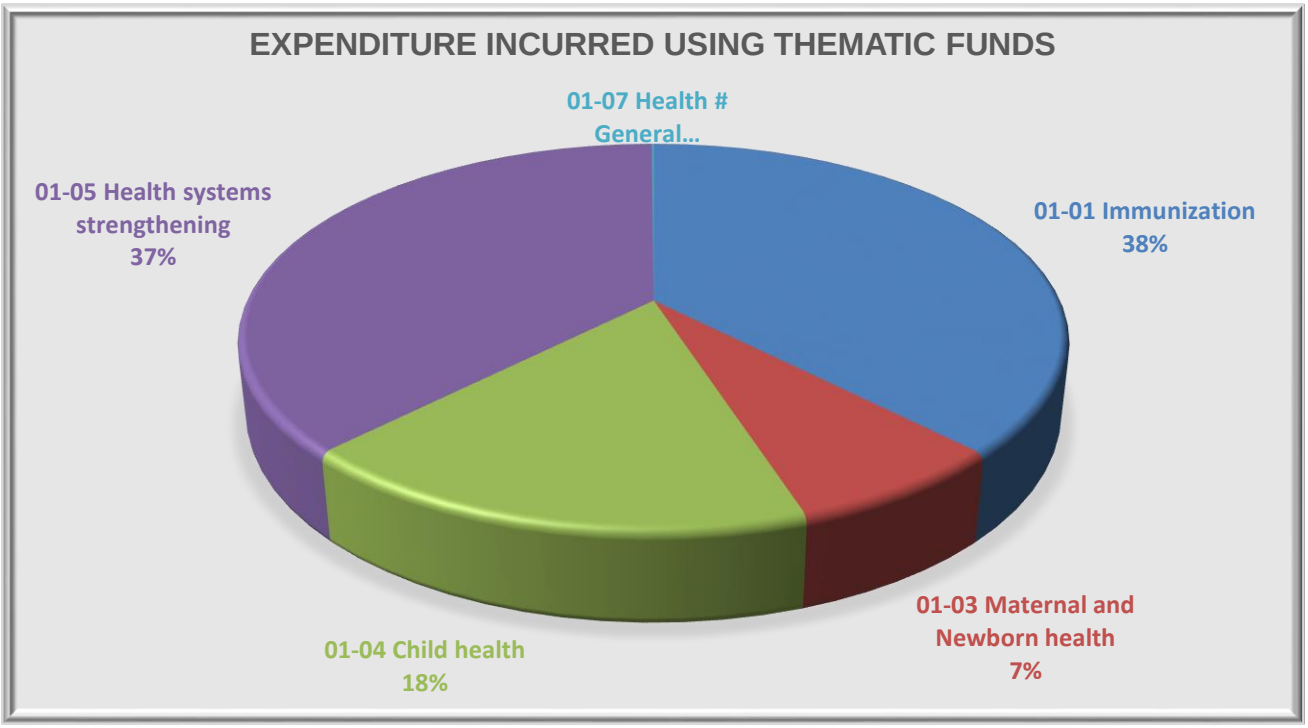
The total expenditure for the health outcome area was **US$49,935,894.00** (as shown in Table 3 above). Table 4, below, shows the components of this expenditure that were directly supported by thematic funding. From the analysis below, thematic funds were very key in supporting all organizational targets for health

Table 4: Thematic expenses by programme area for Outcome Area 1: Health
Zimbabwe

Organizational Targets	Expenditure Amount (US$)
01-01 Immunization	449,694
01-03 Maternal and Newborn health	87,770
01-04 Child health	208,892
01-05 Health systems strengthening	447,198
01-07 Health # General	1,089
Grand Total	**1,194,643**

The pie chart below illustrates the key expenditures incurred using thematic funds in 2016

[6]Expenditure figures provided do not include recovery cost, and are indicative figures obtained from UNICEF Performance Management System



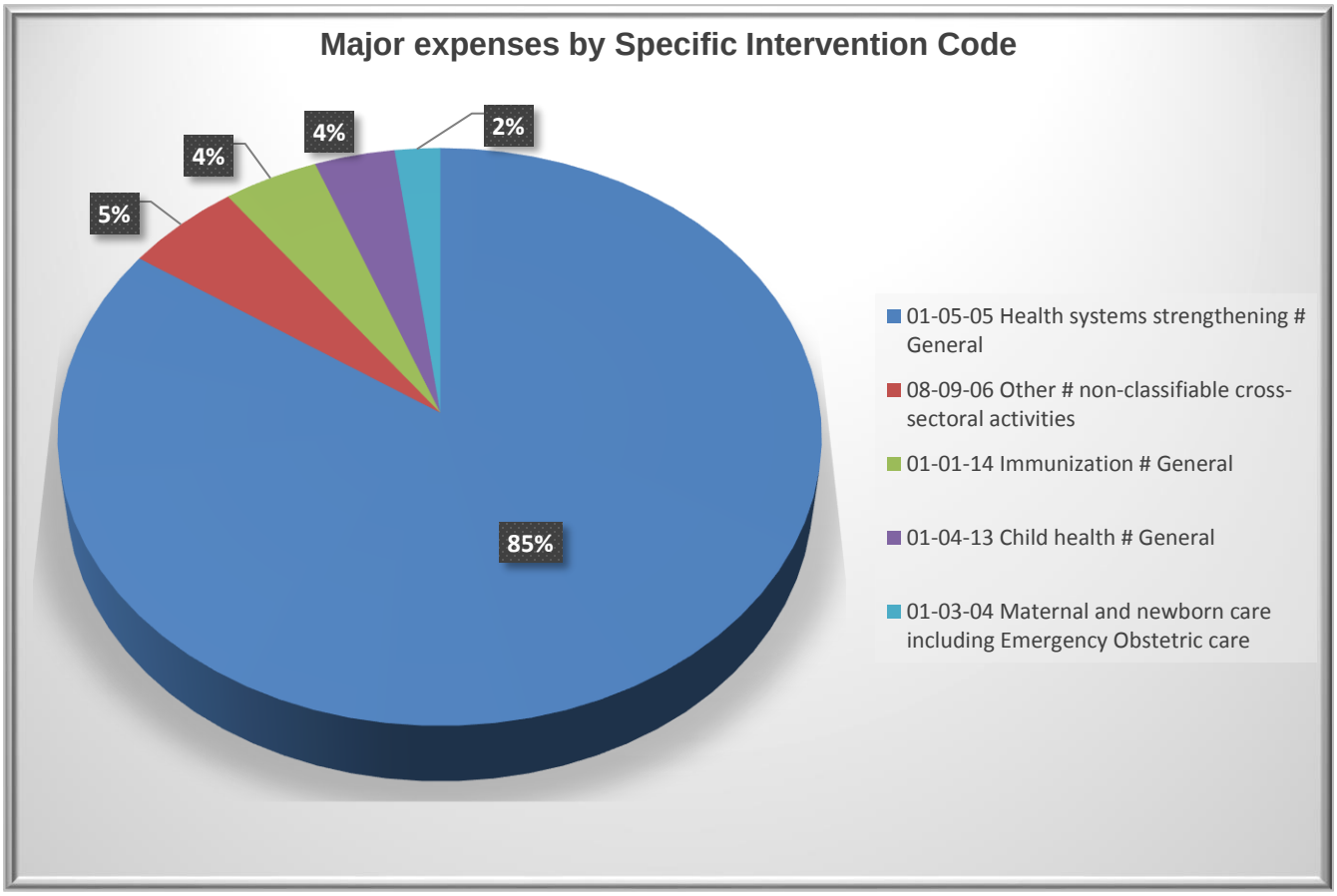
UNICEF also analyses expenditures using Specific Intervention Codes (SICs). Specific Intervention Codes refer to one of four codes that are used to identify an activity in UNICEF's Performance Management System. They enable compilation of data on expenditure by organizational target and key result area. In 2016, the following were the major expenses incurred in the health outcome area, analysed using Specific Intervention Codes.

Table 5: Expenses by Specific Intervention Codes for Outcome Area 1: Health Zimbabwe

Specific Intervention Code	Total Utilized (US$)
01-05-05 Health systems strengthening # General	40,271,568
08-09-06 Other # non-classifiable cross-sectoral activities	2,548,313
01-01-14 Immunization # General	2,083,921
01-04-13 Child health # General	1,753,386
01-03-04 Maternal and newborn care including Emergency Obstetric care	990,491
7921 Operations # financial and administration	481,981
01-07-03 Health # General	432,423
01-04-10 IMNCI # facilities	398,440
01-01-10 Logistics support for immunization	374,812
01-05-02 Health # MIS	234,909
08-02-08 Monitoring # General	113,936
01-03-03 Antenatal and Postnatal care	65,357
08-09-07 Public Advocacy	54,476

6902 Operating costs to support multiple focus areas of the MTSP	28,093
01-04-09 IMNCI # community	27,638
08-06-02 Building global/regional/national stakeholder evaluation capacity	22,208
10-02-05 ICT capacity at country level	21,414
10-03-06 Public Alliances and Resource Mobilization capacity at HQ	10,382
Total	**49,913,748**

The pie chart below illustrates the major expenses incurred by Specific Intervention Codes in 2016.



5.0 Future Work plan

During the subsequent period of 2017 and beyond, the Health Programme will continue to focus on sustaining the gains in the critical areas of MNCH and Health Systems strengthening, while ensuring quality and equity. Needless to mention, in the context of further dwindling of resources, ongoing emergencies and economic challenges including the worsening liquidity crisis, the programme will continue to seek innovation on how best to maximise the meagre resources and ensure efficiencies and value for money. The health outcome area will:

- Build capacity of health workers and facilities to provide comprehensive Immunisation services including outreaches and in humanitarian situations.

- Enhance the capacity of primary health workers and prescribers to provide IMNCI services, including pre-service training institutions.
- Select, forecast and procure vaccines, essential medicines, blood and blood products and RMNCH-A health and nutrition commodities, including during humanitarian situations.
- Support and strengthen national capacity to store and distribute vaccines, essential medicines, blood and blood products, RMNCH-A health and nutrition commodities.
- Strengthen national capacity for rational use of medicines, including product quality assurance, pharmacovigilance activities and support to medicines and therapeutics committees.

Table 6: Planned Budget for 2017 Outcome Area 1: Health
Zimbabwe

Output	Funding Type	Planned Budget	Funded Budget	Shortfall
OUTP 1.1: Health Systems Strengthening	RR	507,667	407,300	100,367
	ORR	36,915,559	9,557,687	27,357,872
OUTP 1.2: Health Policy And Management	RR	240,589	185,205	55,384
	ORR	9,736,902	9,397,739	339,163
OUTP 1.3: Health Services Utilized	RR	184,354	160,000	24,354
	ORR	5,842,141	78,778	5,763,363
OUTP 1.10: Programme Support Costs	RR	437,743	437,700	43
	ORR	5,165,398	1,320,124	3,845,274
Sub-total Regular Resources	**RR**	**1,370,353**	**1,190,205**	**180,148**
Sub-total Other Resources - Regular	**ORR**	**57,660,000**	**20,354,328**	**37,305,672**
Total		**59,030,353**	**21,544,533**	**37,485,820**

6.0 Expression of Gratitude

UNICEF Zimbabwe would like to extend its gratitude to the European Union, GAVI and the Governments of Ireland, Sweden and the United Kingdom for their generous support to the health outcome area which has contributed to the results described in this report.

A special thank you to the Government of Sweden for providing country specific thematic funding that enabled the country office to be more responsive to the issues affecting children with greater flexibility and enabled activities under the health outcome area to continue seamlessly in 2016. Sweden actively participated in several joint field visits to review results based programming. It is also worth noting that Sweden is an active member of the HDF Steering Committee that met monthly under the leadership of the Ministry of Health and Child Care (MoHCC) to steer forward the implementation of the Health Development Fund, which is embedded in the country's National Health Strategic Plan 2016 - 2020 that outlines the priorities of the health sector.

List of Acronyms

ANC	Ante Natal Care
AIDS	Acquired Immunodeficiency Syndrome
ARK	Absolute Return to Kids
ARVs	Anti Retrovirals
BEMOC	Basic Emergency Obstetric Care
CPD	Country Programme Document
CEMOC	Comprehensive Emergency Obstetric Care
CERF	Central Emergency Response Fund
CMAM	Community Management of Acute Malnutrition
DPT	Diphtheria, Pertussis and Tetanus
EMONC	Emergency Obstetric and New-born Care
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
FNSAU	Food and Nutrition Security Analysis Unit
GAVI	Global Alliance for Vaccines and Immunization
GoZ	Government of Zimbabwe
HAART	Highly Active Anti-Retroviral Therapy
HepB	Hepatitis B
HERU	Health Emergency Response Unit
Hib 3	Haemophilus influenza type B vaccine
HIV	Human Immunodeficiency Virus
HTF	Health Transition Fund
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IYCF	Infant and Young Child Feeding
JSI	John Snow International
MDG	Millennium Development Goals
MER	More Efficacious (Antiretroviral) Regimens
MoHCC	Ministry of Health and Child Care
MTCT	Mother to Child Transmission of HIV
OVC	Orphans and Vulnerable Children
PHCs	Primary Health Clinics
PMTCT	Prevention of Mother to Child Transmission of HIV
SAG	Strategic Advisory Group
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
UNFPA	United Nations Population Fund
VMAHS	Vital Medicines Availability and Health Services Survey
WERU	WASH Emergency Response Unit
WFP	World Food Programme
WHO	World Health Organization
YCSD	Young Child Survival and Development
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

Annex 1: Case Studies and photos

The pride of a Village Health Worker

By Meggie Gabida

Village Health Workers (VHWs): Mrs Viola Chapwanya (right) and her mentees at Nemanwa Clinic, Masvingo, August 2016

Nemanwa clinic, Masvingo district, Zimbabwe, 2016 –

In Nemanwa village, south east of Zimbabwe in Masvingo province lies grass thatched round huts that follow a linear pattern along the shoulders of Great Zimbabwe Mountains. Viola Chapwanya, a 58 year old village health worker (VHW) lives in Nemanwa with her husband and grandchildren.

Although her means of livelihood is subsistence farming, Mrs Chapwanya has a passion for saving lives. To achieve this against all odds, she volunteered her time to be a community health worker since independence in 1980 (37 years ago when she was just a 21 year old).

When Mrs Chapwanya saw the UNICEF vehicle heading towards Nemanwa clinic, she was in a nearby village mobilizing communities for the ongoing HIV testing and counselling campaign that was running for five days. She excused herself and came to Nemanwa clinic.

UNICEF is associated with the VHW programme in Zimbabwe as the organization with support from the donors and other partners has played an important role in trainings, procurement of VHWs kits including uniforms, bicycles medical supplies and equipment and payment of the token incentive.

Mrs Viola Chapwanya explained that she has been a volunteer since independence in 1980 and was trained as a VHW in 2000 under the revitalization of the VHW programme. Prior to training as a VHW, she had also volunteered as a chloroquine holder, participated in the village development committee, ward health committee and always had a strong desire to be a community health worker.

"I am a VHW because I am used to do community work and I feel the pride as the community appreciates my work now and then as they come to consult me in my village." – Mrs Viola concluded with a big smile on her face.

Viola was also recently trained with 49 other VHWs in Masvingo district as a mentor/peer VHW supervisor to support, mentor and supervise other VHWs within her ward. This was an initiative supported by UNICEF under the German Natcom funding to take supervision closer to VHWs as there was a gap in supervisory visits from health workers within the community.

Mrs Chapwanya narrated how she felt when she was chosen to be a mentor in her ward.

"The refresher training was so informative and I learnt a lot. When I came back from training, I gave feedback to my colleagues and I am ready to cascade the trainings to other VHWs in my ward. This will help them to improve their skills and confidence to provide health services and support our communities", said Mrs Chapwanya with a broad smile.

The VHWs are playing a pivotal role in providing services at community level ranging from demand creation, treatment of minor ailments and referrals to facility across all generations though UNICEF's thrust is on maternal, new-born and child health services. Data collected through the DHIS 2 shows that VHWs are contributing significantly to early antenatal booking, malaria case management at community level where more than 90% of cases identified within the community are being treated within their homes and referrals for delivery at facility including an increase in the screening of malnourished children