



Independent evaluation of the Health Development Fund (HDF)

*A multi-donor pooled fund supporting the Ministry of Health and
Child Care to improve equitable access and quality of healthcare
in Zimbabwe, with special emphasis on women, newborns,
children and adolescents*

Institutional contract 43251295

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Health Development Fund

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



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The Centre for Maternal and Newborn Health (CMNH) at the Liverpool School of Tropical Medicine (LSTM) conducted the independent mid-term evaluation of the Health Development Fund (HDF) in Zimbabwe from July to December 2018.

The evaluation design and implementation followed the terms of reference for the evaluation, and the approach proposed in the inception report which was approved by the HDF Steering Committee in August 2018.

Following the reviews and approvals from relevant authorities (LSTM Research Ethics Committee, Medical Research Council of Zimbabwe), data collection took place in September and October 2018. Sixty-six stakeholders were consulted through in-depth interviews at various level of the health system. One hundred and fifty-six community members, including women of reproductive age, men, adolescent boys and girls, and community health workers, were involved in evaluating the HDF through focus group discussions. In addition, a quantitative survey was undertaken at District Health Office (DHOs), District Hospitals (DHs) and Primary Health Care (PHC) facility level in 26 districts, targeting 103 health facilities and 26 DHOs.

This **Final Report** presents the key findings of the mid-term evaluation of the HDF, and aims to offer evidence-based, independent reflections on possible short-term options that may be suitable to enhance the effectiveness, equity, value for money and relevance of the HDF. Medium to long term solutions are also presented, reflecting on the sustainability of the measures supported via HDF and of the gains achieved during the implementation so far.

Although the evaluation adopted a participatory approach, with various formal and informal steps of validation and discussion of findings and conclusions, this remains an independent exercise and therefore the views expressed in this report are those of the evaluation team and do not represent those of the institutions referred to in the report. The anonymous statements from key informants presented in the report, represent and express common findings rather than individual opinions.

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The Evaluation Team
Liverpool, 20 December 2018

Acronyms

AAAQ	Availability, Accessibility, Acceptability, Quality
ANC	Antenatal Care
ARV	Antiretrovirals
BEmONC	Basic Emergency Obstetric and Newborn Care
BRTI	Biomedical Research and Training Institute
CBOs	Community-Based Organisations
CDC	United States Centres for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHP	Catastrophic Health Payments
CHS	Community Health Strategy
CHW	Community Health Workers
CMNH	Centre for Maternal and Newborn Health
CoC	Continuum of Care
DALY	Disability Adjusted Life Year
DFID	United Kingdom Department for International Development
DH	District Hospital
DHO	District Health Office
DHS	Demographic Health Survey
DMO	District Medical Officer
DNO	District Nursing Officer
EA	Evaluability Assessment
EOC	Emergency Obstetric Care
EU	European Union
FGD	Focus Group Discussion
FP	Family Planning
GAVI	Global Alliance on Vaccines and Immunisation
GBV	Gender-Based Violence
GDP-PC	Gross Domestic Product Per Capita
GDPR	General Data Protection Regulation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCC	Health Centre Committee
HCP	Healthcare Provider
HCW	Healthcare Worker
HDF	Health Development Fund
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HTF	Health Transition Fund
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
ISP	Integrated Support Programme on Sexual and Reproductive Health and Prevention of HIV and Gender Based Violence
IUCDs	Intra Uterine Contraceptive Devices
JRM	Joint Review Mission
KEQ	Key Evaluation Questions
KII	Key Informant Interview
LF	Logical Framework
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and Evaluation
MDTF	Multi Donor Trust Fund
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoHCC	Ministry of Health and Child Care
MOWAGCD	Ministry of Women Affairs, Gender and Community Development

MRCZ	Medical Research Council of Zimbabwe
MTCT	Mother-To-Child Transmission
MVA	Manual Vacuum Aspiration
NatPharm	National Pharmaceutical Company of Zimbabwe
NGO	Non-Governmental Organisation
ODI	Overseas Development Institute
OECD/DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
PHC	Primary Health Care
PI	Principal Investigator
PNC	Post Natal Care
PSM	Procurement and Supply Chain Management
RBF	Results Based Financing
RMNCH+A	Reproductive, Maternal, Newborn and Adolescent Health
SADC	Southern African Development Community
SBA	Skilled Birth Attendance
SC	HDF Steering Committee
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
ToC	Theory of Change
ToR	Terms of Reference
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
VEN	Vital Essential Medicines
VfM	Value for Money
VMAHSS	Vital Medicines Availability & Health Services Survey
VHW	Village Health Worker
WHO	World Health Organisation
ZAPS	Zimbabwe Assisted Pulled System
ZimAsset	Zimbabwe Agenda for Sustainable Economic Transformation
ZMRC	Zimbabwe Medical Research Council
ZNFPC	Zimbabwe National Family Planning Council
ZUNDAF	Zimbabwe United Nations Development Framework 2016-2020

KEY INFORMATION ABOUT THE EVALUATION

Object of the evaluation	
Programme under evaluation	Health Development Fund
Country	Zimbabwe
Duration of the programme	2016-2020
Total programme proposed budget	681.9 million USD
Evaluation	
Organisation commissioning the evaluation	UNICEF Zimbabwe
Organisation performing the evaluation	Liverpool School of Tropical Medicine
Evaluation reference group	HDF Evaluation Technical Committee
Contract	Service contract 43251295
Timeframe	July to December 2018
Type of evaluation	Mid-term (covering the period January-June 2018)
Scope of the evaluation	Nationwide
Focus priority areas	Health, HIV/AIDS, Nutrition, Gender Equality
Evaluation design	Theory based
Contract deliverables	<ul style="list-style-type: none"> ◇ Minutes of inception meeting ◇ Draft inception report ◇ Final inception report ◇ Field work report ◇ Preliminary evaluation report ◇ Draft final report ◇ Final evaluation report
Date of evaluation report	Final Report: 20 th of December 2018
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Executive summary

Overview of the intervention

The HDF is a multi-donor pooled fund designed to improve reproductive, maternal, newborn, child and adolescent health (RMNCH+A) and nutrition in Zimbabwe between 2016 and 2020. LSTM was contracted by the United Nations Children's Fund (UNICEF) to conduct the mid-term evaluation of the HDF, under the guidance of the HDF Evaluation Sub-Committee and the MoHCC Zimbabwe and with technical and quality assurance from UNICEF Zimbabwe Technical Research and Evaluation Group (TREG).

Intended audience

The final evaluation report is intended for review and use by the HDF Steering Committee (SC) members, including MoHCC officials, other associated line Ministries, donors, UN Agencies and implementing partners.

Evaluation purpose

The purpose of the evaluation was to provide the SC with an independent, rigorous assessment of progress made in the implementation of the fund during the period 2016-2018, and with options for adaptive redesign of the fund and to maximise the efficiency and impact of the fund during the period 2018-2020.

Evaluation objectives

The overall objective was to assess the extent to which the HDF strategies, approaches and overall intervention logic have contributed, during the implementation period, to sustain the delivery of quality, equitable RMNCH+A and nutrition services in Zimbabwe.

The specific objectives were:

1. To assess the HDF programme implementation against the HDF Theory of Change (ToC) using modified Organisation for Economic Co-operation and Development - Development Assistance Committee (OECD-DAC) evaluation criteria which include relevance, effectiveness, sustainability, value for money and efficiency, and equity.
2. To assess to what extent the programme has incorporated human rights-based approach, promoted equity and applied a gender perspective.
3. To conduct robust in-depth analysis of the logical framework (LF) to support the evaluation conclusions.
4. To assess if the available programme data collection tools are definitive and provide good monitoring of the programme performance and make recommendations on how to improve programme monitoring.
5. To analyse the available programme data and information and document lessons learnt, best practices and make recommendations on better programme delivery.

Evaluation methodology

A theory-based approach was taken to the design of the evaluation. A draft ToC was developed through a desk-based review, enhanced and validated through a stakeholder's workshop held in Harare in July 2018. The draft ToC provided a description of the HDF programme logic and of the causal chain envisaged to determined change via HDF supported interventions, and therefore provided a reasonable basis to evaluate the programme.

The evaluation was conducted in line with Norms and Standards for Evaluation set by the United Nations Evaluation Group (UNEG), and the overall protocol was approved by the Zimbabwe Medical Research Council and the Liverpool School of Tropical Medicine Ethics Committee.

Primary data collection was conducted in partnership with BRTI.

Ten key evaluation questions were explored in alignment with the OECD/DAC criteria for international development evaluations, including questions related to relevance, effectiveness, efficiency, sustainability, equity and value for money. Underlying assumptions in the ToC were tested and verified, and issues of gender and human rights embedded in each stage of the evaluation cycle. Primary data were collected through a survey of DHOs and healthcare facilities, key informant Interviews (KIIs), focus group discussions (FGDs) with HDF target beneficiaries, and an online questionnaire. Secondary data was also sourced and reviewed. Data were then triangulated from the various sources to inform the findings, with a ranking method to inform conclusions on the strength of findings.

Key findings

RELEVANCE

Evaluation question 1: Are the HDF interventions and expected results relevant to the needs of its intended recipients?

- **The bundle of intervention strategies supported via the HDF is fully consistent with current international strategies for RMNCH+A**, including the Astana Declaration on Primary Health Care, the Global Strategy for Women's, Children's and Adolescent's Health 2016-2030, the WHO-recommended continuum of care (CoC) and the Global Universal Health Coverage agenda.
- **The HDF supported intervention strategies are highly relevant to the HDF objectives** of reducing maternal, newborn and child mortality and to reduce malnutrition. The HDF design is also highly responsive to the expressed health needs of its *women, men, adolescent boys and girls and children*.

EFFECTIVENESS

Evaluation question 2: How effectively has the HDF pooled fund mechanism performed, against the key principles of aid effectiveness?

- **The HDF pooled fund mechanism performs very well against the key principles of aid effectiveness** including for ownership, alignment and harmonisation, with the highest scores for delivery of results and mutual accountability. Location of financial management of the HDF being largely located outside the MoHCC reduced the score for ownership.
- **HDF governance is well performed, and is catalytic as a broad, health sector coordination support mechanism** with a SC led by the Permanent Secretary of the MoHCC and active participation of all members.
- The original funding expectations for the HDF were higher than the actual allocations available in 2016 and 2017, **but the HDF planning function has allowed additional resources to be catalysed and resources used flexibly and according to priorities**. However, plans were complex and present some areas where improvement in integrated planning could take place (e.g. training, outreach, social mobilisation).
- **The fund management function was well performed**, particularly given the complexity of HDF plans and a fast-changing environment
- **Monitoring and evaluation (M&E) function is performed to high standards** in terms of data collection and reporting, although some of its design features present areas of improvement. This has particularly to do with the utilization of a dual logframe, to report indicators of the Fund. Also, stronger analysis may be an opportunity for better use of data for decision making. While the LF is not a strength of the fund, a great deal of data is produced, used and reported via the HDF

Evaluation question 3 and 4: What was the progress in achieving the HDF intended results, during the period 2016-2018? What were the main facilitators and barriers to achieving the HDF results, during the period 2016-2018?

- **The procurement of medicines, supplies and commodities for RMNCH+A and nutrition has only partially contributed to enhance availability of care**. Most milestone targets were achieved for these indicators in the LF, reported through the VMHAS survey and largely confirmed by the LSTM survey in October 2018. However, there is also evidence of

regular stock outs, with reported expiry of medicines and long lead times for receiving products. The availability of medicines remains a critical bottleneck in both providing and accessing care.

- **The procurement of equipment has been supportive to ensuring availability of care** across programmes including nutrition, antenatal care (ANC), newborn care, cervical cancer screening, manual vacuum aspiration (MVA) and others. Some barriers are noted but, in spite of these challenges, lack of equipment is not a major bottleneck in providing and accessing care.
- **Village health workers (VHWs) are a strong contributor to linking communities with health services, and to providing health promotion, preventive care and referral.** Investment in VHWs has been a key strategy of the HDF. Challenges include timely payment of allowances, availability and replacement of equipment, availability of supplies of medicines and commodities and fragmentation of the overall approach. However, there is overwhelming evidence of the contribution of VHWs to availability and access to care, with strong links and collaboration between VHWs and HCPs, and high appreciation of the services provided by VHWs by community members.
- **Improvements in the availability of key HCPs have been achieved but some downwards trends are evident in recent years.** The overall health workforce grew by approximately 10% between 2015 and 2018, with the greatest increase among nursing cadres, followed by doctors and nutrition cadres. The availability of many key cadres improved over the period under review, leading to a significant decline in vacancy rates, from 21% in 2015 to 13% in 2018. However, progress towards achieving the LF target has been variable in recent years, with the proportion of district hospitals with at least 3 doctors declining from 80% in 2016 to 60% in 2018. Deficiencies and imbalances in the supply of critical cadres across the sector continue to be a challenge for the sector, affecting the availability and accessibility of services.
- **Capacity development interventions have improved the knowledge and skills of HCPs and is improving the availability and coverage of essential services** Increasingly a mix of training approaches are being used and there is less reliance on workshop training. A high proportion of HCPs are receiving on the job training and mentorship across a range of subject areas at both primary and district facility level. Because of these capacity development initiatives, HCPs report improved knowledge, skills and competencies and enhanced confidence in applying learning to the job supportive supervision is also consistently performed and highly appreciated by HCPs. However, further improvements are needed in reducing workshop-based training, ensuring health workers have the tools to apply their knowledge and skills, and in retaining trained HCPs, trainer and mentors.
- **The results-based financing (RBF) has strongly contributed to enhance access and availability of care, and to strengthen accountability at health facility and community level** RBF has enabled the removal of user fees for RMNCH+A and nutrition services (LSTM survey found that zero facilities charging user fees for ANC), with positive effects on demand and access. However, 54% of respondents were not satisfied with the administrative procedures, and 63% of facilities reported delays in payments. At national level there have been some delays to transitioning RBF into MoHCC structures.
- **There is strong evidence of the contribution of the HDF to enhancing governance at all levels of the health system** At national level, the HDF has contributed to strategies, policies and plans, and supported multi-sectoral dialogue and planning. At district level, the planning function is universally performed. 100% of health facilities receive at least one supportive supervisory visit per quarter and 100% of health facilities have a Health Centre Committee (HCC) in place. 90% of PHC facilities display the Patient's Charter and 86% have a suggestion box.
- **Essential care for RMNH+A and nutrition is available and performed** A range of essential RMNCH+A and nutrition services are universally available to the population at health care facilities, at both primary and secondary levels of care. A high proportion of secondary level facilities report offering services continuously on a 24/7 basis including delivery (100%), postnatal care (PNC) (81%) and sexual and gender-based violence (SGBV) (88%). Services, including emergency obstetric care (EOC), are also regularly performed.
- **There is some evidence of improvement in quality of care, and care is largely acceptable to clients** The RBF reported quality scores ranged from 75% to 95% across the 42 HDF districts. Care is also largely acceptable to end users. Client satisfaction scores measured via RBF surveys ranged from 79% to 96% in Q2 2018. Qualitative evidence from this evaluation also provides a strong, consistent story of improved satisfaction with quality of services and with attitude of staff at healthcare facilities.

- **Access has improved, although structural barriers in accessing basic needs persist** Qualitative findings from the evaluation indicate that women, children and adolescents were no longer paying user fees. The abolition of user fees has been the main driver for people coming in numbers to the health facilities and for making home deliveries a rare event. However, challenges remain including with transport to reach facilities, money for emergency transport in case of referral, access to food and clean water sources, and gender issues including male partners knowledge and behaviour and sex of health care workers (male nurses to care for male adolescents).
- **The utilisation of healthcare services has largely been sustained during the period 2016 to mid-2018, despite the fragility of the external environment in Zimbabwe** Routine data from the Health Management Information System (HMIS) suggest that the utilisation of services has been sustained, and that it has improved for some indicators, during the period of implementation of the HDF. Trends are mostly in line with the improvements noted in the two years that preceded the inception of the HDF.
- **There is some evidence of change of behaviour and practices at community level** The FGDs highlighted that some health seeking behaviours have changed, including increased booking early for ANC, attending a health facility for delivery, and seeking care from VHWs and health facilities for other health concerns.

Evaluation question 5: Is there any evidence of any unintended results produced by the HDF?

- Limited evidence is found about major unintended effects produced by the HDF.

EQUITY

Evaluation question 7: Does the HDF embed an equity focused approach in its design and in its delivery mechanisms?

- **The HDF design is fully and strongly respondent to a logic of addressing inequities.** Various features of the HDF programme design are strongly confirmatory of the fact that the programme was designed with equity in mind, as a critical dimension of the programme. Most of the HDF supported interventions have been identified and implemented with equity in mind as one of the drivers for action.
- **The HDF delivery mechanisms present opportunities for further enhancing an equity-focused approach** The HDF implementation strategies demonstrate various degrees of equity-focused implementation. Procurement of medicines, supplies and commodities and outreach demonstrate high equity-focused implementation, with RBF demonstrating moderate equity focused implementation. There are opportunities to enhance the equity focused implementation patterns of support for VHWs, Community Mobilisation and Maternity Waiting Homes (MWHs).
- **Available data at mid-term do not show reductions in the equity gap for key RMNCH interventions** Two possible lenses of analysis were applied to assess whether the HDF, besides adopting highly equitable interventions, has also contributed to prioritize those most in need in receiving such intervention. There is no evidence to support this case. This finding highlights the need and opportunity to adopt an equity lens in monitoring progress and achievements of the HDF, and in planning for the allocation of resources to the health sector, via HDF.

EFFICIENCY AND VALUE FOR MONEY

Evaluation question 8: What are the costs of the HDF and what are the main cost drivers related to fund management and implementation?

- **Total HDF spending amounted to 42% of the originally planned HDF budget.** This proportion reflects the availability of funds provided by donors to the fund over the course of implementation so far.
- **The major cost drivers** include procurement of medicines and supplies (PSM) (27.39%), human resources for health (HRH) incentives and allowances (16.16%) and financing (13.52%).
- **Minor cost drivers**, defined as those categories under 1% of expenditure include supervision, advocacy and communication, mentoring, and support to Technical Working Groups (TWGs).
- **The average spending** for the HDF is estimated to be 5.18 USD per capita.

Evaluation question 9: What is the Value for Money (VfM) of HDF when relating these costs to economy, efficiency, effectiveness and equity?

- **The timeliness of the disbursement of funds is adequate.** The average days to disbursement among the small sample of activities is 15.75 days and reflects a standard level of disbursement efficiency of two weeks
- **The HDF is cost effective and provides good VfM.** The HDF is “cost-effective” relative to reducing child mortality when compared to international benchmarks and WHO cost-effectiveness guidelines. Based on the base case analysis, the cost per disability adjusted life years (DALY) averted is cost-effective. Based on a sample of resource cost items provided, the economy and efficiency in current financing is acceptable.

Evaluation question 10: How can available resources be used more efficiently and effectively, to maximise the benefits of the HDF?

- **The relationship between burden of disease and HDF resource allocation will be examined** to guide and ensure maximum efficiency and VfM within the context of limited health sector resources in Zimbabwe. The existing VfM Framework can be complemented by cost effectiveness analysis assist the HDF going forward, into the subsequent years of implementation.

SUSTAINABILITY

Evaluation question 6: What are the risks to sustainability of the results and outcomes produced through the HDF?

- **The HDF at mid-term lacks a roadmap to transition.** This is a critical gap for the sustainability of the interventions sustained through the programme. A roadmap to transition may entail various options, which do not necessarily imply a full ‘exit’, including dissolving the fund completely; handing over the activities to the government, transitioning to budget support, or shifting to another pooled fund. There is already a transition plan in place for RBF which can serve as an example to draw a broader exist strategy encompassing the other interventions supported through the HDF.
- **Fiscal space and the current external environment remains a critical barrier to transferability and long-term sustainability of the HDF supported strategies** The HDF operates in a complex environment in terms of social, political and economic outlook. This remains a critical feature that will require continuous monitoring and critical assessment from the SC, to inform judgements about the sustainability of and need for the HDF in the short and medium term.
- **The degree of technical sustainability and transferability of the major HDF supported strategies varies across interventions. Not all risks to technical sustainability may be addressed within the life of the HDF.** The degree of sustainability of intervention strategies is assessed against the following criteria: enabling environment; organisation capacity; community capacity; scale and scale-ability; and non-financial risks to sustainability. The assessment demonstrates there are aspects of technical sustainability and transferability of the interventions to be addressed for various HDF supported interventions, including RBF, procurement of medicines, commodities and supplies, capacity strengthening of HRH and community health system strengthening.

Key Conclusions

- The package of services supported through the HDF is highly responsive to the needs of its intended target groups.
- Consistently with its design and ToC, the implementation of the HDF has contributed to sustain availability, quality, accessibility and acceptability of care for RMNCH+A, and community engagement in Zimbabwe.
- This has been possible thanks to a consolidated model of funding and delivery, which has benefitted from a solid governance and fund management, with strong MoHCC leadership and teamwork of multiple stakeholders.
- As a result, notwithstanding budget constraints and more importantly an increasingly difficult economic situation, the Fund has contributed to sustain utilisation of care nationwide.

- This has been done efficiently and providing good VfM.
- Systemic challenges persist within the health sector. Concurrently, communities face significant access barriers, related to basic needs.
- Also, some gender-based issues emerge, that are a barrier at household and community level for women and for adolescent girls in attaining their right to health.
- Monitoring the challenges and barriers – with a focus on the most at risk - and being able to flexibly provide a response to immediate needs will be a critical function of the HDF, looking forward.
- Besides sustaining the gains achieved in Zimbabwe through possible short-term measures, the added value of the HDF will be preserved by protecting the key strategies that it has supported, and by identifying pathways to transition – in the medium or long term.

Key recommendations

The evaluation recommends that:

Recommendation 1 – Transition roadmap

The SC develops a Roadmap for Transition which may entail various options including a staged approach, or a third pooled fund phase, or complete hand over to government.

Recommendation 2 – Planning

UNICEF and UNFPA provide technical guidance to continue using the HDF planning process as a catalyst for joint action at health sector level. In the current situation, plans and agreed allocations should be reviewed on a regular basis to be responsive to the changing environment, informed by regular assessments of risk analysis and forecasting.

Recommendation 3 – M&E

UNICEF and UNFPA invest in strengthening the ability of the HDF to make strategic use of the high-quality information produced via various M&E sources used by the HDF, and work to produce an agreed dashboard to serve as a platform where strategic information from various sources will be brought to synthesis to inform planning. In the current situation, targets should be revised on a quarterly basis with reinforcement of real time monitoring of HMIS data on utilisation of services.

Recommendation 4 – Equity

UNICEF provides technical leadership for an in-depth assessment of how the design of the HDF can sustain a stronger equity focused implementation approach, across its strategic components. Under the guidance of UNICEF, the SC would then support the definition of an equity strategy and monitoring plan.

Recommendation 5 – Gender

UNICEF and UNPA use their technical capacity in community-based behaviour change interventions, to design and implement appropriate strategies aimed at addressing gender-based issues that affect women of reproductive age and adolescent girls at community level. These initiatives will prioritize addressing the attitude and behaviour of men and of male adolescents, which acts as barriers for women and adolescent girls in attaining their right to health.

Recommendation 6 – HR strategies

The HDF supports the MoHCC to disseminate the new HRH Strategic Plan across all levels and to translate and prioritise the strategies and interventions contained in the Strategic Plan into a costed annual implementation plan, will target and address key HRH priorities and challenges and be aligned with the Health Sector annual workplan and budget. In the current situation, any consideration of short term measures to address current workforce deficits and imbalances should be in close consultation with policy-makers at the national level in the health, finance and planning sectors, and be rooted in an analysis of real constraints, and an in-depth understanding of labour market dynamics.

Recommendation 7 – Capacity development

The HDF continues to support the design and delivery of coordinated capacity development interventions across the continuum of learning. In the current situation the HDF could prioritise capacity development in areas related to emergency response, SGBV and malnutrition.

Recommendation 8 – Result Based Financing

While monitoring closely the 'pilot transition phase' to be supported via WB, SC will work to remove technical/implementation barriers to the transition, seeking solutions to simplify the mechanism related to payments, verifications, and data collection of the RBF. In the current situation, the HDF should sustain RBF and seek short term solutions to address current operational challenges related to shortage of goods and cash. If additional funding is made available, HDF could also consider demand side financing mechanisms to overcome barriers to access.

Recommendation 9 – Community Health Strategy

The SC ensures that the Community Health Strategy (CHS) is finalized, supported by an operational plan, and implemented. In the short term, as the strategy is finalised, current VHWs should be supported with necessary equipment and supplies where needed. Mechanisms to ensure timely accessible payments will be pursued. In the current situation, VHWs will be sustained to increase activities for surveillance, active case finding, health education with increased support from facilities (via supervision at community level).

Recommendation 10 – Procurement and supply management

UNICEF and UNFPA continue to procure medicines, commodities and supplies as per current arrangements. The MoHCC should continue to mobilise domestic resources for procurement of medicines, commodities and supplies, and prioritize the finalization of procurement frameworks (LTA), to allow for timely and cost-effective procurement at the lower levels. In the current situation, UNICEF/UNFPA will support the MoHCC to use available domestic resources to procure essential drugs not provided via HDF. Additional available funds should prioritise actions that ensure availability of medicines (procurement, distribution, monitoring).


INTRODUCTION

The HDF is a multi-donor pooled fund designed to improve reproductive, maternal, newborn and adolescent health (RMNCH+A) and nutrition in Zimbabwe between 2016 and 2020. The design is based on a consolidated model of pooled financing mechanisms, implemented in Zimbabwe across various social sectors¹ since 2009, the HDF entails a plan of investment of nearly 700 million US\$ to support the MoHCC in strengthening health systems and in scaling up the implementation of RMNCH+A and nutrition interventions.

LSTM was contracted by UNICEF to conduct the mid-term evaluation of the HDF under the guidance of the HDF Evaluation Sub-Committee and the MoHCC. The evaluation covers the period of HDF implementation going from its launch in early 2016, to mid-2018.

The structure and content of this evaluation report are designed according to recommended practice for evaluation and particularly follow the UNICEF guidelines for evaluation reports, and the UNICEF Global Evaluation Reports Oversight system^{2,3}.

- **Section 1** of the report presents a descriptive analysis of the object of the evaluation, of the context in which the intervention under evaluation has been implemented, and of the key stakeholders involved in it.
- **Section 2** presents a short description of the purpose, objectives and scope of the evaluation, largely drawing on the Terms of Reference (ToR) for the evaluation, and on the inception report.
- **Section 3** provides the key features of the design adopted for the evaluation, and of the methods of data collection and analysis used to address the evaluation questions. Detailed description of the design and methods are contained in the inception report, and in the data collection reports, all included as Annexes. All the data collection tools and all the data sets utilized for the evaluation have been provided to UNICEF, as per contractual obligations.
- **Section 4** documents the implementation arrangements utilized to perform the evaluation. This includes a detailed workplan, a presentation of the various deliverables achieved throughout the process, and a description of the partnerships made to implement the work at its various stages.
- **Section 5** presents the findings of the evaluation, by evaluation criteria and against each of the agreed key evaluation questions (KEQ).
- **Section 6** focuses on the conclusions which stem from the analysis and triangulation of the key findings, and on the key lessons learned in performing the evaluation work.
- **Section 7** presents a set of short and medium-term recommendations to the key stakeholders involved in the implementation of the HDF.

Key findings and considerations on the aspects of gender and human rights are presented within each section of the report, where relevant, rather than in a stand-alone chapter. Considerations on gender are specifically flagged in the various section of the report with the symbol: 

In order to optimise the readability and usefulness of the report, key data and information that are useful for the reader, although too detailed to be included in the main body of the report, are presented as **Appendixes** and included as part of this report. Other additional documents useful as background information are presented instead as stand-alone **Annexes**, which are provided to the reader as separate files from this report.

¹ Post-crisis Zimbabwe's innovative financing mechanisms in the social sectors: A practical approach to implementing the new deal for engagement in fragile states. BMC International Health and Human Rights. 2014

² UNICEF Global Evaluation Reports Oversight System, https://www.unicef.org/evaluation/index_GEROS.html

³ UNICEF-Adapted UNEG Evaluation Reports Standards, Updated June 2017

SECTION 1. OBJECT OF THE EVALUATION

The Health Development Fund (HDF) at a glance

Object of the evaluation

- 1.1. The object of the evaluation is the HDF. The HDF is a multi-donor pooled fund designed to ‘continue consolidating and improving on gains that Zimbabwe has made in RMNCH+A and nutrition over the period 2016-2020. The HDF aim is ‘to support the MoHCC in the context of the 2016-2020 National Health Strategy to achieve the goal of improving the quality of life of its citizens, through guaranteeing every Zimbabwean access to comprehensive and effective health services’.

The HDF has a total duration of five years (2016-2020), with an estimated budget of 681 million USD.

- 1.2. The key features of the HDF are summarized in [Table 1](#)

Table 1. Key features of the HDF

Object of the evaluation	Health Development Fund	
Country	Zimbabwe	
Donors	The Governments of the United Kingdom of Great Britain and Northern Ireland represented by the Department for International Development (DFID); the Government of Ireland represented by Irish Aid; the Government of Sweden; the European Commission represented by the Delegation of the European Union to Zimbabwe; GAVI, the Vaccine Alliance	
Fund manager	UNICEF	
Duration of the programme	5 years, from 2016 to 2020	
Total proposed programme budget	681 million USD	
Proposed programme budget for the period 2016/2017	270.9 million USD	
Expenditure for the period 2016-2017	113.9 million USD (42.1% of programme budget for the period)	
Coverage	National	
Focus population	Women, children and adolescents (especially pregnant and lactating women and children under-5)	
Key programme components	Component	Total 5-year budget (2016-2020)
	Thematic Area 1, Maternal, Newborn and Child Health and Nutrition	39.4 M (6%)
	Thematic Area 2, Sexual Reproductive Health Rights	185 M (27%)
	Thematic area 3, Medical Products, Vaccines and technologies (Medicines and Commodities)	208.7 M (31%)

Thematic area 4, Human Resources for Health	70.2M (10%)
Thematic area 5, Health Financing	56.9 M (8%)
Thematic area 6, Health Policy, Planning, M & E and Coordination	18.8 M (3%)
Thematic area 7, Technical Support, Operations Research and Innovation	23.2 M (3%)
Programme management costs	35 M (5%)
Indirect cost recovery	44.6 M (7%)

The logical model of the Health Development Fund (HDF)

Purpose, goal and logic model of the HDF

1.3. The purpose and goal of the HDF are defined as follows⁴

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 mother-to-child transmission (MTCT) by 2020, combating HIV and AIDS, malaria and other prevalent diseases.

Purpose To continue to consolidate and improve on gains made in maternal, newborn child and adolescent (young people) health by strengthening health systems and scaling up the implementation of high impact RMNCH+A; and nutrition interventions through support to the health sector.

1.4. The HDF was designed in 2015. Its design and intervention logic stem from previous initiatives implemented to support the health sector in Zimbabwe, and in particular from the Health Transition Fund (HTF), a pooled fund managed by UNICEF and supporting maternal, newborn and child health and nutrition outcomes from 2012 to 2015, and the Integrated Support Programme on Sexual and Reproductive Health and Prevention of HIV and Gender Based Violence (ISP) managed by UNFPA, supporting sexual and reproductive health and rights.

1.5. Bringing together the experience and expertise gained through the two initiatives, the HDF is designed to sustain coverage of essential RMNCH+A and nutrition interventions. These include: ANC, intrapartum care, PNC, immunization, child health services, maternal and child nutrition, family planning, cervical cancer, MWHs, adolescent sexual and reproductive health, gender-based violence (GBV), fistula, post abortion care.

1.6. The HDF programme logic entails that this is realized via three major intervention strategies, delivered nationwide in support of the Ministry of Health National Health strategy 2016-2020:

- Policy development, governance and coordination at national level
- Integrated measures to strengthen the health system and health service delivery nationwide
- Demand side interventions to sustain community engagement and participation in health

⁴ HDF Programme Document, accessed at: https://www.unicef.org/zimbabwe/HDF_Final_Draft.pdf

1.7. These strategies are implemented through a well-defined architecture, articulated in the HDF programme document and agreed by all stakeholders at programme design stage. In fact, the HDF programmatic design is developed and implemented along seven key thematic areas of work (**Figure 1**) that are fully consistent and coherent with the building blocks of the WHO Health Systems Framework⁵.

Figure 1. Thematic areas of the HDF



1.8. The HDF did not have an explicit ToC in place. The evaluation supported the design of a draft HDF ToC at inception, as a basis to evaluate the programme. The ToC was developed through a desk-based review of all programme documents, and then enhanced and validated through a stakeholder’s workshop held in Harare in July 2018. The draft ToC provides a description of the HDF programme logic and of the causal chain envisaged to determined change via HDF supported interventions.

1.9. The ToC is presented in summary **Figure 2**. The full ToC as designed at the inception of the evaluation is included in **Appendix 1**; its narrative can be summarized as follows:

Within a resource constrained socio-economic environment, with limited government expenditure on health, the gains obtained in enhancing maternal, newborn and child health outcomes can be sustained via a pooled fund, that catalyses financial and technical resources to support the MoHCC in strengthening the health system and in improving community participation, hence improving RMNCH+A and nutrition nationwide. Therefore,

if Zimbabwe’s political environment remains stable and its commitments to maternal, newborn and child health is maintained and increased;

if donor’s commitment to support the national health strategy via pooled fund is maintained as per plans

if MoHCC provides leadership and stewardship of the interventions to be sustained via pooled fund

if the fund manager provides efficient and effective coordination, fund management and technical assistance,

then:

→ The policy environment and the overall capacity of governance and management of MoHCC at all levels will be supported and improved;

→ Healthcare managers and HCPs will be retained at healthcare facilities, supported in their technical capacity and motivated to deliver quality services;

→ Commodities, medicines and essential equipment and infrastructures will be available at primary and secondary care levels, to deliver quality services for adolescents, women and children;

→ Facilities at primary and secondary level will have sufficient funding to deliver services effectively and at required standards;

→ Communities will be engaged in action for social change;

if these conditions are met, **then the availability, accessibility, acceptability and quality⁶ of healthcare will improve.**

Consequently, Zimbabweans will fulfil their essential right to equitably access health care services for RMNCH+A and nutrition nationwide, and communities, households and duty bearers will improve their knowledge, behaviour and participation in health and social change.

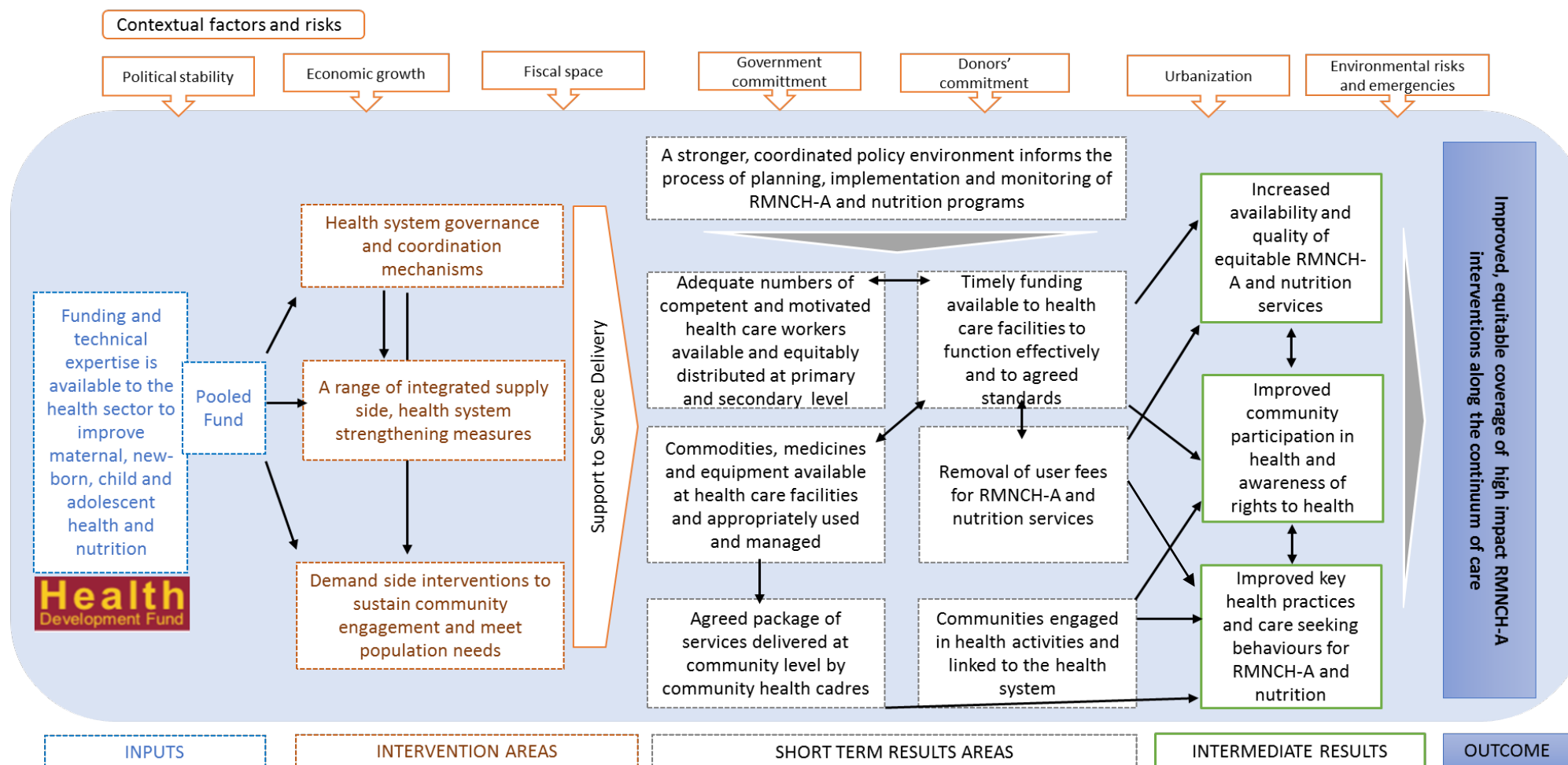
This will permit to sustain coverage of essential RMNCH+A and nutrition interventions at scale, and therefore to reduce mortality and morbidity for adolescents, women and children.

⁵ Monitoring the Building Blocks of Health Systems. WHO, 2010. Accessed at: http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

⁶ World Health Organisation. The Right to Health, Fact Sheet. August 2017. Accessed at: http://www.who.int/mediacentre/factsheets/fs323_en.pdf

Figure 2. Theory of Change of the Health Development Fund

The Health Development Fund in Zimbabwe: Theory of Change



Results framework of the HDF

- 1.10. The key impact and outcome indicators were developed at proposal stage and are clearly summarized in the programme document. A detailed results framework was then developed at inception, identifying seven levels of outputs as the key areas that would support the achievement of outcome and impact.
- 1.11. The results framework is constructed as per the DFID LF format and presents a total of 112 indicators: 8 at impact level; 33 at outcome; 71 at output level. Its features are highlighted in **Table 2**.

Table 2. Key features of the HDF results framework as per logframe

Level of change	Type of change measured	No. of indicators	Sources
Impact	Population level: Mortality; Morbidity; Fertility	8	National surveys (DHS, MICS)
Outcome	Population level: coverage of essential RMNCH+A and nutrition interventions	33	National surveys (DHS, MICS)
Outputs			
Output 1: Maternal and newborn care	Availability of health personnel Availability of MNH services Performance of services Availability of equipment and supplies Reporting	15	HMIS; Vital Medicines Availability and Health Services Survey (VMAHS); Administrative reports
Output 2: Child health	Availability of skilled health personnel Availability of MNH services Performance of services Service coverage Availability and functionality of equipment Availability of medicines and vaccines	8	HMIS; VMAHS; Administrative reports
Output 3: Nutrition services	Planning Availability of nutrition commodities Service availability and performance	4	Administrative reports VMAHS
Output 4: HIV prevention services	Availability of skilled personnel Implementation of guidelines Service utilization Availability of services and supplies	6	Administrative reports VMAHS HMIS
Output 5: Sexual and reproductive health	Availability and performance of services Service utilization Service coverage Planning Availability of skilled health workers Availability of medicines and supplies Campaigns	24	Administrative reports VMAHS HMIS Ad hoc surveys
Output 6: Community awareness	Population coverage with community interventions Training of community-based cadres	8	Project records
Output 7: M&E	National and District level planning and reporting Delivery of Operations Research Support to policies and strategies	6	Project records VMAHS

Intended beneficiaries

1.12. The HDF programme document identifies the focus population and ultimate beneficiaries of the HDF as follows:

- Women (in particular pregnant and lactating women)
- Children (in particular children under-5)
- Adolescent boys and girls
- Healthcare managers, HCPs, community health volunteers and community-based organisations (CBOs) will also benefit from programme activities

The intended beneficiaries (right holders) of the programme, by type of intervention area supported by the HDF, are indicated in **Table 3**. Given the national intended coverage of the HDF, the intended beneficiaries are presented here as the entire population groups for Zimbabwe.

Table 3. HDF intended beneficiaries

Stakeholders' groups	Estimated beneficiaries, by intervention		
	Maternal and newborn health	Child health and nutrition	Sexual and reproductive health
Adolescents boys and girls			3,620,000 ⁷
Women of reproductive age	3,760,000 ⁷		3,760,000
Pregnant women	665,000 ⁸		
Newborns	535,000 ⁶		
Children under the age of 5		2,539,000 ⁶	

HDF structure and key stakeholders: governance, management and implementation

Fund structure

- 1.13. The HDF is designed and managed according to a consolidated model of governance, implementation and monitoring of activities, and on the basis of a well-articulated set of processes and tools.
- 1.14. As per initial plans, the donors to the HDF included: The Governments of the United Kingdom of Great Britain and Northern Ireland represented by DFID; the Government of Ireland represented by Irish Aid; the Government of Sweden; the European Commission represented by the Delegation of the European Union to Zimbabwe; GAVI, the Vaccine Alliance. During the implementation of the HDF, additional funding was also raised towards the HDF via UNICEF, UNFPA and MoHCC.
- 1.15. The fund structure presents features of a highly participatory involvement of multiple stakeholders, at both national and subnational level, under the strategic and operational leadership of the MoHCC.

It is intended to perform the following key functions:

Fund governance

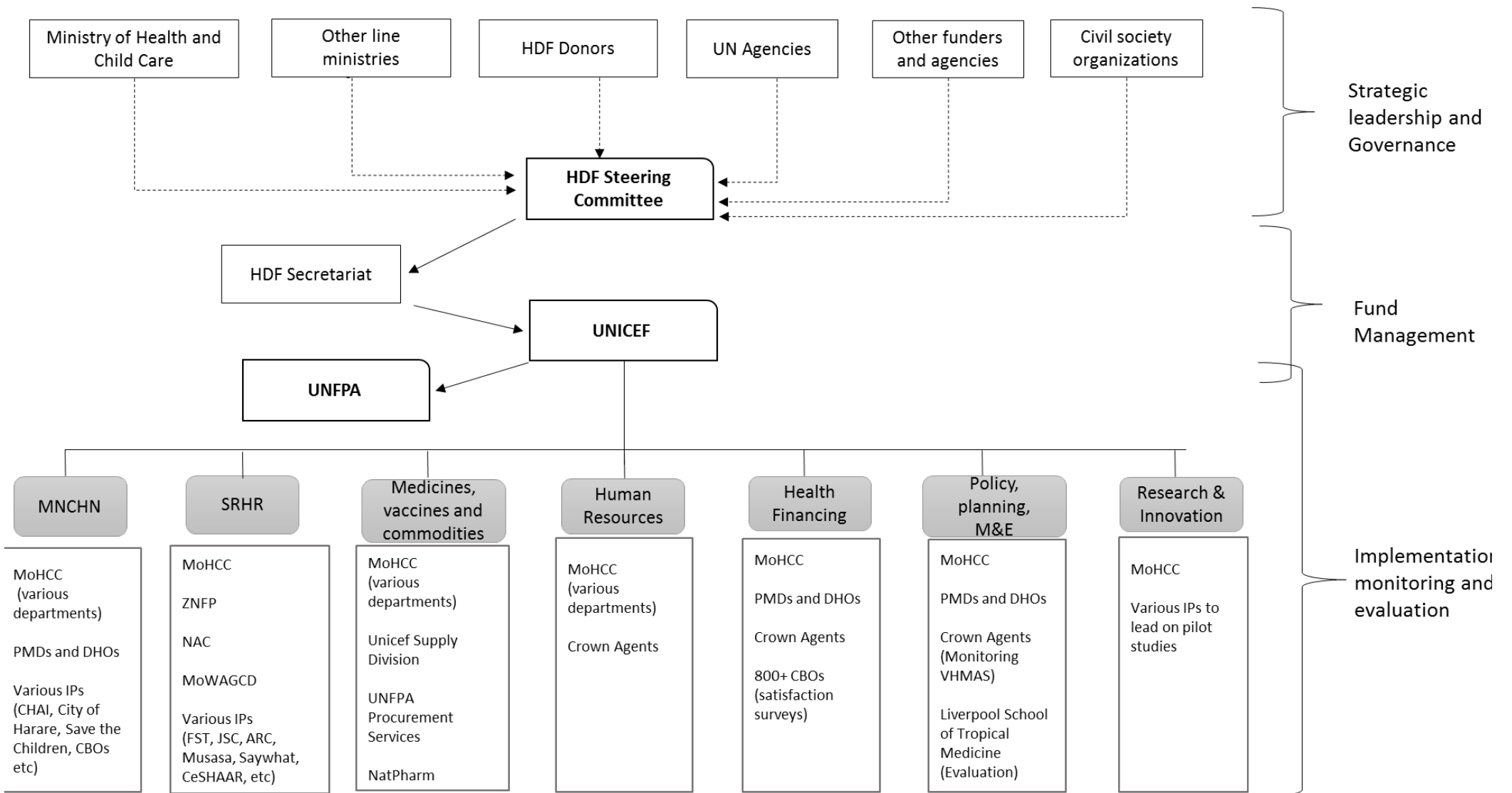
- ◇ Fund management
- ◇ Technical assistance and implementation of activities
- ◇ M&E

The overall structure of the fund is represented in **Figure 1**. A short description of the above referred key functions of the Fund and of the stakeholders involved in each of those functions is provided below.

⁷ Countdown to 2030 Dashboard for Zimbabwe: <http://profiles.countdown2030.org/#/ds/ZWE>

⁸ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205239>

Figure 3. Governance, management and implementation structure of the HDF



Governance

- 1.16. The HDF is governed by a SC, chaired by the MoHCC with a partner co-chair. The SC is **responsible for strategic leadership, planning of activities, oversight and decision making of the HDF.**

The role and function of the SC are regulated by ToR. Membership rules are in place, entailing the participation of nine voting members (the quorum is set at 2/3 of voting members to adopt decisions), and a predefined list of participating members.

- 1.17. Voting members include: MoHCC, Ministry of Women's Affairs. Gender and Community Development (MOWAGCD), UNICEF, UNFPA, and HDF donors (The Governments of the United Kingdom of Great Britain and Northern Ireland represented by DFID; the Government of Ireland represented by Irish Aid; the Government of Sweden; the European Commission represented by the Delegation of the European Union to Zimbabwe; GAVI, the Vaccine Alliance).
- 1.18. Participating members include: MoHCC Principal Directors and Directors relevant to the programme components, one Provincial Medical Director, WHO and other UN agencies, Ministry of Finance and Economic 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.

Fund management

- 1.19. UNICEF is the fund manager of the HDF.
- 1.20. The fund manager receives funding from all the donors, and is responsible for:
- Disbursement of funds against agreed workplans and activities
 - Management of subcontracts with identified implementing partners
 - Financial and technical reporting to donors
- 1.21. UNICEF also serves as the Programme Coordinator for the HDF. To that effect, a dedicated HDF secretariat is in place, composed of an HDF coordinator and an assistant coordinator, and is hosted at UNICEF.

Implementation and M&E arrangements and status of implementation at mid-term

- 1.22. UNICEF oversees the implementation of all activities. UNFPA is responsible for the design and implementation of activities related to Thematic Area 2 as well as relevant activities under other pillars.
- 1.23. The key features of each programme component, the implementation arrangements for delivery of key activities and the status of implementation at midterm are summarized below.

Thematic Area 1 This thematic area entails a proposed investment of 39.4 million USD (6% of the total budget), over the 5 years life of the HDF. It is designed to provide a blend of health system and community health system strengthening activities, aimed to sustain the availability and quality of ANC, intrapartum care including EOC, PNC, newborn care, child care, immunisation, and nutrition.

As per costed, approved workplans of the HDF, most of the activities are designed and intended to be implemented by various departments of the MoHCC, with a nationwide scope.

For the period 2016-2017, the total proposed budget for this area of work was of 16.5 million USD⁹, and the total spent was of 19.9 million USD¹⁰, i.e. 120% of the initial forecast.

Thematic Area 2 This thematic area entails a projected investment over the fund life of 185 million USD (27% of the total budget), over the life of the programme. The activities planned under this thematic pillar cover a broad range of SRH interventions, including family planning, cervical cancer screening, fistula repair, adolescent and youth friendly services, HIV prevention, GBV. Implementation plans entail the involvement of a mix of implementing actors including MoHCC, MOWAGCD, the Zimbabwe National Family Planning Council (ZNFPC), and various national NGOs. The scale of activities presents a mixed approach, with implementation of some of the programmes limited to some districts/sites.

For the period 2016-2017, the total budget for this area of work was of 91 million USD, and the total spent was of 16.3 million USD, i.e. 16.8% of the initial forecast.

Thematic Area 3 Thematic areas 3 was designed to support the availability of essential equipment, medicines, supplies, commodities and vaccines across the entire country. The activities in this area of work are complementary to those of other donors supporting the MoHCC in procurement, notably USAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

For selected medicines, commodities and vaccines, following a national quantification process, procurement is managed via UNICEF Supply Division and UNFPA Procurement Services.

Distribution is operated by the National Pharmaceutical Company of Zimbabwe (NatPharm).

The 5-years planned budget for this activity is of 209 million USD (31% of the total budget).

For the period 2016-2017, the total initial budget for this area of work was of 79.6 million USD, and the actual spent was of 33.6 million USD, i.e. 42.1% of the initial forecast for the biennium.

Thematic Area 4 The activities planned within this area of work are primarily meant to retain and motivate the health workforce via targeted retention allowances, and to support scaling up the VHWs across the country, via training and remuneration. This activity complements efforts supported by the GFATM, both for the retention allowances and for the support to training VHWs.

The HDF supported retention allowances for 2016 and 2017, before withdrawing its support to this measure, which was intended to be temporary since its start.

The 5-years planned budget for this activity is of 70.2 million USD (10% of the total budget).

For the period 2016-2017, the total initial budget for this area of work was of 27.8 million USD, and the actual spent was of 11.8 million USD, i.e. 42.4% of the initial forecast for the biennium.

Thematic Area 5 Health financing is primarily supported through a RBF scheme, adopted nationwide in Zimbabwe. The support of the HDF focuses on 42 Districts of the country, with the other 18 Districts benefitting of support for the same intervention from the WB.

The RBF was designed and implemented as a measured aimed at: providing healthcare facilities with disposable funding for recurrent expenditure; enhancing accountability and linkages between facilities and communities; supporting facilities in removing user fees for clients. The

⁹ HDF Programme Document, accessed at: https://www.unicef.org/zimbabwe/HDF_Final_Draft.pdf

¹⁰ HDF Annual Reports 2016 and 2017

scheme was initially implemented at primary care level only; it was then scaled up to secondary level facilities during the HDF implementation.

The implementation of the RBF activities is subcontracted to a dedicated provider, Crown Agents, which oversees the day to day operations of reporting, verification, payments, data collection and analysis across all the 42 districts. Crown Agents subcontracts dedicated providers for some of the activities; of note, more than 800 CBOs are contracted across the target districts, to delivery quarterly client satisfaction surveys at facility level.

The 5 years budget for this thematic area was estimated at 56.9 million USD (8% of the total). The budget for 2016-2017 was of 22.4 million USD and the actual reported expenditure of 19.5 million USD (87% of the planned budget).

Thematic Area 6

This area of work is primarily designed to provide technical assistance to the MoHCC to design policies, strategies and plans. Key activities supported include annual planning meetings, provincial planning meetings, support to technical assistance and TWGs for strategy design, production and dissemination.

On the M&E side, the main activities supported under this pillar are: the independent evaluation of the HDF; the delivery of a quarterly census of all healthcare facilities of Zimbabwe (VMHAS); and the support to annual joint review mission (JRM) implemented by all stakeholders involved in the HDF.

The initial 5 years budget for this thematic area is of 18.7 million USD (3% of the budget). The budget for the biennium 2016-2017 was of 9.8 million USD, and the actual reported spent of 4 million USD (40.4% of the planned allocation).

Thematic Area 7

Innovation is primarily thought as a cross cutting thematic area, that allows to pilot and test possible solutions across all the thematic pillars of the HDF.

The activities planned under this thematic area include mostly focused pilot studies and some operational research, to be mostly implemented by the MoHCC.

The 5 years planned budget for this area of work was of 23.2 million USD (3.2%). The budget for the period 2016-2017, as per initial plans, was of 9.6 million USD, and the actual expenditure of 2.7 million USD (28% of the budget).

Context

Social, political and economic context

- 1.24. Located in southern Africa, Zimbabwe is a land locked country of 390.757 sq km, bordering Botswana, Mozambique, South Africa and Zambia. The country is administratively divided into 10 Provinces and 60 districts. The Inter Censal Demographic Survey of Zimbabwe¹¹, performed in 2017, estimated that number of people living in private households was 13 572 560 inhabitants. According to other projections from the UN¹², the population of the country in 2016 could be estimated instead at more than 16 million inhabitants, as of 2017.
- 1.25. Zimbabwe is a Presidential Republic. The political and socio-economic environment in the country suffered major turbulences before and during the period of implementation of the HDF. These are summarized below:

2007 – 2008: period of extreme hyperinflation

2008 - 2009: Cholera outbreak affecting over 100,000 people and leaving over 4,000 dead

2009 – Government allows the use of foreign currencies, to counter hyperinflation. Government adopts US dollar.

2013 March – New constitution approved by in a referendum.

2013 July – Presidential and parliamentary elections. Mr Mugabe gains a seventh term in office and his Zanu-PF party wins three-quarters of the seats in parliament.

2015 – the Central Bank of Zimbabwe formally phases out the Zimbabwe dollar, formalizing the multi-currency system introduced to counter hyperinflation.

2016 November - Government introduced Bond Notes in to wide circulation to seek to deal with liquidity crisis

2017 November - Mr Mugabe resigns. Former vice-president Emmerson Mnangagwa is sworn in as the second executive President.

2018, July - Mr Mnangagwa wins presidential election. New Government administration is elected following the harmonised elections.

2018, September - a cholera outbreak was reported in several suburbs of Harare. As of 3 October 2018, 8535 cumulative cases and 50 deaths had been reported¹³. A robust public health response was rapidly mounted by the MoHCC and partners, with a resultant decline in the numbers of new cases. Control of the outbreak is ongoing.

- 1.26. 68% of Zimbabweans live in rural areas and more than 40% of the population is under 15 years of age. In 2017, life expectancy at birth for both sexes was estimated at 60 years, with females recording a higher rate (61) as compared to their male counter-parts (58)¹⁴. Rural areas are home to 79% of the poor and 92% of the extreme poor¹⁵. According to the 2015 Zimbabwe Poverty Atlas¹⁶, poverty is found to be most prevalent in Matabeleland North (85.7%) while it is least prevalent in Harare (36.4%) and Bulawayo (37.2%). The rest of the provinces have poverty prevalence rates ranging between 65% and 76%.

¹¹ Inter-Censal Demographic Survey (ICDS) 2017, Zimbabwe National Statistics Agency. Accessed at: http://www.zimstat.co.zw/sites/default/files/img/publications/Population/ICDS_2017.pdf

¹² United Nations Department of Social and Economic Affairs, Population Division. Estimates accessed at: <https://population.un.org/wpp/DataQuery/>

¹³ Cholera – Zimbabwe. Disease Outbreak News: Update 5 October 2018 <http://www.who.int/csr/don/05-october-2018-cholera-zimbabwe/en/>

¹⁴ Inter-Censal Demographic Survey (ICDS) 2017, Government of Zimbabwe

¹⁵ Zimstat, PICES survey, 2012

¹⁶ Zimbabwe Poverty Atlas 2015, Zimbabwe National Statistical Agency, August 2015

- 1.27. The economy of the country remains fragile. As summarized by the World Bank¹⁷: *'Zimbabwe had double-digit growth rates shortly after dollarization in 2009, but growth started to decline in 2012 as confidence started to diminish and the investment-to-gross domestic product (GDP) ratio declined sharply. Besides, higher growth in 2017 of 3.4% (partly due to recovery in agriculture production), up from 0.6 in 2016, the economic growth trend is now some 2% below the average for Sub-Saharan Africa. It is projected to slow to 2.7% in 2018 partly due to liquidity shortages. The overall trend is below population growth and thus negative in per capita income terms, contributing to higher poverty rates.'*
- 1.28. The economic outlook of Zimbabwe recently produced by the African Development Bank confirms an unstable scenario: *'Weak economic activity in 2016 led to a fall in total revenues of 6% (in nominal terms), exacerbating liquidity shortages. The 2016 introduction of bond notes pegged to the U.S. dollar saw the emergence of a parallel market for foreign exchange, owing to the shortage of foreign currency. According to the World Economic Forum's 2017/18 Global Competitiveness Report, the most problematic factors for doing business include policy instability, inadequate foreign currency regulations, inefficient government bureaucracy, difficulties in access to finance, inadequate supply of infrastructure (....)'*¹⁸,
- 1.29. In 2017, Zimbabwe was ranked 156 of 189 countries worldwide, in terms of its Human Development Index (HDI)¹⁹.

The health sector in Zimbabwe

- 1.30. The **right to health** care addressed in section 76, subsection 1 to 4, of the Constitution is the overarching national framework that provides direction to the health sector. The country's current socioeconomic development plan, the Zimbabwe Agenda for Sustainable Economic Transformation (ZimAsset), which ran from October 2013 to December 2018, also fully recognized the importance of health and integrates the health sector's main goals and targets.
- 1.31. The **National Health Strategy** 2016-2020 is being implemented under the auspices of the ZimAsset, which outlines Zimbabwe's development path to December 2018 "towards an empowered society and a growing economy"²⁰ and provides a framework for attaining health and health related goals and objectives. The HDF therefore also supports the MoHCC contribute to the realisation of the vision for ZimAsset and its overall development goals.
- 1.32. The government formulated and approved its first **Health Financing Policy** in 2017 and finalized the **Health Financing Strategy** in June 2018. These guiding documents articulate the policy direction of the Government of Zimbabwe in moving towards Universal Health Coverage (UHC). These guiding documents provide the overall framework within which health financing initiatives should be designed and implemented to overcome Zimbabwe's challenges with health funding.
- 1.33. The unpublished Zimbabwe Joint Needs Assessment²¹ summarizes well the **health financing scenario of Zimbabwe**: *'Government expenditure on the health sector increased from 6.5 percent in 2014 to 8.7 percent in 2015 (ZIMSTAT, MoHCC, ZIMREF, 2017). However, this remains lower than most Southern African Development Community (SADC) countries, with an average of about 10 percent, and falls short of the Abuja Declaration of allocating 15 percent of a government's budget to health. The public sector and external financing, mainly from donors, constituted 34.7 percent and 24.9 percent of total health expenditure, respectively. Private health insurance covers less than 10*

¹⁷ <https://www.worldbank.org/en/country/zimbabwe/overview>

¹⁸ <https://www.afdb.org/en/countries/southern-africa/zimbabwe/zimbabwe-economic-outlook/>

¹⁹ United Nation Development Programme. Human Development Indicators and Indices: 2018 Statistical Update. Accessed at: http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf

²⁰ Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset). Government of Zimbabwe October 2013-December 2018

²¹ Zimbabwe Joint Needs Assessment. Sector Note 15: Health. Unpublished Draft, accessed in September 2018

percent of the population. Out-of-pocket payments constitute 24 percent of the total health expenditure. Approximately 7.6 percent of all households incurred catastrophic health payments (CHP) in 2015; the incidence of CHP was highest among households in the poorest quintile (13.4 percent), in contrast with 2.8 percent for households in the richest quintile.’

- 1.34. According to a recent analysis of fiscal space for health in Zimbabwe²², external assistance remains a critical resource to finance healthcare in Zimbabwe, although the prevalence of earmarked allocations hinders the flexibility of the Government to support health programs. ‘Zimbabwe relies to a large extent on Development Assistance for Health (DAH). In comparison to countries in the region and countries with similar GNI per capita, Zimbabwe has one of the highest shares of SAH in total health expenditures. DAH is the primary source of financing for health in Zimbabwe, with external resources accounting for more than 50 percent of total health expenditures. (...) Zimbabwe’s DAH is skewed towards disease specific programs, in particular HIV/AIDS, which absorbed on average 59% of total DAH over the period 2010-2013.(...) Even if Zimbabwe receives a relatively high share of DAH, opportunities for fiscal space are limited if the majority of resources are earmarked; this limits resources available for other programs and the freedom to work with the remaining, non-earmarked external resources.’
- 1.35. The Joint Needs Assessment also provides a useful snapshot of the structure of **health services in Zimbabwe**: ‘The majority of health facilities are public/government owned. Health services are provided through 1,848 health facilities, of which 214 (11.6 percent) are hospitals and 1,634 (88.4 percent) are PHC facilities, the majority of which are public/government owned. Hospitals are organized into central, provincial, district, and rural. Mission and private sector facilities also contribute significantly to the provision of health services in rural and urban areas, respectively.²³ At the community level, the main cadre are the VHWs, who cover about 77 percent of the country; there are various other cadres that deliver different packages of health services on a voluntary basis or for token payments (for instance, USD 14/month for VHWs).’

Maternal, newborn, child and adolescent health and nutrition in Zimbabwe

- 1.36. Following Independence in 1980, Zimbabwe built a very strong and flourishing health system. However economic challenges of the last decade combined with a high HIV prevalence contributed to challenges to the health system, with resultant decline in key health indicators including those for maternal, newborn, child and adolescent health.
- 1.37. Although affected by the 2008 socioeconomic crisis, the health sector has since registered several notable achievements. HIV prevalence has decreased by 28 percent, while tuberculosis (TB) incidence has dropped by nearly 60 percent over the last decade. The overall incidence of malaria has fallen drastically, by 79 percent from 136 per 1,000 population in 2000 to 29 per 1,000 population in 2015. Full immunization, uptake of contraceptives, ANC, and skilled birth attendance (SBA) have also gone up. A cervical cancer programme was started and is expanding. Health facilities are offering clinical and counselling services for sexual and reproductive health (SRH) and GBV. Maternal mortality rate has declined from 960 deaths per 100,000 live births in 2010–2011, to an estimated 651 deaths in 2015; and under-five mortality has fallen from 94 per 1,000 in 2009 to 47 in 2015. Despite this, Zimbabwe did not attain all the Millennium Development Goals.
- 1.38. The main target groups or primary beneficiaries for the HDF are women, children and adolescents. Data on the overall health of these population groups prior to the commencement of the Health Development Fund in 2016 is available from the Zimbabwe Demographic and Health Survey (ZDHS 2015), and the Multiple Indicator Cluster Survey (MICS 2014) and is well described in the original programme document for the HDF. These are summarized in [Figure 4](#).

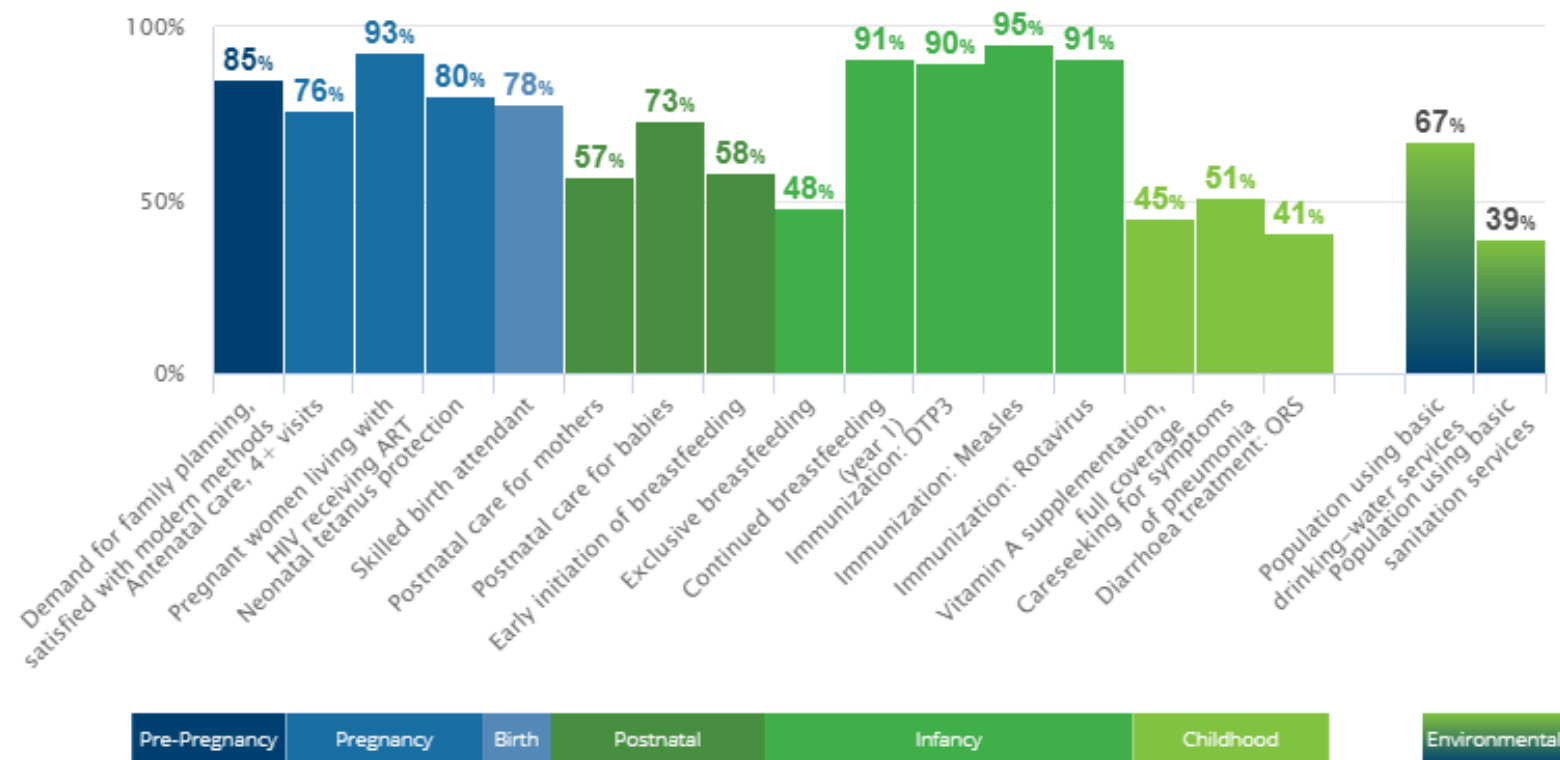
²² Analysing Fiscal Space Options for Health in Zimbabwe. The World Bank, 2017

²³ The National Health Strategy for Zimbabwe: 2016-2020.

Figure 4. Continuum of care coverage for RMNCH+A and nutrition (Zimbabwe, DHS 2015)

Continuum of Care Coverage

Percentage of those in need receiving coverage of key interventions across the continuum of care



The HDF within the current context of Zimbabwe

Relevance of the HDF to government's strategies and priorities

- 1.40 In 2011, the MoHCC developed the Health Sector Investment Case²⁴, which analysed the bottlenecks to health service delivery and formed the basis of the design of the Health Transition Fund (HTF) and other key initiatives to support maternal and child health. With support from Government and Development Partners, the HTF and other major programmes helped to improve the health of Zimbabweans by supporting and revitalising Zimbabwe's health sector. These programmes worked very successfully to strengthen the overall health system, with a particular emphasis on reducing the maternal mortality ratio (MMR) and the infant mortality rate (IMR) as maternal and child health programmes were the most underfunded programmes. Significant achievements were made in these indicators to 2016, but desired targets were not yet reached.
- 1.41 The HDF was therefore designed in 2015 as a follow-on phase of support to Zimbabwe, with financing partners and UN agencies collaborating under the leadership of the MoHCC to support further progress in maternal and child health as well as other key programme and health system building blocks. Sexual and Reproductive Health and nutrition were acknowledged as critical areas within the National Health Strategy and were therefore included in the HDF planning and implementation. The change of name, from transition to development, reflected *'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'*²⁵.
- 1.42 All of the HDF interventions are guided by the National Health Strategy 2016-2020²⁶ and led by the MoHCC, with a focus on equity and quality of health services including reaching specific vulnerable populations such as newborns, adolescents and people living in hard to reach communities. The focus is to consolidate gains made at the primary care level and in district hospitals throughout the country, and to move to selected provincial hospitals. The HDF was thus designed to contribute to national efforts in support of the MoHCC to attain their vision to have the highest possible of level of health and quality of life for all citizens.
- 1.43 Given the design of the HDF, which focuses on equity and quality of health care in particular for vulnerable groups, HDF is also highly relevant in supporting implementation of the 2013 Constitution of Zimbabwe which provides for the Right to health care and other associated rights.
- 1.44 The HDF also supports the MoHCC in its efforts to address the unfinished agenda of the Millennium Development Goals and attainment of the new Sustainable Development Goals (SDGs), explicitly Goal 3, "Ensure health lives and promote wellbeing for all at all ages" and Goal 5, "Achieve gender equality and empower all women and girls".

Relevance of the HDF to UN goals and priorities

- 1.44. UNICEF is the fund manager for the HDF, a role which is closely aligned with the overall mandate of UNICEF "to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential"²⁷.

²⁴ The Zimbabwe Health Sector Investment Case (2010-2012): Accelerating progress towards the Millennium Development Goals. Zimbabwe Ministry of Health and Child Care 2010. Accessed at

https://www.unicef.org/zimbabwe/Health_Investment_Case_Report.pdf

²⁵ HEALTH DEVELOPMENT FUND - Programme Document for a Multi-Donor Pooled Fund for Health in Zimbabwe (2016-2020). Ministry of Health and Child Care, August 2015 (accessed at: https://www.unicef.org/zimbabwe/HDF_Final_Draft.pdf)

²⁶ The National Health Strategy for Zimbabwe 2016-2020 – Equity and Quality in Health: Leaving No One Behind. Ministry of Health and Child Care. Accessed at https://www.unicef.org/zimbabwe/National_Health_Strategy_for_Zimbabwe_2016-2020_FINAL.pdf


²⁷ UNICEF'S Mission Statement https://www.unicef.org/about/who/index_mission.html

- 1.45. More specifically, the delivery of the HDF supports key results of the Zimbabwe United Nations Development Framework 2016-2020 (ZUNDAF)²⁸, including those related to food and nutrition security, gender equality, HIV & AIDS and Social Services and Protection.
- 1.46. The management of the HDF contributes to results for the current UNICEF-Government of Zimbabwe Country Programme of Cooperation (2016-2020), which “aims to support Zimbabwe to sustain and build upon the gains achieved for children during the 2012-2015 Country Programme of Cooperation. The programme focuses on improving the quality of social services, increasing access to services, and helping to build national and sub-national capacities to provide low-cost, high-impact interventions for all children, especially the most vulnerable”.²⁹

Equity, gender and human rights in the HDF design

- 1.47. Health is a fundamental right in Zimbabwe, and this is clearly articulated in the Constitution of Zimbabwe³⁰, that states in Section 76 that ‘Every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services, including reproductive health services.
- 1.48. The HDF is designed to support the promotion of the right to health, as well as to address barriers related to gender and to equity that may hinder the attainment of the fundamental right to health for particular strata of the population.
- 1.49. This is clearly and extensively articulated in the HDF programme document, that clarifies how the programme was designed to promote human rights, and to address disparities related to gender and to inequity in access to care. **Table 4** below summarizes the key features of the HDF with regards to gender and equity, as presented in the HDF Programme Document³¹.

Table 4. HDF approach to gender and equity

Gender and equity: Areas of focus of the HDF	
Gender 	<p>The HDF will focus on:</p> <p>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.</p> <p>Men's role in RMNCH+A (such as through male champions) is emphasised.</p> <p>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.</p> <p>GBV 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.</p> <p>Ensuring age and sex disaggregated data in all stages of the programme cycle (analysis, implementation, monitoring, and evaluation) wherever required.</p> <p>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.</p>
Equity	<p>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 healthcare 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 healthcare</p>

²⁸ Zimbabwe United Nations Development Framework 2016-2020: Supporting Inclusive Growth and Sustainable Development. Government of Zimbabwe and United Nations Zimbabwe

²⁹ UNICEF Zimbabwe overview <https://www.unicef.org/zimbabwe/about.html>

³⁰ Accessed at: http://www.constitutionnet.org/sites/default/files/final_copac_draft_constitution_of_zimbabwe_date-1.2.2013_time-14.30-1.pdf

³¹ Accessed at: https://www.unicef.org/zimbabwe/HDF_Final_Draft.pdf

	<p>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 newborns 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 programmes, designing a more responsive and innovative health service delivery system for newborns 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.</p>
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SECTION 2. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

Purpose and objectives of the evaluation

2.1. The purpose of the evaluation was clearly defined by the ToR (**Annex 1**), as follows: to provide the SC with a mid-term, independent, rigorous assessment of progress made in the implementation of the fund during the period 2016-2018, and an informed menu of options for adaptive redesign of the fund, based on the findings of such assessment and to maximize the efficiency and impact of the fund during the period 2018-2020.

2.2. Objectives

The overall objective of the evaluation is to assess the extent to which the HDF strategies, approaches and overall intervention logic have contributed, during the implementation period, to sustain the delivery of quality, equitable RMNCH+A and nutrition services in Zimbabwe.

The **specific objectives** were approved in the inception report (**Annex 2**) as follows:

1. To assess the HDF programme implementation against the HDF ToC using modified OECD-DAC evaluation criteria which include relevance, effectiveness, sustainability, VfM and efficiency, and equity.
2. To assess to what extent the programme has incorporated human rights-based approach, promoted equity and applied a gender perspective.
3. To conduct robust in-depth analysis of the LF to support the evaluation conclusions
4. To assess if the available programme data collection tools are definitive and provide good monitoring of the programme performance and make recommendations on how to improve programme monitoring
5. To analyse the available programme data and information and document lessons learnt, best practices and make recommendations on better programme delivery

Scope of the evaluation

2.3. Focus of the evaluation

In line with the original ToR, the mid-term evaluation focused on the HDF in Zimbabwe, and on its implementation during the period from 2016 to mid-2018.

The object of the evaluation was the pooled fund, intended as one, comprehensive, integrated package of measures sustained via different mechanisms and modalities. In doing so, the evaluation encompassed an analysis of its seven pillars (thematic areas), although the analysis of each pillar was not the central focus of the evaluation. The thematic areas are:

- Maternal, Newborn, Child Health and Nutrition (1)
- Sexual and Reproductive Health and Rights (SRHR) (2)
- Medical Products, Vaccines and Technologies (3)
- Human Resources for Health (4)
- Health Financing (5)
- Health Policy, Planning, M&E and Coordination (6)
- Technical Support and Innovation (7).

Moreover, the effect (or not) of integration and coherence across the seven pillars, as well as complementarity with other initiatives supporting the health sector in Zimbabwe, have been explored.

2.4. Geographical scope

The HDF evaluation was designed to assess the programme nationwide. The evaluation questions were addressed at a national level, looking at the fund as a whole.

2.5. Time period

The evaluation covers the period 2016 to mid-2018.

2.6. Evaluation criteria

As per requirements from the ToRs, the evaluation attempts to provide an independent midterm assessment of the HDF against the **OECD/DAC criteria** for international development evaluations³². In addition, VfM and equity were underlying, cross cutting criteria informing the evaluation design.

The criterion of impact was not assessed, for reasons that are fully articulated in the inception report, and that are primarily related to the fact that measuring change (impact) at mid-term was not relevant to the objectives of the mid-term evaluation, and that it may bias the interpretation of achievements from stakeholders, since activities were designed to generate change within a longer period of time than the mid-term point of the programme.

We therefore focused on a thorough assessment and validation of the ToC up to the intermediate results level, rather than outcomes and impacts. This is also fully in line with the objective of the evaluation as stated in its TORs: *to assess the extent to which the HDF strategies, approaches and overall intervention logic have contributed, during the implementation period, to sustain the **delivery of quality, equitable RMNCH+A and nutrition services in Zimbabwe***. This corresponds to intermediate results level in our ToC.

Key evaluation questions

2.7. The ToR for the evaluation did not present nor suggest lead evaluation questions.

2.8. Therefore, based on the objectives of the evaluation and on the inception activities, a **set of ten (10) key evaluation questions** (KEQ), were designed by the evaluation team to address all the proposed evaluation criteria, as well as to meet the objectives of the evaluation.

2.9. These questions were discussed with key stakeholders during the inception visit, and formalized and confirm via the submission of the inception report, and its review and approval from SC members.

They are presented in **Table 5**.

Table 5. Key evaluation questions

<i>Evaluative criteria</i>	<i>Key evaluation questions</i>
Relevance <i>Extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor</i>	EQ1. Are the HDF interventions and expected results relevant to the needs of its intended recipients?
Effectiveness <i>Extent to which an aid activity attains its objectives.</i>	EQ2. How effectively has the HDF pooled fund mechanism performed, against the key principles of aid effectiveness?

³² Guidelines developed by the OECD/DAC Network for Development Evaluation (OECD/DAC 2010)

<p>Sustainability <i>Measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn</i></p> <p>Equity <i>The absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy.³³</i></p> <p>Efficiency and value for money <i>The optimal, most efficient and cost-effective use of resources to achieve intended outcomes³⁴</i></p>	<p>EQ3. What was the progress in achieving the HDF intended results, during the period 2016-2018?</p> <p>EQ4. What were the main facilitators and barriers to achieving the HDF results, during the period 2016-2018?</p> <p>EQ5. Is there evidence of any unintended results produced by the HDF?</p> <p>EQ6. What are the risks to sustainability of the results and outcomes produced through the HDF?</p> <p>EQ7. Does the HDF embed an equity focused approach in its design and in its delivery mechanisms?</p> <p>EQ8. What are the costs of the HDF and what are the main cost drivers related to fund management and implementation?</p> <p>EQ9. What is the VfM of HDF when relating these costs to economy, efficiency, effectiveness, and equity?</p> <p>EQ10. How can available resources be used more efficiently and effectively, to maximize the benefits of the HDF?</p>
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³³ Defining equity in health. P Braveman and S Gruskin. doi: 10.1136/jech.57.4.254 *J Epidemiol Community Health* 2003 57: 254-258 (Accessed at: <http://dx.doi.org/10.1136/jech.57.4.254>)

³⁴ DFID's Approach to Value for Money (VfM). Department for International Development, July 2011 (Accessed at: <https://www.gov.uk/government/publications/dfids-approach-to-value-for-money-vfm>)

Evaluation principles

Norms and standards for evaluation

2.10 This evaluation was designed and delivered in line with the Principles for Evaluation of Development Assistance³⁵, as well as with the **Norms and Standards for Evaluation set by the United Nations Evaluation Group**³⁶ (UNEG) and the **UNICEF Evaluation Policy**³⁷.

2.11 The measures undertaken to comply with those UNEG standards that are specifically relevant to evaluators is summarized in **Table 6**, updated to the inception stage (August 2018).

At implementation stage, all the UNEG standards were duly tracked, and compliance with such standards is being reported to UNICEF at the agreed milestones, and per each stage of the evaluation.


Table 6. Measures taken by LSTM to meet UNEG Standards

<i>UNEG standard</i>	<i>LSTM measures to meet standards</i>
Standard 3.1. Competencies	<ul style="list-style-type: none"> - Proposed team of evaluators was approved by UNICEF based on CVs submitted at proposal stage. - Team leader conversant with UN system, principles and values - Team leader and LSTM Researchers trained in Research with Humans in Health and Social Sciences; Data protection essentials; General Data Protection Regulation (GDPR)
Standard 3.2. Ethics	<ul style="list-style-type: none"> - Application to LSTM Ethics approved (Appendix 2) - Application to Zimbabwe Medical Research Council approved (Appendix 3) - Teams involved in data collection were trained in ethical principles - Interaction with all stakeholders maintained regularly and respectfully at all stages of the evaluation.
Standard 4.1. Timeliness and intentionality	<p>Intentionality: purpose, objectives and methods discussed during inception visit, and approved through the iterative process of review and approval of the inception report</p> <p>Timeliness: timeliness was affected by various unexpected events, including: the political elections at inception stage; a cholera outbreak during data collection, limiting evaluation activities at national level; delays due to ethics submission and approval.</p> <p>The evaluation regularly provided updates on implementation schedule to UNICEF with delays and mitigation strategies discussed in real time with UNICEF. Notwithstanding the delays, the evaluation was performed within the contract timelines.</p>
Standard 4.2. Evaluability assessment	Inception report and overall approach to evaluation was based on initial, rapid Evaluability Assessment, and informed by scoping interviews; preliminary analysis of data and reports; literature review.
Standard 4.3. Terms of reference	Purpose, scope, design and plan proposed by UNICEF and by the SC were revised during inception phase. Modifications proposed to initial ToRs were summarised in the approved inception report.

³⁵ Principles for Evaluation of Development Assistance, Development Assistance Committee. 1991

³⁶ United Nations Evaluation Group (UNEG): Norms and Standards for Evaluation. June 2016.

³⁷ Discussion Paper: 2018 Revised Evaluation Policy for UNICEF. UNICEF Evaluation Office, January 2018

Standard 4.4. Evaluation scope and objectives	Scope and objectives proposed through ToRs confirmed via inception report. Specific objectives redefined via inception report, based on initial evaluability assessment, and approved via inception report.
Standard 4.5. Methodology	Overall evaluation design (theory-based evaluation) presented at proposal stage and via inception report. Methods to address evaluation questions also presented, highlighting scope of the analysis and limitations. Methods of data collection and analysis for both qualitative and quantitative research strictly followed quality standards for research.
Standard 4.6. Stakeholders engagement and reference groups	Ample base of stakeholders involved at design stage via initial scoping interviews, as well as via participatory workshop to design a ToC for the HDF. At implementation stage, the HDF Evaluation sub-committee were regularly consulted at various stages of submission of deliverables for review, discussion and approval.
Standard 4.7. Human rights approach and gender mainstreaming 	<p>Right holders and duty bearers were extensively consulted during data collection (communities; CHWs; health workers; donors; UN; civil society and other involved as key informants).</p> <p>Data collected via evaluation reflected the views of various right holders and duty bearers. In particular, the FGDs involved 156 participants of which: 34 were adult males; 74 were adult females; 17 were adolescent boys; 31 were adolescent girls.</p> <p>Interviews at facility, district and national levels saw the participation of 66 HCPs and managers, of which 42 were female and 24 were male participants. The self-administered questionnaire (SAQ) collected at health care facilities involved 231 HCPs, of which 151 were female health workers.</p> <p>Gender and human rights perspective were embedded in data analysis and reporting.</p>
Standard 4.8. Selection of evaluation team	<p>Team constructed to present an overall balance of technical skills and of evaluation competencies</p> <p>LSTM team composition (gender): more than 50% of women.</p> <p>Team diversity: team composed of six different nationalities.</p> <p>Participation of professionals from the country: one team members is Zimbabwean. Other team members conversant with the Zimbabwean environment.</p> <p>Firm undertaking data collection sub-contract was Zimbabwean. The selected group, the BRTI has a solid track record of quantitative and qualitative research in Zimbabwe and was selected on the basis of a rigorous tendering process.</p> <p>All data collectors selected could speak local dialects, to facilitate interviews and FGDs at local level.</p>
Standard 4.9. Evaluation report and products	<p>The evaluation report has been produced as per UNICEF Adapted Evaluation Reports Standards³⁸</p> <p>All the evaluation products, including technical Annexes to the report, data collection tools, and data sets have been delivered to UNICEF at the end of the evaluation, as per contractual obligations.</p>

³⁸https://www.unicef.org/evaluation/files/UNICEF_adapted_reporting_standards_updated_June_2017_FINAL.pdf

Standard 4.10 Recommendations	<p>Internal peer review sessions and meetings were held at LSTM for quality assurance of the evaluation report and for discussion on recommendations. The final report was submitted in draft at various stages to key stakeholders for discussion, and to test consistency, clarity and feasibility of recommendations.</p> <p>In December 2018, a stakeholders' workshop was organized in Harare, with the participation of SC Members, to review and discuss the key findings and recommendations of the evaluation. Concurrently, the exercise allowed evaluators to facilitate a session aimed at discussing strategic options for the future design and implementation of the HDF.</p>
Standard 4.11 Communication and dissemination	<p>Final dissemination at the HDF SC planned at the end of the evaluation.</p>

Ethics

- 2.12. This evaluation was performed in accordance with the **Helsinki declaration for medical research** (World Medical Association 1964 and subsequent amendment 2013). All researchers involved in the evaluation adhered to the LSTM's Code of Practice for Research Conduct.
- 2.13. For this evaluation:
- ◇ The study protocol was submitted and approved by the **LSTM Research Ethics Committee**.
 - ◇ The study protocol was submitted via BRTI and approved by the **Zimbabwe Medical Research Council (ZMRC)**.
- 2.14. During data collection, maximum attention was given to applying ethical principles for research:
- Verbal and written consent was obtained from participants who were recruited in the survey. Qualitative teams sought verbal, written and audio recording consent from their participants before conducting any interviews and for those who were not willing to be audio recorded the research assistants would take written notes. Consent forms for the health facility assessment and SAQs were in English. For the FGDs, consent forms were translated into the two main local languages (Shona and Ndebele).
 - All data collection tools were approved by the Medical Research Council of Zimbabwe (MRCZ).
 - Consent forms, information sheets and withdrawal forms were also produced in English and Shona languages, approved and stamped by the MRCZ. These are available from LSTM upon request.

Gender and human rights, including child rights

- 2.15. The LSTM team ensured that issues of gender and human rights were fully embedded in each stage of the evaluation cycle. This was done by ensuring: a fair composition of teams of consultants and field workers involved in data collection; that equal voice was given to different groups assessed/involved in data collection at management, facility or community level; that data analysis provided disaggregation by gender and/or by socio-economic characteristics of the population where possible.
- 2.16. The tools for the evaluation included the following elements related to gender and human rights (**Table 7**):

Table 7. Data collection tools: gender and human rights aspects

	Survey tool	FGDs	KIIs
Gender	Data disaggregated by sex for service utilisation, peer education, health care managers, HCPs, HCC members Availability of services attending to gender issues e.g. male involvement in HIV testing, SRHR, male and female condom distribution	FGDs conducted with males and females separately, for both adults and adolescents.	KIIs number of males and females interviewed
Human Rights	Assessment of availability of services Assessment of user fees as potential barrier to accessibility of services Assessment of quality improvement processes	Questions exploring the availability, accessibility, acceptability and quality of services	Questions exploring the availability, accessibility, acceptability and quality of services

The findings of the evaluation highlight relevant gender equality and human rights issues.

SECTION 3. EVALUATION DESIGN AND METHODOLOGY

Evaluation design and methodology

3.1. Evaluation design

A **theory-based approach** to the evaluation was identified as a suitable design for the evaluation at proposal stage, and then confirmed at inception. This implied designing and testing a ToC, to draw conclusions about whether and how an intervention contributed to observed results.

The approach largely draws on the key features of contribution analysis³⁹. The methodological steps undertaken to inform the evaluation were as follows:

Step 1 - Develop a ToC. This was done via initial review of project documentation, which allowed to construct a first draft of the ToC. The newly produced ToC and the related findings on assumptions and pathways to change were discussed and validated with key stakeholders through a 2-day workshop in Harare following the submission of the first draft report to the SC. Through the workshop, participants were engaged in discussing the findings and in validating or further modifying the ToC. The ToC included a detailed set of assumptions at anticipated each level of change.

Step 2 - Gather evidence on the ToC. This was done via a mixed methods approach, whereby quantitative and qualitative data were collected via primary research or through secondary data sets, reports and documents, and used to test the assumptions informing the ToC.

Multiple lines of evidence were used to confirm and validate the ToC, and its underlying assumptions. To build a ToC which was based on a solid and objective approach to **drawing conclusions** based on available data, various methods of **triangulation** were used.

Data triangulation: various approaches to data triangulation were adopted. As an example, data available from existing HDF monitoring tools (e.g. VMAHSS) was triangulated with the findings of the survey performed by LSTM at health care facilities.

Methodological triangulation: through the proposed mixed methods approach, evidence from both qualitative and quantitative data was used to assess each of the hypotheses being tested. Multiple lines of quantitative data were used to inform reasoning around hypotheses testing, whereas emerging themes from qualitative data were used to validate the credibility of hypotheses and to construct plausible explanations of findings.

Investigator triangulation: both qualitative and quantitative data were analysed independently by LSTM researchers assigned to the evaluation. In addition, researchers also independently interpreted data; different interpretations were then being used by the LSTM team for collective analysis and brainstorming.

Step 3 - Reconstruct the ToC and validate it with key stakeholders

This step entailed at first re-building the story, i.e. critiquing the ToC based on the findings gathered and analysed at step 2. Secondly, it entailed discussing the key findings of the evaluation with key stakeholders, to validate the reconstructed ToC and/or to further improve it with additional evidence.

³⁹ https://www.betterevaluation.org/en/plan/approach/contribution_analysis

Step 4 - Use the ToC to address the evaluation questions. This was done using a dynamic **evaluation matrix**, where all the assumptions were tested, assessed and scored based on available evidence, and/or refined during the work. It should be noted that the matrix was not informed by a fixed/pre-defined analysis plan with a rigid list of indicators and targets, but that it was rather an iterative exercise of using evidence against ToC assumptions at various stages of the evaluation.

- 3.2. A full detailed description of the evaluation design and of the methods used to address the evaluation questions is included in the Inception Report.
- 3.3. A detailed Evaluation Matrix is included in **Appendix 4**.

Methods of data collection and analysis

- 3.4. The process of data collection and analysis was continuous throughout the evaluation. The collection and review of secondary data started from the onset of the exercise and continued until its end. The collection of primary data took place from the 27th of September to the 17th of October 2018.
- 3.5. A full data collection report is available in **Annex 3**.
- 3.6. All the tools used for the data collection exercise are available in **Annex 4**.

Primary data

- 3.7. **Table 8** below presents a summary of all the primary data collected through the evaluation. Each of the methods is then described below and presented in detail in relevant annexes.

Table 8. Summary of primary data collection methods

Data collection methods	Participants	Location
Survey of DHOs	26 DHEs	26 Districts, selected across the 42 where HDF implements RBF activities, in:
Survey of healthcare facilities	103 health care facilities	Matabeleland North; Midlands;
SAQ with HCPs	231 questionnaires collected from all facilities participating to the survey	Mashonaland West; Mashonaland Central; Matabeleland South; Masvingo; Manicaland
KIIs	35 KIIs, with 66 participants in total (9 at national level, 26 at District and facility level)	Full details in Annex 3
FGDs	15 FGDs, with 156 participants including: 34 male adults 74 female adults 17 adolescent boys 31 adolescent girls	National level KIIs in Harare 26 Key Informant Interviews were conducted in four districts (Chimanimani, Mutasa, Zvimba and Umguza) drawn from three provinces which are Manicaland, Mashonaland West and Matabeleland North.
Online questionnaire with national key informants	8 participants	FGDs were conducted in four purposively selected districts within these three provinces: Manicaland (Mutasa and Chimanimani), Matabeleland North (Lupane) and Mashonaland West (Zvimba)
		National level stakeholders

Survey of DHOs and healthcare facilities

3.8. LSTM conducted a quantitative survey of **healthcare facilities and DHOs**, to collect primary data on specific outputs that informed the ToC and on selected output indicators that are included in the LF of the HDF programme.

3.9. The specific objective of the survey was to collect primary data at health facility level and DHO level to measure outputs on the following areas of interest.

At healthcare facility level

Service Delivery

- Health services provided at health facility (ANC, Maternity, PNC, FP, Immunisation, HIV, Nutrition, Cervical cancer, IMNCl, SGBV, Youth Friendly Health Services)
- Availability and performance of signal functions for BEmONC and CEmONC
- Quality improvement methods utilized at health care facilities
- Outreach services
- Referral mechanisms
- Availability of guidelines and job aids for various MNCH-N packages at health care facilities
- Information on MWHs

Human resources for health

- Staff distribution across healthcare facilities
- Staff turnover at healthcare facilities
- Trainings received by HCPs
- **SAQ** targeting individual HCPs. This complemented the survey data and ‘drill down’ on areas related to training, mentoring, supportive supervision, motivation, and job satisfaction.

Procurement and supply management

- Availability of selected drugs supplies and equipment
- Information on supply chain management
- Expired drugs

Facility management

- RBF
- HMIS reporting
- Supportive Supervision
- User fees

Accountability mechanisms

- Mechanisms for receiving/processing patients’ complaints
- Patient charter

At District Level

- Planning
- Budgeting
- Reporting
- Mentoring and Supervision
- Staffing levels

3.10. The survey population included DHOs, DHs (or Designated District Hospitals) and PHC facilities which are in the **42 districts supported by all the programmatic components of the HDF (inclusive of RBF)**. These 42 districts are within eight of the ten provinces in Zimbabwe (none in Harare or Bulawayo) with each province having five or six districts implementing all programmatic components of the HDF. In the initial study design and plans, we had estimated that

at up to 30 district health offices, 30 district health hospitals and 89 PHC facilities were to be sampled in order to ensure a margin of error not exceeding 10% for all indicators. During data collection, the sample size was slightly reduced, to a total of 26 districts and 77 facilities. Whilst this reduction did not affect the quality of estimates, it did allow to manage the study on time and on budget despite of the several logistics issues encountered at the time of conducting the survey (lack of cash, lack of fuel, frequent absence of staff from facilities due to cholera response, amongst others). In fact, the sample size allowed to achieve a margin of error not exceeding 10% if the proportion being estimated is below 25% or above 75%, and of no more than 12% if it does not fall within these ranges. The reduction was done by selecting a sub sample of the yet un-surveyed facilities /DHOs to remain in the sample and ensured a consistent sampling fraction within each Province in which the survey had not been completed.

- 3.11. The SAQ nested in the survey collected semi-structured information from 216 HCPs, across the facilities sampled for the survey.
- 3.12. The sample size of the survey was determined in a way to provide estimates at national level. Each estimate derived is reported with a 95% confidence interval which reflect the sampling strategy. A full Analysis Plan was produced to produce all the indicators to be analysed, and the detailed methods that should be used to calculate them. Analyses was then performed using the suite of commands in STATA version 14 using descriptive statistics (frequencies) to support evidence for the ToC and inform the HDF LF. Quantitative data from the SAQ were analysed as simple proportions, whereas qualitative information gathered via the questionnaire was used to inform other qualitative analysis performed during the evaluation (see section below)
- 3.13. The survey was implemented by the selected subcontractor for data collection, BRTI (See [Section 3](#) of this report for more details), under the supervision of LSTM.
- 3.14. A full survey report, providing a detailed description of the sampling methods, of data collection tools, and of the key indicators collected through it, is available in [Annex 5](#). This includes methods, key findings and the detailed analysis plan.

Key Informant Interviews and Focus Group Discussions

- 3.15. The evaluation included interviews with key informants from different levels of the health system. These **KIIs** explored the perspectives of key stakeholders about the RMNCH+A and nutrition in the country. Key informants were purposively selected from national, district and facility levels. At the national level, staff members from multilateral and bilateral organisations who are familiar with the HDF and the MoHCC officials were included. At the district level, interviews were conducted with District Health Management teams such as DMO, DNO. At the district level health facility (designated District Hospital), three parallel small group interviews were conducted with staff members conversant with: RBF, retention and other HR issues; procurement and supply of medicines (pharmacists and dispensing officer). At PHC facility level, interviews were conducted with the health facility in-charge. In total, **35 interviews took place, involving 66 participants.**
- 3.16. **FGDs** were also conducted with service users of the HDF supported interventions, including VHWs, women of reproductive age, men, mothers and caregivers of children under 5, pregnant women and mothers with babies less than one-month old, and adolescents. **15 FGDs were conducted** with groups of VHWs and different community groups. These data complemented data obtained through the quantitative survey.
- 3.17. Purposive sampling was employed for both interviews and FGDs.
- 3.18. FGD and interviews were translated (where applicable) and transcribed by BRTI. Data were then analysed using a combination of thematic and grounded learning approaches. Transcripts and field notes were imported into NVIVO for analysis. The data from the transcripts was coded into pre-defined themes guided by the evaluation questions

under the five evaluation criteria. After construction of a preliminary coding scheme, each code was examined in detail and further refined into categories. A framework was developed for each evaluation objective in which categories/sub-themes were allocated a column and used to code data. Thematic visual maps were generated using Mind Genius® Business Version 6 to display key patterns and findings, by each of the main thematic areas. During this stage, the validity of the themes and whether or not they accurately represented the data was ensured.

- 3.19. The analysis explored the context-specific interpretation of the coded data and assessed relationships between themes, districts and respondent characteristics.
- 3.20. For the **analysis of FGDs**, three levels of analysis were employed to answer some evaluation questions through the proposed Theory of Change. The first level included identifying specific causes or drivers of change (both positive and negative) reported explicitly or implicitly by the HDF beneficiaries (community members and VHWs). The second level included identification of selected outcomes of change reported by the beneficiaries. The third level involved the identification of possible causal link between the reported drivers of change and selected outcomes.
- 3.21. A full protocol presenting in detail the design of qualitative research, and the key findings, is presented in **Annex 6**.

Online survey:

- 3.22. The evaluation also conducted an online survey with key informants from the national level in Zimbabwe, exploring the perspectives of key stakeholders of the key features of the HDF as a pooled fund mechanism. The questionnaire and analysis were informed by a framework designed by the Overseas Development Institute (ODI)⁴⁰ to assess the fit and the performance of the HDF against the Paris principles of aid effectiveness.
- 3.23. Key stakeholders who are familiar with the HDF were recruited using a purposeful sampling strategy, with an email invitation sent out to potential participants along with a participant information sheet which outlined the objectives of the survey, and the consent form. The link to the questionnaires will also be included in the invitation emails.
- 3.24. The questions for the online survey were pre-tested in-house. Pilot testing focused on the understanding and ordering of the questions, comprehensiveness of the contents, provision of clear and adequate instructions, feasibility of the technology (for instance, download time), skipping patterns, data compatibility and transfer issues. Based on the experience from the pre-testing, the questionnaires were revised.
- 3.25. The online survey was conducted using the software SelectSurvey.NET. The online survey was in a format that protects against the loss of data and facilitates data transfer into a database for analysis. The questions will be formatted in a form which prevents survey modification by the study participants. There were inbuilt mechanisms to protect data, with access to data only allowed to limited staff via a private key and it was not accessible to the anyone else.
- 3.26. A list of 25 relevant stakeholders from national level was selected, based on participation to the SC. Invitations were shared via email with participants, with three recall emails over a period of three weeks. A total of eight questionnaires were collected.
- 3.27. Responses were composed of quantitative data which was exported from the online survey software (SelectSurvey.NET) into Microsoft Excel. Descriptive analysis was conducted using Microsoft Excel.
- 3.28. Data were triangulated with an independent review/assessment of the same questions of the online survey, independently done by three LSTM researchers. The overall, combined analysis informed then the findings against the evaluation question related to pooled funding (KEK 2).

⁴⁰ Measuring good pooled funds in fragile states. Erin Coppin. November 2012

Secondary data

- 3.26. The evaluation collected, systematized and used secondary data sources, including reports, studies, data sets, and existing surveys, to address the evaluation questions.
- 3.27. Criteria for selection and assessment of secondary data included: relevance to the health sector in Zimbabwe; relevance to time period under evaluation; usefulness in addressing evaluation questions and/or HTF LF; quality and reliability of sources. Reports and data sets collected during the evaluation were reviewed and screened by LSTM researchers to assess their quality, accuracy, and relevance to the evaluation. Limitations of the data in terms of quality and representativeness were explicitly clarified during the analysis and through this evaluation report.
- 3.28. The secondary data used for the evaluation included data sets (HMIS; VMHAS), HDF reports (HDF Reports, VMAHS reports, RBF Reports), as well as multiple studies and assessments conducted in Zimbabwe amongst others.
- 3.29. A full list of secondary data mapped and utilised for this evaluation are listed in [Appendix 5](#).

Data management

Data were managed according to international data protection regulations, and in line with national requirements. LSTM and BRTI ensured that controls were duly put in place to manage risk to the confidentiality, integrity and availability of sensitive data in any form and represent a minimum standard for protection of this data.

All procedures abided to GDPR. Additional controls required under applicable laws, regulations, or standards governing specific forms of data (MRCZ) were also considered.

It is the responsibility of all researchers and research administrators to ascertain and comply with any ethics or contractual confidentiality conditions relating to the primary materials and research data and related records. All research documents are kept in lockable cabinets for a minimum of five years, at the discretion of the Principal Investigator (PI).

Consent forms, SAQs and FGD logs were kept in a locked truck during data collection and subsequently transferred and locked in metal cabinets at BRTI after data collection. Copies of audio recordings were backed up on laptops during data collection and submitted to LSTM after translations and transcriptions. All transcripts had an encrypted password.

Tablets that were being used in the data collection process were password protected and researchers had to sign the confidentially form. These tablets were stored in a lockable metal trunk during field work and all collected data were uploaded to the LSTM server at the end of each day.

Limitations of the evaluation

- 3.30 General limitations of the proposed evaluation design and methods, and strategies taken to address them are presented below.

Limitations	Description	Mitigation measures where relevant
Limitations related to the evaluation design		
Attribution/ Contribution	The evaluation is not designed to attribute a net impact of change in outcomes to the HDF	Contribution analysis was identified as a suitable method to address the evaluation questions.

Limitations	Description	Mitigation measures where relevant
Focus of the evaluation (Subject)	<p>The focus of the evaluation has been on HDF as a whole, and not on the various individual programs supported through it. As a consequence, the ToC developed and tested for the evaluation is a generic ToC focusing on the Fund and on the major strategies supported.</p> <p>Assessing in detail individual programs would have entailed drawing and testing multiple theories of change. This was beyond the scope of the evaluation</p>	<p>Scope and focus of the evaluation clarified via inception report and approved by all stakeholders</p> <p>ToC participatorily designed at country level with key stakeholders</p>
Focus of the evaluation (Results)	<p>This midterm evaluation had a primary focus on immediate and intermediate results.</p> <p>Impact level results were not part of the evaluation design. Outcome level has only partially been addressed, and a broader assessment of it will be required at final evaluation stage.</p>	<p>Design issues covered in the inception report and highlighted in that report as limitations of the evaluation.</p>
Construct validity (ToC design and testing)	<p>the HDF builds on a consolidated model in country, but there is very limited evidence of ToCs for pooled funds from other countries in Africa and in other regions. Therefore, stakeholders' involvement in the design stage constituted the primary and only mechanism of to verify the validity of the hypotheses being tested, prior to initiating data collection.</p>	<p>Where possible, hypothesis of the ToC were tested/verified against other literature on pooled funds.</p> <p>At data collection level: for the purpose of this evaluation, well established definitions and measurement procedures were adopted and used for quantitative data collection. Many of the 'steps' along the chain of the theory of change have therefore and where possible been measured through standardized indicators drawn from globally adopted tools of from existing monitoring tools used in Zimbabwe.</p>
Limitations related to specific methods of data collection and analysis		
Analysis of secondary data	<p>Secondary data was collected via various UN Agencies, MoHCC, donors and implementing partners.</p> <p>Data and data sets was used for testing the ToC by triangulating evidence from various data sources.</p> <p>on of evidence with</p> <p>Whilst overall the quality of data was found to be good, an assessment of data quality was beyond the scope of this evaluation.</p>	

Limitations	Description	Mitigation measures where relevant
	<p>Main limitations found:</p> <p><i>HMIS data</i> At times data trends presented variations between consecutive quarters – for some HMIS indicators, eg Vitamin A supplementation - which are unlikely to reflect actual implementation patterns.</p> <p><i>Consistency of other secondary data</i> Triangulation of various data and reports – used as a method to strengthen the evidence for the findings – often highlighted inconsistencies across various data sets provided.</p> <p><i>Definition of indicators and change of indicators</i> For the HDF, the detailed definition of indicators was a weakness and a limitation. Also, the change of some indicators (VMHAS) over time limited the possibility to conduct consistent trend analysis</p>	<p>Outliers are flagged as a limitation of the study. Such indicators are not used for the analysis presented in the report</p> <p>Inconsistencies highlighted in the report where relevant, or main/most reliable source of information used for reporting</p> <p>Change in indicators highlighted were relevant in the report and its annexes.</p>
Qualitative Research	<p>The findings of the evaluation might have limited generalisability beyond its immediate locality as it included a limited number of stakeholders, interviewed at a specific stage.</p>	<p>By applying qualitative research methods such as KIIs and FGDs, the evaluation team sought to get in-depth information to answer evaluation questions. Generalisability is not the main goal of good qualitative research. We have used purposive sampling of “information-rich” participants to represent (not statistically) the broad types of informants relevant to our evaluation. Marshall (1996: 523) noted that ‘...an appropriate sample size for qualitative study is one that adequately answers the research question’.</p>
Survey of CHWs and of Health Facilities	<p>The Survey performed by LSTM was designed and approved to be significant at national level, with a margin of error of +/- 13%.</p> <p>Disaggregation by rural/urban or geographical setting was therefore not feasible via the survey.</p>	<p>In the report, confidence intervals are reported for all estimates, to allow the reader to assess the precision of the estimate.</p> <p>The survey design and sampling approach was discussed approved via inception report.</p> <p>Were possible, secondary data have been used to disaggregate information.</p>

Limitations	Description	Mitigation measures where relevant
	<p>Data collection was not performed across the whole country, but only in those areas where the HDF is implemented in all its components.</p> <p>The survey was cross sectional, and therefore capturing indicators which provide a snapshot as is of the facilities at the time of the survey.</p>	<p>The reader should be aware that the survey was designed to assess the HDF, and not the status of health care facilities in Zimbabwe as a whole. The proposed focus was approved at inception stage</p> <p>Triangulation with VMHAS was systematically used, where possible, to cross reference findings.</p>
VfM analysis	<p>The cost effectiveness analysis was limited primarily by the lack of available national data/trends in key coverage and mortality indicators</p>	<p>IGCME child mortality estimates used for the CEA</p> <p>Portion of costs attributable to child health only were used to conduct the CEA</p>
	<p>Comparability with other similar initiatives</p> <p>The unique blend of strategies and implementation approaches supported via this pooled fund made it unfeasible to compare the HDF with other pooled funds implemented elsewhere</p>	<p>n/a – this was a methodological limitation that needs to be taken into account in interpreting the results</p>
	<p>The analysis of efficiency relied primarily on a sample of transactions made available via UNICEF and UNFPA</p> <p>The sample was limited and not meant to be statistically significant</p>	<p>n/a – this was a methodological limitation that needs to be taken into account in interpreting the results</p>
Limitations related to implementation		
Data collection	<p>The data collection exercise was performed during at a stage where several external issues occurred in Zimbabwe. Of note, a cholera outbreak hit the country during the weeks preceding data collection and was still being addressed through various control measures during the data collection exercise. This caused major challenges in terms of availability of participants to the data collection, from national level (KIs, self-administered questionnaire) to the facility survey, where absence of respondents led to repeated visits to several facilities.</p> <p>Concurrently, the cash crisis occurring in Zimbabwe during the same period also caused major issues, both in terms of availability of respondents and of logistics (access to fuel for transport, access to cash for daily activities).</p>	<p>In general, all challenges were addressed without compromising the quality of the data collection exercise.</p> <p>A small reduction of the sample survey for the survey was necessary but did not affect the quality of its results. Interviews were rescheduled were necessary and multiple visits to facilities were organized, when respondents were not available.</p> <p>Thanks to the flexibility of local stakeholders and of the implementing p[artner BRTI, most implementation challenges were managed successfully.</p> <p>The evaluation was completed on time and to budget.</p>

SECTION 4 –IMPLEMENTATION ARRANGEMENTS

Contract and deliverables

4.1. This evaluation was designed and delivered under the Institutional Contract 43251295, signed between UNICEF and LSTM. LSTM was accountable to UNICEF for the contract deliverables, which are reported below:

- Minutes of inception meeting
- Draft inception report
- Final inception report
- Field work report
- Preliminary evaluation report
- Draft final report
- Final evaluation report

The main phases of the evaluation included:

- Evaluation design: this took place from inception, to mid-September 2018 when the inception report was approved
- Data collection: this phase included the training of data collectors, field work, data cleaning, and translation and transcription of qualitative data. Training took place in mid-September. Field work took place from 27th September to 17th October 2018. Quantitative data were received and cleaned in real time, whereas qualitative data transcripts were received by mid-November.
- Data analysis and reporting: this phase initiated at the end of the data collection phase, in mid-October. A first, preliminary report was then compiled at the end of November 2018.

A detailed timeline of all the evaluation activities is included in [Appendix 7](#)

Evaluation reference group and quality assurance

4.2. The evaluation reported formally to the HDF Evaluation Technical Committee, a sub-group of the larger SC.

Most of the evaluation deliverables were shared to a wider group of stakeholders – largely members of the SC – for validation and discussion.

4.3. Quality assurance mechanisms were put in place, to ensure the compliance to standards of all deliverables, as follows:

- a. Internally to LSTM, all deliverables were peer reviewed by the team and by senior academics.
- b. SC members provided comments to all deliverables, which were tracked, analysed and addressed by the evaluation
- c. The UNICEF Zimbabwe Technical Research and Evaluation Group (TREG) provided quality assurance of the evaluation, by reviewing the terms of reference, the inception report and the draft final report.
- d. The UNICEF Regional Office supported the review of the Inception Report and Draft report.
- e. DFID also provided a peer review of the Inception Report, via its central office of evaluation

Evaluation team

4.4. We purposively selected a multidisciplinary team that combined: sound expertise in the thematic areas that are relevant for this assignment; sound capacity in evaluation and technical assistance; expertise and competencies in quantitative and qualitative research methods; knowledge and understanding the Zimbabwean context; and previous experience of working with UNICEF.

4.5. The team members were:

Mr Luigi D'Aquino	Team Leader
Ms Margaret Caffrey	HRH Expert
Ms Esitinah Austin Chidzanira	PSM Expert
Mr Aaron Blaakman	RBF/VfM Expert
Dr Anna Miller	Policy Expert
Dr Thidar Pyone	Research Expert
Ms Audrey Mahieu	Research Expert
Dr Sarah White	Quantitative Research Expert
Mr Simone Filiaci	Research Assistant
Dr Fiona Dickinson	Research Assistant
Mr Tim Garner	Programme Manager

4.6. Curriculum vitae for all team members were provided and approved at proposal and inception stages. A table with profiles of all team members is included in **Appendix 8**.

Subcontractors

4.7. In line with the proposed approach to the evaluation, LSTM sub-contracted the **BRTI** a Zimbabwean organisation, through a competitive tender exercise to deliver selected components of the evaluation work. These included:

- Delivery of the health service assessment in selected facilities
- Delivery of FGDs in selected communities
- Delivery of KIIs
- Administrative and logistic support throughout the evaluation

4.8. The selection of the partner was formally approved by UNICEF. The subcontract signed between LSTM and BRTI and all the tendering documentation is available at LSTM upon request.

SECTION 5. FINDINGS

Relevance

EQ1. Are the HDF interventions and expected results relevant to the needs of its intended recipients?

FINDING 1 THE BUNDLE OF INTERVENTION STRATEGIES SUPPORTED THROUGH THE HDF IS FULLY CONSISTENT WITH THE CURRENT INTERNATIONAL STRATEGIES FOR RMNCH+A

5.1. In October 2018, Heads of State and Government, ministers and representatives of States and Governments, participating in the Global Conference on *Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals*, agreed upon key principles on PHC, that are summarized in the **Declaration on Primary Health Care** (the ‘Astana Declaration’)⁴¹. The Declaration reaffirms the importance of PHC as a cornerstone for achieving UHC, and for meeting Sustainable Development Goals. The key commitments of the Declaration and the fit of the HDF with such commitments is summarized below, in **Table 9**. Although such declaration was made well later the design and start of implementation of the HDF, it reflects key principles agreed at global level. The HDF does largely – if not entirely – fit with such principles.

Table 9. HDF and Astana Declaration

Commitments of the Astana Declaration	HDF features meeting the commitments of the Astana Declaration
<p><u>Make bold political choices for health across all sectors</u></p> <ul style="list-style-type: none"> Promote multisectoral action Empower communities Address social, economic and environmental determinants of health Promote CoC 	<ul style="list-style-type: none"> Multisectoral approach largely supported: 3 different Ministries represented in the HDF SC. Various Multisectoral plans promoted (e.g. nutrition) Large investment in community participation for action and social change Health promotion at scale CoC embedded in the HDF design
<p><u>Build sustainable primary health care</u></p> <ul style="list-style-type: none"> PHC will be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable. Success of PHC will be driven by: Knowledge and capacity-building HRH Technology Financing 	<p>Principles of availability, accessibility, acceptability and quality of care embedded in HDF design.</p> <ul style="list-style-type: none"> Strong investment on HRH and on sustaining knowledge at policy, management, and service delivery level Strong emphasis on provision of quality medicines, commodities and vaccines at all levels of care Strong investment in technology to improve information and the use of information for decision making Support to health system financing mechanisms (RBF) at scale
<p><u>Empower individuals and communities</u></p> <ul style="list-style-type: none"> Protect and promote human rights Increase community ownership Promote participation of civil society in development and implementation of policies and plans 	<ul style="list-style-type: none"> Large investment in community participation for action and social change

⁴¹ Declaration on Primary Health Care Astana, 2018. Accessed at: <http://www.who.int/primary-health/conference-phc/declaration>

<p><u>Align stakeholder support to national policies, strategies and plans</u></p> <ul style="list-style-type: none"> • All stakeholder will align with national policies, strategies and plans • All stakeholders will fully respect national sovereignty and human rights 	<p>The HDF is conceived and implemented to support national policies and strategies</p> <p>Full leadership of MoHCC in the design and governance of the HDF</p>
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5.2. Under the broader political commitment of working towards SGDs, the HDF design is also fully in line with the **Global Strategy for Women’s, Children’s and Adolescent’s Health 2016-2030**⁴². This consistently applies to the action areas of focus of the strategy, to its guiding principles, and to its implementation approach. **Figure 5** below presents the Strategy’s objectives, highlighting those that are met by the HDF.

Figure 5. Relevance of the HDF to Global Strategy for Women’s, Children’s and Adolescent’s Health 2016-2030

SURVIVE End preventable deaths

- Reduce global **maternal mortality** to less than 70 per 100,000 live births
- Reduce **newborn mortality** to at least as low as 12 per 1,000 live births in every country
- Reduce **under-five mortality** to at least as low as 25 per 1,000 live births in every country
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- Reduce by one third **premature mortality from non-communicable diseases** and promote mental health and well-being

THRIVE Ensure health and well-being

- End all forms of **malnutrition** and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
- Ensure universal access to **sexual and reproductive health-care services (including for family planning) and rights**
- Ensure that all girls and boys have access to good-quality early childhood development
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage, including financial risk protection and access to **quality essential services, medicines and vaccines**

TRANSFORM Expand enabling environments

- Eradicate extreme poverty
- Ensure that all girls and boys complete free, equitable and good-quality primary and secondary education
- Eliminate all harmful practices and all discrimination and **violence against women and girls**
- Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
- Enhance scientific research, upgrade technological capabilities and **encourage innovation**
- Provide legal identity for all, including birth registration
- Enhance the global **partnership for sustainable development**

5.3. The package of interventions and the delivery strategies supported by the HDF is fully aligned with the package of interventions for delivery within the CoC, as recommended by published literature⁴³ and as **recommended by WHO**⁴⁴

⁴² Every Woman Every Child 2015. Global Strategy for Women’s, Children,s and Adolescent’s Health 2016-2030. Accessed at: http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

⁴³ Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Kerber et Al. The Lancet, 2007. DOI:[https://doi.org/10.1016/S0140-6736\(07\)61578-5](https://doi.org/10.1016/S0140-6736(07)61578-5)

⁴⁴ The Partnership for Maternal, Newborn & Child Health. 2011. A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RmncH). Geneva, Switzerland: PMNCH.

- 5.4. The focus on quality of care, which in the HDF design builds on the concept of availability of care that was central instead to the HTF, does fully align with recent global evidence confirming that of 8.6 excess deaths amenable to health care, 5 million were due to **receipt of poor quality care**, and 3.6 million to non-utilisation of health care⁴⁵.
- 5.5. Finally, the focus on **equity** – also an incremental ambition compared to the previous HTF – responds to the global UHC agenda, and to its underpinning ‘logic of first reducing barriers to coverage for groups that are disadvantaged in terms of service coverage or health’⁴⁶

FINDING 2 THE HDF SUPPORTED INTERVENTION STRATEGIES ARE HIGHLY RELEVANT TO THE HDF OBJECTIVES OF REDUCING MATERNAL, NEWBORN AND CHILD MORTALITY AND TO REDUCE MALNUTRITION

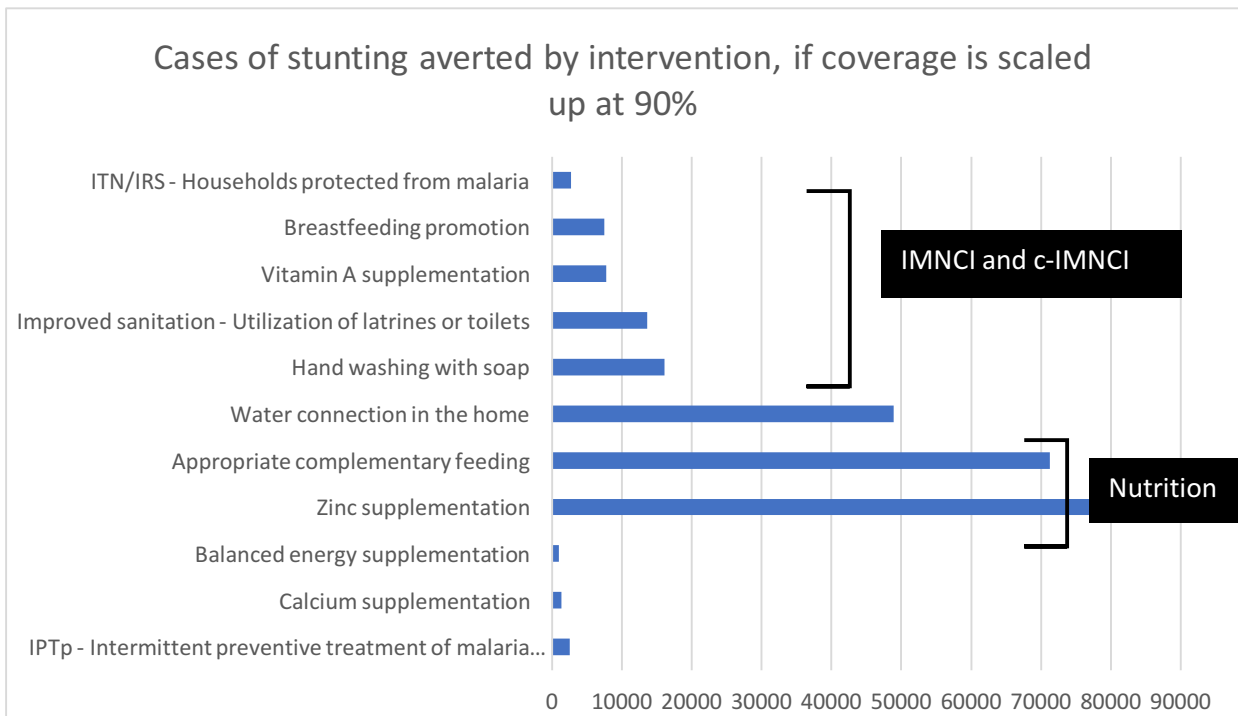
- 5.6. The HDF impact statement clearly indicates the reduction of mortality and reducing malnutrition as critical success measures of the fund, in line with the goals and targets defined by the MoHCC Strategy 2016-2020. Reducing mortality entails not only sustaining the gains achieved in the past years in Zimbabwe in terms of coverage of essential interventions (e.g. coverage of ANC, SBA, Immunisation above regional averages), but also focusing the investment on those areas where more progress is needed.
- 5.7. We have applied the ‘Missed Opportunity’ tool⁴⁷, to map what interventions would allow for the greatest number of lives saved, if they were scaled up from the current coverage levels in Zimbabwe (data from DHS 2015), to a level of 90%. The Missed Opportunities is a visualisation tool for quickly comparing the relative impact of different interventions reaching universal coverage on saving children's and women's lives. The MO is a module of the LiST tool.
- 5.8. The application of the model (**Figure 6**, for number of stunting averted, and **Figure 7** for stillbirths, newborn, maternal and child deaths prevented) indicates which interventions would avert more additional deaths, if they were scaled up in Zimbabwe from current coverage levels, to 90% coverage.
- 5.9. Although the modelling is purely theoretical and has limitations (it does not calculate how many additional lives would be lost, if intervention with current high coverage levels were reduced, e.g. EPI), the exercise shows high consistency of the HDF plans and activities, with the interventions recommended for prioritisation by the model. In particular:
- Community level interventions to promote complementary feeding and sanitation, and support to procurement of zinc and zinc supplementation are part of the HDF programme, and are shown by the model as interventions of high impact to reduce stunting (See Figure 6);
 - The scale up of family planning, largely supported by the HDF at policy, service delivery and community levels, is of extremely high impact in preventing/averting stillbirth, as well as maternal and newborn mortality (See Figure 7);

⁴⁵ Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. Kruk et Al. The Lancet, 2018. DOI:[https://doi.org/10.1016/S0140-6736\(18\)31668-4](https://doi.org/10.1016/S0140-6736(18)31668-4)

⁴⁶ Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage I. World Health Organisation, 2014. Accessed at: http://apps.who.int/iris/bitstream/handle/10665/112671/9789241507158_eng.pdf;jsessionid=4CE5A1095E13C27CA72D4D7D6611F2C5?sequence=1

⁴⁷ Using the missed opportunity tool as an application of the lives saved tool (LiST) for intervention prioritization Yvonne Tam and Luwei Pearson. BMC Public Health 2017, 17(Suppl 4):735. Accessed at: <https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-017-4736-3>

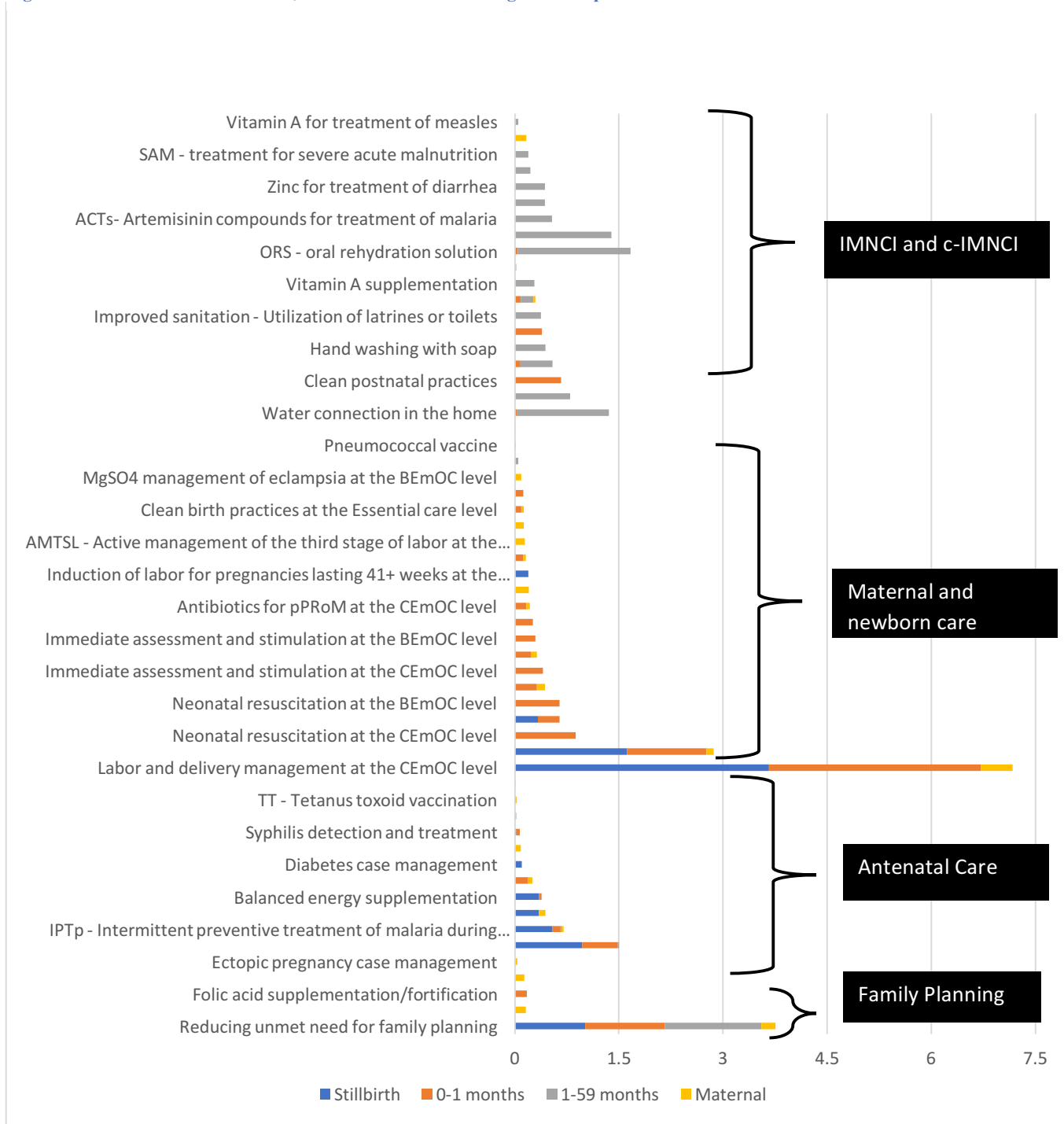
Figure 6. Number of stunting averted, with interventions coverage scaled up at 90%



- Child healthcare interventions implemented at universal scale at PHC and/or community level will immediately impact on the reduction of under-5 mortality. These interventions are primarily related to treatment for diarrhoea, malaria and pneumonia, treatment of sever acute malnutrition, and safe hygiene practices at household level.
- The strongest impact on newborn mortality, stillbirth and maternal mortality is related to scaling up essential interventions at the time of birth or immediately after birth, at primary and secondary care levels. Once again, the investment in EOC and in newborn care promoted by the HDF via training of HCPs, procurement of essential medicines and blood products, procurement of equipment, is fully in line with the concept of prioritising high impact interventions
- The same applies to ANC, which is a strong contributor to preventing/averting stillbirth and maternal mortality, and that has been largely promoted by the HDF both in terms of coverage, and of content and quality of care.

5.10. Overall, we conclude that the focus of key HDF strategies is highly consistent with its goal and objectives.

Figure 7. Number of deaths averted, with interventions coverage scaled up at 90%



FINDING 3 THE HDF DESIGN IS HIGHLY RESPONSIVE TO THE HEALTH NEEDS OF ITS INTENDED TARGET GROUPS

- 5.11. The needs of the target populations of the HDF are explored via primary qualitative research performed during the evaluation.
- 5.12. The analysis conducted confirms – in line with studies and reports already available – that the HDF is highly responsive to the expressed needs of women, men, adolescent boys and girls and children.

5.13. HDF interventions have been designed to support key services including safe delivery, ANC and PNC, family planning, sexual and reproductive health rights, nutrition and youth-friendly services with attention to embedded gender issues in access to and utilisation of services. Looking at these services, findings from our research confirm the following:

- Pregnant women express their first and immediate need as having a safe delivery.
- Women participating in the FGDs felt that men were ignorant of the needs of pregnant women, while men felt they got involved in supporting the pregnancy:

Woman: *"The health of pregnant women or their living conditions are in danger because men do not want to come to the clinic and be educated, one about health, two they do not understand that they are supposed to raise money to buy things required for the delivery"*.

Man: *"What makes me rush to the hospital it's because there a lot of investigations done at the hospitals on mothers like syphilis screening, HIV screening and to see if she has enough blood and what they call vital observations like blood pressure. (...) So, I run to the clinic to get good package"*.

- Men need education sessions on health to better understand the health needs of women.
- Women of reproductive age need Family Planning (FP) services, which they get from the clinic or from VHWs:

Woman: *"When you are seeking help to avoid getting pregnant you come to the clinic to get the tablets. Because this is where we can only get the medicine to avoid getting pregnant"*

- Male adolescents listed their main health problems as the lack of nutritious food and the lack of drinking water, drug abuse and STIs and expressed the need for youth friendly services:

"There are no youth friendly services in our community. We rather go to cafés because there are no youth friendly services here. Nobody organises that we must meet to discuss life matters"

- Female adolescents mentioned sexual harassment and sexual abuse, early pregnancies, suicide, STIs and menstrual cycle as their main health problems. Some of them also mentioned early marriage, abortions, physical abuse and lack of food and drinking water.
- Many girls raised the problems of communication that they have with their parents and the elders in the community. They fear that they will be judged and misunderstood:

Adolescent girl: *"For me it is not easy to tell my parents. The reason why is while dating my boyfriend we can have sex then I get infected with STIs, so for me to go and tell my mother (...) before I even finish telling her she would have beaten me up"*

- Female adolescents expressed their wish to have more educational sessions and people in the community to help them such as peer educators. Women also saw this as a need for female adolescents

Effectiveness

EQ2. How effectively has the HDF pooled fund mechanism performed, against the key principles of aid effectiveness?

- 5.14. This evaluation question is intended primarily to draw evidence-based conclusions and to learn lessons about the platform used to design, oversee, coordinate, implement and monitor the HDF plans, i.e. the pooled fund mechanism established in Zimbabwe via HDF. The HDF *de facto* has brought together two initiatives, the UNFPA supported ISP and the UNICEF supported HTF, under a single coordination and oversight mechanism.
- 5.15. To address the evaluation question, we have primarily used a framework designed by the ODI⁴⁸ to assess the fit and the performance of the HDF against the Paris principles of aid effectiveness⁴⁹.

The framework has been used as a scoring tool, and the scoring has been produced as a weighted combination of the response of in-country stakeholders to an online questionnaire (n=8) and of an independent assessment and scoring performed by three LSTM experts.

- 5.16. The scoring criteria utilised followed the metrics shown in **Table 10** (as per *Inception Report*):

Table 10. Scoring criteria for the assessment of pooled fund

CRITERION	N. INDICATORS	CUMULATIVE SCORING
Ownership	4	Scoring will be calculated as the average of the 4 indicators for the criterion. 0-<50%: needs improvement 50-<75%: good 75-100%: excellent
Alignment	9	As above
Harmonisation	3	As above
Delivery for results	4	As above
Mutual accountability	3	As above

FINDING 4 THE HDF POOLED FUND MECHANISM PERFORMED VERY WELL AGAINST THE KEY PRINCIPLES OF AID EFFECTIVENESS

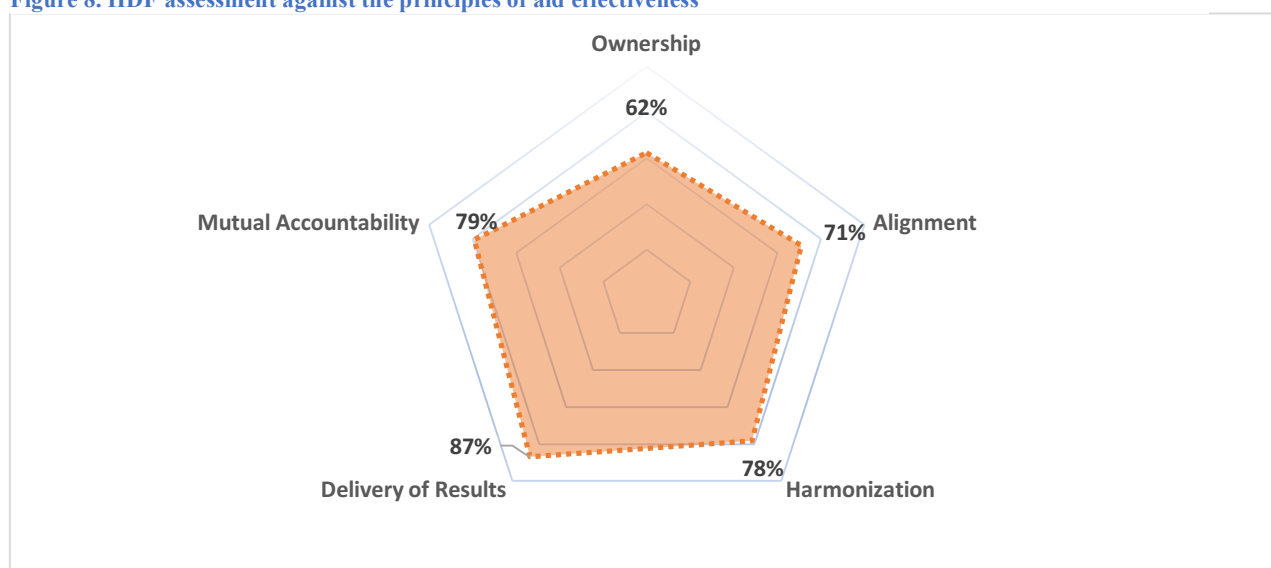
- 5.17. Overall, the scoring of HDF against the Paris principles demonstrates good to excellent fit with the principles of: ownership; alignment; harmonisation; delivery of results and mutual accountability.

Figure 8 summarises the score in each of these domains.
The combined cumulative score of **76%** is excellent.

⁴⁸ Measuring good pooled funds in fragile states. Erin Coppin. November 2012

⁴⁹ Paris Declaration on Aid Effectiveness, 2005. Accessed at: <https://www.oecd.org/dac/effectiveness/34428351.pdf>

Figure 8. HDF assessment against the principles of aid effectiveness



- 5.18. The scoring for **alignment** is good (71%), with very high scoring on alignment of the HDF with national plans and budgets, low proportion of earmarked funds, flexible technical assistance going beyond management of the fund, public availability of HDF documentation and synchronisation with the national financial planning cycle. However, the overall score was (partially) reduced due to limited alignment of budget categories with national budget classifications.
- 5.19. The scoring for **harmonisation** of the HDF is excellent (78%), with regular interface between a wide group of donors and the experience and competence of the fund administrator (UNICEF).
- 5.20. The scoring for **delivery of results** is excellent (87%), due to financing being received for committed projects, actual spending linked to planned spending, flexibility of reallocation of funds to different priorities as required, and the absence of a formal requirement for counterpart financing.
- 5.21. The scoring for **mutual accountability** was excellent (81%), with monitoring of HDF including Government processes, timely reporting and the inclusion of independent reviews (such as this mid-term evaluation).
- 5.22. The scoring for **ownership** (62%) is good, with very high scoring on the relationship of the HDF to Government strategy and accountability. However, the overall score was reduced due to the location of financial management of the HDF being largely located outside the MoHCC.

The detailed scoring matrix utilised to assess the HDF is attached in **Appendix 6**

Supporting the above presented assessment, we have further explored and analysed the performance of the key functions of the fund mechanism: governance; planning of activities; fund management; M&E.

The main benchmarks used for the assessment of such functions are those presented in the DFID policy briefing 'Pooled Funds to Support Service Delivery – Lessons of Experience from Fragile and Conflict Affected States (2013)'⁵⁰


Our key findings are presented below.

⁵⁰ Accessed at: https://assets.publishing.service.gov.uk/media/57a08a10ed915d622c00053d/61050-PFs-Full_Volume_May2013_.pdf

FINDING 5 THE HDF GOVERNANCE IS WELL PERFORMED, AND IS CATALYTIC AS A BROAD, HEALTH SECTOR COORDINATION SUPPORT MECHANISM (*Governance function*)

- 5.23. There is clear evidence that the HDF has a functional SC, with ToRs available, and membership rules in place. This clarifies well the structure, mechanisms and responsibilities of various participants to the HDF.
- 5.24. During the review period (Jan 2016 to June 2018), 14 SC meetings were held, with a two-monthly frequency. The mean number of participants was 28 per meeting. The **mean participation of the 9 HDF voting members was of 80%**, with 100% participation from the following voting members: MoHCC, DFID, UNICEF, UNFPA, and EU. Leadership is clearly with MoHCC, with the Permanent Secretary being the chair of the SC and one rotating donor member being co-chair. All but one meetings analysed for the period under review were chaired by the Permanent Secretary of the MoHCC.
- 5.25. **Donors** are highly involved in the HDF governance. Besides the formal SC meetings, there is evidence of a strong commitment from all donors to maintain a regular and constructive dialogue with the MoHCC and with UNICEF and UNFPA. This is a critical asset allowing for flexibility and rapid decision making, when required.
- 5.26. There is also clear evidence of good **participation from other line ministries and parastatal institutions** involved with the HDF. Examples include: MoWAGCD (participation to 33% of the meetings), Health Services Board (75%), NatPharm (33%), ZNFPC (92%) and Ministry of Finance and Economic Development (42%)
- 5.27. The **participation from non HDF partners** to SC meetings was fairly regular. In particular, on average GF CCM/PCU participated to 58% of the meetings; World Bank to 42%; USAID to 33%. Civil society was also represented in 83% of the meetings.

I suppose that there is always room for improvement, but I think it's been working very well. It has been working well in the sense that all the funders are in, even some that are not directly funding, they are in and have their voice. They may not have voting rights, but I think it's been functioning optimally
(Key Informant Interview, national level)

- 5.28. The HDF has a Secretariat in place. The function of the secretariat is clear, and is performed to standards, by experienced members with sufficient seniority and competencies required to coordinate the various stakeholders involved in the SC, at high levels (Source: KIIs).
- 5.29. The gender balance of the SC is fairly equitable.  The median number of female participants to the HDF SC meetings is 48%. More importantly, there is evidence from the review of meeting minutes that the level of seniority of participants was fairly balanced in terms of gender, and so were the inputs to the various meetings.
- 5.30. An area of improvement emerged through the review is the level of authority and responsibility of the various representatives of the organisations participating to the SC. In particular, the level of participation of members of the various institutions/departments is inconsistent and in the views of some participants to KIIs undermines the capacity of perform decisions at SC level.
- 5.31. Qualitative review of the minutes of the steering committee meetings and evidence from KIIs provide strong evidence that the **Steering Committee has largely been a forum for coordination and information sharing**. A critical function, to support the health sector dialogue and coordination.

5.32. However, there is evidence of a positive shift towards more strategic and decision-making oriented discussions as of mid-2018. An example is the regular presentation of a dashboard presenting key performance indicators (KPIs) by province and by progress (RAG status). The strategic level of the SC function and focus remains an area of improvement. Weaknesses in such function are perceived as due to both the quality of inputs provided by the TWGs informing the fund, and to the capacity to make critical and focus analysis on high level issues.

In my view, the technical working groups or the thematic group discussions need to be stronger in terms of feeding the HDF steering committee with tangible and concrete proposal
(Key Informant Interview)

5.33. In summary, given the absence of a formal health sector coordination mechanism in Zimbabwe, there is evidence that the SC has actually served as a **broad coordination mechanism**, that goes beyond the mere function of oversight of the HDF funds and supported programmes. This is evident from KIIIs and from the review of the SC meeting minutes, which confirm that some/many of the items discussed are broad sector wide issues that are related – but not only limited to HDF plans.

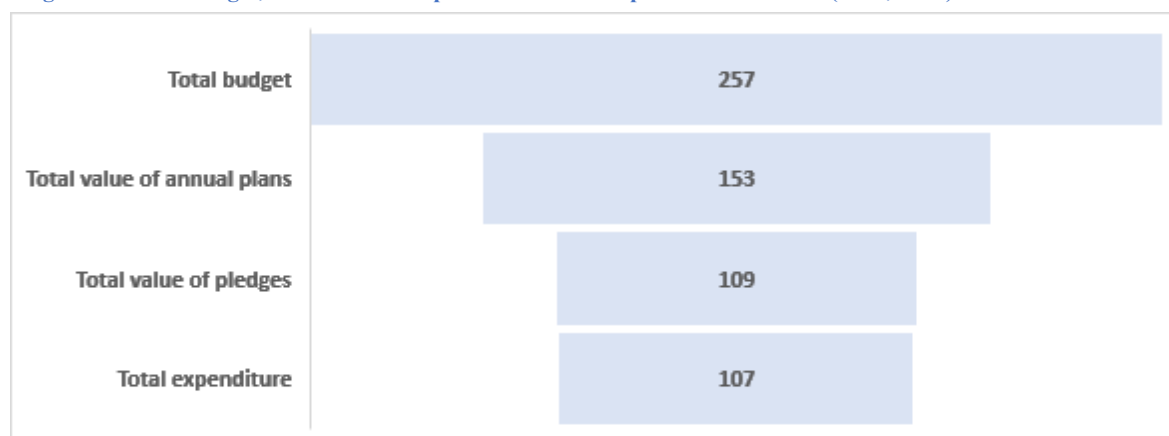
FINDING 6 THE HDF PLANNING FUNCTION HAS CATALYSED THE FLEXIBLE USE OF RESOURCES ACCORDING TO PRIORITIES.
(Planning function)

5.34. The HDF Programme Document presented a budget of 681 million USD. As per the same Programme Document, with such a budget allocation the HDF would support up to 30% of the total requirements of the health sector for the thematic areas of interest.

5.35. The evaluation could not reconstruct the detailed assumptions informing the costing exercise that led to the HDF budget. As a background, the evaluation of the Health Transition Fund documented that the predecessor of the HDF has an initial budget of 435 million US dollars, and that the actual expenditure was instead of 207 million USD. With such an historical background, despite of the expansion of activities to other areas of work thanks to the contribution of UNFPA, the decision of informing HDF plans and budgets at such ambitious levels may have been an unnecessary risk. HDF actors were forced into a ‘catch up mode’ since the start of the initiative, trying to accommodate a broad and ambitious workplan with funding which was not at the levels expected.

Figure 9 shows, for the period 2016-2017: the initial budget; the value of costed plans approved at the beginning of the year; the total initial pledges as per costed annual workplans, and the actual reported expenditure.

Figure 9. Initial budget, value of annual plans and actual expenditure for HDF (2016, 2017)



- 5.36. As per above presented data, the HDF annual plans had to be reduced to about 40% of the initial estimated budget. Also, the actual annual plans as approved by the SC on an annual basis, were more ambitious than the level of resources which was eventually mobilised and availed to implement the plans.
- 5.37. Despite such a scenario, some major positive features of the HDF emerged from the evaluation, regarding the planning function of the HDF:

- **Prioritisation**

The SC was forced to prioritise activities, in light of the available funding levels, on an annual basis. This was based on a process of formal approval of annual workplans. A bottom up process of review and prioritisation of activities was conducted at the level of thematic TWGs, then consolidated and discussed with MoHCC directors and donors, prior to final review and sign off at SC level.

Yes, it was a challenge in that yes we had anticipated more money than was eventually raised. But the process that is followed in HDF is participatory. So, I think that we reached consensus on the priorities.
(Key Informant Interview)

- **Flexibility**

Once approved, plans were managed rigorously, but also with the necessary flexibility. Evidence of flexibility, always managed under the leadership of the SC, included various decisions made during the review period, to adjust the HDF to contextual factors. As examples: the allocation of funds to respond to epidemics; the termination of the retention allowance for healthcare workers; the freeze of the scale up of community health workers; the transition of HIV/AIDS activities to the GFATM.

- **Fitness and integration with MoHCC plans**

In principle, the HDF plan is fully integrated with the national plans of the MoHCC. Although the timing of the annual MoHCC plans may not fully align with the annual process of planning of the HDF (which depends on donors' commitments), the HDF plans largely respond and address gaps of the annual MoHCC plans.

In the words of a participant to our KIIs:

The planning process is really where people at programme level start discussions and agree on issues and priorities. Of course, the Ministry has its perceptions and the funders have theirs. So at that level they sit and discuss and then t's brought up to the HDF Steering Committee
(Key Informant Interview)

- **Catalyst role of the HDF plans**

A review of the annual plans of the HDF and KIIs confirm that the process of planning for the HDF also had the benefit of catalysing additional resources around the HDF plan.

Examples include additional contributions from UNFPA, UNICEF and also from the MoHCC, which were used to complement the HDF plans.

This is not a common feature of most pooled funds and should be regarded as a strongly positive practice.

FINDING 7 PLANS WERE EXTREMELY COMPLEX AND PRESENT AREAS OF IMPROVEMENT IN TERMS OF INTEGRATION

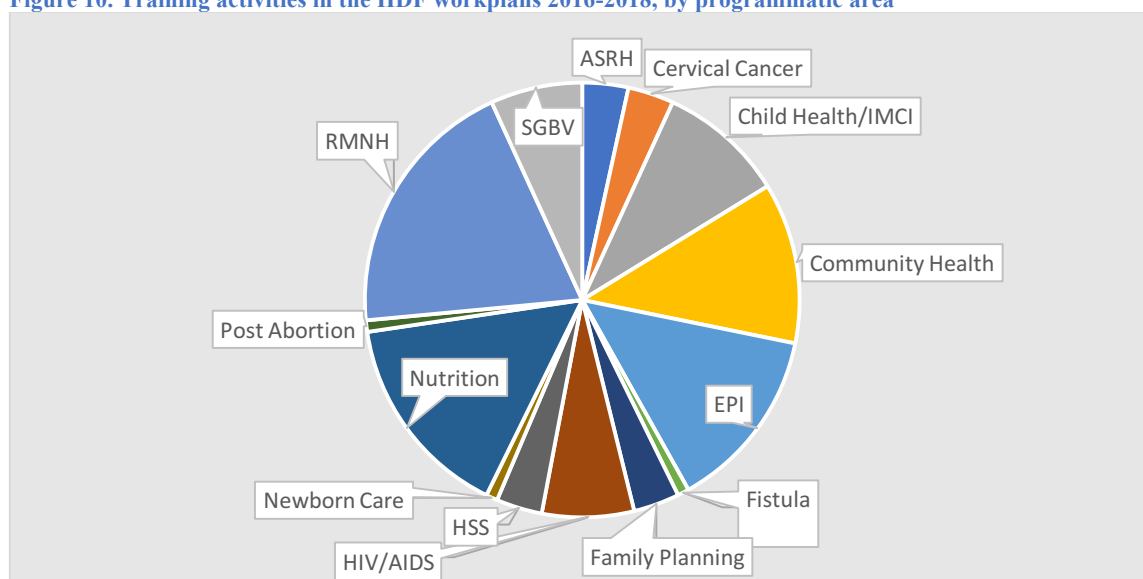
5.38. The evaluation has reviewed and analysed the HDF workplans for 2016, 2017 and 2018. The workplans were merged and coded by the LSTM team by ‘type of activity’ and by ‘programmatic area’, for analysis.

5.39. Key features emerging from the analysis:

- The consolidated workplan for 2016-2018, only for those activities for which there was funding available or pledged, amounts to 170 million USD. This is for direct costs only
- This total projected expenditure is broken into **769 activity lines**, across the seven thematic areas. This makes a total of more than 250 activity lines per year, to be managed via the pooled fund. Although there is no benchmark readily available for comparison, this seems a fairly ambitious volume of work for the Fund Manager, also taking into account that a substantial number of activities are managed by the MoHCC, via the UN HACT system.
- The average monetary value of the activity lines in the workplan is of **221,000 USD**. This sees a range going from 200 USD to 9.5 million, reflecting an extremely strong variety in nature of the activities planned, but also a varied approach to the planning exercise, which for some programmatic areas are extremely detailed, compared to others.
- In reviewing the workplan, the evaluation notes the fragmentation of some of the activities across programmatic areas of the HDF. This is an area where opportunity for further integration may be sought. Examples include training, outreach, and social mobilisation. For all these activities, the review of workplans seems to point towards a process of planning by ‘programmatic area’ (eg child health, EPI, nutrition, etc). While this is fairly normal since it reflects the organisational division of labour within the MoHCC and to a certain extent within UN agencies, it remains an approach to planning that can be improved.

As an example, **Figure 10** shows the classification of training activities by programme areas (expressed as number of activity lines in the workplan, and not as financial value of the activities). This shows that resources were allocated to about 15 different areas (some of them could be further sub-divided), for training. The plans do not clarify the level of overlap in terms of geographical coverage of the various trainings undertaken.

Figure 10. Training activities in the HDF workplans 2016-2018, by programmatic area



A similar example applies to outreach, where the workplan show that outreach is supported for ‘priority districts’ via separate budget lines for nutrition; immunisation; VIAC; HIV/AIDS; and nutrition, respectively. The level of integration and convergence of these outreach plans in terms of geography and time is not clear via workplans.

FINDING 8 THE FUND MANAGEMENT FUNCTION WAS WELL PERFORMED

5.40. Three key features are identified, that define a ‘good’ fund manager⁵¹: leadership including quality staff; context understanding and established local relationships; management.

5.41. Since the model of fund management was largely built on the basis of the predecessor fund, the HTF and on the back of a consolidated experience of UNICEF in managing pooled funds in Zimbabwe and in other countries and regions, this function was not assessed in depth. Yet, evidence from mixed sources including review of workplans; review of financial transactions; KIIs allow to make the following conclusions:

- Plans have been largely managed to time and to budget
- Reports have been produced on due course and shared with donors
- Regular updates are provided to partners
- Coordination and dialogue with HDF stakeholders and with non HDF key actors is recognised as an asset and an added value of the Fund manager

5.42. A unique feature of the HDF – compared to other models – was the initial ‘merge’ of two initiatives, two steering committees and therefore two UN Agencies, under one single programme. Although the Fund manager role sits with UNICEF, UNFPA has also received funds directly via HDF at the beginning of the Fund. The interaction and dialogue between the two agencies was a critical feature to ensure smooth implementation.

Evidence from KIIs confirms that, following a slow start, the dialogue and integration of plans between the two agencies as strongly improved and has become an asset for the HDF.

5.43. An additional positive feature of the fund management was that of effectively utilizing ‘virtual pooling’ of resources, in order to ensure the regular management of activities despite of the different timelines at which donors would disburse funds. This is reported as a positive feature by key informants at national level.

5.44. Areas of improvement primarily concerned with reporting. In reviewing annual report of the HDF, the evaluation noted the following:

- Reports are extremely detailed, but since they are structured by thematic areas and then by outputs under each thematic area, the reader may struggle to find a comprehensive synthesis of what has been implemented, when and where. This is possibly related to the complexity of the LF – which also dictates the structure of the report (see Finding 9 below re LF).
- Financial information is reported inconsistently. The structure of the financial information is different between the annual report for 2016 and that of 2017, and that makes it difficult to analyse it across years. Also, UNICEF reports cumulative expenditure in the 2017 report, whereas the UNFPA data report annual expenditure. Again, this may cause confusion in reading and interpreting financial data.

⁵¹ Pooled Funds to Support Service Delivery – Lessons of Experience from Fragile and Conflict Affected States DFID, 2013

- 5.45. Given the complexity of the HDF plans in terms of: multiple donors; multiple participating government ministries and agencies, complexity of implementation arrangements; scale and coverage, and more importantly a fast-changing environment, the overall performance of the Fund Manager is reported consistently as a strong asset to the Fund from multiple stakeholders.

FINDING 9 MONITORING AND EVALUATION FUNCTION IS PERFORMED TO HIGH STANDARDS IN TERMS OF DATA COLLECTION AND REPORTING, ALTHOUGH SOME ITS DESIGN FEATURES PRESENT AREAS FOR IMPROVEMENT AND STRONGER ANALYSIS IS AN OPPORTUNITY FOR BETTER USE OF DATA

- 5.46. The M&E function of pooled funds is a critical one. The global literature and reports on pooled funds and multi-donor trust funds indicate that this is also a neglected function in many cases. This is not the case for the HDF.
- 5.47. The conceptual backbone of the monitoring of the HDF is its LF. Several weaknesses are noted regarding the LF. Many of them reflect similar considerations made by the evaluation of the HTF, in 2016. The key points to be noted:
- The evaluation could not find any evidence of consistent use of the LF as a monitoring tool. There is no reference to the LF in the HDF Annual reports (other than its inclusion as an Annex in the 2017 report. To the best of our knowledge, the LF was first updated in June 2018. Equally, there is no mention of the LF in the SC meeting minutes.
 - The HDF has recently initiated to discuss critical results via a Dashboard of 9 KPIs. At the most, two of these coincide with the indicators suggested in the LF.
 - DFID has also introduced, recently, payment based performance indicators. The consistency of these indicators with the LF has not been verified.
 - Whereas most of targets of HDF activities were (and are) regularly changed in the VMHAS reports, there is no evidence that the LF targets have been updated since HDF inception.
 - For impact and outcome indicators, the LF indicates data from MICS 2014 as the baseline, and data from DHS 2015 as milestone1. Since the HDF started in 2016, the LF should rather use DHS 2015 as baseline, and link milestones measurements to the years where DHS and/or MICS reports will be produced.
 - For output indicators, managing and making sense of 71 indicators across the various output areas of the HDF is not a straightforward exercise. And not necessarily meaningful.
 - The 71 output indicators do not 'follow the money' (eg there is no indicator on the performance of RBF, which is one of the major components of the HDF), and present various issues in their design, including:
 - a) Lack of definition of numerators and denominators
 - b) Clear definition of source of the information/data
 - c) Rationale for target setting
 - Concurrently, it is noted that a second LF for the HDF was introduced during the course of its implementation, as per requirements from DFID. This LF consists of 5 impact indicators, 6 outcome indicators, and 19 output indicators. Besides being more manageable in terms of the quantity of indicators tracked at the various levels of the theory of change, it is noted that this second LF also presents more conservative – and hence to some extent more realistic – targets for the HDF.

→ Operating on a dual LF plus an additional dashboard is not good practice nor efficient for the program. A combination of the current DFID LF and of the dashboard used at SC level appear to be the best way forward to manage the M&E function going forward.

5.48. Although the LF is not a strength of the Fund, a vast amount of data is produced, used and reported via HDF. This include:

→ The **VMHSS**. This tracks a number of LF indicators (24 of 71, in its version of Q1 2018). The VMHAS is a full census of all health facilities of Zimbabwe, administered on a quarterly basis to 1,425 facilities across the country. This is performed by Crown Agents.

Given the scope and coverage of the survey, VMHAS has become a real time monitoring tool for the health sector as a whole. Performed at less than 0.5 million USD per year, this is a highly effective measure to complement the HMIS data and to monitor the status of health care facilities. VMHAS reports are shared quarterly with relevant national stakeholders.

Possible areas in which the investment in VMHAS may be beneficial are:

- a) Measurement of selected indicators on Quality of Care
- b) Staffing levels at facilities

→ **HMIS data**. The HDF accesses and utilises HMIS data on a regular basis to monitor a number of programmatic activities, in terms of progress/utilisation of care, at both facility and community levels. Although there is no evidence of the HDF investing significant resources in capacity strengthening for HMIS, the use of routine data is a positive feature of the fund.

→ **RBF data** are collected on a monthly basis. These include patient satisfaction surveys performed at all health care facilities in 42 Districts where UNICEF supports the RBF, and data on quality assessments of facilities. RBF reports are shared quarterly with the Steering Committee.

5.49. In reviewing multiple reports, data and data sets for this evaluation, the team has encountered various issues regarding the consistency, harmonisation, and definition of the data produced and analysed. More importantly, the evaluation notes that the vast amount of data produced via HDF and by the MoHCC are used to track outputs to a great level of detail, but they are not systematically brought together, critiqued, cleaned, triangulated, and analysed in a systematic manner.

EQ3. What was the progress in achieving the HDF intended results, during the period 2016-2018?
EQ4. What were the main facilitators and barriers to achieving the HDF results, during the period 2016-2018?

5.50. The intended impact of the HDF is to contribute to the reduction of maternal, newborn, child and adolescent morbidity and mortality, and to improve the overall health status of these population groups. The ToC of the HDF, and consistently its LF, postulates that contributing to these long-term changes will imply generating results at outcome level that can be summarised as follows: **‘Improved, equitable coverage of high impact RMNCH+A and nutrition interventions along the continuum of care’**. Such statement captures and synthesises two key dimensions of the intended results of the HDF, which are clearly expressed by the outcome level indicators of the HDF LF: improved coverage of a range of effective **preventive and curative interventions for RMNHC-A and nutrition** and, improved **knowledge, practices, behaviour at household and individual level** (underlying health determinants).

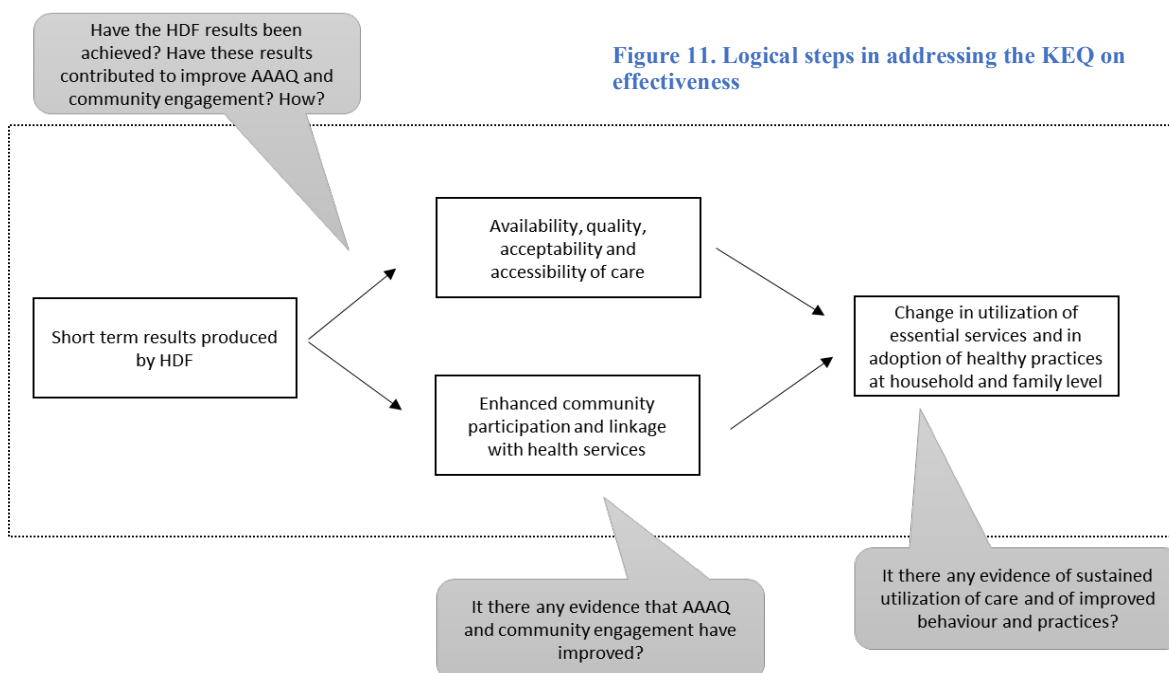
In order to contribute to its postulated outcome level results, the HDF is designed to achieve two broad and ambitious results (*intermediate results* in the ToC): Enhanced availability, quality, accessibility and acceptability of care; communities linked with health services and empowered in their awareness of their right to health

5.51. Addressing the EQ on effectiveness required therefore assessing three levels of the ToC:

- 1) Whether the HDF interventions have achieved their intended results, and whether/how these have contributed (or not) to improved availability, quality, accessibility and acceptability of care and to link communities with health services (*short term results level of the ToC*).
- 2) Whether there is any evidence that availability, quality, accessibility and acceptability of care and community awareness/engagement have actually been sustained in Zimbabwe.
- 3) Whether such contribution has yielded effects in terms of improved care seeking practices and behaviour and to improved utilisation of care (*outcome level of the ToC*)

This is visually represented in **Figure 11**, which simplifies the logic of the HDF theory of change.

Our assessment of effectiveness is therefore presented along the above described three steps.



The HDF contribution to change in maternal, newborn, child and adolescent health and nutrition (Short term results of the ToC)

5.52. The HDF has supported the implementation of a vast and varied range of interventions, at different scale and targeting different populations. The Availability, Accessibility, Availability & Quality (AAAQ) framework⁵² provides a good model to visually capture the contribution logic of the key strategies implemented via HDF (**Table 11**).

Table 11. Key HDF strategies and their contribution to AAAQ of care

Availability of care	Accessibility of care	Quality of care	Acceptability of care
Procurement of medicines, commodities and supplies	Outreach MWHs	Improved capacity of HRH (Training of HCPs; mentorship and supportive supervision)	
Availability of HRH (Retention and motivation of HCPs)		Quality improvement strategies	
Procurement of equipment			
VHWs Other community participation/social mobilisation initiatives			
RBF			
Management and governance			

5.53. The analysis of implementation of HDF strategies, their possible effects on change and the key barriers and bottlenecks encountered in implementing them are presented below. The analysis presented in this report will focus on key, strategic pillars of the HDF: procurement; availability and improved capacity of HRH, RBF, community health system strengthening, governance.

FINDING 10 THE PROCUREMENT OF MEDICINES, SUPPLIES AND COMMODITIES FOR RMNCH+A AND NUTRITION HAS ONLY PARTIALLY CONTRIBUTED TO ENHANCE AVAILABILITY OF CARE

5.54. The HDF has made a large investment in supporting the availability of a range of selected medicines, supplies, commodities and vaccines in Zimbabwe. Approximately 30% of the USD value of the HDF approved workplans for the period 2016-2018 are directly allocated to this function.

In addition, facilities can (and do) spend part of their RBF financing payments for local procurement of medicines, as and if required. The combination of direct support to procurement and of RBF makes the HDF a critical mechanism to support MoHCC and NatPharm in the supply of selected medicines in Zimbabwe, alongside USAID and the Global Fund.

HDF was also involved in policy and programmatic aspects related to PSM, with UNICEF serving as the secretariat for the *Procurement and Supply Management Advisory Group*, co-chaired by the MoHCC and DFID.

5.55. Various targets were established by the HDF at inception to ensure that a range of critical products are available at healthcare facilities. In particular, explicit targets set via the LF for PSM include those listed in **Table 12**.

⁵² http://www.who.int/mediacentre/factsheets/fs323_en.pdf

Most milestone targets were achieved for these indicators. This is reported through the VMHAS survey (Q1 2018) and largely confirmed by the independent, survey conducted by LSTM in October 2018.

Table 12. HDF indicators for procurement and supply management

HDF Indicator Ref.	HDF Indicator	2018 milestone target	2018 milestone achievement	Status at mid-term
1.2.11	Proportion of health facilities with no stock out of selected key maternal health medicines (Oxytocin and Magnesium Sulphate)	93%	Oxytocin: 94.9% VMAHS 98% LSTM Magnesium sulphate: 94.8% VMAHS 78% LSTM	Achieved
1.3.2	Stock out rate for essential medicines	0%	0% VMAHS n/a LSTM ⁵³	Achieved
2.2.2	Proportion of health facilities with at least 80% availability of antiretrovirals (ARVs) for children	80%	VMAHS: 83% LSTM: Above 95% for DHs Above 83% for PHCs	Achieved
2.2.3	Proportion of health facilities with at least 80% availability of selected antibiotics	80%	VMHAS: 92% Q1 2018 LSTM: all antibiotics available in more than 80% of facilities, with exception of Cotrimoxazole dispersible tablets / syrup and cephalosporine.	Achieved
2.2.4	Proportion of health centres with at least 70% availability of traditional vaccines throughout the year	100% (final target)	VMAHS: 97.2% Q1 2018 LSTM: 100% availability at DH level. Availability above 95% for all antigens	Achieved
3.1.2	Proportion of health facilities with no stock out of critical nutrition supply (vitamin A, IFA, RUTF) throughout the year	98% ⁵⁴	VMAHS: 88% Q1 2018 LSTM survey: stock outs reported in October 2018 of iron supplements and folic acid at both PHC and DH	To be monitored
4.1.6	Proportion of Health facilities reporting no stock outs of 80 % of selected STI drugs in the past three months. (Ceftriaxone injection, Metronidazole, Doxycycline, Benzathine Penicillin injection, Ciprofloxacin and Efythromycin) (National)	60%	VMHAS: 62% Q2 2018 LSTM: stock our reported for any item is below 12% for DH and below 25%, with exception of benzathine penicillin	Achieved
5.1.7	Proportion of health facilities with no stock out of long acting contraceptives (Implants or IUCD)	95%	88% VMAHS Q2 2018	To be monitored
2.2.5.	Number of districts with at least 2 people trained in LMIS and rational use of medicines	n/a	48% of DHOs surveyed by LSTM	No target set

5.56. More broadly, the VMAHS report tracks on a quarterly basis the availability of various product categories across the country, as well any stock out registered for the quarter preceding the survey. This covers a total of 49 products, in the following categories: vaccines; antibiotics; maternal health medicines; ARVs for children; nutrition commodities;

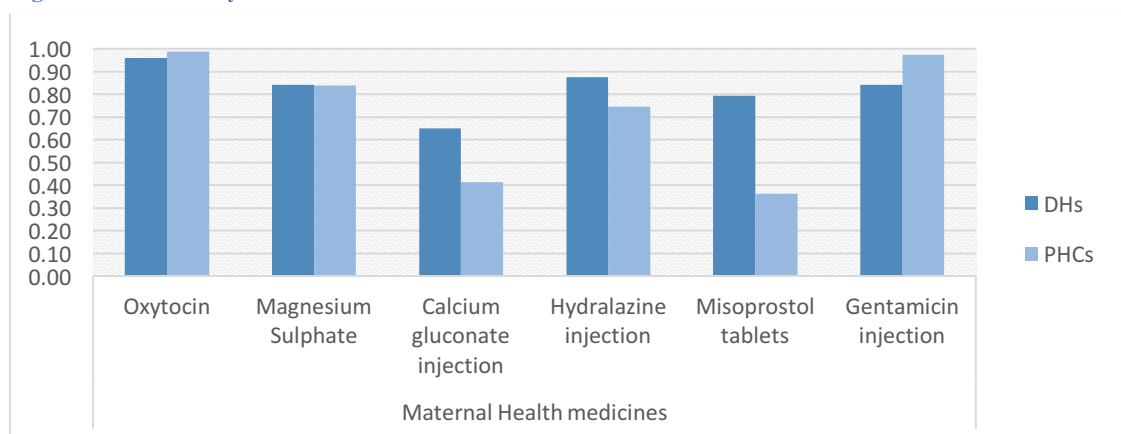
⁵³ The medicines for which stock out should be tracked are not explicitly defined. Therefore, the LSTM independent survey could not verify this indicator.

⁵⁴ Target defined via VMHAS report for Q1 2018. No evidence of target for this activity in the HDF LF

STI medicines; other vital essential medicines (VEN). Achievements and critical gaps in ensuring the availability of medicines and commodities alongside these categories is reported below.

- The availability of **vaccines**, largely supported by HDF with GAVI co-financing, is maintained at high levels. The VMAHS survey reports an increase in availability of selected vaccines from 89% in 2016, to 93% in Q1 2018, at PHC facilities. This data is confirmed by the recent survey from LSTM, reporting that the levels of availability of vaccines above 96%, for all the antigens. Stock out is also minimal at health care facilities, estimated by both VMHAS and LSTM at less than 2.5%. Supporting these achievements, the strong investment from GAVI via HDF, that has not only contributed to procurement, but also to targeted investments in maintaining the cold chain at all levels, in facilitating storage and distribution of vaccines, and in regular capacity building of HCPs on vaccines management (*see section on equipment*).
- **Maternal and reproductive health medicines** have been largely available. VMHAS reports consistent availability of some products in all facilities, in particular: oxytocin and magnesium sulphate are available in more than 90% of facilities, and gentamicin availability is consistently above 80%. Other products, such as misoprostol, hydralazine and calcium gluconate are instead available in 25-30% of facilities, on average. The LSTM survey largely confirmed this picture (**Figure 12**).

Figure 12. Availability of maternal health medicines



Of note, the LSTM survey also present evidence of recurrent stock out of some of the maternal health medicines. At PHC facilities, the stock out for the three months preceding the survey was negligible for oxytocin and gentamicin. For other products instead, stock outs were consistently reported. As an example, 45% of PHC facilities (CI: 0.35;0.55) reported stock out of calcium gluconate, and 57% (CI: 0.41;0.72) of misoprostol.

- **Nutrition commodities** are largely available. VMHAS data of high levels of availability are confirmed by the LSTM survey, with the availability of vitamin A, ferrous and folic tables and RUTF estimated consistently between 90% and 100% across the products. Data on stock out are also consistent between the two assessments, confirming that about 10% of facilities experience stock out of RUTF, and 15% of Vitamin A (100 000 IU), whereas other products are consistently available.
- **ARVs**
The availability of ARVs for children, and in particular of Lopinavir/Ritonavir in either tabs or syrup, has been inconsistent during the life of the HDF, ranging from 70% to 85% over time. The LSTM survey indicates a strong availability of these products, in line with VMAHS (96% at secondary level and 83% at primary level).
- **Family planning**
The most common contraceptives provided under the programme were Control; Secure, male and female condoms. The long-term contraceptives tracked under the period under review are the Intra Uterine

Contraceptive Devices (IUCDs) and implants. The male and female sterilisation was the permanent methods applied. The availability of FP methods is high across various products, including pills and condoms.

- **STIs**

The following selected STI medicines were tracked during the VMAHS rounds were: Ceftriaxone injection, Metronidazole, Doxycycline, Benzathine Penicillin injection, Ciprofloxacin and Erythromycin. However, in Q4 2017 cefixime and azithromycin were added onto the list. In Q1 2018 these two additional items were not tracked. The overall availability for the products is high – above 70% for all products as per VMHAS and LSTM survey. In line with VMHAS, the LSTM survey confirmed that about 20% of DHs and 35% of PHCs reported stock outs of Ceftriaxone.

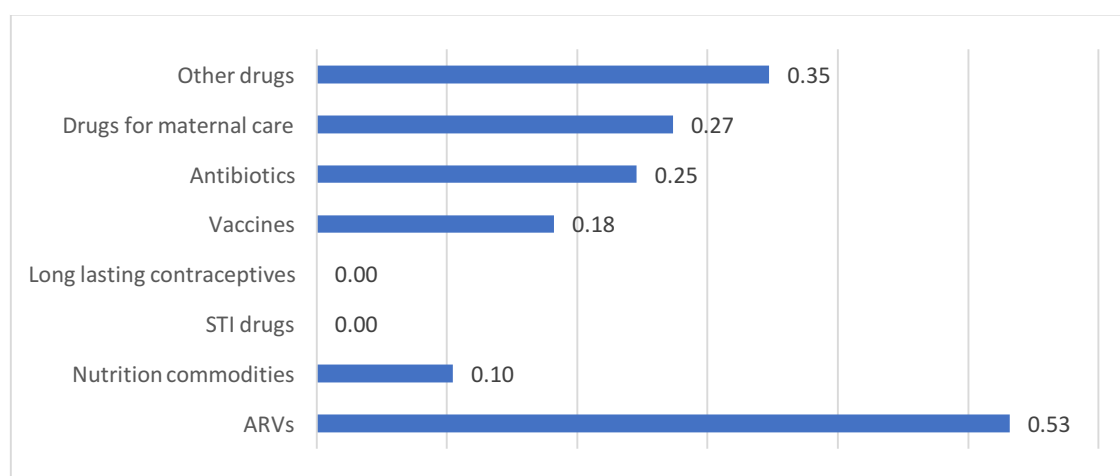
5.57. Despite of the above reported achievement, there is evidence of issues related to the availability of selected medicines, commodities and supplies:

- **Expired drugs**

The LSTM survey provides evidence of issues related to expiry of drugs at healthcare facilities. 78% (CI: 0.67;0.89) of district hospital surveyed and 43% (CI: 0.32; 0.56) of PHC facilities surveyed reported to have some expired products at the facility, on the day of the survey. Amongst the facilities reporting to have any expired drugs, the most common reported product categories were ARVs, other (non-specific medicines) and medicines for maternal care.

Figure 13 below shows the most reported categories of expired drugs at PHC facilities.

Figure 13. Reported product categories, for which primary health care facilities had drugs expired



Some evidence from JRM reports 2017 partially confirm this finding. Although in the view of many national level stakeholders the issue is primarily related to the kits previously distributed via push system, this remains a sign of the inefficiency of the system in absorbing, redistributing drugs prior to expiry, or in disposing expired drugs.

- **Lead time in processing orders**

In line with what reported by VMHAS, the LSTM survey confirms that virtually all facilities use NatPharm as the primary source of supply of medicines and commodities. Provision of drugs for most facilities is through the newly adopted Zimbabwe Assisted Pulled System (ZAPS).

In 75% (CI: 0.65;0.83) of surveyed district level hospitals, the main focal person for procurement is the pharmacy technician, whereas at facility level the most common cadre in charge is the nurse (82%, CI: 0.7;0.89)

Lead times for receiving orders vary significantly across levels of care.

For district level facilities, 50% (CI: 0.37; 0.63) of hospitals report to receive orders within 2 weeks, and an additional 42% (CI: 0.28; 0.55) between 2 weeks and 1 month.

The situation is different at PHC level, as shown in **Figure 14**. Nearly 50% of facilities receive products between one and three months from placing the order; an additional 16% in more than three months. Of note, the relevant MoHCC Standard Operating Procedures⁵⁵ suggest that parameter for the time interval between ordering stock and the time that received stock is ready for use is **1 month**.

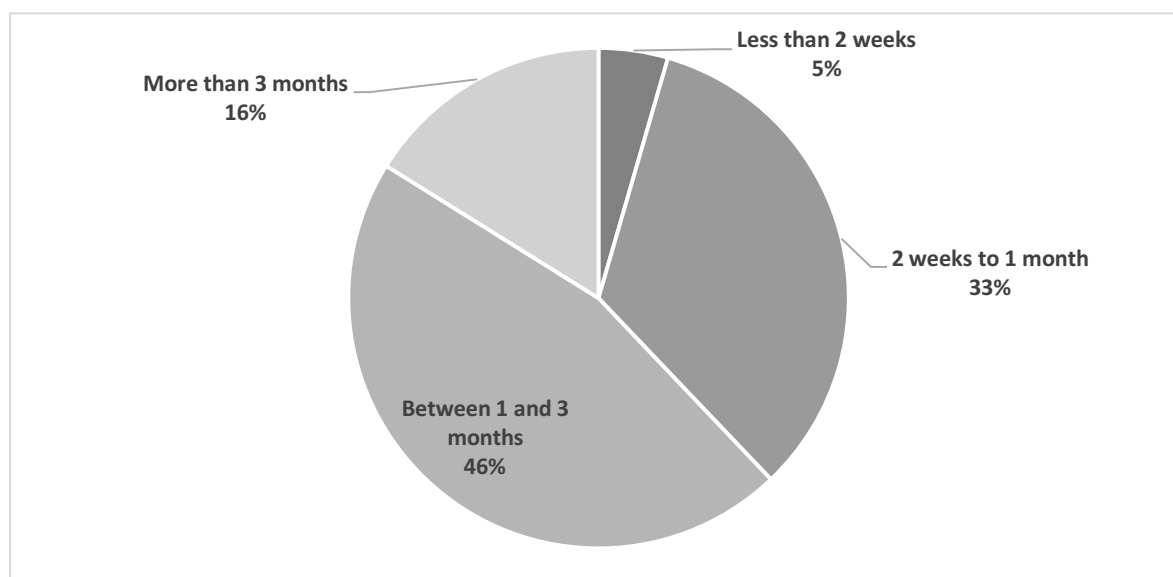


Figure 14. Reported average lead time for processing orders. Primary health care facilities

Issues with delayed or partial deliveries are also consistently reported via JRM reports for 2017.

The minutes of the ZAPS PSM advisory group suggest various bottlenecks causing the delays, including the quality of orders, the multiplication of emergency orders that take priority over routine management, issues with software systems, amongst others.

- **District management for PSM**

According to the LSTM survey, only 48% (95% CI: 0.34; 0.62) of DHOs have two staff trained in LMIS and rationale use of medicines.

5.58. The picture presented so far shows mixed evidence, with availability preserved at acceptable levels for most products, but also with regular stock outs, with reported expiry of medicines and with long lead times for receiving products.

Consistent evidence from qualitative research reveals that the availability of medicines remains a critical bottleneck in accessing care.

⁵⁵ Standard Operating Procedures Manual for the Management of the Zimbabwe Assisted Pull System (ZAPS) for Health Commodities to Primary Health Care Facilities and Hospitals. MoHCC and NatPharm, Updated May 2016

HCPs responding to the SAQ implemented as part of the data collection exercise of the evaluation consistently report that **the lack of availability of medicines is the most critical barrier that they experience in providing care to patients.**

Consistently with this feedback, participants to FGDs at community level also report that the **lack of medicines is a strong barrier to accessing care.** For many, the lack of medicines is a disincentive to visit health care facilities when needed.

For others, it is a barrier, as the need to purchase medicines at private pharmacies become an access barrier, due to costs of medicines and travel, that may offset the benefits of not paying user fees.

I am not really seeing a change in not paying user fees because you are coming here to get a prescription for you to then go and buy medicines yourself.

(FGD with men)

It was useless to come to the clinic, it was the same with staying at home because there is no medicine at the clinic.

(FGD with pregnant women)

I would like to add on the issue of medication, I think they should make medicines available at the clinic.

(FGDs, community women)

Yes, that is one of the biggest challenges at the moment as the facility does not have medicines. Therefore, in many cases we get prescriptions to buy at local pharmacies.

(FGD with adolescents)

FINDING 11 THE PROCUREMENT OF EQUIPMENT HAS BEEN SUPPORTIVE TO ENSURING AVAILABILITY OF CARE.

5.59. The HDF has played an important function in supporting the procurement of equipment across various programmes, and in supporting the regular management and operation of such equipment, and its maintenance. The HDF LF refers to only two indicators related to equipment (**Table 13**). For one indicator, targets have been achieved, for the other not.

Table 13. HDF indicators for procurement and supply management

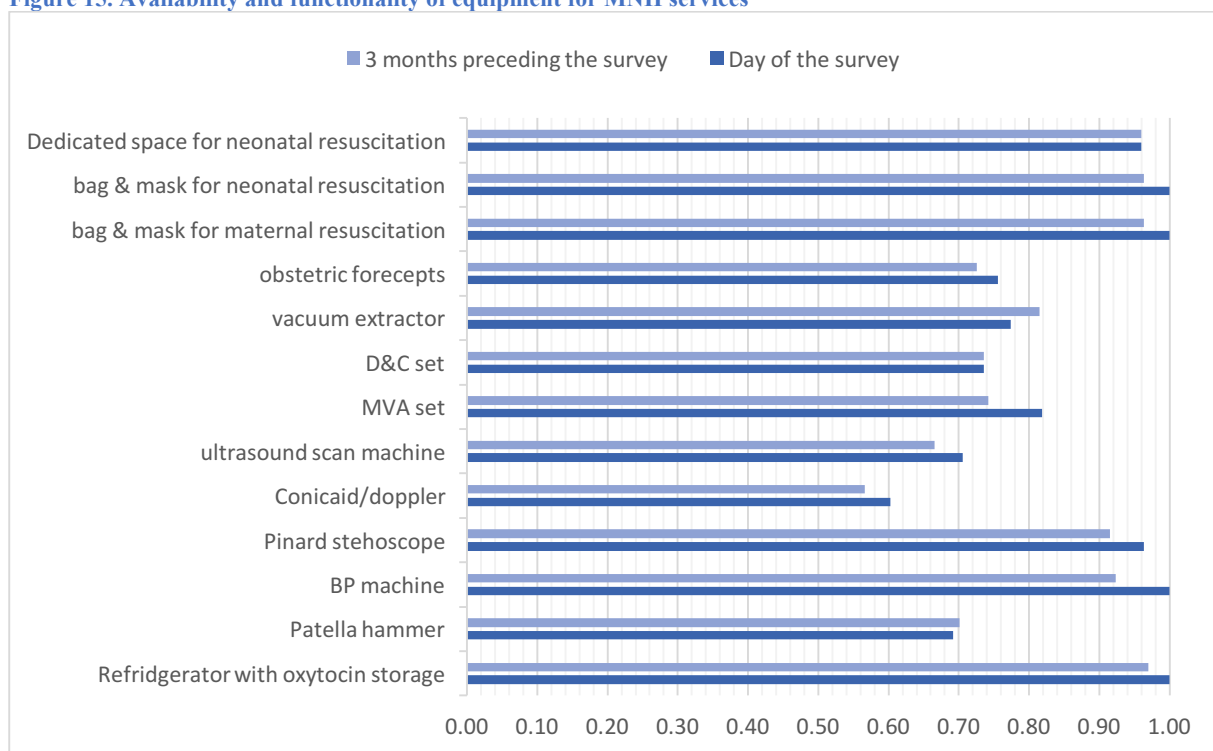
HDF Indicator Ref.	HDF Indicator	2018 milestone target	2018 milestone achievement	Status at mid-term
2.2.1	Proportion of health facilities with 100% availability of functional cold chain equipment	98%	98.5% VMAHS 100% DH and 95% PCH with refrigerator available and functioning. 100% of all facilities with cold boxes available	Achieved
1.2.8	Proportion of health facilities with fully functional communication equipment for emergency referral	95%	64% VMAHS Q2 2018 91% of DH and 77% of facilities having at least a cell phone available	Not Achieved To be monitored

5.60. The HDF workplans clearly indicate that the support to sustaining the availability and functioning of equipment has been much broader than what the HDF LF indicators express. In fact, procurement of equipment has spanned ANC, newborn care, cervical cancer screening, delivery kits, equipment for MVA, and others.

VMHAS tracks the availability of equipment for nutrition (growth monitoring and nutrition assessment) and for maternal and neonatal services. Such availability is consistently above 90% across tracer equipment items monitored.

LSTM has also assessed the availability of other equipment that is essential for MNH services. As shown in **Figure 15**, most of the equipment is available and functioning at district level hospitals. The reported levels of availability and functionality of equipment are mostly equivalent for the day of the survey and for the three months preceding the survey, confirming that overall the picture is stable over time.

Figure 15. Availability and functionality of equipment for MNH services



5.61. Although the equipment is largely available at facilities, some barriers are noted, from various sources:

- Challenges in maintenance of equipment due to lack of funding and capacity (JRM reports. LSTM survey also reporting that only 8% of facilities had spare parts for maintenance of cold chain)
- Need of replacement of old equipment (JRM, KIIs)
- Lack of standards leading to procurement of equipment from different sources and of different quality
- Need for training of staff in maintenance of equipment (JRM, KIIs)

The issue of the cold chain is not having adequate trained technicians to actually make sure that the equipment is maintained in good conditions (KII)

5.62. Despite the above referred challenges, overall there is satisfaction with the available levels of essential equipment. Both the SAQ and the KIIs at facility level point towards evidence that the **lack of equipment is not a major bottleneck for HCPs.**

5.63. The lack of equipment is not perceived as a bottleneck to care from participants to FGDs also.

5.64. **Table 14** below presents in summary the main barriers observed regarding the procurement and supply of medicines, commodities, vaccines and equipment.

Table 14. Barriers to procurement and availability of medicines & equipment

Efficiency/VfM	Effectiveness
Expiry of medicines Stock outs Delays in processing orders and delivery at all levels Procurement of drugs through local providers because of shortages and of lack of framework agreements with local pre-qualified suppliers	Quantification by central level may not meet facility needs Gap between quantities planned, ordered and received Progress with developing eLMIS Availability of foreign currency to access drugs from external markets for NatPharm and recently for facilities Limited availability of suppliers within the catchment areas Availability of LMIS officers at district level Plans/quantification for equipment

Additional details on the achievements in the area of procurement and supply management are available in **Annex 8**.

FINDING 12 VILLAGE HEALTH WORKERS ARE A STRONG CONTRIBUTOR TO LINKING COMMUNITIES WITH HEALTH SERVICES, AND TO PROVIDING HEALTH PROMOTION, PREVENTIVE CARE AND REFERRAL

5.65. The investment in community health, and in particular in VHWs has been a key strategy of the HDF, aimed at enhancing access to basic services at community level, and in particular at providing health education and early detection and referral to facilities.

By 2016, there were a total of 15,517 trained VHWs across the country, against the national target of 22,000, with all districts having reached above 60% VHW coverage (VMHASS 2016 Q4 Report and HDF Annual Report 2016). The Health sector strategy reported that 60% of villages had access to VHWs in 2016⁵⁶. VHW coverage increased again from 75.6% in 2016 to 76% in 2017, when there were 17,600 VHWs in the 1,362 health facilities outside of Harare and Bulawayo. There has been a steady increase in VHW numbers since 2015, when there were 11,565, up to the end of 2017, when there were 17,600. However, data from Q1 2018 show a decline in the numbers, with a total of 16,960 available at this time.

The support from HDF in scaling up the programme has mainly consisted of contribution to allowances; support to the procurement of equipment and commodities for VHWs; training. The other major contributor to the programme in Zimbabwe is the Global Fund.

At the end of 2017, following a period of continued scale up of the programme, the SC agreed to freeze the expansion of this cadre, and to wait for the finalisation of a national CHS, as an overarching framework defining role, scope of work, selection criteria, training packages and other key programme features for VHWs.

In fact, a Mapping of Community Cadres, completed in 2016, found that seventy-seven (77) types of community-based cadre were available across the country. VHWs were the most common cadre that functions as a link between the community and the formal health care system, with various other cadres such as the BCFs, Community ART Refill Groups, Community Child Care Workers and Home-Based Care givers, also linking directly with the health facilities on similar health issues. (HDF 2016 Annual Report). The findings of the mapping study also highlighted the overall weak coordination of community health services, with multiple community service providers working in an uncoordinated manner, with further expansion of the VHW programme put on hold in 2017 until improvements could be made in the coordination and management of community health systems as a whole (HDF 2017 Annual Report).

5.66. The HDF LF indicators referring to VHWs are two (**Table 15**).

No targets or milestone are provided for these indicators.


Table 15. HDF indicators for procurement and supply management

HDF Indicator Ref.	HDF Indicator	2018 milestone target	2018 milestone achievement	Status at mid-term
6.1.6	Proportion of villages with at least one VHW providing community based preventive MNCH, nutrition, HIV, SRH and selected curative MNCH services.	n/a	76% (VMHAS)	
6.1.7	Proportion of VHWs trained on standard package of community based MNCH and SRH services	n/a	100% of target (3.000) (VMHAS)	

⁵⁶ MoHCC (2016) National Health Strategy for Zimbabwe 2016–2020.

5.67. VHWs provide a range of services, for which they are trained, that include: distribution of contraceptives, distribution of vitamin A capsules, cIYCF, screening for malnutrition, emergency response.

VHWs report to the PHC facilities of the catchment area where they live and work. The clinic nurse is responsible for supervising the VHWs and provides them with on-the-job training and mentoring. The mean number of VHWs reporting to a facility is estimated in 13 (LSTM survey).

Of note, given the focus of the HDF, and its target population, more than 75% of VHWs are female  volunteers.

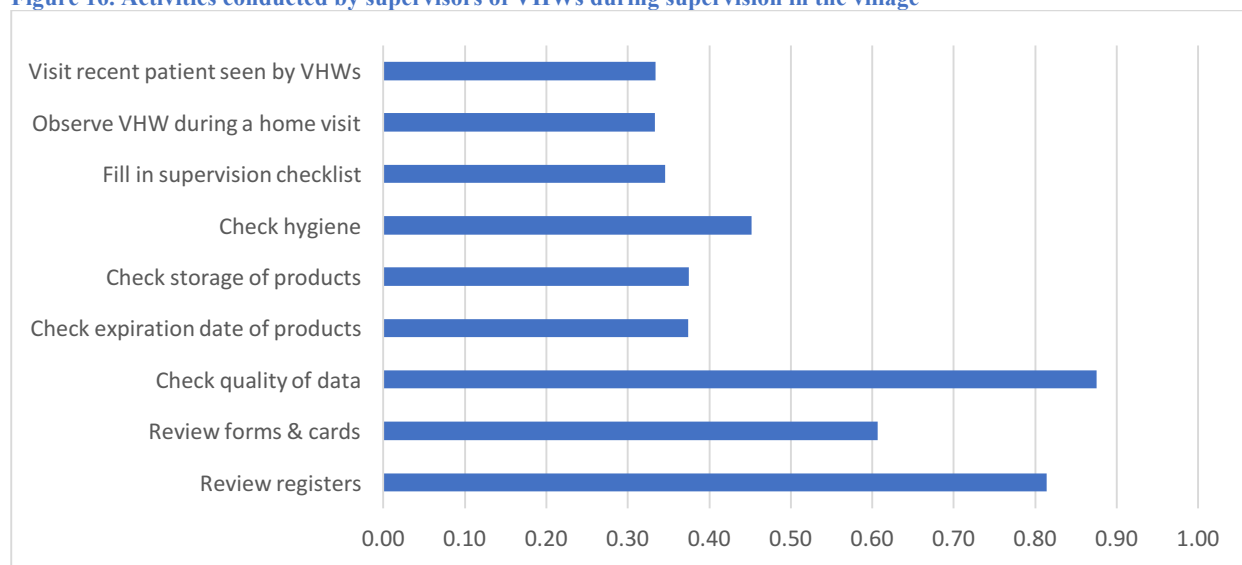
The integration of VHWs with healthcare facilities is good.

The LSTM survey reveals that at primary level, 100% of facilities organise a monthly meeting with VHWs. The attendance rate to meetings is estimated at 70% (95% CI: 0.52; 0.88).

Most facilities at primary level (69%) also report to regularly organise supervision of VHWs at village level. Of those, 75% do so on a monthly basis.

The most common features of supervision of VHWs are regularly performed

Figure 16. Activities conducted by supervisors of VHWs during supervision in the village



5.68. Barriers to the functioning of this cadre

- Lack of formal and standardised training
- Experience of delays in payment of allowances
- Lack of functional bicycles (41% of CHWs have a functional bike, as per LSTM survey)
- Irregular supply of drug kits (61% of facilities report providing kits to VHWs, as per LSTM survey)
- Multiplication of cadres at community level

Consistent sources of data confirm these barriers, including the JRM, the LSTM survey, the FGDs with VHWs, the FGDs with men and women in communities.

Table 16 below summarises the main barriers observed through the evaluation, with regard to the community health program supported via HDF. Some of the barriers reported below have been presented in this section of the

report. Those regarding equity and sustainability are discussed more in detail in the relevant sections of the report where these evaluation criteria are addressed.

Table 16. Barriers to strengthening community health

Efficiency	Effectiveness
Fragmentation (multiple cadres) Delays in receiving allowances	Supply of equipment (bikes) and drugs Maintenance of bikes Definition of role and responsibilities of VHWs Traditional healers Religious leaders

5.69. The evidence of the contribution of VHWs to availability of and access to care is overwhelming.

- As per HDF annual report 2017, during the course of 2017 ‘VHWs screened 1,323,211 children for malnutrition using MUAC, identified 254,554 and referred 43,352 EPI objectors to the health facilities for vaccinations and visited 52,954 pregnant women and referred them to book early for ANC before 14 weeks. Additionally, 39,006 pregnant women identified in communities were referred for delivery at health facilities. A total of 6,359,521 million people were reached with health promotion messages through the VHWs in the eight rural provinces (DHIS2, 2017)’
- Qualitative research confirms that there is a **strong link and collaboration between VHWs and HCPs**. Illustrative quotes from interviews with health care workers express the views of many, in terms of the collaboration with VHWs and of their added value in providing care and in enhancing access to services. (See below)

The performance of VHWs – Illustrative quotes from interviews with HCPs

Village health workers are an extension of the clinic.

Ok, we usually meet them every month, we do monthly meetings we discuss every issue that concerns the clinic and the community at large, then we inform them in everything that we need from the community.

It is going very well because we have village health workers who have been trained about nutrition who are doing active screening for children

We have low malnutrition index because village health workers are doing their best to educating mothers on the best food to give to the child

Then we dispatch the baby to the community where the village health worker will also be assessing any abnormalities in the village

Aaah, the main is health education. Health education to the community

- Concurrently, **community members also express high appreciation of the services provided by VHWs at community level**. The main value seen by communities in the support from VHWs is in immediately accessible and available advice for basic care; preventive care for children; linking women and children to healthcare facilities where either preventive or curative services are needed.

The performance of VHWs – Illustrative quotes from community members

Yes, we have village health workers in our communities, they are role models for us we look up them. They are here to represent the community in terms of health issues and work hand in hand with the facility.

Ministry has realised that having village health workers who stay in the community can be more helpful than coming and going. It is good to have people who help other people coming from the same community. So, we are saying that there is change in terms of health, because it start from the ground

Me and my wife first go to the village health worker and share our case and she refers us to the hospital. This is because village health workers provide teaching on pregnancy.

Yes, we encourage village health workers to continue with their good job

They are encouraging us to wash our hands after using the toilet. Village health workers also encourage us to have rubbish pits and also to clean the dish drying rake, they monitor us to see if we have all that.

Aaah we have village health workers and we are so grateful for the work they do for us

FINDING 13 IMPROVEMENTS IN THE AVAILABILITY OF KEY HEALTH CARE PROVIDERS HAVE BEEN ACHIEVED BUT SOME DOWNWARDS TRENDS ARE EVIDENT IN RECENT YEARS

5.70. The HDF Programme document (2015) proposes that this phase of support will focus on a number of key HR related objectives, strategies and interventions. Those related to improving the availability of HCPs are outlined below.

Focus area	Objectives, strategies and interventions
Availability of health workers	Current trend in reducing vacancy rates is maintained and improved
Strategic HR planning	Complete the Work Indicators of Staffing Need assessment and support implementation of findings within the national Human Resources planning framework
Retention of key health workers	Continued retention of key staff and increased dialogue for fiscal space for government contribution 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
Performance based incentives	Explore the possibility of paying for staff based on performance

5.71. Key HDF indicators. The only target related to improving the availability of HCPs is the proportion of district hospitals with at least 3 doctors. The progress made to date in achieving this target is presented in **Table 17** below.

Table 17. HR related targets and progress 2016 -2018

Indicator	2016		2017		2018	
	Target (%)	Progress (%)	Target (%)	Progress (%)	Target (%)	Progress (%)
Proportion of district hospitals* with at least 3 doctors	80%	80.4%	90%	Q1 69.6% Q4 66.7%	80% (HDF LF June 2018)	Q1 60% (VMAHS, 2018 Q1); 65.5% (HDF LF June 2018)

Source: HDF LF June 2018

*Note: The LF indicators is 'Proportion of districts with at least 3 doctors'

Key strategies to achieve these objectives included:

- building the capacity of the MoHCC HR Department to formulate policies, plans and strategies to strengthen the planning and management of the health workforce;
- improving the availability and retention of critical cadres in district level hospitals and PHC facilities through the provision of critical post and retention allowances;
- providing incentives to improve health worker performance through the RBF

5.72. HR data show that the overall health workforce grew by approximately 10% between 2015 and 2018, with an additional 2,439 posts filled on the establishment during this time. The greatest increase was among nursing cadres, followed by doctors and nutrition cadres. As shown in **Table 18** below the availability of many key cadres improved over the period under review, leading to a significant decline in vacancy rates, from 21% in 2015 to 13% in 2018. This improvement was due in part to Treasury approving the unfreezing of posts, enabling the MoHCC recruit additional health workers to fill critical existing vacant posts (RBF 2017). One hundred and thirty-nine (139) doctors

were recruited over this period, which reduced the vacancy rate to 30%; on the other hand, however, there was a slight decrease in the stock of environmental health and pharmacy cadres available. Vacancy levels for senior management posts have also improved and 7 of the 8 PMD posts were filled in August 2018., but 24 (43%) of the 56 District Medical Officer post were vacant at this time (MoHCC HR database). However, the LSTM survey found that in the 26 DHEs surveyed all posts in the DHE were filled except for some of the District Laboratory Scientist posts, where 43% were vacant (LSTM Survey, 2018).

Table 18. Availability of key cadres 2015 and 2018

Cadre	2015				2018			
	Est	In post	Vacant	% Vacant	Est	In post	Vacant	% Vacant
Senior Management (HQ)	83	45	38	46	82	50	32	39
Doctors	1888	1230	658	35	1951	1369	582	30
Nurses	20754	17217	3537	17	20876	19613	1263	6
Environmental health	2494	1612	882	35	2513	1530	983	39
Pharmacy	589	414	175	30	584	354	230	39
Radiography	511	245	266	52	515	246	269	52
Nutrition	980	811	169	17	975	847	128	13
Laboratory	644	389	255	40	646	395	251	39
Total	27943	21963	5980	21	28142	24404	3738	13

Source: MoHCC HR database December 2015 and May 2018

- 5.73. VMAHS 2017 and 2018 data and findings on staffing levels in district level hospitals and clinics also corroborate these findings, however some discrepancies were noted between the MoHCC 2018 HR data (May) and the data obtained through VMAHS in February 2018 from the 1,425 health facilities surveyed.
- 5.74. Of the available 1,369 doctors on the MoHCC HR database at different levels across the country, 214 Government Medical Officers (GMO) (15% of the total number of doctors) were based in district level hospitals, including district hospitals, including hospitals owned by GOZ, Mission, Rural District Councils (RDC), as well as General and Rehabilitation Hospitals (MoHCC HR Database, September 2018).
- 5.75. Throughout the HTF and under the HDF, up to the end of 2017, the fund supported attractive allowances for critical posts, including PMDs, PHEs, doctors, midwives and midwifery tutors. A key objective for the HDF was ensuring that each district hospital had at least 3 doctors to provide essential services. Retention data gathered throughout this period demonstrated that the provision of critical post and retention allowances for these district hospital-based doctors (Government Medical Officers/GMOs) contributed to an increase in their availability and retention, a trend which continued up to the end of 2016 (HDF 2016 Annual Report).
- 5.76. Further analysis of the VMAHS data indicate that there was an overall increase in the availability of doctors in the facilities surveyed throughout 2016, and by the end of that year 2016 over 80% of these facilities had at least three doctors in post (**Table 19** below). These findings suggest that the reduction in the critical post and retention allowances provided to these doctors instituted in 2016, had limited adverse impact on the availability and retention of district level doctors at that time. The number of doctors available in the district hospitals continued to grow beyond 2016, with VMAHS data showing an additional 64 available by the end of 2017. However, despite the

improvement in the overall number of doctors available, there was a **downward trend in the proportion of hospitals with at least three doctors over the following 2 years**, and by the first quarter of 2018, the rate had declined to 60%. Most of the hospitals with less than three doctors were in the three provinces of Mashonaland East, Matabeleland North and Midlands (VMAHS 2018).

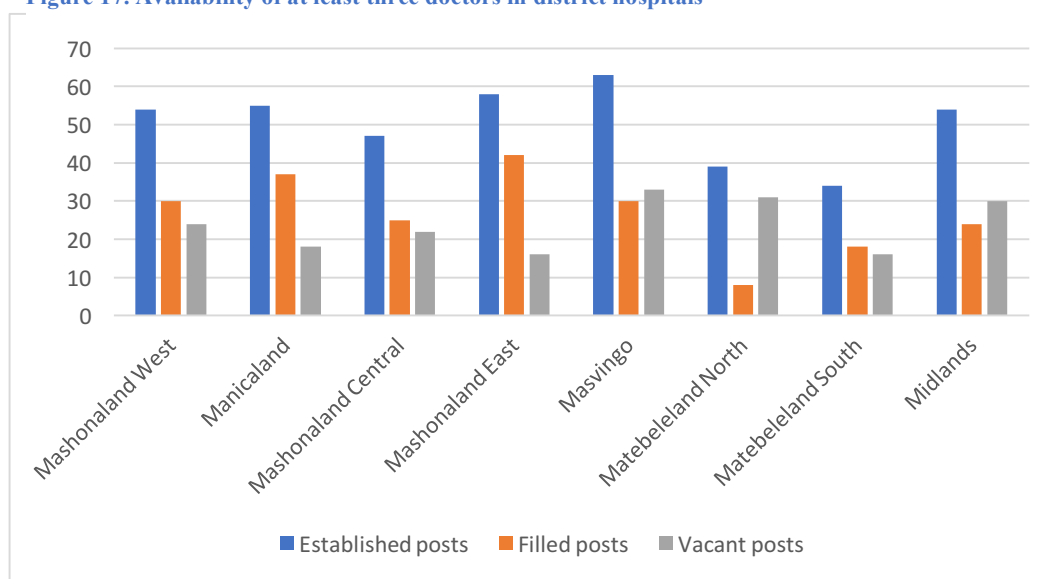
Table 19. Availability of at least three doctors in district hospitals

Year	2016		2017	2018
	Q1	Q4	Q4	Q1
<i>No of district hospitals surveyed</i>	49	56	60	60
<i>Doctors in District Hospitals</i>	141	191	255	247
At least 3 doctors per hospital (%)	67.40%	80.40%	66.70%	60%

Source: VMAHS 2016 – 2018

5.77. An examination of the staffing returns from 55 government and mission district hospitals in 2018 presents a continuing decline, with only 17 of these hospitals having 3 or more doctors and 3 hospitals Matabeleland North with no doctors. Data from the Crown Agents administered HRHS Retention database also confirms the decline in the stock of doctors in these facilities in the last year: from 167 doctors in 2016 to 140 in 2018 (RBF Quarterly Reports 2016 & 2018). The main causes for the loss of doctors were resignation (40%), study leave (manpower development leave/MDL) (20%) and transfers (40%) (RBF Quarterly Report, October to December 2017). MoHCC data reveal that the overall vacancy rate for GMOs across all district level hospitals was 47% in 2018 (**Figure 17**), including hospitals owned by GOZ, Mission, Rural District Councils (RDC), as well as General and Rehabilitation Hospitals (MoHCC GMO database, September 2018).

Figure 17. Availability of at least three doctors in district hospitals



5.78. JRM findings from Midlands province in 2017 also highlight the increasing shortage of doctors reporting that ‘Mvuma District hospital has no doctors following the resignation of two doctors for better paying employment in Swaziland.’ Field staff reported that they had difficulty locating GMOs to complete the HR related SAQ in the 26 district hospitals they surveyed; only 20 of the 231 respondents were GMOs. Health workers who responded to the SAQ indicated that staffing shortages and the associated increased workload were some of the key negatives changes that they had experienced in their working lives over the last 2 years. However, the LSTM survey found that the 26 District Hospitals surveyed had on average 3 doctors (LSTM 2018).

5.79. Availability of nursing cadres

Nursing cadres make up the majority of staff in the PHC facilities, with a total of 16,310 nurses. distributed across all levels of care - central, provincial and district hospitals, and primary health centres. Every government owned Rural Health Centre should have 3 qualified nurses (1 RGN and 2 PCNs), whilst RDC and Mission clinics should have 2 nurses. In 2016 it was reported that every PHC facility had at least two qualified nurses.⁵⁷

Nursing cadres	2016	2017	2018
RGN	11020	12826	12370
SCN	535	468	450
PCN	3059	3462	3490
Total Nurses	14614	16756	16310

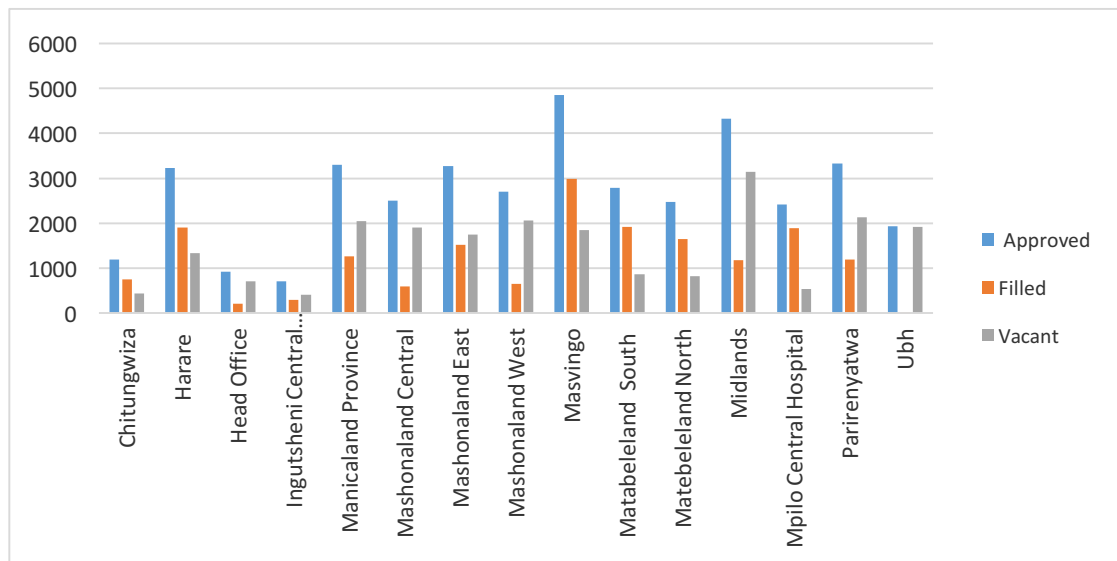
Source: VMAHS 2016, 2017 & 2018

- 5.80. Of the total number of nurses available 10,976 (67%) were deployed in district level hospitals (6108/56%) and PHC facilities (4868/44%). There were 2,097 RGNs and 2591 PCNs available across the 1290 PHC facilities surveyed, with just over 40% of the total number of midwives and upskilled PCNs (7621) also based at these facilities (VMAHS, March 2018).⁵⁸ While there have been improvements in the overall availability of nursing cadres over the period under review, some facilities have shortages. For example, analysis of the MoHCC August 2018 HR database revealed that at least 19 district level hospitals had vacancy rates of over 50% for RGNs. In terms of the urban-rural distribution of the nursing cadres, in 2016 just over half (54%) of all the nursing cadres were deployed in rural facilities (VMAHS 2016). In 2017 93.8% (n=1,210) of the PHC facilities surveyed had at least one trained health worker to provide basic EmONC services, with health facilities in rural areas (94.5%) having a significantly higher proportion compared to the health facilities in urban areas (90.0%), however health facilities with at least two health staff trained was significantly higher in urban areas (VMAHS October to December 2017). In 2018 95.9% of the rural PHC facilities reported having at least one health worker regardless of category able to provide BEmONC services (VMAHS, February 2018)
- 5.81. In 2016 it was reported that the number of hospitals performing caesarean sections has declined slightly, due in part to the limited number of nurse anaesthetists available. This situation was exacerbated when the Nurses Council stopped allowing nurses with 6 months anaesthesia training to practise anaesthesia as they are not recognised as 'qualified anaesthetists (HDF 2016 Annual Report). However, throughout 2017 the availability of anaesthetists reportedly improved, due in part to increased training and production of these specialised nurses from rural provinces and districts. Of the 26 district hospitals in the LSTM survey, 79% (CI 0.69- 0.89) reported that they had on average one nurse anaesthetist and 76% had an average of one theatre nurse. However, HR data for August 2018 show that of the 77 established posts for nurse anaesthetics at central, provincial and district hospitals, 35 (45%) were vacant at this time. MoHCC engagement with the Nurses Council and the Department of Anaesthetics at the University of Zimbabwe may result in more doctors receiving anaesthetist training, as well as more anaesthetists available to mentor doctors and nurses at provincial and district hospitals, which would help to increase numbers, improve coverage and assure the quality of the services provided.
- 5.82. While the availability of key cadres shows some improvement and numbers have largely been maintained the overall trend is of ongoing shortages of staff and an increasing overall, vacancy rate. There was a total of 39,938 health worker posts on the Establishment in August 2018 (MoHCC HR Database, accessed in November 2018), of which 18,015 were filled, representing a 55% vacancy rate; a 20% vacancy rate was reported in 2015 (Health Systems Assessment Report, 2017), although this estimate did not include mission or urban municipal facilities.

⁵⁷ MoHCC (2016) National Health Strategy for Zimbabwe 2016–2020

⁵⁸ This is the first time VMAHS provided data disaggregated cadre and facility /level of care, so it is not possible to examine trends, but these can be monitored in subsequent survey to assess distribution and retention of critical staff across the different levels of care

Figure 18. Vacancy rates across health workforce. 2018



- 5.83. HR data, VMAHS survey data, HDF and RBF quarterly reports and findings from the 2017 Joint Review Mission (JRM) point to continuing inadequacies in the supply of critical cadres such as doctors, pharmacists, anaesthesiologists, nurse anaesthetics, radiographers, and paramedics and the need to invest in pre-service training to address these critical staffing shortages.⁵⁹ MoHCC institutional capacity to oversee the health system is also undermined; recent MoHCC staffing data report indicate a vacancy rate of 39% at the senior management level and gaps in key national RMNCAH programmes, as well as the MoHCC Policy, Planning and M&E function, which had a 50% vacancy rate.
- 5.84. The HDF support to retention allowances and critical posts allowances was completely withdrawn at the end of 2017 and since then 2018 HDF support to the retention of health worker has been through the RBF incentives. One of the key positive changes in the working lives identified by many of the health workers who completed the SAQ was the provision of RBF incentives and improved personal benefits, such as promotions, improved salary and allowances RBF Incentives.

⁵⁹ MOHCC HR Database, May 2018

FINDING 14 CAPACITY DEVELOPMENT INTERVENTIONS HAVE IMPROVED THE KNOWLEDGE AND SKILLS OF HEALTH CARE PROVIDERS AND IS IMPROVING THE AVAILABILITY AND COVERAGE OF ESSENTIAL SERVICES

- 5.85. The HDF proposed to support more coordinated *provincially implemented* capacity development interventions for health workers in which capacity gaps would be identified and priority needs addressed 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’. It planned to incorporate training content delivered through in-service training into pre-service training curricula and to and revise these curricula to include changes and new developments in RMNCH-A and SRHR. In addition, it would support mentoring interventions on all thematic areas for health workers at all levels of service delivery, from community level to referral centres and ensure regular supportive supervision for health facilities
- 5.86. The key objectives, strategies and interventions related to the improving the capacity and quality of HCPs are outlined below.

Focus area	Objectives, strategies and interventions
Coordination of training	A national assessment of remaining training needs to assess overall progress to date, identify priorities and address specific targeted need Develop a nationally coordinated, provincially implemented training programme covering all appropriate subjects 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 Incorporate in-service training into pre-service training and revision of curricula to include changes and new developments in RMNCH-A and SRHR
Mentoring and supportive supervision	Ensure adequate mentoring to health staff and regular supportive supervision to health facilities Support mentorship programmes on all thematic areas and include all levels of service delivery, from community level to referral centres Ensure adequate mentoring to health staff and regular supportive supervision to health facilities
Quality of care	Health staff provide a minimum level of quality of care that is regularly assessed

5.87. Key HDF indicators.

A number of key indicators were formulated to track the implementation of these strategies and interventions and to monitor progress toward the achievement of the objectives. These targets and the progress made to date in achieving them (where data were available) are presented in **Table 20** below.

Table 20. HR related targets and progress 2016 -2018

Indicator	2016		2017		2018	
	Target	Progress	Target	Progress	Target	Progress
	(%)	(%)	(%)	(%)	(%)	(%)
Proportion of health centres with at least one upskilled Primary Care Nurse	82%	96.3%	98%	94%	98%	92.4%
Proportion of rural health centres with at least one nurse with midwifery skills to	40%	96.6%	N/A	94.0% have at least 1;	70% (HDF LF June 2018)	95.9% have 1 hw;74% have at least 2 hws (VMAHS, 2018 Q1)

Indicator	2016		2017		2018	
	Target	Progress	Target	Progress	Target	Progress
	(%)	(%)	(%)	(%)	(%)	(%)
provide basic EmONC services				69.9% have at least 2 staff trained (VMAHS, 2018 Q1);		40% (HDF LF June 2018)
Proportion of district hospitals having at least two health professionals who can do C/S	82%	89.3%	85% (HDF LF, June 2018)	91.7%	94%	91.7% (VMAHS, 2018 Q1); 96.2% (HDF LF June 2018)
Proportion of district hospitals with at least two health professional who can provide anaesthesia for emergency obstetric surgery	82%	51.8%	85%	61.7%.	60%	71.2% (HDF LF June 2018)
Percentage of health facilities (tertiary, secondary and selected rural hospitals - 200 facilities in total) with at least one HCP trained on MVA in programme supported districts	8%	36%	64%	57% (114 health facilities)	76% (HDF LF June 2018)	67% (HDF LF June 2018)
Proportion of health centres having at least one Health Worker trained on IMNCI	70%	89.8%	90%	87.6% have at least one; 49.8% have at least two	90% (HDF LF June 2018)	88.3% have at least one; 52.1% have at least two (VMAHS, 2018 Q1); 77.4% have at least one (HDF LF June 2018)
Proportion of villages with at least one VHW providing community based preventive MNCH, nutrition, HIV, SRH and selected curative MNCH services.	70%	75.6%		76%		76%
Proportion of VHWs trained on standard package of community based MNCH and SRH services	3000	3002				100%

Indicator	2016		2017		2018	
	Target	Progress	Target	Progress	Target	Progress
	(%)	(%)	(%)	(%)	(%)	(%)
Number of HCPs trained in survivor centred approaches and clinical management of sexual violence in 20 supported districts	N/A	National guidelines finalised; HW training in clinical management of SGBV; selection of provincial focal persons and sensitisation of PMDs	50%	N/A	100%	0% (HDF LF June 2018)

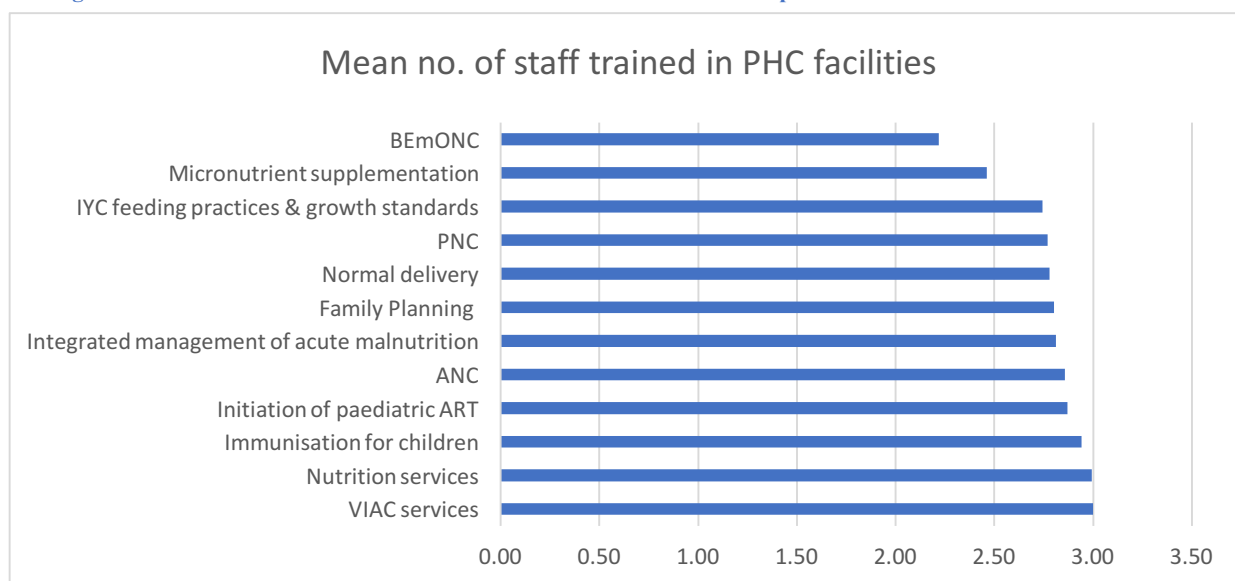
Source: HDF 2016 & 2017 Annual Reports; VMAHS Q4 2016 & Q1 2018; HDF LF June 2018

- 5.88. Key strategies to achieve these objectives included: building and strengthening health worker knowledge, skills and competencies and the transfer of skills to practice through the provision training, mentoring and supportive supervision, providing incentives to improve health worker motivation and performance and the provision of quality services through the RBF.
- 5.89. A review of the HDF workplans for the period under review shows that a significant proportion of the HDF activities under Thematic Areas 1 and 2 involve developing the capacity of health workers in areas that cover the CoC for mothers, babies and children. The knowledge, skills and competencies of the health workforce were strengthened in areas including family planning, EmONC, SRH, cervical cancer screening and treatment, fistula repair, HIV prevention, treatment care and support services, nutrition, and GBV were planned over the period. Interventions including initial and refresher training, and training of trainers targeted health workers at all levels from community-based cadres to HCPs in PHC facilities and districts hospitals, as well as facility managers, DHE members, supervisors and trainers at district level.
- 5.90. A key focus of the HDF supported capacity development interventions was to address the low coverage (19.9%) of health facilities providing all the six (6) BEmONC signal functions. BEmONC on-job training (OJT) continued to be rolled out to all PHC facilities, enhancing knowledge and skills and increasing the number of facilities with health workers with the capacity to manage managing obstetric and neonatal complications and the proportion of PHCs providing the 6 selected signal functions (HDF 2016 and 2017 Annual Reports). For example, by March 2018, 99.9% of all health facilities had at least one trained health worker to provide basic EmONC services, while 98.0% reported having at least two health staff trained to provide these services (VMAHS March 2018). Skills mix and capacity to provide maternity services is also improving across PHC facilities. The ongoing PCN upskilling programme is increasing the proportion of PHC facilities with at least two upskilled nurses to provide BEMONC services; 79% of PCNs in these facilities were upskilled in 2018 (VMAHS, February 2018). Results of the LSTM survey indicate that 97% of the PHC facilities in had an average of 2 PCN with midwifery skills (LSTM 2018). The HDF also supported the introduction of OJT to enhance the skills of the PCNs who had not managed to go for the upskilling training. By 2018, 92.5% of all health centres had at least one upskilled PCN, and 95.9% of RHCs had at least one nurse with midwifery skills, while 74% of these had least two health workers to provide basic EmONC services (VMAHS March 2018).
- 5.91. There is evidence that more targeted capacity development interventions were supported by the HDF to address specific knowledge gaps and improve the distribution of trained health workers across all levels. For example, improve the coverage of health facilities providing all six (6) BEmONC signal functions, health workers were trained in MVA, with at least one HCP trained in MVA increasing from 36% in 2016 to 67% in 2018 in the 200 tertiary,

secondary and selected rural hospitals targeted through the training intervention. Focused capacity development interventions are improving the availability of caesarean section and anaesthesia services in district hospitals. The proportion of district hospitals having at least two health professional who can perform caesarean sections increased from 89.3% in 2016 to 96.2% and the proportion of these facilities with at least two health professional who can provide anaesthesia for emergency obstetric surgery, improved to 71.2% by March 2018, up from 51.8% in 2016.

- 5.92. Capacity building along with community mobilisation activities, were identified as key factors in increased availability and access to contraceptives and the significant increase in IUCD and implant insertions among women in programme supported sites (HDF 2016 and 2017 Annual Report) In 2018, 73.6% of health facilities had at least one health professional trained in the insertion and removal of implants, and 12% of facilities had at least one health professional trained in the insertion and removal of IUCDs (VMAHS March 2018).
- 5.93. Health worker capacity to deliver child related services was also targeted and strengthened, with a focus on providing IMNCI training to those facilities without trained prescribers. Significant results were achieved, with 88.3% of health facilities having at least one health worker trained, above the global target of 60%, and 52.1% having at least two (2) health staff trained in IMNCI in 2018 (VMAHS, 2018, HDF 2018 Report and LF June 2018). In addition, 99.3% (n=1,415) of the health facilities surveyed in February 2018 had at least one health worker trained in the care and management of children and adolescents and (VMAHS March 2018) and an average of 3 nurses per health facility were trained in paediatric ART in facilities initiating these services. To strengthen the management of children at referral facilities, health workers were trained on emergency triaging and assessment treatment (ETAT) in three provinces (Masvingo, Matabeleland South and Matabeleland North), with post training follow up conducted for all the health workers trained to assess the application of the skills acquired (VMAHS March 2018).
- 5.94. The strengthening of health workers' capacity in institutional management of malnutrition and VHWs capacity in active case finding is improving the screening and referral of children with acute malnutrition for treatment and is creating a critical mass of trained human resources that can quickly respond to future emergencies. (HDF 2017 Annual Report). The availability of nutrition services is improving; 82% of facilities had at least one staff member trained to provide IYCF services, and 88.2% health facilities providing IMAM services had at least one staff member trained (VMAHS March 2018). The training of Ward Food and Nutrition Security Committees is enabling these committees to implement community-based action plans for stunting reduction (HDF 2017 Annual Report).
- 5.95. The LSTM 2018 Survey also provided evidence of increased capacity and skills mx in the DHs surveyed with results indicating that all of the facilities had at least one health worker trained to provide ANC, PNC, normal delivery, immunisation, initiation of paediatric ART, nutrition, IMNCI, IMAM and IYCF. In addition, between 80% and 96% of these hospitals had at least one health worker trained to provide MVA, family planning, micronutrient supplementation and VIAC services, while 75% had at least one health worker trained to provide caesarean sections. Findings from the LSTM Survey show that district hospitals had on average 14 to 23 health workers trained to provide family planning, BEmONC, ANC, and PNC services. There were also on average 5 health workers trained to provide clinical management of sexual and GBV and 2 to 3 health workers to provide caesarean sections and VIAC services in these facilities (LSTM Survey).
- 5.96. Improved capacity to provide a range of MNCH services was also noted in the PHC facilities surveyed, with over 90% of these having at least one health worker trained to provide ANC, PNC normal delivery, immunisation, initiation of paediatric ART, nutrition, family planning, IMNCI, IMAM, micronutrient supplementation and IYCF services (LSTM Survey). All of these facilities had at least one health worker trained to provide HIV services for adults, while 30% had at least one health worker trained to provide MVA services (LSTM 2018 Survey). In addition, PHC facilities surveyed reported that they had on average 2 to 3 health workers trained to provide family planning, BEmONC, ANC, and PNC services (**Figure 19**) .

Figure 19. Mean number of health workers in PHC facilities trained to provide selected services



- 5.97. A significant number of the 232 respondents who completed the SAQ, comprising 202 nurses, 20 GMOs and 5 DMOs from 26 district hospitals and 77 PHC facilities across the 8 provinces, indicated that they had received training in key areas related to their work. These included EmONC (81%), Paediatric ART (77%), Nutrition (89%), Youth Friendly Services (78%), IMNCI (82%), Sexual Reproductive Health (87%), PNC (84%), Family Planning (84%), and HIV (93%). The numbers trained in fistula repair and anaesthesia were understandably lower at 11% and 31% respectively, as these are specialised services offered at district hospitals.
- 5.98. Of the health workers who completed the SAQ, 97.33% indicated that they **felt confident in applying the knowledge and skills acquired, while 98% indicated that the areas they had been trained in were relevant for their current job.** Many respondents indicated that their improved 'ability', 'competence', and 'confidence' in the provision of services in their facilities was one of key positive changes in their working lives over the last 2 years. Improved ability to provide services such as management of obstetric and neonatal emergencies, resuscitation of newborns, contraceptive implants, identification and treatment of malnourished children, paediatric ART, youth friendly services, and GBV counselling, were mentioned most frequently. Building the capacity of multi-sectoral teams to better respond to SGBV was also a focus of HDF support. District GBV multi-sectoral teams and religious leaders were trained to enable them sensitise their congregants on GBV and child marriage prevention. Multi sectoral trainings on the referral pathway were conducted aimed at strengthening GBV coordination at district level.
- 5.99. There is strong evidence from various sources (HDF, VMAHS, and RBF reports, LSTM survey, health worker SAQs) that over the period under review more of the HDF supported capacity development interventions were delivered through OJT, with **the acquired knowledge, skills and competencies complemented and reinforced through coaching and mentoring,** contributing to improved skills mix and service availability in facilities at all levels. This aim of this change in approach was to reduce the cost of training, improve the application of knowledge and skills, and reduce the time health workers were away from their workplaces through attending workshop-based training. For example, an IMNCI distance learning module was piloted in 2016 to increase the proportion of health facilities managing sick children using the IMNCI approach; 100 health workers undertook the course in 2016 (HDF 2016 Annual Report). A number of interventions focused on enhancing the capacity of provincial and district trainers and supervisors to adopt and use OJT approaches for MNH service provision were also implemented.
- 5.100. Clinical mentoring The HDF aimed to support clinical mentoring for health workers at *all levels of service delivery, from community level to referral centres* over the period under review. Reportedly, many health workers trained

received post training support and mentoring, which improved their confidence in applying and using newly acquired knowledge and skills (HDF 2017 Annual Report).

- 5.101. The MoHCC Clinical Mentorship Guidelines for RMNCH-A set out the rationale, expected outcomes and benefits of a RMNCH-A clinical mentorship programme.⁶⁰ The 2018 HDF workplan indicates that the clinical mentorship guidelines will be reviewed and updated and OJT trainers trained, but there was no information available in 2018 as to whether these activities had been undertaken as planned.
- 5.102. A number of mentoring reports were reviewed, including from Matabeleland North, Midlands and Mashonaland West. Mentoring reports from Matabeleland North indicated that mentoring is provided on a quarterly basis to staff in district level hospitals and RHCs across the province, including doctors, clinical officers, midwives, nurse anaesthetist, paediatric nurses and PCNs, by a provincial based team, including the Provincial Medical Director and other members of the provincial medical directorate, and medical specialists.
- 5.103. During these mentoring visits, mentors supported mentees to perform procedures (e.g. caesarean section and hysterectomy), demonstrated good practice (e.g. neonatal resuscitation, ultrasound scan, use of partograph), conducted consultations with screened clients, conducted grand rounds observed health workers' performance, and provided feedback to improve practice. Nurse anaesthetists were mentored on best practices in anaesthesia for obstetric emergencies and improvising in case of stock outs and emergencies (3rd and 4th Quarter Mentorship Activities Report, 2018). Improvements in the availability of anaesthesia services were attributed to the clinical mentorship programme, enhancing nurse anaesthetist's ability to use and apply skills and increasing the number of doctor-nurse teams with skills to perform obstetric surgery (HDF 2017 Annual Report). Crown Agents found that HIV-PMTCT, management of obstetric complications and MWHs had improved because health facilities were correcting mistakes picked up through DHE mentorship. Increasingly, facility nurses are using social media platforms to communicate with their supervisors and get assistance when required (RBF Quarterly Reports, Q4, 2017). Of the 231 health workers who completed the SAQ, 83% indicated that they had received clinical mentoring.
- 5.104. Barriers to the effective provision of mentoring included staff shortages, lack of cases at the rural health facilities, shortage of lab reagents to conduct tests, unavailability of emergency preparedness kits for EmONC and anaesthesia drugs to conduct surgical interventions, and lack of equipment, or equipment in too poor a condition to conduct the obstetric and gynaecological procedures. It was recommended that further mentoring was required on IMNCI to achieve at least two staff trained per facility, and to strengthen nutrition services. The Midlands JRM team in highlighted the need to strengthen the mentorship programme to ensure effective knowledge transfer to facility staff and ensure continuation of services where there might be high staff turnover. Other recommendation included documenting good practice and including paediatricians as part of the mentorship programme (JRM 2017 Summary Recommendations).
- 5.105. Supportive supervision Support through the HDF aimed to ensure that regular supportive supervision was provided to all health facilities. Of the 231 health workers who completed the SAQ, 98% indicated that they receive supportive supervision in their facility. DHOs indicated that 92% of them provide quarterly supportive supervision, 85% had a schedule for supervisory visits in place, while all used a checklist to conduct supportive supervision and completed a report after each visit (LSTM survey). One of the key factors that motivates health workers to provide quality services was regular support and supervision from supervisors, including the sister in charge, the DHE (SQA, 2018). Respondents mentioned that supervisors and senior staff provided good leadership, were non-hostile and professional, and provided constructive feedback.
- 5.106. The main barriers observed in supporting capacity development interventions through the HDF are summarized in **Table 21** below

⁶⁰ MoHCC (2015) Clinical Mentorship Guidelines

Table 21. Barriers to capacity strengthening interventions

Efficiency	Effectiveness
Fragmentation – geographic and thematic – in training provided Workshop based delivery approaches still common	Training needs assessment Criteria for selection of participants Attrition and transfer of trained staff Evaluation to assess impact and inform design and training areas Tools and equipment to apply knowledge and skills Use of scarce clinicians to conduct mentoring and supportive supervision

Additional details on the achievements related to the HRH interventions supported via HDF are available in **Annex 7**.

FINDING 15 THE RESULTS BASED FINANCING HAS STRONGLY CONTRIBUTED TO ENHANCE ACCESS AND AVAILABILITY OF CARE, AND TO STRENGTHEN ACCOUNTABILITY AT HEALTH FACILITY AND COMMUNITY LEVEL

- 5.107. A RBF scheme was introduced in Zimbabwe since 2012, when it was introduced in 18 districts with the support of the World Bank, as a fee for services mechanism financing HCPs (public facilities) based on their outputs and on their achievements in terms of quality standards. The scheme was subsequently scaled up via HTF to an additional 42 Districts, and is now implemented at full scale in Zimbabwe, with the HDF continuing to support 42 District. The RBF key features are shortly described in **Annex 9**.
- 5.108. The World Bank has historically worked with Cordaid as managing agent of the RBF, whereas the HTF and then the HDF have collaborated with Crown Agents as the managing agent of the scheme. Progressively, under the coordination of the MoHCC, the RBF design and operating procedures have been harmonised in order to reach convergence in the design and implementation features of the RBF across the country. In 2017, the MoH in its Health Financing Strategy presented a Roadmap for Institutionalisation of the RBF. At the time of this writing, a RBF Unit is formally instituted to manage the RBF centrally at the MoHCC. Such unit sits within GF Management Unit and is supported by Cordaid. The interruption of RBF activities in the 18 WB supported districts since the beginning of 2018 has not permitted to ‘test’ the model of transition of the RBF into government structures, as per plans.
- 5.109. The HDF has allocated approximately 20 million USD to the RBF, for the biennium 2016/2017. This constitutes approximately 20% of the total expenditure of the Fund. Of note, the RBF has been the component of the HDF that has suffered the least reduction in allocations vis a vis the initial budget. The investment in RBF has been directed to PHC facilities in the 42 Districts. As of early 2018, the RBF has been extended to secondary level facilities as well. Taking Q3 2017 as an example, the RBF scheme has **supported 833 facilities across the 42 Districts, with an average disbursement made to facilities of about 2.400 USD** (min 57 USD; max 18.000 USD).
- 5.110. The RBF design has constantly been updated and fine-tuned. In particular, during the course of the implementation of the HDF, a strong shift towards quality indicators was introduced, in the management of the scheme and of its associated outputs-based payments. Also and of note, during the period the RBF was extended to district level hospitals – following recommendations from the Health Systems Assessment of 2017.
- 5.111. The HDF LF presents only one target indicator to measure the contribution of RBF to HDF supported activities:

Table 22. HDF indicators RBF

HDF Indicator Ref.	HDF Indicator	2018 milestone target	2018 milestone achievement	Status at mid-term
1.4.1	Proportion of health facilities charging user fees for ANC	6%	1.84 % (VMHAS) 0% (LSTM survey)	Exceeded

5.112. The RBF is a systemic platform. Its intended benefits are assumed to address various governance, financing, and delivery issues at local level. The expected benefits include in particular: reduced user fees (as per above indicator); contribution to retention of healthcare workers via allowance paid via RBF; contribution to improvement in quality and outputs, via disposal of locally available resources to improve the day to day operations of facilities (medicines, equipment, infrastructure, outreach, other running costs), sustained governance via Health Centre Committees, a mechanism that sees the participation of facility and community members and that oversees the RBF plans and spending.

5.113. The benefits of the RBF observed via evaluation include the following:

- Contribution to reducing user fees
Both VMHAS and the LSTM survey suggest a progressive decrease in the practise of charging user fees for services, at public health care facilities.

Healthcare workers confirm that this is a positive feature and that thanks to RBF the abolition of user fees is happening and is supportive of attracting more clients.

The abolition of user fees – Illustrative quotes from HCPs

I think that the introduction of RBF has helped a lot because most of the mothers are no longer paying because of RBF, under-fives are being catered for, so the numbers have increased.

We are no longer charging user fees because we have RBF covering everything for the clients as a result more people are now coming to the facilities seeking care and treatment.

The same finding is confirmed by users of services at community level.

The abolition of user fees – Illustrative quotes from community members

Now it is better. People used to fear coming to hospitals because of acquired debt, but now it is cheap.

People do not pay anything at this clinic. It is just giving birth, there is no payment that is the other change we have.

It is worth noting that community members highlight other main issues and **barriers that potentially undermine the positive effects of the abolishment of user fees**. These include, in particular, the need to pay for medicines at private pharmacies, and also the need to pay for emergency transport, especially in the case of referral.

- Allowance for HCPs

The RBF guidelines allow health care facilities to distribute up to 25% of the RBF earnings amongst the healthcare workers of the facility.

Despite the interruption of the retention allowance supported concurrently via HDF, there is consistent evidence that the **RBF allowance has had positive effects, both in terms of retention and motivation, and in terms of equity** (retention allowances were previously paid to specific cadres only).

The SAQ to HCPs consistently and strongly indicates that the RBF incentives are the strongest motivating factor for many, to remain at the facility. This direct effect is complemented by indirect effects of the RBF, and namely the fact that there are better conditions at health facilities due to RBF funds. The most commonly reported factors in this sense are the availability of water, good accommodation, and better working conditions.

Findings from the questionnaire are confirmed consistently by KIIs, which do also report that RBF allowances are a factor of motivation.

The RBF allowances – Illustrative quotes from HCPs

Staff are actually eager to work since there is something they get out of performing and out of providing quality care...I think everyone is just boosted to support and to work unlike in the case like years back, when we would get those funds they would come and say they are only for maternity and child care and RBF says it is for the whole hospital which involves everyone.

- Facility improvements

The facilities manage the RBF spending according to facility plans. The HCC reviews and approved the spending plans on a quarterly basis.

The LSTM survey confirms that all facilities at primary level have HCCs in place and produce plans. In fact, the transparency in the use of funds is the cited factor of very high satisfaction with RBF, amongst the facilities surveyed (47%).

Part of the funds is allocated to running costs, infrastructure improvement, and procurement of equipment and medicines.

Of note, both HCPs and users of services consistently report MWHs as an area where improvements have been possible thanks to the RBF, and extremely beneficial.

The use of RBF funds

You will find that before HDF came most of our facilities did not have waiting mothers' shelters and you know the distances between communities and facilities but now because we have got facilities that are constructing waiting mothers' shelters, facilities are now using them. (KII, healthcare provider).

We can see that waiting mother shelter build over there, food is provided at the hospital. Long ago expecting mothers did not want to come and wait for delivery at the hospital due to food problems but now as men we are quickly left alone because they get good care at the hospital. (FGD, community men).

- Governance and autonomy

A less tangible but equally important results consistently reported by HCPs is the sense of responsibility and accountability gained by the fact that the facility is responsible for its own results and for spending its resources autonomously.

5.114. The barriers observed in the implementation of the RBF are well documented in the RBF reports, and in the HDF annual reports. Consistently, they are confirmed by the survey and by KIIs with HCPs. These include:

- Delays in payments of the RBF funds (63% of facilities reported delay via LSTM survey)
- Procedural complications, especially related to the lengthy times due to obtain quotations and approvals for procurement
- Administrative procedures, the most commonly referred cause of dissatisfaction reported via LSTM survey, alongside the insufficient amount of payments.
- Lack of autonomy in procuring medicines outside of ZAPS/NatPharm
- Scarce clarity in some circumstances on how to calculate and distribute the allowances

These are summarized below (**Table 23**):

Table 23. Barriers to financing and RBF

Efficiency	Effectiveness
<p>Cost of overheads for management of the fund</p> <p>Timeliness of payments reported as a problem: 63% of facilities reported delay via LSTM survey</p> <p>Delays in DHE quality assessment affecting timely disbursements</p> <p>Prioritisation of the use of funding by facility</p> <p>Frequency of verification visits</p> <p>Cost of administering Client Satisfaction Surveys (800 CBOs)</p> <p>Cost and time used to procure drugs when unavailable through NatPharm</p> <p>Financial management capacity & systems at facility level</p>	<p>Separation of duties with regard to DHE assessing & scoring their own facilities to inform allocation of funding</p> <p>Complex procedures to implement plans e.g. quotation, approval of procurement of goods and services, etc.</p> <p>Decision making/prioritisation of how to utilise the funds</p> <p>Evolving protocols</p> <p>Demand side financing i.e vouchers</p> <p>Harmonisation with RBM</p> <p>Use of clinical staff for procurement and admin RBF related tasks</p>

FINDING 16 **THERE IS STRONG EVIDENCE OF THE CONTRIBUTION OF THE HDF TO ENHANCING GOVERNANCE AT ALL LEVELS OF THE HEALTH SYSTEM**

5.115. In other sections of this report (see Finding 5), the evaluation has reported the ability of the HDF pooled fund and of its SC, to serve as a catalytic initiative at sector level to enhance stakeholders' coordination, under the leadership of the MoHCC.

In addition to that, the evaluation notes there is evidence of additional contribution of the HDF to support other key governance functions, at national and subnational levels.

5.116. At **national level**, there is strong evidence of contribution of the HDF to the design and dissemination of strategies, policies and plans. In various instances, the HDF has also supported multi-sectoral dialogue and planning exercises at national or subnational level.

5.117. **At sub-national level** there is evidence that key governance features have been sustained during the period:

- Districts are strongly linked to supervisors at provincial level. 100% of DHOs report to receive supervision from the PHO (Provincial Health Office). 96% receive it at least quarterly, and 86% report to receive regular feedback from the supervisors. (Source: LSTM survey of DHOs)
- The planning function at district level is universally performed, with the proportion of DHOs developing annual plans estimated at 93% (95% CI, 84-97) in mid-2018. All DHOs regularly perform district management meetings, and at least 80% (95% CI, 66-90) report to meet at least quarterly to review progress against annual plans. (Source: LSTM survey of DHOs). Reporting at district level is also universally performed, with key data and maps of the district on display and updated.
- DHOs perform a consistent supervisory function of the facilities within their catchment areas. 100% of DHOs report to do regular supportive supervision visits to facilities (LSTM survey). Confirming this finding, 100% of PHC facilities report to receive one supervision visit per quarter. Key functions of the health facility (data and reports; availability of personnel; pharmacy and stock) are consistently reported to be observed during supervisory visits.
- All health facilities produce annual plans. Participation to planning is good: the most commonly reported participants to planning (LSTM survey) are: HCC members (83%), head of the facility (56%), other facility staff (66%), DHE representatives (12%).
- Facilities – at least at primary care level - are strongly linked with communities via HCCs. 99% of PHC facilities (95% CI, 0.9;1.0) of PHC facilities report having a HCC in place (mean number of HCC members: 10.3).
- Among those PHC facilities reporting having a HCC in place, 87% (95% CI, 0.76;0.94) report having ToRs on HCC functions and responsibilities. Among PHC facilities reporting having a HCC in place, 99% (95% CI, 0.92;1.0) of PHC facilities report that their HCC meet to discuss health issues. Most facilities (76%) report that HCCs meet on a monthly basis.

The availability, quality, accessibility and acceptability of care, and community awareness (Medium term results of the ToC)

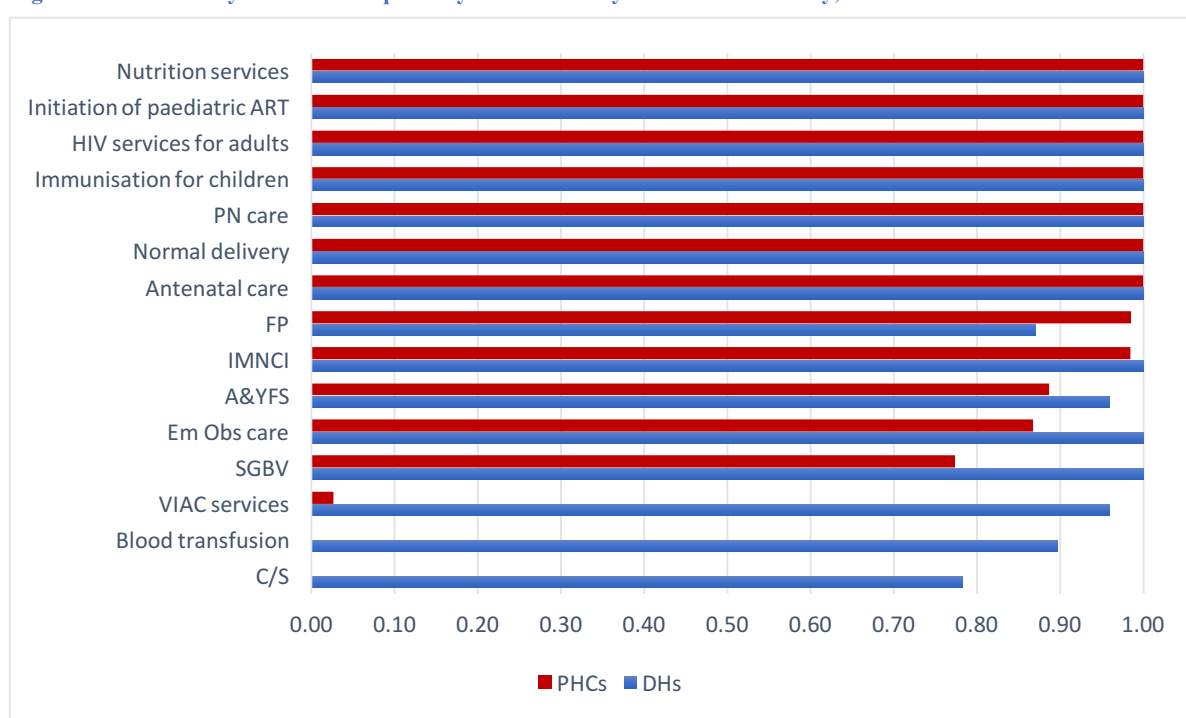
FINDING 17 ESSENTIAL CARE FOR RMNH-A AND NUTRITION IS AVAILABLE AND PERFORMED

5.118. The evaluation findings confirm that **a range of essential RMNCH+A and nutrition services is universally available** to the population at health care facilities, at both primary and secondary levels of care.

Data on availability of care are available via VMHAS. The survey of healthcare facilities performed by LSTM confirms the results produced by VMHAS.

Figure 20 shows results from the evaluation survey regarding availability (and availability 24/7) of services at primary and secondary levels.

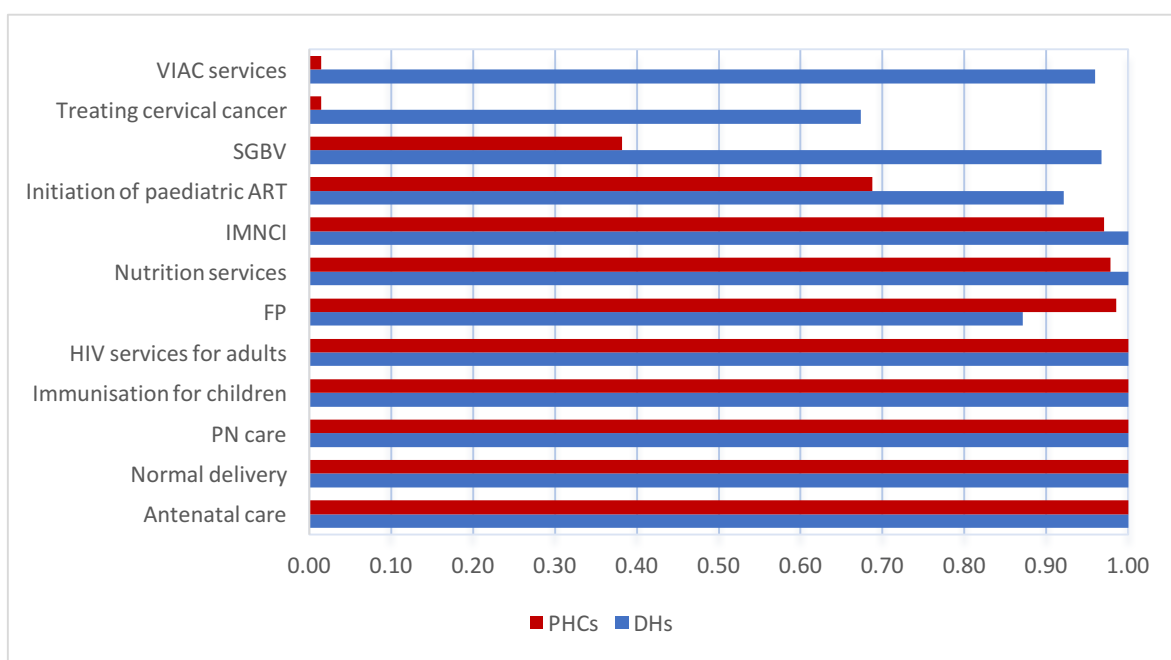
Figure 20. Availability of services at primary and secondary level. LSTM Survey, October 2018



There is evidence that critical services are offered on a 24/7 basis. The LSTM Survey indicates a high proportion of secondary level facilities reporting to offer services continuously. All the service that require continuous availability are offered on a 24/7 basis. This includes delivery (100%), PNC (81%) and SGBV (88%).

5.119. There is also evidence that services are regularly **performed**. This is shown in **Figure 21**, which reports the proportion of facilities reporting to have performed a bundle of essential services at any time during the quarter preceding the survey, performed in October 2018.

Figure 21. Proportion of facilities reporting to perform services during the quarter preceding the survey, at secondary and primary care levels (LSTM Survey, 2018)



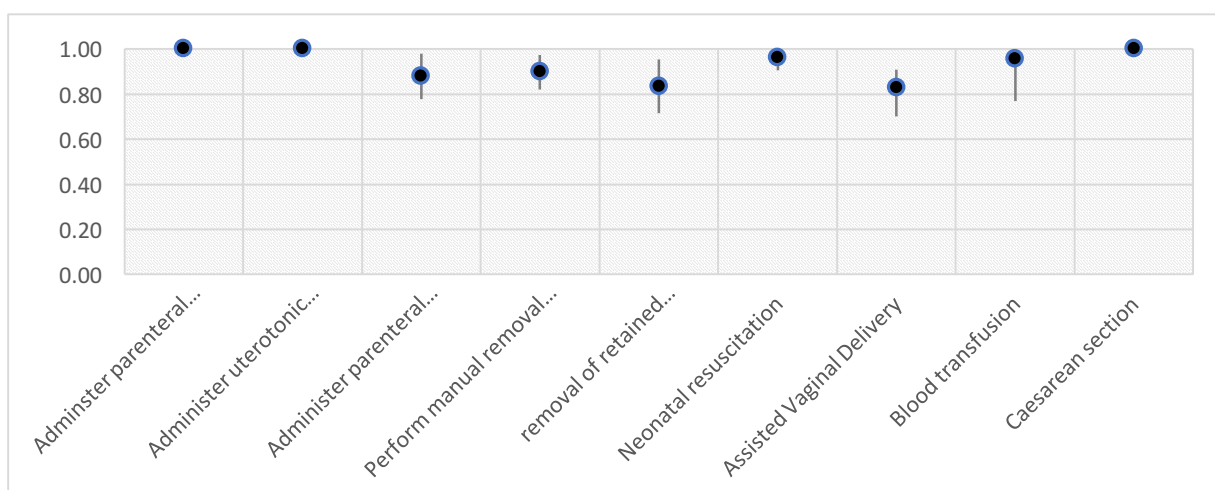
Of note, EOC is also available and performed. According to VMAHS (Q1 2018 Report), 7.6% of PHC facilities offered all the six signal functions for EmONC, across the country in Q1 2018. Data from the LSTM survey show that 26% (95% CI, 0.15; 0.4) of PHC facilities had all the 6 BEmONC signal functions available in October 2018.

VMAHS also reports that in Q4 2017 and in Q1 2018, 91.7% of hospitals directly supported by the HDF had all the CEmONC signal functions available. The LSTM survey performed in October 2018 shows a slightly less positive picture, with 73% (95%CI: 0.6;0.83) having such services available.

More importantly, data indicate that not only service for EOC and newborn care are available, but also that they are largely performed.

Figure 22 shows the proportion of DHs reporting to perform any of the 9 CEmONC signal functions in the three months preceding the survey, administered by LSTM in October 2019

Figure 22. Signal functions performed at CEmONC level. LSTM Survey, October 2018



FINDING 18 THERE IS SOME EVIDENCE OF IMPROVEMENT IN QUALITY OF CARE, AND CARE IS LARGELY ACCEPTABLE TO CLIENTS

5.120. No comprehensive assessment or study of quality of RMNCH+A was accessed during the evaluation.

5.121. Data available from RBF reports produced via HDF, provide a useful picture of quality of care in Zimbabwe. The RBF reported quality scores ranged from 75% to 95% across the 42 HDF districts. These scores are calculated against the observation and assessment – made by DHEs - of key defined parameters of quality care that include 11 areas spanning structural indicators, management of care, and adoption of best practices.

5.122. There is also evidence of the fact that care is largely acceptable to end users. Client satisfaction scores measured via RBF surveys ranged from 79% to 96% in Q2 2018. Complementing such evidence, our qualitative research provides a strong, consistent story of improved satisfaction with quality of services and with attitude of staff at health care facilities

Satisfaction with care – illustrative quotes from community FGDs

Here at the Clinic, we are impressed with the way we are served.

I was treated very well. It was a Sunday, but they never considered that, they opened the clinic when they heard that a patient was coming.

Here the senior nurse asks the patients if she notices that people have been sitting at the clinic for long or if there is a long queue. She then asks to check if we have been served and why we are not served.

So ... there is a lot of change, and if you come and you are sick, you will be well treated.

When I last visited the clinic, I saw a lot of changes that made me happy. I was very happy with the way the nurses treated me and also the change that is here.

FINDING 19 ACCESS HAS IMPROVED, ALTHOUGH STRUCTURAL BARRIERS IN ACCESSING BASIC NEEDS PERSIST

- When it comes to their own health, most women said that they make the decision alone to seek care at the clinic.

Woman: *"I did not consult anyone or seek approval from anyone. I made my decision on my own to come to the facility because of my health"*

- Women express **challenges in acceptance of HIV testing and family planning services by their male partners.**
- In a way, the abolition of user fees has empowered women to seek care by themselves and their children without being constrained to wait for the husband to give money to pay for the fees. However, women who live far from the facility still **depend on their husband to get the money to pay for the transport** and this can be a barrier to access care.
- All participants of FGDs confirmed that women, children and adolescents were not paying user fees anymore. They explained that the abolition of user fees has been the main driver for people coming in numbers to the health facilities and for making home deliveries a rare event.

Male adolescent: *"As children we used to pay for the treatment at the clinic but now it is free".*

Woman: *"We can now come to the clinic anytime because we are no longer paying user fees, everything is now for free, be it registering a pregnancy, it's now all for free so home deliveries are now very few because everything is free at the clinic".*

- Some participants mentioned that they faced **informal user fees.**

Male adolescent *"Everyone is supposed to pay a dollar which is meant to pay the guard at the clinic"*

Woman: *"What causes pregnant women not to come to the mother's shelter or coming to deliver at the clinic is because of the forty dollars that they should have so that if there is an emergency they (the health care workers) can transfer you to another hospital. You are supposed to come with that money (...) if you do not have that money you cannot come to the mothers' waiting shelter because the clinic requires you to bring that emergency money".*

- Women and children living far from a health facility appreciate mobile clinics and outreach activities:

Pregnant woman: *"You can walk about three hours to the hospital. You have to sacrifice and walk to the clinic because your days for delivery are closer, you can't even ask for bus fare to your husband, he doesn't have it. You walk three hours in the hot sunny weather. By the time you arrive here your blood pressure would have risen, and you will be admitted".*

Mother: *"We have outreach programmes in our respective villages whereby they weigh our babies, which we highly appreciate as it saves us on walking long distances and saves money that we hardly have"*

- Women living far from a facility also appreciated MWHs to help make sure that they deliver at facility. However, can be difficult to stay for a long time at MWHs as they have young children going to school.

Woman: *“I have children and I stay alone, some are in grade 2 and so on, I do not have someone to leave my children with, so I can’t come and stay here for a full month leaving my children alone”*

- Some women also complained about **MWHs not offering decent living conditions.**

Woman: *“The mother’s waiting shelter is too small, at times some pregnant mothers will be left with no option but to sleep down without a bed”*

Of note, this is possibly due in part to the fact that MWHs are often overcrowded. The LSTM survey reports that 70% of designated DH have a functional MWH, and that the mean occupancy rate on the day of the survey was of 130%.

- Women and children living far from a health facility also seem to visit more VHWs than the ones living close to a health facility.

Woman: *“Like us who come from (...) a village which is 19 km away from (...) the clinic (...) we want to thank the Village Health Workers (...) We used to travel by foot to come to this clinic but now the VHWs are weighing our babies and giving them some vitamin A”.*

- VHWs are also visited to get family planning products, this prevents not only women walking long distances, but it also helps women whose husband doesn’t allow them to use family planning as they do not have to find any excuse to go to the clinic.

Woman: *“The pills are easier to use because Village Health Workers have the pills and also the nurses bring them when they come to our village for the babies. For other family planning you need to travel to the clinic so it can be a problem when you tell your husband about that”*

- Some **male adolescents mentioned that they did not feel comfortable to be examined by female nurse**, but because there are few male nurses they had to travel long distance to come to a facility with a male nurse.

Male adolescent: *“There must be a male nurse. Most clinics only have female nurses thus putting the male’s health at stake. Some men then travel long distance to the hospital because they can’t bear being seen their private parts by the female nurses. They are afraid that they will gossip around in the community”*

The utilisation of care and change in behaviour and practices (*Outcome level results of the ToC*)

- 5.123. A full measurement of the achievements of the HDF at outcome level is not possible at the time of this midterm evaluation. In fact, all the 33 indicators proposed to assess change in coverage at outcome level are designed are typically measured via nationally representative population-based surveys (DHS, MICS). The results of the next MICS 2018/19 will only be available after this midterm review, and this is a known limitation of the evaluation exercise, since its design stage (ToRs).
- 5.124. As an attempt to overcome the above described limitation, the evaluation has used HMIS data for the period 2014-mid 2018, to analyse the trends in utilisation of tracer interventions along the CoC. Although such analysis does not allow to fully capture the achievements as a household survey would do, it still provides some indications of uptake of essential services at national level. Of note, the analysis presented and used by the evaluation team to draw conclusions regarding utilisation of care does not attempt to use denominators (population estimates) and hence it presents absolute numbers. This is purposively done, to avoid 'denominator issues' which may lead to report biased estimates of coverage.
- 5.125. For behaviour change indicators, the evaluation has used qualitative research to explore evidence around change achieved during the HDF implementation period.

FINDING 20 THE UTILISATION OF HEALTH CARE SERVICES HAS LARGELY BEEN SUSTAINED DURING THE PERIOD 2016 TO MID-2018, DESPITE OF THE FRAGILITY OF THE EXTERNAL ENVIRONMENT IN ZIMBABWE

- 5.126. Trends in coverage of essential healthcare interventions for RMNCH+A and nutrition are analysed.

Maternal and newborn health

Utilisation of ANC (4 or more visits) is maintained at steady levels throughout the implementation period (**Figure 23**), and the trend of utilisation is in line with the biennium that precedes the start of the HDF. With ANC estimated at 93.3% and ANC 4+ at 76% in 2015 (ZDHS 2015), simply sustaining the coverage levels of ANC at the levels of 2015 would still leave Zimbabwe at levels of uptake of ANC that are well above the median coverage of 62% observed for 58 countries tracked by the Countdown to 2030⁶¹ initiative. SBA was estimated at 78% in 2015 (ZDHS), in line with the median coverage of the Countdown countries (median coverage for Countdown countries = 77%).

Figure 24 plots as a proxy of SBA the trend in the number of deliveries (live births) at healthcare facilities, from 2014 to mid-2018. Again, the trend indicates that the levels of utilisation of services have been maintained during the period under review.

As shown in **Figure 25**, routine HMIS data show an encouraging, albeit modest, upward trend in the utilisation of PNC in Zimbabwe.

Immunisation

Immunisation coverage is very high in Zimbabwe, and largely in line with the achievements of Countdown countries, with the proportion of children 12-23 months receiving all basic vaccinations estimated at 76% in 2015 (ZDHS). We have tracked trends in utilisation of BCG (vaccine given at birth) and of PCV (3rd dose given at 9 months). The trends for provision of both antigens show a fairly stable picture (**Figure 27** and **Figure 26**), for

⁶¹ Tracking Progress towards Universal Coverage for Reproductive, Newborn and Child Health: The 2017 Report. Washington, DC: United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO), 2017. Accessed at: <http://countdown2030.org/pdf/Countdown-2030-Report-with-annexes-only.pdf>

the biennium preceding the HDF and for the period of implementation of the HDF so far. The levels of utilisation of immunisation services have been maintained.

Child health care

Trends in utilisation of child health services show, for two selected tracer indicators of diarrhoea and of malaria in children under the age of 5 years, a significant decrease in number of cases treated at healthcare facilities ([Figure 28](#) and [Figure 29](#)). This can be interpreted very positively as a substantial reduction of prevalence of these two diseases across the country. Yet, confirmation of such assumption can only be produced via national surveys.

Family planning

The median coverage of demand for family planning satisfied with modern methods of contraception is estimated at 48% across 52 countries tracked via Countdown to 2030, for which data are available. In 2015, Zimbabwe was already above such median coverage, with an estimated 66% women of reproductive age using any modern method of family planning. Oral pills are the most common methods of family planning for Zimbabwean women (44%). Trends in new clients initiating oral pills in Zimbabwe show again to be relatively stable (progesterone shown in [Figure 30](#)).

More importantly, as shown in [Figure 31](#), there is evidence of a marked and steady increase in the number of repeated visits for family planning, which suggests a marked improvement in retaining clients for modern contraceptive methods.

Screening for cervical cancer

Screening for cervical cancer is one of the critical SRH interventions supported via HDF. As noted in [Figure 32](#), there is evidence of a marked increase in the number of new clients for VIAC screening services.

5.127. In summary, routine data from HMIS suggest that there is evidence that the utilisation of services has been sustained, and that it has improved for some indicators, during the period of implementation of the HDF. Trends are mostly in line with the improvements noted in the two years that preceded the inception of the HDF.

Figure 23. Number of women attending 4 or more ANC visits, by quarter. Zimbabwe, January 2016 to June 2018

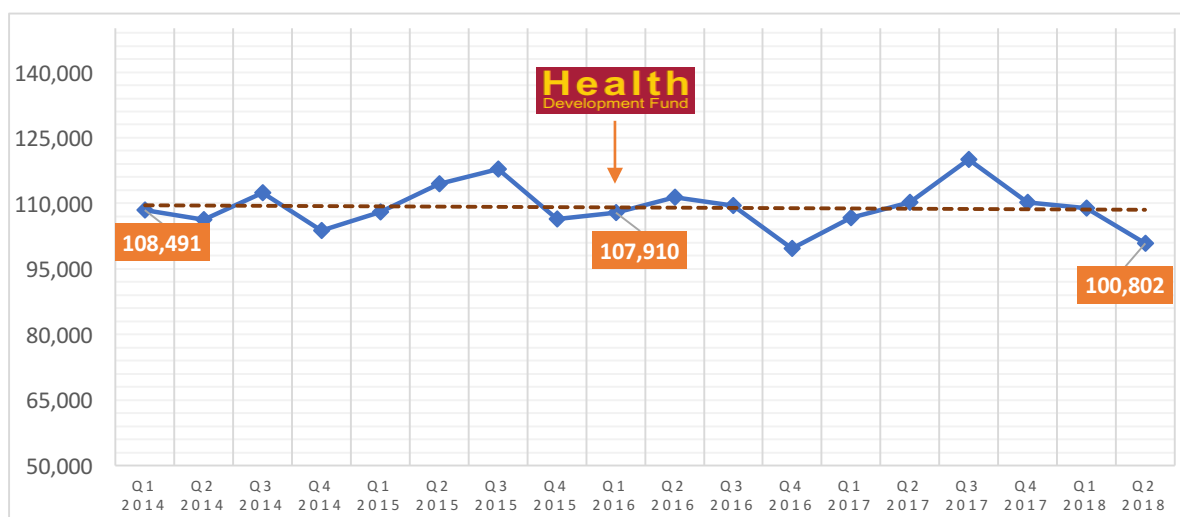


Figure 24. Number of deliveries at health care facilities (live births). Zimbabwe, January 2014 to June 2018

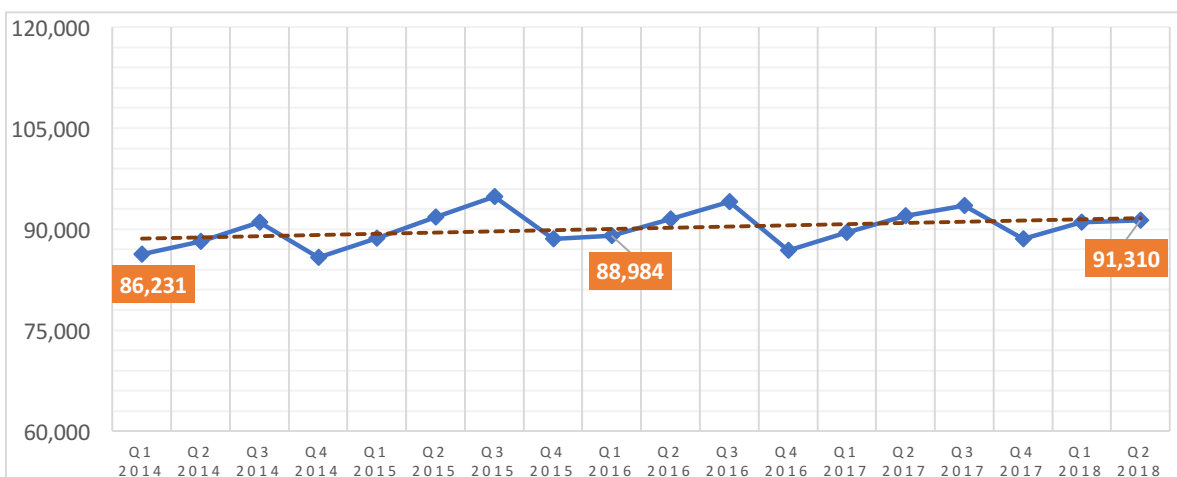


Figure 25. Number of post-natal care visits at health care facilities (7 days), by quarter. Zimbabwe, January 2014 to June 2018

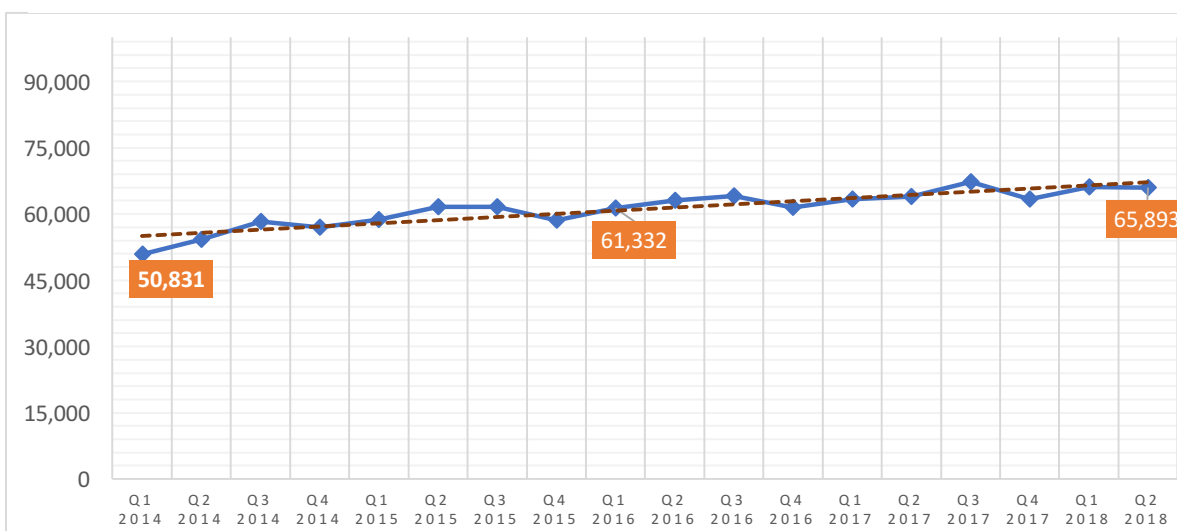


Figure 26. Number of children receiving 3rd dose of PCV vaccine. Zimbabwe, January 2014 to June 2018

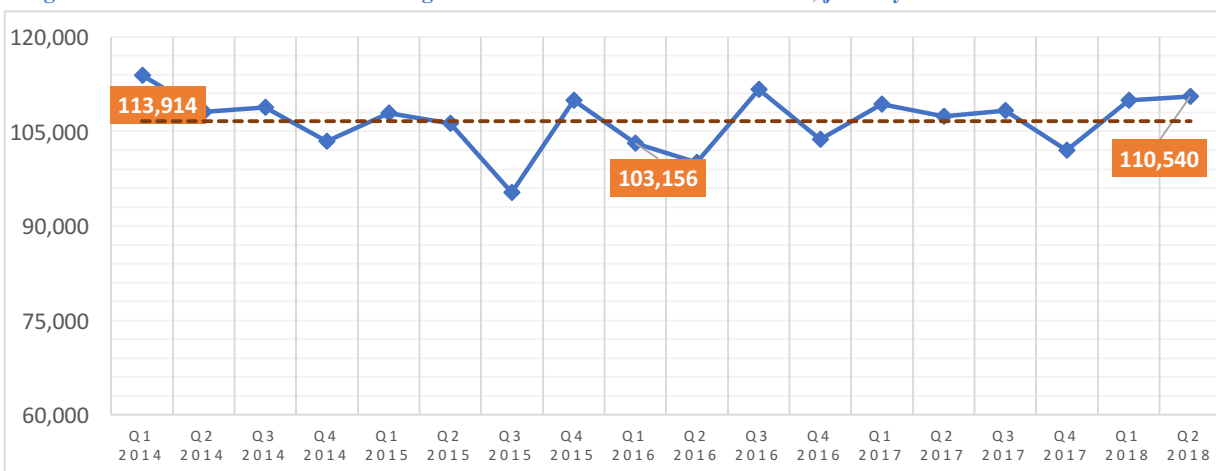


Figure 27. Number of children under 1 year receiving the BCG vaccine initial dose. Zimbabwe, January 2014 to June 2018

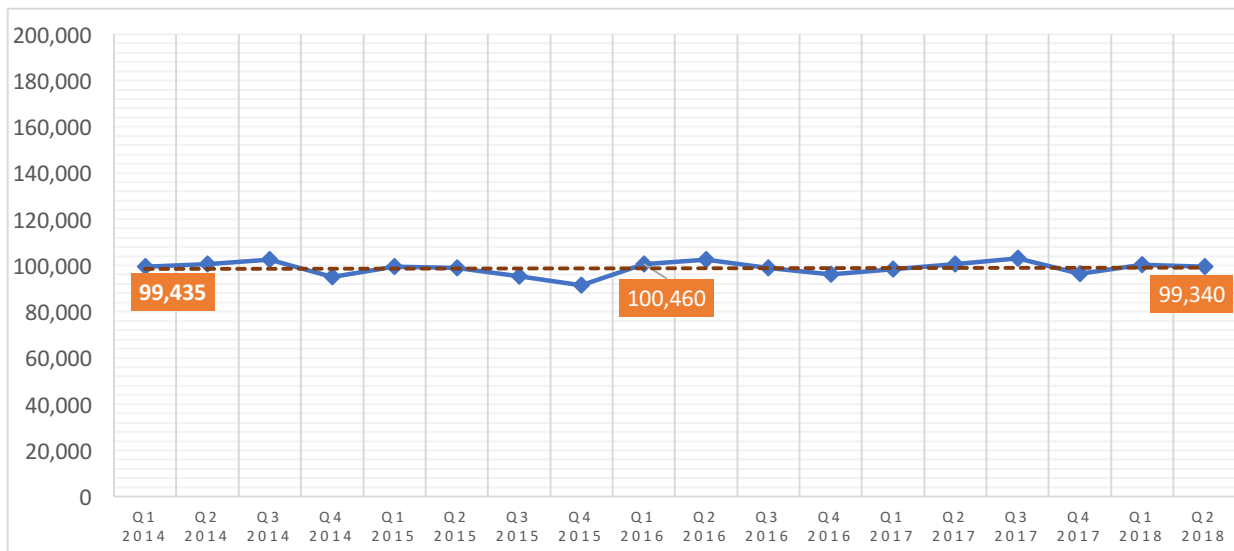


Figure 28. Total number of malaria cases of children U5 (confirmed and suspected). Zimbabwe, January 2014 to June 2018

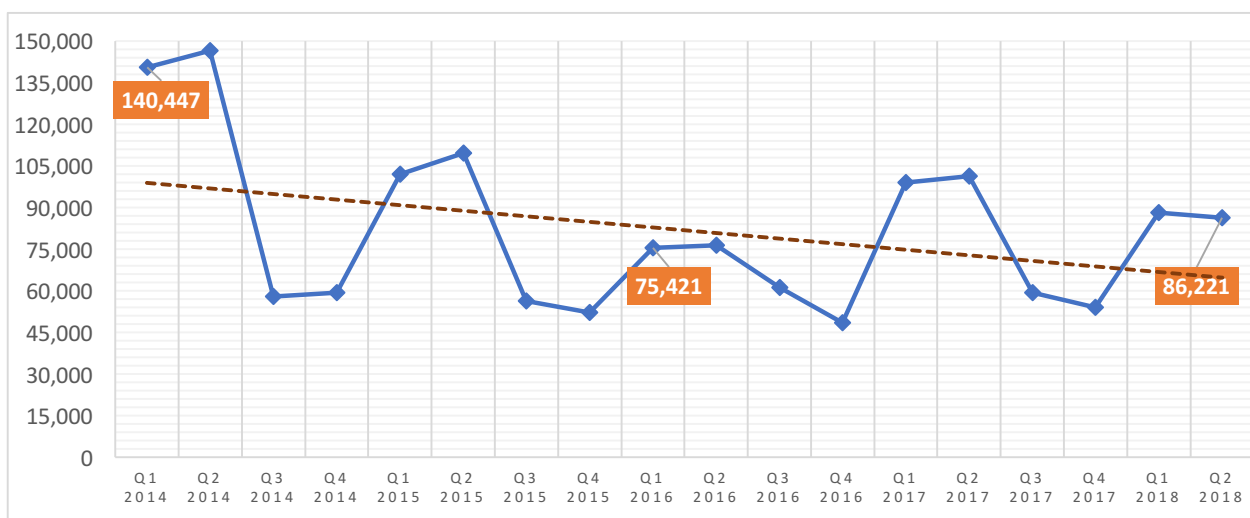


Figure 29. Number of cases of diarrhea treated at health care facilities, in children U5. Zimbabwe, January 2014 to June 2018.

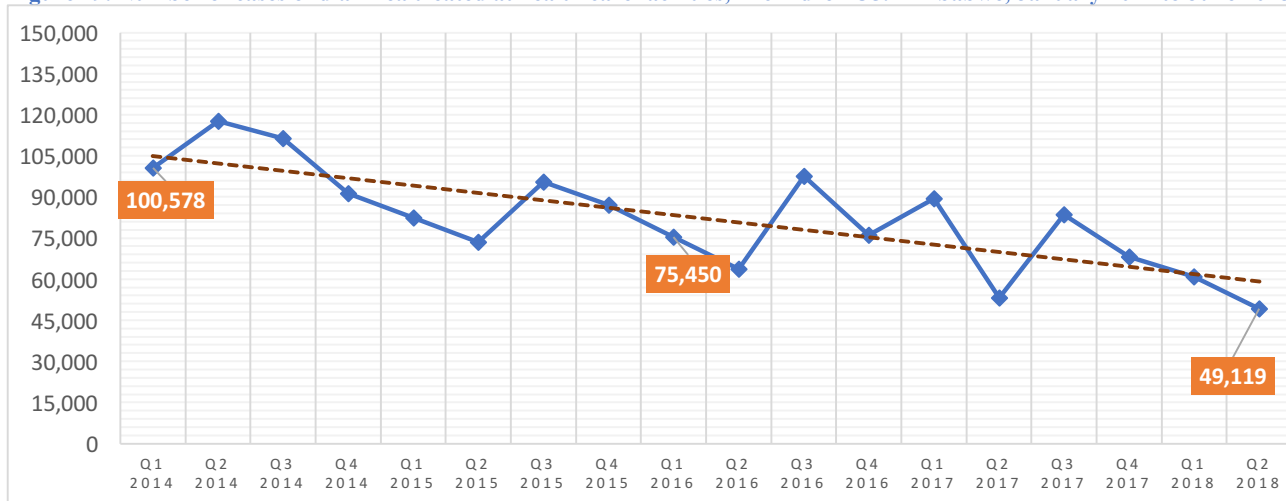


Figure 30. Number of new clients of family planning (progestogen oral pill). Zimbabwe, January 2014 to June 2018

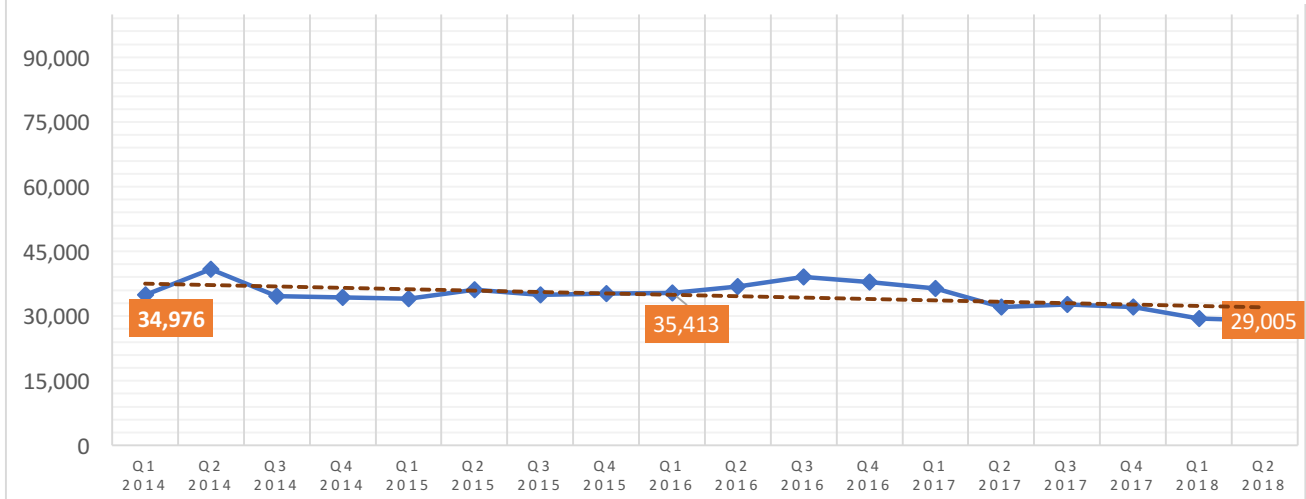


Figure 31. Number of repeated visits for family planning (progestogen oral pill). Zimbabwe, January 2014 to June 2018

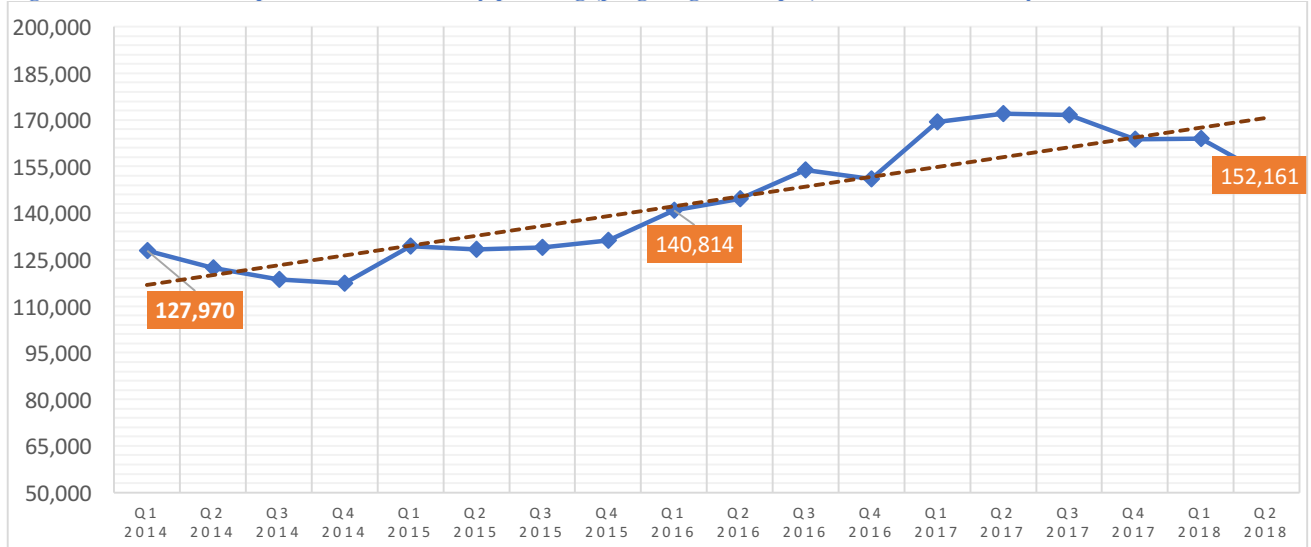
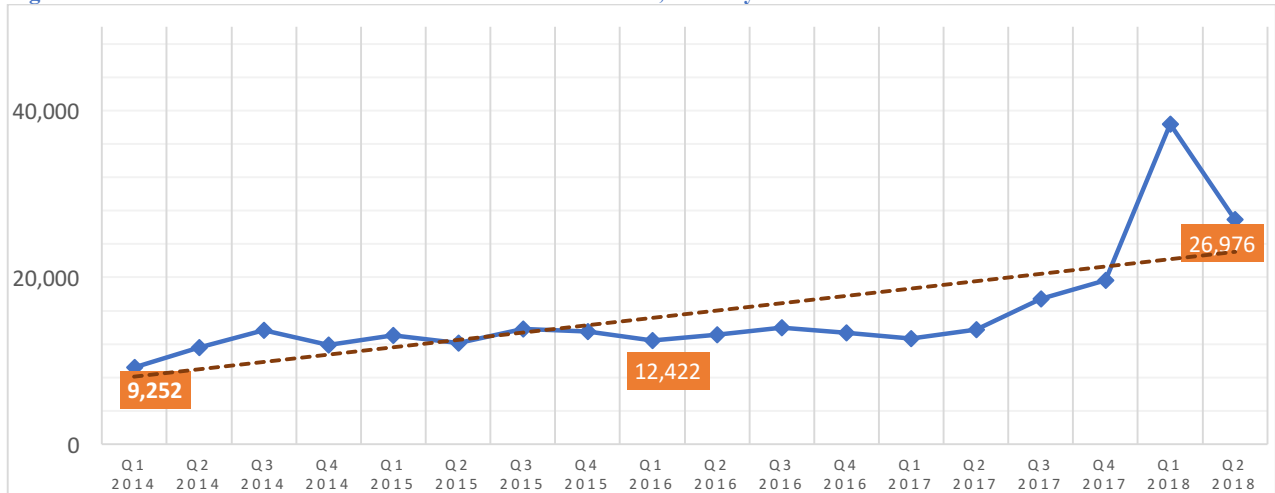


Figure 32. Number of new clients for VIAC services. Zimbabwe, January 2014 to June 2018



5.128. The following part of this section will seek to provide evidence of how the HDF has (or not) contributed to sustaining the levels of utilisation of care observed in Zimbabwe. This will be explored looking at the four dimensions of: availability; acceptability; accessibility; and quality of care (AAAQ framework). Common denominator to the four dimensions will be the aspect of governance, which will also be analysed.

FINDING 21 THERE IS SOME EVIDENCE OF CHANGE OF BEHAVIOUR AND PRACTICES AT COMMUNITY LEVEL

5.129. The FGDs highlighted that some health seeking behaviours have changed, including increased booking early for ANC, attending a health facility for delivery, and seeking care from VHWs and health facilities for other health concerns.

- Most pregnant women said that they **come at early stages to the health facility to confirm their pregnancy, register their pregnancy and be tested for HIV to protect their baby.**
- Women, men and VHWs, all emphasised the fact that **women do not deliver at home anymore.** Health facilities are perceived as a safe place to deliver. VHWs explained that this change is highly attributable to the information and education sessions that they conduct in the community, including with members of the Apostolic faith.

VHW: *“The knowledge they [women] get in their communities to go to the hospital is what pushes them to come”*

- The abolition of user fees acts as an incentive for institutional deliveries and has contributed to the **decline of the recourse to prophets and traditional healers.**

Man: *“... people are now starting to seek healthcare services. A factor to this is that if a woman gives birth at a hospital, she is given everything, and the husband doesn’t need to buy anything”*

- Another incentive for the women to deliver in health facilities is that they receive the necessary administrative documents required for **birth certificate and social welfare services.**
- VHWs noted that the increase in institutional deliveries has highly contributed to reduce the transmission of HIV from mother to child.

VHW: *“Before when we used to give birth at home, (...) a HIV positive mother would give birth and the child would not have access to medication (...) but there were changes in that now children are born at the clinic and even if their mother is HIV positive the baby is now able to be HIV negative and they continue to take their medication in the manner they have been told at the hospital”*

- Women who already had several pregnancies tend to visit the health facility at a later stage of their pregnancy.

Woman: *“Some of us think that we are experienced, and we do not want to come to the clinic on time”*

- Most women agreed that **traditional healers' influence is fading out**, although Prophets seem still to have an influence when it comes to decide where to seek care.

Woman: *"Some people used to believe in that way, but now we are modernised we opt for clinics rather than them".*

- When **adolescent boys and girls have a health problem, most of them said that they go first to the clinic**. Adolescents consider that health facilities provide more reliable care and there they can find everything they need to be treated. However, women of reproductive age reported that adolescents are reluctant to go to health facilities and to get tested for HIV
- Some of the adolescents go first to the VHWs before the health facility as they are available at any time, come from the same community and are closer than the health facility. When adolescents need additional care, the VHWs counsel them and advise them to go to the health facility. Adolescents feel more confident when they go to the health facility as they have received information from the VHWs beforehand.
- Traditional healers are a second choice for adolescents when they failed to be treated at health facility.
- When they need information about reproductive and sexual health, adolescent girls usually turn to aunts, grandmothers and elders. These latter ones advise them not have sex and not to yield to peer pressure.
- When it comes to the health of children, the preference is to seek care at the health facility. People report that **nurses know what to do and nurses know the history of the baby and the mother since she has received ANC and deliver in the facility**. Some men encourage their wife or children to visit first the VHW before being referred to the health facility, and some women said that they first go to visit the VHWs to assess the seriousness of the disease. However, VHWs may not have drugs in stock.

Man: *"I look at the complexity of the illness and assess if I go to the Village Health Worker or I run straight to the hospital. There are certain illnesses that you need to rush straight to the hospital and get diagnosed"*

Woman: *"Because the clinic is very far so you go to the Village Health Worker to get some paracetamol for the child and then come to the clinic".*

- People will go to traditional healers as a second choice when medical treatment offered at the facility is not working.
- The lack of nutritious food and clean water is a cross-cutting issue that was mentioned by each category of participants in every FGD, with particular effects on children:

Woman: *"We are unable to get all the different foods that are healthy for them. We just continue to give them the same type of food because we cannot afford to change"*

EQ5. Is there evidence of any unintended results produced by the HDF?

5.130. Limited evidence is found about major unintended effects produced by the HDF. The positive and negative unintended results that have come to attention by reviewing all the findings from qualitative and qualitative research are shortly presented below. Some have already been highlighted in other sections of the report.

- Abolition of user fees

While the abolition of user fees has been a key driver for people to come in great numbers to health facilities, many participants to the evaluation expressed their dissatisfaction with the lack of drugs at facility and they blamed the abolition of user fees for causing this shortage of drugs. Some women said that they preferred the time when they had to pay user fees because at least there were drugs available at facility.

“When it comes to medication it was better when we were paying the \$2 because the medication was available, now that we are no longer paying we come and get treated for free but there is no medication. (...) It was better when we would pay our \$2 and get medication” told a mother from Mashonaland West province.

- On a positive side, the abolition of user fees has strongly contributed to reducing the influence of the Apostolic church on health issues, since the availability of free services per se removes a motivation to choose alternative sources of care.
- Enhanced access to HIV prevention
Even though HDF primary focus is on RMNCH+A and nutrition, communities also report that it has also considerable impact on preventing HIV/AIDS, since almost all women now attend ANC and deliver at facility, they are tested for HIV and access PMTCT.
- Impact of RBF on behaviour at healthcare facilities
Qualitative research from the evaluation highlighted the risk that healthcare workers tend to maximise their efforts towards activities that are rewarded by RBF and areas that are not covered by RBF tend to be left out. In the word of a midwife at District Hospital: *“As far as HDF is concerned, they look at indicators. So, what happens is when we are doing our work we will be looking at those indicators, which means that there are other areas which will be left out. (...) And since as nurses you now have more workload, there are other partners who are also coming in like ITEC, they also want their job to be done perfectly (...) so due to these increased workloads you will find that there are some areas which will be left out”*.
- Use of RBF funds at facility level
Two major ‘unintended’ effects are noted as a consequence of transferring funds to facilities for their use. One is the (reported) tendency to prioritise infrastructural improvements over other perhaps more important expenses such as running costs for activities, and/or the procurement of medicines. In particular, for the procurement of medicines, the cash crisis and the slow response from NatPharm to have been a disincentive.
- Out of pocket costs
Consistent evidence from FGDs points to the fact that the need of end users to have disposable ‘emergency’ money to cover costs of referral has become a disincentive to accessing even primary care.
- Village Health Workers
The recruitment of VHWs who come from the Apostolic church has had a strong effect in behaviour change for this particular group, when this strategy is implemented. In fact, motivating members of the apostolic church and training them as VHWs makes them ‘champions’ in changing behaviour within their own community.

- Factors motivating healthcare workers to stay in service and to provide quality services have not to do primarily with allowances, but rather with positive working environment, infrastructure, and motivation to do good work for the community and to see improved health outcomes.
- Team work emerges as a critical improvement in the approach to delivering care at facilities. HCPs consistently report good relationships within the facilities and with superiors and supervisors as a strong contributor to improved quality of services.
- DHEs have multiple demands to address that may compromise their effectiveness in governing the district. These include mentoring, supervision, and RBF quality assessments. There are risks of inability to conduct timely quality assessments for the RBF with knock on effects on the timely disbursements of RBF funds to facilities.
- There is consistent reporting of women being fined if they do not deliver at the health care facility. This is an underlying reason for high occupancy of MWHs in some areas.

Equity

EQ7. Does the HDF embed an equity focused approach in its design and in its delivery mechanisms?

5.131. For this evaluation, we will adopt the following definition of equity: *The absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy.*⁶²

5.132. Critical to addressing the evaluation question is a clear and detailed picture of the equity gaps in access to health in Zimbabwe. In that, data from the ZDHS 2015 provide a detailed picture of the major inequities observed in Zimbabwe in terms of maternal, newborn and child mortality, and of coverage of key RMNCH+A and nutrition interventions.

The key features of the equity analysis can be summarised as follows:

Under five mortality rates → Strong variation across provinces, with Manicaland, Mashonaland East and Mashonaland West presenting the highest rates of U5 mortality, and Manicaland and Mashonaland East also reported as the provinces where **more children die.** (Figure 33).

Extremely high equity gap due to wealth, with U5 mortality rates reported at 46 per 1,000 live births in the richest quintile, vs 90 per 1,000 live births in the poorest quintile. High disparity in mortality rates between rural and urban areas, with mortality rates estimated at 80 per 1,000 live births in urban areas and 50 in rural areas, respectively. Education status of the mother is the strongest socio-demographic factor observed as a driver of disparity in mortality rates, with mortality rates observed at 106 per 1,000 live births in women with primary education vs 26 with women with secondary education or higher.

- **Neonatal mortality rate** → Strong disparities across provinces, with Mashonaland West presenting the highest rates of neonatal mortality, but with Manicaland and Mashonaland East presenting the highest toll in terms of

⁶² Defining equity in health. P Braveman and S Gruskin. doi: 10.1136/jech.57.4.254 *J Epidemiol Community Health* 2003 57: 254-258 (Accessed at: <http://dx.doi.org/10.1136/jech.57.4.254>)

absolute number of neonatal deaths (**Figure 34**).

Less dramatic equity gap across provinces and wealth quintiles, compared to U5 mortality, with an equity gap between poorest and wealthiest and between rural and urban areas that does not exceed 5 percentage points in mortality rates. Strong effects of levels of mother’s education on mortality rates (38 per 1,000 live births vs 14 per 1,000 live births).

- **Malnutrition** → Extremely strong effect of residence (urban vs rural) of children on the disparities in the number of cases of malnourished children reported. (**Figure 35**)

Figure 33. Equi Plots for Child Mortality in Zimbabwe

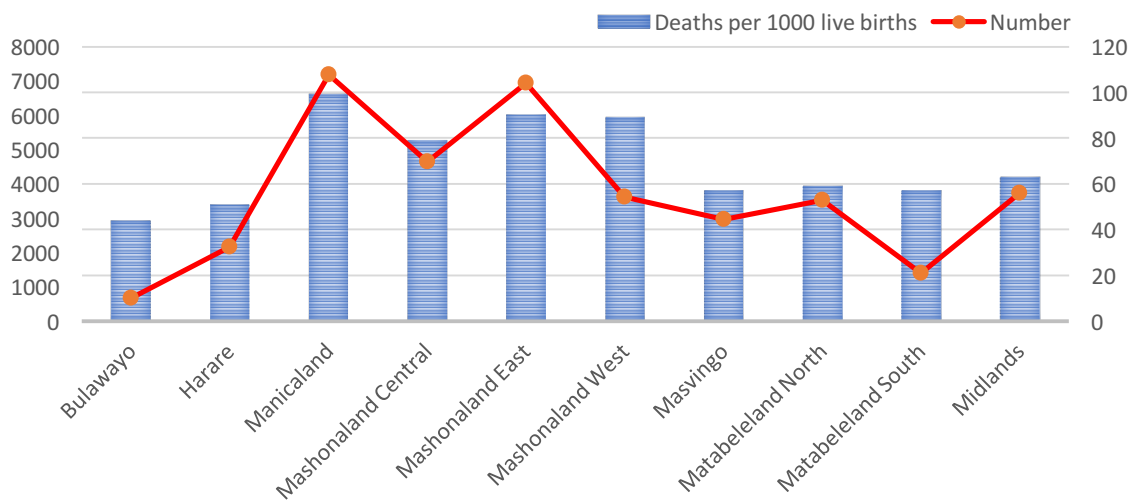


Figure 34. Neonatal mortality: rates and number of newborn deaths by province (Source: DHS, 2015)

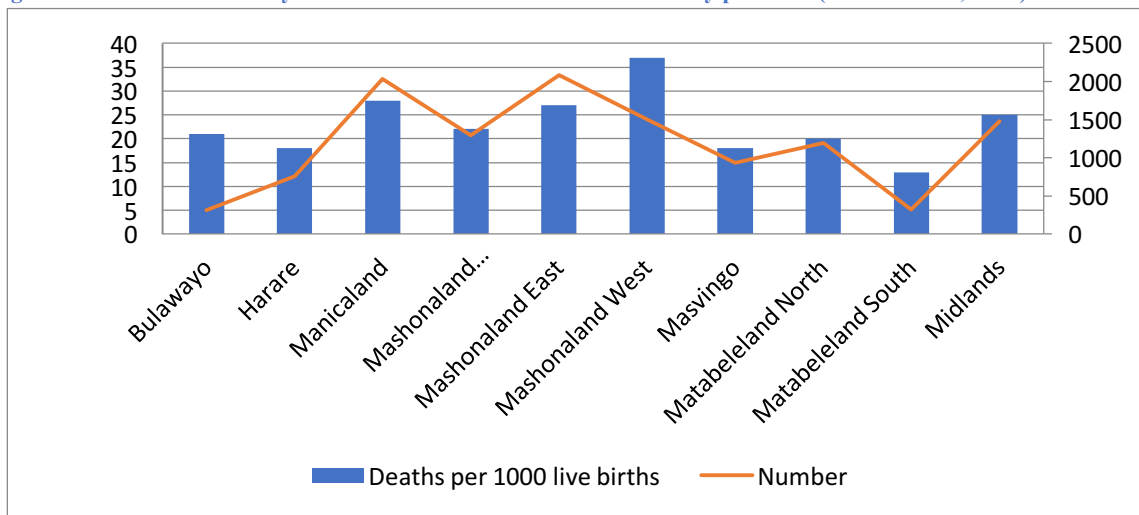
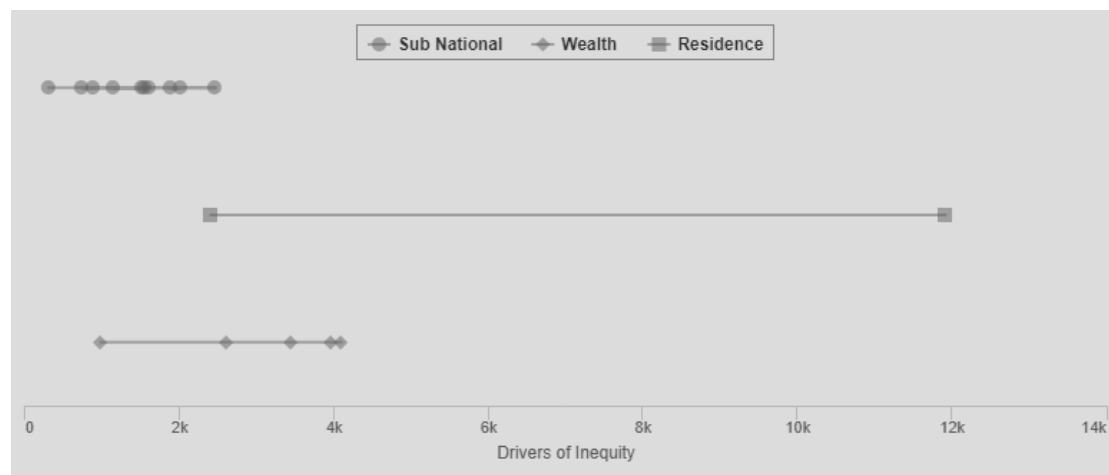


Figure 35. Equity plot: Moderate & severe stunting (proportion U5 children height for age < -2SD)



5.133. The strong disparities observed in mortality and malnutrition are largely driven by underlying inequities in coverage of essential preventive and curative interventions for RMNCH+A and nutrition. Presenting a disaggregated assessment of coverage of interventions by wealth, geography and provenience goes beyond the scope of this report. A full picture of the equity assessment of Zimbabwe, available from EQUIST⁶³, is included in **Appendix 9** as a background for the reader.

Useful instead to address the evaluation question is the **equity frontier analysis**. The equity frontier indicates how many lives could have been saved or malnutrition cases averted if Zimbabwe was to equalise coverage values for the least disadvantaged within the most disadvantaged population. This is disaggregated by intervention package.

Newborn and child mortality

Figure 36 shows the number of deaths that could be averted in newborns and children under the age of 5, if coverage of various interventions was scaled to the levels of the better off group in Zimbabwe, by location.

Figure 37 presents the same analysis, by residence, and **Figure 38** by wealth quintile.

According to the modelling exercise, the major gains in terms of child mortality reduction may be driven by addressing ineffective and unequal coverage in two major intervention areas: WASH, including sanitation, access to safe water, key family practices such as hand washing and safe disposal of faeces; and access to EOC.


In that, there is a very marked difference in access between the poorest and wealthiest, and between those living in rural areas and urban areas. Also, and interestingly, there are marked disparities in access to WASH and EmONC across the different provinces of Zimbabwe and this has a strong effect on the level of observed deaths.

Maternal mortality

The equity frontier for maternal mortality presents a slightly different picture. The critical interventions that would concur to reducing the toll of maternal deaths are SBA and access to EOC. For those interventions, the level of disparity across wealth quintiles is less marked (**Figure 40**): all strata of the populations would equally benefit of accessing the same levels of care of the wealthiest quintile, which means that the only marked difference in access and quality of care is between the better off group and all the others. There are also very strong geographical variations across provinces (**Figure 39**), showing that Midlands, Manicaland, Mashonaland Central and Mashonaland East are the provinces where disparities in accessing services bear the highest effects.

⁶³ Accessed at: <http://www.equist.info>

5.134. In synthesis, the rapid analysis of inequities presented above shows some clear indications of the fact that the major disparities that drive inequity in maternal and child mortality and morbidity are related to typical factors such as wealth, education, and residence in rural areas.

5.135. No major disparity is observed in terms of gender. 

5.136. The analysis also shows that there are area of interventions falling within the scope of the HDF, such as access to ANC, SBA and EmONC, which bear strong potential for enhancing equity and reducing morbidity and mortality, if those are addressed via an equity focused approach in some provinces of the country. Other areas, in particular WASH, may require multisectoral action and a range of interventions that fall outside the focus of the HDF.

Figure 36. Equity frontier by geographical location, child mortality

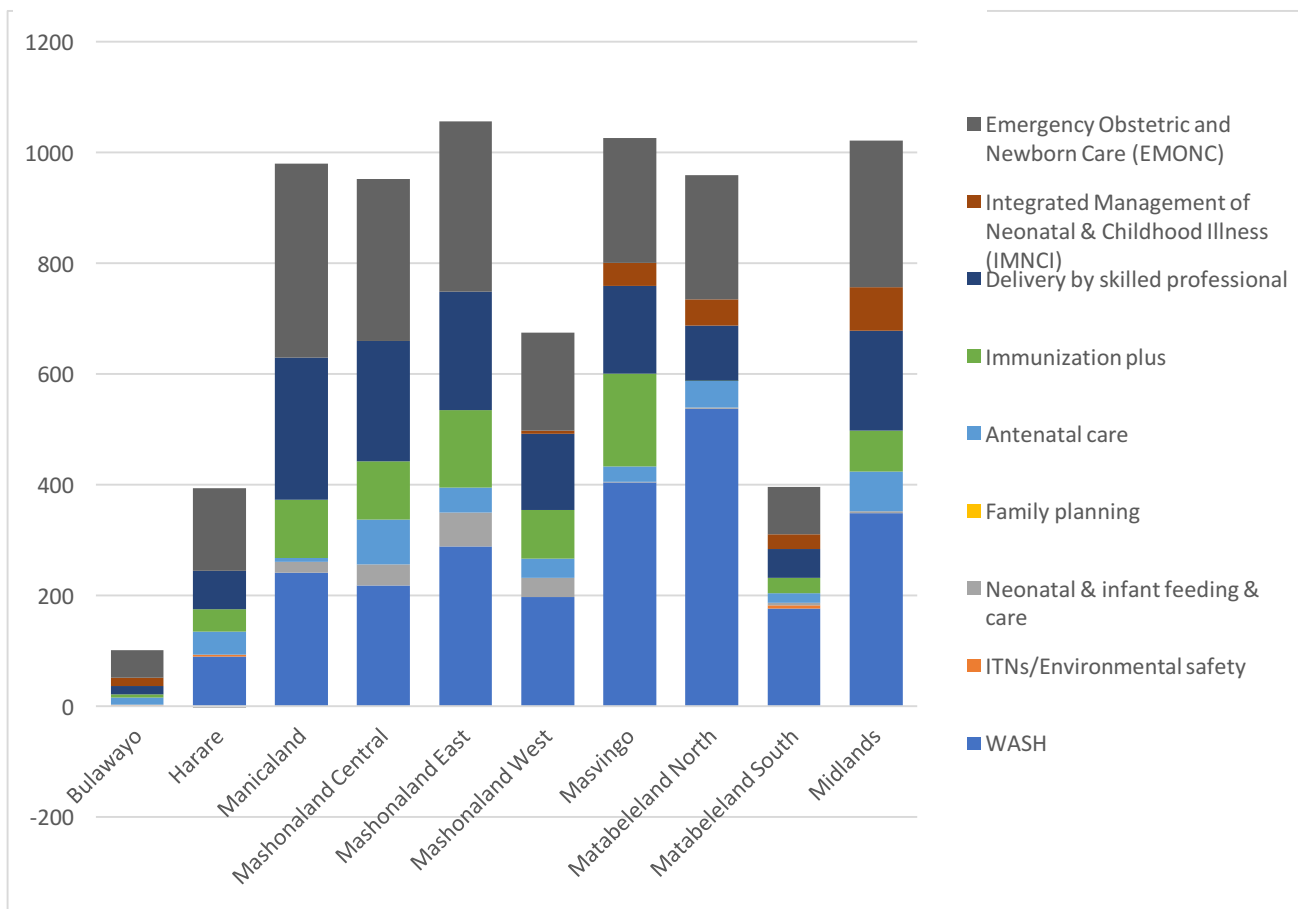


Figure 37. Equity frontier for child mortality, rural-urban

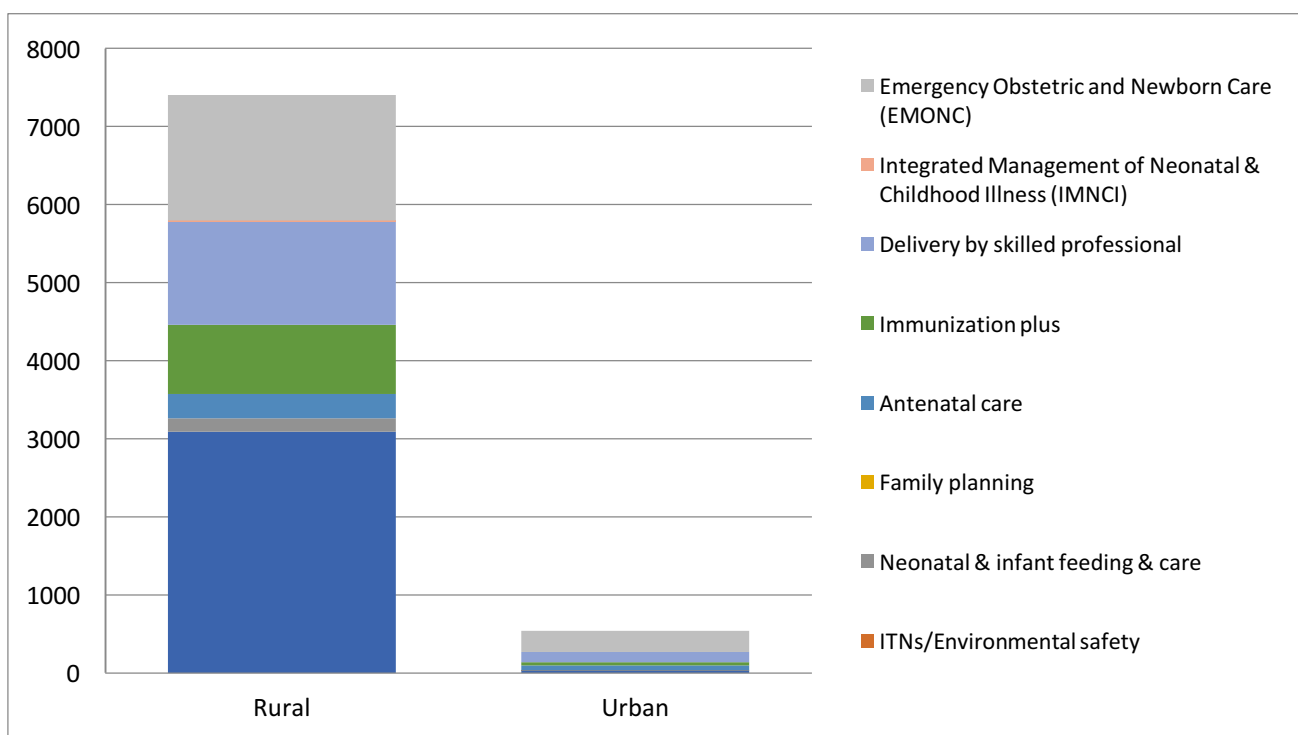


Figure 38. Equity frontier for child mortality, by wealth quintile

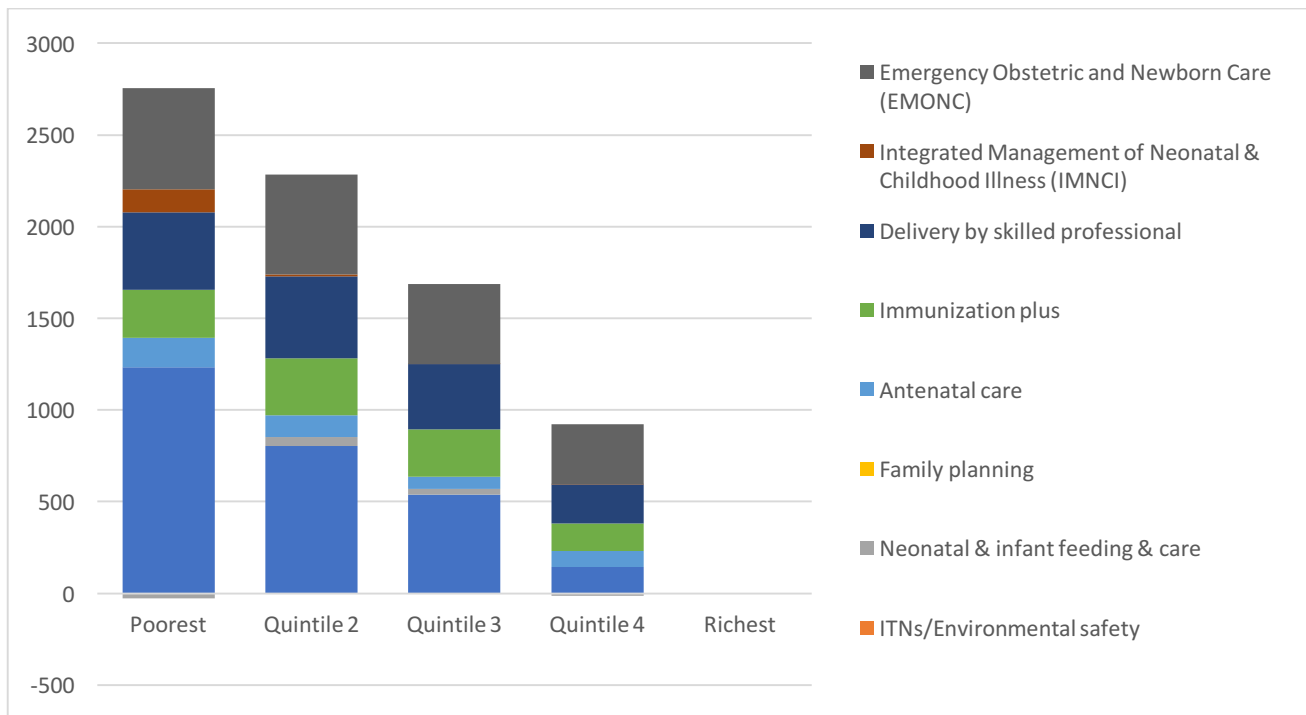


Figure 39. Equity frontier for maternal mortality, by Province

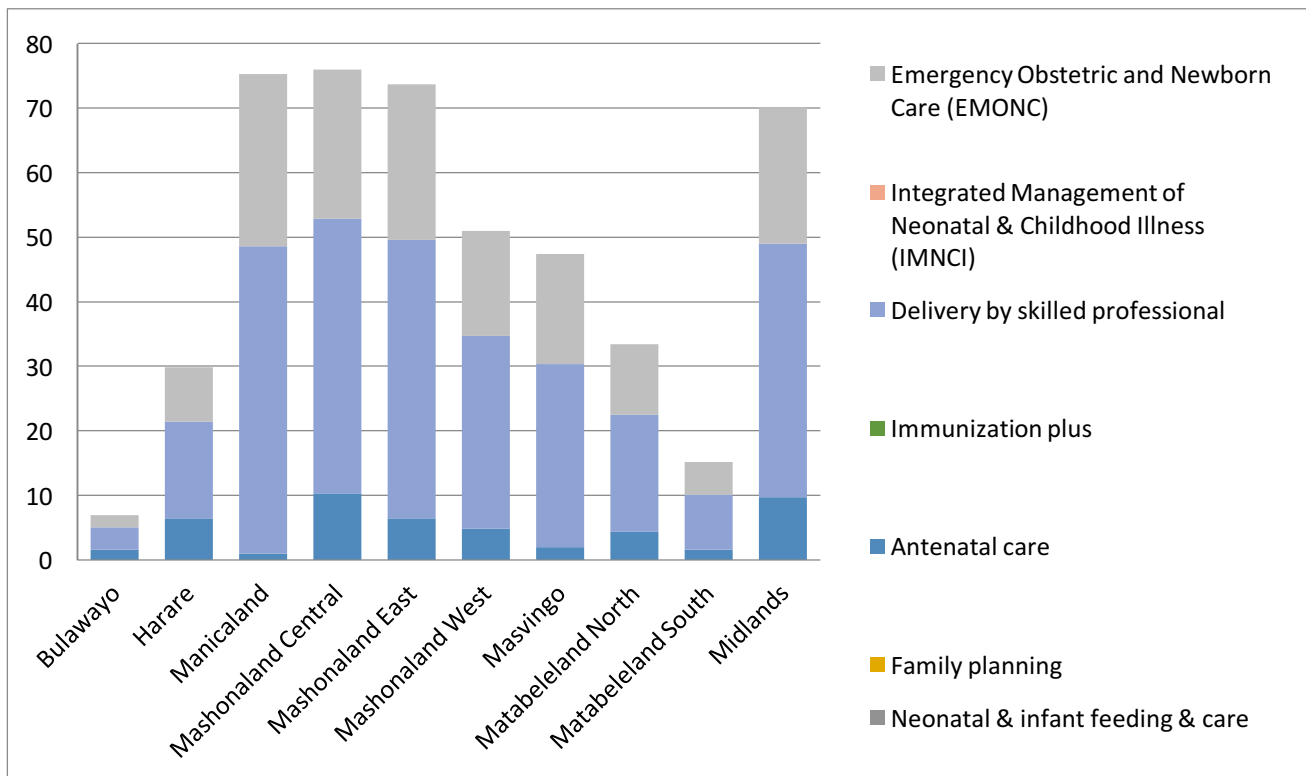
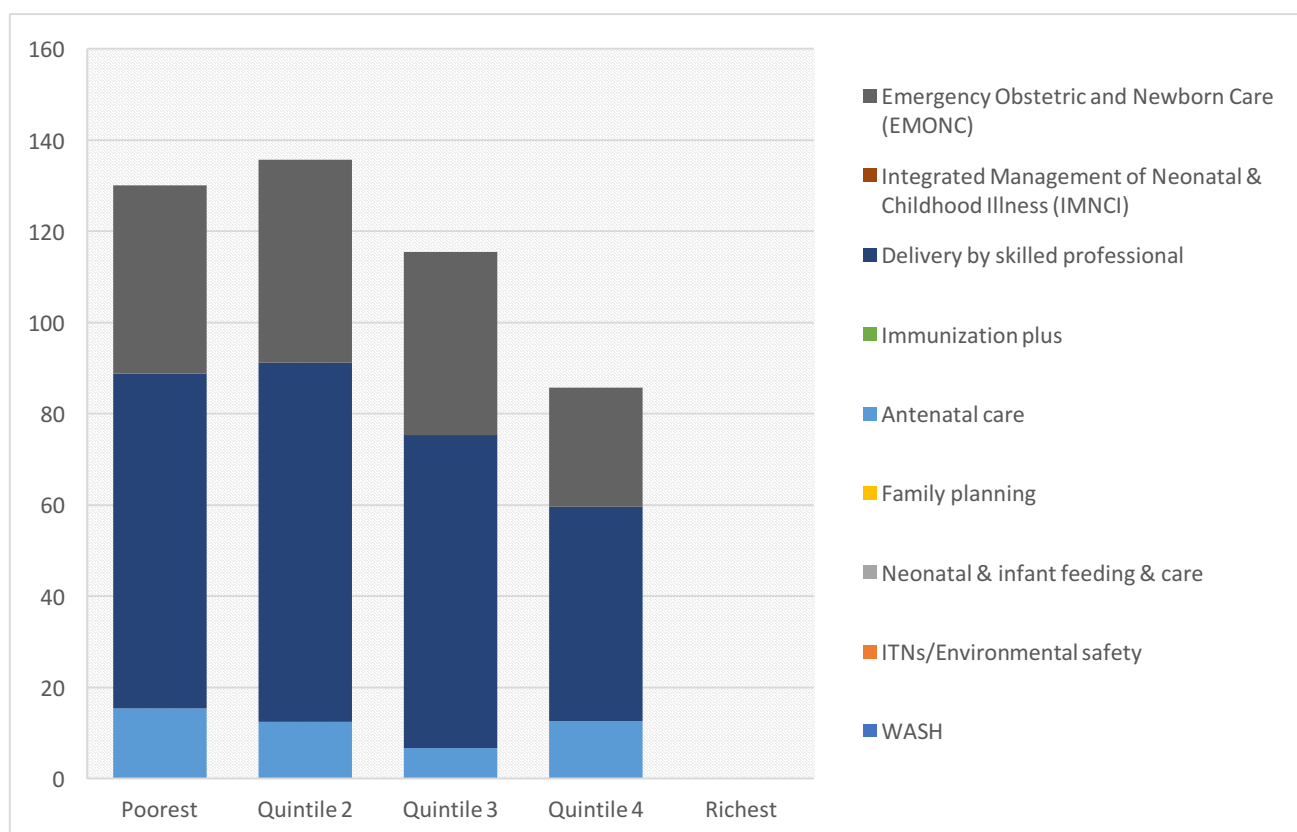


Figure 40. Equity frontier for maternal mortality, by wealth quintile



FINDING 22 THE HDF DESIGN IS FULLY AND STRONGLY RESPONDENT TO A LOGIC OF ADDRESSING INEQUITIES

5.137. Various features of the HDF programme design are strongly confirmatory of the fact that the programme was designed with equity in mind, as a critical dimension of the programme.

5.138. A first consideration is that equity is clearly identified as a central component of the HDF, at design stage. In the foreword of the HDF programme document, signatory parties to the HDF programme document state:

*'We the undersigned pledge our commitment to realising 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'.*

5.139. A second consideration, stemming from the above reported high level commitment to equity, is that the HDF programme document highlights the key areas on which the HDF will focus, to address equity⁶⁴, as shown below.

*'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.***

⁶⁴ HDF programme document. Accessed at: https://www.unicef.org/zimbabwe/HDF_Final_Draft.pdf

*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 programmes, 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.'*

5.140. A third consideration is that, in principle, the overall goals and objectives of the HDF are designed and intended to address the needs of the most vulnerable groups in Zimbabwe, identified as: pregnant women; newborns; adolescents, and women of reproductive age. Also, the key focus of the HDF supported interventions is on rural areas, with support at community, primary and secondary levels of care. Hence and therefore, the overall design of the HDF as a high equity focus in terms of population needs.

5.141. Lastly and more importantly, most of the HDF supported interventions have been identified and implemented with equity in mind as one of the drivers for action.

A framework produced by Jacobs et al⁶⁵ summarises evidence on demand and supply side monetary and non-monetary interventions that reduce various dimensions of access barriers to health, including geographical accessibility, availability, affordability and acceptability of care. Although the framework was developed based on evidence for Asian countries, it provides a useful and unique benchmark to map interventions against their fit with the objective of reducing barriers to access and hence to enhance equity.

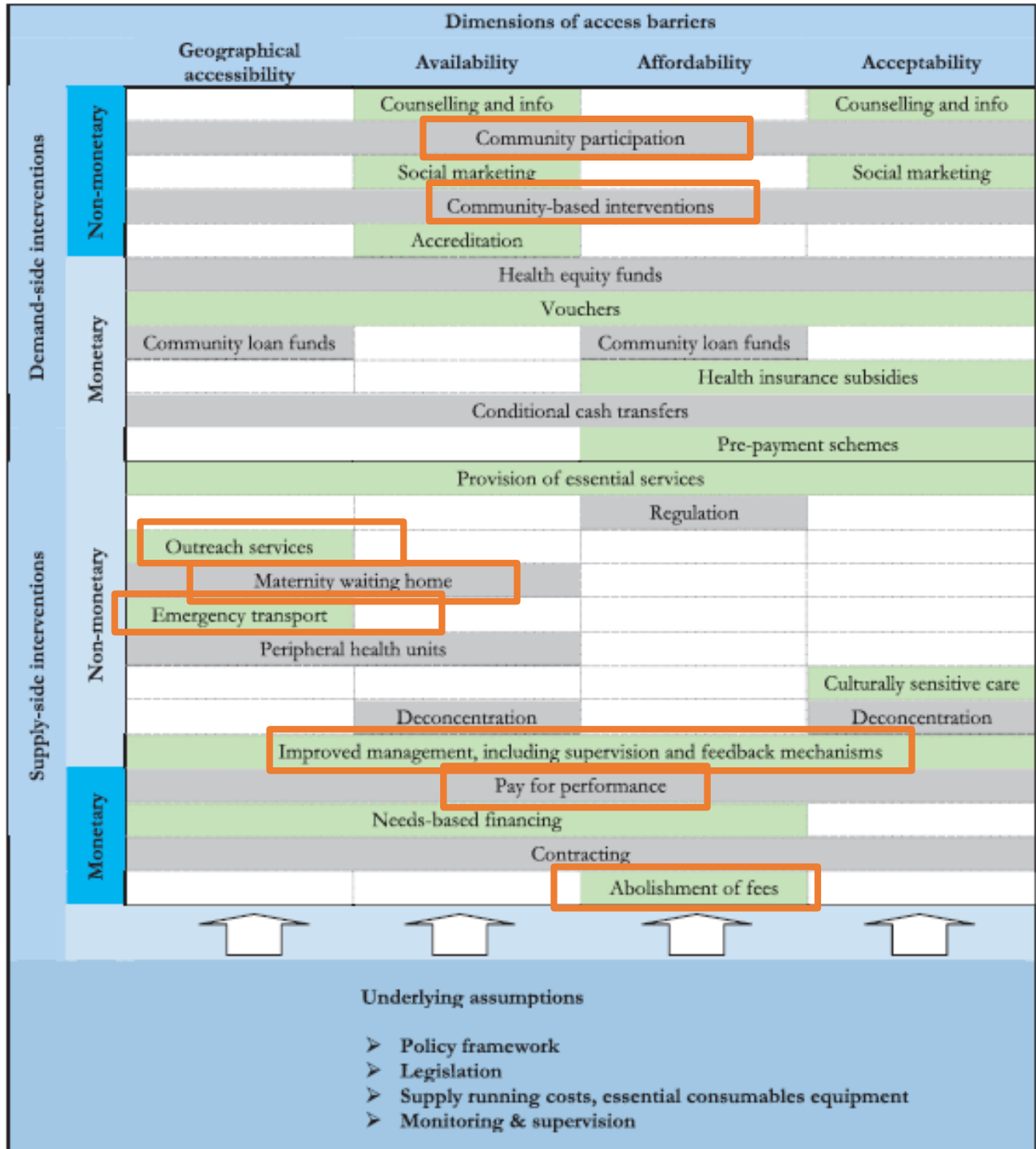
Benchmarking the HDF key strategies against this framework (**Figure 41**) provides a clear picture of the how the HDF design is conducive to address access barriers. It also highlights possible areas where other intervention strategies may be conceived in future.

- On the demand side, the HDF has invested substantially in
 - Community participation
 - Scale up of VHWs
- On the supply side, the HDF present even stronger design features reasoning with an equity-focused approach. In fact, the HDF has invested in and continues to invest in:
 - Outreach services, either supported through direct budget lines or indirectly via RBF payments
 - MWHs, for which there have been efforts in scaling up availability but also in improving quality of MWHs.
 - Indirect support to emergency transport, via RBF and more importantly via extension/expansion of the RBF to secondary level facilities in the 42 districts supported by the HDF.
 - A pay for performance mechanism introduced a consolidated across the country, the RBF.

⁶⁵ Bart Jacobs, Por Ir, Maryam Bigdeli, Peter Leslie Annear, Wim Van Damme; Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries, *Health Policy and Planning*, Volume 27, Issue 4, 1 July 2012, Pages 288–300, <https://doi.org/10.1093/heapol/czr038>

- The overarching support to improve supervision and management capacity at district level and below via training, mentorship and supportive supervision.
- The successful investment in reducing user fees (primarily via RBF).

Figure 41. Analytical framework for interventions addressing demand and supply barriers to health



FINDING 23 THE HDF DELIVERY MECHANISMS PRESENT OPPORTUNITIES FOR FURTHER ENHANCING AN EQUITY-FOCUSED APPROACH

5.142. Evidence provided so far shows that the design of the HDF is strongly equity focused. The next question is whether this overall equity focused approach has been translated operationally into activities that have supported addressing the major inequities in Zimbabwe.

Addressing such question presents complex a methodological challenge. This is: **how to address equity, within an overarching framework of UHC.**

In theory, equity should be implicit within UHC.

In practice, as well documented by Rodney et al⁶⁶:

'While equitable access and financing should be integral outcomes of UHC, evidence emerging from country case studies is however showing that in spite of gains in health coverage, and/or the overall level of population health, inequities can persist or even widen when there is insufficient focus on equity. To ensure that the push towards UHC does not make the same mistakes and leave the same disadvantaged populations behind, countries and development partners must make equity an explicit priority within UHC design and ongoing M&E plans.'

Addressing the risk of generating inverse inequities in the path to UHC, joint work by WHO and the World Bank has stressed the importance of monitoring equity as countries adopt models and policies to progressive UHC⁶⁷:

'So, in addition to measuring levels of coverage of essential health services and financial protection, it is critical to have measures disaggregated by a range of socioeconomic and demographic "stratifiers". For country monitoring of equity in coverage, the choice of stratifiers should be informed by an assessment of both those that are salient and those that are measurable, given the data available. The global framework proposes three primary elements for disaggregation that can be measured comparably in all settings: household income, expenditure or wealth (coverage of the poorest segment of the population as compared with richer segments), and place of residence (rural or urban) and gender.'

5.143. The theoretical debate re UHC and equity finds a translation in a practical approach, suggested by the WHO Consultative Group on Equity and Universal Health Coverage⁶⁸.

The approach suggested a three stages strategy, that provides a useful benchmark to analyse the operational features of the HDF and their support to equity:

(a) Categorise services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection;

(b) Expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds;

⁶⁶ Achieving equity within universal health coverage: a narrative review of progress and resources for measuring success *International Journal for Equity in Health* The official journal of the International Society for Equity in Health 2014;13:72 <https://doi.org/10.1186/s12939-014-0072-8>

⁶⁷ Monitoring Progress towards Universal Health Coverage at Country and Global Levels Published: September 22, 2014 <https://doi.org/10.1371/journal.pmed.1001731>

⁶⁸ Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. World Health Organisation, 2014.

(c) While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations. If interventions cannot reach everyone, the most disadvantaged groups should be prioritised.

Of interest to our analysis, is the extent to which the main HDF strategies have fallen under category b) or c), i.e. the extent to which the HDF has worked with a ‘blanket approach’ to cover all, or rather with a focused lens on the most disadvantaged.

We assess this feature of the fund in [Table 24](#) below

Table 24. Equity features of the HDF implementation strategies

HDF Intervention strategy	Equity-focused implementation features
Procurement of medicines, supplies and commodities	<p>High equity-focused implementation</p> <p>Medicines and commodities are procured based on a mechanism of quantification that takes into account population size, but also its epidemiological profile. In that, distribution of medicines and supplies indirectly takes into account the health needs of the population and is tailored to its (expected) needs.</p> <p><i>Potential barriers to equity</i></p> <p>Out of pocket (OOP) expenditure on medicines impact the poorest, when those are not available in the facilities</p> <p>Greater availability of medicines at lower levels for MNCH medicines</p>
Results based financing	<p>Moderate equity-focused implementation</p> <p>RBF payments are based on a complex assessment of performance of health care facilities, based on volumes of health care produced and on quality of care provided.</p> <p>A remoteness bonus included in the RBF calculation parameters was included in the scheme, to ensure that most remote facilities were not penalized because of small volumes of services.</p> <p>In general, RBF is highly sensitive to volumes and quality, not necessarily tailored to deliver higher investments in areas with highest need. (See Box 1 for analysis)</p>
Village health workers	<p>Risk of inverse equity in program operationalization</p> <p>Scaling up VHWs has been a significant investment of the HDF, with the total number of VHWs scaled from 11,744 in early 2016 to 16,960 in Q1 2018.</p> <p>The scale up of the program has worked during the period under review against a target of ensuring that there is at least one VHW deployed in each village of 8 provinces of Zimbabwe. While investing in VHW is a highly equity-focused intervention, we observe that the implementation patterns of the scale up bear risks of generating inverse equity effects. (See box 2)</p> <p><i>Potential barriers to equity</i></p> <p>Criteria for distribution of VHWs</p> <p>Unequal workload with some health workers/facilities having large of numbers of VHWs to supervise</p>
Allowances for health care providers for MNH	<p>Intervention interrupted as of early 2018.</p> <p>The payment of allowances to HCPs consisted of supporting all nurses working in maternity wards across the country, and doctors at district level.</p>

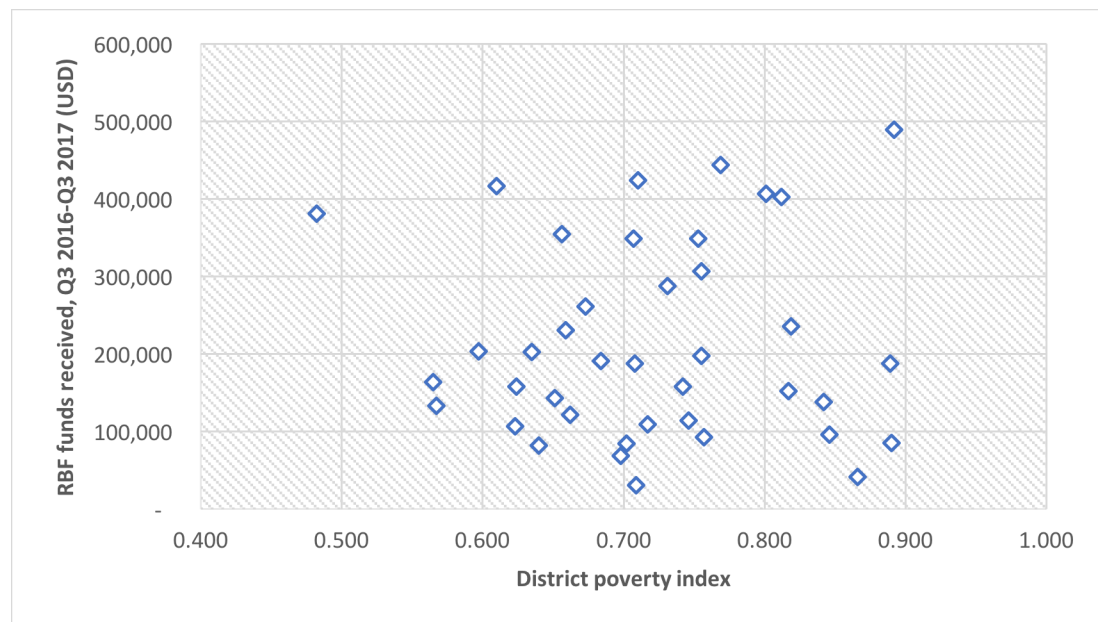
	Such interventions responded to a logic of ensuring the provision of essential services to rural areas primarily
Capacity strengthening of health care providers	<p>No evidence available of how areas of focus were selected, for capacity strengthening of HCPs.</p> <p><i>Potential barriers to equity</i> Selection of participants</p> <p>More investment in some areas – choice to invest in one area over another based on funding availability or donor priorities</p>
Community mobilization	<p>Evidence of development of RMNCHA communication strategy to target religious and cultural objectors.</p> <p>No evidence available of how various social mobilization activities were prioritized.</p> <p><i>Potential barriers to equity</i> Fragmentation across themes and geography</p>
Outreach	<p>Moderate evidence of high equity-focused implementation</p> <p>The workplan and the reports from the HDF indicate that the focus of support to outreach was on high priority districts. This includes in particular the identification of low performing districts where focused support for EPI was provided. Data sources also indicated bottlenecks, primarily due to budget constraints, in reaching hard to reach area.</p> <p>No evidence can be produced of where outreach activities were performed. Yet the reported selection of priority districts points towards moderate evidence of selection and reach of communities most in need, via this activity.</p>

Box 1. RBF funding by district poverty and by district population size

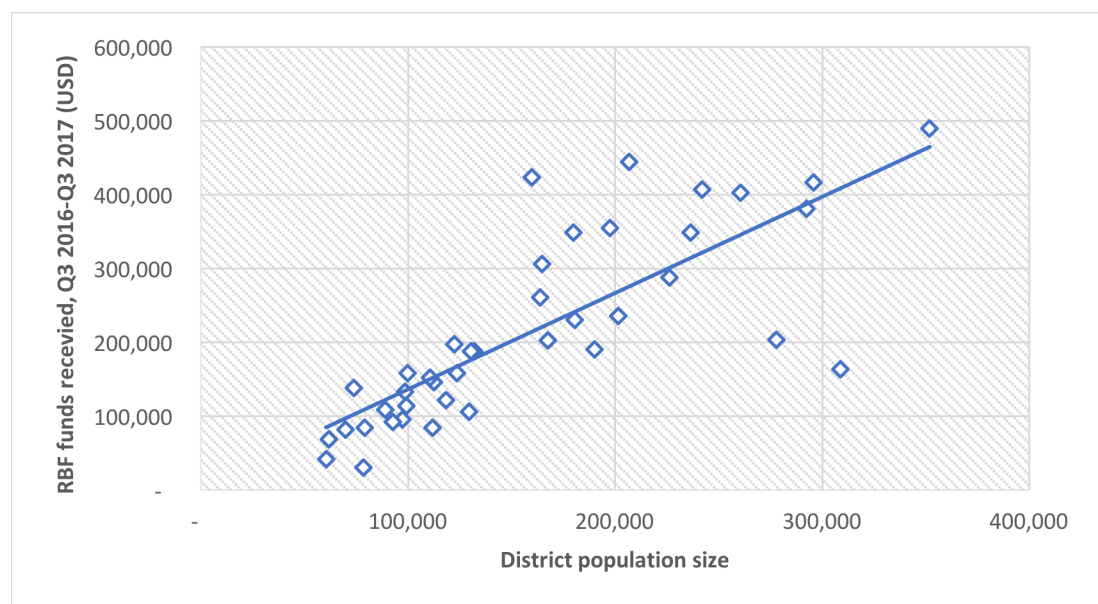
This analysis presents the RBF payment made to health care facilities in 42 districts of Zimbabwe, disaggregated by district, for the period Q3 2016 to Q3 2017.

Payments by district are plotted against the district poverty index, drawn from the Zimbabwe Food Poverty Atlas 2016 (https://www.unicef.org/zimbabwe/Zimbabwe_Food_Poverty_Atlas2016_FINAL_A4.pdf)

No particular association is observed between the volume of payments and the poverty of districts.



RBF payments are also plotted against the district population size.



The analysis shows a strong correlation between the population size of the district and the volumes of RBF payments made to facilities in those districts.

No evidence can be drawn instead on sensitivity of RBF investment to facilities to district level poverty status.

Box 2. Distribution of Village Health Workers

VHWs were estimated at 11,744 in early 2016.

The maps below (source: HDF Report 2016) show that at the start of the HDF, there was a very skewed distribution of the VHWs, with the areas where mortality is higher (circled in red in **Figure 41**) presenting actually the lowest coverage of village with at least one active VHWs. By the end of 2017, following an additional investment in training new VHWs, the distribution has partially been adjusted to provide higher coverage in the provinces where child mortality is higher.

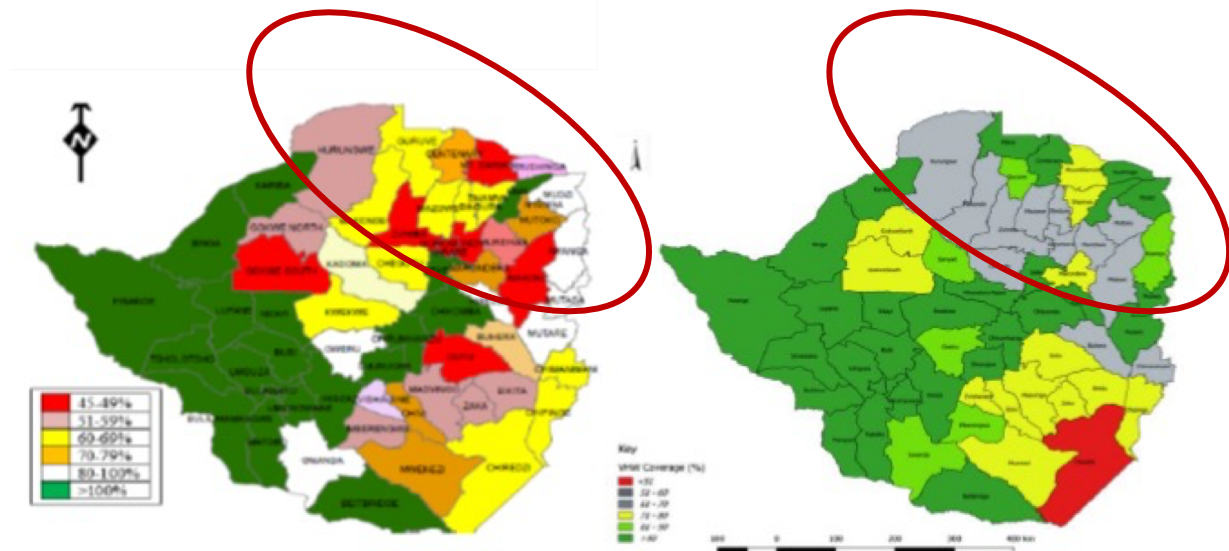
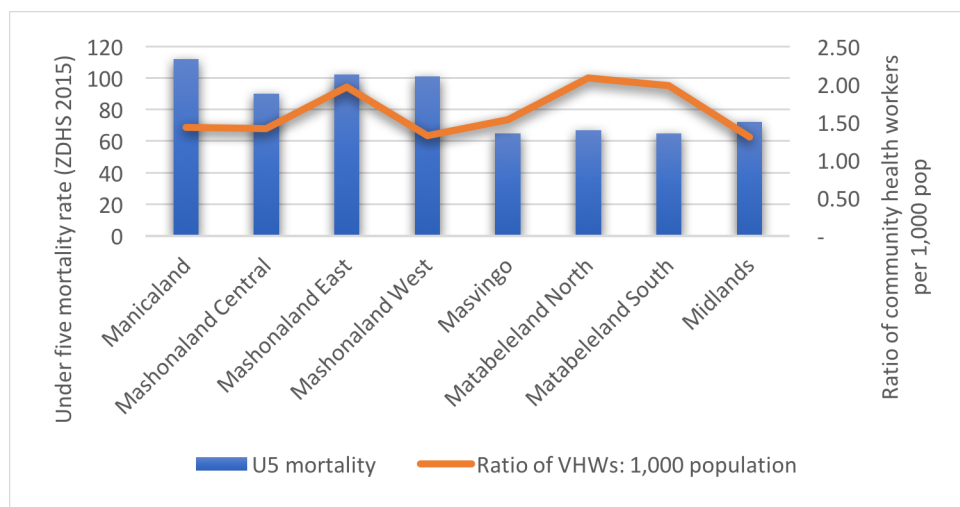


Figure 42. Coverage of village health workers, 2015 and 2017 (source: HDF annual reports 2016, 2017)

Although such improvement is a positive result achieved with support from the HDF, two considerations should be made. The first is that using a parameter of coverage of 1 VHW per village bears risks of generating issues of inverse equity. Not all villages will have the same population, and therefore a parameter of tailoring VHWs scale up to population size might be more appropriate.

The second is that, as it stands, the VHWs programme still presents a skewed distribution. As shown in **Figure 42**, the provinces with the highest density of VHWs are those where mortality is lower. Although child mortality is not necessarily the key parameter to be used to distribute VHWs, the example highlights the need to have a clear equity approach in mind, to be used to analyse inequities and to inform allocation of additional resources to the sector.



FINDING 24 AVAILABLE DATA AT MID-TERM DO NOT SHOW REDUCTIONS IN THE EQUITY GAP FOR KEY RMNCH INTERVENTIONS

5.144. The analysis presented below, drawing on available data from HMIS disaggregated by district, presents two examples of the possible effects of HDF interventions on equitable coverage/utilisation of key RMNCH+A interventions.

- ◇ At first, based on the available data on poverty at district level (Zimbabwe Poverty Atlas 2016), we selected the five better off and the five worse off districts of Zimbabwe, in terms of poverty index. These are reported below, in **Figure 44**.

Figure 44. Better off and worse off districts of Zimbabwe, in terms of Poverty Index (2016)

We then plotted the HMIS available data for these districts, for selected, available indicators of utilisation of care, expressed in terms of number of contacts with the health services, per year.

Data were plotted for the period 2014-2017.

The analysis presented overleaf shows a mixed picture. Although point estimates for each year cannot be compared between clusters, due to the different population size of the clusters, the trends observed from 2014 to 2017 across the two sets of districts show:

DISTRICT	POVERTY INDEX (2016)
Masvingo	0.482
Kwekwe	0.565
Shurugwi	0.567
Goromonzi	0.597
Makoni	0.610
Lupane	0.846
Bubi	0.866
Mudzi	0.889
Tsholotsho	0.890
Hurungwe	0.892

- A strong reduction in the equity gap for ANC, with an average annual rate of increase in consultations against the baseline year of 7% in the cluster of worse off districts vs -8% in the better off ones (**Figure 45**);
 - A moderate reduction in the equity gap for SBA, with an average annual rate of increase in consultations against the baseline year of 5% in the cluster of worse off districts vs no change in the better off ones (**Figure 48**);
 - No substantial reduction in the equity gap for all the other indicators tracked. For family planning, the annual average rate of change is 25% in better off districts vs 15% in worse off districts (**Figure 50**); for PNC visits, the annual average rate of change is 8% in better off districts vs 6% in worse off district (**Figure 46**); for immunisation, the annual average rate of change is 1% in better off districts vs 2% in worse off districts (**Figure 47**).
- ◇ Secondly, we have compared the same indicators across two provinces, Mashonaland East which presents the highest rate of under-five mortality in the country (102 per 1,000 live births), and Masvingo, which was purposively chosen as representative of the average mortality rate of the country (65 per 1,000 live births). The results of this second analysis do not show any evidence from available data of a reduction in the equity gap for those most in need, in this case for the province where child mortality is higher. (**Figures 49 to 52**)

5.145. Two possible lenses of analysis have been applied to assess whether the HDF, besides adopting highly equitable interventions, has also contributed to prioritise those most in need in receiving such intervention. There is no evidence to support this case.

Figure 45. Number of ANC visits (4 or more), 2014-2017 (Source: HMIS)

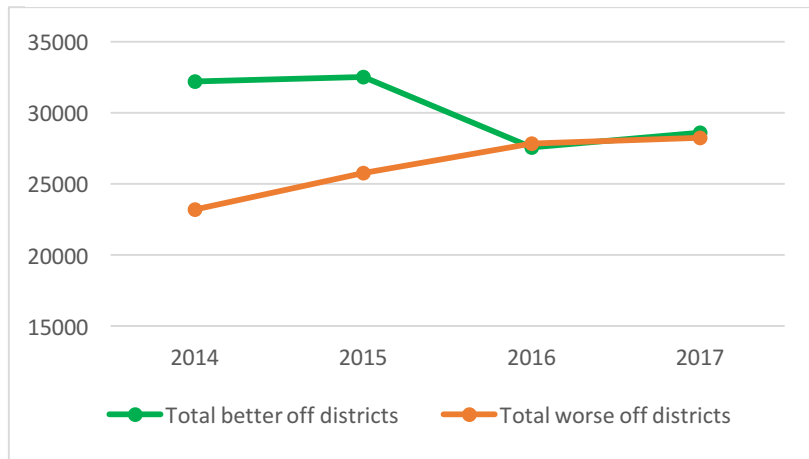


Figure 48. Number of live births at facilities, 2014-2017. (Source: HMIS)

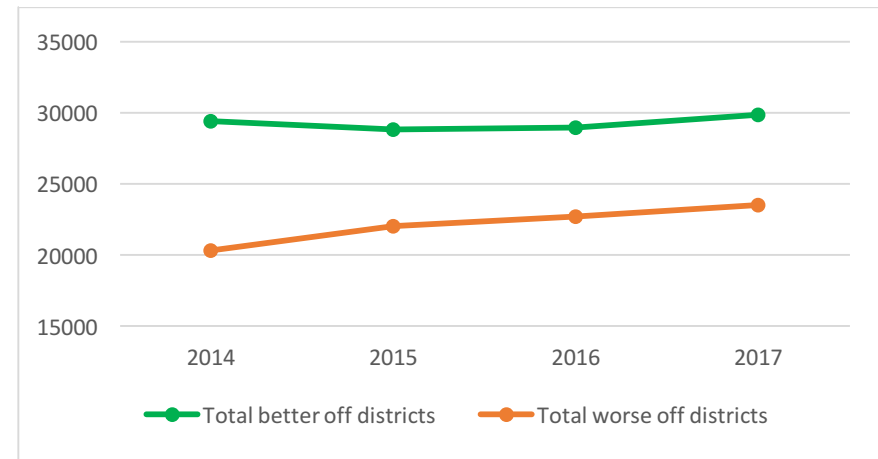


Figure 46. Postnatal care check ups (7 days), 2014-2017. (Source: HMIS)

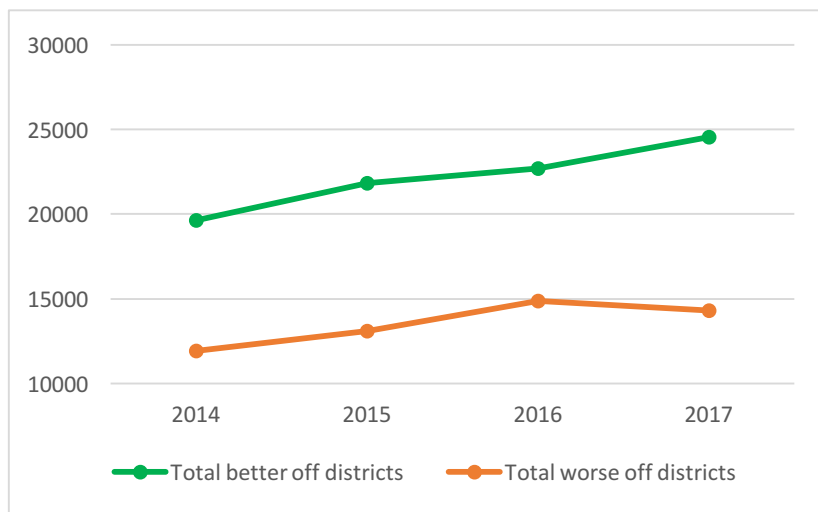


Figure 47. Children immunized with PCV 3rd dose, 2014-2017. (Source: HMIS)

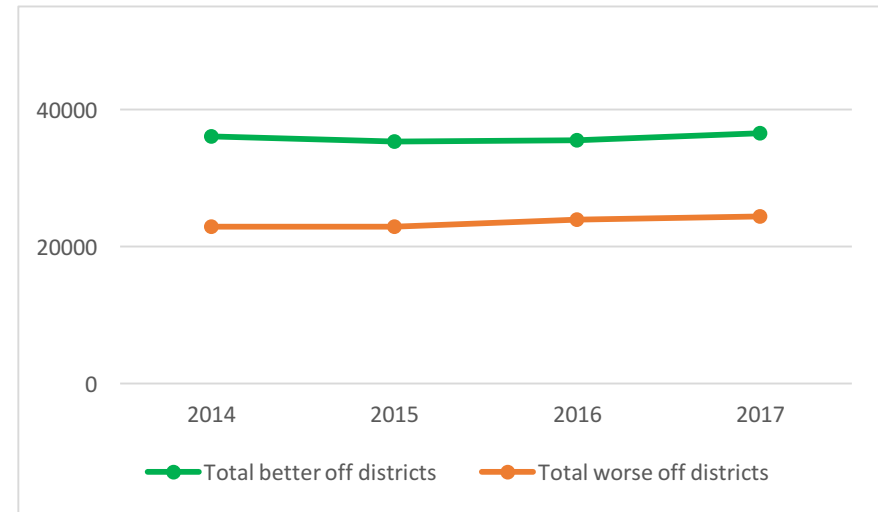


Figure 50. Repeated visits for oral pills, 2014-2017 (Source: HMIS)

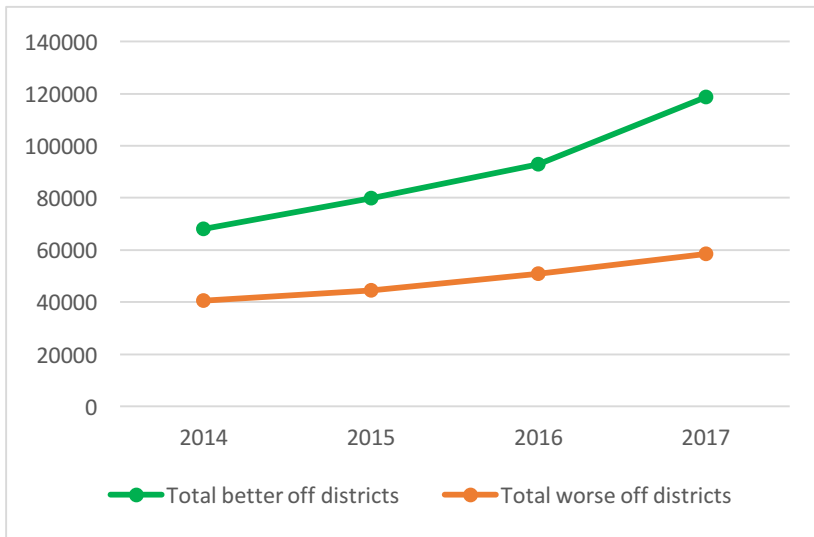


Figure 49. Postnatal care visits (7 day). Masvingo and Mashonaland East. (Source: HMIS)

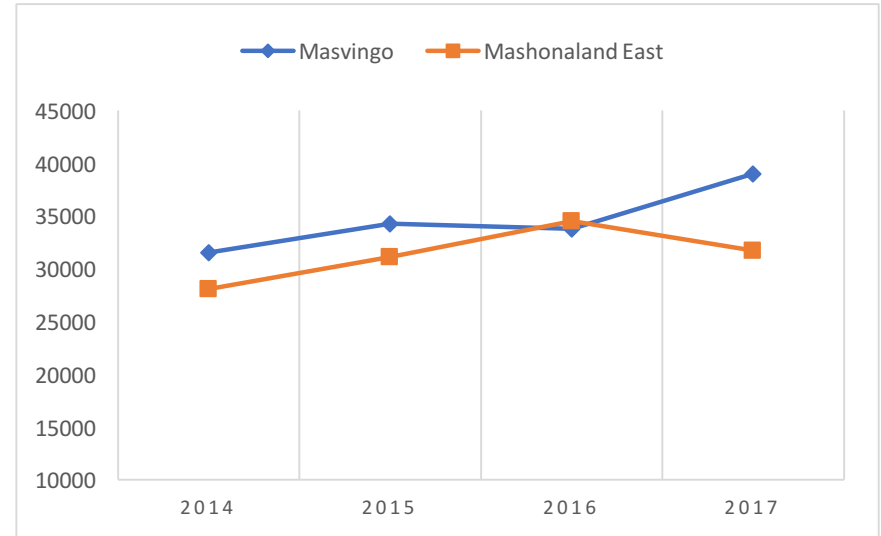


Figure 51. Live births at healthcare facilities. Masvingo and Mashonaland East, 2014 to 2017. (Source: HMIS)

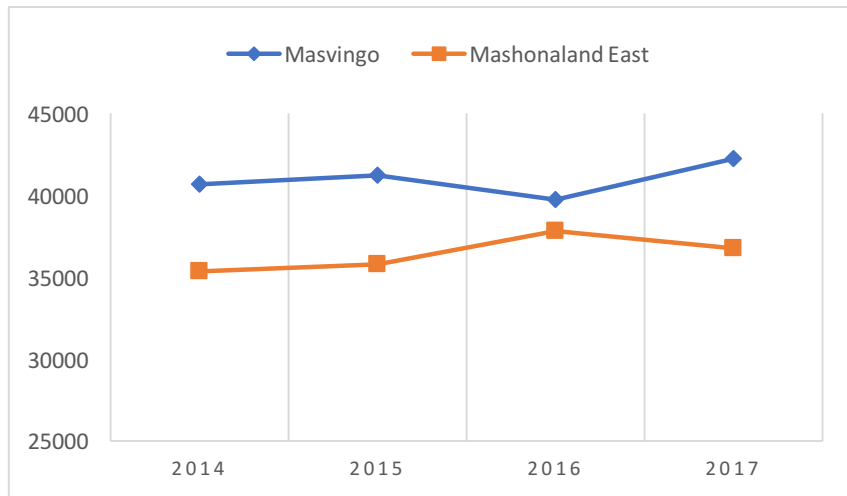


Figure 52. ANC visits (4 or more). Masvingo and Mashonaland East, 2014 to 2017 (Source: HMIS)

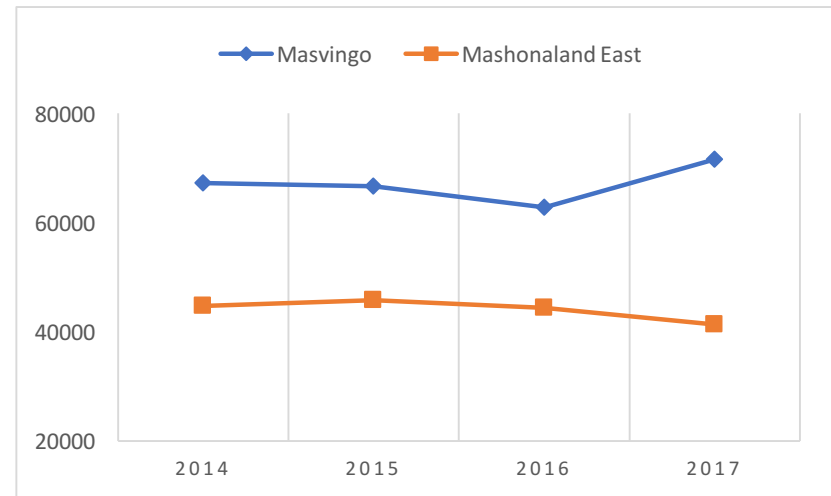


Figure 53. Children immunised with 3rd dose of PCV, Masvingo and Mashonaland East, 2014-2017

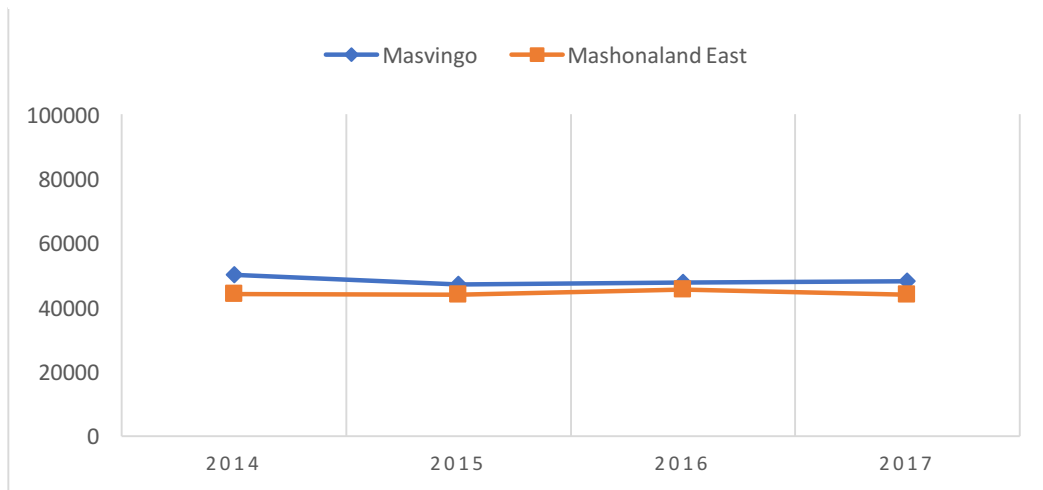
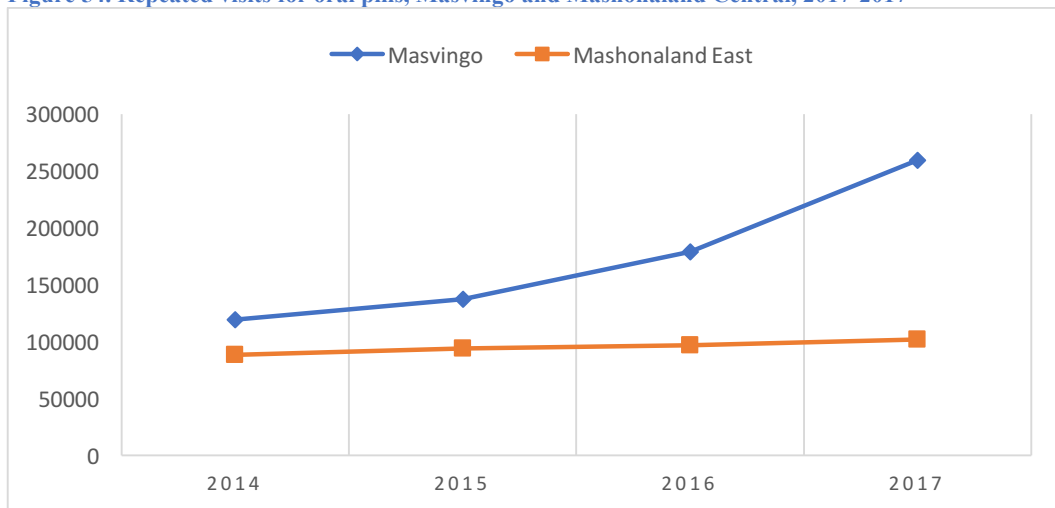


Figure 54. Repeated visits for oral pills, Masvingo and Mashonaland Central, 2014-2017



Efficiency and Value for Money

EQ8. What are the costs of the HDF and what are the main cost drivers related to fund management and implementation?

- 5.146. Resources expended over the course of the HDF Fund during 2016 and 2017 span 18 resources input categories ranging from advocacy and communication to financing, human resource incentives and allowances to procurement of medicines and supplies, and technical assistance to supervision and mentoring.
- 5.147. **Table 25** below presents the main cost driver categories along with the proportion of HDF expenditure funded or pledged during the course of HDF 2016-2017 implementation. The major cost drivers include procurement of medicines and supplies (27.39%), HRH incentives and allowances (16.16%) and financing (13.52%). Minor cost drivers, defined as those categories under 1% of expenditure include supervision, advocacy and communication, mentoring, and support to TWGs.

Table 25. Health Development Fund (HDF) main cost drivers and the proportion of HDF Expenditure (Funded or Pledged), 2016-2017

Cost Drivers	Proportion of HDF Expenditure Funded or Pledged
Advocacy and communication	0.79%
Coordination and planning meetings	2.02%
Financing	13.52%
HRH incentives and allowances	16.16%
M&E	3.23%
Mentoring	0.88%
Policy and guidelines design/distribution	1.46%
Procurement of medicines and supplies	27.39%
Procurement/management of equipment	3.84%
Research/assessments/pilots	4.49%
Service delivery	5.04%
Shipment, storage and distribution	2.19%
Social mobilisation	5.01%
Supervision	0.59%
Technical assistance	2.02%
Technical working groups	0.34%
Training	6.88%
Programme support costs	4.15%
Grand Total	100.00%

- 5.148. **Table 26** below indicates the 2016 and 2017 planned budget, total USD 270.86 million and total actual expenditures, total USD 113.94 for the HDF Fund across all thematic areas (also summed as direct programme costs with management costs).

Table 26. Total Planned Budget 2016/17 and Actual Expenditure 2016/17 (\$USD millions)

Thematic and resource area	Budget				Expenditure				% Spent vs planned Budget
	2016	2017	TOTAL BUDGET	%	UNICEF16 /17	UNFPA 16/17	TOTAL EXP	%	
1 RMNCH/A	7.97	8.57	16.54	6.1%	18.7	1.21	19.9	17%	120.3%
2. SRHR	37	54	91	33.6%		15.29	15.3	13%	16.8%
3. PSM	39.09	40.57	79.66	29.4%	27.2	6.37	33.6	29%	42.1%
4. HRH	14.53	13.28	27.81	10.3%	11.8	0.00	11.8	10%	42.4%
5. Finance	11.07	11.32	22.39	8.3%	19.5	0.00	19.5	17%	87.1%
6 Policy planning and me	4.97	4.87	9.84	3.6%	2.3	1.68	4.0	3%	40.4%
7. Innovation	4.5	5.12	9.62	3.6%	2.7	0.00	2.7	2%	28.1%
<i>Direct programme costs</i>	119.13	137.7	256.86	94.8%	82.2	24.55	106.7	94%	41.6%
Programme management costs	7	7	14	5.2%	4.2	2.99	7.2	6%	51.4%
Total Programmable budget/exp	126.13	144.7	270.86	100.0	86.4	27.54	113.94	100	42.1

5.149. The total planned budget for 2016 was USD 126.13 million, while the total planned budget for 2017 was USD 144.73 million, both years reflecting 94.8% direct programme costs, and 5.2% programme management costs.

5.150. Expenditures combined for the two-year period are shown separately for both UNICEF and UNFPA, HDF main implementers. Spending for UNICEF over 2016 and 2017 totalled USD 86.4 million and spending for UNFPA totalled USD 27.54 over the same period. Proportionally, the highest amount of spending occurred in thematic areas 1 (RMNCH/A), 3 (PSM), and 5 (Finance), at 17%, 29%, and 17%, respectively. UNICEF and UNFPA programme management costs remained constant at 6%.

5.151. When comparing expenditures to original budget over the two years of implementation, changes in resource allocation occurred primary in the following thematic areas (RMNCH/A, 17% versus planned 6.1%, SRHR 13% versus planned 33.6%, Finance, 17% versus planned 8.3%).

5.152. Total HDF spending amounted to 42% of the originally planned HDF budget. This proportion reflects the availability of funds provided by donors to the fund over the course of implementation thus far.

5.153. The average spending for the HDF is estimated to be 5.18 USD per capita. Although health service packages differ in scale and scope, per capita spending estimates of the HDF can be understood within the context of average basic health service package costs in low income and fragile state countries, which generally range from 5-10 USD per capita, depending on the cost perspective and inclusivity of resources in the calculation.^{69,70} This level of spending, and its relative variation among provinces, can be informative for both cost-effectiveness analyses and equity analysis.

⁶⁹ Cost analysis of the Essential Package of Health Services (EPHS) in Somalia, 2014, HEART.

⁷⁰ Note that country data may differ in terms of definitions, data-collection methods, population coverage and estimation methods used: see <http://wdi.worldbank.org/table/2.15>

EQ9. What is the Value for Money of HDF when relating these costs to economy, efficiency, effectiveness, and equity?

FINDING 25 THE HDF IS COST EFFECTIVE AND PROVIDES GOOD VALUE FOR MONEY

5.154. In order to understand VfM within the HDF, it is critical to relate costs to the VfM categories of efficiency, economy, effectiveness and equity. This lens can provide insight into the timeliness of disbursement and the flow of funds, unit costs relative to market prices and international benchmarks, overall cost-effectiveness of the fund (relative to national public health indicators), and equity of the fund in terms of its distribution across the population.

5.155. These critical components of VfM assessment are presented below.

a) Efficiency

5.156. The average time between a funding request by the MoHCC and disbursement of funds by UNICEF is an indicator, which reflects process efficiency in execution of the Health Development Fund. **Table 27** indicates a sample of four activities for which there was a funding request including the request date, the disbursement date, number of days to disbursement and the disbursed amount. The average days to disbursement among the small sample of activities is 15.75 days and reflects a standard level of disbursement efficiency of two weeks. Continued timeliness with regard to funding disbursement will ensure continued efficiency of financial flows.

Table 27. Sample HDF Activity Funding Requests and Time to Disbursement of Funds

Cash transfer request	Request date	Disbursement date	Days to disbursement	Amount
Village health worker training	May 3, 2017	May 10, 2017	7 Days	\$170,000
Nutrition training	June 21, 2018	July 5, 2018	14 Days	\$66,022
Support to clinical mentorship activities	August 16, 2018	August 30, 2018	14 Days	\$89,683
Training and equipment of service providers	July 31, 2017	August 29, 2017	28 Days	\$45,721

b) Economy and Efficiency

5.157. Examining unit costs of sample resource items related to HDF implementation is effective for understanding VfM at a detailed level of resource cost inputs relative to market prices. During the data collection phase, invoices and costings were provided to show evidence of unit costs incurred during the first two years of HDF implementation. **Table 28** below provides the sample of cost items, a market comparator and estimated difference. In the HDF evaluation inception report, LSTM proposed the following cost comparison ranking for HDF resource input costs. HDF Unit costs are scored accordingly in the last column of the table relative to the comparator.

RANKING	DESCRIPTION OF COST EVALUATION
Highly acceptable	Costs are in alignment with relative standards (+/-5%)
Acceptable	Costs are benchmarked with relative standards (+/-15%)
Limited acceptability	Costs are benchmarked with relative standards (+/-15% to +/-25%)
Unacceptable	Costs are benchmarked with relative standards (+/- greater than 25%)

5.158. **Table 28** below indicates sample resource cost items, unit costs under HDF and a cost comparator within market context, along with a source of the comparator, calculated difference and acceptability of difference.

Table 28. HDF Sample Resource Cost Items and Market Comparator

Sample resource cost items	Unit cost under HDF	Comparator or Cost	Source of comparator	Difference	
Depo Provera	\$22.03	\$25.40	https://www.healthpolicyproject.com/pubs/243_GhanaFPCostingStudyFINAL.pdf	-13%	Acceptable
Secure (pack of 3)	\$0.89				
Implanon	\$8.50				
DSA rates	\$75				
National consultancy daily fee rates	\$400	\$425	UN remuneration for consultants (B-level average)	-6%	Highly acceptable
Cost of fuel (per litre)	\$1.25	\$1.41	Market price	-12%	Acceptable
Communication campaigns	\$2,850	\$3,000	Basic national advertising campaign	-5%	Highly acceptable

c) Cost-effectiveness

5.159. Understanding cost-effectiveness of the HDF is critical for informing funders, decision-makers, and implementers about this core VfM component for both evaluation purposes and investments going forward. WHO considers national strategies and interventions to be cost-effective if the cost per DALY averted is less than three times the Gross Domestic Product per capita (GDP-PC) and highly cost-effective if less than the GDP-PC. The GDP per capita in Zimbabwe 2018 is estimated at USD 1,079 according to World Bank sources.

5.160. Due to limited impact data availability and constraints to achieving a high level of precision in the analysis, at the time of this midterm review, it was not possible to conduct a “full perspective” cost-effectiveness analysis of the HDF (including all costs and all impacts). Rather, a partial cost-effectiveness analysis of the HDF was conducted to examine the relationship between costs (expenditures of the HDF through 2017), and reductions in mortality of children under 5⁷¹, and subsequent deaths averted, and DALYs averted⁷².

5.161. For this analysis, costs were allocated to child health according to a review of total HDF funded and pledged activities during 2016 and 2017 including direct child health costs and indirect expenditures, (health systems strengthening, etc.). This allocation of indirect costs was based on the proportion of newborns and children under 5 in the targeted HDF stakeholder groups (42.3%). The total cost allocation to child health under the HDF is estimated to be USD 52,911,146 and calculated as follows based on total pledged or funded amounts under the HDF (Child Health Specific Expenditures: USD 614,348, Community Health Systems Strengthening: USD 2,656,634, EPI: USD 9,354,517, Health Systems Strengthening Allocation USD 19,232,677, Nutrition: USD 12,003,339, Programme Support Costs: USD 295,139 and RMNH Allocation USD 8,754,490).

5.162. Given different Under 5 Child Mortality (U5MR) estimates from various sources, a sensitivity analysis was conducted. A cost-effectiveness sensitivity analysis was conducted by applying alternative expected child health outcome scenarios of the HDF, by varying direct benefits based on possible different outcomes of changes in

⁷¹ Estimates generated by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2018, Zimbabwe

⁷² Institute for Health Metrics and Evaluation (IHME), Global Health Data Exchange, 2016

U5MR⁷³. Changes in the U5MR include estimates generated by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2018, Zimbabwe as well as from the impact indicator estimates of the DFID/HDF LF. The sensitivity analysis provides for specification of the cost-effectiveness analysis within a context of uncertainty.

5.163. The base case assumes median bound estimates for changes in under 5 mortalities in Zimbabwe as follows:

U5MR - 2015	U5MR - 2016	U5MR - 2017
57	53.3	50.3

5.164. **Table 29** below presents the base care cost-effectiveness estimation of cost per child death and DALY averted (2016-2017).⁷⁴ The total number of child deaths averted each year in Zimbabwe corresponds with the change in the U5MR from the previous year. The number of child deaths averted in 2016, relative to 2015 is 1,994 while the total deaths averted in 2017 is 1,617. The total number of deaths attributed to the HDF is 506. This number represents 14% of children under 5 deaths in Zimbabwe during 2016 and 2017 and corresponds with the proportion of the Zimbabwe RMNCH costs (USD 113,935,035) covered by the HDF.

5.165. As a result, the cost per child death averted is USD 104,654, yielding a cost per DALY averted of USD 1,199 (based on a ratio of 87 DALYs averted per child death averted⁷⁵). The resulting cost per DALY averted is 1.11. Under WHO guidelines, this analysis shows that the HDF intervention is cost-effective when relating costs to children under 5 lives saved.

Table 29. Base Case (Median) Cost-Effectiveness estimation of Cost Per Child Death (U5) and

Indicators and estimates	2015 estimate	2016 estimate	2017 estimate
Under 5 mortality rate (per 1,000 births)	57	53.3	50.3
Live births	539,000	539,000	539,000
Total estimated under 5 deaths per year	30,723	28,729	27,112
Calculations			
Total deaths averted in 2 years (Child)		1994	1617
Total deaths averted attributed to HDF contribution (14%) – 2 years			506
Total HDF programme Investment (USD)			\$52,911,146
Cost per child death averted (attributed to HDF), USD			\$104,654
Average DALYs averted per death averted			87.31
Cost per DALY averted - USD			\$1,199
Zimbabwe - Gross Domestic Product - Per Capita (2018 est.)			\$1,079
Standard Cost per DALY averted difference measure			1.11
WHO Guidelines			
<=1 (highly cost-effective), >1<3 (cost-effective), >3 (not cost-effective)			

⁷³ Estimates generated by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2018, Zimbabwe

⁷⁴ Maternal mortality estimates are not applied in this calculation as data are not available during this period.

⁷⁵ Institute for Health Metrics and Evaluation (IHME), Zimbabwe data 2016.

Sensitivity analysis - Scenario 1

5.166. A cost-effectiveness sensitivity analysis was conducted by applying alternative expected outcome scenarios of the HDF, by varying direct benefits based on possible different outcomes of changes in U5MR⁷⁶. The sensitivity analysis assumes lower bound estimates for changes in U5MR in Zimbabwe as follows:

U5MR - 2015	U5MR - 2016	U5MR - 2017
45	39.8	35.6

5.167. **Table 30** below presents the lower bound cost-effectiveness estimation of cost per child death and DALY averted (2016-2017).⁷⁷ The total number of child deaths averted each year in Zimbabwe corresponds with the change in the U5MR from the previous year. The number of child deaths averted in 2016, relative to 2015 is 2,803 while the total deaths averted in 2017 is 2,264. The total number of deaths attributed to the HDF is 709. Again, this number represents 14% of children under 5 deaths in Zimbabwe during 2016 and 2017 and corresponds with the proportion of the Zimbabwe RMNCH costs (USD 52,911,146) covered by the HDF.

5.168. As a result, the cost per child death averted is USD 166,947, yielding a cost per DALY averted of USD 1,919 (based on a ratio of 87 DALYs averted per child death averted⁷⁸).

5.169. The resulting cost per DALY averted is 1.78. Under WHO guidelines, this analysis shows that the HDF intervention is cost-effective when relating costs to children under 5 lives saved and more cost-effective compared to the median estimate.

Table 30. Lower Bound Cost-Effectiveness Estimation of Cost Per Child Death (U5) and

Indicators and estimates	2015 estimate	2016 estimate	2017 estimate
Under 5 Mortality Rate (per 1,000 births)	45	39.8	35.6
Live births	539,000	539,000	539,000
Total estimated under 5 deaths per year	24,255	21,452	19,188
Calculations			
Total deaths averted in 2 years (Child)		2803	2264
Total deaths averted attributed to HDF contribution (14%) - 2 years			709
Total HDF programme Investment (USD)			52,911,146
Cost per death averted (attributed to HDF), USD			166,947.94
Average DALY averted per death averted			87.00
Cost per DALY averted - USD			1,919
Zimbabwe - Gross Domestic Product - Per Capita (2018 est.)			1,079
Standard Cost per DALY averted difference measure			1.78

⁷⁶ Estimates generated by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2018, Zimbabwe

⁷⁷ Maternal mortality estimates are not applied in this calculation as data are not available during this period.

⁷⁸ Institute for Health Metrics and Evaluation (IHME), Zimbabwe data 2016.

Sensitivity Analysis - Scenario 2

5.170. This sensitivity analysis assumes upper bound estimates for changes in U5MR in Zimbabwe as follows:

U5MR - 2015	U5MR - 2016	U5MR - 2017
70.9	68.9	67.9

5.171. **Table 31** below presents the upper bound cost-effectiveness estimation of cost per child death and DALY averted (2016-2017).⁷⁹ The total number of child deaths averted each year in Zimbabwe corresponds with the change in the U5MR from the previous year. The number of child deaths averted in 2016, relative to 2015 is 1,078 while the total deaths averted in 2017 is 539. The total number of deaths attributed to the HDF is 226. Again, this number represents 14% of children under 5 deaths in Zimbabwe during 2016 and 2017 and corresponds with the proportion of the Zimbabwe RMNCH costs (USD 52,911,146) covered by the HDF.

5.172. As a result, the cost per child death averted is USD 233,727, yielding a cost per DALY averted of USD 2,677 (based on a ratio of 87 DALYs averted per child death averted⁸⁰). The resulting cost per DALY averted is 2.48. Under WHO guidelines, this analysis shows that the HDF intervention is not cost-effective when relating costs to children under 5 lives saved and certainly less cost-effective compared to the lower bound and median estimates.

Table 31. Upper Bound Estimation of Cost Per Child Death (U5) and DALY averted

Indicators and Estimates	2015 estimate	2016 estimate	2017 estimate
Under 5 Mortality Rate (per 1,000 births)	70.9	68.9	67.9
Live births	539,000	539,000	539,000
Total estimated under 5 deaths per year	38,215	37,137	36,598
Calculations			
Total deaths averted in 2 years (Child)		1078	539
Total deaths averted attributed to HDF contribution (14%) – 2 years			226
Total HDF programme Investment (USD)			\$52,911,146
Cost per death averted (attributed to HDF), USD			\$233,727
Average DALY averted per death averted			87.31
Cost per DALY averted - USD			2,677
Zimbabwe - Gross Domestic Product - Per Capita (2018 est.)			1,079
Standard Cost per DALY averted difference measure			2.48

5.173. The Upper Bound estimation of the U5MR represents very little change in the measure between 2015 and 2017 and is, as a result, expected to be less cost-effective relative to the base case and lower bound case estimations.

5.174. In summary, the cost-effectiveness analysis reflects that when applying the UNIGME estimates, the HDF is “cost-effective” relative to reducing child mortality when compared to international benchmarks and WHO cost-effectiveness guidelines.

⁷⁹ Maternal mortality estimates are not applied in this calculation as data are not available during this period.

⁸⁰ Zimbabwe, 2016, Institute for Health Metrics and Evaluation (IHME), Global Data Exchange

5.175. Going forward into the second half of the HDF, as more data become available and in order to assess the full perspective of cost-effectiveness, it will be important to consider costs relative to the other main impact measures and associated reductions in burden of disease including the changes in the maternal mortality ratio, changes in the child mortality rate, changes in prevalence of stunting in children under five, and changes in the number of unwanted pregnancies averted.

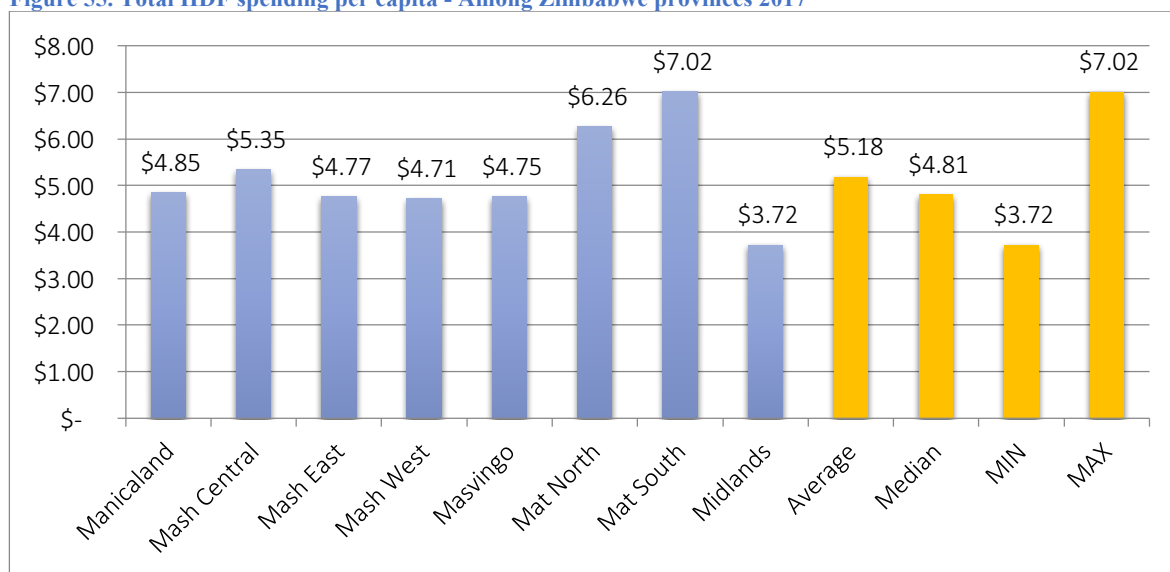
d) Equity

5.176. Understanding the distribution of costs across provinces provides some insight into the level of equitable distribution of HDF resources among the Zimbabwe population, although some cost difference among provinces and districts is to be expected. As previously indicated, the average per capita cost is USD 5.18 during 2017.

5.177. **Figure 55** below shows the total HDF spending per capita across eight provinces of Zimbabwe in USD. Total spending per capita is highest in Matabeleland South USD 7.02 per capita and lowest in Midlands 3.72. The median per capita cost estimate is 4.81.

5.178. In summary, the allocation across provinces is relatively equivalent with limited variation, which is primarily restricted to Matabeleland North and South, which are the least populated provinces.

Figure 55. Total HDF spending per capita - Among Zimbabwe provinces 2017



EQ10. How can available resources be used more efficiently and effectively, to maximise the benefits of the HDF?

5.179. The existing VfM Framework can assist the HDF going forward into the subsequent years of implementation. Measures are in accordance with VfM principles of economy, efficiency, effectiveness and equity. In order to strengthen this existing VfM framework in the context of HDF, **Table 32** below outlines proposed additional VfM measures to be tracked over the course of the remainder of HDF support.

5.180. By the end of HDF, the measure of cost-effectiveness is recommended to include maternal deaths averted, unwanted pregnancies averted, and cases of stunting averted in addition to child deaths averted, previously

presented in the VfM analysis. These data should be available by 2020, converted to DALYs averted and can be reflected accordingly.

Table 32. Proposed VfM Framework for the remainder of the HDF until 2020.

VfM component and measure	Description of the measure	Justification (HDF and partners) needs	Data sources	Periodicity	Comparators/ benchmarks and example literature
COST-EFFECTIVENESS					
Unit cost per unwanted pregnancy averted	Total allocated intervention costs over x years (numerator)/ estimated number of unwanted pregnancies averted (denominator)	HDF understands full benefits of programme investment	Economic modelling by Economist or HDF staff	Final programme two years	International Health Economics Literature, example Adam, T, Lim, SS, Mehta, S et al. Cost effectiveness analysis of strategies for maternal and newborn health in developing countries. BMJ. 2005; 331: 1107
Unit cost per stunting case averted	Total allocated intervention costs over x years (numerator)/ estimated number of stunting cases averted (denominator)	HDF understands full benefits of programme investment	Economic modelling by Economist or HDF staff	Final programme two years	Bhutta, Zulfiqar A., Tahmeed Ahmed, Robert E. Black, Simon Cousens, Kathryn Dewey, Elsa Giugliani, Batool A. Haider, et al. "What Works? Interventions for Maternal and Child Undernutrition and Survival." The Lancet 371, no. 9610 (February 2, 2008): 417–40. doi:10.1016/S0140-6736(07)61693-6.
Unit cost per maternal death averted and child death averted	Total allocated intervention costs over x years (numerator)/ estimated number of maternal deaths and child deaths averted (denominator)	HDF understands full benefits of programme investment	Economic modelling by Economist or HDF staff	Final programme two years	Mobilising financial resources for maternal health Borghi, Jo et al. The Lancet, Volume 368 , Issue 9545 , 1457 - 1465
Unit cost per DALY averted	Total intervention costs over x years (numerator)/ estimated	HDF understands benefits of programme investment	Economic modelling by Economist or HDF staff	Final programme two years	International Health Economics Literature, example Adam, T, Lim, SS, Mehta, S et al. Cost effectiveness analysis of strategies

	number of DALYs averted over x years (denominator)				for maternal and newborn health in developing countries. BMJ. 2005; 331: 1107
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Sustainability

EQ6. What are the risks to sustainability of the results and outcomes produced through the HDF?

5.181. To address the evaluation question on sustainability, we explore the critical risks that may undermine the sustainability of the main HDF supported intervention strategies, from both a financial and a technical perspective. In doing so, the major intervention areas that will be explored are: procurement; capacity strengthening of human resources; RBF; community mobilisation activities. The key dimensions of sustainability that will be assessed are: scale (or scalability); technical transferability to government; costs and risks of financial sustainability. We will also assess whether there are strategies in place and defined to transition activities.

FINDING 26 THE HEALTH DEVELOPMENT FUND AT MID-TERM LACKS A TRANSITION PLAN. THIS IS A CRITICAL GAP FOR THE SUSTAINABILITY OF THE INTERVENTIONS SUPPORTED THROUGH THE PROGRAMME

5.182. Literature on pooled funds and multi donor trust funds points at exit strategies as one of the key features informing the success of these initiatives. In the words of Barakat⁸¹ ‘With *additional attention being provided to capacity development, activities, whether administrative or programmatic (...)* should be accompanied by exit strategies explaining the handover of external roles to the state. (...). This strategy is the responsibility of the recipient government but should be demanded by MDTF governance structures.’

5.183. A DFID review⁸² of pooled funds support this argument, pointing to the factual evidence that in most cases pooled funds lack exit strategies: ‘*The design of a pooled fund should include a flexible but clear goal on **what is intended when the fund’s mandate ends.** (...). In many cases, no consideration is given to exit strategy at the point of fund establishment, but you need the capacity to adapt your systems in line with your exit/transition strategy. Transitioning a fund to recovery too early can overload it with expectations resulting in failure. The vision for the pooled fund may include dissolving the fund and a completion process, or evolving to sector or general budget support, depending upon the context, but it is vital to avoid becoming entrenched in unchanging programming, prioritisation, and execution – doing the same thing year after year, driven by inertia rather than strategy.*’

5.184. **An exit strategy may entail various options, which do not necessarily imply a full ‘exit’.** Such options may include dissolving the fund completely; handing over the activities to the government, transitioning to budget support, or even shifting to another pooled fund if conditions do not allow to act otherwise.

5.185. At the end of 2016, the independent evaluation of the HTF⁸³ noted that the HTF – the predecessor of the HDF – lacked an exit strategy and this had been a weakness of the initiative. At the time of this writing and to the best of our knowledge, the HDF does not have a comprehensive exit strategy in place as yet.

5.186. This midterm evaluation is an opportunity for the SC to reflect on results, achievements and bottlenecks encountered so far and to consider designing an exit strategy. Of note, the evaluation gives full credit to the MoHCC and other stakeholders for the fact that there is a transition plan in place for one of the key strategic pillars of the

⁸¹ Barakat, Sultan. (2009). The Failed Promise of Multi-Donor Trust Funds: Aid financing as an impediment to effective state-building in post-conflict contexts. Policy Studies

⁸² Pooled Funding to Support Service Delivery. Lessons of Experience from Fragile and Conflict Affected States. DFID, May 2013

⁸³ Evaluation report accessed at: https://www.unicef.org/evaldatabase/index_92882.html

HDF, the RBF. This is the 'RBF Institutionalisation Roadmap of the MoHCC'⁸⁴. Such case can serve as an example to draw a broader exist strategy encompassing the other interventions supported through the HDF.

FINDING 26 THE EXTERNAL ENVIRONMENT REMAINS A CRITICAL BARRIER TO TRANSFERABILITY AND LONG TERM SUSTAINABILITY OF THE HDF SUPPORTED STRATEGIES

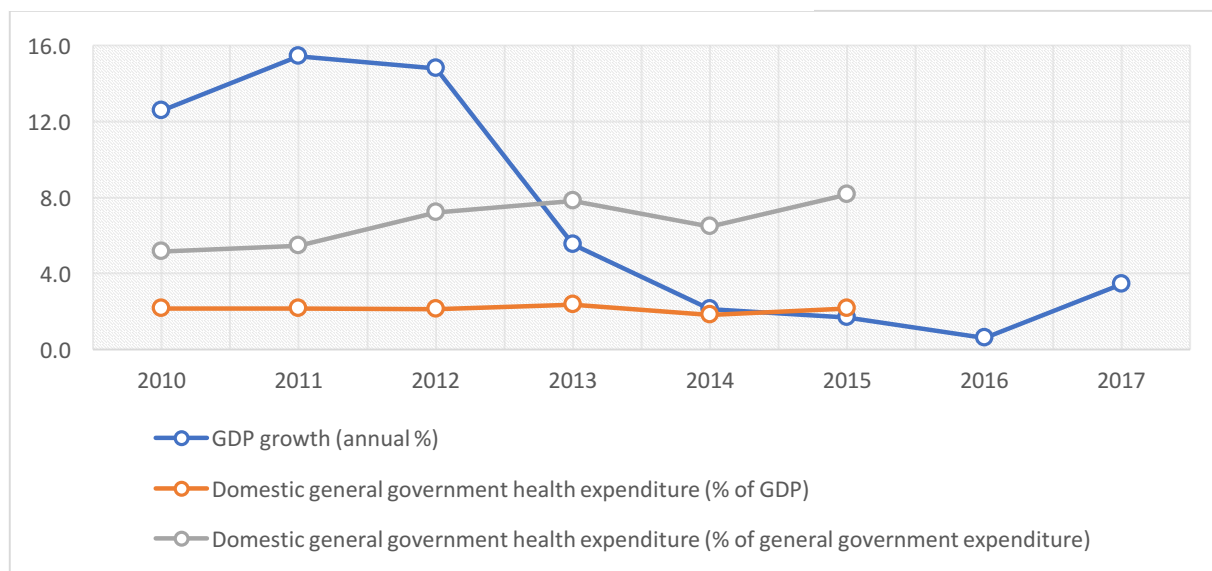
5.187. In other section of this report (See: Social, political and economic context, page 21) we have highlighted the complexity of the environment in which the HDF operates, and its current fragility in terms of social, political and economic outlook. This remains a critical feature that will require continuous monitoring and critical assessment from the SC, to inform judgements about the sustainability of and need for the HDF in the short and medium term.

5.188. The overall economic scenario, as well as the government expenditure on health, remain a major threat to the sustainability of the health gains achieved by Zimbabwe in recent years.

As shown in **Figure 56** below, available data⁸⁵ show that in the past eight years Zimbabwe has suffered a dramatic crisis in terms of economic growth. The GDP annual percentage growth has reduced to below 2% during the period 2014-2016. The World Bank estimates that the growth observed in 2017 will again 'slow to 2.7% in 2018 partly due to liquidity shortages. The overall trend is below population growth and thus negative in per capita income terms, contributing to higher poverty rates.'

The government health expenditure remains marginal in terms of proportion of the GDP (steady at about 2%), and despite some improvement, the government health expenditure remains at about 7% of the total government expenditure, therefore well below the Abuja target of 15%.

Figure 56. GDP growth and health expenditure in Zimbabwe, 2010-2017.



⁸⁴ Zimbabwe Health Financing Strategy. Ministry of Health and Child Care. 2017

⁸⁵ Data from database: World Development Indicators. Accessed at: <http://databank.worldbank.org/data/source/world-development-indicators#>

According to the *Analysis of the 2018 National Budget*⁸⁶ produced by the Community Working Group on Health, the government expenditure on health is largely absorbed by employment costs (72% of the total budget allocation for 2018), and by capital expenditure (7%).

Although additional efforts have been made by the Government to raise additional funds via various levies, it is evident that the support from external funds has been critical to sustain the recurrent costs of health service delivery in the country.

- 5.189. Although recent evidence regarding the health budget 2019 suggests positive efforts from the Government (See **Box 3**), the flexibility of external aid to sustain the country in its current situation of stagnant economic growth, and prolonged crisis of cash liquidity, will remain essential at least in the short term.

Box 3. Domestic funding for health

Domestic funding for health has gone up by 11 percent from 2017 to \$583 million this year, accounting for 59 percent of total resources in the health sector, Secretary for Health and Child Care Dr Gerald Gwinji has said.

Presenting the 2019 health sector budget framework before the Parliamentary Portfolio Committee on Health and Child Care on Wednesday last week, Dr Gwinji said of this amount, 78 percent (\$455 million) came from Government through budget allocations while the remainder was availed by local authorities and the National Aids Council (NAC).

He said the Health Levy, which is funded by airtime deductions, has so far received about \$42 million from Treasury and the allocations have since been channelled towards procurement of medicines, blood and blood products, medical equipment, vaccines, central hospital dialysis and BOC gases.

Source: <https://www.zimbabwesituation.com/news/domestic-funding-for-health-up/>

- 5.190. Despite of the efforts, it is worth noting that a recent analysis of fiscal space for health financing in Zimbabwe⁸⁷ clearly indicates that *‘In the short and medium term, the National Health Strategy cannot be implemented without significant support from Development Assistance for Health. Even in the most optimistic scenario for domestic resource mobilization, the funding gap for the NHS would average 660\$ annually. Continued support from development partners to the levels registered between 2014 and 2016 would not suffice to close the funding gap’.*

- 5.191. From a purely funding perspective, the sustainability of the HDF supported strategies will depend on two major variables:

- The ability of the Government to continue to increase its allocation to health in the short/medium term, and
- The availability of HDF donors to commit to further investment in the health sector in Zimbabwe (via HDF or other mechanisms), in the current political and economic situation.

FINDING 27 THE DEGREE OF TECHNICAL SUSTAINABILITY AND TRANSFERABILITY OF THE MAJOR HDF SUPPORTED STRATEGIES VARIES ACROSS INTERVENTIONS. NOT ALL RISKS TO TECHNICAL SUSTAINABILITY MAY BE ADDRESSED WITHIN THE LIFE OF THE HDF

- 5.192. Besides considerations on the external environment and on the financial sustainability of interventions, there are also aspect of technical sustainability and transferability of the interventions, that needs addressing. We have adapted a sustainability framework for development interventions developed by the Centre for Design and Research in Sustainability⁸⁸, and mapped the key variables that will influence sustainability of various HDF

⁸⁶ Accessed at: <http://www.cwgh.co.zw/cwgh-input-to-the-2018-national-health-budget/>

⁸⁷ Analysing Fiscal Space Options for Health in Zimbabwe. The World Bank, 2017

⁸⁸ CEDARS: <http://www.cedarscenter.com/index.cfm>

supported interventions. The mapping exercise is summarised overleaf, in **Table 33**, and present the degree of sustainability of intervention strategies against the following criteria: enabling environment; organisation capacity; community capacity; scale and scale-ability; and non-financial risks to sustainability.

Key considerations for each of the strategies assessed are then presented more in detail in the following paragraphs.

Table 33. Sustainability of HDF supported interventions

Intervention	Enabling environment	Organisational capacity	Community capacity	Scale and scale-ability	Risks to sustainability (non-financial)
Results based financing	<p>Commitment from MoHCC to adopt RBF as a strategy Institutionalisation plan in place</p> <p>RBF unit set in place at MoHCC with support from WB/Cordaid.</p> <p>Unit not yet functional/tested since WB/Cordaid support is currently frozen.</p> <p>Unit is the CCM management unit of GF, hence not fully sustainable/integrated within MoHCC</p> <p>RBF scheme still completely reliant on external funding</p>	<p><u>At national level</u> Programme currently managed and implemented via external agents.</p> <p>Operational problems persist in terms of timeliness of payment and complexity of the procedures involved in the scheme</p> <p><u>At local level</u> Programme implemented with support of DHEs and of CBOs (800+) for monthly verifications and assessments at facility level</p>	<p>Communities involved in RBF via HCC, with HCCs established in all facilities of the country, and functional</p> <p>Community capacity to influence investment of RBF funds via HCCs requires further strengthening</p>	<p>Programme currently implemented at full scale</p>	<p>Capacity of RBF management unit not tested (central)</p> <p>PMU is not an MoHCC structure</p> <p>Complexity of verification system (monthly verifications, multiple subcontractors involved)</p> <p>Complexity of payment system</p>
Procurement of medicines, commodities and supplies	<p>Current issues with procurement due to cash crisis (Funding Partners used as 'currency swap mechanism' for procurement)</p> <p>Increase in national allocation to health primary utilised to sustain procurement</p>	<p><u>At national level</u> Procurement managed via international supply mechanisms via UNICEF and UNFPA</p> <p>Distribution managed via local systems Limited evidence of efficient functioning of ZAPS</p> <p><u>At local level</u> Regulation regarding spending of RBF for procurement on local market unclear Local distribution</p>	n/a	<p>Programme currently implemented at full scale for selected products</p>	<p>Feasibility of national procurement due to current cash crisis</p> <p>Capacity of Natpharm to manage procurement at scale</p> <p>Parallel procurement systems</p> <p>Maintenance of equipment (capacity & spare parts)</p>

<p>Capacity strengthening of human resources for health</p>	<p>Strong capacity of Zimbabwe to produce highly skilled health professionals</p> <p>Training curricula fully embedded within national health system</p> <p>Mentorship guidelines in place</p>	<p>HDF supported training and mentorship activities fully implemented via national resources</p>	<p>n/a</p>	<p>In service training supported via HDF fragmented by programs.</p> <p>Mentorship supported at scale</p>	<p>National Training plan</p> <p>Availability of domestic resources to continue training and mentoring at the same levels</p> <p>Availability and retention of trainers and mentors to continue</p>
<p>Community health system strengthening</p>	<p>CHS currently under design. At the moment, multiplication of cadres and initiatives</p>	<p><u>At national level</u></p> <p>No clear accountability within MoHCC</p> <p><u>At local level</u></p> <p>Multiple accountability mechanisms at community level</p>	<p>High involvement in/ownership of community-based initiative.</p> <p>Strong support to VHWs</p>	<p>VHWs close to full scale</p> <p>Other community-based programs fragmented and implemented with limited focus (geographical and thematic)</p>	<p>Definition of an integrated strategy for CHSS, with clear accountability mechanisms at central and local levels, definition of harmonized cadres for community work with clear criteria for selection, training, remuneration. Agreed scope of work for community cadres.</p> <p>MoH capacity/systems to coordinate VHWs</p> <p>Responsibility and accountability within MoH for the community health programme and VHWs</p>

5.193. **Results-based financing**

The commitment from the Government to institutionalise the RBF constitutes a strong base to consider transition of this component from the pooled fund to the MoHCC.

The feasibility of such transition at scale in the short term is undermined by two major variables:

The first, is that the Unit set within the MoHCC, with the support of the WB and Cordaid, is not yet operational. This is largely due to the fact that the 18 Districts where RBF is implemented with WB support – which are meant to be the test for the transition of the scheme – have seen an interruption of activities during the course of 2018.

In addition to that, the Unit identified to manage the RBF is not a fully ‘owned’ unit within the MoHCC, since such unit is the GF management unit, that is therefore conditional to future support from the GF.

The second broad set of issues has to do with the technical transferability of the current model, which entails an extremely demanding process in terms of payments, verifications, and data collection. No road map or operational plan has been accessed by the evaluation, explaining how all the procedures, processes and systems that are currently managed via external agents would be supported by a single Unit within the MoHCC.

5.194. **Procurement**

The procurement of medicines, commodities and supplies via UNICEF and UNFPA has been, by definition, a temporary measure, that has instead become a permanent and convenient solution to overcome various issues that have to do with national procurement.

In the short term, the major bottleneck to sustainability at macro level is the cash liquidity crisis that Zimbabwe is facing. In fact, external agents have served as a ‘clearing house’ in currency terms, for the Ministry as well, to access international markets efficiently and at convenient prices.

Unless such crisis is resolved, no viable alternative is anticipated to transition the procurement function to the MoHCC.

Concurrently, the evaluation has identified and confirmed issues (lead times; expiry of drugs; stock outs) – well documented through other sources as well – that have largely to do with critical bottlenecks within the supply chain. Problems with bottom up quantification, management of orders, timeliness of distributions, expiry of medicines and stock outs, are clear symptoms of systemic technical weaknesses that will need immediate attention and further adjustment, with the contribution of the HDF and of other partners.

5.195. **Capacity strengthening of human resources for health**

Most of the efforts set in place via HDF, from the design of curricula and policies to the assessments of training needs and to the delivery of training and mentorship, have been implemented relying on local capacity and resources.

No major non-financial risks are seen, to transition these activities to the MoHCC

5.196. **Community health system strengthening**

Consistently with the comments presented above re HRH, the community health interventions – at least those implemented at national scale with the support of the HDF – have fully relied on local health system and community capacity.

Although operational problems persist in the implementation of the VHW programme (delays in payment of allowances, lack of equipment and supplies, fragmented training), the major issue remains the definition of a

policy framework that harmonises under one umbrella the accountability, scope of work, selection criteria, remuneration policies, training packages, supervision approaches of the multiple cadres currently operating at grassroots level within the community health system.

This issue has been clearly (and correctly) identified by MoHCC and partners as a priority. As soon as the policy and guidelines are produced, no major barrier is seen at health system and community level, to transition the VHWS programme in full to the MoHCC.

SECTION 6. CONCLUSIONS AND LESSONS LEARNED

Conclusions

- 6.1. The HDF has implemented from the period 2016 to mid-2018 (midterm) to a scale of an approximate investment of 115 million USD (2016-2017 only), to support the MoHCC Health Strategy 2016-2020.
- 6.2. Designed as a natural evolution of the HTF, the HDF was conceived on the basis of two overarching assumptions. The first was that the country would transition to a phase of growth and stability that would allow progressive hand over of interventions to the MoHCC, hence prioritising capacity strengthening over direct service delivery. The second assumption – largely a preventable risk – was that the HDF would succeed in attracting funding in the region of about seven times of what has currently been leveraged at midterm.
- 6.3. The *failure* of these assumptions has majorly shaped the actual implementation of the HDF, essentially forcing the HDF steering committee to address several ambitious and comprehensive targets with a budget that was smaller than what was anticipated, and within an environment that presented significant political, economic and social challenges. Hard choices had to be made and were made, by a cohesive and motivated SC, to respond to needs and to optimise the use of resources.
- 6.4. As a result, the **contribution story of the HDF is largely consistent with its ToC** and does indicate that the Fund has been a critical mechanism to sustain RMNCH+A and nutrition in Zimbabwe. In that:
- 6.5. The HDF activities are **strongly relevant to the essential health needs of adolescents, women of reproductive age, pregnant women, newborn and children**. The range of the HDF supported strategies is consistent with a logic of sustaining impactful interventions along the CoC, in line with global evidence and strategies as well as with the national defined priorities. More importantly, the pillars of the HDF appear to be consistent with addressing priority barriers and bottlenecks experienced by its intended beneficiaries.
- 6.6. Systemic challenges persist within the health sector. Concurrently, communities face **significant access barriers**, related to basic needs (food, water, cash, transport) that go beyond the reach of the health sector. Under the current situation, these challenges and barriers may further deteriorate.
- 6.7. The evaluation has also highlighted some **gender related barriers**. In particular, lack of knowledge and inappropriate attitude from men influences care seeking practice at community level. Also, female adolescents consistently report issues related to sexual harassment and sexual abuse, early pregnancies, as major health problems. Community based interventions supported by the HDF are a potential channel through which these barriers can be addressed aggressively in the next phase of the HDF.
- 6.8. The HDF has relied on a strong SC, inherited as a governance structure from the predecessor fund, the HTF. Supported by a well-functioning Secretariat, **the SC has actively been involved in fulfilling its critical functions of governance, coordination and strategic direction**. There is consistent evidence that the SC has managed to catalyse critical decisions that had to do with the HDF and with the health sector at large, bringing together HDF and non HDF stakeholders to ensure continued dialogue and coordination. The leadership of the MoHCC has been driving the SC consistently.
- 6.9. UNICEF, the HDF **Fund Manager**, supported by UNFPA, has provided multiple functions of fund management, coordination, technical assistance and service delivery in some instances (e.g. procurement). There is no evidence

of conflict of interest of UNICEF and UNFPA in performing the functions. There is instead positive evidence that plans have been largely implemented as intended; that M&E has been strongly performed; and that funds were disbursed efficiently.

- 6.10. The HDF logic model has relied on the delivery of an extremely **complex range of activities**, covering a broad scope from community to health system strengthening, and across various programme interventions. In some cases, interventions have been ‘systemic’, horizontal and delivered at scale (or designed with scale-ability in mind); in other instances, interventions have been of smaller scale and ambitious. Whilst at the start of the programme the ‘platform’ of the HDF was not fully utilised to **promote integration and horizontal HSS and CHS activities**, there is evidence at midterm that the SC is prioritising integrated strategies rather than programme driven, fragmented activities. Examples include the vision of shifting from short term, programme driven in service training to integrated training packages and towards mentorship. Or the vision – supported by a wise although perhaps unpopular decision – to suspend the investment in VHWs in order to prioritise the definition of the key features of the community health system strategy of the MoHCC.
- 6.11. Despite the critical challenges due to budget limitations, plans have been defined on an annual basis at a great level of detail and largely implemented. Communication on progress to the SC members has been regular. HDF plans have succeeded in attracting more funds from both HDF and non HDF donors, hence providing a harmonised platform for funding. Plans have been managed with a high degree of flexibility, and dialogue across various stakeholders was consistently promoted as a mechanism to reach consensus on decisions.
- 6.12. There is evidence that the key **measures supported via HDF have contributed – to various degrees – to enhancing access, availability, quality and acceptability of care, and to engaging communities at the grassroots levels.**
- 6.13. Of note, the strength of evidence of quality of care is limited to data collected via RBF, and to qualitative research performed via the evaluation. Further unpacking of the available monitoring information collected on quality indicators will be a useful exercise to better understand the bottlenecks experienced in providing quality care at healthcare facilities.
- 6.14. While Zimbabwe has the capacity to produce most of the health workers required for a functioning health system, both in terms of absolute numbers and mix of skills, it continues to face challenges in attracting and absorbing graduates, and retaining existing staff, largely as a result of the economic environment, a growing wage bill and limited fiscal space. Domestic resources are also almost fully devoted to paying salaries, for example in 2016, remuneration costs accounted for 60.5% of the government’s total allocation to the health sector and 93% of MoHCC’s total expenditure^{89 90}, which leaves little fiscal space for workforce expansion.
- 6.15. The investments made in HRH have contributed to maintaining the current availability of nurses. Less positive results are observed in terms of availability of doctors in district hospitals, which is decreasing. Also, quality improvement strategies have led to HCPs (self-reported) enhanced confidence in providing care, and more positive team work at health care facilities.
- 6.16. The **RBF has been to a large extent the platform that has provided the most comprehensive, systemic approach to strengthen health services at district level and below.** Although areas of improvement are observed, that can further support fine tuning the model, the RBF has contributed to support through a single platform: governance and accountability of healthcare managers; strengthened linkages between facilities and district health offices; support to performance based incentives for HCPs; availability of resources at facility level to meet running costs and to invest in needed improvements (equipment, infrastructure), in collaboration with communities.

⁸⁹ Zimbabwe Joint Needs Assessment Sector Note 15: Health (DRAFT)

⁹⁰ Community Working Group on Health (2018) Input into the 2018 National Health Budget

- 6.17. Despite the efforts made, the **availability of medicines remains a critical issue in Zimbabwe**, and the HDF has only managed – within a reduced resource allocation – to mitigate impact. Yet for most providers and end users of care, the lack of medicines remains a critical barrier to care. Optimising issues related to PSM management (expiry of drugs, quantification, processing of orders) may help to sustain the situation, but it is clear that without significant investments in procurement this area will remain a problem for Zimbabwe. Also, the lack of forex and of products in the current context of Zimbabwe, makes it difficult for facilities to use their RBF funds to offset the lack of medicines procured via national, central systems.
- 6.18. The investment in the **community health system has been strategic** in complementing supply side efforts sustained via HDF. The success of the VHWs programme in enhancing access to care and health promotion has been partially offset by the systematic lack of medicines and equipment from VHWs, and more importantly by the fragmentation of cadres and actors who are active in communities. The evaluation concurs with the decision made by HDF partners to suspend the scale up of activities, in order to prioritise the design of a coherent strategic approach for community health system strengthening.
- 6.19. Some of the other strategies and activities supported via HDF have been to a large extent characterised by either **limited scale, or by fragmentation by ‘programmes’**. An example is outreach, which end users report to be a critical service to overcome access barriers to health. The HDF – partly due to reduced funding – has only delivered outreach in some districts for EPI, and in some (not necessarily the same) districts for VIAC, and for nutrition. Programmatic fragmentation has been to a certain extent a weakness of the HDF so far.
- 6.20. As a result, the HDF has succeeded – in a fragile environment – to **contribute to sustain the utilisation of care nationwide. Women, children and adolescent use health services, and they are generally satisfied with their quality. The fund has also succeeded in contributing to strengthening the interface and the dialogue between communities and health services.** There is evidence of stronger bonds between facilities, VHWs and communities, and also some evidence of positive behaviour change occurring.
- 6.21. Although only the DHS data will confirm the results produced through this evaluation in terms of outcome and impact, the exercise of **testing the theory of change through this midterm review strongly suggest that the efforts made by the HDF are going in the right direction.** The major risk to the gains achieved so far remains the external environment.
- 6.22. The focus on equity of the HDF was extremely strong at design stage; namely in the selection of target groups and in the identification of a range of ‘equity-focused’ interventions. On the other hand, the review of data performed via this evaluation suggests that the **HDF presents opportunities to improve the focus on equity in implementation.** There is a risk that – in pursuing UHC – the divide between those most in needed and the other strata of the population, will worsen. The HDF has the opportunity to embed operational adjustments in its strategies in order to overcome this risk.
- 6.23. Overall, **the fund has provided good VfM** for the investment, and it has been efficient.
- 6.24. The sustainability of the strategies implemented and supported via HDF is primarily threatened by external conditions. The economic situation and related to that the lack of liquidity and of goods, bring the country into a situation that was hardly predictable at the start of the programme.
- 6.25. Monitoring the situation – with a focus on the most at risk – and being able to **flexibly provide a response to immediate needs will be a critical function of the HDF**, looking forward. The HDF is a platform that functions rapidly and effectively and, using it to support short term measures if required, will be important going forward.

- 6.26. Besides sustaining the gains achieved in Zimbabwe through possible short-term measures, the added value of the HDF will be preserved by protecting the key strategies that it has supported so far, and by identifying pathways to transition – in the medium or long term. The best mechanism that the HDF can put in place, in order to effectively cope with the current condition and further external shocks, is a **road map to transition +, informed by a participatory scenario planning exercise**. Transition may entail various options; these may include dissolving the fund completely; handing over the activities to the government, transitioning to budget support, or shifting to another pooled fund if conditions do not allow to act otherwise.

Lessons Learned

The midterm evaluation of the HDF provides the opportunity to reflect on some key features of the initiative, that should be considered as learning points going forward, both in Zimbabwe and for other similar initiatives in other countries.

6.27. Design of the pooled fund

The design of the Fund was driven by funding expectations that were largely not met at implementation stage. Also, bringing together two initiatives previously implemented in parallel by MoHCC with support from UNICEF and UNFPA respectively, entailed that a very complex program design was set in place at the start of the fund. Starting with more conservative expectations, and with less comprehensive and diverse implementation strategies – possibly informed by a theory of change – may be a good approach in future for similar initiatives.

6.28. Focus on delivery for results

The HDF has proven to be strongly focused on delivering for results. The strong focus on agreed strategies and expected results between donors, government and implementing agents were and are an essential feature of the HDF, supporting a results-oriented approach. In addition, targets were established at outcome and output levels that were aligned to and supportive of the national health strategy. The strong alignment of the HDF with national priorities and the positive and constructive coordination amongst all stakeholders should be a model for other initiatives.

6.29. Flexibility of the pooled fund

During the six months of this midterm evaluation, the situation in Zimbabwe changed rapidly and dramatically. This highlights the need for most pooled funds – which are usually an aid modality implemented in fragile contexts – to embed formal and informal mechanisms that allow for flexibility and continuous communication amongst key stakeholders, to adjust the fund to emerging needs and priorities. In that, the evaluation has observed that the HDF has proven to be an extremely flexible mechanism – with MoHCC, Donors and UN agencies always positively engaged in providing solutions to respond to immediate needs and problems arising in the country. Such flexibility is a positive feature that needs to be acknowledged and preserved in future.

6.30. Funding governance

Flexibility and delivery for results were primarily possible due to a strong governance function of the Fund. In that, the leadership from MoHCC, the strong capacity of the Fund Manager, the active engagement of the Donors are positive lessons learned, mostly stemming from a previously consolidated model of pooled funding in Zimbabwe and enhanced during the implementation of the HDF.

6.31. Monitoring and evaluation

A common issue that evaluators commonly face is the lack of quality, consistent and representative reports and routine data from the program under evaluation. In the case of the HDF, extensive data could be retrieved by the evaluators, which are a unique asset to the program and to the MoHCC more broadly; data overall are consistent and of good quality. One key learning of this evaluation is that such data is possibly an under-exploited asset, in that their analysis, triangulation and use for decision making could be further enhanced. It is opinion of the

evaluators that the data sets generated routinely through the program provide an opportunity to perform more in-depth analysis that can help the policy maker in informing strategic decisions regarding the program

During the evaluation, LSTM has observed a unique spirit of commitment and a positive approach in participating to the evaluation at all levels of the system, from communities to high level officials, and despite of the challenges related to the current crisis in Zimbabwe. This is an asset that should not be underestimated, as the active engagement of stakeholders positively supports the quality, completeness and relevance of findings and recommendations.

SECTION 7. RECOMMENDATIONS

- 7.1. This chapter presents the recommendations identified by the evaluation team. The recommendations were discussed at a dissemination workshop, which was held in Harare on the 4th of December 2018. The workshop, which saw the participation of MoHCC, UNICEF, UNFPA, WHO, UNDP, MCAZ, DFID, Irish Aid, Swedish Government, European Commission, Cordaid, and others, was an opportunity to present and discuss the findings, and to validate the preliminary recommendations presented by the evaluation.
- 7.2. The recommendations have been produced following the UNEG Improved Quality of Evaluation Recommendations Checklist⁹¹. In that, we have kept the number of recommendations to a maximum number of ten. Suggested timelines and lead actor(s) are proposed, for each of the recommendations. These are presented below and classified as 'Fund Governance' and 'Programmatic' recommendations.
- 7.3. This evaluation occurred at a time when – during its 6-months life – the scenario in terms of economic development of Zimbabwe changed, with a rapid deterioration of the economic outlook of the country. The situation remains fluid and it can of course change again. In light of such scenario, the evaluation has produced a set of 'sub-recommendations', to advise on how the HDF may support the sector in coping with the short-term scenario in which it is currently operating.

Recommendations related to Fund Governance

The evaluation recommends that:

Recommendation 1 – Roadmap for transition

The SC forms a small, high level working group, tasked to produce a Roadmap for Transition, complemented by an agreed operational plan with agreed milestones.

The Roadmap will ideally include:

- A short-term plan to flexibly address the immediate priorities related to the current economic situation
- Steps for transitioning the HDF strategies in the medium/long term

The road map may entail various options including a staged approach, or a third pooled fund phase, or complete hand over to government. The roadmap will be governed by an overarching performance agreement and will be monitored against agreed milestones.

The plan will ideally be approved by the SC by mid-2019 and will be informed by a scenario planning exercise to be conducted at two levels: the transition in terms of overall funding environment; and the transition in terms of main activities/interventions currently supported by the HDF.

Recommendation 2 – Planning

Based on funding allocations for the remainder of the HDF, UNICEF and UNFPA provide technical guidance to continue using the HDF planning process as a catalyst for joint action at health sector level, efficiently and effectively.

In doing so, they will strengthen the annual plans, in that harmonisation and integration through existing health system and community health system platforms will be prioritised over programmatic approaches. In doing so, common areas for

⁹¹ Improved Quality of Evaluation Recommendations Checklist, UNEG. June 2018. Accessed at: [file:///C:/Users/luigi.daquino/Downloads/Checklist%20on%20Quality%20fo%20Evaluation%20recommendations.%20\(2\).pdf](file:///C:/Users/luigi.daquino/Downloads/Checklist%20on%20Quality%20fo%20Evaluation%20recommendations.%20(2).pdf)

prioritisation – geographical and technical – will be sought, and technical and financial support from non HDF donors will be mobilised.

Concurrently, the MoHCC will provide leadership in harmonising and streamlining the planning processes, and in using planning as a catalyst process to attract funds from additional partners and from internal resources, and to allocate those funds against a joint, common plan for RMNCH+A and nutrition.

In the current situation:

- Plans and agreed allocations will be reviewed on a regular basis, to respond to a fluid and dynamic changing environment.
- Regular assessments risk analysis and forecasting considering the economic situation will inform the reviews of plans.

Recommendation 3 – M&E

UNICEF and UNFPA invest in strengthening the ability of the HDF to make strategic use of the high-quality information produced via various M&E sources used by the HDF, and work to produce an **agreed and single LF** – stemming from the recently adopted DFID LF and the new dashboard used at SC level – of maximum 20 indicators, that will capture aspects of coverage, capacity, quality, equity, VfM and performance.

The LF will serve as a platform where strategic information from various sources (HMIS, RBF, VMHAS and others) will be triangulated, analysed and brought to synthesis to inform planning.

To implement this recommendation, the SC will agree on a final LF satisfying the reporting needs of all partners, which – at least at output level – maintains a clear focus on the key strategies supported by the HDF.

Also, UNICEF and UNFPA will consider investing in high level expertise to analyse and triangulate data available from all monitoring sources used by the HDF.

In the current situation:

- Targets should be revised on a quarterly basis
- Real time monitoring of HMIS data on utilization of services will be reinforced

Recommendation 4 – Equity

UNICEF provides technical leadership for an in-depth assessment of how the design of the HDF can sustain a stronger equity focused implementation approach, across its strategic components. Under the guidance of UNICEF, the SC will therefore support the definition of an equity strategy, which will include:

- Definition of key equity priorities
- Review of current equity-focused initiatives
- Definition of possible additional implementation approaches to address such priorities
- An equity-focused monitoring plan

Programmatic recommendations

At programmatic level, the evaluation recommends that:

Recommendation 5 – Gender

UNICEF and UNPA use their technical capacity in community-based behaviour change interventions, to design and implement appropriate strategies aimed at addressing gender-based issues that affect women of reproductive age and adolescent girls at community level.

These initiatives will prioritize addressing the attitude and behaviour of men and of male adolescents, which acts as barriers for women and adolescent girls in attaining their right to health.

Recommendation 6 – HR strategies

The HDF supports the MoHCC to disseminate the new HRH Strategic Plan across all levels and to translate and prioritise the strategies and interventions contained in the Strategic Plan into a costed annual implementation plan, will target and address key HRH priorities and challenges and be aligned with the Health Sector annual workplan and budget. A M&E plan aligned with the targets and indicators contained in the national health sector strategic plan will be also be developed and M&E information used to modify strategies and activities and to inform the design of subsequent plans and interventions.

In the current situation:

- Stocks and flows of critical HCPs across all levels, but particularly at PHC levels and in rural and remote areas needs regular monitoring (monthly staffing returns)
- Any consideration of short term measures to address current workforce deficits and imbalances should be in close consultation with policy-makers at the national level in the health, finance and planning sectors, and be rooted in an analysis of real constraints, and an in-depth understanding of labour market dynamics.

Recommendation 7 – Capacity development

The HDF continues to support the design and delivery of coordinated capacity development interventions across the continuum of learning.

- On the job training and mentoring will be prioritised over workshop-based trainings.
- The support will be based on identified needs
- Evaluation of learning outcomes will be embedded in all capacity development interventions

In the current situation:

- The HDF will prioritise capacity development in areas related to emergency response, SGBV, malnutrition.

Recommendation 8 – Result Based Financing

While monitoring closely the ‘pilot transition phase’ to be supported via WB, it is recommended that the SC work to remove technical/implementation barriers to the transition, seeking solutions to simplify the mechanism related to payments, verifications, and data collection of the RBF.

The HDF SC will:

- Keep the current implementation arrangements as the roadmap to institutionalisation evolves
- Explore technical and capacity barriers to manage the key functions of the RBF
- Seek solutions to simplify the mechanisms of verification, payments, data collection, and spending of RBF earnings

- Explore options to reduce the overhead costs of the scheme

In the current situation:

- The HDF will Sustain RBF and seek short term solutions to address current operational challenges related to shortage of goods and cash;
- The HDF will consider – if additional funding is made available – to introduce demand side financing mechanisms to overcome barriers to access

Recommendation 9 – Community Health Strategy

The HDF SC will:

- Ensure that the CHS is finalised, supported by an operational plan, and implemented. The strategy will define: roles and responsibility, package of services at community level, distribution of VHWs; selection/recruitment/remuneration approaches.
- In the short term, as the strategy is finalised, current VHWs will be supported with necessary equipment and supplies where needed. Mechanisms to ensure timely accessible payments will be pursued.

In the current situation:

- VHWs will be sustained to increase activities for surveillance, active case finding, health education (eg via refresher training), with increased support from facilities (via supervision at community level)

Recommendation 10 – Procurement and supply management

UNICEF and UNFPA will continue to procure medicines, commodities and supplies as per current arrangements.

The MoHCC will continue to mobilise domestic resources for procurement of medicines, commodities and supplies.

The MoHCC will prioritise the finalisation of procurement frameworks (LTA), to allow for timely and cost-effective procurement at the lower levels.

In the current situation:

- UNICEF/UNFPA will support the MoHCC to use available domestic resources to procure essential drugs not provided via HDF.
- Additional available funds should prioritise actions that ensure availability of medicines (procurement, distribution, monitoring).

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APPENDIX 1

Theory of Change of the Health Development Fund

APPENDIX 2

Ethical Approval from the LSTM Research Ethics Committee

APPENDIX 3

Ethical Approval from the Zimbabwe Medical Research Council

APPENDIX 4
Evaluation Matrix

Evaluation Plan

Evaluation criteria	Key evaluation questions	Level of the theory of change assessed through the KEQ	Evaluation method	Data Sources/Tools
Relevance	EQ1. Are the HDF interventions and expected results relevant to the needs of its intended recipients?	Interventions Short term results	Thematic framework analysis	KIIs and FGDs Qualitative studies on CHP available in Zimbabwe
Effectiveness	EQ2. How effectively has the HDF pooled fund mechanism performed, against the key principles of aid effectiveness?	Inputs (the pooled fund mechanism)	Coppin's criteria for scoring pooled funds	Key informants' online questionnaire
	EQ3. What was the progress in achieving the HDF intended results, during the period 2016-2018?	Short and medium-term results	Testing of HDF theory of change at short term results level Assessment of HDF indicators as defined through the HDF log frame, against milestones/targets	All evaluation primary (Survey, KIIs and FGDs) and secondary data LSTM survey VHMAS HMIS Other reports
	EQ4. What were the main facilitators and barriers to achieving the HDF results, during the period 2016-2018?	Short and medium-term results	Thematic framework analysis	KIIs and FGDs Review of available studies and reports
	EQ5. Is there evidence of any unintended results produced by the HDF?	Short and medium-term results	Triangulation of quantitative data Thematic framework analysis	KIIs and FGDs Review of available studies and reports
	Sustainability:	EQ6. What are the risks to sustainability of the results and outcomes produced through the HDF?	All theory of change, including contextual factors	Descriptive Synthesis of barriers and facilitators to sustainability Scenarios for optimisation of the programme in terms of design, effectiveness, efficiency
Equity:	EQ7. Does the HDF embed an equity focused approach in its design and in its delivery mechanisms?	Interventions, short and intermediate results	Desk based assessment of equity features of the HDF	Reports; M&E frameworks and data; project records; expenditure; etc HMIS, VHMAS, Other data sets and reports

			Assessment of HDF log frame selected indicators, disaggregated by equity dimensions	available in country
Value for Money:	EQ8. What are the costs of the HDF and what are the main cost drivers related to fund management and implementation?	Inputs, interventions and short-term results	Descriptive assessment of major cost categories and cost drivers Financial flows analysis	UNICEF Budget and Expenditure Reports Financial Flows Analysis by Thematic Area
	EQ9. What is the value for money of the HDF when relating its costs to economy, efficiency, effectiveness and equity?	Inputs, interventions and short-term results	Benchmarking of key cost drivers and unit costs against international cost standards	Log frame and targets Expenditure tracking records HMIS
	EQ10. How can available resources be used more efficiently and effectively, to maximize the benefits of the HDF?	Short and intermediate results	Calculation of unit cost per output for selected indicators and comparison with available standards Normative cost analysis Prospective cost analysis	Sub-contractor contracts and invoices Expenditure tracking records Training records Patient/Client Count Data Public Health Records and datasets Facility Cost Analyses

Data Analysis Matrix

ToC Assumption	Lines of Evidence	Source	SCORING FOR THE ASSUMPTION
Key Assumptions from Inputs to HDF supported interventions			
A pooled fund is the most efficient mechanism to deliver HDF supported activities in the current environment	Strong Evidence in literature about pooled funding in Zimbabwe	Salama et al. BMC International Health and Human Rights 2014, 14:35 http://www.biomedcentral.com/1472-698X/14/35	Good evidence that HDF was the most efficient mechanism at inception for the delivery of RMNCH+A and nutrition in the zimbabwean environment
	Pooled funds largely been a successful instrument for joint action in post crisis setting	file:///C:/Users/luigi.daquino/Dropbox%20(LSTM)/Program%20Management/HDF%20Zimbabwe/7.%20Data%20Analysis/7.0%20Pooled%20Funding/MTDF%20literature/Review%20of%20MDTF%20in%20post%20crisis%20Scateam.pdf	
	No other options available to donors at the time of the HDF inception, for more effective investment of funds in the sector	Key informant interviews	
	Overall the scoring of HDF against the Paris Principles demonstrates good to excellent fit with the principles of: ownership; alignment; harmonisation; delivery of results and mutual accountability. The combined cumulative score of 76% is excellent	Online questionnaire	
Governance by the Steering Committee allows for rational, evidence-based decision making and consensus in prioritizing the activities	Steering Committee has TORs and membership rules in place	TORs; Membership documents	Good evidence of strong leadership and functionality of the SC, as a governance mechanism for the HDF and for the sector at large
	14 HDF Steering Committees meetings held during the period under review (Jan 2016-June 2018) - bymonthly	Minutes of Steering Committes of HDF (from meeting 1 to meeting 14)	
	Agenda of items for discussions circulated in advance to the meeting to all participants	Key informant interviews national level	

	Mean no of participants: 27.8 (median 29.5) over 12 meetings minutes analyzed	SC Meeting minutes analyzed	
	Mean proportion of female participants to SC: 47% (median 48%) over 12 meeting minutes analyzed	SC Meeting minutes analyzed	
	Mean participation of 9 voting members to HDF SC: 80%	SC Meeting minutes analyzed	
	Participation from MoHCC, UNICEF, UNFPA, DFID and EU to 12 SC meetings assessed: 100%	SC Meeting minutes analyzed	
	SC meeting minutes provide evidence of summary achievements by agenda items, and consensus reach or recommendation.	SC Meeting minutes analyzed	
	Annual HDF workplan approved and signed off by Permanent Secretary of MoHCC (2016, 2017, 2018)	Annual workplans 2016, 2017 and 2018	
	Moderate documentary evidence of plenary discussions in advance to the approval of annual workplan	30th HTF SC meeting minutes, reference to approval of HDF plan for 2016	
	No documentary evidence found on processes and metrics adopted to allocate resources across thematic areas		
HDF plans are aligned with government and other funders' plans, and with HDF objectives	Annual HDF workplan approved and signed off by Permanent Secretary of MoHCC (2016, 2017, 2018)	HDF annual workplans; KIIs	Strong Evidence of alignment of HDF plans to MoHCC priorities and strategy
	Fairly regular Participation from non HDF donors to HDF SC meetings: GF CCM/PCU: 58%; World Bank: 42%; USAID: 33%	12 SC Meeting minutes analyzed (missing minutes for meeting 1 and meeting 12)	
	The scoring for alignment is good (71%),	online questionnaire	
Accountability for results is achieved through reliable monitoring mechanisms	The logframe is referenced once in the 12 steering committee minutes and was updated in June 2018	SC meeting minutes, updated logframe	Strong evidence of use of various monitoring tools, including government systems.

	Evidence from documentary review and KIIs of utilization of a double logframe from HDF	Review of HDF documents; KIIs	Good evidence of potential for better use/triangulation of data
	Evidence from reports of utilization of various sources: VMHASS; HMIS; RBF are the main monitoring sources	Review of annual reports	
	The scoring for monitoring of pooled fund includes government processes is 48%, as monitoring includes both HMIS and other MoHCC systems, and VHMSS (UNICEF) and RBF (Crown Agents)	online questionnaire	
	No evidence found of triangulation of data sets for analysis	Review of HDF documents	
Funds from HDF donors are available as per plans and allocated in a timely way	Spent for 2016/17 equals to 42% of the originally planned budget for the biennium	HDF proposal document and expenditure reports	Good evidence of timely disbursement of funds and of good fund management practice in spending against plans
	Total expenditure for the biennium 2016/17 equals to 98% of the pledges for the period.	HSD annual workplans 2016 and 2017; HDF expenditure reports 2016 and 2017	
	No evidence is found of delayed disbursement from donors against agreed annual workplans	HDF annual report; KIIs	
	Evidence found of UNICEF allocating funds against annual workplans by bridging funds disbursed at different times by donors (virtual pooling)	KIIs	
UNICEF and UNFPA disburse funds timely to partners and subcontractors	Evidence of execution of disbursement against funding requests ranging between 7 and 28 days (2 weeks average, fully acceptable)	VfM analysis of a sample of expenditure records from UNICEF and UNFPA	Good evidence of efficient management of funds
	No evidence of delays affecting implementation from KIIs	KIIs	
Fund manager provides good value for money for its services	Overheads and program management costs below 15% overall	VfM analysis of a sample of expenditure records from UNICEF and UNFPA	Strong evidence of well performed FM function from UNICEF

	Evidence of acceptable to highly acceptable costs compared to international standard market prices for a sample of cost items	VfM analysis of a sample of expenditure records from UNICEF and UNFPA	
	Timely and comprehensive reports provided to donors and MoHCC (although financial information in reports needs improvement)	HDF annual reports	
	Evidence of strong role of Fund Manager in coordination, technical advice and communication sharing	KIIs	
GoZ ownership and leadership in implementing HDF plans and interventions	Full adherence/alignment of HDF with National Health Strategy 2016-2020	NHS 2016-2020 document	Strong evidence of MoHCC leadership at planning and oversight level. Limited ownership due to use of external management systems for fund management and procurement primarily
	Scoring of ownership against Coppin's framework: 62% (weakness in utilization of national systems for management)	Online questionnaire and LSTM review	
	Evidence of leadership at SC level - all but one of the 12 SC meetings during period being evaluated were co-chaired by the PS. The one occasion he was not present the co-chair was a Principle Director (next most senior MoHCC official)	12 SC Meeting minutes analyzed (missing minutes for meeting 1 and meeting 12)	
	Evidence of involvement of MoHCC in key decisions re planning and implementation of HDF strategies	KIIs, HDF reports	
Pooled fund mechanisms allow for flexibility in adjusting plans and interventions to respond to change	Evidence of annual planning process in place, with involvement of MoHCC	Review of SC meeting minutes; KIIs	Good evidence of flexibility of annual plans
	Evidence of review of plans due to necessary adjustments (emergency response, interruption of HCWs allowances, suspension of scale up of VHWs)	HDF annual reports; HDF annual plans; KIIs	
Key Assumptions from Health System Governance Interventions to Short Term Results			
HDF support to policy formulation contributes to the definition of	Evidence of various policies and strategies supported with the contribution of the HDF	HDF Annual reports; HDF costed workplans; Strategy documents referring to HDF (eg National Health Financing Strategy 2017)	Strong evidence of HDF contribution of RMNCH+A

evidence-based strategies, policies and plans	Strategic high level dialogue across social sectors informed and supported via Policy Briefs	Draft Policy Briefs (unpublished)	policies and plans and to multisectoral coordination
	Various national action plans and multisectoral planning processes supported via funding and technical assistance.	HDF costed workplans; annual report HDF	
HDF technical assistance contributes to strengthening the planning process at central, provincial and district level	District level planning consistently performed. 93% of districts had annual plans in place in mid 2018	LSTM Survey of DHOs, 2018	Good evidence of planning function in place and implemented
	100% of District Health Offices have district management meetings; 80% meet quarterly to review progress against annual plans	LSTM Survey of DHOs, 2018	
	Partners involved in District level meetings (DHO reporting that partners attended the last review meeting = 63%)	LSTM Survey of DHOs, 2018	
	100% of DHOs report to receive supervision from the Provincial Health Office. 96% receive it at least quarterly, and 86% report to receive regular feed back from the supervisors	LSTM Survey of DHOs, 2018	
	All health facilities report to produce annual plans	LSTM survey of HCFs, 2018	
The accountability mechanisms created through the HDF improve social accountability	Patient charters available at health care facilities (90% at primary care level)	LSTM survey of HCFs, 2018	Strong evidence of social accountability mechanisms in place. Some evidence of utilization of such mechanisms
	Suggestion boxes available at health care facilities (86% at primary care level)	LSTM survey of HCFs, 2018	
	Health Centre Committees active at health care facilities (99% of PHCs with HCC in place; 79% report to meet at least monthly)	LSTM survey of HCFs, 2018	
	Report from end users of knowledge and use of suggestion boxes	FGDs with community men, women of reproductive age and adolescents	

	Evidence from end users of common practice of exit interviews at health care facilities	FGDs with community men, women of reproductive age and adolescents	
HDF provides technical assistance to strengthen HMIS	Indirect support provided - evidence of improved accuracy of HMIS reporting due to RBF verification and counter-verification mechanisms	RBF Reports 2017/18; KIIs	Good evidence
SC serves as a forum for coordinating activities, with benefits for the broader sector	Evidence of discussion of broader sectoral issues	SC stteting committee minutes; annual reports; KIIs	Good evidence
SC ensures proper coordination and harmonization of activities with other stakeholders	Fairly regular Participation from non HDF donors to HDF SC meetings: GF CCM/PCU: 58%; World Bank: 42%; USAID: 33%	SC Meeting minutes	Good evidence of coordination with non HDF stakeholders
	Set up of ad hoc periodic meetings with GFATM for coordination	KIIs	
	Good coordination in supporting national programs with other funders (VHWs with GFATM; RBF with WB)	Reports; KIIs	
SC decisions are duly communicated by relevant MoHCC departments to subnational level structures and consistently implemented	Decisions from SC communicated to lower levels via MoHCC communication structures and processes	KIIs	Some evidence available
VMHASS is complementary to HMIS, and collects the right information with robust methodology	VMHASS information is designed to be complementary to HMIS data	Review of VMHASS data sets	Strong evidence that VMHASS is a strong monitoring tools, with potential for improvement in its design and methods
	Methodology is robust, although the evaluation observes: need to have a shared analysis plan for data; need to have improved data syntax	Review of VMHASS data sets	
	Indicators definition not available at the required standards/level of details needed to assess indicators	Review of VMHASS data sets and indicators	
	Change of indicators definition over time shows stronf flexibility of the tool, although it makes time trend analysis not feasible for some indicators	Review of VMHASS reports	

	Possibility to include in VMHASS additional features (e.g. supervision; mentorship; training; staff distribution; staff training; availability and use of job aids and guidelines; referral; quality improvement methods)	Comparison of VMHASS against LSTM survey	
VMHASS data is used by SC for decision making	VMHASS reports produced and shared quarterly with SC	Review of VMHASS reports	Strong evidence of use of VMHASS for decision making
	VMHASS used as basis to report against HDF indicators and targets	Review of VMHASS reports and of HDF annual reports	
Key Assumptions from Supply Side Interventions (RBF) to Short Term Results			
The RBF model is efficient, effective and acceptable to managers and HCWs	All public facilities in 42 HDF districts implement RBF	LSTM Survey; RBF reports	Strong evidence that RBF functions effectively and at scale. Barriers to efficiency include timeliness of payments; administrative procedures
	RBF PMI periodically reviewed to enhance effectiveness and fitness for purpose of the model	KIIs; documents review	
	RBF payments experience delays (63% of PHC facilities report delays in payments)	LSTM Survey; HDF Annual Reports; RBF Quarterly Reports	
	Administrative procedures for verification and training on RBF (due to staff turnover) are main barriers to efficiency	KIIs	
	RBF highly accepted by managers and health care providers (autonomy; motivation; accountability; incentives)	KIIs at DH and PHC level; LSTM survey	
The RBF model supports measurable improvements in quality of care	Quality outcomes introduced and measured to reward facilities with RBF payments	RBF PIM; RBF reports	Some evidence that quality of care is consistently measured via RBF monitoring system.

	Overall satisfaction of clients (males, women, adolescents) with quality and respectfulness of care from HCFs	FGDs with community men, women of reproductive age and adolescents	
	Quality scoring via quarterly assessments from DHE show a range of 75% to 95% in RBF supported districts	RBF Reports Q2 2018	
	Patient satisfaction scores rated 79% to 96% in RBF supported facilities	RBF Reports Q2 2018	
The RBF model is transferrable to government and transition plan developed	Transition plan developed and approved by MoHCC	MoHCC Health Financing Strategy 2017	No evidence to date that the transition to MoHCC functions efficiently and effectively
	RBF management Unit set within the GF CCM Unit at MoHCC	KIIs; documents review	
	Transition plan delayed, due to interruption in payments for the 18 WB District (pilot districts for transition of RBF management to MoHCC)	KIIs; documents review	
RBF supported facilities are compliant with policy of user fees removal	User fees reported at < 1% by VMHASS and LSTM survey	VHMSS; LSTM survey; FGDs with community members; KIIs with health care providers	Strong evidence of progress in abolition of user fees
Government support to cover capital expenditure for facilities is continuous and sufficient	100% of districts produce annual budget	LSTM survey, 2018	Strong evidence of insufficient Government contribution to budget at district level and below
	55% of annual budget received on average at district level	LSTM survey, 2018	
	Main sources of funding: RBF; user fees; Central Governments; NGOs	LSTM survey, 2018	

RBF funds are used by facilities responsibly, expenditure is made according to agreed procedures	Transparency of utilization of funds and clarity of process reported as main factors of satisfaction with RBF amongst HCPs	LSTM survey, 2018	Strong evidence of good use of RBF funds although need emerges of fine tuning PMI to facilitate procedures, and to further simplify mechanisms for procurement of drugs on the local market
	Complexity of procedures reported as main factor of dissatisfaction amongst health care providers	LSTM survey, 2018	
	Staff turnover generates need of additional training on RBF procedures	RBF reports	
	Delays reported in RBF payments	LSTM survey 2018; HDF annual reports	
	Complexity reported about allocation of 25% incentive to HRH. Calculator not yet fully introduced	KIIs; RBF reports	
	No clear boundaries set in how to invest RBF resources at facility level - risk of prioritizing non urgent expenditure (eg construction)	KIIs	
	Complexity reported in procedures needed to procure medicines via RBF funds (time; quotations; price on the local market)	KIIs; Reports	
RBF incentives motivate health care workers, and lead to improved performance and retention	Strong satisfaction with RBF incentive from HCPs	Self administered questionnaire; KIIs with HCPs	Strong evidence of effectiveness of RBF allowance as a mechanism of retention and motivation of HCPs
	RBF incentive reported as more equitable than the previous targeted retention allowance	KIIs with health care providers and DHEs	
	Incentives reported to be a lead factor for HCP to stay at health care facilities and to provide good quality care	Self administered questionnaire; KIIs with HCPs	

Management capacity is sufficient at facility and district level to implement RBF	Reported delays in RBF payments due to delayed verification from DHE to all facilities	KIIs with health care providers and DHEs	Some evidence of need for increase capacity to manage RBF at District and facilities level
	RBF poses additional tasks on DHEs with risk of generating competing priority with other tasks related to DHE functions	KIIs with health care providers and DHEs	
	Some facilities report need of additional training due to staff turnover	KIIs with health care providers and DHEs	
Health Centre Committees (HCC) exist in every RBF supported facility, are functional and meet regularly	99% of PHC facilities have HCC in place	LSTM survey, 2018	Strong evidence of good functioning of HCCs as a coordination mechanism at facility level
	Mean number of HCCs members: 10.6	LSTM survey, 2018	
	More than 80% HCCs meet at least monthly	LSTM survey, 2018	
	66% of facilities have TORs available for the HCC	LSTM survey, 2018	
	99% of HCC report to meet regularly to discuss health issues	LSTM survey, 2018	
	HCC members reported to participate to facility planning meetings by 83% of PHCs	LSTM survey, 2018	
	Facility staff report consistent utilization of the HCC as a coordination mechanism with communities	KIIs with health care providers	

HCC members are accountable and responsible to their mandate of supporting facility improvements via the HCC	See above		Strong evidence
Facilities develop and implement activities according to agreed quarterly plans	100% of facilities report to develop annual plans	LSTM survey, 2018	Good evidence
	Planning consistently reported as the foundation of RBF allocations	KIIs with health care providers and DHEs	
Key Assumptions from supply side interventions (HRH) to short term results			
Training and mentorship lead to improved health care workers knowledge, skills and competencies on selected interventions	Evidence of high proportion of HCPs trained in various essential RMNCH+A and nutrition packages	Health Facility Assessment/Self Administered questionnaire	Strong evidence of effectiveness of mentorship and supportive supervision. Need to continue shifting from workshop based trainings to on the job support
	Workshop based training approach still prevails - fragmentation by vertical programs observed	KIIs; review of training plans	
	High proportion of DHOs with mentors trained	DHO questionnaire	
	High % HCPs report to receive regular clinical mentorship	Self administered questionnaire; LSTM survey of health care facilities	
	Good frequency of mentorship and good coverage of essential clinical areas	Self administered questionnaire	
	High proportion of HCPs reporting improved competencies and confidence	Self administered questionnaire	
	Mentorship and supervision reported as a strong motivating factor	Self-administered questionnaire	

	Mentorship and supervision reported a key facilitator to strengthen team work at facility level	Self administered questionnaire	
Improved knowledge, skills and competencies result in improved practice and performance	High proportion of HCPs reporting improved competencies and confidence	Self administered questionnaire	Good evidence of enhanced skills and competencies reported by HCPs, and of patient satisfaction
	Clients report satisfaction with attitude of health care providers and with quality of their performance	FGDs with community men, women of reproductive age and adolescents	
	Mentorship and supervision reported a key facilitator to strengthen team work at facility level	Self administered questionnaire	
	No evidence found of consistent use of pre and post test for training or of regular monitoring of training needs	KIIs, reports	
	Needs reported for skills labs for regular practicing of clinical skills	KIIs, reports	
Adequate numbers of skilled health care workers are recruited, equitably distributed and available at primary and secondary care facilities	Evidence of reduction in number of doctors at District level	HRH data; VMHASS	Good evidence of persisting issues with quantity, skills mix and distribution of HCPs at district level and below
	No evidence of reduction of nurses available at health care facilities	HRH data; VMHASS	
	Ratio of HCPs: population remains lower than WHO recommended standards	HRH data	
	Possible distribution issues will require further analysis	HRH data; KIIs	
Key assumptions from supply side interventions (PSM) to short term results			
Sufficient funding is available for procurement	Procurement of medicines strongly reliant on external donors	Natpharm data; KIIs; reports	Strong evidence that the availability of medicines remains a major barrier, despite

	HDF allocation to procurement significantly lower than initially proposed budget	Analysis of HDF expenditure vs budget	of the efforts made via HDF to address the issue
	Health care providers report lack of medicines as the main barrier to provision of care	KIIs; self administered questionnaire	
	Clients report lack of medicines as a major barrier to accessing good quality care (risk of cannibalization of benefits deriving from abolition of user fees)	FGDs with community men, women of reproductive age and adolescents	
Functional, coordinated and efficient storage and distribution systems are in place	ZAPS introduced and consistently implemented at all levels of the system	LSTM survey, 2018 ; KIIs on procurement	Strong evidence of sub-optimal functioning of the storage and distribution system
	Evidence of expiry of drugs at health care facilities (43% of PCHs and 78% of DH)	LSTM survey	
	Stock out of individual items reported consistently at facility level	LSTM survey; VMHASS	
	Long lead time for processing orders - especially for PHC facilities	LSTM survey	
	Insufficient coverage of LMIS trained personnel at district level (48% of DH offices have 2 LMIS trained personnel)	LSTM survey	
	Barriers reported to use RBF funds to restock medicines via procurement on local markets (time; cost; availability)	KIIs; Health Sector assessment; JRM	
National health information system provides real time, quality information on stock levels across the country	No evidence gathered via evaluation	-	No evidence

Medicines and equipment are distributed to VHWs as per agreed standards	41% of VHWs have functional bikes	LSTM survey, 2018	Good evidence that availability of drugs and equipment remains a barrier for VHWs
	61% of PHC report to distribute drugs to VHWs regularly	LSTM survey, 2018	
	Clients report not using VHWs for curative services due to the fact that they do not have medicines available	FGDs with community men, women of reproductive age and adolescents	
	Self reported issues with availability of drugs and equipment	FGDs with VHWs	
Selected HDF products are the most relevant for the clients' needs	No evidence gathered via evaluation	-	No evidence
Key Assumptions from demand side interventions to short term results			
HDF program design provides an adequate platform for communities to participate	Evidence of several community based initiatives, mostly dependant on vertical program approaches	HDF reports	Moderate evidence
Communities have the capacity and willingness to engage with health initiatives	community members report appreciation and engagement with various community initiatives (nutrition, sanitation, home visits, etc)	FGDs with community men, women of reproductive age and adolescents	Some evidence of behaviour change available. Barriers still persist at community level
	community members report consistently change in practices and behaviour due to health education	FGDs with community men, women of reproductive age and adolescents	
	Barriers still hinder the adoption of practices (lack of food, water, transport, cash)	FGDs with community men, women of reproductive age and adolescents	
Sufficient resources are in place to conduct outreach activities	72% of PHC facilities report to provide integrated outreach	LSTM survey, 2018	Good evidence of consistent implementation of outreach. Need to integrate outreach

	80% of PCH facilities have a scheduled for outreach. 94% of PHC facilities report to meet the schedule in the past quarter	LSTM survey, 2018	within HDF plans; currently fragmented by programs
	Reported suboptimal investment in outreach via HDF due to reduced funding	HDF reports	
	Strong fragmentation of plans and budget for outreach observed in HDF annual plans (vertical programs)	Review of HDF plans	
Good coordination and integration in planning and delivery community activities	Strong fragmentation of cadres at community level, implementing different activities with poor coordination	Report on community health; KIIs; FGDs with communities and VHWs	Good evidence of fragmentation
VHWs and other community-based cadres are skilled and equipped to regularly provide services at community level, as per current mandate	Scale up of VHWs implemented and then suspended in 2018 to prioritize CH strategy	HDF reports	Good evidence
	VHWs consistently trained in selected packages	VMHASS	
VHWs are linked to health facilities, and regularly mentored and supervised	100% of facilities report to meet monthly with VHWs	LSTM survey, 2018	Good evidence of link/oordination of VHWs with facilities
	69% of facilities report to organize supportive supervision at community level; of these, 74% report to do it at least monthly	LSTM survey, 2018	
Key Assumptions from short term results to intermediate results (Supply Side)			
All HDF supported RMNCH-A services are available and performed as per quality standards	Essential RMNCH+A and nutrition services available at DH and PCH level	LSTM survey 2018; VMHASS	Good evidence that services are available and performed
	Essential RMNCH+A services performed (in the three months preceding the survey)	LSTM survey 2018	
	HCPs report to consistently offer essential services	KIIs, SAQ	

Quality improvement initiatives are in place to sustain QoC at facility level	100% of DH and 66% of PCH have a QI committee in place	LSTM survey, 2018	Good evidence that QI mechanisms are in place and implemented at lower levels of care
	97% of QI committees at DH and 91% of PCH report to have taken action in the year preceding the survey	LSTM survey, 2018	
	more than 955 of QI committees report to meet at least quarterly	LSTM survey, 2018	
	100% of DHs and 75% of PHCs have systems in place for review of maternal deaths	LSTM survey, 2018	
	MDSR guidelines available in 98% of DHs and 63% of PHCs	LSTM survey, 2018	
	100% of DH and 97% of PHC report to have a MDSR meeting whenever a death occurs, or at least quarterly	LSTM survey, 2018	
QoC is measured and reported at all levels	No evidence of any QoC implemented in Zimbabwe	Documents review	Good evidence that quality is primarily measured via RBF
	Quality regularly monitored via RBF	Documents review	
	No evidence of how quality indicators are used/analysed centrally for monitoring	Documents review	
	The evaluation did not assess how quality indicators were designed and their fitness for purpose	-	

	Potential issue of conflict of interest/separation of duties observed since quality scoring is done by DHEs (the facilities' supervisors)	KIIs national level, DHEs and HCPs	
Accountability mechanisms in place for quality of care	See above under Qi mechanisms	-	Good evidence
Attitudes of health care workers encourage care seeking behaviour	Consistent satisfaction reported by end users re attitude of staff, reduced waiting times, good quality services	FGDs with community men, women of reproductive age and adolescents	Some evidence available
	High quality scores for RBF client satisfaction surveys	RBF reports	
Sufficient referral means in place	Mean number of 3 ambulances available at DH level for referral	LSTM survey, 2018	Good evidence that referral remains a barrier both because of insufficient availability of functioning transport means, and because of costs for clients needing referral
	54% of DH report having a functional ambulance on the day of the survey	LSTM survey, 2018	
	Money for referral reported as a major barrier to accessing care from clients, especially PWs	FGDs with WRA	
	Mean charge for referral from PHC to DH: 8 USD	LSTM survey, 2018	

APPENDIX 5

List of secondary data sources

Health Development Fund

- HDF Programme Document for a Multi-Donor Pooled Fund for Health in Zimbabwe 2016-2020
- UNICEF HDF Annual Report April 2017
- UNICEFHDF Annual Report April 2018
- HDF Workplans 2016, 2017, 2018
- HDF Logframe – original and updated June 2018
- HDF UNFPA Delivery Chain 2018
- HDF UNICEF Delivery Chain 2018
- Terms of Reference HDF Steering Committee
- HDF participants list updated June 2018
- HDF Programme expenditure reports 2016, 2017, 2018

Policy, Planning, Strategies

- Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset), Government of Zimbabwe, October 2013-December 2018
- National Health Strategy 2016-2020, MoHCC
- National M&E Policy and Strategy, MoHCC
- Zimbabwe National Health Profile 2014, MoHCC and Zimstat
- National Child Survival Strategy 2016-2020, MoHCC November 2015
- Zimbabwe Maternal and Neonatal Health Strategy 2017-2021, MoHCC
- Zimbabwe Reproductive Maternal, Newborn, Child, Adolescent Health and Nutrition Strategy 2017-2021, MoHCC
- Quality Assurance and Quality improvement strategy 2016-2020, MoHCC
- Inter-Censal Demographic Survey ICDS 2017
- Comprehensive Multi Year Plan for EPI 2014, MoHCC
- Assessment of Maternal and Perinatal Death Surveillance and Response Implementation in Zimbabwe (MoHCC, USAID, MCHIP) November 2017
- District Core Health Services for Zimbabwe, 2nd Edition 2013, MoHCC
- Health Centre / Clinic Quality Supervision Checklist, February 2016, MoHCC

Monitoring and Evaluation

- Health Management Information Systems (HMIS) Reports 2016-2018, MoHCC
- The VMAHS Survey dataset from 2016 to June 2018
- VMAHS Survey data collection tools (questionnaires)
- VMAHS Indicators' definitions
- VMAHS quarterly reports (Q1 2016 - Q1 2018), MoHCC, UNICEF & HDF
- List of facilities by category Zimbabwe
- Assessment and redesign of the systems for RBF, Human Resources for Health and Pharmaceuticals in Zimbabwe, Final Report, February 2017, EU
- Multiple Indicator Cluster Survey (MICS) 2014, GoZ and Zimstat
- Zimbabwe Demographic and Health Survey (DHS) 2015, Zimstat and ICF International
- Zimbabwe Service Availability and Readiness Assessment 2015, MoHCC
- UN/WBD Joint Needs Assessment Sector Notes 2018 (education, health, WASH, social protection, food security and nutrition)
- JRM Reports 2016, 2017 (provincial reports and overall), MoHCC and HDF
- Institute for Health Metrics and Evaluation, Global Health Data Exchange, Zimbabwe, 2016
- HDF Steering Committee Monitoring Dashboard Q2 2018
- Assessment and Redesign of the systems for RBF, Human Resources for Health and Pharmaceuticals in Zimbabwe – Final Report February 2017, European Union and Partners
- Theory of Change from DFID programme

- DFID logframe for HDF
- DFID Annual review of programme
- DLIS 2018

Health Financing including Results Based Financing

- Zimbabwe Health Financing Policy: Resourcing Pathway to Universal Health Coverage 2016, MoHCC
- Zimbabwe Health Financing Strategy 2017, MoHCC
- Zimbabwe National Health Accounts 2015, Zimstat, MoHC, Zimref
- Crown Agents Quarterly Magazines on RBF - August and October 2017 editions
- HDF – RBF Human Resources for Health Retention Scheme (HRHRS) Programme, Zimbabwe. Quarterly reports 2016-2018, Crown Agents
- Q3 2016 – Q3 2018 RBF Earnings Database
- List of districts supported by RBF in Zimbabwe
- Health Centre / Clinic Quality Supervision Checklist
- Cost-effectiveness analysis of RBF in Zimbabwe (ppt) June 2016
- Exploring Fiscal Space in Health Budgeting (ppt) June 2016
- Zimbabwe RBF Impact Evaluation – overview of key messages (ppt)
- Zim IE PME Findings IV – Health Worker Satisfaction and Motivation (ppt)
- Analyzing Fiscal Scape Options for Health in Zimbabwe Feb 2017 (MoHCC, Zimref & WB)
- Health Public Expenditure Review Zimbabwe, May 2015 (GoZ and WB)
- Health Financing in Zimbabwe – World Bank Health, Nutrition and Population Team, October 2017 Short Policy note
- Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes – Evidence from Zim RBF IE, June 2016 (ppt)
- RBF – Overview of approach and design in Zimbabwe, June 2016 (ppt)
- Early evidence from RBF in rural Zimbabwe (2015 journal article)
- Rewarding provider performance to improve quality and coverage of maternal and child health outcomes- Zimbabwe RBF Pilot Programme. Evidence to inform policy and management decisions, June 2016
- Learning from implementation – process monitoring and evaluation II of Zimbabwe’s Results Based Financing Programme: the case of Mutoko, Chiredzi, Nkayi and Kariba Districts May 2
- National RBF Approach: Programme Implementation Manual Draft May 2017
- Zimbabwe Health RBF Programme – Urban Voucher Component – Project Implementation Manual (PIM) February 2016
- Technical and Operational Modifications to Zimbabwe’s RBF Scheme, Final Report May 2017
- Africa Scorecard on Domestic Financing for Health, 2018 (AU and GF)
- Financing the Health Sector – some insights from fiscal space analysis (ppt). WB Sept 2016
- Preliminary findings for household survey on out of pocket health expenditure in Zimbabwe, Sep 2016
- CWGH Analysis of the 2018 National Budget – Health Implications
- CWGH Position paper on the Budget for Health – 2018 and Beyond
- CWGH Post Budget Analysis – Health Sector Allocations 2017
- CWGH Position on Budget Allocations for Health Sector 2017
- UNICEF VfM Framework, February 2018
- UNFPA Purchase Orders 2016, 2017
- HDF selected Disbursement requests
- UNICEF expenditure by province
- UNFPA expense report by province
- UNICEF contract with Crown Agents,
- Fedex invoices,
- Goal Zimbabwe Programme Document
- Sample of contraceptives

Procurement and Supply Chain Management

- Essential Medicines Strategy
- ZAPS reports from MoHCC DPS
- Balancing NatPharm – Zimbabwe Inventory Optimization Study, USAID Global Health Supply Chain Program, February 2018
- HDF Procurement Progress
- Evaluation of the Zimbabwe Assisted Pull System (ZAPS) – Baseline Report, USAID Deliver Project, February 2015

- Minutes of ZAPS PSM Advisory Committee Meetings, 2016, 2017, 2018
- NatPharm Harare Warehouse Review – Zimbabwe Inventory Optimization Study, November 2017, USAID
- Q3 2018 Summary Ordering Report
- Summary of Pharmacovigilance and Quality Control Activities under HDF 2016 – 2018
- UNICEF Shipment Summary for Essential Medicines April 2018

Human Resources for Health

- Database for Health worker retention
- Human Resources for Health Policy, HSB and MoHCC Zimbabwe
- Health Development Fund Proposals, HSB April 2016
- Mission consolidated staff returns May 2018
- RDC consolidated staff returns May 2018
- MoHCC consolidated staff returns May 2018
- Trainee posts returns May 2018
- MoHCC Top Management staff returns May 2018
- Summary by category consolidated staff returns May 2018
- Packages for selected grades in the health sector
- ZimIE PME findings 090616 RBF
- HSB Annual Report 2016
- Policy Brief: Human Resources for Health – The Way Forward for Zimbabwe, September 2017

SRHR

- National Adolescent Fertility Study, Technical Report 2016, UNFPA
- National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Services Provision (YFSP), MoHCC, ZNFPC, UNFPA, WHO – 2016 Edition
- Needs Assessment for Adolescents (15-24), Bulilima & Mbire Districts, Zimbabwe – UNFPA December 2017
- ASRH Baseline Assessment Summary Indicator Sheet: Mbire and Bulilima
- Clinical Mentorship Guidelines, MoHCC
- Draft Report on ASRH Programme Baseline and Needs, Assessment Study, Quantitative - UNFPA
- Gender Based Violence: Knowledge – Attitudes – Practices. Baseline Survey Report (Infographic) March 2018 , UNFPA
- List of 20 UNFPA supported districts for GBV
- Mashonaland West Clinical Mentorship Proposal 4th Quarter 2017
- Matabeleland North 4th Quarter Mentorship Activities: 2018
- Matabeleland North Provincial Mentorship Report 3rd quarter 2017
- Midlands Province 3rd and 4th quarter 2017 mentorship reports

Community ownership and engagement

- HCC Training Manual
- Community Scorecard
- Brochure on Patient's Charter
- CWGH Annual Report 2017

- CWGH Post Budget Analysis – Health Sector Allocations 2017
- CWGH Position on Budget Allocations for Health Sector 2017
- Barrier Analysis Research (Socio Economic, Religious, Cultural) Determinants Hindering Access and Utilisation of Health Services – Strengthening Community Participation in Health Final Report Dec 2015
- CWGH Case Studies – Strengthening of CSOs Social Accountability Monitoring and Responsiveness to SRHR in Matabeleland and Midlands region
- OPM & UKAID – Does promoting community participation increase the use of health services in Zimbabwe? October 2017 (brief)
- Strengthening community participation in health (SCPH) Final Evaluation, March 2017 (ppt)
- Strengthening Community Participation in Health Final Evaluation – Volume II: Technical Compendium, April 2017
- Strengthening Community Participation in Health Final Evaluation: Summary Report April 2017
- Policy Brief: Community System Strengthening for Health in Zimbabwe, Analysis and Recommendations, September 2017

Mortality estimates

- EQUIST Country Profile Zimbabwe 2014
- UNIGME Rates and Deaths Under 5
- UNIGME Sex Specific U5MR, CMR and IMR

APPENDIX 6

Scoring Matrix for the Assessment of the HDF against the Paris Principles

APPENDIX 7
Evaluation Timeline

APPENDIX 8

Profile of Evaluation Team Members

Team Member	Profile	Role for the Evaluation and main responsibilities
<p>Luigi DAquino</p> <p>LSTM Senior Technical Officer</p>	<p>18 years of experience</p> <p>Areas of expertise: design and implementation of health sector assessments and evaluations, including team lead of Zimbabwe HTF independent evaluation team; ex-UNICEF staff member experienced in working with UN agencies; design, planning, implementation and monitoring of maternal, newborn and child health (MNCH) programmes; design and delivery of health systems strengthening and capacity development interventions; health financing; governance and leadership; and service delivery.</p> <p>Country experience: Angola, Cambodia, Bangladesh, Ghana, India, Kenya, Malawi, Mozambique, Nigeria, Rwanda, South Africa, Sudan, Tanzania, Togo, and Zimbabwe.</p>	<p>Team Leader</p> <p>Overall design and coordination of the evaluation work</p> <p>Dialogue with stakeholders</p> <p>Oversight and quality assurance of deliverables</p> <p>Coordination of data triangulation workshops</p> <p>Report writing</p>
<p>Margaret Caffrey</p> <p>LSTM Senior Technical Officer</p>	<p>25 years of experience</p> <p>Areas of expertise: design and implementation of human resources for health assessments and evaluations including HR lead on Zimbabwe HTF evaluation team and Health Systems Assessment; design, implementation and evaluation of human resources planning, management and development policies, plans and programmes; stakeholder engagement and participatory planning and M&E approaches; design, delivery and evaluation of capacity development interventions; design and implementation of HR audits and capacity assessments; technical lead and management of HRH, HIV/AIDS, and capacity development programmes.</p> <p>Country experience: Bangladesh, Bhutan, Eritrea, Gambia, Ghana, Kenya, Lesotho, Malawi, Myanmar, Namibia, Nepal, Nigeria, Sierra Leone, South Africa, Sudan, South Sudan Swaziland, Tanzania, Timor Leste, Uganda, Zambia and Zimbabwe.</p>	<p>HRH Expert</p> <p>Participation to the inception interviews and ToC design workshop</p> <p>Collection and analysis of secondary data</p> <p>Report writing</p> <p>Thematic lead for HRH</p>
<p>Esitinah Austin Chidzanira</p> <p>Independent consultant</p>	<p>28 years of experience</p> <p>Area of expertise: strengthening public and private health pharmaceutical and health products procurement and supply chain management systems (PSM) and capacity; design of standard operation procedures for PSM processes,</p>	<p>PSM Expert</p> <p>Participation to the inception interviews and ToC design workshop</p> <p>Collection and analysis of primary and secondary data</p>

	<p>pharmaceutical QA manuals, and inventory and stock management principles; procurement manager for the National Pharmaceutical Company of Zimbabwe and supported Zimbabwe Tender Board with procurement rules and regulations.</p> <p>Country experience: Angola, Botswana, Cambodia, Lesotho, Malawi, Mauritius, Zambia, South Africa, Uganda, Nigeria and Zimbabwe.</p>	<p>Report writing</p> <p>Thematic lead for PSM</p>
<p>Aaron Blaakman</p> <p>Independent consultant</p>	<p>Over 20 years of experience</p> <p>Areas of expertise: health economics; health sector financing; costing and budgeting, financial, cost-efficiency, cost-effectiveness, economic and value for money (VfM) analysis and evaluation; governance and financing, results-based financing, performance-based financing; design of VfM M&E frameworks</p> <p>Country experience: Afghanistan, Bangladesh, Guinea, Kenya, Lao PDR, Libya, Mali, Malawi, Mauritius, Mongolia, Nigeria, Pakistan, Philippines, Republic of Congo, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, South Sudan, Uzbekistan, Vietnam, Yemen, Zambia, Zimbabwe</p>	<p>PSM Expert</p> <p>Participation to the inception interviews and ToC design workshop</p> <p>Collection and analysis of primary and secondary data</p> <p>Report writing</p> <p>Thematic lead for PSM and VfM analysis</p>
<p>Anna Miller</p> <p>LSTM Senior Technical Officer</p>	<p>20 years of experience</p> <p>Areas of expertise: Global and national public health policy, health programme implementation and management; health systems strengthening; Maternal and Child Health; HIV, TB, Malaria.</p> <p>Country experience: Zimbabwe, Ghana</p>	<p>Policy expert</p> <p>Participation to the inception interviews and ToC design workshop</p> <p>Collection and systematization of secondary data</p> <p>Participation to primary data collection</p> <p>Review and editing of the evaluation reports</p> <p>Support to coordination and organization of in-country workshops</p>
<p>Thidar Pyone</p> <p>LSTM Clinical Research Associate</p>	<p>15 years of experience</p> <p>Areas of expertise: evaluation of large scale MNCH programmes; lead researcher on Zimbabwe HTF evaluation team, mixed methods research and evaluation; Health system strengthening; health system and policy research; health system governance; programme implementation and evaluation; health programme management; public health and nutrition</p>	<p>Research Expert</p> <p>Design of topic guides for FGDs and KIIs</p> <p>Coordination of training activities with BRTI</p> <p>Coordination of Data Collection and liaison person with BRTI</p>

	Country experience: Bangladesh, India, Kenya, Malawi, Myanmar, Nigeria, Rwanda, Somaliland, Sri Lanka, and Zimbabwe	
Audrey Mahieu LSTM Senior Technical Officer	<p>Areas of expertise: coordinating health programmes in emergency and post-conflict contexts. She has worked for different organisations in Africa, Asia and in the Caribbean region. Her work has focused on strengthening health systems; improving accessibility to and quality of primary and secondary health care; testing and implementing new monitoring tools for health facility assessment and accountability mechanisms; elaborating and implementing sustainable cost recovery strategies; building Health Facility Committee Members and Community Health Workers' capacities.</p> <p>Country experience: India, Senegal, Central African Republic, Haïti, CAR, the Philippines, Burkina-Faso, Mali, Niger, Rwanda.</p>	<p>Research Expert</p> <p>Design of topic guides for FGDs and KIs</p> <p>Design of DHO and HFA questionnaires and data collection tools</p> <p>Production of data analysis plan for the survey</p> <p>Analysis of survey data</p> <p>Design of coding framework for qualitative data analysis</p> <p>Analysis of qualitative data</p> <p>Lead persons for qualitative research report</p>
Dr Sarah White LSTM Senior Clinical Research Associate	<p>Over 30 years of experience</p> <p>Areas of expertise: teaching and application of a broad range of statistical methods relevant to the design and analysis of biomedical research; design of statistical methods for the analysis of cluster randomised trials and stepped wedge trials; coordination of research projects; scientific and ethical review of research proposals; production of statistical content for reports.</p> <p>Countries experience: UK, Malawi</p>	<p>Quantitative Research Expert</p> <p>Contribution to survey design</p> <p>Analysis of survey data (production of survey tables)</p>
Simone Filiaci LSTM Research Assistant	<p>3 years of experience</p> <p>Areas of expertise: public health research using Electronic Data Collection; research design, data collection management, analysis, reporting and dissemination of research findings; analysing quantitative data using SPSS and STATA; participatory processes with national and international stakeholders for drafting projects for EU calls for proposals.</p> <p>Country experience: Togo, Ghana, Niger, Croatia, Slovenia</p>	<p>Research Assistant</p> <p>Design of survey questionnaires</p> <p>Conversion of survey questionnaires in Survey CTO software</p> <p>Uploading of data on LSTM servers</p> <p>Training of BRTI team in quantitative data collection</p> <p>Data cleaning</p>
Fiona Dickinson	<p>More than 10 years of experience</p> <p>Areas of expertise Fiona qualified as a Nurse and then Midwife in the UK where she worked within the NHS as a staff midwife and then later as a Research Assistant.</p>	<p>Research Expert</p> <p>Support to coding of qualitative data</p>

	<p>After completing an MSc in Social Research Methods, Fiona moved to Morocco for 4 years, working in an NGO run orphanage, as Health Care Manager.</p> <p>Research areas include: the use of patient reported outcomes for measuring quality of care provided in maternity services in low and middle-income countries; Healthcare facility assessment on antenatal and postnatal care, with specific focus on HIV, TB and Malaria</p> <p>Conversant with mixed methods research approaches. Experienced in design and implementation of qualitative research. Data analysis and report writing.</p>	<p>Analysis of qualitative data</p>
<p>Tim Garner</p>	<p>18 years</p> <p>Areas of expertise: Programme management of multiple projects in the international development sector, funded by various donors. Budget and proposal development. Logistics management in emergency response settings, particularly supply chain management, capacity building and improving systems.</p> <p>Country experience: Haiti, Liberia, South Sudan, Turkey, Lebanon, Nepal, Sudan, Namibia, Ghana</p>	<p>Programme Manager</p> <p>Grant management</p> <p>Oversight of subcontract with BRTI</p> <p>Review and editing of all evaluation reports</p> <p>Coordination of field activities and logistics</p>

APPENDIX 9
EQUIST report for Zimbabwe