



Independent Evaluation of the Health Transition Fund in Zimbabwe

FINAL REPORT

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health

July 2016



The banner features the Zimbabwean Primary Health Care logo on the left. The main title 'Health Transition Fund' is in large yellow letters on a dark red background. To the right, the subtitle 'Supporting the National Health Strategy to improve access to quality health care in Zimbabwe' is in dark red on a yellow background. Below the title, a row of logos includes the Canadian International Development Agency, the European Union, Irish Aid, the Norwegian Embassy, the Swiss Confederation, the Swedish government, UKaid, and the United Nations.

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ACKNOWLEDGEMENTS

The Centre for Maternal Newborn Health, Liverpool School of Tropical Medicine conducted the independent evaluation of the Health Transition Fund (HTF) from 2013 to 2015.

Throughout its various stages, the evaluation design and implementation followed the terms of reference approved by the HTF Steering Committee in 2012.

In January 2016, detailed and updated terms of reference for the final evaluation report were approved by the Steering Committee of the HTF. In March 2016, data collection took place throughout the country. More than thirty stakeholders were consulted through in-depth interviews at various level of the health system; approximately two hundred community members, including village health workers, were involved in evaluating the HTF through focus group discussions. In addition, a quantitative survey was undertaken in 44 Districts, targeting 44 District Health Executives and 165 facilities at primary and secondary level of care.

This Final Evaluation Report attempts to draw evidence-based conclusions of the results produced through the HTF and to document the key lessons learnt during its implementation in Zimbabwe, by synthesizing the extensive body of evidence available in Zimbabwe through primary and secondary data.

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.

In presenting this report, we wish to express our sincere appreciation to all the institutions and individuals who, since 2013, have contributed in various capacities to the evaluation of the Health Transition Fund in Zimbabwe, including community members, village health workers, health workers, health managers, policy makers, members of donor institutions, non-governmental organizations and UN Agencies.

We also wish to extend our thanks to those behind the scenes in this exercise: data collectors, translators, transcribers, drivers, IT consultants, data managers, data analysts and editors.

Finally, our sincere appreciation goes to the Ministry of Health and Child Care, UNICEF and the HTF Donors, for their continued support and open dialogue maintained during all the stages of the evaluation. Without their facilitation and guidance, this exercise would not have been possible.

The Health Transition Fund ended in December 2015, more than six months prior to the submission of this report. Nevertheless, we sincerely hope that some of the key learnings documented through this final evaluation can be of use to the Ministry of Health and Child Care in Zimbabwe and to its partners and donors, as they continue in their efforts to improve the health of Zimbabwean women and children.

The evaluation team
Liverpool, 20th of July 2016

ABBREVIATIONS

AAR	Average Annual Rate
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BFHI	Baby Friendly Hospital Initiative
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMAM	Community Management of Acute Malnutrition
CMNH	Centre for Maternal and Newborn Health
CSO	Civil Society Organisation
DfID	Department for International Development
DHE	District Health Executive
DHS	Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GF	Global Fund
HCC	Health Centre Committee
HDF	Health Development Fund
HMIS	Health Management Information System
HRH	Human Resources for Health
HAS	Health Services Assessment
HSF	Health Services Fund
HTF	Health Transition Fund
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
LSTM	Liverpool School of Tropical Medicine
MAR	Multilateral Aid Review
MICS	Multiple Indicators Cluster Survey
MIMS	Multiple Indicator Monitoring Survey
MNCH	Maternal, Newborn and Child Health
MoHCC	Ministry of Health and Child Care
NatPharm	National Pharmaceutical Company
NIHFA	National Integrated Health Facility Assessment
ODA	Official Development Aid
OECD	Organization for Economic Co-operation and Development
OPD	Outpatient Department
PCN	Primary Care Nurses
PCV	Pneumococcal Vaccine
PEPFAR	President's Emergency Plan for AIDS Relief
PHCP	Primary Health Care Package
PMD	Provincial Medical Director

PNC	Postnatal Care
PSM	Procurement and Supply Management
RBF	Results-Based Financing
RGN	Registered General Nurse
RMNCH	Reproductive, Maternal, Newborn and Child Health
RUTF	Ready to Use Therapeutic Foods
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendance
SC	Steering Committee
SCM	State Certified Midwife
ToR	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VfM	Value for Money
VHW	Village Health Worker
VMAHSS	Vital Medicines Availability and Health Services Survey
WB	World Bank
WHO	World Health Organization

GLOSSARY OF DEFINITIONS

- Health Care Workers: Health workers are people whose job it is to protect and improve the health of their communities. Together these health workers, in all their diversity, make up the global health workforce. (WHO)
- Beneficiary: when not otherwise defined, beneficiaries refer to the target group of the HTF including: Women of reproductive age, mothers and children under five years of age.
- Donors: refers to the organisations that financially contributed to the HTF including European Commission and Governments of Ireland, Sweden, Norway, Canada, United Kingdom.
- Partners: Organizations involved in the HTF without providing financial support
- Fund Manager: refers to the managing organization of the HTF in this case UNICEF

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1. OBJECT OF THE EVALUATION

1.1. CONTEXT

1.1.1. Country background

Located in southern Africa, Zimbabwe is a land locked country of 390.757 square km, bordering Botswana, Mozambique, South Africa and Zambia. The country is administratively divided in 8 Provinces, 59 districts and 2 cities with provincial status, Harare and Bulawayo. The population is estimated at 14.2 million inhabitants in 2016¹: approximately 70% of Zimbabweans live in rural areas and more than 40% of the population is under 15 years of age. According to the Zimbabwe 2012 Census, life expectancy is estimated at 58 years.

Rural areas are home to 79% of the poor and 92% of the extreme poor². According to the recent Zimbabwe Poverty Atlas³, 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%. Zimbabwe's economy depends heavily on its mining and agriculture sectors. Following a decade of contraction from 1998 to 2008, the economy recorded real growth of more than 10% per year from 2010-13, before slowing to roughly 3% in 2014 due to poor harvests, low diamond revenues, and decreased investment⁴.

The introduction to the Zimbabwe Equity Watch Report 2014⁵, reported below, provides a comprehensive summary of the situation of the country during the decade preceding the implementation of the HTF, to date:

“There have been many challenges in the past decade. These include a falling Gross Domestic Product (GDP), hyperinflation, rising debt and falling exports between 1999 and 2008 (ZIMSTAT UNICEF 2009; IMF 2014). Land reform post 2000 led to the transfer of around 8 million hectares of land across 4,500 farms to over 160,000 households, hence raising opportunities for more equitable economic benefit from land and challenges to support production in newly settled farms (Scoones et al. 2010). After high levels of political contestation, a 2009 ‘inclusive government’ was set up under a Global Political Agreement. The adoption of a multicurrency regime was followed by a period of economic recovery, with a real annual GDP growth of 4.4% in 2012, improved manufacturing sector output, a rising supply of goods and services and a contraction in the debt to export ratio (ZEPARU et al. 2013; IMF 2014).

The national average household income in April 2013 of US\$95 was 12% higher than the same period in 2012 (ZIMVAC 2013). In March 2013 the country adopted a new constitution that included the rights to health care and health determinants, discussed later.

Elections in July 2013 resulted in a ZANU-PF led government, and the launch in October 2013 of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset). ZimAsset set short term interventions to December 2015 and longer term measures to December 2018 within clusters of food security and nutrition; social services and poverty eradication; infrastructure and utilities and value addition and beneficiation (GoZ 2013). At the same time economic improvements have slowed down,

¹ Zimbabwe Census 2012: Population Projections Thematic Report. Zimbabwe National Statistics Agency, August 2015

² Zimstat, PICES survey, 2012

³ Zimbabwe Poverty Atlas 2015, Zimbabwe National Statistical Agency, August 2015

⁴ <https://www.cia.gov/library/publications/the-world-factbook/geos/zi.html>

⁵ *Zimbabwe Equity Watch 2014*, Training and Research Support Centre and Ministry of Health and Child Care, Zimbabwe, April 2015

with GDP growth estimated at 2.9% in 2013, 3.1% in 2014 and 1% growth forecast in 2015, lower than African averages (ZEPARU et al. 2013, GoZ 2014b, World Bank 2014b).

The revenue collection from key economic activities has been lower than expected, with mining company dividends dropping from US\$174 million in 2010 to US\$ 45 million in 2012 and zero in 2013 (Sibanda and Makore 2013). The Zimbabwe Revenue Authority (ZIMRA) reported a revenue much lower than expected from diamond production (Mzumara 2014).

Zimbabwe's Human Development Index (HDI) fell between 1990 and 2008, at a time when the Sub-Saharan African HDI rose (UNDP 2011). It rose after 2009 to 1980 levels and to 0.492 in 2013 (UNDP 2014). The trends reflect the fall in life expectancy in the 1990s due to AIDS, improving after 2005; rising education completion to 2005, plateauing thereafter and falling incomes to 2008, with a small rise thereafter."

In 2015, Zimbabwe ranked 155 out of 188 countries globally, on the Human Development Index (HDI)⁶.

1.1.2. Maternal and child health in Zimbabwe

In the 1980s and 1990s, Zimbabwe was a model for many African countries, for the quality and availability of health and social services to the population.

The health system was severely hit by the crisis that affected Zimbabwe between 2000-2008, and the impact of this crisis was further exacerbated by the severe HIV/AIDS epidemic that hit the country during the same period.

Government expenditure on health decreased and, although donors progressively stepped up their support, households were forced to absorb a much larger share of the costs of the health sector through user fees⁷. Life expectancy dropped and maternal and child mortality increased as a consequence of reduced access to goods and services.

The infant mortality rate increased from 49 per 1,000 live births in 1998 to 60 in 2005-2006 and remained stable at 57 in 2010-2011 (ZDHS 1998; 2005-6; 2010-11). Similarly, the under-five mortality rate was estimated at 71 per 1,000 live births in 1998; 102 in 1999 and 84 in 2010-2011.

Maternal health indicators worsened even more dramatically due to the HIV/AIDS epidemic: the maternal mortality ratio increased from 364 per 100,000 live births in 1994 to 960 in 2010-11 (Source: ZDHS 1994; 2010-11).

In such social, economic and political context, **the HTF was designed to contribute to tackle a dramatic situation and to support the government in inverting trends in maternal and child health for all Zimbabweans.**

"The expenditure on health per capita deteriorated significantly from US\$42 in 1991 (which was the highest in sub-Saharan Africa) to just under US\$6 in 2009. As a consequence, major challenges were faced in the health sector including; loss of professional staff, dysfunctional health infrastructure, lack of drugs and equipment, outdated policies and procedures and facilities being unable to cover their running costs. By 2008/ 2009, the health system was in a state of near collapse, manifested in emerging disease

⁶ Human Development Report 2015 – Briefing Note for Zimbabwe. UNDP, 2015

⁷ *Zimbabwe Economic Update*, The World Bank, February 2016

(<http://www.worldbank.org/en/country/zimbabwe/publication/zimbabwe-economic-update-changing-growth-patterns-improving-health-outcomes>)

epidemics, and a huge cholera outbreak in 2008 which the system was unable to contain, resulting in the loss of 4,000 lives. A measles outbreak in 2009 claimed the lives of 1,600 young children. (...)

At the same time the rapid spread and lack of widely available treatment for HIV and AIDS increased mortality and morbidity amongst mothers and children and reduced the life expectancy of the adult population. The HIV prevalence increased steadily through the 90s to an estimated peak of 29% in 1997 and life expectancy dropped from to 60.1 years in 1990 to just 47 in 2000. Non-communicable disease prevalence also rose steadily with an estimated 1,855 women were being diagnosed with cervical cancer and 1,286 dying annually from the disease (WHO/HPV Centre 2010 estimates). Amongst the poorest, all of this was further exacerbated by poor nutrition as Zimbabwe continued to face nutritional challenges with an estimated 35% of all children under the age of 5 experiencing stunting in 2010.”⁸

“After the economic and humanitarian crisis and the near collapse of social services in 2008-2009, the need was for funding modalities that would channel external financing to revitalise key public social services in a stable currency. The transition fund mechanisms (TFM) were established at a time when emergency funding to Zimbabwe was waning, and official development assistance increasing, but with most development partners unable to channel money through government. Options during this time would have been for development partners to finance social services directly through a series of individual programmes and projects, but it was recognised by all stakeholders that this would fragment social service provision and be hugely detrimental to government ownership, alignment and harmonisation of external resources, and government capacity. (...)

In the health sector the HTF – launched in December 2011 - was a response to increasing rates of maternal and child mortality. (...). This occurred within the context of an acute shortage of qualified practitioners and essential equipment and medicines, of user fees which suppressed demand for health services, and the skewing of external financing to HIV/Aids programmes.”⁹

⁸ HEALTH DEVELOPMENT FUND: A Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020). Proposal Document, March 2015

⁹ Assessment of the Transition Funding modality, a pooled funding mechanism for the social sectors in Zimbabwe. Final Report. Mokoro, January 2015

1.2. THE HEALTH TRANSITION FUND (HTF) AT A GLANCE

The key features of the HTF are summarized below in [Table 1](#) below.

Table 1 - The HTF program: key features

Program duration	1 st January 2012- 31 st December 2015
Initial program budget	USD 435,336,586
Actual budget	USD 235,222,354
Actual expenditure¹⁰	USD 207,743,840
Donors	DFID, EC, Governments of Ireland, Sweden, Norway, Canada, UK
Fund manager	UNICEF
Geographic Focus	Nationwide
Target groups	Women of reproductive age, mothers and children under five years of age
Purpose	To improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact interventions through the health sector
Goal	To contribute to reduced maternal mortality and under five mortality and combat, halt and reverse trends in HIV and AIDS, malaria and other diseases by 2015
Objectives	<p><i><u>In the area of MNHC</u></i></p> <ul style="list-style-type: none"> - Enhancing obstetric and newborn health capacity of the health system - Strengthening the community health services system for MNCH and Nutrition - Improving child health through strengthened EPI and IMNCI - Strengthen national capacity at all levels in maternal, newborn, infant and young child nutrition <p><i><u>In the area of Medical products, vaccines and commodities</u></i></p> <ul style="list-style-type: none"> - To maintain availability of 80% of essential medicines and commodities and 100% of vaccines and injection equipment, cold chain equipment and nutrition commodities in all health facilities <p><i><u>In the area of Human Resources for Health</u></i></p> <ul style="list-style-type: none"> - To ensure that 95% of health management offices and health facilities are staffed with the minimum standards of qualified health professionals by 2015 <p><i><u>In the area of Health policy, planning and finance</u></i></p> <ul style="list-style-type: none"> - To improve national capacity for policy, planning and financing across all service delivery levels, with special emphasis on peripheral health facilities

¹⁰ Funds utilization amount reported through Annual Reports of HTF to Donors 2012; 2013; 2014; 2015.

1.3. THE HTF DESIGN; IMPLEMENTATION AND LOGICAL MODEL

1.3.1. The HTF design and rationale

The design logic of the HTF entailed setting in place a number of specific measures at all levels of the health system, which included:

- Capacity building (via training, mentoring and supportive supervision) of healthcare workers with a focus on primary care level;
- A retention scheme for healthcare workers to enhance motivation and ensure retention of critical staff within the health system;
- Procurement and distribution of essential medicines, equipment and supplies, with a focus on the primary healthcare level;
- Introduction of a facility financing mechanisms (a fixed allowance called health services fund during the period 2012-2014, and then a performance based financing scheme as of 2014)
- Support to monitoring and planning capacity at district level and below, in order to support evidence based decision making;
- Deployment and training of a cadre of village health workers, as the frontline interface between community and the health system;

Such interventions were aimed at:

- Restoring **availability and functionality of essential health maternal, newborn and child care services**, with a focus on primary care level facilities;
- Stimulating **demand for/access to services**, by removing barriers to access health care (user fees) and by strengthening the linkage between facilities and communities (health centre committees);
- Promoting **behaviour change**, improved care seeking and referral and the adoption of healthy household practices, through the deployment of village health workers;
- **Enhanced policy and planning** capacity and practice at all levels of the system underpinned the above-mentioned strategies.

Through the implementation of these strategies at scale, the HTF aimed at contributing to **increased coverage of key MNCHN indicators, along the continuum of care**.

1.3.2. Policy framework

The HTF was designed to support the Ministry of Health and Child Care to achieve progress in its mandate of *‘achieving the highest possible level of health and quality of life for all Zimbabweans’*.

The overall objective of the HTF programme was to contribute to reduced maternal mortality and under-5 mortality and eliminate user fees for children under 5 and pregnant and lactating women in Zimbabwe by 2015. The programme also aimed to contribute to reducing the prevalence of underweight children under 5 by half and to combat, halt and reverse trends in HIV/AIDS, malaria and other diseases.

The HTF was implemented under the National Health Strategy (2009-2013) and revised **National Health Strategy for Zimbabwe (2009-2015)**, alongside two key strategic policies: the Maternal and Neonatal Roadmap (2007-2015) and the National Child Survival Strategy (2010-2015). The overall program design

was informed by the National Health Strategy and conceived to support its realization, at the least in key areas of work related to maternal and child health.

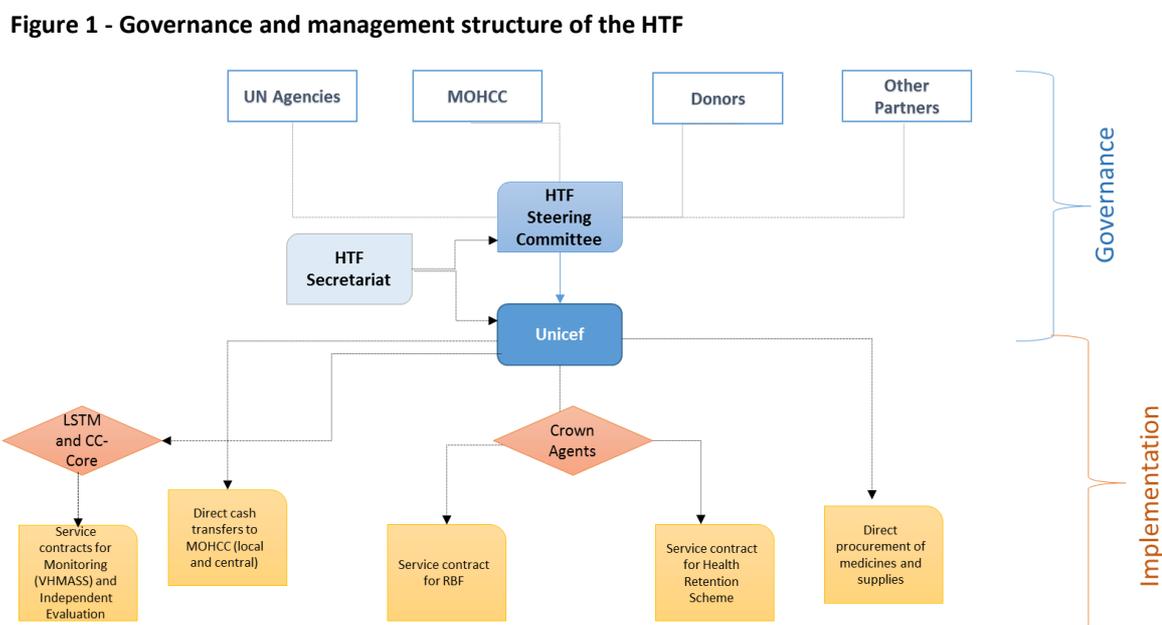
1.3.3. HTF Governance and management structure

Throughout its implementation, the HTF relied on a well-defined management and governance structure, outset at program design stage¹¹ and agreed amongst donors, partners, UNICEF and MoHCC.

This structure, reflecting an underlying participatory approach and a logic of ensuring government leadership and ownership of the initiative, relied primarily on a Steering Committee as the core body overseeing the governance and decision making processes and on a fund manager (UNICEF) tasked to ensure the implementation at scale of all the initiatives approved by the Steering Committee.

Planning and implementation were based on an initial program concept and logframe and guided by annual work plans and budgets approved year-by-year the HTF Steering Committee.

The program governance and management structure of the HTF is summarized in [Figure 1](#)¹².



1.3.4. Logical framework

The HTF counted on a very articulated logframe, which was designed and approved by the steering committee at program inception, based upon the program logic and rationale that is well articulated in the HTF proposal document.

¹¹ HTF proposal document, 2011: http://www.unicef.org/zimbabwe/ZIM_resources_htfoutline.pdf

¹² LSTM: adapted from HTF proposal document

To the best of our knowledge, the HTF lacked an explicit theory of change guiding the design of its logframe.

The HTF logframe presents three major levels of assessment: impact, outcomes, outputs.

At each level, indicators were defined according to the main thematic areas around which the HTF was designed:

- Theme 1: Maternal, newborn and child health and nutrition
- Theme 2: Medical products, vaccines and commodities
- Theme 3: Human resources for health
- Theme 4: Health policy, planning and financing

A set of 100 activities were defined through the original HTF logframe as a means to realize the HTF objectives and to meet the targets set in the logframe: 71 activities for Theme 1; 13 for Theme 2; 4 for Theme 3; 12 for Theme 4.

As summarized in Table 2 below, the logframe is composed of **86 indicators**, the majority defined and set for Theme 1 (60) and for output level results (54).

Table 2 - HTF logframe structure

<i>Results framework Level</i>	<i>Theme 1</i>	<i>Theme 2</i>	<i>Theme 3</i>	<i>Theme 4</i>	<i>Total</i>
Impact	3	-	-	-	3
Outcome	21	3	3	2	29
Output	36	8	3	7	54
Total	60	11	6	9	86

The HTF logframe is presented in detailed in **Annex 1**.

An analysis of the HTF logframe is provided in Chapter 3.4 of this report.

1.4. KEY STAKEHOLDERS INVOLVED IN THE HTF

1.4.1. Partners

At proposal document stage, the HTF clearly identifies the partners in the program. These were defined at the beginning as:

- Government of Zimbabwe
- UNICEF
- The Governments of the United Kingdom of Great Britain and Northern Ireland ("the United Kingdom") represented by the Department for International Development (DFID)
- The Government of Ireland represented by Irish Aid
- The Government of Sweden
- the Government of Norway
- The European Commission represented by the Delegation of the European Union to Zimbabwe.

1.4.2. The Steering Committee

An HTF Steering Committee (SC) was set in place as the governing body responsible for the oversight and decision making of the HTF. As per initial HTF proposal document, *‘the HTF Steering Committee is composed of MoHCC, funding partners to the HTF, a representative organisation from Civil Society, UNICEF, WHO and UNFPA. The latter three agencies will also serve as technical advisors and UNICEF will serve as the Secretariat. The steering committee may invite individuals or representatives of other organisations to participate in discussions.’*

A review of HTF meeting agendas accessed by the evaluation team highlighted that the initial SC set up was broadened during the course of the program implementation, to ensure a larger base of participation and dialogue. Additional organizations invited to SC meetings included: the World Bank, UNAIDS, UNDP, USAID, Crown Agents, NatPharm and the Health Services Board. Email invitations to SC meetings included on average 50 invitees. The HTF SC was chaired by MoHCC, in the person of the Permanent Secretary, and co-chaired by an HTF donor.

The SC was supported by and HTF Secretariat, in charge of coordinating day-to-day communications and the activities of the SC.

1.4.3. Implementing partners

Various implementing partners were involved in the planning, design and delivery of various HTF activities. These included, but were not limited to the partners indicated below:

Table 3 - HTF Implementation partners

Partner	Role within HTF
Crown Agents	Subcontractors for Results Based Financing; Payment of Health retentions scheme
Health Service Board	Monitoring of Health Retention Scheme
Natpharm	Distribution of medicines
UNICEF Supply Division	Procurement of medicines and supplies
Collaborating Centre for Operational Research (CCORE) – until 2014	Management of the quarterly Vital Medicines Availability and Health Services Survey (VMAHS)
Liverpool School of Tropical Medicine	Independent evaluation of the HTF

2. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

2.1. PURPOSE AND OBJECTIVES OF THE EVALUATION

The terms of reference, deliverables and timelines for the Independent Evaluation of the HTF were designed and approved at inception by the HTF Steering Committee and stipulated through a Service Contract with UNICEF (N. 43137287). The initial TORs of the evaluation are enclosed to this report, in **Annex 2**.

TORs defined the purpose of the Independent Evaluation of the HTF as follows:

To assess to what extent HTF strategies, approaches and overall intervention logic have contributed to changing the health situation of the population with a special focus on maternal, newborn and child health and at the same time to determine whether the resources have been used in the most efficient way to achieve those changes.

The Liverpool School of Tropical Medicine has worked alongside the HTF and, to date, the following reports have been made available to the Steering Committee:

- Baseline Report, 2011
- Annual Review, 2012
- Mid-Term Review, 2013
- Annual Review, 2014

In line with the Inception Report submitted by LSTM in 2013 and with the contract signed with UNICEF for the Independent Evaluation of the HTF, the **final evaluation** is designed to document the overall programme achievements and the effectiveness of the HTF along its life span.

The **purpose of the final evaluation** is two-fold:

- To assess the achievement of HTF intended results by the end of its implementation in 2015.
- To document lessons learnt and identify success factors and areas to be improved after the end of the program.

Detailed ToR and a design note for the final evaluation were submitted to the HTF Steering Committee in December 2015 and approved in January 2016. These are available in **Annex 3**.

2.2. SCOPE OF THE EVALUATION

2.2.1. Geographical scope

The evaluation is designed to assess the program nationwide; this is in line with the scope of the HTF, which is in nature a funding mechanism through which a number of interventions were deployed at scale throughout Zimbabwe. The evaluation questions are addressed at a national level. Therefore, routine data, available through HMIS and other sources have been analysed at national level; equally, primary data collection was designed to provide representative findings for the entire country.

Where feasible, the evaluation has explored and documented differences amongst various provinces in achieving the HTF intended outputs and outcomes.

2.2.2. Time period

The evaluation covers the period 2012-2015, during which the HTF was implemented.

2.3. EVALUATION CRITERIA AND QUESTIONS

In line with the OECD-DAC criteria for international development evaluations, the evaluation will provide an assessment of the achievements of the HTF against the following criteria:

Relevance (*Are we doing the right things?*)

Relevance is defined by OECD-DAC as “the extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor”.

Effectiveness/Efficiency (*Are we doing things right?*)

Effectiveness is defined by OECD-DAC as “A measure of the extent to which an aid activity attains its objectives”. Efficiency measures the outputs in relations to inputs.

Impact (*Did we contribute to change?*)

Impact is defined by OECD-DAC as “the positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended”.

Sustainability (*Will change last?*)

According to OECD-DAC, “Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn”.

A set of evaluation questions were defined and agreed with the Steering Committee, for the final evaluation of the HTF. These are presented in **Table 4**.

2.4. IMPLEMENTATION ARRANGEMENTS

2.4.1. The evaluation function: roles and responsibilities

The HTF embedded an independent evaluation in its design since inception.

The HTF Steering Committee was in charge of defining the terms of reference for the evaluation, and for overseeing its implementation, through the HTF M&E sub-group.

UNICEF had the responsibility of managing the contractual arrangements with an external service provider, selected via a competitive tendering process to deliver the evaluation (LSTM).

On an annual basis, LSTM submitted updated terms of reference for its annual contractual deliverables for review and approval of the HTF Steering Committee.

The terms and conditions for the evaluation are regulated by the Service Contract n. 43137287 signed between UNICEF and LSTM in March 2013.

The evaluation was implemented from March 2013 to July 2016.

2.4.2. Evaluation team

The team of consultants assigned to the HTF evaluation encompassed a broad range of expertise, spanning public health policy and planning; epidemiology and statistics; maternal, newborn and child health (MNCH); human resources for health (HRH) and procurement and supply management (PSM).

The team was comprised of the following members:

Mr. Luigi D'Aquino – Team Leader

Prof. Nynke van den Broek – Technical Supervision and Advice

Dr. Thidar Pyone – Coordination; Research design and analysis

Dr. Helen Owolabi – Research design and analysis

Prof. Stephen Munjanja – Thematic Area 1, Maternal Newborn and Child Health

Mrs. Margaret Caffrey – Thematic Area 2, Human Resources for Health

Mr. Michael Lijdsman – Thematic Area 3, Medical Products, Vaccines and Technologies

Dr. Sarah White - Analysis of quantitative data

Ms. Siv Steffen Nygaard – Analysis of qualitative data

Additional specialists at LSTM-CMNH collaborated to the final evaluation, including: Dr Barbara Madaj in the research design, Mrs Fiona Dickinson in the planning and design of the survey questionnaire, Miss Caroline Hercod in the editing and formatting of reports, Mr Fred Yeomans in program management, Miss Sara McManus in administration and Mr. Nik Cooper in logistics.

In Zimbabwe, Mr. Sunhurai Mukwambo collaborated in the planning and organizing fieldwork as a technical officer.

2.4.3. Implementing partners

Local institutions were sub-contracted by LSTM for qualitative (FGDs) and quantitative (survey) data collection activities in Zimbabwe.

The selection of sub-contractors followed the LSTM internal procurement rules, and entailed a careful assessment of quality of technical and price proposals; knowledge of local context and stakeholders (and languages); references; ability to deliver on time and at required quality standards.

In line with contractual obligations, approval from UNICEF was sought and obtained prior to subcontracting partners.

For the Health Services Assessment performed through the evaluation, the external company **Development Data** was sub-contracted by LSTM to collect survey data at DHEs and facility level.

For the FDGs performed in communities in 2016, the **Department of Community Medicine at the University of Zimbabwe** was sub-contracted by LSTM for the administration, translation and transcription of FDGs.

The above mentioned partners had the primary role of implementing data collection activities at field level (facility surveys; focus group discussions).

LSTM maintained the responsibility of designing data collection tools; training the field teams together with partners; providing quality assurance during data collection; and analysing both quantitative and qualitative data.

2.5. ETHICAL CONSIDERATIONS

The specific research protocol for this evaluation was submitted to and approved by the LSTM Research Ethics Committee.

Approval to conduct data collection was obtained by the MOHCC Zimbabwe, prior to the initiation of any field activity.

A major ethical issue in this evaluation involved protecting the confidentiality of participants, for example due to the potential leakage of information discussed during the interviews and/or focus group discussions.

Participation without coercion or fear was ensured throughout the process: all participants received explanations prior to data collection, and were given the full right of withdrawing from the exercise at any time. Consent forms were signed before recording data.

In order to minimize these potential breaches of confidentiality, all data were anonymised during data collection and analysis and when preparing reports so that responses cannot be traced to individual respondents. Pseudonyms/labels were used in place of individual names and home villages.

Discussion of any sensitive but useful information obtained from the discussions was explored further privately with the participant after the FGD.

Hard copies of all data were kept in locked cupboards and soft copies on password-protected computers so that people that are not part of the project team would not have unauthorised access to the data.

3. EVALUATION METHODOLOGY

3.1. METHODS

3.1.1. Principles

The research team strictly adhered to the LSTM's Code of Practice for Research Conduct in designing and implementing the evaluation. The LSTM's Code of Practice for Research Conduct expects all researchers to understand and apply the following principles:

- Being open, honest and fair, including properly attributing the contribution made by others
- Providing leadership and co-operation in research, including the appropriate supervision and mentoring of young researchers
- Appropriately recording and reporting research, allowing ready verification of the quality and integrity of the research data
- Appropriate dissemination, application and exploitation of the results of research
- Compliance with relevant regulations or policies, whether legal, institutional or other, which govern particular aspects of research
- Professional participation only in work which conforms to accepted ethical standards and which ensures the safety of all those associated with the research
- Participation only in work which the researcher is competent to perform
- Avoidance of real or apparent conflicts of interest
- Strict maintenance of the confidentiality of all those involved

These principles are fully aligned with key United Nations Evaluation Group¹³ standards, and in particular: integrity, independence and impartiality (UNEG 2.5.); participation of stakeholders throughout the evaluation process (UNEG 3.11); respect and honesty (UNEG 3.10); anonymity and confidentiality of individual information (UNEG 2.7.).

The evaluation also ensured that **gender equality and human rights** were fully embedded in each stage of the evaluation cycle.

The approach to gender equality and human rights will entail the following minimum standards:

Evaluation input and process level

- Fair composition of teams of consultants and field workers involved in data collection;
- Equal voice to different groups assessed/involved in data collection at management, facility or community level;

¹³ United National Evaluation Group (UNEG): Standards for the Evaluation in the UN System. April 2005.

Evaluation output and outcomes

- Disaggregation of quantitative data by socio-economic characteristics of the population;
- Disaggregation of data by gender (where available);
- Analysis of qualitative research coded relevant emerging themes according to gender and socio economic characteristics of the population;
- The findings of the evaluation – when this was possible - have highlighted relevant aspects of gender equality and human rights, exploring barriers/bottlenecks to equal access to care for different groups of the population.

3.1.2. Evaluation Design

The evaluation was designed to assess the plausible contribution of the HTF to national level progress in improving maternal and child health outcomes in Zimbabwe.

The HTF Logframe formed the cornerstone against which progress made during implementation was analysed.

A **mixed methods approach** utilising quantitative and qualitative evaluation methods has been used for the final evaluation.

In particular, methods of data collection and analysis have included:

- A nationwide health services assessment, conducted in 2014, 2015 and 2016 to assess the availability of health services at district level and at primary care level through a modular survey administered at three levels of the health system: District Health Management, District Level Hospitals and Level 1 Facilities.
- Key informant interviews conducted in 2015 and 2016 and used to gather views and perspectives of stakeholders at three levels: national, district in health facilities, and community in health centre committees.
- Focus group discussions with members of district health offices, village health workers and beneficiaries (women of reproductive age, caregivers of children under-5) conducted in 2016.
- Secondary data and reports available in Zimbabwe and internationally

The evaluation methodology adopted to assess the evaluation criteria and the related evaluation questions are presented in detail in the **Evaluation Design Note**, approved by the HTF Steering Committee in January 2016 and available in **Annex 3**.

Table 4 overleaf provides a summary of the methods and data sources used to address the evaluation questions.

Table 4 - Evaluation methods

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
Impact	<ul style="list-style-type: none"> Has the HTF contributed to improve maternal newborn and child health and nutrition outcomes in Zimbabwe, from 2012 to 2015? 	<p>Analysis of change in HTF impact and outcome level indicators (Trends analysis/Annual Rate of Change) from 2011 to 2015</p> <p>Estimates of additional maternal and children's lives saved from 2011 to 2015 (LiST tool)</p>	<p>Baseline: MIMS 2009 or DHS 2010 Endline: DHS 2015 key findings or projections (UN IGME) HMIS data and trends will be used to inform the simulation and for triangulation</p> <p>As above</p>
Relevance	<ul style="list-style-type: none"> To what extent did the HTF address needs and priorities of beneficiaries including women of reproductive age, mothers and children, and indirectly healthcare providers? How valuable were the results to beneficiaries? Were the HTF supported interventions consistent with national health and nutrition policies and plans, and with global health and nutrition priorities? Has the HTF made a difference in terms of governance and coordination at national and local level? 	<p>Thematic framework analysis of perspectives of relevant stakeholders at facility and community level</p> <p>Analysis and review of policy documents and plans</p> <p>Thematic framework analysis of perspectives of relevant stakeholders at national, district and community level</p>	<p>KIIs with healthcare providers (2-3 healthcare workers/facility; 2-3 facilities/district; 6-9 interviews in total)</p> <p>FGDs with VHWs and with communities (men and women) (2-3 FGDs with VHWs/district; 2-3 FGDs with communities/district; 6-9 FGDs with VHWs in total; 6-9 FGDs with communities in total)</p> <p>Policy documents and plans International policy documents and guidelines</p> <p>KIIs with multilateral and bilateral organizations and with HTF Steering Committee members (4-5 interviews)</p> <p>FGDs with DHO personnel (minimum one/facility; 2-3 facilities/district; 6-9 FGDs in total)</p> <p>Key Informant interviews with health centre committees (3 districts in total; 3 FGDs in total)</p>
Effectiveness	<ul style="list-style-type: none"> To which extent were HTF intended results achieved during its implementation? 	<p>Trend analysis of outputs against targets Disaggregation by geographical area/target group (secondary data, where applicable)</p>	<p>LSTM health services assessments 2014, 2015 and 2016; Secondary data sets and reports (VHMASS, HMIS, MODO, etc.)</p>

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
	<ul style="list-style-type: none"> ▪ What were the main facilitators and barriers to achieving intended results? ▪ What unintended results – positive and negative – did the intervention produce? How did these occur? 	<p>In depth analysis of progress by HTF thematic areas</p> <p>Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level</p> <p>Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level</p>	<p>Secondary data and reports</p> <p>FGDs with DHE personnel (minimum one/facility; 2-3 facilities/district; 6-9 FGDs in total)</p> <p>KIIs with health centre committees (3 districts in total; 3 FGDs in total)</p> <p>FGDs with VHWs and with communities (men and women; 2-3 FGDs with VHWs/district; 2-3 FGDs with communities/district; 6-9 FGDs with VHWs in total; 6-9 FGDs with communities in total)</p>
Efficiency:	<ul style="list-style-type: none"> ▪ To what extent was the HTF implemented as per plans and budget throughout its implementation period? ▪ To what extent did the intervention represent the best possible use of available resources to achieve results of the greatest possible value to participants and the community? 	<p>Costing outline by intervention/thematic area and by year</p> <p>Case Study on cost benefits, utility and sustainability of procurement and supply management (kits)</p>	<p>HTF Implementation plans, proposed budgets and expenditure data 2013, 2014 and 2015 Costs available via UNICEF</p> <p>Questionnaires; interviews; secondary data and reports</p>
Sustainability:	<ul style="list-style-type: none"> ▪ To what extent does the government, at all levels of the system ‘own’ the HTF achievements? ▪ Are any positive results likely to be sustained? ▪ How will the institutional and technical capacity and the systems developed be sustained? 	<p>Thematic framework analysis of perspectives of relevant stakeholders at national, district, facility and community level</p> <p>Case study on Health Retention Scheme</p> <p>Thematic framework analysis of perspectives of relevant stakeholders at national, district, facility and community level</p>	<p>KIIs and FGDs (as above) Analysis of government budget allocations</p> <p>Questionnaires, interviews, review of secondary data and reports KIIs and FGDs</p>

3.2. PRIMARY DATA SOURCES

3.2.1. Health Services Assessment

Rapid health services assessments (HSA) was conducted in 2014, 2015 and 2016 to assess progress in enhancing quality and availability of care at all levels of the system.

The HSA was conducted nationwide to assess the availability of health services at district level and at primary care level through a modular survey administered at three levels of the health system: District Health Management, District Level Hospitals and Level 1 Facilities.

The LSTM Survey provided an independent measurement of a subset of **HTF outcome and output indicators**, collectable at health services level.

The assessment looked at three different study populations: District Health Offices; District level hospitals; Level 1 facilities.

The sampling frames for the study population were obtained through the MOHCC (2005 census) and adjusted in coordination with the Directorate of Health Information and Surveillance.

Sampling of District Health Offices was stratified by province.

The district level hospitals sampling was based on a cluster sampling approach. Hospitals were clustered by district and only hospitals within the districts from which DHOs were selected were included

For sampling of level 1 facilities, a cluster sampling approach was also used. Similar to hospitals, facilities were clustered by district and only facilities within the selected districts were included.

In line with the sampling calculations presented in the evaluation design note, the assessment covered:

- 1) 44 District Health Offices
- 2) 47 District Level Hospitals – including both Government District Hospitals, and Mission facilities performing comprehensive emergency obstetric and newborn care (CEmONC) in the districts.
- 3) 118 Level 1 facilities

For each population the margin of error in estimation was set not to exceed 10%, at national level.

Data analysis was performed using the commands of survey data analysis within Stata version 12.0. For each of the three populations sampled the analysis accounted for clustering (by district) and sampling weights as applicable.

Each indicator and other proportion, ratio or mean was estimated and reported with a 95% confidence interval.

A full report of the **Health Services Assessment 2016** is available in **Annex 4**.

Previous HFA reports have been submitted to the HTF Steering Committee alongside the Mid-Term Review 2014 and the Annual Review 2015 respectively.

3.2.2. Key Informant Interviews and Focus Group Discussions

Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted in 2016 to collect the views and perspectives of stakeholders at various levels of the health system, with regard to the relevance, effectiveness/efficiency and sustainability of the strategies set in place through the HTF.

Purposive sampling was used to identify and recruit potential participants for FGDs and KIIs. The districts were chosen due to difference in socio-economic and health characteristics.

We conducted a total of 30 KIIs with national level policy makers, members from DHE, managers and healthcare providers from health facilities with the districts of Matabeleland South, Mashonaland East and Masvingo provinces. In addition to public health staff, we also interviewed informants from multilateral and bilateral organizations who were familiar with HTF and results-based financing.

In addition, a total of 20 FGDs were conducted (six in Masvingo province; six in Matabeleland South and eight in Mashonaland East) comprising of 124 community men and women; and 73 VHWs.

All transcribed FGD and KII material was analysed thematically. Anonymised transcripts were imported into MS Word and Excel for analysis. Two qualitative researchers coded the data. The data were initially coded using open codes and compared against the evaluation framework (Richie and Lewis 2003: 201).¹⁴ After construction of the preliminary coding scheme, each code was examined in details for further refinement. The codes were grouped under categories and key themes. Analysis was guided by qualitative content analysis of Graneheim and Lundman (2004), which focuses on the key areas of consensus and disagreement, and where relevant, triangulating KIIs with FGDs.¹⁵

A full report of the **key findings of our qualitative research** is available in **Annex 5**.

3.3. SECONDARY DATA SOURCES

The evaluation made extensive use of available reports and data sets that were relevant to both the Zimbabwe health system and the HTF programme.

Criteria for selection and assessment of secondary data included:

- Relevance to the health sector in Zimbabwe
- Relevance to thematic analysis (eg. evidence from other countries on RBF)
- Usefulness in addressing evaluation questions and/or HTF log-frame
- Quality and reliability of sources

Routine data from HMIS were obtained via MoHCC.

Other reports were either access through partners in Zimbabwe or via literature searched conducted by the LSTM teams.

All secondary data and reports were systematically used to triangulate information and validate key findings.

The main secondary data sources used for the final evaluation are included as a complete **list of reports and data sets** in **Annex 6**.

¹⁴ Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). Qualitative research practice: A guide for social science students and researchers: Sage.

¹⁵ Graneheim and Lundman (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness

3.4. THE HTF LOGFRAME

LSTM has used the HTF logframe as the guiding tool for its reviews of progress of the program, and of its final achievements.

The logframe, compiled as of end 2015, is presented in full in **Annex 1**.

Some issues in the methodological design and usability of the logframe have emerged and are highlighted below, since they are relevant to this evaluation:

- Indicators and related targets were set to measure the overall progress of achievement at national level, in Zimbabwe. Because various factors would contribute to change in national level indicators, both external to the health sector (eg. changes in the economic and political situation over time) and internal to it (eg. reforms; other funding initiatives/programs), the logframe was certainly an appropriate tool to monitor the overall progress of key MNCHN indicators in Zimbabwe. Instead, the tool would not permit to assess results that are directly attributable to the HTF. The question of attribution is treated more in depth in chapter 3.5. - Limitations.
- Despite the complexity of the HTF, managing a results framework of nearly 90 indicators is not necessarily good practice, both because of the investment required in managing the logframe and due to the underlying complexity of interpreting information to inform decisions.
- The logframe was updated annually by LSTM, and used during annual review meetings. The locus of responsibility for *managing* the logframe is not clear to the evaluation team, nor is the extent to which this tool has been used to steer the programme.
- More than 10% of the indicators of the logframe are not measurable through available routine or survey indicators, and would require ad hoc studies to be assessed (e.g. capacity of VHWs). Such an approach would require additional demand for data and research, which was not always met during the course of the HTF implementation.
- The sources of information, the definition of the indicators and the frequency of data collection are not specified for each indicator. In some cases, indicators defined as output level indicators are instead outcome indicators in nature (e.g. immunization coverage indicated as output indicator).
- A large number of indicators rely on population-based surveys or on facility assessments (including VMAHSS). Only a handful of the 86 indicators used by the program rely on HMIS data. This approach to monitoring generates continuous demand for ad hoc surveys, instead of stimulating investment in the quality and use of routine information and data.
- Outcome level indicators aim at assessing results in terms of coverage and hence they are largely and correctly focusing on Theme 1.
For output level indicators, the architecture of the logframe does not appear to be best tailored to the investments supported by the programme. In fact, whereas approximately 85% of the HTF funding is invested in activities supporting Theme 2 (Logistics and Supply), Theme 3 (Human Resources for Health)

and Theme 4 (Policy and Health Financing), less than a third of the outputs indicators have been designed and set in place to monitor progress under these themes.

- To the best of our understanding, targets were set based on the key targets defined through the Zimbabwe Health Sector Investment Case¹⁶ and following a bottlenecks analysis performed at country level prior to the inception of the HTF. Yet, the methods and metrics adopted for the construction of targets could not be accessed and remain unclear to the evaluation team. Most targets at both outcome and output level are set at values of 80%; 90% or 100%, and we could not reconstruct how these were set *vis a vis* baseline levels, historical trends or analysis of achievable growth. This issue undermines, in our opinion, an objective assessment of progress towards targets.

3.5. LIMITATIONS

A number of limitations related to this evaluation are identified, and are outlined in [Table 5](#) below. These have been taken into account by the evaluation team, when documenting findings and drawing conclusions.

Table 5 - Limitations of the evaluation

Limitations	Description	
Attribution/ Contribution	Due to the nature of the programme under evaluation – which was in essence a pooled fund mechanism that supported MOHCC plans and delivery strategies at scale, rather than an intervention in itself - identifying a control group to test a counterfactual hypothesis of ‘no HTF’, was not deemed to be a viable approach for the evaluation. In fact, the (underlying) theory of change of the HTF openly assumes that the achievement of the desired impacts and outcomes will potentially be (co)-determined by other contextual and causal influencing factors rather than solely by the intervention itself. Hence, isolating the effect of the HTF to the desired change in state may neither be relevant, nor of interest. Attribution could not be measured.	<p>Limitations regarding attribution have been raised with the Steering Committee since the inception phase</p> <p>As an alternative approach, <u>contribution</u> of activities to outputs and of outputs to outcomes has been documented, to prove (or not) the causal links between interventions and results, and to inform findings.</p> <p>It should be noted though that this evaluation did not rely explicitly on a theory-based approach (contribution analysis) since inception.</p> <p>This remains a limitation of the design of the evaluation.</p> <p>A theory-based approach may be considered in future as a suitable method to evaluate programs similar to the HTF.</p>
Quality and availability of secondary data	<ul style="list-style-type: none"> ▪ For various MoHCC reports, the primary source of data is uncertain or not documented ▪ Updated and/or disaggregated data on HRH and PSM not available for the period 2014-2015 ▪ Detailed costing information regarding program activities not accessed 	<ul style="list-style-type: none"> ▪ The quality and availability of secondary data were beyond the control of the evaluation team. However, we have tried our best to triangulate the information from secondary sources to ensure the quality of information.

¹⁶ THE ZIMBABWE HEALTH SECTOR INVESTMENT CASE (2010 – 2012), Ministry of Health and Child Care, March 2010

Limitations	Description	
	<ul style="list-style-type: none"> ▪ Lack of survey data for endline: only DHS 2015 Key Findings Report available, in June 2016. 	
<p>Generalizability of qualitative research findings</p>	<ul style="list-style-type: none"> ▪ FGDs and KIIs with Healthcare Providers, VHWs and communities limited to six districts of the country only 	<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.</p> <p>We have used purposive sampling of “information-rich” participants to represent (not statistically) the broad types of informants relevant to our evaluation.</p> <p>We are mainly trying to understand the meaning of what we hear from “information-rich” participants with regard to our evaluation questions in Zimbabwe context (social, cultural, economic, political etc.).</p> <p>Marshall (1996: 523) noted that ‘...an appropriate sample size for qualitative study is one that adequately answers the research question’.</p>
<p>LSTM survey Sample size and sampling frame of health facility assessment</p>	<ul style="list-style-type: none"> ▪ Sampling frame provided by MoHCC potentially incomplete: an updated census of health facilities is being finalized by MoHCC ▪ Sample size of the LSTM survey only allowed for national level estimates and not for disaggregation of findings by province 	<ul style="list-style-type: none"> ▪ LSTM has used the latest available census of health facilities available at the time of designing the evaluation. ▪ The sample size of the survey has been agreed and endorsed by the HTF Steering committee since the inception phase. Other sources (eg. SARA; VHMASS) have been used where possible to produce disaggregated analysis. Data from the LSTM survey were only used to provide national level estimates.
<p>Comparability of data sources in assessing log frame indicators</p>	<p>Log frame indicators use different sources at baseline (primarily DHS 2010 and NIHFA 2011).</p> <p>For endline measurement, various sources are used including: MICS 2014, SARA 2015, LSTM survey 2016</p> <p>Comparison with end line estimates is affected by:</p> <ul style="list-style-type: none"> - Differences in the definition of indicators - Changes in indicators definition over time 	<p>To overcome the issue of different data sources available at different time points of the evaluation, where possible we have used the same data sources of data using similar methodology.</p>

Limitations	Description	
	<ul style="list-style-type: none"> - Differences in methods (eg NIHFA was a self-administered census, whereas SARA and LSTM are administered surveys) <p>Comparison presented in the report are, therefore largely, meant to provide an indication of trends but not statistically representative differences of proportions.</p>	
Design of the HTF log frame	<p>Missing baseline data for indicators (for 2 outcome level and 23 output level indicators); Unclear source of data collection/missing data: 10 and 13 output level indicators</p>	<p>LSTM updated the log frame systematically every year. Inconsistencies and gaps in the logframe were reported throughout the life of the evaluation to the Steering Committee.</p>

4. FINDINGS

4.1. RELEVANCE

Q1 *Were the HTF supported interventions consistent with national health and nutrition policies and plans, and with global health and nutrition priorities?*

Finding 1.1. The HTF was fully consistent with global health policies, strategies and targets

The overall objective of the HTF programme was to contribute to reduced maternal and under-5 mortality and eliminate user fees for children under-5 and pregnant and lactating women in Zimbabwe by 2015.

These objectives and related targets were designed with a view of sustaining progress in achieving the MDG goals 4 and 5, in line with global targets set at international level.

In addition, the core intervention areas along the continuum of care that the HTF aimed at restoring are fully in accordance with the literature and international recommendations on evidence-based interventions for maternal, newborn and child health at community level, primary healthcare level and referral level¹⁷.

Finding 1.2. The HTF was fully aligned with national health and nutrition policies and strategies

The HTF was implemented under the National Health Strategy (2009-2013) and the revised National Health Strategy for Zimbabwe (2009-2015), and informed by two key strategic policies: the Maternal and Neonatal Roadmap (2007-2015) and the National Child Survival Strategy (2010-2015). The broader objectives of the HTF remained consistent throughout the project with relevance to most aspects of the Zimbabwe National Policies and Roadmap. The overall program design was informed by the National Health Strategy and conceived to support its realization, at the least in key areas of work related to maternal and child health.

As stated in the HTF program document (December 2011) the National Health Strategy included a total of 33 specific goals; of them, the HTF aimed at supporting to the least 20 of those in the first 2 years of implementation. The evaluation also notes that the HTF has aligned most of its nutrition-related interventions to the National Nutrition Strategy (2014-2018) under the framework of National Development Agenda, i.e. the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset).

Finding 1.3. The HTF contributed to the design of health and nutrition policies and plans

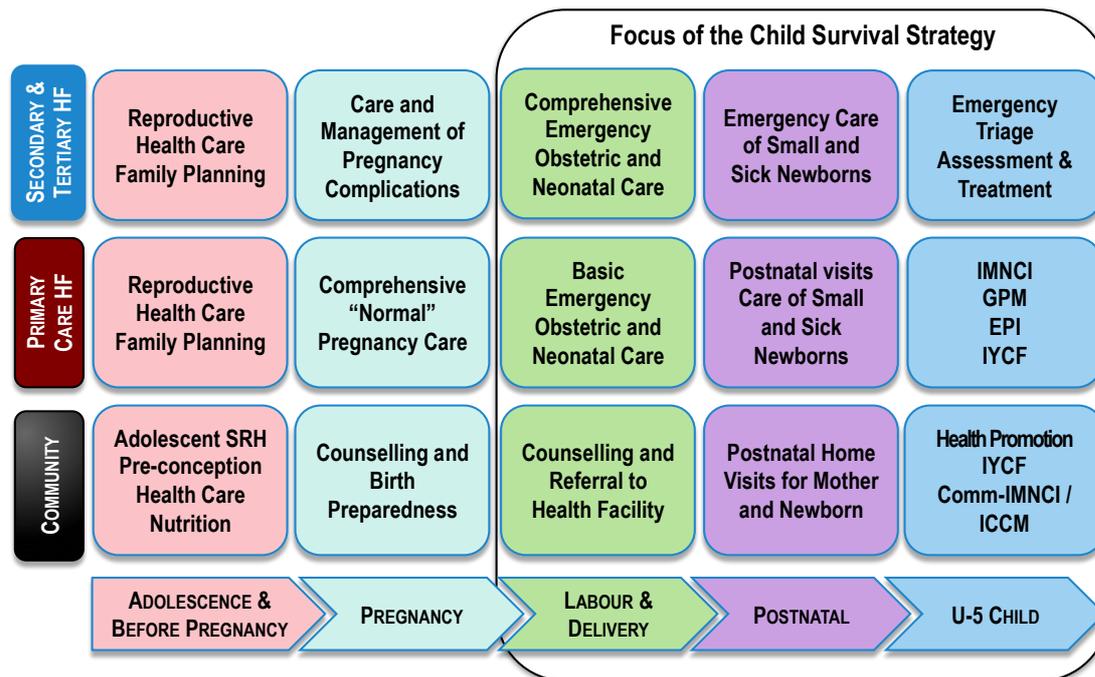
Besides aligning itself to national health strategies and plans, the HTF has actively contributed to policy design, through the evidence generated during the course of its implementation. In particular, the National Health Strategy for Zimbabwe 2016-2020 and the National Child Survival Strategy 2016-2020, in their current drafts, explicitly refer to the HTF as a source of evidence for policy design.

In addition, the HTF provided the financial assistance to MoHCC to produce the Child Survival Strategy.

¹⁷ 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

The relevance of the HTF strategies and priorities interventions remains extremely high *vis a vis* the interventions prioritized along the continuum of care in the MOHCC Child Survival Strategy 2016-2020, summarized in [Figure 2](#)¹⁸ below.

Figure 2 - Prioritization of Interventions within the Continuum of Care



Finding 1.4. The HTF was complementary to other initiatives implemented in Zimbabwe

The Government expenditure on health was estimated at USD469 million in 2015¹⁹; this is a very significant improvement from the estimated USD167 million allocated in 2009²⁰, although official development assistance (ODA) still accounts for more than 50% of the overall annual envelope for the health sector. In addition, taking into account that most of the Government expenditure on health (60%) goes towards salaries, donor funding is a vital asset to ensure service delivery to the Zimbabwean population. In such a scenario, the HTF accounted for approximately 7% of the total resources allocated to the health sector in 2015, but contributed to more than 46% of the total external funds directly allocated to RMCH activities during the same year, i.e. to approximately a quarter of the total allocation to RMNCH activities in Zimbabwe.

The HTF was therefore a major contributor to health systems strengthening approaches within RMNCH, alongside the Global Fund. Other major donors include USAID, the Global Fund, the World Bank, GAVI.

There is evidence that the HTF worked to complement and support other donors’ initiatives, rather than duplicating efforts. As an example, the RBF, sustained via HTF, was designed drawing upon the model that was being implemented with World Bank funding in 18 districts of Zimbabwe. In addition, the health retention scheme supported via the HTF complemented and progressively absorbed the support provided to healthcare workers with GF resources. More importantly, the HTF Steering Committee formed a platform where non HTF

¹⁸ Ministry of Health and Child Care. 2015. National Child Survival Strategy 2016-2020. Draft Version 1

¹⁹ Ministry of Health and Child Care. 2015. Resource Mapping Round 1, Key Findings

²⁰ Ministry of Health and Child Care. National Health Strategy for Zimbabwe 2016-2020. Draft

donors could participate, which offered a unique opportunity for all partners to discuss policies and to ensure coordination and coherence between the various funding initiatives designed and implemented in Zimbabwe.

Q2 *To what extent did the HTF address needs and priorities of beneficiaries including women of reproductive age, mothers and children, and indirectly healthcare providers? How valuable were the results to beneficiaries?*

Finding 2.1. The HTF was relevant to key identified priorities of target groups for maternal and child care

“There are a lot of things, which our community is getting; for instance, pregnant women are getting free services when delivering. So far things are really better. Health workers are disseminating information on children’s vaccination dates, some people do not have radios, but the information is getting to people. The number of women delivering at home has declined.”

Primary research from LSTM (FGDs at community level, 2016) indicates that communities perceived improvements in the **availability and accessibility of service provision** and that there has been an increased demand for services since 2012.

The main reasons described by different participants at community level included removal of user fees, increased availability of infrastructure including maternity waiting rooms and refurbished facilities, increased availability of health supplies and equipment, increased availability of skilled health workers and community mobilization and behavioural change interventions.

All these reasons are regarded as highly important by communities.

Finding 2.2. Barriers to access health care and bottlenecks in accessing quality care persist

Qualitative research from LSTM indicates that there are persistent problems that communities still face and that are considered as important bottlenecks by beneficiaries. These are mainly related to barriers to access, and to experience in the use of services.

“...the shortage of nurses is also another cause she will be working hard but because she is alone she will seem to be very slow. Some nurses are very rough in handling patients and cannot communicate with people well you will end up leaving the hospital and not coming back when you ask to be served early they will tell you to follow the line even when you look very sick.”

Beneficiaries described the following three main factors as major barriers in accessing care: distance, out of pocket expenditure, cultural and religious beliefs. For some communities, **distance** to the nearest facility has been one of the key barriers. Thus, decision to seek care depends mostly on the distance from a health facility

and financial resources available in the household. For example, some pregnant women consciously chose to register late, as they did not want to travel throughout the duration of their pregnancy because the facilities were very far from their villages. **User fees** was another barrier in accessing healthcare services as some healthcare providers explained that users refused to be referred when they could not pay for the services. Additionally, some Village Health Worker (VHWs) and female community members described how pregnant women preferred not to deliver at the health facilities if they could not afford to bring the items requested by the facilities for delivery such as a bed sheet, sanitary napkins, baby wrappers, baby blankets, matches and candles. **Cultural and religious factors** still influence essential child care practices particularly infant and young child feeding practices and seeking care during illnesses. In certain communities, the population groups seek care from religious healers and VHWs and face challenges in convincing these community groups to seek care at health facility level. VHWs and community groups confirm that dangerous child care practices still prevail within their communities.

Beneficiaries also shared their experiences in accessing quality of care. **Negative experiences** included healthcare providers disclosing sensitive patient information, lack of confidentiality and privacy of care and negative attitudes and behaviours of health staff. Some community women recounted how they were scolded and treated badly by the health staff. Beneficiaries perceived that the negative attitude and behaviour of healthcare workers were primarily attributed to workload issues.

Such findings are confirmed by a recent qualitative research from Save the Children in Zimbabwe²¹, which highlights that some of the major barriers encountered by women in accessing care include; poorly functional facilities; unfriendly health care workers; required payment of fees; required payment in case of referral to higher levels of care.

Q3 Has the HTF made a difference in terms of governance and coordination at national and local level?

Finding 3.1. The HTF has been catalytic in enhancing coordination and governance at national level

The evaluation notes that the design, governance and coordination mechanisms of the HTF are in line with the seven guiding principles of the current Maternal and Neonatal Roadmap: country ownership; equity, access and acceptability; health systems approach; evidence-based; clear definition of roles and responsibilities; partnership and complementarities.

“For me the legacy of HTF is with good corporate governance, if there is good corporate governance UNICEF coordinating and resources are there, and if resources are channelled in a way which is holistic which covers everything”

Most of the respondents to LSTM interviews felt that by engaging high level policy makers such as the Permanent Secretary of Health in the steering committee, the programme promoted the full **ownership and leadership role of the Ministry of Health** in the design and implementation of the programme. Engaging high level health policy

²¹ Barrier Analysis Research (Socio Economic, Religious, Cultural): Determinants Hindering Access and Utilization of Health Services – Save the Children in Zimbabwe, December 2015

makers facilitates a sector-wide approach and makes it easier to engage other sectors outside health, such as finance.

The majority of the respondents in our interviews felt that the governance structure of the HTF, including its steering committee, was **inclusive** and allowed the key players in the country's health system to contribute towards the planning and implementation of the programme. Governance mechanisms of the HTF are perceived to promote accountability and transparency as key stakeholders engage closely and regularly with the MoHCC and implementing partners. The presence of a steering committee, which provides oversight, improves **accountability** with the execution of the HTF programme.

Finding 3.2. – The HTF has been catalytic in enhancing governance at local level through HCCs

In Zimbabwe, the role of Health Centres Committees (HCC) has been revitalized under HTF particularly with the introduction of the RBF mechanism which has improved the accountability of health facilities. HCCs are joint community/ health service structures covering the entire RHC catchment area. "They assist in uniting the communities and health workers, to identify the communities' priority health problems, plan how to raise their own resources, organize, oversee the implementation of the complaints response/feedback mechanism and manage community contributions and tap available resources for community health activities"²¹.

HCC members are selected from the communities and are responsible for financial accountability through involvement in planning and allocation of the reimbursements received under the RBF.

By February 2016, 3,640 members of 794 HCCs had received training under the HTF-RBF in 42 districts and 8 provinces across Zimbabwe (HCC training workshops report, 2016).²²

"The Health Centre committee they bring back from the community to us and they are just working between us and the community.

If they have any complaints from the community they will when we come to meet then they will say the community is saying this and that why can't you improve on this..."

By early 2016, 86.5% of Level 1 facilities had a HCC in place in Zimbabwe (LSTM Survey, 2016). Of those, 71% held coordination meetings on a monthly basis. Health workers participating in the evaluation acknowledged the role of HCC in establishing a link between the communities and facilities, helping them to share information on needed improvements and complaints. However, volunteers in HCC and health care workers shared the view that HCC members should be compensated for their travel and time spent in the HCC to avoid absence and dropout.

Finding 3.3. Governance mechanisms at national and local level may be further improved

Evidence shows that 'pooled funds have done well when the Steering Committee is supported by technical working groups that can address specific operational matters.'²³ The HTF SC lacked dedicated technical working groups, and therefore technical decisions were primarily taken at SC level through participatory (albeit time consuming given the number of members) discussions. Some steering committee members who participated in our interviews felt that they were not adequately engaged and that important personnel were excluded from

²² (Community Working Group on Health, 2016) Provision of Health Centre Committee Training for the Health Transition Fund-Results Based Financing: National. Report on HCC Training Workshops. (Community Working Group on Health, 2016)

²³ Pooled Funds for Service Delivery in Fragile and Conflict-Affected States. Research commissioned by DFID, May 2013. Accessed at: [http://r4d.dfid.gov.uk/pdf/outputs/misc_Gov/61050-PFs-Part_I-PolicyBrief\(May2013\).pdf](http://r4d.dfid.gov.uk/pdf/outputs/misc_Gov/61050-PFs-Part_I-PolicyBrief(May2013).pdf)

some technical meetings/consultations, which took place “behind closed doors”, without the involvement of some partners. The opinion that the steering committee is too big for effective decision-making was also expressed and that having sub-committees for policy, MNCH, pharmacy and HRH within the main steering committee might be more effective.

Healthcare providers participating in the evaluation extensively discussed the role of HCC. They acknowledged the role of HCC establishing a link between the communities and facilities to exchange information such as complaints. However, limited information on the role of the HCC was obtained from the community level group discussions because community members were not always aware of the presence or composition of the HCC within their communities, indicating that a gap still exists in the link between community and facility.

This issue is confirmed by research from Save the Children, “in some districts the communities were not aware of the HCC, their roles and responsibilities.”²⁴

Finding 3.4. Internal and external accountability mechanisms partially improved at local level

The HTF has shown to have strengthened internal and external (community) accountability mechanisms. Internal accountability was improved through strengthened supervision and monitoring systems. Under the HTF, district and facility health staff received regular supervision with feedback.

There were also significant improvements in external (community) accountability as most health facilities started using different community complaint procedures such as suggestion boxes, public relation officer, patient information/ customer care desk. and HCCs. However, the extent and level of functioning of those mechanisms varied between districts and facilities.

“...because when you go to complain and it is heard that you once complained next time when you are sick again, the sister will say to you “you are the one who complained about me to so or so today I will show you” you will not be treated well that is why people keep quiet even if they are treated badly.”

Most healthcare workers were aware of the request to have a suggestion box available at facility level; however, not all facilities had installed it yet. The use of suggestion boxes was limited and some communities expressed that they did not feel comfortable using them because they were concerned about the potential consequences from the healthcare providers or because they felt that their suggestions would not be considered anyway. Thus, communities rarely disclosed negative experiences about the services they received, as they had no other alternative to accessing health care.

²⁴ Barrier Analysis Research (Socio Economic, Religious, Cultural): Determinants Hindering Access and Utilization of Health Services – Save the Children in Zimbabwe, December 2015

Another weakness in community accountability was that there was no complaint mechanism for the VHWs where they could receive feedback on their concerns. Some VHWs described only upward accountability, meaning accountability to managers or higher levels. VHWs rarely received feedback from facility health workers though they provided regular reports to the clinics. VHWs also felt that there was favouritism and nepotism within their village administration, which they witnessed when providing food assistance and for job distribution within the communities.

Summary of Findings on Relevance

Evaluation Question

Q1. Were the HTF supported interventions consistent with national health and nutrition policies and plans, and with global health and nutrition priorities?

Q2. To what extent did the HTF address needs and priorities of beneficiaries including women of reproductive age, mothers and children and indirectly healthcare providers?

Q.3 Has the HTF made a difference in terms of governance and coordination at national and local level?

Findings

The HTF design and implementation was highly consistent with national strategies and policies, as well as with global health policies and targets. In addition, the HTF did actively contribute to the design of new policies for the health sector.

Beneficiaries perceive the improved availability of services as a major improvement for communities. Major barriers persist in accessing services, including distance, burden of out of pocket expenses and inappropriate care seeking practices. Beneficiaries also perceive bottlenecks in the experience of care, including long waiting times, negative staff attitudes, user fees, and lack of medicines.

The HTF has made a difference in coordination and governance at national level, where the HTF SC has been catalytic in promoting dialogue amongst HTF and non HTF partners and donors. The MoHCC has been fully involved in the HTF and central to all decisions. Technical working groups supporting the SC were not in place; this may be an improvement in future.

HCCs have been revitalised across the country and function as a core body in the governance at facility level (especially with regard to the allocation of RBF funds) as well as a linkage with communities.

4.2. EFFECTIVENESS

Q4 To which extent were HTF intended results achieved during its implementation?

Finding 4.1. There has been consistent progress since 2012 in achieving the HTF intended results and targets were partially achieved

Our assessment of effectiveness focuses on output level indicators as defined by the HTF logframe, which identifies 54 indicators as the key measures to monitor progress of the program at output level. Of these, 29 indicators present baseline and endline data, which allow to measure progress between 2012 and 2015: **28/29 indicators (96%) show progress.**

For 35 of the 54 output level indicators, there was data available to measure the **achievement of targets** set by the HTF for the end of 2015.

- For 19 indicators (54%), the target set by the program was achieved and exceeded;
- For 16 indicators (46%) the target was not achieved.

The key results achieved during the life of the HTF at output level are presented in the paragraphs below, by relevant HTF thematic area.

MATERNAL, NEWBORN AND CHILD HEALTH (THEME 1)

Finding 4.2. The availability of essential MNCH services has been restored and maintained at high levels across the country

As summarized in [Table 6](#) below and reported in detail in [Annex 7](#), the availability of services for maternal, newborn and child health was largely restored during the period of implementation of the HTF.

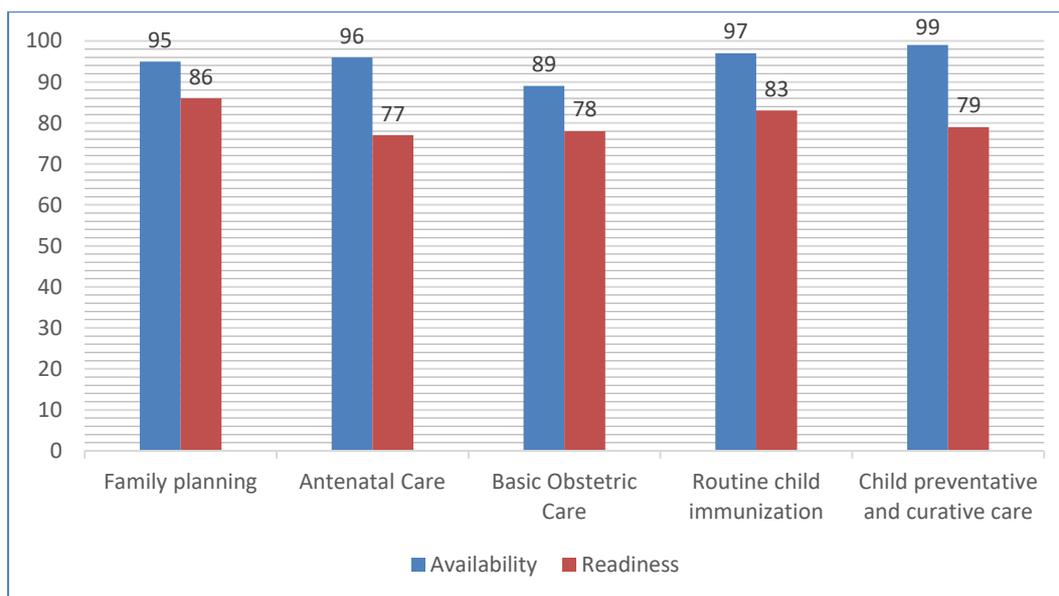
Table 6 - Progress in availability of services 2011-2015

Healthcare service provision along the continuum of care	Baseline (NIHFA 2011)	Endline (Multiple sources)
Antenatal Care (ANC)	Baseline levels: 87.9% of facilities offering ANC (VMAHSS R11)	99.6% facilities provide ANC services (VMAHSS R26) 96% of facilities offer ANC with all essential components of ANC package (SARA, 2015) 77% of facilities presents mean availability of tracer items for ANC service readiness (SARA 2015)
Emergency Obstetric Care Services	Availability of CEmONC: 38% (NIHFA, 2011) Availability of BEmONC: 4.1% at level 1 facilities (NIHFA, 2011)	Availability of CEmONC services: 82.5% (VMAHSS R26) 73% (LSTM 2016) Availability of BEmONC: 67% at level 1 facilities (VMAHSS R26)
Postnatal care services	87.9% (VMAHSS R11)	Facilities offering PNC: 87.8% (LSTM 2016 survey) PNC within 6 weeks: 99.9% (VMAHSS R26)
Immunization services	91% of Level 1 facilities provide routine immunization on a daily basis	97% of facilities offer routine services (SARA, 2015)

Healthcare service provision along the continuum of care	Baseline (NIHFA 2011)	Endline (Multiple sources)
	(NIHFA, 2011)	
Infant and young child nutrition services	20% (MoHCC reports)	Facilities providing Vitamin A supplementation to children : 96.1% (LSTM, 2016) 97.1% of the facilities provide routine iron and folic acid to pregnant women (LSTM, 2016)
Child health: curative care services	Level 1 facilities in rural provinces were more likely to manage severely ill children compared to urban areas. More than 90% of hospitals reported managing severe acute pneumonia, diarrhoea and malaria for children under 5 years of age. Capacity to manage acute malnutrition was only reported by 23% of Level 1 facilities and 88% of hospitals. (NIHFA, 2011) % of PHC facilities with at least 1 HCW trained in IMNCI: 75% (VHMASS R14)	Facilities offering services: 99% (SARA, 2015) % of PHC facilities with at least 1 HCW trained in IMNCI: 81.1% (LSTM, 2016) 85.2% (VMAHSS R26) 90% (SARA, 2015)

The positive picture of availability and readiness of maternal and child health services at healthcare facilities across Zimbabwe is summarized in [Figure 3](#) below:

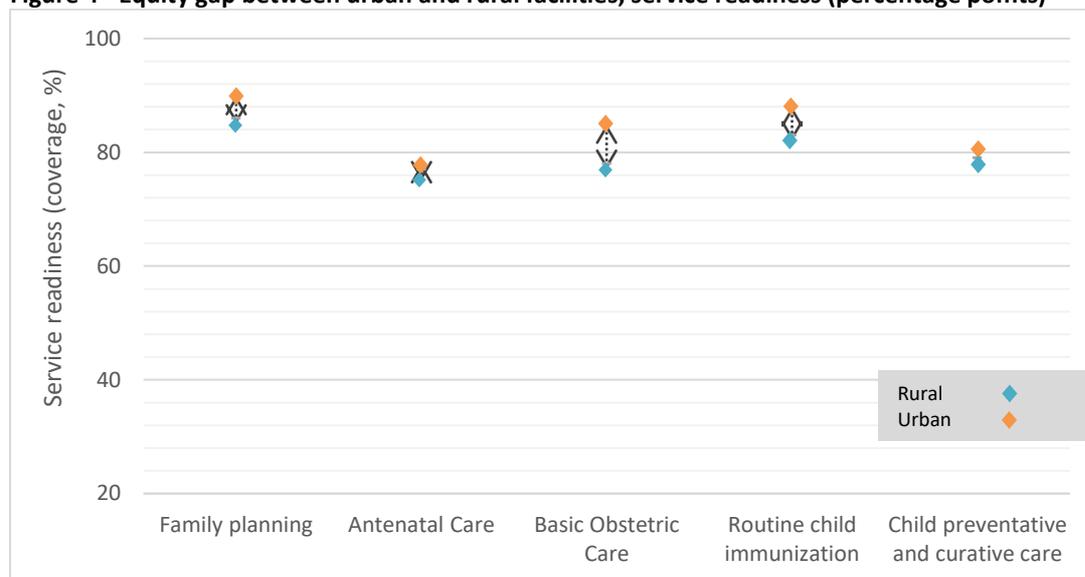
Figure 3 - Availability and readiness of MNCH services



Source: SARA, 2015

The equity gap in the average readiness score for essential MNCH services between urban and rural facilities does not provide indications of major inequities in service provision with regard to the location of health facilities as shown in [Figure 4](#) below.

Figure 4 - Equity gap between urban and rural facilities, service readiness (percentage points)



Source: SARA, 2015

Restored availability of services has contributed to increase the utilization of health services.

The LSTM surveys estimate the **outpatient department utilization rate for Level 1 facilities at 1.34 in 2015** (95% CI=1.10,1.58) and at **1.03 consultations per person per year** (95% CI= 0.87,1.18) in 2016, i.e. in line with the MoHCC target of one consultation per person per year.

Finding 4.3. A systemic approach to community health is lacking

The Zimbabwe Health Sector Investment Case (2010-2012) clearly identifies the **community health system** as a critical resource to improve population health: “There are a number of home or community based health practices or behaviors that can be carried out by households or communities themselves after receiving guidance. The role of the health system, in this situation, is to empower communities through information, education and other communication strategies, as well as other forms of support (...) Community health workers are often the key link between communities, especially rural, and local health services. These cadres mobilize households and communities in activities that foster promotive, educative, and preventive health behaviour. In Zimbabwe Village health workers (VHWs) are the commonest community health worker in rural areas where they are usually the service provider in the prevention of locally endemic conditions, treatment of simple conditions and disease surveillance”.

A mapping exercise conducted in Zimbabwe in April 2016²⁵ revealed that: “Seventy-seven (77) community based cadre types/titles were found throughout the provinces. Principally, community cadres are implementing and addressing a range of sexual reproductive health issues including maternal and child health, adolescent and sexual reproductive health and HIV and AIDS. Their roles and responsibilities are generally similar. Although the Village Health Worker (VHW) is the main/common cadre that functions as a link between the community and the formal health care system, various other cadres such as the Community ART Refill Groups, Behaviour Change Facilitators, Community Mobilisers for VMMC and Community and Home based Care givers, also link directly with the health facilities on similar health issues.”

Such findings highlight that an overall strategic approach to the community health system is currently lacking and – as commonly seen in many other countries – fragmented projects and various donors’ initiatives lead to

²⁵ MOHCC, UNFPA (2016). Community based cadres mapping exercise. Final draft report. Zimbabwe.

investment in multiple community health cadres, resulting in the inefficient utilization of available resources as well as duplication of work at community level.

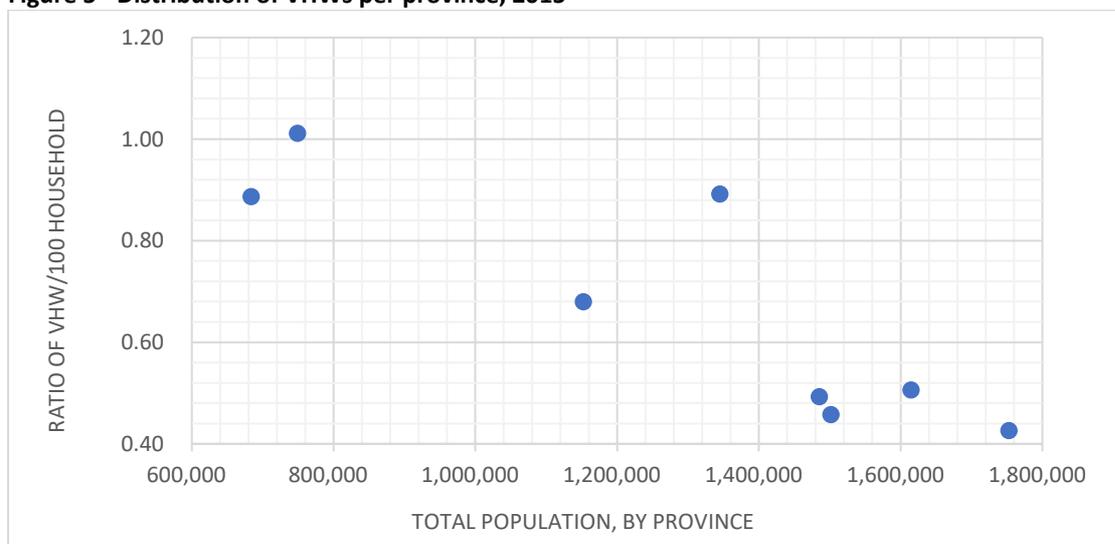
The absence of a clear policy framework for the community health system and related accountability mechanisms are the major underlying causes of the fragmented picture currently in place in Zimbabwe.

Finding 4.4. The VHWs encounter operational challenges in performing their duties, and targets in expanding community health services have not been met

The MoHCC planned to train and deploy a total of 22,000 VHWs, one per 100 households (i.e. 500 population), by the end of 2015. At the end of the HTF, 13,477 VHWs had received training covering 61% of the total target (HTF Annual Report, 2016). Among them, 1,647 new VHWs were trained under the HTF programme reaching 54.9% of the annual target of 3,000 in 2015. Hence, the country did not achieve the scale up plans for VHWs by 2015.

The evaluation also notes that the deployment of VHWs to date was possibly not rolled out based upon population coverage criteria, as current coverage is not equitable amongst provinces. Smaller provinces are closer to reaching the target of 1 VHW: 500 population compared to larger provinces which still present very poor coverage ([Figure 5](#)).

Figure 5 - Distribution of VHWs per province, 2015



In the FGDs with VHWs conducted by LSTM in early 2016, VHWs explained that once they are recruited, they are supposed to receive supplies and equipment; support materials such as stationery, bicycles and some financial incentives. However, the vast majority of VHWs described encountering serious challenges in performing their duties mostly due to big catchment areas, lack of mobility equipment such as bicycles and/or of spare parts for their bicycles (apparently not easily available on the market), lack of functioning equipment such as weighing scales, shortage of medicines and supplies, not receiving financial incentives, lack of regular refresher trainings and lack of effective means of communication.

“As Village Workers, we should be equipped with kits to assist people (...). We also need

improvement in communication. What I mean is that, we do not afford to communicate by mobile because of lack of financial resources. We expect some allowances.”

VHWs acknowledged that they should provide voluntary services for their own communities but they had been promised “little incentives” (USD42 per quarter) as compensation at the time of recruitment. Therefore, they now expected to receive these incentives regularly to cover some of the costs they had invested in their voluntary work. However, the majority of them did not receive incentives in time and some of them had never received anything since their recruitment. Payments via mobile phones was not deemed a feasible and efficient solution by most of VHWs participating to FGDs.

MEDICINES AND SUPPLIES (THEME 2)

Finding 4.5. The availability of essential medicines and supplies has been secured countrywide

The principal pillar of the HTF support to the availability of health products is the procurement of a package of selected essential medicines, commonly known as the Primary Healthcare Package (PHCP). The availability of this input is relatively stable over the entire HTF period and the observed trend is upwards. The quarterly average stands at 85.3%, 5.3% higher than the minimum target of 80%. According to data available through VHMSS, in the years before the implementation of HTF, the availability was considerably lower: 2011-Q1 stands at 12.1% while it was 77.3% in 2012-Q1 (R11) and 78.9% in 2013-Q1 (R15). From 2013-Q1 (R15) to 2015-Q3 (R25) there was a stable growth with the Quarterly Round score above the average with the exception in 2014-Q1 where the availability stood at 75.6%. Additionally, there was an extreme drop in 2015-Q4 (R26) down to only 64.7%. During the interviews with key informants at various levels of the system, performed by the LSTM evaluation team in early 2016, this drop was confirmed and justified by the decrease in purchased number of kits due to insufficient funding. Data received shows that in FY2015 only **10.136²⁶ PHCP were ordered, against 19.167 in FY2012²⁷** (Table 7).

Table 7. Number of PHCP ordered and received, 2012-2015

YEAR	ORDERED	RECEIVED	TRANSIT	PENDING	TOTAL
2012	19,167	17,727	1,440		19,167
2013	19,556	19,332	224		19,556
2014	13,680	13,680			13,680
2015	10,136	5,936	3,360	840	10,136

As a complement to PHCP, a second pillar of the health products input was the addition of a range of health products, purchased in bulk. These products could be purchased by the health facilities as a topping up of the PHCP to increase quantities received in the PHCP and extend the range of health products. District Health Pharmacies could purchase these health products as well. These bulk stocks were also used for the distribution of health products in the frame of the ZAPS in Manicaland. From the available data, it was not possible to estimate the availability and value of bulk inputs at the level of facilities.

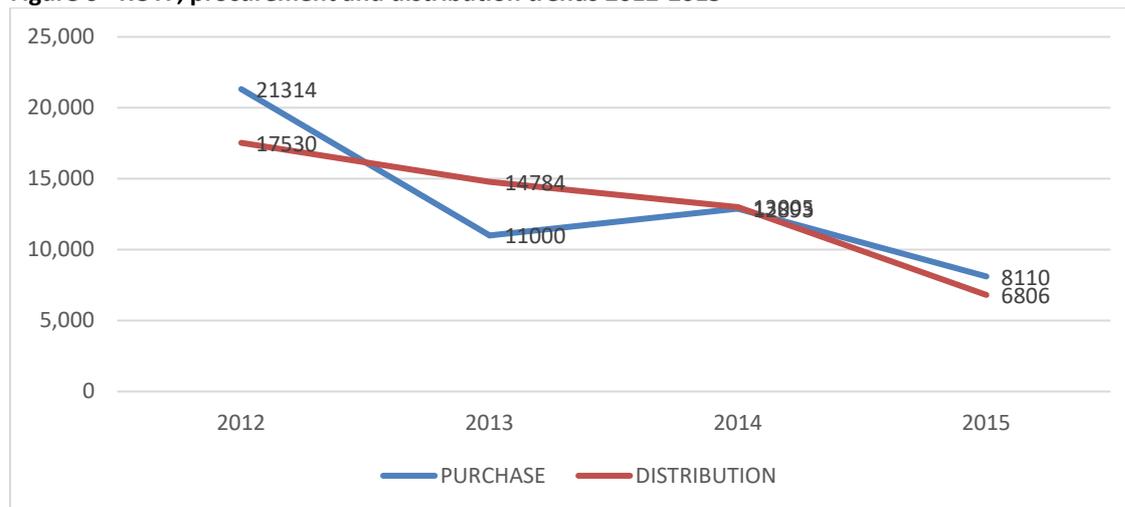
The third pillar of the health products input was the purchase and supply of the Ready-to-Use Therapeutic Food (RUTF). In FY2012, distribution was implemented through a parallel supply chain but from FY2013 onwards the distribution was consolidated with the PHCP. Overall data on the availability of RUTF were not accessed through

²⁶ HTF Year Report 2015

²⁷ HTF Year Report 2012

the evaluation. An important number of RUTF has been procured. As per available data, most of purchased RUTF was distributed (Figure 6). The RUTF procurement and distribution trend is downwards over the years.

Figure 6 - RUTF, procurement and distribution trends 2012-2015



Finding 4.6. The provision of blood coupons supported improving the availability of blood transfusion services

The HTF supported the gap in blood transfusion (through provision of blood coupons only for pregnant women with bleeding complications that require blood transfusion in order to eliminate user fees as a barrier to blood transfusion for pregnancy complications) to the MoHCC beginning in 2013. Over this period, there was a strong growth in the issuing of the blood coupons (from 2,000 in FY2013 to 11,000 in FY2015). In 2015 a total number of 9,851 (89.5%) has been distributed and 3,954 patients have benefited of the coupons (average of 2.5/woman).²⁸

Because of the initiative, there was remarkable progress in availability of blood transfusion services since 2011 (53%, NIHFA 2011). This is confirmed by VMAHSS Round 26 indicating that 84.1% of all district, provincial and central hospital facilities performed blood transfusion. Additional data on the availability of blood transfusion collected in the LSTM 2016 survey, estimate the availability of blood transfusion services at district level hospitals at 77.8%.

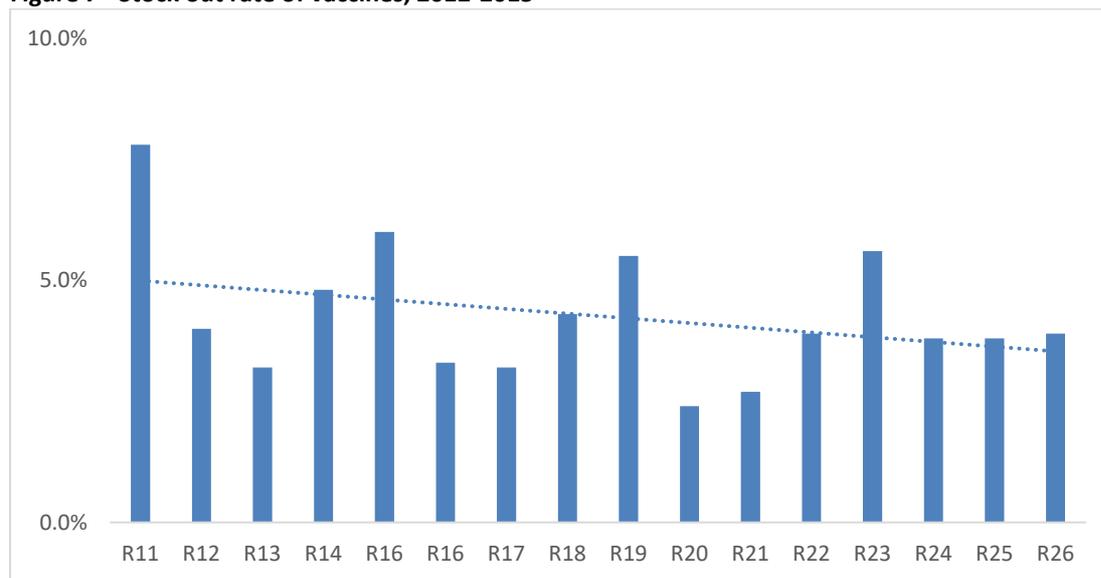
Finding 4.7. Immunization supplies have been guaranteed countrywide

The supply of vaccines, cold chain equipment and immunization supplies such as needles, syringes, safety boxes, among other supplies has been a core pillar of the HTF support in the area of procurement, distribution and cold chain maintenance. The trend in availability of at least 80% of the primary childhood vaccines (BCG, DT, Pentavalent, Measles, oral Polio, PCV) varies over the years between 90.2% (VMAHS 2011-Q1 R11) and 78.9% (2015-Q4 R26). The overall average for Level 1 health facilities stands at 90.4%. The period of 2012 to mid-2014 is higher than the average. From 2014 Q3 R22 all periods are below the average with a sharp drop in 2015 Q4 R26 where the real availability is under 80% and 12.3% under the average.

²⁸ HRF Yearly Report 2015

The trend in a total stock out of all vaccines is between 7.8% (highest, 2012-Q1 R11) and 2.4% (lowest, 2014-Q2 R20) and stands at 3.9% by the end of the FY 2015 (R26). The average stock out stands at 4.3%. The average is influenced by rather high stock outs during 4 periods

Figure 7 - Stock out rate of vaccines, 2012-2015



HUMAN RESOURCES FOR HEALTH (THEME 3)

Finding 4.8. The availability of health care workers has improved during the period of HTF implementation

- **Vacancy rate for doctors**

MoH data available on overall vacancy rates for doctors against the establishment in 2015 indicate that the overall number of doctors increased by 346 over the period and vacancy levels declined from 60% in 2009 to 31% in 2015 (MODO, July 2016). This is corroborated by the findings of the 2016 LSTM Survey, other secondary data and the KIIs conducted in February 2016 which all indicate an overall improvement in the availability of doctors in district level hospitals across all provinces. The LSTM 2016 Survey found that in the 47 district level hospitals (both government and mission) surveyed, all had at least one medical doctor available, compared to 96% in the 2015 Survey. Furthermore, sixty-eight (68%) of the district level hospitals surveyed had three or more doctors, which when compared to the situation in March 2012 when PMD reports indicated there were 21 hospitals without any doctor at all, are very significant improvements. The LSTM 2016 Survey found that most (87%) of the doctors available were present in the facility on the day of the survey, an improvement on 2014 when 73% were present. Moreover, although some of the doctors are recent graduates, many have the skills to perform caesarean sections.

However 5 provinces show a drop (an average of 2 per province) in the number of doctors available between 2014 and 2015. The retention data highlight fluctuations in the number of doctors over the period, the reasons for this are unclear, however turnover and movement of doctors could have a negative effect on team morale, workload for other health workers, client satisfaction and quality of care, as well as increasing the administrative and recruitment costs incurred to replace them.

- **Vacancy rates for midwives**

There are no established posts or staffing norms for midwives and other specialist nurses and as these cadres tend to be included in aggregated datasets for the general nursing cadre, it is impossible to accurately assess vacancy rates or staffing trends. The MoH 2015 data on overall vacancy rates for nurses however, show that vacancy levels have fallen from 14% in 2009 to 7% in 2015; in 2015 of all the professional health cadres, nursing had the lowest vacancy rate. Furthermore, data from the 2016 LSTM Survey revealed that of the 47 district level hospitals surveyed, there were 18 State Certified Midwives (SCM) on average available in each facility, while in each of the 118 Level 1 facilities surveyed there was one SCM available on average.

Retention and training data were also examined in order to get a clearer picture of the staffing situation in 2015. The data available on the numbers of midwives receiving the retention and critical post allowances indicate that the number of practicing midwives increased from 1,838 in 2012 to 3,362 in 2015, resulting in an additional 1,525 midwives practicing in the public health sector. Compared to the situation in 2011 when there were an estimated 500 midwives practicing in Zimbabwe, this represents significant progress in producing and deploying this cadre.

However according to the retention data in 2015 there were 470 less midwives receiving the critical post allowance than there were in 2014. The majority (198) of these losses were from Mashonaland West province.

- **Vacancy rates for nurse anaesthetists**

It is not possible to accurately assess vacancy rates for nurse anaesthetists, as there are no established posts or staffing norms for this cadre, and those who have been trained on the job and do not have recognised formal qualifications, are often reported under the general nursing category. The 2015 JRM found that the availability of this cadre was still limited and recommended that the number of anaesthetists be improved 'through formal training of doctors and nurses or through an attachment'. A review of the available training data however revealed that in recent years' intakes onto the nurse anaesthetist diploma course have increased and if these are redeployed across public health facilities the availability of these cadres should improve. Moreover, there was a slight increase in the availability of nurse anaesthetists in district level facilities in 2016, where 66% of the district level hospitals surveyed had a nurse anaesthetist, compared to 61.7% in 2015. Of the 47 district level hospitals surveyed during the 2016 LSTM Survey, each had on average one Nurse Anaesthetist.

Finding 4.9. Constraints on the availability of staff persist due to the freeze on recruitment and the out-dated establishment

The ongoing recruitment freeze and the inadequacy of the out-dated staff establishment to meet nursing and midwifery requirements were perceived as the main reasons for staffing shortages, which are impacting on the provision and quality of services. Staff shortages are also increasing workloads, which negatively affects staff motivation and job satisfaction, and may eventually lead to increased attrition. Heavy workloads and low motivation is in turn affecting health worker attitudes and behaviour. One staff member reported that one of the most common complaints in the hospital's suggestion box is '*staff attitudes*', which she attributed to '*workload and poor remuneration*'. Another consequence of the recruitment freeze is that the Government cannot secure employment for the nurses it has produced.²⁹ In 2013, the Ministry of Finance authorized the

²⁹ <http://www.thestandard.co.zw/2015/01/18/govt-cuts-nurses-police-recruitment/>

appointment of 2,080 Registered General Nurses (RGNs) to fill vacant posts, but since then the number of unemployed nurses has continued to rise. In 2015, there were an estimated 2,800 unemployed RGN, excluding the 742 RGNs that graduated in 2015, and 1,126 Primary Care Nurses (PCN).

Finding 4.10. Pre-service training capacity of the health system has improved

Despite losing many specialized tutors and lecturers from the health training institutions during the crisis years, the government with support from the HTF, UNFPA and other donors has invested in pre-service training capacity since 2012. This includes, recruiting additional tutors, improving facilities, equipment and supplies, which led to an expansion in the number of nursing and midwifery schools and increased production of health registered nurses, midwives and upskilled PCNs. These additional cadres will help to fill vacancies and provide a buffer to ensure that any further losses can be replaced.

Five thousand, four hundred and forty nine (5,449) RGNs have been produced by the 25 nurse training schools located across the country since 2012. Many of whom will go on to train as midwives after they have completed the specified number of years of service.

Finding 4.11. In-service training has improved the availability of skilled healthcare workers

An examination of the UNICEF 2013 and 2014 costed activity plans show that within the HTF budget for Theme 1 MNCH and Nutrition financing and expenditure on capacity development and training related activities was allocated against three budget lines: ‘Strengthen National (at all levels) Midwifery capacities; Strengthen National capacity (at all levels) Maternal, Infant and Young Child Nutrition; and Building health workers capacity to assess and manage common childhood illnesses (including HIV/AIDS)’. In 2012, 25% of the total Theme 1 MNCH and Nutrition budget was allocated to these 3 budget lines, 47% in 2013, and 50% in 2015. This included expenditure on the refurbishment of the midwifery schools, curriculum review, tutor allowances, training of tutors, training of nurse anaesthetists, EmONC, IMNCI, CMAM and IYCF training for health workers and provision of allowances and training for VHWs

With the HTF support the number of Midwifery Schools expanded from 12 institutions in 2010 to 22 institutions in 2015 and schools increased their intakes. The support provided for the critical post allowances for full and part time midwifery tutors, resulted in increased numbers of tutors, from 44 in 2012 to 62 tutors in 2015. As [Table 8](#) below shows between 2012 and 2015, 2,943 midwives were produced, exceeding the MoHCC target of 2,500 midwives. In 2015, 835 midwives graduated, compared to 521 graduates in 2012 and these graduates are now practicing and providing MNCH services across the country. The UNICEF 2015 retention data indicates that the number of practicing midwives receiving the critical post allowance increased from 1,727 in 2012 to 3,941 in 2015.

Table 8: Certified midwives produced and pass rates 2011-2015

Year	No. of graduates	Pass rate (%)
2012	521	76
2013	808	90
2014	779	89
2015	835	90
Total	2943	86%

Source: Nursing Department, April 2016

Midwifery training will need to continue at an equal or higher rate if the MoHCC is to achieve its target of 60% (9,685) of the 16,142 RGN established posts trained as midwives,³⁰ however the recent government directive to the training schools to reduce their intakes may make this a difficult target to reach.³¹

The 2016 LSTM Survey show that 97.4% of the district level hospitals surveyed had at least one staff member trained to perform C/S and that 95.2% of these facilities had at least one staff member able to give obstetric anaesthesia. Of the 47 district level hospitals surveyed during the 2016 LSTM Survey, each had on average one (1) Nurse Anaesthetist; 66% of the district level hospitals surveyed had a Nurse Anaesthetist. According to the 2014 MICS, 67.6% of all the deliveries were assisted by a nurse/midwife, with 87.5% of deliveries attended by a midwife in a public health facility.³² In 2015 Crown Agents also reported increasing numbers of facility-based deliveries attended by skilled health workers, up from 15,900 in 2014 to 19,504 deliveries in 2015.³³

According to VMAHS Round 26 and 2015 HTF Annual Report staff have been trained in Infant and Young Child Feeding (IYCF), Baby Friendly Hospital Initiative (BFHI), community management of acute malnutrition (CMAM) and Integrated Management of Neonatal and Childhood Illnesses (IMNCI). The R26 VMAHS survey found that 71% of the 1,385 health facilities visited had at least one staff member trained in IYCF. Around 177 (45%) of the hospitals had carried out BFHI training. Among the CMAM sites visited 2,782 health staff had been trained in CMAM; each site had at least one staff member trained in CMAM on average, 85.2%, of facilities had at least one staff member trained in IMNCI.

Finding 4.12. The health retention scheme has been effective in retaining health workers in post

One measure of the effectiveness of the retention scheme is the increase in the number of health workers retained and in post. The HTF funded retention and critical post allowances targeted critical services at district and PHC levels and have helped to reduce clinical and managerial attrition and vacancy rates. According to an MoHCC official and the 2015 HR staffing data (presented at MODO in July 2016) since the implementation of the retention scheme in 2009, the overall vacancy rate for the key health professional cadres has fallen from 42% in 2009 to 30% in 2015; the number of doctors increased by 346 over the period and vacancy rates declined from 60% in 2009 to 31% in 2015. Vacancy rates for the nursing cadres fell by half in the period; from 14% in 2009 to 7% in 2015.

The 2015 Retention data show that there was a total of 135 doctors in district hospitals receiving the critical post allowance in 2015, an increase of 57 doctors from the 78 that were available in 2012 (Crown Agents 2016). The HTF funded allowances were effective in improving the numbers of midwives trained and retained. The number of practicing midwives increased from 1,838 in 2012 to 3,362 in 2015, resulting in an additional 1,525 midwives practicing in the public health sector.

On the other hand the key informant interviews and FGDs revealed that health workers perceived the scheme to be divisive and was causing conflict and resentment in some facilities, and the rationale for who was benefiting was not always clearly understood. Some respondents were more concerned about the exclusion of others from the scheme and felt this was impacting negatively on teamwork and working relationships. A common complaint and one raised repeatedly over the years by respondents was the issue of the untimeliness and unpredictability of disbursements, with many confused and frustrated with the lengthy payment processes.

³⁰ Human Resources for Health Report 2014: Presentation to the Health Transition Fund (HTF) Steering Committee (SC), PowerPoint Presentation: HR Department, MOHCC (February 2015)

³¹ Key Informant Interview

³² Multiple Indicator Cluster Survey. Final Report, UNICEF March, 2015

³³ Communication with Crown Agents February 2016

Respondents also expressed dissatisfaction with the declining value of the incentives and reduction in the allowances over the years, especially when there has not been a corresponding increase in government salaries to make up for the shortfall. Some indicated that nurses and midwives were staying in their jobs only because they had no other alternative and or did not have sufficient resources to leave.

There was a sense of anxiety amongst health workers, managers, government officials and donors alike about the future and sustainability of the retention scheme, especially given the uncertain national macroeconomic situation and reductions in donor funding. Concerns about the consequences of further reducing or removing the current HTF funded allowances both on the continued retention of critical cadres and on service delivery were raised at all levels. Health workers' concerns are further compounded by the lack of information and communication available on the new HDF and uncertainty about government and donors plans for future support to the health workforce.

Respondents cautioned that withdrawing or reducing the allowances may lead to more 'brain drain' and/or demotivated health workers. It was reported that some countries in the region are actively recruiting Zimbabwean nurses and midwives, that recently there has been an increase in the numbers requesting transcripts; an indication that they are preparing work in another country. The fluctuations and movements observed within the doctors' group receiving the allowances and the fall in the numbers of midwives between 2014 and 2015 could be an indication of an emerging attrition problem.

A case study on the retention scheme is presented in **Annex 8**.

HEALTH POLICY, PLANNING AND FINANCING (THEME 4)

Finding 4.13. The HTF has significantly contributed to design and operationalization of national policies

The contribution of the HTF to the policy dialogue and to identification, design and launch of relevant MNCHN policies is undoubted.

The HTF contributed to various policies and plans between 2011 and 2015, including:

- 1) Development of National Health Strategy 2016-2020
- 2) Development of draft National Child Survival Strategy for Zimbabwe, 2016-2020
- 3) Development of the Health Development Fund (HDF)
- 4) Development of the National Nutrition Policy 2013
- 5) Development of National Nutrition Strategy 2014-2018
- 6) Development of Programme Implementation Module (PIM) for RBF
- 7) Development and distribution of Integrated Young Children Feeding (IYCF) guidelines
- 8) Review of Essential Drugs List of Zimbabwe (EDLIZ)
- 9) Development and dissemination of the MNCH scorecards
- 10) Development of Guidelines on Rational Use of Blood
- 11) Printing of Village Health Worker Handbook
- 12) Clinical mentorship guidelines

In addition to specific policies, plans and guidelines, the evaluation notes that the HTF Committee has played a key role in the past years in advancing the policy debate and in transforming policies into practice.

Finding 4.14. District Health Executives (DHE) develop annual plans and hold management meetings

The HTF set specific targets to enhance the capacity at district level to plan, monitor, and review and report health activities. The evaluation team assessed DHE performance through the LSTM 2016 Survey. Full details on district level planning, leadership and governance is provided in the survey report.

We postulated that the development of annual workplans in each of the three years under observation (2013; 2014; 2015) was a required condition to draw conclusions on the regularity of this process. According to survey findings, 83.4% developed an annual workplan in 2015, indicating a high adoption of planning as standard practice despite of a declining trend compared to levels reported for 2013 and 2014.

Table 9: District Health Executives developing Annual Work Plans (LSTM 2016)

	% of DHEs: (n=44)	95% CI
District Work plans		
Work plan developed in 2013	95.2	(91.4,99.0)
Work plan developed in 2014	93.1	(89.2,97.1)
Work plan developed in 2015	83.4	(77.3,89.6)

Within all the districts surveyed, 100% of the DHEs reported holding management meetings and 79% held these meetings on a monthly basis. Annual Review Meetings (with records of last meeting available) were held by 63% of DHEs.

The LSTM 2016 Survey also revealed an encouraging situation with regards to health information management at district level. Within the surveyed districts (n=44) at DHE level, charts and diagrams summarizing health indicators and statistics of the districts were on display in most cases (98%). Nearly all districts reported having a computer available for HMIS (98%) and an internet connection (80%). All DHEs reported to provide timely feedback to facilities (100%).

Finding 4.15. There is strong evidence that charging user fees is a reduced practice

One of the primary objectives of the strategies set in place by the HTF and of the facility financing mechanism sustained through the fund in particular, was stimulating facilities to remove user fees for beneficiaries. In mid-2014, the HTF transitioned from a fixed payment scheme, the Health Service Fund, to a results based financing mechanism, supported in 44 districts of the country. In early 2012 (VMAHSS R11), only 59.5% of facilities in Zimbabwe offered free full maternity services. In addition, 19.8% of facilities charged user fees for child care. According to VMAHSS R26, approximately **95% of facilities offered free full maternity services** during the course of 2015. These levels have remained stable during 2014 and 2015. According to the same survey, in 2015 the proportion of facilities charging for antenatal care declined from 11.4% to 7.7%.

The LSTM surveys performed in 2015 and 2016 presents a similar picture. Among the facilities surveyed in 2016, 18% of district level hospitals and 18.8% of Level 1 facilities charged user fees for one or more MNCH services. Whereas the percentage of Level 1 facilities charging user fees for MNCH services has not changed much from the 2015 survey (17.5% in 2015), there has been a decrease in the percentage of district hospitals charging user fees for MNCH services (24.8% in 2015).

As shown in [Table 10](#) below, amongst facilities charging user fees, none charged fees for child health services; whereas, approximately 50% (i.e. 9% of all facilities) charged user fees for maternity services at hospital level. These findings are consistent with those reported through VMHASS. The majority of fees were charged for ANC, PNC and family planning. The table indicates the average price charged per service.

Table 10 - Facilities charging user fees for MNCH services

<i>Services Charged, amongst Facilities charging user fees</i>	<i>Level of care (95% CI)</i>		<i>Mean Price (\$)</i>
	<i>District level hospitals</i>	<i>Level 1 facilities</i>	
% Facilities charging user fees for MNCH of which:	18 (11,24)	18.8 (14.6,22.9)	-
<i>ANC only</i>	<i>13 (>0,45)</i>	<i>4.9 (NE*)</i>	<i>15.5 (4.7,26.3)</i>
<i>ANC and PNC</i>	<i>64 (31,97)</i>	<i>90.1 (84.3,95.9)</i>	<i>25.0 (23.1,26.9)</i>
<i>Normal Delivery</i>	<i>49 (17,81)</i>	<i>7.9 (>0,46.5)</i>	<i>22.7 (0,53.0)</i>
<i>Caesarean Section Delivery</i>	<i>49 (17,82)</i>	-	<i>150 (0,390)</i>
<i>PNC only</i>	<i>0 (--)</i>	<i>7.9 (>0,46.5)</i>	<i>12.7 (NE)</i>
<i>Blood transfusion</i>	<i>49 (17,82)</i>	-	<i>50.5 (NE)</i>
<i>Child Health (incl. vaccination)</i>	<i>0</i>	<i>0</i>	<i>NA</i>
<i>Family planning services</i>	<i>60 (28,93)</i>	<i>79.1 (33.0,99)</i>	-
<i>PMTCT</i>	<i>0 (--)</i>	<i>6.6 (>0,58.1)</i>	<i>1</i>
<i>Other</i>	<i>0</i>	<i>0</i>	<i>3 (NE)</i>

Source: LSTM 2016

Finding 4.16. Preliminary, unpublished evidence regarding the effects of results based financing suggests that the scheme yields some positive results

Results based financing (RBF) was introduced in Zimbabwe in 2011, with support from the World Bank, in 18 districts of the country. In 2014, the country decided to scale up the intervention nationwide, with the HTF supporting the introduction of the RBF in 42 districts of Zimbabwe.

This intervention replaced a fixed, inputs based financing mechanism - the Health Services Fund - in place until then to support facilities abolish user fees and offer free services. Whilst the experience from the World Bank was largely used to inform the planning and implementation of the scaled up intervention, the operational processes adopted in the 42 districts supported via the HTF differed from the ones adopted from the WB, in terms of the managing agents, procedures and guidelines, and reporting mechanisms, amongst other.

The LSTM Survey 2016, which was performed throughout the country and not only in HTF/RBF supported facilities, indicates that 66.8% of Level 1 facilities received support through the RBF in 2015.

The RBF was therefore a main pillar of the HTF, introduced as a measure to cover the routine running costs of primary healthcare facilities, linking payments to a determined set of performance measures.

To date, no impact study has been conducted on the implementation of the RBF in the 42 HTF supported districts. In addition, because the intervention is still being scaled up, a full assessment of its effects would have to wait for it to reach a more mature stage of implementation. The only unpublished evidence on the effects of RBF in Zimbabwe is available via a study from the World Bank³⁴ on RBF implementation in 18 districts.

The results of the effects of RBF according to the existing evidence are mixed:

1. The RBF has sustained the removal of user fees

Through our survey in 2016, we measured the association between the access to financial support for the facilities (i.e. RBF) and the practice of charging user fees. Our analysis suggests that facilities not receiving financial incentives are five times more likely to charge user fees than those not receiving financial support (RR=5.0, 95% CI=2.4, 10.3).

Our data did not allow for the comparison of this finding with a scenario of facilities receiving other forms of non-outputs based incentives as the previously supported HSF.

2. Impact of RBF on outcome level is limited to some interventions

Results from an impact evaluation of the RBF conducted by the World Bank indicate that facilities (within 18 World Bank supporting districts) benefitting from RBF present a significant increase (14.7%; p-value 0.002) in skilled birth attendance at facilities compared with facilities with no RBF. No effects were found on coverage of antenatal care and postnatal care and no significant effects were found on immunization coverage rates.

3. Effects of RBF on quality of services are mixed

The same study reports improvements in selected measures of structural quality, primarily related to the availability of equipment, medicines and supplies. There is also evidence of improved practices for child care (classification of danger signs; correct management of cough and difficult breathing).

No significant change is reported in the quality of ANC.

4. RBF does not lead to major changes in facility governance

The World Bank impact evaluation of the RBF did not find any significant change in facility management practices (operating hours, development of annual workplan, supervision from DHE, obtaining patient opinion) in its implementing 18 districts.

5. RBF is an highly cost effective intervention

Unpublished research from the World Bank and Brandeis University³⁵ indicates that the RBF is a highly cost effective intervention, based on an incremental cost effectiveness (ICER) analysis where additional costs and benefits of the RBF are compared to a situation of “no intervention”. The same study has modelled and projected an even more positive ICER once the program reaches a mature stage.

The detailed analysis of progress for each thematic area of the HTF and related indicators is presented in **Annex 7**.

Q5 *What were the main facilitators and barriers to achieving intended results?*

³⁴ Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes EVIDENCE FROM ZIMBABWE RESULTS BASED FINANCING IMPACT EVALUATION. The World Bank, June 2016. Powerpoint presentation

³⁵ Cost-Effectiveness Analysis of Results-Based Financing in Zimbabwe, the World Bank and Brandeis University. PowerPoint presentation, June 2016

Barriers and facilitators to achieving HTF results are described in various sections of this report. Table 11 below summarizes the major barriers and facilitators identified through the evaluation, at each level of the system.

Table 11 - Barriers and facilitators

Implementation level	Barriers	Facilitators
HTF Governance and management	Complex procedural arrangements for administration and management Recurrent delays in disbursements Funding constraints	Government leadership Accountability Transparency Alignment with national strategies Participation
Health Services provision	Inadequate staffing and related workload Referral problems Shortages of supplies Delays in receiving allowances and RBF Reducing value of the allowances Health worker attitudes and behaviour	Support from other partners Motivation of healthcare workers
Village Health Workers	Lack of regular payment of incentives Lack of equipment and supplies Large catchment areas for VHWs Poor feedback from HF to VHWs Religious and cultural beliefs within communities	High social status and self-esteem related to role of VHWs High motivation of VHWs
Communities	Transport costs Other out of pocket expenses User fees Cultural and religious beliefs	Improved knowledge and care seeking practices

Q6 What unintended results – positive and negative – did the intervention produce? How did these occur?

The main unintended results produced through the HTF and identified by the evaluation are reported below:

- Workload and behaviour of health workers – increased demand for services coupled with pressure due to increasing reporting requirement for RBF placed increased pressure on healthcare workers. This resulted in frustration and in poor attitude and behaviour towards beneficiaries. It also resulted in poor reporting, which led to less funding for the respective health facility.
- Referral practices – through our qualitative research, we identified cases of purposely deferred delays, justified by the possibility for the facility to gain additional RBF funding if retaining clients. Furthermore, some clients refused to go to the facilities they were referred to, because these facilities charged fees.

- Low volume facilities penalized by RBF – due to the RBF mechanism, low volume facilities – even though they may be well performing – could not earn sufficient funds to sustain running costs and capital investments.
- HCC delaying investments at facility level – the revitalization of health centre committees was a core strategy of the HTF in strengthening the link between facilities and communities and enhancing accountability. In most cases, HCCs oversee the process of investing RBF funds at facility level, approving facility plans and related expenditure. There is evidence that in various instances the poor capacity or low motivation of HCCs was a barrier for facilities investing resources in a timely manner.
- Discontent amongst healthcare workers due to retention allowances - the retention and especially the critical post allowances benefits a limited number of health workers in the facilities. This issue causes dissatisfaction with the beneficiaries and the limitations of the scheme; only those midwives practicing and working in the maternity wards are eligible to receive the critical post allowance. Some suggested that the resources available for these allowances is dictating the number of midwives that can be allocated to the maternity ward, rather than patient numbers and service needs.
- The introduction of new vaccines was a key strategy promoted through the HTF. As anticipated in our Annual Review 2014, the introduction of new vaccines requires a much higher capacity in terms of volumes of vaccines procured; higher costs per dose and reaching new target/age groups.

The additional costs related to the introduction of new vaccines are subsidized in the short term, but sustaining an expanded immunization schedule requires significant long-term government commitment. Regretfully, as reported in the Annual Report to HTF Donors 2015, the Government did not manage to fulfil its co-financing commitments with GAVI during the year.

Summary of Findings on Effectiveness

Evaluation Question	Findings
Q4. To which extent were HTF intended results achieved during its implementation?	<p>The evaluation reports consistent progress in achieving the intended program outcomes throughout the life of the HTF.</p> <p>Of the 54 indicators identified to monitor output level results, 29 present both baseline and endline data, which allows for the measurement of progress between 2012 and 2015: 28/29 indicators (96%) show progress.</p> <p>For those indicators for which there were data available to measure the achievement of targets set by the HTF (n=35), 65% show that set target were achieved.</p>
Q5. What were the main facilitators and barriers to achieving intended results?	<p>Various barriers and facilitators are identified at all levels and for all stakeholders involved in the HTF, from communities to donors and policy makers. Table 11 provides a summary.</p>
Q6. What unintended results – positive and negative – did the intervention produce? How did these occur?	<p>Major unintended results are primarily related to negative, unanticipated effects of introducing mechanisms such as the retention and critical post allowances and the RBF.</p>

4.3. EFFICIENCY

Q7 To what extent was the HTF implemented as per plans and budget throughout its implementation period?

Finding 7.1. The HTF was largely implemented as per defined and approved annual plans and budget

The initial design of HTF entailed an investment of USD435 million over a period of five years (2011-2015). During the four years of life of the Fund (2012-2015), the HTF SC approved plans and budgets on an annual basis. As the final certified financial statements of the HTF had not been released by UNICEF at the time of writing, the evaluation has used expenditure figures presented through the HTF Annual Reports to Donors 2012, 2013, 2014, 2015.

A summary of the annual approved budgets for HTF activities and of related expenditure is presented below:

Table 12 - HTF Annual budget and expenditure, 2012-2015 (USD)

	2012	2013	2014	2015	TOTAL
Annual Budget	62.707.748	62.811.531	53.422.843	56.408.151	235.222.354
Annual Expenditure	54.510.396	45.912.719	51.973.634	55.347.091	207.743.840
<i>Utilization rate</i>	<i>87%</i>	<i>73%</i>	<i>97%</i>	<i>98%</i>	<i>88%</i>

As shown in [Table 12](#) above:

- The actual, total amount allocated to the HTF for direct programming (i.e. not including overhead costs) was USD235 million over four years, against an initial budget of 435 ML USD initially planned over 5 years.
- Overall, the HTF absorbed nearly 90% of allocated resourced throughout its life, with a marked improvement in the expenditure rate during the FY2014 and 2015, where 98% of allocated resources were utilized.

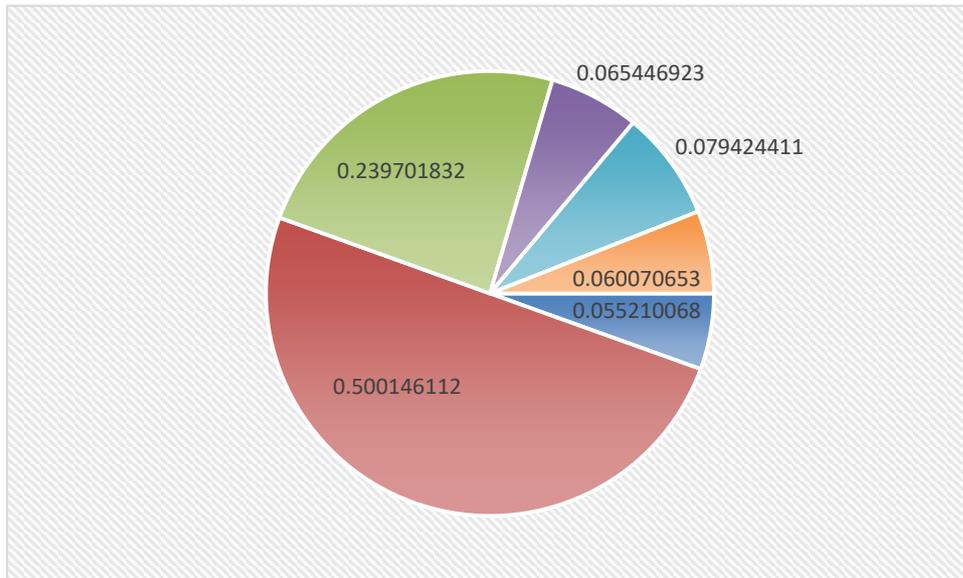
Finding 7.2. Donors were effective in fulfilling their commitments to the HTF

For the two financial years where information was available through HTF reports on approved HTF budgets, the disbursements from donors were in line with the annual budget approved by the HTF SC. In FY2012, 97% of the planned budget was actually disbursed and in FY2014 more than 100% of the annual planned budget was disbursed.

Interviews with key informants at central level confirmed that one of the perceived advantages of a pooled fund mechanism was the fact that donors could support each other in fulfilling commitments in order to minimize the impacts of delayed/unavailable funding on the overall programme plans.

The proportional contribution to the HTF from Donors is presented in [Figure 8](#).

Figure 8: Contribution from participating donors to the HTF (%)



Finding 7.3. More than 80% of the HTF expenditure focused on key strategies identified to support the health system

The HTF maintained a strong focus on core interventions, which were identified as critical to sustain the recovery of the health system, throughout its implementation.

As shown in Figure 9 below, the HTF maintained a focused pattern of expenditure across its life:

Figure 9. Patterns of expenditure, 2012-2015 (in USD, ML)



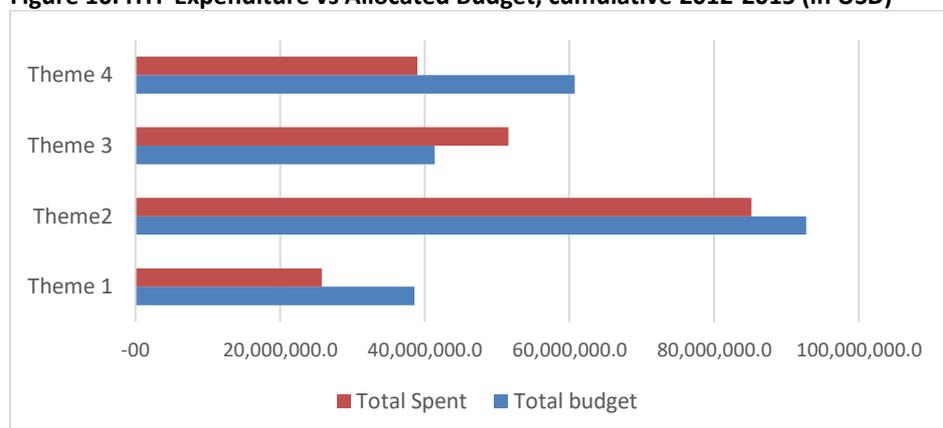
- Expenditure in MNCHN programming (Theme 1) focused primarily on sustaining capacity strengthening and in investments in capital equipment for facilities. The efforts supported in this area, worth 25 ML USD in total (13% of the total HTF expenditure) decreased over time from an initial 11.3 ML USD in 2012 to 3.1 ML USD in 2015, as the system recovered and availability of care was restored.
- Expenditure in medical equipment and supplies (theme 2) was the major investment supported through the HTF, totalling 85 ML USD (42% of the total HTF expenditure). This was consistent and steady over time, with the exception of a drop in late 2015, which caused an immediate drop in availability of essential medicines at health care facilities.
- The expenditure in sustaining human resources for health (theme 3) amounted to a total of 51.3 ML USD during the period 2012-2015, which constitutes 25% of the total HTF spent. This funding was allocated to two major initiatives: a top up payment for critical posts (17 ML USD) and support to retention allowances for staff in Grades C5 and above (34.5 ML USD). The investment in HRH increased constantly over time, doubling from 2012 to 2015, due to the inclusion of additional staff onto the scheme.
- The investment in health facility financing – a fixed inputs based scheme until 2014 and then a results based financing scheme afterwards – absorbed 39 ML USD (19% of the total HTF spent). Investments in this area also increased over time, as the payment mechanisms consolidated and were scaled up.

Finding 7.4. There is evidence of flexibility in adjusting plans and budgets to emerging priorities and needs

“So it has been flexible....just great flexibility....so that flexibility also I think has helped it be what it is as compared to other processes that are sort of rigid and.....we can’t change anything”

Overall, financial utilization figures indicates a good degree of flexibility from the HTF in adjusting the distribution of planned allocation to needs emerging during implementation, and in line with SC orientation. Both in FY 2014 and in FY 2015 the budget forecast was readjusted in order to allocate additional resources to Thematic area 3, by reallocating resources from other budget lines as shown in [Figure 10](#) below. Flexibility was perceived by many central level stakeholders as a key asset of the HTF according to qualitative findings.

Figure 10. HTF Expenditure vs Allocated Budget, cumulative 2012-2015 (in USD)



Q8 To what extent did the intervention represent the best possible use of available resources to achieve results of the greatest possible value to participants and the community?

Finding 8.1. The investment in a pooled funding mechanism is perceived by relevant stakeholders as a comparatively efficient mechanism of aid

KIIs performed in 2015 and 2016 highlighted a clear perception of key stakeholders that the HTF design is “more efficient than having multiple vertical programmes implemented by different partners”, each with a set of objectives, monitoring and evaluation requirements, audit requirements and paper work for health workers. Some respondents suggested that this model should serve as an example for future donors who wished to fund programmes in the country. The majority of the respondents felt that the HTF mechanism is efficient as it is coordinated and implemented through the existing MoHCC structures. Some of the respondents believe that one of its key strengths is that it is sufficiently flexible to respond to what is needed based upon evidence, rather than being fixed and unresponsive to changing circumstances and developments

Finding 8.2. UNICEF offered good value for money in managing the HTF

The UK Multilateral Aid Review (MAR) Update 2013³⁶ rates UNICEF as *Very Good Value for Money* for UK Aid. In order for UNICEF to deliver planned HTF activities, a fixed rate for management and technical support costs was awarded by donors. Expenditure incurred by UNICEF for the management of the fund and its technical oversight in Zimbabwe ranged from a minimum of USD3 million (FY 2013) to a maximum of USD4.1 million per annum, at approximately 7% of direct program costs. In addition, a flat rate of 7% was charged throughout the life of the program by UNICEF as overall overhead rate charged by the agency.

A recent benchmark study of civil society organizations (CSOs) cost recovery practice,³⁷ provides a useful reference to assess the cost of managing the HTF through UNICEF against comparable organizations. According to the study, the central support cost percentage for those surveyed was between 4% and 26%, with an average of 11.42%. The programme support cost rate varied between 2% and 28% and the average was 13.99%. Table 13 below reports the average central support cost rate and the program support rate for very large CSOs, i.e. for those organization with an average annual income above GBP200 million), to which UNICEF is comparable.

Table 13 - Comparison of management costs: UNICEF vs benchmark study

Cost category	Benchmark study: very large CSOs	UNICEF/HTF
Average central support cost rate	10.13%	7%
Program support cost rate	16.45%	6-7%

For both central support cost rate and program support costs, the fees charged by UNICEF fall below the average fees charged by other organizations, as per evidence provided through the above-referred benchmark study.

³⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/264461/UNICEF-2013-summary-assessment.pdf

³⁷ Cost recovery: what it means for CSOs, February 2016 Published by Bond, Society Building, 8 All Saints Street, London, N1 9RL, accessed at: <https://www.bond.org.uk/sites/default/files/resource-documents/cost-recovery-0216.pdf>

The efficiency and the costs related to managing sub-contractors for service delivery (eg. Crown Agents) was not part of this analysis.

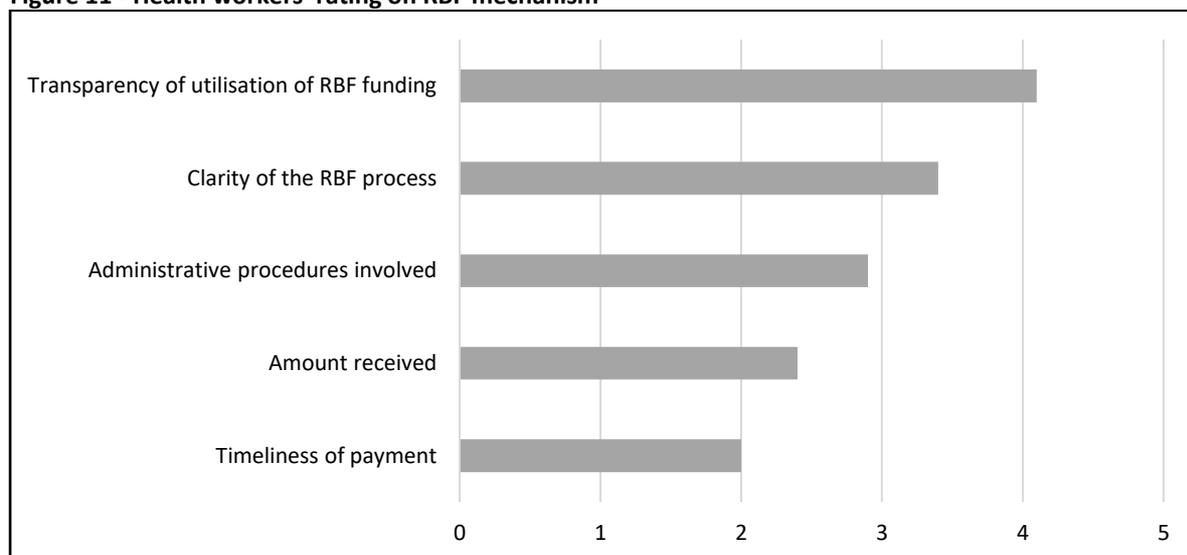
“.....because it’s in the UN family, many donors can put fund without going to tender. If a private company, it will be cheap than this role UNICEF is playing in terms of the administrator but will lose the capacity of integrating the partners.”

In addition to efficiency considerations, it is noted that UNICEF provided a multi-faceted role in managing the HTF: in addition to the functions of fund manager, UNICEF also played a critical role in providing technical assistance and expertise; in facilitating coordination and communication amongst stakeholders; and in directly implementing some of the HTF activities (procurement).

Finding 8.3. There is evidence of operational challenges in implementing the RBF mechanism

The evaluation surveyed health workers to rate the RBF process on a Likert scale (0 to 5), with regards to five aspects related to its implementation (Figure 11): timeliness of disbursement, amount received, administrative procedures to follow, clarity on the process and transparency in the utilization of the funds. Transparency in funds utilization rated highest followed by clarity of the process and administrative procedures involved. Timeliness in receiving the disbursement scored lowest.

Figure 11 - Health workers’ rating on RBF mechanism



Source: LSTM survey, 2016

The results of the survey were explored in depth via informant interviews. The key issues emerging from the users’ perspectives with regard to the RBF implementation are summarized below:

Reporting requirements for RBF

Several health workers participating in the evaluation explained that they were struggling to manage their clinical work load and at times they could not prioritise the RBF reporting, which meant they received less funding, which negatively affected the facility and caused staff to be demotivated. Health workers acknowledged that RBF highlighted gaps in their capacity, specifically registration and reporting. They confirmed that their skills in documentation, recording and reporting have improved with the introduction of RBF. However, as the

majority of them were not used to such type of strict registration processes before, they felt that the amount of documentation required in addition to their existing workloads and resources, was overwhelming.

Respondents from the national level confirmed that the RBF reporting mechanism was complicated, as they (themselves) could not get them right although they had attended several trainings.

The World Bank Report “Learning from Implementation of RBF, May 2015” echoes the same conclusions: *“The nurses experience heavy workloads as they now divide their attention between supervisory, administrative and technical duties. The RBF linked extra tasks in reporting, local procurement and organizing logistics further aggravated the shortage and workload situation leading to too few staff being available to do core clinical tasks at the clinics. This situation deserves attention; the program and the sector in general needs to fully understand the nature of tasks and workload and question whether it is the best way for the health workers to spend their time or the only solution to completing other essential but nonclinical tasks”.*

Amount of funding received

Respondents understood that RBF has tried to improve the quality of services but reported that the **amount of funds received under the RBF** mechanisms were not sufficient to cover the needs of the community even if they performed well. In the context of progressively declining external funding, RBF did not consider other running costs for the facility, such as kitchen and laundry charges.

The low level of funding at facility level was confirmed during interviews with national level respondents who reported a surplus of RBF funds due to errors in reporting from facilities.

Disaggregated data regarding payments of facilities could not be accessed by the evaluation, to ascertain the proportion of facilities that experienced reduced payments during the transition from HSF to RBF.

Timeliness in receiving the reimbursement and procedures for spending funds

Timeliness was another strongly perceived challenge to implement the RBF. This was further complicated by the procedures following the reimbursement. Often health facilities did not receive any communication on when they would receive the funds. Hence, some respondents preferred the input based payment under HTF since they at least received some regular funds to run their services rather than the unpredictable amounts disbursed under the RBF.

“RBF is complicated even for myself it is too complicated. I have been trained I don’t know how many times. But every time I think I need more training. It is too complicated imagine the health worker who is supposed to seeing patients now has to fill in these forms so they end up being penalized if they get more than 5% of margin of error you are penalized.”

Delay in receiving disbursements was further complicated by certain procedures and requirements under the RBF. In most cases, facilities did not have full financial autonomy to utilize the revenue collected under RBF, as they had to follow specific procedures that such as getting approval from the HCC, receiving three quotations and getting approval from the DHE. At times, health workers found that the quotations were no longer valid by the time they received approval from the DHE. Additionally, the majority of health workers felt that the DHE only chose the cheapest quotations and that they were not concerned about quality.

Accountability and transparency

Important principles promoted under the RBF mechanism were accountability and transparency as RBF plans to improve both internal and external accountability mechanisms within the health system.^{38, 39} Internal accountability can be improved through functioning information and feedback mechanisms about the funds and its operation. However, communication within the programme at different levels of the system appears to have been inadequate especially since health workers were not informed about when they would receive the reimbursement and the reasons for the delays. This finding from our key informant interviews is confirmed by the “Health services assessment” conducted at the beginning of 2016 (Figure 10. Health workers’ rating on RBF mechanism).

National level respondents participated in the interviews also agreed that they were not in a position to disclose the reasons of these delays, even when they knew what these were. This negatively affected the potential and credibility of the RBF mechanism, compromising accountability among key actors.

Finding 8.4. There is potential to improve the efficiency of the health retention scheme

Three main areas have been identified for potential efficiency improvement in the design and implementation of the health retention scheme:

1. Allocative distribution of the scheme and duplication with other incentives

As shown in [Figure 12](#) below, there is a skewed distribution of the funds allocated to healthcare workers through the retention scheme. These allowances provided to frontline health workers (practicing midwives, staff of grade C5 and above) is disproportionately lower than the funding accessed by other cadres. This generates discontent, particularly because the cadres receiving the highest allowances are also often beneficiaries of additional schemes in place within the sector or those who already receive much higher salaries .

Through the critical posts allowance, doctors received on average approximately USD574 per month in 2015, compared to USD480 in 2012, a tutors’ monthly allowance increased from USD380 in 2012 to USD500 in 2015, while practicing midwives’ allowance increased from USD37 to USD45 per month in 2015. The average salary top-up for each health workers at Grade C5 and above was approximately USD276 per year⁴⁰.

Currently, a range of allowances and incentives are provided targeted at different cadres based on skills, training and qualifications, and duties and job responsibilities, with some cadres getting a retention allowance, as well as a critical post allowance and/or other historical government allowances,

³⁸ KIT (Royal Tropical Institute) In Collaboration with Cordaid and WHO. Learning lessons on implementing performance based financing, from a multi-country evaluation. 2009.

³⁹ World Bank Group. A smarter approach to delivering more and better reproductive, maternal, newborn and child health services. World Bank Group, 2014.

⁴⁰ Calculations based on UNICEF expenditure data, accessed in April 2016

which are paid separately from their government salary and funded from different sources. A percentage of the RBF payments received by facilities are also provided as incentives to health workers.

Typically, those health workers and managers getting the higher retention and critical post allowances will also access additional allowances from different sources.

Figure 12 - Distribution of health retention allowance by cadre



2. Eligibility criteria

While the scheme funded through the HTF and GF has helped to stabilise and retain critical health workers in recent years, during key informant interviews many health workers voiced dissatisfaction with the selection and eligibility of beneficiaries and with the overall administration of the scheme. Some health workers perceived the scheme to be divisive, as the rationale for who was benefiting was not always clearly understood.

The allowance for ‘practicing midwives’ seemed the most divisive, especially

“The divide and rule policy the Ministry of Health has is very dangerous. Someone working in labour ward gets an allowance, someone has got midwifery and working in outpatient is not getting it, but now when they happen to have a problem in maternity, which they know I can assist them, if they call me I don’t go, because I am not getting an allowance”

in the district level hospitals, where it is paid only to those midwives who are working in the maternity wards. Many hospitals have sent their RGNs for midwifery training and now have large numbers of midwives, who cannot all work in the maternity ward. Hospital management mentioned that they have put in place a rotation system for the midwives to ensure that everyone gets a chance to work in the maternity wards but it is not clear how well this is working in practice. This is creating an oversupply in the hospitals while lower level facilities have a shortage of midwives.

3. Timeliness of payments and information transparency

A common complaint and one raised repeatedly over the years by respondents is the issue of the untimeliness and unpredictability of the disbursement of the allowances, with many confused and frustrated with the verification and payment processes. The overall disbursement of funds was perceived to be erratic and haphazard; disbursements vary and can sometimes be several months in arrears.

“You sometimes go for long periods without anything and then when it comes you are not sure whether you have received what you are supposed to be receiving because it comes as a lump sum. Like now I see something on my phone that money is coming but I am not sure where it is coming from”

Respondents also reported a lack of information regarding disbursement amounts and schedules, with many reporting that they have now lost track of which month the allowance is for and have no way of checking if they have received all the allowances they are entitled to. Some suggested that issuing pay slips and sending them directly to the health worker rather than to the provincial offices, would help them know how much they have received, for what period and on what date.

More details on the health retention scheme are provided in [Annex 7](#).

Finding 8.5. The procurement and distribution of medicines and supplies was highly efficient

The procurement and supply management (PSM) implementation arrangements, based a mix of a standardized primary health care package (PHCP) complemented with a parallel availability of around 100 in bulk purchased health products assured a high efficiency in the supply chain. This was further supported by an efficient single sourced procurement, direct delivery to the regional Natpharm warehouses and distribution logistically assured by NatPharam and financially supported by the HTF.

The procurement, receipt and distribution of the PHCP and bulk health products was a well organized and permanent flow of commodities into the health system and is well documented. Although there are some disruptions in the supply (2014, 2015) this is not directly linked to the PSM configuration but related to late or limited funding and rather long supply lines.

The supply of vaccines and related medical supplies was also efficient: the availability rates for these products was reported as very high over the entire HTF period and stock out rates reduced. The investment in the cold chain management (cold rooms, gas, training) was a major factor in the availability of the vaccines country wide.

The main findings of the analysis consistently point toward indication of a high level of efficiency of the procurement system for PHCP, as supported by the HTF. In particular, the evaluation notes that the system fulfilled all the requirements expressed in annual MOHCC procurement plans (2012-2014), and that this was done at competitive price values in comparison to international benchmarks. The continuous revision of the PHCP content on a year to year basis allowed to adjust the kit to needs, and consequently there is no evidence of particular issues related to over or under estimation of health products.

A case study on the efficiency of the PHCP is presented in [Annex 9](#).

Summary of Findings on Efficiency**Evaluation Question**

Q7. To what extent was the HTF implemented as per plans and budget throughout its implementation period?

Q8. To what extent did the intervention represent the best possible use of available resources to achieve results of the greatest possible value to participants and the community?

Findings

The HTF was implemented in line with annually approved budgets and work plan. There is evidence that donors met their commitments, and that the fund utilization rate was high. Flexibility was secured to manage the plans and budgets to response to emerging needs.

There are significant margins to improve the efficiency of two main mechanisms supported via HTF, the health workers retentions scheme and the results based financing mechanism.

Lengthy, unclear and complicated processes hinder the added value of such mechanisms.

Procurement of medicines and supplies was efficient.

4.4. IMPACT

Q9. Has the HTF contributed to improved maternal newborn and child health and nutrition outcomes in Zimbabwe, from 2012 to 2015?

Finding 9.1. Impact and outcome level targets set by the HTF were not achieved

Three impact indicators and 29 outcome indicators were identified to measure the success of the HTF (see HTF Log-frame in **Annex 1**).

For 18 indicators (3 impact; 15 outcome) we were able to measure the achievement of targets:

- None of the impact level indicators was achieved
- For 3 of 15 outcome indicators (20%) targets were achieved.

As previously explained in this report (see chapter 3.4), we believe that the poor level of achievement of targets may be largely attributable to a very ambitious setting of targets at inception rather than to poor performance/progress of the country.

Improvements have indeed been remarkable, as documented below.

Finding 9.2. Coverage of essential MNCHN interventions has improved during the period 2012-2015

The HTF identifies a core set of essential MNCHN interventions along the continuum of care as the primary outcome measure of its success. A detailed assessment of progress for each indicator is presented in the updated evaluation logframe (**Annex 1**); for the purpose of this final evaluation, MICS 2014 data have been used to populate the logframe endline values, since the latest DHS 2015 report was not available at the time of writing.

Evidence from national surveys shows substantial **progress in coverage of key MNCHN interventions along the continuum of care**. For all interventions coverage indicators for which a comparable baseline and endline measure are available, progress from baseline has been observed during the period 2009-2014. For all interventions coverage indicators for which a comparable baseline and endline measure are available (n=11), only 1 indicator is reported to have achieved HTF set target by 2014 (Skilled Birth Attendance).

Progress against key tracer indicators along the continuum of care is also summarized in **Table 14**. To estimate coverage change, we have used the average annual rate of change as a method of analysis, which we calculated by subtracting the endline point estimate (DHS 2015 Key Findings and when unavailable MICS 2014) from baseline point estimate (DHS 2010/11), divided by the total number of years within the time period of analysis. Data presented in **Table 14** indicates that during the period 2005-2010, for most interventions, there coverage decreased (negative average annual rate) or showed very little improvement. This trend inverted during the period 2010-2014, where coverage increased significantly.

Table 14 - Average Annual Rate of Change for tracer HTF outcome indicators

Interventions along the continuum of care	Tracer indicators	Pre-HTF	Baseline	Endline	AAR 2005/6 - 2010/11	AAR 2010/11 - 2015
		DHS 2005/6	DHS 2010/11	DHS 2015 Key findings	(%)	(%)
Maternal and Newborn Health	Antenatal care visits (4+)	71%	64.8%	75.7%	-1.3%	3.1%
	Skilled attendance at delivery	68.50%	66.20%	78.1%	-0.5%	2.4%
	Postnatal care visits	30.30%	27.1%	51.1%	-0.6%	4.8%
Immunization coverage	Full immunization (12-23 months)	52.60%	55.60%	73%	0.6%	3.5%
Infant and young child nutrition	Exclusive breastfeeding 0-5 months	22.20%	31.40%	47.8%	1.8%	3.3%
	Vitamin A supplementation	47.10%	65.60%	32.3%*	3.7%	-8.3%
Care seeking and access to treatment for sick children	Diarrhea treatment (ORS or RHF)	61.6%	63.30%	72.5%*	0.3%	2.3%
	Children with pneumonia treated with antibiotics	7.9%	31%	34.3%*	4.6%	0.8%

*From MICS 2014 as these indicators were not available in DHS Key Findings 2015.

The only exceptions to this picture were:

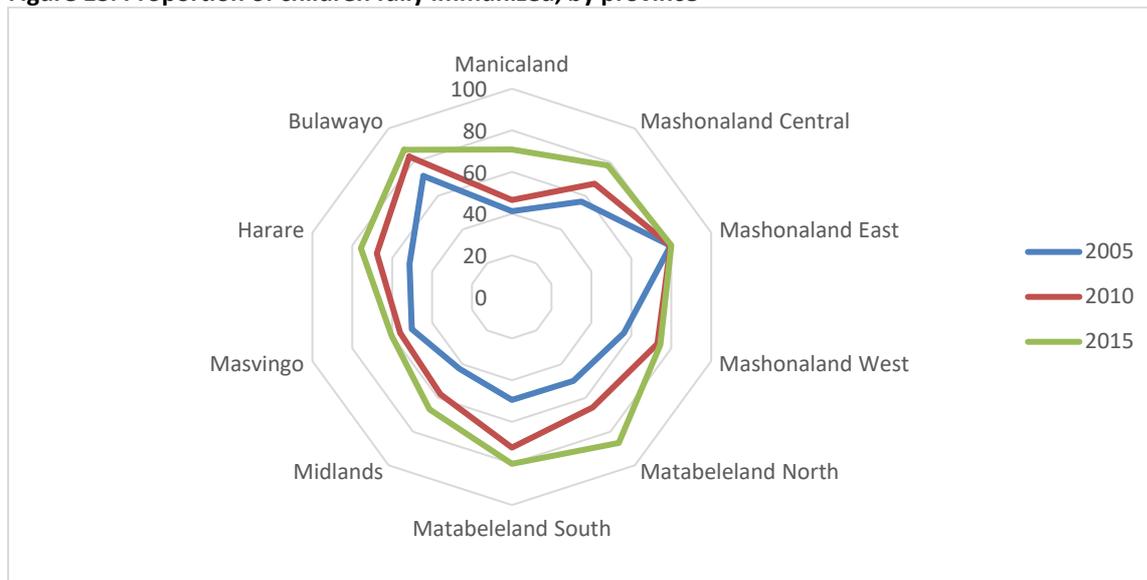
- Vitamin A coverage, which decreased from 65% in 2010 to 32% in 2014.
- Access to treatment with antibiotics for children with pneumonia, which increased at an AAR of 4.6% per year during the period preceding the HTF, and then plateaued during the following period.

For both indicators, results from the DHS 2015 are not available at the time of this writing, and the results presented refer to data available through MICS 2014. Whilst an analysis of DHS 2015 data may provide additional evidence for these results, it must be noted that no decrease in the availability of vitamin A and of antibiotics is reported at primary health care facilities during 2014. Reasons may therefore be sought in healthcare seeking patterns (pneumonia), and/or in performance/non-performance of supplementation campaigns (vitamin A) during the survey years.

Finding 9.3. Increased coverage has been consistent across provinces

Not only trends in coverage of essential MNCHN interventions inverted during the period 2010-2015. Also, as shown in [Figure 13](#) below using the example of immunization coverage, progress was consistent across provinces: all provinces improved during the decade 2005-2015, and growth was proportionately higher for those provinces that reported lower baseline rates (eg. Manicaland, Matebeleland South)

Figure 13. Proportion of children fully immunized, by province



Source: DHS 2005-06; DHS 2010-11; DHS 2015

Finding 9.4. Coverage of essential interventions presents inequities

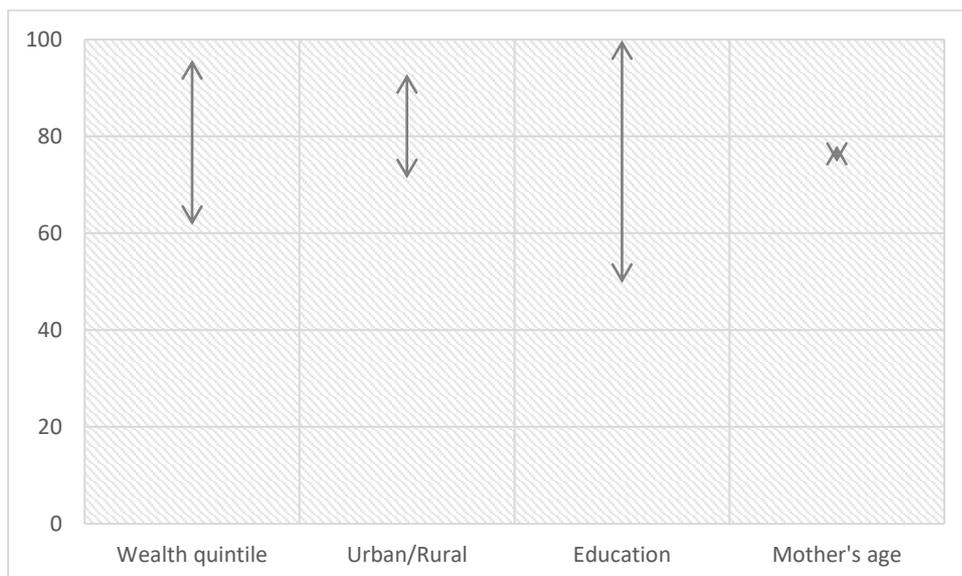
The analysis of coverage data available through MICS 2014 reveal certain aspects of equity of access that are of interest for programming and for the evaluation of results.

- Using skilled attendance at birth as a tracer indicator, evidence suggests that there is limited association between poverty levels⁴¹ measured at provincial level and coverage, when disaggregating coverage data by province.
- Women’s provenience (rural/urban) is an underlying factor for equity gaps for SBA and PNC.
- Access to/utilization of essential maternal and newborn services is influenced highly by the economic status of households and by the level of women’s education.
- Some provinces clearly show to be better off than others, when observing a combined score of coverage with ANC, PNC and SBA. This is a relevant issue, since according to MICS 2014 data there is an immediate correlation between coverage with key MNH services and newborn mortality.

This is summarized in **Figure 14** below, which shows the coverage for the worse and the better off categories and the equity gap amongst the two, for various socio economic characteristics of the population.

⁴¹ Zimbabwe Poverty Atlas, 2015

Figure 14-Equity gap in skilled birth attendance, by socio economic characteristics



Source: DHS, 2015

Finding 9.5. No major disparities related to gender are observed in accessing services

The limited number of coverage indicators available through the DHS Key Findings Report 2015 do not indicate any significant barrier to access to child health services related to the sex of the child. As shown in [table 15](#), access to interventions is slightly higher for girls than for boys.

Table 15. Coverage of interventions by sex

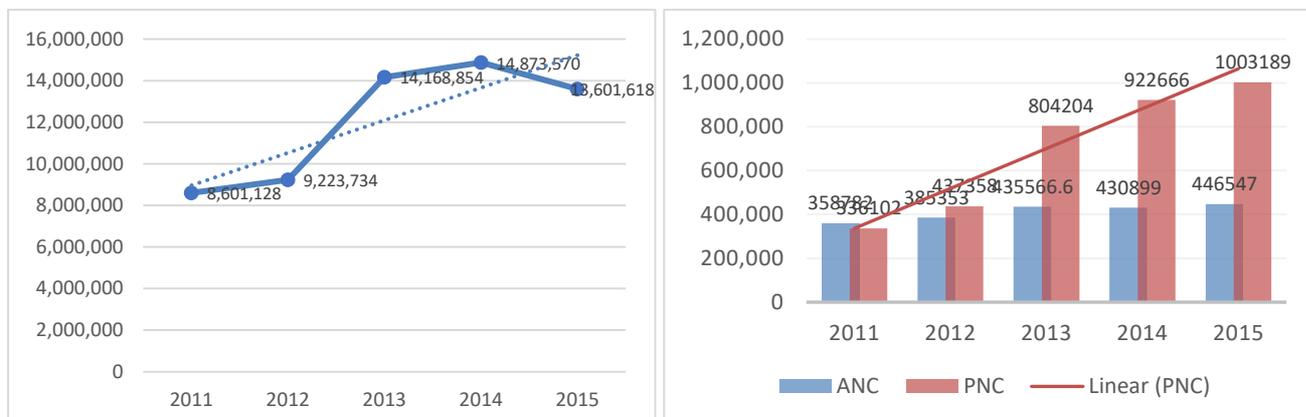
<i>Indicator</i>	<i>Coverage (DHS 2015)</i>	
	Male	Female
All basic vaccinations	70.6%	74.9%
Children with symptoms of ARI for whom treatment was sought from health facility	47.3%	55.3%
Children with diarrhoea given ORS	39.8%	41.3%

Finding 9.6. Improved utilization of care is confirmed through routine data

The total number of attendances at health facilities increased from 8.6 to 13.6 million consultations from 2011 to 2015 with a peak (14.8 million) in 2014 as shown in Figure 15.

The number of PNC visits is also reported to have grown significantly, whereas ANC visits increased at a lower rate. This confirms the indications of improved access to care provided through survey data.

Figure 15 – Trends in OPD attendance at health facilities and in numbers of ANC/PNC consultations



Source: HMIS

Finding 9.7. Mortality rates have reduced since 2010 contributing to saving lives

While the under-5 mortality rate was stagnant during the 5 years preceding the HTF inception, data from the recent DHS 2015 suggests that Zimbabwe inverted trends and reported significant reduction in child mortality since 2010, which decreased from 84 deaths per 1,000 live births in 2010/11⁴² to 69 deaths per 1,000 live births in 2015. Current estimates developed by the UN Inter-agency Group for Child Mortality Estimation project child mortality at 71 deaths per 1,000 live births in 2015.

Using household survey data available through DHS, we modelled the effects of changes in child mortality rates in Zimbabwe from 2005 to 2015, by estimating the additional lives saved due to the changes observed in mortality across two time periods: before the start of the HTF programme (2006-2010) and during the first phase of the program (2011-2015).

Table 16 - Effects of changes in child mortality rates in Zimbabwe from 2005 to 2015

	2006-2010	2011-2015
Cumulative number of births during the period	1.966.000	2.183.500
Under five mortality rate at baseline	82	84
Under five mortality rate at endline	84	69
Estimated n. Of annual deaths at endline year	34.490	31.333
Cumulative estimated number of U5 deaths during the period	163.319	163.502
Counterfactual: cumulative estimated deaths with no change in mortality trends from baseline	161.212	183.414
Additional U5 lives saved/lost during the period	- 2.107	19.913

Overall, we estimate that approximately 20,000 additional lives were saved during the period 2011-2015. Using MIMS mortality rates for 2009 (94 per 1,000 live births) instead of DHS mortality rates as pre-HTF point estimate, the estimate of additional children’s lives saved would be of approximately 30,000.

⁴² DHS 2010/11

It is important to acknowledge that progress in achieving improved outcomes cannot be attributed to a single initiative, but is rather due to joint efforts of the Government, donors, agencies and other civil society organizations, of which the HTF is part. Various initiatives were set in place in Zimbabwe during the period under evaluation to sustain the country in enhancing maternal, newborn and child health outcomes. These included, amongst others:⁴³

1. **H4+**: a joint UN initiative that sustained RMNCH-A programs through support at national level for policy design, and through focused implementation support to 6 districts of the country.
2. **Revitalizing Maternity Waiting Homes** (UNFPA): the Agency supported through a specific program the revitalization of maternity waiting homes, procuring also ambulances and sustaining the provision and distribution of equipment and nutrition supplies
3. **ISP** - Integrated Support Programme on Sexual and Reproductive Health and Prevention of HIV and Gender Based Violence: this program, led by UNFPA, focused primarily on gender based violence, family planning and screening of cervical cancer
4. The **Health Sector Development Support Project**: funded by the World Bank, this 15.5 initiative included capacity building of healthcare workers, support to the rehabilitation of health infrastructure, capacitating planning and monitoring systems at District level, and the introduction of results based financing in 18 districts of Zimbabwe.
5. Other initiatives included support from the Global Fund, USAID/PEPFAR, GAVI.

⁴³ Health Development Fund, Program Document 2015

Summary of Findings on Impact**Evaluation Question**

Q9. Has the HTF contributed to improved maternal newborn and child health and nutrition outcomes in Zimbabwe, from 2012 to 2015?

Findings

Coverage of essential MNCHN interventions (SBA, ANC4+, PNC) has increased from 2012-2015 according to national surveys.

Other initiatives and external factors have certainly contributed to change in MNCH outcomes. However, the HTF has been instrumental in building a catalytic platform for planning and coordination and in addressing broad health systems bottlenecks.

4.5. SUSTAINABILITY

Q10. To what extent does the government, at all levels of the health system ‘own’ the HTF achievements?

Finding 10.1. The results achieved through the HTF and strategies set in place are fully owned by the government

The HTF has shown an effective partnership and coordination mechanism within the health sector, which needs to be further strengthened and sustained. HTF has strengthened corporate governance through the steering committee where donors and the MOHCC meet regularly, ensuring **ownership** and leadership.

Although not measurable as an output, the capacity of the HTF Steering Committee to function as a catalytic force in stimulating dialogue and coordination amongst HTF and non-HTF partners should not be underestimated.

HTF has laid the ground in setting up structures, which can function well if financial resources are given.

In addition, the HTF proved to be a clear and well-understood mechanism throughout the health system; enhanced planning at district level and reinforced accountability systems at facility level have generated **ownership along the whole value chain of the HTF**.

Finding 10.2. Ownership may be undermined by uncertainty, inefficiencies and information asymmetry

Ownership of the HTF results and of its implementation strategies may be endangered by various factors:

- Information asymmetry^{44, 45} observed at various levels of the system, which generates uncertainty, lack of clarity, discontent and mistrust.
- Inefficiencies of some HTF supported strategies, particularly RBF and the retention and critical post allowances, cause delays and health worker dissatisfaction. Not only does this issue undermine the effectiveness of such mechanisms, also it weakens ownership and the commitment of health workers at the lower levels of the health system.

Q11 Are any positive results likely to be sustained?

Q12 How will the institutional and technical capacity and the systems developed be sustained?

Finding 10.2. Results will not be sustained in the short term without additional external assistance

“The economic and humanitarian crisis of 2008-2009 was underpinned by a difficult political environment. In 2008 however, an agreement to share power was negotiated between the ruling party and the official

⁴⁴ Bloom G, Standing H, Lloyd R. Markets, information asymmetry and health care: towards new social contracts. *Social science & medicine*. 2008;66(10):2076-87.

⁴⁵ Miller GJ. Solutions to principal-agent problems in firm. In: Ménard C, Shirley MM, editors. *Handbook of new institutional economics*. 9: Springer; 2005. p. 875.

opposition, with a coalition government being put in place in early 2009. In 2009 the hyper-inflated Zimbabwe dollar was suspended, and the economy dollarized. From 2009 onward the conditions were therefore somewhat more favourable for economic recovery”.⁴⁶

The graph below shows gross domestic product per capita between 1990 and 2015 in USD current prices, indicating that following the crisis, the GDP per capita has recovered to 1990 levels.

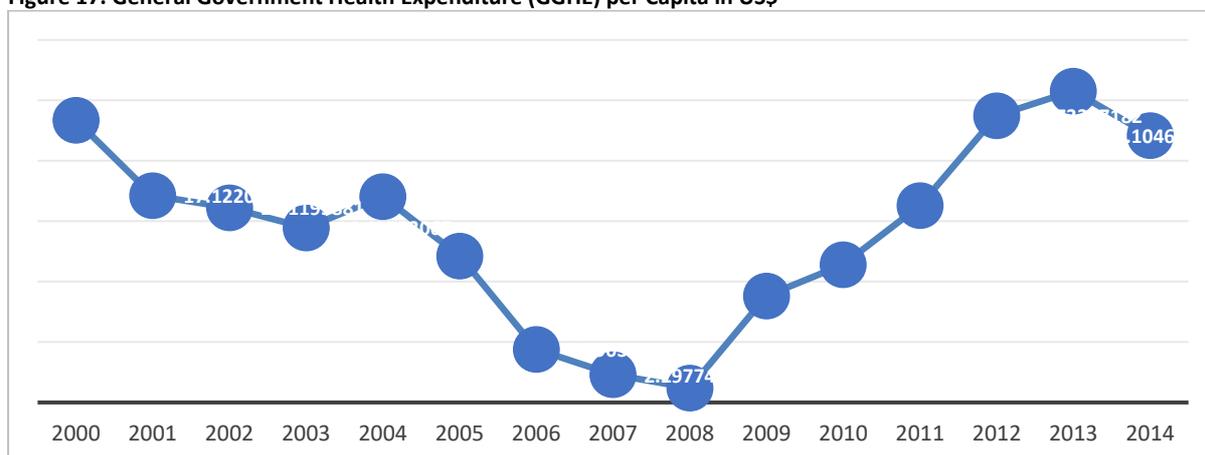
Figure 16. Zimbabwe Gross Domestic Product per capita, 1990-2015 (Current USD)



Source: World Bank

Despite of this economic growth, the government allocation to the health sector: the general government health expenditure as a proportion of the general government expenditure has decreased from 11% in 2011 to 8% in 2014 (WHO, Global Expenditure Database, accessed in July 2016) and as a result the Government per capita health expenditure is estimated at 22 USD in 2014, i.e. at the same levels of the year 2000.

Figure 17. General Government Health Expenditure (GGHE) per Capita in US\$



Source: WHO Global Expenditure Database (July 2016)

⁴⁶ Assessment of the Transition Funding modality, a polled funding mechanism for the social sectors in Zimbabwe. Mokoro, January 2015

The health sector in Zimbabwe remains therefore underfunded and highly dependent on ODA.

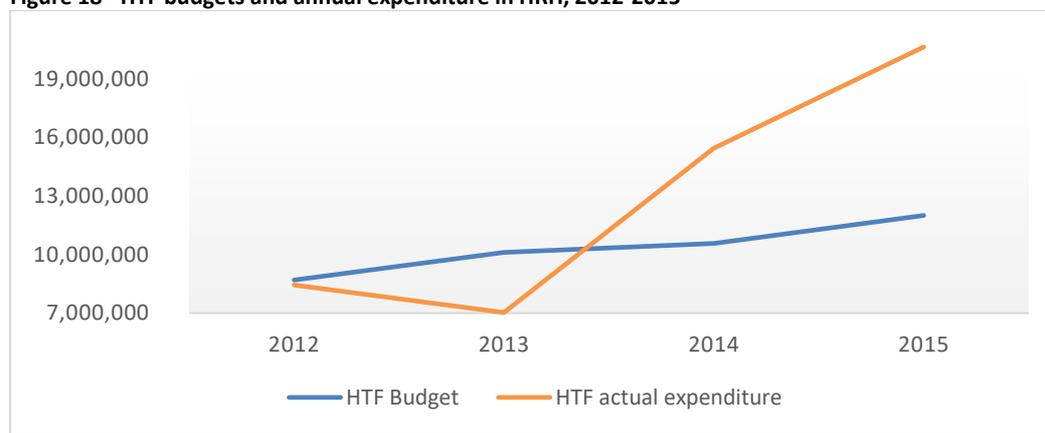
In early 2015, the LSTM Annual Review 2014 concluded that under the current health-financing scenario, the decision of MOHCC and stakeholders to design and set in place a post-HTF phase (the Health Development Fund) had been timely and appropriate.

There is evidence that an additional transition phase is required.

As an example, towards the end of Q4 2015, the availability of essential medicines dropped significantly, as a result of decreased funding from HTF.

Concurrently, the investment in sustaining retention allowances increased significantly in the last year of the HTF, nearly tripling the investment in HRH since 2013, and over spending the initially allocated budget.

Figure 18 - HTF budgets and annual expenditure in HRH, 2012-2015



In such scenario, the results achieved through the HTF cannot be sustained, unless the pillars of its implementation strategy are given continued and regular financial support.

Finding 10.2. Results will not be sustained in the medium term without a transition strategy aimed at strengthening local capacity and systems

In addition to funding constraints, the evaluation notes that some of the core strategies set in place via HTF are still in early stages, and not “mature” and consolidated sufficiently for the MOHCC to absorb them within its system.

A transition towards **full ownership of implementation capacity** from the Government lacked during the transition phase, and needs immediate planning and action under the HDF.

- Procurement is fully reliant on a single source, external mechanism (UNICEF) and there is no evidence that Natpharm or other government agency would have the capacity to take over and efficiently manage a process of procurement of medicines and supplies for the entire country in the short term. It is opinion of the evaluation that such capacity was not build through the HTF, for legitimate reasons related to prioritizing results rather than capacity building during a crisis period.
- The management and administration of the results based financing scheme has been contracted out to multiple implementing agents, which vary depending on the funding source (eg. World Bank – Cordaid vs UNICEF-Crown Agent for the RBF scheme). Procedures and mechanisms for both the RBF and the retention scheme are not harmonized and the current monitoring of performance and results is far too complex and demanding for the MOHCC to absorb it within its system.

- The massive and fruitful investment in lower levels structures and mechanisms of accountability and governance (HCC; District level mentoring and supervision; improved planning and monitoring) has formed a solid platform to enhance the capacity of the system to fulfil its mandate at the frontline. The platform is now available; however it is the opinion of the evaluation team that it is not yet ready and consolidated enough to yield results.

Summary of Findings on Sustainability

Evaluation Question

Q9. *To what extent does the government, at all levels of the health system 'own' the HTF achievements?*

Q10. *Are any positive results likely to be sustained?*
Q11. *How will the institutional and technical capacity and the systems developed be sustained?*

Findings

Ownership of the HTF results and of its strategies is high at all levels of the system. Such ownership may be endangered by current inefficiencies in the system, by information asymmetry and by uncertainty.

In the short term, results will not be sustained without further external assistance. In the medium term, a sound approach to building local capacity and systems will have to be prioritized (via HDF) as part of an exit strategy from donors.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. CONCLUSIONS

The following section provides the main conclusions emerging from the findings of the final evaluation performed in early 2016. These are presented by evaluation criteria, and framed to address the initial evaluation questions. Please refer to the log frame in Annex 1 for a list of progress against HTF indicators.

Relevance

- The HTF was consistent with global and national health policies following the structure of the MoHCC. The HTF was designed as a mechanism to support national health strategies and plans; it was fully embedded within the MoHCC and hence it is a means of realizing its objectives rather than a parallel mechanism. At national level the experience of the HTF governance is positive and conducive of an enhanced coordinated environment and dialogue amongst partners. At local level, although HCCs have been largely restored as a mechanism for local coordination and accountability, their full functionality needs to be strengthened.
- Progress achieved at outcome and output levels suggests that there is high consistency of the interventions promoted through the HTF with its intended outcomes and impact. As an example, improving the availability of health service delivery and human resources for health has contributed to increased SBA, and ultimately to reduced maternal mortality. The underlying strategies of ensuring availability of supplies and of training and retaining health workers at all levels supported this achievement. In some areas, the strategies supported through the HTF seem to be necessary but not sufficient: this holds true in particular for the nutrition interventions, which require a multi-sectorial approach and a coordinated effort that goes beyond the health sector; as well as the behaviour change strategies, which cannot be limited to promoting a cadre of community health volunteers at scale.
- The HTF addressed the needs of beneficiaries. The evaluation observed a good degree of relevance of the HTF to the needs and priorities of target groups. Issues such as the availability of care for mothers and babies, removal of user fees, increased availability of health care workers and supply of medicines, and enhanced linkages of communities with health services were highly appreciated by beneficiaries.
- Supply side bottlenecks related primarily to quality of care were identified as critical, unaddressed issues. These supply side bottlenecks need to be addressed as a matter of priority. Beneficiaries' perceptions of quality of services highlights areas for improvement, including attitudes and behaviours of health care workers; long waiting times; issues with payments at secondary care level, and having to bring personal supplies to the facility for delivery.
- Demand side bottlenecks persist. Demand side bottlenecks were only partially within the HTF design and scope but need consideration. Critical barriers and bottlenecks persist at community level, including the burden of out of pocket expenses; distance from facilities; cultural and religious beliefs. Additionally, streamlining the VHW programme and the number of health worker cadres operating within the country and adopting a more systemic approach to community

health will be instrumental for strengthening demand side interventions. Village Health Workers alone are not a sufficient response to remove demand side bottlenecks, in the absence of complementary initiatives.

Effectiveness

- The HTF has demonstrated consistent progress in achieving intended results. Our assessment of effectiveness focuses on output level indicators as defined by the HTF logframe, which identifies 54 indicators as the key measures to monitor progress of the program at output level. Of them, 29 indicators present baseline and endline data, which allow to measure progress between 2012 and 2015: 28/29 indicators (96%) show progress. This suggests that the HTF strategies have been effective in achieving intended results.

The evaluation will not draw conclusions about performance of the HTF against set targets, since the methods and rationale adopted to construct such targets were not clear and sometimes questionable.
- HTF contributed to restoring services at primary and secondary level. The availability and readiness of services for MNCH at primary and secondary level was largely restored across the country, due to a mix of interventions including provision of equipment and supplies, availability of trained and qualified staff, RBF, improved planning and supervision.
- Community level services were insufficiently restored. The availability of services at community level was only partially restored. Sub-optimal achievements in this area are related to both slow scale up and operational challenges in implementation, which generate discontent and frustration amongst an otherwise well motivated cadre of volunteers.
- HTF increased access to health services by removing user fees. Health financing mechanisms set in place at primary care level have been successful in sustaining the **release of user fees** for maternal, newborn and child health services. In early 2012 (VMAHSS R11), only 59.5% of facilities in Zimbabwe offered free full maternity services. Towards the end of 2015 (VMAHSS R26), approximately 95% of facilities offered free full maternity services during the course of 2015. These levels have remained stable during 2014 and 2015.
- There is evidence that the introduction of the RBF provides some benefits. In 2015, the HTF advanced in the transition of its supported facility financing mechanism from a fixed, inputs based scheme (HSF) to a **results based financing scheme (RBF)**. The LSTM survey 2016 results show that in 2015, 66.8% of level 1 facilities had actually accessed resources via RBF during the year. Data on spending of the RBF from facilities in terms of actual total expenditure and of its allocation were not available. Available, preliminary and unpublished research provides evidence of some additional benefits of sustaining facilities via performance based financing.
- HTF contributed to securing availability of essential medicines. The **procurement and supply system** has ensured availability of essential medicines at primary health facilities. The PHCP system, although limited in its number of items, has a high performance for availability of selected medicines, and it works efficiently. On average, since 2012, 85.4% of facilities had essential medicines available during the life of the HTF, a considerable improvement vis a vis the pre-HTF situation (12.1% in 2011).
- HTF improved health worker availability.

Payroll data reveal that the provision of the HTF funded targeted and differentiated **retention and critical post allowances** between March 2012 and December 2015 was an effective means to train, retain and motivate critical health workers (Crown Agents 2016; UNICEF 2016). The overall vacancy rate for the key health professionals dropped from 42% in 2009 to 30% in 2015⁴⁷ and the number of staff at Grades C5 and above receiving the retention allowance increased from 18,593 in 2012 to 20,584 health workers in 2015. There was an overall increase in the availability of doctors in all provinces, between 2012 and 2015.

The number of doctors receiving the critical post allowance and deployed in district level hospitals increased from 78 in 2012 to 135 in 2015 (Crown Agents 2016). All the 47 district level hospitals surveyed in 2016 had at least 1 medical doctor available, and sixty-eight (68%) had three or more doctors, significant achievements coming from a situation in 2012 when PMEs reported there were 21 hospitals without any doctor at all.

The number of midwives receiving the retention allowance increased from 1,838 in 2012 to 3,362 in 2015, representing an additional 1,524 midwives practicing in the public health facilities. Compared to the situation in 2011 when there were an estimated 500 midwives practicing in Zimbabwe, this represents significant progress.

However, growing dissatisfaction with the value of the allowances, anxiety and uncertainty about the future funding of the allowances, as well as the recent fluctuations and movement noted within the doctor and midwife cadres could signal an emerging attrition issue, that needs to be closely monitored.

This lack of robust monitoring and evaluation systems for the retention scheme impacted on the quality of the retention data available and the ability of the reviewers to make an accurate assessment of the effectiveness and impact of the scheme. Consistent disaggregated information on the stock, distribution and characteristics of the health workforce was not readily available over the period, it often had to be compiled from a patchwork of different datasets and sources, and made it impossible to present a up-to-date and reliable overview of staffing levels and vacancies, distribution and/or health worker flows and/or attrition trends over the period. Lastly, there was no definitive baseline on vacancy rates at the start of the retention scheme against which to measure results, and discrepancies and inconsistencies were observed across and within the different retention databases

- HTF improved the capacity of health workers to deliver MNCH services
HTF funding for capacity development and training related activities, including refurbishment of the midwifery schools, curriculum review, tutor allowances, training of tutors, training of nurse anaesthetists, EmONC, IMNCI, CMAM and IYCF training for health workers and provision of allowances and training for VHWs help to strengthen the number and capacity of health workers providing MNCH services.

The investment in the Midwifery Schools and provision of allowances for tutors increased the number of schools and improved production capacity. There were 3,941 trained and practicing midwives receiving the critical post allowance in 2015, compared to an estimated 500 in 2011. According to the 2014 MICS, 67.6% of all the deliveries were assisted by a nurse/midwife, with 87.5% of deliveries attended by a midwife in a public health facility.⁴⁸ In 2015 Crown Agents reported increasing numbers of facility-based deliveries attended by skilled health workers, up from 15,900 in 2014 to 19,504 deliveries in 2015.⁴⁹

⁴⁷ HR staffing data MODO July 2016.

⁴⁸ Multiple Indicator Cluster Survey. Final Report, UNICEF March, 2015

⁴⁹ Communication with Crown Agents February 2016

Of the 47 district level hospitals surveyed during the 2016 LSTM Survey 97.4% had at least **one staff member trained to perform C/S**, 95.2% had at least one staff member able to give obstetric anaesthesia, while 66% had a Nurse Anaesthetist. Staff have been trained in Infant and Young Child Feeding (IYCF), Baby Friendly Hospital Initiative (BFHI), CMAM and Integrated Management of Neonatal and Childhood Illnesses (IMNCI). The R26 VMAHS survey found that 71% of the 1,385 health facilities visited had at least one staff member trained in IYCF. Around 177 (45%) of the hospitals had carried out BFHI training. Among the CMAM sites visited 2,782 health staff had been trained in CMAM; each site had at least one staff member trained in CMAM on average, while 85.2%, of facilities had at least one staff member trained in IMNCI.

However, some facilities continue to report shortages of skilled staff: some hospitals have an oversupply of midwives, while lower level facilities are understaffed and do not have the required skills mix.

Efficiency

- The HTF was efficient in disbursing funds.
Overall, the HTF absorbed nearly 90% of allocated resourced throughout its life, with a marked improvement in the expenditure rate during the FY 2014 and 2015, where 98% of resources were utilized. This suggests that solid planning mechanisms are in place; that donors disbursements were efficiently and timely managed; and that resources were absorbed by the system as per plans.
The management costs of the fund manager (UNICEF) appear to be competitive *vis a vis* with standard practice in the sector, and the added value of UNICEF in terms of technical assistance and of a facilitator that is widely perceived to go well beyond the role of fund manager.
- Some of the implementation strategies set in place via HTF present significant areas of efficiency improvement:
 1. There is an unnecessary and overwhelming duplication of mechanisms and systems set in place to sustain financial incentives to facilities and health workers. To the least, at the time of this writing there are: one mechanism to support RBF via WB and one mechanism via HTF; one mechanism to pay retention allowances via GFATM and a second one via HTF; equally, one mechanism to pay VHWs via GFATM and a second one via HTF. This scenario creates confusion, discontent, and delays. More importantly, the investment on parallel bureaucratic and reporting mechanisms via different sub partners generates the costly set up of parallel mechanisms and are overall an unnecessary cost to the health system.
Although the evaluation did not quantify the costs of managing all these schemes, it is evident that a rationalization and harmonization of schemes would save resources to MoHCC and donors, and ultimately would enhance the effectiveness of the mechanisms.
 2. The retention scheme needs simplification. There are efficiency related issues of various types, including: allocative distribution of the allowances amongst various cadres of health workers; lack of clarity regarding criteria for eligibility; timeliness of payment and availability of information for health workers. All these issues hinder the effects of the retention allowance scheme, generating frustration, discontent and lack of clarity amongst health care workers.
 3. The results based financing mechanism set in place with the support of the HTF presents significant challenges and associated costs in its implementation. Major areas of efficiency gaps concern the overwhelming reporting requirements of RBF, which creates additional

workload for health workers and lack of clarity; systematic delays in payments of the scheme, which hinders facility-based plans and affects availability of services; lengthy processes for approvals of facility use of RBF funding. To reduce this reporting burden, there is a need to strengthen and streamline HMIS indicators with RBF indicators.

4. Although highly dependent on external funding and on external procurement mechanisms, the investment in sustaining the supply of medicines, vaccines and other equipment was efficient. There is limited evidence of major issues related to overstock or of stock out, and the average cost of the procurement mechanism supported by UNICEF is fully in line with international benchmarks.

Impact

- The HTF contributed to reducing mortality rates.
Modelling shows that 4.000 to 6.000 per year additional children’s lives were saved during the period 2010/11-2015. This is due to significant improvements in coverage of essential MNCH interventions across the country.
- HTF strengthened comprehensive planning and coordination.
Although the proportional support of the HTF to the health sector is relatively modest in financial terms (5-10%) and other initiatives and external factors certainly contributed to change in MNCH outcomes, the value and contribution of the HTF in building a catalytic platform for planning and coordination and in addressing broad health systems bottlenecks in a comprehensive manner and at scale has been crucial and unique to the context of Zimbabwe.
- Please refer to the log frame in Annex 1 for a list of indicators achieved.

Sustainability

- The ownership of the HTF results and of its strategies is high at all levels of the system.
Such ownership may be endangered by current inefficiencies in the system, by information asymmetry and by uncertainty, especially at lower levels of the system.
- The HTF lacked an exit strategy for financial and technical sustainability.
In the short term, there are no conditions to transition the HTF results to full government ownership, and in that the HDF will have to play a critical role in building such transition.
In fact, in addition to funding constraints, the evaluation notes that some of the core strategies set in place via HTF are still in early stages of implementation, and not “mature” and consolidated sufficiently for the MoHCC to absorb them within its systems and structures.
- Capacity building of MoHCC to take over the HTF approach needs to be a priority in the post-HTF phase.
The technical and management capacity of the MoHCC to manage and monitor complex mechanisms at scale (eg. RBF, procurement) requires systematic, long-term support, which was not fully built in the design of the transition phase, where the obvious focus was on restoring immediately a nearly collapsed system rather than building long-term capacity. Again, this challenge is left to the HDF phase.

5.2. RECOMMENDATIONS

1. A leaner and **strategic steering committee**, possibly supported by dedicated technical working groups on operational matters, should focus on a communication and fundraising strategy aimed at broadening the donors' base in support of the HDF, nationally and internationally.
2. A simplified and more focused **monitoring and evaluation mechanism** can be used to assess progress at national and local level. This will entail focusing on core desired outcomes; and on using key performance indicators at output level to measure progress against investments in key activities. Ideally, such framework will be built against a theory of change and it will rely on routine systems (HMIS), rather than on additional research or data collection efforts.
3. **Harmonization and simplification** of various financing mechanisms that are currently in place in Zimbabwe to sustain facilities and health care managers and workers should be a priority for the HDF since its early stages, to enhance the efficiency and effectiveness of such mechanisms and to save resources to the system.
Harmonization would entail streamlining approaches, guidelines, and possibly implementation arrangements across the country. Simplification would entail leaner and more transparent monitoring and verification mechanisms, and less complex procedures of funds disbursement and use. Convergence of the health retention scheme and of the RBF scheme into a single, unified and transparent performance based financing mechanism could be explored as a potential short-term option.
4. Staffing shortages and heavy workloads are contributing to health worker demotivation; a revised and more realistic **establishment** is needed to ensure adequate numbers of skilled health workers are available, distributed equitably and accessible across the health sector. Results and data generated through the 2015 WISN study should be packaged and disseminated to policy makers to advocate for a revised establishment and increased fiscal space to fill vacancies and new posts.
5. Continued support to retention and critical post allowances should be framed within a broader strategic approach to human resource planning and management, including a mix of interventions aimed at improving recruitment, deployment, retention, performance and health worker motivation. The design of a modified package of **targeted and differentiated allowances and monetary and non-monetary incentives** linked to performance, as well as the identification of specific incentives to improve staffing and skills mix in rural and remote areas, should draw on the lessons learned from the implementation of the HTF funded retention scheme.
6. Continued support to **procurement and supply** of a minimum package of health products for Level 1 facilities is conditional to the well-functioning of the health sector and should be sustained in full through external assistance in the short term.

7. At the same time, it will be important to assess the capacity of NatPharm to resume responsibility for the quantification and procurement of medicines and supplies and continue to strengthen its distribution capacity and to develop an action plan to ensure transition.
8. At lower levels of the system, the investment in governance structures and mechanisms should be sustained, to further reinforce **district, facility and community level planning**, monitoring and accountability mechanisms.
9. The investment in village health workers, with clearly defined roles and responsibilities, needs acceleration, possibly under a broader, revised strategy for **community health** looking at a mix of approaches to address demand side bottlenecks to access, care seeking practices and behaviour.
10. A realistic longer term disengagement/exit strategy and action plan should be put in place to replace external financing with domestic resources over time, with a demonstrated commitment by the government to put the necessary measures in place to ensure the objectives of the exit strategy are achieved to the scale and within the timeframe agreed. Commitments and measures should be clearly articulated and monitored.

6. LIST OF ANNEXES

Annex 1 – Logical Framework of the Health Transition Fund

Annex 2 – Terms of Reference of the Evaluation (UNICEF, 2011)

Annex 3 - Evaluation Design Note (LSTM, 2016)

Annex 4 – Health Facility Assessment 2016 Report

Annex 5 – Key findings of qualitative research (2016)

Annex 6 – List of secondary data and reports

Annex 7 – Analysis of HTF thematic areas

Annex 8 – Case study on Health Retention Scheme

Annex 9 – Case study on procurement of Primary Health Care Package