Research Project

"An evaluation of the Health Development Fund programme implemented by the Ministry of Health and Child Care in Zimbabwe."

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Abstract

Deteriorating health systems are a major problem in third-world African countries like Zimbabwe. Many women lose their lives and children due to high maternal mortality and malnutrition in children under five years. A political crisis in the country that lead to an economic decline has largely contributed to the poor health system. The implementation of the Health Development Fund is a multi-donor pulled fund, that attempted to address the poor health system in Zimbabwe. The aim of the study was to establish whether the Health Development Fund brought about an improvement in the provision of health care in Zimbabwe. Desk review and field data collection with tools such as KIIs and Exit Patient Interviews were used to draw conclusions. The study established that the programme had a positive impact on the health system in Zimbabwe as it led to a decline in mortality for pregnant women and children under five. The programme also responded to emergency situation like covid19. The health budget that had declined over the years has risen. The study recommends that there be sustained support to retain nursing staff through the provision of allowances. On ending of the programme the village health workers that were paid by the programme were left with no pay. Government as a partner in implementing HDF should have the village health workers on its payroll.

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List of Acronyms

ARC	AIDS-related Complex
ART	Antiretroviral Therapy
ANC	Antenatal Care
ARSH	Adolescent Reproductive and Sexual Health
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
CHWs	Community Health Workers
COVID-19	Coronavirus SARS-CoV-2
DAC	Development Assistance Committee
DFID	Department for International Development
DHOs	District Health Officers
EU	European Union
FGDs	Focus Group Discussions
FNC	Food and Nutrition Council
FST	Family Support Trust
GAP	Gender Action Plan
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender-based violence
GE	Gender Equality
GoZ	Government of Zimbabwe
HDF	Health Development Fund
HDI	Human Development Index
HRH	Human Resources for Health
HSS	Health Strengthening System
HTF	Health Transition Fund
ISP	Integrated Support Programme
KIIs	Key Informant Interviews
LHWs	Lady Health Workers
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Maternity Ratio
MoFED	Ministry of Finance and Economic Development
MoHCC	Ministry of Health and Child Care
MoWAGCD	Ministry of Women Affairs, Gender and Community Development
MWHs	Maternity Waiting Homes
NAC	National AIDs Council of Zimbabwe
NNS	National Nutrition Strategy
OECD	Organisation for Economic Co-operation and Development's
PAZ	Paediatric Association of Zimbabwe

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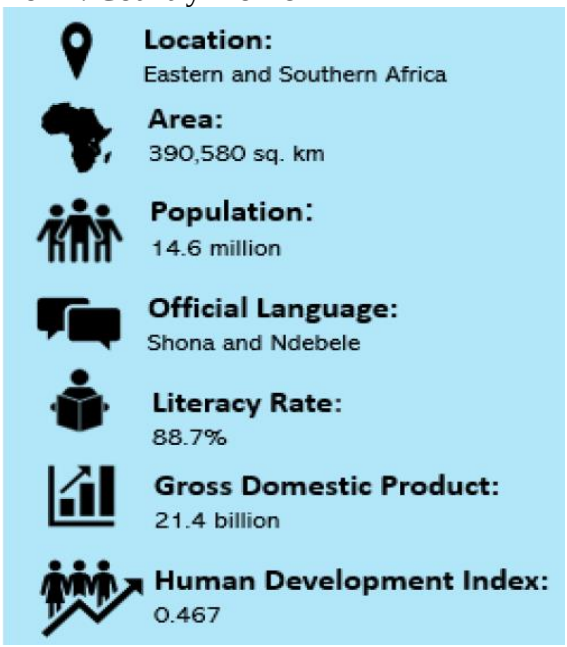
1.1 Introduction

1.1.1 Country Profile

The country Zimbabwe is landlocked, found in the Eastern and Southern African Region. Its neighbors are South Africa on the south, Zambia to the northwest, Botswana to the west and southwest, and Mozambique to the east. The country has a total area of 390,580km^2 (ZimASSET 2013-2018). It is administratively divided into eight (8) provinces and two (2) cities with provincial status, Harare and Bulawayo. These are also subdivided into 63 districts. Zimbabwe has an estimated total population of 14.6 million with 52.3% female population compared to 47.7% male population, ZimStats (2019). Zimbabwe's population is largely divided into urban and rural population, with a proportion of 32.21% and 67.79% respectively as was published in the Unicef HDF Annual report (2016). Of the 16 official languages spoken in Zimbabwe, 75% speak Shona and 17% speak Ndebele and English is the official business language. According to the 2019 HDF Annual progress report the major religions are Christianity, indigenous beliefs, and Islam. The country profile is summarized in Box 1 below.

Box 1: Country Profile



Source: MICS (2019)

The nation has encountered economic stresses in the previous decade. From having a yearly growth rate of 19.7% in 2010, it dropped to 1.8% in 2015, and is probably going to fall further to - 7.4% in 2021. In 2019, Zimbabwe was hit by serious dry season and Cyclone Idai that prompted a twofold constriction of farming, power, and water harvesting, and drove the greater part of the populace into food insecurity. Total national output (GDP) is assessed to have

shrunk by 8.1% in 2019 and the downturn is projected to proceed for a very long time because of constant environment shocks. In 2019, inflation reached triple digit levels (521%) and was projected to remain high in 2021 as COVID-19 further disrupted the production and trade. Extreme poverty has reached to 40% ZIMVAC (2019), up from 33.4% in 2017. Urban poverty is rising faster (from 4% to 10%) than rural poverty. The poverty levels are projected to rise further in 2021 due to continuing economic contraction (largely due to COVID-19) and loss of employment and incomes, driven by the restrictions on mobility, inflationary pressures, and drought conditions.

Figure 1: Map of Zimbabwe

Source: HDF Annual report (2016)

The politico-administrative map of Zimbabwe is illustrated in Figure 1 above.

1.1.2 Intervention Context

This section gives an overview of the socio-political and institutional context, rationalizing the need for intervention. The focus is on delivery of mother and child healthcare and wellbeing through improved health systems.

1.1.2.1 Global and Regional Sector Context

Health and well-being of people is a listed priority on the global development agenda that is, Sustainable Development Goals (SDGs 2030, Goal #3 in particular). Despite Universal Health Coverage being the cornerstone of Goal 3, about half the population in the world lacks access to essential health services as was published in the HDF Value for money framework (2019). Majority of those deprived include children and women across the globe. RMNCAH-N encompass the health issues faced through the life cycle by the adolescent girls and women (before and during pregnancy and delivery), and to the new-borns and children. Over the past 25 years, child and maternal mortality rates have decreased by more than half. Recent research shows that, for every 100,000 children born worldwide, 211 women still die due to pregnancy-related complications. Furthermore, Stunting, an indicator of chronic undernutrition also remains a global challenge, affecting approximately quarter of all children under 5 years of age. Despite substantial progress in recent decades, disparities in child and maternal health between and within developing countries persist. Most of the world's maternal deaths occur in developing regions, with Sub-Saharan Africa alone accounting for two in three deaths (66%). The lifetime risk of maternal death for women in least developed countries overall is one in 56. And it is even higher for Sub-Saharan Africa, with one in every 37 women dying due to complications related to pregnancy, compared with one in just 7,800 in high-income countries. Most of these deaths are preventable if pregnant women receive the healthcare that they need when they need it. The adolescent fertility rate is 102 births per 1,000 girls. More than a fourth of girls and women in this region cannot access family planning services, fueling unplanned pregnancies and maternal, infant and child mortality and morbidity.

1.1.2.2 Zimbabwe's Sector Context

Zimbabwe remains a country which saw serious deterioration of health system and services over the past two decades. The country has had one of the best healthcare services in the 90s but, was severely struck by the political crisis that affected Zimbabwe between 2000-2008. The expenditures on healthcare significantly reduced from US$42 in 1991 (which was the highest in sub-Saharan Africa) to just under US$6 in 2009, which was even lower (US$ 4.734) in 2018.

The key challenges that it faced post-crisis included loss of professional staff; nonfunctional infrastructure; lack of medicines and equipment, outdated policies and regulations, and failure by health facilities to sustain running costs. The situation is summarized in Box 2 below.

Box 2: Zimbabwe's RMNCAH Situation

- **32** Neonatal mortality rate (deaths/1000 live births)
- **47** Infant mortality rate (deaths/1000 live births)
- **65** Under 5 mortality rate (deaths/1000 live births)
- **19** Child mortality rate (deaths per 1,000 children surviving to age one)
- **14** Post-neonatal mortality rate (difference between infant and neonatal mortality)

Source: MICS (2019)

The economic growth declined again during 2013–2017, with 38.3% of the populace living at the public poverty lines and 33.9% living on $1.90 every day in 2018. This influenced the public authority's capacity to finance public health conveyance and limits needy individuals' admittance to health care. In 2015, just 21% of health financing was from government, while families contributed 25% all through off-pocket consumption in addition to private commitments to health protection and partnerships.

1.1.4 Government Funding

According to HDF MTE & Joint Review Mission Recommendations, funding for health constituted 8.7% of total government expenditure in 2015, this was later 7% and 10% in 2019 and 2020 respectively, which is significantly lower in context of The Abuja Declaration 2001 (15% minimum). While the financial leakages in the public health systems have weakened the health systems, the health budget execution has also been weak as evidenced by the huge deviations of actual expenditure from the approved budget. Overall, the 2019, budget underperformed by 6% compared to over expenditure of 20% in 2018. The JRM Summary Report Manicaland (2019), revealed that, the capital budget performance worsened, underperforming by 86%. Among 25 African countries surveyed in 2016/2018, Zimbabwe ranks well below the average of 53% in approval for how the government is handling basic

health care, well behind Swaziland (83%), Botswana (71%), and Namibia (67%) as stated in the same JRM Summary report. Furthermore, 59% of respondents went without medicine or medical care at least once during the year.

According to The Service Availability and Readiness Assessment (SARA) 2015, the General Service availability score was 42%, with service utilization scoring least at 22%. Only 55% of hospitals met requirements for comprehensive surgical readiness. Overall/national facility density was 1.1 facilities per 10 000 population nationally, well below the benchmark of 2 facilities per 10,000 population. Although the rural population has better health coverage in terms of population per health facility, compared to urban areas, 47.8% of women in the rural areas reported distance as a challenge in accessing health facilities.

Weak health systems directly contribute to rapid deterioration in maternal, new-born, and child health indicators. The maternal mortality ratio was 651 deaths per 100 000 live births in 2014 (462 deaths per 100,000 live births in 2019); the infant mortality rate was 55 deaths per 1000 live births (55 deaths per 1000 live births in 2019), and the under-5 child mortality rate was 69 deaths per 1000 live births (73 deaths per 100 live births in 2019) as is recorded in the Hospital Issues from JRM. Weaknesses in RMNCAH delivery platforms, including limited access to care, poor quality of services, and shortages of health workers or medicines, have a major barrier to improving RMNCAH-N outcomes. Zimbabwe also has high prevalence of adolescent pregnancy which is linked to Zimbabwe's high rates of child marriage, barriers to education. In 2015, nearly one quarter of Zimbabwean girls aged 15-19 are currently married or in unions similar to marriage, but this figure increases to 40.2% in rural areas. Pregnancy rates among girls in rural areas were three times higher than among their urban counterparts. Zimbabwe still faces extreme nutritional challenges with an estimated 35% of all children under the age of 5 experiencing stunting in 2010 and more recent estimates at 28% in 2014 and 23.5% in 2019.

1.1.5 Legal and administrative framework around health and nutrition in Zimbabwe:

A series of laws, regulations, and policy frameworks administer the RMNCH and health sector in Zimbabwe. Table 1 lists the key relevant international and regional human rights conventions that are ratified by the Government of Zimbabwe (GoZ).

Table 1: Zimbabwe's Global Legal Commitments around Health and Nutrition

Treaty/Convention	Commitments
UN Convention on the Rights of the Child	Article 27: Right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
The Abuja Declaration	Pledge: to allocate at least 15% of their national budgets to public health.
The Regional Child Survival Strategy for the African Region (WHO, UNICEF and the World Bank)	To accelerate the reduction of neonatal and child mortality in line with the Millennium Development Goals by achieving high coverage of a defined set of effective interventions.
The Maputo Plan of Action (2016-2030)	Universal access to comprehensive sexual and reproductive health services in Africa beyond 2015.
Global Strategy for Women's, Children's and Adolescents' Health (2016-30)	To achieve right to the highest attainable standard of health for all women, children, and adolescents.
Universal Declaration of Human Rights	Article 25: Right to an adequate standard of living.
African Charter on the Rights and Welfare of the Child	Article 14 2(c): Commitment to food and nutrition security.
The International Conference on Nutrition (ICN2) Rome Declaration on Nutrition	Commitment 15a: To eradicating hunger and all forms of malnutrition.
Sustainable Development Goals (SDGs)	SDG Target # 3: Ensure healthy lives and promote well-being for all at all age.

Zimbabwean national laws and policy frameworks around health (including RMNCAH & SRHR) and nutrition are outlined in Box 3 below. It starts with the Constitution of Zimbabwe (Section 76, subsection 1 to 4) that states: (i) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services, (ii) Every person living with a chronic illness has the right to have access to basic healthcare services for the illness, (iii) No person may be refused emergency medical treatment in any health-care institution and (iv) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realization of the rights.

Box 3: Regulatory Health and Nutrition Frameworks in Zimbabwe

- **Constitution of Zimbabwe** (Section 76)
- **ZimAsset** (2013-2018) and **TSP** (2018-2020)
- **National Nutrition Strategy** (NNS) 2014 to 2018
- **National Health Financing Policy** (2017) and Strategy (2018)
- **National Health Strategy** 2016-2020
- **National Adolescent and Youth Reproductive Health** (ARSH) Strategy II (2016 to 2020)

Source: MICS (2019)

Furthermore, The Government of Zimbabwe within the overall frameworks of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation 2013-2018 (ZimAsset) and the current Transitional Stabilization Programme 2018-2020 (TSP) has sought to improve the quality of health care of its people as elaborated in its National Health Strategic Plan 2016 to 2020, with an emphasis on RMNCAH and Nutrition, SRHR, HIV, TB, and Malaria. Furthermore, Zimbabwe's first ever National Health Financing (2016) Strategy is also aimed towards improving financing for the health of the people of Zimbabwe by ensuring affordable and equitable access to quality healthcare services to realize the goal of health for all as enshrined in the constitution.

1.2 Programme Overview

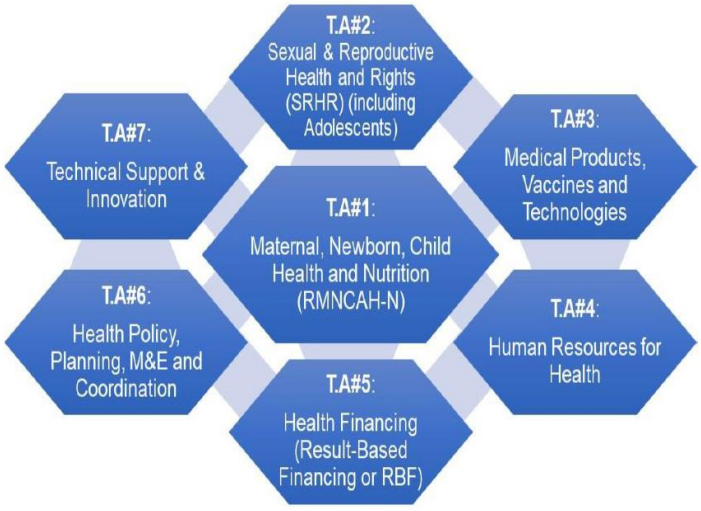
This section describes the Programme being evaluated that is, HDF 2016-20. HDF is a multi-donor funded Programme, managed by UNICEF Zimbabwe. The HDF objectives and strategies overlap with those laid out in the ZimAsset, its successor the Transitional Stabilization Programme (TSP) and related National Health Strategy 2016-2020. The HDF provides support across the full range of health services, whilst prioritizing RMNCH-A and nutrition services. It prioritizes improving equity in healthcare availability, through targeting new-borns, adolescents, hard to reach communities and specific sections of society either poorly reached or unreached by health system. The HDF focused healthcare services include ANC, intrapartum care, PNC, immunization, child health services, maternal and child nutrition, family planning, cervical cancer, MWHs, adolescent sexual and reproductive health, gender-based violence (GBV), fistula, post abortion care.

1.2.1 Programme Goals and Expected Results

The Goal of the HDF (as per HDF Programme document) is to contribute to "reducing maternal mortality (by 50%) and children under-5 mortality (by 50%), by ensuring equitable access to quality health services for women and children by 2020; and to contribute to the reduction of the unmet need for family planning to 6.5%, halving the prevalence of stunting in children under-5 and eliminating MTCT by 2020, and combating HIV & AIDS, Malaria and other prevalent diseases9." The overall intended outcome of the HDF programme is to achieve improved and equitable coverage of high impact RMNCAH-N interventions along the continuum of care. The programme aims to compliment the MoHCC to achieve the following expected intermediary results/outcomes.

The HDF programme primarily intends to ensure that funding and technical expertise is available to the health sector (in support of the MoHCC) in Zimbabwe to consequently improve maternal, new-born, child and adolescent health and nutrition. Detailed programme strategies and components are highlighted in Figure 2 below. A holistic approach underpinning health systems strengthening was evolved in the Programme.

Figure 2: Seven Thematic Areas of The HDF Programme



Source: Unicef Zimbabwe (2016)

The HDF automatic plan is actualized across seven key thematic areas (TAs) of work that are completely relevant and consistent with the structure squares of the WHO Health Systems Framework. Figure 2 above, illustrates the thematic areas that are supported to provide continuity and build on the existing foundations.

1.2.2 Geographic Spread

While the HDF interventions for the 6 thematic areas (1,2,3,4,6 &7) have been implemented nationally across 63 districts in all 10 provinces, RBF support to Primary Health Facilities (Thematic Area # 5) has been implemented across 42 districts of the country.

1.2.3 Programme Stakeholders

A series of primary and secondary sector key stakeholders remained involved in the design and implementation of the nationwide programme. These Stakeholders, along with their types, descriptions, and respected role in the Programme have been elaborated in the Table 2 below:

Table 2: Stakeholders' Role in the HDF Programme

Name	Stakeholders' Role in Programme
Government	
Government of Zimbabwe (GoZ)	**Ministry of Health and Child Care (MoHCC):** The MOHCC is the lead public sector implementer for developing and implementing 'The Health Development Fund Programme 2016-2020' meant to improve equitable access to quality RMCNAH and Nutrition services among the general population. • Primary "owner" of the HDF • Leading strategy and driving implementation. • Provide governance, leadership, and coordination of HDF implementation. **Other key Government Stakeholders:** • **Focusing on (Maternal, New-born, Child Health & Nutrition)** include: Food and Nutrition Council (FNC) • **Focusing on (Sexual & Reproductive Health & Rights)** include: Zimbabwe National Family Planning Council (ZNFPC), National AIDS Council of Zimbabwe (NAC), and Ministry of Women Affairs, Gender and Community Development (MoWAGCD). • **Focusing on (Medical Products, Vaccines, and Technologies)** include: Nat Pharm. **NB*** Ministry of Finance and Economic Development (MoFED) is a key government

	stakeholder in the HDF, supporting MoHCC in policy development and relevant affairs pertaining to the HDF.
HDF Steering Committee	
HDF Steering Committee (Co-chaired by MoHCC, and representation from donors, CSOs, Private Sector, UN Agencies, the Ministry of Finance106)	HDF is coordinated and managed with the **HDF Steering committee** taking a central role in the decision-making processes. The role of HDF Steering Committee includes: 1. The HDF Steering Committee is primarily responsible for the oversight and decision making of the HDF. 2. Approving funding allocations to thematic areas and related activities in accordance with the HDF annual plan and budget. 3. Ensuring alignment of HDF allocations with the MoHCC Performance Contract/Annual Plan within the thematic areas agreed upon in the Programme Document.
UNICEF, UNFPA & Donors	
UNICEF Zimbabwe Office (UNICEF ZCO)	UNICEF has two distinct roles in the HDF: as **Programme Manager** and **Fund Manager**; and is responsible for the overall implementation of the programme including the grant management. It provides technical support to the MoHCC for developing and improving regional strategies towards health and nutrition services and systems. UNICEF ZCO ensures overall financial management and attainment of programme results across all thematic areas. This also includes responsibility for the appropriate use of funds as well as the performance of contractors and HDF implementing partners.
UNFPA Zimbabwe	Primarily responsible for Thematic Area 2: SRHR pertaining to the HDF programme. UNFPA also supports the MoHCC with technical and implementation capacity in the designated thematic area as required and in building capacity for overall financial and programme management of such funding mechanisms.
UNICEF & UNFPA HQ & Regional Offices	Regional offices – to provide technical guidance and quality assurance support to the programme.

Donors (EU, Government of Sweden; FCDO; Irish Aid, and GAVI)	To provide unearmarked financial support necessary to fully implement the coordinated interventions set out in the HDF Programme Document and make timely transfers of funds through the agreed-upon pooled funding mechanisms.
INGOs (Implementation Partners)	
INGOs (Implementation Partners)	Although the majority of the HDF activities will be implemented by the MoHCC, specific components may be delivered by academic or research institutions, private sector companies, UN agencies, or nongovernmental organizations using the UN tender or partnership cooperation agreement procedures. The following INGOs/IPs (based on thematic areas) were involved in various capacities including implementation, monitoring and evaluation: • **TA # 1**: Clinton Health Assessment Initiative (CHAI), City of Harare, Save the Children, CBOs, PMDs and DHOs • **TA # 2:** Family Support Trust (FST), Judicial Service Commission (JSC) Zimbabwe, The Adult Rape Clinic (Zimbabwe), Musasa, Saywhat Zimbabwe, The Centre for Sexual Health and HIV AIDS Research (CeSHHAR) Zimbabwe • **TA # 3** : NatPharm; **TA # 4**: Crown Agents; **TA # 5**: Crown Agents108 (for RBF monitoring); **TA # 6:**Crown Agents (Monitoring VHMAS), and Liverpool School of Tropical Medicine (for Mid-term Evaluation of HDF).

Source: Pyone & Broek (2016)

1.2.4 Programme Participants (Beneficiaries)

A range of direct and indirect participants / beneficiaries of the Programme include:

Public Sector Entities: such as MoHCC at national and provincial levels, healthcare managers, HCPs, community health volunteers and community-based organisations (CBOs) will also benefit from programme activities. Service Providers who were directly/indirectly involved or benefitted from the Programme in terms of implementation, monitoring or evaluation. Community level actors: They are also the primary beneficiaries (Figure 3) of the HDF Programme, listed as following:

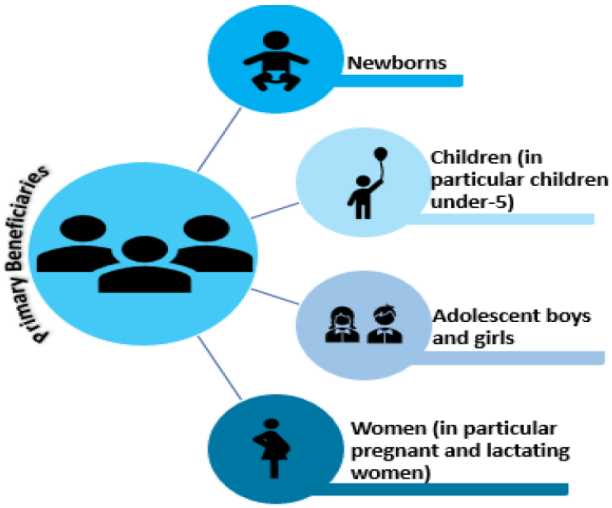
• Newborns

• Children under-5

• Adolescent boys and girls

• Women particularly pregnant and lactating

Figure 3: HDF Programme Primary Beneficiaries



Source: MICS (2019)

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

Table 3: Estimated beneficiaries, by intervention

Primary Beneficiaries' Groups	Maternal & newborn health	Child health and nutrition	Sexual & reproductive health
Adolescent boys and girls			**3,620,000**
Women of reproductive age	**3,760,000**		**3,760,000**
Pregnant women	**665,000**		
New-borns	**535,000**		
Children under the age of 5		**2,539,000**	

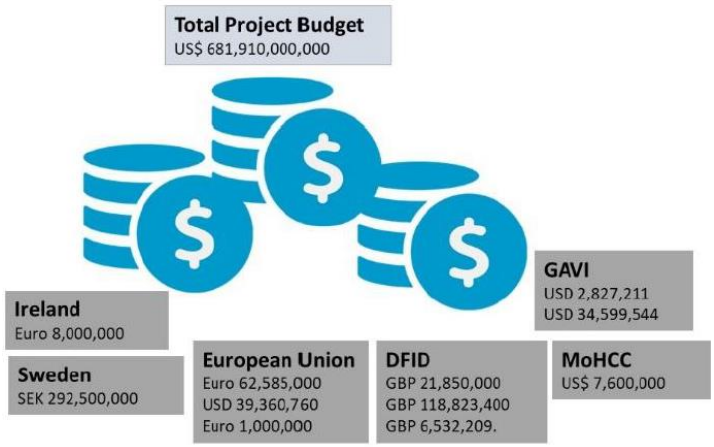
Source: Unicef Zimbabwe (2016)

1.2.5 Programme Resources & Donors

The HDF total budget comes to 681 million USD111 for activities to be implemented for 5 years (2016-2020). UNICEF remains the fund manager. The HDF is multi-donors funded Programme including European Union; Foreign Commonwealth and Development Office

(FCDO); Irish Aid; Government of Sweden; and The Global Alliance for Vaccines and Immunizations (GAVI). The breakup of donors' contributions to HDF ae as shown in Figure 4 below.

Figure 4: Programme Budget

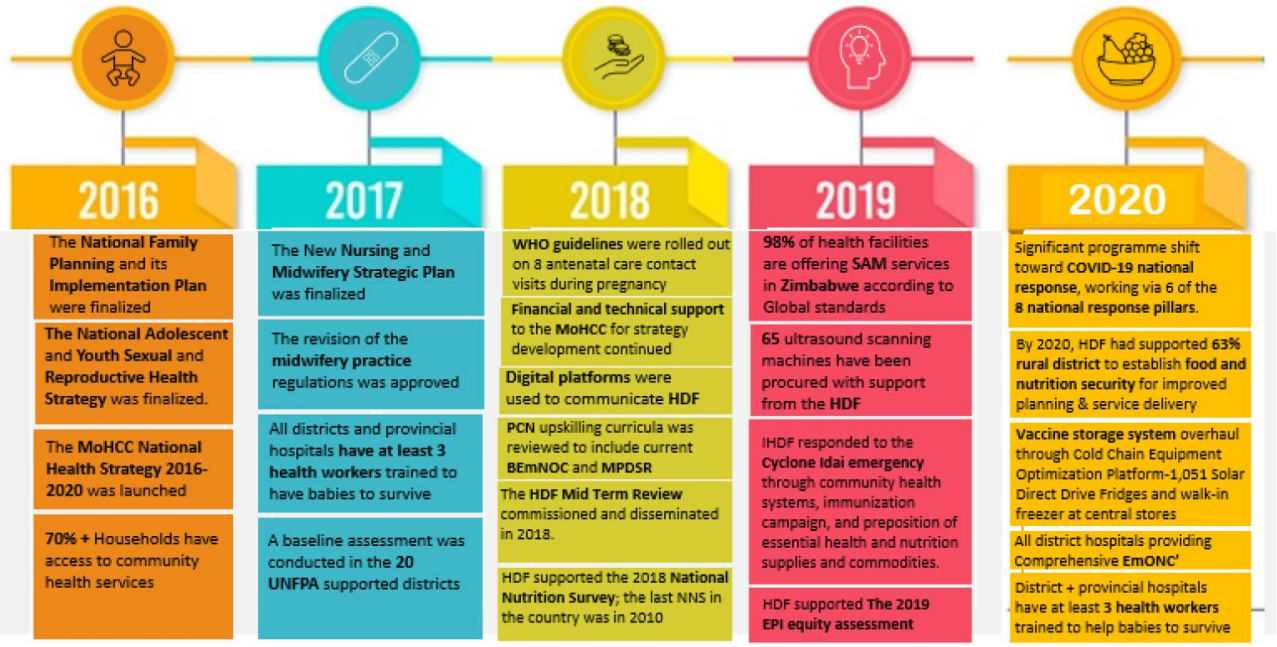


Source: Unicef Zimbabwe (2016)

1.2.6 Programme Timeline & Milestones

The following exhibit, Figure 5, outlines the Programme milestones. The milestone exhibit is produced from information extracted from Programme's documents (specifically annual reports).

Figure 5: Programme Milestones



1.2.7 Significance of the Programme

The description below illuminates the importance or significance of the Programme for different stakeholders. This is drawn from the TORs, initial (remote) discussions with Programme stakeholders, and preliminary literature review carried out. This will be validated through fieldwork and improved for the final report.

1. For the GoZ:

- The programme is significant because it directly contributes to the National efforts by supporting the MoHCC achieve its goals and strategies that aims at improving the quality of life of Zimbabweans, attained though guaranteeing every Zimbabwean access to comprehensive and effective health services. Designed as a natural evolution of the HTF, the HDF Programme is important as it aims to strengthen the Health System of Zimbabwe under the leadership of the MoHCC with all partners contributing to one plan, one coordinating mechanism and one monitoring framework.
- The Programme contributes towards achievement of the Millennium Development Goals (MDGs) and also directly contributes to the Sustainable Development Goals, specifically for SDG-3 to "Ensure healthy lives and promote well-being for all at all ages".

2. For UNICEF & UNFPA:

- The HDF Programme is of substantial importance to UNICEF as it aligns with their global mandate of equal rights for women including girls, survival, protection, and development of children that are integral to human progress. HDF also aligns with UNICEF's country strategy, Zimbabwe, which covers several areas including health, nutrition, HIV/AIDS, child protection, and social protection. The HDF Program is critical for UNICEF and UNFPA as it can fill in as a model for successful interagency coordination. The association worked under this Program can likewise be utilized for actualizing other comparative interventions.

3. For Donors:

- The Programme is significant for various donors, including Government of Zimbabwe (GoZ) itself, and EU, Irish Aid, FCDO, GAVI and others. The Programme donors strive to aid the most vulnerable people with little or no access to basic level RMNCAH-N and SRHR services, owing much to insufficient health infrastructure, health

professionals, and health commodities. This makes the Programme significant to its donors.

4. For beneficiary communities:

- While the HDF provided support across the full range of health services, it provided key support to RMNCH-A, SRHR and nutrition services (through improved and strengthened health systems), as well as enhancing equity in health care availability, through targeting women, new-borns, adolescents, hard to reach communities and specific sections of society either poorly reached or unreached by health system.

2.1 Evaluation Objectives

The evaluation TORs outline a series of evaluation objectives (refer Appendix-4 for details). Find below a shorter list of specific evaluation objectives, teased out and rephrased by the evaluators from the ToRs.

- To determine the relevance, coherence, effectiveness, efficiency, sustainability and, to the extent possible, the impact of the HDF programme.
- To assess the extent to which the HDF programme has integrated human rights-based approach, result based management, gender, and equity principles, and addressed issues of disability in its design, implementation, and monitoring.
- To identifying lessons learnt (about what worked and did not work) as well as the challenges, and success factors faced during the implementation of the HDF programme.
- To formulate futuristic recommendations to inform the remaining period of HDF implementation and guide the formulation of follow-up Programme.

2.1.1 Evaluation Criteria and Key Questions

The evaluation criteria are based on the components prescribed by the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) including relevance, coherence, effectiveness, efficiency, impact, and sustainability.

Figure 6: Evaluation Criteria

Source: OECD (2019)

Find below the key evaluation questions (Table 4) for DAC criteria

Table 4: Evaluation Criteria and Key Questions

Relevance
EQ1 – To what extent HDF objectives and design are relevant to community needs, local context, public policy priorities and Programme remained adaptive?
Coherence
EQ2 – To what extent has HDF objectives, approaches and interventions aligned to national health sector priorities and managed to leverage internal and external synergies and complementarities of key stakeholders (MoCCH, UNICEF, UNFPA and donors)?
Effectiveness
EQ3 - What were the most significant enabling and disabling factors for HDF achievements and how well did it build on gains and lessons of Health Transition Fund *(predecessor).*
Efficiency
EQ4 - To what extent did HDF manage to economically convert resources (funds, expertise, and time) to achieve intended outputs – in terms of quality, quantity, and timeliness?
Impact
EQ5 – To what extent has HDF Programme been able to achieve/contribute to intended and unintended impact - systems norms and human wellbeing?
Sustainability
EQ6 - To what extent did the Programme create institutional and community capacities (including those needed) for sustaining interventions and benefits accrued (including resilient healthcare system) for medium to long term period?

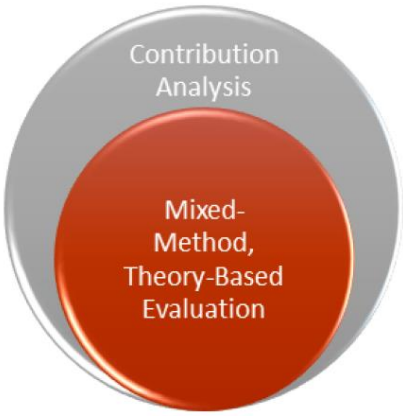
3.1 Evaluation Design, Methodology

3.1.1 Evaluation Design

This evaluation design will be guided by mixed-method and theory-based approaches. The mixed-method approach (featuring among other key informant interviews, desk review and

focus group discussions,) underpins this study, to generate evidence to inform evaluation findings, analysis, and recommendations. The use of mixed methods will enable gathering of comprehensive and rich information (from varied sources), cross-verification and triangulation of data gathered.

Figure 7: Evaluation Design



The evaluation design in Figure 7 above, will consist of contributory analysis, which will enable iterative mapping of available primary and secondary evidence against the HDF theory of change, while identifying and addressing challenges to causal inference. The Determinant Layers of Universal Health Coverage will be used as a framework for the contribution analysis.

Contribution analysis assesses causal questions and inferring causality in real-life program evaluations. It offers a step-by-step approach designed that generates conclusions about the contribution the program has made for outcomes. It offers an approach designed to reduce uncertainty about the contribution of the intervention to the observed results through an increased understanding of why the observed results have occurred or not and what factors may have influenced them. It provides substantial evidence and a line of reasoning from which stakeholders can draw a plausible conclusion that the program has made an important contribution to the results. The design will enable a clear affirmation of the impact, by presenting the overall change, compared to the evidence driven change resulting from the findings of the mid-term evaluation. This may then be used appropriately to compare causal linkages between drivers of change and the resultant change, as single difference.

The study will review the HDF programme actions in light of the following Integrated WHO RMNCAH-N services package134,135. This package defines the layers at which services should be addressed to have an impact on the overall human life cycle (at the defined stages). The evaluation will be carried out using two standardized frameworks: (i) The WHO 6 Building Blocks for Health Systems Strengthening; and (ii) The Determinant Layers of Universal Health Coverage (specific to Sustainable Development Goals). The HDF programming components will be evaluated using the following WHO health systems strengthening framework, keeping in view the recommended priority areas for each block including (i) health service delivery, (ii) health workforce, (iii) health information, (iv) medical products, vaccines, and technologies, (v) health financing as well as (vi) leadership and governance.

3.2 Evaluation Methodology

The mixed-method approach (Figure 7) featured the use of desk review, focus group discussions, key informant interviews, and patient exit interviews. The data was ensured via secondary sources review and primary data collection. The study used the existing quantitative as well as qualitative information and then gathered additional primary qualitative information.

The ‘qualitative’ methods were used for primary data collection. The application of multiple qualitative methods enabled an extensive data gathering. Additionally, the study considered cross-verification of primary information with quantitative data from multiple sources for triangulation purpose. The secondary sources included both internal (to the programme) and external data sources.

The study reviewed the HDF programme actions in light of the integrated WHO RMNCAH-N services package which defines the layers at which services should be addressed to have an impact on the defined stages of human life cycle. The evaluation will be carried out using two standardized frameworks including the WHO six building blocks for health systems strengthening and the determinant layers of Universal Health Coverage (specific to sustainable development goals). All data collection methods are designed to capture information from all seven thematic areas of the program as presented in Table 5. More specific details on what methods will be applied for assessment of specific thematic areas are available in the description of individual methods.

Table 5: Methods used for Thematic Areas Assessment

Thematic Areas	Desk Review	KIIs	FGDs	Health Facility Visits	
				Health Facility Assessment	Patient Exit Interviews at Facility
Thematic Area 1 Maternal, New-born, Child Health and Nutrition	✓	✓	✓		✓
Thematic Area 2 Sexual & Reproductive Health & Rights (SRHR) including adolescents	✓	✓	✓		✓
Thematic Area 3 Medical Products, Vaccines & Technologies (Medicines + Commodities)	✓	✓	✓	✓	
Thematic Area 4 Human Resources for Health	✓	✓	✓	✓	
Thematic Area 5 Health Financing (Results Based Financing)	✓	✓	✓		✓
Thematic Area 6 Health Policy Planning, Monitoring and Evaluation and Coordination	✓	✓			
Thematic Area 7 Technical support and Innovation	✓	✓			

3.2.1 Desk Review

The aim of desk review was to inform findings on HDF adequacy, availability, conduciveness, plausibility, feasibility, and usefulness with respect to exploring and understanding the Programme design, ToC, results framework, challenges, learnings, appropriateness of health interventions, content of the life cycle-based messages, and evolution of the Programme.

3.2.2 Primary Qualitative Data Collection

The primary data collection component will focus on collecting relevant qualitative data to satisfy the information requirements of the evaluation. The qualitative element consists of three categories of evidence generation including (i) key informant interviews (influencers/decision makers), (ii) focus group discussions, with beneficiaries (direct/indirect), and (iii) patient exit interviews.

3.2.3 Key Informant Interviews

Key informant interviews (KIIs) were conducted with key influencers and decision makers, to explore their opinions, suggestions, and perceptions regarding RMNCAH-N and the HDF programme interventions (seven themes) through open ended, structured interview questionnaires. Questionnaires and areas for exploration were developed for each group of respondents to ensure that the data collection covers the 360-degree information spectrum.

3.2.4 Focus Group Discussions

Focus group discussion (FGDs) were used to explore the opinions, perceptions, behaviors, and practices of the direct and indirect beneficiaries of the HDF Programme Interventions. Key exploration areas were qualitative aspects of time critical value, adequacy, appropriateness, quality, and impact on beneficiaries (i.e., human life cycle effects). These parameters also covered information on beneficiary preferences, needs, opinions, perceptions, and behaviours, while also reflecting on trajectory of change subjectively. FGDs were conducted with homogenous groups of 7-9 self-selected individuals, for each group in locations with documented coverage of HDF interventions. A purposive sample was used for selection of sites and participants for FGDs.

3.2.5 Health Facility Assessment

Health facility observations were undertaken as part of the study. The focus of the assessment were elements within the primary healthcare facilities that corresponds to thematic areas of the programme in particular areas of Medical Products, Vaccines and Technologies (Thematic Area 3) and Human Resources for Health (Thematic Area 4), as well as the facility infrastructure and health information.

3.2.6 Patient Exit Interviews

Patients exit interviews were performed at the already selected sample of primary health facilities. These were conducted in the form of user exit interview at the point of service

delivery. Patients were interviewed as they left their final service delivery point at the primary health facility. 16 interviews were conducted. A simple random sampling was used to select patients. A semi-structured interview format was used to collect information. This method examined the impact within the first three thematic areas of the programme, namely, RMNCH and Nutrition, SRHR as well as Medical Products, Vaccines and Technologies.

3.3 Limitations, Constraints and Proposed Mitigation Measures

During inception phase the team has analyzed in detail the foreseeable limitations and constraints as well as the possible mitigation measures to address these limitations and constraints. These limitations and constraints as well as proposed measures of mitigation are presented in Table 6 below.

Table 6: Limitations, Constraints and Proposed Mitigation Measures

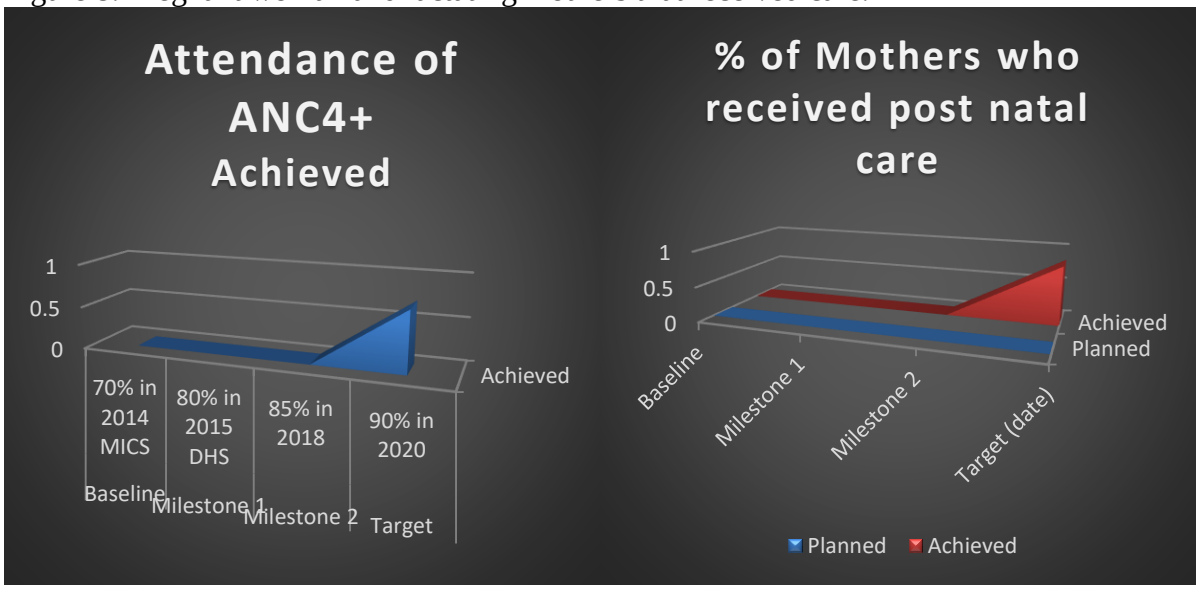
Risks & Limitations	**Mitigation Measures**
Unavailability of disaggregated performance measurement information to assess all programme outcomes.	Where appropriate, the Evaluators may refer to anecdotal (cross checked across stakeholders) accounts to make up for the limited information. The extent to which the data may not be available for outcomes is unknown at this point, however the proposed alternative strategies may help overcome this.
Partial or non-availability of some of the UNICEF/Govt. partners/other stakeholders for interview may lead to an information gap on their reflections about the Programme.	Where possible, with UNICEF support, the evaluators will try to reach these partners (former executives/key managers) through phone/Skype calls to interview them and have their reflections on evaluation questions related with partnership modalities and contributions in the Programme.
The COVID-19 pandemic environment and uncertainties (including ethical compulsions) may affect direct interaction with the respondents	✓ The Evaluators intend to use technology for remote data collection and quality assurance. The Evaluators have drawn up a remote field data collection plan, using remote data collection tools and quality assurance (read details in the next chapter). The Evaluators will remain in touch with UNICEF Zimbabwe and local partners/consultants to stay informed on COVID-19 related restrictions and find ways to initiate field work. ✓ Strong national team with complementary knowledge and expertise and context understanding.

	✓ Extensive training on going technical support will be done remotely and innovative approaches for training will be used.

4.1 Findings/Evaluation of Data

The was a positive association from the data collected, which revealed an improvement in the number of pregnant women who attended ANC4+ in their current pregnancy. Baseline records show this to have been 70% in 2014 but an escalation to 90% by year 2020. There was a similar pattern with the number of lactating mothers that received post-natal care as shown in Figure 8 below.

Figure 8: Pregnant woman and lactating mothers that received care.



Source: (MICS 2019)

Table 7: Proportion of infants fully immunised

	Baseline	Milestone 1	Milestone 2	Target (date)
Planned	69.2% in 2014 MICS	71% by 2015 ZDHS	73% by 2018	85% by 2020
Achieved		76% (DHS 2015)	85.9% (MICS 2019)	86%

Source: (MICS 2019)

From Table 7, above, it can be noted that there were 69.2% infants that were planned to be fully immunised at baseline in 2014. By the time the programme reached its first milestone in 2015, the planned immunisation was 71% but, the achieved was higher than the target at 76% as per the (DHS 2015). At the second milestone, the planned target was 73%, however, according to the (MICS 2019), the achieve infant immunisation was 85.9%. The programme

target was to reach a full infant immunisation of 85% by the year 2020 and the achieved was 86%.

Table 8: Improved capacity for Maternal, Infant and Young Child Nutrition at all levels

	Baseline	Milestone 1	Milestone 2	Target (date)
Planned	41% in MICS 2014	43% by 2016 ZDHS	45% by 2017	47% by 2020
Achieved		47.8% (ZDHS 2015)	41.9% (MICS 2019)	45%

Source: (MICS 2019)

With regards to improving the institutional capacity to manage maternal, infant and young child nutrition at all level, at baseline, the planned target was 41%. At the first milestone, according to 2016 ZDHS, the planned target capacitation was 43%. The achieved result was higher at 47.8%. At the second milestone, the planned target was 45%, however, the actual capacitation achieved was lower at 41.9%. The programme planned target was 47% but, according to (MICS 2020), the programme achieved 45%.

Table 9: Incidence of cervical cancer screening

	Baseline	Milestone 1	Milestone 2	Target (2020)
Planned	164,013 in 2015	340,701 in 2017	440,701 by 2018	740,701 by 2020
Achieved		101,489	484,739	688354

Source: (MICS 2019)

With regards to incidences of screening for cervical cancer, the programme at baseline planned to screen 164 013 women. At milestone 1, the planned target was 340701 women but the achieved was 101489. On the second milestone, the planned target was 440701 and the actual achieved was higher at 484739 women. The programme target was 740701 women by 2020 and the achieved was 688354 women that were screened for cervical cancer.

5.1 Discussion and Conclusion

5.1.1 Relevance

It was noted form the KIIs that the HDF programme was in line with national strategy and was flexible enough to adjust implementation to take into consideration response to national disasters like cyclone Idai and covid19. HDF was able to reprogramme to adapt to shocks by humanitarian situations. From 2019 HDF through its medical supplies resulted in no cholera outbreaks. Health care financing/RBF had discrepancies in how salaries were paid resulting in demotivated health staff and some would not turn up for work. Most intervention were for

MNCH and were supported at community level. There was an increase in uptake of contraceptives. ANC above 94% was provided by skilled health providers. HDF supported capacity building for institutions at community level through having different supplies to address acute malnutrition.

5.1.2 Coherence

Interviews with donor partners noted that, GFF funded by World Bank and Global Fund complimented health system strengthening alongside HDF. There is need to take advantage of the current phase of HDF to invoke strategic thinking so that there is no duplication of interventions. There is independent thinking amongst development partners that resulted in some functions being done in silos or as independent entities. They also stated that leadership should drive the coordination processes, so that strategic platforms maybe used to unify partners towards a unified front.

5.1.3Effectiveness

Through KIIs it emerged that HDF has been effective to a certain level. They stated that there are discrepancies as per the regions or some locations in the country that is, some specific concerns may or may not have been addressed with regards to some remote districts. The EU only channeled the means but the implementation was done by civil servants and MoHCC. Some parts of the health delivery system are not working effectively for example, the nursing staff do not have adequate resources to utilize in executing their duties. HDF played a key role to maintain health care services not to improve them. It failed to have wider coverage above and beyond the previously implemented programmes like ISP and HTF.

5.1.4Efficiency

KIIs with MoHCC staff noted that adequate inputs from HDF lead to no cholera outbreaks as from March 2019 to date. There were difficulties in training the village health workers because of internet connectivity challenges. The study also learnt that HDF would have two shipments per year of medical supplies hence gaining economies of scale and reduced the cost of doing business. Service delivery had challenges at times due to system bureaucracy where money had to move through the government system. Staff retention was a challenge as government was not forthcoming in its payment of salaries. HDF stopped paying in 2019 remaining with only 18 technical staff.

5.1.5 Impact

The programme had a positive impact on the health sector in Zimbabwe as it emerged from a review of the programme reports. There was a drop in MMR now at 462 from over 600 when HDF was initially introduced. There were no cholera outbreaks recorded in the country from march 2019. Health facilities now have functional health committees that coordinate resources utilization. The programme trained and engaged over 17000 village health workers across the country. RBF lead to staff at health facilities being motivated and had renewed energy to work through the incentives system. HDF lead to the development of the National Community Health strategy, which has initiated the strengthening of health systems at community level. Through HDF advocacy government is now paying for its own traditional vaccines that are now easily available at most health facilities. In addition, HDF facilitated forecasting, availability of essential medicines in which is now more than 80% in the health facilities. The programme lobbied for an increased Government budget towards the health sector, that has since gone up to 12.8% from about 7% which is not very far from the 15% Abuja Declaration target stated in Table 1 above.

5.1.6 Sustainability

Through the programme, there was the development of the National Community Health strategy developed for strengthening systems at community level is a positive drive towards the perpetuations on the programme interventions. The programme was however weak in developing a sustainability plan as there was a high donor dependency. There is uncertainty as to which structure will carry forward or will be responsible for improving what has already been implemented. EPIs revealed that, at grassroots level, HDF had trainings at local level with Village health workers incorporated. HDF therefore becomes the springboard for devolution of resources in all sectors, health included whereby there is channeling of funds down to the community level. This created local level accountability in resources utilization. HDF also resulted in the creation of a referral system in which patients with greater needs could be referred to higher level health facilities also resulting in synergies. Incorporation of local authorities led to increased motivation and ownership of the HDF programme. This has fostered continued Village health worker's functionality in the communities.

6.1 Recommendations

The evaluation therefore recommends that there be sustained support to retain nursing staff through the provision of allowances. On ending of the programme the village health workers

that were paid by the programme were left with no pay. Government as a partner in implementing HDF should have the village health workers on its payroll.

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Appendices

Appendix 1: Evaluation Qualitative Tools – KII Guide

Following types of KIIs guides have been prepared for KIIs.

KEY INFORMANT INTERVIEW GUIDE – STAFF OF UNICEF, UNFPA AND OTHER DONORS

KEY INFORMANT INTERVIEW GUIDE – STAFF OF GOVERNMENT OF ZIMBABWE

KEY INFORMANT INTERVIEW GUIDE – MEMBERS OF STEERING COMMITTEE

KEY INFORMANT INTERVIEW GUIDE – INGOS AND OTHER IMPLEMENTATION PARTNERS

Key Informant Interview Guide – Staff of UNICEF and other Donors

Informed Consent

Hello. My name is _____, The information that will be collected during this evaluation will inform the key evaluation findings and recommendations that will help UNICEF, Government and other relevant donors stakeholders to revisit the current HDF Programme strategies, develop future plans and further make best use of the remaining funds of HDF.**Today, I would like to interview you** and ask questions about the HDF. As one of the key donors/stakeholders with direct knowledge of the HDF Programme, your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview. To ensure that I do not miss any of your feedback or comments, the interview will be recorded on tape. With your permission we would record the interview only for such purpose.

Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway. The interview should take about 2 hours (120 minutes) to complete. Your participation in this interview is voluntary and if we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time without giving any reason.

Do you have any questions about the evaluation or the Interview process at this time?

Do you agree to participate in this interview: Yes [ ] No [ ]

May I begin the interview now? Yes [ ] No [ ]

Interview Guiding Questions

1. Warming up

Q1. Could you describe your position and role within UNICEF?

a. How long have you been with UNICEF in HDF?

b. How (in what roles) were you involved with the HDF?

Intro Question: Please share your understanding of HDF Programme. Can you please elaborate particularly on HDF interventions in your domain/s of work?

2. Relevance

(Now let us talk about the time when the HDF was being designed and to be implemented i.e. 2015/2016)

Q2. How well are you aware of the national health strategy, its purpose and objectives? What are those?

a. Are you aware of the HDF strategies, objectives, and interventions?

b. Can you identify areas of coherence between both?

c. Was there any divergence between the HDF and the national policies? If yes, please give rationale.

d. Was your office/department/institute consulted during the time of HDF design?

Q3. In your opinion, how consistently the HDF strategies and interventions adhere to:

a. Global frameworks/guidance's such as Health System Strengthening, Universal Health Coverage and SDGs?

b. Guidance's/frameworks of the Funding Partner (EU, GAVI, Irish Aid, SIDA, FDCO, UNICEF, UNFPA)

c. Is there any divergence between the HDF and these guidance's/frameworks? If yes, please give rationale.

d. To what extent was your office/department consulted at the time of HDF design?

Q4. What were the health and nutrition needs of the women, new-borns, children, adolescents, elderly, and other vulnerable groups (including people living with disabilities and those in hard-to-reach communities) in Zimbabwe in 2016?

a. To what extent HDF design, objectives and approaches were relevant to beneficiary needs (including vulnerable groups) at the time of its implementation (in 2016)? Give specific examples.

b. Do you know of any needs assessments or intervention assessments that have been carried out in this regard?

c. In your opinion, how have beneficiary needs evolved over time? Please give examples of how similar or different are the beneficiary needs today compared with what they were at the start of the HDF.

d. Did the HDF consider and adapt to these changing needs? Give specific examples.

Q5. Was the HDF programme sensitive to the local context & public policy at the time of its design, in terms of (i) economic, (ii) social, (iii) environmental, (iv) equity, (v) political, (vi) capacity of institutions?
a. What were the major contextual changes in the country during the implementation of the programme?
b. To what extent the HDF programme adapted to these contextual changes?
c. Were there any humanitarian/emergency situations that emerged during the implementation of the HDF?
d. To what extent the HDF programme responded or adapted to these humanitarian / emergency situations? Specifically probe regarding HDF adaptation to Covid-19. If respondent is informed, do more probing as this was not foreseen in initial program design but is important segment of evaluation.
Important Questions to be asked in Relevance, not directly corresponding to the indicator:

Q6: What were the major gaps and shortcomings in the design of the HDF? How could those be addressed in future design? Please share evidence and examples.

3. Coherence
Q7. Are there any programmes or interventions (similar to HDF) that were jointly implemented by Government/MoHCC, UNICEF, UNFPA and other development partners?
a. Which stakeholders were involved?
b. What was their (programmes) size?
c. Any relation with HDF you can think of?

Q8. Were there any mechanisms in place to identify synergies or establish linkages between HDF with other partners or programs?
a. What form did these mechanisms take?
b. Did that result with any complementarities?
c. Did that result with any harmonization of program and efforts?
d. Were there any duplications by HDF and other programs?

Q9. Did the HDF program leverage the complementarities among internal and external partners or programs by using:
a. Strategies.
b. Policies.
c. Learning processes.
d. Resources.
Please provide and specific example you can think of.

4. Effectiveness
Q10. To what extend the programme has achieved its intended outcomes?
a. Can you provide examples of achievements of specific outcomes as specified in the log frame?

b. Can you provide examples when project didn't achieve specific outcomes as specified in the log frame?
c. What were reasons for achievement or failure to achieve such outcomes?
d. In your view what was program contribution for the following:
Outcome 1: Maternal and Newborn Care.
- Pregnant women attendance for ANC4+ during the current pregnancy.
- Deliveries attended by a skilled birth attendant.
- Mothers receiving postnatal care (at least 2 times) in the first week after delivery.
Outcome 2: Improving Child Health.
- Full immunization of infants.
- Coverage with DTP3 in the lowest wealth quintile of children population (as compared to the highest wealth quintile).
- Overall vaccination with DPT3 containing agent; pentavalent -3.
- Vaccination of infants for measles.
- Treatment with antibiotics of newborns (0- 28 days old) with sepsis.
- Treatment with antibiotics of children under five years with pneumonia.
- Treatment with ORT and zinc of children under five years with diarrhoea.
- Treatment with standard anti-malarial drugs of children under five years of age with confirmed malaria.
Outcome 3: Enhancing national capacity in Maternal, Infant and Young Child Nutrition.
- Breastfeeding of children aged (0-6 months, exclusively breastfed).
- Feeding of children 6-23 months with a minimum acceptable diet.
- Administration of recommended dose of Vitamin A for children of 6-59 months.
- Children under five years of age with severe acute malnutrition in need of a standard treatment for SAM.
Outcome 4: HIV and AIDS.
- HIV exposed children in need of ARVs for prophylaxis.
- DNA/PCR test within two months of age for HIV exposed children.
- HIV positive children in need of antiretroviral therapy (ART).
- Rates of circumcision for men aged 15 to 29.
- Use of condom by partners during sexual intercourse with female and male aged 15–49.
Outcome 5: Sexual Reproductive Health
- Unmet need for family planning among females 15-19 years.
- Women aged 15-49 using long-acting contraceptive methods.
- Screening of eligible women (25-55cyears) for cervical cancer in public and private health facilities.
- Girls (15-19 years) who have begun childbearing.
- Women and girls who report having used services after being abused.
- Sexually abused clients who report to the health facility (within 72 hours).
- Women who experience physical violence (in the last 12 months).
Outcome 6: Strengthened Community Interventions

- Providing the population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS.
- Funding of Partners.
- Awareness among people aged 15-49 about household abuse.
Probe how, for each line that respondent has information.

Q11. To what extend the programme has achieved its intended outputs?
a. Can you provide examples of achievements of specific outputs as specified in the log frame?
b. Can you provide examples when project didn't achieve specific outputs as specified in the log frame?
c. What were reasons for achievement or failure to achieve such outputs?

Q12. What were specific outcomes or outputs of HDF Programme when it comes to COVID-19 response?
a. Did any formulation of such outcomes or outputs occur? Were they integrated into the log frame?
b. What were specific outcomes influenced by the Programme? How?
b. What were specific outputs accomplished by the Programme? How?

Q13. Were there any disabling factors during the implementation of the HDF Programme?
a. What disabling factors had to be addressed?
b. How such disabling factors were addressed?
c. What mitigation strategies were enacted?
d. Did that contribute to improvements in project achievements? How? Please provide concrete examples.

Q14. In your opinion, how well did HDF benefited (in both design and implementation) form Health Transition Fund in terms of:
a. Gains made during HTF implementation.
b. Lessons learnt during/after HTF implementation.
c. Lessons learnt that were incorporated into the design and implementation of HDF.
d. Influence in the design and implementation of HDF.
e. Extension of gains of HTF.

5. Efficiency
Q15. Do you know of any evidence that shows how efficient the program was in use of resources? For example:
a. Achievement of outputs with the given resources (including quality, quantity and timeliness).
b. Rate of return on investment (RoI).
c. Yield/returns vs other comparable country/regional/global programmes.
d. Rate of return as per the type of funding mechanism and of interventions (value for money).
e. Utilisation of ratio of resources used.

Q16. In your view how well did the HDF program perform in terms of:

a. Adequacy of allocated resources vs planned results.
b. Achievement of results efficiently – cost/beneficiary and observed/likely changes.
c. Application of adaptive programming approaches (measures taken) to reduce time and costs.
d. Level of satisfaction with cost efficiencies achieved.
e. Bottlenecks/challenges that increased cost and time for interventions.
f. Alternative approaches that may have helped achieved greater efficiencies.

6. Impact

Q17. Do you think HDF has impacted the following impact indicators?
a. Maternal mortality ratio (MMR).
b. U 5 mortality rate (U5MR).
c. Neonatal mortality rate (NMR).
d. Mortality and morbidity due to malnutrition.
e. Prevalence of stunting (moderate and severe) in children less than five years of age
f. Adolescent fertility rate.
g. Incidence of cervical cancer per 10000 women.
h. HIV Incidence among adults and adolescents (15 - 49years).
i. Unwanted pregnancies averted.
Can you point out to any evidence and / or explanation for that?

Q18. Do you think HDF has contributed to other non-intended impacts?
a. What impacts?
b. How did that happen?
c. Can you point out to any evidence explaining or describing such impacts?

Q19. Do you think HDF has contribute in any way to SDG goals, targets and indicators for the country?
a. What impacts?
b. How did that happen?
c. Can you point out to any evidence explaining or describing such impacts?

Q20. Do you think that such impacts could have been possible without HDF support? Why? Please explain.

7. Sustainability

Q21. How did HDF perform when it comes to:
a. HDF exit strategy plan (interventions and resources), implementation and results.
b. Interventions (included in the Programme) to build system-wide capacities for responsive healthcare system.
c. Institutional capacities and interventions needed to strengthen the sustainability of Programme supported interventions and results.
d. Interventions (included in the Programme) to build community level systems and capacities sustaining interventions and results.

e. Community systems and capacities needed to strengthen sustainability of Programme supported interventions and results.
f. Broader social, cultural, political, and economic systems needed to sustain benefits over medium to long term.
g. Interventions made to improve systemic resilience to shocks and results achieved.

Q22. How did HDF perform when it comes to:
a. HDF sustainability strategy (including interventions and resources), implementation and results around strengthening community systems and capacities.
b. Interventions (included in the Programme) to leverage/strengthen community systems and capacities and benefits.
c. Community systems and capacities needed to sustain programme supported interventions and results.
d. Community motivation and ownership to sustain community systems and capacities.

Q23. Is there anything that we did not ask but in your view is significant, please do share?

Thank the respondent for their time and emphasize that the interview has been useful. Do you have any questions for us?

Appendix 2: Evaluation Qualitative Tools – FGD Guide

Following types of KIIs guides have been prepared for KIIs.

Informed Consent

Hello. My name is _____, The information that will be collected during this evaluation will inform the key evaluation findings and recommendations that will help UNICEF, Government and other relevant donors stakeholders to revisit the current HDF Programme strategies, develop future plans and further make best use of the remaining funds of HDF.**Today, I would like to conduct a focus group discussion with you** and ask questions about the HDF. To ensure that I do not miss any of your feedback or comments, the discussion will be recorded on tape. With your permission we would record the interview only for such purpose.

Please be assured that the information you provide will be kept confidential. Your responses will also be kept anonymous and not tied back to you in anyway. The discussion should take about 2 hours (120 minutes) to complete. Your participation in this discussion is voluntary and if we ask you any questions you don't want to answer, let us know and we will go on to the next question..

FGD Guiding Questions

1. Warming up

Q1. Could you describe your position and role within UNICEF?

a. How long have you been with UNICEF in HDF?

b. How (in what roles) were you involved with the HDF?

Intro Question: Please share your understanding of HDF Programme. Can you please elaborate particularly on HDF interventions in your domain/s of work?

2. Relevance

(Now let us talk about the time when the HDF was being designed and to be implemented i.e. 2015/2016)

Q2. How well are you aware of the national health strategy, its purpose and objectives? What are those?

a. Are you aware of the HDF strategies, objectives, and interventions?

b. Can you identify areas of coherence between both?

c. Was there any divergence between the HDF and the national policies? If yes, please give rationale.

d. Was your office/department/institute consulted during the time of HDF design?

Q3. In your opinion, how consistently the HDF strategies and interventions adhere to:

a. Global frameworks/guidance's such as Health System Strengthening, Universal Health Coverage and SDGs?

b. Guidance's/frameworks of the Funding Partner (EU, GAVI, Irish Aid, SIDA, FDCO, UNICEF, UNFPA)

c. Is there any divergence between the HDF and these guidance's/frameworks? If yes, please give rationale.

d. To what extent was your office/department consulted at the time of HDF design?

Q4. What were the health and nutrition needs of the women, new-borns, children, adolescents, elderly, and other vulnerable groups (including people living with disabilities and those in hard-to-reach communities) in Zimbabwe in 2016?

a. To what extent HDF design, objectives and approaches were relevant to beneficiary needs (including vulnerable groups) at the time of its implementation (in 2016)? Give specific examples.

b. Do you know of any needs assessments or intervention assessments that have been carried out in this regard?

c. In your opinion, how have beneficiary needs evolved over time? Please give examples of how similar or different are the beneficiary needs today compared with what they were at the start of the HDF.

d. Did the HDF consider and adapt to these changing needs? Give specific examples.

Q5. Was the HDF programme sensitive to the local context & public policy at the time of its design, in terms of (i) economic, (ii) social, (iii) environmental, (iv) equity, (v) political, (vi) capacity of institutions?
a. What were the major contextual changes in the country during the implementation of the programme?
b. To what extent the HDF programme adapted to these contextual changes?
c. Were there any humanitarian/emergency situations that emerged during the implementation of the HDF?
d. To what extent the HDF programme responded or adapted to these humanitarian / emergency situations? Specifically probe regarding HDF adaptation to Covid-19. If respondent is informed, do more probing as this was not foreseen in initial program design but is important segment of evaluation.
Important Questions to be asked in Relevance, not directly corresponding to the indicator:

Q6: What were the major gaps and shortcomings in the design of the HDF? How could those be addressed in future design? Please share evidence and examples.

3. Coherence
Q7. Are there any programmes or interventions (similar to HDF) that were jointly implemented by Government/MoHCC, UNICEF, UNFPA and other development partners?
a. Which stakeholders were involved?
b. What was their (programmes) size?
c. Any relation with HDF you can think of?

Q8. Were there any mechanisms in place to identify synergies or establish linkages between HDF with other partners or programs?
a. What form did these mechanisms take?
b. Did that result with any complementarities?
c. Did that result with any harmonization of program and efforts?
d. Were there any duplications by HDF and other programs?

Q9. Did the HDF program leverage the complementarities among internal and external partners or programs by using:
a. Strategies.
b. Policies.
c. Learning processes.
d. Resources.
Please provide and specific example you can think of.

4. Effectiveness
Q10. To what extend the programme has achieved its intended outcomes?
a. Can you provide examples of achievements of specific outcomes as specified in the log frame?

b. Can you provide examples when project didn't achieve specific outcomes as specified in the log frame?
c. What were reasons for achievement or failure to achieve such outcomes?
d. In your view what was program contribution for the following:
Outcome 1: Maternal and Newborn Care.
- Pregnant women attendance for ANC4+ during the current pregnancy.
- Deliveries attended by a skilled birth attendant.
- Mothers receiving postnatal care (at least 2 times) in the first week after delivery.
Outcome 2: Improving Child Health.
- Full immunization of infants.
- Coverage with DTP3 in the lowest wealth quintile of children population (as compared to the highest wealth quintile).
- Overall vaccination with DPT3 containing agent; pentavalent -3.
- Vaccination of infants for measles.
- Treatment with antibiotics of newborns (0- 28 days old) with sepsis.
- Treatment with antibiotics of children under five years with pneumonia.
- Treatment with ORT and zinc of children under five years with diarrhoea.
- Treatment with standard anti-malarial drugs of children under five years of age with confirmed malaria.
Outcome 3: Enhancing national capacity in Maternal, Infant and Young Child Nutrition.
- Breastfeeding of children aged (0-6 months, exclusively breastfed).
- Feeding of children 6-23 months with a minimum acceptable diet.
- Administration of recommended dose of Vitamin A for children of 6-59 months.
- Children under five years of age with severe acute malnutrition in need of a standard treatment for SAM.
Outcome 4: HIV and AIDS.
- HIV exposed children in need of ARVs for prophylaxis.
- DNA/PCR test within two months of age for HIV exposed children.
- HIV positive children in need of antiretroviral therapy (ART).
- Rates of circumcision for men aged 15 to 29.
- Use of condom by partners during sexual intercourse with female and male aged 15–49.
Outcome 5: Sexual Reproductive Health
- Unmet need for family planning among females 15-19 years.
- Women aged 15-49 using long-acting contraceptive methods.
- Screening of eligible women (25-55cyears) for cervical cancer in public and private health facilities.
- Girls (15-19 years) who have begun childbearing.
- Women and girls who report having used services after being abused.
- Sexually abused clients who report to the health facility (within 72 hours).
- Women who experience physical violence (in the last 12 months).
Outcome 6: Strengthened Community Interventions

- Providing the population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS.
- Funding of Partners.
- Awareness among people aged 15-49 about household abuse.
Probe how, for each line that respondent has information.

Q11. To what extend the programme has achieved its intended outputs?
a. Can you provide examples of achievements of specific outputs as specified in the log frame?
b. Can you provide examples when project didn't achieve specific outputs as specified in the log frame?
c. What were reasons for achievement or failure to achieve such outputs?

Q12. What were specific outcomes or outputs of HDF Programme when it comes to COVID-19 response?
a. Did any formulation of such outcomes or outputs occur? Were they integrated into the log frame?
b. What were specific outcomes influenced by the Programme? How?
b. What were specific outputs accomplished by the Programme? How?

Q13. Were there any disabling factors during the implementation of the HDF Programme?
a. What disabling factors had to be addressed?
b. How such disabling factors were addressed?
c. What mitigation strategies were enacted?
d. Did that contribute to improvements in project achievements? How? Please provide concrete examples.

Q14. In your opinion, how well did HDF benefited (in both design and implementation) form Health Transition Fund in terms of:
a. Gains made during HTF implementation.
b. Lessons learnt during/after HTF implementation.
c. Lessons learnt that were incorporated into the design and implementation of HDF.
d. Influence in the design and implementation of HDF.
e. Extension of gains of HTF.

5. Efficiency
Q15. Do you know of any evidence that shows how efficient the program was in use of resources? For example:
a. Achievement of outputs with the given resources (including quality, quantity and timeliness).
b. Rate of return on investment (RoI).
c. Yield/returns vs other comparable country/regional/global programmes.
d. Rate of return as per the type of funding mechanism and of interventions (value for money).
e. Utilisation of ratio of resources used.

Q16. In your view how well did the HDF program perform in terms of:

a. Adequacy of allocated resources vs planned results.
b. Achievement of results efficiently – cost/beneficiary and observed/likely changes.
c. Application of adaptive programming approaches (measures taken) to reduce time and costs.
d. Level of satisfaction with cost efficiencies achieved.
e. Bottlenecks/challenges that increased cost and time for interventions.
f. Alternative approaches that may have helped achieved greater efficiencies.

6. Impact

Q17. Do you think HDF has impacted the following impact indicators?
a. Maternal mortality ratio (MMR).
b. U 5 mortality rate (U5MR).
c. Neonatal mortality rate (NMR).
d. Mortality and morbidity due to malnutrition.
e. Prevalence of stunting (moderate and severe) in children less than five years of age
f. Adolescent fertility rate.
g. Incidence of cervical cancer per 10000 women.
h. HIV Incidence among adults and adolescents (15 - 49years).
i. Unwanted pregnancies averted.
Can you point out to any evidence and / or explanation for that?

Q18. Do you think HDF has contributed to other non-intended impacts?
a. What impacts?
b. How did that happen?
c. Can you point out to any evidence explaining or describing such impacts?

Q19. Do you think HDF has contribute in any way to SDG goals, targets and indicators for the country?
a. What impacts?
b. How did that happen?
c. Can you point out to any evidence explaining or describing such impacts?

Q20. Do you think that such impacts could have been possible without HDF support? Why? Please explain.

7. Sustainability

Q21. How did HDF perform when it comes to:
a. HDF exit strategy plan (interventions and resources), implementation and results.
b. Interventions (included in the Programme) to build system-wide capacities for responsive healthcare system.
c. Institutional capacities and interventions needed to strengthen the sustainability of Programme supported interventions and results.
d. Interventions (included in the Programme) to build community level systems and capacities sustaining interventions and results.

e. Community systems and capacities needed to strengthen sustainability of Programme supported interventions and results.
f. Broader social, cultural, political, and economic systems needed to sustain benefits over medium to long term.
g. Interventions made to improve systemic resilience to shocks and results achieved.

Q22. How did HDF perform when it comes to:
a. HDF sustainability strategy (including interventions and resources), implementation and results around strengthening community systems and capacities.
b. Interventions (included in the Programme) to leverage/strengthen community systems and capacities and benefits.
c. Community systems and capacities needed to sustain programme supported interventions and results.
d. Community motivation and ownership to sustain community systems and capacities.

Q23. Is there anything that we did not ask but in your view is significant, please do share?

Thank the participants for their time and emphasize that the discussion has been useful.

Appendix 3: Exit Poll Interview (EPI) at the Health Care Facility
Following types of Exit pool interviews were prepared for different groups to be interviewed.

EPI WITH PREGNANT AND LACTATING MOTHERS
EPI WITH HH WITH CHILDREN UNDER 5 YEARS OF AGE
EPI WITH ADOLESCENT GIRLS AND BOYS
EPI WITH VURNERABLE GROUP

EPI with Pregnant and Lactating Women
Informed Consent
Hello. My name is _____, and I am conducting an exit poll interview with the patients to see how the Health Development Fund programme (2016-2020) has helped improving the health services at the health facility level. The information will be collected through interviewing you. Information collected will help UNICEF, Government and other donors and stakeholders to further improve the health services at user end.

I would appreciate your participation in this assessment. Your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview and facilitating us in making observations where necessary. Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous.
The interview should take about quarter of an hour (15-30 minutes) to complete. Your participation in this interview is voluntary and if we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time without giving any reason.

At this time, do you want to ask me anything about the survey?

Do you want to participate? [YES] [NO]

May we start the interview now? [YES] [NO]

Signature of interviewer: _____ Date: _____

_____

Administrative Information
To be filled in by the Enumerator before starting the exit interview

Date of Exit Interview	
Province Name	
District Name	
Ward Name	
Village/Community (Optional)	

Health Care Facility NAME	
Health Care Facility CODE (if applicable)	
Type of Health Facility (classification)	
Catchment Population (if information available)	
Type of Locality of HCF (rural, urban, semi-rural)	

Patient Profile
Women that have received perinatal care at the facility.

Eligible Respondent: Pregnant and lactating women (15-49 years of age). Have received care at the facility for longer period of time (at least few (2-3) years).

Interview

Please list what are some of the key challenges in recieving care in this facility?
a. Services not available (i.e. visits, check-ups, medication. supllies)?
b. Infrastructure of facilities inadequate (i.e. waiting space, chairs to rest, hard to find the examination office, etc)?
c. Communication with health care staff is difficult (i.e. did they listen, how much time they spend with them, etc)?
d. Were there any barriers to access care (i.e. facilities too far, no money for travel, no money to buy medication, no money to pay for visit, faced discrimination at health care facility)?

For what kind of care are you here today? Check whatever applies.
a. Care before birth.
b. Care during birth.
c. Care after birth.
d. Vaccination services for your child.
e. Infection treatment services for your child.
f. Nutrition support services for your child.
g. Family planning services.

Which of following health care services you have used? Check whatever applies.
a. Check-up visit.
b. Examinations (such as weight measurement, ultrasound check up).
c. Specific treatments. Please specify.
d. Therapy, medicines or vaccines adminsitration.
e. Regular appointment.
f. Diagnostic services (blood analysis, urine analysis, mamography, x ray, etc)
g. Advisory services.

How would you describe your experience (satisfaction level) with receiving such health care services at this facility? *5.Very Satisfied; 4. Mostly Satisfied; 3. Neutral; 2. Somewhat/Little Satisfied; 1. Totally Unsatisfied.*

	1	2	3	4	5
a. The package of medical care or services offered					
b. The availability of medicines and equipment needed to provide complete medical care					
c. The overall quality of services offered					
d. Staff/doctor availability at the time of visit or when needed					
e. The staff/doctor attitude					
f. Waiting time to get check up					
g. The waiting room space					
h. Hygience of facility					
i. Amount of payment paid for all services"					

Did you note any improvements in service delivery over the course of last five years? [Probe: What were the improvements? Please describe them.]
Has the situation with supplies improved during this period? Please be as specific as you can. [Probe: Can you illustrate with specific examples?]
Were there any factors that made it easy or difficult to get the health services? [Probe: Can you illustrate this with specific examples?]
How do you think the availability (or non availability) of services impacted you and your children health?
Was there any noted effort that helped you gain more information on your right to care? Like brochures, posters or any other source of information? [Probe: Did that change over the course of last five years?]
Did you ever had any serious dissatisfaction with care received? [Probe: Were you able to complain about that? How? Where? Please provide details. Did that change over the course of last five years? What were the results of your complaint?]
Does being male or female influence how one is receiving health care? [Probe: How? Did that change over the course of last five years?]
Does being disadvantaged (disabled, poor, unemployed, HIV positive) influence how one receives health care? [Probe: How? Do you think everyone in the community (i.e. people with disabilities, sex workers, adolescents, elderly, poor) can get the care they need? Did that change over the course of last five years?]
Did you ever hear about HDF Programme? If yes, where? [Probe: Different names for the program (UNICEF programme, special programme, support program for your facility). Which media? Did you get a brochure or other information material? How often? What do you know about the HDF?]