HTF INDICATORS - Tracking matrix

HTF INDICATORS	Baseline (2010/11)		Endline (2015/16)		Progress at endline from baseline (% decline)	Target	Gap to target (%)
	Estimate	*Source*	Estimate	*Source*			
IMPACT INDICATORS							
Under five mortality rate (per 1,000 live births)	**84**	*DHS 2010/ 11*	**69**	*DHS 2015*	18%	46	-33%
Maternal mortality ratio (per 100,000 live births)	**960**	*DHS 2010/ 11*	**651**	*DHS 2015*	32%	600	-8%
Prevalence of underweight in children U5	**10.0%**	*DHS 2010/ 11*	**8.4%**	*DHS 2015*	16%	6%	-29%
OUTCOME INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**Progress at endline from baseline (Percentage Points)**	**Target**	**Gap to target (Percentage points)**
	Estimate	*Source*	**Estimate**	*Source*			
THEME 1. Maternal, newborn and child health and nutrition							
1.1. Enhancing obstetric and newborn are capacity of the health system							
1.1.1. Proportion of pregnant women who attended ANC4+ during the current pregnancy	**64.8%**	*DHS 2010/ 11*	***76.00%***	DHS 2015	11%	90%	-14%
1.1.2. Proportion of deliveries attended by a skilled birth attendant	**66.2%**	*DHS 2010/ 11*	***78.00%***	DHS 2015	12%	80%	-2%
1.1.3. Proportion of district hospitals providing comprehensive emergency obstetric and newborn services	**38.0%**	*NIHFA-2011*	**73.0%**	LSTM survey 2016	35%	80%	-7%
1.1.4. Percentage of mothers who received postnatal care at least 3 times in the first week after delivery (*)	**27.1%**	*DHS-2010/ 11*	**51.10%**	DHS 2015	24%	80%	**N/A**
1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	**20.1%**	*NIHFA-2011*	**82.10%**	LSTM survey 2016	62%	100%	-18%
1.2 Improve the Community Health Services System for MNCH and Nutrition							
1.2.1. Proportion of health centres with functional health committees	**78.20%**	*NIHFA-2011*	**86.6%**	LSTM survey 2016	8%	90%	-3%
1.2.2. Proportion of villages with at least one VHW providing community based preventive and selected curative MNCH services	**25%**	*NIHFA-2011*	**N/A**		**N/A**	80%	
1.3 Improve Child Health Through Strengthening the EPI and Integrated Management of Newborn and Childhood Illnesses							
1.3.1. Proportion of infants fully immunised	**65%**	*DHS 2010/ 11*	**73.00%**	*DHS 2015*	9%	90%	-12%
1.3.2. Pneumococcal and Rota Virus vaccines included in the national EPI program implementation	**-**		**Achieved**				**Achieved**
1.3.3.1. Proportion of newborns (0- 28 days old) with sepsis treated with antibiotics	**11%**	*NIHFA-2011*		*N/A*	**N/A**	60%	**N/A**
1.3.3.2. Proportion of children under five years with pneumonia treated with antibiotics	**16%**	*MIMS 2009*	**34.3%**	*MICS 14*	18%	70%	-36%
1.3.3.3. Proportion of children under five years with diarrhoea treated with ORT (****)	**20.9%**	*DHS 2010/ 11*	**40.50%**	*DHS 2015*	20%	80%	-40%
1.3.3.4. Proportion of eligible HIV positive children under 2 years of age treated with ART	**13.0%**	*Administrative data*	**N/A**		**N/A**	80%	**N/A**
1.3.3.5. Proportion of children under five years of age with severe acute malnutrition who received treatment	**25.0%**	*National nutrition survey 2010*	**N/A**		**N/A**	80%	**N/A**
1.3.3.6. Proportion of children under five years of age with malaria treated with anti-malarial drug (**)	**13.90%**	*MIMS 2009*	**79.8%**	*MICS 14*	66%	80%	**N/A**
1.4 Strengthen National Capacity for Maternal, Infant and Young Child Nutrition							
1.4.1. Availability of national nutrition policy and strategy document	**-**		**Available**	*HTF AR 16*	**100%**	Available	**100%**

1.4.2. Proportion of infants (0-6 months) exclusively breastfed	**31.0%**	*DHS 2010/ 11*	**48%**	*DHS 2015*	**17%**	50%	**-2%**
1.4.3. Proportion of infants 6-9 months of age who received timely and appropriate complementary feeding (***)	**82.70%**	*DHS 2010/ 11*	**90.00%**	*DHS 2015*	**7%**	50%	**N/A**
1.4.4. Proportion of children 6 - 59 months who received Vitamin-A supplementation twice a year.	**22.6%**	*DHS 2010/ 11*	**32%**	*MICS 2014*	**9%**	90%	**-58%**
1.4.5. Proportion of pregnant women who received Iron /folate supplementation during their current pregnancy	**50.0%**	*DHS 2010/ 11, 27.8% (Nutrition survey 2010*	**N/A**		**N/A**	80%	**N/A**
1.4.6. Proportion of mothers who received Vitamin A supplementation within the first 42 days after delivery	**34%**	*MIMS 2009*	**N/A**	*NA*	**N/A**	80%	**N/A**
THEME 2: Medical Products, Vaccines and Technologies (Medicines)							
2.1. Proportion of health facilities with 80 % availability of (the selected package of) medicines and health commodities in the previous year	**90%**		**64.70%**	*VMAHSS 26*	**-25%**	80%	**-15%**
2.2. Proportion of health facilities with 100% availability of vaccines (antigens), vaccine supplies and cold chain equipment in the previous year	**90%**		**N/A**	*N/A*	**N/A**	100%	**N/A**
THEME 3: Human Resources for Health							
3.1. Vacancy rate for Doctors	**69%**		**31%**		**-38%**	20%	**-11%**
Vacancy rate for Midwives	**80%**		**N/A**		**N/A**	5%	**N/A**
Vacancy rate for Nurse anaesthetist			**N/A**		**N/A**	5%	**N/A**
THEME 4: Health Policy, Planning and Finance							
4.1.1. Number of national policy documents on MNCH finalized and translated into action (implementation started)	**-**				**N/A**	9	**N/A**
4.1.2. Health expenditure per capita per annum (Government expenditure)	**$11.00**		**$22.00**	*WHO global expenditure database, 2014*	**100%**	$46.00	**-109%**
4.1.3. Proportion of health facilities charging user fees for MNCH services	**NA**		**18.5%**	LSTM survey 2016			**N/A**

(*) Proportion of mothers receiving a post natal check within 2 days after delivery used as a proxy indicator
(**) Proportion of children with fever used as a proxy
(***) Proportion of infants aged 6-9 months receiving breastfeeding and consuming complementary foods

HTF INDICATORS - Tracking matrix

OUTPUT INDICATORS	Baseline (2010/11)		Endline (2015/16)		Progress at endline from baseline (percentage points)	Target	Gap to target (percentage points)
	Estimate	Source	Estimate	Source			
THEME 1. Maternal, newborn and child health and nutrition							
1.1 Enhancing Obstetric and Newborn Care Capacity of the Health System							
1.1.1.1.Proportion of PCNs trained on focused ANC	**20%**	*Admin report 2011*	**69.2%**	*LSTM survey 2016*	**49%**	**80%**	**-11%**
1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	**20%**	*Admin report 2011*	**86.3%**	*LSTM survey 2016*	**66%**	***N/A***	**N/A**
1.1.2.2. Proportion of rural health centres with the necessary equipments and consumables for basic EmONC services	**20%**	*NIHFA 2011*	***45.0%***	*SARA 2015**	**N/A**	**80%**	**N/A**
1.1.3.1. Proportion of District Hospitals having at least one health professional who can do C/S	**55%**	*NIHFA 2011*	***97.4%***	*LSTM survey 2016*	**42%**	**80%**	**17%**
1.1.3.2. Proportion of district Hospitals with at least one health professional who can provide anaesthesia for emergency obstetric surgery	**55%**	*NIHFA 2011*	**93.0%**	*LSTM survey 2016*	**38%**	**80%**	**13%**
1.1.3.3. Proportion of District Hospitals with fully functional operation room to perform emergency obstetric surgery	**55%**	*NIHFA 2011*	**88.5%**	*LSTM survey 2016*	**34%**	**80%**	**9%**
1.1.3.4. Number of district hospitals with fully functional mother waiting homes (MWHs)	**20%**	*Admin report 2011*	**82.3%**	*LSTM survey 2016*	**62%**	**100%**	**-18%**
1.1.3.5. Number/Proportion of district hospitals having at least 1 ambulance	**55.2%**	*NIHFA 2011*	**85.6%**	*LSTM survey 2016*	**30%**	***N/A***	**N/A**
1.1.3.6. Proportion of health facilities with at least one fully functional mode of communication equipment for emergency referral	**Landline 19.4%**	*NIHFA 2011*	**97.5%**	*LSTM survey 2016*	***Not comparable***	**80%**	**18%**
1.1.3.7. Number/Proportion of District Hospitals with the capacity to provide blood transfusion for emergency obstetric care	**53%**	*NIHFA 2011*	**78%**	*LSTM survey 2016*	**25%**	***N/A***	**N/A**
1.1.4. Proportion of rural health facilities conducting at least 3 PNC visit within the 1st week after delivery	**12%**	*DHS 2010/11*	**87.8%**	*LSTM survey 2016*	***76%***	**70%**	**18%**
1.1.5.1. Number/Proportion of districts conducting quarterly supportive supervision to health facilities	**57%**	*NIHFA 2011*	**85.6%**	*LSTM survey 2016*	**29%**	**100%**	**-14%**
1.2 Improve the Community Health Services System for MNCH and Nutrition							
1.2.1. Proportion of health committees at the health centre level conducting regular monthly meetings to discuss health issues	**78.2%**	*NIHFA 2011*	**86.6%**	*LSTM survey 2016*	**8%**	**80%**	**7%**
1.2. 2. OPD utilisation rate	**N/A**	*N/A*	**1.01**	*LSTM survey 2016*	**N/A**	**100%**	**1%**
1.2.1.2. Proportion of households washing hands with soap	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**80%**	**N/A**
1.2.1.3. Proportion of villages with Zero Open Defecation	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**100%**	**N/A**
1.2.2.1. Proportion of villages that have at least one VHW per 100 households	**25.0%**	*NIHFA 2011*	**61.0%**	*HTF AR 2016*	**36.0%**	**80%**	**-19.0%**
1.2.2.2. Proportion of VHWs with the right skill to provide full package of community based MNCH services	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**80%**	**N/A**
1.3 Improve Child Health Through Strengthening the EPI and Integrated Management of Newborn and Childhood Illnesses							
1.3.1.1. Proportion of infants vaccinated for penta -3	**72.9%**	*DHS 2010/11*	**83.0%**	*DHS 2015*	**10%**	**90%**	**-7%**
13.1.2. Proportion of infants vaccinated for measles	**79.1%**	*DHS 2010/11*	**81.9%**	*DHS 2015*	**3%**	**90%**	**-8%**
1.3.2.1. Proportion of infants vaccinated for pneumococcal vaccine	**0%**	*N/A*	**82.2%**	*DHS 2015*	**82%**	**90%**	**-8%**
1.3.3.1. Proportion of health centres having at least one Health Worker trained on IMNCI	**0%**	*N/A*	**81.1%**	*LSTM survey 2016*	**81%**	**80%**	**1%**
1.3.3.2. Proportion of health centres with essential medicines for managing common newborn and childhood illnesses	**88%**	*VMAHS R 9*	**90.6%**	*VMAHS R 26*	**3%**	**NA**	**NA**
1.4 Strengthen National Capacity for Maternal, Infant and Young Child Nutrition							
1.4.1.1. Availability of national food and nutrition policy	**0.0%**	*N/A*	**100%**	*Launched May 13*		**Implemented by 2015**	
1.4.1.2. Availability of National Nutrition Strategy	**0.0%**	*N/A*	**100%**	*Launched May 13*		**Implemented by 2015**	
1.4.2.1. Availability of IYCF communication strategy	**0.0%**	*N/A*	**100.0%**	*Launched May 15*	**100%**	**Implemented by 2015**	**50%**
1.4.2.2. Proportion of health facilities with at least one health worker trained in IYCF	**N/A**	*N/A*	**71.1%**	*VMHAS R 26*	***N/A***	**90%**	**-19%**
1.4.2.3. Proportion of VHWs with the right skill to promote IYCF	**N/A**	*N/A*	**39.0%**	*HTF AR 2016*	***N/A***	**90%**	**-51%**
1.4.3.1. Proportion of children less than 3 years of age who have access to growth promotion services.	**N/A**	*N/A*	**N/A**	*N/A*	***N/A***	**80%**	**N/A**
1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	**20%**	*2010 Admin Report*	**96.1%**	LSTM survey 2016	**76%**	**80%**	**16%**

HTF INDICATORS - Tracking matrix

OUTPUT INDICATORS	Baseline (2010/11)		Endline (2015/16)		Progress at endline from baseline (percentage points)	Target	Gap to target (percentage points)
	Estimate	*Source*	Estimate	*Source*			
1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	**25%**	*2010 Admin Report*	**94.6%**	LSTM survey 2016	**70%**	**80%**	**15%**
1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	**25%**	*2010 Admin Report*	**97.1%**	LSTM survey 2016	**72%**	**80%**	**17%**
1.4.6.1.1. Number of district providing quarterly report on nutrition program implementation	**N/A**		**73.5%**	LSTM survey 2016	***N/A***	**100%**	**-27%**
1.4.6.1.2. Availability of at least 1 trained nutrition manager at provincial and district level of the health system	**N/A**		**85.9%**	LSTM survey 2016	***N/A***	**80%**	**6%**
1.4.6.1.3. Number of districts conducting quarterly supportive supervision on nutrition	**N/A**	*N/A*	**N/A**	*N/A*	***N/A***	**100%**	**N/A**
1.4.6.2. Proportion of nutrition program and project managers with the right skill to planning, management and monitoring nutrition program implementation at all levels	**N/A**	*N/A*	**N/A**	*N/A*	***N/A***	**90%**	**N/A**
THEME 2: Medical Products, Vaccines and Technologies (Medicines)							
2.1.1.1. Proportion of primary health centers with adequate supply of medicines (selected drugs) and health commodities *(at least 80%)*	**78.9%**	*VMHAS R11*	**67%**	*VMAHS R26*	**-12%**	**80%**	**-13%**
2.1.1.2. Number of months per year when vaccines (EPI program) are available in health centres	**N/A**	*N/A*	**N/A**	*N/A*	***N/A***	**12/12**	**N/A**
2.1.1.3. Stock out rate of vaccines, vaccine supplies and cold chain equipments commodities	**7.8%**	*Stockout VMAHS R 11*	**3.9%**	*VMAHS R 26*	**-4%**	***N/A***	**N/A**
2.1.2.1. Proportion of hospitals with adequate supply of medicines (selected drugs) and health commodities	***N/A***	*N/A*	**N/A**	*N/A*	N/A	**N/A**	**N/A**
2.1.2.2. Stock out rate of vaccines, vaccine supplies and cold chain equipments commodities in hospitals	***N/A***	*N/A*	**N/A**	*N/A*	N/A	**N/A**	**N/A**
2.1.2.3. Number of months per year when basic equipment (selected list) is available in hospitals	**N/A**	*N/A*	**N/A**	*N/A*	***N/A***	**12/12**	**N/A**
2.1.3. Number of districts with at least 1 person trained in LMIS and rational drug use	***N/A***	*N/A*	**87.20%**	LSTM survey 2016	**N/A**	**48%**	**39%**
2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	***N/A***	*N/A*	**78.9%**	LSTM survey 2016	**N/A**	**80%**	**-1%**
THEME 3: Human Resources for Health							
3.1.1. Number of active midwifery schools graduating at least 25 midwifes / year	**13**	*HTF logframe*	**22**	*HTF AR 2016*	**69%**	**20**	**9%**
3.1.2. Number of midwives trained per year	***N/A***	*N/A*	**835**	*MOHCC training report*	**N/A**	**N/A**	**N/A**
3.1.2. Vacancy rate for nurse anaesthetist	***N/A***	*N/A*	**N/A**	*N/A*	**N/A**	**5%**	**N/A**
THEME 4: Health Policy, Planning and Finance							
4.1.1. Number of districts that regularly develop AWP	***N/A***	*N/A*	**62.8%**	LSTM survey 2016	**N/A**	**100%**	**-37%**
4.1.2. Number of districts conducting regular annual review meeting	**N/A**	*N/A*	**63.2%**	LSTM survey 2016	**N/A**	**100%**	**-37%**
4.1.3.Number of districts regularly providing reports using the standard core indicators of the HMIS	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**100%**	**N/A**
4.1.4.1. Functional performance based contracting of health services is put in place (TBC)	**0**	*HTF logframe*	**100.0%**	*LSTM survey 2016*	**100%**	**80%**	**20%**
4.1.4.2. Functional system for health services fund is available at national level	**0**	*HTF logframe*	**100.0%**	*LSTM survey 2016*	**100%**	**80%**	**20%**
4.1.5. Proportion of Health facilites receiving regular financial support through the Health service fund to cover basic recurrent cost	**0**		**57.2%**	*LSTM survey 2016*	**57%**	**80%**	**-23%**
4.1.6. Number of quality assurance surveys conducted over the next five years	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**N/A**	**N/A**

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REQUEST FOR PROPOSAL ZIM/2012/015-0

RFP No. ZIM/2012/015-0 **Date: Friday, 05 October, 2012**

UNITED NATIONS CHILDREN'S FUND (UNICEF)

Invites Proposals for:

INSTITUTIONAL CONSULTANCY SERVICES TO CONDUCT AN INDEPENDENT EVALUATION OF THE HEALTH TRANSITION FUND IN ZIMBABWE

This is a **rebid of previous RFP ZIM/2012/008-0** which did not result in an award of an Institutional Contract.
Sealed Proposals should be sent/placed in the Bid Box (located in the Reception area of the UNICEF office). Proposals forwarded by mail or courier services must contain written instructions on the external envelope that allows the receiving mail agents to place the envelope in the Bid Box. The mailing address for Proposals is:

UNICEF Harare Office
6 Fairbridge Avenue
P.O. Box 1250
Belgravia, Harare
Zimbabwe

IMPORTANT – ESSENTIAL INFORMATION

The reference "RFP No. ZIM/2012/015-0" Subject: "**INSTITUTIONAL CONSULTANCY SERVICES TO CONDUCT AN INDEPENDENT EVALUATION OF THE HEALTH TRANSITION FUND IN ZIMBABWE**" must be written/typed on the envelope containing the Technical Proposal and on the envelope containing the Financial Proposal, as well as on the outer packaging containing both envelopes. Proposals must be submitted in four (4) copies, in a securely sealed envelope in accordance with the Instructions to Institutions attached to this RFP.

The Proposal MUST be received at the above address by latest **11:00 a.m.** Harare local time on **Thursday, 15 November 2012** and will be opened at the same day **Thursday, 15 November 2012**.

Proposals received after the stipulated date and time will be invalidated.

THE FORM *"RFP ZIM/2012/015-0 PROPOSAL FORM"* ON PAGE 6 MUST BE COMPLETED, SIGNED AND ATTACHED TO THE TECHNICAL PROPOSAL WHEN REPLYING TO THIS RFP. **E-mail replies will not be accepted in place of hard copies.**

Institutions, or their authorized representative, who obtain the minimum qualifying points for their Technical Proposals will be invited to attend the public opening of the Financial Proposals at the time, date and location specified. The Technical Proposal will not be opened publicly (please refer to Clause 2.3).

THIS REQUEST FOR PROPOSAL HAS BEEN:

Prepared By: Hla Aye, Supply & Logistics Section/ Dr. Assaye Kassie MNCH Manager/ Dr. Aboubacar Kampo Chief YCSD.

Approved By:
Wanda Krekel, Supply & Logistics Manager

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REQUEST FOR PROPOSAL ZIM/2012/015-0

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REQUEST FOR PROPOSAL ZIM/2012/015-0

PROPOSAL FORM

The PROPOSAL FORM on the opposite page *(**RFP ZIM/2012/015-0: PROPOSAL FORM**)* which is also attached as a separate *.pdf document must be completed, signed and returned to UNICEF together with your detailed Proposal and supporting documents. The Proposal must be made in accordance with the instructions contained in this Request for Proposal.

It is important that you read all of the provisions of the request for proposal, to ensure that you understand UNICEF's requirements and can submit a proposal in compliance with them. Note that failure to provide complete proposals may result in invalidation of your proposal.

TERMS AND CONDITIONS OF CONTRACT

Any Institutional Contract resulting from this RFP shall contain UNICEF's General Terms and Conditions and any other Specific Terms and Conditions as detailed herein.

INFORMATION

Any request for information concerning this RFP must be forwarded via e-mail to serviceszim@unicef.org or by fax +263 4 791163 to Supply & Logistics Section, with specific reference to the RFP number and subject. A copy of the request for information should be emailed to haye@unicef.org.

All efforts will be made to provide additional information expeditiously, but any delay in providing such information will not be accepted as a reason for extending the submission date of your Proposal. Requests for additional information/clarifications should reach serviceszim@unicef.org and Ms. Aye no later than **Friday, 02 November 2012**. Requests for additional information/clarifications received after this date may not be responded to.

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REQUEST FOR PROPOSAL ZIM/2012/015-0

RFP ZIM/2012/015-0: PROPOSAL FORM

This Proposal Form must be completed, signed and returned to UNICEF with your Proposal.

RFP No. ZIM/2012/015-0 INSTITUTIONAL CONSULTANCY SERVICES TO CONDUCT AN INDEPENDENT EVALUATION OF THE HEALTH TRANSITION FUND IN ZIMBABWE

The undersigned, having read the Terms and Conditions of RFP **No.** ZIM/2012/015-0 set out in the attached document, hereby offers to supply the services specified at the price or prices quoted, in accordance with the specifications stated and subject to the Terms and Conditions set out or specified in the document.

Name of authorized representative: _____

Title: _____

Signature: _____

Date: _____

Company Name: _____

Postal Address: _____

Telephone No.: _____

Fax No.: _____

E-mail Address: _____

Validity of Offer (not less than 90 days): _____

Currency of Offer: _____

Payment Schedule/Terms: _____

Please indicate, after having read **UNICEF Payment Terms** stated under **Discounts and Payment Terms**, Clause **2.8** if any cash discounts are offered by you for early payment:

10 days 3.0% _____ 15 days 2.5%_____ 20 days 2.0%_____ 30 days net_____

Other trade or item discounts: _____

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INSTITUTIONAL CONSULTANCY SERVICES TO CONDUCT AN INDEPENDENT EVALUATION OF THE HEALTH TRANSITION FUND IN ZIMBABWE

1.0 TERMS OF REFERENCE

1.1 ORGANIZATIONAL BACKGROUND

The United Nations Children's Fund (UNICEF), is mandated to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. Guided by the Convention on the Rights of the Child, UNICEF strives to establish children's rights as ethical international principles and standards of behavior towards children. UNICEF's role is to mobilize political will and material resources to help countries place children as a top priority. UNICEF is committed to ensuring special protection for the most disadvantaged children and in emergencies to protect the rights of children. UNICEF believes that nurturing and caring for children are the cornerstones of human progress and advocate for measures to give children the best start in life. UNICEF promotes girls' education and work to prevent the spread of HIV/AIDS among young people. Striving for peace and security, UNICEF works to hold everyone accountable to the promises made for children.

1.2 PURPOSE OF THE RFP

This Request for Proposal (RFP) is issued to identify qualified institutions to undertake an independent evaluation of the Health Transition Fund (HTF) in support of the HTF steering committee.

The RFP is open to experienced, qualified institutions only – either in the private sector or civil society organizations – who have conducted high level Monitoring and Evaluation and Reporting work in similar context previously.

1.3 NATURE OF CONSULTANCY:

The Health Transition Fund (HTF) is a multi-donor pooled fund, managed by UNICEF, to support the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe to "achieve the highest possible level of health and quality of life for all Zimbabweans. The HTF initially focuses on the following four thematic areas, but according to the burden of diseases and available financial resources this could be extended to other areas as included in the National Health Strategy for Zimbabwe (2009-2013). The four thematic areas are:

1) Maternal, newborn and child health and nutrition
2) Medical products, vaccines and technologies (Medicines and commodities)
3) Human resources for health (Health worker management, training and retention)
4) Health policy, planning and finance (Health Services Fund and Research)

The HTF is governed by a Steering Committee, co-chaired by the MoHCW and a donor representative. Steering Committee members include all funding partners, UN agencies, representatives from civil society and other health development partners. UNICEF serves as the Secretariat

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The Prime purpose of the Evaluation is to assess to what extent the HTF strategies, approaches and the overall intervention logic have contributed to change in people's health, with special focus to Maternal, New-born and Child health, and to evaluate whether the resources have been used in the most efficient way to achieve those changes.

Specific objectives of the independent Evaluation include:

- To assess the HTF program implementation against the goals and objectives set in the HTF Logical framework and the evaluation criteria endorsed by the OECD-DAC, namely **relevance, effectiveness, efficiency, sustainability and impact.**
- To assess the HTF's effectiveness in reaching the target populations and vulnerable groups and to see how well the HTF transformed the available resources into the intended outputs and outcomes in terms of quantity, quality and timeliness of delivery (value for money)
- To conduct robust in-depth analysis of the four key thematic areas to support the evaluation conclusions

Evaluation Methodology

The HTF Steering Committee expects the final evaluation to be based on a robust methodology, drawing upon best practice for evaluations to the extent possible. The HTF Evaluation Institution or consultants will present an evaluation framework with detailed methodology, which includes both quantitative and qualitative elements, designed to accurately address the key questions.

The methodology for in-depth questions will show outline information available, a clear problem statement, questions and issues to be covered, assumptions to be tested, sampling, methods, quality assurance measures, and how data will be analysed and reported. The methodology will describe the rationale for this methodology, and the feasibility and the accuracy, comprehensiveness and usefulness of the findings that can be expected.

1.4 WORK ASSIGNMENTS:

Based on the following Elements of the Impact Evaluation:

- ***A baseline assessment***: This information will primarily come from the 2012 National Integrated Health Facility Assessment, the 2011 DHS, and 2010 MIMS and from the 2011 routine administrative reports of the MoHCW as indicated in the HTF log frame**.**
- ***Annual Reviews:*** Review of annual achievements, challenges and opportunities. HTF annual monitoring results will be used for the annual reviews.
- ***Mid Term Review (MTR):*** This is intended to report on the overall HTF progress and also provides an opportunity to reorient priorities if required in order to achieve key program goals
- ***Final Impact Evaluation*****:** This is to document the final program achievements, lesson learned and the effectiveness of the HTF. It will be conducted in the final year of the HTF life span.

The HTF Evaluation Institution or consultants are expected to implement the following steps while developing the evaluation work plan with an appropriate time frame:

- Plan and organize the evaluation
- Develop the evaluation matrix

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- Identify key indicators from the HTF log frame and recommend new indicators and other information needs when necessary
- Identify and organize baseline information from available sources
- Collect and process the necessary data for evaluation
- Analyze and critically reflect on all findings
- Communicate findings, drawing linkages between findings and program effectiveness and efficiency
- Compile and report final evaluation findings

Management of the Evaluation

Although the impact evaluation activity will be conducted independently from the implementation of the HTF by an independent evaluation Institution, it is also proposed that this Institution report to the HTF Steering Committee through an Evaluation Sub-committee established specifically for this purpose.

Therefore, the role of the HTF evaluation subcommittee with respect to this task will be:

- To commission and oversee the evaluation, and the contracting process by the HTF Steering Committee
- To conduct a technical appraisal of the Evaluation proposals received
- To ensure that the evaluation team has access to and has consulted all relevant information sources and documents related to the programme
- To approve the evaluation plan and design report with proposed evaluation framework and methodology
- To provide timely questions of clarification on notes and reports delivered by the evaluation team
- To assist in communication of the findings, conclusions, lessons learned and recommendation from the evaluation

Planning Phase

The selected institution or Institutions will be responsible for the entire evaluation of Health Transition Fund. The institution in consultation with the HTF Evaluation sub-Committee will develop a work plan, Evaluation matrix showing how in-depth area analysis will support the synthesis of information for the overall report, and how different methods and respondents will be deployed to explore topics to answer evaluation criteria, detail Evaluation methodology and reporting template to be used throughout the duration of the contract will also be prepared during the planning phase.

Implementation Phase

The institution will implement the independent Evaluation through the following Elements of Evaluation:

- ***A baseline assessment***: This information will primarily come from the 2012 National Integrated Health Facility Assessment, the 2011 DHS, and 2010 MIMS and from the 2011 routine administrative reports of the MoHCW as indicated in the HTF log frame**.**
- ***Annual Reviews:*** Review of annual achievements, challenges and opportunities. HTF annual monitoring results will be used for the annual reviews.
- ***Mid Term Review (MTR):*** This is intended to report on the overall HTF progress and also provides an opportunity to reorient priorities if required in order to achieve key program goals
- ***Final Impact Evaluation*****:** This is to document the final program achievements, lesson learned and the effectiveness of the HTF. It will be conducted in the final year of the HTF life span. In drawing together the Final Impact Evaluation, the Institution or the team of consultants will conduct detailed analysis in the four

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thematic areas. Evaluation criteria and in-depth questions to be assessed for the final HTF evaluation will be attached in *Annex 4*

Reporting Phase

The standalone reports of the in-depth questions should adhere to quality standards of peer-reviewed academic publications. The main report should have excellent analytical quality and writing, but will be written in clear, crisp language, understandable to an informed lay reader.

The text of the report and annexes should be illustrated, as appropriate, with maps, graphs and tables.

The Institution or team will submit the following reports:

Initial preparatory report (maximum 20 pages) to be produced after 15 days from signing the contract and start of the mission. In this report the team will provide an evaluation framework with detailed methodology and detailed budget and time frame, the foreseen degree of difficulties in collecting data, other encountered and/or foreseen difficulties in addition to their detailed methodology, programme of work and staff mobilization.

This report will outline the four phases of the evaluation process: the baseline assessment, the annual review, the mid-term review and the final impact evaluation. This report will serve as a basis for the debriefing meeting of this phase of the mission with the HTF Evaluation Sub-committee. This report will need to be formally approved by the HTF Steering Committee before the Institution/consultants move to the next phase of the evaluation process. In addition to the preparatory report, the Institution is expected to submit the following reports for the Annual Review, MTR and the Final Impact Evaluation

Preliminary report (maximum 20 pages) for each of the evaluation processes (Annual review, MTR and Final Impact Evaluation). The preliminary report is to be submitted after the data collection and field phase, and the analysis and synthesis phase is completed. This report will be submitted to the HTF Evaluation Subcommittee for technical review.

Draft final report (of maximum 40 pages + annexes) taking into account the clarification comments received from the Evaluation Sub-committee on the preliminary report. Besides answering the evaluation questions, the final report should also synthesis findings and conclusions to form an overall assessment of the HTF. The draft report will contain the required annexes each addressing the in-depth areas for analysis, using scientific rigor to report methodology, findings and conclusion.

The final draft will be submitted 15 days after the end of the mission, and the HTF Steering Committee will provide comments on it 15 days after reception.

Final report (of maximum 40 pages + annexes)**.** After incorporating the comments and feedbacks from the HTF Evaluation Subcommittee and HTF Steering Committee, the final evaluation report will be submitted to the HTF Steering Committee. The final report will be presented within 15 days of receiving the comments and feedback from the Steering Committee.

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Key outputs

The Institution or consultants are expected to produce candid, uncompromising, high quality reports, containing well-evidenced findings and clear conclusions and recommendations. These reports will be initially submitted to the Evaluation Sub-committee and through them to the HTF Steering Committee

1.5 WORK SCHEDULE:

1. Baseline assessment at the beginning of the project, December 2012/January,2013
2. Annually for the annual reviews
3. After 2 years the Midterm review
4. After four years the final impact evaluation

1.6 END PRODUCT(S):

1. Initial Preliminary report
2. The baseline Report : Preliminary report, draft final and final report
3. Annual Review report (monitoring and JRM) : Preliminary report, draft final and final report
4. Mid –Term review report : Preliminary report, draft final and final report
5. Final Impact Evaluation : Preliminary report, draft final and final report

1.7 ESTIMATED DURATION OF CONTRACT:

It is expected that this assignment will take place over the next three+ year period, from November 2012 to December 2015 *Annex 5*

1.8 OFFICIAL TRAVEL INVOLVED

For all the four stages of HTF Evaluation the institution is expected to have an official travel to the Provinces, districts and when necessary to the health facilities and to the community and this has to be clearly mentioned in the detail implementation plan of the independent Evaluation

1.9 QUALIFICATIONS OR SPECIALIZED KNOWLEDGE/EXPERIENCE REQUIRED:

The Evaluation Institution or team should comprise a multidisciplinary team that collectively includes the following skills and knowledge:

- Relevant post-graduate technical qualifications and at least ten years' experience in health programme evaluation
- Demonstrated skills and experience in leading similar large scale evaluations; including with highly developed management and negotiation skills and high level analytical and writing skills

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- Strong previous experience in conducting qualitative and quantitative research and program evaluations in less developed countries
- Skills and experience in health economics is essential, including costing, cost effectiveness and cost benefit analysis
- Skills and experience in epidemiology, and impact analysis in developing countries, particularly in sub-Saharan Africa
- Understanding of health systems strengthening approaches and service delivery within a constrained operational environment, with Zimbabwe experience desirable
- Experience in analysis and evaluation of gender, social and poverty analysis, and equity issues in health.
- Experience of working with different stakeholders and through local consultants and research or health institutions to deliver a quality product and providing advice and skills development where required
- Previous experience of similar work in countries that are emerging from serious health system crises and are in transition to recovery and development
- Experience in conducting national level evaluations in Zimbabwe or other countries.
- Fluent English (both spoken and written) is essential.

1.10 TYPE OF SUPERVISION THAT WILL BE PROVIDED:

The UNICEF Young Child Survival and Development Section (YCSD), in close consultation with the HTF Steering Committee, will be responsible for overseeing the entire work assignment, including the dissemination of the expected reporting deliverables.

1.11 CONSULTANT'S WORK PLACE:

The institution is expected to work from its own premises, with official travel to Provinces, Districts, Health facilities and conduct local household and community visits when necessary.

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REQUEST FOR PROPOSAL ZIM/2012/015-0

2.0 RFP TERMS, CONDITIONS AND INSTUCTIONS

2.1 MARKING AND RETURNING OF PROPOSALS

SEALED PROPOSALS, clearly marked on the outside with the RFP number, must be dispatched to arrive at the UNICEF office and placed in the Bid Box in the reception area NO LATER THAN **11:00 a.m.** Harare local time on **Thursday, 15 November 2012**. Proposals received in any manner other than as outlined below, and Proposals received after this date and time, will be INVALIDATED. **Proposals submitted by e-mail will not be accepted in place of hard copies**.

Proposals shall be submitted in English with four (4) original copies, duly signed and dated, and **accompanied by an electronic version of the offer on a CD**. Proposals shall be sealed in an outer and two inner envelopes. All envelopes shall indicate the institution's name and address. The **outer envelope** shall be addressed as follows:

Name & Address of the Institution

UNICEF Harare Office
6 Fairbridge Avenue
P.O. Box 1250
Belgravia, Harare, Zimbabwe

PLEASE PUT THIS ENVELOPE INTO THE BID BOX LOCATED IN THE RECEPTION AREA OF THE UNICEF OFFICE

RFP ZIM/2012/015-0 DUE DATE: **Thursday, 15 November 2012**

The **first inner envelope** shall be marked "**Technical Proposal" and addressed in the same manner as the outer envelope**, and shall contain all documentation and CD relevant to the Technical Proposal. The Form **"RFP ZIM/2012/015-0: PROPOSAL FORM"** on page 6 must be completed, signed and attached to the Technical Proposal.

The **second inner envelope** shall be marked "**Financial Proposal", sealed and addressed in the same manner as the outer envelope**. A separate CD with the electronic version of the Financial Proposal must be included in the Financial Proposal's envelope.

All proposals must be placed in the designated Bid Box located in the reception area of the UNICEF Harare Office. If the proposal is being sent via courier services (i.e., FedEx, DHL, UPS, etc.), the courier service provider should be instructed to place the proposal in the Bid/Tender Box. Appropriate instructions to this effect are the responsibility of the participating institution. UNICEF undertakes no responsibility in the event the delivery courier service fails to place the proposal envelope into the Bid/Tender Box.

Offers delivered at a different address or in a different form than prescribed in this RFP, or which do not respect the required confidentiality, or received after the designated time and date, will be rejected.

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2.2 TIME FOR RECEIVING PROPOSALS

Sealed Proposals received prior to the stated closing time and date will be kept unopened in the Bid Box. The Officer of the Bid Opening Unit will open Proposals at the specified time and no Proposal received thereafter will be considered.

UNICEF will accept no responsibility for a premature opening of a Proposal which is not properly addressed or identified. Any delays encountered in the mail delivery will be at the risk of the institution.

Modification of sealed Proposals already submitted in a sealed envelope will be considered if notice is received by fax prior to the stated closing time and date.

All references to descriptive materials should be included in the appropriate response paragraph, though the material/documents themselves may be provided as annexes to the proposal/response.

The institution must also provide sufficient information in the Technical Proposal to address each area of the Technical Proposal Evaluation to allow the evaluation team to make a fair assessment of the candidates and their proposal.

2.3 PUBLIC OPENING OF PROPOSALS

There will not be a public opening of the Technical Proposal. The Technical Proposals will be opened by an internal UNICEF Bidding Committee at the stipulated opening date and time mentioned above. Acknowledgements of Proposals from participating Institutions will communicated in writing by **Tuesday 20 November 2012**. All proposals will then be reviewed by a Technical Evaluation Panel.

Following successful conclusion of the Technical Proposal, the Financial Proposals of Institutions that have obtained the minimum qualifying points for their Technical Proposals will be invited to attend the public opening of the Financial Proposals currently planned for **11:00 a.m.** on **Tuesday 27 November 2012**. Qualifying Institutions may attend this public opening or send an authorized representative with appropriate identification to attend the public opening of the Financial Proposal.

The Financial Proposals will be combined with the evaluation results of the Technical Proposal for a final adjudication to identify the Best and Final Offer (BAFO) no later than **Thursday, 06 December 2012.**

2.4 REQUEST FOR INFORMATION

All requests for information/clarification or queries concerning this RFP must be forwarded via e-mail to serviceszim@unicef.org or by fax +263 4 791163 to the Supply & Logistics Section, with specific reference to the RFP number and subject.

Only written, email or fax inquiries will be entertained. Please be informed that if the question is of common interest, the answer will be shared with all potential RFP institutions.

All efforts will be made to provide additional information expeditiously, but any delay in providing such information will not be accepted as a reason for extending the submission date of your Proposal. Requests for additional information/clarifications should reach UNICEF **no later than Friday, 02 November 2012.** Requests for additional information/clarifications received after this date may not be addressed.

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2.5 RFP RESPONSE

Formal submission requirements
The formal submission requirements as outlined in this Request for Proposal must be followed, e.g. regarding Proposal Form, timing of submission, marking of the envelopes, etc.

Mandatory criteria
All mandatory (i.e. must/have to/shall/should) criteria mentioned throughout this Request for Proposal have to be addressed and met in your proposal.

Technical Proposal
The Technical Proposal should address all aspects and criteria outlined in this Request for Proposal, especially in the Terms of Reference detailed in Section 1.0 of this Request for Proposal. UNICEF welcomes new ideas and innovative approaches. Technical Proposals must be complete and provide all relevant support documentation to enable the RFP Evaluation Team to adequately assess and evaluate the Proposal.

At a minimum, the Technical Proposal must include:

a. Detailed Overview of the Institution:
   - Profile
   - History
   - Scope of services
   - Management, operations and organizational structure
   - Organization (include affiliations or associations with other professional firms and/or consultants)
   - Supporting documentation on the financial status of the institution
   - Evidence/samples of previous evaluations conducted of Health Sector at national level or similar national level evaluation.

b. Approach to the work, including methodology
c. Work Plan with deliverables and schedule
d. Profile of the Team and qualifications including detailed CV of all key personnel
e. References – Institution shall provide details of the names, addresses and contact details of 2-4 clients for whom the same type of services were provided in various and disperse geographical locations (please complete the attached **Bid Experience and Reference Form in Annex 1**). UNICEF reserves the right to contact these references without notifying the participating institution.
f. Subcontractors – Participating Institutions must identify and clearly state in their proposal any services which may be subcontracted from another institution. UNICEF reserves the right to review all subcontracting parties prior to award.

No financial/price information should be contained in the technical proposal.

Financial Proposal
The **Financial Proposal** must include costs for all the services to be provided including aspects mentioned in **TABLE 1 - EVALUATION ASSESSMENT CRITERIA.** The currency of the Financial Proposal must be in **US Dollars**.

At a minimum, the Financial Proposal should include all professional costs/consultancy fees, daily living allowance (in line with UN rates), administrative fees and transport costs. The institution will be responsible for its own travel costs to Zimbabwe (if not currently located in-country), as well as travel costs within Zimbabwe to conduct the field visits. In addition, the institution is expected to be equipped with all necessary data collection tools, including laptops and related software.

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Institutions are requested to propose a reasonable and realistic payment schedule and payment terms in accordance with the deliverables and complete evaluation plan as part of the financial response of this RFP. All payment schedules and terms must be in line with global UNICEF policies and procedures.

Information which the institution considers to be proprietary should be clearly marked "proprietary", if any, next to the relevant part of the text. All information provided by the institution will be treated as confidential and used for UNICEF's internal purposes only.

Checklist to guide institutions in submission of proposals:

☑ **RFP ZIM/2012/015-0 Proposal Form** filled in and signed

☑ Envelope for **technical proposal**
- Technical proposal
- CD with electronic files
- **RFP ZIM/2012/015-0 Proposal Form**
- Technical proposal does not contain prices
- Envelope is sealed
- Envelope is marked as follows:
  Name of company, RFP number and subject, opening date and time, "Technical Proposal"

☑ Envelope for **Financial Proposal**
- Financial proposal
- CD with electronic files
- Envelope is sealed
- Envelope is marked as follows:
  Name of company, RFP number and subject, opening date and time, "Financial Proposal"

☑ 1 outer enveloped
- Containing ☑ Technical Proposal Envelope and ☑ Financial Proposal Envelope
- Envelope is sealed
- Envelope is marked as per details in **2.1**

2.6 CORRECTIONS, MODIFICATION AND WITHDRAWAL

Erasures or other corrections in the proposal must be explained and the signature of the institution shown alongside. Institutions are expected to examine all instructions pertaining to the work. Failure to adequately cover all technical and financial aspects will be at the institution's own risk and disadvantage.

All changes to a Proposal must be received prior to the closing time and date. It must be clearly indicated that it is a modification and that it supersedes the earlier Proposal or states the changes from the original Proposal.

Proposals may be withdrawn on written or faxed request received from Institutions prior to the opening time and date. Negligence on the part of the Institution provides no right for the withdrawal of the Proposal after it has been opened.

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2.7 VALIDITY OF PROPOSALS

Proposals should be valid for a period of not less than 90 days after RFP opening, and must be signed by an authorized representative of the Institution in question. Proposals must indicate the period of validity as UNICEF reserves the right to consider or award additional contracts against the Best and Final Offer (BAFO) if requests for identical services are received during the validity period of the Proposal. UNICEF may also request the validity period to be extended if necessary.

2.8 DISCOUNTS AND PAYMENT TERMS

UNICEF'S standard payment terms are net 30 days after delivery of contractual milestones agreed to in the Contract, acceptance of the deliverables by UNICEF and receipt of Company's Invoice in duplicate. Payment will be effected by bank transfer in the currency of billing.

UNICEF offers standard cash discounts for early payment as follows: 3.0% for payment within 10 days, 2.5% for payment within 15 days; and 2.0% for payment within 20 days. Alternative discount proposals may be offered. Time in connection with discounts offered will be computed from the date of receipt at UNICEF office of **complete payment documentation** as specified in the Contract. Any discounts for any reason other than those mentioned on the RFP Form must be stated in the Proposal Form.

2.9 LATE DELIVERY

Without limiting any other rights or obligations of the parties hereunder, if the Institution will be unable to deliver the services by the delivery date stipulated in the Contract, the Institution shall (i) immediately consult with UNICEF to determine the most expeditious means for delivering the services and (ii) use an expedited means of delivery, at the Institution's cost, if reasonably so requested by UNICEF.

2.10 FAILURE TO PERFORM

In case of failure by the Institution to perform under the terms and conditions of the Contract, UNICEF may, after giving the Institution reasonable notice to perform and without prejudice to any other rights or remedies, exercise one or more of the following rights:

a. Procure all or part of the services from other sources, in which event UNICEF may hold the Institution responsible for any excess cost occasioned thereby. In exercising such rights UNICEF shall mitigate its damages in good faith;
b. Refuse to accept delivery of all or part of the services;
c. Terminate the Contract without any liability for termination charges or any other liability of any kind;
d. For late delivery of services or for services which do not meet UNICEF's terms of reference/statement of work and are therefore rejected by UNICEF, claim liquidated damages from the Institution and deducts 0.5% of the value of the services pursuant to a Contract per additional day of delay, up to a maximum of 10% of the value of the Contract. The payment or deduction of such liquidated damages shall not relieve the Institution from any of its other obligations or liabilities pursuant to this Contract.

2.11 RIGHTS OF UNICEF

Intellectual Property Rights to be specified in the Contract:

1. All intellectual property rights with regard to material which bear a direct relation to or is made in consequence of, the services provided by the Institution in compliance with the requirement of any contract

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arising from this RFP, including those related to any programming or innovations used, reports and documents shall be considered the property of UNICEF.

2. Institutions may only use the official logo and name of UNICEF/its funding partners in connection with this Contract and with the prior written approval of UNICEF.

Rights pertaining to the RFP and competitive bidding process:

This RFP, along with any responses there to, shall be considered the property of UNICEF and the responses will not be returned to their originators.

UNICEF reserves the right to accept any proposal, in whole or in part; or, to reject any or all proposals. UNICEF reserves the right to invalidate any Proposal received from an Institution who has previously failed to perform properly or complete contracts on time, or a Proposal received from an Institution who, in the opinion of UNICEF, is not in a position to perform the contract. UNICEF shall not be held responsible for any costs incurred by the Institution in preparing the response to this Request for Proposal. The Institution agrees to be bound by the decision of UNICEF as to whether her/his proposal meets the requirements stated in this Request for Proposal.

UNICEF will treat in confidence those parts of the RFP proposal that are marked "Confidential" by the Institution.

Specifically, UNICEF reserves the right to:

- Contact any or all references supplied by the Institution
- Request additional supporting or supplementary data (from the Institution)
- Arrange interviews with the proposed project team/consultants
- Visit and inspect the Institution's premises
- Reject any or all of the proposals submitted
- INVALIDATE any Proposal received from an Institution who, in the opinion of UNICEF, is not in a position to perform the Contract
- Accept any Proposals in whole or in part
- Negotiate with the service provider(s) who has/have attained the best rating/ranking, i.e. the one(s) providing the overall best value proposal(s);
- Contract any number of institutions as required to achieve the overall evaluation objectives

2.12 EVALUATION OF PROPOSALS

After the opening of the RFP, Technical Proposals will be evaluated by a multidisciplinary Technical Evaluation Panel. The Technical Evaluation will be restricted to the contents of the Technical Proposal and supporting documents submitted.

Evaluation of the **Technical Proposal** will be completed prior to evaluation of the **Financial Proposal.** The Proposal must contain complete documentation and information required for UNICEF to comprehensively evaluate each Proposal in accordance with the Evaluation Assessment Criteria contained in Table 1.

The **Technical Proposal** has a total possible evaluation value of **75** points. **Technical Proposals receiving** 55 points or higher, will be considered technically compliant and the relevant Financial Proposal will be opened. Proposals which are not considered to be technically compliant and non-responsive will not be given further consideration.

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The total number of points allocated for the **Financial Proposal** is **25**. Points will be awarded on the basis of the best overall value. The Financial Evaluation will consider not only costs, but also review the items listed in the Financial Proposal Evaluation Assessment Criteria contained in Table 1. The Proposal must contain a payment schedule for the Contract, linked to unambiguous Contract milestones/deliverables. All prices/rates quoted must list/state all taxes separately as applicable as UNICEF is entitled to local tax reimbursement against proof of payment. Institutions that incur tax-related expenditure in Zimbabwe will be reimbursed such expenses at the time of payment as long as the relevant taxes are listed as a separate item on the Invoice. Presentation, details and clarity of Financial Proposals will influence the final assessment.

In addition to the Technical and Financial Evaluations, UNICEF reserves the right to conduct an independent, administrative validation exercise to ensure that potential institutions meet the minimum legal, financial and structural suitability requirements. Institutions that do not meet such requirements could be disqualified.

The most-favoured Proposal will be selected on the basis of the Best and Final Offer (BAFO) to UNICEF in terms of both Technical and Financial Scores.

All references to descriptive material and brochures should be included in the appropriate response paragraph, though the material/documents themselves may be provided as annexes to the Proposal.

The institution must also provide sufficient information in the Proposal to address each area of the Evaluation Assessment Criteria in Table 1 to allow the evaluation team to make a fair assessment of the individual/company and their capacity to execute the services offered in the Proposal.

Information, which the institution considers proprietary, should be clearly marked "proprietary", if any, next to the relevant part of the text, and UNICEF will treat such information accordingly.

2.13 RFP AND DESIRABLE CONTRACT IMPLEMENTATION SCHEDULE

The schedule of the contractual process and **targeted dates for execution** of this RFP are as follows, subject to revision depending on program and government partners' priority and availability:

1) Last date to request clarifications/further information on RFP: **Friday, 02 November 2012**.
2) Closing date of Proposal (RFP) submission: **Thursday, 15 November 2012**
3) Opening of Technical Proposals: **Thursday, 15 November 2012**
4) Acknowledgement of receipt of Technical Proposals to Participating Institutions: **Tuesday 20 November 2012**
5) Clarifications and fine tuning of Technical Proposals by Technical Evaluation Panel: **Wednesday, 21 November 2012**
6) Public opening of Financial Proposals (tentative): **Tuesday 27 November 2012***(tentative date)*
7) Contract award notification to selected institution(ies): **Thursday, 06 December 2012** ***(tentative date)***
8) Implementation date to start contract work: **to be mutually agreed depending upon details of Proposals.**
9) Completion of all contracted works as indicated in the Terms of Reference and this RFP: approximately **31 December 2015**. The actual work plan and schedule will be established based on the successful Proposal.

Institutions are encouraged to submit realistic timeframes closely linked to the period of time when the team of proposed consultants is available to undertake this project. Preparation time required to start implementation of Contract action should be mentioned in your response.

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2.14 FULL RIGHT TO USE AND SELL

The institution warrants that it has not and shall not enter into any agreement or arrangement that restrains or restricts UNICEF or the recipient Governments rights to use, sell, dispose of or, otherwise, deal with any item that may be acquired under any resulting Contract.

2.15 ETHICS, UNETHICAL BEHAVIOUR, CORRUPT AND FRAUDULENT PRACTICES

UNICEF strictly enforces a policy of zero tolerance concerning unethical, unprofessional or fraudulent acts. Accordingly, companies or individuals that are found to have undertaken unethical, unprofessional or fraudulent activities will be suspended or forbidden from business relations with UNICEF.

UNICEF requires that all institutions associated with this Request for Proposal observe the highest standard of ethics during procurement and execution of the work, fully complying with international Codes of Conduct and in particular, but without limiting the foregoing. Institutions are expected to conduct themselves in a manner consistent with the ***UN Evaluation Group Ethical guidelines for Evaluation*** attached to this RFP for your easy reference ***(Annex 3),*** the Standards of Conduct in the International Civil Service, UNICEF Standards of Electronic Conduct and the requirements set forth in the Secretary General's Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse, both of which are incorporated by reference into the contract between the Institution and UNICEF

In pursuance of these policies UNICEF

a. defines for the purpose of this provision the terms set forth as follows:
   i. corrupt practice means the offering, giving, receiving or soliciting of anything of value to influence the action of a public official in the procurement process or in the execution of a contract, and
   ii. fraudulent practice means a misrepresentation of facts in order to influence a procurement process or the execution of a contract to the detriment of the client, and includes collusive practice among institutions (prior to or after bid submission) designed to establish bid prices at artificial non-competitive levels and to deprive the client of the benefits of free and open competition;

b. will reject a proposal for award if it determines that the selected supplier/Institution have engaged in any corrupt or fraudulent practices in competing for the contract in question;

c. will declare an institution ineligible, either indefinitely or for a stated period of time, to be awarded a UNICEF-financed contract if at any time it determines that it has engaged in any corrupt or fraudulent practices in competing for, or in executing a UNICEF-financed contract.

2.16 GUIDELINES ON GIFTS AND HOSPITALITY

Institutions shall not offer gifts or hospitality to UNICEF staff members. Recreational trips to sporting or cultural events, theme parks or offers of holidays, transportation, or invitations to extravagant lunches or dinners are also prohibited.

2.17 CONTRACTUAL TERMS AND CONDITIONS

The UNICEF General Terms and Conditions for Institutional/Corporate Contracts included as Annexe 2 to this RFP will form part of any contract resulting from this RFP. A UNICEF Institutional Contract will be awarded to the successful Institution. .

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TABLE 1 - EVALUATION ASSESSMENT CRITERIA

Technical Proposal	Points
1. OVERALL RESPONSE - Demonstrated understanding of requirements, objectives and deliverables. - Demonstrated understanding of scope, including ability to perform the work assignments articulated in this RFP. - Adequacy of the technical plan demonstrated through the overall concord between RFP requirements and the Proposal submitted. - Demonstrated understanding of health systems specifically of health systems in Zimbabwe - Workplan, Methodology and Timeline. - Overall clarity and completeness of the Proposal.	**15**
2. STRATEGY/METHODOLOGY - Quality of proposed approach/methodology. - Quality of proposed Implementation Plan, i.e. how the institution will undertake and execute each stage, with proposed project schedules	**20**
3. PROPOSED TEAM - Structure, qualifications, experience and skills of proposed Team to undertake this assignment. - Team leader: relevant experience leading similar projects, qualifications and position with the institution. - List of Access and ability to identify, manage and support networks of qualified community-based data collection personnel.	**20**
4. Evidence-supported TECHNICAL CAPACITY and Institution's Company Profile - Company Profile assessment of the Institution to be based on documents and other information submitted with this proposal. Review will include (but is not limited to) the following areas as relevant: facilities and resources; reputation, competence and reliability, litigation and arbitration history, financial standing, legal establishment of company to conduct business; proven ability to manage complex projects of a similar nature and deliver within tight timelines. - Range and depth of relevant experience in conducting similar projects including experience in research in development sector. - **Sample of previous evaluation conducted in Health Sector at National Level or similar National Level Evaluation essential** - Financial status - References of clients for whom the institution has carried out similar studies. (UNICEF may contact references for feedback on institution). ***NOTE: Institutions that fail to submit relevant documentation that will enable a thorough review of the Intuition in all relevant areas, do so at their own risk and will be subject to disqualification or penalty of reduced points. The assessment of the Institution will be made on the basis of documents submitted for review in the Proposal.***	**20**
Financial Proposal	
5. FINANCIAL Assessment/review will include: - Overall Price. - Cost benefit comparison related to number and quality of personnel in the Proposal who will execute the Study and plan to monitor implementation (quality of staff, no of trips etc.). - **Completeness of the Financial Proposal** (ensure that all costs, including professional fees, costs of travel, salaries, insurance, etc. are included in the price offered). - **Payment terms/schedule of payment proposed.** - Timeline proposed. - Period of validity of Proposal.	**25**
TOTAL MARKS	**100**

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ANNEX 1:

INSTITUTION'S EXPERIENCE AND REFERENCE FORM

As part of the Technical Proposal, please provide information on minimum 1-3 assignments for which your institution and your institution's personnel were legally contracted during the last 3 years either individually as a corporate entity or as one of the major institutions within an association, for carrying out services related to the assignment outlined in this advertisement. Experience with UNICEF, other UN Agencies, Government, other bilateral and multi-lateral development agencies and international NGOs should be included.

Project # 1

Name of Client and reference contact address/email:	
Assignment name:	Duration of assignment (months): Start date (month/year): End date (month/year):
Approx. value of the contract (in USD):	Total number of staff of the assignment:
Narrative description of Project: (attach sample of final report/publication if applicable)	

Project # 2

Name of Client and reference contact address/email:	
Assignment name:	Duration of assignment (months): Start date (month/year): End date (month/year):
Approx. value of the contract (in USD):	Total number of staff of the assignment:
Narrative description of Project: (attach sample of final report/publication if applicable)	

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Project # 3

Name of Client and reference contact address/email:	
Assignment name:	Duration of assignment (months): Start date (month/year): End date (month/year):
Approx. value of the contract (in USD):	Total number of staff of the assignment:
Narrative description of Project: (attach sample of final report/publication if applicable)	

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ANNEX 2: UNICEF GENERAL TERMS AND CONDITIONS

GENERAL TERMS AND CONDITIONS FOR INSTITUTIONAL/CORPORATE CONTRACTS

1. ACKNOWLEDGMENT COPY

Signing and returning the acknowledgment copy of a contract issued by UNICEF or beginning work under that contract shall constitute acceptance of a binding agreement between UNICEF and the Contractor.

2. DELIVERY DATE

Delivery Date to be understood as the time the contract work is completed at the location indicated under Delivery Terms.

3. PAYMENT TERMS

(a) UNICEF shall, unless otherwise specified in the contract, make payment within 30 days of receipt of the Contractor's invoice which is issued only upon UNICEF's acceptance of the work specified in the contract.

(b) Payment against the invoice referred to above will reflect any discount shown under the payment terms provided payment is made within the period shown in the payment terms of the contract.

(c) The prices shown in the contract cannot be increased except by express written agreement by UNICEF.

4. LIMITATION OF EXPENDITURE

No increase in the total liability to UNICEF or in the price of the work resulting from design changes, modifications, or interpretations of the statement of work will be authorized or paid to the contractor unless such changes have been approved by the contracting authority through an amendment to this contract prior to incorporation in the work.

5. TAX EXEMPTION

Section 7 of the Convention on the Privileges and Immunities of the United Nations provides, inter alia, that the UN, including its subsidiary organs, is exempt from all direct taxes and is exempt from customs duties in respect of articles imported or exported for its official use. Accordingly, the Vendor authorizes UNICEF to deduct from the Vendor's invoice any amount representing such taxes or duties charged by the Vendor to UNICEF. Payment of such corrected invoice amount shall constitute full payment by UNICEF. In the event any taxing authority refuses to recognize the UN exemption from such taxes, the Vendor shall immediately consult with UNICEF to determine a mutually acceptable procedure.

Accordingly, the Contractor authorizes UNICEF to deduct from the Contractor's invoice any amount representing such taxes, duties, or charges, unless the Contractor has consulted with UNICEF before the payment thereof and UNICEF has, in each instance, specifically authorized the Contractor to pay such taxes, duties or charges under protest. In that event, the Contractor shall provide UNICEF with written evidence that payment of such taxes, duties or charges has been made and appropriately authorized.

6. LEGAL STATUS.

The Contractor shall be considered as having the legal status of an independent contractor vis-a-vis UNICEF. The Contractor's personnel and sub-contractors shall not be considered in any respect as being the employees or agents of UNICEF.

7. CONTRACTOR'S RESPONSIBILITY FOR EMPLOYEES

The Contractor shall be responsible for the professional and technical competence of its employees and will select, for work under this Contract, reliable individuals who will perform effectively in the implementation of the Contract, respect the local customs and conform to a high standard of moral and ethical conduct.

8. INDEMNIFICATION

The Contractor shall indemnify, hold and save harmless and defend, at its own expense, UNICEF, its officials, agents, servants and employees, from and against all suits, claims, demands and liability of any nature or kind, including their costs and expenses, arising out of the acts or omissions of the Contractor or its employees or sub-contractors in the performance of this Contract. This provision shall extend, inter alia, to claims and liability in the nature of workmen's compensation, product liability and liability arising out of the use of patented inventions or devices, copyrighted material or other intellectual property by the Contractor, its employees, officers, agents, servants or sub-contractors. The obligations under this Article do not lapse upon termination of this Contract.

9. INSURANCE AND LIABILITIES TO THIRD PARTIES

(a) The Contractor shall provide and thereafter maintain insurance against all risks in respect of its property and any equipment used for the execution of

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this Contract.

(b) The Contractor shall provide and thereafter maintain all appropriate workmen's compensation and liability insurance, or its equivalent, with respect to its employees to cover claims for death, bodily injury or damage to property arising from the execution of this Contract. The Contractor represents that the liability insurance includes sub-contractors.

(c) The Contractor shall also provide and thereafter maintain liability insurance in an adequate amount to cover third party claims for death or bodily injury, or loss of or damage to property, arising from or in connection with the provision of work under this Contract or the operation of any vehicles, boats, airplanes or other equipment owned or leased by the Contractor or its agents, servants, employees or sub-contractors performing work or services in connection with this Contract.

(d) Except for the workmen's compensation insurance, the insurance policies under this Article shall:

(i) name UNICEF as additional insured;

(ii) include a waiver of subrogation of the Contractor's rights to the insurance carrier against UNICEF;

(iii) provide that UNICEF shall receive thirty (30) days written notice from the insurers prior to any cancellation or change of coverage.

(iv) The Contractor shall, upon request, provide UNICEF with satisfactory evidence of the insurance required under this Article.

10. SOURCE OF INSTRUCTIONS

The Contractor shall neither seek nor accept instructions from any authority external to UNICEF in connection with the performance of its services under this Contract. The Contractor shall refrain from any action which may adversely affect UNICEF or the United Nations and shall fulfil its commitments with the fullest regard to the interests of UNICEF.

11. ENCUMBRANCES/LIENS

The Contractor shall not cause or permit any lien, attachment or other encumbrance by any person to be placed on file or to remain on file in any public office or on file with UNICEF against any monies due or to become due for any work done or materials furnished under this Contract, or by reason of any other claim or demand against the Contractor.

12. TITLE TO EQUIPMENT

Title to any equipment and supplies which may be furnished by UNICEF shall rest with UNICEF and any such equipment shall be returned to UNICEF at the conclusion of this Contract or when no longer needed by the Contractor. Such equipment when returned to UNICEF shall be in the same condition as when delivered to the Contractor, subject to normal wear and tear.

13. COPYRIGHT, PATENTS AND OTHER PROPRIETARY RIGHTS

UNICEF shall be entitled to all intellectual property and other proprietary rights including but not limited to patents, copyrights and trademarks, with regard to documents and other materials which bear a direct relation to or are prepared or collected in consequence or in the course of the execution of this contract. At UNICEF's request, the Contractor shall take all necessary steps, execute all necessary documents and generally assist in securing such proprietary rights and transferring them to the UNICEF in compliance with the requirements of the applicable law.

14. CONFIDENTIAL NATURE OF DOCUMENTS

(a) All maps, drawings, photographs, mosaics, plans, reports, recommendations, estimates, documents and all other data compiled by or received by the Contractor under this Contract shall be the property of UNICEF, shall be treated as confidential and shall be delivered only to the UN authorized officials on completion of work under this Contract.

(b) The Contractor may not communicate any time to any other person, Government or authority external to UNICEF, any information known to it by reason of its association with UNICEF which has not been made public except with the authorization of the UNICEF; nor shall the Contractor at any time use such information to private advantage. These obligations do not lapse upon termination of this Contract with UNICEF.

15. FORCE MAJEURE; OTHER CHANGES IN CONDITIONS

(a) In the event of and as soon as possible after the occurrence of any cause constituting force majeure, the Contractor shall give notice and full particulars in writing to UNICEF of such occurrence or change if the Contractor is thereby rendered unable, wholly or in part, to perform its obligations and meet its responsibilities under this Contract. The Contractor shall also notify UNICEF of any other changes in conditions or the occurrence of any event which interferes or threatens to interfere with its performance of the Contract. On receipt of the notice required under this Article, UNICEF shall take such action as, in its sole discretion, it considers to be appropriate or necessary in the circumstances, including the granting to the Contractor of a reasonable extension of time in which to perform its obligations under the Contract.

(b) If the Contractor is rendered permanently unable, wholly, or in part, by reason of force majeure to perform its obligations and meet its responsibilities under this Contract, UNICEF shall have the right to suspend or terminate this Contract on the same terms and conditions as are provided for in Article

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16, 'Termination', except that the period of notice shall be seven (7) days instead of thirty (30) days.

(c) Force majeure as used in this Article means acts of God, war (whether declared or not), invasion, revolution, insurrection or other acts of a similar nature or force.

16.TERMINATION

If the Contractor fails to deliver any or all of the deliverables within the time period(s) specified in the contract, or fails to perform any of the terms, conditions, or obligations of the contract, or should the Contractor be adjudged bankrupt, or be liquidated or become insolvent, or should the contractor make an assignment for the benefit of its creditors, or should a Receiver be appointed on account of the insolvency of the contractor, UNICEF may, without prejudice to any other right or remedy it may have under the terms of these conditions, terminate the Contract, forthwith, in whole or in part, upon thirty (30) days notice to the Contractor.

UNICEF reserves the right to terminate without cause this Contract at any time upon thirty (30) days prior written notice to the Contractor, in which case UNICEF shall reimburse the Contractor for all reasonable costs incurred by the Contractor prior to receipt of the notice of termination.

In the event of any termination no payment shall be due from UNICEF to the Contractor except for work and services satisfactorily performed in conformity with the express terms of this contract.

Upon the giving of such notice, the Contractor shall have no claim for any further payment, but shall remain liable to UNICEF for reasonable loss or damage which may be suffered by UNICEF for reason of the default. The Contractor shall not be liable for any loss or damage if the failure to perform the contract arises out of force majeure.

Upon termination of the contract, UNICEF may require the contractor to deliver any finished work which has not been delivered and accepted, prior to such termination and any materials or work-in-process related specifically to this contract. Subject to the deduction of any claim UNICEF may have arising out of this contract or termination, UNICEF will pay the value of all such finished work delivered and accepted by UNICEF.

The initiation of arbitral proceedings in accordance with Article 22 'Settlement of Disputes' below shall not be deemed a termination of this Contract.

17. SUB-CONTRACTING

In the event the Contractor requires the services of subcontractors, the Contractor shall obtain the prior written approval and clearance of UNICEF for all sub-contractors. The approval of UNICEF of a sub-contractor shall not relieve the Contractor of any of its obligations under this Contract. The terms of any sub-contract shall be subject to and in conformity with the provisions of this Contract.

18.ASSIGNMENT AND INSOLVENCY

a. The Contractor shall not, except after obtaining the written consent of UNICEF, assign, transfer, pledge or make other dispositions of the Contract, or any part thereof, of the Contractor's rights or obligations under the Contract.

b. Should the Contractor become insolvent or should control of the Contractor change by virtue of insolvency, UNICEF may, without prejudice to any other rights or remedies, terminate the Contract by giving the Contractor written notice of termination.

19.USE OF UNITED NATIONS AND UNICEF NAME AND EMBLEM

The Contractor shall not use the name, emblem or official seal of the United Nations or UNICEF or any abbreviation of these names for any purpose.

20.OFFICIALS NOT TO BENEFIT

The Contractor warrants that no official of UNICEF or the United Nations has received or will be offered by the Contractor any direct or indirect benefit arising from this Contract or the award thereof. The Contractor agrees that breach of this provision is a breach of an essential term of the Contract.

21.PROHIBITION ON ADVERTISING

The Contractor shall not advertise or otherwise make public that the Vendor is furnishing goods or services to UNICEF without specific permission of UNICEF.

22.SETTLEMENT OF DISPUTES

Amicable Settlement

The Parties shall use their best efforts to settle amicably any dispute, controversy or claim arising out of, or relating to this Contract or the breach, termination or invalidity thereof. Where the parties wish to seek such an amicable settlement through conciliation, the conciliation shall take place in accordance with the UNCITRAL Conciliation Rules then obtaining, or according to such other procedure as may be agreed between the parties.

Arbitration

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Any dispute, controversy or claim between the Parties arising out of this Contract or the breach, termination or invalidity thereof, unless settled amicably under the preceding paragraph of this Article within sixty (60) days after receipt by one Party or the other Party's request for such amicable settlement, shall be referred by either Party to arbitration in accordance with the UNCITRAL Arbitration Rules then obtaining. The arbitral tribunal shall have no authority to award punitive damages. In addition, the arbitral tribunal shall have no authority to award interest in excess of six percent (6%) and any such interest shall be simple interest only. The Parties shall be bound by any arbitration award rendered as a result of such arbitration as the final adjudication of any such controversy, claim or dispute.

23.PRIVILEGES AND IMMUNITIES

The privileges and immunities of the UN, including its subsidiary organs, are not waived.

24.CHILD LABOUR

UNICEF fully subscribes to the Convention on the Rights of the Child and draws the attention of potential suppliers to Article 32 of the Convention which inter alia requires that a child shall be protected from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

25.ANTI-PERSONNEL MINES

UNICEF supports an international ban on the manufacture of anti-personnel mines. Anti-personnel mines have killed and maimed thousands of people, of whom a large proportion are children and women. Anti-personnel mines present a serious obstacle to the return of populations displaced from their residences by fighting around their villages and homes. UNICEF has, therefore, decided not to purchase products from companies that sell or manufacture anti-personnel mines or their components.

26.AUTHORITY TO MODIFY

No modification or change in this Contract, no waiver of any of its provisions or any additional contractual relationship of any kind with the Contractor shall be valid and enforceable against UNICEF unless provided by an amendment to this Contract signed by the authorized official of UNICEF.

27.REPLACEMENT OF PERSONNEL

UNICEF reserves the right to request the Contractor to replace the assigned personnel if they are not performing to a level that UNICEF considers satisfactory. After written notification, the Contractor will provide curriculum vitae of appropriate candidates within three (3) working days for UNICEF review and approval. The Contractor must replace the unsatisfactory personnel within seven (7) working days of UNICEF's selection.

If one or more key personnel become unavailable, for any reason, for work under the contract, the Contractor shall (i) notify the project authority at least fourteen (14) days in advance, and (ii) obtain the project authority's approval prior to making any substitution of key personnel. Key personnel are designated as follows:

(a) Personnel identified in the proposal as key individuals (as a minimum, partners, managers, senior auditors) to be assigned for participation in the performance of the contract.

(b) Personnel whose resumes were submitted with the proposal; and

(c) Individuals who are designated as key personnel by agreement of the Contractor and UNICEF during negotiations.

In notifying the project authority, the Contractor shall provide an explanation of circumstances necessitating the proposed replacement(s) and submit justification and qualification of replacement personnel in sufficient detail to permit evaluation of the impact on the engagement.

Acceptance of a replacement person by the project authority shall not relieve the Contractor from responsibility for failure to meet the requirements of the contract.

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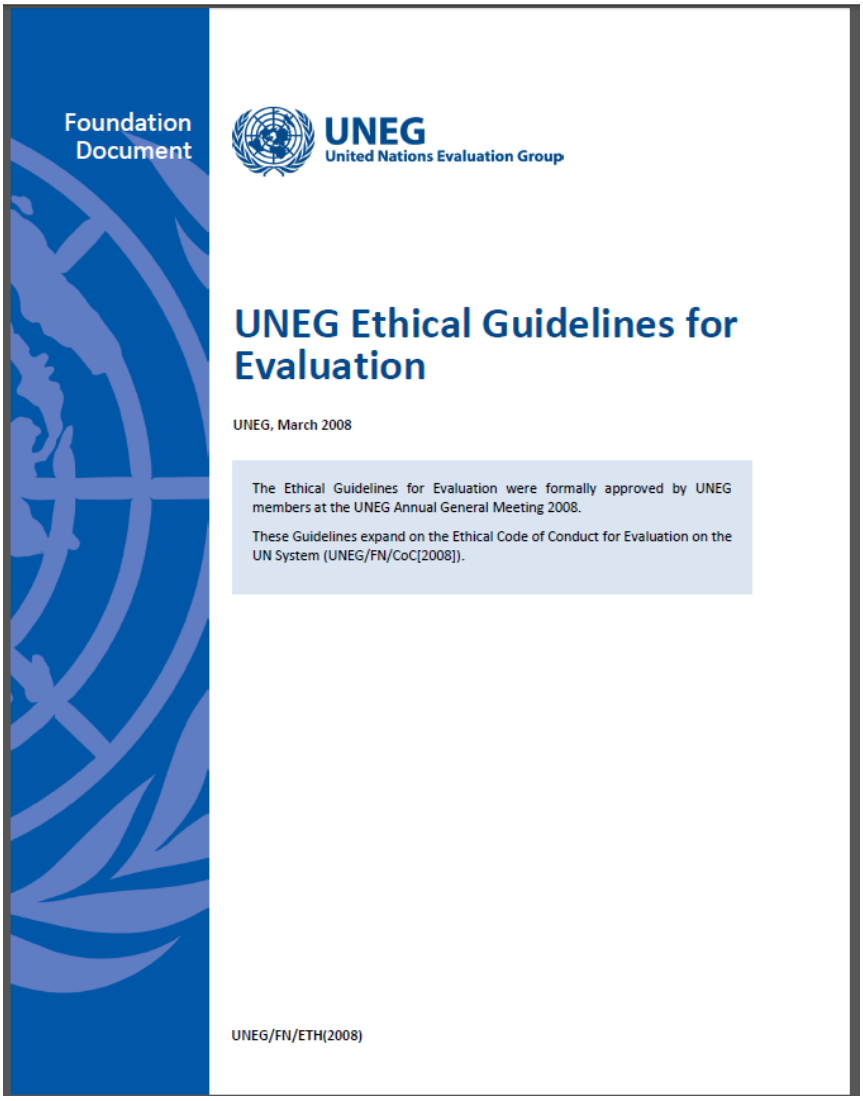
ANNEX 3: UNEG ETHICAL GUIDELINES FOR EVALUATION

Please refer to Annex 3 attached separately to this RFP.



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ANNEX 4: EVALUATION CRITERIA AND IN-DEPTH QUESTIONS TO BE ASSESSED FOR THE FINAL HTF EVALUATION

Annex 4: Evaluation criteria and in-depth questions to be assessed for the final HTF evaluation

In drawing together the Final Impact Evaluation, the Institution or the team of consultants will conduct detailed analysis in the four thematic areas. This in-depth analysis will be presented as stand-alone annexes. The preparatory phase will allow the development of an evaluation framework showing how in-depth area analysis will support the synthesis of information for the overall report, and how different methods and respondents will be deployed to explore topics to answer evaluation criteria.

Evaluation criteria	In depth areas for analysis
1. Impact *The extent to which the objectives of the Health Transition Fund have been achieved as intended and its contribution to the overall HTF goal.*	**In depth question 1:** **What changes have resulted as an impact of the HTF, including an equity and gender analysis?** 1. *Direct and indirect results, outcomes and impact of the Health Transition Fund* 2. *Who has benefitted, particularly in terms of gender equity and vulnerable populations* 3. *Assessment that change has occurred; whether change can be attributed to the HTF* 4. *What are the plausible scenarios if there was no HTF* 5. *Evaluating the monitoring and evaluation arrangement, reflection on ability to conduct an impact evaluation; appropriateness of the monitoring and evaluation arrangements, and key lessons for future funding* 6. *The extent to which the objectives of the HTF has been achieved as intended and its contribution to the overall HTF goal*
2. Relevance *The extent to which the objectives of the program are consistent with beneficiaries requirements, country needs, global priorities and funding partners' policies*	**In depth question 2:** **Are we doing the right thing**? *The HTF relevance to the operating context and situational changes. This will focus on four main areas:* 1. *Consistency of objectives of the program with beneficiaries requirements, country needs, global priorities and funding partners' policies* 2. *Appropriateness of governance arrangements; alignment; consistent with aid effectiveness principles in a country that is coming out of crisis and moving towards development. Flexibility and adaptability to risk identification and management*

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Evaluation criteria	In depth areas for analysis
	3. *Facilitation or constraint by external factors; program design, management, governance arrangements; participation of relevant stakeholders* 4. *Whether the impacts have made a difference in terms of governance and funding partners development programs*
3. Effectiveness *How far the project results were attained and specific objectives are achieved*	**In depth question 3:** **Are we doing things right?** 1. *Effectiveness in reaching the target populations and vulnerable groups* 2. *Whether the program is effective in terms of improving MNCH and other social gains* 3. *How unintended results have affected the outcomes and could have been foreseen and managed*
4. Efficiency – value for money and sound management *How well the HTF transformed the available resources into the intended outputs and outcomes in terms of quantity, quality and timeliness of delivery*	**In depth question 4:** **Has the HTF delivered value for money?** Considering the HTF as a whole, and the four thematic areas: 1. *Whether the incremental benefits outweighed the incremental costs (cost-benefit);* 2. *The overall rate of return; including a sensitivity analysis of reasonable variations in the assumptions* 3. *Whether it yielded a better return than comparable programs, including an analysis as far as possible of unit costs per beneficiary reached with key interventions* 4. *Whether it provided the best return possible from this type of funding mechanism and of interventions (value for money)*
5. Sustainability *Whether the positive outcomes of the project and the flow of benefits are likely to continue after HTF ends.*	**In depth question 5:** **Will changes last?** 1. *Ownership of objectives and achievements* 2. *Policy support and the responsibility of beneficiary* 3. *Institutional and technical capacity of implementing partners* 4. *Extent to which the target group were involved in design and implementation* 5. *Financial and economic sustainability* 6. *How cross cutting issues such as gender equity, governance and accountability were addressed*

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ANNEX 5: ELEMENTS OF IMPACT EVALUATION AND TIME FRAME

Below is a tentative plan for the impact evaluation as presented in the HTF document. The detailed evaluation matrix with the appropriate time frame is to be developed by the Institution in consultation with the Evaluation Sub-committee and HTF Steering Committee.

Elements of Impact Evaluation and Time Frame														
Activity	Year 1		Year 2				Year 3				Year 4			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop HTF Evaluation Plan with Evaluation Matrix														
Identify core indicators for the BL, AR, MTR & Final Evaluation														
Collect Baseline Information														
Conduct Annual Review														
Conduct Mid-Term Review														
Final Impact Evaluation														
Complete and submit Final Evaluation Report														

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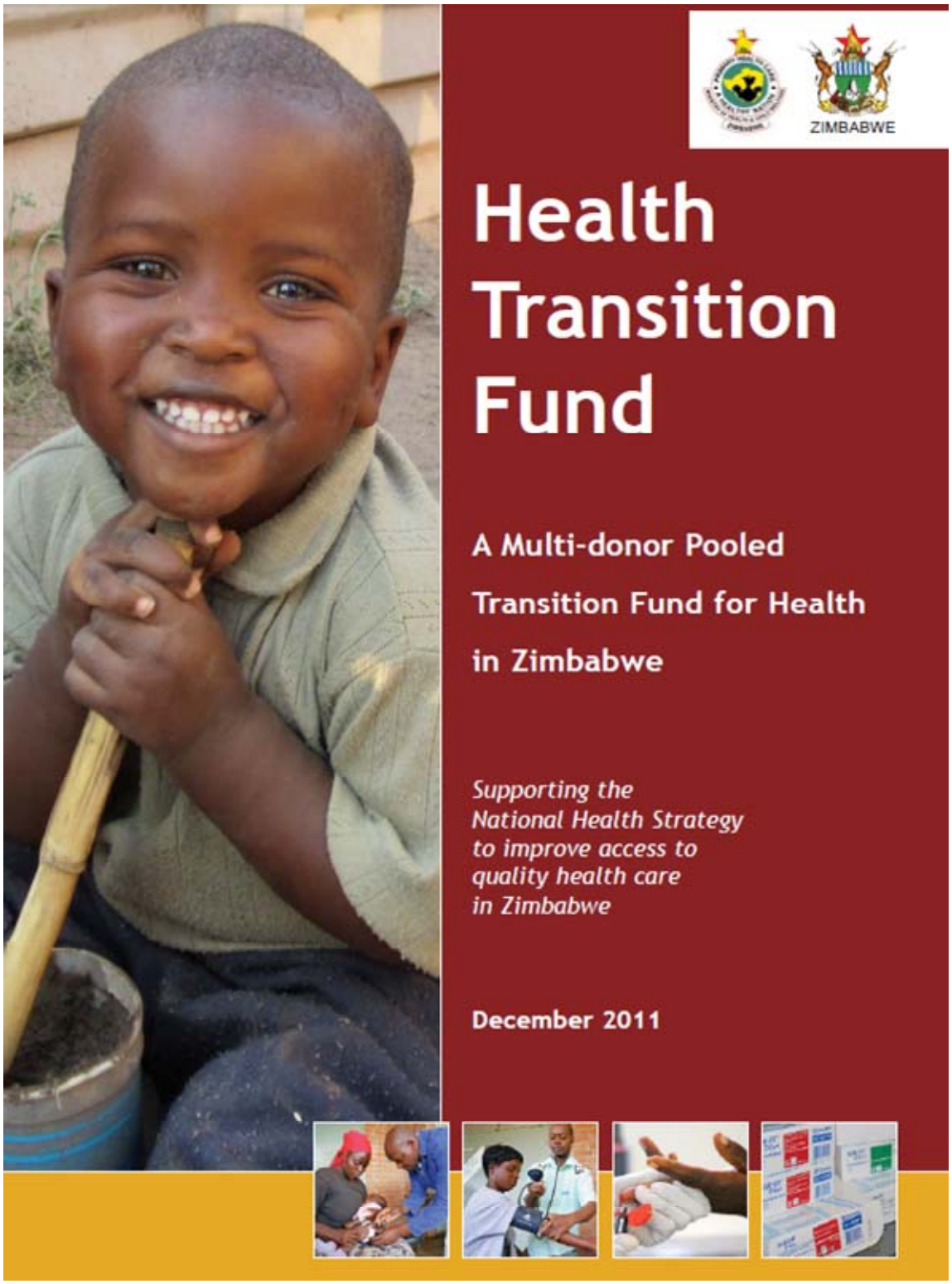
ANNEX 6: BACKGROUND INFORMATION – HEALTH TRANSITION FUND…



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Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 3
Evaluation Design Note

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
15th of January 2016

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1. Purpose and Objectives of the final evaluation

The overall purpose of the **Independent Evaluation of the HTF** is 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 purpose of the final evaluation is:

- 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.

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:

- **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
- **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.
- **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."

2. Methods

3.1 EVALUATION QUESTIONS

In line with the evaluation design presented at inception and endorsed by the HTF Steering Committee, a set of evaluation questions is proposed for the Final Evaluation.
The questions are reported in table 1 below, grouped by OECD-DAC criteria.

Table 1 - Evaluation Criteria and Key Evaluation Questions

Evaluation Criteria	Key Evaluation Questions
Impact	▪ Has the HTF contributed to improved maternal newborn and child health and nutrition outcomes in Zimbabwe, from 2012 to 2015?
Relevance	▪ To what extent did the HTF address the 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 of health services at national and local level?
Effectiveness	▪ To what extent were HTF intended results achieved during its implementation? ▪ What were the main facilitators and barriers to achieving intended results? ▪ What unintended results – positive and negative – did the interventions produce? How did these occur?
Efficiency:	▪ 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?
Sustainability:	▪ To what extent does the government, at all levels of the health 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?

3.2 EVALUATION DESIGN

Impact

The World Bank defines Impact Evaluation as: *'…assessing changes in the well-being of individuals, households, communities or firms that can be attributed to a particular project, program or policy'*. Attribution involves a causal claim about the intervention as the cause of the impact, and measurement of how much of the impact can be linked to the intervention.

Epidemiological methodology uses experimental and quasi-experimental designs to address issues of attribution and causality.[1] From inception, an experimental or quasi experimental design aimed at inferring attribution was

[1] *BROADENING THE RANGE OF DESIGNS AND METHODS FOR IMPACT EVALUATIONS*: *Report of a study commissioned by the Department for International Development, APRIL 2012.* Elliot Stern, Nicoletta Stame, John Mayne, Kim Forss, Rick Davies, Barbara Befani

not embedded in the evaluation of the HTF to assess attribution of impacts.

In fact, due to the nature of the programme under evaluation – which is in essence a pooled fund mechanism that supports MOHCC plans and delivery strategies, rather than an intervention in itself - identifying a control group to test a counterfactual hypothesis if there were 'no HTF', was not deemed to be a viable approach. Also and more importantly, the question of attribution may not be relevant to the evaluation of such a mechanism. In fact, the underlying rationale of the HTF was to **strengthen and complement** the services of the health system in Zimbabwe. In other words, the 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. Instead, more relevant questions will be **whether and how the intervention has had a contribution to impact achievements**.

To assess impact, we will analyse progress achieved in Zimbabwe and address the following questions:

- Was a reduction in maternal and child mortality observed during the period of HTF implementation?
- To which extent the change in mortality outcomes observed during the period 2012-2015 differed from trends observed in the pre-HTF period?
- How many additional lives were saved?

Household survey data available through DHS and MICS will be used to assess 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 program and during the life of the program.

At the time of this writing, data collection for the DHS 2015 is ongoing[2] in Zimbabwe; the results of this survey would constitute the ideal end line measurement to document changes in mortality rates by 2015.
However, it is anticipated that the results of the DHS 2015 may not be available during the lifetime of the LSTM evaluation.

In such case, modelling of projected trends in child mortality will be used for this evaluation, using as primary source the 2015 *Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation.* Survey data will be triangulated with available routine data on women and children deaths available through the HMIS, where feasible. The Lives Saved tool (LiST) will be used to estimate the effects of changes in mortality outcomes on the actual number of additional lives saved during the period under analysis.

Relevance

The evaluation of the relevance of the HTF intervention strategies and governance mechanisms will primarily explore three dimensions:

1. Relevance to beneficiaries (women of reproductive age, mothers and children and indirectly health care workers)
   Interviews at District and health facility levels and focus group discussions at community level will be conducted to capture the views of intermediate and final users, i.e. health care workers and community members. A framework analysis approach will be used to produce descriptive analysis and draw explanatory conclusions clustered around the themes emerging from interviews and FGDs. Semi structured interview guides will be developed, and thematic visual maps will be generated through the analysis of the data to display key patterns and findings regarding the intermediate and final users'

[2] Progress update as of 27/11/2015 from: http://dhsprogram.com/what-we-do/survey/survey-display-475.cfm

perceptions of the appropriateness of the HTF supported interventions, and of what worked and what not, and why.

2. Consistency with national strategies, policies and plans and alignment with global health and nutrition strategies and approaches
   This will be assessed through the analysis of policy documents available at country level and global health strategies available internationally through existing literature.

3. Contribution to governance and coordination
   The qualitative data and the HTF Annual Review (AR) 2014 conducted by LSTM in mid-2015 provided an extensive analysis of the contribution of the HTF to coordination and governance of the health sector in Zimbabwe, with a primary focus on national level.

   The final evaluation will further elaborate and investigate these issues and seek to explore the contribution of the HTF to the governance and coordination ?of service delivery at lower levels of the system, looking in particular at District Health Executives (DHE) and at health centre committees (HCCs). At the central level, KIIs will be conducted with selected multilateral and bilateral organizations and with HTF Steering Committee members.

   At the District level, the analysis will rely on Focus Group Discussions with members of the DHE; qualitative data will be triangulated with key (quantitative) findings from the district health services assessment that LSTM will conduct in early 2016. Finally, KIIs will also be conducted with health centre committees at facility level.

Effectiveness

The assessment of effectiveness will focus on **outcome and output level indicators**, as defined by the HTF. Mapping the progress of each indicator from the baseline levels measured in 2011 and against the targets set for 2015 will inform our analysis of effectiveness.

Absolute change, calculated as the difference in coverage from baseline to 2015, will be used as the primary measure of change (progress), per each outcome and output indicator. The same measure will be used in the report to present the gap to target, according to the end of project targets set by the HTF.

For population coverage indicators (outcome level), the availability of preliminary data from the DHS 2015 would be essential to provide a reliable estimate of progress achieved in various maternal and child health and nutrition interventions.

As previously discussed in this paper, DHS 2015 data may not be available to the LSTM team during the final LSTM evaluation, and this is a serious limitation to the evaluation work. As an alternative to DHS data, secondary data available through HMIS and other secondary sources (eg UN estimates) will be used to model possible scenarios of change achieved at population level for key interventions.

The quantitative analysis produced through the update of log frame indicators will be complemented by findings from the qualitative research (KIIs and FGDs) that will be conducted at all levels of the system and will inform the evaluation of the barriers and facilitators to achieving (or not) the programme results. Secondary data such as reports, assessments and research available in country will also be used to support the analysis.

Efficiency

The OECD-DAC defines efficiency in terms of transformation of inputs into results. Various methods have been

identified to assess efficiency of aid interventions. Palenberg[3] classifies methods for efficiency analysis into three main categories: Level 2, the most potent, is capable of assessing the efficiency of an aid intervention so that it can be compared with alternatives or benchmarks (e.g., cost effectiveness analysis); Level 1, which is capable of identifying the potential for efficiency improvements within aid interventions; Level 0, which is entirely descriptive and hence informative rather than formative.

A mix of these methods will be used to assess efficiency through the final evaluation of the HTF.

A descriptive approach (level 0) will be adopted to document the main costs, patterns of expenditure and the performance of the HTF in delivering against planned budgets, for the period 2012-2015.

Qualitative research at lower levels of the systems (Districts and Health Facilities) will be used to explore perceptions of managers and service providers of potential areas for efficiency improvements (Level 1) along the service delivery chain.

In addition, it is proposed that a **case study** targeting one of the key HTF strategies designed to support the availability of **medical products, vaccines and technologies (Theme 2)** is conducted, to underpin the dimensions of cost benefits, utility and sustainability of the investments promoted by the HTF in the area of procurement and supply management. Whilst the case study approach has limitations in terms of external validity, it is expected that it can generate evidence and reflections amongst key stakeholders about costs and value for money.

The proposed case study will look in particular at the supply of prepacked, standard kits of health products to rural health facilities, and explore whether the initially proposed supply mechanisms has been efficient and cost effective in achieving supporting the HTF objective of enhancing the availability of essential health products at primary health care level.

Through the collection and review of secondary data and the administration of questionnaires and in-depth interviews, the proposed case study will seek to document the cost-utility and cost-benefits of the kit delivery system, focussing on: the efficiency of the organization of the procurement and distribution system; the comparison of unit costs with available benchmarks; and the improvement in availability of health products.

Sustainability

The evaluation will look at two core aspects of the sustainability of the HTF:

- The ownership of the programme results from relevant stakeholders
- The plans and arrangements in place to sustain programme results at the end of the HTF period

Qualitative research conducted via KIIs and FGDs will inform the analysis and build on the work on sustainability already initiated through the Annual Review 2014. To complement the findings of primary data collection, the evaluation team will also analyse available policy documents and reports.

In addition to this overall assessment, a **case study** is proposed to assess the sustainability of the gains achieved through the **health worker retention scheme** supported through the HTF.

In particular, the case study will seek to examine the extent to which the retention scheme represents value for

[3] Palenberg, M. (2011): Tools and Methods for Evaluating the Efficiency of Development Interventions. *Evaluation Working Papers*. Bonn: Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung.

money and how improvements in health worker availability, distribution and skills mix can be safeguarded and sustained. The case study will draw on the findings and recommendations of the 2012 Impact Assessment of the Zimbabwe Harmonized Health Worker Retention Scheme (HHWR) conducted in 2011[4] and will use a modified version of the conceptual framework for measuring efforts to increase access to health workers in underserved areas.[5]

Additional quantitative and qualitative data will be collected and analysed where necessary to cover the following elements: description of the retention scheme; results; challenges and how they were met; lessons learned; and way forward.

[4] Marjolein Dieleman, Mark Watson & Chenjerai Sisimayi (2012) Impact assessment of the Zimbabwe Health Worker Retention Scheme. Final Report. February 2012. DFID Human Development Resource Centre

[5] Luis Huicho, Marjolein Dieleman, James Campbell, Laurence Codjia, Dina Balabanova, Gilles Dussaut & Carmen Dolea (2010) Increasing access to health workers in underserved areas: a conceptual framework for measuring results. *Bulletin of the World Health Organization* 2010;88:357-363. doi: 10.2471/BLT.09.070920 http://www.who.int/bulletin/volumes/88/5/09-070920/en/

3. Data Collection and analysis

3.1 Primary Data sources

- ### Health Services Assessment

A rapid health services assessment (HSA) will be conducted to assess progress in enhancing quality and availability of care at all levels of the system. The proposed health facility survey will build on the survey previously conducted by LSTM in 2014 and 2015.

It is anticipated that – in line with the exercise conducted in 2015, the HSA will be 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; Level 1 Facilities.

The LSTM Survey 2016 will provide an independent measurement of a sub-set of **HTF outcome and output indicators**, collectable at health services level, providing estimates at national level, with 95% confidence intervals.
In line with the sampling calculations presented for the AR 2014, it is expected that the assessment will reach:

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

The HSA will be conducted and managed by LSTM in collaboration with UNICEF, MOHCC and partners. An external company will be contracted to perform data collection in the field. Data will be collected through electronic systems, using Filemaker as software platform for data entry.

This document is a complete survey protocol specifying sample size and tools that will be used for the HSA upon endorsement of the Terms of Reference for the Final Evaluation.

Design

The proposed health services assessment will cover the entire country, in order to provide a picture of progress in improving availability of care at country level.
The design of the assessment is tailored to the HTF results framework, designed by MOHCC and partners at project inception, and to national standards and protocols of care.

The survey methods have been refined based on lessons learnt through the assessments conducted by LSTM in March 2014 and April 2015, and reviewed to maximize the consistency and relevance of the exercise to HTF information needs, also taking into account other surveys conducted and routine data mechanisms used in country.

In line with the proposed HSA objectives, the survey will consist of:

- A module focusing on health services functioning at District Health Office level;

- A module focusing on availability of maternal and child health services at facility level, targeting district level hospitals (both government and mission hospitals) and Level 1 facilities.

INDICATORS

The Health Transition Fund Results Framework relies on a total of 3 impact, 29 outcome and 55 output indicators which were identified at program inception to measure progress in achieving the planned HTF targets.
Of those, a sub-set of **31 HTF indicators (4 outcome and 27 output indicators)** will be collected through the Health Services Assessment, to assess progress of the HTF initiative in strengthening health services at various level of the system. They are presented in **table 2**.

The indicators collected through the LSTM survey will be triangulated with routine information available in country, as well as with other existing surveys or monitoring mechanisms. Also, the evidence collected through the survey (*what*) will be complemented by qualitative research that will be used to enrich the analysis (*why? How?*).

Table 2. List of HTF Indicators to be collected through the LSTM Health Services Assessment

N.	INDICATORS (number and name)	Targeted level of health system
Outcome indicators		
1	1.1.3. Proportion of district hospitals providing comprehensive emergency obstetric and newborn services	District level hospitals
2	1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	District health offices
3	1.2.1. Proportion of health centres with functional health committees	Level 1 Facilities
4	4.1.3. Proportion of health facilities charging user fees for MNCH services	District level Hospitals and Level 1 Facilities
Output indicator number and name		
THEME 1. Maternal, newborn and child health and nutrition		
1.1 Enhancing Obstetric and Newborn Care Capacity of the Health System		
5	1.1.1.1.Proportion of PCNs trained on focused ANC	District Level Hospitals and Level 1 Facilities
6	1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	Level 1 Facilities
7	1.1.2.2. Proportion of rural health centres with the necessary equipments and consumables for basic EmONC services	Level 1 Facilities
8	1.1.3.1. Proportion of District Hospitals having at least one health professional who can do C/S	District level hospitals
9	1.1.3.2. Proportion of district Hospitals with at least one health professional who can provide anaesthesia for emergency obstetric surgery	District level hospitals
10	1.1.3.3. Proportion of District Hospitals with fully functional operation room to perform emergency obstetric surgery	District level hospitals
11	1.1.3.4. Number of district hospitals with fully functional mother waiting homes (MWHs)	District level hospitals
12	1.1.3.5. Number/Proportion of district hospitals having at least 1 ambulance	District level hospitals
13	1.1.3.6. Proportion of health facilities with at least one fully functional mode of communication equipment for emergency referral	District level hospitals
14	1.1.3.7. Number/Proportion of District Hospitals with the capacity to provide blood transfusion for emergency obstetric care	District level hospitals
15	1.1.4. Proportion of rural health facilities conducting at least 3 PNC visit within the 1st week after delivery	Level 1 Facilities
16	1.1.5.1. Number/Proportion of districts conducting quarterly supportive supervision to health facilities	District health offices
1.2 Improve the Community Health Services System for MNCH and Nutrition		
17	1.2.1. Proportion of health committees at the health centre level conducting regular monthly meetings to discuss health issues	Level 1 Facilities
18	1.2. 2. OPD utilisation rate	District Level Hospitals and Level 1 Facilities
1.3 Improve Child Health Through Strengthening the EPI and IMNCI		
19	1.3.3.1. Proportion of health centres having at least one Health Worker trained on IMNCI	Level 1 Facilities
20	1.4.2.2. Proportion of health facilities with at least one health worker trained in IYCF	Level 1 Facilities
21	1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	Level 1 Facilities
22	1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	Level 1 Facilities

23	1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	Level 1 Facilities
24	1.4.6.1.1. Number of district providing quarterly report on nutrition program implementation	District health offices
25	1.4.6.1.2. Availability of at least 1 trained nutrition manager at provincial and district level of the health system	District health offices
26	1.4.6.1.3. Number of districts conducting quarterly supportive supervision on nutrition	District health offices
THEME 2: Medical Products, Vaccines and Technologies (Medicines)		
27	2.1.3. Number of districts with at least 1 person trained in LMIS and rational drug use	District health offices
28	2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	District level Hospitals and Level 1 Facilities
THEME 4: Health Policy, Planning and Finance		
29	4.1.1. Number of districts that regularly develop AWP	District health offices
30	4.1.2. Number of districts conducting regular annual review meeting	District health offices
31	4.1.5. Proportion of Health facilites receiving regular financial support through the Health service fund to cover basic recurrent cost	District level Hospitals and Level 1 Facilities

QUESTIONNAIRE DEVELOPMENT

Survey questionnaires will be adapted from the survey conducted by LSTM in March 2014 and April 2015, and adjusted to respond to the comments and feedback received from the HTF Steering Committee following the 2015 exercise.

At District Health Executive level, a rapid assessment tool has been designed based on the WHO guidelines[6] to assess District Health Systems, and adapted to the local context and to the specific HTF information needs.
This exercise is intended to complement available secondary data for District level management and supervision of health services.

At health facility level, the assessment will rely on the questionnaire and methodology tools already used by LSTM in 2014 and 2015, which are based on standard tools for the assessment of quality and availability of care at facility level, already widely tested in Zimbabwe. In order to maximize consistency with national protocols, the questionnaires have been triangulated with other surveys and routine data sources used in country, including: the National Integrated Health Facility Survey 2011 (NIHFA); VHMAS questionnaires and reports; HTF Joint Review Mission assessment tools (JRM); Health Monitoring Information System indicators.

SAMPLE SIZE

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

Therefore, we have three sample size calculations.
For each indicator a 95% confidence interval is to be provided along with an estimate of the indicator. For each population the margin of error in estimation was set not to exceed 10%.

To calculate sample sizes, the following formulae were used to determine the required sample sizes using simple random sampling:

$$n_0 = \frac{z^2_{1-\alpha/2}\,\pi(1-\pi)}{\varepsilon^2} \text{ and } n = \frac{n_0}{1+\frac{(n_0-1)}{N}}$$

where n_0=required sample size for a very large population

- α = significance level (5%)
- $z_{1-\alpha/2}$ = the two-tailed critical value corresponding to a significance level of α (1.96)
- π = the assumed proportion (50%)
- ε = margin of error (10%)
- n = required sample size corrected for a finite population size
- N = the population size

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.

The three study populations for the study are:

4) District Health Offices
5) District Level Hospitals – these would include both Government District Hospitals, and Mission level facilities performing comprehensive obstetric care (cEmONC) in the districts.

[6] Tools for Assessing the Operationality of District Health Systems, WHO 2003

6) All level 1 facilities

For each study population the number required if using simple random sampling independently for each population is indicated in Table 3.

Table 3. Study Populations and Required Sample Sizes when using simple random sampling

Population	**Population size**	**Sample size required** (sampling fraction)
District Health Offices	63	39 (62%)
District level Hospitals (*Government and Mission hospitals*)	78	43 (55%)
Level 1 Facilities	1,336	90 (6.7%)

SAMPLING STRATEGY

For this phase the same facilities will be re-assessed as were assessed in the previous assessment in 2015. Details of the sampling are explained below.

District Health Offices.

For sampling of District Health Offices, although estimation at province level is not required, sampling will be stratified by province and the required sampling fraction will be achieved (by rounding required numbers upwards) across all provinces. This will ensure that at province level the districts have approximately equal chance of being included in the sample, and that the sample is approximately self-weighted with regard to province.

District level Hospitals (government and mission hospitals)

For sampling of District level hospitals a cluster sampling approach will be used, namely hospitals will be clustered by district and only hospitals within the districts from which DHOs were selected will be included. Since the sampling will be clustered the sample size required has to be increased based on there being intracluster correlation (ICC). The design effect depends not only on the ICC but also on the mean cluster size and the coefficient of variation of cluster size, all of which were not available for the 2013 evaluation conduced in 2015. Adams et al (2004) reported the IQR for ICCs for cluster-based studies in primary care to range from 0 to 0.032. It is assumed that the ICCs for the present study do not exceed 0.065.

With 78 hospitals distributed between 63 districts the design effect was expected to vary between 1.03 and 1.10 if all hospitals within selected facilities are included. Thus a 10% increase in the total number of clusters was expected to suffice to account for clustering for this level of sampling. Therefore 47 district level hospitals (government and mission) were sampled from the 44 selected districts. The number of hospitals within each district was capped at 2 to achieve the required number of hospitals. In districts with more than two hospitals random sampling was used to select hospitals.

Level 1 Facilities

For sampling of level 1 facilities a cluster sampling approach was also used, again they were clustered by district and only facilities within the selected districts were included. Two or three facilities were to be sampled for

each selected district, thus the coefficient of variation of the cluster size was 0.20. Again assuming that the ICC would not exceed 0.065 the design effect would be no more than 1.10. Thus a total of 99 facilities was expected to be sufficient to account for clustering at this level of sampling. To achieve this number, among the districts sampled within each Province the two districts with the largest number of facilities was identified, three facilities were randomly selected from each of these two districts, two facilities were randomly selected from each of the other sampled districts. Two largely urban provinces have no district hospitals and no more than two districts whereas four or more districts are to be sampled from all other provinces. To ensure adequate representation of facilities within these provinces they were over-sampled: a sample of 10 facilities was selected from each of these Provinces. Therefore a total of 118 level 1 facilities was sampled from the 44 selected districts.

Table 4 indicates the numbers of facilities to be selected within each Province at each level.

Table 4 Numbers of districts and facilities for each level by province and numbers to be sampled (n)

Province	**Total population**	**Districts**	**District Level hospitals***	**Level 1 facilities**
Bulawayo	653,337	1 *(1)*	0 *(0)*	26 *(10)*
Harare	2,123,132	2 *(2)*	0 *(0)*	67 *(11)*
Manicaland	1,752,698	8 *(5)*	12 *(7)*	244 *(13)*
Mashonaland Central	1,152,520	8 *(5)*	10 *(7)*	129 *(11)*
Mashonaland East	1,344,955	9 *(6)*	13 *(6)*	169 *(15)*
Mashonaland West	1,501,656	6 *(4)*	9 *(7)*	162 *(9)*
Masvingo	1,485,090	7 *(5)*	9 *(5)*	165 *(13)*
Matabeleland North	749,017	7 *(5)*	7 *(5)*	106 *(12)*
Matabeleland South	683,893	7 *(5)*	7 *(5)*	109 *(12)*
Midlands	1,614,941	8 *(6)*	11 *(5)*	159 *(12)*
Total	**13,061,239**	**63 *(44)***	**78 *(47)***	**1336 *(118)***

Data Analysis will account for pairing, clustering and sampling weights as applicable. Each indicator will be estimated and reported with a 95% confidence interval.

During data collection there will be triggers to ensure that wherever possible no piece of data is unrecorded. Any selected facilities that decline to participate or are found not to exist will be documented.

During data collection there will be triggers to ensure that wherever possible no piece of data is unrecorded. Any selected facilities that decline to participate or are found not to exist will be documented.

▪ KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) will be administered 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 Health Transition Fund.

Through the KIIs, we will:

- Analyse perspectives of health policy makers, of members of health centre committees and of health managers and providers with regard to the implementation mechanisms supported through the HTF;
- Map and explore barriers and facilitators to the achievement of the HTF objectives and results, at various levels of the system;
- Perform an in depth thematic analysis of progress towards achieving selected HTF outputs and outcomes, and in particular progress in specific HTF thematic areas where relevant.

Through FGDs, we will:

- Collect the views of key stakeholders in the communities and districts on the accessibility and appropriateness of project activities; and of what worked, what did not work, and why.
- Map and explore barriers and facilitators to the achievement of the HTF objectives and results at various levels of the system;
- Perform an in depth thematic analysis of progress towards achieving selected HTF outputs and outcomes, and in particular progress in specific HTF thematic areas where relevant.

In addition to national level interviews, we anticipate collecting qualitative data in a maximum of 3 districts in the country. It is proposed that the following districts are purposively chosen, due to their different socio-economic and health characteristics: **Murehwa, Matobo and Chivi**, within Matabeleland South, Mashonaland East and Masvingo provinces.

A summary of the proposed approach to qualitative research is illustrated in table 5 below.

Table 5: Characteristics of participants to be included in the qualitative component

Type of participants	Level	Reach	Data collection methods
Women of reproductive age and care givers of children under-5 (men & women separately)	Community	6-9 FGDs (72-108 participants; men & women separately)	Focus group discussions
Village health workers	Community	6-9 FGDs (72-108 participants)	Focus group discussions
Members of health centre committee (one/facility; 2-3 facilities/district)	Health Centre Committees	6-9	Key informant interviews
Health workers (2-3 health workers/facility; 2-3 facilities/district)	Health facilities	12-27	Key informant interviews
Staff from District Health Executive (3 districts in total, 3-5 participants/district)	District	3 FGDs (9-15 participants)	Focus group discussions
Staff members of multilateral and bilateral organizations and HTF Steering Committee members	National	4-5	Key informant interviews
Total interviews anticipated		***22-41***	
Total FGDs anticipated		***15-21***	
Total numbers of participants		**184-263 participants**	

DESIGN

The use of KIIs and FGDs responds to the opportunity for assessing the views of stakeholders with regard to *why and how* results were achieved (or not) and to *what worked and what did not work* in implementing the program.

Besides collecting the views of key stakeholders on the overall HTF program design and implementation, it is proposed that through KIIs and FGDs the evaluation also explores selected thematic areas, which are deemed to be key pillars of the HTF conceptual design.

The conceptual framework underlying the rationale of KIIs and FGDs is proposed here below, in line with the above mentioned objectives:

Table 6 - Key Informant Interviews, conceptual framework

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
Relevance	▪ 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?	Thematic framework analysis of perspectives of relevant stakeholders at facility and community level	Key Informant interviews with health care providers(2-3 healthcare workers/facility) (2-3 facilities/district) (6-9 interviews in total) Focus Group Discussions with VHWs and with communities (men and women)
	▪ Were the HTF supported interventions consistent with national health and nutrition policies and plans, and with global health and nutrition priorities?	Analysis and review of policy documents and plans	Policy documents and plans International policy documents and guidelines Key Informant interviews with multilateral and bilateral organizations and with HTF Steering Committee
	▪ Has the HTF made a difference in terms of governance and coordination at national and local level?	Thematic framework analysis of perspectives of relevant stakeholders at national, district and community level	Focus Group Discussions with DHO personnel (minimum one/facility) Key Informant interviews with health centre committees
Effectiveness	▪ What were the main facilitators and barriers to achieving intended results?	Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level	Focus Group Discussions with DHE personnel (minimum one/facility) Key Informant interviews with health centre committees
	▪ What unintended results – positive and negative – did the intervention produce? How did these occur?	Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level	Focus Group Discussions with VHWs and with communities (men and women)
Sustainability:	▪ To what extent does the government, at all levels of the system 'own' the HTF achievements?	Thematic framework analysis of perspectives of relevant stakeholders at national, district,	KIIs and FGDs (as above) Analysis of government budget allocations

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
		facility and community level	
	▪ Are any positive results likely to be sustained?	Case study on Health Retention Scheme	Questionnaires, interviews, review of secondary data and reports
	▪ How will the institutional and technical capacity and the systems developed be sustained?	Thematic framework analysis of perspectives of relevant stakeholders at national, district, facility and community level	KIIs and FGDs

DATA COLLECTION

Semi-structured topic guides will be designed to respond to the proposed framework and objectives of the KIIs and FGDs; pilot testing of the topic guides with non-participating informants will be conducted in advance of the field data collection.

It is anticipated that the KIIs will be conducted in English and will take maximum one hour. Before the start of each interview, the participants will be asked to read the informed consent, check their willingness to participate and record that on the consent form. The evaluation team will also obtain consent to audio record the interviews. For those participants who do not consent to audio record the interviews, the evaluation team will try their best to take notes of the discussion. We will ensure that both copies of the consent form handed out to the participants at the beginning of the interview are signed. Given one copy to the participants and keep the other in the evaluation file. The researcher will inform the participants that before closing the interview she will read the notes back to them so that they can clarify any points made.

It is anticipated that the FGDs will be conducted in local dialects and that an expert, local firm will be contracted to deliver this work. Before the start of each FGD, the facilitators will read the informed consent to the participants, check the willingness of the participants to take part and record that on the consent form. The evaluation team will also obtain consent to audio record the FGDs. For those FGDs who do not consent to audio record their discussions, the evaluation team will try their best to take notes of the discussion. We will ensure that both copies of the consent form handed out to the participants at the beginning of the FGDs are signed. Given one copy to the participants and keep the other in the evaluation file. The facilitator will inform the participants that before closing the FGDs she will read the notes back to them so that they can clarify any points made.

3.4 SECONDARY DATA SOURCES

We will use available reports that are relevant to both the Zimbabwe health system and the HTF programme. The main secondary data sources used for the final evaluation will include, but not limit to:

- DHE reports
- DHS 2005/06, DHS 2010/11, MIMS 2009 and MICS 2014 Reports

- Health Management Information System (HMIS) data for 2012-2015
- Health Services Fund (HSF plus) and Results Based Financing (RBF) Rollout Update to HTF SC. 5 February, 2015. PowerPoint Presentation
- Minutes of HTF Steering Committee (SC) meetings
- National Child Survival Strategy for Zimbabwe, 2010-2015

- Provincial Medical Director (PMD) Reports from 8 provinces
- Report of Joint Review Missions (JRM)
- The National Health Strategy for Zimbabwe (2009-2013) (Revised: 2009-2015)
- The Zimbabwe National Maternal and Neonatal Health Road Map (2007-2015)

- UNICEF HTF Annual Project Reports
- UNICEF's consolidated report on PMD
- Vital Medicines Availability Health Survey (VMAHSS) Quarterly Reports
- Zimbabwe MOHCC Review and Planning (MODO) Meeting Reports
- Zimbabwe MOHCC Review and Planning (MODO) Workshop Implementation Progress Presentations
- Zimbabwe National Health Profile (2012)
- Other MOHCC HR related PowerPoint presentations, data and reports

3.5 Data Analysis

All data will be managed in accordance with the LSTM policy.
Data will be collected via electronic devices and immediately checked for consistency as soon as uploaded on a central encrypted server. Any issues will be raised straight away with the respective site supervisor and LSTM Zimbabwe technical officer in charge of the health services assessment to ensure robust and accurate data is collected. Survey data will be analysed descriptively using SPSS ver. 22; appropriate statistical analysis to detect and describe difference amongst identified strata (e.g. urban/rural; distance from health facility; health system performance) will be performed.

Qualitative data will be transcribed verbatim as soon as possible following collection, ensuring all identifying information is removed and transcripts anonymised. Recordings of interviews and group discussions will be stored on password protected data devices and destroyed once the data have been transcribed and analysed. Every effort will be made to ensure that confidentiality and privacy of respondents is protected at all stages of data collection and processing.

The transcribed key informant interview material will be analysed thematically by two team members using Nvivo 10.

3.6 Research Policy and Ethical Standards

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

4. Implementation arrangements

4.1 Evaluation Team

The team assigned to the HTF final evaluation will encompass 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 is comprised on 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 data 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 and Health Financing
Dr. Sarah White - Statistician

4.2 Implementation partners

Local institutions will be contracted for qualitative (FGDs) and quantitative (survey) data collection activities.

For the **Health Services Assessment**, in line with previous surveys conducted by LSTM within the HTF evaluation and as approved through the Evaluation Inception report by the HTF Steering Committee, it is proposed that the the external company *Development Data* is contracted by LSTM to collect quantitative data. Development Data a leading southern African regional organisation provides technical support to governments, civil society and private sector entities in data collection and analysis and information management for development projects (www.developmentdata.info).

For the **Focus Groups Discussions** in communities, it is proposed that the *Department of Community Medicine at the University of Zimbabwe* is contracted by LSTM for the administration, translation and transcription of

FGDs. The Department of Community Medicine (DCM) was established in 1974 It is a service department that teaches public health across all programmes in the College of Health Sciences to both under and post graduate students. The DCM plays a very crucial role by providing the MOHCC in Zimbabwe and other countries in the SADC region with technical advice in evidence based planning, policy development, research, surveillance responding to diseases outbreaks monitoring and evaluation of public health interventions.

4.3 DELIVERABLES

. Final Evaluation Report
. Health Facility Assessment Report
. Power Point presentation summarizing the key findings of the final evaluation

4.4 TIMELINE AND WORK PLAN

The evaluation will take place between January and July 2016.

A detailed work plan is presented overleaf

Final Evaluation of the Health Transition Fund in Zimbabwe – WORK PLAN

Activities	Dec-15				Jan				Feb				Mar				Apr				May				Jun			
	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4	wk 1	wk 2	wk 3	wk 4
I. Planning and Design																												
1.1. Planning for 2014 Annual Report																												
Development of TOR for AR-2014 (work plan & proposed methods)																												
Submission of TOR to the HTF																												
Set up of evaluation team																												
Approval of End of Project TORs from MOHCC																												
Set up of HTF logframe (4 years)																												
1.2. Design of the Health Facility Survey																												
Update/Review of protocol for data collection and submission to MOHCC																												
Administrative authorization from the MOH for primary data collection (submission and approval)																												
Development of tools incl. revised questionnaires																												
Renewal of contract with survey company																												
Shipment of Tables to Zimbabwe (subject to authorization from MOHCC)																												
1.3. Design of key informant interviews and focus group discussions																												

Development of tools (interview topic guide, infor sheet, consent form)																												
Finalisation of tools for KII																												
Finalization of tools for FGDs																												
Identification of local institution for FGDs and contract award																												
II. Implementation & data collection																												
2.1. Health facility survey																												
Preparation/review of training guidelines and material																												
Training of data collection teams																												
Deployment of survey teams and data collection																												
2.2. Key informant interviews																												
Selection of key informants and scheduling of interviews																												
Administration of Interviews																												
2.3. Focus Group Discussion																												
Selection of target areas for FGDs; preparation																												
Administration of FGDs																												
Transcription of KIIs and FGDs																												
III. Data analysis & report writing																												
Survey data cleaning and processing																												

Survey data analysis																												
Survey report																												
Qualitative analysis of key informant interviews																												
Review of secondary data and desk based analysis and projections																												
Report writing																												
Submission of Draft evaluation report to UNICEF																												
Comments from HTF Steering Committee																												
Incorporation of comments/Submission of Final Report																												
Presentation of Evaluation Findings to HTF Steering Committee																												

5. Evaluation Design Matrix

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
Impact	▪ Has the HTF contributed to improve maternal newborn and child health and nutrition outcomes in Zimbabwe, from 2012 to 2015?	Analysis of change in HTF impact and outcome level indicators (Trends analysis/Annual Rate of Change) from 2011 to 2015	Baseline: MIMS 2009 or DHS 2010 Endline: preliminary data from DHS 2016 if available or projections (UN IGME) HMIS data and trends will be used to inform the simulation and for triangulation
		Estimates of additional maternal and children's lives saved from 2011 to 2015 (LiST tool)	As above
Relevance	▪ 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?	Thematic framework analysis of perspectives of relevant stakeholders at facility and community level	Key Informant interviews with health care providers(2-3 healthcare workers/facility) (2-3 facilities/district) (6-9 interviews in total) Focus Group Discussions 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)
	▪ Were the HTF supported interventions consistent with national health and nutrition policies and plans, and with global health and nutrition priorities?	Analysis and review of policy documents and plans	Policy documents and plans International policy documents and guidelines Key Informant interviews with multilateral and bilateral organizations and with HTF Steering Committee members (4-5 interviews)
	▪ Has the HTF made a difference in terms of governance and coordination at national and local level?	Thematic framework analysis of perspectives of relevant stakeholders at national, district and community level	Focus Group Discussions with DHO personnel (minimum one/facility) (2-3 facilities/district) ((6-9 FGDs in total) Key Informant interviews with health centre committees (3 districts in total; 3 FGDs in total)

Evaluation Criteria	Key Evaluation Questions	Methods	Sources
Effectiveness	▪ To which extent were HTF intended results achieved during its implementation?	Trend analysis of outputs against targets Disaggregation by geographical area/target group (secondary data, where applicable) In depth analysis of progress by HTF thematic areas	LSTM health services assessments 2014, 2015 and 2016; Secondary data sets and reports (VHMASS, HMIS, MODO, etc., etc.) Secondary data and reports
	▪ What were the main facilitators and barriers to achieving intended results?	Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level	Focus Group Discussions with DHE personnel (minimum one/facility) (2-3 facilities/district) ((6-9 FGDs in total) Key Informant interviews with health centre committees (3 districts in total) (3 FGDs in total)
	▪ What unintended results – positive and negative – did the intervention produce? How did these occur?	Thematic framework analysis of perspectives of relevant stakeholders at district, facility and community level	Focus Group Discussions 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)
Efficiency:	▪ To what extent was the HTF implemented as per plans and budget throughout its implementation period?	Costing outline by intervention/thematic area and by year	HTF Implementation plans, proposed budgets and expenditure data 2013, 2014 and 2015 Costs available via UNICEF
	▪ 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?	Case Study on cost benefits, utility and sustainability of procurement and supply management (kits)	Questionnaires; interviews; secondary data and reports
Sustainability:	▪ To what extent does the government, at all levels of the system 'own' the HTF achievements?	Thematic framework analysis of perspectives of relevant stakeholders at national, district, facility and community level	KIIs and FGDs (as above) Analysis of government budget allocations
	▪ Are any positive results likely to be sustained?	Case study on Health Retention Scheme	Questionnaires, interviews, review of secondary data and reports
	▪ How will the institutional and technical capacity and the systems developed be sustained?	Thematic framework analysis of perspectives of relevant stakeholders at national, district, facility and community level	KIIs and FGDs

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 4
Health Facility Assessment Report 2016

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
May 2016

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INTRODUCTION

Background

The Liverpool School of Tropical Medicine (LSTM), Centre for Maternal and Newborn Health was contracted as the independent institution responsible to conduct the evaluation of the Health Transition Fund in Zimbabwe (UNICEF contract N. 43137287), from 2013 to 2015.

The purpose of the **Independent Evaluation** is to assess to what extent the HTF strategies, approaches and the overall intervention logic have contributed to changing the health situation of the population in Zimbabwe, with a special focus on maternal, newborn and child health.

In line with the Terms of Reference submitted by LSTM in February 2014 and with the contract signed with UNICEF for the Independent Evaluation of the HTF, the LSTM conducted the final stage of the evaluation in the last quarter of 2015 and the first quarter of 2016.

As part of the final evaluation, LSTM undertook a rapid **Health Services Assessment (HSA)** to assess progress in enhancing quality and availability of care at all levels of the system. For comparability, the HSA built on the surveys previously conducted by LSTM in 2014 and 2015.

In line with the 2015 survey, 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; Level 1 Facilities.

Data collection took place in Zimbabwe from the 22nd February to 4th March 2016.

Objectives of the Health Services Assessment

The purpose of the **Final Evaluation** is:

- 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.

The LSTM Survey 2016 provides an independent measurement of a sub-set of **HTF outcome and output indicators**, collectable at health services level, providing estimates at national level, with 95% confidence intervals.

In line with the sampling calculations presented for the Annual Review 2014, the assessment covers:

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

METHODS

Design

The health services assessment covered the entire country, in order to provide a picture of progress in improving availability of care at country level.
The design of the assessment was tailored to the HTF results framework, designed by MOHCC and partners at project inception, and to national standards and protocols of care.

The survey methods have been refined based on lessons learnt through the previous assessments conducted by LSTM in March 2014 and April 2015, and reviewed to maximize the consistency and relevance of the exercise to HTF information needs, also taking into account other surveys conducted and routine data mechanisms used in country.

In line with the HSA objectives, the survey consists of:

- A module focusing on health services functioning at District Health Office level;
- A module focusing on availability of maternal and child health services at facility level, targeting district level hospitals (both government and mission hospitals) and Level 1 facilities.

LSTM submitted a survey protocol to the Ministry of Health and Child Care (MOHCC) in Zimbabwe for approval in January 2016. This is available in **Design Note for the Final Evaluation**.

Indicators

The HTF Results Framework relies on a total of three impact, 29 outcome and 55 output indicators, which were identified at programme inception to measure progress in achieving the planned HTF targets. The four HTF thematic areas include maternal, newborn and child health and nutrition; medical products, vaccines and technologies; human resources for health and; health policy, planning and finance. Of those, a sub-set of **31 HTF indicators (four outcome and 27 output indicators)** were collected through the Health Services Assessment to assess progress of the HTF initiative in strengthening health services at various levels of the system. These are presented in **table 2**.

The indicators collected through the LSTM survey were triangulated with routine information available in country, as well as with other existing surveys or monitoring mechanisms. Furthermore, the evidence collected through the survey (*what*) was complemented by qualitative research used to enrich the analysis (*why? How?*).

Table 1 below lists the indicators collected through the assessment.

Table 1 - Type of indicators collected through the LSTM Health Service Assessment

HTF Thematic Area	*Number of HTF-defined Output Indicators*	*Number of Indicators collected by LSTM through the HSA*
Theme 1 – Maternal, Newborn and Child Health and Nutrition	37	26
Theme 2 – Medical products, vaccines and technologies	8	2
Theme 3 – Human Resources for Health	3	-
Theme 4 – Health Policy, Planning and Finance	7	3
Total	**55**	**31**

The table below presents the full list of indicators.

Table 2 - HTF Indicators measured through the LSTM Health Services Assessment

N.	INDICATORS (number and name)	Targeted level of health system
Outcome indicators		
1	1.1.3. Proportion of district hospitals providing comprehensive emergency obstetric and newborn services	District level hospitals
2	1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	District health offices
3	1.2.1. Proportion of health centres with functional health committees	Level 1 Facilities
4	4.1.3. Proportion of health facilities charging user fees for MNCH services	District level Hospitals and Level 1 Facilities
Output indicator number and name		
THEME 1. Maternal, newborn and child health and nutrition		
1.1 Enhancing Obstetric and Newborn Care Capacity of the Health System		
5	1.1.1.1.Proportion of PCNs trained on focused ANC	District Level Hospitals and Level 1 Facilities
6	1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	Level 1 Facilities
7	1.1.2.2. Proportion of rural health centres with the necessary equipments and consumables for basic EmONC services	Level 1 Facilities
8	1.1.3.1. Proportion of District Hospitals having at least one health professional who can do C/S	District level hospitals
9	1.1.3.2. Proportion of district Hospitals with at least one health professional who can provide anaesthesia for emergency obstetric surgery	District level hospitals
10	1.1.3.3. Proportion of District Hospitals with fully functional operation room to perform emergency obstetric surgery	District level hospitals
11	1.1.3.4. Number of district hospitals with fully functional mother waiting homes (MWHs)	District level hospitals
12	1.1.3.5. Number/Proportion of district hospitals having at least 1 ambulance	District level hospitals
13	1.1.3.6. Proportion of health facilities with at least one fully functional mode of communication equipment for emergency referral	District level hospitals
14	1.1.3.7. Number/Proportion of District Hospitals with the capacity to provide blood transfusion for emergency obstetric care	District level hospitals
15	1.1.4. Proportion of rural health facilities conducting at least 3 PNC visit within the 1st week after delivery	Level 1 Facilities
16	1.1.5.1. Number/Proportion of districts conducting quarterly supportive supervision to health facilities	District health offices
1.2 Improve the Community Health Services System for MNCH and Nutrition		
17	1.2.1. Proportion of health committees at the health centre level conducting regular monthly meetings to discuss health issues	Level 1 Facilities
18	1.2. 2. OPD utilisation rate	District Level Hospitals and Level 1 Facilities
1.3 Improve Child Health Through Strengthening the EPI and IMNCI		
19	1.3.3.1. Proportion of health centres having at least one Health Worker trained on IMNCI	Level 1 Facilities
20	1.4.2.2. Proportion of health facilities with at least one health worker trained in IYCF	Level 1 Facilities
21	1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	Level 1 Facilities

N.	INDICATORS (number and name)	Targeted level of health system
22	1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	Level 1 Facilities
23	1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	Level 1 Facilities
24	1.4.6.1.1. Number of district providing quarterly report on nutrition program implementation	District health offices
25	1.4.6.1.2. Availability of at least 1 trained nutrition manager at provincial and district level of the health system	District health offices
26	1.4.6.1.3. Number of districts conducting quarterly supportive supervision on nutrition	District health offices
THEME 2: Medical Products, Vaccines and Technologies (Medicines)		
27	2.1.3. Number of districts with at least 1 person trained in LMIS and rational drug use	District health offices
28	2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	District level Hospitals and Level 1 Facilities
THEME 4: Health Policy, Planning and Finance		
29	4.1.1. Number of districts that regularly develop annual work plans	District health offices
30	4.1.2. Number of districts conducting regular annual review meeting	District health offices
31	4.1.5. Proportion of Health facilities receiving regular financial support through the Health service fund to cover basic recurrent cost	District level Hospitals and Level 1 Facilities

Sampling Methodology

The survey assessed three different study populations:

1) District Health Offices
2) District Level Hospitals – these would include both Government District Hospitals, and Mission level facilities performing comprehensive obstetric care (CEmONC) in the districts.
3) All level 1 facilities

Therefore, there are three sample size calculations.
For each indicator a 95% confidence interval is provided along with an estimate of the indicator. For each population the margin of error in estimation was set not to exceed 10%.

To calculate sample sizes, the following formulae were used to determine the required sample sizes using simple random sampling:

$$n_0 = \frac{z^2_{1-\alpha/2}\,\pi(1-\pi)}{\varepsilon^2} \quad \text{and} \quad n = \frac{n_0}{1+\frac{(n_0-1)}{N}}$$

Where n_0=required sample size for a very large population

α = significance level (5%)

$z_{1-\alpha/2}$ = the two-tailed critical value corresponding to a significance level of α (1.96)

π = the assumed proportion (50%)

ε = margin of error (10%)

n = required sample size corrected for a finite population size

N = the population size

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.

Table 3 indicates the number required for each study population if using simple random sampling independently for each population.

Table 3 - Study Populations and Required Sample Sizes when using stratified sampling

Population	***Population size***	***Sample size required*** *(sampling fraction)*
District Health Offices	63	39 (62%)
District level Hospitals (*Government and Mission hospitals*)	78	43 (55%)
Level 1 Facilities	1,336	90 (6.7%)

Sampling strategy

The same facilities as in the previous assessment in 2015 were re-assessed. Details of the sampling strategy are explained below.

District Health Offices.

Sampling of District Health Offices was stratified by province and the required sampling fraction was be achieved across all provinces by rounding required numbers upwards. This ensures that at provincial level the districts have approximately equal chance of being included in the sample, and that the sample is approximately self - weighted with regard to province. A total of 44 districts were selected in the sample.

District level Hospitals (Government and mission hospitals)

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. Since the sampling was clustered the sample size required had to be increased based on there being intracluster correlation (ICC). The design effect depends not only on the ICC but also on the mean cluster size and the coefficient of variation of cluster size, all of which were not available for the 2013 evaluation conduced in 2015. Adams et al (2004) reported the IQR for ICCs for cluster-based studies in primary care to range from 0 to 0.032. It is assumed that the ICCs for this assessment do not exceed 0.065.

With 78 hospitals distributed between 63 districts the design effect was expected to vary between 1.03 and 1.10 if all hospitals within selected facilities are included. Thus, a 10% increase in the total number of clusters was expected to suffice to account for clustering for this level of sampling. Therefore 47 district level hospitals (government and mission) were sampled from the 44 selected districts. The number of hospitals within each district was capped at 2 to achieve the required number of hospitals. In districts with more than two district level hospitals random sampling was used to select hospitals.

Level 1 Facilities

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. Two or three facilities were sampled for each selected district, thus the coefficient of variation of the cluster size was 0.20. Again, assuming that the ICC would not exceed 0.065 the design effect would be no more than 1.10. Thus, a total of 99 facilities was expected to be sufficient to account for clustering at this level of sampling. To achieve this number, among the districts sampled within each Province the two districts with the largest number of facilities was identified, three facilities were randomly selected from each of these two districts, two facilities were randomly selected from each of the other sampled districts. Two largely urban provinces have no district hospitals and no more

than two districts whereas four or more districts were sampled from all other provinces. To ensure adequate representation of facilities within these largely urban provinces they were over-sampled: a sample of 10 facilities was selected from each of these Provinces. Therefore, a total of 118 level 1 facilities was sampled from the 44 selected districts.

Table 4 below indicates the numbers of facilities selected within each Province at each level.

Table 4 - Numbers of districts and facilities for each level by province and numbers to be sampled (n)

Province	Total population	Districts	District Level hospitals*	Level 1 facilities
Bulawayo	653,337	1 *(1)*	0 *(0)*	26 *(10)*
Harare	2,123,132	2 *(2)*	0 *(0)*	67 *(11)*
Manicaland	1,752,698	8 *(5)*	12 *(7)*	244 *(13)*
Mashonaland Central	1,152,520	8 *(5)*	10 *(7)*	129 *(11)*
Mashonaland East	1,344,955	9 *(6)*	13 *(6)*	169 *(15)*
Mashonaland West	1,501,656	6 *(4)*	9 *(7)*	162 *(9)*
Masvingo	1,485,090	7 *(5)*	9 *(5)*	165 *(13)*
Matabeleland North	749,017	7 *(5)*	7 *(5)*	106 *(12)*
Matabeleland South	683,893	7 *(5)*	7 *(5)*	109 *(12)*
Midlands	1,614,941	8 *(6)*	11 *(5)*	159 *(12)*
Total	**13,061,239**	**63 *(44)***	**78 *(47)***	**1,336 *(118)***

A complete list of the District Health Offices, District Level Hospitals and Level 1 Facilities surveyed through the LSTM Health Facility Assessment is provided in **Annex I and Annex II**.

Survey Tools

The survey questionnaires used for the assessment were adapted from the survey previously conducted by LSTM in Zimbabwe in March 2015, and adjusted to respond to the comments and feedback received from the HTF Steering Committee following the 2015 data collection exercise.

At District Health Office level:
The district level survey was first conducted in 2015 by LSTM; it was introduced to complement available secondary data for District level management and supervision of health services.
A rapid assessment tool was designed based on the WHO guidelines[1] to assess District Health Systems, and adapted to the local context and to the specific HTF information needs.

At health facility level:
The tool used at health facility level was adapted from the one used by LSTM in 2014 and 2015. In order to maximize consistency with national protocols, the questionnaires were triangulated with other surveys and routine data sources used in country, including:

- The National Integrated Health Facility Survey 2011 (NIHFA);
- VHMAS questionnaires and reports;
- HTF Joint Review Mission assessment tools (JRM);
- Health Monitoring Information System indicators.

[1]Tools for Assessing the Operationality of District Health Systems, WHO 2003

The questionnaires were also tested with various cadres of the health system, in order to ensure consistency, clarity, and adherence to protocols.

The survey questionnaires, alongside with training materials and field guides are available from LSTM upon request.

Once finalized and tested, the questionnaires were converted into electronic questionnaires, using the software FileMaker©, and then uploaded on 20 tablets (iPads mini 3G) that were used for data collection.
The tablets were temporarily shipped to Zimbabwe from Liverpool, upon authorization from the MOHCC. After completion of the fieldwork, they were returned to LSTM in UK.

Data Collection

LSTM contracted an external company to conduct data collection, **Development Data,** which is a leading southern African regional organisation that provides technical support to governments, civil society and private sector entities in data analysis and information management for development projects (www.developmentdata.info).

Development Data recruited 20 data enumerators, who received intensive electronic data collection training during the period 15-17 February 2016 in Harare. LSTM and Development Data jointly conducted the training. Data collection took place in Zimbabwe from22nd February to 4th March 2016.

The training agenda is available in **Annex III.**

Data Analysis

Data cleaning and quality assurance

Validation mechanisms were in-built in the electronic data collection tools, to minimize the risks of errors in entering information during the survey.
During data collection, the survey teams e-mailed completed questionnaires from each iPad to a central repository upon completion, as soon as they had access to a 3g internet connection.
This allowed for a "nearly" real-time quality assurance, analysis and review of questionnaires from a LSTM research assistant, deployed to Zimbabwe for the duration of the survey.

Afterwards, data were reviewed at LSTM and specific queries were sent back to the data collection team for clarification or request of information. Development Data in turn addressed all the queries by contacting the health facilities, and data cleaning was finalized by the third week of March 2016.

Data analysis

Electronic questionnaires were merged into data sets in FileMaker and then exported into Stata.
Two separate data sets were created: one for the survey administered to District Health Offices, and one for the survey administered to Health Facilities. The data sets are encrypted and stored at LSTM, and available upon request.

The LSTM statistician conducted data analysis, during the months of March and April 2016.

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. The weighting of each facility reflected the number of facilities available for sampling at the same level within the district. Where estimates are provided for facilities at both levels these have been derived to give each facility in the study population equal weight, regardless of type, i.e. the over-sampling of district level hospitals does not give greater weight to this level of care in the estimates provided. For two indicators (proportion of PCNs training in FANC and OPD utilization rates) the size of population at the facility was used to weight the estimates rather than using the sampling weights (since it is not possible to simultaneously weight by population size and specify sampling weights).

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

Some statistics are reported only among facilities, which provided data. Among the indicators the statistics concerned are mean charges for services are based on facilities charging for the service, and OPD utilization rates.

Where the upper limit of a confidence interval was reported by Stata to exceed 100 or the lower limit was below 0, to approximations by Stata being used in derivation of the confidence interval. These values have been reported as 1% or 99% to reflect the impossibility of the values lying on our outside the boundaries of the range 0% to 100%. Clearly, the percentage cannot be 100 (or 0) unless all individuals observed had the indicator present (or absent).

KEY FINDINGS

SECTION 1 - CORE INDICATORS

1.1. District Level Indicators

Table 5 - District level indicators

HTF INDICATOR	*Weighted % (95% CI)*
1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	82.1 (76.2, 88.1)
1.1.5.1. Proportion of districts conducting quarterly supportive supervision to health facilities	85.6 (80.9,90.4)
1.4.6.1.1. Proportion of district providing quarterly report on nutrition program implementation	73.5 (66.4,80.6)
1.4.6.1.2. Proportion of districts with at least 1 trained nutrition manager at provincial and district level of the health system	85.9 (81.1,90.7)
2.1.3. Proportion of districts with at least 1 person trained in LMIS and rational drug use	87.2 (81.5,92.9)
4.1.1. Proportion of districts that regularly develop annual work plan	62.8 (56.9,68.8)
4.1.2. Proportion of districts conducting regular annual review meetings	63.2 (56.2,70.2)

1.2. Facility Level Indicators

Table 6 - Facility level indicators

HTF INDICATOR	*Level*	*Weighted % (95% CI)*
1.1.3. Proportion of district-level facilities providing comprehensive emergency obstetric and newborn services	District Hospital	73.0 (63.8,82.1)
1.1.3.1. Proportion of district-level facilities having at least one health professional who can do C/S	District Hospital	97.4 (94.6,100)
1.1.3.2. Proportion of district-level facilities with at least one health professional who can provide anaesthesia for emergency obstetric surgery	District Hospital	93.0 (87.9,98.0)
1.1.3.3. Proportion of district-level facilities with fully functional operation room to perform emergency obstetric surgery	District Hospital	88.5 (82.3,94.7)
1.1.3.4. Proportion of district-level facilities with fully functional mother waiting homes (MWHs)	District Hospital	82.3 (74.8,89.7)
1.1.3.5. Proportion of district-level facilities having at least 1 ambulance	District Hospital	85.6 (80.4,90.8)
1.1.3.7. Proportion of district-level facilities with the capacity to provide blood transfusion for emergency obstetric care	District Hospital	77.8 (69.0,86.6)

HTF INDICATOR	*Level*	*Weighted % (95% CI)*
1.1.1.1. Proportion of PCNs trained on focused ANC[2]	All[3] (n=109)	69.2 (63.1,75.2)
4.1.3. Proportion of health facilities charging user fees for MNCH services	All	18.5 (15.0,21.9)
1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	All	96.1 (93.1,99.0)
1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	All	94.6 (91.5,97.6)
1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	All	97.1 (95.0,99.2)
2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	All	78.9 (73.4,84.5)
4.1.5. Proportion of Health facilities receiving regular financial support through the Health service fund (RBF) to cover basic recurrent cost	All	57.2 (50.9,63.4)
1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	L1 rural[4] (n=77)	86.3 (78.4,94.2)
1.2.1. Proportion of rural health centres with functional health committees	L1 rural	86.6 (78.7,94.5)
1.2.1. Proportion of rural health centres with functional health committees conducting regular monthly meetings to discuss health issues	L1 rural	65.9 (55.0,76.8)
1.1.2.2. Proportion of rural health centres with the necessary equipment and consumables for basic EmONC services	L1 rural	4.2 (0.0,9.0)
1.1.3.6. Proportion of health facilities with at least 1 mode of communication equipment for emergency referral	All	97.5 (95.9,99.2)
1.1.4 Proportion of rural health facilities conducting at least 3 PNC visits within the first week after delivery	L1 rural (n=80)	87.8 (80.7,94.9)
1.2.2. OPD utilisation rate for level 1 facilities[5]	L1 (n=113[6])	1.03 (0.87,1.18)
1.3.3.1 Proportion of health centres having at least 1 health worker trained on IMNCI	L1	81.1 (74.0,88.2)

[2] Weighted mean proportion, where weighting is according to the number of PCNs
[3] Number indicates the number of facilities with any PCNs
[4] Number of rural health centres
[5] Weighted mean proportion, where weighting is according to the size of the catchment population
[6] Number of facilities with available data (population size and number of OPD visits)

SECTION 2 - DISTRICT HEALTH OFFICES ASSESSMENT

2.1. Characteristics of the Study Population

Forty-four District Health Offices were randomly selected for the survey; they were distributed as follows:

Table 7 – District health offices included in the survey

Province	*N. Districts*
Harare	2
Bulawayo	1
Mashonaland East	6
Mashonaland West	4
Mashonaland Central	5
Manicaland	5
Masvingo	5
Midlands	6
Matebeleland North	5
Matebeleland South	5
Total	**44**

A complete list of the District Health Offices interviewed through the survey is available in **Annex I.**

The mean reported population of the districts surveyed was of 190,624 inhabitants (range: 64,901 to 682,562).

The mean number of health facilities in the districts surveyed was 24 (range: 7 to 52).

The districts assessed presented:
- a mean number (range) of 1.5 (0.2,3.2) health facilities per 10.000 population
- a mean number (range) of 0.03 (0,0.09) medical doctors per 1.000 population
- a mean number (range) of 1.0 nurses and midwives per 1.000 population

Based on information collected at district level, we explored the correlation between:
- The number of health facilities and the total population;
- The number of health facilities and the number of skilled health workers (medical doctors, midwives, nurses);
- The number of skilled health workers and the total population.

Among the districts surveyed, the number of facilities is positively associated with the population size; the number of skilled health workers was positively associated with each of the population size and the number of facilities. Although such an analysis cannot be considered exhaustive, it is consistent with an equitable design and distribution of the health system (infrastructure and personnel) to respond to the needs of the targeted population.

2.2. Progress at District Health Management Level in HTF Defined Indicators

Seven core indicators identified by the HTF log-frame were collected at DHO level to measure progress against targets.

For most of these indicators (n=5), baseline data were not available, and therefore progress from 2011 to date could not be assessed.

The table 8 below summarizes the coverage levels measured for each indicator through the LSTM assessment, and the gap to the target set by the program for end of 2015.

Table 8 - Progress in HTF indicators at District Level

HTF indicators at district health management level-End of project evaluation 2016	Baseline (2010/11)	Endline (2015/2016)	Target	Gap to target
1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	20.10%	82.10%	100.00%	-18%
1.1.5.1. Number/Proportion of districts conducting quarterly supportive supervision to health facilities	57%	85.60%	62.00%	24%
1.4.6.1.1. Number of district providing quarterly report on nutrition program implementation	?	73.50%	100.00%	-27%
1.4.6.1.2. Availability of at least 1 trained nutrition manager at provincial and district level of the health system	0	85.90%	80.00%	6%
2.1.3. Number of districts with at least 1 person trained in LMIS and rational drug use	NA	87.20%	48.00%	39%
4.1.1. Number of districts that regularly develop AWP	NA	62.80%	100.00%	-37%
4.1.2. Number of districts conducting regular annual review meeting	NA	63.20%	100.00%	-37%

In summary, the survey provided the following evidence:

- ✓ Three out of seven indicators have met their targets set for the end of the program at DHO level;
- ✓ Four indicators relevant to planning and reporting have not met their targets.

2.3. Additional Findings at District Health Office Level

The section on additional findings provides a detailed description of the information collected at District Health Office level through the LSTM-HAS survey, in addition to the coverage levels of the above reported core indicators.

2.3.1. Leadership, management, & governance

Planning

The District Health Executives (DHEs) surveyed developed their annual work plans regularly during the past three years, although survey data show a declining trend in the proportion of districts developing annual work plans (AWPs) is observed from 2013 to 2016.

Table 9 - District Health Executives developing Annual Work Plans

	% 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)
Work plan 2016 developed and implemented	68	(63,73)
Work plan developed with partners' participation	62	(55,69)

Management

Within all the districts surveyed, all 100% of the DHEs reported to hold management meetings and 79% to hold such meetings on a monthly basis.

Annual Review Meetings (with records of last meeting available) were held by 63% of DHEs.

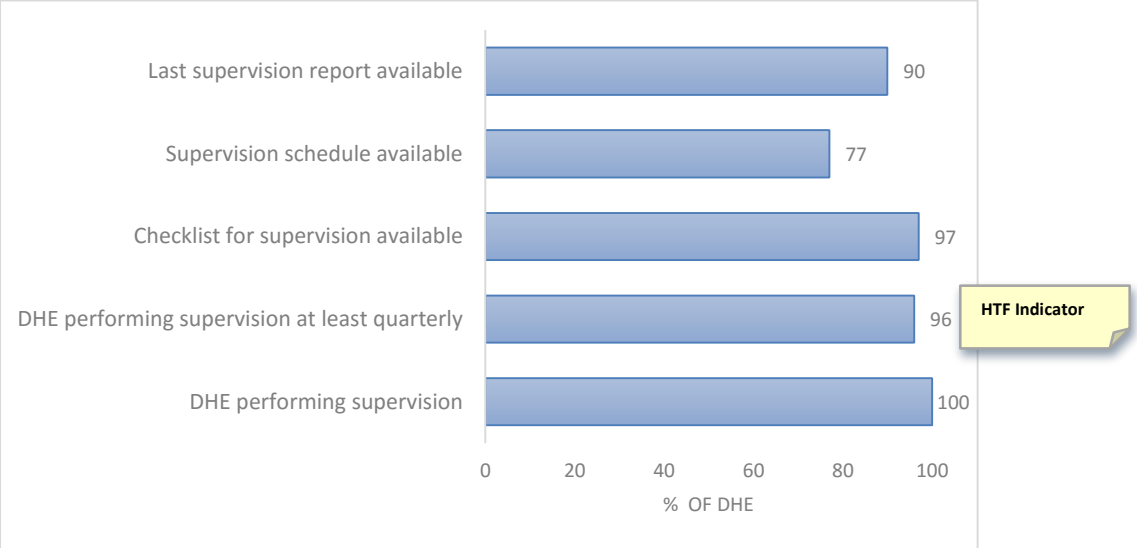
Table 10 – District Health Executives holding management and review meetings

	% of DHEs: (n=44)	95% CI
Management Meetings		
DHEs holding management meetings:	100%	
Frequency of meetings:		
Monthly	*79*	(72,85)
Quarterly	*6*	(3,9)
Other	*15*	(9,22)
Records of DHE meetings available:	100	
Annual Review meetings		
DHE holding annual review meetings (*records of last meeting available*)	63	(56,70)
Last annual review meetings with partners participation	45	(38,52)

Supportive Supervision

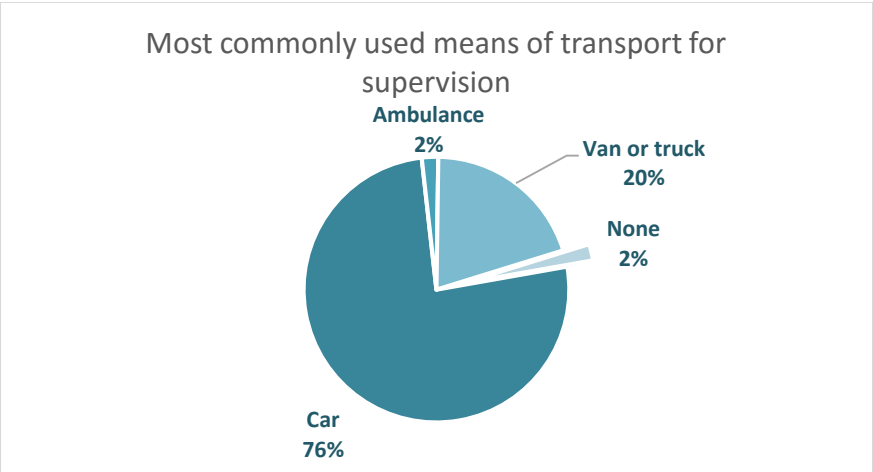
Amongst the district health offices surveyed, 100% reported to perform supportive supervision to health facilities in their district, and 95.5% reported to do it at least quarterly.
Concurrently, 95.5% of DHOs reported to receive supervisory visits from the Provincial Health Offices.
Findings on supervision at DHO level are summarized in Figure 1 below.

Figure 1 - Supervision from District Health Offices



At District level, the most common means of transportation used for supervision was cars (76%).
Only 2% of the DHOs reported to have no means of transport available for supervision.

Figure 2 - Most common means of transport for supervision



2.3.2. Human Resources for Health

The District Health system in Zimbabwe is under the responsibility of DHE, a core team in charge of planning, management and supervision of health services in each district of the country. Both HTF and other initiatives provide support to DHEs, including training and allowances.

Our assessment at district level indicates that most of the critical posts at DHEs level were filled in the majority of the districts. Table 11 below illustrates this.

Within the districts with the DHE posts filled, more than 90% of each cadre of DHE post holders are receiving retention allowances and at least 81% of DHE post holders of each cadre have been trained in management, with the exception of pharmacy technicians (68%).

Within the districts, 77.3% have at least one trained nutrition manager at district level (HTF indicator: 1.4.6.1.2). 88.6% of districts have with at least one person trained in LMIS and rationale drug use (HTF indicator 2.1.3).

Table 11 – Districts with DHE established posts in place

District Health Executive Established Posts	Districts with DHE Post Filled (%)	Among districts with DHE post filled		
		Districts with person in post > 2 years	Post holder Receiving retention allowances	Post holder trained in Management
Medical Officer (n=42/43)	97 (94,99)	50 (43,57)	97 (97,97)	84 (78,89)
Nursing Officer (n=43/44)	98 (95,99)	73 (64,81)	94 (94,98)	89 (83,96)
Environmental Health Officer (n=38/44)	87 (81,92)	85 (79,91)	91 (85,96)	83 (75,91)
Health Services Administrator (n=34/37)	92 (86,98)	55 (43,66)	91 (87,94)	86 (78,94)
Pharmacy technician (n=41/42)	97 (94,99)	72 (63,80)	96 (92,99)	68 (59,76)
Accountant (n=36/37)	97 (9399)	81 (71,90)	95 (90,99)	81 (73,89)

2.3.3. Health Care Financing

All the Districts (100%) surveyed confirmed that annual budgets were developed.
During the assessment, detailed financial information regarding the amount of funding received at District level and its breakdown by source was not available.
More than half (61%) of DHEs assessed reported to have received less than 50% of the annual budget for 2015. This suggests an improvement from the preceding year where the vast majority (94.4%) of DHEs assessed reported to have received less than 50% of the budget for 2014. However, it is not possible to provide any conclusion as almost a quarter of the surveyed facilities do not know the proportion of their annual budget though it seems unlikely that all unknowns would be <50%.

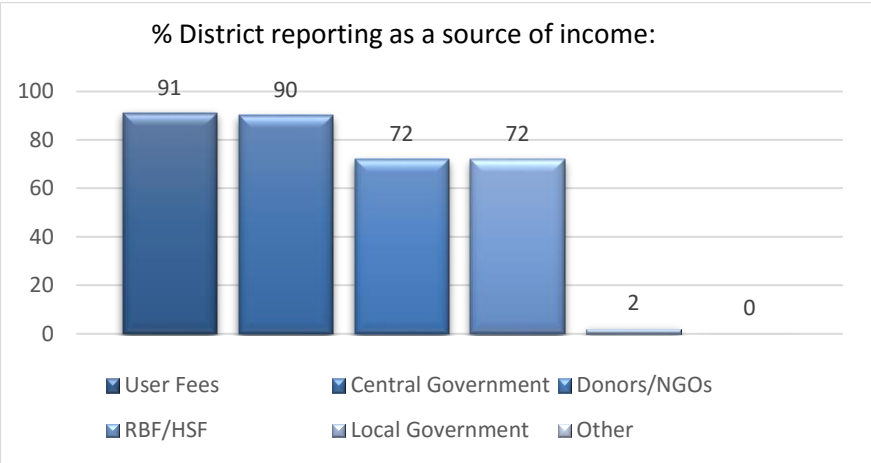
Table 12 - Distribution of Districts by proportion of annual budget for health received in 2015

	%DHE (n=41)			
	≤50%	**>50% to ≤75%**	**>75%**	**Unknown**
Proportion of annual budget disbursed to district in 2015	61 (54,67)	10 (8,12)	2 (>0,5)	27 (20,33)

Proportion of districts receiving past quarterly disbursement on time: 17% (n=7). Of those seven, only one DHE received 100% of the requested budget. (Other values: 32%, 40%, 55% and unknown value).

User fees (91%) and the Central Government (90%) were the most common source of income reported among the districts at 91%. The other main source of income was; nearly three quarters (72%) was reported from Donors/NGOs and from RBF/HTF, and only 2% from the Local Government.

Figure 3 - Proportion of districts reporting each source of income



2.3.4. Health Information

The survey revealed an encouraging situation with regard 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 also reported to have a computer available for HMIS (98%) and an internet connection (80%). All DHEs reported to provide timely feedback to facilities (100%).

Table 13 - Availability of equipment for HMIS and utilization of HMIS data at DHE level

HMIS at District Level	*% DHEs (n=44)*	*95% CI*
Functioning computer for HMIS available	98	(97,99)
Internet connection available	80	(73,87)
DHE with charts and diagrams on display	98	(97,99)
DHE providing feedback to facilities on HMIS reports	100	

SECTION 3 – HEALTH FACILITY ASSESSMENT

3.1. Characteristics of the Study Population

The health facility survey was administered to 165 facilities throughout Zimbabwe, distributed as follows:

Table 14 - Distribution of surveyed health facilities

Province	*Level 1 Facilities*	*District Level Hospitals**	*Total*	*%*
Bulawayo	10	-	10	*6.1*
Harare	11	-	11	*6.7*
Manicaland	13	7	20	*12.1*
Mashonaland Central	11	7	18	*10.9*
Mashonaland East	15	6	21	*12.7*
Mashonaland West	9	7	16	*9.7*
Masvingo	13	4	18	*10.9*
Matebeleland North	12	5	17	*10.3*
Matebeleland South	12	5	17	*10.3*
Midlands	12	5	17	*10.3*
Total	**118**	**47**	**165**	***100.0%***

(*) This includes mission hospitals that are designated as district hospitals

A complete list of the Health Facilities interviewed through the survey is available in **Annex II.**

The facilities surveyed presented the following key features:

- The mean catchment population for the surveyed facilities was estimated at 15,152 (range: 418-171,911) pop. for level 1 facilities, and at 36,613 (2,567 - 257,894) for district level hospitals.

- During the year preceding this survey, the mean (range) annual number of OPD consultations was estimated at 10,965 (106-101,802) for level 1 facilities, and at 20,256 (1,152 -176,295) per district level facilities;

- The mean number of live births per facility was 232 (0 - 3,435) in level 1 facilities, and 1,294 (45 - 3,161) at district level facilities.

- In total, five maternal deaths were recorded at Level 1 facilities during the year preceding the survey, and 99 at District Level Hospitals.

- 161 of the facilities surveyed offered maternity services (four level 1 facilities did not).

3.2. Progress at Health Facility Level in HTF Defined Indicators

Twenty-two core indicators were collected at health facility level to measure progress against HTF defined targets. The coverage per each indicator and the gap to the HTF defined target is summarized in **Table 15** overleaf. At facility level, the assessment revealed the following key features, concerning progress in achieving HTF targets:

Progress 2011-2015 (end of programme)

- For 3 of the 22 indicators measured through the assessment, a baseline was not available and therefore progress could not be assessed;
- For 1 indicator (1.1.2.2. equipment for EmONC), we did not determine a single composite value for the end of the programme, although all the equipment availability for EmONC was measured, since a clear definition of "necessary equipment for BEmONC" could not be documented;
- For the remaining 19 indicators, the LSTM assessment shows a clear progress compared to the situation in 2011.

Gap at the end-of-programme

- For 4 of the 20 indicators, no target had been set at program inception and hence the gap to target could not be measured;
- For 10 of the 22 indicators, the targets set for 2015 have already been achieved and in many cases they have been largely exceeded;
- For 1 indicator, the distance to target is minimal (less than 1%);
- For 1 indicator (1.1.2.2. equipment for EmONC), we did not determine a single composite value although all the equipment availability for EmONC was measured through the survey, since a clear definition of "necessary equipment for CEmONC" could not be documented.
- For 6 of the 22 indicators, there is still considerable progress to be made; this may be due to two potential reasons:
    - The targets set at project inception were too ambitious;
    - Change in the socio-economic context and in HTF investments and priorities, which were not reflected in a revised log-frame

Table 15 - Progress in HTF Indicators at Health Facility Level

HTF INDICATORS - Tracking matrix				
HTF indicators at facilities level-End of project evaluation 2016	**Baseline (2010/11)**	**Endline (2015/2016)**	**Target**	**Gap to target**
1.1.3. Proportion of district hospitals providing comprehensive emergency obstetric and newborn services	38%	73.0%	80%	-7%
1.2.1. Proportion of health centres with functional health committees	78%	86.6%	90%	-3%
1.1.1.1.Proportion of PCNs trained on focused ANC	20%	69.2%	80%	-11%
1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	20%	86.3%	NA	NA
1.1.2.2. Proportion of rural health centres with the necessary equipments and consumables for basic EmONC services	20%	Not comparable	80%	NA
1.1.3.1. Proportion of District Hospitals having at least one health professional who can do C/S	55%	97.4%	80%	17%
1.1.3.2. Proportion of district Hospitals with at least one health professional who can provide anaesthesia for emergency obstetric surgery	55%	93.0%	80%	13%
1.1.3.3. Proportion of District Hospitals with fully functional operation room to perform emergency obstetric surgery	55%	88.5%	80%	9%
1.1.3.4. Number of district hospitals with fully functional mother waiting homes (MWHs)	20%	82.3%	100%	-18%
1.1.3.5. Number/Proportion of district hospitals having at least 1 ambulance	55.2%	85.6%	NA	NA
1.1.3.6. Proportion of health facilities with at least one mode of communication equipment for emergency referral	Landline 19.4%, Radio11.6%	97.5%	80%	18%
1.1.3.7. Number/Proportion of District Hospitals with the capacity to provide blood transfusion for emergency obstetric care	53%	77.8%	NA	NA
1.1.4. Proportion of rural health facilities conducting at least 3 PNC visit within the 1st week after delivery	12%	87.8%	70%	18%
1.2.1. Proportion of health committees at the health centre level conducting regular monthly meetings to discuss health issues	78.20%	86.6%	80%	7%
1.2. 2. OPD utilisation rate	NA	1.01	1.00	1%
1.3.3.1. Proportion of health centres having at least one Health Worker trained on IMNCI	0	81.1%	80%	1%
1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	20%	96.1%	80%	16%
1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	25%	94.6%	80%	15%
1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	25%	97.1%	80%	17%
2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	NA	78.9%	80%	-1%
4.1.3. Proportion of health facilities charging user fees for MNCH services	NA	18.5%	NA	NA
4.1.5. Proportion of Health facilites receiving regular financial support through the Health service fund to cover basic recurrent cost	0	57.2%	80%	-23%

3.3. Additional Findings at Health Facility Level

The section on additional findings provides a detailed description of the information collected at Health Facility Level through the LSTM survey, in addition to the coverage levels of the above reported core HTF indicators.

3.3.1. Utilities and Infrastructure

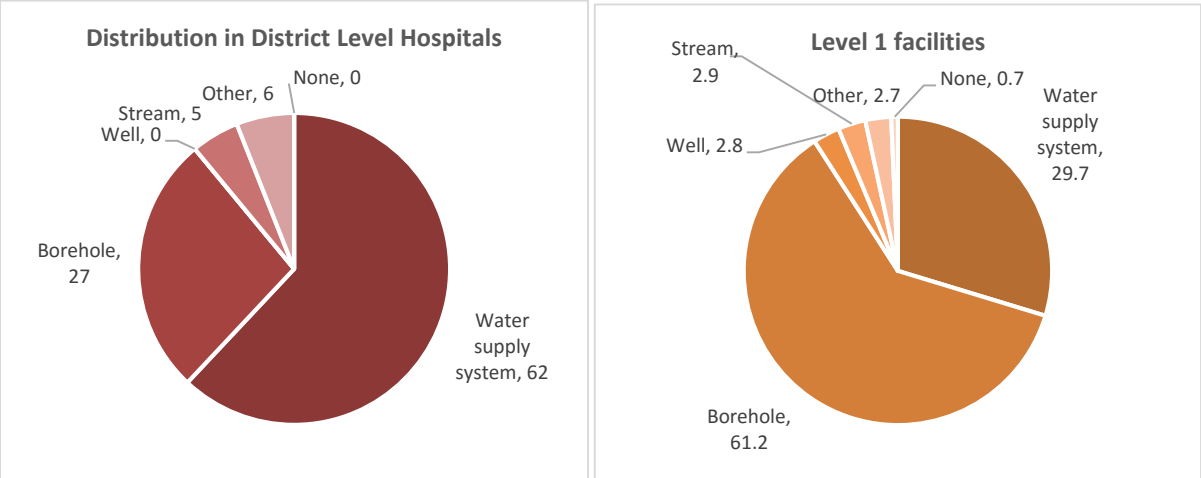
Water and sanitation facilities

The survey fully confirms the findings of the *VMAHS report round 26*: 88.2% of health facilities have onsite functional water supplies (system connection or borehole).

The main source of water in district hospitals was water supply system (62%) and in level 1 facilities is was boreholes 61.2%).

None (0%) of the District Level Hospitals and only 0.7% of Level 1 facilities reported to have no access to water. The charts below illustrate the distribution of water sources by facility level:

Figure 4 - Distribution of water supply sources in District Level Hospitals and in Level 1 facilities



Amongst the facilities surveyed though, 61% (95% CI= 51, 70) of District Level Hospitals and 67.7% (95% CI= 59, 76) of Level 1 facilities reported to have constant supply of water.

Sanitation facilities for clients were available in 97.4% of the District Level Hospitals surveyed and of these, 97.9% were functional. In Level 1 facilities, 94.9% had sanitation facilities available of which 98.6% were functional.

Electricity

According to the most recent Vital Medicine Health Survey (VMHAS-26), 67.5% of facilities are connected to electricity. The findings of our facility assessment are in line with the VMHAS report for Level 1, where 67.7% of facilities reported mains as the main source of power. All (100%) District Level Hospitals surveyed reported to be connected to electricity.

Table 16 - Distribution of sources of power supply in facilities

Level of care	*Mains*	*Generator*	*Solar*	*Other*	*None*
District level hospitals (n=44)	100%	0	0	0	0
Level 1 facilities (n=110)	67.7% (59.5,75.9)	2.5% (1,5.3)	19.5% (12.8,26.3)	7.0% (2.5,11.5)	3.2% (0.1,6.4)

We also assessed the regular availability (supply) of electricity within facilities: the proportion of facilities reporting constant supply was 55% (38, 52) for district level hospitals; and 70.4% (62.2, 78.6) for level 1 facilities.

Communication

Again, in line with the VMHAS reports, our survey confirmed that in most facilities had a functional handset and cellular line available, which constituted the main mode of access to communication for health facilities at all levels. Access to mobile networks was available in 100% of district level hospitals and in 93.9% of level 1 facilities. The landline is also an important means of communication at district level (66.8%), but remains widely unavailable at level 1 facilities (25.2%). The availability and use of VHF radios is low at both levels.

Table 17 - Means of communication available at health facilities

Level of care	*VHF Radio*	*Landline Telephone*	*Cellular network*	*Functional handset and cellular line*
District level hospitals (n=47)	6.2% (0.7,11.7)	66.8% (58.4,75.2)	100%	98.3% (96.0,99)
Level 1 facilities (n=118)	4.5% (0.7,8.4)	25.2% (19.2,31.1)	93.9% (90.3,97.4)	85.5% (79.8,91.1)

Availability and functioning of refrigerators for vaccines

All (100%) District level hospitals and most (97.2%) Level 1 facilities surveyed had refrigerators for vaccines available on the day of the survey.

Among the facilities that had the refrigerators, all (100%) District level hospitals and most (96%) Level 1 facilities reported that the equipment was functioning on the day of the survey. The main reasons reported for non-functioning in Level 1 facilities were no gas and need of repair.

Table 18 - Availability and functionality of refrigerator(s) for vaccines

Level of care	*Available (%)*	*Functioning (%)*	*Reason(s) for non-functioning*			
			No Electricity	No Gas	Needs Repair	Other
District level hospitals (n=47)	100	100	-	-	-	-
Level 1 facilities (n=118)	97 (94,99)	96.0 (92.0,99)	0	25 (NE)	100 (NE)	

Transport

According to our assessment, 98% of the District Level facilities had at least one ambulance available on the day of the survey, of which all (100%) were in running conditions on the day of the survey.
The table below indicates the essential requirements utilized by the survey to define functionality.

Table 19 - Availability and functionality of ambulances for referral

Level of care	*Facilities with at least 1 ambulance available*	*Functionality of ambulance, amongst facilities with at least 1 available*			
		% in running condition	% with medical staff and driver on standby	% fuelled on the day of the survey	% service provided free of charge
District level hospitals	98 (95,99)	100	96 (92,99)	96 (93,99)	90 (85,95)
Level 1 facilities	11.0 (5.2,16.9)	93 (92,95)	79 (53,99)	86 (61,99)	90 (64,99)

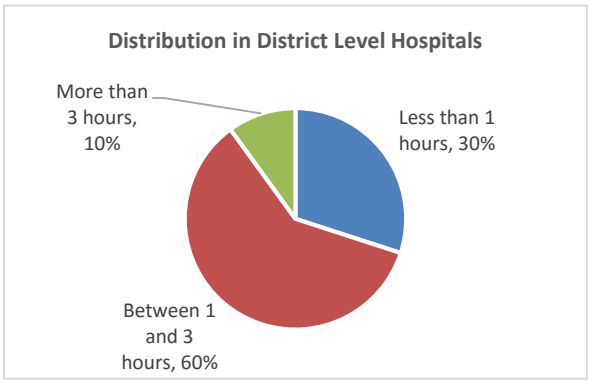
At Level 1 facility level, more than half of the facilities had alternative means of transport available for referral (car: 61.8%; van or truck: 9.5%).

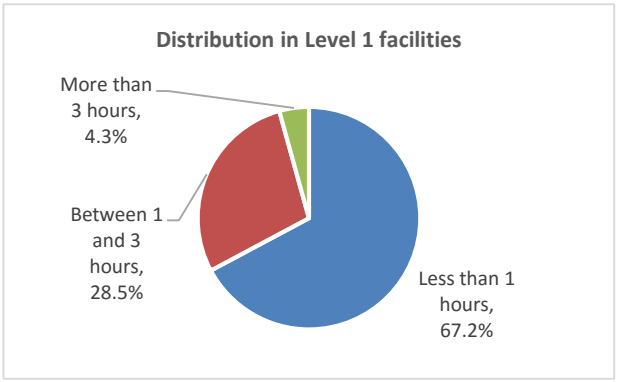
Table 20 - Availability of alternative means of transport for referral

Level of care	*Car*	*Motorbike*	*Bicycle*	*Van/Truck*
District level hospitals (n=46)	43.0 (33,52)	0	0	18.0 (12,24)
Level 1 facilities (n=118)	61.8 (53.3,70.5)	0	0	9.5 (3.9,15.0)

The survey also assessed average time required to refer a patient from the facility to the next level of referral. The findings are reported below, indicating that most of peripheral facilities (67.2%) are able to reach the closest District Level hospital within an hour, whereas the time required to refer a patient from a district level facility to the referral Provincial Hospital is higher namely between one and three hours in more than half (59.6.4%) of the cases.

Figure 5 - Average time for referral of patients from the facility to the next level of care





Maternity waiting homes

The promotion of maternity waiting home (MWHs) has been a key intervention promoted by the HTF, with the objective of increasing institutional deliveries, by the means of providing accommodation and basic services to pregnant women who live far from health facilities.

According to the *VMHAS report Round 26,* maternity waiting homes were available in 50.7% of rural facilities by December 2015. Our survey confirms the VMHAS findings, which found that MWHs were available in 82.3% of the District Level Hospitals and in 46.9% of Level 1 facilities surveyed.

The essential characteristics measured through the survey to assess the functionality of MWHs are reported in Table 21 below.

Table 21 - Availability and functionality of maternity waiting homes

Level of care	MWHs Available	*Functionality of MWHs, amongst Facilities with a MWH available in %:*				
		ANC Services provided	Nurse aide available 24/7	MWH provides food	MWHs with cooking shed/kitchen	Aver. N. of new admissions past quarter
District level hospitals (n=38/47)	82.3 (79,94)	100	45 (33,57)	68 (54,82)	97.0 (93,99)	242 (180,304)
Level 1 facilities (n=56/118)	46.9 (35.5,55.3)	100	55.8 (44.7,66.8)	36.9 (25.1,48.6)	81.3 (71.8,90.8)	21.3 (15.3,27.4)

Demographic and Health Information

Our survey explored the utilization of health information at facility level. In particular, we assessed whether facilities had maps and graphs on display; whether monitoring graphs were used to monitor trends in essential indicators, and whether demographic data regarding the facility catchment area were available.
The findings, presented in Table 22 below, indicate a very high availability of health information at facility level with nearly all (98%) District level hospitals and (98.3%) level 1 facilities displaying a catchment population map.

Table 22 - Availability of demographic and health information in facilities

Level of care	*Proportion of facilities with catchment population map on display*	*Monitoring graphs (health statistics)*	*Demographic data*
District level hospitals (n=44)	98 (94,99)	98 (94,99)	96 (92,99)
Level 1 facilities (n=118)	98.3 (96.0,99)	97.7 (95.1,99)	94.9 (90.9,98.8)

3.3.2. Leadership, management and governance

Health Centre Committees

The HTF has supported the set up or re-establishment of Health Centre Committees at facility level, to enhance and improve coordination between facilities and communities.

Level 1 facilities had significantly better results than District Hospitals, where only 66% had a committee in place and only 21% of these met at least on a monthly basis.

Table 23 - Availability and functionality of Health Centre Committees

Level of care	*Committee in place*	*ToRs available*	*Meetings held at least monthly*
District level hospital (n=30/46)	66.0 (58,74)	82.0 (71,92)	21.0 (13,29)
Level 1 facilities (n=99/118)	86.5 (81.2,94.7)	89.0 (82.9,95.4)	71.0 (62.6,80.3)

Supportive Supervision

The health facility survey assessed the provision of supportive supervision from DHE to District Level Hospitals and Level 1 facilities. Results show that only 41.1% (95% CI= 37.9, 44.3) of Level 1 facilities had received supervisory visits during the quarter preceding the survey, compared to 94.5% for the previous quarter in the preceding year. Similarly, only 39.3% (95% CI=33.7, 44.9) of surveyed District Level Hospitals received supervision during the same quarter. However, all facilities (100%) received feedback after a supervisory visit.

Table 24 - Supportive supervision at health facilities

Facilities	**Proportion that received supervision during the quarter preceding the survey**	**Proportion receiving feedback**
District level hospitals	39.3 (33.7,44.9)	100
Level 1 facilities	41.1 (37.9,44.3)	100

3.3.3. Human Resources for Health

Availability of staff

The findings of the survey indicate that few district level hospitals have specialist doctors available; however, all had one doctor who was present in the hospital on the day of the survey. The proportion of district level hospitals with four or more medical doctors increased from 25.8% in 2015 to 34.3% in 2016.

Specialist doctors

On the day of the survey, none of the district level hospitals had an anaesthetist or a paediatrician available. There are only few of any other type of specialist doctor (surgeon or physician) available.

Table 25 - District level hospitals with specialist doctors in place (at least 1)

Level of care	*Obs&Gynae*	*Anaesthetist*	*Paediatrician*	*Surgeon*	*Physician*
District level hospitals	2 (0,4)	0 (.)	0 (.)	2 (0,4)	2 (0,4)

Medical Doctors

As shown in Table 26 below, all district level hospitals had at least one medical doctor and 34.3% of the district hospitals surveyed had four or more doctors available.

Table 26 - District level hospitals with medical doctors in place

Level of care	*Proportion of District level hospitals with at least 1 Medical Doctor (%)*	*Proportion of District level hospitals with 4 or more Medical Doctors (%)*
District level hospitals	100	34 (25,44)

Approximately half of the nursing cadres employed at the district level hospitals were present on the day of survey while it was 63.8% at Level 1 facilities. Most of the district level hospitals had a medical doctor present in the facility on the day of the survey. More level I facilities than district level hospital had one of the nursing cadres present on the day of the survey than were present in table below.

Table 27 - Health personnel present in facilities on the day of the survey

Level of care	*Proportion of specialist doctors present on the day of survey (%)*	*Proportion of medical doctors present on the day of survey (%)*	*Proportion of nursing cadres present on the day of survey (%)*
District level hospitals	50*	87.0 (84.1,89.9)	51.8 (46.6,57.0)
Level 1 facilities	-	25.3 (3.5,47.0)	63.8 (58.5,69.1)

** Only two district hospitals reported having any (one) specialist doctors. Of the two one was on duty at the time.*

Availability of nursing cadres

The survey assessed the availability of seven different nursing cadres, including State Certified Midwife, Registered General Nurse, Nurse Anaesthetist, Theatre Nurse, Primary Care Nurse, Student Midwife, and Student Nurse. The table below reports the mean and range of nursing cadres available per level of care on the day of the survey. For example, there was a mean of 18 State Certified Midwives available in the district hospitals on the day of the survey but the range of the State Certified Midwives available in the different district hospitals varied from 0-57.

Similar to the preceding year, the district level hospitals had more Registered General Nurses than any other nursing cadre; followed by State Certified Midwives and Student Nurses. Few district level hospitals had a Nurse Anaesthetist or a Theatre Nurse available, which is similar to the situation reported in the 2014 and 2015 surveys. The Level 1 facilities had significantly less staff available and most had no student midwives available.

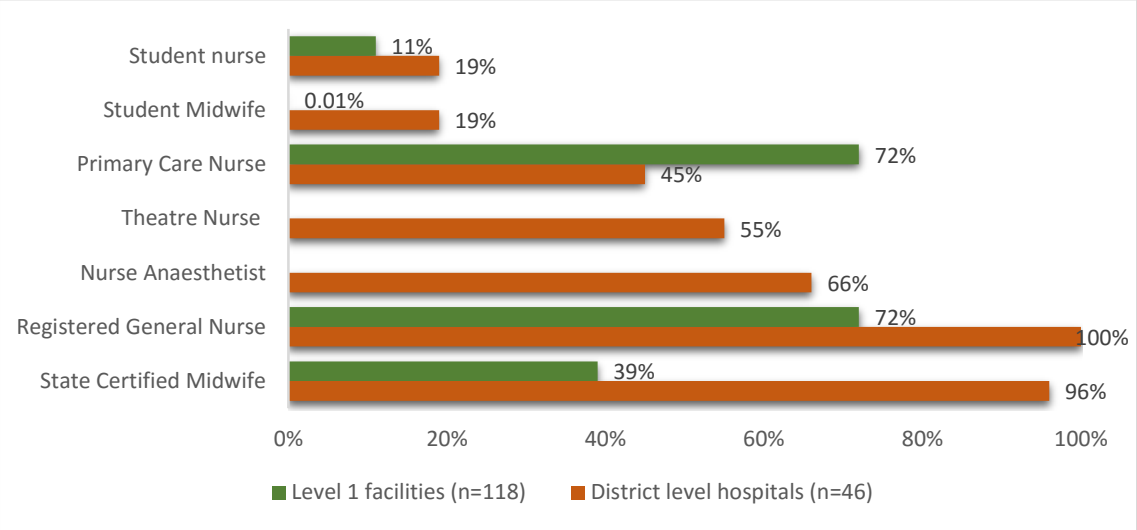
Table 28 – Availability* of nursing cadres in facilities

Level of care	*State Certified Midwife*	*Registered General Nurse*	*Nurse Anaesthetist*	*Theatre Nurse*	*Primary Care Nurse*	*Student Midwife*	*Student Nurse*
District level hospitals	18.2 (0-57)	38.4 (1-102)	1.1 (0-4)	0.9 (0-4)	6.1 (0-70)	2.9 (0-42)	9.5 (0-100)
Level 1 facilities	1.8 (0-22)	1.4 (0-10)	-	-	1.8 (1-12)	0.01 (0-1)	0.35 (0-8)

*Availability refers to "mean number and range presented in brackets".

In regard to availability of nursing cadre regardless of the number, Registered General Nurses (RGN) are in greatest supply in district level hospitals with every hospital having at least 1 RGN, most (96%) had at least one State Certified midwife, and just over half (66%) had a Nurse Anaesthetist and 55% had a Theatre Nurse. The majority (72%) of Level 1 facilities had at least one PCN and one RGN; and 39% had one State certified midwife.

Figure 6 - Availability of nursing cadres: Proportion of facilities with at least 1 staff/cadre



Availability of other cadres

Nurse Aides was the other cadres most available in the district level hospitals and Level 1 facilities. Significantly, less Pharmacists were available at district hospital level compared to the 2015 survey where an average of 11 Pharmacists were available on the day of the survey.

Table 29 – Availability* of other cadres of health workers in facilities

Level of care	*Clinical Officer*	*Nurse Aide*	*Environmental health officer*	*Nutrition Officer*	*Pharmacist*
District level hospitals	0.5 (0-2)	14.5 (5-32)	1.5 (0-15)	0.6 (0-2)	0.2 (0-3)
Level 1 facilities	0	1.6 (0-9)	0.5 (0-2)	0.01 (0-1)	0

*Availability means “mean number and range in brackets”.

Vacancy rates for doctors and nurses

District level hospitals had few vacancies amongst the specialist medical doctor and doctor cadres. In contrast to the 2015 survey, vacancy levels were greatest for nurses at district level hospital.

Table 30 - Average number of vacancies in district hospitals by cadre[7]

Level of care	Average number of vacancy for specialist medical doctors (min, max)	Average number of vacancy for doctors (min, max)	Average number of vacancy for nurses (min, max)
District level hospitals	1 (0-2) N=3	1.3 (0-2) N=15	7.2 (0-21) N=29

The figures presented in the table below do not provide much insight into flows in and out of the facilities; except of showing that recruitment of doctors and nurses seems to be keeping pace with attrition at district level facilities.

Table 31 - New appointments and attrition rate for medical doctors and nursing cadres at district level facilities

Medical Doctors joined	*Medical Doctors left the post*	*Nursing cadre joined*	*Nursing cadre left the post*
Staff joined the facilities in 2015 against total number in post	*Staff left the facilities in 2015 against total number in post*	*Staff joined the facilities in 2015 against total number in post*	*Staff left the facilities in 2015 against total number in post*
0.17 (0.13-0.21)	0.11 (0.08,0.15)	0.02 (0.01,0.02)	0.02 (0.01,0.02)

Training of Staff

The list below provides list of indicators related to training of staff. The numbers of the indicators correspond to the Table 15 (Progress in HTF indicators at Health Facility Level).

- Primary Care Nurses (PCNs) trained on FANC (Indicator 1.1.1.1)
- Midwife trained to provide EmONC(Indicator 1.1.2.1)
- Nurses trained to provide EmONC services (Indicator 1.1.2.1)
- Health workers trained in integrated management of neonatal and childhood illnesses (IMNCI) (Indicator 1.3.3.1)
- Nutrition Programme Managers(Indicator 1.4.6.1.2)

3.3.4. Medical equipment, health commodities and medicines availability

Previous stages of the HTF evaluation identified a need for more information on the effectiveness of the PUSH system particularly regarding primary healthcare (PHC) kits. Hence, in this final evaluation, questions on PHC kits were included.

Among 118 Level 1 facilities surveyed, 80 facilities (65.8%, 95% CI=58.4-73.1) received PHC kits in the last quarter of 2015. On average, facilities received 1.8 kit (95% CI=1.5-2.2). The three most commonly reported stock out items are Amoxicillin 250mg dispersible tabs; Hydrochlorothiazide 25mg tablets; and Erythromycin 250mg tabs.

Furthermore, common over stock items reported include Magnesium sulphate injections; Paracetamol 500mg tabs; and Doxycycline 100mg tabs and Sulphamethoxazole + Trimethoprim 400mg.

Regarding availability of essential medicines for EmONC, all district level hospitals reported to have all the essential medicines for EmONC (injectable antibiotics, uterotonics, and anticonvulsants & anti-hypertensives) available on the day of the survey and in the three months preceding the survey. This is a slight improvement

[7] Ratios of vacancies per filled place. Denominator is the number of facilities with any filled place. Many facilities had no filled place so were excluded from these statistics.

from the 2015 survey, where 96.1% of district hospitals had injectable antibiotics available both on the day and in the three preceding months.

Table 32 - Availability of essential medicines for EmONC

Category	*District level hospitals*		*Level 1 facilities*	
	Available on the day of the survey, %	Available in 2015 Q 4, %	Available on the day of the survey, %	Available in 2015 Q 4, %
Injectable antibiotics group	100	100	93.0 (88.3,97.7)	95.1 (91.5,98.8)
Uterotonics group	100	100	88.0 (82.8,93.7)	88.9 (84.1,93.7)
Anticonvulsants & anti-hypertensive group	100	100	97.0 (93.8,99)	97.0 (93.8,99)

Table 33 - Availability of vitamins and supplement

Medicine	*District level hospitals*		*Level 1 facilities*	
	Available on the day of the survey, %	Available in 2015 Q 4, %	Available on the day of the survey, %	Available in 2015 Q 4, %
Vitamin A	92.1 (86.9,97.3)	96.2 (92.9,99.5)	91.8 (87.5,96.1)	94.0 (89.7,98.2)
Iron AND Folic acid or FeFO	93.6 (84.5,99.7)	91.4 (85.3,97.5)	80.8 (73.8,87.8)	88.8 (83.2,94.4)

Table 34 - Availability of equipment for EmONC

Category	*District level hospitals (n=47)*		*Level 1 facilities (n=118)*		*Rural Level 1 facilities (n=77)*	
	Available on the day of the survey, %	Always available in 2015 Q4, %	Available on the day of the survey, %	Always available in 2015 Q4, %	Available on the day of the survey, %	Always available in 2015 Q 4, %
Equipment for retained products of conception	97.4 (94.6,99)	97.4 (94.6,99)	18.9 (11.9,25.9)	18.0 (11.2,24.8)	24.7 (15.3,34.2)	23.5 (14.2,32.7)
Equipment for assisted vaginal delivery	95.2 (91.0,99.4)	93.0 (88.0,97.9)	-	-	-	-
Equipment for maternal resuscitation	100	100	92.3 (87.5,97.2)	90.5 (85.2,95.9)	96.2 (92.3,99)	93.6 (88.2,99.0)
Equipment neonatal resuscitation	100	100	94.2 (90.1,98.3)	94.2 (90.1,98.3)	98.7 (97.3,99)	98.7 (97.3,99)

Table 35 - Availability of essential consumables and equipment

Category	*District level hospitals (n=47)*		*Level 1 facilities (n=118)*		*Rural Level 1 facilities(n=77)*	
	Available on the day of the survey	**Always available in 2015 Q4**	**Available on the day of the survey**	**Always available in 2015 Q 4**	**Available on the day of the survey**	**Always available in 2015 Q 4**
Syringe for injection	89.4 (82.3,96.4)	82.5 (74.8,90.2)	97.1 (94.2,99)	98.1 (95.8,99)	98.6 (96.0,99)	100
IV giving set	91.7 (91.0,92.4)	97.8 (95.1,99)	87.0 (82.8,91.3)	94.9 (91.3,98.5)	88.5 (83.0,94.0)	94.8 (90.1,99.6)
IV fluid (Ringer)	84.8 (77.6,92.0)	76.9 (70.1,83.85)	90.2 (84.5,95.8)	89.5 (84.2,94.8)	88.5 (81.3,95.8)	90.0 (83.7,96.4)
IV fluid (NS)	82.2 (74.3,90.1)	72.9 (64.8,81.0)	90.6 (85.0,96.1)	88.8 (83.2,94.4)	89.5 (82.1,96.9)	89.0 (82.0,96.1)
Sterile glove	85.4 (78.8,92.0)	87.8 (82.1,93.4)	76.4 (69.3,83.6)	77.3 (70.8,83.8)	82.3 (73.3,91.3)	85.9 (78.5,93.3)
Elbow length gloves	23.6 (14.9,32.3)	30.3 (20.6,40.1)	15.1 (8.5,21.6)	17.0 (10.1,23.9)	16.9 (8.0,25.7)	20.7 (11.3,30.2)
Suture materials	86.8 (80.7,92.9)	86.7 (80.1,93.2)	80.2 (73.2,87.1)	79.6 (73.0,86.2)	82.3 (73.7,90.9)	83.6 (75.6,91.6)
Fridge for oxytocin	95.8 (91.8,99.9)	95.8 (91.8,99.9)	59.7 (51.0,68.3)	58.5 (49.9,67.1)	56.1 (45.5,66.7)	55.8 (45.2,66.4)
Patella hammer	67.0 (57.9,76.1)	69.4 (60.6,78.2)	19.6 (13.0,26.2)	21.1 (14.2,27.9)	9.9 (3.7,16.1)	12.0 (5.2,18.8)
BP machine	100	97.4 (94.6,99)	98.6 (96.6,99)	96.8 (93.8,99.9)	97.9 (95.0,99)	95.4 (90.9,99.9)
Pinard stetho	100	97.4 (94.6,99)	97.9 (95.8,99)	95.4 (92.0,98.8)	98.7 (96.3,99)	95.1 (90.5,99.8)
Sonicaid/doppler	93.7 (88.7,98.6)	89.0 (82.7,95.3)	31.4 (23.5,39.3)	28.8 (21.0,36.6)	31.8 (21.4,42.2)	30.7 (20.4,40.9)
Ultrasound scan	77.2 (67.5,87.0)	72.5 (64.4,80.6)	1.9 (>0,4.4)	1.1 (>0,3.2)	1.3 (>0,3.7)	100

3.3.5. Health financing

Access to Results Based Financing (RBF) mechanisms

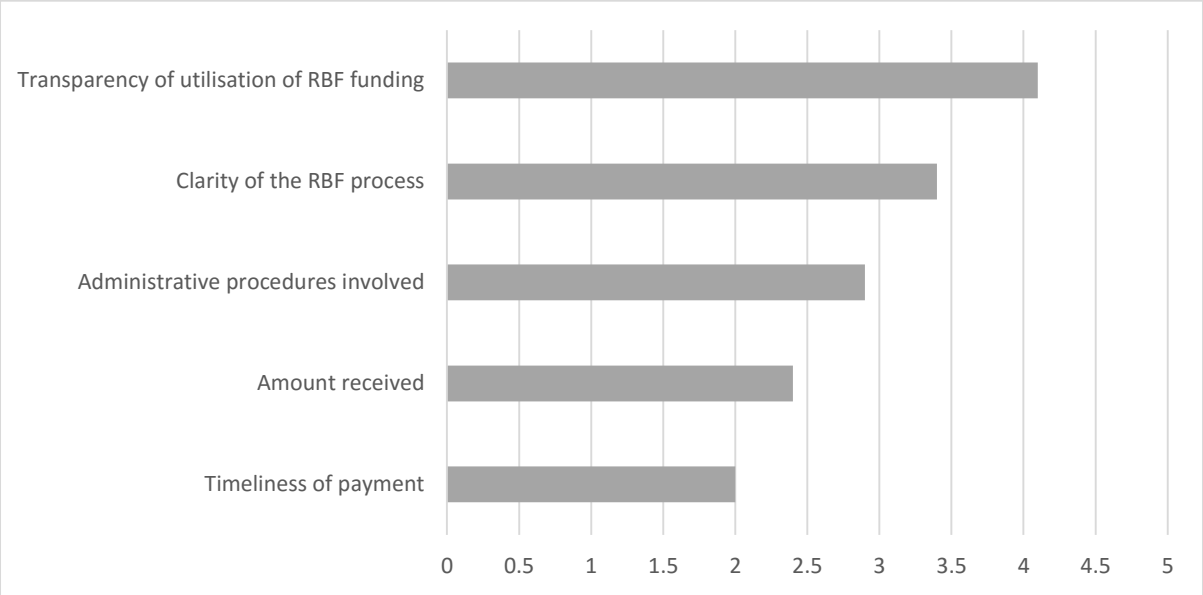
Since its inception the HTF has invested in supporting health facilities through funds made available to cover operational/ running expenses, "with primary health facilities getting $750, district hospitals $1,500 and provincial hospitals $2,000 per month, and were therefore able to meet their routine operational/ selected running costs including basic maintenance/ renovation of infrastructure" (HTF annual report 2014).

In 2014, the HTF initiated a transition from the HSF to RBF. Our survey, which was performed throughout the country and not only in HTF/RBF supported facilities, indicates that only 57.2% of any type of facilities received

support through RBF in 2015, and of those only 1.8% received such support in all quarters of 2015. The proportion among Level 1 facilities is higher as 66.8% of facilities received support through the RBF in 2015, and of those only 5.6% received such support in all quarters of 2015. Level 1 facilities received 3,074 USD on average as RBF support.

Our survey also asked health workers to rate the process of RBF mechanism from five aspects: timeliness of disbursement; amount received; administrative procedures to follow; clarity on the process; and transparency in utilization of the funds. Transparency in funds utilization rated highest followed by clarity and administrative procedures involved. Timeliness in receiving the disbursement scored lowest.

Figure 7 - Health workers' rating on RBF mechanism



User fees

In line with the findings of the 2015 survey, some facilities still continue to charge user fees for health services in the area of maternal and child care despite receiving HTF funds.

Among the facilities surveyed, 18% of district level hospitals and 18.8% of Level 1 facilities charge 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 36 below, amongst facilities charging user fees, none (0%) charge fees for child health services. The majority of fees were charged for ANC, PNC and family planning. The table indicates the average price charged per service**.**

Table 36 - Facilities charging user fees for MNCH services

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

*NE=Not estimable as sample size is too small

We explored the association between the financial support provided to the facilities (i.e.,RBF) and the tendency to charge. Our analysis suggests that a facility tends to charge user fees if it does not receive any financial support from other sources. Facilities are five times more likely to charge user fees if they do not receive any financial support (RR=5.0, 95% CI=2.4, 10.3).

3.3.6. Service provision

Availability and Performance of Emergency Obstetric Care Services

Table 37 - Availability of signal functions in BEmONC and CEmONC facilities

Level of care	**Percentage of BEmONC facilities that are fully functional (n=118)**	**Percentage of CEmONC facilities that are fully functional (n=46)**
Services available 24/7	19.4 (12.4,26.5)	73.0 (63.8,82.1)
Services performed in the last 3 months	5.5 (1.4,9.7)	70.0 (59.0, 80.5)

Table 38 - Percentage of BEmONC and CEmONC facilities performing signal functions

Signal Function	BEmONC facilities		CEmONC facilities	
	proving signal functions 24/7 (Available)	performing signal functions in 2015 Quarter 4 (Performed)	proving signal functions 24/7 (Available)	performing signal functions in 2015 Quarter 4 (Performed)
Administer parenteral antibiotics	78.3 (71.1,85.4)	67.9 (59.7,76.1)	96 (90.5,99)	100
Administer uterotonic drugs	84.2 (78.3,90.1)	83.3 (77.2,89.4)	96 (90.5,99)	100
Administer anticonvulsants	82.1 (76.0,88.1)	51.5 (42.9,60.0)	96 (90.5,99)	100
Perform manual removal of placenta	69.1 (61.9,76.2)	43.0 (35.0,51.0)	93 (87.2,98.7)	89.2 (81.7,96.6)
Perform removal of retained products of conception	21.9 (14.7,29.2)	9.4 (3.9,14.9)	93 (87.2,98.7)	97.4 (94.6,99)
Perform assisted vaginal delivery	-	-	86.3 (78.5,94.1)	89.3 (82.2,96.4)
Perform newborn resuscitation	84.1 (78.1,90.1)	63.4 (54.6,72.1)	95.6 (90.5,99)	100
Perform blood transfusion	-	-	77.8 (69.0,86.6)	80.4 (71.8,89.1)
Perform caesarean section	-	-	93.0 (87.2,98.7)	97.4 (94.6,99)

Table 39 - Availability of services for blood transfusion at District Level Hospitals only

Service	*Available on the day of the survey*	*Always available in 2015 quarter 4*
Blood Transfusion available	77.8 (69.0,86.6)	75.6 (66.3,87.8)
Blood Bank	71.5 (62.9,80.0)	67.3 (57.2,77.1)
Blood available in bank	50.3 (41.1,59.5)	45.9 (37.0,54.8)
Fridge for storing blood	80.8 (72.8,88.7)	78.7 (69.6,87.7)
Reagents for grouping and cross matching blood	86.9 (79.9,94.0)	84.7 (77.7,91.6)

Table 40 - Availability of operating theatres (District Level only)

Facilities performing obstetric surgery and availability of operating theatres and staff

Service available	*Available on the day of the survey*	*Always available in 2015 quarter 4*	HTF indicator
Operating theatre for performing emergency obstetric surgery	97.4 (94.6,99)	97.4 (94.6,99)	1.1.3.3
Caesarean Section /laparotomy set	97.4 (94.6,99)	97.4 (94.6,99)	
Proportion of facilities with at least one staff trained to perform C/S	97.4 (94.6,99)	97.4 (94.6,99)	1.1.3.1
Proportion of facilities with at least one staff able to give obstetric anaesthesia	95.2 (91.0,99.4)	93.0 (88.2,97.7)	1.1.3.2

ANNEXES

Annex I – List of District Health Offices Surveyed

N.	District_Name	Province_Name
1	Chitungwiza	Harare
2	eastern Harare	Harare
3	Bulawayo	Bulawayo
4	Chikomba	Mashonaland East
5	Hwedza	Mashonaland East
6	Murewa	Mashonaland East
7	UMP	Mashonaland East
8	Mudzi	Mashonaland East
9	Seke	Mashonaland East
10	Kadoma	Mashonaland West
11	Kariba	Mashonaland West
12	Hururungwe	Mashonaland West
13	Zvimba	Mashonaland West
14	Centenary	Mashonaland Central
15	Mt. Darwin	Mashonaland Central
16	Rushinga	Mashonaland Central
17	Guruve	Mashonaland Central
18	Shamva	Mashonaland Central
19	Mutare City	Manicaland
20	Chipinge	Manicaland
21	Buhera	Manicaland
22	Mutasa	Manicaland
23	Nyanga	Manicaland
24	Masvingo	Masvingo
25	Mwenezi	Masvingo
26	Zaka	Masvingo
27	Bikita	Masvingo
28	Gutu	Masvingo
29	Chirumanzu	Midlands
30	Shurugwi	Midlands
31	Zvishavane	Midlands
32	Kwekwe	Midlands
33	Gokwe South	Midlands
34	Gokwe North	Midlands
35	Hwange	Matebeleland North
36	Lupane	Matebeleland North
37	Bubi	Matebeleland North
38	Umguza	Matebeleland North
39	Tsholotsho	Matebeleland North
40	Mangwe	Matebeleland South

N.	District_Name	Province_Name
41	Bulilima	Matebeleland South
42	Insiza	Matebeleland South
43	Beitbridge	Matebeleland South
44	Kezi Matopo	Matebeleland South

Annex II – List of Health Facilities Surveyed

N.	Province	District	Facility Name	Facility Type	Facility Level
1	Harare	Harare	kambuzuma polyclinic	Urban Polyclinic/Clinic	Level-1 facility
2	Harare	Harare	highfield clinic	Urban Polyclinic/Clinic	Level-1 facility
3	Harare	Harare	malborough clinic	Urban Polyclinic/Clinic	Level-1 facility
4	Harare	Harare	dzivarasekwa maternity clinic	Urban Polyclinic/Clinic	Level-1 facility
5	Harare	Harare	kuwadzana poly clinic	Urban Polyclinic/Clinic	Level-1 facility
6	Harare	Harare	rutsanana poly clinic	Urban Polyclinic/Clinic	Level-1 facility
7	Harare	Harare	highlands poly clinic	Urban Polyclinic/Clinic	Level-1 facility
8	Harare	Harare	green dale clinic	Urban Polyclinic/Clinic	Level-1 facility
9	Harare	Harare	mabvuku maternity poly clinic	Urban Polyclinic/Clinic	Level-1 facility
10	Harare	Harare	tafara clinic	Urban Polyclinic/Clinic	Level-1 facility
11	Harare	Harare	belvedere clinic	Urban Polyclinic/Clinic	Level-1 facility
12	Bulawayo	Bulawayo	magwegwe clinic	Urban Polyclinic/Clinic	Level-1 facility
13	Bulawayo	Bulawayo	pelandaba clinic	Urban Polyclinic/Clinic	Level-1 facility
14	Bulawayo	Bulawayo	princess Margaret rose clinic	Urban Polyclinic/Clinic	Level-1 facility
15	Bulawayo	Bulawayo	E.F Waston maternity Clinic	Urban Polyclinic/Clinic	Level-1 facility
16	Bulawayo	Bulawayo	luveve clinic	Urban Polyclinic/Clinic	Level-1 facility
17	Bulawayo	Bulawayo	maqhawe clinic	Urban Polyclinic/Clinic	Level-1 facility
18	Bulawayo	Bulawayo	pumula clinic	Urban Polyclinic/Clinic	Level-1 facility
19	Bulawayo	Bulawayo	Dr shennan clinic	Urban Polyclinic/Clinic	Level-1 facility
20	Bulawayo	Bulawayo	khulumane clinic	Urban Polyclinic/Clinic	Level-1 facility
21	Bulawayo	Bulawayo	Northern suburbs clinic	Urban Polyclinic/Clinic	Level-1 facility
22	Mashonaland East	Hwedza	Goneso clinic	Rural Health Centre/Rural Clinic	Level-1 facility
23	Mashonaland East	Hwedza	Sengezi	Rural Health Centre/Rural Clinic	Level-1 facility
24	Mashonaland East	Chikomba	Bvumbura Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
25	Mashonaland East	Seke	Marirangwe	Rural Health Centre/Rural Clinic	Level-1 facility
26	Mashonaland East	Murewa	Chitowa 2	Rural Health Centre/Rural Clinic	Level-1 facility

N.	Province	District	Facility Name	Facility Type	Facility Level
27	Mashonaland East	Murewa	Jekwa Rural Centre	Rural Health Centre/Rural Clinic	Level-1 facility
28	Mashonaland East	UMP	mutawatawa District Hospital	District Hospital	District-level facility
29	Mashonaland East	Mudzi	Kotwa Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
30	Mashonaland East	Mudzi	Makaha clinic	Rural Health Centre/Rural Clinic	Level-1 facility
31	Mashonaland East	Hwedza	Hwedza rural district hospital	Rural Hospital	Level-1 facility
32	Mashonaland East	Chikomba	Unyetu clinic	Rural Health Centre/Rural Clinic	Level-1 facility
33	Mashonaland East	Seke	Acton Raynolds	Rural Health Centre/Rural Clinic	Level-1 facility
34	Mashonaland East	Murewa	Murewa hospital	District Hospital	District-level facility
35	Mashonaland East	Murewa	Munamba	Rural Health Centre/Rural Clinic	Level-1 facility
36	Mashonaland East	UMP	Nyakasoro	Rural Health Centre/Rural Clinic	Level-1 facility
37	Mashonaland East	UMP	Sowa	Rural Health Centre/Rural Clinic	Level-1 facility
38	Mashonaland East	Mudzi	kotwa	District Hospital	District-level facility
39	Mashonaland East	Hwedza	Mt St Mary's Mission hospital	Mission Hospital	District-level facility
40	Mashonaland East	Chikomba	Daramombe clinic	Other	Level-1 facility
41	Mashonaland East	Chikomba	Chivhu Government Hospital	Rural Hospital	District-level facility
42	Mashonaland East	Murewa	St Paul's Musami Hospital	Mission Hospital	District-level facility
43	Mashonaland West	Kariba	marina district hospital	District Hospital	District-level facility
44	Mashonaland West	Kariba	mola rural health centre	Rural Health Centre/Rural Clinic	Level-1 facility
45	Mashonaland West	Kariba	mega de rural clinic	Rural Health Centre/Rural Clinic	Level-1 facility
46	Mashonaland West	Hururungwe	chidamoyo rural hospital	Mission Hospital	District-level facility
47	Mashonaland West	Zvimba	banket district hospital	District Hospital	District-level facility
48	Mashonaland West	Zvimba	Chirau clinic	Rural Health Centre/Rural Clinic	Level-1 facility
49	Mashonaland West	Kadoma	kadoma district hospital	District Hospital	District-level facility
50	Mashonaland West	Kadoma	St michaels hospital	Mission Hospital	District-level facility
51	Mashonaland West	Kadoma	man yoni clinic	Rural Health Centre/Rural Clinic	Level-1 facility
52	Mashonaland West	Kadoma	jompani clinic	Rural Health Centre/Rural Clinic	Level-1 facility
53	Mashonaland West	Hururungwe	karoi	District Hospital	District-level facility
54	Mashonaland West	Hururungwe	Karoi static	Urban Polyclinic/Clinic	Level-1 facility

N.	Province	District	Facility Name	Facility Type	Facility Level
55	Mashonaland West	Zvimba	masiyarwa	Rural Health Centre/Rural Clinic	Level-1 facility
56	Mashonaland West	Zvimba	zvimba	Rural Hospital	Level-1 facility
57	Mashonaland West	Kadoma	sanyati	Rural Hospital	District-level facility
58	Mashonaland West	Kadoma	manyewe	Rural Health Centre/Rural Clinic	Level-1 facility
59	Mashonaland Central	Mt. Darwin	Mt Darwin District Hospital	District Hospital	District-level facility
60	Mashonaland Central	Mt. Darwin	karanda Hospital	Mission Hospital	District-level facility
61	Mashonaland Central	Rushinga	Chimhanda	District Hospital	District-level facility
62	Mashonaland Central	Rushinga	Mukonde	Rural Health Centre/Rural Clinic	Level-1 facility
63	Mashonaland Central	Mt. Darwin	Tsakare	Rural Health Centre/Rural Clinic	Level-1 facility
64	Mashonaland Central	Centenary	Hoya RHC	Rural Health Centre/Rural Clinic	Level-1 facility
65	Mashonaland Central	Centenary	St Alberts	Mission Hospital	District-level facility
66	Mashonaland Central	Guruve	Bakasa	Rural Health Centre/Rural Clinic	Level-1 facility
67	Mashonaland Central	Shamva	Nyamaropa	Rural Health Centre/Rural Clinic	Level-1 facility
68	Mashonaland Central	Mt. Darwin	Pachanza rural	Rural Health Centre/Rural Clinic	Level-1 facility
69	Mashonaland Central	Mt. Darwin	Nyamahobogo	Rural Health Centre/Rural Clinic	Level-1 facility
70	Mashonaland Central	Rushinga	Mary mount hosptal	Mission Hospital	District-level facility
71	Mashonaland Central	Rushinga	Nhawa	Rural Health Centre/Rural Clinic	Level-1 facility
72	Mashonaland Central	Centenary	Dambakurima	Rural Health Centre/Rural Clinic	Level-1 facility
73	Mashonaland Central	Guruve	Guruve District Hospital	District Hospital	District-level facility
74	Mashonaland Central	Guruve	Shinje Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
75	Mashonaland Central	Guruve	Chitsungo	Mission Hospital	District-level facility
76	Mashonaland Central	Shamva	chidembo	Rural Health Centre/Rural Clinic	Level-1 facility
77	Manicaland	Mutare City	Fern Valley Clinic	Urban Polyclinic/Clinic	Level-1 facility
78	Manicaland	Chipinge	ngaone clinic	Rural Health Centre/Rural Clinic	Level-1 facility
79	Manicaland	Buhera	chiweshe clinic	Rural Health Centre/Rural Clinic	Level-1 facility
80	Manicaland	Mutasa	Jombe Rural Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
81	Manicaland	Mutasa	Bonda mission	Mission Hospital	District-level facility
82	Manicaland	Nyanga	Elim Mission Hospital	Mission Hospital	Level-1 facility

N.	Province	District	Facility Name	Facility Type	Facility Level
83	Manicaland	Nyanga	Mt Mellery Hospital	Mission Hospital	Level-1 facility
84	Manicaland	Mutare City	chikanga clinic	Urban Polyclinic/Clinic	Level-1 facility
85	Manicaland	Chipinge	Chipinge district hospital	District Hospital	District-level facility
86	Manicaland	Chipinge	St Selinda Hospital	Mission Hospital	District-level facility
87	Manicaland	Chipinge	Takwirira/Arda Chisumbanje	Rural Health Centre/Rural Clinic	Level-1 facility
88	Manicaland	Chipinge	madhuku clinic	Rural Health Centre/Rural Clinic	Level-1 facility
89	Manicaland	Buhera	Murambinda District Hospital	District Hospital	District-level facility
90	Manicaland	Buhera	Muzokomba Rural Health Centre	District Hospital	Level-1 facility
91	Manicaland	Mutasa	Hauna District Hospital	District Hospital	District-level facility
92	Manicaland	Mutasa	Redwing Mine Clinic	Other	Level-1 facility
93	Manicaland	Nyanga	Nyanga District Hospital	District Hospital	District-level facility
94	Manicaland	Nyanga	Regina Coeli Mission Hospital	Mission Hospital	District-level facility
95	Manicaland	Nyanga	Nyangombe Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
96	Manicaland	Mutasa	Guta Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
97	Masvingo	Masvingo	morgenister district hospital	Mission Hospital	District-level facility
98	Masvingo	Masvingo	Zano clinic	Rural Health Centre/Rural Clinic	Level-1 facility
99	Masvingo	Mwenezi	mweneza health centre	Rural Health Centre/Rural Clinic	Level-1 facility
100	Masvingo	Zaka	jichidza health centre	Rural Health Centre/Rural Clinic	Level-1 facility
101	Masvingo	Bikita	marozva clinic	Rural Health Centre/Rural Clinic	Level-1 facility
102	Masvingo	Gutu	nyazvidzi clinic	Rural Health Centre/Rural Clinic	Level-1 facility
103	Masvingo	Gutu	serima clinic	Rural Health Centre/Rural Clinic	Level-1 facility
104	Masvingo	Masvingo	Masvingo provincial hospital	District Hospital	District-level facility
105	Masvingo	Masvingo	Masvingo teachers college clinic	Urban Polyclinic/Clinic	Level-1 facility
106	Masvingo	Masvingo	zimuto mission clinic	Rural Health Centre/Rural Clinic	Level-1 facility
107	Masvingo	Mwenezi	Neshuro District Hospital	District Hospital	District-level facility
108	Masvingo	Mwenezi	rutenga rural health centre	Rural Health Centre/Rural Clinic	Level-1 facility
109	Masvingo	Zaka	Ndanga District Hospital	District Hospital	District-level facility
110	Masvingo	Bikita	silveira mission hospital	District Hospital	District-level facility

N.	Province	District	Facility Name	Facility Type	Facility Level
111	Masvingo	Zaka	chipinda rural health centre	Rural Health Centre/Rural Clinic	Level-1 facility
112	Masvingo	Bikita	gava rural health centre	Rural Health Centre/Rural Clinic	Level-1 facility
113	Masvingo	Gutu	Gutu Rural Hospital	Rural Health Centre/Rural Clinic	Level-1 facility
114	Masvingo	Gutu	Cheshuro Rural Health Centre	Rural Health Centre/Rural Clinic	Level-1 facility
115	Midlands	Chirumanzu	Nyautonge	Rural Health Centre/Rural Clinic	Level-1 facility
116	Midlands	Chirumanzu	Denhere Rhc	Rural Health Centre/Rural Clinic	Level-1 facility
117	Midlands	Chirumanzu	Tokwe 4Rhc	Rural Health Centre/Rural Clinic	Level-1 facility
118	Midlands	Shurugwi	Tongogara Rdc	Rural Health Centre/Rural Clinic	Level-1 facility
119	Midlands	Shurugwi	Rockford clinic	Rural Health Centre/Rural Clinic	Level-1 facility
120	Midlands	Zvishavane	Lundi hospital	Rural Hospital	Level-1 facility
121	Midlands	Kwekwe	Dambridge clinic	Rural Health Centre/Rural Clinic	Level-1 facility
122	Midlands	Kwekwe	Malisa zhombe	Rural Health Centre/Rural Clinic	Level-1 facility
123	Midlands	Gokwe	Manoti clinic	Rural Health Centre/Rural Clinic	Level-1 facility
124	Midlands	Gokwe	Kana mission hospital	Mission Hospital	Level-1 facility
125	Midlands	Gokwe	Norah rhc	Rural Health Centre/Rural Clinic	Level-1 facility
126	Midlands	Chirumanzu	St Theresa Mission Hospital	Mission Hospital	District-level facility
127	Midlands	Chirumanzu	Hanke Mission Clinic	Other	Level-1 facility
128	Midlands	Shurugwi	Shurugwi District Office	District Hospital	District-level facility
129	Midlands	Zvishavane	Zvishavane District Hospital	District Hospital	District-level facility
130	Midlands	Kwekwe	Kwekwe District Hospital (Silobela)	District Hospital	District-level facility
131	Midlands	Gokwe South	Gokwe South District Hospital	District Hospital	District-level facility
132	Matebeleland North	Hwange	no 2 Clinic	Urban Polyclinic/Clinic	Level-1 facility
133	Matebeleland North	Hwange	Victoria falls district hospital	District Hospital	District-level facility
134	Matebeleland North	Lupane	Mdlankunzi	Rural Health Centre/Rural Clinic	Level-1 facility
135	Matebeleland North	Bubi	mbembeswana	Rural Health Centre/Rural Clinic	Level-1 facility
136	Matebeleland North	Tsholotsho	Tsholotsho District Hospital	District Hospital	District-level facility
137	Matebeleland North	Tsholotsho	mpanedziba	Rural Health Centre/Rural Clinic	Level-1 facility
138	Matebeleland North	Umguza	umuntu	Rural Health Centre/Rural Clinic	Level-1 facility

N.	Province	District	Facility Name	Facility Type	Facility Level
139	Matebeleland North	Umguza	Unicem	Urban Polyclinic/Clinic	Level-1 facility
140	Matebeleland North	Hwange	wankie	Other	District-level facility
141	Matebeleland North	Hwange	lukunguni	Rural Hospital	Level-1 facility
142	Matebeleland North	Hwange	Nrz dete	Urban Polyclinic/Clinic	Level-1 facility
143	Matebeleland North	Lupane	St lukes	District Hospital	District-level facility
144	Matebeleland North	Lupane	dongamuzi	Rural Health Centre/Rural Clinic	Level-1 facility
145	Matebeleland North	Bubi	inyathi	District Hospital	District-level facility
146	Matebeleland North	Bubi	majiji	Rural Health Centre/Rural Clinic	Level-1 facility
147	Matebeleland North	Tsholotsho	jimila	Rural Health Centre/Rural Clinic	Level-1 facility
148	Matebeleland North	Umguza	igusi	Rural Health Centre/Rural Clinic	Level-1 facility
149	Matebeleland South	Kezi Matopo	Maphisa	District Hospital	District-level facility
150	Matebeleland South	Kezi Matopo	Ekukhanyeni	Rural Health Centre/Rural Clinic	Level-1 facility
151	Matebeleland South	Bulilima	Solusi Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
152	Matebeleland South	Bulilima	Matjinge	Rural Health Centre/Rural Clinic	Level-1 facility
153	Matebeleland South	Mangwe	Plumtree District Hospital	District Hospital	District-level facility
154	Matebeleland South	Mangwe	Empandeni Mission Clinic	Rural Health Centre/Rural Clinic	Level-1 facility
155	Matebeleland South	Mangwe	Mambale	Rural Health Centre/Rural Clinic	Level-1 facility
156	Matebeleland South	Kezi Matopo	St Joseph Mission	Mission Hospital	Level-1 facility
157	Matebeleland South	Kezi Matopo	Tshelanyemba	Rural Hospital	District-level facility
158	Matebeleland South	Insiza	Filabusi District Hospital	District Hospital	District-level facility
159	Matebeleland South	Beitbridge	Beitbridge District Hospital	District Hospital	District-level facility
160	Matebeleland South	Beitbridge	Shabwe	Rural Health Centre/Rural Clinic	Level-1 facility
161	Matebeleland South	Insiza	Singwambizi	Rural Health Centre/Rural Clinic	Level-1 facility
162	Matebeleland South	Insiza	Singwango	Rural Health Centre/Rural Clinic	Level-1 facility
163	Matebeleland South	Insiza	Insiza health clinic	Rural Health Centre/Rural Clinic	Level-1 facility
164	Matebeleland South	Beitbridge	Nottingham Rural health centre	Rural Health Centre/Rural Clinic	Level-1 facility
165	Matebeleland South	Beitbridge	Chituripasi	Rural Health Centre/Rural Clinic	Level-1 facility

Annex III– Training agenda for survey

Location: Holiday Inn, Harare, Zimbabwe
Date: 15-17 February 2016
Facilitators

1. Professor Stephen Munjanja
2. Dr Thidar Pyone
3. Dr Helen Owolabi
4. Mr Tendayi Kureya

DAY 1: 15 February 2016

Time	***Activity***	***Facilitator/s***
09h00 – 09h30	• Introductions • Setting ground rules • Clarification of expectations (Incl. Obligation for Ipad returns)	Prof. Thidar Helen
09h30 – 10h15	• Introduction to the survey • Workshop objectives and agenda	Thidar
10h15 – 10h30	**Tea**	
10h30 – 11h	• Practical use of Ipads	Helen
11h00 – 12h00	• Questionnaires and guidelines (Health Facilities)	Helen
12h00-12h10	Short break	
12h10-- 13h00	• Questionnaires and guidelines (Health Facilities)	Thidar
13h00 – 14h00	**Lunch**	
14h00- 15h00	• Questionnaires and guidelines (health facilities)-continued	Helen
15h00-15h10	• Short break	
15h10-16h30	• Questionnaire role play in pairs	
16h30-16h45	• Feedback from role play • Clarifications	Thidar, Helen, Tendayi
16h45 - 17h00	**Wrap up**	Tendayi

Day 2: 16 February 2016

Time	*Activity*	*Facilitator/s*
09h00-09h30	• Recap and further clarifications from Health Facility Questionnaires	Tendayi/Helen
09h30- 10h30	• Role play in reverse order	All
10h30-11h00	**Tea**	
11h00-12h30	• Continue role play	All
12h30-13h00	• Feedback from role play • Clarifications	Helen Tendayi, Thidar
13h00-14h00	**Lunch**	
14h00-15h30	• Questionnaires and guidelines (District health office)	Thidar, Helen
15h30-15h45	**Break**	
15h45-16h30	• Questionnaires and guidelines (District health office)-continued	Thidar, Helen
16h30-17h00	• Wrap up and clarifications	Thidar/Helen

Day 3: 17 February 2016

Time	*Activity*	*Facilitator/s*
09h00-09h30	• Recap and further clarifications from District Health Office Questionnaires	Helen/Thidar
09h30- 10h30	• Questionnaire role play in pairs	All
10h30-11h00	**Tea**	
11h00-12h45	• Feedback from role play • Clarifications	Helen Tendayi, Thidar
13h00 –14h00	**Lunch**	
14h00- 15h15	• Role play in reverse order	All
15h15-15h45	• Feedback from role play • Clarifications	Thidar, Helen, Tendayi
15h45-16h30	• Survey record sheet • Surveyor record IDs • Facility and DHO information sheets	Helen, Tendayi
16h30-16h45	• Wrap up and clarification	Thidar, Helen, Tendayi
16h45 - 17h30	• Surveyors meeting • Supervisors meeting • Logistics arrangement	Tendayi & Development Data

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 5
Key Findings of Qualitative Research

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
May 2016

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Introduction

This report presents key findings of qualitative research conducted as part of the independent evaluation of HTF in 2016. It begins with the description of the methods employed in the research: sampling, data collection, data management and analysis. Following from this, the report describes ethical consideration; limitations of the evaluation and strategies to minimise the impact of these limitations. Finally, the report presents key findings of the qualitative research.

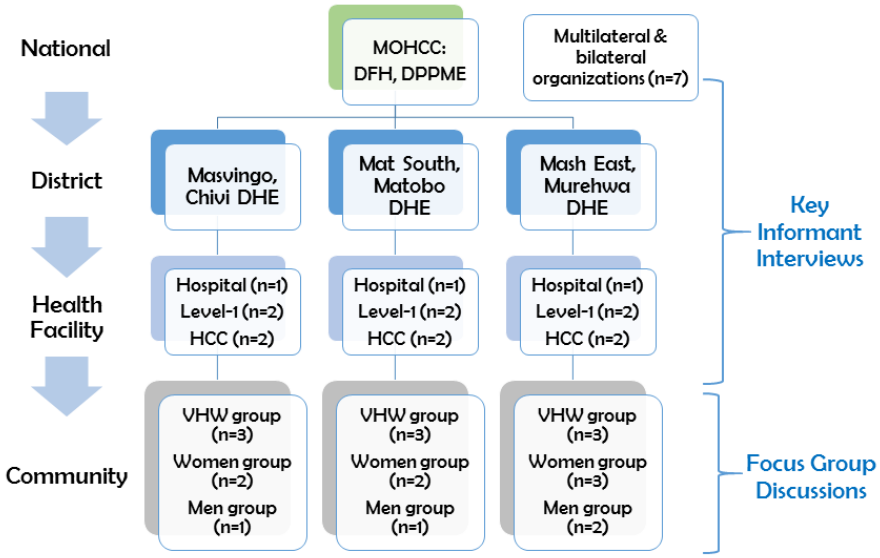
Methods

The LSTM evaluation team used qualitative research methods including key informant interviews (KIIs) and focus group discussions (FGDs) to evaluate the HTF. We have conducted interviews with national level policy makers, members from district health executives (DHE), managers and healthcare providers from health facilities with the districts of Matabeleland South, Mashonaland East, and Masvingo provinces (Figure 1). In addition to public health staff, we also interviewed informants from multilateral and bilateral organizations who were familiar with HTF and results-based financing (RBF).

Sampling

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. Figure 1 illustrates characteristics of respondents participated in FGDs and KIIs.

Figure 1: Characteristics of stakeholders participated in KIIs and FGDs



Acronyms used in Figure 1:
MOHCC=Ministry of Health and Child Care
DFH=Department of Family Health
DPPE=Department of Policy, Planning, Monitoring and Evaluation
DHE=District Health Executive
HCC=Health centre committee
VHW=Village health worker

In total 30 KIIs were conducted at national, district and facility levels. Twelve respondents from national level involves key staff members of the Ministry of Health and Child Care (MOHCC), and multilateral and bilateral organizations who are familiar with the HTF and RBF mechanisms. At district level, group interviews were conducted with members of the DHE and who were also part of the district hospitals. At health facilities, healthcare providers and managers including doctors, nurses, midwives, primary care nurses, pharmacist in-charges, etc. In total, three group interviews were conducted with managers and staff members from three district health offices; six Level-1 facilities; and six Health Centre Committees (HCC).

A total of 20 FGDs (six in Masvingo province; six in Matabeleland South and eight in Mashonaland East) comprising of 124 community men and women; and 73 VHWs. Participants for community groups were selected based on the criteria such as adults who have been living in the villages for the last five years. FGDs were held separately for men and women to create an environment where participants could express themselves comfortably in the absence of the other gender counterparts. Overall, the community level respondents were composed of women and men in reproductive age and/or caregivers of children under 5, reflecting the selection criteria required for the evaluation. 71% of community groups were of reproductive age of which 57% were women. Among participating VHWs, 89% were of reproductive age of which 73% were women. Table 1 presents characteristics of community level participants included in FGDs.

Table 1: Characteristics of Participants in Focus Group Discussions

Age group and sex of focus group discussion participants	Number of participants in each district									Total
	Mash East District 1	Mash East District 2	Mash East District 3	Mas-vingo District 1	Mas-vingo District 2	Mas-vingo District 3	Mat South District 1	Mat South District 2	Mat South District 3	
Community										
18-24 years										
Male										**0**
Female	1	4	2	5	3			3	2	**20**
25-49 years										
Male	10		8			12	8			**38**
Female	8	8	7	5	10			6	6	**50**
50 years and above										
Male						2	1			**3**
Female	2					3		4	4	**13**
Village health workers										
18-24 years										
Male										**0**
Female	1									**1**
25-49 years										
Male				1		2		1	2	**6**
Female	5	7		8	8	5	4	2	8	**47**
50 years and above										
Male							3	2	1	**6**
Female	1					3	3	5	1	**13**
Total participants	**28**	**19**	**17**	**19**	**21**	**27**	**19**	**23**	**24**	**197**

Data collection

The MOHCC granted approval to access potential respondents for KIIs and FGDs. Permission to access the DHE and health facilities was further obtained from the Provincial Medical Directors of each province.

Topic guides were developed for each FGD and KII category (Annexes 1-5). These were pilot-tested in the non-participating district Mashonaland West and further refined before use. KIIs were conducted by LSTM evaluation team while FGDs were conducted by the Community Medicine Department from the University of Zimbabwe. Data collection took place from the 22nd February to 3rd March 2016.

Before the start of each interview or FGD, participants were asked to read an informed consent form, to express their willingness (or not) to participate and to record that on the consent form. If a participant was unable to read, the researcher undertaking the interview or FGD would read the form aloud to him or her.

For KIIs, two copies of the consent form were handed out to the participants at the beginning of the interview and signatures were obtained. One signed copy was given to the participants and the other was kept by the evaluation team in a secure study file. For FGD, verbal informed consent was recorded on tape before the start of each discussion. The researchers read the notes back to the participants at the end of the interviews or discussions so that clarifications could be made.

All interviews were conducted in English and voice-recorded with the consent of each participant. They were transcribed in English. All transcribed data were anonymised and given labels. All FGDs were conducted in vernacular languages (Matobo- IsiNdebele, Chivi –Chikaranga, Murehwa- Zezuru) and voice-recorded after group consent was obtained. They were translated and transcribed verbatim from vernacular languages into English. All transcribed data were anonymised and given labels within the FGDs.

Data Management and Data Analysis

All data were managed in accordance with the LSTM internal data management policy and protocols.

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).[1] 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.[2]

Recordings of KIIs and FGDs were stored on password protected data devices and will be destroyed after the report has been approved by the HTF Steering Committee. Every effort has been made to ensure that confidentiality and privacy of respondents were protected at all stages of data collection and processing.

Ethical Considerations

The specific research protocol for this evaluation was submitted to and approved by the LSTM Research Ethics Committee. Approval to conduct field data collection of interviews and focus group discussions has been granted by the MOHCC Zimbabwe.

A major ethical issue in this evaluation involves protecting the confidentiality of the KII and FGD participants for example due to the potential leakage of information discussed during the FGDs . Participants in the communities may feel that their views and responses could affect the quality of health care they receive at health facilities or the type of health services available for their communities.

In order to minimize these potential breeches of confidentiality, KII and FGD 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. Participation without coercion or fear was ensured throughout the process. 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

[1] Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). Qualitative research practice: A guide for social science students and researchers: Sage.
[2] Graneheim and Lundman (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness

password-protected computers so that people that are not part of the project team would not have unauthorised access to the data.

The research team strictly adhere 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 accepts 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

Limitations

As all other studies, this evaluation faced some limitations in data collection and analysis. Limitations and mitigation strategies to minimise the impact of these limitations are listed below.

The researchers validated their interpretation with the respondents after completion of each interviews or discussions to minimize the researcher's bias or errors. When necessary, the researchers asked the respondents to provide specific examples to make the right interpretation of a situation.

It is possible that respondents give standard responses that might not reflect their own opinions. For that, the researchers triangulated the information that collected from other key stakeholders. This has been used to look for opposing or contradicting information as researchers can identify how different findings corroborate with different opinions.

Participants may have been reluctant to openly express their opinions for fear of recrimination during KIIs and FGDs even though researchers are external to the programme. Therefore, the researchers appointed by the LSTM have used open-ended questions (where applicable) based upon the topic guides to minimize interviewer/facilitator bias. The researchers have tried their best to be as facilitative as possible in order to avoid the influence of interviewer/facilitator's presence during KIIs and FGDs and to make sure that informants felt comfortable to express their views.

Some of the data and its meaning/implications may have been lost during translation even though all efforts were deployed to ensure data integrity. This is particularly relevant for the FGDs, which were conducted in local language.

Due to the nature of the qualitative component of the evaluation, the positions of the researchers could have an effect on some of the data generated and this could lead to bias. This limitation was minimised by having a team of different researchers collecting and analysing data so one researcher's opinion could not have affected the results.

The findings of the study may have limited generalisability beyond its immediate locality as it included a limited number of stakeholders, interviewed at a specific stage (point in time). However, the aim of the study was specifically to evaluate the HTF in Zimbabwe, which generalisability to other settings might also be limited.

However, by applying qualitative research methods such as KIIs and FGDs, the evaluation team sought to get in depth information to answer evaluation questions to hear about their perspectives and why. We have used purposive sampling of "information-rich" participants to represent (but not statistically) the broad types of informants relevant to our evaluation.

Marshall (1996: 523) noted that '…an appropriate sample size for qualitative study is one that adequately answers the research question'. Generalisability is not the main goal of good qualitative research. Instead, as discussed above, 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.).

Additionally, we have taken into account the following aspects in our data collection and analysis to achieve the optimum sample sizes we have selected[3]:

- There is no new or relevant data seem to emerge regarding a category (sub-theme) under study
- The category is well developed in terms of its properties and dimensions demonstrating variation
- The relationships among categories are well established and validated new data

In addition to generalizability, we have considered two other aspects: "reliability and validity" of the qualitative data we have collected.

Reliability refers to "replicability" of a study's findings (Ritchie et al, 2013)[4]. Bowling (2009) highlights the importance on homogeneity of the tools used in the study which can be free from random error.[5] Therefore, she recommends pilot testing of the tools before embarking the study to examine practicability, reliability and validity of the tools. LSTM has piloted topic guides with non-study participants and incorporate them in the guides used for the evaluation. Additionally, the evaluation has engaged in five strategies: tape recording, transcription, double coding, getting inter-coder agreement and analysis by different researchers to maximize the reliability of the study.

[3] Kielman, K., F. Cataldo and J. Seeley (2011). Introduction to qualitative research methodology. DFID: 84.
[4] Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). Qualitative research practice: A guide for social science students and researchers: Sage.
[5] Bowling, A. (2009). Research Methods In Health: Investigating Health and Health Services: McGraw-Hill Education.

Validity refers to the extent to which a finding is well-founded and reflects the accuracy of a phenomenon of a study (Ritchie et al, 2013). Validity is part of our evaluation design as we have considered potential threats to the evaluation and identified strategies to overcome this (Maxwell, 2012).[6] In this evaluation, the evaluation has engaged in three strategies; triangulation, clarifying researcher bias and member checking to maximize the validity of the evaluation. We have anticipated some validity threats in our evaluation and have planned the following strategies to mitigate those issues (Table 2).

Table 2: Key threads to validity of the evaluation with mitigation measures employed

Key threats to validity	Mitigation measures employed
Researcher's bias or errors in understanding and interpretation	Validation with the participants after completion of each interview or focus group discussion if the participants allow. Presentation of the first draft of evaluation findings in the MODO meeting which includes some of the participants.
Contradicting or opposing information	Triangulation of information from different sources (interviews, focus group discussions, health facility assessments and secondary data and reports)
Reactivity-interviewing with the respondents may get standard responses and might not reflect their own opinions. (What they say may differ from what they do?)	The evaluation has used open-ended questions (where applicable) in topic guides to minimize researcher's bias. Different members of the evaluation team has used standard topic guides for interviews and focus group discussions to maintain consistency in data collection (interview or discussion timing, questioning, emphasis and potential reaction). The evaluation team has tried to be as facilitative as possible in order to avoid the influence of their presence during the interviews and discussions.

Data generated through FGDs could be subject to recall error or recall bias as women and men were asked to recall practices around maternal and newborn health care. This limitation was minimised by asking for recent examples and by conducting a sample of 20 FGDs where results were categorised and compared to identify similarities and differences in responses.

Findings

The findings were grouped according to the OECD-DAC evaluation criteria, the conceptual framework for evaluation namely: effectiveness; relevance; efficiency; and sustainability. Under each evaluation criteria, findings were categorised into key HTF interventions: design, governance and coordination;

[6] Maxwell, J. A. (2012). Qualitative Research Design: An Interactive Approach: An Interactive Approach: SAGE Publications.

maternal health; child health including nutrition; community health services system and health financing including results-based financing (RBF). The findings were categorised into themes as presented below.

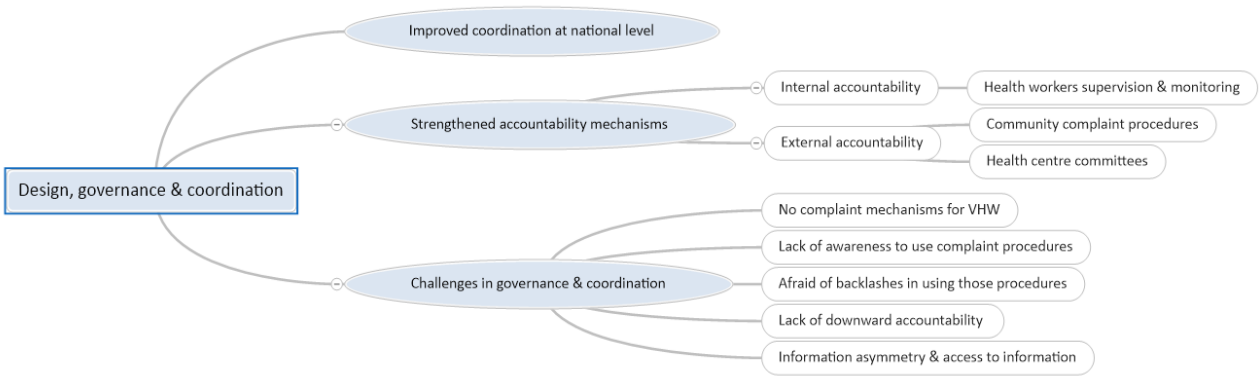
The findings in this report do not include human resources for health, and procurement, supplies and medicines as those analysis form part of the standalone thematic reports.

Effectiveness

Design, Governance and Coordination

Three key themes emerged through the qualitative analysis with regard to design, governance and coordination mechanisms of HTF. These are summarized in Figure 2 below.

Figure 2: Visual map on design, governance and coordination mechanisms of HTF



National level respondents perceived that design and coordination mechanisms of HTF have been useful in reviving the Zimbabwean healthcare system as the programme has been instrumental in supporting existing key pillars of the health system. Respondents saw human resources for health, health financing, supplies and information system as key drivers for the achievements. HTF has also **improved coordination at national level** because of its basket fund structure instead of vertical programme financing (Box 1, Quote 1). However, there were gaps in the design of the HTF programme since it only focused on primary level facilities leaving out higher level facilities within the referral chain (Box 1, Quote 2).

HTF showed 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, however, the frequency had decreased (Box 1, Quote 3). 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 Health Centre Committees (HCC). However, the extent and level of functioning of those mechanisms varied between districts and facilities (Box 1, Quote 4.).

Most health care workers were aware of the request to have a suggestion box available at facility level, however, not all facilities had installed the box yet (Box 1, Quote 5). The use of the suggestion

box was limited and some communities expressed that they did not feel comfortable in using them because they were concerned about the consequences from the healthcare providers or because they felt that their suggestions would not be considered anyway (Box 1, Quote 6 and 7). Thus, communities rarely disclosed negative experiences about the services they received as they had no alternative choice to seek health care (Box 1, Quote 8 and 9).

Another weakness in community accountability was that there was no complaint mechanism for the Village Health Workers (VHWs) where they could receive feedback for their complaints. Some VHWs described that there was **only upward accountability -** meaning accountability to managers or higher level. VHWs rarely received feedback from facility health workers though they provided regular reports to the clinics. VHWs also felt that there were favouritism and nepotism within their village administration, which they witnessed when providing food assistance and for job distribution within the communities (Box 1, Quote 10).

Information symmetry and access to the right information are critical elements to ensure functional accountability mechanisms. Almost every VHWs who participated in the evaluation commented on the discretion of information regarding the incentives that they were supposed to receive as they did not receive adequate information in time. In some facilities, VHWs did not receive information from facility staff, which reduced their credibility and status (Box 1, Quote 11). Community access to information about health facility procedures was another major issue. For example, communities were unaware of the service fees at facility level (Box 1, Quote 12). Nevertheless, it was encouraging that some community groups were requesting information on issues such as user fees and service charters at facility level to increase their access to information (Box 1, Quote 13).

Box 1. Illustrative quotes for "design, governance and coordination"

Quote 1. "…I think there was also improved coordination at national level by bringing these funding mechanism together in one basket. That was one thing that was a very huge positive in terms of focusing resources on the priority area. For me that was the driving forces of the success of that program." (KII respondent 29)

Quote 2. "…it concentrated on primary health care facilities it was not supporting the secondary level…" (KII respondent 8)

Quote 3: "…we do get regular supervision visits from the ministry we do get supervision from the districts, which is the DHE members and the Provincial Medical Director Office also does come here for supervisions… I think generally may be the frequency of supervisions I think has gone down. Mainly due to challenges that those offices are actually facing by some fund that are coming from the districts." (KII respondent 15)

Quote 4: "Yes, we do have a suggestion box but it is not usually used by the public… They [the public] come to complain to me or they go to Superior…" (KII respondent 1)

Quote 5: "That one [suggestion box] we do not have, but the DHE has pointed out that we should have one such a facility, a suggestion box." (KII respondent 27)

Quote 6: "The channel is there, but we are ignorant of it. I come from the village; if I say it out in public showing my rights, People from my village will think I am preventing them from being well treated at this hospital... Personally I have no right to tell the nurses and staff that you are not being treated well." (FGD community men 11)

Quote 7: "…what we have noticed those authorities seem to forgive whatever wrong is done at the clinic. So there is no point in expressing your views even if the services are bad." (FGD community women 19)

Quote 8: "The suggestion box is there but nobody uses them. We don't know who opens it." (FGD VHW 17)

Quote 9: "…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." (FGD VHW 6)

Quote 10: "…the way they are distributing their food handout from the President, is not fair, there is favouritism. They do not look at the situation, and end up giving food handout to families with working parents." (FGD VHW 6)

Quote 11: "When they come here I book them and when I tell them I have no medicines, they became very angry and say you are wasting my time. You see, they make people to take us like very low people. Today a woman came to me and before saying anything she shouted "*do you have what I need*?" (FGD VHW 6)

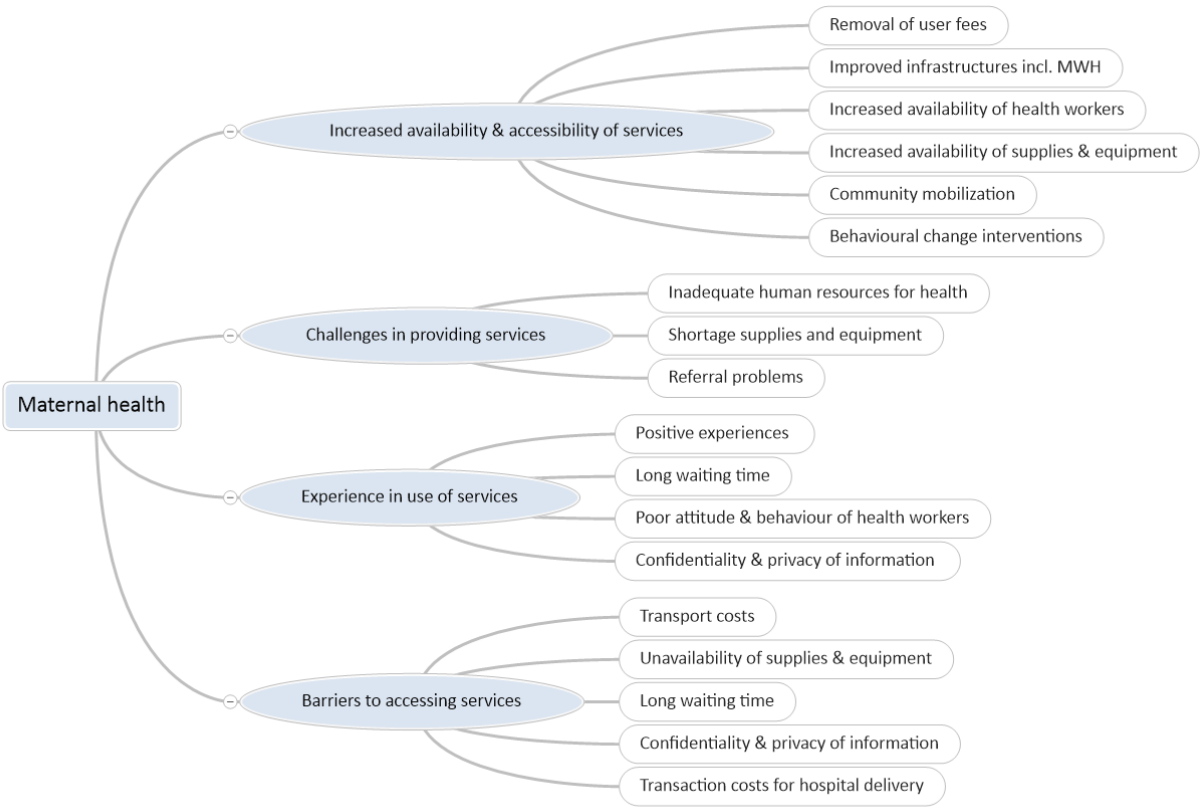
Quote 12: "Sometimes it is lack of information that is when we tell them that expecting mothers do not pay for the services." (FGD VHW 16)

Quote 13: "We also need educational information on the birth cards or on the charts on the walls, so that we can also read on our own." (FGD community women 4)

Maternal Health

For maternal health, key themes emerged regarding availability and accessibility of services; challenges in providing services; experience in use of services; and barriers to accessing services. Figure 2 illustrates the themes in the maternal health category.

Figure 3: Visual map on the maternal health component



The majority of the respondents were under the impression that there has been improvements in the availability and accessibility of service provision and increased demand for services since 2012. The main reasons described by different participants included removal of user fees; increased availability of infrastructure including maternity waiting rooms and refurbished facilities; increased availability of health supplies and equipment; and community mobilization and behavioural change interventions (Box 2, Quotes 1 and 2).

However, **challenges** were identified in the availability and adequacy of medical supplies, shortages of healthcare providers and referral problems particularly regarding users not being able to pay for transportation costs (Box 2, Quote 3). 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 (Box 2, Quote 4). Some 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 bedsheet, sanitary napkins, baby wrappers,

baby blankets, matches and candles. They were aware that the facilities also did not have these items. (Box 2, Quotes 5, 6, and 7)

Another circumstance that hindered communities from accessing healthcare services was when health care providers were unable to prescribe medication due to supply shortages. Hence, the majority of healthcare providers commented that HTF has increased the demand for services but as long as health system challenges such as staff and drug shortages remain, the quality of services will be compromised (Box 2, Quotes 8 and 9). Similarly, some VHWs were not convinced about the improvement in availability and accessibility of health services as fees for medication are still a significant barrier for communities to seek care (Box 2, Quote 10). Some community groups questioned the availability of maternity waiting rooms in the health facilities as the infrastructure has been occupied by police forces (Box 2, Quote 11). User fees was another barrier in accessing healthcare services as some health care providers explained that users refused to be referred when they could pay for the services (Box 2, Quote 12).

In regard to maternal health seeking behaviour and practices, there has been an **increasing trend in use of health services**. Yet, religious and cultural practices still prevailed in certain communities where some population groups seek care from religious healers (Box 2, Quotes 13 and 14). VHWs faced challenges in convincing these community groups of seeking care at health facility level, requesting support from the Government to resolve this (Box 2, Quote 15).

Community members and VHWs expressed **general satisfaction in using maternal health services** within their communities although few respondents provided specific examples of improvements, which were mainly centred around increased knowledge of women to seek health care at facility level (Box 2, Quotes 16 and 17). However, negative accounts seemed to outweigh the general satisfaction. Negative experiences included healthcare providers disclosing sensitive patient information; lack of confidentiality and privacy of care; and negative attitudes and behaviours of health staff (Box 2, Quotes 18, 19, 20). Some community women recounted how they were scolded at and treated badly by the health staff (Box 2, Quotes 21, 22).

Despite the increasing demand for services and the removal of service fees for maternal care, key **barriers identified in accessing maternal health services** included user fees, transport costs, unavailability of medical supplies and equipment at the facilities, long waiting times, lack of confidentiality and privacy; and negative attitudes and behaviour of healthcare providers.

Box 2. Illustrative quotes for "maternal health"

Quote 1: "Yes, we are seeing things improving; there is a waiting room for expectant mothers… It was built in 2013 then it was opened in 2015." (FDG community men 18)

Quote 2: "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." (FGD community women 2)

Quote 3: "There are issues when an expecting mother comes to delivery, sometimes she needs to transferred to Murehwa Clinic and she has no money for transport and the clinic have no ambulance or a clinic vehicle." (FGD community women 8)

Quote 4: "…even those who are married register very late they say that: "[I] don't want to walk to hospital for the whole 9 months, it is better to stay at home for 5 months then I only walk the distance for 4 months". Because of the distance." (FGD VHW 17)

Quote 5: "Yes, all the baby's preparation is required, things like candle and matches because sometimes there is no electricity. So when mothers do not get the required maternity requirements, they end up giving birth at home. Sometimes shortage of food while mothers are waiting can detail them not to come to the clinic… The other problem is that, some mothers have very young children who need mother's care. So they will end up delaying going to the clinic and end up giving birth at home. If only we can get things like napkins, baby wrappers, baby blankets for reuse at the clinic to enable those women who cannot afford to benefit, so that we can end up not having home deliveries." (FGD community women 19)

Quote 6: "Yes, yes, it happens, sometimes one will not be having the required things. There are quite a number of things wanted. As expectant mothers we are given a list of things required during delivery. Due to financial constraints mothers fail to bring all these thing. The hospital requires all the things on the list. So as a result most women end up delivering at home." (FGD VHW 14)

Quote 7: "Candles and matches, in case lighting is not available, buckets to use when bathing, sanitary pads, code clamps." (FGD community women 13)

Quote 8: "Since the coming of HTF the work load is now too much and the number of staff it is no longer increasing we have been 3 and we are still 3 if 1 stand to go on leave 2 nurses are left and no replacement." (KII respondent 10)

Quote 9: "It is okay on paper, but the workload is too much. We are not only concentrating on maternal health care only, but we have different programmes which we have also to cover. For instance, if you had visited us last week, one nurse had gone for an outreach. Most of the time we do not have lunch or tea break. When you try to serve one patient, a mother will be brought in the labour ward to be attended." (KII respondent 1)

Quote 10: "I can see that since 2010 up to now that is nothing better. People have no money for medication for the child, the child will die. If you stay in this community you will not get any help, but if you go to town and go to places like the army you can get medication" (FGD VHW 14)

Quote 11: "One thing is the waiting shelter; it is not conducive place and police stay there that makes women not happy about staying in it." (FGD community men 7)

Quote 12: "We sent to Marondera. And Marondera raises a fee because it's a provincial hospital. And for those who need onward referral to Chitungwiza that's where the real problem comes. Because Chitungwiza it's a money first patient later." (KII respondent 15)

Box 2. Illustrative quotes for "maternal health" (continued)

Quote 13:"These prophets also help a mother by informing her that there is a breach child in the womb. The prophet gives you water to administer and some strings to tie around your waist then you are cured…Oh yes**,** the prophets' medication works**,** but you also have to go to the hospital and compare. *[What of it if the results do not tally?]* We will trust the hospital because at the clinics they have testing machines but there is no harm in seeking a second option..." (FGD community women 13)

Quote 14: "Most of the mothers seek treatment from the traditional healers." (FGD community women 19)

Quote 15: "We do have challenges though with some religious groups who do not want to come for help at the clinics, especially the *Marange Apostolic Sect church*, mothers and children are dying including men because they do not want to come to the clinic. We would want the government to intervene because we are losing many lives in the community. We have tried our best to convince them but our efforts have not yielded any fruits." (FGD VHW 3)

Quote 16: "When one has miscarriage these days, I think this is due to your own negligence. Assistance and care is being given at the clinic. I think all is well here; many programs are being carried out. Things are improving quite a lot because we are now getting food for our children at the hospital" (FDG community women 19)

Quote 17: "We can see that health issues in or community has changed for the better. Mothers seem to understand and many people are now coming to the clinic in at 14 weeks after getting information on the disadvantages of delivering at home." (FGD VHW 17)

Quote 18: "Nurses are not concerned about privacy, sometimes issues are discussed in private, so much that patients end up divulging wrong information which will not be recorded as a correct record." (FGD community women 4)

Quote 19: "…a woman who had a baby who tested positive but was embarrassed to come for help because the information about the people's status is divulged… this is evident that the information about somebody's status is not kept secretary. I would not even come here because of lack of secrecy at the clinic" (FGD VHW 3)

Quote 20: "…it all depends with someone's luck, or someone has bad luck and it depends how the person is treated by the nurse." (FGD community women 8)

Quote 21: "Yes, Yes, really, this is really an issue. There is an incident which happened, nurses continued on scolding her until she delivered while on the floor." (FGD community women 4)

Quote 22: "Yes even the injection administered by a person without good customer care is very painful *[Laughing]* women will stay out of the hospital until another nurse is on duty. Nurses should have a clean heart as white as their uniform." (FGD VHW 9)

Child Health

The key themes that emerged when analysing the qualitative interviews for child health were more than for maternal health. As illustrated in Figure 3 below, they included key drivers of improvement, gaps in IMNCI interventions, perceptions of EPI programme, HFT support on nutrition, common child health practices, and barriers in seeking health services.

Figure 4: Visual map on the child health component

Respondents from different levels of the health system provided their views on **improvements in child health** as evidenced by the decrease in child mortality since the inception of the HTF. Key drivers identified for these achievements were increased availability of medicines, communication and advocacy activities, improved outreach services, and behavioural change interventions. However, persisting challenges in different aspects of the child health component included gaps in design of the programme. For instance, respondents perceived that HTF has supported mostly facility based **IMNCI** interventions but has not been able to cover the community-based IMNCI component particularly the training of VHWs on IMNCI (Box 3, Quote 1). Other important gaps highlighted by national level respondents included availability of medical supplies; shortage of healthcare providers, and barriers in access to healthcare due to distance to the facilities and user fees. These findings were supported by healthcare providers who described experiences with child caregivers who did not comply with their referral advice as they could not afford transport charges or user fees at referral facility, as identified for maternal health as well (Box 3, Quote 2).

The majority of the respondents perceived that there has been **improvements in EPI coverage** and that main reasons for such improvements include support from other key implementing partner such as GAVI; a functioning procurement system; appropriate cold chain management; HTF providing health sector support rather than vertical project support; and effective outreach services including follow up within the communities (Box 3, Quote 3 and 4). However, some districts commented on the gaps such as regularity of services, strengthening monitoring and evaluation mechanism (for data verification), improving community participation, and distances for outreach activities (Box 3, Quotes 5 and 6).

Malnutrition in children is related to the socio-economic situation within the communities, which is aggravated by food insecurity and environmental conditions such as drought. Respondents perceived that both nutrition sensitive and nutrition specific interventions are instrumental to improve the situation of malnutrition (Box 3, Quote 7). Respondents acknowledged the support of the HTF because it came in when the communities were in dire need to improve the nutrition situation (Box 3, Quote 8). HTF has supported nutrition sensitive interventions such as training communities on food production; supporting school gardens and communal gardens; inter-sectoral collaboration such as working with the Ministry of Agriculture as well as nutrition specific interventions such as promoting facility based infant and young child feed practices (IYCF) (Box 3, Quote 9).

Respondents also highlighted challenges in the nutrition programme as some nutrition sensitive interventions were no longer supported by HTF. Hence, some healthcare providers perceived that HTF only focused on nutrition specific interventions such as provision of plumpy nut for severely malnourished children. They were frustrated to receive relapse cases of malnourished children who have been discharged from their hospitals because the caregivers could not afford to provide nutritious food even if they had the knowledge (Box 3, Quote 10). At times, health workers also faced shortage in the supply of Plumpy Nut and thus had to refer malnourished children to another level of care (Box 3, Quote 11). Other challenges in the nutrition programme were failure of school gardens due to unfavourable weather; failure in attempt to provide real time information on nutrition through HMIS due to timeliness of the HMIS information; and failure to train adequate numbers of VHWs for community IYCF (Box 3, Quotes 12, 13 and 14).

Regarding newborn and **child healthcare practices**, pneumonia, vomiting and snake bites were reasons to seek urgent health care (Box 3, Quote 15). There was no difference among female and male groups in regard to their first contact in seeking treatment for a sick child. Decision to seek care depended mostly on the distance to a health facility and financial resources available in the household. Cultural and religious factors still influenced essential child care practices particularly infant and young child feeding practices; and seeking care during illnesses (Box 3, Quotes 16, 17 and 18). VHWs and community groups confirmed that dangerous child care practices still prevailed within their communities (Box 3, Quote 19).

Key barriers in seeking appropriate health care for sick children were similar to those of maternal health, including long waiting time due to shortage of health staff, poor attitude of healthcare providers, and lack of medicines and supplies (Box 3, Quote 20). There were instances where

caregivers have been turned away from health facilities due to unavailability of the right medication or functioning equipment for the children.

Box 3. Illustrative quotes for "child health"

Quote 1: "About the IMCI from the community based, we need to be strengthened because the village health worker is a cadre whom we are not even sure how they are recruited." (KII respondent 8)

Quote 2: "And a challenge comes to those with severe malnutrition who needs hospitalization at the district or provincial hospital. Sometimes we refer them but they don't go there maybe because of distance, sometimes they go to their homes." (KII respondent 13)

Quote 3: "…it's the strengthening of the whole coaching system, procurement, consistent procurement of vaccines. All of them are bought through the HTF, the basic vaccines, the newer vaccines they are contributed to by GAVI with a co-financing by the government." (KII respondent 18)

Quote 4: "… [EPI] this also goes back the HTF supports, the programme in the health sector in this county, which is the health system programmatic support as opposed to project support." (KII respondent 28)

Quote 5: "We have to do data verification. We have to do quarterly supervision, it is the HTF vehicle, and we also have to do follow up on EPI verification. We realize because of the vehicle being overburdened the vehicle goes off the road for about 3 to 4 weeks. We are planning to increase community participation remember primary and health care approach, is talking about community participation, where the community will be participating even in the provision of resources using the RBF approach." (KII respondent 22)

Quote 6: "One has to travel very far away to render EPI services. Sometimes nurses spent the whole day only to serve two sites...Nurses come back to the clinic very late without having lunch."(KII respondent 1)

Quote 7: "…we have a programme, ZIMASSET we have to use the little resources that we have in order to produce food and educate the communities in terms of what is required with the little resources we have." (KII respondent 4)

Quote 8: "It is only that with HTF funds, they only got us when we were really in dire need, so we had to consider very critical lifesaving activities. We were mainly doing teaching in the community on how to feed the children. We also trained the community on food production. We also have a problem of children who are brought into the country because some of these children are brought in the country in bad shape, they will not have been breast fed." (KII respondent 22)

Quote 9: "We also conducted mentorship activities for the staff and capacitating courses for food production which was done in collaboration with Ministry of Agriculture. So we would say our nutrition rate is high." (KII respondent 22)

Quote 10: "I think it's a household nutritional issue that's what I wanted to say and also there used to be a school feeding programme where children used to get nutrition and that sort of a thing but that has faded. The matron even mentioned that you get malnourished children and you have them recover and feed them and once they are discharged they may go and may return because the support is not in the community. We asked about the village health workers whether they are providing that support and they said that they do it provided there is food without food there is nothing much we can do. And when they come at the Hospital there are times when we actually run out of ready to use therapeutic feeds because we have to improvising from F75 - F800 using our own resources." (KII respondent 11)

Quote 11: "As for the plumpy- nut we have some hick-ups there are some interactions it's not always available. This other month it's there 3 weeks we don't have it. If the plumpy nut is not there the babies still starving and we end up referring that baby to the hospital." (KII respondent 13)

Box 3. Illustrative quotes for "child health" (continued)

Quote 12: "…school gardens were gone, well they had to try it as well, yeah. Because of draught otherwise we had a very good programme that with the FTU that is looking at village level gardens, community level, yah, but a draught is a draught." (KII respondent 18)

Quote 13: "Because the thing about the health information system, and nutrition, the health information system is a slow system, you get to the results maybe after 4 months or the most if you are lucky you can get a monthly report" (KII respondent 18)

Quote 14: "There is staff but they have not gone under such a training, there is a lot to learn in IYCF not only to know about but you have to breast feed exclusively up to 6 months and continue breast feeding up to 3 years even include the skills that you should use when counselling a mother such that is covered in training." (KII respondent 4)

Quote 15: "Yes, yes, things like pneumonia, vomiting or snake bites need urgent attention by a medical practitioner. So we go with the children at the nearest hospital or clinic even at night." (FGD community women 13)

Quote 16: "I will speak of my own experience, I went to the church with my baby for treatment, at first they could not cure the baby, but when I visited for the second time the fontanelle was cured. They just gave the baby water." (FGD community women 19)

Quote 17: "Yes some go to the prophets and they are advised to give children suffering from diarrhoea to give children cooking oil." (FGD community women 8)

Quote 18: "Women are taught about salt and sugar solution if it is diarrhoea but something else they do not know. If it is flue we sometimes make the child sweat so that the flue can be better. We don't just rush to hospital the body must heal itself; we will only come to the hospital when it is serious." (FGD community men 7)

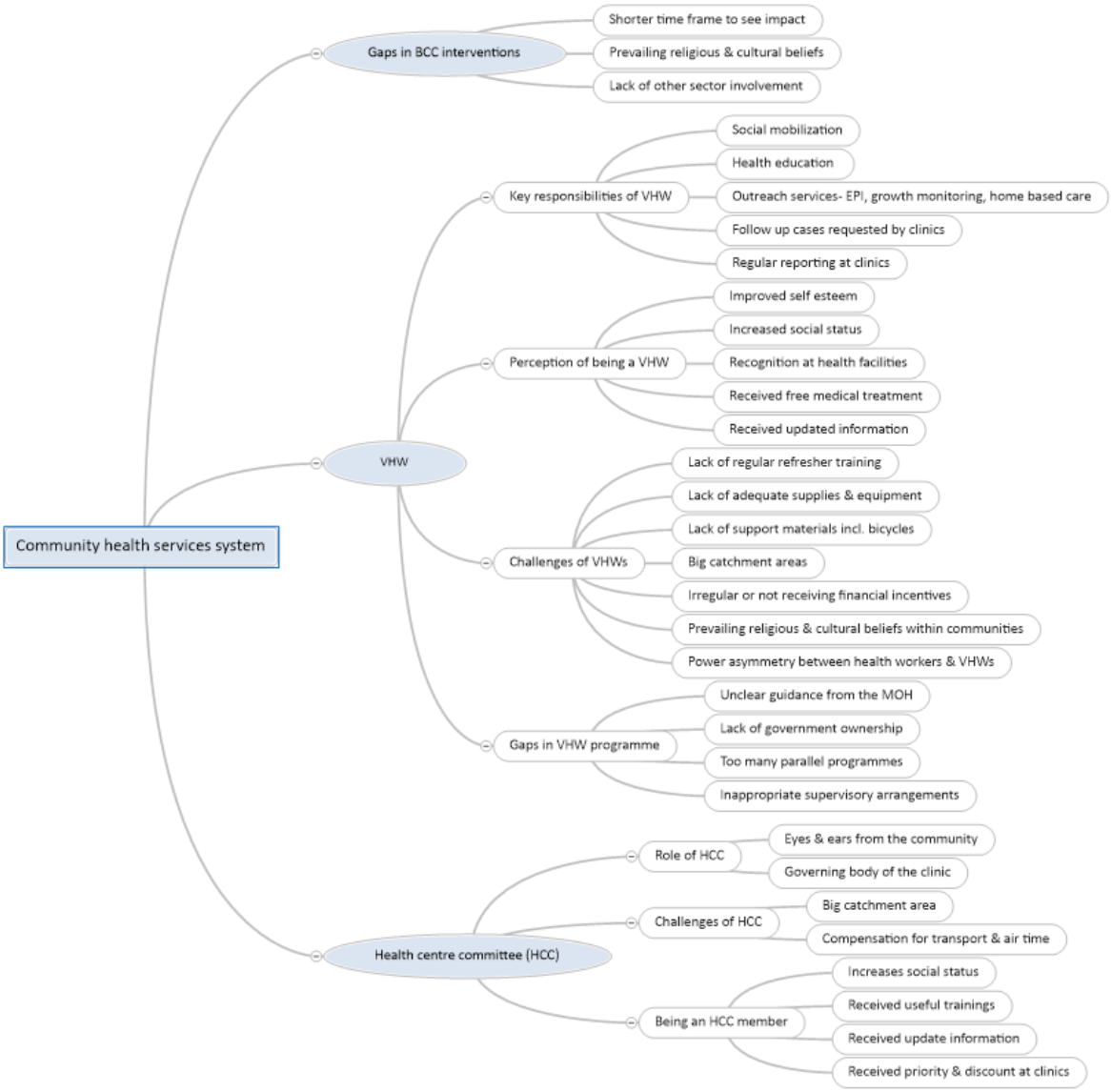
Quote 19: "…some people still go to their churches for help. They are given water and salt to scribe children's throat, but as VHW we encourage them to go to the clinic or give the child more water to avoid dehydration. As VHW we encourage them to go to the hospital." (FGD VHW 3)

Quote 20: "…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." (FGD community men 11)

Community Health Service System

For the community health service system, three key themes emerged each including several sub-themes particularly the VHW theme. Figure 5 provides an overview of these.

Figure 5: Visual map on community health services system supported by HTF



The community health service system was one of the key interventions supported by HTF. Areas of support included behavioural change communications through VHWs and other health promotion activities, and reviving the role of Health Centre Committees. Respondents at national level described a slow progress in the behavioural change interventions given that four years is a short time frame to witness significant changes in behaviour (Box 4, Quote 1). To address the religious and cultural beliefs prevailing in some parts of the country, respondents from national level suggested that the behavioural change programme should involve other sectors such as gender and child protection by

developing specific behavioural change communication packages and identification of important gate keepers (Box 4, Quote 2).

Another key intervention under the HTF is the reinforcement of the **VHWs**. These perceived themselves as the "foot soldiers" or "eyes of the hospitals" establishing an essential link between health facilities and communities (Box 4, Quote 3 and 4). VHWs described that their **key responsibilities** include social mobilization; health promotion; outreach activities such as immunization and growth monitoring for under-5; follow up of patients requested by health facilities; and home based care. VHWs also acted as sentinel in checking the availability of supplies and equipment and inform their communities when they should go to seek care at the facilities for users to avoid travelling in vain (Box 4, Quote 5). The majority of community groups acknowledged the role of VHWs for imparting health education knowledge, social mobilization for immunization, and environmental sanitation.

VHWs are **selected** by the communities and receive initial **trainings,** which usually lasts for six months though some received shorter training for one to two months only. Some of the VHWs had received refresher trainings while majority had not. Every VHW recruited is supposed to receive supplies and equipment; support materials such as stationery, bicycles and some financial incentives. However, the vast majority of VHWs described **challenges** in performing their duties mostly due to big catchment areas; lack of mobility equipment such as bicycles; lack of functioning equipment such as weighing scale; shortage of medicines and supplies; not receiving financial incentives, lack of regular refresher trainings, and lack of effective means of communication (Box 4, Quote 6). VHWs acknowledged that they should provide voluntary services for their own communities but they were promised to receive those "little incentives" (42 USD per quarter) as compensation at the time of recruitment. Therefore, they somehow expected to receive those incentives regularly to cover some of the costs they had invested for their voluntary work. However, the majority of them did not receive incentives in time while some of them had never received anything since their recruitment. Some VHWs were even registered as receiving incentives that they had never received (Box 4, Quote 7 and 8). Additionally, VHWs encountered challenges due to religious and cultural practices in the communities. At times, the VHWs found it difficult to convince the communities of abandoning harmful health practices and seek care at the clinics (Box 4, Quote 9).

Despite the many challenges described, most of the VHWs who participated in the evaluation felt **positively about being a VHW** due to increased social status within their communities; recognition at health facilities; access to free medical treatment, improved self-esteem, and access to updated information (Box 4, Quotes 10 and 11).

In regard to the structure of the **VHW programme**, some respondents at national level believed that the community health service structures in Zimbabwe is better compared than other Sub-Saharan African countries. Zimbabwe has had very strong system at community level since the 90s even though there was no supervision mechanism in place (Box 4, Quote 12). However, another national respondent explained that there was no clear guidance on the type of profile they were looking for during the recruitment of VHWs (Box 4, Quote 13). This was further affected by other parallel programmes assigning VHWs with multiple tasks such as IMNCI, environmental health, HIV, TB, malaria. Thus, a respondent suggested to have a model of more integrated support to ensure an

effective and structured VHW programme (Box 4, Quote 14). Most national level respondents believed that the VHW programme was supported not only by HTF but also from other projects. Therefore, formalization was considered essential because the programme was seen as lacking ownership from the Government in taking a lead role in the VHW programme including strengthening its monitoring and evaluation system (Box 4, Quote 15).

Another important aspect within the community health services system was the role of **health centre committee** (**HCC**) within the communities. The concept of HCCs has been introduced into east and southern Africa together with the adoption of primary health care to involve community level participants in planning, implementation and monitoring health services. The basic principle of the HCC is to provide an accountability mechanism for communities by ensuring access and appropriate use of resources to respond to the needs of the communities. In Zimbabwe, the role of HCC has been revitalized under HTF particularly with the introduction of the RBF mechanism to function as a governing body to improve accountability of health facilities. **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 (Box 4, Quote 16). Health workers participating in the evaluation acknowledged the role of HCC establishing a link between the communities and facilities to exchange information such as complaints (Box 4, Quote 17). Though the role of HCC was extensively discussed by healthcare providers, little information was obtained from the community level group discussions-both from VHW and community groups because they were often not aware of the presence of the HCC within their communities.

Some HCC members faced **difficulties** in mobilizing communities especially when their catchment area was vast as they did not have the means for transportation. There were cases where some members stopped their engagement after realizing that they did not receive any monetary benefits by volunteering (Box 4, Quote 18). Similarly, some health workers felt that HCC members should receive some compensation such as transport charges for attending meetings and communication charges like air time for mobile phones (Box 4, Quote 19). Despite these challenges, all HCC members participating in the evaluation expressed that they were proud of **being a member of the committee** as it increased their social status within their communities. Furthermore, there were advantages like receiving useful trainings in topics such as accounting, planning and financial management; receiving updated information on their health facilities and receiving priority and discount for treatment at health facilities.

Box 4. Illustrative quotes for "community health services system"

Quote 1: "They have also managed to strongly establish educating and managing to share their behaviour among communities. So I will not be happy to say we did not change anything. We need to give it a bit of time and continue to send the message and I think we have better results of behaviour change." (KII respondent 29)

Quote 2: "The behaviour change that…specific communities that we need to address, that we will be having a problem of accessing a health service because of their beliefs. Say the apostolic, for example, but during the past four years we have done studies to try and see how we can manage a communication strategy that can lead to behaviour change and who are the gate keepers in there during the HTF time, we will have a strategy that focus on apostolic on cultural issues and when we talk about cultural issues, they are not only health related, they are related to gender, they are related to violence against children and those go outside the health sector." (KII respondent 18)

Quote 3: Our work is important in that we are close to the community; people are not scared to give us their problems which we will then forward onwards… We quickly note problems in the community… What I am saying is that, we are the foot solders we are also the first people to note the problems facing the community." (FGD VHW 5)

Quote 4: "As the VHW we are the eyes of the hospital, we advise them to come for children immunisation, we encourage them to come with children so that they can be weighed the problem is that we have no scales to use. In terms of the under 5 years children when we go around in the community when we visit we want to see their conditions, their health and how they are feeding." (FGD VHW 6)

Quote 5: "Sometimes some mothers ask us to check if the medicine which is out of stock is available so that they avoid travelling long journeys and find no services" (FGD VHW 15)

Quote 6: "As Village Workers, we should be equipped with kits to assist people and also an ambulance should be available. 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" (FDG VHW 3)

Quote 7: "What the ladies are saying is true, the allowances we are given is very low and it comes after 3 months. Our lives are becoming unbearable. We must be always be smart yet we cannot afford washing soap." (FDG VHW 9)

Quote 8: "When we were engaged we were informed that the work is voluntary, but we were informed that there will be a small token of appreciation which will amount to US$14-00 a month… We were asked how we want to be paid and we agreed that we would want to be given the money after three months but up until now there is nothing we have been given." (FDG VHW 5)

Quote 9: "We also have challenges with stubborn mothers who do not book on time for their delivery. They book very late and we end up having problems, to make matters worse they come here when they are due and sometimes they are tested positive." (FDG VHW 5)

Quote 10: "Recognitions, uniforms, free medical treatment in hospitals and we were equipped with information that boosted our confidence. It has also changed our life style." (FGD VHW 9)

Quote 11 "I see myself as an important person when I am asked to stand and speak to the community and people listening to me.
-I see myself as a small hospital and help people
-I feel important when patients are referred to me and I help them take their medicines
-People envy me and I am happy the people come with the sick people and I help them
- Just to be Village Health worker is very important in the community." (FGD VHW 17)

Quote 12: "About the system (community health system) that Zimbabwe has, it's much better than anywhere else I've been to, I've been to Rwanda, I've been to Malawi and my own country in Kenya, and the way the system was designed in the 90s, very strong system plus community level it was still there." (KII respondent 18)

Quote 13: "…village Health Worker Programme is an important aspect in mixing us with communities, but I don't think that in this country for several reasons it is doing what it is supposed to be doing. Because for a start the recruitment of the VHW maybe we don't have clear guidance on which cadre are we looking at?" (KII respondent 8)

Box 4. Illustrative quotes for "community health services system" (continued)

Quote 14: "It's too much! Where we can have an integrated village health worker programme where ourselves, malaria, TB, we come up with a curriculum and say even if we are going to do meeting or trainings, this is the package I cannot go and talk about diarrhea and the next day someone talks about breast feeding to the same Village Health Worker. So I think there is need for it to be structured in a way so that it becomes effective because we think is an important programme. But at the moment I think it's fragmented even their manual does it take care of everything?" (KII respondent 8)

Quote 15: "At this country you know you have a mixture of various community levels health workers that are being supported not only from HTF but through other systems through other sources…the lack of formalization. It is not really formalized, ownership by government, is another issue in this country." (KII respondent 28)

Quote 16: "Every time we do any transaction we are together they put their signature. *[They also help you to plan on how to use RBF?]* Yes we sit together and plan. We call for a meeting, all members come and when they come we sit down for the meeting." (KII respondent 13)

Quote 17: "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…" (KII respondent 10)

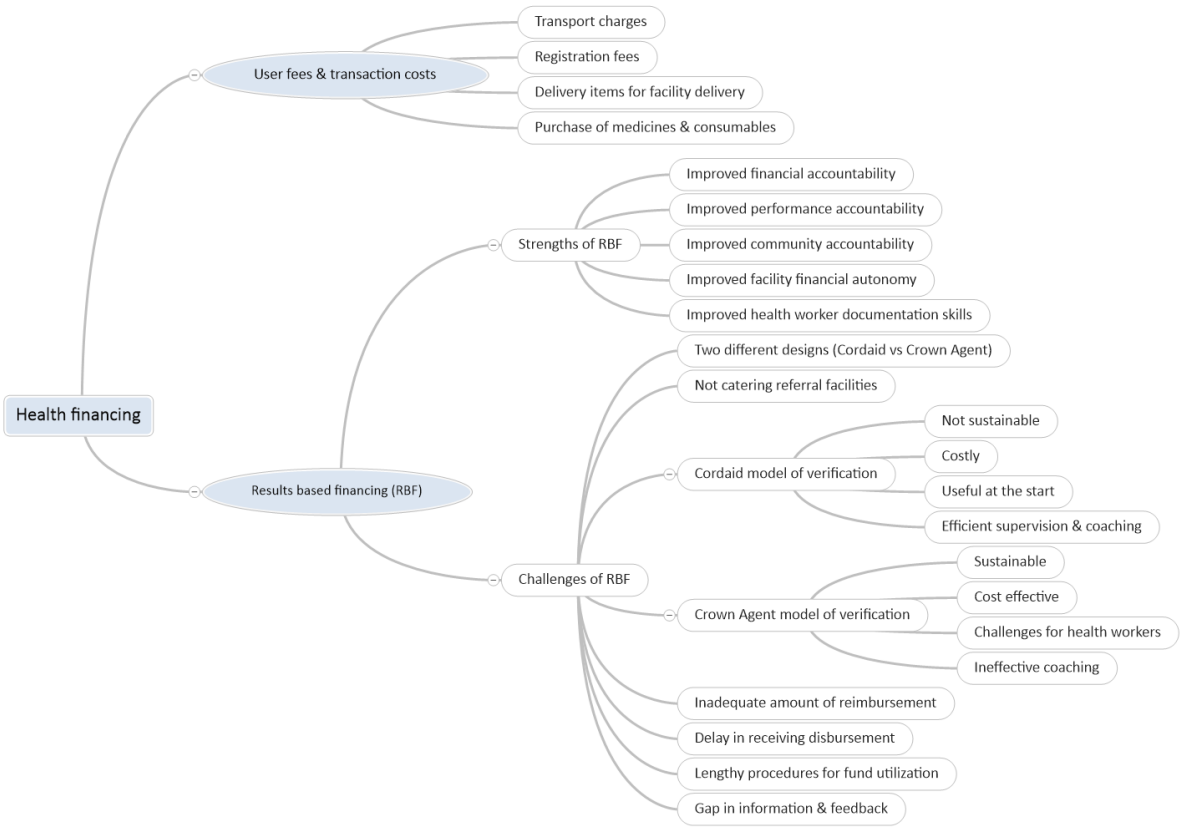
Quote 18: "One thing I can tell is I think there is this problem of people finding being an HCC member and not getting anything in return so people just get disinterested and feel are no its wasting their time." (KII respondent 6)

Quote 19: "[We] are happy with the HTF fund and the RBF fund but [we] wish if [we] could get an allowance for airtime." (KII respondent 9)

Health Financing

Two key themes emerged for health financing: User fees and transaction costs to receive care; and Results Based Financing (RBF) (Figure 6 below).

Figure 6: Visual map on health financing



Evaluation participants were keen to discuss financial aspects of the HTF and emphasized that inadequate health financing has been a critical stumbling block to deliver essential services resulting in the country health system becoming vulnerable to embezzlement. During the evaluation, national, district and facility respondents discussed different aspects of health financing including user fees; transaction costs to receive care; and RBF of health services. Health workers commented that health facilities used to receive health services fund (HSF) from the Government of Zimbabwe erratically with an inadequate amount to cover the health needs of their population (Box 5, Quote 1). Almost every healthcare provider participating in the evaluation agreed that HTF has significantly contributed to improved service delivery at facilities (Box 5, Quote 2).

Unfortunately, **user fees** and transaction costs were identified as still constituting barriers for communities to access health care. Even in facilities where women were not required to pay for services, other transaction costs affected their access to health care. Transaction costs, excluding the actual costs of diagnosis and treatment, typically arise when there is an asymmetry of health care information and weak regulation of health system. Participants explained how pregnant women

encounter a financial barrier when accessing health services such as booking fees for delivery, transportation costs, and items required to bring to the hospital for delivery (Box 5, Quotes 3 and 4). Some pregnant women were reluctant to deliver at health facilities as they could not afford to have emergency fees and necessary items, which they were asked to bring "without fail" for delivery at the facilities. They were also worried to be treated badly by health workers if they did not bring the required items (Box 5, Quotes 5 and 6). Health workers confirmed that they still had to charge the patients for non-maternity services, ask the patients to purchase medicines and consumables, or ask pregnant women to bring items for delivery at the facilities. In response to this, other financing mechanisms such as insurance (community based insurance) are being explored at national level though respondents indicated that insurance companies are not functioning well in Zimbabwe (Box 5, Quote 7).

Respondents expressed different views regarding **input based financing** under HTF and **output/performance based financing** under RBF. The majority of the respondents commented that RBF was intended to contribute improving of health workers' performance through improving quality of health service delivery at operational level. Many understood that it was the way the health facilities were financed with a shift from input based (HTF) to output based (RBF) funding. However, this requires changes in accountability structures and redistribution of tasks and responsibilities among different actors. Hence, the system requires changes in architecture of the health system arrangements with mechanisms for accountability, transparency and key actors to carry out verification of the process.

Respondents perceived that **RBF** has improved financial autonomy of the health facility. Revenue collected under RBF resulted in health workers' incentives, investing in supplies and improving facility infrastructure and resources (Box 5, Quote 8). Most health workers felt that the supply management under RBF was more efficient than the PUSH system under HTF where they experienced a lot of unnecessary wastage with predefined kits (Box 5, Quote 9). Some health workers suggested that the kits should be tailored to the needs and size of health facilities. Health workers realised that their generation of income depended on the facility performance and thus some preferred the RBF model (Box 5, Quote 10).

Challenges in the implementation process of RBF outweighed the advantages shared by the respondents. These included the design of the RBF programme; RBF reporting mechanism; amount of reimbursement; timeliness in receiving those funds; and procedures required to follow before utilizing those funds and information/feedback mechanisms and verification of the process. A lesson learnt that came out of the evaluation was that it would have been better to have one pool fund for RBF instead of two different funding sources (Box 5, Quote 11).

Healthcare providers experienced that patients were not complying with their referral advice when they referred them to non-RBF facility where they had to pay for services. This was particularly alarming for urgent services such as caesarean sections (Box 5, Quotes 12 and 13). This experience was shared by facilities under the districts of the Crown Agent as only primary healthcare facilities received support for RBF.

Another major challenge in implementing RBF was the **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 reporting, which then negatively affected the facility because they would receive less funding causing demotivation among staff (Box 5, Quote 14). Health workers acknowledged that RBF has highlighted their missing skills set, which was registration and reporting. They confirmed that their skills in documentation, recording and reporting have improved with the introduction of RBF. However, as majority of them were not used to such type of strict registration before, they felt that the amount of documentation required to do was too overwhelming with their existing workload and resources (Box 5, Quote 15, 16 and 17). Some health workers were even questioning the focus of RBF on whether the improvement in quality was driven by changes in reporting practices, but not mirroring their increased work load that would have happened anyway. Respondents from national level confirmed that the RBF reporting mechanism was complicated as they (themselves) could not get them right although they had attended several trainings (Box 5, Quote 18).

Respondents understood that RBF has tried to improve the quality of services but the **amount of funds received under the RBF** mechanisms were still not sufficient to cover the needs of the community even if they had the best performance. Furthermore, RBF did not consider other running costs for the facility such as kitchen and laundry charges (Box 5, Quotes 19, 20 and 21).

Timeliness in receiving the reimbursement was another 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 (Box 5, Quotes 22). Hence, some respondents preferred the input based payment under HTF since they at least received some regular funds to run their services instead of unpredictable amounts under the RBF (Box 5, Quotes 23). Delay in receiving funds disbursement was further complicated by certain **procedures requirements under the RBF**. In most cases, facilities did not have full financial autonomy to utilize their revenue collected under RBF as there were procedures such as getting approval from the HCC; receiving three quotations for the items under request; and receiving approval from the District Health Executive (DHE). Health workers experienced that at times the quotations were no longer valid when 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 (Box 5, Quotes 24).

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. Internal accountability can be improved through functioning information and feedback mechanisms about the funds and its operation. 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 will receive the reimbursement and the reasons for delays. National level respondents agreed that they were not in a position to disclose the reasons of those delays even in cases when they were aware (Box 5, Quote 25). This negatively affected the potential and credibility of RBF mechanism compromising accountability among key actors.

Regarding **independent verification** at facilities, respondents commented on two approaches employed by Cordaid and the Crown Agent. Being an output-based financing, independent verification

ensure accuracy of health facility reporting. Yet, achieving this may not be straight forward in Zimbabwe context without any cost. Some respondents recommended the Cordaid model of verification though it was more costly than the Crown Agent model, which used district health staff. Almost every respondents including members of HCC perceived that investment in training and appointing field officers as in the Cordaid model were essential costs to invest in to provide supportive supervision and data verification while RBF was first introduced.

To ensure that health facility embed the RBF mechanism, it is vital to engage with both managers and health workers from the inception of the RBF as it can be less effective in cases where an inclusive approach does not exist. Health workers need clarification on what is expected of them and this being linked to reward (positive) or penalty (negative) consequences of their actions. However, some of the health workers were not aware about the functioning of RBF mechanisms producing a lot of unnecessary reporting mistakes leading to the loss of income for the facilities (Box 5, Quotes 26). This was confirmed by national level respondents as they witnessed that Crown Agent was reporting surpluses. (Box 5, Quote 27).

Box 5. Illustrative quotes for "health financing"

Quote 1: "I think the last time I received GOZ funding was 2 years ago if I still remember the figure was about $2500. So those disbursements from the government of Zimbabwe have actually been very, very erratic actually nonexistence. (KII respondent 15).

Quote 2: "HTF funding, is the one which has greatly improved our service delivery because we are now able to buy commodities for use medicines and also our theatre is now functional, before it was not functional, we were unable to offer caesarean session in the district, but now we are able it has even improved. It has improved even human resources, with this retention allowance we get midwives, even the number of doctors has increased." (KII respondent 22).

Quote 3: "Sometimes these who end up giving birth at home fails to get o the clinic on time. Sometimes these women will not have financial resources to pay for maternity fees so they end up giving birth at home." (FGD VHW 5)

Quote 4: "When we come here we face many challenges for instance, one gets a consultation card and on this card there will be need to buy medication, but shortage of financial resources to travel to go and buy medication becomes a challenge. There is need to first pay for the card and get temperatures before given some prescriptions. They cannot prescribe medication before getting temperatures and weight. So one will need to travel to get medication from the surgery. They cannot tell you anything before paying for the card." (FGD community women 4)

Quote 5: "Sometimes shortage of financial resources might prevent a mother to come to the clinic. Mothers are mandated to bring an emergency fee without fail… In some instances, even if there is no emergency, one needs to bring along a certain emergency fee amounting to US$2-00. If you come without the emergency money, they will not accept you. So women end up not coming to the clinic". (FGD community women 13).

Quote 6: "Yes, yes, these are the scenarios where one will then say, *nurses have a bad attitude;* because to tell the truth, you will have a bad time if you do not have the required things. Yes, at times mothers fail to get these requirements due to poverty." (FGD community women 13).

Quote 7: "I think the biggest one is to look at health financing from a perspective of innovative financing, insurance including community based insurance, but again insurance companies are not doing so well here." (KII respondent 18)

Quote 8: "We are really improving the system. We have managed to refurbish many structures at the health centre, we have done painting, electricity was connected at the waiting mothers' shelter. Even the chairs which you are used was bought using the HTF. We have managed to buy blankets to use in wards and best of all, we spent most of the money for medicines of mother and child health care." (KII respondent 1)

Box 5. Illustrative quotes for "health financing" (continued)

Quote 9: "I think primary health care package; it is better disbursed on consumption; it is important because push tends to be wasteful." (KII respondent 22)

Quote 10: "I think, I would choose RBF. The reason with the client base, we are looking at a number of clients and with the RBF a lot of work will generate a lot of income for the district hospital; and our performance is good. Is good Yaa!" (KII respondent 10)

Quote 11: "…it would have been ideal to have one pool fund that finances RBF but not to two with different funding sources with different procedures." (KII respondent 5)

Quote 12: "Normally the para Os, the prima ups we all refer because have fear of the complications for the mother and the baby. So we refer for better management at the hospital… But since we are talking about the paying, they refuse and they stay at home and they come here fully dilated, you have nothing to do, you are going to deliver her or not." (KII respondent 12)

Quote 13: "We have a patient she is post-dates we admitted for induction and gave two circles of oral she hasn't gone into labour so we wanted to escalate for caesarean section but she refuses so it's been the second day." (KII respondent 15)

Quote 14: "…we are in the rural areas a lot are waiting for my service outside there… some are coming from far away resettlement areas and they come by transport and for them to go without my service I feel guilty… At the end of the day my work is not done because my paperwork is incomplete." (KII respondent 10)

Quote 15: "In the nursing field one is supposed to be multi-skilled. Sometimes you even become a doctor, a pharmacist, health educationist, canceller, data collector, nutritionist, you also supply drugs at the end of the day you will obviously feel exhausted." (KII respondent 1)

Quote 16: "They also pay for deliveries and if you have more deliveries you have more money and if you have ANC mother which book below 14 weeks there is also a certain amount which you get but if our data has discrepancies they subtract the amount from what we have got…" (KII respondent 10)

Quote 17: "Continuous training, in-house training you can call it updating information the staff has. It is always changing. Especially with Ministry of Health, their tools they just wake up there where they are sited these guy and write what they want and just send forms or t the tools without training such things, people have to be inducted most of these tools." (KII respondent 4)

Quote 18: "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." (KII respondent 8)

Quote 19: "…they just tell you we have given you the money according to your performance based but we are trying, we feel it is still too little." (KII respondent 7)

Quote 20: "Normally RBF is good to us since we are getting incentives its good but for us to meet the targets. Its good RBF because its teaching us to do the quality work that but then if you can follow we can have a lot of money but now you can see staff shortages discrepancies are many because at the end of the day you to book an ANC mother HIV testing at times there is a delivery and at times there is one nurse and to cover for all those it's difficult that's when you find some discrepancies which will subtract our money. Instead of getting a lot of money doing to quality work we have discrepancies because of the shortage." (KII respondent 10)

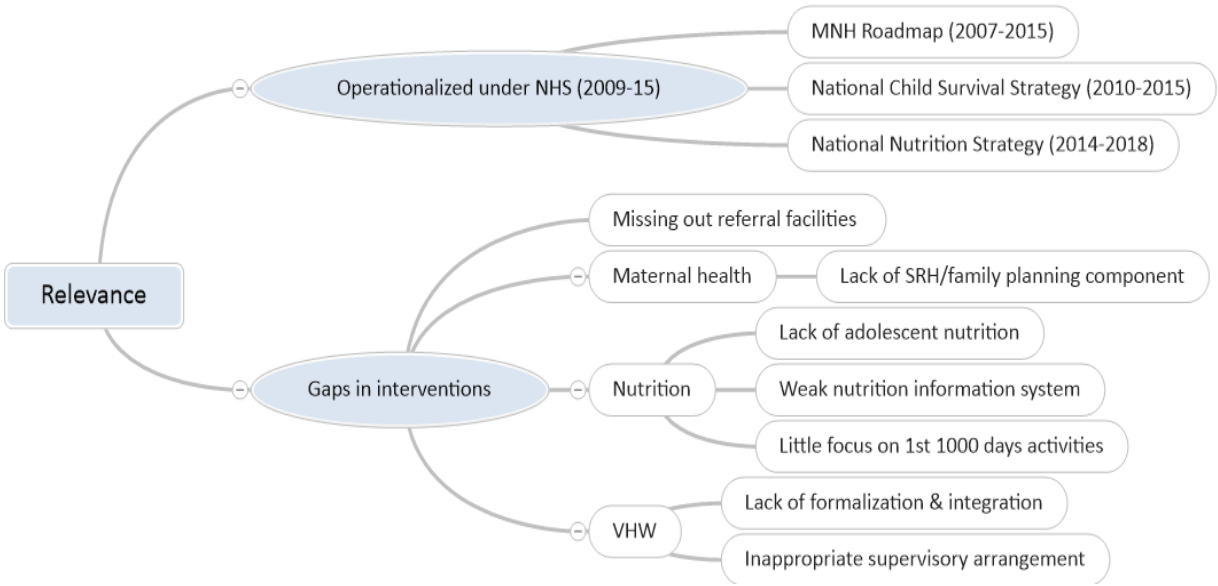
Quote 21: "I just want to make a comment of suggestion, I think with the experience we have in HTF and RBF I thought it was important if RBF can cover Kitchen and laundry." (KII respondent 4)

Quote 22: "The time frame we really do not know. You sometimes see it in the account… It does not arrive on time. What we are not sure is when it is disbursed from Crown agents." (KII respondent 26)

Relevance

Two key themes emerged during the qualitative data analysis for Relevance: Operationalized under NHS (2009-15); and Gaps in Interventions. These are illustrated in Figure 7 below.

Figure 7: Visual map on relevance of HTF interventions with national health & nutrition policies



National level respondents described how the HTF has been relevant in supporting the key pillars of the Zimbabwean health system as it followed the Government of Zimbabwe's structure without creating parallel mechanisms (Box 6, Quote 1). HTF has been instrumental in reviving the country health system because it came in a crisis situation and by supporting the essential pillars like human resources for health; commodities and supplies; policy and finance.

However, district and facility respondents highlighted gaps in the design relevance of HTF particularly for excluding referral facilities. The majority of respondents perceived that while the HTF strategy of focusing attention to lower level of the health system has reduced the need for unnecessary referrals, the gains made in maternal and newborn health are undermined if women are referred from the lower to the higher levels of the health system where they are required to pay for services particlarly emergency care. Similar challenges were experienced under the RBF mechanism as patients refused to comply with referral advices as they were afraid of having to pay unaffordable fees and requested additional referral notes from the healthcare providers when they were referred from the RBF facilities. The other negative impact due to design gap in RBF mechanism was late referral of patients as health workers were afraid of missing out on the RBF payment. Consequently, health workers delayed the referral of patients sometimes risking the lives of these patients (Box 6, Quote 2).

Another limitation was that HTF was limited to maternal and child health while other health services such as infectious diseases, non-communicable diseases, such as hypertension and diabetes, were proved to be the out of scope of the HTF (Box 6, Quote 3). Hence, health facilities ended up using

other resources to cover the proposed MCH activities under HTF if it was not enough to cover those services (Box 6, Quote 4).

Finally, a relevance design gap was identified regarding the VHW programme highlighted by a national level respondent. The respondent felt that VHWs would be better supervised by the environmental health technicians (EHT) due to the preventive nature of their work rather than by district nursing officers or matrons in the field (Box 6, Quote 5).

Box 6. Illustrative quotes for "relevance"

Quote 1: "It should be emphasized is obvious around the government system so it's not a parallel system and for the HTF, it's actually the leadership of a steering committee is in the Ministry of Health by the PS." (KII respondent 18)

Quote 2: "We have had instances whereby some clinics because they are being paid maybe for example by the number of deliveries they had contacted at their clinics some of them instead of referring some patients they end up detaining them and referring the when it's too late to given an example I have had several instances some institutions would even maybe keep 2 previous ceasarian section patients only to refer such a patient only maybe when in labour some of them are actually doing some trial scar at local clinic and then you only get such a patient at times when you feel that maybe it's a bit too late." (KII respondent 15)

Quote 3: "So at the end of the day we have had a scenario where by medicines maybe for other patients they end up with nothing in stock then when the HTF disbursement do actually come the funds actually would not be enough to cater for all our needs." (KII respondent 15)

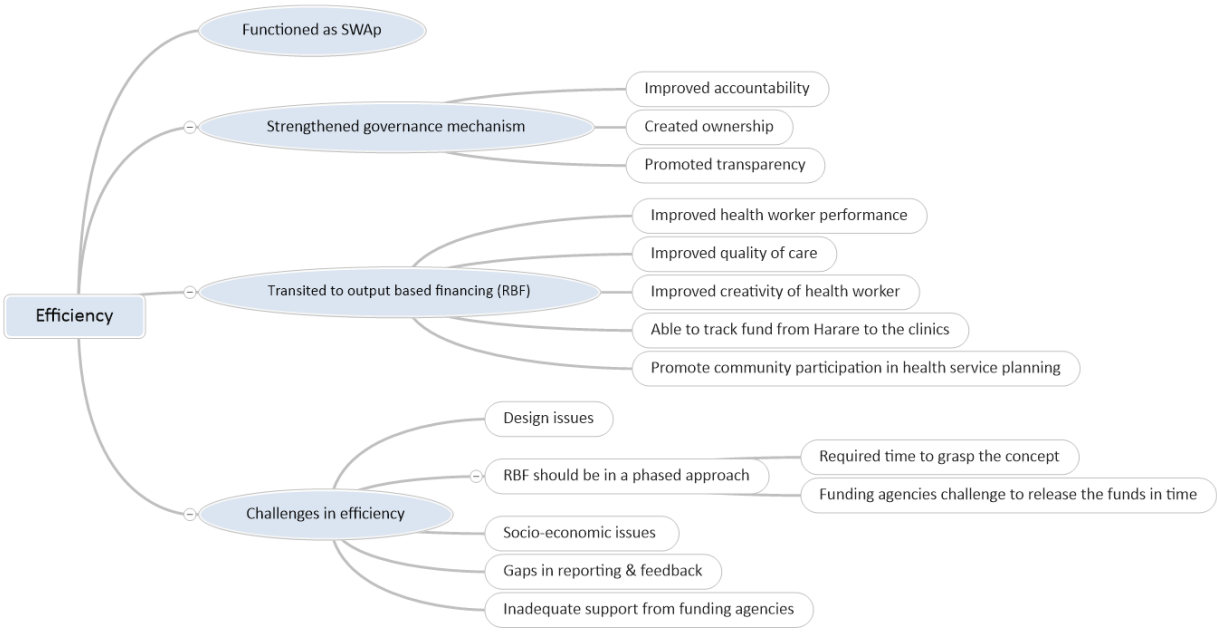
Quote 4: "…what usually now happens is that at the end of the day you end up using the resources that you may not supposed to maybe to procure HCT or even the Nephedipine for other patients we end up trying to make sure that we concentrate all our resources toward maternal child health." (KII respondent 15)

Quote 5: "…I think this is where the challenge starts from this is preventive work and if you go to the clinic level the environmental health technician is the one goes into the community with his motorcycle so this is the person best placed to supervise the village health workers." (KII respondent 8)

Efficiency

Four key themes emerged for efficiency: HTF functioned as SWAp; strengthened governance mechanisms; transited to output based financing (RBF); and challenges in efficiency as illustrated in Figure 8 below.

Figure 8: Visual map on efficiency of HTF



Although there are criticisms that HTF was only focused on primary healthcare facilities, it has been an efficient mechanism in that most of the people are attended at lower level facilities. On the overall, many mothers and children have benefited from the HTF. HTF has functioned as a SWAP (sector-wide approach) as it was a coordinated fund implemented by the Ministry of Health. Respondents from national level commented that if it had not been for the weakness in financial management system of the MoH, the basket fund would have been managed by the MoH instead of by UNICEF (Box 7, Quote 1).

HTF has managed to transit from input based to output based financing to ensure improvement of health workers' performance through improved quality of service delivery at operational level. This has improved accountability, created ownership and management capacity and promoted transparency, in other words, it has strengthened the **governance mechanism** within the health system. Through the RBF mechanism, three different forms of accountability have improved within the health system: financial accountability, performance accountability, and community accountability. RBF allows lower level facilities to plan and manage their own funds creating space and creativity of facility staff to manage their own resources with the identified needs (Box 7, Quote 2). Additionally, donors and implementers can track the funds from Harare down to facility level promoting transparency on the use of funds (Box 7, Quote 3). RBF also proved useful to improve efficiency of community accountability mechanisms through strengthening the role of health centre committees in managing the funds and involving them in the planning of the services. This has

enhanced community participation and accountability as the HCC performs an oversight role for the facility (Box 7, Quote 4).

On the other hand, respondents shared challenges in implementing RBF and how it affects the efficiency of the whole process due to different **designs of RBF models** (the Cordaid and the Crown Agent model). The model of Cordaid included district level facilities from the start of the programme thus referral cases have been catered for while the Crown Agent model does not. Hence, within the districts covered by the Crown Agent, the gains made under the RBF are undermined as women could not afford to pay for neither services nor transport charges.

Another efficiency challenge in the implementation design of RBF is verification of data. National level respondents felt that the model of verification & counter verification adapted by the Crown Agent seemed to be more sustainable and cost effective than the Cordaid one as the latter uses project appointed field officers. However, within the current scenario of Zimbabwe's health system, which is recovering from human resources shortage and brain-drain, the Crown Agent model received resistance from the already overburdened health staff (Box 7, Quote 5). This somehow compromised the credibility and potential of the aim and principles of RBF. As a result, the districts under the Crown Agent model could not effectively do coaching to the clinical staff who were just introduced new RBF procedures and guidelines and they ended up doing mistakes and receiving less refund (Box 7, Quote 6). Hence, some national level respondents suggested starting with the Cordaid model of verification until the systems were in place (Box 7, Quote 7).

The process of **introducing RBF** needs to be **in an appropriate pace**. The process should be incremental using a phased approach as RBF was introduced into districts and primary healthcare facilities. Therefore, it is of crucial importance for the key stakeholders to understand their new roles. However, the Crown Agent introduced their model of RBF in 46 districts without any piloting (Box 7, Quote 8). It will require time for participating health facilities to grasp the concept of RBF as those institutions still have challenges with staff shortages (Box 7, Quote 9). Additionally, there is a need for consideration of donor and government policy, socio-economic and political factors which all impact on results of RBF. However, this was not the case for RBF implementation under both models as there have been gaps in efficiency in terms of disbursement and release of funds, reporting and feedback mechanisms (Box 7, Quote 10).

Box 7. Illustrative quotes for "efficiency"

Quote 1: "It's like a SWAP because it's run by the Ministry. But the basket is not within the Ministry because there is a weakness in the financial management system of the Ministry" (KII respondent 28)

Quote 2: "The money goes directly to the clinic where as previously the money went to the provincial and district level. It never went down to the clinic. Once you give money to a nurse to plan and set priorities, nurses and Health Centre Committees do know what priorities are in the clinic so there will be able to spend it according to the need in the beginning. They also become a little bit creative in organizing to increase the coverage." (KII respondent 5)

Quote 3: "For the RBF, money it is the most transparent everybody can trace the money from Harare down to the clinic." (KII respondent 5)

Quote 4: "The health center committee thus the community is involved so they also know how much money comes to the clinic and they are involved in making the plans." (KII respondent 5)

Quote 5: "For Crown Agent, it's the Ministry will take up their roles a bit. Then will be even better there is staff shortage in the ministry at district level. And also it is the matter of priority setting there are a million of program that need attention of the same District Nursing Officer and the same community nurse too little time for the district to do the coaching of the health facility." (KII respondent 5)

Quote 6: "It takes time for the health facility to grasp the concept and to understand that if they produce more they will receive more money. In addition they were used to receive amount of $ 750 and suddenly that was cut so there was a lot of confusion at the level of health facility in the beginning. Because Crown had to manage 42 districts at once it is not easy to get everybody up to scratch at once." (KII respondent 5)

Quote 7: "…you also have to take into account that Cordaid invested in training and also invested in Field Officers who were supporting all district for supervision they were the once going round doing the verification. But in the Crown Agency RBF is the Sister in Charge community who is supposed to now do the work, which was being done by someone who was employed specifically to do just go to the centers to support. So Maybe that has attributed for the drop in the earnings, I don't know I still have to find out. I can say that the way we ended 2015 was not on a high note definitely in terms of support." (KII respondent 8)

Quote 8: "Now if the donor released money on time, we pay on time. If not, we send out letters to information that there is delays in payment which is bad. These are donor issues. The XXXX have been slow in releasing the money." (KII respondent 5)

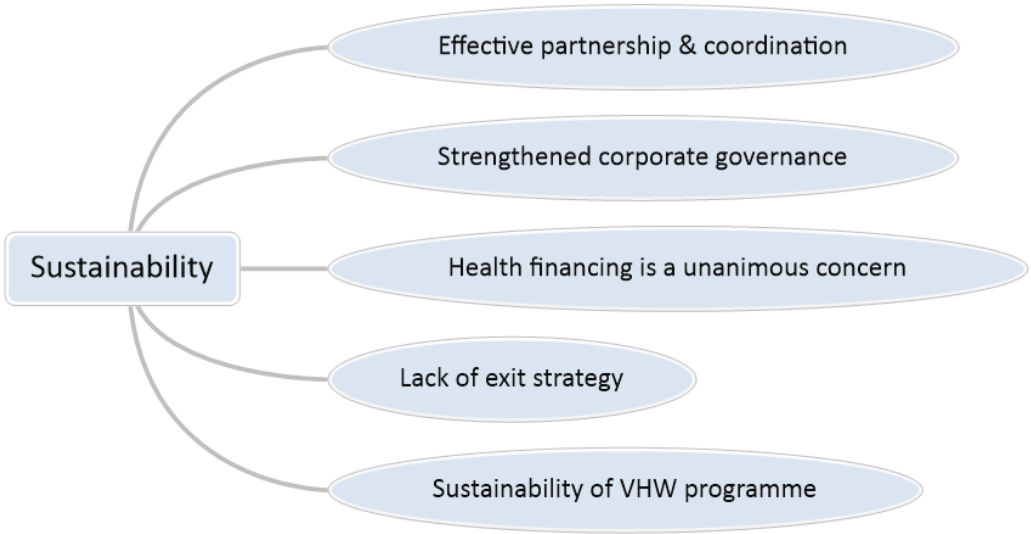
Quote 9: "RBF model funding at our institution the critical challenges I think that of staff shortage… when you try to look at an institution like ours which is critically short staffed then you try to think at the end of the day even if you are going to be on RBF model then you are going to be paid according to the scoring you have achieved in as far as quality is concerned so it becomes an issue you may actually be not able even to score anything. Because the quality of the service may be difficult to improve because of the staff shortage take for example if I am to take you to the labour ward you will realize that some of the documentation may have not been done properly." (KII respondent 15)

Quote 10: "We do not know when the money is coming, how much is coming. We provide feedback we have a nominee person who gives the communication." (KII respondent 2)

Sustainability

Five key themes emerged during the qualitative data analysis for the sustainability theme (Figure 9).

Figure 9: Visual map on sustainability of HTF



The majority of the national level respondents believed that HTF has shown an **effective partnership and coordination mechanism within the health sector,** which needs to be further strengthened and sustained (Box 8, Quote 1). HTF has **strengthened corporate governance** through the steering committee where donors and the MOHCC meet regularly (Box 8, Quote 2). This has strengthened the principles of ownership and leadership as high level members of the Ministry are actively involved in the meetings. HTF has laid the ground in setting up structures, which can function well if financial resources are given. However, **health financing** has been **a unanimous concern** for all national level respondents to sustain the gains achieved under the HTF. Though respondents were impressed with the results of the HTF, everyone was concerned with future financing of the health sector as the Government of Zimbabwe has not yet invested as expected, not only in the health sector but in several other sectors. The HTF therefore received criticism from the different national-level stakeholders because it **misses an exit strategy**. For instance, the revenue collected from the RBF funds should be used by health facility managers to update the infrastructure, purchase drugs, supplies and equipment; provide incentives to health workers to deliver quality services, and compensate long working hours. Over-dependence on funds poses a risk regarding the sustainability of health services in the absence of the RBF. In the current scenario where there is no significant investment in health sector from other sources, RBF has been the only source of financing for health facilities. Respondents from national level suggested looking into alternative funding opportunities such as borrowing money from international organizations in the current scenario.

The other issue with sustainability under the HTF programme was relevant to **sustainability of the VHW programme** due to lack of Government ownership. Some national level respondents felt that VHWs should be part of the salary structure with a defined service package and a clear accountability mechanism. Only in this way, the country could sustain the work of VHW achieved so far.

Box 8. Illustrative quotes for "sustainability"

Quote 1: "The HTF has shown a very effective partnership and coordination mechanism in the health sector between various stakeholders we need to strengthen that and carry it forward." (KII respondent 28)

Quote 2: "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 channel in a way which is holistic which covers everything" (KII respondent 8)

Annexes

Annex 1: Topic Guide for Focus Group Discussions with VHW

English version

Format

- Introduce yourself and welcome the group.
- Explain that we are here to learn more about the groups' views on the situation of MNCH in your communities; and on availability and quality of services for mothers and children.
- Ensure everyone has provided information for the registration log sheet and has a participant information sheet.
- Obtain informed consent.
- Brief introduction to the ground rules for the focus group discussion: (1) that the discussion will last about an hour; (2) that the content of the discussion will remain confidential and will not be used outside of the group expect for the purposes of the research and (3) that participants' names will not be used when reporting the findings (4) every statement is right; (5) please do not hesitate to disagree with someone else (6) but do not all talk at once.
- A voice recorder will be used only to ensure that none of the information from the FGD is lost, and to facilitate analysis of the data from the FGD.

Materials

Focus Group discussion guide, FGD log, notepad, pens, voice recorders, batteries, information sheet, consent form, transport reimbursement and reimbursement form, refreshments.

FGD Question guide

I. EFFECTIVENESS

1. In your opinion, how is the situation of maternal, newborn and child health (MNCH) in your communities?
2. Do you notice any major changes in MNCH within the last few years? What are those? *(Probe: What are the determinants of those changes?)*
3. How about the availability and quality of MNCH services provided by health facilities? Did you notice any change in them? *(Probe: What are the determinants of those changes?)*

II. RELEVANCE

1. What are the main MNCH needs within your community?
2. What factors determine/contribute to these gaps?
3. How do you help in your capacity, as a VHW, to address the MNCH needs of the community?
4. In your opinion, do health services address the MNCH needs of the community? What could be done better and how?

III. SUSTAINABILITY

1. Are there any mechanisms in place for community members to provide feedback for the health services they receive? What they are? *(Probe: Find out those mechanisms. Give some examples which you may be aware of.)*
2. Do you think those mechanisms are functioning? *(Probe: whether community voices are heard or not? Whether their issues or concerns have been addressed?)*
3. Who else is providing MNCH services within the community? How do those actors coordinate within your community?

IV. CHW PROGRAMME

1. Can you explain how VHWs are chosen in the community? (*Probe: Criteria used in VHW selection, who are the members in selection committee/group, how the process was*)
2. Can you describe how you were trained as a VHW? (*Probe: Which organization provided the trainings? Who are the trainers? Type of training-theory and practical mix. How often they received refresher trainings?*)
3. Normally, do VHWs get paid for their services in the community? (*Probe: Who pay them? Type of remuneration-salary, incentives, in-kind or others. How often they got paid? Are they paid regularly/on time?)*
4. Please share us whether you are supervised for your tasks. (*Probe: Who supervises, Type of supervision, Frequency and feedback of supervision*)
5. Do you link with health facilities within the community? When do you go to the facilities? (*Probe: their experiences of working with facilities, any referral activities with the facilities*).
6. From where do you receive supplies and equipment to perform your tasks as a VHW? How often do you get them? Please share us your experiences in receiving those supplies. (*Probe: Who provide the supplies? Any experience with the stock out? How do they solve if there is any stock outs?*)
7. In delivering your tasks as a VHW, what are the common challenges you are facing?

- **Ask if they would like to add further comments**
- **Bring the meeting to a close by summarizing the main points**
- **Do not forget to say thank you to the participants for their time and active participation.**

Annex 2: Topic Guide for Focus Group Discussions with Community Members

English version

Format

- Introduce yourself and welcome the group.
- Explain that we are here to learn more about the groups' views on maternal, newborn and child healthcare (MNCH) and related care-seeking practices, accessibility, barriers and facilitators to access MNCH services and quality.
- Ensure everyone has signed the registration log sheet and has a participant information sheet.
- Obtain informed consent.
- Brief introduction to the ground rules for the focus group discussion: (1) that the discussion will last about an hour; (2) that the content of the discussion will remain confidential and will not be used outside of the group expect for the purposes of the research and (3) that participants' names will not be used when reporting the findings (4) every statement is right; (5) please do not hesitate to disagree with someone else (6) but do not all talk at once.
- A voice recorder will be used only to ensure that none of the information from the FGD is lost, and to facilitate analysis of the data from the FGD.

Materials

Focus Group discussion guide, FGD log, notepad, pens, voice recorders, batteries, information sheet, consent form, transport reimbursement and reimbursement form, refreshments.

FGD Question guide

I. MATERNAL, NEWBORN AND CHILD HEALTH

1. In your opinion, how is the situation of maternal, newborn and child health (MNCH) in your communities?
2. Do you notice any major changes in MNCH within the last few years? What are those? (*Probe: What are the determinants of those changes?*)
3. What are the main MNCH needs within your community?

II. MATERNAL,NEWBORN AND CHILD CARE PRACTICES

1. Where did you (or your wife) normally go for health care or advice during pregnancy or birth? When do you normally start going for health care? (*Probe: Who are the care providers for pregnancy and childbirth (including CHW, TBA, formal health staff from government and faith based institutions, etc.,*)
2. What about if you have a sick child or baby? When do you go for care? Are there things you do at home first if you have a sick child or baby to try to make them better before you use a health facility?

III. EXPERIENCE ON THE USE OF MNH SERVICES

1. Share with us your most recent experiences of going to a public health facility in your community for care of maternal or child health services? Was it a government or other provider (e.g. faith-based)?
2. What did you like about the experience? What could have made the experience better? What improvements would you like to see in those health facilities?
3. Are you aware of health centre committees (HCCs) within your community? What do they do for your community? (*Probe: their experiences with HCCs*)

IV. BARRIERS AND FACILITATORS

1. Have any of you or your children been ill but you chose not to seek any MNH or under-five care service? If any of you have had that experience, would you please spend a little time telling us about it? (*Probe: Why did you choose not to seek care (explore barriers to care seeking)? Was it the first time you decided not to seek care when you or your child was ill? Was your decision influenced by a previous experience at a healthcare centre*?)
2. Is there anything that makes it difficult for you to seek care when you need for yourself or your children? What are some of the things that make it easier for you to seek or obtain healthcare?
3. What could be done/or do you expect to be done differently to get better healthcare for you and your family?

- **Ask if they would like to add further comments**
- **Bring the meeting to a close by summarizing the main points**
- **Do not forget to say thank you to the participants for their time and active participation.**

Annex 3: Topic Guide for Key Stakeholder Interviews (Central Level)

Format

- Introduce yourself. Explain that the purpose of the interview is 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 Health Transition Fund.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Explain the ground rules for the interview: (1) that the discussion will last about 30-40 minutes; (2) that the content of the interview will remain confidential; and (3) that the participant's name will not be used when reporting the findings. A voice recorder will only be used to ensure that all the information from the interview is captured.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form

INTERVIEW Question guide

I. EFFECTIVENESS AND RELEVANCE

1. One major objective of the HTF was to restore the capacity of the health system to deliver quality maternal and newborn health care. Evidence from survey data suggests that during the period 2009-2014 there has been a dramatic improvement in coverage of antenatal care, skilled birth attendance and post-natal care in Zimbabwe.
    a. In your opinion, what have been the key drivers (facilitators) of such improvement?
    b. How has the HTF contributed to this improvement? Through which specific initiatives/interventions? *(Probe: maternity waiting homes; deployment of health care workers; training of health care workers; availability of supplies; improvement of infrastructure; supportive supervision; etc)*
    c. What can be done better or differently to further improve maternal and newborn care in future?
2. A second major objective of the HTF was to improve community health services systems across the country. Evidence shows that behaviour change has been somewhat limited during the period 2009-2014, and also that the investment in deploying VHWs has been slower than anticipated.
    a. Do you agree that results have been sub-optimal in this areas? *(If not, ask why)*
    b. In your opinion, what have been the key barriers in limiting the scale up of VHWs? And what the key barriers in limiting behaviour change?
    c. How has the HTF contributed to this area of work? Through which specific initiatives/interventions? *(Probe: training of VHWs; set up of health centre committee; health education/promotion; etc)*
    d. What could have been done better or differently to improve community health services through the HTF?

3. A third major area of focus of the HTF was to enhance child health by improving EPI and IMNCI services.
   Looking at evidence, EPI coverage is a success story in Zimbabwe.
   a. In your opinion, what have been the key drivers (facilitators) of such improvement?
   b. How has the HTF contributed to this improvement? Through which specific initiatives/interventions?
   c. What can be done better or differently in future to sustain the gains achieved so far?

   Improvement in access to care for sick children (Diarrhea, Malaria, Pneumonia) has been somewhat more limited.
   a. Do you agree that results have been sub-optimal in this areas? *(If not, ask why)*
   b. In your opinion, what have been the key barriers in limiting the scale up IMNCI interventions?
   c. How has the HTF contributed to this area of work? Through which specific initiatives/interventions? *(Probe: training of health workers; procurement of medicines/supplies; procurement of vaccines and cold chain; outreach activities)*
   d. What could have been done better or differently to improve IMNCI through the HTF?

4. The HTF also aimed at sustaining infant and young child nutrition
   Evidence from national survey presents a mixed picture: prevalence of underweight and of wasting has not improved, whereas stunting (chronic malnutrition) shows some progress.
   a. What is your assessment of progress in infant and young child nutrition in Zimbabwe?
   b. In your opinion, what have been the key barriers and facilitators contributing to change in nutrition amongst children?
   c. How has the HTF contributed to this area of work? Through which specific initiatives/interventions? *(Probe: procurement of nutrition supplies; policy and guidelines; training of health workers and VHWs; nutrition promotion)*
   d. What could have been done better or differently to improve nutrition through the HTF?

II. SUSTAINABILITY

1. In your opinion, what is the biggest legacy of the HTF after its conclusion?
2. Can you describe any particular activity which is likely to discontinue because of the end of the HTF support?
3. Can you describe activities which are likely to continue after HTF? How will they get funded?
4. What is your main lesson learnt through the HTF (*Probe: one main thing that worked well, and one main thing that did not work well*)
5. For donors only, why did you fund or not fund HTF? Would you contribute to a similar fund in future?

- **Ask if they would like to add further comments**
- **Bring the meeting to a close by summarizing the main points**
- **Do not forget to say thank you to the participants for their time and active participation.**

Annex 4: Topic Guide for Key Informant Interviews (District Level)

Format

- Introduce yourself. Explain that the purpose of the interview is 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 Health Transition Fund.
- Ensure participants have copies of the information sheet. Obtain informed consent.
- Explain the ground rules for the interview: (1) that the discussion will last about 30-40 minutes; (2) that the content of the interview will remain confidential; and (3) that the participant's name will not be used when reporting the findings. A voice recorder will only be used to ensure that all the information from the interview is captured.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form

INTERVIEW Question guide

III. OUTCOMES

2. Evidence from national data suggests that during the period 2009-2014 there has been a dramatic improvement in coverage of antenatal care, skilled birth attendance and post-natal care in Zimbabwe.
    a. Does this apply to your district?
    b. In your opinion, what have been the key drivers (facilitators) of such improvement?
    c. Which specific initiatives/interventions contributed to improve maternal and newborn care? *(Probe: maternity waiting homes; deployment of health care workers; training of health care workers; availability of supplies; improvement of infrastructure; supportive supervision; etc)*
    d. What could be done better or differently to further improve maternal and newborn care in future?

3. Improvement in community health services across the country has been more limited. Evidence shows that behaviour change has progressed slowly during the period 2009-2014, and also that the investment in deploying VHWs has not happened as per national plans/targets.
    a. Does this apply to your district?
    b. In your opinion, what have been the key barriers in limiting the scale up and the work of VHWs?
    And what the key barriers in limiting behaviour change?
    c. Which specific initiatives/interventions are in place in your district to enhance community health services and why did they work/not work well? *(Probe: training of VHWs; set up of health centre committee; health education/promotion; etc)*

d. What could have been done better or differently to improve community health services?

4. Two major strategies to enhance child health are EPI and IMNCI.
   Looking at evidence, EPI coverage is a success story in Zimbabwe.
   a. Is this the case in your district?
   b. In your opinion, what have been the key drivers (facilitators) of such improvement?
   c. Which specific initiatives/interventions contributed to improved immunization coverage?
   d. What can be done better or differently in future to sustain the gains achieved so far?

   Instead, improvement in access to care for sick children (Diarrhea, Malaria, Pneumonia) has been somewhat more limited.
   e. Is this the case in your district? *(If not, ask why)*
   f. In your opinion, what have been the key barriers in limiting the scale up (or facilitators determining success) of IMNCI interventions?
   g. How has the District Health system contributed to this area of work? Through which specific initiatives/interventions? *(Probe: training of health workers; procurement of medicines/supplies; procurement of vaccines and cold chain; outreach activities)*
   h. What could have been done better or differently to improve IMNCI?

5. Evidence from national survey presents a mixed picture: prevalence of underweight and of wasting has not improved, whereas stunting (chronic malnutrition) shows some progress.
   e. What is your assessment of progress in infant and young child nutrition in your district?
   f. In your opinion, what have been the key barriers and facilitators contributing to change in nutrition amongst children?
   g. How has the district health system contributed to this area of work? Through which specific initiatives/interventions? *(Probe: procurement of nutrition supplies; policy and guidelines; training of health workers and VHWs; nutrition promotion)*
   h. What could have been done better or differently to improve nutrition through the HTF?

IV. INPUTS/PROCESSES

A. LEADERSHIP, GOVERNANCE AND MANAGEMENT

1. Planning and coordination
   Can you shortly describe the planning cycle at district level?
   Do partners participate to planning, and at which stage of the process?
   What are the main barriers and problems that you experience in the district with regards to planning and coordination of activities?

2. Supportive supervision
   Can you describe how the DHE organizes supportive supervision to health facilities in the district?
   Is this implemented regularly? Who attends?
   What are the main issues for the DHE in providing good quality supportive supervision to facilities?
   What are the main findings of supervisory visits? How does the DHE feed back facilities?

B. HUMAN RESOURCES FOR HEALTH

1. Are there any staff on the health workers retention scheme in this facility? Briefly explain if you are aware of the scheme including what was done (activities, interventions and inputs).
2. How do you find its implementation? Do you think the approach taken by the MOHCC to implement the retention scheme was appropriate?
3. Can you share with us the challenges or difficulties encountered? What would you suggest should be done to overcome them?

C. HEALTH FINANCING

1. Can you describe the budgeting process for the districts?
   Is the availability and timeliness of resources allocation in line with DHE plans? Has it improved over the past years?
2. Are you aware of RBF (Results Based Financing)?
3. How do you find its implementation in the district? Can you share with us the challenges in working with the RBF? Do you have any suggestions for its improvement?

D. PROCUREMENT AND SUPPLY MANAGEMENT

1. How would you describe the medicine supply chain that has been supporting this facility?
2. Do you notice any changes in availability of medicines and equipment during the last four years? What do you think are the drivers of those changes?
3. How would you describe the usefulness of available medicines and equipment in relation to the needs of this facility? (This question compares the supply of medicines and equipment to the demand for them).
4. What suggestions would you make to improve the performance of the medicine supply chain?

- **Ask if they would like to add further comments**
- **Bring the meeting to a close by summarizing the main points**
- **Do not forget to say thank you to the participants for their time and active participation.**

Annex 5: Topic Guide for Key Informant Interviews (Health Facility Level)

Format

- Introduce yourself. Explain that the purpose of the interview is 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 Health Transition Fund.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Explain the ground rules for the interview: (1) that the discussion will last about 30-40 minutes; (2) that the content of the interview will remain confidential; and (3) that the participant's name will not be used when reporting the findings. A voice recorder will only be used to ensure that all the information from the interview is captured.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form

INTERVIEW Question guide

V. MNCH SITUATION

4. How would you describe the situation of maternal, newborn and child health (MNCH) in your catchment area?
5. Did you notice some changes in MNCH within the last few years, especially since 2012? *(Probe: What are the determinants of those changes?)*

VI. BARRIERS AND FACILITATORS (HEALTH SYSTEM PROCESS)

5. In the area of maternal and newborn care, what are the barriers and challenges to providing good quality services that you experience in this facility? (*Probe: supplies; shortage of health workers; lack of equipment; poor demand from communities; no transport; etc*)

6. In the area of child health (Immunization, IMNCI), what are the barriers and challenges to providing good quality services that you experience in this facility? (*Probe: supplies; shortage of health workers; lack of equipment; poor demand from communities; no transport; etc*)

7. In the area of nutrition, what are the barriers and challenges to providing good quality services that you experience in this facility? (*Probe: supplies; shortage of health workers; lack of equipment; poor demand from communities; no transport; etc*)

8. Are there village health workers in the catchment area of this facility? How to you coordinate? How do they support your work?

VII. ACCOUNTABILITY

9. Do you notice any changes in the past years to oversight mechanisms such as monitoring and supervision of your facility? What are those changes?

10. Are there any existing complaint mechanisms for staff? Do staff feel empowered to use them? Why/why not?
11. Are there any existing complaint mechanisms for the community? Do people feel empowered to use them? Why/why not? (*Probe if there are procedures in place for addressing grievances of healthcare providers and community*)
12. Do you have any health centre committee (HCC) for this facility? How do you find their role in improving services provided by this facility? (*Probe to find out who are the HCC members. How they are selected and by whom? How HCC participate in providing oversight, service planning and delivery. Their level of engagement and barriers/facilitators for engagement)*

VIII. HEALTH SYSTEM INPUTS/PROCESSES

A. RBF IMPLEMENTATION

1. Are you aware of RBF (Results Based Financing)?
2. How do you find its implementation in this facility? Can you share with us the challenges in working with the RBF? Do you have any suggestions for its improvement?

B. RETENTION SCHEME

1. Are there any staff on the health workers retention scheme in this facility? Briefly explain if you are aware of the scheme including what was done (activities, interventions and inputs).
2. How do you find its implementation? Do you think the approach taken by the MOHCC to implement the retention scheme was appropriate?
3. Can you share with us the challenges or difficulties encountered? What would you suggest should be done to overcome them?

C. MEDICINES AND SUPPLIES

5. How would you describe the medicine supply chain that has been supporting this facility?
6. Do you notice any changes in availability of medicines and equipment during the last four years? What do you think are the drivers of those changes?
7. How would you describe the usefulness of available medicines and equipment in relation to the needs of this facility? (This question compares the supply of medicines and equipment to the demand for them).
8. What suggestions would you make to improve the performance of the medicine supply chain?

- **Ask if they would like to add further comments**
- **Bring the meeting to a close by summarizing the main points**
- **Do not forget to say thank you to the participants for their time and active participation.**

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 6-List of Secondary Data and Reports

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
July 2016

Annex 6-List of Secondary Data and Reports

- Zimbabwe National Statistics Agency and ICF International. 2016. Zimbabwe Demographic and Health Survey 2015: Key Indicators. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.
- National Health Strategy for Zimbabwe (2009-2013) (Revised: 2009-2015)
- Draft National Health Strategy 2016 -2020
- National Child Survival Strategy for Zimbabwe, 2010-2015
- Draft National Child Survival Strategy for Zimbabwe, 2016-2020
- Zimbabwe National Maternal and Neonatal Health Road Map (2007-2015)
- Zimbabwe National Health Profile (2012)
- Draft Zimbabwe Service Availability and Readiness Assessment 2015
- Zimbabwe National Nutrition Strategy 2014
- Fölscher & Hodson (2015). Assessment of the Transition Funding modality, a pooled funding mechanism for the social sectors in Zimbabwe. FINAL REPORT
- Barrier Analysis Research (Socio Economic, Religious, Cultural) Determinants Hindering Access and Utilization of Health Services. Strengthening Community Participation in Health. Final Report. December 2015.
- Training and Research Support Centre and Ministry of Health and Child Care, Zimbabwe (2014)
- Zimbabwe Equity Watch 2014, TARSC, MoHCC, EQUINET Harare
- Zimbabwe Village Health Workers Strategic Direction 2010
- Zimbabwe Health System Assessment 2010, USAID 2011
- Evaluation of the Zimbabwe assisted pull system, End line report, USAID 2015
- Health Management Information System (HMIS) data from 2011 to 2015
- UNICEF 2016 HTF Annual Project Report
- UNICEF 2015 HTF Annual Project Report
- UNICEF 2014 HTF Annual Project Report
- UNICEF 2013 HTF Annual Project Report
- Health Development Fund Proposal March 2015
- Round One Resource Mapping Report 2016 (MOHCC Zimbabwe)
- RBF Zimbabwe Progress Report. MOHCC, World Bank, Cordaid. July to December 2014
- RBF Lighter Verification Manual. September 2015. MOHCC, World Bank, Cordaid.
- HTF-RBF Quarterly Report. Crown Agent. Q1-4 2014, Q1-Q4 2015
- Zimbabwe MOHCC Review and Planning (MODO) Workshop Implementation Progress Presentations (January 2014)
- Zimbabwe MOHCC Review and Planning (MODO) Meeting 2014 Expected Outputs (7-9 January 2014)
- Vital Medicines Availability Health Survey (VMAHSS) Quarterly Reports (Rounds 11 to 26)
- Report of the 2014 Joint Review Mission (JRM) (23-28 February 2014)
- MoHCC, July 2014. Update on the status of the (2014) Joint Review Mission Recommendations
- Joint Review Mission 2015: Summary findings and recommendations (PowerPoint presentation)
- DHS 2005/06, DHS 2010/11, MIMS 2009 and MICS 2014 Reports
- Minutes of HTF Steering Committee (SC) meeting, February 2015
- Health Services Fund (HSF plus) and Results Based Financing (RBF) Rollout Update to HTF SC. 5 February, 2015. PowerPoint Presentation
- MOHCC HR related PowerPoint presentations, data and report documents:
    - PowerPoint Presentation:
        - MOHCC/World Bank/Cordaid (Cape Town September 2014) Zimbabwe Results Based Financing Project: Evidence and Lessons
        - HR Department, MOHCC (February 2015) Human Resources for Health Report 2014. Presentation to the Health Transition Fund (HTF) Steering Committee (SC**)**

    - B. Madzima (November 2014) Mentorship Programme
- 2014 Training Report, Nursing Department
- Health services board (2014) Submission of a health worker retention plan (2015-2016) in fulfilment of the special terms and conditions in the new HIV new funding model grant agreement between the Global Fund and UNDP
- MoHCC (2011) Human Resources for Health Task Force: Terms of Reference
- Human Resources Department (2014) Workload Indicator of Staffing Needs: Draft Implementation Plan: 2014-2015
- Human Resources Department (April 2015) Data on Specialists Nurses

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 7
Analysis of HTF Thematic Areas

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
June 2016


Health
Transition Fund
Supporting the National Health Strategy to improve access to quality health care in Zimbabwe
Canadian International Development Agency
Irish Aid
SWEDEN
UKaid

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List of Abbreviations

ACT	Artemisinin-based Combination Therapies
ANC	Antenatal care
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
AVD	Assisted Vaginal Delivery
BCG	Bacillus Calmette-Guérin
BEmONC	Basic Emergency Obstetric and Newborn Care
BFHI	Baby Friendly Hospital Initiatives
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
c-IYCF	Community-based Infant and Young Child Feeding
CMAM	Community-based Management of Acute Malnutrition
CMNH	Centre for Maternal and Newborn Health
DHS	Demographic Health Survey
DT	Diphtheria and Tetanus
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
ETAT	Emergency Triaging and Treatment
FANC	Focused Antenatal Care
FeFo	Folic Acid
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
HCC	Health Centre Committee
HIV/AIDS	Human Immunodefiency Virus/Acquired Immune Deficiency Syndrome
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HTF	Health Transition Fund
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Newborn and Childhood
IPV	Inactivated Poliomyelitis Vaccine
IYCF	Infant and Young Child Feeding
JRM	Joint Review Mission
LSTM	Liverpool School of Tropical Medicine
MICS	Multiple Indicator Cluster Survey
MIMS	Multiple Indicator Monitoring Survey
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MOHCC	Ministry of Health and Child Care
MR	Measles-Rubella
MSD	Measles Second Dose
MTR	Mid-term Review
MWH	Maternity Waiting Homes
NIHFA	National Integrated Health Facility Assessment
NMR	Neonatal Mortality Rate
OPD	Outpatient Department
OPV	Oral Polio Vaccine

ORS	Oral rehydration salts
ORT	Oral Rehydration Therapy
PCV	Pneumococcal vaccines
PHCP	Primary Health Care Package
PNC	Postnatal Care
RBF	Results-based financing
RDT	Rapid Diagnostic Test
RED	Reach Every District
RHC	Rural Health Centre
RUTF	Ready to Use Therapeutic Food
SAGE	Strategic Advisory Group of Experts on Immunization
SAM	Severely Acute Malnourished
SBA	Skilled Birth Attendance
SIA	Supplemental Immunization Activity
SUN	Scaling Up Nutrition
SWAp	Sector-wide Approach
UNICEF	United Nations Children's Fund
VMAHSS	Vital Medicines Availability and Health Services Survey
WFNSC	Ward Food and Nutrition Security Committee
WISN	Workload Indicators of Staffing Needs
WHO	World Health Organization

Findings on Four HTF Thematic Areas

The analysis of the **effectiveness** component has been designed to respond to the following evaluation questions:

To what extent was HTF intended results achieved during its implementation?

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

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

The HTF Logical Framework, as approved by the Steering Committee at inception, was used as the guiding tool to address these evaluation questions.

The assessment of effectiveness has been performed exploring progress in the four thematic areas of intervention as defined by the HTF:

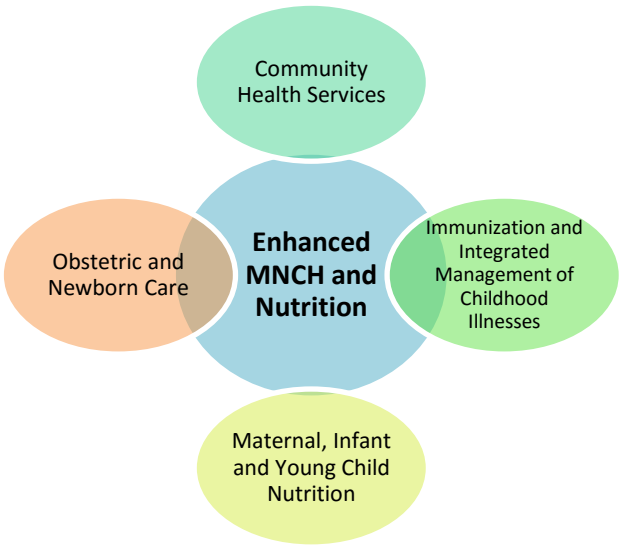
1. Maternal, Newborn and Child Health and Nutrition
2. Medical products, vaccines and technologies
3. Human resources for health
4. Health policy, planning and finance

Findings are reported in the four thematic areas of the HTF below.

Within each theme, a short recall on progress achieved at outcome level is provided, before presenting the findings on progress at outputs level. The HTF log-frame indicators are used to guide the discussion.

Theme 1: MNCH and nutrition

Theme 1 constitutes the overarching thematic area identified for the design and implementation of the HTF, focussing on delivering at scale supply and demand side interventions that may impact maternal, newborn and child health in Zimbabwe.



The HTF efforts on MNCH and Nutrition are "designed" around four major intervention areas:

- **Obstetric and Newborn Care**
  The interventions supported by the HTF to sustain obstetric and newborn care are essentially aimed at strengthening health service delivery (supply side), by restoring the availability of essential antenatal, delivery and post-natal care services.

- **Community Health Services**
  The HTF supports two key pillars of the community health strategy: health committees and village health volunteers. This effort is intended to sustain three key strategies: promoting behaviour change and healthy family practices; increase the uptake of service delivery; increase the availability of essential services at community level.

- **IMNCI and Immunization**
  In order to reduce the burden of common, preventable childhood illnesses such as malaria, acute respiratory infections (ARI) and diarrhoea, the HTF provides support to the introduction of new vaccines and sustains strategies to increase vaccination coverage in country. In addition, efforts in training health workers in IMNCI and in ensuring the availability of essential medicines are designed to offer immediate, high quality care to sick children at primary care level.

- **Maternal, Infant, Young Child, and Nutrition**
  In order to improve the nutritional status of mothers and children in Zimbabwe, and to promote appropriate nutritional practices, the HTF supports a variety of nutrition interventions, spanning from multi-sectoral policy design, to strengthening health service delivery and the availability of essential supplies, to nutrition promotion.

Progress achieved in each of these four areas (HTF outcomes) is presented below.

Outcome 1.1. Enhancing Obstetric and Newborn Care Capacity of the Health System

Summary of key findings

Data from MIMS 2009 and MICS 2014 show that progress in accessing essential reproductive health services has been remarkable in Zimbabwe. Coverage of ANC 4+, SBA and PNC is above regional levels. Prevalence of common childhood diseases (ARI, malaria, diarrhoea) has remained stable, despite of the introduction of new vaccines and of the increase in uptake of services. No significant progress in behaviour change has been achieved during the period 2009-2014, according to MIMS 2009 and MICS 2014 data.

- **Antenatal Care** Not achieved

The HTF has set the target of 90% ANC 4+ while only 70.1% of pregnant women attended ANC4+. 99.6% of facilities providing maternity service do offer ANC services for women. The proportion of PCNs at facilities trained in focused ANC has more than doubled from 20% in 2011 to 69.2% in 2016. MICS data highlight some gaps and opportunities in the provision of services for women accessing ANC, such as the suboptimal provision of folate tablets and of urine tests.

- **Emergency Obstetric and Newborn Care (EmONC)** Not achieved

In 2011, only 38% of District level hospitals provided CEmONC services. Data from different sources confirm that there has been significant progress in the availability of CEmONC services: VMAHSS Round 26 estimates this at 82.5%, and the LSTM Survey 2016 at 73%. Eight of the nine signal functions for CEmONC are individually available in more than 85% of facilities. Blood transfusion remains an area of priority, despite the progress achieved since 2011.

- **Postnatal Care** Achieved

According to the LSTM Survey 2016, 87.8% of health facilities now provide PNC services as per recommended schedule (3 PNC within the first week after delivery). The proportion of women receiving PNC within two days after delivery has increased from 27.1% in 2010 to 51.1% in 2015 (DHS 2015).

- **Maternity Waiting Homes (MWHs)** Not achieved

The HTF set a target of making MWHs available and functional in 100% of the District Level Hospitals. According to VMAHSS Round 26, 50.7% of rural health facilities had a MWH available at the end of 2015. These results were confirmed by the LSTM Survey 2016, which estimates availability of MWHs at 82.3% at district level and 46.9% Level 1 facilities.

- **Essential communication and referral equipment to support EmONC referral** Achieved

The LSTM Survey 2016 estimates that mobile phones are the main mode of communication across the country and that a mobile network is available in 100% of district level hospitals and in 93.9% of Level 1 facilities. The LSTM Survey 2016 also indicated that 98% of district level hospitals surveyed have at least one ambulance available but that only 85.6% have an ambulance available and fully functional.

- **Supportive Supervision** Not achieved

All DHEs surveyed by LSTM perform supervision and 85.6% perform it at least quarterly. The proportion of DHEs performing supervision at least quarterly and having checklists and reports available was estimated at 77%.

A full summary of the progress against indicators for outcome 1.1 is provided in table 1 overleaf.

Table 1 - HTF Indicators for Outcome 1.1. Progress from baseline and against defined targets

Outcome 1.1. Enhancing obstetric and newborn are capacity of the health system							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.1.1. Proportion of pregnant women who attended ANC4+ during the current pregnancy	**64.8%**	*DHS-2010/ 11*	**76.0%**	*DHS 2015*	**90%**	**11%**	**-14%**
1.1.2. Proportion of deliveries attended by a skilled birth attendant	**66.2%**	*MIMS 2009*	**78.0%**	*DHS 2015*	**80%**	**12%**	**-2%**
1.1.3. Proportion of district hospitals providing comprehensive emergency obstetric and newborn services	**38.0%**	*NIHFA-2011*	**73.0%**	*LSTM survey 2016*	**80%**	**35%**	**-7%**
1.1.4. Percentage of mothers who received postnatal care at least 3 times in the first week after delivery (*)	**27.1%**	*DHS-2010/ 11*	**51.1%**	*DHS 2015*	**80%**	**24%**	**-29%**
1.1.5. Proportion of districts providing quarterly report on MNCH program implementation	**20.1%**	*NIHFA-2011*	**82.1%**	*LSTM survey 2016*	**100%**	**62%**	**-18%**

PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.1.1.1.Proportion of PCNs trained on focused ANC	**20%**	*Admin report 2011*	**69.2%**	*LSTM survey 2016*	**80%**	**49%**	**-11%**
1.1.2.1. Proportion of rural health centres with at least one midwife or upgraded nurse to provide basic EmONC services	**20%**	*Admin report 2011*	**86.3%**	*LSTM survey 2016*	***N/A***	**66%**	***N/A***
1.1.2.2. Proportion of rural health centres with the necessary equipments and consumables for basic EmONC services	**20%**	*NIHFA 2011*	***45.0%***	*SARA 2015**	**80%**	***25%***	***-35%***
1.1.3.1. Proportion of District Hospitals having at least one health professional who can do C/S	**55%**	*NIHFA 2011*	***97.4%***	*LSTM survey 2016*	**80%**	**42%**	**17%**
1.1.3.2. Proportion of district Hospitals with at least one health professional who can provide anaesthesia for emergency obstetric surgery	**55%**	*NIHFA 2011*	**93.0%**	*LSTM survey 2016*	**80%**	**38%**	**13%**
1.1.3.3. Proportion of District Hospitals with fully functional operation room to perform emergency obstetric surgery	**55%**	*NIHFA 2011*	**88.5%**	*LSTM survey 2016*	**80%**	**34%**	**9%**
1.1.3.4. Number of district hospitals with fully functional mother waiting homes (MWHs)	**20%**	*Admin report 2011*	**82.3%**	*LSTM survey 2016*	**100%**	**62%**	**-18%**
1.1.3.5. Number/Proportion of district hospitals having at least 1 ambulance	**55.2%**	*NIHFA 2011*	**85.6%**	*LSTM survey 2016*	***N/A***	**30%**	**N/A**
1.1.3.6. Proportion of health facilities with at least one fully functional mode of communication equipment for emergency referral	**Landline 19.4%**	*NIHFA 2011*	**97.5%**	*LSTM survey 2016*	**80%**	***Not comparable***	**18%**
1.1.3.7. Number/Proportion of District Hospitals with the capacity to provide blood transfusion for emergency obstetric care	**53%**	*NIHFA 2011*	**77.8%**	*LSTM survey 2016*	***N/A***	**25%**	**N/A**
1.1.4. Proportion of rural health facilities conducting at least 3 PNC visit within the 1st week after delivery	**12%**	*DHS 2010/11*	**87.8%**	*LSTM survey 2016*	**70%**	***Not comparable***	**18%**
1.1.5.1. Number/Proportion of districts conducting quarterly supportive supervision to health facilities	**57%**	*NIHFA 2011*	**85.6%**	*LSTM survey 2016*	**100%**	**29%**	**-14%**

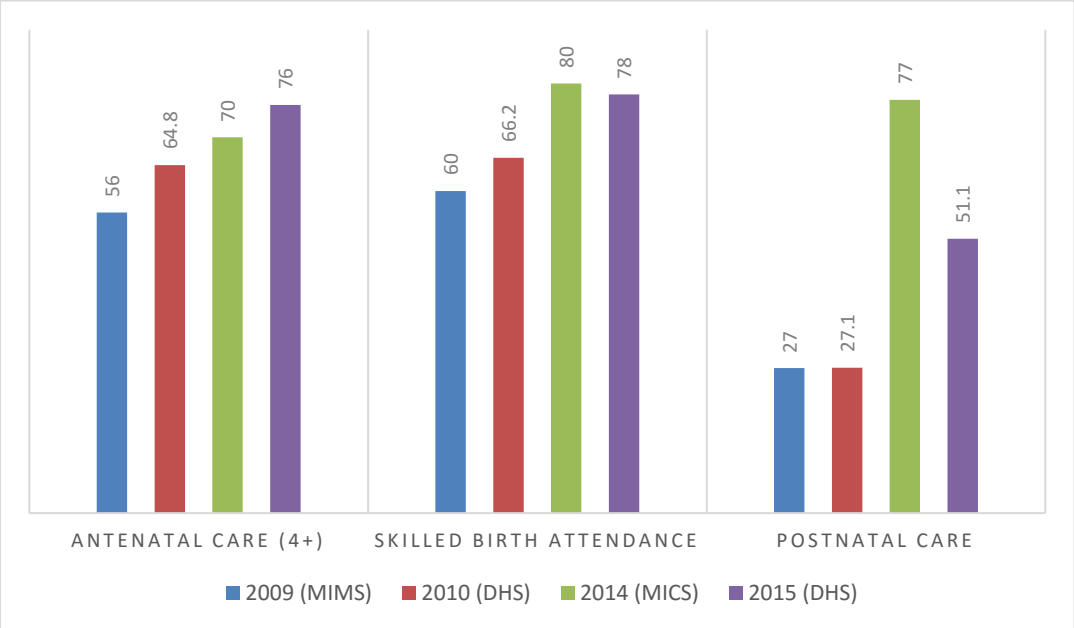
*Service availability and readiness assessment (SARA) 2015 reports availability of BEmOC equipment nationally (including urban,rural, private, public health facilities).

Progress at outcome level

Improvement in Maternal, Newborn, Child Health and Nutrition has contributed significantly by the HTF due to increased availability of and access to essential reproductive health services such as antenatal care (ANC), skilled birth attendance (SBA) and postnatal care (PNC).

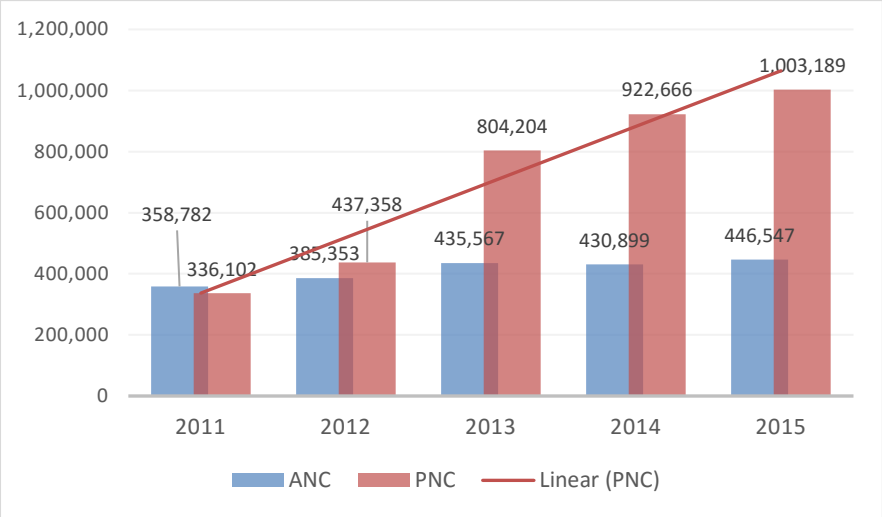
According to MICS 2014, 70.1% of pregnant women completed the recommended four ANC visits during their last pregnancy compared to 56% in 2009. Similar improvement was observed for skilled birth attendance where the coverage has increased from 60.2% in 2009 to 80% in 2014 (MICS) and 66.2% in 2010 to 78% in 2015 (DHS). For postnatal care, access has increased dramatically: the number of women receiving postnatal care within 2 days after delivery was 27% according to the Demographic Health Survey (DHS) 2010/11, while the rate was 51.1% (DHS 2015) by 2015. (Figure 1)

Figure 1 - Progress in coverage along the continuum of care



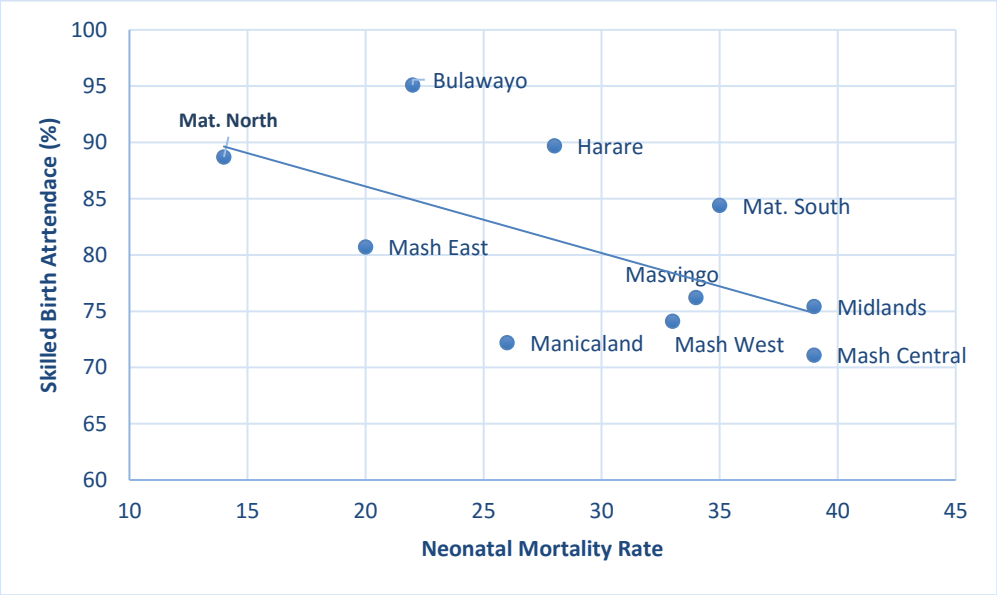
From the routine HMIS information, a similar trend was observed for pregnant women attending four or more ANC visits. Similarly for postnatal care, from the routine HMIS information, the total number of women attending postnatal care has increased dramatically since 2011. (Figure 2)

Figure 2 - Total numbers of women attending ANC4+ and PNC (Source: HMIS)



It is evident that the gains achieved in enhancing access to essential reproductive health services are the major determinant of the reduction observed in maternal and newborn death in Zimbabwe, in recent years. As it was reported in the LSTM Annual Evaluation Report 2014, availability of skilled birth attendance is positively correlated with reduced neonatal mortality. The correlation coefficient (r=-0.6) between SBA and NMR highlights there is a need to improve access to services in low performing provinces. This is also confirmed by the correlation between postnatal care for newborns and neonatal mortality rate (r=-0.7) suggesting a stronger association between access to care and mortality outcomes.

Figure 3 - Correlation between SBA and NMR (Source: MICS 2014)



Progress at output level

ANTENATAL CARE (ANC)

One of the key interventions which HTF supported to improve maternal health is improving antenatal care (ANC). According to the HTF Annual Report 2016, 99.9% of health facilities are providing ANC services. Similar finding is observed in VMAHSS Round 26 as 99.6% of facilities surveyed were providing ANC services. However, only 40.6% were having a dedicated room for ANC consultations (VMAHSS Round 26).

Possible contributions as a result of HTF interventions are training of PCNs; updating and distribution of focused antenatal care (FANC) protocols. According to the HTF Annual Report 2016, 483 PCNs have received upskilling training in 15 midwifery schools while 5000 copies of updated FANC protocols have been distributed to all primary care facilities during 2015.

Regarding health staff to provide ANC services, LSTM 2016 survey identified that **69.2% (95% CI= 63.1,75.2) of primary care nurses (PCN) have been trained in focused ANC**. This is an improvement of 14% increase (95% CI = 7.2,20.8) (p value =0.001) from 53.5% (95%CI = 46.7,60.4) in the last LSTM survey in 2015.

However, only 70% of pregnant women complete the recommended 4 ANC visits (MICS 2014). Additionally, the content of antenatal care still presents some missed opportunities to enhance the quality of the services offered to women during pregnancy. Only 52.9% of pregnant women had their urine samples taken; 66.9% received folate tablets; 83.5% received iron tablets; 83.5% had their blood samples taken; and 89.4% had their blood pressures measured (MICS 2014). However, it was not clear whether these were due to lack of available kits and supplements or inadequate practice or gaps in training/knowledge/competencies.

One of the potential barriers in accessing ANC from the user's perspective is user fees and transaction costs. According to the VMAHSS Round 26, 7.7% of health facilities are still charging user fees for ANC services with an average cost of USD 18.72 (95%CI=6.66-20.79). The findings are confirmed by the LSTM Survey 2016 as 13% of district hospitals and 4.9 % of Level 1 facilities showed to be charging ANC services with an average cost of USD 15.5 (95% CI= 4.7-26.3). Additionally, focus group discussions (FGD) conducted by LSTM identified user fees as key barriers in accessing maternal health services.

EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC) SERVICES

Pregnancy should be a normal life event for the majority of women and yet every pregnancy faces risks. For an estimated 15% of all women, complications will be unexpected and life threatening unless they have access to emergency obstetric and newborn care (EmONC). As these life threatening complications are generally not predictable, to reduce maternal mortality it is important that all women have access to maternal health care services, particularly skilled attendance at birth and timely access to EmONC. Two levels of EmONC can be distinguished: basic EmONC (BEmONC) and comprehensive EmONC (CEmONC). The signal functions of these 2 levels are listed in Box 1. The UN recommends that for a population of 500,000 at least one CEmONC and four BEmONC facilities should be available and functioning. However, in Zimbabwe, Level 1 facilities are designated as fully functional BEmONC facilities if they provide 6 signal functions of a BEmONC; Assisted Vaginal Delivery (AVD) is an optional signal function (BEmONC minus 1).

Box 1: Levels of Emergency Obstetric and Newborn Care and their signal functions

BEmONC:

1. Parenteral antibiotics
2. Parenteral oxytocics
3. Parenteral anti-convulsants
4. Manual removal of a retained placenta
5. Removal of retained products of conception by manual vacuum aspiration (MVA)
6. Assisted vaginal delivery (vacuum extraction, forceps)
7. Neonatal Resuscitation using bag and mask

CEmONC:

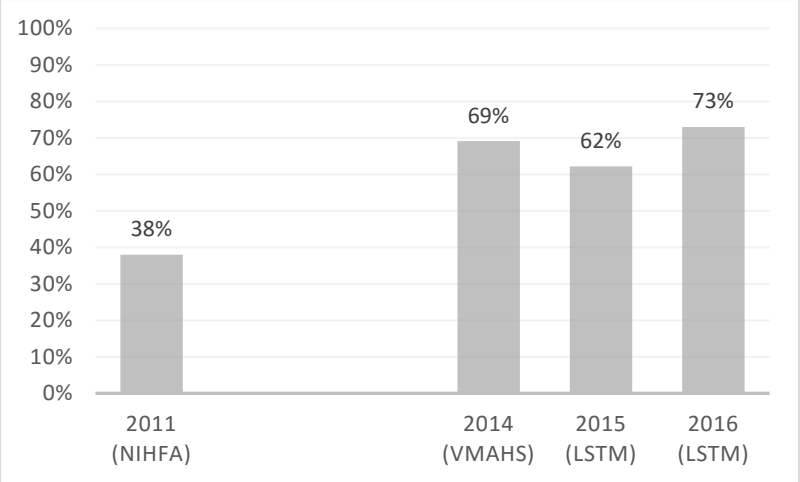
All 7 BEmONC functions, plus:

1. Caesarean Section
2. Blood Transfusion

Availability of CEmONC services at District Level

The HTF set the target of increasing the availability of comprehensive emergency obstetric and neonatal care to 80% of district hospitals by 2015. The National Integrated Health Facility Assessment (NIHFA) reported that only 38% of district hospitals provided CEmONC services in 2011. According to the VMAHSS Round 26, at the end of 2015, 82.5% of all district, provincial and central hospital facilities offered CEmONC services. This estimate is confirmed by the 2016 LSTM survey, which estimates **CEmONC availability at District Level Hospitals at 73%** (95% CI: 63.8,82.1). This showed an improvement from the 2015 LSTM survey, which was 62.2% (95% CI= 54.0,70.5).

Figure 4 - Proportion of District Level Hospitals offering CEmONC services



The availability of individual signal functions at CEmONC level is reported below:

Table 2 - Availability of signal functions at CEmONC level, 2011-2016

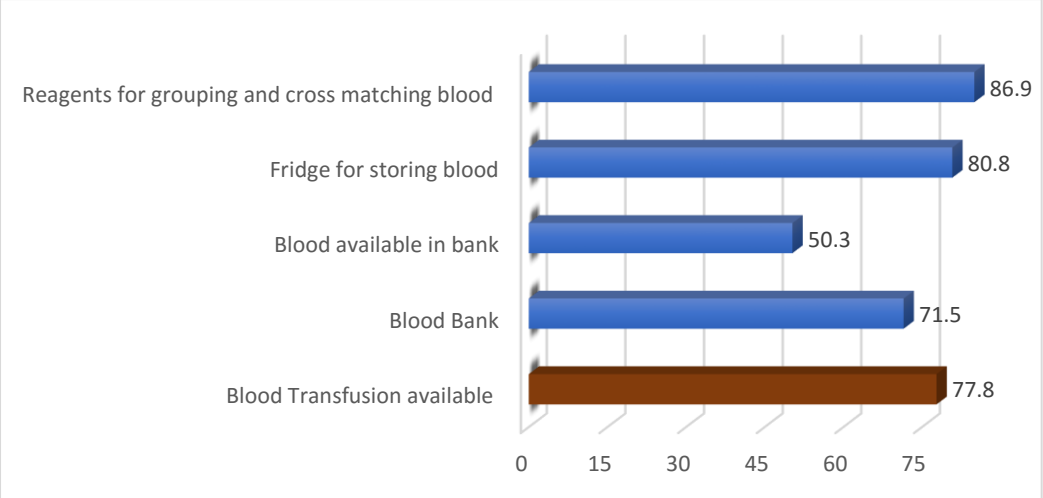
Availability of Signal Functions for CEmONC	*2011 (NIHFA)*	*2014 (VMAHSS)*	*2015 (LSTM*)*	*2016 (LSTM*)*	*Progress 2011-2016*
Administer parenteral antibiotics	98.3%	98.4%	97.8%	96.0%	→
Administer uterotonic drugs	98.3%	100.0%	100.0%	96.0%	→
Administer anticonvulsants	88.9%	100.0%	97.9%	96.0%	↗
Perform manual removal of placenta	85.5%	98.4%	94.0%	93.0%	↗
Perform removal of retained products of conception	77.8%	93.5%	98.2%	93.0%	↗
Perform assisted vaginal delivery	59.8%	98.2%	93.7%	86.3%	↗
Perform newborn resuscitation	*N/A*	100.0%	100.0%	95.6%	↗
Perform blood transfusion	53.0%	70.4%	78.6%	77.8%	↗
Perform caesarean section	60.3%	88.9%	95.6%	93.0%	↗

*District level hospitals only.

Among nine signal functions, performing blood transfusion still remains the major bottleneck in providing CEmONC services though there was a remarkable progress since 2011. This is confirmed by the 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 was collected in the LSTM 2016 survey, and is available in the Survey Report in Annex 1. The survey findings are summarised in Figure 2 illustrating the availability of blood transfusion services at district level hospitals.

Figure 5 - Availability of blood transfusion services at district level facilities (LSTM Survey 2016)



HTF has supported the gap in blood transfusion through provision of blood coupons to the MOHCC. According to the HTF Annual Report 2016, a total of 11,000 blood coupons were distributed in 2015.

Another critical element to ensure provision of CEmONC services is availability of skilled birth attendants and health workers who are trained to provide EmONC services. The HTF has invested significantly in training of health workers in emergency obstetric care, and has set specific targets to enhance the availability of skilled health workers to expand the coverage of CEmONC services.

With HTF support, 107 MNCH managers have undergone mentorship to upgrade their knowledge and skills in management of EmONC enabling them to provide technical support, on the job training and supervision of their staff.
These results concur with the achievements reported below:

- The LSTM 2016 Survey estimated that **97.4% of district hospitals have at least one professional who can perform caesarean sections**. This achievement is a significant increase from baseline levels estimated at 55% (NIHFA 2011) and indicates that the target set for 80% has been exceeded.

- Similarly, our survey found that **93% of district hospitals have at least one healthcare professional who can provide anaesthesia for obstetric surgery**. This achievement is a significant increase from baseline levels estimated at 55% (NIHFA 2011) and indicates that the target of 80% has been exceeded.

- The LSTM evaluation estimates that **88.5% of district level hospitals have a fully functional operation theatre to perform surgery**. Again, this is a significant increase from baseline levels estimated at 55% (NIHFA 2011) and indicates that the target set for 80% has been exceeded.

Availability of BEmONC services at Level 1 facilities

The National Integrated Health Facility Assessment found that in 2011 only 4.1% of Level 1 facilities were providing *BEmONC minus 1* services (6 signal functions). According to VMAHSS Round 26, the proportion of Level 1 facilities providing BEmONC services was estimated at about 68%.

The LSTM 2016 Survey found that 19.4% (95% CI= 12.4,26.5) of Level 1 facilities provide full BEmONC services 24/7.

The availability of individual signal functions at BEmONC level is reported below (Table 3), according to data available for baseline (NIHFA 2011), 2014 (VMAHSS 22) and early 2016 (LSTM Survey 2016).

Table 3 - Availability of BEmONC minus one signal functions: 2011-2016

Availability of Signal Functions for BEmONC	2011 (NIHFA)	2014 (VMAHSS)	2015 (LSTM)	2016 (LSTM)	Progress 2011-2016
Administer parenteral antibiotics	47.60%	99.40%	76.00%	78.30%	↗
Administer uterotonic drugs	50.80%	99.60%	83.80%	84.20%	↗
Administer anticonvulsants	21.40%	99.40%	75.90%	82.10%	↗
Perform manual removal of placenta	27.20%	84.10%	60.10%	69.10%	↗
Perform removal of retained products of conception	12.50%	66.60%	34.00%	21.90%	→

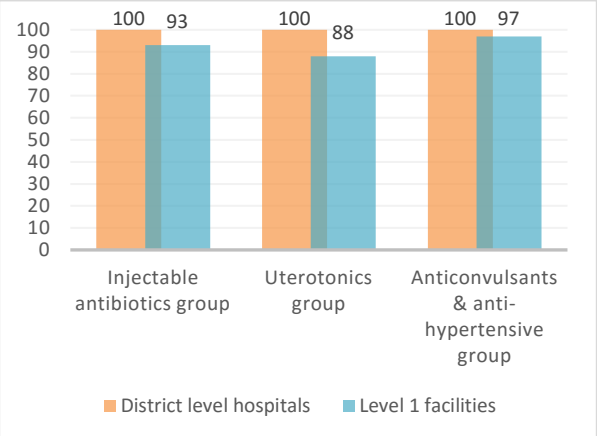
Although LSTM surveys used a more cautious estimate than VMAHSS, the results suggest that there are significant improvements in the availability of BEmONC signal functions compared to baseline. The results indicate that the removal of retained products of conception is the major bottleneck in order to provide all the BEmONC signal functions.

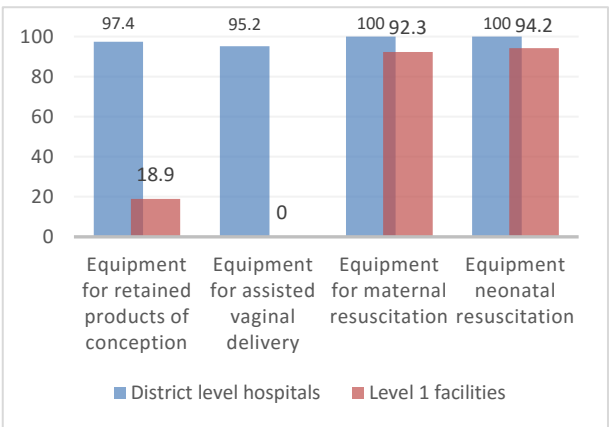
To assess the barriers in provision of BEmONC services, the LSTM 2016 survey looked into two essential building blocks of the health system: human resources, and equipment and medicines required to provide EmONC services.

In terms of human resources, the survey identified that **86.3% of rural health facilities at level 1 have at least one midwife or nurse to provide BEmONC services**.

Findings on essential EmONC equipment and medicines from the LSTM 2016 survey are summarized in Figure 6. Results show a wide availability of both medicines & equipment for EmONC, with the exception of the equipment for retained products of conception, which is estimated at 18.9% at BEmONC level facilities.

Figure 6 - Availability of EmONC medicines & equipment by level of care (LSTM Survey 2016)





POSTNATAL CARE

The first week following childbirth—the postnatal period—is a critical phase in the lives of mothers and newborn babies. Most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours[1], and 66% occur during the first week. [2] Hence, follow up to postnatal mothers and infants within the first week after delivery is critical. Zimbabwe adopted a new Postnatal Care (PNC) schedule recommending postnatal visits at day 1,3 and 7, and at six weeks after delivery.

HTF has supported postnatal care activities with the coverage target of 70% of rural facilities provide 3 PNC visits within the first week after delivery. According to the LSTM 2016 survey, **87.8% of health facilities provide PNC services** as per the MOHCC recommended schedule. Unfortunately, the result shows regression as the result was 98.8% in previous LSTM survey.

It should be noted that this result refers to the availability of the recommended service at facility level, and not at population coverage estimates. However, care should be taken to compare the findings from the baseline as the LSTM survey result refers to the availability of the recommended service at facility level, and not at population coverage estimates. Using a different way of measurement, VMAHSS Round 26 reported that 99.9% of all facilities surveyed are providing postnatal care to both mothers and babies within the first six weeks after birth.

In terms of women accessing PNC at facilities, HMIS data showed gradual increase in numbers of women receiving PNC services at facilities (Figure 2). DHS (2015) also confirmed the increase in PNC as 51.1% of women received PNC services in 2015 while it was 27.1% in 2010 (Figure 1).

MATERNITY WAITING HOMES

According to WHO, maternity waiting homes (MWH) are residential facilities, located near a qualified medical facility, where “high risk” women can await their delivery and be transferred to a nearby health facility shortly before delivery, or earlier if complications arise. The concept of MWH is to remove geographical barriers in reaching obstetric care in hard to reach areas. During HTF interventions, the use of MWHs have been promoted with the objective of increasing institutional deliveries, through providing accommodation and basic preventive services to pregnant women who live far from health facilities. During programme inception phase, the HTF set the ambitious target of having 100% of district level hospitals with a fully functional MHW by the end of 2015.

According to the VMHASS Round 26, MWHs were available in 50.7% of rural health facilities at the end of 2015. LSTM 2016 survey confirms the VMHASS findings, which found that MWHs were available in 82.3% of the District Level Hospitals and in 46.9% of Level 1 facilities surveyed.

The essential characteristics measured through the survey to assess the functionality of MWHs are reported in Table 4 below. (LSTM 2016 Survey)

[1] Every Newborn, An Executive Summary for The Lancet’s Series. May 2014.

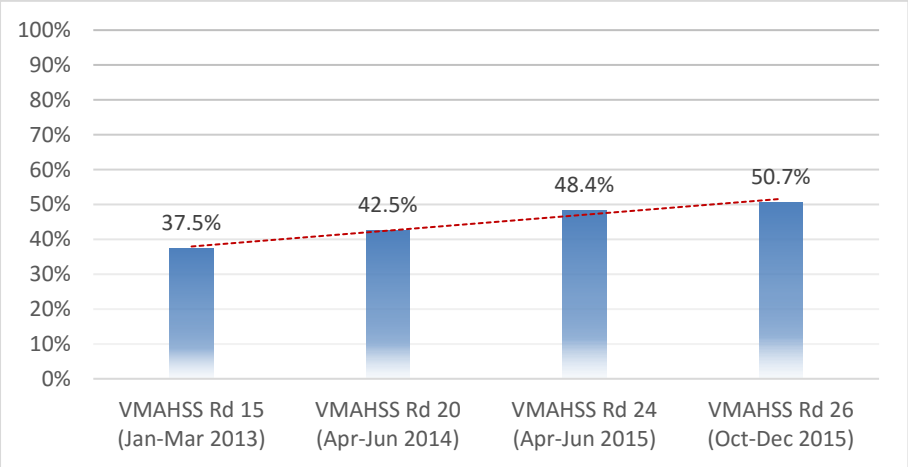
[2] Nour N. 2008. An Introduction to Maternal Mortality. Reviews in Obstetrics & Gynecology. 1:77–81.

Table 4 - Availability and functionality of maternity waiting homes, by level of care

Level of care		*Functionality of MWHs, amongst Facilities with a MWH available in % (95% CI)*				
	MWHs Available	ANC Services provided	Nurse aide available 24/7	MWH provides food	MWHs with cooking shed/kitchen	Aver. N. of new admissions past quarter
District level hospitals (n=38/47)	82.3 (79,94)	100	45 (33,57)	68 (54,82)	97.0 (93,<100)	242 (180,304)
Level 1 facilities (n=56/118)	46.9 (35.5,55.3)	100	55.8 (44.7,66.8)	36.9 (25.1,48.6)	81.3 (71.8,90.8)	21.3 (15.3,27.4)

The availability of MWHs at rural health facilities have increased gradually since the start of HTF (Figure 7).

Figure 7 - Availability of MWHs in rural health facilities (Source: VMAHSS)



Regarding the use of MWHs, some community groups who participated in FGDs during the LSTM evaluation in 2016, expressed concerns about the availability of maternity waiting rooms in the health facilities because the infrastructure was occupied by police forces (Box 2, Quote 1).

Box 2. Illustrative quote for "maternal health-maternity waiting homes"
Quote 1: "One thing is the waiting shelter; it is not conducive place and police stay there that makes women not happy about staying in it." (FGD community men 7)

ESSENTIAL COMMUNICATION AND REFERRAL EQUIPMENT TO SUPPORT EMONC REFERRAL

Communication means

In 2011, only 19.4% of facilities had landline telephones and 11.6% had radios for communication for emergency referral (NIHFA 2011). With the advancement of information technology and network coverage, the LSTM 2016 survey identified that 100% of district level hospitals and 93.9% of level 1 facilities have access to mobile networks. The survey reveals that the landline is an important mean of communication at district level (66.8%), but remains widely unavailable at level 1 facilities (25.2%). The availability and use of VHF radios is low at both levels.

Table 5 - Means of communication available at health facilities, by level of care

Level of care	*VHF Radio*	*Landline Telephone*	*Cellular network*	*Functional handset and cellular line*
District level hospitals	6.2% (0.7,11.7)	66.8% (58.4,75.2)	100%	98.3% (96.0,99)
Level 1 facilities	4.5% (0.7,8.4)	25.2%(19.2,31.1)	93.9% (90.3,97.4)	85.5% (79.8,91.1)

The findings are confirmed by the VMHASS Round 26 report, whichidentified mobile phones as the most commonly used mode of communication among health facilities with a coverage of 95%.

Transport

In 2011, only 55% of district hospitals had at least one ambulance (NIHFA 2011). According to LSTM 2016 survey, 98% of the District Level facilities had at least 1 ambulance available on the day of the survey, of which all (100%) were in running conditions on the day of the survey. Among them, **85.6% of them were fully functional.** Functionality was assessed according to the four requirements listed in table 6 below.

This shows 8.7% improvement (95% CI=8.0,25.4) in availability of functional ambulances among district level hospitals as previous LSTM 2015 survey showed 76.2% availability.

Table 6 - Availability and functionality of ambulances for referral, by level of care

Level of care	*Facilities with at least 1 ambulance available*	*Functionality of ambulance, amongst facilities with at least 1 available*			
		% in running condition	% with medical staff and driver on standby	% fuelled on the day of the survey	% service provided free of charge
District level hospitals	98 (95,99)	100	96 (92,99)	96 (93,99)	90 (85,95)
Level 1 facilities	11.0 (5.2,16.9)	93 (92,95)	79 (53,99)	86 (61,99)	90 (64,99)

The LSTM 2016 survey also revealed that among District Level hospitals, most of the facilities had alternative means of transportation available for referrals (e.g. car: 43%; van or truck: 18%). While at Level 1 facility level, means of transportation available for referrals were car (61.8%); and van or truck (9.5%). The survey findings were confirmed by findings from focus group discussions with community women as they recounted on the referral problems particularly regarding users not being able to pay for transportation costs (Box 3, Quote 1).

Box 3. Illustrative quotes for "maternal health-referral problem"
Quote 1: "There are issues when an expecting mother comes to delivery, sometimes she needs to transferred to Murehwa Clinic and she has no money for transport and the clinic have no ambulance or a clinic vehicle." (FGD Community Women 8)

The survey also assessed the average time required to refer a patient from the facility to the next level of referral. The findings indicate that most of peripheral facilities (67.2%) are able to reach the closest District Level hospital within an hour, whereas the time required to refer a patient from a district level facility to the referral Provincial Hospital is higher, which is between one and three hours for more than half (59.6.4%) of the cases.

SUPPORTIVE SUPERVISION

WHO defines supportive supervision as "a process to improve the work performance of the staff continuously, carrying out in a respectful and non-authoritative way with an opportunity to improve knowledge and skills of health staff". [3] Supportive supervision aims to improve the work performance to achieve certain gaols through providing an open, two-way communication using data for decision-making and regular follow up with the staff. HTF has supported the MOHCC in ensuring supportive supervision to enhance the quality of services provided in hospitals and in district level facilities. Since 2015, LSTM surveys have assessed the extent to which supervision has been implemented at peripheral level.

Amongst the district health offices surveyed by LSTM in February 2016, 100% reported to perform supportive supervision to the health facilities in their district, and 95.5% reported to do it at least quarterly. The findings indicate 11.6% improvement from the last LSTM 2015 survey, which recorded 74.6% (95% CI=67.1,82.2). However, this was not statistically significant (p=0.3) (95% CI=-8.0,31.3).

Concurrently, 95.5% of DHOs reported to receive supervisory visits from the Provincial Health Offices. Findings on supervision at DHO level are summarized in Table 7 below.

Table 7 - DHEs conducting and receiving supervision

	% DHEs (n=44)	*95% CI*
District Level Supervision		
DHE performing supervision	100	
Frequency of supervision *(at least quarterly)*	96	(86,99)
Supervision schedule available	77	(69,84)
Checklist for supervision available	97	(94,99)
Last supervision report available	90	(86,93)
Provincial level supervision		
Districts receiving supervision from the Province	96	(94,99)

At District level, cars were the most commonly used means of transportation for supervision (76%). Only 2% of the DHOs reported to have no means of transportation available for supervision.

The above findings from DHOs somehow differed from the findings from health facilities in the same survey. Results show that only 41.1% (95% CI= 37.9, 44.3) of Level 1 facilities had received supervisory visits during the

[3] WHO 2008. Module 4 : Supportive supervision: training for mid-level managers (MLM)

quarter preceding the survey, compared to 94.5% the preceding year. Similarly, only 39.3% (95% CI=33.7, 44.9) of surveyed District Level Hospitals received supervision during the same quarter. However, all facilities (100%) received feedback after a supervisory visit.

Outcome 1.2. Improving the Community Health Service System for MNCH and Nutrition

Summary of key findings

The National Child Survival Strategy for Zimbabwe 2010-2015 identifies community participation as a core strategy, setting the objective of strengthening "individual, family and community capacity to promote key family and community practices for maternal, newborn and child health". The contribution of the efforts undertaken to enhance community health to the overall health gains achieved in country could not be ascertained. Progress in behaviour change and in uptake of services at community level present mixed results.

- **Health Committees** Achieved

In 2011, 78.2% of health centres had a functional health committee in place. The HTF has set the target that 80% of health committees at the health centre level conduct monthly meetings to discuss health issues. According to the LSTM Survey 2016, 86.6% of rural health centres had a committee in place and 65.9% of these facilities had a committee in place and meeting at least monthly to discuss health issues.

- **Village Health Workers** Not achieved

The HTF has invested in expanding the VHW programme in Zimbabwe. The country has a target of training and deploying at least 22,000 VHWs with support from different implementing partners including HTF by 2015. The target has not be achieved as only 13,447 VHWs were trained as of 2015, i.e. 61% of the planned number.

- **Behaviour change** Not achieved

The LSTM Mid-term Review Report highlighted that data available through the MICS 2014 did not indicate any significant improvements from 2010 in behaviour change and in the adoption of key family practices. However, care seeking practices for sick children have improved since 2009.

- **Access to preventive and curative services at community level** Not achieved

Routine data from the VHW programme was not available to be analysed for our evaluation to ascertain the actual achievements of this cadre at community level. Data from the MICS survey 2014 provide some indication that the contribution of VHWs to address childhood illness (curative services) is somewhat limited. Care seeking patterns for children with fever, diarrhoea or ARI symptoms clearly indicate that families use primarily health facilities as a source of advice and treatment. Less than 3% of cases for which care was sought are reported to seek care from VHWs according to MICS data. The same applies to the provision of curative services: of all children who received prescriptions for ORS, antibiotics or antimalarial, only 5% were prescribed and offered the medicine by a VHW though this should be their first point of contact with the health system.

- **Utilization of health services** Achieved

Utilization of health services has increased in Zimbabwe. Routine data indicates that the uptake of outpatient department (OPD) services has increased from 8.6 million in 2011 to 13.6 million in 2015. Similarly, the LSTM Survey 2016 estimates that the OPD utilization rate for Level 1 facilities is at 1.01 consultations per person per year and hence slightly above the target set by the HTF at 1 consultation/person/year.

A full summary of the progress against indicators for Outcome 1.2 is provided in Table 8 overleaf.

Table 8 - HTF Indicators for Outcome 1.2: Progress from baseline and against defined targets

Outcome 1.2. Improve the Community Health Services System for MNCH and Nutrition						Progress 2011-2015	Gap to target
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**		
	Estimate	*Source*	**Estimate**	*Source*			
1.2.1. Proportion of health centres with functional health committees	**78.2%**	*NIHFA-2011*	**86.6%**	*LSTM survey 2016*	**90%**	**8%**	**-3%**
1.2.2. Proportion of villages with at least one VHW providing community based preventive and selected curative MNCH services	**25.0%**	*NIHFA-2011*	**NA**	*NA*	**80%**	**NA**	**NA**

PROGRESS AT OUTPUT LEVEL						Progress 2011-2015	Gap 2015 to target
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**		
	Estimate	*Source*	**Estimate**	*Source*			
1.2.1. Proportion of health committees at the health centre level conducting regular monthly meetings to discuss health issues	**78.2%**	*NIHFA 2011*	**86.6%**	*LSTM survey 2016*	**80%**	**8%**	**7%**
1.2. 2. OPD utilisation rate	**N/A**	*N/A*	**1.01**	*LSTM survey 2016*	**1.00**	***N/A***	**1%**
1.2.1.2. Proportion of households washing hands with soap	**N/A**	*N/A*	**N/A**	*N/A*	**80%**	***N/A***	**N/A**
1.2.1.3. Proportion of villages with Zero Open Defecation	**N/A**	*N/A*	**N/A**	*N/A*	**100%**	***N/A***	**N/A**
1.2.2.1. Proportion of villages that have at least one VHW per 100 households	**25.0%**	*NIHFA 2011*	**61.0%**	*HTF AR 2016*	**80%**	**36%**	**-19%**
1.2.2.2. Proportion of VHWs with the right skill to provide full package of community based MNCH services	**N/A**	*N/A*	**N/A**	*N/A*	**80%**	***N/A***	***N/A***

(*) Proxy Indicator: Proportion of Household with soap or other cleansing agent anywhere in the dwelling

(**) Proxy Indicator: Proportion of Households using any improved or unimproved sanitation facility

Progress at outcome level

In line with the Primary Health Care approach, community participation is crucial to improve the health of a population. As enshrined in the Alma Alta Declaration, community based health services are one of the corner stones of the health system particularly empowering communities through information, education and communication strategies. Hence, a successful community health system through village health workers (VHWs) and other community based cadres have the potential to improve health seeking behaviour of communities such as for use of immunization, and appropriate infant and young child feeding practices.

In Zimbabwe, VHWs are the most commonly used community health worker in rural areas where they operate as the usual service provider for prevention of local endemic diseases, treatment of simple illnesses, and disease surveillance. The VHW programme was introduced by the MOHCC under the Nursing Directorate (VHW Strategic Direction 2010). The increased attention towards the VHW programme was influenced by factors such as high maternal and neonatal mortality, the cholera outbreak in 2008-2009, and high burden of diseases such as HIV/AIDS.

According to the VHW Strategic Direction, VHWs are supervised by Nurse in Charge of the RHC who supply appropriate medicines and commodities and provide on-going technical supervision and support to VHWs. According to the Zimbabwe VHW Strategic Document, one VHW should serve 100 households (approximately 500 population).

Health Centre Committees (HCC) is another group of community-based volunteers representing their community. These committees were formed in the 1980ies when Zimbabwe developed participatory structures in health policy planning and decision making.[4] However, their level of functionality differed in terms of quality and effectiveness with the reason that the guidelines for HCCs were not clear.

The HTF aimed to support two pillars of the community health strategy through establishment of HCCs to strengthen the link between communities and primary healthcare facilities, and the scale up of VHWs to deliver an essential package of preventive and curative interventions at community level. The rationale for investing in these two pillars was to:
a) Promote behavioural change and the adoption of key family practices
b) Increase uptake of service delivery
c) Increase the availability of an essential package of preventive and curative services at community level.

However, assessing the specific contribution of the investments undertaken so far in restoring HCCs and in expanding the VHWs to improved maternal and child health was not possible through this evaluation. Hence, we have analysed the progress observed in behaviour change and in the utilization of services, to which community health services are key contributors. The results are presented in the following output section and are complemented by findings from health facility surveys; interviews with key stakeholders and target beneficiaries as part of the evaluation.

[4] USAID (2011). Zimbabwe Health System Assessment 2010.

Progress at output level

HEALTH CENTRE COMMITTEES

The concept of HCCs has been introduced into east and southern Africa together with the adoption of the primary health care concept to involve community level participants in planning, implementation and monitoring of health services. The basic principle of the HCC is to provide an accountability mechanism for communities by ensuring access to and appropriate use of resources responding to the needs of the communities. In Zimbabwe, the role of HCC has been revitalized under the HTF particularly with the introduction of the results-based financing (RBF) mechanism to function as a governing body to improve accountability of health facilities. It also aims to enhance and improve coordination and communication between facilities and communities.

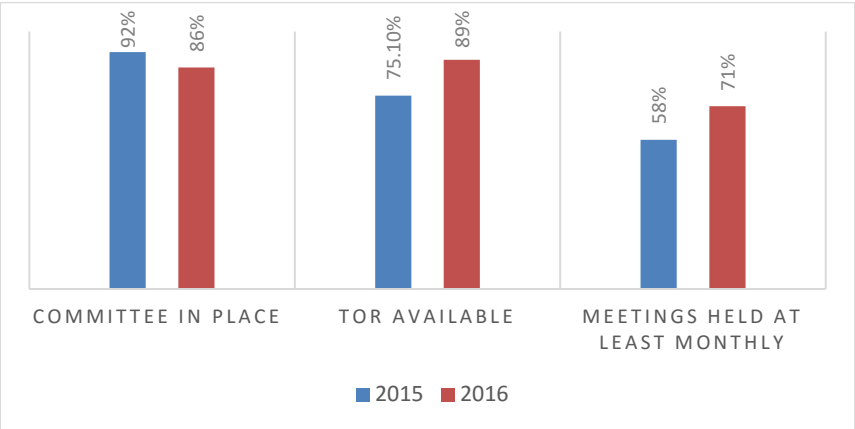
From the LSTM 2016 survey, Level 1 facilities had significantly better results than District Hospitals as **86.5%** had a committee in place and **71% of these met on at least monthly basis**. Among District level hospitals, only 66.6% reported having a committee in place of which only 21% conducted monthly meetings to discuss health issues. The table below presents these findings.

Table 9 - Availability and functionality of Health Centre Committees

Level of care	*Committee in place*	*ToRs available*	*Meetings held at least monthly*
District level hospital (n=30/46)	66.0 (58,74)	82.0 (71,92)	21.0 (13,29)
Level 1 facilities (n=99/118)	86.5 (81.2,94.7)	89.0 (82.9,95.4)	71.0 (62.6,80.3)

The findings show 10.5% (p=0.12, 95% CI=-2.1,23.1,) improvement from the LSTM 2015 survey where only 78.0% (95% CI=70.5,85.5) of rural health centres had a functional health committee.

Figure 8 - Performance of Health Centre Committees (HCC) (Source: LSTM surveys)



Similar findings were observed from our qualitative evaluation using interviews with healthcare providers and HCC members. Health workers recalled that the **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 (Box 4, Quote 1). Health workers participating in the evaluation acknowledged the role of HCC establishing a link between the communities and facilities to exchange information such as complaints

(Box 4, Quote 2). Though the role of HCC was extensively discussed by healthcare providers, little information was obtained from the community level group discussions-both from VHW and community groups because they were often not aware of the presence of the HCC within their communities.

Box 4. Illustrative quotes for "community health services system"

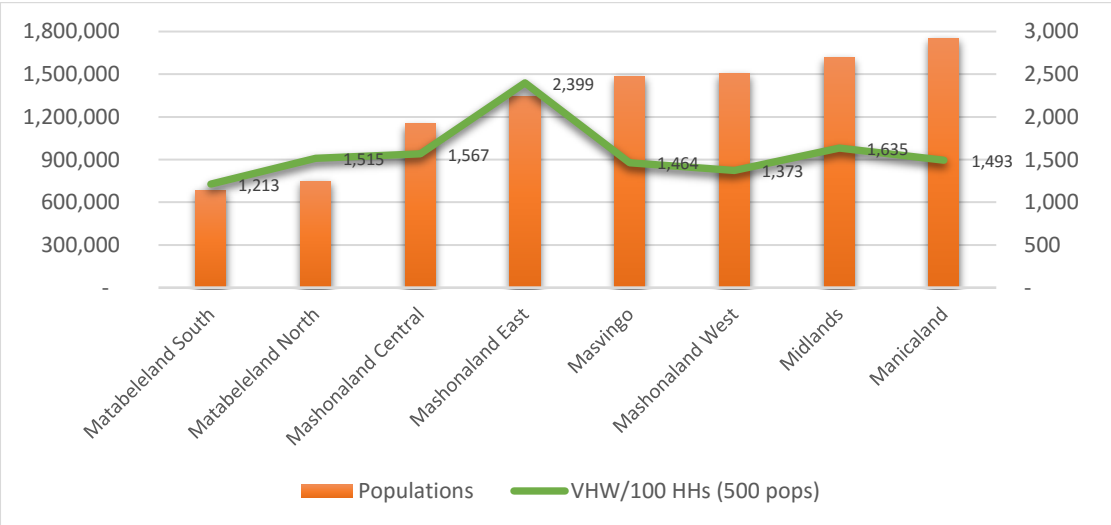
Quote 1: "Every time we do any transaction we are together they put their signature. *[They also help you to plan on how to use RBF?]* Yes we sit together and plan. We call for a meeting, all members come and when they come we sit down for the meeting." (KII respondent 13)

Quote 2: "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…" (KII respondent 10)

VILLAGE HEALTH WORKERS

The MOHCC planned to train 22,000 VHWs with the target of one VHW per 100 households by 2015. By the end of 2015, 13,477 VHWs have 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. Detailed mapping of VHWs trained per province is available from the HTF annual report 2016 (Figure 9). The findings highlight that the **coverage of VHWs is not proportionate to the population** as planned by the VHW Strategic Direction 2010 at 1 VHW/100 households or 500 population.

Figure 9 - VHW coverage per provinces (Source: HTF Annual Report 2016)



Among all trained VHWs, 89% are reported to have received allowances under the Global Fund (55.3%) and HTF (34%). The same report identified 399 (3%) of VHWs were lost or missing during the payment period.

The VHW Strategic Direction (2010) recommends minimum 5-6 months of initial training (8 weeks-classroom based; 8 weeks-field based and 4 weeks) followed by twice a year refresher trainings for 3-4 days. The VHWs are supposed to be supervised by the Nurse in charge of the rural health centre together with the ward health team at community level and to attend monthly meetings at the rural health centre (RHC). They are supposed to receive USD 14 per month paid quarterly with support from the Global Fund Round 8. There is no specification

on the support materials provided to the VHWs but the MOHCC suggests that partners support equipment and working tools.

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 challenges in performing their duties mostly due to big catchment areas; lack of mobility equipment such as bicycles; lack of functioning equipment such as weighing scale; shortage of medicines and supplies; not receiving financial incentives, lack of regular refresher trainings, and lack of effective means of communication (Box 5, Quote 1). VHWs acknowledged that they should provide voluntary services for their own communities but they had been promised to receive those "little incentives" (42 USD per quarter) as compensation at the time of recruitment. Therefore, they somehow expected to receive those 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. Some VHWs were even registered as receiving incentives that they had never received (Box 5, Quote 2 and 3).

During the FGDs, VHW also commented about the trainings they received as they are selected by the communities and receive initial trainings, which usually lasts for six months though some received shorter training for one to two months. Some of the VHWs had received refresher trainings while majority had not.

Box 5. Illustrative quotes for "community health services system"

Quote 1: "As Village Workers, we should be equipped with kits to assist people and also an ambulance should be available. 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" (FGD VHW 3)

Quote 2: "What the ladies are saying is true, the allowances we are given is very low and it comes after 3 months. Our lives are becoming unbearable. We must be always be smart yet we cannot afford washing soap." (FGD VHW 9)

Quote 3: "When we were engaged we were informed that the work is voluntary, but we were informed that there will be a small token of appreciation, which will amount to US$14-00 a month… We were asked how we want to be paid and we agreed that we would want to be given the money after three months but up until now there is nothing we have been given." (FGD VHW 5)

Another core HTF indicator is to provide VHWs with the right skills to deliver a package of MNCH community based interventions. The HTF Annual Report 2016 indicates that approximately 61% of the targeted villages now have VHWs with skills to provide MNCH, HIV/AIDS, and nutrition services at community level (13,447 out of targeted 22,000). However, the LSTM evaluation could not identify any specific studies or other sources of information that provides evidence of the capacity of VHWs and their ability to deliver a package of services at community level. Hence, the LSTM evaluation has used available secondary data regarding key intervention areas, which illustrate the core functions of VHWs. These include:

1. Community mobilization and health promotion
2. Linkage between facilities and health communities
3. Provision of essential preventive and curative services at community level

1. Community mobilization and health promotion

Our Mid-Term Review (MTR) Report highlighted that data available through the MICS 2014 did not indicate any significant improvements from 2010 in behaviour change and in the adoption of key health practices.

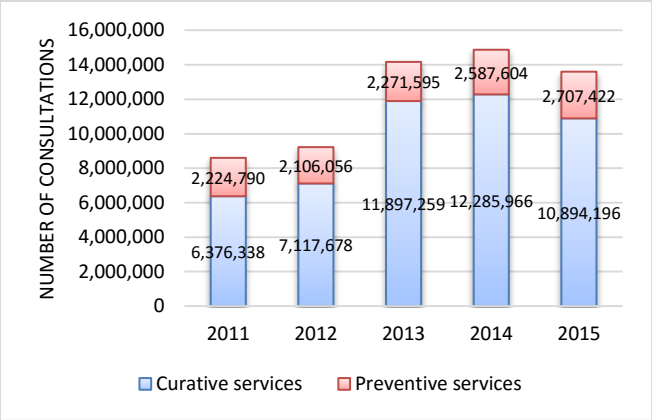
Whilst this suboptimal progress may be partly due to the insufficient progress in scaling up VHWs, it should also be noted that as highlighted in our MTR report, VHWs alone cannot be the only initiative to address behaviour change, and therefore **additional behavioural change communication strategies** should be explored to complement the work of VHWs.

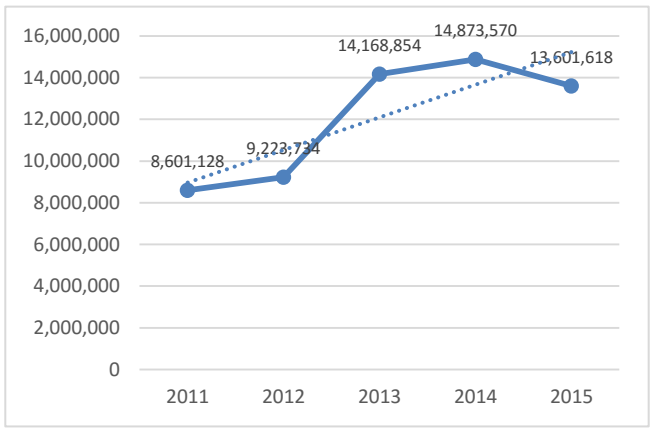
2. *Strengthened linkage between facilities and health communities*

At HTF inception, the government set the target of achieving an OPD utilization rate of 1 consultation per person per year, by the end of 2015. The LSTM 2016 survey estimates the **OPD utilization rate for Level 1 facilities at 1.03 consultations per person per year** (95% CI= 0.87,1.18). This shows reduction in numbers of OPD consultations from the 2015 survey where it was 1.34 consultation per person per year (95% CI=1.10,1.58). The survey findings are confirmed by the routine HMIS where a peak was observed in 2014 and a slight decrease in 2015.

As shown in figure 10, 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.

Figure 10 - OPD attendance at health facilities (Source: HMIS)

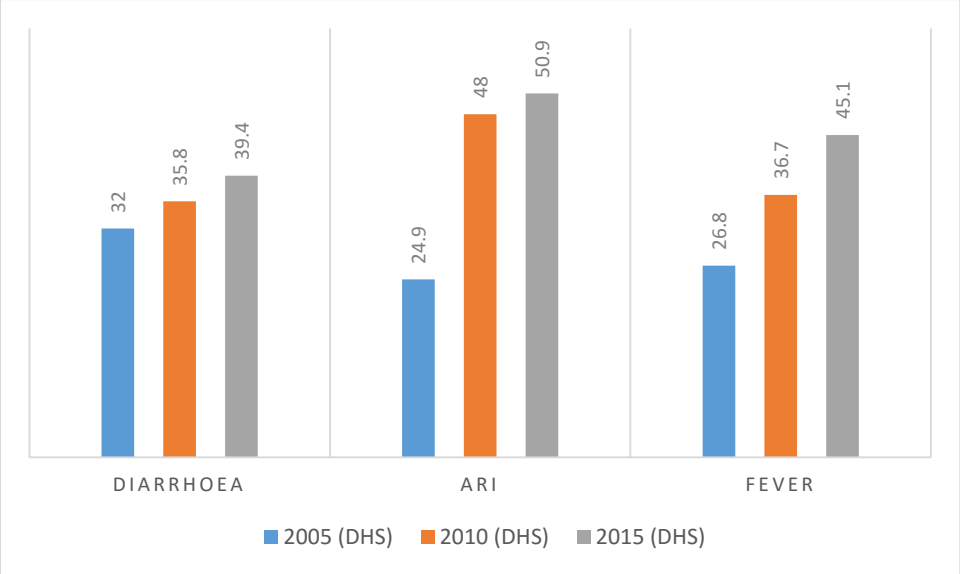




3. *Provision of essential services at community level*

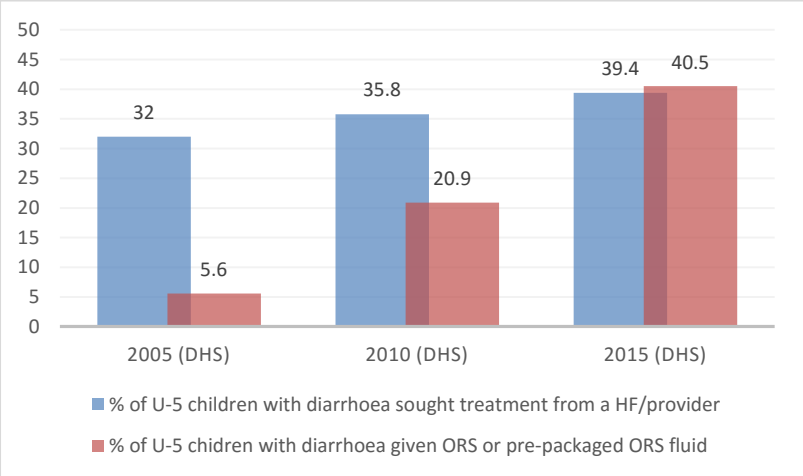
The most recent available population-based surveys, the DHS 2015 and MICS 2014, report interesting findings regarding the provision of essential services for mothers and children at community level. According to available DHS data, care-seeking behaviour for malaria, ARI and diarrhoea all increased exponentially between 2005 and 2015 particularly for treatment of fever and diarrhoea (Figure 11).

Figure 11 - Care seeking behaviour of common childhood illnesses



From DHS 2015, the proportion of under-5 children who received ORS or pre-package ORS fluid has increased significantly highlighting the fact that every children who sought treatment from a health facility or healthcare provider received ORS. (Figure 12).

Figure 12: Children with diarrhoea receiving ORS or pre-package ORS



As reported in the LSTM Annual Review 2014, there are multiple reasons and factors for such an increase and there is no evidence available to attribute the achievement in care seeking patterns to the implementation of the VHM strategy only. The LSTM evaluation did not have access to routine data collected through VHWs to assess their actual performance and results. From the MICS 2014 data, for both care seeking (Figure 13) and treatment of common childhood illnesses (Figure 14), the proportion of cases attended or cared for by VHWs is low.

Figure 13 - Care seeking for child illnesses (Source: MICS 2014)

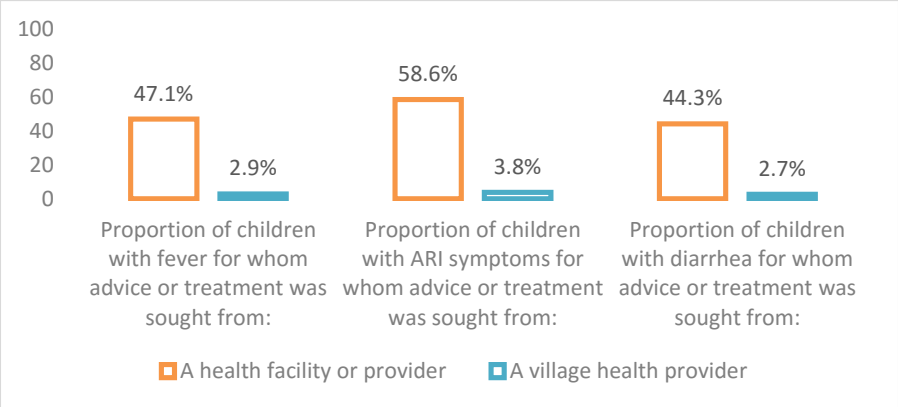
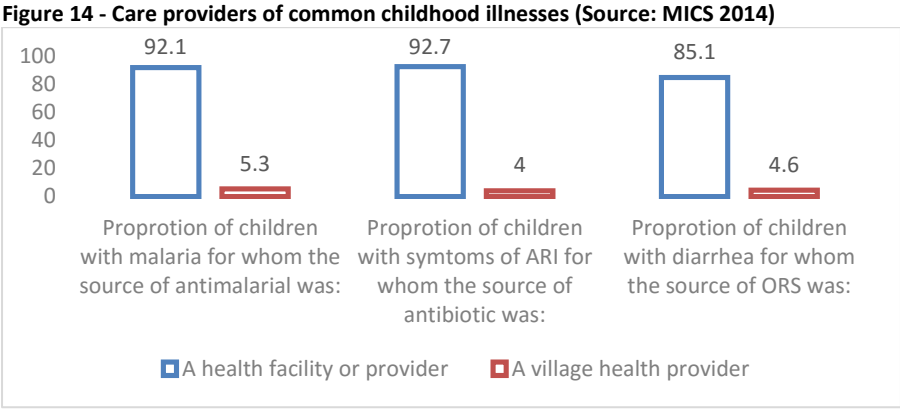


Figure 14 - Care providers of common childhood illnesses (Source: MICS 2014)



The pattern of seeking care from VHWs for children with suspected pneumonia has reduced significantly as 31.8% of children were brought to VHWs in 2009 while only 3.8% were brought to VHWs in 2014 (MICS 2009 and 2014). The qualitative component of the evaluation did not identify any reasons for this decline.

Outcome 1.3. Improving Child Health through Strengthening the EPI and Integrated Management of Newborn and Childhood Illnesses

Summary of key findings

Reduction in under five mortality indicates that efforts in enhancing preventive measures or timely access to diagnosis and treatment of common, life threatening childhood illnesses have been successful in improving child health in Zimbabwe.

- **Routine Immunization** Not achieved

  The percentage of full immunisation for 12-23 month old infants has improved from 36.8% in 2009 to 69.2% (MICS 2014), at an average annual rate of change of 6.5 percentage points per year. DHS 2015 shows similar coverage with 72.7% of full immunisation rate. Despite such a remarkable improvement, the (ambitious) target of providing a full course of immunization to 90% of children was not achieved by 2015. Furthermore, according to MICS 2014 and DHS 2015 data the immunization coverage for individual vaccines stands above 80% for all the antigens except newly introduced ones like Penta and PCV.

- **Introduction of new vaccines** Achieved

  Zimbabwe successfully applied for assistance from the Global Alliance for Vaccines and Immunization (GAVI) to introduce new vaccines. Pneumococcal vaccines (PCV) was introduced into the national EPI programme in July 2012, Rotavirus and human papilloma virus (HPV) (demonstration) were introduced in 2014. During 2015, the measles-rubella (MR) combined vaccine, measles second dose (MSD), and (IPV) were introduced. The PCV coverage two years post-introduction was measured through the MICS at 71% (3 doses) despite of such result, no evidence of reduced prevalence of ARI is available through survey data, since this was estimated at 6.4% in 2009, and at 5.3% in 2014.

- **Integrated Management of Newborn and Childhood Illness (IMNCI)** Achieved

  Availability of IMNCI services has increased substantially in Zimbabwe. The evaluation notes that by the beginning of 2016, 81.1% of health facilities had at least one health worker trained in IMCI (LSTM Survey 2016) and that 90.6% of facilities had at least 80% of paediatric medicines available (VMHASS Round 26). Due to operational challenges in implementing IMNCI particularly due to the costs of training, the MOHCC has piloted IMNCI distance learning in two districts with the plan to roll out nationally during the year 2016.

A full summary of the progress against indicators for Outcome 1.3. is provided in Table 10 overleaf.

Table 10 - HTF Indicators for Outcome 1.3: Progress from baseline and against defined targets

Outcome 1.3 Improve Child Health Through Strengthening the EPI and Integrated Management of Newborn and Childhood Illnesses							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.3.1. Proportion of infants fully immunised	**64.5%**	*DHS 2010/11*	**73.0%**	*DHS 2015*	**90%**	**9%**	**-17%**
1.3.2. Pneumococcal and Rota Virus vaccines included in the national EPI program implementation	-	*N/A*	**Achieved**	*0%*	**0%**		**100%**
1.3.3.1. Proportion of newborns (0- 28 days old) with sepsis treated with antibiotics	**11.0%**	*NIHFA-2011*	**N/A**	*N/A*	**60%**	***N/A***	***N/A***
1.3.3.2. Proportion of children under five years with pneumonia treated with antibiotics	**16.0%**	*MIMS 2009*	**34.3%**	*MICS 14*	**70%**	**18%**	**-36%**
1.3.3.3. Proportion of children under five years with diarrhoea treated with ORT	**20.9%**	*DHS 2010/11*	**40.5%**	*DHS 2015*	**80%**	**20%**	**-40%**
1.3.3.4. Proportion of eligible HIV positive children under 2 years of age treated with ART	**13.0%**	*Administrative data*	**N/A**	*N/A*	**80%**	***N/A***	***N/A***
1.3.3.5. Proportion of children under five years of age with severe acute malnutrition who received treatment	**25.0%**	*National nutrition survey 2010*	**N/A**	*N/A*	**80%**	***N/A***	***N/A***
1.3.3.6. Proportion of children under five years of age with malaria treated with anti-malarial drug (**)	**13.9%**	*MIMS 2009*	**79.8%**	*MICS 14*	**80%**	**66%**	**0%**

PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.3.1.1. Proportion of infants vaccinated for penta -3	**72.9%**	*DHS 2010/11*	**83.0%**	*DHS 2015*	**90%**	**10%**	**-7%**
13.1.2. Proportion of infants vaccinated for measles	**79.1%**	*DHS 2010/11*	**81.9%**	*DHS 2015*	**90%**	**3%**	**-8%**
1.3.2.1. Proportion of infants vaccinated for pneumococcal vaccine	**0.0%**	*N/A*	**82.2%**	*DHS 2015*	**90%**	**82%**	**-8%**
1.3.3.1. Proportion of health centres having at least one Health Worker trained on IMNCI	**0.0%**	*N/A*	**81.1%**	*LSTM survey 2016*	**80%**	**81%**	**1%**
1.3.3.2. Proportion of health centres with essential medicines for managing common newborn and childhood illnesses (*)	**88.0%**	*VMAHS R 9*	**90.6%**	*VMAHS R 26*	**N/A**	**3%**	***N/A***

(**) Proportion of children with fever tested positive for malaria, who were given ACT

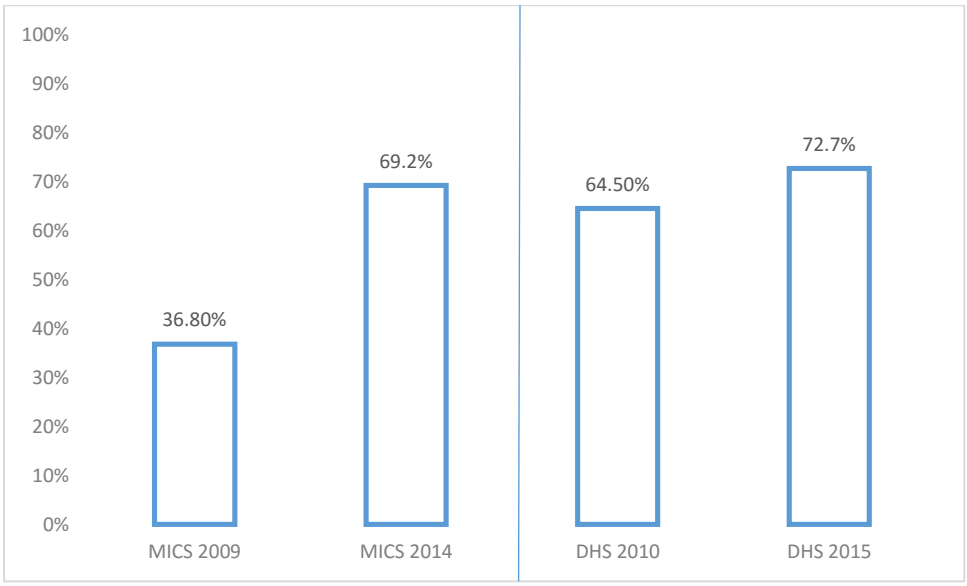
(*) At least 80% of paediatrict medicines available

Progress at outcome level

Improvements in child health is evident in Zimbabwe as the Under-5 mortality rate has reduced from 94 deaths per 1,000 live births in 2009/2010 to 75 deaths per 1,000 live births in 2014 (MICS 2014). DHS 2015 also confirmed similar reduction as it reduced from 84/1,000 LB in 2010 to 69/1,000 LBs in 2015. The improvements in child health have been achieved through immunization, timely access to IMNCI and behavioural change interventions.

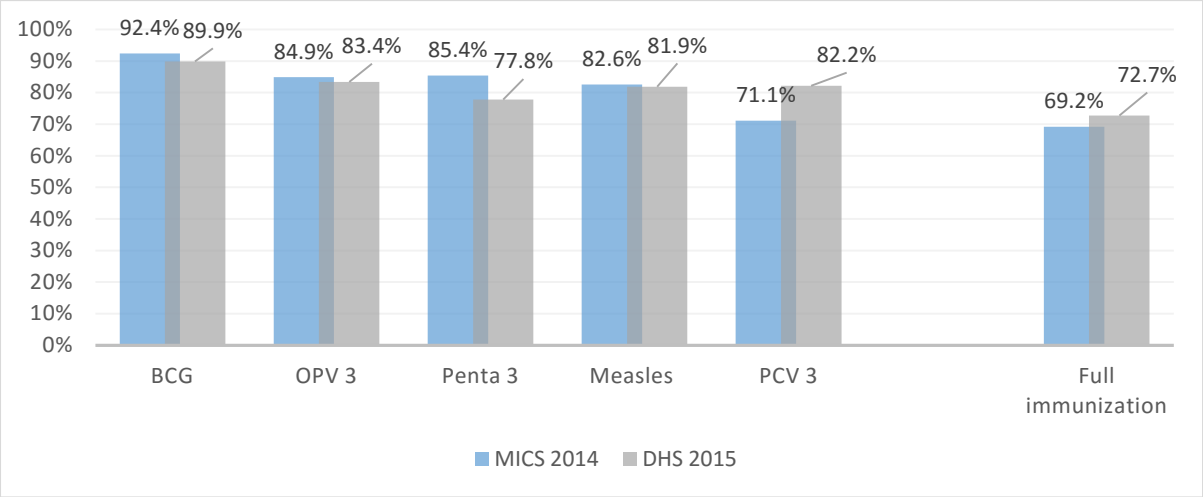
As noted in the LSTM Annual Review 2015, the **immunization** coverage in Zimbabwe has steadily increased since 2009; the percentage of fully immunized 12-23 month old infants has increased from 36.8% to 69.2% in 2013 (MICS 2014) at an average annual rate of change of 6.5 percentage points per year. However, DHS 2015 shows a less optimistic findings as it was 64.5% in 2010 with an annual average rate of 1.64 percentage points per year. In both cases, the HTF target of 90% immunization rate was not achieved by 2015.

Figure 15: Full immunization coverage (2009-2015)



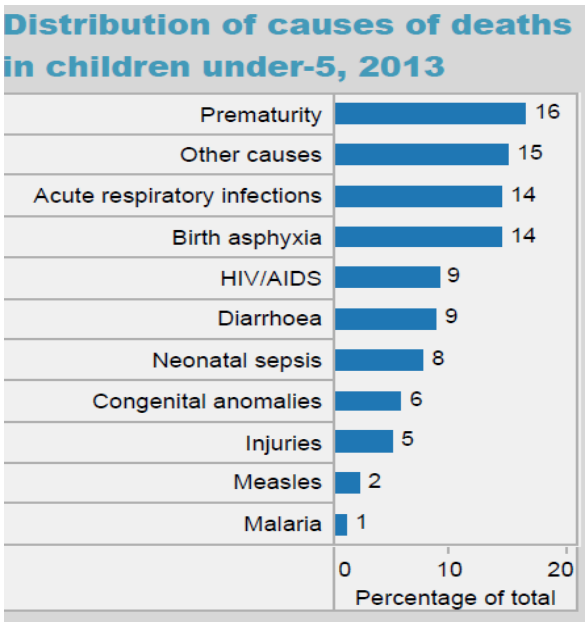
Additionally, it is also worth noting that according to MICS 2014 and DHS 2015 data, the immunization coverage for individual vaccines stands above 80% for all the antigens except the newly introduced vaccines like Penta and PCV (Figure 16).

Figure 16 - Immunization Coverage (Source: MICS, DHS)



In Zimbabwe, ARI, diarrhoea and malaria together account for 25% of under-5 children deaths (Figure 17).

Figure 17 - Distribution of major causes of deaths among children under-5 (Source: WHO 2015)



As noted in the LSTM 2014 Mid-Term Report, "*the prevalence of diarrhoea and of ARI has been relatively stable over the past five years, according to survey data. Surprisingly, the MICS 2014 survey indicates that 27.1% of children had fever during the two weeks preceding the survey, which is inconsistent with prevalence data available through previous surveys; this information needs to be interpreted with caution before drawing conclusions.*"

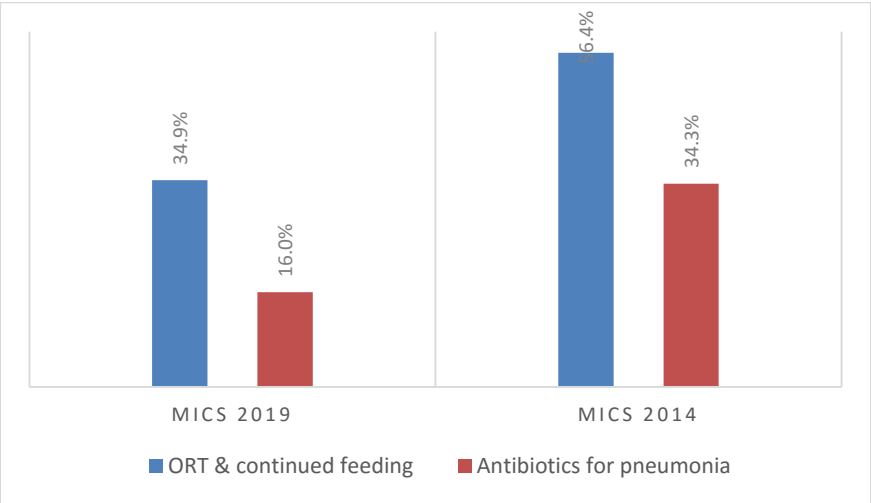
Table 11 - Pattern on prevalence of common childhood illnesses

Prevalence of childhood ilness	MIMS 2009	MICS 2014
Fever	7.7	27.1
Diarrhea	11	15.5
ARI	6.4	5.3

The situation of IMNCI presents a less satisfactory picture. As reported in the LSTM Annual Report 2015, only 56% of children with diarrhoea were treated with oral rehydration therapy (ORT) and 13.8% received ORS and Zinc (MICS 2014). With the observed annual average change of rate of 4.3 percentage points per year from the 2009 coverage, the target of 80% ORT coverage was not achieved by 2014. However, these results do not consider the DHS conducted in 2015.

In relation to treatment of under-5 children with suspected pneumonia, 42% of children under-five with suspected pneumonia were referred to an appropriate healthcare provider in 2009 while 52.7% of children with ARI symptoms were referred in 2014 (MICS 2014). Among those referrals, 16% of children received antibiotics treatment in 2009 while 34.3% received treatment in 2014 (MICS 2014). At the observed annual average rate of change (+3.7 percentage points/year), the target of 70% antibiotics treatment for children with ARI symptoms has not be achieved by 2014. Nevertheless, it will be interesting to observe the results from the DHS 2015.

Figure 18 - Access to treatment for ARI and Diarrhoea (Source: MICS 2014)



With regard to fever, the LSTM evaluation notes that 79.8% of children who tested positive for malaria received artemisinin-based combination therapies (ACT) according to MICS 2014.

Progress at output level

IMMUNIZATION

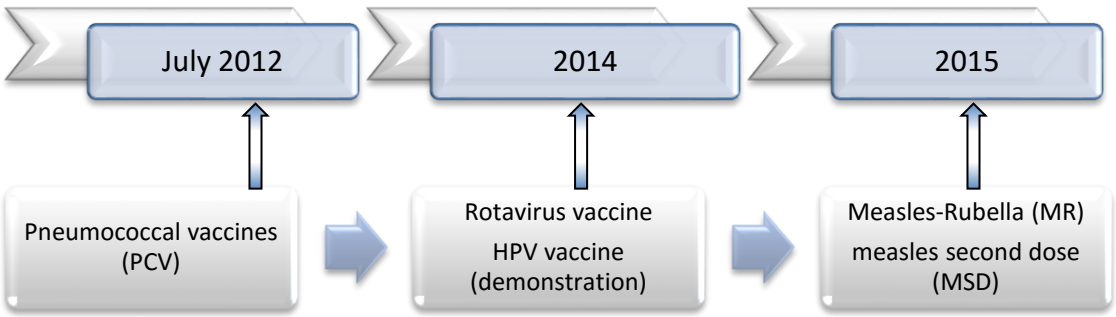
One major preventive child health activity supported by the HTF was immunization. The support has been focused on two key areas: introducing new vaccines as part of the routine immunization services and strengthening the existing immunization services.

Introduction of new vaccines

The MOHCC has strengthened the implementation of the Expanded Programme on Immunization (EPI) with financial support mainly from GAVI and HTF programmes. The introduction of new vaccines has entailed a dramatic paradigm shift in immunization programmes in developing countries, since these vaccines require a much higher capacity in terms of volumes; higher costs per dose (although in the short term these are heavily subsidized); and reaching new target/age groups.

As described under Outcome 1.3, Zimbabwe has introduced the new vaccines listed in the table below with support from HTF and GAVI.

Figure 19 - Introduction of new vaccines as part of the routine immunization services



The HTF has supported sensitization workshops to introduce new vaccines and to plan the revision of vaccination schedules in Zimbabwe. Particularly, HTF supported two sensitization workshops, which aimed at introducing the IPV to Zimbabwe in 2015. The Strategic Advisory Group of Experts on Immunization (SAGE) has recommended the introduction of IPV in all oral polio vaccines (OPV) using countries across the world by the end of 2015.

Additionally, the SAGE recommended achieving >95% vaccination coverage in all districts with two doses of measles- and rubella-containing vaccines to achieve and maintain high levels of herd immunity. Hence, HTF and GAVI supported the MR 2015 supplemental immunization activity (SIA) with the aim to achieve three interrelated objectives: 1) to eliminate measles; 2) to introduce the measles second dose and the rubella vaccines into the routine programme of immunization, 3) and to provide Vitamin A supplementation. According to the HTF Annual Report 2016, the MR-2015 SIA campaign was conducted in September 2015 and obtained very good coverage at all vaccination points, which resulted in achievement of the targeted numbers in all Provinces. The coverage of the PCV vaccine (3 doses) has quickly reached high levels upon its introduction in 2012 and is estimated at 71% in 2014 (MICS 2014) and 82.2% in 2015 (DHS 2015). Additionally, the coverage of

Rota-2 has reached 49.5% in 2015 (DHS 2015). Similarly, the coverage of MR vaccines for 9 months to <15 years of age stands at 97% nationally in 2015 (HTF Annual Report 2016).

Routine Immunization

In addition to introducing new vaccines, HTF has supported routine EPI programme through three strategic areas: coordinating EPI activities, capacitating health workers on EPI and supporting the EPI outreach programme.

HTF has supported **coordination activities** led by the EPI Unit from the MOHCC in collaboration with key stakeholders. Specifically, HTF has supported sensitization workshops to introduce the above mentioned new vaccines. The HTF also supported **capacity building of health workers on EPI**, using the "Reach Every District" (RED) approach as the platform for planning, delivering and monitoring effective immunization services. This was complemented by targeted training of both new health workers who joined the system and poorly performing districts.

Additionally, HTF invested in **supporting the outreach programme**. HTF has provided logistical and financial support to 2944 EPI outreach centres across Zimbabwe (HTF Annual Report 2016). However, some health facilities had challenges in conducting outreach services particularly in the last year of implementation. Hence, only 55% of the 29 Primary Health Care facilities visited by the Joint Review Mission (JRM) team were able to conduct outreach activities (HTF Annual Report 2016).

This finding is also reflected in interviews with key stakeholders during the LSTM qualitative evaluation in February 2016. Informants reported that some EPI outreach activities have been on hold as they did not receive regular funding. The majority of the respondents participating in the evaluation perceived that there has been **improvements in EPI coverage** and that main reasons for these include support from other key implementing partners such as GAVI; a functioning procurement system; appropriate cold chain management; HTF providing health sector support rather than vertical project support; and effective outreach services including follow up within the communities (Box 6, Quote 1 and 2). However, some districts commented on the gaps such as regularity of services, strengthening monitoring and evaluation mechanisms (for data verification), improving community participation, and distances for outreach activities (Box 6, Quotes 3 and 4).

Box 6. Illustrative quotes for "child health-EPI"

Quote 1: "…it's the strengthening of the whole coaching system, procurement, consistent procurement of vaccines. All of them are bought through the HTF, the basic vaccines, the newer vaccines they are contributed to by GAVI with a co-financing by the government." (KII respondent 18)

Quote 2: "… [EPI] this also goes back the HTF supports, the programme in the health sector in this county, which is the health system programmatic support as opposed to project support." (KII respondent 28)

Quote 3: "We have to do data verification. We have to do quarterly supervision, it is the HTF vehicle, and we also have to do follow up on EPI verification. We realize because of the vehicle being overburdened the vehicle goes off the road for about 3 to 4 weeks. We are planning to increase community participation remember primary and health care approach, is talking about community participation, where the community will be participating even in the provision of resources using the RBF approach." (KII respondent 22)

Quote 4: "One has to travel very far away to render EPI services. Sometimes nurses spent the whole day only to serve two sites...Nurses come back to the clinic very late without having lunch." (KII respondent 1)

By the time of drafting this final evaluation, there was no population based information later than the MICS (2014). Hence, we have checked the routine HMIS information covering the period 2011-2015 provided by the MOHCC (Figure 17). Interestingly, there is no significant improvement in the total number of children receiving the traditional vaccines apart from the two new vaccines; pneumococcal and rotavirus, as they were introduced in 2012 and 2014 respectively (Figure 17).

Figure 20 - Routine immunization of children under-5

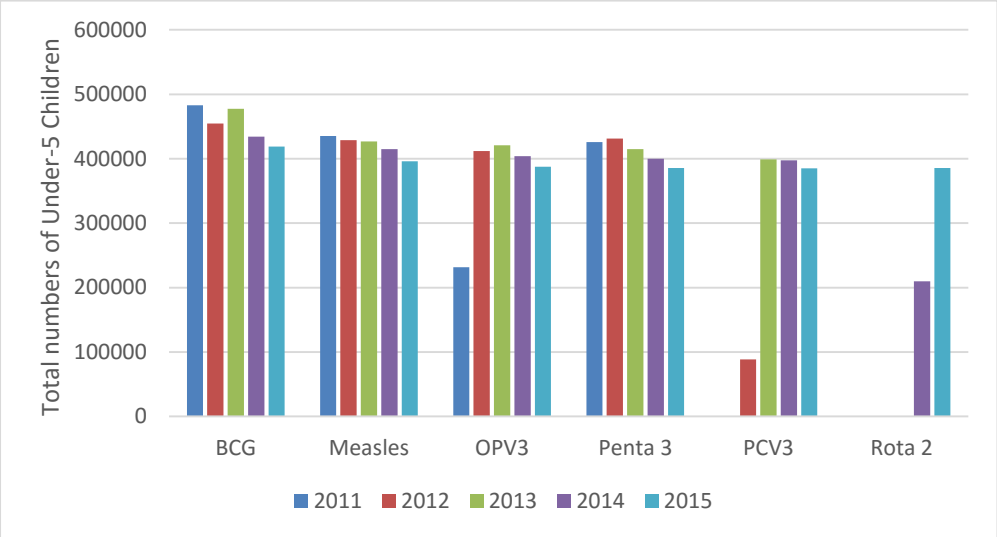
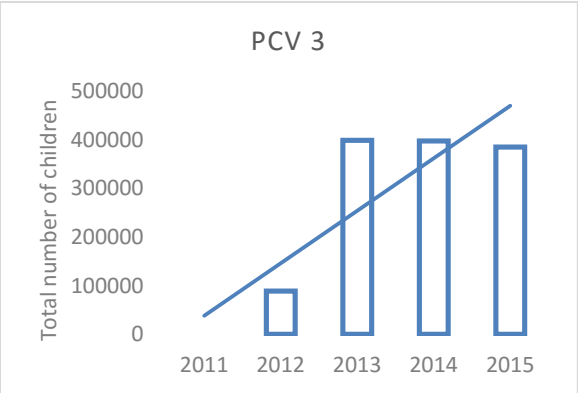
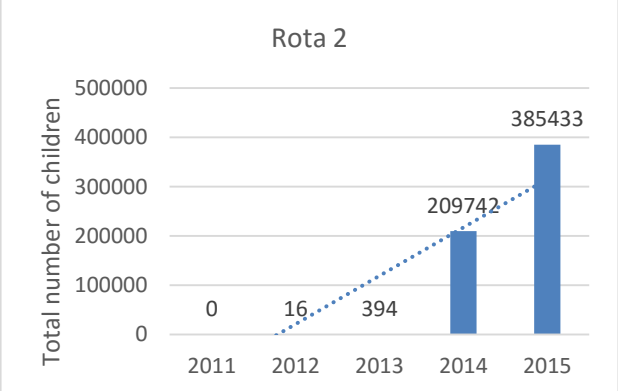


Figure 21 - Uptake of two new vaccines (Source: HMIS)





Echoing our qualitative findings from interviews with healthcare providers from the districts, the HTF Annual Report 2016 stated how the EPI programme has encountered some major challenges during the implementation particularly during 2015. These included: tight fiscal space with the inability of Government to meet its co-financing commitments to GAVI; reduced HTF funds flow; global shortage of some key vaccines (BCG and IPV); human resources for health (HRH) shortage for the EPI programme at national level; skills gaps at sub-national level (poor vaccine management at sub-national and service delivery level); and socio-cultural barriers and socio-economic inequities.

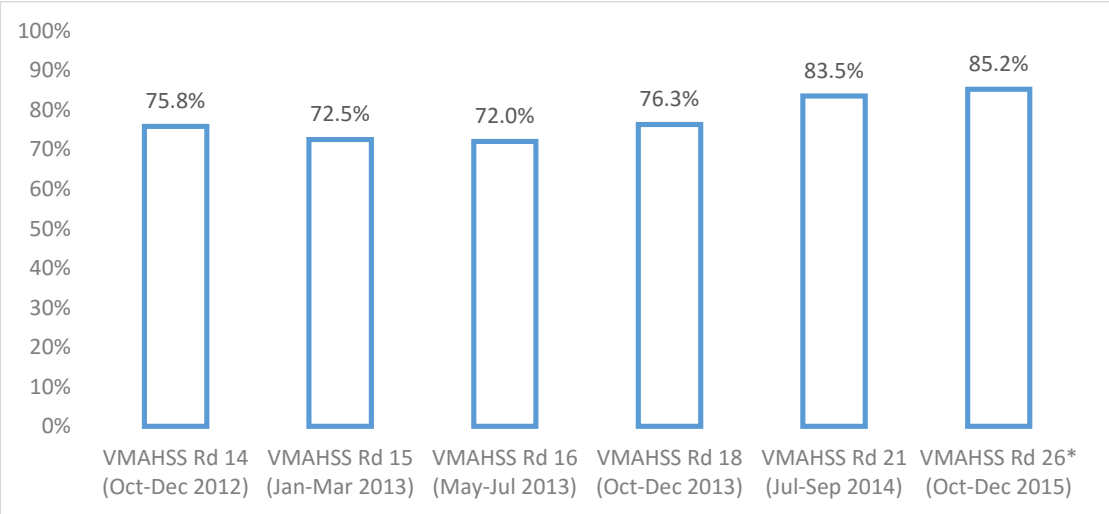
INTEGRATED MANAGEMENT OF NEWBORN AND CHILDHOOD ILLNESSES (IMNCI)

The Integrated Management of Childhood Illnesses (IMCI) was first introduced in Zimbabwe in 1995. The guidelines and protocol were reviewed in 2010 to include neonatal health problems such as resuscitation, management of severe malnutrition, management of malaria including the use of rapid diagnostic test (RDT), and management of paediatric HIV/AIDS including ART.

HTF has supported the scale up of IMNCI, through the training of health workers; improvements in case management skills; and procurement and distribution of essential medicines required for managing IMNCI cases.

As a result, ***the proportion of Level 1 facilities with at least one health worker trained in IMNCI is estimated at 81.1%*** according to the LSTM Survey 2016 (95% CI. 74.0, 88.2). This finding is confirmed by the VMAHSS Round 26, which shows that 85.2% of public health facilities have at least one health worker trained in IMNCI. There has been a gradual improvement from 2013, where the same indicator was estimated at 76.3% (VMAHSS Round 18) and 79.7% (LSTM 2015 survey). According to VMAHSS, availability of rural health facilities with at least one health worker trained in IMNCI has steadily improved with an overall average of more than 80% since 2014 (Figure 19).

Figure 22 - Rural facilities with at least one health worker trained in IMNCI (Sources: VMAHSS)



According to the HTF Annual Report 2016, a total of 19 Paediatric Nurses (15 females and 4 males) from Harare Central Hospital have knowledge and skills in clinical IMNCI. A clinical mentorship team on IMNCI was built consisting one IMNCI Course Director and four IMNCI facilitators creating the platform for introducing emergency triaging and treatment (ETAT) in Harare Central Hospital. An additional 102 health workers were trained on IMNCI in Mashonaland Central, Mashonaland West, Mashonaland East, Midlands and Matabeleland. This was followed up by a pool of 122 IMNCI facilitators averaging 14 in each province. However, there were operational challenges in implementing IMNCI particularly due to the costs of training, which resulted in the inability to sustain the training of large numbers of health workers. Hence, the MOHCC has piloted IMNCI distance learning in two districts, Bindura and Seke, with the plan to roll out nationally during 2016.

The availability of essential paediatric medicines remained stable ***and 90.6% of facilities had at least 80% of selected medicines in stock*** (VMAHSS Round 26).

Outcome 1.4. Strengthen National Capacity for Maternal, Infant and Young Child Nutrition

Summary of key findings

Zimbabwe's food and nutrition situation is classified as "serious" according to the 2014 Global Hunger Index. The country did not reach Millennium Development Goal 1 – halving extreme poverty and hunger by 2015. According to WHO standards, the rate of wasting and underweight among under-5 children are "acceptable" while stunting are classified is "poor".

- **Nutrition policy and strategy** Achieved

  HTF has been instrumental in supporting the improvement of nutrition in Zimbabwe particularly through its nutrition sensitive interventions. These include development of a National Food and Nutrition Security Policy and implementation plan; the costed National Nutrition Strategy; drafting legislation for mandatory food fortification; technical support to the MOHCC for the implementation of the National food fortification strategy; and promoting infant and young child feeding (IYCF) practices using a multi-sectoral approach.

- **Capacity building of facility based health workers on nutrition** Not achieved

  In total, 2610 health workers have been trained in various capacities using revised guidelines under the HTF programme. This has resulted in 71.1% of health facilities having at least one health worker trained in IYCF. However, the number did not achieve the HTF target of 90% of health facilities by 2015.

- **Capacity building of district nutrition manager** Achieved

  According to the LSTM 2016 Survey, 85.9% of districts have at least one trained nutrition manager; this achievement indicates that the country is largely on track to reach its target, set by the HTF at 80%.

- **Capacity building of community based health workers on nutrition** Not achieved

  Only 51% (32) of a total 62 districts in Zimbabwe have VHWs with the required skills to promote appropriate community based infant and young child feeding (c-IYCF) practices. This represents a significant gap in training of VHWs on c-IYCF as only 4800 (35.6%) of the total 13,447 VHWs in country have received c-IYCF counselling services for mothers and care providers. Hence, the HTF target of training 90% of VHWs was not achieved.

- **Ensuring availability of nutritional supplies and micronutrients** Achieved

  96.1% of facilities are providing bi-annual Vitamin A supplementation to children aged 6-59 months while 94.6% provide to mothers within the first 42 days after delivery. The levels of supplies of iron and folic acid (FeFo) are encouraging as 97.1% of assessed health facilities are providing routine iron and folic acid to pregnant women.

- **Monitoring, planning and reporting for nutrition** Not achieved

  73.5% of districts are providing quarterly report on nutrition programme implementation. Hence, the HTF target of 100% reporting was not achieved.

  A full summary of the progress against indicators for Outcome 1.4. is provided in Table 12 overleaf.

Table 12 - HTF Indicators for Outcome 1.4: Progress from baseline and against defined targets

Outcome 1.4. - Strengthen National Capacity for Maternal, Infant and Young Child Nutrition							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.4.1. Availability of national nutrition policy and strategy document	**0.0%**	*N/A*	**100.0%**	*HTF AR16*	**100%**	**100%**	**100%**
1.4.2. Proportion of infants (0-6 months) exclusively breastfed	**31.0%**	*DHS 2010/11*	**48.0%**	*DHS 2015*	**50%**	**17%**	**-2%**
1.4.3. Proportion of infants 6-9 months of age who received timely and appropriate complementary feeding (***)	**82.7%**	*DHS 2010/11*	**90.0%**	*DHS 2015*	**50%**	**7%**	**40%**
1.4.4. Proportion of children 6 - 59 months who received Vitamin-A supplementation twice a year.	**22.6%**	*MIMS 2009*	**32.0%**	*MICS 14*	**90%**	**9%**	**-58%**
1.4.5. Proportion of pregnant women who received Iron /folate supplementation during their current pregnancy	**50.0%**	*DHS 2010/ 11, 27.8% (Nutrition survey 2010*	**NA**	*NA*	**80%**	**N/A**	**N/A**
1.4.6. Proportion of mothers who received Vitamin A supplementation within the first 42 days after delivery	**34.0%**	*MIMS 2009*	**NA**	*NA*	**80%**	**N/A**	**N/A**

PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Endline (2015/16)**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
1.4.1.1. Availability of national food and nutrition policy	**0.0%**	*N/A*	**100.0%**	*Launched May 13*	**Implemented by 2015**	**100%**	**100%**
1.4.1.2. Availability of National Nutrition Strategy	**0.0%**	*N/A*	**100.0%**	*Launched May 13*	**Implemented by 2015**	**100%**	**100%**
1.4.2.1. Availability of IYCF communication strategy	**0.0%**	*N/A*	**100.0%**	*Launched May 15*	**Implemented by 2015**	**100%**	**50%**
1.4.2.2. Proportion of health facilities with at least one health worker trained in IYCF	**N/A**	*N/A*	**71.1%**	*VMHAS R 26*	**90%**	**N/A**	**-19%**
1.4.2.3. Proportion of VHWs with the right skill to promote IYCF	**N/A**	*N/A*	**39.0%**	*HTF annual report 2016 (p-40)*	**90%**	**N/A**	**-51%**
1.4.3.1. Proportion of children less than 3 years of age who have access to growth promotion services.	**N/A**	*N/A*	**N/A**	*N/A*	**80%**	**N/A**	**N/A**
1.4.4.1. Proportion of health facilities providing bi-annual Vitamin A supplementation to children less than five years of age	**20.0%**	*2010 Admin Report*	**96.1%**	*LSTM survey 2016*	**80%**	**76%**	**16%**
1.4.5.1. Proportion of Health facilities that provide Vitamin A supplementation for mothers within the first 42 days after delivery	**25.0%**	*2010 Admin Report*	**94.6%**	*LSTM survey 2016*	**80%**	**70%**	**15%**
1.4.5.2. Proportion of health facilities that provide Iron/FA supplementation to pregnant women	**25.0%**	*2010 Admin Report*	**97.1%**	*LSTM survey 2016*	**80%**	**72%**	**17%**
1.4.6.1.1. Number of district providing quarterly report on nutrition program implementation	**N/A**	*N/A*	**73.5%**	*LSTM survey 2016*	**100%**	**N/A**	**-27%**
1.4.6.1.2. Availability of at least 1 trained nutrition manager at provincial and district level of the health system	**N/A**	*N/A*	**85.9%**	*LSTM survey 2016*	**80%**	**N/A**	**6%**
1.4.6.1.3. Number of districts conducting quarterly supportive supervision on nutrition	**N/A**	*N/A*	**N/A**	*N/A*	**100%**	**N/A**	**N/A**
1.4.6.2. Proportion of nutrition program and project managers with the right skill to planning, management and monitoring nutrition program implementation at all levels	**N/A**	*N/A*	**N/A**	*N/A*	**90%**	**N/A**	**N/A**

(***) Proportion of infants aged 6-9 months breastfeeding and consuming complementary foods

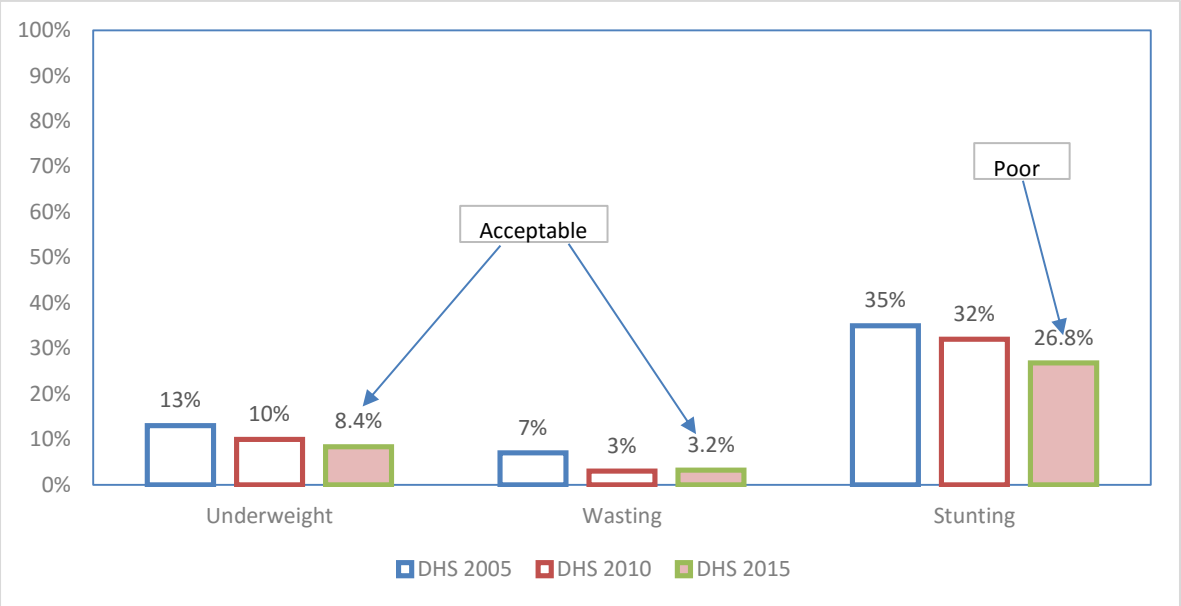
Progress at outcome level

The prevalence of malnutrition in Zimbabwe has reduced since 1999, but remains high. In 2015, the prevalence of chronic stunting has reduced from 32% to 26.8% (DHS 2015). However, according to the WHO standards[5], the improvement in stunting is "poor" (Figure 23).

Similar stagnation was observed for acute malnutrition as wasting deteriorates from 3% in 2010 to 3.2% in 2015 (DHS 2015). There has been some improvement in proportion of underweight as it improved from 10% in 2010 to 8.4% in 2015 (DHS 2015). Using the WHO standard of nutrition, the prevalence of underweight and wasting are classified as "acceptable" (Figure 23).

According to the 2014 Global Hunger Index, Zimbabwe's food and nutrition situation is classified as "serious". The country did not reach Millennium Development Goal 1 – halving extreme poverty and hunger by 2015.[6] The context analysis (covering 2009–2014) conducted by WFP in 2015 estimated that 8.3% of the population (equivalent to 1 million people) were food-insecure.[7] Among them, 38% were chronically food-insecure. Zimbabwean households' access to food is related to poverty, low productivity, inadequate employment opportunities, high food prices, recurrent climate shocks, macroeconomic instability, depressed economic growth, and lack of financial liquidity.[8] Hence, the National Nutrition Strategy (2014-2018) highlighted prevalence of stunting among under-5 children in Zimbabwe as the country's top nutrition challenge.

Figure 23: Status of malnutrition among under-5 children



To promote healthy growth and development of infants and young children, optimal feeding practices are critical within the first 1,000 days (the 1,000 days between a woman's pregnancy and her child's 2nd birthday) window. Evidence suggests that the 1,000 days has a profound impact on infants' ability to grow, learn, and thrive as nutrition provides the essential building blocks for brain development, healthy growth and a strong immune

[5] WHO. 2010. Nutrition Landscape Information System: Country Profile Indicators: Interpretation Guide. Geneva.

[6] Zimbabwe Ministry of Economic Planning and Investment Promotion and the United Nations. 2013. Millennium Development Goals Progress Report. Harare.

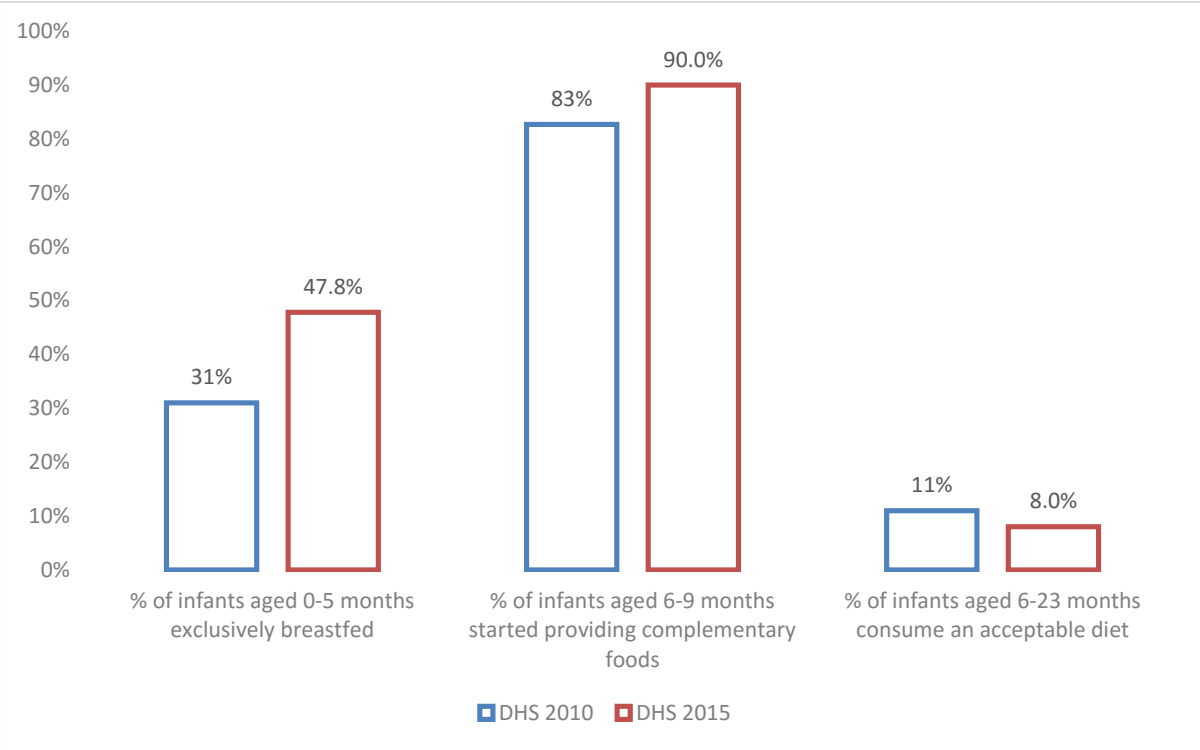
[7] Zimbabwe Country Strategic Plan 2016-2020. World Food Programme. September 2015

[8] Zimbabwe Country Strategic Plan 2016-2020). World Food Programme. September 2015

system. Hence, it is instrumental to promote essential feeding practices such as early initiation of breastfeeding (within one hour of birth), exclusive breastfeeding for the first 6 months of life, and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to two years of age or beyond.

In Zimbabwe, majority of the infants are breastfed but sub-optimal feeding practices are still predominant. For instance, exclusive breastfeeding for infants less than 6 months was 47.8% though the finding shows major progress since 2010 where it was 31% (DHS 2015). Similarly, according to MICS 2014, early initiation of breastfeeding remains only increased slightly in the last five years (51.2% in 2009 to 58.9% in 2014). Regarding complementary feeding, there is slight improvement in timely introducing complementary foods to infants aged 6-9 months as it increases from 83% in 2010 to 90% in 2015. However, proportion of infants aged 6-23 months who received minimum acceptable diet has reduced from 11% in 2010 to 8% in 2015 (DHS 2015).

Figure 24: Breastfeeding and complementary feeding practices



Progress at output level

In order to improve the situation of nutrition in maternal, infant and young children, HTF has provided supports ranging from policy to community level interventions including both nutrition sensitive and nutrition specific interventions.

NUTRITION SENSITIVE INTERVENTIONS

HTF has been instrumental in supporting the improvement of nutrition in Zimbabwe particularly through its nutrition sensitive interventions, which include development of a National Food and Nutrition Security Policy and implementation plan; the costed National Nutrition Strategy; drafting legislation for mandatory food fortification; technical support to the MOHCC for the implementation of the National food fortification strategy; and promoting infant and young child feeding (IYCF) practices using multi-sectoral approach.

The National Food and Nutrition Policy was launched by the President on 16th May 2013 while the **National Nutrition Strategy** was launched at a high profile meeting at Zimbabwe International Trade Fair on 3rd May 2015. This was followed by dissemination at community level with participation of provincial health offices, district nutritionists and community representatives. The current strategy adopted the Scaling Up Nutrition (SUN) common results framework for Zimbabwe providing strategic guidance on how stakeholders can address stunting in a collaborative manner.

Following the results of micronutrient survey conducted in 2012, HTF has initiated a programme for **food fortification with essential micronutrients** to prevent micronutrient deficiencies. This included developing National Standards for fortification of vegetable oils, sugar, wheat flour and maize meal with multiple micronutrients. As a result, draft legislation for mandatory fortification of vegetable oil and sugar with vitamin A and the fortification of wheat flour and maize meal with multiple micronutrients based on the national fortification standards of 2014, has been submitted to the Attorney General's Office for legal promulgation. During the year 2015, a total of three oil industries, two sugar industries and five out of 32 grain millers were mentored and guided to start voluntary food fortification in Harare, Bulawayo, Gweru, Chiredzi and Chinhoyi. On the other hand, advocacy efforts resulted in a high level launch of the National Food fortification by the Minister of Health and Child Care.

Among strategies to improve nutrition, HTF has supported developing **a communication strategy for IYCF** with the aim to remove socio-cultural barriers inhibiting healthy infant and young child feeding practices. This includes developing a National Nutrition Communication Strategy engaging national and sub-national level key stakeholders in partnership with the MOHCC. The strategy was initiated in 2015 with intensified efforts to improve the update of fortified foods; door to door campaigns to promote work place breastfeeding; and age appropriate feeding practices.

According to the HTF Annual Report 2016, the private sector has been invited to get involved in promotion of breastfeeding in the work place. The promotion was conducted during the World Breastfeeding week showcasing a lactating room at Larfarge Company, one of the biggest cement manufacturing company. The

advocacy effort has resulted in the establishment of the lactation room at Lafarge demonstrating public-private partnership in nutrition.

NUTRITION SPECIFIC INTERVENTIONS

Nutrition specific interventions supported by the HTF include capacity building of health workers and programme managers (national, facility and community based), ensuring the availability of nutritional supplies and essential micronutrients, as well as the monitoring and evaluation of the interventions.

Capacity building of facility-based health workers on nutrition

HTF has supported the update of guidelines and training materials on National Infant and Young Child Feeding practices to ensure they are in line with global protocols and guidelines. These include Baby Friendly Hospital Initiatives (BFHI), HIV guidelines, integrated IYCF guidelines and the first Zimbabwe IYCF on the job training guide. The revised training guidelines were used in training of different levels of health workers across the country.

In total, by the end of 2015, **71.1% of health facilities had at least one health workers trained in IYCF** while 45.2% of the hospitals had carried out the BFHI training (VMAHSSS Round 26).
A total of 2610 healthcare providers were trained as part of the Integrated Management of Acute Malnutrition (IMAM) training programme to improve facility management of acute malnutrition (HTF Annual Report 2016). According to the same report, 92% of targeted facilities are providing community based management of acute malnutrition (CMAM) treatment while 90% of targeted facilities have at least one health worker trained in CMAM treatment. VMAHSS Round 26 reports that a total of 2782 health workers have been trained in CMAM. As a result, 54% (18167) of the targeted 33,340 severely acute malnourished (SAM) children aged 6-59 months have been treated.

Capacity building of nutrition programme managers

HTF has supported the capacity building of provincial and district nutrition managers in planning, management and monitoring of nutrition programmes at different levels of implementation. According to the HTF Annual Report 2016, total 68 district mentors (district nutritionists and community nurses) and 8 provincial managers received training on monitoring framework for the National Nutrition programme in line with the National Nutrition Strategy in 2015. Hence, 90% (n=56) of the total 62 districts has an assigned district nutritionist (HTF Annual Report 2016). This was an improvement from 46 districts in 2014 to 56 in 2015. Similar findings were observed by the LSTM 2016 Survey showing that **85.9%** (95% CI= 81.1,90.7)**of districts have at least one trained nutrition manager**. This showed improvement since the last LSTM survey 2015 where it was 77.9% (95% CI= 72.1,83.6). However, the increase was not statistically significant as there was only 4.7% difference (95% CI=-13.4,22.7).

Capacity building of community based health workers on nutrition

To successfully implement a nutrition programme, the involvement of communities is an essential component due to socio-cultural and personal beliefs influencing feeding practices for infants and young children. However, only 51% (32) of the 62 districts in Zimbabwe have VHWs with the required skills to promote appropriate c-IYCF practices (HTF Annual Report 2016). This represents a significant gap in training of VHWs on c-IYCF as only 4800 (35.6%) of the total 13,447 VHWs in country have received c-IYCF counselling services for mothers and care providers.

Additionally, HTF has supported training for nutrition programme planning, implementation, monitoring and evaluation at the lowest administrative level in Zimbabwe. According to the HTF Annual Report 2016, during

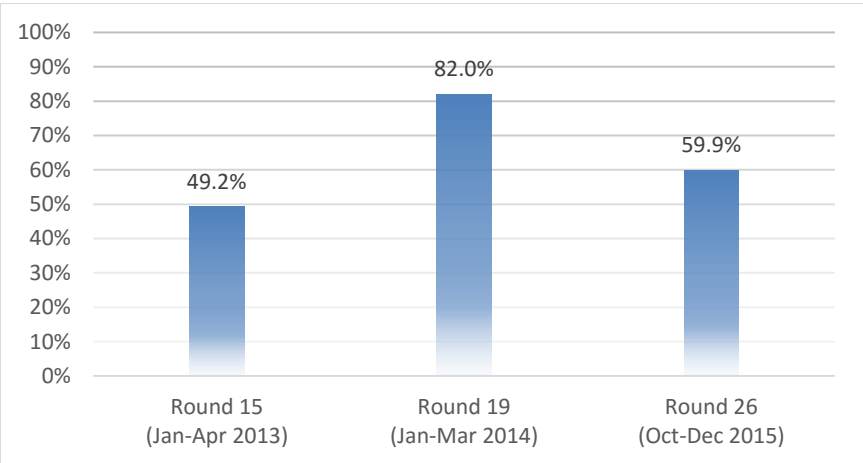
2015, the country has established Ward Food and Nutrition Security Committees (WFNSCs) in 109 out of a targeted 120 districts. Over 1000 government officers (agriculture extension officers, environmental health technicians, community nurses, councillors, school health masters, youth and women and gender development officers) out of a targeted 1100 from four highly vulnerable districts were trained with critical skills for assessing context specific drivers of stunting, developing action plans to address stunting, monitoring and evaluation of key food and nutrition security indicators. Ward level action plans have been developed and initial implementation for stunting prevention interventions have started with the target to reach 64,000 children under-2 years in the four target districts.

Ensuring availability of nutritional supplies and essential micronutrients

For facility management of malnutrition, the availability of nutritional supplies and essential micronutrients are important to ensure an effective nutrition programme. These include nutritional supplies such as Ready to Use Therapeutic Food (RUTF) to treat SAM and micronutrients, which are essential to prevent the nutritional deficiencies among mothers, infants and young children.

The patterns on RUTF availability at health facilities is irregular throughout the HTF implementation period (Figure 21). However, 96% of facilities surveyed in the VMAHSS Round 25 reported of 90% availability of RUTF as of September 2015. According to HTF Annual Report 2016 reported, there were operational challenges due to funding constraints stating that only 54% of the planned RUTF was procured in 2015. Hence, only half of the CMAM facilities (59.9%) surveyed by the VMAHSS in Round 26 reported to have RUTF in stock on the day of the survey while 42.7% of the facilities had stock out of RUTF in the third quarter of 2015.

Figure 25 - Availability of RUTF at CMAM sites (Source: VMAHSS Reports)



These findings corresponded with results from interviews with healthcare providers at district and facility level. They reported that at times, they faced shortage in the supply of Plumpy Nut and thus had to refer malnourished children to another level of care (Box 7, Quote 1). Other challenges included the failure of school gardens due to unfavourable weather; failure in attempt to provide real time information on nutrition through HMIS due to timeliness of the HMIS information; and failure to train adequate numbers of VHWs for community IYCF (Box 7, Quotes 2, 3 and 4).

Box 7. Illustrative quotes for "child health-nutrition"

Quote 1: "As for the plumpy- nut we have some hick-ups there are some interactions it's not always available. This other month it's there 3 weeks we don't have it. If the plumpy nut is not there the babies still starving and we end up referring that baby to the hospital." (KII respondent 13)

Quote 2: "…school gardens were gone, well they had to try it as well, yeah. Because of draught otherwise we had a very good programme that with the FTU that is looking at village level gardens, community level, yah, but a draught is a draught." (KII respondent 18)

Quote 3: "Because the thing about the health information system (and nutrition), the health information system is a slow system, you get to the results maybe after 4 months or the most if you are lucky you can get a monthly report" (KII respondent 18)

Quote 4: "There is staff but they have not gone under such a training, there is a lot to learn in IYCF not only to know about but you have to breast feed exclusively up to 6 months and continue breast feeding up to 3 years even include the skills that you should use when counselling a mother such that is covered in training." (KII respondent 4)

In terms of essential micronutrients, HTF has been supporting the procurement of supplies of Vitamin A, Iron and Folic Acid. The WHO guidelines on Vitamin A Supplementation in postpartum women from 2011 encourage adequate dietary intake of Vitamin A by pregnant and postpartum women. Therefore, preventive Vitamin A supplementation in pregnant and postpartum women is no longer recommended.[9],[10]

Based upon these revised guidelines, Vitamin A supplementation in Zimbabwe was given only to children aged 6-59 months and its provision to postpartum women after 2014 was discontinued.

The HTF has supported the availability of Vitamin A in health facilities and VMAHSS Round 26 reported that 95.7% of assessed facilities have Vitamin A in stock. The LTSM 2016 survey showed similar results as **Vitamin A was available in 92.1% of district level facilities and in 91.8% of Level 1 facilities**. In regard to provision, **96.1%** (95%CI= 93.1,99.0) **of facilities are providing bi-annual Vitamin A supplementation to children aged 6-59 months**, while **94.6%** (95% CI= 91.5,97.6) **provide it to mothers within the first 42 days after delivery**.

In terms of national coverage, routine data indicates that 45% of children aged 6-59 months (816,629 out of a total 1,817,635) received one dose of Vitamin A during 2014 (HTF Annual Report 2016). Among those 45% children, 89% (1,621,571 out of 1,817,635) received 2nd dose of Vitamin supplements during the year 2015.

Another essential micronutrients supported by the HTF is iron and folic acid to pregnant women. The results of LTSM 2016 survey showed that supplies of iron and folic acid (FeFo) are available, with **97.1% of the facilities surveyed providing routine iron and folic acid to pregnant women**.

Monitoring, planning and reporting for nutrition

Finally, HTF has been supporting monitoring and evaluation of nutrition programme interventions. In order to assess the results of interventions, it is essential to utilise the most accurate sources of information for programme planning and implementation. To this end, HTF has provided support to strengthen reporting on

[9] WHO. Guideline: Vitamin A supplementation in postpartum women. World Health Organization, 2011. http://apps.who.int/iris/bitstream/10665/44623/1/9789241501774_eng.pdf

[10] WHO. Guideline: Vitamin D supplementation in pregnant women. Geneva, World Health Organization, 2012. http://apps.who.int/iris/bitstream/10665/85313/1/9789241504935_eng.pdf?ua=1

nutrition programme implementation at district level. The LTSM 2016 survey shows that **73.5% of districts are providing quarterly reports on nutrition programme implementation.**

Theme 2: Medical Products, Vaccines and Technologies (Medicines)

Medicines, supplies and commodities is one of the six building blocks of a health system. HTF has supported this building block through procurement and capacity building. Procurement efforts included: selected essential medicines and medical supplies; blood coupons to ensure availability of blood for pregnancy-related conditions; vaccines, injection materials and cold chain equipment for immunization; emergency obstetric care equipment and newborn care supplies; ready to use therapeutic foods (RUTF) and supplementary nutrition commodities.

HTF has the procurement, storage and distribution of the above items, with a goal to maintain their availability at 80%. Procurement was implemented through a PUSH system and by supplying a uniform Primary Healthcare Package to ensure availability of essential medicines. This also helped to ensure that basic medicines are available at clinic level. This also has formed a platform for other programmes within the Primary Healthcare System of Zimbabwe.

Hence, Theme 2 constitutes the support of HTF in the area of health products, vaccines and technologies through the following five pillars:

1. The supply of a standardized package of essential health products, Primary Health Care Package, to around 1,400 Level 1 health facilities
2. The supply of bulk essential health products to i) Level 1 health facilities ii) Health District Pharmacies and iii) Manicaland's health facilities (via ZAPS)
3. The issue and distribution of blood coupons
4. The supply of selected vaccines and related medical supplies to Level 1 health facilities
5. A capital input in cold chain equipment and human resources

Summary of key findings

- Focus areas within Theme 2 are i) the quarterly supply of a pre-packed Primary Health Care Package (PHCP); ii) the supply of selected essential health products bulk health products; iii) the Ready-to-Use Therapeutic Food (RUTF); iv) blood coupons; v) vaccines and injection materials and vi) cold chain equipment (one time investment 2013/2014). During the FY 2012 to FY2014 approximatively 45% of the HTF overall financial support was dedicated to Theme 2; this reduced to 34% in FY2015. This funding is designated principally to support Level 1 health facilities.

- At least 1,400 health facilities received quarterly a Primary Health Care Package (PHCP), which contains between 19 (2012) and 25 (2015) essential medicines and medical supplies. A total number of 67.476 PHCP have been supplied over the years. Although the supply was not always the best practice, this regular distribution resulted in a low level of stock outs for selected medicines and medical supplies.

- Since 2013, the total number of distributed blood coupons has been gone up from 2.000 (FY2013) to 11.000 coupons in FY2015.

- Around 90% (2014 data) of all health facilities receive quarterly boxes of RUTF. Over the years the number of boxes of RUTF distributed went down from 17.530 (FY2012) to 6.802 in FY2015.

- Appropriate forecasting, and timely procurement and distribution resulted in low stock outs of vaccines and rather high immunisation coverages. Pneumococcal vaccines (PCV) was introduced into the national EPI programme in July 2012, Rotavirus and human papilloma virus (HPV) (demonstration) were introduced in 2014. During 2015, the measles-rubella (MR) combined vaccine, measles second dose (MSD), and (IPV) were introduced.

- The cold chain supply infrastructure was strengthened in the course of FY2013 and FY2014) with the installation of a total of 21 cold rooms, measuring between 30m³ and 40m³. Cold rooms were installed both at national as well at provincial levels. 34 selected health districts were equipped with solar photovoltaic powered refrigerators. Finally, 11 technicians were trained in preventive and daily maintenance of cold chain equipment.

A full summary of the progress against indicators for Theme 2 is provided in Table 13 overleaf.

Table 13 - HTF indicators for Theme 2: Progress from baseline against defined targets

THEME 2 - Medical Products, Vaccines and Technologies							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
2.1. Proportion of health facilities with 80 % availability of (the selected package of) medicines and health commodities in the previous year	**90.0%**	*N/A*	**64.7%**	*VMAHSS Rd 26*	**80%**	**-25%**	**-15%**
2.2. Proportion of health facilities with 100% availability of vaccines (antigens), vaccine supplies and cold chain equipment in the previous year	**90.0%**	*N/A*	**N/A**	*N/A*	**100%**	**N/A**	**N/A**

PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
2.1.1.1. Proportion of primary health centers with adequate supply of medicines (selected drugs) and health commodities	**78.9%**	*VMHAS R11*	**67.0%**	*VMAHSS Rd 26*	**80%**	**-12%**	**-13%**
2.1.1.2. Number of months per year when vaccines (EPI program) are available in health centres	**N/A**	*N/A*	**N/A**	*N/A*	**12/12**	***N/A***	***N/A***
2.1.1.3. Stock out rate of vaccines, vaccine supplies and cold chain equipments commodities	**7.8%**	*Stockout VMAHS R 11*	**3.9%**	*VMAHSS Rd 26*	**N/A**	**-4%**	***N/A***
2.1.2.1. Proportion of hospitals with adequate supply of medicines (selected drugs) and health commodities	**N/A**	*N/A*	**N/A**	*N/A*	**N/A**	**N/A**	***N/A***
2.1.2.2. Stock out rate of vaccines, vaccine supplies and cold chain equipments commodities in hospitals	**N/A**	*N/A*	**0.0%**	*N/A*	**0%**	***N/A***	***N/A***
2.1.2.3. Number of months per year when basic equipment (selected list) is available in hospitals	**N/A**	*N/A*	**N/A**	*N/A*	**12/12**	***N/A***	***N/A***
2.1.3. Number of districts with at least 1 person trained in LMIS and rational drug use	**N/A**	*N/A*	**87.2%**	*LSTM Survey 2016*	**48%**	***N/A***	**39%**
2.1.4. Proportion of health facilities providing quarterly report on logistics and supply chain management system of health commodities	**N/A**	*N/A*	**78.9%**	*LSTM Survey 2016*	**80%**	***N/A***	***N/A***

(*) Proxy Indicator: Proportion of Facilities with at least 70% of vaccines available

Progress at outcome level

ESSENTIAL HEALTH PRODUCTS PHCP

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 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 VHMASS, 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 a the decrease in purchased number of kits due to insufficient funding. Data received shows that in FY2015 only **10.136**[11] **PHCP were ordered, against 19.167 in FY2012**[12]**.**

ESSENTIAL HEALTH PRODUCTS - BULK HEALTH PRODUCTS

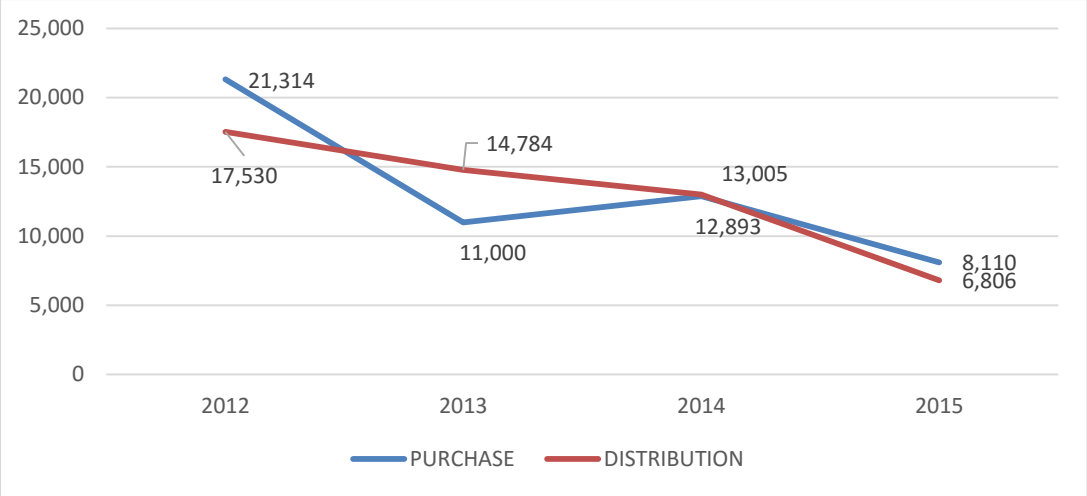
The second pillar of the health products input is the addition of a range of health products to the PHCP, purchased in bulk. These products could be purchased by the health facilities as a topping up of the PHCP to increase quantities received in the PHCP and extend the range of health products. District Health Pharmacies could purchase these health products as well. These bulk stocks were also used for the distribution of health products in the cadre of the ZAPS in Manicaland. From the available data, it is impossible to calculate the values of inputs at the level of facilities.

READY TO USE THERAPEUTIC FOOD (RUTF)

The third pillar of the health products input was the purchase and supply of the RUTF. During the fiscal year FY2012, the distribution had been completed in a parallel supply chain but from FY 2013, the distribution was consolidated with the PHCP. An important number of RUTF has been procured and available procurement data became reliable. However, there was no systematic information on the distribution of RUTF within the available information. As per available data, there was a decreasing pattern of distribution trend since 2012 with a dramatic fall in 2015 due to insufficient funds. The procurement plan indicated the purchase of 15.000[13] RUTF, however, the purchased quantity is 8.110 only.

[11] HTF Year Report 2015
[12] HTF Year Report 2012
[13] HTF Year 2015

Figure 26 - Procurement and distribution of RUTF, 2012-2015



BLOOD COUPONS

The fourth pillar of the HTF thematic area 2 is the availability of "blood coupons". Blood transfusion is one of the nine signal functions for comprehensive emergency obstetric care to avert maternal death. Following the introduction of coupons supported through the HTF in 2013, there has been an increase in the number of hospital providing blood transfusions. Through the HTF, UNICEF procured and distributed blood coupons. According to the HTF Annual Report 2014, 80% of hospitals offered blood and blood products transfusion services. Hence, there has been a significant increase in the issue of the blood coupons (from 2.000 in FY2013 to 11.000 in FY2015). In 2015, a total number of 9.851 (89.5%) blood coupons were distributed and 3.954 patients benefited from the coupons (average of 2.5/woman).[14]

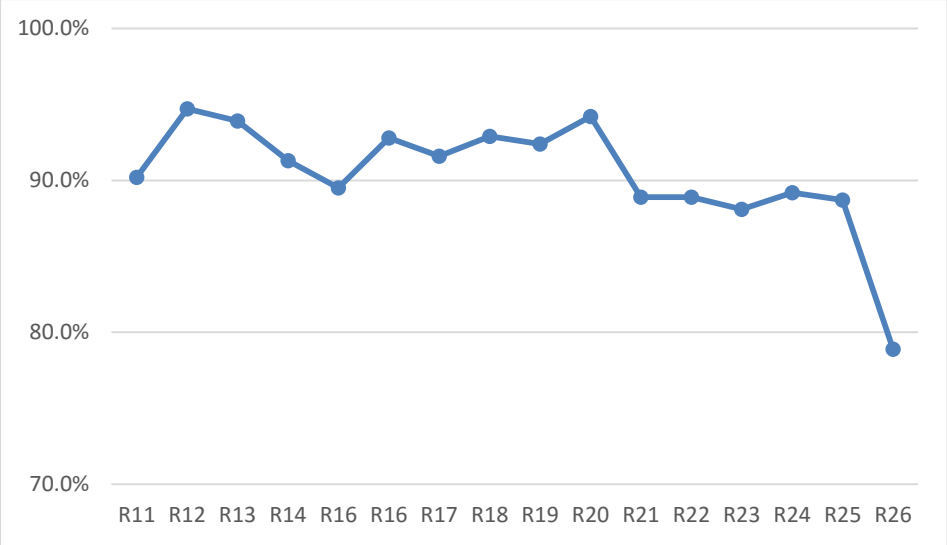
VACCINES AND MEDICAL SUPPLIES

The fifth pillar of the health products is the supply of vaccines and related medical supplies like needles, syringes, safety boxes, among other supplies. The trend in availability of at least 80% of five out of six 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).

As per VHMASS reports, the overall average of availability of vaccines at Level 1 health facilities stands at 90.4%, while the overall availability was higher than average during the period 2012 to mid-2014. There has been decreasing trend in availability since 2014-Q3 R22 as it was below the average with a sharp decline in 2015 Q4 R26 where the real availability is under 80% and 12.3% lower than the average.

[14] HTF Year report 2015

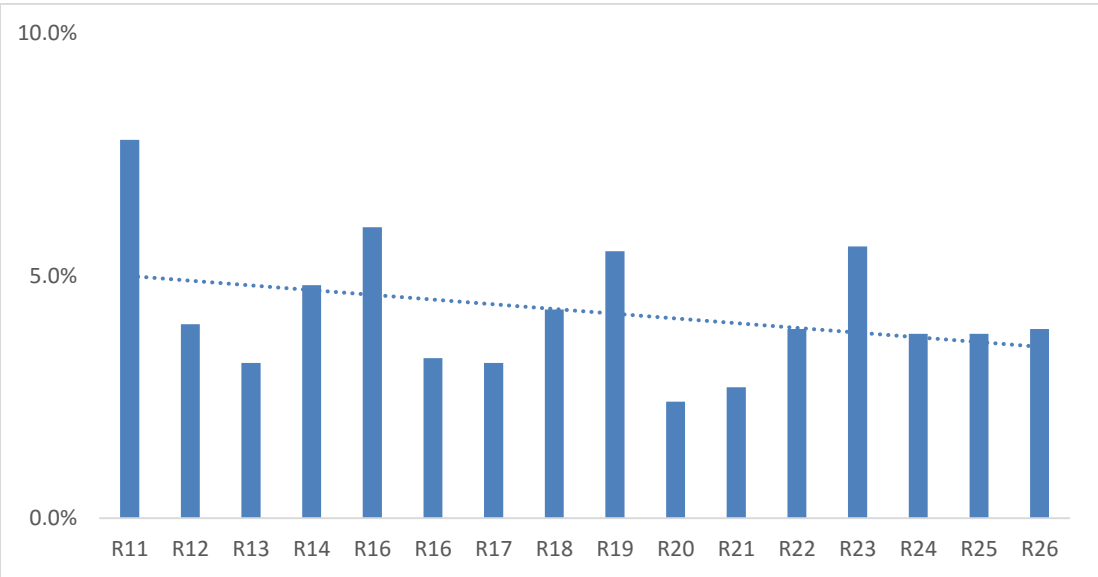
Figure 27 - Availability of vaccines, 2012-2015



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 five periods (R13, R16, R17, R20, R21). Twelve periods are under the average. No reasons were given, nor was any evidence found for these total stock outs.

Figure 28 - Stock out rate of vaccines, 2012-2015



The HTF also disposed a budget for the procurement of vaccine supplies. However, the LSTM evaluation team did not identify any available data concerning the availability of vaccines supplies (syringes, needles, safety boxes, etc.).

Progress at output level

ESSENTIAL HEALTH PRODUCTS PHCP

The LSTM qualitative research highlights that some partners and health facilities reported over stock of some health products and/or frequent stock-outs of others (Box 7, Quote 1). This could be an indication that the kit system is inadequate or should be redesigned to match needs for the basic package of health products in Level 1 facilities. However, it is difficult to get solid evidence for these perceptions except for the Magnesium Sulphate, which was maintained in the PHCP (FY2013-FY2015) and this medicine is no longer used in Zimbabwe. Despite the results from spot-checks of pharmacies at health facilities, key informant interviews and health facility assessment implying that that there are difficulties in permanent availability of the PHCP health products, no evidence is found for significant amounts of overstocks or long lasting out-stocks. Hence, the evaluation predicts that there should be some communication gap among different levels of the health system. Health facilities were not aware about the availability of PHCP at the NatPharm store; whether there have been PHCP ordered or not; whether they were enough budget to procure, etc. As a consequence, health facilities could not predict the availability and allocate their funds to purchase the missing items in time.

Since 2013, there has been a stable supply of PHCP to Level 1 facilities with a peak in 2014 where a total of 20,523 PHCP were supplied. This is particularly high since the around 2,200 of these PHCP were redistributed to other regions because Manicaland was moved from the PHCP system to the ZAPS. A possible reason for the sharp decline in 2015 could be due to lack of funding from HTF stakeholders. The LSTM evaluation data collection in February 2016 confirmed this assumption: health facility respondents argued that during the second half of 2015, PHCP came late and in different numbers of what health facilities used to receive before. Ever since the distribution cycle of 2015 Q4, no PHCP had been received yet and it was not known when the next distribution was expected.

PHCP were purchased by UNICEF and delivered by DDP to the six NatPharm warehouses (Bulawayo, Chinhoyi, Gweru, Harare, Masvingo, Mutare).

The logistics of the distribution is managed by NatPharm while related warehousing and distribution costs are financed by the HTF.

The availability of the NatPharm services and the guarantee of funds, were crucial conditions for the timely delivery of the PHCP to the Level 1 HF.

Table 14 - Number of PHCP distributed per CMAM regional warehouse, 2015[15]

WAREHOUSE	Q1	Q2	Q3	Q4	TOTAL	%
2012						
BULAWAYO	800	1,026	889	521	3,236	17.6%
CHINHOYI	848	761	410	618	2,637	14.3%
GWERU	626	761	411	437	2,235	12.1%
HARARE	1,607	1,464	1,521	1,342	5,934	32.2%
MASVINGO	730	824	233	403	2,190	11.9%
MUTARE	641	594	677	273	2,185	11.9%
TOTAL	5,252	5,430	4,141	3,594	18,417	
2013						
BULAWAYO	1,093	1,150	947		3,190	17.4%
CHINHOYI	569	648	700		1,917	10.4%
GWERU	752	500	874		2,126	11.6%
HARARE	1,605	1,952	3,050		6,607	36.0%
MASVINGO	622	798	924		2,344	12.8%
MUTARE	712	756	708		2,176	11.9%
TOTAL	5,353	5,804	7,203	0	18,360	
2014						
BULAWAYO	1,188	1,266	1,278	285	4,017	19.6%
CHINHOYI	712	956	480	490	2,638	12.9%
GWERU	846	840	217	377	2,280	11.1%
HARARE	2,870	2,995	997	1,165	8,027	39.1%
MASVINGO	1,060	1,026	337	276	2,699	13.2%
MUTARE	862	ZAPS			862	4.2%
TOTAL	7,538	7,083	3,309	2,593	20,523	
2015						
BULAWAYO	908	597	0	524	2,029	19.9%
CHINHOYI	506	507	0	327	1,340	13.2%
GWERU	460	443	0	298	1,201	11.8%
HARARE	1,540	1,634	0	985	4,159	40.9%
MASVINGO	527	500	0	420	1,447	14.2%
MUTARE	ZAPS				0	0.0%
TOTAL	**3,941**	**3,681**	**0**	**2,554**	**10,176**	

The quantities of health products injected via the PHCP into the Level 1 health facilities have increased considerably over the period 2012 – 2015.

The number of items included in a PHCP has increased from 19 to 25 (+32%), and moreover the dispensing units (the total of packs x pack units = dispensing units) have tripled over the HTF years as presented in the following summary table.

[15] HTF Year reports

Table - 15 Extension of PHCP content

	HEALH PRODUCTS	N. Dispensing Units
2012	19	13,849
2013	20	34,220
2014	24	40,469
2015	25	40,769

The composition of the PHCP has improved significantly over the years.

First because the number of health products included in the PHCP increased from 19 to 25: several health products were cancelled while new were added according to assessed need. Quantities per health product either increased or decreased. This is a positive output since showing that the PSM is based on a flexible and dynamic approach and attempts to better perform to the daily needs.

Table 16 - Evolution of PHCP content[16]

HEALTH PRODUCT	PACK UNIT	2012		2013		2014		2015	
		PACKS	UNITS	PACKS	UNITS	PACKS	UNITS	PACKS	UNITS
AMOXICILLIN SUSP 125MG / 100ML	1			30	30				
AMOXICILLIN TAB 250MG	100					5	500	5	500
AMOXICILLIN TAB 250MG	1,000			3	3,000	5	5,000	5	5,000
BANDAGE 8CMx4M	1			20	20	30	30	30	30
COMPRESS GAUZE 10x10CM	100	3	300	3	300	3	300	3	300
COTTON WOOL 500GR	1	5	5	3	3	3	3	3	3
DOXYCYCLINE TABS 100MG	100					5	500	5	500
ERYTHROMYCIN TAB 250MG	100	12	1,200	5	500	5	500	5	500
FERROUS+FOLIC 60+0.4MG	100	2	200	1	100	1	100	1	100
GLOVES EXAMEN LATEX MEDIUM	100	5	500	7	700	5	500	5	500
HYDROCHLOROTHIANZIDE 25MG	100	17	1,700	10	1,000	10	1,000	10	1,000
MAGNESIUM SULPHATE INJ 500MG	10			1	10	1	10	1	10
METRONIDAZOLE 250MG	1,000	2	2,000			1	1,000	1	1,000
MICONAZOLE NITRATE CREAM 2% 30GR	1	10	10			5	5	5	5
NEEDLE 19G	100	2	200						
NEEDLE 21G	100	1	100	1	100	1	100	1	100
NEEDLE 23G	100	1	100						
ORS SACHET FOR 1 LTR	100	2	200	1	100	1	100	1	100
ORS SACHET FOR 1 LTR + ZINC 20MG TAB	10							30	300
PARACETAMOL SOLUTION 125MG / 60ML	1	25	25	40	40				
PARACETAMOL TAB 100 (125)MG	100					5	500	5	500
PARACETAMOL TAB 500MG	1,000	6	6,000	8	8,000	10	10,000	10	10,000
POVIDONE IODINE SOL 10% 500ML	1	4	4			1	1	1	1

[16] HTF Year Reports; UNICEF; NatPharm

HEALTH PRODUCT	PACK UNIT	2012		2013		2014		2015	
SALBUTAMOL TAB 4MG	1,000	1	1,000						
SULF 100GR + TRIMET 20MG	100			50	5,000	20	2,000	20	2,000
SULF 400GR + TRIMET 80MG	500			30	15,000	36	18,000	36	18,000
SYRINGE DISPOSABLE 5ML	100	1	100	1	100	1	100	1	100
TAPE ADHESIVE 2.5CMx5M	1	5	5	5	5	5	5	5	5
TETRACYCLINE EYE OINTMENT 1% 5GR	1			12	12	15	15	15	15
ZINC TAB 20MG	100	2	200	2	200	2	200	2	200
		19	**13,849**	**20**	**34,220**	**24**	**40,469**	**25**	**40,769**

ESSENTIAL HEALTH PRODUCTS BULK HEALTH PRODUCTS

It is impossible to measure the output level of the bulk health products as information on detailed purchase and delivery data for the different support (Level 1 Health facilities, District Pharmacy, are missing or discontinue over the years.

The imported values, the quantities reported (available for FY2012[17] only) and the fact that during the key informant interviews and field visits it was strongly stated that Level 1 health facilities and district hospital purchased health products at NatPharm. It is clear that this additional package of bulk health products is a strong output of the HTF.

Less visible is the output of the slightly higher presence of essential medicines in Manicaland's Level 1 health facilities once the HTF supported ZAPS system was set-up (FY2014). The ZAPS endline study[18] shows that in the migration phase (from the PHCP push system into the bulk health products pull system) there were similar stock outs for the four surveyed products (Amoxicillin, Doxycyline, Magn/sulphate, Paracetamol). Once the ZAPS system was in place, the stock outs were reduced by 50 to 75% (depending of the health product)

The fact that health facilities can purchase bulk health products at NatPharm (as the PHCP these health products were supplied trough the HTF) or at the private market offer HF the opportunity to fulfil still better their needs. The procurement process can be long due the fact that there should be a tender process, which can eventually result in lower prices but is laborious and time consuming process. Additionally, health facilities were not aware of the stock positions at NatPharm, which it difficult to order efficiently. Purchasing at the private market can be more expensive, have risk of inapt quality though purchase at private market can be more convenient (shorter delivery time, products in stock, etc.) and less time consuming.

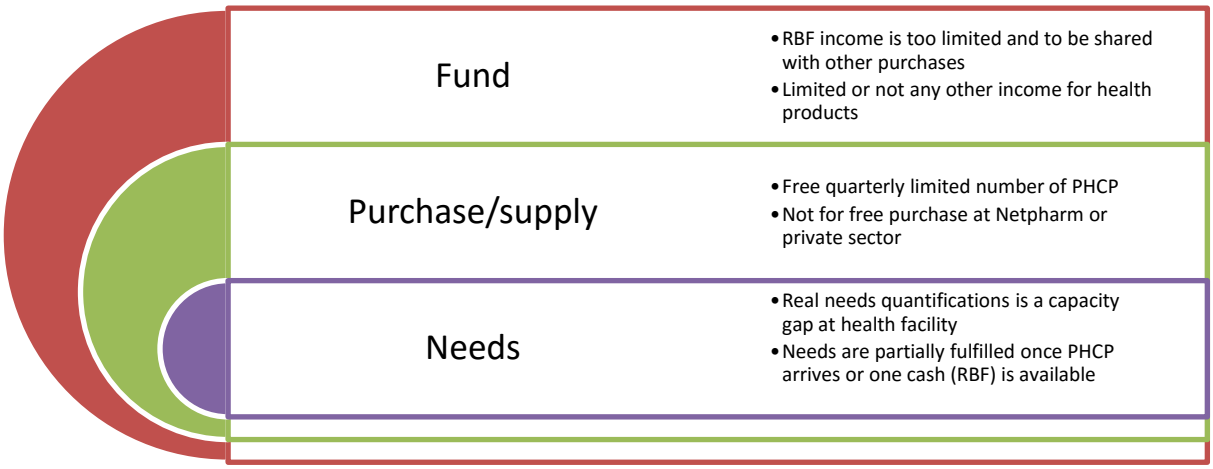
The total purchase value of the bulk health products is erratic over the HTF period and it is somewhat problematic to find the real figures. From the available information it is not evident how these products were allocated at the various levels of the system, In general, the information available is mainly financial and less logistical[19].

[17] HTF Report 2012, the only year report that mentioned the purchased health products and quatities
[18] Evaluation of the Zimbabwe Assisted Pull System – Endline report, Deliver project, 2015
[19] The HTF year report 2012 contains all details but this was considered as too detailed by the HTF steering committee and consequently no longer presented in following year reports

Table 17 - Value of ordered and received bulk health products

	NUMBER ITEMS	ORDERED		RECEIVED	
2012	98	$ 7,108,920	100.0%	$ 5,003,609	100.0%
2013	53	$ 4,900,000	68.9%	$ 3,800,000	75.9%
2014	87	$ 8,300,000	116.8%	$ 6,900,000	137.9%
2015	103	$ 3,703,415	52.1%		

A strict interdependence exists among i) availability of funds at HF's ii) the purchase/supply side (for free PHCP; payable bulk health products) and iii) the health facilities real needs.



As described above, funding shortage resulted in shortage of health products at Level 1 facilities.

Another limitation is that District Hospitals are not associated with the HTF PSM component. Before 2008, Zimbabwe had a well-organized, pull pharmaceutical supply system. The MOHCC decided in 2013 to experiment a similar pull system in Manicaland (Region supplied by NatPharm's Mutare warehouse) where the standard PHCP were replaced by a bulk health product supply consolidated with family planning, TB and Malaria products as well the ARV. The consulted ZAPS information[20] is insufficiently focused on the "essential medicines" to give an opinion if the pull system will considerable reduce the actual PHCP problems.

Over the years NatPharm received institutional HTF support to maintain its Logistic Management Information System (Navision).

RUTF

An important number of RUTF has been purchased by the HTF and distributed by the NatPharm, consolidated with the quarterly PHCP distribution. Although the input is clear (total received number of 52,125 packs), the outcome is less known since the distribution data are not clearly stated in the reports: only the yearly total numbers are available. Distribution data by NatPharm warehouse, health facilities or even the number of served health facilities are not available. Over the years the distributed numbers went down from 17.530 (FY2012) to 6.806 (FY2015). It is not known to which extend the distributed quantities respond to real needs. This is particularly important in the drought-affected regions where severe malnutrition could rise and distribution is

[20] For more details see the ZAPS Baseline and Evaluation reports of the Zimbabwe Assisted Pull system

in a decreasing trend. The available data (principally in the VMAHS) are dissimilar to elaborate a table to show the trends in availability and stock outs.

BLOOD VOUCHERS

The introduction of the blood vouchers has been positive in resolving a number of health problems and has resulted in life saving interventions. However, the table below shows that there are still some issues requiring attention. The number of blood banks and transfusion services now stands at over 70% but this still means that about 25% of the districts have not yet been equipped with infrastructure to provide blood transfusion.

On management of blood products and instant availability of blood more serious problems were identified. Blood bags are available in only half of the blood banks. In practice this implies that only one third of the districts has blood instantly available (50% of 70%).

Table 18 -Availability of services for blood transfusion

Service	*Available on the day of the survey*	*Always available in 2015 quarter 4*
Blood Transfusion available	77.8 (69.0,86.6)	75.6 (66.3,87.8)
Blood Bank	71.5 (62.9,80.0)	67.3 (57.2,77.1)
Blood available in bank	50.3 (41.1,59.5)	45.9 (37.0,54.8)
Fridge for storing blood	80.8 (72.8,88.7)	78.7 (69.6,87.7)
Reagents for grouping and cross matching blood	86.9 (79.9,94.0)	84.7 (77.7,91.6)

VACCINES

EPI vaccines are purchased with support from UNICEF and GAVI. UNICEF channels its efforts via the HTF and the HTF annual plans include a number of activities such as purchase of five vaccines, vaccines medical supplies, among capital investments, and other support activities.

Management of the GAVI contracts is not under the responsibility of the HTF but fully with the MOHCC. However, it seems that contractual activities were slowly implemented, which negatively impacted on the EPI performance and nation-wide coverage. 88.9% of level 1 facilities have vaccination coverage of over 70%. This coverage is confirmed by both the routine EPI program data collection[21] and by the VMAHS reports. Due to this high coverage, no outbreaks of these preventable diseases have reported.

The high vaccination coverage is most probably a direct result of the HTF, since the five vaccines supplied by the HTF (BCG, measles, OPV, DTTP, TT) covers five out of the six vaccines necessary to obtain at least 70%. Only 4% (VMAHS 2014 Q4 R22) of Level 1 health facilities have a total stock out of vaccines. Although there is no explanation about the stock out from available reports, possible assumption could be linked to the 4.4% of Level 1 facilities without refrigerator[22] (LSTM 2015 survey).

[21] HTF 2014 Annual Report
[22] LSTM 2015 Survey

Where the availability of vaccines is monitored and reported, there was no information on the medical supplies associated to the EPI, which has negatively affected the management and reporting of the EPI activities.

The LSTM evaluation team did not identify any information available about stock out rate of vaccines nor stock out rate of vaccine supplies at hospital level.

Furthermore, through the procurement and supply support, HTF provided the following institutional technical assistances to the MOHCC – EPI department:

1. EPI team received technical and logistical support for forecasting, procurement, storage and cold chain management and distribution of vaccines. Key activity was the entire computerizing of the Central Vaccines Store in Harare. The installed computer programme delivers information about characteristics of vaccines, prices of vaccines, needs estimates and projections, receipts of commodities, issues of commodities, distribution figures, temperature monitoring among other functions.
2. Organisation of several sensitisation workshops as one of the steps in the preparation process for new vaccines predicted to be introduced in 2015;
3. Financial and logistic assistance to 2,691 immunization outreach centres over the country. This assistance includes vehicle maintenance, fuel and allowances for staff;
4. Eleven technicians were trained in preventive and daily maintenance of cold chain equipment.

COLD CHAIN INFRASTRUCTURE

Considerable support was given to the re-establishment of the cold chain infrastructure. The HTF 2013 work plan included an investment budget for the purchase and installation of sixteen cold rooms. The HTF 2014 Annual Report stated the installation of a total number of 21 cold-rooms each with a capacity between 30m³ and 40m³. These cold-rooms are installed at the Central Vaccines Stores (Harare), Bulawayo, and all the eight provinces. This major investment in the cold chain infrastructure guaranteed appropriate temperature management and storage conditions for vaccines at proximity of the health facilities.

During 2013, HTF installed and connected 43 solar photovoltaic powered refrigeration systems in health facilities. This activity continued in 2014 with the installation and connection of another 107 solar photovoltaic refrigeration systems. Photovoltaic solar equipment is an important provision to an almost maintenance free power supply and permits a health facility a power source without running costs. It is a highly reliable power source for appropriate vaccines storage in health facilities. The LSTM Survey 2015 and 2016 indicates that around 20% of Zimbabwe's Level 1 health facilities are now powered by solar photovoltaic equipment.

Table 19 - Distribution of sources of power supply in health facilities[23]

Level of care	*Mains*	*Generator*	*Solar*	*Other*	*None*
District level hospitals (n=44)	100%	0	0	0	0
Level 1 facilities (n=110)	67.7% (59.5,75.9)	2.5% (1,5.3)	19.5% (12.8,26.3)	7.0% (2.5,11.5)	3.2% (0.1,6.4)

As well, HTF supported the procurement of 300 tonnes of gas to be used by health facilities for powering gas depending refrigeration systems. The availability of gas will improve the appropriate vaccines storage conditions and decrease out of stock due to absence of appropriate storage conditions. According to the LSTM 2016 Survey,

[23] LSTM survey 2016

more than 95% of all the facilities, regardless of the level of care, had refrigerators for vaccines available on the day of the survey. A very limited number of refrigerators (less than 3%) were not working

Table 20 - Availability and functionality of refrigerator(s) for vaccines[24]

Level of care	*Available (%)*	*Functioning (%)*	*Reason(s) for non-functioning*			
			No Electricity	No Gas	Needs Repair	Other
District level hospitals (n=47)	100	100	-	-	-	-
Level 1 facilities (n=118)	97 (94,99)	96.0 (92.0,99)	0	25 (NE)	100 (NE)	

BASIC EQUIPMENT AT HOSPITAL LEVEL

Concerning the availability of the basic equipment in hospitals, little is known as a selected list of basic equipment is not available. The LSTM Survey 2016 and sought information on the availability of emergency obstetric care related equipment. Results are presented in following tables:

Table 21 - Availability of consumables and other equipment[25]

Category	*District level hospitals (n=47)*		*Level 1 facilities (n=118)*		*Rural Level 1 facilities(n=77)*	
	Available on the day of the survey	**Always available in 2015 Q4**	**Available on the day of the survey**	**Always available in 2015 Q 4**	**Available on the day of the survey**	**Always available in 2015 Q 4**
Syringe for injection	89.4 (82.3,96.4)	82.5 (74.8,90.2)	97.1 (94.2,<100)	98.1 (95.8,<100)	98.6 (96.0,<100)	100
IV giving set	91.7 (91.0,92.4)	97.8 (95.1,<100)	87.0 (82.8,91.3)	94.9 (91.3,98.5)	88.5 (83.0,94.0)	94.8 (90.1,99.6)
IV fluid (Ringer)	84.8 (77.6,92.0)	76.9 (70.1,83.85)	90.2 (84.5,95.8)	89.5 (84.2,94.8)	88.5 (81.3,95.8)	90.0 (83.7,96.4)
IV fluid (NS)	82.2 (74.3,90.1)	72.9 (64.8,81.0)	90.6 (85.0,96.1)	88.8 (83.2,94.4)	89.5 (82.1,96.9)	89.0 (82.0,96.1)
Sterile glove	85.4 (78.8,92.0)	87.8 (82.1,93.4)	76.4 (69.3,83.6)	77.3 (70.8,83.8)	82.3 (73.3,91.3)	85.9 (78.5,93.3)
Elbow length gloves	23.6 (14.9,32.3)	30.3 (20.6,40.1)	15.1 (8.5,21.6)	17.0 (10.1,23.9)	16.9 (8.0,25.7)	20.7 (11.3,30.2)
Suture materials	86.8 (80.7,92.9)	86.7 (80.1,93.2)	80.2 (73.2,87.1)	79.6 (73.0,86.2)	82.3 (73.7,90.9)	83.6 (75.6,91.6)
Fridge for oxytocin	95.8 (91.8,99.9)	95.8 (91.8,99.9)	59.7 (51.0,68.3)	58.5 (49.9,67.1)	56.1 (45.5,66.7)	55.8 (45.2,66.4)

[24] LSTM survey 2016
[25] LSTM survey 2016

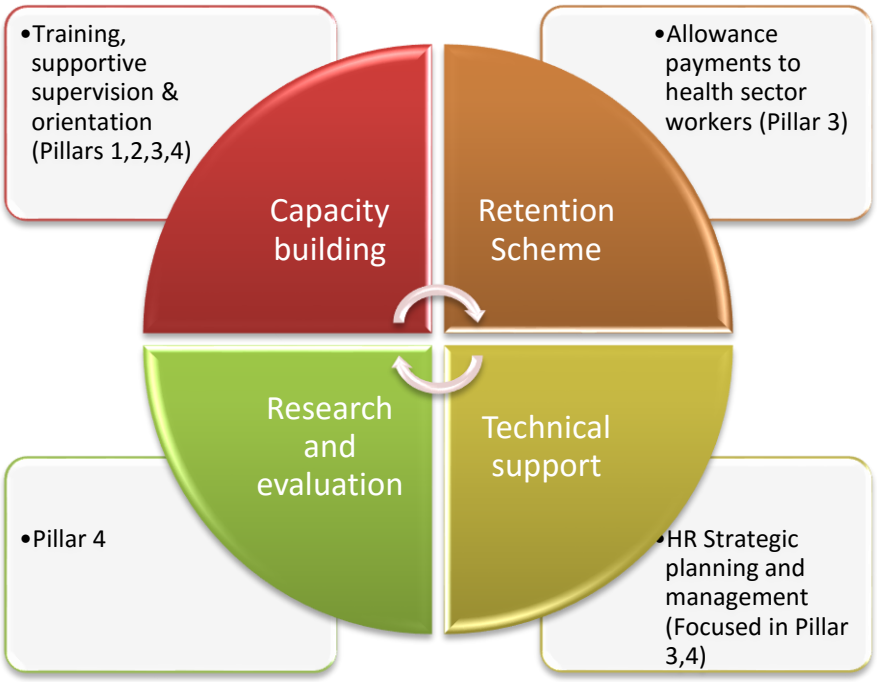
Category	*District level hospitals (n=47)*		*Level 1 facilities (n=118)*		*Rural Level 1 facilities(n=77)*	
Patella hammer	67.0 (57.9,76.1)	69.4 (60.6,78.2)	19.6 (13.0,26.2)	21.1 (14.2,27.9)	9.9 (3.7,16.1)	12.0 (5.2,18.8)
BP machine	100	97.4 (94.6,<100)	98.6 (96.6,<100)	96.8 (93.8,99.9)	97.9 (95.0,<100)	95.4 (90.9,99.9)
Pinard stetho	100	97.4 (94.6,<100)	97.9 (95.8,<100)	95.4 (92.0,98.8)	98.7 (96.3,<100)	95.1 (90.5,99.8)
Sonicaid/doppler	93.7 (88.7,98.6)	89.0 (82.7,95.3)	31.4 (23.5,39.3)	28.8 (21.0,36.6)	31.8 (21.4,42.2)	30.7 (20.4,40.9)
Ultrasound scan	77.2 (67.5,87.0)	72.5 (64.4,80.6)	1.9 (>0,4.4)	1.1 (>0,3.2)	1.3 (>0,3.7)	100

Theme 3: Human Resources for Health

At stated under the National Health Strategy (2009-2015), one of the key challenges facing the Zimbabwe Health System is to produce, attract and retain adequate numbers and mix of HRH (including Health Worker Management, Training and Retention).

HTF has supported this key pillar of the health system by ensuring appropriate numbers and categories of HRH are available for effective and efficient implementation of the National Health Strategy. The HTF supports the **retention scheme**, which provides salary top-ups and incentives to help reduce clinical and managerial turnover and improve the retention of essential staff nationwide, targeting critical areas and levels. The target is to reduce vacancy rate for doctors from 69% to 20% and the midwifery vacancy rate from 80% to 5%.

Figure 29 - HTF support to human resources for health



Progress achieved in this thematic area is presented below.

Summary of key findings

- **Vacancy rates for doctors** **Not achieved**

The overall vacancy rate among health workers has dropped from 21% in 2012 to 16% in 2015. It was not possible to accurately assess vacancy rates for doctors specifically as there were no data made available for 2015. The data available in the number of doctors receiving the retention allowance since 2012 show that the number of doctors deployed at the district level has increased from 78 in 2012 to 135 in 2015 , an overall increase of 57 (42%) doctors. Of the 47 district level hospitals (government and mission) surveyed through the LSTM Survey 2016, all had at least 1 medical doctor.

- **Vacancy rates for midwives** **Not achieved**

There are no established posts or staffing norms for midwives, which makes it impossible to accurately assess vacancy rates. However data on the numbers of midwives receiving the retention allowance indicate that there were 3,362 practicing midwives in the health sector in 2015, compared to 1,838 midwives in 2012, an increase of 1,525 midwives. In the 47 district level hospitals surveyed through the 2016 LSTM Survey there were 18 State Certified Midwives (SCM) on average available in each facility, while each of the 118 Level 1 facilities surveyed had on average one SCM available.

- **Vacancy rates for nurse anaesthetists** **Not achieved**

It is not possible to accurately assess vacancy rates as there are no established posts or staffing norms for nurse anaesthetists. A review of the available training data revealed that in recent years intakes of the nurse anaesthetist diploma course have increased, but there were no data available to check numbers graduated and deployed in government health facilities. However, of the 47 district level hospitals surveyed during the 2015 LSTM Survey, there was on average 1 Nurse Anaesthetist in each facility, but some facilities did not have any.

- **Number of active midwifery schools graduating at least 25 midwives per year** **Achieved**

In 2014 there were 22 active midwifery schools across the country, exceeding the 2015 target by 2. Some schools had less than 25 midwives enrolled in 2014, however overall enrolment has increased in all the schools, with 743 midwives enrolled in all the schools in 2015.

- **Number of midwives trained per year** **Achieved**

Eight hundred and thirty five (835) midwives graduated in 2015, compared to 521 graduates in 2012. Between 2012 and 2015 a total of 2,943 midwives were trained.

A full summary of the progress against indicators is provided in table 22 overleaf.

Table 22: HTF Indicators for Theme 3: Progress from baseline and against defined targets

Theme 3 - Human Resources for Health							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
3.1. Vacancy rate for Doctors	**69.0%**		**N/A**	*N/A*	**20%**	**N/A**	**N/A**
Vacancy rate for Midwives	**80.0%**		**N/A**	*N/A*	**5%**	**N/A**	**N/A**
Vacancy rate for Nurse anaesthetist			**N/A**	*N/A*	**5%**	***N/A***	***N/A***
PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
3.1.1. Number of active midwifery schools graduating at least 25 midwifes / year	13	HTF logframe	**22**	HTF AR 2016	**20.00**	**9**	**2**
3.1.2. Number of midwives trained per year	N/A	N/A	**835**	MOHCC training report	**N/A**	***N/A***	***N/A***
3.1.2. Vacancy rate for nurse anaesthetist	N/A	N/A	-	*N/A*	**5%**	***N/A***	***N/A***

Progress at outcome level

VACANCY RATES FOR DOCTORS

There were no national data made available to assess the overall vacancy rates for doctors against the establishment in 2015, however the findings of the 2016 LSTM Survey, other secondary data and the key informant interviews conducted in February 2016 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 1 medical doctor available, compared to 96% in the 2015 Survey. Some facilities (34%) had 4 or more doctors, which is an also improvement on the situation in 2015. The 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 when73% were present.

Although some of the doctors are new graduates, many have the skills to perform caesarian sections. For example findings from 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 that was available on the day of the survey and was always available in 2015, and that 95.2% of these facilities had at least one staff member able to give obstetric anaesthesia on the day of the survey.

Table 23 - Facilities performing obstetric surgery and availability of staff

Service available	Available on the day of the survey (95%CI)	Always available in 2015 Quarter 4 (95%CI)
Proportion of facilities with at least one staff trained to perform C/S	97.4 (94.6,<100)	97.4 (94.6,<100)
Proportion of facilities with at least one staff able to give obstetric anaesthesia	95.2 (91.0,99.4)	93.0 (88.2,97.7)

Data from VMAHS Round 26 also indicate improvements in the availability of doctors. It reported that 74% (49) of the fifty-three (53) district hospitals surveyed had at least 3 doctors in post; fifteen (15) hospitals had less than 3 medical doctors. Compared to the situation in March 2012, where PMD reports indicated there were 21 hospitals without any doctor at all, these improvements are very significant.

One doctor described how the arrival of additional doctor in the facility had made a difference for him, the referral system and service delivery (Box 8, Quotes 1 and 2).

Box 8. Illustrative quotes for "Vacancy rates for doctors"

Quote 1: "…the hospital offers caesarean sections but it is a challenge when there is only one doctor….when that doctor is away for a meeting or a workshop all our cases will be referred to the Provincial Hospital' … from May last year a second doctor came on board ….so we are now able to structure and give the other rest while you cover and so on." (KII respondent 15)

Quote 2: "There was a time when some districts didn't have a single doctor but some are now boasting of four doctors, and for me this is improving access to the ordinary populace, including the mothers and their children." (KII respondent 20)

The success in attracting and retaining doctors and the decrease in overall vacancy rates is attributable in part to the provision of retention and other allowances. Retention payroll data provided by Crown Agents indicate that the number of doctors in district hospitals receiving the critical post allowance rose from 78 in 2012 to 135 in 2015. As only 3 doctors per district receive the allowance and as doctors in mission hospitals do not receive the allowance, these figures do not reflect the total number of doctors deployed at the district level. There was an overall increase in the availability doctors in all provinces except Masvingo, however all provinces experienced a drop in numbers between 2014 and 2015, except Mashonaland Central, where numbers continued to rise with an overall increase over the period of 15 doctors.

The distribution of doctors receiving the allowances across the provinces is uneven. As shown in Table 15 below Matabeleland North has almost half the population of Masvingo, yet it has 17 doctors compared to 10 in Masvingo.

Table 24 - Distribution of doctors across provinces based on retention data

Province	Population 2012	Doctors 2015
Manicaland	1,752,698	18
Mashonaland East	1,344,955	20
Mashonaland Central	1,152,520	22
Mashonaland West	1,501,656	17
Masvingo	1,485,090	10
Matabeleland North	749,017	17
Matabeleland South	683,893	12
Midlands	1,614,941	19
Total Population	**10,284,770**	**135**

Source: Crown Agent 2016

VACANCY RATES FOR MIDWIVES

There are no established posts or staffing norms for midwives and other specialist nurses, and these cadres tend to be included in aggregated datasets for the general nursing cadre, which makes it impossible to accurately assess vacancy rates or staffing trends. However data from the 2016 LSTM Survey reveal 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 (See Table 16 below).

Table 25 - Availability of nursing cadres in facilities

Level of care	*State Certified Midwife*	*Registered General Nurse*	*Nurse Anaesthetist*	*Theatre Nurse*	*Primary Care Nurse*	*Student Midwife*	*Student Nurse*
District level hospitals	18.2 (0-57)	38.4 (1-102)	1.1 (0-4)	0.9 (0-4)	6.1 (0-70)	2.9 (0-42)	9.5 (0-100)
Level 1 facilities	1.8 (0-22)	1.4 (0-10)	-	-	1.8 (1-12)	0.01 (0-1)	0.35 (0-8)

Source: LSTM 2016 Survey

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 allowance indicate that the number of practicing midwives increased from 1,838 midwives in 2012 to 3,362 in 2015, with 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.

Most of those interviewed in 2016 reported the increased number of midwives in their facilities is helping to improve the utilisation of services and the quality of the care provided (Box 9, Quotes 1,2 and 3).

Box 9. Illustrative quotes for "Vacancy rates for midwives"

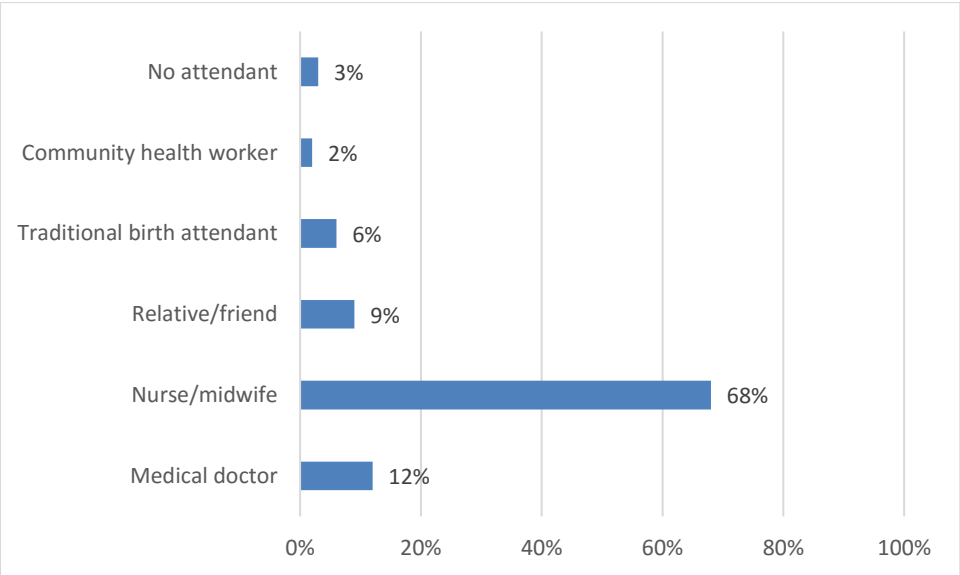
Quote 1: "In terms of quality of care …it has improved from previously because a lot of our nurses have gone for midwifery." (KII respondent 15)

Quote 2: "We have had more nurses going for midwifery training partly because one of the training schools is nearby …we enjoy a good relationship with them, so we have sent a lot of our nurses and sisters to go for training …and when they are undergoing training some of them are actually attached the district hospital here so that they gain experience. The ones that go from our hospital they all come back… they can still work in other departments but at least they are trained and we rotate them." (KII respondent 11)

Quote 3: "In 2012 we used to have 3 midwives, now we have 13 midwives." (KII respondent 15)

There has been a significant increase in skilled birth attendance from 60% (MIMS 2009) up to 80% (MICS 2014). 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.[26] In 2015 Crown Agents also reported increasing numbers of facility-based deliveries attended by skilled health workers, up from 15,900 in Quarter 2, 2014 to 19,504 deliveries in Quarter 1, 2015.[27]

Figure 30 - Person assisting at delivery (MICS 2014)



[26] Multiple Indicator Cluster Survey. Final Report, UNICEF March, 2015
[27] Communication with Crown Agents February 2016

Manicaland had the largest overall increase in the number of practicing midwives, while Mashonaland West had the smallest gain. Midwives who are not practicing and/or not receiving the allowance are not captured in this dataset, and therefore the numbers reflected in the Table below are not indicative of the total number of midwives available in the whole of the country.

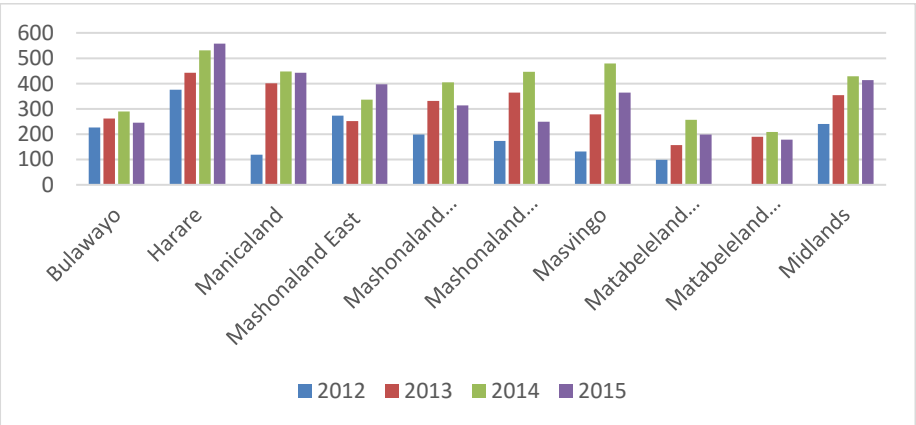
Table 26 - Practising midwives receiving allowances in district level facilities [14]

Province	2012	2013	2014	2015
Bulawayo	226	262	290	246
Harare	376	442	531	558
Manicaland	119	401	448	442
Mashonaland East	273	252	337	397
Mashonaland Central	199	331	405	314
Mashonaland West	173	364	447	249
Masvingo	132	278	479	364
Matabeleland North	99	157	257	199
Matabeleland South	0	190	209	179
Midlands	241	354	429	414
Total	**1838**	**3031**	**3832**	**3362**

Source: Crown Agents[28], February 2016

All provinces show a steady increase in the numbers of practising midwives receiving the retention allowances up to 2014, however between 2014 and 2015 there are 470 less, with the majority (198) of these losses from Mashonaland West. The reason for this fall in numbers is unclear, but should be closely monitored to ensure this is not an emerging attrition problem.

Figure 31 - Numbers of practising midwives (2012-2015)



[28] The data available from Crown Agents on the numbers of midwives receiving the retention allowances under the HTF between 2012 and 2015 as shown above in Table X differed from the numbers provided by UNICEF, which indicated there were 3,941 midwives receiving the allowances in 2015. Attempts to clarify and resolve this discrepancy were unsuccessful.

When the distribution of midwives receiving the allowances is compared to the population of each province the results show a somewhat skewed pattern. For example, as shown in Table 18 below Bulawayo, with a population of just over 650,000 has a greater ratio of midwives per 1000 population than Harare and Midlands, while Mashonaland West has the lowest ratio of midwives per 1000 population.

Table 27 - Ratio of midwives per 1000 population

Province	Population 2012	2012	2013	2014	2015	Ratio MW/per 1000 in 2015
Bulawayo	653,337	226	262	290	246	0.38
Harare	2,123,132	376	442	531	558	0.26
Manicaland	1,752,698	119	401	448	442	0.25
Mashonaland East	1,344,955	273	252	337	397	0.30
Mashonaland Central	1,152,520	199	331	405	314	0.27
Mashonaland West	1,501,656	173	364	447	249	0.17
Masvingo	1,485,090	132	278	479	364	0.25
Matabeleland North	749,017	99	157	257	199	0.27
Matabeleland South	683,893	0	190	209	179	0.26
Midlands	1,614,941	241	354	429	414	0.26
Total Population	**13,061,239**	**1838**	**3031**	**3832**	**3362**	

Training and production data from the midwifery schools show a steady supply of midwives from the 22 training schools from 2012 to 2015, and as most of these are RGNs previously employed in government facilities, the assumption is that they have or will return to their original workplace after training.

Many complained that they are often allocated to other wards in the hospital after their training because there are too many for them all to work in the maternity ward. In a discussion about push and pull factors, a group of trainee midwives interviewed in 2016 indicated that if they were sent to a general ward and not allowed to practice as a midwife after their training, they would leave the country and seek work elsewhere. Another respondent corroborated this, reporting that many of her former students would not stay if they could not work in a maternity ward.

This issue is also related to the general dissatisfaction expressed by key informants with the beneficiaries and limitations of the retention and critical post allowances; respondents reported that only those midwives practicing and working in the maternity wards are eligible to receive the critical post allowance for 'practicing midwife". Others suggested that the resources available for these allowances is dictating the number of midwives that can allocated to the maternity ward, rather than patient numbers and service needs.

The 2016 LSTM Survey data also show that some of the 47 district level hospitals and the 118 Level 1 facilities surveyed had no State Certified Midwives (SCM). The MoHCC plans to 'upskill' many of the primary care nurses (PCN) that are not equipped with midwifery skills currently in government RHCs to enable them provide ANC services[29], thereby increasing the availability of skilled providers and improving service utilisation in these areas. By 2014, 479 PCN had successfully completed this upskilling training and returned to the workplace; unfortunately no data were made available on the numbers produced and deployed in 2015.
Compared to 2015 staffing levels, Table X also shows that there were less midwives available in district level

[29] UNICEF (2014) The Health Transition Fund Implementation Report, January – December 2014,

hospitals and Level 1 facilities, as well as less RGNs at Level 1 facilities in 2016. These trends should be closely monitored.

Table 28 - Proportion of facilities with at least one cadre in 2015 and 2016

Level of care	*State Certified Midwife*		*Registered General Nurse*		*Nurse Anaesthetist*		*Theatre Nurse*		*Primary Care Nurse*		*Student Midwife*	
Year of Survey	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**
District level hospitals	100%	96%	100%	100%	61.7%	66%	55.3%	55%	44.7%	45%	29.8%	19%
Level 1 facilities	41%	39%	74%	72%	0%	0%	0%	0%	75%	72%	0%	.01%

Source: LSTM surveys 2015, 2016

The 2015 JRM found that 72.4% of the 29 PHC level facilities visited did not have a midwife to conduct deliveries. Key informants in 2016 reported that some facilities still lack midwives, and in facilities where there is a midwife they noted that one is inadequate for the current workload, and also pointed out that when that person is away on training or leave there is no one trained in the facility to conduct deliveries (Box 10. Quotes 1 and 2).

In 2015 some RBF rural health facilities reported that because of the staffing shortages, Nurse Aides, who do not have the necessary training, are conducting deliveries when the nurses/midwives are away attending workshops, up-skilling courses or are on leave.[30] (Box 10, Quotes 3, 4 and 5).

One of the observations at the MoHCC's mid-year planning and review meeting was that '*inadequate human resources and a lack of qualified personnel at some health facilities*' was continuing to affect optimal service delivery[31]. Informants also raised this issue and reported that it is a challenge to achieve RBF targets because of the staffing shortages. (Box 10. Quotes 6,7 and 8).

Others commented that they could not effectively respond to community demands for services because of staffing shortages and heavy workloads. (Box 10, Quotes 9 and 10)

Staff from one of the mission hospitals described how they have been experiencing drops in utilisation and reduced workload at certain times in the quarter in recent years. They believe this is because some of their patients are opting to access care in nearby RBF facilities, because of the improved services they offer and their regular supply of drugs. This could be contributing to the increased workload, an issue raised repeatedly by staff in the RBF facilities. (Box 10, Quotes 11 and 12)

[30] Crown Agents (2015) Quarterly Report Q4 2015 (October, November and December 2015) Health Transition Fund (HTF), Results Based Financing (RBF) Programme, Zimbabwe
[31] UNICEF (2016) 2015 HTF Annual Report

Box 10. Illustrative quotes for "Vacancy rates for midwives -2"

Quote 1: "Another challenge is the shortage of midwives ….we have only 2 trained midwifes here, so I think if we can get a lot of trained midwives it would go a long way in improving …antenatal care." (KII respondent 6)

Quote 2: "In the nursing field one is supposed to be multi-skilled. Sometimes you even become a doctor, a pharmacist, health educationist, counseller, data collector, nutritionist, you also supply drugs, at the end of the day you will obviously feel exhausted." (KII respondent 1)

Quote 3: "We now have more midwives but it's still not enough, we still have times when a lady comes in in labour and the only person on the ground attending is not a trained midwife, so that is still a challenge" (KII respondent 15)

Quote 4: "If funds permit it would be wise to have at least 4 nurses per each centre but sometimes you find only one or two at each centre, when one wants to go on leave, only one is there. Two nurses or one nurse cannot manage… at least 4 nurses." (KII respondent 4)

Quote 5. "The number of nurses going for training to become midwives has been very good but because of that there are only 13 midwives … that complicates things in terms of 2 or 3 other staff who are not yet midwives…. there are still times when they are the only person manning the labour ward." (KII respondent 15)

Quote 6: "They have to add more staff because normally we are failing because most of our data is not captured in the correct books." (KII respondent 7)

Quote 7: "RBF is good to us since we are getting incentives, it's good for us to meet the targets, it's teaching us to do quality work but with staff shortages it's difficult to do everything, which will subtract our money. Instead of getting a lot of money for doing quality work, we have discrepancies because of the shortage." (KII respondent 21)

Quote 8: "With the RBF model of funding …one of the most critical thing is the quality of the service being offered but when an institution is critically short staffed …you may actually be not able even to score anything. …. for example if I take you to the labour ward you will realize that some of the documentation may have not been done properly …..not because the nurse or midwifery who was on duty did not know what to do….they actually know what to do but they get too busy …..so from a professional point of view it would not make sense for me to have a nurse spending all the time trying to make sure that they have updated all the registers, while someone is delivering on the floor …this issue of staff shortages actually needs to be addressed if we are to move to RBF model or else there is a need to change the indicators." (KII respondent 15)

Quote 9: "Some they say reduce waiting time. But sometimes it's beyond our control. Sometimes we have 1 to 2 nurses and a lot of people for example in the labour ward." (KII respondent 13)

Quote 10: "The delays in receiving medical attention is mainly because the health workers are overwhelmed with other emergency things." (KII respondent 4)

Quote 11: "Previously most of those clinics were not even conducting deliveries but now when the HTF, RBF thing came on board we realize that most of the clinics actually managed to improve their services. When you start to look at the statistics from mid-2015 up to-date there hasn't been a significant increase in the hospital's deliveries." (KII respondent 15)

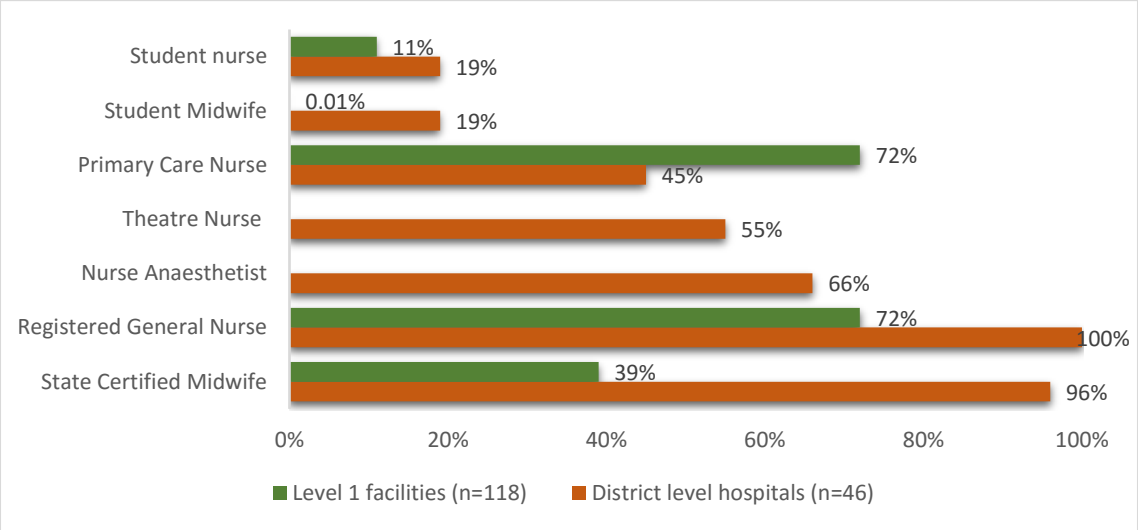
Quote 12: "When the RBF disbursement comes the OP bench will tell you because people will go there, because I think staff are more motivated around that time. …especially chronic patients, they know that if RBF just paid there is a higher chance drugs are there ….and then 2 weeks later when they are dry then normal services. We appreciate it but sometimes you will be wondering when that patient I asked to review in a month has not come back, what happened." (KII respondent 15)

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 a recognised formal qualifications, are often reported under the general nursing cadre. The 2015 JRM found that the availability of this cadre was still limited and recommended that the number of anesthetists be improved 'through formal training of doctors and nurses or through an attachment'. A review of the available training data revealed however, that in recent years intakes onto the nurse anaesthetist diploma course have increased

Of the 47 district level hospitals surveyed during the 2016 LSTM Survey, each had on average one (1) Nurse Anaesthetist. Figure X below shows that 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 (see Figure 31 below).

Figure 32 - Availability of nursing cadres: Proportion of facilities with at least one staff/cadre



Progress at output level

CONSTRAINTS ON THE AVAILABILITY OF STAFF

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. Respondents also commented on the impact of staffing shortages on the provision and quality of services. (Box 11. Quotes 1,2,3,4,5 and 6)

Respondents identified how factors, such as low remuneration and heavy workloads, are also negatively affecting staff motivation and job satisfaction, as well as health worker attitudes and behaviour. One staff member reported that one of the most common complaints in the hospital's Suggestion Boxes is *'staff attitudes'*, which she attributed *to 'workload and poor remuneration'.* (KII respondent 19)

Another consequence of the recruitment freeze is that the Government cannot secure employment for the nurses it has produced.[32] In 2013, the Ministry of Finance authorized the appointment of 2,080 RGNs to fill

[32] http://www.thestandard.co.zw/2015/01/18/govt-cuts-nurses-police-recruitment/

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

The HR Department successfully conducted a pilot Workload Indicators of Staffing Needs (WISN) study in 2015 and while the results of the study were not available at time this report was complied, the MOHCC hopes to use the data generated through the study to review the establishment and advocate for the unfreezing of posts.

The completion of the WISN study is a key activity area of the new HDF [33] including support to the '*implementation of findings within the national Human Resources planning framework and the revision of the national health strategy.'* The full study should provide more complete data on the stock and distribution of the health workforce, which will help to improve HR planning, address current shortages and promote greater equity in health worker distribution and training, however the roll out of the full WISN study to other facilities is subject to availability of funding[34].

Box 11. Illustrative quotes for "Constraints on availability of staff"

Quote 1: "At the hospital in labour ward, we might have about 5 deliveries at one go but have only two nurses and one on duty this compromises the services …we could have at least 4 midwife at a time in case one will be delivering, the other one resuscitating, the other one will be admitting, so if all those duties are done by one person, at the end of the day there will not be quality, and there will be missed information or missed whatever opportunities for the mother to be screened." (KII respondent 4)

Quote 2: "We are supposed to have four (4) nurses but we are only two (2) qualified nurses. We are also supposed to have 4 Nurse Aides, 4 General hands, but we have only two (2) each group." (KII respondent 1)

Quote 3: "We still remain under-staffed, so even if all our workers were midwives we would still have challenges with arranging shifts and so on, because we have not yet been able to get more staff to reach the required establishment." (KII respondent 15)

Quote 4: "The establishment was made in 1980s for a population which was less than what we are seeing now" (KII respondent 11)

Quote 5: "They are saying according to the establishment which has not been revised as yet, we consider your clinic is over staffed to the extent that they are even pulling some of the staff to cover other clinics" (KII respondent 13)

Quote 6: "We are in a dire situation, trying to balance what we have and what we should have." (KII respondent 3)

HEALTH WORKER TRAINING

Despite losing many specialized tutors and lecturers from the health training institutions, with support from the HTF, UNFPA and other donors since 2012 the country has continued to produce a steady supply of health workers, especially doctors and midwives, as shown in Table 36 below. These additional cadres will help to fill current vacancies and provide a buffer to ensure that any further losses can be replaced.

[33] Health Development Fund Draft August 2015
[34] Unicef (2016) Zimbabwe Health Transition Fund 2015 Annual Report to HTF Donors

Table 29 - Enrolment and graduates 2012-2013

Cadre	Intakes			Graduates		
	2012	2013	Total	2012	2013	Total
Physicians (MBChB)	299	216	515	143	172	315
Nurses (BSc Nursing)	34	51	85	8	7	15
Midwives	726	901	1627	521	265	876
Nurses (RGN)	1743	1618	3361	1374	1209	2583
Primary Care Nurses	0	19	19	335	27	362
Pharmacists (HPM)	66	64	130	53	11	64
Pharmacist Technicians	0	24	24	0	0	0
Laboratory Scientist (HBMLS)	30	29	59	11	28	39
Environment & public health workers (HEHP)	19	20	39	12	28	40

Source: HRH Country Profile Update 2013

TRAINING OF REGISTERED GENERAL NURSE

Five thousand, four hundred and forty nine (5,449) RGNs, many of who will go on to train as midwives after they have completed two or more years of service, have been produced since 2012 by the 25 nurse training schools located across the country. In 2015, 742 nurses graduated, while 898 nursing students were enrolled.

Table 30 - Registered General Nurses produced and pass rates 2011-2015

Year	*No of Graduates*	*Pass rate (%)*
2012	1374	79
2013	1209	75
2014	793	67
2015	742	84
Total	5449	79%

Source: Nursing Department, April 2016

As a result of the growing numbers of unemployed nurses and ongoing budgetary constraints, the government in 2015 instructed the training schools to reduce their intakes.[35]

MIDWIFERY TRAINING

Midwifery training capacity has significantly improved over the period under review with the number of active midwifery schools increasing from 12 in 2010 to 22 in 2015, exceeding the 2015 target of 20. Training schools have increased their intakes over the period; Harare Central Hospital midwifery training school for example, doubled its annual intakes in 2013 from 60 to 120 students. On a directive from government in 2015, it reduced its intakes to 60. As the majority trained were RGNs from the hospital, almost two thirds of the hospital's current nursing workforce is now composed of trained midwives.

No new disaggregated enrolment data for each the midwifery schools for 2015 was made available, but 2014 data showed that nine (9) schools had enrolled less than 25 midwives; enrolment was highest in Harare, which

[35] Key informant interview

had a total of 98 students. However overall enrolment has been fairly constant over recent years, increasing from 726 midwives enrolled in 2012 to 837 in 2014, but dropping to 743 in 2015.

As shown in Table X below between 2012 and 2015 a total of 2,943 midwives were produced, exceeding the MoHCC target, which aimed to train 2,500 midwives. In 2015 eight hundred and thirty five (835) midwives graduated, compared to 521 graduates in 2012, and these are now practicing and providing MNCH services across the country. Training will need to continue at an equal or higher level in the coming years if the MoHCC is to achieve its target of 60% (9,685) of the 16,142 RGN established posts trained as midwives.[36]

Table 31 - State Certified Midwives produced and pass rates for final examinations 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

IMPROVED MIDWIFERY TRAINING CAPACITY

The improved midwifery training capacity was due to a combination of factors, including the support the schools received from HTF and UNFPA and other donors for infrastructural improvements, equipment and teaching materials, and for the expansion and professional development of the teaching faculty. The critical post allowances provided through the HTF have helped to attract and retain 18 additional midwifery tutors in the schools, with tutor numbers increasing from 44 in 2012 to 62 in 2015.

Table 32 - Midwifery tutors in post 2012-2015

Province/Institution	2012	2013	2014	2015
Chitungwiza	3	2	4	5
Harare Central Hospital	3	3	3	3
Manicaland	4	8	9	9
Mashonaland Central	6	8	9	8
Mashonaland East	2	2	2	7
Mashonaland West	4	4	4	4
Masvingo	2	3	3	4
Matabeleland North	1	1	4	3
Matabeleland South	2	2	2	3
Midlands	7	6	6	6
Mpilo	5	4	4	6
Parirenyatwa	5	4	4	4
Total	**44**	**47**	**54**	**62**

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

As shown in Table 39 above the number of midwifery tutors in the schools increased over the period, expect for the schools in Midlands and Parirenyatwa, which currently have one tutor less than they had in 2012. While student enrolment increased substantially in Harare Central Hospital Midwifery Training School from 2013 to 2015, the number of tutors in post remained unchanged, resulting in potentially higher student; tutor ratios and compromised teaching quality. There is still a great demand for the midwifery training from RGNs; all of the midwifery students in the group interviewed had applied more than once before being accepted onto the course.

During the period under review the midwifery curriculum was reviewed and is now being fully implemented in all the schools. Tutors from the midwifery and PCN schools have received EmONC training as well as orientation in basic adult teaching and competency-based training methodologies.

Despite this support, respondents indicated that some of the midwifery training schools still lack all the necessary resources (e.g. tutors, clinical instructors, practicum sites, equipment and training materials classrooms and library facilities) required to provide quality training. Midwifery students described how the lack of supplies and equipment (e.g. bandages, gloves, syringe pumps, delivery packs, aprons) in the hospital hindered the application of the theory and good practice learned in the classroom in the practical ward setting. Not having access to the Internet, lack of library facilities, and inadequate water and electricity supply were also problematic.

Students are often sent to the larger hospitals for clinical practice, to get exposure to complicated cases and to get number of deliveries required to graduate. This is causing overcrowding on the wards in these hospitals, and with a limited numbers of clinical instructors available to mentor and supervise these students, this could potentially lead to deterioration in the quality of training.

Midwifery students interviewed indicated that working in a midwifery ward and being able to practice their newly acquired midwifery skills would be a key factor in whether they remained in the public health sector and/or the country. They indicated that this is already a challenge; there are often insufficient midwife posts and/or space available in the maternity wards for all the midwives trained and those still in training, and as a result they are rotated and often sent to work in other wards. Posts in the maternity wards are also in demand because of the allowances they attract. They indicated that midwives could be sent to other wards for six months or more after training, with the result that they forget much of what they have learned. Students from the private health facilities reported they are mostly allocated to a maternity ward after training.

Staff in one of the midwifery school suggested that increasing the number of students enrolled from outside the hospital, while reducing intakes from within the hospitals, would help to prevent crowding and bottlenecks in the maternity wards, and enable them retain the same group of midwives on the ward rather than having to constantly rotate and change them.

Currently Harare Central Hospital allows only 10 nurses from the hospital to be released and enrolled on the midwifery training course; the other 10 are from private facilities (who will be fee paying from 2016), and/or municipal or provincial hospitals. One of the advantages of the hospital training its own staff trained is that it is easier to provide post training follow up.

Support provided by the HTF and EU has been also been used to improve the teaching facilities and student accommodation for the accelerated midwifery (upskilling) programme, which is helping to expand the pool of health workers with midwifery lifesaving skills.

IN-SERVICE TRAINING

According to VMAHS Round 26 staff were trained in Infant and Young Child Feeding (IYCF), Baby Friendly Hospital Initiative (BFHI), CMAM and Integrated Management of Neonatal and Childhood Illnesses (IMNCI). The survey found that 71% of the 1,385 health facilities visited had at least one staff member trained in IYCF; a quarter had no staff 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. The training and capacity development of health workers supported through the HTF has helped to improve the quality of care and management of obstetric and neonatal emergencies, which has led to a reduction in maternal mortality. This is reflected in key informant interviews conducted in 2016 (Box 12, Quote 1).

The new Health Development Fund (HDF) acknowledges that a professional and skilled workforce is critical for improving the quality of services, and is committed to continued investment in in-service training for staff in key shortage areas, in clinical mentorship and supportive supervision, integration of SRH-HIV services, YFHS and continued professional development. However, it recommends that a review of IST approaches at national level should be undertaken to inform the development of a nationally coordinated, provincially implemented training programme covering all appropriate competencies. This would ensure there are *'appropriate numbers of adequately trained staff at all levels, while minimizing duplication and time away from station'*.[37] Efforts will also be made under the new HDF to incorporate IST components into pre-service training and revise curricula '*to include changes and new developments in RMNCH-A and SRHR'*.

Under the new HDF there will be less focus on the in service training of midwives, since the *'manageable quota'* for midwives has almost been reached and on the training of prescribers on clinical IMNCI, and any further gaps will be filled by WHO and other partners[38]. However, it proposes a national assessment of remaining training needs, which will assess overall progress to date, and to identify and target remaining priorities.

Box 12. Illustrative quotes for "Constraints on availability of staff"

Quote 1: "the HTF has not only standard IMCI training but also the introduction of IMCI training by distance, where health workers are trained at their institution, they don't go to hotels to be trained'. The numbers of health workers with IMCI training has increased and with the introduction of computer based IMCI training, nurses and doctors who are still in school can be targeted. With the previous approach only 600 per year were trained for the whole country, 'when only one is trained and she is not there, then there is no service." (KII respondent 8)

[37] Health Development Fund Draft August 2015

[38] Health Development Fund Draft August 2015

Theme 4: Health Policy, Planning and Finance

The objective of Thematic Area 4 is to improve national capacity for policy, planning and financing across all health service delivery levels, with special emphasis on the most peripheral health facilities by 2015. Interventions in health policy, planning and finance include financial support to peripheral health facilities through the Health Services Fund and external Monitoring and Evaluation and Operational Research and provision of Technical Assistance. The HTF has provided technical assistance in areas of governance, management, HMIS, and policy development as well as in its prioritized thematic health care areas.

Progress achieved in this thematic area is presented below.

Summary of key findings

- **Support to MNCHN policy** Achieved

  Since 2012, HTF has continued to provide a fertile platform for the planning, design and implementation of relevant MNCH and nutrition policies. The HTF contributed to the finalization of more than 11 policies/plans/protocols/guidelines for MNCH and nutrition.

- **Health expenditure** Not achieved

  Available data from Ministry of Finance indicate that the Government allocation to the health sector is not increasing in actual terms. This is probably related to the slowdown of the economic growth in country which decelerated after a rebound observed during 2009-2012.

- **User fees** Not achieved

  VMAHSS monitors regularly the proportion of facilities charging user fees for ANC; this is a tracer indicator of the facilities charging for MNCH services. Whilst the facilities charging user fees were estimated at 41% in early 2012, this decreased to 5% by the end of 2015. The LSTM 2016 Survey findings indicate that 18% of district level facilities and 18.8% of Level 1 facilities charge user fees for one or more MNCH services. Hence, the HTF target of "*no user fees"* scenario has not achieved.

- **Results based financing and Health Services Funds** Achieved

  In 2014, the HTF program successfully transitioned from the Health Services Fund to the Results Based Financing scheme. The transition occurred with some delays and obstacles. As a result, the LSTM 2016 Survey found that throughout the year only 57.2% of facilities received support through the RBF, and of those only 1.8% received in all quarters of 2015.
  The impact of the RBF in reducing user fees is high: the LSTM 2016 Survey revealed that a facility tends to charge user fees if it does not receive any financial support from other sources. Facilities are five times more likely to charge user fees if they do not receive any financial support.

- **District level planning** Not achieved

  The efforts promoted through the HTF in enhancing district level planning and managing has yielded positive results. The LSTM 2016 Survey suggests that approximately 62.8% of DHEs conduct annual planning on a regular basis and that 63.2% conduct annual review meetings.
  The targets of achieving a 100% performance for these indicators by the end of 2015 was not achieved.

A full summary of the progress against indicators for Theme 4 is provided in Table 33 overleaf.

Table 33 - HTF Indicators for Theme 4: Progress from baseline and against defined targets

THEME 4: Health Policy, Planning and Finance							
PROGRESS AT OUTCOME LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
4.1.1. Number of national policy documents on MNCH finalized and translated into action (implementation started)	-	*N/A*	**>7**	*HTF AR 2014*	9		
4.1.2. Health expenditure per capita per annum	**25.00**	*N/A*	**31.00**	*WHO global expenditure database*	**46.00**	**24%**	**-48%**
4.1.3. Proportion of health facilities charging user fees for MNCH services	**NA**	*N/A*	**18.5%**	*LSTM Survey 2016*	**0%**	**N/A**	**-18.5%**

PROGRESS AT OUTPUT LEVEL							
INDICATORS	**Baseline (2010/11)**		**Progress 2015**		**HTF Target 2015**	**Progress 2011-2015**	**Gap to target**
	Estimate	*Source*	**Estimate**	*Source*			
4.1.1. Number of districts that regularly develop AWP	**N/A**	N/A	**63%**	*LSTM Survey 2016*	**100%**	**N/A**	**-37%**
4.1.2. Number of districts conducting regular annual review meeting	**N/A**	N/A	**63%**	*LSTM Survey 2016*	**100%**	**N/A**	**-37%**
4.1.3.Number of districts regularly providing reports using the standard core indicators of the HMIS	**N/A**	N/A	**N/A**	*N/A*	**100%**	**N/A**	**N/A**
4.1.4.1. Functional performance based contracting of health services is put in place (TBC)	**0%**	HTF logframe	**100%**	*Documents review*	**Available & functioning by 2015**	**100%**	**Available & functioning**
4.1.4.2. Functional system for health services fund is available at national level	**0%**	HTF logframe	**100%**	*Documents review*	**Available & functioning by 2015**	**100%**	**Available & functioning**
4.1.5. Proportion of Health facilites receiving regular financial support through the Health service fund to cover basic recurrent cost	**0%**	N/A	**57%**	*LSTM Survey 2016*	**80%**	**57%**	**-23%**
4.1.6. Number of quality assurance surveys conducted over the next five years	**N/A**	N/A	**N/A**	*N/A*	**2**	**N/A**	**N/A**

Progress at outcome level

The policy, planning and financing pillar of the HTF was designed to restore and sustain the enabling environment that was needed to enhance maternal, newborn and child health outcomes in the country. In particular, the main outcomes expected through the measures set in place are:

- Increased government expenditure on health;
- A conducive RMNCH policy environment;
- Free access to essential MNCH health services

POLICY ENVIRONMENT

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

FREE ACCESS TO ESSENTIAL MNCH SERVICES (ABOLISHMENT OF USER FEES)

One of the key objectives of the HTF since its inception has been to contribute to the abolishment of user fees for MNCHN services at all levels of the system.

The Health Services Fund (HSF) and more recently the Results Based Financing (RBF) scheme were measures supported extensively through the HTF. The HTF Annual Report 2016 notes that the HSF has been revitalized health facilities to cover the running costs and maintenance expenses of the health facilities. The report also highlights that all primary healthcare facilities are providing free under-5 children services. From the beginning of 2015, all 44 HSF supported districts have been fully transitioned into RBF run by the Crown Agents. The World Bank has been supporting other 18 districts through Cordaid.

The VMHASS Round 26 presents a mixed picture with regards to free services. On one hand, the report states that ***95.3% of the facilities offering full maternity services were offering those for free***. On the other, the same report indicates that ***7.7% of the assessed facilities do charge fees for ANC***. The two results are discordant.

The LSTM 2016 Survey provides a different picture from the data available through VMHASS: according to our survey, 18% of district level hospitals and ***18.8% of Level 1 facilities charge user fees for one or more MNCHN services*.**

Data on user fees were confirmed through KIIs and FGDs as evaluation participants were keen to discuss financial aspects of the HTF and emphasized that inadequate health financing has been a critical stumbling block to deliver essential services resulting in the country health system becoming vulnerable to embezzlement. During the interviews, national, district and facility respondents discussed different aspects of health financing including user fees; transaction costs to receive care; and RBF of health services. Health workers commented that health facilities used to receive health services fund (HSF) from the Government of Zimbabwe erratically with an inadequate amount to cover the health needs of their population (Box 13, Quote 1). Almost every healthcare provider participating in the evaluation agreed that HTF has significantly contributed to improved service delivery at facilities (Box 13, Quote 2).

Unfortunately, user fees and transaction costs were identified as still constituting barriers for communities to access health care. Even in facilities where women were not required to pay for services, other transaction costs affected their access to health care. Transaction costs, excluding the actual costs of diagnosis and treatment, typically arise when there is an asymmetry of health care information and weak regulation of health system. Participants explained how pregnant women encounter a financial barrier when accessing health services such as booking fees for delivery, transportation costs, and items required to bring to the hospital for delivery (Box 13, Quotes 3 and 4). Some pregnant women were reluctant to deliver at health facilities as they could not afford to have emergency fees and necessary items, which they were asked to bring “without fail” for delivery at the facilities. They were also worried to be treated badly by health workers if they did not bring the required items (Box 13, Quotes 5 and 6). Health workers confirmed that they still had to charge the patients for non-maternity services, ask the patients to purchase medicines and consumables, or ask pregnant women to bring items for delivery at the facilities. In response to this, other financing mechanisms such as insurance (community based insurance) are being explored at national level though respondents indicated that insurance companies are not functioning well in Zimbabwe (Box 13, Quote 7).

Box 13. Illustrative quotes for "User fees"

Quote 1: "I think the last time I received GOZ funding was 2 years ago if I still remember the figure was about $2500. So those disbursements from the government of Zimbabwe have actually been very, very erratic actually nonexistence." (KII respondent 15).

Quote 2: "HTF funding, is the one which has greatly improved our service delivery because we are now able to buy commodities for use medicines and also our theater is now functional, before it was not functional, we were unable to offer caesarian session in the district, but now we are able it has even improved. It has improved even human resources, with this retention allowance we get midwives, even the number of doctors has increased." (KII respondent 22)

Quote 3: "Sometimes these who end up giving birth at home fails to get o the clinic on time. Sometimes these women will not have financial resources to pay for maternity fees so they end up giving birth at home." (FGD VHW 5)

Quote 4: "When we come here we face many challenges for instance, one gets a consultation card and on this card there will be need to buy medication, but shortage of financial resources to travel to go and buy medication becomes a challenge. There is need to first pay for the card and get temperatures before given some prescriptions. They cannot prescribe medication before getting temperatures and weight. So one will need to travel to get medication from the surgery. They cannot tell you anything before paying for the card." (FGD Community women 4)

Quote 5: "Sometimes shortage of financial resources might prevent a mother to come to the clinic. Mothers are mandated to bring an emergency fee without fail… In some instances, even if there is no emergency, one needs to bring along a certain emergency fee amounting to US$2-00. If you come without the emergency money, they will not accept you. So women end up not coming to the clinic". (FGD community women 13)

Quote 6: "Yes, yes, these are the scenarios where one will then say, nurses have a bad attitude; because to tell the truth, you will have a bad time if you do not have the required things. Yes, at times mothers fail to get these requirements due to poverty." (FGD community women 13).

Quote 7: "I think the biggest one is to look at health financing from a perspective of innovative financing, insurance including community based insurance, but again insurance companies are not doing so well here." (KII respondent 18)

As shown in Table 34 below from the LSTM 2016 Survey, amongst those facilities charging user fees, none charged fees for child health services, whereas the majority charges fees for ANC, PNC, delivery and family planning. At District Hospital level, amongst those facilities charging user fees, most charged fees for combined ANC and PNC. The average prices charged per each service are also indicated in Table 34, below.

Table 34 - Facilities charging user fees for MNCH services

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

These unsatisfactory results may be explained by the efficiency of the reimbursement mechanisms and facility unfamiliarity with the RBF mechanisms. These are reflected clearly from interviews with key informants as many respondents complained about the procedures on RBF under the section of RBF.

Progress at output level

The tactical targets set to achieve the above mentioned outcomes at policy and financing levels entailed:

- ✓ Enhanced planning at district level
- ✓ Set up of financial mechanisms to support health facilities relieving user fees
- ✓ Monitoring and Evaluation

Progress against these targets is analysed in the following paragraph.

DISTRICT LEVEL PLANNING

The HTF set specific targets to enhance the capacity at District Level to plan, monitor, 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 (**Annex 1**).

According to the survey findings, a declining trend is observed in the proportion of districts developing an Annual Work Plan (AWP) from 2013 to 2015.

We postulated that the development of AWPs in each of the three years under observation (2013; 2014; 2015) was a required condition to draw conclusions on the regularity of this process.

The results of our survey show that the proportion of Districts that developed AWPs and developed is estimated at 68%. Partners' participation to AWP development was estimated at 62%.

Table 35 - District Health Executives developing Annual Work Plans

	% 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)
Work plan 2016 developed and implemented	68	(63,73)
Work plan developed with partners' participation	62	(55,69)

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

Table 36 – District Health Executives holding management and review meetings

	% of DHEs: (n=44)	95% CI
Management Meetings		
DHEs holding management meetings:	100%	
Frequency of meetings:		
Monthly	*79*	(72,85)
Quarterly	*6*	(3,9)
Other	*15*	(9,22)
Records of DHE meetings available:	100	
Annual Review meetings		
DHE holding annual review meetings (*records of last meeting available*)	63	(56,70)
Last annual review meetings with partners participation	45	(38,52)

The LSTM 2016 Survey also revealed an encouraging situation with regards to health information management at district level.

The survey revealed an encouraging situation with regard 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 also reported to have a computer available for HMIS (98%) and an internet connection (80%). All DHEs reported to provide timely feedback to facilities (100%).

Table 37 - Availability of equipment for HMIS and utilization of HMIS data at DHE level

HMIS at District Level	*% DHEs (n=44)*	*95% CI*
Functioning computer for HMIS available	98	(97,99)
Internet connection available	80	(73,87)
DHE with charts and diagrams on display	98	(97,99)
DHE providing feedback to facilities on HMIS reports	100	

HEALTH SERVICES FUND AND PERFORMANCE BASED FINANCING

Since its inception, the HTF has invested in supporting health facilities through funds made available to cover operational/running expenses, "*with primary health facilities getting US$750, district hospitals US$1,500 and provincial hospitals US$2,000 per month, and were therefore able to meet their routine operational/selected running costs including basic maintenance/renovation of infrastructure*" (HTF Annual Report 2014).

The aim was to revitalize the public financial management system. This includes providing additional financial resources to different health facilities enabling health facilities to cover some of the running costs of the health

facilities such as electricity and water bills; procure sanitation and hygiene consumables (soap, brooms, chlorine, washing powder) which are not provided by the HTF and also to cover small scale rehabilitation work such a window glass, lighting in the facility. The HTF has revitalized the Health Services Fund (HSF) through financial and accounting management procedures within the health system at all level.

The HSF was established "to collect and administer fees to supplement the health budget, both recurrent and capital budget allocations for the development and maintenance of health facilities, programme equipment, and related activities. The package of service and the total budget allocated is always to be approved by the Secretary for Health and Child Welfare in consultation with Treasury". The HSF is still actively operating at the secondary and tertiary levels of the health system. Structures and performance agreements are still in place. As noted in the HTF Annual Report 2013, the HSF management has been out contracted by UNICEF to a third party with proven record of rigorous financial management, but also with strong skills in building capacity of public finance management. The MOHCC through UNICEF and other stakeholders of the HTF Steering Committee members conducted an open bidding process which has resulted in sub-contracting the HSF management to Crown Agents to fully implement and monitor this program.

By providing this support, health facilities are able to provide primary healthcare services free of charge to all pregnant and lactating women and children under 5 years of age. The HSF has been providing financial support to those provinces which are not covered by the World Bank-funded Results Based Financing (RBF) support scheme. These include 44 districts across Zimbabwe except those in Bulawayo and Harare. The facilities and executives teams benefiting from the HSF included: rural health centres, district level hospitals, district health executives (DHE), provincial hospitals and provincial health executives (PHE).

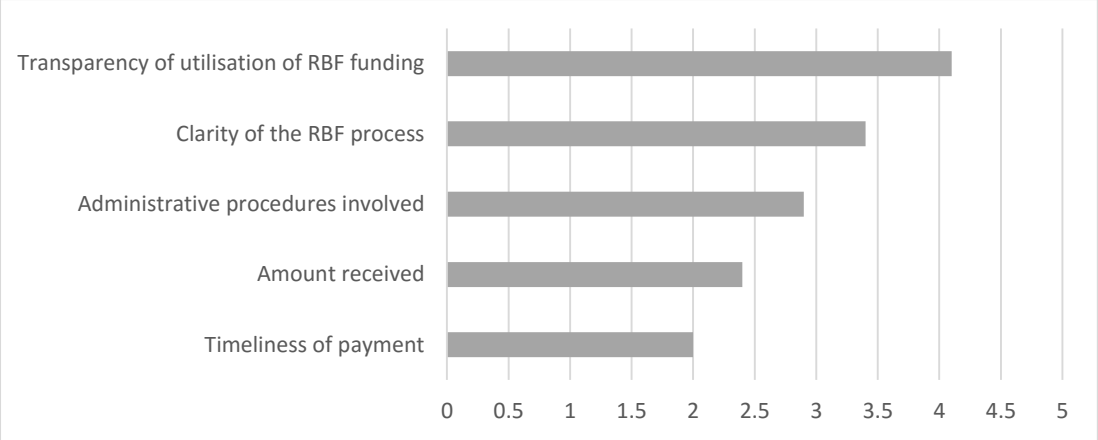
In early 2014 (Q1), a total of 873 health facilities and health executive teams in 44 districts of the country benefited from the Health Services Fund (> 80% of the facilities targeted through this scheme via HTF).

In the mid 2014, the HTF initiated a transition from the HSF to RBF.
The LSTM Survey 2015, performed throughout the country and not only in HTF supported facilities, indicates that only 53% of facilities received support through the HSF or the RBF in 2014, and of those only 34% received such support on a regular basis (at least quarterly).

The LSTM Survey 2016, which was performed throughout the country and not only in HTF/RBF supported facilities, indicates that only 57.2% of any type of facilities received support through RBF in 2015, and of those only 1.8% received such support in all quarters of 2015. The proportion among Level 1 facilities is higher as 66.8% of facilities received support through the RBF in 2015, and of those only 5.6% received such support in all quarters of 2015. Level 1 facilities received 3,074 USD on average as RBF support.

Our survey also asked health workers to rate the process of RBF mechanism from five aspects: timeliness of disbursement; amount received; administrative procedures to follow; clarity on the process; and transparency in utilization of the funds. Transparency in funds utilization rated highest followed by clarity and administrative procedures involved. Timeliness in receiving the disbursement scored lowest.

Figure 33: Health workers' rating on RBF mechanism



Respondents participated in interviews also expressed different views regarding input based financing under HTF and output/performance based financing under RBF. The majority of the respondents commented that RBF was intended to contribute improving of health workers' performance through improving quality of health service delivery at operational level. Many understood that it was the way the health facilities were financed with a shift from input based (HTF) to output based (RBF) funding. However, this requires changes in accountability structures and redistribution of tasks and responsibilities among different actors. Hence, the system requires changes in architecture of the health system arrangements with mechanisms for accountability, transparency and key actors to carry out verification of the process.

Respondents perceived that RBF has improved financial autonomy of the health facility. Revenue collected under RBF resulted in health workers' incentives, investing in supplies and improving facility infrastructure and resources (Box 14, Quote 8). Most health workers felt that the supply management under RBF was more efficient than the PUSH system under HTF where they experienced a lot of unnecessary wastage with predefined kits (Box 14, Quote 9). Some health workers suggested that the kits should be tailored to the needs and size of health facilities. Health workers realised that their generation of income depended on the facility performance and thus some preferred the RBF model (Box 14, Quote 10).

Challenges in the implementation process of RBF outweighed the advantages shared by the respondents. These included the design of the RBF programme; RBF reporting mechanism; amount of reimbursement; timeliness in receiving those funds; and procedures required to follow before utilizing those funds and information/feedback mechanisms and verification of the process. A lesson learnt that came out of the evaluation was that it would have been better to have one pool fund for RBF instead of two different funding sources (Box 14, Quote 11).
Healthcare providers experienced that patients were not complying with their referral advice when they referred them to non-RBF facility where they had to pay for services. This was particularly alarming for urgent services such as caesarean sections (Box 14, Quotes 12 and 13). This experience was shared by facilities under the districts of the Crown Agent as only primary healthcare facilities received support for RBF.

Another major challenge in implementing RBF was the 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 reporting, which then negatively affected the facility because they would receive less funding causing demotivation among staff (Box 14, Quote 14). Health workers acknowledged that RBF has highlighted their missing skills set, which was registration and reporting. They confirmed that their skills in documentation, recording and reporting have improved with the introduction of RBF. However, as majority of

them were not used to such type of strict registration before, they felt that the amount of documentation required to do was too overwhelming with their existing workload and resources (Box 14, Quote 15, 16 and 17). Some health workers were even questioning the focus of RBF on whether the improvement in quality was driven by changes in reporting practices, but not mirroring their increased work load that would have happened anyway. Respondents from national level confirmed that the RBF reporting mechanism was complicated as they (themselves) could not get them right although they had attended several trainings (Box 14, Quote 18).
Respondents understood that RBF has tried to improve the quality of services but the amount of funds received under the RBF mechanisms were still not sufficient to cover the needs of the community even if they had the best performance. Furthermore, RBF did not consider other running costs for the facility such as kitchen and laundry charges (Box 14, Quotes 19, 20 and 21).

Timeliness in receiving the reimbursement was another 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 (Box 14, Quotes 22). Hence, some respondents preferred the input based payment under HTF since they at least received some regular funds to run their services instead of unpredictable amounts under the RBF (Box 14, Quotes 23). Delay in receiving funds disbursement was further complicated by certain procedures requirements under the RBF. In most cases, facilities did not have full financial autonomy to utilize their revenue collected under RBF as there were procedures such as getting approval from the HCC; receiving three quotations for the items under request; and receiving approval from the District Health Executive (DHE). Health workers experienced that at times the quotations were no longer valid when 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 (Box 14, Quote 24).

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. Internal accountability can be improved through functioning information and feedback mechanisms about the funds and its operation. 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 will receive the reimbursement and the reasons for delays. National level respondents agreed that they were not in a position to disclose the reasons of those delays even in cases when they were aware (Box 14, Quote 25). This negatively affected the potential and credibility of RBF mechanism compromising accountability among key actors.

Regarding independent verification at facilities, respondents commented on two approaches employed by Cordaid and the Crown Agent. Being an output-based financing, independent verification ensure accuracy of health facility reporting. Yet, achieving this may not be straight forward in Zimbabwe context without any cost. Some respondents recommended the Cordaid model of verification though it was more costly than the Crown Agent model, which used district health staff. Almost every respondents including members of HCC perceived that investment in training and appointing field officers as in the Cordaid model were essential costs to invest in to provide supportive supervision and data verification while RBF was first introduced.

To ensure that health facility embed the RBF mechanism, it is vital to engage with both managers and health workers from the inception of the RBF as it can be less effective in cases where an inclusive approach does not exist. Health workers need clarification on what is expected of them and this being linked to reward (positive) or penalty (negative) consequences of their actions. However, some of the health workers were not aware about the functioning of RBF mechanisms producing a lot of unnecessary reporting mistakes leading to the loss of income for the facilities (Box 14, Quote 26). This was confirmed by national level respondents as they witnessed that Crown Agent was reporting surpluses. (Box 14, Quote 27)

Box 14. Illustrative quotes for "RBF"

Quote 8: "We are really improving the system. We have managed to refurbish many structures at the health centre, we have done painting, electricity was connected at the waiting mothers' shelter. Even the chairs which you are used was bought using the HTF. We have managed to buy blankets to use in wards and best of all, we spent most of the money for medicines of mother and child health care." (KII respondent 1)

Quote 9: "I think primary health care package; it is better disbursed on consumption; it is important because push tends to be wasteful." (KII respondent 22)

Quote 10: "I think, I would choose RBF. The reason with the client base, we are looking at a number of clients and with the RBF a lot of work will generate a lot of income for the district hospital; and our performance is good. Is good Yaa!" (KII respondent 22)

Quote 11: "…the money goes directly to the clinic where as previously the money went to the provincial and district level it never went down to the clinic. Once you give money to a nurse to plan and set priorities, nurses and Health Centre Committees do know what priorities are in the clinic so there will be able to spend it according to the need…" (KII respondent 5)

Quote 12: "…it would have been ideal to have one pool fund that finances RBF but not to two with different funding sources with different procedures." (KII respondent 5)

Quote 13: "Normally the para Os, the prima ups we all refer because have fear of the complications for the mother and the baby. So we refer for better management at the hospital… But since we are talking about the paying, they refuse and they stay at home and they come here fully dilated, you have nothing to do, you are going to deliver her or not." (KII respondent 12)

Quote 14: "We have a patient she is post dates we admitted for induction and gave two circles of oral she hasn't gone into labour so we wanted to escalate for caesarean section but she refuses so it's been the second day." (KII respondent 15)

Quote 15: "…we are in the rural areas a lot are waiting for my service outside there… some are coming from far away resettlement areas and they come by transport and for them to go without my service I feel guilty… At the end of the day my work is not done because my paperwork is incomplete." (KII respondent 10)

Quote 16: "In the nursing field one is supposed to be multi-skilled. Sometimes you even become a doctor, a pharmacist, health educationist, canceller, data collector, nutritionist, you also supply drugs at the end of the day you will obviously feel exhausted." (KII respondent 1)

Quote 17: "They also pay for deliveries and if you have more deliveries you have more money and if you have ANC mother which book below 14 weeks there is also a certain amount which you get but if our data has discrepancies they subtract the amount from what we have got…" (KII respondent 10).

Quote 18: "Continuous training, in-house training you can call it updating information the staff has. It is always changing. Especially with Ministry of Health, their tools they just wake up there where they are sited these guy and write what they want and just send forms or t the tools without training such things, people have to be inducted most of these tools." (KII respondent 4)

Quote 19: "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." (KII respondent 8)

Quote 20: "…they just tell you we have given you the money according to your performance based but we are trying, we feel it is still too little." (KII respondent 7)

Box 14. Illustrative quotes for "RBF"

Quote 21: "Normally RBF is good to us since we are getting incentives its good but for us to meet the targets. Its good RBF because its teaching us to do the quality work that but then if you can follow we can have a lot of money but now you can see staff shortages discrepancies are many because at the end of the day you to book an ANC mother HIV testing at times there is a delivery and at times there is one nurse and to cover for all those its difficult that's when you find some discrepancies which will subtract our money. Instead of getting a lot of money doing to quality work we have discrepancies because of the shortage." (KII respondent 10)

Quote 22: "I just want to make a comment of suggestion, I think with the experience we have in HTF and RBF I thought it was important if RBF can cover Kitchen and laundry." (KII respondent 4)

Quote 23: "The time frame we really do not know. You sometimes see it in the account… It does not arrive on time. What we are not sure is when it is disbursed from Crown agents." (KII respondent 26)

Quote 24: "The HTF was better because it used to support us with a little bit of money where we were able to do something with that money you know; with RBF you have to work for that money… if somebody books after the 14th week there is no money, if somebody has to deliver at home, there is no money, if people are not coming to the clinic that means there is no money." (KII respondent 26)

Quote 25: "We source 3 quotations or 4 quotations, umm, the DHE they are not concerned about anything except the price. They choose the lowest price despite the poor quality what they want is the lowest price not considering the quality." (KII respondent 13).

Quote 26: "…it's not up to us or UNICEF to disclose, we just suffer between us because we have a contract, it is easy to say so and so donor has not yet paid noting that each donor has their own circle back home." (KII respondent 2)

Quote 27: "But I think the challenge lies actually on the lack of knowledge by some of the health workers the only trained people are the sister in charge the EHT the members of the health committee were training they were trained about the RBF but the other junior were not trained and I suggest there be training so everyone plays their role and we get a lot of funding and see great improvement" (KII respondent 6)

Quote 27: "…facilities were not familiar with RBF way of reporting and they ended up making many mistakes some of them earning less much much less money I know that in the last meeting we had with Crown Agency they told me that they had made servings of $6 000 000 or something because facilities earned less…" (KII respondent 8)

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 8
Case Study on Health Retention Scheme

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
May 2016

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Introduction

This report presents a description of the case under study, namely, the Zimbabwe Harmonised Health Worker Retention Scheme (HWRS) ('the retention scheme') as part of the independent evaluation of HTF in 2016. It begins with an overview and description of the Retention Scheme, which provides information on the financing of the scheme; the mechanisms established to communicate the purpose and objectives of the scheme; and the monitoring systems put in place for the scheme. Following on from this, the case study describes the methods employed to inform and prepare this case study. Then it examines the results of the retention scheme; stakeholders' perceptions of the effectiveness of the scheme, and the challenges encountered. Finally, the case study describes key lessons learnt and the legacy of the retention scheme within the context of Zimbabwe.

Background and Overview of the Retention Scheme

Between 2004 and 2008 Zimbabwe experienced mass migration of skilled health workers, which adversely affected the delivery of health services. In order to reverse migration trends and to ensure that numbers produced by the health training schools made up for and/or exceeded the losses from the sector, the Government of Zimbabwe (GoZ), through the Health Service Board (HSB) and the MOHCC, and with the support of development partners implemented a range of measures to improve the numbers of critical health workers retained in the public health sector.

Methodology

A **mixed methods approach**, which utilised quantitative and qualitative methods was used for the case study.

In particular, methods of data collection and analysis included:

- Key Informant Interviews (KIIs) conducted in 2015 and 2016 to gather views and perspectives of stakeholders at national level and at district hospital and health facility level,
- Focus Group Discussions (FGDs) with DHE members, health workers, including doctors, midwives, pharmacists and PCNs in district hospitals and level 1 facilities conducted in 2016 to collect their views and perspectives with regard to the effectiveness and sustainability of the retention scheme funded through the Health Transition Fund.
- Secondary data and reports, including HR and retention data available in Zimbabwe and internationally

Limitations

A number of limitations are identified, which were taken into account by the reviewer when documenting findings and drawing conclusions. These include:

- Updated, disaggregated data on HR were not available for the period 2014-2015;
- Discrepancies and inconsistencies were observed across and within the different retention databases held by UNICEF and Crown Agents;
- Financial information on the retention scheme provided by UNICEF in different documents had a number of unexplained variances and discrepancies;
- Focus group discussions and KIIs were limited to DHE members and health workers in three districts of the country only;
- Some HR baseline data for indicators is missing and the classifications used for some cadres are not listed on the official establishment or officially recognised;
- There was no definitive baseline on vacancy rates established at the start of the retention scheme.

Financing the Retention Scheme

The GoZ is the main contributor to the current health sector wage bill, with its contribution increasing over the years from about 11% to about 20% in 2015, and projected at 22% in 2016. The GoZ provides a basic salary, and housing and transport allowances. Critical posts also get at least one health sector specific allowance, such as night duty allowance, on call allowance, uniform allowance, rural allowance, psychiatric allowance, residence allowance for junior doctors and representation allowance for deputy directors and others in the same grade.

A Medical and Health Factor allowance was introduced in 2015 for health professionals based at a health facility/institution, with different rates paid to those with a medical qualification and those with non-medical qualifications. Health workers can also apply for a housing loan through the Civil Service Housing Loan Fund and can import vehicles duty free through the government's duty free car. There is also a 'bonding system' in place for newly graduated health workers such as doctors and nurses, which requires graduates to work for a set period of time according to the number of years of training, before they receive their certificate.1

The contributions of the GOZ, as well as the Global Fund (GF) and the HTF towards the health sector wage bill between 2012 and 2016 are shown in Table 1 below.

Table 1 - Contributions to the health workforce salaries and allowances 2012-2016

Funding Source	*2012*	*2013*	*2014*	*2015 Projected*	*2016 Projected*
GOZ	128,796,221	153,474,920	176,384,536	194,384,536	213,822,989
Global Fund	16,999,459	12,966,821	8,627,864	10,615,138	10,615,138
HTF	6,545,680	9,005,058	10,637,542	12,000,000	12,000,000
Total	152,343,372	175,448,812	195,651,956	217,001,689	236440,143

Source: Health Service Board, 2014

The HWRS ('the retention scheme') was introduced in 2009 to reduce outward migration and stabilise the health workforce and revitalize the health system. Discussions with various stakeholders who were involved in the conceptualization and design of the retention scheme

[1] Marjolein Dieleman, Mark Watson & Chenjerai Sisimayi (2012) Impact assessment of the Zimbabwe Health Worker Retention Scheme. Final Report

confirm that the intervention logic was that payment of incentives would help retain and increase the number of health workers providing services.

In the first phase of the scheme (2008-2009), development partners pooled funds to provide a tax-free monthly allowance/salary top-up for all health workers and tutors, based on grade and location, ranging from 30 USD for the lowest grades to 850 USD for District Medical Officers, and conditional on attendance at work2. In February 2009, the economic situation stabilised and the government introduced new USD salary scales. As a result the 'emergency' scheme was reviewed and modified3 to cover health workers at grade C5; health workers in city council health facilities and workers from Grade C4 and below, deemed less likely to leave, were excluded from the scheme. The modified scheme represented a more coordinated and coherent approach to health worker retention, and replaced and harmonized a number of individual donor funded retention initiatives that had been in place up to this time.

The Global Fund (GF) approved funding for the scheme from September 2009 under Round 8, and agreed an exit strategy with the government, whereby GoZ would take over 25% of the GF contribution on an annual basis from January 2011, until the GF funding was phased out in 20134. It was envisaged that the government would increase health worker salaries at a rate corresponding to the reduction and that by 2013 the retention allowance would cease altogether and be replaced by a competitive and attractive salary for health workers.

The first 25% reduction in payments made to health workers was implemented in January 2011, with the government increasing salary and allowances by the same percentage at the same time. According to the 2012 impact assessment of the scheme health workers were 'informed about these reductions through circulars and meetings'. However, as a result of budgetary and fiscal constraints the GoZ was unable to continue to meet this commitment, and the Health Transition Fund (HTF) agreed to absorb the 25% drop in the GF contribution from 20125.

While the GF continues to support the scheme, in 2011 it imposed a cap on the funding it would provide, approving funding for18,860 health workers under the scheme for the period 2014 to 2016, equating to 60% of its 2013 contribution.. Through Phase 2 of its Health Systems Strengthening grant the GF also supported allowances for health workers from Grades F+ to C5; for community home-based caregivers, community-based health workers and urban health promoters for HIV/AIDS, TB and malaria services; supported the strengthening of the capacity of the HSB and the MoHCC to sustain the retention scheme with government resources; and the strengthening of the communication infrastructure and national HMIS6.

The HTF currently provides funding for 25% of the retention allowances for staff at Grade C5 and above, which was formerly paid by the GF, as well as an allowance for "critical posts", including doctors, practicing midwives and midwifery tutors, members of the provincial health executive (PHE) and district health executive (DHE) and programme managers. It is unclear whether an exit strategy or any other form of agreement was drawn up, which sets out the scope and timeframe of this arrangement.

[2] Dieleman, et al (2012) as previously cited
[3] MoHCW (2009) Reviewed Short-Term Human Resource Retention Policy. Nation-wide approach in collaboration with all funding partners
[4] UNDP/The Global Fund (2012) Global Fund Increases Support to Zimbabwe
http://www.undp.org/content/dam/zimbabwe/docs/hivaids/UNDP_ZW_HIVAIDS_GlobaFundSupportZw.pdf
[5] Health Service Board (2014) Submission of a health worker retention plan (2015-2016) in fulfilment of the special terms and conditions (STCs) in the new HIV new funding model grant agreement between the Global Fund and UNDP
[6] UNDP/The Global Fund (2012) Global Fund Increases Support to Zimbabwe
http://www.undp.org/content/dam/zimbabwe/docs/hivaids/UNDP_ZW_HIVAIDS_GlobaFundSupportZw.pdf

In addition to the allowances and incentives supported and financed by GoZ, GF and the HTF, since 2015 the Results Based Financing (RBF) programme, which is jointly implemented by the government, Cordaid7 and Crown Agents8, has been allocating a portion (25%) of the performance based payments made to the rural health centres and hospitals for staff incentives, which are shared amongst all staff working in that facility, based on grade. Crown Agents data for Quarters 1- 3 in 2015 indicates that the average quarterly amount paid to each facility was USD $1,4009, of which 25% would be available for staff incentives.

The retention scheme discussed in this case study refers specifically to 1) the retention allowances provided for all health workers at Grade C5 and above, and 2) the critical post allowances paid to specific staff. This case study will focus mainly on the impact of the scheme on the doctors, practicing midwives and midwifery tutors that were funded through the HTF for the period 2012 to 2015.

Communicating the Purpose and Objectives of the Scheme

The terms and condition of the Retention schemes are set out in the 2008 MoHCW (2008) Emergency Short Term Human Resource retention Policy and the 2009 reviewed version. When the retention scheme was first implemented the MoHCC HRH Task Force developed and disseminated an information pack and organized meetings to provide health workers with clear and accurate information about the scheme. While most health workers understand that the purpose of the retention allowance is to retain staff and to stop the "brain drain", they seem to be less aware of the specific objectives and arrangements for the payment of the critical post allowances. Respondents at the national level reported that circulars and national meetings and workshops are the most commonly used channels to share information with PHEs and DHEs, who are then expected to pass on this information to facility manager, HR manager and other staff, however this does not always happen in practice. (Box 1. Quote 1) Have moved quotes to text below.

Box 1. Illustrative quotes for "Communication & purpose of the retention scheme"
Quote 1: "National Authorities are very much in the picture, provincial and district managers very much in the picture… once you inform your managers at various workforce you then want them to manage the flow of information. There might have been gaps in terms of inclusion of health workers but ….we have learnt that we need to consult health workers. …. making sure that everybody is really on board." KII respondent 20

Monitoring and Evaluation of the Retention Scheme

The 2008 Retention Policy is clear that 'health workers will only continue to receive retention allowance subject to confirmation of being at work and with no record of unauthorized leave of absence in the month prior to receipt of their allowance'10. The HSB took over responsibility for verifying attendance and conducting spot-checks from Crown Agents in the January 2011. HSB 'monitors' conduct spot checks in facilities and institutions on a regular basis to verify that the staff

[7] World Bank is currently implementing the RBF programme in 16 rural districts, including district hospitals
[8] Crown Agents is currently implementing the programme in 42 rural districts, covering 817 Rural Health Centres and Rural Hospitals by 2015 - Crown Agents (2015) Quarterly Report Q4 2015 (October, November and December 2015) Health Transition Fund (HTF), Results Based Financing (RBF) Programme, Zimbabwe
[9] Crown Agents (2015) Quarterly Report Q4 2015 (October, November and December 2015) Health Transition Fund (HTF), Results Based Financing (RBF) Programme, Zimbabwe. Extracted from Table 2 p. 10
[10] MoHCW (2008) Emergency Short Term Human Resource retention policy. Harmonised and nation wide approach in collaboration with all funding partners. 3 December 2008

receiving the allowances are present, and check the attendance registers kept by the Sister in Charge (SIC) or matron. They verify names and grades with the MoHCC HR department, then sign the registers and submit them to Crown Agents for processing the payments. When Crown Agents receives the funds from UNICEF, they transfer the allowances into the individual's bank account. One respondent from the MOHCC acknowledged the support from the partners, such as the Global Fund, which enabled the HSB and MOHCC Performance Monitoring Department to conduct spot checks and verifications. (Box 2, Quote 1).

Based on a review of the retention documentation available and the key informant interviews it would appear that there was no systematic monitoring and evaluation system put in place to monitor outcomes and impact, beyond these routine monitoring and verification processes. Furthermore there was no accurate baseline established for the numbers, type and of staff that were in place across the country before the retention scheme began, when the HTF began funding the scheme. Therefore, it is difficult to see how the MOHCC could accurately assess the extent to which the allowances impacted on retention/attrition rates and/or to evaluate the overall impact of the scheme. It was also not clear who was responsible for monitoring the implementation of the beyond the verification process conducted by the HSB and the MoHCC HR Department. The only retention data available to the evaluation team in 2016 were payroll data, which reflected the numbers and critical cadres (as shown in Table 2 below) receiving the allowance on a quarterly basis between 2012 and 2016. No disaggregated data were available on the distribution by service level and/or work station of the cadres receiving the retention allowance.

This lack of robust monitoring and evaluation systems impacts 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. Information on the stock, distribution and characteristics of the health workforce is not readily available, and has to be compiled from a patchwork of different datasets and sources. While data on staffing level and vacancy rates for key health professionals over the period of the HTF were made available by the MoH, there was no complete dataset on the health workforce for this review and case study, which made it impossible to present a up-to-date and reliable overview distribution and/or health worker flows and/or attrition trends over the period up to 2015.

An impact assessment of the retention scheme was conducted in 2011 however, which assessed the relevance, efficiency, effectiveness, sustainability and impact of the health worker retention scheme up to that time. The assessment team made a number of recommendations and proposed three scenarios for moving forward, including a review of the establishment, a vision and strategy for retention, and thirdly, linking staff retention to a package of interventions.11

Box 2. Illustrative quotes for "Monitoring and evaluation of the retention scheme"
Quote 1: One respondent indicated that monitoring consisted of: 'looking for retention for doctors, retention for nurses. We were also fortunate to have support towards health retention from the Global Fund, so we simply continued to use those indicators - the retention rates - so it is both the Board (HSB) and our (CC) Performance Monitoring Department who are responsible for monitoring that." KII respondent 20

[11] Dieleman, et al (2012) as previously cited

HTF Financing for the Retention Scheme

Between 2012 and 2015 the HTF contributed a total of US $37,763,945 towards health workers retention and critical posts allowances. HTF contributions have been increasing annually, with an overall 42% increase in funding over the period as shown in the table below.

Table 2 - Annual expenditure for HRH retention and critical posts allowances

Category	*2012*	*2013*	*2014*	*2015*
Retention Allowance:				
C5 and above	4,473,067	5,385,626	5,788,976	5,900,237
Critical Post Allowance:				
National Level	160,412	N/A	357,152	221,424
Provincial Health Executive			429,552	322,320
Doctors	472,589	958,996	1,085,570	1,115,896
Midwifery Tutors	209,747	339,126	353,091	431,165
District Health Executive	403,680	735,665	318,031	321,155
Practicing Midwives	769,170	1,585,645	2,146,731	2,129,462
Village Health Workers	N/A	N/A	527,220	822,240
Total	**6,488,665**	**9,005,058**	**11,006,323**	**11,263,899**

Through the critical posts allowance doctors received on average approximately US $574 per month in 2015, compared to US $480 in 2012; tutors' monthly allowance increased from US $380 in 2012 to USD $500 in 2015, while practicing midwives' allowance increased from US $37 to US $45 per month in 2015. The average salary top-up for each health workers at Grade C5 and above was approximately $276 per year.

Table 3 HTF Actual expenditure on the Theme 3 HRH 2012-2015

Activity Description	**2012 Actual Expenditure**	**2013 Actual Expenditure**	**2014 Actual Expenditure**	**2015 Actual Expenditure**
Health worker retention scheme	$6,969,314.92	$5,686,213.20	$11,793,524.41	$10,058,246.82
Critical post allowances	$1,469,566.81	$1,344,686.10	$3,646,040.41	$10,578,825.72
Total	**$8,438,881.73**	**$7,030,899.30**	**$15,439,564.82**	**$20,637,072.54**

A comparison of the financial information for the Theme 3: Human Resources for Health presented in the UNICEF 2015 HTF Annual Report (March 2016) with the information on the HTF actual expenditure versus planned expenditure for 2012 to 2015 provided by UNICEF in May 2016 revealed some discrepancies. For example the UNICEF May 2016 expenditure data indicate that over the period a total of USD $51,546,418.39 was allocated to the retention, compared to a total of USD $37,763,945 presented in the March 2016 Report. No disaggregated information was provided on the expenditure data to allow an analysis of the expenditure across the different critical posts.

As shown in Table 4 below the greatest difference between planned and actual expenditure is in 2015, which shows a variance of was approximately USD $8.5m. UNICEF explained that these *discrepancies and the increased expenditure was because 'the allowances for the fourth quarter of the year are paid in the first quarter of the next year and as well in 2014 there was an increase in the*

number of nurses because the Ministry of Health was granted authority to lift its freeze on recruitment of staff. The number of midwives receiving the retention allowances also increased above the number in the expected expenditure'.

Table 4 - Financial information on Human Resources for Health (2015 HTF Annual Report)

Description	***Planned Budget***	***Actual expenditure***	***Variance/overspend***	
			No	%
Health worker retention scheme	6,421,852.00	10,058,246.82	3,636,394.82	36
Technical Support and 'Top Up payments for key MoHCC positions (including HTF Coordinator TA and Fin Assistants) **(Critical Post Allowance)**	5,578,744.00	10,578,825.72	5,000,081.72	47
Total	**12,000,596.00**	**20,637,072.54**	**8,636,476.54**	**41**

Source: Extracted from UNICEF planned versus actual expenditure (May 2016)

Variances were also identified between the UNICEF financial information and the expenditure data provided by Crown Agents in April 2016. Some of these difference may be due to the management fees chareged by UNICEF, which in 2012 were estimated to range from15% to 18%.

Findings

Results of the Retention Scheme

The effectiveness of the retention scheme can be measured by the increase in the number of health workers retained and in post. HTF funded allowances targeted critical posts and services at district and PHC levels and have helped to reduce clinical and managerial attrition and vacancy rates. According to an MOHCC official since the implementation of the retention scheme in 2009, vacancy rates have fallen for most of the key health professionals; more doctors, midwives and midwifery tutors especially have been attracted and retained across all the provinces.

As noted in the HDF report, the HTF has been crucial in retaining skilled and motivated health workers contributing to increased availability of quality health services (Box 3. Quote 1, 2). Similar finding observed from interviews with key policy makers from the MOHCC as the respondent commented the increased availability of health workers in hard to reach areas has been "one of the legacies of the HTF" (Box 3. Quote 3).

Staffing data available for the period 2009 to 2015 (presented in Table 5 below) were examined to identify staffing trends and assess retention rates. As these data show there was an increase in the overall health workforce up to 2013, with a total of 25,513 professional staff in post. However there

is decrease in staffing between 2013 and 2015, especially amongst the nursing cadres, which the HR Director indicated may be due to the exclusion of nursing aides and students from the 2015 figures.

The overall number of doctors increased by 346 over the period while there is a small increase in in the pharmacy cadre. There has been a decline in the number of environmental health workers available over the period; with 235 fewer in 2015 than in 2013 and in the number of radiography staff. The HSB estimates that by 2013 the annual retention rate for nurses had improved by about 1.5% from 96% in 2010 to 97.5% in 2013, and for doctors by about 1.2% from 93.4% in 2010 to 94.6% in 2013. 12

Table 5 - Staffing trends for selected cadres 2009-2013

Cadre	2009	2010	2011	2012	2013	2015	Increase (2009-2015)
Doctors	827	916	1000	1059	1122	1173	346
Nurses	16668	17029	16458	15536	18677	12057*	(4611)
Pharmacy	383	472	443	378	391	409	26
Laboratory & Pathology	274	417	349	352	341	385	111
Radiography	251	206	239	233	237	252	1
Environmental Health	1141	1433	1758	1905	1902	1667	526
Nutrition	774	905	839	856	843	n/a	69
Total	**20318**	**21378**	**21086**	**20319**	**23513**	**15943**	

Source: Staff Returns, 2013 extracted from the HRH Country Profile Update 2013; 2015 staffing data presented at MODO, July 2016
*Does not include trainees or nurses aides

Between 2009 and 2013 the total health workforce increased from 27,840 health workers to 31,347 (12.6%) as shown in table 6 below. HSB staffing data indicate that by 2014 a total of 37,412 health workers were employed in public, mission and Rural District Council (RDC) facilities across the country.

Table 6 - Health workforce expansion 2009 -2013

Year	Public Health Workforce
2009	27840
2010	28851
2011	29092
2012	28071
2013	31347

Source: Staff Returns, 2013 extracted from the HRH Country Profile Update 2013

Between 2009 and 2015 vacancy rates for key cadres rates fell, with the greatest decrease in doctors' vacancies, from 60% in 2009 to 31% in 2015 (MODO, July 2016). Vacancy rates for midwives could not be determined as only aggregated data were presented for all nursing cadres and there are still no established posts for this cadre to enable disaggregated recording, however as Table 7 shows vacancies within the nursing cadre fell by half over this period, and in 2015 of all the professional health cadres, nursing had the lowest vacancy rate. The highest vacancy levels were

[12] Health Service Board (2014) Submission of a health worker retention plan (2015-2016) in fulfilment of the special terms and conditions (STCs) in the new HIV new funding model grant agreement between the Global Fund and UNDP

amongst the radiography cadre (51%), followed by top management (43%), the pharmacy cadre (34%), and then doctors (37%).

Table 7 - Vacancy rates for selected cadres in 2009, 2013 and 2015

Cadre	*Vacancy rate 2009 (%)*	*Vacancy rate 2013 (%)*	*Vacancy rate 2015 (%)*
Top Management	48	43	47
Doctors	60	37	31
Nursing	14	10	7
Environmental Health	50	24	33
Pharmacy	39	34	31
Radiography	54	50	51
Nutrition	18	14	N/a
Lab /Pathology	58	47	40

Source: Staff Returns, 2013 extracted from the HRH Country Profile Update 2013; 2015 data from HR Director MODO presentation July 2016

According to the 2014 HTF report the overall vacancy rate among health workers dropped from 21% in 2012 to 16% in 2014.13 In 2014 the staffing establishment for public, mission and Rural District Council (RDC) sectors was 43,254, 37,412 posts were filled and there was an overall vacancy rate of 14%. As shown in Table 8 below, 15% of the 35,525 established posts in the public sector and 13% of posts at grade C5 and above were vacant in 2014.

Table 8 - Vacancy Rates by Sector

Sector	Establishment	In-post September 2014	Vacancy Rate (%)
Public Sector	35,525	30109	15
Public Sector, Grade C5 and above	19,608	17,066	13
Mission	4,517	4154	8
Mission, Grade C5 and above	2,181	2052	6
RDC	3,212	3149	2
RDC, Grade C5 and above	1,419	1149	19
Total	43,254	37412	14
Total Grade C5 and above	23,208	20267	13

Source: Health Service Board, September 2014

Payroll data reveal that the HTF funded allowances and incentives were effective in increasing the number of health workers attracted and retained in the government health sector between March 2012 and December 2015 (Crown Agents 2016; UNICEF 2016). During this period the number of staff at Grades C5 and above receiving the retention allowance increased by 1,991 (10.7%), from 18,593 in 2012 to 20,584 health workers in 2015. Table 9 below also shows that in 2015 35 national level managers, 51 provincial health executive (PHE) and 281 district health executive (DHE) members, 162 doctors, 72 midwifery tutors, 3,941 practicing midwives and 4,568 village health workers (VHWs) were also receiving the HTF funded critical posts allowances.

[13] The Health Transition Fund Implementation Report January – December 2014, UNICEF (2015)

Table 9 - Number of staff receiving retention and critical post allowances from 2012 to 2015

Category	*2012*	*2013*	*2014*	*2015*
Retention Allowance:				
C5 and above	18,593	18,640	20,204	20,584
Critical Post Allowance:				
National Level Managers	35	35	35	35
Provincial Health Executive	51	51	51	51
Doctors	82	121	138	162
Midwifery Tutors	46	47	60	72
District Health Executive	269	284	285	281
Practicing Midwives	1,727	2,691	3,822	3,941
Village Health Workers			4,073	4,568
Total	20,752	21,783	28,668	29,694

Source: UNICEF 2016

There are indications that the scheme has also been efficient. All the 47 district level hospitals surveyed (2016 LSTM Survey) in 2016 all had at least 1 medical doctor available, while 74% of the fifty-three (53) district hospitals surveyed during VMAHS Round 26 (VHMAS Round 26, October to December 2015) had at least 3 doctors in post. This is coming from a situation prior to the HTF where half of these districts had no doctors.

The spot checks and the verification processes put in place have also had a positive effect on health worker attendance; there are more staff available for work and less absenteeism as a result. The RBF programme also reports that it is also reinforcing this trend, as health workers who are not present on the day service outputs are achieved do not benefit from the incentives provided.

Respondents participated in interviews in 2016 confirmed that absenteeism was declining and where there was a problem with an absent health worker there were well established procedures in place to deal with it. (Box 3. Quote 4, 5).

Furthermore, the RBF programme found that client satisfaction was higher as a result of more positive staff attitudes.14 Community members reported that staff reported for work on time, were more willing to serve the community even after clinic hours and to conduct outreach services and to listen to the communities' perspectives[15].

While length of stay and attrition data were not available for review, one respondent commented that the availability of doctors had improved as a result of the retention allowances, not only in terms of numbers but also in terms of the time they stayed in the facility. Some reported that before the HTF they were no doctors in the district but now most districts have an average of three doctors. Other respondents indicated that there was greater availability of staff because there were fewer resignations in recent years. (Box 3. Quote 6).

[14] World Bank Group (2014) Results-Based Financing Progress Report, 2014. Health Results Innovation Trust Fund (HRITF)
[15] World Bank Group (2014) Results-Based Financing Progress Report, 2014. Health Results Innovation Trust Fund (HRITF)

Box 3. Illustrative quotes for "Results of the retention scheme"

Quote 1: "the allowances and incentives supported under the HTF were crucial in retaining a skilled and motivated health workforce, essential for the continued availability of quality health care services. The health workers retention scheme has proved to be an important contributory factor in the reduction of vacancies in the health sector and the increase in facility-based births."

Quote 2: "There was a time when some districts didn't have a single doctor but some are now boasting of four doctors, and for me this is improving access to the ordinary populace, including the mothers and their children." KII respondent 20

Quote 3: "[HTF] is the availability of health workers in remote, remote settings. Now most districts have doctors, 3 on average, which never used to happen. This is because they were getting the HTF allowances. It really worked wonders; I think the availability and capacity of health workers in all our facilities and this is across doctors, midwives, …I think that one, is a legacy." KII respondent 29

Quote 4: "There is no absenteeism because of the money they are getting people are just working." KII respondent 4

Quote 5: "…now that they are now getting an extra mile in form of HTF, we haven't seen much of that in terms of resignation because they are being treated by that form of allowance." KII respondent 19

Quote 6: "When a person is absent from duty for 5 days we inform the PMD that so and so has not reported for duty and after 14 days we cease the salary and after 30 we discharge, so that one we have been dealing with it." KII respondent 4

Quote 6: ": 'length of stay within the posting, there are less resignations, there is continuity in service provision. …the skills mix have improved." KII respondent 20

Retention of Doctors

Table 10 below shows a total of 135 doctors receiving the allowances in district hospitals in 2015, an increase of 57 doctors from the 78 that were available in 2012. The greatest influx of doctors was between Q2 2012 and December 2013, when an additional 52 doctors were added to the payroll. There was an overall increase in the availability of doctors in all provinces, between 2012 and 2015, except in Masvingo, however, most of the provinces experienced a falloff in numbers between 2014 and 2015. Mashonaland Central was the exception; numbers continued to rise in the province and it the highest overall increase of 15 doctors over the period.

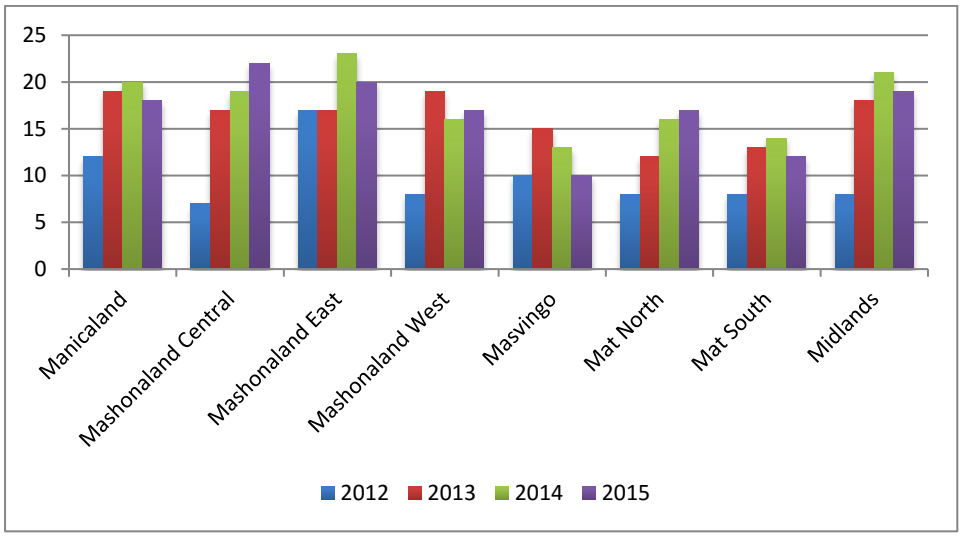
Table 10 - Doctors receiving retention allowances 2012-2015

Province	*2012 (Q2)*	*2013*	*2014*	*2015 (Q4)*	*Overall increase*
Manicaland	12	19	20	18	6
Mashonaland Central	7	17	19	22	15
Mashonaland East	17	17	23	20	3
Mashonaland West	8	19	16	17	9
Masvingo	10	15	13	10	0
Matabeleland North	8	12	16	17	9
Matabeleland South	8	13	14	12	4
Midlands	8	18	21	19	8
Total	**78**	**130**	**142**	**135**	**54**

Source: Crown Agents retention database, March 2016[16]

The data highlight fluctuations in the number of doctors over the period, both within and between the years, as shown in Figure 1 below. While the exact causes of these fluctuations is unclear, this type of turnover and movement of doctors could have a negative effect on team morale, workloads, client satisfaction and quality of care, as well as increasing the administrative and recruitment costs incurred to replace them. These fluctuations should be closely monitored so that any negative effects can be mitigated.

Figure 1 - Fluctuations in doctor numbers 2012-2015



Some discrepancies were observed between the UNICEF retention data and the payroll data maintained by Crown Agents, with the UNICEF data reflecting higher numbers of doctors (162 versus 135 documented by CA) and midwives (3941 versus the 3362 recorded by CA) and tutors (72 versus 62 documented by CA) receiving the critical post allowances, as shown in Figure 1 above. These discrepancies could be explained by the fact that UNICEF are responsible for paying the allowances for the PHE and DHE members and senior management in the MoH, HSB and NatPharm, which could include include some doctors and others in the critical post categories.

However, as the data from Crown Agents were disaggregated and more amenable to analysis and interpretation, they were selected and used to highlight trends in doctors, midwives and tutors retention in this case study.

Retention of Midwives

The HTF funded allowances were effective in improving the numbers of midwives trained and retained. Table 11 below shows that 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 sector. Compared to the situation in 2011 when there were an estimated 500 midwives practicing in Zimbabwe, this represents significant progress.

[16] The data provided by Crown Agents on the numbers of doctors receiving the retention allowances under the HTF between 2012 and 2015 as shown above in Table 9 differed from the numbers provided by UNICEF, which indicated a total of 162 doctors receiving the allowances in 2015. Attempts to clarify and resolve these discrepancies were unsuccessful.

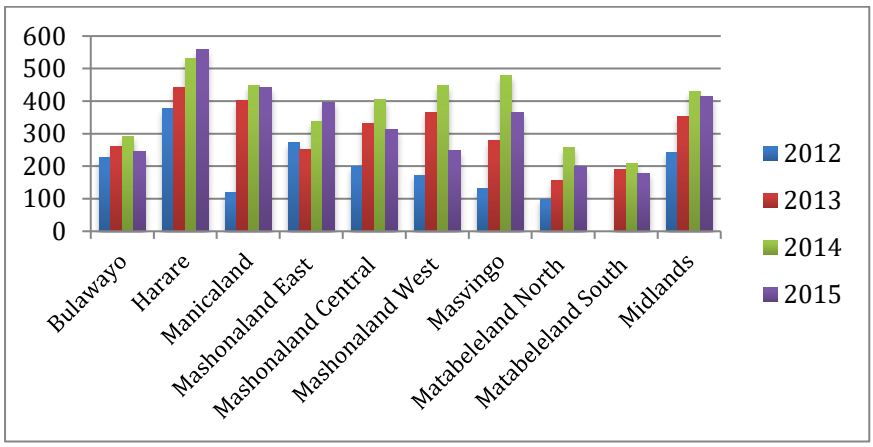
Table 11 - Practicing midwives receiving allowances in district level facilities

Province	*2012*	*2013*	*2014*	*2015*	*Overall Increase*
Bulawayo	226	262	290	246	20
Harare	376	442	531	558	182
Manicaland	119	401	448	442	323
Mashonaland East	273	252	337	397	124
Mashonaland Central	199	331	405	314	115
Mashonaland West	173	364	447	249	76
Masvingo	132	278	479	364	232
Matabeleland North	99	157	257	199	100
Matabeleland South	0	190	209	179	179
Midlands	241	354	429	414	173
Total	**1838**	**3031**	**3832**	**3362**	**1524**

Source: Crown Agents retention database, March 2016 [17]

All provinces show a steady increase in the numbers of practising midwives receiving the retention allowances up to 2014, however between 2014 and 2015 there are 470 less midwives on the payroll, with the majority (198) of these losses from Mashonaland West province. The reason for this fall in numbers is unclear, but should be closely monitored to ensure this is not an indication of an emerging attrition problem.

Figure 2 - Numbers of practising midwives 2012-2015



Midwifery Tutors

The HTF support for midwifery tutors was effective in improving midwifery training capacity. The HTF funded critical post allowances for tutors helped to attract and retain 18 additional midwifery tutors in the schools, with tutor numbers increasing from 44 in 2012 to 62 in 2015. The number of active midwifery schools increased from 12 in 2010 to 22 in 2015, with a total of 2,943 midwives trained and 3,362 retained during this period.

[17] The data available from Crown Agents on the numbers of midwives receiving the retention allowances under the HTF between 2012 and 2015 as shown above in Table 10 differed from the numbers provided by UNICEF, which indicated there were 3,941 midwives receiving the allowances in 2015. Attempts to clarify and resolve this discrepancy were unsuccessful.

Table 12: Midwifery tutors in post 2012-2015

Province/Institution	2012	2013	2014	2015
Chitungwiza	3	2	4	5
Harare Central Hospital	3	3	3	3
Manicaland	4	8	9	9
Mashonaland Central	6	8	9	8
Mashonaland East	2	2	2	7
Mashonaland West	4	4	4	4
Masvingo	2	3	3	4
Matabeleland North	1	1	4	3
Matabeleland South	2	2	2	3
Midlands	7	6	6	6
Mpilo	5	4	4	6
Parirenyatwa	5	4	4	4
Total	**44**	**47**	**54**	**62**

As shown in Table 12 above the number of midwifery tutors in the schools increased over the period, expect for the schools in Midlands province and in Parirenyatwa, both schools currently have one tutor less than they had in 2012. While student enrolment increased substantially in Harare Central Hospital Midwifery Training School from 2013 to 2015, no corresponding increase in tutors is reflected in the data.

The team-based performance incentives provided to staff in facilities in rural districts under the RBF programme have also been shown to improve staff morale and facilitate teamwork.[18] A recent World Bank impact assessment of the RBF programme concluded that it has triggered and facilitated changes in staff performance, and influenced staff motivation and satisfaction in the facilities covered by the programm.[19] Furthermore, more frequent and improved support supervision and feedback, availability of technical expertise and coaching by the district health executives (DHE) was reported to have boosted health workers performance and promoted relationship building between health providers and district health supervisors.[20]

HTF Support to Village Health Workers

The HTF effectively supported and strengthened the village health workers (VHW) programme over the period, and in 2015 was providing 4,568 VHWs with a monthly allowance of $14. Table 13 below provides a breakdown of the number of VHWs receiving the allowance in each of the provinces in December 2015. Since 2014 there has been an increase in the number of VHWs in all provinces, except Mashonaland East, where numbers dropped by 20. Midlands province had the greatest increase, adding 154 VHWs between 2014 and 2015.

Table 13: Number of VHW receiving allowances and cost

Province	August 2014 to April 2015		May 2015 to December 2015	
	Number	Amount	Number	Amount

[18] Results Based Financing (RBF) Impact Evaluation: Key Messages. MODO Meeting Nyanga 5 January 2015

[19] World Bank Group (2015) Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes. Evidence from Zimbabwe Results Based Financing Impact Evaluation

[20] World Bank Group (2014) Results-Based Financing Progress Report, 2014. Health Results Innovation Trust Fund (HRITF)

Manicaland	533	67,158	579	63,504
Mashonaland East	1,131	136,710	1,111	119,644
Mashonaland Central	454	57,204	530	56,000
Mashonaland West	358	45,108	413	44,576
Masvingo	344	43,344	392	41,272
Matebeleland North	524	66,024	562	59,584
Matebeleland South	367	46,214	447	46,704
Midlands	362	45, 612	516	54,428
Total	**4,073**	**507,374**	**4,568**	**453,900**

Source: HTF 2015 Annual Report (March 2016)

Stakeholders' Perceptions of the Effectiveness of the Retention Scheme

Many of the respondents who participated in the interviews and group discussions described how the retention allowances have stabilized the staffing situation, reduced staff turnover and absenteeism, improved skills mix, and the availability, retention of trained and skilled staff, especially in remote facilities. (Box 4. Quote 1, 2, 3, 4, 5, 6, 7). Other described how the supervision and verification processes linked to the scheme ensure that health workers 'channel their efforts on the work, rather than looking for income generation opportunities elsewhere and as a result have led to 'work improvement'. Most key informants agreed that the allowances had been helpful in improving staff motivation and the quality of service provision. (Box 4. Quote 8, 9, 10).

One doctor described how moving from a central hospital to a district level hospital had provided him with greater opportunities for professional development (Box 4. Quote 11). While another health worker described how having additional doctors in the hospital was helping her to improve her skills and knowledge(Box 4. Quote 12).

Box 4. Illustrative quotes for "Stakeholders' perceptions of the retention scheme"

Quote 1: "There is also stability in staff at the rural centres and even at the hospital." KII Respondent 11

Quote 2: "Most of the staff in the facility have been here for over 8 years, doctors have been here for over 3 years." KII Respondent 19

Quote 3: "Staff are remaining in post and we have other cadres wanting to come back for re-engagement, so I would say it worked." KII Respondent 31

Quote 4: "Registered nurses have gone for training… before the HTF we used to have less than 5 midwives, now the department is being managed by more then 18 midwives." KII Respondent 19

Quote 5: "With the allowances, one will channel your effort on your work other than looking for money elsewhere. The incentives also come with supervision, so there is a lot of work improvement." KII Respondent 21

Quote 6: "In 2012 we used to have 3 midwifes. And now we have 13 midwives." KII Respondent 15

Quote 7: "One that is very visible is the availability of Health workers in remote, remote settings. I think as at the end of the year, even now, most districts have doctors, 3 on average which never used to happen. This is because they were getting the HTF allowances. It really worked wonders; I think the availability and capacity of health workers in all our facilities and this is across doctors, midwives, specifically I think that one, is a legacy." KII Respondent 29

Quote 8: "…giving midwives some money, just to thank them for working in maternity areas, motivated many nurses to go for midwifery, that allowance motivated a lot of people, and after being motivated they were working very well." KII Respondent 4

Quote 9: "The Retention Allowance played a huge role in ensuring that there is adequate human resource capacity across the country; which then improved the services." KII Respondent 29

Quote 10: "It's little but we appreciate. It's better than nothing; at least we are getting something to motivate us. It's little but to us it goes a long way." KII Respondent 13

Quote 11: "…at least now I can do caesarean section, I treat children, I treat elderly, getting a better feel of everything." KII Respondent 19

Quote 12: "…the doctors we are having here, we are learning a lot through them. We do grand rounds, they give us lectures and when even attending to patients they even teach us some of the thing we haven't been taught at school." KII Respondent 19

Challenges

While the scheme funded through the HTF and GF has helped to stabilise and retain critical health workers in recent years, many voiced dissatisfaction with the selection and eligibility of beneficiaries and with the overall administration of the scheme. 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, which are paid separately from the salary and funded from different sources.

Some health workers perceived the scheme to be divisive and caused conflict and resentment amongst health workers, as the rationale for who was benefiting was not always clearly understood.. One respondent suggested that if staff were being paid what they were 'worth', they would not be 'looking at what the other person is earning', but because 'every dollar makes a difference' in the

current economic climate, c health workers get resentful when they see others getting allowances that they are not getting. (Box 5. Quote 1)
Many respondents had concerns particularly with the 'practicing midwives' allowance ; this allowance seemed the most divisive, especially among the midwives in the district level hospitals surveyed, where it is paid to only those midwives who are allocated to and working in the maternity wards. Many of these hospitals have sent their RGNs for midwifery training and now have large numbers of midwives in the facility, all of which cannot work in the maternity ward. Hospital management mentioned 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.

One of the most common complaints raised by respondents was related to who was eligible to get the practicing midwife allowance and the divisions this created as some health workers felt they were being excluded and their skills and long service were not recognized. On respondent described how she had undergone training and had been a midwife for 35 years in the same facility but was not receiving the midwife allowance, because she was not working in the maternity ward.'

Some described how the eligibility criteria for the retention scheme were unfair and they were so demotivated because they were not receiving the allowance that they would refuse to treat patients or would refer them to those who are receiving the allowances. The tensions and 'rifts' between those receiving the allowances and those who are not, was also an issue raised during the 2015 JRM. (Box 5. Quote 2, 3, 4, 5) Others respondents were more concerned about the exclusion of others and felt that it was divisive and impacting negatively on teamwork and working relationships. (Box 5. Quote 6,7,8)

A common complaint and one raised repeatedly over the years by respondents is the issue of the untimeliness and unpredictability of disbursements, 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.

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. Furthermore respondents felt that there were no communication channels to get information and no one that they could raise these concerns with or who could help them resolve the issue. (Box 5. Quote 9,10). Some suggested that the government should issue and provide each health worker with a pay slip, rather than the current practice of sending the information to the provincial offices; this would then help them know how much they have received, for what period and on what date.

This lack of communication and information about the scheme was a common thread throughout many of the discussion and interviews with health workers at the facility level. This issue was also raised in the 2012 Impact Assessment[21], which concluded that while administrative staff and PHE and DHE members had easy access to information through notices or circulars, this information was less accessible to staff in the facilities, especially those in remote areas. Officials consulted about this issue in 2016 acknowledged the importance of information sharing and engaging health workers, however information continues to be communicated regularly managers, through circulars or at meetings and workshops, and is not always passed on down to staff at the facility level. (Box 5. Quote 11)

[21] Dieleman, et al (2012) as previously cited

Respondents also expressed dissatisfaction with the declining value of the allowances which in the current economic climate *'is very little, the money is not sufficient to take care of my family'* and they had not received any notification about the changes.. This was all the more difficult as there had not been a corresponding increase in government salaries and other benefits to make up for the shortfall. Some indicated that the payment of salaries were also unpredictable and *'erratic' and* have been decreasing in recent years, with the government taking deductions for rent and pensions, with one respondent complaining that they could not *'survive'* on the salary alone. One respondent reported that with these deductions health workers were, '*going to get peanuts'* and they had '*no other sources of getting money'*. Another respondent complained that the payment of salaries was unpredictable and *'erratic'* and health workers often did not know when they would be paid, '*maybe today we are paid, the next month postponed.'* None of the health workers interviewed in March 2016 had yet received their '13th cheque' from 2015. (Box 5. Quote 12)

Others indicated that the allowances received were not sufficient to motivate them. One midwife commented that midwives were not staying in the facilities because of the allowances but rather that they had no alternative or opportunity to move and did not have the necessary financial resources to process visa and leave. (Box 5. Quote 13)

Many respondents perceived that workloads are increasing, particularly for midwives and doctors, and this is affecting performance and staff motivation, and could potentially reduce the quality of care over time. This reported increase in workload could be due to a number of factors, including staff shortages, outdated establishment, increase in facility deliveries, the introduction of the RBF with its focus on performance and targets, as well as the additional administrative tasks it requires. The improved availability of drugs and supplies and the abolition of user fees in the facilities may also be attracting new patients and increasing utilisation. (Box 5. Quote 14,15)

Some respondents indicated that the lack of equipment and drugs, as well as workload were causes of dissatisfaction and frustration and was affecting the quality of the services they were providing.. Doctors felt frustrated when they prescribed drugs that they knew '*the patient is not going be able to afford or will not be able to buy because it is not available at the hospital pharmacy'.* Another doctor complained about the shortage of equipment and drugs, and commented that if these were available he could improve the patient's health outcome.

Many respondents are very concerned about the reduction or withdrawal of the allowances as the HTF transitions to the HDF 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 the cuts in the funding for the HDF. Concerns about the consequences of reducing or removing the current package of HTF funded incentives and allowances both on the continued retention of critical cadres and on service delivery were raised at all levels.

Respondents cautioned that withdrawing or reducing the allowances would lead to more '*brain drain'* and/or further demotivate health workers. Others warned about '*a huge attrition of health workers'*, a potential '*looming disaster' and* '*chaos'* if the allowances are stopped, and suggested that that '*people will look for jobs elsewhere…outside the country ….or the private sector.*' Other described how both the health worker and the patient will '*suffer'* and there will be *a need for 'greener pastures'.* (Box 5. Quote 16). A few respondents were more positive about the future and felt that health workers would not leave; '*they will continue working but they will be demotivated',*

and may *'abuse sick leave*' or '*engage in some activities to cushion up their salary, that might affect the quality of services.*

The uncertain situation is further exacerbated by the lack of information available to health workers regarding future arrangements and support for the payment of allowances under the HDF. This is creating speculation and distrust among frontline staff about the motives of senior management, who they suspect will protect their own allowance while cutting those of the staff at lower levels. (Box 5. Quote 17)

All of these issues including, low remuneration, uncertainty about the allowances, staffing shortages, increased workloads, and poor workplace environments are starting to affect staff motivation and morale, and adding to these push factor are the pull factors exerted by other countries in the region (e.g. Namibia and South Africa currently) that are actively recruiting Zimbabwean health workers, especially midwives.

One respondent reported that many of her former midwifery students have been requesting transcripts; an indication that they are preparing to go and work in another country. She also confirmed that one of major causes of discontent among midwives was the lack of opportunities to work in a maternity ward after their training. (Box 5. Quote 18)

Another key informant described a recent meeting with the Namibian nursing and midwifery registrar, who informed her that *'in a week she is processing 500 applications of midwives from Zimbabwe'.* Zimbabwean nurses and midwives are reportedly in demand because *'they are well trained, nobody compares with us in the region*.

Box 5. Illustrative quotes for "Challenges of the retention scheme"

Quote 1: "…we are not paid what we are worth. You then look at people focusing more of their attention on what the next person is receiving, rather than doing their work. But if I am paid what I am worth I don't the time to look at what the other person is earning but because we are living in an environment where every dollar make a difference, we spend a lot of time analysing the benefit accruing to the next person, which is to me most unfortunate." KII Respondent 20

Quote 2: "I am not getting the retention allowance; it is given to other midwives, so it is a disadvantage on my side, but I am also a maternal and child health care midwife. For me, I think it demotivates me, since others are getting and I am not getting it." KII Respondent 29

Quote 3: "I am 35 years here I have never received a midwife allowance, yet I went through the midwifery course. When you check with the district, they informed us that the allowance is for only those nurses who work in wards." KII Respondent 6

Quote 4: "For the midwifery allowance there are some great discrepancies, take for an example there is an emergency pertaining to maternity case, a midwife who is working in the female ward might be called to attend …remember we have shortage of staff, so we have to move staff from female ward to assist in maternity ward for a day or two. This person is not getting the midwifery allowance." KII Respondent 4

Quote 5: "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." KII Respondent 4

Quote 6: "It divides the staff and can put patients at risk because someone can say this duty is for midwife, I am not getting midwifery allowances." KII Respondent 19

Quote 7: "If other staff members are not getting the allowance, we feel it is not fair because we work as a team; they should also be paid." KII Respondent 14

Quote 8: "Another way of doing it is increasing salaries across the board as opposed to given an allowance that causes all this conflict, and then it becomes complicated and takes time to manage." KII Respondent 14

Quote 9: "We are not being paid timorously, we don't even have someone who can answer our questions, like this money that we are getting it's for which month? We don't even know if we can communicate directly to the person who is disbursing this money, then we could get the actual information on who is supposed to get this amount and when are we getting it, and why did we not get it this month. We just compile the reports but no feedback is given to us." KII Respondent 4

Quote 10: "The issue of feedback is very important, communication is very vital and if we are not getting an allowance this month, they should communicate this to us …so that people can budget." KII Respondent 4

Quote 11: "People don't have information of the allowance that comes, whether it is for that quarter or the previous one, there is no communication we just find money in your bank and they say is for retention but for which quarter, for which period, most of the people don't know." KII Respondent 4

Quote 12: "It has to come on time, rather than the 5 months or after two quarters. Sometimes when it's late you don't get it back, they will always say to us they are no back pays once you are skipped. We don't know how best we can rectify such a problem." KII Respondent 19

Quote 13: "The salary is actually going down, they are saying we are taking $40 pension and now they say the housing is $75, and we are going to take it back dated. I don't know up to what, so it means we are going to get peanuts, that's the honest truth, and we have no other sources of getting money." KII Respondent 12

Quote 14: "It's very little; I can't go to Murehwa to take $20, yet I have nothing in my pocket. It completely goes to the transport and it's over." KII Respondent 12

Quote 15: "The salaries are erratic because we don't know our pay days, we don't know our days for March, April, maybe today we are paid the next month postponed." KII Respondent 19

Box 5. Illustrative quotes for "Challenges of the retention scheme"-continued

Quote 16: "There is a shortage of equipment and drugs, things that you know if I had this and give the patient, the patient will get better. But they don't have it. I had to write a prescription for the patient to go and buy in the pharmacy, and I don't know whether the patient will have money or not but I just hope somehow they will get it." KII Respondent 11

Box 17: "No, they will not leave, they will continue working but they will be demotivated." KII Respondent 23

Box 18: "Employees will not absent themselves but they may abuse the sick leave, so that they can engage in some activities to cushion up their salary that might affect the quality of services." KII Respondent 4

Lessons Learned

Some of the key lessons learned from the implementation of the retention scheme are presented as follows**:**

- The provision of targeted and differentiated retention allowances and incentives has been an effective and efficient means to train, retain and motivate critical health workers
- While the verification processes were perceived to be unwieldy, the attendance monitoring and management as a result of these processes has reduced absenteeism
- A realistic longer term disengagement/exit strategy and action plan will help to ensure external financing is replaced with domestic resources within a specified period of time.
- The capacity to evaluate the effectiveness and impact of attraction and retention policies is hampered by the absence of a reliable baseline and robust monitoring and evaluation systems
- Ongoing policy dialogue on health workforce financing is critical to create fiscal space and move towards a more sustainable government funded harmonized remuneration system
- Staffing shortages and heavy workloads adversely affect health worker motivation and performance threatening the gains made in attracting and retaining staff; a revised and more realistic establishment is needed to ensure adequate numbers of skilled health workers are available and accessible across the health sector
- The influence of push and pull factors on health workers' job preferences should be well understood and intelligence used to design appropriate attraction and retention polices
- Non-engagement of health workers in the design of attraction and retention policies and lack of information on the management arrangements and components of the scheme, including amounts paid and payment schedules and notifications may cause resistance and conflict .

Beyond Results

Sustaining the positive results achieved through the HTF funded retention scheme remains uncertain given the national macroeconomic situation and level of donor funding committed to date for the HDF. Health workers, managers, government officials and donors alike reported being anxious about the sustainability of the scheme and identified the need for continued external funding to ensure the continued retention and motivation of critical cadres. The HDF suggests that *'the critical staff retention scheme will remain as another major area that requires support to ensure adequate numbers of appropriately trained staff are in place'.* (Health Development Fund Programme 2015)

Some health workers reported that they would stay even if the allowances were removed because they wanted to continue serving their communities, others however indicated that they would leave if they had the funds to process the visas required to work in other countries. The majority the midwifery trainees interviewed reported that they would not stay if they were not posted to a maternity ward and allowed to utilise their skills.

Generally health workers were dissatisfied with the unpredictability and the current value of the allowances; therefore reducing the allowances even further or removing them altogether could cause greater demotivation and frustration. These and other factors, such as low remuneration, heavy workloads and poor working and living conditions may push many out of the public health system, into the countries in the region that are actively recruiting Zimbabwean health workers. The lack of information available to health workers concerning future support for the scheme under the HDF is causing further uncertainty, and a growing resentment towards and distrust of senior management.

While continued external support and financing is likely to be required in the medium to long term to safeguard the gains made and enhance sustainability, there are a number of other measures that could be adopted to enhance sustainability of the results achieved under the HTF as follows:

- A realistic longer term disengagement/exit strategy and action plan should be put in place to replace external financing with domestic resources over a specified timeframe, with demonstrated commitments by the government to put the necessary measures in place to ensure the objectives of the exit strategy are achieved. Commitments and measures should be clearly articulated and monitored. Ongoing policy dialogue and advocacy on health workforce financing will be critical in moving towards a more sustainable government funded harmonized remuneration system for the public health workforce, that is embedded in realistic sector financing plans
- Continued support to retention allowances and incentives should be framed within a broader strategic approach to staff recruitment, retention, management and motivation, which utilises an integrated and coherent range of approaches that allows for localised solutions. 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.
- Engaging health workers in the design of new attraction and retention policies and/or modifications to the existing policy will ensure greater buy in, reduce resistance, help to manage expectations, and minimise conflict during implementation. Clearly communicating the purpose and objectives of retention policies and interventions to all staff, even those not targeted or benefiting from the scheme, will ensure the arrangements are perceived to be transparent and fair, including eligibility criteria, and the selection of beneficiaries
- Staffing shortages and heavy workloads are contributing to health worker demotivation and

poor performance; a revised and more realistic establishment is needed to ensure adequate numbers of skilled health workers are available 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 approval sought to recruit to fill vacancies and new posts

- Reliable and up-to-date information, and robust monitoring and evaluation systems are needed to ensure quality data and intelligence are available to policy makers and managers to monitor health worker flows and fluctuations, and to evaluate the effectiveness and impact of attraction and retention policies and interventions. Data on health workforce stock and flows, distribution, characteristics, vacancy rates, attrition trends, etc. should be generated and disseminated on a regular basis
- Working within government systems and promoting government leadership in the design and management of HR interventions will promote greater local ownership and will strengthen management capacity to develop localised solutions to address problems and bottlenecks.

Independent Evaluation of the Health Transition Fund in Zimbabwe

Annex 9
A case study on procurement of the Primary Health Care Package in Zimbabwe

Liverpool School of Tropical Medicine
Centre for Maternal and Newborn Health
May 2016

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1. Objectives and Methods of the Case Study

This case study focus on the supply of the pre-packed "Primary Health Care Package" (PHCP) which is a standardized pack of around 25 health products supplied to Level 1 health facilities.

The principle objective of the case study is to document to which **extent the monthly supply of PHCP to Level 1 health facilities has been efficient** to support the aims of availability of essential health products and as such a major factor for health status improvement.

The LSTM evaluation team refers to the "Value for Money"[1] (VfM) approach and in particular to How efficient is the supply chain (purchase, storage, delivery, appropriate package)

The table below outlines the key evaluation questions to determine the extent to which the results achieved can be sustained. The LSTM evaluation team used the following questions as guidelines to consider the Cost benefit and the Cost Utility. In addition to the VfM approach the LSTM evaluation team tried to identify a transition strategy to the post HTF.

Key evaluation questions
○ Was the procurement cycle efficiently organized? ○ Was the cost related to the procurement cycle reasonable in light of the expected utility? ○ Was the cost of the commodities in line with a bench mark?

2. Procurement and Supply Management in Zimbabwe

2.1 Background

Zimbabwe established in the eighties a well-functioning purchase, warehousig and distribution system incorporated in the NatPharm. The supply of health products was based on a pull system. Health products were delivered on demand of health facilities, based on individualized needs and in bulk health prodcuts. Management systems were and still are fully computerized with Microsoft's Enterprise Resources System Navision. NatPharm's PSM was known as well performing.

From 2005, the PSM slipped away with a total collapse in 2008 and the following years. The absence of health products in Zimbabwe had a disastrous impact on the health status of Zimbabwe's population.

The VHMAS study concerning period 2010-Q1 indicates that only 12.1% of the Level 1 health facilities had at least 80% of the selected list of health products in stock.

[1] Value for money, Flemming, 2013

Consequently the re-establishment of the PSM was considered as high priority by the HTF. The renewed set-up of the PSM and assure at least a minimum package of essential health products, it was decided to introduce the PHCP:

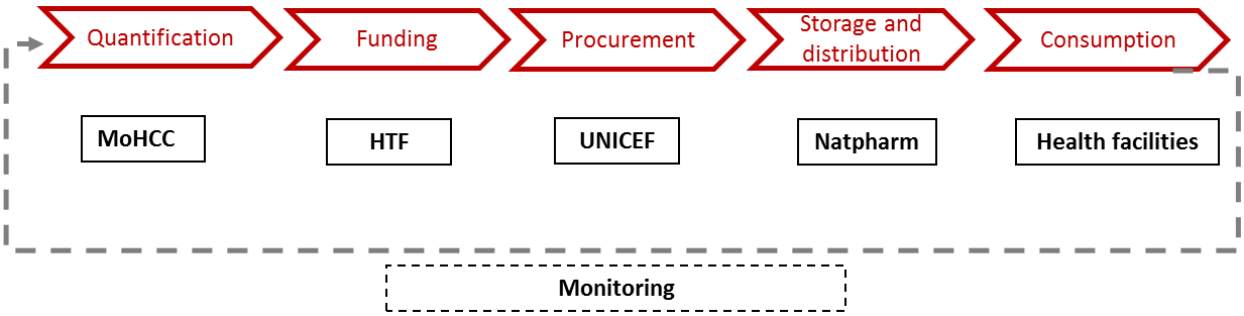
- Around 20 health products
- Standard quantities
- Financed by the HTF
- Purchased by UNICEF
- Received, warehoused and distributed by NatPharm

In addition to the PHCP HTF imported other health products (bulk health products, RUTF, blood coupons and vaccines), however these items will not be reviewed in this case study.

2.2 Role and responsibilities within the HTF programme arrangements

The PHCP PMS flow can be presented as following:

Figure 1. Procurement process and responsibilities for PHCP



2.2.1 Qualification

Every year the PHCP content (products and quantities) are reviewed. This process is guided by the MOHCC.

The review process results in a yearly adjustment of the PHCP content (products included and quantities).

During the duration of the HTF, the list of health products contained in the PHCP was extended from 19 (FY2012) to 25 for FY2015.

In addition, the quantities of dispensing units for selected PCHP items – defined as “number of packages X quantities in box” – increased substantially as shown in the table below.

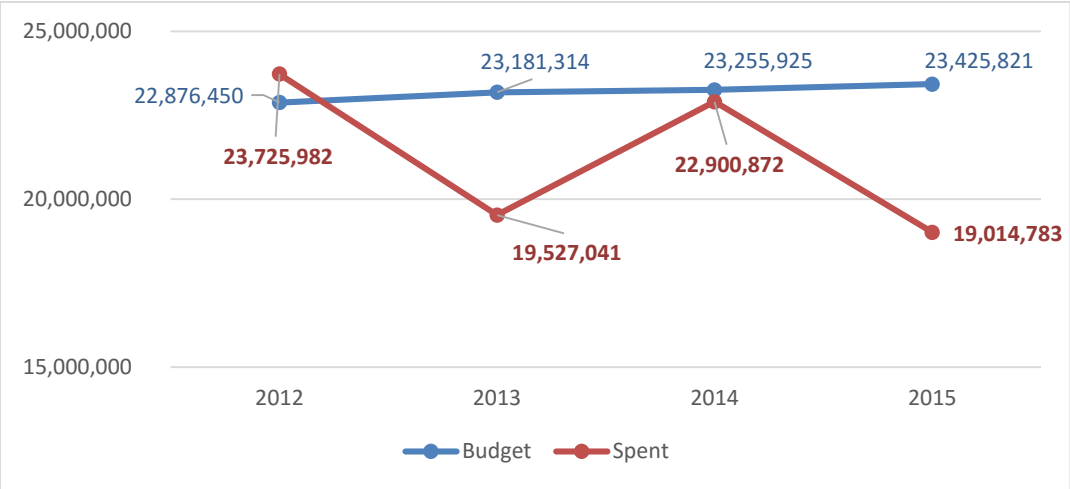
Table 1 - Health products in PHCP / Total number of dispensing units per PHCP (2012-2015)

Year	*Health products contained in PHCP*	*Tot. dispensing units*
2012	19	13,849
2013	20	34,220
2014	24	40,469
2015	25	40,479

2.2.2 Funding

The support to the procurement of health products was a major component of the HTF budget. The total annual allocation and expenditure for all health products is summarized below in Figure 2[2].

Figure 2 - HTF Health Products Budget



The health products budget covered several product groups including: i) the PHCP, ii) bulk health products, iii) Ready to use therapeutic food (RUTF); iv) blood coupons and v) vaccines. The procurement costs per PHCP are estimated at:

Table 2 - Unit costs of procurement of PHCP, 2012-2015 (USD)

Year	2012	2013	2014	2015
Unit cost of PHCP (USD)	***499.48***	***481.03***	***549.24***	***536.85***

Based on the number of the ordered PHCP (see below) and the estimated PHCP unit cost, the total costs of the PHCP have been calculated. The following table shows the yearly PHCP purchase value and the PHCP share of the overall health products budget.

[2] HTF year reports 2012, 2013, 2014, 2015

Table 3 - Cost of PCHP budget and relative cost to HTF budget for health products (USD)

Year	*Total value of Procurement of PHCP*	*% on HTF allocation to procurement*
2012	8,107,585	35%
2013	7,784,956	42%
2014	9,744,581	43%
2015	5,462,986	29%

2.2.3 Procurement

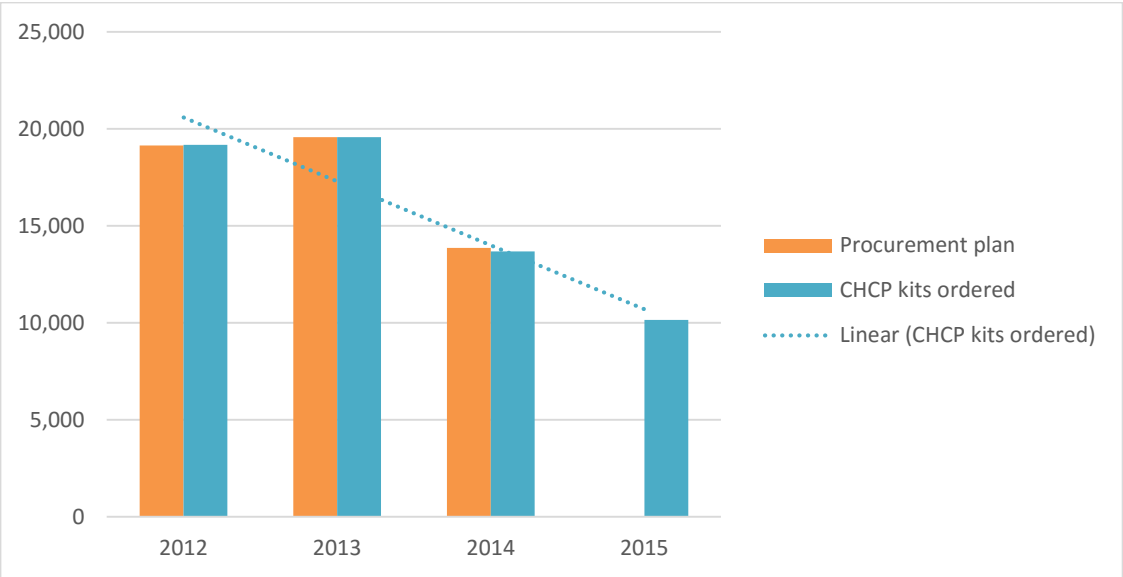
Purchase

The HTF PHCP procurement plan is stable over FY2012 and FY2013, with a sharp drop in FY 2014. Data on the FY 2015 procurement planning were not made available.

The HTF actually purchased the total of PHCP included in the MOH procurement plan for the year. Although the FY 2015 procurement planning is unknown, there is a very strong drop in the ordered numbers.

The purchased number of PHCP for FY 2015 stands at 52.9% of the number of PHCP ordered for FY2012.

Figure 3 - Procurement plan of PHCP and actual purchase from UNICEF



Receipt

After ordering, the PHCP are prepared as per Zimbabwe's yearly fixed health products and numbers. Over the financial year the PHCP are directly shipped to the 6 regional NatPharm warehouses. Not all PHCP are received in the same FY as they are ordered.

In FY 2012 the quantity transferred to FY 2013 was around 7.5% of the ordered quantity, in FY 2013 to 1.1% and in FY 2015 to around 33.1%.

In FY 2015, there is also an important number of PHCP not yet delivered to the shipping company by the end of the year: 840 PHCP (8.3%) of the ordered quantity. Since there was also a high quantity of PHCP still in transit, the total quantity of not received PHCP during FY2015 tops at 41.5% or 4.200 PHCP.

This high amount of PHCP in transit or pending delivery at the end of FY2015 can be an indicator of late funding by the HTF, late ordering by UNICEF or delay in delivery by the UNIPAC.

Figure 4 - Total number of PHCP ordered and received, 2012-2015

YEAR	*PHCP ORDERED*	*PHCP RECEIVED*		*TRANSIT*	*PENDING*	*TOTAL*
2012	19,167	17,727	92%	1,440		19,167
2013	19,556	19,332	99%	224		19,556
2014	13,680	13,680	100%			13,680
2015	10,136	5,936	59%	3,360	840	10,136

2.2.4 Distribution

Distribution to health facilities is ensured through NatPharm regional warehouses. Each warehouse serves one or more provinces. To know the population served per warehouse (catchment population) the estimated population has been calculated. The "Population" and "Provincial growth rates" were sourced from the "2012 National Census" report. The yearly population was extrapolated by the forecasted provincial growth rate (Base 2012). Hereafter the table, which shows the estimated Population of the Natpharm warehouses catchment areas:

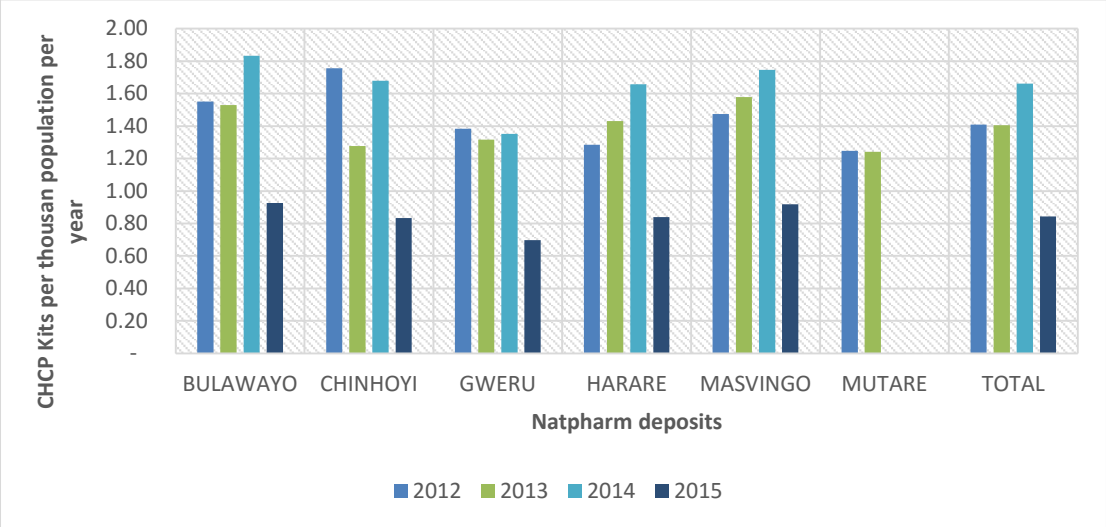
Table 4 - Estimated population per province/ warehouse catchment area

WAREHOUSE	CATCHMENT AREA	GROWTH	2012	2013	2014	2015
BULAWAYO	Bulawayo	1.8%	653,337	665,097	677,069	689,256
	Matabeleland North	1.8%	749,017	762,499	776,224	790,196
	Matabeleland South	1.4%	683,893	693,468	703,176	713,021
CHINHOYI	Mashonaland West	2.3%	1,501,656	1,536,194	1,571,527	1,607,672
GWERU	Midlands	2.2%	1,614,941	1,650,470	1,686,780	1,723,889
HARARE	Mashonaland East	2.1%	1,344,955	1,373,199	1,402,036	1,431,479
	Mashonaland Central	2.3%	1,152,520	1,179,028	1,206,146	1,233,887
	Harare	2.6%	2123132	2,178,333	2,234,970	2,293,079
MASVINGO	Masvingo	2.0%	1,485,090	1,514,792	1,545,088	1,575,989
MUTARE	Manicaland	2.3%	1,752,698	1,793,010	1,834,249	1,876,437
	Total Population		**13,061,239**	**13,346,090**	**13,637,265**	**13,934,905**

The distribution has been realized per NatPharm regional warehouse. Concerning Manicaland, the PHCP push system has been migrated after the first distribution round 2014 in to an "on demand pull" ordering system. In the calculation for FY2012 and FY2013 the distribution of PHCP in Manicaland (Mutare warehouse) has been taken in account, for FY2014 and FY2015 Manicaland was no longer taken in consideration.

Based on distribution data and on population estimates by "warehouse catchment area", we estimated the number of PHCP kits per thousand population, for each catchment area and for the whole period of the HTF.

Figure 5- PCHP kits per 1.000 pop, per year and by Natpharm warehouse



The following trends are observed:

1. On average, from 2012 to 2015, 1.3 PCHP per 1.000 population per year were procured and distributed
2. This ratio decreases over time from 1.4 in 2012 to 0.84 in 2015, partly because of the reduced procurement of kits, and partly because of population growth
3. Bulawayo was systematically oversupplied compared to other warehouses; Gweru was under supplied

3. PNCP costing and per capita input

Costing

The costs of a PHCP contains various components i) Cost of product ii) Cost of pick and packing by supplier iii) Cost of shipment and iv) Cost of clearing.

Once the PHCP are in the Natpharm warehouses, NatPharm has warehousing costs (storage, order preparation) and distribution costs.

These different costs elements are not easy to quantify via available reports and required additional information was only received partially and/or presented in a way that it makes it difficult to use that data.

From interviews with UNICEF, we do understand that UNICEF Zimbabwe orders straight from UNIPAC (Denmark) with INCOTERM DDP[3] regional warehouse NatPharm (all six).

The PHCP unit price becomes a general gross price including product cost, pick and packing, shipment, clearing and delivery up to the designated regional warehouse.

The LSTM Evaluation team used an internationally recognized drug price indicator list as a benchmark[4] to compare the HTF/UNICEF cost price per PHCP to the international average costs for similar health products.

The average costs used in the benchmark costing are those of 2014; these values were used for all years. To obtain the transport and clearing costs, the percentage paid by UNICEF have been used (FY 2015: 9%[5]).

This costing seems reasonable for a landlocked country and the long road distances to drive between the transit port of Beira (Mozambique) to the different NatPharm warehouses. E.g. Beira - Harare is estimated at 560KM and Beira - Bulawayo is estimated at 850KM[6].

The UNICEF costs unit price for each FY from 2013 to 2015 has been estimated:

- 2013: sourced from HTF year report 2013 + 9% transport costs
- 2014: sourced from HTF year report 2014 + 9% transport costs
- 2015: Sourced from real purchase costs received from UNICEF

Table 5 below compares the total estimated cost per kit as per actual quantities and reference price, and the costs actually incurred by UNICEF.

Table 5 - Cost of PCHP: comparison between UNICEF costs and benchmark (2013-2015)

HEALTH PRODUCT	PACK UNIT	UNIT PRICE	2013	2014	2015
AMOXICILLIN SUSP 125MG / 100ML	1	$ 0.54	$ 16.20	$ -	$ -
AMOXICILLIN TAB 250MG	100	$ 1.84	$ -	$ 9.20	$ 9.20
AMOXICILLIN TAB 250MG	1,000	$ 18.40	$ 55.20	$ 92.00	$ 92.00
BANDAGE 8CMx4M	1	$ 0.22	$ 4.36	$ 6.54	$ 6.54
COMPRESS GAUZE 10x10CM	100	$ 4.08	$ 12.24	$ 12.24	$ 12.24

[3] DDP is a transaction in which the seller must pay for all of the costs related to transporting the goods and is responsible for the goods unti they have been received and transferred to the buyer. This includes paying for shipping, the duties and any other expenses incurred while shipping the goods

[4] MSH (Management Sciences for Health). 2015. International Drug Price Indicator Guide, 2014 edition

[5] UNICEF

[6] In most cases the trucks drive back empty due to absence of export cargo. Client is charged for the entire return trip of the truck

HEALTH PRODUCT	PACK UNIT	UNIT PRICE	2013	2014	2015
COTTON WOOL 500GR	1	$ 2.58	$ 7.74	$ 7.74	$ 7.74
DOXYCYCLINE TABS 100MG	100	$ 1.41	$ -	$ 7.05	$ 7.05
ERYTHROMYCIN TAB 250MG	100	$ 3.91	$ 19.55	$ 19.55	$ 19.55
FERROUS+FOLIC 60+0.4MG	100	$ 0.31	$ 0.31	$ 0.31	$ 0.31
GLOVES EXAMEN LATEX MEDIUM	100	$ 2.74	$ 19.18	$ 13.70	$ 13.70
HYDROCHLOROTHIANZIDE 25MG	100	$ 0.43	$ 4.30	$ 4.30	$ 4.30
MAGNESIUM SULPHATE INJ 500MG	10	$ 1.32	$ 1.32	$ 1.32	$ 1.32
METRONIDAZOLE 250MG	1,000	$ 6.40	$ -	$ 6.40	$ 6.40
MICONAZOLE NITRATE CREAM 2% 30GR	1	$ 0.01	$ -	$ 0.07	$ 0.07
NEEDLE 19G	100	$ 1.29	$ -	$ -	$ -
NEEDLE 21G	100	$ 1.29	$ 1.29	$ 1.29	$ 1.29
NEEDLE 23G	100	$ 1.29	$ -	$ -	$ -
ORS SACHET FOR 1 LTR	100	$ 10.68	$ 10.68	$ 10.68	$ 10.68
ORS SACHET FOR 1 LTR + ZINC 20MG TAB	10	N/A	$ -	$ -	$ -
PARACETAMOL SOLUTION 125MG / 60ML	1	$ 0.10	$ 3.82	$ -	$ -
PARACETAMOL TAB 100 (125)MG	100	$ 0.20	$ -	$ 1.00	$ 1.00
PARACETAMOL TAB 500MG	1,000	$ 4.50	$ 36.00	$ 45.00	$ 45.00
POVIDONE IODINE SOL 10% 500ML	1	$ 4.35	$ -	$ 4.35	$ 4.35
SALBUTAMOL TAB 4MG	1,000	$ 3.30	$ -	$ -	$ -
SULF 100GR + TRIMET 20MG	100	$ 0.51	$ 25.50	$ 10.20	$ 10.20
SULF 400GR + TRIMET 80MG	500	$ 6.20	$ 186.00	$ 223.20	$ 223.20
SYRINGE DISPOSABLE 5ML	100	$ 2.86	$ 2.86	$ 2.86	$ 2.86
TAPE ADHESIVE 2.5CMx5M	1	$ 0.22	$ 1.09	$ 1.09	$ 1.09
TETRACYCLINE EYE OINTMENT 1% 5GR	1	$ 0.05	$ 0.62	$ 0.77	$ 0.77
ZINC TAB 20MG	100	$ 4.52	$ 9.04	$ 9.04	$ 9.04
		Estimated cost	$ 417.30	$ 489.90	$ 489.90
		Delivery DDP	$ 37.56	$ 44.09	$ 44.09
		Benchmark price	**$ 454.86**	**$ 533.99**	**$ 533.99**
		Purchase UNICEF	**$ 481.03**	**$ 540.24**	**$ 536.85**

The HTF purchase price is in line with the benchmark.

4. Efficiency

4.1 Evolution of content

Over the years the PHCP content improved in number of items and in quantities per item. Consequently this adjustment trend response positively to the real dispensing needs of health facilities. Additionally, the HTF imported an important amount of bulk health products which could be purchased by the health facilities (e.g. by using the RBF funds).

During the field visits most health facilities expressed the need to extend the product list and increase the quantities specifically for the medical supplies for Level 1 health facilities and to integrate the District Hospitals in the supply system.

4.2 Underestimation

Underestimation is a rather complex matter in health products management. Forecasting is mainly based on the past distributed – and sometimes past dispensed - health products, what is not necessarily the appropriate basis for future needs.

The principle underestimations noticed are the “medical supplies” like cotton wool and gloves. Several HF made observations that they in principle received an insufficient number of “needles” since the purchased number (21G) was not the one needed (19G).

The second underestimation noticed is the number of PHCP received which are not in the correct numbers for a certain catchment area or numbers of PHCP varies per delivery.

The third underestimation noticed is the uncertain delivery time. Although the PHCP should be supplied quarterly, this is not always the case (2013, 2015)

4.3 Overestimation

Little evidence was found that there existed over the years a serious problem of overestimation and consequently over-storage for certain items. Over-storage is one of the principle origins of expired health products.

In visited districts and health facilities LSTM evaluation team was informed that there exist a local (regional) exchange system between health facilities to adjust available heath products and real needs and to avoid as much as possible expired health products.

There is one item (Magnesium sulphate, injectable 500MG) where exist a serious problem of over-storage. This item was included in the 2013 PHCP, the 2014 and still in the 2015 PHCP. This is strange since LSTM evaluation team was informed that this medicine is no longer in use in Zimbabwe.

Several HF made observations that they in principle received a sufficient number of “needles” but that the purchased number (21G) was not the one needed, resulting in little use and over-storage.

5. Conclusion

The provision of a PHCP was a core strategy supported through the HTF to restore the availability of essential medicines in Zimbabwe, with a focus on level 1 Health Facilities.

For almost the entire HTF period the indicators of availability for selected items were not only on the rather high side but also very stable.

Data available to the evaluation 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.

The only exception notes was related to delays in distribution of kits and in inappropriate quantification/distribution of kits to address the needs of a given catchment area.

The major issue with regard to PHCP remains the full dependence on external assistance for the procurement of this kit.