

**TERMS OF REFERENCE FOR  
THE END-LINE EVALUATION OF THE HEALTH DEVELOPMENT FUND (HDF) -**

**A MULTI DONOR POOLED FUND SUPPORTING THE MINISTRY OF HEALTH AND CHILD CARE TO IMPROVE EQUITABLE ACCESS TO AND QUALITY OF HEALTH CARE IN ZIMBABWE WITH SPECIAL EMPHASIS ON WOMEN, NEWBORNS, CHILDREN AND ADOLESCENTS**

<b>Title</b>	End-line Evaluation for the “2016-2020 Health Development Fund; HDF”.
<b>Purpose</b>	To generate evidence and document lessons learned on what worked well, what did not work well, where, why and under which circumstances to inform decisions and the design of future health programmes.
<b>Proposed Budget</b>	\$300,000.00
<b>Location</b>	National
<b>Duration</b>	120 Working Days in (24 Weeks)
<b>Start Date</b>	Dd/mm/2020 (Proposed start month is August 2020)
<b>Reporting to</b>	Chief of Planning, Monitoring and Evaluation
<b>Budget Code/Grant</b>	SC160418
<b>Programme and activity codes</b>	

**1. Background and Context**

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The context in Zimbabwe has evolved rapidly during 2019. The country is currently facing multiple hazards, which include widespread economic shocks, recurrent drought, a severe food insecurity crisis, recovery from the devastating cyclone Idai, risk of outbreaks of cholera and typhoid, and now the COVID-19 Pandemic. Regarding the economy, the country continues to face weak growth. Limited functionality of the formal foreign exchange market, unsustainable public debt, high inflation, a depreciating local currency, and persistent shortages of fuel and electricity remain critical major headwinds constricting economic performance. The economy is expected to have shrunk by around 6.5 percent in 2019 (2020 National Budget Statement, Ministry of Finance and Economic development). Incomes and purchasing power have been eroded significantly. In June 2019 the

Zimbabwean Dollar was made the only legal tender, causing a number of challenges for programme implementation, for instance as social cash transfers were delayed due to issues in sourcing local hard currency and fluctuating prices of critical goods and services hampered procurement.

The economic situation and the drought have resulted in disruptions to social services.

The widespread industrial action by doctors and other health professionals especially in the last quarter of 2019 negatively impacted the provision of quality health services in public institutions and staff morale among health-workers. Access to maternal, newborn, emergency obstetric and child health services was particularly affected due to work stoppages/reduced level of effort by demotivated health workers, themselves affected by poor remuneration, a lack of tools of the trade, and poor availability of medicines and medical supplies. Access to supplies have been negatively affected by insufficient financing and shortages of forex for importing commodities, and poor availability of functional equipment as a result of lack of resources to replace obsolete equipment. Erratic fuel supplies are disrupting scheduled outreach services and other logistics. Inflation has created additional financial barriers for people in accessing care, and health facilities struggle to meet their operational costs.

Zimbabwe's expenditure on health per capita deteriorated significantly from US\$42 in 1991 (which was the highest in sub-Saharan Africa) to just under US\$6 in 2009. Whereas notable increases in per capita spending for health were noted when expenditure rose from US\$19.9 in 2011 to US\$32.9 in 2018, this however, dropped to US\$21.2 in 2019. While there are some signs of improvement, a midterm review of the 2019 budget revealed some persistent challenges.

For 2020 total Health Budget by the government is estimated at ZWL\$6.57 billion (USD305.45 million). This represents 10% of the total national budget (ZWL\$65.6 billion), compared to 7.7% of the total revised 2019 budget as a percentage of GDP, the Health Budget share is 2%. Overall Budget execution rate for 2019 stood at 81% of the total allocated budget.

The proportion of the health budget in relation to the total budget has continued to decline from a high of approximately 10% in 2011 to 7.7% in the 2019 revised budget (in real terms). In addition, the level of spending still falls well below international thresholds – both the 15% Abuja target and the 5% of GDP, SADC average. Such low level of public investments will continue to undermine health outcomes and the country's progress toward meeting the SDG targets for health.

Zimbabwe suffered a prolonged socio-political crisis from 2000 to 2008. Following 48% drop in Gross Domestic Product the country experienced extreme hyperinflation reaching a peak in November 2008. Major challenges were faced especially in the health sector including;

loss of professional staff, dysfunctional health infrastructure, lack of drugs and equipment, outdated policies, strategies and procedures and facilities being unable to cover their running costs. By 2008/2009, the health system was in a state of near collapse, manifested in emerging disease epidemics, and a huge cholera outbreak in 2008 which the system was unable to contain, resulting in the loss of 4,000 lives, with recurrent outbreaks especially in Harare with the last occurring in 2018/19 affecting 10,000 persons with 18 deaths. The impact of these crises was a rise in maternal mortality from 390/100,000 live births recorded in 1990 to 960/100,000 live births in 2010 (ZDHS-2010). Infant and under five mortality also decreased from ZHDS 1994 levels of 53 and 77/1,000 live births to 47/1,000 and 5/1,000 live births respectively (MICS-2019). Adolescents fertility increased from 99/1,000 women (ZHDS 1994) to 108 live births per 1000 women (MICS – 2019).

At the same time the rapid spread and lack of widely available treatment for HIV and AIDS increased mortality and morbidity amongst mothers and children and reduced the life expectancy of the adult population. The HIV prevalence increased steadily through the 90s to an estimated peak of 29% in 1997 and life expectancy dropped from 60.1 years in 1990 to just 47 in 2000. Non-communicable disease prevalence also rose steadily with an estimated 1,855 women being diagnosed with cervical cancer and 1,286 dying annually from the disease (WHO/HPV Centre 2010 estimates). Amongst the poorest, all of this was further exacerbated by poor nutrition as Zimbabwe continued to face nutritional challenges with an estimated 35% of all children under the age of 5 experiencing stunting in 2010 and more recent estimates at 24% (MICS, 2019).

Key interventions under the Health Transition Fund (HTF) 2012-2015, the Integrated Support Programme (ISP) (2012-2016) and ongoing Health Development Fund (HDF) 2016-2020 – all of which are programmes of multi-donor pooled funds supporting the Ministry of Health to improve equitable access to and quality of health care in Zimbabwe with a special emphasis on women, newborns, children and adolescents – have contributed to improve health outcomes, putting Zimbabwe more on the way to recovery.

Despite these recent gains, key challenges still prevent the health sector in Zimbabwe from reaching its full potential. Through the mid-term evaluation of the HDF programme 2016-2020, the Mid-term evaluation of the National Health Strategy (NHS) 2016-2020, Joint Monitoring Reviews by government and partners, and the NHS 2021-2025 development process, key challenges were identified across thematic areas that include leadership and governance; health financing, human resources for health; Reproductive, Maternal, New-born Child and Adolescent Health & Nutrition (RMNCAH&N); Health Management Information Systems (HMIS) and Monitoring and Evaluation (M&E); Service Delivery and Community Systems; Non-Communicable Diseases; Pharmaceutical Supply Chain Management (PSM); as well as Emergency Preparedness and Response.

Key Risks to the Health Sector Gains

- Health sector underfunding remains the biggest risk to safeguarding gains made since 2011, and progress towards the SDGs.
- As has been the trend over the past few years, the amount budgeted for vaccines is less than GAVI Co-Financing. Consequently, the government is unable to procure traditional vaccines currently paid for donors through the HDF (estimated at US\$1.8million).
- Lack of government funding towards essential medicines and Family Planning commodities and dwindling funding from donors may lead to erratic supplies of these essential commodities.
- Inflation remains a major risk to health programming with potential negative impacts on budgets, and consequently the quality and coverage of health programmes.
- Quality of health care infrastructure remains compromised by both low budgetary allocation and weak execution rate.
- Misalignment between MoHCC structure on one hand and the National Health Strategy (NHS) and programming needs on the other, compromises sustainability of gains achieved and resilience of the health system as capacity gaps are still filled by donor funded positions outside of the approved establishment.
- Demotivated workforce with risks of recurrent industrial action and challenges with retaining skilled staff.
- The risk of recurrent health emergencies related to cholera outbreaks and the now COVID19 pandemic threat, and impact of drought poses a challenge to basic children's rights and gender equality.

#### National and global framework guiding the evaluation

The Government of Zimbabwe within the overall frameworks of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation 2013-2018 (ZimAsset) and the current Transitional Stabilization Programme 2018-2020 (TSP) has sought to improve the quality of health care of its people as elaborated in its National Health Strategic Plan 2016 to 2020, with an emphasis on RMNCH-A and Nutrition, SRHR, HIV, TB, and Malaria. The HDF draws its strategic direction and objectives from the national imperatives laid out by the ZimAsset, its successor the Transitional Stabilization Programme (TSP) and related National Health Strategy 2016-2020; and assumes a Health Systems Strengthening approach based on the WHO Health Systems Strengthening Framework. The HDF programme design aimed to facilitate scale-up of an effective package of high impact interventions through a combination of health systems strengthening actions at national, provincial, district, health centre, and community levels in nationwide with special focus on 42 districts, including through, but not exclusively Results Based Programming and establishing a well skilled and motivated workforce.

The implied HDF programme logic assumes that interventions will be implemented against a background of progressive economic recovery, political stability, and increasing government public health expenditure toward the Abuja threshold of 15% and SADC GDP threshold of 5%. Consistently, the HDF was coined in contrast to its predecessors the HTF

and ISP to reflect a progressive shift from support for recurrent costs to a combination of necessary recurrent support and capital investments to the sector that make funds from all sources more effective.

In addition to this overall framework for the HDF, the following guiding instruments listed here should be considered to guide the evaluation framework:

1. The Zimbabwe Constitution Section 76, subsection 1 to 4, which addresses **the right to health**.
2. The 2014-2016 National Nutrition Strategy is the basis of nutrition multisector programming and further articulates nutrition programming in Zimbabwe even beyond the health sector.
3. Towards Universal health Coverage, the country finalized its first ever national health Financing Policy in 2017 and released a compliment National health Financing strategy in June 2018.

## 2. HDF Program Description

The Health Development Fund (HDF) is a multi-donor pooled fund managed by UNICEF and implemented from 2016 – 2020 to support the Ministry of Health and Child Care to achieve planned progress towards achieving the highest possible level of health and quality of life for all Zimbabweans. The HDF aims to further strengthen the health system and scale up implementation of high impact interventions for reproductive, maternal, new-born, child, adolescent health and nutrition. The 2016 - 2020 MoHCC National Health Strategy is the main guiding document for all supported interventions and the document from which the HDF programme is drawn. The HDF is implemented in all provinces under the leadership of the MoHCC with all partners contributing to one plan, one coordinating mechanism and one monitoring framework.

The goal of the HDF is to contribute to reducing maternal mortality (from 614 per 100,000 in to 2014 to 400,000 by 2020) and under 5 mortality (by 50%) by ensuring equitable access to quality health services for women and children by 2020; and to contribute to the reduction of the unmet need for family planning to 6.5%, halving the prevalence of stunting in children under-5 and eliminating mother to child transmission (MTCT) of HIV by 2020, combating HIV and AIDs, malaria and other prevalent diseases. The purpose of the HDF is to continue to consolidate and improve on the gains made in maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact reproductive maternal new-born and adolescent health (RMNCH-A) and nutrition interventions through support to the health sector.

The HDF provides support across the full range of health services whilst continuing to provide key support to RMNCAH and nutrition services as well as enhancing equity in health care availability through targeting new-borns, adolescents, hard to reach communities and specific sections of society either poorly reached or unreached by the health system in all 63 districts.

The focus is to consolidate gains made at the primary care level and in district hospitals throughout the country and to move to selected provincial hospitals. Within this

context, the following seven thematic areas are supported to provide continuity and build on the existing foundations:

- Thematic Area 1: Maternal, New-born, Child Health and Nutrition
- Thematic Area 2: Sexual and Reproductive Health and Rights (SRHR) including adolescents
- Thematic Area 3: Medical Products, Vaccines and Technologies (Medicines and Commodities)
- Thematic Area 4: Human Resources for Health (including Health Worker Management, Training and Retention)
- Thematic Area 5: Health Financing (Results Based Financing)
- Thematic Area 6: Health Policy Planning, Monitoring and Evaluation and Coordination
- Thematic Area 7: Technical support and Innovation

Of the USD 650,000,000 requested, the program to date has managed to mobilize less than 50% of the required total resources (See table below).

Table1: Estimated budget per thematic area and available funds

	Thematic area	Direct/primary beneficiaries	Planned budget 2016-2020	Available Programmable Budget Utilisation (2016-2020)	Implementing agency and partners
1	RMNCH and Nutrition	Pregnant and lactating mother, children	\$39,410,000.00	\$44,363,576.76	MoHCC, UNICEF, Nutrition Action Zimbabwe, PAZ, FNC
2	SRHR	Adolescents, Women, pregnant women	\$185,000,000.00	\$55,574,770.72	UNFPA, MoHCC, ZAPSO, FST, ARC, City of Harare, ZNFPC, CeSHHAR, NAC, GALZ
3	Medical Products, Vaccines and Technologies	Pregnant and lactating mothers, children, Adolescents, men	\$208,740,000.00	\$79,784,862.99	MoHCC, UNICEF, NatPharm
4	Human Resources for Health	Health workers	\$70,230,000.00	\$27,954,068.03	MoHCC, UNICEF, UNFPA
5	Health Financing	Pregnant and lactating mothers, children, Adolescents, men and health workers	\$56,900,000.00	\$49,394,699.33	MoHCC, UNICEF, Crown Agents
6	Health Policy Planning, Monitoring and Evaluation and Coordination	Health workers, women and men, children	\$18,790,000.00	\$3,894,495.09	MoHCC, UNICEF, UNFPA
7	Technical Support and Innovation	Health workers, women and men, children	\$23,230,000.00	\$1,139,864.76	MoHCC, UNICEF, UNFPA
	<b>TOTAL</b>		\$602,300,000.00	\$ 262,106,337.68	

The Health Development Fund is governed through the HDF Steering Committee which has representation from funding partners, Civil Society, Private Sector, UN Agencies, Ministry of Finance and is co-chaired by MoHCC and a funding partner, who is rotated on annual basis. The Health Development Fund is implemented through UNFPA and UNICEF. UNICEF is also the fund manager.

**HDF Theory of Change and Results Framework**

The results framework is attached to this document as Annex 3 and the ToC for the Programme is attached as PDF to this ToR.

**3. Purpose of the HDF End-line Evaluation**

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The purpose of the evaluation is to generate evidence and document lessons learned on what worked well, what did not work well, where, why and under which circumstances to inform decisions and the design of future health programmes supported by development partners.

The intended primary users of the evaluation are the HDF funding partners, UN agencies, the Government, health workers and private sector.

The secondary users of the evaluation are the: Civil society organizations, Community based organizations, as well as beneficiaries of the HDF (children, adolescents, community structure – VHWs etc.).

**2.1 Users and Intended Use of the Evaluation**

<b>Users</b>	<b>Intended use</b>
UNFPA at country level	To strengthen policy advocacy for strengthening reproductive health in Zimbabwe
UNICEF at country level	To advocate and lobby for strengthened health systems  To inform UNICEF health strategies and the next country programme cycle (CPD)
United Nations at country level	To inform the next Zimbabwe UN Sustainable Development Cooperation Framework

HDF Steering Committee at country level	To assess relevance, impact, sustainability, efficiency and effectiveness of programme management strategies for future/similar interventions
UNFPA and UNICEF Headquarters and regional offices	To improve regional strategies towards health and nutrition services and systems  To document best practice and lessons learnt that can be replicated in similar context  To promote UN Interagency collaboration for health and nutrition
Implementing partners and actors at country level	To improve formulation and implementation of similar programmes
Donor(s)	To inform strategic investment decisions in the future
The Zimbabwe Government	To inform future planning of similar interventions  To establish an evidence repository for maternal, neonatal, child and productive health and nutrition programming
Communities and Village Health Workers	To reflect on the community actions that yield positive results for health and nutrition and empower them for future programming

#### 4. Objectives of the HDF End-line Evaluation

The overall objective of the end-line evaluation is to use innovative ways to assess to what extent the HDF strategies, approaches and the overall intervention logic have contributed to change in people's health with special focus on Reproductive, Maternal New-born, Child and Adolescent health and nutrition by evaluating whether the resources have been used in the most economic and efficient way and in a manner that achieved value for money and promoted equity. This evaluation will be guided by the OECD criterion of efficiency, effectiveness, coherence, impact, sustainability and UNEG norms and standards.

The specific objectives of the end line evaluation include:

1. To assess the extent to which the HDF programme objectives and design have responded to the rights<sup>1</sup> and priorities of beneficiaries; and national needs, policies and priorities over the course of the programme as circumstances evolved.
2. To assess the synergies and interlinkages between the HDF programme and other interventions and programmes carried out by UNICEF, UNFPA and the government, as well as other programmes supported by development partners, and the consistency and complementarity of the HDF programme with other interventions in the country.
3. To assess the extent to which the HDF programme achieved, or is expected to achieve its objectives, and its results including any differential results across groups such as: children and women living with disabilities, children and women in hard to reach communities, adolescents, and pregnant and lactating women.
4. To assess the extent to which the HDF programme inputs (funds, expertise, time, etc.) were converted into outputs, outcomes and impacts in the most cost-effective way possible and within the intended timeframe or reasonably adjusted timeframe to address the demands of the evolving context.
5. To assess the extent to which the HDF programme has generated or is expected to generate significant positive or negative, intended or unintended, higher level changes in systems and norms and potential effects on people's wellbeing, human rights, gender equality and the environment.
6. To examine the financial, economic, social, environmental and institutional capacities of the systems to sustain the net benefits of the HDF programme over time including an analysis of resilience, risks and potential trade-offs.
7. To assess to what extent the HDF programme has incorporated human rights-based approach, results-based management, addressed issues of disability, promoted equity and applied a gender perspective.
8. To identify internal and external enabling and hindering factors to achievement of the intended results of the HDF programme.

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<sup>1</sup> Important as a needs-based approach as opposed to rights based approach, focuses on meeting key needs and immediate causes of problems but not necessarily changing the conditions behind unfulfilled needs, i.e. the structural causes and their manifestations.

## 5. Scope of the HDF End-line Evaluation

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This final joint end-line evaluation of the HDF programme will be guided by the following scope:

**5.1. Time period covered by the intervention:** January 2016 to August 2020

**5.2. Thematic coverage of the evaluation:** The evaluation will cover the seven thematic areas as outlined below and at all the levels of the public health system supported:

- Thematic Area 1: Maternal, New-born, Child Health and Nutrition
- Thematic Area 2: Sexual and Reproductive Health and Rights (SRHR) including adolescents
- Thematic Area 3: Medical Products, Vaccines and Technologies (Medicines and Commodities)
- Thematic Area 4: Human Resources for Health (including Health Worker Management, Training and Retention)
- Thematic Area 5: Health Financing (Results Based Financing)
- Thematic Area 6: Health Policy Planning, Monitoring and Evaluation and Coordination
- Thematic Area 7: Technical support and Innovation

**5.3. Geographical coverage:** The end line evaluation will be a national exercise as the HDF programme supports interventions at national level (covering all provinces). The Results Based Financing (RBF) component of the programme is in all 8 rural provinces covering 42 districts. This information will be availed to the Evaluators as the team refines the methodology. The intention is for the evaluators to visit all 10 provinces, and randomly select at least one district within each province to visit, which also has RBF support. The evaluator will devise a methodology to ensure sufficient coverage at provincial level.

**5.4. Agency led interventions:** The evaluation will cover all interventions led, managed and coordinated by UNICEF and UNFPA. This is a joint programme evaluation and as such the evaluation should be implemented from a joint programme perspective and not agency specific.

**5.5 Evaluation added value:** A midterm evaluation of the HDF programme was conducted covering the period January 2016-June 2018 and final report was produced in December 2018. This final evaluation should therefore take this into consideration and aim to be strategic and not just repeat information especially conclusions, recommendations and lessons learned already known, i.e. this evaluation should add value to what is already known based on the findings of the evaluation and present more strategic conclusions, recommendations, lessons learned. Further the evaluation could add value by also assessing to what extent were the HDF midterm recommendations implemented and improved implementation of the HDF programme.

**5.6. Norms and standards guiding the evaluation**

This evaluation will be held to the highest standards employed by the UN for the conduct of evaluations and research. This means it will abide by the following:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System, 2016
- UNEG Guidelines for Integrating Human Rights and Gender Equality in Evaluations, 2014. Found here. [UNEG Gender Guidelines](#)
- Ethical Guidelines for UN Evaluations;
- Ethical guidance for Research in UNICEF
- UN Secretary General’s Bulletin on Special measures for protection from sexual Exploitation and Sexual Abuse and the United Nations Protocol on Allegations of Sexual Exploitation and Abuse Involving Implementing Partners.

The final report is expected to meet the UNEG Evaluation reports standards as well as benchmarks used in UNICEF’s Global Evaluation Reports Oversight System (GEROS).

### 5.7. Limitations

- As per the geographical coverage paragraph above, not all districts will be covered by the evaluation exercise due to financial and time constraints. The evaluators will be required to visit at least one district per province and more as possible. The exact methodology will be agreed as part of the inception phase.
- COVID 19 implications: The current COVID 19 pandemic will pose limitations to the evaluation process due to restrictions to movement and access to stakeholders; thus, the evaluation team will need to design innovative and creative evaluation methodologies.

**5.8: Gender, equity and child rights<sup>2</sup>:** Advancing gender equality and the empowerment of women and girls is essential to realizing the rights of all children. It is central to UNICEF’s work throughout the organization, and clearly articulated in key international instruments such as the UNCRC, the CEDAW, UNICEF’s Strategic Plan (SP), Gender Action Plan (GAP), and the United Nations System-Wide Action Plan (UN-SWAP). The Evaluation should apply a human rights and gender lens throughout the evaluation process to ensure strong human rights and gender analysis including an analysis of unobserved gender norms and practices that influenced programme implementation and outcomes for diverse groups of people including pregnant and lactating women; Adolescents, Women, girls, men and boys and children (boys and girls), children, people with disabilities. In the bidding proposal the team will be required to demonstrate how a strong human rights-based approach and gender analysis will be integrated in the evaluation including evidence of capacity within the team to integrate human rights and gender analysis.

## 6. Evaluation Methodology

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<sup>2</sup> Human Rights Based Approaches to programming (HRBA) is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. Respect for human rights is a cornerstone of the UN Charter and guides the actions of all UN entities. (UNEG Guidance on Human rights and Gender Equality in Evaluations.

A theory-based approach will be taken to design this evaluation, and this will be confirmed at inception stage. The end-line evaluation team will be required to present a detailed methodology which is gender and human rights responsive and collects and analyzes both quantitative and qualitative data. The institution will present a detailed evaluation framework detailing the techniques used for data collection and analysis, which includes both quantitative and qualitative elements designed to accurately address the key questions. Guiding evaluation questions are presented below. Evaluators where necessary can add additional questions and justify the additional questions, in consultation with the evaluation manager. Bidders can further provide sub-questions to answer the broad questions in the ToRs. In the proposal bidders are required to present a detailed evaluation framework providing data collection methods; tools and data analysis plan for each of the evaluation questions. Bidders are also encouraged to use the available information in developing the draft evaluation framework and methodology to ensure that the proposed methodology in this ToR is appropriate for the evaluation.

The evaluation framework will include a justification of the evaluation methodology approach chosen and its limitations and shortcomings explained. The evaluation methodology will include multiple methods (triangulation) with analysis of both quantitative and qualitative data and the data collection methods will be human rights based, including child rights based and gender sensitive, and cover a wide range of the HDF stakeholders to the extent possible. Where feasible the data collected, and analysed data will be disaggregated by sex, ethnicity, age, disability, etc. The evaluation framework will provide logical and explicit linkages between the data sources and the data collection methods and analysis methods and will also include the sampling plans

**Evaluation Questions**

Evaluation Criteria	In depth areas for analysis
<p><b>1. Impact</b></p> <p>To assess the extent to which the HDF programme has generated or is expected to generate significant positive or negative, intended or unintended, higher level changes in systems and norms and potential effects on people’s wellbeing, human rights, gender equality and the environment.</p>	<p>What difference does the intervention make?</p> <ol style="list-style-type: none"> <li>1. What have been positive / negative/ intended/unintended effects of the programme on people’s wellbeing; human rights, gender equality and equity.</li> <li>2. What have been the effects of the HDF programme to the relevant SDG goals, targets and indicators?</li> <li>3. What have been the transformative changes that happened as a result of the HDF programme, taking into account human rights and gender equality dimensions?</li> <li>4. What are the higher-level changes in norms that are a result of the HDF programme?</li> </ol>

	<p>5. Who has benefitted, particularly in terms of gender, equity and vulnerable populations</p> <p>6. What are the plausible scenarios if there was no HDF</p>
<p><b>2. Relevance</b></p> <p>To what extent do the HDF objectives and design respond to the needs and priorities of beneficiaries; global and national needs, policies and priorities and continue to do so if circumstances change.</p>	<p><b>Are we doing the right thing?</b></p> <p>The HDF relevance to the operating context and situational changes. This will focus on:</p> <ol style="list-style-type: none"> <li>1. To what extent were the programme objectives and design responsive to the needs, rights and priorities of beneficiaries including people living with disabilities and those in hard to reach communities needs and priorities, taking into account country, international Human rights &amp; Gender Equality commitments, such as the SDGs and funding partners; policies</li> <li>2) To what extent was the HDF programme responsive and adaptive to any changing context to remain relevant including responsiveness to humanitarian/emergency.</li> <li>3. To what extent is the HDF programme sensitive to the national economic, social, environmental, equity, political and capacity of institutions.</li> </ol>
<p><b>3. Coherence</b></p> <p><b>To what extent is the HDF compatible with other interventions in the health sector and the country</b></p>	<p><b>How well does the intervention fit?</b></p> <ol style="list-style-type: none"> <li>1. To assess the synergies and interlinkages between the HDF programme and other interventions carried out by UNICEF, UNFPA and the government (internal coherence), as well as programmes supported by other development partners</li> <li>2. To assess the consistency, complementarity and coordination between HDF programme and other interventions in the country (external coherence)</li> </ol>
<p><b>3. Effectiveness</b></p> <p>To what extent has the HDF programme achieved, or is expected to achieve its objectives, and its results including any differential results across groups such as: children and women living with disabilities, children and women in hard to reach</p>	<p><b>Is the HDF programme achieving its objectives and intended results?</b></p> <ol style="list-style-type: none"> <li>1. To what extent did the programme reach women (including pregnant and lactating women), men, adolescent boys and girls and children under five in all 63 districts, with and without disabilities?</li> <li>2. To what extent did the programme improve RMNCH(A) and other social gains</li> <li>3. How unintended results have affected the outcomes and could have been foreseen and managed</li> </ol>

<p>communities; adolescents.... Etc.</p>	<p>4. To what extent has the HDF programme delivered its intended results?</p> <p>5. What were the enabling and hindering factors to achieving the intended results of the HDF programme</p> <p>6. To what extent had the HDF program built on the gains and lessons from the Health Transition Fund?</p>
<p><b>4. Efficiency</b></p> <p><i>How well the HDF transformed the available resources into the intended outputs and outcomes in terms of quantity, quality and timeliness of delivery</i></p>	<p>How well are resources being used?</p> <p>Considering the HDF as a whole, and the seven thematic areas:</p> <ol style="list-style-type: none"> <li>1. Whether the incremental benefits outweighed the incremental costs (cost benefit)</li> <li>2. How economically did HDF convert resources/ inputs (funds, expertise, time, etc.) to achieve results?</li> <li>3. The overall rate of return; including a sensitivity analysis of reasonable variations in the assumptions</li> <li>4. Whether it yielded a better return than comparable programmes, including an analysis as far as possible of unit costs per beneficiary reached with key interventions</li> <li>5. Whether it provided the best return possible from this type of funding mechanism and of interventions (value for money)</li> <li>6. Were the objectives achieved economically by the development intervention?</li> <li>7. How big is the efficiency or utilisation ratio of the resources used (Comparison: resources applied – results)?</li> </ol>
<p><b>5. Sustainability</b></p> <p>To examine the financial, economic, social, environmental and institutional capacities of the systems to sustain the net benefits of the HDF programme over time including an analysis of resilience, risks and potential trade-offs.</p>	<p><b>Will the benefits last?</b></p> <ol style="list-style-type: none"> <li>1. What are the institutional capacities needed to ensure benefits accrued continue over time after the end of the programme? And to what extent are the institutions ready to sustain the benefits?</li> <li>2. What are the social, cultural, political, economic systems needed to sustain the benefits over medium to long term period? And to what extent have these been established?</li> <li>3. What are the community level systems and capacities needed to sustain the benefits and how ready are these systems to sustain the benefits over the medium- and long-term period?</li> <li>4. How resilient is the health system against likely shocks?</li> </ol>

	<p>5. Was the HDF designed to address the root/structural causes of exclusion and marginalisation in order to sustain results of interventions?</p>
<p><b>6. Gender equality, equity and human rights including child rights.</b></p> <p>To assess to what extent the programme has incorporated human rights-based approach, results-based management, addressed issues of disability, promoted equity and applied a gender perspective.</p>	<p><b>Whilst Gender equality, equity and human rights is not an evaluation criterion but an approach, the evaluation should ensure the following question are addressed throughout the evaluation process. And the bidders should demonstrate in their proposal how all these components will be integrated in the evaluation.</b></p> <ol style="list-style-type: none"> <li>1. Did the HDF’s theory of change incorporate Human Rights perspectives, Gender Equality and Equity dimensions and are these reflected in implementation and monitoring frameworks?</li> <li>2. To what extent the HDF programme utilize and deliver results based on: Human rights; Equity; Gender; risk/emergencies.</li> <li>3. Do the HDF results contribute to addressing the underlying causes of inequality and exclusion for the most vulnerable populations?</li> <li>4. Did the HDF contribute to the empowerment of rights holders to claim their rights and duty bearers to fulfil Human Rights and Gender Equity norms? In what ways?</li> <li>5. Was sufficient information collected to measure progress on health equity (disaggregated-age, sex, disability, location and wealth quintiles?)</li> <li>6. Was sufficient resource allocated towards the achievement of equity in health results?</li> </ol>

Given the current context of COVID-19 and its uncertainties over the next months; the bidding firm is expected to provide a detailed methodology and data collection methods and tools with Options or Scenarios to allow for flexibility and adaptability within the COVID 19 environment. Scenario 1: Access is not restricted; and Scenario 2: Access is restricted. A detailed budget for each of the scenarios should be presented.

Whilst the evaluation is being conducted in a COVID 19 environment which poses some challenges and requires a different way of thinking and evaluation methodologies, the overall methodological approach and design for the evaluation should to the extent possible be participatory, and gender and human rights responsive considering the overall purpose of the evaluation, as well as the needs of the HDF SC and other HDF stakeholders.

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

Existing information sources including the following will be used in the evaluation:

- The HDF programme document
- The HDF logical framework
- THE HDF Midterm Evaluation Report
- The HDF annual donor reports
- The Quarterly Vital Medicine and Health Services Report
- The MoHCC Health Management Information System
- The Mid-term Review Report for the National Health Strategy 2016-2018
- The Results Based Financing and Human Resources for Health monthly and quarterly reports
- The Health Systems Assessment Report

The available programme data and data collection tools will be appraised in quality and reliability in providing good monitoring of the programme performance going forward.

Surveys, Interviews and Focus Group Discussions - Areas of the evaluation that could benefit from primary data collection should be identified and included in the methodology. Surveys should be designed appropriately in the context and administered to suit the profiles of the respondents (age, sex, geographical location, access to Information Communications and Technology (ICTs) and literacy). Potential respondents should include UN Officials (including HDF technical officers), HDF Steering Committee members, Ministry of Health Officials, Partner Organizations, Community Health Workers, Pregnant and Lactating Women, and other clients of the Zimbabwe Health System. Evaluators are encouraged to be innovative to ensure that as they collect primary data, they do not contribute to the further spread of COVID-19.

The evaluation will follow United Nations Evaluation Group (UNEG) norms and standards for evaluations, as well as ethical guidelines found here. <http://www.uneval.org/document/detail/1401>

### **Potential evaluation informants**

Below are the potential evaluation informants but this is not the exhaustive list and thus at inception phase the Firm is expected to include an updated list of informants.

- HDF Steering Committee Members
- Ministry of Health and Child Care Officials at all levels (Head office, Province, District and facility)
- Health Center Committees

- Community Health Workers (Village Health Workers, Community Based facilitators, Lead Mothers, Ward Coordinators)
- UN officials (UNICEF, UNFPA, including technical officers)
- Ministry of Finance and other relevant government ministries and agencies

Community and health care system clients (including vulnerable groups, pregnant and lactating women, people with disabilities, adolescents)

### **Data Analysis**

The Evaluator is expected to develop a clear data analysis framework that includes both the quantitative and qualitative dimensions of the data collected. The analysis plan should demonstrate impact of the HDF interventions including coverage (and geographic reach), as well as detailed equity analysis that is considerate of the most vulnerable groups within the health system (including but not limited to wealth, gender, age, pregnancy, disability).

### **Limitations**

The availability of sufficient and disaggregated performance measurement information to assess all programme outcomes and thematic groups may also present a challenge. The Evaluator will be expected to provide innovative mitigation measures to counter this while maintaining quality and usefulness. The Evaluators are expected to conduct field data collection activities in all provinces; however, there may be some travel restrictions due to the COVID-19 situation and other unanticipated factors; where this is the case, alternative sites to those initially planned may be selected for visiting, or remote data collection modalities may be considered, if deemed necessary.

### **Evaluability of the HDF Program and reliability of data**

The HDF programme can be evaluated as the programme has a clear ToC, Results Framework with SMART indicators, baselines, milestones and targets. A Midterm evaluation of the programme has been successfully conducted. However, to further define the evaluability and identify any possible data gaps and ascertain data validity and design strategies of closing the gaps, the evaluation team will be required to conduct an evaluability of the HDF programme at impact, outcome and output level. At inception phase the consulting firm should include an assessment of the reliability of the disaggregated data. Thus, at inception phase the Consulting firm should include an Evaluability assessment of the programme and an assessment of the reliability of disaggregated data. The consulting firm should include in their bid the process for evaluability assessment and assessment of reliability of data. However, if the review of current ToC deems that it needs to be revised, then it is the expectation for the contracted evaluation team to do so.

## **7. Evaluation Work Plan**

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Below is presented a guide to the expected work plan but bidding firm is expected to adapt the work plan to the current environment and the proposed methodology based on the two scenarios proposed by the firm.

The end-line evaluation is expected to start in July 2020 with the final report being available to the HDF SC committee by October 2020. The HDF end-line evaluation

institution will be expected to implement the following steps in the evaluation process and within the proposed timeline:

Activity	Deliverable	Number of days per deliverable	Proposed Activity Schedule	Payment Schedule
<i>Phase 1: Planning</i>				
Activity 1: Inception meeting with UNICEF Harare and HDF Evaluation committee members	Meeting minutes submitted electronically a day after the meeting	1 day	Within 1 week of signing of contract	
Activity 2: Development of the evaluation framework showing how in-depth 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 the evaluation criteria; identification of key indicators from the HDF log frame and/or recommendation of new indicators and other information needs where necessary; identification and organizing information from the available sources; finalisation of the evaluation questions, methodology and work plan; development of the data collection tools and reporting template.  Evaluability assessment should be included as part of the Inception report preparation process.	Draft inception report including evaluability assessment report and an assessment of reliability of disaggregated data. Inception report should not be more than 12 pages excluding annexes  Revised ToC (if deemed necessary to revise the ToC)  Presented in word and power point shared with members of the evaluation committee	21 days <sup>3</sup>	Within 3 weeks of signing of contract	
Activity 3:  Presentation of Inception report to the HDF Evaluation Reference Group	Meeting minutes maximum 10 pages shared electronically within 24 hours with members of the evaluation committee	1 day	Within 1 week after receiving the draft IR	

<sup>3</sup> 21 days covers the total number of days for the Inception report development until final approval by Steering Committee.

Activity 4: Review of Inception Report; incorporation of comments from HDF Evaluation Taskforce/ REG			Week 5-6	
Activity 5: Evaluation Taskforce/ REG Meeting- Presentation of the Final Inception Report	Final inception report (maximum 20 pages) in electronic version And Power point version no more than 10 slides		Week 7	30% of total payment
<i>Phase 2: Data collection and analysis</i>				
Activity 6: Institutional review board (IRB), <sup>4</sup> submission and approval			by week 10 <sup>5</sup>	
Activity 7: Training of data collectors and Pretesting of data collection tools		3 days	Week 11	
Activity 8: Field pre-test update meeting: highlighting any key issues, e.g. if any changes are needed with respect to data gathering tools, consent forms, data gathering procedure or consent procedures, etc.		1 day	Week 11	
Activity 9: Field work / data collection		21 days	Week 12 – 14	
Activity 10. Production of Field work report including a data and analytical Framework	Field work report and data analytical plan and framework not more than 12 pages.	5 days	Week 15 Within 1 week after field work	20% of total payment
Activity 11: Data Entry, Transcription, Coding, Analysis and		10 days	Week 16-18	

<sup>4</sup> Bidding institution should ensure budget includes payment to be made for IRB approval and it is the responsibility of the bidding institution to submit and follow up on IRB approval.

<sup>5</sup> It is assumed that IRB approval may take 2-3 weeks and thus in planning the bidders are advised to plan with this in mind

critical reflection of all findings; drafting of the interim report			Within 3 weeks after presentation of field work report	
<i>Phase 3: Reporting and communication of results</i>				
Activity 9: Submission of the draft report to the Evaluation Technical Committee and the UNICEF REG	Preliminary report submitted electronically (maximum 20 pages)		Week 19 Within 4 weeks after field work report	20% of total payment
Stakeholder validation and input on draft report	Minutes of the meeting submitted 24 hours after the meeting		Week 20 Within a week after submission of draft report	
Activity 10: Incorporation of comments and Submission for circulation to HDF SC for validation and commenting	Draft Final Report (maximum 40 pages excluding annexes). And a Power point version not more than 20 slides		Week 21 Within 1 week after stakeholders meeting	
Activity 11: Incorporation of comments from HDF SC			Week 22 Within 1 week after receipt of comments from HDF	
Activity 12: Presentation of evaluation findings to HDF SC, drawing linkages between findings and programme effectiveness and efficiency	Meeting minutes shared 24 hours after the meeting has been concluded		Week 23 Within 2 weeks after submitting final draft report	
Activity 13: Finalisation of Report	Final Evaluation Report (maximum 40 pages excluding annexes. Multiple rounds of revisions may be required based on external quality review processes)  Annexes to include in depth analysis reports of the selected thematic areas		Week 24 Within 1 weeks after Steering Committee comments	30% of total payment

	<p>Abridged Evaluation Report (print ready)</p> <p>2-page summary of key findings and recommendations (print ready)</p> <p>Power Point Presentation of the Evaluation Findings</p> <p>Cleaned data files</p> <p>All qualitative data transcripts</p>			
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**8. Ethical Considerations**

The consulting institution shall abide by and be governed by UNICEF Procedures on Ethical Standards in Research, Evaluation and Data Collection and Analysis, as well as national regulation on ethical research, in designing and implementing the study. To ensure that the key ethical principles for the conduct of studies involving human subjects are followed, the selected evaluators will be required to get clearance to conduct the research from a national ethical review board (<https://www.mrcz.org.zw/>). The evaluation protocol, data collection tools and informed consent will have to be submitted to the national ethical review board and for clearance before any fieldwork can commence. The work plan should reflect this aspect of the process. Consideration should also be given to basic ethics in researching human subjects such as consent to participation, confidentiality, the purpose of the research and potential advantages / disadvantages participation, their rights, and how the information collected will be used.

The consulting firm shall not make use of any unpublished or confidential information, made available in the course of executing this consultancy, without written authorization from UNICEF. The products of this consultancy are not the property of the consulting firm and cannot be shared without the permission of Ministry of Health and UNICEF.

It is vital that the consulting firm at all levels fully comply with the precautionary measures put in place by UNICEF and the government of Zimbabwe, in order to protect the women and children we serve. It is of utmost importance that the **‘do no harm’** principle consistently guides this evaluation. The bidding firm should ensure that a detailed description is provided on measures that will be put in place to protect the women, children and stakeholders whom we serve.

Some important information to guide the development of the proposal are:  
UNICEF Ethical consideration guidelines:

[www.uneval.org/document/download/548](http://www.uneval.org/document/download/548);

[www.uneval.org/document/download/2535](http://www.uneval.org/document/download/2535)

UNICEF Guidance on Gender Integration in Evaluation:

<https://unicef.sharepoint.com/sites/EO/DL1/UNICEF-Guidance%20on%20Gender-LR.pdf?csf=1&e=OUwumz&cid=1b511963-6aa0-4b17-b5b3-8b59339121ec>

Guidance on Adolescent participation in Monitoring and Evaluation:  
[https://www.unicef.org/evaldatabase/files/UNICEF\\_ADAP\\_GuidanceNote.pdf](https://www.unicef.org/evaldatabase/files/UNICEF_ADAP_GuidanceNote.pdf)

In addition, the Evaluation team is expected to complete mandatory online training on the Protection from Sexual Exploitation and Abuse and are expected to submit evidence of completion of the UNICEF Prevention of Sexual Exploitation and abuse (PSEA) training found here: <https://agora.unicef.org/course/info.php?id=7380>.

## **9. Evaluation Reporting**

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The evaluation institution is expected to produce candid, uncompromising high-quality End-line evaluation report, containing well-evidenced findings and clear conclusions and recommendations that are in line with the UNEG UNICEF Evaluation report standards. Geros quality assurance standards and UNICEF\_UNEG Evaluation report standards: link <https://unicef.sharepoint.com/sites/EO/DL1/Forms/AllItems.aspx?id=/sites/EO/DL1/UNICEF%20procedure%20on%20Ethics.PDF&parent=/sites/EO/DL1>

The reports will be initially submitted to the Evaluation Subcommittee and through them to the HDF Steering Committee.

The main report should have excellent analytical writing, and will be written in clear, crisp language, understandable to an informed lay reader and shall follow UNICEF editing and formatting requirements in line with the UNICEF Style Book 2015 and UNICEF Brand Toolkit 2012. The findings, conclusions and recommendations shall be thorough and clearly prove linkages with the evidence available. The final evaluation report shall not exceed 40 pages (excluding a not more than 5-page executive summary and annexes). All final data collection tools, datasets and frameworks used or developed during the process should be attached as part of the appendices.

The evaluation institution will provide as an annex to the final report, an in-depth analysis report of each of the seven thematic areas. The stand-alone reports of the in-depth analysis should adhere to quality standards of peer-reviewed academic publications.

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

The contractor will submit the following reports

1. Draft Inception report, including an evaluability assessment and evidence of completion of mandatory PSEA training.

2. Final Inception report, including an evaluability assessment
3. Field work report including data and information analytical framework
4. Preliminary evaluation report (maximum 20 pages) submitted to the HDF Evaluation Committee for technical review
5. Draft Final Report (maximum 40 pages excluding annexes). This report will consider clarifications and comments received from the Evaluation Committee on the preliminary report.
6. Final report (maximum 40 pages excluding annexes). After incorporating the comments and feedback from the HDF Evaluation Committee and the HDF Steering Committee, the final evaluation report will be submitted to the HDF Steering Committee. The contractors will present the final report to the HDF Steering Committee at the earliest convenient HDF Steering Committee meeting
7. Power Point Presentation of the Evaluation Findings
8. A 3-5-page executive summary
9. Seven in-depth analysis reports (one for each of the HDF thematic areas)
10. Abridged Evaluation Report (print ready)
11. 2-page summary of key findings and recommendations (print ready)

## **10. Management of the Evaluation**

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**10.1. HDF Evaluation Reference Group (ERG):** The evaluation shall establish an ERG and the purpose of the ERG is to ensure quality assurance of the evaluation and support the evaluation on the day to basis and ensure that expected quality and timelines are met. The ERG will be made of UNICEF Technical Research and Evaluation Group (TREG) members; UNFPA M & E; Funding partners M & E focal persons; Ministry of Finance and Ministry of Health M & E Experts. ERG is not a decision-making structure but only an advisory body. ERG under the leadership of UNICEF PME section shall:

- 1) Participate in the first inception meeting with the consultants
- 2) Review Inception report and provide written comments on the draft inception report using the template based on UNEG evaluation standards.
- 3) Participate in IR meeting if deemed necessary to meet.
- 4) Participate / support the training of data collectors and pre-testing of data collection tools.
- 5) Support Field work logistics and monitor field work / data collection process
- 6) Participate in the field work report and data analysis framework presentation meeting and provide any support that may be needed to close data gaps.
- 7) Participate in stakeholder's validation meeting
- 8) Review draft reports before submission to HDF Steering Committee
- 9) Draft Evaluation report communication plan and Evaluation Management for approval by Steering Committee.

**10.2 HDF Steering Committee:** HDF Steering Committee will oversee the management of the evaluation and is the decision-making body with the following specific tasks:

- 1) Review and approval of the Terms of Reference

- 2) Review and approval of inception report
- 3) Review and approval of evaluation report
- 4) Review and approval of evaluation communication plan
- 5) Review and approval of the Evaluation Management Response.

The ERG will be represented in the HDF steering committee to provide support to the Steering Committee.

### **11. Estimated Duration of Contract**

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The end-line evaluation is expected to be undertaken during the third and fourth quarter of 2020 with the final report being available to the HDF SC committee by mid of fourth quarter 2020. The contract for the evaluation institution/consultants will be expected to be for a period of 24 weeks.

### **11. Official Travel Involved**

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Given the current situation of COVID 19, travel to programme sites is mostly restricted and thus Evaluation Team should come up with clear remote data collection methods and tools targeting all relevant stakeholders in Provinces, districts and health facilities and to the community. However, some critical field travel using the travel standard operating procedure of the UN may be possible and if circumstances change and by the time of the evaluation more official travel is possible, the Evaluation Team and UNICEF will further discuss and agree on feasible modalities.

### **12. Budget**

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The institution is expected to provide a budget for undertaking the consultancy using the attached budget template (Annex II)

### **13. Qualification/Knowledge/Skills**

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The Evaluation Institution should comprise a multidisciplinary team that collectively demonstrates no conflict of interest with the HDF programme. Individuals who have been involved in the design or implementation of the interventions will not be considered as part of the team. The team will collectively demonstrate 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
- Strong previous experience in conducting qualitative and quantitative research and programme evaluations in low- and middle-income country contexts

- Skills and experience in health economics including, costing, cost effectiveness and cost benefit analysis; epidemiology, 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
- Demonstrated expertise and experience in analysis and evaluation of rights based; gender, social and poverty analysis and equity issues in health and nutrition
- Experience of working with different stakeholders and through local consultants and research or health institutions to deliver a quality product and providing advice
- 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 sub Saharan African countries

Specifically, the Team Leader should have the following desired qualifications:

- Advanced degree in public health, health policy, social work, sociology, economics, anthropology, etc.
- Relevant international experience in reproductive, maternal, new-born and child health and health systems.
- At least 15 years of experience in the health/social sector
- Demonstrated work experience and collaboration with governments in Africa
- Strong track record of liaising with international development agencies
- Proven diplomatic and liaison skills
- Excellent written and oral communication skills
- Proven ability to work under tight deadlines
- Fluency in English

The evaluation team members should comprise at least members with the following expertise:

**(1) Results Based Financing**

- Advanced degree in public health, health policy, or economics
- At least 10 years of relevant international experience in implementation and evaluation of RBF
- Work in African health systems
- Strong track record of liaising with international development agencies
- Proven diplomatic and liaison skills
- Excellent written and oral communication skills
- Proven ability to work under tight deadlines

**(2) Human Resources for Health**

- Advanced degree in public health, health policy, economics or management
- At least 10 years of relevant international experience in implementation and evaluation of HRH
- Work in African health systems
- Strong track record of liaising with international development agencies
- Proven diplomatic and liaison skills
- Excellent written and oral communication skills
- Proven ability to work under tight deadlines

**(3) Procurement and Supply Management (PSM)**

- Advance degree in supply management
- At least 10 years of experience in public health procurement supply management
- Strong track record of liaising with international development agencies
- Proven diplomatic and liaison skills
- Excellent written and oral communication skills
- Proven ability to work under tight deadlines

**(4) Gender and human rights**

- Proven experience and knowledge on gender and human rights including child rights
- Proven experience in integrating gender and human rights in evaluations.
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**(5) Reproductive Maternal Newborn Child and Adolescent Health**

- An advanced degree in Reproductive Maternal Newborn Child and Adolescent Health
- At least 10 years' experience in public health integrated RMNCH and nutrition programming
- Traceable experience in large scale evaluation work, both quantitative and qualitative skills
- Strong track record of liaising with international development agencies
- Proven diplomatic and liaison skills
- Excellent written and oral communication skills
- Proven ability to work under tight deadlines

**14. Proposal Evaluation Criteria**

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The technical proposals will be reviewed by the HDF Evaluation Reference Group using the criteria below. The financial proposals for those institutions whose technical proposals score above 80 points on the technical assessment will be evaluated by UNICEF.

Technical and financial evaluation will contribute a maximum of 80 points and 20 points respectively for total possible score of 100 points. Scores will be determined using the following formula:

Overall score= average technical score by panel + financial score.

*Specific Proposal Evaluation Criteria*

Technical Proposal	Points
<p><b>1. OVERALL RESPONSE</b></p> <ul style="list-style-type: none"> <li>- Understanding of and responsiveness to the requirements of the TOR.</li> <li>- Understanding of scope, objectives and completeness of response.</li> <li>- Overall concord between RFP requirements and proposal.</li> </ul>	<b>10</b>
<p><b>2. STRATEGY, METHODOLOGY AND APPROACH</b></p> <ul style="list-style-type: none"> <li>- Quality of proposed approach / methodology which, among other things, defines parameters of evaluation, proposes methods that can effectively measure programme effects and makes clear links to achieving the objectives of the TOR.</li> <li>- Clear and detailed approach to analysis</li> <li>- Clarity, feasibility and consistency with global effective practices (of strategies and methods).</li> <li>- Quality of proposed implementation plan i.e. detailed proposed plan for accomplishing task within proposed timeframe.</li> <li>- Recognition of direct risks and strategies to manage risks.</li> </ul>	<b>30</b>
<p><b>3. PROPOSED TEAM AND PROFESSIONAL ORIENTATION</b></p> <ul style="list-style-type: none"> <li>- Structure of Management Team.</li> <li>- Team leader: relevant experience, qualifications and position with bidding firm.</li> <li>- Team members: experience and qualifications relevant to proposed roles.</li> <li>- Professional expertise and knowledge.</li> <li>- Quality of local partner(s) or other source of local expertise, if applicable.</li> </ul>	<b>20</b>
<p><b>4. Evidence-supported TECHNICAL CAPACITY and ORGANIZATIONAL EXPERIENCE</b></p> <ul style="list-style-type: none"> <li>- Range and depth of experience with similar projects, contracts and clients.</li> <li>- Financial status of Institution.</li> <li>- Evidence of similar assignments undertaken in the country, region, continent and elsewhere.</li> </ul> <p><b>NOTE:</b> The assessment of the Institution will be made on the basis of documents submitted for review in the Proposal. Institutions that fail to submit relevant documentation that will enable a thorough review of the Institution in all relevant areas, do so at their own risk and will be subject to disqualification or penalty of reduced points.</p>	<b>10</b>
<b>Financial Proposal</b>	
<p><b>5. FINANCIAL</b></p> <p>Assessment/review will include:</p> <ul style="list-style-type: none"> <li>- Overall Price</li> <li>- Cost benefit comparison related to number and quality of personnel</li> <li>- Completeness of the Financial Proposal (ensure that all costs, including professional fees, costs of travel, salaries, insurance, etc. are included in the price offered).</li> </ul>	<b>30</b>

<ul style="list-style-type: none"> <li>- Payment terms/schedule of payment proposed.</li> <li>- Timeline proposed.</li> <li>- Period of validity of Proposal.</li> </ul> <p><b>NOTE:</b> As the most financially attractive offers will be at an advantage, if the bidder can offer any discounts or cheaper options, it should be clearly set out in the financial proposal for consideration during the review.</p>	
<b>TOTAL MARKS</b>	<b>100</b>

**Technical Proposal (s) scoring 70 % (=Score of 49 out of 70) or more following Technical Proposal Evaluation will be listed and included for review and Evaluation on The Financial Offer.**

**15. General Conditions: Procedures and Logistics**

**Policies both parties should be aware of:**

- i. **Contractual issues:** Evaluation Institution will enter into a Contract with UNICEF and hence all contractual obligations, procedures and process will be to UNICEF. As per UNICEF Evaluation Policy, (para 19(a)), management arrangements for each evaluation should ensure independence and impartiality. The designated evaluation manager should not be part of the team that designed and or managed the implementation of the programme to be assessed. Thus, for the HDF evaluation, in UNICEF the evaluation shall be managed by the Planning, Monitoring and Evaluation (PME) section.
- ii. The institution will be responsible for all supports required to complete the assignment including accommodation, meals, transportation, and tools of trade (including computers);
- iii. Due to the COVID-19 prevention measures, meetings and consultations will be conducted virtually in line with Government guidance. Office space will be provided by UNICEF for use during the evaluation and UNICEF premises will be available for the meetings and consultations provided there is a change in the current context;
- iv. The institution will not be entitled to the use of UNICEF transportation;
- v. Where applicable, UNICEF will cover cost of air travel (economy class) and pay DSA. These costs should be included in the proposed budget;
- vi. No contract related activities may commence unless the contract is signed and received by both parties. For institutions outside the duty station, signed contracts must be sent by fax or email;
- vii. Institutions or their staff will not have supervisory responsibilities or authority on UNICEF budget; and,
- viii. Institutions will be required to sign the Health statement for team members prior to taking up the assignment, and to document that they have appropriate health insurance, including Medical Evacuation.

Prepared by: *Gmatsika*  
**Getrude Matsika: M & E Specialist**

Date: 19 August 2020

Supply Review by: *Abeba*

Date: 20/08/2020

**Abeba Tadesse: Contracts Specialist**

*JAMES HEDGES*  
*JH*  
 Recommended by: .....

Date: 20 August 2020

**James Hedges: Chief PME**

*Amina*  
 Endorsed by: .....

Date: 20/08/2020

**Amina Mohammed: Deputy Representative**

*Laylee*  
 Approved by: .....

Date: 20/8/2020

**Laylee Moshiri: Representative**

**APPENDICES**

Some of Documents to be considered during the End line Evaluation

- Program Document for a Multi – donor pooled Fund for Health in Zimbabwe (2016 - 2020)
- National Healthy Strategy (2016 – 2020)
- Mid-term Review of the National Health Strategy (2016-2018)
- Health Management Information Systems (HMIS) Reports
- Assessment and redesign of the systems for RBF, Human resources for Health and Pharmaceuticals in Zimbabwe Final Report (2016)
- Multiple Indicator Cluster Survey (MICS 2015 and 2019)
- Reports on the performance of the health system including, but not limited to, HMIS
- HDF quarterly and annual donor reports

- National Adolescent and Youth Sexual and Reproductive Health Strategy (2016 -2020)
- Zimbabwe Reproductive Maternal New-born Child Adolescent Health and Nutrition Strategy (2017 -2020)
- National Nutrition Strategy (2014-2018)
- Quality Assurance and Quality Improvement Strategy (2016 -2020)
- Zimbabwe Maternal and Neonatal Health Strategy (2017 -2021)
- Programme budgets and expenditure reports
- Provincial Medical Directors Generic reports
- Ministry of Health and Child Care Family Health Department Annual Reports
- Child Survival Strategy (2016 -2020)

**ANNEX II**

<b>BUDGET TEMPLATE</b>				
<b>Activity</b>	<b>Unit</b>	<b>Number of Units</b>	<b>Unit cost</b>	<b>Total Cost</b>
<b>1. Consultancy Fees (Specify)</b>				
<b>2. Contracted Staff (specify)</b>				
e.g. Enumerators				
<b>3. Planning and Inception</b>				
Per diem and Allowances (specify costs)				
Transport (specify costs)				
Other costs (specify)				
<b>4. Training</b>				
Per diem and Allowances (specify costs)				
Stationery (Specify costs)				
Transport (specify costs)				
Other costs (specify)				
<b>IRB application</b>				
<b>5. Data Collection</b>				
Per diem and Allowances (specify costs)				
Stationery (Specify costs)				
Transport (specify costs)				
Other costs (specify)				
<b>7. Data Entry and Analysis</b>				
<b>8. Report writing and presentation</b>				

9. Other Costs				
GRAND TOTAL				

### Annex 3: HDF Log Frame

## HDF Log frame - IMPACT

HEALTH DEVELOPMENT FUND IMPACT						
PROJECT NAME	HEALTH DEVELOPMENT FUND					
<b>IMPACT 1</b>	<b>Impact Indicator 1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Revised Target (date)</b>
To reduce maternal mortality ratio from 614 to 400 by 2020	Maternal mortality ratio	Planned	614 per100,000 LB 2014 MICS	ZDHS 2015	MICS 2019	400 per 100,000 LB by 2020
		Achieved		651	462	
		<b>Source</b> DHS/MIMS, CSO/Zimstat				
<b>IMPACT 2</b>	<b>Impact Indicator 2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
To reduce the Under-five mortality rate from 75 to 60 deaths per 1000 live births	Under-5 mortality rate	Planned	75 per 1,000 LB 2014 MICS	ZDHS 2015	MICS 2019	60 per 1,000 LB by 2020
		Achieved		69	65	

			Source			
			DHS/MIMS, CSO/Zimstat			
IMPACT 3	Impact Indicator 3		Baseline	Milestone 1	Milestone 2	Target (date)
To reduce Neonatal Mortality Rate from 29 to 20 deaths per 1000 live births	Neonatal mortality rate	Planned	29 per 1,000 LB 2014 MICS	ZDHS 2015	MICS 2019	20 per 1,000 LB by 2020
		Achieved		29	32	
			Source			
			DHS/MIMS, CSO/Zimstat			
IMPACT 4	Impact Indicator 4		Baseline	Milestone 1	Milestone 2	Target (date)
To reduce mortality and morbidity due to malnutrition	Prevalence of stunting (moderate and severe) in children less than five years of age	Planned	MICS 2014	ZDHS 2015	MICS 2019	19% by 2020
		Achieved	28%	26.80%	23.50%	
			Source			
			DHS/MICS, CSO/Zimstat, National Nutrition Survey			
IMPACT 5	Impact Indicator 5		Baseline	Milestone 1	Milestone 2	Target (date)
To reduce adolescent fertility rate from 120 per 1,000 to 100 per 1,000 by 2020.	Adolescent fertility rate	Planned	120 per 1,000 (MICS 2014)	ZDHS 2015	MICS 2019	100 per 1,000 by 2020 (Subject to revision according to the revised ASRH strategy)
		Achieved		110	113	
			Source			
			DHS/MICS			
IMPACT 6	Impact Indicator 6		Baseline	Milestone 1	Milestone 2	Target (date)
To reduce incidence of cervical cancer from 40.9 per 10,000 women	Incidence of cervical cancer per 10000 women	Planned	40.9		2019 Human Papillomavirus and Related Diseases Report	35 by 2020

to 35 per 10,000 by 2020.		Achieved			36.70%	
<b>Source:</b>						
Cancer Database, Human Papillomavirus and Related Diseases Report						
<b>IMPACT 7</b>	<b>Impact Indicator 7</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
To prevent new HIV infections and to reduce deaths due to HIV by 50%	HIV Incidence among adults and adolescents (15 - 49years)	Planned	0.98 (2013)	2015 HIV Estimates	2018 HIV Estimates	0.49 by 2020
		Achieved		0.59	0.5	
		<b>Source</b>				
HIV Estimates						
<b>IMPACT 8</b>	<b>Impact Indicator 8</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
To reduce unwanted pregnancies	Unwanted pregnancies averted	Planned			608,000	904822
		Achieved	409,000	619,000 (2015)	671,000 (2019)	
		<b>Source</b>				
FP2020 Projections						

## HDF Log frame - OUTCOMES

### Maternal and Newborn Care

OUTCOME 1	Outcome Indicator 1.1		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Improved maternal and	Proportion of pregnant women	Planned	70% in 2014 MICS	80% in 2015 DHS	85% in 2018	90% in 2020	Support for all the 7 thematic areas that are indivisible and work interdependently are

new born care	who attended ANC4+ during the current pregnancy.	Achieved			93.3% (MICS 2019)		<p>maintained in order to achieve the overall goal of the Health Development Fund.</p> <p>The political and economic situation do not worsen to a state where routine functioning of social services is disrupted.</p> <p>UNICEF and UNFPA continue to be mandated and are able to effectively work with all partners especially with the Government as well as other development partners to fully implement and monitor the programme.</p> <p>The Government of Zimbabwe allocates at least 15% of the national budget to the health sector as per its commitments to the Abuja Declaration.</p> <p>The MTP 2016-2020, the National Health Strategy and Child Survival Strategy are fully implemented by Government of Zimbabwe.</p> <p>Access to facilities and communities is sustained in order to carry out effective monitoring.</p>
			<b>Source</b>				
<b>HDF Funding Partners US\$</b>			<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
<b>HDF Funding Partners (FTEs)</b>							
<b>Outcome Indicator 1.2</b>			<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Proportion of deliveries attended by a	<b>Planned</b>		80% 2014 MICS	81% in 2015	82% in 2018	85% in 2020	Above assumptions above considered to apply to all elements of the log frame, unless otherwise stated
	<b>Achieved</b>				86% (MICS 2019)		

	skilled birth attendant.		<b>Source</b>				
			HMIS, DHS/MICS, Administrative Report, HFA, CSO/Zimstat				
	<b>HDF Funding Partners US\$</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
	<b>HDF Funding Partners (FTEs)</b>						
	<b>Outcome Indicator 1.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
	Percentage of mothers who received postnatal care at least 2 times in the first week after delivery.	<b>Planned</b>	78% in MICS 2014	80% in 2015 DHS	85% in 2017	85% by 2020	As stated above
		<b>Achieved</b>			82.1% (MICS 2019)		
		<b>Source</b>					
			HMIS, DHS/MICS, Administrative Report, HFA, VHMAS.				
<b>INPUTS (£)</b>	<b>HDF Funding Partners US\$</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	
<b>INPUTS (HR)</b>	<b>HDF Funding Partners (FTEs)</b>						
<b>Improving Child Health</b>							
<b>OUTCOME 2</b>	<b>Outcome Indicator 2.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Improved Child Health	Proportion of infants fully immunised	<b>Planned</b>	69.2% in 2014 MICS	71% by 2015 ZDHS	73% by 2018	85% by 2020	As stated above
		<b>Achieved</b>		76% (DHS 2015)	85.9% (MICS 2019)		

		Source				
		HMIS, DHS/MICS, Administrative Report.				
HDF Funding Partners US\$		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
HDF Funding Partners (FTEs)						
Outcome Indicator 2.2		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Percentage point coverage of DTP3 in the lowest wealth quintile as compared to the highest wealth quintile.	Planned	10%% in 2014.	9%% in 2015.	7% in 2017.	5% by 2020.	As stated above
	Achieved					
	Source					
	DTP3 Highest Q	95%	95% in 2015	95% in 2017.	95%	
	DTP3 Lowest Q	85%	86% in 2015.	88% in 2017.	90%	
		DHS/MICS (MICS 2014 Report page 63), Administrative Report.				
HDF Funding Partners US\$		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
HDF Funding Partners (FTEs)						
Outcome Indicator 2.3		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of infants vaccinated with DTP3 containing	Planned	85.4% in 2014	87% in 2015.	88% in 2017.	90% 2020	As stated above
	Achieved		83.4% (DHS 2015)	91% (MICS 2019)		

agent; pentavalent -3	<b>Source</b>					
	HMIS, DHS/MICS Administrative Report.					
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>HDF Funding Partners (FTEs)</b>						
<b>Outcome Indicator 2.4</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
Proportion of infants vaccinated for measles	<b>Planned</b>	88% in 2014	88.5% in 2015.	89% in 2017.	90% 2020	
	<b>Achieved</b>		81.9% (DHS 2015)	87.9% (MICS 2019)		
	<b>Source</b>					
	HMIS, DHS/MICS Administrative Report.					
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>HDF Funding Partners (FTEs)</b>						
<b>Outcome Indicator 2.5</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Proportion of newborns (0- 28 days old) with sepsis treated with antibiotics	<b>Planned</b>	N/A	38% by 2015 ZDHS	42% by 2017	50% by 2020	As stated above
	<b>Achieved</b>					
	<b>Source</b>					
	HMIS, DHS/MICS, Administrative Report, HFA. Need to conduct HFA					

HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)
HDF Funding Partners (FTEs)					
<b>Outcome Indicator 2.6</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
Proportion of children under five years with pneumonia treated with antibiotics	<b>Planned</b>	34% by 2014 (MICS)	38% by 2015 ZDHS	42% by 2017	45% by 2020
	<b>Achieved</b>				
	<b>Source</b>				
HMIS, DHS/MICS, Administrative Report, HFA. Need to conduct HFA					
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)
HDF Funding Partners (FTEs)					
<b>Outcome Indicator 2.7</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
Proportion of children under five years with diarrhoea treated with ORT and zinc	<b>Planned</b>	14% by 2014 (MICS)	16% by 2015 ZDHS	25% by 2017	20% by 2020
	<b>Achieved</b>		15.1% (DHS 2015)	2019 MICS 16.5%	
	<b>Source</b>				
HMIS, DHS/MICS, Administrative Report, HFA.					
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)
HDF Funding Partners (FTEs)					

			Baseline	Milestone 1	Milestone 2	Target (date)		
	<b>Outcome Indicator 2.8</b>							
	Proportion of children under five years of age with confirmed malaria treated with standard anti-malarial drugs.	<b>Planned</b>	79% by 2014 (MICS)	82% by 2015 ZDHS	85% by 2018	90% by 2020		
		<b>Achieved</b>						
		<b>Source</b>						
			HMIS, DHS/MICS, Administrative Report, HFA. No data					
	<b>HDF Funding Partners</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>		
	<b>HDF Funding Partners (FTEs)</b>							

<b>Enhancing national capacity in Maternal, Infant and Young Child Nutrition.</b>							
			Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
<b>OUTCOME 3</b>	<b>Outcome Indicator 3.1</b>						
Improved capacity for the managed Maternal, Infant and Young Child Nutrition.at all levels	Proportion of children aged (0-6 months) exclusively breastfed	<b>Planned</b>	41% in MICS 2014	43% by 2016 ZDHS	45% by 2017	47%	As stated above
		<b>Achieved</b>		47.8% (DHS 2015)	41.9% (MICS 2019)		
		<b>Source</b>					
			HMIS, DHS/MICS, Administrative Report, National Nutrition Survey				
	<b>DFID (£)</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>	

DFID (FTEs)						
<b>Outcome Indicator 3.2</b>		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of children 6-23 months fed a minimum acceptable diet	<b>Planned</b>	13% in MICS 2014	14% by 2016	14.5% by 2018	15% by 2020	As stated above
	<b>Achieved</b>		8% (DHS 2015)	10.7% (MICS 2019)		
	<b>Source</b>					
		DHS/MICS, National Nutrition Survey				
DFID (£)		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
DFID (FTEs)						
<b>Outcome Indicator 3.3</b>		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of children 6-59 Months receiving the recommended dose of Vitamin A supplementation	<b>Planned</b>	43% in MICS 2014	50% in 2015 ZDHS	75% in 2017	75% by 2020	As stated above
	<b>Achieved</b>		67% (DHS 2015)	85%		
	<b>Source</b>					
		HMIS, DHS/MICS, Administrative Report, National Nutrition Survey				
DFID (£)		Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
DFID (FTEs)						
<b>Outcome Indicator 3.4</b>		Baseline	Milestone 1	Milestone 2	Target (date)	

	Proportion of children under five years of age with severe acute malnutrition who received standard treatment for SAM.	<b>Planned</b>	65% by 2014 (Administrative reports)	68% by 2017	72% by 2018	75% by 2020		
		<b>Achieved</b>			70%			
	<b>Source</b>							
	HMIS, DHS/MICS, Administrative Report, HFA.							
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>		
<b>HDF Funding Partners (FTEs)</b>								
<b>HIV and AIDS</b>								
<b>OUTCOME 4</b>	<b>Outcome Indicator 4.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>	
Increased uptake of integrated HIV prevention services among children, women and men, including young people and key populations.	Proportion of HIV exposed children receiving ARVs for prophylaxis	<b>Planned</b>	88% in 2014	95% in 2016	95% in 2018	95% in 2020	As stated above, these are being dropped as per the last recommendation	
		<b>Achieved</b>						
	<b>Source</b>							
	<b>MoHCC ATP annual reports</b>							
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>		
	<b>Outcome Indicator 4.2</b>							
	Proportion of HIV exposed children receiving DNA/PCR test within two months of age	<b>Planned</b>	TBD	80% in 2016	90% in 2018	95% in 2020		
		<b>Achieved</b>						
	<b>Source</b>							
<b>MoHCC ATP annual reports</b>								

HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)
HDF Funding Partners (FTEs)					
<b>Outcome Indicator 4.3</b>					
Proportion of HIV positive children receiving antiretroviral therapy (ART) disaggregated by age	Planned	38% in 2014	52% in 2016	67% in 2018	81% in 2020
	Achieved				
		Source			
		MoHCC ATP annual reports			
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)
HDF Funding Partners (FTEs)					
<b>Outcome Indicator 4.5</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
Percentage of men 15 to 29 circumcised	Planned	16%	13% in 2016	16% in 2018	20%
	Achieved		16.6% (DHS 2015)		
		Source			
		ZDHS			
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)
HDF Funding Partners (FTEs)					

			Baseline	Milestone 1	Milestone 2	Target (date)		
	<b>Outcome Indicator 4.6</b>							
	% of female and male aged 15–49 who had more than one partner in the past 12 months and who used a condom during their last sexual intercourse	Planned	49% (Females) 33% (Males)			60% (Females) 60% (males)		
		Achieved						
	<b>Source</b>							
	MICS, DHS							
	<b>DFID (£)</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>		
	<b>DFID (FTEs)</b>							
<b>Sexual Reproductive Health</b>								
<b>OUTCOME 5</b>	<b>Outcome Indicator 5.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>	
Improved sexual and reproductive health status of women and young people (10-24 years)	Unmet need for family planning among females 15-19years	Planned	10.4 % (MICS 2014)	9.1% in 2016	7.8 in 2018	6.5% (FP2020Commitment)	As stated above (Note, milestone data is only available every 5 years through DHS/MICS)	
		Achieved		10%	No data			
			<b>Source</b>					
			ZDHS, MICS, FP2020 Commitment document					
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>		

HDF Funding Partners (FTEs)					
<b>Outcome Indicator 5.2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
Percentage of women aged 15-49 using long-acting contraceptive methods.	<b>Planned</b>	10%	DHS 2015	MICS 2019	15%
	<b>Achieved</b>		11%	No data	
	<b>Source</b>				
	ZDHS, MICS,				
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>
<b>DFID (FTEs)</b>					
<b>Outcome Indicator 5.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
% of eligible women (25-55years) ever screened for cervical cancer in public and private health facilities	<b>Planned</b>	13%	Cervical Cancer Database, 2016	MICS 2019	30% in 2020
	<b>Achieved</b>		18%	No data	
	<b>Source</b>				
	Cervical Cancer Database, DHS				
<b>DFID (£)</b>		<b>Govt (£)</b>	<b>Other (£)</b>	<b>Total (£)</b>	<b>DFID SHARE (%)</b>
<b>DFID (FTEs)</b>					

Outcome Indicator 5.4		Baseline	Milestone 1	Milestone 2	Target (date)
% of girls (15-19 years) who have begun child bearing	Planned	23%	2015 DHS	2019 MICS	18%
	Achieved		22%	17.60%	
<b>Source</b>					
DHS/MICS					
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)
DFID (FTEs)					
Outcome Indicator 5.5		Baseline	Milestone 1	Milestone 2	Target (date)
Percentage of women and girls who report having used services after being abused	Planned	15% police 2.2% social services	2015 DHS	2019 MICS	20% police 10% social services
	Achieved		20.8% police Social services 5.5%	no data	
<b>Source</b>					
DHS/MICS					
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)
DFID (FTEs)					
Outcome Indicator 5.6		Baseline	Milestone 1	Milestone 2	Target (date)

	Percentage of sexually abused clients who report to the health facility within 72hours.	<b>Planned</b>	30% (2015)	31% by 2016	31% by 2018	32%	
		<b>Achieved</b>		30.40%	2019 MICs 29%		
			<b>Source</b>				
			HMIS				
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						
	<b>Outcome Indicator 5.7</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
	Percentage of women who experienced physical violence in the last 12 months	<b>Planned</b>	18% (2015)	DHS 2015	MICS 2019	11%	
		<b>Achieved</b>		35%	30.9% (15-49)		
<b>Strengthened Community Interventions</b>							
<b>OUTCOME 6</b>	<b>Outcome Indicator 6.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Strengthened community health service delivery systems for RMNCH-A and nutrition	Percentage of population age 15-24 years with comprehensive correct knowledge of HIV/AIDS	<b>Planned</b>	46%	DHS 2015	MICS 2019	55%	
		<b>Achieved</b>		46.30%	no data		
			<b>Source</b>				
			DHS/MICS				
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						

Outcome Indicator 6.2		Baseline	Milestone 1	Milestone 2	Target (date)	
HDF Funding Partners (US\$)	Planned	50%	DHS 2015	MISC 2019	75%	
	Achieved		72%	no data		
	<b>Source</b>					
DHS/MICS						
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
DFID (FTEs)						
Outcome Indicator 6.3		Baseline	Milestone 1	Milestone 2	Target (date)	
Percentage of people aged 15-49 who state that husband/wife is justified in hitting or beating his wife in at least one of the following circumstances. (i) she goes out without telling him (ii) she neglects the children (iii) she argues with him (iv) she refuses sex with him (v) she burns the food.	Planned	37.4% (women) 23.7% (men) MICS 2014	DHS 2015	MICS 2019	32% (women) and 18% (men)	
	Achieved		33%	30.90%		
	<b>Source</b>					
DHS/MICS						

## HDF Log frame - OUTPUTS

### OUTPUTS FOR THEME 1: Maternal, Newborn, Child Health and Nutrition

#### Output 1: Maternal and Newborn Care improvements in Obstetric and Newborn Care

OUTPUT 1.1	Output Indicator 1.1.1		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Increased capacity to provide ANC services	Proportion of health centres with at least one upskilled Primary Care Nurse	Planned	80% in 2014	82% in 2016	85% in 2018	90% by 2020	<p>Support for all the 7 thematic areas that are indivisible and work interdependently are maintained in order to achieve the overall goal of the Health Development Fund.</p> <p>The political and economic situation do not worsen to a state where routine functioning of social services is disrupted.</p> <p>UNICEF and UNFPA continue to be mandated and are able to effectively work with all partners especially with the Government as</p>
		Achieved		96.30%	97.90%		

							<p>well as other development partners to fully implement and monitor the programme.</p> <p>The Government of Zimbabwe allocates at least 15% of the national budget to the health sector as per its commitments to the Abuja Declaration.</p> <p>The MTP 2016-2020, the National Health Strategy and Child Survival Strategy are fully implemented by Government of Zimbabwe.</p> <p>Access to facilities and communities is sustained in order to carry out effective monitoring.</p>
		<b>Source</b>					
		VHMAS					
<b>INPUTS (US\$)</b>	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	

INPUTS (HR)	DFID (FTEs)						
<b>OUTPUT 1.2</b>	<b>Output Indicator 1.2.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Increased capacity to provide EmONC Services at primary and secondary level	Proportion of rural health centres with at least one nurse with midwifery skills to provide basic EmONC services	<b>Planned</b>	28% in 2014	40% in 2016	70% in 2018	90 % by 2020	As stated above
		<b>Achieved</b>		96.60%	94.63%		
	<b>Source</b>						<b>RISK RATING</b>
	VHMAS						
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						
	<b>Output Indicator 1.2.2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
	Proportion of PHCs providing the 5 selected signal functions of basic emergency obstetric and newborn services.	<b>Planned</b>	57% in 2014 (VMAHS)	65% by 2016	75% by 2018	90% by 2020	
		<b>Achieved</b>		97.50%	91.8% in 2019		
		<b>Source</b>	VHMAS				
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
<b>DFID (FTEs)</b>							
<b>Output Indicator 1.2.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>	
Proportion of districts with at least 3 doctors.	<b>Planned</b>		80% by 2016	80% by 2018	80%	As stated above	
	<b>Achieved</b>		80%	63.3% in 2019			

		<b>Source</b>					
		VMAHS					
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>		
<b>DFID (FTEs)</b>							
<b>Output Indicator 1.2.4</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>	
Proportion of district hospitals performing Caesarean Section on pregnant women who require it.	<b>Planned</b>	87% in 2015 (VMAHS)	90% by 2016	90% by 2018	90% by 2020	As stated above	
	<b>Achieved</b>		94.10%	91.21% in 2019			
		<b>Source</b>					
		VHMAS					
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>		
<b>DFID (FTEs)</b>							
<b>Output Indicator 1.2.5</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>	
Proportion of District hospitals having at least two health professional who can do C/S	<b>Planned</b>	80% by 2014 (Administrative report)	82% by 2016	85% by 2017	90% by 2020		
	<b>Achieved</b>		89.30%	85% in 2019			
		<b>Source</b>					<b>RISK RATING</b>
		VHMAS					
<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>		
<b>DFID (FTEs)</b>							

Output Indicator 1.2.6		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of district hospitals with at least two health professional who can provide anaesthesia for emergency obstetric surgery	Planned	80% by 2014 (Administrative report)	82% by 2016	85% by 2017	90% by 2020	
	Achieved		51.80%	92.7% in 2019		
Source						RISK RATING
VHMAS,						
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
DFID (FTEs)						
Output Indicator 1.2.7		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of district hospitals with fully functional operation room to perform emergency obstetric surgery.	Planned	91% in 2014	94% in 2016	97% in 2018	85 % by 2020	
	Achieved			75% in 2019		
Source						RISK RATING
VHMAS.						
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
DFID (FTEs)						
Output Indicator 1.2.8		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Proportion of health facilities with fully functional communication	Planned	90% in 2014	92% in 2016	95% in 2018	85% by 2020	
	Achieved		75%	72% in 2019		

	equipment for emergency referral	Source				RISK RATING	
		VHMAS.					
	HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	DFID (FTEs)						
	Output Indicator 1.2.9		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
	Proportion of district hospitals with the capacity to provide blood transfusion for emergency obstetric care	Planned	71% in 2014	75% in 2016	85% in 2018	90% 2020	National Blood Service of Zimbabwe (NBSZ) capacity, collaboration
		Achieved		91.10%	92.9% in 2019		
		Source				RISK RATING	
		VHMAS					
	HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	DFID (FTEs)						
Output Indicator 1.2.10		Baseline	Milestone 1	Milestone 2	Target (2020)	Assumptions	
1.2.10 Proportion of maternal deaths reported through the national health information system (National)	Planned	12%	12% in 2016	20 % in 2018	25%	As stated above	
	Achieved		12%	15%			
	Source: Programme Reports, eMPDNS*				RISK RATING		
HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)		

DFID (FTEs)						
<b>Output Indicator 1.2.11</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
Proportion of health facilities with no stock out of selected key maternal health medicines (Oxytocin and Magnesium Sulphate)	<b>Planned</b>	89 % in 2016	91 % in 2017	93 % in 2018	95% in 2020	
	<b>Actual</b>		98%	95.4% Oxytocin, 88.6% Mag Sulphate		
	Source: VMAHS					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>DFID (FTEs)</b>						
<b>Output 1.3</b>	<b>Output Indicator 1.3.1</b>		<b>Baseline (2014)</b>	<b>Milestone 1 2016</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
Increased availability of postnatal care services	% of health facilities offering postnatal care services	<b>Planned</b>	97%	97%	99% in 2018	100%
		<b>Achieved</b>		100%	99.58%	
		Source				
	Administrative reports, VMAHS					
	<b>HDF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>
<b>DFID (FTEs)</b>						
	<b>Output Indicator 1.3.2</b>		<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
	<b>Planned</b>	80%	0%	0% in 2018	5%	

	Stock out rate for essential medicines (need to specify the medicines)1. <b>Amoxicillin</b> 2. Paracetamol tablets 3. Zinc + ORS 4. ORS 5. Tetracycline Eye Ointment 6. Ferrous/Folic Acid tablets 7. Diazepam Inj 8. DPT 9. RUTF 10. 5ml syringe	Achieved		0%	0%		
		Source					
		VHMAS, administrative reports					
	HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	DFID (FTEs)						
<b>OUTPUT 1.4</b>	<b>Output Indicator 1.4.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Increased access to MNCH services	Proportion of health facilities charging user fees for ANC	<b>Planned</b>	7.70%	7.00%	6% in 2018	0%	
		<b>Achieved</b>		5.30%	2.1%		
		Source					
		Administrative Reports, VHMAS					
	HDF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	DFID (FTEs)						
<b>Output 2: Child Health Outputs: Consolidating improvements in Obstetric and Newborn Care</b>							
<b>OUTPUT 2.1</b>	<b>Output Indicator 2.1.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	

Increased capacity of health facilities to manage common newborn and childhood illnesses including HIV/AIDS and severe acute malnutrition by 2020	Proportion of health centres having at least one Health Worker trained on IMNCI	<b>Planned</b>	60% in 2014	70% by 2017	90% by 2018	95% by 2020	
		<b>Achieved</b>			50%	89.24%	
	<b>Source</b>						
	HMIS, Administrative Report, HFA, VHMAS.						
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						
<b>Output Indicator 2.1.2</b>							
Proportion of health facilities offering paediatric ART services.	<b>Planned</b>	Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions	
	<b>Achieved</b>	39% in 2014	60% in 2016	70% in 2018	95% (2020)	Health workers would have capacity to initiate ART at lower health facilities including availability of paediatric ART formulations	
<b>Source</b>							
HIMS, Administrative reports, HFA.							
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>		
<b>DFID (FTEs)</b>							
<b>Output Indicator 2.1.3</b>							
Proportion of districts with at least 80% DTP3 coverage.	<b>Planned</b>	Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions	
	<b>Achieved</b>	91% in 2014.	85% in 2016	88% in 2018	90% by 2020.	As stated above	

			Govt (£)	Other (£)	Total (£)	DFID SHARE (%)	
	HDF Funding Partners US\$						
	HDF Funding Partners (FTEs)						
	Output Indicator 2.1.4		Baseline	Milestone 1	Milestone 2	Target (date)	
	Proportion of girls (10 years) in and out of school reached with HPV	Planned				95% in 2020	
		Achieved					
		Source					
		DHS					
<b>OUTPUT 2.2</b>	<b>Output Indicator 2.2.1</b>		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
Increased availability of essential child health medicines including ART and SRH commodities	Proportion of health facilities with 100% availability of functional cold chain equipment	Planned	96.% in 2014 VMAHS	97% by 2016	98% by 2018	100% by 2020	As stated above
		Achieved		98.10%	94.4%		
	Source						
	Administrative Reports, VHMAS						
	HTF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)	
	DFID (FTEs)						
	Output Indicator 2.2.2		Baseline	Milestone 1	Milestone 2	Target (date)	Assumptions
	Proportion of health facilities with at least	Planned		80% in 2016	85% in 2018	90%	

80% availability of ARVS for children	<b>Achieved</b>		73.90%	87.72%		
	<b>Source</b>					
	Administrative Reports, VHMAS					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>DFID (FTEs)</b>						
<b>Output Indicator 2.2.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Proportion of health facilities with at least 80% availability of selected antibiotics	<b>Planned</b>		80% in 2016	85% in 2018	<b>80%</b>	
	<b>Achieved</b>		93.00%	98.80%		
	<b>Source</b>					
	Administrative Reports, VHMAS					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>DFID (FTEs)</b>						
<b>Output Indicator 2.2.4</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	<b>Assumptions</b>
Proportion of health centres with at least 70% availability of traditional vaccines throughout the year	<b>Planned</b>		95% in 2016	95% in 2018	100%	
	<b>Achieved</b>		97.70%	96.76%		
	<b>Source</b>					
	Administrative Reports, VHMAS					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>DFID (FTEs)</b>						

OUTPUT 2.2 1								
Output 2.2.1	Output indicator 2.2.1.1		Baseline	Milestone 1	Milestone 2			
Increased capacity to respond to COVID-19 outbreak.	Number of people reached on COVID 19 through messaging on prevention and access to services	Planned	0		2,500,000	12/31/2020		
	source							
	Administrative reports							
		Output indicator 2.2.1.2		Baseline	Milestone 1	Milestone 2		
	Number of healthcare facilities staff and community health workers provided with Personal Protective Equipment (PPE)	Planned	0		33,800	12/31/2020		
		Achieved						
	source							
Administrative reports								
	Output indicator 2.2.1.3		Baseline	Milestone 1	Milestone 2			
Number of healthcare facility staff and community health workers trained in Infection Prevention and Control (IPC).	Planned	0		1,000	12/31/2020			
	Achieved							
source								
Administrative reports								
	Output indicator 2.2.1.4		Baseline	Milestone 1	Milestone 2			

	Number of healthcare providers trained in detecting, referral and appropriate management of COVID-19 cases among children, pregnant and breastfeeding women.	Planned	0		3000	12/31/2020		
		Achieved						
	<b>Output indicator 2.2.1.5</b>							
	Number of COVID-19 infected persons treated in designated treatment centres	Planned			20% of identified cases needing specialised care			
Achieved								
	<b>source</b>							
<b>OUTPUT 3.1</b>								
Increased capacity of districts to provide comprehensive nutrition services	Number of districts that have adopted plans for scaling up of high impact critical nutrition interventions through multi sectorial community based model approach (innovative model)	<b>Planned</b>	4 in 2015	total 8 in 2016	total 23 in 2018	40 districts by 2020	<b>Adequate resources , continue commitment at all levels</b>	
		<b>Achieved</b>		19	31			
		<b>Source</b>						
		HMIS, DFNSC, DHS/MICS Administrative Report, HFA, VHMAS, CSO/Zimstat						<b>Assumptions</b>
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	As stated above	
	<b>DFID (FTEs)</b>					<b>RISK RATING</b>		

Output Indicator 3.1.2		Baseline	Milestone 1	Milestone 2	Target (date)	
Proportion of health facilities with no stock out of critical nutrition supply ( vitamin A, IFA, RUTF ) throughout the year	Planned		95% in 2016	98% in 2018	98% in 2020	Adequate resources , continue commitment at all levels
	Achieved		96%	97.50%		
	<b>Source</b>					
	HMIS, DFNSC, DHS/MICS Administrative Report, HFA, VHMAS, CSO/Zimstat					
HTF Funding Partners (US\$)		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)	As stated above
DFID (FTEs)						<b>RISK RATING</b>
Output Indicator 3.1.3		Baseline	Milestone 1	Milestone 2	Target (date)	
Proportion of wards with multi-sectorial, costed and sustainable ward action plans (that include clear targets on reducing stunting).	Planned	0% 2015	40% in 2016	60% by 2018	90% by 2020	
	Achieved		40%	87%		
	<b>Source</b>					
	Administrative Report					
HTF Funding Partners (US\$)		Govt (US\$)	Other (US\$)is its source	Total (USD)	HTF Donor SHARE (%)	As stated above
DFID (FTEs)						
Output Indicator 3.1.4		Baseline	Milestone 1	Milestone 2	Target (date)	
Proportion of primary health care centres assessing and managing	Planned	70% 2015	80 % 2016	85% 2018	90% 2020	
	Achieved		74.20%	98.50%		
	<b>Source</b>					

	children with severe acute malnutrition as per the global standard.(SPHERE Standards: Cure rate)	HMIS, Administrative Report, HFA, VHMAS.					<b>Assumptions</b>	
<b>INPUTS (US\$)</b>	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	As stated above	
<b>INPUTS (HR)</b>							<b>RISK RATING</b>	
<b>Output 4: HIV and AIDS</b>								
<b>OUTPUT 4.1</b>	<b>Output Indicator 4.1.1</b>		<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>		
Increased capacity to provide HIV prevention services among children, women and men, especially young people and key populations	Proportion of health facilities implementing national guidelines on integrated delivery of SRH & HIV services in 20 supported districts	<b>Planned</b>	0	10 % by 2016	44% in 2018	95%		
		<b>Achieved</b>		3%	76%			
	<b>Source</b>							
	<b>Programme Reports, Survey</b>							
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>		
	<b>DFID (FTEs)</b>							
	<b>Output Indicator 4.1.3</b>		<b>Baseline (2019)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>		
	Number of sex workers seen in Hot spot districts	<b>Planned</b>	1,800			3,600		
		<b>Achieved</b>						
	<b>Source</b>							
<b>Programme Reports</b>								
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>			

	<b>DFID (FTEs)</b>					
	<b>Output Indicator 4.1.5</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
	4.1.5. Proportion of antenatal care attendees positive for syphilis who received treatment. (National)	<b>Planned</b>	82%	76% in 2016	80% in 2018	85%
		<b>Achieved</b>		76%	82%	
		<b>Source</b>				
		HMIS, Programme Reports				
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
	<b>DFID (FTEs)</b>					
	<b>Output Indicator 4.1.6</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>
	Proportion of Health facilities reporting no stock outs of 80 % of selected STI drugs in the past three months. (Ceftriaxone injection, Metronidazole, Doxycycline, Benzathine Penicillin injection, Ciprofloxacin and Erythromycin.) (National)	<b>Planned</b>	35% in 2016	50 % in 2017	60% in 2018	80% in 2020
		<b>Achieved</b>			70%	
		<b>Source</b>				
		VMAHS				
<b>Output 5: Sexual Reproductive Health</b>						
<b>OUTPUT 5.1</b>	<b>Output Indicator 5.1.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>

Increased availability of and access to voluntary family planning, especially long acting contraceptive methods	5.1.1. Percentage of hospitals providing IUCD in the last 3 months. (National)	<b>Planned</b>	23% in 2016	45% by 2017	74% by 2018	80%	
		<b>Achieved</b>		48%	70%		
	<b>Source: Programme Reports</b>						
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						
	<b>Output Indicator 5.1.2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	5.1.2. Percentage of health facilities (clinics and hospitals) providing implants.	<b>Planned</b>	58 % in 1026	62 % in 2017	65 % in 2018	80%	
		<b>Achieved</b>		78%	83%		
	<b>Source</b>						
	HMIS, Programme Reports						
	<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>DFID (FTEs)</b>						
	<b>Output Indicator 5.1.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	5.1.3. Number of IUCD insertions among women aged 16 to 49 years. (National)	<b>Planned</b>	5002 in 2015	16,000 by 2017	22,000 by 2018	69,000	
		<b>Achieved</b>		6,735	35,640		
	<b>Source</b>						
	HMIS, Programme Reports						
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>		
<b>DFID (FTEs)</b>							

		Baseline	Milestone 1	Milestone 2	Target (2020)
<b>Output Indicator 5.1.4</b>					
5.1.4. Number of implant insertions among women aged 16 to 49 years.(National)	<b>Planned</b>	78,681 in 2015	232,700 in 2017	309,700 in 2018	519,000
	<b>Achieved</b>		74,884	315,278	
<b>Source</b>					
HMIS, Programme Reports					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>DFID (FTEs)</b>					
<b>Output Indicator 5.1.5</b>					
5.1.5 Number of additional women15-49 using modern FP methods (National)	<b>Planned</b>	213,638	268,918 in 2016	371,245 in 2018	400,000
	<b>Achieved</b>		428,000	289,000	
<b>Source</b>					
HMIS, Programme Reports					
<b>HTF Funding Partners (US\$)</b>		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>Output Indicator 5.1.7</b>					
Proportion of health facilities with no stock out of long acting contraceptives (Implants or IUCD)	<b>Planned</b>	95% in 2016	95 % in 2017	95% in 2018	95%
	<b>Achieved</b>		72%	82%	
<b>Source: VMAHS</b>					



			Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	<b>HDF Funding Partners (US\$)</b>						
	<b>DFID (FTEs)</b>						
			<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	<b>Output Indicator 5.4.2</b>	Planned	70	120 by 2016	540 by 2018	850	
	<b>Number of fistula cases repaired in supported sites</b>	Achieved		117	537		
		<b>Source</b>	Programme reports				
			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
	<b>HDF Funding Partners (US\$)</b>						
	<b>DFID (FTEs)</b>						
<b>OUTPUT 5.5</b>	<b>Output Indicator 5.5.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
National cervical cancer screening programme using visual inspection with acetic acid and cervicography strengthened and scaled up	<b>5.5.1. Proportion of public health facilities (hospitals and clinics) in supported sites (200) (tertiary and secondary level) providing VIAC services</b>	<b>Planned</b>	78% (2015)	85% in 2017	90% in 2018	100%	
		<b>Achieved</b>		100%	100%		
			<b>Source</b>				
		HMIS, Programme Reports					
			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>HTF Funding Partners (US\$)</b>						
	<b>DFID (FTEs)</b>						
	<b>Output Indicator 5.5.2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	

	5.5.2. Number of women screened for cervical cancer in supported sites	<b>Planned</b>	164,013 in 2015	340,701 in 2017	440,701 by 2018	640,701
		<b>Achieved</b>		101,489	484,739	
		Source				
		HMIS				
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>HTF Funding Partners (US\$)</b>					
	<b>Output Indicator 5.5.3</b>					
	5.5.3. Proportion of visual inspection with acetic acid positive women treated (National)	<b>Planned</b>	55% in 2015	62 % in 2017	60% in 2018	65%
		<b>Achieved</b>		57%	58%	
	<b>HTF Funding Partners (US\$)</b>					
	<b>DFID (FTEs)</b>					
<b>OUTPUT 5.6</b>	<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
Increased national capacity to provide information and services that prevent teenage pregnancy	<b>Output Indicator 5.6.1</b>	<b>Planned</b>	7% (23 facilities)	85% in 2017 (249 facilities)	90% in 2018	95%
	5.6.1. Proportion of health facilities in 20 supported districts providing youth friendly services that meet established national standards.	<b>Achieved</b>		125%	90%	
			Source			
			Programme Reports			
	<b>HTF Funding Partners (US\$)</b>					

	<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	<b>Output Indicator 5.6.2</b>	<b>Planned</b>	0	58% in 2016	79% by December 2018	100%	
	5.6.2. Proportion of secondary schools with teachers trained in evidence-based life skills, sexuality, and HIV and AIDS in 20 supported districts	<b>Achieved</b>		76%	92%		
			Source				
			Programme Reports				
			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>HTF Funding Partners (US\$)</b>						
	<b>Output Indicator 5.6.4</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	5.6.4. Number of participatory platforms that advocate for increased investment in marginalized adolescents and youth within development and health policy and programmes	<b>Planned</b>	5	7 in 2017	11 in 2018	13	
		<b>Achieved</b>		11	12		
<b>Output 5.7.</b>	<b>Output Indicator 5.7.1</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
Increased national capacity to prevent gender-based violence and enable the delivery of multi-	Proportion of health facilities with at least two health care providers with knowledge and skills	<b>Planned</b>	0	50% in 2017	100% in 2018	100%	
		<b>Achieved</b>		0%	58%		
			Source				

sectoral services, including in humanitarian settings	to provide clinical management of SGBV cases and refer SGBV survivors (National)	Program reports				
		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)	
	HTF Funding Partners (US\$)					
	Output Indicator 5.7.2	Baseline	Milestone 1	Milestone 2	Target (2020)	
	Number of SGBV clients accessing health services within 72 hours in supported 20 districts	Planned	1,575	1,872 in 2017	7,345 in 2018	10,905
		Achieved		1,509	6,351	
		Source				
		Program reports				
		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)	
	HTF Funding Partners (US\$)					
	Output Indicator 5.7.3	Baseline	Milestone 1	Milestone 2	Target (2020)	
	5.7.3 Proportion of survivors from One stop centres and shelters eligible and who opted for medical termination of pregnancy who receive it	Planned	85%	85% in 2017	85% in 2018	85%
		Achieved		56%	37%	
		Source				
	HMIS, Programme Reports					
	Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)		

<b>HTF Funding Partners (US\$)</b>					
<b>DFID (FTEs)</b>					
<b>Output Indicator 5.7.4</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
5.7.4 Number of survivors who accessed One stop centres	<b>Planned</b>	15,188	10000in 2017	39,000 in 2018	59,000
	<b>Achieved</b>		11,156	49.691	
<b>Source</b>					
HMIS, Programme Reports					
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>HTF Funding Partners (US\$)</b>					
<b>Output Indicator 5.7.5</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
5.7.5 Number of survivors who accessed shelters	<b>Planned</b>	3,268	2500 in 2017	10,400 by 2018	16,800
	<b>Achieved</b>		2,588	11,299	
<b>Source</b>					
Programme Reports					
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>HTF Funding Partners (US\$)</b>					

<b>OUTPUT 6.1</b>	<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
Increased coverage of community awareness programmes on SRH/HIV, GBV prevention messages, preventive and curative MNCH and nutrition	<b>Output Indicator 6.1.1</b>	<b>Planned</b>	0%	20% in 2017	37% in 2017	69%	
	Proportion of households reached at least once by integrated social behavioural change communication and demand generation strategies in supported districts.	<b>Achieved</b>		24%	48%		
		<b>Source</b>					
		Program reports, DG Database					
			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
	<b>HTF Funding Partners (US\$)</b>						
	<b>Output Indicator 6.1.2</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	Number of girls recruited into the Sista 2 Sista clubs who completed 75% of sessions in supported districts	<b>Planned</b>	5,000	18280 in 2016	32,280 By December 2017	87,120	
		<b>Achieved</b>		23566	50,905		
		<b>Source</b>					
		Program reports, Demand Generation Database					
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>		
	<b>HTF Funding Partners (US\$)</b>						
	<b>Output Indicator 6.1.3</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>	
	Number of parents who complete 80 % of PCC sessions in supported districts	<b>Planned</b>	2,491	4800 in 2016	22,900 By December 2017	77,000	
<b>Achieved</b>			2701	36,010			

		Source			
		Program reports, Demand Generation Database			
		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)
HTF Funding Partners (US\$)					
Output Indicator 6.1.4		Baseline	Milestone 1	Milestone 2	Target (2020)
Number of person exposures to community dialogues on SRH/HIV and GBV issues.	Planned	0	123750 in 2017	288,750 in 2018	618,750
	Achieved		103720	431,870	
		Source			
		Programme Reports			
		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)
HTF Funding Partners (US\$)					
Output Indicator 6.1.5		Baseline	Milestone 1	Milestone 2	Target (2020)
Number of person exposures among sex workers to SRH and HIV prevention messages in supported sites	Planned	106,428	130428 in 2016	156,428 in 2017	156,428
	Achieved		32,984	163,092	
		Source			
		GBV and Demand Generation programme reports			
		Govt (US\$)	Other (US\$)	Total (USD)	HTF Donor SHARE (%)

<b>HTF Funding Partners (US\$)</b>					
<b>DFID (FTEs)</b>		<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
	<b>Planned</b>		75% in 2017	76% in 2018	
<b>Output Indicator 6.1.6</b>	<b>Achieved</b>		76%	76%	
Proportion of villages with at least one VHW providing community based preventive MNCH, nutrition, HIV, SRH and selected curative MNCH services.	<b>Source</b>				
	Survey, Programme reports				
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>HTF Funding Partners (US\$)</b>					
<b>DFID (FTEs)</b>		<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (2020)</b>
	<b>Planned</b>		75% in 2017	76% in 2018	
<b>Output Indicator 6.1.7</b>	<b>Achieved</b>		76%	76%	
Proportion of VHWs trained on full package of community based MNCH and SRH services	<b>Source</b>				
	Survey, Programme reports				
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>
<b>HTF Funding Partners (US\$)</b>					
<b>DFID (FTEs)</b>		<b>Baseline (2014)</b>	<b>Milestone 1</b>	<b>Milestone 2 2018</b>	<b>Target (2020)</b>
	<b>Planned</b>		100% in 2017	100%	100%

	<b>Output Indicator 6.1.8</b>	Achieved		100%	100%		
	Proportion of health centres with functional health centre committees	<b>Source</b>					
<b>IMPACT WEIGHTING (%)</b>		Survey, Programme reports					
<b>INPUTS (US\$)</b>			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HTF Donor SHARE (%)</b>	
<b>INPUTS (HR)</b>	<b>HTF Funding Partners (US\$)</b>						<b>RISK RATING</b>
<b>INPUTS (HR)</b>	<b>DFID (FTEs)</b>						
<b>Output 7: Monitoring and Evaluation Output</b>							
<b>OUTPUT 7.1</b>			<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
Strengthened capacity to plan, monitor and evaluate the HDF funded activities	<b>Output Indicator 7.1.1</b>	<b>Planned</b>	100 % in 2014 (Administrative reports)	100% by 2018	100% by 2018	100% by 2020	
		<b>Achieved</b>		100%	100%		
	Proportion of districts that conduct regular bi-annual review meetings	<b>Source</b>					
		HMIS, Administrative Report.					
			<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
	<b>HDF Funding Partners (US\$)</b>						
	<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
		<b>Planned</b>	100% in 2014	100% in 2016	100% in 2018	100% in 2020	
	<b>Output Indicator 7.1.2</b>	<b>Achieved</b>		95%	95%		

Proportion of districts regularly providing reports using the standard core indicators of the HMIS	<b>Source</b>					
	HMIS, Administrative Report, HFA, VHMAS.					
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
<b>HDF Funding Partners (US\$)</b>						
<b>DFID (FTEs)</b>						
		<b>Baseline</b>	<b>Milestone 1</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1 2016</b>	<b>Milestone 2 2018</b>	<b>Target (date)</b>	
	<b>Planned</b>	2	2	2	1	
<b>Output Indicator 7.1.3</b>	<b>Achieved</b>		2	1		
Number of national planning and review meetings conducted annually.	<b>Source</b>					
	Administrative Report					<b>Assumptions</b>
		<b>Govt (US\$)</b>	<b>Other (US\$)</b>	<b>Total (USD)</b>	<b>HDF Donor SHARE (%)</b>	
<b>HDF Funding Partners (US\$)</b>						
<b>DFID (FTEs)</b>		<b>Baseline</b>	<b>Milestone 1 2016</b>	<b>Milestone 2</b>	<b>Target (date)</b>	
	<b>Planned</b>	16	16	16	8	
<b>Output Indicator 7.1.4</b>	<b>Achieved</b>		16	8		
		<b>Source</b>				
		Administrative Report				

	Number of provincial bi annual planning and review meetings		Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	HDF Funding Partners (US\$)						
	DFID (FTEs)						
							<b>Assumptions</b>
							List of policies and strategies: ASRH, National Health Strategy, EmONC Improvement Plan
		<b>Planned</b>	Baseline 1	Milestone 1 2016 2	Milestone 2 2018 3	Target (date) 4	
	<b>Output Indicator 7.1.5</b>	<b>Achieved</b>		2	2		HRH and HMIS strategy supported
	Number of policies and strategies supported by the HDF		<b>Source</b>				
				Administrative Report			
			Govt (US\$)	Other (US\$)	Total (USD)	HDF Donor SHARE (%)	
	HDF Funding Partners (US\$)						
	DFID (FTEs)						<b>Assumptions</b>