Independent Commission for Aid Impact (ICAI)

DFID's Health Programme in Zimbabwe

Inception report

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1. Introduction

1.1 The Independent Commission for Aid Impact (ICAI) is the independent body responsible for scrutinising UK aid. We focus on maximising the effectiveness of the UK aid budget for intended beneficiaries and on delivering value for money for UK taxpayers. We carry out independent reviews of aid programmes and of issues affecting the delivery of UK aid. We publish transparent, impartial and objective reports to provide evidence and clear recommendations to support UK Government decision-making and to strengthen the accountability of the aid programme. Our reports are written to be accessible to a general readership and we use a simple 'traffic light' system to report our judgement on each programme or topic we review.

1.2 We wish to assess UK-funded support for healthcare in Zimbabwe over the period 2004-11. The nature and purpose of this review, together with the main themes and questions it will address, were set out in the Terms of Reference. This report contains more precise evaluation questions, mapped against the sources of evidence that will be used to answer them. It sets out the methodology in more detail, identifies the team members and their roles and contains an indicative timeline. It is, however, intended that the methodology and work plan are flexible enough to allow the review to explore new issues and questions emerging over the course of the study.

2. Background

2.1 Zimbabwe is a country twice the area of the UK. It has a population of 12 million, of which just over one million live in the capital, Harare.[1] A further three million Zimbabweans are now estimated to live outside the country. Two main ethnic groups – the Shona and the Ndebele – constitute 90% of the indigenous population, with Christianity the main religion.

2.2 In spite of having once had a well-developed infrastructure and financial system, Zimbabwe's economy declined rapidly from the late 1990s. National income fell by half between 1998 and 2008: 'the longest, deepest economic decline seen anywhere outside a war zone'.[2]

2.3 Since the formation of the Government of National Unity in 2009, there has been a recovery. Economic growth reached 9% in 2010.[3] International relations are beginning to normalise, although some sanctions are still in place and the situation remains fragile.

[1] UN estimate, 2008.

[2] *DFID Departmental Report 2006*, DFID, 2006, Chapter 2, www.dfid.gov.uk/Documents/publications1/departmental-report/2006/CHAP%2002.pdf?epslanguage=en.

[3] *IMF Zimbabwe Staff Report for the 2011 Article IV Consultation*, International Monetary Fund, May 2011, www.imf.org/external/pubs/ft/scr/2011/cr11135.pdf.

2.4 Health in Zimbabwe

2.4.1 Economic decline took its toll: HIV/AIDS prevalence rose to be amongst the highest in the world during the 1990s[4] and a series of failed harvests during the 2000s increased rural poverty and malnutrition.

2.4.2 In August 2008, a nationwide cholera epidemic broke out. At the same time, inflation reached record levels. Doctors and nurses found their salaries worthless, causing many to leave. A foreign currency crisis resulted in a serious drugs shortage. Hospitals and clinics closed. By 2009, HIV/AIDS accounted for half of the disease burden in the country. Life expectancy for women had fallen to 34 years from over 60 only a decade earlier.[5]

2.5 DFID and other donors in Zimbabwe

2.5.1 Aid to Zimbabwe from the Organisation for Economic Co-operation and Development (OECD)[6] countries during the first half of the period of our review (2003-06) averaged about £100 million a year,[7] with UK aid rising to £30-35 million a year during this period.[8] OECD aid rose sharply during the crisis years of 2007-09 and has continued to rise.

2.5.2 During the crisis years, international aid agencies provided emergency food aid and health services, including basic pharmaceuticals, contraceptives and salary subsidies in order to retain health workers. There are aspects of the health sector in Zimbabwe which are reported as success stories, particularly in the area of HIV/AIDS prevention. HIV prevalence in Zimbabwe has declined remarkably in recent years, dropping from 26% to 14% between 1997 and 2009. Several key factors in Zimbabwe's success were supported by donors.[9]

2.5.3 The UK is the second-largest bilateral donor to Zimbabwe after the United States.[10] Total direct UK spending in 2010-11 was just over £70 million.[11,12] This is set to rise to £80 million in 2011-12 and

[4] *UNGASS Report on HIV and AIDS, Follow-Up To The Declaration Of Commitment On HIV and AIDS: Zimbabwe Country Report*, 2010, www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/zimbabwe_2010_country_progress_report_en.pdf.

[5] *Dead by 34: How Aids and starvation condemn Zimbabwe's women to early grave*, The Independent, 17 November 2006.

[6] *International Development Statistics Online*, OECD, www.oecd.org:80/dac/stats/idsonline.

[7] Annual average 2009 dollar/sterling exchange rate of £1 = $1.60 has been used in this report.

[8] *Statistics on International Development 2003/04-2007/08*, DFID, November 2008, www.dfid.gov.uk/Documents/publications1/sid2008/FINAL-printed-SID-2008.pdf.

[9] *A Surprising Prevention Success: Why Did the HIV Epidemic Decline in Zimbabwe?*, Halperin DT, et al., PLoS Medicine, February 2011, www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000414.

[10] OECD Zimbabwe Aid at a Glance, www.oecd.org/dataoecd/12/60/1883524.gif.

£84 million in 2012-13[13] if recent progress by the Government of Zimbabwe is maintained. Support to the health sector is expected to be 35% of DFID's total bilateral spending in Zimbabwe.[14]

2.5.4 DFID support to the health sector has concentrated on HIV/AIDS and maternal and child health. Spending has been with or through partner organisations and via multi-component programmes:[15]

Health Sector Support area	Total UK spend (£m)	Duration
HIV/AIDS Expanded Support Programme for HIV/AIDS	**35.0**	**2004-11**
HIV Prevention and Behaviour Change Programme	**21.0**	**2006-11**
Maternal and Newborn Health	**25.0**	**2006-11**
Emergency Medicines	**16.5**	**2008-11**
Emergency Hospital Rehabilitation	**2.3**	**2009-11**
Sanitation and Hygiene	**3.0**	**2010-15**
Demographic and health survey	**0.3**	**2010-11**
Nutrition Surveillance	**0.2**	**2010**

2.5.5 The political situation and institutional fragility in Zimbabwe makes delivering aid and maximising value for money difficult. The health sector is vulnerable to several challenges: keeping costs down in crises and emergencies, delivering through multiple partners and corruption risks.

3. Purpose

3.1 To assess how effectively DFID provides support for health care in Zimbabwe.

[11] A further £5-8 million a year is estimated as UK contributions to Zimbabwe through multilateral programmes (*DFID Annual Report*, 2011, Volume 1, Table A.5). Funds made available through the Civil Society Challenge Fund/Global Poverty Fund are not included.

[12] *Annual Report and Accounts 2010-11*, Volume 1, DFID, 2011, www.dfid.gov.uk/Documents/publications1/departmental-report/2011/Annual-report-2011-vol1.pdf.

[13] *Annual Report and Accounts 2010-11*, Volume 1, DFID, 2011, Table B.6, www.dfid.gov.uk/Documents/publications1/departmental-report/2011/Annual-report-2011-vol1.pdf.

[14] From Zimbabwe project data in DFID Key Facts, www.dfid.gov.uk/Where-we-work/Africa-Eastern--Southern/Zimbabwe/?tab=2.

[15] http://projects.dfid.gov.uk/Default.aspx.

4. Relationships to other evaluations/studies

4.1 The International Development Committee (IDC) undertook its own review of DFID in Zimbabwe, published in March 2010.[16] It concluded that UK aid has helped to deliver progress in Zimbabwe since the Government of National Unity was established and that UK support has been effective in reaching poor and vulnerable people. On health, it concluded that:

'DFID support is making a significant difference to the availability and quality of health care available in Zimbabwe. The retention scheme for health workers is an important intervention which is making a contribution to addressing the lack of trained staff and supporting committed staff to continue to work in health care. The Vital Medicines programme has ensured that all health facilities in the country have basic drugs and medical supplies. We commend DFID's work in the health sector to date and recommend that it continue to give priority to supporting the rebuilding of health services.'

4.2 DFID Zimbabwe has commissioned its own independent impact assessments and regular annual reviews of some of its larger programmes, which it has shared with us. We will draw on these where appropriate. An impact assessment of the Health Worker Retention Scheme is planned to run concurrently with ours. We are aware of other impact assessments by other development partners that are reported to be in the pipeline or are not publicly available. We will investigate whether these are of use to this review when we are in-country.

4.3 In 2009, DFID commissioned a case study of its health programme in Zimbabwe as part of a department-wide Health Sector Portfolio Review. Another background paper to the Portfolio Review was an evaluation of DFID's influence in the health sector, which will be relevant to use, given DFID's role as a partner of others in Zimbabwe. We hope to be able to draw on these reports.

4.4 DFID's 2011 *Multilateral Aid Review*[17] found that the UN agencies with which DFID works in Zimbabwe often have weaknesses around financial management and reporting. Different country offices perform differently and we will investigate how far the generalised UN diagnosis applies in Zimbabwe and to what extent any partners' weaknesses affect the VFM of DFID expenditure.

[16] *DFID's Assistance to Zimbabwe*, International Development Committee, March 2010, www.publications.parliament.uk/pa/cm200910/cmselect/cmintdev/252/252i.pdf.

[17] *Multilateral Aid Review: Ensuring maximum value for money for UK aid through multilateral organisations*, DFID, March 2011, www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf.

5. Methodology

5.1 The Commissioners' detailed questions in the Terms of Reference (ToR) will be assessed according to the evaluative criteria set out in the table below, focussing on the evidence available. The assessment of each question will be used to make a judgement on the 'traffic light score' (green, green-amber, amber-red or red) for each of ICAI's main criteria for assessing value for money and effectiveness. Scoring for each of these criteria will then be used to make a judgement that enables us to generate the overall summary assessment traffic light.

5.2 In view of ICAI's emphasis on impact and intended beneficiary perspectives, we aim to include participatory approaches wherever possible. The proposed framework and methodology is as follows:

Evaluation Questions	Criteria for Assessment	Sources of Evidence
1) Are intended beneficiaries involved in development, roll-out and evaluation of the programme? If so, how? (ToR 6.2.1) 2) Is this assistance demand-driven? (ToR 6.4.1) 3) How are partners engaged? How often? 4) To what extent do DFID staff and partners engage the population in the field as part of the rolling out of this programme? How many visits, by whom, when? (ToR 6.2.8)	• Evidence of expressed demand from partners prior to design? • Evidence that partners are part of the design process (both scope and delivery)? • Evidence that partners and intended beneficiaries see the assistance as needed now? • Evidence that partners/intended beneficiaries effectively participate in current decisions about the operation and allocation of the funding at all levels?	• Interviews with Zimbabwe partners • Documented beneficiary assessments associated with projects • Memoranda of Understanding
5) Are resources being leveraged to maximise impact and provide value for money? (ToR 6.2.4)	• Evidence that UK money funds activities that otherwise would not have taken place? • Evidence that UK investment has stimulated other sources of funding to be provided from elsewhere (domestic or international)?	• Key informant meetings • Document review • DAC Aid statistics
6) Are there actions that will improve the effectiveness and value for money? (ToR 6.4.6)	• Are there outstanding recommendations to be followed? • Are they being implemented?	• Document review • Key informant meetings

Evaluation Questions	Criteria for Assessment	Sources of Evidence
7) What evaluations or reports have been done in the past six years and how have their key recommendations been followed up? (ToR 6.4.2) 8) What are the lessons learned to date from this programme? (ToR 6.4.3)	• Key evaluations shared amongst partners? • Are their lessons and recommendations common knowledge? • Are they reflected in subsequent action or phases of projects?	• Key informant meetings • Document review
9) How are risks managed & mitigated? (ToR 6.2.11)	• Meaningful risk assessments for major projects? • Monitoring of key risks through life of projects? • Evidence of changes as a result?	• Document review • Key informant meetings
10) How do DFID's implementation partners demonstrate effectiveness & value for money? (ToR 6.2.5) 11) How is DFID sharing lessons from / into this programme across its activities globally? (ToR 6.4.4)	• Do partners' reports to DFID link spending to outcomes? • Do DFID advisers use the information to change implementation?	• Document review • Key informant meetings
12) How has the context influenced DFID's choices in delivery of healthcare support to Zimbabwe? What is unique about this context that affects value for money? (ToR 6.2.2)	• Is the rationale clear? • Is it based on evidence? • Has there been consideration of options? • Has expertise been consulted and knowledge incorporated? • Are programmes demonstrably different from other Southern African countries?	• Key informant meetings • DFID document review • Published independent reviews
13) How has context influenced value for money?	• Evidence of accurate assessment of contextual issues to inform design choices? • Evidence of links of the above to cost implications?	• Key informant meetings • Unit cost comparisons • Strategy and contract documents

Evaluation Questions	Criteria for Assessment	Sources of Evidence
14) How has UK aid supported the strengthening of Zimbabwe's overall health system? (ToR 6.3.6)	• WHO six-pillar health systems checklist questions	• Internal Ministry of Health and Child Welfare financial and Human Resources data • Key informant meetings
15) How is DFID applying international lessons in its delivery? (ToR 6.4.5)	• Evidence of examples from other countries informing Zimbabwe programmes?	• Document review • Key informant meetings
16) How is effectiveness assessed given the context is high-risk? (ToR 6.3.1)	• Evidence of accurate assessment of contextual issues to inform design choices? • Evidence of variations in technical aspects in response?	• Key informant meetings • Document review
17) How is sound financial management maintained? (ToR 6.2.6)	• Financial systems understood and implemented by staff? • Is regular oversight practiced? • Evidence of robust and appropriate budgeting? • Evidence of robust financial control systems being in place? • Evidence of effective measures against corruption? • Evidence of third-party audit?	• Systems review • Selected project contract case study
18) How is the impact being measured, both in terms of quantitative outputs (e.g. the number of people reached) and qualitative outcomes (such as changes to individual behaviour or government policies)? (ToR 6.3.2)	• Evidence of logical results chain with clear impact criteria? • Evidence of robust monitoring and evaluation system? • Evidence of verifiable results being collected? • Evidence of monitoring information being used to inform decision-making?	• Key informant meetings • Document review • Field visits

Evaluation Questions	Criteria for Assessment	Sources of Evidence
19) Is DFID's programme complementary with that of other organisations (locally, nationally, internationally, including the private sector)? (ToR 6.2.3)	• Evidence of co-ordination with other deliverers and funders through design and implementation? • Evidence that this co-ordination is effective? • Evidence that options were considered? • Evidence of clear rationale for choice of approach, given those of other funders?	• Government of Zimbabwe health sector strategy • Other development partners' project documentation • Meetings with key informants and intended beneficiaries • Annual project reviews and project completion reports • Project correspondence
20) Is it possible to identify the broader and long-term social and economic impacts of the support for healthcare for Zimbabwe's people? (ToR 6.3.3) 21) How will the long-term and sustainable impact of the programme be assured (in the context of global targets on development and aid effectiveness)? (ToR 6.3.8) 22) What would happen if DFID left next month? (ToR 6.3.9)	• Evidence of institutional, structural or regulatory changes? • Evidence of long-term cost reductions – internally and for health system users? • Do budget forecasts support changes?	• Key informant meetings • Ministry of Health and Child Welfare budgets • User fees analysis
23) Is technology being used to increase effectiveness of delivery and reporting? (ToR 6.2.12)	• Are the latest appropriate (low-cost) medical regimens in use? • Are mobile IT applications in use? • Are there examples of technical innovation?	• Key informant meetings
24) Is the community involved in delivery? 25) Are there identifiable impacts that are clear to recipient communities? Are local people involved in community health training? How? If not, why not? (ToR 6.3.4)	• Comparison of community participation versus similar programmes elsewhere	• Conversational meetings during field visits • Project memos (setting out rationale) • Project reviews (monitoring achievement) • Comparison with regional norms

Evaluation Questions	Criteria for Assessment	Sources of Evidence
26) Is the programme delivering against objectives? Have amendments been made if required? (ToR 6.2.9)	• Are the objectives clear? • Do baseline and progress data exist? • How does progress compare with counterfactual, expectations and benchmarks? • Are amendments well founded?	• Quantitative indicators in annual reviews and project completion reports • Zimbabwe Demographic and Health Surveys and Working Paper Series (produced every five years) • Other quantitative indicators • Meetings with intended beneficiaries • Other independent evaluations
27) Is there good governance at all levels and what are the steps being taken to avoid corruption? (ToR 6.2.7) 28) Is there transparency and accountability to intended recipients? (ToR 6.3.5)	• Evidence that funding and expected outcomes are transparent at all levels of activities to all partners and intended beneficiaries? • Evidence of mechanisms of reporting, redress and remedy if failures identified?	• Meetings with intended beneficiaries • Expenditure tracking • Media reports
29) What are the linkages to other assistance provided by DFID? How holistic is the DFID approach in-country? (ToR 6.2.13)	• Evidence of co-ordination with other DFID projects' design and implementation? • Evidence that this co-ordination is effective? • Evidence that options were considered? • Evidence of clear rationale for choice of approach given those of other funders?	• DFID Country Strategy documents • Key informant meetings • Annual project reviews and project completion reports
30) Has there been sustainable policy change on the part of the Zimbabwe government? (ToR 6.3.7)	• Evidence of planning and budgeting for long-term management of investments funded by this programme? • Evidence of increasing transfer of oversight to Zimbabwe planned and underway?	• Government of Zimbabwe health sector strategy • Key informant meetings

Evaluation Questions	Criteria for Assessment	Sources of Evidence
31) What is the cost of delivery (at each stage of the delivery process, examining the delivery chain)? (ToR 6.2.10)	• What is spending against allocation? • Is allocation linked to proposed outputs? • Can spending be attributed to actual outputs? • Are unit costs benchmarked?	• DFID financial statistics • Partner financial summaries

5.3 The evaluation will principally be conducted over a two-week period in Zimbabwe during September 2011, supported by preparatory review work.

It will consist of the following phases.

5.4 Phase 1: Preliminary Assessment

a) Compile a comprehensive summary of UK bilateral, civil society challenge fund, health and humanitarian assistance to Zimbabwe during 2004-11 (from British Aid Statistics).
b) Prepare an initial contextual analysis through a short literature review, project document review and UK-based key informant interviews, including previous DFID advisers.
c) Prepare initial assessments of quality and comprehensiveness of financial data provided by DFID Zimbabwe and prepare detailed plan for value for money work-stream.

5.5 Phase 2: Field Work

a) Conduct semi-structured interviews with development partners, intended beneficiaries, health sector cadres, civil society representatives, DFID staff and the Government of Zimbabwe.
b) Undertake detailed financial analysis of two or three major DFID projects (as planned in Phase 1), taking initial UK-based work further and tracking flows of money, comparing budgeted allocations to actual spending, allocating inputs to outcome categories and checking incidence of changes to planned spending and rules to be followed in order to achieve this. Compare outcome categories to impacts to assess value for money.
c) Undertake a beneficiary assessment through field visits, an estimation of end-user fees and other costs and a review of additional locally-available analyses and other community perspectives.

5.6 Phase 3: Final Analysis

a) Presentation of initial findings to Commissioners.
b) Follow-up interviews, fact checking and additional data searching.
c) Drafting of report on the basis of feedback.
d) Revisions and preparation for publication.

6. Roles and Responsibilities

6.1 The review will use a six-person core team:

Team leader, health economics
She is an Associate of Agulhas Applied Knowledge. She is an economist specialising in health, education and labour market economics. She has over 20 years' experience in all aspects of international development from strategy development to evaluation. She will lead the team. She will also lead on the economics and sector budget aspects.

Health systems expert
She has extensive experience in Africa, Asia and Latin America and in HIV/AIDS. She specialises in capacity building and organisational development. She will lead on questions of health impact, the technical dimensions of sustainability and beneficiary participation.

Audit lead (week one)
He is a Director in KPMG's public sector audit practice. He has over 20 years' VFM and financial management experience in the UK public sector. He has led on developing approaches to VFM and has undertaken many VFM studies across government. He has over 15 years' experience of public sector healthcare in the UK, covering acute, primary and community services. He will lead on the financial management aspects of the review, including risk management and demonstrating cost control.

Audit lead (week two) and data evaluation
She is a Chartered Accountant with a Masters in Development Studies and has over 5 years' experience with KPMG working across public sector audit. She has also worked at the European Commission's Humanitarian Aid Office and at the Institute of Development Studies. Within KPMG, she has worked for two years as part of the internal audit team at King's College Hospital NHS Foundation Trust and has experience of auditing charitable funds at a range of healthcare organisations. She will lead on the audit aspects in week two and contribute to the data synthesis and evaluation tasks.

Data evaluation support
She is a Zimbabwe-based evaluator of development assistance projects, with work experience in over 15 sub-Saharan African countries. Her particular specialism is in HIV/AIDS and gender issues. She will assist the team on the local data synthesis and evaluation aspects.

Audit support
He is an accountant and internal auditor who has been with KPMG Zimbabwe for over six years. He has gained significant experience in performing VFM Audits, including examining the effectiveness of the malaria prevention programme at the Ministry of Health. Before joining KPMG, he was in the office of the Auditor & Comptroller General in Zimbabwe. He will support the work of the audit leads and other members of the team as appropriate.

Expert Peer Review

Subject-matter experts will be used to undertake a peer review of analysis and findings.

7. Management and Reporting

7.1 A first draft report will be produced for review by the Secretariat and Commissioners by 11 October 2011, followed by revision and review prior to completion and sign off in mid-November 2011.

8. DFID/other partner liaison

8.1 We will undertake interviews in Zimbabwe and London (and elsewhere by telephone where necessary) with DFID's key delivery partners and contractors:

Multilaterals	Bilaterals	International NGOs	Government of Zimbabwe & local NGOs	Contractors
UNICEF	USAID	Oxfam	National Aids Council	Crown Agents
WHO	SIDA	Elisabeth Glaser AIDS Foundation	Ministry of Health & Child Welfare	Liverpool School of Hygiene & Tropical Medicine (LATH)
UNAIDS	Irish Aid	Save the Children	University of Harare	
UNDP	Norway	PSI	Other local NGOs to be identified	

8.2 We will also seek interviews with previous DFID Zimbabwe advisers.

9. Expected outputs and timeframe

- Detailed description of country programme, country context and evaluation synthesis – by 9 September
- UK-based interviews – first round by 9 September
- Zimbabwe-based interviews and field visits – 12 - 23 September
- Supplementary/follow-up interviews – 26 - 30 September
- Presentation of initial findings to Commissioners – 4 October
- First draft of report - 11 October
- Final report - Mid-November

10. Risk and mitigation

10.1 The main risks to completing a satisfactory review are:

Risk	Level of risk	Specific Issues	Mitigation
Inability to access key information	Medium/high	Unable to have full access to partner systems NGOS & UN partners do not have the same reporting requirements	Identify selected programmes for detailed study and concerted effort (in collaboration with partners, if possible)
Limited institutional memory	High	Previous emergency-type assistance used different systems and personnel, now gone as delivery moves into different mode	Make special effort to trace individuals who were in-country during the period under review
Intended beneficiary voices partial or anecdotal	Medium	Inability to reach excluded groups NGO "capture" of aid attention Tendency to hear only medical staff views	Ensure field visits cover different regions and groups Triangulate with field observation and alternative objective data wherever possible

11. How will this ICAI Review make a difference?

11.1 DFID in Zimbabwe is an example of how the UK has remained engaged in a fragile state during an extended complex emergency, with challenging diplomatic relations. It offers lessons on how a sector-specific approach (in this case, the health sector) could deliver both immediate welfare benefits to the population as well as longer-term, institutional development gains – while containing the moral hazard of substituting for the state functions. If we find this has been a successful strategy, DFID should be well-placed to strengthen its influential role amongst donors as the country moves through a fragile transition onto a sustained development path and to learn wider lessons on how to manage the risks to value for money in similar situations.

11.2 Since DFID spending in fragile states, the health sector and with and through partners is expected to rise, the findings of this review will be an important contribution to achieving value of UK aid in the future.