SOUTHERN AFRICAN REGIONAL NETWORK (SARN) – RBM ZAMBIA MISSION

14th to 18th March 2011

SARN Secretariat
Gaborone, Botswana
1) **Background of the Mission**

The SARN Steering Committee Members held a teleconference meeting on 17th November 2010 and agreed that assessment missions should be carried out to countries experiencing Global Fund (GF), Principal Recipient (PR) and procurement Supply-chain Management (PSM). Zambia is one such country that is experiencing some of these bottlenecks and as such a Mission team was sent to assess the situation on the ground.

A team composed of these members of SARN Steering Committee was sent on this mission to Zambia: Dr Mutambu (Delegation leader – Acting Director National Institute of Health Research, Zimbabwe), Brigadier General (Dr) L S Msangi (Military Health Services, Tanzania), Colonel (Dr) P Njobvu (Military Health Services, Zambia), Dr B Maket (Director Regional Programmes Macepa, Zambia) and Mr S. Kunene (Programme Manager – NMCP, Swaziland). Some of the major issues that the mission team looked at were:

i. The bottlenecks associated with the Global Fund, Local Funding Agent (LFA), Principal Recipient (PR) and Procurement, Supply-chain Management (PSM), Sub Recipients (SRs) and Sub-Sub recipients (SSRs)

ii. Weak HSS - M&E systems for planning and tracking progress

iii. Identify support required from SARN Secretariat and RBM Secretariat

2) **Objectives of the Mission**

i. Identify NMCP strengths and good practices

ii. Assess the current state of Global Fund Grants including bottlenecks and challenges affecting grant signing

iii. Identify PSM bottlenecks affecting programme/logistics delivery

iv. Identify challenges and bottlenecks affecting financial flows from Global Fund and any other funders including reporting

v. Develop jointly with Government and partners agreed corrective measures and plan of action

vi. Identify the type of technical support required to deal with the situation and resources for executing such TA beginning with resources available within the country partnership

vii. Provide recommendations on the way forward and next steps, update all relevant sections of the 2011 road map and agree an *aide memoire* outlining roles and responsibilities of all stakeholders and SARN
3) Methodology

The SARN mission acknowledges that Zambia is currently faced with many challenges that have contributed to malaria indicators not performing as well as they should have in 2010 (2010 MIS, MPR 2010). The country has numerous partners who support the NMCP in the various malaria interventions who if well coordinated can a huge impact in resolving these challenges. In order to identify and understand the nature and cause of these challenges, the Mission team used a participatory and inclusive approach. It also wanted to know what steps could be taken to resolve the identified challenges and in addition share with NMCP and its partners the good practices in the programme. The following activities were carried out.

ii. Discussion with PS-MoHCW, NMCP, PATH MACEPA, PR I (UNDP including PMU), PRII (CHAZ), GF Grant Manager, PMI/USAID, UNICEF, SFH, Zambia Military Health Services and JSI.
iii. Debriefed the NMCP manager and shared the findings of the mission with the PS and NMCP manager
iv. Developed a mission report and Aide memoire
v. Follow-up support activities and follow-up support mission

4) Findings

4.1) Programme strengths, good practices and opportunities

a. Structure of NMC

i. The NMCP has a clear organogramme and is housed at the National Malaria Control Centre, which is located quite a distance away from the MOH. It is highly prioritized within the MOH and headed by the Deputy Director of Public Health and Research (DDPHR) who reports to the Director of Public Health and Research. The DDPHR is assisted by the following officers:

- Case Management Officer
- Chief Parasitologist
- Chief Entomologist
- Malaria epidemiologist

These officers are assisted by programme assistants who include:

- Principal Operational Research Officer
- Principal IEC Officer
- Principal IRS Officer
- EPR Officers
- M&E Officers

ii. The above officers are assisted by programme assistants. The current structure was developed after the restructuring exercise in the Ministry of Health and all positions except that of the Case Management Officer have been filled.

Cooperation partners for the NMCC have provided/seconded staff to the NMCP to give technical support to the various technical sections within the NMCP. These include ZISP, MACEPA, CHAZ, PMI, UNICEF, DFID and WHO. A wide range of support with regards to planning and implementation has been achieved by various private, public, faith based organizations and interest groups. DFID is the biggest NMCP funder and John Snow International (JSI) does logistics management for NMCP.

iii. The NMCP has functional technical committees that advise in various thematic areas. These committees are Case Management, ITN, M&E, IRS, EPR and are composed of various partners from the private sector (eg sugar cane industry, mobile phone companies), academia/research (UNZA), civil society (traditional leaders, neighborhood health community system which is centred around districts and helps with programme activities) and church based organizations.

iv. The decentralized structure of the NMCP which is made up of Technical Working Groups includes a broad range of partners. All policy and technical decisions/communications are relayed to Provincial Health Offices (PHOs) to designated Malaria Control technical personnel who then relay the necessary information to the district health offices for implementation. At the district, District Health Offices (DHOs) level work with Neighborhood Health Committees and Community Health Workers to deliver the services into the community.

v. The NMCP has a strong M&E component as shown below:

- Existence of M&E technical working group
- M&E framework which has now been revised
- The M&E technical working group has developed a number of tools that could be of assistance to some programs within the region
- Systematic collection of data through surveys and other approaches to inform strategic direction. Copies of the following documents are available:
  - 2010 MPR
  - 2010 MIS (Zambia is the only SADC country that has done 3 MISs, 2006, 2008, 2010)
  - PFM plan
  - Draft NMCP Strategic Plan 2011 – 2015
  - A Health Facility Survey is currently underway

- Data base on ITNs and IRS consumption has been developed
vi. Mobilization of a large partner base that has been able to assist the program in achieving the gains made to date. Such partners include donor agencies, bilateral and multilateral partners, cooperating partners, private sector, Faith Based Organizations, Non-Governmental Organizations and others.

vii. Identification of gaps in the programme with subsequent effective mobilization of funding from partners other than Global Fund.

viii. Government funding for malaria has steadily increased over the years despite a challenging economic situation faced by most countries including Zambia.

ix. Current process of developing a National Malaria Strategic Plan (2011-2015) as informed by the recent MIS and MPR.

x. Participation in Trans=Zambezi Malaria Initiative and Trans Caprivi-Kazungula Cross-Border Initiatives

b. Global Fund Grants

NMCP has received the following grants:

- GF Round 1 – now closed
- GF Round 4 – has received a no cost extension
- GF Round 7 – on hold and Phase II not yet signed and hence no funds have yet been released

Interest has also been expressed by the CCM in submitting a National Strategic Application (NSA). During the discussion it came to light that the NMCP staff (including the Programme Manager) was not sure of the latest performance rating for Zambia which is currently a B2 rating.

The delay in the signing of Global Fund Round 7 Grant has resulted in commodities not being purchased hence led to a reduction in coverage rates with an increase in malaria incidence rates in some parts of the country, especially the Northern part of the country i.e. Luapula, Northern and Eastern Provinces. A shortfall in commodity needs has been met in some cases by some of the cooperating partners such as PMI and World Bank. It was noted that if all commitments are met this year by all partners the country will have all the required ITNs.

In 2009 United Nations Development Program (UNDP) took over from MOH as the Principal Recipient (PR) from the Ministry of Health (MOH) and this will last for two years time. During the transition phase of this take over:

i. Access of funds from the Global Fund has been withdrawn and it has been extremely difficult to implement activities.

ii. UNDP will build the finance capacity of the NMCP

iii. Only life saving commodities will be supplied using Voluntary Pooled Procurement (VPP) facility.

Currently GF Round 7 is on hold, Phase II has not yet been signed even though NMCP has provided all the requirements needed by the Global Fund. The reasons for not signing the grant are not very clear and the grant has been reprogrammed more than once. Things have not been very definite since the
change of PR from MOH to UNDP and it has become very unclear dealing with GF in comparison to other partners. There has not been a forum in the last two years to address issues that affect grant implementation.

Price Water House is the Local Funding Agency (LFA) for Global Fund in the country.

c. Strategic Planning

The NMCP:

i. Has the mandate to coordinate malaria control activities
ii. Co-ordinates partners in the malaria control programme
iii. Is also involved in resource mobilization
iv. Has the authority to make decisions

The NMCP has just completed a Malaria Programme Review (2010) and Malaria Indicator Survey (2010) which show that indicators for 2010 have not done as well as they should have due to the change of PR. It is currently undertaking a Health Facility Survey.

Although funding from government has been increasing over time, it is not enough and NMCP is still heavily donor dependent. MACEPA, WHO, UNICEF, World Bank, SHF, DFID and other partners have assisted with funding to move the malaria programme forward. DFID and PMI have procured RDTs and ACTs. The programme has just received nets from World Bank and GF and these have been distributed to Luapula Province. Society for Family Health and World Vision assist with storage of and distribution of ITNs. The programme is using the door to door distribution and involves community volunteers who make sure that the nets are hanged.

ITNs – there will not be a gap this season

IRS – more than 80% coverage for this season

Currently, there are strategies to strengthen surveillance and scale up IEC, IRS and Case Management. However with all this in mind, there is need to give more emphasis on the treatment of malaria, in particular community aspect of home management of malaria. There is also need to ensure that the strategic plan includes an implementation plan that is mindful of NMCP staff who are supported by funders.

The National Strategic Plan currently being developed will:

i. Focus on activities that will strive to address issues of malaria control and prevention in the three transmission zones that have been identified by the NMCP following the MIS 2010 results.
ii. Strive to maintain gains made from the previous Strategic Plan.
iii. Focus on diagnostics to ensure that only positive diagnosed malaria cases will be treated
iv. Strengthen surveillance as another key activity
Resource mobilization has also been identified as another activity that will take precedence due to the challenges with regards resource flow from Global Fund experienced towards the end of the previous strategic plan.

4.2. Programme weaknesses/challenges

i. Funding from Global Fund for both Round 4 and 7 has not been available for the past two years and this has resulted in an increase in malaria incidence rates in some parts of the country especially in the Northern, Eastern and Luapula Provinces.

ii. Malaria commodities are only being purchased under the Voluntary Pooled Procurement (VPP) arrangement.

iii. Suspension of the Global Fund funds has also led to Staff morale being very low and job uncertainties.

iv. Change of PR from Ministry of Health (MOH) to UNDP has necessitated a transitional period of two years for capacity building within the PR and MOH personnel. The transition is taking long and consequently leading to delays in procurement and distribution of commodities. In addition Round 7 Phase II has not been signed yet and several millions of dollars have been lost in Round 4 and 7 Phase I. Funds were also lost due to the grant consolidation processes for the same grants. More funding is expected to be lost if the delay in signing the grant is further prolonged.

v. No specific structure for a malaria forum and thus lack of regular meetings between NMCP and big stakeholders to resolve bottlenecks such as commodity quantification (RDTs and ACTs where response is to demand of the product and is based on episodes and not on confirmed malaria), timing of commodity distribution and inadequate budget for distribution of commodities all the way to the end user (e.g., nets). Thus there is a lack of clear communication on malaria activities amongst members of NMCP and also partners.

vi. NMCP not well capacitated to do PSM.

vii. Clinicians not adhering to protocols by breaking down presentations of ACTs and thus messing up the supply chain system

viii. UNDP (PR I) and CHAZ (PR II) are not sure when GF Round 7 Phase II will be signed which has led to NMCP staff and partners not being confident on the status of Global Fund grants, i.e., confidence crisis.

ix. PR II – data consumption and reports hard to come by from districts in which they are working to complement government efforts.
x. The NMCP is still heavily donor dependent

xi. CCM does not allow international non-governmental organizations to access global funds as is in the case of SFH (PSI)

xii. A large crop of nets from GF under SFH storage and awaiting instruction from GF on moving them to districts. Some districts are currently inaccessible now due to heavy rains.

xiii. PR II (CHAZ) pointed out that LFA was not handing over reports on time to GF Secretariat to facilitate release of funds. LFA was also noted on some occasions to alter documents without consulting the PR eg cutting of budgets, which lead to frustrations and misunderstanding.

xiv. GF has also introduced new procedures that have led to a lot of frustrations in accessing funds as people spend more time responding to queries than doing the actual work.

4.3. On the spot solutions (Bottlenecks resolved during the mission)

Team members please add on this section.

i. Encouraged more open discussions between the LFA and PRs to avoid miscommunication to Global Fund on issues that could easily be resolved at country level.

5. Recommendations

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<thead>
<tr>
<th>Thematic Area</th>
<th>Description of the Challenges</th>
<th>Proposed Actions/Recommendations</th>
<th>Driver/responsible person for the output</th>
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<tbody>
<tr>
<td>1. Coordination and communication</td>
<td>1.1. Strong partnerships have been established with major stakeholders that include communities, WHO, MACEPA, UNICEF, GFATM, UNDP, PMI, CHAZ, SFH, World Bank, and others. However, there is no mechanism in place that allows all these partners to meet regularly to resolve malaria related issues that may arise during programme planning and implementation. Consequently there are also huge challenges in communication between the NMCP and these partners.</td>
<td>1.1.1. NMCP to come up with a mechanism to allow for regular and not ad hoc meetings with partners 1.1.2. NMCP needs to take the responsibility to coordinate partners meetings to resolve bottlenecks related to malaria activities</td>
<td>NMCP</td>
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<td>1.2. Communication challenges also exist between UNDP (PR I) and CHAZ (PR II) and LAF this has resulted in frustrations when eg budgets are amended without the knowledge of the PRs and submitted to GF</td>
<td>1.2.1. The two PRs and LAF should hold monthly review meetings with partners, SRs and SSRs 1.2.2. The two PRs and LAF</td>
<td>UNDP CHAZ LFA</td>
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<table>
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<tr>
<th>Secretariat</th>
<th>should agree on what final draft documents, including budgets should be submitted to GF Secretariat</th>
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<tr>
<td><strong>1.3. Communication challenges</strong> between GF and PRs/SRs (eg NMCP) where GF requirements entail protracted rounds of justification from the SRs. A lot of time gets wasted in this process and this leads immense frustration.</td>
<td><strong>1.3.1.</strong> There should be clear communication (instruction) at the proposal writing stage from GF on how to do things. An example is some indicators in the GF instructions are not applicable to certain malaria situations and the SRs and SSRs should come up with what is applicable to their situations</td>
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<td><strong>2. Capacity building for malaria control</strong></td>
<td><strong>2.1.</strong> It was noted that the current structure of the NMCP was developed after the restructuring of MOH and it omitted some positions such as that of a drugs logistics which were in the previous structure. It was pointed out that this would leave a gap in the functionality of the NMCP.</td>
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<td><strong>2.1.1.</strong> The structure that was submitted by the NMCP that included critical cadres such as the drug logistician should be adhered to in order to allow the NMCP to carry out its mandate effectively</td>
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<td><strong>2.2.</strong> Low morale amongst NMCP staff due to irregular payment of salaries and job uncertainties</td>
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<td><strong>2.2.1.</strong> Staff should be paid by government of Zambia at competitive salaries in order to retain and motivate staff.</td>
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<td><strong>3.0 Surveillance, Monitoring and Evaluation (SME)</strong></td>
<td><strong>3.1.</strong> The just completed 2010 MIS and MPR show that malaria indicators for 2010 have not done as well as they should have done due to lack of flow of funds from GF. Some areas of the country are now entering the pre-elimination phase and there are still challenges in data quality and timeliness of reporting and rigorous monitoring of activities</td>
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<td><strong>3.1.1.</strong> The quality and timeliness of data for planning and decision making should be enhanced through alternative methods of data transfer such as SMS</td>
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<td><strong>3.2.</strong> CHAZ indicated having major challenges in getting reports on consumption data and other reports from the 22 GF districts that they support on time for quarterly submission to GF. The district’s reporting system is behind by 6</td>
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<td></td>
<td><strong>3.2.1.</strong> Same as above</td>
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<td>4.0 NMCP Structure and Infrastructure</td>
<td>4.1. The MNCP is strategically placed within the MOH organizational structure and housed out of the MOH. It is headed by a Deputy Director of Public Health and Research who can make decisions on most aspects of the programme activities. However, during the mission, the team noticed that the post of Case Management Specialist had not been filled although there was an acting cadre.</td>
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<td>5.0 Procurement Supply Chain Management (PSM)</td>
<td>5.1. NMCP heavily donor dependent and does not have the capacity to do MSP.</td>
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<td>5.2. UNDP and LFA are still building their capacities to allow for full functionality. This process has already taken a year for UNDP.</td>
<td>5.2.1. UNDP and LFA to complete their capacity building so that they can also capacitate the NMCP within a short time as possible.</td>
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<td>5.3. It was indicated that the PMU is now in place and will be housed within WHO premises.</td>
<td>5.3.1. UNDP should reconsider locating the PMU within the NMCC (space allowing) so that the process of NMCP capacity building is quickened due to proximity</td>
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<td>5.4. There has been no flow of funds from GR rounds 4 and 7 for the past two years and round 7 not yet signed and this has resulted in no</td>
<td>5.4.1. Legal departments of UNDP GF to agree on the GF grants as soon as possible so that funds for procurement of</td>
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<td><strong>6. MPR</strong></td>
<td><strong>6.1.</strong> The Zambian NMCP is the only programme that has conducted 3 MPRs in the SADC region. It successfully conducted an MPR in 2010 and a full report is now available. The 2010 MPR report is one of the key documents that have been used to update the National Malaria Control Programme Strategic Plan 2011 – 2015. The MPR showed that the progress in malaria control is mostly seen at the national level.</td>
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<td><strong>7. IEC/Advocacy/BBCC</strong></td>
<td><strong>7.1.</strong> The Mission Team observed a number of best practices, some which have been documented and can be shared with other programmes in SADC</td>
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<td><strong>8. Malaria Strategic Plan (MSP)</strong></td>
<td><strong>8.1.</strong> National Malaria Control Programme Strategic Plan 2011 – 2015 has been produced and is now in draft form</td>
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<td><strong>9. Preparation for R7 Phase II grant signing</strong></td>
<td><strong>9.1.</strong> Although all the GF paper work has been completed and most queries addressed, there has not been any disbursement in the past two years for procurement and implementation of activities. Grant performance is rated B2</td>
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<td><strong>10. Preparation for the TZMI meeting and Re-battle for MOZIZA R9</strong></td>
<td><strong>10.1.</strong> The next TZMI meeting has been planned for April and will be held in Livingstone, Zambia. MACEPA has plans to fund this meeting</td>
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<td><strong>11. GF, PMU and LFA capacity building</strong></td>
<td><strong>11.1.</strong> Capacity building plan has been developed and UNDP has recruited staff with requisite expertise but has not yet recruited a Capacity Development Specialist. <strong>11.2.</strong> The current relationship of UNDP and LFA is problematic in that it is strong on financial issues and weak in</td>
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**UNDP**

**LFA**
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<tr>
<th>Programmatic Issues</th>
<th>Critical for the Smooth Running of GF Grants</th>
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<tr>
<td>12. CCM – Role and Function and Conflict of Interest</td>
<td>Role and Function of CCM to be Clarified to Partners</td>
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<td>12.1. Partners were not sure who appointed UNDP as PR. However, UNDP pointed out that CCM had recommended that it be PR.</td>
<td>CCM Chairperson</td>
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<td>12.2. One of the partners SFH indicated that CCM did not allow an NGO to be a PR.</td>
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### 6. Commitment by RBM Partners

#### 6.1. SARN

- a. Support Implementation of MPR and MSP/operational plan development
- b. Provision of TA for PSM
- c. Communicate with MACEPA for M&E TA
- d. Resources mobilization to fill gaps
- e. Signing of Aide memoire and arrange for a follow up mission

#### 6.2. PATH - MACEPA

- a. Assist with the MIS and community based activities. Zambia has had 3 MISs and the information becomes less and less relevant because it is provincial based.
- b. Support with TA to develop data collection tools, M&E plan and capacity building in IEC activities
- c. Assist with collection of evidence based information for decision making and quality assurance.

#### 6.3. PMI

- a. Support with IRS, ITNs, Case Management, Supply Chain Management and IEC/BCC activities
- b. Purchase of a lot of malaria commodities

#### 6.4. UNICEF Role in NMCP?

- a. Support both ITN s and ACTs by being part and parcel of the technical working groups but does not procure any of these two malaria control and prevention commodities.
- b. Support financially in development of both ITN distribution guidelines and Case Management guidelines.
- c. Provided funding and logistical support towards trainings associated with regards to these two guidelines i.e. ITN and Case Management.
Technical and financial support has been provided towards the various Malaria Indicator Surveys and other studies carried out in the country.

6.5. SFH (PSI)

a. Receive nets and store them for NMCP
b. Fund the distribution of nets
c. Part of the IEC and ITN technical working groups

6.6. WHO

a. Provides overall advisory role on malaria
b. Provides TA on various malaria interventions

6.6. UNDP

a. Currently Global fund PRI
b. Work closely with the NMCC with regards to GF procedures
c. Liaise with NMCP with regards malaria commodity needs, procurements/distribution and other activities

6.7. Zambia Military Health Services and Defence Forces

a. Support implementation of malaria IRS in Lusaka only
b. Observe and participate in World Malaria Day activities
c. Distribution of malaria commodities to hard to reach areas

6.8. CHAZ

a. Currently Global Fund PR II
b. Member of the malaria technical working groups
c. Provide trainings to community health workers on case management of uncomplicated malaria, malaria prevention and diagnostics
d. Develop M&E activities that feed into its secretariat at central level in all the 22 GF supported districts
e. Procure malaria commodities (SP and ITNs)
f. Train Laboratory technicians and clinicians in malaria case management

6.9. John Snow International (JSI)

a. Provide TA in forecasting of quantities of commodities
b. Provide commodities all the way to the community level

c. Enhanced Supply Chain System

7. Acknowledgement

SARN Secretariat is grateful to the Zambian Ministry of Health Permanent Secretary (PS) for making this mission possible, NMCP for arranging meetings with various partners, MACEPA for providing transport to the Mission Team and all partners who participated in the mission.