



SARN - ROLL BACK MALARIA ZIMBABWE MISSION

7th to 11th March 2011

**SARN Secretariat
Gaborone, Botswana**



1.0 Background of the Mission:

The SARN Steering Committee Members on 17th November 2010 agreed to carry out a joint-partner mission to Zimbabwe to consult with the National Malaria Control Program (NMCP) and in-country RBM partners, review progress in program and road map implementation, identify bottlenecks/challenges affecting program and Global Fund implementation and performance and develop a strategy to support the program to maximize implementation performance. The mission was carried out from 7 to 11 March 2011 by Dr Boniface Maket (MACEPA and SARN Steering Committee), Col (Dr) Panganani Njobvu (Zambia Military Malaria Manager and SARN Steering Committee) and the SARN Focal Point. In-country Members of the SARN Steering Committee included Mrs Martha Mpisaunga (SARN co-chair and Reagent Laboratories), Dr Susan Mutambu (NIHR) and Mr Farai Chieza (PSI). The SADC Regional Military Malaria Coordinator (Major Alexio Tafirenyka) and Flight Lieutenant Caroline Muringazuva (Zimbabwe Military Malaria Manager) also participated. Some key issues that the mission was requested to look at include:

1. 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)
2. Weak HSS - M&E systems for planning and tracking progress
3. Identify support required from SARN Secretariat and RBM Secretariat



Group Photo of the Zimbabwe SARN-RBM In-country Partnership Consultative Meeting held at UNDP (PR) Offices, Harare, Zimbabwe, 7-11 March 2011

2.0 Objectives of the mission

- a. Identify program strengths and good practice
- b. Identify current state of R8 and 10 including bottlenecks and challenges affecting R 10 grant signing preparation
- c. Identify PSM bottlenecks causing delayed/late delivery of logistics/commodities by the PR, LFA, SRs and SSRs
- d. Identify challenges and bottlenecks with financial flows from the GF and any other significant funders including reporting
- e. Develop jointly with NMCP and partners agreed corrective measures and plan of action
- f. Identify the type of technical support required to deal with the situation and resources for executing such as TA beginning with resources available within the country partnership



- g. Provide recommendations on the way forward and next steps , update all relevant sections of the 2011 roadmap and agree an aidememoire outlining roles and responsibilities of all stakeholders and SARN
- h. Discuss road map, SARN work plan, MPR and MSP implementation and bottlenecks
- i. Discuss progress towards malaria elimination, E8 and cross-border collaboration

3.0 Approach

The SARN mission acknowledges that many solutions to challenges facing the malaria control program in Zimbabwe lie within the national program and the wider partnership in the country. In view of this, a participatory and inclusive approach was used to understand good practices and identify challenges and solutions. The following activities were carried out.

- a. Reviewed program documents (MIS, MPR, draft Malaria Strategic Plan, previous mission reports, Global Fund Grant documents and those from partners);
- b. Discussed with PS-MoHCW, NMCP, LFA, PR (UNDP including PMU), GF, Plan International, WHO-WCO and IST, PSI, WHO-WCO and IST, National Pharmaceutical Company of Zimbabwe (NATPHAM), Zimbabwe Military Health Services (MHS), CHAI (Clinton Foundation), National Laboratories and National Institute of Health Research (NIHR);
- c. Debriefed the PS and partners.
- d. Developed a mission report and Aide memoire
- e. Follow-up support activities and follow-up support mission

4.0 Findings

4.1 Program strengths, good practice and opportunities

1. NMCP has a compliment of 10 core staff covering all program areas
2. NMCP has continued to perform well and has registered significant successes in areas of IRS, case management and diagnosis, IEC and LLINS, providing areas of best practice to be shared with other countries
3. Program has functional malaria technical sub-committees such as, (a) case management and diagnostics, (b) Vector control, IEC/BCC, M/E – these are made up of a host of multi-sectoral partners who meet quarterly and when required to review progress



4. At the end of 2010, NMCP met most of the required 2010 targets for universal coverage
5. Functional health system in place – from peripheral/rural health facilities through the district and provincial health centres.
6. Deployed malaria provincial focal points in all the malaria provinces
7. Available partners who are providing support for IRS, LLINs, IEC and BCC and these can be further garnered/strengthened to improve and enhance program capacity: Radio, TV and print media malaria messages are on-going
8. Global Fund R8 performance currently rated A2
9. Awarded Global Fund R10 which will provide more funding to fill gaps and the drive for strengthening cross-border collaboration
10. Has functional malaria sentinel sites which provide on-going data
11. The National Institute of Health Research continues to provide research opportunities and Quality Control of both microscopy and RDTs
12. Participating in the MOZIZA and TZMI cross-border initiatives
13. Four SARN Steering Committee members and the SADC Regional Military Malaria Coordinator are in Zimbabwe – they provide readily available expertise and experience to the NMCP
14. Dedicated resources for capacity building from the government (government provided USD 1 million in 2011) is providing opportunities to strengthen program implementation capacity at the central, district and peripheral health facility levels.
15. The PMU is now fully established and this should enhance the NMCP's capacity to deliver however there is need for them to be in the same building for closer collaboration



16. Preparations for MPR are going well, they are currently in the desk review stage and partners are involved and also providing additional technical and logistical support

4.2 Program Weaknesses/Challenges

1. **NMCP structure** - the position of the program manager in the Ministry of Health and Child Welfare (MoHCW) is too low as he has to report through several stages before reaching the PS
2. **Infrastructure** - NMCP is housed in the main MoHCW building where there is no adequate space and they are not adequately equipped including erratic communication services (phone, fax and e-mail) – this lack of space has led to the Program Management Unit (PMU) being housed elsewhere.
3. The MoHCW HMIS and HSS is weak (failure to capture core-malaria data), as a result Surveillance, Monitoring and Evaluation (SME) remains the weakest link in the operations of the NMCP and this has impacts on reporting cycles and data management/flow/use: M/E plan for GF requires review and Indicators harmonized with the GF, PR and LFA.
4. Implementation delays due to severe delays in the disbursements and delivery of commodities by the PR has at times severely affected the timeliness of ground operations especially in IRS, ACTs and RDTs since malaria is seasonal.
5. **PSM** – the program continues to experience chronic PSM weakness/bottlenecks especially in areas of quantification, specification, micro-planning and consumption data hence they encounter severe PSM bottlenecks: these PSM bottlenecks are inherent in both the NMCP (inadequate data – much needed to inform decision making and quantification of commodities), and PR (delayed disbursement/supply of logistics), NATPHAM (failure to provide consumption data much needed in quantification of commodities and guide procurement).
6. Weak systems for Coordination/communication with partners, PR, SRs, SSRs and LFA and definition of roles in diagnosis: Public Health laboratory (service delivery), Reference laboratory (QA/QC) and NIHR (Research/QC) not well streamlined

7. CCM is weak – requires strengthening in terms of its political leadership and oversight and conflict of interest
8. Principal Recipient (PR) – the PR (UNDP) has experienced serious PSM challenges such as delayed procurement and disbursement of commodities to the NMCP and these have resulted in the NMCP failure to meet targets for example, commodities for IRS are supplied after the spraying cycle is over and sometimes commodities are supplied with little time left for implementation and the required time for reporting back to the PR. Delayed establishment of the PMU and capacity building at the PMU also compounded the bottlenecks.
9. The Global Fund – the PR indicated that the GF also delays their disbursement to them and hence the delays in procurement
10. The NMCP uses morbidity data as a proxy for consumption but there seems to exist different understanding of consumption data and specifications between the NMCP, NATPHAM, LFA, PR, and the Global Fund and this is another bottleneck causing delayed procurement.
11. As the team was visiting there were stock outs of ACTs and RDTs resulting from delayed disbursement of funds and procurement of logistics
12. The bottlenecks/weaknesses cited above were agreed (there was consensus) by both the NMCP, PR (UNDP), LFA and partners (WHO, PSI, Plan International and NATPHAM) as the main areas requiring resolution and support from the MoHCW, partners, and SARN Secretariat

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

The team managed to correct the following bottlenecks through discussions with the PS, NMCP, partners, PR, LFA, SRs and SSRs:

1. There now exists an atmosphere (PR, LFA, NMCP, PS, NATPHAM and partners) of willingness to resolve the situation and strengthen communication

2. Both the PR and LFA agreed to organize monthly meetings with partners, SRs, SSRs and NMCP to review the situation and provide updates of the state of implementation
3. Strengthening of In-country-RBM partnership: partners, PR, LFA, NATPHAM SRs, SSRs all agreed to attend the SARN monthly Teleconferences
4. The NIHR, National reference Laboratory and Public Health Laboratory agreed to uphold their roles to avoid duplication of efforts.

5.0 RECOMMENDATIONS

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
1. Coordination and communication	<p>1.1. There exists a host of partners in Zimbabwe however challenges in communication between the NMCP, PR, and LFA, SRs, SSRs which undermines the potential of fully optimizing the capacity in the country to address PSM, technical and knowledge/research related challenges.</p> <p>1.2 some partners raised the issue of lack of Transparency in selection of PRs, SRs and SSRs</p>	<p>1.1.1 NMCP to strengthen communication with PR, LFA, SRs, SSRs and partners through meetings/TCs</p> <p>1.2.1. PR and LFA to hold monthly peer review and update meetings with partners, SSR, SRs</p> <p>1.3.2 In-country RBM partners to participate in the monthly SARN organized TCs</p> <p>1.4.1 Ensure that all partners understand the process on selection of PR, SR & SSR for GFATM</p>	<p>NMCP</p> <p>PR and LFA</p> <p>SARN Secretariat</p> <p>NMCP</p>
2. Capacity building for malaria control	2.1 Although the NMCP has a compliment of 10 people some of them do not possess the skill levels to meet targets under the Strategic Plan and for Global Fund (GF) grants.	2.1.1 Capacity building of NMCP staff through skill-based training and recruitment of qualified personnel	NMCP ,and MoCHW Partners
3.0 Surveillance, Monitoring and Evaluation (SME)	3.1 SME remains a critical challenge. Although data from the district is consolidated by the HMIS at district and national level, HMIS does not capture core malaria data and also chronic delays in the data	<p>3.1.1 Development of clear malaria data flow from health facility to district and NMCP with the role of provincial malaria coordinators clearly spelled out.</p> <p>3.1.2. Development of a</p>	<p>NMCP</p> <p>WHO/NMCP/Partners</p>

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
	<p>reaching the NMCP. The HMIS form is limited and in addition there are challenges related to tracking of ACTs and validating consumption vs case load.</p> <p>3.3. M/E plan – Indicators not aligned with those of the PR and LFA. This is presenting reporting challenges and measurement of impact (Our M&E plan was developed with participation of all stakeholders, and was approved by the GF. As such it becomes part and parcel of the grant agreement package, which the LFA and all implementers including the PR should by into). It would be improper if UNDP who came later after the proposal was approved would develop their own M&E plan and indicators for malaria- lets remember the MOHCW custodian of all health programmes.</p>	<p>malaria data collection tool to capture what is not on the HMIS as an interim measure while the HMIS is being improved.</p> <p>3.1.3. Strengthening of the existing mobile phone system for malaria data capture and re[po]rting</p> <p>3.2.1 Recruitment of a qualified M/E focal point</p> <p>3.3.1. NMCP, PR, LFA and GF to agree on harmonized Indicators and review the M/E plan</p>	<p>MoHCW</p> <p>In the interim MACEPA is willing to engage Sr TA to support specific activities on M&E for program NMCP, PR, LFA and GF SARN Secretariat to follow up on progress and when required provide TA to review the M/E plan with the support of MACEPA and WHO</p>
4.0 NMCP Structure and Infrastructure	<p>4.1 Current position of the program manager on the MoHCW leaves him with no decision making power as he has to report through several stages before accessing the PS: as the program prepares for malaria elimination, this limitation will present severe challenges</p> <p>4.2. The NMCP is housed in the MoHCW building where they have no space and experience</p>	<p>4.1 Since other program in the SADC region are run by directors, there is need for the MoHCW to elevate the manager thereby giving him power to make decisions and access the PS without going through several stages</p> <p>4.2.1. MoHCW to provide NMCP with new offices outside the main building</p>	<p>PS</p> <p>PS and PR</p>

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
	chronic, shortage of equipment, poor e-mail and fax services. Due to lack of space, they cannot bring in the PMU	4.2.2. Future GF proposal development to include funds for infrastructure development/renovation	NMCP and GF, PR
5.0 Procurement Supply Chain Management (PSM)	<p>5.1 The PR has experienced PSM challenges which have resulted in delayed and untimely procurement and supply of commodities</p> <p>5.2 PR cited delays by the GF in disbursement of Funds</p> <p>5.3. NATPHAM which is responsible for delivery of ACTs and RDTs to health facilities, is failing to provide adequate consumption data and their transport is currently in a bad shape and some vehicles are not ideal for rough terrain</p>	<p>5.1.1 The PR needs to strengthen its PSM and since the PMU is now fully established and capacity strengthened – the situation is likely to improve.</p> <p>5.2.1. GF to speed up disbursements to the PR</p> <p>5.3.1 NATPHAM should improve its logistic delivery systems (provide new ideal vehicles, storage facilities, consumption data capture, including timely reporting)</p> <p>5.3.2 The Ministry should employ personnel qualified in logistics/PSM or carry out in-service training</p> <p>5.3.3. Engage TA to train in PSM</p>	<p>PR</p> <p>Fund Portfolio Manager and SARN to present problem to HWG and RBM Secretariat</p> <p>NATPHAM and PR</p> <p>PS, PR and NATPHAM</p> <p>SARN</p>
6 MPR	6.1 NMCP is carrying out an MPR and requires additional support of USD 20,000 and TS for external review and have requested for managers from Mozambique and Zambia during the MPR to discuss cross-border issues	6.1.1. SARN Secretariat have received a request for the additional USD 20,000 but the NMCP needs to submit a budget line to justify the request.	NMCP and SARN
7. IEC/Advocacy/BCC	7. The team observed several areas of best practice that require documentation and be shared with other programs in the region.	7.1 SARN to arrange for a TA for documentation of the best practice	SARN Secretariat, NMCP
8. Malaria Strategic Plan (MSP)	8.1 Review, update of MSP and program re-orientation for malaria elimination	8.1.1 MSP to be reviewed soon after completing MPR and program re-orientation to be tailored according to MPR recommendations	NMCP

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
9. Preparation for R10 grant signing	9.1. NMCP was successful in getting GF R10 and they will require support in preparation for grant signing and grant consolidation including improving R8 performance from A2 to A1	9.1.1 GF and PR to improve disbursement of logistics/PSM: NMCP to build capacity in M/E and (can you be more specific here, is it a health system capacity, human resource, etc) NATPHAM to build capacity in PSM and availability of consumption data and SARN to provide TA when required and to seek HWG and RBM Secretariat support	PR, LFA, PMU, GF NMCP NATPHAM SARN
10. Preparation for the TZMI meeting and Re-battle for MOZIZA R9	10.1 TZMI NMCP were requested to finalize their TZMI action plans and mobilize TZMI partners to establish cross-border RBM partnership committees	10.1.1 SARN Secretariat has already received the Zimbabwe TZMI action plan. NMCP to speed up establishment of the cross-border RBM partnership committees	NMCP, SADC Secretariat NMCP and SARN Secretariat
11. GF, PMU and LFA capacity building	11.1 Partners, SRs and SSRs complained that they are sometimes not included in capacity building courses/training 11.2. SARN reminded the PR that the GF expects the PR to act on all TAs requested by the NMCP 11.3 PMU is overwhelmed by the demands from HIV, TB and Malaria and the problem of competing priorities	11.1.1 Both PR and LFA agreed that they will ensure all partners, SRs and SSRs are included 11.2.1 PR to ensure timely response to TA requests by the NMCP as indicated by the GF 11.3.1. PMU has now recruited a malaria focal point and it is hoped that there will be an improvement	PR and LFA PR and NMCP PR and PMU
12. CCM – role and function and conflict of interest	12.1. The current CCM is weak and this is the observation of the NMCP, all partners, PR, LFA and the PS. Organizations in the current CCM are represented by very junior officials who cannot take decisions and very often different people attend on different sittings.	12.1.1 Since the new CCM takes over in the coming 2 months, MoHCW should ensure that representation from all organizations is made up of top officials who are able to provide the political leadership and oversight role that the CCM is supposed to provide. All members should sign conflict of interest forms	CCM Chairperson, MoHCW, organizations CCM Chairperson and

Thematic Area	Description of the Challenges	Proposed Actions/Recommendations	Driver/responsible person for the output
		before being accepted as members and that attendance for sittings should be monitored for consistency. The PS outlined that measures to strengthen the CCM and ensure that the new CCM starts on the right platform are underway	Secretariat PS

6.0 COMMITMENTS 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 Aidememoire and arrange for a follow up mission

6.2 MACEPA

- a. Support with TA to develop malaria data collection tools, M&E plan and capacity building

6.3 Zimbabwe Military Health Services and Defence Forces

- a. Distribution of commodities to hard to reach areas- they would be very useful in this area, but currently the capacity needs to be built in terms of personnel and logistics.
- b. Support implementation of IRS-in some areas
- c. Case management of civilian population within cantonment catchment areas

6.4 Plan International: is an SSR for ACTs

- a. In-service training and orientation on malaria policies and case management
- b. BCC using the church machinery
- c. Procurement of ACTs



- d. Currently providing support in 6 districts and have trained 674 health workers in case management and 1238 Village Health Workers for ACT roll out
- e. The same PR challenges observed by others were also outlined by Plan International

6.5 PSI - a GF R8 SSR who received USD 1.4 million for LLINS and BCC and in R10 2 million LLINs are to be distributed.

- a) In 2009 PSI distributed 570,000 LLINS.
- b) PSI outlined that they face challenges when it comes to getting commodities in time from the PR. In some cases, they agree to use their own funds to supply and then get re-imburement from the PR. The reimbursement process has been very rigorous and has challenges.
- c) PSI is also a member of the malaria technical committees and is current chair of the sub-technical committee for communication and also of the ITN Work Group.
- d) They will support the development and implementation of the MSP and are currently supporting and participating in the MPR.

6.6 WHO continues to play its role as the lead TA provider

6.7 National Institute of Health Research (NIHR) :

- a) Provide support for malaria research
- b) Responsible for all the malaria sentinel sites
- c) Providing services for Quality control of both slides and RDTs
- d) Have developed capacity for PCR
- e) Preparations for the SADC inspection for Supra-regional malaria laboratory are on schedule
- f) Operations hampered by lack of appointment of a full time director
- g) Carrys out training in microscopy and RDTs

6.8 Clinton Access to Health Initiative (CHAI):

They are in the process of establishing their office in Harare and will start providing support the NMCP as program analysts



7.0 Dates for the follow up mission:

These will be agreed on by the NMCP and it is expected to take place within 2 or 3 months of submitting the report

8.0 Acknowledgement

SARN Secretariat is grateful to the Zimbabwe Ministry of Health and Child Welfare Permanent Secretary (PS) for making this mission possible, to the NMCP for the support and transport and all partners who participated in the mission.