



REPORT

Zimbabwe Global Fund Grant Implementation Support Needs Assessment Visit

27th to 31st October 2008



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EXECUTIVE SUMMARY

The Office of the Global AIDS Coordinator (OGAC) of the United States Government (USG) made available, through UNAIDS, a pool of funds to support GF grant implementation in key areas of grant management. These include procurement and supply management, financial management, monitoring and evaluation (M&E) and strengthening private-public partnerships (PPPs). Funds are also available to strengthen Country Coordinating Mechanism (CCM) governance for more effective CCM functioning. This support entails the provision of quality short-term technical assistance (STTA) to build the capacity of principal recipients (PRs) and sub recipients (SRs) at country level. For this process to be evidence based and to derive value for money; country-specific needs assessments are done by the Technical Support Facility responsible for the Southern African (TSF-SA) region, in consultation with the CCMs, Fund Portfolio Managers (FPMs) at the Global Fund (GF) Secretariat, UNAIDS Country Coordinators (UCCs), PRs and other key stakeholders. One such capacity assessment visit was made to Zimbabwe from 27th to 31st October 2008

Approach

Unstructured discussions with the CCM Secretariat, Chairperson of the CCM, local fund agent (LFA) and PRs were held to gain an insight of how the grants were performing, the challenges that were being experienced and the solutions being pursued to address the challenges. Key challenges and findings are detailed below.

Challenge

The most significant challenge that is being faced by the PRs is the delayed and/or limited release of funds (both local and foreign currency) from the Reserve Bank of Zimbabwe (RBZ) which is significantly impeding grant implementation in the country. At the time of the TSF trip, the Office of the Inspector General (OIG) was conducting an audit of the Round 5 grants in Zimbabwe and this issue was high on the agenda.

Findings

Global Fund grant management processes were generally not harmonized and aligned to the PR organizations' systems and processes. Consequently grants were being managed as projects requiring separate structures and systems within the PR organization. This resulted in parallel management systems and it significantly reduced the efficiency of PRs. Another consequence is that there was limited organisation-wide learning regarding grant implementation processes.

Recommendations

The following areas were recommended for TSF support:

- Provision of consultants in:
 - Strategic and operational planning
 - Systems strengthening (M&E, HSS, CSS)
 - Coaching and mentoring
- Strategies for resource mobilisation including GF proposal writing
- Capacity building of PRs and SRs on:
 - Results based management and planning
 - Financial management
 - Procurement and supply management
 - Resource tracking

INTRODUCTION

The Office of the Global AIDS Coordinator (OGAC) of the United States Government (USG) made available, through UNAIDS, a pool of funds to support GF grant implementation in key areas of grant management. These include procurement and supply management, financial management and M&E and strengthening private-public partnerships (PPPs). Funds are also available to strengthen Country Coordinating Mechanism (CCM) governance for more effective CCM functioning. This support entails the provision of quality short-term technical assistance (STTA) building the capacity of principal recipients (PRs) and sub recipients at country level. For this process to be evidence based and to derive value for money; country-specific needs assessments are done by the Technical Support Facility responsible for the Southern African (TSF-SA) region, in consultation with the CCMs, Fund Portfolio Managers (FPM) at the GF Secretariat, UNAIDS Country Coordinators (UCCs), PRs and other key stakeholders. One such capacity assessment visit was made to Zimbabwe from 27 to 31 October 2008

Assessment Objectives

The aim of the visits was to assess the successes and challenges facing implementation of grants by getting a sense of what is working well on the programme, with an aim to strengthening those aspects, and also to look at the challenges that are faced by the PRs with an aim of devising strategies to remove the blockages.

Approach

The assessment was based on unstructured discussions with key stakeholders around the following topics:

- The organisation's systems, structure and capacities in general
- The relationship or interface of the organisation's systems, structure and capacities with the organisation's PR functions.
- General understanding of GF procedures and processes within the entire organisation
- Alignment of the GF procedures and processes to the organisation's procedures and processes;
- Grant performance from the PRs perspective-strengths, challenges and weaknesses

Unstructured discussions were held with CCM Secretariat, the Chairperson of the CCM, LFA and PRs. This process allowed the team to gain a broader insight on how the current political and macroeconomic challenges were affecting the programme implementation.

Activities

The TSF team conducted assessment meetings with the CCM Secretariat, CCM Chair and Minister of Health and Child Welfare, National AIDS Council of Zimbabwe (NAC) – HIV/AIDS PR, Ministry of Health and Child Welfare (MoHCW) - Malaria PR, Zimbabwe Association of Church-related Hospitals (ZACH) - HIV/AIDS and TB PR and the local fund agent (LFA), Pricewaterhouse Coopers.

The details of these meetings are provided in Annex C to this report.

General Findings

The volatile socio-economic and political environment in Zimbabwe is impeding the performance of the social sector in ways that are now well documented. With respect to GF grant implementation the most recent performance rating received by all Round 5 PRs across portfolio of grants was B2 i.e. inadequate but potential demonstrated. Demonstrably, grant implementation supported is needed to close institutional and systemic bottle-necks. However, this assessment found that there were other challenges which fell outside the ambit of technical assistance. .

The most significant challenge that was being faced by the PRs were delays and/or limited release of funds (both local and foreign currency) by the Reserve Bank of Zimbabwe (RBZ). This significantly impeded grant implementation and thus the attainment of the expected outcomes. At the time of the TSF trip, the Office of the Inspector General (OIG) was conducting an audit of the Round 5 grants in Zimbabwe and this issue was high on the agenda.

It was feared that the cause of this limited performance could threaten the Round 5 Phase 2 processes; including the approval of funding for the Round 8 Proposal. In addition, although some PRs had had their capacities assessed and capacity building activities done; the delays in the disbursement of resources did not allow for the testing of these capacities. As a result it can also be inferred that the resources that were used for capacity assessment and capacity building processes were rendered ineffective.

A number of capacity and institutional challenges were commonly identified across PRs. These include the following:

- Understanding of performance-based funding and GF processes/requirements
- Poor working conditions and low remuneration
- Programme management capacity
- Financial and asset management
- Weak health information systems
- Communications
- M&E, particularly around data collection and quality and drug consumption data
- Reporting
- Procurement and supply management
- Communications
- Training to district level
- Implementers to be involved/consulted in proposal writing

Across the PRs for the Round 5 grants it was found that Global Fund processes and procedures were not understood by senior or key staff of the institution in which the PR resides. Consequently the grants and their attendant processes operated as projects. Consequently the term "Global Fund Project" was used to suggest that the grant was not aligned to the institution's systems and capacities. In this regard, it was illustrative to observe that in all the institutions in which PRs are resident; meetings were held with Global Fund M&E, finance and procurement experts.. For instance relevant directorates in the Ministry of Health were not engaged in what is essentially viewed as Global Projects. Further top managers in these institutions were not oriented on Global Fund as a financing mechanism and how the institutions' systems, processes, and procedures fit the Global Fund processes, systems and procedures.

PR Support Requirements

Some PRs had capacity assessments done including capacity development emanating from these assessments. Notably the capacities could be tested because of the delays in the release of funds by the Central Bank. It is therefore agreed that capacity assessment of these PRs could be done only after the funds had been released and implementation starts in earnest.

In addition to the common challenges highlighted above, specific support needs were articulated by the PRs as follows:

Ministry of Health and Child Welfare (Malaria PR)

PR requirements:	TSF Support Possible:
Fine-tuning National Malaria Strategic Plan (2008-2013)	Yes with other partners
Business plan for National Malaria Control Programme	Yes-as above
Policies and procedures for National Malaria Control Programme	WHO-TSF and other partners
Update malaria stratification maps	No-Procure TA from other Providers-check with WHO
Management and professional capacity building at national, provincial and district level	Yes with other technical support providers
Development of guidelines and documents for new artemisinin-based combination therapy (ACT) policy	Yes with other technical support providers
Monitoring and Evaluation (M&E): <ul style="list-style-type: none"> M&E plan Standardisation of indicators National malaria database including M&E indicators Development of data collection and data quality tools 	Yes with WHO
Documentation – reporting formats etc	No
Harmonisation of regional initiatives	SADC and other TA providers
Programme website	No
Procurement and supply management (PSM) plan not finalised	Yes
Public financial management system (PFMS)	Yes-harmonize with MoH systems

National AIDS Council (HIV/AIDS PR)

PR requirements:	TSF Support Possible:
M&E <ul style="list-style-type: none"> Provincial and district structures weak on M&E Support for SRs including dedicated M&E personnel Consumption data Data collection and analysis 	Yes
Financial management and resource tracking	Yes
PSM <ul style="list-style-type: none"> Issue of lack of capacity for follow up Drug forecasting Stock levels at sites 	Yes
Currently meeting key but not process indicators e.g. training	Yes – alternative funding sources
Rationalisation of healthcare worker salaries (HR plan)	Yes - resource mobilisation as an option; other ideas?
Good practice documentation	Yes
Timely reporting by SRs	Yes
HR issues	No (but can assist with HR and resource mobilisation strategies)

Zimbabwe Association of Church-Related Hospitals (TB and HIV/AIDS PR)

PR requirements:	TSF Support Possible:
Cotrimoxazole consumption data-quantification (PSM)	Yes
Procurement logistics (limited/no capacity at ZACH – relies on consortium & wants to strengthen internal capacity)	Yes
M&E plan for TB is not yet finalised but a self-assessment has been done	Yes
Financial management (lack of segregation of duties, reporting not defined, no internal audit)	Yes
Documentation – library and document services support	Yes
Disbursement systems in place but not yet tested	Yes – can assist if found wanting once tested
National statistics for TB are lacking	Yes with other TS providers e.g. WHO
Strategic planning and writing needed – there is no strategic TB plan & framework	Yes
Governance down to mission hospital level – area is being reviewed with other partner (World bank) but synergy with TSF would be good	Yes with other TS providers

Recommendations

On the final day, a debriefing meeting with PRs, CCM Secretariat and FPM was held. The TSF presented an assessment of what the various PR needs were and the type of support, if any, that the TSF can provide. PRs were invited to provide corrections and/or clarifications where necessary in order for the identified support requirements to truly reflect their needs.

The following areas for TSF support were recommended:

- Provision of consultants in:
 - Strategic and operational planning
 - Systems strengthening (M&E, HSS, CSS)
 - Coaching and mentoring
- Strategies for resource mobilisation including GF proposal writing
- Capacity building of PRs and SRs on:
 - Results based management and planning
 - Financial management
 - Procurement and supply management
 - Resource tracking

Key considerations in developing a support strategy:

- Limited implementation performance for R 5 grants – Phase 2 eligibility in 6 months at risk
- Obstacle created by RBZ not releasing funds
 - Affects training in particular
 - De-motivated SRs/SSRs and uncertain residual capacity
- Impending Round 8 negotiation and approval
- Desirable to integrate capacity and support across grants
- Desirable to integrate grant implementation with overall health system strengthening

Proposed Support Strategy and Way Forward

It was agreed that TSF support will be focused towards:

- Support that will be relevant and effective despite disbursement delays by RBZ.
- Strengthening Round 8 grant implementation
- Assist the CCM and PRs resolve capacity and/or system weaknesses issues that may be raised in the OIG Audit Report

Key next steps:

1. TSF to arrange GF orientation for PRs and SRs. It was agreed that a GF orientation workshop for senior managers of these institutions was to be conducted with the aim of ensuring:
 - General understanding of GF processes, procedures and practices-including the performance based funding approach and its implications on the institution's planning, programme, performance reporting and management issues,
 - Alignment and harmonisation of GF processes and procedures into the institutions' processes and systems.
 - Strategic relationship between policy and strategy in the management of GF support,
 - Capacity of PRs to develop coherent communication and information sharing strategies to facilitate transparency and accountability,
 - A coherent process of strengthening the capacity and/or enhancing the systems of the PRs or SRs.
2. A proactive relationship between the CCM, PRs and TSF-SA in the assessment and review of capacity and the functionality of systems that support effective grant implementation. TSF-SA will be available to provide TA in organisational development of SRs as required by PRs. TSF support to commence in 2009 assuming fund blockages have been resolved and the Round 8 grant status has been confirmed.

Accessing support:

Support from TSF-SA can be obtained through the UNAIDS country office by submitting technical assistance fund (TAF) applications. These forms can be obtained from the UNAIDS country office. The terms of reference which are embedded in the TAF applications are to be completed by the PRs and submitted to TSF through the UNAIDS country office. Where TA funding is from a source other than the TAF, the CCM, PR or SR will prepare the terms of reference and submit the same to TSF-SA.

ANNEX A:

ZIMBABWE NEEDS ASSESSMENT REPORT BACK PRESENTATION

TSF Southern Africa
Scaling up Technical Support to accelerate GFATM grant implementation

Zimbabwe Needs Assessment Report Back

31 October 2008



Discussion Outline

- Background
- Focus Areas
- Common Challenges
- PR Needs and Support Parameters
- Possible Areas for TSF Support
- Key Considerations in Developing Support Strategy
- Potential GF Implementation Support Strategy and Way Forward

Background

- Funding through UNAIDS to support GFATM implementation in key areas of grant management, CCM governance
 - ↳ Consultant support
 - ↳ Capacity building
- Consultation with PRs, CCM, NAC, LEA, FPM
- Substantial progress and strengths at all levels under very difficult circumstances, but limited performance threatening RS and potentially RS

Focus Areas

<ol style="list-style-type: none"> 1. GF grants implementation <ul style="list-style-type: none"> • Procurement and supply management incl. plans, quality control, systems • Financial management incl. reporting, accountability systems • M&E systems, incl. quality, harmonization, data validation 	<ul style="list-style-type: none"> • Grant negotiation: TRP clarification, workplans, budgets, indicators • Phase 2 renewal applications <ol style="list-style-type: none"> 2. CCM governance <ul style="list-style-type: none"> • formee effective CCM function 3. Participation of civil society and PPPs <ul style="list-style-type: none"> • in all GF processes
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Not GF proposal writing

Common Challenges (1)

- Understanding of PBF & GF processes & requirements (GF Orientation)
- Poor working conditions and low remuneration
- Organisational performance
- A ceasing funds (local currency and not all service providers can be paid in foreign currency)
- Weak programme management capacity (Need for GF focal person at PR and/or SR level)
- Financial and asset management
- Health Information Systems

Common Challenges (2)

- Training to district level
- Communications
- Reporting
- Capacity building of implementers
- Implementers to be involved/ consulted in proposal writing
- PSM
- M&E
 - ↳ data collection and quality
 - ↳ drug consumption data

MOHCW (Malaria PR) (1)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
1. Fine-tuning National Malaria Strategic Plan (2008-2013)	1. Yes
2. Business plan for National Malaria Control Programme	2. Yes
3. Policies and procedures for M&E	3. Yes
4. Update malaria stratification maps	4. No
5. Management and professional capacity building at national, provincial and district level	5. Yes with other TS providers
6. Development of guidelines and documents for new ACT policy	6. Yes with other TS providers

MOHCW (Malaria PR) (2)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
7. M&E	7. Yes with WHO
M&E plan	
Standardisation of indicators	
National malaria database including M&E indicators	
Development of data collection and data quality tools	
8. Documentation – reporting formats etc	8. No
9. Harmonisation of regional initiatives	9. No
10. Programme website	10. No
11. PSM plan not finalised	11. Yes
12. PFM&E	12. Yes

NAC (HIV/AIDS PR) (1)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
1. M&E	1. Yes
<ul style="list-style-type: none"> Provincial and district structures weak on M&E Support for SRs including dedicated M&E personnel Consumption data Data collection and analysis 	
2. Financial management and resource tracking	2. Yes

NAC (HIV/AIDS PR) (2)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
3. PSM	3. Yes
Issue of lack of capacity for follow up	
Drug counselling	
Stock levels at sites	
4. Currently meeting key but not process indicators e.g. training	4. Yes – alternative funding sources
5. Rationalisation of HCW salaries (HR plan)	5. Yes – resource mobilisation as an option, other ideas?
6. Good practice documentation	6. Yes
7. Timely reporting by SRs	7. Yes
8. HR issues	8. No (but can assist with HR and resource mobilisation strategies)

ZACH (TB and HIV/AIDS PR) (1)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
1. Cotrimoxazole consumption data	1. Yes
2. Procurement logistics (limited/no capacity at ZACH – relies on connections & wants to strengthen internally)	2. Yes
3. M&E plan for TB is not yet finalised but a self-assessment has been done	3. Yes
4. Financial management (lack of signatories of duties, reporting not defined, no internal audit)	4. Yes

ZACH (TB and HIV/AIDS PR) (2)	
<u>PR requirements</u>	<u>TSE Support Possible</u>
5. Documentation – library and document services support	5. Yes
6. Disbursement systems in place but not yet linked	6. Yes – can assist if found wanting once linked
7. National statistics for TB are lacking	7. Yes with other TS providers e.g. WHO
8. Strategic planning and writing needed – there is no strategic TB plan & framework	8. Yes
9. Governance down to midtown hospital level – areas being reviewed with other partner (Worldbank) but synergy with TSE would be good	9. Yes with other TS providers

Possible Areas for TSF Support

- Provision of consultants for:
 - ↳ M&E systems strengthening within the strategic and operational planning context
 - ↳ Coaching and mentoring
 - ↳ Systems strengthening (HSE, CS)
 - ↳ Strategic and operational planning (SOP/MP)
- Strategies for resource mobilisation
 - ↳ Includes GF Proposal Writing
- Capacity building of PR and SRs on:
 - Results based management and planning (Strategic and operational planning)
 - M&E
 - ↳ Financial Management and Reporting
 - ↳ FSM
 - ↳ Revenue tracking (NASA, NDA, accounting reporting, kenya)



Key Considerations in Developing Support Strategy

- Limited implementation performance for R 5 grants – Phase 2 eligibility in 6 months at risk
- Obstacle created by RBZ not releasing funds
 - ↳ Affects training in particular
 - ↳ De-motivated SRs/SSRs and uncertain residual capacity
- Impending Round 8 negotiation and approval
- Desirable to integrate capacity and support across grants
- Desirable to integrate grant implementation with or small health system strengthening



Potential GF Implementation Support Strategy and Way Forward

- Focus on support that:
 - ↳ Remains relevant and effective even if holdup with RBZ continues
 - ↳ Strengthens Round 8 implementation
 - ↳ Tackles issues raised in OIG Audit Report



Potential GF Implementation Way Forward

- Proposed next steps
- Global Fund Orientation for PR and SRs
 - Consultants support to assess in detail priority system and capacity needs and gaps, that impede implementation and which require strengthening
 - ↳ Should cover e.g.: all grants and PFs, SFs, M&E, FSM, financial management; OD needs such as unit structures and ways of working
 - ↳ Should be available early in new year once fund flows clarified, Round 8 status confirmed/ being negotiated



THANK YOU!!!!



ANNEX B:

NOTES OF MEETINGS WITH STAKEHOLDERS

Meeting with Country Coordinating Mechanism (CCM) Secretariat Deputy Coordinator. Mrs Nokutula Mujuru

Malaria Grant

The malaria programme is performing fairly considering the challenge that is faced in accessing funds. The major problem is that there are no focal points at district level. In addition, there is inadequate data collection, incompleteness of records and reports are not submitted on time. Problems are also experienced around communications, with regards to access to telephones, transport and stationery such as paper etc. Health Information Officers (HIO), who are often clerks, are responsible for data collation. Malaria data is collected from the out patient departments from different services and the HIO is then responsible for collating this information. It is noted that data is not collected from pharmacies and other departments.

The head office comprises a Programme Manager (reports to the Deputy Director who in turn reports to the Principal Director), Vector Control Officer, M&E Officer, Epidemiologist and Finance and Administration Officer (FAO). The Programme Manger post is not supported by the GF but the four other posts are. This structure is not replicated at the provincial level. At provincial level there is a PMD, Provincial Epidemiology and Disease Control Officer (PEDCO), Provincial Nursing Officer and Provincial Environment Officer. At district level there is a DEO, DMO who is responsible for case management, Health Environment Officer (HEO) and Health Information Officer (HIO). There is no M&E Officer.

All staff is also responsible for other programmes. At district level there was no orientation to GF grant management. A new drug management policy on ACT was rolled out with intended training packages. Training of trainers was done at the provincial level but this was not cascaded down. There is also heavy staff turnover in the districts.

ESP and EU help to support other general programmes, together with Plan International and other NGOs.

It is recognized that this is a difficult environment in which to implement systems but that general systems seem to be in place. If this was an environment with adequate staff, the systems would be sufficient.

At the district and provincial level there is no ownership of information collection and reporting. There is confusion in some districts about the new ACT policy. There is a need to strengthen systems. The grant has a budget for training and M&E.

The problem is that PRs are failing to access funds from the RBZ. The RBZ's new policy from May states that all foreign donor funds will be taken from commercial banks and held by the RBZ to be released as and when requested. In response, the GF came up with the Fund Manager post to facilitate release of funds and deal with the inflation issue. ZACH is getting small amounts of money from Barclays Bank and is distributing the funds amongst recipients. The malaria programme which is funded mainly by the GF is not receiving many funds.

Support that would be most useful to the programme:

1. to have a focal person at provincial and district level so that malaria duties are not a shared component because in the end they become nobody's business
2. capacitate those recruited

3. Strengthen the programme at national level – the team is sufficient but there is a need to refine job descriptions and assign the task of follow up on issues in order to make people accountable.

The expectation is that the Epidemiologist should be the champion of the programme but this has not happened.

At district level there are no posts for malaria focal points. These need to be created when additional funding is sourced. The suggestion is that the Community Sister, Environmental Health Officer or Health Promotion Officer can fill the post and be effective.

Issues need to be discussed at a high level, for example, at the level of Principal Director, because although they are aware that challenges are being faced, they have lost touch with what is happening on the ground. The Minister, Permanent Secretary, Principal Director, Finance Director and programme office team are invited to attend the audit and finance meetings with the GF.

There are some districts such as Manicaland that are working with other partners, for example, MSF and Plan International. The collaboration was initiated by the partners because they realized that there was duplication of efforts. This collaboration has worked well. They coordinate activities and do annual planning together. At the Malaria Annual conference the partnership came up with one national plan. A draft national strategic plan for 2008-2015 is in existence.

The District Health Executive have a quarterly meeting at district level which feeds into the quarterly provincial planning meeting which in turn feeds into the half-yearly model. The status of these meetings is unclear due to lack of resources for vehicles and workshops etc. as funding is primarily from the GF.

At the last CCM meeting, a delegation was constituted, including the CCM Chair (who is also the Minister of Health) to have an audience with the RBZ governor and his advisor regarding the release of funds. The CCM has also encouraged PRs to liaise with their banks. NAC and ZACH have done this and have received some funds.

The NMCP manager was appointed in an acting capacity. The post requires someone with experience in working in the district, from a public health perspective and not a clinical one.

The financial management system faces many challenges. Under Round 1 Phase 2, approximately \$950,000 was lost because of issues of no follow up and also difficulties in producing the relevant documentation to close the grant. The FAO works through an already weak Ministry of Finance structure including the PFMS payment system.

HIV/AIDS

A summary of the grant implementation across the programmes is that HIV/AIDS under NAC are performing adequately with room for improvement. There is a need for more in depth capacity building of some of the SRs and SSRs. Staff turnover in these organizations is very high with health workers being very frustrated. The delayed release of funds has meant that they are often not paid on time. This negatively impacts on grant implementation. In addition, nurses are not supported by the GF but doctors and laboratory scientists are. This frustration has led to issues in the quality of information being collected by nurses who are responsible for the counseling, clerking and data collection of patients in opportunistic infections (OI) clinics. They are also working without resources such as paper, gloves etc.

TB

ZACH's role is primarily procurement and the monitoring of the distribution of the procured items. There has been no progress under TB because of lack of access to funds. There is a need to have a GF focal person as this structure is important for accountability of GF activities. An

example of this is where Cotrimoxazole was procured and kept at Natpharm but there was a stock out at sites. No-one knew that this was the case and it was only discovered at audit. The initial feeling is that ZACH was not performing but the reality is that there has not been a free flow of funds in order for them to be able to implement. The structure is that of Deputy Director, M&E Officer and Accountant. There is still a need for a Coordinator to make things happens. The TB programme is focused on strengthening the diagnostic centre looking at refurbishment, procuring microscopes ad reagents etc. There is also a component of operational research through the University of Zimbabwe, training of microscopists and the procurement of Cotrimoxazole. The programme targets 66 sites in 22 districts but has currently reached 35 sites.

The CCM secretariat will not be excluded from the CCM strengthening activities because the CCM is only as strong as the support that is provided.

Meeting with key staff from the Ministry of Health and Child Welfare (MoHCW) National Malaria Control Programme (NMCP)

The TSF team met with the M&E Officer, Epidemiologist, Vector Control Officer, IEC Officer, Secretary and Finance Officer. The Programme Manager had other commitments at the time of the meeting.

Service Delivery Area: Vector Control

The strategy is vector control using an indoor spraying programme. Insecticide treated mosquito nets are distributed. The use of Biodicin is on a smaller scale as evidence of its efficacy is still being gathered.

SDA: Case Management

Procurement of drugs and treatment including that of malaria in pregnancy using sulphadoxine pyrimethamine.

Epidemic preparedness and response – mobilize resources for outbreaks

Behaviour change communication – sensitize communities and advocate for prevention

Support is required in the following areas:

1. There is no continued professional development targets
2. Documentation and the development of policies and procedures There are none currently in place for the NMCP. Government o Zimbabwe (GOZ) systems are currently used but this does not meet the needs of donors and is bureaucratic with a payment request having to pass through 10 or so hands. GF is performance based so doing things within the GOZ systems makes meeting targets very difficult.

Vector control unit have managed to liberate certain zones from malaria. They have developed a 3-tier training manual for spray operators. The manual however till needs to be printed and widely distributed.

The NMCP des not do blanket spraying and so have capacitated people to identify where to do the spraying and why. These individuals have been trained in basic entomology to do stage 1, 2 and 3 identification. There are no entomologists at the national level. As a result, for species identification which is difficult, specimens are sent to South Africa for identification.

The programme has been able to procure insecticides with adequate resources. This has been scaled up over the past few years to coverage of around 25% compared to 5% previously.

The programme has vibrant networks including vector subcommittees and working groups which meet quarterly.

The vector needs assessment is for the malaria control programme but will assist in quantifying what will be included in the malaria NSP. It will also help identify the gaps in intervention areas in order to identify where to put more weight in planning.

Technical and financial support is required in drawing up a business plan for the programme. Rollback Malaria encourages the use of a needs assessment and business plan.

In terms of what has been working well on the programme, funds have been obtained from the GOZ and partners including the GF. GF support under R1 was for vector control and R5 was case management. R1 has since ended. Funding under R5 has been a challenge due the RBZ issue.

District Accounting Assistants need capacity building in terms of the GOZ versus GF/donor accounting procedures. For example, original invoices are to be kept at district level until the audit has been conducted. However, donors require the original invoices. This requires awareness creation at district level.

The funding gap for vector control is approximately 50% of requirements. There should be 70 teams spraying in 45 districts but there are only currently 7 teams.

The NMCP is involved in cross border initiatives. They have a programme running with South Africa and want to bring Mozambique on board. They also have a programme with ZIMOSA. Support is required in harmonisation of the regional initiatives to support similar interventions.

Support is required:

1. To develop a programme website.
2. In M&E to:
 - a. Develop a tool to collect information including consumption data. Currently it is very difficult to know how much or when to procure drugs.
 - b. Develop data quality tools
 - c. Develop reporting formats which are to be in tandem reporting systemsIt is important to build capacity for those driving the process to understand the M&E mechanism and processes as internationally recognized.
3. To train health workers in case management.

It was suggested that the programme take stock of the findings from the OIG audit and then put together their technical support requirements.

Meeting with the Global Fund Unit of the National AIDS Council (NAC)

The assessment team met with the Global Fund Coordinator, the Global Fund M&E Officer and the Communications Director.

Meeting with CCM Secretariat Coordinator, Mr Rangarirai Chiteure

The CCM secretariat is of the opinion that there are more challenges being faced than successes in GF grant implementation and that the challenges have little to do with the implementers themselves. Areas to be strengthened include the following:

- Understanding of performance-based funding by PRs and SRs
- Understanding of GF processes and requirements by PRs
- Organisational structures for GF grant implementation
NAC conducted capacity assessments of SRs and even assisted them to conduct capacity assessments of SSRs. Under Malaria, MoHCW did not undertake capacity assessments of

SRs. Instead, they took the ones done by the NAC under HIV/AIDS. ZACH commissioned Ernst & Young to conducted assessments but this could have lead to a lack of understanding of the challenges faced by SRs.

NAC have GF Coordinator and GF Unit integrated into NAC structures. Until recently, GF focal person was not present within MoHCW and ZACH.

- **Planning**
Do not have grant close-out plans e.g. MoHCW Malaria R1.
NAC HIV/AIDS R1 have submitted close out plan ending October 2008. Phase 2 begins in 6 months.
- **M&E**
A national M&E strategy exists and the GF draws from this.
Malaria and TB are yet to finalise checklist, strategy and framework and these are conditions precedent for the next disbursement of funds.
EY developed manual for ZACH that do not take into account GF requirements.
Sustainable ways of collecting data
Malaria: ACT consumption data is required by GF for next procurement but this information cannot be obtained form the districts.
TB: Cotrimoxazole data is also not available
HIV/AIDS: NAC also has some challenges with the flow of data.
- **Relationship issues**
In-country structures of the GF must be clearly understood. There is a need for clarity in roles, responsibilities and communication protocols. Can the CCM claim an oversight role to SRs directly or can it go only to the level of the PR? The Malaria programme lost \$1.1 million due to issues of lack of follow up. CCM can assist in unblocking grant implementation blockages and facilitating effective implementation
The CCM secretariat is divorced from the CCM in terms of grant implementation Cases exist where the PR reports directly to the CCM instead of through the CCM secretariat.
- **Financial and asset management**
How to prevent a vehicle from becoming a Ministry pool vehicle that is then not available for programme work.
- **Communications challenges**
Includes infrastructure and equipment as well as a lack of urgency/capacity to get things done e.g. the PSM plan has taken more than 6 months and is still not yet finalised.

There is a need to understand that the GF is flexible and wants grants to be implemented according to country needs provided that communication is maintained with the GF and approval sought. We can only talk about harmonisation and alignment once the GF system is clearly understood. We should not loose the good things about our systems whilst borrowing from GF systems.

CCM issues:

- Do not have operational documents/guidelines for the CCM secretariat on policy and procedures, asset management salary structures, TORs, performance managements system. It was agreed that CCM members would be up for re-election every two years but some members have been on the CCM since its inception.
- Employment contracts are held with UNICEF but operationally report to the CCM Chair
- There is a need to develop a strategic plan for the CCM.
- Technical assistance is required around grant negotiation.

RBZ has allowed some players in country to charge in foreign currency so there is a need to reposition in order to undertake activities in foreign currency.

Support to PRs around GF processes can be through mentoring around submission of quarterly reports/progress updates, disbursements requests etc for timely submission of reports that meet requirements. There can also be training workshops for PRs in M&E, PSM, finance and administration etc.

The PSM plan is not finalised for MoHCW and ZACH. NAC has submitted and is working on comments received. MoHCW and ZACH are still behind in what needs to be done around M&E but NAC is on the right path. NAC is responsive as a PR.

GF is working with African Corporation Services to look at exchange rates in country and investigate the best ways of making the money available. This has included the option of offshore accounts. The RBZ should in theory allow this as externalization only applies to money generated in country. ZACH was advised to do what NAC did i.e. advise their bankers to withhold foreign currency from the RBZ but their bankers would not do this without RBZ approval first.

Meeting with Local Fund Agent Associate Director, Mr Daniel Muchemwa

The PRs are at different stages of development. NAC demonstrated how capacity can be built by having the right people and paying them a decent salary. Strength is not in area of M&E as there is no investment in provincial and district structures for M&E to be effective. At facility level the staff are mainly MoHCW or MoHCW affiliates and therefore look to the Ministry for systems and controls. There is a need to look at the NAC and how its structures interface with the MoHCW.

Health Information Systems is a priority area for intervention as a structure is required that can be maintained and reported on. A good system was previously in existence but is no longer as priorities shifted. HIO posts are not considered professional health personnel and are in a worse position than nurses.

The GF has had a problem getting training to district level. For example, ACT is in use in Mount Darwin but no-one has been trained in the protocol of ACT use and delivery is therefore happening in a dangerous manner. One unit in the Malaria programme produced an ACT protocol document but it was not distributed because the unit responsible for delivery had no transport.

MoHCW has restructured and hopefully the issue of silos has been resolved. For example, an M&E Officer on the Malaria programme should also look at HIV and TB targets when out on site visits.

There are motorcycles at ZACH that have not been distributed in the past four months. ZACH blames the TB unit and vice versa.

TB and Malaria should not be outside of MoHCW as PR because they are major public health problems and ZACH is unsurprisingly struggling. The programme is the GF but patients are public health patients. We need a functioning TB unit within the MoHCW. There is a need to look at financial management systems, reporting systems and decent recognition to stop staff attrition

TB and HIS have barely been funded. HIS will be more difficult but TB will be easier and can benefit from the association with HIV. There is a need to establish what the TB unit requires in terms of manpower and equipment.

Malaria

MoHCW has been slow to restructure and respond to identified problems within. Problems are mainly about personnel and responding to roles and responsibilities but can be fixed through training and appropriate pay structures and systems. There is an issue of the public financial

management system (PFMS). Excel is not an accounting package but there are some programmes that are being run on it. The option is for the MoHCW to go for a different package or to go the SAP route which government uses but which is very resource hungry.

PSM is done by NatPharm which is a government medical store and shares common problems with all other government medical stores in that there is poor maintenance of infrastructure, no distribution vehicles and an issue between the actual and indicated stock.

The private sector side of HIS is working.

The RBZ problem is not systemic. It is bound by time and relationships and will be resolved with resolution of the political situation. GF is putting in enough safeguards to ensure that the money is not taken and that programmes go ahead.

In summary, recommendation is to pursue three agendas; M&E, financial management and general organisational structures. Significant investment is required in basic management skills as people have moved up through the ranks very quickly.

It was suggested to use the Permanent Secretary of Health as a champion to lead this process and act as a key change agent by first getting him to buy into the vision. It was however agreed to avoid the use of a champion at this time due to the polarized political environment.

The way forward is to propose a technical diagnosis and then work with stakeholders to push a technical set of issues. We have been very programme focused but we need to look at strengthening health systems particularly health information management systems. We should be taking advantage of GF PBF in order to strengthen country systems.

Meeting with Minister of Health and Child Welfare and CCM Chair, Dr David Parirenyatwa and Permanent Secretary of Health, Dr Mabhiza

The Minister noted that the TSF visit was timeous in that the Auditor General from the GF had just the previous day debriefed the CCM on their audit findings.. He is confident that the TSF will be relevant after the CCM retreat where they will identify the gaps and areas for TSF support.

The initial idea was for the TSF to provide a facilitator at the retreat but it happened that the CCM wants a different focus for the retreat where they want to manage the direction themselves after which the TSF will be invited to come in. There are two agendas; one is operational in order to resolve issues and fill gaps and the second is strategic looking at the role of the Cm and where it should fit in relation to health and the AIDS response in Zimbabwe. It was suggested that the TSF would only provide support on the first day of the retreat, during which strategic issues would be looked at.

After it was clarified that technical assistance request are country driven and TORs would need to be developed, the Minister confirmed that the Zimbabwe CCM would be applying for technical assistance through the TSF

Meeting with key management and staff members of Zimbabwe Association of Church Related Hospitals (ZACH)

The assessment team met with the Executive Director, Deputy Director and GF Accountant.

In preparation for becoming a GF PR, ZACH took the initiative to do an internal assessment to ensure that they had the capacity to do so. They went to Zambia to see what was being done as PR working with the government looking at success and tools in use etc. CDC, UNICEF and UNAIDS provided the services of a consultant firm to do an assessment of the organisation looking at systems, technical skills etc. ZACH engaged Ernst & Young who also worked with SRs

identified gaps and came up with a roadmap on the way forward. ZACH came up with its strategies after looking at both national and international strategies e.g. 3-1's and MDGs. ZACH was ahead in terms of interventions because it has a large constituency and was already into ART through its various institutions. It had teething problems and weaknesses around issues of accountability including management systems, procurement and logistics and M&E. In terms of PSM, there exists no capacity at ZACH and it relies on the consortium for this. In terms of M&E, ZACH relied on HIOs to collect and analyse the data.

Internal systems are working but external factors are affecting implementation. It was asked if the TSF support extends to material and other resource inputs as the roadmap that was developed in conjunction with Ernst & Young defines the resource inputs required. TSF support however is limited to technical assistance.

The Deputy Director responsible for management and financial systems is on a twelve month study leave and the accountant is acting in the position. An assessment done before the GF activities highlighted an issue regarding the segregation of duties. Prior to the GF other grants were easily managed but the onset of the GF grant made the appointment of an accountant necessary. A European Commission programme has provided support for another finance position. The issue of internal audit is weak. GF has provided funding but ZACH has failed to fill the position but hope to have this resolved by early in the new year.

External audits are conducted by Ernst & Young on a half-yearly (requested by one funder) and annual basis. Until the end of 2006, three audits were occurring during the year so staff were continuously either preparing for audit or going through audit.

In terms of financial management, preliminary finding from an audit from the GF's Office of the Inspector General indicate that duties are still not segregated. ZACH is looking at resolving these issues through an Ernst & Young supported programme in the coming year.

The current economic situation makes it difficult to operate and has reduced programme implementation. The exchange rate management system is difficult. Initially a flexible exchange rate mechanism was spoken of where the Fund Manager was supposed to get ZWD at a rate as close to the true USD rate as possible and as wanted by development partners but this mechanism has not worked and money has not been obtained through it.

Procurement consortium – WHO is authorized to make purchases on ZACH's behalf.

Money was being received from the RBZ until early in 2008 but in March money began taking 30 to 45 days to be received, if at all. In May, all corporate foreign currency balances were no longer required to be held at the RBZ and any new money would come through but the GF refused to make further disbursements until the outstanding balances have been recovered. This has significantly slowed grant implementation.

Segregation of duties is an issue. All job descriptions are in place and are different for each post but the challenge is that there is no clear supervision process. The clerk reports to the bookkeeper/finance officer who reports to the accountant who in turn reports to the deputy director. The small nature of the organisation does not allow for complete segregation of duties. They had requested for certain posts which did not materialise and have now turned to other partners to fund these posts outside of the GF but which will also support GF activities.

The financial management systems as it related to grant implementation is working well. The system however is not perfect and the audit has highlighted areas that should be improved, for example, IT management (there is no dedicated IT person). The auditors also indicated that challenges in ZACH were on reconciliations between accounts on procurements. Transactions were conducted well but the documentation and paper trail displayed gaps. This is not an issue

about the non-existence of systems but about due diligence in following and enforcing these systems. Money is being pushed to the consortium but there is no forensic financial management. ZACH with the services of Ernst & Young, trained SRs on GF processes (accounting, M&E and procurement etc). Everything now seems to be in place but the system is yet to be tested as there have been no transactions as yet, due to no disbursements having been made.

ZACH does not have capacity in procurement and so it agreed to the appointment of a procurement consortium comprising of Crown Agents and Natpharm. Systems are clearly defined but there is a need to strengthening the procurement chain. OIG observed that there is no person dedicated to procurement but there are two administration secretaries who are responsible for coordinating at their level with the consortium and responsible for local level procurement of, for example, stationary. Support is needed for capacity development in procurement. Also, the lowest bidder has not always been awarded the tender but there has not been a justification as to why.

The grant implementation cycle at SR level is clear. There are no SSRs.

Procurement for HIV is almost completed but problems exist in the procurement for TB. The TB PSM plan has not yet been finalised. Problems exist in that ZACH as the PR is supervising the MoHCW as the SR and there are often disagreements. The TB staff were appointed by August 2008, eleven months after the first disbursement was made. The staff were still using the proposal documents and not the GF approved documents. Lack of agreement of the specification of laboratory equipment has resulted in delays. TB activities have not begun and the SRs have not had to report. Q5 for HIV and Q4 for TB are zero reports as there is nothing happening.

ZACH has delayed in submitting reports which are due 45 days after the end of quarter. They are submitted to the LFA who verify the report.

The capacity strengthening programme provided through Ernst & Young worked well. Some systems are inadequate and need to be bolstered. One SR from the TB grant, CARE, was lost as they did not agree to sign the grant agreement in light of the USD/ZWD issue. They were responsible for 30% of the total grant and this must now be shouldered by ZACH with the Ministry of Agriculture.

One issue raised from ZACH's perspective is that programming is very much disease-orientated and does not take into consideration other mitigation interventions such as community issues etc. Also, the national strategies to guide proposal writing are still in draft form. M&E systems, for example, national TB statistics, are lacking and affect proposal writing and implementation. Proposals also seem to involve shopping lists with the aim of enhancing departments instead of addressing the disease. There is a need for capacity building in strategic planning and writing.

In terms of how the TSF can strengthen ZACH as an organisation:

- ZACH requires an institutional M&E system.
- ZACH has a policy and procedures manual and a finance and administration procedures manual. The criticism is that the procedures do not stand out.

In terms of partnership and systems alignment, ZACH has other implementing partners based on national strategies looking at HIV/AIDS, water sanitation and capacity development. They also work with the European Commission to do capacity building and training of health care workers including primary care nurses, health information officers, laboratory technicians, pharmacy technicians and Xray operators. Because vertical implementation often results in duplication, government is now putting together a proposal to look to partners (DFID, CDC, UNFPA, UNICEF and UNAIDS) for basket funding in terms of systems alignment especially ESP and EC.

Financial management needs to be strengthened in terms of reporting including frequency of reports generated. ZACH has the processes in place but they need to be formalized through, for example, management accounting meetings.

ZACH has requested Ernst & Young to provide library and document services as one of the posts that they will support for a twelve month period.

ZACH does not have a specific M&E policy but does have one tied to the GF through the HIS unit in place to collate and analyse data from institutions.

A gap exists with regards to procurement and supply management as ZACH requires this capacity after the use of the consortium.

In terms of organisation structure, there exists a large gap in project management that needs to be rectified. The unit is headed by the Deputy Director (Projects) and the next level is that of Project Assistant.

Gender and other policies are not in place.

Governance needs to be strengthened not only within ZACH but within its partners even at mission hospital level.

ZACH shared their roadmap, linked herewith:

P:\UNAIDS-TSF\Capacity_Development_Programme\Global_Fund_Workshops\CD_041-W-ZW\CCM_GF_Grant_Implementation_Support_-_Zimbabwe\Background_Documents\ZACH_Draft_Primary_Roadmap_Oct08.xls

Meeting with NAC Directors

The assessment team met with the M&E Director, HR & Administration Director and Audit Director. It was noted that the TSF team had already met with the Global Fund unit but that a meeting with the leadership of NAC was deemed necessary in order to get the NAC's opinion as a whole.

NAC need their capacity to be assessed in terms of their ability to deliver on their mandate as PR for R1, R5 and R8. There is a need to be prepared in terms of leadership etc.

In terms of grant management, there has not been an independent assessment of the national AIDS levy. Is the fund being managed and disbursed well in order to reach the intended beneficiaries? Disbursements are not being made on a scientific basis.

M&E is a challenge and NAC is not currently doing well. There are many gaps in the systems mainly as a result of trying to meet the many challenges faced on the ground. Data flow and the use of a database is also an issue. The population in Southern Africa is very mobile but this is not being tracked from an ART perspective. In terms of evaluation, the focus has been indicator monitoring but there has been little evaluation by external evaluators.

The Zimbabwe National AIDS Strategic Plan (ZNASP) requires a final evaluation in 2010. TSF support will be required to evaluate and plan the next strategic framework.

There is an absence of data for certain indicators, for example, there is no IUD, MSM and commercial sex worker studies. There is therefore a need to do the groundwork in knowing the epidemic in Zimbabwe. There are consultants currently in country doing an M&E plan working through GMS funded by GF.

Procurement and logistics is an area of capacity need. NAC is currently working with the consortium but NAC should be able to stand alone or effectively supervise those who are contracted to do the work. There is a general issue of high staff turnover. Those who are capacitated often leave and attention needs to be paid to this. There is also a need to look beyond the NAC to the capacity of SRs.

The organisation has sufficient capacity but the OIG audit that is currently taking place is sure to highlight any gaps that exist, especially around financial management and resource tracking. NAC previously used a manual auditing system but there is a need to look at auditing in a computerised environment. This will require capacity building around the use of the Pastel and Paynet packages.

In terms of procurement, the consortium currently manages this area but NAC want a larger role to play or to manage it entirely as much resources are lost through subcontracting. The issue of procurement will need to be looked at on a number of levels and to clarify which areas of support is required, for example, training, procedures etc. Logistics and distribution is causing problems as stock-outs are being experienced at the site level when commodities can be found in the central store. This issue has been discussed with Natpharm and the reason supplied was that there is no fuel and allowances for the drivers. It was suggested that NAC request that Natpharm share with them the status of drugs in their central store, in other stores and in the pipeline. This system was previously in place and the information was sent by email on a weekly basis.

NAC shared their strategic plan 2005-2007, linked herewith:

P:\UNAIDS-TSF\Capacity_Development_Programme\Global_Fund_Workshops\CD_041-W-ZW_CCM_GF_Grant_Implementation_Support_-_Zimbabwe\Background_Documents\NAC_Strategic_Plan_2005-2007.doc

The 2008-2011 plan is in first draft.

Joint Feedback Meeting

The CCM Secretariat Deputy Coordinator chaired a meeting of the TSF with representatives from all PRs. The purpose of the meeting was to agree the way forward on what the TSF can do to strengthen GF grant implementation in Zimbabwe.

The TSF thanked those who participated in the assessment meeting for their time, the openness which punctuated the discussions and the sincerity in articulating the challenges that are faced by the country, the PRs and the SRs. PR's were requested to articulate if the challenges identified were misunderstood and to provide clarifications or additions were necessary.

There is an issue regarding the low remuneration of staff in regular structures versus GF structures, creating an island of excellence. A holistic HR strategy is needed that allows for the attraction and retention of staff across the health sector even if this means tapping into resources outside of the GF.

It was noted that the challenges identified are based on long-term systems strengthening but the technical assistance is short-term in nature. The question was raised if a long-term systems approach will be developed that will accommodate for short-term requirements. The TSF's mandate is short-term but when visiting countries, TSF tries to develop a framework in totality of country needs and are open ideas to other partners who may be able to provide long-term support. The TSF can also provide short-term support on an ongoing basis in for example, mentorship. It was said that the Zimbabwe situation is difficult in that people are looking for immediate solutions to the many challenges faced. It will be difficult to do this if funds are not released. Many issues are policy related but there is the option of looking at systems that can be implemented now in order to move forward wherever possible. There is a need to be practical

and realistic yet also innovative in what can be done now to make a difference and what needs to and should only be done at a later stage.

Linked herewith is TSF presentation amended to include PR clarifications:

P:\UNAIDS-TSF\Capacity_Development_Programme\Global_Fund_Workshops\CD_041-W-ZW_CCM_GF_Grant_Implementation_Support_-_Zimbabwe\Zimbabwe_GF_Grant_Implementation_Support_Needs_Assessment_Presentation_31Oct08.pdf

Field Code Changed

The TSF will assist NAC with GF orientation and also PSM which will be an exciting process as this will be a new area of focus for the TSF. If PSM systems are weak, even a very robust financial management system will not stop the organisation from losing money. The TSF does not provide funds but can assist in the development of a resource mobilisation strategy outside of the GF.

In terms of documentation, good things are happening in the region but these are not being documented and are as a result falling below the radar.

There is a need to look at internal reporting and not just reporting to the GF as reporting is being done to comply with GF requirements instead of enhancing programme performance.

NAC felt that the issue of evaluation is not adequately covered in terms of the response itself and also understanding the impact of programmes. The TSF noted that it regularly works with partners in country in joint annual and mid-term reviews and end of programme/grant evaluations. NAC requested that financial management should be broken down into specific areas as was done with M&E. It noted that some work is being done with the TSF around resource tracking. The need to enhance capacity in a computerized environment should also be included under the list of areas for TSF support. There is also a need to come up with an overall M&E strategy across all players in the response. The GF FPM added that there is a need to look at strategic plans and put in place frameworks before going down to systems level. There is a need for just a single M&E framework for cohesive reporting. The NAC noted that one omission from the draft support plan was that of exit strategies. PRs need to proactively talk with partners about what will happen when the grant comes to an end. The GF FPM noted that the NAC youth component will leave a gap but that this could possibly be supported from the new round under cost savings or from bridging funding as the GF does not want invested resources to go to waste.

ZACH are of the opinion that when the issues are teased out, they point to two key areas; one is that there is no coherent M&E system for TB and the other is that this is because there is no national TB strategy in place. It was agreed that there is an urgent need for this. It was noted that the TB unit has a draft strategy and are receiving support from WHO around this. ZACH added that it needs to re-examine its structure with regards to financial management. They are currently working with Ernst & Young to have a Finance Office and Documentation Officer in place. The cooperation of Ernst & Young however is for a defined period and ZACH will require additional support to continue. ZACH requested it noted that there is a need to engage more people with diverse experience during proposal writing as implementation begins at this stage. There is a need to be clear about how proposals are written as a country. For example, with the TB proposal, the strategy and data are not clear and the budget is not in line with the anticipated activities. The proposals do not talk to the strategic frameworks and implementers.

The TSF expressed their disappointment that the NMCP, which faces numerous grant implementation challenges, was only represented at this meeting by the Finance Officer. The NMCP Manager and representatives from Roll Back Malaria subsequently joined the meeting. There was a request for training for support and supervision at all levels of the programme, from national to district level, in order to strengthen the core. The NMCP will be working on a response to the OIG findings once the draft report has been received. There will be a malaria needs assessment at the request of Roll Back Malaria. It was noted that although the implementation of

HIV activities are continuing, the lack of performance of the malaria programme can affect the entire grant.

The TSF concluded by saying that the assessment that was conducted, although rapid, led to an impression which the PRs have since indicated as correct. The TSF will prepare a plan that looks at the common and specific challenges faced around GF grant implementation in Zimbabwe. The way forward will mostly be tied to the implementation of Round 5 grants while attention is also being given to the assessment of the capacity of in-coming PR in Round 8. The Global Fund Board will be sitting on the 7th of November 2008 to make the final Round 8 decision. It was agreed that there is a need to coordinate between PRs in order to develop a technical support plan by area giving an overall, clear plan in terms of support that is needed and then look at the long term capacity needs and short term technical assistance needs. An elaborate technical support plan is required for each of the areas but these do need to talk to each other. There is a need for programmes within the Ministry to work together more closely. TSF noted that there is a need to look at challenges on a global capacity level first and then look at the specific for each PR. The discussion had during this visit will be triangulated with the OIG findings once they become available.

ANNEX C:
BACKGROUND INFORMATION¹

Country Statistics

Total population	13,120,000
Population age 0 to 4	1,706,000
Population age 15 to 49	6,670,000
Income Level	Low income
Under-5 mortality rate	85,000
GNI per capita (USD)	340
Total health expenditure per capita (USD)	21
Number of physicians	2,086
Number of nursing and midwifery personnel	9,357

Disease Indicators

HIV/AIDS

Adult HIV prevalence	20.116 %
People living with HIV/AIDS	1,700,000
People dying with AIDS	180,000
Estimated number of people needing ARV therapy	570,000
Estimated number of people receiving ARV therapy	98,000
AIDS orphans	1,100,000

Tuberculosis

TB prevalence, all forms	78,978
TB incidence, all forms	73,714
TB mortality, all forms	17,269
TB incidence, smear-positive	30,028

Malaria

Reported cases	1,252,668
Reported deaths	626
Estimated deaths (in 1000's)	0.380

¹ Adapted from The Global Fund Website: www.theglobalfund.org

Country Coordinating Mechanism (CCM) Membership

Name	Sector Represented	Organisation / Institution	Position	CCM Role
Dr David Parirenyatwa	Government	Ministry of Health and Child Welfare	Minister of Health	Chair
Dr Custodia Mandlhate	Multilateral and Bilateral Development Partners in Country	World Health Organisation	WR/Zimbabwe	Vice-chair
Mr Thomas Machingaidze	Government	Ministry of Education, Sports and Culture	Director	Member
Mr Chandaida Maforo	Government	Ministry of Finance	Principal Accountant	Member
Mrs Martha Mpisaunga	Private Sector	Syngenta	Regional Manager	Member
Ms Evelyn Mashamba	PLWD	Batanai AIDS Support Group	Member	Member
Mrs Vuyelwa Chitimbire	Faith-Based Organisation	ZACH	Executive Director	Member
Mrs Matilda Jambga	Faith-based Organisation	Interfaith	Chairperson	Member
Dr Kwame Ampomah	Multilateral and Bilateral Development Partners in Country	UNAIDS	Country Coordinator	Member
Dr Ruth Walkup	Multilateral and Bilateral Development Partners in Country	CDC	Country Director	Member
Mr Michael Chommie	NGOs/Community-based Organisations	Populations Services International	Country Director	Member
Mr Cephas Zinhumwe	NGOs/Community-based Organisations	NANGO	Chief Executive	Member
Mr Sydney Mhishi	Government	Ministry of Public Services and Social Welfare	Director	Member
Mr Rodgers Mozhentiy	Government	Association of Rural District Council	Chief Executive	Member
Ms Lindiwe Chaza-Jangira	NGOs/Community-based Organisations	Civil Society	National Director	Member
Mrs Sipiwe Mukuwapasi	Academic/educational sector	Chinhoyi University of Technology	Life Skills Coordinator	Member
Ms Barbra Plinkert	Multilateral and Bilateral Development	European Commission	Head of Section	Member

	Partners in Country			
Dr Tapuwa Magure	Government	National AIDS Council	Chief Executive	Member
Dr David Mutambara	Private Sector	Zimbabwe Business Council on AIDS	Executive Director	Member
Mrs Lynde Francis	PLWD	The Centre	Director	Member

Portfolio of Grants

	Round	Principal Recipient	Total Funding Request (\$)	Approved Maximum (\$)	Total Funds Disbursed (\$)
HIV/AIDS	1	UNDP NAC	14,100,000	14,100,000	11,149,443
	5	NAC ZACH	62,478,891	35,931,159	8,736,484
	8	TBA	296,752,070	86,821,730	-
			373,330,961	136,852,889	19,885,927
Malaria	1	MoHCW	8,559,911	8,559,911	8,250,984
	5	MoHCW	28,491,009	20,121,670	6,798,371
	8	TBA	141,316,927	70,994,472	-
			178,367,847	99,676,053	15,049,355
TB	5	ZACH	12,041,766	9,230,076	3,410,626
	8	TBA	58,298,297	29,538,652	-
			70,340,063	38,768,728	3,410,626
TOTAL			622,038,871	275,297,670	38,345,908

Fund Portfolio Manager - Ms Tracey Burton

HIV/AIDS Grant

Round 1

Project Title: Strengthen and scale up disease prevention and care for HIV/AIDS in Zimbabwe

This programme aims to reduce the spread of HIV in Zimbabwe and minimize its impact. The focus of the programme is to:

- Prevent transmission of HIV among young people by improving sexual and reproductive health for youth in 12 districts
- Improve access to testing and counseling services for people living in 12 rural districts of the country
- Expend services for prevention of mother to child transmission of HIV to 12 rural districts strengthen provision of community and home based care services for people living with HIV/AIDS in 12 districts
- Provide antiretroviral treatment to 7,000 people living with HIV/AIDS at public health facilities.

PR: UNDP
Grant start date: 1 May 2005
Grant end date: 30 November 2007
Total funding requested: \$14,100,000
Approved funding: Phase 1: \$7,830,753
Phase 2: \$0

Total funds disbursed: \$6,312,533

Service Delivery Area Ratings

Based on the results achieved against targets for each indicator, the following ratings were obtained:

- Prevention: Youth education and Prevention – A (expected or exceeding expectations)
- Prevention: Counseling and testing – A (expected or exceeding expectations)
- Prevention: PMTCT – B2 (inadequate but potential demonstrated)
- Other: Palliative care – A (expected or exceeding expectations)
- Treatment: ART and monitoring – B1 (adequate)

UNDP received an overall grant performance rating in Phase 1 of B1 (adequate).

NAC took over as PR in Phase 2. The grant was signed with UNDP as PR in Phase 1 because NAC did not have the capacity to be the PR at that time. UNDP built the capacity of NAC by having staff attachments during the transition to ensure adequate orientation and training.

PR:	NAC	
Grant start date:	1 November 2007	
Grant end date:	30 April 2008	
Total funding request:	\$14,100,000	
Approved funding:	Phase 1:	\$2,469,247
	Phase 2:	\$3,800,000
Total funds disbursed:	\$4,836,910	

NAC's latest overall grant performance rating is that of B1 (adequate).

Round 5

Project Title: Programme to support the scale up of ART and HIV testing and counseling services in 22 districts in Zimbabwe

The programme's goal is to improve the quality of life and reduce HIV/AIDS mortality amongst people living with HIV/AIDS. The programme shall support the scale-up of ARTs and HIV T&C services in 22 districts in Zimbabwe, which shall include the expansion of services in 12 districts covered by the Global Fund's Round 1 HIV/AIDS grant. The programme shall build on existing National strategies, including PMTCT; TB and ART programmes; care and support for the chronically ill and families affected by HIV/AIDS; and HIVT&C services.

PR:	NAC	
Grant start date:	1 August 2007	
Total funding request:	\$62,478,891	
Approved funding:	Phase 1:	\$32,742,685
	Phase 2:	\$0
Phase 1 end date:	31 July 2009	
Total funds disbursed:	\$7,444,080	

The NAC's latest overall grant performance rating received was that of B2 (inadequate but potential demonstrated).

PR:	ZACH	
Grant start date:	1 June 2007	
Total funding request:	\$62,478,891	
Approved funding:	Phase 1:	\$3,188,474
	Phase 2:	\$0
Phase 1 end date:	31 May 2009	

Total funds disbursed: \$1,292,404

The NAC's latest overall grant performance rating received was that of B2 (inadequate but potential demonstrated).

MALARIA GRANT

Round 1

Project Title: Improving the quality of interventions and scaling up malaria control in Zimbabwe

With the assistance of the Global Fund, the national Roll-back Malaria (RBM) programme shall be further strengthened and scaled up into 10 new districts that are considered as the most affected by malaria in Zimbabwe.

The main strategies are as follows:

1. To increase coverage of the vector control program (to 100%), using mainly indoor residual spraying as well as distribution of Insecticide Treated Nets (ITNs) with activities focused at the district level (10% per year per district)
2. To strengthen malaria case management in 10 program districts at the community and primary health care level through training in vector control and in malaria diagnosis and case management.

Drug supplies and other consumables will be provided. The most vulnerable groups including children and pregnant women will receive a special attention. Morbidity and mortality rates from malaria should be reduced by 10% every year. The project will also pilot the use of rapid diagnostic tests kits to reduce malaria over-diagnosis in 10 districts with epidemic or seasonal malaria. The monitoring and evaluation of the project will be integrated into the M&E component of the national RBM program which already had training components for health workers at all levels in data collection, management and analysis.

PR:	MoHCW
Grant start date:	1 August 2004
Total funding request:	\$8,559,911
Approved funding:	Phase 1: \$6,716,250
	Phase 2: \$1,843,661
Programme end date:	31 January 2008
Total funds disbursed:	\$8,250,984

Service Delivery Area Ratings

Based on the results achieved against targets for each indicator, the following ratings were obtained:

- Prevention: Indoor residual spraying/vector control – A (expected or exceeding expectations)
- Prevention: Insecticide-treated nets – B2 (inadequate but potential demonstrated)
- Treatment: Prompt, effective antimalarial treatment – B1 (adequate)
- Prevention: Malaria in pregnancy – B2 (inadequate but potential demonstrated)
- Treatment: Monitoring drug resistance – B1 (adequate)
- Supportive environment: Monitoring and evaluation and operations research – B1 (adequate)

The MoHCW received an overall grant performance rating in of B1 (adequate).

Round 5

Project Title: Program to Make ACT Available for the Treatment of Malaria in 51 Districts in Zimbabwe

The goal of the Program is to reduce malaria specific morbidity and mortality by 15% in 51 malaria districts by the year 2008 through improvements in access to treatment, prompt and effective treatment of malaria.

The newer anti-malarial drugs such as artemisinin-based combination therapy (ACTs) have been shown to have higher parasite clearance rates and therefore the potential to reduce the gametocyte carriage in any given population. This has the effect of reducing malaria transmission and malaria related morbidity. Complemented with the current vector control measures of Indoor Residual House Spraying and use of ITNs Zimbabwe has the potential of greatly reducing the morbidity and mortality related to malaria.

In order to achieve this goal, the Program plans:

- To increase the proportion of mothers/caretakers who are able to identify early symptoms and signs of uncomplicated and severe malaria and seek treatment promptly to 85% in 51 malaria districts by 2008;
- To increase proportion of malaria cases accurately detected and diagnosed according to national policy to 60% in 51 malaria districts;
- To increase the number of patients with uncomplicated and severe malaria receiving the correct treatment according to national guidelines to 80% in the 51 malarious districts by 2008; and
- To monitor the efficacy of artemether-lumefantrine at 8 sentinel sites in the country.

PR:	MoHCW
Grant start date:	1 October 2007
Total funding request:	\$28,491,009
Approved funding:	Phase 1: \$20,121,670
	Phase 2: \$0
Total funds disbursed:	\$6,798,371

TUBERCULOSIS (TB) GRANT

Round 5

Project Title: National Programme to Reduce TB Morbidity and Mortality in Zimbabwe

The goal of the Tuberculosis component is to reduce TB mortality and morbidity in Zimbabwe. The proposed interventions are designed to support and strengthen the existing National Tuberculosis Program efforts. The Program focuses on 5 areas: (a) strengthening program management and supervisory capacity; (b) strengthening laboratory diagnostic capacity (achieving 70% diagnosis); (c) improving treatment outcomes (80% success) and patient support; (d) coordination between TB and HIV services; and (e) strengthening Monitoring and Evaluation capacity. The Program will benefit the disadvantaged poor and People Living with HIV/AIDS as these groups are disproportionately affected by Tuberculosis. The Program will contribute to the fight against AIDS by offering all TB patients the opportunity to know their HIV status. The TB clinics will thus become a major entry point for HIV/AIDS care. The combined activities of both the HIV and TB components can be expected to result in synergistic enhancement of care and treatment for patients across the country.

PR:	ZACH
Grant start date:	1 September 2007
Total funding request:	\$12,041,766

Approved funding:	Phase 1:	\$,9,230,076
	Phase 2:	\$0
Total funds disbursed:		\$3,410,626

ANNEX D:

PRINCIPAL RECIPIENT PROFILES

1. National AIDS Council of Zimbabwe (NAC)²

NAC is an organization enacted through the Act of Parliament of 1999 to coordinate and facilitate the national multi-sectoral response to HIV and AIDS. It is also mandated to administer the National AIDS Trust Fund (NATF) collected through the AIDS Levy i.e. the 3% collected from every workers taxable income (PAYE) and corporate tax.

Mandate:

To provide for measures to combat the spread of Human Immuno Deficiency Virus (HIV) and management, coordination and implementation of programmes that reduce the impact of HIV and AIDS.

Vision:

To be recognised as the leader in the reduction of HIV and AIDS and its impact in Zimbabwe and beyond.

Goal:

To empower communities to reduce HIV transmission and minimize the impact of the AIDS epidemic on families and society.

Mission:

NAC is committed to providing quality and effective leadership for a comprehensive and coordinated multi-sectoral response to HIV and AIDS in Zimbabwe.

Values:

Accountability, Efficiency, Transparency, Effectiveness (Making a difference), Empathy (Compassion), Commitment, Non-discrimination and Teamwork

Strategic Framework

NAC's operations since inception to date have been governed by The National HIV/AIDS Strategic Framework (2000-2004). Currently its operations are guided by a three-year Strategic Plan (2005-2007) and an operational guideline for HIV and AIDS Programmes in Zimbabwe. The development of a Strategic Framework for the next five years (2005-2008) to guide NAC's operations is underway.

Strategic Areas are prevention, mitigation and support, Care for infected, Advocacy, Workplace, Youth focused, Capacity building and infrastructure and research.

The NAC Board members are appointed by His Excellency the President of Republic of Zimbabwe. Their term of office is three years. Functions and powers of the Council are to:

- To ensure the development of strategies and policies
- To combat HIV and AIDS and
- To control and ameliorate the effects of the HIV and AIDS epidemic and to promote and coordinated the application of such strategies and policies.
- To mobilise and manage resources whether financial or otherwise in support of a national response to HIV and AIDS.

² Adapted from The National AIDS Council website: www.nac.org.zw

- To enhance the capacity of the various sectors of the community to respond to the HIV and AIDS epidemic and coordinate their response.
- To encourage the provision of facilities to treat and care for persons infected with HIV and AIDS and their dependants.
- To monitor and evaluate the effectiveness of the strategies and policies referred to in paragraph and generally, the national response to HIV and AIDS.
- To promote and coordinate research into HIV and AIDS and to ensure the effective dissemination and application of the results of such research.
- To disseminate and to encourage the dissemination of information on all aspects of HIV and AIDS.
- To submit regular reports to the President, through the Minister, concerning the HIV and AIDS epidemic.
- To exercise any other function that may be conferred on the Council by or in terms of this Act or any other enactment.
- Generally. To do all things which in the Board's opinion are necessary or appropriate to combat HIV and AIDS and to ameliorate the effects of those diseases.

The board is multisectoral and meets on a monthly basis.

NAC Secretariat

The secretariat is present at national, provincial and district levels. Its task is developing and realizing management and administrative systems to promote and support the expanded multi-sectoral response to HIV and AIDS.

- Facilitating and supporting the establishment and operations of HIV and AIDS.
- Coordination mechanisms for sectoral and district/community action on HIV and AIDS.
- Providing guidance and technical support for sectoral and district/ community strategic planning and priority setting for HIV and AIDS.
- Supporting implementation of sectoral and community/district response to HIV and AIDS.
- Mobilizing and managing resources and ensuring transparency and accountability in their utilization.
- Putting in place and realizing appropriate strategies for effective monitoring and evaluation of responses to HIV and AIDS as well as tracking accounting for resources mobilized to fight HIV and AIDS.
- Reviewing and appraising proposals submitted for funding.
- Providing strategic guidance, facilitation and technical support for planning, implementation, coordination and monitoring of HIV and AIDS programmes on youth, gender, workplace and social support for impact mitigation.
- Assisting to establish and maintain appropriate management and technical capacity necessary to support scaling up of response initiatives on HIV and AIDS throughout the country.
- Initiating and realizing strategic partnership against HIV and AIDS with key stakeholders (NGOs, private sector, public sector, local authorities, donor media etc.)
- Developing and maintaining a database and website for the purpose of data capture, monitoring and evaluation and information sharing.
- Designing and implementing advocacy strategies in order to make HIV and AIDS everyone's concern and promote the necessary action to counter the epidemic
- Documentation and sharing of best practices.
- Supporting prioritization of research on HIV and AIDS and promoting dissemination and utilization of research findings.

Mr. Amos. Mpofu - Monitoring and Evaluation Director

Mr. Evaristo. Nyamutswa - Audit Director

Mr. Raymond. Yekeye - Operations Director

Ms. Sidudzile. Ntombie - Human Resources and Administration Director
Ms. Medelina. Dube - Communications Director
Dr. Tapuwa. Magure - Chief Executive Officer
Mr. Albert. Manenji - Finance Director

2. The Ministry of Health and Child Welfare of the Government of Zimbabwe (MoHCW)³

The overall purpose of the MoHCW is to promote the health and quality of life of the people of Zimbabwe. In pursuing this, the MoHCW is committed to:

- Equity: the MoHCW seeks to achieve equity in Health by targeting resources and programmes to the most vulnerable and needy in our society.
- Primary health care: the primary health care approach will be the main strategy for health development.
- Priority health issues - priority health problems will be identified and resources will be targeted to alleviating those problems.
- Quality: programmes will seek to provide high quality care which is accessible and appropriate.
- Health promotion: programmes will emphasise on Health promotion and disease prevention.

The MoHCW aims:

- to keep as many people as possible in good health in the community.
- to provide appropriate quality services for those needing care in the community.
- to high quality hospital services at the appropriate level for those few requiring that form of treatment and care.

In pursuing these health objectives the MoHCW will:

- ensure value for money through efficient and effective services.
- plan and manage its resources effectively.
- form strong links with the community at all levels in the delivery of appropriate health services in acceptable ways.
- mobilise more resources for the health sector whilst ensuring their optimum utilisation.

The National AIDS Coordination Programme leads and coordinates national efforts for HIV/AIDS prevention, control, care and impact mitigation:

- It coordinates the development and promotion of a national multisectoral strategy and workplan for HIV/AIDS prevention, control, care and impact mitigation.
- It coordinates the development of national HIV/AIDS policies and guidelines and promotes their application.
- It mobilises resources for supporting the National Response.
- It promotes and coordinates multisectoral involvement in HIV/AIDS prevention, control, care and impact mitigation and ensure harmonisation of inputs from the different sectors.
- It identifies and foster the implementation of practical strategies to enhance the capacity of sectors to respond to the AIDS epidemic.
- It monitors sectoral compliance to national goals, objectives and strategies in response to AIDS.
- It monitors and evaluates the comprehensiveness, appropriateness and effectiveness of the National response to the epidemic.
- It promotes and coordinates priority AIDS research aimed at identifying ways to respond better to AIDS and dissemination and utilisation of research findings.

³ Adapted from The Ministry of Health and Child Welfare website: www.mocw.gov.zw

- It organises regular consultative and coordination fora with different stakeholders in order to promote interchange of information and experiences and a harmonised and coherent approach to HIV/AIDS.

3. The United Nations Development Programme (UNDP)⁴

Vision:

To be a credible and leading development partner of choice in Zimbabwe for promoting sustainable human development

Mission Statement:

To strategically support Zimbabwe's development agenda towards the achievement of the MDGs and economic recovery

UNDP in Zimbabwe

The partnership between the Government of Zimbabwe and UNDP dates back to 1980, when the Standard Basic Service Agreement (SBSA), which provides the legal framework for the cooperation, was signed by both parties.

In 1997, the Government of Zimbabwe and UNDP formulated the first Country Cooperation Framework (CCF) for Zimbabwe, covering the period 1997 to 2000. On the basis of an evaluation of the first CCF, the second CCF (2000 to 2003) was formulated, emphasizing on economic policy advocacy, governance and the combat of HIV/AIDS. The second CCF was extended to 2006 to allow for implementation of outstanding activities in the light of the complex and emerging socio-economic and political challenges that Zimbabwe has been facing since the year 2000.

Development Challenges and Operating Environment

Since 2000, the country has been going through a period of transformation, which has seen most of the human development indicators decline. A politically polarized environment resulting from lack of consensus on policy issues, capacity erosion in all sectors of the society and a diminished resource base for development activities characterize UNDP's operating environment.

4. Zimbabwe Association of Church Related Hospitals (ZACH)⁵

ZACH is the medical arm of Christian churches in Zimbabwe. Its mandate is to improve the quality of health and health care delivery in Zimbabwe. It is ecumenical in practice. ZACH has a membership of 126 mission hospitals and clinics. ZACH believes in the holistic approach to health and healing. Most of the healthcare in the rural areas of Zimbabwe is provided by mission hospitals. Mission hospitals constitute a core component of the health care system in Zimbabwe, operate within the health policy framework of the Ministry of Health and Child Welfare and have close liaison relationship with the MoHCW to assure synergy in the delivery of health services in Zimbabwe. 13 ZACH hospitals are designated as district hospitals and many are used for best practice models in terms of ART. ZACH's activities cover community HIV&AIDS prevention, peer education, ART provision, PMTCT, VCT, peer education and training, CHBC and orphan care, STI management, youth friendly services and OI clinics.

Mandate:

To assist and support member institutions in the provision of quality health care and service delivery to all Zimbabweans, especially to the most vulnerable groups in society.

⁴ Adapted from UNDP website: www.undp.org.zw

⁵ Adapted from various ZACH pamphlets

Vision:

ZACH envisages a healthy society in which all people in Zimbabwe have access to a sustainable high quality holistic healthcare system

Mission statement:

Following the example of our Lord Jesus Christ, ZACH will adopt a holistic approach to health and healing, encompassing principles of equity, quality and accessibility. ZACH promotes the highest standard of health care among its members for the benefit of all people in Zimbabwe.

ANNEX E:

LOCAL FUND AGENT PROFILE

PricewaterhouseCoopers⁶

The LFA role falls under transformation services. Transformation services is primarily a performance improvement service provider to the public sector, servicing Zimbabwe, Malawi and occasionally supporting Mozambique. Transformation focuses on large projects/programmes with at least a 3 year life span where long term technical assistance is provided. Most of these projects/programmes are funded by multilateral and bilateral funding agencies.

Services include:

- Sector or Ministries Transformation and Restructuring
- Privatization, Commercialization and Corporatization
- Results Based Projects Assessment
- Monitoring and Evaluation
- Performance Improvement
- Strategy Formulation
- Performance Diagnostic
- Financial Reviews, Budgeting, Corporate Planning and Legal and Institutional Reviews

The LFA role involves:

- managing the interface between the Global Fund and the CCM, the PR and other relevant stakeholders;
- PR assessments covering general background assessments, institutional and programmatic, finance and management and monitoring and evaluation;
- review of all documentation submitted to the Global Fund by the PRs;
- assisting with grant negotiations; and
- making disbursement recommendations.

⁶ Adapted from the PricewaterhouseCoopers website: www.pwc.com