NATIONAL HIV/AIDS/STI/TB COUNCIL

COUNTRY COORDINATING MECHANISM CCM ZAMBIA

REPORT ON THE ASSESSMENT

OF THE GLOBAL FUND PRINCIPAL RECIPIENTS

Ministry of Health (MoH)

Churches Health Association of Zambia (CHAZ)

2020

CONTENTS

1. ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy (for the treatment of malaria)
AGAPE	Adolescent Girls Accessing Prevention and Education, a project implemented by CHAZ
AGYW	Adolescent Girls and Young Women
ART	Anti-Retroviral Therapy
ATM	HIV/AIDS, Tuberculosis and Malaria
CAG	Community Adherence Group
CBO	Community Based Organization
CBV	Community Based Volunteer
CCM	Country Coordinating Mechanism of the Global Fund
CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
CoI	Conflict of Interest
CP	Cooperating Partner
CSO	Civil Society Organization
DHIS	District Health Information System
DHO	District Health Office
DHS	Demographic Health Survey
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
FBO	Faith Based Organization
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRZ	Government of the Republic of Zambia
HCW	Healthcare Workers
HMIS	Health Management Information System
ICCM	Integrated Community Case management
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
KP	Key Population
LLIN	Long Lasting Insecticide treated Net
LTFU	Lost to follow up
M&E	Monitoring and Evaluation
MDR-TB	Multi Drug Resistant Tuberculosis
MMD	Multi-Month Dispensing
MRR	Malaria Rapid Reporting
MOE	Ministry of Education
MOF	Ministry of Finance
MoH	Ministry of Health
MSL	Medical Stores Limited
MTR	Mid-Term Review
NSP	National Strategic Plan
OC	Oversight Committee of the CCM
OIG	Office of the Inspector General

PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PLHIV	Persons living with HIV
PMU	Program Management Unit
PPAZ	Planned Parenthood Association of Zambia
PR	Principal Recipient (of a Global Fund grant)
RDT	Rapid Diagnostic Test
SDP	Service Delivery Point
SP	Sulfadoxine-Pyrimethamine (drug to prevent malaria in pregnancy)
SR	Sub Recipient (of a Global Fund grant)
TB	Tuberculosis
TLD	Tenofovir, Lamivudine, Dolutegravir (HIV drug)
TLE	Tenofovir, Lamivudine, Efavirenz (HIV drug)
TTT	Technical Task Team
UNHLM	United Nations High Level Meeting
VL	Viral load
WHO	World Health Organization
ZAMMSA	Zambia Medicines and Medical Supplies Agency

2. EXECUTIVE SUMMARY

To guide the nomination of the Principal Recipients for the 2021-2023 implementation period, the Country Coordinating Mechanism (CCM) of the Global Fund to Fight AIDS, Tuberculosis and Malaria formed a technical task team (TTT) to assess the current PRs' performance and suitability to implement the GF grant under the next grant implementation cycle. The TTT consisted of 15 members: seven members of the CCM Oversight Committee (OC) and eight coopted members to compliment the OC´s competence.

The objectives of the PR assessment were to:

a. Evaluate the performance of the current PRs (MoH and CHAZ) so as to make recommendations to the CCM on their suitability to implement the subsequent Global Fund grants.
b. Identify new program areas or areas that shall be significantly expanded and evaluate the respective PRs´ suitability to implement them during the next allocation cycle.
c. Assess the strengths and weaknesses of each of the PRs and propose options on how to address these weaknesses.
d. Review the advantages and disadvantages of alternative implementation arrangements.
e. Submit the results/findings and recommendations to the CCM for consideration.

Between December 2019 and May 2020, this PR assessment was carried out through a combination of desk reviews of various documents and key respondent interviews, involving PR and SR representatives, cooperating and other partners, and beneficiaries, taking experiences of the CCM Oversight Committee into consideration. All TTT members signed a confidentiality agreement and a conflict of interest declaration. All statements made by key respondents as well as TTT members are anonymized in this report.

Based on the findings in this PR assessment, the TTT presents the following recommendations to the CCM:

1. Re-nominate MoH and CHAZ as PRs: Considering the important role of MoH and CHAZ in the Zambia health system, their experience with the Global Fund grant implementation as well as their overall good grant performance, both organizations should continue the implementation of the 2021-2023 grants as PRs. The TTT did not identify any significant competency gaps in the current PRs that would justify nominating a third PR.
2. Adjust the SR implementation arrangements as follows:
    a. Shift all CBO interventions currently under MoH with the exception of the KP interventions to CHAZ considering the challenges experienced under MoH on the one hand and the expertise of CHAZ in community engagement on the other hand.
    b. Engage KP organizations as implementing partners to reach out more effectively to key populations targeted and build their capacities over time.
3. Ensure consistently high value for money in grant implementation:
    a. Global Fund grants should be primarily used for catalytic, high impact interventions. Standard interventions of prevention, treatment and care shall be increasingly taken up by GRZ.
    b. The PRs shall enhance the impact of their interventions on the national scale prioritizing cost effective interventions (e.g. avoidance of silo projects without measurable national impact, prioritization of high prevalence areas, esp. for HIV and TB community interventions).

c. Projects shall be implemented within existing systems to ensure their sustainability beyond the Global Fund support. Maintaining or creating parallel systems shall be discouraged.
d. PRs shall strengthen their collaboration with PEPFAR, PMI and other partners to ensure that all programs are strictly complementary. The CHAZ malaria engagement should be reviewed and possibly shifted to provinces with higher malaria prevalence and lower level of partner support.
e. Quality assurance processes shall be applied to ensure that interventions are implemented in such a way that maximizes impact. This includes the timely procurement of commodities needed e.g. IRS.

4. Review the historically applied 70% / 30% budget split between MoH and CHAZ. The budget split should be strictly the result of implementation considerations based on core competences of either PR and their expected impact.
5. Prioritize interventions across the three diseases and revise the budget split accordingly. Malaria is likely to require additional funds in order to make progress towards malaria elimination by 2021. The reliance on additional funds through the unfunded quality demand mechanism appears risky.
6. Improve data collection, reporting, and analysis both for DHIS and community HMIS:
   a. MoH and CHAZ shall collaborate to eliminate the parallel reporting systems currently in use.
   b. The community DHIS needs to be made fully functional in order to be used as a basis for decision making.
   c. Both PRs shall address challenges of data completeness, data quality as well as data analysis.
7. Advocate to accelerate the transition for ZAMMSA for them to fulfill their mandate to cover procurement, storage and distribution for all public health facilities as soon as possible. During the transition period, the CHAZ procurement share should be increased to reduce the risk of shortages and stock outs. All efforts must be made to ensure consistent buffer stocks for a minimum of six months.
8. Enhance collaboration and communication with SRs, relevant MoH departments, other stakeholders and other sectors, including the private sector. Both PRs shall also make additional efforts to improve timeliness of submissions to the CCM and to fully comply with the communication related Global Fund Standard Terms and Conditions.
9. Both PRs shall address programmatic and other challenges that are listed under findings in this report. The CCM Oversight Committee shall follow up on the implementation of respective actions.
10. Advocate for GRZ to increase ownership and responsibility for financing the national responses for HIV/AIDS, TB and Malaria, including timely and full payments of grants and initiation of procurements scheduled in the yellow book.

3. BACKGROUND OF THE PRINCIPAL RECIPIENTS ASSESSMENT

The Global Fund (GF) requires all CCMs to[1]:

a. Nominate one or more Principal Recipients (PR(s)) at the time of submission of their application for funding,
b. Document a transparent process for the nomination of all new and continuing PRs based on clearly defined and objective criteria.
c. Document the management of any potential conflicts of interest that may affect the PR nomination process.

Thereby, the CCM needs to ensure that the PRs selected have the programmatic, financial, and management capacities and systems to be good stewards of the funding.

During the 2018-2020 grant implementation cycle, the Ministry of Health (MoH) and the Churches Health Association of Zambia (CHAZ) are implementing the Global Fund grants as PRs. In preparation of the upcoming funding request for the 2021-2023 implementation period, the CCM requires guidance for the selection of PRs for the next grant cycle. Therefore, in August 2019, during the Quarter 3 CCM meeting, the decision was made to form a technical task team (TTT) to assess the current PRs' performance and suitability to implement the GF grant during the next grant implementation cycle and provide recommendations to the CCM.

The TTT consisted of 15 members: seven members of the CCM Oversight Committee (OC) as well as eight coopted members to complement the OC´s competency in procurement and supply chain management, grant management, finance, M&E, research, human rights, TB and HIV experts, community level experts and key populations. The co-opted members were selected by requesting through CCM Member institutions/organizations. The TTT membership was endorsed by the CCM in the Quarter 4 2019 CCM meeting.

TTT members were guided by the CCM TTT Terms of Reference and eligible members received allowances to cover for their expenditures/ logistics supported by the CCM Secretariat Co Funding and no kind of remuneration.

4. OBJECTIVES

The objectives of the PR assessment were to:

f. Evaluate the performance of the current PRs (MoH and CHAZ).
g. Identify new program areas or areas that shall be significantly expanded and evaluate the respective PRs´ suitability to implement them during the next grant implementation cycle.
h. Assess the strengths and weaknesses of each of the PRs and propose options on how to address these weaknesses.
i. Review the advantages and disadvantages of alternative implementation arrangements.
j. Submit the results/findings and recommendations to the CCM for consideration.

[1] The Global Fund, Guidance on CCM Eligibility Requirements 1 & 2, 2019

5. METHODOLOGY

The PR assessment was conducted through a combination of:

- Desk reviews of various documents (see annex)
- Key respondent interviews, including PR and SR representatives, cooperating and other partners, and beneficiaries (see annex).

The TTT developed a question guide for each type of respondents (see annex). Questions that arose from the desk review process were incorporated into the respective question guides as means of seeking clarification. The interviews focused on weaknesses rather than strengths in order to assist the PRs and other stakeholders with respective recommendations for improvement.

PRs were not only assessed for their programmatic performance alongside the agreed GF indicators but also for their financial and management performance, including SR management.

The TTT completed the PR assessment according to the below schedule:

1. One day inception meeting on 9th December 2019 to review the assignment, create a common understanding and agree on a roadmap
2. Half day training workshop conducted by the CCM Secretariat for participants not familiar with GF performance assessment on respective tools and reports.
3. Two-day retreat on 23-24 January 2020 to consolidate the information on grant performance of oversight and desk review and refine the way forward (i.e. identify the information needs and prepare questions for each type of interview key respondents and further fine-tune the road map)
4. A half-day meeting before the start of the interviews for finalization of the various question guides for the interviews with key respondents.
5. Virtual meetings to consolidate the results on May 6th, 7th and 18th, 2020.
6. Validation of the report by TTT members.
7. Submission of the final report to the CCM before 1st June 2020.

6. CHALLENGES ENCOUNTERED DURING THE PR ASSESSMENT

a) Delayed receipt of key inputs and delayed processes
The NASF mid-term review (MTR) report and the TB National Operational Plan MTR report were delayed by several weeks. As the MTR reports are a key source of information for the PR assessment, the TTT postponed the finalization of the assessment report to take these MTR findings into consideration. The key respondent interviews had to be postponed repeatedly due to the rescheduling of the MoH Program Review thus impacting the assessment schedule.

b) Unavailability of PR documents needed for the preparation of PR interviews

Although the request for documents needed for the desk review was shared with the PRs two weeks before the submission due date, and despite several oral and written reminders, none of the PRs complied. During their interview, CHAZ invited TTT team members to review hard copies of the requested documents after the interview. As the TTT had not been informed about this opportunity in advance, the team was not able to review the documents and was not permitted to take hard copies of the documents for a later review. MoH submitted the requested documents a few days after their interview. Both PRs missed an opportunity was missed to ensure that the TTT was better prepare for the PR interviews.

c) Impact of COVID-19

With the emergence of the COVID -19 pandemic, the Ministry of Health issued prevention guidelines which discouraged face to face meetings thereby limiting the amount of interaction with key stakeholders. The TTT's meeting schedules were affected as a result of these developments as virtual meetings held through various web conferencing apps were not as interactive as in-person meetings. The inability of some TTT members (especially those from outside of Lusaka) to connect and unstable internet connections resulted in interruptions in the conversations. These disruptions affected the flow and the quality of the interviews.

7. MANAGEMENT OF CONFLICT OF INTEREST AND CONFIDENTIALITY

To adhere to the CCM conflict of interest (CoI) policy, all TTT and supporting CCM Secretariat members signed a declaration of conflict of interest form (see annex) at the beginning of the TTT proceedings. This CoI declaration was specifically developed for the purpose of this PR assessment. In this context, Sibu Malambo, National Coordinator of the Zambian Youth Platform, a CHAZ SR, recused himself from all interviews with CHAZ and its SRs.

All TTT members and the CCM Secretariat staff involved in the process signed a confidentiality agreement that bound members to not disclose any confidential information from key respondents and their organizations. This served to not only protect the key respondents and their organizations but also enabled them to express themselves freely without fears of any sanctions. For this reason, this report keeps the identities of the key respondents confidential. Furthermore, in this confidentiality declaration all TTT members and supporting CCM Secretariat members agreed to keep opinions and statements of other team members confidential at all times and accept collective responsibility for the statements and opinions expressed in this assessment report.

8. LIMITATIONS

There was only a limited number of key respondents per category, e.g. SRs. It is possible that these key respondents have had different experiences with the PRs and hence contradicting opinions. For this reason, the findings may partly seem contradictory; however they reflect what the team found on the ground.

9. FINDINGS

The following findings are based on the experiences of the oversight committee, the TTT desk reviews and the interviews with various key respondents undertaken by the TTT members. The interviews focused on weaknesses rather than strengths in order to assist the PRs and other stakeholders with respective recommendations. This shall by no means imply that the strengths listed are the only ones. Similarly, key respondents may have mentioned certain strengths for one PR only, which does not necessarily imply that the other PR does not possess this strength.

In the following chapters, the TTT findings are organized according to areas relevant to the grant implementation. Each chapter contains two tables: a) PR strengths in the first table with the green header and b) PR weaknesses in the table underneath with the red header. The first row that cuts across the entire table contains findings that apply similarly to both PRs. The following rows with separated cells for each of the PRs contain findings that apply only to MoH or to CHAZ.

9.1 General suitability

Based on the desk reviews and interviews with various key respondents, the TTT identified the following general strengths of the PRs:

<table>
<tr><th colspan="2">STRENGTHS</th></tr>
<tr><th>MoH</th><th>CHAZ</th></tr>
<tr><td colspan="2">• Biggest healthcare providers in Zambia.
• Decades of experience in HIV/TB/malaria service delivery in all 10 provinces and across all levels of health care.
• Have built the health systems over the decades, robust supply chains, established the M&E systems
• Several years of experience with Global Fund grant implementation. GF performance ratings as evidence of their capacity to deliver on expected results
• GF interventions mostly integrated into existing systems, no parallel systems
• Institutional memory built</td></tr>
<tr><td>• Largest health care provider in Zambia</td><td>• Second largest healthcare provider in Zambia, delivers 50% of healthcare services in rural areas, complements MoH efforts</td></tr>
<tr><td>• Custodian of health policies and National Strategic Plans (NSPs), relevant policies are in place</td><td>• PR for more than 15 years uninterrupted</td></tr>
<tr><td>• Coordinates efforts of all stakeholders</td><td>• Strong links with communities and health facilities</td></tr>
<tr><td rowspan="2">• National mandate and mechanisms in place to oversee both preventive aspects and treatment</td><td>• Quality assurance implemented and technical support provided wherever necessary</td></tr>
<tr><td>• High level of proactiveness, issues pointed out in the management letters addressed timely</td></tr>
</table>

9.2 Programmatic performance

Performance ratings are key considerations for the CCM and Global Fund in deciding to continue or replace a PR under a new grant. An implementer may be replaced or added during grant implementation for the following reasons:

- if the implementer is not able to perform their role and to carry out their responsibilities properly under the grant; and/or
- the CCM and/or PR, and the Global Fund wish to transfer some or all of the responsibilities of the implementer under the grant to another entity.[2]

Programmatic strengths mentioned include the following:

<table>
<tr><th colspan="2">STRENGTHS</th></tr>
<tr><th>MoH</th><th>CHAZ</th></tr>
<tr><td colspan="2">• High program implementing capacity
• Overall good programmatic performance results
• TB: Targets for 7 out of the 9 core NSP indicators and UNHLM targets for 2018 have been met[3]
• Decentralized HIV response structures
• Great improvements in community malaria case management</td></tr>
<tr><td rowspan="3">• Malaria improvement plan as part of latest operational plan</td><td>• Consistent A-level performance ratings, some programs showcased as best practices (AGAPE)</td></tr>
<tr><td>• Minimal bureaucracy in program implementation</td></tr>
<tr><td>• Improvement plans in place for
  ◦ EID early infant diagnosis
  ◦ Logistics
  ◦ Community engagement</td></tr>
<tr><td colspan="2">Experiences of ART clients:
• Performance of HIV implementation has improved significantly over the years, now considered as satisfactory by PLHIV.</td></tr>
</table>

Areas that require strengthening according to the findings from the desk review and interviews include:

<table>
<tr><th colspan="2">WEAKNESSES</th></tr>
<tr><th>MoH</th><th>CHAZ</th></tr>
<tr><td colspan="2">HIV
• Suboptimal VL and EID performance (low achievement against indicators)
• Underperformance on pediatric ART and high HIV conversion rate of HIV-exposed infants
• High level of LTFU
• CBO interventions do not sufficiently prioritize high prevalence districts
• Rising HIV incidence among adolescents and young women and other key populations</td></tr>
</table>

[2]The Global Fund, Guidelines on Implementers of Global Fund Grants, 2015

[3] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

<table>
<tr><th colspan="2">WEAKNESSES</th></tr>
<tr><th>MoH</th><th>CHAZ</th></tr>
<tr><td colspan="2">Tuberculosis
Poor drug susceptible and MDR-TB case detection (58%[4]) and TB notification. Low pediatric case detection.[5] Number of notified cases remains stable despite increasing number of samples tested on GeneXpert. Only 1/10 of prison population screened for TB in 2019[6].
Underutilization of GeneXpert. Sputum transport arrangement has improved but challenges persist. High level of clinical diagnoses (>40%) in spite of availability of roughly 300 GeneXperts[7].</td></tr>
<tr><td colspan="2">Malaria
Insufficient progress to achieve a malaria-free status by 2021, most 2018 NSP vector control intervention coverage targets missed[8]
Malaria interventions not sufficiently geographically targeted according to transmission intensity levels
Geographical focus of CHAZ malaria interventions: Eastern/Southern Provinces are already supported by several other partners
Insufficient use of malaria microscopy even where it is available[9]
Inconsistent utilization of ITNs</td></tr>
<tr><td colspan="2">Cross-cutting / other
Shortages and stock outs of Isoniazid and vitamin B6, HIV and malaria test kits, LLINs and ACTs, GeneXpert cartridges[10] affecting diagnosis, prevention and treatment.
Planning processes are not sufficiently strategic.
Insufficient involvement of all kinds of stakeholders into planning, implementation, and reviews, e.g. private sector, other sectors, NAC for TB, academia, etc.
Decision making does not adequately consider data available.
Reprogramming not proactive enough, challenges with prioritization of interventions.
CPs like WHO are not adequately engaged during grant implementation</td></tr>
<tr><td>B1 performance ratings for both grants indicates room for improvement</td><td>Lack of follow up on ART clients transferred to newly established MoH facilities
Lack of a system to track transition from TLE to TLD as well as to DSD[11]</td></tr>
<tr><td>Inadequate coordination of health promotion efforts within one as well as across diseases areas resulting in fragmented and less effective implementation</td><td>Work too much in isolation / inadequate involvement of other stakeholders</td></tr>
</table>

[4] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[5] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[6] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[7] Ministry of Health, Underreporting of TB Patients in Zambia, December 2019

[8] National Malaria Elimination Programme, Mid-term Review of the National Malaria Elimination Strategic Plan (2017–2021), 2019

[9] Global Fund Management letter, 28th October 2019

[10] Stock status reports, findings from CCM site visits, National Malaria Elimination Programme, Mid-term Review of the National Malaria Elimination Strategic Plan (2017–2021), 2019

[11] Global Fund Management letter, 28th October 2019

<table>
<tr><th colspan="2">WEAKNESSES</th></tr>
<tr><th>MoH</th><th>CHAZ</th></tr>
<tr><td>• Inadequate involvement of relevant stakeholders (e.g. MoH community systems unit, health promotion, adolescent health unit, other sectors) in planning and implementation of interventions</td><td>• Inadequate information sharing with cooperating partners, other stakeholders and CCM
• Irregular attendance in various malaria coordination meetings</td></tr>
<tr><td>• Service delivery affected by delayed procurement of commodities (esp. malaria) and delayed disbursements</td><td rowspan="8">• Some activities (e.g. malaria testing) are implemented in a way that is not in accordance with MoH guidelines</td></tr>
<tr><td>• Major and repeated delays in implementation of interventions reduces impact and cost effectiveness, e.g. IRS, DSD.</td></tr>
<tr><td>• Delayed implementation of management actions[12]</td></tr>
<tr><td>• Insufficient proactiveness to address challenges</td></tr>
<tr><td>• Lack of communication strategies for specific target groups, e.g. Persons with disabilities, for youth and adolescents, parents</td></tr>
<tr><td>• Inadequate commitment to strengthen malaria in pregnancy component</td></tr>
<tr><td>• Waste of money and suboptimal impact because of wrong spraying techniques (IRS)</td></tr>
<tr><td>• ACTs not always prescribed according to guidelines (#ACTs > # positives)</td></tr>
<tr><td colspan="2">Experiences of ART clients:
• ART rationing still occurs from time to time
• Vitamin B6 had to be purchased after the initial month from a chemist
• Long waiting times and congestion despite appointment schedule while certain clients are seen to receive preferential treatment.
• Very short time allotted to VL sample collection (8-10am). If missed, need to come back, which is not always easy for the ART clients.
• Reduction of drug supplies from MMD to only 1-2 weeks following missed appointments is perceived as an inappropriate and punitive measure
• DSD incl. CAG not considered as functional / has not started everywhere
• Counseling by CHWs not comprehensive and empathic enough. Info is usually obtained from support groups. Lack of peer counselors specifically for youth and adolescents
• Main reasons for LTFU listed below need to be addressed much better:
○ inadequate counseling for new clients who may not be ready to accept the diagnosis
○ inadequate VL literacy as suppression is understood as HIV negative, hence discontinuation of treatment
○ married people and teenagers who fear the reaction of spouse or partner regarding the HIV status and who do not receive the needed support
○ impact of faith healing on treatment adherence.</td></tr>
</table>

[12] Global Fund Management letter, 28th October 2019

9.3 Grant and financial management performance

STRENGTHS	
MoH	**CHAZ**
• Earned public trust that PRs take stewardship of GF resources very seriously • Instituted internal control systems to prevent and detect misuse or fraud • Significant improvements in financial management capacity	
• PMU improvement plan developed but not followed up	• Strong grant management capacity, manage grants from various donors (CDC, USAID, EU)
• Adherence to the Public Financial Management Act of 2018	• Strict governance and financial systems – clean OIG and audit reports
• Audits provide evidence of improvements in financial management	• Address timely any grant management issues pointed out in the management letters
• Prevention of misuse of funds at SR level: monthly visits to districts from provincial level and biannual audits	
• Roll out of NAVISION at national and provincial level increases internal controls and timeliness of retirements and reduces risk of over-expenditures and ineligible expenditures	
• End Malaria Council established to increase domestic resource mobilization	

WEAKNESSES	
MoH	**CHAZ**
• Strong dependence on donor support jeopardizes sustainability of interventions • Delays in the grant implementation at the beginning of the grant implementation cycle • Expenditures do not always offer enough value for money, e.g. unnecessary expenditures for meetings, IRS expenditures for incorrectly implemented spraying and inadequate coverage per community, irrational use of malaria RDTs and ACTs, interventions in low prevalence areas • Inconsistent follow up on financial information to readily identify savings for reprogramming • Reprogramming requests do not contain all the information required by the GF resulting in delays • Insufficient candidness about severity of challenges • Potential of private sector engagement not adequately exploited • Risk registers not routinely reviewed and updated	
• PMU has gaps in management and coordination • finance team's performance improved but is not yet up to GF expectations • PMU improvement plan not followed up	• Insufficient coordination and communication between CHAZ departments[13]
• Collaboration between programs and PMU still inadequate; "Disconnect"	• Financial systems used not optimal for GF reporting needs, e.g. commitments

[13] Global Fund Management Letter, 28th October 2019

WEAKNESSES	
MoH	**CHAZ**
• Inadequate participatory planning and budgeting processes involving district level[14]	• No spot rates or average exchange rates used[15]
• Ineligible expenditures for funding of activities that are not in the budget and not related to the three diseases[16]	
• Frequently delayed disbursements to SRs without information or explanation, challenges with timely SR retirements[17]	
• Gaps in financial management at implementation level	
• Retirement of imprest is still a challenge resulting into delays in fund disbursements	
• Untimely feedback to GF management letters[18]	

9.4 Health Systems Strengthening

STRENGTHS	
MoH	**CHAZ**
• Expertise in GF procurement, warehousing, and distribution • Both PRs have their own warehouse(s) and distribution system • Existing memorandum of understanding between both PRs • Complementary efforts to prevent shortages and stock outs as much as possible	
• MSL made significant improvements in storage and distribution (enhanced security measures, additional hubs, new warehouse management system Expert, trucks GPS-tracked)	• Allowed to undertake direct procurement without going through Wambo and without using a third party partly resulting in lower commodity and handling costs
• MSL has the mandate and capacity to take up the complete warehousing and distribution system for MoH facilities under the condition of adequate funding	• More efficient procurement processes[19]
• Hubs and GF commodities are fully insured	• Provides support for MSL to remain operational (operational cost for 3 hubs)

[14] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020, CCM 2019 site visits

[15] Global Fund Management Letter 28th October 2019

[16] Global Fund Management letter, 28th October 2019

[17] National Malaria Elimination Programme, Mid-term Review of the National Malaria Elimination Strategic Plan (2017–2021), 2019

[18] Global Fund Management letter, 28th October 2019

[19] Global Fund Management letter, 28th October 2019

STRENGTHS	
MoH	**CHAZ**
• Supply chain coordination unit soon in place. Will also improve visibility into national stock levels.	• Successful implementation of Last Mile Delivery (LMD)
• Recent formation of a unit for performance improvement and quality assurance to address various challenges	• Proactively developed a reporting systems to comply with reporting requirements despite lack of access to MoH DHIS
• National roll out and use of e-LMIS	• Lab competence being built (VL)
• Successful transitioning of GF funded staff to GRZ	

WEAKNESSES	
MoH	**CHAZ**
• Inadequate coordination of the MSL/CHAZ procurements and distribution, e.g. unilateral decisions on procurements that are not timely communicated to other stakeholders partly leading to wastage, two trucks going to the same facility, • No overview on total commodity quantities available in the country because of different warehousing systems that are not interoperable and electronic warehouse management system that has not been rolled out to all hubs • Inconsistent flow of commodities into warehouses: Shortages require rationing and then unnecessary additional distribution rounds when stock finally arrives • Shortages and stock outs of Isoniazid and vitamin B6, HIV and malaria test kits, LLINs and ACTs, GeneXpert cartridges; minimum stock levels are not consistently ensured[20] • e-LMIS hardly (5%) used for TB commodities[21] • Limited use of data analysis (e.g. sub-national level analyses) for decision making • Lack of data on people with disabilities • Lack of power backup affects functionality of health facilities at all levels, esp. laboratory, data collection[22] • Health facility infrastructure often not suitable for persons with disabilities • Inadequate staffing levels, resulting in carrying out dual functions, burn out, and delayed deliverables • Lack of trained health workers in sign language	
• Weaknesses in forecasting and quantification skills	• Insufficient alignment of and communication on orders placed and estimated time of arrival

[20] Stock status reports, findings from CCM site visits, National Malaria Elimination Programme, Mid-term Review of the National Malaria Elimination Strategic Plan (2017–2021), 2019

[21] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[22] CCM Site Visit November 2019, Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

WEAKNESSES	
MoH	**CHAZ**
• MSL performance is highly dependent on punctual and full disbursement of MOF grants • Only partial MOF disbursements for MSL – key operations sustained thanks to significant support from USAID / PSM	• No access to DHIS data for data analysis and reporting, hence resorting to undesirable parallel reporting systems as well as dependence on PMU to access data
• Delayed procurement of commodities leading to shortages and stock outs	• Incomplete roll-out of e-LMIS resulting in incomplete consumption data[23]
• Insufficient communication on ○ orders and shipments to complete MSL pipeline data affecting management of inventories ○ payment of invoices to MSL	• Continued lack of systematic data sharing and analyzing amongst relevant departments[24]
• Failure to effect timely LMD to CHAZ facilities[25] and MoH facilities[26]	
• Risks related to ZAMMSA transition, funding not yet secured for needed additional investments and risk mitigation in this context. ZAMMSA Act has no provision for punitive measures e.g. in line with PFM Act against misuse or fraud	
• No competitive recruitment at director level within MoH, appointments only, perception that it affects the performance	
• Limited visibility into interventions of all stakeholders on the ground	
• Insufficient coordination to keep all stakeholders informed about interventions and achievements	
• Data collection / documentation issues at facility/district level[27], inadequate M&E capacity, inadequate data harmonization, and weak feedback loops and poor data use culture. [28]	
• Parallel reporting system for TB data still in use	

[23] Global Fund Management Letter, 28th October 2019
[24]Global Fund Management Letter, 28th October 2019
[25]Global Fund Management Letter, 28th October 2019
[26] CCM Site visit November 2019, Global Fund Management Letter, 28th October 2019, National Malaria Elimination Programme, Mid-term Review of the National Malaria Elimination Strategic Plan (2017–2021), 2019
[27] Among others: Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020
[28] Among others: National AIDS Strategic Framework 2017-2021 Mid Term Review, April 2020

WEAKNESSES	
MoH	**CHAZ**
• Lack of a data sharing policy that allows CHAZ to access DHIS data	

9.5 Community Systems Strengthening / Community based interventions

STRENGTHS	
MoH	**CHAZ**
• Necessary structures in place • Reasonable involvement of community structures to support the implementation of HIV interventions.[29]	
• New unit created to work with CSOs and create efficiencies in community led interventions	• Decades of experience in community interventions. Community based interventions mentioned as a CHAZ core skill by several key respondents
	• Close collaboration with MoH, esp. on ICCM and HIV adherence support

WEAKNESSES	
MoH	**CHAZ**
• Community structures often not functional[30] • Slowness of communication with the civil society. PRs do not act on time. • Suboptimal SR CBO arrangements as a result of accommodating both GF and PEPFAR geographic coverage requirements • Adequacy of geographical targeting questioned by several interviewees (e.g. KP interventions, CHAZ malaria support to PHOs, CBO/FBO engagement in AGYW projects tends to focus on lower prevalence settings) • Absence of a mapping of CBOs. Risk of redundancies and missing of synergies • Insufficient coordination of community based interventions across programs and across implementing partners[31], no framework for the engagement of CBVs • Evaluation of cost effectiveness and sustainability of community interventions missing • Gaps in data collection consistency at community level work e.g. TB treatment supporters do not provide any reports, volunteers have not received airtime for reporting[32], malaria CBVs do not use MRR[33],	

[29] National AIDS Strategic Framework 2017-2021 Mid Term Review, April 2020
[30] National AIDS Strategic Framework 2017-2021 Mid Term Review, April 2020
[31] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020
[32] CCM Site visit, November 2019
[33] Global Fund Management Letter, 28th October 2019

WEAKNESSES	
MoH	**CHAZ**
• Lack of tools to track CHW activities and capture data for routine quantification of their contribution to case detection and management[34]	
• Lack of experience with CSO engagement	• Limited scope of interventions and target groups due to organizational values, e.g. KPs
• Significantly delayed start of AGYW interventions in spite of Zambia having been selected as a pilot for adaptive leadership[35]	• Insufficient information of and collaboration with MoH Community Systems Unit
• Inadequate engagement of and collaboration with1) community systems unit / community health, 2) Department for Health Promotion Environment and Social Determinants 3) Adolescent Health Unit	• Trust issues due to misunderstandings by civil society who feel that the PR focuses on FBOs
• Community strategies are not well coordinated at central level and not adequately documented	• Parallel community reporting system in use that is not aligned with community HMIS
• Despite trainings, reporting coverage on community HMIS is too low for evidence-based decision making; Therefore, cost effectiveness of training is questioned	

9.6 Capacity to manage SRs effectively

STRENGTHS	
MoH	**CHAZ**
• Transparent SR selection, open tenders • PRs have capacity and systems for effective management and oversight of SRs • Regular performance reviews with SRs and provincial level activity monitoring • Regular audit visits	
• Good relationship with SRs (esp. PHOs, DHOs)	• Vast experience in SR management (currently >200 SRs across different donors)
• Support offered when requested	• Punitive measures in place to ensure that SR health facilities adhere to guidelines
• Communication efforts rated as good or adequate. Most positive feedback from SRs within MoH (regular interactions through MoH structures, meetings and Whatsapp groups)	• Competent staff to manage SRs, efficient administration and communication, accountability, transparency, and integrity – acting as a role model and ensuring compliance at SR level

[34]Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[35] Global Fund Management Letter, 28th October 2019

STRENGTHS	
MoH	**CHAZ**
• Concerns regarding SRs within MoH quickly addressed since technical assistance is part of the general MoH structure	• Strong understanding of HIV response transferred to SRs, good initial trainings, materials shared are of high quality, clear expectations, ongoing support
	• Proactive, monthly interactions with CSO SRs, meetings to review performance and address challenges, effective coordination of all SRs for annual meetings to share best practices and challenges, timely technical assistance always available to resolve challenges
	• Mostly timely disbursements
	• Proactive addressing of challenges in collaboration with SRs
	• Rated highly on quality and frequency of communication with SRs

WEAKNESSES	
MoH	**CHAZ**
• Delayed contracting of SRs • Implementation arrangements for HIV treatment adherence project not clear • Changes made to interventions that were not communicated to the CCM • Some interventions are too small in scale to result in a measurable impact[36] (e.g. PHO funds partly covering isolated activities only, AGAPE is considered as "drop in the ocean" by various interviewees) • Weak coordination of CBOs implementing community TB Care[37]	
• Almost two years lapsed before CSOs were contracted and received funding; no plan in place to shorten CSO recruitment	• Rushed SR selection due to a delay posed a danger to quality of the selection
• Submitted SR work plans and budgets needed revisions to strengthen scope and associated budgets	• The experience that CHAZ does not respond to issues mentioned in the SR reports gives the impression that CHAZ does not read them
• MoH takes time in meeting their mandate; SR reprogramming takes too long	• Little room for CSOs to expand scope
• PR does not always proactively follow up on SR performance to resolve challenges	• Disbursements to SRs not always timely
• Scheduled meetings with SRs to review their performance often do not take place	

[36] National AIDS Strategic Framework 2017-2021 Mid Term Review, April 2020

[37] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

WEAKNESSES	
MoH	**CHAZ**
• Frequently delayed disbursements to SRs without information or explanation, making SR planning challenging	

9.7 Effectiveness of implementation arrangements

STRENGTHS	
MoH	**CHAZ**
• Both PRs with long GF grant implementation experience and good results • Activities implemented by both PRs serve as risk mitigation and increases flexibility. If MoH does not move fast enough, CHAZ may compensate – the same applies for the dual procurement, storage and distribution • Almost all key respondents indicated that risks of having a third PR outweighs the benefits	
• Engages MoH system from central level to sub national thus fostering ownership throughout the system	

WEAKNESSES	
MoH	**CHAZ**
• Budget split between MoH and CHAZ: 30/70% based on historical practice, not strictly on comparative advantage • Enormous number of SRs may inhibit needed supervision and attention for each SR	
• Funding level for some SRs may not justify administrative effort for reporting, which could be a reason for untimely retirement	• CHAZ core competences may be needed more in different provinces than in Eastern/Southern Province
• PPAZ not considered as ideal organization to reach out to KPs effectively	• Authority of CHAZ (PR) over PHOs and DHOs (SRs) questioned
• No strong history in engagement of CBOs, no results until December 2019	
• Bureaucratic processes hinder effective grant implementation at SSR level – too many layers	

9.8 Other aspects of PR performance

STRENGTHS	
MoH	**CHAZ**
• Quarterly reporting to the CCM	

WEAKNESSES	
MoH	**CHAZ**
• PRs have not internalized that they implement on behalf of the CCM and the respective implications • PRs do not seem to fully respect GF guidelines on communication with the CCM. Important information is exchanged between PRs and GF bypassing the CCM • PRs do not consistently seek opinion of the CCM before submission of reprogramming requests	
• Lack of overview and coordination on interventions of different implementers entails risk of duplication	

9.9 Other observations

The following are mostly findings on weaknesses or gaps that cannot be taken into consideration for this PR assessment as the Global Fund does not currently provide (adequate) funding for the interventions noted below. Nonetheless the TTT considers these findings as important considerations for the CCM.

WEAKNESSES	
MoH	**CHAZ**
• Case detection focused on clinical setting, leaving out opportunities at community level. • Data, e.g. DHS, indicate a need for more intense prevention / health promotion efforts. Health seeking behaviors are not sufficiently strengthened. Lack of access to age-appropriate, gender-sensitive and socio-culturally relevant HIV prevention information for young people and adolescents[38]. TB resources are skewed towards curative services with low investment in prevention services.[39] • Zambia was classified as a WALKING country with regards to HIV prevention[40]. Insufficient prevention efforts through mass media, schools or else. Targeted messages necessary. Too many false rumors on social media that are not corrected • Lack of stipends affects impact and accountability of CBVs. Overestimation of what can be expected of volunteers who are not even paid allowances • Challenges related to cross-border movements / treatment. • MOH / MoE staff rotation results in loss of competence and additional cost for additional trainings • No long-term transition plan for increasing domestic resources and for reducing dependence from CPs	
• History of shortages and stock-outs of SP for IPTp	

[38] National AIDS Strategic Framework 2017-2021 Mid Term Review, April 2020

[39] Independent Review of the TB and Leprosy Programs of Zambia Report, Midterm Review of the strategic plan 2017-2021, 2020

[40] UNAIDS

10. RECOMMENDATIONS

The following recommendations arise from the findings of the TTT during the PR assessment and are partly directed to the CCM and partly to other stakeholders as the PR or the writing team.

10.1 Re-nominate MoH and CHAZ as PRs

Considering the important role of MoH and CHAZ in the Zambian health system, their experience with the Global Fund grant implementation as well as their good grant performance, all key respondents agreed that both organizations should continue the implementation of the 2021-2023 grants as PRs. While some key respondents proposed MoH as the only PR in charge of all clinical interventions, the TTT considers this proposal as premature. CHAZ has not only been delivering predominantly excellent results, they also play an important role in mitigating risks related to MoH weaknesses.

The TTT concurs with key respondents that MoH and CHAZ are the two biggest implementers of health services in Zambia with decades of experience. Both PRs have been implementing Global Fund grants for several years, have improved their systems over the years, have working knowledge of the Global Fund expectations, and have shown evidence of their capability to deliver accordingly. CHAZ has been receiving A-level grant performance ratings, while MoH performance has been fluctuating between A2 and B1. The B1 grant ratings have usually been due to low performance on individual indicators, not an overall B1 performance. The TTT also saw positive trends for less performing indicators over time. While acknowledging weaknesses in some areas, the TTT members agreed that based on the overall PR performance there are no objections to the PRs continuing as such. It was also agreed that both organizations would be best suited as PRs to ensure the sustainability of the interventions and their impact.

10.2 Nomination of a third PR should not be considered

Since there has been a history of advocacy for a third PR, particularly for community based interventions, the TTT assessed the respective advantages and disadvantages of this course of action during the PR Assessment. With one exception all key respondents were of the opinion that the risks would outweigh the benefits. A third PR should bring in an additional skill set that none of the current or nominated PRs possesses. The TTT, while acknowledging some weaknesses in both nominated PRs, did not find significant competency gaps that would justify nominating a third PR.

10.3 Revise SR implementation arrangements

CHAZ has an outstanding history in community engagement and has achieved respectable results in their adolescents' projects. Considering the challenges that MoH encountered in engaging CBOs and the inadequate experience with respective programs, the TTT recommends to shift all CBO interventions with the exception of the KP interventions to CHAZ.

The TTT has reservations about the suitability of PPAZ in implementing KP interventions. The TTT is convinced that KP organizations are more effective in reaching out to KPs as they are usually run by KPs who know their peers, their attitudes and behaviors, as well as their hot spots and who enjoy the KPs' trust. The TTT recommends to recruit KP organizations to reach out to the various targeted KP groups and build their capacities over time.

10.4 Review the geographical scope of interventions

While key respondents pointed out the value of CHAZ in implementing ICCM in Southern, Eastern and North Western provinces, they share concerns on maintaining Eastern and Southern provinces during the 2021-2023 implementation period. In both provinces a number of other partner organizations assist the MoH in the malaria response, so that a certain saturation level is reached. The TTT therefore recommends to review the added value that CHAZ could provide to other provinces with a high malaria incidence that currently do not enjoy much partner support.

The HIV adolescent health projects are currently primarily implemented in lower prevalence areas, both at the level of CHAZ and MOH. During the subsequent grant these projects should be purely implemented in high prevalence areas for a higher impact. While particularly the CHAZ projects have achieved good results, surveys like DHS as well as key respondents indicate that there is no major impact on the national scale. Therefore, the TTT recommends to scale up respective efforts, preferably within existing systems in order to ensure sustainability beyond the currently available financing.

10.5 Advocate for the acceleration of the ZAMMSA transition / CHAZ to scale up procurement

One of the key issues the TTT **e**nquired about is the dual procurement, warehousing and distribution arrangements with both MoH and CHAZ playing a key role. Most stakeholders, including the Global Fund, consider these arrangements as advantageous to mitigate some of the PSCM risks.

The transition of MSL to ZAMMSA opens up new opportunities to better streamline the services. While it is desirable that ZAMMSA eventually fulfills its mandate to cover procurement, storage and distribution for all public health facilities, it is expected that a transition period is needed to build the necessary capacities and systems. Considering the challenges of MoH related to timely procurements, the TTT recommends to increase the CHAZ procurement share to reduce the risks of shortages and stock outs while accelerating the transition for ZAMMSA simultaneously. All organizations in charge of procurement shall make maximum efforts to maintain minimum stock levels at all time.

10.6 Advocate for GRZ to increase ownership and responsibility for financing the national responses for HIV/AIDS, TB and Malaria

Several stakeholders indicated GRZ has a bigger capacity to finance healthcare services. Donor funding reportedly distorts the public financing capacity of Zambia. GRZ should hence make increasing efforts to take up standard interventions of prevention, treatments and care. In the same context, the CCM shall

hold GRZ accountable for ensuring full and timely payments of the monthly grants to health facilities as well as MSL/ZAMMSA and for availing funds for procurements scheduled in the yellow book. Institutions shall be informed by MOF about any delays to guide their planning. These institutions play a pivotal role to ensure the health of entire nation, which is an important prerequisite for reducing poverty and promoting economic and social development.

10.7 Ensure that the new funding request addresses programmatic and other challenges

The TTT encountered a number of weaknesses as listed in the findings in this report that will however not affect the above recommendation. The PRs shall make maximum efforts to address these challenges as quickly as possible. The CCM Oversight Committee shall provide a regular follow up on the implementation of respective actions.

10.8 Review the 70% / 30% budget split between MoH and CHAZ

Historically, MoH and CHAZ have started off from a 70% / 30% budget split and situated their respective interventions within the resulting budget. The TTT recommends to deviate from this practice. The budget split should not be a starting point but strictly the result of implementation considerations based on core competences of either PR and their expected impact.

10.9 Prioritize interventions across the three diseases and revise the budget split accordingly

The CCM may agree with or revise the budget split for HIV, TB and malaria proposed by the Global Fund in the allocation letter. The TTT noted significant gaps in achievements related to core goals of the National Malaria Strategic Plan (Malaria elimination by 2021) despite the significantly higher funding in 2019-2021. The TTT hence fears that a reduced budget in 2021-2023 may widen the gap. While there may be the chance of additional funding through the PAAR, there is no guarantee that respective funding becomes available, how much will be allocated to Zambia and when. The strategy to rely on these additional funds appears risky to the TTT. The TTT therefore recommends to compare priorities across the three diseases in order to identify additional funds for the malaria response.

10.10 Ensure value for money invested in each intervention

Several stakeholders requested that Global Fund grants should be primarily used for catalytic, high impact interventions. The cost effectiveness of proposed interventions should be critically evaluated and compared, and emphasis should be strictly given to those more cost effective based on available evidence. In this context, stakeholders strongly recommend a stronger collaboration with PEPFAR, PMI and other partners to ensure that all programs are strictly complementary. Quality assurance processes shall be applied to ensure that interventions are implemented in such a way that maximizes impact.

More emphasis shall also be accorded to ensuring sustainability of interventions. Projects that are not realistically envisioned to achieve desired results during the grant period should be carefully evaluated to see if their implementation is cost-effective in case their continuation cannot be reliably assured. In the same context, projects shall be implemented as much as possible within existing systems to ensure their sustainability beyond the Global Fund support.

10.11 Enhance collaboration and communication with relevant MoH departments, other stakeholders and other sectors

Both PRs were reported as insufficiently reaching out to stakeholders and partners working in the same field, including relevant departments within the MoH, such as the 1) Community Systems Unit / Community Health, 2) Department for Health Promotion Environment and Social Determinants 3) Adolescent Health Unit, as well as other Ministries that could play an important role in the response to the three diseases, which do not only have medical implications. There is vast experience in these departments and sectors that should be leveraged for a higher impact in the programs. The potential of engaging the private sector in a targeted manner, e.g. for IRS or distribution of commodities, has hardly been exploited so far. While MoH feels that they do engage their SRs proactively, the SRs see room for improvement in terms of continuous communication and coordination. Similarly for CHAZ whose approach is perceived as secretive by different stakeholders, gaps in collaboration and communication may result in synergies not being exploited, redundant efforts and other implementation challenges.

Neither PR has fully complied with the Global Fund Standard Terms and Conditions according to which they are obligated to copy the CCM on all notices, requests, documents, reports, or other communication exchanges with the Global Fund and to provide program-related reports and information timely to the CCM upon request. As this information sharing is crucial for the CCM's functionality, the TTT strongly recommends redress these omissions and to improve on timeliness of feedback.

10.12 Improve data collection, reporting, and analysis both for DHIS and community HMIS

Data collection and reporting is related to a number of challenges: CHAZ is still using parallel reporting systems both in clinical and community settings, only few facilities report results for TB indicators using DHIS and the community DHIS is largely unused. It is known that there are additional challenges with data completeness and data quality. As data are the basis for decision making, the TTT considers addressing these problems as a key priority. In the same context, CHAZ needs to be granted access to HMIS data. M&E Officers shall enhance their capacities to not only present data in reports but to analyze them thoroughly.

11.ANNEX

11.1 Composition of the Technical Task Team

Members

Name	Status	Organization	Key competences
Mr. Lameck Kachali - Chair	Co-opted	GHSC-PSM	PSCM
Mr. Kennedy Chungu	OC member	ZANERELA	HIV and Key Populations
Ms. Rhoda Ohito	OC member	PEPFAR	Grant Management and HIV
Dr. Nanthalile Mugala	OC member	PATH	TB and Malaria
Dr. Christine Manyando	OC member	TDRC	Malaria
Mr. Groy Shauma	Co-opted	Associate Consultant	Human rights
Mr. Sibu Malambo	CCM member	ZYP	Adolescent and Youth
Mr. Lukwesa Kalumba	OC member	ZAPD	Community Systems
Ms. Theresa Kambobe	Co-opted	MOG	Gender
Ms. Kasonde Makumba	Co-opted	MOF	Finance
Ms. Mildred Miti	Co-opted	MCDSS	Social Economic
Dr. Stephen Mupeta	Co-opted	UNFPA	M&E
Mr. Solomon Kagulura	Co-opted	WHO	Health Systems Strengthening /Health Economist

CCM Zambia Secretariat

- Kaluswika Kakoma Kintu – CCM Program Officer Oversight
- Annekatrin El Oumrany – Integrated Expert

11.2 Key respondents

For confidentiality reasons, the identity of the key respondents shall not be revealed. The list is archived at the CCM Secretariat.

- PRs: MoH and CHAZ
- SRs: PHOs, DHOs, CBOs, FBOs
- Cooperating Partners : WHO, PEPFAR, USAID, PMI
- CCM Secretariat
- Local Fund Agent
- PLHIV on ART

11.3 Documents reviewed

The following documents were provided to the TTT for their desk review:

Category	Documents shared (39 files)
Performance frameworks and budgets	• Latest performance frameworks for both PRs (4 files) • Grant budgets for both PRs (4 files)
Grant agreements	• Grant agreements for both PRs (4 files)
NSPs and reports	• Current National Strategic Plans for each disease component (3 files) • Midterm Review Reports for each disease component (3 files) • MSL Strategic Plan (1 file) • EMTCT and Syphilis National Plan
Grant performance	• Q3/2019 reports of both PRs to the CCM (6 Excel and PPT files) • December and January stock reports (2 files) • Global Fund Jan-June 2019 Management letters to both PRs (4 files) • 2017 OIG report (1 file) • 2017 OIG MSL investigation report (1 file) • TB DQA report (1 file)
Epidemiological data	• HIV Knowledge, Attitudes, and Behaviours / ZDHS 2018 (1 file) • HIV prevalence in Zambia / ZDHS 2018 (1 file) • 2019 Malaria incidence (1 file)
Implementation arrangements	• Initially proposed implementation arrangements (2 files) • Overviews on MoH and CHAZ SRs (2 files) • Key population implementation arrangements (1 file)
Other	• Global Core CSS Framework (1 file) • ZAMMSA Act 2019 (1 file)

11.4 Confidentiality agreement

CONFIDENTIALITY AGREEMENT

This confidentiality agreement is made between …… [name TTT member or CCM Secretariat member facilitating this TTT] (both hereon referred to as the "TTT Member") and the CCM Zambia (hereon referred to as the "CCM-Z").

The TTT Member agrees to the terms of this agreement:

1. The TTT Member acknowledges that, in the course the CCM-Z PR Assessment, the TTT Member has, and may in the future, come into the possession of certain confidential information belonging to the CCM-Z, Ministry of Health, CHAZ, or the various key respondents contacted.

2. The TTT Member hereby covenants and agrees that he or she will at no time, during or after the time of the PR Assessment, use for his or her own benefit or the benefit of others, or disclose or divulge to others, any such confidential information.
3. The TTT Member commits to protect the identity of all key respondents, including SRs, at all time regardless of any request for clarification from the PR(s).
4. The TTT member commits to keep confidential the views, statements, and recommendations of other individual TTT and CCM Secretariat members at all time.
5. The TTT member understands himself/herself and other TTT members as part of a team and assumes collective responsibility.
6. The TTT Members may disclose confidential information solely for the purpose of reporting or investigating a suspected violation of applicable law; however, he or she is strongly encouraged to discuss such proceedings with the CCM Chair and/or the TTT upfront.
7. Upon termination of the PR Assessment, the TTT Member will return to the CCM-Z all documents obtained during the said Assessment.
8. Violation of this agreement by the TTT Member will entitle the CCM-Z to an exclusion of the TTT member from current and subsequent CCM-Z activities.

Signed at **CHONGWE**, **WATERFALLS HOTEL**:

This …… day of March 2020; Signature: _____

11.5 Conflict of Interest declaration

Conflict of Interest Declaration Statement and Form for Members of the CCM-Z Technical Task Team for PR Assessment

I, _____ (name), agree to comply with the CCM-Z Ethics and Conflict of Interest (ECoI) Policy and CCM-Z-related policies, guidelines and procedures.

I certify that I have read and understood the ECoI Policy and will adhere to it. I will declare immediately to the Chair of the Technical Task Team (TTT) for PR Assessment any real, potential, or perceived conflict of interest on a particular issue during relevant meetings or at any other time in the workings of the TTT. I will seek clarification and any further responses to questions that I might have regarding the interpretation of these ethics guidelines or other conflict of interest matters.

As a member of this TTT, I shall not discuss, advocate, or vote on any matter in which I have a real, potential, or perceived conflict of interest or an interest which reasonably might appear to be in conflict with the concept of fairness in dealing with the business of the Zambia GF programs. In such a case, I will state the nature of the conflict, and follow directions of the TTT Chair that may involve recusal from any TTT discussions, decision making or TTT meetings concerning the matter in question or discontinuation of my work on the TTT depending on the severity of the issue.

I confirm that if I violate this provision, the CCM-Z will take appropriate measures outlined in the policy which may include suspension or discontinuation of my work in the TTT, in other CCM-Z committees or of my membership in the CCM-Z.

I also acknowledge that I am obliged to raise any conflict of interest I may be aware of amongst other members of the TTT to safeguard the reputation of the CCM-Z and ensure that it conducts business in a balanced and transparent manner, as well as adhere to ethical standards.

In keeping with the above principles and those further stated in the Ethics and Conflict of Interest Policy, I hereby declare as follows for the current year [tick the appropriate box]:

□ I do not have any foreseeable conflict of interest that relates to the functions and operations of TGF grants in Zambia.

Alternatively,

□ I have or may have conflict of interest in the functions and operations of TGF grants in Zambia, as listed below (please tick as appropriate):

I am personally affiliated with	A close relative or friend is affiliated with	The organization I am working for or with is affiliated with
□ MoH	□ MoH	□ MoH
□ MoH SR	□ MoH SR	□ MoH SR
□ MoH SSR	□ MoH SSR	□ MoH SSR
□ CHAZ	□ CHAZ	□ CHAZ
□ CHAZ SR	□ CHAZ SR	□ CHAZ SR
□ CHAZ SSR	□ CHAZ SSR	□ CHAZ SSR

TTT MemberName, Organization, Email address and cellphone:_____
I hereby certify that I have read the Ethics and Conflict of Interest Policy and, as a CCM-Z TTT member, I will act in accordance with the norms and standards set therein.

Date and signature:_____

Witness name, address and cell phone:_____
Witness signature:_____

11.6 TTT PR Assessment Road Map

Activity	No of Days/ Date	Details
Kick off meeting	9th December2019 (1 day)	• Strategize on Q1 TTT activities • Review documents/reports performance of PRs 2018 - 2019 • Review TTT ToR's and roadmap • Member roles and membership constituted • Identify documents for desk review
Orientation for new TTT members	8th January 2019 (1/2 day)	• Orient four TTT members on GF budgets, PF and CCM performance reviews
Share desk review documents with the TTT members	December 2019–April 2020	• Ongoing desk review
Retreat 1	22nd / 23rd January 2020 (2 days)	• Conflict of interest and Confidentiality agreement • Elect the TTT chairperson • Define interview needs (tools, list of interviewees)
Preparation of interviews	February 2020	• Finalize question guide • Send official letter with question guide to the PRs • Desk review ongoing
Retreat 2	2nd/ 3rd March 2020	• Desk review ongoing • Finalize interviewee list • Fine tune questions guides to interviewee category
Interviews of current PRs and SRs, Cooperating Partners, service beneficiaries Desk reviews on going for all TTT members	2nd March – 5th May2020	• CHAZ • MoH / PMU • Community Health and Health Promotion Dept of MoH • MSL • ART Clients (Beneficiaries) • DHOs (Vubwe and Petauke) • PHOs (Lusaka and North Western) • NAC • WHO • PMI • USAID • PEPFAR • CCM Secretariat • LFA

Activity	No of Days/ Date	Details
Retreat 3 / Core team	18th May 2020 (1 day)	• Review and consolidate TTT findings • Determine recommendations to be provided to the CCM
Report shared with CCM, PRs and other partners	25thMay 2020	• Share report
CCM Adhoc Meeting	TBA	• Present summary of findings to the CCM

11.7 Question guides

A. Guiding questions for both PRs (MoH and CHAZ)

1. Where do you see the core competences of MoH and CHAZ in the context of the grant implementation? In which areas either of the organizations should play a stronger role? Please comment on your organization and the other PR.
2. Which are the PRs' biggest weaknesses? How does your organization proactively address these weaknesses? Which other support may help you to overcome these weaknesses? In which areas each of the organizations needs to step up the game or should possibly outsource the interventions? Please comment on your organization and the other PR.
3. Explain the rational through which the grants were split up between MoH and CHAZ. What worked well and should be sustained? What would you do differently with today's experience and knowledge? How is mapping organized?
4. What are the pros and cons of the dual procurement and distribution system? How do you expect the new ZAMMSA Act to affect these arrangements?
5. What measures did you put in place to proactively address challenges related to low performance? For which areas does your organization have written improvement plans?
6. What is needed for effective and sustainable prevention of HIV/TB and malaria? Which organizations would be most suitable to implement prevention interventions?
7. Explain to which extent low performance for specific indicators could be improved by different implementation arrangements (e.g. stronger role of the other PR, partial or full implementation by SRs or different SRs).
8. Based on what criteria did your organization select your SRs and treatment sites? Why does CHAZ have treatment sites as SRs for HIV/TB and not malaria?
9. What were your organization's experience with SR management? Also consider challenges that may be related to the big number of SRs.
10. How are the CBO and FBO results and impact measured? How are the CBO/FBO SRs guided to improve their performance? Which were the challenges your organization encountered? Which were the lessons learned (if your organization had to decide on SR arrangements today, what would you do differently?)

11. Which is the rational of having PHOs and DHOs as SRs compared to PHOs being SRs and DHOs being SSRs? Can you think of a more effective/efficient way of managing the large numbers of PHOs and DHOs?
12. Considering the large number of SRs, how does your organization prevent misuse of funds at their level?
13. What would you consider as advantages/opportunities and disadvantages/risks of having a third PR in charge of community based interventions?

A1 Guiding questions for MoH

1. Why did it take more than 1.5 years to contract the CBOs and another three months to disburse the funds to them? What is being done to address the long lead times and what is a realistic lead time for the processes in the next grant?
2. What is the reason for the CBOs not being managed under NAC?
3. Considering the low retirement rates of PHOs/DHOs and their low budgets, which other alternatives can you think of to engage them (does it make sense to have SRs with such low budgets?)

A2 Guiding questions for CHAZ

1. Why does CHAZ have treatment sites as SRs for HIV/TB? Why does CHAZ have SRs receiving treatment in districts where MoH is also present?
2. What were the reasons that not all CSOs and FBOs were managed by the lead CSOs? Is one or more of the organizations capable to coordinate all CSOs and FBOs as SSRs?
3. Which percentage of CSOs and FBOs really delivered on your expectations? Could they scale up geographically? Based on which criteria are you going to decide if and under which conditions the others continue?

B. Guiding questions for MSL

1. What are the pros and cons of the dual procurement, storage and distribution system (CHAZ/MoH-MSL)?
2. How do you expect the new ZAMMSA Act to affect these arrangements?
3. What advantages does CHAZ have in
   a) Warehouse management
   b) The implementation of last mile distribution?
4. How can it be ensured that MSL has the resources necessary to professionally manage last mile distribution?
5. Which solutions can you think of to improve the financing situation of MSL?
6. What are the plans for the engagement of private third party providers of warehousing and distribution solutions? How are these expected to affect the current dual distribution system?
7. On a scale of 1-5 (5 being) best, how would you rate each PR on
   a. Clarity of expectations

b. Quality and frequency of communication:
c. Proactive addressing of challenges emerging from performance reports:
d. Timely and effective assistance in cases of challenges communicated to the PR

Probing questions: Give an example / Why / What was missing / trends over time / How could the PR do better?

8. How are MSL results and impact measured?
9. How does the PR review MSL performance and provide feedback? Give a few examples on how the PR helped to address challenges within your organization.
10. How often does the PR usually interact with MSL per quarter?
11. Does MSL find challenges in retiring disbursed funds to the PRs?
12. How did the PR prepare MSL in preventing the misallocation of funds?
13. Which are the PRs' biggest weaknesses in managing MSL? What could the PRs do better in order to address the observed weaknesses?

C. Guiding questions for Community Health Department of MoH

1. % of 2020 health budget that goes to community health systems? Is there a recommended standard?
2. How is her unit involved in GF implementation? In which areas could they play a stronger role?
3. How does her unit interface with community organizations and structures? How do the community health structures (CHAs) with CBOs?
4. What is the coverage and functionality of community based structures for health? And their impact?
5. How do supported facilities including Community Health Structures feed information into the National HMIS? Which are missing indicators? How are the data used for decision making?
6. How are the social economic/ cultural determinants in HIV/TB/Malaria are taken into consideration in the programs?
7. What is currently being done in terms of socio-behavioral change communication? Are there any impact analyses? How are gaps being addressed?
8. Which organizations at community level would be most suitable to implement KP interventions?
9. What caused the delay of the recruitment of CBOS? What support is needed to accelerate the recruitment process for CBOs?
10. Which strategies would enhance the impact of TB case finding in the communities? To which extent would these enhance the numbers?
11. What would be the pros and cons of combining all/most CBO SRs under one PR?
12. Attrition rates for CHAs? Strategies for retention of CHAs? Same for CBVs.
13. Which additional interventions are necessary to strengthen community systems?
14. Is there anything else that that has not been mentioned but is considered as important and relevant?

D. Guiding questions for SRs

1. Where do you see the core competences of (PR) in the context of managing the SR organizations?

2. How did you become aware of this funding opportunity? How organized, fair, and transparent did you perceive the selection process? How could the selection process be improved?
3. On a scale of 1-5 (5 being) best, how would you rate your PR on
    a. Clarity of expectations
    b. Quality and adequacy of initial training
    c. Quality and frequency of communication
    d. Proactive addressing of challenges emerging from performance reports
    e. Timely and effective assistance in cases of challenges communicated to the PR

    Probing questions: Give an example / Why / What was missing / trends over time / How could the PR do better?
4. How are the SR results and impact measured?
5. How does the PR review SR performance and provides feedback? Give a few examples on how the PR helped to address challenges within SR organizations.
6. Does the PR encourage / initiate an exchange amongst SRs? How?
7. How often does the PR usually interact with the SR per quarter?
8. What are the challenges for timely retirement of funds?
9. How did the PR prepare the SRs to prevent misuse of funds?
10. Which are the PRs' biggest weaknesses in managing its SRs? What could the PR do better in order to address these weaknesses?
11. Any other recommendations for the PR?

D1 Questions for PHOs and DHOs

1. How do you think being a GF SR changes the way of implementation or management of the grant?
2. What is the rational of having PHOs and DHOs as SRs compared to PHOs being SRs and DHOs being SSRs?
3. Considering the low retirement rates of PHOs/DHOs and their low budgets, which other alternatives can you think of to engage them (does it make sense to have SRs which such low budgets?)?
4. Can you think of a more effective/efficient way of managing the large numbers of PHOs and DHOs?
5. What are the advantages and disadvantages to implement the GF grants for both MoH and CHAZ compared to combining all interventions in one grant?

D2 Guiding questions for NAC

1. What do you think is the reason for the CBOs not being managed under NAC?
2. What would be the advantages and disadvantages of NAC managing SRs currently under CHAZ and MoH?
3. What would you consider as advantages/opportunities and disadvantages/risks of having a third PR in charge of all community based interventions?

D3 Guiding questions for CSO/FBO SRs

1. What would you consider as advantages/opportunities and disadvantages/risks of having a third PR in charge of all community based interventions?
2. MoH CSOs only: When did you become aware of this funding opportunity and when were you finally contracted? Which processes happened in between? How were you informed about the status quo of the selection process?
3. Only CHAZ lead CSOs/FBOs:
   a) On a scale of 1-5 (5 being best), how did the PR prepare your organization to manage a large number of SSRs? How could some of the challenges have been avoided?
   b) What do you think is an ideal number of SSRs per SR and why?
   c) Do you know the reasons why not all CSOs and FBOs are managed by the two lead CSOs?
   d) How many CSOs and FBOs really delivered on your expectations? How many of them could scale up geographically?

E. Guiding questions for Cooperating Partners

Ensure that the CP replies in respect of programmatic, PSCM, RSSH, management and financial aspects

1. In which areas relevant to the GF does your organization closely collaborate with MoH and/or CHAZ?
2. Where do you see the core competences of MoH and CHAZ in the context of the grant implementation? Please comment separately on each of the disease areas.
3. To which extent do you observe the PR to make strictly evidence based decisions?
4. What do you think about the roles of MoH and CHAZ respectively / grant split up between the two organizations?
5. In which areas do you think the two organizations have unused / insufficiently used potential where they could and should step up the game?
6. Which are the PRs' biggest weaknesses? Do you see them proactively addressing these weaknesses? Which other support may help them to overcome these weaknesses? In which areas each of the organizations should possibly outsource the interventions?
7. Are the programs targeting the right geographic locations, e.g. through health facilities (CHAZ) and CBOs/FBOs?
8. Which other organizations should be engaged to improve TB case finding results?
9. What are your experiences with the current PRs in terms of effective and efficient use of funds? What are your experiences with misuse of funds at PR level within the past 2-3 years?
10. What are the pros and cons of the dual procurement and distribution system (CHAZ/MSL)? How do you expect the new ZAMMSA Act to affect these arrangements?
11. How can it be ensured that MSL has the resources necessary to professionally manage last mile distribution?
12. How strong do you think are the PRs in terms of HSS and CSS?
13. How effective are the current prevention efforts in the communities undertaken by the PRs? What is needed for effective and sustainable prevention of HIV/TB and malaria? Which organizations would be most suitable to implement prevention interventions?
14. Which role should the CSOs/FBOs play in each of the disease areas in the light of effective and sustainable interventions? Which interventions, currently mostly implemented by CSOs/FBOs should be rather taken up by the current PRs?

15. Which challenges have you experienced with the SR selection, both in terms of processes and the organizations selected?
16. Can you think of different implementation arrangements that could help to improve low performance for specific indicators (e.g. stronger role of the other PR, partial or full implementation by SRs or different SRs).
17. From what you observed, how would you rate the PRs' capacities to manage their SRs effectively on a scale from 1-5 (5 being best)?
18. What do think is the maximum number of SRs that a PR can realistically and effectively manage? Can you think of any potentially more effective SR implementation arrangements?
19. What would you consider as advantages/opportunities and disadvantages/risks of having a third PR in charge of community based interventions?
20. From your experiences, which other organizations have the capacities to be engaged as SR or PR?

E1 Questions on PSCM

1. What are your views regarding both CHAZ and MoH/MSL procuring, storing and distributing commodities under the same grant (competence CHAZ/MSL in warehouse management and LMD, transparence)?
2. How do you expect the new ZAMMSA Act to affect these arrangements?
3. How can it be ensured that MSL has the resources necessary to professionally manage last mile distribution?
4. Which solutions can you think of to improve the financing situation of MSL (e.g. conditional funding)?
5. If sufficient funding was available, to which extent would MSL be capable to run storage and distribution effectively alone for the entire country?
6. On a scale of 1-5 (5 being) best, how would you rate CHAZ and MoH on
    a. Clarity of expectations:
    b. Quality and frequency of communication:
    c. Proactive addressing of challenges emerging from performance reports:
    d. Timely and effective assistance in cases of challenges communicated to the PR:
    e. Capacity to manage MSL effectively:

    Probing questions: Give an example / Why / What was missing / trends over time / How could the PR do better?
7. How does the PR review MSL performance and provide feedback?
8. How do the PRs prepare MSL in preventing the misallocation of funds?
9. Which are the PRs' biggest weaknesses in managing MSL? What could the PRs do better in order to address the observed weaknesses?
10. What are your opinion about the forecasting and quantification processes?

F. Guiding questions to the LFA and CCM Secretariat

1. Where do you see the core competences of MoH and CHAZ in the context of the grant implementation? (To consider HSS and CSS).

2. In which areas either of the organizations should play a stronger role? What do you think are the gaps in the grant implementation that need to be covered for an effective and sustainable response? To which extent would you say the PRs make strictly evidence-based decisions (If SR issues are raised, proceed to Q 11-14)
3. Which are the PRs' biggest weaknesses (both programmatic and PR admin/support functions)? What are your experiences with the PRs identifying and addressing these challenges proactively? For which of these weaknesses may the PRs need external support to overcome them? Which support is needed?
4. What are the strengths and weaknesses of the PMU? How should the role of the PMU evolve during the next grant cycle? (*Consider SR issues, proceed to Q 11-14*)
5. (LFA only)MoH and CHAZ have had a budget split of 70/30 for over the years. With your today's experience of the grant implementation, which changes to the budget split would you propose?
6. **(**LFAonly) What are your experiences with misuse of funds at PR level within the past 2-3 years? On a scale of 1-10, how well do the PRs take value for money into consideration for their investment decisions? What practical steps would you recommend in order to ensure better value for money?
7. Reprogramming seems to take a long time. What could be done to accelerate the reprogramming process?
8. What are the pros and cons of procurement, storage, and distribution done by both MoH and CHAZ? If MSL was appropriately funded, do you think that they have the capacity to manage warehousing and distribution to all public health facilities? Which challenges for the current supply chain operations do you anticipate during the transition to ZAMMSA?
9. Explain to which extent low performance for specific indicators could be improved by different implementation arrangements (e.g. stronger role of the other PR, third PR, partial or full implementation by SRs or different SRs)? What do you think about an engagement with the private sector for specific interventions?
10. What are the strengths and weaknesses of both MoH and CHAZ in selecting, managing and coordinating their SRs?
11. Do you have insight into SR performance? What do you think about the SR arrangements? (high number of SRs per PR, many organizations are SRs and could theoretically be SSR)? Which changes would you propose to the SR/SSR arrangements? If so, what are your thoughts about the SR capacity and impact?
12. To which extent do you think the PRs are currently targeting the right geographical locations through their SRs? Would you recommend changes and if so what would those changes be?
13. On a scale from 1-10, how would you rate both PRs on
    a) Coordination of grant implementation
    b) Pro-activeness
    c) Communication (with partners (incl. LFA and GF) and SRs)
    d) Accountability
    e) Transparency / sharing of information
    f) Collaboration efforts (e.g. other departments at MoH, other stakeholders)
    g) SR management
    h) Punctuality with submissions of reports
    i) Quality of reports
    j) Value for money

14. Which measures should be put in place to ensure that GRZ honors its co-financing agreements, e.g. procurement of commodities, funding of MSL, etc.?
15. Do you have any additional information that you consider as relevant for the PR assessment?