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2012 ANNUAL REPORT

GLOBAL FUND GRANTS IN ZIMBABWE



31 May 2013

LIST OF ABBREVIATIONS

ACADA	:	Communication, Analysis, Design and Action
ACT	:	Artemisinin Based Combination Therapy
ANC	:	Antenatal Care Clinic
APTP	:	Intermittent Preventive Therapy in pregnancy
BCC	:	Behaviour Change Communication
CHAI	:	Clinton Health Access Initiative
CHWs	:	Community Health Workers
DDT	:	Dichlorodiphenyl-trichloroethane
EPR	:	Epidemic Preparedness and Response
GFATM	:	Global Fund to Fight Aids, Tuberculosis and Malaria
HMIS	:	Health Management Information System
HWs	:	Health Workers
IDSR	:	Integrated Disease Surveillance and Response
IPT	:	Intermittent Preventive Treatment
IPTp	:	Intermittent Preventive Treatment of Pregnant Women
IRS	:	Indoor Residual Spraying
ITNs	:	Insecticide Treated Nets
JSI	:	John Snow Inc
LPAC	:	Local Project Appraisal Committee
LLIN	:	Long Lasting Insecticidal Treated Nets
MCHIP	:	Maternal and Child Health Integration Programme
M&E	:	Monitoring and Evaluation
MIS	:	Malaria Indicator Survey
MOHCW	:	Ministry of Health and Child Welfare
MPR	:	Malaria Programme Review
MSSF	:	Malaria Single Stream of Funding
NatPharm	:	National Pharmaceutical Company of Zimbabwe
NFA	:	Nets for Africa
NMCP	:	National Malaria Control Programme
OSDV	:	Onsite Data Verification Exercises
PMI	:	Presidential Malaria Initiative
PSI	:	Population Services International
PR	:	Principal Recipient
RBM	:	Roll Back Malaria
RDT	:	Rapid Diagnostic Testing
RTI	:	RM International
SADC	:	Southern African Development Community
SDAs	:	Service Delivery Areas
SSF	:	Single Stream Funding
SP	:	Sulphadoxine Pyrimethamine
SRs	:	Sub-Recipients
TZMI	:	Trans-Zambezi Malaria Initiative
TORs	:	Terms of References
TOT	:	Training of Trainers WDSS
WDSS	:	Weekly Disease Surveillance System
UMCOR	:	United Methodist Committee on Relief
UNDP	:	United Nations Development Programme
UNICEF	:	United Nations Children's Fund
WHO	:	World Health Organization
ZAM-ZIM CBMI	:	Zambia and Zimbabwe Cross-border Malaria Initiative
ZNMCPs	:	Zimbabwe National Malaria Control Programme Strategy
ZMCSP	:	Zimbabwe Malaria Control Strategic Plan

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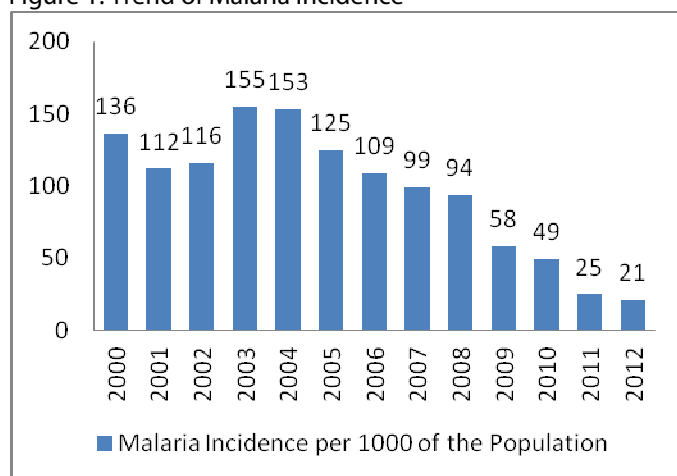
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10 INTRODUCTION

Malaria remains a major health burden especially for developing countries despite the fact that it is an entirely preventable and treatable disease. According to the 2012 World Malaria Report, globally, an estimated 3.3 billion people were at risk of malaria in 2011, with populations living in sub-Saharan Africa having the highest risk of acquiring malaria. Africa alone contributes 80% of cases and 90% of deaths, with children under five years of age and pregnant women being most severely affected.

In Zimbabwe, malaria is a major public health problem and is the third leading cause of morbidity and mortality in the country. About half of the population of 12,973,808 million (*2012 Preliminary Population Census*) is at risk of contracting malaria infections annually.

Figure 1: Trend of Malaria Incidence



There has been a significant decrease in malaria incidence in the country over the last decade as shown in figure 1. Malaria transmission has been falling in the country partly due to increased access and availability of effective anti-malarial drugs, bed nets, and other vector control interventions. The scale-up of these interventions has been mainly due to increased domestic and international resources towards malaria control and prevention in the country. In the past 3 years, international resource flows for malaria control interventions in Zimbabwe amounts to over 90 million American Dollars, whilst Government resources, excluding staff costs and other capital expenditures amounted to over 3.4 million American Dollars. Despite concerted efforts which include a growing partnership and stakeholder base (Global Fund, PMI, PSI, Plan International, CHAI, UMCOR, UNICEF, UNDP, Private Sector, MCHIP, JSI, RTI), malaria continues to be a major public health threat with unrelenting transmission in significant vast areas of the country. Although the current available interventions have significantly reduced malaria related morbidity and mortality, implementation has been met with various persistent challenges which include insufficient funding, shortage of Health workers, unstable economic climate and the growing threat of insecticide resistance (Munhenga et al. 2008).

1.1 Background of Malaria Prevention and Control in Zimbabwe

1.1.1 Malaria Epidemiology

Malaria Parasites and Vectors

As in most African countries the predominant malaria parasite in Zimbabwe is *Plasmodium falciparum* which accounts for 98% of all reported malaria cases. *Plasmodium ovale* and *Plasmodium malariae* account for the remainder. The *Anopheles arabiensis* is the major vector for malaria

transmission. It rests both outdoors and indoors and feeds both on humans and animals both indoors and outdoors making it difficult to eliminate by IRS. *Anopheles merus* and *Anopheles funestus* occur sporadically and may be involved in malaria transmission in isolated incidences (Munhenga et al, 2008). The most abundant species of the *Anopheles Gambiae* complex in Zimbabwe is the *Anopheles quadriannulatus* which feeds mainly on cattle and is not a vector of malaria but coexists with *Anopheles Arabiensis*. This co-existence underlines the importance of species identification to guide targeted malaria vector control.

Malaria Transmission

Zimbabwe is generally an unstable malaria transmission country, however there are low lying districts with stable transmission and a few high lying districts with no local malaria transmission (see fig 2). In total, 45 of Zimbabwe's 61 districts have conditions that support moderate to high transmission. These districts cover large geographical areas and a range of epidemiological strata, so malaria control is targeted to the ward level to allow for more accurate matching and targeting of interventions to the epidemiological profile of malaria; as such 476 wards with approximately 3.2 million people are targeted for malaria activities. The highest transmission occurs along international border areas, especially in the North (Zambia) and the East (Mozambique). The borders to the West (Botswana) and South (South Africa) support little transmission but are epidemic prone. The central highlands area is largely malaria free.

Malaria stratification last took place in 2002 (Fig2) and plans are already underway to re-stratify the country taking into account the recent changes to the malaria picture as reflected in the recent malaria transmission pattern (Fig 3) based only on malaria incidence.

Figure 2: Distribution of Malaria Burden In Zimbabwe (2002)

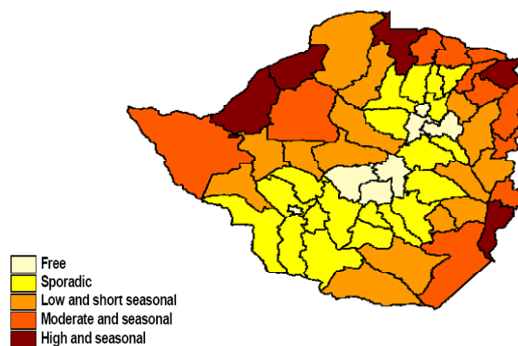
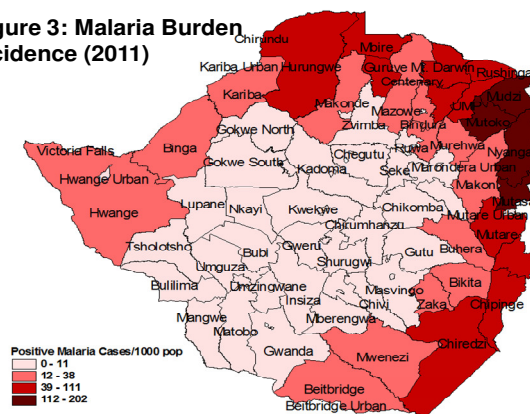


Figure 3: Malaria Burden Incidence (2011)



1.1.2 National Malaria Control Program Description

The vision of the National Malaria Control Programme (NMCP) is to have a malaria free Zimbabwe and in a bid to achieve a malaria free Zimbabwe, the NMCP is guided by the (2008-2015) Zimbabwe Malaria Control Strategic PLAN (ZMCSP). The overall goal of the strategic plan is to reduce the malaria incidence from 95/1000 in 2007 to 15/1000 by 2015 and malaria deaths to near zero by 2015.

In its life span, the strategic plan has been revised twice in response to the changing malaria epidemiology and programme management operating environment. The mid-term review and extension of the strategic plan were conducted in March 2012 and February 2013 respectively. The extension of the current ZMCSP was to align it to the overall Zimbabwe National Health Strategy which ends in 2015. The strategic plan is aligned with the Roll Back Malaria (RBM) 2010 targets for achieving universal access of key interventions and the 2015 Millennium Development Goals.

The strategic plan sets forth seven key objectives with targets that are planned to be achieved by the year 2015. The objectives are as listed,

1. To ensure universal access of the population at risk to effective and appropriate malaria prevention interventions by 2015
2. To ensure access to prompt and appropriate management of all malaria cases within 24 hours of onset of symptoms by 2015
3. To detect 100% of epidemics within one week of onset and effectively manage 100% of malaria epidemics within two weeks of detection
4. To expand district implementing malaria pre-elimination from 7 to 15 by 2015.
5. To increase utilisation of correct malaria prevention and control measures to at least 80% by 2015.
6. To strengthen monitoring and improve evaluation of malaria activities at all levels.
7. To expand and maintain strong multi sectoral partnerships for effective program management and coordination

In order to meet the objectives set forth in the strategic plan the NMCP employs sound strategies and implements activities in a timely and coordinated manner.

1.1.2.1 Malaria Prevention Interventions

Vector Control

The strategy aims to achieve universal access to malaria prevention interventions by scaling up Indoor Residual Spraying (IRS) and Insecticide Treated Nets (ITNs) to cover at least 95% of the population in moderate to high transmission areas by 2015. IRS is the mainstay of malaria prevention in the 45 moderate and high transmission districts. According to the end of programme Vector Control reports in the 2012 IRS season the country protected 88% of the population at risk residing in the 45 districts.

As part of vector control strategies the country uses ITNs/LLINs in the 30 districts where malaria transmission is high. High coverage rates of ITNs are essential in order to realise the full potential of vector control, in this regard, the programme targets to give all people at risk ITNs. Since 2010, the country has distributed more than 1,8 million Long Lasting Insecticide Nets (LLINs) and the recent 2012 Malaria Indicator Survey (MIS) showed that only 46.4% of households owned at least 1 LLIN/ITN, reflecting a huge gap in ownership of ITNs/LLINs. In order to achieve higher vector control coverages the country combines IRS & ITNs/LLINs in the 30 districts.

The programme also implements larval control in breeding sites usually in the winter period mostly using bio-larvicides.

Intermittent Preventive Treatment of Pregnant Women (IPTp)

Malaria in pregnancy is a common cause of severe maternal anaemia and low-birth-weight babies, and in non-endemic areas it is associated with extreme high risks of both maternal and peri-natal mortality. With the above facts in mind, the programme aims to prevent malaria at all costs in pregnant women living in the 30 moderate to high malaria transmission districts by providing a minimum of 2 doses of Intermittent Preventive Treatment (IPT) to at least 80% of women attending antenatal care clinics (ANC). The recently concluded 2012 MIS showed that only 35.3% of pregnant women were receiving the recommended Intermittent Preventive Treatment of Pregnant Women (IPTp). Coverage of IPTp is very low due to various reasons which include erratic supplies of *Sulphadoxine Pyrimethamine* (SP), delayed attendance to 1st ANC and low attendance to 2nd and 3rd ANC. There is need for a concerted effort to improve the coverage of IPT among the target population to at least 80% by 2015.

1.1.2.2 Case Management

Prompt access to effective malaria treatment is central to the success of malaria control worldwide (Chuma et al, 2010). WHO recommends that all persons of all ages in all epidemiological settings with suspected malaria should receive parasitological confirmation of diagnosis by either microscopy or rapid diagnostic testing (RDT), and that uncomplicated malaria should be treated with Artemisinin Based Combination Therapy (ACT). Currently the programme is implementing the T3: Test, Treat and Track and aims to ensure that at least 85% of all suspected malaria cases receive appropriate management within 24 hours by 2015. There is, however, more emphasis on Testing and Treatment than on Tracking.

The 2011 Case Management Audit report showed a testing rate of 86.5% amongst malaria suspected cases attended to at health facilities. Over all, Health Facilities maintained above 85% testing rate in throughout 2011. The testing rate of suspected cases attended to by CHWs is essential but has not yet been determined.

The programme has witnessed a gradual improvement in prompt management of suspected malaria cases within 24 hours. The proportions of suspected malaria cases receiving management within 24 hours rose from 40% in 2009 to 67% in 2010 and according to the 2011 Case Management Audit 81.4% of patients with uncomplicated malaria were treated according to the national treatment guidelines. Eighty nine percent of severe malaria cases were appropriately managed according to the national treatment guideline in 2011.

In order to support delivery of prompt early treatment to malaria cases the programme places emphasis on Community Case Management of malaria using Community Health Workers (CHWs). The programme has since 2010 years scaled-up training of both CHWs and Health Workers (HWs) in Case Management in order to ensure quality management of malaria cases, between 2008 and 2011, 7,478 HWs and 2,983 CHWs were trained in Malaria Case Management.

1.1.2.3 Malaria Epidemic Control

As highlighted earlier, the epidemiological nature of malaria in Zimbabwe is such that epidemics are not uncommon. Therefore as one of its objectives, the strategic plan aims to ensure that all epidemics are detected within a week of onset and effectively controlled within 2 weeks. Eighty Seven percent (1,165/1,342) of health facilities from the rural provinces were capacitated with cell phones to enhance completeness and timeliness of the Weekly Disease Surveillance System (WDSS). As a result the WDSS completeness has increased from 31% in 2009 to 68% in 2011. Nationally, 1,200 health workers have been trained in Integrated Disease Surveillance and Response (IDSR). Epidemic Preparedness and Response (EPR) guidelines were produced and distributed to Health Facilities in 2011. In view of early detection of epidemics, districts have updated malaria epidemic thresholds which are currently in use. However, in the future if the ongoing trend of a declining malaria incidence is maintained towards elimination, then it becomes more crucial to have epidemic forecasting and warning systems as part of the tools to enhance management of epidemics.

1.1.2.4 Momentum towards Malaria Pre-elimination

The 2011 Malaria Programme Review (MPR) noted a decline in malaria incidence in the country and that a significant number of districts, especially those in the central part of the country, have significantly decreased incidence to such levels that they can be considered for reorientation from malaria control towards pre-elimination (Fig 3).

The start of the Malaria Single Stream of Funding (SSF) Grant in April 2012 kick-started reorientation of 7 districts in Matabeleland South Province from malaria control towards pre-elimination. The programme has been developing capacity within the province to effectively implement pre-elimination activities through training of HWs and CHWs and through building efficient and proactive Malaria Surveillance and Data Management Systems. In order to enhance surveillance of the disease, in Matabeleland South Province, malaria is now classified as a notifiable disease.

In addition to the 7 districts in Matabeleland South Province, the programme aims to orient 8 more districts from other provinces towards malaria pre-elimination by 2015.

1.1.2.5 Enhance Utilisation of correct malaria prevention and control measures

As stipulated in the strategic plan the programme aims to increase utilisation of correct malaria prevention and control measures to at least 80% by 2015. Behaviour Change Communication (BCC) is a vital means of increasing correct knowledge and promoting the correct use of available malaria prevention and control measures. The national malaria BCC strategy uses the Assessment, Communication, Analysis, Design and Action (ACADA) planning model to maximize stakeholder participation in development and implementation of communications. The operational framework includes advocacy, social mobilization and programme communication through community participation. The 2012 MIS showed that 74.9% of the population know that fever is a common and key symptom of malaria; there has been an increase in knowledge when compared to the 2008 MIS which showed knowledge level of 65.4%. Knowledge levels about the effectiveness of key vector control (IRS & ITNs) interventions are very low amongst the population. The results from the 2012 MIS show that only 16.9% and 38.3% of the population know that IRS and ITNs are effective malaria prevention interventions respectively. There is a need to intensify BCC in order to increase utilisation of these effective and efficacious interventions.

1.1.2.6 Strengthening Monitoring and Evaluation

The NMCP has a Monitoring and Evaluation (M&E) Plan that monitors and evaluates the activities that have been set out in the strategic plan. The Provincial and District Health Offices have M&E Frameworks that are extracted from the National M&E Framework, resulting in them setting targets that cumulatively contribute to the national targets.

In the past 3 years, HWs have been trained in M&E in order to enhance collection of quality data, and advance analysis for comprehensive data utilisation in programme planning and management. There are Malaria Focal persons at Provincial and District levels, these cadres coordinate malaria support and supervision exercises at all levels. The programme has installed the malaria data base at all Provincial and District Health Offices with support from the WHO. This data base stores data on all malaria activities, epidemiological trends of the disease allowing for quick data analysis and retrieval when required for use.

1.1.2.7 Partnerships and Programme Management and Coordination

The MOHCW coordinates all malaria control activities in the country, with several partners providing technical, financial and implementation support. The partners include WHO, UNDP, PSI, PLAN Zimbabwe, PMI, UMCOR and the Private Sector. WHO provides technical support and guidance to the programme and advice on policy changes. Organizations like PMI and UMCOR provide funding for some of the malaria interventions. PSI and plan Zimbabwe implement some of the activities on behalf

of the MOHCW. UNDP remains the PR for the malaria grant and provides guidance and direction on the Global Fund processes.

2.0 IMPLEMENTATION OF 2012 ACTIVITIES

During the 1st quarter of the year under review, the Round 8 Phase 1 Type 1 extension grant was implemented as a continuation of the Round 8 Phase 1 grant, in parallel with the Round 10 grant. Starting from the 2nd quarter (April), however, the Malaria Round 8 Phase 2 and the Round 10 grants were consolidated into the Single Stream Funding (SSF) grant as per the new GF requirements (see finance section for detailed budget).

2.1 Malaria Single Stream of Funding Grant

The SSF grant seeks to achieve pre-elimination in the southern region of Zimbabwe. Under the SSF grant, the 7 Districts in Matabeleland South Province are being reorienting from malaria control towards pre-elimination. The grant is also supporting malaria control interventions in the other districts of the country.

Specific Objectives

1. By 2016 at least 85% of the population in targeted malaria endemic areas have slept under an LLIN the previous night.
2. By 2016 at least 90% of health facilities in the 7 districts targeted for pre-elimination are carrying out enhanced malaria.
3. By 2016, 45 districts have the capacity and resources to rapidly detect and respond to malaria epidemics.
4. By 2016, at least 90% of population in targeted malaria endemic areas are covered by IRS.
5. By 2016, at least 90% of malaria cases are managed according to the National Treatment Guidelines.
6. By 2016, at least 95% of people in endemic areas know the cause, symptoms, preventive measures and treatment of malaria.
7. To consolidate evidence-based programme management for an effective response to malaria in Zimbabwe by 2016.

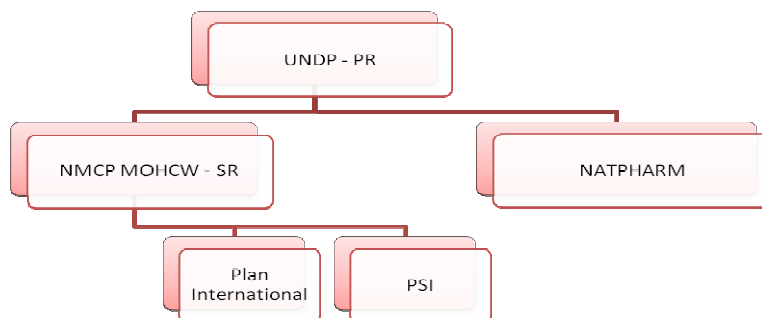
The SSF Grant has 7 Service Delivery Areas (SDAs) that are aligned to the SDAs in the current strategic plan and these are as follows:

- Vector control: IRS & ITNs/LLINs
- Case management: malaria diagnosis and ACTs
- Behaviour change communication
- Malaria in pregnancy: IPTp
- Epidemic preparedness and response
- Supporting evidence based programming and management

2.1.1 SSF Grant Implementation Architecture

There are 5 organisations involved in the implementation of the SSF grant; these are the United Nations Development Programme (UNDP), the National Malaria Control Programme (NMCP) under the Ministry of Health and Child Welfare (MOHCW), National Pharmaceutical Company of Zimbabwe NatPharm, Plan International and Population Services International (PSI). The structure of implementation is illustration in Fig 4 below.

Figure 4: SSF Grant Architecture 1



In the implementation of the grant, UNDP as Principal Recipient (PR) engages as Sub-Recipients (SRs) the MOHCW-NMCP and NatPharm. UNDP manages the grant offers technical support program management, monitoring and evaluation, procurement supply management and financial towards the effective and efficient implementation of the grant.

The NMCP within the MOCHW is responsible for the implementation of programmatic activities whilst NatPharm is the responsible for storage and distribution of pharmaceutical and non pharmaceutical products.

PSI and Plan International are sub-sub –recipients (SSRs) and are responsible for implementation of some key activities, example BCC, IRS, and programme planning and distribution of LLINs in the community.

3.0 PROGRAMME ACHIEVEMENTS

Implementation of the SSF grant commenced on the 1st of April 2012, following a successful grant negotiation for the grant in the 1st quarter of the year that resulted in the consolidation of the Round 8 Phase II and Round 10 grants. In order to minimise delays in grant implementation, an interim arrangement was made to use funds from the Round 8 Phase I Type 1 extension and the Round 10 Phase 1, in Quarter 1. Various programmatic activities were implemented throughout the year and these include Vector Control, Malaria Case Management, Pre-elimination, Procurement of malaria related commodities and medicines, Training and Capacity Development, Malaria Indicator Survey, Revision of the Malaria Strategic and M&E Plans, the Zimbabwe/Zambia Cross Border Initiative, Bioassays and Behaviour Change and Communication etc.

3.1 Orientation of SRs and SSRs on SSF Malaria Grant

Implementation of the SSF Malaria grant activities started with the orientation of all the SR and SSRs on the new grant and the modalities of implementation. The orientation focused on Program management, M&E guidelines, Finance, PSM and Communication. The new reporting timeliness were agreed upon with the SRs and the new financial, program and M&E templates developed to facilitate effective and efficient implementation of the grant were discussed and shared with implementers at the meeting.

Prior to the orientation, the Local Project Appraisal Committee (LPAC) meeting was held as per UNDP program requirements of new projects and was attended by representatives from the WHO, MOHCW (NMCP), UNDP, PLAN and PSI

3.1 2012 Malaria Prevention Interventions

3.1.1 Vector Control Activities

3.1.1.1 2012 Indoor Residual Spraying Programme (IRS)

IRS is a major vector control intervention that is implemented yearly in 45 districts with moderate to high malaria transmission in the country. IRS activities commenced in September and were completed in December 2012. Before the start of IRS, a number of preparatory and planning activities, including training and procurement of insecticides were implemented as detailed below:

- **National planning and review meeting on IRS:** The national planning and review meeting was conducted during the 2nd quarter of 2012 in Kadoma District, with the objective of reviewing the vector control program for the 2011 season and planning for 2012 season. The meeting was held for three days and was attended by a total of 40 officers from districts and provinces. The meeting reviewed the 2011 IRS programme and planned for the 2012 programme. The review involved looking at what worked well and the challenges faced in 2011 and this formed the basis for planning for the 2012 IRS programme..
- **IRS Level 1 Training:** This training activity was held at Gokwe hotel in Gokwe South district from the 29th of July to the 3rd of August 2012. Out of the 50 participants expected to attend the workshop, 47 attended showing an attendance rate of 94%. The participants comprised of provincial, and district environmental officers as well as provincial field officers and district malaria coordinators. The main objectives of the workshop were to finalise the IRS Provincial plans for the 2012 IRS season and to train trainers for the IRS Level 2 training. The workshop was evaluated using Pre and Post tests. The lowest and highest results for the pre and post tests were 24% and 90% and 38% and 90% respectively. Due to funding challenges, the duration of the training was shortened to 5 days instead of the recommended 10 days.
- **IRS Level 2 Training Activities:** Eight level 2 training workshops were conducted at the provincial level for all the rural provinces. Out of the expected 436 participants, 410 participants (94%) were trained. Like the Level 1 training, the number of workshop days was reduced from 10 to 5, due to funding challenges. Facilitators who had attended the Level 1 training conducted the Level 2 training workshops. The training module included topics on sprayer calibration, sprayer maintenance, waste management and bioassays. The participants trained under Level 2 training facilitated the Level 3 training workshops, and were drawn from the MOHCW environmental experts, private sector and NFA. NFA was responsible for training on the DDT handling and waste management.
- **IRS Level 3 Training Activities:** The training focused on general principles on malaria, spraying techniques, handling of insecticides, use of spraying equipment and environmental management. A total of 32 IRS level 3 training workshops were conducted throughout the country in September and October, each of them running for 5 days, instead of the recommended 10 days, due mainly to inadequate funding. Spray Operators are recruited yearly, and have to be trained in-depth on malaria and preventive techniques such as IRS. The training course involved a lot of practical and theoretical sessions to ensure that participants get well acquainted with the rudiments of spraying with DDT. The Zimbabwe Malaria Spray Operators Guide was used to guide the training activities. It must be placed on record that, in Midlands Province, the 2 IRS level 3 training workshops in the province were conducted for the recommended 10 days, due to additional financial support received from the Provincial and District Health Offices.

It is imperative that a critical activity such as IRS which involves use of hazardous substances be implemented according to the approved and recommended guidelines. It is, therefore, recommended that adequate resources are mobilized in preparation for the 2013 IRS programme in order to guarantee quality work output.

In districts where Dichlorodiphenyl-trichloroethane (DDT) was used for IRS, an additional module on use and safe handling of the insecticide was taught. This module was taught by consultants from Nets for Africa (NFA).

A total of 1,215 spray operators were trained on IRS spraying techniques under IRS level 3 training, compared to the NMCP target for the season of 1,334. The inability of the program to meet its target was due mainly to budgetary constraints. Each spray operator received a total of USD630, for 63 days (USD10 per day) and this was fully funded by the Global Fund grant.

- **Implementation of IRS:** The spraying commenced in October instead of September due to delays in the delivery of DDT and Disbursement of Funds to the Provinces. The delivery of DDT to the Districts was delayed mainly due to delays in the approval and disbursement of the SSF grant by the GF. The IRS activities were completed in 44 of the 45 districts by the 31st of December 2013. Buhera district only managed to complete IRS in January 2013 due to budgetary challenges; the partner that was supposed to support IRS in the district could not manage to provide the required financial support at the appropriate time, and GF funding has to be sourced from savings under the SSF grant to implement the activity in the district.

In total, 2,159,332 rooms were sprayed in the 45 districts, out of a target of 2,433,990, representing 89% coverage; 88% of the population residing in these were therefore protected i.e. 3,106,659 of the target population of 3,540,794. With the 2012 performance, the programme over achieved the WHO recommended coverage of above 80% in order to realise adequate community protection; 89% of the rooms and 88% of the population were protected. Despite the fact that the recommended WHO coverage was exceeded, the 1st quarter of 2013 witnessed a Malaria Outbreak in Manicaland Province. The province achieved 86% room coverage and 92% population protected, however, it was noted that in some areas where the outbreak was confirmed, IRS had not taken place. IRS was not done in these areas because of various reasons, which include shortage of fuel (Chipingo District). With this in mind, it is imperative to forecast areas prone to outbreaks and conduct intensive high quality IRS in those areas.

The successful implementation of the 2012 IRS programme was achieved through the progressive partnership amongst the key partners which include, Global Fund, NMCP-MOHCW, WHO, UNDP, PMI, Plan International, PSI, Abt Associate and the private sector.

- **DDT Local Support Services:** In compliance with the Stockholm Convention on Persistent Organic Pollutants and the Zimbabwe Public Health ACT Chapter 15: 09, UNDP aims to ensure protection of the highest standard for both human health and the environment from persistent organic pollutants. In this regard, UNDP entered into a contract with Nets for Africa (NFA), where the latter offers DDT local support services. These services included acquisition of import licence from relevant authorities for the importation of DDT into the country, storage and distribution of DDT, training of spray operators and collection and incineration of DDT waste. Prior to the signing of the agreement, UNDP consulted widely with the NMCP, MOHCW Department of Environmental Health, WHO and other relevant stakeholders in designing the most appropriate Terms of References (TORs) that met the required standards in environmental protection and use of persistent organic pollutants. Input into the TORs was also sought from UNDP Procurement and Supply Office (PSO) in Copenhagen. After the development of the TORs UNDP held a series of meetings with NFA which included inspection of their warehouse and vehicles intended for DDT storage and distribution. Inspection of the warehouse and vehicles was done under the guidance of NMCP and MOHCW Department of Environmental Health, and focused on the appropriateness of the vehicles and warehouse for the intended purpose in light of environment and public health safety. The agreement was finalised and signed on the 25th of October 2012 after UNDP had been satisfied with the resolution of the recommendations that were made towards the improvement of safety considerations at the warehouse and the vehicles

As part of the Local Support Services, NFA facilitated the component of DDT handling, use, waste management and disposal during the Level 1, 2 and 3 IRS training activities. UNDP witnessed 2 of

these training activities at Sesame in Gokwe South and Nembudziya in Gokwe North districts during the regular Spot checks.

DDT waste generated in the 2012 IRS programme was collected from the 21 districts that used DDT in the 1st quarter of 2013. There was a delay in the collection of the waste and this resulted in the waste being collected in February and March. The delay was attributed to heavy rains which rendered some areas inaccessible. UNDP assessed and inspected the collection of waste in 6 of the districts and confirmed the waste collection for the rest through telephone calls to the Provincial and District Environmental Officers.

Incineration of DDT was conducted at Hwange Colliery Incinerator in March 2013. A total of 12,100kgs of waste was incinerated; this included expired DDT, DDT empty boxes and sachets. The incineration was conducted under the guidance and supervision of the Environmental Health Officer for Hwange Colliery and at the recommended temperature of 1400 degrees-Celsius. UNDP witnessed part of the incineration process.

Fig 5: Scene of incineration of DDT waste at Hwange Colliery, Mat. South Province



(Photo taken on 12/03/2013)

NFA has been sub-contracted to provide DDT local support services to the country for the past 3 years since the commencement of the Round 8 grant in 2010. In as much as NFA has provided adequate services in ensuring proper waste management of DDT, there remains a huge void with regards to sustainably capacitating the MOHCW in DDT waste management. Given the current malaria epidemiologic status, Zimbabwe is likely to use DDT in IRS for a couple more years to come and it is ideal to build the capacity of the MOHCW in the management of DDT waste and not to rely on private organisations since funding to support such an exercise through the current channel is not guaranteed. It is recommended that UNDP starts exploring avenues of building sustainable capacity of the MOHCW in this regard, one way might be to build an appropriate incinerator for the MOHCW.

- **2012 Bioassays:** In order to determine the quality of spraying as well as the residual effect of insecticides on sprayed surfaces, several efficacy studies including cone bioassays were conducted on the sprayed surfaces. Cone bioassays on walls sprayed during the 2011 IRS were conducted in the 1st half of 2012 and bioassays for the walls sprayed in 2012 commenced in October 2012 and will run until May 2013 in order to monitor the residual effect insecticides for a minimum of 6 months.

Results from the Bioassays conducted against the 2011 IRS in the 1st quarter of 2012 showed that the insecticides (DDT, lambda-Cyhalothrin, Deltamethrin) still had an efficacious residual effect. Bioassays conducted in Burma Valley in Manicaland after the 2012 IRS showed that the walls had a low mortality rate of 58% with a knock down effect after 30 minutes of 48%. According to Taylor et al. (1981), residual insecticides are required to have a minimum residual effect of 6 months (greater or equal to 80% mortality). The bioassay results from Burma Valley are far below the recommended level and this

could have been attributed to poor deposition of insecticides on the walls by the spray operators. This can therefore be partly responsible for the persistent outbreak in the area in the 1st quarter of 2013.

Insecticide susceptibility tests were conducted at 13 of the 16 vector sentinel sites countrywide. These exercises were conducted at the following vector sentinel sites Muzarabani, Mazowe River Bridge, Kasimure, Chakari, Zindi, Chilonga, Mashoko, Tshelanyemba, Makhakavhule, Manjolo, Jotsholo, Kamhororo and Sidekeni. Efficacy of the following insecticides was evaluated, DDT 4%, Deltamethrin 0.05%, Bendiocarb 0.1%, Malathion 5% and lambda Cyhalothrin 0.05%. The results showed 100% mortality implying no insecticide resistance to the 5 insecticides currently in use in the country.

3.1.1.2 Long Lasting Insecticide Treated Nets

According to the 2009 WHO Position Paper on Insecticides, LLINs are designed to maintain their biological efficacy against vector mosquitoes for at least three years in the field under recommended conditions, obviating the need for regular insecticide treatment. It is against this background that UNDP procured more than 1.3 million nets to replace the LLINs procured and distributed in 2010. The LLINs arrived in country in December 2012 and distributions commenced in the 1st quarter of 2013 and they will be distributed in 17 of the 30 districts with high malaria transmission following the distribution of 500,000 by PMI in the 7 other districts in 2012.

3.2 Prompt effective anti-malarial treatment of Malaria cases

- **Training of CHWs/VHWs**

According to the approved 2012 training plan, 1,112 HWs were targeted for case management training. During the year 1,412 HWs were trained, the additional 300 were trained with support from PMI. The case management training was conducted using the National Malaria Case Management Guideline. The duration of the workshops was 4 days and targeted all HWs with a focus on diagnosis and a management of simple and complicated cases of malaria, IPTp, ACTs stock management and on how to use RDTs.

In line with the thrust towards Community Case Management of Malaria, 1,640 CHWs were trained with support from PMI, MCHIP, UMCOR, and UNICEF. The SSF grant will support the training of CHWs on Community Case Management of Malaria in 2013 and 2014. CHWs are essential in the delivery of prompt treatment to patients presenting with uncomplicated malaria within the community. In so doing they contribute to the decline in the number of cases developing severe malaria.

- **Procurement of ACTs and RDTs**

Under the SSF grant, UNDP procured 66, 528 RDTs and 15,000 treatment kits of Artemisinin-Combination Therapies (ACTs) for the management of malaria cases. Natpharm distributed these commodities throughout the country under the Zimbabwe Informed Push (ZIP) System. This ensured that the Health Facilities were adequately stocked with these essential commodities. However, joint field visits conducted by UNDP and NMCP as well as visits by the OIG Mission in November confirmed expiries of significant numbers of ACTs in some health facilities visited. The stock out may be attributed to the issue of quantification and mal distribution of drugs as a result of inadequate health facility-based consumption data. This observation prompted the Global Fund to place a Condition Precedent (CP) on the grant regarding quantification of these commodities. The PR has not managed to meet the CP and quantification of ACTs and RDTs remains a tenacious challenge to the cost effective management of malaria cases.

According to the 2012 report generated by the Health Management Information System (HMIS), 274,770 confirmed malaria cases were attended to at Health Facilities and by CHWs.

The year 2012, witnessed an unprecedented increase in malaria related case fatality in 2 provinces, Mashonaland East and Mashonaland Central. These deaths were concentrated in 2 districts, Mutoko

in Mashonaland East and Mt Darwin in Mashonaland Central. Of the 104 deaths reported in Mashonaland East, Mutoko District accounted for 58.7% (61) of the deaths, and Mt Darwin District accounted for 62.8% (43) of the deaths reported in Mashonaland Central Province. A task force was set up to conduct audits of the malaria related deaths in these districts in the 1st half of 2013 and to identify the possible cause of such high deaths in these districts. However in Mt. Darwin the deaths could be attributed to malaria outbreak, which was picked later on.

3.3 Pre-elimination in Mat South Province

One of the key objectives of the Malaria SSF grant is to reorient the 7 districts in Matabeleland South Province from malaria control phase to pre-elimination. Pre-elimination activities in Matabeleland South Province started in April 2012 with the hiring of the Pre-elimination Coordinator in September 2012. The purpose of the Pre-elimination Coordinator is to coordinate the implementation of pre-elimination activities within the Province.

Due to the fact that the requirements of pre-elimination are different from those of malaria control, the NMCP-MOHCW had to train HWs and CHWs within the province on Integrated Disease Surveillance and Response (IDSR) and Enhanced Surveillance with more emphasis on malaria. Twenty seven HWs were trained during a Training of Trainers (TOT) and these in turn trained 1,542 CHWs who are part of the ward health teams. The CHWs in Matabeleland South Province were capacitated to conduct malaria active case surveillance and investigations, and identify and report breeding sites to the Health centre within their catchment areas. It is hoped that the use of ward health teams in implementing malaria pre-elimination activities is an efficient way of achieving sustainable results.

A total number of 136 cases were notified in the province and of these 8% (11 cases) were investigated. The investigation rate was very low mainly due to delays in the commencement of pre-elimination activities in Matabeleland South Province. The Pre-elimination Coordinator to coordinate pre-elimination activities took office only on 24th September 2012, which in turn affected implementation of other pre-elimination activities. The Health Workers who are supposed to conduct the Case Investigations were only trained in Enhanced Surveillance in October and yet there were supposed to be trained in May 2012.

Under the SSF grant and as a means of capacitating the province to efficiently implement pre-elimination activities, UNDP procured and distributed 124 Bicycles. These bicycles will be used by the Ward health teams to follow-up on malaria cases and to conduct other pre-elimination activities. The bicycles were officially handed to the Governor of Matabeleland South Province on the 12th of March 2013 at a ceremony that was well attended by various stakeholders.

3.4 Zambia Zimbabwe Cross Border Malaria Initiative

Zimbabwe and Zambia are signatories to the Malaria Elimination 8 (E8) in southern Africa, launched in March 2009 and which centres on the 4 countries (Botswana, Namibia, South Africa & Swaziland) that aim to achieve elimination by 2020 and the neighbouring countries Angola and Mozambique.

The 2 countries met on the 26th & 27th of November 2012 and explored the feasibility and opportunities for them to engage and coordinate on cross border malaria control and elimination interventions within the framework of the existing Global Fund supported programs. At the meeting there was consensus that joint coordination of malaria control interventions, harmonisation of policies, and tools and synchronisation of operations would accelerate reduction of malaria transmission among the border communities and contribute significantly towards malaria elimination.

The meeting was attended by Global Fund Country Support Team, representatives from SADC, UNDP Offices in Zambia and Zimbabwe, NMCPs in Zambia & Zimbabwe, WHO, the Army and Religious groups. Other participants were representatives from the districts and provinces along the Zambezi valley; two provinces and 4 districts from Zimbabwe and two provinces and three districts from Zambia. The Minister of Health and Child Welfare (MOHCW), Head of High Impact Africa 2 of GF and the FPMs of the two countries graced the occasion. In his opening address, the Honourable Minister

of Health of Zimbabwe gave assurance of the commitment and support of his government to the initiative, and added that the ongoing effort will ensure total elimination of malaria along the Zambezi valley. He expressed his government's appreciation to the Global Fund and partners for providing technical support and funding for the meeting. The outcome of the meeting gave birth to the Zambia and Zimbabwe Cross-border Malaria Initiative (ZAM-ZIM CBMI) which leverages on the Trans-Zambezi Malaria Initiative (TZMI), a malaria collaboration of 5 countries Angola, Botswana, Namibia, Zambia and Zimbabwe.

The main objective of the Zambia-Zimbabwe Malaria Initiative is to scale up universal coverage of malaria control interventions towards malaria pre-elimination in the target 7 cross-border districts from the 2 countries. The districts include Hwange, Binga, Hurungwe and Kariba from Zimbabwe, Kazungula, Siavonga and Livingstone from Zambia.

At the time of compiling this Annual report the costed 2013 Work plan for the Zam-Zim CBMI amounting to a total cost of US\$882,000-00 had been submitted to Global Fund for consideration. The formal launch The Zam-Zim CBMI took place on the 25th April 2013 in Livingstone, Zambia, with the participation of the Deputy Minister of Health (Zimbabwe), Minister of Health and Deputy Minister of Women and Health (Zambia), Head of Africa Impact II and the Senior Fund Portfolio Manager of Global Fund, UNDP, WHO, USAID/PMI, the Private Sector, NGOs and Government Ministries and Departments from the two countries. Prior to the launch, a pre conference was held at Victoria Falls, Zimbabwe on 2th April.

3.5 Training Activities

The Global Fund approved a total of 18 training activities i.e. training of health workers in malaria case management, IRS, enhanced surveillance and ISDR, and Monitoring and Evaluation. UNDP conducted spot checks on 25 trainings as a way of strengthening fiduciary measures.

3.6 Follow-Up on Health Workers Trained

As part of the risk mitigating measures instituted by UNDP in the management of the Global Fund (GF) grants in Zimbabwe, two separate joint field missions were conducted to follow up on Health Workers (HWs) and Community Health Workers (CHWs) trained in 2011. The exercise was used to a) confirm the participation of the HWs and CHWs trained, b) interacted with a sample of them in order to assess their utilization of skills and knowledge acquired at the trainings, c) validated financial records on the trainings and payment of allowances made to CHWs, and d) followed up on implementation of previous recommendations.

The activity was carried out in two Phases (phase1, 25- 31 March 2012 and Phase 2, 25-29 June 2012), of which three teams were formed and went to Midlands (Zvishavane, Gweru ,Mberengwa Kwekwe district), Mashonaland West Province (Kadoma, District Chegutu District, Kariba District) and Masvingo Province (Bikita district, Zaka district ,Chiredzi district). In general most of the guidelines were complied with, except in some few cases where they did not strictly adhere to the guidelines. The findings were shared with the NMCP to ensure that some of the observations bordering on non compliance are not repeated in future trainings.

During these field visits, the UNDP teams (integrating staff from finance, program and M&E) provided technical support in the respective areas to Implementing Partners (IPs). All SRs and SSRs also participated in the field visits.

4.0 MONITORING AND EVALUATION

In 2012 the grant witnessed implementation of major M&E activities. New M&E reporting templates were developed and all SRs and SSRs were oriented on them at the SSF grant orientation meeting held in March 2012. The 2012 Malaria Indicator Survey (MIS) was conducted in April 2012 to provide data to track key population coverage indicators. The malaria SSF Performance Framework was developed following the consolidation of the malaria Round10 and Round 8 phase 2 grants, and further revised when GF changed the frequency of reporting from quarterly to semester. In order to continuously improve data quality and efficiency of the M&E system, the PR conducted Onsite Data Verification Exercises (OSDV) targeting service delivery areas; this resulted in the revision and improvement of the malaria component of the T-5 monthly return form. Following the Mid-term review of the Zimbabwe National Malaria Control Programme Strategy (ZNMCP) the Monitoring & Evaluation Plan for the ZNMCP was also reviewed.

4.1 Programme Monitoring

4.1.1 Developing of M&E Reporting templates/ tracking tools

Following lessons learnt from the Rd 8 Phase 1 and to ensure standardization of reporting, a number of M&E templates were developed to facilitate the effective implementation of reporting on the Rd 8 Phase 2 Grants. The tools developed include the daily participants' registration and payment of allowances during trainings, training reporting format, quarterly reporting format, action plan format, etc. The PR sought inputs from the SRs and SSRs before finalizing them and they were later oriented on their proper use during the orientation sessions on the Rd 8 Phase 2 Grant. These tools were subsequently used in reporting effective quarter 10 and Semester1 (July-December). In addition to the templates, the PMU developed tracking tools for its internal use; these include the field visit plan and tracking tool, sites visited during OSDVs, and implementation of action plans to address observations of OSDVs.

4.1.2 On-Site Data Verification

During the year three OSDVs were conducted against results reported under the Round 8 Phase 1, Type 1 extension, and the Malaria Single Stream of Funding grants. These OSDVs were conducted in the months of June and December 2012 and February 2013. The three OSDVs were conducted in 3 provinces (Matabeleland South and North and Manicaland), 10 districts (Tsholotsho, Binga, Lupane, Hwange, Makoni, Chimanimani, Chipinge, Mutasa, Beitbridge and Gwanda) and 6 health centres. All 3 OSDVs were conducted jointly with the NMCP and anomalies identified in the field were immediately rectified at the service delivery areas. The major challenge noticed during these OSDVs was under and over-reporting against the 2 variables (Suspected and tested cases) used to calculate the indicator on "Proportion of suspected malaria cases that received parasitological test (microscopy/RDT)"

The OSDVs were fruitful in identifying and rectifying challenges to the malaria M&E system affecting data quality. Variables to improve collection of quality routine data for the indicator "Percentage of pregnant women attending antenatal clinics who received at least two doses of IPT for malaria" were recommended and adopted as part of the DHIS following one of the OSDV's. During that particular OSDV, the team analysed the available data collection tools at the health centres and the flow of data and recommended monthly aggregation of number of women attending ANC-2 and those IPT3 in order to support reporting of quality enhanced data. Through OSDVs variables collecting monthly statistics of confirmed and unconfirmed malaria cases receiving ACTs were added to the DHIS thereby improving the quality of data collected and reported to the Global Fund.

There was no formal standardised Malaria Surveillance and Data Management system reactive to malaria case investigations as part of the drive towards malaria pre-elimination in Matabeleland South province in 2012. Following an OSDV that was conducted in February 2013 a temporary malaria surveillance and data management system was established in the Province to collect, analyse, store and transmit data related to malaria case investigations in the province.

4.1.3 Data Quality

One of the key highlights of 2012 with regards to data quality, was the sudden decline in data quality for the indicator “Proportion of suspected malaria cases that received parasitological test (microscopy/RDT)” in the 1st quarter (April-June 2012) of the SSF grant following a consistent reporting of high quality results in 2011 and Jan-Mar 2012 period. In the April-June 2012 period, the grant reported a malaria testing rate of 114.7%. This result was directly due to reporting less number (122,197) of suspected malaria cases compared to the cases tested (140,168) at national level. Further analysis into the issue revealed that a malaria related M&E training course that had been facilitated between April and June 2012 resulted in misinterpretation of the indicator amongst health workers at data generation centres resulting in this anomaly. In a bid to improve the sensitivity and specificity of the variables collecting data against this indicator, new variables (suspected cases not tested and suspected cases tested by RDT & microscopy) replaced the old variables (suspected malaria cases & tested cases) on the T-5 form and DHIS respectively. Unfortunately this supposed improvement brought about more confusion amongst the health workers, further compounding the already compromised quality of data reported against this indicator.

Following the 2012 Annual Malaria conference held in December, it was agreed to revert back to measuring this indicator using the old variables that health workers had become accustomed to. It was agreed that the variables would be reinstated in 2013 following the revision of the T-5 forms and on-job training of health workers to improve the understanding of the indicator and the related variables would be conducted regularly. In the 2012 World Malaria Report, data quality challenges affecting this indicator were cited as the main reason for not including the section on testing rate for the country in the World Malaria Report. It therefore becomes more imperative to consistently improve the quality of data collected at service delivery areas.

The addition of variables measuring ANC-2, ANC-3, and IPT3 to the T-5 form resulted in the improvement of quality of data reported against the indicator “Percentage of pregnant women attending antenatal clinics who received at least two doses of IPT for malaria” .Measuring and analysing the variable on ANC2 attendance in comparison to ANC1 assisted in determining possible reasons behind the drop in IPT2 compared to IPT1.

The national malaria treatment policy in the country focuses on treating only malaria cases that have been confirmed by a parasitological test (RDT & Microscopy). In order to measure adherence to this policy variables measuring confirmed and unconfirmed malaria cases receiving ACTs were added to the T-5 Form in July 2012 for routine monitoring.

4.1.4 Training Spot Checks on 2012 approved Training Plans

In compliance with the new training guidelines by the GF, the PR/UNDP conducted spot checks on selected approved training activities in the 2012 Approved Training Plan. The spot checks were conducted to ensure compliance by the facilitators to the requirements of the approved training plan thereby mitigating the risks associated with training activities.

A total of 14 training activities were approved by the GF for the SSF Malaria grant in 2012. In conformity with the new GF guidelines on the implementation of the training plan, UNDP conducted a total of 25 training spot checks (Table 1) on the approved trainings for the grant in 2012. The objectives of the spot checks were to (i) verify and validate the number of participants and facilitators attending the training (ii) assess adherence to the planned training requirements as defined in the new training guidelines issued by the Global Fund in July 2012 and (iii) assess documentation of the activity processes. The findings and recommendations of the spot checks were shared with all SRs and also discussed at CCM Committee meetings. Action plans (where necessary) were developed to address any non-compliance issues observed during the spot checks.

The summary findings of the training spot checks and the challenges in the implementation of the new training guidelines were shared with the LFA and Global Fund to inform a possible adjustment to the guidelines for the context of Zimbabwe.

In general most of the training activities were conducted according to the approved training plan, there were, however, some challenges to the implementation of the training activities and these included late disbursements of funds to support the training, reduction of number of training days to accommodate the inadequate unit costs, not all facilitators requested participants to write pre-and post tests, and at some workshops facilitators did not consistently complete daily attendance registers.

Table 1: Spot checks conducted by type of approved trainings

Type of Training	Total Approved Training Activities	Number of spot checks conducted
Drug Efficacy Monitoring	1	1
Mapping, Epidemiological, and Entomological Surveillance	1	1
Malaria Case Management	66	3
IRS Level 1 Training	1	0
IRS Level 2 Training	8	2
IRS Level 3 Training	12	9
Community IDSR & malaria pre-elimination	109	9
Training of Media personnel	1	0
Training of health workers in enhanced surveillance	30	0
District Level Training in community surveillance participatory education	7	0
Training of Ward health teams in participatory education	15	0
Training of road shows facilitators	1	0
International Trainings	1	0
Regional Trainings	2	0
Training in M&E Activities	8	0
Total Number of Spot checks	262	25

4.1.4 Change in Frequency of Reporting

In September 2012 (implementation Letter #2) the GF approved the change in the frequency of submitting Progress Updates and Disbursement requests (PUDR) reports from quarterly to semester. Prior to the announcement, two quarterly reports had been submitted for quarters 9 and SSF Q1.

In order to strengthen its oversight over the grant over the grant implementation, the CCM took a decision to maintain the quarterly reporting to the CCM. In view of this decision, the SRs continued to submit quarterly progress updates to the PR.

4.1.5 Capacity Assessment in Matabeleland South Province

A Capacity Assessment was conducted in August/September 2012 within the province with the aim of indentifying the capacities of the province with regards to human resources, medical commodities and equipment, incidence of malaria etc. The Capacity Assessment report will be used to design a resource mobilisation strategy to support the implementation of pre-elimination activities.

4.2 PROGRAM EVALUATION

4.2.1 Mid-term Review of the (2008-2013) NMCP & M and E Plan

The mid-term review of the Strategic and M&E Plans was done in the 1st quarter of 2012 incorporating mainly the findings from the 2011 Malaria Programme Review and the progress made in malaria control. Two meetings were held during the review of the document, the 1st meeting in Nyanga district at Mont Claire hotel from the 23rd -28th January 2012 and second at Kadoma District

at Kadoma Ranch hotel from the 28th – 30th. This meetings were attended by key stake holders in malaria control in the country and included National, Provincial and District representatives' from the MOHCW, WHO, UNDP, NMCP,PSI, Plan International, and the Private sector. The coming together of these key stake holders brought together a wealth of knowledge and experience that informed the review and resulted in finalization of both the Strategic and M&E plans.

The key changes that were made included incorporating Malaria Pre-elimination into the Strategic Plan and resetting the targets for malaria incidence for the prospective years 2012 and 2013. Malaria Pre-elimination was set to target 7 districts in Matabeleland South Province starting from 2012 and a further 8 districts would be added to the list of districts undergoing pre-elimination by 2015. The targets for malaria incidence for years 2012 and 2013 were reset from 50 per 1000 and 45 per 1000 to 25 per 1000 and 20 per 1000 respectively. This change was necessitated in part by the adoption of the policy on treatment of confirmed malaria cases in the strategic plan.

4.2.2 Malaria Indicator Survey, 2012

The 2012 MIS is the second to be implemented in the country, following the 2008 MIS. UNDP took part in the planning, designing of the questionnaire, data collection, data analysis and review of the MIS report. Other key stakeholders that were involved included WHO, PSI, Plan International, PMI, and ZIMSTAT and were led by the NMCP. The GF also provided technical assistance to the analysis of the data and report writing.

Approval of the MIS proposal was sought from the Medical Research Council of Zimbabwe (MRCZ) in March, and this was followed by a week-long training of enumerators and supervisors before the field in April 2012. Data analysis was conducted at a meeting held in Mudzi District from the 5th -9th of July 2012. The final meeting to review the draft MIS report was conducted in Masvingo Province.

Fig 6: An Enumerator interviews a responded during the 2012 MIS, Lupane District, Matabeleland North Province.



Photo taken on (22/03/2013)

The key findings from the 2012 MIS are summarized below:

Table 2: Coverage of key population based indicators, 2012 MIS

Indicator	2012 MIS
Proportion of households with at least 1 net	55.7%
Proportion of the population sleeping under a net the previous night.	57.9%
Proportion of women receiving at least 2 doses of IPTp	35.3%
Parasite Prevalence : Percentage of children age 6-59 months with Malaria Infection	0.4%
Proportion of households protected by IRS	15.5%

4.8 Performance of the Malaria Grants in 2012

The grant maintained the A2 performance it had achieved in the previous year for the two quarterly reports and B1 for the first semester report (July-December) submitted to the GF during the period. The under performance of the grant in the first semester was affected mainly by the under performance of the pre-elimination indicators due to the late start of implementation of activities.

4.8.1 Performance under Rd 8 Phase 1 type 1 Extension

According to the approved PF for the Round 8 Phase 1 Type1 Extension grant, 4 indicators (1 impact and 3 outputs) were tracked in the Jan-Mar 2012 period. The performance of the indicators is outlined in the table below:

Table 3: Performance of Round 8, Phase 1, Type 1, Extension Indicators (Jan-Mar 2012)

Indicator	Target	Result	Data Source of results
Impact Level			
Incidence of Malaria Cases (estimated/reported)	5.5%	2.5%	HMIS/DHIS
<i>Comments: The reported malaria incidence for 2011 was 2.5% and it was lower than the set target. 316,465 confirmed malaria cases were reported in 2011. These cases were confirmed by either RDT or microscopy. The estimated population for 2011 was 12,721,372. The high performance of the indicator was partly due to scaling up of malaria prevention and control Interventions</i>			
Output Level			
Number of insecticide treated nets distributed	1,735,345	1,807,901	Vector control programme reports
<i>Comments: The target was set over the program term, and was achieved by 104.2%. A total of 1,807,901 LLINS had been distributed by end of 2010. GFATM contributed approximately 71% (1,235,295) of the LLINs distributed, and other donors (UnitAid through UNICEF) contributed 29% (500,000).</i>			
Number of Health workers trained in Malaria case management.	3,435	2,784	Training Activity reports
<i>Comments: The target was achieved by 81%, The target of 3,435 is cumulative from Rd 8 phase 1 (the cumulative target for Rd 8 phase 1 was set at 3,360, of which 2,718 was achieved). The target for the Type 1 extension as a contribution to the cumulative target is 75. Out of the target of 75 for the quarter 66 health workers were trained 38 in Entomological Surveillance and 28 in Therapeutic Efficacy Monitoring</i>			
Proportion of suspected Malaria cases with laboratory confirmation (microscopy and RDT).	85%	94%	HMIS/DHIS
<i>Comments: The target for Q9 was achieved by 110.5%. About 94% (144,964) of the 154, 364 reported suspected cases were tested for malaria using either RDT or microscopy. The submission rate was 95%</i>			

4.8.2 Performance under SSF Malaria

There are 14 indicators in the approved SSF P.F, 4 at Impact level, 3 and 7 at outcome and output levels respectively. Performance of the grant using these indicators was measured twice during the course of the year. Prior to the semester reporting which commenced in August, performance was measured quarterly for the period April-June 2012. After the shift to semester reporting, performance is now being measured at 6 month intervals, and it was measured for July-December

Table 4: Performance of the SSF Malaria Grant (July-December 2012)

Indicators	April-June		July-Dec		Data source of results
	Targets	Results	Targets	Results	
Impact Level					
In patient malaria cases per 1000 persons per year	N/A	N/A	0.85/1000	0.32/1000	HMIS/IMMIS
<i>Comments: This indicator is measuring the 2012 annual malaria related admissions. The T-9 system has not been working therefore completeness of reporting was low, data was only received from 2 of the 10 provinces. 4,145 malaria admissions were reported from the 2 provinces (Mashonaland East and Midlands).</i>					
In patient malaria deaths per 1000 persons per year	N/A	N/A	0.051/1000	0.02/1000	HMIS/IMMIS
<i>Comments: This indicator is measuring the 2012 annual malaria related deaths. The T-9 system has not been working therefore completeness of reporting was low, data was only received from 2 of the 10 provinces. 255 malaria related deaths were reported from the 2 provinces (Mashonaland East and Midlands).</i>					
Parasite prevalence: percentage of children age 6-59 months with malaria infection	N/A	N/A	TBD	0.4%	2012 MIS
<i>Comments: The 2012 MIS reported a parasite prevalence of 0.4% within the 6-59 months age group. Such low parasite prevalence is synonymous to the decrease in malaria related burden partly due to scale up of malaria prevention and control interventions.</i>					
Proportion of confirmed malaria cases per 1000 persons per year	N/A	N/A	45/1000	21.2/1000	HMIS/DHIS
<i>Comments: The annual malaria incidence for 2012 was 21.2 per1000 of the population. This surpassed the set target of 45/1000. 274,770 malaria cases were confirmed and reported through the HMIS, the population for the country in 2012 was 12,973,808.</i>					

Indicators	April-June		July-Dec		Data Source of Results
	Targets	Results	Targets	Results	
Outcome Level					
Percentage of households with at least one LLINs in 30 targeted areas	N/A	N/A	85.0%	46.4%	2012 MIS
<i>Comments: The set target was achieved by 54.6%. The results were reported in the 2012 MIS and it showed that the majority (53.6%) of households in areas of moderate to high malaria transmission do not own an LLIN.</i>					
Percentage of population who slept under an LLIN the previous night in the 30 targeted districts	N/A	N/A	55.0%	49.0%	2012 MIS
<i>Comments: The set target was achieved by 89.2%. The majority (51%) of the population had not slept under an LLIN the night preceding the survey. The low utilisation of LLINs corresponds to low access to nets</i>					
Percentage of the first line treatments among children under five years old with fever in the last two weeks who received any antimalarial medicines	N/A	N/A	TBD	100%	2012 MIS
<i>Comments: According to the 2012 MIS, all (23) children who presented with fever and received an antimalarial 2 weeks preceding the survey, received the recommended Artemisinin Cased Combination Therapy (ACTs). 255 children presented with fever within 2 weeks preceding the survey.</i>					
Output Level					
2.1) Proportion of reported malaria cases that are fully investigated in Matabeleland	N/A	N/A	80%	8.1%	Activity Reports
<i>Comments: The target was achieved by 10%. Of the 136 confirmed and reported malaria cases, only 11 were investigated. The indicator did not perform satisfactorily due to delays in the start of pre-elimination activities and also the absence of a reporting system for case investigations</i>					
3.1) Percentage of Health Facilities in Matabeleland South Submitting weekly Malaria Surveillance reports	65.3%	52.5%	75%	59.3%	HMIS
<i>Comments: The target was achieved by 80.4% and 79.1% in the period April-June and July-Dec 2013 respectively. There was a slight decline in performance between the 2 reporting periods. Under the SSF Grant all 124 Health Facilities in Matabeleland South Province are expected to be part of the Malaria Weekly Disease Surveillance System. The reporting facilities were gradually increased from 70 facilities in June to 87 facilities by December 2013. The increase, however, failed to meet the set targets.</i>					
4.1) Percentage population-at-risk protected by IRS in targeted 45 districts	N/A	N/A	85%	88%	Vector Control activity reports
<i>Comments: The target was achieved by 103%. Of the 3,540,572 people residing in the 45 Malaria transmission districts 3,106,659 people were protected by IRS in the 2012/2013 IRS Programme. The indicator performed well due to the productive partnership amongst partners and the timely procurement and delivery of IRS commodities.</i>					
5.1) Percentage of confirmed outpatients malaria cases that received first line treatment according national policy (includes both facility and community level)	80.3%	146.1%	80.3%	56.4%	HMIS/DHIS
<i>Comments: There were data quality challenges that affected the performance of the indicator in the April-June period. The T-5 data collection form did not have adequate variables to respond to the indicator. In the period Jul-Dec, 56.4% of confirmed malaria cases were reported to have received the recommended antimalarial medicine. This is not a true representation of the actual situation prevailing during the period. Although the T-5 form was revised and improved, data quality issues noted previously were still inherent.</i>					
5.4) Percentage of pregnant women attending antenatal clinics who received at least two doses of IPT for malaria	80%	47.8%	80.0%	41.3%	HMIS/DHIS
<i>Comments: The target was achieved by 59.7% and 51.6% in the 2 reporting period (April-Jun) and (Jul-Dec) respectively. The performance of the indicator against the set target was very low. The failure to meet the target was partly due to erratic supplies of S.P, presently the drug of choice for malaria chemoprophylaxis in p. falciparum prevalent regions. The decline in ANC repeat visits also contributed to the poor performance</i>					
Proportion of suspected malaria cases that received parasitological test (microscopy/RDT)	80%	114.7%	80.0%	63.7%	HMIS/DHIS
<i>Comments: There were data quality challenges that affected the performance of the indicator in the April-June period. The malaria variables on the T-5 data collection form were misinterpreted resulting in generation of data of poor quality. Although the T-5 form was revised and improved, data quality issues noted previously were still inherent.</i>					

5.0 PROCUREMENT

5.1 LLINs

A total of 1.3 million LLINs were procured in 2012 for distribution in 2013. This will bring us to a total of 3.6 million ITNs and LLINs distributed in the country by the end of 2013. The LLINs will be distributed in 23 districts.

5.2 DDT

A total of 140 tonnes of DDT was procured in 2012 and distributed to 21 districts for IRS.

5.3 Procurement of Malaria Commodities

UNDP's procured anti-malarial commodities such as Rapid Diagnostic Tests (RDTs) and Artemisinin-combination therapies (ACTs) by UNDP continued in 2012. In addition UNDP procured reagents and IT equipment.

5.4 Bicycles

A total of 124 bicycles were procured by UNDP for the programme. In a major boost to the fight against malaria in Matebeleland South Province, UNDP has facilitated the procurement of 124 bicycles that will be used to conduct door-to-door campaigns by community health workers, sensitizing the public on behaviour change activities as well as following up of all malaria cases and identification of mosquito breeding sites.

6.0 FINANCE

The implementation of the Malaria activities in 2012 were financed through 3 global fund grants: (i) extension of the Phase 1 of the Round 8 grant; (ii) Round 10 grant; and (iii) the Single Stream of Funding. The total amount available for the implementation of the Malaria activities in 2012, amounted to US\$ 21,724,677 of which US\$ 15,896,527.49 was spent during the year representing 73% of the available resources as indicated in the Table below:

Table 5: Source and Uses of Funds

Sources of Funds			Uses of funds	
ZIM-809-G13-M			Total Expenditures Round 8 Grant	390,883.28
Disbursement from GFATM	21-Mar-12	339,131.00	UNDP/PSM Costs	197,341.20
2012 Interest		1,244.23	UNDP/PMU & GMS	193,542.08
ZIM-011-G15-M			Total Expenditures Round 10 Grant	107,347.00
Disbursement from GFATM	10-Feb-12	124,543.11	MOHCW/NMCP	48,538.00
2012 Interest		184.50	UNDP	58,809.00
ZIM-M-UNDP			Total Expenditures SSF Grant	15,398,297.21
Disbursement 1 from GFATM	30-May-12	16,806,981.07	MOHCW/NMCP	3,409,132.46
Disbursement 2 from GFATM	02-Oct-2012	4,394,492.93	NATPHARM	201,256.55
2012 Interest		58,099.89	PSI	180,887.00
			Plan International	441,234.90
			UNDP	11,165,786.30
21,724,676.73				15,896,527.49

7.0 CAPACITY DEVELOPMENT ACTIVITIES

The Phase 2 Capacity Development Plan approved by the Global Fund in July 2012 aims to build upon the Phase 1 work to address institutional systems, in the areas of coordination and management, accountability and risk management; and strengthening the country Health Information System.

The high-level capacity development objectives identified in the plan are:

- Strengthened Risk and Results Based Management, Accountability, and Oversight at National and Provincial Level.
- Comprehensive, Accurate, & Timely Data Capture, Analysis & Reporting from District & Provincial levels.
- Strengthening Procurement & Supply Management.
- CD Project Management and M&E.

Following the GF and CCM approval by September 2012, the remaining three months of 2012 available for implementation focused mainly on preparatory work to enable CD plan activities to start in earnest in 2013, as well as the implementation of activities under the budget of the 2012 UNDP CO funds.

Procurement

Procurement was completed for a variety of activities such as the assessment of the needs for the proposed Management & Leadership Development Programme; the assessment of storage conditions of urban and rural peripheral health facilities, procurement of a refrigerated truck for the MOHCW to strengthen its public health laboratory services, and technical experts to support HSB in carrying out their capacity development activities, and the MOHCW in their midterm review of the HR Strategy.

Other procurement was started but has had to be re-tendered, such as that for IT groups to install the Pastel Financial Management system at all SSRs which do not currently have this software.

Recruitment

To support the implementation and coordination of the Phase 2 Capacity Development Plan, a Capacity Development Associate started in June 2012 with support from a Capacity Development Consultant. The Capacity Development Team works closely with the PR Program Officers, Finance Team and M&E Team as CD is a cross cutting program.

Additionally the recruitment was completed of the MOHCW GF Grants Coordinator; a post which aims to support the overall coordination of the implementation of the GFATM activities across the three national MOHCW programs (HIV, TB and Malaria) plus the Health Systems Strengthening Component.

Key Activities Implemented

Management and Leadership Development Programme

The Management and Leadership Development Programme aims to be one of the key interventions of the Phase 2 CD Plan. This intervention aims to strengthen Ministry of Health and Child Welfare management and leadership capacity via the practical application of acquired skills to real life issues, ultimately enabling the transfer of skills in a sustainable manner. In 2012, as part of the development of the detail of this activity, a horizontal learning exchange programme was arranged in order to benefit from the Zambia Management and Leadership Academy (ZMLA) model.

The ZMLA model is being implemented by the Broadreach Institute for Training and Education (BRITE) in Zambia with the Ministry of Health; and through the exchange visit a team made up of the MOHCW, HSB and the PR gained first-hand experience of how the programme is being implemented and how a similar programme could be implemented in Zimbabwe.

In addition to the exchange programme, a national consultant was recruited to facilitate the detailed assessment of what the programme should focus on in Zimbabwe. The consultant completed interviews with key staff of NAC, ZAN, HSB, NatPharm and MOHCW and the draft assessment report was shared with the PR and SRs at the end of 2012. The findings of this assessment will inform the detailed design of the management and leadership development programme.

Revision of the Global Fund Sub-Recipient Implementation Manual

There was also a need identified to revise the GF SR Implementation Manual developed in Phase 1, to incorporate changes in the Global Fund structures, SR reporting timeliness and the revised reporting templates. This revised manual was then disseminated to all SRs.

Successes and Challenges

A key challenge was the delay in finalising the workplan and budget, which has reduced the allowable implementation time. This reduction is a significant challenge considering that capacity development and change management require a longer period of implementation to make the desired impact.

There has been close collaboration with the SRs especially engaging the MOHCW PMDs. The PMDs will play a critical role in the implementation of Phase 2, based on the fact that most of the Phase 2 activities will roll out to Provincial and District levels.

CD Budget

The total approved budget for the Phase 2 Capacity Development Plan is \$2,125,881.47. The following table shows the approved budgets by grant and by Sub Recipient

Grant	Phase 2 Budget	Budget 2012	Actual 2012	Variance	Reason for Variance
HIV	1,129,504.20	309,478.00	95,140.00	214,338.00	Activities not started due to delay in workplan budget agreement.
TB	127,398.00	90,911.33	130,227.33	-39,316.00	WHO disbursement for 2012 and 2013 done in 2012.
Malaria	331,900.67	72,480.00	247,798.00	-175,318.00	WHO disbursement for 2012 and 2013 done in 2012.
HSS	70,280.60	27,160.60	0	27,160.60	Activities not started due to delay in workplan budget agreement.
UNDP Contribution	466,798.00	291,798.00	20,400.00	271,398.00	
TOTAL	2,125,881.47	791,827.93	493,565.33	298,262.60	Spend rate 62%

8.0 SUCCESS STORIES, LESSONS LEARNT AND CHALLENGES

8.1 Success stories

8.1.1 DDT Local Support Services

UNDP has been procuring DDT since Round 8 to spray in 21 districts of the country. The production and use of DDT are strictly restricted by an international agreement known as the Stockholm Convention on Persistent Organic Pollutants. The Convention's objective is to protect both human health and the environment from persistent organic pollutants. DDT is one of 12 chemicals identified as a persistent organic pollutant that the Convention restricts. In line with the Stockholm convention and other international bodies there is a need for provision of local services with regard to DDT import, storage, distribution, training, waste management and incineration to recommended incinerators in the country.

Since 2010 UNDP, contracted Nets For Africa (NFA) to provide local support services. At inception there were a lot of challenges faced with the implementation of the local support services. But in 2013 season there has been a great improvement in the implementation of the local support services. Due to improved communication and close monitoring of the local support services, NFA managed to comply with international and local requirements; including transporting DDT in designated vehicles and storing the DDT in recommended warehouse. NFA managed to collect 100% of the waste generated during spraying and incinerated it at recommended temperatures of 1,200 degrees Celsius.

8.1.2 Steady decline in malaria incidence

The country has realised a decline in malaria incidence from 45 cases per thousand population in 2010 to 21 cases per thousand population in 2012. This achievement have been due to concerted efforts by key malaria partners, increasing in the funding of malaria and multiple malaria interventions instituted in the 30 high burdened malaria cases.

8.1.3 Lessons Learned

1. During grant implementation, it was apparent that working together as a team would reduce the incidence of malaria in Zimbabwe
2. The programme realised an improvement in communication with the implementing partners and this helped us to procure malaria commodities on time, since we managed to access the specifications and quantifications on time. For example despite the delay in the start of the SSF grant (1 April 2012), the grant managed to procure and distribute DDT on time. During grant negotiation MOHCW was requested to endorse and approve the PSM Plan at planning stage and this also contributed to timely procurement of commodities.

8.1.4 Challenges

The following are the major challenges that were faced during the implementation of grant

1. The programme continues to experience challenges with accurate quantification of ACTs and RDTs, and this leads to expiries of the commodities in some cases without being noticed.
2. There has been poor distribution of malaria commodities in the SDP leading to false shortages of ACTs and RDTs. This is partly because the distribution of commodities is population-based and not based on burden.
3. It appears the quantification of DDT is less accurate as some quantities (difficult to quantify though) of DDT end up expiring in the shelves.
4. Data Quality, continues to be a challenge. This was partly due to challenges in interpreting the T-5 series on malaria indicators

5. There was a delay in the start of Mat South Pre-elimination activities in Mat South province and this affected negatively on the indicators in the Performance Framework.

9.0 CONCLUSION

The programme has continued to realize a decrease in malaria incidence and deaths and this is partly due to concerted effort of all the partners in malaria control and prevention activities. Most of the performance indicators were achieved and the grant continued to be rated A1. Generally the programme is realising a gradually increase in funding from various partners including Global Fund, PMI and the government. However it remains very important to scale up malaria activities, focusing on pre-elimination.

REFERENCES

- 1) 2012 Zimbabwe Malaria Indicator Survey Report
- 2) 2012 Zimbabwe Preliminary Census Report
- 3) Munhenga, G., Masendu, H.T., Brooke, B.D., Hunt, R.H., Koekemoer, L.K., (2008) "Pyrethroid resistance in the major malaria vector *Anopheles arabiensis* from Gwave, a malaria-endemic area in Zimbabwe". *Malaria Journal*, 7:247.
- 4) Taylor, P., Mutambu, S.L., (1986) "A review of the malaria situation in Zimbabwe with special reference to the period 1972-1981". *Trans R Soc Trop Med Hyg*, 80:12-19.
- 5) World Health Organisation (2012) *World Malaria Report 2012*, Switzerland, WHO.
- 6) Zimbabwe National Malaria Strategic Plan (2008-2013).

ANNEX 1: Statement of Assets and Equipment as at 31 December 2012

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
GF000434	NMCP	6.5.24	ADDH0400000001081	Mash West PMD	Nissan Diesel Lorry (7t)	MV	11/30/2009	65,216.91
GF000436	NMCP	6.5.24	ADDH0400000001101	Mutoko Hospital	Nissan Diesel Lorry (7t)	MV	11/30/2009	65,216.91
GF000437	NMCP	6.5.24	ADDH0400000001103	Manicaland / Chimanimani	Nissan Diesel Lorry (7t)	MV	11/30/2009	65,216.91
GF000438	NMCP	6.5.24	ADDH0400000001104	Masvingo / Bikita	Nissan Diesel Lorry (7t)	MV	11/30/2009	65,216.91
GF000439	NMCP	6.5.24	ADDH0400000001137	Mat South / Gwanda	Nissan Diesel Lorry (7t)	MV	11/30/2009	65,216.91
GF000440	NMCP	6.5.24	ADDH0400000001139	Mat South / Bulilima	Nissan Diesel Lorry (7t)	MV	3/25/2010	65,216.91
GF000441	NMCP	6.5.24	ADDH0400000001141	Mat South / Lupane	Nissan Diesel Lorry (7t)	MV	3/25/2010	65,216.91
GF000442	NMCP	6.5.24	ADDH0400000001142	Kwekwe	Nissan Diesel Lorry (7t)	MV	3/25/2010	65,216.91
GF000845	NMCP	6.5.23	JT00B71J-X07008206	1HZ-0636841 - Mat north / Binga Hsp	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000846	NMCP	6.5.23	JT00B71J-207008250	1HZ-0637078 - Ndanga Hospital Masvingo Province	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000847	NMCP	6.5.23	JT00B71J-307008239	1HZ-0637033 - Neshuro Hsp MWENEZI	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000848	NMCP	6.5.23	JT00B71J-X07008402	1HZ-0637956 - Chiredzi Hospital	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000849	NMCP	6.5.23	JT00B71J-007008280	1HZ-0637264 - Mat North / Vic falls Hsp	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000850	NMCP	6.5.23	JT00B71J-207008264	1HZ-0637175 - Mat South / Mangwe	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000851	NMCP	6.5.23	JT00B71J-307008273	1HZ-0637231 - Mat South / Mangwe	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000852	NMCP	6.5.23	JT00B71J-307008306	1HZ-0637402 - Kwekwe Hsp	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000853	NMCP	6.5.23	JT00B71J-307008385	1HZ-0637850 - CHIMANIMANI	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000854	NMCP	6.5.23	JT00B71J-507008372	1HZ-0637786 - Chimanimani	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000855	NMCP	6.5.23	JT00B71J-507008386	1HZ-0637862 - MT DARWIN	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000856	NMCP	6.5.23	JT00B71J-507008258	1HZ-0636914 - Centenary St Alberts Mission hsp	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000857	NMCP	6.5.23	JT00B71J-707008308	1HZ-0637428 - GURUVE	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000858	NMCP	6.5.23	JT00B71J-807008401	1HZ-0637953 - Mash East / MUREHWA	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000859	NMCP	6.5.23	JT00B71J-007008134	1HZ-0636332 - Mash East PMD	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000860	NMCP	6.5.23	JT00B71J-507008145	1HZ-0636438 - Mash West PMD MAKONDE	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000861	NMCP	6.5.23	JT00B71J-407008251	1HZ-0637086 - Mash west / Siakobvu Dist hsp	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF000862	NMCP	6.5.23	JT00B71J-507008288	1HZ-0637297 - NYANGA	LANDCRUISER HARD TOP 5 DOOR	MV	2/3/2010	36,889.50
GF001927	NMCP	1.1.1	10HIN0C00003N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
GF001928	NMCP	1.1.1	10HIN0C00007N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001929	NMCP	1.1.1	10HIN0C00013N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001930	NMCP	1.1.1	10HIN0C00023N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001931	NMCP	1.1.1	10HIN0C00049N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001932	NMCP	1.1.1	10HIN0C00054N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001933	NMCP	1.1.1	10HIN0C00058N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001934	NMCP	1.1.1	10HIN0C00061N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001935	NMCP	1.1.1	10HIN0C00070N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001936	NMCP	1.1.1	10HIN0C00077N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001937	NMCP	1.1.1	10HIN0C00082N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001938	NMCP	1.1.1	10HIN0C00083N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001939	NMCP	1.1.1	10HIN0C00088N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001940	NMCP	1.1.1	10HIN0C00092N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001941	NMCP	1.1.1	10HIN0C00100N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001942	NMCP	1.1.1	10HIN0C00105N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001943	NMCP	1.1.1	10HIN0C00108N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001944	NMCP	1.1.1	10HIN0C00114N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001945	NMCP	1.1.1	10HIN0C00243N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF001946	NMCP	1.1.1	10HIN0C00249N	Mat South PMD	Pharos Traveller 565	ICT	12/13/2010	660.00
GF002043	NMCP	6.5.20	CNCKJ72368	Mash West PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002044	NMCP	6.5.20	CNC1845168	Mash East / PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002045	NMCP	6.5.20	CNCKJ72482	Mash Central PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002046	NMCP	6.5.20	CNCKJ63377	Midlands /' PMD Gweru	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002047	NMCP	6.5.20	CNC1845167	Masvingo / PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002048	NMCP	6.5.20	CNCKJ72364	Mat North PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002049	NMCP	6.5.20	CNCKJ72363	Mat South PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002050	NMCP	6.5.20	CNCKJ72370	Manicaland PMD	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002051	NMCP	6.5.20	CNC1845062	NMCP HQ	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002052	NMCP	6.5.20	CNC1845169	NMCP Vector Control;	1 X HP2055 LASER JET PRINTER	ICT	3/7/2011	493.50
GF002158	NMCP	3.2CD	CNC101VSX2	NMCP HQ Programme asst Office	1 X HP 500B Desk top Core Duo E7500, 4GB, 320GB, Office 2010 Pro nPlus, Norton 2011, 19" LCD	ICT	3/24/2011	957.00

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
					Monitor, External Speakers			
GF002194	NMCP	6.5.21	CNO5CVH1T6	Manicaland / PMD (stores)	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002195	NMCP	6.5.21	CN078VH04X	NMCP HQ	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002196	NMCP	6.5.21	CN078VH04D	Mash West PMD	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002197	NMCP	6.5.21	CN078VH04Z	Mash East / PMD	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002198	NMCP	6.5.21	CN078VH04Y	PMD Bindura	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002199	NMCP	6.5.21	CNO5CVH1T5	PMD Gweru	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002200	NMCP	6.5.21	CN078VH1TC	Masvingo / PMD	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002201	NMCP	6.5.21	CNO78VHD42	Mat North PMD	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002202	NMCP	6.5.21	CN05CVH1TQ	Mat South PMD	HP Scan jet 5590	ICT	3/24/2011	458.33
GF002246	NMCP	6.5.22	CN5SC2NOCP	HQ Minister of Fin Office	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002247	NMCP	6.5.22	CN5SC2NOBC	NMCP HQ - FAD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002248	NMCP	6.5.22	CN5SC2NORS	MUDZI	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002249	NMCP	6.5.22	CN5SC2SOKY	Mash East / PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002250	NMCP	6.5.22	CN5SC2NOKX	Mash east / Mudzi Hsp	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002251	NMCP	6.5.22	CN5SC2NOCP	Mash West PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002252	NMCP	6.5.22	CN5SC2NOBW	Mash West / Siakobvu	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002253	NMCP	6.5.22	CN5SC2NOLO	Manicaland / PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002254	NMCP	6.5.22	CN5SC2NOC2	Mash Central / Centenary	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002255	NMCP	6.5.22	CN5SC2NOCK	Mash Central / Rushinga	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002256	NMCP	6.5.22	CN5SC2NOBO	Manicaland / Hauna	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002257	NMCP	6.5.22	CN5SC2NOCF	Midlands - PMD Gweru	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002258	NMCP	6.5.22	CN5SC2SONB	Midlands / Gokwe South Hospital	LASER JET M5025 MFP	ICT	4/26/2011	3,807.65

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
					PHOTOCOPIER			
GF002259	NMCP	6.5.22	CN5SC2NOLD	NMCP HQ	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002260	NMCP	6.5.22	CN5SC2NOQ1	Mat South / Beitbridge	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002261	NMCP	6.5.22	CN5SC2NOJ9	Mat South PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002262	NMCP	6.5.22	CN5SC2NOLZ	Mildlands / Gokwe North Hsp	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002263	NMCP	6.5.22	CN5SC2NOBL	Mat North PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002264	NMCP	6.5.22	CN5SC2NOH6	Masvingo / Chiredzi	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002265	NMCP	6.5.22	CN5SC2NOK8	Masvingo PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002266	NMCP	6.5.22	CN5SC2NOKF	Manicaland / Nyanga	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002267	NMCP	6.5.22	CN5SC2NOKX	Mat North PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002268	NMCP	6.5.22	CN5SC2NOKL	Mat North PMD	LASER JET M5025 MFP PHOTOCOPIER	ICT	4/26/2011	3,807.65
GF002493	NMCP	2.1.2.11	KCTNU14510192. KCTNU14510180. KCTNU14812984. KCTNU14811826. KCTNU14811800. KCTNU14811737. KCTNU13717766. KCTNU14811489	NMCP HQ	Kodak Easy Share digital Cameras	EQUIP	11/15/2012	1,328.00
GF002656	NMCP	6.1.2.4	N/A	Mazoe Bridge Clinic -Rushinga	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002657	NMCP	6.1.2.4	N/A	Muzarabani Clinic-Muzarabani	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
GF002658	NMCP	6.1.2.4	N/A	Kotwa Government Complex- Mudzi	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002659	NMCP	6.1.2.4	N/A	UMP Sentinel Site- UMP	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002660	NMCP	6.1.2.4	N/A	Burma Valley Clinic- Mutare	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002661	NMCP	6.1.2.4	N/A	Zindi Clinic- Mutasa	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002662	NMCP	6.1.2.4	N/A	Kasimure Clinic- Hurungwe	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002663	NMCP	6.1.2.4	N/A	Chakari Dalny Mine Clinic-Chakari	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002664	NMCP	6.1.2.4	N/A	Manjoro Sentinel Site- Binga	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002665	NMCP	6.1.2.4	N/A	Jocholo Clinic- Lupane	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002666	NMCP	6.1.2.4	N/A	Tshelanyemba Mission-Kezi	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002667	NMCP	6.1.2.4	N/A	Makakabule Clinic- Beit Bridge	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
GF002668	NMCP	6.1.2.4	N/A	Mashoko Mission- Bikita	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002669	NMCP	6.1.2.4	N/A	Chilonga Clinic- Chiredzi	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002670	NMCP	6.1.2.4	N/A	Sidakeni Clinic- Silobela	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF002671	NMCP	6.1.2.4	N/A	Kamhororo Sentinel Site-Gokwe South	Weather station (stevensons Screen, wet & dry bulb hygrometer,MaxMin thermometer, copper raingauge)	EQUIP	8/1/2011	2,938.73
GF000473	NMCP	6.5.18	(S)2CE02401VR	Head Office-BCC Officer	Laptops	ICT	6/4/2010	1,159.00
GF000474	NMCP	6.5.18	(S)2CE02401RZ	Chipinge -DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000475	NMCP	6.5.18	(S)2CE02401S7	Head Office-Vector Control Office	Laptops	ICT	6/4/2010	1,159.00
GF000476	NMCP	6.5.18	(S)2CE02401W1	Chiredzi-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000477	NMCP	6.5.18	(S)2CE02401V5	Head Office-Data Manager	Laptops	ICT	6/4/2010	1,159.00
GF000478	NMCP	6.5.18	(S)2CE02401VJ	Head Office-Logistician	Laptops	ICT	6/4/2010	1,159.00
GF000479	NMCP	6.5.18	(S)2CE02401V6	Kadoma -DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000480	NMCP	6.5.18	(S)2CE02401VK	Murehwa-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000481	NMCP	6.5.18	(S)2CE02401WD	Mat South-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000482	NMCP	6.5.18	(S)2CE02401TQ	Mat North-PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000483	NMCP	6.5.18	(S)2CE02401SL	Mash Central-PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000484	NMCP	6.5.18	(S)2CE02401TV	Centenary-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000485	NMCP	6.5.18	(S)2CE02401WL	Mt Darwin-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000486	NMCP	6.5.18	(S)2CE02401SH	Binga -DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000487	NMCP	6.5.18	(S)2CE02401S8	Midlands -PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000488	NMCP	6.5.18	(S)2CE02401VN	Mash West - PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000489	NMCP	6.5.18	(S)2CE02401S6	Head Office-Programme Manager	Laptops	ICT	6/4/2010	1,159.00
GF000490	NMCP	6.5.18	(S)2CE02401S5	Mash West-PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000491	NMCP	6.5.18	(S)2CE02401V7	Kariba-DEHO	Laptops	ICT	6/4/2010	1,159.00

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
GF000492	NMCP	6.5.18	(S)2CE02401SQ	Mash East-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000493	NMCP	6.5.18	(S)2CE02401S1	Mash East-PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000494	NMCP	6.5.18	(S)2CE02401SZ	Gokwe South-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000495	NMCP	6.5.18	(S)2CE02401SN	Midlands-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000496	NMCP	6.5.18	(S)2CE02401SM	Head Office-M and E Officer	Laptops	ICT	6/4/2010	1,159.00
GF000497	NMCP	6.5.18	(S)2CE02401S	Masvingo-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000498	NMCP	6.5.18	(S)2CE02401SC	Mat South-PEHO	Laptops	ICT	6/4/2010	1,159.00
GF000499	NMCP	6.5.18	(S)2CE02401RX	Mwenezi-DEHO	Laptops	ICT	6/4/2010	1,159.00
GF000500	NMCP	6.5.18	(S)2CE02401VD	Mat North-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000501	NMCP	6.5.18	(S)2CE02401TS	PMD Mat North	Laptops	ICT	6/4/2010	1,159.00
GF000502	NMCP	6.5.18	(S)2CE02401TD	Mash Central-PEDCO	Laptops	ICT	6/4/2010	1,159.00
GF000668	NMCP	6.5.19	3CB94622HG	Shamva-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000669	NMCP	6.5.19	3CB94222HD	Nkayi-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000670	NMCP	6.5.19	3CB94222BS	Makonde-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000671	NMCP	6.5.19	3CB94623TF	Mutasa-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000672	NMCP	6.5.19	3CB94223LR	Zaka-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000673	NMCP	6.5.19	3CB94623FY	UMP-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000674	NMCP	6.5.19	3CB946236V	Gokwe North-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF000675	NMCP	6.5.19	3CB94622PY	Mutoko-DEHO	Desktops, complete with monitors	ICT	6/4/2010	876.00
GF001395	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001396	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001397	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001398	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001399	NMCP	2.1.2.11	5.23454E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001400	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001401	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001402	NMCP	2.1.2.11	5.23444E+11	NMCP Kaguvi Building	Canon HFR-306 Video Camera	ICT	10/9/2012	547.25
GF001406	NMCP	2.1.2.10	TRF1470Q60	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
GF001407	NMCP	2.1.2.10	TRF1470P27	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
GF001408	NMCP	2.1.2.10	TRF1470Q45	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD	ICT	10/9/2012	992.00

GFATM Asset No.	Entity (PR, SR & SSR)	Activity No.	Engine/Serial Number	Location	Description	Category	Date of Acquisition	Total
					Monitor			
GF001409	NMCP	2.1.2.10	TRF1470QFY	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
GF001410	NMCP	2.1.2.10	TRF1470Q05	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
GF001411	NMCP	2.1.2.10	TRF1470Q7V	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
GF001412	NMCP	2.1.2.10	TRF1470PVG	NMCP Kaguvi Building	HP Pro 3400MT with 18.5" LCD Monitor	ICT	10/9/2012	992.00
Grand Total								1,397,986.90

Balance As at 31 December 2011		\$1,343,558.90
Additions for 2012	30 x Laptops	\$34,770.00
	8 x Desktops	\$ 7,008.00
	8 x canon video camera's	\$ 4,378.00
	8 x Kodac digital camera's	\$ 1,328.00
	7 x Pro3400mt Desktops	\$ 6,944.00
Register balance as at 31 December 2012		\$1,397,986.90