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The Global Fund programs in challenging monetary environment: Example of Zimbabwe

Report

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Preface

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- Global Fund investments in Adolescents and Youth in Eastern and Southern Africa for the years 2018-2020
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- Involvement of Supreme Audit Institutions (SAIs) in Global Fund Grants Oversight
- Value for money of Global Fund investment in HIV, TB and malaria in selected sub-Saharan African countries

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Executive summary

Zimbabwe is among African countries with the highest HIV prevalence, with adult prevalence of 13.3% in 2017. The country has a generalized HIV epidemic but has higher prevalence rate among key populations. It is also among the 30 high TB countries in the world and has a major malaria public health problem. The Global Fund to Fight AIDS, Tuberculosis and Malaria has been supporting Zimbabwe to fight the three diseases.

Zimbabwe's economy relies on its agriculture and mining sectors. Between 1998 and 2008, Zimbabwe's economy shrunk significantly due to economic consequences of a land reform program. As a result, the country faced severe episode of hyperinflation in recorded history. Due to the hyperinflation, Zimbabwe abandoned the use of Zimbabwean dollar in February 2009 and opted for the use of US dollar, a foreign currency, as the main means of exchange. This dollarization stabilized the economy and cured the hyperinflation.

In November 2016, Zimbabwe introduced bond notes as a financial instrument for use within the country to remedy the scarcity of foreign reserves and promote exports. Although the bond notes were issued officially at par with the US Dollar (1:1), the bond note lost value on parallel markets. On 1 October 2018, Zimbabwe introduced monetary and fiscal policy measures that brought turmoil in the economy. The Reserve Bank of Zimbabwe (RBZ) required retail banks to separate foreign currency accounts (FCAs) into two categories: the Nostro denominated in foreign currency and Real Time Gross Settlement (RTGS) denominated in bond notes. At the same time, the Minister of Finance and Economic Development announced hiked taxes on electronic transactions: every dollar transferred electronically in Zimbabwe attracted a two (2) percent tax.

We sought to explore the effect of these changes in monetary and fiscal policies on Global Fund grants in Zimbabwe. Data for the study came from two sources: document reviews and key informant interviews.

The change in monetary and fiscal policies had negatively affected Global Fund grants in Zimbabwe. First, it delayed Global Fund grant implementation, particularly during the last quarter of 2018, due to challenges in paying for goods and services. Suppliers and healthcare workers were unwilling to accept transfers because of the high likelihood of receiving bond notes and not US dollars. Secondly, the change in monetary policy brought about differences in the exchange rates, which affected the prices of goods and services thereby introducing difficulties in establishing value for money.

Thirdly, the healthcare workers were affected by the change in monetary policy as there were delays in paying their top-up allowances. This lowered their morale. Fourthly, it affected the ability of the State, particularly National AIDS Council (NAC), to procure ARVs. Fifthly, it contributed to the expanded role of UNDP, at the expense of the Ministry of Health and Child Care, to procure some essential drugs and non-health products outside the Global Fund Pooled Procurement Mechanism (PPM) and the Global Drug Facility (GDF) mechanism.

Background

Zimbabwe is among African countries with the highest HIV prevalence. In 2017, the country had an adult prevalence of 13.3%, higher than that of eastern and southern Africa (region with highest HIV prevalence globally) of 6.8% [1]. The HIV prevalence was higher among women (16.1%) than men (10.5%) in 2017 [2]. Young women aged 20 – 24 years bear a disproportional HIV burden: HIV prevalence among them was 2.78 times that of men of the same age group. Social and structural factors such as early sexual debut and transactional sex are among the main drivers of HIV epidemic in Zimbabwe, particularly among the adolescent girls and young women (AGYW) [3]. Although Zimbabwe has a generalized HIV epidemic, the prevalence rate is higher among key populations. For instance, in 2017 HIV prevalence was 56.2% among sex workers, 31% among men who have sex with men (MSM) and 28% among prisoners [2]. The country has recorded significant success in the HIV fight: the number of new HIV infections declined from 79,000 in 2010 to 41,000 in 2017; and that of AIDS-related deaths from 60,000 to 22,000 in the same years [1].

Zimbabwe is among the 30 high TB countries in the world. In 2017 (the latest year with available data), the TB incidence was 221 cases per 100,000 population, lower than Africa's (region with highest TB incidence globally) of 237 cases per 100,000 population but higher than the global rate of 133 cases per 100,000 population [4]. TB incidence was higher among males than females, with 21 and 15 cases per 1,000 people respectively [4]. In the same year, Zimbabwe's estimated TB mortality rate was 50 deaths per 100,000 population, higher than the global estimates of 21 deaths per 100,000 population.

Malaria is also a major public health problem in Zimbabwe, especially during the rainy season when more than half the population is at risk of getting it. In 2016, Zimbabwe's malaria incidence declined to 21 cases per 1,000 population, down from 39 cases per 1,000 population in 2014 [5]. Still in 2016, most (82%) of malaria cases in Zimbabwe occurred in three of the ten provinces which are Manicaland, Mashonaland East and Mashonaland Central [6]. The risk of malaria is highest in regions bordering Mozambique and Zambia. Zimbabwe has 20 districts, out of the 47 with malaria transmission, implementing malaria elimination activities [7].

The Global Fund to Fight AIDS, Tuberculosis and Malaria grants accounts for 48% of the main funding for HIV in Zimbabwe [8 9]. For the current implementation period 2018–2020, Zimbabwe allocation was US$ 501,872,596; 85% of this amount (US$ 426,411,012) was for HIV, while 10% (US$ 51,685,777) went to Malaria and 5% (US$ 23,775,807) to TB [10]. The United Nations Development Programme (UNDP) is the Principal Recipient (PR) for the HIV and AIDS grant while the Ministry of Health and Child Care (MOHCC) is the PR for TB and Malaria grants. Zimbabwe is a high impact country for Global Fund and has been on additional safeguard policy (ASP) since 2009.

Before the Global Fund was created and with the aim of raising funds for its national HIV programmes, Zimbabwe introduced the National AIDS Trust Fund (NATF), known as 'AIDS Levy', in 1999. Formal employers and their employees in Zimbabwe are required to contribute 3% of their profits and income, respectively, to the AIDS Levy. Since 2016, Zimbabwe's mining sector was roped in to contribute to the AIDS levy [11]. On average, the AIDS Levy generate about

US$ 35 million annually, half of which is used to procure ARVs and the rest spent on HIV prevention and administrative costs [9]. The National AIDS Council (NAC) administer the AIDS levy.

Zimbabwe's economy relies mainly on its agriculture and mining sectors [12]. Value added tax (VAT), income and excise tax are the main source of state revenue in Zimbabwe. Between 1998 and 2008, Zimbabwe's economy shrunk significantly due to economic consequences of a land reform program referred as Fast Track Land Reform Programme (FTLRP). This policy effected fully in 2000 aimed to transfer agricultural lands from a minority White Zimbabweans who constituted less than one percent of the population and owned 70% of arable land to their Blacks compatriots. The policy was followed by international sanctions which precipitated penuries, lack of investor confidence, price controls among other factors [13].

Zimbabwe faced the second most severe episode of hyperinflation in recorded history in November 2008 when the value of the Zimbabwean dollar, its official currency, decreased by 79.6 billion percent [14]. As a result of the hyperinflation, Zimbabwe abandoned the use of Zimbabwean dollar in February 2009 and opted for the use of US dollar, a foreign currency, as the main means of exchange [15]. This dollarization stabilized the economy [16] and cured the hyperinflation. While the dollarization solved the inflation problem, it came with the inability to use monetary policy, especially the devaluation, to boost exports or address other economic challenges.

Figure 1: Zimbabwe location in southern Africa

In November 2016, Zimbabwe introduced bond notes as a financial instrument for use within the country [15] to remedy the scarcity of foreign reserves and promote exports. Although the bond notes were issued officially at par with the US Dollar (1:1), the bond note lost value on parallel markets, and by September 2018 they traded at discount of up to one USD for 1.80 bond notes. By February 2019, when RBZ renamed bond notes as 'RTGS dollars', they had further lost value on the parallel market, exchange at 1 USD for 4 bond notes [17-19]. As of 24 June 2019, the parallel market rate of USD to RTGS dollar was 1:11 while the official rate was 1:6 [20]. Nevertheless, the US dollar remained the main currency and health programs, even those managed by the State, held bank accounts denominated in USD for payment of health workers, purchasing of health commodities, fuel, utilities and other payment necessary for a functioning health system.

On 1 October 2018, Zimbabwe introduced monetary and fiscal policy measures that brought turmoil in the economy. First, the Reserve Bank of Zimbabwe (RBZ) required retail banks to separate foreign currency accounts (FCAs) into two categories: the Nostro and Real Time Gross Settlement (RTGS). The RBZ directed retail banks to separate the FCAs without account holders' consent but based on the principle of know-your-client (KYC). The Nostro accounts remained in foreign currency while the RTGS accounts were all denominated in bond notes and coins only [21]. There was no mechanism to transfer foreign currency among banks, and when a Nostro account holder transferred fund to another account outside its bank, the receiver would receive RTGS denominated in bond notes (local currency). This policy brought economic turmoil as Zimbabweans were reluctant to accept bond notes that had lower values in the market. Second, the Minister of Finance and Economic Development announced hiked taxes on electronic transactions: every dollar transferred electronically in Zimbabwe attracted a two (2) percent tax. This was an increase from the five (5) cents charged for every transaction regardless of the amount, in effect since January 2003 [22].

Facing economic crisis, in February 2019, the RBZ announced a second monetary policy and established an inter-bank foreign exchange to allow transfers across banks, renamed the local currency as 'RTGS dollar', [19] and to let the exchange rate be determined by market forces and not by RBZ policy. The Zimbabwe government required all entities in the country to settle domestic transactions using the RTGS dollar. Thus, health programs, health workers and all Zimbabweans were to use the RTGS dollar in the delivery of health services.

We sought to explore the effect of these changes in monetary and fiscal policies on Global Fund grants in Zimbabwe and discuss the way forward. Findings of the study intend to strengthen Global Fund grants implementation in Zimbabwe.

Methods

Study design

This study is exploratory qualitative case study on effect of change in monetary and fiscal system on Global Fund grants.

Data collection

Data came from two sources. The first source is the review of official documents of the Global Fund, the Reserve Bank of Zimbabwe, and other government entities that issue direction on money and health policy. The second source of data was key informant interviews conducted via Skype and phone calls. The key informants were employees of the Principal Recipients, the Global Fund Secretariat, Global Fund grants implementers and civil society in Zimbabwe. The key informants' selection was purposively done based on their familiarity with Global Fund grants implementation in Zimbabwe. We prepared semi-structured interview guides to help in data collection. For interviewees comfort and encouraging fluent dialogue with detailed responses, the interviewer adopted a conversational style of interviewing.

The interviewer asked a set of open-ended questions that revolved around the change in monetary and fiscal policies, and Global Fund grant implementation in Zimbabwe. Documentation of the responses was through note taking. We conducted the interviews at the end of May and early June 2019.

Data processing and analysis

This study analysis used the framework analysis for qualitative content. Initial analysis was done by categorizing issues highlighted by the interviewees. The highlighted issues informed thematic framework development. Deeper analysis was done by indexing data within thematic framework thereby guiding identification of themes.

Findings

From the analysis, five themes were identified:

1. Delayed Global Fund grant implementation,
2. Financial and accounting challenges,
3. Low healthcare worker morale,
4. Inability of the State to procure ARVs,
5. Expansion of the UNDP's role.

Delayed Global Fund grant implementation due to late payments and hiked prices

In Zimbabwe, the was delay in Global Fund grant implementation particularly during the last quarter of 2018, following the monetary policy requiring the separation of foreign accounts into Nostro and RTGS, because of challenges in paying for goods and services. Retail banks automatically converted all the cash balances in the established RTGS FCA accounts, at the time of the announcement of the monetary policy, to RTGS denominated in bond notes. However, the policy did not provide a framework for interbank transactions in USD in effect blocking electronic bank transfers from one bank to another in USD.

Suppliers and healthcare workers were unwilling to accept transfers because of the high likelihood of receiving bond notes and not US dollars. The RTGS accounts denominated in bond

notes was not exchanged outside the central bank at 1:1 at parity that the reserve bank announced. As a key informant states,

> *"The Monetary Policy had immediate impact on grant implementation to the extent that most of planned programmatic activities could not be implemented as planned in for the last quarter of last year [2018] …. even in situations where implementation had been done people were not willing to accept payment because it would be done in RTGS and they would not get the same value, and thus affecting year 1 financial performance of the grant"* (KII 1, Principal Recipient, UNDP).

Another key informant also echoed these sentiments,

> "*we were paying our community health workers…. their allowances in local currency as opposed to US dollar. Practically we all knew it was not 1:1 but in terms of policy it was 1:1"* (KII 2, Civil Society)

It was in February 2019 that the Reserve Bank of Zimbabwe established the framework for inter-banking transactions and acknowledged that the RTGS was not the same as the US dollar. Upon this admission, the RBZ introduced an exchange rate of 2.5 RTGS for every US dollar. However, this rate was lower than the then prevailing parallel market rate of 4 RTGS for every US dollar.

Financial and accounting challenges

The differences in the exchange rates also affected the prices of goods and services thereby creating disparity between the budgeted and quoted unit cost. Also, the change in monetary policy also introduced difficulties in establishing value for money, as indicated by a key informant,

> *"there is a drop in procurement of all goods and services in [the] country, so everything which is not dollar priced will have a different price [in bond notes] so value for money is difficult to establish."* (KII 4, Global Fund)

Difference between the official and parallel market US dollar exchange rates in Zimbabwe posed grant accountability challenges. For instance, if the exchange rate of one US dollar was 3.5 and 5.5 RTGS dollars in the official and parallel market rates, respectively, the goods and services quoted in local currency can only be accounted for using the 3.5 rate which did not reflect the true value of the US dollar as indicated by a key informant,

> *"if the price is quoted in local currency but you want to pay in USD it means you have to convert it using 3.5 [official exchange rate] so you end up using more US dollars"* (KII 2, Civil Society).

In fact, those who used the formal channels got fewer local currencies so can fund fewer activities.

Global Fund grants were newly subjected to 2% tax on all electronic transactions introduced on 1 October 2018. The Global Fund resources under UNDP, the HIV principal recipient (PR) in Zimbabwe, were not affected due to their UN status (the UNDP was exempted as part of the Convention on the Privileges and Immunities of the UN); however, the UNDP sub-recipients

were not. In fact, Global Fund grant implementers paid the tax as from October 2018 when it was introduced as indicated by a key informant:

> *"…some of the implications, as part of the fiscal policy to introduce a 2% tax on all electronic transactions and there was no exemption meaning that the Global Fund resources […] were supposed to pay taxes using Global Fund [resources] ….and indeed the deductions were automatically done."* (KII 1, Principal Recipient, UNDP)

Cascading grant funds from the PRs to the implementers attracted more charges depending on the number of bank accounts it has to go through as indicated by a key informant,

> *"If there are three layers to the community organization ….if [money] is sent to three different bank accounts, it attracts three times the 2% because every transaction is affected, so the cost is on Global Fund grants, but it is not just Global Fund grants but every transaction, its universal."* (KII 4, Global Fund)

UNDP and the MOHCC engaged the Minister of Finance to exempt tax on Global Fund resources and obtained this approval in March 2019, pending the issuance of Statutory Instrument by Parliament. Thus, all the Global Fund grant implementers that paid the tax had to get a refund as indicated by a key informant:

> *"but […] we are not going to lose any funds because we put in place a tracking tool to document all the payments, and those partners who had paid had to get the refund. So, going forward the Global Fund resources […] will not be affected by this new tax. But it was a challenge initially, it took time to engage at the highest level"* (KII 1, Principal Recipient, UNDP)

UNDP had earlier engaged with the Reserve Bank and the Ministry of Finance to ring fence all Global Fund and UN resources and ensured US dollars were available as and when needed. This ring-fencing facility was availed with Standard Chartered Bank—the UN bank in Zimbabwe. At the beginning of the new grant in 2018, UNDP requested its sub-recipients to open bank accounts with Standard Chartered Bank to ease implementers' access to US dollars while reducing disbursement delay with the view of a timely implementation. But implementers receiving funds in other banks could not receive them in USD.

Low healthcare worker morale due to delays in paying health care workers

The Global Fund grant in Zimbabwe provides for a top-up allowance for health care workers, paid in USD, as an incentive and retain them. As a result of the changes in the monetary policy, over 24,000 healthcare workers could not receive their top-up allowances from the Global Fund grants in USD, affecting their morale and thereby slowing down implementation of programs supported by the Global Fund. Moreover, payment to over 7,600 village health workers supported by the Global Fund was not timely, due to the same challenges. The lack of payment of top-up allowances to health workers may have contributed to their industrial action, as indicated by a key informant:

> *"the village health workers, community health workers, who are supposed to be out there providing services who cannot be paid their salaries, their allowances and with all that*

what do we expect? Certainly, their morale is affected and since October there have been a series of strike action by health workers" (KII 1, Principal Recipient, UNDP)

Inability of the State to procure ARVs

Zimbabwe, like other countries receiving Global Fund investments, committed to fund part of the HIV responses with domestic funds. As part of this co-financing, NAC committed to procure ARVs for about 100,000 patients using the AIDS levy which are domestic funds raised through tax to fight HIV. However, the NAC could not honor this commitment as it could not get the equivalent USD needed even though it had adequate bond notes. As a temporary measure, the NAC requested the UNDP to procure ARVs using UNDP's own resources, ahead of schedule, to avoid treatment disruption among the 1.1 million people who are on ARV treatment. As stated by a key informant:

> *"the challenge is […] the government committed to buy ARVS for […] patients. We are having challenges to access US dollars to do the actual procurement. So, there will be delays [of] government to meet its obligations."* (KII 3, Sub-Recipient)

Compounding the issues of obtaining US dollars is the depreciation of the bond-note:

> *"the problem is what was set aside was about 30 million dollars which we thought was equivalent to US dollars because the rate was 1:1 but we woke up one morning after the change in the monetary policy when we introduced the RTGS dollars again, it was no longer 30 million US Dollars again it was something else"* (KII 2, Civil Society)

In 2019, Zimbabwe had shortage of ARVs arising from the gap between targets and commitments by donors (Global Fund and PEPFAR) and NAC. The Global Fund bridged the gap by re-investing savings made from procurement of ARVs. Thus, Zimbabwe has enough ARVs for the year 2019 as stated by our key informant,

> *"this [2019] year, there are no stock-outs and there will be drug supply irrespective of the economic situation."* (KII 4, Global Fund)

According to the formers Permanent Secretary of the Ministry of Health and Child Care, Zimbabwe is still committed to meet its co-financing commitments, despite the inability to procure ARVs using RTGS dollars from the AIDS levy. The MOHCC is considering swapping its co-financing commitment, which needs foreign currency, with other HIV-related activities that are payable with local currency.

Expansion of the role of UNDP

The State PR for TB and malaria, the MOHCC, procured some health products and non-health products through the Global Fund Pooled Procurement Mechanism (PPM) and the Global Drug Facility (GDF). However, the MOHCC could not procure other health products and non-health products outside those mechanisms, after the change in monetary policy. To deal with the challenge, UNDP's role was expanded beyond its initial fund administrator role to the government PR, to procuring some essential drugs and non-health products, outside the PPM and GDF mechanism.

In the original agreement, the UNDP was a fund administrator; its role was to verify the procurements processes to ensure that they comply with both national and international standards and make recommendations for local procurement payments, but not to procure commodities for the MOHCC. The UNDP was to sequester funds, oversee procurement and strengthen capacity in supply chain and financial management systems.

With the monetary challenges, the MOHCC requested the UNDP to procure some health and non-health products on its behalf, as our key informant said:

> *"So we have had amendment to the Support Services Agreement with both the Global Fund and MOHCC as we speak, and we are doing some procurement of health and non-health products that they should have procured on their own"* (KII 1, Principal Recipient, UNDP)

Discussion and conclusion

We set to explore the effect of change in Zimbabwe monetary system and policies on Global Fund grants. The change in monetary policies slowed grant disbursement to local implementers and thus implementation, introduced new grant financial and accounting challenges, lowered morale of healthcare workers, and lowered market value of government funds to be used for procurement of health commodities. The turmoil consecutive to the policy change led to expansion of the role of UNDP for procurement and fund administration support services at the expense of the national ministry.

The policy requiring separation of banks accounts into Nostro and RTGS affected grants in several ways. First, consumers lost confidence in the local currency leading to its depreciation relative to US dollars in parallel markets compared to the set official rates. Considering that most traders, service providers and suppliers preferred payments in US dollar and the fact that the parallel market exchange rate was at higher premiums [15], the purchasing power of Global Funds grant in implementers accounts using official route was lowered. Overvaluation of local currency has been associated with shortages in foreign exchange [23] reducing the ability of Zimbabwe to import essential drugs.

Second, the framework for interbank transactions in US dollars was absent for five months rending impossible the transfer of funds denominated in foreign currency between banks. The absence of the framework for interbank USD transactions delayed payments to suppliers and healthcare workers unwilling to be paid in the lower value local currency. In fact, for residents, accepting payment in local currency at the exchange rate at par with US dollars would have shortchanged them in the parallel market where they often exchange currencies. Unless acceleration plans are put in place, programs supported by the Global Fund for the 2018-2020 are at risk of delayed implementation.

Third, the change in monetary policy delayed salary payments to health workers in Zimbabwe thereby lowering their morale. Similar findings have been reported in low and middle income countries, where delays in salaries payments were documented to cause fear, anxiety and lower morale of health workers [24] [25]. Besides being a demotivator, delayed payments is one of the

factors that may influence health workers to leave health service [26] or resort to industrial action [27]. Considering that health workforce is one of the key pillars of a functional health system [28], the delay of their payments could not only negatively affect service delivery and the fight against the three diseases but the entire health system in Zimbabwe. Additionally, it may hamper efforts to fight brain drain in programs supported by the Global Fund in Zimbabwe.

Requesting implementers to open bank accounts with Standard Chartered Bank to allow access to USD was a good initiative in tackling grant disbursement delays. However, the initiative did not solve the challenge of access to USD to those without accounts with Standard Chartered Bank. The solution to this issue lies with the country using a currency accepted by its citizens as a stable means of payment.

The Zimbabwe AIDS levy is regarded as an international best practice to increase domestic financing to HIV programs [11]. According to UNAIDS, the AIDS levy is an innovative fund that ensures sustainability of HIV programming and reduces reliance on international financing [29]. Findings from this study indicate that the AIDS levy is at risk of losing its glory as it has lost its buying power when it was converted to local currency (RTGS). Zimbabwe committed to meet co-financing using AIDS Levy [9] to procure ARVs. However, NAC which administer the AIDS levy could not access foreign currency to procure essential drugs from international suppliers. In the current circumstances, the co-financing commitment can be considered at risk until the national currency stabilizes. Such issues are beyond the Global Fund grants and are related to country sovereignty. Nevertheless, a speedy solution to the depreciating local currency is needed to enable the NAC and other government institutions to procure ARVs and other commodities. The well-being of the 1.3 million Zimbabweans who live with HIV as well as the prevention effort towards the remaining of the 15.2 millions of Zimbabweans depends greatly on it.

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