# CBM Partner Assessment Tool

**Purpose of CBM Partner Assessment Tool**

A partner assessment (PA) will be conducted with all organisations with whom CBM wishes to formally partner. The PA is a discussion between CBM and the organisation. It provides an opportunity for mutual learning and to reflect on organisational capacities in relation to quality, accountability and good practice standards as defined by CBM and which are also reflective of wider good practices and minimum standards across the sector. The purpose of CBM's PA is to:
 • Help organisations to identify its strengths and weaknesses and identify steps to address capacity gaps, allowing for organisational development and      sustainability of programme goals;
 • Ensure CBM meets due diligence requirements;
 • Provide an opportunity for mutual learning and to identify practices that can be shared within CBM and its partners.

In some cases, more technical aspects of the work of an organisation, e.g. infrastructure, equipment, quality of treatments, surgeries, production of devices and capacity to train third parties among others, will also need to be considered. Technical assessments will be conducted for this purpose as there are different approaches and/or checklists for each area of work. As much as possible, technical assessments will be conducted at the same time as the PA with the support of a CBM advisor.

**Partner Assessment tool**

The tool is divided into three parts:

Part 1: Information about the organisation

Part 2: PA questionnaire (includes governance & leadership, financial and programmatic section), which includes:
 • Minimum criteria (Red) are the benchmark to determine whether the organisation has the minimum capacity required for CBM to consider pursuing a formal partnership with the prospect of funding.
 • Criteria to attain(Green). This is not a repetition of the minimum criteria but identifies areas that will be gradually strengthened by the organisation to improve the quality and accountability of work, as well as organisational performance. Depending on the envisaged partnership and funds involved, some of the green criteria might be required from the beginning of the partnership to ensure adequate management of funds.

Part 3: PA Action Plan

The practices of the organisation will be assessed against the identified statements according to the following appraisal system:
 • Yes: the practices of the organisation are aligned with the statement. Area of work does not need improvement. Please

capture good practices of the partner in the comment section.
 • Partially: the practices of the organisation are partially aligned with the statement. Area of work requires some improvement. Please clarify in the comments section existing practices and areas that require strengthening.
 • No: the practices of the organisation are not aligned with the statement. Area of work requiring much work. Level of capacity requires significant strengthening.
 • N/A: if a criteria is not applicable to the organisation (for example, when a registration is not required), please select Not applicable (N/A) and provide a brief explanation in the comment section.

Comments for all appraisals will be added to the comments box to substantiate the appraisal. Comments will elaborate on how the practices of the organisation and policies align with the criteria provided. In the case of a 'Partially' appraisal, it will also be indicated whether the organisation has just initiated work in this area or if significant progress has already been made.

When a criteria is not applicable to the context and/or the type of organisation, this will be clarified in the comment box and a brief explanation will be provided.

Sources of verification (SoV) need to be provided for all criteria. Examples of SoVs that can be used are provided in the tool. Tick the boxes as relevant.

SoVs need to be reviewed and copies of relevant documents need to be provided by the organisation and kept on file by CBM. This will include:
 • Registration document
 • List of Board members
 • Organisational chart
 • Last annual financial report
 • Latest annual activity report
 • Latest audit report (when available)

**Outcome of the assessment**

The PA tool will be completed by CBM staff. The outcome of the assessment will be discussed with the organisation. The organisation will be provided with an opportunity to comment and share feedback on CBM's findings and recommendations. CBM and the organisation will jointly agree on appropriate steps to address identified capacity gaps (if any), including actions that can be taken without external support and specific areas where CBM should consider providing technical assistance or funding. The PA Action Plan of partner organisations will be implemented according to agreed timelines. CBM will follow-up and monitor the implementation progress with partners at least once every six months, ideally during project monitoring visits.

**Review of the partner assessment**

CBM's partner assessment will be reviewed every three years, to take stock of changes within the organisation and external events. The PA tool will be completed by CBM staff. The outcome of the review will be discussed with the partner organisation. The outcome will also inform CBM's decision on whether to continue and/or further the relationship with the partner organisation. CBM will liaise with the organisation to communicate the decision and reasons for the same.

# Part 1. Information about the organisation

**General information about the organisation**

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| Name of the organisation and country: | *Beit Cure Hospital* |
| Overall annual budget (last 3 years average): | *US$4,100,000* |
| Does the organisation have a positive track record of managing funds from CBM or other donors? | *Yes* |
| Does the organisation have experience in responding to emergencies? | *Yes, the Hospital is currently running a COVID response program* |

**Information about the prospective/ongoing partnership**

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| Date of partnership approval: | Indicate date of initial partnership approval |
| Date of the last partner assessment: | |
| Reason for intended partnership/renewal of partnership: | |

**Introduction about the organisation and its work**

*The Beit CURE International Hospital of Zambia was established in 2004. CURE International signed an agreement with the Zambian Ministry of Health to operate a pediatric teaching hospital specializing in the treatment and care of children living with physical disabilities.  The hospital is based in Lusaka.*

*Beit CURE Zambia is one of the few hospitals in Zambia able to adequately address the surgical needs of the disabled children in the country. The hospital campus is comprised of six buildings, housing 45 patient beds in the children's ward*

*and 16 beds in the private patients ward. The hospital also houses a chapel and spiritual center, three operating theaters, an outpatient clinic, an administrative building and a general services building. Services at the hospital will be focused on pediatric orthopedics, neurosurgery and reconstructive plastic surgery.*

*Since opening its doors, Beit CURE Zambia has seen over 8,000 patients and performed nearly 4,000 surgeries*

# Part 2. Partner Assessment Questionnaire

**Section I. Governance and leadership section**

The objective of the section is to review the organisation's governance structure and compliance with legal requirements, to ensure that minimum accountability standards are in place and identify areas which need strengthening.

| Criteria | Appraisal (select from drop down menu) | Sources of Verification (tick boxes as relevant) | Comment |
|---|---|---|---|
| **MINIMUM GOVERNANCE AND LEADERSHIP CRITERIA (red)** | | | |
| 1.1 The organisation is **registered**.<br><br>Definition: The organisation is a legal entity and registered with an approving body responsible for the sector in the country. | Yes | Registration document ☑<br><br>Other: | The Hospital is registered under Registrar of Societies, PACRA and HPCZ. Registration is up to date and available. |
| 1.2 The **vision & mission** of the organisation guides its work and is used to set priorities.<br><br>Definition: The organisation has a clear and shared understanding of its vision & mission spelled out in a strategic plan; or at least a stated purpose of existence and set of objectives. | Yes | Website ☑<br><br>Strategy plan ☑<br><br>Annual reports ☑<br><br>Other: list other sources | The Hospital has a functional website https://cure.org/, which reflects their vision and mission, strategic plan is in place, outlining their vision and mission, key objectives, activities and targets. Annual reports are available and shared with the country office. |

| 1.3 The organisation **collaborates** with other relevant stakeholders and has good standing at community, district and local/government levels.<br><br>Definition: The organisation is an established and a visible part of the community or relevant network. The organisation has strong linkages with other civil society groups and networks, as well as local authorities. It is known and respected within the community and amongst its peer organisations. | Yes | Feedback from stakeholders ☐<br><br>Project and field trip reports ☑<br><br>Website ☑<br><br>Other: List other sources. | The Hospital has existing and active linkages with other stakeholders and partners, including CBM, their webiste as a clear outline of their partnerships and these are also highlighted in their project and field trip reports, furthermore the Hospital has held Two(2) stakeholder's meetings which included Civil society groups to identify further collaboration opportunities, the reports are avilable and have been shared. The website link is attached below: https://cure.org/ |
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| 1.4 The Organisation has a **functioning governing body** that meets regularly.<br><br>Definition: The governing body regularly provides strategic direction, oversight and holds management to account. The governing body operates on the basis of clear roles and responsibilities and meets at least twice a year. | Yes | Schedule of meetings and participation ☐<br><br>Terms of Reference ☑<br><br>Other: | The Hospital has Two Advisory Board members, including the Executive Director, however most strategic decisions are supported by the International Board. |

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| 1.5 The organisation has a track record of successful work and can articulate and **demonstrate achievements**.<br><br>Definition: The organisation has the skills, knowledge and expertise to effectively implement, complete and maintain its projects, and can demonstrate past achievements. | Yes | Project reports ☑<br><br>Feedback from beneficiaries ☑<br><br>Annual report ☑<br><br>Website ☑<br><br>Other: | The organisation has a documented track record of compiling achievements, as demonstrated through their webiste and facebook page, project reports, annual reports which have all been shared. The hospital also conducts a quarterly in patient survey, to get feedback from beneficiaries, on the quality of services recieved. The Hopsital also has a project management Project manager, M&E officer, Community Mobilisation Officer and an Accountant. |
| 1.6 The organisation's board/leadership is **aware of and supportive of the partnership** with CBM.<br><br>Definition: CBM partnership has been discussed by the board/leadership of the organisation and the decision to enter into partnership has been documented. | Yes | Interviews ☑<br><br>Other: List other sources. | The Board/ Leadership is aware of the partnership with CBM, as evidenced by the signed contract between the Two (2) organisations, the Board is involved in project implementation as well, where approval is given before activities are implemented, reports are also shared with the Board. |

| 1.7 The organisation has a **code of conduct/equivalent statement** or is committed to developing one where this is absent, setting out its position on **all forms of unacceptable conduct** and actively promotes its adoption by staff.<br><br>Definition: The organisation has or is willing to develop within the first 6 months of its partnership with CBM a code of conduct/equivalent statement setting out its position on all forms of unacceptable conduct, including abuse of children and vulnerable adults, sexual exploitation and harassment, fraud and corruption, discrimination etc. The organisation can demonstrate that all staff and persons affiliated with the organisation (e.g. donors, free-lancers, volunteers, consultants, board members and visitors) have read, understand and signed the code of conduct. Staff has an induction at the beginning of employment and refresher trainings. | Yes | Code of conduct or similar stating remedial/disciplinary measures ☑<br><br>Solid, publicly available channels to report incidents incl. anonymous reporting channels ☐<br><br>Incident reporting & trackable handling of incidents by board/leadership ☑<br><br>Code of conduct integrated into employment and project contracts ☐<br><br>Documented induction procedures of staff/training with proof of participation ☐<br><br>Other: List oth☐: | The Hospital has a code of conduct, enshrined in the employment contract which every staff member, has to endorse upon enegagement, however they do not have an anonymous reporting channel, with incidents handled through the HR office, they are committed to developing an anonymous reporting channel. |

| 1.8 Is the organisation, its leadership and management, **named on the international sanctions lists** or adversely mentioned in local judicial action?<br><br>Definition: The name of the organisation, names of leaders and management are checked against the EU, UK, US Office of Foreign Assets Control (OFAC) and UN sanctions list. Other requirements from donors might apply and, if applicable, will also be checked. | | EU, UK, US Office of Foreign Assets Control (OFAC) and UN sanctions list<br>☐<br>Other: List other sources. | The organisation is not on the sanctions list, and no<br><br>staff member or members of the leadership are named |
| | No | | on the sanctions list. |

| Criteria | Appraisal<br>(select from drop down menu) | **tick boxes as relevant**<br>(tick boxes as relevant) | Comment |
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**GOVERNANCE AND LEADERSHIP CRITERIA to attain (green)**

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| 1.9 The organisation has a **written constitution/trust deed/bi-laws** or other governing document specifying its purpose and governance structure.<br><br>Definition: The organisation has a written governing document specifying its purpose and governance structure. Governance and management structures are well defined. The document is updated regularly and allows the organisation to work in CBM areas of work. In countries where bylaws are requested to secure the organisation's registration, this should be indicated in the comment section. | Yes | List of governing body members ☐<br><br>Written constitution/trust deed/bylaws ☑<br><br>Other: List other sources. Articles of Association | The Hospital has a valid constitution outlining all the bylaws, and also has an article of association, which outlines, the objective for which the organisation is established, and the governance structure outlining their duties and regulations of staff and the organisation. |

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| 1.10 The governing body (e.g. Board) is **independent and is appointed** by, and responsible to, a wider membership.<br><br>Definition: Members are elected based on their qualifications for a fixed-term and subject to a maximum term of service. Members are not paid and not allowed to benefit financially from their position. Board members are not related to each other and to management. A Terms of Reference (ToRs) or similar for the Board exists, or the tasks of the Board are defined in the constitution. | Yes | Written constitution/trust deed/bylaws ☑<br><br>Operational plan ☐<br><br>Terms of Reference Policies in place ☑<br><br>Processes in place ☐<br><br>Other: List other sources: Articles of Association | The hospital has an independent international board, where members are non paid, and members are appointed based on their qualifications, the members then in turn elect the Board Chairperson. |
| 1.11 The management of the organisation **reports regularly to the board/governing body**.<br><br>Definition: The management of the organisation reports at least twice a year to the board/governing body. Board provides the CEO with clear targets and reviews progress. | Yes | Written constitution/trust deed/bylaws ☐<br><br>Policies in place ☐<br><br>Processes in place ☑<br><br>Other: List other sources used: | The organisation reports through the Monthly Executive Directors's meetings , where country specific reports are given and later compiled into one report to be shared with the International Board. |

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| 1.12 The **board has the final responsibility** for the approval of strategic plans, budgets, annual accounts, policies, etc.<br><br>Definition: The governing body is legally liable for the actions of the organisation. | Yes | Policies in place<br>Annual reports  ☑<br><br>Financial statements/regulatory reports  ☑<br><br>Terms of Reference  ☐<br><br>Other: List other sources | The organisation seeks approval and endorsement of all strategic plans,budgets, and policies, which are shared for approval through the regional office in Kenya. |
| 1.13 The organisation has clear policies on **inclusive employment and gender equality.**<br><br>Definition: The organisation has policies that actively promote an accessible workplace and the recruitment of staff with disabilities to ensure equality and diversity. Adequate budget (as part of the overall budget) is allocated to address any inclusion and accessibility issues that arise unplanned. | Yes | HR and other policies in place  ☑<br><br>Budget for current financial year  ☐<br><br>Other: List other sources. | The organisation has an HR policy, which encourages the aspect of diversity and inclusion, which is also included in their job advertisements, the physical infrastructure is acessible at face value, though a thorough accessibility audit should be conducted. The organisation also has staff with disabilities. the organisation also has an OPD operating within their premises, Zambia Association for Children with Disabilities (ZACD), which is comorised of persons with disabilities are supported by the organisation through engagement in the production of assistive devices. |

| 1.14 The organisation has a strategic plan and the **capacity to document outcomes** and articulate achievements of its projects.<br><br>Definition: The organisation has a strategic plan/Business plan, which is aligned with its vision and mission, guides decisions and has been translated into a limited set of measurable performance targets. The organisation develops yearly plans and budgets for its operations (or at least for its projects), and has the capacity to monitor them, as well as measure outcomes and conduct feedback. | Yes | Plans & budgets for oper☑tions/projects<br><br>Project reports and evaluations<br><br>Data generated from own monitoring processes<br>☑<br>Other: List other sources. | The organisation has an existing strategic plan 2021 to 2025, annual plans and budgets are shared, including those of projects being implemented with CBM, evaluations have been conducted and reports are available. The organisation has a functional M&E personnel, responsible for monitoring and measuring outcomes. Reports are shared with CBM. |

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| 1.15 The organisation has **technical expertise** in at least one of CBM's areas of work and it **collaborates and develops effective partnerships** with relevant stakeholders.(the criteria builds on the minimum criteria 1.3 and identifies further areas that should be attained)<br><br>Definitions: The organisation has a strong understanding of the programmatic local context, which is reflected in the ability to mobilise and communicate with communities. Partnerships with relevant groups, networks and stakeholders exist. Expertise is recognised by policymakers, government officials and other stakeholders. This is reflected in the invitation to participate in expert groups, conferences etc. | Yes | Other: List other sources used ; MOU with the Ministry of Health, Staff CVs. | The organisation is recognised as one of the leading providers of orthopedic and Ear, Nose Throat services in the country. With an existing MOU with the Ministry of Health, they have strong community presence with a personnel dedicated to community mobilisation (Community Mobility Officer) and are currently implementing a Community Based Inclusive Development (CBID) project, the organisation is facilitating the initiative for the formation of the National ENT Committee. |

| 1.16 The organisation strives to uphold a professional basis for **health, safety and security of staff**.<br><br>Definition: The organisation has standardized operating procedures, policies, guidelines and strategies to ensure that the mechanisms for managing and mitigating health, safety and security risks for personnel, programmes, property and assets are in place. Where absent, the organisation is committed to promote safety and security awareness & training, best practices and protocols. Special focus is directed towards disability inclusive health, safety and security. | Yes | Plans available ☐<br><br>Country risk rating ☐<br><br>Policies in place ☑<br><br>Procedures in place ☑<br><br>Other: List other sources: Project Risk Register, Interviews. | The organisation has an updated risk register, conducted alongside CBM, annual safety training and fire drills are conducted, protective clothing is provided including ear plugs for gardeners and all relevant staff. COVID 19 preventive measures are in place with sanitisation stations, handwashing buckets, and social distancing measures are in place. Additionally, staff are covered under the Workers Compensation fund, in the case of accidents while conducting their duties. |

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| 1.17 The organisation has implemented a **feedback / complaints system** and effectively responds to the feedback, with accessible reporting mechanisms so that any stakeholder affected by their work may hold them accountable and to ensure transparency.<br><br>Definition: The organisation has a formal feedback /complaints system in place i.e. incoming feedback/complaints are registered, documented and followed up with timeliness and confidentiality. They consult with the people/community they serve to choose one or more ways of communication which are accessible and felt safe to use. Their code of conduct, any policies (e.g. whistleblowing), any projects planned (aims, budget, roles and responsibilities) are clearly communicated, so the community knows what to hold them accountable for. A culture of accountability, mutual respect and learning from mistakes is established in order to improve the | Partially | Whistle blower policy or similar document ☐<br><br>Registry of cases ☑<br><br>Examples of feedback/complaint position paper/document ☐<br><br>Feedback/complaint mechanisms in place and in use ☑<br><br>Other: List other sources. | The organisation does conduct quarterly surveys for feedback from beneficiaries, on services provided. However the organisation doesnot have a whistle blower system or anonymous feedback mechanism, which they are committed to developing. |

| 1.18 The organisation has **comprehensive HR policies** that enable the organisation to recruit, retain and managed staff that has the professional skills, knowledge and experience to fulfil their role.

Definition: Comprehensive policies are in place to recruit and retain staff, as well as to adequately manage staff, avoid conflict of interests and address complaints. Updated job descriptions are available for each position and performance appraisals are held at least once a year. Recruitment processes are transparent and competitive, and terms and conditions of employment are compliant with local legislation and regulations. | Yes | Policies in place ☐

Procedures and systems in place ☑

Guidelines in place ☑

Other: List other sources. - Environmental protection guidelines seen ☑ | Beit cure Hospital has an existing HR policy which guides their recruitment , management and retainment of staff. Job descriptions are available, and Jobs are advertised which promotes transparency and performance appraisals are conducted annually. |
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**Additional comments**

*1.7: Strengthen anonymous incident reporting channel*
*1.17: Develop stand alone whistle blower policy and develop anonymous feedback channels*

# Part 2. Partner Assessment Questionnaire

**Section II. Finance**

The objective of the section is to review the financial structures and systems, and to assess the organisation's compliance with financial and legal requirements, to help determine where and what areas need to be strengthened and to assess whether the (prospective) partner has the capacity to manage the envisaged volume of funds.

**Notes regarding completion**: The financial section should be completed by Finance staff or programme staff with suitable financial qualifications. Where none are available, this could also be outsourced to a financial consultant (auditor).

| Criteria | Appraisal (select from drop down menu) | Sources of Verification (tick boxes as relevant) | Comment |
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| **MINIMUM FINANCE CRITERIA (red)** | | | |

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| 2.1 The organisation has a **sufficient financial system** to meet requirements for internal control and financial reporting.<br><br>Definition: The partner organisation maintains proper books of accounts, which can be audited. There is a valid supporting document for each income and expenditure transaction. Basic accounting policies and procedures exist. | Yes | Bank reconciliation ☑<br><br>Cash count report ☑<br><br>Chart of accounts ☑<br><br>Accounting manual ☑<br><br>Petty cash procedures ☑<br><br>Project recording ☑<br><br>Reporting manual ☐<br><br>Other: List other source | The Partner has got sufficient financial systems in place required for internal control and reporting.Bank reconciliations are done monthly after monthend closures and are signed by the finance director and the one preparing.Chart of accounts is in place and guides when posting Transactions into their accounting system-X-Ledger. Petty Cash Procedures- Petty cash is posted and reconciled everyday at close of business and monthly reports produced and the finance director does spot checks. The Accounting manaual  is in Place and in use. Segregation of duties is also followed. |
| 2.2 The organisation has access to **qualified finance staff.**<br><br>Definition: The organisation employs qualified finance staff employed by the organisation and/or receives qualified finance services via an accredited accounting firm. | Yes | CVs of finance staff and verified work experience and/or Certification of qualification ☑<br><br>Other: List other sources. | The partner has got qualified finance team handling its finances. They are also accredited to the governing body of accountants in the country(ZICA)-CV's shared with us |

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| 2.3 The organisation has **adequate financing and reserves** to cover its expenditure when they fall due.<br><br>Definition: The organisation shows solvency at a first glance i.e. it is not expected to be forced to halt operations and liquidate its assets in the foreseeable future. | Yes | Verification of bank balance (positive) ☑<br><br>Balance sheet to have net assets ☑<br><br>Other: List other sources. | The partner manages 10 bank accounts , 4 specifically for each individual projects and the 6 for the main hospital.There is also a balance sheet that shows net assets.Partner also receives monthly income from its HQ. |
| 2.4 The organisation **complies with national tax, social security, and other legal requirements.**<br><br>Definition: There organisation complies with legal and financial requirements and regulations. The organisation does not have any open court cases (fiscal, legal or employee-related). Positive endorsement and/or feedback by the authorities is documented and acted upon when needed. | Yes | Income tax, sales tax, employee tax, social security ☑ returns<br><br>Tax exemption if applicable ☑<br><br>Other: List other sources. | The partners is tax compliant  and some of the taxes that they pay are: pay as you earn, withholdong tax, NAPSA,NHIMA. The partner is exempted from VAT.The organization has got a separate company handling all its tax obligations-HLB. |

| 2.5 The organisation can **forecast cashflow** into the future.<br><br>Definition: The organisation is able to identify when project funds and organisation funds will be required by month or per quarter. | Yes | Forecast for current year ☑<br><br>Budget for previous year ☑<br><br>Cashflow for last year ☑<br><br>Current set of financial reports relating to previous month or latest previous quarter ☑<br><br>Other: List other sources | The orgazition does cash flow forecasts .Budgeting is also one. In relation to the P4079 project currently being implemented by the partner, detailed forecasts are done quarterly,as of last year 2021, there transfers and spends were above 90%, demonstarting that they request what they can spend. and budgets are analysed by the partner, identifying any potential underspends or overspends, which led to the processsing of 2 IYAs for the partner after they identified potential budgetary gaps |

**FINANCE CRITERIA to attain (green)**

| Criteria | Appraisal (select from drop down menu) | Sources of Verification (tick boxes as relevant) | Comment |
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| 2.6 The organisation has a **comprehensive double-entry financial system** to meet internal control requirements and financial reporting (the criteria builds on the minimum criteria 2.1 and identifies further areas that should be attained).<br><br>Definition: Comprehensive generally acceptable accounting policies and procedures exist. There is a clear chart of accounts, which is applied by accounting staff. Clear categories exist for project cost recording and non-project costs. A cashbook, a general ledger and a petty-cash procedure exists. | Yes | Signed audit report for the previous 2 years (not older than 14 months) ☑<br><br>Audit conducted by properly registered audit firm ☑<br><br>Unqualified audit report verified ☐<br><br>Other: List other sources. | The organizations strictly runs a double entry system, using x-ledger which does not accept a posting if not posted twice. There is a clear chart of accounts for cost recording and expensing. Partner to share the audit reports for the hospital . Financial runs from July to June-Currently the finacial year running is 2021-July-June 2022. |

| 2.7 The organisation employs staff who are responsible for finances, with **adequate financial qualifications** and experience (the criteria builds on the minimum criteria 2.2 and identifies further areas that should be attained).<br><br>Definition: The organisation has qualified accounting staff. Bachelor of Arts / Bachelor of Science or equivalent in accounting or finance required. Professional qualification is preferred (CA - Chartered Accountant, CPA - Certified Public Accountant, CAT - Certified Accounting Technician). The finance manager/officer has a financial qualification with minimum 2 years work experience. Proficiency in use of the accounting software used at the project is required. All staff receive the training and support they need to carry out their financial management responsibilities. Respective job descriptions have to be available. | Yes | Specific review of Finance Manager or Head of Finance CV and profile<br>☑<br><br>External financial services contracts and SLA (if external accounting firm used)<br>☑<br><br>Other: List other sources. | The finance Director and Accountant have got necessary accounting qualifications and experiences as seen on their cv;s and academic/Professional qualifications provided |

| 2.8 The organisation is **financially viable** (the criteria builds on the minimum criteria 2.3 and identifies further areas that should be attained).<br><br>Definition: The financial stability of the organisation is established from its last balance sheet. The organisation has adequate financing and reserves to cover its expenditure. Any loans or borrowings need to be identified and management needs to explain how these will be settled. There are no negative trends in operating results, such as a series of losses, no major loans by the organisation, there is no trade credit to the organisation by its suppliers and there are no legal proceedings against the organisations. | Yes | Other sources of income e.g. own income or other donor funding for last 3 years<br>☑<br><br>Other: List other sources. | Mostly their income is donors including CBM, (currently implementing 4 projects) and other counterparts including grants from the government of zambia and MOH( Audit report-June 2021 page 24),List of donors and contracts availed for review. |

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| 2.9 An adequate **procurement system** is in place.<br><br>Definition: Sound procurement system/capacities in place, with clear procedures and procurement records maintained. Procurement policy is available. | Yes | Examples of multiple quotations for major procurement items ☑<br><br>Procurement manual and/or process ☑<br><br>Procurement focal point ☐<br><br>Other: List other sources. | The organization has a procurement policy that is followed when doing all the procurements. There is a procurement officer in charge of procurement. Theres a threshold that is in place and for major procurements they go to tender and competitive bids.e.g construction, medical equipment and vehicles. Also there is no single sourcing |
| 2.10 The organisation has a well-established **process for budgeting, forecasting, cash flow management** and reporting.<br><br>Definition: The organisation has the capacity to plan reinvestments from surpluses or the need to raise additional capital due to expected deficits. | Yes | Budgeting process with all steps and all key players ☑<br><br>Other: List other sources. | Theres a proper budgeting process in place and forecasting as even confirmed by the audit reports.programs team and finance team . The money the hospital receives is for specific items and no reivestments at the moment |

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| 2.11 The organisation has a valid user friendly and reliable **accounting software**.<br><br>Definition:  The organisation has a user friendly, reliable software that protects the integrity of the accounting data, is capable of generating the necessary accounting reports, and is operated by trained staff. | Yes | Accounting Software type, version, configuration☑ etc.<br><br>Safely stored computer system backed ups<br>☑<br><br>Access to computer system verified (restricted to authorized staff, use of passwords that are regularly<br><br>Other: List other sources. | The accounting software currently in use is user friendly and reliable. The system is called X-Ledger and its used by Cure international as a whole. It's a cloud based data storage. Acces is restricted to the users, and in this case the finance team and HR team different user rights. They use passwords to log in and every three months passwords are changed. Its centrally managed from USA and its real time |
| 2.12 The organisation has implemented an **Anti-Corruption policy**.<br><br>Definition: The organisation has a clear commitment to anti-corruption (including bribery, embezzlement of funds and fraud) reflected in briefing of staff, training, an approved Anti-Corruption Policy among others. | Yes | Anti-Corruption policy document published ☑<br><br>Staff trained on policy ☑<br><br>Other: List other sources. | Staff currently underwent fraud policy training for the entire hospital.. There is a fraud policy in place |

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| 2.13 The organisation has a comprehensive **fixed assets register** in place<br><br>Definition: All fixed assets (eg vehicles, computers, equipment) are registered in the name of the organisation. The assets are insured and controlled using a fixed assets register. The assets register is regularly updated. Annual inventory checks are carried out. Persons who carried out the check sign the register and put a date of the checks on it. | Yes | Inventory list and codification label on the assets<br>☑<br><br>Other: List other sources. | The organization has a fixed asset register in place and deprciation provided for as well. Assets are properly labelled with tags. All the assets are insured comprehensively with Hollard insurance. Annual inventory checks are done |

| 2.14 The organisation has a **grant management** system.<br><br>Definition: Grant agreements signed by official signatories are available for each grant. They are known to implementing staff and conditions are followed. Donor funds are kept for the activities they are meant for and are never 'borrowed' for other activities. Monthly management information is generated and shared with the respective managers. | Yes | Conditions of grant agreements are checked before signing ☑<br><br>Signed grant agreement (for each grant) available and compliance verified ☑<br><br>Grant conditions on procurement are known by finance staff, budget holders and procurement officer(s) ☑<br><br>Reporting to donors<br><br>Other: List other sources. ☑ | The organization has MoU's with other partners in place and grant agrrements with cbm |

**Additional comments**

# Part 2. Partner Assessment Questionnaire

**Section III. Programme**

The objective of the section is to review the organisation's policies and practices on disability inclusive development and programme planning, to ensure the quality and sustainability of programmes and identify areas that need to be strengthened.

| Criteria | Appraisal (select from drop down menu) | Sources of Verification (tick boxes as relevant) | Comment |
|---|---|---|---|
| **MINIMUM PROGRAMME CRITERIA (red)** | | | |
| 3.1 The work of the organisation is relevant to and informed by the **country development agenda**.<br><br>Definition: The organisation is well informed about the national policies and development agenda. It seeks to align its activities and programmes with it, particularly with the Universal Declaration of Human Rights, Convention on the Rights of Persons with Disabilities, Convention on the Elimination of All forms of Discrimination against Women, Convention on the Rights of the Child and Sustainable Development Goals – Agenda 2030. Programmes and projects are relevant and appropriate to the communities it works with. | Yes | Strategic plan ☑<br><br>Project plans and reports ☐<br><br>Interviews ☑<br><br>Other: List other sources. | The organisation works in line with the country development agenda, aligning activities to respond to the development agenda, including the SDGs. Furthermore their Strategic plan, is in line with the National Health Strategy and their currently implementing Community Based Inclusive Development (CBID) projects. |

| | | | |
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| 3.2 The organisation is committed to **valuing, respecting and encouraging diversity**, and seeks to be impartial and non-discriminatory in all activities.<br><br>Definition: The organisation's policies, position papers and practices promotes equality, are non-discriminatory and in line with the CRPD. The organisation effectively monitors and measures equality of opportunities and inclusion of women, men, girls and boys with disability in its activities. If not, the organisation is willing to develop relevant policies and procedures where these are absent. | Yes | Position papers and policies ☑<br><br>Programme planning & implementation ☑ practices<br><br>Policies in place ☑<br><br>Procedures in place ☑<br><br>Other: List other sources. | Beit Cure Hospital, though christian based, attends to everyone, inspite of Gender, religious beliefs and sexuality. Their services have a bias to children with disabilities, including the under privilledged who access services at no cost, to ensure inclusion in service delivery. The hosptal has a strategic policy position paper to reflect this. They follow the National Gender Policy, but they are committed to developing a stand alone gender policy, however non discrimination clauses are enshrined in their HR policy. |
| 3.3 The organisation is committed to **seeking feedback/working with and supporting Disabled People's Organisations** and to strengthening the voice of women, men, girls and boys with disabilities, in accordance with its vision and mission.<br><br>Definition: The organisation has or is willing to develop adequate channels to engage and receive feedback from DPOs and/or persons with disabilities; and to strengthening the voice of women, men, girls and boys with disabilities in its programmes and projects, in accordance with its vision and mission. | Partially | Feedback and complaint ☐ mechanisms in place<br><br>Programme development, ☑ implementation and evaluation practices<br><br>Project plans ☑<br><br>Other: List other sources. | The Hospital, through its programming and CBID project interventions, are in engagement with OPDS, and have facilitated the formation of Support Groups in the communities of intervention. The programme Manager also sits on the board of the Zambia Association of Children with Disabilities (ZACD), However there is need to develop a clear system for feedback from the OPDs. |

| Criteria | Appraisal | Sources of Verification | Comment |
|----------|-----------|-------------------------|---------|
| 3.4 The organisation is committed to the **safeguarding of the children and adults-at-risk** it works with so that they do not face abuse, neglect or exploitation through the organisation's people, programs or operations.<br><br>Definition: The organisation has programmes and operations that are children and adult friendly. It is committed (and has timelines) to developing relevant policies and procedural safeguards where these are absent or weak. The organisation promotes and safeguards the voice, choice, dignity and autonomy of people with disabilities in its programmes and work places. | Partially | Safeguarding policy/integration of safeguards into policies/manuals (e.g. HR manual, volunteer policy) ☑<br><br>Employment/project contracts incl. child and/or adults safeguarding issues ☑<br><br>Staff/stakeholder induction, training schedules and registration lists ☑<br><br>Safeguarding incident management procedural guidelines and safeguarding incident register ☐<br><br>Safeguarding risks ☑ reflected in organisational risk | The Hospital, does have a child safegauriding policy, though it lacks the component of adults at risk, induction is done for all staff and any other parties including contractors, it is signed by all staff as they are hired. Safegaurding is also inlcuded in the risk register. They have also adpoted the CBM sfegaurding policy, but are committed to improving their stand alone policy. |

| Criteria | Appraisal<br>(select from drop down menu) | Sources of Verification<br>(tick boxes as relevant) | Comment |
|----------|-------------------------------------------|------------------------------------------------------|---------|
| **PROGRAMME CRITERIA to attain (green)** | | | |

| | | | |
|---|---|---|---|
| 3.5 The organisations follows a **iPCM** (inclusive project cycle management) approach in its projects.<br><br>Definition: Communities, DPOs and persons with disabilities are actively engaged in every stage of PCM, i.e. development, implementation and evaluation. Lessons-learnt and feedback received is built into further project development. The organisation measures its impact and is able to effect change. | Partially | Manual and guidelines in place, including templates ☑<br><br>Frameworks/plans in place ☐<br><br>Project monitoring and evaluation ☑ reports<br><br>Other: List other sources. | Engagement of OPDs during project development is not strong though improving with the implementation of the new CBID project. How ever project monitoring aand evaluation shows aspects if onclusiveness as evidenced through their templates for data collection. More training is required to fully intergrate iPCM. |
| 3.6 The organisation is committed to **rights and equality for women, men, girls and boys** in all its programmes, ensuring equal value, participation and decision making by all.<br><br>Definition: The organisation is committed to a) collecting disaggregated data by sex, age and impairment/disability, b) monitor and measure the equality of both opportunities and outcomes of women, men, girls and boys involved in its programme work and c) addressing all forms of violence, discrimination, intimidation and exploitation for women, men boys and girls so they can fulfil their aspirations | Yes | Disaggregated data is collected by sex, age and ☑ impairment/disability<br><br>Gender analysis is applied when ☑ designing programme<br><br>Other: List other sources. | The organisation collects, disagregated data by sex, age and impairment/disability. And Gender analysis is done when designing programmes. Registers and data collection forms available. |

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| 3.7 The organisation has the **capacity to manage, deliver and maintain its projects** and activities without dependency on one funding source.<br><br>Definition: The organisation has a proven track record of successful fundraising from a variety of donors and of drawing on local resources and local economies, where applicable. Cost recovery policies are in place. Exit strategies and/or phase out plans have been developed during project planning to maintain activities after donor support is phased-out. | Yes | Plans and exit strategies are available ☐<br><br>Fundraising ☑ strategies<br><br>List of donors ☑<br><br>Examples of use of local resources and economies ☑<br><br>Policies and ☑ practices in place<br><br>Other: List other | The Hospital is mainly funded by Cure International which covers, 60 to 70%, of the funding. Coorporate entities such as Toyota Zambia,Stanbic Bank also provide in-kind support through applied fundraising strategies, the Hospital also receives a grant from Government. They are also registered to the National Health Insurance Management Agent (NHIMA) as a sustainability measure. |
| 3.8 The organisation's programmes and operations are progressing towards being **fully accessible** in line with the principles of universal design.<br><br>Definition: The organisation undertakes accessibility audits and has pro-actively addressed recommendations arising from these audits. The organisation's infrastructure, services, communications and technologies are accessible. | Partially | Personal observation ☑<br><br>Interviews ☑<br><br>Accessibility audit report ☐<br><br>Examples of communication and technologies in place ☑<br><br>Other: List other sources. | From personal observation the hospital infrastructure is accessible for Persons with Disabillities, with ramps, rails and accessible ablution blocks. The Hospital has staff trained in sign langauge for the deaf and hard of hearing. However an accessibility audit is yet to be conducted. |

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| 3.9 The organisation has **mechanisms and resources in place to manage risks** that might impact the organisation and the implementation of project activities.<br><br>Definition: The organization identifies and evaluates potential risks and responds with mitigation strategies. These risks are monitored on a regular basis and recommendations are duly implemented if required. | Yes | Project risks are reflected in the planning documents ☑<br><br>Risk register with a ranking of risks and mitigation strategies available ☑<br><br>An update of the risk register or risks is reflected in a monitoring document ☑<br><br>☐ Risk Management Framework<br><br>A designated staff has been identified for risk management issues ☑<br><br>Incident ☑ management team and procedures<br><br>Other: List other | The organisation has a risk management committee, which is responsible for the development and monitoring of the hospital risk register. Additionally the hospital has rolled out the CBM risk register for the projects funded by CBM and this is updated and monitored bi-annually. |
| 3.10 The organisation has the experience and capacity to **manage and support sub-contracted** parties.<br><br>Definition: The organisation has the policies, capacities and systems to monitor the implementation of sub-contracted activities in a transparent and accountable manner. | Yes | Policies in place ☑<br>Procedures and systems in place ☑<br><br>Other: List other sources. | Though the organisation has not sub contracted yet,policies and procedures are in place, and staff is sufficient for monitoring a sub grantee. |

| 3.11 The organisation is committed to assessing and **avoiding potential negative impact on the environment** and seeking opportunities to enhance environmental sustainability in its operations and programmes, when possible.<br><br>Definition: The organisation has integrated assessment and mitigation of environmental risks and their potential impacts in its processes. It constantly reflects on improvements in a participative and systematic way, has developed standards for local purchase, use of renewable material, if possible, and has expressed its commitment to avoid unnecessary waste, travel or use of resources. | Yes | Policies in place ☐<br><br>Procedures and systems in place ☑<br><br>Guidelines in place ☑<br><br>Other: List other sources. - | The organisation being a Hospital, they are annually assessed by the Zambia Environmental Management Agency (ZEMA), which assesses and certifies for emissions, pollutants and hazardous waste management. Certificates are available and shared. However the hospital is committed to developeing an enevironmental management policy. Furthermore the Hospital has received a grant from USAID to develop a solar feild for clean energy, additinaly, the Hospital has a solar powered mobile Ear Nose Throat Clinic. |

**Additional comments**

*3.3  Establish clear feedback mechanism for OPDs*
*3.4 Include aspect of Adults at Risk in Safegaurding policy*
*3.5 Train staff in iPCM*
*3.8  Conduct accessibility Audit*

# Part 2. Partner Assessment Questionnaire

**Feedback from partner**

*The Beit CURE Hospital (BCH) is very grateful to CBM for the partner assessment which was conducted very professionally. The process was very helpful and contributed to the identification of weak areas in the hospital system and corporate governance as a whole. The hospital is currently in the process of reviewing most of its policies and procedures, and the findings from the PA will form part of the improvement process. Therefore, the hospital will endeavor to implement all the recommendations more especially those aimed at developing new policies or strengthening existing ones. The PA further highlighted the importance of the BCH strengthening its inclusive project cycle management system.*

**Please indicate the name & position of individuals that conducted the assessment** (please insert lines as need

For the Partner
Date:    10.02.2022
Name:   Frida Kabaso Phiri
Position Executive Director

Date:    10.02.2022
Name:   Stephen Chishimba
Position Programme Manager

Date:    10.02.2022
Name:   Isaac Simukonda

For CBM
Date:    10.02.2022
Name:   Slinganiso Homela
Position Program Officer

Date:    10.02.2022
Name:   Noah Mwanza
Position Finance Officer

Date:
Name:

Position Project Accountant                                    Position:

# Part 3. PA Action Plan

Name of the organisation and country:  *Beit Cure Hospital*

Project number:  *P3851, P3747, P3954 and P3589*

| Criteria number | Recommendation (suggested action) | Action to be taken (agreed action) | Who | When | Priority | Progress as of date |
|---|---|---|---|---|---|---|
| | Insert as many lines as needed | | | | | |
| 1.7 | Beit Cure to Strengthen incident reporting system | Establish incident reporting system for staff and clients | Project Manager | December, 2022 | Long-term | |
| 1.17 | Beit Cure to Strengthen Anonymous Whistleblower System | Develop anonymous whistle blower system accessible to staff, partners and clients | Project Manager | December, 2022 | Long-term | |
| 3.3 | Beit Cure to establish clear feedback mechanism for OPDs | Develop system to get feedback from OPDs, on service delivery | Project Manager | June, 2022 | Medium-term | |
| 3.4 | Beit Cure to Strengthen Safe gaurding Policy | Include component of Adults at risk in safegaurding policy | CBM + Project M... | June, 2022 | Medium-term | |
| 3.5 | Beit Cure to strengthen inclusive project cycle management | Train project staff in inclusive project cycle management (iPCM) | CBM + Project Manager | December, 2022 | Long-term | |
| 3.8 | Beit Cure to document accessibility status through accessibility audit report | Collaborate with OPDs to conduct accesibility audit and compile report | Project Manager | December, 2023 | Medium-term | |
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Name, designation and signature of organisation's representative: Stephen Chishimba, Programme Manager, Beit Cure Hospital.

Date of approval of the Action Plan: 10.02.2022

Date: 10·02·2022
Name: STEPHEN CHISHIMBA
Position: PROGRAMME MANAGER

Date of last update of the Action Plan: *please insert date of update, if applicable*

# Summary of the partner assessment

**Overall level of partner capacity:** ⭐ 5.6

Explanation of scoring: The highest scoring for the overall partner capacity is 6. The overall level of partner capacity is the sum of scoring from governance & leadership, finance and programme category.

| Section of the Partner Assessmnent | PA Baseline | Review [Insert Year] 2021 | Review [Insert Year] |
|---|---|---|---|
| Governance & Leadership scoring: | 2.0 | | |
| Minimum criteria | 1.0 | | |
| Criteria to attain | 1.0 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.3 have capacity in place; between 1.4 and 1.8 have strong capacity; and with a scoring above 1.8 have very strong capacity.

| | | | |
|---|---|---|---|
| Finance scoring: | 2.0 | | |
| Minimum criteria | 1.00 | | |
| Criteria to attain | 1.0 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.1 have capacity in place; between 1.2 and 1.7 have strong capacity; and with a scoring above 1.7 have very strong capacity.

| | | | |
|---|---|---|---|
| Programme scoring: | 1.6 | | |
| Minimum criteria | 0.8 | | |
| Criteria to attain | 0.9 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.1 have capacity in place; between 1.2 and 1.6 have strong capacity; and with a scoring above 1.6 have very strong capacity.

## Summary of the partner assessment

**Overall level of partner capacity:** ☆ 5.6

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| Section of the Partner Assessmnent | PA Baseline | Review [Insert Year] 2021 | Review [Insert Year] |
|---|---|---|---|
| Governance & Leadership scoring: | 2.0 | | |
| Minimum criteria | 1.0 | | |
| Criteria to attain | 1.0 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.3 have capacity in place; between 1.4 and 1.8 have strong capacity; and with a scoring above 1.8 have very strong capacity.

| | | | |
|---|---|---|---|
| Finance scoring: | 2.0 | | |
| Minimum criteria | 1.00 | | |
| Criteria to attain | 1.0 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.1 have capacity in place; between 1.2 and 1.7 have strong capacity; and with a scoring above 1.7 have very strong capacity.

| | | | |
|---|---|---|---|
| Programme scoring: | 1.6 | | |
| Minimum criteria | 0.8 | | |
| Criteria to attain | 0.9 | | |

Explanation of scoring: The highest scoring for this category is 2. The *minimum criteria (red)* is attained with a scoring of 1. The maximum scoring for *criteria to attain (green)* is 1. The complete scoring for the caretogy is the sum of the scoring of the *minimum criteria (red)* and the *criteria to attain (green)*. In this category, organisations with a scoring 1 and 1.1 have capacity in place; between 1.2 and 1.6 have strong capacity; and with a scoring above 1.6 have very strong capacity.

**Overall outcome of the assessment (max. 150 words)**

*The partner has proven strong capacity to implement projects, including LCDF projects. Having been a partner since 2010, Beit Cure has implemented Seven (7) projects with CBM Zambia which include: P2490, P2740, P3509, P3589, P3747 (Scottish Government), P3851 (BMZ) and P3954. Despite being primarily a Hospital, Beit Cure has shown proven improved capacity to implement diverse projects, including CBID projects. Though few areas of capacity development still exist, we continue to recommend Beit Cure as a strong and strategic partner, and this is further solidified through this re-assessment and their proven track record as an existing partner.*

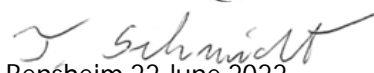Recommended by Country Director: Linda Kasonka 13/04/2022

Approved by Regional Hub Director: *Insert name and date*          Sign here/Insert signature

Albert Kombo, June 17th 2022

Approved by Initiative Director: *Dominique Schlupkothen*          Sign here/Insert

Approved by: Thorsten Schmidt, Director FaOD

Bensheim 22 June 2022

Approved by Director FaOD: *Insert name and date*                    *Sign here/Insert signature*