The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Office of the Inspector General

Audit of Global Fund Grants to the Republic of Zimbabwe

GF-OIG-13-012
31 May 2013

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A. EXECUTIVE SUMMARY

Four grants audited

Previous audit 2008

USD 333.5 million disbursed of USD 355 million approved

1. As part of its 2012 work plan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to Zimbabwe from 22 October to 30 November 2012.

2. The audit focused on the four active grants and covered the operations of the Sub-recipients, a sample of Sub-sub-recipients, the Country Coordinating Mechanism, the Local Fund Agent and the Global Fund Secretariat. The grants under review totaled USD 355 million, of which USD 333.5 million had been disbursed by 30 September 2012. In addition, this audit considered progress made since the previous OIG audit of Global Fund grants to Zimbabwe in 2008.

UNDP activities not covered as subject to own internal and external audits

3. The audit did not cover the United Nations Development Programme as Principal Recipient as its activities were the subject of an audit by its Office of Audit and Investigations, which took place concurrently with the OIG review. This was published online in March 2013.[1]

A.1 Key Findings

CCM oversight improved

4. The Country Coordinating Mechanism has functional oversight committees that review program implementation. Significant steps had been taken to improve the overall control environment following our 2008 audit.

Country team proactive in managing grant risks

5. The Global Fund Secretariat was proactive in managing grants and commissioned risk-based analyses by the Local Fund Agent to strengthen portfolio management, e.g., the review of the status of implementation of the capacity building plan, controls around the payment of retention allowances, a review of status of the additional safeguards, and a review of the effectiveness of community health workers.

Funding gaps should be addressed

6. Sustainability of the programs is a key concern due to critical funding gaps. If not addressed urgently, there will be shortages in antiretroviral therapy by 2014.

Need to utilize national systems and improve coordination

Need to strengthen laboratory services

7. Parallel systems to manage Global Fund grants have been established alongside national systems, which may undermine established national structures in the long term. There was room to improve coordination among implementers and funders of the three disease programs to minimize the risk of duplication of activities and maximize available human resources. The laboratory department of the Ministry of Health and Child Welfare needs strengthening to support service delivery.

Key populations should be prioritized

8. Key populations at higher risk were not sufficiently prioritized in the strategic HIV/AIDS and malaria program interventions.

9. While there was significant scale-up of access to health services,

[1] http://audit-public-disclosure.undp.org/view_audit_rpt_2.cfm?audit_id=1089

Quality of service delivery and data a concern

the quality of service delivery remained a concern. Data and reporting systems were not sufficiently reliable to yield accurate and precise information.

Need to ensure effective use of procured resources

10. There were fundamental weaknesses in supply chain management with poor control over distribution and stock management resulting in expiry of laboratory reagents, Artemisinin-combination therapies, and Rapid Diagnostic Test kits. Long-expired medicines had not been disposed of.

A.2 Conclusion

Major improvements needed

11. Outside of the grants to the United Nations Development Program, the OIG concludes that **major improvements are needed** in the management and implementation of Global Fund grants. This means that "Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives would be met."

12. The OIG offers ten recommendations, of which one is rated "Very High", requiring immediate action to ensure that sufficient antiretrovirals are available to treat patients. The remaining nine are "High" priority.

A.3 Actions subsequent to the audit

Mitigating actions taken by Secretariat and in-country stakeholders

13. A number of actions have already been taken to address the risks that emerged from the audit findings. These include:

- The Country Team is working with the United States President's Emergency Plan for AIDS Relief to develop a laboratory logistics management information system to generate reliable consumption data for quantifying required reagents. An action plan has been developed, but not yet fully funded;
- The National Aids Council has agreed to pay the National Pharmaceuticals Company of Zimbabwe 2.5% of the value of products stored and distributed;
- Support and supervision visits by the Ministry are now being undertaken with support from Research Triangle International;
- With regard to the reduced impact of Community Health Workers due to their not being integrated into the Ministry's formal structures, the Secretariat commissioned an independent study to assess the extent to which Community Health Workers were contributing to or integrated in the health system. Recommendations are being implemented by the Ministry of Health and Child Welfare to strengthen Community Health Worker integration;
- The Secretariat's Zimbabwe Country Team engaged the World Health Organization in Quarter 4 of 2012 to develop an multi-drug resistant tuberculosis expansion plan beyond 2012, and is currently discussing the potential for technical assistance in the actual implementation of multi-drug resistant tuberculosis; and
- A Condition Precedent has been put in place relating to the review and strengthening of storage and distribution systems by the United Nations Development Programme with an action plan under development.

B. MESSAGE FROM THE EXECUTIVE DIRECTOR OF THE GLOBAL FUND

The Global Fund
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23rd May 2013

MESSAGE FROM THE EXECUTIVE DIRECTOR

I would like to thank the Office of the Inspector General for its thorough and insightful work on the audit of Global Fund grants to the Republic of Zimbabwe.

The audit focused on 4 grants totalling US$ 323.2 million, of which US$ 301.6 million had been disbursed by the time of the review. Fieldwork for the audit was carried out in late October and in November 2012.

The audit did not cover the United Nations Development Program (UNDP) in its capacity as Principal Recipient, as expenditures incurred directly were subject to the UNDP's own audits which took place concurrently with the review by the Office of the Inspector General.

The sustainability of the health programs due to funding gaps was a key concern raised in the audit. If this issue is not addressed urgently, shortages in antiretroviral therapy will arise in 2014. Also, the audit noted that key populations at higher risk were not sufficiently prioritized in the HIV and malaria program interventions.

Parallel systems to manage Global Fund grants have been established alongside national systems which may undermine established national structures in the long term. The audit also found there was a need to improve coordination among implementers and funders of the three disease programs to minimize risk of duplication of activities.

Outside of the UNDP grants, the OIG concluded that major improvements are needed in management and implementation of Global Fund grants.

Numerous specific control weaknesses were noted. The Office of the Inspector General found that controls evaluated were unlikely to provide reasonable assurance that risks were being managed and the Global Fund's strategic objectives would be met.

Zimbabwe faces important challenges in program implementation: the economy is struggling and the amount of domestic resources allocated to the health sector is limited; this has an impact on retention of skilled professional staff some of whom seek opportunities abroad; storage and distribution of health commodities is constrained by inadequate capacity; and implementation of health programs is at province level, which have varying capacities.

At the time of the audit, The National Pharmaceuticals Company of Zimbabwe (NatPharm), which is responsible for storing and distributing health products, showed a US$8 million debt against the Zimbabwean government. Unless NatPharm is recapitalized, it may not be able to distribute medicines and products purchased under the grants, the audit concluded.

The Office of the Inspector General makes ten recommendations, including one rated very high, and the remaining which are high priority.

The most urgent recommendation is that the Country Coordinating Committee (CCM), working with the Global Fund Secretariat, should engage with the government and development partners to: identify sources of funding for medicines, health products and staff salaries and explore options for recapitalizing NatPharm.

The Office of the Inspector General also recommends that the CCM in its oversight role should prioritize the implementation of activities to address key populations at risk of exposure to HIV as well as use of insecticide-treated nets for children under five years.

The Ministry of Health and Child Welfare should also set clear and specific timelines for including grant-related functions, roles and responsibilities into existing national structures. It should also ensure that a quality improvement program is instituted for all facilities providing antiretroviral therapy, the audit said.

Actions have been taken to address risks that emerged from audit findings. Among these, the Secretariat's country team is working with the United States President's Emergency Plan for AIDS Relief to generate reliable consumption data for quantifying required reagents. The National AIDS Council has also agreed to pay NatPharm 2.5 percent of the value of products stored and distributed.

Audits by the Office of the Inspector General are an essential form of quality control for the Global Fund. The Office of the Inspector General plays an indispensable role in helping us all achieve our mission of effectively investing the world's money to save lives.

Yours sincerely,

C. MESSAGE FROM THE COUNTRY COORDINATING MECHANISM

ZIMBABWE CCM RESPONDING TO
HIV & AIDS, TUBERCULOSIS AND MALARIA
Telephone: +263-4- 798536-60, Fax +263-4-729154/793634
c/o Ministry of Health and Child Welfare, P. O. Box CY1122, Causeway, Harare

19 April 2013

Mr. Norbert Hauser
Inspector General
The Global Fund
Chemin de Blandonnet 8, 1214 Vernier
Geneva, Switzerland

Dear Mr. Norbert Hauser

The Zimbabwe Country Coordinating Mechanism (CCM) hereby expresses its deep gratitude to the Office of the Inspector General of the Global Fund for its great contribution on successful implementation of the HIV, TB and Malaria programs in Zimbabwe.

With the help of the Global Fund, the country could make significant improvements in fighting the three diseases in the last years. Zimbabwe has expanded programs for HIV prevention and has achieved in providing anti-retroviral treatment for the people living with HIV. The TB program in the country has been strengthened and drug resistant TB patients have been taken into strict control. The malaria program has been successful and the country is close to the elimination of this disease.

The diagnostic review mission of the OIG conducted between October and November 2012 was helpful in preparing key findings on the Global Fund programs in Zimbabwe and their valuable recommendations will certainly be taken into consideration and implemented with a view to increase the efficiency of programs carried out in the country.

Once more, we express our deep gratitude to you and OIG team for their constructive visit to Zimbabwe and commitment to fight against HIV, tuberculosis and malaria and we wish to continue our fruitful cooperation in the future.

Sincerely,

Zimbabwe Country Coordinating Mechanism (CCM)
(for Global Fund to Fight HIV & AIDS Tuberculosis and Malaria)
23 APR 2013
c/o Ministry of Health and Child Welfare
P.O. Box CY1122
Causeway, Harare

Rev. Dr. S Zwana
Zimbabwe CCM Vice Chair

D. AUDIT OBJECTIVES AND SCOPE

D.1 Audit Objectives

Audit assessed adequacy and effectiveness of controls

14. The objectives of this audit were to assess the adequacy and effectiveness of the controls in place to ensure:

- Value for money from funds spent;
- The achievement of programmatic objectives;
- Compliance with Global Fund grant agreements, policies and procedures, and with relevant laws and regulations;
- The safeguarding of grant assets against loss or misuse; and that
- Risks were effectively managed.

An important focus of this audit was to identify opportunities to strengthen grant management.

Multi-skilled team deployed

15. The OIG deployed a multi-skilled team comprising financial auditors, public health specialists, and a procurement and supply management specialist, each of whom participated in various stages of the audit.

D.2 Audit Scope

Audit examined operations of main grant stakeholders

16. As part of its 2012 work plan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to Zimbabwe from 22 October to 30 November 2012. The audit focused on Round 8 grants and covered the operations of the Sub-Recipients (SRs), a sample of Sub-Sub-Recipients (SSRs), the Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA) and the Global Fund Secretariat.

One Principal Recipient was implementing the four grants

17. The audit covered the following Global Fund grants to Zimbabwe, totaling USD 323.2 million, of which USD 301.6 million had been disbursed by 30 September 2012.

Principal Recipient	Round and Component	Amount Committed (USD)	Amount Disbursed (USD)
UNDP	Round 8 HIV	204,782,820	203,606,657
UNDP	Round 8 Tuberculosis	38,006,893	31,229,319
UNDP	Round 8 HSS	59,162,805	50,002,237
UNDP	Malaria Single Stream	21,201,474	16,806,981
Total		**323,153,992**	**301,645,194**

Table 1: Summary of Grants committed and disbursed as at 30 September 2012

18. The audit did not cover the United Nations Development Program (UNDP) as Principal Recipient as expenditures incurred directly were subject to UNDP's internal and external audits. UNDP expenditure included all procurement and amounted to approximately half of total grant expenditure. Reliance was placed on the UNDP Office of Audit and Investigations for assurance.

Field visits in six provinces

19. In addition to audit tests carried out at the central level, the audit team visited a sample of 66 program sites in six provinces including Bulawayo and Harare to review the quality of services at health facilities, data quality, warehousing and storage.

Country team and CCM involved in site visits

20. The audit team was joined by members of the CCM on 13 site visits and by members of the Global Fund Secretariat's country team on one site visit.

E. OVERVIEW

E.1 Background to the grants

Until July 2009, country had three PRs

21. From inception until July 2009, Global Fund supported-programs were managed by three PRs, the Ministry of Health and Child Welfare (MOHCW), the National Aids Council and the Zimbabwe Association of Church Related Hospitals. Following the 'lodgment'[2] of grant funds with the central bank, the OIG conducted an audit of the Round 5 grants in October 2008. The 2008 audit raised significant concerns about the governance of the grants in the country and highlighted the adverse impact that the retention of grant funds by the Reserve Bank of Zimbabwe had on program implementation. Consequently, the OIG could not at the time provide the Global Fund Board with assurance about the adequacy of country structures and systems in place to safeguard Global Fund resources.

ASP invoked due to pervasive risk across the grant portfolio

22. In May 2009, the Global Fund Secretariat invoked the Additional Safeguard Policy (ASP)[3] over all its grants to Zimbabwe. The Global Fund discontinued the grant agreements with the three PRs and signed an agreement with the United Nations Development Programme (UNDP) to manage its grants. In September 2012, the Global Fund Grant Management Executive Committee reviewed and upheld the decision to have Zimbabwe grants managed under the ASP (with amendments to imposed safeguards).[4]

Challenges to program implementation

23. The health sector in Zimbabwe faces the following challenges that are important to bear in mind when reading this report:

- Zimbabwe remains a fragile state in transition.[5] The national economy continues to struggle and the amount of domestic resources allocated to the health sector is limited;
- Zimbabwe's economy has a negative impact on the retention of skilled, professional staff, especially midwives and doctors, some of whom look for opportunities abroad;
- Storage and distribution of health commodities is constrained by inadequate capacity at national and service delivery point level; and
- Implementation of health programs happens at province level, which have varying capacities and levels of program ownership.

E.2 Actions subsequent to the audit

Briefings held in Harare with relevant stakeholders

24. Exit debrief meetings were held at the end of the audit fieldwork with the PR and SRs to discuss all findings in detail to ensure that the findings reported were factual and proposed recommendations were

[2] In October 2007, the Government of Zimbabwe issued a directive that all foreign currency accounts were to be centralized at the Reserve Bank of Zimbabwe. Funds were supposed to have been available to owners as required, which did not happen.
[3] ASP is part of the Global Fund's risk-management strategy, which can be invoked in full or in part based on risks identified in the country where a particular grant or group of grants is being implemented.
[4] The following requirements were waived: (i) quarterly disbursements and reporting, without provision for funding the buffer period; (ii) maintenance of off-shore accounts of program funds; (iii) the need to minimize exchange rate distortions by significantly reducing the amount of funding for use in local currency; (iv) retaining a Finance Taskforce to monitor the dynamic country context; and (v) an increase in the number of LFA on-site data verifications.
[5] The World Bank: Zimbabwe Overview. http://www.worldbank.org/en/country/zimbabwe/overview.

appropriate. A draft of this report was shared with the CCM, the PR and the Global Fund Secretariat. Feedback received has been incorporated in this report.

Mitigating actions taken by Secretariat and in-country stakeholders

25. The OIG audit team noted that a number of actions have been taken to address the risks that emerged from the audit findings. These include:

- The Country Team is working with PEPFAR to develop a laboratory logistics management information system to generate reliable consumption data for quantifying required reagents. An action plan has been developed, but not yet fully funded;
- The National Aids Council has agreed to pay the National Pharmaceuticals Company of Zimbabwe (NatPharm) 2.5% of the value of products stored and distributed;
- Support and supervision visits by the Ministry are now being undertaken with support from Research Triangle International;
- With regard to the reduced impact of Community Health Workers (CHWs) due to their not being integrated into the Ministry's formal structures, the Secretariat commissioned an independent study to assess the extent to which CHWs were contributing to or integrated in the health system. Recommendations are being implemented by the MOHCW to strengthen CHW integration;
- The Secretariat's Zimbabwe Country Team engaged the World Health Organization (WHO) in Quarter 4 of 2012 to develop an MDR-TB expansion plan beyond 2012, and is currently discussing the potential for technical assistance in the actual implementation of MDR-TB; and
- A Condition Precedent has been put in place relating to the review and strengthening of storage and distribution systems by UNDP with an action plan under development.

F. OVERSIGHT AND GOVERNANCE

Critical	Steps have been taken to improve the overall control environment. However, CCM oversight to ensure the sustainability of the programs remains a key concern due to critical funding gaps. Unless addressed urgently, the funding gaps will lead to shortages in antiretrovirals in 2014. The key populations at higher risk were not prioritized in the HIV and malaria program interventions.

CCM oversees the grant funded programs

LFA verifies grant implementation

26. As part of the Global Fund grant architecture, a Country Coordinating Mechanism (CCM) oversees the Global Fund-supported programs and a Local Fund Agent (LFA) verifies grant program implementation for the Global Fund Secretariat; these oversight measures are critical to good fiduciary and program management.

F.1 Country Coordinating Mechanism

CCM generally meets its mandate

27. The CCM is a country-level public-private partnership that has performed well in coordinating the development of grant proposals. It has functional oversight committees which reviewed program implementation against plans. However, the CCM could have done more to support the PR and its SRs in overcoming the challenges they faced during grant implementation in the following areas:

F.1.1 Program sustainability

Gaps noted in funding raising sustainability concerns

28. The phasing out of key interventions such as the "Expanded Support Program for HIV/AIDS" and Global Fund contributions to the Health Retention Scheme have created a funding gap.[6] The Global Fund Secretariat is actively attending to this. However, if left unaddressed, the funding gaps in the following areas will disrupt lifesaving interventions and implementation of key program activities:

Risk of treatment disruption due to funding gaps

- There is a USD 38 million ARV funding gap for 2014. For ARVs to arrive on time, orders need to be placed by mid-2013;
- The phase-out of Global Fund support to the Health Retention Scheme from 2013[7] will create an immediate gap of USD 4 million (2013) and USD 22 million (2014). Failure to pay retention allowances directly impacts program implementation and is likely to result in a loss of gains registered in this area;
- There are restrictions on Global Fund funding towards the purchase of Artemisinin-based Combination Therapies (ACTs) and Rapid Diagnostic Test kits (RDTs) due to inadequate quantification processes caused by the lack of reliable consumption data; and
- There is a shortage in funding of USD 38.1 million for the purchase of Long Lasting Insecticides Nets (LLINs) and related costs from 2013.

Government should honor NatPharm

29. The National Pharmaceuticals Company of Zimbabwe (NatPharm) is responsible for storing and distributing health products. At the time of the audit, NatPharm's records showed a USD 8 million

[6] The Health Worker Retention Scheme provides a tax-free salary top-up to health workers. It was set up as an emergency response in 2009 by government and development partners in order to reverse the emigration of health staff, and ensure there were enough newly trained health workers entering the system to fill vacancies.
[7] Government commitments to fund the gap as Global Fund phased out its funding for the Scheme was agreed as follows: 25% (Y2), 50% (Y3), 75% (Y4), and 100% (Y5).

obligations

debt against the Zimbabwe government.[8] This affected NatPharm's ability to distribute on time and undermined sustainability. Unless NatPharm is recapitalized, it may not be able to distribute medicines and products purchased under the grants.

Recommendation 1 (Very High)
The CCM, working with the Global Fund Secretariat, should enter into dialog with government and development partners to:

i. Identify sources of funding for medicines, health products and staff salaries; and specifically
ii. Explore options for recapitalizing NatPharm in order for it to meet its mandate.

F.1.2 Interventions not aligned to areas of greatest need

30. HIV/AIDS and malaria are two leading causes of morbidity and mortality in Zimbabwe.[9] The following areas were identified in the national disease strategies as critical to achieve impact, but were neither included in Global Fund proposals nor funded by Government:

HIV prevention activities not aligned to identified areas of greatest need

i. Targeting of couples in discordant relationships: The majority of people living with HIV (PLHIV) are in unions (75% of males and 50% of females). Forty-seven per cent of PLHIV in unions are sero-discordant; they contribute 55% of new HIV infections. There was no national strategy on key populations at higher risk of HIV exposure;

Male circumcision not wide spread

ii. Male circumcision: Zimbabwe is one of the priority countries for voluntary medical male circumcision, with a 2015 target of 80% against a current prevalence of 11% (men aged 15 to 49); and

LLIN mass distribution insufficient to meet needs

iii. Routine distribution of LLINs through antenatal clinics and child welfare clinics: Children below the age of five and pregnant women in Zimbabwe are the most vulnerable to malaria.[10] LLIN use among children under five is only 17.3%.[11] LLIN distribution has taken place through mass campaigns, without accompanying routine distribution at health facilities.

Recommendation 2 (High)
The CCM in its oversight role should prioritize the implementation of activities to address key populations at risk of exposure to HIV and use of LLINs for children under five years.

F.2 Local Fund Agent (LFA)

LFA has a good understanding of grant-related risks

31. The LFA (PricewaterhouseCoopers) provides independent oversight of the implementation of program activities. The LFA has a good understanding of grant-related risk.

F.3 The Global Fund Secretariat

Global Fund Secretariat

32. The Global Fund Secretariat was proactive in managing grants and commissioned risk-based analyses by the Local Fund Agent to

[8] Over 60 per cent of NatPharm's business is with Government.
[9] World Health Organization, World Health Statistics 2012.
http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf
[10] Zimbabwe Global Health Investment Strategy, February 2012
[11] Zimbabwe Statistics Agency, UNICEF. 2009. Multiple Indicator Monitoring Survey (MIMS)

proactive in managing grant risk	strengthen portfolio management, including a review of the status of implementation of the capacity building plan, a review of the controls around the payment of retention allowances, a review of status of the additional safeguards, and a review of the effectiveness of community health workers. The Country Team was aware of most issues identified in the audit and at the time of the audit was in dialogue with in-country stakeholders to find solutions to key risks facing the grants.

G. GRANT MANAGEMENT

Major Improvement Needed	Parallel systems to manage Global Fund grants were established alongside national systems, which presented a missed opportunity to strengthen national structures. There was room to improve coordination among implementers and funders within and among the three disease programs in order to minimize the risk of duplication and maximize the use of available human resources. The laboratory department of the MOHCW needed strengthening to support service delivery.

G.1 MOHCW oversight

Need to strengthen the MOHCW's oversight of program delivery

33. Although the MOHCW is not the PR, it holds primary responsibility for the health agenda in Zimbabwe and for the delivery of health programs. The following areas reflect how Global Fund-supported program implementation was affected by the lack of ownership of key processes:

- 31 of the 81 laboratories renovated with grant funds were not operational due to a disagreement about who was responsible for their operations;
- Delays in provision of specifications affected the timely procurement of equipment, e.g., X-ray machines and reagents;
- Inadequate coordination between the disease programs, the Department of Pharmacy Services and the Directorate of Laboratory Services resulted in poor quantification of pharmaceutical products and delays in agreeing specifications;
- The rejection of procured RDTs by the MOHCW despite their being on the list of registered kits of the Medical Laboratory and Clinical Scientists Council;
- Procurement of health products (e.g., microscopes and reagents) that remained undistributed at NatPharm despite shortages at peripheral levels; and
- 360 laboratory technicians trained under Phase 1 who were not deployed rapidly, which resulted in 160 finding employment outside of the grant programs.

These findings imply the need for stronger oversight of program implementation by the leadership of the MOHCW.

Questionable value add of the parallel systems created

34. Parallel implementation arrangements have been established within "disease" programs in the health sector using Global Fund support. For example, the Global Fund-supported program units purchased Softline's Pastel accounting software as they waited for the roll out of the government's Integrated Financial Management System.[12] Health information systems demonstrate similar parallel monitoring and evaluation structures (funded by the Global Fund). The implementation of a District Health Information System (DHIS) is expected to address this. Such parallel systems are generally not sustainable beyond Global Fund support and fail to strengthen national structures.

[12] However, staff continued to use Microsoft Excel to record and report program transactions.

Recommendation 3 (High)
The MOHCW should set clear and specific timelines for the inclusion of grant-related functions, roles and responsibilities into existing national structures.

G.2 Laboratory services

35. Zimbabwe's national laboratory system is critical for diagnosis and treatment. Shortcomings in this department impacted the effectiveness of program implementation as follows:

Insufficient laboratory capacity

- A number of the laboratories visited were not (fully) operational due to a lack of staff, reagents and equipment, including CD4 count machines and microscopes. While some laboratories lacked microscopes, others had remained undistributed at NatPharm for over two years;

Poor maintenance of equipment affected service delivery

- CD4 count machines at three of the eight sites visited had broken down. Arrangements for maintenance by the MOHCW were not fully operational. For example, at the time of the field visit, the machine in Gokwe South district hospital was broken. The audit team was informed that it had been continuously non-functional for six months and had recently been nonfunctional more than two years. The hospital had expected the maintenance group in October 2012, but they had not visited the hospital. However, records at the central level show that the machine had been serviced in June 2012;

No logistics management information system for reagents

- The laboratory department did not have a logistics management information system to generate reliable consumption data for quantifying required reagents. This was the primary contributor to reagent stock-outs and expiries noted during the audit; and

Weak arrangements for transporting sputum specimens

- Many patients either had to travel to distant centers for immediate tuberculosis (TB) diagnosis (direct smear microscopy) or wait over one week for results. This resulted in some patients not returning to collect their results. The arrangements with Unifreight to transport sputum specimens nationwide did not address this problem.

Recommendation 4 (High)
The MOHCW should ensure that the MOHCW laboratory department, is strengthened, particularly with respect to (i) ensuring that relevant laboratory equipment is in place; (ii) operationalizing machine maintenance arrangements; (iii) ensuring availability of reagents; (iv) ensuring adequate human resources; and (v) improving sample transport systems and turnaround time for communication of results

G.3 Human Resources

High investment in health systems strengthening

36. As a consequence of Zimbabwe's recent political and economic past, the availability of qualified and well-motivated human resources in sufficient numbers remains one of Zimbabwe's biggest challenges to the provision of quality health services and effective program implementation.

37. The health systems strengthening (HSS) grant had a budget of USD 74.67 million (Phase 1 and 2), 82% of which were for top-up

allowances for 18,860 health workers. This has led to an increase in health workers. However,

- Salaries remain low when benchmarked against other countries in the region, which contributes to high attrition rates;
- Staff shortages persist in specialized health categories, e.g., radiographers and laboratory technicians;
- Staff shortages are more pronounced at district and health facility level and in functional areas such as monitoring and evaluation and procurement; and
- The work force is increasingly typified by "young and inexperienced" health staff, especially in rural areas, [13] which requires more in-service training and stronger supervisory systems.

Services of community health workers have been fragmented and uncoordinated

38. Several interventions supported by the Global Fund present opportunities to optimize the use of available resources. Over 11,500 community health workers (CHWs) were trained under the HSS Phase 1 grant. However, CHWs were not integrated in the Ministry's disease program activities, resulting in their services being fragmented and poorly coordinated, and their effectiveness questioned.[14]

Global Fund is Zimbabwe's biggest funder for training

39. An unpublished report commissioned by a bilateral donor to Zimbabwe remarked that the Global was Zimbabwe's biggest funder of training in the health sector. It also highlighted the following shortcomings:

Several training related control weaknesses noted

- Workshops were the most common training method employed. Consideration was not given to other training methods, e.g., mentorship or on the job training;
- Training was driven by the availability of funding;
- No needs assessments were undertaken;
- No evaluations of training were undertaken;
- Criteria for selection of participants were not clear; and
- Related courses by technical area, e.g., M&E courses across the three programs, were not combined.

40. UNDP maintains a training database, which presents an opportunity to analyze available data related to training and use this information to improve planning.

41. UNDP also developed training and capacity building plans to monitor training, avoid duplication and improve cost effectiveness.

Recommendation 5 (High)
The MOHCW should ensure that human resources for health, particularly those supported by the Global Fund, are managed optimally. This should include a Human Resources for Health baseline assessment to inform further policies aimed at closing identified human resource gaps.

[13] Zimbabwe Global Health Initiative Strategy, February 2012
[14] Global Fund evaluation of the effectiveness of GF investments in CHWs June 2012

H. PROGRAM IMPLEMENTATION

Major Improvement Needed	While there was significant scale-up of access to health services, quality of service delivery remains a concern. Data and reporting systems were not sufficiently reliable to yield accurate and precise information.

A number of good practices noted

42. The following good practices were noted in the implementation of public health programs:

- There were national strategic plans for HIV/AIDS, tuberculosis and malaria;
- Priority interventions had been identified in Zimbabwe, with detailed national guidelines for program implementation;
- Disease monitoring and evaluation plans were in place that captured both country- and funding agency-specific indicators;
- Harmonized data collection tools were in place, with reporting of key national indicators through the national Health Management Information System (HMIS);
- Service delivery for the three diseases was integrated at the facility level in order to improve patient access; and
- Programs adopted an integrated services approach for service delivery related training of personnel.

H.1 HIV

H.1.1 Quality of service

Zimbabwe close to achieving universal coverage of ART

43. At the time of the audit, Zimbabwe had more than 437,000 HIV-positive patients on treatment (73% of need).[15] This achievement was primarily driven by the policy on ART service decentralization that ensured geographical access to antiretroviral medications. However, the gains in ART service expansion had not always been accompanied by similar achievements in the quality of ART service delivery.

Quality of service is a concern

Non-compliance with ART management guidelines

44. The ART decentralization strategy provided for the categorization of facilities as either initiating sites (to support clinical and laboratory monitoring) or follow-up sites (to provide ARV refills and assure treatment adherence). [16] However, the following instances of non-compliance with the ART decentralization guidelines were noted:

- Clinics designated as follow up sites, e.g., Sasame rural clinic and Jichidza mission clinic also initiated ART but lacked the capacity to undertake the required clinical and laboratory monitoring;
- None of the follow-up facilities visited sent patients back to initiating sites periodically for clinical assessment/monitoring; and
- None of the initiating sites visited were assessing patients clinically (WHO T-staging)[17] at follow up visits.

H.1.2 Laboratory monitoring

Inadequate clinical and laboratory monitoring

45. The program has detailed national guidelines in place for program implementation. These generally adhere to WHO guidelines. However:

[15] This is close to the universal coverage benchmark of 80%. Zimbabwe Round 8 Q10 PUDR 06 September 2012
[16] Treatment was scaled up to include 950 initiating and follow-up ART sites (220 and 730 respectively).
[17] Staging is based on clinical findings that guide the diagnosis, evaluation, and management of HIV/AIDS, and does not require a CD4 cell count.

No evidence that CD4 count testing was routinely undertaken

i. At seven of the eight facilities visited, CD4 count tests were not routinely undertaken at initiation of ART and at follow up. At one site visited, 31 out of a cohort of 50 patients had CD4 count tests recorded upon ART commencement with only 22 in the same cohort having follow up CD4 count tests after six months of treatment. This implies that critical information required to guide treatment decisions was not available;
ii. Only one facility was recording CD4 percentage for children under five and none of the facilities performed total lymphocyte count tests for this age group; and
iii. Only one of the eight clinics visited (Entumbane) performed baseline and routine hemoglobin and chemistry tests for HIV clients.

Recommendation 6 (High)
The MOHCW's National AIDS Program should ensure that a quality improvement program is instituted for all ART facilities. This should be guided by a standardized Service Quality Assessment checklist and include indicators for clinical and laboratory monitoring as well as ART defaulter tracking. It should be used during supportive supervision to reinforce the national guidelines.

H.2 Tuberculosis

Improvement in TB case detection and treatment success rates

46. Zimbabwe is ranked 17th of the 22 high-burden TB countries. TB case detection increased from 24% in 2009 to 50% in 2011. Treatment success rates rose from 74% in 2009 to 81% in 2011. A TB prevalence survey was in the planning stage and will provide more reliable information on the burden of the disease.

H.2.1 Gaps in TB control

Weak mechanisms for monitoring treatment compliance

47. Zimbabwe had adopted the Directly Observed Therapy (DOT)[18] strategy in order to enhance patients' adherence to treatment. This strategy follows the global direction that emphasizes patient engagement and support for treatment. The following components of effective TB case management were inadequate:

- In all sites visited, direct observation of treatment was left primarily to family members. There was no evidence that family members had received adequate training or that they were held accountable by the health system, since they seldom provided feedback on treatment to clinics as required.[19] Funding is available under the Round 8 grant to train family members on DOT.
- Treatment sites visited used no DOT-related data collection tools, which resulted in an inconsistency in the compliance records maintained and made it difficult to identify defaulters. At the time of the audit the PR was developing a tool to record DOT results.

H.2.2 MDR-TB Interventions

Lack of systems and facilities for

48. MDR-TB is increasingly becoming a public threat in Zimbabwe, with 1.9% of new cases and 8.3% of retreatment cases diagnosed as

[18] DOT means that patients are supervised by health facility staff, community or family members as they swallow every dose.
[19] This was highlighted in the Secretariat's TB grant scorecard as well as by WHO: Global Tuberculosis Control 2009 Epidemiology, Strategy, Financing.

effective MDR patient management

MDR.[20] The full extent of MDR-TB remains unknown because there is no systematic monitoring and a lack of accurate survey data.[21] A drug resistance survey to provide information about the extent of MDR-TB is planned for 2014.

49. The audit noted the following risk factors for the development of MDR-TB:

- Stock-outs of anti-TB medicines leading to non-adherence to treatment guidelines (noted in 11 centers that reported stock-outs of first line TB drugs);
- Inadequate monitoring of patients on anti-TB treatment due to the reliance on unsupervised DOT by family members and the lack of proper records;
- Poor storage conditions for anti-TB medicines;
- Poor or inadequate training of health workers providing TB services;
- Inadequate supervision and monitoring of TB activities;[22] and
- Patients experiencing difficulties in accessing TB diagnostic facilities.

50. The timely identification and subsequent management of MDR-TB cases was affected by:

- MDR-TB guidelines being in draft at the time of the audit;
- Centralized diagnosis of MDR-TB, which resulted in patients having to travel to diagnostic or microscope sites to get tested and then wait for eight weeks for results;
- Limited inpatient bed capacity for MDR-TB. The renovation of MDR-TB wards under the Round 5 grant had not been completed; and
- The lack of proper MDR-TB patient registers impeding the rapid identification and follow-up of defaulters.

H.2.3 HIV/TB Collaborative Activities

Scope for strengthening HIV/TB interventions

51. The LFA Phase 1 report noted that the HIV/TB co-infection rate was 70% (74% for TB patients who had started Cotrimoxazole). However, only 30% of TB patients diagnosed with HIV were on ART. This was not in line with national treatment guidelines. In a country with high co-infection rates, ART coverage among TB patients should be 100%. As part of the Secretariat's grant renewal decision, funds were re-programmed to provide additional resources for TB/HIV collaborative activities.

Recommendation 7 (High)

The MOHCW's National TB Program should:

a) Strengthen the implementation of DOT, for example, by employing CHWs to support supervision of patients;

b) Institute mechanisms for monitoring adherence, e.g., by using patient indicators of non-adherence such as delayed clinical improvement or clinical deterioration while on TB therapy, or missed appointments for clinical follow up; and

c) Improve the response to MDR-TB by ensuring better prevention (early diagnosis and adequate treatment of drug-susceptible

[20] WHO Country profile based on 2007 surveillance and epidemiological data
[21] National TB guidelines
[22] See also WHO: Global report Results: Planning and DOTS implementation, 2004

cases), diagnosis (molecular and conventional methods), treatment (ambulatory and hospital-based) and patient support (in health facilities and at home).

H.3 Data Quality

Poor data collection and validation mechanisms

52. The computerization of the country's M&E and reporting systems is underway through the implementation of a DHIS, which includes the pilot testing of a patient tracking system starting with ART patients.[23]

53. Visits by the audit team to 53 facilities identified data quality issues, specifically relating to data availability, timeliness, consistency and validity. These data discrepancies had been previously highlighted in On-site Data Verifications undertaken by the LFA and in at least one data quality audit.

Reported program results may be misleading due to unreliable data

54. The data discrepancies noted related to variances between results captured in patient records and periodic reports at the peripheral and the national level for HIV/TB collaboration, DOTS and MDR-TB. These had also been identified by the Country Team and were due to:

- The absence of requisite forms and registers, different versions of data collection tools, incomplete registers, inconsistencies between register totals and summary form totals and inaccurate entries in registers;

High workload at primary health care level contributing to poor data quality

- The absence or non-use of equipment. Cell phones and computers procured to facilitate data transfer had in some cases not been connected more than one year after purchase;
- Inadequate cascading of relevant training to facility level;
- Ineffective data quality review by the districts; and
- Heavy staff work load (One example from our visits to two facilities showed that two nurses were expected to complete 19 registers in addition to the provision of health services).

Recommendation 8 (High)

The MOHCW should :

a) Strengthen supportive supervision in the MOHCW by developing standard operating procedures, standardized checklists and reporting templates as well as formal feedback forms. On the job training and mentoring should be part of supportive supervision visits;

b) Develop a customized and shortened set of national HMIS data collection tools for primary health care facilities and ensure that the correct versions of such tools are available through supportive supervision; and

c) Develop standard operating procedures for patient tracking to improve the detection and reporting of defaulters and ensure that patients are retained on treatment.

[23] Version 1 is being updated to Version 2

I. PROCUREMENT AND SUPPLY MANAGEMENT

Major Improvement Needed	The lack of reliable consumption data affected the quantification and forecasting process for health products. Shortcomings in supply chain management resulted in poor controls over distribution and stock management which caused expiry. Long-expired medicines had not been disposed of.

I.1 Quantification

Quantification did not take into account risk of expiry

Consumption data not reliable

55. The quantification process for health products was affected by a lack of reliable consumption data for ACTs, RDTs and reagents. This was raised as a problem in the malaria Phase 2 report (October 2011). In response, the Global Fund suspended the procurement of ACTs and RDTs in April 2012, pending availability of reliable consumption data.

Stock out of critical health products noted

56. Inadequate quantification contributed to stock-out and expiry of medicines and health products. This was observed by the audit team and documented also in UNDP's 2011 review[24] of storage facilities, which reported stock-out and expiry across the three disease programs, including LLINs, ACTs, ARVs, TB drugs, reagents etc. In November 2011, 11 centers reported that they had had stock-outs of seven first-line TB drugs for more than two weeks.

I.2 Storage and distribution

I.2.1 Distribution

Weaknesses in distribution mechanisms

57. NatPharm is responsible for distributing health products. There were several shortcomings noted with regard to distribution, including:

- The lack of batch tracking, which would facilitate recall;
- Inconsistent application of the first expiry first out system, which contributed to expiries; and
- A failure to distribute program assets (drugs, reagents and equipment) in a timely manner. Some of the assets were held in the Central Medical Stores for over two years.

Weak secondary distribution capacity

58. While primary distribution capacity (from the Central Medical Stores to regional stores) was generally satisfactory, secondary distribution capacity (from regional stores to facilities) remained weak. The concerns raised by facilities during our site visits were:

- Delays in receiving deliveries from NatPharm;
- Facilities sometimes receiving drugs they did not need;
- Orders not always completely filled;
- Short-dated stock delivered regardless of need; and
- Excess stock not withdrawn from facilities.

Implementation of marketing push

59. NatPharm employed different distribution systems, i.e., procurement push for TB, "Zimbabwe Informed Push (ZIP)"[25] for

[24] Consolidated report on the oversight/verification services for NatPharm, November 2011

[25] The "Zimbabwe Informed Push" system (ZIP) is a procurement marketing push system from NatPharm regional stores and branches to service delivery points (SDPs). At each SDP, the District Pharmacy Manager physically counts the commodities (TB and malaria), calculates losses and adjustments, analyzes consumption since last delivery, and determines the average monthly consumption (AMC). Based on the minimum and

should be strengthened

malaria, marketing pull for HIV and "Delivery Team Topping Up" for PMTCT. The decision to follow push was driven by capacity constraints. However, the implementation of push was affected by the lack of reliable information to guide decisions on what and how much to distribute.

I.2.2 Storage

Poor storage facilities

60. The storage conditions at facility level were generally below acceptable standards. Common issues noted at all stores visited had previously been highlighted in LFA reports and included:

- Lack of temperature control mechanisms;
- Inadequate storage layout and equipment to facilitate the movement of stock ;
- Incomplete isolation of expired drugs and drugs that had not passed quality control;
- Non-investigated stock discrepancies;
- Inadequate warehousing procedures, as evidenced by facilities holding quantities other than the recommended 3-5 months buffer stock (as little as zero and as much as fourteen months);
- Lack of accountability over stock movement with inter-facility transfers not recorded; and
- Unexplained variances between records and physical stock cards at the NatPharm Central Medical Stores.

Recommendation 9 (High)

a) The MOHCW should undertake a review of the adequacy of storage capacity at facility level with the objective of addressing identified gaps;

b) NatPharm should strengthen controls over stock held and distributed by instituting (i) batch tracking of commodities through the entire distribution chain; and (ii) an early warning mechanism to prevent expiries; and

c) NatPharm should integrate the redistribution of medicines and health products within its routine distribution schedule.

I.3 Quality control

I.3.1 Disposal of expired medicines

High cost of expired medicines

61. All the facilities visited were holding expired medicines, some of which had been in stock for over a decade. All facilities visited in Gweru, Bulawayo and Masvingo (with the exception of Mpilo hospital) held stocks of expired ACTs and RDTs. An analysis of the January 2011 to June 2012 data in the ZIP logistics management information system indicated expired drugs for malaria and TB worth USD 165,000 (4.75%) and USD 275,000 (5.5%), respectively.

Long expired medicines not disposed

62. The delays in the disposal process were caused by the centralization of disposal decisions and the need for several ministries to approve the process. The retention of expired medicines came at the cost of using up valuable storage space for holding expired medicines, which had not been segregated or secured to prevent unauthorized

maximum stock levels of two and four months of stock, respectively, the AMC tells the delivery staff which quantity to deliver or withdraw.

access.

I.3.2 Pharmacovigilance

Weak pharmacovigilance system

63. Zimbabwe has no pharmacovigilance policy, training manual, trainings, data collection tools or implementation at the facilities. While the Zimbabwe National HIV and AIDS strategic plan 2011–15 committed to strengthening pharmacovigilance systems for ARV, anti-TB and opportunistic infection drugs, there was no systematic implementation from the national level to the facilities. Post-market surveillance of medicines bought with Global Fund support was not implemented in line with the grant agreement.

Recommendation 10 (High)

a) The MOHCW should work with the Medicines Control Authority of Zimbabwe (MCAZ) to establish and roll out a national ARV pharmacovigilance plan;
b) The disposal exercise planned by the MOHCW for long expired drugs should be expedited; and
c) MCAZ should institute post-market surveillance of drugs.

ANNEXES

Annex 1: Abbreviations

ACT	Artemisinin-based Combination Therapies
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CCM	Country Coordinating Mechanism
CHW	Community health worker
DHIS	District Health Information System
DOT	Directly Observed Therapy
HMIS	Health Management Information System
HSS	Health systems strengthening
LFA	Local Fund Agent
LLIN	Long Lasting Insecticides Nets
MCAZ	Medicines Control Authority of Zimbabwe
MDR	Multi-drug resistant
MOHCW	Ministry of Health and Child Welfare
NatPharm	National Pharmaceuticals Company of Zimbabwe
OIG	Office of the Inspector General
PLHIV	People living with HIV/AIDS
PR	Principal Recipient
RDT	Rapid Diagnostic Test
SR	Sub-Recipient
TB	Tuberculosis
UNDP	United Nations Development Programme
ZIP	Zimbabwe Informed Push procurement strategy

Annex 2: Classification of Audit Findings and Recommendations

Rating of Functional Areas: Each functional area reviewed (e.g., financial management) is rated as follows:

Effective	Controls evaluated were adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Some Improvement Needed	Some specific control weaknesses were noted; generally however, controls evaluated were adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Major Improvement Needed	Numerous control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Not Satisfactory	Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Critical	An absence of or fundamental weakness in one or more key controls, or a serious non-compliance. Non-mitigation will jeopardize the achievement of the Global Fund's strategic objectives. It requires urgent attention.

Implementation and Prioritization of Audit Recommendations: The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. While the CCM and the recipients of grants bear the responsibility to implement specific recommendations, it is the responsibility of the Global Fund Secretariat to ensure that this takes place as part of their mandate to manage grants effectively. Audit recommendations are prioritized as follows to assist management in deciding on the order in which recommendations should be implemented:

Very High	An absence of or fundamental weakness in a key control, or a serious non-compliance. Non-mitigation will jeopardize the achievement of the objectives of the Global Fund. It requires urgent attention.
High	A key control evaluated was not adequate, appropriate, or effective. It is unlikely that the control will manage risk and meet objectives. It requires immediate attention.
Medium	A specific key control weakness was noted. It is possible that this control will not manage risk and meet objectives. It requires attention within a reasonable period.
Low	A specific control weakness was noted in a non-critical area that, if left unattended, will not manage risk and meet objectives. It requires attention in the medium term.

Letter to Management: The implementation of all audit recommendations would significantly mitigate the risks and strengthen the internal control environment in which the programs operate. Audit findings classified 'Medium' and 'Low' have been reported separately in a Letter to Management. When such isolated findings in aggregate constitute a significant risk, this is mentioned in the report and in our conclusion. Though these findings and recommendations do not necessarily warrant immediate action, they represent specific key control weaknesses which should be addressed in a reasonable time period. If these deficiencies are not addressed, risks will not be managed appropriately.

Annex 3: Recommendations and Management Action Plan

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)		
Oversight and Governance	***Recommendation 1 (Very High)*** *The CCM, working with the Global Fund Secretariat, should enter into dialog with government and development partners to:* *i. Identify sources of funding for medicines, health products and staff salaries; and specifically* *ii. Explore options for recapitalizing NatPharm in order for it to meet its mandate.*	The Country Team (CT) has been proactively engaging the CCM and other partners to source additional funding for treatment and support for Human Resources (HR). Therefore when Zimbabwe was invited as an early applicant under the New Funding Model, the CT highlighted inadequate support for HR and treatment as issues that the CCM needed to address in the Concept Note (CN). The CCM has made provision in the CN for addressing treatment and HR issues, and therefore once the new grant is signed, this recommendation will be addressed.	i. The CCM has applied to the GF under NFM for HIV and main focus of the grant is to address gaps in ARVs for starting 2014. The CCM has also recommended that that savings identified in the procurement of ARVs for the 2012 and 2013 purchases be directed towards procurement of ARVs for the first two quarters for 2014. The CCM has included Health Worker retention in the NFM for HIV recently submitted to GF to cover the period 2014-2015. The HTF is also contributing to the retention of health workforce. Government has been increasing it workers' salaries over the years ii. NatPharm working with the government and partners developed a roadmap in 2010 to improve its systems. Warehouse SOPs were reviewed and staff trained, storage capacity was improved through additional racking, the management	NatPharm	December 2014

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)		
			information system has been strengthened among other activities. Other activities of the roadmap are ongoing and funding has been requested for under the NFM including introduction of barcoding and additional storage capacity at provincial branches. iii. The MOHCW and NAC have agreed on NAC paying to NatPharm 2.5% of the value of ARVs and related products supported by NAC and some partners as storage and distribution charges. iv. MOHCW and MOF are exploring ways of recapitalizing NatPharm including the possible retirement of the USD 8million debt accrued by MOHCW. The Ministry of Finance has been paying NatPharm some amounts to cover worker's salaries on a regular basis.	MOHCW & NAC MOHCW and MOF	done April 2014
	Recommendation 2 (High) *The CCM in its oversight role should prioritize the*	The CT will participate in the program reviews currently underway in	Currently HIV service provision in the country does not discriminate anyone because of their sexual, political and/or		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	implementation of activities to address key populations at risk of exposure to HIV and use of LLINs for children under five years.	April-May and will strongly encourage the program to include in the review report the extent to which activities appropriately prioritize key populations at risk of exposure to HIV and use of LLINs for children under five.	cultural orientation and clients can access HIV services anywhere anytime. A recent study in the sites indicated that about 54-70% of SWs are accessing ART at the health facilities, the prison population is also accessing ARVs from the national ART programme NAC continuously advocating for implementation of activities guided by the ZNASP II which is built on 8 guiding principles, three of which inform the engagement with key populations i.e. 1]Putting human rights at the centre of the national response to HIV and AIDS; 2]Addressing gender inequalities in the national response to HIV and AIDS and 3]Meaningful participation of those for whom HIV and AIDS interventions are planned. The CCM will use the findings of the program review to determine the extent to which key populations at risk are addressed. USD2 million funding support secured from the UNODC to extend implementation of HIV/AIDS activities to congregate settings (prisons). Relevant strategic plans were developed, a steering committee including among other stakeholders the National AIDS Council	NAC NAC	December 2013 October 2013

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)		
			(NAC) as chairman, Zimbabwe Prison Service (ZPS) as secretariat and MOHCW, was set up and implementation expected to start in 2nd half of 2013 Collaboration formed with PSI, MOHCW, Batsirai and CESHAAR with support from the Integrated Support Program (ISP) and other partners to address HIV/AIDS issues among sex workers and this is anticipated to involve most of health facilities that lie along the major highways in the country	MOHCW and Partners	Dec 2013
		The CT will take steps to ensure that during grant making for the new grant under the NFM, the population size estimate study is planned for implementation in 2014 with the results expected by end of December 2014.	There is currently no local data on the population size estimate or HIV prevalence in men who have sex with men (MSM) in Zimbabwe and plans are underway to conduct a study to address this and this has been factored in the GF NFM concept note development, however MSM and commercial sex workers remain illegal. and this may present some barriers to implementation of this activity	NAC and Civil Society Organizations	December 2014
			LLIN distribution policy now aims at universal coverage, that is, a net for every two people in a household or a net per sleeping space. Using this strategy all the vulnerable population groups such as the Under 5s, pregnant women and other immune-compromised persons are all	NMCP	December 2014

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			covered. The MOHCW will be receiving around 500,000 LLINs in mid-2013 through PMI support, and these will be used to pilot distribution through routine outlets such as the ANC and EPI delivery points, with a view to expand in 2014. *The report to demonstrate this distribution will be available end of December 2014.*		
Grant Management	***Recommendation 3 (High)*** *The MOHCW should set clear and specific timelines for the inclusion of grant-related functions, roles and responsibilities into existing national structures.*	The CT will work closely with the CCM and UNDP to ensure development of an action plan with clear timelines for the integration of grant-related functions into the national structure as specified by the CCM.	The PR in coordination with the MOHCW will propose an action plan with clear and specific timelines for the integration of grant-related functions, roles and responsibilities into the MOHCW structure as noted below: 1. **Financial Management**: i The Public Financial Management System (PFMS) used by GoZ was revamped in 2010 and is being integrated in the Government ministries. Pending the finalization of the integration process for the PFMS the PASTEL recommended in the 2008 OIG report for other partners is being used in the interim ii. The Ministry developed a Risk Management Policy (RMP) in 2011, and the RMP roll out plan to Central Hospitals and Provinces. iii. The Ministry is in the process of	PR, MOHCW MOHCW - Finance and Administration and Programmes MOHCW - Internal Audit	31 July 2013 TBD in PR action plan TBD in PR action plan

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			implementing an Audit Committee, and the relevant draft charter is in place. 2. **Health Information System**: In 2011 the MOHCW started a process to integrate all the program databases into the national health information system or the DHIS-2. The MOHCW, with technical and financial support from CDC/Research Triangle International (RTI) is piloting the DHIS-2 in Manicaland Province, which has incorporated the weekly surveillance reporting system, Inpatient Mortality and morbidity Information System (IMMIS), HIV/AIDS system and the T-5 system. The piloting, review of the system and training of HWs in the DHIS-2 will be completed in July 2013 for nationwide rollout of the system. The TB system will also be integrated into the DHIS-2 during the rollout. The implementation of the DHIS-2 later in 2013 to a harmonized transmission of data from district level to provincial and national level from the different program specific databases.	MOHCW – Internal audit MOHCW - HMIS	TBD in PR action plan December 2013
	Recommendation 4 (High) *The MOHCW should ensure that the MOHCW laboratory department, is strengthened, particularly with respect to (i) ensuring that relevant*	The CT is working with UNDP and PEPFAR to jointly support strengthening MOHCW Directorate of	The audit noted that there were reagent stock-outs and expiries as the laboratory department did not have a logistics management information system to generate reliable consumption data for quantifying required reagents. The Country	Lab services directorate and JSI	December 2013

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	laboratory equipment is in place; (ii) operationalizing machine maintenance arrangements; (iii) ensuring availability of reagents; (iv) ensuring adequate human resources; and (v) improving sample transport systems and turnaround time for communication of results	Laboratory services. The support includes development of a LMIS that will help UNDP (PR) enter into bundling agreements for reagents and maintenance of laboratory equipment, thus reducing the cost and also preventing stock out of reagents, be providing quantification based on reliable consumption data from the LMIS. The LMIS is expected to be fully functional by December 2013.	Team is working with JSI to develop a laboratory logistics management information system to generate reliable consumption data for quantifying required reagents. Trainings are currently going on. 31 of the 81 laboratories renovated with grant funds were not operational due to a disagreement about who was responsible for their operations. The lab services directorate is responsible for their operations. They went round these centers to inspect and some were condemned whilst others were operationalised although there is a shortage of staff to work there. MOHCW to follow up and ensure all renovated laboratories are functional The MOHCW will continue to validate new RDTs that are introduced in the country and a criteria that is to be used is generally if the kit is WHO prequalified, has been validated in Zimbabwe,ease of use, cost per test, etc. Health products (e.g., microscopes and reagents) that had been procured have now been distributed from NatPharm to peripheral levels 360 laboratory technicians trained under	Lab services directorate Lab services directorate Lab services directorate Lab services	June 2014 done done Done

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			Phase 1 have since been deployed. CD4 count machines were serviced in March 2013. There has also been deployment of PIMA POC CD4 machines in hard to reach areas to ensure good patient management. Most TB patients either have to travel to distant centers for immediate tuberculosis (TB) diagnosis (direct smear microscopy) or wait over one week for results. TB microscopy centers that have microscopists have now been established and specimens are referred to the 2 reference laboratories using SWIFT. However other means of sample transportation need to be identified as SWIFT does not cover all areas.	directorate Lab services directorate Lab services directorate	 June 2014 June 2014
	Recommendation 5 (High) **1.** *The MOHCW should ensure that human resources for health, particularly those supported by the Global Fund, are managed optimally. This should include a Human Resources for Health baseline assessment to inform further policies aimed at closing identified human resource*	The CT will work closely with UNDP to ensure that HSB conducts a review of current health workers by December 2013	As the economy continues to improve the Government of Zimbabwe is committed to continuously review the salaries of Health Workers with the intention of eventually coming to levels comparable to countries in the region. The low numbers in the critical categories in 2012 can largely be attributed to the employment freeze by the Ministry of Finance due to the shortage of financial resources.	HSB and MOHCW HR	

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	gaps.		However the freeze was relaxed for the Ministry of Health and Child Welfare effective January 2013. The Ministry of Finance having noted the need to facilitate the filling of critical posts including nurses put in place a mechanism whereby replacements necessitated by attrition against posts budgeted for would be filled with minimal delays. Treasury also acceded to the creation of 1269 nurses posts for the Rural Health Centres and District Hospitals. As a result the in-post for March 2013 for the critical categories have increased drastically with some Central Hospitals getting to full establishment. The inpost for nurses is now at 100%. Example of New appointments effective 1 March. Nurse 2 174, Pharmacy 38, Dental 22, laboratory 144, Environmental 170, Physiotherapy 66 and Radiographer 31. Efforts are being made to convince Treasury to increase the Ministry's Staff establishment in view of the increased workload. In 2011 the Government increased salaries by 25% , 8% in 2012 and 5% in 2013. Efforts continue to be made to convince		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			Treasury to continuously review salaries. The Health Transition Fund (HTF) which is a Multi-Donor Pooled Fund for Health in Zimbabwe has significantly contributed towards paying of allowances to Health Workers in C5 and above categories since March 2012. The HTF covers the 25% reduction in Global Fund allowances effected in January 2012. It also pays retention allowances to Doctors in District Hospitals, Midwifery Tutors, Midwives and Management at District, Provincial and Head Office level. With Management at all levels receiving such allowances from the HTF it is hoped that this will increase retention levels hence contribute to an improvement in management of the Human Resources for health. A Health Worker staff satisfaction Survey funded by the Global Fund is commencing in April 2013. The focus of the survey is to determine satisfaction, motivation levels and identification of non-financial incentives. This assessment will inform and guide the development of further policies on motivation and retention of staff.		December 2013
Program Implementati	***Recommendation 6 (High)*** *The MOHCW's National AIDS*	The CT will work closely with UNDP and	MOHCW has a Quality Improvement Policy in place and introduced the quality	MOHCW –	December

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
on	*Program should ensure that a quality improvement program is instituted for all ART facilities. This should be guided by a standardized Service Quality Assessment checklist and include indicators for clinical and laboratory monitoring as well as ART defaulter tracking. It should be used during supportive supervision to reinforce the national guidelines.*	MOHCW's National AIDS Program and take steps to ensure that the proposed action plans are implemented according to the proposed timelines. The CT will utilize the services of the LFA to verify the implementation of the proposed actions.	improvement component under the HIV program in 2012 with support from HEALTHQUAL and CDC. Since then indicators to track on quality improvement and data abstraction tools have been developed and implementation has been commenced in 50 sites selected to implement Quality Improvement for 2013 Plans are underway to incorporate the service quality assessment checklist into the supportive supervision tools currently in place Development of QI guidelines, training of HCWs on QM and QI with performance measurement, site assessment, development of site OI plans and baseline abstraction with analysis form the list of priority next steps in QM and QI program implementation in the country. To strengthen and compliment the already existent patient defaulter tracking mechanisms in most facilities, the MOHCW will continue to strengthen collaborations with EHTs, CHWs , Community nurses and networks of PLHIV As for laboratory monitoring of patients on ART, the MOHCW during training of	Quality Improvement Directorate MOHCW MOHCW MOHCW MOHCW	2013 Dec 2013 Dec 2013 June 2014 Dec 2013

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			health workers is emphasizing on regular lab monitoring six monthly tests as per national ART guidelines. The NMRL is also on a drive to resource mobilize to support regular viral load testing		
	Recommendation 7 (High) *The MOHCW's National TB Program should* *a) Strengthen the implementation of DOT, for example, by employing CHWs to support supervision of patients;* *b) Institute mechanisms for monitoring adherence, e.g., by using patient indicators of non-adherence such as delayed clinical improvement or clinical deterioration while on TB therapy, or missed appointments for clinical follow up; and* *c) Improve the response to MDR-TB by ensuring better prevention (early diagnosis and adequate treatment of drug-susceptible cases), diagnosis (molecular and conventional methods), treatment (ambulatory and hospital-based) and patient support (in health facilities and at home).*	The CT will work closely with UNDP and MOHCW's National TB Program and take steps to ensure that the proposed action plans are implemented according to the proposed timelines. The CT will utilize the services of the LFA to verify the implementation of the proposed actions.	a) Currently as part of the implementation plan of the Round 8 Grant CHWs specifically Village Health Workers and Secondary Care givers are receiving training aimed at strengthening their capacity to manage TB. The Ministry has recently revised the TB M/E tools to enhance the accurate collection of TB data and it is anticipated that full implementation of the Revised tools will take place in Quarter 3. Furthermore as part of the ongoing actions to strengthen DOT the Ministry is engaging external TA through KNCV Tuberculosis Foundation for the development of National Policy and Guidelines for Community based DOT. b) Currently all patients are reviewed at least monthly at the health facility and adherence is assessed during the visit. Missed appointments are followed up by visits to the patient's home to identify the causes of treatment interruption and take corrective action.	MOHCW-NTP MOHCW-NTP	March 2014 March 2014

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			There is need to support the Environmental Health Technician who carry out this activity with maintenance of their motorcycles and fuel. In the long term adherence to treatment will also be strengthened by the application of the Community Based TB care model c) The Ministry has developed a draft **3** year MDR-TB expansion plan to address all the key aspects of a national comprehensive response. The plan was developed jointly with in country partners and the GLC. The Plan will be finalized before the end of the 2nd Quarter.	MOHCW-NTP	June 2013
	Recommendation 8 (High) *The MOHCW should:* *a) Strengthen supportive supervision in the MOHCW by developing standard operating procedures, standardized checklists and reporting templates as well as formal feedback forms. On the job training and mentoring should be part of supportive supervision visits;* *b) Develop a customized and shortened set of national*	The CT will work closely with UNDP and MOHCW and take steps to ensure that the proposed action plans are implemented according to proposed timelines. The CT will utilize the services of the LFA to verify the implementation of the proposed actions.	a. Support and supervision (S&S) visits are now being done with support from RTI (S&S visits conducted in 5 provinces during Quarter 1, 2013). S &S Checklist and reporting templates developed and distributed to all provinces for their use. Training in the use of the tools conducted. National Level now attending Provincial Health Team (PHT) meetings where extra day to discuss data issues including S&S tools is being funded by RTI. b. Customized data collection tools in	MOHCW	done

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	HMIS data collection tools for primary health care facilities and ensure that the correct versions of such tools are available through supportive supervision; and *c) Develop standard operating procedures for patient tracking to improve the detection and reporting of defaulters and ensure that patients are retained on treatment.*		place ever since. PMTC & ART Registers revised and implemented since February 2013. Consultative meeting with all stakeholders to prioritize indicators in April. *Benchmark indicator report* c. The MOHCW has in place job aides which always form part of M&E tools that are distributed to facilities which spells out who is a defaulter and who is a lost to follow up case and what steps to take when a patient is reported lost to follow or as having defaulted. Plans underway to develop SOPs for tracking patients using the ePMS. Through CSS MOHCW with support from partners is going to train CHWs to monitor adherence at community level and strengthen their reporting to the health center	MOHCW MOHCW	July 2013 March 2014
Procurement and Supply Management	***Recommendation 9 (High)*** *a) The MOHCW should undertake a review of the adequacy of storage capacity at facility level with the objective of addressing identified gaps;* *b) NatPharm should strengthen controls over*	The assessment has been completed and an action to address the weaknesses in the 52 high volume sites has been developed and costed. The CCM has made provision in the CN of the NFM to	a) The Assessment of the Health Facilities responsible for the storage of health products was completed in January 2013 and the Action Plan and Associated Costs to address the identified gaps prepared in February 2013, in consultation with concerned stakeholders (SRs, SSRs, donors and the CCM). From the three options	MOHCW	December 2016

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	stock held and distributed by instituting (i) batch tracking of commodities through the entire distribution chain; and (ii) an early warning mechanism to prevent expiries; and *c) NatPharm should integrate the redistribution of medicines and health products within its routine distribution schedule.*	finance this action plan. The CT is planning to bring forward funding to support implementation of a third of this action plan by the end of December 2013 before the new grant starts. Provision has also been made to improve conditions at NatPham in the CN, and the CT will monitor implementation of the proposed actions plan in the CN through the LFA.	proposed to the approach the stakeholder meeting held in February agreed that Option 1 – renovation of selected SDPs be adopted based on the 52 sites visited during the assessment. The estimated budget for the implementation of the recommended option in the 52 sites is at $3,952,524. Additional funding is being proposed in the NFM proposal recently submitted to the GF. The action plan will be implemented after GF approval. b) Batch tracking will cover all commodities once a redesigned pull system for all commodities is instituted and rolled out. The system will be piloted in one province starting the 4th quarter of 2013 and rolled out in the 2nd half of 2014. The currently operated informed push systems use a data capturing tool that has a column for reporting of short dated stock to facilitate redistribution. The Medicine Information system whereby facilities report on essential data elements for all medicines and medical supplies on a monthly basis	MOHCW and NatPharm MOHCW-DPS	October 2013 December 2013

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			has a similar column. The Ministry is working on strengthening this system so that reporting rates improve through support and supervision and the on the job mentorship with funding from UNFPA and WHO.		
	Recommendation 10 (High) *a) The MOHCW should work with the Medicines Control Authority of Zimbabwe (MCAZ) to establish and roll out a national ARV pharmacovigilance plan;* *b) The disposal exercise planned by the MOHCW for long expired drugs should be expedited; and* *c) MCAZ should institute post-market surveillance of drugs.*	The CT will work closely with UNDP and MOHCW and will take steps to ensure that the proposed action plans are implemented per proposed timelines. The CT will utilize the services of the LFA to verify the implementation of the proposed actions.	a) Funding has been requested in NFM to help in the development of a pharmacovigilance policy. A roll out of the targeted spontaneous reporting of Adverse Drug Reactions for ARVs and TB medicines will be rolled out in 2013 b) Outstanding approvals will be followed up and facilities facing challenges with disposal of expired items assisted. The ministry has also streamlined the process of disposal of expired and obsolete essential medicines and medical supplies c) MCAZ is able to work with funding partners to roll out a more comprehensive post-marketing surveillance. Funding for this activity has been requested for in the NFM.	MCAZ and MOHCW MCAZ MOHCW MCAZ	April 2014 June 2013 December 2013 April 2014