



Audit Report

Global Fund Grants in Zimbabwe

GF-OIG-20-008
26 March 2020
Geneva, Switzerland

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Audit Report

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1. Executive Summary

1.1 Opinion

Zimbabwe has made significant progress in the fight against the three diseases, despite a prolonged economic crisis that has led to a deterioration of health infrastructure, loss of experienced health staff and a decline in the quality of health services. National malaria incidence almost halved in 2017¹, while many countries globally were experiencing malaria resurgence. TB incidence declined by almost 60% between 2010 and 2017², with treatment coverage and treatment success rate both exceeding 80% by 2018. HIV prevalence has decreased significantly among adults as well as children³. AIDS-related deaths fell by 60% and annual infections fell by 38% from 2010 to 2018⁴. Zimbabwe ranks among the top 18 countries achieving an incidence-to-prevalence ratio of 3%⁵.

However, some challenges remain. There are HIV data anomalies, with significantly higher cases detected annually than estimates, and efforts are required to understand the underlying root causes and inform an appropriate programmatic response. Further improvements are needed in outreach among hard-to-reach populations, and in putting all identified patients on treatment. Part-time health facility staff means a risk of deteriorating access and quality of care, as well as other grant management areas, over the long term. The program is currently **partially effective** in patient tracking and counseling, key population coverage, early infant diagnosis, and overall viral load suppression; further improvements will be needed to reach the ambitious program objectives.

Regarding the supply chain, no material stockouts or expiries of ARVs were detected at any level for the three diseases during 2018-19. Monthly stock counts and warning mechanisms for near-to-expiry products are in place. Global Fund commodities are generally traceable. The country is expanding the drug storage capacity of central and regional warehouses and has rehabilitated 169 health facility stores to address warehousing challenges. However, overall capacity needs are almost twice the current warehousing capacity, and an updated assessment of warehousing needs is required. Space issues prevent good inventory management; the audit noted cases of slow stock rotation, forced 'transfer' of drugs to health facilities which stretches their capacity and increases risks of expiries, and simultaneous expiries and stock-outs of commodities at different facilities. Gaps were also noted around timely and accurate data entry into inventory systems, reconciliation of inventory records, triangulation of drugs consumption and patient data, and oversight and supervision. The Secretariat has made efforts with the national programs to optimally utilize existing warehouses, and register supply chain improvements; however, further improvements are needed. Overall, supply chain management is assessed as partially effective.

1.2 Key Achievements and Good Practices

Significant ownership and progress in the fight against the three diseases:

Despite its constraints, the Government of Zimbabwe, with support from the Global Fund and other partners, has achieved strong results on all three diseases. HIV incidence per 1,000 adults fell from 8.52 to 4.86 during 2010-18⁶. The adult HIV prevalence decreased from 15.4% in 2010 to 12.7% in 2018⁷. HIV deaths decreased from 54,000 to 22,000 annually between 2010-2018⁸, making

¹ 2018 Annual Malaria Report-MoHCC

² Global Tuberculosis Report-2018

³ <http://aidsinfo.unaids.org/>: Prevalence for adults 15-49 years old has decreased from 15.4% [13.1-17.5] in 2010 to 12.7% [10.8-14.5] in 2018

⁴ All information in this section comes from UNAIDS Zimbabwe website:

<https://www.unaids.org/en/regionscountries/countries/zimbabwe>

⁵ UNAIDS 2019 estimates https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

⁶ Key HIV Indicators - AIDS info: ZIMBABWE <http://aidsinfo.unaids.org/>

⁷ Key HIV Indicators - AIDS info: ZIMBABWE <http://aidsinfo.unaids.org/>

⁸ UNAIDS 2019 estimates https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Zimbabwe one of five countries globally to halve AIDS deaths in that period⁹. The country's incidence-to-mortality ratio stood at 1.8% in 2018. Zimbabwe has over one million patients on antiretroviral treatment, the number having steadily increased.

Similarly, Zimbabwe registered a drop in malaria incidence from 34 cases to 19 cases per 1000 population in 2017¹⁰. The country distributed 844,000 Long-Lasting Insecticidal Nets in 2018 against a target of 595,000¹¹. Malaria elimination expanded from 7 to 28 districts between 2012 and 2018. Regular case management audits, mentorship program for malaria case management and Village Health Worker peer-to-peer supervision have all supported programmatic achievements.

Regarding TB, Zimbabwe is among six countries in southern Africa where TB incidence is estimated to have fallen rapidly in 2010–2017, with a 10% average annual decline¹². TB treatment coverage increased from 71% in 2017 to 83% in 2018. Among HIV-positive TB cases, the treatment success rate is 82%.

1.3 Key Issues and Risks

HIV data anomalies should be investigated to inform national strategy:

While UNAIDS estimates indicate almost 90% achievement throughout the HIV treatment cascade, including number of tests and positive cases identified, data anomalies were noted. There are consistently higher numbers of positive cases than national strategy targets in 2017-19 and spectrum estimates. Therefore, there is a risk that disease burden, testing and treatment coverage estimates might require revisions. The HIV strategy needs to consider these aspects to ensure it is based on accurate estimates, and incorporates any revisions required in the disease response.

Viral load testing mechanisms require significant improvement: Viral load (VL) testing coverage is low; in 2018, only 44% of eligible patients were tested for viral load. Even when tested, results are not automatically shared with health facilities, meaning people living with HIV do not know their VL suppression status; only 54% of test results were communicated back to health facilities. Contributing factors include: the absence of a systematic process to follow up clients for VL testing; limited point-of-care availability of VL machines; an unstructured sample transportation mechanism; unreliable power supply; and insufficient health staff.

Low performance of Early Infant Diagnosis: There are gaps in testing HIV-affected children and putting them on appropriate treatment. Only 57% of children estimated to be affected by HIV know their status. Performance of tests that should be done maximum 6-8 weeks after birth remains low (56% in 2018 and 63% in first semester of 2019 for visited facilities, against the national target of 75%). This low performance relates to: birth testing being performed only for high-risk newborns (who represent 4% of the population); the lack of a mechanism and Unique Identifier Code to track mothers and babies not tested at birth; electricity shortages; and lack of standard procedures for sample transportation.

Low warehouse capacity is affecting inventory management: Low warehouse capacity at all levels is preventing good inventory management. Drug volumes distributed by the central medical store, NatPharm (and the space required for them) are approximately double 2011 estimates and current capacity, and a revised needs assessment is required.

⁹ ibid

¹⁰ 2018 Annual Malaria Report-MoHCC

¹¹ ibid

¹² Global Tuberculosis Report-2018

1.4 Rating

	Objective 1. The effectiveness of processes and controls over testing including outreach, viral load suppression testing, early infant diagnosis, in reducing infections and deaths. Partially effective.
	Objective 2. The effectiveness of the supply chain mechanism to store, deliver and account for the health commodities to the last mile. Partially effective.

1.5 Summary of Agreed Management Actions

The Secretariat will work with the HIV program and technical partners to investigate the data anomalies regarding HIV positive cases tested compared to national PLHIV estimates, and use the results to inform future grant implementation and national HIV strategy. The Secretariat will also assess the feasibility on whether to roll out Unique Identification Code (UIC) for all identified PLHIV in Zimbabwe.

The Secretariat will work with the MOH and partners to revise the Early Infant Diagnosis (EID) policy to test all infants from PLHIV mothers, and develop costed plans to enhance EID coverage and improve systematic tracking of lost-to-follow-up patients on ART.

For supply chain, the Secretariat will ensure that Principal Recipients improve stock management at central and health facility levels by revising operating procedures, reassessing national storage capacity needs, reducing physical stock count variances against electronic system, and improving inventory management and accountability framework of health products at health facilities.

2. Background and Context

2.1 Overall Context

Zimbabwe is a lower-middle income country¹³; 70% of its population live below the national poverty line.¹⁴ The national health system comprises 63 Health Districts and 1,848 health facilities, of which 94% are public sector facilities.¹⁵ Between 2012 and 2016, government health expenditure increased from 6.6% to 9.4% of total public spending.¹⁶

Zimbabwe faces a critical shortage in its health workforce, with 0.08 physicians and 1.2 nurses and midwives per 1,000 population,¹⁷ well below the WHO's recommended minimum target of 2.3 doctors, nurses and midwives per 1,000 population.¹⁸ Due to an economic context marked by shortages of essential items and hyper-inflation, the country faces recurrent shortages of drugs and equipment in primary healthcare services.¹⁹

Population: **14.4 million**

GNI per capita: **US\$1,790**
(World Bank, WDI, 2018)

UNDP Human Development Index: **156 of 189** (2018)

Transparency International
Corruption Perceptions Index:
160 of 180 (2018)

UNDP Gender Inequality Index:
128 of 160 (2017)

2.2 Differentiation Category for Country Audits

The Global Fund has classified the countries in which it finances programs into three portfolio categories: Focused, Core and High Impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics. Countries can also be classified into two crosscutting categories: Challenging Operating Environments and those under the Additional Safeguard Policy. Challenging Operating Environments are countries or regions characterized by weak governance, poor access to health services, and man-made or natural crises. The Additional Safeguard Policy is a set of extra measures that the Global Fund can put in place to strengthen fiscal controls and oversight in a particularly risky environment.

The Global Fund classifies Zimbabwe as:

- Focused: (Smaller portfolios, lower disease burden, lower mission risk)
- Core: (Larger portfolios, higher disease burden, higher risk)**
- High Impact: (Very large portfolio, mission critical disease burden)
- Challenging Operating Environment
- Additional Safeguard Policy (ASP)²⁰

¹³ World Bank, 2019, [New Country Classifications by income level: 2019-2020](#).

¹⁴ World Bank, 2017 [World Development Indicators](#) (WDI) data for Zimbabwe.

¹⁵ Ministry of Health, [National Health Strategy for Zimbabwe 2016-2020](#). Health facilities are categorized into four main groups: Central Hospitals (quaternary care), Provincial Hospitals (tertiary care), District, Mission and Private Hospitals (secondary care), and Primary Care Facilities accounting for 88% of all health facilities.

¹⁶ Domestic and external funding accounted for 28% and 25% respectively of national health expenditure. World Bank, [World Development Indicators](#) (WDI) 2016 data for Zimbabwe.

¹⁷ World Bank, 2014 [World Development Indicators](#) (WDI) data for Zimbabwe.

¹⁸ See 2014 WHO Global Key Messages on Global Health Workforce Alliance.

¹⁹ Ministry of Health, [National Health Strategy for Zimbabwe 2016-2020](#).

²⁰ Additional safeguards initially invoked for Zimbabwe in November 2008. Two major safeguards currently remain: PR selection by the Global Fund and measures to manage the risk of sequestration of the Global Fund resources. Hence, a PR enjoying privileges and immunities (UNDP) has been appointed.

2.3 Global Fund Grants in Zimbabwe

The Global Fund has signed grants totaling US\$1.67 billion in Zimbabwe since 2003, covering HIV/AIDS, TB, malaria and health system strengthening.²¹ Overall disbursements amounted to US\$1.5 billion as of November 2019.

Active grants in Zimbabwe for the funding cycle 2018 -2020 are:

Grant No.	Grant component	Grant period	Signed amount (US\$)	Disbursement as at June 2019 (US\$)
ZWE-H-UNDPP02	HIV	January 2018 - December 2020	402,930,000	146,099,318
ZWE-M-MOHCCP02	Malaria		48,170,000	25,050,481
ZWE-T-MOHCCP02	Tuberculosis		23,340,000	12,544,490
Total			474,440,000	183,694,289

Two Principal Recipients manage the implementation of the active grants. UNDP manages the implementation of the HIV grant, while the Ministry of Health and Child Care (MoHCC) manages the implementation of the Malaria and Tuberculosis grants. The MoHCC is also one of the sub-recipients of the HIV grant.

2.4 The Three Diseases

HIV/AIDS²²: Prevalence among adults aged 15 to 49 is 12.7% (2018). The HIV epidemic is high among key populations, with 41.4% prevalence among sex workers, 31% prevalence among men who have sex with men, and 28% among prisoners. Prevalence is also considerable among young women (5.7% compared to 3.2% for young men).



In 2018, 94% of HIV-positive pregnant women received antiretroviral treatment (ART) for PMTCT.

The Global Fund contributes 27% of available funding (US\$416 million) during 2018 – 2020; the United States Government finances 27%. Government and other partners contribute 47% of the available funding. There is an overall funding gap of 26%.²³

Estimated 1.3 million people living with HIV, of whom 90% know their status. 95% of people who know their status were on treatment in 2018.

AIDS-related deaths (for all ages) fell from 54,700 in 2010 to 22,000 in 2018.

Annual infections have decreased by 38% since 2010, with about 38,000 new infections in 2018.



Malaria: Malaria is highly seasonal; pre-elimination activities have been implemented in Zimbabwe since 2015. Zimbabwe ranks 30th globally in terms of incidence, with 95/1,000 population at risk (2017).²⁴ High transmission is

29% of the population at high risk of malaria (WHO 2017).²⁸

²¹ Global Fund data explorer page for Zimbabwe accessed on November 12, 2019.

²² All information in this section comes from UNAIDS Zimbabwe website:

<https://www.unaids.org/en/regionscountries/countries/zimbabwe>

²³ Calculations made using Funding Gap documents of the Global Fund and LFA data.

²⁴ World Bank, 2017 [World Development Indicators](#) (WDI) data for Zimbabwe.

²⁸ WHO, 2018, [Malaria Country Profile for Zimbabwe](#)

still observed in the northern and eastern parts of the country.²⁵

Since 2014, the number of reported malaria cases has ranged between 740,000 and 1.2 million per year.²⁶

In 2017, 48% of the households had at least one Insecticide Treated Net.²⁷

In 2017, **467,508 cases** were confirmed out of 1.2 million estimated cases.²⁹

Estimated annual deaths have been stable in 2012 and 2017, with between 200 and 406 deaths per year.³⁰



Tuberculosis: TB case detection has been around 71% during the 2010-2017 period.³¹

Mortality rate decreased by 60%, from 13/100,000 in 2014 to 7.7/100,000 in 2018 (World Health Organization).³²

Incidence was 210/100,000 population in 2018,³³ down from 384/100,000 population in 2011.

Treatment success rate is 83% (new and relapse cases),³⁴ compared to 80% for the 2011-2017 period.³⁵

2.5 Portfolio Performance

Based on results reported by the country to the Global Fund, the grants are generally performing well against the targets set in the performance framework. Performance on key coverage indicators reported by the country as of 30 June 2019 is shown in the table below:

2018 key indicators achievement rate (as of June 2019)			
Indicator	Target	Actual	Achievement rate
HIV			
Percentage of people (children and adults) living with HIV currently receiving antiretroviral treatment	83.3%	87.8%	105%
Number of women and men aged 15+ who received an HIV test and know their results	1,339,578	1,293,040	97%
Percentage of HIV-positive pregnant women who received antiretroviral medicine during pregnancy to reduce risk of mother-to-child transmission	93%	93.8%	101%
Malaria			
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	587,642	585,488	100%
Proportion of confirmed malaria cases that receive first line anti-malaria treatment in the community	309,079	294,233	95%
Number of long-lasting insecticidal nets distributed to targeted risk groups through continuous distribution (Dec 2018) ³⁶	132,495	171,038	120%

²⁵ WHO 2018 World Malaria Report

²⁶ ibid

²⁷ ibid

²⁹ WHO, 2018, [Malaria Country Profile for Zimbabwe](#)

³⁰ WHO 2018 World Malaria Report

³¹ World Bank, 2017 [World Development Indicators](#) (WDI) data for Zimbabwe.

³² WHO, 2019 [World Tuberculosis Report](#)

³³ WHO, 2019 [World Tuberculosis Report](#)

³⁴ WHO, 2019 [World Tuberculosis Report](#)

³⁵ World Bank, 2017 [World Development Indicators](#) (WDI) data for Zimbabwe.

³⁶ June 2019 PUDR does not report this data due to revision in the Performance Framework).

Tuberculosis			
Number of notified cases of all forms of TB (includes new and relapse cases)	15,400	11,153	72%
Percentage of new and relapse TB patients tested using WHO recommended rapid tests at the time of diagnosis	60%	94.8%	120%
Percentage of registered new and relapse TB patients with documented HIV status	97.4%	92.5%	95%

The indicator “Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment” for the TB grant was dropped in the NFM 2 performance framework. Latest results reported by the country indicated a high treatment success rate of 89 % (July-December 2017 PUDR).

Key

Exceeding Expectations	>100%
Meet Expectations	90-100%
Adequate	60-89%
Inadequate but potential demonstrated	30-59%
Unacceptable	<30%

2.6 Country risk appetite consideration

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries³⁷ representing most of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund’s Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants.

Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by the second line functions and senior management from the Grant Management Division. Grant risk ratings are weighted using the country allocation amount to arrive at an aggregate risk level for the country portfolio. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee (PPC)³⁸ during the Country Portfolio Review (CPR). Aggregated risk levels for Zimbabwe have been determined by the Country Team and Zimbabwe went through a CPR in July 2019. See Annex C for further details of the Risk Appetite methodology.

The OIG compared the Country Team’s aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Zimbabwe portfolio with the residual risk that exists based on OIG’s assessment, mapping risks to specific audit findings. Please refer to the table below:

Risk	Secretariat aggregated assessed risk level³⁹	Assessed risk, based on audit results	Relevant audit findings
1. Program Quality	Low	Moderate	4.1/ 4.2
2. In-country supply chain	High	High	4.3

The OIG audit scope mainly covered two of the eight country-level risks defined under the risk methodology. This was because during the initial risk assessment based on audit planning (including limited walkthrough of documents), OIG assessed those risks as low, which was aligned with Secretariat risk assessments as well. For Supply Chain risk covered during the audit, both the Secretariat and OIG assessed the risks as high.

³⁷ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d’Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe

³⁸ The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews

³⁹ This is the aggregated risk levels for the three grants in Zimbabwe as at June 2019.

However, in case of Program Quality, OIG assessed risk levels are different from the Secretariat. The main factors considered in OIG assessment are high risks that PLHIV are higher than current estimates, and program testing and treatment coverage are lower than reported levels. This is likely to require revising the HIV strategy to address the challenges. The program results had anomalies indicating such gaps, but these have not so far been used effectively to consider impact on disease response. Further, the program has low viral suppression testing and low progress on early infant diagnosis. After the audit start, the Secretariat has also revised the Program Quality risk rating to moderate in September 2019.

3. The Audit at a Glance

3.1 Objectives

The overall objective of the audit was to provide reasonable assurance on the adequacy, effectiveness and efficiency of Global Fund Grants to the Republic of Zimbabwe.

Specifically, the OIG assessed:

- the effectiveness of processes and controls over HIV infection testing, viral load suppression testing and early infant diagnosis in reducing infections and deaths;
- the effectiveness of the supply chain mechanism to store, deliver and account for health commodities.

3.2 Scope and Methodology

The audit was carried out in accordance with the methodology described in Annex B, covering both Principal Recipients (UNDP and Ministry of Health) of the Global Fund programs in Zimbabwe, all three diseases, and the period January 2017 to June 2019. The auditors visited 40 health structures, including 21 national and district hospitals, 16 clinics and polyclinics, three health centers providing specific services for key populations, the National Pharmaceutical Company of Zimbabwe (NatPharm) in Harare, and two provincial warehouses in Bulawayo and Mutare regions.

Exclusion from scope

The United Nations General Assembly has adopted a framework known as the “single audit principle”, whereby the UN and its subsidiaries cannot consent to third parties accessing their books and records. All audits and investigations are conducted by the UN’s own oversight bodies. Accordingly, the OIG cannot provide assurance on activities and transactions directly implemented by UN agencies.

3.3 Progress on Previously Identified Issues

The last OIG audit of grants in Zimbabwe in 2016 identified successes on scale-up of ART, TB treatment and malaria diagnosis. However, gaps were identified in quality of services, mainly on low confirmatory and viral suppression testing for HIV, and a delayed response to malaria outbreaks. This 2019 audit identified satisfactory management of malaria outbreaks. Significant progress has been registered on confirmatory testing, with roll-out of self-testing, initiatives to improve testing yield, and introducing recency testing to inform program direction. The program has exceeded performance targets on testing, reaching a level of 90% of people living with HIV knowing their status, although this overall coverage might have accuracy issues (details in Finding 1). Viral suppression testing was 29% for 2017 and 44% for 2018, with significant variation across regions and sites, and only 54% of those tested receiving results (Finding 3).

Previous relevant OIG audit work

[2013: Audit of Global Fund Grants to the Republic of Zimbabwe \(GE-OIG-13-012\)](#)

[2016: Audit of Global Fund Grants to the Republic of Zimbabwe \(GE-OIG-16-019\)](#)

On supply chain, the 2016 audit found improved distribution mechanisms, expiry management and central warehousing capacity. However, record-keeping and accountability of drugs, and provincial storage capacity issues were noted. This 2019 audit did not identify any material expiries, and found improved distribution. However, warehousing capacity at both central and provincial levels, and record-keeping and accountability of drugs, showed limited improvements (Finding 3).

4. Findings

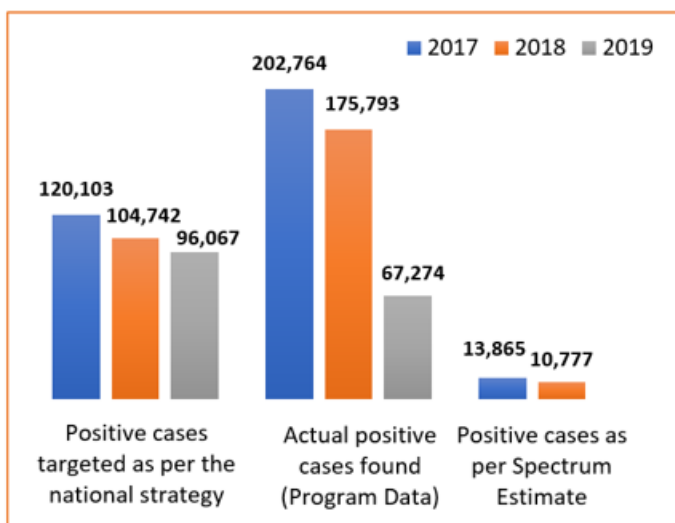
4.1. Strong program performance on HIV testing, but there are HIV data anomalies

Zimbabwe has made progress towards achieving the 90-90-90 targets by 2020. There were an estimated 1.3 million people living with HIV in 2018⁴⁰, 90% of whom know their status, out of which 95% are on Antiretroviral Therapy (ART). Of the people on treatment who get tested for viral load, 87% were virally suppressed.⁴¹ The number of new HIV infections among adults and children fell by 9% and 27%, respectively, between 2015 and 2018⁴².

The Ministry of Health and Child Care (MoHCC) updated its National HIV Testing Services Strategy 2017-2020 to increase testing coverage in the general population and enhance testing “yield”. The country rolled out self-testing in 2016-17, and index-testing (testing at-risk contacts of people living with HIV) in 2018. Tests to confirm the recency of HIV infection were rolled out in five districts in 2019. With these improvements, Zimbabwe has exceeded program targets on cases detected and testing yield, identifying 446,000 new cases in 2017-19 (as of June) with an average of 6% positive yield; OIG sample-based testing of records corroborated these results.⁴³

While this evidences strong progress on number of tests and positive cases identified, data anomalies were noted, with possible risks of PLHIV being higher than current estimates in Zimbabwe, meaning the current national HIV strategy may not be based on accurate data.

The figure on the right shows consistently significant higher numbers of positive cases than national strategy targets in 2017-19. These gross numbers of new cases require adjustment for deaths, loss to follow-up, migration, cases of re-testing and double-testing, and other adjustments, before they can be compared with estimates of net gains in the number of PLHIV. However, given the size of differences year-on-year, there are risks that other factors might also be contributing to the significantly higher number of annual positive cases found. Further, current estimates suggest approximately 130,000 undetected HIV cases in Zimbabwe; at the current detection rate, cumulative detected cases are likely to surpass total estimated population in 2020, which would clearly be a data inaccuracy. A likely contributing factor is that the real number of PLHIV in Zimbabwe may be higher than current estimates. Recency tests corroborate this risk; 86% of cases tested in five districts were old cases, indicating that they had remained undetected and had longer periods of transmission risks.



Note: The actual positive cases for 2019 are up to 30 June 2019 only (half-year results). So actual annual cases by end of 2019 are expected to align with previous year trends.

⁴⁰ <http://aidsinfo.unaids.org/>

⁴¹ <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe>

⁴² Zimbabwe National and Sub-National HIV Estimates Report- 2018

⁴³ HIV testing strategy 2017-2020 planned 8.5 Million tests in 2017-2019, with 321k positive cases expected (4% yield). However, program data shows 6.9 M tests and 446k positive cases till Jun-2019 (6% yield). OIG sample-based tests at health facilities reported 7% yield.

While double-testing and double-counting of patients are likely contributing to this data anomaly, they alone do not adequately explain it, since a high number of double-counted tests would lead to a very low percentage of treatment registrations (since patients are unlikely to register twice for treatment); however 70% of detected patients are also subsequently registering for treatment (see Finding 2). Zimbabwe does not have an Unique Identifier Code (UIC) system to track patients across facilities.

The data differences need to be investigated to understand their underlying drivers, and to ensure that the national HIV strategy incorporates the appropriate programmatic response going forward. The Ministry of Health and Child Care is planning to perform a Demographic Health Survey in 2020, to generate more information on disease burden, geographical and epidemiological trends.

Agreed Management Action 1

The Secretariat will work with the HIV program and technical partners to:

- Investigate the identified data anomalies regarding HIV positive cases tested compared to national PLHIV estimates. The results of the study/survey will be used to inform the Global Fund HIV grant implementation and the mid-term review of the national HIV strategy.
- Perform a feasibility study to roll out Unique Identification Code (UIC) for all identified PLHIV in Zimbabwe, ensuring that the results of the study are used to decide on feasibility of rolling out UIC in Zimbabwe.

Owner: Head Grant Management Division

Due date: 30 June 2021

4.2. Improvements are needed in treatment coverage, viral suppression and early infant diagnosis

Treatment coverage: Zimbabwe adopted a Test and Start (Treat All) Strategy in 2016⁴⁴, and has developed national plans to improve linkages to treatment, enrolment, adherence and retention.⁴⁵ The country has not however achieved national treatment targets. Between Jan 2018 and Jun 2019, Zimbabwe initiated only 70% of the 264,000 new cases identified⁴⁶. Slightly better results were noted in OIG's sampled facilities, but with significant variances between facilities. Further, the first national census of active patients in ART care revised the number of patients on treatment downwards, from 1.16 million to 0.97 million (13% variance),⁴⁷ altering estimated treatment coverage from 84% of all people living with HIV on ART treatment⁴⁸ to 74%.

The following factors are hindering treatment coverage:

- *No Unique Identifier Code (UIC).* The absence of an UIC mechanism makes it difficult to track patients who are lost to follow-up after treatment initiation. All visited facilities track patients through a donor-supported phone call system, but gaps in operating procedures and gaps in patient contact details restrict its effectiveness. The mechanism also requires a gradual shift to domestic funding for long-term sustainability.
- *Deferred ART initiation.* In cases where treatment initiation is deferred, a mechanism is needed for follow-up, to avoid the risk of loss of patients.
- *Weak counselling capacities.* Counsellors at 21 visited facilities had not received any training on HIV testing and counselling services for over two years. High workload for a low number of counsellors was observed at all visited facilities, enhancing risks of treatment initiation being deferred and consequent loss of patients.
- *No Key Population and Adolescent Girls and Young Women programs at public sector facilities.* A study in three provinces estimated 54% prevalence among female sex workers⁴⁹ and a prevalence study among men who have sex with men is being prioritized, however complete HIV epidemiological profiles and data for key populations are not available. The Global Fund grant is supporting key community activities for AGYW and KPs, however 90% of health facilities have no key population or AGYW-related programs from the government, apart from a few sensitization sessions and support group discussions. The National AIDS Council recently rolled out a National Key Population Implementation Plan for 2019-2020, and health facility staff are currently being trained. Higher government prioritization of key populations and AGYW will be necessary for these hard-to-reach populations to attain higher coverage.
- *Data challenges.* At the health facilities visited, there were 5-15% variances in treatment numbers between the reports from health facilities and the numbers reported in DHIS 2. In addition, an ART census revealed significant data quality deficiencies⁵⁰. These issues impact reliability of treatment coverage results.

Viral load suppression: National VL data for 2017 and 2018 show 29% and 44% of patients on treatment were respectively tested for viral load⁵¹. VL coverage at the sites visited by the OIG had

⁴⁴ Extended National HIV Care and Treatment Strategic Plan 2018 -20

⁴⁵ Extended National HIV Care and Treatment Strategic Plan 2018-20 targets putting 90% of all PLHIV on treatment by 2020.

⁴⁶ Aggregated analysis based on Programmatic data shared by the HIV Grant PR (UNDP)

⁴⁷ National census abstracted and analyzed data for 1508 (95%) ART sites from 12 November 2018 to 6 May, 2019.

⁴⁸ UNAIDS, 2018.

⁴⁹ Size Estimation and Engagement in Services Among FSWs in the Harare, Bulawayo, & Mashonaland Central Provinces 2017.

⁵⁰ Census of Active Clients in ART care in Zimbabwe- June 2019

⁵¹ 851k VL tests conducted against 2.27M tests potentially required, assuming at least one VL test per ART patient per year. The tests define virologic failure as > 1,000 copies/mL on 2 consecutive measurements). Unsuppressed patients can access enhanced adherence counseling (EAC) and are initiated on 2nd line regimens, if required.

slightly better coverage (48% for 2018 and 78% for Jan-Jun 2019). In those sites, of 26,000 sampled cases, only 54% received test results back at the facility. For the results received back, 89% were found to be virally suppressed.

The country is thus far behind the target of >95% VL testing by the end of 2020. In response, Zimbabwe has updated its Viral Load Testing Scale-Up Plan for 2018-2020.⁵²

The following causes contribute to low VL coverage and limited sharing of results with the facilities:

- *Weak follow-up of patients.* There is no systematic process to follow up patients for VL testing. Over 90% of facilities arrange ART patients in monthly cohorts, but these cohorts are not systematically organized to book and track patients for VL tests as they fall due.
- *Limited health staff capacity.* None of the visited facilities had a full-time doctor; 86% had visiting or supporting doctors, and 50% had a doctor coming only once a week.
- *Weak tracking systems and cross-border collaboration.* For patients who work or live in neighbouring countries (mainly from Bulawayo and Matabeleland who work in South Africa and Botswana), medicines are dispensed to relatives or care givers, without seeing the patient for long periods (6 months to over a year). There is no UIC to monitor patient testing, and weak systems to track lost patients which rely on phone calls, with poor documentation. There are no cross-border collaborative programs to ensure VL testing in neighbouring countries.
- *Non-functional Point of Care VL machines.* Machines were present at only 6 of the 21 visited health facilities due to funding constraints. Of these, four were non-functional, due to electricity or other technical issues, with no power backup arrangements. Samples were thus mostly sent to the main city referral labs, with turnaround times from one month to over a year.
- *Lack of integrated sample transportation mechanism.* VL samples are transported to referral labs through multiple sample courier mechanisms.⁵³ There are no standard procedures and tools for recording, reporting and tracking samples and delivery of results.
- *Viral load reporting issues.* DHIS 2 monthly reporting forms for 2018 did not cover the complete VL testing cascade, leading to poor and variable data, although the reporting templates were revised in 2019. While viral load suppression coverage is a key portfolio issue, VL indicators were dropped from the grant performance framework in 2019.

Given significant implementation and funding challenges in Zimbabwe currently, the Secretariat will work with partners to accelerate the viral load testing coverage in both the current and next funding allocation period.

Early infant diagnosis (EID): the HIV program has made slow progress, impacting results across the treatment cascade. Of an estimated 91,000 children (0-14 years) living with HIV in Zimbabwe, only 57% know their status, of whom 57% are on treatment. Of those who are on treatment and who were tested for viral suppression, 52% were found virally suppressed⁵⁴.

Zimbabwe's 2018-20 elimination of mother-to-child transmission plan covers EID services. Program data show a deterioration in EID coverage from 82% in 2017 to 52% in early 2019. OIG-visited facilities depict similar results and corroborate the slow progress.

Low birth testing is a critical contributor to low results. Out of ten visited facilities with Point of Care machines, eight were following the national guidelines of testing only high-risk new-borns, while the other two were testing all new-borns. Sample review of records for four facilities indicated that only

⁵³ Mechanisms used include Association of Public Health Laboratories, City Health Department, FedEx, the hospital ambulances etc.

⁵⁵ National HIV Estimate Report 2019.

4% of the new-borns were high-risk; this means that as per national guidelines, most new-borns would not get tested. This approach, coupled with a weak follow-up mechanism, results in a missed opportunity to easily test new-borns, with no assurance they will get tested at a later stage. Mother-baby pair registration at family health clinics is practiced, which can facilitate longitudinal follow-up of mothers and babies; however, this needs to be supported with UICs and linked to electronic health record systems to reduce risk of loss to follow-up.

Agreed Management Action 2

The Secretariat will work with the MOH and in-country partners to:

- Revise the EID policy to include testing of all infants from PLHIV mothers, including a costed action plan to increase EID coverage in HIV exposed infants;
- Develop a costed action plan to improve systematic identification and tracking of people on ART who are lost-to-follow-up, including a differentiated approach tailored for priority populations.

Owner: Head Grant Management Division

Due date: 30 September 2021

4.3. While health products are available on-shelf and wastage is controlled, storage capacity and oversight need improvement

At the central level (NatPharm warehouses), Global Fund health commodities were generally found to be traceable down to the product batch level. Products generally had tracked expiry dates and had acceptable remaining shelf lives. No material stock-outs or expiries were detected at any level for 2018-19. NatPharm's ERP data (Microsoft Dynamic - Navision) were materially accurate for stock receipts and were supported by sufficient documentation.

However, the following warehousing and oversight challenges impact traceability and other controls:

Warehousing space constraints

At central level, NatPharm⁵⁵ warehouse space constraints hamper good inventory management of efficient stock rotation, regular physical counts, effective use of bin locations, and timely processing of orders. In particular, donor-funded commodities in Harare were congested, with bulk ARV pallets permanently stored in aisles. There are plans to expand NatPharm warehouses. A new warehouse has been constructed in Masvingo, one is being designed in Mutare and another has started in Harare through Chinese support. However, the storage capacity 'needs assessment' has not been updated. The last assessment in 2010 estimated that 6,817 cubic meters were required to hold up to eight months' inventory. However, in 2019 (Jan to Aug), NatPharm distributed 12,875 cubic meters, almost twice the 2010 estimation. Thus, even with efficient inventory management practices such as staggered deliveries, the ongoing expansions are unlikely to be adequate.

Space issues force NatPharm (at Harare and Bulawayo) to 'push' commodities to health facilities wherever possible. While this improves drugs availability at health facilities, it stretches storage space (only 31% of visited facilities had adequate space). Exceeding maximum stock levels increases risks of expiries and produces mismatches between consumption and needs, with simultaneous expiries and stock-outs of commodities at different facilities.

Data entry, reconciliation and oversight gaps

At central level (NatPharm, MoHCC and PR), there are no key performance indicators defined by the PR and MoHCC on timeliness/accuracy of receipts entered by NatPharm. In 2018, on average, NatPharm took nine days to enter data on drugs received into Navision, with 82% taking more than the five days required by standard operating procedures. This contributed to data errors and traceability issues; for example, 89,000 packs of HIV tablets (TLE) were recorded in incorrect batches that were distributed in 2018, due to incorrect bin card entry. Similarly, manual distribution of commodities in March 2019 had not been adjusted at the time of audit, leading to variances exceeding US\$350K between drugs and physical counts in June 2019.

Further, commodities consumption/distribution and programmatic data have not been triangulated. On average, 1.8 times more screening tests were issued to facilities compared to the number of screening tests done (HMIS 2018-2019); and on average, 2.2 times more HIV confirmation tests were issued to facilities compared to the number of confirmation tests done (2018-2019). These numbers need to be reconciled to ensure against leakage or loss.

At health facility level, there was no evidence of supervision by district pharmacists. Their role includes procurement, receiving commodities, quality assurance, waste management, pharmacovigilance and coordination, but excludes the review and triangulation of data. This contributes to various data issues in health facilities:

⁵⁵ NatPharm was established in 2000 as a 'commercialized national medical stores', under the Ministry of Health and Child Care. It operates six branches with six warehouses in the country, of which two (Harare and Bulawayo) are regional warehouses.

- more than 60% of ARVs and lab items at facilities had a mismatch totalling 107,000 TLE boxes between quantities recorded in Navision, NatPharm delivery notes and quantities on stock cards;
- physical stocks of ARVs and lab items in visited facilities varied from stock-cards by over 30%;
- drugs logistics data and Monitoring & Evaluation data had a >20% variance in 93% of visited facilities;
- no aggregated data were available on quantities delivered to patients at service delivery points;
- 83% of visited health facilities do not record batch numbers and expiry dates on stock cards;
- no tool exists to capture transfers from stores and service delivery points: reconciliation indicated inaccuracies in 87% of visited health facilities;
- some distributions were incorrectly recorded in Navision against the wrong health facilities.⁵⁶

Documentation and retention

At the central level, gaps exist in legibility and retrievability of stock documentation. This often leads to wastage of time and effort by implementers and assurance providers in verifying records. For example, the stock verification review commissioned by the Global Fund Secretariat and performed by the Local Fund Agent for the period June-December 2018 identified variances of US\$1.7 million, although 90% of the difference was subsequently justified.

Similar issues were detected in health facilities. Only 47% (for ARVs) and 51% (for lab items) of visited facilities had legible and complete stock orders. Around 35% of visited facilities were not able to provide full signed delivery notes as proofs of delivery. Stock cards were missing or incomplete: 14% for ARVs and 27% for lab items.

Agreed Management Action 3

The Secretariat will ensure that Principal Recipients improve stock management at the NatPharm warehouses and Health Facilities through:

- Revision of Standard Operating Procedures;
- Conducting a national storage capacity needs assessment of NatPharm to:
 - estimate additional storage space required for managing health products, and
 - detailing interim storage solutions;
- Reduction in physical stock count variances against electronic system (Navision) balances through mid- and end of year stock counts;
- Improvement of inventory management and accountability framework of health products at peripheral health facilities.

Owner: Head Grant Management Division

Due date: 30 June 2021

⁵⁶ For example, 6,287 packs of TLE 400mg delivered to Mahusekwa District Hospital but recorded for Marondera Provincial Hospital; 1,000 packs of TLE 400mg delivered to Xanadu Clinic and but recorded for Chinhambhora / Makumbe Hospital.

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
<p>1. The Secretariat will work with the HIV program and technical partners in order to:</p> <ul style="list-style-type: none"> • Investigate the identified data anomalies regarding HIV positive cases tested compared to national PLHIV estimates. The results of the study/survey will be used to inform the Global Fund HIV grant implementation and the mid-term review of the national HIV strategy. • Perform a feasibility study to roll out Unique Identification Code (UIC) for all identified PLHIV in Zimbabwe, ensuring that the results of the study are used to decide on feasibility of rolling out UIC in Zimbabwe. 	30 June 2021	Head Grant Management Division
<p>2. The Secretariat will work with the MOH and in-country partners to:</p> <ul style="list-style-type: none"> • Revise the EID policy to include testing of all infants from PLHIV mothers, including a costed action plan to increase EID coverage in HIV exposed infants; • Develop a costed action plan to improve systematic identification and tracking of people on ART who are lost-to-follow-up, including a differentiated approach tailored for priority populations. 	30 September 2021	Head Grant Management Division
<p>3. The Secretariat will ensure that Principal Recipients improve stock management at the NatPharm warehouses and Health Facilities through:</p> <ul style="list-style-type: none"> • Revision of Standard Operating Procedures; • Conducting a national storage capacity needs assessment of NatPharm to: <ul style="list-style-type: none"> ○ estimate additional storage space required for managing health products, and ○ detailing interim storage solutions; • Reduction in physical stock count variances against electronic system (Navision) balances through mid- and end of year stock counts; • Improvement of inventory management and accountability framework of health products at peripheral health facilities. 	30 June 2021	Head Grant Management Division

Annex A: General Audit Rating Classification

<p>Effective</p>	<p>No issues or few minor issues noted. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.</p>
<p>Partially Effective</p>	<p>Moderate issues noted. Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.</p>
<p>Needs significant improvement</p>	<p>One or few significant issues noted. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met.</p>
<p>Ineffective</p>	<p>Multiple significant and/or (a) material issue(s) noted. Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised.</p>

Annex B: Methodology

The OIG audits in accordance with the global Institute of Internal Auditors' (IIA) definition of internal auditing, international standards for the professional practice of internal auditing (Standards) and code of ethics. These standards help ensure the quality and professionalism of the OIG's work.

The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help our auditors to provide high quality professional work, and to operate efficiently and effectively. They also help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing takes place at the Global Fund as well as in country, and is used to provide specific assessments of the different areas of the organization's activities. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.

Annex C: Risk Appetite and Risk Ratings: Content, Methodology and Implications

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries⁵⁷ representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants.

As accurate risk ratings and their drivers are critical to effective risk management and operationalization of risk appetite, a robust methodology was developed with clear definitions, granular risks, root causes as well as an extensive review process as detailed below.

The eight grant-facing risks for which risk appetite has been set represent an aggregation from 20 risks as depicted in the table on the following page. Each of these 20 risks is rated for each grant in a country using a standardized set of root causes and considers a combination of likelihood and severity scores to rate risk - Very High, High, Moderate or Low. Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by second line functions and senior management from the Grant Management Division.

The ratings at the 20-risk level are aggregated to arrive at the eight risks using simple averages, i.e. each of the component parts are assumed to have similar importance. For example, the risk ratings of *Inadequate program design (1.1)* and *Inadequate program quality and efficiency (1.3)* are averaged to arrive at the rating of Program Quality for a grant. As countries have multiple grants, which are rated independently, individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. As the ratings of grants often vary significantly and to ensure that focus is not lost on high-risk grants, a cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee⁵⁸ during the Country Portfolio Review.

Leveraging Risk Appetite in OIG's work

As the Risk Appetite framework is operationalized and matures, OIG is increasingly incorporating risk appetite considerations in its assurance model. Important considerations in this regard:

- The key audit objectives that are in the scope of OIG audits are generally calibrated at broad grant or program levels (for example, effectiveness of supply chain processes, adequacy of grant financial management, quality of services, reliability of data, overall governance of grant programs, etc.) as opposed to narrower individual risk levels. Thus, there is not a one-to-one match between the overall audit rating of these broad objectives and the individual rating of narrower individual risks. However, in the absence of a one-to-one match, OIG's rating of an overall audit objective does take into consideration the extent to which various individual risks relevant to that objective are being effectively assessed and mitigated.
- The comparison of OIG's assessed residual risks against the Secretariat's assessed risk levels is done at an aggregated level for the relevant grant-facing risks (out of the eight defined ones) that were within the scope of the audit. This comparison is not done at the more granular level of the 20 sub-risks, although a narrative explanation is provided every time the OIG and the Secretariat's ratings differ on any of those sub-risks. This aggregated approach is designed to focus the Board and AFC's attention on critical areas where actual risk levels may differ from perceived or assessed levels, and thus may warrant further discussion or additional mitigation.

⁵⁷ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe.

⁵⁸ The role of the Portfolio Performance Committee is to conduct country portfolio reviews.

For risk categories where the organization has not set formal risk appetite or levels, OIG focuses on the Secretariat's overall processes for assessing and managing those risks and opines on their design and effectiveness.

Table of risks

Corporate Risks (8)	Operational Risks (20)
Program Quality	1.1 Inadequate program design and relevance
	1.3 Inadequate program quality and efficiency
M&E	1.2 Inadequate design and governance of M&E Systems
	1.4 Limited data availability and inadequate data quality
	1.5 Limited use of data
Procurement	3.3 Inefficient procurement processes and outcomes
In-Country Supply Chain	3.2 Unreliable forecasting, quantification and supply planning
	3.4 Inadequate warehouse and distribution systems
	3.6 Inadequate information (LMIS) management systems
Grant-Related Fraud & Fiduciary	2.1 Inadequate flow of funds arrangements
	2.2 Inadequate internal controls
	2.3 Fraud, corruption and theft
	2.5 Limited value for money
Accounting and Financial Reporting by Countries	2.4 Inadequate accounting and financial reporting
	2.6 Inadequate auditing arrangements
National Program Governance and Grant Oversight	4.1 Inadequate national program governance
	4.2 Ineffective program management
	4.3 Inadequate program coordination and SR oversight
Quality of Health Products	3.1 Inappropriate selection of health products and equipment
	3.5 Limited quality monitoring and inadequate product use