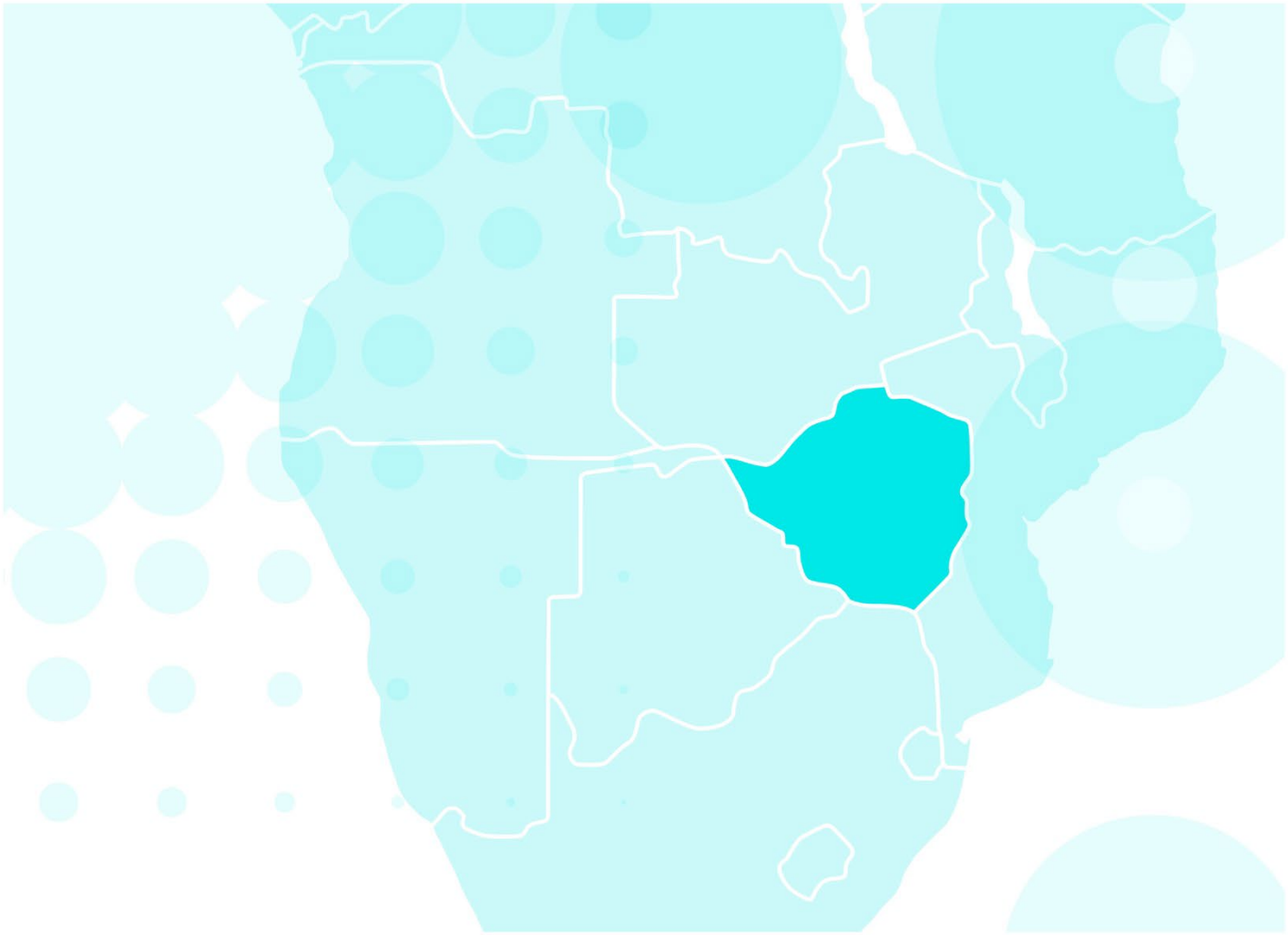

Audit Report

Global Fund Grants to the

Republic of Zimbabwe

GF-OIG-24-017
5December 2024
Geneva, Switzerland

THE GLOBAL FUND
Office of the Inspector General

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1. Executive Summary

1.1 Opinion

The Republic of Zimbabwe has received US$2.8 billion from the Global Fund since 2003 to fight HIV, tuberculosis (TB) and malaria, and to strengthen the health system. The country has continued to make significant progress in the fight against the three diseases despite economic difficulties that prompted high staff attrition at all levels. HIV incidence and death rates in 2022 decreased by 78% and 64%, respectively, since 2010. Zimbabwe has achieved the UNAIDS 95-95-95 target and is among the best ranked across the region and globally. TB incidence in 2022 decreased by 53% since 2010, with a Drug-Sensitive TB (DS-TB) treatment success rate of 90% (2021 cohort), while malaria incidence and deaths decreased by 67% between 2010 and 2022. More than 50% of the country's districts are in malaria pre-elimination phase.

Global Fund-supported programs are integrated into the national systems, and innovations have been implemented to strengthen the country's health system. To sustain the gains, Zimbabwe needs to address key population intervention challenges to ensure reduction in HIV incidence. Issues with population size estimates and low pre-exposure prophylaxis (PrEP) adherence due to limited resources, data quality challenges and stigma continue to impact the key population program.

Despite significant progress in malaria outcomes, Zimbabwe saw a 72% increase in malaria cases from 137,585 in 2022 to 237,385 in 2023 with an approximately 79% increase in malaria deaths from 177 to 317 during the same period. Vector control implementation challenges including procurement delays, commodity quality issues and low community awareness of the campaigns risk undermining the gains and progress achieved in malaria control and elimination. Migration of health workers continues to impact service delivery. Delays in finalization of the investment compact document which is to address the Human Resource for Health issues poses a risk to program sustainability. The implementation of HIV, TB and malaria interventions to ensure access to key services by vulnerable and key population is **partially effective**.

The Global Fund has invested significantly in data management systems to enhance timely, reliable and accurate programmatic and supply chain data. Despite these investments, the OIG noted substantial data quality issues in the health facilities visited. The electronic management systems are not yet optimally utilized to support program and logistics management effectively. Delays in rollouts of the electronic management systems, inadequate implementation of recommendations from previous assessments, limited staff capacity, and the absence of an interface between the Electronic Logistics Management Information System (eLMIS) and the Electronic Health Record (EHR) system, contributed to data quality challenges. Processes and systems to ensure completeness, timely availability, and accountability of programmatic and logistic data need **significant improvement**.

Global Fund grants in Zimbabwe are managed under the Additional Safeguard Policy, which allows the Global Fund Secretariat to put additional measures in place to safeguard grant resources. Overall, there are adequate independent assurance mechanisms in the programs that helped to proactively identify financial management issues. The OIG, however, noted gaps in the timely issuing and implementation of recommendations, resulting in procurement and financial control gaps. Grant oversight and functions to support the effective and efficient achievement of grant objectives are **partially effective**.

1.2 Key Achievements and Good Practices

Significant progress made in the fight against the three diseases

Zimbabwe has made significant strides toward achieving the UNAIDS targets,[1] with a 95-94-89[2]achievement rate, surpassing the Eastern & Southern Africa average of 92-83-77 and the global average of 86-89-93. HIV-related deaths have dropped by 65%, from 57,000 in 2010 to 20,000 in 2022, and new infections have decreased by 78%, from 78,000 in 2010 to 17,000 in 2022.

Regarding TB, the country has transitioned out of the World Health Organization (WHO) list of 30 high TB-burden countries, but remains on the high burden list for TB/HIV and drug-resistant TB (DR-TB).[3] Between 2010 and 2021, TB incidence decreased by 53%, and the TB treatment success rate reached 90% compared to 76% in 2010. Malaria incidence fell from 32 per 1,000 to 9 per 1,000, and the death rate decreased from 2.8 to 1.2 per 100,000 from 2020 to 2022. Case management indicators show that 100% of confirmed malaria cases receive first-line malaria treatment. About 52% (32) of the country's districts are in the malaria pre-elimination phase.

Global Fund-supported programs are integrated into the national systems

Despite implementing Global Fund-supported programs under the Additional Safeguard Policy, implementation arrangements are integrated into Zimbabwe's national systems. DHIS2, a national data system, is used to report key national indicators for the three diseases, and NatPharm, a state-owned company, stores and distributes health commodities funded by the Global Fund. The Office of Auditor General audits the Global Fund-supported program managed by the Ministry of Health and Child Care (MoHCC). The Global Fund supported the ISO accreditation and certification of the National Reference Lab.

Innovations and initiatives to effectively address systemic and infrastructure challenges

The government, in collaboration with the United Nations Development Programme (UNDP) and with the support of the Global Fund and other development partners, have implemented several innovations that have strengthened the country's health system. For example, integrated sample transportation (IST) has helped to improve turnaround times of samples and improved health outcomes. The IST, funded by several partners, has integrated various sample transportation systems into one. The Solar for Health initiative has also helped to address the scarcity of electricity in 1,066 health facilities by equipping these facilities with solar panels. As of December 2023, solar-powered boreholes had been installed at 398 health facilities to provide safe water access for staff and patients.[4]

1.3 Key Issues and Risks

Strong HIV outcomes, but better implementation of key population interventions is necessary to further reduce the HIV infection rate

Zimbabwe's HIV program has shown strong outcomes, but there are significant challenges in interventions for key populations. For GC6, HIV prevention program coverage in the country is 35% for sex workers (SW), 26% for men who have sex with men (MSM), and 28% for transgender

[1] This seeks to ensure that 95% of people living with HIV (PLHIV) are aware of their status, 95% of those diagnosed are receiving treatment, and 95% of those treated achieve viral suppression by 2030
[2] UNAIDS Data, https://www.unaids.org/en/regionscountries/countries/zimbabwe, accessed on 4 July 2024
3 WHO new global lists of high-burden countries for TB, HIV-associated TB and drug-resistant TB (https://www.who.int/news/item/17-06-2021-who-releases-new-global-lists-of-high-burden-countries-for-tb-hiv-associated-tb-and-drug-resistant-tb) – accessed on 12 July 2024
[4] UNDP Zimbabwe Annual Report, 2023

people.[5] The HIV cascade for key population continues to be below the UNAIDS 95-95-95 target. For GC7, there is a plan to cover 90% of MSM and SWs by end of the grant period.

Despite the increase in coverage, not having comprehensive population size estimates and challenges in prevention interventions including PrEP[6] adherence and condom programs affect the key population program. If these challenges are not addressed, there is a risk that the country will not achieve the target of reducing the rate of new HIV infection from 17,000 to 12,600 by 2025. Limited government resources for key population interventions, non-availability of data for reliable target setting, as well as stigma and discrimination, contributed to the low coverage of key population interventions.

Good progress in malaria case management, but inefficiencies in vector control implementation risk undermining the gains and progress made

In 2023, Zimbabwe saw a 72% increase in malaria cases. Malaria deaths also rose from 177 to 317 during the same period. This contributed to the incidence rate increasing from 9 to 14 per 1,000 people, and the mortality rate increasing from 1.2 to 2.1 per 100,000. This surge threatens to reverse progress in malaria elimination, especially in targeted districts. Delays in procurement and quality issues with IRS insecticides, along with operational challenges like inadequate training and supervision, and low community awareness affected the successful implementation of vector control interventions. Additionally, the lack of Malaria Indicator Surveys since 2016 hindered effective planning of vector control campaigns.

Significant investment in RSSH, but sustainability of HRH investment challenges and suboptimal implementation of interventions hinder sustainable impact

The Global Fund has made significant investments to support and strengthen the country's health systems. However, sustainability of human resources for health (HRH) investment and effective implementation of resilient and sustainable systems for health (RSSH) interventions are crucial to sustain the gains made in the fight against the three diseases. Gaps in health worker positions due to migration and challenges in utilization of the AIDS Levy Fund for HRH persist, posing risks to service quality and program sustainability. The MoHCC is yet to align its program management setup within the reduced program management budgets of 10% for 2024, 20% for 2025, and 20% for 2026. Implementation delays of RSSH projects in Grant Cycle 6 (GC6) also led to not fully achieving the intended benefits. Contributing factors of the delays include structural inefficiencies, lack of monitoring mechanisms, and delays in finalizing contracts and designs.

Interventions in HMIS and eLMIS coupled with limited supervision and HRH capacity are not effectively implemented, leading to poor health and logistic data quality

Despite significant investment, programmatic and logistics data continue to present challenges. The 2022 internal data quality assessment and the 2023 malaria data quality assessment revealed substantial data quality challenges in health facilities. The OIG also noted substantial data quality issues in 19 health facilities visited. The eLMIS, despite being rolled out to 63% of health facilities by the end of 2023, is facing significant issues that hinder its effectiveness in supporting stock management. These issues affect the quality and usability of data for decision-making. Inadequate follow-up and implementation of recommendations from previous internal data quality assessments, limited staff capacity and training, as well as lack of robust data quality assurance mechanisms, contributed to the data quality challenges. The absence of an interface between eLMIS and the EHR system also hampers effective triangulation of patient and logistics data.

[5] UNAIDS Data 2023
[6] Pre-exposure prophylaxis (or PrEP) is medicine taken to prevent getting HIV

Strong implementation arrangements exist, but improvements are needed in grant management and oversight to safeguard grant resources

Global Fund grants in Zimbabwe are managed under the Additional Safeguard Policy, with several independent assurance mechanisms in place to ensure effective and efficient use of resources. However, delays in implementation of recommendations have contributed to financial and procurement management and control gaps, which resulted in a qualified opinion by the Office of Auditor General on the 2022 malaria grant financial statements. The UNDP Office of Audit and Investigations also highlighted that management of the HIV grant needs improvement.

1.4 Objectives, Ratings, and Scope

This audit was part of the Office of the Inspector General's 2024 work plan, approved by the Audit and Finance Committee in October 2023. The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on grants in Zimbabwe. Specifically, the audit assessed the adequacy and effectiveness of:

Objectives	Rating	Scope
Implementation of HIV, TB and malaria interventions to ensure access to key services by vulnerable and key populations.	Partially Effective	**Audit period** January 2022 to December 2023 **Grants and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund-supported programs in Zimbabwe. **Scope exclusion** United Nations System organizations have generally adopted internal rules 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.
Processes and systems to ensure completeness, timely availability, and accountability of programmatic and logistic data.	Need Significant Improvement	
Grant oversight and functions to support the effective and efficient achievement of grant objectives.	Partially Effective	

Details about the general audit rating classification can be found in **Annex A** of this report.

OIG auditors visited 19 health facilities/hospitals and key and priority populations in all Global Fund-supported districts. The visited regions account for 12% of the TB burden, 16% of patients on antiretroviral therapy (ART), and 43% of malaria cases in the country.

2. Background and Context

2.1 Country Context

Zimbabwe is a lower middle-income country with a population of 16 million, 40% of whom live below the poverty line. Despite a GDP growth rate of 6.5%, the country continues to face harsh economic conditions and socio-political risks, which have adversely affected the health sector. Inflation stands at 105%, and the country struggles with a persistent shortage of the US Dollar, which particularly impacts the government's ability to purchase essential health commodities.

The country faces socio-economic challenges and high attrition rates among health workers. There is a significant shortage of doctors and health professionals throughout the health care system. With about 3,080 physicians in Zimbabwe, there are about 0.2 doctors per 1,000 population, compared to worldwide standard of 1.7 physicians per 1,000 population [7,8]

Country data[9]	
Population	16 million (2022)
GDP per capita	US$1,677 (2022)
Corruption Perception Index	149 of 180 (2023)
UNDP Human Development Index	146 of 191 (2021)
Government spending on health (% of GDP in 2020)[10]	3.4%
Health expenditure as % of government budget	5.2% (2020)[11]

2.2 COVID-19 Situation

The COVID-19 pandemic adversely impacted both the implementation of grants and the economy for a period of time. The country experienced increased poverty due to the impact of COVID-19, and continued attrition of health workers post-COVID-19. Additionally, the multiple lockdowns led to significant disruptions in service delivery across the implemented grants.

COVID-19 statistics[12]	
Confirmed cases	266,359
Deaths	5,740
Recovered	85,782

[7] World Bank, 2020 (https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=ZW) Accessed on 3 July 2024
[8] World Data (https://www.worlddata.info/africa/zimbabwe/health.php#:~:text=With%20about%203%2C080%20physicians%20in,in%20the%20EU%20is%204.28.) Accessed on 3 July 2024
[9] Sources: population, GDP from World Bank, 2023 (https://data.worldbank.org/country/zimbabwe); transparency corruption index, 2023 (https://www.transparency.org/en/countries/malawi); health expenditure from The Global Economy, 2021 (https://www.theglobaleconomy.com/Malawi) (https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22pdf_1.pdf) - all accessed on 4 April 2024
[10] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?end=2020&locations=ZW&start=2010&view=chart accessed on 16 April 2024
[11] https://data.who.int/indicators/i/B9C6C79 accessed on 16 April 2024
[12] Zimbabwe COVID-19 data; https://www.worldometers.info/coronavirus/country/zimbabwe/ - accessed on 14 April 2024

2.3 Global Fund Grants in Zimbabwe

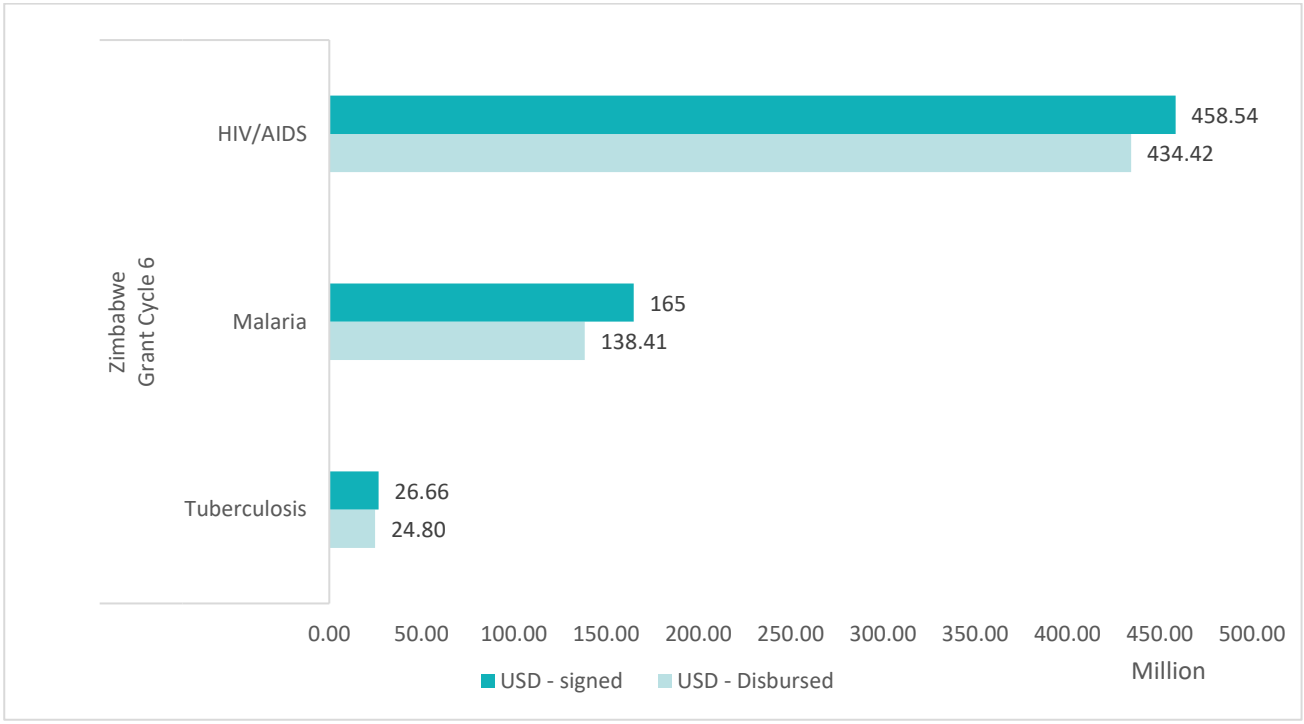
Since 2003, the Global Fund has invested over US$2.8 billion in Zimbabwe. For Grant Cycle 6, the Global Fund signed agreements for three grants: US$459 million for HIV, US$27 million for TB, and US$165 million for malaria.

The HIV grant aims to support interventions aligned with Zimbabwe's National HIV and AIDS Strategic Plan, which focuses on accelerating progress toward ending HIV as a public health threat by 2030.

The TB grant is dedicated to continuing and scaling up TB care, prevention and treatment regimens, with intensified efforts in screening, case finding and monitoring, as part of the "Gearing up to End TB in Zimbabwe" program.

The malaria grant, under the "Moving Zimbabwe Towards Malaria Elimination" program, supports the National Malaria Strategic Plan's goals to reduce malaria incidence to 15 cases per 1,000 people and cut malaria deaths by at least 90% by 2025 (from 2015 levels).

The total signed amount for these three grants includes US$163 million from the COVID-19 Response Mechanism (C19RM) funding. The UNDP implements the HIV grant, while the MoHCC is responsible for the TB and malaria grants.



2.4 The Three Diseases

HIV / AIDS

1.3 million people are living with HIV in Zimbabwe, of whom 95% know their status. Among identified people living with HIV (PLHIV), 94% were on treatment, and 89% had suppressed viral loads.

Annual new infections have decreased by 78% since 2010, from 78,000 newly infected people to 17,000 in 2022. Zimbabwe has the 5th highest HIV rate in the world.

AIDS-related deaths reduced by 65% from 57,000 in 2010 to 20,000 in 2022.

Zimbabwe demonstrated a **downward prevalence trend** from 16% in 2010 to 11% in 2022.

Source: UNAIDS Factsheets 2023-Zimbabwe

TUBERCULOSIS

Zimbabwe transitioned out of the list of 30 high TB burden countries but remains on the **HIV-associated TB (HIV/TB) and MDR/RR-TB** list.

TB incidence has reduced by 53%, from 416 per 100,000 people in 2010 to 194 in 2021. In Zimbabwe, an estimated 29,945 people developed active TB in 2021, and only 16,541 were diagnosed and put on treatment.

TB treatment success rate has improved from 76% in 2010 to 90% in 2021.

Zimbabwe had achieved 55%-84% against 90-90 goals (reaching at least 90% of people with TB and successfully treating at least 90% of notified people).

Source: WHO Global TB Report 2023 https://databank.worldbank.org/source/world-development-indicators# https://www.stoptb.org/static_pages/ZWE_Dashboard.html

MALARIA

Zimbabwe is the **40th largest contributor** to total malaria cases globally.

Zimbabwe carries 0.2**%** of the **global malaria burden**.

There were 1,097,776 estimated malaria cases in 2010 and 365,695 estimated malaria cases in 2022, a **67% reduction from 2010**.

Estimated **malaria-related deaths dropped by 68%**, from 2,810 in 2010 to 936 in 2022.

Source: World Malaria Report 2023, p.206

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Performance and grant ratings for Grant Cycle 6 (NFM 3) Allocation (2020-2022) are shown below.[13]

Comp	Grant	Principal Recipient	Total Signed (USD)	Disbursement[14] (USD)	(%)	Dec-21		Dec 22		Dec-23	
	ZWE-H-UNDP	UNDP	458,539,414	434,419,960	95 %	C	3	C	2	C	2
	ZWE-T-MoHCC	Ministry of Health and Child Care	26,659,935	24,825,101	93 %	C	1	C	3	C	2
	ZWE-M-MoHCC	Ministry of Health and Child Care	165,002,651	138,414,139	84 %	C	3	B	5	C	4
TOTAL			**650,202,000**	**597,659,199**	**92 %**						

3.2 Risk Appetite

Of the key risk categories covered by the audit, the OIG compared the Secretariat's aggregated assessed risk levels with the residual risk based on the OIG's assessment, mapping risks to specific audit findings. Annex B of this report details the full risk appetite methodology and explanation of differences.

Audit area	Risk category	Secretariat aggregated assessed risk level (January 2024)	Assessed residual risk based on audit results	Relevant audit issues
Program quality	HIV	**Moderate**	**Moderate**	Finding 4.1
	Malaria	**Moderate**	**Moderate**	Finding 4.2
	TB	**High**	**Moderate**	
In-country data	Monitoring and evaluation	**Low**	**Moderate**	Finding 4.4
In-country supply chain	In-country supply chain	**Moderate**	**Moderate**	Finding 4.4
In-country procurement	Procurement	**Moderate**	**Moderate**	Finding 4.5
Financial assurance framework and mechanism	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	Finding 4.5
	Accounting and financial reporting	**Low**	**Moderate**	Finding 4.5
Health Financing	**Health Financing**	**Very High**	**Very High**	Finding 4.3

[13] The programmatic performance rating is represented by letter A to E (Excellent/A (>=100% achievement), Good/B (90%-99%), Moderate/C (60%-89%), Poor/D (30%-59%) and Very Poor/E (<30%). Financial performance rating is represented by numbers 1-5 [Excellent (1: >=95% achievement), Good (2: 85%-94%), Moderate/3 (3:75%-84%), Poor/4 (65%-74%) and Very Poor/5 (<65%)]

[14] The portfolio performance figures above are based on total disbursements processed for the 2021-2023 Implementation Period as of 30 June 2024, against the total signed amounts. The disbursement data is as of 30 June 2024

4. Findings

4.1 Strong HIV outcomes, but better implementation of key population interventions is necessary to further reduce the HIV infection rate

The HIV program has achieved the UNAIDS 95-95-95 targets with deaths and new infections decreasing significantly over the last 10 years. Interventions for key population interventions can be better implemented to reduce the HIV infection rate and sustain the gains made.

Zimbabwe is making significant progress toward achieving UNAIDS targets, with a 95-94-89[15] achievement rate compared to the Eastern and Southern Africa average of 92-83-77 and the global average of 86-89-93. HIV-related deaths have decreased by 65%,[16] from 57,000 in 2010 to 20,000 in 2022, and new infections have dropped by 78%, from 78,000 in 2010 to 17,000 in 2022. The HIV National Strategic Plan was revised following the Mid-Term Review in 2022, demonstrating the country's commitment to effective and up-to-date HIV management strategies.

The country has implemented an advanced IST system for laboratory testing/diagnosis of HIV/TB and other diseases to improve turnaround times, which could serve as a model for other Global Fund-supported programs. In August 2022, Zimbabwe updated its guidelines for HIV prevention, testing, and treatment to align with the latest WHO recommendations. The country has also engaged peer-led micro-planners to reach key populations such as female sex workers (FSW) and MSM, supported by a system of civil society organizations (CSOs), comprised of social movements, professional organizations, faith-based groups and nongovernmental organizations, among others.

Despite these initiatives, Zimbabwe faces challenges with key population interventions. According to available program data (2023), HIV prevention program coverage for Global Fund supported sites is 77% for sex workers and 48% for MSM.[17] Prevention program data for transgender and people who inject drugs (PWID) were not available. Not having comprehensive population size estimates and issues in prevention interventions including PrEP and condom programs affect the key population program.

No comprehensive Population Size Estimates (PSE) to inform program design: There was no comprehensive PSEs for transgender individuals and PWID, making it difficult to assess the adequacy of the response. The PWID program was introduced toward the end of Grant Cycle 6 (GC6) in 2023. For FSWs, the estimates used for GC7 is different from the data from the PSE. For example, GC7 estimated a population of 94,702, but a site-wise PSE exercise by the Centre for Sexual Health and HIV AIDS Research Zimbabwe (CeSHHAR) in November 2023 estimated only 70,423.

For GC7, the target for MSM was more than doubled compared to GC6 estimates. For GC6, the targets for MSM and FSW for "package of services" and testing were below 30% of the target population but were not achieved.[18] The achievement rates for MSM knowing their status in GC6 have been consistently low while testing for FSW has been performing consistently well (e.g. exceeding targets with 120% achievement against results in 2023). Without an accurate population size estimate, it is not clear whether the low or high performance rate is due to high or low targets, or low coverage of the interventions. Following the audit, a National Integrated Biological and Behavioural Surveillance (IBBS) survey for MSM, PWID and transgender individuals was started.

[15] UNAIDS Global AIDS Update: The Path That Ends AIDS 2023, page 6
[16] UNAIDS Report 2023, page 165
[17] Zimbabwe, National AIDS Commission, 2023 programmatic data
[18] For MSM, the targets were 16% (Year 1), 18% (Year 2), and 19% (Year 3) for services, and 15% (Year 1), 16% (Year 2), and 17% (Year 3) for testing. For FSW, the targets were 25%, 27%, and 28% for services in years 1, 2, and 3, respectively, and 30% for testing in all three years

Progress has been good in prevention, but improvement is needed in condom programming and use among key populations: According to the 2021 UNAIDS Condom Fast Track tool calculations, Zimbabwe needed 218 million condoms, but the current distribution only met 54% of this need. Condom use among SWs, MSM, and transgender people was 43%, 69%, and 82%, respectively.[19]

Low PrEP screening, enrollment, and adherence rates: Nationally, only 16% (155,177) of clients who tested HIV-negative were screened for PrEP.[20] Between January and September 2022, only 55% of the 97,859 of clients who tested HIV-negative received PrEP, and 57% of MSM received PrEP. For FSW, 12,792 were put on PrEP against a target of 12,212.[21] Poor Adherence to PrEP was also noted. The AMETHIST[22] Study by CeSHHAR and the Liverpool School of Tropical Medicine revealed that of the 491 FSW reportedly taking PrEP, only two had evidence of protective plasma tenofovir diphosphate (TDF) levels (≥700) in their blood.[23]

The above issues contributed to the HIV cascade for key populations in Zimbabwe being below the 95-95-95 targets. Despite the high HIV prevalence among key population (45% among SWs, 21% among MSM, and 27% among transgender individuals), HIV testing rates among FSW and MSM are 67% and 48%, respectively, while ART coverage for both groups stand at 83%.[24] ART consists of a combination of antiretroviral drugs (ARVs) to suppress the HIV virus and stop the progression of HIV disease within people living with HIV. Key populations contribute 9%[25] (based on available data) of new HIV infections in the country, and addressing these challenges would help the country to achieve its target of reducing new HIV infections to 12,600 by 2025, with the number at 17,000 in 2022.

The issues affecting the HIV response for key populations in Zimbabwe can be attributed to several factors including:

Data quality challenges: Inadequate data accuracy and availability hamper programming, decision-making and improvement efforts. The OIG noted a disconnect between CSO-led key population program data and data at public health facilities, which limits the tracking of key populations referred to public facilities for testing and treatment. This in turn hampers the assessment of the HIV cascade and increases loss to follow-up (LTFU). OIG site visits found that 42% (eight out of 19) of public health facilities had poor LTFU mechanisms. The Agreed Management Action (AMA) from the 2019 OIG audit of a Unique Identifier Code is yet to be fully implemented.[26] Computer tablets procured for CSO peer educators to facilitate key population data collection were suboptimally used, with parallel paper-based data reporting causing oversight challenges.

Legal context, stigma[27], and discrimination: HIV-related stigma remains a significant issue, which contributed to 18% of key populations discontinuing ART.[28] Stigma and discrimination experienced by people living with HIV increased from 65% in 2014[29] to 69% in 2021,[30,31] with stigma at 57%, especially among young people aged 18 - 19. Stigma due to interactions with health care services for key populations was reported among 36% of FSW, 52% of transgender individuals, and 57% of MSM. Legal barriers, such as the criminalization of sex work, anti-homosexuality laws, and the

[19] Mid Term Review Report, 2022
[20] 155,177 out of 980,149 clients who tested HIV-negative, Mid Term Review attachment 4 HIV/AIF+DS Strategi Plan 2021-2025 p.42.
[21] Mid Term Review Report, 2022
[22] AMETHIS is a risk-differentiated, community-led intervention to strengthen uptake and engagement with HIV prevention and care cascades among female sex workers in Zimbabwe
[23] AMETHIST Study Report, 2022 by CESHHAR and Liverpool School of Tropical Medicine
[24] UNAIDS data 2023 p.165
[25] New HIV infection data on transgender individuals is not available
[26] Global Fund Office of the Inspector General Zimbabwe Audit Report, 2020 (oig_gf-oig-20-008_report_en 2020, page13)
[27] As per the UNAIDS Lawa and policies scorecard (refer UNAIDS Data Report 2023) among other legal barriers there are laws criminalizing sex work and requiring parental consent for adolescents access HIV testing.
[28] Stigma Index 2.0 for Zimbabwe 2021
[29] Zimbabwe HIV Stigma Index Research report 2014
[30] ZNNP Stigma Index 2021
[31] Final Zimbabwe Stigma Index Report 2021

requirement for parental consent for HIV testing (for adolescent girls and young women), hinder access to preventive and treatment services.

Limited government resources: Despite a government-led key population program implemented by the National AIDS Council (NAC). Zimbabwe's generalized HIV epidemic affects prioritization on key population interventions due to limited resources. The Mid-Term Review in 2022 highlighted limited resources for key and vulnerable population strategic surveys, assessments, and programming, impacting capacity building for service providers and causing low stock levels for commodities such as test kits, condoms and STI treatments.

Agreed Management Action 1:
Given the most recent introduction of the PWID key population group into the GC7 portfolio, and in view of a slow start of the program, the Global Fund Secretariat will work with the MoHCC, NAC, UNDP and relevant partners to operationalize the PWID program in GC7. This will involve developing an implementation plan aimed at ensuring accountability and efficiency.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2026

4.2 Good progress in malaria case management, but inefficiencies in vector control implementation risk undermining the gains and progress made

Progress has been made in the reduction of malaria incidence and malaria deaths with more than 50% of districts in Zimbabwe in the malaria pre-elimination phase. However, suboptimal implementation of vector control interventions could erode the gains made.

In Zimbabwe, 68% of the population is at risk of malaria. According to the World Malaria Report, Zimbabwe is on track to meet the Global Technical Strategy (GTS) target of a 75% reduction in malaria incidence by 2025. From 2010 to 2022, the country achieved a 67% reduction in malaria cases.[32] Malaria incidence decreased from 32 per 1,000 to 9 per 1,000 and the death rate from 2.8 to 1.2 per 100,000 from 2020 to 2022.[33] Case management indicators show that 100% of confirmed malaria cases receive first-line malaria treatment.

Currently, 32 districts are in the pre-elimination phase, representing 52% of the country, with 16 districts not implementing any interventions. There are 22 districts in the control zone, utilizing Indoor Residual Spraying (IRS), a standardized process of spraying insecticide inside houses and buildings to kill mosquitoes that spread malaria, requiring trained and supervised personnel and high quality spraying equipment. An elimination tracker app, an electronic real-time application based on DHIS2, tracks cases that have been notified, investigated and classified in the elimination areas.[34]

Zimbabwe conducts malaria case management audits every two years to identify clinical case management gaps and recommend appropriate interventions.[35] Regular national quarterly meetings bring together all provinces to review implementation progress on key interventions, and to plan for the next quarter. Digital mentorship sessions are conducted on a platform that facilitates communication between mentors and mentees to complement physical visits.[36]

A key component of the response for GC6 is vector control with the Global Fund investing US$23 million in such malaria interventions in Zimbabwe. The OIG noted challenges across all intervention areas, including IRS, Long-Lasting Insecticidal Nets (LLINs), and pre-elimination interventions:

IRS intervention districts: Despite high coverage rates for households, malaria cases in IRS intervention districts increased by 90% from 67,252 in 2022 to 127,855 in 2023. About six-month delays in the procurement and arrival of IRS insecticides and personal protective equipment (PPE) resulted in insufficient commodities for the campaign. Procured IRS insecticides and PPE amounting to US$0.9 million failed quality testing, leading to inadequate availability of insecticides. Reports of insecticide resistance to various chemicals were also noted, but there was no national entomological survey to inform decision-making on resistance management. Operational issues during the IRS campaign, such as inadequate training and supervision, were observed by the National Malaria Control Program. Limited pre-IRS awareness sensitization also contributed to increased rejections/refusals during spraying. High refusal rates and locked doors at households during IRS campaigns indicate the need for improved social behavioral change communication (SBCC) strategies.[37]

LLIN implementing districts: Despite reported 136% LLIN ownership after mass distribution campaigns in 2022, and through continuous distribution, malaria cases in LLIN intervention districts increased by 168% from 6,024 in 2022 to 16,134 in 2023. Low LLIN utilization (58%)[38], including refusal to use nets due to low-risk perception and/or religious beliefs, misused or stolen LLINs, and deprioritization of SBCC interventions due to funding constraints, were among the challenges found

[32] World Malaria Report 2023, page 151, 206
[33] MOHCC Malaria Annual Report 2022 page 2
[34] DHIS2 Tracker APP Guide
[35] Case Management Audit report 2022, MOHCC
[36] Digital Mentorship Midterm Report, 2023, MOHCC and Clinton Health Access Initiative
[37] Consolidated IRS wards coverage 2022/2023, MOHCC
[38] Global Fund Secretariat Briefing Notes_Zimbabwe Malaria, June 2023

which risk undermining the gains made in malaria control and elimination. Other contributing factors include the lack of updated Malaria Indicator Surveys (MIS) since 2016, and the absence of post-mass distribution campaign surveys/assessments to inform future LLIN implementation strategies.

Pre-elimination districts: Malaria cases increased by 92% from 893 in 2022 to 1,719 in 2023. Surveillance and foci[39] management need to be strengthened; about 86% of reported malaria cases were fully investigated in pre-elimination areas, attributed to inadequate entomology kits/equipment and high staff attrition.

These issues contributed to the country experiencing a significant increase in malaria cases and deaths in 2023. Reported malaria cases rose by 73%, from 137,585 in 2022 to 237,385 in 2023, with outbreaks in the Binga, Centenary and Chipinge districts. Malaria deaths also increased from 177 to 317 during the same period,[40] These contributed to the malaria incidence rate increasing from 9 per 1,000 in 2022 to 14 per 1,000 in 2023, and the malaria mortality rate increasing from 1.2 to 2.1 per 100,000.

Addressing the root causes, including strengthening procurement processes, enhancing operational efficiency, conducting entomological surveys, improving surveillance systems, and strengthening social and behavior change communication interventions, will contribute to reducing the risk of malaria re-introduction in the malaria elimination districts and effectively combatting malaria in Zimbabwe.

Agreed Management Action 2:
The Global Fund Secretariat will work with the Ministry of Health and Child Care (MoHCC) to build on the Technical Review Panel's recommendation to strengthen vector control response and safeguard gains made in the country. This will be achieved through National Malaria Control Program's development of a vector surveillance strategy and the establishment of prioritized sentinel sites.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2026

[39] Malaria foci is a defined and circumscribed area situated in a currently or formerly malarious area that contains the epidemiologic and ecological factors necessary for malaria transmission (Source: A Framework For Malaria Elimination, Global Malaria Program, WHO)
[40] Vector-Control-Coverages-2018-2023 - analyzed data

4.3 Despite significant investment in RSSH, sustainability of HRH investment and suboptimal implementation of interventions hinder sustainable impact

The Global Fund has made significant investments in supporting and strengthening the country's health systems. However, sustainability of HRH investment and effective implementation of RSSH interventions are crucial to sustain the gains made in the fight against the three diseases.

Since 2003, the Global Fund has invested over US$500 million in activities aimed at building resilient and sustainable health systems (RSSH) in Zimbabwe, with integration into the National Health Strategy. However, several challenges persist, particularly in human resources for health (HRH), and optimizing RSSH investments.

Sustainability of HRH investment in Zimbabwe could impact achievements made in the delivery of HIV, TB and malaria services

Migration of the country's health workers to other countries have been persistent. The economic constraints faced by Zimbabwe have affected its ability to fully fund human resource requirements. As a result, support from the Global Fund and other health partners has been crucial in sustaining the health workforce, with over 50,000 health workers supported.[41] Notably, the Global Fund invested over US$60 million in HRH in Grant Cycles 5 and 6, and outlined a transition plan in Grant Cycle 7 (GC7) to gradually absorb specialized health workers onto the government payroll.

The MoHCC has taken various measures to address these issues, such as conducting health labor market assessments, salary harmonization efforts, developing a health workforce strategy for 2023-2030, and negotiating investment compacts where the government is expected to contribute 75% to the total HRH cost. While these efforts hold promise, their full implementation is pending approval and rollout.

There are significant gaps[42] in approved and filled positions for health workers, and health workforce spending is below the regional average. Zimbabwe's health workforce spending is US$9 per capita compared to the regional average of US$24 per capita.

As part of the co-financing requirement for the grant, the Global Fund support is conditioned upon increased domestic HRH investments through the Investment Compact. This involves gradually integrating Global Fund-supported and externally funded positions into the government establishment, in line with the 2022 Salary Harmonization Policy. The MoHCC must align its program management setup within the reduced program management budgets of 10% for 2024, 20% for 2025, and 20% for 2026. The Ministry is expected to explore opportunities to optimize and streamline structures, focusing on integration, salary harmonization and workforce sustainability as part of the overall HRH investments.

Significant progress has been made by the country in formalizing and agreeing on the Investment Compact between the government and its partners, ensuring alignment and sustainability of HRH investments. The Compact Agreement was signed in October 2024. Government commitment through the Ministry of Finance is, however, critical to the success and sustainability of Zimbabwe's health workforce.

Significant investment in RSSH activities to support disease programs, but improvement is needed in optimizing these key interventions to achieve the desired impact

At the end of GC6 (i.e., 31 December 2023), the absorption rate for RSSH and C19RM interventions was 82% and 58% respectively. These interventions were expected to support the implementation of other program activities in GC6. However, a number of these projects have been delayed and

[41] Health Labor Market, analyses for Zimbabwe p.16
[42] 17% and 18% in 2021 and 2022, respectively

could not be completed by the end of the grant period. For example, US$34 million was allocated for renovations and constructions (i.e., infrastructural projects) in GC6, but only 19% of RSSH projects and 9% of C19RM projects had been substantially completed by the end of GC6.[43] Establishment of Heating Ventilation Air Systems (HVAC) for the TB reference lab, with a budget of US$1.7 million, was expected to start at the end of December 2022 and be completed by December 2023. At the time of the audit in March 2024, the work had not started. However, a contractor has been contracted and the work is expected to be completed in November 2024.

The country planned to roll out eLMIS in all the 1,835 health facilities. According to the eLMIS operational plan, eLMIS was to be rolled out in 1,200 health facilities by the end of 2023.[44] The rollout has not started for 800 health facilities, three months after the end of 2023.

The below factors contributed to delays in implementation of RSSH investments:

Design and feasibility assessment gaps: Initial design gaps, as seen in the Mutare warehouse, led to space inefficiencies and increased construction costs. For example, mismatch in rack height (8.5m) and HVAC system (7.5m) reduced available storage space from 3,582 pallet locations to 2,782 pallet locations (i.e. 22% lost space).

Absence of monitoring mechanisms.: The absence of monitoring mechanisms, including RSSH indicators or Work Plan Tracking Measures (WPTM) contributed to ineffective oversight of investments. For instance, there was no routine monitoring of internet connectivity despite significant investments. Some 53% of health facilities visited had inadequate and unreliable internet connectivity despite investment of US$4.4 million and US$7.4 million in GC5 and GC6 respectively to ensure access to internet. About 23% of these facilities visited were expected to receive direct internet connectivity support from the Global Fund grant.

Bureaucracy in the approval and contracting processes: Delays in finalizing drawings/designs and Bills of Quantities (BoQs) by the Ministry of Local Government and Public Works, which is the Sector Ministry with regulatory authority for all government infrastructure work. Up to four-month delays in site assessments and up to 12-month delays in contract signings further hindered project implementation.

Agreed Management Action 3:
In accordance with the terms of the Investment Compact, the Global Fund Secretariat will work with the relevant Government ministries and partners to support timely implementation of the respective Government and partner Investment Compact commitments to address the HRH challenges in the country, specifically in the areas of: a. Government financing; b. MoHCC human resources; and c. The establishment and operationalization of MoHCC compact governance and oversight mechanisms.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2026

[43] C19RM implementation has been extended to December 2025
[44] i.e., eLMIS in 400 health facilities to be completed by 2022, and 800 health facilities to be completed by 2023

4.4 Limited implementation of interventions in HMIS and eLMIS coupled with limited supervision led to poor health and logistic data quality

The Global Fund has invested significantly in HMIS and eLMIS. However, these interventions are not yet optimally utilized to ensure program and logistics data quality and availability. These are due to inadequate supervision, system, and operational challenges which continue to undermine the accuracy and reliability of health data.

Zimbabwe, a high-impact country for the Global Fund, relies heavily on its health management information systems (HMIS), primarily using DHIS2, to report data on HIV, TB and malaria. The country has implemented an eLMIS to enhance end-to-end data visibility, tracking, and inventory management across the country. These systems are crucial for ensuring timely, reliable and accurate programmatic and supply chain data, which is essential for program planning and reporting, efficient ordering, stock monitoring, early warning against expiries, and national-level quantification processes.

The Global Fund has supported the expansion of the country's central warehouse and Medicines Control Authority Zimbabwe (MCAZ) lab improvements. Efficiencies and savings from GC4 and GC5 grants were utilized to establish 1,044 solar systems at health care facilities. Monitoring and evaluation plans are available, and data quality assessment was conducted in 2022 for the malaria program. Most (74%) of the health facilities visited by the OIG use eLMIS for commodities management, and have received training on eLMIS use. The auditors also noted evidence of regular stock counts and stock cards are generally available at the facilities.

Despite significant investments and efforts in HMIS[45] – over US$50 million since GC4 and US$22 million since GC6 – the systems are not yet optimally utilized to support program and logistics management effectively. Persistent data quality issues continue to undermine the accuracy and reliability of health data.

Limited human resource for health (HRH), inadequate supervision, lack of robust systems and operational challenges have led to poor programmatic and logistics data quality:

Inadequate monitoring and supervision: Although there are mechanisms like supportive supervision, and efforts to improve data linkages, these have not been fully effective in ensuring data quality. Supportive supervision and oversight activities were reduced due to delayed disbursement by the MoHCC, and decrease in oversight and training budgets. For example, there is no dedicated budget for support, supervision and monitoring activities for eLMIS. The audit noted inadequate follow-up and implementation of recommendations from previous internal data quality assessments. None of the recommendations from the 2020 Routine Data Quality Assessment (RDQA) had been completed at the time of the RDQA in 2022.[46] Following the OIG's 2019 audit, the agreed management action to resolve anomalies on reported HIV data through investigation of root causes and the feasibility study to roll out Electronic Heath Record, which includes unique identification codes for all identified people living with HIV in Zimbabwe, had not been fully addressed.[47]

Data quality checks through triangulation of patient and consumption data are not being performed by the Principal Recipient due to the non-interoperability of the country's core health information systems. There has been no external data quality assessment conducted since 2016 which would give an independent opinion on data quality and allow for any necessary course correction in a timely manner. Although the country conducted health facility assessment, the assessment did not focus on data accuracy checks.

[45] Signed GC4 and GC6 Grant Agreements
[46] 2022 Routine Data Quality Assessment (RDQA) (page 67)
[47] 2019 OIG Audit of Global Fund grants to the Republic of Zimbabwe, https://www.theglobalfund.org/media/9476/oig_gf-oig-20-008_report_en.pdf

Lack of robust systems and controls to support routine data reporting: The lack of robust data quality assurance mechanisms and the ineffective implementation of existing protocols contribute to data inaccuracies. There are no approved data quality validation standard operating procedures across the country's health system data flow for HIV, TB and malaria. There are no robust internal controls and processes on data entry or change of data in DHIS2 after the reporting period; modifications can be made to the system without data entry controls.

The eLMIS is not consistently updated with stock information on time, leading many facilities to rely heavily on paper-based reporting tools. This reliance on paper-based tools resulted in unreconciled stock levels between the eLMIS system, and monthly stock counts at 64% of facilities visited. Discrepancies were noted between stock cards and eLMIS records, and between stock cards and physical inventory, at 74% of the facilities visited. There were also inconsistencies between DHIS2 data and eLMIS data. For instance, DHIS2 accounted for only two out of three Determine HIV test kits and one out of two malaria rapid diagnostic tests used.[48]

Commodities dispensed at the point of care without an eLMIS workstation were not consistently reflected in the eLMIS system. About 32% of health facilities could not track stock issued at the point of care.[49] In some facilities, stock cards were not properly completed with essential information, such as expiry dates.[50] eLMIS stock summary reports did not exclude expired commodities, leading to potential inaccuracies. The absence of an interface between eLMIS and the EHR system hampers effective triangulation of patient and logistics data, which is not integrated with NatPharm's warehouse management system, delaying order processing.

Operational gaps: The audit noted delays in the implementation and assessment of the systems. Although eLMIS pilot sites were launched in 2019 and scaled up significantly in 2023, there have been delays in the comprehensive assessment of the system's use. The Digital Health Strategy 2021-2025, which outlines critical priorities for health facility coverage, connectivity, digitization, and interoperability, was only approved in 2022. Delays in its implementation have slowed down the optimization of the eLMIS.

The Directorate of Pharmacy Services' Strategic Plan aims for 100% eLMIS reporting by 2024 and includes enhancements to eLMIS user requirements. However, the execution of the eLMIS has been slow. By the end of 2023, the eLMIS had been rolled out to 63% (1,150 out of 1,800) of health facilities across the country. The rollout of eLMIS in 1,800 health facilities faced delays due to lack of programmers and constrained human resources.

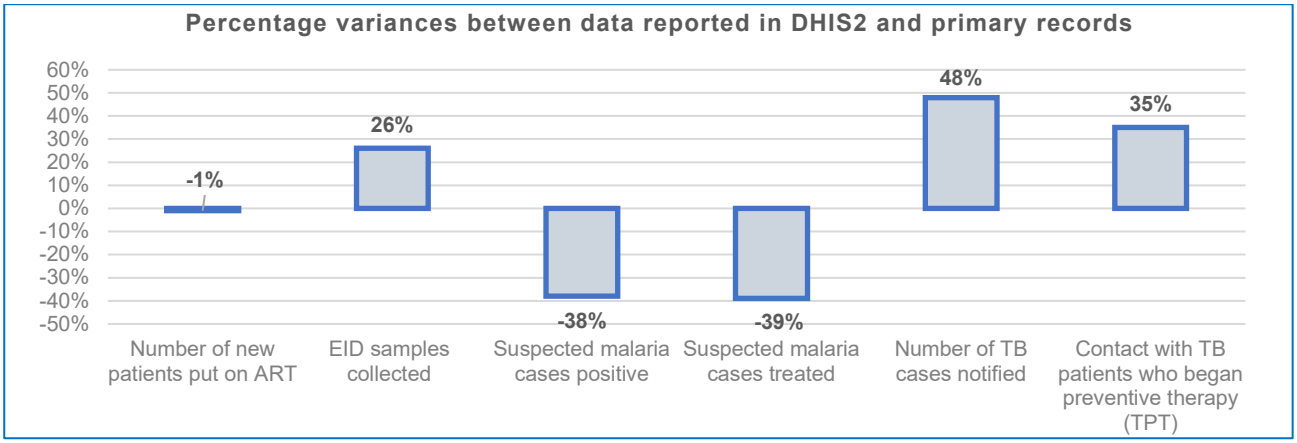
Significant investments were made in internet connectivity,[51] solar power backups and computer hardware, but these have not substantially improved the timeliness and quality of HMIS and eLMIS data. Despite these investments, 53% of facilities visited by the OIG reported inadequate internet bandwidth, affecting data synchronization with the central server at defined intervals. Insufficient or non-operational solar power backups lead to interruptions in the use of HMIS and eLMIS, especially in areas with unreliable electricity supply. Limited computer hardware availability also contributed to the continued use of manual record-keeping methods, which increases the workload for health workers and fosters resistance to HMIS and eLMIS adoption.

Limited staff capacity and training on data management: The OIG noted cases of low staff morale at five out of 19 health facilities visited due to delays in the payment of salaries,[52] and increased workload resulting from the continuous staff attrition. Data focal persons at 55% (5/9) of health facilities at the district level visited by the OIG had not been trained in the use of DHIS2, and data focal persons at 37% (7/19) of sites visited confirmed that they had not received any training on data management. About 690 (38%) of the health facilities set to be trained on eLMIS had not been

[48] OIG triangulated DHIS 2 patient data and commodities consumption
[49] (6/19) 32% of health facilities visited did not have any tools or mechanisms in place to record stock issued at the point of care
[50] (10/19) 53% of health facilities visited by the OIG had incorrectly filled stock cards
[51] US$11.8 million in internet connectivity during GC5 and GC6
[52] Global Fund-supported staff reported systemic salary arrears at 26% (5/19) of health facilities visited

covered. High turnover rates among health workers lead to a loss of trained personnel, which negatively impacts HMIS and eLMIS use and necessitates repeated training sessions.

The above issues contributed to significant data quality challenges.[53] Only 28% of health facilities were within an acceptable data quality range in the 2023 Malaria Data Quality Assessment (DQA). The timeliness of data reporting in DHIS2 was relatively low at 77% by the end of 2023. The OIG also noted substantial data quality issues in all the 19 health facilities visited. Five out of six selected indicators for HIV, TB and malaria showed absolute variances above the 10% threshold for poor data quality; see the Fig. 1 for details.



About 68% of facilities visited under or over-reported the number of treated malaria cases by average of -39%, while all the facilities visited under or over-reported TB cases notified by average of 48%. About 89% of facilities visited under or over-reported the number of Early Infant Diagnosis (EID) samples collected by average of 26%. The absolute variance for the number of new patients put on ART was only 1%.

For eLMIS, the data produced is not complete, timely or accurate. As a result, stock ordering process relies on physical quarterly visits to health facilities to assess consumption and stock levels. This manual process is time-consuming, labour-intensive, and prone to errors, undermining the efficiency and responsiveness of the supply chain. About 95% of the health facilities reported experiencing stockouts,[54] and 21% of health facilities visited reported receiving damaged or expired commodities,[55] while 74% reported having expired drugs/commodities during the audit period.[56] During the GC7 grant-making process, a US$16.9 million commodity funding gap was identified, which was partly due to overestimation in the quantification process and gaps in the assumptions used for quantification. Following the audit, an assessment of the eLMIS was conducted in June 2024.

[53] The 2022 internal data quality assessment and the 2023 Malaria Data Quality Assessment (DQA)
[54] 95% (18/19) of health facilities visited by the OIG reported having experienced stock-outs in one or more essential commodities during the audit period
[55] 21% (4/19) of health facilities visited by the OIG reported having received damaged or expired goods
[56] 74% (14/19) of health facilities visited by the OIG reported experiencing commodities expiring during the audit period

Agreed Management Action 4:
The Global Fund Secretariat will work with the MoHCC and UNDP to strengthen data management by: a. incorporating the updated WHO DHIS2 Data Quality Toolkit into the country's DHIS2, accompanied with standard operating procedures; and b. developing standard operating procedures for Health Management Information System (HMIS) and Monitoring and Evaluation (M&E)
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2026

4.5 Strong implementation arrangements exist, but improvements are needed in grant management and oversight to safeguard grant resources

The Global Fund has implemented several arrangements to safeguard grant resources. However, the audit noted gaps in the timely issuance and implementation of recommendations, resulting in procurement and financial control issues.

Global Fund grants in Zimbabwe are managed under the Additional Safeguard Policy. This allows the Global Fund Secretariat to put in place additional measures, including selecting the UNDP as the Principal Recipient of the HIV grant and a fund administrator for the TB and malaria grants, managed by the MoHCC. Therefore, in addition to its Local Fund Agent (LFA) role, UNDP serves as an in-country assurance mechanism to safeguard the Global Fund's investments for the TB and malaria investments.

Overall, there are adequate independent assurance mechanisms in the programs, such as yearly independent audit by the Zimbabwe Office of the Auditor General for malaria and TB programs, periodic audits by the UNDP Office of the Audit and Investigation, and a yearly external audit for the UNDP sub-recipients. As a fund administrator, UNDP reviews on average 74% of the TB and malaria program expenditure. Health commodity procurements are executed through UNDP, Wambo.org, and the Stop TB Partnership's Global Drug Facility (GDF).[57] The MoHCC conducts the local procurement for non-health commodities, and UNDP regularly reviews major procurements.

Out of the total expenditure of US$58 million,[58,59] the OIG sampled 20% (US$11.6 million) for review. Despite the progress made, the OIG noted gaps in oversight and follow-up on assurance recommendations. These contributed to recurring financial and procurement management issues that adversely impacted reporting and accountability of grant funds.

Weak follow-up on assurance recommendations: The Program Coordination Unit (PCU) of the MoHCC maintains two separate trackers for recommendations. These trackers include recommendations from the fund administrator, external auditor, internal auditor, LFA, and PCU audit and monitoring teams. However, recommendations from the fund administrator and internal auditor findings after March 2022 are yet to be included in these trackers. As of February 2024, progress in implementing these recommendations, totaling 188, shows only 55% implemented, with the remaining 45% categorized as ongoing or in progress. Notably, recommendations scheduled for implementation by February 2024, including 35% from 2021, 41% from 2022, remain outstanding. Additionally, 77% of recommendations lacking specific implementation deadlines, totaling ten out of 13, have yet to be addressed.

Delayed submission of performance letters: The OIG observed delays in the provision of performance letters by the Global Fund Country Team to the Principal Recipients in all 12 samples reviewed, with an average delay of 65 days.

The issues above contributed to gaps in controls on financial reporting, payment, fraud management and procurement:

Gaps in financial reporting: The TB and malaria programs continue to rely on a manual accounting system, which affects the quality and reliability of the financial information of these programs. The Principal Recipient uses two parallel systems: MS Excel for accounting and report preparation, and the Public Financial Management System (PFMS) for recording MoHCC transactions. However, PFMS does not capture transactions outside the MoHCC, such as those conducted by Wambo.org, UNDP, or GDF. The lack of coordination between these systems coupled with noncompletion of the

[57] The Stop TB Partnership's Global Drug Facility (GDF) facilitates global access to quality-assured, affordable TB diagnostics and treatments
[58] Malaria: US$16.9m (2021 – 2023); TB: US$9.1m (2021 – 2023); HIV: US$32m (2023 - UNDR SRs)
[59] The expenditure of US$58 million excludes UNDP (HIV PR) expenditure and direct payment by Global Fund for procurements through the pool procurement mechanism

Grant Management Module in PFMS contributed to unreconciled transactions between PFMS, Cashbook, and the financial statements. The Progress Update and Disbursement Request forms (PUDR), as well as annual financial statements, are prepared by the Project Coordination Unit by manually consolidating the monthly cash book/financial reports of Principal Recipients and Sub-Recipients. This is time-consuming and could impact the quality of the financial information.

These contributed to errors and inconsistencies in reports including PUDR submitted to the Global Fund. For example, there was a discrepancy of US$3.5 million and US$3.2 million between the Annual Financial Report and the PFMS 2022 expenditures for the Malaria and TB grants, respectively. Consequently, the Zimbabwe Office of Auditor General issued a qualified opinion on the malaria grant 2022 financial statements. The UNDP Office of Audit and Investigation deemed the management of the HIV grant by UNDP unsatisfactory in its 2019 reports and highlighted a need for major improvement in the 2022 report. The external auditor of UNDP sub-recipients assessed the internal control of all sub-recipients as partially satisfactory in its management letters for 2021 and 2022.

Inadequate implementation of internal controls over payments: Several inadequately documented and unsupported payments were noted by the OIG. For instance, photocopies were attached instead of original documents for 49% (216 out of 440) of transactions sampled amounting to US$4.3 million,[60] risking paying duplicate invoices. There was also no proof of payment for 21% (69 out of 332) of transactions amounting to US$1.6 million,[61] and controls to prevent duplicate payment were not effectively implemented for 69% (229 out of 332) of transactions amounting to US$5.7 million,[62] risking duplicate payments. The Office of the Auditor General discovered duplicate payment voucher numbers in 17 transactions during the 2022 audit of the malaria grant. Additionally, weak controls over fuel coupon utilization for transactions amounting to US$1.2 million were noted.

Noncompliance with procurement processes and controls: Although the Principal Recipients generally adhere to procurement policies and approval mechanisms, there was noncompliance in some of the transactions reviewed by the OIG. For example, no purchase orders were available for 61% (82 out of 135) of procurements sampled amounting to US$1.8 million.[63] Delivery notes were missing for 56% (75 out of 135) of procurements sampled totaling US$1.5 million,[64] and there was no control measure for preparing goods receipt notes to acknowledge the receipt of goods for all three grants. The procurement process was also not carried out in a timely manner – taking an average of 196 working days from initiation to contract signing.[65]

Improvement needed in fraud risk management and assurance: The Principal Recipient (MoHCC) has implemented preventive measures for Global Fund grants, such as finance and procurement manuals, segregation of duties, and oversight by the Project Coordination Unit, as well as detective measures through assurance mechanisms. However, there are no written anti-fraud guidelines, fraud prevention training for staff, or fraud risk registers.

[60] TB: 110 instances out of 208 samples; Malaria: 46 instances out of 124 samples; and HIV: 60 instances out of 108 samples. US$4.3 million out of sample value of US$11.6 million
[61] TB: 63 instances out of 208 samples; and Malaria: 6 instances out of 124 samples. US$1.6 million out of sample value of US$11.6 million
[62] TB: 180 instances out of 208 samples, Mal: 49 instances out of 124 samples. US$5.72 million out of sample value of US$11.6 million
[63] 71%, 74%, and 58% of TB, Malaria, and HIV procurement samples, respectively
[64] 48%, 67%, and 58% of TB, Malaria, and HIV procurement samples, respectively
[65] Ranging from 145 to 264 working days

Agreed Management Action 5:
The Global Fund Secretariat will work with the MoHCC and UNDP to reduce TB and malaria programs reliance on manual accounting system and strengthen internal controls through: a. Advancing the country's utilization of the Grant Management Module in PFMS to improve the quality and reliability of financial information; and b. Performing a diagnostic of internal controls to identify the gaps in the payment and procurement processes, with resulting intervention to address prioritized issues.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2026

Annex A. Audit Rating Classification and Methodology

Effective	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.
Partially Effective	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.
Needs Significant Improvement	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.
Ineffective	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.

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, and international standards for the professional practice of internal auditing 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 safeguard the independence of the OIG's auditors and the integrity of its work.

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 is used to provide specific assessments of these different areas. 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 B. Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for 11 key risks affecting Global Fund grants, formed by aggregating 31 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks that fall within the audit's scope. In addition, a narrative explanation is provided every time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund Grants in Zimbabwe: Comparison of OIG and Secretariat Risk Levels

Based on the result of the audit, OIG has rated two out of nine risk areas within the audit objectives as higher compared to the Secretariat rating, and one that is lower. The Secretariat rated TB program quality “high” while the OIG rated it “moderate.” Though the TB program is generally not doing well, there has been improvement in the last three years. Key risks identified are mainly on drug-resistant TB (DR-TB). These risks have been identified by the country and are being addressed as part of the TB catch up plan.

M&E Risk: the OIG audit has rated this risk moderate compared to a low rating by the Secretariat due to the moderate risk identified in all three sub-risks. The audit noted inadequate data quality assurance contributing to poor data quality. OIG visits to selected health facilities noted discrepancies between data reported in the electronic records and the source documents, resulting in underreporting or overreporting of programmatic data.

Accounting and Financial Reporting Risk: the OIG has rated in-country accounting and financial reporting risk as a moderate risk (excluding UNDP) compared to a low-risk rating by the Secretariat, due to high risks identified in one of the two sub-risks: the use of manual accounting systems, and the difference between reports and the underlying accounting system resulting in audit qualification. This is due to the inadequate configuration of the grant management module in PFMS. There have been persistent delays in the validation and submission of PUDR and the issuing of performance letters. External auditors have issued qualified audit reports. The Secretariat risk rating is moderate for the MoHCC grants and low for UNDP. The rating of low is the weighted average of the two ratings.