GLOBAL FUND-SUPPORTED HIV PROGRAM AND SUPPLY-CHAIN MANAGEMENT IN ZIMBABWE REQUIRE IMPROVEMENTS, OIG SAYS

In this fourth audit of Global Fund grants to Zimbabwe, the Office of the Inspector General (OIG) found anomalies in HIV data, low coverage of viral load testing, low performance in testing for HIV among children, and low warehouse capacity. As a result, the OIG rates the country's HIV program as 'partially effective' in each of these four identified areas.

The audit, published on 26 March 2020, covered the period from January 2017 to June 2019. The OIG uses a four-tier audit rating from 'ineffective', 'needs significant improvement', 'partially effective' to 'effective'.

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The OIG noted that Zimbabwe made strides in the fight against HIV, tuberculosis, and malaria. The country increased its public spending on health from 6.6% of the budget in 2012 to 9.4% in 2016. New HIV cases declined from 852 to 486 per 100,000 people between 2010 and 2018. In the same period, HIV prevalence among adults decreased from 15.4% to 12.7%. New tuberculosis cases dropped from 384 to 210 per 100,000 people from 2011 to 2018. New malaria cases decreased from 3,400 to 1,900 per 100,000 people in 2017.

Zimbabwe is a lower-middle-income country, according to the World Bank's classification. Since 2000, Zimbabwe has been experiencing economic challenges, including periods of hyperinflation, which reached its peak in November 2008. Furthermore, the country has been grappling with a challenging monetary environment that has negatively impacted its health system.

The Global Fund classifies Zimbabwe as a 'High Impact' country. High-impact countries have a very large

Global Fund portfolio and a 'mission critical' disease burden. Zimbabwe is also under the Additional Safeguard Policy, which reinforces fiscal controls and oversight. Since 2003, Zimbabwe has received $1.67 billion worth of grants to fight HIV, TB, malaria, and strengthen its health system. For the current implementation cycle (2018-2020), the Global Fund has allocated $474 million to Zimbabwe. The largest proportion (85%) of these funds, which amounts to $403 million, funds HIV programs. The United Nations Development Programme (UNDP) is the Principal Recipient (PR) of the HIV grant. The Ministry of Health and Child Care (MoHCC) is the PR for malaria and tuberculosis programs, with grants in the amounts of $48 million and $23 million, respectively.

Audit scope

The audit covered all three Global Fund grants to Zimbabwe to assess the effectiveness of processes and controls in place for testing HIV, viral load, early infant diagnosis, as well as the supply chain effectiveness to store, deliver and account for health products. The OIG obtained data for the audit from 40 health facilities, the National Pharmaceutical Company of Zimbabwe (NatPharm), and two provincial warehouses. However, the OIG excluded activities explicitly implemented by UNDP due to the United Nations General Assembly's 'single audit principle' barring third parties accessing UN agencies' books and records.

Audit findings and agreed management actions

The OIG report discusses three main audit findings, as summarized below with their associated Agreed Management Actions (AMAs).

1. HIV data anomalies noted

The audit revealed that Zimbabwe does well against the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets by 2020. The 90-90-90 targets are ambitious goals of diagnosing 90% of all people living with HIV, 90% of those diagnosed put on antiretroviral treatment, and 90% of those on treatment achieving viral suppression, by 2020. Of the estimated 1.3-million people living with HIV in Zimbabwe in 2018, 90% knew their HIV status; thus, Zimbabwe was at par with the UNAIDS target of 90%. Of the people that know their HIV status, 95% are on antiretroviral therapy, surpassing the UNAIDS target of 90%. Of those on antiretroviral therapy, 87% have viral suppression, inching close to the UNAIDS target of 90%.

However, Zimbabwe seems to do well against the targets because of the overall under-estimation of people living with HIV. The audit detected HIV data anomalies: a high discrepancy between data from Zimbabwe's National HIV Testing Services Strategy for 2017-2020, and the HIV program data. For instance, the Zimbabwe's National HIV Testing Services Strategy had a target of 120,103 HIV positive cases, which the program surpassed by 69%, and reported 202,764 positive cases, in 2017. Similarly, in 2018, the HIV program data indicated that Zimbabwe had surpassed its target of 104,742 HIV positive cases by 68% and reported 175,793 positive cases. The target for 2019 was 96,067 HIV positive cases, but by the first half of 2019, 70% of the targeted 96,067 HIV positive cases had already been reported. At this rate, Zimbabwe is likely to surpass its targets for 2020. A plausible explanation for the anomaly is that Zimbabwe may have a higher number of people living with HIV than the current estimates.

AMA 1: The Head of the Grant Management Division of the Global Fund Secretariat is required to ensure that by 30 June 2021, the Secretariat has worked with the HIV program of Zimbabwe to:

- Conduct a survey to investigate data anomalies identified on the number of HIV-positive cases and national estimates on people living with HIV to inform the review of Zimbabwe's HIV strategy
- Conduct a feasibility study to roll out Unique Identification Codes (IUC) for people living with HIV to inform the possibility of rolling out IUC in Zimbabwe.

2. HIV treatment coverage, viral suppression, and early infant diagnosis require improvements

In 2016, Zimbabwe adopted a 'treat all' strategy, where all individuals who test positive for HIV are put on treatment. However, Zimbabwe did not achieve this target during the period covered by the audit. Only 70% of the 264,000 new HIV cases identified between January 2017 and June 2019 were put on antiretroviral therapy. Several factors help explain why the country missed its target. Among those factors is the lack of a mechanism to track patients, deferred initiation of antiretroviral therapy, the lack of programs targeting key populations and adolescent girls and young women at public health facilities, and inaccurate data. Data from the country's health facilities vary markedly with data reported in the District Health Information Software (DHIS 2)—an open-source software platform for reporting, analysis, and dissemination of health data.

The audit revealed that only 48% of the people on antiretroviral therapy were tested for viral load in 2018, and 78% during the first half of 2019. The viral-load testing in Zimbabwe is thus below the target of 90% of those on HIV treatment by 2020. Furthermore, the OIG noted a gap in communicating test results to patients, as only 54% of the 26,000 sampled cases received test results back at the facility, out of which 89% were virally suppressed. This is attributed to the lack of a systematic process to track people on antiretroviral therapy for viral-load testing, and to low numbers of healthcare workers, as 86% of the health facilities visited during the audit had visiting or supporting doctors because they lacked permanent staff. Also, due to a weak tracking system and lack of a cross-border program to ensure viral-load testing for Zimbabweans who work in South Africa. Moreover, non-functional viral-load machines at the point of care due to electricity issues and lack of standard procedures and tools for the transportation of samples to referral laboratories contributed to low levels of viral-load testing.

According to the audit, Zimbabwe has made slow progress in fighting HIV among children aged 0-14 years living with HIV. Only 57% of the estimated 91,000 children living with HIV in Zimbabwe know their status, out of which only 57% are on antiretroviral therapy, far below the UNAIDS target of 90% in both cases. Furthermore, only 52% of the children on antiretroviral therapy were virally suppressed, which is also far below the UNAIDS target of 90%. Early infant HIV testing in Zimbabwe dropped from 82% in 2017 to 52% in early 2019. This is attributed to low levels of testing at birth as only high-risk newborns were tested.

AMA 2: The Head Grant Management Division of the Global Fund Secretariat is required to ensure that by 30 September 2021, the Secretariat has worked with the Ministry of Health and Child Care to:

- Include the testing of all infants from women living with HIV in the Early Infant Diagnosis (EID) policy and establish an action plan on how to increase HIV testing coverage among infants and its subsequent cost
- Establish an action plan on how to improve the tracking of patients on antiretroviral therapy who fail to return to health facilities for continued care or evaluation and its associated cost

3. Improvements are needed on warehouse storage capacity and oversight

On a positive note, health products procured with funding from the Global Fund were traceable using the product batch number at the NatPharm warehouses. Also, the audit found no substantial stockouts or expiries, and the health products had a warning mechanism for expiries and adequate remaining shelf life. However, the audit revealed space constraints at the central warehouse in Harare, which hinders good inventory management. The warehouse was congested with donor-funded commodities. A space requirement assessment conducted last in 2010 estimated that 6,817 cubic meters were required to hold up to eight months' stock of health commodities. However, NatPharm distributed almost twice as many health commodities in 2019 as it did in 2010: NatParm distributed the equivalent (in storage terms) of 12,875 cubic meters of health commodities between January and August 2019. Space constraints force the warehouses in Harare and Bulawayo to 'push' health commodities to health facilities, thereby stretching storage spaces of the health facilities.

The audit also revealed data entry and reconciliation issues at the central warehouse, due to the unavailability of key performance indicators on the accuracy of receipts that NatPharm enters. NatPharm's standard operating procedures requires data on drugs received entered into its enterprise resources planning software within five days. However, it took more than five days to enter the data on 82% of the drugs received in 2018, contributing to data errors and traceability issues. In addition, health commodity consumption or distribution is not triangulated with programmatic

data. For instance, screening tests distributed to health facilities were 1.8 times higher than the number of screening tests done. Also, the confirmation tests distributed to health facilities amounted to 2.2 times the number of confirmation tests performed. The audit found no evidence on health facility supervision by the district pharmacists, which contributes to data anomalies at the health facility level.

AMA 3: The Head Grant Management Division of the Global Fund Secretariat is required to see to it that by 30 June 2021, the Secretariat ensure that both PRs improve the warehouses and health facilities stock management through:

- Review of Standard Operating Procedures (SOPs)
- Establishing additional storage space required and offer interim storage solutions after assessing the NatPharm's national storage capacity needs
- Conducting mid- and end year stock counts to reduce variances between physical stock count and electronic system balances
- Improving the health facilities' inventory management and accountability of health products.

Further resources:

· This audit report is 'Global Fund Grants in Zimbabwe' (GF-OIG-20-008), 26 March 2020.

· The 2013 audit report, 'Audit of Global Fund grants to the Republic of Zimbabwe' (GF-OIG-13-012), 31 May 2013.

· The 2016 audit report, 'Global Fund grants to the Republic of Zimbabwe' (GF-OIG-16-019), 13 July 2016.

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