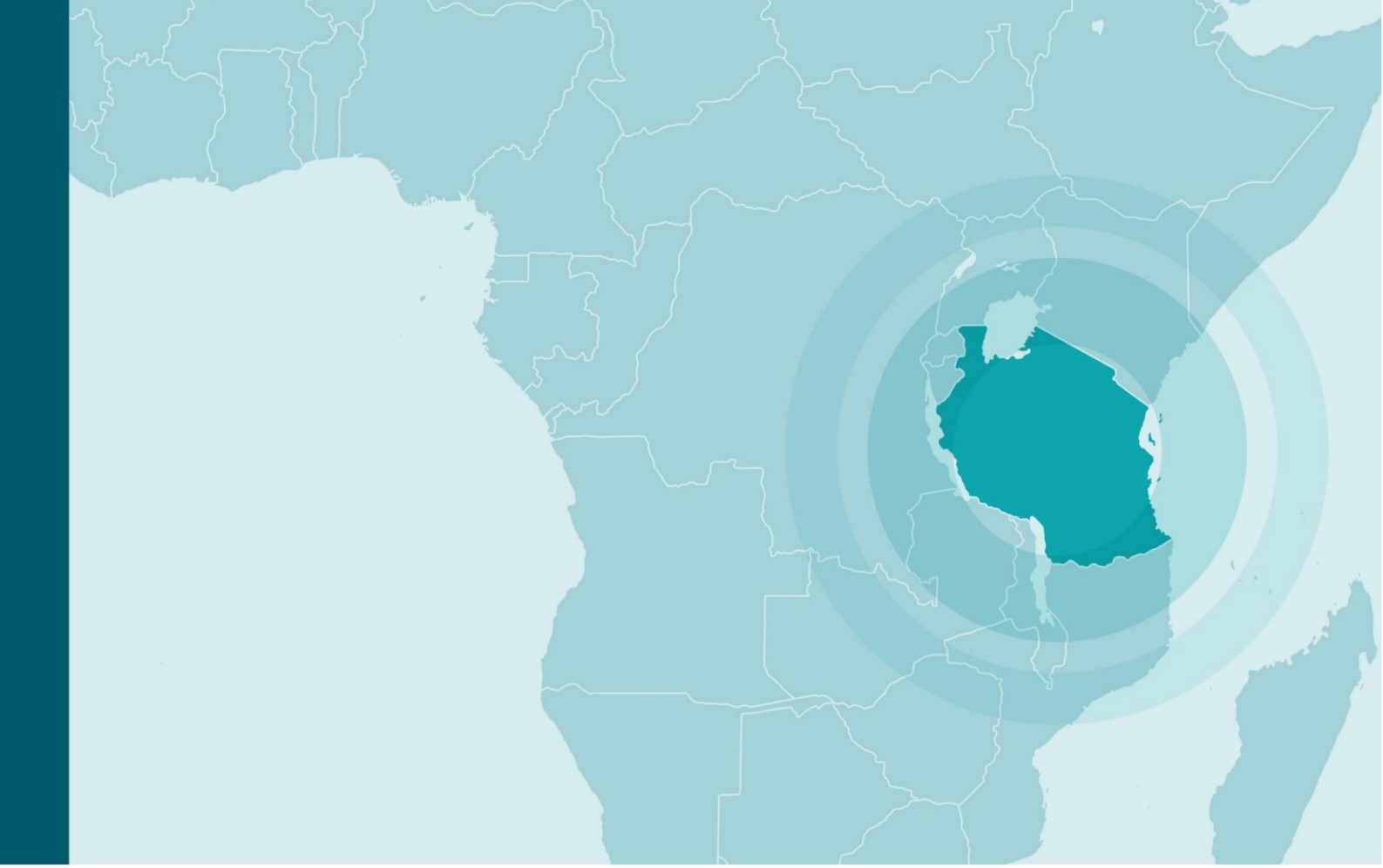

AUDIT REPORT

Global Fund grants to the United Republic of Tanzania

GF-OIG-23-003
27 March 2023
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Tanzania is a key country in the global fight against the three diseases. It has an estimated 1.7 million people living with HIV and is among the top 10 countries in the world for malaria incidence and mortality. Overall, there has been solid programmatic progress in the HIV response, and in reducing malaria mortality. There has also been remarkable improvement in the availability of lifesaving commodities for beneficiaries, which highlights the significant progress made by the country since the last OIG audit. All these achievements were made with the health system operating at 50% of its required human resource capacity. But recurring issues were noted regarding the traceability of commodities, sub-optimal implementation of key malaria and HIV prevention, as well as gaps in financial management.

Tanzania achieved programmatic success with estimated malaria-related deaths decreasing by 70% between 2015 and 2021. To support the malaria response, the country adopted an ambitious and innovative national malaria strategic plan (2021-2025), which defined a more targeted and tailored approach to malaria interventions. However, there were indications of low LLIN coverage and low LLIN use despite significant investments as well as sub-optimal community case management. All have contributed to stagnant malaria incidence. In addition, there was an over issuance of artemisinin-based combination therapy (ACT) by 6.7 million doses in the last six years in relation to positive cases, and there were issues with malaria programmatic data quality. For HIV, there has been strong programmatic progress with the country achieving 88%-86%-83% for the 95-95-95 targets and there has been a reduction between 2010 and 2021 in the number of HIV infections (down by 85%) and AIDS-related deaths (60% fewer). However, implementation challenges of key prevention activities – especially for adolescent girls and young women beneficiaries – along with an unclear picture of antiretroviral therapy (ART) attrition, and significant condom stock outs threaten further progress. Thus, the adequacy and effectiveness of the program implementation for HIV and malaria **needs significant improvement**.

As at the time of the audit fieldwork (in the fourth quarter of 2022), good financial management and implementation oversight were noted for the Principal Recipient, Amref Health Africa.[1] However, there were various financial and sub-recipient management issues under the Ministry of Finance and Planning (MOFP) grants. Gaps in sub-recipient oversight have resulted in US$3.9 million of long outstanding advances under the HIV and malaria grants, US$0.6 million of unsupported expenditure and some challenges with fixed asset management. Thus, the adequacy and effectiveness of financial management and oversight is **partially effective**.

Three quarters of the NFM3 grants relate to procurements. Since the last OIG audit, there have been improvements in the availability of ARVs and ACTs, with no material stock-outs noted. However, weaknesses in central level warehouse management systems and stock management at health facilities limit commodity traceability. In addition, laboratory-related procurement supply management has significant limitations, primarily in how key CD4, hematology and chemistry commodities/reagents are managed and distributed. This has caused numerous stock-outs and expiries of key lab commodities, impacting the services received by beneficiaries. Overall, the effectiveness of procurement and supply chain management is **partially effective**.

[1] Amref Health Africa is one of the largest health development non-governmental international organizations based in Africa. with the mission to increase sustainable health access to communities in Africa.

1.2 Key Achievements and Good Practices

Strong sub-recipient management under Amref

Under the Amref grant, the OIG noted well designed sub-recipient management policies, guidelines and procedures. As a result, there was robust monitoring and oversight that resulted in timely supervision and feedback to Sub-Recipients and timely retirement of advances. In addition, the OIG noted no unsupported expenses or material irregularities from the sample of transactions reviewed.

Introduction of innovative approaches to tackle malaria and HIV

The country approved an ambitious National Malaria Strategic Plan (NMSP) 2021-2025. It has resulted in the design of more targeted and tailored interventions including vector control, leading to multiple distribution channels for LLINs being developed, including mass replacement campaigns and targeted routine distribution for pregnant women and infants, children in schools and other vulnerable groups. For HIV, the country approved legislation to support the introduction of HIV self-testing, as well as reducing the age of consent for testing to boost coverage. In addition, no material issues were noted with the data quality of key HIV indicators at sampled sites.

Continuous availability of HIV and malaria treatment at service delivery points

Tanzania has made strong progress in ensuring treatment commodity availability especially at point of care. While there were widespread issues with stock-outs and expiries of ACTs and ARVs in prior OIG audits, in the latest review, OIG noted no material stocks-outs or expiries for either. In addition, efforts have been made to extend the reach of electronic Logistics Management Information Systems (eLMIS) to the health facility level, along with the establishment of technical working groups to strengthen monitoring and oversight over the entire supply chain.

1.3 Key Issues and Risks

Weaknesses around the financial and Sub-Recipient management under MOFP

Ministry of Finance and Planning (MOFP) grants account for 94% of the Global Fund portfolio in Tanzania during the NFM3 period[2]. Under the MOFP grant, oversight over implementation by the lead Sub-Recipients was sub-optimal (the Ministry of Health and the President's Office of Regional Administration and Local Government), with no evidence of effective oversight of HIV and TB sub-recipients and sub-sub recipients, no systems and processes to support effective monitoring of sub-recipient advances and outdated operating manuals for sub-recipient and financial management. Linked to this, the OIG audit identified US$3.9 million of sub-recipient advances that have been outstanding for over 18 months under both the HIV and malaria grants. Staff advances totaling US$0.2 million were also overdue and not in line with the timelines set by MOFP financial policies. In addition, inadequate supporting evidence was provided to the OIG to account for US$0.6 million of transactions sampled by the OIG.

Suboptimal implementation of HIV prevention activities both for general population and adolescent girls and young women (AGYW) beneficiaries

For general and targeted prevention, there was inadequate condom availability noted with stock-outs of condoms in 44% of sampled sites, with an average stock-out of 87 days, 65% of condom dispensing boxes sampled were stocked out at the time of the review. This disrupted supply is due to inadequate monitoring of boxes by District AIDS Council Coordinators, as well as by implementers under the MOFP grant. For AGYW beneficiaries, there were issues in the quality of service received for social and behavior change communication (SBCC) activities. While AGYW beneficiaries were being filtered for Sexually Transmitted Infections (STI) screening, female contraception, family planning, as well as Gender Based Violence (GBV) services, there was limited evidence as to whether there is sufficient follow up to confirm the receipt of these services by beneficiaries.

[2] The majority of this funding relates to procurements of commodities

Implementation challenges noted in vector control and limited community case management

Two key surveys conducted by Tanzania indicated low national coverage and usage of long-lasting insecticidal nets (LLINs) with a 52% coverage against the national target of 80%. This was linked to large delays in the roll out of the national Mass Replacement Campaign (MRC) due to issues with protracted local procurement and non-adherence to macro plans. There has been limited community case management with 10 councils out of the planned 64 (16%) starting this activity as of October 2022.

Variances in ACT usage persist resulting in increased risk of poor treatment, ACT misuse and diversion

The number of recorded ACTs dispensed is higher compared to the number of confirmed malaria cases reported. Although the differences have become more acute, the previous OIG audit in 2018 highlighted similar discrepancies, attributed to staff dispensing ACTs without a test or with a negative result, as well as poor documentation practices caused by pressures on health workers at the facility level linked to large gaps in staffing. This raises significant risks of misuse, drug resistance and does not allow for proper accountability of funded commodities.

Persistent challenges around traceability of treatment commodities

There are varying levels of traceability of commodities along the distribution chain. No issues were found in tracing commodities from the central warehouse to zonal warehouses, however, issues between the zonal level and health facility were noted for 3 out of 20 (15%) sites sampled. There were gaps in the audit trail that made it difficult to track several commodity types within the health facilities to the intended patients in all sampled sites (20 out of 20). These issues – previously highlighted in OIG audits as far back as 2009 – are linked to system gaps at the central and regional level, as well as to weak stock management within health facilities, compounded by cross-cutting governance challenges. As a result, almost one quarter (23%, representing US$268,000) of sampled commodities could not be traced all the way to the final dispensing point to beneficiaries.

1.4 Objectives, Ratings and Scope

The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on the adequacy, effectiveness, and efficiency of Global Fund Grants to the United Republic of Tanzania. Specifically, the audit assessed the objectives below.

Objectives	Rating	Scope
Design and effectiveness of controls around fixed assets, financial accounting and reporting and Sub-Recipient management, including financial management systems, tools and processes to support the achievement of grant objectives.	**Partially Effective**	**Audit period** NFM2 and NFM3 grants from January 2020 to June 2022 **Grants and implementers** The audit covered the Principal Recipients and Sub-Recipients of Global Fund supported programs.
Adequacy and effectiveness of the program implementation for HIV, malaria and key RSSH (Resilient and Sustainable Systems for Health) activities to ensure sustainable programmatic results and robust data quality.	**Needs significant improvement**	
Effectiveness of procurement, supply chain processes and focused IT systems to ensure timely availability of commodities and to mitigate risks of stock-outs and expiries.	**Partially Effective**	

OIG auditors visited 34 health facilities and procurement supply management sites in 12 districts and five regions. Details about the general audit rating classification can be found in Annex A.

2. Background and Context

2.1 Overall Context

Tanzania is a low middle-income country with an estimated population of 61.4 million people. The country has achieved relatively strong economic growth and declining poverty rates. It is the most populous country in East Africa and constitutes about 30% of the regional population. The majority of the population are under 25, meaning that it is critical that health programs are adapted to the needs of young adults and children.[1] Tanzania (mainland) has 26 regions, 133 districts and 185 councils. The councils (local governments) are the most important administrative and implementation units for public services, with health decentralized to this level.

There are 11,251 health facilities, a figure that represents an average of 21 facilities per 100,000 people. They are managed by the councils under a decentralized governance structure. Health expenditure is estimated at 3.8% of the government budget[1] and health expenditure per capita is US$40,[1] which is below the WHO target of US$84 per capita. This has resulted in large funding shortages and a severe lack of health workers, with 0.01 physicians per 1,000 people (2016, World Bank database) against a standard of one per 1,000. There is shortage in health workers, the current workforce only meets about 50% of the required numbers. This is a cross-cutting root cause for many issues highlighted in this report.

Country data[3]	
Population	61.4 million (2021)
GDP per capita	US$1,135 (2021)
Transparency International	87 of 180 (2021)
UNDP Human Development	160 of 191 (2021)
Government spending	3.8% (2019)

2.2 COVID-19 situation

Tanzania's first COVID-19 case was reported in March 2020. However, the country paused publishing any official data on the disease until June 2021 when it recorded 509 infections, 183 recoveries, and 21 deaths.[4] In May 2021, the Government of Tanzania acknowledged the impact of the disease on public health and the economy. Since then, it put in place several control measures, put greater emphasis and expanding on existing differentiated service delivery models, like the 6 monthly dispensing of ARVs, to minimize the impact on grant implementation.

COVID-19 statistics (15.11.22)
- Cases – 40,152
- Deaths – 845

These included expanding differentiated service delivery models that encourage longer prescriptions, shorter clinic stays to reduce congestion, and the effective use of PPE. The highest number of cases was reported in July 2021 at 7,662. Between May 2020 to June 2021, country data on cases was non-existent (i.e., not reported).[5] In terms of vaccines, Tanzania has reached 42.1% doses per 100 people.[6]

[3] Sources: population, GDP, Health expenditure from data.worldbank.org; Transparency International 2021; UNDP Human Development Index; (Accessed on 15, November, 2022)
[4] One Article - *After a year of denial, Tanzania responds to COVID-19* – (https://www.one.org/africa/blog/tanzania-president-samia-suluhu-hassan-2/) (Accessed on November 15, 2022)
[5] United Republic of Tanzania WHO Coronavirus Disease – (https://covid19.who.int/region/afro/country/tz). (Accessed on 15, November 2022)
[6] Bloomberg Vaccine tracker – (https://www.bloomberg.com/graphics/covid-vaccine-tracker-global-distribution/). (Accessed on 15, November 2022)

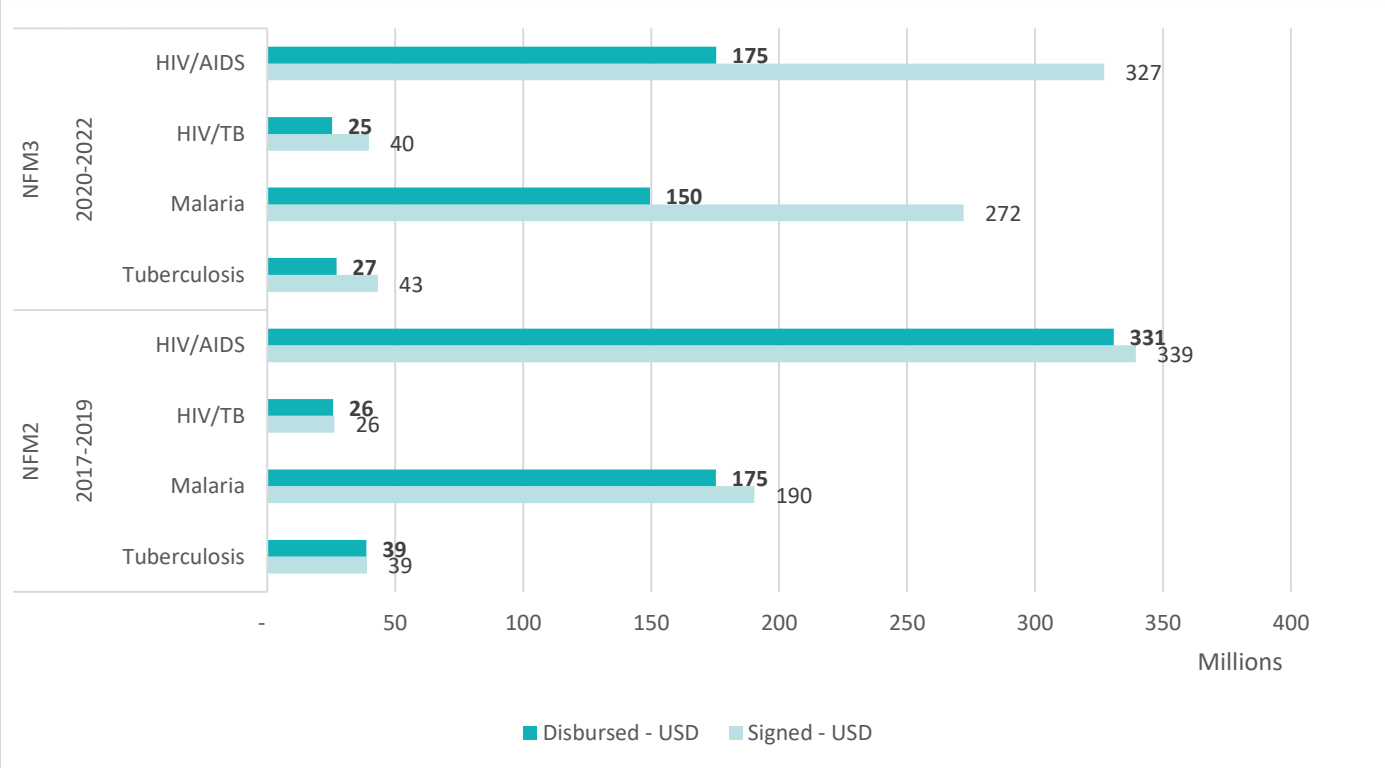
2.3 Global Fund Grants in Tanzania

Since 2003, the Global Fund has signed over US$3.2 billion and disbursed over US$2.8 billion to the United Republic of Tanzania. Active grants total US$682 million for the 2020-2022 Funding Allocation (January 2021 to December 2023 implementation period), of which 66% had been disbursed by 15 December 2022. This includes the C19RM 2021 award of $112m but excludes the in-country closing balances of $39m validated in the previous implementation period. Full details on the grants can be found at the Global Fund's Data Explorer.

Tanzania mandates that all international aid is channeled through the MOFP. Accordingly, the Ministry of Finance and Planning (MOFP) is the Principal Recipient for three of the grants, one for each of the three diseases – including RSSH – and implements 94% of the funding. The PR has established a 3-4 person Project Management Unit to support management of grant funds. MOFP disburses funds to the implementing sub-recipients, which are the Ministry of Health – housing a Global Fund Coordinating Unit that supports management of grants over the national programs – and the President's Office of Regional Administration & Local Government (PORALG). PORALG is responsible for the management and administration of public services at the regional and council level, and for supporting the delivery of services at the health facility level.

Amref Health Africa, an international non-government organization implementing the combined TB/HIV grant, is the second PR. This grant includes the community component for the TB response, and HIV key population interventions, including for AGYW.

Figure 2: Funding allocations, prior and current funding cycles (as of 15 November 2022)[7]



Approximately 75% of grant funding goes towards procuring medicines and health products in NFM3. The central medical store, Medical Stores Department (MSD), is responsible for storing and distributing these commodities to grant beneficiaries.

[7]The Global Funds Data Explorer website

2.4 Disease Burden

HIV / AIDS	TUBERCULOSIS	MALARIA
An estimated 1.7 million people are living with HIV, of whom 88% know their status, compared to 89% in the region. Among identified PLHIV, 86% were on treatment (77% in region) and 83% have suppressed viral loads (70% in region). **Annual new infections decreased by 55%** from 100,000 in 2010 to 54,000 in 2021. **AIDS-related deaths decreased by 60%** from 73,000 in 2010 to 29,000 in 2021. **Weaker results for adolescents** seen in the UNAIDS 95-95-95 cascade at 65-65-43**.** *Source:* UNAIDS – Tanzania fact sheet 2021	Tanzania is among **30 high-burden TB and TB/HIV** countries globally. **TB estimated cases decreased by 39% between 2011 and 2021** (from approximately 183,000 in 2010 to approximately 132,000 in 2021). **TB estimated deaths decreased** by 75% between 2011 and 2020 (from 39,000 in 2011 to 9,800 in 2020). **GeneXpert testing has expanded** from 76 in 2016 to 259 platforms in 2020. **High TB treatment success rates,** exceeded by 90% for DSTB and exceeded by 70% for MDR-TB during 2015-2019. *Source:* Global TB Report 2021 and WHO data	Tanzania is among the **20 countries with the highest malaria incidence** (10th) and mortality (8thglobally. It has 3% of the global malaria case burden. Malaria **cases have remained stagnant** since 2016 **Estimated malaria-related deaths decreased by 70%,** from 6,315 in 2015 to 1,909 in 2021. *Source:* World Malaria Report 2021

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

NFM 2 Allocation (2017-2019)

Comp	Grant	Principal Recipient	Total Signed (USD)	Disbursement[8] (USD)	(%)	Jun20	Dec20
	TAZ-H-MOFP	Ministry of Finance and Planning of the United Republic of Tanzania (MOFP)	339,399,279	330,742,963	98%	B1	B1
	TAZ-T-MOFP	MOFP	38,977,405	38,703,772	97%	A2	B1
	TAZ-M-MOFP	MOFP	190,295,807	175,296,417	92%	A1	B1
	TAZ-C-AMREF	AMREF Health Africa	26,224,876	25,782,958	98%	A1	A1
TOTAL			594,897,367	570,526,109	**96%**		

NFM 3 Allocation (2020-2022)

Comp	Grant	Principal Recipient	Total Signed (USD)	Disbursement (USD)	(%)	Jun21	Dec21	Jun22
	TAZ-H-MOFP	MOFP	326,967,276	206,656,330	63%	B1	C	
	TAZ-T-MOFP	MOFP	43,232,655	29,886,582	69%	B1	C	
	TAZ-M-MOFP	MOFP	272,116,894	178,656,732	66%	B1	C	
	TAZ-C-AMREF	AMREF Health Africa	39,676,760	32,680,013	82%	B1	C	
TOTAL			681,993,585	447,879,657	**66%**			

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels covered in the audit objectives for the Tanzania portfolio, with the residual risk that exists based on OIG's assessment, mapping risks to specific audit findings.

Audit area	Risk category	Secretariat aggregated assessed risk level (March 2021)	Assessed residual risk based on audit results	Relevant audit issues
Program quality	HIV	**Moderate**	**Moderate**	Finding 4.2
	Malaria	**High**	**High**	Finding 4.1
M&E	Data availability and data quality	**Moderate**	**Moderate**	Finding 4.1 and 4.2
In-country governance	In-country governance	**High**	**High**	Finding 4.4
Procurement and supply chain management	In-country supply chain	**High**	**High**	Finding 4.3
Financial assurance framework/mechanism	Grant-related fraud and fiduciary risks	**High**	**High**	Finding 4.4
	Accounting and financial reporting	**High**	**High**	Finding 4.4

The full risk appetite methodology and explanation of differences are detailed in Annex B.

[8] The portfolio absorption figures below/above are based on total disbursements processed for the 2020-2022 Implementation Period as of 15 December 2022, against the total signed amounts.

4. Findings

4.1 Slow progress in achieving malaria grant objectives due to delays in vector control and challenges with case management

Malaria program slow progress in achieving malaria grant objectives due to the delays and the incorrect quantification of needed LLINs for mass campaigns and routine distribution, limited community case management and discrepancies in ACT usage.

Malaria is one of the leading causes of death and disease in Tanzania. The country has the tenth highest level of estimated malaria incidence and the eighth highest estimated mortality rate in the world.[9] Solid progress has been made overall in the fight against the disease with the estimated malaria-related deaths decreasing by 70% between 2015 and 2021. But, while the trajectory is positive, the country has fallen short of its ambitious targets, especially in reducing prevalence.

The country has an ambitious National Malaria Strategic Plan (NMSP) 2021-2025 based on the sub-national malaria risk stratification conducted in 2020. The result has been the development of more targeted and tailored interventions including multiple distribution channels for LLINs, including mass replacement campaigns and targeted routine distribution for vulnerable groups. There is constant availability of malaria commodities (ACTS and mRDTs) at service delivery points, ensuring access for beneficiaries. However, despite solid interventions and this availability of commodities, the impact of the malaria program has been limited by implementation challenges on key activities.

Low coverage and use of LLINs contribute to stagnant malaria morbidity and prevalence

There is an estimated 52%[10] national coverage of LLINs, below the NMSP target of 80%. Usage of the available LLINs is estimated at 49%[11] against a performance framework target of 70%, with use for pregnant women at 29%. This sub-optimal access to LLINs has been linked to the following operational challenges in the roll out of both mass and routine distributions:

Delays in starting the Mass replacement campaign
There were delays in conducting the Mass Replacement Campaign (MRC), set to begin in August 2019, but only started in May 2020. This delay was due to the protracted local procurement processes for LLIN transport, electronic tablets for household registrations and the printing of guidelines and other campaign materials. In addition, the program did not follow their macro-plans to guide the campaign roll-out, including the mitigating actions, such as early procurement and development of micro-plans, which are based on lessons learnt from the previous 2015-2017 mass campaign.

Missed routine distribution targets for pregnant women, children in schools and vulnerable groups
There were gaps in LLIN distribution for pregnant women and children under five, with 42% of nets distributed against target.[12] The distribution guidelines states that LLINs should be given to vaccinated children, and in turn a shortage of vaccinations led to front-line staff stopping supplies of nets to unvaccinated children.[13] The School Net Program (SNP) also had significant delays in distribution. The SNP distribution channel aimed to distribute 1.5 million LLINs across ten regions in 2021. However, by June 2022, only 0.8 million nets had been distributed across one region. The LLINs allocated to the school net program were diverted to cover the MRC. This is due to the MRC having a shortfall in quantities based on inaccurate assumptions used for forecasting.

[9] World Malaria report 2021, World Health Organization
[10] 2021 Malaria behavioral survey highlighting access to ITN for one net to two people
[11] 2021 Mobile Phone Monitoring of Malaria Vector Control analysis
[12] 0.8m nets distributed against a target of 1.9m
[13] The Programs Operational Research Report of July 2021 stated that unavailability of MR vaccine led to halt of providing ITNs

Social and behavior change communication challenges impact use of LLINs
National surveys highlighted gaps in knowledge and understanding of LLINs especially around the benefits of appropriate use.[14] These gaps can be attributed to underfunded social and behavior change communication activities in country with only 20% of financing received against budgeted need.

Overall, due to the above, there has been slow progress in reducing malaria morbidity and prevalence. The estimated malaria incidents stagnated at around 6 million between 2017 and 2020.

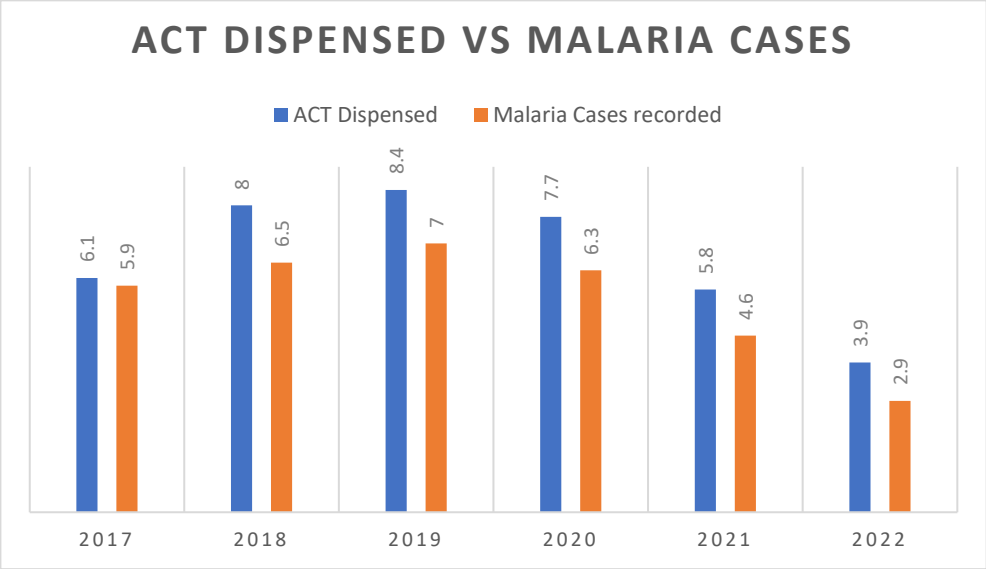
Sub-optimal community case management results in lost opportunities to increase programmatic impact

Community case management aims to support underserved communities in high and moderate risk areas with improved access to malaria testing and treatment. However, as of October 2022, only 10 councils out of the planned 64 (16%) had completed the roll out, despite being required to do so by the end of 2021. This was due to the delayed approval of the protocol for allowing community case management to be implemented in the country.

Under this protocol, approved in June 2021, the malaria intervention should be carried out by the Community Own Resource Persons (CORPs) who are trained healthcare staff, thereby preventing of the engagement of community health workers. As a result, there were only 78 CORPs covering 273 eligible villages, limiting the ability to further maximize testing and treatment coverage in country.

ACTs dispensing and recording variances lead to risks of wastage, poor traceability, irrational use and diversion

The number of ACTs dispensed has routinely exceeded the confirmed malaria cases as per HMIS records.[15] The previous OIG audit (2018) highlighted similar discrepancies.[16]



The root causes of the aforementioned discrepancies are diverse, and several contribute to the overall variance as outlined below.

Issuance of ACTs without a malaria test or negative results risk misdiagnosis of beneficiaries and drug resistance
From the sites visited by the OIG, 47% (7 out of 15) prescribed ACTs without a confirmed malaria test or with a negative result, despite the availability of rapid tests. In total 19% of patients issued with ACTs lacked either a parasitological test or had a negative test result in the visited facilities. This is due to the lack of supervision by senior staff within the health facilities, as well as an absence of effective supervision recommendation follow-up by the national program.

[14] Malaria Behavioral Survey (2021) and Mobile Phone Monitoring of malaria Vector Control (2021)
[15] Per DHIS2 which is the national HMIS aggregate data system for malaria and HIV
[16] The 3.9M for 2022 represented Jan-Sept 2022, some facilities changed their reporting unit from doses to tablets following a request from MoH. It gave an initial number of 6.9m ACT dispensed and further increased the variances between reported ACTS dispensed and malaria cases to 120%. Further analysis had to be conducted by the national malaria program to correct for this reporting error.

Challenges in the availability, completeness and accuracy of ACT dispensing data
Data challenges impact the ability to effectively analyze the cause of the variances. Health facilities are not required to report the dispensing data monthly, limiting the ability of the national program to make data-informed decisions. While before 2021, ACT stock movement data was used as a less accurate proxy data point, from 2021 onwards, dispensing data was reported from the health facility level. In addition, 11% of visited health facilities did not have systems capable of reporting ACT consumption. Challenges in ACT traceability were also noted by the OIG, this is further detailed in finding 4.3.

The above weaknesses affected the control environment of ACTs, creating a risk of wastage, as well as irrational use that can lead to drug resistance and could mask red flags or other warnings regarding stock diversion.

Variances in malaria data impact effective program decision making

The OIG review of programmatic data across 15 health facilities showed over-reporting of confirmed malaria cases by at least 15% in nine of the 15 sites, and infants who received LLINs by 68% in all of them.

At all 15 sites visited by the OIG, evidence of review and approval of submitted data by supervisors or spot checks on reported data was not available. Despite requirements for all regional and council sites to be reviewed at least once a year, data quality assurance was only conducted for 18% and 21% of sites in 2020 and 2021 respectively for the seven Councils reviewed by the OIG.

At the national level, there were functionality issues with DHIS 2 in 2022, preventing the national programs from properly reviewing data accuracy.[17] In addition, coverage of national assessments of data quality (DQAs and MSDQIs[18]) was low, with only 12 conducted out of the planned 26 regions. For all sites visited where DQAs or MSDQIs took place, there was no subsequent change to the data in the national system or any follow up to ensure corrections were made to reported results.

Constraints in human resources, especially at the point of service delivery, were a cross-cutting root cause for the poor data quality. Staffing was at 53% of required levels at sites visited by the OIG. This increases the level of workload on the existing staff, who are required to record patient data in multiple tools and systems[19] due to system fragmentation and the lack of interoperability between data platforms.

Agreed Management Action 1
The Global Fund Secretariat will work with the Ministry of Finance and Planning (MoFP) and the Ministry of Health (MoH) to: A) Design and implement a roadmap to address issues and root causes identified with the reporting, monitoring and use of ACTs, including variances between HMIS and LMIS data. B) Operationalize the roadmap, as stipulated in part A.
OWNER: HEAD OF GRANT MANAGEMENT DIVISION
DUE DATE: PART A: 31 December 2023 & Part B: 31 December 2024

[17] Issues were noted with exception reporting in the data quality module that were being reviewed by the regional DHIS2 network [18] National data quality assessments and the Malaria Service Data Quality improvement (MSDQi) application

[18] National data quality assessments and the Malaria Service Data Quality improvement (MSDQi) application

[19] Lab Information systems, Private sector systems, eLMIS, GoTHoMIS, Afya care in total 6 data staff in the 15 HFs we visited

4.2 Suboptimal prevention implementation and ART attrition monitoring hinder progress on UNAIDS fast track goals

Strong programmatic progress towards 95-95-95 is threatened by suboptimal implementation of prevention activities for key vulnerable populations, with gaps in monitoring patient attrition.

Tanzania has demonstrated strong progress towards achieving the UNAIDS 95-95-95 cascade, having achieved 88%-86%-83%[20] which is ahead of the worldwide and regional average. It has reduced the number of new HIV infections by 85% and AIDS-related deaths by 60% between 2010 and 2021.[20] In 2019, the Government of Tanzania approved key innovations such as HIV self-testing to improve testing reach. No material issues were noted with the data quality of key HIV indicators[21] at sites sampled by the OIG. However, continued programmatic progress is hindered by challenges with monitoring HIV attrition and in implementing key prevention activities.

Lack of clarity in the number of HIV patients lost to follow up including patient transfers

OIG observed weaknesses in the effective tracking and monitoring of patients on anti-retroviral therapy who are lost to follow up (LTFU) or transferred between facilities, posing a threat to further progress. From the 15 visited sites, there were disparities in the number of LTFU cases recorded across different systems with 9,941 LTFU cases recorded in DHIS2[22] against 76 in CTC 2, with CTC 2 as the system point of reference. When comparing CTC 2 records against primary registers and tools, the total LTFU reported was 432 LTFU cases. This contributes to the uncertainty around the final number of HIV patients that are lost to follow up, affecting the program's ability to make informed decisions.

The lack of an approved national LTFU register at health facilities is problematic. Patient tracking registers should be used but these were missing in 11 out of 15 (73%) of sampled sites. The definition of who should be considered as LTFU was also not uniform across sampled sites, compounding issues on how LFTU is recorded and when.[23] There was no evidence on training on treatment adherence and follow up in 7 out of 15 (47%) of sampled sites. Evidence of dedicated tools to track or report patients being transferred in, out and/or re-initiated was not noted at any sampled sites and the lack of an overall national biometric unique identifiers also inhibits effective tracking across facilities. Another contributing factor was the shortage of healthcare human resources, which remain at around 50% of the actual need.[24] This low capacity coupled with manual recording and reporting processes, as well as multiple data entry systems, significantly increases the workload on the limited number of front-line staff and impacts quality of service.

Limited condom availability due to inadequate operational oversight reduces impact of prevention activities

Tanzania has a well-designed approach to improving condom access for both the general population, as well as for key and vulnerable groups. A diverse range of distribution channels was established, including condom champions, peer educators, and condom dispensing boxes at both health facilities and community hot spots. However, stock-outs of condoms were noted in 44% of sampled sites[25] with an average stock-out of 87 days in 2021. These stock-outs were due to challenges with local procurements and poor supplier performance management that resulted in delayed delivery. In addition, 65%[26] of boxes sampled were stocked out at the time of the OIG visit and seven could not be located. This is due to inadequate monitoring of boxes by District AIDS Council Coordinators, as well as by Global Fund intervention implementers.

[20] Tanzania UNAIDS data 2021
[21] OIG visited 15 HIV health facilities in 3 Regions and assessed the data quality of two HIV indicators, number of new clients positive (Provider Initiated Test and Counselling - PITC register) and number of new clients initiated on ART (last full quarter).
[22] DHIS 2 is the national Health Management Information System (HMIS) aggregate reporting system for HIV and CTC 2 is HIV case management system used at health facility level.
[23] As per the Care and Treatment Clinic Card, LTFU is defined when a patient has not been seen for 3 months (90 days) or more since las scheduled appointment show up while others use the PEPFAR guidelines used 28 days since las scheduled appointment.
[24] Health Sector Strategic Plan (July 2021 - June 2026) (HSSP V)
[25] 4 out of 9 health facilities tested for condom availability
[26] 33 out of 51 - 7 out of 12 (58%) condom dispensers at HF sites and 26 out of 39 (67%) condom dispensers at community sites not stocked at time of visit

Limited implementation of AGYW income generating activities in NFM3 affects targeted intervention impact

Prevention activities for key and vulnerable groups is a critical component of the fight against HIV in Tanzania. This group have higher prevalence rates and weaker progress in achieving 95-95-95 targets. Among HIV-positive females aged 15-24 years, 59% were unaware of their HIV status, 36% were aware and on ART, and the remaining 5% were aware, but not on ART.[27] Interventions included in both NFM2 and NFM3 – related to improving access to key services to AGYWs – increased access to behavior changing activity and education, as well as financial empowerment.

Release of funds to support AGYW income generating activities delayed
Under NFM3, an intervention was included to support up to 60,000 AGYW beneficiaries with training on entrepreneurship and to support them with funds to foster their economic independence. However, 22 months[28] after the start of NFM3 with circa 17,000 beneficiaries been trained, only circa 2,500 of these beneficiaries (5% of those targeted to be trained) have received seed funds for their projects. The main delay in the overall intervention is linked to complex arrangements led by different implementers. For instance, if one implementer is delayed, it affects the overall project rollout. Providing the seed funds to the participants was challenging because not everyone had the national identification documents required to open a bank account. The development of the intervention and the initial risk assessment did not identify these operational challenges at the design stage. At the time of the audit, there was no approved program acceleration plan to catch up on the delays incurred.

The intervention has already been downsized due to deficiencies in the data base used to target AGYW beneficiaries resulting in reduction of the AGYW target from 60,000 to 46,000 with US$ 1.5 million reprogrammed to other areas, thereby affecting AGYW opportunities to become economically independent.

Examples of overreporting of Adolescent Girls and Young Women (AGYW) Social and Behavior Change Communication activities and gaps in follow up for key services limits impact

A core prevention activity to support AGYW under the Global Fund grants is the provision of a comprehensive package of services to beneficiaries. This includes a core "Social and Behavior Change Communication" (SBCC) component provided by peer educators. There is also a subsequent vulnerability assessment, referral process and follow up of beneficiaries to other services.[29] However, in the OIG sample review of beneficiaries reached there was no evidence to confirm the AGYWs were provided with the full package of services. For example, in the sample of beneficiaries reviewed by the OIG, AGYWs were counted as reached with SBCC, when only six SBCC sessions were provided. The national guidelines state that beneficiaries should receive a minimum of ten sessions. In addition, while there was evidence of referral, there is no evidence of follow up of beneficiaries to key services such as STI screening, female contraception, family planning or Gender Based Violence (GBV) services. There are however effective systems in place for access to condoms and HIV testing. There were also issues with eligibility screening and linkage to pre-exposure prophylaxis (PrEP) across all sites visited.

The above was caused by a lack of adherence to the national guidelines by implementers, coupled with insufficient supervision by the Principal Recipient on quality of services. There is also a gap in the processes as there are no tools to effectively record and monitor follow up of beneficiaries to determine access to key services. These prevention activity issues contributed to stalling progress on achieving National Strategic Plan (NSP) targets for reducing new infections from 54,000 per year (2021)[30] to 15,000 by 2023 and to an increased risk of continued HIV transmission. This all has an impact on the accuracy of reporting to the Global Fund and adequate assessment of performance by implementers.

[27] The Tanzania HIV Impact Survey 2016-2017 (THIS)
[28] As of October 2022
[29] Other services include condoms, testing, STI, female contraception, family planning and Gender Based Violence services
[30] Tanzania UNAIDS data 2021

Agreed Management Action 2
The Secretariat will work with the MoH, MoFP and other key implementers to resolve the operational challenges identified in the audit relating to key prevention activities including: A) The development of clearer processes around routine condom distribution and dispensing B) Reviewing previous reporting for SBCC support to AGYW C) The development of catch-up plans for the provision of Income Generating Activities to AGYWs
OWNER: HEAD OF GRANT MANAGEMENT DIVISION
DUE DATE: 31 December 2024

4.3 Key commodities available for beneficiaries, but drug traceability and laboratory procurement and supply chain management (PSM) remain challenging

A continuous supply of ARVs & ACTs was noted at the health facility level, but weak inventory management systems, weak stock management and governance deficiencies resulted in issues with traceability of key commodities. While viral load products are available, significant issues in HIV lab PSM resulted in expiries and stock-outs of key lab consumables (CD4, hematology, chemistry reagents) which impacted services to beneficiaries.

Global Fund grants to Tanzania are heavily commoditized with US$458 million (75%) of NFM3 used to procure health commodities and equipment. In both the 2016 OIG audit and the 2018 follow-up, issues were noted with material expiries and commodity stock-outs that impacted services to beneficiaries. However, in 2022 OIG noted a significant improvement with no material stocks-outs or expiries for ARVs and ACTs. Tanzania has extended eLMIS systems down to the health facility level and established technical working groups to strengthen monitoring and oversight over procurement and supply chain management (PSM). Despite these key successes, there were significant gaps in commodity traceability, as well as systemic issues with laboratory procurement and supply chain.

Inadequate inventory management impacts visibility and tracking of ARVs and ACTs, leading to receipt and delivery of expired commodities

There were no challenges observed in tracing commodities between the central and zonal warehouses, However, at the health facility level, expected stock was not reconciled well with physical stock levels in 13 out of 20 (65%) sites. There were no records tracing commodity deliveries to dispensing points in 18 out of 20 (90%) sites, and there were discrepancies in tracing commodities to the final patient in all sites sampled (20 out of 20). These tracking issues were previously highlighted in OIG audits as far back as 2009.

Expired commodities were also being delivered and received at various levels of the supply chain. According to the central and zonal warehouse management system module in EPICOR 10, US$0.4 million of laboratory commodities were expired when accepted at the central warehouse during the audit period. There was evidence that five out of eight (68%) sampled commodity shipments between two zonal warehouses to health facilities were expired. The traceability and expired stock challenges stem from system weaknesses at the central and regional levels, weak stock management practices within health facilities and cross-cutting governance difficulties:

Inaccurate reporting from warehouse management system module in EPICOR 10 at central and zonal level
Medical Stores Department (MSD), which manages the PSM processes for Global Fund grants, use EPICOR 10 as their warehouse management system. The generated reports from EPICOR 10 on stock movement are inaccurate, with commodities issuance duplications affecting monitoring. The system has control weaknesses. For example, it does not require a secondary approval to issue stock from the warehouses or to enter stock adjustments. There have also been gaps in the past in preventing/flagging the acceptance and issuance of expired stock.[31] Complete documentation was also lacking to support commodity issuances to zonal and health facility levels.

Ineffective stock management at health facility level
There was limited oversight of registers and little capacity to support stock management within the health facilities sampled. In 16 of 20 (80%) sampled sites there were stock outs of inventory management tools such as dispensing logs, expiry tracker and bin cards. For 13 of 20 (65%) sites there was no evidence of PSM supervision visits from council or regional teams since January 2020. Like with other challenges outlined in the audit, the limited human resources impacted the effective management of stock with 50% of dedicated PSM positions at HIV facilities and 40% for malaria sites being vacant.

[31] From reviews of the system, a control was in place to flag expiries to users in October 2022 but there was no evidence from when this control was installed and operationalized.

Sub-optimal governance and oversight over key PSM issues
While there is an established PSM technical oversight body,[32] the effectiveness of governance and oversight activities are sub-optimal. This is due to low participation of key stakeholders – including MSD and members of the Global Fund Coordinating Unit (GFCU) – in meetings. The establishment of formal sub-committees for each program to discuss disease specific PSM issues was not complete at the time of the audit.

These weaknesses meant that 23% (US$268,000) of OIG sampled commodities could not be fully traced from the central level to final dispensing points to beneficiaries.

Significant issues in procurement and supply chain activities for laboratory consumables have resulted in expiries and stock-outs

The Global Fund has made considerable investments in laboratory services (equipment, consumables, and other support), with US$58 million and US$69 million budgeted under NFM2 and NFM3 respectively. However, there is no process to measure forecast accuracy for lab commodities, despite this being in place for other commodities like ARVs. In terms of inventory management, there are long delays in MSD's handling of laboratory commodities at the central level. From OIG's review of lab commodities, it took an average of 21 days to quality inspect goods after offloading (the maximum for one shipment was 73 days). It took an average of 77 days to physically verify goods (maximum for one shipment was 254 days). Steps in the physical verification process were missing, with laboratory commodities being physically verified and accepted after the expiration date based on physical records. There were also lapses in the monitoring, maintenance, and repair of laboratory equipment. Root causes for the above issues include:

- Lack of representation of key laboratory stakeholders,[33] such as the National Public Health Laboratory or National Laboratory Coordination Unit, in the national PSM technical oversight body. This inhibits the ability to ensure issues related to laboratory PSM are identified, escalated, and resolved.

- Lab supplier performance is in some instances weak, with an average delay of 4.5 months for key vendors to deliver reagents. Such delays are not effectively monitored or managed, as there is no evidence of any vendor performance appraisals despite national guidelines requiring contract compliance and enforcement officers to prepare frequent supplier performance appraisals.

- While there were initial efforts to map all laboratory platforms and create a nationwide standardized list of platforms, these initiatives have not been fully finalized, which impacts the forecasting and oversight of the full laboratory supply chain.

- There are limited human resources to support timely PSM management with only four lab specialists at MSD Central and one specialist for each zonal warehouse.

- In addition, the HIV program did not quantify or procure adequate reagents quantities due to limited number functional machines as the laboratory standardization has not been completed.

As a result of the above, the OIG noted expiries of lab commodities worth US$1.6 million at the central level and US$0.4 million at the health facility level.[34] In addition, there was significant equipment downtime in several sampled sites with no alternative. The average downtime for hematology[35] platforms was 184 days and 441 days for chemistry platforms.[36] There were also pervasive stock-outs of key consumables. For example, chemistry reagents were stocked out for an average 224 days in six of eight sites, CD4 cartridges stocked out for 104 days at all six sites and hematology reagents stocked out for 155 days at five of eight sites, affecting the quality of service provided to PLHIV.

[32] Health Commodities, Equipment and Technology technical working group (known as TW9)

[33] National Public Health Laboratory or National Laboratory Coordination Unit

[34] Expires noted at 4 out of 12 sampled sites

[35] Hematologic abnormalities are the most common complications of human immunodeficiency virus (HIV) infection being more pronounced during the late stages of the disease, thereby indicating the progressive nature of the disease. Anemia is the most frequent hematologic abnormality in HIV

[36] Speciation chemistry of drugs example of ARVs and drugs used in management of opportunistic infections.

Agreed Management Action 3
The Secretariat will work with the MoFP, MOH and MSD to strengthen supply chain management and oversight through: A) Replacing the current MSD warehouse management system with a new system that resolves the key issues with reporting and controls identified by the OIG B) Finalizing a harmonized list of standard lab equipment to support better PSM planning for lab services
OWNER: HEAD OF GRANT MANAGEMENT DIVISION
DUE DATE: 31 December 2024

4.4 Sub-optimal financial management under MOFP grants resulted in long outstanding advances, gaps in asset traceability and unsupported expenditure

Limited sub-recipient management and oversight under the Ministry of Finance and Planning resulted in financial management lapses and unsupported expenditure. Fixed asset management has strengthened but weaknesses remain, leading to moderate risk of misuse and traceability of assets.

A variety of implementers are supporting the implementation of grants in Tanzania. These include national and local government entities, national procurement and supply chain organizations, as well as international and local NGOs. In this context, robust sub-recipient and financial management is critical to ensure interventions can be delivered as planned. In Tanzania, this is the primary responsibility of Amref, as the Principal Recipient, and the two lead sub-recipients – under the MOFP – the Ministry of Health (MoH) and the President's Office of Regional Administration and Local Government (PO-RALG).

Amref has well-designed sub-recipient management policies, guidelines and procedures. The OIG observed appropriate monitoring and oversight, with timely supervision and feedback to sub-recipients and quick retirement of advances. At the time of the audit fieldwork, adequate financial controls were present, with no unsupported expenses or material irregularities found from the Principal Recipient's 2022 sampled transactions.[37] However, the MOFP lacked the robust implementation oversight through the two lead sub-recipients as described below.

Limited financial oversight and monitoring by lead sub-recipients under MOFP grant leads to unsupported expenditure, long outstanding advances and financial reporting errors

The OIG audit revealed weak controls and persistent issues in sub-recipient management, financial accounting and reporting, and fixed assets management under the Ministry of Finance and Planning grant.

Lack of effective oversight of sub-recipients and sub-sub-recipients
There was no evidence of financial reviews performed on the HIV and TB sub-recipients and sub-sub-recipients sampled[38] by the OIG. Capacity assessments were not undertaken for any sub-recipients for NFM2/ NFM3, and no sub-recipient agreements were signed for key implementers under the HIV program. Advances, which were provided to sub-recipients for the implementation of agreed activities were not retired in line with standard operating procedures. Further advances were issued without the requirement of 80% of prior advances being settled being met. There was a lack of advance aging analysis in the system, combined with a lack of clarity in the role key finance staff at the lead sub-recipient with regards to their financial management duties to oversee and validate sub-recipient & sub-sub-recipient financial information. These uncleared advances pose the risk of loss of funds due to the system's inability to monitor the clearance process.

Existing operating manuals do not reflect current implementation roles and responsibilities
The Grant Operations Procedures Manual for the MOFP grant is out of date. The roles and responsibilities around financial management and oversight still highlight the Principal Recipient (MOFP) as having the main responsibility, despite responsibility having been transferred to the lead sub-recipients as per signed grant agreements for NFM3.

[37] A historical process to pay participants through delegates was in place since AMREF became an implementer of Global Fund grants. It had been identified by the Principal Recipient's internal audit function as exposing the organization to financial risk including fraud. It was suspended and replaced by a mobile wallet payment system to strengthen financial controls. This mobile payment system was in place at the time of the OIG audit fieldwork.
[38] Eight sub-recipients and sub-sub-recipients under the HIV and TB grants out of eight (100% of implementers sampled by the OIG), evidence was provided for the two sub-recipients and sub-sub-recipients under malaria

Job descriptions of finance staff specify only key tasks regarding sub-recipient management and financial management, falling short of the overall terms of the GFCU
The job descriptions of key finance staff within the Global Fund Coordinating Unit (GFCU) in the Ministry of Health do not list key tasks, such as monthly finance reviews and the quarterly review of sub-recipient reports that are submitted to the GFCU manager. This is despite these tasks being included in the overall terms of reference of the GFCU unit.

Inconsistent approach to sub-recipient agreements and contracting under MOFP grant
Sub-recipient agreements that would cascade Global Fund requirements between MOFP and key government implementers under the HIV grant are not in place. There are no signed sub-sub-recipient agreements in place for the Tanzania Commission for AIDS (TACAIDS) or the Drug Control and Enforcement Authority (DCEA), which receive funding under the HIV grant for key activities. However, all government entities under the malaria grant had signed performance agreements with the Ministry of Health.

The above weaknesses in the overall financial and sub-recipient management control environment under the MOFP grant increase the overall risk. From OIG's review of the finance system, there were significant sub-recipient advances that have been outstanding for over 18 months under both the HIV and malaria grants, totaling US$1.6 million and US$2.3 million respectively.[39] There were also staff advances totaling US$0.2 million that were outstanding beyond the timelines set by the MOFP financial policy, which requires settling advances within 14 days compared to an average delay of 111. There was also inadequate support provided to the OIG for US$0.6 million (6%) of transactions out of US$10 million sampled by the OIG.

Gaps in strengthening fixed asset management under the MOFP grant lead to moderate issues relating to misuse and lack of physical verification of key assets

While there has been good progress in strengthening fixed asset management to safeguard Global Fund investments, incomplete recording was also observed. When reviewing the fixed asset register of the MOFP grant, the OIG was able to physically verify US$10 million worth of assets, out of US$17 million total assets in the fixed asset register, with no issues noted from the sample. However, US$0.9 million of assets bought during NFM3 were not included on the register, raising concerns over its completeness. In addition, deficiencies were noted in the process to ensure all assets procured under the Global Fund grants were insured, in line with grant requirements.

The incomplete recording, monitoring and insuring of assets was linked to systems, tools and oversight problems at the lead sub-recipient level and within MOH programs. The fixed asset register is not in an electronic database or financial management system, but instead in a Microsoft Excel spreadsheet, increasing risk of manual errors in recording as there are no formal controls on quality of asset data. There was also a lack of evidence of monitoring, oversight and coordination between finance staff within the MOH programs and the work performed by fixed asset focal points within the disease program teams that are responsible for recording and monitoring assets.

Due to the above, OIG was unable to track and physically verify 66% of assets sampled from this group of items procured using the grant funds, but not included in the register.[40] These assets included highly marketable assets such as electronic tablets for teachers to support the AGYW comprehensive sexual education program in schools. A limited number of these assets were not being used for their intended purpose, but rather for the use of senior management staff at a key sub-recipient. In addition, US$3.1 million assets, including IT equipment and vehicles were uninsured at the time of the audit fieldwork. [41] This opens the risk of assets becoming damaged or lost with no ability to replace without further costs to the grant.

[1] 4 out 4 sub-recipients and 4 out of 4 sub-sub-recipients sampled for HIV and TB Programs
[39] As of 30 September 2022
[40] 53 out of 80 tablets sampled for the HIV AGYW comprehensive sexual education program in schools (the asset value in USD$ at risk amounts to USD0.5m if extrapolated across the entire asset class)
[41] As of 2 October 2022

Agreed Management Action 4
The Secretariat will work with the MoFP to: a. Clarify core financial management roles and obligations, key financial controls, and define oversight activities and responsibilities. b. This will also include defining sub-recipient sub-agreements to include key responsibilities and obligations. The subsequent revised requirements and definitions will be cascaded from MOFP to key government implementers under each MOFP grant. c. Operationalize monitoring and oversight, as stipulated in part a.
OWNER: HEAD OF GRANT MANAGEMENT DIVISION
DUE DATE: PART A: 31 December 2023 & Part B: 31 December 2024

Annex A: Audit Rating Classification and Methodology

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, 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.

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**.**

Annex B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 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.

For country audits of High Impact and Core countries, OIG assesses residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which 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 to the United Republic of Tanzania

OIG and Secretariat risk levels are aligned with no variances noted for any risks or sub-risk categories.