



Audit Report

Global Fund Grants to the Republic of Mozambique

GF-OIG-17-006
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I. Background

Country context

Mozambique is a low income country with a population of 27.98 million¹ and gross domestic product of US\$14.67 billion as of 2015. The country is ranked 180 out of the 188 countries in the 2015 United Nations Development Program (UNDP) human development index report.² Transparency International's 2016 Corruption Perceptions Index ranked the country at 142 out of a total of 176.

With a government allocation of approximately 9%³ of total budget to the health sector, the country is heavily reliant on external development partners to fund public health interventions. A health sector common fund (ProSaude) is supported by donors such as Ireland, the Belgium Technical Cooperation, the Swiss Development Cooperation and Canada. The United States Government and the Global Fund are the largest donors, financing HIV, TB and malaria interventions.

The country is currently facing challenges with a depreciation of the local currency and ongoing conflict in Zambezia, Nampula and Sofala provinces. Economic and social conditions have deteriorated with the International Monetary Fund and development partners suspending financial aid to Mozambique in April 2016, as a result of undisclosed debts.⁴

Human resources for health are severely constrained with 1.74 health workers per 1,000⁵ compared to a minimum of 2.5 per 1,000 as recommended by the World Health Organization (WHO). Mozambique's health infrastructure has been devastated by decades of war. The health facility network remains inadequate for the size and distribution of the population despite significant rebuilding. There were 17,585 inhabitants per health facility in 2015.⁶ Health expenditure per capita, at US\$42, is the lowest in the region, well below the US\$60 recommended by WHO.⁷ The funding provided to the health sector by the Government of Mozambique is primarily spent on health human resources and other recurrent expenditures.⁸

The National Health System is decentralized across the 11 provinces, 30 municipalities and 157 districts. The Ministry of Health sets the strategic direction and policy for the health sector. The Provincial Health Directorate provide technical policy and oversight to districts and provincial hospitals, whilst districts oversee health facilities.⁹ The national disease programs are responsible for developing their specific strategies and guidelines. The country has approximately 1,591 health facilities and rural hospitals. There are about 3,500 health workers providing services at the community level.

The three diseases in Mozambique

HIV

WHO estimates that 1.6 million people are living with HIV in Mozambique. This places the country among the top four globally and accounts for 5% of the global disease burden. HIV incidence rate reached its peak in 2001 (1.81%) and decreased to 0.98% at the end of 2013. UNAIDS estimates the adult prevalence at 10.5%.¹⁰ There are substantial regional variations in HIV prevalence ranging from 25.1% in the southern provinces to 3.7% in the northern provinces. The country has made the following progress in the control and treatment of HIV and AIDS:

¹ World Bank Country Profile, <http://data.worldbank.org/country/mozambique>

² 2015 UNDP Human Development Report

³ JANS Assessment of the Mozambican Health Sector Strategic Plan 2013

⁴ <https://www.imf.org/external/np/sec/pr/2016/pr16184.htm>

⁵ Mozambique Ministry of Health Annual Human Resources Report 2015

⁶ World Bank Country Profile, <http://data.worldbank.org/country/Mozambique> (population) and DHIS facility data (2016)

⁷ World Bank Country Profile, <http://data.worldbank.org/country/Mozambique>

⁸ UNICEF Mozambique Health Report 2014 and 2015

⁹ Mozambique Concept Note HIV/TB October 2014

¹⁰ <http://aidsinfo.unaids.org/>

- From 2000 to 2014, the HIV death rate decreased by 9%, and the HIV incidence has declined by 57%.¹¹
- The number of people on antiretroviral treatment has increased by over 40% from 646,312 to 922,054 (2013 to 2016);
- There is universal knowledge of HIV status among pregnant women receiving antenatal services and among People with TB;¹² and
- Over 87% of HIV positive pregnant women receive antiretroviral treatment to reduce the risks of mother to child transmission.

Malaria

Mozambique shares 3% of the global burden and is ranked 6th in the world. Malaria is endemic throughout the country and the entire population is at risk with a peak during the rainy season from December to April. Progress has been made in reducing malaria related deaths. Malaria related deaths decreased by 74% between 2000 and 2014.¹³ Malaria incidence has also decreased by 37%.¹⁴ The country has universal access to diagnostic testing and the treatment of uncomplicated malaria. As of the time of the audit (October 2016), with the support of the Global Fund, the country had started a universal distribution of bed nets to prevent malaria infections.

Despite the progress, the malaria burden remains high; WHO estimated incidence was 335 per 100,000 in 2015.

Tuberculosis

Mozambique has the third and fourth highest TB incidence and prevalence rates, respectively, among WHO's 22 high burden countries. The TB related death rate decreased by 25%, and the incidence increased by 5%¹⁵ from 2000 to 2014. For multi-drug resistant TB, 2,800 cases are estimated to occur annually.¹⁶ WHO estimates TB prevalence for 2015 at 551 per 100,000 population,¹⁷ which has remained stable in recent years. With the support of the Global Fund and partners, the TB treatment success rate has increased to 89%.

At the time of the audit, the country was planning its first national TB prevalence survey. This is expected to provide a more updated and accurate picture of TB in Mozambique.

Global Fund support in Mozambique

In total, the Global Fund has signed 17 grants amounting to US\$0.9bn, out of which US\$664 million has been disbursed as of September 2016. There are six active grants amounting to US\$529 million with US\$222 million disbursed to the three Principal Recipients as of September 2016. The country is implementing a dual track financing mechanism. The Global Fund has opted not to be part of the health sector common fund (ProSaude) since 2011.

The Ministry of Health is the public sector Principal Recipient and there are two Non-Governmental Organizations – World Vision and Fundação para o Desenvolvimento da Comunidade (FDC):

- The Ministry of Health (MISAU) is responsible for the HIV, TB and malaria grants in the public sector with total budgets of US\$445m. It also implements the Health systems strengthening grant with a budget of US\$16.8m.
- Fundação para o Desenvolvimento da Comunidade (FDC), a local non-governmental organization implements HIV and TB activities at the community level with a budget of US \$22m.

¹¹ World Bank Country Profile, <http://data.worldbank.org/country/mozambique>

¹² Universal is defined by WHO as over 90%

¹³ World Bank Country Profile, <http://data.worldbank.org/country/mozambique>

¹⁴ Mozambique Concept Note October 2014

¹⁵ World Bank Country Profile, <http://data.worldbank.org/country/mozambique>

¹⁶ WHO Global TB report 2016

¹⁷ World Health Organization, Tuberculosis country profiles,

https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=MZ&LAN=EN&outtype=html

- World Vision, an international Non-Governmental Organization, manages a malaria grant with a budget of US\$45m.

Approximately 84% of Global Fund grants to Mozambique are spent on the procurement of medicines and health products. Medicines and health products are procured through the Secretariat's Pooled Procurement Mechanism and Global Drug Facility. Warehousing and distribution of medicines and commodities are decentralized in Mozambique. Central de Medicamentos e Artigos Médicos (CMAM), a department of the Ministry of Health, stores and distributes medicines up to the provincial level. The provincial health departments distribute medicines to the district warehouses. The facilities/hospitals receive medicines from the district or provincial warehouses.

In terms of risk mitigations, the commoditization of the grants aims to reduce the amount of funds disbursed directly to the country, estimated to be 16% of the total portfolio budget. The Global Fund has instituted measures to further reduce fiduciary risks on the portfolio including the Local Fund Agent's quarterly review of expenditure and verification of procurement processes before contracts are signed.

The last OIG audit of the portfolio in 2012¹⁸ highlighted weaknesses in the capacity of the Ministry of Health. There were key actions on improving the quality of service delivery, procurement efficiency and reliability of data for decision-making. The country has addressed some of the issues related to supply chain. However, some capacity weaknesses at the Ministry of Health and quality of service delivery issues remain unresolved.

¹⁸ Country audit report on grants in Mozambique (OIG report numbers GF-OIG-11-018)

II. Scope and Rating

01 Scope

The audit sought to provide reasonable assurance over whether the:

- (i) grant implementation arrangements are adequate, efficient and effective to achieve the grant objectives; and
- (ii) controls and assurance mechanisms within the supply chain are adequate and effective to ensure the availability of quality assured medicines and health products to patients.

The audit covered grants implemented by two Principal Recipients - The Ministry of Health of the Republic of Mozambique and Fundação para o Desenvolvimento da Comunidade (FDC) - and their sub-recipients from January 2014 to June 2016. The Ministry of Health is responsible for HIV, TB, malaria and Health System Strengthening grants while the FDC manages HIV/TB grant.

The OIG visited principal and sub-recipients, as well as a sample of 19 sites across five provinces in Mozambique; these sites included warehouses and health facilities. The auditors engaged with in country partners during the audit planning and fieldwork stages.

This audit did not cover procurement activities undertaken by the Global Fund's Pooled Procurement Mechanism or the malaria grant for which World Vision is the Principal Recipient. The World Vision grant was not covered by the audit due to its relatively low risks compared to the other grants. The OIG did not perform a detailed expenditure verification for Global Fund grants because the Secretariat has engaged the Local Fund Agent to review 80% of financial transactions every quarter. These reports were reviewed by the OIG.

02 Rating

Operational Risk	Rating	Reference to findings
Grant implementation arrangements are adequate, efficient and effective to achieve the grant objectives	Need Significant Improvement	1.1, 1.2, 1.3, 3 and 4
Controls and assurance mechanisms within the supply chain are adequate and effective to ensure availability of quality assured medicines and health products to patients	Need Significant Improvement	2.1 and 2.2

III. Executive Summary

Mozambique is one of the Global Fund's high impact countries, with US\$629 million earmarked for 2014-2017 funding cycle and almost US\$1 billion in signed grants since the creation of the Global Fund. As of 2015, Mozambique makes up 8.7% of the total number of people currently on antiretroviral therapy in the countries supported by the Global Fund, 1.21% of new smear-positive TB cases that are detected and treated, and 3.7% of the total number of bed nets distributed.

Implementation of health care interventions in Mozambique is affected by the limited availability of health workers, access to facilities and ongoing conflicts in certain parts of the country. The recent economic downturn and high inflation rates may affect the government's efforts to increase its health sector funding allocation.

This audit focused on the assessment of the effectiveness of the implementation arrangements in achieving grant objectives, and controls and assurance mechanisms within the supply chain.

Effectiveness and efficiency of implementation arrangements including oversight structures and mechanisms

Grants in Mozambique are implemented through the dual track financing mechanism which has increased coverage. The number of people on antiretroviral treatment increased by over 40% between 2014 and 2016 from 646,312 to 922,054. TB case notification rate increased by 26% (from 48,749 to 61,559) between 2013 and end of 2015. There is also universal confirmation of uncomplicated malaria before treatment. These have resulted in the reduction of mortalities related to the three diseases. A District Health Information System has been rolled out to make data available at all levels. However, there has not been a commensurate and consistent improvement in the quality of diagnosis and treatment of patients. This is due to ineffective oversight, coordination and management of the funded interventions.

Diagnosis: Proficiency testing conducted by the National Institute of Health in Mozambique indicates poor diagnosis of the three diseases. These tests are designed to ensure that providers make accurate diagnoses in line with WHO standards. Some providers of HIV testing failed proficiency testing, which increases the risks of incorrect diagnosis of patients. This means that there is the risk that HIV positive people may not get treatment and HIV negative people may be put on treatment unnecessarily. Accurate diagnosis is critical, especially for HIV, as the country implements a 'test and start' and Option B+¹⁹ programs where HIV positive patients are immediately initiated on antiretroviral treatment.

Treatment: The country continues to have low retention rates of patients on antiretroviral and multi-drug resistant TB treatments, despite increased coverage of interventions. Currently, only 66% of HIV patients remain on antiretroviral treatment 12 months after initiation. Similarly, 38% of the cohort of patients initiated on multi-drug resistant TB treatment either die, develop drug reactions or are lost to follow up after 24 months. The TB case notification and detection rates have also remained low despite the availability of grant resources to address the gaps.

Although the above issues are not unique to Mozambique, the country's retention rate of patients on antiretroviral treatment is the lowest in the region. The Secretariat has identified quality of service as a significant issue in its corporate risk register. The Global Fund is currently developing tools to proactively identify and address quality of service issues in its funded programs. Despite the limited availability of corporate tools to identify quality of service issues, the Mozambique Country Team has identified some of the above gaps and provided resources to address them. However, challenges

¹⁹ Option B+ is an approach for utilizing antiretroviral medicines to prevent mother-to-child transmission of HIV, also called perinatal or vertical transmission, which occurs when HIV is transmitted from an HIV-positive woman to her baby during pregnancy, labour and delivery, or breastfeeding.

in the implementation arrangements have delayed execution of measures to address the systemic issues as follows:

Oversight mechanism: The Country Coordinating Mechanism has been strengthened through technical assistance program supported by the United States Government. The Country Coordinating Mechanism engages with in-country stakeholders to secure funding from the Global Fund but it does not effectively oversee implementation of the grants. There is limited engagement of senior management of the Ministry of Health in the mechanism's activities. Actions agreed at its meetings are not followed up for implementation. At the Ministry of Health level, senior management do not regularly oversee implementation of the grants and resolution of identified challenges.

The infrequent and inconsistent coordination of ten implementing agencies within the Ministry of Health has resulted in delays in key activities. There is also duplication of activities for key affected populations by different donors and the Global Fund.

The Project Management Unit responsible for the coordination of the Global Fund grant at the Ministry of Health lacked the required technical, managerial capacity and resources to ensure the effective implementation of the grant. This has delayed the implementation of activities to address identified programmatic challenges. Due in large part to this weak implementation capacity, only 25% of funds disbursed to the Ministry of Health has been used. Moreover, weak financial management of the funds disbursed to the country resulted in a potential exchange loss of US\$4 million to the grant due to the depreciation of the local currency.

The Global Fund Secretariat has increased its engagement with in-country partners and the implementers through regular visits to the country. It also identified some of the challenges raised in this audit report and instituted measures to address them. However, there are potential areas of improvement within the Secretariat's management of the portfolio to ensure resolution of some of the issues identified. For instance, the Ministry of Health's grants included agreed actions required to be met by the implementer before funds could be disbursed. One of the agreed actions has been outstanding since 2013. This has delayed the implementation of grant activities to improve quality of service delivery.

The country has made significant progress in the past few years in its fight against the three diseases. However, the significant weaknesses at the Ministry of Health and in the Country Coordinating Mechanism are fundamental to effective grant implementation and oversight. The implementation arrangements of the grants are therefore rated as **need significant improvement**.

Controls and assurance mechanisms within the supply chain

With 84% of funds allocated to the procurement of medicines and health products, commoditization of the grant for the three diseases has ensured the availability of drugs in the country. The Government pays for in-country distribution costs for medicines and health products procured under the grants. The Country Team engages the Local Fund Agent to conduct routine reviews of certain aspects of the supply chain, including tracking of commodities, which contributed to improved reconciliation of inventories at facilities. CMAM has been supported by Global Fund and partners to institute controls to improve distribution of medicines since the last OIG audit in 2012. This includes the development of Key Performance Indicators to monitor CMAM's performance.

The supply chain is able to distribute medicines but gaps exist in storage, distribution and logistics management systems, creating inefficiencies.

Storage: There is insufficient physical space and inadequate measures to monitor and control the temperature of storage rooms. All the warehouses visited were overfilled with products, exceeding recommended storage density levels several times, according to WHO guidance. The storage conditions cannot support planned scale-ups under the three diseases, especially with the

commencement of HIV ‘test and start’, which is estimated to increase the volume of medicines by 76%.

Distribution: The HIV program generally distributes medicines through a pull mechanism based on requests from facilities. However, the mix of push and pull distribution mechanisms are used under the TB and malaria programs across the supply chain. The related inefficiencies result in stock-outs at certain levels of the supply chain while other places experience expiries.

Logistics Management Information Systems: The country has put in place initiatives to improve its information systems since the last OIG audit. However, the existing systems used to collect distribution and consumption data have not been effectively integrated to provide reliable information for supply planning. The country has consistently reported variances between the distribution and consumption data of medicines, which are yet to be resolved.

In country quality assurance mechanisms: Medicines and health products under the grants are procured through the Pooled Procurement Mechanism and Global Drug Facility from WHO prequalified suppliers. There are limited in-country mechanisms to routinely monitor quality of medicines across the supply chain in line with Global Fund requirements. There is no WHO prequalified laboratory or ISO 17025 certified laboratory in Mozambique to quality assure medicines procured. The Global Fund has earmarked resources to enable the country to secure services from WHO prequalified laboratories outside the country, but the procurement processes are yet to be completed. The storage and distribution conditions in the country require routine monitoring of the efficacy of health products across the supply chain.

The gaps contributed to stock-outs and expiries across the supply chain. Stock-outs of varying magnitude were noted at all levels, with the situation worsening at the lower level of health facilities. Although the Ministry of Health instituted measures to report expired medicines as recommended by the OIG during the 2012 audit, they were not consistently implemented across all levels of the supply chain. With the limited information available, the audit noted expiries of US\$1 million.²⁰ The expiries could potentially be significantly higher if they were consistently recorded by the national program and CMAM.

Accountability and ownership of the supply chain network are split across the administrative levels of the country. This has resulted in a lack of holistic oversight of the overall supply chain network. A supply chain strategy developed by the Ministry of Health to address the above gaps has not been operationalised. Activities in the strategy have not been prioritised and costed. The Ministry’s protracted procurement processes impact effective utilisation of resources provided by donors to address supply chain related issues. The Global Fund earmarked US\$ 7.6 million under the health systems strengthening grant to address some of the supply chain challenges, but activities have not been completed since 2013. Therefore the controls and assurance mechanisms within the supply chain **need significant improvement.**

²⁰ Expiries of US\$ 0.8 million at the central level, at visited provincial warehouses of US\$81,414 and at visited facilities for US\$22,670 as of September 2016.

IV. Findings and Agreed Management Actions

01. Quality of health services under funded programs

1.1 Quality of service delivery has been affected by delays in implementation of measures.

The Global Fund, together with partners, has supported the scale-up of HIV, TB and malaria interventions in the country. For instance, over 890,000 people are on antiretroviral treatment, 89% of identified TB cases are successfully treated and over 95% of malaria cases in health facilities are treated after confirmed diagnosis. However, there have not been commensurate improvements in the quality of services to patients.

Suboptimal diagnosis under the three diseases: Accurate diagnosis is a fundamental component of service delivery under the funded programs. The number of diagnosis made under the three diseases increased²¹ during the audit period. However, many of the service providers failed proficiency testing conducted by the National Institute of Health, the entity responsible for External Quality Assurance²²:

- (i) The proportion of service providers who failed the proficiency tests, that is did not provide accurate diagnosis in line with WHO standards, is high across the various service delivery points: HIV tests at community level (17%), TB test centres (14%), Prevention of Mother to Child Transmission (PMTCT) sites (13%), blood banks (5%) and clinical laboratories (4%);
- (ii) 34% and 20% of providers conducting malaria diagnosis with microscopes and rapid diagnostic tests (RDTs), respectively, failed the proficiency tests; and
- (iii) 14% and 22% of those conducting TB diagnosis with microscopes and GeneXpert tests, respectively, did not pass the proficiency tests.

Failure of proficiency tests increases the risk of false diagnosis provided to patients. Inaccurate diagnosis at blood banks could also result in transfusion of HIV infected blood to HIV negative patients. Accurate diagnosis is extremely important especially for HIV as the country implements the 'test and start' and Option B+²³ programs where those diagnosed with HIV are immediately initiated on anti-retroviral treatment upon retesting.

A primary cause for these low proficiency levels is the lack of effective training and supervision for service providers. The Global Fund's active grant has provided resources to improve the quality of diagnosis under the TB program. The Ministry of Health procured the diagnostic machines under the grant, but the related training and supervision activities are yet to be completed. Similar activities are not included in the HIV and malaria grants.

Poor retention of patients on antiretroviral and multi-drug resistant TB treatment: Retention on treatment is required for effective clinical outcomes for patients with HIV infection or drug resistant TB. About 66% of HIV patients remained on treatment 12 months after initiation. Similarly, 38% of the cohort of patients initiated on multi-drug resistant TB treatment either died, were lost to follow up after 24 months or had other unfavourable outcomes.

Low HIV and TB retention rates were identified by the Global Fund and Partners. Activities were included in the grants to address the issues. However, the activities have not been implemented. For example, FDC's grant supported activities to improve antiretroviral treatment retention rates have not been implemented since 2014. Similarly, recruitment, training and deployment of community-based adherence supporters and deployment of 'treatment reminders' through Short Message

²¹ 15.6 million, 3 million and 486,528 diagnosis conducted under HIV, malaria and TB respectively.

²² According to the proficiency testing conducted in 2016 by the National Institute of Health (INS), the entity responsible for External Quality Assurance.

²³ Option B+ is an approach for utilizing antiretroviral medicines (ARVs) to prevent mother-to-child transmission of HIV, also called perinatal or vertical transmission, which occurs when HIV is transmitted from an HIV-positive woman to her baby during pregnancy, labour and delivery, or breastfeeding.

Service have not taken place since 2015. Expansion of electronic patient tracking systems for patients on antiretroviral and TB treatment under the Ministry of Health's grant have been delayed by 16 months. Resources earmarked for nutritional supplement and transport allowances to enable drug resistant TB patients to effectively access the medicines have not been used for the past 16 months.

Low case finding under TB and multi-drug resistant TB, resulting in low treatment coverage: TB treatment coverage was estimated at 38% at the end of 2015²⁴. There is low case detection rates for TB (43%) and drug resistant TB (26%). The national TB program failed to meet its targets over the audit period. The failure to meet case notification targets contributed to excess drugs that expired at central and health facility levels (refer to finding 2.1 in this report).

The case detection rates have remained low due to limited implementation of active case finding by the National TB program and ineffective use of equipment at the facilities. For instance:

- (i) Less than 1% of clients attending outpatient services were screened for TB.
- (ii) 38% of HIV positive patients (who have a high risk of contracting TB) were not screened for TB.
- (iii) Existing national guidelines require that health workers are screened annually for TB. However, this was not consistently implemented. In the facilities visited, 37% of health workers had not been screened for TB in 2015.
- (iv) The 59 GeneXpert machines available in the country (including 17 machines provided under Global Fund grants at a cost of US\$278,000) to improve diagnosis of drug resistant TB are not effectively utilized. As of December 2015, the machines had a utilization rate of 40%. Only 7% of reported TB cases in 2015 were diagnosed with these machines.

TB infection control remains unaddressed: Five out of the 10 facilities visited did not have a designated area for patients to produce sputum specimens. Four out of the 10 facilities had not undertaken any infection control assessments in 2015 as recommended by existing regulations and guidelines. At the community level, 40% of the community-based TB treatment supporters and activists funded by the grant used inappropriate protective masks for TB activities.

The grants have earmarked resources to address infection control gaps, but related activities have not been implemented. For example, construction and rehabilitation of open air waiting shelters at facilities have been delayed by 16 months. Similarly, equipment to disinfect air containing bacteria that causes TB in facilities had not been procured at the time of the audit.

Quality of malaria case management: There are no arrangements in place to assess the quality of malaria case management undertaken by community health workers. These workers diagnosed and treated 1.3 million cases of malaria between January and June 2016. Similarly, at the facility level, case management audits and related supervisions supported by the grant have not been conducted.

The limited implementation of measures to address quality of service in Mozambique are caused by:

- (i) *Gaps in the Principal Recipient, Country Coordinating Mechanism and Secretariat management of the agreed actions.* Delays in addressing agreed actions to disbursement and implementation of activities affected quality of service delivery as indicated under finding number 4.
- (ii) *Gaps in the quantity and quality of healthcare workforce at all levels.* The OIG noted:
 - Posts not filled: 65% and 39% of technical and managerial positions in the national TB and Malaria programs, respectively, were not filled although resources have been allocated in the active Global Fund grants to address some of the human resource

²⁴ Global TB report, 2016.

gaps at the national level.²⁵ In the 10 health facilities visited by the OIG, 16% of the established posts had not been filled.

- **Health workers not trained:** 43% of health workers performed HIV diagnoses without the certification required by national guidelines.²⁶ Moreover, 19% and 23% of the health workers performed malaria diagnosis with, respectively, rapid test kits and microscopy, without relevant training.²⁷

(iii) *Ineffective technical supervision arrangements:* Supervision arrangements are decentralized which require the national programs to supervise activities at the provincial level. The Provinces are mandated to supervise the districts while the latter supervise the service delivery points (facilities). However, the supervision arrangements have been ineffective in identifying and addressing the quality of service delivery issues. For instance:

- Provincial working groups responsible for the supervision of HIV diagnosis have not been established in seven out of the 11 provinces. In the four where the working groups have been established, resources were not available to enable them to undertake the required supervision. Effectiveness of provincial level supervision has been affected by the inability of the Ministry to disburse grant funds to the provinces (see finding 4 for details);
- Provincial and district supervision activities under the malaria grant had not been conducted at the time of the audit (16 months after grant signature) despite the availability of funds;
- The existing Global Fund grants did not include funding for supervision of laboratories which perform most diagnosis under the three diseases. With the limited funding provided by the Government, the Central Laboratory Department under the Ministry of Health completed only 15% and 10% of planned supervisions in 2014 and 2015, respectively;
- The national HIV program implements quality improvement activities. The effectiveness of the quality improvement is impacted by their limited coverage. Only 20% of the health facilities had benefited from the HIV quality improvement activities at the time of the audit.²⁸

Agreed Management Action 1: The Secretariat and partners will conduct a national sample based follow-up study to track and determine the status of lost-to-follow-up cases of people on anti-retroviral treatment in selected sites.

Owner: Head of Grant Management

Target Date: 31 December 2018

Agreed Management Action 2: The Secretariat will work with the Ministry of Health to support development and implementation of a plan for decentralized and integrated supervision for the three diseases and Health Management Information System (HMIS). This will include direct financial flows to the provinces.

Owner: Head of Grant Management

Target Date: 31 December 2017

²⁵ Vacancies' in Organograms for the National Programs at October 2016

²⁶ National AIDS program data on trained and certified counsellors

²⁷ Malaria End Use Verification reports 2014-2016

²⁸ National HIV program Quality Improvement program covers only 308 facilities out of 1,120 offering services

1.2 Sub-optimal implementation of community HIV and TB interventions affecting achievement of impact.

The community interventions were designed to contribute to the prevention of HIV among key affected populations²⁹ and to improve adherence to antiretroviral and TB treatment. However, inadequate design of the implementation arrangements and limited coordination between the implementers resulted in suboptimal execution of the interventions:

(i) **Interventions implemented in the absence of national standards, guidelines and operating procedures:** The community based HIV prevention interventions for men who have sex with men and female sex workers have been implemented without national standards, guidelines and operating procedures. The National AIDS Council (CNCS), which is mandated to develop the national strategies, policies and standards for the interventions, was not included in the grant implementation arrangements. In the absence of the national standards, the implementers developed generic guidelines which are inconsistent with normative guidance provided by UNAIDS.

(ii) **Inconsistent availability of commodities for diagnosis and prevention at community level:** Required commodities such as test kits, condoms and masks to provide services at the community level were not consistently available during the audit. On average, the Ministry of Health provided only 17% of the necessary quantities of HIV rapid diagnostic test kits required for community based interventions to the FDC. As a consequence, community based activists who had been trained and received allowances could not provide the required services, creating inefficiencies. For instance, the community activists received their allowances although the planned services could not be provided due, in part, to the unavailability of commodities. The cost per person counselled and tested by the community activists increased from US\$1.47 to US\$5.33 per person as only 32,292 people were tested by the activists instead of the target of 121,347. Similarly, the Ministry of Health placed an order for condom-compatible lubricants to support condom promotion and distribution efforts for the key affected populations 12 months after commencement of the grant. The commodities had still not been received at the time of the audit (October 2016).

(iii) **Limited availability of data to inform appropriate programmatic decisions.** Community interventions for the key affected populations were being implemented based on mapping and size estimations undertaken in 2011, which is outdated. The previous and active Global Fund grants earmarked resources to support the implementation of Integrated HIV Bio-behavioural surveillance for key affected populations but none of the surveys had been completed at the time of the audit.

The community based HIV and TB interventions have been affected by limited coordination, allocation and sequencing of activities between the two Principal Recipients (Ministry of Health and FDC). For instance:

- It took an average of three months for the two Principal Recipients to agree on a memorandum of understanding for the supply of commodities at the community level. FDC requested the required commodities from the Ministry of Health on average 5 months (up to 7 months) after the memorandum of understanding had been signed.
- The Ministry and FDC are responsible for training of peer educators and lay counsellors to deliver a full package of services for female sex workers. The peer educators and lay counsellors are recruited and supervised by FDC. The inability of the implementers to effectively manage their interdependencies resulted in FDC engaging activists who had not been trained by the Ministry of Health.
- Some of the activists engaged by FDC had not been trained by the Ministry of Health at the time of the audit. Moreover, 52% of facilities where activists refer key affected populations for prevention and treatment services had not been trained by the Ministry of Health.

See Agreed Management Action 5

²⁹ Female sex workers, men who have sex with men and young girls and women aged 10-24

1.3 Improvements have been made in data collection but quality of data issues require further attention.

The previous OIG audit in 2012 and subsequent in-country assurance providers, including the Local Fund Agent, have identified data quality issues. This audit did not perform detailed data validation since issues had been identified through previous OIG and ongoing country team initiated reviews.

The country has made significant progress in the roll out of District Health Information System to address availability of data at all levels. Data validation initiatives have also been incorporated in the grants. However, the related quality issues such as accuracy and completeness require further attention to achieve complete reporting by all health facilities. For instance, 12% of facilities providing malaria diagnosis and treatment had not submitted their reports at the end of September 2016, 16% of those that submitted did so after the national deadline. Similarly, 11% of the facilities offering HIV counselling and testing services did not submit reports as expected at the end of September 2016.³⁰

Inconsistent availability of data collection tools at facilities continue to affect quality of data. Data collection tools such as outpatient consultation registers were not available in 76% of facilities providing malaria case management since May 2016. Those registers are used to generate the underlying data recorded in the District Health Information System. The grants included funding to print and distribute data collection tools, but at the time of the audit these funds had not been used due to procurement delays at the Ministry of Health.

The national disease programs continue to conduct data related training and central level supervision to the provinces. However, planned integrated data quality audits for the three diseases have been conducted under only the HIV grant.

See Agreed Management Action 2

³⁰ DHIS2 report extract generated 27-10-2016

02. Control and Assurance over supply chain

2.1. Gaps in supply chain management leading to inefficient service delivery

The supply chain is able to distribute medicines but the storage constraints and gaps in internal controls over distribution and logistics management systems create inefficiencies. These lead to stock-outs and expiries across the chain.

The country has shown significant progress in addressing the OIG's 2012 audit recommendations to improve supply chain arrangements. This includes continuous improvement of logistics management information systems at the central level, the establishment of a national quantification committee and the development of warehouse and inventory standard operating procedures. However, the following gaps continue to affect efficient supply chain management:

Inadequate storage capacity to accommodate current and future scale-up activities.

Insufficient space and inadequate measures to monitor and control the temperature of storage rooms were found across the three regional, three provincial, three district warehouses and ten health facility pharmacies visited. For example, a regional warehouse in Zimpeto with a capacity of 3,816 pallet spaces, is currently overfilled with twice its capacity. All the warehouses visited were overfilled with products, exceeding recommended storage density levels several times, according to WHO guidance. Medicines are stored in unsuitable places including corridors, entry and exit areas of warehouses. This has resulted in difficulties in implementers using existing standard operating procedures on inventory management such as the 'First Expiry First Out' concept and regular physical inventory count at the central level. For instance, there has not been a physical inventory count at the central warehouse since 2015.

The current storage capacity cannot support the Ministry of Health's scale-up activity including HIV "test and start" which requires an estimated 76% increase in existing storage space. The Ministry of Health has initiated actions to expand two regional warehouses but is yet to secure the required funding from Government and donors.

Use of a mix of push and pull systems in distribution arrangements cause stock-outs and overstocks.

The HIV program consistently uses a pull system (where health products are delivered based on requests from facilities). However, malaria and TB medicines are distributed through both pull and push mechanisms. This means that the malaria and TB medicines are pushed from the central level to the provinces and from the latter to the districts. Of the 10 health facilities visited, seven facilities operate a push system for malaria test kits while three used pull mechanism. The push system has resulted in both expiries and stock-outs as supply was not based on the need of the facility. The audit also noted that the established minimum and maximum stock levels to ensure stability of medicines and commodities at each level had not always been respected in most of the warehouses visited.

In a decentralized distribution setting like Mozambique, challenges at each level affect the timely availability of medicines at the facilities. The Government of Mozambique has shown a strong commitment to fully fund the distribution costs of medicines and health products under the three diseases. However, limited funding at the provincial level affected the ability to effectively distribute medicines to the facilities. For instance, only one out of five provinces visited has allocated sufficient funds to effectively distribute medicines and other health products procured by the Global Fund. The facilities have therefore resorted to using ambulances and motor bikes to collect medicines and commodities from the provincial and district warehouses which could compromise the quality of health products.

Limited effectiveness of the Logistic Management Information System to improve supply planning.

With support of Global Fund and partners, the country has improved its information system since the last OIG audit in 2012. For instance, SIMAM (a warehouse management system) is functioning in 126 out of the 159 districts (79%). However, there is limited

integration of existing logistics management systems between the central and regional warehouses (where the MACS system is used), the provincial and district warehouses (where SIMAM is used) and the health facilities (where records are maintained manually). This has resulted in the limited availability of timely data at higher levels to monitor distribution and consumption of medicines for effective supply planning. The country has consistently reported differences between quantities of medicines distributed (reported through the logistic management information system at central level, MACS) and the consumption data collected by the respected programs. In 2015, there was a variance of 32% and 55% between quantities distributed and reported as consumed for HIV “Determine” and Uni-gold test kits respectively. As indicated above, the CMAM is unable to conduct physical inventory regularly due to inefficient storage, which reduces its ability to reconcile the expected stock in the information system to actual stock balances.

Gaps in the quantification process: The HIV and malaria quantification processes are satisfactory. The Ministry of Health through the HIV and malaria Quantification Sub Working Groups led the annual quantification of medicines with participation from CMAM, the national programs and technical partners. TB, however, has limited human resources dedicated to quantification and forecasting resulting in constraints in determining treatment and diagnosis needs. The existing TB technical working group needs strengthening to support the national TB program.

Delays in procurement of medicines: The country experienced delays through procurement of medicines under Global Fund’s Pooled Procurement Mechanism and Global Drug Facility. There was delayed arrival of anti-malaria medicines resulting in 1.6 months of stock-out in January 2016. The TB program experienced a 6-month delay in four shipments due to the lack of agreement between the country and the Global Drug Facility to transport products in pallets.

The above limitations have resulted in stock-outs and expiries of medicines across the supply chain. The Ministry of Health and Local Fund Agent have regularly reported actual or potential stock-outs to the Global Fund during their routine reviews since 2014. From the limited samples of medicines, warehouses and facilities visited in 2016, the OIG confirmed the issue of stock-outs or expiries for the following:

- (i) Stock-outs were present at all levels with varied magnitude, but the situation was worse at the lower level. Within the 18-month audit review period, stock-outs for anti-malaria medicines were found at all levels except at the central level. The health facilities visited had an average of 24 days (maximum of 93 days) of stock-outs for at least one dose of anti-malaria medicine. The effects of the malaria stock-outs were limited by the ability of the health workers to dispense other doses in smaller sizes to patients. Under the HIV program, there was no stock-out of anti-retroviral medicines in the facilities visited. However, there were stock-outs of “Determine” test kits lasting an average of 17 days (maximum of 108 days) at the facilities visited. First line TB medicines had average stock-outs of 33 days (maximum of 198 days) in the facilities visited despite availability of stocks at other layers of the supply chain.
- (ii) Expiries were noted across all levels of the supply chain. The Ministry of Health has instituted measures to report the expired medicines. However, the measures were not consistently used across all levels of the supply chain. With the limited information available, the audit noted expiries of US\$1 million.³¹ This figure could have been higher if the expiries had been consistently recorded by the national program and CMAM.

The above gaps in the supply chain are due to:

- (i) **Limited coordination and prioritization of supply chain interventions by the Government.** The country has developed a Procurement and Supply Chain management strategic plan referred to as, ‘*Plano Estratégico de Logística Farmacêutica (PELF)*’, in line with

³¹ the audit noted expiries at central level for an amount of US\$ 0.8 million, at visited provincial warehouses of US\$81,414 and at the 10 facilities visited for US\$22,670. There are approximately 1591 health facilities in the country and thus the health facilities sampled represent only 0.6%

recommendations from the OIG 2012 audit. Actions in the work plan and budget to execute the strategy focused on central level activities without consideration of the needs of the provincial and district levels. The interventions indicated in the strategy have not been prioritized to provide guidance on areas to be supported by government and donors. As a result, some donors provided support directly to the provinces based on their own assessments and not in line with the PELF. The Ministry of Health is unable to coordinate the interventions provided directly to the provinces by donors.

- (ii) **Accountability and ownership of the supply chain network is split across the different administrative levels of the country.** The central medical stores responsibility for the supply chain ends when the medicines are delivered to the provinces. The provinces oversee supply chain up to the district level. At the facilities, the districts are responsible for the oversight and management of the supply chain. There is no dedicated entity responsible for the overall supply chain network.
- (iii) **Delayed implementation of the Health System Strengthening grant:** The Global Fund provided resources for this grant to address some of the supply chain challenges since 2013. However, the Ministry of Health is yet to complete the activities. For instance, resources earmarked to renovate warehouses, procure equipment and vehicles to support distribution had not been utilized as at the time of the audit. The delays are due to lengthy procurement process and the weak coordination within the Ministry of Health to oversee the implementation of the grant (See finding 4 in this report).

Agreed Management Action 3: The Secretariat will review the status of implementation of the Health Systems Strengthening (HSS) grant activities, and the status of conditions in disease grants together with the PRs and develop an implementation plan for the remaining duration of the grants

Owner: Head of Grant Management

Target Date: 30 June 2017

2.2. Limited monitoring of quality of pharmaceutical and health commodities at the country level.

The Global Fund procures medicines and commodities through the Global Drug Facility and the Pooled Procurement Mechanism with WHO prequalified suppliers. The suppliers undertake relevant quality control measures on those medicines and health products before they are shipped to the country. Where quality issues are identified, the suppliers, with in-country stakeholders, initiate actions to mitigate the consequences. For instance, anti-malaria medicines supplied in 2015 that failed the supplier's post shipment quality controls were recalled and replaced by the supplier. However, there are limited in-country mechanisms to routinely monitor the quality of medicines across the supply chain in line with Global Fund requirements.

There is no WHO pre-qualified laboratory or ISO 17025 certified laboratory in Mozambique to quality assure medicines procured under the funded programs. The Global Fund has allocated resources to enable the country to procure services from a WHO prequalified laboratory outside the country but the procurement processes had just started at the time of the audit.

The country has not developed quality assurance plans for medicines as required by The Global Fund. The Mozambique National Laboratory undertakes some quality assurances but its effectiveness is affected by capacity constraints and limited coverage. The laboratory is not WHO prequalified and therefore unable to perform tests in line with Global Fund requirements. It has not been able to analyze and test all samples collected in 2015 and first half of 2016. For instance, it tested 53% of samples collected in 2015.

See Agreed Management Action 3

03. Management of grant funds disbursed to the country.

84% of the grants are paid directly to medicine suppliers by the Global Fund, which increases overall absorption. However, the Ministry of Health has had difficulty in using the remaining funds. Protracted procurement processes and inadequate management of foreign exchange risks have led to potential exchange loss.

The Country Team has instituted measures to reduce fiduciary risks on the portfolio. This includes engagement of the Local Fund Agent to review procurement processes before the contracts are signed by the Ministry of Health and quarterly verification of payments made with grant funds by the Principal Recipients.

The procurement processes for non-health commodities span at least two years across all material procurements during the audit period. This has resulted in low absorption of grant funds available in the country. The Ministry of Health has only spent 25% (US\$3.4 million) of the funds disbursed by the Global Fund since 2013 (US\$13.4 million). Aggregate funds disbursed by the Global Fund during that period amount to US\$222 million, the majority of which is spent in direct procurement of drugs through the Pooled Procurement Mechanism. The total absorption rate including the procurement of pharmaceutical and other health products paid directly by the Secretariat was 62% in 2016.

Most activities (at least 67%) in the Health Systems Strengthening grant, designed to address some of the systemic challenges and quality of service issues, involve procurement of non-health equipment and commodities. The protracted procurement processes within the Ministry of Health have delayed the implementation of activities that should have addressed some of the findings in this report. The Ministry of Health initiated 14 major procurement activities in 2014 and only one was completed as of October 2016. For example, procurement of computers, servers and forklift trucks to support warehousing and distribution of medicines started in September 2014 but had not yet been completed as of October 2016. The recruitment of consultants to develop a staff performance management system at CMAM has been ongoing since November 2014.

The Ministry of Health has been unable to effectively mitigate the recent foreign exchange rate risks affecting grant funds disbursed to the country. The Ministry converted US\$8 million received from the Global Fund into local currency before the activities started. Delays in the procurement processes coincided with foreign exchange movements that devalued these converted funds by approximately US\$3.9 million. This increases the risk that the Ministry of Health will have fewer resources to support the implementation of earmarked activities.

The Global Fund Secretariat has put in place actions to improve the absorption rates and to reduce the effect of the foreign exchange fluctuations. It also engaged the United Nations Office for Project Services (UNOPS) as a procurement agent to manage some of its activities. The agent is currently responsible for the procurement of trucks, which accounts for 10% of the Health System Strengthening grant. The Secretariat intends to make direct disbursements to the agent when the procurement is completed to reduce future foreign exchange losses.

See Agreed Management Action 5

04. Implementation arrangements for funded programs

The weaknesses in design and operating effectiveness of the implementation arrangements have adversely impacted oversight, coordination and management of funded programs; this has resulted in delays in executing grant activities, duplication of activities and lack of progress in resolving known issues.

Oversight

Efforts have been made to strengthen the Country Coordinating Mechanism through technical assistance funded by the United States Government. The mechanism actively engages with in-country stakeholders in developing concept notes for Global Fund grants; however, its oversight of grant implementation has been ineffective:

- *Lack of effective follow-up mechanisms:* Actions discussed at the Country Coordinating Mechanism meetings are not followed up for implementation by the Principal Recipients. For instance, the mechanism agreed on 24 March 2016 that the Principal Recipients will develop accelerated integrated work plans but this had not been done as at October 2016.
- *Insufficient information sharing:* The Country Coordinating Mechanism has not defined the minimum level of information required from the Principal Recipients to ensure effective oversight. This has resulted in the Principal Recipients providing ad-hoc information to the mechanism. For instance, the status of implementation of grant activities and recommendations from Secretariat were not consistently reported to the mechanism by the Principal Recipients.
- *Lack of engagement by key Country Coordinating Mechanism members:* Key members of the, including the Ministry of Health, are not actively engaged in the oversight of the grants. The attendance rate by all members, including alternates, for the 12 meetings between 2015 and 2016, was 45%. Five members had not attended any meetings since January 2015. Senior management of the Ministry of Health and FDC who are also members of the Country Coordinating Mechanism do not regularly attend the meetings.

At the Ministry of Health, the level of oversight of the grants by senior management is not commensurate with investments managed by the Program Management Unit. There is no evidence that the senior management of the Ministry oversee grant implementation and follow up on resolution of identified programmatic challenges.

Coordination

There are limited mechanisms within the Ministry of Health to coordinate between the Program Management Unit, the three national programs and six other departments at the Ministry that are involved in the implementation of Global Fund grants. There are no detailed implementation plans with assigned timelines and roles for the grant activities. Although weekly coordination meetings are held, their effectiveness is weakened by limited participation and information sharing by various departments.

At the provincial level, management committees referred to as '*Comites de Gestão*' have been established to coordinate activities. However, their effectiveness has been affected by the lack of information sharing among stakeholders. This has resulted in the duplication of activities for key affected populations. For instance, in one province, the Global Fund and partners supported activities in the same 'hot spots' and paid the same community activists to provide the same services. There are also duplications in two different grants funded by the Global Fund. The Global Fund regional HIV (Southern African Development Community – SADC) had the same activities for the same target groups and areas planned under the Mozambique country grants.

The provinces are responsible for the implementation of activities and supervision of the districts. However, the Ministry of Health does not disburse funds earmarked for those activities to the provinces as the current model makes direct payments to beneficiaries. The provinces submit supporting documentation for all activities to the Ministry of Health which makes direct payments to the service providers. This has delayed implementation of provincial level activities such as

technical supervision and roll out of the District Health Information System. Arrangements to build the financial management capacity of the provinces have not been effectively implemented by the Ministry of Health. Only two out of the eleven provinces have been assessed by the Ministry of Health with no actions taken on the assessments conducted.

There are similar coordination challenges between the Ministry of Health and FDC, a civil society Principal Recipient resulting in sub optimal implementation of community level interventions (as detailed in finding 1.2).

Management of grants by Principal Recipients

The Project Management Unit is responsible for coordinating as well as supporting the implementation of funded programs at the Ministry of Health. However, roles and responsibilities of the various implementers and departments within the Ministry are not clearly defined resulting in inadequate ownership and accountability for grant implementation. The unit undertakes roles that should have been performed by the national disease programs resulting in inefficiencies. For instance, some terms of reference and other technical program related documents were prepared directly by the Project Management Unit instead of the national programs. Structurally, the unit is at the same level as national program managers which limits its ability to provide the requisite oversight and direction to coordinate their activities.

There are gaps in the technical and managerial capacity of the Project Management Unit to effectively undertake its role. For instance, management do not have the necessary training to oversee the financial and procurement specialists assigned to the unit. This has affected the ability of the Ministry of Health to submit detailed budgets for lump sums included in grant documents and other procurement related conditions. Similarly, the Ministry of Health has no staff with expertise in managing anti-malaria medicines which has contributed to the stock-out and expiries of malaria medicines. The unit has not been able to develop the required terms of reference and related documents on time to ensure early commencement of procurement processes. For instance, it took the unit nearly two years to provide responses to the Global Fund for the purchase of a new performance management system. In another instance, it took over seven months for feedback to be provided by the Project Management Unit on the terms of reference for the purchase of forklift trucks. The unit does not have systems and tools to track deliverables submitted through the national programs. As a consequence, it took an average of five months for the Project Management Unit to send documents prepared by the national program to the Country Team.

FDC has limited technical and managerial capacity to effectively manage and supervise community based interventions targeting men who have sex with men. Prior to FDC's appointment as Principal Recipient for this grant, it had not managed interventions for this exposed group

Portfolio management by Global Fund Secretariat

The Country Team at the Global Fund Secretariat has increased engagement with in-country stakeholders through regular visits to Mozambique. It also proactively identified some of the issues raised in this report. However, the Country Team could improve the management of agreed actions which contributed to the delays in resolution of some of the identified challenges. The Secretariat signed grants with agreed actions tied to disbursements. The country has not met some of the agreed actions to start implementation of the related activities. One of these actions has been outstanding since 2013. This has delayed implementation of measures to improve quality of services. For instance, the condition to engage treatment adherence supporters to improve retention rates on antiretroviral treatment has not been met since 2015, delaying implementation of grant activities to address the low antiretroviral treatment retention rates (see finding 1.1). As part of the Secretariat's risk management of this portfolio, the Country Team reviews the Terms of Reference and technical specifications developed by the Principal Recipients (Ministry of Health and FDC) to engage consultants or procure non-health commodities respectively. These reviews go through many iterations since the implementers are unable to prepare the Terms of Reference in a way that is acceptable to the Secretariat. The Country Team could have been more efficient in resolution of the

deficiencies in the Terms of Reference submitted by the Principal Recipients. For instance, one set of Terms of Reference had at least six iterations before approval by the Country Team.

Limited funds are disbursed to the country due the commoditisation of the grants. However, 16% of the total budget to be spent in the country (US\$6.5 million of US\$39.8 million) were included in the Ministry of Health's grant as lump sums and had not been translated into a detailed budget; this further contributed to the delays in implementation of activities. The amount to be disbursed to the country is critical to address the quality of service gaps in ensuring that medicines procured are optimised. For instance, the medicines are procured to ensure their availability but the grant cannot achieve the desired impact if measures are not implemented to ensure patients initiated on antiretroviral or multi drug resistant TB remain on treatment. These delays have affected quality of service delivery under the funded programs (see finding number 1.1).

There are potential areas of improvement in the engagement of stakeholders throughout the grant cycle. For instance, the National AIDS Council, which has the mandate to develop national strategies and guidelines, is not included in the grant implementation arrangement. The lack of national standards impacted on effective implementation of the community interventions. Moreover, some activities were included in the work plans of implementers least suited to complete the activities on time. For instance, training of peer educators to implement community based prevention activities for female sex workers were included in the Ministry of Health's grant instead of FDC who works with the population group.

Agreed Management Action 4: The Secretariat will work with the CCM, Government and Partners to engage senior level involvement of Government and Partners in the CCM.

Owner: Head of Grant Management

Target Date: 31 December 2017

Agreed Management Action 5: The Secretariat will support the Ministry of Health to:

- Develop a plan to enhance oversight of Global Fund grants by the Senior Management of the Ministry.
- Restructure the PMU, including performance indicators and clear lines of authority; and
- Strengthen the existing coordination structures between the PRs of TB and HIV grants

Owner: Head of Grant Management

Target Date: 31 December 2017

V. Table of Agreed Actions

#	Category	Agreed Management Action	Target date	Owner
1.1	Quality of health services under funded programs	The Secretariat and partners will conduct a national sample based follow-up study to track and determine the status of lost-to-follow-up cases of people on anti-retroviral treatment in selected sites.	31 December 2018	Head of Grant Management
2	Quality of health services under funded programs	The Secretariat will work with the Ministry of Health to support development and implementation of a plan for decentralized and integrated supervision for the three diseases and Health Management Information System (HMIS). This will include direct financial flows to the provinces.	31 December 2017	Head of Grant Management
3	Control and assurance over supply chain	The Secretariat will review the status of implementation of the Health Systems Strengthening (HSS) grant activities, and the status of conditions in disease grants together with the PRs and develop an implementation plan for the remaining duration of the grants.	30 June 2017	Head of Grant Management
4	Implementation arrangements for funded programs	The Secretariat will work with the CCM, Government and Partners to engage senior level involvement of Government and Partners in the CCM.	31 December 2017	Head of Grant Management
5	Implementation arrangements for funded programs	The Secretariat will support the Ministry of Health to: <ul style="list-style-type: none"> • Develop a plan to enhance oversight of Global Fund grants by the Senior Management of the Ministry; • Restructure the PMU, including performance indicators and clear lines of authority; and • Strengthen the existing coordination structures between the PRs of TB and HIV grants. 	31 December 2017	Head of Grant Management

Annex A: Message from the Executive Director

The Global Fund partnership was designed to provide effective and efficient funding to accelerate the end of HIV, tuberculosis and malaria as epidemics. It is committed to constantly strengthening measures to increase value for money, and improving grant implementation and quality of health services and medicines.

Value for money and quality of services are of critical importance to the Global Fund, a priority that extends to all its partners, from donors to technical partners to implementers on the ground, in order to deliver treatment, care and prevention to the people most in need. We can only accelerate investments by working with partners in a coordinated way. Each specific country requires specialized attention, and grant implementation is the major part of how we do this together. Through the Impact through Partnership initiative, we are using data on use of funds to drive a collective and accountable approach to support countries to strengthen systems and use money effectively and efficiently.

The Global Fund Secretariat implements controls and assurance through various mechanisms and the independent Office of the Inspector General (OIG) conducts regular audits to help grants achieve their objectives. The OIG is a central and important part of ensuring that our investments are made in the most effective and efficient way to accelerate the end of the diseases.

The scope of the audit report by the Office of the Inspector General on Global Fund Grants to Mozambique was to look at grant implementation arrangements, and controls and assurance mechanisms in the supply chain.

The OIG's Audit Report on Global Fund grants to Mozambique found that with the support of Global Fund and partners, Mozambique has made significant progress in the fight against the three diseases. It also identified significant, systemic challenges across Mozambique in providing prevention, treatment and care. Addressing these weaknesses will require a coordinated approach by the Government of Mozambique, the Global Fund and partners.

The report recognizes that Mozambique is a low-income country with many challenges, including severely constrained human resources for health and inadequate health infrastructure. Mozambique is heavily reliant on development partners to fund public health interventions, which adds more meaning to the responsibility of all partners to constantly improve our work to deliver better in the future.

The report cites significant progress in Mozambique in recent years, but also cites weaknesses at the Ministry of Health and in the Country Coordinating Mechanism in effective grant implementation and oversight. Equally, the report notes that while medicines are being delivered through the supply chain, there is a need for significant improvements in the controls and assurance mechanisms, whose accountability and ownership is split across the administrative levels of the country.

Following the audit's findings, the Secretariat has developed an action plan including a series of time-bound actions to address the weaknesses identified in the audit report and to further strengthen and improve Global Fund-supported programs:

- The Secretariat and partners will conduct a national sample to track and determine the status of lost-to-follow-up cases of people on antiretroviral treatment.

- The Secretariat will work with the Ministry of Health to support development and implementation of a plan for decentralized and integrated supervision for the three diseases and the Health Management Information System. This will include direct financial flows to the provinces.
- The Secretariat will review the implementation of the Health Systems Strengthening grant, and the status of conditions in disease grants together with the Principal Recipients and develop an implementation plan for the remaining duration of the grants.
- The Secretariat will work with the Country Coordinating Mechanism, government and partners to engage senior level involvement of government and partners in the Country Coordinating Mechanism.
- The Secretariat will support the Ministry of Health to develop a plan to enhance oversight of Global Fund grants by the senior Management of the ministry; restructure the Project Management Unit responsible for the coordination of the Global Fund grant at the Ministry of Health; strengthen existing coordination structures between the Principal Recipients of TB and HIV grants.

As we work to end HIV, tuberculosis and malaria as epidemics, we must focus on quality and efficiency of services to achieve the best possible impact with the resources available.

We are grateful for the suggestions for improvements and will pursue them in coordination with our partners.

Annex B: General Audit Rating Classification

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

Annex C: Methodology

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

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

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

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

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