



Audit Report

Global Fund Grants in the Republic of Indonesia

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1. Executive Summary

1.1. Opinion

Indonesia continues its progress towards malaria elimination. The majority of districts, covering 72% of the country's population, have officially been declared malaria-free¹ There has been a 50% reduction in confirmed cases and a 66% reduction in malaria-related deaths.² Similarly, the country's case notification outcomes for presumptive TB increased by 24% between 2017 and 2018, and the number of key affected populations tested for HIV is steadily increasing. Indonesia however remains far from reaching the UNAIDS 90-90-90 target. The country's HIV treatment cascade remains low at 50-17-7, while Indonesia is among the top 10 countries that account for 80% of missing TB cases globally.

Improvements are needed in the design of the grants if the HIV and TB program targets by 2020 are to be achieved. The HIV grants are yet to include a plan to increase the number of facilities conducting both testing and treatment, a critical component of rolling out the 'test and treat' policy to improve treatment rates. Grant interventions to scale up viral load coverage have been developed, but are yet to be implemented. Referral systems and information sharing between public sector facilities and civil society organizations are weak for HIV, TB and HIV/TB collaboration activities. The TB grants do not adequately address the scale-up of the public/private mix and treatment of MDR-TB patients. The adequacy and effectiveness of grant design to ensure efficient and sustainable achievement of grant impact are **partially effective**.

There are inefficiencies in programmatic implementation. For HIV, there are delays in rolling out innovative outreach and prevention activities. The 'test and treat' policy is not fully implemented, and monitoring of patients on treatment is not effective, resulting in high treatment drop-out. There is a need to improve TB contact tracing activities to increase case finding, treatment initiation (especially for MDR-TB), and to improve utilization of GeneXpert diagnostics to leverage the technology for HIV viral load testing. Weaknesses were noted in Principal Recipient supervision of sub- and sub-sub-recipients. The effectiveness and efficiency of the implementation and assurance arrangements in supporting the achievement of grant objectives **need significant improvement**.

1.2. Key Achievements and Good Practices

Government financial commitment to fight the three diseases: Indonesia's co-financing requirements for the 2018-2020 allocation period for the three diseases is 20% (US\$80 million). The Government has met the co-financing requirement and finances procurement of most HIV, TB and malaria commodities including medicines, HIV test kits, malaria bed nets and test kits, and viral load and GeneXpert cartridges. Government contribution for the three diseases increased by 28% in 2017 and 16% in 2018. The Ministry of Health has issued a decree to increase the number of hospitals providing MDR-TB treatment to 260. The social health insurance scheme, JKN, covers a variety of health services.

Good programmatic performance: The number of HIV tests conducted on key affected populations increased from 166,000 in 2017 to 183,000 in 2018, mainly through the use of mobile clinics. The program has bridged the gap between outreach and testing and deepened the collaboration between health facilities and civil society organizations. A "test and treat" policy was

¹ <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2818%2930198-0/fulltext>

² WHO- world malaria report 2017

introduced in 2018, contributing to increasing the number of people on antiretroviral treatment from 91,000 in 2017 to 108,000 in 2018. The introduction of mandatory TB case notification contributed to a 24% increase in case notification outcomes in 2018. Over 800 GeneXpert machines have been installed in health facilities, and the number of hospitals providing MDR-TB services increased following a decree by MOH in 2017 to increase number of MDR-TB hospitals to 260.³ In addition, over 2000 puskesmas are ready to become satellites for MDR-TB treatment following decentralization. New partnership model between Civil Society Organizations (CSOs) and the National TB Program for active case finding is an opportunity for the CSOs to start accessing district funding in the future and sustain their involvement in community TB case finding.

Complementarity between government and civil society organizations in implementing interventions for key affected populations: The involvement of civil society organizations and UN agencies in outreach activities has contributed to increased numbers of key affected populations being tested. The number of men who have sex with men (MSM) who received an HIV test and who know their result increased from 82,000 in 2017 to 112,000 in 2018. The partnership model for active TB case finding that civil society organizations have with the Ministry of Health allows them to access district funding and sustain their involvement in community TB case finding. This partnership has helped the country to continuously improve case notification numbers.

1.3. Key Issues and Risks

Unsatisfactory progress on the HIV 90-90-90 cascade: Despite high HIV prevalence among key affected populations in Indonesia, HIV testing targets are low and the positivity yield from outreach activities remains stagnant. The effectiveness of a new ‘virtual outreach’ method to improve positivity yield has not been evaluated and key grant activities including community-based screening and pre-exposure prophylaxis are yet to start, due to administrative and legislative challenges. Limited documentation has affected the notification and testing of partners of key affected populations. Mobile testing is limited in scale.

More than 31% of people living with HIV who know their status are not initiated on treatment, and more than 29% of patients are lost to follow-up after 12 months of treatment initiation. Contributing factors include gaps in the referral system to link patients to treatment, failure to track people who were not put on treatment through the national system, and sub-optimal implementation of the ‘Test and Treat’ policy by all districts. Although all primary health facilities and district hospitals in 96 “priority districts” are expected to test and initiate treatment, only 57 districts have at least one health facility capable of doing this. Limited central-level oversight and facilities not sharing patient information with civil society organizations contribute to patients being lost to follow-up. Nationally, less than 7% of patients receive a viral load test, risking high mortality and undetected drug resistance.

Improvements needed to achieve the desired TB and MDR-TB notification and treatment outcomes: Although 67% of estimated cases are notified by the National TB Program (MoH), Indonesia is among the top 10 countries that account for 80% of missing cases globally; TB is the fourth leading cause of death. An average of 50% of cases referred by civil society organizations are not tested at health facilities, due to the different screening parameters used by both parties. Although public/private mix (DPPM) packages were expected to be provided in 243 regular districts and 271 high priority-high impact districts in 2018, only 37 districts have been prioritized. There have been no clear guidelines from the central level on the implementation of DPPM at the district level.

³ Currently has 202 hospitals providing MDR-TB services

Approximately 49% of MDR-TB patients diagnosed do not start treatment, and there is no mechanism to track them. Information is not available about the remaining patients (i.e. 51%) who started treatment, were lost to follow up, and who were brought back to treatment. The current enabler payment mechanism is not in line with the agreed policy, affecting the uptake of MDR-TB treatment. Gaps in the management of GeneXpert machines were also noted. At the time of the audit, 66 machines had been dispatched to health facilities but were not installed, and 104 machines were still at the warehouse due to the health facilities' lack of readiness to receive them. In addition, 240 GeneXpert machines are out of warranty. Of the machines under warranty, 38% (44/117) had broken parts and were awaiting repair.

Improvement needed in TB/HIV collaboration activities: TB and HIV programs have vertical structures with limited collaboration. TB is primarily diagnosed and treated at the primary healthcare level, while HIV treatment is mostly hospital-based, meaning many co-infected patients receive care in two different facilities, increasing the chance of being lost to follow-up. Integrated TB/HIV supervision is not yet happening and only 15% of people newly enrolled in HIV care have started TB preventive treatment, due to the reluctance of physicians to prescribe it.

To increase the accessibility to viral load testing, Indonesia is leveraging the use of GeneXpert machines. However, there is a prolonged time (around one year) between training and roll-out of viral load testing. As a result, some trained staff had left the health facilities and others had forgotten how to use the machines. The scale-up of viral load testing supported by a third-party supplier is still being negotiated and is yet to start.

Gaps in oversight and assurance arrangements: Four out of five Principal Recipients (PRs) have no timely and costed supervision plan, and supervision visits are not always in line with the outcomes of the risk assessment tool used by PRs. Challenges such as insufficient human resources for supervision and the lack of a formal system for communicating or tracking issues or recommendations raised in supervision remain unaddressed. These gaps are affecting the PRs' oversight ability of activities at sub- and sub-sub-recipient levels.

1.4. Rating

	<p>Objective 1: Adequacy and effectiveness of grant design to ensure efficient and sustainable achievement of grant impact.</p> <p>OIG rating: Partially Effective</p>
	<p>Objective 2: Effectiveness and efficiency of the implementation and assurance arrangements in supporting the achievement of grant objectives.</p> <p>OIG rating: Need Significant Improvement</p>

1.5. Summary of Agreed Management Actions

The OIG and the Secretariat have agreed a set of actions and related deliverables to address the findings. Specifically, the Global Fund Secretariat and in-country stakeholders will work to:

- review the implementation arrangements to meet treatment coverage targets by Dec 31 2020, as per the grant Performance Framework.
- ensure that staff from GF-supported CSOs consider all bacteriologically confirmed cases in their lists for contact investigation follow up, and revisit DDPM activities based on recent case notification data.
- work with the Federal Ministry of Health and other development partners to finalize the budget for the Acceleration plan of TB/HIV control.

- ensure that all Principal Recipients develop risk-based, sub-recipient supervision plans, and systemic feedback and follow up mechanisms are in place.

2. Background and Context

2.1. Overall Context

Indonesia is the world’s largest archipelago with over 16,000 islands. The country has 34 provinces with 514 districts. Over 55% of the population live in urban areas, and the island of Java accounts for over half of the country’s population.⁴

<p>Population: 264 million</p> <p>GNI per capita: US\$3,840 (2018)</p> <p>UNDP Human Development Index: 116 of 189 (2018)</p> <p>Transparency International Corruption Perceptions Index: 89 of 180 (2018)</p>
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A G-20 member, Indonesia has seen its income levels rise steadily in the last 20 years, suggesting it may reach upper middle-income status within a few years,⁵ likely to make the country ineligible for the future allocations under the G-20 rule.⁶ However, taking into consideration the country’s disease burden and the possibility that a sudden change would jeopardize the gains made through cumulative Global Fund investments of over US\$1 billion, the Strategy Committee endorsed the option of removing the G-20 rule during the 39th Global Fund Board meeting.

Indonesia’s total health expenditure is around 3.1% of gross domestic product.⁷ The 2014 launch of a universal health care program has been a major boost to the health sector; the aim is to cover the entire population by 2019, 74% of the population having been enrolled by the end of 2018.⁸ Since 2001, as part of a wider policy of decentralization, the health system has been decentralized, with the responsibility of providing health services devolved to provinces and districts.

2.2. Differentiation Category for Country Audits

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

Indonesia is classified as:

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

⁴ BPS Statistik Indonesia - <http://www.indonesia.go.id/in/sekilas-indonesia/geografi-indonesia>

⁵ According to the World Bank, upper-middle-income are economies with a GNI per capita between US\$ 3,896 – US\$ 12,055.

⁶ According to the GF eligibility policy, only UMIC G-20s with an ‘extreme’ disease burden are eligible; this applies to all three diseases.

⁷ World Bank Data - [Indonesia country profile](http://data.worldbank.org/ID)

⁸ Healthpolicy plus <http://www.healthpolicyplus.com/indonesiaUHC.cfm>

2.3. Global Fund Grants in Indonesia

Since 2003, the Global Fund has signed 38 grants totaling US\$1.1 billion, of which US\$901 million has been disbursed to date across the three diseases and for Resilient and Sustainable Systems for Health. The current grant allocation for 2018-2020 is US\$264 million: US\$92 million for HIV; US\$117 million for TB; and US\$53 million for malaria.

Grant	Principal Recipient	Component	Grant period	Signed amount (USD)
IDN-H-MOH	Directorate General of Disease Prevention and Control, Ministry of Health of The Republic of Indonesia	HIV	01-Jan-2018 to 31-Dec-2020	60,661,386
IDN-H-SPIRITI	Yayasan Spiritia	HIV	01-Jan-2018 to 31-Dec-2020	32,116,331
IDN-T-AISYIYA	Central Board of 'Aisyiyah	Tuberculosis	01-Jan-2018 to 31-Dec-2020	14,768,459
IDN-T-MOH	Directorate General of Disease Prevention and Control, Ministry of Health of The Republic of Indonesia	Tuberculosis	01-Jan-2018 to 31-Dec-2020	103,034,752
IDN-M-MOH	Directorate General of Disease Prevention and Control, Ministry of Health of The Republic of Indonesia	Malaria	01-Jan-2018 to 31-Dec-2020	44,574,010
IDN-M-PERDHAK	Persatuan Karya Dharma Kesehatan Indonesia (also known as "PERDHAKI", Association of Voluntary Health Services of Indonesia)	Malaria	01-Jan-2018 to 31-Dec-2020	9,070,896
Total				264,225,834

As part of the NFM 2 allocation, catalytic funding has been granted through matching funds addressing key issues, in particular: TB missing cases (US\$15 million); Human Rights barriers to HIV services access (US\$2.7 million); and Data Strengthening and Use (US\$1.97 million). Approximately 64% of the funding to fight the three diseases in Indonesia is provided by the Government. The Global Fund is the largest external donor (26% of funding), with significant funding and technical assistance provided by the United States Government (4.5% of funding).⁹

⁹ Funding Landscape Table (2018-2020 funding request)

2.4. The Three Diseases



HIV/AIDS: Indonesia accounts for about 2% of the global disease burden. The country has relatively low overall adult HIV prevalence at 0.4%, with prevalence rates of 28.8% among people who inject drugs, 25.8% among men who have sex with men, 24.5% among transgender and 5.3% among sex workers.¹⁰ Key affected populations are the most affected by HIV and remain hard to reach.

52% of estimated people living with HIV know their status¹¹ and 17% of them are on treatment. Only 7% of those on treatment accessed viral load testing in 2018.¹²

640,000 estimated people living with HIV in 2018.¹³

46,000 new HIV infections and **38,000** AIDS-related deaths in 2018.¹⁴

108,479 people on antiretroviral therapy in 2018.¹⁵



Malaria: Indonesia has been successful in combatting malaria, reducing numbers of malaria cases by 38% and malaria-related mortality by 31% between 2012 and 2017.¹⁶ The majority of districts are now considered malaria-free.¹⁷

Challenges remain, particularly in Eastern Indonesia where most of the burden persists. Overall, 17% of the 1,530,566 estimated cases are confirmed with microscopy, and 2,680 deaths were estimated in 2017.¹⁸

2,347,408 insecticide-treated nets distributed in 2017 through a mass campaign¹⁹

261,617 confirmed cases in 2017.²⁰



Tuberculosis: TB remains a major issue in Indonesia, representing 8 of the global disease burden, with 564,000 new and relapsed cases notified in 2018.

HIV/TB co-infection is significant, with 40 incidents per 100,000 and a mortality rate of 3.5 per 100,000 in 2017.²¹ Resistance is also a challenge, with 8,076 patients diagnosed with RR/MDR-TB and 4,379 enrolled in treatment in 2018.²²

Estimated TB incidence of **319** per 100,000 population, representing 845,000 people in 2018.

Estimated mortality in 2018 is **98,000** people.

Treatment success rate for susceptible TB from 2017 cohort is **85%**.²³

¹⁰ Integrated Bio-Behavioral Survey 2015

¹¹ UNAIDS - Indonesia profile

¹² Global Fund Progress Update Disbursement Request – December 2018

¹³ UNAIDS Indonesia factsheet 2018

¹⁴ UNAIDS Indonesia factsheet 2018

¹⁵ Global Fund Progress Update Disbursement Request – December 2018

¹⁶ Global Fund Malaria Result Profile 2017

¹⁷ Global Fund Secretariat Briefing Note 2017

¹⁸ WHO Malaria Report 2018a

¹⁹ Global Fund Malaria Results Profile

²⁰ WHO Malaria Profile 2017

²¹ WHO TB Indonesia Factsheet 2017

²² Global Fund Progress Update Disbursement Requests – FY December 2018

²³ WHO TB Indonesia Factsheet 2017

2.5. Portfolio Performance

Grants in the country are performing well against the agreed indicators, as shown by the achievement rate of key mandatory coverage indicators. The issues and root causes for the incorrect reporting for outreach activities, low rates of HIV prevention and TB case notification are analyzed in sections 4.1 and 4.2 of this report.

For malaria, the low achievement on insecticide-treated nets distribution is due to the limited numbers of nets available due to a delay in the procurement process. For the indicator “Proportion of suspected malaria cases that receive a parasitological test in the community”, OIG noted that the Principal Recipient has changed the denominator due to the unavailability of rapid test kits; the target for this indicator was to reach 74,000 people, but with only 24,000 test kits available they reduced the indicator and reported 100% achievement.

Global Fund key indicators achievement rate (as of December 2018)			
Indicator	Target	Actual	Achievement
HIV			
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs	170	30	18%
Percentage of sex workers that have received an HIV test during the reporting period and know their results	17%	18%	108%
Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results	32%	24%	75%
Percentage of people living with HIV currently receiving antiretroviral therapy	20%	17%	82%
Percentage of people living with HIV and on ART, who have a suppressed viral load at 12 months (<1000 copies/ml)	85%	91%	107%
Tuberculosis			
Number of notified cases of all forms of TB (i.e. bacteriologically confirmed + clinically diagnosed), includes new and relapse cases	267,368	235,928	88%
Number of TB cases with RR-TB and/or MDR-TB notified	3,372	4,807	120%
Number of cases with RR-TB and/or MDR-TB that began second-line treatment	2,866	2,443	85%
Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	4,901	1,718	35%
Percentage of people living with HIV newly enrolled in HIV care started on TB preventive therapy	26,363	3,933	15% ²⁴

²⁴ Although the PR achieved only 15% on this indicator, the agreed target was 25%. As a result, they are performing adequately on this indicator

Malaria			
Number of long-lasting insecticidal nets distributed to at-risk population through mass campaign.	3,984,224	2,017,540	51%
Proportion of suspected malaria cases that receive a parasitological test in the community	100%	100%	100%
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	100%	96%	96%
Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities	100%	93%	93%

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

2.6. Risk Appetite

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries,²⁵ representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants. Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by the second line functions and senior management from the Grant Management Division. Grant risk ratings are weighted using the country allocation amount to arrive at an aggregate risk level for the country portfolio. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee (PPC).²⁶

Indonesia went through the country portfolio review in November 2018. The Program Quality risk rating was updated in June 2019, following the submission of the Progress Update reports. The OIG compared the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Indonesia portfolio with the residual risk that exists based on OIG's assessment, mapping risks to specific audit findings. Please refer to the table below.

Risk category	Secretariat aggregated risk levels	Assessed residual risk (OIG audit)	Relevant audit issues
Program Quality	High	High	Finding 4.1, 4.2 & 4.3
National Program Governance and Grant Oversight	Medium	Medium	Finding 4.4

Although the overall OIG and Secretariat's ratings are aligned on the above risks, there were some differences at the sub-risk level. Several issues were either not identified by the Secretariat, such as incorrect reporting on the outreach indicators or the lack of an action plan for delayed activities like DPPM (both under program quality).

²⁵ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe

²⁶ The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews

3. The Audit at a Glance

3.1. Objectives

This audit sought to assess the:

- adequacy and effectiveness of grant design to ensure efficient and sustainable achievement of grant impact
- effectiveness and efficiency of the implementation and assurance arrangements in supporting the achievement of grant objectives

3.2. Scope and Methodology

The audit was in accordance with the methodology described in Annex B, covering the period from January 2017 to December 2018. All active grants and Principal Recipients of Global Fund programs in Indonesia were included in the scope. The audit covered six grants implemented by four Principal Recipients: the Directorate General of Prevention and Disease Control at the Ministry of Health; Yayasan Spiritia; Central Board of 'Aisyiyah; and Persatuan Karya Dharma Kesehatan Indonesia (PERDHAKI). The auditors visited selected health facilities, laboratories and warehouses in Jakarta.

Scope Limitation

The United Nations General Assembly has adopted a series of resolutions and rules which create a framework known as the “Single Audit Principle”. Under this framework, third parties are not allowed to access books and records of the United Nations and its subsidiaries. All audits and investigations are conducted by the UN’s own oversight bodies. The Global Fund Board and its committees have considered this assurance over funds managed by the UN agencies and subsidiaries and rely on the assurance provided by these UN oversight bodies. Accordingly, the OIG team did not audit the internal controls and processes of UNFPA, the Sub-Recipient under the Federal Ministry of Health.

3.3. Progress on Previously Identified Issues

The last OIG audit of the Global Fund grants to the Republic of Indonesia in 2015 focused on the Secretariat’s management of risks. It assessed programmatic and data management, procurement and supply chain management, as well as financial and fiduciary risks.

Previous relevant OIG audit work

[Audit of Global Fund grants to the Republic of Indonesia, 2015](#)

The audit highlighted the existence of unmitigated risks at the provincial, sub-recipient level of Indonesia’s decentralized environment, as well as the necessity for the Secretariat’s portfolio risk management and assurance response to apply a differentiated approach and follow-up on program sustainability risks. This audit resulted in three agreed management actions that have since been addressed:

- Government Principal Recipients to develop and roll out a risk-based sub-recipient management plan, including identifying focus provinces and districts, and a limited number of time-bound priority actions;
- Management letters to Principal Recipients to focus on high-impact, prioritized residual risks;
- Programmatic and financial sustainability assessment with relevance to the Global Fund interventions to be completed, in line with the Global Fund strategy on sustainability and in collaboration with the World Bank, DFAT and other development partners in Indonesia.

4. Findings

4.1. PLHIV testing and linkage between testing/treatment and monitoring need improvement, to reach the HIV 90-90-90 cascade

Noticeable progress has been made towards achieving the “90-90-90” targets over the past several years. For example, the number of men who have sex with men who received an HIV test and who know their result increased by 27%, from 82,000 in 2017 to 112,000 in 2018.²⁷ This was mainly due to collaboration with civil society organizations and the use of mobile clinics for key affected populations. The number of people living with HIV receiving anti-retroviral treatment increased by 19%, from 91,000 in 2017 to 108,000 in 2018, mainly due to the adoption of a “test and treat” policy in 2018. Indonesia has committed to increasing the number of people living with HIV who are receiving anti-retroviral treatment, from 18% in 2018 to 45% in 2020. Despite the progress made on the indicators agreed with the Secretariat as part of the performance framework, the country’s current HIV treatment cascade remains low (i.e. 50-17-7)²⁸ compared to regional or global numbers. The low performance of the HIV treatment cascade poses risks to the success of the grant and the gains made so far. Indonesia risks missing its HIV cascade targets by 2020 if the challenges below are not addressed.

Stagnant testing yield and testing targets among key affected populations: Despite high HIV prevalence among key affected populations,²⁹ the targets for the number of people to be tested and know their results are generally low: Men who have sex with men – 32%; Transgender – 15%; People who inject drugs – 12%; Sex workers – 16.8%; and Prisoners - 17%. The positivity yield from the key affected population outreach program also remains stagnant³⁰, notably lower than the prevalence rates from the 2015 Integrated Biological and Behavioral Survey (IBBS). For example, the change in testing yields for key affected populations from 2017 to June 2019 are:

- Men who have sex with men: 7% to 9%
- People who inject drugs: 4% to 3%
- Transgender: 4% in both periods
- Female sex workers: 2% in both periods

The low testing coverage and yield among key affected populations represent a missed opportunity for early diagnosis and timely initiation of antiretroviral therapy. Indonesia is one of the 35 countries (ranked 7th) that account for 90% of new infections globally and is 2nd highest in Asia after India. To improve the positivity yield, a new ‘virtual outreach’³¹ method was adopted; the Principal Recipient is however yet to evaluate the effectiveness of this method. Notification and testing of partners of key affected populations was introduced in 2018, but there is limited documentation to trace partners and their positivity yield. Mobile testing was also adopted in collaboration with civil society organizations, however its availability is limited.

Regarding the number of female sex workers and men who have sex with men who were tested and know their results, the data reported to the Secretariat represented the number of tests rather than individuals tested (one individual may do multiple tests). Grant activities to reach more key affected populations are yet to start, due to administrative and legal barriers; these include community-based screening, due to the unavailability of oral HIV test kits and pre-exposure prophylaxis. The Integrated Bio-behavioral Survey planned for 2018 is yet to be finalized, making it difficult to set new targets or evaluate the success of the current approach.

²⁷ Numbers reported in the 2017 and 2018 Progress Update/ Disbursement Requests.

²⁸ UNIDS 90-90-90= 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustainable antiretroviral therapy, 90% of all people receiving antiretroviral therapy will have viral suppression.

²⁹ MSM (25.8%); TG (24.8%); FSW (7.9%); PWID (28.8%) compared to national prevalence of 0.4% (adults 15-49).

³¹ Virtual outreach is a new methodology adopted by the Spiritia to reach the hidden KAPs through social media and other platforms

Low linkage to treatment, high loss to follow-up of people on treatment, and inadequate PLHIV treatment monitoring: More than 60% of people living with HIV who know their status are not initiated on treatment and over 23% are lost to follow-up after 12 months, contributing to high mortality; AIDS-related deaths in Indonesia increased from 24,000 in 2010 to 38,000 in 2018.³² The contributing factors of the low treatment coverage and high loss to follow-up include:

Gaps in the referral system to link patients to treatment: The mandate of outreach workers ends when they refer a person to test, and the mandate of peer supporters starts after anti-retroviral treatment initiation. There is no support during the period between testing and anti-retroviral treatment initiation, nor a system to track patients from diagnosis to treatment initiation, making it difficult to track patients who did not initiate treatment. People who were tested but did not receive their results are also not recorded. HIV testing is mostly conducted at primary healthcare facilities, but treatment initiation is performed at hospitals, which requires travelling. To address this, the Ministry of Health committed to implementing activities such as expanding HIV testing and treatment at all primary health care facilities and district hospitals in 96 districts categorized as “priority districts”. However, only 57 districts have at least one primary health care facilities conducting both testing and treatment initiation, and only 15% of facilities providing HIV tests can provide treatment.

The Secretariat and the in-country partners are in the process of finalizing an acceleration plan, which will include relevant arrangements to increase the number of facilities conducting both testing and treatment.

Improvement needed in implementing the “test and treat” policy: According to the “test and treat” policy, people living with HIV are supposed to be initiated on treatment within seven days following diagnosis. Although “test and treat” was adopted in October 2018, it is yet to be fully implemented by all districts. The physical distance between diagnosis and treatment sites, as well as the practice among physicians to prescribe a multitude of patient-financed tests before initiating treatment contribute to the policy’s ineffective implementation. There is no mechanism to track whether facilities have adopted the policy.

Limited central-level oversight on patients lost to follow-up, including the number of lost to follow-up that have been investigated and those that were successfully brought back to treatment. Health facilities are not sharing patient information with patient supporters at civil society organizations, affecting efforts to reduce the number of lost to follow-up. A recent decree authorizing the sharing of data with civil society organizations is expected to improve the situation.

Gaps in monitoring clients on HIV treatment: Indonesia has adopted WHO guidelines of using viral load testing³³ to monitor treatment efficacy after six months, 12 months and then annually. The use of viral load testing is however very limited, with testing coverage less than 7%. Low viral load testing increases the risks of higher mortality and drug resistance. According to WHO, for each additional month of delay in taking the first viral load test, the risk of virological failure increases by 9%, and the risk of treatment switching increases by 14%.³⁴

The Government finances reagents for viral load through domestic funding, and the Global Fund finances the costs of testing not covered under social health insurance. Confusion around which costs are reimbursed by the Global Fund has led to a reluctance of clinicians to prescribe viral load testing as per the interviews OIG had at lower levels. As a result, the budget line for costs associated with

³² UNAIDS- Indonesia country profile

³³ A viral load test measures the number of HIV viral particles per millilitre of blood. A low viral load indicates that treatment is effective. A high viral load in a person on treatment indicates either that the medication is not being taken properly or that the virus is becoming resistant to the medication.

³⁴ WHO HIV testing guidelines, 2011

viral load testing is under-utilized. In addition, patients on treatment for more than 15 months are expected to pay for viral load tests themselves. Only 60% (18/30) of viral load machines are functioning due to low demand.

Agreed Management Action 1

Based on the finalized IBBS and lessons from the HIV acceleration plan, the Secretariat will review the implementation arrangements to meet treatment coverage targets of Dec 31 2020, as agreed in the grant Performance Framework, and ensure proper mechanisms for monitoring patient cohorts are in place.

Owner: Head, Grants Management Division

Due date: 31 January 2021

4.2. Improvements needed to achieve the desired TB and MDR-TB notification and treatment outcomes

Indonesia has improved case notification outcomes by 24%, from 447,000 in 2017 to 564,000 in 2018. The scale up of GeneXpert testing, outreach and contact tracing activities, as well as the introduction of mandatory notification contributed to this achievement. The country has developed and rolled out a Community Based Monitoring and Feedback application aimed at improving knowledge of TB patients, access to services and reporting. A specimen referral mechanism, SITRUST³⁵ is also helping to monitor transportation of sputum specimens from non-GeneXpert health facilities to labs with GeneXpert machines to be tested. A Ministry of Health decree in 2017 to increase the number of MDR-TB hospitals to 260 and bolster patient support mechanisms is improving the management of MDR-TB. Nevertheless, challenges persist around the effectiveness of contact tracing activities, limited implementation of Public/Private Mix at the district level, improvements needed in the management of GeneXpert machines, and low MDR-TB retention in care. About 67% of the estimated incidence was notified by the National TB Program (MoH) nationally. The country is among the top 10 countries (ranked 3rd) accounting for 80% of missing cases globally,³⁶ with TB the fourth leading cause of death.

(i) Challenges with the effectiveness of contact tracing activities: More than 50% of cases referred by volunteers are not being tested in health facilities (see table below for details), this is due to the absence of updated guidelines on who qualifies for referral; each party uses different screening parameters. For example, volunteers refer any suspect who meets one of six screening symptoms, while health facilities test only people who have two of the six symptoms.

Table 1: Number of TB-positive contacts found by the Principal Recipient (Aisyiyah) and sub-recipient (LKNU) under the Ministry of Health between July 2018 and June 2019:

Implementer	Number of contacts referred	Number of contacts tested	Number of contacts with positive TB
Aisyiyah	85,332	45,209	5,461
LKNU	34,933	13,525	1,479

Contact investigation is not conducted in the households of bacteriologically-confirmed TB patients as per the agreed indicator. Staff from civil society organizations (CSO) instead take their index information from the register of TB patients already on treatment, a lower number compared to the register of notified TB cases with testing results, as not all notified cases start treatment. Further, staff members do not report results back to the health facility, making it difficult for nurses to track whether all eligible contacts of TB patients have been investigated. There is also no formal mechanism to evaluate the quality of the CSO's screening, and the primary health care facilities in the districts do not have a budget to investigate contacts. Contact investigation guidelines are currently being updated; this should allow for a better standardization of activities.

(ii) Limited implementation of Public/Private Mix at the district level: Indonesia's large private health sector is not yet firmly linked to the reporting network of the National TB Program.³⁷ Although 74% of initial care-seeking for TB occurs in private health care facilities,³⁸ only 3% of TB notifications come from the private sector/community. An approach has not yet been developed to respond to the Global Fund's Technical Review Panel request to "elaborate a comprehensive strategy/plan for engaging private providers in TB care"³⁹. Basic and comprehensive district public/private mix

³⁵ SITRUST is a user-friendly and web-based application.

³⁶ Global TB Report, 2018, page 2 and 79

³⁷ Global TB Report, 2018, page 87

³⁸ Global TB Report, 2018

³⁹ issue number 6: Strategy for private sector engagement in TB programme activities

(DPPM) packages were expected to be provided in 243 regular districts and 271 high priority-high impact districts respectively in 2018. However, only 37 districts have been prioritized.

While the DPPM approach, guidance and action plan were supposed to be finalized during NFM1 (2016-2017) and implemented in 2018, the first half of the NFM2 grant was mainly spent on developing guidelines and operational plans, as well as advocacy and informal socialization. There are no clear central guidelines regarding DPPM implementation at district level. As many missing cases go to the private sector, the limited progress on the DPPM strategy may affect the country's ability to increase case notification.

(iii) Improvement needed in the management of GeneXpert machines: At the time of the audit fieldwork concluded on 4 September 2019, 979 GeneXpert machines were in the country, of which 875 machines had been distributed to the relevant health facilities and 809 installed. Sixty-six machines had been dispatched but were not installed, due to the health facilities' lack of preparedness. Over 100 machines had been at the warehouse since March 2018 because facilities were not ready to receive them; these idle machines with a value of US\$3 million were no longer under warranty at the time of the audit (GeneXpert machines come with a one-year warranty on parts, effective from the date of shipment). For machines under warranty, OIG noted delays in replacing broken parts (over 10 months) impacting the capacity of the GeneXpert machines. 38% (44/117) of machines with broken parts had a valid warranty but were yet to be fixed; the remaining machines have expired warranties and were also yet to be repaired.

The Secretariat has started addressing the issue after the audit. As at November 2019, the remaining machines that have not been distributed are 68 machines, and eight machines have been distributed but not installed. The warranty on 234 machines have been extended for six months until April 2020. The Country Team is currently facilitating a shift to a service model and the establishment of a repair center, which is at an early stage of negotiation.

(iv) Improvement needed in the management of MDR-TB: Indonesia is one of the world's 27 high-burden MDR-TB countries. About, 49% of MDR-TB patients diagnosed do not start treatment, and there is no mechanism to track them. Case Managers and Patient Supporters are only involved after treatment initiation, and there is no mechanism/indicator to measure their performance. Patient referrals and follow up from/to primary health facilities and district health offices are done through WhatsApp, with no dates or results of visits. Results of sputum tests are also often sent via WhatsApp due to a lack of system access. Patient information is shared with civil society organizations for them to follow up and conduct house visits. While personnel record their activity and outcomes in an Excel file, they report follow-up outcomes verbally to the Head Nurse, making it difficult to evaluate the results of NGO work at the national level.

Agreed Management Action 2

The Secretariat will work with the Federal Ministry of Health, relevant civil society organizations and development partners to:

- ensure that staff from relevant Global Fund-supported CSOs are instructed to consider all bacteriologically confirmed cases in their lists for contact investigation follow up.
- in the context of the country dialogue process, revisit the DDPM activities based on recent case notification data and assess the need to maintain, scale up or scale down this activity.

Owner: Head, Grants Management Division

Due date: 31 January 2021

4.3. TB/HIV collaborative activities, including GeneXpert utilization, require strengthening

There are several examples of good TB/HIV collaboration, including HIV outreach workers systematically conducting screening for TB symptoms as part of HIV outreach to key affected populations. All health facilities visited conduct TB screening of HIV patients, and TB patients are tested for HIV. Indonesia is among the top 20 countries in the world with high TB/HIV co-infection. In 2018, an estimated 36,000 people were diagnosed with TB/HIV.⁴⁰ Challenges relating to the implementation of TB/HIV collaboration activities persist, resulting in limited performance on grant coverage indicators. For example: only 35% of HIV-positive new and relapse TB patients were put on anti-retroviral treatment during TB treatment, and only 15% of people living with HIV who were newly enrolled in HIV care started TB preventive treatment.⁴¹ The main cause of mortality in people living with HIV is TB; inadequate TB/HIV collaboration reduces the possibility to diagnose and enrol people on treatment and save lives. Key challenges include:

Vertical TB and HIV program structure: TB is primarily diagnosed and treated at the primary healthcare level, while HIV treatment is mostly hospital-based, meaning that many co-infected patients receive care in two different facilities, putting an additional burden on the patient. While all primary healthcare facilities can conduct TB testing and administer treatment, only 34% of primary healthcare facilities and 26% of hospitals are able to provide HIV testing services. There are different reporting systems for TB and HIV, and there is no cross-validation of data between the two programs. Integrated TB/HIV supervisions are not yet happening, and the HIV/TB integrated supervision plan is yet to be approved.

Sub-optimal use of GeneXpert machines for viral load testing: To increase accessibility to viral load testing, Indonesia is leveraging the use of GeneXpert machines. The project commenced with a pilot in 53 districts in Q4 2018 from the total of 809 GeneXpert machines. The use of GeneXpert machines for viral load testing is contingent on their level of utilization for TB testing; machines with utilization for TB testing of less than 50% are leveraged for viral load testing. The contributing factors of the low utilization of GeneXpert machines for viral load testing include:

- Prolonged time (approximately one year) between training and roll-out of viral load testing using GeneXpert machines. By the time cartridges for the machines were received, some staff who had been trained to use the machines had left the health facilities, while others indicated they had forgotten how to use them.
- The scale-up of viral load testing is envisaged to be supported by a third-party supplier, who submitted a proposal which includes optimizing the current viral load machines as well as developing a sample transportation system. This is however still under negotiation, expected to result in a call for proposals by the end of 2019.

A plan⁴² to improve TB/HIV collaboration was developed in 2018. Whilst the plan was approved at the time of the audit in August 2019, its budget had not been finalized.

Agreed Management Action 3

The Secretariat will work with the Federal Ministry of Health and other development partners to finalize the budget for the Acceleration plan of TB/HIV control.

Owner: Head, Grants Management Division

Due date: 30 June 2020

⁴⁰ WHO Global Tuberculosis Report 2017; cases notified with known HIV status

⁴¹ Progress Update/ Disbursement Request- 31 December 2018- Coverage Indicators_1B

⁴² "Acceleration plan of TB-HIV control with integration to the Mother-Child Health (MCH) Program in Indonesia 2018-2020"

4.4. Gaps in oversight and assurance arrangements

The Principal Recipients, who have over 540 implementers⁴³, have instituted measures that have improved the financial management of grants. Manuals guide the administrative function of grant implementation. All six Principal Recipients have bank accounts dedicated for Global Fund grants as well as proper accounting systems, and maintain fixed asset registers to safeguard assets procured through the grants. Despite the progress made, oversight and supervision by the Principal Recipients are weak: only 69% (46/67) of planned supervision visits to sub-recipients took place.

The audit noted that five⁴⁴ of the six Principal Recipients do not have a comprehensive supervision plan in place, and supervision visits were not in line with the outcomes of the PRs' risk assessment. Some sub-recipients who were rated as high risk were not visited, while other medium- or low-risk rated sub-recipients were visited. The PR Aisiyiyah has four staff who perform supervision across 14 sub-recipients and 130 sub-sub-recipients, while the National HIV Program (MoH) has eight staff performing supervision across 46 sub-recipients and 240 sub-sub-recipients. There is no difference in the approach towards sub-recipient reviews and monitoring, despite variations in grant size and risk level. This has contributed to 50% of the Principal Recipients exceeding their supervision budgets in 2018, despite there being fewer supervision visits than planned.

For five⁴⁵ of the six PRs, there is no documented evidence that they communicated review findings and recommendations to sub- and sub-sub-recipients; the PRs stated that they communicate findings verbally. There is no system in place to track findings and recommendations raised in supervision, and no formal mechanism for providing post-supervision feedback to sub-recipients after supervision. These gaps are reducing the PRs' ability to ensure a proper internal assurance mechanism which provides adequate oversight over the effectiveness and efficiency of sub-recipient activities. Notably, 53% of findings in 2018 highlighted by the Secretariat were recurring (i.e. outstanding from NFM1).

Agreed Management Action 4

The Secretariat will ensure that all Principal Recipients develop risk-based sub-recipient supervision plan for monitoring of their sub-recipients, and ensure that systemic feedback and follow up mechanisms are put in place.

Owner: Head, Grants Management Division

Due date: 30 June 2020

⁴³ The implementers include sub-recipients and sub sub-recipients at the sub national level

⁴⁴ Aisiyiyah, Perdahki, MOH – TB, MOH – HIV – MOH - Malaria

⁴⁵ Aisiyiyah, Perdahki, MOH – TB, MOH – HIV – MOH - Malaria

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
<p>1. Based on the finalized IBBS and lessons from the HIV acceleration plan, the Secretariat will review the implementation arrangements to meet treatment coverage targets by Dec 31 2020, as agreed in the grant Performance Framework, and ensure proper mechanisms for monitoring patient cohorts are in place.</p>	31 January 2021	Head, Grants Management Division
<p>2. The Secretariat will work with the Federal Ministry of Health, relevant civil society organizations and development partners to:</p> <ul style="list-style-type: none"> ▪ ensure that staff from relevant Global Fund-supported CSOs are instructed to consider all bacteriologically confirmed cases in their lists for contact investigation follow up. ▪ in the context of the country dialogue process, revisit the DDPM activities based on recent case notification data and assess the need to maintain, scale up or scale down this activity. 	31 January 2021	Head, Grants Management Division
<p>3. The Secretariat will work with the Federal Ministry of Health and other development partners to finalize the budget for the Acceleration plan of TB/HIV control.</p>	30 June 2020	Head, Grants Management Division
<p>4. The Secretariat will ensure that all Principal Recipients develop risk-based sub-recipient supervision plan for monitoring of their sub-recipients, and ensure that systemic feedback and follow up mechanisms are put in place.</p>	30 June 2020	Head, Grants Management Division

Annex A: General Audit Rating Classification

Effective	<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>
Partially Effective	<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>
Needs significant improvement	<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>
Ineffective	<p>Multiple significant and/or (a) material issue(s) noted. Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised.</p>

Annex B: Methodology

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

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

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

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

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

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

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries⁴⁶ representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants.

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

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

The ratings at the 20-risk level are aggregated to arrive at the eight risks using simple averages, i.e. each of the component parts are assumed to have similar importance. For example, the risk ratings of *Inadequate program design (1.1)* and *Inadequate program quality and efficiency (1.3)* are averaged to arrive at the rating of Program Quality for a grant. As countries have multiple grants, which are rated independently, individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. As the ratings of grants often vary significantly and to ensure that focus is not lost on high-risk grants, a cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee⁴⁷ during the Country Portfolio Review.

Leveraging Risk Appetite in OIG's work

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

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

⁴⁶ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe.

⁴⁷ The role of the Portfolio Performance Committee is to conduct country portfolio reviews.

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

Table of risks

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