Audit Report

Global Fund Grants in the Republic of Côte d'Ivoire

GF-OIG-20-007
26 March 2020
Geneva, Switzerland

The Global Fund
Office of the Inspector General

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Audit Report

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1. Executive Summary

1.1 Opinion

With €191 million of signed grants in the current funding cycle, the Global Fund is Côte d'Ivoire's major financing partner in the fight against malaria and tuberculosis, providing approximately 40% of total funding.

Grant implementation arrangements at the Ministry of Health (MOH) changed significantly in early 2018 with the setup of a program management unit, Unité de Coordination des Projets (UCP). The ministerial decision to create UCP outlined its remits but did not define the type of implementing entity it should be, either in the short or long term. This makes it difficult to design a structure supporting UCP's evolution. UCP's limited accountability for centralized functions, notably procurement, does not help address bottlenecks and challenges in the procurement process. The effectiveness and efficiency of the new implementation arrangements at MOH are rated as **partially effective.**

Drug traceability is satisfactory at the central level. Likewise, items delivered by the National Medical Store (Nouvelle Pharmacie de la Santé Publique - NPSP) to districts and hospitals are traceable in most cases. A unit for validating orders from health facilities/districts has been put in place at the NPSP. Challenges with issued stock remain mainly at health facilities level. At several health centers and TB care centers, the consumption of anti-malaria and anti-tuberculosis drugs was nearly double the number of reported cases, with no explanation for the discrepancies. Drug transfers between health facilities are not supervised or adequately documented, leading to limited transparency and accountability. Both UCP internal audit and the supply chain department of the National Malaria Programme (PNLP) uncovered similar findings in health facilities out of those visited by OIG. Main contributing factors include the limited scope of supervision as well as the existence of a large informal health products market. The adequacy and effectiveness of controls and processes for distribution and traceability of malaria and TB health commodities mainly at health facilities **need significant improvement.**

According to routine data from the MOH's health management information system (HMIS) and estimates from the World Health Organization (WHO), there has been little improvement in reducing malaria impact indicators such as malaria incidence, mortality and malaria test positivity rates, compared to 2015 results and the national targets. Vector control challenges (low bed nets utilization rate, increasing resistance to insecticide) and malaria case management at community level (recurring stock-outs of commodities, low coverage), among other factors, could have contributed to the slow progress. Concerning TB, community-based interventions have helped stabilize case notification and reduce the rate of cases lost to follow-up, from 7% in 2016 to 3% in 2017. However, the mortality rate of TB/HIV co-infected (21%) has been high for 5 years, due to insufficient joint management of co-infection as well as a high proportion of HIV patients who are lost to follow-up. Community-based HIV interventions have improved the linkage of new HIV cases to care, but insufficient coordination among implementers results in overlapping interventions at the community level and sub-optimal coverage of targeted populations. The adequacy and effectiveness of community interventions to achieve intended grant objectives are rated **as partially effective.**

1.2 Key Achievements and Good Practices

Various positive changes since the last OIG audit. UCP was put in place in response to challenges including difficulties in implementing RSSH[1] activities. With a reporting line to the MOH Cabinet Director, UCP enjoys high positioning in MOH compared to other implementers, namely the national disease programs. UCP has developed various tools and templates to assist RSSH beneficiaries to better plan and manage RSSH activities. Its internal audit function plays a good

[1] Resilient and Sustainable Health System

oversight role on funded commodities through recurring reviews of inventories. The creation of an orders validation Unit at NPSP in January 2019 is helping to ensure alignment between health facilities' needs and orders. The above new initiatives still require improvements to fully meet expectations.

Good traceability of drugs received at central and peripheral level. There is good traceability of health commodities from suppliers to the country through the NPSP. At the peripheral level, there is satisfactory traceability of health commodities directly delivered by NPSP to district pharmacies and referral hospitals. Issues are rather at health facilities level (see below).

Increasing grant focus on linkage to care and retention. Various initiatives, including the active search of lost to follow-up pregnant women at the community level, have contributed to increasing malaria intermittent preventive therapy coverage from 23% in 2016 to 42% in 2018[2]. The allocation of a budget to escort new HIV-positive people to treatment helped increase antiretroviral enrolment of newly HIV-positive key populations, from 69% in 2017 to 95% in 2018[3]. Regarding TB, intensification of interventions at community level reduced lost to follow-up patients from 7% in 2016 to 3% in 2017.

1.3 Key Issues and Risks

UCP's governance and procurement functions need to improve. Nearly two years after its establishment, a vision for what UCP should be, in both the short and long term, has not been defined, despite this being essential to determining how UCP's structure should evolve. UCP's current structure does not allow it to achieve many of the activities set out in the ministerial decision for its creation. UCP's accountability is limited for key functions such as procurement and financial reporting. As a result, recurring delays remain for centralized procurement of goods/services, as the procurement process is shared between both entities.

Insufficient traceability of drugs issued at health facilities level. Stock accounting at health facilities remains a challenge. At 27% (7 out of 26) of health centers and 20% (2 of 10) of TB care centers visited, reported consumption of anti-malaria and anti-tuberculosis drugs was almost two times higher than the number of reported cases, with no explanation for the discrepancies. Inter-health facility drugs transfers are unsupervised and inadequately documented, preventing transparency and accountability over transfers.

Little progress against national malaria targets. According to data provided by the country's health management information system and estimates from the WHO, little progress has been achieved towards the 2020 malaria targets. Specifically, the reported malaria incidence rate in 2015, which was expected to have fallen by 40% by 2020, has not reduced at all. Weaknesses on vector control are possible contributing factors, besides other factors such as lack of sanitation, possible quality issue of malaria case testing, and improved notification of cases. There is widespread vector resistance to Long-Lasting Insecticide Nets (LLIN), a low LLIN utilization rate (63% [4]in 2019), as well as inconsistencies in the mass campaign registration process which were not investigated to confirm the reliability of registration data.

Need to strengthen community-based malaria interventions. The coverage of population living at least 5 km from the nearest health center is still low, with nearly 48% coverage in the 12 regions supported by the Global Fund grants. In covered areas, more than 20% of Community health workers (CHWs) experienced recurring stock-outs of malaria rapid tests and anti-malaria drugs, reaching at least 15 days per month. In addition, a significant proportion of CHWs cover high population numbers, well beyond the nominal limit of 500 inhabitants per CHW. This limits CHWs'

[2] Progress Update Disbursement report as at December 2016 and December 2018
3 Alliance annual activity reports 2017 and 2018
[4] Preliminary report on evaluation of post-campaign LLIN distribution 2017 - 2018

capacity to conduct active malaria case finding throughout their communities, to achieve early diagnosis of malaria.

1.4 Rating

Rating	Objective
(yellow)	Objective 1: Effectiveness and efficiency of new implementation arrangements at MOH OIG Rating: Partially effective
(orange)	Objective 2: Adequacy and effectiveness of controls and processes for distribution and traceability of malaria and TB health commodities OIG Rating: Needs significant improvement
(yellow)	Objective 3: Adequacy and effectiveness of community interventions to achieve intended grant objectives. OIG Rating: Partially effective

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:

- develop a business plan for the UCP including vision statement, terms of reference, service level agreement for key services;
- strengthen oversight over commodities through revision of supervision terms of reference and increased assurance reviews;
- develop an updated operational plan for the upcoming LLIN mass campaign distribution;
- develop measures to promote an integrated approach and improve joint management of the HIV/TB response, with a particular focus on high burden sites.

2. Background and Context

2.1 Overall Context

Located in West Africa, the Republic of Côte d'Ivoire is divided into 31 regions, 108 departments and 410 sub-districts, and two autonomous districts: the largest city Abidjan, which is home to many central government institutions, and the political capital, Yamoussoukro. Half of the population lives in urban areas.

A lower middle-income economy, GDP growth has averaged 8% per year since 2011, but 46% of the population still live below the poverty line[5]. Following a series of violent crises, the latest being post-electoral conflict in 2010-2011, the country held peaceful elections in 2015; political stability has since returned.

Population: **26 million**

GNI per capita: **US$1,610** (2018, World Bank)

UNDP Human Development Index: **165 of 189** (2019)

Transparency International Corruption Perceptions Index: **106 of 180** (2019)

UNDP Gender Inequality Index: **165 of 189** (2018)

In 2016, health expenditure per capita was US$68. Total health expenditure declined from 6% of GDP in 2012 to 4.4% in 2016[6] (against a 5.15% average in non-high income Sub-Saharan Africa countries).

2.2 Differentiation Category for Country Audits

The Global Fund classifies the countries in which it finances programs into three 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 classified into two crosscutting 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 controls and oversight in a particularly risky environment.

The Global Fund classifies Côte d'Ivoire as:

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

2.3 Global Fund Grants in Côte d'Ivoire

Between 2003 and 2019, the Global Fund signed 18 grants with Côte d'Ivoire, totaling US$736 million[7], of which US$625.5 million has been disbursed to date across the three diseases, including in activities focusing on Resilient and Sustainable Systems for Health.

The current grant allocation for 2018-2020 totals €191 million, detailed in the below table:

5 World Bank Côte d'Ivoire profile
6 World Bank indicator
7 Global Fund explorer

Grant	Principal recipient	Component	Signed amount (EUR)	Disbursed Amount (EUR)
CIV-T-ACI	Alliance Nationale Contre Le Sida en Côte d'Ivoire	Tuberculosis	4,400,000	2,070,113
CIV-T-MOH	Ministry of Health and Public Hygiene of the Republic of Côte d'Ivoire – PNLT	Tuberculosis	5,805,039	5,668,694
CIV-M-SCI	Save the Children Federation, Inc.	Malaria	29,973,175	15,108,501
CIV-M-MOH	Ministry of Health and Public Hygiene of the Republic of Côte d'Ivoire – PNLP	Malaria	81,750,750	22,836,716
CIV-H-MOH	Ministry of Health and Public Hygiene of the Republic of Côte d'Ivoire – PNLS	HIV	46,017,378	21,490,334
CIV-H-ACI	Alliance Nationale Contre Le Sida en Côte d'Ivoire	HIV	23,595,463	11,170,513
Total			**191,541,805**	**78,344,871**

As part of the NFM 2 allocation, catalytic funding has been granted through matching funds addressing key issues, in particular: Human Rights and Key Population in HIV (US$2.1 million and US$3.6 million respectively) as well as Data Strengthening and use (US$2.7 million).

Approximately 25% of the funding to fight the three diseases in Côte d'Ivoire is provided by the government. The Global Fund is the largest external donor for TB and Malaria (approximately 40% of each disease's total funding), and the second largest donor for HIV (approximately 13% of total funding) after the United States government through PEPFAR.[8]

2.4 The Three Diseases

HIV/AIDS[9]: Côte d'Ivoire has the highest (2.6%)[10] HIV prevalence in the West and Central Africa region for population 15 – 49 years, with a higher burden among women (3.5% vs 1.7% for men).

With prevalence rates of 12.2% among female sex workers and 12.3% among men having sex with men, key populations are particularly affected.

Challenges in reaching the 90-90-90 objective remain significant, with only 63% of estimated PLHIV

460,000 estimated people living with HIV in 2018

17,000 new HIV infections and 16,000 AIDS-related deaths in 2018, both figures having decreased by 32% since 2010

252,125 people on antiretroviral therapy in 2018[11]

[8] Landscape Funding Table 2017
[9] All data are from UNAIDS Côte d'Ivoire profile
10 The Côte d'Ivoire Population-based HIV Impact Assessment (CIPHIA) conducted in 2017 – 2018 has slightly different data on prevalence compared to UNAIDS. Estimated prevalence for the population for 15- 49 was 2.5%, 3.6% for women and 1.4% for men. https://phia.icap.columbia.edu/wp-content/uploads/2018/08/CIPHIA_Cote-DIvoire-SS_FINAL.pdf
[11] Global Fund Progress Update Disbursement Request PNLS – December 2018

knowing their status and 55% on treatment. 41% of those on treatment had suppressed viral load in 2018.

Malaria: With endemic malaria and high transmission across the entire country (peak during the rainy seasons, P. falciparum), Côte d'Ivoire represents 4% of the global burden.

From 2010 to 2014, the estimated number of malaria cases dropped by 26%, from 9.6 million to 7.1 million. However, the estimated number of cases have not reduced since then with a slight increase (3%) in estimated incidence rate from 2015 to 2018.

The Global Fund and the President's Malaria Initiative (PMI) are the two major partners funding the fight against malaria. The Global Fund's contribution accounts for 40% of available funding for the period 2018 – 2020.

15.9 million insecticide-treated nets distributed in the 2017/2018 mass campaign[12]

Estimated cases have increased since 2015 with a slight reduction in the number of deaths (WHO malaria world report 2019):

- 8.3 million estimated confirmed cases in 2018 against 7.4 million[13] cases in 2015;
- 9,297 deaths due to malaria in 2018 against 9,501 deaths[14] in 2015.

Tuberculosis:

HIV/TB co-infection is significant, with incidence of 28 per 100,000[15]. The HIV-TB mortality rate has been stagnant at 21% since 2014[16].

Notification of MDR-TB cases is low: in 2018, there were an estimated 2,200 cases. 484 (34%) were notified and 372 put on treatment.

Important funding gaps exist, with 70% of needs remaining unfunded[17].

TB incidence has reduced from 170 per 100,000 in 2013 to 142 in 2018 but remains high, with 21,303 new notified cases per year.

Mortality rate of 32 per 100,000 population in 2018.

Treatment success rate of 83% in 2018, slightly below national target of 85%[18].

2.5 Portfolio Performance

Based on results reported by the country to the Global Fund, grants are generally performing well against the targets set in the performance framework, except for the indicators related to routine distribution of bed nets and malaria intermittent preventive therapy for pregnant women. Performance on key coverage indicators reported by the country as of 31 December 2018 is shown in the table below:

[12] Global Fund Progress Update Disbursement Request – December 2017
[13] World malaria report annex 3-H
[14] World malaria report annex 3-J
[15] WHO Tuberculosis Côte d'Ivoire 2018
[16] Annual activity report PNLT 2018, page 24
[17] WHO Tuberculosis Côte d'Ivoire 2018
[18] WHO Tuberculosis Côte d'Ivoire 2018

HIV	Target	Results	Achievement
Number of HIV-infected pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission	91%	72%	79%
Number of adults and children with advanced HIV infection who are currently receiving ART (overall)	68%	55%	81%
Percentage of newly diagnosed MSM linked to HIV care (individual linkage)	70%	45%	64%
Percentage of newly diagnosed FSW linked to HIV care (individual linkage)	70%	84%	120%

Malaria	Target	Results	Achievement
Proportion of pregnant women attending antenatal clinics who received at least three doses of intermittent preventive treatment (ITp) for malaria	80%	41%	51%
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	95%	85%	90%
Proportion of confirmed malaria cases that received first line antimalarial treatment at public sector health facilities	93%	93%	100%

TB	Target	Results	Achievement
Number of notified cases of all forms of TB, includes new and relapse cases	22,174	21,031	95%
Percentage of all forms of TB cases (bacteriologically confirmed plus clinically diagnosed) successfully treated (cured plus treatment completed) among all forms of TB cases registered for treatment during a specified period. Includes new and relapse cases.	83%	83%	100%

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

The minimum of three doses of intermittent preventive treatment (IPT) for pregnant women remains a challenge to the country, mainly due to the high number of lost to follow-up pregnant women attending antenatal clinics. The active search of lost to follow-up pregnant women in communities was not fully operational across the country in 2018. The country is now considering prescription of IPT at community level through CHWs to improve this indicator.

2.6 Country risk appetite consideration

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries[19] representing most 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)[20] during the Country Portfolio Review (CPR). See Annex C for further discussion of Risk Appetite methodology.

The OIG compared the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Côte d'Ivoire portfolio with the residual risk that exists based on OIG's assessment, mapping risks to specific audit findings. The assessments of risk levels by the OIG and the Secretariat aligned for the covered risk domains. Please refer to the table below:

Risk	**Secretariat aggregated assessed risk level**	**Assessed residual risk, based on audit results**	**Relevant audit findings**
National Program Governance and Grant Oversight (MOH only)	Moderate	Moderate	4.1
In-country supply chain	High	High	4.2
Program quality	Moderate	Moderate	4.3

[19] 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
[20] 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

The overall objective of the audit was to provide reasonable assurance to the Global Fund Board on the adequacy, effectiveness and efficiency of the Global Fund grants to Côte d'Ivoire.

Specifically, the OIG assessed the adequacy and effectiveness of:

- new implementation arrangements at MOH;
- controls and processes for distribution and traceability of malaria and TB health commodities;
- community interventions to achieve intended grant objectives.

3.2 Scope and Methodology

The audit was carried out in accordance with the methodology described in Annex B, covering the Principal Recipient of the Global Fund programs in Côte d'Ivoire, and the grants from January 2017 to June 2019.

In total, the auditors visited 49 health structures comprising:

- 17 district health offices
- 31 health facilities
- national drug store warehouse (NPSP)

3.3 Progress on Previously Identified Issues

Previous relevant OIG audit work

Audit of the Global Fund grants to the Republic of Côte d'Ivoire, 2016

OIG's 2016 audit of Global Fund grants in Côte d'Ivoire assessed the adequacy, efficiency and effectiveness of implementation arrangements, as well as the adequacy of supply chain controls and assurance mechanisms.

Regarding implementation arrangements, the audit highlighted both the lack of the required authority and flexibility to efficiently implement a large number of cross-cutting grant activities, leading to delays and under absorption of funds, and gaps in fiduciary control and support arrangements for the national disease programs which led to limited value for money. Regarding the supply chain, the audit found that the central medical store's inventory, reporting and distribution systems did not ensure all procured health products were properly accounted for and distributed. There were stock-outs and expiries due to limited ownership of the health product management and monitoring processes by the national disease programs.

The 2016 audit resulted in three agreed management actions that have since been closed:

- AMA 1 implementation has resulted in the creation of a new program management Unit (UCP). That new implementing entity was assessed as part of the audit (finding 4.1).

- AMA 2 refers to the transfer of fiduciary oversight responsibility from the fiduciary agent to the new UCP. This is effective since September 2019. However, UCP's effectiveness in playing this role is limited due to its insufficient independence (finding 4.1).

- AMA 3 aimed at strengthening accountability over health products at both central and peripheral level. Improvement actions taken at central are effective as the audit did not identify material issues at NPSP. However, challenges on drugs traceability remain persistent at peripheral level (finding 4.2).

4. Findings

4.1 UCP's governance and procurement function need improvement

The creation in early 2018 of a program management unit, Unité de Coordination des Projets (UCP) represents a major change in implementation arrangements within the Ministry of Health (MOH) between the previous (2015 – 2017) and current (2018 – 2020) financing cycles. With a reporting line to the Cabinet Director of MOH, UCP was set up in response to the need for better coordination and oversight of Global Fund programs managed by MOH.

A steering committee made up of senior staff from MOH and the Ministry of Finance/Budget has been set up to monitor UCP's activities and oversee programs. It includes an audit sub-committee, in charge of reviewing all matters in relation to UCP's internal auditing function. Both committees meet regularly and discuss various topics concerning grant implementation. UCP's internal audit unit is proving effective, based on the quality of its audit plan and its reports.

Notwithstanding these improvements, UCP's evolution and implementation of activities face challenges that need to be addressed.

The lack of a clear vision for UCP makes it difficult to define a structure supporting its evolution.

The ministerial decision to create UCP outlines its remits without indicating the type of implementing entity the UCP should be in the short or long term. The Secretariat proactively performed an assessment[21] of UCP in June 2019, with the purpose of identifying the most suitable structure for UCP. Five structural options were suggested by the assessment, but the Global Fund Secretariat and in-country stakeholders, namely the Country Coordinating Mechanism and the MOH, have not been able to adopt any of them, due to the lack of a clear vision at the time of UCP's inception.

According to the decision supporting the creation of UCP, its remit encompasses almost all core activities of grant management: (i) coordination of grant related activities, (ii) financial management of grants, (iii) procurement, (iv) preparation and communication of programmatic and financial reporting, (v) program monitoring and evaluation. UCP's current structure is not aligned to these remits, affecting its accountability on activities supposedly under its responsibility. In practice, UCP has limited accountability over the procurement of goods and services despite the centralization of this activity, as well as over financial reporting. Except for RSSH-related activities, UCP has no responsibility for coordination of program activities, monitoring and evaluation, or for programmatic reporting. UCP is tasked with validating the programmatic sections of the Progress Update and Disbursement Requests (PUDR), despite having little visibility of programmatic activities and results. For example, UCP failed to identify major inconsistencies in reported malaria data as part of its review of the December 2018 PUDR.

Financial management is effective, but could be strengthened to play a more centralized role.

Overall, the processing of financial transactions as well as key financial controls (e.g. bank statement reconciliation) are effective. Testing of transactions did not reveal material issues as supporting documents and records were adequate and sufficient in most cases. In anticipation of the upcoming departure of the fiscal agent, UCP has initiated prior review of all payments incurred by both UCP and National disease programs since September 2019. The verification is performed using an adequately designed validation tool. However, as part of MOH, UCP has limited independence to perform fiduciary control over transactions incurred in MOH grants.

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[21] Rapport d'évaluation de l'UCP-FM de Juillet 2019

There is still no real centralization of financial reporting at UCP. UCP's role on financial reporting is mainly limited to consolidating financial reports from national programs and adding reports related to RSSH activities. The centralization of financial reporting will remain a challenge as long as financial and accounting functions are spread between UCP and national disease programs. UCP does not monitor MOH's grants budget, a key activity towards financial reporting. The resource allocated to this activity has been directed to the prior review of payments.

Procurement function needs to be strengthened, with more accountability.

The procurement of goods and services has been centralized at UCP. UCP's procurement unit (three staff members) has developed procurement guidelines which are aligned to international standards and best practices. With the creation of UCP, no procurement staff remain at National Program entities.

Responsibilities over the procurement process are shared between the requisition entity (national disease programs) and UCP. UCP is responsible for the tendering process while the national disease programs are tasked with contract signing and monitoring execution. This situation dilutes the accountability of the centralized procurement function at UCP, particularly in cases of delayed procurements. At the time of the audit, various procurements (e.g. renovation of laboratories, medical equipment, IBBS surveys, etc.) with programmatic implications delayed by at least three months.

UCP could bring more value to the procurement process than is currently the case. For example, UCP does not organize pooled procurements for common items among programs to achieve economy of scale. There are recurring delayed procurements, some attributable to the long time spent by UCP on contract negotiation. UCP provides only limited support to the national disease programs on the timely submission of procurement requisitions, the maintenance of accurate and complete annual procurement plans, and the monitoring of contract execution.

One of UCP's key roles with regards to procurement is its ability to ensure compliant procurements. OIG identified non-compliance with procurement guidelines in 27% of tested procurements (7 out of 26) with a value of €1 million. These refer either to cases involving national rather than international calls for tender, or direct procurements with no competitive process. In two other instances, suppliers were awarded contracts despite not fulfilling the basic requirements of the tender.

Agreed Management Action 1

The Secretariat will work with the Ministry of Health, the Country Coordinating Mechanism and partners to develop a business plan for the UCP, taking into consideration ongoing discussions of the MOH and partners regarding management of external sources of financing for health, including HIV, TB, Malaria and RSSH investments.

Owner: Head, Grant Management Division

Due date: 31 December 2021

4.2 Insufficient traceability of drugs issued at health facility level

Health commodities and related procurement and supply chain costs account for approximately 67% of total MOH grants in the funding cycle 2018 – 2020. In response to OIG observations in the 2016 audit, a commodities orders validation unit was put in place at the national drugs store (Nouvelle Pharmacie de la Santé Publique - NPSP) to ensure alignment between orders from health facilities/district pharmacies and actual needs based on patient data.

Oversight over health commodities has improved, with on-site stock verification conducted on a sample of health facilities by both UCP internal audit and the supply chain department of the national malaria program in 2019. There is good traceability of health commodities from suppliers to the country through the NPSP. At peripheral level (district pharmacy and health facilities), there is satisfactory traceability of health commodities delivered by NPSP to district pharmacies and from districts to health facilities, with few exceptions.

Challenges with regards to stock management.

At health facility level, drugs are not safe from leakage. In 2 of 10 TB care centers visited, leakages of anti-TB first line pills (RH150), equaling to 10% of distributed drugs in first semester of 2019, were identified and reported by health facilities as part of quarterly reports on commodities.

There were significant unexplained gaps between consumption and reported cases. Eight out of 26 health facilities could not account for consumption of malaria rapid diagnostic tests exceeding reported tested cases by 75%. Similarly, in seven health facilities, consumption of anti-malaria treatment was almost double the number of reported treated cases. The same applies to TB drugs consumption, which was double the number of notified TB cases in two health facilities. Based on the quality of patient data registers reviewed at health facilities, these situations are likely due to leakage rather than under-notification of cases. In five health facilities, the physical stock of LLINs[22] and malaria rapid tests available on the day of visit was respectively 13% and 20% less than the balance of stock as per stock cards and/or the expected arithmetically determined balance of stock. It is worth noting that both UCP internal audit and the supply chain department of PNLP uncovered similar findings in health facilities outwith those visited by OIG.

Inter-health facility transfers are a common practice to reduce the risk of drug stock-outs. However, these transfers are completed without coordination and supervision from the district pharmacy, reducing transparency over the transfer process. Four health facilities could not account for transfers to other health facilities due to the lack of delivery notes.

The following factors contribute to the insufficient traceability of drugs:

- **Existence of a huge, informal market for health products:** there is a large, unofficial health product market in Abidjan. A 2016 OIG Investigation report (GF-OIG-16-013) confirmed that TB drugs procured through Global Fund grants in Côte d'Ivoire and other countries in the region were on sale on this market. A follow-up market survey, six months after the investigation, indicated that the sale of Global Fund-financed TB drugs had significantly reduced. However, the continued existence of the market creates the opportunity for diverted medicines to be sold.

- **Limited scope of supervision:** almost all visited health facilities received at least one integrated supervision mission during 2018/2019. However, traceability of drugs was not an area of focus for these visits.

- **Excess deliveries compared to actual needs:** in three visited health facilities, anti-TB drugs (RHZE) delivered by the NPSP from January to June 2019 represented at least double the number of TB cases notified in the same period. The orders validation unit failed to

[22] Long Lasting Insecticidal Nets, distributed routinely in health facilities to pregnant women and children

properly validate orders received from those health facilities. In case of excess deliveries, leakage of health products may go unnoticed because remaining drugs are sufficient for treatment continuity.

- **Lack of real-time visibility of stock at health facility level:** health facilities do not use an electronic inventory management tool that would provide real-time stock information for better monitoring and supervision. The Global Fund is considering financing the use of an electronic inventory management system (mSupply) in a number of health facilities across the country.

Agreed Management Action 2

The Secretariat will work with the Ministry of Health to strengthen oversight of commodities, specifically to:

a) revise Terms of Reference of supervision teams to incorporate drugs traceability as a standard element;

b) plan and implement assurance reviews (at least once a year) on drugs traceability including effectiveness of related mitigation measures over key processes (e.g. inter health facilities transfers, ordering process, distribution).

Owner: Head, Grant Management Division

Due date: 30 June 2021

4.3 Need to enhance malaria community-based interventions and impact of investments

Global Fund grants in Côte d'Ivoire cover community-based interventions for the three diseases, which are implemented by civil society organizations. In the current funding cycle, the community-based interventions for each disease have been strengthened through budget increase, especially for malaria, which increased by 135% from €12.7 million to €29.9 million. The interventions for malaria face some challenges that limit their effectiveness.

Key malaria impact indicators have not improved since 2015, despite previous high performance in reducing the malaria burden.

According to the WHO World malaria report (2019), the estimated number of malaria cases dropped by 26%, from 9.6 million to 7.1 million, from 2010 to 2014. However, the malaria epidemiology situation has not improved since then, with an increase of 3% in estimated malaria incidence and only a 2% decrease in the estimated number of deaths from 2015 to 2018. During that period, it is worth noting that vector control implementation was intensified mainly through two LLIN mass campaign distributions, resulting in the distribution of 14.6 million bed nets in 2014 and 15.9 million bed nets in 2017. The national health management information system (HMIS) data also show an increase in all key reported malaria impact indicators since 2015: a 26% increase[23] in the reported incidence rate against a target[24] of a 40% reduction by 2020; a 20% increase for reported malaria deaths, from 2,604 in 2015 to 3,133 in 2018; and the malaria test positivity rate increasing from 68% to 78% in the same period. However, a recent study on malaria death notification suggested an overstatement of reported deaths due to malaria in the HMIS in 2017 and 2018. Other studies are planned or ongoing to review the accuracy of these impact indicators determined through the national HMIS.

In Côte d'Ivoire, Global Fund malaria grants target four main interventions which are key drivers of impact in the fight against malaria: case management in health centers (public sector); specific interventions, namely intermittent preventive treatment (IPT) for pregnant women; community case management; and vector control. Regarding the last two interventions, some challenges remain to be addressed.

Challenges in malaria vector control limit its effectiveness.

The post-distribution LLIN mass campaign (2017/2018) evaluation indicates that 80.8% of households possess at least one LLIN and 55.9% of them have at least one LLIN for two people. In order to achieve better performance, some weaknesses need to be addressed before the 2020 mass campaign:

- **Resistance to insecticide and quality of LLINs:** recent studies[25] have shown mosquito resistance to LLIN insecticide across the country. This may lower LLINs' effectiveness, with a significantly reduced proportion of mosquitoes killed[26] after exposure to LLIN. Resistance has been closely monitored in the past five years[27], but the country was not in a position to address this issue in the previous mass campaign due to the lack of alternative LLINs

[23] The OIG acknowledges that inaccuracies may affect quality of data used to determine this incidence rate. Other factors such as increase in number of health facilities, improved notification of cases can justify the increase in the number of malaria cases. However, all these factors (even when considered) cannot fully account for the upwards trend reported through the HMIS.
[24] Malaria National Strategic Plan 2016 - 2020
[25] Reports on entomological research covering 16 sentinelle sites – vector link 2019.
[26] https://malariajournal.biomedcentral.com/articles/10.1186/s12936-019-2656-7 Malaria Journal - Implications of insecticide resistance for malaria vector control with LLIN
[27] « Surveillance de la résistance aux insecticides des vecteurs du paludisme pour le maintien de l'efficacité de la lutte anti-vectorielle » – report as of June2018 covering data collected for period 2013 - 2018

available. For the next mass campaign scheduled in 2020, the country has developed a stratified distribution plan with distribution of second-generation LLINs in areas identified as insecticide-resistant. About 23% of LLINs (3.7 million out of 15.7 million procured) did not undergo a quality control inspection before shipment to Côte d'Ivoire, making it difficult to have sufficient assurance on their quality.

- **Household registration process**: while good controls are in place to assess the accuracy of registered households, the registration validation process does not involve stakeholders beyond regional/district health management; reconciling their data against data from other bodies (e.g. administration, agriculture) would provide more assurance over their completeness. Inconsistencies in 22% of districts (18 out of 83) were not investigated during the registration process. These mainly relate to situations where the registered population in 2017 had either fallen significantly from 2014, or where the population had increased from 2014 but the number of households had decreased at the same time. These situations may hide possible under-coverage of the population: 35% of respondents[28] to the LLIN post-campaign distribution survey indicated that they don't use LLINs because they don't have any.

- **Low utilization rate of LLINs:** despite progress achieved compared to previous LLIN distribution campaigns, the LLIN utilization rate of 2017/2018 mass campaign (63.2%) still remains low considering the national target of an 80% utilisation rate. Lessons learnt from post-campaign evaluation are essential to inform the strategy for the 2020 mass campaign.

Need for enhanced community-based malaria interventions.

At community level, coverage of the population at risk remains low despite substantial efforts to improve it in the current funding cycle. Complete coverage of the population living at least 5 km from a health center in the 12 regions supported by Global Fund grants requires approximately an estimated 12,000 Community Health Workers[29] (CHWs). Under the current financing cycle, the Global Fund grants have supported 5,900 CHWs providing integrated community case management (48% of the need in the 44 covered districts). In these areas, the effectiveness of malaria community case management is limited by the following factors:

- **Recurring stock-outs of malaria commodities**: in 31 districts[30], the proportion of CHWs who have experienced stock-outs of malaria RDTs for at least 15 days in a month increased from 23% (851 CHWs out of 3,628) in January 2019 to 41% (1,417 out of 3,498) in October 2019. The situation is even worse for anti-malaria drugs, for which 52% and 36% of CHWs in the 31 districts reported stock-outs for at least 15 days in a month respectively in October and September 2019. Stock-outs are mainly due to the lack of commodities earmarked to CHWs at health facility level. Cote d'Ivoire is one of 16 countries selected for a supply chain transformation plan aimed at increasing commodities availability at health facilities. This is likely to reduce the risk of stock-outs of malaria commodities at community level, as supplies to CHWs highly depend on availability of drugs at health facilities.

- **Households covered not aligned to the number of assigned CHWs:** in 14 out of 44 supported districts (32%), CHWs individually cover on average 50% more people than the maximum of 500 inhabitants[31] per CHW as recommended by national community-based

[28] Preliminary report on evaluation of LLIN post campaign distribution conducted in 2019
[29] Data from the 2017 micro planning of 2017 LLIN mass campaign distribution
[30] Global Fund grants cover 44 districts. At the time of the audit, the figures provided refer to 31 districts where data were collected on stock-out of malaria RDT and anti-malaria drugs.
[31] Plan stratégique de la santé communautaire 2017 – 2020, page 58

intervention guidelines. This limits their capacity to conduct active case finding in their communities, for early diagnosis of malaria.

Agreed Management Action 3

The Secretariat will work with the Ministry of Health and partners to:

(a) develop an updated Operational Plan with measures to improve effectiveness of the next LLIN mass campaign distribution through strengthening the registration process, ensuring quality testing of distributed LLINs, and increasing LLIN utilization rate;

(b) conduct a mapping review including costed options to optimize the coverage of services provided by community health workers.

Owner: Head, Grant Management Division

Due date: 30 June 2021

4.4 Better coordination required for efficient HIV community-based intervention and mitigation of high co-infection mortality rate

1. HIV

The Global Fund's contribution towards the fight against HIV mainly focuses on commodity supply and interventions at community level. For the latter, major changes from the previous funding cycle (2015-2017) include an emphasis on targeted HIV testing and assisted antiretroviral therapy (ART) enrolment of newly HIV-positive people. In 2018, the Global Fund Principal Recipient, Alliance Côte d'Ivoire, identified almost 1,400 newly-HIV positive people[32] at community level, with almost 97% being enrolled on ART.

A review of the HIV community-based interventions reveals two main challenges:

- **Insufficient HIV coordination among implementers**

The Global Fund and PEPFAR are the two major partners implementing community-based interventions through Civil Society Organizations in Côte d'Ivoire. Insufficient coordination between both partners has resulted in sub-optimal coverage at various levels.

In 4 out of 17 districts covered by Global Fund grants at the time of the audit, implementers from both partners are providing similar packages of service to the same targeted key populations, especially Female sex workers (FSW) and Men having sex with men (MSM).

Regarding HIV patient retention, the Global Fund grant provides support to HIV patients under ART in 176 ART centers. The PEPFAR intervention provides the same services in 81 (or 46%) of the ART centers served through the Global Fund grant. The duplication of interventions is more emphasized where ART centers cover a small number of patients under ART (less than 100), occurring in 38 (or 47%) of them.

Global Fund-financed interventions targeting vulnerable populations (e.g. men above 25 years old, adolescents and young women) take place mostly in cities with smaller population sizes, rather than in larger cities where PEPFAR is present. This geographical distribution of interventions limits the ability of Global Fund grants to achieve maximum value for money. Global Fund-funded interventions offer a larger package of services, with a wider scope for HIV testing than PEPFAR, which limits its intervention to index testing at community level for strategic reasons. This may have contributed to the low yield of HIV testing of young women in areas supported by the Global Fund grant; the HIV positivity rate of 0.4%[33] was well below the national HIV prevalence in women (3.5%[34]) in 2018.

Allowances paid by PEPFAR to HIV community health workers and peer educators are between 20% and 39% higher than those paid under Global Fund grants. This has contributed to a high staff turnover (reaching 35% in 2018/19) in Global Fund interventions, affecting the smooth implementation of Global Fund grants.

A memorandum of collaboration to improve coordination between the Global Fund Principal Recipient and PEPFAR has been developed but is yet to be approved by both entities.

- **Unclear size of key populations**

With respect to key populations, grant coverage indicators targets for the current funding cycle were determined based on population sizes estimated by the National AIDS Program (PNLS). For female

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[32] Progress Update Disbursement Request (PUDR) Alliance Côte d'Ivoire June – December 2018
[33] Progress Update Disbursement Report as of December 2018
[34] UNAIDS website https://www.unaids.org/fr/regionscountries/countries/ctedivoire

sex workers (FSW), the estimated population size is materially disconnected from the number of FSWs reported as having been reached by the Principal Recipient, Alliance Côte d'Ivoire, in the previous funding cycle: PNLS's estimate of the population (8,719 in 2016) is three times lower than the reported number of FSWs covered (28,117) in the same year.

Inaccurate population estimates affect decision-making as well as performance measurement (e.g. on the number of HIV-positive FSW) in the districts covered by Alliance Côte d'Ivoire. Confusion around the size of the FSW population is mainly due to the lack of a survey (e.g. Integrated Biological and Behavioral Survey) and of a FSW unique identifier. At the time of the audit, two consultants had been contracted to conduct an Integrated Biological and Behavioral survey on key populations.

2. TB

Since 2016, community-based TB interventions have contributed to stabilizing the number of notified TB cases, which had previously been falling by around 5% annually. Interventions at community level have also allowed a reduction of lost to follow-up TB patients, from 7% in 2016 to 3% in 2017. However, there are still some challenges around the response to the mortality of TB/HIV co-infected patients and the TB service expansion initiative.

Limited response on high HIV/TB co-infected mortality rate.

With respect to TB case management, a stagnant mortality rate (21%)[35] among co-infected TB/HIV patients was observed in the past five years. In two referral hospitals accounting for most co-infected deaths, 68% of co-infected TB/HIV patients died during the first two months of TB treatment. This is attributable to weaknesses at both central and operational level. At central level, the joint management of TB/HIV co-infection faces various challenges, including the use of an outdated collaboration framework which was not signed off by the national TB program (PLNT) and PNLS, insufficient joint planning of activities, and a lack of joint supervision. At operational level, the low proportion of HIV patients screened for TB (67%[36] in 2018) combined with the high lost to follow-up rate (17%)[37] are not conducive to early treatment of co-infected patients.

Limited impact of TB service expansion investments.

The country has initiated a project to expand the TB care center network, to bring care services closer to the population. From 2015 to 2018, the number of TB care centers increased by 67%, from 184 to 307. The Global Fund has contributed to this initiative to a value of €1.07 million. However, the impact of the TB care center expansion is still not visible:

- The number of notified TB cases remained almost stagnant between 2015 and 2018 (21,000 to 22,000 cases), far from the 36,000 expected new cases according to World Health Organization estimates.
- In 2018, the 123 new TB care centers accounted for only 11% of notified TB cases. 46% of them have notified less than 10 cases per year.

The low attendance at the new TB centers is mainly due to a lack of communication around their existence, both towards the general population and to clinicians, who continue to guide patients to established TB care centers. PNLT has planned differentiated approaches to prevention, case detection and treatment for hot spots, remote, and hard-to-reach areas as part of its revised National Strategic Plan 2021 – 2025; this may be implemented in the next funding cycle with Global Fund support. This is expected to improve the utilization rate of the new TB centers.

[35] PNLT annual activity report 2018
36 Progress Update Disbursement report PNLT December 2018
37 Progress Update Disbursement report PNLT December 2017

Agreed Management Action 4

The Secretariat will work with the Ministry of Health and partners to develop measures to promote an integrated approach and improve joint management of the HIV/TB response, with a particular focus on high burden sites.

Owner: Head, Grant Management Division

Due date: 30 June 2021

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
1. The Secretariat will work with the Ministry of Health, the Country Coordinating Mechanism and partners to develop a business plan for the UCP, taking into consideration ongoing discussions of the MOH and partners regarding management of external sources of financing for health, including HIV, TB, Malaria and RSSH investments.	31 December 2021	Head of Grant Management Division
2. The Secretariat will work with the Ministry of Health to strengthen oversight of commodities, specifically to: a) Revise ToRs of supervision teams to incorporate drugs traceability as a standard element; b) Plan and implement assurance reviews (at least once a year) on drugs traceability including effectiveness of related mitigation measures over key processes (e.g. inter health facilities transfers, ordering process, distribution).	30 June 2021	Head of Grant Management Division
3. The Secretariat will work with the Ministry of Health and partners to: (a) Develop an updated Operational Plan with measures to improve effectiveness of the next LLIN mass campaign distribution through strengthening of registration process, ensuring quality testing of distributed LLINs and increasing LLIN utilization rate; (b) Conduct a mapping review including costed options to optimize the coverage of services provided by community health workers.	30 June 2021	Head of Grant Management Division
4. The Secretariat will work with the Ministry of Health and partners to develop measures to promote an integrated approach and improve joint management of the HIV/TB response, with a particular focus on high burden sites.	30 June 2021	Head of Grant Management Division

Annex A: General Audit Rating Classification

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

Annex B: 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 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 countries[38] 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 Committee[39] 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.

[38] 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.
[39] 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