Executive Summary

LFA Assurance Services

November 2023

**Executive Summary**

1. **LFA**
2. **Portfolio**
3. **LFA Service** *(the name of the service which is being completed. In case of use of “Split Service” functionality, this would be the name of the “Child” service)*
4. **Year of LFA service delivery**
5. **Grant(s)** *(Choose from drop down menu displaying the active grants pertaining to the respective portfolio)). Several grants can be selected.*
6. **Disease component(s)**
7. **It is highly recommended that LFAs complete an Executive Summary inside each relevant service in the LFA workplan. In the rare cases when the Executive Summary consolidates the findings from more than one service, please name those services.**
8. **Period under Review** *(Indicate, with dates, the time period under review (From dd/mm/yyyy) to dd/mm/yyyy)*
9. **Please certify that the information provided in this form has been shared with the Country Team and that it represents the final version of the executive summary.**

[ ] Yes, I certify

1. **For the service [XXX], please indicate to which technical area(s) the findings relate:**

[ ] Finance

[ ] Health Product & Supply Chain Management

[ ] Programmatic/M&E

[ ] Governance and Health Financing

***Only the sections selected here will be visible in the online form. For example, if Finance and Programmatic/M&E are selected, then only the Finance and Programmatic/M&E sections below will appear.***

To aid in your selections, the following table summarizes the **technical sub-areas** and **areas of concern** related to each technical area listed above. Please ensure you select the appropriate technical sub-areas and level of concern for each area of concern listed and avoid selecting ‘Other’ unless necessary. If ‘other’ is chosen, limit your response to a *brief* description of the area(s) of concern not listed. If there is more than one area of concern, clearly separate them in your response.

|  |  |  |
| --- | --- | --- |
| Technical Area | Technical Sub-area | Area of concern |
| Finance | Grant-related Fraud & Fiduciary | Flow of funds arrangement  |
|   |   | Internal controls  |
|   |   | Financial fraud, corruption, and theft |
|   |   | Value for Money – Financial Management |
|   |   | Other (please specify) |
|   | Accounting & Financial Reporting | Accounting and financial reporting  |
|   |   | Auditing Arrangements |
|   |   | Other (please specify) |
| Health Products & Supply Chain Management | Procurement | Quantification: forecasting and supply planning |
|   |   | Health Product procurement processes and outcomes |
|   |   | Non-health product procurement processes and outcomes |
|   |   | Other (please specify) |
|   | In-country Supply Chain | Health Product warehouse systems |
|   |   | Health Product distribution systems |
|   |   | Health Product information systems  |
|   |   | Other (please specify) |
|   | Quality of health products  | Pre-market approval and registration |
|   |   | Post-market approval and use  |
|   |   | Other (please specify) |
| Programmatic/M&E | HIV – Program Quality | Program design and relevance |
|   |   | Program implementation and efficiency |
|   |   | Other (please specify) |
|   | TB – Program Quality | Program design and relevance |
|   |   | Program implementation and efficiency |
|   |   | Other (please specify) |
|   | Malaria – Program Quality | Program design and relevance |
|   |   | Program implementation and efficiency |
|   |   | Other (please specify) |
|   | RSSH & Pandemic Preparedness | Laboratory systems |
|   |   | Human resources for health (HRH), excluding Community Health Workers (CHW) |
|   |   | Human resources for health (HRH) - Community Health Workers (CHW) ONLY |
|   |   | Community Systems |
|   |   | Other (please specify) |
|  Programmatic/M&E | M&E | Data governance & management  |
|   |   | Data generation, availability and quality |
|   |   | Data analysis and use  |
|   |   | Other (please specify) |
|   | Human Rights and Gender Equality | Human rights |
|   |   | Gender equity  |
|   |   | Other (please specify) |
| Governance and Health Financing | In-country governance | Health sector governance |
|   |   | National program governance |
|   |   | PR governance |
|   |   | Implementation Effectiveness |
|   |   | CCM governance |
|   |   | Other (please specify) |
|   | Health Financing | Domestic health financing and co-financing |
|   |   | Sustainability & efficiency |
|   |   | Other (please specify) |

If ‘major issues’ is selected for an area of concern, a corresponding list of descriptors of major issues will appear. These areas are broadly in line with the Integrated Risk Management (IRM) risks, sub- risks, and root causes. Please select those most appropriate and avoid choosing ‘other’ unless necessary. If ‘other’ is chosen, limit your response to a *brief* description of the descriptor(s) of major issues not listed. If there is more than one descriptor of major issues, clearly separate them in your response.

Avoid including information that is not strictly an area of concern or descriptor of major issue in the ‘Other’ fields provided. There is a free text-box at the end of each technical area where you can indicate any additional relevant information on the identified findings.

**Please note the following definitions are used throughout the executive summary:**

* No Issues: No issues have been identified that would impact the outcome of the process or activity being reviewed (ex., procurement exception procedures were followed as per manual of procedures).
* Minor Issues: Issues identified that would have **some** (insignificant) negative impact on the outcome of the process or activity being reviewed (ex., procurement exception procedures were reportedly followed but not documented according to manual of procedures).
* Moderate Issues: Issues have been identified that would have a **clear** negative impact on the outcome of the process or activity being reviewed (ex., procurement exception procedures were not followed according to manual of procedures, value for money of the procurement is in question).
* Major Issues: Issues have been identified that would have a **serious** impact on the outcome of the process or activity being reviewed (ex., procurement exception procedures were not followed according to manual of procedures and irregularities were flagged with the procurement leading to retendering and/or ineligible/recoveries).
* Level of materiality: LFA applies professional judgment to determine the overall materiality to guide the scope of their review based on the results of risk assessment, understanding of the entity and its environment. The level of materiality normally should be agreed between the LFA and the Global Fund Country Team prior to the start of the work.

**Key findings**

Technical area

1. **FINANCE**
	1. **For the service [XXX], please indicate to which finance area(s) the findings relate.**

Technical sub-area

[ ]  Grant-related Fraud & Fiduciary

[ ]  Accounting & Financial Reporting

* 1. Please indicate for each of the following areas of concern the level of issues identified. *If ‘Major Issues’ are identified in any of the areas of main concern, please indicate to which of the sub-categories they relate.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Areas of concern | N/A – not reviewed | No issues | Minor issues IdentifiedArea of concern | Moderate Issues Identified | Major IssuesIdentified |
| Grant-related Fraud & Fiduciary |
| Flow of funds arrangement | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Concerns related to tracking of funds when the bank account receiving funds is a co-mingled account
 |  | Descriptors of ‘Major Issues Identified’. This only appears if in *Area of Concern* ‘Major Issues Identified’ is ticked. |  |  | [ ]  |
| * Challenges with geographical coverage of banks and/or money transfer mechanisms in the country.
 |  |  |  |  | [ ]  |
| * Gaps related to the procedures for selection of banks in which GF funds are maintained.
 | [ ]  |
| * Concerns regarding operational controls for alternative fund transfer mechanism (alternative payment options like mobile money, payment agent, etc.).
 | [ ]  |
| * Gaps in policies and procedures for the receipt, accounting and/or administration of funds by the PR or any of the other entities and/or Lack of experience by the proposed implementing agencies in handling significant volumes of donor funding.
 | [ ]  |
| * Issues regarding adverse macroeconomic situation in-country (hyperinflation, FX fluctuations, embargo, etc.…).
 | [ ]  |
| * Challenges with availability of foreign currency to make payment to external suppliers.
 | [ ]  |
| * Challenges with implementation arrangements where it is complex (too many implementers, pass-through PRs, devolved structures).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
|  *Free text box* |
| Internal controls  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Gaps in the written financial policies and procedures manual describing the process flow and the embedded controls.
 | [ ]  |
| * Gaps in the written policies and procedures on monitoring grant implementation, including SRs/SSRs oversight.
 | [ ]  |
| * Gaps in the process for management to communicate financial reports provided by the various assurance providers to the board of directors or equivalent body.
 | [ ]  |
| * Gaps in the processes for management to ensure that the board of directors, audit, finance, or other governance or oversight committee periodically reviews the financial policies and procedures.
 | [ ]  |
| * Gaps in the process in place for management to ensure that the financial management system operates as intended and provides reliable data.
 | [ ]  |
| * Deficiencies in internal controls are not communicated or are communicated with significant delays to those parties responsible to take actions.
 | [ ]  |
| * Lack of action taken by senior management and the board to address internal control deficiencies reported to them.
 | [ ]  |
| * Procedures to detect and report management override of controls are weak or non-existent and/or management accountability regarding respect of procedures is weak.
 | [ ]  |
| * Insufficient competency of staff in charge of conducting internal control reviews.
 | [ ]  |
| * Disruptions to effective implementation of key controls and procedures including assurance mechanisms due to political unrest and/or sudden disease outbreaks.
 | [ ]  |
| * Challenges in monitoring of key controls relating to approval system for procurement of non-health products and services.
 | [ ]  |
| * Challenges in monitoring of key controls relating to payment and invoicing.
 | [ ]  |
| * Gaps in reporting and monitoring mechanisms to track the use of funds (including open advances) disbursed to SRs and other implementing partners (including decentralized levels).
 | [ ]  |
| * Challenges in monitoring of key controls relating to fixed asset management.
 | [ ]  |
| * Challenges in monitoring of key controls relating to cash and bank management.
 | [ ]  |
| * Challenges in monitoring of key controls relating to payroll management.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Financial fraud, corruption, and theft | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * PR’s or key SRs’ governance bodies (e.g., audit committee or equivalent) and other oversight bodies (e.g., internal audit) lack the remit, independence, resourcing, or stature to effectively oversee and ensure accountability for management of integrity risk and prohibited practices.
 | [ ]  |
| * No periodic fraud risk assessment is conducted to identify the various ways that fraud and misconduct can occur, and/or no documentation of this assessment is maintained.
 | [ ]  |
| * Insufficient PR and SR procedures, staff levels, skills and experience to develop and implement adequate processes and controls to identify fraud / corruption / theft triggers.
 | [ ]  |
| * Leadership and senior managers in PRs, SRs, CCMs and Medical Stores are exposed to significant political or cultural pressures or possess personal affiliations that could undermine their ability to execute their functions with integrity.
 | [ ]  |
| * Absence of or weak enforcement by PR of fit-for-purpose ethics and anti-corruption program, including an insufficient or weak policy, tone at the top, integrity risk assessment, accountability, codes of conduct, training & communication, monitoring and reporting to governance body.
 | [ ]  |
| * Absence of or weak enforcement by PR of whistleblowing hotlines, investigative and forensics audit functions, as well as a remediations or sanctions mechanism in relation to its own internal operations as well as those of grant implementers and suppliers. Concerns regarding the personal integrity of senior leadership in PRs, SRs, CCMs and Medical Stores.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Value for Money – Financial Management | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Gaps in the procedures in place or staff are not systematically orientated and/or trained regarding budgetary changes.
 | [ ]  |
| * Challenges in monitoring of budget execution resulting in delayed identification of savings and/or overspending.
 | [ ]  |
| * Challenges in monitoring of the key controls in the budget development process including gaps in policies, procedures or staff skills and experience regarding the budget development process.
 | [ ]  |
| * Gaps in the policies and procedures or staff are not systematically orientated and/or trained to enable the determination of the cost per service delivery for key interventions.
 | [ ]  |
| * Challenges in the coordination by implementers in areas being funded by more than one donor resulting in potential duplications.
 | [ ]  |
| * Gaps in the procedures and/or staff levels to ensure efficiencies in non-health procurement, tax and foreign exchange management.
 | [ ]  |
| * Challenges in PR management oversight on foreign exchange management.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| *Free text box* |
| Accounting & Financial Reporting |
| Accounting and financial reporting  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Challenges in the written policies, procedures and monitoring of the key controls relating to accounting activities, including the reconciliation of the general ledger to the subsidiary ledgers.
 | [ ]  |
| * Gaps in the written policies and procedures or staff not systematically orientated or trained on the procedures relating to preparation, approval, and posting of transactions.
 | [ ]  |
| * Gaps in the written policies, procedures, and controls for retention of accounting records.
 | [ ]  |
| * Challenges with the accounting system (including back-up process) to provide all the required functionalities (including reporting) and all the required flexibilities.
 | [ ]  |
| * Challenges in monitoring of the key controls relating to the preparation, approval, and posting of transactions.
 | [ ]  |
| * Challenges in the processes, systems, and controls in place to ensure that the financial management system between the PR and subrecipients is sufficient to ensure timely availability and integrity of consolidated financial data.
 | [ ]  |
| * Staff using the accounting software do not have access to the procedures manual of the software or are not systematically orientated or trained on the computerized accounting system.
 | [ ]  |
| * Gaps in staff capacity and/or systematic orientation or training on the reporting module of the accounting software.
 | [ ]  |
| * Challenges in the system capacity and/or staff knowledge to link the financial information with the project's programmatic progress.
 | [ ]  |
| * Gaps in PR’s senior finance management control processes to adequately supervise and monitor key accounting reconciliations and financial reports and ascertain their linkages to programmatic results.
 | [ ]  |
| * Challenges in monitoring of the key controls relating to SR reporting.
 | [ ]  |
| * Absence of or gaps in the written policies, and procedures and controls relating to grant financial management reporting.
 | [ ]  |
| * Gaps in the process or staff not systematically orientated or trained on the procedures in place for doing proper variance analysis, including taking corrective action.
 | [ ]  |
| * Gaps in the process or staff not systematically orientated or trained on the procedures in place to ensure that the financial management system between the PR and subrecipients are sufficient to ensure timely availability and integrity of consolidated financial data.
 | [ ]  |
| * Inadequate written policies, procedures including staff levels and/or controls relating to preparation and changes to the Chart of Accounts (CoA).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Auditing Arrangements | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Gaps in the procedures, staff or controls related to the selection process for audit services.
 | [ ]  |
| * Gaps in the quality review process of the auditor leading to poor reports including errors in the reports, inadequate opinion on the financial statements, non-compliance with the audit terms of reference.
 | [ ]  |
| * Gaps in oversight over the external audit process, including lack of an audit committee/equivalent body tasked with external audit oversight; or they lack competencies for proper external audit oversight; or their roles and responsibilities poorly defined.
 | [ ]  |
| * Gaps in the process or staff not systematically orientated or trained on the process relating to the follow up of internal and/or external audit issues.
 | [ ]  |
| * Mandate of the Internal Audit does not cover the Global Fund grant.
 | [ ]  |
| * Lack of or inadequate tools and procedures to cover the required audit scope due to prioritization and resource issues
 | [ ]  |
| * Lack of an internal audit unit due to lack of budget for an internal audit function, IA not part of the entity structure, management does not place importance on Internal Audit.
 | [ ]  |
| * Lack of independence of the Internal Audit unit, including budget influenced by management; Internal Audit staff are appointed and/or can be terminated by management; Internal Audit staff are involved in operational activities.
 | [ ]  |
| * Gaps in the procedures manual or staff not systematically orientated or trained on the procedures relating to the conduct of internal audits.
 | [ ]  |
| * Internal Audit not adequately resourced in terms of staff numbers and limited skills, inadequate qualification of key staff, lack of continuous professional training, etc.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**Please indicate any additional relevant information on the identified findings.**

1. **Health Products & Supply Chain Management**
	1. **For the service [XXX], please indicate the Health Products & Supply Chain Management area(s) to which the findings relate.**

[ ]  Procurement

[ ]  In-country Supply Chain

[ ]  Quality of health products

* 1. Please indicate for each of the following areas of concern the level of issues identified. *If ‘Major Issues’ are identified in any of the main areas of concern, please indicate to which of the sub-categories they relate.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Areas of concern | N/A – not reviewed | No issues Identified  | Minor issues Identified | Moderate Issues Identified | Major IssuesIdentified |
| Procurement |
| Quantification: forecasting and supply planning | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   |
| * Quantification process not properly managed (i.e., lack of coordination, lack of participation of stakeholders, fragmentation, lateness, poor documentation, insufficient oversight of national demand forecast function, no periodic review of performance).
 | [ ]  |
| * Inaccurate forecasting assumptions (i.e., latest diagnosis algorithm/treatment regimens not updated or used, program scale up/down or changes in product use guidelines not appropriately considered, national strategies not updated/appropriately considered).
 | [ ]  |
| * Poor data availability & quality (i.e., issues with availability, quality and/or utilization of essential, epidemiologic (disease caseload), population (census), consumption & stock level data (LMIS)), impede the Quantification & Forecasting process.
 | [ ]  |
| * Quantification process suffers from human resource constraints (i.e., availability and skill set of staff - technical, program, finance, logistics).
 | [ ]  |
| * Forecasting tools are not fit for purpose and prone to error (i.e., tools that are too elaborated/complex for the team to use effectively, use of old versions that have internal bugs, tools not in the language of the user).
 | [ ]  |
| * Misrepresentation or manipulation of assumptions data (such as stock levels, cohort data) to hide an in-country SC risk such as leakages, partial/non-execution of co-financing commitments.
 | [ ]  |
| * Government and/or other donor financing does not materialize (this could be due to government non-compliance to co-financing, change of other donors' commitments, etc.).
 | [ ]  |
| * Forecasts and supply plans are not updated and reviewed frequently enough to ensure they remain accurate/current, or inadequate assessment and/or tracking of forecast accuracy, such as introduction of forecast bias in earlier processes, etc.
 | [ ]  |
| * Lack of periodic independent market analyses of key budgetary variable rate inputs to ensure historical rates carried over from prior grants reflect actual prices in country.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Health Product procurement processes and outcomes | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Gaps in procurement policies, laws/regulations, manual and/or guidelines to guide and support the procurement cycle for health products.
 | [ ]  |
| * Gaps in tools or guidelines necessary to complete the sourcing process (i.e., staff do not have the purchasing and procurement forms, documents and/or registers needed to properly record and file activities and transactions; gaps in records available).
 | [ ]  |
| * Gaps in contract management processes to prevent and/or resolve complaints, issues, delays, changes, etc. (i.e., signed contracts do not adequately address important commercial/legal issues).
 | [ ]  |
| * Gaps in procedures to ensure on-time delivery and in-full of health products, generate savings, or otherwise ensure efficiencies in health product procurement.
 | [ ]  |
| * Procedures to detect and report management override of controls are weak or non-existent and/or management accountability regarding respect of non-health procurement procedures is weak.
 | [ ]  |
| * Challenges related to leadership and/or staffing capacity: e.g., the lack of training or expertise in procurement policy implementation or lack of market knowledge may hinder procurement activities and management of end-to-end sourcing process.
 | [ ]  |
| * Uncertain/delayed financial commitments by partners, including government, to procure health products, which may be due to misalignment in procurement and fiscal cycles or difficulties to materialize co-financing.
 | [ ]  |
| * Health Product global supply events outside the span of control of PRs that may lead to uncertainties in supply of key health products and may hinder the procurement plan.
 | [ ]  |
| * Lack of a procurement plan or use of an ineffective procurement plan may hamper Health Product procurement (i.e., when the procurement timeline doesn't effectively link to program needs, or when processing times and/or lead times are improperly accounted for).
 | [ ]  |
| * Tender management challenges, including non-compliance with procurement procedures (i.e., incorrect procurement procedure selection, opportunistic use of ambiguity in procurement procedures, lack of full documentation of the procurement process).
 | [ ]  |
| * Health Product procurement operations are not subject to regular internal or external audits, or other independent review around sourcing process compliance.
 | [ ]  |
| * Financial planning is not effectively linked with procurement schedules to ensure that funds are available when payment is due.
 | [ ]  |
| * Challenges in monitoring the implementation of the HP procurement plan to ensure timely order conversion and reinvestment of savings.
 | [ ]  |
| * Poor monitoring of budget execution resulting in delayed identification of savings and/or overspending.
 | [ ]  |
| * Supplier performance is not measured, not effectively monitored, or managed against agreed performance metrics, or it is not taken into consideration into future procurements evaluations.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Non-health product procurement processes and outcomes | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Tender management challenges, including gaps in procedures regarding the selection process for purchasing and procurement of non-health products.
 | [ ]  |
| * Process to appoint bid evaluation committee does not take potential conflicts of interest into account and/or members do not sign a conflict-of-interest statement.
 | [ ]  |
| * Gaps in tools or guidelines necessary to complete the sourcing process (i.e., staff do not have the purchasing and procurement forms, documents and/or registers needed to properly record and file activities and transactions; gaps in records available).
 | [ ]  |
| * Gaps in contract management processes to prevent and/or resolve complaints, issues, delays, changes, etc. (i.e., signed contracts do not adequately address important commercial/legal issues).
 | [ ]  |
| * Gaps in the procedures and/or staff to ensure efficiencies and due process in non-health procurement, tax, and foreign exchange management.
 | [ ]  |
| * Gaps in key controls relating to the procurement cycle for non-health product and services in particular, approval system for procurement of non-health products and services, payment, and invoicing.
 | [ ]  |
| * Procedures to detect and report management override of controls are weak or non-existent and/or management accountability regarding respect of non-health procurement procedures is weak.
 | [ ]  |
| * Procurement systems are not adequate to complete the end-to-end sourcing process.
 | [ ]  |
| * Gaps in procedures to ensure on-time delivery of non-health products, generate savings, or otherwise ensure efficiencies in non-health product procurement.
 | [ ]  |
| * Procurement process is hindered by non-compliance with procurement procedures or the lack of a procedure manual that clearly documents procurement process.
 | [ ]  |
| * Financial planning is not effectively linked with procurement schedules to ensure that funds are available when payment is due.
 | [ ]  |
| * Procurement activities (e.g., properly accounting for lead times) are not planned effectively or properly organized to avoid delays, or procurement timeline does not effectively link to program needs or lead times.
 | [ ]  |
| * Challenges related to leadership, staffing or organizational capacity/market knowledge that may hinder procurement activities and management of end-to-end sourcing process.
 | [ ]  |
| * Lack of procurement plan of non-health products and/or challenges in monitoring the implementation of the non-health products procurement plan to ensure timely order conversion and reinvestment of savings.
 | [ ]  |
| * Procurement operations are not subject to regular internal or external audits, or other independent review around sourcing process compliance.
 | [ ]  |
| * Supplier performance is not measured, not effectively monitored, or managed against agreed performance metrics, or it is not taken into consideration into future procurements evaluations.
 | [ ]  |
| * Poor monitoring of budget execution resulting in delayed identification of savings and/or overspending.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| In-country Supply Chain |
| Health Product warehouse systems | [ ]  | [ ]  | [ ]  | [ ]  | ☐ |
| * Inadequate facility capacity at central level (i.e., lack of space, improper storage conditions; poor storage planning; no temperature monitoring), warehouse equipment is lacking or poorly maintained, inadequate physical security and access controls.
 | ☐ |
| * Inadequate facility capacity at peripheral level (i.e., lack of space, improper storage conditions; poor storage planning; no temperature monitoring), warehouse equipment is lacking or poorly maintained, inadequate physical security and access controls.
 | [ ]  |
| * Central: Inadequate provisions for safety and fire prevention (i.e., lack of facility risk assessment, no/out of date emergency and fire plans, lack of functioning/maintained specialized fire protection equipment, staff not trained in emergency protocols).
 | [ ]  |
| * Region: Inadequate provisions for safety and fire prevention (i.e., lack of facility risk assessment, no/out of date emergency and fire plans, lack of functioning/maintained specialized fire protection equipment, staff not trained in emergency protocols).
 | [ ]  |
| * Insufficient staffing or human resource capacity (i.e., lack of appropriate staffing at central and/or peripheral level, lack of sufficient training and supervision on the job).
 | [ ]  |
| * Warehouse management policy, processes and SOPs may be poorly defined or missing (i.e., policy of FEFO may need to be updated as it cannot be enforced, receiving inbound shipments is not well defined).
 | [ ]  |
| * Substandard inventory management at central level (i.e., lack of warehouse management system/processes (WMS) or use thereof, insufficient oversight of stock levels or physical stock counts, inadequate recording, or reporting).
 | [ ]  |
| * Substandard inventory management at peripheral level (i.e., lack of warehouse management system/processes (WMS) or use thereof, insufficient oversight of stock levels or physical stock counts, inadequate recording, or reporting).
 | [ ]  |
| * Substandard service provision by contracted service provider (i.e., logistics service provider does not effectively execute warehouse processes, poor management by the PR, SR, WH management or 4PL).
 | [ ]  |
| * Storage sites not properly secured, increasing the risk of theft (i.e., multiple keys available, suboptimal tracking of visitors, lack of physical barriers to limit car access to the site, warehouse roof/doors/windows not properly secured).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Health Product distribution systems | [ ]  | [ ]  | [ ]  | [ ]  | ☐ |
| * Distribution planning challenges at central level from national to provincial or regional stores (i.e., planned delivery frequency can be improved or inability to stick to defined frequency).
 | ☐ |
| * Distribution planning challenges at peripheral levels from provincial or regional stores out to subsequent layers (i.e., planned delivery frequency can be improved or inability to stick to defined frequency).
 | ☐ |
| * Manipulation of distribution documents made possible by design or practice (i.e., delivery bills not signed at reception, shipments left at the primary site for pick-up, signed delivery bills not collected and reviewed for consistency).
 | ☐ |
| * Substandard service provision by contracted service provider (i.e., logistics service provider does not effectively execute warehouse processes, poor management by the PR, SR, WH management or 4PL/3PL).
 | ☐ |
| * Inadequate budget and/or fleet for first- and middle-mile distribution (i.e., from national to subnational level, such as provincial, regional, district stores).
 | ☐ |
| * Inadequate budget and/or fleet for last mile distribution (i.e., distribution leg that serves health facilities).
 | ☐ |
| * Insufficient staffing or human resource capacity (i.e., lack of appropriate staffing at central and/or peripheral level, lack of sufficient training and supervision on the job).
 | ☐ |
| * Transport management governance, policy or SOPs are poorly defined or missing.
 | ☐ |
| * Poor network design (e.g., use of parallel supply chains that are ineffective or duplicative), independent delivery planning for different HP streams (e.g., per disease program), suboptimal linkage of health care facilities to storage facilities.
 | ☐ |
| * Other (please specify)
 | ☐ |
| Health Product information systems  | [ ]  | [ ]  | [ ]  | [ ]  | ☐ |
| * Absence of a good master data policy and systems: e.g., there is no master policy in place, the master policy in place is poorly defined, the health product information systems necessary for master policy implementation are not in place.
 | ☐ |
| * Absence of national-level updated master data: e.g., Health Product information systems using different master data, supply chain & regulatory authorities not coordinated, no possibility for regular direct/indirect updates (interoperability & data analysis challenges).
 | ☐ |
| * Health facilities supply planning policy/governance and SOPs poorly defined or missing. All levels of the supply chain are not using a pre-defined approach to supply planning, affecting forecasting, and leading to wastage or scarcity.
 | ☐ |
| * Health facilities procurement policy/governance and SOPs may be poorly defined or missing. Health facilities procurement system is not adequately configured, personnel may not understand the process or their roles.
 | ☐ |
| * Lack of/weak track and trace policy, such as: GS1 compliant barcodes are not available on all products, there is no central data repository in country to validate product details, information systems may not support capture of GS1 serialization data.
 | ☐ |
| * Master data governance policy may be missing or poorly defined and/or governance is ineffective.
 | ☐ |
| * Supply chain data analysis and interpretation expertise/guidelines missing or limited which affects decision making.
 | ☐ |
| * Comprehensive data of good quality not available (i.e., supply chain information systems are interoperable to provide quality supply chain data) to allow effective supply chain analysis.
 | ☐ |
| * Health Product Information System may be inadequately configured, such as: unable to capture necessary details of health products, warehouse locations may be poorly defined, health product locations may be incorrectly assigned.
 | ☐ |
| * Product batch details are not being captured in the system at all levels in the supply chain, or product scanning is not being done.
 | ☐ |
| * Data manipulation of Health Product information systems (e.g.: LMIS, WMS) made possible by the system design, increasing the risk of theft (i.e., poor segregation of access by user type, use of a single ID/password by multiple users, outdated versions of the software).
 | ☐ |
| * Other (please specify)
 | ☐ |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Quality of health products  |  |  |  |  |  |
| Pre-market approval and registration | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Need for new treatments/technologies is not determined or there is insufficient planning for introduction of new products.
 | [ ]  |
| * Modelling of scenarios for scale down of old treatments/technologies and the scale up of new ones is not well documented to allow for adjustment of assumptions.
 | [ ]  |
| * Lack of standardization and harmonization of laboratory tests and health technologies.
 | [ ]  |
| * Procurement of non-quality assured products as a result non-adherence to National Regulatory Authority (NRA) guidelines; reliance on NRA guidelines that are inadequate; or failure to implement additional controls (required by NRA/SRA/GF).
 | [ ]  |
| * Selection is not compliant with up-to-date, internationally accepted therapeutic or national treatment guidelines, essential medicines lists, protocols, or algorithms.
 | [ ]  |
| * Good Manufacturing Practices are not adequately implemented, inspected, and/or enforced by the National Regulatory Authority (NRA).
 | [ ]  |
| * Health product substitution and counterfeiting: misrepresentation or manipulation of QA related information (such as WHO prequalification, Quality Control results) to mislead NRA/PR/GF.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Post-market approval and use  |
| * Grant-specific QA plan is not adequate or appropriately resourced to address gaps in national quality assurance/post-marketing surveillance/market control systems.
 | [ ]  |
| * Inadequately qualified staff, training or tools related to preserving and monitoring product quality.
 | [ ]  |
| * National Regulatory Authority capacity and/or systems are not adequate to implement effective market surveillance and market control activities (identify and remove poor quality, unsafe or non-effective products from the market).
 | [ ]  |
| * Inadequate pharmacovigilance system that includes systematic screening, recording, and reporting on standardized forms.
 | [ ]  |
| * Inadequate systems to safely remove and dispose of expired, contaminated, or unusable health products.
 | [ ]  |
| * Inadequate biosafety/biosecurity systems at laboratories and/or inadequate laboratory waste management.
 | [ ]  |
| * Storage and transportation conditions are not adequate to ensure product quality; products are exposed to potentially harmful environmental conditions or not handled/stored in line with their specifications.
 | [ ]  |
| * Inadequate lab service quality monitoring programs; no participation in external quality assurance programs; use of quality control laboratory that is not WHO prequalified or ISO 17025 certified.
 | [ ]  |
| * Illegal trade, illegal import practices or poor border controls, resulting in out of specification products on the market.
 | [ ]  |
| * Prescriber non-adherence to approved national or WHO treatment guidelines, essential medicines lists, national policies, protocols, or algorithms; and/or poor advice provided to patients on appropriate use of products.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

 **Please indicate any additional relevant information on the identified findings.**

1. **Programmatic/M&E**
	1. **For the service [XXX], please indicate the programmatic/M&E area(s) to which the findings relate.**

[ ]  HIV – Program Quality

[ ]  TB – Program Quality

[ ]  Malaria – Program Quality

[ ]  Resilient and Sustainable Systems for Health (RSSH) & Pandemic Preparedness

[ ]  Monitoring & Evaluation (M&E)

[ ]  Human Rights and Gender Equality

* 1. Please indicate for each of the following areas of concern the level of issues identified. *If ‘Major Issues’ are identified in any of the main areas of concern, please indicate to which of the sub-categories they relate.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Areas of concern | N/A – not reviewed | No issuesIdentified | Minor issues Identified | Moderate Issues Identified | Major IssuesIdentified |
| HIV – Program Quality |
| Program design and relevance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The scale of interventions financed under the grant, domestically and through partners are not sufficient to achieve desired programmatic coverage, outcome and impact.
 | [ ]  |
| * Cross-cutting gaps in the NSP and/or in the financing of interventions focusing on key and vulnerable populations most in need of services.
 | [ ]  |
| * Inadequate capacity or implementation arrangements to support design & implementation of the planned program including expansion of services.
 | [ ]  |
| * There are substantial structural barriers to health services within the health sector as a whole, which significantly impede HIV program performance for several of the supported interventions.
 | [ ]  |
| * Suboptimal stewardship of technical areas within the national HIV program, especially prevention.
 | [ ]  |
| * The HIV prevention interventions and modalities are not adequately people-centered and/or do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * The prevention interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The prevention targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * There are policy and regulatory hurdles in relation to program essentials related to accessing prevention services.
 | [ ]  |
| * The HIV diagnostic interventions and modalities are not adequately people-centered and/or do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * The HIV diagnosis & testing interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The HIV testing targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * There are policy and regulatory barriers related to accessing screening & diagnosis program essential services.
 | [ ]  |
| * The HIV treatment interventions and modalities are not adequately people-centered and not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations, and health-seeking behavior.
 | [ ]  |
| * HIV treatment interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * HIV treatment targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * Policy and regulatory barriers related to accessing HIV program essential treatment services.
 | [ ]  |
| * Missed opportunities for integrating HIV with other health services including TB, ANC, NCDs, SRH, Hepatitis as well as cervical and anal cancer.
 | [ ]  |
| * HIV program design inadequately explores and utilizes relevant ministries, programs, and partners to provide a multisectoral approach.
 | [ ]  |
| * Innovative approaches, service delivery modalities, tools or technical recommendations are not adopted or rolled out where appropriate to achieve the greatest output and outcome.
 | [ ]  |
| * The strategy to scale up proven innovations and/or integrate into the health system is inadequate.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Program implementation and efficiency | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Allocations at intervention level: Implementers do not strategically allocate available program resources across HIV interventions, priority populations and geographic areas.
 | [ ]  |
| * Allocations at activity level: Implementers do not control costs per HIV service delivered and achieve the greatest possible output by choosing the appropriate technology/service delivery modality, input mix and processes.
 | [ ]  |
| * The guidelines or plans describing how the package of program essential services is to be delivered by health workers and informal and/or non-medical lay service providers are not developed, not well-defined or are outdated.
 | [ ]  |
| * The guidelines and plans for implementation of program essential services are defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * Guidelines and plans for implementation are available and well understood, but relevant resources are not available.
 | [ ]  |
| * Guidelines and plans for implementation are available, are well understood and relevant training and resources are available, but relevant stakeholders do not follow the guidelines.
 | [ ]  |
| * The guidelines, tools, processes, and planning to review and address quality of program essential services through supervision and capacity building are not developed or inadequate.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available and well understood, but relevant resources are not available.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available, are well understood and relevant training and resources are available, but relevant stakeholders do not follow the guidelines.
 | [ ]  |
| * There is an absence of regulations and/or regulatory authorities to enforce program essential HIV service as outlined in national or WHO guidelines in certain sector(s).
 | [ ]  |
| * Intentional delivery of sub-optimal quality, incomplete delivery of defined package of services, and/or targeting of services (including capacity building and trainings) that reduces Value for Money and/or impact of the investments.
 | [ ]  |
| * Inadequate planning and implementation of programmatic assurance to prevent program fraud in relation to the program targets and service delivery.
 | [ ]  |
| * Program technical assistance (TA) is not planned based on e.g., program review findings, not managed well and/or data is not shared to ensure that the results are acted upon and used efficiently.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| TB – Program Quality |
| Program design and relevance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The scale of interventions financed under the grant, domestically and through partners are not sufficient to achieve desired programmatic coverage, outcome and impact.
 | [ ]  |
| * Cross-cutting gaps in the NSP and/or in the financing of interventions focusing on key and vulnerable populations most in need of services.
 | [ ]  |
| * Inadequate capacity or implementation arrangements to support design and implementation of the planned program including expansion of services.
 | [ ]  |
| * There are substantial structural barriers to health services within the health sector as a whole, which significantly impede TB program performance for several of the supported interventions.
 | [ ]  |
| * The TB prevention interventions and modalities do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * The prevention interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The prevention targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * Prevalence of policy and regulatory barriers in relation to accessing prevention services and benefitting from infection control efforts.
 | [ ]  |
| * The TB diagnostic interventions and modalities do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * The TB diagnosis & testing interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The TB testing targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * Prevalence of policy and regulatory barriers in relation to accessing screening and diagnosis services.
 | [ ]  |
| * There are (infra)structural and procedural design gaps in diagnostic capacity.
 | [ ]  |
| * The TB treatment interventions and modalities are not adequately people-centered and/or do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * TB treatment interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * TB treatment targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * Prevalence of policy and regulatory barriers in relation to accessing treatment services.
 | [ ]  |
| * Missed opportunities for integrating TB and other health services.
 | [ ]  |
| * TB program design inadequately explores and utilizes relevant ministries, programs and partners to provide a multisectoral approach including stakeholders working with prisoners, miners, human rights, gender barriers to services and other risk factors.
 | [ ]  |
| * Innovative approaches, service delivery modalities, tools or technical recommendations are not adopted or rolled out where appropriate to achieve the greatest output and outcome.
 | [ ]  |
| * The strategy to scale up proven innovations and/or integrate into the health system is inadequate.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Program implementation and efficiency | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Allocations at intervention level: Implementers do not strategically allocate available program resources across TB interventions, priority populations and geographic areas.
 | [ ]  |
| * Allocations at activity level: Implementers do not control costs per TB service delivered and achieve the greatest possible output by choosing the appropriate technology/service delivery modality, input mix and processes.
 | [ ]  |
| * The guidelines or plans describing how the package of program essential services is to be delivered by health workers and informal and/or non-medical lay service providers are not developed, not well-defined or are outdated.
 | [ ]  |
| * The guidelines and plans for implementation of program essential services are defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * Guidelines and plans for implementation are available and well understood, but relevant resources are not available.
 | [ ]  |
| * Guidelines and plans for implementation are available, are well understood and relevant training and resources are available, but relevant stakeholders do not follow the guidelines.
 | [ ]  |
| * The national guidelines and tools to review quality of program essential services provided at the intervention level are not available, inadequate and/or the program is not routinely quality reviewed at national and sub-national level.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available and well understood, but relevant resources are not available.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available, are well understood and relevant training and resources are available, but relevant stakeholders do not follow the guidelines.
 | [ ]  |
| * There is an absence of regulations and/or regulatory authorities to enforce relevant program essentials for Global Fund supported TB services as outlined in national or WHO guidelines related to TB in certain sector(s).
 | [ ]  |
| * Intentional delivery of sub-optimal quality, or incomplete delivery of defined package of services, and or targeting of services (including capacity building and trainings) that reduces value for money and/or impact of the investments.
 | [ ]  |
| * Inadequate planning and implementation of programmatic assurance to prevent program fraud in relation to the program targets and service delivery.
 | [ ]  |
| * Program technical assistance is not managed well and/or data is not shared to ensure that the results are acted upon and used efficiently.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Others, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Malaria – Program Quality |
| Program design and relevance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The interventions, targets and/or modalities of implementation are not based on a sub-nationally tailored (SNT) strategy which considers epidemiologic and social context and/or implementation realities.
 | [ ]  |
| * The scale of interventions planned under the grant, domestically and through partners are not sufficient to achieve desired programmatic coverage, outcome and impact.
 | [ ]  |
| * Cross-cutting gaps in the NSP or in the financing of interventions focusing on vulnerable populations most in need of services such as pregnant women and children.
 | [ ]  |
| * Inadequate programmatic capacity or implementation arrangements to support design & implementation of the planned program including expansion of services.
 | [ ]  |
| * There are substantial structural barriers to health services within the health sector as a whole, which significantly impede malaria program performance for several of the supported interventions.
 | [ ]  |
| * The malaria prevention interventions and implementation modalities do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, health-seeking behavior as well as geographic/climatic factors.
 | [ ]  |
| * The prevention interventions, health products and implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The prevention targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * The case management interventions and implementation modalities do not adequately tailor investments to the epidemiological context, societal drivers of risk and vulnerability, relevant populations and health-seeking behavior.
 | [ ]  |
| * The case management interventions, health products & implementation modalities financed under the grants are not aligned with global recommendations and/or the NSP.
 | [ ]  |
| * The case management targets are not realistic based on the recent trends and/or are not aligned with globally recommended targets (where relevant).
 | [ ]  |
| * Efforts to strengthen quality of case management services to be financed under grants do not account for subnational differences in quality and/or are not tailored to the known challenges.
 | [ ]  |
| * Policy and regulatory barriers in relation to accessing case management services.
 | [ ]  |
| * Missed opportunities for integrating malaria and other health services.
 | [ ]  |
| * Malaria program design inadequately explores and utilizes relevant ministries, programs, and partners to provide a multisectoral approach. This includes relevant stakeholders in equity, human rights and gender, community, private sector, etc.
 | [ ]  |
| * Innovative approaches, service delivery modalities, tools or technical recommendations are not adopted or rolled out where appropriate to achieve the greatest output and outcome.
 | [ ]  |
| * The strategy to scale up proven innovations and/or integrate into the health system is inadequate.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Program implementation and efficiency | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Allocations at intervention level: Implementers do not strategically allocate available program resources across malaria interventions, priority populations and geographic areas.
 | [ ]  |
| * Allocations at activity level: Implementers do not control costs per malaria service delivered and achieve the greatest possible output by choosing the appropriate technology/service delivery modality, input mix and processes.
 | [ ]  |
| * The guidelines or plans describing how the package of relevant services is to be delivered by health workers and informal and/or non-medical lay service providers (e.g., community or peer educators) are not developed, not well-defined, or are outdated.
 | [ ]  |
| * The guidelines and plans are well-defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * Guidelines and plans are available and well understood, but relevant resources such as relevant data or commodities are not available to implement them.
 | [ ]  |
| * Guidelines and plans are available, are well understood and relevant training and resources are available, but implementers do not follow the guidelines.
 | [ ]  |
| * The national guidelines and tools to review quality of program essential services provided at the intervention level are not available, inadequate and/or the program is not routinely quality reviewed at national and sub-national level.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are defined, but the relevant knowledge has not been disseminated adequately or is not well understood at relevant levels.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available and well understood, but relevant resources are not available.
 | [ ]  |
| * The guidelines for supervision, capacity building and technical reviews are available, are well understood and relevant training and resources are available, but relevant stakeholders do not follow the guidelines.
 | [ ]  |
| * Intentional delivery of sub-optimal quality, or incomplete delivery of defined package of services, and or targeting of services (including capacity building and trainings) that reduces value for money and/or impact of the investments.
 | [ ]  |
| * Inadequate planning and implementation of programmatic assurance to prevent program fraud in relation to the program targets and service delivery.
 | [ ]  |
| * Program technical assistance is not managed well and/or data is not shared to ensure that the results are acted upon and used efficiently.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| RSSH & Pandemic Preparedness |
| Laboratory systems | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Inadequate/weak national laboratory leadership and governance/no coordination of inputs/labs not in tiered network/no coordination/no national lab directorate or lab Technical Working Group (TWG).
 | [ ]  |
| * Inefficiencies in deployment and use of equipment/reagents due to frequent equipment breakdown/failure/no equipment maintenance or poor management of maintenance contracts
 | [ ]  |
| * Inefficiencies in deployment and use of equipment/reagents due to Human Resource inadequacies. Inadequate staffing level and or capacity (not qualified/untrained)
 | [ ]  |
| * Laboratory systems and support fragmented across donor funded vertical disease programs and global health financing mechanisms
 | [ ]  |
| * Lack of standardization of platforms in country resulting in increased costs to manage supply chain, maintenance and high training costs and variability in interpretation of results.
 | [ ]  |
| * Need for new medical technologies not determined; insufficient planning for introduction of new products; or plans are not followed to ensure optimal placement and utilization of new products.
 | [ ]  |
| * Weak supply chain management systems, no quality control (QC) materials, reagent deterioration (inappropriate shipping/storage conditions), expiry, poor preparation or QC material degradation, poor quantification.
 | [ ]  |
| * Inadequate Lab environment - infrastructure not ready. No dust/temperature/humidity control, unstable electricity supply, inadequate water quality, water pressure, biosafety level and/or inadequate space and layout.
 | [ ]  |
| * Inadequate laboratory information management system for managing test results/lab results not used for patient care/ results not returned in a timely manner.
 | [ ]  |
| * Risk of programmatic fraud - intentional delivery of sub-optimal quality or sub-standard equipment and reagents or deployment of equipment, that reduces value for money and/or impact of the investments.
 | [ ]  |
| * Poor quality of laboratory test results due to Human resource inadequacies. Inadequate staffing level and or capacity/skill (not qualified/untrained)
 | [ ]  |
| * Poor quality of laboratory test results due to Inadequate financing for laboratory services
 | [ ]  |
| * Poor quality of laboratory test results due to frequent equipment breakdown/failure/ no equipment maintenance or poor management of maintenance contracts
 | [ ]  |
| * Poor quality of laboratory test results due to inadequate lab environment (infrastructure not ready, no dust/temperature/humidity control, unstable electricity supply, inadequate water quality, water pressure, biosafety level and/or inadequate space and layout)
 | [ ]  |
| * Poor quality of laboratory test results as post market surveillance of in vitro diagnostics (IVD) not effective/none in place
 | [ ]  |
| * Poor quality of laboratory test results as quality management systems inadequate at test sites/no participation in external quality assurance (EQA) programs
 | [ ]  |
| * Poor quality of laboratory test results due to weak supply chain management systems - reagent stockouts, no quality control (QC) materials, reagent deterioration (inappropriate shipping/storage conditions), expiry, poor preparation or QC, material degradation.
 | [ ]  |
| * Poor quality of laboratory test results due to specimen not functioning/weak transport system
 | [ ]  |
| * Poor quality of laboratory test results due to unregulated laboratory service delivery - no licencing of laboratory service delivery or personnel/ no oversight of lab quality management systems (QMS)
 | [ ]  |
| * Risk of programmatic fraud - Intentional delivery of poor-quality laboratory test results to enrol a client on program benefits and or decline population from eligible services.
 | [ ]  |
| * Biosafety and biosecurity, including environmental, risk due to unregulated laboratory service delivery - no licencing of laboratory service delivery or personnel/no oversight of lab quality management systems (QMS)
 | [ ]  |
| * Biosafety and biosecurity, including environmental, risk due to Human Resource inadequacies. Inadequate staffing level and or capacity/skill (not qualified/untrained)
 | [ ]  |
| * Biosafety and biosecurity, including environmental, risk due to inadequate biosafety and biosecurity systems in laboratories, including lab design, to meet biosafety standard
 | [ ]  |
| * Biosafety and biosecurity including environmental risk due to inadequate laboratory waste management systems (policy, procedure, financing)
 | [ ]  |
| * Service delivery disruption due to Human Resource inadequacies. Inadequate staffing level and or capacity/skill (not qualified/untrained)
 | [ ]  |
| * Service delivery disruption due to inadequate financing for laboratory services
 | [ ]  |
| * Service delivery disruption due to frequent equipment breakdown/failure/ no equipment maintenance or poor management of maintenance contracts
 | [ ]  |
| * Service delivery disruption due to inadequate lab environment - infrastructure not ready, no dust/temperature/humidity control, unstable electricity supply, inadequate water quality, water pressure, biosafety level and/or inadequate space and Layout
 | [ ]  |
| * Service delivery disruption due to specimen transport system is not functioning/weak
 | [ ]  |
| * Service delivery disruption due to weak supply chain management systems - reagent stockouts, no quality control (QC) materials, reagent deterioration (inappropriate shipping/storage conditions), expiry, poor preparation or QC, material degradation.
 | [ ]  |
| * Service delivery disruption due to inadequate laboratory information management system for managing test results/lab results not used for patient care/results not returned in a timely manner.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Human resources for health (HRH), excluding Community Health Workers (CHW) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Inadequate data on HRH or inadequate use of data and analysis for intervention design
 | [ ]  |
| * HRH strategy does not exist, is outdated or inadequate, or poorly implemented
 | [ ]  |
| * Insufficient or inadequate production of HRH
 | [ ]  |
| * High vacancy rates, sub-optimal distribution or poor retention of HRH
 | [ ]  |
| * Inadequate training and continuous professional development of HRH resulting in poor performance
 | [ ]  |
| * Non-existent, infrequent or poor quality integrated supportive supervision of HRH
 | [ ]  |
| * Low trust or limited acceptability of HRH
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Human resources for health (HRH) - Community Health Workers (CHW) ONLY | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Inadequate data on CHWs or inadequate use of data and analysis for intervention design
 | [ ]  |
| * CHW not included in HRH strategy and/or nationally agreed scope of work for all types of CHWs does not exist, is outdated or inadequate
 | [ ]  |
| * Insufficient or inadequate production of CHWs
 | [ ]  |
| * High vacancy rates, sub-optimal distribution or poor retention of CHW
 | [ ]  |
| * Inadequate training and continuous professional development of CHW resulting in poor performance
 | [ ]  |
| * Non-existent, infrequent, or poor quality integrated supportive supervision of CHW
 | [ ]  |
| * Low trust or limited acceptability of CHW
 | [ ]  |
| * Stockouts of and/or difficulty accessing the health products or equipment affecting CHW productivity
 | [ ]  |
| * Lack of functional referral system/counter referral system between CHW and health facility
 | [ ]  |
| * Lack of complete, accurate, and timely data on CHWs and CHW services
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Community Systems | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The existing legal and policy framework restricts CSOs’ ability to organize, register, fulfill their roles in health service provision, advocacy and community mobilization
 | [ ]  |
| * There is no defined package of services to be delivered at community level; and/or where the defined package is limited in its content and delivery, outdated and/or not in line with international normative guidance
 | [ ]  |
| * Lack of enforceable formal agreements (e.g., Service-level agreements, MoUs) between MoH/district authorities governing health facilities and CSOs delivering health services
 | [ ]  |
| * Community level data system are not interoperable with national routine systems/HMIS because data from community service providers is not fed into HMIS and/or there is no or limited agreed upon list of indicators for collecting data for community level service delivery
 | [ ]  |
| * There has been insufficient mapping/capacity assessment of community-led and based organizations and/or there is insufficient context-specific package of capacity development activities based on identified weaknesses
 | [ ]  |
| * There is no well-defined scope/framework for community led monitoring (CLM) adopted by the program
 | [ ]  |
| * A framework for community led monitoring (CLM) exist but the program does not fully engage the affected communities in the design and/or enable community-led organizations to independently monitor service provision and/or advocate for service improvement based on analysed data.
 | [ ]  |
| * Data and analyses from community-based and community-led organizations (incl. through CLMs) are not optimally used to inform programmatic, financial or policy decisions
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| M&E |
| Data governance & management  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   |
| * There are no laws or regulations related to privacy, confidentiality and access to health information and Data Protection, or those that exist are inadequate/not enforced
 | [ ]  |
| * There are no laws and regulations on data security (cybersecurity, storage, transmission, use) relevant to protection of health data, or those that exist are inadequate/not enforced
 | [ ]  |
| * There is no costed M&E plan for the NSP or one or more components of the plan are insufficient (e.g. the grant indicators are not adequately reflected, the indicator measurement guidance is inadequate)
 | [ ]   |
| * There is ineffective leadership provided by the MoH for the M&E agenda, such as relevant M&E policies/guidance, lack of dedicated national bodies/mechanisms for data and digital health governance
 | [ ]  |
| * There is insufficient planning, funding, and support for digital health infrastructure maintenance (hardware or software).
 |  |
| * There is insufficient funding dedicated to implement M&E activities and insufficient human resources dedicated for M&E (i.e., staffing, training, collection tools).
 | [ ]  |
| * Technical assistance for M&E is not being coordinated and used effectively and efficiently.
 | [ ]  |
| * There have been instances of documented or suspected manipulation and/or fraud of program and performance data, and/or the system has particular vulnerabilities in this regard.
 | [ ]  |
| * There is no workforce strategy, policy, or guide that recognizes digital health professional careers and/or the distribution of digital health work force is ad hoc.
 | [ ]  |
| * There is ineffective coordination between the MOHs M&E Unit / department and the M&E units of the disease/HSS programs.
 | [ ]  |
| * Other (please specify)
 |  |  |  |  | [ ]  |
| Data generation, availability and quality | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The HMIS is not digitalized or only partially digitalized, is not well-maintained and/or there is inadequate digital identity management of facilities including location data for GIS mapping.
 | [ ]  |
| * The case based digital data system is inadequate and/or Individual level monitoring is not integrated or poorly integrated across diseases/programs (e.g., HIV/TB patient trackers, national electronic medical record (EMR).
 | [ ]  |
| * National digital health architecture blueprint and/or health information exchange (HIE) to promote data sharing and system interoperability is weak or non-existent.
 | [ ]  |
| * The National reporting platforms (DHIS, LMIS, the Lab Information System and/or other mechanisms) are not interoperable or do not easily facilitate data triangulation.
 | [ ]  |
| * The community service data system is not digitalized or only partially digitalized, is not well-maintained and/or there is inadequate digital identity management of community service providers including location data for GIS mapping.
 | [ ]  |
| * There is no system in place for mortality and cause of death reporting in the national HMIS.
 | [ ]  |
| * HIV: There are no national, population-based surveys or studies planned or conducted as per guidelines/standard protocols (e.g., IBBS, Drug Resistance Studies)
 | [ ]  |
| * TB: There are no national, population-based surveys & studies planned, funded, and conducted as per guidelines/protocols (e.g., Drug Resistance Studies, TB prevalence survey)
 | [ ]  |
| * Malaria: There are no national, population-based surveys & studies planned and/or conducted as per guidelines/protocols (e.g., Drug Resistance Studies, MIS)
 | [ ]  |
| * The country has received a poor/very poor rating for reporting completeness and/or timeliness but is not implementing an improvement plan.
 | [ ]  |
| * There has not been a Data Quality Review/Audit in the last 2-3 years, or the country has not developed/has not implemented a data quality improvement plan in follow up to DQR.
 | [ ]  |
| * The relevant HMIS data systems are not integrated into the national HMIS (e.g., disease specific HMIS, community systems data, private health sector data).
 | [ ]  |
| * Most at risk population size estimates are not available (HIV: Sex Workers, MSM, PWID, TG, AGYW at risk of HIV in AGYW focus countries; TB: prisoners, migrants/mobile populations, mining & peri mining communities; Malaria: geographic areas).
 | [ ]  |
| * The country has not conducted stigma index survey or human rights assessment as per protocol.
 | [ ]  |
| * Country does not collect disaggregated programmatic data (e.g., by age, gender/sex, geographic area, availability of HTM services and/or where/who is experiencing new infections and HTM risk).
 | [ ]  |
| * HMIS or community systems do not collect relevant routine disease-specific data for key grant-related indicators and decision-making (including entomological data).
 | [ ]  |
| * The measures/strategies to ensure quality of patient data are inadequate, either because there is no plan, the design is inadequate, or because they do not get implemented (e.g., routine data quality reviews, checks/controls, PR check of SR data).
 | [ ]  |
| * There are gaps in the resources required to improve data quality (supervision, guidelines, data storage, tools, change management).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Data analysis and use  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Required disaggregated data is not used to inform planning or programmatic decision making for priority.
 | [ ]  |
| * National analysis of sub-national disaggregated data has not been conducted in the last 12 months and/or a low percentage of Regions/States/Provinces/districts produce at least semi-annual analytical reports.
 | [ ]  |
| * Systematic analysis of mortality and cause of deaths has not been done in the last 3 years.
 | [ ]  |
| * Relevant analyses have not been conducted and used to inform resource mapping, stratification/optimization, intervention targeting and efficient deployment of resources (e.g., geospatial analysis within the last 3 years).
 | [ ]  |
| * Required HIV specific program analysis has not been done (e.g., HIV treatment cascade and ART outcome analysis for GP, KPs, PMTCT, TB/HIV, and/or HIV prevention effectiveness analysis by population groups and prevention services in the last 12 months)
 | [ ]  |
| * Required TB specific program analysis has not been done (e.g., TB patient pathway analysis within the last 3 years, TB care cascade analysis including at subnational level within the last year)
 | [ ]  |
| * Required Malaria specific program analysis has not been done (e.g., Malaria epi and intervention trend analysis within the last 12 months, analysis of malaria case management (test, treat and track) cascade within the last three years)
 | [ ]  |
| * Disease-specific program review with epi and impact analysis has not been done in the last three years and/or is not quality assured according to WHO standards.
 | [ ]  |
| * Program review/evaluation recommendations have not been used for at least one of the following purposes i) NSP development or adjustments; ii) Global Fund Funding request development iii) strategic reprogramming.
 | [ ]  |
| * HIV data is not routinely and/or effectively used for programming, e.g., HIV prevention effectiveness analysis is not used to optimize prevention interventions.
 | [ ]  |
| * TB data is not routinely and/or effectively used for programming, e.g., TB care cascade analysis is not used to prioritize TB Interventions.
 | [ ]  |
| * Malaria data is not routinely and/or effectively used for programming, e.g., entomological data is not routinely used for adjustments to LLIN and IRS strategies.
 | [ ]  |
| * There are significant gaps in analytical capacity to analyze program data at the relevant level(s).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Human Rights and Gender Equality |
| Human rights | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Harmful laws, regulations, or policies limit access to services for key and vulnerable populations and others left behind
 | [ ]  |
| * Harmful and/or discriminatory social and cultural practices limit access to health services for key and vulnerable populations and others left behind
 | [ ]  |
| * CCMs and implementers demonstrate limited political will and leadership to address human rights-related barriers to services which prevents appropriate interventions from being incorporated into national disease programs and strategies
 | [ ]  |
| * CCMs and implementers have limited understanding of the ways failure to address human rights-related barriers to services reduces the impact of grants, and of the need for quality and comprehensive programming to reduce these barriers
 | [ ]  |
| * CCMs and implementers show limited recognition of the specific and unique expertise key and vulnerable populations have in contributing to effective programming which prevents them from being involved in program design and implementation
 | [ ]  |
| * Safety and security issues affect implementation of human rights and KPs programming as a result of frequent incidents of arbitrary arrest, harassment, violence and/or threats of violence against KPs and/or program implementers and beneficiaries
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Gender equity  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * CCMs and implementers demonstrate limited political will and leadership to adequately acknowledge and address gender-related barriers in access to services for key and vulnerable populations and others left behind
 | [ ]  |
| * Insufficient investments in national systems and processes for collection and analysis of appropriately disaggregated data that can be used to effectively address gender inequities in programming
 | [ ]  |
| * Implementers have limited capacity to collect and analyze appropriately disaggregated data, which limits their ability to use data to address gender inequities in programming
 | [ ]  |
| * Poor engagement and lack of meaningful participation of gender advocates, including women's groups, and representatives from KPs and other left behind in GF-related processes results in insufficient programming to remove gender-related barriers to services
 | [ ]  |
| * Limited knowledge and organizational capacity of health system planners, implementers and CCMs on effective gender-responsive or gender-transformative programming hinders effective programming to remove gender-related barriers to services
 | [ ]  |
| * Harmful and/or discriminatory gender-related social and cultural practices limit access to health services for key and vulnerable populations and others left behind.
 | [ ]  |
| * Harmful laws, regulations and policies exacerbate—or fail to protect against—gender inequalities including gender-related discrimination and gender-based violence, thus limiting access to services for key or vulnerable populations and others left behind
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**Please indicate any additional relevant information on the identified findings.**

1. **Governance and Health Financing**

* 1. **For the service [XXX, please indicate the governance and health financing area(s) to which the findings relate.**

[ ]  In-country governance

[ ]  Health Financing

* 1. Please indicate for each of the following areas of concern the level of issues identified. *If ‘Major Issues’ are identified in any of the main areas of concern, please indicate to which of the sub-categories they relate.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Areas of concern | N/A – not reviewed | No issues Identified  | Minor issues Identified | Moderate Issues Identified | Major IssuesIdentified |
| In-country governance |  |  |  |  |  |
| Health sector governance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Limited awareness of key government officials (MoH, MoF, President or key advisors, and others) about the Global Fund and limited provision of necessary support and leadership to facilitate the program objectives.
 | [ ]  |
| * Limited representation and/or engagement of communities in health sector decision making processes.
 | [ ]  |
| * The national strategic health plan and/or national health policy do not specify the mission, strategy, target population and short- to long-term outcomes, and/or strategies are not monitored or appropriately adjusted during implementation.
 | [ ]  |
| * Limited MOH human resources (staff, consultants, technical assistance etc.) including adequate management, to ensure the right people are in the right jobs, with clear TORs, conflict of interest and integrity checks and defined accountability.
 | [ ]  |
| * The MOH does not sufficiently engage with or leverage the relevant entities (including central-level functional departments, national programs, and decentralized health structures) for effective implementation and independent inspection or evaluation of programs.
 | [ ]  |
| * Limited MOH/National Program engagement from central to local level and/or limited coordination with external stakeholders to ensure strong health sector performance.
 | [ ]  |
| * MOH has not established fit-for-purpose organizational structures with clear roles, responsibilities, separations of duties, and controls at the national and local levels that are aligned with organizational objectives.
 | [ ]  |
| * MOH has not established efficient organizational processes, fit-for-purpose policies/procedures, templates, systems and controls, to deliver the desired performance.
 | [ ]  |
| * The PR does not have a mature Ethics & Compliance Program on paper or in practice.
 | [ ]  |
| * MOH/National Program does not carry out effective, data-driven decision making; and/or has not defined measurable targets that drive an integrated impact measurement system.
 | [ ]  |
| * The governmental assurance and accountability bodies (e.g., inspection unit, supreme audit agency, anticorruption agency) are weak either in performance of their reviews or in exerting accountability vis-à-vis the MOH.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| National program governance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Program technical assistance and/or capacity building is not planned, for and managed well and/or data is not shared to ensure that the results are acted upon and used efficiently.
 | [ ]  |
| * The implementation arrangements are not designed to implement the program effectively and efficiently.
 | [ ]  |
| * Lines of authority and responsibility from national to local levels to implement the disease program are not clearly defined, separated, and/or do not operating effectively.
 | [ ]  |
| * The program does not have technical assistance and capacity-building activities to address known weaknesses.
 | [ ]  |
| * The National Program has not established adaptable, fit-for-purpose, organizational structures that are aligned with the objectives for the disease program; and/or structure lacks clear roles, responsibilities, and controls.
 | [ ]  |
| * The National Program has not established efficient organizational processes, fit-for-purpose policies, templates, systems, and controls, to deliver the desired performance.
 | [ ]  |
| * The National Program is not subject to adequately robust internal checks that evaluate whether it is operating in accordance with the principles of economy, efficiency and effectiveness (e.g., Performance audits, as per ISSAI 300).
 | [ ]  |
| * The government does not hold the national programs accountable for their performance in achieving the national strategy and objectives.
 | [ ]  |
| * There are frequent changes in the National Program leadership that limits the program’s ability to develop cohesive and sustainable plans.
 | [ ]  |
| * The national disease program leadership does not ensure that cross-cutting HSS/RSSH interventions are being appropriately funded within the available resources to maximize the impact of the program.
 | [ ]  |
| * The National Program does not have an aligned vision and roadmap, with clarity on defined objectives, priorities and required resources.
 | [ ]  |
| * The implementer is not collaborating well between government and non-government stakeholders to facilitate the achievement of program objectives.
 | [ ]  |
| * Insufficient/sub-optimal donor coordination. Ineffective planning, budgeting, implementation, and supervision performed across GF and other external donors such as GAVI, U.S. President’s Malaria Initiative (PMI), PEPFAR, World Bank.
 | [ ]  |
| * Limited National Program human resources (staff, consultants, technical assistance etc.), including adequate management, to ensure the right people are in the right jobs, with clear TORs, conflict of interest and integrity checks, and defined accountability.
 | [ ]  |
| * Limited collaboration between National and other disease programs & directorates at the MOH, leading to limited opportunities to obtain programmatic efficiencies across disease programs (e.g., through standard forms, unit costs, supervision visits etc.).
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| PR governance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * The PR does not have established fit-for-purpose organizational structures with clear roles, responsibilities, separations of duties, and controls at the national and local levels that are aligned with organizational objectives.
 | [ ]   |
| * Limited PR-ability to operate in key programmatic areas/geographic regions where grant activities will be implemented. The PR lacks the physical facilities, office, IT equipment, transport, etc. to monitor program implementation in these areas.
 | [ ]   |
| * Opportunities exist for the PR to improve its organizational processes, policies, procedures, templates, systems, and controls, to deliver the desired performance.
 | [ ]   |
| * The PR does not have sufficient oversight mechanisms in place to identify and mitigate risks in a timely and quality manner, including in terms of program implementation (at PR, SR and SSR levels).
 | [ ]   |
| * Only for INGO PRs: No clear contractual relationship exists between the INGO HQ (Regional Office if applicable) and the Country Offices, or the CO is not registered in-country as a local organization.
 | [ ]   |
| * Only for INGO PRs: HQ does not oversee the performance of Country Offices and Regional Offices (if applicable), including planning, budgeting, and program implementation.
 | [ ]   |
| * Only for INGO PRs: HQ does not plan and implement regular, fit-for-purpose in-country supervision visits related to Global Fund grants, or the outcomes of the supervision are not well-documented and followed-up until resolution.
 | [ ]   |
| * Limited PR-staff that have necessary experience, expertise, or knowledge of Global Fund requirements to perform their assigned roles. PR lacks adequate mix of staff with public health and cross-functional expertise (finance, procurement, M&E, legal).
 | [ ]   |
| * Limited PR stakeholder engagement & management from central to local level, including limited coordination with disease/health partners, to maintain continued alignment with national program’s priorities and donor efforts to ensure strong performance.
 | [ ]   |
| * Limited PR human resources (staff, consultants, technical assistance etc.), including adequate management, to ensure the right people are in the right jobs, with clear TORs, conflict of interest and integrity checks, and defined accountability.
 | [ ]   |
| * Only for non-MOH PRs (UN, INGO, CSO, etc.): Lack of SMART plans in place and being implemented to transition the PR-role to a Ministry of Health entity; and/or Lack of a SMART capacity building plan in place and being implemented for the MOH entities.
 | [ ]   |
| * Only for non-MOH PRs (UN, INGO, CSO, etc.): Limited engagement of the MOH entities in the current implementation arrangements. Lack of clarity in the role of the MOH entities (e.g., SR), their capacity and performance.
 | [ ]   |
| * Only for INGO PRs: Senior HQ/RO staff (senior management/advisors) have limited awareness of the Global Fund programs or do not provide the necessary leadership, guidance, and support to Country Offices to enable the achievement of the grant objectives.
 | [ ]   |
| * Only for INGO PRs: HQ staff do not have clearly documented GF grant oversight & support responsibilities, or they are not evaluated against these responsibilities.
 | [ ]   |
| * Only for INGO PRs: HQ does not address PR/SR capacity gaps and TA needs (i.e., financial/ programmatic/ procurement or HR capacity gaps) that are impacting grant implementation.
 | [ ]   |
| * Limited PR ability to provide the needed services and/or conduct sufficient oversight and supervision, due to sudden disease outbreaks (epidemic/pandemics).
 | [ ]   |
| * Challenging Operation Environment (COE) conditions - characterized by unconstitutional change of government, social unrest, armed conflicts, poor physical infrastructure, natural disasters, humanitarian crises, etc. - impedes the PR’s ability to operate effectively.
 | [ ]  |
| * Limited engagement of communities by PRs and SRs in grant implementation, verifications, or monitoring.
 | [ ]  |
| * Other (please specify)
 | [ ]   |
| Implementation Effectiveness | [ ]   | [ ]  | [ ]   | [ ]   | [ ]   |
| * Limited SR human resources (staff, consultants, technical assistance etc.), including capable management, to ensure the right people are in the right jobs, with clear TORs, conflict of interest and integrity checks, and defined accountability.
 | [ ]   |
| * The SR has capacity gaps and Technical Assistance needs that might negatively impact grant implementation.
 | [ ]   |
| * There are no/limited established structures, protocols and/or infrastructure for PRs and/or sub-offices, SRs, external stakeholders to ensure proper communication and frequent and quality engagements (site visits, grant activity verification etc.).
 | [ ]   |
| * Existing implementation arrangements do not adequately enable the PR and SRs to achieve the grant objectives.
 | [ ]   |
| * The implementation arrangements do not sufficiently leverage the mandates, reporting lines and competencies of the responsible central and de-centralized institutions and departments, including non-government PRs.
 | [ ]   |
| * The implementation arrangements do not demonstrate sufficient horizontal and/or vertical integration. They do not enable strong collaboration from central to regional, district & facility levels in country.
 | [ ]   |
| * The implementation arrangements do not adequately balance the programmatic needs and fiduciary responsibilities to ensure timely and quality program delivery.
 | [ ]   |
| * The grant support function arrangements (Finance, M&E, PSM, Administration etc.) are not effective and efficient. Their alignment with existing national laws and government procedures for operating such functions is limited.
 | [ ]   |
| * Grant implementers have weak mechanisms to prevent, detect, deter, and respond to unethical practices (e.g., sexual exploitation and abuse and sexual harassment, corruption, terrorist financing, money laundering).
 | [ ]   |
| * Grant staff and implementers (SRs) are not transparently identified, managed, and overseen so that the agreed performance is delivered.
 | [ ]   |
| * PR's contractual agreements with SRs do not include responsibilities, accountability, targets, and timelines to ensure quality and timely implementation of and reporting on grant activities.
 | [ ]   |
| * Other (please specify)
 | [ ]   |
| CCM governance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]   |
| * Limited CCM engagement with and participation in the national health agenda.
 | [ ]   |
| * Limited ability of the CCM members and/or secretariat to manage conflicts of interest and/or carry out their duties in accordance with the ethical code of conduct.
 | [ ]   |
| * Limited ability of the CCM to carry out its core functions in facilitating regular, representative, and inclusive dialogue; in on-boarding new members selected through transparent processes; and in managing the CCM Secretariat budget resources.
 | [ ]   |
| * Limited ability of the CCM to ensure the development of a quality funding request, based on a fit-for-purpose program design, and including transparent selection of the appropriate PRs.
 | [ ]   |
| * The CCM (or oversight committee) does not continuously ensure the PRs are implementing their activities in accordance with GF expectations and does not hold the PRs accountable when their performance is weak.
 | [ ]   |
| * Limited representation and/or engagement of communities on the CCM.
 | [ ]   |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Health Financing |  |  |  |  |  |
| Domestic health financing and co-financing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Short term macroeconomic and fiscal constraints that can impact realization of negotiated co-financing commitments for current grant implementation period.
 | [ ]  |
| * Domestic political bottlenecks or challenges limiting the realization of co-financing commitments, impacting financing for health and disease programs.
 | [ ]  |
| * Poor management and internal coordination at the senior management level by national health authorities/MOH impacting realization of co-financing commitments.
 | [ ]  |
| * Constraints in negotiating, confirming, and realizing co-financing commitments due to the nature of fiscal devolution and decision-making power at lower levels of government.
 | [ ]  |
| * Lack of data and systems to reliably measure realization of co-financing commitments on a routine basis.
 | [ ]  |
| * Weak systems and arrangements to prevent health financing data manipulation/fraud and/or indications that health financing data fraud is happening with the deliberate intent to misrepresent domestic health financing allocations and execution.
 | [ ]  |
| * Failure to adequately finance and purchase critical commodities with domestic funds.
 | [ ]  |
| * Weak assurance mechanisms for public financing, leading to lack of reliability of co-financing compliance and uncertainties for effective transition of Global Fund support to domestic budgets.
 | [ ]  |
| * Lack of alignment between co-financing ambition with country capacity and context.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Sustainability & efficiency | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * Medium to long term macroeconomic and fiscal constraints that impact long term sustainability of domestic financing for health.
 | [ ]  |
| * Available resources are not strategically allocated/attributed to the most appropriate, evidence-based investments.
 | [ ]  |
| * Misalignment between disease and Universal Health Care (UHC) financing mechanisms and reforms.
 | [ ]  |
| * Non-integration of grants into government budgets/ external financing poorly integrated with domestic resource planning.
 | [ ]  |
| * Insufficient capacities and governance to design and implement solutions for budget underutilization within the health sector.
 | [ ]  |
| * Issues related to budget reliability - i.e., whether the government budget is realistic and implemented as intended - within the health sector.
 | [ ]  |
| * Risks related to Health sector technical efficiency.
 | [ ]  |
| * Low prioritization of health, impacting sustainable financing for health and disease programs in the long term.
 |  |
| * The National Program has limited capacity and/or has insufficiently initiated country level dialogue on sustainability and transition challenges overall.
 | [ ]  |
| * Inability to domestically fund interventions for key and vulnerable populations (KVP) in an optimal and sustainable manner.
 | [ ]  |
| * Ineffective health financing strategies and policies for Universal Health Care (UHC).
 | [ ]  |
| * Financing for Human Resources for Health (HRH) is not sustainable.
 | [ ]  |
| * Financing and payment systems for Community Health Worker (CHW) Human Resources for Health (HRH) are not sustainable or not contextualized in line with WHO normative guidance.
 | [ ]  |
| * Other (please specify)
 | [ ]  |
| Other, please specify: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**Please indicate any additional relevant information on the identified findings.**

1. **Conclusion**
	1. **Overall Conclusion and Recommendations**
2. If the LFA has not identified any major issues (i.e., only selected *‘N/A-not reviewed’, ‘No Issues’, ‘Minor Issues’, or ‘Moderate Issues’),* the system creates the following automatic message:
* No major issues were identified by the LFA when it performed the service.

Please tick to confirm. If no, please review the findings in above sections and modify your responses, as needed.

[ ] Yes, I confirm no major issues were identified.

1. If the LFA has identified at least one area of concern with a major issue, the system creates the following automatic message and lists those areas of concern and for each the respective sub-areas which were identified as having ‘major issues’ (see below table):
* At least one major issue was identified and reported in the executive summary. Please indicate for each of the reported major issues the degree of impact on grant implementation *(choose one option only)*:

|  |  |  |
| --- | --- | --- |
| Areas of concern with major issues | Impact on grant implementation is insignificant and/or is manageable  | Impact on grant implementation is significant |
| Area concern 1 | [ ]   | [ ]   |
| * *Description of major issue selected*
 |
| * *Description of major issue selected*
 |
| Area concern 2 | [ ]   | [ ]   |
| * *Description of major issue selected*
 |
| * *Description of major issue selected*
 |

**Definition:**

1. Insignificant/manageable impact on grant implementation: the financial impact is limited; timely corrective actions can be or were taken; the quality and timeliness of the implementation of key activities are not much affected; etc.
2. Significant impact on grant implementation: the financial impact is significant; the quality of implementation is majorly affected; the progress of implementation of key activities is majorly delayed, including the recruitment of key staff; products/services are not reaching the intended beneficiaries as planned; etc.
3. If the LFA has identified in the above table at least one area where the major issue has a significant impact on grant implementation, the system creates the following automatic message:
* Please choose from the below list of recommendations the most relevant to address those major issues which have a significant impact on grant implementation: *(choose as many as are applicable)*:

[ ]  Non-compliant expenditure was identified and the Global Fund should pursue their recovery as stipulated in the Guidelines for Grant Budgeting

[ ]  Re-tendering is required and it is practical to do so

[ ]  Indicators of fraud were identified which may require further review

[ ]  Consider changes in implementation arrangements (PRs, SRs, service providers)

[ ]  Controls and management processes of the implementer(s) need to be strengthened

[ ]  Policies/guidelines/tools/capacity related to HIV/TB/malaria service(s) need to be strengthened to facilitate implementation

[ ]  Grant implementation at the health facility level, including monitoring and delivery of HIV/TB/malaria service(s), needs to be strengthened

[ ]  Grant implementation at the Community level, including monitoring and delivery of HIV/TB/malaria service(s), needs to be strengthened

[ ]  Timeliness of submission of HIV/TB/malaria reports from health facilities needs to be improved

[ ]  Other(s), please specify

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