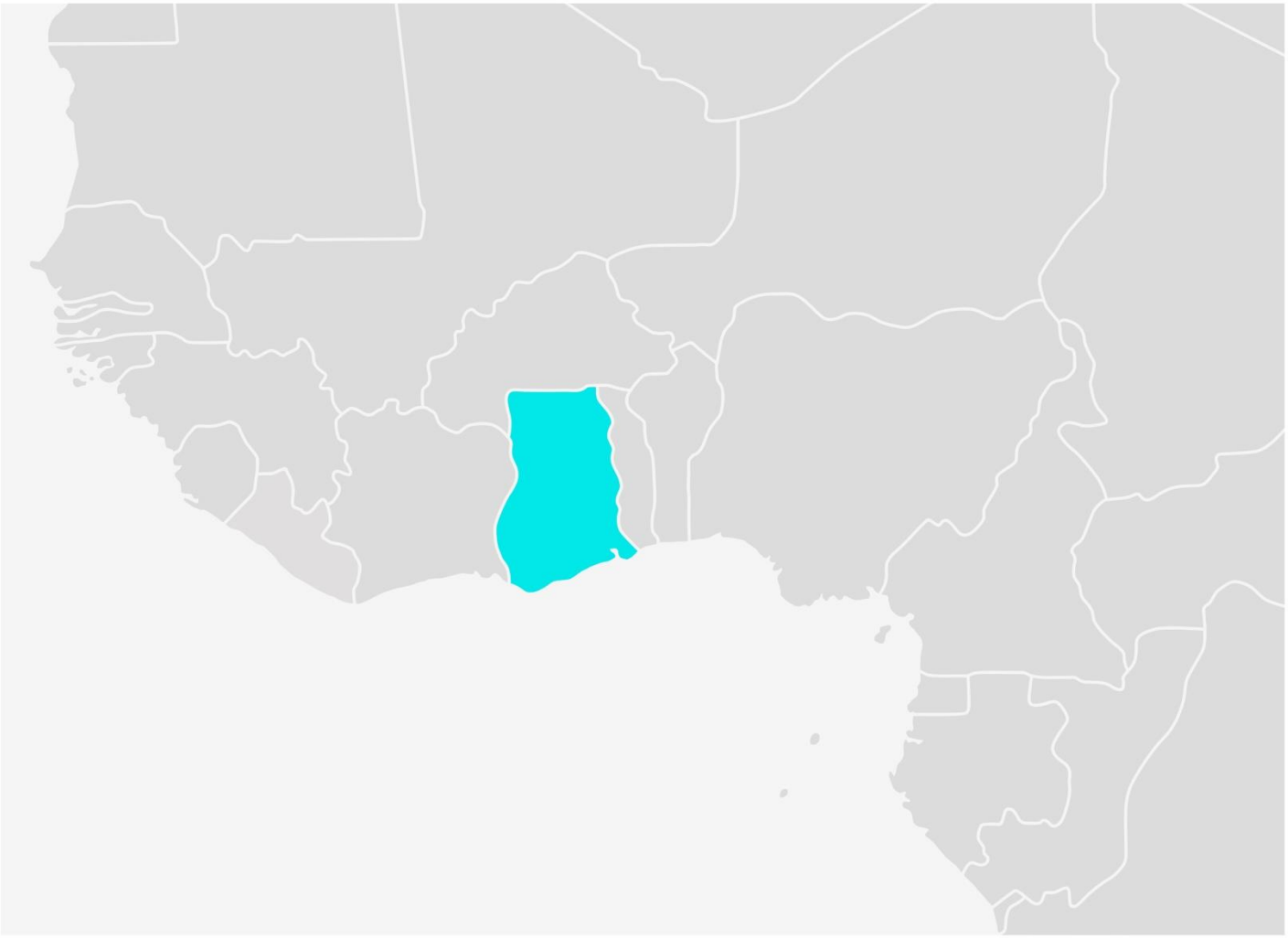

Audit Report

Global Fund Grants in Ghana

GF-OIG-23-020
18 December 2023
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Ghana is a key country in the fight against the three diseases and has a long history of partnership with the Global Fund.[1] It has seen good progress in malaria, with the country moving towards pre-elimination. Increased antiretroviral therapy (ART) coverage for people living with HIV and availability of first-line HIV, tuberculosis (TB) and malaria commodities were noted by the Office of the Inspector General (OIG), highlighting progress since its last audit (2019). However, there are continued challenges in terms of HIV testing and prevention, TB treatment coverage and data accuracy.

Ghana has made strong progress in the malaria response. There have been positive reductions in malaria-related morbidity and mortality, and this is linked to the country developing a comprehensive approach to malaria prevention. Progress has also been made in linking people living with HIV (PLHIV) to ART.[2] Among PLHIV, 98% that know their status are on ART. However, HIV testing and prevention remains challenging. Sub-optimal quality of testing, gaps in guidelines, and HIV test kits and condoms stock-outs, threaten progress. There is limited progress in the fight against TB, with case detection and treatment coverage low – at around 30% – for the past 15 years. This is due to health facility screening gaps, a limited national community response, low GeneXpert use and low government investment in TB. This longstanding low TB treatment coverage and limited progress, along with gaps in coverage, quality and scale up of HIV testing and prevention, means the adequacy and effectiveness of TB and HIV implementation is rated as **needs significant improvement**.

Despite suffering perennial challenges for the past three grant cycles, there have been some solid improvements in procurement and supply chain management (PSM) since the last audit. Auditors found good inventory management at the central warehouse,[3] as well as timely distribution through third party logistics providers (3PLs). But there have been delays in completion of strategic PSM initiatives, with port clearance still taking a significant amount of time and commodity traceability remaining difficult at the sub-national level. Key treatment commodities are available, including antiretroviral medicines (ARVs), first- and second-line TB drugs, as well as artemisinin-based combination therapies (ACTs) and rapid diagnostic tests (RDTs). However, delays in the government fulfilling domestic procurements have led to stock-outs of key prevention and diagnostic commodities. As such, the design and effectiveness of PSM is rated as **partially effective**.

Large data inaccuracies in routine programmatic data were noted, with variances over 20% at the majority of the 17 sites visited by the OIG. Global Fund operational guidelines rate data accuracy as very poor when data variances above 20% are noted. [12] This increases the risk of the Global Fund not being able to accurately assess grant performance for the three disease programs. Weak sub-recipient financial management and oversight by the Ghana Health Service and Christian Health Association of Ghana (CHAG) increase financial risks. Lastly, improvement is needed in reporting allegations of prohibited practices to the Global Fund in a timely manner. Thus, the adequacy and effectiveness of grant oversight to support achievement of grant objectives is rated as **needs significant improvement**.

1.2 Key Achievements and Good Practice

Significant progress made in malaria response: Ghana met WHO targets,[4] reducing malaria incidence by 40% between 2015-2020. Ghana also achieved a 17% decline in malaria-related deaths in the same period. This is

[1] Ghana was the first recipient of Global Fund grants in 2002
[2] UNAIDS 2022 treatment cascade special analysis (accessed 5 June 2023)
[3] The central warehouse stores Global Fund commodities run by Imperial Health Sciences, funded by the Global Fund and is different to the National Temporary medical store.
[4] Global Technical Strategy (GTS) 2020 – reduce malaria incidence by 40% and Ghana reduced from 27.7K to 16.5 K cases per 100K.

linked to a robust approach to malaria prevention through vector control, preventive chemotherapies (SMC & IPT) and vaccinations (piloting the RTS, S malaria vaccine).

Availability of key drugs and improved traceability at central level: HIV antiretrovirals, first-line tuberculosis and malarial treatments were available at central level and at health facilities visited by the OIG. This shows significant positive progress, given the substantial stock management issues noted in the last two OIG audits since 2015. Good central level warehouse management was noted at the warehouse storing Global Fund commodities, helping with central level visibility of commodities. Timely distribution services drawing on third-party logistics providers (3PLs) were also observed. With both warehouse management and distribution being supported by the Global Fund.

Roll out of Ghana Integrated Logistics Management Information System (GhILMIS): The Global Fund supported GhILMIS for malaria and TB. The system was rolled out in January 2019 across the country, with 500+ participants trained to use the system. All commodity orders are made through this system, improving the ordering process and visibility on demand for health products which is a critical data point for procurement management.

Good financial and sub-recipient management at West Africa Program to Combat AIDS and STI (WAPCAS): WAPCAS is implementing the HIV prevention interventions for key populations in Ghana. Well-designed sub-recipient management policies, guidelines, and procedures were noted. There was timely supervision and feedback to sub-recipients, timely retirement of advances, and no issues with program data accuracy were noted. In addition, strong programmatic results under the WAPCAS grant were observed when implementing prevention work for female sex workers (FSWs) and men who have sex with men (MSMs).

1.3 Key Issues and Risks

Substantial inaccuracies noted for routine programmatic data that can hamper reliable measurement of performance: Significant programmatic data inaccuracies were identified across key routine coverage indicators for the three diseases at 17 sites visited by the OIG. Global Fund operational guidelines rate data accuracy as very poor when data variances above 20% are noted.[12] There were variances of over 20% at most of the sites visited by the OIG. This is linked to gaps in reviewing data at all levels, ineffective monitoring and oversight through data quality reviews and gaps in training and supervision at the sub-national level. Community-level data is also weak, with significant data validation challenges noted under the CHAG grant. These data inaccuracies can impact the ability to reliably assess the grant performance. Gaps in the Global Fund risk management approach over M&E risks were also noted.

Continual low TB treatment coverage linked to a lack of prioritization and investment in TB: TB treatment coverage in Ghana has stagnated at an average of 31% for the past 15 years. Consequently, Ghana is materially off track in meeting its grant objectives for TB. Low coverage of TB screening and inadequate design of TB community case finding interventions are impacting Ghana's ability to find missing patients. Low utilization of GeneXpert machines also affect timely diagnosis. These challenges are underpinned by declining domestic funding for TB interventions, highlighting a lack of prioritization and ownership of the TB response by the Government.

Suboptimal HIV prevention and testing threaten to stall and reverse programmatic progress: An estimated 100,000 PLHIV in Ghana are unaware of their status[5] as per UNAIDS special analysis 2022. Efforts to strengthen testing approaches are noted but the OIG observed incomplete coverage (31% of health facilities do not provide HIV testing and counselling services) and a lack of quality HIV testing at the health facility level. This was linked to gaps in training, supervision, and large-scale stock-outs of test kits. For prevention, there are strategic and

[5] UNAIDS 2022 treatment cascade special analysis – Estimate of people living with HIV is 350,000 vs 250,000 people living with HIV who know their status (accessed 5 June 2023)

operational gaps in implementing key population activities against a backdrop of increasing stigma and discrimination and a lack of government prioritization of these activities.

Delayed implementation of national PSM strategic plans resulting in the failure to address persistent delays in port clearance and some gaps in commodity traceability: Key initiatives in the 2015-20 and 2021-25 supply chain master plans are delayed or not started, including efforts to improve the number of human resources, create an autonomous supply chain oversight agency, deal with customs clearance and challenges with LMIS data. This is linked to gaps in the governance and oversight over PSM activities, as well as roles and responsibilities around PSM being fragmented and duplicated across different departments within the Ministry of Health. This has led to persistent delays in port clearance and gaps in traceability of key commodities.

Delayed fulfilment of domestic commodity commitments leading to stock-outs and increased stock-out risk: At the time of the OIG audit, Ghana had achieved 12% of the initial planned commodity commitments. There were several reasons for this, including the late submission of requests for domestically financed commodities and long procurement timelines for government-funded commodities. As a result, the OIG noted stock-outs of HIV test kits, GeneXpert cartridges and some artemisinin-based combination therapies (ACTs) across health facilities, impacting HIV, TB and malaria activities. This increases the risk of Ghana not meeting its co-financing commitments for Grant Cycle 6 (GC 6).

1.4 Objectives and Scope

The audit's overall objective was to provide reasonable assurance on the adequacy, effectiveness, and efficiency of Global Fund grants to the Republic of Ghana. Specifically, the audit assessed the adequacy, efficiency, and effectiveness of:

<table>
<tr><th>Objective</th><th>Rating</th><th>Scope</th></tr>
<tr><td>Grant interventions to:
scale up TB case detection and treatment coverage; and
provide HIV prevention and testing to ensure achievement of grant objectives</td><td>Needs significant improvement</td><td rowspan="3">Grants and implementers: The audit covered the Principal Recipients and sub-recipients of Global Fund NFM 3 grants in Ghana.

Audit period: The audit covered grants from 1 January 2021 to 31 December 2022, as well as the design of future arrangements for the implementation of grants in Ghana.

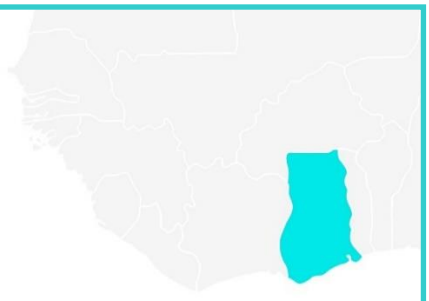
Scope exclusion: None</td></tr>
<tr><td>Procurement and supply chain arrangements, processes, and systems to ensure timely availability and accountability of commodities at all levels</td><td>Partially effective</td></tr>
<tr><td>Grants oversight and functions to support the achievement of grant objectives, with a focus on:
data management; and
financial management including sub-recipient oversight and monitoring</td><td>Needs significant improvement</td></tr>
</table>

The audit team visited 17 health facilities and hospitals (with 15 GeneXpert diagnostic laboratory sites) spread across 16 districts in eight regions in Ghana. The districts visited account for 32% of HIV patients under antiretroviral therapy, 23% of the 2021 notified TB cases and 8% of 2021 malaria-positive cases in the country. The sites visited are a sub-set of the total sites in each district. The audit team also visited five regional medical stores (RMS), as well as the Temporary Central Medical Stores (TCMS) and the central warehouse managed by Imperial Health Services (IHS) in Accra.

Details about the general audit rating classification can be found in Annex A of this report.

2. Background and Context

2.1 Country Context



Ghana is a lower-middle-income country with an estimated population of 34.1 million people. A Western African country, Ghana is administratively divided into 16 regions. These regions are further subdivided into 216 districts.

Public health programs in Ghana are implemented through various agencies of the Ministry of Health i.e., the Ghana Health Service, teaching hospitals, and quasi government health institutions amongst others. The national disease programs, under the Ghana Health Service, operate through a tiered regime – regional, district and health facility level.

Despite experiencing a rebound in GDP growth of 5.4% in 2021 after the COVID-19 pandemic (GDP growth of 0.5% in 2020), Ghana has been experiencing an economic crisis since 2022. This is evidenced by high inflation rates, currency depreciation and suspension of payments on selected external debt.[7]

While the budgetary allocation to the Ministry of Health has been increasing in absolute terms, the proportion of the Ministry of Health budget to the national budget is low. It has averaged 7% since 2018, well below the 2001 Abuja declaration target of 15%.

Country data[6]	
Population estimate (2023)	34.1 million
GDP per capita (2021)	US$2,363
Corruption Perception Index (2022)	72 of 180
UNDP Human Development Index (2021)	133 of 191
MoH budget as % of National Budget (2023)	6.7%

2.2 Global Fund Grants in the Republic of Ghana

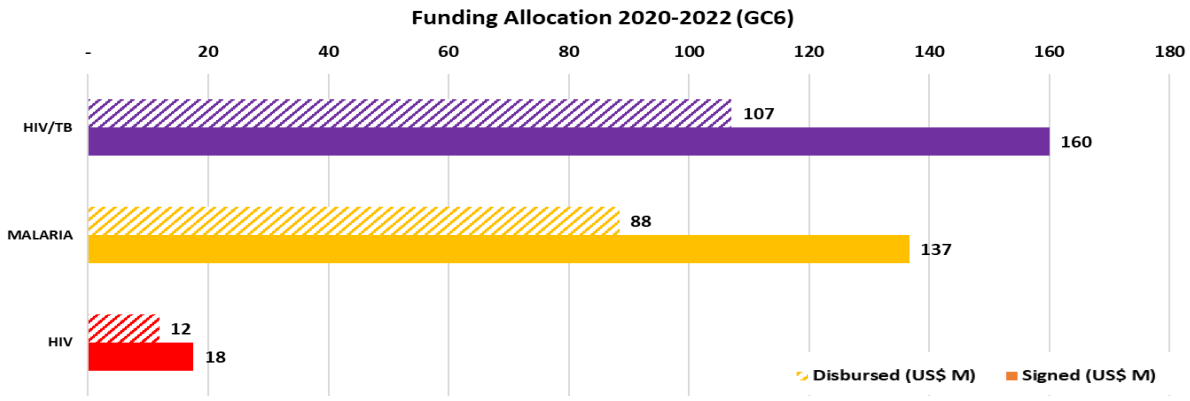
Since 2002, the Global Fund has signed grants of over US$1.29 billion and disbursed more than US$1.18 billion to Ghana.[8] Active grants total US$314 million for the 2020-2022 funding allocation period (i.e., the January 2021-December 2023 implementation period), of which 66% has been disbursed.[9]

The Ministry of Health, West African Program to Combat AIDS and STI (WAPCAS), Christian Health Association of Ghana (CHAG) and the AngloGold Ashanti (Ghana) Malaria Control Limited (AGAMal) are the Principal Recipients for Global Fund grants. The Ghana Health Services (GHS), through the national disease programs for the three diseases, implements these grants on behalf of the Ministry of Health.

Each disease program is implemented by a government implementer and non-governmental organization. The combined HIV/TB grants are implemented by the National Tuberculosis Control Program (NTP), National AIDS/STI Control Program (NACP) and CHAG. WAPCAS implements the HIV grant, while the malaria grants are implemented by the National Malaria Elimination Program (NMEP) and AGAMal.

[6]Population size estimate by UNFPA; GDP from World Bank Database; Corruption Perception Index by Transparency International; Human Development Index by UNDP; Ministry of Health budgets – all accessed on 5 May 2023
[7] Ministry of Finance of Ghana: Suspension of payments on selected external debts – accessed on 9 May 2023
[8] Global Fund Data Explorer, accessed on 9 May 2023
[9] Grant Operating System (GOS) data, accessed on 9 May 2023. US$104M allocated through C19RM.

Figure 1: Funding allocation for current funding cycle (as of May 2023)



2.3 The Three Diseases

HIV/AIDS

Ghana has a **generalized HIV Epidemic** (HIV prevalence of **1.7%**) with **key populations disproportionately affected** (HIV prevalence amongst **FSW is 4.6%, MSM is 5%**).

345,000 people are living with HIV as of 2021, of whom 71% know their status.

Linkage to care: 98% of estimated PLHIV who know their status are on ART. **96%** ART enrollment rate for HIV/TB positive patients.

Only **79%** of those on ART have been **virally suppressed**.

HIV incidence decreased by **32%** between 2015 and 2021. **AIDS-related deaths decreased** by **47.5%** between 2016 and 2021.

Source: UNAIDS – Ghana fact sheet (accessed on 9 May 2023); 2020 FSW IBBS report

TUBERCULOSIS

TB missing cases: only 30% of estimated TB cases notified in 2021.

TB incidence of **136 cases per 100,000.**

High treatment success rates: **DS-TB 86%** (2020 cohort) & **DR-TB 71%** (2019 cohort)

High TB case fatality ratio of **39%:** 2021 high estimated TB mortality (HIV-negative 36, HIV-positive 11, per 100,000).

Source: 2021 WHO Ghana TB country profile (accessed on 9 May 2023)

MALARIA

Ghana has the **12th highest global malaria burden** and is among the WHO/RBM **High Burden to High Impact Approach (HBHI)** countries.

The country accounts for **2.2%** of the Global **malaria burden** and **2%** of the Global **malaria deaths.**

Low LLIN use rate of **43%** despite **74% ownership** of at least one ITN.

Reduction in malaria deaths: 17% decline in malaria deaths between 2015 (47) and 2020 (39) per 100,000 people.

Source: 2022 World Malaria Report and 2019 Ghana Malaria Indicator Survey, (accessed on 9 May 2023)

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

NFM 3 (Jan 2021-Dec 2023) Grant performance and grant ratings are shown below:

Comp	Grant	Principal Recipient	Grant Period	Total Signed Amount (USD)	Budget as at June 2022 (USD)	Expenditure as at June 2022 (USD)	Absorption as at June 2022 (%)	June 2021	Dec 2021*	June 2022
	GHA-C-MOH	Ministry of Health of the Republic of Ghana	1 Jan 21 – 31 Dec 2023	138,240,851	77,171,025	59,501,716	77%	B1	C5	C3
	GHA-C-CHAG	Christian Health Association of Ghana	1 Jan 21 – 31 Dec 2023	21,762,972	8,095,905	7,991,745	99%	B1	C3	C1
	GHA-H-WAPCAS	West African Program to Combat AIDS and STI	1 Jan 21 – 31 Dec 2023	17,532,714	10,400,931	7,606,165	73%	B1	A2	A3
	GHA-M-MOH	Ministry of Health of the Republic of Ghana	1 Jan 21 – 31 Dec 2023	113,472,296	32,274,493	40,821,706	127%	B1	C3	C1
	GHA-M-AGAMal	AngloGold Ashanti (Ghana) Malaria Control Limited	1 Jan 21 – 31 Dec 2023	23,276,567	14,629,113	13,150,435	90%	Only in Dec	A1	Only in Dec
				314,285,400	**142,571,467**	**129,071,767**	**91%**			

* Effective January 2022, the Global fund updated the PU/DR performance rating methodology[10] with programmatic performance assessed via alphabetic ratings, while financial performance assessed via numerical ratings.

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Ghana portfolio with the residual risk that exists based on the OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanation of differences are detailed in Annex B of this report.

AUDIT AREAS	RISKS	SECRETARIAT AGGREGATED ASSESSED RISK LEVEL[11]	ASSESSED RESIDUAL RISK, BASED ON AUDIT RESULTS	RELEVANT AUDIT ISSUES
Program quality	Program quality – TB	**High**	**High**	Finding 4.2
	Program quality – HIV	**High**	**High**	Finding 4.3
Procurement and supply chain	Procurement	**High**	**High**	Finding 4.4
	In-Country Supply Chain	**Low**	**Moderate**	
Financial management and oversight and data management	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	Finding 4.5
	Monitoring and Evaluation	**Moderate**	**High**	Finding 4.1
Domestic financing	Materialization of Co-financing commitments	**Very High**	**Very High**	Finding 4.4

[10] Revised PU/DR and Performance Ratings (2022), accessed 3 May 2023
[11] As per the January 2023 Ghana Country Risk Management Memorandum (CRMM)

4. Findings

4.1 Limited oversight and follow-up has led to inaccuracies in routine program data for the three diseases, potentially impacting the ability to assess grant performance

Progress has been made in rolling out a national health management information system (HMIS) across the country. There have also been improvements in the completeness of HIV and TB data in district-wide health information systems (DHIMS). However, at the 17 sites visited by the OIG, substantial data inaccuracies for key programmatic indicators across the three diseases at health facility and community levels were noted. This is linked to gaps in Health Management Information Systems (HMIS) use, limited training, and supervision, as well as lack of availability of M&E tools – all can undermine the ability to fully assess grant performance.

There have been several improvements made to strengthen programmatic data management in Ghana. This includes expanding coverage of the national and district HMIS and DHIMS. This has included expanding coverage across the country and at the health facility level. Standard operating procedures were also developed for the use of DHMIS to support effective use of the system. In addition, prior OIG audit issues raised around incomplete reporting of HIV and TB data from teaching hospitals in DHIMS have been resolved.

However, the OIG noted substantial data inaccuracies in routine programmatic data at the 17 sites visited. These were observed in several key coverage indicators across the three diseases. The inaccuracies in turn can undermine the ability of the Global Fund to assess grant performance. These challenges persist despite investment in the national HMIS. Data quality errors were also identified in the last OIG audit in 2019 and are now more material.

Substantial programmatic data inaccuracies can impact the ability to assess performance of grants.
Global Fund guidelines rate data accuracy as very poor when data variances above 20% are noted. According to this measure, very poor data quality (with +/- 20% discrepancies)[12,13] was observed across HIV, TB, and malaria indicators in most sites visited by the OIG (see table 1). Several factors contributed to these:

Table 1: Data results from OIG site visits

	Indicator[14]	Sites with data inaccuracies above +/- 20%	Min - max % variances observed
HIV	HIV tested cases	11 of 17 (65%)	-514% to 92%
	HIV positive cases	8 of 17 (47%)	-118% to 85%
TB[15]	No. of cases screened	13 of 17 (76%)	-222% to 100%
	No. of presumed cases	12 of 17 (71%)	-228% to 100%
Malaria	Suspected tested cases	17 of 17 (100%)	-100% to 309%
	Positive cases	15 of 17 (88%)	-100% to 136%

National HMIS systems not properly leveraged: The national HMIS system has the functionality to identify data errors, but this is not effectively used. There was no evidence of data validation checks within the system being performed during 2021-2022. There are no

[12] Data accuracy is measured as the ratio of recounted value in source documents at the health facility to the value in the reporting system (i.e. HMIS). Ratings as follows: >20% (Very Poor); +/-11% to 20% (Poor); +/- 6% to 10% (Moderate); and +/-5% (Good). (Global Fund's Operational Guidelines for Data Use and Improvement at Country Level)
[13] Discrepancies noted between the source documents at the health facilities (patient registers) and the consolidated monthly data reported in DHIMS.
[14] These are the short form names for indicators tracked by the disease programs. The HIV and malaria indicators shown are reported to the Global Fund. The TB indicators of number of cases screened and number of presumed cases are not reported to the Global Fund but are critical program data points to assess the full TB treatment cascade.
[15] Variances in number of TB cases notified were at 5% across all sites visited by the OIG, which is considered good per Global Fund guidelines.

guidelines on creating and using system validation rules to assess data quality.[16]

Gaps and limited coverage of national DQA: While Ghana has developed HMIS Standard Operating Procedures and DQA guidelines and tools to perform national data quality assessments (DQAs), gaps remain in the coverage and quality of DQAs. Existing DQA tools do not cover community-level data or some TB and HIV indicators covering MDR-TB and HIV-TB. The guidelines also do not specify the required coverage and frequency of reviews which would help determine what is the appropriate level of oversight. As such, 75% of all districts did not have any DQAs between 2021-22. Where DQAs were conducted in sites visited by the OIG, no identified errors were corrected and there was no evidence of follow up to ensure data was adjusted or that lessons were learned to prevent further mistakes.

Lapses in data management at the sub-national level: In 88% (7/8) of regions visited by the OIG, data errors identified through validation checks were not corrected or followed up on. At district level, transposition errors were noted in 36% (5/14) of districts and 29% (4/16) did not input data into DHIMS despite data being available. At the health facility level, there was no evidence of data checks prior to input into DHIMS at any OIG sites visited. This is related to evidence of no training or supervision for data management at any sites visited and 82% (14/17) of sites lacking adequate registers for recording data.

Data quality verification challenges and irregularities in TB community data under CHAG

CHAG is a new Principal Recipient for Grant Cycle 6 (GC6) and there is a need for time to develop new processes and tools. However, after two years as Principal Recipient, major gaps were still noted around this organization's data management and quality.

The OIG could not fully validate a substantial proportion of reported TB cases notified in the community. Only 13% (24/188) of sampled TB community referral cases could be supported by adequate primary documents as defined by CHAG's standard operating procedures.[17] This was linked to gaps in compliance with protocols for verifying cases. Similar challenges with validating results and irregularities in data reported and reporting practices were also self-identified by the Principal Recipient in 2021 and 2022.[18] However, these findings were not reported to the Global Fund Secretariat, and results reported to the Global Fund were not adjusted to remove results that were not validated.[19] A referral to the OIG Investigations Unit has been made regarding these irregularities. Several factors have contributed to these data issues:

- There was no Principal Recipient M&E plan to guide monitoring visits over implementers and community workers.
- DHIMS does not capture community-level data, resulting in the Principal Recipient developing a new platform.
- This new platform does not have data validation rules and no guidelines on verifying data in the system. Functionality gaps have led the Principal Recipient to rely on Excel spreadsheets.

A Principal Recipient capacity assessment for CHAG, conducted by the LFA in November 2020, highlighted several of these M&E-related system, tool, and guideline gaps.[20] These gaps have persisted throughout CG6. The Global Fund Secretariat performance letters continued to correctly identify these gaps throughout GC6 and raise them to the attention of the Principal Recipient, but the Principal Recipient has not been able to adequately resolve them.

[16] No rules were set up for key indicators for HIV and malaria numbers tested for HIV and number of patients on first-line treatment; confirmed malaria cases that received first-line antimalarial treatment in the community and at public sector health facilities (malaria).
[17] Out of 188 community referral cases reported from sites with TB champions visited by the OIG: 13% (24/188) had endorsement forms with the correct approvals from the District Health Director (DHD), 10% (18/188) had forms but with no DHD signoff, 5% (9/188) did not have endorsement forms hence could not be verified, 46% (87/188) of forms existed but did not have DHD signoff and were signed off by hospitals, 23% (43/188) forms were provided after OIG field visit (these were not accepted by the OIG due to indications that these were not reliable) and 4% (7/188) forms provided were modified after OIG site visits (a referral to Investigations has been made regarding the evidence reliability and modifications after OIG site visits).
[18] 42% of the reported cases in the period January to June 2021 could not be verified during monitoring visits undertaken by the Principal Recipient. Self-identified irregularities in data reported and reporting practices were noted by the Principal Recipient in 2022.
[19] These instances of data fraud have been referred to the OIG Investigations Unit for further assessment.
[20] This includes a lack of tools and guidelines over community-based data.

Gaps in M&E risk management by the Global Fund Secretariat

There are gaps in the Global Fund Secretariat's risk management for M&E. Data quality risks focused on data accuracy were not captured in the Global Fund Integrated Risk Management (IRM) module,[21] affecting how these risks can be routinely tracked, mitigated, and reported. In addition, the last completed Global Fund-supported independent assurance review of data accuracy was in 2017.[22] Reliance was placed on national DQAs conducted by the MoH. For CHAG, despite M&E-related system, tool and guideline gaps being identified in the 2020 Principal Recipient capacity assessment, none of the OIG-identified control gaps and risks were captured in the IRM module. There have also been delays completing data quality assurance reviews for CHAG that could have identified the above issues sooner.

Overall, these aforementioned challenges with data accuracy can affect how grant performance can be effectively assessed, as routine reported data from DHMIS is a key source of data for Progress update and disbursement request (PU/DR) reporting to the Global Fund. This can undermine the Global Fund's monitoring of grant performance.

Agreed Management Action 1
The Global Fund Secretariat will work with the Ministry of Health and other partners to conduct a data quality assessment with a focus on data accuracy. This will include key indicators reported to the Global Fund across the three diseases and health facility and community related data.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2025

[21] The Integrated Risk Management (IRM) module is an online platform that is part of the Global Fund's Grant Operating System (GOS). Country teams use the IRM to manage risks in their portfolios.

[22] Targeted reviews covering HMIS systems (e-trackers) and a triangulation exercise between program and health product consumption data were completed in 2020-2021

4.2 Limited progress in the fight against TB with low treatment coverage for 15 years due to weak country prioritization and investment

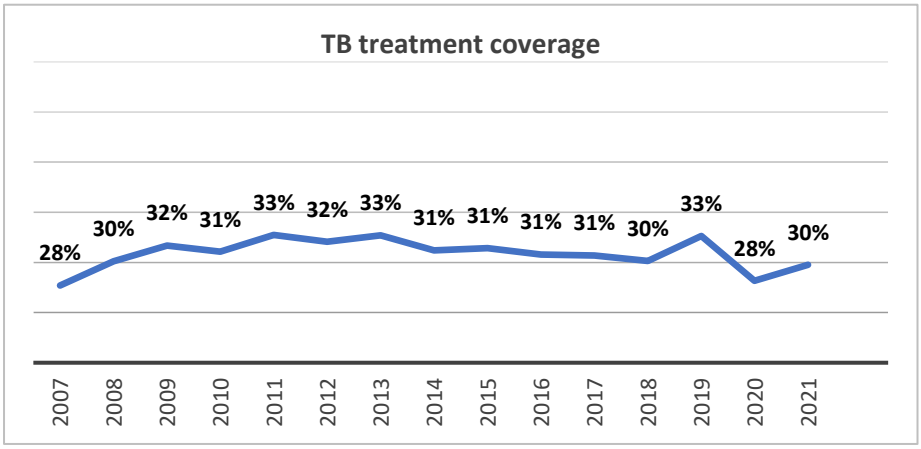
Ghana has had limited progress in addressing low TB treatment coverage for the past 15 years despite investments from the Global Fund. This is linked to gaps in health facility screening, a limited community response, low GeneXpert utilization and weak government prioritization and investment in TB activities.

Ghana has implemented several innovations and achieved some successes in its TB response, including a high rate (96%) of enrolment on ARVs for co-infected (HIV/TB) patients, good TB treatment success rates and the introduction of Tuberculosis Preventive Treatment (TPT) regimens. However, there has been limited improvement for key outcome and impact indicators, indicating weak progress in the overall National TB response, despite continued investment by the Global Fund.

Ghana is not achieving its TB National Strategic Plan and Global Fund targets[23] and the country is not on track to reach its grant objectives to increase TB treatment coverage to 90% by 2025. Instead, treatment coverage remains low at circa 31% and key impact indicators are worsening, with HIV negative TB mortality increasing by 9% since 2015.[24]

TB treatment coverage in Ghana has stagnated at circa 31% since 2008.[25] This issue was raised in the prior 2019 OIG audit.[26]

This weak treatment coverage is linked to: (1) gaps in screening in health facilities, (2) deficiencies in the community response, (3) issues with use of GeneXpert platforms and (4) limited government funding.



Source: WHO TB Burden estimates[25]

Low coverage and significant gaps in TB screening at health facilities

The TB National Strategic Plan (NSP) aims to prioritize TB screening in hospitals and healthcare facilities.[27] This is a key opportunity to identify suspected TB patients and link to TB services. However, there are gaps in TB screening being implemented at the health facility level and there is limited staff dedicated to TB screening,[28] with only 85 dedicated TB task shifting officers operating nationally (supported by the Global Fund). In addition, national TB screening guidelines were outdated or not available in all sites visited by the OIG. There was also no evidence of TB training and supportive supervision at any sites visited by the OIG despite funding being available. Lastly TB screening in Outpatient Departments (OPDs) is not being routinely monitored and reported on.

Sub-optimal design of community interventions impacting effective implementation of active case finding

Ghana has developed community engagement through the Community-based Health and Planning Services (CHPS), with over 7,000 CHPS sites across the country. However, there is a missed opportunity in leveraging CHPS staff to support TB community services. This issue was also raised in the OIG's 2019 audit.

[23] PU/DR results for number of notified cases of all forms of TB, new and relapse cases: the achievement rate at 58% (6,620/11,496 January-June 2021) and 61%, (7,382/12,148 for semester one of 2022).

[24] WHO TB burden estimates (Accessed 10 May 2023) – measured in absolute numbers.

[25] WHO TB burden estimates, Case notifications; (Accessed 10 May 2023)

[26] Ghana 2019 Audit report

[27] Ghana Tuberculosis National Strategic plan 2021-2025 – page 70

[28] Only 7% (85/1,236) of these TB screening health facilities have dedicated TB task shifting officers. TB task shifting officers are responsible for administering a screening tool and ensuring that samples for suspected TB cases are taken to the lab for testing.

At the time of the audit, there were no national CHP operational guidelines for TB screening and the national training curriculum did not include TB screening. In addition, there are no nationally approved technical SOPs for community-based active case finding. However, it is important to note that the ability to leverage CHPS staff is dependent on a range of factors, including increasing training and provision of equipment and tools, both of which require additional funding.

Under the CHAG grant, TB community interventions are implemented but with design and implementation challenges. At the start of GC6, districts selected for activities were not determined based on programmatic data but were selected based on where implementers operated, as opposed to areas of the highest need. In addition, during grant implementation, directives from the Ghana Health Service (in 2021) prevented CHAG workers from accessing TB index patient data from facilities. This prevented CHAG workers from conducting active case finding (ACF).

Continual low utilization of GeneXpert machines

There has been low utilization of GeneXpert machines. In the 15 GeneXpert sites visited by the OIG, the average utilization rate was 23% for 2022.[29] Low use was also noted in the prior 2019 OIG audit. This is due to:

- *No equipment maintenance contracts and warranties in place*: Warranties expired in June 2021 and replacement Government-funded warranties were not signed leading to non-functioning modules.[30]
- *Stock-outs of GeneXpert cartridges at some sites:* Cartridges were continuously stocked out for 126 days in 2022 at the central level. 20% (3/15) of health facilities visited by the OIG had stocks-outs for 68 days (average) in 2021-2023. This is linked to gaps in domestic financing further discussed in finding 4.5.
- *No system to monitor GeneXpert utilization:* The prior system contract to monitor utilization expired in 2022 and the roll out of its replacement has been delayed since Q2 2021, despite the funding available from the Global Fund.[31]
- *Coverage gaps and challenges in sample transportation:* Only 11% of health facilities are linked to GeneXpert sites by sample transportation, although these include the high-volume sites to maximize patient coverage. Furthermore, there was low absorption of Global Fund budgets (32%) for sample transportation and referral activities and failure to track turnaround time for TB samples. Consequently, TB sample transportation system performance[32] could not be assessed. Issues with sample transportation were also highlighted in the 2019 OIG audit.

Limited prioritization of domestic funding and support for the TB program

A cross-cutting root cause is the lack of Government prioritization and ownership over the TB response. There is declining domestic funding for TB with 9% of the TB program funded by the Government in 2021, compared to 24% in 2017.[33] There is a lack of domestic funding of task shifting officers, limited funding for community health workers who can support TB activities and delays in domestic procurement of GeneXpert cartridges. At a strategic level there has also been limited government support for studies[34] to inform strategic planning.

Agreed Management Action 2
The Global Fund Secretariat will work with the Ministry of Health and Ghana Health Services to assess the effectiveness of the sample transportation approach taken by Ghana in the context of regional decentralization. This assessment will include an analysis of the key benefits and challenges with the current approach and recommendations to be implemented at both the national and sub-national levels.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2024

[29] 23% assuming three testing cycles per day (WHO Xpert MTB/RIF implementation manual)
[30] In 73% (11/15) of sites visited by the OIG, there was at least one nonfunctioning module
[31] Budgeted Global Fund investment in the Aspect is US$1.1m in NFM 3 and Absorption of investment is 13% (US$141k/1m) on 31 Dec 2022
[32] The current approach is decentralized with each region defining its own approach to sample transportation.
[33] WHO Tuberculosis Profile Ghana (accessed 10 May 2023)
[34] This includes as an updated TB prevalence survey, inventory study and Patient cost survey

4.3 Strong progress in scaling ART treatment, but low coverage and implementation challenges for prevention and testing activities hinder further progress

There has been strong progress in scaling ART treatment with an estimated 98% of People Living with HIV that know their status being on ART. In addition, differentiated approaches to HIV testing have been established in the country. However, challenges with HIV testing and prevention – especially those targeted at key population groups and prevention of mother-to-child transmission (PMTCT) – remain a challenge. Without strengthening these areas, the country's long-term ability to achieve 95-95-95 and UNAIDs targets is limited.

Ghana has made progress in key elements of the HIV response with 98% of People Living with HIV (PLHIV) knowing their status being on ART.[35] Differentiated Service Delivery and HIV Testing Service (DSD/DHTS) strategies and HIV self-testing guidance have been rolled out.[36,37] Through Global Fund Strategic Initiatives, there is also technical support to scale up virtual HIV self-testing.[38] However, there are persistent gaps in coverage and quality of HIV testing and prevention, especially for key population groups (KPs), hindering further progress.

Gaps in coverage and sub-optimal quality of HIV testing impacting achievement of the first '95'

There have been challenges in identifying people living with HIV. As per UNAIDS estimates, 71% of PLHIV know their status, below national strategic plan (NSP) and global targets. In addition, HIV index testing of partners and children of PLHIV has been limited.[39] There was also sub-optimal quality of HIV testing. In 59% (10/17) sites visited by the OIG, a national HIV testing algorithm[40] was not being followed. These findings were caused by:

- *Inadequate HIV Counselling and Testing (HCT) coverage:* Only 69% of health facilities provide HTC services. The DSD scale-up plan, which aims to improve coverage, was still under development at the time of the audit and does not include targets for scale up and the costing required to implement.

- *Stock-outs of HIV test kits:* Stock-outs of HIV test kits were noted in 76% (13/17) of sites visited by the OIG.[41] These commodities are supported by the Government of Ghana and these stock-outs are linked to the domestic financing, and procurement and supply chain issues detailed in finding 4.5.

- *Lack of guidelines and tools at health facility level and delays in updating guidelines*: Up-to-date national guidelines for HIV testing and family screening have been developed. However, these guidelines were missing at sites visited by the OIG: 53% (9/17) of sites had outdated HIV testing guidelines and no copies of the family screening algorithm were available at any site. There were also delays in finalizing community HIV index testing standard operating procedures (these were developed in January 2023 - 24 months into GC6).

Low testing coverage gaps are impacting the ability of the program to achieve the 95-95-95 fast track goals and reach the GC6 grant objectives.[42] Currently, an estimated 100,000 PLHIV are not aware of their status.[43]

[35] 2021 UNAIDS data - HIV/AIDS estimates for Ghana (Accessed 15 May 2023)
[36] HIV NSP 2021-2025 & Differentiated service delivery for HIV in Ghana, an operational manual, 2022
[37] HIV self-testing in Ghana, an implementation guide, 2022
[38] Ghana DSD SI Implementation – TA support to update national guidelines, standard operating procedures, develop and scale up virtual service delivery platform for HIV self-testing, including capacity-building at 60 health facilities
[39] 25%-29% of targeted eligible partners and children of HIV index clients tested (Jun-Dec 2022 & Jan-Jul 2022 CHAG PU/DR)
[40] Confirmatory tests conducted for non-reactive cases in 7/17 sites, confirmatory test not conducted for positive cases in 3/17 sites
[41] Sites stocked out at least once for SD-Bioline test kits for an average of 87 days (max 346 days and min 16 days)
[42] Increase estimated PLHIV who know their status from 59% in 2019 to 90% by 2023
[43] UNAIDS 2022 treatment cascade analysis – Est. people living with HIV 350,000 vs 250,000 PLHIV who know their status (accessed 15 May 2023)

Lack of current strategic information and coverage of key population groups hindering long term progress
Interventions to support key population groups are critical in the fight against HIV. This is due to the high risk of infection in these communities.[44] There have been strong results under the WAPCAS grant, which focuses on supporting female sex workers (FSW) and men who have sex with men (MSM). They have achieved over 90% of their targets across most of their performance,[45] including provision of prevention services to these key population groups. However, there are gaps in the overall national HIV key population response:

- Key population prevention activity is limited to international partner funded programs, with limited investment from the Government.
- There are few programs for People Who Inject Drugs (PWID), Male Sex Workers (MSW) and the transgender communities.
- There are also some strategic assessments and surveys for key populations that were out of date at the time of the audit impacting the ability to build a robust national key population response.[46,47]

Limited government funding of key population activities, as well as high stigma and discrimination, have played a role in limiting the scale, coverage, and information available for robust key population prevention activities. This is evidenced in the limited domestic financing provided to key population activities. In addition, proposals for legislation[48] further marginalizes and criminalizes key population groups highlighting the increasingly worsening environment for key populations to access services.

Reliance on old studies limit the design of key population programs contributing to low HIV-positive testing yields.[49] Limited government funding and increased stigma and discrimination also impact the long-term sustainability of these interventions.

Subsequent to the OIG audit fieldwork, the Global Fund Funding Request process for GC7 was completed and the Grant Making process for GC7 has significantly advanced. In the Funding Request process, TRP recommendations were raised to tackle challenges in the HIV response focused around strengthening the response to key populations and use of community actors. These recommendations are to be implemented during the GC7 grant. In addition, there are current proposals being finalized during Grant Making to further support HIV program activity to strengthen prevention services which includes HIV testing.

The above items will aim to help mitigate the challenges highlighted in the OIG audit report. As such, there is agreement that there is no need for a specific Agreed Management Action for this finding. The success of these GC7 actions will be assessed by the OIG in subsequent audits of the Ghana portfolio.

[44] Risk of HIV infection compared to general population, PWID 35 times, TG 34, FSW 26 times, MSM/W 25 times (2021 UNAIDS Global AIDS Update, Accessed 15 May 2023)
[45] As per Jan-June 2022 PU/DR reporting
[46] Ghana Men's Study II 2017 - Population Size Estimate for MSM & Integrated Biological and Behavioral Survey (IBBS) for MSM last undertaken in 2017.
[47] HIV surveillance options for key and vulnerable populations in Global Fund grants, Guidance Note, The Global Fund, 2017 - Global Fund recommendation for these to be conducted every 3-5 years.
[48] Proposed anti-LGBT bill that marginalizes and criminalizes key populations.
[49] 3% for MSM yield in July to December 2022 PUDR and Estimated prevalence for MSM is 18.1% per IBBS (2017)

4.4 Availability of first-line treatment and improvements in warehouse management and distribution noted but port clearance delays, gaps in commodity traceability and domestic financing challenges persist

Strong progress made in first-line treatment availability compared to prior audits. Good central level warehouse management and distribution was also noted. However, delays in commodity clearance, poor sub-national visibility, and inventory management as well as delays in realizing domestic commodity commitments have hampered further improvements in commodity availability and traceability.

Robust procurement and supply chain management (PSM) is a key enabler for grants in Ghana as 62% of GC6 budgets relate to PSM and commodities. PSM strengthening is a long-term undertaking, but the OIG noted improvements in key areas since the last audit. There was good availability of first-line HIV, TB and Malaria treatments at all sites visited. This is a very positive improvement given the issues with stock availability highlighted in prior OIG audits.

In addition, the OIG noted good inventory management practices at the Imperial Health Science (IHS) central warehouse. This warehouse stores Global Fund commodities and is run by a third party (IHS), funded by the Global Fund. It has contributed to improved visibility on commodities at the central level. There was also timely distribution noted down to the sub-national level using third-party logistics providers, also funded by the Global Fund. This helps strengthen commodity availability at lower levels. There was also good inventory traceability between the central and regional medical stores.

However, further improvements to reinforce PSM have been hampered.

Procurement and Supply chain activities are guided by national supply chain master plans,[50] these help to provide strategic direction and focus on improving PSM in the country. However, there were delays in completing key activities in the 2015-20 plan.[51] The 2021-25 plan was launched after an 18-month delay and there are also delays in completing key milestones, impacting functional areas in procurement and customs clearance, LMIS, warehousing and strategic planning. Root causes for this lack of timely progress in key initiatives include:

- *Fragmented roles and responsibilities over supply chain and coordination:* No single entity has overall accountability over the supply chain. Overlapping roles & responsibilities exist between the Ministry of Health and Ghana Health Service over procurement, warehousing, and supply chain. There is no strategic mapping of supply chain stakeholders, resulting in a lack of clarity over roles and responsibilities that can negatively impact effective coordination.
- *Finance limitations impacting key PSM activities:* There is a high reliance on donor funding for key PSM activities. This is noted with third parties funded by donors supporting central warehouse management, distribution and some LMIS activities. The full financial need is not defined, and the latest master plan is not fully costed with identified sources of funding.
- *Limited oversight by PSM technical working groups (TWGs):* The TWGs monitoring supply chain implementation were not fully structured and had ad hoc meetings till June 2022. National TWG terms of reference were then developed. At the time of the audit, only two meetings had been convened, but without evidence of issues being resolved, action points being followed up on or evidence of regional PSM challenges being escalated.

As a result, challenges persist that impact timely availability and traceability of key commodities:

[50] There are two Supply Chain Master Plans for 2015-2020 and 2021-2025
[51] Including improving PSM human resources, financing, warehousing, and creating an autonomous agency for supply chain oversight

Commodity clearance delays at central level impacts availability of prevention and diagnostic commodities
There were delays in port clearance and quality checks by the Food and Drug Authority (FDA) for Global Fund commodities. Clearance delays were also identified in the 2019 OIG audit. For a sample of 14 Global Fund consignments to Ghana, it took 169 days (average)[52] for port clearance after arrival. This is linked to the removal of a blanket waiver for Global Fund-procured commodities[53] and coordination and capacity challenges amongst stakeholders. There were further delays for condoms from FDA quality checks. For 47% of condom consignments, it took 138 days (average) from customs clearance to FDA sample collection.[54] This results from coordination and capacity challenges amongst stakeholders including the FDA. These delays have contributed to stock-outs of key commodities. Condom stock-outs were noted at 60% of all key population friendly sites visited by the OIG.[55] Due to stock-outs, under the WAPCAS grant, 66% of sampled FSW beneficiaries could not be provided condoms as a part of the approved package of prevention services.

Some gaps in commodity traceability due to a fragmented sub-national LMIS landscape, as well as weak inventory management
There has been significant investment in GHiLMIS, a computerized logistics management information system leveraged by the Ministry of Health to ensure the availability of reliable supply chain data and support end-to-end commodity visibility. It is operated at the central level and is intended to be used at the sub-national level. However, different LMIS systems are used at the sub-national level including GHiLMIS, Tally, Light-wave and HAAMS for inventory management. Ensuring integration and interoperability between these systems has been delayed. Sub-optimal utilization of GHiLMIS, weak inventory management, data recording and lack of PSM-related targeted supervision at the health facility level was also noted.[56] These have resulted in multiple and fragmented systems and a lack of sub-national visibility on inventory, which was also a challenge in the prior OIG audit.

As a result, for commodities distributed from the regional warehouse to the health facility level, some gaps in traceability were noted. Of the commodities samples by the OIG, 29% could not be traced to health facility stock records. In addition, all regional medical stores and health facilities visited by the OIG, had large variances between the physical count of stock, manual records and the eLMIS systems.[57] This increases the risk of misuse and diversion of commodities.

Delays in submission of requests for domestic financed commodities, long procurement timelines for government-funded commodities and worsening macro-economic environment impacting availability of funding
For GC6, the co-financing commitment is US$45 million, earmarked for commodities for fighting the three diseases. These included HIV test kits, GeneXpert cartridges and malaria ACTs. But, as of 31 March 2023, only US$5.3 million of commodities (12%) had been procured and delivered. This increases the risk of not meeting Global Fund co-financing commitments.[58]

The national budget process requires timely submission of funding requests.[59] However, there have been delays in requests, with around six months (average) delays for 2021-22.[60] There was additional time taken to confirm the exact budget allocation for 2021 between the Ministry of Health and Ghana Health Service. The subsequent

[52] Processing and issuance of tax exemptions took 53 days (32%) (average), initiating the customs clearance process after tax took 32 days (19%) (average) and iterative port clearance processes took 81 days (48%) (average)
[53] 2017 policy change removing blanket waiver for Global Fund-procured commodities replacing it with a case-by-case tax exemption requisition.
[54] 19.2m condoms required a tax exemption that also were delivered in country but have not been distributed. Nine million (47%) are quarantined pending FDA testing results, 2.4 million (13%) are pending FDA sampling, 7.8 million (40%) are pending custom clearance.
[55] Key population-friendly health facilities are those designed to support key population groups with clinical services. These are 6/10 (60%) KP friendly HFs stocked out at least once for Male Condoms for an average of 132 days (Max 356 days and Min 12 days)
[56] Incomplete recording of stock deliveries in health facility records was noted in 29% (8/17) of sites visited by the OIG and 46% (6/17) of sites did not have bin cards available for all commodities. Also, 88% (15/17) of sites had no evidence of PSM related supervision visits being conducted
[57] 17 out of 17 sites had variances: 1) Physical count vs stock cards – 42% of HF had variances for TB commodities, 41% of HF for Malaria and 26% of HF for HIV commodities 2) Physical count vs GhiLMIS – 66% had variances for TB commodities, 80% for Malaria and 55% for HIV commodities
[58] For GC6, Ghana needs to meet the threshold for its allocation (20% of US$266M (USD 45.3M) per the Sustainability, Transition and Co-financing Policy.
[59] Requests should be submitted in Q3 of the prior year to be approved in the next year's budget Ghana Ministry of Finance Budget Operations Manual
[60] The national disease programs raised 2021 commodities requests in March 2021 (6-month average delay), 2022 commodities requests were raised in February 2022 (NACP) and May 2022 (NTP) (6.5-month average delay)

approval and procurement process, after the budget allocation is agreed, is complex. It involves many stakeholders, including the Ghana Health Service, Ministry of Health, Public Procurement Authority and Ministry of Finance. There is no overall oversight by the Ministry of Health over the process to ensure timely completion. There are also no systems or tools to track this process within the Ministry of Health. This has contributed to further delays with the 2021 requests taking 425 days (average) to be converted into signed contracts. Issues with contracting, including the inability to agree to some supplier requirements for advanced payment, have also impacted procurement.

In addition, since February 2022, there has been a worsening of the macro-economic environment, pressurizing the fiscal space of the government. Inflation has reached an average of 50.5% in Q1 2023[61] and the local currency has significantly depreciated. This impacts the available funding for domestic financed commodities.

Due to the above, there were stock-outs of commodities. At most OIG-visited sites, HIV test kits[62] were stocked out, along with GeneXpert cartridges and some ACTs.[63] This led to program disruption – see findings 4.2 and 4.3.

Agreed Management Action 3
The Global Fund Secretariat will work with the Ministry of Health to further the technical integration and interoperability between GhiLMIS and other PSM and financial related systems, including establishing effective governance and oversight and capacity building to improve the efficacy of service delivery and data utilization.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2025

Agreed Management Action 4
The Global Fund Secretariat will work with the Ministry of Health and Ghana Health Services to revise the clearance processes of Global Fund financed health products to facilitate the timely clearance within 21 days before demurrage costs are charged following national policies. This includes establishing operating procedures, revision of payment processes and establishment of payment mechanisms that allow for and support timely customs clearance.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2025

[61] Ghana Statistical Services Inflation data (53.6% Jan 23, 52.8% Feb 23 & 45% March 23)
[62] 13/17 HFs stocked out at least once for SD- Bioline test kits for an average of 87 days (Max 346 days and Min 16 days), 9/17 HFs stocked out at least once for HIV/Syphilis test kits for an average of 90 days (Max 321 days and Min 14 days)
[63] 11/17 HFs stocked out at least once for Sulfadoxine + Pyrimethamine 500/25mg for an average of 79 days (Max 302 days and Min 11 days)

4.5 Gaps in oversight of financial and operational risks are curbing further impact

Good sub-recipient-level management observed under the WAPCAS grant. However, minor issues with small amounts of unsupported expenditure under the Ministry of Health (MoH) grant along with delays in settling outstanding sub-recipient advances and some disruption in program implementation under the MoH and CHAG grants were noted. There are also increased financial risks related to ACT income. This was linked to weak processes, systems, and oversight for sub-recipient management, under MoH and CHAG and ACT income, under MoH.

Robust financial and sub-recipient management are key enablers for grants to be prudently implemented. The OIG noted adequate financial and sub-recipient policies, controls and processes under WAPCAS. For the MoH, there were adequate financial controls for Principal Recipient-level expenditure with no unsupported expenses identified from the transactions sampled by the OIG. In addition, for asset management under the Ministry of Health, no discrepancies were noted in physically verifying the existence of OIG-sampled health equipment.

However, some challenges were noted in the sub-recipient management under the MoH and CHAG grant.

Weak sub-recipient financial management increasing financial risks at sub-recipient level for MoH and CHAG grants

Principal Recipients have a key role in providing monitoring and oversight over sub-recipients both for programmatic and financial reporting. However, no evidence of financial management reviews was provided for 45% of sampled sub-national implementers across 2021-22 under the MoH grant. Where financial oversight was observed, there was no evidence of sharing of feedback with implementers and follow up to resolve identified financial errors. This is linked to a lack of evidence of joint monitoring plans[64] at sub-national level, outdated Principal Recipient guidelines for sub-recipient management with no guidance on sub-recipient advances, as well as no financial management system at national program level and below, resulting in Excel being used. In addition, oversight gaps by the program management unit (the RMU[65]) and senior Ministry of Health officials[66] were observed.

This has led to increased risks to funds provided to sub-national implementers under the MoH. However, it is important to note that the OIG only identified minor amounts of unsupported expenditures (US$0.2m) and long-term open advances outstanding to sub-national implementers (US$0.5m) as at March 2023.

Under the CHAG grant, limited financial monitoring of sub-recipients and NGO implementers was observed.[67] There were also delays in signing implementer partner contracts,[68] which halted funding for TB community activities. There were also gaps in the reporting tools, templates and workplans cascaded down to the sub-recipient level.[69] In addition, there were no capacity assessments conducted for TB NGOs by the Principal Recipients and gaps in assessing implementer capacity over community-level activities.

CHAG was a new Principal Recipient for GC6 and needed to develop the relevant systems, processes, and tools. Gaps were identified in a Principal Recipient capacity assessment conducted in November 2020. However, gaps

[64] To be conducted by RMU, GHS and the programs
[65] The Resource Mobilization Unit (RMU) in the MoH is the program management unit for MoH grants. US$0.6m budgeted for RMU staff during GC6.
[66] Monthly and quarterly review were to be set up by the RMU with the GHS, national programs, and senior ministry officials in attendance to discuss financial and programmatic challenges. However, only 13% of the planned monthly and quarterly oversight meetings were conducted in 2021 and 2022, although COVID-19 limited in-person meetings for half of this period.
[67] No evidence of financial management reviews was provided for 38% of the sampled sub-recipients and NGO implementers across 2021-22
[68] These were finalized 23 months after the start of GC6
[69] Sub-recipient financial reporting templates were finalized halfway through GC6, no programmatic M&E reporting tools were shared with the sub-recipient, and workplans for year two and three of GC6 implementation have yet to be shared with the sub-recipient.

have persisted[70] throughout GC6 and have not been adequately addressed or mitigated. Global Fund Secretariat performance letters have correctly identified these gaps throughout grant implementation but there has been an inadequate resolution of these by the Principal Recipient.

As a result, TB community interventions were halted in 2022 while legal contracts were finalized resulting in activities stopping. This led to a 42% decline in TB cases screened and 26% in TB samples collected.[71]

Increased financial risks under the Ministry of Health grant due to gaps in framework to safeguard Global Fund income from sale of ACTs

In Ghana, patients are charged for ACTs funded by the Global Fund. ACTs procured using both domestic financing and Global Fund are sold to facilities at a price determined by the Ghana National Health Insurance Scheme (NHIS). A dedicated ACT bank account holds income from these sales. Any resulting Global Fund-related income is treated as a cash balance in the Ministry of Health grant to fund approved activities.

The OIG estimates US$2.2 million[72] of revenue relate to Global Fund ACT sales in 2021-2022. However only US$0.6 million was held in the dedicated bank account at the end of 2022 and no GC6-related income was used for Global Fund activities. Neither the Ministry of Health nor the Global Fund Secretariat had yet determined the Global Fund income accrued for this period.

Delayed tracking and use of Global Fund ACT income are linked to the lack of formal and approved written country guidelines by the Ministry of Health. There are delays in income being collected and transferred to the central level, linked to an absence of agreed timelines. There was also limited evidence that the Ministry of Health was routinely assessing and monitoring the amount of income owed to the Global Fund. Similar findings around delays in collecting and using income were also highlighted in the 2019 audit.

There are also gaps in the Global Fund Secretariat's approach. There was high level guidance provided by the Global Fund to the Government in March 2020.[73] However, this guidance does not include details around requirements for the Ministry to routinely assess, collect and ensure the use of income in a frequent and time-bound manner. They do not include provisions for any significant delays. There were also delays in the Secretariat validating Global Fund-related ACT income. While the guidance describes a validation process to be conducted every six months, the work to validate 2021 and 2022 income was still ongoing at the time of the audit fieldwork (April 2023). Although this was during a period of significant disruption due to COVID-19.

Risks around delays in collection, monitoring and use of Global Fund ACT income are not captured in the Global Fund IRM.[21] This was due to the Secretariat assessing the risk as minimal and for monitoring through routine management of the grant. However, this can limit the ability for risks to be properly managed.

Overall, these gaps heighten the risk of Global Fund ACT income not being used in a timely manner, missed and potentially being diverted and/or misused. The OIG cannot provide assurance that revenue from Global Fund commodities has been used only for Global Fund activities during 2021-22.

Agreed Management Action 5
The Global Fund Secretariat will put in place a GC7 grant agreement condition for the Ministry of Health to establish a framework/guidance which governs the management, reinvestment of funds, and reporting of ACT income relating to Global Fund commodities.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2024

[70] Including no approved sub-recipient management guidelines and no annual plan to determine how and when Principal Recipient supervises sub-recipients and implementers

[71] Comparing PU results from Jan-June 2022 to July-December 2022

[72] Estimated using quantities of Global Fund ACT delivered to the regional warehouses by IHS, multiplied by unit price agreed with Ghana Health Insurance

[73] This includes guidelines on how ACT income generated across the country should be split between the Global Fund and Government of Ghana, this split has been communicated for NFM2 but was not yet finalized for NFM3.

4.6 SEAH allegations not reported to the Global Fund in a timely manner

Positive advances in strengthening the ability of the CCM and Principal Recipient to identify and monitor SEAH allegations have been noted. However, gaps in policies and procedures to report issues have been a contributing factor in delayed reporting of allegations to the Global Fund Secretariat and the OIG.

In 2021, the OIG published an investigation highlighting corrupt and coercive practices, including sexual exploitation and abuse and harassment (SEAH), by a recipient of grant funds in Ghana. Since this investigation, there were several initiatives aiming to strengthen the ability of the CCM and Principal Recipient to identify and monitor SEAH allegations. All Ghana CCM members had completed the Code of Conduct training and have signed the updated CCM Code of Conduct covering SEAH. A CCM Ethics Officer was also hired to support PSEAH initiatives.[74]

However, gaps were noted in reporting allegations to the Global Fund in a timely manner. A contributing factor to this was no evidence that monitoring of SEAH risks was included in routine Principal Recipient oversight over implementers that engage vulnerable populations. In addition, while sub-recipient and community implementer contracts include SEAH elements, there are no details on the approach for reporting SEAH incidents. At the CCM level, a Ghana SEAH Network was to be established[75] to improve the response to PSEAH, but the network was not operationalized at the time of the audit fieldwork (April 2023).[76]

At the Global Fund Secretariat level, work is underway to strengthen the response to SEAH risks.[77] However, at the portfolio level, SEAH risks are not yet captured in the IRM. For Ghana, the Country Risk Management Memorandum (CRMM)[78] was also approved in January 2023 but this did not include SEAH risks. The Secretariat has established internal governance and oversight bodies looking at SEAH, including the PSEAH steering committee and case review panel. There is also an ongoing roll out of SEAH specific risk management initiatives.

The OIG audit team was alerted to two SEAH allegations under Global Fund grants. These had not been reported to the Global Fund, as required by the Global Fund Code of Conduct for Recipients.[79] Thus, the risk of SEAH allegations not being identified and reported in a timely manner has materialized. A referral to the OIG Investigations Unit has been made regarding these allegations.

No additional Agreed Management Action was deemed necessary for this finding due to the ongoing work that the Secretariat is undertaking to advance the implementation of the Global Fund Operational Framework on the Protection from Sexual Exploitation and Abuse, Sexual Harassment, and Related Abuse of Power. The monitoring of this implementation is being performed under existing Agreed Management Actions 1 and 2 from the OIG Investigation reports GF-OIG-2023-008, GF-OIG-2023-009, GF-OIG-2023-010.

[74] This includes conducting supervision visits with WAPCAS and CHAG – Principal Recipients that engage in activities focused on vulnerable populations
[75] A concept note for the network was completed in January 2021
[76] The network was subsequently launched in June 2023 - https://www.wapcas.org/news/official-launch-of-the-ghana-pseah-network
[77] https://www.theglobalfund.org/media/13088/oig_gf-oig-23-008_report_en.pdf - the latest reports from the OIG focused on PSEAH matters highlight AMAs related to ongoing work to advance the implementation of the organization's Operational Framework on the Protection from Sexual Exploitation and Abuse, Sexual Harassment, and Related Abuse of Power (the "PSEAH Operational Framework")
[78] The CRMM ensures Global Fund senior management have visibility over and can approve a country's risk profile and its management strategies
[79] The Global Fund Code of Conduct for Recipients, dated 16 July 2012 and 11 February 2021 respectively, Section 3.3.2.

Annex A: Audit Rating Classification and Methodology

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

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing and code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of its work.

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

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

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

Annex B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

The OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

The OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks that fall within the audit's scope. In addition, a narrative explanation is provided every time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, the OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Ghana: comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit assessment, except for:

- In-Country Supply Chain
    - Logistics information management systems (LMIS)/ Health Product Information Systems
- Monitoring and Evaluation (M&E)
    - Inadequate design and operational capacity of M&E systems
    - Limited data availability & inadequate data quality/ Data Availability, Disaggregation & Quality

The OIG's higher risk level compared to the Global Fund Secretariat for LMIS is due to:

- Multiple and fragmented LMIS systems being used at the sub-national level, as well as weak inventory management, data recording and lack of PSM-related supervision at health facility level. This has resulted in a moderate lack of accountability and traceability of commodities at the sub-national level.

The OIG's higher risk level compared to the Global Fund Secretariat for M&E is due to:

- Issues with data accuracy of programmatic data being over/under-reported by verification factor greater than 20% at the majority of sites visited by the OIG. This was caused by gaps in how the national HMIS systems and DQAs were being utilized to ensure data accuracy, as well as a limited community HMIS system and approach.

Domestic Financing is a new grant facing risk that is now being tracked and monitored by the Global Fund Secretariat from 2023 onwards. PSEAH-related risks are not captured in the Secretariat's current grant facing risks and so are not included in the comparison table in section 3.2.