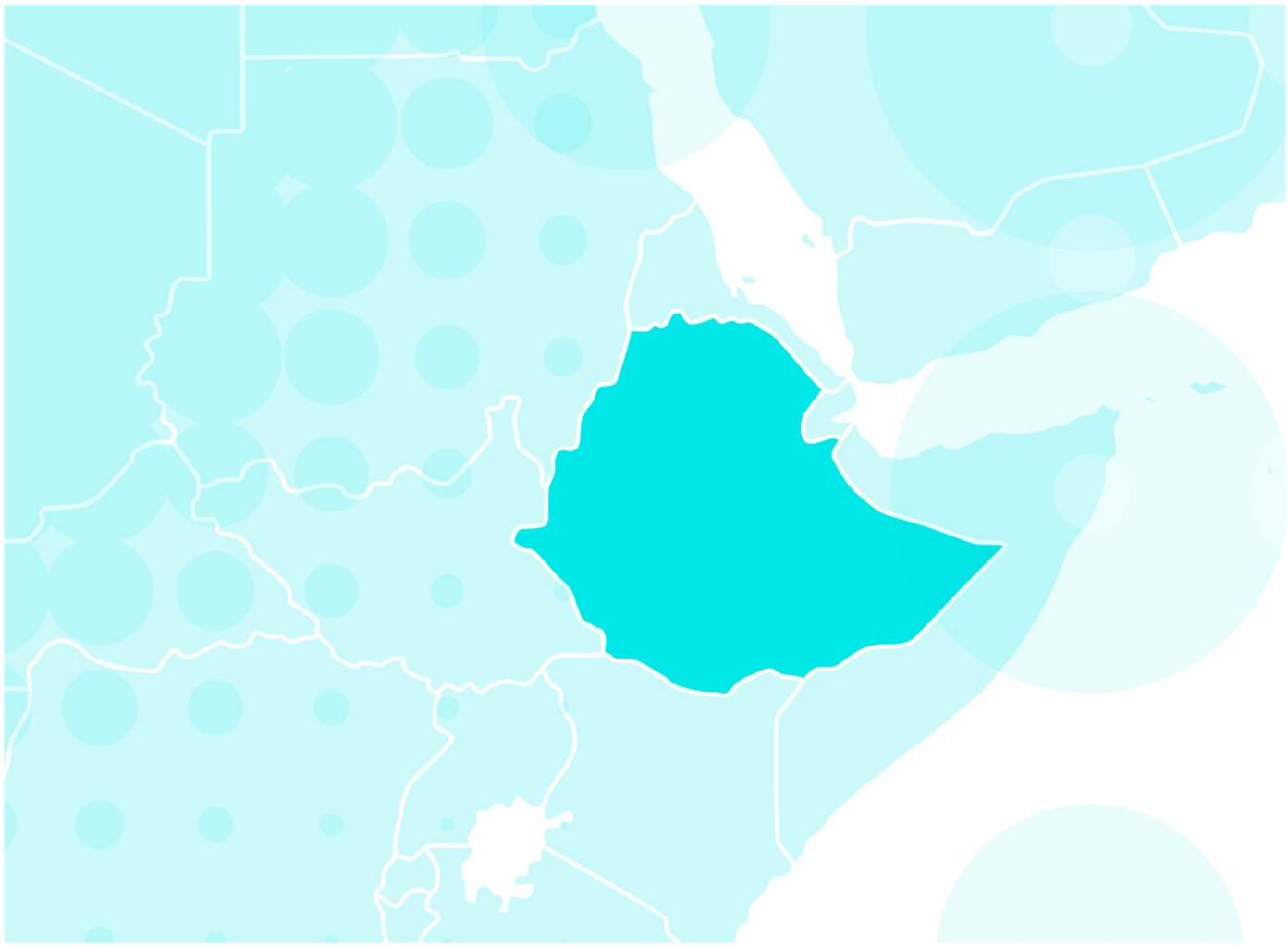

Audit Report

Global Fund Grants in the

Federal Democratic Republic of Ethiopia

GF-OIG-23-021
19 December 2023
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Since 2004, the Global Fund has invested more than US$3 billion in Ethiopia to fight the three diseases. For Grant Cycle 6, the Global Fund signed a total grant of US$588 million with the country.

Ethiopia has made significant progress in addressing the HIV, tuberculosis (TB), and malaria epidemics. HIV incidence and death rates have decreased by 54% and 56% respectively since 2010. Ethiopia has progressed well in the achievement of the 95-95-95 UNAIDS targets with an achievement rate of 84%-93%-96% in 2021. Since 2002, TB incidence has decreased by 55% and TB-related deaths decreased by 53% between 2010 and 2021. Malaria incidence and deaths decreased by 63% and 58% respectively between 2010 and 2021. HIV and malaria programs, however, require improvement in prevention and vector control programs respectively. Low coverage and the use of out-of-date strategic information are contributing to the stagnation of HIV testing and prevention for pregnant women, children under the age of five, adolescents, and other key populations, limiting effective targeting and intervention design for key and vulnerable populations. Delays in implementing key activities are another contributing factor.

Ethiopia achieved significant malaria treatment coverage but has experienced a surge in malaria cases in the last two years. Inadequate coverage and use of insecticide treated nets resulted from delays in the procurement process and inadequate social and behavioral change activities. The organization does have various mechanisms allowing country teams to adapt the implementation to countries in crisis that are not classified as Challenging Operating Environments (COEs),[1] such as what Ethiopia experienced during the Grant Cycle 6 implementation. These guidelines and processes were not leveraged on time, delaying the response to the relevant support needed to ensure continuity of services to conflict-affected areas in Ethiopia. Implementation of HIV and malaria interventions to ensure access to services by beneficiaries needs **significant improvement.**

Procurement and supply chain of health commodities and equipment constitute about 71% of the Grant Cycle 6 budget. Improvements were noted in supply chain since the last OIG audit in 2017, including warehouse management and distribution arrangements. Despite this progress, procurement delays and use of morbidity data used for forecasting and demand planning are impacting timely availability of commodities. Project planning and implementation of the new Enterprise Resource Planning is delayed, and key activities are not prioritized. Supply chain processes and systems to ensure the timely availability and accountability of commodities, at all levels, are **partially effective.**

There is limited oversight of sub-recipients by the Principal Recipient. Delays in signing these grant agreements contributed to late disbursements to sub-recipients. Limited supervision visits by the Principal Recipients, late advance settlements and gaps in the Principal Recipient's grant accounting software lends to instances of accounting errors. Grant oversight and assurance functions to support the achievement of grant objectives, with a focus on financial and procurement controls and in-country assurance are **partially effective.**

1.2 Key Achievements and Good Practices

Integration of Global Fund-supported programs into the National Systems has enhanced country ownership
The Ethiopia Global Fund implementation arrangement is fully integrated into the national systems and is in line with Global Fund country ownership principles. Global Fund-supported programs are part of the Federal Ministry of Health structure and involve the Regional Health Bureaus up to the district level. With the highly commoditized grant (71% of total Grant Cycle 6), the Ethiopian Pharmaceuticals Supply Service procures most of the health and

[1] These are implementing countries that are not classified as challenging operating environment countries but faced various forms of crises or environment disasters during grant implementation

non-health products for Global Fund-supported programs, contributing to savings of US$12.4 million when compared with international procurement prices and supply chain-related costs. Disbursement of funds up to the district level for the implementation of activities has strengthened ownership of programs at all levels.

Progress made in the fight against the three diseases

The HIV program showed good progress in the UNAIDS 95-95-95 target.[2] Ethiopia's current achievement rate is 84-98-97, according to the UNAIDS 2022 report. The HIV new infection rate has decreased by 54% since 2010, and AIDS-related deaths by 56%. The HIV prevalence trend decreased from 1.4% in 2010 to 0.8% in 2021. Malaria incidence and mortality decreased by 63% and 58%, respectively, between 2010 and 2021, although there was an upsurge in malaria cases in 2022, similar to other countries in the region. Treatment coverage of confirmed malaria cases was between 90% and 120% for the audit period, and 19 million insecticide-treated nets were distributed in 2022/2023 mass campaigns. Ethiopia is among the 30 countries with the highest tuberculosis (TB) and TB/HIV co-infections, with 143,000 TB estimated cases. TB incidence has reduced by 55.6% since 2010, from 268 to 119 per 100,000 people in 2021. TB treatment success rate stood at 86% in 2020.

1.3 Key Issues and Risks

Good progress on malaria case management but inadequate vector control interventions, diagnosis inaccuracy and data quality issues are contributing to an increase in malaria cases

Ethiopia is among the top 20 countries in the world for malaria incidence, contributing 1.7% of the world's malaria burden and 1.5% of global malaria deaths. In 2022, malaria incidence increased by 84% compared to 2021. Inadequate vector control interventions and data quality issues contributed to the surge in malaria incidence. The audit noted low coverage and utilization of insecticide treated nets. Ten-month delays in the procurement process for nets and inadequate social and behavioral change activities were also contributing factors. Despite significant investment in vector control campaigns and the surge in malaria cases, no surveys were conducted after insecticide-treated net distributions or indoor residual spraying campaigns to inform future activities. Data quality issues also impacted timely information for program planning and decision-making linked to an expediated response to the upsurge of malaria cases in 2022.

While significant progress has been made in the fight against HIV, strategic and operational program challenges are impacting achievement of HIV prevention and testing

Currently, an estimated 100,000 people living with HIV (PLHIV) in Ethiopia are not aware of their status.[3] A high risk of infection exists in key and vulnerable communities.[4] However, the achievement rate for grant indicator performance for interventions related to key and vulnerable populations is low, 65% of sex workers and 28% of vulnerable populations received HIV testing. This is mainly due to use of outdated strategic information limiting effective targeting and design of appropriate interventions for key and vulnerable populations. Delays in implementation of key activities, including the establishment of Drop-in-Centers (DICs) and non-adherence to a package of service monitoring/reporting, as well as stock-out of HIV test kits and condoms are contributing factors.

The achievement rate of HIV-exposed infants receiving a virological test for HIV within two months of birth was below target between January 2021 to June 2022. High (17.9%) mother-to-child transmission and low Early Infant Diagnosis (EID) rates are negatively impacting the country's prevention of mother-to-child transmission (PMTCT) response. The target for the percentage of HIV positive women who received antiretroviral therapy is low and the achievement rate has consistently been below this target. Limited geographical coverage of EID testing, stock-out of Dried Blood Sample kits and a long turnaround time for EID results are affecting timely testing of HIV-exposed infants. Low antenatal care (ANC) coverage (43%) and low birth at any medical facilities (48.5%) due to cultural

[2] The UNAIDS targets: the first 95 is all people living with HIV will know their HIV status, the second 95 is all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and the third 95 is all people receiving antiretroviral therapy will have viral suppression

[3] UNAIDS 2022 treatment cascade analysis – Estimated people living with HIV 6,100,000 vs 5,100,000 PLHIV who know their status (accessed 2 August 2023)

[4] 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)

and social factors, such as low levels of education and long travel distances to health facilities, contributed to the high vertical transmission.

Improvement needed in Global Fund's response during the crises in Ethiopia

Almost half of the regions in Ethiopia are experiencing conflicts and security issues. The Global Fund has an operational policy on Challenging Operating Environments (COE), and several mechanisms allowing Country Teams and implementers to adapt implementation for countries in crisis that are not classified as COE. These were, however, not fully leveraged, thereby impacting the speed of response and support to Ethiopia. For example, although Ethiopia had a very high External Risk Index (ERI)[5] since 2021, the Global Fund Secretariat classified the Tigray region as a COE in June 2023, delaying the relevant support and flexibilities needed for the region. Emergency Funding application submitted by the country in March 2022 to support and ensure continuity of services in the five regions impacted by conflicts was assessed by the Global Fund Secretariat in September 2022, but was not considered further due to overlaps in the country's C19RM funding application.

Progress made in strengthening supply chain management has been hampered by procurement delays and use of inaccurate data

Ethiopia continues to rely on morbidity data and a target-based approach for forecasting and quantification despite the availability of consumption data at Ethiopian Pharmaceuticals Supply Service EPSS hubs. The Global Fund is supporting the country to replace the warehouse and distribution system with an Enterprise Resource Planning System (ERP) to improve accountability and traceability for drugs. However, the implementation of this project has been delayed and critical processes, such as product master list coding, are not finalized. While the in-country procurement mechanism resulted in savings compared to the Global Fund Wambo benchmarked prices, protracted procurement processes impacted the timely availability of health commodities.

Limited sub-recipient oversight arrangements impacting implementation of key grant activities

Only 12 out of 96 planned monitoring visits had been completed at the time of the audit, and only one visit to the four high-security alert regions was carried out. This contributed to late settlement of advances, with 54% of advances outstanding as of 31 December 2022. The delay in disbursements to sub-recipients, including to Regional Health Bureaus, impacted implementation of key activities. The accounting software used by the Principal Recipients for recording and reporting grant funds is not licensed and poses a risk of loss of grant financial information due to unlimited access to the information.

[5] UNHCR Data May 2023

1.4 Objectives, Ratings and Scope

This audit was part of the Office of the Inspector General's 2023 work plan, approved by the Audit and Finance Committee in October 2022. The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on grants in the Federal Democratic Republic of Ethiopia. Specifically, the audit assessed the adequacy and effectiveness of the objectives below.

Objective	Rating	Scope
Implementation of HIV and malaria interventions to ensure access to key services by beneficiaries including those in challenging operating regions.	**Needs significant improvement**	**Audit period** July 2021 to December 2022 **Grants and implementers** The audit covered the Principal Recipient and sub-recipients of Global Fund-supported programs in Ethiopia.
Supply chain processes and systems to ensure timely availability and accountability of commodities at all levels.	**Partially Effective**	
Grant oversight to support the achievement of grant objectives, with a focus on financial and procurement controls and in-country assurance.	**Partially Effective**	

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

Of the 11 regional states and two chartered cities, only seven regions were accessible to the audit due to security issues. OIG auditors visited 20 health facilities/hospitals and 11 key and priority populations and youth friendly drop-in centers in the three largest regions in Ethiopia. The regions visited account for 54% of the TB burden, 51% of patients on antiretroviral treatment, and 30% of the malaria cases in the country.

2. Background and Context

2.1 Overall Context

Ethiopia is a low-income country and has a population of 123 million. It is the second most populous nation in Africa and was the fastest growing economy in 2020 and 2021, with a gross domestic product (GDP) per capita of US$1,027. Ethiopia's GDP has increased by 735% since 2000. Due to the continued increase in the inflation rate, the health spending per capita shows an increasing trend. The 2020 health spending comprised 6.3% of GDP.

In 2022, Ethiopia experienced drought, political conflict, particularly in the northern part of the country, leading to loss of life, livelihoods, and infrastructure. The conflict in the North was very acute during the period of July to December 2021. All of this was compounded by the effects of the COVID-19 pandemic. Ethiopia hosts 840,000 refugees[6] from neighboring countries and has about 3.1 million Internally Displaced Populations[7] owing to civil disturbances and strife.

About 48% of the population, or 62% of the total area, are in unstable security zones. As a result, only seven of 13 regions were accessible for the audit.

Country data[8]	
Population	123 million
GDP per capita	US$1,027
Transparency International Corruption	94 of 180
UNDP Human Development Index	139 of 191
Gov't spending allocated to health	3.48%

2.2 Global Fund Grants in Ethiopia

Since 2004, the Global Fund has invested more than US$3 billion in Ethiopia. For Grant Cycle 6, the Global Fund signed an HIV grant of US$346 million (including US$88 million for C19RM). The goal of the investment is to attain HIV epidemic control nationally by 2025, by reducing new HIV infections and AIDS mortality to less than 1 per 10,000 population.

The TB grant, with a signed amount of US$56 million, is to support Ethiopia in its goal of ending TB as a public health threat by funding interventions to reduce TB incidence from 151 to 91 per 100,000 by 2025/2026 and reduce the TB mortality rate from 22 to 7 per 100,000 by 2025/2026.

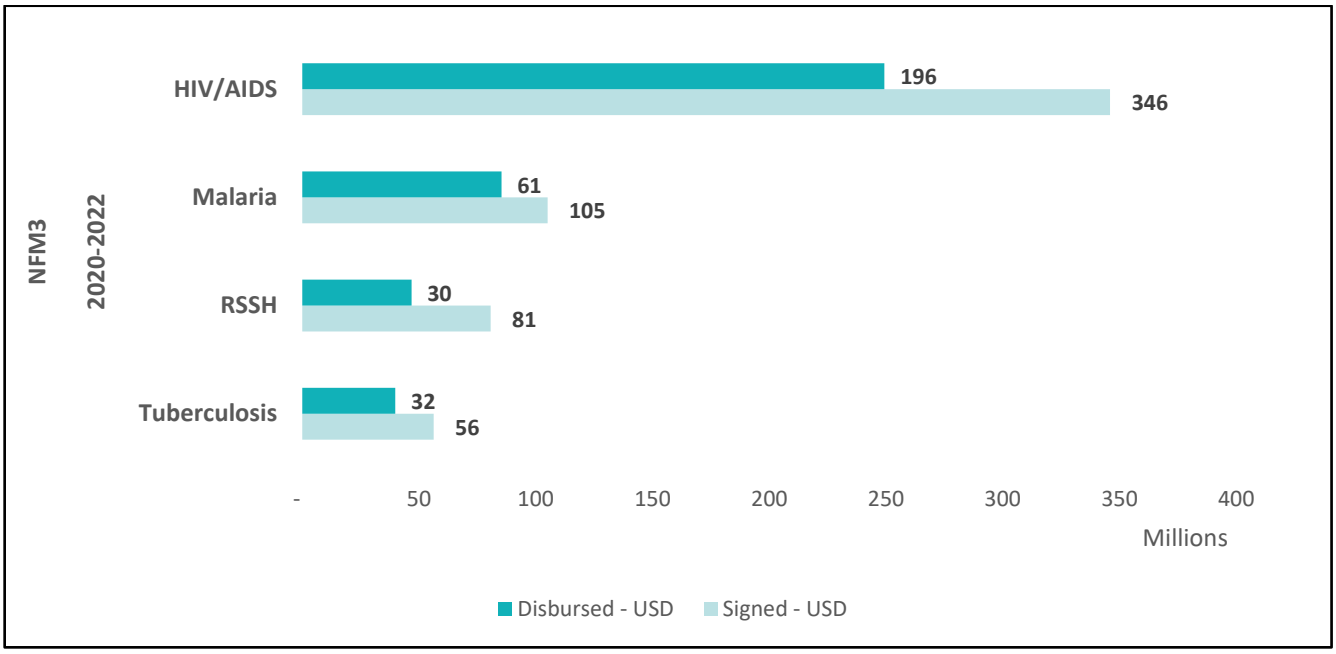
The malaria grant, with a signed amount of US$105 million, is to support interventions designed to reduce malaria mortality and morbidity by 50% by 2025 (compared to 2020). Also, by 2025, Ethiopia aims to achieve zero indigenous malaria cases in districts with an annual parasite index (a measure of malaria morbidity) of less than 10 and to prevent the re-introduction of malaria in districts that report zero indigenous cases of malaria.

[5] UNHCR Data May 2023
[6] DTM Ethiopia - Endorsed National Displacement Report 15, Nov 2022 - Jan 2023
[7] Sources: Population and GDP from World Bank, 2022 (https://data.worldbank.org/country/ethiopia); Transparency Corruption Index, 2022 (https://www.transparency.org/en/countries/ethiopia); Health expenditure from The Global Economy, 2021
[8] (https://www.theglobaleconomy.com/Ethiopia); The HDI 2021 (https://hdr.undp.org/data-center/specific-country-data#/countries/ETH); all accessed on 3 July 2023

The cross-cutting investment of US$81 million (including US$48 million for C19RM) is to strengthen the resilience of health systems in Ethiopia. The grant supports the Government in delivering the priorities of the national health plan while simultaneously enabling continued and increased impact for HIV, TB, and malaria programs.

At the beginning of Grant Cycle 6, the Global Fund grants were implemented by two Principal Recipients: the Federal HIV/AIDS Prevention and Control Office (HAPCO) and the Federal Ministry of Health. With the integration of HAPCO to the Federal Ministry of Health in 2021, the Federal Ministry of Health became the single Principal Recipient, with 18 sub-recipients, 10 Regional Health Bureaus, two City Administrations and six Civil Society Organizations (CSOs).

Figure 2: Funding amount, disbursed and signed amounts for 2020-2022 funding cycles (as of December 2022)[9]



[9] Global Fund Data Explorer (https://data.theglobalfund.org/location/ETH/signed/treemap), accessed 3 July 2023

2.3 The Three Diseases

HIV / AIDS	TUBERCULOSIS (TB)	MALARIA
610,000 people are living with HIV in Ethiopia, of whom 84% know their status among identified people living with HIV (PLHIV), 98% were on treatment and 97% had suppressed viral loads. **Annual new infections decreased by 54 % since 2010,** from 26,000 newly infected people to 12,000, ranking Ethiopia with the 45th highest HIV rates in the world. **AIDS-related deaths reduced by 56%** from 27,000 in 2010 to 12,000 in 2021. **The epidemic is mixed,** with wide regional variations, distinct transmission pockets among KPs and in some sectors of the general population with overall higher prevalence in urban areas**.** Ethiopia demonstrated a **downward prevalence trend from 1.4% in 2010 to 0.8%** in 2021. *Source: UNAIDS Country factsheets Ethiopia 2021*	Ethiopia is among the 30 **high TB and TB/HIV burden countries**, with 143,000 estimated cases, of which 73% are notified (2021). **TB incidence has reduced by 55.6% since 2010**, from 268 to 119 per 100,000 people in 2021. 81.5% of TB patients have a **known-HIV status.** Of these, 5.2% are HIV-positive patients, 99% of whom are enrolled in ART. **TB treatment success rate** is at 86% (2020), putting it 4% short of the WHO End TB Strategy target of 90% by 2025. In 2022, **MDR/RR-TB** was estimated at 1,800 cases. *Source: WHO TB Report 2021-Ethiopia*	Ethiopia is the **16th largest contributor** to total malaria cases globally. Ethiopia carries **1.7% of the global malaria burden** and **1.5% of the mortality rate**. There were 3,783,896 estimated malaria cases in 2021, representing a **63% reduction since 2010**, when there were 10,362,488 cases. Estimated **malaria-related deaths dropped by 58%,** from 19,144 in 2010 to 8,041 in 2021. *Source: World Malaria Report 2022*

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Performance and grant ratings are shown below for Grant Cycle 6 (NFM 3) Allocation (2020-2022).[10]

Comp	Grant	Principal Recipient	Total Signed (USD)	Disbursement[11] (USD)	(%)	Dec-21	Jun-22	Dec-22
	ETH-H-HAPCO	Federal Ministry of Health (FMOH)	345,997,734	195,672,064	57%	C5	C5	C3
	ETH-M-FMOH	Federal Ministry of Health (FMOH)	105,068,361	60,981,796	58%	A5	C5	A1
	ETH-T-FMOH	Federal Ministry of Health (FMOH)	56,261,728	31,983,369	57%	C1	C3	C1
	ETH-S-FMOH	Federal Ministry of Health (FMOH)	80,684,420	29,782,303	37%	C5	C5	B5
TOTAL			**588,012,243**	**318,419,532**	**54%**			

3.2 Risk Appetite

Of the key risk categories covered by the audit, the OIG compared the Secretariat's aggregated assessed risk levels 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 area	Risk category	Secretariat aggregated assessed risk level (May 2023)	Assessed residual risk based on audit results	Relevant audit issues
Program quality	HIV	**High**	**High**	Finding 4.2
	Malaria	**High**	**High**	Finding 4.1
In-country data	Monitoring and evaluation	**Moderate**	**Moderate**	Finding 4.1 and 4.2
In-country supply chain	In-country supply chain	**High**	**High**	Finding 4.3
In-country procurement	Procurement	**High**	**High**	Finding 4.3
Financial assurance framework and mechanism	Grant-related fraud and fiduciary risks	**High**	**High**	Finding 4.5
	Accounting and financial reporting	**High**	**High**	Finding 4.5

[10] The programmatic performance rating is represented by letter A to E (Excellent/A (>=100% achievement), Good/B (90%-99%), Moderate/C (60%-89%), Poor/D (30%-59%) and Very Poor/E (<30%). Financial performance rating is represented by number 1-5 (Excellent (1: >=95% achievement), Good (2: 85%-94%), Moderate/3 (3:75%-84%), Poor/4 (65%-74%) and Very Poor/5 (<65%).

[11] The portfolio absorption figures above are based on total disbursements processed for the 2020-2022 Implementation Period as of 31 December 2022, against the total signed amounts

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit assessment. OIG objective 3, financial controls and in-country assurance, is considered partially effective despite the high-risk rating related to the financial assurance framework and mechanisms, though rated high for both sub-risk categories. The OIG's rating of partial effectiveness is because of:

- **Adequate control mechanisms in place**. The Global Fund Secretariat implemented several mechanisms to address the grant-related fraud and fiduciary risks, and accounting and financial reporting risks such as the overall internal control review mechanism done in October 2021. An additional Global Fund Secretariat review of expenditures conducted immediately before the audit did not identify any significant ineligible or in compliance cases.
- **Implementation of Key Mitigation Actions.** Five mitigation actions have been implemented to address the identified risk on grant-related fraud and fiduciary. Two delayed mitigation actions related to inadequate documentation processes and unclear segregation of duties.
- Two of four mitigation actions on accounting and financial reporting risk are on track, and one is completed. One delayed mitigation action is related to the implementation of a robust financial system, which is currently under ongoing discussion with another donor, GAVI.
- The OIG financial samples did not find any material findings on both risk categories.

4. Findings

4.1 Inadequate vector control interventions, misdiagnosis and data inaccuracies are contributing to an increase in malaria cases

Good progress has been made in case management. However, suboptimal vector control implementation, false-negative Rapid Diagnostic Test (RDT) results due to gene deletions,[12] and data inaccuracies are contributing to an increase in malaria cases in Ethiopia.

Until 2021, Ethiopia's malaria program showed good performance with malaria incidence and mortality decreasing by 63% and 58% respectively between 2010 and 2021.[13] Good progress has also been made in case management, with achievement rates of the treatment targets ranging between 90% to 120% during the audit period. The Global Fund assessment has commissioned a review of LLIN mass campaigns after distribution indicated that the pre-registration was conducted right at the household level.

Global Fund support to malaria prevention in Ethiopia is focused on universal coverage of insecticide-treated nets and indoor residual spray (IRS) interventions.[14] Despite the co-deployment of insecticide-treated nets and IRS for high-endemic areas (with Annual Parasite Index (API) above 50),[15] ineffective implementation of vector control interventions, misdiagnosis of malaria and data inaccuracies are contributing to an increase in malaria cases and mortality. Cases increased by 84% between 2021 to 2022. Number of deaths per 100,000 in populations at risk of malaria also increased from 0.25 to 0.33 between 2021 and 2022.[16] The number of districts reporting indigenous malaria cases increased from 236 to 277, and the number of districts with high malaria risk increased from 69 to 89.[17]

Gaps in vector control interventions contributing to increase in malaria cases

Vector control interventions constitute about 70% of total Grant Cycle 6 malaria grants. As per the country's malaria strategy of universal coverage, each household should be covered with one net for every two persons. The country's data for 2020, however, reported that insecticide-treated net (ITN) ownership is 67% and only 40% of households are covered with one ITN for every two persons.[18] This is significantly below the country's target of 80%. With the new distribution in 2022/2023, the expected target for 2022/2023 coverage is 90% as described in the recent independent external malaria program review. Some 23 million nets were estimated for the GC6 mass campaign, however only 19.7 million (82%) nets were procured and distributed due to funding constraints. The country's latest study[19] also noted low utilization of nets and only a slight improvement since 2015, with 44% of the adult population having slept under a net the night before. The ITN use rate for children and pregnant women was 52% and 62% respectively although the target for categories was 75%. Contributing factors of the ITN low coverage and utilization include:

Sup-optimal planning: The microplanning for the campaign included only one million internally displaced people (IDPs) and refugees compared to an estimated 3.5 million IDPs and 0.9 million refugees due to limited funding available.[20] In addition, there was no formal pre-registration for households before distribution due to lack of

[12] P. falciparum histidine-rich protein 2/3 (pfhrp2/3) gene deletions causing false-negative HRP2 RDTs
[13] World Malaria Report, 2022
[14] Ethiopia – Malaria – Federal Ministry of Health (ETH M- FMOH) detailed budget
[15] National Malaria Strategic Plan (NMSP) 2021-2025, pg. 18
[16] National Malaria Midterm Review (NMMTR), 2023
[17] National Malaria Midterm Review (NMMTR), 2023
[18] Post LLIN distribution, 2020, EPHI/NMEP
[19] The Ethiopian Public Health Institute (EPHI), 2020
[20] Ethiopia Humanitarian Crisis https://www.unrefugees.org/emergencies/ethiopia/#:~:text=Emergencies&text=There%20are%20over%20924%2C000%20refugees,South%20Sudan%2C%20Somalia%20and%20Eritrea.&text=An%20estimated%209%20million%20people,Amhara%20regions%20need%20food%20aid, accessed 5 July 2023

budget, and no post ITN distribution survey has been conducted since 2020 to inform future ITN campaigns despite a surge in malaria cases.

Not adhering to guidelines: The ITN distribution did not follow the malaria burden stratification – the first step to malaria planning and prevention – resulting in more nets being distributed to low and very low-burden areas.[21] The audit noted low coverage of ITNs in high and moderate burden areas. Key mitigation actions to perform disaggregated geographic/regional analysis to ensure effective ITN campaign were not fully implemented.

Procurement delays: The procurement and distribution of the ITNs for the 2022 mass campaign was delayed for more than 10 months due to irregularities stemming from non-compliance with the in-country procurement process. This resulted in moving the procurement process to the Global Fund Wambo mechanism resulting in higher procurement costs of US$2.8 million.

Inadequately planned and implemented social and behavioral change (SBC) activities: The SBC activities have been focused more on communication than behavior change and aimed at motivating communities to collect their nets during mass distribution campaigns. Despite 83% of the ITN distribution being done by Health Extension Workers (HEWs), only 38% of the community had knowledge of net use, care and repair.[22] The national HEP assessment has shown that the current HEW strategies lack effectiveness for household behavior change.[23] As of 31 December 2022, only 30% of funds for IEC/BCC[24] activities had been spent.

Misdiagnosis of malaria with RDT due to gene deletion might contribute to severe malaria cases

Plasmodium falciparum infections account for 65% of the reported malaria cases in Ethiopia. The Ethiopian Public Health Institute has reported an increase in false negative cases when using Rapid Diagnostic Tests (RDTs) with a national average at 7.1%.[25] These RDTs diagnose *P. falciparum* (Pf) infection by targeting one of its antigens, histidine-rich protein 2 (HRP2). Due to the emergence of parasites not expressing the HRP2 protein because of mutations, HPR2-based RDTs are unable to detect infections with such parasites. WHO recommends a change in testing strategy. This would include a change in the RDT kit in instances where there is more than a 5% prevalence of gene deletions causing incorrect identification. Ethiopia has developed and endorsed the policy to adopt this approach.[26] The increased risk of misdiagnosis not only puts patients at risk but can also contribute to an increase in severe malaria cases. The Global Fund and the Partner are currently providing guidance to the Principal Recipient and have begun the procurement of non HRP2 mRDTs.

Data quality issues impacting malaria program planning

Some 85% of the health facilities visited by the OIG did not have a mechanism to review data in DHIS2, and 30% did not have standard registers.[27] Inaccurate data was reported to the DHIS2 (between 48% and 93% of data reported by each health facility) and more than 50% of the health facilities are offline.[28] Arithmetic errors, under- and over-reporting and use of non-standard registers were also identified by a Global Fund Assurance Provider.

The OIG noted inadequate oversight by the Performance Management Team in 85% of the facilities visited, which likely contributed to data quality issues. A detailed plan for the interoperability between eCHIS[29] and DHIS2 has yet to be completed. The varied data collection methods between routine and surveillance systems also contributed to the differences in the number and characteristics of reported data. Delays in reporting timely information

[21] The Global Fund LLIN distribution 2023
[22] Post LLINS HH survey 2020, pg. 26
[23] ACSM, 2022 pg. 8
[24] IEC - Information, Education and Communication; BCC – Behavioral Change Communication
[25] Ethiopian Public Health Institute: 2020-2021 National gene deletion survey in Ethiopia
[26] Statement by the Malaria Policy Advisory Group on the urgent need to address the high prevalence of pfhrp2/3 gene deletions in the Horn of Africa and beyond, May 2021, WHO website
[27] 2023 OIG site visit results
[28] Federal Ministry of Health Data Quality Review, 2022, pg. 13
[29] The electronic community health information system (eCHIS) is a suite of mobile applications with a web-based monitoring portal that captures electronic data on the Health Extension Program and other community-level services

affected program planning and decision-making. As a result, the target achievement rate for reporting is below 50%.

Agreed Management Action 1:
The Global Fund will work with the Principal Recipient to: a. improve malaria case detection and notification at subnational level via targeted interventions in RDT replacement and malaria case detection; b. establish a mechanism to measure routine population-based coverage, equity distribution and utilization of nets, and household-based SBCC for LLIN utilization; c. assess the viability of progressing interoperability between eCHIS and DHIS2, and align data collection methods between routine and surveillance systems.
OWNER: Head of Grant Management Division
DUE DATE: 31 March 2025

4.2 Strategic and operational program challenges are impacting achievement of HIV prevention and testing targets

The HIV program has made significant progress in HIV treatment and increased viral load suppression. However, HIV testing and prevention interventions for pregnant women, children under 5, adolescents and other key populations remain a challenge. Outdated strategic information to design targeted interventions for all key populations threaten to stall and reverse programmatic gains made.

Ethiopia has demonstrated strong progress towards achieving the UNAIDS 95-95-95 target, having achieved 84%-98%-97%[30] in 2022. AIDS-related deaths dropped by 56% between 2010 to 2021[31] and the prevalence trend decreased from 1.4% in 2010 to 0.8% in 2021. The National HIV Strategic Plan 2021-2025[32] has guiding principles for multi-sectoral approaches for program implementation and includes People Who Inject Drugs (PWID) and prisoners as key populations for the first time. The program is also coordinating integration of services to cover specific groups in all health contacts throughout the cascade of care.

Despite the strong progress made, the fight against HIV, including the design and implementation of HIV prevention and testing interventions for key and vulnerable populations need to improve to ensure programmatic gains are sustained.

Inadequate targeting and low coverage of HIV prevention and testing interventions for key populations hinder achievement of grant objectives

Interventions to support key population groups are critical in the fight against HIV due to the high risk of infection in these populations.[33] Despite this, indicator performance for interventions related to key populations is low. As of December 2022, only 65% of sex workers and 28% vulnerable populations received HIV testing against the target of 88,800 and 922,000 respectively.[34] Contributing factors of the low coverage and performance of interventions for key populations include:

Outdated strategic information limiting effective targeting and design of appropriate interventions for key populations. Population size estimates and assessments for female sex workers, long-distance drivers, people who inject drugs and prison inmates are outdated and were limited in terms of geographic coverage. Previous Integrated Biological and Behavioral Surveillance (IBBS) were conducted in 2013 and 2015 to study female sex workers and long-distance drivers, and people who inject drugs. As of December 2022, funds allocated for four IBBS studies under the Grant Cycle 6 were not utilized (US$2.25 million). The IBBS studies agreement between the Federal Ministry of Health and the Ethiopian Public Health Institute was signed in December 2022 and is expected to be completed by December 2023. Further, the budget allocated for two IBBS studies among workers in hot spot areas and widowed and divorced women is being reprogrammed to conduct the Ethiopia Demographic and Health Survey. The outdated data is limiting the understanding of the epidemic among key populations, hampering appropriate program design and target setting.

Not all key population sub-groups are targeted in the HIV National Strategic Plan (2021-2025) and the Global Fund-supported program. The Global Fund Technical Review Panel recommendations in 2015, 2017 and 2021 on inclusion of men who have sex with men (MSM) and transgender people as key populations groups are yet to be implemented. Lack of targeted interventions for these populations limits the design of tailored intervention for

[30] Ethiopia Country factsheet - https://www.unaids.org/en/regionscountries/countries/ethiopia, accessed 2 August 2023
[31] UNAIDS Data 2022
[32] HIV AIDS National Strategic Plan for Ethiopia_2021-2025
[33] 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 13 July 2023)
[34] Progress Update and Disbursement Request (PUDR), December 2022

these groups. Stigma and discrimination linked to religion, social, and cultural barriers are also impacting key population programs.[35]

Delays in implementation of key activities and non-adherence to defined services to be provided monitoring/reporting: Although 50 Drop-in-Centers (DICs) were to be established by December 2021 to serve female sex workers and key populations, only 16 DICs had been established as of June 2023. The Principal Recipient reports on only Behavioral (BCC) interventions but no data on Bio-Medical (Testing, Screening for STI, Condom, PrEP, PeP) or structural interventions is reported (including on gender-based violence, male engagement, reducing stigma and discrimination, economic empowerment, and legal framework/protection). Not providing the minimum package of services contributed to low testing and HIV yield. For example, HIV yield for female sex workers is between 3.3% and 4.1% compared to a target of 18%.[36]

Non-adherence to testing guidelines and stock-out of HIV test kits and condoms: The HIV program procured 36% of planned HIV test kits in 2021 and 2022 due to the worldwide supply chain interruptions caused by the COVID-19 pandemic. This contributed to stock-out of HIV test kits nationwide and in 17/20 of the health facilities visited. Also, 70% (14/20) of health facilities visited did not adhere to the testing algorithm[37] and did not use an HIV risk screening tool.[38]

The issues above contributed to the country not achieving the first 95 of the UNAIDS target. Also, these issues could hinder the country from achieving the grant objective of reaching 90% of key and priority populations with a targeted combination of HIV prevention interventions by 2025.

High mother-to-child transmission and low Early Infant Diagnosis (EID) rates are negatively impacting the country's PMTCT response

High mother-to-child (MTCT) transmission: The 2021 vertical transmission (mother-to-child) rate in Ethiopia remains high at 17.9%.[39] Ethiopia has a Triple-MTCT National Strategic Plan that covers eliminating mother-to-children transmission (EMTCT) of HIV, Syphilis and Hepatitis B virus (HBV)[40] with a target of less than 5% vertical transmission by 2025. In the July 2021 to December 2022 reporting period, the percentage of HIV positive women who received antiretroviral viral therapy was below 40%. Low antenatal care coverage (43%[41]) and low deliveries at health care facilities (49%) due to cultural factors, low education, long travel distance to health facilities[42,43] contributed to the high vertical transmission. Inadequate transition processes for prevention of mother-to-child transmission (PMTCT) oversight at the national level from HAPCO to Maternal and Child Health department in 2022 is another contributing factor. Together, these issues could hinder Ethiopia from attaining virtual elimination of MTCT of HIV and syphilis by 2025.

Low EID coverage: The achievement rate of HIV-exposed infants receiving a virological test for HIV within two months of birth has been below target during the audit period.[44] Contributing factors of the low EID coverage include limited geographical coverage of EID testing (at 28%), stock-out of Dried Blood Sample kits (averaging 108 days)[45] and long turnaround time[46] (between 17-28 days) to report EID results due to delays in transporting minimum required samples and test runs at EID testing sites. Some 55% of health facilities visited by the OIG reported more than two-month delays in getting the EID test results.

[35] PLHIV Stigma Index Survey report, June 2021
[36] MARPS survey, 2014
[37] Sequence in which HIV testing is performed as defined in the national testing algorithm guidelines. In Ethiopia, these are screening, confirmatory and tie-breaker tests.
[38] Tool used at health facilities to identify patients with increased probability of undiagnosed HIV infection.
[39] Ethiopia Country Factsheet, aidsinfo.unaids.org (accessed 4 July 2022)
[40] Triple-National Strategic Plan Triple EMTCT July 2021
[41] The Magnitude of Optimal Antenatal Care Utilization, IJRM, Sept 2022
[42] Determinants of institutional delivery in Ethiopia, 2020
[43] Determinants and spatial distribution Institutional delivery (EMDHS) 2022
[44] Achievement of 42% against a target of 79% for the period January 2021-December 2021 and 46% against a target of 83% for the period January 2022 to June 2022
[45] 65% (13/20) sites visited by the OIG reported stock-out of DBS kits
[46] LFA Assessment of Viral Load and EID Implementation Challenges

Data quality issues comprise a contributing factor in low EID coverage. The OIG noted variances between source documents and reported EID and PMTCT data in the health facilities visited. These factors are impacting the country's ability to better understand its epidemic and achieve the less than 5% target for vertical transmission reduction and are contributing to HIV morbidity and mortality in Ethiopia, with the estimated annual AIDS-related deaths among 0-14 years at 19% of all annual AIDS-related deaths.

Agreed Management Action 2:
The Global Fund will work with the Principal Recipient to: a. conduct population size estimates/IBBS for key population and underserved key populations, in line with the regulatory framework in the country; b. operationalize PMTCT scale up including integration and coordination of PMTCT services incl. EID with SRH, RNMCH and HIV programs; c. develop target and design interventions for key populations and underserved key populations based on the outcome of Part A.
OWNER: Head of Grant Management Division
DUE DATE: Part A: 30 September 2024 Part B: 31 March 2025

4.3 Improvement needed in Global Fund's response during the crises in Ethiopia

Delays in adapting the implementation approach to the crisis hitting northern Ethiopia have affected service delivery in those regions. While the Global Fund has various guidelines for countries facing emergency events, they were not fully leveraged to support implementation.

The Global Fund has an operational policy on Challenging Operating Environments (COEs). The organization also has various mechanisms allowing Country Teams to adapt the implementation to several mechanisms available to support countries in crisis that are not classified as COE,[47] such as what Ethiopia experienced during the Grant Cycle 6 implementation.[48] These guidelines and processes were not leveraged on time, delaying the response to the relevant support needed to ensure continuity of services to conflict-affected areas in Ethiopia.

Late classification of conflict regions and its crises affected service delivery

The Global Fund Secretariat classified the Tigray region as a COE in June 2023, despite the conflict erupting in March 2020. At the time of the audit, the other three regions were not classified as COEs. The conflict in northern Ethiopia started in March 2020 and has impacted Global Fund-supported programs in four regions: Tigray, Amhara, Afar, and Benishangul-Gumuz. These four regions make up 36% of the total population of Ethiopia and account for 40% of people living with HIV (PLHIV), 19% of TB cases, and 47% of malaria cases in the country. The invocation of COE status for a country is not an automatic process, and the Global Fund Secretariat performed rigorous processes to reach this decision.

Services to beneficiaries in these regions have been disrupted due to the conflicts and other security concerns. For example, services were discontinued for 19% (113,561) of PLHIV in Amhara, Tigray, Aftar, and Binishangul-Gumuz regions and 1,840 people with drug-susceptible TB in Amhara and Afar regions. Furthermore, there has been unreported data, or decreased reporting, from these regions. For example, Tigray region has not reported any indicator for the three diseases since 2020. In 2021, reported TB case notifications declined by 10.1% in Afar, 3% in Amhara, and increased 16% in Benishangul-Gumuz regional states.

According to the COE OPN, and the circumstances illustrated above, Ethiopia should have been classified as COE back in 2021 to enable rapid responses to emergency situations. The decision to classify countries as COE is performed annually, which resulted in a delay in requesting flexibilities accessible specifically to COE portfolios. The invocation of COE status for a country is not an automatic process, it is a highly consultative one that considers multiple aspects of a context, including political dimension and humanitarian crises. The OIG has identified the need for further clarity on the Global Fund's approach in such situations, and to consider introducing flexibilities in the approval process, as this has the potential to contribute to delays in the COE classification. The OIG audit on COE in Burkina Faso published in May 2023[49] highlights the improvements needed for this policy and an Agreed Management Action (AMA) to revise the policy is currently under implementation.

The Global Fund Guidelines on Emergency Fund Strategic Initiative[50] suggest eight risk criteria for a country to receive the emergency funding. These risk criteria are relevant to the Ethiopian portfolio. In addition to these criteria, allocation of emergency funding also considers the risk faced during emergencies that require a response. In March 2022, the country requested emergency funding of US$10.31 million to support the three regions (including Tigray Region) impacted by conflicts. This request was considered in September 2022, together with the C19RM Wave 01[51] funding application in parallel. The C19RM Wave 01 of US$36 million was approved

[47] These are implementing countries that are not classified as challenging operating environment countries but faced various forms of crises or environment disasters during grant implementation

[48] Global Fund Operational Policy Note (OPN) on Grant and Budget Revisions, OPN on Budgeting, Emergency fund guidelines, Operational flexibilities and use of EGMC to approve exceptional cases

[49] Audit of Global Fund Challenging Operating Environment Policy implementation – Burkina Faso case, May 2023 (GF-OIG-23-013)

[50] Guidelines on Emergency Fund Strategic Initiative. 12 September 2022

[51] Wave 1 of C19RM Portfolio Optimization took place between August 2022 and January 2023, as a result of which US$547 million in funding is being made available to eligible countries (The Global Fund website – accessed on 29 November 2023)

in December 2022. As such, the Emergency Fund application was not pursued. The Global Fund continued to work with partners in the region to identify opportunities for potential emergency support for Ethiopia.

Assurance mechanisms are affected by the crises, but no compensating oversight was put in place

The audit also noted limited assurance mechanisms in the conflict-affected regions. The Global Fund does not have assurance arrangements to safeguard funding to conflict-affected regions in countries that are not classified as COE. Despite 22% (US$11 million) of total disbursements to Regional Health Bureaus going to the conflict-affected regions during Grant Cycle 6, the Global Fund in-country assurance providers did not perform any work in these regions due to security concerns. The Global Fund has long-term agreements with several UN agencies and humanitarian organizations in COE countries. However, although 46 implementing partners are present in these conflict regions, there is no agreement with the humanitarian agencies to leverage their access and presence to provide services to intended beneficiaries.

These issues are covered by a previous Agreed Management Action raised in the audit of Global Fund Challenging Operating Environment Policy implementation – Burkina Faso case[52] , which aims to update the COE policy and procedures.

[52] Audit of Global Fund Challenging Operating Environment Policy implementation – Burkina Faso case, May 2023 (GF-OIG-23-013)

4.4 Procurement delays and gaps in planning data hamper progress made in strengthening supply chain management, impacting timely availability of, and accountability for, commodities

There has been progress made in central-level warehouse management and distribution arrangements. However, limited use of consumption data for demand planning, procurement inefficiencies and delays in Enterprise Resource Planning System (ERP) rollout are resulting in persistent issues of inadequate inventory management and visibility of end-to-end commodity supply chain.

Procurement and supply chain of health commodities and equipment constitute about 71% of the Grant Cycle 6 budget. Robust procurement and supply chain management (PSM) is needed to ensure that key commodities and consumables reach implementation sites and beneficiaries in a timely and uninterrupted manner.

Ethiopia has been advancing in its journey to enhance PSM with some successes, including improved storage for commodities and implementation of a comprehensive ERP. The OIG also noted strong national-level coordination mechanisms for supply chain, starting in June 2022. There is a strong strategic alliance with key players including Ethiopia Airlines and the Ethiopia Customs Regulatory Authority in the supply chain process. Ethiopian Pharmaceuticals Supply Service (EPSS) direct procurements resulted in savings of US$4.9 million on antiretroviral medicines and US$7.5 million on other PSM-related costs in 2023, based on a comparison with the Global Fund Wambo benchmarked prices. The auditors also noted accurate inventory counts, specifically between the physical count and the balances in the Electronic Logistics Management Information System (eLMIS) at the central warehouse and at all six EPSS hubs visited.

Despite the progress made in supply chain since the last OIG audit in 2017, procurement delays and gaps in data used for forecasting and demand planning are impacting the timely availability of commodities. Project planning and implementation of the new ERP also need to improve to ensure visibility and accountability of commodities at all levels as noted below:

Procurement delays and gaps in data used for forecasting and demand planning affecting timely availability of commodities

Procurement delays: EPSS is mandated to procure, warehouse, and distribute health commodities for the Global Fund grant. As prescribed by the Public Procurement Act, the EPSS procurement follows the existing procurement processes and proclamations. The Public Procurement manual recommends a procurement period of 120 days. However, the OIG noted procurement took on average 227 days.[53] The delays were due to high staff turnover at EPSS[54] and lack of a tracking system for the procurement process. Federal Ministry of Health delays (average of 129 days) to send procurement requests and incomplete product specifications to EPSS also contributed to the delays. EPSS and FMOH do not have service-level agreements that specify key roles and responsibilities. In addition, performance metrics resulted in duplication of efforts and as such in inefficient processes.

Gaps in data used for forecasting and demand planning: Ethiopia relies on morbidity data and a target-based approach for forecasting and quantification. There is a missed opportunity to improve collection and use of consumption data despite Global Fund investments of US$1.4 million to support logistics management information systems. The programs rely on distribution data as a proxy for consumption data despite health facilities reporting consumption data to EPSS hubs when ordering commodities. This data is, however, neither aggregated at the

[53] Minimum days taken was 67 days while the maximum period was 415
[54] EPSS health product specialist's turnover in 2022 was 8%; this increased to 20% at the time of the audit in June 2023

central level, nor shared with the National Programs to inform evidence-based forecasting despite the rollout of Dagu-2[55] in over 85% of health facilities providing antiretroviral therapy services.

Other root causes include a fragmented forecasting process between individual programs and lack of synchronization with the EPSS business process prior to June 2022. Limited automation and data aggregation processed between EPSS hubs and health facilities also contributed to the use of distribution data as a proxy for commodities demand planning.

The procurement delays and gaps in data resulted in EPSS operating at below the minimum stock level for key program commodities. The low inventory holdings resulted in the rationing of key program commodities and multiple emergency distributions. Only 35% of the orders from the 20 health facilities visited were fulfilled by the EPSS hubs, contributing to interruption in implementation of HIV prevention interventions (see Finding 4.2). Among the health facilities visited by the OIG, 85%[56] (17/20) had stocked out on at least one commodity for more than two weeks.
The OIG also noted expiries of various HIV, TB and malaria commodities worth US$2.5 million at EPSS central warehouse and hubs. Further, there were expires amounting to US$9.9 million due to a change in regimen transitioning from nevirapine-based to dolutegravir-based drugs. The country evaluated three options together with various technical partners in the country. The option selected was deemed the most appropriate for patients, but it has also resulted in material expires.

Improvement needed in the new ERP/LMIS project planning and implementation to ensure visibility and accountability of commodities at all levels

Ethiopia is investing in a new ERP system[57] which aims to integrate all EPSS business processes and address logistics data quality issues. Although the workplan tracking mechanism included in the Global Fund RSSH grant measures the percentage of processes incorporated into the ERP, it does not track key project activities such as coverage of ERP implementation or monitoring and oversight of the ERP implementation measures. The ERP implementation workplan design and project endline is limited to the funding cycle period. As a result, project milestones are not properly sequenced and critical activities are not prioritized with adequate timelines provided.

The audit team reviewed the implementation arrangements and critical milestones for the new ERP rollout and noted the following gaps:

- Insufficient time allocated to critical project activities such as User Acceptance Testing (UAT) of the project cycle across all the business functions of EPSS.
- Lack of prioritization of critical milestones. For example, at the time of the audit, two months before uploading the test data sets, there was no final agreement on a commodity naming or numbering regime to ensure consistent health product management and smooth integration with other supply chain data systems in the country.
- At the time of the audit, the ERP project had only identified data currently available within EPSS (Vitas system). It is not clear how the health facilities (more than 90% of which depend on a manual ordering system) were going to interface with the new ERP to ensure data capture from the lower levels.
- The current data migration plan has yet to identify and plan for the extraction, transformation, and migration of data external to EPSS – for instance data from DAGU-2, which is data used as the main LMIS by the health facilities to record consumption data.

The audit team also noted during the deployment that there is no planned independent quality assurance to validate and verify project activities. The Global Fund engaged Deloitte to provide this quality assurance, however, they are also involved in the design of the critical project activities,[58] thereby compromising the independence of

[55] Dagu-2 is used as the main LMIS by the health facilities. Dagu, which means ''information'' in the Afar language, provides information on the inventory and stock status of health facilities
[56] 16/20 health facilities stocked out for HIV rapid test kits, , 3/20 for malaria commodities, and 11/20 for TB commodities
[57] Costed at US$9 million with the Global Fund contributing US$5.6 million
[58] These include design of: business processes and controls (blue printing), execution of the data migration and validation strategies, system testing approach and implementation of user-training

the assurance. The ERP project is four months behind schedule, resulting in project activities being re-adjusted to meet the project completion date of December 2023 and impacting the data accuracy.

Agreed Management Action 3:
The Global Fund will work with the Principal Recipient to develop mechanisms to address issues of user acceptance testing, EPSS's roles and responsibilities, master data management, and data integration & migration.
OWNER: Head of Grant Management Division
DUE DATE: 30 November 2024

4.5 Limited sub-recipient oversight arrangements impacting implementation of key grant activities

The Global Fund has effectively leveraged the existing financial control systems and processes in grant management to reduce financial and fiduciary risks in Ethiopia. However, delayed disbursements to Regional Health Bureaus have hampered implementation of key grant activities. Deficiencies in the program accounting software could result in the loss of grant financial information.

The Principal Recipient, the Federal Ministry of Health (FMOH), has established a Program Management Unit, which is fully integrated into the national system. FMOH independently reviews all significant transactions by the Ethiopia Pharmaceutical and Supply Services (EPSS) that manages over 75% of grant funds. The Auditor General's Office of Ethiopia, through the Audit Service Corporation, audits Global Fund grants and the FMOH internal audit department provides internal audit services for Global Fund-supported programs.

Limited sub-recipient oversight contributed to delayed disbursement and increased financial risks for funds disbursed to regions

Robust sub-recipient and financial management is critical to ensure interventions are delivered as planned. The Principal Recipient's internal audit unit planned to perform eight regional audits in 2022. Of the eight regional audits, six related to Grant Cycle 5 activities and only two covered Grant Cycle 6 activities. At the time of the OIG audit,[59] only 12 of the 96 planned monitoring visits had been completed by the Principal Recipient's finance team. The limited oversight over the Regional Health Bureaus contributed to late settlement of advances as of 31 December 2022, 54% (approximately US$27 million) of advances given to Regional Health Bureaus were not liquidated.

While flow of funds arrangements to implementers are functional, there are delays in the disbursement of funds. It took the Global Fund Secretariat an average of 61 days to disburse funds to the country after the Principal Recipient's funds request date. For in-country disbursements, it took an average of 29 days for funds to be disbursed from the Principal Recipient to the sub-recipients, including the Regional Health Bureaus and EPSS.[60] The OIG noted an instance in which in-country disbursements to implementers took 154 days.

Delayed signing of the sub-recipient grant agreements is a contributing factor to the in-country disbursement delays. This is because the grant agreements have to be signed before disbursements are made to implementers. Out of 47 sub-recipient grant agreements reviewed, 27 of them were neither signed nor dated. Of the 20 that were signed, 18 were delayed by between 67 and 337 days.

Delays in fund disbursements to implementers contributed to delays in the implementation of key programme activities such as the IBBS study, and the procurement of rapid diagnostic tests and condoms, as noted in finding 4.2. The audit noted low absorption at the Regional Health Bureaus (HIV - 42%; Malaria – 48%; TB – 65%; RSSH – 84%; C19RM – 49%). With a year left on the Grant Cycle 6 implementation, some of these activities might not be implemented, which could impact the achievement of the grant objectives.

Deficiencies in the financial management system may result in loss of grant financial information

The Principal Recipient has been using a Sage-based accounting software, known as PeachTree, for recording and reporting financial information of Global Fund grants since 2013. The software is unlicensed and does not have adequate system controls. The software does not have controls to limit access to grant financial information and

[59] The audit fieldwork ended on the 30 June 2023

[60] The OIG focused on RHBs and EPSS to assess in-country disbursement delays because they are the implementers who receive most grant funding; EPSS – procurement & RHBs – oversees implementation of soft activities

to ensure accuracy and completeness of records being posted into the appropriate accounts. It also lacks an appropriate audit trail of accounting entries posted.

The PeachTree system infrastructure set up makes it susceptible to the loss of financial information. Financial information in the form of a backup file is sent manually by the five Grant Accountants to the Grant Finance Specialist who then performs a backup on a central computer. Backups are performed sporadically by the Grant Accountants, and there are no compensating controls to ensure that backups are performed periodically and stored appropriately.

The current configuration of the PeachTree accounting software being used by the Principal Recipient lacks the requisite software-based controls to prevent or detect posting of incorrect accounting transactions. The OIG noted that there are no policies and procedures for the procurement and maintenance of the IT infrastructure and software needed for financial recording, processing and reporting. The deficiencies in the financial management system increase the risk of loss of grant financial information or the reporting of unreliable financial information.

Agreed Management Action 4:
The Global Fund Secretariat will work with the Principal Recipient to: a. assess the key financial management processes, controls and reporting systems and processes to address weaknesses identified in the finding above; and b. progress in the implementation of the prioritized outcomes from the assessment as stipulated in part “A”.
OWNER: Head of Grant Management Division
DUE DATE: Part A: 30 November 2024 Part B: 30 November 2025

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**.**

OIG audits are 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 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.

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 effectively assessed and mitigated.

Assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregate level in the eight key risk areas 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 there is no set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.