



Audit Report

# Global Fund Grants to the Democratic Republic of the Congo

GF-OIG-16-022  
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# I. Background

The Democratic Republic of the Congo (DRC) spans 2.3 million square kilometers, making it the largest country in sub Saharan Africa. About 40% of its estimated 75 million inhabitants<sup>1</sup> live in urban areas. With 80 million hectares in arable land and scores of minerals and precious metals, DRC continues to grow at a rapid rate (8% on average over the past three years).<sup>2</sup> Yet as of 2012, almost two thirds of the population were living in poverty<sup>3</sup>.

The country is often listed as one of the most difficult countries in which to deliver health care services. The health care system is organized into 516 health zones (“Zones de Santé”). Decentralization is underway, with a reorganization of 11 provinces into 26 new provinces, and the establishment of Health Provincial Divisions and Health Inspection in each new province.

## Three diseases in DRC: a high burden portfolio, critical to Global Fund success

### *Malaria*

DRC accounts for 7.1% of the global malaria burden, ranking second in the world. Malaria is endemic, with up to 97% of the population living in stable transmission areas (equatorial and tropical variants). With the transition to a new funding model in 2014, the Global Fund is multiplying its efforts in DRC, and has scaled up its coverage from 219 to 313 out of 516 health zones.<sup>4</sup>

In recent years, the national malaria program has also extended its coverage. For example, the number of households with at least one mosquito net increased from 9% in 2007 to 70% in 2014. This means that with Global Fund supporting up to 80% of the mass campaign distributions, the country is moving towards universal mosquito net coverage. Net use also improved between 2010 and 2014; 60% of pregnant women and 56% of children under five slept under a net in 2013-2014 compared to 43% and 38% respectively in 2010. As a likely consequence, the malaria death rate decreased by 72% and incidence by 55% between 2000 and 2014.<sup>5</sup>

### *HIV*

DRC accounts for 1.5% of the global HIV burden, ranking sixteenth in the world. DRC has a generalized HIV epidemic, with pockets of concentrated epidemics affecting key populations including sex workers, men who have sex with men, and injecting drug users. Since June 2015, the Global Fund has scaled up its coverage, increasing from 239 health zones to a long-term plan of reaching 354 out of the 516 health zones by 2017.<sup>6</sup>

From 2000 to 2014, the HIV mortality rate decreased by 50% and incidence by 55%. Over the past five years, the number of people on antiretroviral treatment has increased from 41,000 to 121,762 in 2015. In the context of a funding gap, this steady progress still falls short of covering the majority of affected populations. The most recent UNAIDS estimates suggest that 370,000 people are living with HIV, and an estimated 30,000 deaths can be attributed to AIDS (down from 38,000 in 2008).<sup>7</sup>

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<sup>1</sup> Projection based on the most recent census, 1981, DRC concept notes, Global Fund.

<sup>2</sup> World Bank country profile for DRC: <http://www.worldbank.org/en/country/drc/overview>

<sup>3</sup> As at 2012, 63.6% of the population lived below national poverty lines, according to the World Bank's Global Poverty Working Group: <http://data.worldbank.org/indicator/SI.POV.NAHC/countries/CD?display=default>

<sup>4</sup> Disease burden figures based on those used in the Global Fund's methodology for allocation of funds, other data points sourced in the concept note submitted to the Global Fund and in publically available WHO databases.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> UNAIDS estimates, dated 2016, coming from EPP/Spectrum, which is the Futures Institute's analytical tool developed to support policy decisions concerning public health. Spectrum includes modules for HIV estimates and projectors. For more information, see <http://www.unaids.org/en/dataanalysis/datatools/spectrum>

## *Tuberculosis*

DRC accounts for 2.2% of the global tuberculosis burden, ranking 11th in the world. The disease burden of tuberculosis infection, and HIV co-infection is unevenly spread across the country. The Global Fund supports the national tuberculosis program, which covers all of the country's health zones, and has ambitious goals to curb the trend of co-infections.<sup>8</sup>

From 2000 to 2014, the tuberculosis death rate was reduced by 14%, and HIV co-infection has steadily decreased from 60 to 45 cases per 100,000 inhabitants. However, the prevalence of HIV among tuberculosis patients is estimated to be 16%, with an incidence of 25 per 100,000, which puts DRC amongst the countries with the highest rates of co-infection in the world. More broadly, since 1990, tuberculosis prevalence has remained high, fluctuating between 500 and 600 cases per 100,000 inhabitants; and similarly over the same period, incidence has remained stable around 325 cases per 100,000. Multidrug resistant cases are estimated to be around 2,800.<sup>9</sup>

### The Global Fund in DRC: a large portfolio in one of the most challenging environments in the world

DRC is one of the most challenging environments in which Global Fund grants are implemented. The Global Fund classifies the country as a "Challenging Operating Environment", where the political context continues to create barriers to access to care, and the development of integrated health programs. Following a long history of conflict, DRC has experienced relative political stability over the last few years, but the situation in the eastern provinces remains volatile with the population extremely vulnerable to violence and displacement. Health indicators in DRC are among the worst in the world and reflect the hardships resulting from the protracted conflict and the corresponding deterioration of health services throughout the country. Consequently, the health sector's ability to respond to the needs of the citizens of DRC has declined significantly over the past decades.<sup>10</sup>

Since August 2011, the Global Fund portfolio in DRC is managed under the "Additional Safeguards Policy".<sup>11</sup> Justifications for invocation of additional safeguards included weak management and the lack of internal control capacities of Principal Recipients and sub-recipients; weak capacity and oversight of the Country Coordinating Mechanism; and political instability. To date, owing to continued structural weaknesses, the following safeguards remain in force: the selection of Principal Recipients by the Global Fund; specific oversight over the selection and management of sub-recipients by the Principal Recipients; tailored risk mitigation and procurement arrangements.

Since 2003, the Global Fund has signed a total of 22 grants amounting to US\$1.5 billion, of which US\$1 billion was disbursed by the time of the audit. Three active grants finance the three national programs, with a portfolio of US\$76.61 million, supporting particularly supervision activities across the three diseases. The Global Fund also supports four Principal Recipients from civil society, split between two local non-governmental organizations (NGO) and two international NGOs. Together, these civil society organizations implement a portfolio of US\$791.49 million in approved funding:

- Eglise du Christ au Congo / Santé Rurale (Sanru), a local NGO established in Kinshasa in 1981, covers malaria and HIV activities, including the procurement of antimalarial drugs (local procurement through international suppliers) and antiretroviral medicines (through the Global Fund's Pooled Procurement Mechanism). SANRU manages a portfolio of US\$473.28 million across two grants and their extensions.
- Population Services International (PSI), an international NGO based in Washington DC and present in DRC since 1987, covers activities such as the procurement and distribution of

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<sup>8</sup> Disease burden figures based on those used in the Global Fund's methodology for allocation of funds, other data points sourced in the concept note submitted to the Global Fund and in publically available WHO databases.

<sup>9</sup> WHO 1990-2014 estimates, <http://www.who.int/tb/country/data/download/en/>

<sup>10</sup> Current country context, as described in the Global Fund's memo invoking additional safeguards, August 2011.

<sup>11</sup> The Additional Safeguard Policy is invoked as a risk mitigation measure to enable the Global Fund to institute appropriate measures where Global Fund monies could be placed in jeopardy.

insecticidal nets to protect populations from malaria. It manages one grant of US\$134.22 million.

- Catholic Organization for Relief and Development Aid, Congo (Cordaid), an international NGO based in The Hague and present in DRC since the 1970s, covers activities such as the procurement (through the Pooled Procurement Mechanism) and distribution of antiretroviral medicines. It manages one grant that amounts to US\$145.03 million.
- Caritas Congo, a local NGO established in Kinshasa since 1960, covers community level activities in support of the national tuberculosis program and procurement of drugs through the Global Drug Facility mechanism. It manages one grant of US\$38.96 million.

In terms of budgeted activities, the majority (53%) of the funding is used to procure health commodities. At the central level, the Global Fund relies on its four non-governmental partners to procure, store and transport drugs to the regional level. From the regional level to the health zone level, these implementers rely on a set of 19 local NGOs, organized as a federation of regional warehouses (FEDECAME). Some of those regional warehouses, including the larger ones in Kinshasa and Goma, have contractual agreements with the Global Fund's Principal Recipients. Medical staff of the health facilities also collect drugs from the health zone offices.

The OIG last reviewed this portfolio in 2009 with a full scope audit, published in March 2010, and through an advisory engagement, issued in 2013.<sup>12</sup> The 2009 audit took place at a time where UNDP was Principal Recipient, and therefore focused predominantly on the quality and effectiveness of UNDP's grant management. However, the audit also briefly touched on SANRU's capacities, which was a sub-recipient of UNDP at the time. Since then, other civil society Principal Recipients have been selected and improvements noted both in terms of programmatic activities and the supply chain controls at central and regional level. However, controls at the health facility level remain ineffective.

The limited scope advisory looked at key financial and procurement controls in place. The auditors looked at four organizations which were still Principal Recipients at the time of the writing. The auditors concluded that the Ministry of Public Health's financial management capabilities were suboptimal and its procurement capabilities unsatisfactory. In addition the operations of the Fiduciary Agent were found to be unsatisfactory. Cordaid, Sanru and Caritas needed to improve their financial management. Furthermore, more significant improvements were required in terms of procurement as the OIG found instances of noncompetitive procurements, payment before delivery, and weaknesses in tendering. As a result the Secretariat took the necessary actions and improvements in the financial and procurement controls for the civil society implementers have been put in place. Although a new Fiduciary Agent was appointed at the Ministry of Public Health, its program management unit remained ineffective at the time.

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<sup>12</sup> The audit report is available on the Global Fund website (in [French](#), and [English](#) versions), however in accordance with the policy for disclosure of OIG internal audit reports enforced at the time, the advisory report is not available on the Global Fund website.

## II. Scope and Rating

### Scope

The audit seeks to give the Global Fund Board reasonable assurance as to whether implementation arrangements of grants to DRC are adequate, efficient and effective in achieving the grant objectives in the country. Specifically the audit assessed:

- (i) the effectiveness of Global Fund supported programs to ensure adequate access to care and quality of health services;
- (ii) the design and effectiveness of the internal control environment in safeguarding Global Fund resources including:
  - a. in-country procurement and supply chain management;
  - b. programmatic data and grant performance including data quality, training and supervision; and
  - c. financial and fiduciary management.

The review covered active grants implemented by the Principal Recipients (Ministry of Public Health of the Government of the Democratic Republic of Congo; Sanru; PSI; Cordaid; Caritas Congo) and their sub-recipients, from January 2014 to April 2016. The audit did not cover DRC related procurement activities conducted by PSI headquarters, which represents around 11% of the total portfolio budget 2015-2017. These activities are reviewed as part of the external audit of PSI, under the “Agreed Upon Procedures” with the Global Fund.

The OIG visited 49 sites to back up, on a sample basis, its audit findings on access to care, quality of health services, in-country procurement, supply chain management, programmatic data quality, training and supervision. These sites included four central warehouses in Kinshasa, six regional warehouses, 14 health zone offices, 10 reference hospitals, and 15 health centers. The OIG visited six out of the 26 provinces in DRC.

### Rating<sup>13</sup>

<b>Operational Risk</b>	<b>Rating</b>	<b>Reference to findings</b>
Effectiveness of Global Fund supported programs to ensure adequate access to care and quality of health services.	Needs significant improvement	1.1, 1.2
The design and effectiveness of internal controls over procurement and supply chain management in country.	Ineffective	2.1, 2.2, 2.3
The design and effectiveness of internal controls over programmatic data and grant performance	Needs significant improvement	3
The design and effectiveness of internal controls over financial and fiduciary management.	Needs significant improvement	4

<sup>13</sup> See Annex A for the rating definition

### III. Executive Summary

DRC is critical to the Global Fund's mission to accelerate progress against HIV, TB and malaria and to improve global health. The country represents the third largest allocation in the Global Fund portfolio, and currently benefits from over a billion dollars in approved funding. Recent performance reports are encouraging, with an upward trend in the results against the three diseases.

This is the first OIG audit of the portfolio since the country transitioned to the new funding model. Since the last OIG review in 2013 the portfolio has stabilized. Its structure has been rationalized with civil society Principal Recipients focusing on supply chain and implementing 91% of the value of grants (US\$791.49 million), while the public sector Principal Recipients are responsible for overseeing the quality of services activities. Cooperation with donors has also benefited from better structuring, with a clearer geographical split, and harmonization of salary to ups between the Global Fund and its main partners.

Implementing health in DRC is a serious challenge. The country has come out of two decades of intermittent civil war and strife which severely degraded infrastructure and produced significant political instability. The country's institutions are relatively fragile and the level of corruption is considered generally high. Despite these challenges, the Global Fund and its partners, have achieved progress over the last three years in scaling up interventions, re-designing the supply chain systems, enhancing programmatic reporting, improving data quality, and mitigating the portfolio financial risks. However, these strategic initiatives have not always proved their operational effectiveness, and the OIG has identified room for improvements.

Inadequate programmatic oversight and gaps in mechanisms to ensure quality of services limit the impact of the programs. In a big country with poor infrastructure, and limited capacity, effective programmatic oversight is key to ensuring the success of the Global Fund mission.

The **malaria program** has made important progress in vector control through the effective distribution of long lasting insecticidal nets. With the Global Fund financing 80% of mass campaign distribution, the country is moving towards universal mosquito net coverage. However, improvements are needed for case management, in terms of both diagnosis and treatment. The OIG found that 30% of facilities make inefficient use of malaria tests by duplicating each rapid diagnostic test with a thick blood smear test. Although the guidelines authorize the duplication of treatment in reference hospitals, this was also observed in health centres. This may be partly because the thick blood smear is a paid service, and therefore a source of income for health facilities. By contrast, the auditors found that 12% of the facilities visited do not perform any test before putting patients on treatment for simple malaria, thereby relying solely on clinical signs.

Whilst the **HIV program** has substantially increased the number of people on antiretroviral treatment, the current 32% coverage rate remains low compared to other countries in the region. In addition, weaknesses regarding retention in care and treatment success affect the achievement of program objectives. The effectiveness of mechanisms to retrieve patients lost to follow-up is limited. The number of patients reported to UNAIDS as lost after six months was most recently estimated at around 14%.<sup>14</sup> However, after reviewing individual patient files, the auditors identified that an additional 17% of the population considered to be on active antiretroviral treatment on site had not received treatment for over six months, and should therefore be considered as lost to follow up. The audit also identified weak capacity to routinely monitor people on treatment, as viral load monitoring was deployed only as recently as July 2015. At the time of the audit, 25% of the facilities visited perform viral load monitoring to detect treatment failure and adjust treatment regimens.

**HIV-TB collaboration** is an important element of Global Fund programs and therefore a joint TB-HIV concept note has been drafted to apply for new funding model grants starting in July 2015. In

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<sup>14</sup>The lost to follow up rate was reported as 14%, 22% and 20% respectively in 2015, 2014 and 2013, through UNAIDS Global AIDS Response Progress reports.

spite of recent efforts to improve this collaboration, there are multiple signs of weaknesses in program quality. Although isoniazide prophylaxis to prevent TB for people on antiretroviral treatment was introduced in mid-2015 with the new funding model grants, 65% of facilities did not provide the treatment at the time of the audit.

In its efforts to achieve impact in such a challenging country, the Global Fund Secretariat finances more than 700 staff positions across the country at a cost of about US\$64 million, or 12% of the 2015-2017 grant budgets under review. There has been no detailed analysis by the Global Fund Secretariat on staff distribution across implementers to ensure that these resources are used effectively. In the absence of a mechanism to assess the reasonableness of various cost categories, the OIG also found material variations across different implementers for mosquito net unit price, drug transportation and storage cost and in-country allowances. In a resource-constrained environment, such analysis is critical in ensuring that the Global Fund is investing as efficiently as possible to achieve value for money.

This audit also looked at **supply chain arrangements** and the related internal controls. In a portfolio that has as its main objective to deliver drugs to patients, the supply chain controls were found to be ineffective. The OIG can provide reasonable assurance on drug accountability up to the health zone level, with 96.7% of drugs sampled, traced from regional warehouses to health zones. However, 31.1% of drugs sampled could not be traced from health zone to health facility level. This underscores that drug tracing mechanisms at the health facility level are inadequate, as the last mile transportation to health facilities remains a challenge.

Moreover, in the absence of effective supervision, adequate oversight over the consumption of drugs, and last mile delivery, stock-outs were pervasive along the supply chain. There were no mechanisms in place to mitigate or control drug expiries. The OIG also found issues with the quality control of drugs procured by Sanru through international providers, leading to the circulation of substandard drugs procured with Global Fund financing to fight opportunistic infections. This audit therefore concludes that controls over procurement and supply chain are ineffective. Consequently, the achievement of the grant objectives in terms of health products and drugs distribution to people affected by the diseases is seriously compromised.

Although the Global Fund invests money and efforts in improving the controls over **programmatic data**, there are multiple material gaps in the controls over the collection and transmission of strategic data. This leads to the Global Fund reporting inaccurate data on its performance in a mission critical portfolio affecting the decision-making process. As a result, until the controls over the collection and transmission of data are addressed, there is not yet reasonable assurance over programmatic data reported from DRC.

Finally, the OIG notes that certain recent changes to enhance **financial management** have not yet produced the results the Global Fund is aiming for. While the financial internal controls were deemed to be adequately designed for the civil society implementers, they are ineffective for the public Principal Recipients which oversee the implementation of 9% of the value of the grants (US\$76.61 million).

The Fiduciary Agent, despite being engaged to help build the skills and resources of the Ministry of Health's program management unit, continues to perform predominantly a control role. This is due to the absence of the building blocks of a control environment at the program management unit.



## IV. Findings and Agreed Management Actions

### 1. Effectiveness of programs to ensure quality of services and access to care

#### 1.1. Quality of health services

**Inadequate programmatic oversight at all levels and limited mechanisms to prioritize activities which enhance the quality of health services may reduce the impact of the program.**

In a country where implementing health programs is challenging due to its size, poor infrastructure and difficulties in attracting and retaining qualified personnel, the Global Fund's strategic approach has not always proved effective at the operational level. In addition, the country has an important funding gap. In its concept notes, the country has estimated that only 16% of funds needed to achieve strategic targets are available for HIV, 44% for tuberculosis, and 57% for malaria. The Global Fund and its partners continue to scale-up interventions on the three diseases in spite of the funding gap. However, this is not met by commensurate improvements in the quality of services for people suffering from the three diseases.

**In the malaria program**, important progress is being made in vector control by increased distribution of bed nets. 25.8 million nets were distributed in 2015 compared to less than 1 million in 2011. However, improvements are needed in malaria case management.

Consistent with World Health Organization (WHO) guidelines, national guidelines in DRC provide for two alternative combinations of drugs for the treatment of simple malaria. These first line malaria drugs are Artesunate Amodiaquine (ASAQ) and Artemether Lumefantrine (ALU). In 20% of facilities visited, the OIG identified cases of simple malaria treated with non-recommended antimalarial drugs (for example using quinine tablets, which are a second line treatment for severe malaria). This can be due to ASAQ stock-outs, or the refusal of patients to use ASAQ because of inconvenient side effects. The use of second line drugs for the treatment of simple malaria raises the risk of the development of drug resistance and may represent inefficient use of available medicines and diagnostic services.

The OIG also found issues with respect to parasitological confirmations. Of the 17 facilities visited by OIG, 12% do not perform any test before putting patients on treatment for simple malaria, thereby relying solely on clinical signs. On the other hand, 30% of facilities make inefficient use of malaria tests by duplicating each rapid diagnostic test with a thick blood smear test.

**In the HIV program**, 32% of the people estimated to be living with HIV are on antiretroviral treatment. While this number is low in comparison to other countries in the region, it represents important progress compared to 2011 when only 5% of people living with HIV were enrolled for antiretroviral treatment. In spite of these achievements, the OIG identified weaknesses regarding testing and counseling services, retention in care and treatment success.

Contrary to both national guidelines and WHO guidelines, HIV provider initiated testing and counselling services are not offered consistently to all patients. For example, only 4% of patients (115 out of 2876) received testing and counseling in the two hospitals visited by the OIG in Kinshasa. This creates a risk of under detection of asymptomatic cases in the general population. This is also confirmed by the risk of missing longer terms target of reaching 8 million by the end of 2017. The program has reached 0.8 million people as at the end of 2015, against an objective of 1 million.

Health facilities have put in place mechanisms to retrieve patients lost to follow-up, but their effectiveness is limited. While the number of patients reported as lost after six months is estimated

at around 14%,<sup>15</sup> the OIG identified up to an additional 17% of unsuspected patients lost to follow up after six months, while reviewing the reported figures for documentation of the population on antiretroviral treatment on site. This is due, in most cases, to an improper understanding of the definition of the population on antiretroviral treatment. For example, certain patients are still considered active for up to three years after their last visit to a facility. In comparison, the guidelines define a person as lost to follow up treatment after only six months have passed since their latest consultation. Retention mechanisms are critical for DRC as the number of people on treatment remains low.

The audit also identified weak capacity to routinely monitor people on treatment according to guidelines. As an example, only 25% of the facilities visited perform viral load monitoring to detect treatment failure and adjust treatment regimens. This is mainly due to human resource capacity and lack or unused equipment at the facility level. For example, a reference hospital has a viral load monitoring machine which has been unused since 2005, with the facility citing the absence of trained staff as the reason.

**HIV-TB collaboration** is an important element of Global Fund programs. A joint TB-HIV concept note was drafted in pursuit of new funding model grants approved in July 2015. In spite of recent efforts to improve this collaboration, 65% of facilities did not provide isoniazide prophylaxis to protect people on antiretroviral treatment from TB. This may lessen the impact of the grant in reducing the TB/HIV related mortality.

In addition, the country's policy to limit testing TB patients for HIV to those health facilities offering treatment against both diseases leaves 44% of TB diagnostics centers (719 out of 1655) without HIV testing kits.

**The Ministry of Public Health continues to have limited capacity to ensure program oversight at all levels.** As a Principal Recipient, the Ministry is responsible for ensuring the quality of health services for all activities related to training and supervision. This represents 24% of the overall budget of active grants to the Ministry. The OIG found weak supervision and training activities by the national programs, particularly in overseeing quality of services:

- A review of supervision reports demonstrated the absence of follow up mechanisms to ensure that identified issues were addressed.
- The timeline for supervision activities is not complied with. For example, in 2015, the national programs did not conduct regular supervision visits (for HIV 23 out of 292 planned supervision and for TB, 57 out of 230 planned supervisions) partly due to delays in receiving funds at the implementer level affecting the disbursement of funds.
- CAG, the "Cellule d'Appui et de Gestion" or project management unit of the Ministry, does not have the resources to monitor program implementation at the provincial level. There is no regular report received on provincial activities such as supervision or training.
- There is no clear segregation of tasks to avoid overlapping supervision between the national programs and civil society implementers, both of them covering the same programmatic activities in their supervision visits.
- Training activities have not been planned adequately to ensure their effectiveness. As an example, training on a new TB treatment guideline and data collection (PATI V) was held six months before the tool was made available to health facilities. This means such training sessions may have to be repeated once the tools are available, which is an inefficient use of grant funds.

**Reprogramming of activities.** The mechanism for reassignment of unspent budget to other grant activities is starting to take place in the DRC portfolio. In a resource constrained environment, reprogramming can contribute to focusing additional financing for better quality of services. A review of recent reprogramming activities suggests that these followed an adequate approval

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<sup>15</sup>The lost to follow up rate was reported as 14%, 22% and 20% respectively in 2015, 2014 and 2013, through UNAIDS Global AIDS Response Progress reports.

process. However, improvements are needed to ensure activities contribute to better quality of services. The reprogramming process does not show how different trade-offs are considered and the rationale for prioritization of funding for certain activities over others based on the strategic priorities of the grants.

**Ongoing initiatives at the community level.** At the time of the audit, the Global Fund Secretariat was already taking initiatives to improve access to care and quality of services. These include:

- support to the scale-up of PODI (Poste de Distribution Communautaire d'Antiretroviraux) to improve retention and follow up of patients on anti-retroviral treatment;
- support to the observatory for access and quality of HIV services in North Kivu and Kinshasa provinces to improve civil society monitoring of HIV services;
- roll out, together with UNICEF, of an Integrated Community Case Management system, training community health workers to prevent, treat and provide referral services for common childhood diseases, including malaria.

These initiatives may help to partially mitigate the issues highlighted above.

#### **Agreed Management Action 1**

The Global Fund Secretariat will work with the Principal Recipients Ministry of Health, SANRU, Cordaid and Caritas to develop an integrated supervision plan for HIV, TB and malaria services supported by the Global Fund. This plan will include:

- TORs for supervision at national, intermediate and peripheral levels conducted jointly by the Ministry and civil society PRs, including joint TB/HIV supervision;
- Supervisions guides and reporting tools; and
- Follow up mechanisms on the recommendations coming from supervision findings.

**Owner:** Mark Edington, Head Grant Management Division

**Implementation date:** 31 March 2017

## 1.2. Cost effectiveness of the DRC portfolio

**In the absence of a cross-cutting analysis of expenditures incurred by Principal Recipients to compare efficiency, the Global Fund could miss opportunities to optimize scarce resources.**

Implementing health programs in DRC can be a costly exercise mainly due to the size of the country and the challenges in attracting and retaining qualified personnel. In order to achieve its mission, the Global Fund relies on its implementers in country and finances their activities. Analysis done by the Global Fund Secretariat is not sufficient to ensure that certain unit cost categories are optimized across the portfolio to ensure value for money. This may result in a loss of opportunity to maximize the impact, in the context of a material funding gap.

In the absence of such analysis, the OIG found differences in comparing efficiency across a range of cost categories:

### **a) Human resources.**

Human resources represent US\$63.9 million, or 12% of the 2015-2017 grant budgets under review. In aggregate, the Global Fund finances 731 staff positions across the portfolio. The Global Fund Secretariat has not analysed in detail staff distribution across implementers to ensure that these resources are used effectively. As a result, it is difficult to justify whether the level of staffing employed is in line with program needs. A comparison of reported results and staff available shows one Principal Recipient manages to treat 504 patients per employee, while the other one manages to treat 131. Both Principal Recipients focus on the same HIV program but in different areas of the country.

The OIG also noted significant variances in the salary scales (up to 40% on average) used for Global Fund financed positions by the five Principal Recipients, and important differences in the number of staff working under each Global Fund supported program. A comparison of two HIV Principal Recipients shows that staff and overhead costs per patient treated is US\$36.79 for the first one and US\$47.40 for the second one.

Although the period (second semester 2015), the package of interventions and the mix of activities are comparable, the OIG acknowledges that this analysis did not consider the potential differential in cost of doing business in the regions covered by the two implementers and limited potential for cost sharing over different disease components. Therefore, the above comparison does not constitute evidence of inefficiencies on its own as the cost differentials could also be explained by factors such as geography, patient demography and other variables. However, in the absence of an in-depth analysis taking into account all the relevant factors, the Secretariat is not in a position to determine whether the observed cost differences are justifiable or not and, therefore, whether value-for-money is being achieved.

### **b) Long-lasting insecticidal nets unit price.**

A review of mosquito nets unit price procured by two implementers under the same specifications and the same 'Free-On-Board' international commercial terms<sup>16</sup>, but from different suppliers, shows a unit price difference of about 12%. This difference represents a missed opportunity for one implementer to save about US\$2.5 million. If the comparison was based on 'Cost Insurance Freight' international commercial terms,<sup>17</sup> the difference would decrease to about 5%. But this would still represent approximated US\$1 million in missed savings.

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<sup>16</sup> Under these international commercial terms, the seller delivers the good at the port of departure, cleared for export and ready for boarding. The seller bears all costs and responsibilities thereafter. Free On Board, or FOB, is one of the eleven international commercial terms, also referred to as Incoterms 2010, a set of standard trading terms and conditions.

<sup>17</sup> Under these terms, the seller arranges and pays for transport and insurance to the named port of destination, but the transfer of risks to the buyer takes place when the product is loaded on board at the port of departure. Cost Insurance Freight, or CIF, is one of the eleven international commercial terms, also referred to as Incoterms 2010, a set of standard trading terms and conditions.

Furthermore, missed savings affect the higher volume purchases of nets for mass campaigns. Although the unit price differential may be partly explained by a difference in timing of the two tenders compared, this underscores a missed opportunity to leverage volume purchasing for lower prices. However, although the OIG identified potential savings, it also noted that both Principal Recipients achieved prices in line with those negotiated in other countries for similar specifications through the Global Fund's pooled procurement mechanism.

**c) In-country travel allowances.**

Travel costs represent US\$83.6 million, or 15% of the 2015-2017 grant budgets under review. In the absence of a mechanism to assess reasonableness of the daily allowance charged for supervision activity, the OIG found material variations of between 50 to 100% for the four civil society implementers. As an example, for regions like Gbadolite, the daily allowance for supervision visits of one implementer is US\$95 while a different implementer applies a rate of US\$187 for the same region.

**d) Drugs transportation and storage costs.**

Procurement and storage costs represent US\$61.6 million, or 11% of the 2015-2017 grant budgets under review. In the absence of efficiency measures, the OIG found a difference of up to three times (US\$1.12 versus US\$5) in the drug transportation unit cost paid by the Principal Recipients to transportation companies. This comparison took into consideration costs charged by different implementers to deliver medicines along the same route. The audit also found examples where the rate varies, within the same implementer, by up to 40% (US\$2.5 versus US\$3.5) for the same itinerary based on the transportation company.

In terms of drugs storage, in the absence of a mechanism to generate economies of scale when dealing with the same vendor, the OIG found inconsistencies in the unit costs charged by the same warehouse for different implementers. Some implementers were charged using volume as a basis (by cubic meter per month) whereas others used the mass of stored goods (by kilogram per month or as a percentage of drugs costs including the distribution costs).

**Agreed Management Action 2**

The Global Fund Secretariat will conduct a cost reasonableness analysis of PR expenditures. The analysis will cover SANRU, Caritas, Cordaid and PSI and will include a cross-PR comparison of unit cost categories for: HR costs and numbers; LLIN prices; storage and distribution; and daily subsistence allowances.

**Owner:** Mark Edington, Head of Grant Management Division

**Implementation date:** 30 June 2017

## 2. Control over procurement and supply chain

### 2.1. Controls over inventory at the health facility level

**While the OIG can provide reasonable assurance on drug traceability up to the health zone level, drug tracing mechanisms at the health facility level are inadequate. Overall, 34.4% of drugs dispatched from regional warehouses tested could not be traced in health facilities.**

The difficulty in tracing drugs down to the health facility can lead to the loss of program funds, as leakages go unnoticed. This can also lead to treatment disruptions, as key medicines become unavailable.

#### a) Difficulty in tracing drugs to health facilities.

In its review of drugs distributed at the health facility level, the OIG can provide reasonable assurance that drugs leaving the regional level reach the health zones. Although the country is classified as a challenging environment, the OIG reconciled 96.7% of products shipments from the regional to the health zone level. This underscores the good performance of the principal recipients and regional warehouses in bringing drugs to the health zone level. The loss of documentation for 3.3% of health products sampled is not material, and the OIG can therefore provide reasonable assurance on the traceability of drugs between the regional and health zone levels.

However, the OIG cannot provide reasonable assurance on drugs traceability between the health zone and facility levels. Although the selected sample covered health zone offices and nearby health facilities within an urban setting, where logistical challenges should be reduced, the OIG could not document all receptions. Auditors could not trace 31.1% of products shipments originally dispatched from regional warehouses, between their expeditions from health zones and the expected reception at the health facilities. This lack of documentary evidence to prove that drugs reach health facilities affects certain drugs more than others. For example, 47% of adult formulation of artemisinin combination therapy and 40% of 'Determine' HIV tests could not be traced. By contrast, the auditors were able to track the infant formulation of artemisinin combination therapy down to the health facility level.

Fig. 1. Global Fund drugs traceability along the supply chain.

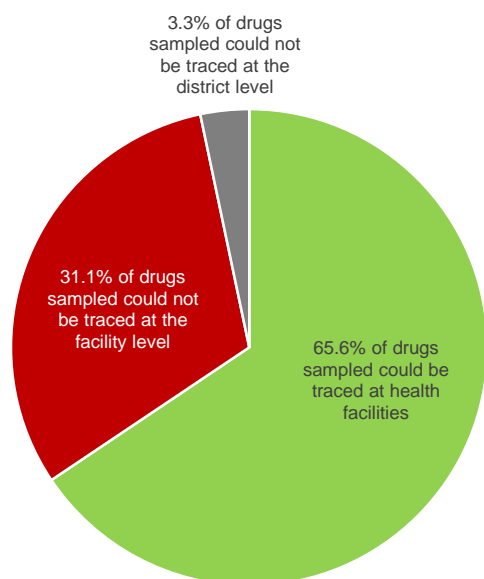
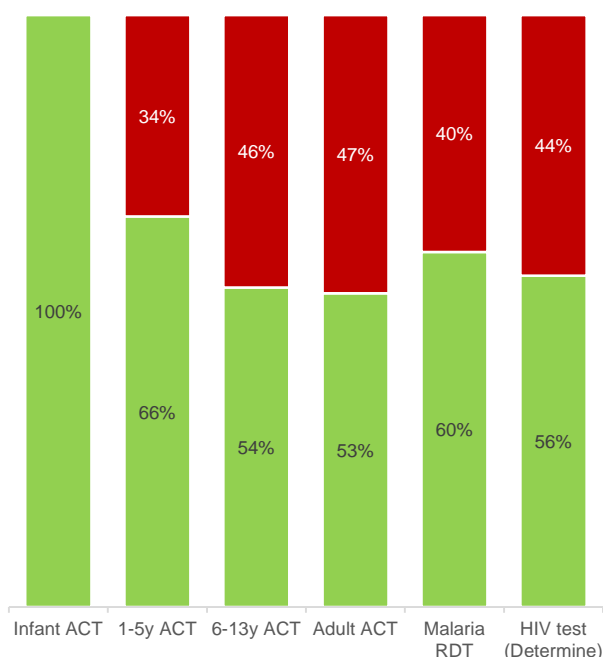


Fig. 2. Traceability of drugs dispatched from health zones.



**b) Stock control mechanisms at the central level are not optimal.**

The OIG assessed stock control mechanisms used by Sanru and Cordaid to manage Global Fund procured drugs, with a central warehouse operator used by all Principal Recipient in Kinshasa. The OIG also assessed stock control mechanisms deployed by Sanru at its own central storage site.

In both locations, the OIG found sub-optimal or missing controls around stock management, such as:

- The inability to produce a stock report for a defined time period. This reduces the ability to retrospectively reconcile stock movements, or explain potential differences found in stock taking.
- The inability to detect duplicate entries. This materialized in seven occurrences of entries listed in the stock journals for the same reception or shipment, leading to inaccurate valuation of stocks.
- The ineffective monitoring of expiry dates, and maintaining stock on a first-expired-first-out basis. This led to the presence of expiries or expiring drugs in the stock, affecting 18 different product batches.

In response to these findings, the warehouse operator contracted by all four non-governmental Principal Recipients in DRC, has established, together with Cordaid, a time-bound plan to put in place or re-inforce controls of stock management. This plan should benefit all implementers working with this warehouse operator. The OIG has not monitored the implementation of the above plan.

**Agreed management action 3**

The Global Fund Secretariat will present an analysis to the Global Fund's Supply Chain Task Force of on-going and planned actions and pilot initiatives to strengthen the DRC supply chain arrangements for HIV and malaria health products financed by the Global Fund.

The analysis will describe expected results, timelines, and the geographical focus of the actions and will cover warehousing, distribution and the last mile delivery arrangements managed by SANRU and Cordaid. The work will include a risk assessment and mitigation response options of the current last mile distribution arrangements for ACT and ART commodities. The analysis will also present options for the Global Fund in collaboration with other partners to sponsor a transformative supply chain project for essential medicines under the leadership of the government of DRC, in line with the new National Supply Chain Strategy.

**Owner:** Mark Edington, Head of Grant Management Division

**Implementation date:** 28 February 2017

## 2.2. Stock management controls at health facility level

**In the absence of effective programmatic supervision, defined accountability for drugs consumption, and formal transportation arrangements from the central level to the health facilities, stock-outs are pervasive along the supply chain and expiries of drugs are not controlled.**

The DRC portfolio consists of material amounts of drug procurement which are channeled through local supply chain mechanisms managed by civil society implementers. Stock-outs and expiries of drugs were noted at all levels of the supply chain by the OIG. At the central level, the OIG reviewed the latest inventories and found low stock levels (below the buffer stock levels for certain drugs). At the regional level, the OIG observed that one of the country's largest regional warehouses, in Kinshasa, was out of stock of all formulations of artemisinin-based combination treatment on the day of the OIG visit.

Based on this, the OIG assessed whether other regional warehouses had been affected, and found documentary evidence at the Principal Recipient, Sanru, that three out of 19 regional warehouses were out of stock of all artemisinin-based combination treatment medicines at the time of the audit. The OIG confirmed the stock-outs by visiting one of the three regional warehouses and also observed stock-outs on the day of its visit in one health zone and four health facilities.

The OIG performed a documentary review to assess whether there had been any stock-outs at the health facility level in the 15-month period prior to the audit (January 2015-March 2016). The OIG found that certain types of drugs were often unavailable. The different formulations of artemisinin-based combination treatment were out of stock for one to four months on average. HIV tests and certain types of antiretroviral treatment drugs were unavailable for up to two months on average. Anti-tuberculosis drugs were also affected, with stock-outs of up to a month in one hospital. These stock-outs were pervasive and affected both reference hospitals, and health centers.

Table 1. Average number of days of stock-out over a 15-month period, from January 2015 to March 2016

Product	General reference hospitals	Health centers
Infant ACT	49 days	143 days
1-5 year ACT	89 days	138 days
6-13 year ACT	30 days	68 days
Adult ACT	42 days	36 days
Rapid diagnostic test (malaria)	53 days	48 days
Unigold (HIV test)	59 days	44 days
Determine (HIV test)	7 days	24 days

In addition, the OIG also found ineffective mechanisms to account for, control and monitor expiries. Of all the facilities visited by the OIG, only one had a procedure in place for handling expired drugs. In the absence of such procedures, 60% of facilities did not keep a log of expired drugs. Where such a log was available, the OIG was able to identify expiries across all product lines tested, except anti-tuberculosis drugs. At the health zone level, the OIG also observed the absence of procedures for handling expired drugs, with those stored in substandard environments with weak access control, and environmental control. In one health zone, the OIG found drugs that had expired three years ago, still awaiting destruction.

The design of the current supply chain arrangements, the lack of drugs traceability to patients as well as ineffective systems to monitor drug consumption and lapses in drug quantification are contributing factors to the pervasive stock-outs identified by the OIG.



### **Supply chain arrangements are not designed to mitigate the risk of loss of goods.**

Formal distribution mechanisms exist between the central, regional and health zone levels. As described above, this leads to reliable traceability of drugs from the regional to the health zone level. However, there is no last mile transportation mechanism in place. Health practitioners are required to find solutions to bring the drugs from the health zone to the health facilities. In this context, the transfer of custody of drugs to a third party transporter is not always formalized at this lowest level of the supply chain.

Drug transportation relies sometimes on informal solutions which tend to circumvent established controls. In addition, the risk of loss, damage, destruction, diversion or theft of cargo, alongside the supply chain is high. This risk is commensurate with the distances covered, and the perceived value of goods being transported. It is not mitigated in the current supply chain arrangements. There remains an unmitigated risk in identifying the accountability for drug management along the supply chain. While there is a mechanism to register goods dispatched at the health zone level, and goods reception at the health facility level, there is none to register the transfer of custody to the transporter.

As an example of weak stock management, the OIG observed an emergency deployment of artemisinin-based combination treatments in April 2016 which circumvented established controls. The usual practice is to entrust the drug storage and distribution to regional warehouses and then health zones. In April 2016, the Kinshasa warehouse was out of stock. Sanru deployed US\$1.6 million worth of treatments to regional warehouses across the country. The following day, Sanru's sub-recipients collected all the artemisinin-based combination treatments from the Kinshasa warehouse, which represented six months worth of stock for further distribution. It is unclear whether the sub-recipients had sufficient storage capacity to safely store drugs awaiting distributions to health zone offices, or whether health zone offices had sufficient storage floor to house six months worth of stock. When this was flagged by the OIG as non-compliant with usual storage and distribution practices, the drugs were returned in part to the warehouse pending distribution to health zone offices based on average monthly consumption.

### **No clear accountability for tracing drugs to patients.**

The performance framework, from the central level to the health facility level, does not incentivize the accurate traceability of drugs to the patient:

- At the health facility level, the nurse is not held accountable by the pharmacist if a consumption register is not kept, and the pharmacist is not held accountable by the head nurse if he or she is unable to trace drugs dispensed to services.
- The reasonableness of drug consumption is not monitored during supervision visits carried out by health zones.
- At the highest level, per the grant agreements, Sanru and Cordaid are responsible for purchase, transport and delivery of drugs across the country; however, these Principal Recipients are not held accountable by the Country Team to trace drugs down to the last mile.

### **The system to monitor drug consumption is inadequate.**

The mechanism to ensure regular reconciliation of drug shipments and receptions by the Principal Recipients is inadequate. For example, one sheet of the health management information system forms records actual drug consumption. However, this is not actively monitored by health zones, to evaluate consumption against drug shipments.

### **There are lapses in drug quantification.**

For HIV, Cordaid has used incomplete existing stock data and an overly complex set of tools to quantify the needs of drugs for 2015-2017. There are up to nine different registers, with differently registered quantities used to quantify needs. As a result, drug orders were inadequate, with certain

orders falling below needs by up to 40% on some antiretroviral treatment commodities, orders far exceeding needs by 20% for common drugs and up to 2000% on seldom-used drugs.

Caritas has failed to properly assess the lead time in placing its orders. For example, one order of TB drugs was placed a full 12 months after completing the quantification exercise. When the order was placed, it only covered half of the quantified needs, which led to stock-outs of drugs.

The Global Fund Secretariat is exploring different options to improve Principal Recipient performance in terms of stock management and quantification. Principal Recipients have started to take steps to address these weaknesses, by setting up quantification committees at the national and provincial level. However, at the time of writing this report, these committees remained untested.

The findings of this section will be addressed by the Secretariat through the **Agreed Management Action 3**.

### 2.3. Quality Assurance mechanisms for health products.

**There are gaps in the design of quality control processes over procurement managed locally. This poses the risk of Global Fund implementers introducing substandard products into the health system.**

Global Fund grants are used to procure HIV and TB drugs through the Global Fund's Pooled Procurement Mechanism. However, Sanru manages malaria commodities procurement through its grants without recourse to pooled procurement. Malaria commodities are purchased through international providers. By nature, such locally managed procurements do not benefit from the upstream controls put in place by the Global Fund through its pooled mechanism. Therefore, to avoid the circulation of substandard health products, the Global Fund relies on the quality controls in place at Sanru to ensure that drugs procured by Sanru comply with the Global Fund's quality assurance policy.

**a) Sanru failed to recall three batches of drugs to fight opportunistic infections deemed non-conformant by a WHO prequalified laboratory, leading to circulation of non-conformant drugs for up to a year.**

Sanru released a non-conformant batch of 4.5 million tabs of paracetamol, as well as a batch of metronidazole and a batch of injectable glucose. These drugs, procured with Global Fund financing to fight opportunistic infections, were distributed to regional warehouses between April and September 2015. During the audit, the OIG noted that these batches had been tested and deemed non conformant by a WHO prequalified laboratory.

However, the Principal Recipient requested a second test by a local certification agency (Office Congolais de Contrôle). When the results of this second test showed the drugs were cleared for consumption, the Principal Recipient decided that it was sufficient to overrule the initial test, and released the batches into the health system. As a result of this finding from the OIG, the Principal Recipient launched a countrywide recall for these batches of drugs on 7 May 2016. There is a risk that the drugs recalled had already been dispensed and consumed. The OIG did not verify whether the recall was successful.

**b) Sanru has not performed quality control incoming drugs for a period of six months.**

Following the Global Fund's quality assurance policy, Sanru should quality control incoming drugs arriving at its rented central warehouse in Kinshasa. However, during the audit, OIG staff observed a cargo of Global Fund purchased drugs being offloaded into the central warehouse in the absence of Sanru's pharmacist. Upon further review, the OIG established that Sanru had failed to perform quality control reviews of incoming drugs between November 2015 and the OIG audit in April 2016. The central warehouse operator kept these drugs in a physically segregated inbound stock. This stock included 3.9 million units of malaria rapid diagnostic tests, and over 450,000 doses of injectable artesunate to treat severe malaria.

#### **Agreed management action 4**

The Secretariat will requests SANRU and Cordaid to submit, for Country Team approval, a Quality Assurance plan with a risk based receiving, inspection, sampling and laboratory testing approach, in line with WHO guidance, for health products purchased under the Global Fund malaria and HIV grants.

**Owner:** Mark Edington, Head of Grant Management Division

**Implementation date:** 31 December 2016

### 3. Control over programmatic data and grant performance

**Despite recent progress by the Global Fund to support data quality management systems, data reliability is still limited. Inaccurate data continues to be reported, leading to decisions made without optimal information.**

With the fourth largest portfolio of active grants, a high burden across all diseases, and the third largest allocation for the current period, DRC bears a strategic importance for the achievement of the Global Fund strategy and objectives. Given the mission-critical nature of this portfolio, data quality has important bearings on the Global Fund's ability to measure and report overall progress in its strategic goals across the three diseases.

The OIG field visits confirmed the unreliability of reported data in DRC. Visits to 21 health facilities and review of data for two key performance indicators (population on antiretroviral treatment and long-lasting insecticidal nets distributed) showed serious weaknesses with regards to both quality of the data compared to source documents, and internal controls around data transmission from one level to another.<sup>18</sup>

#### **a) Weak quality of data compared to source documents**

The OIG verified 6,813 HIV patient files in nine health facilities, and found that the reported number of people on antiretroviral treatment did not correspond to the number of active patient files. Two health facilities had overstated the antiretroviral treatment population by 29% and 19%, respectively, while two health facilities understated the data by 22% and 10% respectively. The remaining five health facilities assessed the anti-retroviral treatment population within 5% of the OIG verified figures.

Table 2. Reliability of reported numbers of people on ARV, against source. OIG verification of 6,813 medical files, in 9 facilities.

Health facility	#1	#2	#3	#4	#5	#6	#7	#8	#9
Health facilities reporting	233	151	587	108	356	1106	671	811	2137
Medical files	180	127	561	106	352	1152	702	897	2736
Variance	+29.4%	+18.9%	+4.6%	+1.9%	+1.1%	-4.0%	-4.4%	-9.6%	-21.9%

Limited mechanisms exist to ensure data quality including a lack of guidance from the implementers on data quality. The data quality process heavily relies on sub-recipient attendance of monthly and quarterly data validation meetings at the health zone and provincial levels, and sub-recipient reports to Principal Recipients.

The Local Fund Agent conducts data quality audits through spot-checks or on-site data verification; however, these are not done on a regular basis. For example, no independent data quality audit has been undertaken since 2012 and no regular data verification was done in 2015 across all the diseases.

The OIG found limited capacity at the data collection point, with the absence of a dedicated data clerk at facility level for data collection and reporting. In most cases, data is collected by clinical staff, already overburdened by routine clinical work.

#### **b) Sub optimal internal controls around data reporting**

Discrepancies in the number of nets distributed to key populations by 12 health facilities and the number of people on antiretroviral treatment reported by 19 health facilities provide evidence of limited controls around data transmission. The comparison between data available at the facility and the records available at upper levels showed discrepancies.

<sup>18</sup> The OIG selected two performance indicators for review: (1) routine LLIN distributed to key populations, and (2) population on ARV.

For the same period, 12 facilities recorded the distribution of 3,300 bed nets in service registers. The same facilities reported 3,343 nets distributed to the health zones. The health zones reported the higher figure of 3,433 to the provincial level. For the same period, the Principal Recipient reported a figure of 3,592 nets distributed to the Global Fund. In aggregate, this 9% upward adjustment from the source registers to the data reported to the Global Fund was not supported by documented justification.

The total antiretroviral treatment population reported to the Global Fund was 4% higher than that reported by the health facilities. In this case, 19 health facilities reported a total of 12,217 people on antiretroviral treatment, the health zones reported 12,430, and the principal recipients reported 12,663.

The existing validation process fails to ensure the reasonableness of reported data. Data validation meetings take place on a monthly basis at the health zone level and on a quarterly basis at the provincial level. However, this process mostly focuses on ensuring that targets are achieved rather than on the quality of reported data. The validation process does not focus on a verification of the primary source documents. The OIG found few examples where no report could be produced by the health facilities, although the health zones had reported a number to the upper levels. If this happens, data reports are adjusted during validation meetings. However, the records do not document the justification for these adjustments. The data reported to the Global Fund is not yet based on the national systems (DHIS2) due to the limited coverage. At present, the data reported by the Principal Recipient to the Global Fund is based on sub-recipient reports.

The lack of an effective mechanism to ensure quality data collection combined with inadequate controls results in unreliable data. The OIG can therefore not provide reasonable assurance about the quality of strategic data, which is critical for performance-based financing, a key tenet of the Global Fund model.

The OIG acknowledges ongoing actions by the Global Fund Secretariat to improve data management but their effectiveness is yet to be proved:

- support for the scale-up the electronic data collection tools (DHIS2) to improve availability of data and facilitate data reporting and analysis;
- support for the scale-up of HIV data collection system (TierNet);
- the on-going recruitment of long-term technical assistance in monitoring and evaluation, through WHO, for the HIV program to address data quality and reporting issues; and
- support to standardize data reporting tools capturing the national health indicators (HMIS), including those of the three programs funded by Global Fund.

#### **Agreed Management Action 5**

The Global Fund Secretariat will work with the Principal Recipients to develop a Monitoring and Evaluation capacity strengthening plan for the 3 diseases with a focus on data collection, quality and analysis. This plan will include appropriate strengthening measures to improve data quality such as the roll-out of DHIS 2 and TierNet systems.

**Owner:** Mark Edington, Head Grant Management Division

**Implementation date:** 28 February 2017

#### 4. Control over financial and fiduciary management.

**The design of financial controls for civil society implementers has improved since the last OIG review in 2013 and was found to be adequate in spite of marginal compliance lapses identified. In contrast, serious weaknesses were identified in management and internal control capacities at the program management unit, which handles a portfolio of US\$76.61 million on behalf of the Ministry of Health.**

In assessing the internal control framework of the four civil society principal recipients, the OIG found that the internal controls over recording, verification, and reporting processes are adequately designed. However, gaps were identified in their effectiveness as some instances of non-compliance were noted.

Procurement processes are not systematically complied with when it comes to justification for direct procurements or elimination of certain suppliers. Non-compliance with salary advance procedures and the Global Fund policies on support costs were also identified. Limited oversight of sub-recipients expenditures and not enough justification for training selections are other areas of improvement.

However, at the other Principal Recipients operating under the Ministry of Health, issues found were of a more serious nature. The portfolio is managed using the Additional Safeguards Policy to compensate for weak management and internal control capacities. These weaknesses in management and internal control capacities are most pronounced at the Program Management Unit called “Cellule d’Appui et de Gestion” (CAG). This structure was established at the Ministry of Public Health to compensate for management and internal control weakness in the national programs. However, successive reviews have showed that it is ineffective in its role:

- A prior OIG review concluded in 2013 that the CAG capacities were too weak to fulfill its role of program management unit. Furthermore, most of the OIG recommendations remain overdue.
- More recently, the External Auditor could not provide an opinion on its 2014 Financial Statement citing significant internal control weaknesses and inadequate justification of expenditures.<sup>19</sup>

##### **a) Absence of the building blocks of a control environment.**

CAG holds the responsibility of a program management unit for the Ministry of Public Health. It manages a portfolio of three grants, valued at US\$76.61 million in approved funding. However, its control environment fails in multiple areas, such as:

- CAG is not structured to meet its role as the project management unit for the Principal Recipient. It has neither procurement, internal audit, nor accounting units, it does not have accounting or budget tools, and all its financial accounting management is done by the Fiduciary Agent.
- CAG has no capacity to manage sub-recipients financial management, as demonstrated by the expiry of sub-recipient contracts, an out-of-date sub-recipient manual, inadequate control on sub-recipient expenditures, and no mechanism to control sub-recipient cash balance. For example, the OIG noted outstanding advances of US\$317,000 that were unjustified for the malaria program.<sup>20</sup>
- CAG has no reliable controls over inventory management, an inventory manual, regular physical verification and updates of its inventory list.
- A CAG 2014 audit report should have been finalized by 30 June 2015, as per the grant agreement. However, it was only finalized on 11 May 2016 due to the CAG’s inability to produce the financial statements.

<sup>19</sup> The 2014 External Audit report, dated 11 May 2016.

<sup>20</sup> According to the Fiduciary Agent, this amount has been partially accounted for in 2016, although documents supporting this statement were not received by OIG at the time of writing.

## **b) Weak procurement process in the absence of a procurement agent.**

In its 2013 advisory engagement, the OIG recommended employing a procurement agent to assist CAG in its procurements.<sup>21</sup> This recommendation has not been implemented by the Global Fund. During the recent audit, CAG was also not able to produce a comprehensive list of finalized procurements.

In addition, a review of CAG procurement by the OIG found that 21% of procurements were not compliant with CAG's own procedures, based on a US\$12 million sample. These noncompliant procurements were due to lapses in the selection process. Examples of these irregular procurements include:

- US\$713,868 for the procurement of 18 vehicles: the tenders were published locally although the procurement manual called for international tendering. The winning bidder was awarded an advance payment of 15% or US\$107,080 in spite of failing to provide a valid bank guarantee, the previous one being expired.
- US\$1,139,285 for the procurement of re-agents: at the time of the audit only 50% of goods had been delivered; however, despite the absence of valid bank guarantee, the previous one being expired, 80% of the payments had been made through an advance payment of US\$512,678 (which represent an advance of 45% and not 10% as required by the tender documents) and a deposit of US\$398,750.

## **c) The role of fiduciary agent**

To mitigate the financial and fiduciary risk, the Global Fund put in place a Fiduciary Agent in 2012 with a view to building stronger financial management capacity. The first agent was replaced in 2014 because of weak performance. The new Fiduciary Agent has been in place since March 2015.

The OIG found that the current Fiduciary Agent performs their control role but is not yet able to build CAG capacity as a recent capacity building plan was put in place. Furthermore, the Fiduciary Agent action plan has not been executed and the agent has assumed the role of an accounting unit for CAG.

### **Agreed Management Action 6**

The Global Fund Secretariat will transmit to the 'Cellule d'Appui et de Gestion (CAG)' within the Ministry of Health, a set of minimum performance requirements (financial and procurement) to be implemented in order for the CAG to continue to be considered as PR.

**Owner:** Mark Edington, Head of Grant Management Division

**Implementation date:** 31 December 2016

### **Agreed Management Action 7**

The Global Fund Secretariat will complete an assessment of the 'Cellule d'Appui et de Gestion (CAG)' within the Ministry of Health to determine progress against the set of minimum requirements communicated to the CAG. The assessment's findings and recommendations will inform a plan of action.

**Owner:** Mark Edington, Head of Grant Management Division

**Implementation date:** 31 December 2017

<sup>21</sup> The advisory report on key financial and procurement controls in place over grants to the Democratic Republic of the Congo was performed at the request of the Global Fund secretariat. It sought to provide assurance over the design and adequacy of the key controls in place at the time of finance and procurement matters, and found weaknesses in both due to weak capacity of the project management unit. In accordance with the policy for disclosure of OIG reports enforced at the time, the report was not published on the Global Fund website.

## V. Table of Agreed Actions

Agreed Management Action	Target date	Owner
<p>Agreed Management Action 1</p> <p>The Global Fund Secretariat will work with the Principal Recipients Ministry of Health, SANRU, Cordaid and Caritas to develop an integrated supervision plan for HIV, TB and malaria services supported by the Global Fund. This plan will include:</p> <ul style="list-style-type: none"> <li>▪ TORs for supervision at national, intermediate and peripheral levels conducted jointly by the Ministry and civil society PRs, including joint TB/HIV supervision;</li> <li>▪ Supervisions guides and reporting tools; and</li> <li>▪ Follow up mechanisms on the recommendations coming from supervision findings.</li> </ul>	31 March 2017	Mark Edington, Head Grant Management Division
<p>Agreed Management Action 2</p> <p>The Global Fund Secretariat will conduct a cost reasonableness analysis of PR expenditures. The analysis will cover SANRU, Caritas, Cordaid and PSI and will include a cross-PR comparison of unit cost categories for: HR costs and numbers; LLIN prices; storage and distribution; and daily subsistence allowances.</p>	30 June 2017	Mark Edington, Head of Grant Management Division
<p>Agreed management action 3</p> <p>The Global Fund Secretariat will present an analysis to the Global Fund's Supply Chain Task Force of on-going and planned actions and pilot initiatives to strengthen the DRC supply chain arrangements for HIV and malaria health products financed by the Global Fund.</p> <p>The analysis will describe expected results, timelines, and the geographical focus of the actions and will cover warehousing, distribution and the last mile delivery arrangements managed by SANRU and Cordaid. The work will include a risk assessment and mitigation response options of the current last mile distribution arrangements for ACT and ART commodities. The analysis will also present options for the Global Fund in collaboration with other partners to sponsor a transformative supply chain project for essential medicines under the leadership of the government of DRC, in line with the new National Supply Chain Strategy.</p>	28 February 2017	Mark Edington, Head of Grant Management Division
<p>Agreed management action 4</p> <p>The Secretariat will requests SANRU and Cordaid to submit, for Country Team approval, a Quality Assurance plan with a risk based receiving, inspection, sampling and laboratory testing approach, in line with WHO guidance, for health products purchased under the Global Fund malaria and HIV grants.</p>	31 December 2016	Mark Edington, Head of Grant Management Division



<b>Agreed Management Action</b>	<b>Target date</b>	<b>Owner</b>
<p>Agreed Management Action 5</p> <p>The Global Fund Secretariat will work with the Principal Recipients to develop a Monitoring and Evaluation capacity strengthening plan for the 3 diseases with a focus on data collection, quality and analysis. This plan will include appropriate strengthening measures to improve data quality such as the roll-out of DHIS 2 and Tiernet systems.</p>	28 February 2017	Mark Edington, Head Grant Management Division
<p>Agreed Management Action 6</p> <p>The Global Fund Secretariat will transmit to the 'Cellule d'Appui et de Gestion (CAG)' within the Ministry of Health, a set of minimum performance requirements (financial and procurement) to be implemented in order for the CAG to continue to be considered as PR.</p>	31 December 2016	Mark Edington, Head of Grant Management Division
<p>Agreed Management Action 7</p> <p>The Global Fund Secretariat will complete an assessment of the 'Cellule d'Appui et de Gestion (CAG)' within the Ministry of Health to determine progress against the set of minimum requirements communicated to the CAG. The assessment's findings and recommendations will inform a plan of action.</p>	31 December 2017	Mark Edington, Head of Grant Management Division

## Annex A General Audit Rating Classification

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

## Annex B: Methodology

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

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

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

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

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

## Annex C: Message from the Executive Director

The Global Fund pays special attention to safeguarding investments with the goal of making all resources count. The Global Fund has zero tolerance for corruption or fraud. When any misspent funds are identified, the Global Fund pursues recovery, so that no donor money is lost to fraud or ineligible expenses.

The Office of the Inspector General (OIG) is an integral and important part of risk management and controls, conducting independent audits and investigations to complement the active risk management and controls put in place by the Secretariat with oversight by the Board of the Global Fund.

I want to thank the Office of the Inspector General for the insight in this audit report on Global Fund grants to the Democratic Republic of Congo (DRC), which raises concerns that we have already taken steps to address. The audit also cites the strong progress in several areas since the previous OIG audit in 2013.

For HIV, DRC has substantially increased the number of people on antiretroviral treatment, and new data show that the number of deaths from HIV decreased by 59 percent, and HIV incidence decreased by 84 percent, since 2000.

New data also show that deaths from malaria are down 75 percent in DRC since 2000, in part from successive mass distribution campaigns of mosquito nets. DRC is now on track to achieve universal coverage of nets in 2017, up from 9 percent in 2007. For TB, success rates for TB treatment reached 89 percent in 2015. Overall, the mortality rate for children under five decreased from 158/1000 in 2010 to 104/1000 in 2013, the most recent year for which data are available.

To make significant advances in implementation, the Global Fund is working on several groundbreaking partnerships in DRC with local experts and with the U.S. Government, the UK Government, UNICEF, Gavi, the World Bank and others. They include a geographical rationalization of program coverage, performance-based funding, reforms in the Ministry of Health, supply chain optimization and others.

The Global Fund follows strict standards and has initiated corrective actions to mitigate the risks of loss of goods. Regular audits are critical to ensuring the continued improvement of systems and quality of services provided through Global Fund-supported programs.

### **Findings**

A routine audit by the OIG of Global Fund grants to DRC found that despite a challenging operating environment, significant progress in the effectiveness of implementation arrangements of grants was achieved. The audit identified areas for improvement, and highlighted challenges in DRC faced by all development partners, not just the Global Fund.

The audit report did not identify any potential amounts to be recovered due to ineligible or undocumented transactions, and comes at a time when financial controls in DRC grants are proving strong and effective.

The audit recognized strong progress in enhancing supply chain and data reporting management systems and mitigating financial risks. For instance, the OIG found that 96.7 percent of products are effectively warehoused and transported all the way from port to the health zone level, with 3.3 percent non-traceable, an impressive achievement in a challenging operating environment.

The audit also identified gaps in the design of quality control processes over procurement managed locally, leading to irregular stocking of health facilities and expiries of medicines. The OIG audit on DRC found that 12 percent of the facilities visited did not perform any test before putting patients on treatment, suggesting that 88 percent of facilities did so, surpassing the national target of 80 percent.

The audit acknowledged the strengthening measures introduced by the Global Fund to implement effective data collection mechanisms, but discrepancies in data reporting remain a challenge. However, the audit does not identify any areas of falsified data.

The audit also found persistent challenges in the 'last mile' of delivery, a steep challenge for all health partners, not specific to the Global Fund. The audit rated supply chain arrangements as "ineffective" because 31 percent of products had inadequate tracing on the final leg of delivery, typically meaning a village-level health facility. 'Inadequate tracing' does not refer to losses, but to inadequate documentation.

## **Actions Taken**

The Global Fund has been strengthening its work managing grants to DRC over the past two years, improving the overall quality of supervision and increasing the number of people working on monitoring grants. The Global Fund has established a risk-based oversight strategy for all local procurement that uses money from Global Fund grants, so that a cohesive and effective approach is in place.

It appointed a Fiscal Agent, with a team of 45 people in DRC, to control and monitor expenses in real-time. At the Global Fund headquarters, the size of the country team working on DRC grants more than doubled, from 6 people to 13.

The Global Fund is working with the Principal Recipients Ministry of Health, SANRU, CORDAID and Caritas to develop an integrated supervision plan for HIV, TB and malaria services supported by the Global Fund. For health products purchased with malaria and HIV grants from the Global Fund, SANRU and Cordaid will submit a Quality Assurance plan with a risk-based receiving, inspection, sampling and laboratory testing approach, in line with WHO guidance.

The Global Fund will present an analysis to the Global Fund's Supply Chain Task Force of ongoing and planned actions and pilot initiatives to strengthen the DRC supply chain arrangements for HIV and malaria health products financed by the Global Fund.

The Global Fund Secretariat will also work with the Principal Recipients to develop a Monitoring and Evaluation capacity strengthening plan for the 3 diseases with a focus on data collection, quality and analysis.

The Global Fund Secretariat will transmit to the 'Cellule d'Appui et de Gestion (CAG)' within the Ministry of Health a set of minimum performance requirements (financial and procurement) to be met by 30 June 2017 in order for the CAG within the Ministry of Health to continue to be considered as Principal Recipient. Progress against these requirements will be monitored by the Secretariat and will represent the basis for further decisions.

Actions taken have not been limited to DRC. A series of reforms at the Global Fund include building a comprehensive risk framework, a new allocation model, more proactive risk management, increased controls and coordinated management measures focused on achieving impact.

Fiduciary risk is not the only risk in countries like DRC. As part of the Global Fund's proactive approach to risk management, we identified and launched several organizational priority projects – Accelerated Integration Management (AIM), Differentiation for Impact and Implementation

through Partnership (ITP) – that are having a transformational impact on grant-making and on the effectiveness of our programs. A newly formed project management team has been tasked with tracking progress and ensuring coordination.

In July 2016, the Global Fund submitted a Prioritized Action Plan to the Board that outlined coordinated steps toward effective risk management. Embedding risk management in the culture of the Global Fund partnership includes building the systems and controls to identify, mitigating, evaluating, responding in real time to inevitable changes and regularly reporting on risks and controls at all levels. The Prioritized Action Plan provided a platform to bring together all efforts into one cohesive whole and an accountability framework for top management and Board oversight to help enable and ensure success is achieved.

Publishing this and other OIG reports demonstrates our strong commitment to transparency and accountability, a key element of driving change in countries for better fiduciary responsibility and health outcomes. The Global Fund is a leader in transparency – the 2016 Aid Transparency Index rated the Global Fund in the top five of all international aid organizations.

Managing risk, identifying problems and addressing them forcefully is core work for the Global Fund, and proactive work in DRC is just one instance. The overarching goal is to resolve systemic problems in order to reduce further risk in the years ahead.

Respectfully,

Mark Dybul

Executive Director