



THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

## **Audit of Global Fund Grants to the Republic of Angola**

### **Report**

**GF-OIG-12-002**

**7 September 2012**

**TABLE OF CONTENTS**

**EXECUTIVE SUMMARY ..... 1**  
**MESSAGE FROM THE GENERAL MANAGER OF THE GLOBAL FUND ... 3**  
**MESSAGE FROM THE COUNTRY COORDINATING MECHANISM ..... 5**  
**OVERVIEW ..... 6**  
**OVERSIGHT ..... 8**  
**PROCUREMENT AND SUPPLY CHAIN MANAGEMENT ..... 12**  
**FINANCIAL MANAGEMENT AND CONTROLS.....17**  
**PROGRAM REVIEW ..... 22**

**ANNEXES**

- Annex 1: Abbreviations**
- Annex 2: Summary of Global Fund Grants to Angola**
- Annex 3: Background and Context**
- Annex 4: Recommendations and Management Action Plan**

### **EXECUTIVE SUMMARY**

#### Introduction

1. As part of its 2012 workplan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to Angola from 16 April to 24 May 2012. The audit covered two grants (Round 7 malaria and Round 9 tuberculosis) totaling USD 40 million, of which USD 28 million had been disbursed from 1 November 2008 (the inception date of the malaria Round 7 grant) to 15 February 2012. The Principal Recipient was the Ministry of Health.

2. Three earlier grants were managed by the United Nations Development Programme.<sup>1</sup> Since expenditures incurred directly by UNDP were subject to UNDP's internal and external audits, these were not covered by the OIG audit. Also, the OIG audit focused only on grants from Round 6 forward.

3. Risks to the portfolio included: (i) implementation of the Global Fund grant using a project approach, frequently implemented in parallel to existing activities of the Ministry of Health (with dependence on contracted technical staff that gave rise to risks relating to sustainability); (ii) the limited qualifications held by staff (in program and financial management) in the public health sector; (iii) frequent stock-outs of key commodities (medicines, diagnostics, laboratory reagents and long-lasting bed nets); (iv) the oversight of distribution of malaria health products (drugs and diagnostic tests); and (v) long transitions between Phase 1 and 2 of Global Fund grants.

#### Overall conclusion

4. There was scope for grant recipients to more consistently apply controls to manage key risks in the financial management area. The Global Fund Secretariat needs to work with the PR to improve financial management capacity of sub-recipients as well as the Principal Recipient's capacity to provide an appropriate level of oversight and supportive supervision of sub-recipients. Grant oversight arrangements need to be improved by involving national oversight institutions and strengthening the role and quality of work of assurance providers such as external auditors and the Local Fund Agent.

5. Based on the findings in this audit, the OIG is not able to provide the Global Fund Board with reasonable assurance over the effectiveness of controls in place to manage financial risks impacting the Global Fund-supported programs. Firm commitments have been made by stakeholders to take action to mitigate the risks identified. The OIG offers 17 recommendations categorized as "Critical" and 12 categorized as "Important".<sup>2</sup>

#### Oversight

6. There was scope for the CCM to strengthen its oversight of the grants by (a) obtaining the necessary funding to support its oversight activities; and (b) activating the four CCM technical working groups established to support its oversight function. Further, there was a need for the Local Fund Agent to have staff based in the country to facilitate its review activities and strengthen its interaction with the Principal Recipient, the CCM and implementing organizations. Finally, there was scope for national oversight institutions such as the Tribunal de Contas and the Health Inspectorate of the Ministry of Health to be involved in the oversight of the grants.

#### Financial Management

7. There was a need for improvement in financial management and internal controls at all grant implementing organizations audited, and specifically strengthen the accounting systems, book-keeping and internal controls. The audit findings point to a need for sub-

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<sup>1</sup> Malaria Round 3, TB Round 4, and HIV/AIDS Round 4.

<sup>2</sup> Please see the Overview section for a definition of these categories.

## **Audit of Global Fund Grants to Angola**

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recipients to recruit qualified accountants and for the Ministry of Health/Unidade Técnica de Gestão do Fundo Global to strengthen its financial oversight over Sub-Recipients.

### Malaria

8. A comprehensive national strategy for malaria control (Plano Estratégico Nacional 2011-2015) has been developed. The strategy includes treatment of malaria cases after confirmation of diagnosis, distribution of bed nets at ante-natal care clinics and through social marketing and indoor residual spraying. During the first phase of Round 7 (November 2008 through January 2011), significant progress in malaria control was made with training and supervision. Outcome measurement was done through Malaria Indicator Surveys in 2006 and 2011. However, sustainability of activities supported by the Global Fund was not ensured due to lack of integration of Global Fund-supported activities within the National Malaria Program (i.e., project staff worked in parallel to National Malaria Program staff).

### Tuberculosis

9. At the time of the audit, the Ministry of Health and the National Tuberculosis Program had not yet started implementing the Round 9 tuberculosis grant. The audit team therefore sought to identify key risks which the grant was exposed to and make recommendations for risk mitigation. Key programmatic challenges included: (a) limited access to tuberculosis services by the population due to an inadequate number of treatment centers and laboratory facilities; (b) insufficient application of the principles of Directly Observed Treatment, Short-Course in Angola; (c) shortages of tuberculosis medicines; and (d) limited facilities for diagnosis and treatment of multi-drug resistant tuberculosis. The tuberculosis program was highly dependent on Global Fund support and had limited funding from government and development partners.

### Quality Concerns

10. There was scope for the Ministry of Health to establish a modern and efficient quality control laboratory and to develop, adopt and implement a Quality Assurance Policy for all types of health products. In addition, frequent and more detailed testing, in both the private and the public sector, should be conducted. Stronger regulation of the healthcare and pharmaceutical sectors in particular would be desirable.

### Data for Decision-making

11. During Phase 1 of the Round 7 malaria grant (1 November 2008 to 31 January 2011), procurement of health products was carried out by WHO (malaria drugs and diagnostic tests), UNICEF (bed nets), and PSI (bed nets for social marketing). Quantification at the time did not consider that non-confirmed cases of malaria still received treatment. Furthermore, the data collected at peripheral health facilities on the number of malaria cases, the number of diagnostic tests, stock levels, and drug consumption were often not reliable. There was a need for improvement in monitoring and evaluation at all levels in line with findings of the 2010 on-site data verification.

### Stock-Outs

12. The above findings on forecasting and data quality contributed to stock-outs. In addition, anti-tuberculosis medicines were financed by the Government of Angola and played a critical role in the success of the program. Unfortunately, there were frequent stock-outs from 2010 to May 2012. There was significant scope to improve availability of drugs, particularly given that the scale-up of tuberculosis services under the Round 9 TB grant will increase the number of patients who need medicines.

### Transition from Phase 1 to Phase 2

The long transition between the end of Phase 1 in January 2011 and the beginning of Phase 2, which had not started as at May 2012, contributed to the drug supply situation and affected program outcomes.

## MESSAGE FROM THE GENERAL MANAGER OF THE GLOBAL FUND



10 YEARS  
OF IMPACT

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### MESSAGE FROM THE GENERAL MANAGER

I would like to thank the Office of the Inspector General for its thorough and insightful work on the audit of Global Fund grants to the Republic of Angola.

The audit was carried out between April 16 and May 24, 2012 and covered two grants (Round 7 malaria and Round 9 tuberculosis), totalling US\$40 million. Of that, US\$ 28 million was disbursed from November 1, 2008 (the inception date of the malaria Round 7 grant) to February 15, 2012.

The implementation of the Round 9 tuberculosis grant had not started yet at the time of the audit. For that reason, the team focused on identifying key risks and making recommendations for their mitigation.

Angola has developed a comprehensive national strategy for malaria control for 2011–2015. During the first phase of the Round 7 grant (November 2008 through January 2011), training and supervision contributed to significant progress in the disease's control. The sustainability of Global Fund supported activities, however, has been jeopardized by lack of integration of grant project arrangements within the country's National Malaria Program.

On tuberculosis, the audit report points out that the program is highly dependent on Global Fund support, with limited funding from the government and other development partners. In addition, programmatic aspects and financial management need to be strengthened.

The audit also found scope for improvement in grant oversight, financial management, and internal controls at all levels. Specifically, there is a need to strengthen the accounting systems, book-keeping, and internal controls. Quality control and data collection also require attention. Inaccurate information collected at peripheral health facilities has contributed to stock-outs of medicines, which were frequent from 2010 to 2012. The audit identified significant scope – and need – to improve the availability of drugs, as the scale-up of tuberculosis services under the Round 9 grant will increase the number of patients requiring medication.

## Audit of Global Fund Grants to Angola

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To address such challenges, the report makes 29 recommendations. Some of them are already under implementation.

Audit reports by the Office of the Inspector General are an essential form of quality control for the Global Fund. The Office of the Inspector General plays an indispensable role in helping us all achieve our mission of effectively investing the world's money to save lives.

Yours sincerely



**MESSAGE FROM THE COUNTRY COORDINATING MECHANISM**

The Angola Country Coordinating Mechanism was not in a position to issue a message for inclusion in this report.

The CCM has informed the OIG that because of recent elections in Angola it cannot complete a number of responses to this report until mid-October at the earliest, since they depend on the finalization of new government structures.

As a result, the response to certain action items in the Management Action Plan reads as follows, "This recommendation depends on Government institutions and at this time the country is in transition with elections being held on 31 August 2012. The new Government is expected to be in place in October 2012 after which an appropriate response will be provided." In addition, the CCM says that the due dates for some action items may need to be revised.

## Audit of Global Fund Grants to Angola

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### OVERVIEW

#### Audit Objectives

13. The objectives of this audit were to assess the adequacy and effectiveness of the controls in place to ensure:

- Achievement of value for money from funds spent;
- Accomplishment of programmatic objectives including quality of service provision;
- Compliance with Global Fund grant agreements, related policies and procedures, and relevant laws and regulations;
- Safeguarding of grant assets against loss, misuse or abuse; and that
- Risks were effectively managed.

In undertaking this audit an important focus was to identify opportunities to strengthen grant management.

#### Audit Scope

14. The audit examined the operations of the Principal Recipient (PR), their interactions with its Sub-Recipients (SRs) and implementing partners, the supply chain for goods and services purchased with the Global Fund Grant funds, and the oversight functions of the Country Coordination Mechanism (CCM), the Local Fund Agent (LFA) and the Global Fund Secretariat. The Principal Recipient was the Ministry of Health (MINSA). The key sub-recipients for the malaria program were the National Malaria Program (PNCM), Population Services International (PSI), the World Health Organization (WHO), and the United Nations Children's Fund (UNICEF). The designated sub-recipients for the TB program were Programa Nacional de Controlo da Tuberculose (PNCT) and Collegio Universitario Aspiranti Medici Missionari (CUAMM).

15. The audit covered two Global Fund grants to Angola shown below. The audit sampled transactions from November 2008 to January 2011.

Disease Round &	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
Malaria Round 7	Ministry of Health (MINSA)	AGO-708-G04-M	32,512,648	27,171,691
Tuberculosis Round 9	Ministry of Health (MINSA)	AGO-911-G05-T	6,357,572	966,144
<b>Total</b>			<b>38,870,220</b>	<b>28,137,835</b>

*Table 1: Global Fund grants to Angola audited by the OIG (Source: Global Fund website, 24 May 2012)*

16. At the time of the audit, implementation of Round 9 tuberculosis activities had not started. For the TB portfolio, the audit focused on key risks to implementation and makes recommendations for risk mitigation where weaknesses and gaps were found in the current risk response.

17. The Office of the Inspector General (OIG) used the following approaches to conduct its work: Discussions with program and financial personnel of relevant grant recipients, review of grant program documents, monitoring/supervision reports, implementation and procurement plans, examination of supporting documents for grant expenditures as well as program and financial progress reports.

18. In addition to audit tests carried out at the national/central level, the audit team visited a sample of program sites at provincial, municipal and peripheral levels in five provinces (Cabinda, Huambo, Malanje, Kwanza Norte and Bengo) and the capital city, Luanda. During the field visits the audit team carried out tests and made observations at provincial and municipal hospitals, health centers, health posts, as well as at provincial and municipal pharmacies.

19. UNDP was the Principal Recipient for three grants. Since expenditure incurred directly by the PR covered early grant rounds which were subject to UNDP's internal and external audits, they were not covered by this review.

### **Prioritization of Audit Recommendations**

20. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. The recommendations have been prioritized as follows to assist management in deciding on the order in which recommendations should be implemented:

(a) **Critical**: There is a material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization interests, erode internal controls, or jeopardize the achievement of aims and objectives. It requires immediate attention by senior management.

(b) **Important**: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

(c) **Desirable**: There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of good practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

### **Letter to Management**

21. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. However, not all audit observations have the same urgency or priority. Audit findings deemed 'desirable' have been reported separately in a Letter to Management. This "Letter to Management" lists audit findings that constitute a less significant control weakness or noncompliance within the system, which require remedial action within an appropriate timescale. The adoption of best practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs. Though these findings and recommendations do not warrant immediate action, their implementation would help to strengthen the overall control environment for Global Fund-supported programs. The OIG would expect Management at the Global Fund Secretariat and/or the PRs to follow up as appropriate.

### **OVERSIGHT**

There is scope for the CCM to strengthen its oversight of the grants by (a) obtaining the necessary funding to support its oversight activities; and (b) activating the four CCM technical working groups established to support its oversight function. There is also the need for the Local Fund Agent (LFA) to have staff based in the country to facilitate its review activities and interaction with the Principal Recipient, the CCM and implementing organizations. And there is need for national oversight institutions such as the Tribunal de Contas and MINSA's health inspectorate department to be involved in the oversight of the grants. There is also scope for the Global Fund Secretariat to engage the CCM and MINSA to develop and implement a time-bound action plan to integrate contracted Global Fund project staff in the PNCM and PNCT as regular government staff.

### **Country Coordinating Mechanism**

22. CCM membership was renewed in April 2012 and complied with Global Fund regulations. To strengthen its governance and grant oversight role, the CCM received technical support in 2011 from Grant Management Solutions (GMS). CCM internal regulations were revised to strengthen its functioning. Since September 2011, the CCM had been active and regular meetings had taken place. However, four technical working groups established to support the CCM were not yet functional. Further, an oversight plan drawn up had not yet been implemented and thus supervisory field visits to monitor program implementation had not taken place. According to CCM officials supervisory visits had not taken place because of inadequate funding for CCM oversight activities.

23. In August 2011, a CCM Secretariat independent of the Program Management Unit (UTG) of MINSA was established and staffed with contracted personnel with financial support from the Global Fund, the Government of Angola and USAID. There is scope to improve the sharing of information and communication between the national programs, the UTG and the CCM Secretariat, since key information concerning the grants, e.g., PUDRs, program updates, and external audit reports were not routinely shared with the CCM Secretariat. There is scope for the national programs and the program management unit to keep the CCM Secretariat better informed of all issues affecting the grants.

### **Local Fund Agent**

24. Grant Thornton became LFA for the Global Fund-supported programs in January 2009. PricewaterhouseCoopers had served as the LFA from the beginning of the grant programs in Angola in April 2005. The handover note from PwC to Grant Thornton was comprehensive, detailing key programmatic and PSM issues facing the grants. At the time of the audit, Grant Thornton's LFA Team for Angola was based in various countries including Mozambique and the USA. During the nearly two and half years it had served as LFA, three team members had stayed in Angola, on a short-term basis, for two to six months. In March 2012, a local M&E specialist was recruited by Grant Thornton.

25. The absence of a country-based team to interact regularly with PR and SR staff and respond to their queries was a contributory factor to delays in the delivery of LFA services. In May 2012, the Global Fund Secretariat retendered the Angola LFA contract.

### **Global Fund Secretariat**

26. There was a financing gap of 17 months between the end of Phase 1 (31 January 2011<sup>3</sup>) and the start of the Phase 2 grant program<sup>4</sup>. The gap in funding may have contributed to the resignation of eight out of the 18 Global Fund grant-financed provincial malaria program supervisors. Staff demotivation and unavailability of appropriate technical staff could lead to the achievements of the malaria program being compromised. The funding gap may also have contributed to stock outs of ACTs, Rapid Diagnostic Tests and LLINs, which were observed by the audit team during field visits to health facilities and warehouses.

27. There had been on average a new FPM every year since 2009. Program officials interviewed said that this high turnover was a contributory factor for delayed grant management actions of the Global Fund Secretariat such as late disbursements to the PR. In addition, the LFA in its response to the performance assessment by the Global Fund Secretariat cited the high turnover<sup>5</sup> of grant management staff for the Angola grant portfolio at the Global Fund Secretariat and lack of feedback for work done in the area of procurement. Hence, there is a need for the Global Fund Secretariat to reduce the high turnover of its grant management staff for the Angola portfolio.

28. PR capacity assessments did not cover key sub-recipients, for example, PNCM.

### **The Principal Recipient (MINSa)**

#### The Program Management Unit (UTG)

29. The Program Management unit (UTG) was set up for the sole purpose of coordinating program and financial management of all the Global Fund grants. Established in mid-2008 when the decision was made to transfer the management of the Global Fund grants from UNDP to the MINSa, the UTG was under the direct responsibility of the Director of Planning and Health Statistics in the MINSa. It was staffed by contracted personnel under the leadership of a Program Coordinator. It provided oversight of grant implementing units of the MINSa (PNCM and PNCT) and other sub-recipients (PSI, UNICEF and WHO).

30. To strengthen its capacity, in October 2011, it received technical assistance from Grant Management Solutions. With increasing workload due to additional grants (Round 9 TB and Round 10 malaria consolidated with Phase 2 of Round 7 malaria grant into a single stream funding) it had been planned to augment the technical and financial management capacity of the UTG. Two new positions were recommended that had been budgeted for: a financial controller reporting to the Director of Planning and Health Statistics in the MINSa and a deputy coordinator.

31. Quarterly supervisory visits and assessments of services and programs at provincial and municipal level health facilities were reduced due to inadequate funds for supervision when the Phase 1 of the malaria grant ended in January 2011. Program officials confirmed that there was limited budget at the provincial level for supervision of peripheral health facilities and municipal warehouses.

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<sup>3</sup> There was a three-month extension after the initial end date of October 2010 to 31 January 2011.

<sup>4</sup> Phase 2 of the Round 7 malaria grant was consolidated into a single stream funding with the new Round 10 malaria grant. This was signed on 15 June 2012.

<sup>5</sup> The LFA stated that from November 2008 through May 2012 it was challenging for it to work with three Fund Portfolio Managers, three program officers, five finance specialists and three M&E specialists.

## **Audit of Global Fund Grants to Angola**

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32. The audit team noted that the capacity of UTG to provide sufficient oversight and supportive supervision of sub-recipients was inadequate as it had only two accounting staff.

### **Assurance Providers**

#### Internal Audit

33. There was no internal audit unit in MINSA to provide audit oversight.

#### Inspecção Geral de Saúde

34. The Inspectorate General of Health of the MINSA did not provide oversight of the Global Fund grants. Its mandate had been limited to inspection of health facilities, sanitation and oversight of the private pharmaceutical sector. Until 2010, its staffing consisted mainly of physicians and nurses. However, from 2011, following enactment of new statutes governing and regulating the pharmaceutical sector, it had established new units that would provide additional oversight of pharmaceutical procurement and financial management areas of the MINSA. The Minister of Health nominates/appoints the Inspector General of Health. In the provinces inspectorate staff report to the Directors of the Provincial Health Services. Therefore its independence is limited. Its oversight of anti-malaria drugs and RDTs bought with grant funds was limited to verification of certificates of origin and pre-shipment quality control when medicines and health supplies arrived at the country's ports. The audit team learned that the capacity of the Inspectorate General of Health was being strengthened through staff training programs with partners in Brazil and Portugal. It had been planned to extend inspection activities to all programs of MINSA when a multi-disciplinary staff including pharmaceutical professionals have been recruited.

#### The Drug Regulatory Authority: DNME

35. DNME is the drug regulatory authority in the country and it operated under MINSA. It was responsible for quality control testing and monitoring of all medicines and health supplies imported into the country or produced locally. The audit team learned that routine testing of medicines and health products did not take place because there was no laboratory in the country with the capacity to do quality control tests. Therefore in practice DNME did not perform quality control testing for lack of a laboratory with the needed technical capacity. Its oversight was therefore limited to verification of existence of certificates of origin and quality and registration of importation of medicines. DNME was collaborating with MSH in training and capacity-building of warehouse managers to improve drug management and development of integrated supervision tools for provincial warehouses and pharmacy units of public health facilities.

### **Other Assurance Providers**

#### Tribunal de Contas

36. Established in 2002, to enhance transparency and accountability in the public sector, the Tribunal de Contas has statutory responsibility for providing oversight of public sector procurement with estimated cost of USD 1.0 million or more. It had not exercised its mandate over Global Fund grants to the MINSA. The OIG was informed that it could be encouraged to do so. The Tribunal de Contas had professional staff of 240 that included procurement, financial specialists, auditors and engineers. It outsourced additional competencies based on the needs of assignments. It has also prosecutorial and judicial

powers. There is therefore scope to engage with the Tribunal de Contas in the oversight of Global Fund grants, after a capacity review.

### External Audit

37. External audit of the Round 7 malaria grant program was carried out annually by Deloitte Angola. A number of the areas for improvement noted in the financial management section of this report were similarly raised by the external auditors. These included: (i) bank reconciliations, preparation and revision; (ii) missing supporting documentation and (iii) the need for regular petty cash. However, there was scope for the external auditors to have been more proactive in pointing out the need for a good accounting system at the PNCM, and the need to strengthen accounting staff capacity at sub-recipients. Further, this indicates the need for more substantive quality work by external auditors at the level of sub-recipients.

### **Recommendation 1 (Critical)**

*The CCM should:*

- a) *Seek operating funds to enable it to perform its governance, coordination and oversight functions;*
- b) *Activate its technical working groups in order to obtain and analyze program and financial reports to support and facilitate its oversight functions;*
- c) *Ensure that MINSA and UTG, and all sub-recipients include the CCM Secretariat in the communication loop regarding issues affecting the grants. Progress Updates and Disbursement Requests (PUDR) and external audit reports should be routinely shared with the CCM by the PRs;*
- d) *Work with MINSA to develop and implement a time-bound action plan to integrate contracted Global Fund project staff in the PNCM and PNCT as regular government staff;*
- e) *Strengthen its technical capacity, as recommended by Grant Management Solutions, to provide effective oversight of the grant programs; and*
- f) *Work with MINSA to involve national oversight institutions, such as the Tribunal de Contas and MINSA's health inspectorate department, in the oversight of the grants programs, after a review of their capacities.*

### **Recommendation 2 (Critical)**

*The Global Fund Secretariat should ensure that:*

- a) *The Local Fund Agent (LFA) has staff based in Angola to facilitate its review activities and interaction with the Principal Recipient, the CCM and implementing organizations;*
- b) *All PR capacity assessments include assessment of capacity of key sub-recipients to manage grant funds; and time-bound action plans should be prepared to address any weaknesses found to mitigate any risks to the grants;*
- c) *The Global Fund Secretariat, the LFA and the PR work together to avoid implementation gaps such as the one experienced in the transition from Phase one to Phase two of the Round 7 malaria grant;*
- d) *It reduces the high turnover of its grant management staff for the Angola portfolio; and*
- e) *The external auditors improve upon the quality of their oversight work on the grant programs as per Global Fund audit guidelines.*

**PROCUREMENT AND SUPPLY CHAIN MANAGEMENT**

Procurement of health products for the malaria program was carried out by WHO (ACTs and RDTs), UNICEF (LLINs), and PSI (LLINs for social marketing). Quantification did not sufficiently consider that non-confirmed cases of malaria still get treatment. From the data collected at peripheral health facilities, on a number of cases the number of tests, stock levels and drug consumption was often not reliable. These factors contributed to stock-outs during and after phase 1 of Round 7. The long transition between the end of Phase 1 in January 2011 and Phase 2 may have contributed to the drug supply situation. With regard to the TB program, the audit team noted frequent stock-outs of anti-TB medicines and health supplies financed from the government budget. There was scope for the government to improve the supply of anti-TB medicines and health supplies to TB treatment centers.

**Malaria**

Quantification

38. The PNCM management team supported by a technical assistance team from UNICEF and MSH quantified the needs for ACTs, RDTs and LLINs procured under Round 7 Phase 1.<sup>6</sup> However, the quantification method did not take into account the frequent practice of treating non-confirmed cases due to inadequate facilities for microscopy, stock-outs of RDTs and low quality of laboratory diagnostic services. Data on malaria (use of products, number of cases, etc.) were unreliable (observation based on forms examined); and mistakes in data aggregation were observed at all levels.

Availability of medicines and health supplies

39. Stock cards for 2009-2010 were in many cases not available at health facilities visited by the OIG. Analysis of the supervision reports of program officials confirmed frequent stock-outs of ACTs and RDTs during 2009 and 2010. Further, at the peripheral levels “buffer stock” and “minimum stock level” practices were not adhered to. In addition, the long transition between Phase 1 and Phase 2 of the Round 7 Malaria grant may have contributed to the shortages of ACTs, RDTs and LLINs. The audit team noted stock-outs of ACTs, RDTs and LLINs at provincial and municipal warehouses and health facilities visited in Cabinda, Malanje and partially in Kwanza Norte. However in Huambo province, ACTs and RDTs were available.

**Number of days of stock-outs of anti-malaria health products in health facilities visited (Source: inventory records of health facilities)**

<b>Product</b>	<b>Caongo Municipal Warehouse (Cabinda)</b>	<b>Huambo Provincial Warehouse</b>	<b>Malanje Provincial Warehouse</b>	<b>Malanje Regional Hospital</b>	<b>Catone Municipal Hospital (Kwanza Norte)</b>
Coartem x 6 tab	240	0	210	90	60
Coartem x 12 tab	218	0	200	110	60
Coartem x 18 tab	264	0	200	100	55
Coartem x 24 tab	270	0	220	50	70
RDTs	195	25	180	N/A	80

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<sup>6</sup> A comprehensive gap analysis for the period 2008-2012 was carried out and was used for the quantification of the products; variables included: projected estimated population size (annual growth 3%), % of population per age group, # of estimated episodes of Malaria by age and by endemicity index (National Estimates), public health facility coverage.

### **Recommendation 3 (Critical)**

*MINSAs and PNCMs, in coordination with their technical and development partners, should review the underlying assumptions of the quantification/forecasting model in order to adapt it to prevailing practice of malaria case management. To mitigate the risk of stock-outs, adequate buffer stocks of malaria products should be established.*

### Health Procurement

40. WHO procured ACTs and RDTs. UNICEF procured LLINs for free distribution, while PSI procured LLINs for social marketing. WHO has a long-term agreement with Novartis for procurement of ACTs. UNICEF and PSI procured ACTs and LLINs from WHOPEs<sup>7</sup> prequalified suppliers at competitive prices. Prices paid for RDTs were competitive compared to WHO e-procurement price list.

41. The first year procurement of ACTs and RDTs was received in September and December 2009, respectively. Similarly, the second year procurement of malaria health products (ACTs, RDTs and LLINs) arrived between August 2010 and January 2011, i.e., close to the end of the first phase of the grant.

### **Recommendation 4 (Important)**

*MINSAs and PNCMs should monitor and assess procurement planning and related procurement processes managed by WHO for malaria commodities to ensure timely procurement and delivery of products.*

### Quality Control

42. Quality control was limited to physical examination of samples and inspection of the certificates of origin and pre-shipment quality control when health products imported were received at the country's ports. There was a need to conduct quality testing of medicines and supplies, including ACTs, RDTs and LLINs on receipt and in health facilities. The underlying reason was the lack of a laboratory in Angola with the technical capacity or certification to do testing of drugs.

### **Recommendation 5 (Critical)**

*To strengthen quality control of pharmaceuticals, the PR should seek technical assistance to develop, adopt and implement a quality assurance plan that includes testing of health products for malaria and tuberculosis in line with the Global Fund QA policy.*

### Storage and Inventory Management

43. Central Level. From 2009 to the end of 2010 ACTs and RDTs were stored at the private warehouse of Angomedica<sup>8</sup>. However, for phase 2 of the malaria grant, the Global Fund Secretariat has recommended using another warehouse facility with better storage conditions, security and functioning software for logistics management information system (LMIS).

44. Provincial and Municipal Level. The audit team selected a sample of ACTs and RDTs shipped to the provincial and municipal warehouses in the provinces of Cabinda, Huambo and Malanje in 2010 and noted that they had received correct quantities which had been entered on the stock cards. The "first expiry first out" (FEFO) principle was adhered to. All the warehouses were well staffed. Regular inventory verification/counts were done, but

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<sup>7</sup> The WHO Pesticide Evaluation Scheme

<sup>8</sup> Angomedica is a pharmaceutical institution which was privatized in 2002. It now provides storage facility for the MINSAs.

without involvement of external staff which could have strengthened this monitoring control. However, there were no manuals to provide guidance on standard operating procedures. Further, 2009 stock cards were not available for inspection which pointed to the need for better archiving of stock records and documents. Temperature and humidity in the warehouses were not monitored, and alarm systems or cameras could be used to reinforce warehouse security.

45. **Health Facility Level.** At the end-user level health facilities visited by the OIG team (Huambo Central Hospital, Bailundu Municipal Hospital and Montebello Health Post), stock cards from 2009 to 2010 were not available. This points to a need for improved supervision and training on the importance of maintaining stock records. At the pharmacy unit in Huambo Provincial Hospital, there was scope to improve separation between the central store and the outpatient and in-patient clinics to enhance traceability and accountability for medicines and supplies. In addition, at Malanje Regional Hospital and Catone Municipal Hospital (Kwanza Norte), there was scope to improve drug management by updating stock cards. This points to a need for training and supportive supervision.

### **Recommendation 6 (Important)**

*MINSAs and DNMEs should:*

- a) *Provide provincial and municipal warehouses with manuals that give guidance on standard operating procedures including archiving of stock records and documents;*
- b) *Adopt and implement the policy of carrying out regular independent physical inventory counts in provincial and municipal warehouses to ensure transparency and accountability;*
- c) *Improve stock management at the central store and health facility levels by establishing minimum and maximum stock levels for malaria health products;*
- d) *Consider installing alarm systems or cameras to reinforce warehouse security; and*
- e) *Monitor temperature and humidity in provincial and municipal warehouses to ensure that medicines and health supplies do not rapidly deteriorate.*

### **Distribution and Monitoring**

46. Distribution of ACTs and RDTs during phase 1 was managed by Angomedica using private contractors, while UNICEF shipped LLINs directly to the municipalities. The UTG did not maintain an updated beneficiary list for ACTs and RDTs distributed by Angomedica from 2009 to 2011. This information was subsequently obtained by the audit team from the storage facility. Further, the UTG was not able to explain allocations of ACTs and RDTs to PNCM, DNME and MINSAs from 2009 to 2011. Delivery notes of distribution of ACTs and RDTs for year 1 were not available. Distribution data extracted from the LMIS software utilized at Angomedica during 2009 were not sufficiently reliable for review. Angomedica had discontinued using UNILOG software. PNCM was not able to provide an accounting (through stock cards and issue vouchers) of ACTs and RDTs it received for distribution to the central beneficiaries<sup>9</sup>.

### **Recommendation 7 (Important)**

*The PR should strengthen its oversight of malaria health commodities (ACTs, RDTs and LLINs) to ensure proper records (including for distribution) are maintained. Direct distribution of health commodities (ACTs and RDTs) by PNCM should cease.*

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<sup>9</sup> PNCM, DNME and MINSAs received ACTs and RDTs from the central medical store. The audit team found that controls over these items were inadequate. Total value of these medicines and health supplies from 2010 to 2011 was approximately USD 30,000.

### Supervision

47. UTG conducted supervision visits during Phase 1 of the Round 7 grant in the area of storage, distribution and monitoring at peripheral level. In addition, a checklist was developed for warehouse assessments. Supervisory missions were conducted independently of the PNCM but reports were shared with it. PNCM also carried out supervisory visits of the supply chain for malaria health products. However, the audit team identified the need to ensure that issues found during supervisory missions were followed up to ensure that corrective actions are taken.

### **Recommendation 8 (Important)**

*The PR should ensure that PNCM and UTG coordinate and implement a common program of supervision in order to avoid overlap. The objectives and technical aspects of the supervision should be clearly defined. Checklists should be developed taking into account the different competencies of the PNCM and UTG teams. Findings and recommendations of supervisions should be shared with all stakeholders, particularly the provinces and SRs. Periodic follow-up of actions taken by health facilities should take place and be documented.*

### **Tuberculosis**

48. The audit observed frequent stock-outs of anti-TB medicines and health supplies financed from the government budget. In Huambo and Malanje province, the audit team noted repeated stock-outs of TB medicines in 2010 through May 2012 (100 to 210 days for most TB medicines during 2011).

49. The Government of Angola was responsible for providing anti-TB medicines. The procurement of anti-TB medicines included lengthy bidding processes that delayed procurement.

50. On the other hand, in Cabinda province most anti-TB drugs were available (apart from streptomycin which was out of stock), partly due to the support of Chevron Corporation, which operated in the province. Nonetheless, roles and responsibilities of MINSA, DNME and PNCT were not well defined; and coordination needed to be improved. There was scope for MINSA to consider seeking external technical assistance in order to improve procurement and regular supply of TB medicines, particularly given that the scale-up of TB services in the Round 9 TB grant will increase the number of patients under the treatment program.

51. There was a risk of the spread of TB drug resistance due to the sale of anti-TB medicines in the private pharmaceutical sector. In addition, availability of drugs in the private sector increased the risk of counterfeit drugs.

52. Due to limited laboratory capacity, quality control of medicines in Angola was limited to physical examination of samples at the ports of entry. Certificates of analysis and of origin were required for every batch. MINSA/DNME use external certified quality control laboratories (Portugal, Namibia, Argentina and Spain) when there was a need to test drugs for efficacy. However, there was a need to test drugs on a regular basis.

53. Anti-TB medicines were available in the private sector; and TB treatment centers and sanatoriums could purchase health commodities with their budgets. Further, patients were directed to private pharmacies when TB medicines were not available in public health facilities.

***Recommendation 9 (Critical)***

*MINSA and the PNCT should work with technical partners (e.g., WHO) to prepare and implement a time-bound action plan to prevent the sale of TB medicines in the private sector as per national regulations. Furthermore, regulation of the pharmaceutical sector needs to be strengthened to mitigate the risk of fake/counterfeit medicines being sold in the private pharmaceutical sector.*

### **FINANCIAL MANAGEMENT AND CONTROLS**

There is scope for improvement in the area of financial management and internal controls at all grant implementing organizations audited. The areas for improvement/weaknesses noted point to a need for sub-recipients to recruit qualified accountants, in addition to MINSA/UTG strengthening its financial oversight of sub-recipients.

#### Financial Management Arrangements

54. Grant Funds were kept in separate bank accounts in United States Dollars (USD) by UTG and PNCM to facilitate financial management and control. Joint signatories were required for disbursements. Population Services International (PSI), WHO and UNICEF used their corporate bank accounts and accounting systems for financial management of grant funds. In the first phase of the Round 7 malaria program, MINSA and UTG worked with four sub-recipients. Original supporting documents were retained by the sub-recipients, with photocopies of the documents sent quarterly to the UTG.

55. Grant funds for the Round 9 TB program were disbursed to MINSA in February 2011. Funds were deposited in a separate bank account managed by the UTG. The OIG noted that there was one disbursement to CUAMM on 17 May 2012 for USD 398,923. There had been no disbursements to PNCT by the end of audit fieldwork on 24 May 2012, since the PNCT had not opened a separate bank account as required by the grant agreement.

56. There was scope for improvement in financial management and internal controls at all grant implementing organizations audited. The areas noted point to a need for sub-recipients to recruit qualified accountants, in addition to UTG strengthening its financial oversight of sub-recipients.

#### **Malaria**

##### PR Financial management: UTG

57. The OIG noted scope for improvement in financial management and internal controls of MINSA/UTG as follows:

##### Financial controls and sub-recipient oversight

- a) The PR had not developed financial procedures and operations manuals for SRs;
- b) UTG had two finance staff for financial management and oversight of four sub-recipients. The areas for improvement in financial management noted at the sub-recipient level can be attributed to inadequate supervision and oversight of the UTG. With the addition of Round 9 TB funding, there is an added need for the UTG to strengthen its oversight of sub-recipients.
- c) MINSA/UTG did not assess the capacity of sub-recipients to manage grant funds;
- d) There was no evidence (e.g., in the form of signatures) that quarterly financial reports of sub-recipients were reviewed by UTG accounting staff and feedback provided to the SRs;
- e) Cancellation of invoices and payment vouchers were not done to mitigate the risk of double payments;

##### Bank and cash management

- f) Bank reconciliations for the period July 2009 to January 2011 had not been approved by a senior manager, as required by UTG internal procedures;
- g) Petty cash surprise counts were not done; and

### Payroll management

- h) Income tax was not withheld from employees' salaries.

### **Recommendation 10 (Critical)**

*The PR should ensure that UTG implements the following improvements in its financial system and internal controls:*

#### Financial controls and sub-recipient oversight

- a) *Develop financial procedures and operations manuals for SRs; and provides appropriate training to SR financial and program staff;*
- b) *Develop and adopt guidelines for review of SR quarterly reports and grant expenditures. The guidelines should also require the following: (i) verification that financial controls are being applied, and (ii) feedback to the SRs and monitoring of SR follow-up actions;*
- c) *Assess the capacity of sub-recipients to manage grant funds; and develop time-bound action plans to mitigate risks to grant funds;*
- d) *Cancel invoices as "paid" and indicate appropriate dates on the invoices to mitigate the risk of double payment;*

### **Recommendation 11 (Important)**

*The PR should ensure that UTG implements the following improvements in its financial system and internal controls:*

#### Financial controls and sub-recipient oversight

- a) *Consider the need for additional qualified accounting staff to strengthen the capacity of the UTG to provide adequate financial oversight of SRs;*
- b) *Adopt a policy that requires the program coordinator to ensure that bank reconciliations are reviewed and approved on a monthly basis; and*

#### Salaries

- c) *Consult a tax expert in order to ascertain the individual and institutional liability arising from not having paid income tax.*

### SR Financial Management: PNCM

58. The OIG noted scope for improvement in financial management and internal controls of PNCM, as follows:

#### Financial controls, documentation and financial reporting

- a) Accounting software was not used to facilitate financial management; an Excel spreadsheet was used to manage cash withdrawn from the bank and subsequent disbursement to staff for implementing program activities and for supervision. Considering the amount of grant funds managed during phase 1 (USD 4.3 million), there is scope to strengthen PNCM's financial management system by acquiring accounting software with appropriate controls for the second phase of the grant program;
- b) Payment vouchers were not reviewed (the OIG observed the absence of required signatures of program managers on vouchers);
- c) Financial procedures and operations manual that provide guidance to accounting staff for management and control of grant funds were not available for OIG review;

## **Audit of Global Fund Grants to Angola**

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### Bank and cash management

- d) Cash instead of checks was used for payment of grant expenditures (training, supervision, etc.) with the attendant risk of loss of funds;
- e) Bank reconciliations were not prepared, reviewed and approved during the two years of Phase 1 (1 November 2008 to 31 October 2010); and

### Salaries and benefits

- f) There was no personnel manual detailing human resources policies to be followed for the contracted staff recruited under the grant program.

### **Recommendation 12 (Critical)**

*The PR should ensure that PNCM implements the following improvements in its financial system and internal controls:*

### Financial controls, documentation and financial reporting

- a) *Obtain accounting software and the required training for two users;*
- b) *Introduce a policy that requires that its program coordinator verifies monthly that the financial procedures and controls, such as review and approval of payments and bank reconciliations, are applied;*
- c) *Recruit a qualified professional accountant in addition to the current book-keeper; and*

### Bank and cash management

- d) *Adopt and implement a policy of using checks instead of cash for payments where it is practical, and articulates a reasonable petty cash ceiling.*

### SR Financial Management: PSI

59. The OIG noted scope for improvement in financial management and internal controls of PSI,<sup>10</sup> as follows:

### Financial controls, documentation and financial reporting

- a) Reclassification of prior year expenditures from other donors' grants to the Global Fund account without approval (e.g., for housing allowance USD 16,000; advertising USD 75,695);
- b) PSI accounting policies did not indicate the basis for charging common costs to different donor-financed programs. It was therefore difficult to verify the reasonableness of some costs charged to the Global Fund grant;<sup>11</sup>
- c) The audit team could not validate financial reports (PUDRs) submitted to the Global Fund Secretariat since PSI used accounting codes that were different from those of the quarterly reports, with the risk of misclassification of grant expenditures;
- d) Expenditure related to the procurement of LLINs<sup>12</sup> was incurred at PSI head office in the United States, and supporting documentation was not available at PSI Angola;
- e) Variances of grant expenditure from budgeted amounts (ranging from 22% to 828 %) were not explained on program activities, for instance, distribution of nets, production and placement of radio spots etc.

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<sup>10</sup> Total expenditure by PSI at the time of the audit had been USD 4.6m.

<sup>11</sup> For example, PSI purchased two identical vehicles for a total of USD 82,000; one vehicle was charged to the Global Fund grant at USD 51,000 while the other was charged to a USAID grant at USD 31,000. The invoice for vehicle charged to the GF grant was approximately USD 43,000. There was no explanation provided by PSI for the extra USD 8,000 cost apportioned to the Global Fund grant.

<sup>12</sup> Valued at USD 1.9m.

### **Bank and cash management**

- f) The amount of funds kept in the office safe as petty cash was USD 5,000 because cash was the accepted mode of payment for goods and services in Angola. There was no evidence of supervisory reviews (signatures) on the petty cash vouchers as required by PSI procedures. Surprise petty cash counts were not done;

### **Fixed asset management**

- g) The fixed asset register for program assets had not been maintained or updated regularly. Fixed assets had not been physically verified. There were assets bought with grant funds that had not been entered on the register (e.g., a vehicle and a computer), while some assets on the register were not bought with grant funds;

### **Payroll management**

- h) The audit team noted advances and loans totaling USD 15,000 made to staff; and  
i) An excel spreadsheet was used for payroll of approx. USD 12,000 per month. This did not have the controls necessary to mitigate risks of inappropriate access of non-authorized staff and processing errors. There is scope for PSI to consider acquiring payroll software.

### ***Recommendation 13 (Critical)***

*The PR should ensure that PSI implements improvements in its financial systems and internal controls by:*

- a) *Adopting and implementing a policy that does not allow reclassification of prior years' expenditures from a donor account to the Global Fund grant without the written approval of the Global Fund Secretariat;*  
b) *Adopting a policy on cost-sharing/allocation of common costs amongst its donor-funded programs; and*  
c) *Refunding any amounts charged to the Global Fund grant that were not eligible under the grant agreement or that were not sufficiently documented.*

### ***Recommendation 14 (Important)***

*The PR should ensure that PSI implements improvements in its financial systems and internal controls by:*

- a) *Recruiting qualified accountants for grant financial management in order that financial controls, e.g. bank reconciliations, are routinely done;*  
b) *Seeking technical support to enable PSI's QuickBooks accounting software to produce the Global Fund's quarterly financial reports. Reconciliation between expenditure reports to the PR and reports produced using QuickBooks should be undertaken and documented;*

### **Bank and cash management**

- c) *Reducing the petty cash fund to a reasonable level; payments from petty cash should be made only for transactions of low value and should have manager approval;*

### **Fixed asset management**

- d) *Carrying out and documenting the results of regular physical verification of fixed assets and document the results;*

Payroll management

- e) *Verifying that personal advances and loans to staff have not been charged to the grant; and*
- f) *Considering acquiring payroll software for payroll management.*

**Tuberculosis**

60. There is a risk that the PNCT may not be able to establish sufficient capacity to manage grant funds in a timely manner, which could delay the achievement of program objectives.

61. The program start date of the TB grant managed by MINSA was 1 September 2011. The first disbursement was received in March 2012, one month prior to the start of the audit. PNCT, the Sub-recipient, will manage USD 1.8 million in Phase 1 of the grant. At the end of the audit in May 2012, grant implementation activities had not yet started. There were conditions precedent in the agreement, *inter alia* requiring the PNCT to recruit a qualified accountant and establish an accounting system to manage grant funds. The paucity of qualified accounting staff in the country is a challenge. PNCT did not have a financial and operations procedure manual and relied on the UTG to provide them with accounting software. There had been bottlenecks in the recruitment of staff to augment the PNCT's technical and financial management capacity.

***Recommendation 15 (Critical)***

*The PR should:*

- a) *Recruit technical staff approved in the grant budget for PNCT without further delay;*
- b) *Provide financial and operations manuals to its sub-recipients including the PNCT;*  
*and*
- c) *Provide orientation for two PNCT accounting staff and the required training to use the accounting software.*

### PROGRAM REVIEW

#### The Malaria Program

Significant progress was made with diagnosis and treatment of malaria during Phase 1 of Round 7 (1 November 2008 to 31 January 2011). However, the long transition between the end of Phase 1 and the start of Phase 2, which contributed to shortages of malaria medicines, diagnostic supplies and bed nets, could negatively affect these gains and achievements.

#### Malaria in Angola

62. There were three epidemiological zones for malaria: The north with hyperendemic stable malaria, the middle with mesoendemic malaria, and the south with unstable mesoendemic malaria. Malaria was responsible for 35% of the demand for clinical care, and 20% of inpatient care. Forty percent of perinatal mortality and 25% of maternal mortality were related to malaria (Malaria Incidence Survey, MIS 2011, financed by the Global Fund and PMI). In 2010, approximately 3.7 million disease-episodes were malaria-related. Malaria prevalence (parasitemia) among children was between 8% and 11%. Prevalence was much higher in rural areas (14%) than in urban areas (1%), and was significantly higher among the poor. The prevalence of parasitemia among children has decreased by 40% from 2006 to 2011<sup>13</sup>.

63. The National Strategy for Malaria Control<sup>14</sup> describes the key interventions of malaria control: Universal access to curative services that provide ACT treatment based on confirmation of diagnosis (microscopy and/or RDT); chemoprophylaxis (S-P) among pregnant women; distribution of LLINs among pregnant women (and promotion of universal access to LLINs from 2008); and vector control (indoor spraying<sup>15</sup> and larviciding<sup>16</sup>). The goal was to halt transmission in areas of low transmission, viz. the southern part of the country. In May 2012, new national guidelines on malaria case management were introduced. In addition, the Global Fund and PMI are key partners of PNCM.

#### Capacity Development: Training and Supervision

64. A dedicated PNCM team carried out regular supervision of health facilities at the provincial level during the first phase of the malaria program. A review of supervision reports from 2009 to 2011 showed that there were quarterly supportive supervision visits in most provinces. They typically took four to five days and covered, *inter alia*, the following areas: Drug management, RDT use, bed-net distribution at antenatal care clinics, data validation and direct observations at outpatient clinics, laboratories and pharmacy units. Provincial Malaria Supervisors, financed through the Global Fund grant, ensured regular supervision of all municipalities.

65. At the end of Phase 1 of the Round 7 malaria grant, supervision by the PNCM staff at the central level decreased, but continued at a slower pace with financing from PMI. There has been good collaboration between all malaria partners, particularly between the Global Fund and PMI. However, supervision of the municipalities by the Provincial Malaria

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<sup>13</sup> 2006 and 2011 MIS data

<sup>14</sup> Plano Estratégico Nacional (PEN), 2011-2015

<sup>15</sup> The percentage of houses sprayed in 2011 was 7.7–10.1 %, against 1.4-10.0% in 2006/7. Spraying targeted the meso-endemic unstable malaria zone in the south of the country (Provinces of Huila, Cunene, Namibe, Cuando-Cubango, and Huambo).

<sup>16</sup> In 2009, the Government of Cuba started a nation-wide larvicide project in collaboration with the Government of Angola. In each Municipality, there were teams carrying out health education, identifying breeding grounds, and applying larvicides.

Supervisors decreased when the financial support through Round 7 ceased (salaries and resources for supervision).

66. From 2009 through 2010, health workers were trained on malaria diagnosis and treatment using RDTs and ACTs through an intensive training program carried out by the PNCM. The audit team reviewed reports of training sessions carried out during Phase 1 of the Round 7 malaria grant program. After completion of Phase 1, however, the frequency of training decreased, while training continued in provinces that received PMI grant support.

### Service Delivery

67. In health facilities visited, the audit team noted that clinical staff were aware of the current national guidelines on malaria case management. Service providers understood the policy of treating malaria only after confirmation of diagnosis (microscopy and/or RDT), although this was not always followed.

68. The audit team noted that many<sup>17</sup> cases were treated without confirmation of diagnosis or even after negative laboratory diagnosis. For example, in Malanje province, 141,754 patients were treated with ACTs compared to 84,494 positive tests (i.e., 167%; 2010 provincial annual report on malaria). The audit team noted a similar situation in Kuanza Norte province (2010 and 2011 annual malaria reports), and in municipalities in Cabinda and Huambo provinces. Health staff gave various reasons for lack of adherence to national standards, e.g., stock-outs of RDTs in 2011 and lack of confidence in the results of microscopy.

69. The National Public Health Institute (INSP) had developed a national strategy (2012-2016) on quality assurance of laboratory services. There were plans for a core team of INSP laboratory experts to supervise laboratory facilities in the provinces and municipalities as well as assess samples of laboratory tests for malaria, TB, HIV and other priority diseases.

70. In the absence of a country-wide quality assurance system<sup>18</sup>, quality of laboratory diagnosis cannot be assured. The audit team noted isolated/ad-hoc quality control activities by health staff at the provincial level (e.g., DPS Huambo), but these had not been fully documented. Laboratory staff did not receive feedback on the quality of their work and there was no regular supervision of peripheral laboratories.

### **Recommendation 16 (Critical)**

*MINSa should work with its development partners to ensure a regular supply of ACTs and RDTs in order to facilitate adherence to the policy of treating only confirmed malaria cases. Focused supervisory visits to health facilities should be carried out*

### **Recommendation 17 (Important)**

*The PR should work with development partners to secure resources to support the national strategy for integrated quality assurance of laboratory services. This may also be considered during the re-programming of the Round 9 grant.*

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<sup>17</sup> Numbers varied across provinces visited by the audit team. The OIG team analyzed statistics collected at health facility level, and aggregated statistics made available by Municipal and Provincial health staff.

<sup>18</sup> USAID supported quality assurance development in eight provinces through NGOs. However, the audit team found that results were not fully documented and program activities had not been carried out in close collaboration with the DPS. In 2007, a study was done in five provinces on QA (Cabinda, Uige, Benguela, Huambo and Malanje). Approximately 1,000 slides were examined. The percentage of false positives was 41%, with 27% false negatives.

### Malaria Prevention (IPT and LLINs)

71. Intermittent preventive treatment of malaria (IPT) for pregnant women was low at 17.5% (MIS 2011). The routine health management information system (HMIS) showed low coverage of IPT in Cabinda (Caconge Municipality), with 50% receiving a first dose) and 41% a second. Many health facilities did not provide an integrated package of primary health care services, for example, Dinge Health Center in Cabinda province. Stock-outs of Sulfadoxine-Pyrimethamine (S-P) in 2011 also reduced coverage of IPT.

72. PSI was responsible for procurement and social marketing of LLINs through twelve wholesalers in twelve provinces. Demand for bed nets was created through a mix of interpersonal communication and mass media campaigns. In total, 352,769 LLINs were distributed during Phase 1 of Round 7 (out of 400,000 LLINs procured for distribution). In Bengo and Malanje provinces, behavioral research was carried out to identify factors influencing LLIN use.

73. UNICEF was responsible for procurement and distribution of LLINs during the first phase of Round 7 (1 November 2008 to 31 January 2011). In addition, UNICEF produced IEC training materials, trained community health workers and conducted mass media campaigns.

74. The audit team noted stock-outs (from 2011 to the time of the audit in May 2012) of LLINs for distribution at ante-natal care and under-five clinics in the five provinces it visited. The data from the 2011 MIS show that LLIN use among pregnant women and children under five was 25.6 % and 25.9%, respectively.

### ***Recommendation 18 (Important)***

*The PR should ensure that the PNCM establishes close working relations with the National Reproductive Health Program<sup>19</sup> in order to develop strategies to increase the coverage of IPT at antenatal care clinics.*

### Monitoring and Evaluation and Data Management

75. The PNCM has developed a reporting form to be used at all levels. This form includes information on the number of outpatient contacts, number of suspected malaria cases, number of tests, number of confirmed cases and information on stock flows of malaria products. In all provinces visited, the audit team noted errors in the use of these forms and in the aggregation of routine data at municipal and provincial levels. These findings were in line with observations made by the LFA during the 2010 on-site data verification (OSDV). For example, there were arithmetic errors in reporting laboratory tests conducted and consumption of ACTs and RDTs.

76. The underlying reasons for these errors were lack of registers, lack of reconciliation of data collected from various health facilities (out-patient clinic laboratories and ante-natal care clinics, etc.) The malaria supervisors at provincial levels played an important role in verifying and correcting data. However, routine data on malaria were still not accurate or reliable. M&E capacity at all levels of the public health system needed to be strengthened.

77. In February 2012, an M&E Systems Strengthening workshop was held to discuss the basis for a comprehensive M&E strengthening plan (a pre-condition for the Round 9 TB grant). A detailed report of this workshop had not been completed. Further, an M&E strengthening plan had not yet been finalized by the UTG. At the time of the audit, the M&E capacity within the UTG to effectively deal with these complex tasks was limited.

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<sup>19</sup> The National Reproductive Health Program is responsible for all antenatal care clinics.

78. In 2011, a comprehensive MIS, co-financed by the Global Fund and PMI, was carried out as a follow-up of the survey done in 2006<sup>20</sup>. These surveys have provided valuable outcome data on malaria, and MINSA and its development partners should consider carrying out another survey in 2014. Carrying out a survey earlier than 2014 may not be appropriate since in 2013 a nation-wide population census has been planned.

79. The audit team reviewed the draft consolidated Performance Framework for Phase 2 of Round 7 and for Round 10 (SSF), and did not note material shortcomings.

### **Recommendation 19 (Critical)**

*The PR should:*

- a) *Finalize the M&E system strengthening plan. To this end, the UTG should consider requesting for M&E technical assistance from development partners; and*
- b) *Ensure that the profile of the new position of deputy coordinator at the UTG should include strong technical competence and experience in M&E. Further, s/he should have direct responsibility over UTG's technical staff.*

### **Recommendation 20 (Important)**

*MINSA should increase resources for M&E, training and supervision in order to strengthen the data management capacity at the central, provincial and municipal levels of the public health system.*

### Sustainability

80. The malaria program is dependent on Global Fund financial support, which constitutes a risk to the sustainability of key program activities. At the PNCM, the PR has deployed a contracted project team leader supported by contracted technical staff responsible for program implementation, supervision, training, M&E and PSM. Furthermore, at provincial level the PR contracted Provincial Malaria Supervisors (OPPMs<sup>21</sup>), who played a crucial role in training, supervision, monitoring, and data validation. At the municipal level, malaria focal point persons received monthly salary top-ups. Due to the gap between the end of Phase 1 of Round 7 (January 2011) and Phase 2 (not started at the end of the audit field work in May 2012), many key activities such as training and supervision had been reduced.

81. Supplies of medicines and other malaria products (RDTs and LLINs) were inadequate in 2011 and 2012, which was partly due to a weak procurement and supply management system and partly to the long transition period from Phase 1 to Phase 2.. The audit team noted stock-outs of LLINs from 2010 to May 2012 in all provinces visited. In addition, supplies of ACTs and RDTs had been irregular and inadequate.<sup>22</sup> PMI support alleviated some negative consequences of the delay in funding from the Global Fund in 2011 and 2012, with support to supervision and to supplies. In May 2012, the GOA provided funds for procurement of 1.9 million LLINs, 5.5 million RDTs, and 1.8 million ACT blisters.

### **Recommendation 21 (Critical)**

*To avoid gaps in the procurement and supply of malaria health products, the PR should work with the Government of Angola to prepare a financing plan to progressively replace donor support with funds from the central government.*

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<sup>20</sup> Notable changes from MIS 2006 to MIS 2011 included: The possession of LLINs increased from 27% to 35%. LLIN use increased from 18% to 26% among children and from 22% to 26% among pregnant women. The prevalence of infant mortality in the presence of parasitemia decreased during the same period.

<sup>21</sup> Oficial Provincial do Programa de Malária

<sup>22</sup> There were differences between provinces. In Huambo province, for example, there was regular supply of ACTs and RDTs due to the program activities of PMI and its implementing partners.

### The Tuberculosis Program

Progress in diagnosis and treatment of TB has stagnated due to limited access to TB services. DOTS was practiced only for patients that had been hospitalized. The supply of anti-TB medicines has been irregular, which has led to some TB patients not receiving treatment. In addition, there are significant challenges in assuring the diagnosis and treatment of multi-drug resistant tuberculosis.

#### The National Response to Tuberculosis

82. The current national strategy (2008-2012) focuses on improving geographic access to TB diagnosis and implementation of Directly Observed Treatment, Short Course (DOTS). The national TB strategy aims to achieve the global targets for case detection and successful treatment, i.e., 70 percent and 85 percent, respectively. In 2012, a revised national TB strategy covering the period 2013-2016 will be formulated. In addition, a national M&E plan for TB is envisaged.

83. In 2011, 138 out of 164 municipalities in the country had at least one laboratory with the capacity to test sputum. However, only 190 out of the 2,000 health facilities in the country provided TB services. There were 146 TB diagnosis and treatment centers and 44 centers that provided only TB treatment follow-up.

84. In February 2012, the GOA through its Inter-Ministerial Commission for *Grandes Endemias*, chaired by the Vice-President, put TB control on the national health policy agenda with a commitment to provide increased funding. A technical working group was established to develop action plans in order to strengthen the technical capacity of the PNCT. In addition, the GOA has committed to financing the establishment of three additional MDR-TB laboratories. The TB program plans to collaborate with national laboratories in Portugal and Brazil to improve quality control of laboratories.

85. There are a number of challenges for TB control and risks to the implementation of Round 9 TB grant program.

#### High TB default rates

86. The OIG team noted high default rates<sup>23</sup> for sputum-positive TB cases in three provinces. According to the PNCT annual report for 2011, the nation-wide default rate was 17%. The underlying causes for this low program performance include: a) Low access to TB services due to limited number of TB treatment centers and TB laboratory facilities; b) Insufficient application of the principles of DOTS; e.g., proactive case-finding and case-holding through collaboration between the public health services and community-based organizations; c) The PNCT had not yet adopted the 2009 WHO recommended six-month TB treatment regimen; the longer duration of the current eight-month treatment regimen contributes to high default rates; and d) Drug supply by the Government has been irregular and stock-outs have sometimes led to TB patients not receiving treatment, e.g., at the Luanda TB Sanatorium.

87. Access to TB diagnostic services (sputum analysis) provided by trained clinical staff was low. According to the Performance Framework of Phase 1 of the Round 9 TB grant, the number of TB laboratories will increase from 146 to 202. Further, the number of health facilities providing TB treatment services without TB laboratory services will increase from

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<sup>23</sup> Huambo Province : 26% in 2011; Malanje: 19% in 2011; Luanda Province: 40% in 2010

49 to 94. This planned increase in TB facilities is critical to improve TB control performance.<sup>24</sup>

88. The PNCT had not yet implemented a comprehensive DOTS strategy. At TB treatment centers, outpatients and/or their family members collected medicines for a period of 15 to 30 days. There were no arrangements for daily observation of outpatients on treatment by peers or community health workers to ensure adherence. DOTS was, however, practiced for TB patients who were hospitalized. Contact tracing was not done at the health facilities visited by the OIG team.

89. A community DOTS strategy was included in the national TB guidelines, but had not yet been implemented. Further, MINSA had not developed a nation-wide community-based health care system. Program officials explained that a community-based health care strategy was being developed, which would include policies for involving and incentivizing community health workers.

### ***Recommendation 22 (Critical)***

*The PR should ensure that PNCT provides refresher training and guidance to health staff involved in TB control on strategies to pro-actively identify new tuberculosis patients and on the importance of retention of TB patients on treatment.*

### ***Recommendation 23 (Critical)***

*MINSA and PNCT should train healthcare staff on the DOTS strategy. In addition, supervision tools/instruments needs to be updated to check on adherence to DOTS.*

### ***Recommendation 24 (Important)***

*The PR should ensure that it completes the development of a comprehensive national strategy on community-based health care; and that it adopts and implements the planned strategy of involving community health workers in TB control activities such as identification of new TB cases, case-holding and DOTS therapy.*

90. Given the absence of a comprehensive DOTS strategy, the Round 9 TB grant's performance framework indicator number 1.5, 'Number of DOTS services which are functioning...' was not accurately defined. This also applied to the 2011 baseline number of 146 functional DOTS centers.

### ***Recommendation 25 (Critical)***

*The PR should be more precise in its definition of indicator 1.5 in line with international standards for DOTS. Alternatively, indicator 1.5 should be combined with indicator 1.8 which addresses the quality and completeness of DOTS. The baseline data should be adjusted accordingly, but agreed targets in the performance framework should be maintained.<sup>25</sup>*

## **Treatment regimen for TB**

91. Another contributing factor to the low case-holding was the eight-month treatment regimen for new TB cases, which was followed at all TB treatment centers visited by the OIG. 2009 WHO recommendations require a six-month treatment regimen and a phase-out of the old eight-month regimen. The national treatment guidelines, however, recommend the eight-month treatment regimen as a first choice, with the six-month regimen as an alternative.

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<sup>24</sup> The audit team noted that during 2010, the municipal hospital in Bailundo Municipality (Huambo) started TB treatment based on clinical signs and symptoms in the absence of a functional laboratory to examine sputum. A laboratory was installed to start sputum examination during the first quarter of 2011.

<sup>25</sup> The PNCT annual report for 2011 mentions that 115 Municipalities would have DOTS centers.

### ***Recommendation 26 (Important)***

*MINSAs and the PNCT should adhere to the WHO 2009 recommendation of a six-month TB treatment regimen.*

#### Quality Assurance of TB laboratory services

92. A quality control system for peripheral TB laboratory services, including analyses of sputum microscopy, has not been established. None of the laboratories visited by the audit team had benefited from regular quality control visits. The Round 9 TB grant provided funds for intensive supervision of all provincial TB laboratories by the national public health laboratory as an essential quality improvement measure. The recent strategy for quality control of laboratories by the National Institute of Public Health includes an integrated system of laboratory supervision, under which a pool of trained laboratory supervisors will supervise all provinces on basic laboratory examinations including TB.

### ***Recommendation 27 (Important)***

*The PR should work with development partners to support the national strategy on integrated laboratory supervision. In addition, there is scope for national supervisors to monitor and supervise peripheral laboratories for TB, malaria, HIV and other priority diseases.*

#### Availability of medicines

93. From 2010, the supply of drugs for treatment of TB has been irregular. This has contributed to low treatment success and high default rates. The audit team noted that in May 2012, outpatients at the Luanda Sanatorium were given prescriptions to buy medicines at private pharmacies due to shortage of TB drugs. From January 2012 to the time of the audit (May 2012), there was stock-out of streptomycin, a drug used during the intensive phase of TB treatment.

#### Multi-Drug Resistant Tuberculosis

94. There were no diagnostic facilities in the provinces for MDR-TB. At the central level, there were two facilities for MDR-TB diagnosis: The National Public Health Laboratory and the Military Hospital in Luanda. However, equipment for sensitivity testing at the National Public Health Laboratory had been out of order for three months (February to May 2012). At the time of the audit, the Military Hospital provided services only for military personnel. In the provinces, TB cases that did not respond to first-line and second-line TB drugs were not examined for MDR-TB.

### ***Recommendation 28 (Critical)***

*To improve diagnosis and treatment of MDR-TB, the PR should:*

- a) Implement the decision made by the inter-ministerial commission to establish three MDR-TB regional laboratories;*
- b) Develop guidelines for MDR-TB case management based on the policies laid out in the 2012 TB guidelines; and*
- c) Require PNCT and CUAMM (Sub-recipients of the Round 9 TB program) to prepare training and supervision schedules to educate all peripheral TB staff on managing MDR-TB cases.*

#### Sustainability of TB control

95. At the time of the audit, the technical capacity of the PNCT was limited, comprising one permanent Program Coordinator and one M&E Officer. Additional technical staff were

## **Audit of Global Fund Grants to Angola**

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provided on a temporary basis using Global Fund grant resources<sup>26</sup>. At the provincial and municipal levels, TB focal point persons were nurses employed by the state who received incentive payments from grant resources for program supervision. At the end of the grant program in September 2010, the lack of incentives and resources to carry out routine supervision activities had eroded the motivation of staff involved in tuberculosis control. However, the Round 9 TB grant provides resources for regular supervision of the TB program at all levels.

### ***Recommendation 29 (Critical)***

*The PR should engage with the Government of Angola to provide additional government funding to strengthen the human resource and technical capacity of the PNCT, according to the decisions made in February 2012 by the “Commission on Grandes Endemias”.*

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<sup>26</sup> Round 4 TB grant managed by UNDP as PR.