



Audit Report

Global Fund Grants in the Republic of Uganda

GF-OIG-19-017
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Geneva, Switzerland

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Audit Report

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1. Executive Summary

1.1 Opinion

Uganda is a high disease burden country, ranked 5th and 6th globally for its malaria and HIV burden respectively.¹ In 2017, nearly 14 million malaria cases² were reported, while the number of people living with HIV was estimated at 1.3 million. Since 2015, Uganda is no longer one of the top 30 tuberculosis high burden countries³ but it remains in the list of top 30 HIV/TB burden countries⁴. Between 2015 and 2018, the country significantly improved its results in fighting malaria and HIV in terms of prevention, diagnosis and treatment coverage.

The audit noted a number of good practices including last mile distribution to health facilities and effective coordination of stock monitoring among stakeholders. Despite these improvements, significant issues remain. At central level, inadequate controls at the National Medical Store (NMS)⁵ and Ministry of Health (MOH), and manual system data entry are resulting in failure to detect errors in the recording of product batch numbers and quantities in the NMS inventory management system. At health facility level, incomplete record keeping and infrequent physical inventory counts (mainly due to insufficient human resources and supervision) are contributing to low traceability of commodities, especially for malaria and TB. While there is high availability of antiretroviral drugs (ARV) and malaria commodities, HIV rapid tests and anti-TB first line drugs experience stock-outs.

The HIV program has matured, with various good practices including the implementation of a differentiated service delivery model and the use of an electronic management record to monitor patients under antiretroviral therapy (ART). Uganda is close to reaching the first two of the UNAIDS 90-90-90 targets, relating to people living with HIV who know their status and HIV patients under ART. Regarding malaria, the 2016/2017 mass campaign distribution of bed nets achieved 98% coverage⁶, far exceeding the country target of 85%. The quality of malaria case management at community level varies however across the country. The tuberculosis program is underperforming, with 47% of TB missing cases⁷ in 2017 against a global target of 10%⁸ and treatment success rates consistently under 80%. Contributing factors include insufficient implementation of contact tracing, ineffective community case management, uneven and insufficient supervision and training, and the non-availability of tools and guidelines at health facilities.

Financial oversight has evolved following the transfer of responsibilities from the Ministry of Health's Fund Coordination Unit to the Ministry of Finance, Planning and Economic Development (MoFPED). However, some issues remain: the roles and responsibilities between the new FCU and the MOH remain unclear on areas such as payment and disbursement processes; FCU review of payments and budget monitoring is insufficient; and weaknesses in monitoring advances have resulted in long-outstanding advances of up to 721 days, against the limit of 60 days.

1.2 Key Achievements and Good Practices

Advances in the fight against HIV: The HIV program is progressing towards UNAIDS' 90-90-90 targets⁹. As of December 2017, the number of people living with HIV who knew their status (PLWH) was 81%, up from 73% in 2015. The proportion of diagnosed PLWH under ART increased from 75% to 89% in the same period. Viral load suppression among PLWH under ART (the third of the 90-90-90 targets) was 78%. There were 50,000 new HIV cases in 2017, down from 89,000 in

¹ WHO World malaria report 2018 page xii for malaria and UNAIDS 2017 report for HIV

² WHO World malaria report 2018 page

³ WHO discussion paper "Use of high burden country lists for TB by WHO in the post-2015 era" page 3.

⁴ WHO Global tuberculosis report 2018 page 24

⁵ As part of Global Fund grant implementation, NMS is the selected central medical store responsible for storing and distributing GF funded commodities across the government-owned health facilities.

⁶ 2016-2017 long lasting insecticidal nets universal coverage campaign report by the Ministry of Health, page 26

⁷ https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UG&outtype=PDF

⁸ Target as per the global plan to end TB "the paradigm shift 2016-2020" by Stop TB partnership page 26

⁹ All data inserted in this section is from UNAIDS. <http://aidsinfo.unaids.org/>

2012. AIDS-related deaths fell by 38% between 2012 and 2017. Coverage of pregnant women receiving ART for prevention of mother-to-child transmission is around 95%.

Continuous availability of ARVs and malaria commodities: Commodity availability is actively monitored at the central level. The MOH's Pharmacy Department analyzes stock levels and a high-level task force monitors the commodity supply chain. The NMS implements last-mile delivery of health products to health facilities, with bi-monthly distributions performed for most health facilities. Consequently, the supply chain is able to support the scale up of HIV interventions through continuous availability of key ARVs. Similarly, malaria commodities were continuously available in 2018 (with few exceptions) at visited health facilities.

Enhanced oversight over Global Fund grants: As mentioned above, the Fund Coordination Unit has transferred to MoFPED. Senior MOH management are actively involved in Global Fund grant-related activities through monthly meetings. To strengthen accountability over funded commodities, the Secretariat and PEPFAR have extended the Fiduciary Agent's scope of oversight to include Global Fund-funded HIV commodities.

1.3 Key Issues and Risks

MOH internal control and oversight on traceability of commodities: At central level, internal controls at NMS and MOH do not reconcile health product batch numbers when tracking health commodities received at NMS. As a result, errors in entries manually posted in the NMS inventory management system (MACS) go undetected and uncorrected, limiting NMS's ability to trace health commodities. At health facility level, incomplete record keeping and the lack of regular physical inventory counts, both due to insufficient human resources and a inadequate supervision over commodities from the MOH and the District Health Office, are contributing to low traceability, especially of malaria and TB commodities.

Significant stock-outs of HIV rapid tests and TB first-line drugs: HIV rapid tests (screening tests and confirmatory tests) experienced significant stock-outs in 2018, mostly due to inadequate funding: 27% of sampled health facilities experienced stock-outs of Determine (first line HIV screening test) exceeding 30 days, and 64% of visited health facilities experienced stock-outs of Statpack (HIV confirmatory test) lasting at least 60 days. These resulted from undersupply from the central warehouse level due to a funding gap for HIV rapid tests¹⁰, exacerbated by excessive testing. Stock-outs of anti-TB first-line drugs (RHZE) - due to a global shortage of TB drugs - were noted in three of the 11 health facilities visited, with average stock-outs of 35 days per quarter in 2018. This resulted in partial service disruption at health facilities serving 719 TB patients in 2018.

Significant progress is required in TB case detection and treatment: There are around 47% of TB missing cases, and treatment success rates have consistently been below 80% in recent years. Underperformance is caused by various factors including ineffective community case management, insufficient implementation of contact tracing, lack of supervision and training, and the non-availability of tools and guidelines at health facilities.

Community case management needs strengthening: Malaria community case management levels vary widely across Uganda: Village Health Teams (VHTs) test and treat malaria cases in the Northern region, but do not provide malaria care at community level in the Eastern area, which is covered by other partners. There are weaknesses in supervision of VHTs by health facilities, and in reporting and referring patients from community to health facilities. Community health systems are not strong enough to improve TB case detection, as detailed in finding 4.2.

¹⁰ Analysis by MOH showed HIV test kits had a funding gap of 21.2 million after the allocation across the funding cycle 2018 – 2020.

1.4 Rating

	Objective 1: effectiveness and efficiency of procurement and supply chain arrangement to deliver and account for health products. OIG Rating: Needs significant improvement
	Objective 2: adequacy and effectiveness of controls to ensure the quality of services provided to intended beneficiaries. OIG Rating: Partially Effective
	Objective 3: adequacy and effectiveness of design, oversight and internal controls over financial management. OIG Rating: Partially Effective

1.5 Summary of Agreed Management Actions

The Secretariat will support the Principal Recipient to strengthen overall controls around supply chain distribution, including automating data input and distribution by piloting the use of Enterprise Resource Planning at central level, strengthening the quarterly reconciliation performed by the Principal Recipient and the Ministry of Health, and extending the scope of review of the Fiduciary Agent to include the monitoring of Global Fund health commodities at both central and health facilities level.

The Secretariat will request the Principal Recipient and Ministry of Health to strengthen oversight of the related Global Fund grants on various programmatic aspects including supervision, community case management, updated case finding and treatment guideline roll-out, tracking of lost to follow up and capacity building of health workers.

The Secretariat will also work with the Ministry of Finance, Planning and Economic Development to strengthen oversight of the Fund Coordination Unit, by updating its terms of reference in overseeing Global Fund grants and complementing the Ministry of Health and Ministry of Local Government oversight function.

2. Background and Context

2.1 Overall Context

The Republic of Uganda is a landlocked country in East-Central Africa with a population of 40.8 million.¹¹ With Gross Domestic Product (GDP) per capita of US\$2,400 in 2017¹², Uganda is a low-income country, where almost a quarter of the population live below the national poverty line.¹³ The country is ranked 162 out of 189 countries in the UN Development Program's 2018 Human Development Index¹⁴, and 149 out of 180 countries in the Transparency International 2018 Corruption Perceptions Index.¹⁵

Administratively, Uganda is structured around a central government, with 128 districts responsible for planning, budgeting, hiring and managing personnel at district level. The national health system comprises 6,404 health facilities, 48% being government-owned facilities. Health facilities are categorized into 7 groups ranging from National or Regional referral hospitals to Health Center levels IV, III, II and I at parish and village levels.

Between financial years 2014/2015 and 2017/2018, the Ministry of Health's budget increased from US\$358.5 million to US\$498.4 million.¹⁶ General current health expenditure represented 6% of GDP in 2017/2018¹⁷, down from 9% in 2011/2012¹⁸. Uganda faces a critical shortage in its health workforce,¹⁹ with 0.1 doctors and 0.6 nurses and midwives per 1,000 population⁷, well below the WHO's recommended minimum target of 2.3 doctors, nurses and midwives.²⁰ In 2015, overall staffing level at public health sector facilities was 75%, with significant staffing gaps at Health Center level II (47%) and General Hospitals (32%).²¹ Hospital bed density was only 0.5/1,000 population²², making Uganda the country with the seventh smallest bed density in the world as per latest available World Development Indicators (WDI) data (2010).

2.2 Differentiation Category for Country Audits

The Global Fund has classified the countries in which it finances programs into three portfolio categories: Focused, Core and High impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics. Countries can also be classified into two crosscutting categories: Challenging Operating Environments and those under the Additional Safeguard Policy. Challenging Operating Environments are countries or regions characterized by weak governance, poor access to health services, and man-made or natural crises. The Additional Safeguard Policy is a set of extra measures that the Global Fund can put in place to strengthen fiscal controls and oversight in a particularly risky environment.

The Global Fund classifies Uganda as:

 Focused: (Smaller portfolios, lower disease burden, lower mission risk)

 Core: (Larger portfolios, higher disease burden, higher risk)

¹¹ CIA World Factbook 2019, using July 2018 estimates.

¹² On a purchasing power parity basis. See [CIA World Factbook's page for Uganda](#).

¹³ World Bank, 2017 [World Development Indicators \(WDI\)](#) data for Uganda.

¹⁴ UNDP 2018 Human Development Index (HDI) data HDI: <http://hdr.undp.org/en/2018-update>

¹⁵ 2018 Corruption Perceptions Index of Transparency International Data: <https://www.transparency.org/cpi2018>

¹⁶ Ministry of Finance's [Annual Budget Performance Report](#) for Financial Year 2014/2015 and the Ministry of Finance's [Annual Budget Monitoring Report](#) for Financial Year 2017/2018

¹⁷ Ministry of Finance's [Annual Budget Monitoring Report](#) for Financial Year 2017/2018

¹⁸ Data extracted from the WHO Global Health Expenditure Database

¹⁹ WHO [list of 57 Countries Facing Human Resources for Health Crisis](#)

²⁰ See 2014 WHO [Global Key Messages on Global Health Workforce Alliance](#)

²¹ Ministry of Health's [Human Resources for Health Audit Report](#), January 2017

²² World Bank, [World Development Indicators \(WDI\)](#) data for Uganda.

X High Impact: (Very large portfolio, mission critical disease burden)

Challenging Operating Environment

Additional Safeguard Policy

2.3 Global Fund Grants in Uganda

The Global Fund has signed various grants totaling US\$1,507 million in Uganda since 2003, covering HIV/AIDS, TB, malaria and health system strengthening.²³ Overall disbursements have amounted to US\$1,168 million. The majority of the funds has been directed towards HIV (48%) and Malaria (44%). For funding cycle 2018-2020, US\$478 million has been allocated to five grants (see table below), of which US\$131 million has been disbursed²⁴.

Two Principal Recipients manage the implementation of the active grants. The civil society organization *The Aids Support Organization Uganda Limited* (TASO) manages the implementation of two active grants while the MoH acts as the implementing entity on behalf of the MoFPED for three other grants.

The active grants in Uganda from 2018 to 2020 (NFM2) and the previous grants for funding cycle 2015 – 2017 (NFM1) are as follows:

Grant No.	Principal Recipients	Grant component	Grant period	Signed amount (US\$)
UGA-H-MoFPED	Ministry of Finance, Planning and Economic Development	HIV/AIDS	01 Jan 2018 - 31 Dec 2020	248,212,125
UGA-T-MoFPED	Ministry of Finance, Planning and Economic Development	Tuberculosis	01 Jan 2018 - 31 Dec 2020	18,445,026
UGA-M-MoFPED	Ministry of Finance, Planning and Economic Development	Malaria	01 Jan 2018 - 31 Dec 2020	175,310,366
UGA-C-TASO	The AIDS Support Organisation (Uganda) Limited	Multi	01 Jan 2018 - 31 Dec 2020	21,106,146
UGA-M-TASO	The AIDS Support Organisation (Uganda) Limited	Malaria	01 Jan 2018 - 31 Dec 2020	14,969,534
TOTAL NFM2				478,043,197
UGA-H-MoFPED	Ministry of Finance, Planning and Economic Development	HIV/AIDS	01 Jul 2015 - 31 Dec 2017	212,797,901
UGA-M-MoFPED	Ministry of Finance, Planning and Economic Development	Malaria	01 Jan 2015 - 31 Dec 2017	143,744,529
UGA-M-TASO	The AIDS Support Organisation (Uganda) Limited	Malaria	01 Jan 2015 - 31 Dec 2017	44,606,581
UGA-T-MoFPED	Ministry of Finance, Planning and Economic Development	Tuberculosis	01 Jul 2015 - 31 Dec 2017	21,703,221
UGA-C-TASO	The AIDS Support Organisation (Uganda) Limited	Multi	01 Jul 2015 - 31 Dec 2017	6,592,650
UGA-S-MoFPED	Ministry of Finance, Planning and Economic Development	RSSH	01 Jul 2015 - 31 Dec 2017	13,176,069
UGA-S-TASO	The AIDS Support Organisation (Uganda) Limited	RSSH	01 Jul 2015 - 31 Dec 2017	5,071,189
TOTAL NFM1				447,692,140
TOTAL NFM1 and NFM2				925,735,337

²³ [Global Fund page for Uganda](#)

²⁴ As per May 2019

2.4 The Three Diseases



HIV/AIDS: Prevalence among the general population (adults 15-49-year-old) is 5.9%. The HIV epidemic is concentrated among key populations, with 13% prevalence among MSM, 27% among people who inject drugs and 34% among sex workers (2017, UNAIDS).

95% of HIV-positive pregnant women receive ART for PMTCT. 78% of people living with HIV on treatment have viral load suppressed (2017, UNAIDS).

AIDS-related deaths fell from 47,000 in 2010 to 26,000 in 2017 (UNAIDS).

1.3 million people living with HIV, of whom 81% know their status. Among those identified PLHIV, 89% were on treatment in 2017 (UNAIDS).²⁵

Annual infections have decreased by 50% since 2010, with 50,000 new infections in 2017 (UNAIDS).



Malaria: Malaria is endemic in Uganda. Its incidence rate declined to 201/1,000 people at risk in 2017 from 218/1,000 in 2015²⁶. Since 2012, the number of reported malaria cases has ranged between 13 to 16 million per year.²⁷

LLIN mass campaign distribution increased from 22 million in 2013/2014²⁸ to 26.5 million in 2017/2018, reaching 97.6% of the population in 2018.²⁹

100% of the population at high risk of malaria.

88% of suspected cases were tested in fiscal years 2016/2017 compared to 76% in fiscal years 2015/2016.³⁰ 85% of confirmed cases are treated.³¹

Estimated deaths have remained stable since 2013 (14,000 per year).³²



Tuberculosis: There has been a decline in TB case notification, from 60% in 2013 to 53% in 2017 (WDI).

Mortality rate increased from 20/100,000 in 1990 to 26/100,000 in 2017.³³

45,794 TB cases were notified in 2017 against an estimated 86,000 TB cases.

Treatment coverage is **53%**.

The **treatment success rate is 77%** (new and relapse cases), remaining stable since 2012.

2.5 Portfolio Performance

Global Fund grants for all diseases in Uganda are generally performing well against the targets set in the performance framework, as shown by the achievement rate of key coverage indicators and other related indicators:

²⁵ All UNAIDS data for Uganda were retrieved from the UNAIDS AIDSInfo page: <http://aidsinfo.unaids.org/>

²⁶ World Bank WDI data for Uganda and WHO World Health Statistics 2017 reported in [PMI](#)

²⁷ WHO [2018 World Malaria Report](#)

²⁸ Uganda Bureau of Statistics, [Malaria Indicator Survey 2014-2015](#)

²⁹ MoH national Malaria Control Division [Annual Report July 2017-2018](#), WHO [2018 World Malaria Report](#) and Uganda Bureau of Statistics, [Uganda Demographic and Health Survey 2016](#)

³⁰ MoH national Malaria Control Division [Annual Report July 2017-2018](#)

³¹ Data for the public sector, using the December 2018 PUDR.

³² WHO [2018 World Malaria Report](#) page 128

³³ WHO [2017 Uganda Tuberculosis Profile](#)

2018 key indicators achievement rate (as of June 2018)			
Indicator	Target	Actual	Achievement rate
HIV			
Percentage of HIV-positive pregnant women who received ARV during pregnancy to reduce risk of mother-to-child transmission	95.00%	103.6%	109%
Percentage of PLWH currently receiving ART	74.80%	84.9%	116%
Percentage of adults and children known to be on treatment 12 months after initiation of ART	88.00%	74.14%	84%
Malaria			
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	80.00%	79.2%	99%
Proportion of confirmed malaria cases that receive first line anti-malaria treatment in the community	95.00%	80.2%	84%
Number of LLINs distributed to targeted groups through continuous distribution	1,825,969	1,487,987	81%
Tuberculosis			
Number of notified cases of all forms of TB	24,122	26,726	111%
TB treatment success rate (all rates)	79%	71.5%	91%
Percentage of registered new and relapse TB patients with documented HIV status	99.00%	95.3%	96%

Source: Global Fund Progress Update and Disbursement Request (PUDR) as of 30 June 2018

	Meet or exceed target
	Close to target (80% - 99%)
	Partially achieved (60% - 79%)
	Far below target (below 60%)

2.6 Risk appetite

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries³⁴ representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants. Country Teams determine each risk at grant level using the Integrated Risk Management module (IRM). The ratings are reviewed by the second line functions and senior management from Grant Management Division. Grant risk ratings are weighted using the country allocation amount to arrive at an aggregate risk level for the country portfolio. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee (PPC)³⁵ during the Country Portfolio Review (CPR). Aggregated risk levels for Uganda have been reviewed and validated as part of a CPR in July 2018 and subsequently updated as part of the IRM module

The OIG compared the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Uganda portfolio with the residual risk that exists based on OIG's assessment, mapping risks to specific audit findings. Please refer to the table below.

³⁴ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe

³⁵ The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews

Audit areas	Risk category	Secretariat aggregated assessed risk level³⁶	Assessed residual risk, based on audit results	Relevant audit issues
1/ Supply chain arrangements	In-country supply chain	Moderate	High	Finding # 4.1
2/ Program Management and Quality of Services	Program governance and grant oversight	Moderate	Moderate	Finding # 4.3
	Program Quality	Moderate	Moderate	Finding # 4.2
3/ Financial management controls	Grant-related fraud & fiduciary risks	Moderate	Moderate	Finding # 4.3
	Accounting & financial reporting	Low	Low	Finding # 4.3

Uganda is an operating environment in which risk levels remain moderate to low across most of the grant implementation risk areas. The assessments of risk levels by the OIG and the Secretariat are aligned except for the risk related to **in-country supply chain**. This risk is a composite of three sub-risks which are: (i) information management systems (LMIS), (ii) warehouse and distribution systems and (iii) forecasting quantification and supply planning. These are linked to OIG finding 4.1 which focuses on management information systems (traceability), supply planning (availability of key health products and expiries) and distribution.

The OIG and the Secretariat have similar levels of assessed risk related to **forecasting, quantification and supply planning**, rated “**moderate**” as key health products are available and expiries are limited. They also have similar level of assessed risks related for **information management systems** rated “**high**”.

The OIG and the Secretariat had different levels of assessed risk related to **warehouse and distribution**. The Secretariat rated this sub risk “**high**” due to human resource capacity challenges (including several unfilled posts) at all levels, sub-optimal systems of recording and tracking health commodities at peripheral level, as well inadequate storage space and poor storage conditions for health products at peripheral level (2018 national supply chain assessment). The OIG audit results suggest the current level of residual risk is “**moderate**” as last mile delivery was found to be effective and the National Medical Store delivers health commodities to the lowest level of the health structure. At the peripheral level, proactive transfers of commodities between health facilities are helping to avoid risks of stock-outs. There are risks related to the ordering system as health product requisitions are not validated against patient data (except for ARVs), but these are not severe enough to consider the distribution risk as high. While there is limited storage space at NMS, extension of storage capacity is on-going and temporary measures are in place to reduce this risk to moderate.

However, unlike the Secretariat for which the rating of in-country supply chain is at the high end of “**moderate**” based on the risk rating methodology described in annex C, the **OIG evaluates the overall risk of in-country supply chain “high”** as the risk for the information management systems (traceability) is a key driver of the overall supply chain risk in a context where more than 90% of Global Fund grants are commoditized. All Global Fund drug procurements of US\$300 million for the current grant cycle are dealt with by NMS (inventory management, storage and distribution). In the absence of a preventive control – barcode entry system - and an ineffective detective control, the risk of leakage and diversion at a large scale remains high. Even though the risks pertaining to these control gaps have not yet materialized, they would - if not addressed and they materialize over time - have a material impact on commodities availability in health facilities and therefore on the overall supply chain risk level.

³⁶This is the aggregated risk level for the grants in Uganda as of June 2019

3. The Audit at a Glance

3.1 Objectives

The audit's overall objective was to provide reasonable assurance on the adequacy, effectiveness and efficiency of Global Fund Grants in Uganda.

Specifically, the audit assessed:

- the effectiveness and efficiency of the procurement and supply chain arrangement to deliver and account for health products;
- the adequacy and effectiveness of mitigation measures instituted by the Secretariat to ensure optimal implementation of program activities;
- the adequacy and effectiveness of design, oversight and internal controls over financial management.

3.2 Scope and Methodology

The audit was carried out in accordance with the methodology described in Annex B, covering the Principal Recipients of the Global Fund programs in Uganda, and the new funding model grants from January 2016 to December 2018. The audit covered the seven grants of NMF1 and five grants of NMF2 which included both principal recipients, MoFPED and TASO. Overall, the auditors visited 30 selected health facilities at central and sub-national level, as well as the NMS (which implements last-mile delivery of drugs to health facilities) head office.

3.3 Progress on Previously Identified Issues

The last OIG audit of grants in Uganda took place in 2015. It assessed the adequacy and effectiveness of grant operations and arrangements to safeguard Global Fund resources. It also assessed the risks that Global Fund grants may be exposed to, and what mitigation measures were in place.

Previous relevant OIG audit work

[Audit of Global Grants to the Republic of Uganda, 2016 \(GF-OIG-16-005\)](#)

The main weaknesses identified in the audit were treatment disruption due to limited funding and inadequate management of commodities in the supply chain system; the suboptimal implementation of activities which affected the quality of service to patients; limitations in the supply chain management to effectively store and account for commodities received; the limited quality of data for decision making; and inadequate financial management systems and program funds accountability. Six agreed management actions were prepared in response to the findings, of which five have been implemented and one in relation to fund recoveries remains outstanding.

Implementation of activities financed under the program has since improved, leading to good progress on the 90-90-90 targets, declining incidence of malaria, and improved reporting of routine disease data. However, facility levels still lack effective supervision and sufficient TB training to ensure the delivery of quality care (see section 4.2).

Oversight over drugs traceability has been enhanced, resulting in effective commodity deliveries to final recipients. However, variances in supplies receipts, stock levels, and insufficient tracking oversight systems still need to be addressed (see section 4.1). Likewise, while the 2017 LLIN mass campaign reached universal coverage, around 2 million extra nets were distributed than were in the initial campaign plans. (see section 4.1). With regards to financial management, the integration of previous Global Fund-funded positions into the MOH and processes has reduced bottlenecks, although there is still weak advance monitoring, low in-country fund absorption, and gaps in financial oversight (see section 4.3).

4. Findings

4.1 The traceability and availability of key health products require improvement

Global Fund grants to Uganda are highly commoditized; 90% of grant funds was allocated to commodities and supply chain management costs during the 2015–2017 and 2018–2020 funding cycles. Since the 2015 OIG audit, the country has made significant progress on drug traceability, drug availability and supply chain efficiency.

The Ugandan government, along with in-country partners, has paid particular attention to health commodities through various actions. Coordination among in-country stakeholders has been strengthened through establishing a task force to improve the health commodities supply chain system, involving senior management from the MOH and MoFPED, development partners and civil society organizations. The Global Fund together with other partners co-financed a National Supply Chain Assessment (NSCA) in 2018 to identify key challenges and opportunities to improve the existing supply chain. This audit's findings are generally aligned with the NSCA's findings.

Despite this progress overall, some specific aspects of the supply chain still require attention.

In terms of traceability, inadequate internal controls at the central level and poor record keeping at health facilities prevent full traceability and accountability of health products.

At the central level, the MOH has appointed an internal auditor to track Global Fund funded-products across the supply chain. NMS, which is responsible for storing and distributing funded products to the public sector, has an internal audit unit which reviews entries and supporting documents related to funded commodities received from suppliers as part of the storage service to the MOH.

Internal controls at MOH and NMS are not designed to reconcile batch numbers of health product deliveries. Batch numbers are manually entered in the NMS inventory management system (MACS), increasing the risk of errors. No MOH oversight was performed in the last quarter of 2018, and NMS's annual stock take at end-June, critical to ensuring the actual existence and accuracy of available stocks, took place without the participation of any external party such as the MOH or an external auditor as per the required procedures.

These inadequate internal controls have resulted in failure to identify errors in entries posted in the MACS system. For over 500 entries of receipts posted in MACS, either the batch numbers entered were erroneous/inconsistent, or the entries had incorrect quantities (understated or overstated) of items for specific batch numbers. This resulted in initial reconciliation differences which, while they were later re-examined and clarified by NMS, prove the ineffectiveness of current internal controls. Some of these differences related to 79 entries with incorrect batch numbers. For 101 entries, the batch numbers recorded in MACS for antimalarial drugs (injectable artesunate) differed from the records of the Global Fund pooled procurement mechanism. In the absence of a preventive control (a barcode entry system to avoid manual errors) and an ineffective detective control (not based on batch number) NMS's ability to ensure drugs traceability is limited. To improve accountability over health products, the Secretariat has agreed with a partner to extend the scope of its Fiduciary Agent review to Global Fund-funded commodities.

At the health facilities level, there has been particular improvement for ARVs and for TB medicines³⁷ since the 2015 audit; these were fully traceable in ten and nine of the 13 health facilities visited, respectively. Malaria commodities traceability however has not improved since the last audit. Anti-malaria drugs and malaria rapid tests delivered by NMS were not traceable respectively in 53% and

³⁷ The two TB tracers were the first line anti-TB RHZE and the prophylactic TB treatment INH adult.

47% of health facilities visited. Poor record keeping and the lack of regular physical inventory counts, both due to insufficient human resources, coupled with irregular supervision on commodities from MOH and the District Health Office, have contributed to this traceability gap.

Regarding drug consumption within health facilities (from pharmacy main store to patients through the dispensing point), only 28% and 50% of health facilities visited had accurate consumption data respectively for malaria rapid tests and first line anti-malaria drugs. In four of the 17 health facilities visited, the OIG could not determine the actual number of consumed drugs due to incomplete or missing consumption records.

HIV and TB consumption data were found to be inaccurate. In various instances at the health facilities visited, HIV drug consumption levels in stock records were up to 20% higher than actual consumption. In the case of TB, three of 11 health facilities reported drug consumption which was 50% higher than actual consumption. These deficiencies affect the accuracy of logistic management information system data, which are essential to monitor stocks at health facilities level and to ensure accountability over consumed drugs.

While availability for malaria products and antiretroviral drugs has significantly improved, other health products still face significant stock-outs and shortages.

A number of good practices have contributed to the increased availability of health products at health facilities level, compared to OIG's 2015 audit which identified significant stock-outs of key medicines across the three diseases. These practices include active monitoring of stock availability at central level through the production of comprehensive stock status reports, regular meetings of a high-level task force for commodities monitoring, and last mile delivery of health commodities by NMS to the lowest level of the health structure (Health Center level III and II). At the peripheral level, proactive transfers of commodities between health facilities are helping to avoid risks of stock-outs between NMS deliveries.

In 2018, there was continuous availability³⁸ of the two tracer ARVs and TB prophylactic treatments at the health facilities sampled. Similar continuous availability was observed for malaria commodities, with the exception of three health facilities which experienced two months of stock-outs of ACTs (July–August 2018) due to interrupted deliveries from NMS caused by the semi-annual inventory of stock.

HIV rapid tests (screening tests and confirmatory tests), on the other hand, experienced significant periods of stock-out in 2018. 27% of health facilities visited had stock-out episode of Determine (first-line HIV screening test) exceeding 30 days, while 64% of health facilities experienced stock-out episode of the HIV confirmatory test (Statpack) lasting at least 60 days. These resulted from undersupply from the central warehouse level due to a funding gap for HIV rapid tests³⁹, exacerbated by excessive testing (see section 4.2).

Stock-outs of anti-TB first line drugs (RHZE) were noted in three of 11 health facilities, with average stock-outs of 35 days per quarter in 2018. A global shortage of TB drugs was one contributing factor for the stock-outs, which caused disruption of services at the health facilities. In consequence, the TB drugs order placed in April 2018 took 11 months to be delivered, against a usual lead time of 4-6 months.

The ordering process also contributes to stock-outs. Except for ARVs, the Ministry of Health has no oversight on health product requisition and does not validate orders against patient data or other programmatic considerations (e.g. peak malaria season, outreach activities). Due to product shortages at the central warehouse (e.g. TB first line drugs, HIV rapid test kits), NMS determines delivery quantities for health facilities regardless of patient data.

³⁸ Regarding HIV/TB, we could not perform any verification in two health facilities due to missing 2018 stock cards. Similarly, for malaria, no check was done in 6 health facilities where stock cards were not available for year 2018.

³⁹ The funding gap analysis by MOH showed that the HIV test kits had a funding of 21.2 million after the allocation across the funding cycle 2018 – 2020.

Immaterial expiries of health products across the supply chain, but inefficiencies in the Long-Lasting Insecticide-Treated Nets (LLIN) mass distribution.

Whereas the 2015 OIG audit identified significant amounts of expired drugs throughout the supply chain, the current audit noted low level of expiries at both central and peripheral level. NMS records expiries as accounting for less than 1% of receipts⁴⁰ in 2017 and 2018, and no material quantity of expired drugs was found in any of the 30 health facilities visited.

There were however inefficiencies in the LLIN mass distribution in 2017/2018, despite it meeting its targets (98% overall coverage against a target of 85%). The number of households and population served was overstated⁴¹ by 20% compared to the estimated population, due to weaknesses in the household registration process such as the low involvement of District Health Office and lack of training. The overstatement resulted in the distribution of two million additional nets which were not needed, considering the WHO recommendation⁴² of one bed net per two people at risk of malaria. The Local Fund Agent field visit confirmed that the number of received LLINs per household exceeded the recommended ratio in most cases. This situation was caused by a lack of controls over household data both at district and central level.

Agreed Management Action 1:

The Secretariat will support the PR to strengthen overall controls around supply chain distribution including:

- (a) Improving data input and distribution by piloting the Enterprise Resource Planning software at the central level, including unique identification such as batch number, or other mechanism to reduce human error;
- (b) Increasing oversight by PR (Ministry of Finance, Planning and Economic Development) and MOH to jointly perform quarterly reconciliation between drugs received, entered into the system and distributed using the unique number identification;
- (c) In coordination with in country-stakeholders, extending the scope of review of the Fiduciary Agent to include the monitoring of Global Fund health commodities.

Owner: Head of Grant Management Division

Due date: 31 December 2020

⁴⁰ WHO sets a target of <1% for efficient supply chain P25-26. <http://apps.who.int/medicinedocs/documents/s19906en/s19906en.pdf>

⁴¹ Process evaluation of the 2017 mass distribution campaign of LLIN in Uganda by Makerere University of Public Health, page 39

⁴²<https://apps.who.int/iris/bitstream/handle/10665/259478/WHO-HTM-GMP-2017.20-eng.pdf;jsessionid=A771389376196494B882AE451B911928?sequence=1> Page 1-2

4.2 MOH oversight and community related activities need to be strengthened

Uganda has achieved significant progress towards HIV 90-90-90 targets, and despite a 2015/2016 malaria resurgence in the Northern region, the malaria program is on track to achieve the Uganda Malaria Reduction Strategic Plan 2014-2020 targets for reducing mortality and incidence. The tuberculosis program, however, is consistently underperforming in meeting its key targets.

Tuberculosis

The TB program is underperforming, with a high number of missing TB cases (47% in 2017) and a treatment success rate consistently below 80% in the past three years. With a change in leadership at the Tuberculosis national program the number of notified cases of all forms of TB has increased in 2018 achieving the Global Fund targets. In spite of these recent achievements the number of missing cases remains high.

Various factors relating to MOH responsibility and oversight are contributing to this:

Ineffective supervision: The MOH does not have an integrated supervision framework across the three diseases. At lower level (district and health facilities), the regional performance monitoring teams supporting TB-related activities have been disbanded, and central-level supervision has very limited coverage. In 2018, supervision missions for TB-related activities took place in only three out of 14 health facilities visited.

Training not consistently provided to health workers: GeneXpert machines are not being used systematically to confirm TB cases, as required by the Uganda national guidelines for TB in Health care facilities. This is due to lack of training (observed in half of health facilities) on the updated TB diagnosis guideline. Similarly, 64% of staff at health facilities reported not being trained on TB Isoniazid Preventive Therapy (IPT), which has contributed to low TB IPT performance (21% achievement).

Lack of guidelines and tools at service delivery facilities: Data relating to TB presumptive cases are not being consistently collected and reported in registers at health facilities, making it difficult to investigate and improve TB case notification. The TB diagnosis guideline was either unavailable or outdated in most of health facilities visited. Half of health facilities did not have a TB defaulter tracking tool and guidance; its absence poses challenges in tracking TB patients until they are cured.

Ineffective TB community case management: The weak links between VHTs and health facilities, and the limited financial motivation of community health workers, limits their ability to perform active TB case finding and to follow up with patients who have dropped out of treatment at community level.

Malaria

Uganda's 2017/2018 LLIN mass distribution achieved coverage of 98%, exceeding the country target of 85%. Malaria incidence fell from 218/100,000 population in 2015 to 187/100,000 population in 2017. Estimated malaria deaths, however, have remained constant at 14,000/ year between 2013 and 2017. To achieve better results, various areas require strengthening:

- *Unequal maturity of integrated community case management (ICCM):* ICCM has been unevenly implemented across Uganda's four regions. While community health workers⁴³ provide testing and treatment services in the Northern region, those in the Eastern region have limited involvement in providing the same services. The link between health facilities and village health

⁴³ In Uganda community health workers are represented by Village Health Teams (VHTs), community volunteers acting as a link between the communities and health facilities. The Ministry of Health planned to institutionalize community health workers as Community Health Extension Workers (CHEWs) but this plan has been suspended due to limited funds.

teams (VHTs) is weak, with no supervision of VHTs by health facilities and limited documentation of VHTs activities at health facilities level. Supervision and review of community health workers work is paramount to achieving and reporting key health indicators at community level. 41% of health facilities had no ICCM tools available and only 12% of health facilities visited maintained copies of VHT reports which would have facilitated the tracking and validating of VHT work, as well as triangulation of the data reported for surveillance.

- *Insufficient coordination of supervision:* Half of health facilities reported having received technical supervision for malaria, but limited evidence was available to support this. 47% of health facilities reported having received ICCM training in diagnosing and treating malaria. While some health facilities received regular supervision missions from both implementing partners and the MOH, others received no supervision in the same period. This is due to roles and responsibilities not being defined to avoid overlaps/gaps in supervision between the MOH and implementing partners.

HIV: more programmatic efficiencies could be achieved

Uganda is close to achieving the UNAIDS 90-90-90 targets.⁴⁴ The HIV program is implementing a number of good practices, including a differentiated service delivery approach and the use of an electronic management record to monitor patients under ART. Nevertheless, there remains room for improvement:

- *HIV Testing:* as of December 2017, 81% of people living with HIV were aware of their status, thanks to mass testing in previous years. The same testing strategy was implemented in 2017 and 2018 with overall HIV positivity rate of 3.2% in 2018 and 2.8% in 2017⁴⁵, almost 50% below the overall prevalence rate (5.9%)⁴⁶. This is to be expected as the program nears the 90% target and it becomes harder to find new HIV cases. Since September 2018, Uganda has started implementing a differentiated HIV screening approach, which should identify new HIV cases more efficiently.
- *Delayed prevention-related activities:* despite a decline in new infections (from 89,000 in 2012 to 50,000 in 2017), the number of new HIV infections remains high. To improve prevention, a strategic initiative targeting Adolescent Girls and Young Women (AGYW) was planned for the 2018-2020 grant cycle. It has been delayed, however, along with a new initiative on human rights advocacy, due to difficulties in recruiting implementers for those programs. At the time of the audit, two draft baseline assessments for AGYW and Human Right barriers have been performed, and the implementers recruiting process had been completed. Implementation started in October 2018 and a plan to accelerate AGYW efforts was put in place.

Agreed Management Action 2:

The Secretariat will request the Ministry of Finance, Planning and Economic Development and Ministry of Health to strengthen oversight of the related Global Fund grants by:

- a) updating the MOH's site supervision framework and the relevant roles and responsibilities in the process.
- b) performing an analysis of the VHTs and community health workers programs and developing a plan to improve community case management for Malaria and TB.

⁴⁴ As of end-December 2017, the number of people living with HIV (PLWH) who know their status was established at 81% against 73% in 2015 while the proportion of HIV patients under ART had increased from 75% to 89% in the same period. The viral load suppression among PLWH under ART (3rd 90) was 78%. (Source UNAIDS)

⁴⁵ Data from the DHIS2 maintained by the Ministry of Health

⁴⁶ UNAIDS country fact-sheet – March 2019

- c) developing an action plan to roll out the updated case finding and treatment guidelines, including on patient monitoring and tracing those lost to follow up and conduct health workers trainings to improve alignment with National TB and HIV Program guidelines.

Owner: Head of Grant Management Division

Due date: 31 December 2020

4.3 Oversight by the Principal Recipient and internal controls at the Ministry of Health need strengthening

Uganda has made significant progress in addressing gaps identified in the 2015 audit. The transfer of responsibilities from the MOH coordination unit to the newly created Fund Coordination Unit (FCU) within MoFPED has given the Ministry of Finance more of an accountability and oversight role as Principal Recipient. For example, senior MoFPED and MOH management take part in monthly meetings to discuss progress and implementation bottlenecks. The Global Fund Secretariat requested the external auditor to perform a review of the newly created FCU in 2018; the results of the review are being used to inform initiatives towards improving the FCU.

At the MOH, finance and accounting controls have improved as a result of these changes. For example: an internal auditor was appointed at the MOH in 2017 to provide oversight over commodities and financial accountability; the MOH has introduced an e-cash payment mechanism for workshop and training participants; and the automation of the financial management system is in progress. These measures have led to notable improvement of the management of grant funds. However, MOH oversight and internal controls still require strengthening in some areas:

FCU's role and responsibilities need to be reviewed and enhanced to be aligned to its mandate

The Fund Coordination Unit was established under the MoFPED to oversee Global Fund grant implementation. The new FCU allows Principal Recipients to have better visibility of grant activities: for example, FCU representatives attend monthly MOH implementation progress meetings and the FCU team has implemented financial controls over payments made by the MOH (as implementing agency) from grant funds.

There is however not enough clarity on the defined roles and responsibilities between the MoFPED-FCU and the MOH for Global Fund implementation arrangements: this is especially true for areas such as program management, monitoring and evaluation, support supervision and reporting, developing and monitoring implementation plans for Global Fund grants, processing payments and disbursements, consolidating and submitting Progress Update and Disbursement Requests, and bank account controls. As a result, FCU oversight is limited. For example, the no-objection letter (approval of transaction) for individual payment issued by the FCU is not systematically supporting the payment process at MOH because the FCU cannot subsequently check whether actual payments made by MOH were supported by no-objection letters. On a sample basis, the OIG audit noted five payments totaling US\$172,918 for which there was no evidence that a no objection from FCU was provided. The FCU is aware of these weaknesses and proposed in June 2018 to revise its roles, responsibilities and structure for better alignment with the assigned objectives.

In addition, the FCU does not have sufficient mechanisms to monitor budget execution or activities being implemented. For example, there is no independent follow-up to check that implementers have undertaken the activities for which funds were approved. For procurement and supply chain management, the FCU does not monitor implementation, and does not receive regular reports from implementing bodies. Similarly, there is no FCU oversight over commodities accountability, despite the grants being 97% focused on procurement and supply management.

Reasons for these shortfalls include:

- Limited resources at FCU increasing the work load of FCU staff and creating delays in processing requests from MOH (e.g. issue of no-objections over payments). FCU staff are expected to split their time 80:20 between their assigned work for Ministry of Finance projects and Global Fund activities.

- The automated financial management system is not being used optimally - only the payment module is used. Budget monitoring, advance management and reporting modules are not yet in use for Global Fund grants; those functions are performed manually via Excel spreadsheets.
- Oversight committees (Global Fund Support Steering Committee and Global Fund Technical Committee) are not active.

Inadequate management of advances resulting in long outstanding advances

The MOH provides advances to District Health Offices and staff for various activities such as training, workshops and supervision. The advance management process has a number of weaknesses including recording advances as actual expenditure at the time of payment, the lack of a mechanism for tracking and recovering advances, and the manual processing of advances in Microsoft Excel creating risks on the accuracy, integrity and completeness of data.

As a result of these weaknesses, staff and implementer advances amounting to US\$0.58 million had not been accounted for at the time of the audit. These advances have been outstanding for an average of 471 days (up to 721 days). The retirement of advances should normally be completed within 60 days after the completion of activities, as per Ugandan financial regulations.

Advances totaling US\$0.25 million relating to advances from previous NFM1 grants have not been reimbursed by three sub-recipients at the date of the audit. The sub-recipients concerned requested guidance from the MOH on how to reimburse unspent grant amounts, but the MOH has not provided any guidance to date.

In-country fund absorption remains low

There was good overall budget absorption of the four grants under the MOH for NFM1 (2015–2017), with 97% for HIV, 81% for TB, 78% for Malaria, and 75% for the Health System Strengthening grants. However, for in-country funds absorption⁴⁷, the absorption rate was low for the malaria (57%) and tuberculosis (58%) grants. This had a direct impact on the implementation of programmatic activities:

- Delays in mass screening of TB in prisons: quarterly screening was performed for only one quarter, despite being planned for the whole period of 2016-2017 (i.e. eight quarters)
- Non-implementation of activities, due to the absence of detailed implementation plans accompanying disbursed funds to districts
- Delayed construction of Drop-in Centres due to sub-optimal project management

Agreed Management Action 3:

The Secretariat will work with the Ministry of Finance, Planning and Economic Development to strengthen oversight of the Fund Coordination Unit, by updating its terms of reference in overseeing the Global Fund grants and complementing the Ministry of Health and Ministry of Local Government oversight function. The update should include management of the long-outstanding advances and funds disbursed to districts, monitoring of health commodities, strengthening the payments' approval process.

Owner: Head of Grant Management Division

Due date: 31 December 2020

⁴⁷ In-country funds absorption refers to all expenditure incurred at country level excluding health products and their related procurement and supply chain costs.

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
<p>1. The Secretariat will support the PR to strengthen overall controls around supply chain distributions including:</p> <p>(a) Improving data input and distribution by piloting the Enterprise Resource Planning software at the central level, including unique identification such as batch number, or other mechanism to reduce human error;</p> <p>(b) Increase oversight by PR (Ministry of Finance, Planning and Economic Development) and MOH to jointly perform quarterly reconciliation between drugs received, entered into the system and distributed using the unique number identification;</p> <p>(c) in coordination with in country-stakeholders, extend the scope of review of the Fiduciary Agent to include the monitoring of Global Fund health commodities.</p>	31 December 2020	Head of Grant Management Division
<p>2. The Secretariat will request the Ministry of Finance, Planning and Economic Development and Ministry of Health to strengthen oversight of the related Global Fund grants by:</p> <p>a) updating the MOH's site supervision framework and the relevant roles and responsibilities in the process.</p> <p>b) performing an analysis of the VHTs and community health workers programs and developing a plan to improve community case management for Malaria and TB.</p> <p>c) developing an action plan to roll out the updated case finding and treatment guidelines, including on patient monitoring and tracing those lost to follow up and conduct health workers trainings to improve alignment with National TB and HIV Program guidelines.</p>	31 December 2020	Head of Grant Management Division
<p>3. The Secretariat will work with the Ministry of Finance, Planning and Economic Development to strengthen oversight of the Fund Coordination Unit, by updating its terms of reference in overseeing the Global Fund grants and complementing the Ministry of Health and Ministry of Local Government oversight function. The update should include management of the long-outstanding advances and funds disbursed to districts, monitoring of health commodities, strengthening the payments' approval process.</p>	31 December 2020	Head of Grant Management Division

Annex A: General Audit Rating Classification

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

Annex B: Methodology

The OIG 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 documents 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 at the Global Fund as well as in country, 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: Risk Appetite and Risk Ratings: Content, Methodology and Implications

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries⁴⁸ representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants.

As accurate risk ratings and their drivers are critical to effective risk management and operationalization of risk appetite, a robust methodology was developed with clear definitions, granular risks, root causes as well as an extensive review process as detailed below.

The eight grant-facing risks for which risk appetite has been set represent an aggregation from 20 risks as depicted in the table on the following page. Each of these 20 risks is rated for each grant in a country using a standardized set of root causes and considers a combination of likelihood and severity scores to rate risk - Very High, High, Moderate or Low. Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by second line functions and senior management from the Grant Management Division.

The ratings at the 20-risk level are aggregated to arrive at the eight risks using simple averages, i.e. each of the component parts are assumed to have similar importance. For example, the risk ratings of *Inadequate program design (1.1)* and *Inadequate program quality and efficiency (1.3)* are averaged to arrive at the rating of Program Quality for a grant. As countries have multiple grants, which are rated independently, individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. As the ratings of grants often vary significantly and to ensure that focus is not lost on high-risk grants, a cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee⁴⁹ during the Country Portfolio Review.

Leveraging Risk Appetite in OIG's work

As the Risk Appetite framework is operationalized and matures, OIG is increasingly incorporating risk appetite considerations in its assurance model. Important considerations in this regard:

- The key audit objectives that are in the scope of OIG audits are generally calibrated at broad grant or program levels (for example, effectiveness of supply chain processes, adequacy of grant financial management, quality of services, reliability of data, overall governance of grant programs, etc.) as opposed to narrower individual risk levels. Thus, there is not a one-to-one match between the overall audit rating of these broad objectives and the individual rating of narrower individual risks. However, in the absence of a one-to-one match, OIG's rating of an overall audit objective does take into consideration the extent to which various individual risks relevant to that objective are being effectively assessed and mitigated.
- The comparison of OIG's assessed residual risks against the Secretariat's assessed risk levels is done at an aggregated level for the relevant grant-facing risks (out of the eight defined ones) that were within the scope of the audit. This comparison is not done at the more granular level of the 20 sub-risks, although a narrative explanation is provided every time the OIG and the Secretariat's ratings differ on any of those sub-risks. This aggregated approach is designed to focus the Board and AFC's attention on critical areas where actual risk levels may differ from perceived or assessed levels, and thus may warrant further discussion or additional mitigation.

⁴⁸ Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe.

⁴⁹ The role of the Portfolio Performance Committee is to conduct country portfolio reviews.

For risk categories where the organization has not set formal risk appetite or levels, OIG focuses on the Secretariat's overall processes for assessing and managing those risks, and opines on their design and effectiveness.

Table of risks

Corporate Risks (8)	Operational Risks (20)
Program Quality	1.1 Inadequate program design and relevance
	1.3 Inadequate program quality and efficiency
M&E	1.2 Inadequate design and governance of M&E Systems
	1.4 Limited data availability and inadequate data quality
	1.5 Limited use of data
Procurement	3.3 Inefficient procurement processes and outcomes
In-Country Supply Chain	3.2 Unreliable forecasting, quantification and supply planning
	3.4 Inadequate warehouse and distribution systems
	3.6 Inadequate information (LMIS) management systems
Grant-Related Fraud & Fiduciary	2.1 Inadequate flow of funds arrangements
	2.2 Inadequate internal controls
	2.3 Fraud, corruption and theft
	2.5 Limited value for money
Accounting and Financial Reporting by Countries	2.4 Inadequate accounting and financial reporting
	2.6 Inadequate auditing arrangements
National Program Governance and Grant Oversight	4.1 Inadequate national program governance
	4.2 Ineffective program management
	4.3 Inadequate program coordination and SR oversight
Quality of Health Products	3.1 Inappropriate selection of health products and equipment
	3.5 Limited quality monitoring and inadequate product use