



Audit Report

Global Fund Grants in Togo

GF-OIG-19-022
12 November 2019
Geneva, Switzerland

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Audit Report

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Table of Contents

| | | |
|-----|--|----|
| 1. | Executive Summary | 4 |
| 1.1 | Opinion | 4 |
| 1.2 | Key Achievements and Good Practices | 4 |
| 1.3 | Key Issues and Risks | 5 |
| 1.4 | Rating | 6 |
| 1.5 | Summary of Agreed Management Actions | 6 |
| 2. | Background and Context | 7 |
| 2.1 | Overall Context..... | 7 |
| 2.2 | Differentiation Category for Country Audits | 7 |
| 2.3 | Global Fund Grants in Togo | 7 |
| 2.4 | The Three Diseases | 8 |
| 2.5 | Portfolio Performance | 9 |
| 2.6 | Country risk appetite consideration | 10 |
| 3. | The Audit at a Glance..... | 12 |
| 3.1 | Objectives | 12 |
| 3.2 | Scope and Methodology..... | 12 |
| 3.3 | Progress on Previously Identified Issues..... | 12 |
| 4. | Findings | 13 |
| 4.1 | Inaccuracies in data affect decision-making..... | 13 |
| 4.2 | Poor traceability of drugs at district and service delivery level makes it difficult to account for funded medicines | 15 |
| 4.3 | Assurance and implementation arrangements need improvement..... | 17 |
| 5. | Table of Agreed Actions | 19 |
| | Annex A: General Audit Rating Classification | 20 |
| | Annex B: Methodology..... | 21 |
| | Annex C: Risk Appetite and Risk Ratings: Content, Methodology and Implications | 22 |

1. Executive Summary

1.1 Opinion

The Global Fund is a key partner to Togo in the fight against the three diseases, making cumulative investments of US\$268 million¹ in the country since 2003.

Togo has strengthened its health information management system, completing the roll-out of District Health Information Management System (DHIS2) across all districts in March 2018. Most health facilities are equipped with digital tablets, enabling them to report data directly in DHIS2. As a result, the timeliness of report submission by health facilities improved from 14% at the beginning of 2018 to 56% by the end of the year. Despite these achievements, material inaccuracies in the data reported to the Global Fund are affecting decision-making; these are due to weaknesses in supervision arrangements and limited assurance over data. The systems, processes and controls on data quality **require significant improvement**.

The three active grants in Togo are highly commoditized, with 68% allocated to health products and related supply chain costs. At central and regional level, procured commodities are fully traceable. Below the regional level, the lack of, or poor maintenance of, inventory management tools make it difficult for districts and health facilities to account for drugs received from the central warehouse, CAMEG². For example, of the ten health facilities visited, only three were able to account for the anti-malaria medicines and malaria test kits received. In two health facilities, distributed drugs could not be traced because no records were available, while variances of up to 68% between drugs distributed and health facilities' records were observed in five other facilities. The processes and controls to account for funded medicines across the in-country supply chain are **partially effective**.

The existing grants are performing close to their established targets. The country has successfully managed to coordinate interventions from other donors with those financed by the Global Fund to prevent duplications. However, poor management of the agent sub-contracted to procure non-health products amounting to US\$5.3 million has resulted in significant delays to the renovation of the main central warehouse, and low visibility of required financial information from the agent. Anti-malaria drugs from the private sector continue to be sold to patients in health facilities despite the availability of free drugs procured through Global Fund grants. Implementation arrangements are rated as **partially effective**.

1.2 Key Achievements and Good Practices

Significant progress made in the fight against the three diseases: Regarding HIV³, antiretroviral treatment (ART) coverage almost doubled, from 31% in 2013 to 60% in 2018, surpassing the West and Central Africa⁴ regional average of 51%. New HIV infections declined by 21% between 2013 and 2018, while HIV-related deaths fell by 16% in the same period. From 2013 to 2017, the malaria⁵ related mortality rate declined by 27%, from 1,361 deaths per year to 995. The use of malaria diagnosis tests increased from 808,000 in 2015 to 1 million in 2017. The proportion of tuberculosis⁶ notification reached 80% in 2017, against an average of 48% in the West and Central Africa region.

¹ The Global Fund data explorer <https://data.theglobalfund.org/grants/TGO>

² Centrale d'Achat de Médicaments Essentiels Génériques du TOGO

³ Data on HIV comes from the UNAIDS Togo website <https://www.unaids.org/en/regionscountries/countries/togo>

⁴ Western and Central Africa region.

⁵ Data on malaria comes from the malaria world report 2018

<https://apps.who.int/iris/bitstream/handle/10665/275867/9789241565653-eng.pdf?ua=1>

⁶ Togo TB profile 2017

https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TG&LAN=EN&outtype=html

Effective coordination of donor interventions: Global Fund interventions are well coordinated with those of other donors to avoid duplication and overlaps. For example, the World Bank's "PASMIN"⁷ project complements the Global Fund grants on malaria case management and health management system strengthening. The program's transition has been well planned, to enable Global Fund grants to take over key interventions in geographical areas covered by PASMIN.

Improved availability of health data: The country successfully rolled out DHIS2 in March 2018. Most health facilities are equipped with digital tablets, enabling them to report data directly in DHIS2. As a result, the timeliness of data report submissions by health facilities has improved, from 14% in early 2018 to 56% in December 2018.

1.3 Key Issues and Risks

Data quality requires significant improvement: Material inaccuracies were identified in the results reported to the Global Fund. In a sample of visited health facilities, the OIG was unable to reconcile 42% of pregnant women reported in DHIS2 as being enrolled for PMTCT⁸ to the underlying patient files and registers. The number of patients treated with anti-malaria drugs was underestimated by at least 19% in 30% of the health facilities visited, because of non-reporting of patients treated with non-Global Fund financed anti-malaria drugs, contrary to the performance framework. This is largely due to limited Global Fund assurance over in-country data, as well as ineffective supervision by implementers.

Poor traceability of drugs at district and service delivery level: District health offices, which are responsible for collecting drugs at regional warehouses and dispatching them to health facilities, do not maintain adequate inventory management tools. Four out of six districts visited did not have stock cards nor stock-issued vouchers of medicines supposedly sent to health facilities. Seven of the 10 visited health facilities could not fully account for the drugs received in 2018, due to poor maintenance of stock cards and dispensing logs. This poor traceability is due to weak oversight over commodities at district and health facilities level, and insufficient human resources at health facilities.

Weak monitoring of the procurement of non-health products worth US\$5.3 million: The Principal Recipient failed to promptly monitor deliveries of items procured by its procurement agent, resulting in discrepancies between delivered items and orders. This is partly due to limited information provided by the procurement agent. The procurement agent is responsible for a warehouse renovation which had been delayed by over a year as of July 2019, partly due to weak oversight by the Principal Recipient and insufficient consideration of pharmaceutical storage standards in the construction specifications.

Lack of oversight on sale of anti-malaria medicines could limit access to malaria services: As per government guidelines⁹, all patients suffering from malaria should be given free anti-malaria medicines financed by the Global Fund, regardless of age. Due to lack of oversight to ensure enforcement of this guideline, health facilities continue to sell anti-malaria medicines received from the private sector to patients, despite free anti-malaria medicines funded by the Global Fund being available. In practice, health facilities determine which patient receives free anti-malaria medicine and which one pays for the services. This risks discouraging vulnerable populations from accessing services due to financial barriers. The Secretariat is planning an assessment of the impact of user fees on access to health services in selected West and Central African countries in 2019. This will inform the specific measures to be instituted in each country, including the design of grants to increase access to services for vulnerable populations.

⁷ Projet d'Appui à la Santé Maternelle et Infantile

⁸ Prevention of Mother to Child Transmission

⁹ Décision No 013/2015/MS/CAB/SG du 20 avril 2015 and Décision No 150/2013/PM/CAB du 8 Octobre 2013

1.4 Rating

| | |
|--|--|
| | Objective 1: adequacy and effectiveness of controls and processes in place to ensure the reliability of data for decision making OIG Rating: Needs significant improvement |
| | Objective 2: adequacy and effectiveness of the controls and processes in place for the storage, distribution and traceability of medicines, health commodities and program assets OIG Rating: Partially effective |
| | Objective 3: adequacy and effectiveness of the grant implementation arrangements OIG Rating: Partially effective |

1.5 Summary of Agreed Management Actions

The OIG and the Global Fund Secretariat have agreed a set of actions and related deliverables to address the findings. Specifically, the Global Fund Secretariat and in-country stakeholders will work with the Ministry of Health to:

- Update and implement the manual of procedures of the Health information system (MOP-SNIS). This will include defining the frequency and nature of supervision activities to be performed by national, regional and district levels, communication and coordination channels to share supervision results and measures or procedures to govern changes to data in DHIS.
- Develop a supply chain strengthening road map. The road map will include defined roles, accountability of each stakeholder, measures to improve traceability of medicines and related assurance mechanisms over supply chain activities.
- Develop and disseminate clear guidance for public health facility prescribers on when to prescribe free versus paid antimalarial medicines to patients to ensure vulnerable populations are not disadvantaged, as well as public communications that outline the aforementioned criteria for free versus paid medicines.
- Evaluate the structure of the Principal Recipient as part of the next funding cycle.

2. Background and Context

2.1 Overall Context

Togo is a West African country with a population of 7.9 million.¹⁰ A low-income country, 55% of the population live below the national poverty line.¹¹

The national health system comprises 44 Health Districts and 1,246 health facilities, of which 52% are public sector facilities.¹² Health facilities are categorized into four main groups, including University and Regional hospital centers, Specialized Hospitals, District Hospitals, and Peripheral Care Units (which represent first-level care).

GNI per capita: **US\$960**
(World Bank, 2018)

UNDP Human Development Index: **165 of 189** (2018)

Transparency International Corruption Perceptions Index: **129 of 180** (2018)

UNDP Gender Inequality Index: **165 of 189** (2017)

Between 2012 and 2016, government health expenditure fell from 6.1% to 4.3% of total expenditure.¹³ Togo faces a critical shortage in its health workforce, with 0.05 physicians per 1,000 population and 0.3 nurses and midwives per 1,000 population, well below the WHO's recommended minimum target of 2.3 doctors, nurses and midwives per 1,000 population.¹⁴ The health workforce is also unequally distributed in the country, with 34% of the workforce concentrated in Lomé Commune¹⁵ which accounts for 23% of the national population.¹⁶

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 Togo as:

- Focused: (Smaller portfolios, lower disease burden, lower mission risk)
- Core: (Larger portfolios, higher disease burden, higher risk)**
- High Impact: (Very large portfolio, mission critical disease burden)
- Challenging Operating Environment
- Additional Safeguard Policy

2.3 Global Fund Grants in Togo

The Global Fund has signed grants totaling US\$331 million in Togo since 2003, covering HIV/AIDS, TB, malaria and health system strengthening.¹⁷ Overall disbursements amounted to US\$268 million as of June 2019.

¹⁰ World Bank, 2018 [World Development Indicators \(WDI\) data for Togo](#).

¹¹ World Bank, 2015 [World Development Indicators \(WDI\) data for Togo](#).

¹² Ministry of Health, [Annuaire des Statistiques Sanitaires du Togo, Année 2016](#), June 2017

¹³ Domestic Private support and External funding accounted for, respectively, 59.3% and 20.7% of the national health expenditure. World Bank, 2016 [World Development Indicators \(WDI\) data for Togo](#).

¹⁴ See 2014 WHO [Global Key Messages on Global Health Workforce Alliance](#)

¹⁵ Ministry of Health, [Annuaire des Statistiques Sanitaires du Togo, Année 2016](#), June 2017

¹⁶ CIA, 2018 data, [CIA World Factbook's page for Togo](#).

¹⁷ [Global Fund data explorer page for Togo](#) accessed on July 25, 2019.

Active grants in Togo for the funding cycle 2018 -2020 are shown below:

| Grant No. | Grant component | Grant period | Signed amount (US\$) | Disbursement as at June 2019 (US\$) |
|--------------|-----------------|------------------------------------|----------------------|-------------------------------------|
| TGO-H-PMT | HIV | January 2018 - December 2020 | 34,050,318.04 | 11,833,693.63 |
| TGO-M-PMT | Malaria | | 37,256,213.80 | 9,744,009.63 |
| TGO-T-PMT | Tuberculosis | | 1,934,052.64 | 610,127.88 |
| Total | | | 73,240,584.48 | 22,187,831.14 |

One Principal Recipient, the Primature de la République Togolaise (Prime Minister's office) manages the grants, through a dedicated Program Implementation Unit (*Unité de Gestion des Projets*). The national disease programs under the Ministry of Health implement most grant components as sub-recipients.

2.4 The Three Diseases

HIV/AIDS¹⁸: Prevalence among adults aged 15 to 49 is 2.3%. The HIV epidemic remains concentrated among key populations, with 22% prevalence among men who have sex with men and 13.2% among female sex workers.

In 2018, 80% of HIV-positive pregnant women received antiretroviral treatment (ART) for PMTCT.

AIDS-related deaths fell from 5,700 in 2010 to 3,800 in 2018.

The Global Fund is the major donor to the country's response to HIV, financing 30% of the National Strategic Plan need (EUR90.7 million) during 2018 – 2020. Government and other partners contribute 15% of the need, with an overall funding gap of 55%.

Estimated 110,000 people living with HIV, of whom 73% know their status. 82% of people who know their status were on treatment in 2018.

Annual infections have decreased by 31% since 2010, with about 4,950 new infections in 2018.



Malaria: Malaria is endemic in Togo. Togo is among the 10 countries with highest incidence, with 371/1,000 population at risk (2017).¹⁹

Since 2014, the number of reported malaria cases has ranged between 1.1 and 1.2 million per year.²⁰

In 2017, 85% of households possessed at least one LLIN, 68% of which were obtained through the 2017 mass campaign distribution.²¹

100% of the population at high risk of malaria (WHO 2017).²²

98.5% of suspected cases were tested in 2018 compared to 82.7% in 2016. In 2018, 93% of confirmed cases were treated.²³



¹⁸ All information in this section comes from UNAIDS Togo website <https://www.unaids.org/en/regionscountries/countries/togo>

¹⁹ World Bank, 2017 World Development Indicators (WDI) data for Togo.

²⁰ WHO 2018 World Malaria Report

²¹ Ministry of Health, *Enquete sur les Indicateurs du Paludisme au Togo 2017*, February 2018

²² WHO, 2018, *Malaria Country Profile for Togo*

²³ Data for the public sector, as of December 2018, using the December 2018 PUDR for the Malaria Grant.

Estimated annual deaths decreased to 995 in 2017, from 1,361 in 2013.²⁴

Tuberculosis: There has been a slight increase in TB case notification, from 2,525 in 2014²⁵ to 2,633 in 2017.²⁶

Incidence was 41/100,000 population in 2017, down from 58/100,000 population in 2014.



Mortality rate decreased by 60%, from 13/100,000 in 2014 to 5.2/100,000 in 2017 (World Health Organization).

Treatment coverage is **80% (2017)**. **Treatment success rate is 85%** (new and relapse cases),²⁷ down from 88% (new and relapse cases) in 2013.²⁸

2.5 Portfolio Performance

Based on results reported by the country to the Global Fund, grants are generally performing well against the targets set in the performance framework, except for the indicator related to routine distribution of bed nets. However, there are material data quality issues which impact on reported results (see finding 4.1). Performance on key coverage indicators reported by the country as of 31 December 2018 is shown in the table below:

| 2018 key indicators achievement rate (as of December 2018) | | | |
|--|---------|---------|------------------|
| Indicator | Target | Actual | Achievement rate |
| HIV | | | |
| Percentage of HIV-positive pregnant women who received antiretroviral medicine during pregnancy to reduce risk of mother-to-child transmission | 100% | 88% | 88% |
| Percentage of People living with HIV currently receiving antiretroviral treatment | 60% | 65% | 108% |
| Percentage of people living with HIV who started antiretroviral treatment who have an undetectable viral load at 12 months | 94% | 78% | 83% |
| Malaria | | | |
| Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities | 100% | 91% | 91% |
| Proportion of confirmed malaria cases that receive first line anti-malaria treatment in public sector health facilities | 100% | 95% | 95% |
| Number of bed nets distributed to targeted risk groups through continuous distribution | 429,976 | 221,581 | 52% |
| Tuberculosis | | | |
| Number of notified cases of all forms of TB | 1,588 | 1,256 | 79% |
| TB treatment success rate (all rates) | 86% | 80% | 93% |
| Percentage of registered new and relapse TB patients with documented HIV status | 100% | 97.4% | 97.4% |

The country had a mass campaign distribution of bed nets in 2017, where most households received bed nets, with a coverage of 95²⁹%. Most households therefore decline the nets offered through routine channels

²⁴ WHO 2018 World Malaria Report page 164

²⁵ WHO 2015, Global Tuberculosis Report 2015

²⁶ WHO 2018, Global Tuberculosis Report 2018

²⁷ WHO, 2017, Tuberculosis Country Profile for Togo

²⁸ WHO 2015, Global Tuberculosis Report 2015

²⁹ As per "Rapport général de la campagne MILDA 2017". This coverage excludes Lome commune.

because they were covered during the mass distribution of bed nets. Hence the inadequate performance of the indicator on the continuous distribution of nets.

Key

| | |
|---------------------------------------|---------|
| Exceeding Expectations | >100% |
| Meet Expectations | 90-100% |
| Adequate | 60-89% |
| Inadequate but potential demonstrated | 30-59% |
| Unacceptable | <30% |

2.6 Country risk appetite consideration

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries³⁰ representing most 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. The ratings are reviewed by the second line functions and senior management from the 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)³¹ during the Country Portfolio Review (CPR). Aggregated risk levels for Togo have been reviewed and were approved by the Country Portfolio Review in September 2019. See Annex C for further discussion of Risk Appetite methodology.

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

| Risk | Secretariat aggregated assessed risk level ³² | Assessed residual risk, based on audit results | Relevant audit findings |
|--|--|--|-------------------------|
| Monitoring and Evaluation | Moderate | High | 4.1 |
| In-country supply chain | High | High | 4.2 |
| National Program Governance and Grant Oversight | Moderate | Moderate | 4.3 |

The assessment of risk levels by OIG and the Secretariat are aligned for in-country supply and for national program governance and grant oversight, but not for monitoring and evaluation.

The Monitoring and Evaluation risk is made up of three sub-risks related to design and operational capacity of monitoring and evaluation systems; availability and adequate data quality; and use of data. The OIG and the Secretariat had different levels of assessed risk related to two of these sub-risks, which resulted in the difference between OIG and Secretariat's overall rating of Monitoring and Evaluation.

- *Design and operational capacity of Monitoring and Evaluation systems:*

³⁰ 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

³¹ The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews

³² This is the aggregated risk levels for the three grants in Nepal as at June 2019

The OIG assessed the risk of this area as “high” due to design weaknesses of the controls in the data systems and the different control layers in the data quality review process. These weaknesses resulted in the significant inaccuracies in data reported to the Global Fund. Without correction of these design faults, reported data quality is not likely to improve.

The Secretariat rated this sub risk as moderate, placing reliance on the roll-out of DHIS2 in the country. Furthermore, the risk assessment performed by the Secretariat did not identify a risk in implementers’ ability to use the controls in DHIS2.

- *Availability and adequate data quality:*

The OIG rated this area as high. The roll-out of DHIS has significantly improved timeliness of reporting by the health facilities and availability of data. However, the quality of the data is compromised by the material inaccuracies identified in the reported data for six of the nine indicators assessed during the audit.

The Secretariat’s assessment identified lapses in the analysis of available data, and consequently recommended the Principal Recipient conduct data analysis and triangulation on a quarterly basis to inform decisions. However, the Secretariat assessed this area as moderate, as DHIS2 has improved timely reporting of data by health facilities. The Secretariat did not identify a risk of inaccuracies in the data reported by the Principal Recipient, which OIG identified as a risk during this audit.

3. The Audit at a Glance

3.1 Objectives

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

Specifically, the OIG assessed the adequacy and effectiveness of:

- grant implementation arrangements;
- controls and processes in place for the storage, distribution and traceability of medicines, health commodities and program assets;
- controls and processes in place to ensure the reliability of data for decision making.

3.2 Scope and Methodology

The audit was carried out in accordance with the methodology described in Annex B, covering the Principal Recipient of the Global Fund programs in Togo, and the grants from January 2017 to December 2018. In total, the auditors visited 24 health structures comprising:

- six district health offices
- ten health facilities
- two health centers providing specific care for key populations
- two temporary drug storage facilities at central level
- four regional supply pharmacies (*Pharmacies Régionales d'Approvisionnement*) in three regions

3.3 Progress on Previously Identified Issues

The last OIG audit of grants in Togo took place in 2010. It assessed the adequacy and effectiveness of the internal control systems of the then Principal Recipient, Population Services International (PSI) in managing Global Fund grants. It also assessed the risks that Global Fund grants were exposed to, and what mitigation measures were in place. The audit covered the two grants managed by PSI during the period 2005-2010.

Previous relevant OIG audit work

[Audit of Global Fund Grants to Population Services International Togo \(GF-OIG-10-021\)](#)

Regarding programmatic aspects, the main weaknesses identified in the audit were a risk of treatment disruption, a risk of restricted access to goods and services due to impediments to free-of-charge treatment, and the lack of a national strategy for activities targeting people living with HIV. The Secretariat subsequently instituted measures to address the risks identified in the audit.

The implementation arrangement of the Global Fund grant has significantly changed. PSI ceased to be a Principal Recipient in Togo in 2015; the current Principal Recipient was not involved in grant implementation at the time of the previous OIG audit.

4. Findings

4.1 Inaccuracies in data affect decision-making

Global Fund grants in Togo have well-defined performance indicators to monitor progress of all grant interventions. In March 2018, the country achieved a significant milestone in strengthening its health information management system by completing the roll-out of DHIS2³³, thanks to support from the Global Fund and partners. All districts now report their results in DHIS2, and 57% of health facilities are equipped with digital tablets which enable them to record data directly into DHIS 2. This has improved the timeliness of data submission by health facilities, from 14% at the beginning of 2018 to 56% in December 2018.

Despite these achievements, significant improvement is still required in the accuracy of data being reported. There are material errors in HIV and malaria data. The TB grant was not covered as part of the data validation because it represents only 3% of Global Fund active grants in Togo. For all ten health facilities visited, there were material discrepancies between results reported to the Global Fund and the underlying source documents, for six of the nine sampled indicators³⁴:

- **Malaria data:** three out of four sampled malaria indicators have discrepancies greater than 10%. The number of suspected malaria cases tested and the number of confirmed malaria cases at health facilities were overstated by 24% and 13% respectively. This is mainly due to double counting of cases tested or improper maintenance of underlying data records, such as missing test information in laboratory and patient registers. The number of patients treated with anti-malaria medicine was under-estimated by at least 19% in three out of ten health facilities, due to non-reporting of patients treated with medicines sourced from other stakeholders. This runs contrary to the performance framework which requires the country to report national results, not only those financed by the Global Fund.
- **HIV data:** There are tolerable error rates of 2% and 8% in the results of pregnant women diagnosed as HIV-positive, and people on antiretroviral treatment, respectively. However, the results for pregnant women on antiretroviral treatment under the Prevention of Mother to Child Transmission (PMTCT) program were materially inaccurate: 42% of reported results could not be reconciled to the underlying patient records. In three of the ten sampled health facilities, there were no patient files or registers to confirm that pregnant women were enrolled in the PMTCT program. Certain health facilities incorrectly report all new HIV-positive pregnant women as part of this indicator, without confirmation that the patients are receiving treatment.

In the absence of accurate data, the quality of the decision-making process both at country level (e.g. quantification and forecasting) and at Secretariat level (e.g. performance ratings and disbursements) could be affected.

Data inaccuracies usually demonstrate health system weaknesses which require effort from all stakeholders to address. Some of the above inaccuracies are due to the limited number of health workers and the multiple roles they play in service delivery (including recording data). Togo has a health workforce-to-patient ratio of 3.58: 10,000³⁵, compared to the World Health Organization's (WHO) recommendation of 23: 10,000 and the West and Central Africa health workforce average of 4.4: 10,000³⁶.

Other factors at Global Fund and implementer level also contribute to the data quality issues:

³³ District Health Information Software 2 (DHIS2) is a health management data platform used to aggregate statistical data collection, validation, analysis, management, and presentation.

³⁴ Tuberculosis (TB) was not covered as part of the data review because it accounts for 3% of Global Fund's investment in the country.

³⁵ WHO skilled health personnel per country <http://apps.who.int/gho/data/view.main.HWF10v>

³⁶ Source: Global Fund RSSH Dashboards data derived from WHO/World Bank Data Sets, RSSH Team - SIID

- **At Global Fund Secretariat level**, there is limited assurance over data. The country team assessed in-country data as ‘moderate risk’ but has not performed an independent data verification exercise since 2015. This reduces the Secretariat’s ability to promptly identify the causes of data quality issues and institute mitigation actions. For instance, the country team’s risk assessment indicates that its main mitigation measure for data quality issues is the roll-out of DHIS 2. While DHIS2 improves the availability of in-country data, the system does not address all the major underlying issues that impact data accuracy. The Secretariat is engaging the Local Fund Agent to conduct a targeted data quality review on the Togo portfolio by the end of 2019.
- **At country level**, there are weaknesses in data quality review processes and use of systems. Multiple layers of controls at each level of the health pyramid - central, regional and district - do not coordinate their data validation activities. All these layers visit the same health facilities to perform the same supervision visits without leveraging the work performed by each layer. Furthermore, the supervision visits by these layers focus on the ability of health facilities to use DHIS2, rather than the accuracy and completeness of the data being reported in the system.

DHIS2 has inbuilt data quality assurance tools which are not being optimally used by the implementer to identify data inconsistencies and outliers for follow-up review. For example, while suspected malaria cases are expected to be equal or greater than tested cases, OIG analysis of the data in the system shows that 252 (27%) out of 930 health facilities³⁷ incorrectly reported more tested malaria cases than suspected cases.

DHIS is not locked after each reporting period; as such, the data can be changed after submitting progress updates to the Global Fund. The data changes in DHIS2 are not documented, making it impossible to determine whether modifications of reported results are authorized or not.

The Ministry of Health, with the support of the Global Fund and partners, is implementing measures to enhance data quality following the roll-out of DHIS. The Ministry is expected to train health workers at service delivery points on data quality by the end of 2019.

Agreed Management Action 1:

The Secretariat, in collaboration with partners, will support the Principal Recipient and Ministry of Health in updating and implementing the manual of procedures of the Health information system (MOP-SNIS) to include:

- a) frequency and nature of supervision activities to be performed by national, regional and district levels.
- b) communication and coordination channels to share supervision results
- c) measures or procedures to govern changes to data in DHIS.

Owner: Mark Edington, Head, Grant Management Division
Due date: 31 December 2020

³⁷ The 930 figure refers to the number of health facilities which reported a number of cases in DHIS2 for this specific indicator.

4.2 Poor traceability of drugs at district and service delivery level makes it difficult to account for funded medicines

Most Global Fund grants in Togo are allocated to health products and related supply chain costs, accounting for 68% in the current grant cycle. Health product procurement is managed through the Global Fund Pooled Procurement Mechanism. Except for antiretroviral medicines³⁸ which are directly delivered monthly to health facilities by the central warehouse (CAMEG), the distribution of other commodities must go through the different stages of the health pyramid (central, regional and district level) before reaching health facilities. The audit found no material stock-outs or expiries in the supply chain. This demonstrates that medicines are generally available at service delivery points to support the achievement of overall program objectives. However, the poor traceability of medicines below the regional level is affecting the ability of the country to account for the funded commodities.

At central level, all commodities procured by the Global Fund in 2017–2018 were successfully traced to the central warehouse's electronic and manual records. At regional level, for a sample of eight traced products³⁹, the regional warehouses maintained satisfactory records to ensure accountability of medicines received from the central warehouse. However, there is limited visibility and accountability of medicines at district and health facilities level.

At district level, the lack of inventory management tools is resulting in poor traceability of medicines.

The district health office is the weakest link in the in-country distribution arrangement. In four of the six districts visited, the medicines received from regional warehouses are not recorded in a stock card, making it impossible to trace medicines received from the regional level. In the same districts, the medicines issued to health facilities are not reported in a stock card and there is no acknowledgement of receipt by health facilities. These four districts are expected to receive about US\$1.1 million worth of Global Fund financed medicines under the current funding cycle. In one of the two districts with records, differences of 68% were noted between anti-malaria medicines delivered from regional warehouse and district records. While the related amounts may not be material, they underline systemic weaknesses in the largest health facilities which could be abused if unaddressed.

This situation is partly due to the limited availability of inventory management tools, such as stock cards and commodity issue notes. The printing and distribution of these tools, and the training of staff in inventory management are supposed to be performed by government, but are not being fulfilled.

At service delivery point, health facilities could not account for significant proportions of received drugs.

Overall, antiretroviral medicines delivered directly by CAMEG to health facilities are better accounted for than anti-malaria drugs issued by districts to health facilities. While 30% (3 of 10) of the health facilities visited maintained adequate records for malaria test kits and anti-malaria medicines, the remaining seven facilities could not fully account for supplies received, due to poor record keeping:

- There were no stock cards in two health facilities, meaning that medicines received at those service delivery points could not be traced.
- In five health facilities that have stock cards or inventory records, the OIG could only trace up to 32% of anti-malaria medicines issued to those facilities.
- In seven health facilities, differences of up to 100% were noted between malaria commodities physically counted on the day of visit and stock balances as per stock cards. This is mainly due to lack of timely recording of issued commodities by the health facilities.

³⁸ These don't include antiretroviral drugs meant at pregnant women as part of Prevention to Mother to Child Transmission (PMTCT). The PMTCT antiretroviral drugs are channeled through the district like antimalaria medicines.

³⁹ Three HIV products: ARVs: TLE, LZN and HIV rapid diagnosis test determine. Five malaria related products: four forms of ACTs (AL6, AL12, AL18 and AL24) and the malaria rapid diagnosis test. These eight products were tracked at four regional warehouses, 6 district health offices and 10 health facilities.

The limited ownership and accountability of the end-to-end supply chain in Togo impacts its effectiveness.

The central medical store, CAMEG, has oversight of the supply chain down to the regional level, however no entity oversees supply chain activities at the district and health facility level, except for enquiries on stock availability. In 2018, only three of the ten health facilities visited received supervision visits covering inventory management.

The Secretariat is planning to undertake an assessment of the in-country supply chain to optimize the storage capacity of health products in Togo.

Agreed Management Action 2:

The Secretariat will support the Principal Recipient, Ministry of Health and other stakeholders to develop a supply chain strengthening road map. The road map will include defined roles, accountability of each stakeholder, measures to improve traceability of medicines and related assurance mechanisms over supply chain activities.

Owner: Mark Edington, Head, Grant Management Division
Due date: 31 July 2020

4.3 Assurance and implementation arrangements need improvement

Since 2015, Global Fund grants in Togo have been implemented by a single Principal Recipient, 'Unité de Gestion des Projets (UGP)' under the Prime Minister's Office. UGP has successfully put in place effective mechanisms to coordinate and monitor activities of sub-recipients, including the three national disease programs of the Ministry of Health, and civil society organizations.

There is good coordination between Global Fund activities and other in-country partners, reducing potential duplication and overlaps. The Country Coordination Mechanism (CCM) plays a significant role in coordinating donor activities and has helped in solving various emerging issues, including the availability of anti-retroviral medicines in early 2018.

UGP has well-designed and effective financial oversight of its sub-recipients. However, it does not effectively oversee its procurement agent.

Sub-optimal oversight of the procurement agent results in delayed execution and limited visibility of financial information.

UGP outsourced the procurement of non-health products to an agent in 2016. The sub-contract, valued at US\$5.3 million, was expected to be completed by the end of the previous funding cycle and covered various items, including renovation of the central warehouse and procurement of equipment.

The warehouse renovation project was extended until March 2018; however, it remained far from completion at the time of the audit in July 2019. As a result, procured health commodities are stored in five temporary warehouses in Lomé under sub-optimal storage conditions.

The Principal Recipient does not promptly verify assets supplied by the agent, but rather checks these items a year after receipt and identifies variances in quantities and specifications which could not be reconciled. The Principal Recipient does not receive detailed financial information from the procurement agent to determine the actual cost of items. The agent only provides a summary of the total amount received from the PR and total expenses, without any further analysis of what the funds have been spent on. The procurement agent's financial report estimates unspent fund amounts of US\$452,228 subsequently refunded to the implementer in September 2019.

The above challenges result from unclear definition of roles and responsibilities in the procurement agent's contract, including expected deliverables. For instance, the contract does not require the procurement agent to provide detailed financial reports. In June 2019 the country set up a committee to evaluate the Principal Recipient's engagement with the agent for subsequent actions.

Limited oversight on sale of anti-malaria medicines could limit access to malaria services.

Togo operates a cost recovery health system, whereby health facilities charge for certain services and/or source medicines from the private sector, to sell at health facilities. The health facilities receive anti malaria medicines from two main sources – the government, including those financed by the Global Fund, and the private sector. As per government guidelines⁴⁰, anti-malaria medicines financed by the Global Fund must be dispensed to patients free of charge. Under the cost recovery system, health facilities continue to sell anti-malaria medicines received from the private sector to patients, despite free anti-malaria medicines funded by the Global Fund being available. Health facilities receive a commission from private pharmacies based on the volume of anti-malaria medicines sold. In practice, each health facility decides for itself which patients will receive free anti-malaria medicine, and which will pay for the services. This potentially discourages the most vulnerable populations from accessing services, due to financial barriers. The anti-malaria medicines sold in the health facilities account for 20% of treated malaria cases. Separate inventory management systems are maintained at health facilities for medicines supplied by the government and those by the private sector, the latter being well maintained. The Secretariat is planning an assessment of the

⁴⁰ Décision No 013/2015/MS/CAB/SG du 20 avril 2015

impact of user fees on access to health services in West and Central African Countries to inform specific actions in each country.

UGP's structure could be realigned to be more efficient.

As of end-June 2019, UGP had a total headcount of 33 staff at central level and 12 staff at regional level. There are overlapping roles with the national programs, as well as roles which are not fully related to the grant. For instance, six UGP staff are responsible for oversight of grant activities at regional level. The same roles already exist as part of the terms of reference of the Regional Health Direction (DRS), a sub-recipient of Global Fund grants. Ensuring complementarity with existing roles within the Ministry of Health will be critical for sustainability, in a context of limited financial resources.

At the Principal Recipient level, some roles not related to service delivery are financed by the Global Fund, instead of leveraging existing government structures. These positions could be progressively transferred to the government budget, to allow Global Fund resources to target more key interventions. The Secretariat is planning a review of implementation arrangement across the West and Central Africa region, including Togo. The results of this review will inform decisions for the next funding cycle.

Agreed Management Action 3:

Given the country strategy permitting the financing of public health facilities through the sale of private sector sourced medicines, the Secretariat will support the Principal Recipient and the Ministry of Health to develop and disseminate clear guidance for public health facility prescribers on when to prescribe free versus paid antimalarial medicines to patients to ensure vulnerable populations are not disadvantaged, as well as a communication targeting the population that outlines to the public the aforementioned criteria for free versus paid medicines.

Owner: Mark Edington, Head, Grant Management Division
Due date: 31 December 2020

Agreed Management Action 4:

As part of the ongoing review of implementation arrangements in West and Central Africa and as already planned, the Secretariat, during the country review, in consultation with the CCM and the Prime Minister's Office will evaluate the UGP structure and incorporate changes for the next funding cycle.

Owner: Mark Edington, Head, Grant Management Division
Due date: 30 June 2020

5. Table of Agreed Actions

| Agreed Management Action | Target date | Owner |
|--|------------------|-----------------------------------|
| <p>1. The Secretariat, in collaboration with partners, will support the Principal Recipient and Ministry of Health in updating and implementing the manual of procedures of the Health information system (MOP-SNIS) to include:</p> <p>a) frequency and nature of supervision activities to be performed by national, regional and district levels</p> <p>b) communication and coordination channels to share supervision results</p> <p>c) measures or procedures to govern changes to data in DHIS</p> | 31 December 2020 | Head of Grant Management Division |
| <p>2. The Secretariat will support the Principal Recipient, Ministry of Health and other stakeholders to develop a supply chain strengthening road map. The road map will include defined roles, accountability of each stakeholder, measures to improve traceability of medicines and related assurance mechanisms over supply chain activities.</p> | 31 July 2020 | Head of Grant Management Division |
| <p>3. The Given the country strategy permitting the financing of public health facilities through the sale of private sector sourced medicines, the Secretariat will support the Principal Recipient and the Ministry of Health to develop and to disseminate clear guidance for public health facility prescribers on when to prescribe free versus paid antimalarial medicines to patients to ensure vulnerable populations are not disadvantaged, as well as a communication targeting the population that outlines to the public the aforementioned criteria for free vs paid medicines.</p> | 31 December 2020 | Head of Grant Management Division |
| <p>4. As part of the ongoing review of implementation arrangements in West and Central Africa and as already planned, the Secretariat, during the country review, in consultation with the Country Coordinating Mechanism and the Prime Minister's Office will evaluate the UGP structure and incorporate changes for the next funding cycle.</p> | 30 June 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 countries⁴¹ 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 Committee⁴² 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.

⁴¹ 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.

⁴² 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 |