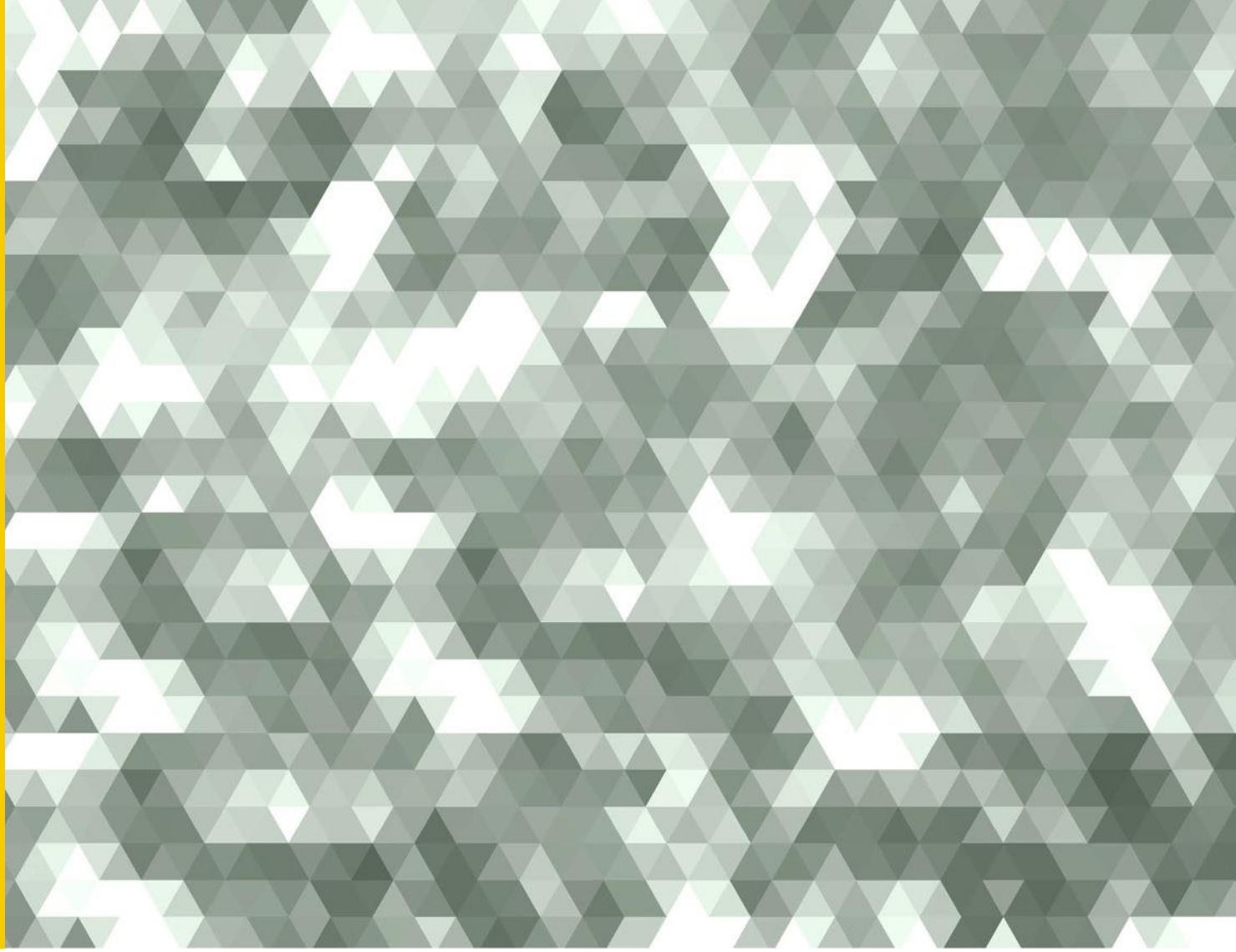

Audit Report

Global Fund Grants in the Republic of Angola

GF-OIG-20-003
27 February 2020
Geneva, Switzerland

The Global Fund
Office of the Inspector General

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Established in 2005, the OIG is an independent yet integral part of the Global Fund. It is accountable to the Board through its Audit and Finance Committee and serves the interests of all Global Fund stakeholders. Its work conforms to the International Standards for the Professional Practice of Internal Auditing and the Uniform Guidelines for Investigations of the Conference of International Investigators.

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Table of Contents

1. Executive Summary

1.1. Opinion

The Global Fund grants in the Republic of Angola are performing poorly. Grant performance suffers from a combination of multiple issues, including weak country ownership, government failure to fulfill domestic commitments, unreliable data and ineffective management structures in the Ministry of Health (MINSA). These issues have persisted in the country since the OIG's last audit in 2012, with limited or no progress in addressing them. As a result, Global Fund grants in Angola have achieved limited programmatic impact, with a significant increase in both mortality and morbidity across all three diseases. This raises significant strategic questions around the role of Global Fund grants in this operating environment, and the need to develop new approaches to engaging with the country. There is a critical and urgent need for the Secretariat to perform an in-depth reevaluation of the Angola portfolio, including the focus of the grants, implementation modalities, the performance framework, accountability mechanisms and grant monitoring.

Based on the country's income level, the Global Fund grants are primarily designed to complement investments from the Government of Angola, which is expected to be the major financial contributor in the fight against the three diseases. Given this design and its underlying assumptions, the success of the grants is heavily dependent on the government of Angola meeting its domestic funding commitments. However, significant government commitments on first-line TB, antimalarial and antiretroviral commodities have not been met, due to various factors including shrinking fiscal space between 2016 and 2019, lack of government ownership and prioritization, and weak monitoring by the Global Fund. The government's failure to meet its commitment has had significant adverse impact on the programs. For example, in the case of TB, there were material stock-outs of drugs and related treatment disruption, requiring an emergency reprogramming of grant funds and the de-prioritization of other critical activities.

The Global Fund has cumulatively invested around $US300 million in Angola since 2004. Yet these investments combined with those of the government and other partners have had limited impact in the country's fight against the three diseases, with most programmatic impact indicators consistently heading in the wrong direction. Estimated TB cases have increased by 19% since 2010 and deaths by 17%, while the number of missing cases has also increased[1]. Likewise, HIV-related deaths in Angola have increased by 29%, in contrast to a global decline of 34% in HIV mortality[2]. The same adverse trends are noted in malaria, which has seen a 48% increase in incidence between 2010-17 and a 72% increase in deaths during the same period[3]. Lack of sufficient government prioritization, limited access and coverage of health services, weak community engagement, lack of program coordination, and poor strategy formulation have all contributed to the limited impact of the grants. Overall, domestic financing, community engagement and programmatic implementation for ensuring access to services are **ineffective**. These are systemic issues that will not be addressed with short-sighted tactical fixes but rather require a comprehensive overhaul of the Global Fund grant programs in Angola.

Programmatic data for key testing and treatment indicators are unreliable for monitoring grant performance and for informed decision-making, with a high level of discrepancies noted across health facilities data. Discrepancies of up to 39% were noted in the audit, as well as gaps in non-routine programmatic data points to inform estimates for loss to follow-up. There are no reliable sub-national data of ART coverage. Material deficiencies also exist in community-based indicators for malaria; 93% of sampled results reported to the Global Fund could not be validated. Thus, the

[1] World TB report 2018, WHO – comparison between 2010 and latest data reported (estimated absolute number results)
[2] World HIV report 2018, UNAIDS – comparison between 2010 and latest data reported (estimated absolute number results)
[3] World Malaria report 2018, WHO - comparison between 2010 and latest data reported (estimated absolute number results)

data management arrangements are **ineffective** in supporting grant objectives and ensuring accurate and timely data for decision-making and reporting.

Improved financial controls were observed at the Ministry of Health (MINSA), with no ineligible expenditures or material financial irregularities identified. While fiduciary agents are embedded and operating effectively within the Ministry of Health, gaps in broader finance management and assurance were noted, with over one-year delays in completing external audits, and over eight-month delays in reporting to the Global Fund, impacting the timely resolution of issues. Overall, the financial management and assurance arrangements are **partially effective** in ensuring that key risks have been effectively mitigated.

Subsequent to the conclusion of the Audit fieldwork, the Global Fund Secretariat has taken several strategic decisions and started a series of assessments that impact the management of the Angola Portfolio going forward. Additional Safeguards Policy (ASP) measures were invoked in December 2019 to immediately safeguard and enhance the impact of Global Fund grants in Angola. These measures include changes in the implementation arrangements in country, including the proposed early closure of grants with MINSA as Principal Recipient and the transfer of funds and activities to UNDP. In addition, for the next grant cycle, the Secretariat is reviewing options to undertake a more targeted sub-national approach which prioritizes specific provinces with high impact interventions, in order to attain better programmatic outcomes and increase value for money. In support of this, the Secretariat has instructed the LFA to perform a series of assessments, including areas such as the sub-national landscape and management of data.

1.2. Key Achievements and Good Practices

UNDP long-term framework agreements used to support purchase of HIV commodities:
UNDP, a key implementer in Angola, is partnering with the Government to leverage UNDP's global procurement framework, procuring over US$21m of government-funded ARVs, diagnostic test kits and viral load reagents at low rates whilst safeguarding quality. This has allowed for more efficient use of Government funding.

Stronger financial controls, with no ineligible expenditures identified:
OIG sample-based review of transactions processed by the MINSA grants did not identify any ineligible expenses or material irregularities. This highlights the effectiveness of the Fiscal/Fiduciary Agent control function and reveals improved financial controls since OIG's investigation in 2016, which highlighted significant misuse of funds by National Disease Programs under MINSA.

1.3. Key Issues and Risks

Poor data quality hampering reliable measurement of performance and impact:
Significant programmatic data quality issues were identified in the programs and grants across all three diseases for key testing and treatment indicators. Routine programmatic reporting from health facilities for the three diseases show errors of up to 39% on key programmatic indicators. There is a lack of non-routine surveys and studies to compensate for pervasive gaps in routine data on loss to follow-up, retention rate and HIV deaths. The HIV program makes unsupported adjustments to estimate the number of people living with HIV on antiretroviral therapy (ART), without basing it on a formal study or survey. Community-level data processes and tools are weak, with very low verifiability of community-based malaria treatment. The pervasive nature of the data issues makes it nearly impossible to reliably measure the performance and impact of Global Fund grant interventions.

Lack of country prioritization & ownership on programmatic performance:
While programmatic data has low reliability, overall trends in key indicators highlight low impact against the three diseases.

Disease	Key Impact and Outcome indicators
TB[1]	Angola is in the top 30 countries in the world for TB burden: ▪ 11th highest for estimated TB/HIV incidence and 18th highest for estimated TB incidence. 19% increase in estimated cases & 17% increase in estimated number of deaths Proportion of missing cases increasing: 49% in 2017 vs. 45% in 2012
HIV[2]	29% increase in estimated HIV-related deaths 18% increase in estimated infections & 21% increase in estimated number of HIV-related deaths for those under 14 years old PMTCT – Vertical transmission at 27.8% compared to regional average of 9.2%[4]
Malaria[3]	48% increase in estimated incidences & 72% increase in estimated number of deaths

TB services were not adequately prioritized, reflected in weak capacity of the National TB program, low coverage of TB services in the country, and negligible community engagement for TB. This has contributed to a 17% increase in estimated TB-related deaths and increased TB incidence. Limited sites for TB/HIV co-management and weak coordination between the National TB program and INLS (HIV program) have contributed to low progress and absorption on key TB/HIV activities, and only 49% of HIV+ registered TB patients on ART. A historical lack of a strategy on prevention of mother-to-child transmission[5] and weak community engagement have contributed to poor ART coverage for HIV-positive pregnant women, high vertical HIV transmission, an 18% increase in child HIV incidence and a 21% increase in HIV-related deaths since 2010.

Failure to fulfil Government commitments impacting Global Fund programs:
The Global Fund and the Ministry of Health agreed on specific government commodity commitments for the three diseases under the past two funding cycles, NFM 1 and NFM 2. However, the government failed to fulfil these commitments in NFM 1 across the three diseases, most notably for TB. This contributed to stock-outs and emergency reprogramming of Global Fund grants to cover commodity shortages, forcing the cancellation or scaling back of key activities for data and diagnosis interventions. For NFM 2, there were gaps in the evidence provided to the OIG to prove that commitments were met, and the OIG was unable to conclude on this. Effective monitoring processes and tools are not in place at MINSA to track these commodity commitments and alert stakeholders about likely non-compliance with agreed commitments.

Key structural bottlenecks impacting implementation of Global Fund grants
Weak oversight and support by the wider Ministry of Health over the project management unit, Unidad Tecnica de Gestao, hamper its financial assurance and sub-recipient management capabilities, despite over US$1m being provided for this purpose between 2016 and 2019. The UTG's mandate has not been defined; its terms of reference were last updated in 2008 and do not reflect current implementation arrangements. There is ambiguity around decision-making, program reporting and overall ownership between UTG, national programs and MINSA, significantly delaying reporting and corrective actions on program activities. UTG has had vacancies in critical positions in NFM 1 and 2, restricting its overall effectiveness.

[4] UNAIDS 2019 Data, UNAIDS
[5] The country was missing an approved national strategy between 2015 and 2019.

1.4. Rating

	Objective 1: design and adequacy of data management arrangements in supporting the achievement of grant objectives and ensuring accurate and timely data for decision making and reporting. OIG rating: Ineffective
	Objective 2: effectiveness of domestic financing, community engagement and programmatic implementation for ensuring access to services and linkages to care for beneficiaries. OIG rating: Ineffective
	Objective 3: effectiveness of financial management and assurance arrangements to ensure key risks have been effectively mitigated. OIG rating: Partially effective

1.5. Summary of Agreed Management Actions

The Global Fund Secretariat will work with the Principal Recipients, the Ministry of Health and relevant stakeholders on agreed management actions that will focus on the following areas:

- A revised strategy for implementing grants to attain increased impact in the fight against the three diseases
- Strengthening monitoring and reporting on agreed Government commitments

2. Background and Context

2.1. Overall Context

From 2013 to 2017, Angola was classified as an Upper Middle-Income country, thanks to its large petroleum revenues[6]: Angola depends on its off-shore petroleum reserves for 50% of GDP, 75% of government revenues and 90% of exports.[7] In July 2017, the World Bank reclassified the country to Lower Middle Income[8] as a result of the global decline in oil prices. Since 2014, the national currency has devalued by 280%, and the health sector budget decreased by 41%[9] from 2014 to 2016.

Population: **31.8 million**

GDP per capita: **US$4,170** (2017)

UNDP Human Development Index: **147 of 189** (2018)

Transparency International Corruption Perceptions Index: **165 of 180** (2018)

The country experiences an endemic level of corruption, as illustrated by its low scoring in the 2019 Africa Integrity Indicators report[10], highlighting very weak transparency and accountability. Angola ranked 165 out of 180 countries in Transparency International's most recent Corruption Perceptions Index[11].

Outbreaks of diseases have impacted health care services, including outbreaks of Yellow Fever[12] in 2016 and Cholera[13] in 2017-2018.

Angola is administratively divided into 18 provinces, which are subdivided into 164 municipalities. The country is currently undergoing a nation-wide process to decentralize health care services to the municipal level.

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. Angola is classified as:

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

[6] https://www.geoexpro.com/articles/2012/10/milestones-in-angola-s-oil-history
[7] https://www.export.gov/article?id=Angola-Oil-and-Gas
[8] World Bank country classification (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups)
[9] WHO GHED data sets on Domestic General Government Health Expenditure (GGHE-D) per Capita in US$ (http://apps.who.int/nha/database/ViewData/Indicators/en)

[10] https://aii.globalintegrity.org/scorecard?country=angola&year=2019
[11] https://www.transparency.org/cpi2018
[12] https://www.who.int/csr/don/14-june-2016-yellow-fever-angola/en/
[13] https://apps.who.int/iris/bitstream/handle/10665/272281/OEW13-2430032018.pdf

2.3. Global Fund Grants in Angola

The Global Fund has signed grants of over US$330 million and disbursed over US$270 million to Angola since 2004, with US$52.8 million signed for current active grants.[14] The Ministry of Health (MINSA), United Nations Development Programme (UNDP) and World Vision International (WVI) are the Principal Recipients for the Global Fund grants for the 2018-2021 implementation period.

Grant No.	Principal Recipient	Grant component	Grant period	Signed amount (US$)	Disbursed amount (US$)
Funding cycle 2016-2018					
AGO-H-UNDP	UNDP	HIV	July 2016 to June 2018	29,928,778	25,198,985
AGO-M-MOH	Ministry of Health, Republic of Angola	Malaria	July 2016 to June 2018	30,532,163	20,687,810
AGO-M-WVI	World Vision International	Malaria	July 2016 to June 2018	8,203,093	6,237,875
AGO-T-MOH	Ministry of Health, Republic of Angola	TB/RSSH	Jan 2017 to Dec 2018	19,193,413	13,510,583
Total				**87,857,450**	**65,635,253**
Funding cycle 2018/19-2020/21					
AGO-H-UNDP	UNDP	HIV	July 2018 to June 2021	23,110,399	5,342,840
AGO-M-MOH	Ministry of Health, Republic of Angola	Malaria	July 2018 to June 2021	13,470,603	2,925,194
AGO-M-WVI	World Vision International	Malaria	July 2018 to June 2021	8,529,397	2,822,113
AGO-T-MOH	Ministry of Health, Republic of Angola	TB	Jan 2019 to Dec 2021	7,674,176	3,923,920
Total				**52,784,575**	**15,014,068**

[14] Signed grant agreements for NFM 2 with World Vision, UNDP and MOH

2.4. The Three Diseases

HIV/AIDS: HIV prevalence among 15 to 49-year olds is 2%; prevalence is higher in sex workers (8%) and prisoners (16%).[15] Women are disproportionally affected by HIV in Angola: of the 300,000 adults living with HIV, 200,000 (67%) are women. New HIV infections among young women aged 15-24 years were three times higher than among young men[16]. The Global Fund is funding 6% of the total funding need for 2018-2020. Support from the Government and other donors represents 22% and 8% respectively, with a funding gap of US$253 million (64%)[17].	**330,000** estimated people living with HIV, of whom **42%** know their status and **27%** are on treatment (2018)[18]. AIDS-related deaths increased by **40%** from 10,000 in 2010 to 14,000 in 2018[18]. New HIV infections have risen by **8%,** from 26,000 in 2010 to 28,000 in 2018[18].
Malaria: Malaria continues to be the principle cause of morbidity and mortality in Angola, with the entire population at risk of infection. It is endemic all over the country and transmission occurs year round. The Global Fund is funding 6% of the total funding need for 2018-2020. The Government provides 34% and other donors 17%, with a funding gap of US$152 million (43%)[17].	Estimated malaria cases increased by **48%** from 3,125,901 in 2010 to 4,615,605 in 2017.[19] **3,874,892** confirmed cases reported in 2017.[19] Malaria related deaths increased by **72%** from 8,114 in 2010 to 13,967 in 2017. [1919]
Tuberculosis: Angola is currently in the top 30 countries in the world for burden of TB, MDR-TB and TB/HIV. It is the 18th highest in terms of estimated incidence for TB, 21st highest in terms of estimated incidence for MDR/RR-TB and 11th highest in terms of estimated incidence for TB/HIV. The Global Fund is supporting 10% of the total funding need for 2018-2020. The Government provides 30%, with a funding gap of US$44 million (60%)[17]	Estimated number of new cases increased by **19%** from 90,000 in 2010 to 107,000 in 2017.[20] TB treatment coverage is **51%**. Treatment success rate is **27%** (2016).[20] Estimated number of deaths from TB increased by **17%** from 24,000 in 2010 to 28,000 in 2017. [20]

[15] UNAIDS DATA 2019 (https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf)
[16] Young women had 6,800 new annual infections, compared to 1,900 among young men https://www.unaids.org/en/regionscountries/countries/angola
[17] Funding landscape (Funding request to the Global Fund)
[18] https://www.unaids.org/en/regionscountries/countries/angola
[19] WHO World Malaria Report 2018 (https://apps.who.int/iris/bitstream/handle/10665/275867/9789241565653-eng.pdf?ua=1)
[20] WHO Global Tuberculosis Report (https://www.who.int/tb/publications/global_report/en/)

2.5. Portfolio Performance

Performance across the grants, as measured by the achievement of key coverage indicators, varies significantly across the programmatic areas. The grants are not achieving their targets on key activities like PMTCT, TB treatment success, and TB/HIV co-infection. The root causes of these low achievements are analyzed in Section 4.2 of this report. In other programmatic areas like ART coverage, TB notification and community-based malaria indicators, the indicators depict positive achievements, but this is not aligned with the overall programmatic coverage and disease impact highlighted in Section 2.4. One contributing factor is the low reliability of programmatic data reported to the Global Fund, limiting the ability for performance to be effectively assessed across all three diseases (detailed in Section 4.1). Thus, the performance data reported by the Secretariat below are highly unreliable and the high achievements in several indicators are not reflective of the generally poor trends in the three diseases.

Global Fund Key Indicator Achievements (December 2018)[21]			
HIV/AIDS	**Target**	**Result**	**Achievement**
Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission	42%	22%	53%
Percentage of people living with HIV currently receiving antiretroviral therapy	24.5%	28%	114%
Percentage of MSM reached with HIV prevention programs - individual and/or smaller group level interventions	3%	1.5%	50%
TB	**Target**	**Result**	**Achievements**
Number of notified cases of all forms of TB (including new & relapse)	38,887	36,100	93%
TCP-other 1: Treatment success rate: Percentage of bacteriologically confirmed TB cases registered that were successfully treated	85%	66%	77%
Number of cases with RR-TB and /or MDR-TB that began second-line treatment	250	379	120%
Percentage of notified TB cases, all forms, contributed by non-NTP providers – community referrals	Not defined[22]		
PSM Other 3: Percentage of health facilities reporting no stock-outs of anti-TB drug (4 FDC) on the last day of the quarter.	100%	Unvalidated Results[23]	
Malaria	**Target**	**Result**	**Achievements**
CM-1a(M): Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	94%	95%	101%
CM-2a(M): Proportion of confirmed malaria cases that received first line antimalarial treatment at public sector health facilities	95%	79%	84%
CM-2b(M): Proportion of confirmed malaria cases that received first line antimalarial treatment in the community	80%	84%	105%
CM-other 2: Proportion of health facilities without stock-outs of key commodities (ACTs) during the reporting period	85%	48%	57%
VC-1(M): Number of long-lasting insecticidal nets distributed to targeted risk groups (continuous distribution)	956,914	337,710	35%

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

[21] Global Fund Performance Letter for the four grants for the period ended December 2018.
[22] The baseline and targets were supposed to be set by March 2018 after one year of implementation of the community-DOTS pilot in 5 provinces however, it was not defined at all, the root-causes for which are stated in section 4.2 of the report.
[23] Data for this indicator could not be verified.

2.6 Risk Appetite

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries[24] 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. 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[25] during the Country Portfolio Review (CPR).

Aggregated risk levels for Angola have been reviewed; subsequent to the audit fieldwork, Angola went through a CPR on 04 November 2019. The OIG compared the Secretariat's aggregated assessed risk levels for the key risk categories covered in the audit objectives for the Angola 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	Assessed residual risk, based on audit results	Relevant audit issues
Program Quality	High	High	Finding 4.2, 4.3
M&E	Very High	Very High	Finding 4.1
Grant-Related Fraud & Fiduciary	Moderate	Moderate	Finding 4.4
National Program Governance and Grant Oversight	High	Very High	Finding 4.1, 4.2, 4.3 & 4.4

Angola is an operating environment in which risk levels remain high to very high across most grant implementation risk areas.

The assessments of risk levels by the OIG and the Secretariat were aligned except for **national program governance and grant oversight**: OIG audit results suggest the current level of residual risk is 'very high' whereas the Secretariat aggregated assessed risk at the time of planning of the OIG Audit was 'high'. Since the planning phase of the OIG Audit, there has been a change in the Secretariat risk methodology. If this revised methodology was applied, the Secretariat rating would have also been 'very high'.

At the time of auditing planning, the OIG and Secretariat were aligned on the rating of 'very high' for two of the sub-risks that fall under this risk; 'Inadequate national program governance' and 'Ineffective program management'. However, for the sub-risk 'inadequate program coordination and SR oversight', the Secretariat rating was 'moderate' and the OIG rating is 'high'. OIG noted significant weaknesses in relation to the SR management of TB sub- (SR) and sub-sub-recipients (SSR), especially in the approval of SR targets, and oversight and supervision of SR activities and results. The interventions being undertaken by these SR and SSRs are key TB activities under the TB grant.

Further, OIG considers national program governance and program management (rated 'very high' by both OIG and the Secretariat) as critical grant activities deserving higher weighting in the overall risk rating.

[24] 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
[25] The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews

3. The Audit at a Glance

3.1 Objectives

This audit sought to assess the:

- design and adequacy of data management arrangements in supporting the achievement of grant objectives and ensuring accurate and timely data for decision making and reporting;
- effectiveness of domestic financing, community engagement and programmatic implementation for ensuring access to services and linkages to care for beneficiaries;
- effectiveness of financial management and assurance arrangements to ensure key risks have been effectively mitigated.

3.2 Scope and Methodology

The audit was in accordance with the methodology described in Annex B, covering the period from January 2017 to December 2018. The audit covered eight grants, including both the active and closed grants for all the three Principal Recipients: UNDP (HIV), Ministry of Health (Malaria and TB/ RSSH, and World Vision (Malaria). Of the eight grants audited: three ended on 30 June 2018; one ended on 31 December 2018; three will end on 30 June 2021 and one will end on 31 December 2021.

The auditors visited multiple sites including Municipal and Provincial Offices (6), ADECOS and service delivery sites for HIV, TB & Malaria across three provinces (Luanda, Benguela and Uige)[26]. The OIG reviewed relevant documents including guidelines, processes, agreements, audit/review reports, assessments, sample transactions, data reports, registers etc.

Exclusion from scope

The United Nations General Assembly has adopted a framework known as the "single audit principle", whereby the UN and its subsidiaries cannot consent to third parties accessing their books and records. All audits and investigations are conducted by the UN's own oversight bodies. Accordingly, the OIG cannot provide assurance on activities and transactions directly implemented by UN agencies.

3.3 Progress on Previously Identified Issues

The last OIG audit of grants in Angola in 2012 highlighted significant issues on financial management, PR oversight, TB service provision, domestic procurements and data quality, with limited progress noted in the current audit:

Previous relevant OIG audit works

Audit of Global Grants to Angola, 2012 (GF-OIG-12-02)

- In 2012, there was a need to improve financial management capacity of the Principal Recipient and sub-recipients, and to strengthen oversight through national oversight institutions and assurance providers. No material ineligible expenditures or recoveries were identified in the sample-based review for the current audit. Financial assurance has been strengthened through the appointment of a fiscal agent from 2016 and a fiduciary agent from 2019. However, there are still challenges in PR oversight over sub-recipient activity, and gaps in LFA and external audit assurance, detailed in findings 4.1, 4.2 and 4.4.
- Weak capacity of UTG to provide sufficient oversight and supportive supervision of sub-recipients was noted. This is still a recurring issue, as highlighted in finding 4.4.

[26] 15 HIV service delivery sites, 11 TB service delivery sites & 19 Malaria service delivery sites (including 16 health facilities and 3 ADECOS sites)

- For TB interventions, issues of limited access, shortages of TB commodities and limited Government ownership and prioritisation over TB interventions were identified in both the previous and current audit (highlighted in finding 4.2 and 4.3).
- Gaps in government procurements of drugs, impacting the Global Fund grants, persist, with stock-outs reported in both audits (highlighted in finding 4.3).
- Data challenges continue to remain critical and significant, impacting all three diseases, particularly new interventions and activities such as community-based outreach (highlighted in finding 4.1).

4. Findings

4.1 Poor data quality hampering measurement of performance and impact

Angola faces critical issues with the quality of programmatic data across the three diseases. This impacts the ability for the Ministry of Health, other grant implementers, the Global Fund and partners to make informed strategic and operational decisions, and to assess the performance of interventions. These issues in programmatic data cut across all areas of data management (systems, processes, people) and impact all implementers. These issues persist despite recent efforts to improve Health Management Information Systems through the introduction of DHIS2[27].

Significant data inaccuracies at health facilities

High levels of over and under reporting of key HIV, TB and Malaria indicators were noted across the majority of OIG sites visited (see table 1).

Table 1: Data results from OIG site visits

Disease	Sites with data issues	Data discrepancy[28]
HIV	**14 of 15 (93%)**	**+/- 30%**
Malaria	**12 of 16 (75%)**	**+/- 39%**
TB	**10 of 11 (91%)**	**+/- 27%**

Differences were noted between facility patient registers and the consolidated monthly reports sent by health facilities to levels above (municipal, provincial & central level), contributing to discrepancies in aggregated data. Similar discrepancies and issues have been identified by UNDP (10% discrepancy in HIV data) [29] and the LFA (between 6%-24% discrepancy in data for all three diseases)[30]. Several factors contributed to these data issues:

Low prioritization and ownership: the National HMIS (Health Management Information System) strategy was designed in 2015, and does not address the current data challenges, along with the strategic vision and resource requirements to improve health data in Angola. It also does not capture the significant changes in new software and systems currently being employed by the Ministry of Health, e.g. DHIS2 for aggregate reporting and new community-based information systems. This results in the strategy not reflecting ground realities and not leveraging the latest IT updates to explore data solutions.

Significant gaps in monitoring and evaluation (M&E) staffing at the central and provincial level contribute to weak data management, reporting and quality; this includes vacancies in positions funded by the Global Fund. All M&E positions at the central level, budgeted for in the Global Fund grants, remained vacant for the majority of NFM1.[31] Similarly, at the provincial level, 10 out of 18 Malaria officers and 11 of 18 TB officers to support programmatic activities and reporting were vacant at end-2018. These vacancies limited the number of M&E supervision visits; the National TB program conducted only 20% of planned supervision visits, while the National Malaria program performed only 5 visits in NFM1 (absorbing only 3% of a US$1.3m training and supervision budget).

Gaps in M&E tools and processes at health facilities level: 66% of the service delivery sites visited by the OIG relied entirely on paper-based reporting, which is more labor-intensive and prone to errors. No guidelines are consistently utilized at this level to reduce potential errors in terms of daily collection and data entry. Gaps exist in the availability of national tools at service delivery points, impacting the quality of data entry. For example, 6 of 16 malaria sites visited did not have national approved tools for data collection and entry. Under Angola's decentralized model of health care, the national program is only responsible for providing tools and registers to provincial offices, who are

[27] A national roll out of DHIS 2 to support data aggregation and reporting for the three diseases has been supported by the Government of Angola, Global Fund and other partners.
[28] Absolute average from sites with errors with both over and underreporting
[29] The ART Data Quality Audit 2018 undertaken and funded through the UNDP grant highlighted 10% data discrepancies for selected HIV indicators on sites, which separate from those sampled by the OIG.
[30] LFA Targeted DQR 2019 highlighted data discrepancies for HIV of 13%, TB 24% and Malaria 6% on separate sites to the OIG.
[31] National Malaria M&E Officer. National TB M&E Officer and MINSA HMIS Officer positions were vacant for significant periods of NFM 1.

in turn responsible for further dissemination; this contributes to role ambiguity and the non-availability of tools.

While the country is now embarking on a national roll-out of DHIS2 to support data aggregation and reporting, mere implementation of a technology solution will not address the poor data quality issues unless broader weaknesses are addressed around people, processes, tools, data governance and accountability. These gaps will also restrict the effectiveness of the DHIS roll-out. Even for manual reporting, DHIS2 roll-out will have limited benefits, since it will only automate data aggregation, while data entry at the patient level (pre-aggregation) will continue to rely on unreliable manual processes at health facilities that are not consistently supported by standardized tools and guidelines.

Limited reliability of data for patients on ART treatment

The Ministry of Health does not have visibility on the number of ART patients at municipality or facility levels. Thus, there is a significant lack of reliability on the overall cohort of ART patients and the reported results for the indicators associated with ART treatment. The absence of geographical and facility-level breakdowns of ART patients hampers the Ministry's quantification and forecasting process, the supply of commodities to service delivery sites, needs assessments of domestic commitments required for ARVs, and regional trends analysis for HIV.

The previous "SIS" system used by the national HIV program (INLS) did not effectively track and subtract loss to follow-up. As a result, the HMIS systems of INLS holds an incorrect number of patients currently on treatment. As of December 2018, the system records 722,000 as people living with HIV on ART, although UNAIDS estimates the total number of PLHIV in Angola at only 330k[32]. This had led to INLS having to make recurring significant manual adjustments to the database number to reach a more appropriate final reported number. Ineffective M&E tools at sub-national level to track and report patients lost to follow-up have contributed to the poor data on PLHIV on ART.

In cases of unreliable routine reporting, countries often rely on non-routine surveys and studies to complement programmatic estimations and inform interventions. However, Angola does not have any up-to-date studies on loss to follow-up (LTFU), retention rate or HIV deaths. INLS currently performs an unsupported annual "haircut" of 30% on the total recorded number of PLHIV on ART to compensate for the lack of accurate information on LTFU and retention. There is no reliable study or survey supporting the haircut percentage. The country has not undertaken a national headcount study nor used the outputs from representative sample studies undertaken by implementers (UNDP) or partner organizations[33].

Poor community malaria data hampering performance assessment of World Vision

Under NFM1 and NFM2, community-based malaria interventions have been funded by the Global Fund to increase coverage of malaria testing and treatment. These interventions have been undertaken through community and health development agents known as ADECOS[34], who have been engaged since 2017 to expand malaria services. The Principal Recipient, World Vision, was engaged to train and supervise ADECOS in the provision of these services in 6 provinces[35], with the Government of Angola funding the agents' remuneration and tools. US$8.8m[36] was budgeted through the World Vision grants for community-based malaria case management activities; this included creating a new community-based information system ("KoboCollect") to record, analyze and report results to MINSA.

However, despite the investments in these important interventions, there are critical gaps in programmatic data and associated data systems. OIG was unable to validate reported results to

[32] UNAIDS World AIDs report 2019
[33] 2011 CDC study highlighted ART retention at 46% and UNDP 2018 DQA highlighted ART retention at 43%.
[34] ADECOS "*Agentes de Desenvolvimento Communitario e de Sanitaria" through a cross ministry partnership between the Ministry of Health and Ministry of Territorial Administration have begun providing Malaria services at the community level*
[35] Within these 6 provinces there has been an expansion of services with 18 municipalities covered in NFM1 and 32 in NFM2
[36] NFM 1 budget US$2.7m and NFM 2 budget US$6.1m for the malaria case management module

ensure their accuracy and ultimately verify the grant performance of World Vision. KoboCollect generated multiple report iterations on data from ADECOS that were shared with OIG, with significant differences in the reported underlying data without any reasonable explanation. For the ADECOS sites visited by OIG to verify reported results, only 7% of the total reported number of malaria cases treated in the community could be validated and matched to underlying records held by ADECOS. These data gaps highlight significant unreliability in several of the key indicators used to measure the performance of the World Vision grant.

Various data management gaps have contributed to these data issues, with accountability split between World Vision and MINSA. At the community level, weak M&E supervision and oversight was noted, with 41% of all Global Fund-trained ADECOS receiving no supervision from the Principal Recipient, the Ministry of Health or dedicated field supervisors as at December 2018. None of the sites visited by OIG had updated M&E tools to record programmatic results, with ADECOS using ad-hoc tools or not recording results at all (and reporting treatments based on memory only). At the central level, World Vision has not developed any data validation and verification guidelines to guide their active monitoring of ADECOS results. In addition, the LFA and Country Team review did not identify any of the above issues highlighting weaknesses in assurance and oversight.

Agreed Management Action 1:

The Global Fund Secretariat will apply a revised strategy for implementing grants to attain increased impact in the fight against the three diseases in Angola. The Global Fund Secretariat will carry out the new approach under the next grant cycle, which will include the following components/and be informed by:

- a comprehensive assessment of implementer capacity and the HMIS landscape, used to determine the future implementation arrangements and PR capacity building initiatives; with a specific focus on M&E reviews, training and supervision and supporting strengthened assurance on programmatic data;
- a more targeted geographic approach and prioritized set of interventions;
- strengthened engagement with relevant/appropriate sub-national actors (including Provincial departments of Health and Community actors).

Owner: Mark Edington, Head Grant Management Division

Due date: 31 December 2021

4.2 Limited country prioritization and ownership of programmatic performance

Despite Angola facing significant and growing programmatic challenges, there has been limited ownership and prioritization from the Government to effectively respond to high vertical transmission of HIV, TB/HIV co-infection and the growing number of TB cases and deaths.

Inadequate prioritization of TB services contributing to high growth in TB cases
Angola has the 18th highest estimated TB incidence globally and ranks among the top 30 countries for MDR-TB and TB/HIV coinfections[37]. The programmatic results show a deteriorating situation:

- 19% increase in estimated TB cases
- 17% increase in estimated deaths since 2010[37]
- 4% increase in proportion of TB missing cases (to 49%) since 2012%[38]

Significant gaps in TB service coverage and quality contribute to these results:

Low coverage of services: as of December 2018, TB services are offered in only 14% (333 out of 2,442) of the health facilities across the country[39], restricting case detection and treatment. This was a recurring issue flagged in the OIG 2012 audit.

Low community outreach: the country recognizes the need for strong community engagement and a strong footprint in health facilities.[40] However, the Government of Angola has not prioritized these activities. No funding has been allocated to them, with the only support coming from the Global Fund. In addition, no national strategy or policies have been developed for TB community outreach that includes active case finding, TB case referral, and support for treatment adherence.

While a community-based pilot for c-DOTS[41] was undertaken in 2010 with support from other partners[42], the pilot was not scaled up, and no lessons learnt have emanated from it. Nearly ten years on, there are no community-based TB activities in 96% of municipalities; the only current c-DOTS activity is a second pilot in six municipalities supported by the Global Fund. There is recurring risk of failure of the second pilot, due to limited government involvement (activities are undertaken by an INGO[43]); there are no agreed performance targets, and limited evidence of Ministry of Health oversight and supervision. The pilot has, accordingly, absorbed only 54% of allocated funding in NFM 1 and achieved only 34% of TB active case finding targets. The Ministry of Health has not conducted or planned any mid-term or final evaluation for the second pilot, despite these being vital to its potential scale-up.

Weak coinfection controls: current national guidelines on TB do not align to WHO policy recommendations[44] on infection control. For example, guidelines do not require, and consequently the Ministry of Health has not formed, any infection control committees or commenced any infection control roll-out plans. As a result, 55% (6/11) of facilities visited by OIG had not conducted any training for health care providers on infection control, 100% (11/11) had not conducted any assessment of infection control measures, and 90% (10/11) of the facilities had not screened their health care providers for TB and HIV. OIG observed breakdowns in infection control, with instances where MDR-TB patients were put in the same ward as TB patients, increasing cross-infection risks, and instances of health care providers contracting TB.

[37] WHO Global Tuberculosis Report (https://www.who.int/tb/publications/global_report/en/) – comparison between 2010 and latest data reported (estimated absolute number results)
[38] WHO Global Tuberculosis Report (https://www.who.int/tb/publications/global_report/en/
[39] Annual Report PNCT, 2018
[40] The NFM 1 Funding Request recognized the fact that the "health care has for decades been based on hospital care and therefore, there has never been a structured community-based health care system"
[41] C-DOTs is Community-based directly observed therapy of the treatment of TB
[42] First pilot of c-DOTS occurring in 2010 with support from USAID in the provinces of Huambo and Bié
[43] The c-DOTS pilot is administered by an INGO SR (CUAMM) under the MINSA under two contracts between NFM 1 and NFM2 worth US$4.1m
[44] https://www.who.int/tb/publications/2009/9789241598323/en/

Weak capacity of the National TB program: significant gaps in the TB Program staff at central and provincial level are impacting the implementation and oversight of TB activities. As of September 2019, the positions of Global Fund TB Program Coordinator and TB Program M&E officer remain vacant. In addition, of 18 budgeted Provincial TB program positions, there were 8 vacancies at the end of 2017 and 11 vacancies at the end of 2018. These positions were eventually removed from the Global Fund grants in 2019, and no additional support has been put in place by the Ministry of Health.

Low diagnostic coverage: only 22 of the 164 municipalities (13%) in Angola have GeneXpert machines. Even when GeneXpert machines have been funded and sent to the country through Global Fund grants, they have been underutilized. For example, 25 GeneXpert machines arrived in the country in April 2019 but, five months on, they still remained in storage as the Government could not support or identify funding for training and the procurement of related printers.

Weak coordination in Ministry of Health impacting TB-HIV activities

Angola is 11th highest globally in terms of estimated incidence for TB/HIV[45] coinfection, yet it has the second lowest co-management of TB & HIV in Southern and Eastern Africa. Only 62 health facilities provide "one-stop-shop" TB/HIV services. The Global Fund grants have not met key TB-HIV programmatic targets, with 49% of HIV+ registered TB patients given ART during TB treatment, against a target of 85%[46], and 67% of TB patients having an HIV test, against a target of 90%[46].

Weak collaboration between various parts of the Ministry of Health contributes to this low performance. The national TB program is housed under the National Disease Division, while the national HIV program is under INLS, which directly reports to the Minister of Health as an independent unit. There has been a lack of central initiatives to integrate and plan joint TB/HIV services between the two bodies. Despite a May 2018 decree by the Ministry for a TB/HIV coordinating body to be formed, no committee has yet been constituted. Thus, there are no joint planning, training, monitoring and evaluation measures in place for TB/HIV activities from the center. The coordination gaps contribute to low absorption: for NFM1, only 41% of a total budget of US$1.8m earmarked for TB/HIV activities under the UNDP HIV and the ministry's TB Grant was spent. Low collaboration has also impacted data sharing: in NFM1, with no HMIS data sharing between the two programs, the TB program and INLS reported materially different results for the same indicators in the same period.

Weak strategies and community engagement leading to poor PMTCT results

Prevention of Mother to Child Transmission (PMTCT) interventions have had low achievements in Angola. In July-Dec 2018, only 22%[47] of HIV-positive pregnant women received ART to reduce the risk of mother-to-child transmission. Weak PMTCT intervention has resulted in a 27.8% mother-to-child HIV transmission rate for Angola, significantly higher than the regional average for Southern and Eastern Africa of 9.2% and the global average of 12.7%[48]. Weak progress in tackling PMTCT has contributed to an 18% increase in under-14 HIV incidence and a 21% increase in HIV-related deaths since 2010[2].

Under NFM1, there was no national PMTCT strategy to tackle low Antenatal Care (ANC) and PMTCT coverage and to improve community outreach. As a result, there has been low integration of ANC and PMTCT services, with only 622 PMTCT sites operating in 2,522 ANC sites. At the community level, there are currently no Government-funded community health workers supporting PMTCT, with the majority funded by the Global Fund. A key move in the right direction was the development of a National Plan for the Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B for 2019–2022, [49] however some gaps in this plan were noted. The plan does not highlight

[45] WHO Global Tuberculosis Report (https://www.who.int/tb/publications/global_report/en/)
[46] Global Fund AGO-T-MINSA PUDR December 2018
[47] PU UNDP July-December 2018 - PMTCT-2 indicator
[48] UNAIDS 2019 Data
[49] Born Free to Shine PMTCT campaign effective from 2019-2021 has been launched based on the National Plan

the need to establish mother-to-mother peer workers or women living with HIV as community outreach agents, approaches that have been used in other countries to expand PMTCT coverage.

Agreed Management Action:

AMA 1 covers a revised strategy for implementing grants to attain increased impact in the fight against the three diseases in Angola, impacting limited prioritization and ownership.

4.3 Failure to fulfil Government commitments impacting Global Fund programs

As Angola is a middle-income country, its government is expected to be a major contributor to the funding for the three diseases, with the Global Fund grants mostly designed to complement government funding. Under NFM 1, the Global Fund supported 12%[50] of the total investment in the three diseases, with the Government of Angola (GoA) contributing 55%; this reliance on government investments driving the disease response has continued in NFM 2. Accordingly, for both NFM 1 and 2, in addition to the normal Global Fund co-financing requirements, specific commodity commitments were also agreed for the government investments. For example, the government committed to procuring adult first-line TB commodities, with the Global Fund supporting second-line. In Malaria, under NFM 2, the Global Fund supports malaria treatment and the GoA supports vector control. For HIV, the government committed to fund 60% of ART commodities in NFM 1. Government commitments are therefore critical for achieving overall programmatic impact and for the effectiveness of Global Fund interventions and investments. Yet the government has failed to fulfil these commitments and the Global Fund does not have any reliable mechanisms to monitor the commitments.

Non-fulfilment of government commitments noted for all three diseases

The Government of Angola has not provided adequate evidence that the previous pledges and agreed commodity commitments have been met. Such evidence has not been provided to the Global Fund throughout the grant implementation so far and, despite repeated requests before and during the audit, the Government of Angola did not provide it to OIG. This has negatively impacted the Global Fund grants:

- For TB first-line drugs (FLDs), the Ministry of Health formally committed to provide US$2.4m annually, for 2016 and 2017.[51] However, both OIG and Global Fund Secretariat analysis concluded a lower materialization of these commitments, with the OIG analysis validating 58% achievement in 2017 on FLD procurement commitments, albeit with stronger domestic procurement for 2018[52].

- For malaria, the government was unable to provide adequate evidence to confirm that anti-malarial commodity commitments were met. OIG analysis validated 74% and 24% achievement in 2016 and 2017, respectively. These issues still persist and, despite repeated OIG requests during the audit, the Ministry of Health has provided only limited data, making it impossible for OIG to validate 2018 commitments for LLINs as being met.

- For HIV, OIG was able to validate 15% and 28% of the 2016 and 2017 monetary commitments, respectively, for ART commodities. Subsequently, the GoA increased its domestic funded procurement of ARTs from 2016 to 2019 ten-fold[53].

These various failures to fulfil commitments have a significant impact on the Global Fund grants, most notably for the TB program which has limited support from other partners. The gaps in TB commitments led to the Global Fund grant being materially reprogrammed in 2017 to cover an emergency order of US$2.4m for first-line TB commodities, which were supposed to be covered by government commitments. These failures to fulfil commitments and short-notice emergency orders contributed to routine stock-outs of first-line drugs between January 2017 and July 2018[54]; an emergency order was delivered in September 2018. These stock-outs impact treatment success rates

[50] 2012-2017 Funding landscape, Global Fund Health Financing Analysis (2018)
[51] Global Fund grants were designed to fund only a small proportion of children's first line TB drugs (FLDs) and second line TB drugs.
[52] Based on MINSA records TB first-line drug send in 2018 was USD$1.4m in 2017 and US$3.4m in 2018
[53] Based on INLS/MINSA records ART domestic funded spend was US$1.2m in 2016 and then US$15.5m in 2019
[54] Jan 17 – July 18 NFM 1 PU/DRs for MINSA TB grant noted 100% of health facilities reported a stock out of TB FLDs per indicator PSM Other 3

and increase the risk of drug resistance and MDR-TB. Further, to accommodate the US$2.4m emergency procurements, grant investments in data systems and HMIS were cut by US$0.7m, and activities to support expanded prevention, case detection and treatment services for TB were cut by US$0.8m (47% of the total Global Fund investment under NFM 1 in these activities). This has also impacted the HIV program, which has limited support from other partners. However, with limitations in quantifying the total number of patients on ART treatment (see Finding 4.1), the programmatic impact of the non-fulfillment of commitments cannot be accurately determined.

These failures to fulfil commitments are partly linked to broader macroeconomic factors impacting available resources. Angola was, and continues to be, impacted by the global decline in oil prices, and subsequently faced a severe economic recession (2016-18), limiting the fiscal space to fulfil government commitments. However, there is also limited government ownership over tracking and adhering to these agreed commitments, or proactively seeking alternative solutions. There are no clear processes or systems in the Ministry of Health to track progress on commitments and flag potential lapses in fulfilling commitments early, both internally and to donors, in order to explore solutions. There is also a lack of clarity over which teams and departments in the Ministry of Health are responsible for monitoring these commitments.

Monitoring issues also exist within the Global Fund Secretariat on the specific commodity commitments agreed for Angola. The Secretariat has an operational policy note on co-financing, which includes guidance on specific commodity commitments. However, in the case of Angola, the Secretariat has failed to set clear accountabilities for the government of Angola to report on delivery against their commitments, and for the Secretariat to track and monitor that these commitments are being fulfilled. This is an important gap that requires attention, since domestic commitments are a cornerstone of the grants' design and play an important role in achieving the objectives across the three diseases in Angola, as explicitly recognized in the country's funding requests.

Agreed Management Action 2:

The Secretariat will review compliance of co-financing commitments in Grant Agreements for Angola under the 2017-2019 funding cycle, in line with the OPN on Cofinancing, including assessing implications of non-compliance. If there is evidence of non-compliance or non-realization of co-financing commitments, the grants may be proportionally reduced.

The Secretariat will continue to engage with the relevant national authorities and in-country stakeholders to support the institutionalization of a monitoring and reporting mechanism for co-financing commitments.

Owner: Mark Edington, Head Grant Management Division

Due date: 31 March 2022

4.4. Implementation bottlenecks hamper effective oversight and management of the Global Fund Grants

The Global Fund has invested in multiple management structures to support the effective implementation of its grants. A key structure has been the UTG (Unidad Tecnica de Gestao)[55] formed in 2008 to act as a Project Management Unit over the Ministry of Health's TB and Malaria Grants. UTG was designed to provide financial and program management support to the national disease programs, costing US$1m[56] between 2016-2019. In addition, the Global Fund has also supported the establishment of an embedded fiscal and fiduciary agent over the ministry grants, at a cost of US$3.8m between 2016-2021. However, despite these investments, significant gaps remain in the effective management of Global Fund grants.

Delays in external Audit and Progress Updates/Disbursement Reports (PU/DRs): external audits have been significantly delayed for both of the ministry's TB and Malaria grants. Audit reports were on average completed with a delay of 415 days between 2016 and 2018. The 2017 and 2018 reports were still outstanding at the time of the OIG audit; 2016 audit reports were completed in November 2018, with 13 high risk findings provided to the Global Fund 605 days after the policy required audit findings to be shared. These issues in timely assurance contribute to recurring and unresolved control gaps on fixed asset management and financial reconciliations. In addition, material delays in Progress Update/Disbursement Request reporting for 2016-2018 were noted; TB and Malaria PU/DR reporting was delayed by 102 days on average, with a maximum delay of 261 days. These delays impact timely oversight, disbursements and grant absorption.

Weak sub-recipient management: gaps exist, despite SR oversight by both the national programs and UTG. For example, community-based TB interventions (c-DOTs) were planned in a pilot project under an INGO[43]**Error! Bookmark not defined.**, however significant delays in contracting SRs and SSRs reduced implementation in NFM 1 from a planned 24 months to 8 months. Similar contracting delays were repeated in NFM 2, resulting in a 5-month delay in starting activities and causing treatment support disruption across the entire c-DOTs pilot project.

PMU structure unable to proactively identify or resolve program management challenges

Design challenges in UTG's structure have contributed to the issues noted above. UTG's role and mandate have not been defined, despite the level of investment in the structure. UTG's Terms of Reference have not been updated since 2008, and no longer reflect the current implementation arrangements and risks. UTG also does not have any delegated authority from the Ministry of Health, resulting in increased bureaucracy and limited empowerment. This lack of a clear mandate has led to gaps and overlaps in roles and responsibilities between the UTG, national disease programs and the ministry. For example, disease programs do not have a formal mechanism of sign off on PU/DR reports, reducing ownership on programmatic results. This has contributed to delays in completion of training and supervision visits. Further, PU/DR reporting is delayed, since sign-off is requested in an ad-hoc manner from multiple departments of the Ministry of Health, including the disease programs, UTG, GEPE and the National Public Health Directorate.

Furthermore, UTG has been significantly understaffed, impacting its ability to effectively monitor and oversee Global Fund grants. Despite an average of 10 positions budgeted under Global Fund grants for the UTG under NFM 1 and 2, there have been several vacancies in key positions[57]. The positions of Project Coordinator, Finance Manager, PSM specialist, and M&E specialist were vacant for the majority of NFM 1, with gaps in M&E positions ongoing in NFM 2.

[55] The UTG is housed in the Ministry of Health under GEPE (Gabinete de Estudos, Planeamento e Estaistica), the Office of Studies, Planning and Statistics

[56] Expenses include staff salaries, vehicle, office equipment & administration costs

[57] 4 out of 10 UTG positions remain vacant in Q4 2019

Agreed Management Action:

AMA 1 covers revised strategy for implementing grants to attain increased impact in the fight against the three diseases in Angola impacting future implementation arrangements.

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
1. The Global Fund Secretariat will apply a revised strategy for implementing grants to attain increased impact in the fight against the three diseases in Angola. The Global Fund Secretariat will carry out the new approach under the next grant cycle which will include the following components/and by informed by: • a comprehensive assessment of implementer capacity and the HMIS landscape, used to determine the future implementation arrangements and PR capacity building initiatives; with a specific focus on M&E reviews, training and supervision and supporting strengthened assurance on programmatic data; • a more targeted geographic approach and prioritized set of interventions; • strengthened engagement with relevant/appropriate sub-national actors (including Provincial departments of Health and Community actors).	31 December 2021	Head of Grant Management Division (Mark Edington)
2. The Secretariat will review compliance of co-financing commitments in Grant Agreements for Angola under the 2017-2019 funding cycle in line with the OPN on Cofinancing, including assessing implications of non-compliance. If there is evidence of non-compliance or non-realization of co-financing commitments, the grants may be proportionally reduced. The Secretariat will continue to engage with the relevant national authorities and in-country stakeholders to support the institutionalization of a monitoring and reporting mechanism for co-financing commitments.	31 March 2022	Head of Grant Management Division (Mark Edington)

Annex A: General Audit Rating Classification

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

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 help our auditors to provide high quality professional work, and to operate efficiently and effectively. They help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing takes place across the Global Fund as well as of grant recipients and is used to provide specific assessments of the different areas of the organization's' activities. Other sources of evidence, such as the work of other auditors/assurance providers, are 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 may also assess how Global Fund grants/portfolios are performing against target for Secretariat-defined key indicators; specific indicators are chosen for inclusion based on their relevance to the topic of the audit.

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 countries[58] 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 Committee[59] 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.

[58] 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.
[59] 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