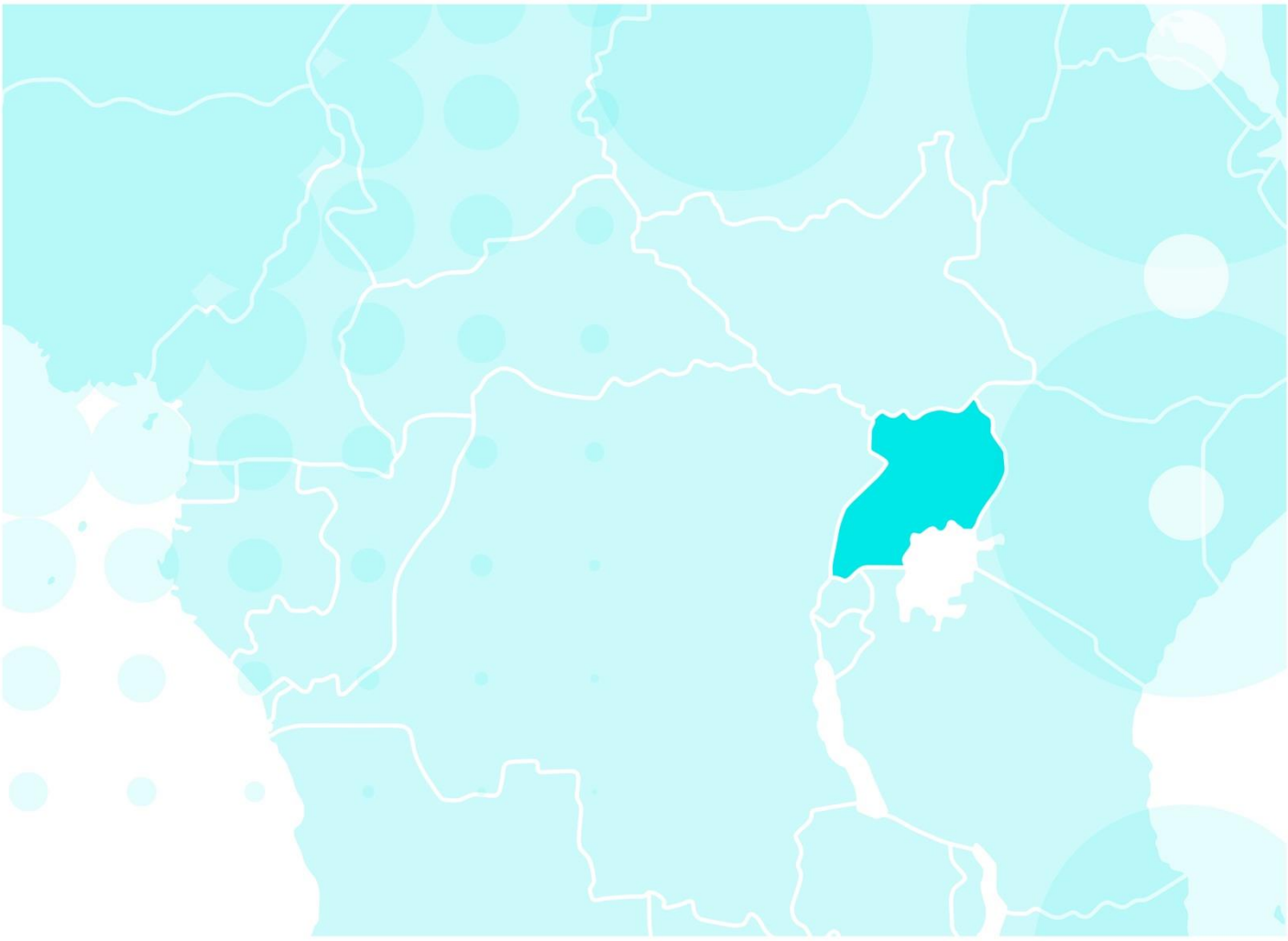

Audit Report

Global Fund Grants to the

Republic of Uganda

GF-OIG-23-019
11 December 2023
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Uganda plays a vital role in the global battle against the three diseases. The country is among the top 20 countries with the highest malaria cases (third) and mortality (eighth),[1] and among the top 10 countries (tenth) with the highest HIV prevalence in the world.[2] Overall, there has been substantial programmatic progress in the HIV response, with an HIV prevalence in 2021 of 5.5%, which is lower than the regional average of 6.2%.[3] Tuberculosis (TB) incidence and TB-related deaths have decreased by 1.6% and 43% respectively between 2015 and 2021.

Uganda has made strong progress in the fight against HIV, decreasing new infections by 58% and mortality by 65% from 2010-2020. This has led to a prevalence standing at 5% below the regional average. Strong progress against the UNAIDS 95-95-95 goals,[4,5] was noted for 1.4 million people living with HIV, with an achievement rate of 90%-94%-94%.[6] The report highlights challenges in HIV prevention, linkage to care, and antiretroviral treatment adherence that could impact the gains made.

The Global Fund's Grant Cycle 6 malaria grant aims to reduce infection, morbidity, and mortality by 50%, but challenges including delayed indoor residual spraying and insecticide-treated net campaigns, treatment provision interruption through iCCM and inadequate data quality hinder the achievement of these goals. Between 2021 and 2022, malaria cases and malaria-related mortalities increased by 37% and 28%, respectively. The lack of a recent Malaria Indicator Survey (MIS) and inadequate data quality have hindered the effectiveness of malaria intervention. Due to these significant challenges with the malaria program, the average rating on program quality, specifically the adequacy and effectiveness of the program implementation audited, **needs significant improvement.**

Some improvement in the supply chain management was noted since the last OIG audit in 2019. However, visibility of commodities at the peripheral level has been challenging due to multiple non-interoperable systems, inadequate IT infrastructure, unreliable power supply, and limited access and viewing rights. This impacted district health teams and the ability of the Ministry of Health[7] to detect and respond to stock-outs and overstock issues. Delays in disbursement of funds from the Government impacted the distribution schedule of the national medical store, leading to stock-out of commodities at the facilities. These delays stemmed from the country's fiscal year closure processes and the debate over payment clearing additional documentation. The effectiveness of procurement and supply chain management **needs significant improvement.**

The Global Fund-supported programs are integrated into the national systems and the Principal Recipients have relevant policies to manage sub-recipients, finances, and fixed assets. The OIG, however, found inadequate sub-recipient management and gaps in financial management of grant funds. Contracting and disbursement to sub-recipients were significantly delayed, hindering the timely implementation of program activities. There were also delays in the accountability of funds disbursed to sub-recipients, including to the district local governments. Direct local procurements reviewed by the OIG were conducted without a competitive bidding process, based on a claim of an unjustified exceptional circumstance. The adequacy and effectiveness of financial management and oversight **needs significant improvement.**

[1] World Malaria Report 2022
[2] Data.worldbank.org accessed on 16 October 2023
[3] www.unaids.org, accessed on 28 August 2023
[4] This seeks to ensure that 95% of people living with HIV (PLHIV) are aware of their status, 95% of those diagnosed are receiving treatment, and 95% of those treated achieve viral suppression by 2030
[5] www.unaids.org/2025-AIDS-Targets, published in 2021.
[6] UNAIDS 2022: AIDSInfo Global data on HIV epidemiology and response. Available at: https://aidsinfo.unaids.org/ , accessed on 28 August 2023
[7] Within Uganda's decentralized health system, DH teams (DHTs) are autonomous segments of the national health system. The MOH has the role of a principal agent with the mandate of encouraging local institutions, such as the DHTs, to make choices that achieve the objectives of the national health system

1.2 Key Achievements and Good Practices

Steady progress toward UNAIDS fast track goals and HIV prevalence reduction

Uganda has made progress towards achieving the UNAIDS 95-95-95 goals, aiming to reach 95% HIV status awareness, 95% treatment, and 95% viral suppression by 2030. As of 2022, approximately 1.4 million were living with HIV, with 90% aware of their HIV status, 94% of people with diagnosed HIV infection were receiving sustained antiretroviral therapy, and 94% of people receiving antiretroviral therapy were experiencing viral suppression. TB coverage and treatment success rate is 82% and 85% respectively, compared to WHO's Africa Region average of 60% and 86%.[8]

The HIV Guidelines in Uganda are consistent with global guidelines for differentiated care delivery. A Community Literacy Handbook was developed to improve patient behaviors and raise awareness of the disease. SafePal, an interactive app preventing gender-based violence, has been developed.

A comprehensive array of services is made available to adolescent girls and young women (AGYW) and is aligned with the PEPFAR DREAMs program. A Unique Identifier Code (UIC) is in use for AGYW. Uganda uses various HIV prevention programs, including testing and treatment promotion, risk reduction, and other similar initiatives. The Global Fund-AGYW Program includes skill-building and economic empowerment.

Malaria interventions were carried out throughout the COVID-19 pandemic

The country uses insecticide-treated nets as a core vector control tool, implemented in all regions through three distribution channels: mass campaigns, Reproductive and Child Health (RCH) clinics, and School Net Programs. Some 28.8 million nets were procured for a mass campaign, with 98.6% delivered in 2020/2021. Due to the resistance to the insecticide (pyrethroids) used in standard LLINs, the country has switched to PBO and new generation nets. Thirty active sentinel sites monitor resistance to insecticides. In addition, the country has operational guidelines for indoor residual spraying (IRS), and a National Malaria Social and Behaviour Change (SBC) Plan 2023-2025 is in place.

The Uganda Malaria Reduction and Elimination Plan (UMRESP) 2021-2025 seeks to reduce malaria transmission in highly seasonal areas among children under the age of five during the height of malaria season. The implementation of Seasonal Malaria Chemoprevention (SMC) in the Karamoja region has resulted in a 12% decrease in malaria cases among children under the age of five in 2022, compared to figures from 2021, and a 25% decrease in Global Fund-supported districts. The country is currently working to finalize the draft SMC implementation guidelines.

Appropriate financial management guidelines and policies are in place, and government contribution has increased

Global Fund-supported programs under MoFPED are integrated into the national systems. For example, the Global Fund grant is incorporated into the country's budget, and the Integrated Financial Management Information System (IFMIS) is used for the grant's financial management and reporting. External audits of Global Fund grants are conducted by the Office of the Auditor General (OAG).

The Treasury Instructions 2017, Public Finance Management Act, and Grant Management Manual for fixed asset management in 2021 provide detailed guidelines, policies, and processes for the Ministry of Health (MoH). The Ministry of Health evaluated the sub-recipient's capacity and determined that it was adequate to carry out the allotted activities. The central medical store has qualified personnel for supply chain management. The Government has established a 10-Year Roadmap for Health Supply Chain Self-Reliance, made incremental investments in supply chain management, including a 40% contribution to Kajjansi Central Medical Store and incremental contributions to procurement of first-line TB drugs reaching 55% in 2021 and 57% in 2022.

The second Principal Recipient, The AIDS Support Organization (TASO), has proper financial management supported by manuals, policies, and guidelines followed by TASO to ensure timely retirement of advances. TASO followed a competitive sub-recipient recruitment process with sub-recipient agreements in place, and a proper monitoring and supervision of the sampled sub-recipients.

[8] World TB report 2022/WHO TB database - Country profile

1.3 Key Issues and Risks

Passage of the Anti-Homosexuality bill and delays in the implementation of HIV prevention intervention for key populations may impact the fight against HIV

Insufficient coverage of prevention services for key populations continues to be a challenge. Only 36% of MSMs and 40% of FSWs received preventive services in the latter half of 2022.[9] Although there has been some increase in coverage, it falls short of the UNAIDS targets. The local legal and political context has very likely contributed to greater human rights barriers to services and safety and security risks for key populations and service providers, requiring adaptation of services and human rights programs. Consequently, three activities related to human rights and scaling up key population services in Grant Cycle 6 have been delayed, resulting in slow progress and expenditure. These activities include supporting research to inform evidence-based strategic litigation, conducting assessments of the impact of laws and policies, and developing advocacy agendas for law and policy review and reform. Additionally, there is a delay in strengthening key population organizations, which is important for the success of the program. Enhancing the coordination roles and capacities of key population-led organizations, consortiums, and networks is essential particularly in the current environment, but has seen low expenditure and delayed progress.

The Ugandan parliament enacted the Anti-Homosexuality Bill in May 2023, which was subsequently signed into law by the President.[2] The law criminalizes same-sex behavior and "promotion of homosexuality," and includes the possibility of a death penalty for those convicted of "aggravated homosexuality." The Bill has been impacting service delivery and program objectives, leading to low absorption of the budget allocated for some of the activities aimed at reducing human rights-related barriers to HIV/TB services. Overall, the gaps in HIV prevention for key populations, coupled with the adverse legal and policy environment, pose significant challenges to reducing the impact of HIV among these vulnerable groups. [10,11]

Inadequacies in vector control, community case management, and data quality contribute to high malaria incidence and mortality

Malaria remains highly endemic in Uganda, with the third highest incidence and eighth highest mortality rates in the world. In common with neighboring countries, the program's impact has been limited, with an increase in malaria cases and deaths. Between 2021 and 2022, malaria cases and deaths increased by 37% and 28%, respectively. The country's inability to achieve the agreed-upon targets is due to gaps in prevention, treatment, and data quality. In particular, delays in mass distribution campaigns, and limited routine distribution of insecticide-treated nets due to two-year closure of schools due to the COVID-19 lockdown have contributed to the program's inability to achieve its objectives. The lack of a Malaria Indicator Survey (MIS) since 2018/1019 and inadequate data quality have hindered the effectiveness of malaria intervention targeting. Non-attainment of intermittent preventive therapy in pregnancy (IPTp) coverage objectives has also contributed to the rise in malaria infections among pregnant women. Disruptions and gaps in iCCM implementation, due to delays in enrolling sub-recipients and training for health professionals, have affected community malaria treatment for children under five.

Improvement needed for sub-recipient and financial management to safeguard grant funds

The Ministry of Health implements the Global Fund grants to the Government of Uganda as the Lead Implementer under the Ministry of Finance, Planning and Economic Development (MOFPED), which is the Principal Recipient. However, sub-recipient management is inadequate and there are gaps in related financial management, accounting, and reporting processes. The Malaria Program spent an average of 13 months contracting sub-recipients including district local governments (DLGs), and funds were disbursed to them on average three months after awarding the contracts caused delays in the implementation of grant activities.

[9] TASO routine reporting, December 2022

[10] Please refer to the scope limitation outlined in 1.4 Objectives, Rating, and Scope

[11] In an attempt to ensure that the law does not affect service delivery, a circular from the Director General of Health Services in Uganda was sent to all health sector service providers on the 5th of June to emphasize that they need to provide service to all people without discrimination

Furthermore, US$1.3 million advanced to a sub-recipient was cleared and reported as entirely retired, with supporting documents being either duplicated or irrelevant to this expense. While US$1 million was later cleared by the OIG by visiting the relevant sub-recipient, the supporting documents for a procurement of US$0.3 million was not found. Finally, five direct local procurements were carried out without a competitive bidding process using exceptional circumstances to justify non-compliance with procurement policies. The two contracts sampled by the OIG worth US$1.1 million did not reflect a situation of exceptional circumstances that would justify non-competitive bidding.

Challenges with distribution, monitoring and visibility of health commodities impacted the timely availability of health commodities

The Government has advocated for the implementation of an electronic Logistics management Information system (eLMIS) to improve data integrity and stock monitoring. However, visibility of commodities at the peripheral level is impaired due to multiple non-interoperable systems, inadequate IT infrastructure, an unreliable power supply, and limited access and viewing rights. The e-LMIS system was found to be inoperable in approximately 50% of the facilities visited by the OIG. The National Medical Stores operation software (NMS+) system lacks controls to alert warehouse teams of expired or near-expiration commodities. The district health teams, and the Ministry of Health do not have visibility over the data in the Client Self-Service Portal (CSSP) and other relevant warehouse systems to detect and respond to stock-outs and overstocks.

The delay in disbursing the last mile distribution funds to NMS caused distribution delays. This contributed to stock-outs across all levels, including at health facilities. There was an average stock-out of two months for key commodities such as first-line treatments for HIV and malaria, as well as diagnostic tests in 15 health facilities visited.

The health facilities stores' inability to maintain and organize inventory caused inventory management and control gaps. Over 70% (11/15) of facilities had stock cards that did not match their stock tally. Stock cards were inaccurately updated, batch-level details were not captured, and health facility stock supervision systems were not accurately updated in 46% (7/15) of sites visited. 73% (11/15) of facilities surveyed had product discrepancies, and US$64,000 in stock went missing throughout the six-month sample. Failure to update record-keeping equipment in real time, arithmetic errors, and failure to reconcile stock cards with delivery notes on-site caused stock card discrepancies.

Challenges in prevention, linkage to care and adherence to antiretroviral treatment could affect the strong gains made in HIV implementation

Uganda has made significant progress in combating HIV/AIDS and improving access to prevention, care, and treatment services. The country, however, faces challenges in treatment linkage and patient retention, as well in the implementation of HIV prevention interventions for key and vulnerable populations. Improper recordkeeping and follow-up, limited to moderate community involvement, inconsistent compliance with guidelines and delays in the implementation of key activities contributed to the linkage to care and treatment adherence issues.

Despite the high HIV prevalence among key and vulnerable populations, these groups have low coverage of services and implementation of interventions has also been delayed. Prevention services for AGYW in schools was delayed by 18 months due to the COVID-19 pandemic, which resulted in the closure of schools. Non-adherence to Prevention of Mother-to-Child Transmission (PMTCT) guidelines, inadequate retesting of pregnant women during labor and delivery, improper documentation of pregnant women receiving ART in the registers, and inadequate linkage of HIV-positive confirmed babies to ART for infants contributed to gaps in PMTCT and Early Infant Diagnosis (EID) services.

1.4 Objectives, Ratings and Scope

The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on Global Fund grants to the Republic of Uganda. Specifically, the audit will assess the design and effectiveness of the objectives below.

Objectives	Rating	Scope
Implementation of malaria and HIV interventions to ensure access to essential services by beneficiaries.	**Needs significant improvement**	**Audit period** The audit covered the period January 2021 to December 2022. **Scope limitation** In May 2023, the Government of Uganda signed the Anti-Homosexuality Act 2023. The Act criminalizes homosexuality and obstructs health education and outreach that can help end AIDS as a public health threat. As a result, the audit team was unable to fully and safely access programmatic interventions provided to the LGBTQI+ community. **TB detection, treatment and care was scoped out of the following grounds:** Materiality: TB grant represented 5% (US$30m) of total CG6 grants. Of this, US$24m (85%) is for procurement of anti-tuberculosis medicines, lab reagents, GeneXpert machines maintenance and service costs and costs associated with Procurement and Supply chain Management. Likelihood & Impact: The increased case notification and treatment success rates (although at a slow pace) coupled with the decrease in TB-related deaths indicates that the program in general is on the right track.
Supply chain processes and systems to ensure timely availability and accountability of commodities at all levels.	**Needs significant improvement**	
Grants oversight and functions to support the achievement of grant objectives, with a focus on financial and procurement controls and an in-country assurance mechanism in safeguarding Global Fund resources.	**Needs significant improvement**	

The audit team:

- Met with relevant stakeholders at the Secretariat, Country Coordination Mechanism, Local Fund Agent, implementers, the National Disease Programs, and development partners to discuss the audit objectives, scope, and approach.
- Reviewed relevant documents and information.
- Performed audit fieldwork, which includes review of systems and processes, testing of internal controls, as well as visits to sample health facilities and medical stores. Conducted a deep-dive review of sampled countries focused on their grant revisions and portfolio.

2. Background and Context

2.1 Overall Context

Uganda is a low-income country with an estimated population of 47 million.[12] It consists of 134 districts and one capital city. Uganda is classified as a high impact country due to its significant contribution to the global burden of the three diseases, accounting for approximately 4% of PLHIV 1% and 5% of respectively TB and malaria cases worldwide.[13]

In 2023, the annual growth rate of Uganda's GDP stood at around 5.3%,[14] with inflation rising to 8.8% and a high central government debt of 51%[5] of GDP. At 4% of GDP, health expenditure per capita is declining. The Global Fund is the second largest donor to the country (after the U.S. government), contributing approximately 26% of the country's available funding for HIV, tuberculosis and malaria.

The programs of the Global Fund are almost entirely integrated with the national system for the grant under the Ministry of Finance and Planning is the Principal Recipient for HIV, tuberculosis, and malaria grants, while The AIDS Support Organization (TASO)[16] manages the HIV/TB prevention component on behalf of the Civil Society.

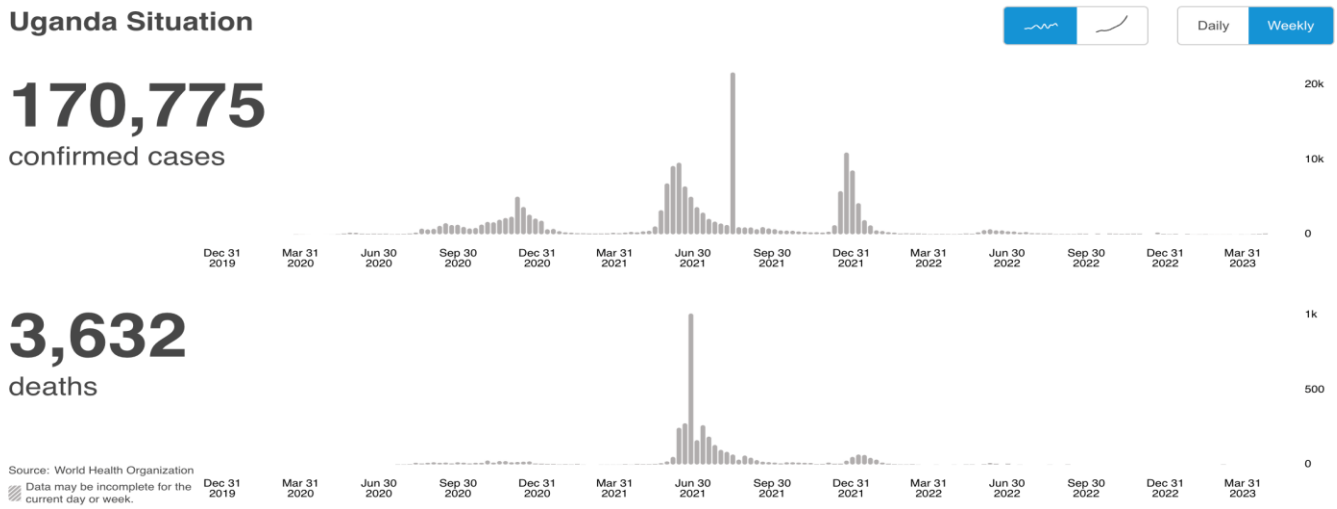
On 26 May 2023, the government approved the Anti-Homosexuality Bill.[17] The law may impact the ability of LGBTQI+ community to access services.

Country data[15]	
Population	47 million (2022)
GDP per capita	US$ 884 (2021)
Transparency International	142 of 180 (2021)
UNDP Human Development	166 of 191 (2021)
Government spending	4% (2020)

2.2 COVID-19 situation

Uganda had the second largest COVID-19 caseload in Eastern Africa after Kenya and ranked 14th in terms of caseload across Africa.[18] It also recorded the longest lockdown and shutdown of schools in the world, with schools closed continuously for two years (March 2020 to January 2022). Approximately 30% of Uganda's population is fully vaccinated, and 45% is partially vaccinated.[19]

[12] data.worldbank.org/country/uganda, accessed on 28 August 2023
[13] UNAIDS 2022 Report, WHO TB database - Country profile, World Malaria report 2022, accessed on 28 August 2023
[14] www.worldbank.org/en/country/uganda, accessed on 28 August 2023
[15] CIA FactBook, UNDP HDI, Corruption Transparency Index, Gender Inequality Index, City Population, https://data.worldbank.org/country/uganda?view=chart, accessed on 28 August 2023
[16] The AIDS Support Organization (TASO) is a non-governmental organization set up in 1987 to offer HIV counseling and medical services to people infected and affected by HIV and AIDS
[17] www.parliament.go.ug, posted on 20 May 2023
[18] https://covid19.who.int/region/afro/country/ug, accessed on 28 August 2023
[19] Bloomberg Vaccine tracker, accessed on 28 August 2023



Impact of COVID-19 on disease/grants

HIV

The restrictions affected outreach programs such as HIV prevention community awareness activities amid school closures, in 2020 and 2021.[20] Some 1,781 newly diagnosed HIV patients experienced delayed enrolment into care, partly as a consequence of COVID-19 restrictions.

Malaria

LLIN continuous distribution to targeted risk groups was not performed as planned in 2021 due to closure of schools during the lockdown. Similarly, the 2020 LLIN mass campaign, concluded in 2021, was disrupted by lockdowns and travel restrictions in the country.[21]

TB

COVID-19 largely affected TB in the country, with case notification dropping by 22% in 2020. However, the reported number of people newly diagnosed with TB in 2021 recovered to 2019 levels.[22] Sustained good performance on some indicators – e.g., % of HIV-positive new and relapse TB patients on ART during TB treatment – as TB/HIV essential services continued and multi-month prescriptions of ARVs were provided.

[20] National Center for Biotechnology Information
[21] Uganda Malaria Reduction Strategic Plan. (2020 -2025) Mid-Term Review Report 2022
[22] World TB report 2022

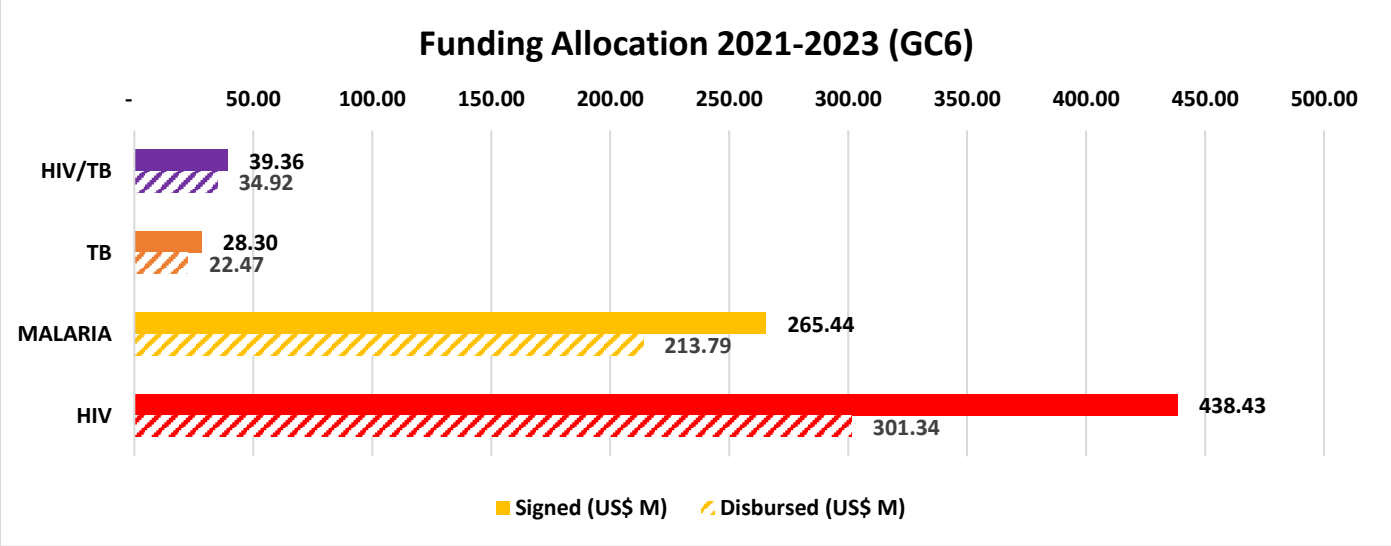
2.3 Global Fund Grants in Uganda

Since 2002, the Global Fund has signed grants of over US$2.30 billion and disbursed more than US$2.03 billion to Uganda.[23] Active grants total US$772 million for the 2020-2022 funding allocation period (January 2021 to December 2023 implementation period), of which 74% has been disbursed.[24]

The Ministry of Finance, Planning and Economic Development (MoFPED and The AIDS Support Organization, TASO) are the Principal Recipients for Global Fund grants. The Ministry of Health (MoH), through the national disease programs for the three diseases, implements the grants.

Each disease component program is implemented by a government implementer and a non-governmental organization. The TB and HIV grants are implemented by the National Tuberculosis and Leprosy Program (NTLP), National AIDS and STD Control Program (NACP) respectively while the combined HIV/TB grant implemented by TASO. The malaria grants are implemented by the National Malaria Control Division (NMCD) and TASO. At the peripheral level, Uganda's healthcare system works on a referral basis; if a level I facility cannot handle a case (HC I),[25] it refers it to a unit the next level up (e.g., HC II).[26]

Figure 1: Funding allocation 2020 -2022 implementation cycle (Jan 21 – Dec 23)



[23] Global Fund Data Explorer, accessed on 24 August 2023
[24] Grant Operating System (GOS) data, accessed on 9 May 2023
[25] Health Center I: The first contact for someone living in a rural area such as Katine would be a community medicine distributor or a member of a village health team
[26] Health Center II: an outpatient clinic serving a few thousand people, should be able to treat common diseases like malaria

2.4 The Three Diseases

HIV / AIDS	TUBERCULOSIS	MALARIA
HIV prevalence in Uganda is at **5.5%** (11th of 124 Global Fund eligible countries) **with an estimated 1.4 million** adults and children living with HIV in 2022. **The HIV cascade of all PLHIV (UNAIDS 2021 data-PLHIV denominator) was 89-82-78,** compared to that in Eastern & Southern Africa of 90-78-73 and a Global cascade of 85-75-68. **In 2021, the Adult HIV cascade (UPHIA and UNAIDS 2021 data)* was 89-96-92 and 90-92-95 respectively,** compared to that in Eastern & Southern Africa of 90-87-93 and a global cascade of 85-88-92. **HIV overall budget is US$334 million or 67% of the total GC6 budget.** The prevention, treatment, care and HTS services account for 60% and 46% of the program budgets under MOFPED (PR1) and TASO (PR2) respectively. **Source:** UNAIDS 2022 Report // HIV/AIDS NSP 2021-2025 // NFM2 & 3 budgets // UNAIDS Factsheet	**TB disease burden:** TB disease burden in Uganda is 0.8% (20th of 115 Global Fund eligible countries). Uganda is among the WHO **30 high burden countries for TB/HIV** co-infection. TB incidence and TB-related deaths have **decreased by 1.6% and 43% respectively** between 2015 and 2021. TB incidence of 91,000 (199 **cases per 100,000** population) and MDR/RR-TB incidence of **3.2 cases per 100,000** population (2021). **TB coverage and treatment success rate is 82%-85%,** compared to WHO's Africa Region of 60%-86%. **Source:** World TB report 2022 // WHO TB database - Country profile	Uganda is among the **20 countries with the highest malaria incidence (3rd) and mortality (8th)** globally in 2021 and is among the WHO/RBM **High Burden to High Impact Approach (HBHI)** countries. In 2022, the World Malaria Report showed a **50% increase in malaria cases** compared to the 2017 data (confirmed malaria cases in 2020 - 17.5m and 2017 – 11.7m). The indicator "Proportion of suspected malaria cases that receive a parasitological test in the community" was **not reached (83.7% actually tested vs. 95% target).** Insecticide treated nets distributed through routine channels: **1.4m nets distributed in 2021** against a target of 4.3m nets and achievement of 32%. In 2022, the **target was 3.1 million** and the result was 1.4 million with an achievement ratio of 46%. **Source:** 2022 World Malaria Report // World Bank data

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

NFM3 Allocation (2020-2022)

Comp	Grant	Principal Recipient	Total Signed (USD)	Disbursement [27] (USD)	(%)	Jun21	Dec21	Jun22	Dec22
	UGA-H-MoFPED	Ministry of Finance, Planning and Economic Development (MoFPED)	438,426,482	258,793,537	59%	B1	C2	C5	A4
	UGA-T-MoFPED	Ministry of Finance, Planning and Economic Development (MoFPED)	28,305,262	20,238,343	71%	B1	C1	B3	A5
	UGA-M-MoFPED	Ministry of Finance, Planning and Economic Development (MoFPED)	233,482,435	168,833,298	72%	B1	C5	B4	C2
	UGA-M-TASO	The AIDS Support Organization (Uganda) Limited (TASO)	31,956,310	25,825,206	81%	A2	A5	A4	A3
	UGA-C-TASO	The AIDS Support Organization (Uganda) Limited (TASO)	39,359,849	28,201,351	71%	B2	C5	A5	A5
TOTAL			**771,530,338**	**501,891,735**	**65%**				

The Global Fund updated the PU/DR performance rating methodology[28] with programmatic performance assessed via alphabetic ratings while financial performance assessed via numerical ratings.

[27] The portfolio absorption figures below/above are based on total disbursements processed for the 2020-2022 Implementation Period as of 15 December 2022, against the total signed amounts.

[28] Revised PU/DR and Performance Ratings (2022) Accessed 3 May 2023

3.2 Risk Appetite

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

Audit area	Risk category	Secretariat aggregated assessed risk level (March 2022)	Assessed residual risk based on audit results	Relevant audit issues
Program quality	HIV	**Moderate**	**Moderate**	Finding 4.4
	Malaria	**High**	**High**	Finding 4.1
M&E	Data availability and data quality	**Moderate**	**Moderate**	Finding 4.1 and 4.4
In-country governance	In-country governance	**High**	**High**	Finding 4.1 and 4.4
Procurement and supply chain management	In-country supply chain	**Moderate**	**Very high**	Finding 4.3
Financial assurance framework/mechanism	Grant-related fraud and fiduciary risks	**Very high**	**Very high**	Finding 4.2
	Accounting and financial reporting	**High**	**High**	Finding 4.2

While OIG and Secretariat risk levels were aligned for program quality, Monitoring & Evaluation, financial assurance framework/mechanism, as well as for in-country governance, they differ for procurement & supply management. Below is a summary of the considerations for the OIG's assessed residual risk ratings.

Due to sub-optimal peripheral commodity visibility, traceability and challenges with the inventory distribution cycles hindering facility-level supply planning and leading to stock-outs and expiration of essential health commodities, the OIG rates procurement and supply management as "Very High" with 82% of the $459 million HIV grant to Uganda is earmarked for the purchase of essential goods to sustain the more than 1.2 million people on HIV treatment. At all levels, greater than two-month supply gaps were discovered, including in 11 of the 15 health facilities visited. The OIG has rated the in-country supply chain risk in Uganda as very high due to the very high impact on the program and the high probability that this risk will continue to materialize.

4. Findings

4.1 Gaps in vector control, community case management and data quality contributing to high malaria incidence and mortality

The Global Fund's malaria grant in Uganda established ambitious targets to accelerate progress towards elimination that were not met. Rising rates of morbidity and mortality can be attributed to weaknesses in prevention (i.e., vector control and Intermittent Preventive Treatment), integrated community case management (iCCM), and data quality.

Malaria continues to be highly endemic in Uganda, where it has the third-highest incidence and eighth-highest mortality rates globally.[29] The entire population is susceptible to malaria, which is the leading cause of morbidity and mortality, especially among small children. Considering this impact, the Global Fund signed a grant of more than $273 million for malaria interventions during Grant Cycle 6. The Government and other partners, including the U.S. President's Malaria Initiative (PMI) and the UK's Foreign, Commonwealth and Development Office (FCDO), also financed malaria interventions in the country in an ambitious effort to attain a malaria-free Uganda.

There have been numerous innovations and successes in the country's malaria response. For example, the country executed a universal mass campaign of Long-lasting insecticidal nets (LLINs) at the height of the COVID-19 pandemic and established 30 active sentinel sites for monitoring resistance to pyrethroid, the active substance used in LLINs. The data from the sentinel sites was used to inform the distribution of the Pyrethroid-piperonyl butoxide (PBO) and new generation nets in districts with resistance to pyrethroid. PBO and new generation nets are effective in killing mosquitoes that have pyrethroid resistance.

Despite these interventions, the impact of the malaria program has been limited, with a negative trend and an increase in cases and deaths in both relative and absolute measures. Between 2021 and 2022, malaria cases and malaria-related mortalities increased by 37% and 28%, respectively.[30]

Despite co-deployment of LLINs and IRS, intervention gaps contributed to high malaria cases

The ambitious Grant Cycle 5 targets of reducing annual malaria mortalities from 29 per 100,000 in 2013 to near zero by 2020 were lowered in Grant Cycle 6 to reduce malaria infection by 50%, morbidity by 50%, and malaria-related mortality by 75% relative to 2019 levels.[31] Specific activities related to vector control (mass and routine distribution of LLINs, as well as IRS) and the treatment component were agreed upon by MoH in consultation with partners to achieve these objectives, but the following challenges contributed to the country's inability to achieve the objectives.

Indoor Residual Spray (IRS): The Government of Uganda, with support from the Global Fund, planned to execute the spraying campaign in thirteen high-burden districts in February 2022. However, due to the NMCD's inadequate planning including the late arrival of the required personal protective equipment for the IRS and the protracted negotiations between the Ministry of Health and partners about the selection of districts, the actual spraying did not begin until November 2022.

The WHO guideline on IRS states that the best practice is to schedule the completion of spray application to coincide with the increase in vector populations just prior to the peak transmission season, but due to the delays, it was executed during and after the peak transmission season. In addition, due to the lack of an evidenced phased exit of

[29] WHO World Malaria Report 2021
[30] DHIS reported incidences on Malaria 2022
[31] 2019 levels: mortality - 9 per 100,000 and total malaria cases - 281 per 1000

ex-DFID districts in 2021 and 2022, and in view of the previously documented rebound under the same circumstances, IRS was conducted in four ex DFID and nine West Nile districts in 2022, however, no further scale-up to the remaining four West Nile districts in 2023.

Gaps in LLIN mass distribution campaigns: Planned to begin in February 2020, the LLIN campaign was delayed by five months due to COVID-19 restrictions, lengthy negotiations to alter the distribution mode, and global supply chain delays. In addition, the Grant Cycle 6 mass campaign was scheduled in February 2023, but began in April 2023 with slow progress covering 17 districts out of the targeted 44 as of June 2023. The delay was mainly due to the inadequate planning and prolonged discussions between the National Malaria Control Division (NMCD), Global Fund and Against Malaria Foundation in finalizing the planning and budgeting process. Monitoring and evaluation systems and tools were expected to track the quantity of LLINs distributed for mass campaigns, but connectivity challenges prevented them from validating the number of delivered LLINs; the Electronic Data Management Information System (EDMIS) developed to capture the household registration and distribution was not utilized for the campaign, and technical malfunctioning of tools used for data collection (mobile phones) also adversely affected the data for effective planning and decision making.

In districts where PBO nets were recommended for distribution during the 2020–2021 mass campaign, a total of 1.3 million standard nets were distributed. In the ongoing 2023 mass campaign, an additional 2.7 million standard nets are intended to be distributed due to budgetary constraints to cover the same population with more expensive PBO nets. This is problematic because distribution of standard nets in regions where insecticide resistance is prevalent reduces the net's effectiveness and limits its use to a physical barrier.

Limited routine distribution of LLIN: The school net program (SNP) targeted to distribute approximately 847,000 nets in 2021 and 2022 under the TASO grant. The achievement was only 28%. The nets were not distributed in 2021 due to the two-year school closure period. Even though schools resumed in February 2022, the insecticide-treated nets were not distributed until September 2022 due to improper planning. Although the nets had been available since August 2021, the districts and schools where the nets would be distributed had not been determined in advance.

Since 2018/2019, the country has not conducted a Malaria Indicator Survey (MIS).[32] Alternative studies have been used to assess net coverage and utilization, although these studies were limited to a few districts. The studies include the LLIN Evaluation in Uganda Project, conducted by the Infections Disease Research Collaboration, which reported an access rate of 56.8% in 12 sampled districts. Also, the net durability study conducted by the Program for Accessible Health Communication and Education found that 58% of people used bed nets the night before the survey in five sampled sub-counties, making Uganda among the best performing countries in the region.[33]

According to the program's mid-term evaluation, the national malaria program's Social and Behavioral Change (SBC) is presently conducted through mass media rather than interpersonal communication, which should be a more effective strategy due to budget constraints. An evaluation conducted by the National Program revealed that 52% of the population was reached with campaign messages. After the 2021 mass campaign, a planned SBC campaign dubbed "go-hung" was not implemented due to a lack of funding. This also limited the coverage of SBC activities.

The rapid assessment report highlighted a persistent increase in malaria cases, this could also be due to sub-optimal coverage.

Non-attainment of intermittent preventive treatment in pregnancy (IPTp) coverage objectives contributes to the rise in malaria infections among pregnant women

[32] MIS collects data on all of the internationally recognized malaria indicators including household ownership of insecticide-treated mosquito nets and their use, especially by children under five years of age and pregnant women.

[33] Zambia - 39.7%, Kenya - 66%, Tanzania 52%

Despite investing US$2 million in IPTp operations, the country did not achieve the IPTp targets outlined in the Global Fund Grant Cycle 6 grant. The program developed a plan to perform research into non-achievement of the IPTp targets. However, the research was affected, along with other research, by the need to reallocate funds to match the increased demand for commodities during the malaria epidemic in 2021/2022.

As of July 2023, 56% (77 of the 137) of districts and none of the 11 cities had received training on the 2019-revised guidelines to increase IPTp dosing from two to four doses. Planned operational research to understand the low uptake of IPTp under the GC6 had not been done as of July 2023. This, in addition to the introduction of testing all expecting mothers for malaria in ANC in 2022, contributed to the rise in malaria infection among expectant women from 17% in January 2020 to 24% by September 2022.

Disruptions in the implementation of integrated Community Case Management (iCCM) affected malaria treatment for Children Under Five

Children account for 40% of Uganda's disease burden despite constituting 17% of the population.[34] According to the Ugandan Community Health Strategy, the objective of iCCM is to increase access to diagnoses and treatment of children under the age of five who have malaria, diarrhea, or respiratory infections. The Global Fund supports the implementation of iCCM in 66 of Uganda's 146 districts, based on criteria predetermined by the program.[35]

In 26 of the 80 remaining districts where other donor funding had ceased, iCCM services were interrupted for one to eight months before being resumed with support from the Global Fund. About 5- to 16-month delays in enrolling sub-recipients to manage the iCCM activities in these districts contributed to disruptions, as well as the stock-out of malaria medicines (ACTs). Lack of continued support in districts previously supported by USAIDS's Malaria Action Program for Districts and FCDO was another factor. This contributed to 15% of children confirmed as malaria positive at community level not receiving treatment services promptly between July and December 2022.

Affected by COVID-19 restrictions, a number of crucial trainings and activities designed to equip health care professionals with the knowledge and skills necessary to treat all malaria cases promptly and effectively were delayed. Only 16% of the budget for case management operations was utilized, with 61% of the intended training for health workers on integrated malaria case management not having been completed. None of the five health facilities visited had integrated malaria management guidelines, although they are available online on the MoH knowledge management portal website. In addition, 40% of clinical audits had not been completed as planned.

Although the country drafted a plan to respond to the malaria outbreak in March 2022, implementation of some key aspects of the plan (such as the formation of task teams, the enhancement of critical human resources for the areas with the outbreak, and the guarantee of continuous availability of medicines and RDTs) was delayed until March 2023.

Limited guidelines and tools to ensure data quality impacting program planning, program performance evaluations

The OIG's review of programmatic data from 15 health facilities revealed an overreporting of confirmed malaria cases of at least 16% across all 15 sampled sites and an over/underreporting of malaria mortalities of an average of 35%. Similarly, the data quality assurance (DQA) administered by the Ministry of Health revealed a 38% over-reporting disparity between DHIS2 and the registers.
There are no DQA implementation guidelines at the national level, as they are still draft. Consequently, the national team conducted only one DQA between 2021 and 2022, covering 12% (18/146) of the country's districts. In addition, the national program's DQA tools had only two out of 11 Global Fund malaria indicators, thereby limiting its coverage

[34] National iCCM Implementation Guidelines, 2020
[35] The selection of the districts is based on (i) a high poverty index and high absolute number of under-five children dying; (ii) bad access to health facilities as measured by the number of public and private facilities relative to the district population; (iii) a high burden of malaria diarrhea or pneumonia, (iv) sub-optimal performance in the MOH District annual health sector league table; and (v) other donor programs that could be leveraged. These parameters were weighted before the final selection

and completeness in assessing data quality. Despite the existence of validation criteria in DHIS2, these are not formally certified by the Ministry of Health and were not applied to reduce data inaccuracies. There are also challenges related to shortage of dedicated staff and the number of required records and reports to be filled.

Inadequate oversight and a lack of data evaluation by the health facility's management prior to publication in DHIS2 were underlying causes of the suboptimal data quality. In 47% (7/15) of the sites visited, test results were not reflected in the registers, indicating incomplete data recording. These inaccuracies in data significantly hinder the effectiveness of malaria intervention targeting.

Agreed Management Action 1:
The Global Fund Secretariat will work with the Principal Recipient, Ministry of Finance, Planning and Economic Development, and Ministry of Health to: a. Optimize and implement tailored vector control interventions to address challenges in deployment of IRS and LLINs including establishing adequate controls and oversight mechanisms to manage operational risks in procurement and financial management of the LLIN campaign. b. Develop a roadmap for improving IPTp coverage and quality. c. Improve implementation of integrated case management of malaria (iCCM) through developing a costed national iCCM operational plan with defined geographical coverage and defined responsibilities to the district level. d. Improve data quality and data validation through the development of necessary guidelines and DQA related tools.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2024

4.2 Improvement needed in sub-recipient and financial management to safeguard grant funds

Financial management of Global Fund supported programs has improved. However, financial and sub-recipients' management processes remain suboptimal hindering effective implementation of grant activities and accountability of grant funds need to be addressed.

The Ministry of Health manages Global Fund grants under MoFPED in accordance with the approved manuals, policies, and guidelines and Global Fund supported programs are integrated into the national systems. For example, the Global Fund grant is incorporated into the country's budget, and the Integrated Financial Management Information System (IFMIS) is used for managing the grant financial processes and reporting. External audits of Global Fund grants are conducted by the Office of the Auditor General (OAG). Despite the progress made to date by MoH, sub-recipient management, financial management, accounting, and reporting need further improvement.

Suboptimal sub-recipient management impacting grant implementation and accounting for advances

The Global Fund's standard terms and conditions require the Principal Recipient to implement a robust mechanism for managing sub-recipients, which includes ongoing monitoring and supervision of grant implementers.

The Malaria Program spent an average of 13 months contracting sub-recipients and district local governments (DLGs), with five-month delays in disbursing funds to them. The delays in awarding of contracts and disbursement of funds translated into delays in the implementation of key grant activities.

According to the Grant Implementation Manual and the Treasury Instructions 2017, sub-recipients must submit their quarterly reports within sixty working days of the end of each quarter. Of the 82 DLGs that received funding in 2022, 79 had not submitted any malaria program accountability reports for a total of US$2.6 million as at June 2023. As of 31 December 2022, five of six sub-recipients under the HIV Program had not submitted their accountability reports one year after funds were advanced. Supervisions to DLGs are not prioritized based on risks or other explicit criteria. A US$1 million advance to a sub-recipient was cleared and reported as entirely retired, without the necessary supporting documents – meaning that the OIG has to rely on documentation held by the sub-recipient in order to verify these expenses. In addition, US$0.3 million of the sampled expenses had no supporting documentation.

Inadequate sub-recipient oversight contributed to reporting and accounting delays for advances. Due to unaccountable advances by the sub-recipients including DLGs, the national disease programs and the MoH have no evidence into the implementation status of the programmatic activities for which funds were allocated.

Gaps in financial management, accounting, and reporting may lead to poor accountability of grant funds

The Public Finance Management Act 2015 and the Public Procurement and Disposal of Public Assets Regulations 2014 mandate the maintenance of complete and accurate financial records, as well as timely financial accounting and reporting. However, the OIG found the following areas which need improvement:

Management of staff advances: According to the MoH's policy, advances to staff should not be processed until older advances are settled, and staff should liquidate advances within 60 days of the activity for which they were granted. Non-compliance with the staff imprests[36] and advance policies resulted in staff under the HIV Program owing US$0.35 million to the program, of which US$.17 million was older than 90 days, as of 31 December 2022. As of June 2023, Malaria Program personnel owed a total of US$0.2 million (>more than 90 days old).[37]

[36] Imprest is a sum of money advanced to a person for a particular purpose

[37] There were 17/94 cases under the Malaria program and 45/438 cases under the HIV program

Payment of distribution cost to NMS with no proof of delivery: A memorandum of understanding (MOU) signed by the national medical store and the MoH in May 2023 and retroactively applied to January 2021 stated that advance payments made for the distribution of commodities to the national medical store would be cleared upon receipt of the commodities. As of December 2021, the national medical store had been paid US$4.2 million without substantiation of delivery. According to the MOU, MoH officials are required to conduct quarterly visits to health facilities to confirm deliveries. The OIG did not obtain evidence of those visits being conducted by MoH officials between 2020-2023.

Direct local procurements conducted by MoH without a competitive bidding process: While direct procurements are permitted under the Public Procurement and Disposal of Public Assets Act of 2003, the Act requires their use when exceptional circumstances prevent the use of competition to achieve efficient and timely procurement. The Department of Health and the Ministry of Planning, Policy, and Economic Development (MoFPED) made five direct Procurements in 2021. The OIG sampled two out of the five direct procurements made in 2021 worth approx. US$1.1 million and found them not to fulfil the circumstances mandating direct procurement.

Gaps in design of controls under LLIN campaign expenditures: MoH and MoFPED had assurance providers in place for the 2020/2021 insecticide-treated nets mass campaign, that included Procurement Financial Management Agent (PFMA) and a Fiduciary Assurance Agent (FAA). However, gaps were noted in the TORs for FAA and PFMA that led to overlapping responsibilities, such as reviewing budgets at the MoH. The design of controls to validate expenditures prior to payment required the PFMA to be at the district level with a mandate to process payments, rather than only at the sub-country level, to ensure the actual implementation of activities during the LLIN campaign. The FAA's role focused mainly on reviewing the PFMA's financial system, financial procedures and procurement policies. As a result, at the district level, there are assurance gaps regarding the actual implementation of activities, with US$18.7 million (74%) of the total LLIN campaign expenditures paid by the PFMA relying solely on documents prepared and provided by MoH officials to justify the payments.

Agreed Management Action 2:
The Global Fund Secretariat will work with the Principal Recipient, Ministry of Finance, Planning and Economic Development, and Ministry of Health to: a. perform an assessment of the financial management and reporting systems / processes to identify the root cause of the shortfalls in the operationalization of the Public Financial Management Act (PFMA). The outcomes of this assessment will guide strengthening assurance mechanisms, reporting, monitoring and oversight for the sub-recipients. b. Operationalize the outcomes of the assessment specific to strengthening assurance mechanisms, reporting, monitoring and oversight for the sub-recipients.
OWNER: Head of Grant Management Division
DUE DATE: Part a: 31 December 2024 Part b. 30 September 2025

4.3 Challenges with the distribution, tracking and visibility of health commodities impacted their timely availability

Sub-optimal visibility and traceability of commodities at peripheral level have hampered facility-level supply planning, leading to stock-outs and expiry of key health commodities. Inadequate distribution cycle inventory management also impacted the timely availability of commodities at health facilities.

The Government of Uganda, with the support of development partners, continues to invest in the supply chain of health commodities. The Government contributed 40% of the total cost to build the new central medical store in Kajjansi which has helped to increase storage capacity for public health products and increased coverage of the e-LMIS at the peripheral level. A 10-Year Road Map for the Health Supply Chain, which outlines the country's transition plan and exit strategy from donor reliance, among others, has been developed. However, budget deficiencies have affected the implementation of this road map.

The Global Fund grant to Uganda is highly commoditized and has significantly invested in the country's medical supply chain. Around 70% of the Grant Cycle 6 grant is allocated to pharmaceuticals and laboratory products. The Global Fund invested a total of US$456 million in health commodities between 2021 and 2023. Despite improvements in the supply chain process since the last OIG audit in 2019, challenges in terms of visibility and traceability of commodities, distribution delays and suboptimal inventory storage management continue to hinder timely availability of health commodities. The audit noted an average of two-month stock-outs of key commodities at the health facilities visited. Between January 2021 and June 2023, expired commodities amounting to US$212,000 and US$2.6 million were found at the joint medical store and the national medical store respectively, the majority of these expiries were related to the change in first-line HIV regimen.

Sub-optimal visibility and traceability of commodities at peripheral level contributed to improper supply planning, stock-outs and expiries at facility level

Despite significant investment, the inventory management e-LMIS system was not functional in eight out of the 15 facilities where it had been implemented. Interoperability challenges, missing indicators, inadequate eLMIS application controls, and limited IT infrastructure contributed to its non-functionality as detailed below:

Interoperability challenges: Multiple systems are in use at the health facility level. Examples include Rx Solution, Clinic Master, EMR, CSSP, and IICS.[38] The numerous systems that handle store management or client dispensing are not always linked to the client management system to help with triangulation of distribution, consumption, and patient data which is essential for data quality assessments.

Additionally, the CSSP (eLMIS) ordering system at the facilities and NMS+, the inventory management system ERP used at the national medical store do not link health facility orders and picked-and-packed goods. The CSSP part of the ERP is also not interoperable with the central level Pharmaceutical Information Portal (PIP) or any MoH e-LMIS. In 2019, the Global Fund invested US$6 million to implement eLMIS (electronic logistics management information system) in health facilities, expanding the use of Intelligent Integrated Computer Systems (IICS) to harmonize e-LMIS nationwide. The implementation was delayed at the peripheral level, where multiple non-interoperable systems still exist, affecting the central level ability to trace commodities at the peripheral level

[38] **Rx Solution** - e-Inventory Tool at Health facility level to manage stock levels; **Clinic Master** - Prescription Tool at Health facility level linked to the Pharmacy; **EMR -** Electronic Medical Record; **CSSP -** Client's Self Service Portal is an electronic tool used for the bi-monthly ordering of health products; **IICS -** Intelligent Integrated computer systems

Missing indicators and inadequate eLMIS application controls: Several indicators were missing from the NMS Operation software (NMS+) system. For instance, NMS's policy of not receiving health products with less than 75% useful life could not be enforced since the manufacturing date of received commodities was not recorded, resulting in the allocation of near expiry goods to health facilities. During the grant period, NMS deliveries were not in line with the health facility (HF) consumption trends for instance, one HF received 18MOS of ABC/3TC Pead, 40% out of which expired at the health facility.

Limited IT infrastructure: Implementation of the eLMIS at the health facility level was also affected by issues with the IT infrastructure, unreliable power supply, and inadequate human resources. Health Centers I & II lacked the computer infrastructure to support their logistics management processes. In Grant Cycle 6, the Global Fund contributed US$2.5 million for the procurement of computers, but nearly one year after delivery, three of 15 sampled health facilities still had these computers in boxes.

Limited access and viewing rights to the CSSP and other relevant warehouse systems impacted the district health teams and the MoH's visibility of stock at various levels of the supply chain. This hampered their ability to guide the national medical store delivery cycle, especially at the facility level. Absence of routine logistics data quality assessment/validation from the central or district/local government area level contributed to the visibility challenges. 20 of the HIV/TB/malaria commodities were monitored on the list of 41 tracer commodities in the DHIS2 105 module and reporting was incomplete (52% in 2022).

Challenges with the distribution cycle management resulting in over stocking, stock-outs and expiries at the peripheral level

The National Medical Store (NMS) and joint medical store manage the country's warehousing and supply by distributing goods from the central level directly to the regional, district, and peripheral level using bi-monthly pre-scheduled plans (i.e., a total of six cycles per year).

NMS did not adhere to the distribution cycles, concluding deliveries for only three out of six cycles in 2022. This contributed to stock-outs across all levels, including at the health facilities. There was an average stock-out of two months for key commodities such as first-line treatments for HIV and malaria, as well as diagnostic tests in 15 health facilities visited. The delayed distribution cycles were mainly due to a four-month disruption in the disbursement of funds by MOFPED caused by country's financial year-end closure processes as well as the discussion regarding the need for appropriate payment clearance supplementary documentation. The national medical store developed catch-up plans to address the outstanding stock orders. However, as of July 2023, these tasks were not completed. Absence of performance management metrics for the national medical store and joint medical store in their respective MOUs with the MOFPED[39] and late payments by MoH, contributed to the performance disparities.

Insufficient inventory storage management practices resulting in gaps in traceability and accountability at the peripheral level

The storage of health commodities at the peripheral level (especially at HC4s) and above remains severely constrained due to the client burden, population growth in the catchment areas, and the rising demand for stocking commodities for public health emergencies.

The inability to adequately store and organize inventory in the stores at the health facilities visited contributed to the challenges in inventory management and controls at the facility level. Stock cards did not match the stock tally on the day of the visit in over 70% (11/15) of the facilities. In 46% (7/15) of the facilities visited, stock cards were not accurately updated, batch-level details were not captured, and health facility stock oversight mechanisms were

[39] Ministry of Finance, Planning and Economic Development

inadequate. Discrepancies were discovered in sampled products in 73% (11/15) of the facilities visited, and stock worth US$64,000 was unaccounted for during the six-month period sampled.

The inaccuracies on the stock cards were attributed to a failure to update the inventory stock cards and stock keeping records in real-time, mathematical errors and, in some instances, a failure to reconcile stock cards with delivery notes on site. The reliance on manual inventory management systems in high-volume sites posed a significant challenge, such that by the time physical counts were performed to reconcile inventory, the facility was unable to investigate and take corrective action reliably. In addition, there were frequent stock redistributions between facilities to compensate for late deliveries or insufficient order fulfilment by the central warehouse. These were however poorly documented, with an absence of supporting records, bypassing the store, or not being recorded at the dispensing points.

Agreed Management Action 3:
The Global Fund Secretariat will work with the Principal Recipient, Ministry of Finance, Planning and Economic Development, and Ministry of Health to: a. address the identified challenges in existing e-LMIS to improve visibility and traceability of health commodities at peripheral levels, by installing safeguards against future interruption of the last-mile distribution plan, support bi-monthly distribution of drugs and avoidance of stockouts. b. Establish risk-based supervision at a central level to review inventory management capacity and practices, which will include increased oversight by the MOFPED and MoH through joint quarterly reconciliation and validation of the GF procured commodities at central and health facility levels.
OWNER: Head of Grant Management Division
DUE DATE: 30 June 2025

4.4 Strong progress on HIV implementation, however challenges in prevention, linkage to care, and ART adherence could limit gains made

The linking and retention of treatment and care needs to be enhanced to sustain the gains in HIV epidemic control. The HIV prevention services were sub-optimal for in-school and out-of-school adolescents and young adults, and there were challenges related to HIV prevention for PMTCT-EID and key populations.

Uganda has made strong progress in combating HIV/AIDS and improving access to prevention, care, and treatment services despite facing significant challenges. Overall, HIV prevalence in 2021 was 5.5%, which is lower than the regional average of 6.2%. There are, however, significant gender disparities, with a prevalence of 7.1% among women compared to 3.8% among men.[40] The country has made significant progress towards achieving the UNAIDS 95-95-95 goals,[41,42] with an achievement rate of 89%-96%-92% in 2021 and 90%-94%-94%[43] in 2022. As of 2022, it was estimated that 1.4 million people were living with HIV. HIV new infections decreased by 38% from 88,000 in 2010 to 54,000 in 2021.[44] AIDS-related deaths also decreased by 66% from 51,000 in 2010 to 17,000 in 2021.[45]

Despite the progress made in the fight against HIV, the country is not achieving the set targets and, in some instances, sub-optimal performance of some key indicators. Although there was a significant decline in new HIV infections (by 39%) over the past decade in Uganda, this falls short of the national goal to reduce new infections by 65%. The number of HIV cases (morbidity) grew from 1.1 million to 1.4 million between 2010 and 2020. Challenges in HIV prevention, linkage to care, and ART adherence contributed to these outcomes and could impact the gains made.

Improvement is needed in linkage to care and retention of antiretroviral treatment

The national test and treat strategy mandates all HIV-positive individuals be promptly linked to and initiated on treatment, with the goal of ensuring that 95% of those with known HIV status receive treatment, remain in care, and achieve viral suppression.[46] However, from July to December 2022, approximately 15% of 66,442 newly diagnosed HIV clients (10,431) were not linked to treatment.[47] In the same period, approximately 34,790 patients were classified as lost-to-follow-up (LTFU), representing approximately 2.5% of people living with HIV (PLHIV) receiving treatment.[13] The contributing factors of the linkage to care and LTFU challenges include:

- *Improper record keeping and follow up*: higher number of patients on antiretroviral treatment in the periodic reporting forms than recorded in the antiretroviral treatment registers. According to the National QI initiative baseline data, 33% of missed appointments did not have documented follow-up actions.
- *Limited to moderate community involvement:* namely in tracing LTFU cases, as well as not adequately leveraging social networks to retain clients in care.
- *Inconsistent application of guidelines*: inconsistent application of the loss to follow-up guidelines in 27% (4/15) of the health facilities visited.[48]
- *Absence of a nationally unique identification system* and a central patient-level data repository for HIV care and treatment fundamentally impedes effective longitudinal management of long-term care for HIV patients.

[40] Uganda Population-Based HIV Impact Assessment UPHIA 2020-2021. Available at: https://phia.icap.columbia.edu/uganda-summary-sheet-2020-2021/
[41] This seeks to ensure that 95% of people living with HIV (PLHIV) are aware of their status, 95% of those diagnosed are receiving treatment, and 95% of those treated achieve viral suppression by 2030
[42] UNAIDS 2025 Targets. Available at: https://www.unaids.org/sites/default/files/2025-AIDS-Targets_en.pdf
[43] UNAIDS 2022: AIDSInfo Global data on HIV epidemiology and response. Available at: https://aidsinfo.unaids.org/
[44] Uganda AIDS Commission 2022. Annual Joint AIDS Review Report FY 2021/22. Pg 12. Available at: https://uac.go.ug/index.php?option=com_content&view=article&id=55:hiv-prevention-29&catid=8&Itemid=101
[45] Uganda AIDS Commission 2022. Annual Joint AIDS Review Report FY 2021/22. Pg 14. Available at: https://uac.go.ug/index.php?option=com_content&view=article&id=55:hiv-prevention-29&catid=8&Itemid=101
[46] Ministry of Health, 2020. Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Uganda.
[47] MoFPED December 2022 PUDRs
[48] The facilities applied the three months benchmark while the new guidelines prescribe follow up for patients lost for 28 days

While the program conducts clinical audits and the Continuity on Treatment Quality Improvement Collaborative Concept (COTQI-CC) exercises, the results indicate a low success rate in returning patients to HIV care, particularly among children, adolescents, and PLHIV. The decline in treatment linkage, as well as high rates of loss to follow-up, contributed to the decrease in the second 95 of the 95-95-95 cascade from 96% in 2021 to 94% in 2022. UNAIDS reported that the incidence-to-mortality ratio for Uganda was 1.9, against an epidemic control target ratio of 1 or less.[49]

Sub-optimal HIV preventive interventions for key and vulnerable populations threaten the gains made in the fight against HIV

Despite the high HIV prevalence[50] among key and vulnerable populations, the following groups have low coverage of services.

In-school and out-of-school AGYW program

Uganda's HIV epidemic is significantly impacted by adolescent girls and young women (AGYW). Some 37% of new HIV infections occur between 15 and 24 years old, with AGYW accounting for 75% of these cases.[51] Prevention services for AGYW in schools were delayed by 12 months due to the COVID-19 pandemic. A significant proportion of AGYW do not receive HIV testing services due to the lack of HIV test kits and the challenges with the eligibility criteria for HIV testing for younger AGYW.[52] The national target for AGYW programming in Uganda is targeting 73 districts of Uganda's 140 districts, 20 districts are targeted by Global Fund grants and 24 districts by PEPFAR Dreams. This leaves 29 of Uganda's targeted districts are uncovered due to insufficient funding by donors and government.

Documentation of in-school AGYW events/activities in all the schools visited needs improvement. Inadequate program monitoring and evaluation by Ministry of Education and Sports (MOES) and insufficient supervision and monitoring of in-school AGYW initiatives by the Ministry of Health is a contributing factor. Target set for AGYW prevention interventions is low (200,000 AGYW targeted out of potential risk group of 1,400,000). Consequently, the country is not on track to achieve grant objective of reducing the number of youth and adult HIV infections by 65% by 2025.

Gaps in PMTCT and EID program hinder achievement of grant objectives

By the end of 2022, about 76% of estimated number of exposed infants had received a virologic test within two months, falling short of the target of 95%[13] Some of the causes for the low EID coverage include:

- *Non-adherence to PMTCT guidelines* and inadequate documentation. There is no proper tracking of testing for EID clients, especially at critical intervals. The monitoring of time stamps at two months, nine months, and 14 months is not consistently adhered to, and when it is, there is inadequate documentation in the EID register and tracking tools.
- *Inadequate retesting of pregnant women during labor and delivery*: the retesting rates are low at the Expanded Immunization Clinic (28%), antenatal clinic/Labor and Delivery combined (67%), and antenatal clinic/labor and delivery/postnatal clinic combined (69%). Retesting pregnant women throughout the pregnancy cascade could help identify HIV-positive mothers early and prevent transmission to their babies.
- *Inadequate provision of Nevirapine prophylaxis to babies born to HIV positive women:* The audit noted inconsistent provision of Nevirapine prophylaxis for babies born to HIV-positive pregnant women in 47% (7/15) of health facilities visited. There was an average of 2.4 months stock-out of Nevirapine in 7/15 facilities visited.

[49] UNAIDS. UNAIDS Info Epidemic Transition Metrics. Available at: https://aidsinfo.unaids.org/. Incidence to Mortality ratio is UNAID's measure of progress toward epidemic control. This ratio tells you how many new cases of a disease are occurring compared to how many people are dying from it.
A high ratio might suggest that many people are getting the disease but not many are dying from it, while a low ratio could suggest that a large proportion of those who get the disease are dying from it. Generally, the recommendation is to have a ratio of 1 or less.
[50] E.g., 31% among sex workers, 17% among PWID, and 13% for MSM
[51] UNAIDS 2025 Targets. Available at: https://www.unaids.org/sites/default/files/2025-AIDS-Targets_en.pdf
[52] Between Jan 2021 to Dec 2022, 18,594 AGYW (20.2% of high-risk AGYW) were tested among the total reached

- *Inconsistent and incorrect documentation* of pregnant women receiving ART in the registers, erroneous aggregation of summary reports in all 15 health facilities visited.

Consequently, about 5,955 new child infections occurred due to gaps in vertical transmission prevention. Although there has been a decrease in new infections through mother-to-child transmission over the past decade, the country is not on track to achieve the grant objective of reducing pediatric HIV infections by 95% by 2025 or ensuring 90% of HIV-exposed infants receive a Viral Load test within two months of birth.

Agreed Management Action 4:
The Global Fund Secretariat will work with the Principal Recipient, Ministry of Finance, Planning and Economic Development, and Ministry of Health to: a. Establish a mechanism to routinely assess the referrals and linkages to treatment for HIV testing and counselling (HTS) among AGYW. b. Improve HIV testing and counseling for AGYW through optimization plan.
OWNER: Head of Grant Management Division
DUE DATE: 31 January 2025

Annex A: Audit Rating Classification and Methodology

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**.**

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing 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 safeguard the independence of the OIG's auditors and the integrity of its work.

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 is used to provide specific assessments of these different areas. 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 B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are effectively assessed and mitigated.

Assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregate level in the eight key risk areas that fall within the audit's scope. In addition, a narrative explanation is provided every time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where there is no set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.