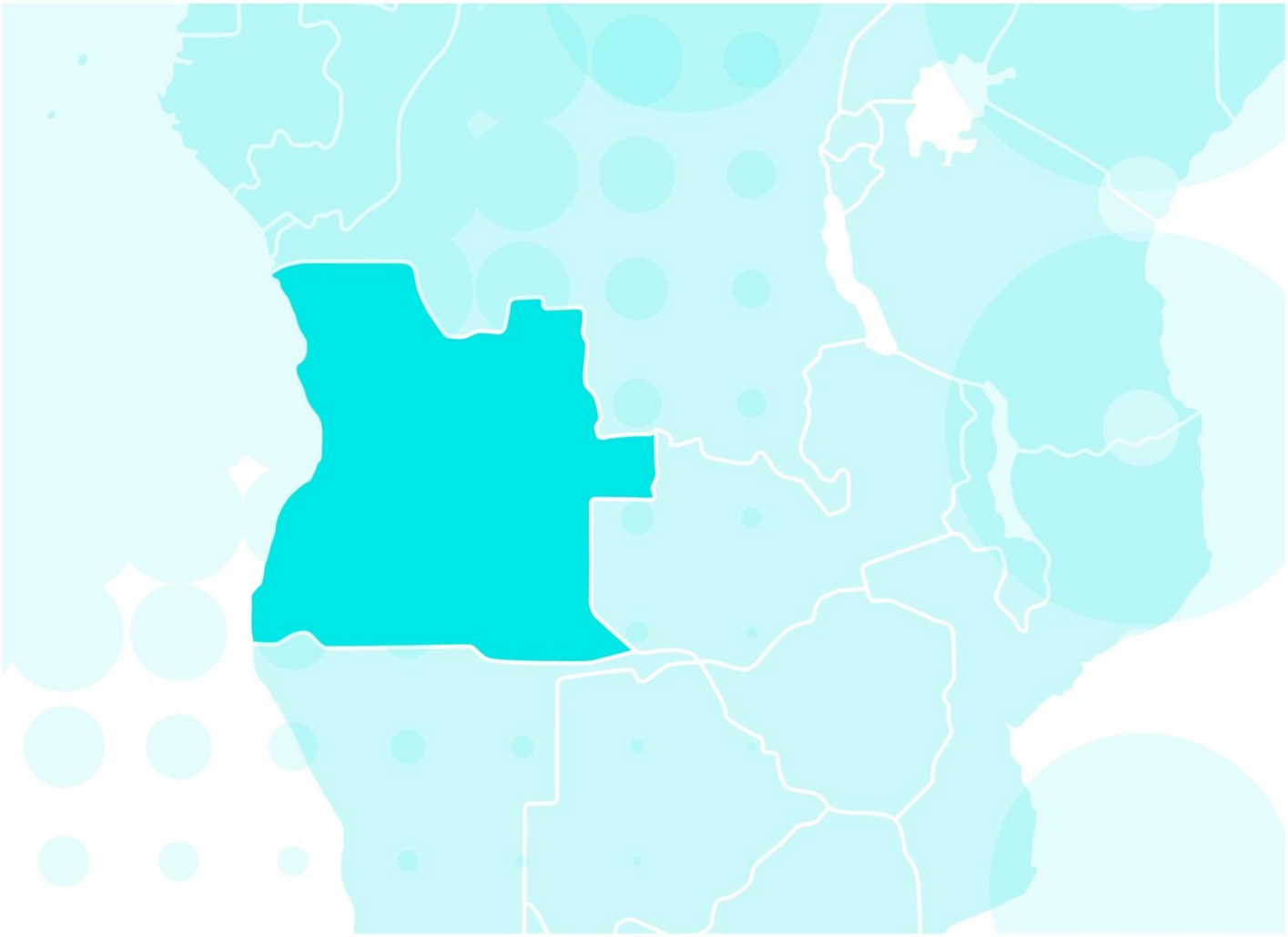

Audit Report

Global Fund Grants to the

Republic of Angola

GF-OIG-24-006
9 April 2024
Geneva, Switzerland

THE GLOBAL FUND
Office of the Inspector General

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The Office of the Inspector General (OIG) safeguards the assets, investments, reputation and sustainability of the Global Fund by ensuring that it takes the right action to end the epidemics of AIDS, tuberculosis and malaria. Through audits, investigations and advisory work, it promotes good practice, enhances risk management and reports fully and transparently on abuse.

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.

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1. Executive Summary

1.1 Opinion

The last audit of Angola, conducted by the Office of the Inspector General (OIG) in 2019,[1] highlighted a significant number of material issues relating to the implementation of Global Fund grants. These included the limited impact of the grants, weak country ownership, failure to meet co-financing commitments and unreliable programmatic data. The Global Fund Secretariat implemented a number of measures to respond to these challenges. In January 2020, Angola was placed under the Additional Safeguard Policy (ASP), with the United Nations Development Programme (UNDP) as the sole Principal Recipient for Grant Cycle 6 (GC6). Implementation was moved to an innovative sub-national approach, focusing Global Fund resources at the sub-national level in two targeted provinces. This was a timely and considered response following the outcome of the prior OIG audit. While improvements to processes to monitor and report co-financing commitments and sub-recipient data verification were noted since the last audit, issues persist in a number of the previously identified areas.

There are significant weaknesses in key procurement and supply chain management (PSM) processes. This has been driven by weak national PSM systems and poor inventory management at the service delivery point. In addition, there has been low absorption (13%) of key RSSH funding to strengthen national PSM and limited UNDP PSM capacity. The low absorption and limited capacity have resulted in material stock-outs of key commodities for all three diseases at the majority of sites visited by the OIG. These stock-outs negatively impact service delivery and resulted in government-funded commodities being directed to Global Fund-supported provinces to maintain services and mitigate the impact on program implementation. Overall, procurement and supply chain processes and systems are rated as **ineffective**.

The sub-national approach was new, innovative and underpinned by robust principles. It was fully launched in GC6 and is still in its first implementation cycle which is not yet complete. In addition, it was launched during the COVID-19 pandemic. Execution has proved challenging. Limited initial collaboration and alignment between key national and sub-national stakeholders affected procurement planning.[2] There was no clear articulation of the role of the Ministry of Health of the Republic of Angola (MINSA) in this sub-national approach to ensure uninterrupted services in the two provinces. Significant programmatic data inaccuracies of +/- 30% were noted at health facilities visited by the OIG, as well as material inaccuracies in community data from World Vision (WVI). This was linked to a lack of national strategic ownership over health information systems, low absorption of RSSH funding and no data validation processes at lower levels. There is also low achievement of malaria commitments in GC6, contributing to substantial increases in malaria cases. Due to the issues in data, which can negatively impact the ability of stakeholders to monitor and oversee grant performance, grant monitoring and oversight is rated as **ineffective**.

There have been positive trends in key estimates for HIV testing and ART coverage at the national level. However, Angola continues to have one of the highest rates of mother-to-child transmission (MTCT) of HIV at 16% and lowest Early Infant Diagnosis (EID) rates at 3% in the East and Southern Africa region. It is also among the top 30 high-burden countries for TB and drug-resistant TB. For TB treatment there were high rates of patient lost to follow up (LTFU) and no documented treatment outcomes at sites visited by the OIG. This has significant negative implications for the TB

[1] www.theglobalfund.org/media/9383/oig_gf-oig-20-003_report_en.pdf Audit fieldwork completed in 2019 and published in March 2020
[2] There were improvements noted in communication and collaboration during the grant period.

response, with a lack of clarity on treatment success. In addition, very high LTFU was also noted for HIV patients on treatment, which impedes progress on reducing mortality and transmission of HIV. Thus, the implementation of key programmatic activities are rated as **needs significant improvement**.

1.2 Key Achievements and Good Practices

Significant improvements in the approach to track and report on co-financing commitments

The Government of Angola has strengthened its policies, processes and tools to track and report on co-financing commitments. There are detailed standard operating procedures, as well as a co-financing technical working group and supervision committee, to support tracking and reporting. Annual reports on commitments have been shared with the Global Fund. The country has also made good progress on the achievement of TB commodity commitments for first- and second-line TB medicine commitments. In addition, the national HIV program (INLS) has continued to leverage the UNDP procurement framework to support domestic procurement of ARVs.

Good data validation process at sub-recipient (ADPP)

Ajuda de Desenvolvimento de Povo para o Povo (ADPP) – a community project-based non-government organization in Angola – is a sub-recipient supporting HIV- and TB-related community implementation. The OIG noted it has good processes to ensure data quality for community-level data, including monthly data validation exercises with stakeholders at the sub-recipient, municipal and community level. In addition, there were no material data accuracy[3] variances noted from the sample reviewed by the OIG.

1.3 Key Issues and Risks

Execution challenges in the subnational approach impacted the Global Fund grant

Initially, there was limited collaboration and alignment between the provincial governments (GPS), UNDP, and MINSA, which affected procurement planning. There was also no documented clear articulation of MINSA's role in the Global Fund's sub-national approach to ensure uninterrupted services in the two provinces. Provincial government representatives are not members of key grant oversight bodies. There were also no impact baselines in place before the start of GC6. This was linked to a lack of quality provincial level data. Suboptimal data can limit the ability of the OIG and other stakeholders to fully assess the impact of the approach and it limits the identification and mitigation of programmatic issues that would be observed if correct data was being reported.

Challenges with procurement and supply chain processes, systems and data that led to material stock-out of key commodities across the three diseases

Quantification and forecasting (Q&F) exercises were delayed during the grant period. There were also issues with accuracy relating to morbidity data and inaccurate and incomplete consumption and stock-level data from national entities. This resulted in inaccurate Q&F that was not routinely updated to inform optimal stock needs. Further, lengthy UNDP procurement processes (up to 106 days post funds being available for ACTs) impacted timely delivery of commodities to the country. As a result, there were material stock-outs, at 40-50% of sites visited by the OIG, during the GC6 period. This impacts programmatic implementation and required

[3] Sample size was 24% of the results reported for the period 1 July 2022 to 31 December 2022 indicator YP-1b (Percentage of young people aged 10–24 years reached by comprehensive sexuality education and/or life skills–based HIV education out of school)

MINSA and the other provincial governments to supply key commodities for all three diseases to the Global Fund-supported provinces, directing products away from other sites.

Substantial inaccuracies noted for routine programmatic data that can hamper reliable measurement of grant performance

There were significant programmatic data inaccuracies across key coverage indicators for the three diseases, as well as variances of over -/+ 30%, at the majority of sites visited by the OIG. This is due to low prioritization and ownership by the Government of Angola over health information systems. There were also weaknesses in recording and reporting data at the health facility level, the absence of systems to report aggregate and patient-level data and low absorption of RSSH funding. Community-level data is also weak, with significant data validation challenges noted for the World Vision International program. This is a recurring issue from the 2019 OIG audit.

Risk of non-fulfillment of government commitments impacting national malaria response

The Global Fund and the Ministry of Health agreed on specific government commodity commitments for GC6 including Long-Lasting Insecticidal Nets (LLINs) and anti-malarial drugs (ACTs). At the time of the audit, Angola had only met an estimated 10% of the initial planned LLINs and 33% of the planned ACT commitments. This is linked to weak government ownership, ineffective oversight for acting on co-financing risks, large macro-economic challenges facing the country, compounded by the COVID-19 pandemic, and delayed domestic procurement processes of LLINs. The challenge in meeting co-financing commitments was also an issue in the 2019 OIG audit.

High mother-to-child transmission, low early infant diagnosis and high LTFU in prevention and retention in care interventions for HIV and TB programs are eroding the gains made

Angola has one of the highest rates of mother-to-child transmission (MTCT) of HIV at 16% and lowest Early Infant Diagnosis (EID) rates at 3% in the East and Southern Africa region. A lack of national operational guidelines, stock-outs of key diagnostic commodities and limited guidance and supervision at service delivery point have contributed to this. Angola is also one of 30 high-burden countries for TB and drug-resistant TB. High rates of patient lost to follow up (LTFU) (13% of sample) and no documented treatment outcomes (30% of sample) were observed by the OIG. This is linked to data quality issues in recording the outcomes in patient registers and files, as well as the lack of operational guidelines, training and supervision at the health facility level. Very high LTFU, 78% in one of the Global Fund-supported provinces, was also noted for HIV patients on treatment. This was linked to a lack of national operational guidelines for LTFU implementation and a national HIV case management system to support LTFU tracking.

1.4 Objectives, Ratings and Scope

Objectives	Rating	Scope
Procurement and supply chain processes and systems to ensure timely availability and accountability of commodities at all levels.	**Ineffective**	**Audit period** July 2021 to December 2023 **Grant and implementers** The audit covered the Principal Recipient and sub-recipients of Global Fund grants. **Scope limitation** United Nations System organizations have generally adopted internal rules known as the “single audit principle”, whereby they are subject to their internal oversight mechanisms at the exclusion of any other. Nevertheless, the Global Fund has access for audit and investigation purposes to Sub-recipients of these entities who are not themselves part of the UN-System. Accordingly, while the OIG cannot provide assurance on activities and transactions directly implemented by these agencies, it can provide some assurance on the activities implemented through these Sub-recipients and contractors.
Grant monitoring and oversight to support the achievement of grant objectives.	**Ineffective**	
The implementation of key TB, HIV, and malaria interventions to ensure access to key services by beneficiaries.	**Needs Significant Improvement**	

2. Background and Context

2.1 Country Context

Angola is a lower-middle income country,[4] classified as a 'core' country under the Global Fund differentiation framework. It has been under the Additional Safeguard Policy (ASP) since January 2020, due to the 2019 OIG audit findings and stalled progress in the fight against the three diseases.

Angola is administratively divided into 18 provinces and 164 municipalities. The National Health System operates under the supervision and guidance of the Ministry of Health and is implemented by provincial governments (through provincial health directorates or the *Gabinete Provincial da Saúde, GPS*) and municipal administrations.

Out-of-pocket spending for health remains high (37.1%),[5] while national contributions to health have slightly increased.[6] Angola has insufficient human resources across its health sector with 2.1 health workers per 1,000 in 2020 (compared to the WHO target of 2.5 per 1,000 population).[7]

Country data[8]	
Population (2022)	35.5 million
GDP per capita (2022)	US$2,998
Corruption Perception Index (2022)	116 of 180
UNDP Human Development Index (2021)	148 of 191
Government spending on health % of GDP (2020)	2.9%

2.2 COVID-19 Situation

Since the outbreak of the COVID-19 pandemic, Angola took stringent containment measures, including lockdowns and curfews, to slow the spread of the virus. Overall, this led to disruption in the continuity of services and access to health facilities. Cumulatively, from the start of the pandemic until 29 November 2023, the case fatality rate has been 1.83%.

COVID-19 statistics[9]	
Confirmed cases	106,001
Deaths	1,936
Recovered	103,419

[4] World Bank Classification
[5] Out-of-pocket expenditure (% of current health expenditure)
[6] Health expenditure (as % of GDP) - Angola - from 2.6% in 2015 to 2.9% in 2020
[7] WHO Health Workforce - Angola
[8] Sources: population, GDP, Health expenditure from World Bank Database; Corruption Perception Index by Transparency International; Human Development Index by UNDP; all accessed on 29 November 2023
[9] Worldometers – Covid info - Angola (accessed on 29 November 2023)

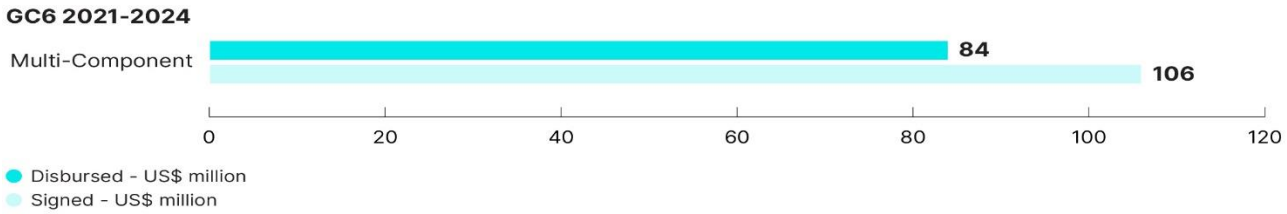
2.3 Global Fund Grants in Angola

Since 2004, the Global Fund has signed over US$406.8 million and disbursed over US$390.4 million to Angola (as of November 2023).[10] There is an active grant totalling US$105.6 million, of which 80%, as of November 2023, was disbursed for the 2021 to 2024 funding allocation period.[11]

For GC6, funding was consolidated into one grant with the **United Nations Development Programme** (UNDP) as the Principal Recipient (PR). UNDP was selected by the Global Fund Secretariat as permitted under ASP. In GC6, a sub-national approach was implemented. Funding was concentrated in two provinces (Benguela and Cuanza Sul).[12] UNDP is the sole Principal Recipient of a single grant covering HIV, TB, malaria, RSSH and C19RM. The total amount is US$105 million. There are five sub-recipients under UNDP, including the Ministry of Health of the Republic of Angola (MINSA), World Vision International (WVI), *Ajuda de Desenvolvimento de Povo para o Povo* (ADPP), and the Benguela & Cuanza Sul Provincial Governments.[13]

In GC6, 63% of the grant is budgeted for procuring medicines, health products and equipment. The World Food Programme (WFP) is the Principal Recipient's third-party service provider for warehousing and last-mile distribution of medicines and health products related to the Global Fund grant.

Figure 2: Funding allocation, current funding cycles (as of November 2023)[14]



[10] The Global Fund's Data Explorer, Angola Overview, accessed on 29 November 2023
[11] Grant Operating System (GOS), accessed on 29 November 2023
[12] Compared to 18 provinces in GC5
[13] The sub-recipients are managing 19% of the grant, World Vision manages 7%, ADPP 5%, MINSA 5% and 1% for each of the Provincial Governments.
[14] Figures from Grant Operating System (GOS), accessed on November 2023

2.4 The Three Diseases

HIV / AIDS (2022)

HIV prevalence in Angola is 0.95% (20th of 124 Global Fund eligible countries) with **an estimated 310,000 people living with HIV** as of 2022. 58% know their status. 46% are on treatment. No data available on viral suppression.

Annual new infections decreased by 46% from 28,000 in 2012 to 15,000 in 2022.

AIDS-related deaths decreased by 24% from 17,000 in 2012 to 13,000 in 2022.

Source: *UNAIDS – Angola fact sheet (Accessed on 30 November 2023)*

TUBERCULOSIS (2022)

TB disease burden in Angola is 1.28% (12th of 115 Global Fund eligible countries). **Of the 119,000** estimated TB cases, 56% are notified.

TB incidence has declined by 12% since 2012, from 380 to 333 per 100,000 people in 2022, but in absolute numbers has increased (96,000 in 2012 vs 119,000 in 2022).

Mortality rate has decreased by 37% since 2012, from 98 to 62 per 100,000 in 2022.

Source: Angola TB country profile 2022; WHO Global TB report 2023 – database (accessed on 30 November 2023)

MALARIA (2022)

5th and 6th highest malaria incidence and mortality globally in 2022. WHO estimated **8.4m malaria cases** in 2022 (vs 3.9 m in 2012).

Estimated **malaria-related deaths increased by 72%,** from 11,170 in 2012 to 19,203 in 2022.

Intermittent preventive treatment in pregnancy started in 2021 but access is low with limited completion of 3rd dose.

Source: World malaria Report 2023, accessed on 30 November 2023

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Global Fund grants in Angola have a relatively good programmatic performance and moderate financial performance against targets, as shown below.

GC6 Allocation (2021-2024)				Grant Rating		
Grant Name	Component Name	PR Name	Total Budget US$	S2 2021	S1 2022	S2 2022
AGO-Z-UNDPP02	Multi	United Nations Development Programme	105,579,589	C5	C1	C4

A new performance rating scale has been defined for all Global Fund portfolios since January 2022 – The Global Fund operational policy manual – performance rating methodology

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels in key categories covered in the audit objectives with the residual risk based on the OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanation of differences are detailed in Annex B.

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit findings
Procurement and supply chain management	In-country supply chain	**High**	**Very High**	4.2
	Procurement	**High**	**Very High**	
Programmatic and Monitoring and evaluation	HIV: program quality	**High**	**High**	4.1 4.3 4.5
	TB: program quality	**High**	**High**	
	Malaria: program quality	**High**	**High**	
	Monitoring and Evaluation	**Very High**	**Very High**	
Health Financing		**High**	**High**	4.4

4. Findings

4.1 Robust principles underpin the innovative sub-national approach, but execution issues negatively impact grant

The sub-national approach was based on robust principles to increase the impact of the Global Fund grant. Sub-optimal execution, including gaps in coordination and collaboration as well as oversight, have resulted in persistent issues in key risk areas for the portfolio.

The Global Fund has invested US$390m[15] in Angola since 2004. Until 2020, Global Fund investments were implemented by national level entities, along with World Vision and UNDP, and covered all provinces in the country. However, due to the stalled progress in the fight against the three diseases, and following the 2019 OIG Audit findings, the Global Fund moved the portfolio under the Additional Safeguards Policy (ASP) and established a sub-national approach for Global Fund investments. The sub-national approach was launched in GC6. This changed the implementation of the portfolio in a number of ways:

- Global Fund investments were focused in two provinces.[16]
- The Global Fund grant was reoriented to supply all HIV, TB and malaria commodities in the two provinces.[17]
- Sub-national Provincial Government authorities would be included in implementation arrangements as sub-recipients along with MINSA.

This new approach to dealing with the material issues identified in the prior OIG audit was innovative because it was the first time that an entire Global Fund country allocation was implemented at the sub-national level. Broad Secretariat consultation, as well as TRP consultation, informed the approach. It was a timely and considered response following the findings of the prior OIG audit.

The approach was fully launched during the COVID-19 pandemic. This impacted Global Fund Secretariat oversight, as they could not conduct in-country visits for a significant period, as well as limiting their ability to meet and engage with provincial-level stakeholders. In addition, in-country implementers had to engage remotely which negatively impacted their ability to build robust relationships with provincial level stakeholders. This was due to travel into and within Angola being limited.

By concentrating Global Fund investments this aimed to bolster the impact of the grant and also mitigate the risk of the Government of Angola not meeting all co-financing commodity commitments. This approach was set to ensure the Global Fund would cover all commodities in the two Global Fund-supported provinces, thereby not impacting the beneficiaries in these regions if the government could not supply agreed commodities.

In addition, the new measures aimed to increase the involvement of sub-national actors as key implementers with the provincial governors (*Gabinete Provincial da Saúde, GPS*) included as sub-recipients. There was also a concerted effort to continually enhance the sub-national approach with the completion of a mid-term evaluation in 2022. This evaluation found issues around the PSM model being used and Principal Recipient capacity constraints impacting implementation.

[15] Total disbursement to Angola. Source: https://data.theglobalfund.org/location/AGO/disbursements/treemap (last accessed Dec 2023)
[16] Under the previous approach, Global Fund support was spread across all 18 provinces of Angola
[17] Provinces were selected by the Global Fund Secretariat based on factors including, disease burden, partner funding landscape, operational considerations and a costing exercise to ensure full coverage of services and commodities

It is important to note that the approach is still in its first implementation cycle, which is not yet complete. Thus, there is a need to reflect on lessons learned in this initial phase to enhance the approach going forward.

Execution challenges in the sub-national strategy negatively impacted grant activities

The sub-national approach requires strong coordination, collaboration and alignment between the provincial governments (GPS), UNDP, and National Ministry of Health (MINSA). However, there were gaps in the engagement between these stakeholders at the start of the grant. There was no coordinated procurement planning across the key stakeholders to support to the sub-national approach and no documented agreement between the stakeholders in advance of UNDP taking over commodity needs in the two provinces. There was also a lack of official sub-national representation in the Country Coordinating Mechanism (CCM) which is necessary for ensuring issues in implementation at the provincial level could be escalated and addressed at senior governance levels. This is linked to CCM member elections not being held since 2018.

There has been low absorption of key Resilient and Sustainable Systems for Health (RSSH) grant activities at the sub-national level. Key RSSH activities such as technical assistance to complete DHIS 2 roll out, design data validation mechanisms and conduct data quality audits at the sub-national level were not implemented.

These above issues are linked to a range of factors:

- The sub-national approach was a new initiative with limited guidance or prior lessons learnt to support and guide implementation.
- There was a need to better articulate the role of national actors in the sub-national approach. The role of MINSA needed to be more clearly defined, specifically in the sub-recipient agreements to ensure full alignment and collaboration. This is critical as even at the sub-national level, national actors play a key role in setting the strategic direction and technical guidance to support implementation.
- There were gaps in UNDP implementer capacity relating to PSM (see Finding 4.2), limiting the ability of the Principal Recipient to fully support the sub-national approach as designed. This is in terms of the total capacity[18] and headcount available, as well as technical capability of the UNDP Program Management Unit (PMU) supporting the Global Fund grant.
- Weak health systems at the provincial level affected how the approach was executed. The two provinces require a more tailored approach, highlighting the need to use available RSSH funds.

As a result,of the challenges above, there was limited progress in mitigating the key risks identified in the 2019 OIG audit, and new risks emerged: There are (1) procurement and supply chain (PSM) challenges with material stock-outs of key commodities for three diseases and weak PSM systems and data noted (see finding 4.2). This has meant the grant has not met its objective of fully supporting HIV, TB and malaria commodities in the two provinces. (2) Data quality for both health facility and community levels remains a key risk to be addressed (see Finding 4.3)

Gaps in sub-national M&E framework result in inability to fully assess impact of approach

There is limited data at the provincial level to support a full assessment of the impact of Global Fund investments. As such, no impact indicator baselines were in place to help measure what was achieved during the GC6[19] period. In addition, there was a lack of available studies and surveys at the provincial level, relating to key population activities. This resulted in the need to leverage proxy data from other provinces to inform Global Fund coverage indicator targets for GC6, thereby

[18] This was due to prolonged vacancies in PSM technical positions
[19] Work has been conducted to support the development of some impact baselines for GC7, mainly for HIV incidences

limiting the ability of the OIG and other stakeholders to fully assess the impact of the approach. This negatively affects the ability to identify and mitigation issues in implementation and thus strengthen programmatic performance.

After the OIG Audit fieldwork, as a part of the ongoing grant making process for GC7, the gaps in the sub-national M&E framework have been sufficiently addressed. The UNDP has progressed on finalizing terms of reference for new studies and surveys at provincial level relating to key population activities during GC6. Funding has also been budgeted under GC7 to further support these new studies and surveys. In addition, efforts have been made by the Secretariat to include more sub-national impact indicator baselines for the GC7 performance framework.

As such, there is agreement that there is no need for a specific Agreed Management Action for this sub-finding. The success of these actions will be assessed by the OIG in subsequent audits of the Angola portfolio. The other sub-findings will be addressed by Agreed Management Action 1 (see below):

Agreed Management Action 1

The Global Fund Secretariat, in cooperation with relevant country partners, will:

A. Perform an end-term assessment of the targeted subnational approach as an investment modality and the GC6 implementation in Angola to establish lessons learns for the 2023-2025 funding cycle (GC7) and recommendations for future investment modalities for Angola. This would also include recommendations for CCM governance and oversight in the sub-national approach.

B. Establish a Memorandum of Understanding (MoU) which clearly defines the roles and responsibilities between the PR and Government SRs (Ministry of Health and three Provincial Health Directorates), and

C. Develop a commodity transition plan for Bie Province to support overall implementation readiness prior to GC7 rollout.

OWNER: Head of Grant Management Division

DUE DATE: For Part A - 30 June 2025, for Part B - 30 September 2024, for Part C – 31 December 2024

4.2 Material stock-outs of key commodities for three diseases due to weak PSM processes, systems and data

Effectiveness of quantification and forecasting processes has been impacted by limited capacity of the overall national health system, poor PSM data quality and implementer challenges. These have contributed to material stock-outs of key commodities impacting services, despite only implementing activities in two provinces.

Robust procurement and supply chain management (PSM) is critical to support the implementation of the Global Fund grant in Angola. Under the sub-national approach, the Global Fund is supporting all of the HIV, TB and malaria commodity needs for the two provinces in GC6, with 63% of the GC6 grant budget relating to health and non-health products and PSM costs.

There were efforts by UNDP to initiate procurements before the start of GC6 to support the 2022 LLIN mass campaign. However, significant weaknesses were found in quantification and forecasting, as well as with the procurement. This resulted in material stock-outs of key commodities at service delivery point.

Unreliable, delayed quantification and forecasting activities, coupled with lengthy procurement processes, led to stock-outs of key commodities in Global Fund-supported provinces

There have been delays in the quality of updates to forecast the stock needs for the two provinces supported by the Global Fund. There has been a large gap in updating the forecast between November 2020 and October 2023. Work to update the GC6 forecast only started in July 2022 and was finalized and approved in October 2023. There are general data issues with the information used to inform quantification and forecasting. There is a lack of timely, accurate and complete consumption data and stock level data from national entities. There are also issues in the quality of morbidity data available to inform forecasting assumptions, which can lead to less accurate forecasting. This is linked to the programmatic data quality issues identified in finding 4.3.

Global Fund commodities are procured through UNDP, which leverages its global procurement frameworks. While funds were disbursed to the country before the start of GC6, it took 106 days for UNDP to complete the procurement process for ACTs and 56 days for first-line anti-retroviral medicines (ARVs) post receiving of funds.[20][21] This extended the timeline to receive commodities.

These above challenges have been caused by the following issues:

- *Weak inventory management at service delivery point:* There is weak inventory management at service delivery point level. This impacts the availability and accuracy of consumption and stock level data to inform replenishment decisions. There are no electronic systems at health facility level[22] to support the gathering and reporting of consumption and stock level information to higher levels. This is caused by the lack of a government-approved national eLMIS system. In addition, consumption data and stock levels were not being routinely recorded even with manual tools for key HIV and TB data at the majority of sites visited.[23] Likewise, at all sites visited by the OIG, there was no evidence of standard operating procedures (SOPs) for inventory management and recording of consumption data resulting in the lack of quality and reliable data to inform key PSM decisions. Funding exists in the Global Fund grant to

[20] However, there was early initiation of the requisition process (1st step to initiate procurement) by the UNDP Angola PMU
[21] There are no set targets by UNDP on the expected procurement timeline to complete the process
[22] There was a reliance on manual tools to support collection of consumption and stock data at all health facilities visited by the OIG
[23] No evidence of routine recording consumption data for (1) key HIV commodities at 78% (7/9), (2) key TB commodities at 40% (4/10) of sites visited by the OIG

strengthen the national PSM system, however only 13% had been spent at the date of the audit.[24] Some key activities had yet to be started. These included the technical assistance for quantification and forecasting, update of national PSM SOPs, and training at the provincial level to support PSM data collection and supply chain management[25].

- *Limited UNDP Programme Management Unit (PMU) capacity related to PSM activities:* There has been high staff turnover in the UNDP PMU for two key PSM roles, with 3 different people in post in 2.5 years for each role. There were also recurring[26] vacancies in the PSM lead staff role due to challenges in attracting suitable qualified international staff. These vacancies were filled by a number of short-term consultants. There has also been limited overall capacity within the UNDP PMU for PSM activities, with only 5 PSM staff positions. This has impacted the ability of UNDP to support RSSH implementation in a timely manner, completion of quantification and forecasting and delays in engaging with sub-national stakeholders.
- *Absence of PSM preparedness plan between UNDP and MINSA at start of GC6:* The move to the sub-national approach represented a large shift in roles and responsibilities between UNDP and MINSA[27]. At the start of GC6, UNDP became responsible for supporting the full commodity need for the three diseases in the two Global Fund-selected provinces. This move did not take into account the lead times needed by UNDP to complete procurement, nor the immediate needs at the start of GC6 of health facilities that had been previously supported with government-procured commodities. There was no preparedness plan between UNDP and MINSA to identify the key challenges and mitigate with a phased approach away from government-procured commodities. However, the development of a preparedness plan was not a requirement for grant implementation.

As a result of the above, the OIG observed material and prolonged stock-outs of key HIV, TB and malaria commodities for both testing and treatment (see Table 1). This negatively affects service delivery (see Finding 4.5 for impact on HIV services).

Table 1:
Sites with stock outs including the average days

Disease	Commodity	Sites	Average Days
HIV	ARV - TLD	4/9 (44%)	57
	Test kits – Unigold	5/9 (56%)	109
	Condoms	4/9 (44%)	190
Malaria	ACTs – AL 6s	4/9 (44%)	55
	ACTs – AL 12s	4/9 (44%)	92
	ACTs – AL 18s	5/9 (56%)	59
	ACTs – AL 24s	5/9 (56%)	53
	Artesunate injectable	5/9 (56%)	78
TB	RHZE	5/10 (50%)	49
	Rifampicin/Isoniazid/ Pyrazinamide	5/10 (50%)	155

Table 2:
Instances where Government commodities provided to provinces supported by Global Fund

Disease	Commodity[1]	Years	No of instances
HIV	1st & 2nd line ARV's	2021 & 2022	2
	HIV test kits – Determine & Unigold	2021 & 2022	6
	HIV reagents and condoms	2021 & 2022	3
Malaria	ACTs	2021, 2022 & 2023	5
	RDTs	2021 & 2022	2
TB	GeneX cartridges	2022	1
	1st line drug	2021	1

To prevent further stock-outs, there have been instances during 2021-2023 where MINSA and the other provincial governments supplied commodities to the Global Fund-supported provinces (see Table 2). These instances led to critical commodities being directed away from nationally supported provinces with unknown implications for HIV, TB and malaria services. It also highlights a key

[24] 13% absorption (USD88k of US$700k) for RSSH Health product management systems (latest validated PU/DR Dec 2022)
[25] Training and supportive supervision on warehousing and inventory management has been provided by UNDP to health facilities
[26] Four people held the position during the audit period and a PSM lead was recruited in November 2023 and expected to take up the role from January 2024
[27] UNDP as Principal Recipient previously provided a proportion of the overall total need for HIV commodities across 18 provinces in GC5. In the final year of GC5, UNDP became the PR for the consolidated HIV, TB & Malaria grants covering the 18 provinces.

challenge in the sub-national approach, as the Global Fund grant was designed to fully cover commodities for the three diseases in the two provinces.

After the OIG Audit fieldwork, as a part of the ongoing grant making process for GC7, the issue with limited UNDP capacity related to PSM activities has been sufficiently addressed. Under GC7, additional funding has been budgeted to support additional PSM positions in UNDP to strengthen capacity.

As such, there is agreement that there is no need for a specific Agreed Management Action for this sub-finding. The success of this action will be assessed by the OIG in subsequent audits of the Angola portfolio.

In addition, issues with the absence of PSM preparedness plan between UNDP and MINSA is addressed by Agreed Management Action 1 - Part C.The other sub-findings will be addressed by Agreed Management Action 2 (see below):

Agreed Management Action 2
The Global Fund Secretariat, along with relevant in-country stakeholders, will support the development and approval of a costed work plan to address key issues of weak data and inventory management at service delivery point.
OWNER: Head of Supply Operations
DUE DATE: 30 September 2024

4.3 Program data inaccuracies impact the ability to monitor progress of sub-national approach

Progress has been slow in addressing programmatic data inaccuracies at the health facility and community levels. This is linked to a lack of clear national ownership, as well as limitations in national systems, tools and processes to support robust data.

There are inherent weaknesses in the national Health Management Information Systems (HMIS) in Angola, but there have been efforts to identify and respond to data challenges in the two provinces supported by the Global Fund. In 2021, an assessment of the HMIS landscape was conducted with recommendations including a roadmap to strengthen HMIS. A follow-up assessment of progress was conducted in August 2023. There have also been improvements in leveraging DHIS2 for aggregate malaria program data. In addition, there are good data validation processes and no significant data accuracy issues from the sample review conducted for sub-recipient *Ajuda de Desenvolvimento de Povo para o Povo* (ADPP), supporting HIV- and TB-related community activities.

While some progress has been made in improving data availability, there were substantial data inaccuracies for key coverage indicators across the three diseases at health facility and community levels. This affects the ability to assess performance of the sub-national approach.

Significant programmatic data inaccuracies in health facilities

Persistent very poor data quality (with +/- 30% discrepancies)[28] was observed across key HIV, TB, and malaria indicators in the sites visited by the OIG (see Table 3). The Local Fund Agent also confirmed issues with inaccuracy in health facility data through its own assessment.[29] UNDP visits to sub-recipient implementers[30] also noted data quality issues.

Table : Data results from OIG site visits

	Key indicator	Sites with variances over 30%	Variance
HIV	Newly initiated & returning to ART for children (<15)	6 of 9 (67%)	+ / - 30 %
	Newly initiated & returning to ART for adults (>15)	7 of 9 (78%)	+ / - 30 %
TB	Number of notified cases of all forms of TB	2 of 10 (20%)	+ / - 30 %
Malaria	Confirmed cases received antimalarials at facilities	8 of 9 (89%)	+ / - 30 %

Poor quality data has been driven by the following root causes:

Limited government prioritization of and ownership over HMIS: There is no up-to-date national strategic plan to strengthen data and data systems. The last health management information strategy is from 2015 and does not reflect updated international digital health and strategic information guidelines to help countries improve their information systems.[31] There is no national monitoring and evaluation Data Quality Assurance plan that would provide guidance to assess and validate data quality. The GC6 funding grant available for this has not been utilized.

[28]Data accuracy is measured as the ratio of recounted value in source documents at the health facility to the value in the reporting system (PUDR reporting source data). Ratings as follows: >20% (Very Poor); +/-11% to 20% (Poor); +/- 6% to 10% (Moderate); and +/- 5% (Good). (Global Fund's Operational Guidelines for Data Use and Improvement at Country Level).
[29] LFA assessment completed a targeted Data Quality Review (October 2023). It highlighted potential inaccuracies of over 30% for confirmed malaria cases that receive treatment at health facilities and number of TB patients (all forms) that are successfully treated.
[30] This included supervision missions, on-site data verification (OSDVs) exercises and spot checks
[31] WHO recommendations on digital interventions for Health System-strengthening 2020; WHO recommendations in digital systems 2022; WHO Global Strategy on Digital Health 2020-2025. Angola adopted DHIS2 as its official HMIS in 2018, after strategy period lapsed.

Lack of electronic systems to support data collection and reporting for HIV and TB: For both the TB and HIV program, there is no national electronic case management system to support patients on TB treatment or ARVs. There is a continual reliance on Microsoft Excel and manual tools at all levels.[32] In addition, Microsoft Excel is used to calculate and report the current numbers of ART patients for the two Global Fund-supported provinces. This hampers the ability to quickly and accurately collect, manage, analyze and use routine clinical information for HIV patient management, impacting services like patient loss to follow up (see Finding 4.5).

Weaknesses in data collection and reporting at health facility level: The OIG noted the biggest source of inaccuracies occur at the health facility level when collecting results from primary records, consolidating these results and reporting them to the municipal level. This is due to weaknesses in processes, systems, tools and staffing at this level. No data validation checks were being conducted at any of the health facilities visited. This is linked to limited staffing, with only a maximum of one data officer[33] at each site visited. Furthermore, no electronic systems were in place at any sites visited to support data collection and reporting. Health workers relied on manual tools and processes, which increase their workload. There were issues with these tools, with all sites using ad hoc tools to aggregate and report data and 30% of malaria sites visited having missing registers.

Delays to complete key RSSH activities for strengthening HMIS: The Global Fund grant included activities to strengthen HMIS in country. However, as of December 2022, only 33% of the RSSH budget had been used. Funding to develop a national monitoring, evaluation and data quality assurance plan, technical assistance for DHIS2 roll out and to develop data dashboards was yet to be utilized. The Principal Recipient was working on an acceleration plan to complete these activities but this was yet to be finalized at the time of the audit (November 2023).

Malaria community data discrepancies

World Vision supports community-based malaria interventions with community development agents known as ADECOS.[34] When reviewing data reported to the Global Fund, for malaria patients who received treatment in the community, the OIG could not materially validate 53% of the results reported to the Global Fund[35] through World Vision's internal HMIS system "KoboCollect".[36] In addition, only 10% of sampled results in the KoboCollect system could be validated.[37] Significant variances were also identified in the 2019 OIG audit.

These issues were due to several contributing factors. Namely, there was no evidence that data validation checks were undertaken by municipal supervisors, World Vision central staff or UNDP PMU. World Vision also did not perform internal data quality audits as required in their SOPs. In addition, there were issues with the stability of the "KoboCollect" system itself and a lack of user controls in place to safeguard data. At the community level, different tools for data collection were being used and were not consistently updated.

These discrepancies can reduce the ability to effectively monitor and assess grant performance as programmatic challenges may not be identified and mitigated if inaccurate data is reported.

[32] This includes national level reporting to UNDP for TB data for PU/DR purposes
[33] This refers either to dedicated data officers or health care workers who were given the responsibility over data
[34] ADECOS "Agentes de Desenvolvimento Communitario e de Sanitaria" are workers supported through a cross-ministry partnership between the Ministry of Health and Ministry of Territorial Administration to provide malaria services at the community level
[35] OIG sampled the July-December 2022 PU/DR semester
[36] World Vision leverages its own supported community-based information system ("KoboCollect") to record, analyze and report results
[37] Only 10% of sampled results in the KoboCollect system could be confirmed by primary records maintained by community agents

Agreed Management Action 3

The Global Fund Secretariat will support the Principal Recipient, Ministry of Health, and Provincial Health Directorates and partners to strengthen M&E tools, health information systems, and the data quality to improve the reliability of the program data and patient tracking for the three disease programs in Global Fund-supported provinces. This will include:

A. Developing an acceleration action plan including timelines and responsible parties to address the identified underlying causes of poor data quality.

B. Conduct a targeted DQA for community level data for HIV, TB, and Malaria with the aim of assessing community-level data and systems in line with WHO best practice guidelines on data quality review.

C. Developing and implementing a data quality action plan for community-based malaria case management under World Vision (SR) with clear milestones and timelines.

D. Developing Standard Operating Procedures (SOP) for the tracking of patients lost to follow up (LTFU) for TB and HIV patients, and PMTCT at both health facility and community levels. This will include details on a return to care approach and will leverage normative guidance where appropriate and relevant.

OWNER: Head of Grant Management Division

DUE DATE: For Part A - 30 September 2024, for Part B and D - 30 June 2025, for Part C – 30 September 2025.

4.4 Processes to track and report on co-financing have improved, but risks in meeting malaria commitments exist

Strong processes have been established by MINSA to track and monitor co-financing, with positive improvements in meeting TB commitments. However, there are gaps in meeting malaria commitments that negatively impact the National Malaria response.

Domestic financing for health plays a critical role in Angola. As a middle-income country, the government is expected to be a major contributor to the funding of the three diseases, with the Global Fund grant only focused on two provinces according to the sub-national approach. Under GC6, the Global Fund supported 24% of the total investment of the three diseases, with the Government of Angola (GoA) contributing 47%. The remaining 29% of the total investment is funded by other donors. Specific commodity co-financing commitments for the three diseases have been agreed with the country for GC6, including ARVs, first- and second-line TB medicines, LLINs and anti-malarials.

The 2019 OIG audit highlighted significant issues in the realization of co-financing commitments. It also identified gaps in government ownership to fulfil these commitments, as well as a lack of processes in MINSA to routinely monitor and report on co-financing commitments throughout implementation.

However, the OIG has subsequently noted substantial improvements in MINSA's approach to co-financing. There have been efforts by the Government to strengthen the policies, processes and tools to track and report on co-financing commitments. Detailed standard operating procedures have been designed and approved to support continual tracking of co-financing commitments and annual reporting by the government on results.[38] In addition, a co-financing technical working group and supervision committee have been established to oversee reporting, with representation from the Ministry of Finance, CCM, MINSA and UNDP. The government has also successfully produced annual reports for 2021 and 2022 on commitments and shared them with the Global Fund. In light of the risks around co-financing, the Global Fund Secretariat has put in place additional assurance over co-financing, and required external assurance on co-financing commitments for the 2021-22 period.

These reviews have shown good progress on the achievement of TB commodity commitments, with first- and second-line TB medicine commitments being achieved for 2021 and 2022. In addition, there has been continual leveraging of the UNDP procurement framework to support domestic procurement of ARVs by the national HIV program (INLS).

Continued risk of not meeting domestic financing commitments for malaria

Specific malaria commodity commitments were put in place for bed nets[39] and ACTs. However, the country had achieved 0% of the annual target for commodity commitments for bed nets (LLINs) for 2021-22 and 27% for anti-malarial commodities, according to the external assurance review.

While progress was noted in 2023, with US$3.1 million-worth of nets procured with domestic financing, these LLINs had not been distributed, thereby missing a key part of the commitment requirement. In 2023, US$3 million-worth of ACTs had been procured with domestic financing. However, this represented only 10% of the overall GC6 commitment for LLINs and 33% of the overall

[38] These reports do not include possible procurements of commodities undertaken by provincial governments and only capture national level procurements, which can lead to an underreporting on domestic financing spent
[39] The government was fully supporting bed net distribution in 10 provinces in Angola

commitment for ACTs, at the time of the audit fieldwork (November 2023[40]). This highlights a significant risk of non-achievement for malaria commitments for GC6.[41]

The low achievement to date of malaria commodity commitments is caused by a range of challenges:

- *Weak government ownership and timely domestic procurement of commodities:* The Government of Angola did not initiate a domestic procurement process for LLINs until March 2022. This was nine months after the start of GC6 and after the planned Q1 2022 LLIN mass campaign. The procurement process was deemed invalid in November 2022. This was due to discrepancies between the specifications submitted by the shortlisted companies and the criteria defined in the Ministry of Health final evaluation report, insufficient documentation of the shortlisted companies' financial ability to cover all expenses, and flaws in the Ministry of Finance's electronic platform, which automatically removed some companies without justification. The process was not restarted and after a further seven months, an emergency procurement of ACTs and LLINs was initiated in June 2023.
- *Lack of effective oversight and action on co-financing risks***:** While there has been strong progress in ensuring timely reporting on the status of co-financing, this has not resulted in the effective follow up of challenges. The CCM executive committee, oversight body and main body met multiple times[42] between July 2021-November 2023. However during this period, discussions on co-financing were limited and no action points or follow up for low achievement of malaria commodities were noted. Similarly, despite the co-financing technical working group meeting 10 times between July 2021-November 2023, there was no discussion on malaria commitments. This highlights a gap in effective oversight and action by the relevant governance bodies that should be monitoring co-financing progress.
- *Macro-economic challenges impacting the fiscal space available to support commitments:* The broader economic landscape is an important contextual factor when discussing co-financing. The Angolan Kwanza depreciated by 39% between December 2022 and November 2023. This is linked to broader issues with lower oil revenues and large external debt servicing,[43] especially after the COVID-19 pandemic, which impacts the fiscal space available to support the overall state budget, including health.

This increased risk of non-achievement of malaria commodity targets has implications on both the Global Fund grant and the broader National Malaria response. Failure to meet co-financing commitments can impact the future GC7 Global Fund allocation. This occurred in prior cycles, with the country receiving a US$1.5 million-reduction in the GC6 funding due to non-fulfilment of GC5 commitments. There are also implications on the broader National Malaria response. There has been a large increase in estimated malaria incidences from 3.3 million cases in 2015 to 8.4 million in 2022[44] linked to the limited number of LLINs distributed in country.

The Global Fund Secretariat have declined an agreed management action (AMA) for this finding. Instead, the Global Fund Secretariat aims to continue to monitor the residual risk of not fully meeting the domestic financing commitment for Malaria in GC6 through its existing and revised operational policies, strategically leveraging multiple avenues within the Secretariat's control to advocate for Angola's compliance. Following the end of the GC6 funding cycle, the Secretariat aims to conduct the final assessment of GC6 co-financing compliance and recommend appropriate next steps to the Grant Approvals Committee.

[40] This is based on documents provided to the OIG during the Audit Fieldwork phase
[41] The final determination on co-financing achievement must occur at the end of the grant period and is made by the Global Fund Secretariat. The OIG is highlighting the potential risks as at the time of the audit fieldwork.
[42] Over 70 meetings were held during this period
[43] Source: https://www.worldbank.org/en/country/angola/overview#1 accessed on 30 November 2023
[44] World malaria Report 2023, accessed on 30 November 2023

Declining Agreed Management Action on co-financing

The Global Fund Secretariat has declined an agreed management action (AMA) for this finding. Instead, the Global Fund Secretariat aims to continue to monitor the residual risk of not fully meeting the domestic financing commitment for malaria in GC6 through its existing and revised operational policies, strategically leveraging multiple avenues within the Secretariat's control to advocate for Angola's compliance. Following the end of the GC6 funding cycle, the Secretariat aims to conduct the final assessment of GC6 co-financing compliance and recommend appropriate next steps to the Grant Approvals Committee.

4.5 Positive trends in HIV testing and treatment but high PMTCT and loss to follow up for HIV and TB persist

There is steady progress towards achieving UNAIDS targets, however, high mother-to-child transmission and gaps in treatment retention, negatively impact the HIV and TB response.

There have been improvements in increasing the proportion of people living with HIV that know their status since 2019.[45] In addition, the coverage of tested pregnant women who receive anti-retrovirals (ARV) for prevention of mother-to-child transmission (PMTCT) has increased from an estimated 58% in 2019 to 80% in 2022.[46] There has also been a reduction in estimated vertical transmission from 21% to 16%[46] in the same period, although this remains very high relative to the Eastern and Southern Africa Region[46] rate of 7%. However, challenges with quality of service, lack of systems and guidelines, and diagnostics stock-outs, hinder further progress towards HIV epidemic control.[47]

High mother-to-child transmission and low Early Infant Diagnosis (EID) rates are negatively impacting the country's PMTCT response

There is still a very high rate of mother-to-child vertical transmission at 16% in Angola.[52] The country did not achieve its objective of reducing mother-to-child-transmission (MTCT) rate to 9% by 2022,[48] and the achievement rate for EID[49] has been significantly below performance targets throughout the audit period.[50] Angola's estimated EID rate remains extremely low at 3%,[51,52] relative to the Eastern and Southern Africa rate of 83%.[52] There are a range of contributing factors for these issues:

- *Stock-outs of HIV test kits at PMTCT sites:* There were stock-outs of HIV test kits at 56% (5/9) of PMTCT sites visited by the OIG (see Finding 4.2), impacting the testing of pregnant women.
- *Lack of guidelines and tools at health facility level, and delays in updating guidelines:* There are no national operational guidelines to support tracking of mothers and babies in the community. There were delays adopting the 3-test approach[53] for HIV-impacted adherence to testing algorithms in all eight PMTCT sites visited by the OIG. Updated guidance and tools were not in place in 63% (5/8) sites with PMTCT services visited by the OIG. In addition, in 88% (7/8) of sites, there was no evidence of supportive supervision and training of staff on EID.
- *Limitations in EID testing capacity*: Angola has only two laboratories with EID diagnostic equipment.[54] The Benguela site, the referral site for the two Global Fund-supported provinces, had no stock of dry blood spot (DBS) kits for 161 days,[55] impacting the ability to run EID testing.

These issues have hindered progress in reducing the high transmission rates and are contributing to high infant HIV morbidity and mortality, with estimated annual AIDS-related deaths among 0-14 years contributing to 26% of all annual AIDS-related deaths.[56]

[45] National level figures for the first 95 of 95-95-95 targets at: 45% (2019) vs 58% (2022) for Angola aidsinfo.unaids.org (accessed on 29 November 2023)
[46] aidsinfo.unaids.org (accessed on 29 November 2023)
[47] GC6 grant aims to reduce new HIV infections among children born to HIV infected mothers by 60% by 2024
[48] This is detailed in the Triple-MTCT National Strategic Plan
[49] Early Infant Diagnosis in HIV-exposed infants receiving a virological test for HIV within two months of birth
[50] PUDR results: Achievement of 19% against a target of 40% (July 2021-December 2021), 17% against a target of 40% (January 2022 to June 2022) and 18% against a target 51% (July 2022-December 2022)
[51] The sub-national rate for the two provinces supported by the Global Fund is estimated at 13.6%
[52] https://aidsinfo.unaids.org/ (accessed on 29 November 2023)
[53] Adopted in May 2023 (WHO released guidelines in 2019 – Accessed on 30 November 2023)
[54] Luanda and Benguela
[55] DBS kits stock out days in 2022
[56] aidsinfo.unaids.org (accessed on 29 November 2023), National level figures

High Lost to Follow Up (LTFU) patients limits ability to improve ART coverage

The HIV patient count supported by UNDP showed high rates of LTFU at 61% in Benguela province (2021) and 78% in Cuanza Sul (2022). There are several drivers for this including:

- *Absence of national systems, tools, processes and guidelines:* There is no national electronic system for HIV case management to support tracking of LTFU. This has led to reliance on unreliable manual processes for tracking at 56%[57] of the ART sites visited by the OIG. The remaining 44% had no system or process to routinely track LTFU. In addition, at 67% of the ART sites there was no evidence of any LTFU follow-up activity. This is linked to a lack of national operational guidance for LTFU activities.
- *Stock-outs of ARV treatments:* There were prolonged stock-outs of first-line HIV treatments at 44% (4/9) ART sites visited by the OIG. This impacts the ability to retain patients on treatment.
- *Misalignment of national guidelines to international standards:* According to UNAIDS guidelines, a patient under ART is considered LTFU if 28 days have lapsed without clinical contact after the last expected clinical contact, but Angola considers a patient as LTFU after 90 days. This impacts the understanding of health facility staff on which definition to follow.

These factors contributed to the country only achieving 29% for ARV coverage for both adults and children compared to the PU/DR target of 45% (December 2022), meaning Angola is at risk of not meeting the grant objectives of ART coverage at 63% in adults and 60% in children by 2024.

Increased Multidrug-resistant tuberculosis (MDR-TB) case notifications, but gaps in both the evaluation of treatment outcomes and completion of treatment negatively impact the achievement of grant objectives

Angola ranks among the top 30 countries for TB, HIV-associated TB and MDR/RR-TB.[58] In progress updates to the Global Fund, there has been progressive improvement in meeting MDR-TB case notification targets since July 2021.[59] However, independent studies[60] have highlighted 37% of TB patients are being lost to follow up or not having their treatment outcomes evaluated. OIG site visits highlighted similar issues with 13% of MDR-TB patients being LTFU while 30% had undocumented treatment outcomes.[61]

Discrepancies in recording treatment outcomes[62] were linked to data quality gaps in completing the patient registers and patient files (see Finding 4.3).

Issues in high loss to follow up were linked to a lack of operational guidelines and training and supervision at the health facility level. Guidelines for tracking TB patients who do not complete treatment were not available at all TB facilities visited by the OIG. There was also no evidence of training or supportive supervision related to MDR-TB management in any of the sites visited.

These factors impact successful treatment of MDR-TB and achievement of the grant objectives to increase the treatment success rate of sensitive TB (all forms) from 25% in 2017 to 85% in 2024.

The Agreed Management Action 3 – Part D aims to address the above issues related to gaps in national guidelines for TB, PMTCT and HIV LTFU as well as weak health management information systems and data. Please refer to Finding 4.2 for actions taken related to issues in commodity availability.

[57] In 5/9 (56%) of the sites, the LTFU tracking calendar had incomplete data compared to patient file and ART register
[58] WHO Global Tuberculosis Report 2023 – page 48
[59] PUDR results: achievement of 37% (July 2021-December 2021), 53% (January-June 2022) and 99% (July-December 2022)
[60] WHO Epidemiological Review of Tuberculosis in Angola (2018-2022): for 2020, Angola TB treatment success rate at 68%, 26% LTFU or not evaluated. For 2021, the treatment success rate declined to 59%
[61] OIG reviewed patient registers from January 2022 to December 2022 at 10 TB sites
[62] The inaccuracies in the treatment success results were also highlighted in the DQR completed by LFA in October 2023

As such, there is agreement that there is no need for a further specific Agreed Management Action for this finding. The success of these actions will be assessed by the OIG in subsequent audits of the Angola portfolio.

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 being effectively assessed and mitigated.

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which 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 the organization has not 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.

Global Fund grants in Angola: comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit rating except in two key risk areas: In-Country Supply Chain and Procurement.

The ***In-Country Supply Chain*** risk is a composite of several sub-risks, including: (i) Health Product warehousing, (ii) Health Product distribution, (iii) Health Product information systems.

The OIG and the Secretariat have similar levels of assessed risk for (i) and (ii), but different levels of assessed risk related to (iii). The Secretariat rated this sub risk "High" however the the OIG rating is "Very High". This is due to the lack of an electronic systems as well as limited processes and tools at service delivery point to capture and report consumption data and stock levels. This limits data driven decision making for supply chain. In addition, there were issues in the governance and use of data for decision making to inform key PSM processes. These issues have contributed to stock outs. The lack of consumption and stock level data also limits the ability to triangulate PSM data with HMIS data. This sub-risk has implications across the In-Country Supply Chain Risk area and results in an overall "Very High" risk rating.

The ***Procurement*** risk is a composite of several sub-risks, including: (i) Quantification and forecasting & Supply Planning, (ii) Health Product Procurement Processes and Outcomes, (iii) Non- Health Product Procurement Processes and Outcomes Product warehousing.

The OIG and the Secretariat determined similar levels of assessed risk for (ii) and (iii), but different levels of assessed risk related to (i). The Secretariat rated this sub risk "High" however the the OIG rating is "Very High". This is due to the systemic issues noted with the reliability and delays in the quantification and forecasting process. This has had downstream implications with 40-50% of sites having stock-outs observed of key commodities. There are also reputational concerns given the objective of the sub-national approach and the request for commodities from the Government of Angola to support Global Fund supported provinces. This sub-risk has implications across the Procurement risk area and results in an overall "Very High" risk rating.