Audit Report

Global Fund Grants to the

Republic of Indonesia

GF-OIG-24-016
8 November 2024
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Indonesia is a key partner of the Global Fund in the fight against the three diseases. The country has the second largest TB burden in the world, accounting for 10% of the global burden. It is also among the WHO highest burden countries for drug resistant (DR) TB. With Global Fund support, the country has achieved a 42% increase in TB case notifications since 2019. Significant progress has been made in malaria response, with 76% of districts now malaria-free. HIV testing coverage has steadily increased, and prevention measures such as Pre-Exposure Prophylaxis medicines (PrEP) and self-testing have been introduced. Strong political leadership and ownership over the health response, large increases in domestic financing for health, and robust health systems linked to strong economic development have underpinned these successes.

Despite significant progress in TB diagnosis, in 2023, 16% of patients diagnosed with drug susceptible (DS) TB and 32% of those diagnosed with DR-TB were not initiated on treatment. DR-TB treatment success also remains low. For HIV, there is high loss to follow up (LTFU), estimated at 37%, and weak treatment initiation, including for self-testing key population groups. The above contributes to stagnant mortality numbers for HIV, increased prevalence for key populations, as well as increased rates of TB incidence and mortality. These issues are caused by a lack of national operational policies and guidelines, a fragmented data system environment, as well as limited community health worker focus on effective treatment activities. HIV and TB interventions to ensure treatment initiation and adherence **need significant improvement.**

Government financing for health has increased significantly since the 2015-2017 grant cycle (GC5), and there were increased commitments for HIV, TB and malaria for the 2023-2025 grant cycle (GC7). A range of innovative and diverse approaches to health financing, including national health insurance and loan buy down arrangements have been implemented. However, finalization of the national transition and financial sustainability plan, which is critical to supporting a more comprehensive approach to sustainability, transition, and co-financing, has been significantly delayed. . This is a key area in the context of a newly classified upper-middle income portfolio. There were gaps in the design of co-financing commitments for the 2020-2022 grant cycle (GC6), as no commitment amount was defined, or baseline set. Co-financing monitoring and reporting, both at country and Global Fund Secretariat level, is not fully effective, not executed in a timely manner, and not based on complete data. Sustainability initiatives and co-financing to support program objectives **need significant improvement**.

Financial management and assurance mechanisms under the Ministry of Health (MoH) and Penabulu grants have been effective in preventing and detecting non-compliant transactions for living support costs and incentive payments. No material issues were identified. However, there have been significant delays in utilizing COVID-19 Response Mechanism (C19RM) funds under the MoH TB and HIV grants. Procurement, installation and use of chest x-rays and whole genome sequencers – that should strengthen the TB and HIV response – were delayed. Key activities such as the use of private providers for TB active case finding were also late, with implications on TB diagnosis in an environment where estimated missing cases have increased. This was linked to regulatory bottlenecks and delays in developing deployment plans rather than specific financial management challenges. Thus, financial management and oversight for living support costs, payment for results incentives, and C19RM investments are **effective**.

1.2 Key Achievements and Good Practices

Strong national leadership and strategic direction in the fight against TB

Government ownership of the TB response provides a clear and ambitious strategic direction to tackle the disease. The 2021 presidential decree on TB and the revised National Strategic Plan (NSP) have set ambitious targets for an effective, comprehensive, and integrated approach to eliminating the disease. This supported significant increases in diagnostic capacity and resources towards the broader TB response.

Innovative approaches to health financing, and increased government funding for health

The Government of Indonesia (GoI) has increased its domestic financing of health,[1] and co-financing commitments for the three diseases almost tripled from US$400 million to US$1.2 billion between GC5 and GC7.[2] Procurement of health commodities has shifted progressively from Global Fund to GoI financing, namely for antiretroviral (ARV) and malaria medicines. The government established a strong national health insurance mechanism to support beneficiaries accessing services for the three diseases. Additionally, through Global Fund support, GoI increased TB health financing with an additional €50 million, mobilized through a debt swap,[3] and a loan buydown supporting a US$300 million World Bank loan.[4] The Government also received US$4 billion in external financial support[5] to improve public health service capacity and utilization.

Significant increase in the number of TB case notifications

TB case notifications increased by 42% between 2019 and 2023. The treatment success rate for DS-TB is 87%. This is linked to a range of factors including strong political leadership, good data systems, and higher usage and numbers of operational molecular TB testing platforms. The number of GeneXpert machines increased from 1,158 in 2020 to 2,340 in 2023, with large increases in GeneX tests performed, from 0.7 million in 2020 to 3 million in 2023.

Innovation in HIV testing and prevention

Despite challenges with stigma and discrimination, there are efforts to support innovations in HIV testing and prevention, with a focus on key population groups. HIV self-testing was rolled out in GC6. Pre-Exposure Prophylaxis (PrEP) services for key populations were also piloted during GC6. Further scale-up of these activities is planned under GC7, as well as piloting of the dapivirine vaginal ring.

Efforts to improve data systems to support better quality and availability of data

In 2022, the GoI launched the Indonesia Health Services (IHS) platform[6] to support the transformation and integration of data systems and data. The national TB program rolled out a sophisticated aggregate health management data system (SITB, Sistem Informasi Tuberkulosis), to support real-time monitoring and improved decision making. The national HIV program is currently rolling out an updated version of the HIV/AIDS Information System - Sistem Informasi HIV/AIDS (SIHA 2.1).

Effective internal controls for managing financial and fiduciary risks relating to living support costs and incentive payments under the MoH and Penabulu grants

[1] Health sector spending rose from US$26.1 billion to US$46.5 billion GC5 (2018-20) and GC6 (2021-23) per Ministry of Finance budget reporting
[2] Global Fund Secretariat analysis of Government of Indonesia co-financing commitments
[3] Indonesia, Germany and Global Fund Sign New Debt Swap Agreement to Fight TB
[4] New World Bank Financing Aims to Strengthen Indonesia's Tuberculosis Response Program
[5] World Bank (US$1.5 Billion), Asian Infrastructure Investment Bank (US$1 bn), Islamic Development Bank (US$0.8bn) and Asian Development Bank (US$0.7 bn)
[6] Health Ministry Launches 'SatuSehat' Platform (Accessed 19 Apr. 24)

No material issues were identified in the OIG sample of transactions. Well-defined policies, procedures, and processes for financial management are established and effectively implemented. UNDP technical assistance to the MoH for financial management has resulted in improved financial management capacity.

1.3 Key Issues and Risks

High DR-TB and DS-TB treatment gaps contribute to increased TB incidence and mortality
An increasing number of patients are diagnosed but not initiated on treatment (32% for DR-TB and 16% for DS-TB in 2023). This contributes to increased incidence and mortality (23% and 44% respectively). This is driven by an absence of national operational policies, limited scale-up of sites providing TB services, fragmented health management information systems, and delayed implementation of key activities under TB grants.

Challenges in linking to and retaining HIV patients on treatment, including key populations
The absence of guidelines and weak processes and systems limit the effectiveness of treatment initiation and adherence initiatives. Limited numbers of community health workers support these activities, and broader issues with stigma and discrimination contribute to high rates of diagnosed people living with HIV (PLHIV) not initiated on treatment and lost to follow up. Some 19% of PLHIV were not initiated on treatment, and as many as 21% in key population groups diagnosed through self-testing, while 37% patients were lost after 36 months for the 2020 antiretroviral therapy (ART) cohort.[7]

Delayed development of sustainability and transition plan, combined with ineffective design, monitoring and reporting on co-financing requirements and commitments
At the start of GC7, the development of a national transition and financial sustainability plan had not yet started, despite being recommended by the Global Fund's Technical Review Panel and included as a GC6 grant requirement. No agreed timeline exists for its completion. Co-financing commitments were not established for GC6, though these have been established for GC7. Processes for monitoring and reporting on co-financing requirements by in-country stakeholders have been weak and the completion of national health accounts by the Ministry of Health to track progress were delayed. The GC6 Secretariat assessment of achievement of co-financing requirements was based on incomplete data and assumptions. These data issues were not clearly reported to Global Fund governance bodies during the GC7 grant making and approval process.

Delayed implementation of C19RM-funded activities under the MoH TB and HIV grants affects the country's diagnostic capacity
There have been significant delays in utilizing C19RM funds under the MoH TB and HIV grants to strengthen diagnosis and monitoring. These investments are intended to support the procurement, installation and use of chest x-ray machines and whole genome sequencers, as well as TB active case finding by private providers. These delays were linked to regulatory bottlenecks, as well as delayed site assessments and planning to support the deployment of key equipment by the Ministry of Health. As a result, there is low financial absorption of C19RM funds for the MoH TB and HIV grants, which stood at 28% and 20% at the end of GC6. This limited the impact of these investments during GC6. There is a risk of continual low absorption as additional C19RM funding was approved in Q4 2023.

[7] HIV Program data from Health Management Information System (SIHA) on 05 January 2024

1.4 Objectives, Ratings and Scope

The audit's overall objective was to provide reasonable assurance to the Global Fund Board on grants to the Republic of Indonesia. Specifically, it assessed the adequacy and effectiveness of:

Objectives	Rating	Scope
HIV and TB interventions to ensure treatment initiation and adherence	**Needs significant improvement**	**Audit period** January 2021 to December 2023
Sustainability initiatives and co-financing to support program objectives	**Needs significant improvement**	**Grants and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund-supported programs
Financial management and oversight for living support costs, payment for results incentives and C19RM investments	**Effective**	**Scope exclusion** Grant IDN-T-IBRD (US$21.12 million)

The OIG selected 7 provinces that account for 64% of estimated people living with HIV in 2023, and 67% of TB case notifications in 2023. The OIG then visited 28 health facilities in 11 districts out of these 7 provinces. The audit did not cover the IDN-T-IBRD (US$21.12 million) grant to the World Bank, contributing to a multi-donor trust fund as part of a Blended Finance Transaction. Assurance with respect to these transactions is provided pursuant to the Global Fund Board's decision F/B50/DP04. In particular, the Secretariat relies on assurances provided by the World Bank for downstream assurance, while OIG assurance work focuses on incorporating blended finance activities into its overall assurance/oversight of the Secretariat and its operations.

Details about the general audit rating classifications can be found in Annex A.

2. Background and Context

2.1 Country Context

Indonesia was recently classified as an upper-middle-income country. It has a population of 278 million, the fourth largest in the world. It is the largest economy in Southeast Asia, with a total GDP of US$1.32 trillion.[8] The country has made significant improvement in poverty reduction, cutting the poverty rate by more than half since 2019.[9]

The country is administratively divided into 38 provinces, further subdivided into 514 districts. Half of the population lives on the island of Java. The health system is decentralized, with responsibilities shared across three levels – central, province and district governments. At the primary public healthcare level, services are delivered by "puskesmas" (an abbreviation of "pusat kesehatan masyarakat" meaning community health centres) and their auxiliary centres, while services at the secondary level are delivered in hospitals. These are complemented by private facilities.

Country data[10]	
Population	277.5 million (2023 estimate)
GDP per capita	US$4,788 (2022)
Corruption Perception Index	110/180 (2022)
UNDP Human Development Index	112/193 (2022)
Government spending on health (% of GDP)	3.4% (2020)

2.2 COVID-19 Situation

In 2020, Indonesia reported the highest number of COVID-19 cases in Southeast Asia. As of 31 December 2020, the country had recorded 735,124 cases and 21,944 deaths.[11] The Global Fund supported efforts to mitigate the impact of COVID-19 on the fight against the three diseases, with a total US$120.7 million (US$108.3 million via COVID-19 Response Mechanism and US$12.4 million via grant flexibilities). COVID-19 mitigations for TB contributed to a significant increase in TB notifications: the number of notifications is now significantly higher than pre-pandemic levels.

2.3 Global Fund Grants in Indonesia

Since 2003, the Global Fund has signed grants totalling over US$1.82 billion and disbursed more than US$1.48 billion to Indonesia.[12] Active grants amount to US$309 million for the 2023-2025 allocation period (i.e. the 2024-2026 implementation period, also called GC7) and were US$483 million for the 2020-2022 funding allocation period (i.e. the 2021-2023 implementation period, also called GC6) of which US$420 million was disbursed. For the GC7 and GC6 funding allocation

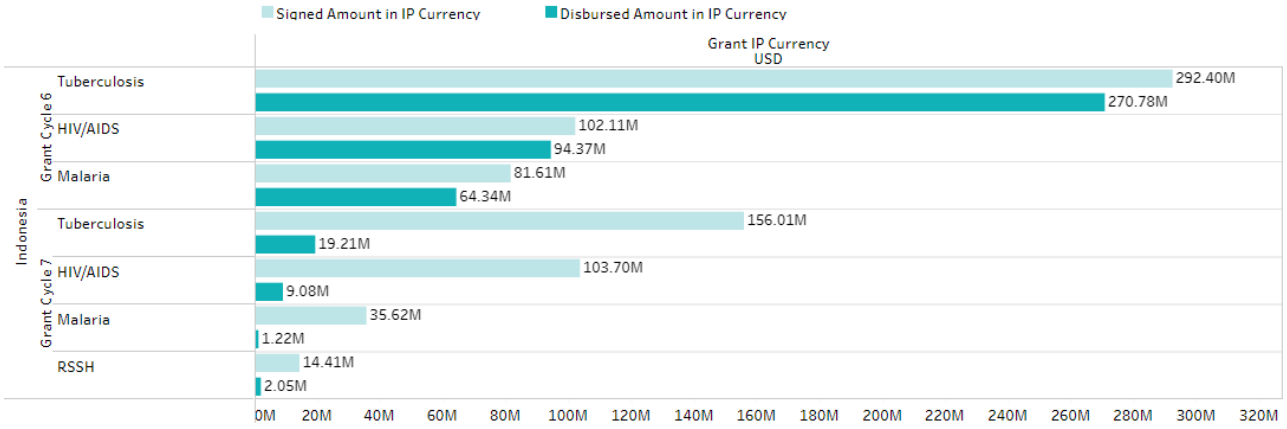
[8] https://data.worldbank.org/country/indonesia
[9] https://www.worldbank.org/en/country/indonesia/overview
[10] UNFPA, World Bank, UNDP, Transparency International, WHO
[11] WHO Intra Action Review
[12] Global Fund Data Explorer, accessed 17 April 2024

periods, the Ministry of Health is respectively the Principal Recipient for four and three grants, representing 69% and 73% of financing, as follows:

G6	• Tuberculosis US$223 million • HIV / AIDS US$63 million • Malaria US$ 66 million
G7	• Tuberculosis US$123 million • HIV/AIDS US$46 million • Malaria US$28 million • RSSH US$14 million

An additional US$21 million in GC6 was disbursed as a contribution to a loan buydown to support a US$300 million loan to the Government of Indonesia from the World Bank, supported by co-financing of US$90 million from the Government of Indonesia

The remaining financing is directed to civil society organizations.[13]



[13] Konsorsium Komunitas PENABULU-STPI; Indonesia AIDS Coalition; Persatuan Karya Dharma Kesehatan Indonesia; and Yayasan Spiritia

2.4 The Three Diseases

HIV / AIDS

An estimated 515,455 people live with HIV as of 2023. **68% know their status.**

51% are on antiretroviral treatment.

Annual new infections decreased by 52% from 50,000 (2010) to 24,000 (2022). New infections are concentrated in key populations.

AIDS-related deaths increased by 63% from 16,000 (2010) to 26,000 (2022). The number plateaued in 2018 and has since been slowly decreasing.

18% of pregnant women living with HIV were accessing antiretrovirals in 2022, an increase from 8% in 2015.

Source: 2023 UNAIDS Data; HIV Program data

TUBERCULOSIS

Indonesia has the second largest TB burden and accounted for 10% of the global TB burden in 2022.

In 2022, Indonesia had an estimated incidence of 385 cases of drug susceptible TB, 11 of MDR/RR TB, and 8.8 HIV-positive TB incidence per 100,000 population.

Notifications increased from 46% of estimated cases in 2021 to 76% in 2023.

Treatment success rate among new and relapse cases registered in 2021 was 87%.

Source: 2022 WHO TB profile for Indonesia; TB Program data

MALARIA

There has been a **positive downward trend in malaria cases and deaths**. Deaths dropped by 84%, reducing from 432 (2010) to 71 (2022). Incidence also fell from 8 to 3 per 100K population.

76% (389 out of 514) of Indonesia's districts are **malaria free.**

Strong progress in western Indonesia is offset by a deterioration in progress in eastern Indonesia (Papua province). In 2022, **93% of malaria cases were in Papua province.**

Sources: Global Fund Partner Information Portal, RBM, AMP

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

GC6 (Jan 2021-Dec 2023) grant performance and grant ratings are shown below:[14,15]

Component	Grant	Principal Recipient	Grant Period	Total Signed Amount (US$)	Budget as at June 23 ($)	Expenditure Last June 23 ($)	Absorb June 23	Jun-21	Dec-21	Jun-22	Dec-22	Jun-23
TB	IDN-T-MOH	Directorate General of Disease Prevention and Control, MoH	1 Jan 21 – 31-Dec-23	222,575,153	199,404,124	94,526,439	47%	B2	D 5	D 5	C 5	D 5
	IDN-T-PBSTPI	Konsorsium Komunitas PENABULU-STPI	1 Jan 21 – 31-Dec-23	48,704,037	39,227,667	26,099,787	67%	C	D 3	C 5	C 4	C 4
	IDN-T-IBRD	International Bank for Reconstruction and Development **		21,120,000						N/A		
HIV	IDN-H-MOH	Directorate General of Disease Prevention and Control, MoH	1 Jan 22 – 31-Dec-23	62,441,872	59,390,394	20,799,351	35%		N/A	C 5	C 5	C 5
	IDN-H-SPIRITI	Yayasan Spiritia	1 Jan 22 – 31-Dec-23	31,957,125	22,635,604	18,714,250	83%		N/A	B 3	B 3	A 2
	IDN-H-IAC	Indonesia AIDS Coalition	1 Jan 22 – 31-Dec-23	13,602,210	10,781,868	7,574,614	70%		N/A	C 5	C 4	C 4
Malaria	IDN-M-MOH	Directorate General of Disease Prevention and Control, MoH	1 Jan 21 – 31-Dec-23	66,319,740	35,908,374	30,071,935	84%	B1	B 5	C 5	C 3	C 2
	IDN-M-PERDHAK	Persatuan Karya Dharma Kesehatan Indonesia	1 Jan 21 – 31-Dec-23	16,443,077	15,300,195	9,731,372	64%	A2	B 4	A 4	A 4	A 4
Total				**483,163,214**	**382,648,226**	**207,517,748**	**54%**					

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 Indonesia portfolio with the residual risk that exists 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 of this report.

Audit area	Risk category	Secretariat aggregated assessed risk level[16]	Assessed residual risk based on audit results	Relevant audit issues
Programmatic and Monitoring and evaluation	TB: program quality	**High**	**High**	4.2
	HIV: program quality	**High**	**High**	4.3
Sustainability	Health Financing	**Moderate**	**High**	4.1
Financial assurance framework and mechanism	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	4.4

[14] Effective January 2022, Global Fund Revised PU/DR and Performance Ratings with programmatic performance assessed via alphabetic ratings while financial performance assessed via numerical ratings (Accessed 22 Apr. 24)
[15] The IBRD grant is excluded from scope (refer to scope exclusion in Sec 1.4.)
[16] Extracted from CRMM on 24 February 2024

4. Findings

4.1 Strong growth and innovation in domestic financing of health, but a lack of sustainability planning and weak co-financing monitoring pose risks to sustainability

There has been strong growth in domestic health financing, leveraging several innovative approaches. But the lack of sustainability planning and ineffective reporting and monitoring processes for co-financing commitments is increasing health financing and sustainability risks.

The Government of Indonesia (GoI) is the main contributor in the fight against the three diseases. During GC6, Global Fund grants represented 32% of funding for the three diseases, against 64% from the GoI. In GC7, Global Fund grants represent 19% of funding for the three diseases against 78% from the GoI.[17] With Indonesia classified as an upper middle-income country, sustainability and transition planning is critical to ensure progress is sustained beyond Global Fund financing. Government health spending increased by 83% in GC6 compared to US$26.1 billion in GC5, and domestic commitments for the three diseases in GC7 tripled compared to US$0.5 billion in GC5. Procurement of key health commodities has progressively been transferred to the GoI since GC5, with domestic funding supporting most ARVs and malaria medicines. A transfer of central program management unit costs to the GoI is planned to be completed during GC7.

Indonesia's approach to health financing uses a range of innovative mechanisms. The national health insurance (JKN) scheme covers 90% of the population and provides access to diagnosis and treatment to patients for the three diseases. A World Bank loan for US$300 million was signed in 2022, focusing on the national TB response. It was supported by a US$21 million loan buydown from the Global Fund. While the above are important steps towards sustainability and transition, they have been made in the absence of an overall sustainability approach to the portfolio. The country was able to get US$4bn of external financial support from four development entities to increase the availability of functional equipment in public health facilities and improve the utilization of public health services across Indonesia.

Significant delays in the development of national transition and financial sustainability plan increases sustainability risks for Global Fund Investments

The Global Fund Sustainability, Transition and Co-financing (STC) Policy encourages all countries to consider how they will progressively transition funding from Global Fund support to domestic financing. In GC6, the Technical Review Panel (TRP) recommended[18] the development of a transition and financial sustainability plan by the end of 2021 and reiterated this recommendation for GC7. This was included as a grant requirement for GC6, but GoI has not completed a transition and financial sustainability plan for Global Fund activities, and there are no timelines set for the completion of the plan.

In the absence of a plan, there was a missed opportunity to design co-financing requirements and the Global Fund RSSH grants to focus on sustainability and more "health for money".[19] This resulted in no agreed timeline to hand over full TB drug treatment and support costs to the GoI, despite this

[17] Source: Funding Landscape Tables provided by Government of Indonesia during grant making for Grant Cycle 7
[18] TRP recommended that by the end of 2021 the Principal Recipient should submit a sustainability and transition assessment plan detailing key targets and milestones in transitioning financing for the three diseases away from Global Fund support.
[19] The Global Fund's Role and Approach to Domestic Financing for Health (DFH)

being the last major investment in commodities supported by Global Fund grants.[20] Global Fund RSSH budgets and grant also continue to fund a large proportion of RSSH[21] support activities.

In GC6, 72% of the US$31 million RSSH budgeted costs were allocated to travel-related costs (per diem for supervision visits, trainings and meetings). In GC7, a standalone RSSH grant is in place for US$14 million, and this cost category remains high, representing 67% of costs. There is no plan to clarify the GoI's uptake of these investments, despite this being a recommendation in the Global Fund RSSH technical guideline.[22]

While the GoI has progressively taken over procurement of health commodities, value for money (VfM) trade-off risks have not been fully assessed or incorporated into a wider sustainability plan. This includes trade-offs[23] between the economy and sustainability VfM dimensions,[24] given that lower PPM/Wambo prices under the Global Fund grants would prevent improving the domestic procurement market. As a result, commodities procured locally are more expensive than the PPM/Wambo ones.

The absence of effective monitoring – by both the Country Coordinating Mechanism (CCM) and the Global Fund Country Team – and the gap in strategic ownership and prioritization by the Government, led to the transition and financial sustainability plan not being completed. A multi-sectorial coordination group comprising a range of ministries was meant to be established, to determine a timeline for the plan completion, but this was not done. Other factors such as COVID-19 diverted efforts away from developing the plan, as well as the prioritization of other health financing activities, such as the development and launch of the World Bank loan for TB and completion of the Global Fund Debt to Health deal.[25]

The design, monitoring and reporting on co-financing commitments limit the ability of the Secretariat to enhance domestic resource mobilization

The final Secretariat determination on co-financing requirements for GC6 was based on incomplete data and assumptions.[26] The issue for HIV and TB requirements was not flagged to the Grant Approval Committee or the Board as a part of the approval process for GC7 grants. In addition, no baseline for GC6 requirements was communicated to in-country stakeholders, and no additional co-financing commitments for GC6 were agreed, although these were established for GC7 grants.

Due to the above, it is not fully clear if all GC6 requirements were met[27] to ensure appropriate action by the Global Fund Secretariat and Board in line with the STC policy.[28] The STC Policy defines two requirements: the first is progressive government expenditure on health to meet national universal health coverage (UHC) goals. The second is demonstrating increased co-financing of Global Fund-supported programs over each allocation period, focused on progressively taking up key costs of national disease plans. Although there are positive indications of requirement 1 being met, this is not clear for requirement 2. In addition, there was a missed opportunity to agree program-specific

[20] For GC6, the Global Fund contributed respectively 17% and 62% of the total procurement of first-line TB and DR-TB drugs.
[21] Resilient and Sustainable System for Health
[22] Information Note on Resilient and Sustainable Systems for Health (Page 7)
[23] Several commodities, previously financed by the Global Fund and procured through PPM/Wambo, were then taken up by GoI and are procured through national procurement channels. In some cases, this resulted in a significant increase in unit prices of commodities compared to the Global Fund PPM reference price. This can reduce the economy achieved by domestic financing and health for money in the short term. There is a potential sustainability benefit in the long run, enhancing the domestic suppliers and pharmaceutical market.
[24] Technical Brief Value for Money details the framework used by the Global Fund to evaluate value for money of investments and defines the five dimensions that comprise value for money: Effectiveness, Efficiency, Economy, Equity and Sustainability.
[25] Indonesia, Germany and Global Fund Sign New Debt Swap Agreement to Fight TB
[26] Draft National Health Accounts (NHAs) for year 1 of GC6 (2021) were available at the time of the Secretariat final assessment
[27] Requirement 2 on increasing co-financing of Global Fund-supported programs cannot be fully confirmed as NHA data for 2022 and 2023 was not completed at the time of the OIG Audit fieldwork in April 2024
[28] The Global Fund Sustainability, Transition and Co-financing Policy

commitments for GC6 to incentivize domestic financing in key areas. This has been resolved for GC7, with specific commitments agreed for key areas such as key population interventions.

The above issues were caused by:

- Delays in completing National Health Accounts, a key source of health financing information. The delays are linked to the complexity of national and subnational health expenditure, requiring data from different ministries and a range of complex sources.
- Absence of operating procedures for MoH monitoring, assessment and reporting on co-financing requirements.
- Absence of routine monitoring of commitments by the CCM during grant implementation, due in part to the fact that no CCM technical working group responsible for STC matters was established.
- Lack of effective Global Fund Secretariat first- and second-line oversight and control over the assessment and reporting of co-financing achievement, to ensure accuracy of reporting to governance bodies.

These root causes will be addressed through Agreed Management Action (AMA) 1, except for the lack of effective oversight over the assessment and reporting on co-financing.

Agreed Management Action 1

The Global Fund Secretariat will work with the Government of Indonesia (GoI) and Country Coordinating Mechanism to strengthen financial sustainability and oversight through an approach which aligns with the Technical Review Panel recommendations for the previous and current grant cycles. This will include:

1. Develop and finalize a comprehensive financial sustainability plan for all Global Fund investments, ensuring long-term support across all areas through domestic funding. The plan should incorporate a sustainability roadmap for securing domestic funding through social contracting, specifically to sustain investments channeled through Civil Society Organizations for essential activities
2. The development of standard operating procedures by the Ministry of Health and other Government institutions to support timely routine reporting and monitoring on co-financing requirements on an annual basis. This will leverage the current approach to develop national health accounts.
3. The updating of the Indonesia CCM Oversight Manual and annual Oversight Work Plan to include engagement and monitoring of the government's development and implementation of the financial sustainability plan, and regular monitoring and oversight on progress to meet Global Fund co-financing requirements and commitments.

OWNER: Head, Grant Management Division

DUE DATE: 31 December 2025

Declining Agreed Management Action on co-financing assessment and reporting

The Secretariat has declined an Agreed Management Action to update the co-financing operational policy note as the Secretariat is already in the process of updating its co-financing operational policies including the co-financing operational policy note (OPN). The Secretariat approved interim guidance for co-financing for GC7 in Q1 2024 and is working to complete the full co-financing OPN (which builds on the interim guidance) in coordination with Health Finance Department and multiple Secretariat teams. Completion of the OPN is expected in late 2024 and/or early 2025.

4.2 Increasing TB case notifications but weak linkage to treatment and low DR-TB treatment outcomes remain

Indonesia significantly increased its notification of TB cases with the support of robust health management information systems, increased diagnostic capacity, enhanced private sector engagement, and strong political ownership. However, low rates of treatment initiation and low DR-TB treatment success rates threaten further progress and contribute to rising TB incidence and mortality.

Indonesia has the second largest TB burden globally, accounting for 10% of the global burden and a significant DR-TB burden.[29] The Country increased its TB case notifications by 42% between 2019 and 2023. It also achieved high treatment success rate for DS-TB at 87%. The GoI's political leadership and engagement was a key enabler in the TB response. A 2021 presidential decree on TB increased ambition and defined a comprehensive approach to tackle the disease. Indonesia almost doubled the number of GeneXpert platforms from 1,158 (2020) to 2,250 (2023). The country rolled out the SITB system, which can provide real-time data on cases. There is also a good Public-Private Mix (PPM) approach, with direct engagement of private providers along with technical assistance and investment in priority districts. However, gains made may be at risk given the rise in TB incidence and mortality, driven among others by suboptimal linkage to treatment and low treatment success rates for DR-TB.

Challenges in enrolling diagnosed TB patients on treatment and low treatment success for DR-TB is contributing to increases in incidence and mortality

In 2023, 16% and 32% of patients diagnosed with DS-TB and DR-TB respectively, were not initiated on treatment. The rate of DS-TB patients not initiated has increased since 2021. The rate for DR-TB has slowly decreased since 2021,[30] but remains significant. Furthermore, DR-TB patients are put on treatment with an average delay of one month. Issues in treatment contributes to the low treatment success rates for DR-TB (56% for the 2021 patient cohort) - while the rate is improving,[31] it is still far below the WHO End TB Strategy[32] 2025 target of 90%. The treatment gap, along with low DR-TB treatment success rates, are contributing to increasing TB incidence and mortality.[33] According to WHO estimates, between 2019 and 2022 TB incidence and mortality rates increased by 23% and 44% respectively.

These issues were driven by several root causes, including.

Limited focus on pre-treatment services and treatment initiation: There are no national operational procedures for DS/DR-TB pre-treatment support or treatment initiation.[34] In addition, the national community health worker (CHW) strategy does not enables government-supported CHWs to support TB activities. The only CHWs supporting DR-TB activities are funded by the Global Fund, however, CHWs are not expected to follow up on patients deemed lost to treatment.[35] Zero-enablers (financial support for DR-TB patients to start treatment) were missing in the initial design of GC6 Global Fund grants, and only added into grants in the third year of GC6.

[29] WHO 2023 Global Tuberculosis report – Page 2
[30] DR-TB Treatment gap - 39% (2021), 35% (2022) & 32% (2023)
[31] MDR/RR-TB treatment success rates increased from 47% (2019 cohort) to 56% (2021 cohort)
[32] WHO End TB Strategy: TB treatment success rate target is ≥ 90% of all notified TB cases (Accessed 17 Apr. 24)
[33] WHO estimated TB incidence increased from 312 (2019) to 385 (2022); DR TB incidence increased from 8.8 (2019) to 11 (2022) & TB mortality (HIV negative) increased from 34 (2019) to 49 (2022) - all per 100K population (WHO TB database Accessed 17 Apr. 24)
[34] No procedures on TB psychological counselling, patient tracking, nor prevention of patients not starting or continuing TB treatment
[35] Village CHWs/cadres supported via the Penabulu GC6 grants focus on contact investigation within the community presenting a missed opportunity to support in tracking those that do not start or complete treatment among TB index patients

Limited scale-up of DS/DR-TB treatment sites and low reporting of TB cases from private sector: In 2023, 27% of Indonesia's districts did not have an operational PMDT site.[36] At Puskesmas level, only 2%[37] of sites can initiate DR-TB treatment. 55%[38] of sites provide DR-TB treatment continuation services, despite the National Strategic Plan target of 100% by the end of 2024.[39] Furthermore, not all DR-TB priority districts are covered by community-based interventions, and regulatory constraints prevent a one-stop-shop approach for the diagnosis and treatment of TB at Puskesmas sites.[40] The low levels of private sector reporting on TB treatment[41] and the absence in the current PPM approach of a defined operation plan to expand the private sector role in TB diagnosis and treatment limits the opportunity to fully leverage the private sector to scale up TB services.

Weak monitoring and oversight: In 2022, only 50% of DR-TB patients on treatment were tested to follow up on treatment success. Completeness and accuracy of Monthly Interim Cohort Analysis (MICAs) for DR-TB is poor in the districts visited by the OIG [42]. MICAs for DS-TB are not conducted, despite being planned under the NSP. None of the sites visited by the OIG had evidence of supportive supervision from district levels, meaning treatment challenges cannot be routinely identified and addressed.

Fragmented data systems and patient data quality errors: Six different non-interoperable patient data recording systems were in use at service delivery points, increasing staff workload and the risk of inconsistencies and errors. 28% of sampled patients recorded as lost to follow up (LFTU) in the health management data system SITB were recorded as initiated on treatment, or transferred to other sites, according to patient case management system data. This results in an unclear picture of the true drop-off rate of TB treatment. Meanwhile, 52% of sampled records did not contain critical contact information about the patient e.g. phone contact and residential address. This limits the ability to follow up on patients to ensure adherence.

Low absorption for key TB programmatic activities as of December 2023 and sub-optimal quality of service: Under the Penabulu TB grant, there was low absorption for the provision of enablers, including zero enablers (38%) and incentives to providers for successful treatment (36%). For the MoH TB grant, there was low absorption for DR-TB cohort management (i.e. MICA - 19%), TB counselling training (46%) and district level monitoring and supervision (31%). This results in implementation challenges at service delivery point: at the sites visited by the OIG, only 32% of healthcare workers were trained on TB treatment and care, no sites were providing psychological counselling at the time of the site visit and only 11% were providing counselling on treatment adherence. In addition, there was no evidence of patient tracking for 79% of sampled records for patients who were either LTFU prior or during treatment.

These root causes will be addressed through Agreed Management Action (AMA) 2, except for fragmented data systems.

[36] Programmatic Management of DR-TB (PMDT) site
[37] Only 1.7% (175/10,453) of Puskesmas initiate DR-TB treatment. These 175 sites operate in a pilot to expand DR-TB services.
[38] 55% (5,760/10,453) of Puskesmas provide DR-TB treatment continuation
[39] The TB NSP target is for all Puskesmas to provide DR-TB treatment continuation by the end of 2024.
[40] All primary health facilities (Puskesmas) provide Directly Observed Therapy (DOT) services, MoH regulation No. 75/2014 restricts the placement of chest x-ray machines at Puskesmas limiting a "one-stop shop" approach for diagnosis and treatment of TB.
[41] In 2023, 3% (213/7695) of GPs, 12% (1193/9705) of private clinics & 81% (1428/1760) of private hospitals reported treated TB cases.
[42] MICA is a monthly district-level activity meant to increase treatment enrolment and adherence of all DR-TB patients residing in the district (KNCV). Only 50% (3/6) districts had completed MICA for 2023; all (6/6) districts had inaccurate MICA data (i.e. SITB vs MICA) & while 83% (5/6) of districts documented reasons for initial LTFU, these were not consistently done for all patients.

Agreed Management Action 2

The Global Fund Secretariat will work with the Ministry of Health and Penabulu STPI to strengthen the pre-treatment services and treatment initiation through:

1. The finalization of a DS treatment gap assessment to identify key mitigation actions, and development and approval of a costed operational plan to address priority gaps identified in the assessment including a national operational procedure for DS TB pre-treatment support and treatment initiation including the role of Community Health Worker (CHW)s to follow up on patients not linked to treatment.
2. The reduction of loss to follow-up of DR-TB by strengthening the implementation of patient-centered service of DRTB management and patient cohort monitoring and supervision, particularly in the aspect of DR-TB service quality.

OWNER: Head, Grant Management Division

DUE DATE: 31 December 2025

Declining Agreed Management Action on fragmentation of health information systems.

The Secretariat has declined an Agreed Management Action to support the National One Health Platform initiative to address this issue which included working with the Ministry of Health to develop an updated costed operational plan with clear timelines, milestones and roles and responsibilities. Instead, this activity will be supported and monitored through existing GC7 Technical Review Panel recommendations and Secretariat key mitigating actions that cover this work.

4.3 Positive trends in HIV testing and new prevention interventions, but insufficient treatment initiation and adherence limit effectiveness of program response

There has been a scale up of testing and treatment sites, as well as efforts to roll out effective prevention activities. However, suboptimal treatment initiation and retention contribute to stagnating HIV mortality and high prevalence in key population groups.

There are an estimated 515,455 People Living with HIV (PLHIV)[43] in Indonesia, with the epidemic concentrated within key populations.[44] The percentage of PLHIV who know their status increased from 44% in 2017 to 68%[45] in 2023. The number of HIV testing locations and treatment sites has grown, alongside efforts to roll out prevention and HIV testing practices, including PrEP and self-testing. Spiritia, one of the civil society organizations that receive HIV funding, implemented key activities in timely fashion, including Peer Supporters (PS) providing Lost to Follow Up (LTFU) services.

However, challenges in treatment initiation and high attrition of patients on ART persist. These are recurring issues from the 2019 OIG audit.

Gaps in ART initiation, weak linkages to treatment for key population groups, low treatment coverage in Papua, and high Lost to Follow Up rates

In 2023, 19% of newly diagnosed PLHIV were not initiated on treatment. For key population groups that self-test, the rate was 21%.[46] For the 2023 cohort of patients initiated on ART, 28% were LTFU after six months, while for the 2020 cohort this increased to 37% after 36 months, highlighting a worsening trend. In the Tana Papua region, where there is a general population epidemic, the LTFU rate is higher than the national average, alongside lower ART coverage at 25%. This has contributed to only 33%[47] of PLHIV being on ART in Indonesia, against the country's target of 95%. HIV prevalence is increasing amongst key population groups,[48] and the country is exposed to a higher risk of ART drug resistance.[49] Issues with treatment initiation and retention have contributed to the number of AIDS-related deaths returning to 2015 levels. UNAIDS estimates that there were 26,000 annual deaths in both 2015 and 2022: since 2010, deaths have increased by 60%.

Contributing factors for these issues include.

Lack of some national operational guidelines, systems, and processes: There are no detailed national operational guidelines for pre- & post-ART initiation activities and patient follow-up. This has led to low treatment initiation and high LTFU rates.[50] Furthermore, national definitions of LTFU are not aligned to international standards. WHO guidelines define a patient as LTFU if 28 days lapse without clinical contact after the last contact engagement, but national guidelines define this as 90 days. No national system or reporting has been established to track patients from diagnosis to ART initiation.

[43] https://www.unaids.org/en/regionscountries/countries/indonesia - Accessed: 06 May 2024
[44] Indonesia Integrated Bio-Behaviour Surveillance Survey 2023: Men who have Sex with Men (MSM) at 17.9%, Female Sex Workers (FSW) at 2.1%, Transgender Women (TGW) at 11.9%, and People Who Inject Drugs (PWID) at 13.7%
[45] HIV Program data from SIHA HMIS system
[46] Furthermore, 51% of key populations with reactive results from self-testing did not go through confirmation tests, meaning potentially higher numbers of PLHIV not linked to treatment.
[47] https://www.unaids.org/en/regionscountries/countries/indonesia (Accessed: 06 May 2024)
[48] Increased HIV prevalence for key populations 2018 vs 2023 IBBS – MSM 17.9% to 18.3%; TG 11.9% to 24.7%, PWID 13.7% to 17%
[49] UNAIDS: HIV & drug resistance (Accessed 16 Apr. 24)
[50] No evidence of efforts across sites visited by the OIG to initiate 50% of sampled HIV+ patients onto ART and no evidence to bring 60% of sampled patients who dropped off treatment after initiation back onto ART

Limited scale-up and implementation challenges in community health worker (CHW) response: There were no government-funded CHWs for HIV activities. The only CHWs implementing specific HIV activities are under the Global Fund civil society organization HIV grants, including peer supporters (PS) under the Spirita grant and outreach workers under the IAC grant. This leads to a high workload for the limited number of CHWs: across the 15 sites visited by the OIG, an average of three PS manage 187 clients each. This reduces the quality of service to beneficiaries. In addition, only 16% of health facilities working with PS have Memoranda of Understanding between the facility and PS. As a result, patient information is not regularly shared with PS to support tracking of patients, nor are outcomes of PS work consistently communicated back to facilities.[51] Finally, the mandate of outreach workers does not include supporting patients between diagnosis and ART initiation.[52]

Fragmented health management information systems and data challenges limit the ability to identify, track and report on LTFU: The GoI began to streamline and improve the HMIS landscape, enhancing systems' interoperability and integration. However, sites visited by the OIG still used multiple fragmented and non-interoperable electronic and manual systems. This leads to overburden for health workers who duplicate efforts to enter data into the multiple systems, increasing the risk of incomplete and inaccurate data. In addition, manual processes to identify patients not initiated on treatment or who were LTFU were used at all sites. This increases the risks of overlooking patients due to human error, with no systems to generate automatic alerts or exception reports, as is used by other countries. The primary national aggregate information system for HIV (SIHA 2.1) cannot generate automated routine reports on LTFU, and SIHA's data validation rules are not implemented, leading to data irregularities[53] at all sites visited. As a result of these issues, LTFU patients were underreported[54] by 32% in 2023 across all sites visited. In addition, 43% of sampled SIHA records for patients reported as not initiated on ART[55] and 13% of sampled SIHA records for patients reported as LTFU had errors.[56] Lastly, 40% of patients recorded as LTFU in SIHA did not have contact information for tracking.

Stigma, discrimination and delays in the implementation of key grant activities during GC6: Stigma, discrimination and the lack of legal protections for vulnerable groups is a significant barrier to patients seeking treatment in Indonesia. There is no legislation to protect groups from discriminating based on HIV status, sexual orientation, or gender identity. The Indonesian parliament also approved a new criminal code (Article 408) forbidding extramarital and premarital sex and limiting contraceptive promotion. Consequently, PLHIV are reluctant to visit health facilities, get tested and undergo treatment.[57] Several key interventions[58] under the MoH & IAC grants are meant to address stigma and discrimination but were not implemented. These include support to legal teams, advocacy to reduce stigma, and comprehensive sexual education, elements which have been included in the GC7 grant.

[51] LTFU patient information is irregularly and informally shared (i.e. verbally or via WhatsApp) with PS for tracking and/or conducting house visits. Similarly, the outcome of LTFU tracking activities is irregularly and informally communicated (i.e. verbally or via WhatsApp) to the HIV clinic staff, making it difficult to evaluate the completeness and adequacy of tracking efforts.
[52] The mandate of CHW outreach workers ends when a person is referred to testing & the mandate of PS only starts after ART initiation
[53] Instances of patients' ART initiation dates recorded as before HIV+ diagnosis date at all sites visited that used SIHA 2.1.
[54] When comparing results in the national aggregate information system for HIV/AIDs (SIHA) and patient case management records
[55] 43% of sampled patients reported as not initiated on ART in SIHA, reported as on treatment, had been transferred to other sites or had HIV results in the patient case management system records at the facility level.
[56] 13% of sampled LTFU patients' records had errors - where the patients had died, were still on treatment, or had been transferred to other sites but were reported as LTFU
[57] 2020 Stigma Index survey which also noted nonconsensual disclosure and discrimination, particularly in healthcare advice to female PLHIV about refraining from sex (HIV clinics 11.3%, non-HIV clinics 9.3%)
[58] Includes comprehensive sexuality education, advocacy with law enforcement and medical schools for HIV, gender, and human rights inclusion; engagement with public figures to reduce stigma and e-learning for paralegals and development of rights-based materials.

Agreed Management Action 3

The Global Fund Secretariat will work with the PRs (MOH, SPIRITI, IAC), in coordination with the TWG and CCM to:

1. Develop national operational guidelines for pre- & post-ART initiation activities and patient follow-up and re-define the LTFU to be aligned with WHO for better adherence on treatment
2. Develop a costed action plan to strengthen coordination between community implementers and health facilities to improve linkages of prevention services to care, address LTFU, accelerate PrEP scale up and VL testing. This will include exploring additional operational modalities to strengthen differentiated services and provide PrEP or ART at community level.

OWNER: Head, Grant Management Division

DUE DATE: 30 June 2025

4.4 Robust financial management and controls for living support costs and incentive payments, but delayed implementation of C19RM-funded activities

Penabulu and MoH established strong financial controls to safeguard living support and payment for results expenditures. However, delays in planning and deploying COVID-19 Response Mechanism-funded diagnostic equipment has hampered the effective utilization of C19RM funds.

Robust financial management processes and controls have been established under the MoH and Konsorsium Komunitas PENABULU-STPI (PBSTPI) grants to safeguard investments in living support payments to beneficiaries[59] and incentive payments to implementing entities,[60] with US$55 million[61] expensed during GC6. No material issues were found in terms of unsupported expenditure or instances of expenditure outside of budget requirements from the OIG sample of transactions. This is due to well-designed and implemented financial management systems, comprehensive financial management manuals, and adequate human resources for financial management. In addition, strong communication and oversight across Principal Recipients, sub-recipients and sub-sub recipients were noted, as well as the use of cashless payments through bank transfers to reduce risks and strengthen controls. UNDP financial management technical assistance was provided to the MoH to strengthen MoH capacity, funded by the Global Fund.

In addition, strong financial absorption and implementation of C19RM funds under the malaria grants was noted, linked to efforts to proactively transfer and re-program funds. However, challenges persist in the timely absorption and implementation of C19RM funds under the TB and HIV grants.

Delayed implementation of C19RM-funded activities under the MoH TB and HIV grants affects the country's diagnostic capacity

There have been significant delays in utilizing C19RM funds under the MoH TB and HIV grants to strengthen diagnosis and monitoring. These funds were meant to procure diagnostic equipment (Whole Genome Sequencers, or WGS)[62] and portable Chest X-rays (CXRs), and to contract private suppliers for TB active case finding (ACF) activities. These would help improve the identification of TB cases in the community and disease surveillance.

The procurement process had been heavily delayed by over 16 months, resulting in only partial delivery of WGS to the country, no delivery of CXR equipment, and no activities implemented under the private supplier contracting for active case finding, as of the end of the GC6 grant. This negatively impacted ACF implementation and limited TB community screening, as evidenced through the low absorption (10%)[61] of ACF incentives under the TB grant. This work is critical for the timely identification of TB cases, without which there is an increased TB transmission risk. Accordingly, a 29%[63] increase in TB case estimates from 2020 to 2022 has been observed.

[59] Cost Category 12: Living Support to Client/Target Population – covers supporting MDR patients throughout the duration of treatment, including expenses to support patients and their families to ensure completion of treatment and cover any related costs.
[60] Cost Category 13: Payment for Results - incentive payments - covers result-based payments to health facility staff managing DR-TB patients e.g. payments for enrolling a diagnosed patient into care and following up until the treatment is completed.
[61] Per unvalidated Global Fund progress update for 31 December 2023
[62] WGS can support disease surveillance in terms of mutations, monitoring drug resistance, transmission patterns and identifying appropriate ART regimes. It can also be used for MDR-TB diagnosis. Delays in use of WGS can limit the National Program's ability to develop a more effective approach to tackling HIV and TB.
[63] WHO TB website (Estimated TB cases were 1,060,000 in 2022 and 824,000 in 2020)

There is also the ongoing risk of C19RM funding not being fully utilized. Absorption was at 28% and 20% for the Ministry of Health TB and HIV grants as of December 2023[64]. There is a risk of continual low absorption, as an additional US$20 million of C19RM funding was approved in December 2023, despite US$42m remaining unspent as of December 2023.

There are several root causes for the delays in procurement and contracting:

- For WGS, as a new technology, this required additional time for the MoH to obtain regulatory sign-off, assess sites, and confirm site selection. However, there were delays in MoH requests to launch the procurement process.
- For CXR, there were delays in the selection of sites by the MoH which was required to initiate the UNDP procurement process. As of the time of the audit fieldwork, the MoH site selection had not been completed and there was no agreed timeline to finalize this process. This is linked to a lack of prioritization by the Ministry of Health to support these activities and limited coordination amongst different government entities.

No Agreed Management Action (AMA) has been proposed by the Global Fund Secretariat for this finding given the immateriality of findings related to financial management and the expected increases in C19RM related deliveries that are planned for the current period of implementation.

[64] The in-country absorption rates as of 31 December 2023 reflects the procurements which were fully executed, delivered and transferred to the Government of Indonesia. However, at this time, there were a large of procurements with approved purchase orders that were yet to be fully executed, delivered and transfered. When these purchases orders are transferred to Government it would increase in-country absorption to 60.5% for the TB grant and 77% for the HIV grant. However, the OIG does not have visibility on when these would be fulfilled and expensed.

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[65], 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 Indonesia: comparison of OIG and Secretariat risk levels

The updated Secretariat risk levels assessment (November 2023) is aligned with the OIG audit rating except for:

Health Financing: For GC6, this risk was not rated and reported by the Secretariat. For GC7, as of February 2024, the risk was rated as 'Moderate'. The OIG rate this risk as 'High'. This was due to the findings raised on gaps in sustainability and transition planning and in the assessment of co-financing requirements in GC6 as well as issues in the timely monitoring and reporting for co-financing (see Findings 4.1). After the OIG audit fieldwork, in May 2024, the Secretariat performed a comprehensive review of risk ratings and increased the rating of Health Financing to "High".

[65] Risk Appetite Framework,