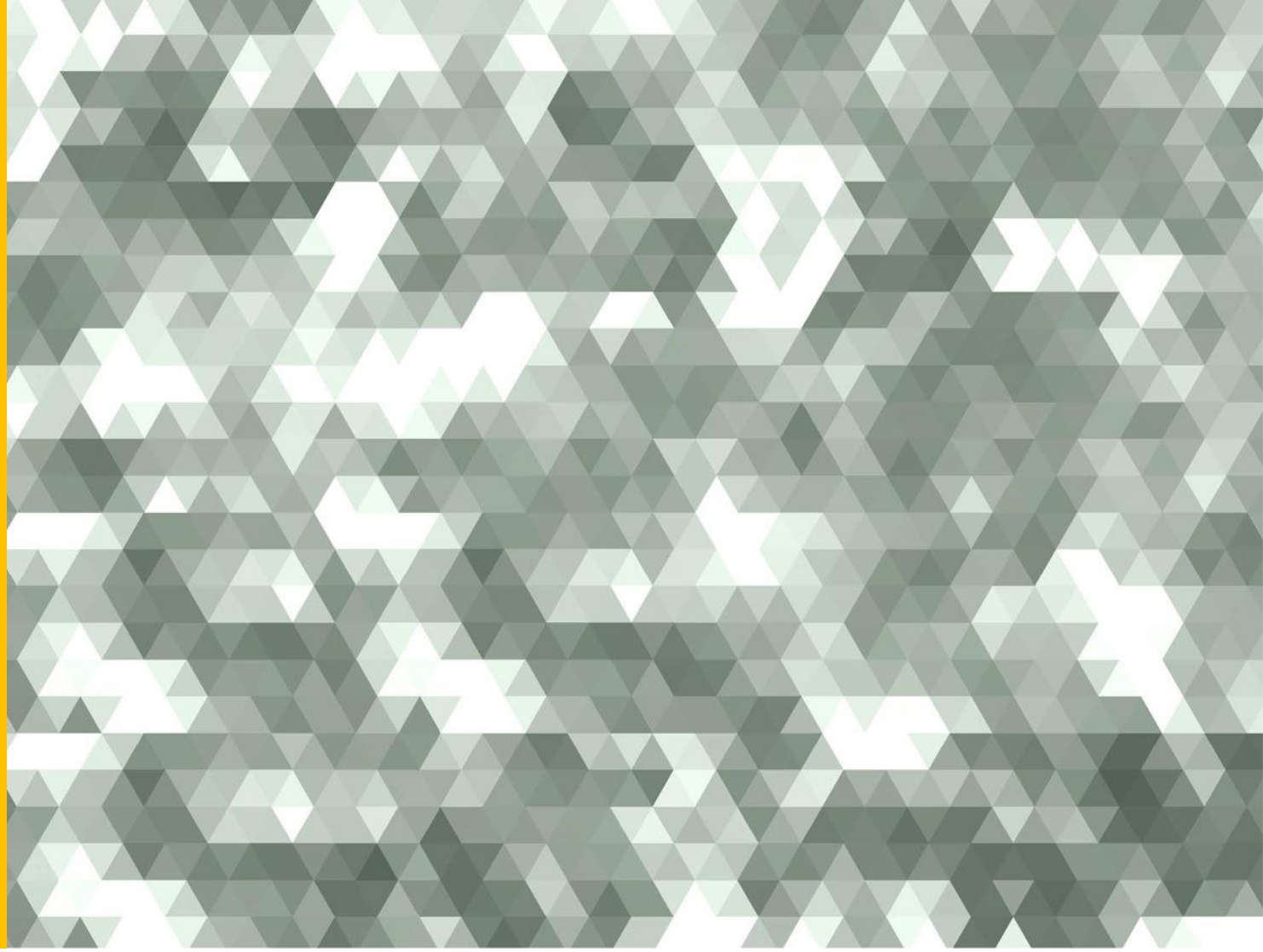

Audit Report

Global Fund Grants to the Republic of South Africa

GF-OIG-17-014
19 July 2017
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1. Opinion

South Africa has the largest number of people living with HIV and the world's largest HIV treatment program.[1] In 2016 it ranked sixth in the world in terms of numbers of people with tuberculosis (TB), with the disease as the leading cause of death.[2] The country is one of the Global Fund's 'high impact' countries (cf section 2.2), with signed grants of US$312 million for the period 2016-2019.

New program activities, such as those with a particular focus on adolescent girls and young women, and innovative approaches, for example, the 'social impact bond', a program aimed at raising additional funding, have been introduced under the current grants. If successful, these will provide the country with additional options to address the HIV and TB epidemics and lessons learned for other countries to follow. The audit was undertaken nine months into the new grant implementation cycle. As such, data to gauge program effectiveness remains limited. However, given the significance of the country's innovative approach, the audit was undertaken earlier in the grant cycle so as to identify key implementation challenges, draw some initial lessons and, where necessary, consider potential course corrections in a timely manner. Certain aspects of grant implementation are significantly behind schedule which can, in part, be attributed to start up challenges. However, the audit also identified other risk factors inherent to the design of the grant activities, which are affecting performance. These areas need to be addressed if the program is to achieve its overall objectives i.e. to address the HIV and TB challenges affecting adolescent girls, young women and other vulnerable populations, inmates and peri-mining communities, treatment support and adherence, men who have sex with men and transgender programs. These represent 32%, 18%, 16% and 5% of the overall signed grant respectively.

The principal message of this report is that the programs are well aligned to the country's needs, as reflected in the national strategic plans, and that the Global Fund's strategies target the right areas; however, weaknesses in design exist that need to be addressed if the programs are to deliver on the stated objectives. **Significant improvement is needed** in the design of systems, processes and controls of funded interventions, monitoring and evaluation frameworks as well as current implementation arrangements that support the achievement of grant objectives. As it is still too premature to conclude on the effectiveness of the current grant program, this rating only concerns the design of the program activities and the implementation approach. It means that a few significant issues were noted which prevent the OIG from giving reasonable assurance that the program objectives will be met until they are addressed. Once these weaknesses are addressed and the required improvements made, the programs should be on track to achieve their objectives.

The internal control environment to ensure that grant funds are spent in an economic, efficient and effective manner is rated **partially effective.** Key risks to the achievement of the grant objectives are elaborated in the key issues and risks section below.

1.2. Key achievements and good practices

Global Fund programs have identified and focus on critical interventions although the Global Fund's financial contribution is limited in relation to the overall national health budget. The South African government funds approximately 80% of the AIDS response and the Global Fund 5% of the overall contribution to HIV and TB funding. Global Fund programs focus on key populations such as sex workers, men who have sex with men, as well as adolescent girls and young women, with

[1] In line with the 2015 WHO guidelines, test and treat interventions are built around two main components: HIV counselling and testing of all to identify those already infected with HIV or diagnosed but not yet linked to treatment and initiation of life-long antiretroviral treatment as soon as possible after HIV diagnosis, regardless of CD4 count. These guidelines were adopted in September 2016.
[2] TB is the leading cause of death in South Africa. Accounting for 7.2% and 8.1% of deaths in all age groups and those aged 15-24 respectively and contributes 7.2% of the national deaths

reported infection rates of up to 59%, 34% and 18%, respectively. These targeted interventions present an opportunity for the Global Fund to achieve impact and contribute significantly to the reduction of infection and death rates.

Global Fund interventions are well-aligned to the country's 2012-2016 and 2017-2022 national strategic plans as well as the national HIV and TB investment case.[3] The South Africa Country Coordinating Mechanism (CCM) sits within the South Africa AIDS National Council (SANAC)[4] structure, which is responsible for coordinating the multi-sectoral response to HIV. Consequently, as designed, funded interventions are aligned to other existing Government, development partners and Global Fund regional interventions to ensure complementarity.

Selected interventions are designed based on evidence. Conceptually, most interventions are comprehensive, technically sound, strategically focused on relevant key populations and informed by use of available epidemiological and programmatic data. The interventions also include innovative approaches such as the social impact bond program. The combination of evidence-based interventions and innovative approaches means that Global Fund interventions could be transformative. The interventions, if successful, could help leverage and provide the country with additional resource mobilization and programmatic options to address the dual heavy HIV and TB epidemics in South Africa.

Programs are managed by both national and civil society implementers. The most recent Principal Recipient selection process generally complied with the set criteria. Grants are implemented by eight government and non-governmental organizations. National implementers focus on setting policies which foster country ownership and build capacity for national partners in the long term. South Africa's vibrant civil society holds the political leadership to account. For example, a strong civil society voice was instrumental in championing the adoption and subsequent expansion of anti-retroviral therapy, in the absence of initial support from the national government. Civil society has also advocated effectively for increased government funding for the national response to HIV and TB.

1.3. Key Issues and Risks

Grant activities are not delivered as designed, which compromises service quality, particularly for the TB program. Although the concept note is sound, the key challenges for the South Africa program lie in the actual delivery of interventions that focus on key populations and new program elements. Catch-up plans have been developed by implementers but had not yet been approved by the CCM at the time of the audit. The audit verified results reported as at 31 December 2016 which were the latest results available at the time of the audit. Challenges were noted in the following areas:

Prioritization of TB programs. Although 18% of Global Fund investments in the current cycle are earmarked to contribute to preventing, treating or mitigating the impact of TB and multi-drug resistant TB (MDR-TB) in the country, low achievement of program results has been reported so far. While actual implementation of the TB program activities under the current grant began in July 2016, and costs have been charged to the grant since April 2016, some grant indicators reflect a 0% achievement as of 31 December 2016. This is mainly due to gaps in the management of the TB program at the national and implementer levels in the planning and delivery of key program activities. Interventions for adolescents and youth in and out of school, as currently implemented, do not have a sufficient focus on TB although these demographic groups are estimated to account for between 15%-20% of notified TB cases in the country.

[3] The investment case is the support the country provides to donors in the HIV and TB programs
[4] SANAC is a multi-sectoral body consisting of 38% government representation and 72% non-governmental organizations that develops implementation strategies, coordinates and monitors the multi-sectoral national response to HIV/AIDS.

Translation of the concept note into implementation for coverage, scope and content. Newly designed interventions may call for changes to be made as lessons are learned and unforeseen implementation challenges become known. However, the audit identified several changes in coverage, scope and content that were neither reviewed by the CCM nor the Secretariat to evaluate the implications on desired targets, value for money and overall program objectives. These changes include:

- a reduction in geographic coverage of interventions addressing treatment adherence from 31 to 21 districts and HIV and TB-related stigma from 18 to 6 districts;
- removal from the TB program of nutrition packages, which improve retention on treatment and adherence;
- patients in adherence clubs not being moved to communities, as intended, in order to decongest facilities and reduce health worker load;
- community systems strengthening interventions are not focused on training organizations that support core grant activities; and
- a reduction in the number of modules and hours per module in prevention packages for adolescent and youth.

Whilst ongoing adjustments and course corrections are inherent to the nature of innovative interventions and critical to their success, effective change management processes are necessary to evaluate upfront the program impact of significant changes and to ensure overall objectives can still be achieved.

Definition of program quality standards. Standards for quality have not been defined for the adolescents/youth programs and key populations,[5] leading to inconsistent delivery of modules by implementers. While standards for HIV testing services are in place, most third party service providers have not undertaken the required proficiency testing, which raises questions on the quality of HIV testing services being provided.

Difficulties in measuring grant performance due to weak monitoring tools. Good quality data is important for the accountability and effective monitoring of grant interventions. This is particularly the case for new grant interventions such as in the South African portfolio. *At a national level*, which is beyond the control of the Global Fund program, there is no national monitoring and evaluation plan under the 2012-2016 National Strategic Plan to provide guidance for measurement. Monitoring and evaluation plan under the new 2017-2022 plan are yet to be finalized. *At the program level*, the indicator definitions for key program activities have not been clarified in the current performance framework. International technical partners have not defined package services nor developed guidance for adolescents and young people related measurement tools. Consequently, standards are needed to ensure that results are consistently measured for related activities. There is also a multiplicity of uncoordinated data systems and tools across the various implementers. For other interventions, the OIG noted inconsistent monitoring and supervision and limited validation of any errors in reported data.

Many grant recipients limit effective program implementation, coordination and make oversight difficult. While the Principal Recipient selection process followed set criteria, challenges noted in the implementation arrangements under the current program emanate, in part, from lack of clarity in that criteria. For instance, the appropriate number of Principal Recipients required to implement programs was not defined. This resulted in the selection of eight Principal Recipients to implement different program components, without mechanisms to ensure consistency and quality across similar activities. This is particularly an issue in activities for adolescents and youth that are implemented by six different implementers, all of which operate to different standards and quality. Program interventions have been allocated to Principal Recipients without taking sufficiently into account core technical competencies and geographic presence in the areas of program delivery. As a result, many of the implementers spent most of the first year of grant

[5] Standards have not been defined for key populations including sex workers, men who have sex with men and people who inject drugs

implementation setting up operations, learning about the new interventions, and trying to obtain from various provinces the necessary approvals to begin grant activities.

Coordination is necessary across the Principal Recipients that are implementing similar or related interventions, as well as with other key stakeholders in the overall program, such as government (at national, provincial and district levels) and development partners. Coordination mechanisms are still at a nascent stage and therefore it is difficult to minimize any gaps or duplications. Synergies have yet to be established across the relevant programs, such as linking people diagnosed positive in the testing programs to the parallel treatment and care programs.

Oversight and assurance are not aligned to the highest risks. In 2016, the Secretariat, with the support of country stakeholders, developed a key risk matrix that outlines risks which, if not mitigated, would affect the delivery of programs. The risk matrix for South Africa did not identify key risks related to quality standards, appropriateness of indicators and adequacy of the sub-recipients budgets to deliver program activities. Assurance arrangements at the country level provide adequate assurance over finance risks; however, oversight and assurance over risks related to program delivery need to be strengthened.

Corrective actions underway: The Country Coordinating Mechanism acknowledged the risks identified in the report. It has committed, through a detailed plan, to address the different issues related to governance, oversight and management; implementation delays and challenges (including quality of programs); and monitoring and evaluation. The agreed management actions proposed by the Secretariat build on these commitments in ensuring that root causes are addressed and that the program stays on track to achieve stated objectives.

1.4. Rating

Objective 1. The systems, processes and controls of funded interventions are designed to deliver quality services to intended beneficiaries.
Needs significant improvement. Grants have not been delivered as designed in the concept note and this may compromise the quality of service delivered to beneficiaries, particularly in the TB program. The availability and quality of TB and drug resistant TB services have also been negatively impacted by weaknesses in the implementation of grant activities. Program implementation has also been affected by insufficient prioritisation and lack of quality standards.
Objective 2. Monitoring and evaluation frameworks in place are able to measure grant performance
Needs significant improvement. Programs managers do not have accurate and timely data for decision-making. This is due to deficiencies in the established indicators used in the performance frameworks to measure grant performance. Deficiencies also exist in the systems used to collect, report and assure quality of data which raises the risk of double counting of beneficiaries. A limited sample of data verified during the audit identified significant errors in the information reported to the Global Fund.
Objective 3. Current implementation arrangements support the achievement of grant objectives.
Needs significant improvement. There is insufficient coordination and oversight arrangements over the funded interventions specifically for TB and drug resistant TB, adolescents and young women interventions and the social impact bond innovation. As a result, key risks that impact the achievement of grant objectives were not identified and mitigated in a timely manner. This has resulted in delayed program implementation which affects the availability of services for intended beneficiaries.
Objective 4. The internal control environment ensures that grant funds are spent in an economic, efficient and effective manner.
Partially effective. The design of the internal control environment over grant funds provides adequate assurance over financial risks. However, delays in program implementation, inadequate

work planning and budgeting for some interventions resulted in inefficient and ineffective use of grant funds in the first year.

1.5. Summary of Agreed Management Actions

The Global Fund Secretariat has plans to address the above weaknesses including the following actions: developing revised budgets and implementation arrangements for the remaining duration of the grants to improve the availability and quality of TB and drug resistant TB services; by supporting the Principal Recipients in the development of quality standards for adolescent girls and young women and revisiting the work plans; strengthening Country Coordinating Mechanism oversight, rolling out a revised consolidated performance framework for interventions related to adolescents and young people in and out of school.

2. Background and Context

2.1. Overall Context

South Africa is an upper middle income country with a population of 55 million people.[6] Politically, the country has three levels of government, national, provincial and municipal. The national government sets policy and provincial governments are responsible for implementing them. The provincial governments operate relatively independently from the national programs. As a result the national level only has limited influence over what the provincial governments do.

South Africa is the third largest economy in Africa[7] with a gross domestic product per capita estimated at US$13,200 in 2016. However, its economic growth has weakened over the past five years.[8] At the time of the audit, South Africa's creditworthiness was lowered and may affect its ability to borrow.[9] South Africa's upper middle income status also masks high levels of inequality and poverty:[10]

- Unemployment is a significant challenge at 26.5% as of December 2016. This rate is even higher among 20-24 year-olds and women, at 47% and 50%, respectively.[11]
- About 40% of the population lives below the poverty line of US$30.[12] South Africa has one of the highest inequality rates in the world, with large disparities across population groups as well as between urban and rural communities. For example, almost 50% of the black population live below the national poverty line, compared with only 2% of the white population.[13] The government is committed to narrowing this income gap through a set of comprehensive policy measures such as black economic empowerment and skills development.
- South Africa's professional density, reported at 58.8 per 10,000[14] of the population in 2015, masks a shortage of skilled health workers in the public sector. The available health resources are unequally distributed with only 30% in the public sector where 84% of the population seek health services.[15]
- South Africa ranks 61 out of 168 countries in the 2015 Transparency International Corruption Perceptions Index.[16]

2.2. Differentiation category for country audits

The Global Fund has classified the countries in which it finances programs into three overall portfolio categories: focused, core and high impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics. Countries can also be classed into two cross-cutting categories: Challenging Operating Environments and those placed under the Additional Safeguard Policy. Challenging Operating Environments are countries or regions characterized by weak governance, poor access to health services, and manmade or natural crises. The Additional Safeguard Policy is a set of extra measures that the Global Fund can put in place to strengthen fiscal and oversight controls in a particularly risky environment.

South Africa accounts for 18.9% and 6.9% of the global HIV and TB burdens respectively.

[6] Word Bank data http://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZA
[7] The World Fact Book https://www.cia.gov/library/publications/the-world-factbook/geos/sf.html
[8] National treasury (2017) Budget review.
[9] Standard and Poor's downgraded South Africa's foreign debt to junk status
[10] Statistics South Africa, Community Survey (CS) 2016 report
[11] Statistics South Africa Labor Force Survey Q4, 2016
[12] The World Bank http://data.worldbank.org/indicator/SI.POV.GINI. Population poverty line is ZAR 416 (Exchange rate 1USD to 13)
[13] Per the statistics SA Poverty Trends in South Africa (2014) report the country's Gini-coefficient is 0.66. The Gini coefficient is the measure of income inequality, ranging from 0 to 1. 0 is a perfectly equal society and a value of 1 represents a perfectly unequal society.
[14] 23 health workers (doctors, nurses, midwives) per 10 000 people - the minimum required as per WHO standards http://www.who.int/hrh/resources/strengthening_hw/en/
[15] Health Systems Trust (2015) South Africa Health Review
[16] Transparency International Corruption Perception Index (the higher the score, the higher the perceived level of corruption).

The Global Fund has classified South Africa as a **High Impact** country. This is based on the 2014/2016 allocation which resulted in signed grants amounting to US$312 million for HIV and TB.

	Focused: (Smaller portfolios, lower disease burden, lower mission risk)
	Core: (Larger portfolios, higher disease burden, higher risk)
X	**High Impact: (Very large portfolio, mission critical disease burden)**

	Challenging Operating Environment
	Additional Safeguard Policy

2.3. Global Fund grants in South Africa

The South Africa government is the largest investor in the national HIV response, providing 78% of funding, followed by the United States Government (17%) and the Global Fund (5%)[17] for critical programmatic areas (see Annex C for further details on the types of interventions supported by the Global Fund). The Government provides 91% of funding for TB, with other donor sources, including the Global Fund, providing the rest. In the 2017/18 financial year, the Government has allocated conditional grant funding of US$1.336 billion for HIV and TB, expected to increase to US$1.516 billion and US$1.676 billion in the 2018/19 and 2019/20 respectively.[18]

The country's adoption of UNAIDS 90-90-90 treatment targets[19] is expected to have the most significant impact on HIV and TB infections and life years saved. However, it also comes with a steadily increasing need for investment in HIV and TB programs, starting in 2016/17. The country has also increased funding for screening campaigns to ensure early detection and treatment of TB. However, given the country's constrained fiscal space, future increases in HIV and TB treatment costs may consume an increasing share of the health budget.

Global Fund investments in South Africa 2004-2019:

Since 2004, the Global Fund has signed cumulative grants worth US$950 million, US$706 million of which had been disbursed to the country at the time of the audit (31 December 2016). For the current allocation cycle, from April 2016 to March 2019, the following grants have been signed:

Principal Recipient	Grant Number	Grant Signed Amount (USD)	Grant Disbursed Amount (USD)
National Department of Health (NDOH)	ZAF-C-NDOH	129,283,633	30,348,068
Networking HIV and AIDS Community of Southern Africa (NACOSA)	ZAF-C-NACOSA	43,478,862	9,305,475
Right to Care (RTC)	ZAF-C-RTC	36,605,560	5,004,587
KwaZulu-Natal Treasury (KZN)	ZAF-C-KZN	31,676,308	1,345,559
Khet'Impilo (KI)	ZAF-C-KHETH	20,246,415	1,474,709
Western Cape Department of Health (WCDOH)	ZAF-C-WCDOH	17,383,597	1,769,078
The Soul City Institute for Health and Development Communication (SCI)	ZAF-C-SCI	16,886,614	3,935,010
AIDs Foundation of South Africa (AFSA)	ZAF-C-AFSA	16,383,562	2,893,120
Total		**311,944,551**	**56,075,606**

[17] 2016 Pepfar Country Operational Plan.
[18] Division of Revenue Bill published in Government Gazette No. 40610 of 10 February 2017
[19] 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression by 2020.

2.4. HIV and tuberculosis in South Africa

HIV/AIDS: South Africa has a generalized, hyper endemic HIV epidemic, and is home to the largest number of people living with HIV in the world (PLHIV). HIV prevalence varies considerably across provinces from 5% in the Western Cape to 16.9% in KwaZulu-Natal. 1 in 20 people who died in in 2015 in the country, died from AIDS.[20]

Adolescent girls (15-19) are eight times more likely to be living with HIV than boys in the same age group, and young women (20-24) three times likely. Young women aged 15-24 account for 25% of all new infections. Key populations including female sex workers (FSW), People Who Inject Drugs (PWID) and Men who have sex with Men (MSM) are also disproportionately affected with reported prevalence rates from 14% to 71.8% among them.

South Africa has the world's largest HIV treatment programme that is being implemented in line with the latest World Health Organization guidelines on HIV treatment.[21] HIV has been integrated into funded TB interventions and TB in HIV treatment care and support interventions.

Number of PLHIV: 7,000,000[22]

3.9 million People on antiretroviral treatment[23]

HIV prevalence

General population: 19.2%;

FSWs: From 39.7% to 71.8%[24].

PWID: 14%[25]

MSM: range from 22.3% to 48.2%[26]

Tuberculosis:[27] South Africa ranked sixth in the world in terms of number of people with TB in 2016 down from third place in 2013. TB is the leading cause of death in the country accounting for 7.2% of deaths among all age groups and 8.1% of all deaths among those aged 15-24.

The TB case notification rate was 454/100,000 population in 2015. Preliminary analysis of 2016 electronic tuberculosis register data suggests that this has risen significantly to 529/100,000. At the time of the audit, the country was in the process of undertaking a national TB prevalence survey that will provide more robust estimates of TB incidence in the country. The 4 provinces of Gauteng, Eastern Cape, Western Cape and KwaZulu-Natal account for 72% of all notified cases in the country.

With an estimated 10,000 MDR-TB cases in 2015, South Africa is ranked 10th among high burden MDR TB countries. However, prompt access to appropriate treatment and achieving successful outcomes continues to be a challenge since 38% and 36% of diagnosed MDR-TB were not initiated on treatment in 2014 and 2015 respectively. A widespread epidemic of XDR TB is occurring in South Africa, where cases have increased by a factor of 10 since 2002, the majority of which are estimated to be due to transmission rather than to treatment of MDR-TB.[28] Treatment success rates for XDR are 24% vs a global average of 28%.

Treatment success rates for drug sensitive TB was 78% at the end of 2014. However, the less than optimal outcome for this indicator were driven by primarily by 9 districts that reported lost to follow up rates of 9.2% to 15.7% respectively.[29]

TB cases notified: 294, 603

TB incidence: 454 per 100,000

Treatment Success Rate drug sensitive TB: 78%

Treatment Success Rate drug resistant TB: 48%

TB contribution to national Mortality: 7.2%

[20] STATSA (2017) Mortality and causes of death in South Africa, 2015: Findings from death notification
[21] 2015 WHO guidelines Test and Treat all already infected with HIV or diagnosed regardless of CD4 count
[22] UNAIDS (2015) estimate http://www.unaids.org/en/regionscountries/countries/southafrica/
[23] Local Fund Agent verified as at 30 August 2016
[24] South African Health Monitoring Survey (2013-14) of FSW in the country's metropolitan areas of Johannesburg, Cape Town and Durban
[25] Scheibe et al (2016) HIV prevalence and risk among people who inject drugs in five South African cities. Int J Drug Policy. 2016 Apr;30:107-15. doi: 10.1016/j.drugpo.2016.01.004
[26] HSRC (2014). The South African Marang Men's Project. HIV bio-behavioural surveys conducted among MSM in Cape Town, Durban and Johannesburg. Page 32
[27] Global TB report (2016) with the exception 2016 TB case notification. 2014 treatment success data from NDOH TB annual reports
[28] Shah et al (2017) Transmission of Extensively Drug-Resistant Tuberculosis in South Africa. NEJM 376:243-253
[29] NDOH TB program 2015 Annual report -Buffalo City, Sarah Bartmaan (EC); Namakwa and ZF Mgcawa (NC); Cape Town, Cape winelands, Eden, Central Karoo and West Coast.

3. The audit at a glance

3.1. Objectives

The audit sought to provide reasonable assurance on the adequacy and the effectiveness of Global Fund grants to the Republic of South Africa in supporting the achievement of impact in the country. Specifically the audit assessed whether:

i. the systems, processes and controls of funded interventions are designed to deliver quality services to intended beneficiaries;
ii. monitoring and evaluation frameworks in place are able to measure grant performance;
iii. current implementation arrangements support the achievement of grant objectives; and
iv. the internal control environment ensures that grant funds are spent in an economic, efficient and effective manner.

3.2. Scope

The audit covered the eight Principal Recipients (cf. above Section 2.3) and a sample of their sub-recipients and sub-sub-recipients. It also covered governance, oversight and assurance mechanisms over the South Africa grant portfolio.

The audit covered January 2015 to December 2016 with a primary focus on grants that are currently under implementation. These grants started officially in April 2016 although most Principal Recipients started actual program implementation three to six months later. Given the significance of the country's innovative approach, the country was audited relatively early in the grant cycle so as to identify key implementation challenges, draw some initial lessons and, where necessary, consider potential course corrections in a timely manner.

3.3. Progress on previously identified issues

The OIG last reviewed this portfolio in 2011 with a "diagnostic review" of four Principal Recipients. This year's audit noted improvements in the financial management of the portfolio and in the structure and engagement of CCM members.

Previous relevant OIG audit work

GF-OIG-11-013; Diagnostic Review of Global Fund Grants to South Africa

However, the following challenges that were noted in the earlier diagnostic review still remain:

- *translation of concept note to implementation* in scope and content to ensure interventions are implemented as designed;
- *management of sub-recipients,* especially within the government implementers and specifically with regards to ensuring a transparent selection process supported by adequate monitoring and supervision;
- *governance* at the CCM level, with unresolved issues related to conflicts of interest within the governance structure and clarity of roles for SANAC, CCM and their secretariats; and
- *data quality and data quality assurance arrangements*, as programs have continued to be impacted by the lack of a national monitoring and evaluation plan to provide guidance for measurement of progress towards the national strategic plan objectives.

4. Detailed findings

4.1. Availability and quality of TB and MDR-TB services impacted by suboptimal implementation of grant activities

Under the current program, the Global Fund has identified prison inmates, peri-mining communities and informal settlements as key populations that needed to be reached for grants to have the most impact. The grant also provides approximately 50% of the required funding for the first prevalence survey which will ascertain the TB burden. However, progress in the implementation of program components related to the prevention, diagnosis and treatment of TB and MDR-TB has been slow. The following challenges in the implementation of funded program activities, if unaddressed, may affect the achievement of the program's objectives.

(i) Delayed implementation of program activities affecting availability of services to intended beneficiaries.

- While activities related to reaching inmates with a comprehensive package had started, only 4,638 out of the 36,528 targeted had been reached by December 2016.[30]
- There are delays in identifying service providers for community mobilization, which the Principal Recipient attributed to changes in the implementation model. Community mobilization is a critical precursor for program activities in targeted communities, and has affected the programs' ability to reach targets. Consequently, in December 2016, none of the intended beneficiaries in peri-mining communities and informal settlement areas had been reached with a comprehensive TB/HIV and sexual transmission infection prevention package, which is a missed opportunity to identify and treat TB cases.
- The training of 3,500 lay counsellors to provide adherence support to patients in adherence clubs had not started by the end of December 2016.[31] This has impacted the establishment of clubs and their roll out to communities as anticipated. Consequently the targeted 245,000 people living with HIV have not received this support in year one.

(ii) Reallocation of funds earmarked for supplementary nutrition for impoverished patients on TB and MDR-TB treatment to travel and related costs.

At the time of the audit, the Principal Recipient had reallocated US$2.7 million originally earmarked for supplementary nutrition to travel and other related costs without making alternative arrangements for the intended beneficiaries. Nor did it obtain approval from the CCM[32] or Secretariat. As a result, 18,000 TB and MDR-TB patients will not receive this support although poor nutrition has been identified as a major barrier to adherence and retention on treatment among impoverished patients with TB and MDR-TB in the country.

(iii) **Delays in the national TB prevalence survey affecting the identification and prioritisation of hotspots for delivery of TB and MDR-TB interventions.**

Contrary to what was envisioned in the concept note, survey data is unlikely to be available before the end of the grant period to inform a more targeted selection of TB hotspots for funded interventions.[33] The Principal Recipient attributed this to delays in identifying relevant partners to undertake the survey as well as mobilizing all the funding required for the survey. In the absence of this information, community focused TB and MDR-TB interventions are not targeted which has

[30] Subsequent to the audit, the program reported that in three months (January to March 2017), it reached and surpassed the annual target of 36,528 (70,130 reported as reached). These results were not verified as part of the audit nor by the Local Fund Agent.
[31] Subsequent to the audit i.e. April 2017, the Principal Recipient has reported that all materials have been printed and training undertaken.
[32] Subsequent to the audit, the Principal recipient revisited the budgets for the SSR and $2.2 million has been reinstated for supplementary nutrition. The changes have been reviewed by CCM
[33] The Concept Note identified the conduct of the survey as a critical to enable prioritisation of reponses to TB: Page 17 paragraph three in the section of context for Health Systems Strengthening

resulted in low yields of 0.5% i.e. tests not identifying sufficient numbers of people with the disease. This low positivity raises questions as to whether the interventions are focused on the right geographical areas to maximise the identification of TB and MDR-TB cases or, alternatively, whether the challenges noted in case findings arise from inappropriate programmatic approaches in the selected areas.

(iv) Limited access to and delivery of quality services to beneficiaries under the nurse initiated MDR-TB treatment intervention

Training of nurses at primary health care facilities to initiate MDR-TB training under the current grant had not started at 31 December 2016.[34] While training targets under the previous grant had been met, a recent assessment of this training by the National Department of Health[35] concluded that only 15% of the MDR-TB cases diagnosed during the period had started treatment. The report attributes this to the following:

- only 17% (59/301)[36] of trained nurses were initiating MDR-TB patients on treatment because preparations of selected facilities for treatment were behind schedule; and
- 23% (71/309)[37] of nurses trained were not deemed competent to initiate treatment and less than 12% of them were supervised.

The assessment provides opportunities for lessons to be learned so that this intervention can be strengthened going forward. This would ensure that nurses are effectively trained, deployed to selected facilities and supervised to strengthen related diagnosis and treatment of MDR-TB.[38]

(v) Accurate data to inform decision making

The concept note provided for the roll out of standard operating procedures to address known data quality issues such as: variability in the completeness and quality of TB and MDR-TB data, backlog of data entry, and incomplete understanding of TB and MDR-TB indicators among staff responsible for recording and reporting TB data.[39] Implementation of this activity had not started as of 31 December 2016.[40] A limited audit verification of the reported data identified incongruence between diagnosed TB and MDR-TB cases at the facilities visited and TB and MDR-TB cases reported in the data base systems used by the Principal Recipient for reporting to the Global Fund. This limited audit verification identified data discrepancies of up to 64% for the months reviewed. This is because all TB/HIV co-infected patients in the facilities audited were reported, rather than just the TB/HIV co-infected patients who are also on antiretroviral treatment, as designed in the program indicators. There is no evidence that supervision or data quality audits were undertaken.

The delays in implementation noted above have been partly attributed to a three-month delay in signing the framework agreement and the related disbursement of funds. They are also caused by deficiencies in the management of the funded program activities. The national TB program does not have the capacity to effectively oversee and support program implementation. The existing structures (program management units) at Principal and Sub-Recipient levels are ineffectivein their management and overall coordination of the program activities. Examples of deficiencies in management and oversight include:

[34] In the period January to March 2017, 88 nurses were reported as having been trained. This number has not been verified by the OIG or the Local Fund Agent.
[35] NDOH (May, 2016) Review of MDR-TB training report
[36] NDOH (May, 2016) Review of MDR-TB training report, Table 2, page 9
[37] NDOH (May, 2016) Review of MDR-TB training report, Table 1, on page 8
[38] In the period January to March 2017, 24 nurses are reported to have completed ancillary training and still operating under supervision of a mentor. This number has not been verified by the OIG or the Local Fund Agent
[39] Podewils et al (2015) Completeness and Reliability of the Republic of South Africa National Tuberculosis (TB) Surveillance System. BMC Public Health. 2015; 15: 765; WHO (2014) Joint Review of HIV, TB and PMTCT programs in South Africa.
[40] Podewils et al (2015) Completeness and Reliability of the Republic of South Africa National Tuberculosis (TB) Surveillance System. BMC Public Health. 2015; 15: 765; WHO (2014) Joint Review of HIV, TB and PMTCT programs in South Africa.

(i) With regard to identification of suitable arrangements for the grant implementation:

- The multiple layers of implementers, with sub-sub-sub recipients for some grants, significantly limits the Principal Recipient's ability to provide effective oversight over program implementation.
- The audit noted that two out of the five implementers had insufficient capacity to effectively implement the activities allocated to them. Implementers were not selected through a competitive processes and capacity assessments were not undertaken prior to their appointment.[41]
- Changes in the implementation arrangements for TB case finding in peri-mining communities have affected the start up and scale up of this program. Community mobilization under the current grant has been separated from screening and the two related activities allocated to different implementers.[42] Community mobilization had not started at the time of the audit and, as a result, limited TB screening had taken place. The implementer responsible for screening had its team ready but was unable to scale up screening until community mobilization was in place to create demand for the screening services. As a result of this weak coordination and sequencing of activities, salaries of health workers worth US$1.3 million had been charged to the program although limited program activities had taken place so far.

(ii) With regard to work planning and budgeting:

- Budgets initially prepared by the Principal Recipient were not comprehensive. For example, they were not aligned with the sub-recipient's operational models and plans to achieve the required outputs. These budgets had to be revised by the implementers within three months of starting program implementation in order to address identified gaps. However, none of the budget revisions proposed by the sub-sub-recipients had been reviewed or approved by the sub-recipient within the TB project management office[43] at the time of the audit (i.e. nine months after they had been proposed). Program activities were slowed down pending budget approval and all the while incurring human resource related costs amounting to US$2.1 million.

- Catch up plans, prepared by sub-sub-recipients at the request of the CCM in order to accelerate program implementation, expired before they were reviewed and approved for implementation by the Principal Recipient.

Agreed Management Action 1

The Secretariat, with support from the CCM and partners, will review the status of implementation of the TB grant activities with the National Department Of Health and assist the Principal Recipient to develop an implementation and grant monitoring plan (including revised budgets and implementation arrangements) for the remaining duration of the grant. This will be the basis for review by the Secretariat to ensure that the program remains on track to meet intended objectives.

Owner: Head of Grant Management

Due date: 31 December 2017

[41] During fieldwork, the TB program commenced capacity assessments for its implemeters to help address implementation challenges noted.
[42] Previously, one implementer was responsible for community mobilisation and screening for TB; and the previous grant reached over 100% of its targets.
[43] A new TB program manager for the Global Fund grants has been appointed and will work to ensure that the program activities are back on track.

4.2. Delivery of quality services to beneficiaries may be affected by gaps in the implementation of program interventions

The approved concept note reflects key areas that should be prioritized through funding from the Global Fund to support the achievement of program impact. However subsequent changes to coverage, scope and content of selected program interventions, which have not been reviewed by the CCM or the Global Fund Secretariat, may impact the achievement of program objectives.

(i) Reduction in geographic coverage of adherence and stigma related interventions as articulated and approved in the concept note:

- Treatment adherence: Delivery of treatment adherence support has been reduced from 31 to 21 districts.[44] As a consequence, 220,000 people on anti-retroviral therapy residing in the excluded 10 districts (ranked as some of the most socially and economically deprived by StatsSA in its most recent survey)[45] will not receive the adherence support envisaged which may affect their retention on treatment. At the time of the audit there was no plan to ensure that the excluded districts would be covered and the reduction had not been approved by the CCM.[46] While the reduction of districts did not affect the overall target to reach 1,088,044 people within the grant period, the program has not assessed whether the targets can be reached within the current geographies and budgets.
- HIV and TB related stigma: Delivery of HIV/TB stigma or discrimation reduction activities have been reduced from the 18 districts envisaged in the concept note to six districts, due to inadequate costing and budgeting for this activity during grant-making. Stigma has been identified as a significant barrier to access and utilization among people with HIV and TB in the targeted districts.[47],[48]

(ii) Interventions not implemented as designed:

- Adherence clubs not transitioning from health facilities to the communities: The Adherence Guidelines for HIV and TB contemplate several strategies for reducing clinical load at health facilities and lowering the likelihood of treatment default by reducing waiting time and transport costs for stable patients on antiretroviral treatment. One of these strategies is through the use of adherence support designed to use a phased approach and decongest the health facilities. Under this approach, stable patients can collect medicines directly from alternative pick-up points in their own community rather than from health facilities. One of the two implementers is establishing clubs at health facilities and as a result only 2% of 5,309 adherence clubs have been transitioned to communities. At the time of the OIG audit, no plan was in place to transition these clubs to the community after the first 12 months as envisioned. This is because the National Department of Health had not finalized a decongestion strategy as well as relevant guidance for these processes.
- Community systems strengthening activities insufficiently aligned to funded interventions: As currently designed and implemented, the institutional capacity building under the community systems strengthening intervention is not targeted at key capacity constraints that have been identified as major barriers. These barriers include shortages in the number of organizations that could implement stigma reduction, adherence or sex worker program delivery. Instead, many of the community systems strengthening activities are currently directed to organizations that either do not support funded interventions or do not operate in the

[44] Districts selected with the understanding that other partners would provide adherence support in the remaining districts.
[45] Statistics South Africa, Community Survey (CS) 2016 report
[46] Subsequent to the audit, the National Department of Health policy on adherence support will ensure that ART patients are covered by the provincial departments of health. This policy
[47] National Stigma Index Report (2014)
[48] Bogart et al (2013) Barriers to care among PLHIV in South Africa, AIDS Care. 2013 Jul; 25(7): 843–853.; Gilbert (2016) http://dx.doi.org/10.1080/17290376.2015.1130644 .

implementation geographies. Thus, the design of the current community system strengthening program is not sufficiently targeted to address current relevant implementation barriers.

(iii) Differences between concept note and actual programs delivered:

- Limited integration of TB in HIV prevention interventions for adolescents and youth: With the exception of the technical and vocational education training colleges, the current curriculum, materials and tools delivered to adolescent girls and young women (Rise Clubs and Soul Buddyz) have limited coverage of TB.[49] The Keeping Girls in School curriculum currently does not make any provision for TB.[50] Since the program covers approximately 280,000 adolescent girls and young women aged 10-24 annually, this may be a missed opportunity to increase TB prevention and case finding amongst a target population.[51] This cohort accounts for between 12%-18% of notified TB cases in the country.[52]
- Reduction of course content for adolescent girls and young women in and out of school: Both the number of stipulated modules and the hours per module have been reduced in all the adolescents and youth programs. For instance, in technical and vocational education training colleges, one module is run instead of the four that were proposed and approved. An additional empowerment module that was proposed in the Concept Note has also not been delivered.[53] Under the Soul Buddyz, Rise Club and Keeping Girls in School program, implementers are rolling out only two or three of the modules and sessions[54] that were included in the program design. However, they are counting these beneficiaries as reached with the stated intervention. The modules are neither the same nor delivered in the same sequence or methodology across the five Principal Recipients responsible for this intervention. These significant changes from the initial program design (which was found to be effective in evaluations commissioned by the Principal Recipient who developed them) and the approved concept note interventions have not been clearly planned and their impact assessed. Instead, different implementers have made ad hoc changes to the curriculum in order to meet their year-end indicator targets without consideration given to the quality of program activities. Thus, while the numbers of adolescents and young people "reached" may be achieved, there is significant risk that the quality of the intervention may not yield the targeted behavioral change.

(iv) Program unable to reach the number of adolescents and youth in technical and vocational education training colleges envisaged in the concept note:

There are several challenges in implementing the prevention and HIV Testing Services program in technical and vocational education training as designed:

- The intervention cannot reach the 530,000 young people over three years as envisaged because these colleges do not have this number of students enrolled. Enrollment figures for colleges in the implementation provinces show only 113,013 students in the targeted age group. This will affect the achievement of overall program targets as this intervention accounts for 63% and 20%, respectively, of adolescents and youth aged 10-24 to be reached with the prevention package and 20% of those to be counselled and tested for HIV/TB.
- The implementer may also be unable to deliver a quality program because the technical colleges are currently unable to commit the 20 hours required to complete the course as currently designed, i.e. the comprehensive package plus the empowerment element which is core to social and behavioral change. This intervention was initially put in place in universities with a 12-36 month curriculum. Instead, for technical colleges, enrolment is over a much shorter period of only six to nine months. Because students have a shorter enrolment period

[49] The Rise Magazine includes a short and brief case scenario paragraph on page 13 while the facilitator manuals.
[50] Keeping girls in school curriculum does not include TB at all for all five sessions.
[51] Currently none of the Principal Recipients report on TB screening. Subsequent to the audit, Principal Recipients will commence reporting in the next reporting period.
[52] Preliminary 2016 NDOH Annual TB report
[53] Based on the First things first manual developed by HEAIDS and currently implemented in South African Universities
[54] The programs have 4, 14 and 5 sessions in the Soul Buddyz, Rise Clubs and Keeping Girls in School, respectively.

and are also non-residential, the technical colleges currently allocate only a half-hour for this course when the program design calls for 20 hours.

- Unlike universities, technical colleges do not have health facilities to deliver HIV testing services. Consequently the Principal Recipient must rely on third party service providers to deliver HIV testing services and they are not always available to deliver these services.

The underlying causes of the issues above include:

(i) Interpretation of the incentives in performance-based funding: Whereas performance-based funding encourages targets that promote impact, the current performance framework does not track the quality of programs. The primary focus of the current indicators, and the related assurance and oversight mechanisms, is on achievement of quantitative targets such as the number of people "reached" rather than on the qualitative content of the programs delivered.

(ii) Planning and budgeting during concept note development and grant-making: Changes in coverage, scope and content have been attributed to challenges in planning, costing and budgeting of new interventions. For instance the delivery of the intervention for the technical colleges as planned would require a minimum of 442,500 days of social and behaviour change communications annually. The current budget provides for only 4,425 days, which is 1% of the requirement.

Agreed Management Action 2

The Secretariat, with inputs from the CCM and partners, will:

- support the Adolescent Girls and Young Women Principal Recipients to develop standards of quality for the Global Fund supported grant activities; and
- revisit the adherence, stigma and Community Systems Strengthening interventions to ensure that their coverage and scope remain aligned to the approved implementation plans and budgets.

Owner: Head of Grant Management

Due date: 31 March 2018

4.3. Performance is affected by insufficient prioritization of critical program activities.

(i) Delays in undertaking mapping and surveys affect identification of vulnerable populations

Grant funds should support the identification of hotspots for prioritisation during program implementation in two provinces. However, the OIG found the following:

- Interventions targeting vulnerable populations in the Western Cape and KwaZulu-Natal provinces have been delayed by at least six months. Although the geospatial mapping profiling to identify 'hotspots'[55] had just been completed at the time of the audit, community profiling had not yet started. The profiling is critical to the identification of vulnerable populations within the community, development of appropriate prevention service packages and contracting of suitable service providers to deliver the packages. As a result, there is a risk that the targeted 2.1 million vulnerable people[56] may not be reached with the comprehensive HIV/TB prevention package by the end of year two as previously planned.
- Interventions targeting key populations under the HIV and TB programs have not been updated. Ongoing surveys are expected to provide more up to date information. However, under the current interventions, the proportion of individuals testing positive for HIV counselling and testing and for TB screening is less than expected. For instance, the actual positivity rate against the yield estimates for:

  - men who have sex with men: 1.5% vs 10.4%-34.5% noted prevalence among this population;
  - people who inject drugs: 1.22% vs 19.4% estimated prevalence; and
  - people in peri-mining areas screened for TB 0.88% vs 1.2% estimated prevalence.

(ii) Missing critical program inputs for reaching adolescents and youth

- Principal Recipients and their implementers are facing challenges in obtaining memoranda of understanding (MOUs) from various government entities[57] that permit them to implement program activities in specific areas/regions. This has affected activities related to prevention interventions to adolescents and youth in primary and secondary schools, HIV testing services, establishment and delivery of adherence interventions. Targets could not be met since interventions in prioritised provinces and districts could not be implemented as of December 2016. However, despite this inability to implement due to outstanding MOUs, administration costs of approximately US$480,000 had been incurred on staff engaged to implement activities at the time of the audit. This reflects the need for better planning and provides lessons learned for the future programming.
- Starter packs[58] and incentives[59] had not been procured and disseminated to all implementers one year into the grant implementation period: these are essential for starting and running Soul Buddyz clubs targeting adolescents aged 10-14 and Rise Clubs targeting young girls aged 15-24 in and out of school. This was caused by procurement delays and non-competitive selection of providers.
- Training of trainers not yet provided for some intervention models for adolescents and youth: While some trainers had been trained for some interventions at 31 December 2016, this was not the case for Principal Recipients/service providers implementing hands on parenting and

[55] A hotspot is a geographical area with evidence of high prevalence of HIV, STIs, TB or behaviors that put people at risk for acquiring infection.
[56] Targets as noted in the approved Performance Framework
[57] Depending on the scope of intervention at national, provincial and district level and with relevant departments i.e. health, basic education and social development depending on the specific interventions
[58] Starter packs consist of manuals, reporting forms, newsletters and facilitator guides essential for beginning implementation of club focused interventions
[59] Incentives consist of merchandise given to adolescents and youth to encourage, motivate and retain them in the clubs

teen parenting modules. However, approved work plans had made provisions for the relevant five Principal Recipients and their sub-recipients to receive this training by the start of the program.

(iii) Standards to assure quality of interventions have not been set and, where set, they are not complied with. Due to a lack of established quality standards in most interventions, recipients often implement the same activities but in different ways, to different quality standards and counting all towards the same targets. Most third party providers delivering HIV testing services have not yet undergone proficiency testing and are therefore non-compliant with national quality assurance guidelines.

(iv) Delays in the set-up of the social impact bond which is expected to raise funding to reach 24,400 sex workers: US$3 million was earmarked for the set-up of a social impact bond. However, the implementation of this intervention is significantly behind schedule due to delays in designing the business case for approval by the relevant responsible government department. Consequently, it is unlikely that this intervention will be implemented within the envisaged timelines of the grant.

The underlying causes of the issues above include:

(i) Ownership of the non-clinical interventions at the national level. These interventions that reach key and vulnerable populations with comprehensive prevention packages account for 32% of the grant funds. However, there is a need for leadership at the national level to ensure that appropriate structures exist for oversight and management of these interventions. There is also a need for integrated national plans, on the part of the government and development partners, to guide the design and geographic prioritization of the activities; and

(ii) Oversight mechanisms do not identify implementation challenges in a timely manner and address them. Although the CCM's oversight committee has a good composition of members and meets on a quarterly basis, its effectiveness has been impacted by:

- limited attendance/participation of members of the oversight committee;
- oversight meetings focus primarily on reviewing individual grant performance with limited consideration given to overall portfolio performance i.e. identifying challenges and putting actions in place to course correct;
- two critical positions at the CCM secretariat remain vacant and this has affected the availability of data to guide oversight activities;
- catch-up plans requested by the CCM oversight committee to accelerate grant implementation had not been reviewed or implemented at the time of the audit;
- coordination mechanisms at different levels are in their infancy and this affects synergy and the ability to minimize gaps/duplications across funded programs in the following areas: (see annex 2.0 for details);
  - between national and provincial levels, with limited collaboration of centrally managed programs such as the Global Fund with the autonomous provinces that are responsible for implementation;
  - among relevant government and provincial departments, with program implementation delayed by limited coordination across government departments that are key to the interventions, e.g. between the Department of Health, the Department of Social Development, and the Department of Basic Education etc.;
  - among funded program implementers and between government and non-governmental organizations implementing program activities at provincial and district levels;
  - at donor level in cases where donors are implementing the same interventions in the same geographical locations; and

- among related interventions, e.g. linking people diagnosed as positive from HIV/TB prevention activities to treatment and care.

Agreed Management Action 3

The Secretariat will work with the CCM and partners to review the CCM Governance and Oversight policies and plans (including non-clinical interventions).

Owner: Head of Grant Management

Due date: 31 March 2018

Agreed Management Action 4

The Secretariat will:

- support the updating of the business plan for the Social Impact Bond to address issues and risks identified by the Department of Science and Technology; and
- follow-up and support the Department of Science and Technology in making a decision on the Social Impact Bond.

Owner: Head of Grant Management

Due date: 31 March 2018

4.4. Limited availability of quality data to aid decision-making due to gaps in monitoring and evaluation frameworks

The quality of reported data is affected by challenges in clearly defining *what should be counted* and the establishment of systems to collect the required data. All implementers have developed reporting tools and systems. The Principal Recipient also has monitoring and evaluation plans that provide further guidance to the reporting process. However, the key issues observed during the audit relate to the following:

(i) Limitations in defined indicators in the performance frameworks as measures of grant performance:

- Some indicators are not reflective of the programs under implementation: Principal Recipients have been allocated some indicators that they have no control or influence over. For instance, one Principal Recipient has an indicator related to HIV testing services,[60] yet it does not have direct access to information for this indicator or its allocated funding. Similarly, for the adherence intervention, the Principal Recipient's report on viral load suppression covered all people on antiretroviral treatment in the facilities they work in and not for the specific adherence clubs the Principal Recipient was supporting.
- The performance framework lacks outcome indicators for key and vulnerable populations like men who have sex with men, sex workers, people who inject drugs. This is despite the fact that related interventions have been identified as key to program impact and 22% of grant funds have been allocated to these interventions. Investments have been allocated to conduct surveys that can provide outcome data on men who have sex with men, but no provision has been made for sex workers, people who inject drugs and transgender people.
- Work-plan tracking measures in performance frameworks for monitoring the pace and quality of implementation and tracking key program drivers/milestones for the new interventions. This would help identify and manage at an early stage any risks that can impede their implementation. For instance, the failure to track the signing of memoranda of understanding as a prerequisite for the commencement of youth activities has contributed to the significant under performance noted with regard to the indicator "*Number of young people aged 10–24 years reached by life skills–based HIV education in and out of schools*". It stands at below 10% against target as of December 2016.

(ii) Information used to support set targets - Errors were made in setting targets for example: (i) Rise Clubs and Keeping Girls in School programs should comprise only girls aged 15-18. Yet the values used included boys as well for three Principal Recipients; and (ii) district data was used as a denominator value even though interventions only cover some sub-districts within the districts. This is because only district information was available at the time grants were signed.

(iii) No standards to ensure consistent interpretation of indicators: The focus of most indicators is on simple variables that can be easily collected for reporting purposes and not on the quality of interventions. For instance:

- Regarding HIV Testing Services indicators, the performance framework measures the number of tests done (services) and not the number of people who were tested and have received their results. If the objective is for people to know their HIV status, then this interpretation gives a false portrayal of the number of people who know their status.
- The interpretation of the indicator "percentage of young people aged 10–24 years reached by life skills–based HIV education in and out of schools youth" is dependent on the intervention. The Soul Buddyz and Rise Clubs count numbers of sessions attended per person, i.e. between 2 to 3 sessions, while the Keeping Girls in School intervention counts content, i.e. number of topics covered. The quality of data reported under this indicator is thus compromised because

the consolidated results comprise both number of sessions (meetings) and topics covered (content).

- The definition of the "HIV prevention package" is not articulated in the performance framework nor in the Principal Recipient indicator protocols[61] with regard to men who have sex with men, transgender and people who inject drugs. The definition of the indicators is dependent on the different prevention interventions that are implemented.

(iv) Gaps in systems in place to collect, report and assure quality of data:

- There is a multiplicity of reporting systems that end up in separate databases, both at Principal Recipient and sub-recipient level. Data is located in various disparate locations with no common national database to pool it for analysis and cleaning (and to remove double counts).
- Multiple implementers are involved in the implementation of different interventions which raises the risk of double counting of beneficiaries. The mechanisms put in place by different Principal Recipients to minimise the risk of double counting still have some limitations, i.e. use of applications, unique identifier codes, biometrics and e-patient systems. (See annex 3.0 for details).
- Deficiencies in data quality assurance mechanisms at Principal Recipient level: A review of supervision arrangements showed that their primary focus was on program reporting, rather than on the quality of interventions delivered. A limited validation of data reported by sub - recipients against primary documentation showed discrepancies in data reported:
  - For HIV testing, forms were incomplete and it was not possible to tell whether patients knew their results. The audit also noted that there were discrepancies between number of patients and corresponding amount of antiretroviral drugs dispatched (50% in one facility visited);
  - Number of patients receiving adherence support was inflated by 60%. This is due to double counting since the numbers reported are cumulative and, as a result, there were discrepancies between the source documents and the numbers reported to Global Fund.

(v) Delayed availability of clinical data: Another challenge to the TB and HIV clinical indicators relates to delays in reporting, which are experienced at service delivery where data is captured late into the electronic health reporting systems. This is a common issue across all systems including the Tier.net, the Electronic TB Register (ETR) and the Multi Drug Resistance Register (MTR). This affects accurate and timely reporting for thirteen coverage indicators reported on by three Principal Recipients in the performance framework.

The **underlying causes of the issues** identified above include the following:

(i) At the government level, there is inadequate guidance due to the lack of a national monitoring and evaluation plan for the National Strategic Plan (2012-2016). In addition, the country has also not established a clear institutional mechanism to lead the coordination of these emerging interventions, including the collection and analysis of emerging data from funded interventions. This is an already known issue at the national level, which is beyond the control of the Global Fund, and which is being addressed through the new strategic plan (2017-2022).[62]

(ii) The grant performance framework is consolidated at a high level for all eight Principal Recipients. Indicators are not customized to reflect grant activities undertaken by the specific recipients. For example, the scale of work related to adolescents and young people interventions on this portfolio provides an opportunity to enhance current indicators so they can provide adequate data as measures of performance.

[61] Indicator protocols provide definitions, compilation guidance, and other information to assist report preparers and users have a consistent interpretation of the performance indicators.
[62] At the time of our review, a national monitoring and evaluation framework was planned for the new national strategic plan (2017-2022) but had not been finalized at the time of reporting.

Agreed Management Action 5

The Secretariat will:

- revise the consolidated performance framework for Adolescent Girls and Young Women (AGYW) interventions; and
- review biometrics and unique identifier codes as part of reporting systems used by AGYW Principal Recipients in terms of being able to correctly identify participants and different interventions received in different locations, and to provide an action plan to improve the current approach.

Owner: Head of Grant Management

Due date: 31 March 2018

4.5. Oversight and assurance challenges affecting the identification and mitigation of key program risks.

Effective oversight and assurance mechanisms are required to ensure that implementation challenges are identified in a timely manner and that lessons learnt can correct programs throughout the implementation period.

The program has an active CCM supported by an oversight committee that meets on a quarterly basis. The CCM and oversight committee have been structured to include stakeholders like development partners, provincial councils on AIDS and technical agencies to support program implementation. However, the auditors noted the following challenges within the oversight and assurance mechanisms.

(i) Gaps in risk identification, assessment and mitigation: In October 2016, the Secretariat held an in-country workshop together with the Principal Recipients and other partners to support the completion of a key risk matrix. This workshop was expected to identify, prioritise and manage risks at a portfolio and grant level. A review of the risk matrices at the time of the audit showed:

- Some key risks were not identified: The risks identified were not sufficiently tailored to the unique circumstances of the South Africa grants. For instance, risks related to implementation of new interventions in South Africa were not articulated e.g. standards to measure quality of programs, appropriateness of indicators to measure program success, implementation arrangements, budgeting and costing challenges and the need for program and detailed implementation plans.
- Limitations in mitigation actions in addressing risks: Proposed actions did not address root causes of key risks identified and therefore may not mitigate identified risks. For example, Principal Recipients were requested to prepare catch up plans to address poor performance in year 1. However, root causes for performance issues such as challenges in setting targets, budgeting and costing of programs were not addressed in these plans.

(ii) Assurance mechanisms not aligned to key risk areas: A review of the assurance work[63]against the key risk matrix and audit findings showed that assurance work needs further alignment to key business risks:

- Assurance by the Local Fund Agent: While programmatic and performance risks have been identified as high risk, there is limited assurance coverage over this area. Specifically, the public health and monitoring and evaluation expert in the Country Team oversees two major country portfolios and is unable to dedicate the time required to support the country. One of the Local Fund Agent's public health experts works part time, whilst the other works remotely. As a result, much of the related work is undertaken by finance staff which affects the quality of analyses undertaken in the programmatic and performance area. Also, while capacity to provide adequate programmatic assurance by the Local Fund Agent was identified in the concept note as a risk, no actions were put in place to mitigate against it at the time of the OIG review.[64]
- Assurance at implementer level: The risks in financial and fiduciary area have been adequately assured through internal, external and Local Fund Agent work (52% of their time), leading to a low risk rating in the risk matrix. Similarly, the in-country implementers have strengthened their finance and compliance units to maintain financial assurance levels. However, adequate attention has not been given to the programmatic performance and data quality risks leading to an imbalanced assurance model.

[63] Assurance work undertaken in the past two years (2015-2017) and proposed for 2017
[64] Subsequent to the audit, the Country Team has changed the Local Fund Agent work plan for 2017 to align to the key risk areas in the portfolio

(iii) Governance arrangements impacting the CCM's ability to fulfil its mandate: The audit identified the following challenges that are impacting the CCM's effectiveness in its governance role over the funded programs:

- Ambiguity in roles, responsibilities, authorities and accountabilities of the CCM and SANAC that houses the CCM, their secretariats and staff. The SANAC CEO is automatically the CCM chair under this structure and staff members play different roles across the SANAC and CCM secretariats. There is no defined protocol on how CCM recommendations and decisions are made and communicated to the implementers. Consequently, a number of decisions made by either SANAC and its secretariat and/or the CCM secretariat have been communicated as CCM decisions. This has created confusion at implementer level as to who had made the decision, in what capacity, and whether they had the authority to make those decisions.
- Poor attendance of meetings by CCM members representing civil society and different government departments that play a significant role in achievement of Global Fund objectives (Basic Education, Social Development and Health). The attendance rate by civil society and the government departments for the nine meetings held between 2015 and December 2016 was 47% and 56% respectively. This is because participation in the CCM positions is voluntary and civil society members typically do not have alternates to ensure adequate participation. Where alternates for other sectors are available, there is no coordination to ensure that specific sectoral issues are tabled and addressed through consistent attendance and follow-up.
- Appointment of sub-recipients without the involvement of the relevant Principal Recipients: As was noted in the 2011 OIG audit report (cf section 3.3), the CCM has appointed sub-recipients directly under the current grants. The Global Fund guidelines on implementers of Global Fund grants strongly recommend that this role is undertaken by Principal Recipients in consultation with the CCM. They also encourage that such selections are undertaken competitively. The audit noted that most organizations that received direct appointments had linkages with CCM members. This has complicated the Principal Recipient and sub-recipient relations especially in cases where the latter had performance issues (which is the case with most directly appointed sub-recipients).
- Information for decision-making: A key role for the CCM secretariat is the collection and aggregation of data and analysis of implementer performance to support decision-making processes for the oversight committee and the CCM. Although performance of each Principal Recipient is presented at the oversight committee meetings, this information is not consolidated to evaluate the overall performance of the grants. For example, mapping of interventions against what was approved for implementation, or provision of data for each intervention across all sources of funding, have not yet been done to review district saturation versus the need for coverage.

The root causes of the issues above include:

(i) Unresolved governance issues within the CCM structure including unadressed management of conflicts of interest since the 2011 OIG review.
(ii) Critical positions at the CCM secretariat have not been filled, for example the Global Fund Manager and Monitoring and Evaluation[65] positions to support and provide timely analysis of program performance to aid decision making by the CCM.
(iii) Format and content of the CCM oversight committee meetings (covered under finding 3).
(iv) With regard to the identification and mitigation of risk:

- The risk assessment and action planning tool at the Global Fund (known as the QUART) has not been completed for the South Africa grants under the current grants to inform the Country Team's risk assessment as the capacity assessments were done instead. However, abridged capacity assessment tools were completed despite the change in the programs and implementation arrangements under the current grants. This is a missed opportunity to identify risks.

[65] The CCM budget provides for technical assistance through a monitoring and evaluation position.

- The key risk matrix follows the risk profile adopted for Global Fund under the four risk themes and was not adequately tailored to reflect the South Africa portfolio risks.
- Institutionally comprehensive assessments are completed to support the financial assurance model. However, the programmatic and Monitoring and Evaluation assessments have not evolved at the same rate leading to challenges in risk management in these areas.

See Agreed Management Action 3

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
1. The Secretariat, with support from the CCM and partners, will review the status of implementation of the Tuberculosis (TB) grant activities with the PR NDOH and assist the PR to develop an implementation and grant monitoring plan (including revised budgets and implementation arrangements) for the remaining duration of the grant.	31 December 2017	Head of Grant Management
2. The Secretariat, with inputs from the Country Co-ordinating Mechanism and partners, will: • support the Adolescent Girls and Young Women (AGYW) Principal Recipients to develop standards of quality for the Global Fund supported grant activities; and • revisit the adherence, stigma and Community Systems Strengthening interventions to ensure that their coverage and scope is aligned to implementation plans and budgets.	31 March 2018	Head of Grant Management
3. The Secretariat will work with the CCM and partners to review the CCM Governance and Oversight policies and plans (including non-clinical interventions).	31 March 2018	Head of Grant Management
4. The Secretariat will: • support the updating of the business plan for the Social Impact Bond to address issues and risks identified by the Department of Science and Technology; and • follow-up and support the Department of Science and Technology in making a decision on the Social Impact Bond.	31 March 2018	Head of Grant Management
5. The Secretariat will: • revise the consolidated performance framework for Adolescent Girls and Young Women (AGYW) interventions; and • review biometrics and unique identifier codes as part of reporting systems used by the Adolescent Girls and Young Women (AGYW) Principal Recipients in terms of being able to correctly identify participants and different interventions received in different locations, and to provide an action plan to improve the current approach.	31 March 2018	Head of Grant Management

Annex A: General Audit Rating Classification

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

Annex B: Methodology

The OIG audits in accordance with the global Institute of Internal Auditors' (IIA) definition of internal auditing, international standards for the professional practice of internal auditing (Standards) and code of ethics. These standards help ensure the quality and professionalism of the OIG's work.

The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help our auditors to provide high quality professional work, and to operate efficiently and effectively. They also help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing takes place at the Global Fund as well as in country, and is used to provide specific assessments of the different areas of the organization's activities. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.

Annex C:

1.0 Funded interventions in South Africa

Prevention programs for the general population - Interventions include social and behavioral change communication, Promotion and distribution of female and male condoms for HIV prevention, HIV testing services, diagnosis and treatment of STIs as part of programs for general population, continuum of care for reproductive, maternal, newborn and child health (RMNCH) linkages and gender-based violence (GBV).

Prevention programs for adolescents and youth in and out of school – Interventions include social and behavioral change communication, promotion and distribution of condoms for sexually active young people, HIV testing services, as part of programs for adolescent and youth, maternal, newborn and child health (RMNCH) linkages and gender-based violence (GBV), interventions aimed at young MSM and harm reduction for young people who are injecting drug users.

The interventions are delivered through the following modules:

- Soul Buddyz clubs focused on young 10-14 year old boys and girls in primary schools;
- Rise Clubs focused on Adolescent Girls and Young Women aged 15-24 out of school;
- Keeping Girls in School (KGS) focused on Adolescent girls in high school;
- Hands on parenting focused on provision of parenting skills to parents of members enrolled in Soul Buddyz and Rise Clubs;
- Teen parenting in school and out of school will cover 50 groups of 20 each in school and 25 groups for out of school;
- Child protection focus on young 10-17 year old Adolescent girls and boys;
- High impact prevention intervention in TVET colleges focused 15-24 year old young people in colleges; and
- Cash plus care focused on young 19-24 year old women.

Prevention programs for key populations – Interventions cover MSMs, transgender people, people who inject drugs, inmates and sex workers. They include social and behavioral change communication, promotion and distribution of female and male condoms and condom-compatible lubricants for HIV prevention, HIV testing services, diagnosis and treatment of STIs, diagnosis and treatment of viral hepatitis for MSM, TGs and PWIDs, harm reduction as part of programs for sex workers and their clients, needle and syringe programs for PWID and their partners, OST and other drug dependence treatment for PWIDs and their partners.

Prevention programs for other vulnerable groups - Interventions include social and behavioral change, promotion and distribution of female and male condoms and condom-compatible lubricants for HIV prevention, HIV testing services, diagnosis and treatment of STIs.

Treatment, care and support – Interventions include, antiretroviral Therapy, treatment monitoring, treatment adherence, prevention, diagnosis and treatment of opportunistic infections, counseling and psycho-social support, in and out-patient care.

Health Systems Strengthening- information systems, procurement and supply chain management and service delivery – Interventions include operationalization of procurement and supply chain management system through Chronic Care Medicine Distribution and Delivery (CCMDD), Routine reporting through Visibility & Analytics Network (VAN) and Electronic Health Patient System (eHPRS), TB prevalence survey, administrative and finance data sources.

Tuberculosis and multidrug-resistant tuberculosis – Interventions include case detection and diagnosis, treatment, prevention, engaging all care providers, community TB care delivery TB/HIV and collaborative interventions.

Community Systems Strengthening – Interventions include institutional capacity building, planning and leadership development.

Key program areas supported by the Global Fund are implemented by eight Principal Recipients as follows:

	NDOH	AFSA	KZN	NACOSA	KI	RTC	SCI	WCDOH
Prevention programs for the general population	■	■		■			■	
Prevention programs for adolescents and youth in and out of school		■	■	■	■		■	■
Prevention programs for key populations[66]			■	■	■		■	■
Prevention programs for other vulnerable groups		■	■					■
Treatment, care and support	■				■	■		■
HSS- information systems, procurement and supply chain management and service delivery	■		■			■		■
Tuberculosis and multi drug resistant tuberculosis	■							
Community Systems Strengthening		■		■				

2.0 Coordination structures for effective grant implementation

Coordination mechanisms at different levels are in their infancy and this affects synergy and the minimizing of gaps/duplications among funded programs in the following areas:

- *Between national and provincial level:* one key challenge noted was the collaboration of centrally managed programs such as the Global Fund with the autonomous provinces that are responsible for implementation for example the roll out of nurse initiated MDR TB treatment programs have been impacted by willingness of the provinces to prioritize the interventions at facility level.
- *Among government departments*: program implementation has been delayed by the need to establish coordination among cross cutting program areas across departments necessary for the interventions. For instance, the social impact bond requires the involvement of the Department of Science and Technology and this had not been obtained at the time of the audit. The distribution of supplementary nutrition under the TB program is provided under the Department of Health yet these activities are typically undertaken by the Department of Social Development.
- *Between government and non-governmental organizations*: Coordination with regard to sharing of grant data with the relevant national structures e.g. the Provincial Councils on AIDS (PACs), gaps in grant supervision arrangements at national level and more importantly, the failure to build relationships that would enhance program sustainability post Global Fund e.g. the gender based violence interventions that will not be funded going forward.

[66] Sex workers and their partners, men having sex with men, transgender, people who inject drugs and their partners

- *Among funded program implementers:* While it is commendable that Principal Recipients had started holding coordination meetings at the time of the audit their format and content needed revisiting in order for them to be more effective.
- *At donor level*: Although donors have been allocated districts for specific interventions, a mapping of interventions at sub district and implementer level has not been completed. Where more than one donor is present in the same sub district, donor activities have not been defined to ensure adequate country coverage, saturation and reduce the risk of duplication.
- *Among related interventions:* there is limited coordination to ensure that linkages are built between related programs e.g. linking (i) people diagnosed as positive from HIV/TB prevention activities to treatment and care; (ii) nurse initiated MDR TB treatment with the decentralisation plan for TB; (iii) stigma reduction to adherence clubs to address internalised stigma among members of the club who are PLHIV, (iv) within the Central Chronic Medicines Dispensing and Distribution program, there is an opportunity to link adherence clubs in the community so that patients are able to pick their medicines through the phased approach.

3.0 Risks within data recording systems

Multiple implementers are involved in the implementation of different interventions and this raises the risk of double counting of beneficiaries. The mechanisms put in place by different Principal Recipients to minimise the risk of double counting still have some limitations as detailed below:

- *The use of an application* (app) to generate unique identifier codes for Soul Buddyz and Rise Clubs. However only 200 (50%) of registered Soul Buddyz and Rise clubs have registered to use the app and out of this number only 5 clubs (3%) have reported *all* their data using the application (and 24 clubs have done so partially).
- *The use of unique identifier codes:* There are at least seven different codes in use at Principal and sub Recipient level and this makes consolidation of data a challenge. Some codes in use are deficient e.g. the use of cell phone numbers for identifying individuals when people can change phone numbers frequently.
- *The use of biometrics:* A limited review of the two biometric systems in place flagged a couple of risks i.e. (i) high related costs for example the broccoli system costs one implementer USD 326,000 per year while another implementer pays USD 36,900 for another system to record similar data; (ii) ability of system to incorporate the different interventions under implementation by the same Principal Recipient; and (iii) whether biometric system data can be linked to other sources of data to check for double counting.
- *E-patient registration system* which combines the use of the national identification and biometric data to identify patients accessing clinical services. It presents an opportunity for linking community interventions with health facilities for continuity of care. But the system faces limitations in as it cannot include data for certain criminalised populations like the sex workers and people who inject drugs which limits centralisation of data. This system is also focuses only on clinically based interventions and does not support non clinical interventions like the adolescents and young people.

Annex D: Message from the Interim Executive Director

South Africa is a leader in the fight against HIV and tuberculosis and building resilient and sustainable systems for health. South Africa has the largest number of people living with HIV and the world's largest HIV treatment program. South Africa's government strongly supports the HIV response, and is by far the largest investor in national HIV programs, providing around 80 percent of funding. South Africa has made great progress against HIV, and has dramatically improved the nation's overall life expectancy in recent years. In addition, South Africa is at the forefront of innovative approaches to preventing infection, recognizing the critically important role of focusing on adolescent girls and young women, who are disproportionately affected by HIV.

South Africa also has the sixth-highest number of people diagnosed with TB in the world, and the government provides more than 90 percent of funding for TB programs.

The Global Fund's support for the response to HIV and TB, while considerable, represents a fraction of what is being invested by South Africa's government. In that context, the Global Fund's support for South Africa is focused on prevention. We provide catalytic investments in critically important areas, and support innovation to increase impact. Many programs in South Africa that are supported by the Global Fund are new and require strong leadership and effective coordination. As in all new interventions, changes are made as lessons are learned.

It is vital to support innovative programs to protect key and vulnerable populations, especially adolescent girls and young women. We are constantly learning and adapting. We will continue supporting innovative programs, while taking calculated risks.

The Office of the Inspector General (OIG) is an integral and important part of risk management and controls, conducting independent audits and investigations to complement the active risk management and controls put in place by the Secretariat with oversight by the Board of the Global Fund.

I want to thank the Office of the Inspector General for this audit report on Global Fund grants to South Africa, which identifies aspects that can be improved. The audit did not identify any misuse of funds or fraud. The audit, conducted nine months into the implementation of the current grant cycle, identified implementation challenges and drew initial lessons, highlighting internal control arrangements that could provide assurance on financial risks. The Global Fund is already working with partners to address coordination and governance as well as programmatic assurance challenges identified in the audit.

The Global Fund is committed to constantly strengthening measures to increase value for money, and improving the effectiveness of health investments so they can reach the people most in need, in countries and communities all over the world.