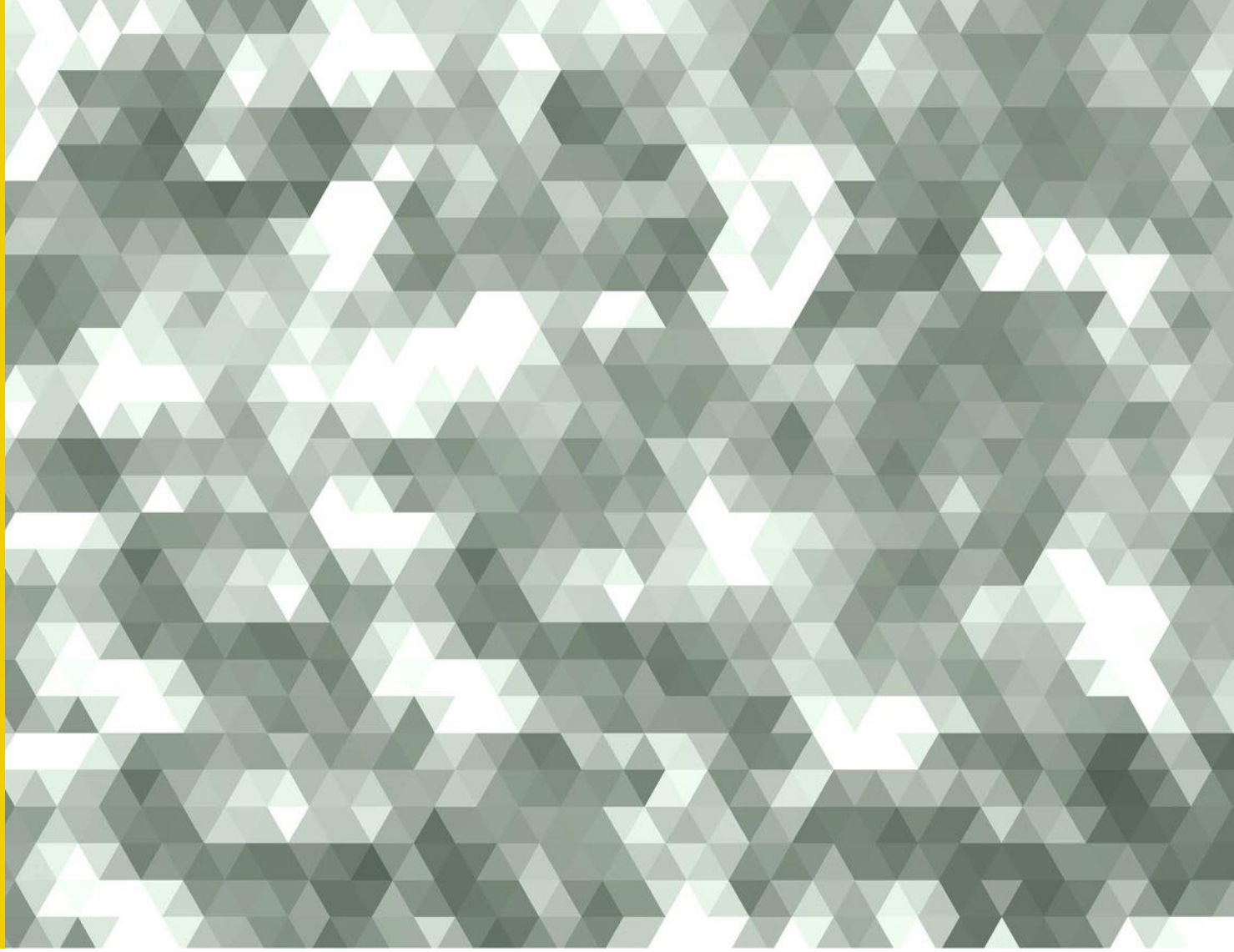


Audit Report

Global Fund Grants in Nepal

GF-OIG-19-015
28 August 2019
Geneva, Switzerland

The Global Fund
Office of the Inspector General

What is the Office of the Inspector General?

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

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

Contact us

The Global Fund believes that every dollar counts and has zero tolerance for fraud, corruption and waste that prevent resources from reaching the people who need them. If you suspect irregularities or wrongdoing in the programs financed by the Global Fund, you should report to the OIG using the contact details below. The following are some examples of wrongdoing that you should report: stealing money or medicine, using Global Fund money or other assets for personal use, fake invoicing, staging of fake training events, counterfeiting drugs, irregularities in tender processes, bribery and kickbacks, conflicts of interest, human rights violations...

Online Form >
Available in English, French, Russian and Spanish.

Letter:
Office of the Inspector General
Global Fund
Global Health Campus
Chemin du Pommier 40, CH-1218, Grand-Saconnex
Geneva, Switzerland

Email hotline@theglobalfund.org

Free Telephone Reporting Service:
+1 704 541 6918
Service available in English, French, Spanish, Russian, Chinese and Arabic

Telephone Message - 24-hour secure voicemail:
+41 22 341 5258

Audit Report

OIG audits look at systems and processes, both at the Global Fund and in country, to identify the risks that could compromise the organization's mission to end the three epidemics. The OIG generally audits three main areas: risk management, governance and oversight. Overall, the objective of the audit is to improve the effectiveness of the Global Fund to ensure that it has the greatest impact using the funds with which it is entrusted.

Advisory Report

OIG advisory reports aim to further the Global Fund's mission and objectives through value-added engagements, using the professional skills of the OIG's auditors and investigators. The Global Fund Board, committees or Secretariat may request a specific OIG advisory engagement at any time. The report can be published at the discretion of the Inspector General in consultation with the stakeholder who made the request.

Investigations Report

OIG investigations examine either allegations received of actual wrongdoing or follow up on intelligence of fraud or abuse that could compromise the Global Fund's mission to end the three epidemics. The OIG conducts administrative, not criminal, investigations. Its findings are based on facts and related analysis, which may include drawing reasonable inferences based upon established facts.

Table of Contents

1. Executive Summary

1.1. Opinion

Nepal is making significant progress in tackling HIV, tuberculosis and malaria. The number of patients on antiretroviral treatment has increased by 25% in the last three years, the TB treatment success rate is stable at 91%, and malaria cases have declined significantly. Nepal has been identified by WHO as one of 21 countries that have the potential to eliminate malaria by 2020.[1] To achieve the UNAIDS 90-90-90 target by 2020, however, challenges in Nepal's HIV program will need to be addressed: specifically, low testing coverage and yield, and monitoring of clients on treatment. To increase TB case detection, improvements are needed in the implementation of TB interventions such as contact tracing and private sector engagement. The systems and mechanisms to ensure quality of services for HIV and TB to intended beneficiaries are therefore **partially effective.**

Following federalization in February 2018, health care delivery was devolved to provinces and municipalities. The Ministry of Health and Population (MoHP) is mainly responsible for policy formulation, resource mobilization, monitoring and regulation of health services, and the Ministry of Social Development (MoSD) has been established to oversee health care delivery in the provinces. Federalization has resulted in a revised administrative structure that does not include a district level; this has led to a lack of clarity in roles and responsibility around oversight, coordination and implementation which has negatively affected supply chains, fund flow, and reporting of programmatic and logistics data. Leadership and ownership of the national disease strategies remain unclear as implementation of health care is devolved to MoSD, and the reporting arrangement from the provinces and MoSD to MoHP is not defined. The capacity of the three national disease programs remains severely limited, despite investments in the last four years to build their capacity. The implementation arrangements to ensure efficient and sustainable achievement of grant objectives **need significant improvement.**

1.2. Key Achievements and Good Practices

Good programmatic performance: Nepal has made good progress in addressing the HIV, TB and malaria epidemics in recent years, despite several natural disasters affecting the country. The number of people on antiretroviral therapy increased by 20% from 12,000 in 2015 to 15,000 at the end of 2017.[2] Retention of clients on antiretroviral therapy increased from 87% in 2016 to 89% in 2018. AIDS-related deaths fell by 22% between 2007 and 2017.[3] TB treatment coverage was 70% in 2017, and treatment success rate has remained relatively stable at 91% since 2017. The country has witnessed a significant decline in confirmed malaria cases, from 42,000 in 1985 to 1,009 in 2016. Malaria-related deaths decreased from 32 in 2006 to six at the end of 2017.[4] Although Nepal's national strategic plan aims at eliminating malaria by 2026, WHO has identified the country as having the potential to eliminate malaria by 2020. Despite the progress made in TB treatment success rate, HIV treatment and retention, improvements are needed in HIV testing coverage, monitoring of HIV clients on treatment and TB case detection (see sections 4.3 and 4.4).

Good collaboration between Government and other stakeholders in planning and implementing interventions for key populations: The Government directly engages non-governmental organizations (NGOs) to implement Government-financed key population interventions. Key populations, civil society and community representatives were involved in the development of the matching funds application for funds to address human rights-related barriers in accessing health services.[5] NGOs in Nepal also contributed to the development of a strategy on key population activities in the country.

[1] http://www.searo.who.int/nepal/documents/communicable_diseases/malaria/en/
[2] UNAIDS – AIDSinfo data base
[3] idem
[4] Nepal Malaria NSP 2014-2025
[5] Secretariat Briefing Notes for Nepal 2017 – 2019 Grant Application

1.3. Key Issues and Risks

Lack of clarity in roles and responsibilities in the provision of health care post-federalization has affected the leadership, coordination and implementation of the disease programs: Following decentralization, provincial and municipal governments are now responsible for planning, health care delivery and reporting to the newly created Ministry of Social Development (MoSD). Responsibilities between the Ministry of Health and Population (MoHP) and the MoSD regarding the oversight and implementation of the three disease programs have not been clearly defined. Federalization resulted in a revised administrative structure that excluded a district layer which previously comprised 77 coordination and reporting units. These 77 health district units for health were reinstated in Q1 2019. The lack of clarity post-federalization has affected implementation of the three disease programs in the areas of supply chain, fund flow, and reporting of programmatic and logistic data.

The flow of TB and malaria commodities from the central level to service delivery points (SDPs), and of logistics and programmatic data from SDPs to the central level has been disrupted. This has led to delays in the distribution of drugs by the central warehouse, leading to expiries[6] at the central level and a high risk of stock-outs at service delivery centers. With the exception of the HIV program, no funds have been disbursed to national disease programs by the Principal Recipient since the start of the grant in March 2018, resulting in key planned activities not being implemented. One year after implementation, none of the municipalities had submitted their TB program data, and as of 31 December 2018, only 32% of malaria cases had been reported in the health management information system. There is a need to adapt the implementation arrangements of Global Fund-supported programs to the new institutional environment, taking into account the changes in the role of the MoHP (i.e. national programs) and the new role of the MoSD.

Improvement is needed to address institutional sustainability of the three disease programs and fulfilment of government commitments: The Government of Nepal has made commitments towards the procurement of HIV, TB and malaria commodities. The Government committed to procuring 56%, 80% and 100% of antiretroviral medicines and other HIV-related commodities in 2018, 2019 and 2020, respectively, but only fulfilled 50% of its HIV commodity procurement commitment in 2018. This resulted in an increased number of emergency procurements, financed with grant funds, to cover Government procurement gaps. If timely government procurement processes are not in place, there is a risk of stock-outs of antiretroviral medicines by September 2019.

Capacity at the national disease programs remains a challenge. The capacity building approach and activities have not been based on an in-depth capacity assessment of the national programs. After four years of grants being managed under the Global Fund's Additional Safeguard Policy, the MoHP still remains largely dependent on Principal Recipient staff embedded within the national programs due to gaps in the staff numbers and expertise.

Inadequate access to quality HIV testing, weak monitoring of clients on treatment, and low TB case detection: Improvements are needed in HIV testing coverage, monitoring of HIV clients on treatment, and TB case detection. Almost half of key populations reached with HIV preventive services are not being tested. The testing yield among key populations is low compared to the estimated prevalence rates for those populations. The low testing coverage and yield represent a missed opportunity for early diagnosis and the timely initiation of antiretroviral therapy. The viral load testing coverage of people on antiretroviral treatment in the country was 31% in 2018, and the estimated average turnaround time of viral load test results was two months. Low levels of viral load testing may increase the risk of higher mortality and drug resistance.

Nepal has intensified efforts to identify missing TB cases in communities, but the interventions deployed (including contact tracing and engaging private providers) have not yet achieved the

[6] Total expires at the central level for period January 2017 to December 2018 is US$0.6 million

desired results. The program exceeded its targets for household coverage and screening family members through mandatory contact tracing, however only 2.4% of cases were diagnosed as positive for TB, against a target of 10%. This is mainly due to the lack of clear guidance on active case finding, and inadequate monitoring mechanisms for volunteers conducting contact tracing. Although 5,389 TB cases were supposed to be notified from the private sector for the period March to December 2018, only 333 TB cases (6.2%) have been notified in the eTB Private Practitioner register (online notification) by private providers.

1.4. Rating:

	Objective 1: Adequacy and effectiveness of the implementation arrangements to ensure efficient and sustainable achievement of grant objectives. OIG rating: Needs significant improvement.
	Objective 2: Adequacy of systems and mechanisms at the central level to ensure quality of services to intended beneficiaries. OIG rating: Partially effective.

1.5. Summary of Agreed Management Actions

The Secretariat will conduct a review of the impact of decentralization on the three disease programs and develop an Action Plan with the PR in collaboration with MoHP to support service delivery and technical assistance to province-level staff. A costed capacity building plan based on capacity building needs of the national disease programs will be developed. The Secretariat will also work with MoHP, PR and partners to develop an Action Plan to strengthen the quality of testing and monitoring of patients on treatment across the HIV and TB programs in the country.

2. Background and Context

2.1. Overall Context

The Federal Democratic Republic of Nepal is a landlocked country in South East Asia. It is the only low-income country in the region with almost a quarter of its population living below the poverty line. Nepal's economy has recovered from the 2015 earthquake, which caused an estimated US$10 billion in damage, equivalent to almost half of the country's GDP. The economy grew by 7.5% in 2017 and 5% in 2018, compared to 0.4% in 2016. Improvements in supply systems, energy availability, expansion of trading activities and speedy construction work have contributed to the country's economic recovery.[7]

Population: **29.9 million**

GNI per capita: **US$960** (World Bank, 2018)

UNDP Human Development Index: **149 of 189** (2017)

Transparency International Corruption Perceptions Index: **124 of 180** (2018)

UNDP Gender Inequity Index: **118 of 160** (2017)

The Ministry of Health and Population's (MoHP) budget increased by 70% between the 2010/2011 and 2016/2017 fiscal years. With increased Government contributions to the health budget, the relative share of external partner funding in MoHP's budget declined from 42% in 2010/2011 to 21% in 2016/2017. Health represented 4.6% of government expenditure in 2016/2017, down from 6.7% in 2011/2012. Nepal is one of the 57 countries classified by WHO as having a critical shortage in its health workforce,[8] with only 0.67 doctors and nurses per 1,000 population[9], well below the 2.3 global benchmark level to provide adequate coverage of essential health services.

In 2007, Nepal was declared a federal state. The decision was formalized in September 2015, when the country promulgated a new constitution. There were parliamentary elections in 2017 and a new government was formed in February 2018, starting the federalization process. Nepal now has three levels of government: federal, provincial and municipal (local). The country comprises seven provinces, subdivided into 753 local administrative units known as municipalities or 'palikas'. Delivery of health services is the sole responsibility of provincial and local governments, while the federal government (i.e. MoHP) focuses on policy-making, regulations, standards development and monitoring. The Ministry of Social Development (MoSD) has been created to oversee the newly created Provincial Health Directorates. In July 2018, following the elimination of districts from the administrative structure, the Government abolished the role of the District Public Health Offices (DPHOs). The 77 DPHOs were re-instated in Q1 2019 as Provincial Health Officers with a limited role. Discussions are ongoing to include them as a cost center in the next government budget; they were not included in the budget for the last financial year. Health Coordination Units located within municipalities oversee health facilities, a role played by the DPHOs before federalization.

2.2. Differentiation Category for Country Audits

The Global Fund has classified the countries in which it finances programs into three portfolio categories: focused, core and high impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics. Nepal is classified as:

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

[7] Economic Survey 2017/18, Government of Nepal, Ministry of Finance
[8] https://www.who.int/workforcealliance/countries/57crisiscountries.pdf
[9] Human Resources for Health Nepal Country Profile. Kathmandu, Nepal
http://www.nhssp.org.np/NHSSP_Archives/resources/NHSSP_quarterly_report_january_march2013.pdf

Challenging Operating Environment

X **Additional Safeguard Policy[10]**

2.3. Global Fund Grants in Nepal

The Global Fund has invested US$233 million in Nepal since 2003, with US$43.6 million in current active grants. Nepal has been allocated catalytic funding of US$1.3 million for human rights interventions, with matching funds of US$1.3 million from the Government. The country submitted its first funding request under the New Funding Model in 2017. Following a review by the Global Fund Secretariat, Nepal's Country Coordinating Mechanism (CCM) did not meet CCM eligibility requirements in 2015; it did however become eligible in August 2017.

Save the Children Federation Inc. has been the Principal Recipient of Global Fund grants in Nepal since 2015. Following the earthquake in 2015, the Additional Safeguard Policy came into effect and the Secretariat nominated the Principal Recipient that year. The Ministry of Health and Population, through the national programs for the three diseases, implements the grants as sub-recipients for interventions in the public sector. Other implementers are non-governmental organizations, who mainly implement interventions for key populations.

Of the six grants audited, three ended on 15 March 2018 and the others will end on 15 March 2021:

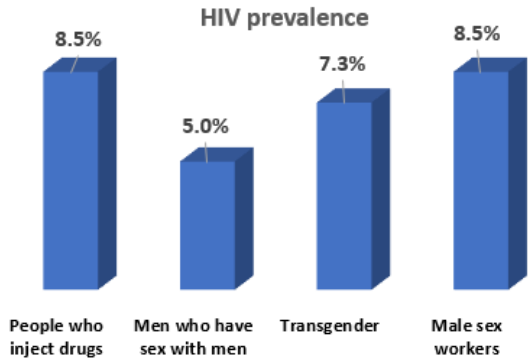
Grant Number	Principal Recipient	Grant period	Signed amount (US$)	Amount disbursed (US$)
Active grants (2018-2021)				
NPL-H-SCF	Save the Children Federation, Inc.	March 2018 to March 2021	23,264,144	8,497,811[11]
NPL-M-SCF	Save the Children Federation, Inc.	March 2018 to March 2021	4,208,547	1,443,855
NPL-T-SCF	Save the Children Federation, Inc.	March 2018 to March 2021	16,138,548	6,944,419
Total			**43,611,239**	**16,886,085**

Closed grants (2015-2018)				
NPL-H-SCF	Save the Children Federation, Inc.	March 2015 to March 2018	23,956,016	23,523,734
NPL-M-SCF	Save the Children Federation, Inc.	March 2015 to March 2018	10,593,376	9,792,270
NPL-T-SCF	Save the Children Federation, Inc.	March 2015 to March 2018	17,643,621	16,351,077
Total			**52,193,013**	**49,667,081**

[10] The Additional Safeguard Policy was put in place in 2015 as result of the earthquake which struck Nepal. Additionally, Nepal was characterized by weak state capacity which translated in limited capacity of the government to deliver essential services, reflected in the consistent poor grant performance of the national programs. Further, weak financial and oversight management by the government PRs, resulted in financial irregularities. This resulted in GF assigning an international NGO (Save the Children) as PR of the Global Fund grants.
[11] The amount disbursed includes direct payment to third parties for drugs procured by the Global Fund.

2.4. The Three Diseases[12]

HIV/AIDS: HIV in Nepal accounts for 0.1% of the global HIV burden. The HIV epidemic remains concentrated among key populations.



The Global Fund is the largest donor to the country's HIV response, representing 20% of funding available for 2018-2021. Support from Government and other donors[13] represent 23% and 7% respectively,[14] with a funding gap of US$55 million (50%).

31,000 people living with HIV, of whom 49% (15,260) are on treatment (2017).

Annual infections have decreased by 61% since 2010, with 835 new infections in 2017.

AIDS related deaths declined from 2,238 in 2013 to 1,306 in 2017.[15]

In 2016, 87% of people living with HIV were still on treatment after 12 months.

Malaria: Nepal is moving towards elimination by 2026. The malaria burden declined steadily from 42,000 confirmed cases in 1985 to 1,009 confirmed cases in 2016. Malaria testing increased from 118,165 in 2015/2016 to 207,581 in 2016/2017 (76% increase).

LLIN distribution increased from 584,503 in 2015/2016 to 665,038 in 2016/2017 (14% increase), with 84% of affected households with at least one LLIN for every two people (72% in 2013).

The Global Fund is the largest donor to Nepal's malaria response (31%). The Government provides 43% of resources for the national malaria control program, with a funding gap of 26% (US$6.5 million).[16]

50% of malaria cases were imported by migrants returning from India and Africa.[17]

Three estimated malaria deaths in 2017.

In 2015/2016, the annual malaria parasite incidence (API) was 0.07 per 1,000 population, putting the country on the path to elimination.[18]

[12] Unless otherwise noted, data has been summarized from latest country funding requests and Global Fund Secretariat Briefing notes, funding request 2018-2020, 2017 UNAIDS, WHO TB and World Malaria reports, and the latest country annual report for three diseases.
[13] Other donors include USG, WHO, UNICEF, AIDs Health Foundation, Norway, Netherlands, etc.
[14] Funding Landscape (Funding request to the Global Fund Sep 2017)
[15] Government of Nepal: Fact sheet 1: HIV Epidemic Update of Nepal 2017
[16] Funding Landscape (Funding request to the Global Fund Sep 2017 – funding cycle 2018-2021)
[17] Malaria Funding Request Application March 2018 – March 2021
[18] The API of Nepal is relatively low compared to other countries in the region. For example, Myanmar and Cambodia had API of 1.39 and 2.82, respectively, in 2017.

Tuberculosis: Nepal is considered a medium TB burden country with estimated rates of incidence and mortality of 156 and 20 per 100,000 population, respectively. TB prevalence (all forms) declined by 55% from 348 in 1990 to 211 per 100,000 population in 2014.[19]

There has been a significant decline in TB case notification in the last two years. Estimated missing cases are 13,000. The first national TB prevalence survey is on-going (started in 2018). The Global Fund is the largest donor to the country's TB response (23%), with 54% provided by the Nepal Government (Funding Cycle 2018-2021). The funding gap is 23% (US$24 million).

32,056 TB cases notified (2016).
TB treatment coverage is 70%.[20] Treatment success rate: TB - 91%; MDR – 71%.

Mortality rate is reducing, from 52 per 100,000 in 1990 to 23/100,000 in 2016.

2.5. Portfolio Performance

Grants in the country are generally performing well, as shown by the achievement rate of key mandatory coverage indicators in the country. The root causes for the low rates of HIV testing and TB case notification are analyzed in sections 4.3 and 4.4 of this report.

Global Fund Key Indicator Achievements (March 2018)[21]			
HIV/AIDS	**Target**	**Actual**	**Achievements[22]**
Percentage of people living with HIV currently receiving antiretroviral therapy	48%	42.2%	88%
Percentage of people who inject drugs that have received an HIV test during the reporting period and know their results	85.5%	74.5%	87%
Percentage of men who have sex with men reached with HIV prevention programs - defined package of services	97.8%	90%	92%
Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results	91.2%	72%	79%
Percentage of transgender people: • reached with HIV prevention programs • that have received an HIV test during the reporting period and know their results	 87.5% 78.7%	 39.4% 29.9%	 45% 38%
Percentage of sex workers reached with HIV prevention programs - defined package of services	88.9%	54.3%	61%
Percentage of sex workers that have received an HIV test during the reporting period and know their results	80%	35.2%	44%

TB	**Target**	**Actual**	**Achievements**
Number of notified cases of all forms of TB	12,485	9,350	75%
Treatment success rate	90%	90.6%	101%
Number of TB cases with RR-TB and/or MDR-TB notified	234	180	77%

Malaria	**Target**	**Actual**	**Achievements**
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	92.4%	97.1%	105%

[19] Nepal Funding Request Application year 2017-2019.
[20] Nepal WHO TB Profile, 2017
https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=NP&outtype=pdf
[21] Global Fund Grant Rating Tool for the three grants for the period November 2017 to March 2018; selected key grant performance indicators based on relevance and importance.
[22] The achievement ratio is calculated as the ratio between actual achievement and target for each indicator.

Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities	100%	100%	100%

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

2.6 Risk Appetite

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries[23] representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants. Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by the second line functions and senior management from Grant Management Division. Grant risk ratings are weighted using the country allocation amount to arrive at an aggregate risk level for the country portfolio. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee (PPC)[24] during the Country Portfolio Review (CPR). Aggregated risk levels for Nepal have been reviewed, but Nepal has not been through a CPR. See Annex C for further discussion of Risk Appetite methodology.

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

Risk	**Secretariat aggregated assessed risk level[25]**	**Assessed residual risk, based on audit results**	**Relevant audit findings**
Program Quality	Moderate	Moderate	4.3 and 4.4
National Program Governance and Grant Oversight	Low	High	4.1 and 4.2

Nepal is an operating environment in which risk levels remain moderate to low across most of the grant implementation risk areas. The assessments of risk levels by the OIG and the Secretariat are aligned except for the risk related to **National Program Governance and Grant Oversight**. This risk is a composite of three sub-risks related to: national program governance; program management; and program coordination and sub-recipients oversight. The OIG and the Secretariat had different levels of assessed risk related to two of these sub-risks, which resulted in the difference between OIG and Secretariat's overall rating of National Program Governance and Grant Oversight:

a) National Program Governance

- OIG audit results suggest the current level of residual risk is 'high' because, post-federalization, the roles and responsibilities of the Ministry of Health and Population (MoHP) and the Ministry of Social Development with regards to the oversight and implementation of the three disease programs have not been clearly defined, impacting Global Fund supported programs. The related risks have already materialized, to a large extent, in the form of: significant delays in reporting of programmatic and logistic data; disruptions in the flow of funds from the Principal Recipient to the national program

[23] Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe
[24] The role of the Portfolio Performance Committee is to conduct country portfolio reviews and enterprise reviews
[25] The aggregated risk levels for the three grants in Nepal as of December 2018

resulting in low absorption of grant funds and non-implementation of key grant activities; and material disruption in the flow of commodities leading to stockpiling of commodities at the central warehouse, with noted expiries of commodities at the central level while high risks of stock-outs remain at the level of service delivery centres.

- The Secretariat initially rated this risk as moderate because, at the time of the rating, a number of discussions on federalization had already been held with other external development partners and MoHP officials. Through these discussions, assurances were provided that the majority of HIV, TB and malaria activities would continue to be funded through the central channel while a 5-year transition plan was being finalized and adopted to devolve roles and responsibilities for the management and financing of national programs in an orderly manner. In parallel, the Country Team continuously liaised with Save the Children (the Principal Recipient), the Local Fund Agent and partners to assess whether services were being impacted by devolution-related decisions. The Secretariat has since adjusted the level of this sub-risk to 'high' because additional information[26] on interruptions to data and commodity flows was reported in Q1 2019 during Country Team missions and in the Principal Recipient's progress update and disbursement report.[27] In response to the new information and the increased risk level, the Country Team commissioned the Local Fund Agent to review the process of decentralization and gaps created in leadership, implementation, supervision and monitoring. The Country Team also engaged with health staff at provincial level to explore solutions to the emerging challenges posed by decentralization in the absence of a transition plan. Save the Children is advancing the dialogue with provinces to provide necessary guidance for the continuation of activities including supply chain and data flows, while the Government pursues decentralization.

b) Program coordination and sub-recipient oversight

- OIG rated this risk as moderate because of gaps in capacity-building arrangements for the three national disease programs, which is one of the factors informing the high level of risk noted in the national program governance.

- The Secretariat rated this risk low as Save the Children has been performing well despite some province-level activities being delayed. These delays are mainly training activities. The Secretariat does not consider this as a material difference of opinion.

The Secretariat has subsequently adjusted the risk level of National Program Governance and Grant Oversight from "Low" to "Moderate".

[26] Data flows from health centers in the palikas, and from provinces, had in fact been interrupted; health commodities were identified as stockpiling in central level warehouses due to the suboptimal distribution channels between the three levels of Government, and; some malaria activities were impacted (distribution of LLINs according to a micro-stratification plan) due to the limited coordination and guidance among different levels of Government.

[27] PUDRs for the period 16 March 2018 (grant start date) to 31 December 2018 were received on 27th March 2019, OIG audit field work and country debrief had been concluded at this time.

3. The Audit at a Glance

3.1. Objectives

This audit sought to assess the:

(i) adequacy and effectiveness of the implementation arrangements to ensure efficient and sustainable achievement of grant objectives. Specifically:
- Impact of decentralization on Global Fund-supported programs
- Sustainability and capacity building

(ii) adequacy of systems and mechanisms at central level to ensure quality of services to intended beneficiaries.

3.2. Scope and Methodology

The audit was in accordance with the methodology described in Annex B covering the period from January 2017 to December 2018.[28] The audit covered two grants (HIV/AIDS and Tuberculosis) implemented by the Principal Recipient, Save the Children Federation Inc., and its sub-recipients including the key implementer, the Ministry of Health and Population. The malaria grant was excluded from the audit as the risks identified during the audit planning stage were low, and the mitigating measures were found to be adequate. The auditors visited selected health facilities, the National Public Health Laboratory, and the central warehouse in Kathmandu.

3.3. Progress on Previously Identified Issues

Previous relevant OIG audit work
Audit of Global Grants to Nepal, 2010 (GF-OIG-09-006)

The last OIG audit of grants in Nepal in 2010 focused on assessing the efficiency and effectiveness of grant operations, and the soundness of policies in place to safeguard Global Fund resources. It assessed the risks that Global Fund grants may be exposed to, and what mitigation measures were in place. The audit highlighted two high priority recommendations, both of which have been addressed. These were:

- Various inventory management and warehouse issues including small, overcrowded, disorderly and dirty warehouses, and a lack of physical stocktaking.
- A requirement for the CCM to develop reporting templates for Principal Recipients to be able to analyse data for better oversight.

Implementation arrangements changed significantly after the earthquake in 2015. Of the five Principal Recipients audited in 2010, only Save the Children remains under the current implementation arrangements.

[28] Progress Update and Disbursement Reports (PU/DR) for the periods July 2016 to December 2018 were reviewed.

4. Findings

4.1. Unclear roles and responsibilities in the provision of health care post-federalization have affected program leadership, coordination and implementation

Nepal was declared a federal state in December 2007, and a new constitution was promulgated in September 2015; however, the federalization process did not officially start until a new government was formed in February 2018. Following federalization, health care delivery in Nepal has been decentralized, giving more autonomy to provincial and municipal governments. The Ministry of Health and Population (MoHP) is now responsible for policy formulation, resource mobilization, and monitoring and regulating health services. A Ministry of Social Development (MoSD) has been established to oversee the work of the newly formed seven provinces and 753 municipalities, which are responsible for delivering health services. Federalization resulted in a revised administrative structure that did not include a district level, which under the previous system comprised 77 coordination and reporting units. These units were reinstated in Q1 2019 due to implementation challenges created by the revised administrative structure.

Post-federalization, various roles and responsibilities are yet to be finalized. Responsibilities between MoHP and MoSD with regards to the leadership, oversight and implementation of the three disease programs have not been clearly defined. Specifically, responsibilities are not defined for the oversight of Global Fund grants at the provincial and municipality levels. Leadership and ownership of the national disease strategies remain unclear as implementation of health care is devolved to the Ministry of Social Development (MoSD), and the reporting arrangement from the provinces and MoSD to MoHP is not defined. The provinces and municipalities that are responsible for health delivery do not report administratively to MoHP.[29] This has affected implementation of the three disease programs in the areas of supply chain, fund flow, and reporting of programmatic and logistic data.

Disruption in the supply of TB and malaria commodities: Distribution of TB and malaria commodities from the central level to the service delivery points, and logistics information from service delivery points to the central stores, have been affected due to unclear roles in the distribution process. This has caused delays in the distribution of drugs by the central warehouse, leading to expiries of commodities and a high risk of stock-outs at service delivery centers. For example, HIV screening test kits worth US$0.4 million, capable of performing approximately 400,000 tests, were at risk of expiring in the central warehouse in April and May 2019. In addition, 137 months of stock of anti-malaria medicines are being held at the central medical store. The removal from the supply chain cycle of the 77 district tiers that used to coordinate, request and report distribution of health commodities, and the lack of a clear supply chain structure at the sub-national level post-federalization have contributed to failures in the flow of commodities and logistics information. Although the municipalities have health-related budgets, they had not yet set up the necessary administrative infrastructure seven months into the fiscal year. Logistics arrangements, including how commodities flow from regional/provincial medical stores to health facilities, are yet to be clearly defined. With the removal of the district level, no budget was allocated to district warehouses, which have been unable to distribute commodities to health facilities.

No flow of funds from the Principal Recipient to the national disease programs (except HIV) since the start of the new grant in March 2018. In the absence of the District Treasury Office, the Principal Recipient and MoHP put on hold the transfer of program funds to sub-national levels, resulting in key planned activities not being implemented. For example, between March and December 2018, the absorption for grants where MoHP is a Sub-Recipient was only 4%, 43% and 53% for malaria, TB and HIV grants respectively. For the HIV grant, the MoHP was only able to spend 27% (i.e. US$600,000) of the budget for program activities other than overheads and procurement. TB grant

[29] Although municipalities do not report administratively to the MoHP, they report data through the HMIS hosted by MoHP

absorption mainly relates to procurement of TB medicines. Activities which the MoHP did not implement included: review meetings with central, regional and local-level staff, interventions for migrants and prisoners, quality assurance and quality control of health products, and supervision and monitoring activities. The financial management function performed by the District Treasury Office before federalization has not been re-assigned, resulting in a lack of clarity on the fund transfer process. Further, with the district level being removed in early 2018, and with no further guidance on how central teams should work with sub-national structures, transfers of funds have been put on hold until clarity on roles is provided.

Incomplete programmatic data reported in the health management information system (HMIS): None of the municipalities had submitted their TB program data one year after implementation of the new Global Fund grants. Only 32% of reports from health facilities had been reported in the HMIS as of 31 December 2018. Antiretroviral therapy and Prevention of Mother to Child Transmission sites reporting through HMIS reduced from 79% to 57% and from 85% to 61%, respectively, between April and December 2018. The reporting delays result partly from unclear roles and accountability regarding data reporting from the new data aggregation and reporting units, of which there are now 753, as opposed to 77 previously. There is also a lack of clarity at service delivery points on where HMIS reports should be submitted. District level statisticians and disease-focal positions that were responsible for entering and validating data, respectively, were abolished after federalization. As a result, data reporting is not taking place. The government has not designated officers responsible for entering or validating data at municipality level. The government has reinstated some district-level office staff, but their roles are yet to be clearly defined.

Oversight and accountability of Global Fund-supported programs could be affected: Changes in the role of the national programs and the autonomy of provinces could affect oversight, accountability and reporting arrangements of the national programs. Global Fund-supported programs in Nepal are currently implemented through MoHP (national programs for the three diseases) and non-governmental organizations, although health care delivery is the sole responsibility of provincial and municipal health authorities. The Principal Recipient does not have any contractual relationship with the MoSD, which oversees the provincial health directorates, and there is no clear reporting arrangement between the MoSD and the MoHP. In the absence of clear accountabilities, the national disease programs may not have effective oversight over the activities being implemented by provinces and local governments. The new role of the national disease programs and the MoSD could affect the implementation arrangements of Global Fund-supported programs in future.

Agreed Management Action 1

The Secretariat will conduct a review of the impact of the decentralization of power on leadership and implementation of the three national disease programs. The Secretariat will develop an Action Plan with the Principal Recipient, and in coordination with the leadership of the MoHP, to highlight where roles and responsibilities of the relevant entities at the three levels of Government need further clarification to ensure: national strategies and program activities are implemented; supervision, monitoring and evaluation are assured; funding can flow to support activities; the disruption in supply of commodities is minimized; and programmatic data can be reported.

Owner: Mark Edington, Head Grant Management Division

Due date: 31 December 2020

4.2. Improvements needed to address institutional sustainability of the three disease programs and fulfilment of government commitments

The Government of Nepal has progressively increased its investments in the national response to HIV, TB and malaria. The Government committed to procuring 56%, 80% and 100% of antiretroviral medicines and other HIV-related commodities in 2018, 2019 and 2020 respectively. The Government also plans to increase funding for the procurement of first and second line anti-TB medicines by 50% and 62% respectively. However, the non-fulfilment of government commitments, coupled with capacity gaps at the national disease program level, may affect the sustainability of the country's response to HIV, TB and malaria.

Non-fulfilment of procurement commitments by the Government.
Despite a 70% increase in the Government contribution to the health budget between the 2010-11 and 2016-17 fiscal years, the share of health within government expenditure declined from 6.7% to 4.6% in the respective fiscal years. The Government has fallen short of its procurement commitments; it committed to procuring US$1.75 million worth of HIV commodities in 2018, but only procured US$0.85 million (49%). The Government also failed to procure TB first line drugs worth US$0.65 million in 2018, which it had previously committed to doing.

These funding shortfalls have resulted in an increase in the number of emergency procurements by the Principal Recipient to cover Government procurement gaps. For example, HIV and TB commodities worth US$0.8 million were procured as emergency orders in 2018. There are no funds in the grant budget for antiretroviral medicines in 2020 as the Government committed to procuring 100% of the medicines that year. There is a risk of stock-outs of antiretroviral medicines from September 2019 if Government commitments are not fulfilled. The delays in fulfilment of Government commitments have contributed to shortages/stock-outs of HIV test kits, specifically of Unigold at the central warehouse,[30] and viral load reagents (see finding 4.3). The non fulfilment of these commitments was due to cancellation of the procurement process as a result of an insufficient allocation in the Government budget, due to high cost estimates by suppliers and the late initiation of government procurement.

Gaps in capacity-building arrangements for the three national disease programs
According to the Global Fund's Sustainability, Transition and Co-financing policy, sustainability planning should be inherent in program design and be considered by all countries, regardless of where they are on the development continuum. Global Fund-financed programs are expected to be implemented, as much as possible, through country systems to build resilient and sustainable systems for health.[31]

Nepal represents a good example of close collaboration between government and non-governmental organizations. The Principal Recipient has worked with the Government to make significant progress against the three diseases in the country, conducting a wide variety of training courses and capacity building activities for service delivery providers and the three national disease programs. However, the national disease programs' capacity remains a challenge, with a notable gap in human resources. As part of the capacity building approach, the Principal Recipient has embedded staff within the national disease programs to provide on-the-job training, however this was not informed by an in-depth capacity assessment of the national programs; the last comprehensive capacity assessment was performed in 2011.

The impact of the Principal Recipient's capacity-building efforts has been limited by frequent staff turnover and limited human resources allocated to the national disease programs. There have been six different Ministers and Health Secretaries at MoHP since 2016, three different directors at the National TB Program since 2017, and yearly changes of the HIV and Malaria program directors.

[30] There were 0.5 months of stock of the Unigold test kit at the central medical store.
[31] The Global Fund Sustainability, Transition and Co-financing Policy 2017 (GF/B35/04) –pages 4&5

Human resource gaps at the national disease programs have also impacted the effectiveness of capacity building activities. The Government has not assigned the number of staff needed for the national programs, contributing to the MoHP's continued high dependency on Principal Recipient staff embedded in the national programs: 68%, 46% and 90% of staff at the HIV, TB and malaria national programs respectively are employed by the Principal Recipient.

Agreed Management Action 2

The Secretariat will work with the Principal Recipient, the MoHP and province-level health staff, to assess the capacity building needs at the MoHP and staff at the province and palika level (as roles and responsibilities through decentralization are defined at the periphery-levels) to implement national program activities. The Principal Recipient will capture results of the assessment in a capacity assessment report and will develop a costed capacity building plan.

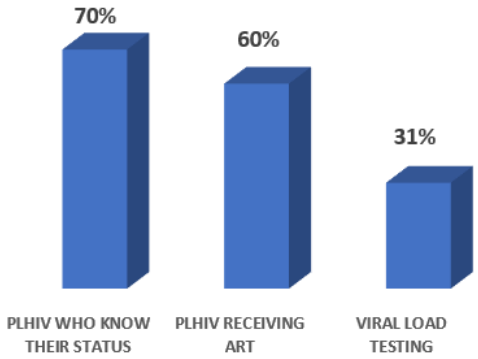
Owner: Mark Edington, Head Grant Management Division

Due date: 31 December 2020

4.3. Inadequate access to quality HIV testing and monitoring of clients on treatment

Global Fund investments in Nepal have significantly contributed to scaling up key interventions across the three disease programs. The country has expanded antiretroviral treatment sites, bringing treatment closer to clients. 60% of people living with HIV are on antiretroviral treatment and the number of people on treatment increased by 25%, from 12,000 in 2015 to 15,000 at the end of 2017, with a retention rate of 89%. Despite this progress, improvements are needed in HIV testing coverage and the monitoring of HIV clients on treatment, as highlighted in section 2.5.

Figure 1: Nepal's progress towards HIV 90:90:90 target[32]



Low testing coverage and yield among key populations

Nepal is not achieving its HIV testing targets, especially among key populations. Although 70% of people living with HIV know their HIV status (as shown above), almost half of the key populations reached with HIV preventive services are not being tested. The program reached 194,959 key population members through HIV prevention services from November 2017 to December 2018, but only 111,411 (57%) were tested. Only 39%, 44% and 79% of transgender, sex workers, and men who have sex with men, respectively, who were reached through prevention services were tested in that period. In addition, community-led testing among key populations supported by the Global Fund has a low testing yield (0.14%) compared to the prevalence rate of 8.5%.[33] The testing yield and prevalence rates of key populations are:

- People who inject drugs: 0.06% vs 8.5%;
- Men who have sex with men: 0.14% vs 5.0%;
- Transgender: 0.14% vs 7.3%;
- Male sex workers: 0.14% vs 8.5%.

The low testing coverage and yield among key populations represent a missed opportunity for early diagnosis and timely initiation of antiretroviral therapy. Contributing factors include:

Gaps in the community-led testing model: Nepal started the community-led testing model in early 2017, rolling it out in 2018. Although this has improved testing coverage, the approach being used in the country is non-differentiated, lacking a risk segmentation strategy to target the most-at-risk within key populations. Outreach workers do not maintain records of the risk profile of key populations during pre-test counselling in order to track the most-at-risk for follow up. This creates difficulties in targeting the most at-risk population to increase the testing yield.

Limited quality control: Despite the availability of funds, External Quality Control is not being systematically conducted at HIV Testing and Counselling confirmation labs. Gaps in recording the sequences of tests undertaken (i.e. Determine, Unigold and Statpack) as per the national guidelines

[32] 70% (19,702 of 27,918) of people living with HIV know their HIV status; 60% (15,260 of 25,126) of people with diagnosed HIV infection receive sustained antiretroviral therapy; and 31% (7,184 of 22,613) of people receiving antiretroviral therapy have viral suppression, which was 89%

[33] 2017 Country IBBS Survey

were noted in the facilities visited. These gaps in documentation are hindering the effective review of the quality of confirmatory testing during supervision visits and could affect the design of appropriate training to improve the quality of testing at facility level.

Different prevention service packages for key populations: The absence of a standardized national HIV prevention package among the different implementing partners has resulted in key populations preferring prevention packages that cover more comprehensive services (e.g. Sexually Transmitted Infections). This has affected the testing coverage of some partners/implementers, leading to varying uptake of services. For example, some implementers do not offer a comprehensive service package including testing of other sexually transmitted infections, making the service unattractive to some of the key population.

Delays in finalizing plans for human rights and migrants' interventions: The Global Fund and the Government of Nepal provided US$2.6 million[34] funding to address barriers to accessing HIV and TB services. The implementation of this intervention has been delayed for 12 months. The human rights baseline assessment was delayed by eight months due to a combination of factors including delays in receiving data from the country and limited human resources at the Global Fund Secretariat (Community, Rights and Gender) to support the project.[35] The Nepal Country Coordinating Mechanism has yet to approve the final work plan due to delays in finalizing implementation arrangements and selecting sub-recipients.

Interventions for migrants and prisoners have not progressed as expected, despite 30% of new HIV infected cases being among male migrants. This is due to delays in the annual contracting of NGOs by the government and also to delays in the migrant assessment. For example, there was a five-month delay in the contracting of NGOs by the government to implement key population-related interventions in 2017. The Global Fund's Technical Review Panel recommended conducting an HIV risk assessment on migrant and prisoner populations to improve interventions targeting them. Although the draft report of the International Office for Migration's assessment of "Health Vulnerabilities of Cross-border Migrants from Nepal" was sent to relevant national stakeholders in September 2018, it is yet to be endorsed, due to the late finalization of the Government's national "migration health policy".

Gaps in monitoring clients on HIV treatment

Viral load testing[36] is the standard for monitoring people living with HIV on treatment. Airlifting samples for viral load testing from peripheral sites to the National Public Health Lab has improved monitoring of treatment outcomes. However, viral load testing coverage of people on antiretroviral treatment remains low at 31%,[37] as shown in *Figure 1* above. Low viral load testing increases the risks of higher mortality and drug resistance. According to WHO, for each additional month of delay in taking the first viral load test, the risk of virological failure increases by 9% and the risk of treatment switching increases by 14%.[38] The viral load suppression for the patients tested is 89%.

Nepal has three viral load machines and has decided to leverage its GeneXpert machines for viral load testing. However, there has been slow progress in using the GeneXpert machines for this purpose, due to an eight-month delay in procuring cartridges as a result of delays in obtaining a duty waiver from the Ministry of Finance. Stock-outs of viral load reagents at the National Public Health Laboratory between August and October 2018, which were due to delays in the delivery of reagents as well as maintenance issues due to the absence of in-country maintenance services, have

[34] The Global Fund provided catalytic funding of US$1.3 million and the Government provided a matching fund of US$1.3 million
[35] CCM is yet to approve the final work plan, pending the agreement on the implementation arrangements and the selection/confirmation of the SRs
[36] A viral load test measures the number of HIV viral particles per millilitre of blood. A low viral load indicates that treatment is effective. A high viral load in a person on treatment indicates either that the medication is not being taken properly or that the virus is becoming resistant to the medication.
[37] 7,184 of 22,613 of people receiving antiretroviral therapy have viral load testing, and their viral suppression is 89%
[38] WHO HIV testing guidelines, 2011

contributed to the low utilization of viral load machines. The machines had an average down time of 76 days (ranging from 42 to 110 days) in 2018, and the estimated average turnaround time for viral load test results was two months.[39] There is no specific process indicator to monitor turnaround times for viral load tests at the National Public Health Lab.

Agreed Management Action 3

The Secretariat will work with partners, including the Principal Recipient, MoHP and other relevant Government departments and PEPFAR, to develop an Action Plan to strengthen the quality of testing and monitoring of patients on treatment across HIV programs in Nepal.

Owner: Mark Edington, Head Grant Management Division

Due date: 30 September 2020

[39] Optimally, it should not exceed 2 weeks

4.4. Interventions to address low TB case notification are not achieving the desired outcomes

Tuberculosis (TB) remains a public health problem in Nepal, being the sixth leading cause of death in the country. The TB treatment success rate is high (91%) and has remained relatively stable since 2017. Despite this, Nepal has consistently not met its TB case notification targets. Case notification has declined in the last two years, and there are 13,000 estimated missing TB cases. A TB prevalence survey is currently ongoing; preliminary findings suggest the TB burden will be higher than expected. The country has intensified efforts to identify missing cases in communities, but the interventions deployed (including contact tracing and engaging private providers) have not achieved the expected results.

Low yield from mandatory contact tracing

The program's mandatory household contact tracing targets all pulmonary bacteriologically-confirmed and childhood TB cases in 38 districts, representing 85% of all TB cases notified and 79% of Nepal's total population.[40] There has been overachievement in the targets for household coverage and for screening family members: 116% of the target for households of bacteriologically-confirmed and child cases were reached, and 140% of the target for families screened for TB from March 2018 to January 2019.

However, the testing yield is low. Of 10,394 presumptive family members referred or sputum samples collected for sputum microscopy, only 250 cases were diagnosed as positive for TB (i.e. 2.4%), compared to a target of 10%, due to the lack of clear guidance on active case finding, and inadequate monitoring mechanisms for volunteers conducting contact tracing. If unaddressed undetected cases may increase morbidity and contribute towards mortality. Only 12.7%[41] of samples of smear-negative presumptive TB cases screened with microscopy were transported to GeneXpert centers for confirmatory tests. The GeneXpert machines experienced a down time of 6.3 months and 2.8 months in 2017 and 2018, respectively. There is no central system to monitor the functionality of GeneXpert, the quality of tests, or the availability of supplies for the machines.

Limited engagement of private providers

The country estimates that 7,200 TB cases should be notified via the private sector through public-private mix interventions. "Pay for Performance", an innovative arrangement to incentivize the private sector in TB case notification, is currently being implemented in 15 districts with 120 physicians. Only 333 (6.2% of grant target of 5,389)[42] of TB cases notified via the private sector were logged in the online eTB Private Practitioner register in 2018. In addition, as of February 2019, only 29 private doctors or institutions (24% of the target) were reporting through the eTB register.

The main root cause for the limited engagement of the private sector is the absence of a nationally-endorsed public-private strategy. This hinders the creation of a national task force and the formal involvement of professional bodies (including task forces at provincial levels). While TB has been included in Public Health Act regulations as a notifiable disease, it is still waiting for Parliamentary approval. Although "pay for performance" has improved engagement with private providers, there is limited monitoring of the private providers enrolled on the program, due to the absence of a dedicated TB surveillance officer within TB high burden municipalities. There is limited motivation for private providers to fully engage in the "pay for performance" program as the training conflicts with their regular working hours, and the financial incentive per notified case is unattractive. Unclear selection criteria also make it difficult to identify doctors handling TB cases in private health facilities.

[40] The program has been designed based on the districts and it is expected that all of the Pulmonary Bacteriologically Confirmed contacts shall be traced. The design of the program was before elimination of districts in July 2018. The program still refers to the districts in some cases since the provinces and municipal structures are still being developed.
[41] 1,109 out of 8,679
[42] 6.2% of the target of 5,389 for the period March – December 2018

Agreed Management Action 4

The Secretariat will work with the Principal Recipient, MoHP and development partners to strengthen quality of testing and monitoring of TB patients on treatment by developing:

a. Clear guidance on active case finding and monitoring mechanism or alternate means of improving testing yield; and
b. national public-private strategy for TB.

Owner: Mark Edington, Head Grant Management Division

Due date: 30 September 2020

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
Agreed Management Action 1 The Secretariat will conduct a review of the impact of the decentralization of power on leadership and implementation of the three national disease programs. The Secretariat will develop an Action Plan with the Principal Recipient, and in coordination with the leadership of the MoHP, to highlight where roles and responsibilities of the relevant entities at the three levels of Government need further clarification to ensure: national strategies and program activities are implemented; supervision, monitoring and evaluation are assured; funding can flow to support activities; the disruption in supply of commodities is minimized; and programmatic data can be reported.	30 June 2020	Mark Edington, Head Grant Management Division
Agreed Management Action 2 The Secretariat will work with the Principal Recipient, the MoHP and province-level health staff, to assess the capacity building needs at the MoHP and staff at the province and palika level (as roles and responsibilities through decentralization are defined at the periphery-levels) to implement national program activities. The Principal Recipient will capture results of the assessment in a capacity assessment report and will develop a costed capacity building plan.	31 December 2020	Mark Edington, Head Grant Management Division
Agreed Management Action 3 The Secretariat will work with partners, including the Principal Recipient, MoHP and other relevant Government departments and PEPFAR, to develop an Action Plan to strengthen the quality of testing and monitoring of patients on treatment across HIV programs in Nepal.	30 September 2020	Mark Edington, Head Grant Management Division
Agreed Management Action 4 The Secretariat will work with the Principal Recipient, MoHP and development partners to strengthen quality of testing and monitoring of TB patients on treatment by developing: a. Clear guidance on active case finding and monitoring mechanism or alternate means of improving testing yield; and b. national public-private strategy for TB.	30 September 2020	Mark Edington, Head Grant Management Division

Annex A: General Audit Rating Classification

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

Annex B: Methodology

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

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

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

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

Audits may also assess how Global Fund grants/portfolios are performing against target for Secretariat-defined key indicators; specific indicators are chosen for inclusion based on their relevance to the topic of the audit.

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

Annex C: Risk Appetite and Risk Ratings: Content, Methodology and Implications

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries[43] representing the majority of the global burden for the three diseases: 85% for HIV/AIDS; 80% for TB; 76% for malaria. The Global Fund's Risk Appetite Framework, operationalized in 2018, sets recommended risk appetite levels for eight key risks affecting Global Fund grants.

As accurate risk ratings and their drivers are critical to effective risk management and operationalization of risk appetite, a robust methodology was developed with clear definitions, granular risks, root causes as well as an extensive review process as detailed below.

The eight grant-facing risks for which risk appetite has been set represent an aggregation from 20 risks as depicted in the table on the following page. Each of these 20 risks is rated for each grant in a country using a standardized set of root causes and considers a combination of likelihood and severity scores to rate risk - Very High, High, Moderate or Low. Country Teams determine each risk at grant level using the Integrated Risk Management module. The ratings are reviewed by second line functions and senior management from the Grant Management Division.

The ratings at the 20-risk level are aggregated to arrive at the eight risks using simple averages, i.e. each of the component parts are assumed to have similar importance. For example, the risk ratings of *Inadequate program design (1.1)* and *Inadequate program quality and efficiency (1.3)* are averaged to arrive at the rating of Program Quality for a grant. As countries have multiple grants, which are rated independently, individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. As the ratings of grants often vary significantly and to ensure that focus is not lost on high-risk grants, a cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating. The aggregated risk levels, along with the mitigation plan and expected trajectory of risk levels, are then approved by the Portfolio Performance Committee[44] during the Country Portfolio Review.

Leveraging Risk Appetite in OIG's work

As the Risk Appetite framework is operationalized and matures, OIG is increasingly incorporating risk appetite considerations in its assurance model. Important considerations in this regard:

- The key audit objectives that are in the scope of OIG audits are generally calibrated at broad grant or program levels (for example, effectiveness of supply chain processes, adequacy of grant financial management, quality of services, reliability of data, overall governance of grant programs, etc.) as opposed to narrower individual risk levels. Thus, there is not a one-to-one match between the overall audit rating of these broad objectives and the individual rating of narrower individual risks. However, in the absence of a one-to-one match, OIG's rating of an overall audit objective does take into consideration the extent to which various individual risks relevant to that objective are being effectively assessed and mitigated.

- The comparison of OIG's assessed residual risks against the Secretariat's assessed risk levels is done at an aggregated level for the relevant grant-facing risks (out of the eight defined ones) that were within the scope of the audit. This comparison is not done at the more granular level of the 20 sub-risks, although a narrative explanation is provided every time the OIG and the Secretariat's ratings differ on any of those sub-risks. This aggregated approach is designed to focus the Board and AFC's attention on critical areas where actual risk levels may differ from perceived or assessed levels, and thus may warrant further discussion or additional mitigation.

[43] Bangladesh, Burkina Faso, Cameroon, Congo (DRC), Côte d'Ivoire, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Myanmar, Nigeria, Pakistan, Rwanda, South Africa, Sudan, Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe.
[44] The role of the Portfolio Performance Committee is to conduct country portfolio reviews.

For risk categories where the organization has not set formal risk appetite or levels, OIG focuses on the Secretariat's overall processes for assessing and managing those risks, and opines on their design and effectiveness.

Table of risks

Corporate Risks (8)	Operational Risks (20)
Program Quality	1.1 Inadequate program design and relevance
	1.3 Inadequate program quality and efficiency
M&E	1.2 Inadequate design and governance of M&E Systems
	1.4 Limited data availability and inadequate data quality
	1.5 Limited use of data
Procurement	3.3 Inefficient procurement processes and outcomes
In-Country Supply Chain	3.2 Unreliable forecasting, quantification and supply planning
	3.4 Inadequate warehouse and distribution systems
	3.6 Inadequate information (LMIS) management systems
Grant-Related Fraud & Fiduciary	2.1 Inadequate flow of funds arrangements
	2.2 Inadequate internal controls
	2.3 Fraud, corruption and theft
	2.5 Limited value for money
Accounting and Financial Reporting by Countries	2.4 Inadequate accounting and financial reporting
	2.6 Inadequate auditing arrangements
National Program Governance and Grant Oversight	4.1 Inadequate national program governance
	4.2 Ineffective program management
	4.3 Inadequate program coordination and SR oversight
Quality of Health Products	3.1 Inappropriate selection of health products and equipment
	3.5 Limited quality monitoring and inadequate product use