



Audit Report

Global Fund Grants in the Republic of South Sudan

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Geneva, Switzerland

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Audit Report

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1. Executive Summary

1.1. Opinion

South Sudan is one of the most challenging operating environments in the Global Fund portfolio. The Global Fund is a key development partner, providing 31% of HIV, 64% of TB and 39% of malaria funding across the 2018-2020 NFM2 period. Despite significant challenges in terms of political stability, economic dependence on oil and inadequate capacity of human resource for health, progress has been made across the three diseases since the 2015 OIG audit. Global Fund grants are materially meeting their performance targets; in particular, over 2 million insecticide treated bed nets were distributed in 2017 and 2018, and steps have been taken to align the grants to the recently devolved state expansion (from 10 to 32¹ states).

While key risks across the portfolio are adequately identified and mitigation activities are generally appropriate, implementers' actions to mitigate risks have been materially delayed or incomplete. Issues exist in the timeliness and accuracy of data that is available for the three diseases, with delays in national health management information system (HMIS) reporting in 2017 and 2018. Despite the challenges, the roll out of DHIS2, which was originally planned to be finalized by December 2017, has been postponed to December 2020. The national monitoring and evaluation framework has not been completed and no data quality audits were conducted in 2017 and 2018 by the Ministry of Health (MoH). Significant delays have also been noted in the completion of key studies and surveys. These have affected the availability of reliable data for strategic decision making and performance measurement.

There was inadequate planning and monitoring for the mass bed net distribution. Malaria behavioral and change communication activities were not undertaken during or prior to mass distribution campaigns in 2017 and 2018. No post-distribution assessments to review the effectiveness of mass campaigns were conducted. The program has taken full advantage of flexibilities² under the Challenging Environments (COE) Policy in bed net distribution as well as the opportunity to use service providers and humanitarian aid delivery to support distribution, but an incomplete framework to implement flexibilities on bed net distribution has resulted in multiple interpretations by different parties on their use. This contributed to implementers not exploring other flexibilities in the Global Fund COE policy (such as on grant revisions, the performance framework or monitoring and evaluation activities) due to lack of clearly defined risk appetite for these flexibilities. The mitigation of significant portfolio risks therefore **needs significant improvement**.

With the Government of South Sudan's contributions to health declining from 7% in 2012 to 1% of GDP in 2016, effective partnerships and coordination play a vital role in the fight against the diseases. The audit found gaps in partner coordination, which contributed to parallel commodity distribution and delays in executing key program activities, including the roll-out of the Boma Health Initiative, a critical intervention for community health engagement in the country. Donor coordination with key donors such as PEPFAR for HIV and the Health Pooled Fund for malaria (through strengthening primary health care at the facility level) is critical in addressing systemic challenges such as parallel commodity delivery, and patient and logistics reporting systems. Implementers also contribute to financing CCM oversight activities, which contravenes Article 3 of the Global Fund CCM Funding policy. Grant implementation arrangements, including governance, oversight and partner coordination to achieve grant objectives are therefore **partially effective**.

Global Fund grants in the country are managed under the Global Fund's Additional Safeguards Policy due to the country's need to rebuild systems, infrastructure and capacity following years of conflict. The audit found non-compliance with Global Fund policies and guidelines, including

¹ South Sudan has expanded from 10 states (at independence in 2011) to 32 states, with each of the former 10 states having been subdivided. The States are the basic levels for health service planning and delivery.

² The GF COE Operational Policy Note outlines specific areas of flexibility country teams can request and the processes for obtaining these permissions. The spirit of the policy also encourages thinking innovatively and requesting flexibilities that are not outlined in the OPN, but which could catalyze results in COE portfolios

unsupported payments (US\$211k) and non-competitive procurements (48% of sampled cases). Processes and controls around fixed asset management, an issue previously identified during the OIG's 2015 audit of South Sudan, have materially improved, however gaps were noted in the utilization and recording of assets. Given the context of South Sudan as a COE country and the magnitude of the financial management issues identified, financial management and assurance over grant funds are therefore **partially effective**.

1.2. Key Achievements and Good Practices

HIV/AIDS treatment and services scale-up: The number of anti-retroviral treatment sites, several of which also provide TB treatment services, increased from 56 in 2017 to 76 in 2018, however, reports were only received from 69 active sites by December 2018. The target is to have 105 anti-retroviral treatment sites by 2020. The focus on delivering anti-retroviral treatment as close to home as possible has contributed to a 102% increase in people on anti-retroviral treatment between 2015 and 2018. Whilst a significant increase has been realized, and the target of 15% was exceeded in Q4 2018, only 17% of people living with HIV currently receive anti-retroviral treatment. The 'mentor mother' program (mother-to-mother support services) has improved HIV prevention and awareness, facilitating an increased uptake of HIV services, including testing, treatment, care and support. In 2018, early infant diagnosis services started at 33 sites, and prevention of mother to child transmission (PMTCT) sites increased to 125 (from 77 sites in 2017). The gradual integration of PMTCT into antenatal care is steadily progressing. Overall coverage, however, remains low at 42% in 2018.

Improvements in TB service availability and treatment: The number of health facilities providing TB services (diagnostic and treatment centers) increased from 32 in 2006 to 95 in 2018. TB treatment coverage (notified/estimated incidence) was 56% in 2017, up from 54% in 2015. As part of improved HIV/TB collaboration, TB testing and initiation to treatment for co-infected patients increased from 87% (2017) to 96% (2018). TB treatment success rate also increased from 71% in 2015 to 80% in 2018 against a target of 82%.

Malaria progress: Malaria remains endemic throughout the country and is a major public health issue, particularly among children under five years old and pregnant women. The 2017 South Sudan Malaria Indicator Survey (SSMIS) indicated that vector control, intermittent preventive treatment of malaria in pregnancy (IPTp), use of rapid diagnostic tests (RDTs)/microscopy and treatment with ACTs have achieved impact. For example, the SSMIS shows 63% of households having access to at least one insecticide treated net against a 2017 target of 75%.³ The survey also showed higher coverage of 84% in Protection of Civilian sites (administered by the UN), and 75% of households in internally displaced person sites (managed by various humanitarian agencies) had at least one insecticide treated net.⁴ IPTp coverage increased from 32% in 2013 to 57% in 2017. Whilst the performance framework does not include targets related to malaria testing for children, parasitological testing of malaria in children under five years old increased from 28% (2013) to 48% (2017). This was mainly due to the availability and use of RDTs and microscopy provided by the Global Fund and other partners. Although accurate national malaria case management data remains a challenge, WHO estimates a 20-40% decrease in malaria mortality rates in the period 2010-2015. The country aims to reduce mortality by 80% by 2021, which will be challenging given current performance.

1.3. Key Issues and Risks

Completion of risk mitigation actions are required to improve data quality and enhance planning and monitoring of interventions: Issues exist in the availability of timely,

³ Malaria Strategic Plan 2014/15-2020/21 (Revised 2017)

⁴ Malaria Indicator Survey 2017. Access to an ITN is measured as the proportion of the population that could sleep under an ITN if each ITN in the household were used by up to two people. This implies that access to a large extent depends on the availability of LLINs in a household.

complete, and accurate data for the three diseases. Combined with inadequate funding and technical staff to deliver, this has resulted in delays to the national HMIS reports for 2017 and 2018. Human resource capacity gaps (number, quality, distribution and turnover); absence of data quality audits; lack of recent nationwide survey-based population (census) and disease prevalence (HIV & TB) data; insecurity (several locations that cannot report/be accessed); fluid population movements due to the incessant conflict situation; and the absence of a national monitoring and evaluation framework (which remains in a draft state) are affecting the reliability of data for strategic decision making and performance measurement. Flexible approaches for M&E activities, which are available to COE portfolios, have not been utilized under the current grants.⁵ Due to inadequate planning and monitoring of malaria interventions, behavioral and change communication activities were not undertaken during or prior to mass bed net distribution campaigns in 2017-2018.

Gaps in governance, oversight and partner coordination: Despite several attempts, detailed planning has not been completed to determine how health facilities are supported by each partner. Commodity delivery, donor-harmonized salary scales and incentive schemes, and joint reporting mechanisms continue to be a challenge. Coordination would facilitate reporting and distribution efficiencies across key health facilities, avoid duplications, and enhance forecasting and quantification for HIV and TB. Donor mapping is a Global Fund requirement in challenging operating environments such as South Sudan. Weak coordination among donor partners and the Government as well as limited transparency over funding have contributed to a delay in the roll-out of the Boma Health Initiative (BHI), a critical intervention for community health engagement. Limited inter-donor coordination by the Ministry of Health, combined with poor CCM meeting attendance by the bilateral constituencies, has meant that partners funding key interventions are not active or represented on the CCM. The CCM's independence may also be compromised as implementers contribute to financing CCM oversight activities.

Internal control weaknesses over quantification, financial and asset management: There is a need to strengthen internal controls and accountability over finance and procurement activities. Inconsistency in the use of assumptions for financial forecasting were noted. Global Fund-negotiated pooled procurement prices were not considered in commodity forecasting by UNDP. Forecast accuracy on HIV and TB health commodities is not reviewed to ensure adjustments are made within a reasonable time-frame. These contributed to 47% (against a target of 80%) of health facilities reporting no stock outs of malaria commodities⁶ in 2018.

Financial documentation submitted by sub-recipients is incomplete and inaccurate, and Principal Recipient reviews are insufficient. The audit found non-compliance with Global Fund policies and guidelines and uncompetitive procurements in half of the transactions sampled.

1.4. Rating

	Objective 1. Whether grant implementation arrangements including governance, oversight and partner coordination are adequate to effectively achieve grant objectives. OIG rating: Partially effective.
	Objective 2. The adequacy and effectiveness of financial management and assurance over grant funds. OIG rating: Partially effective.
	Objective 3. Whether significant risks ⁷ in the portfolio are effectively identified and mitigated. OIG rating: Needs significant improvement.

⁵ M&E flexibilities available to a COE include allowances on the verification of program data in zones where the LFA or a third party may not be able to physically verify reported data. (Global Fund COE Flexibility Tracker)

⁶ Mainly first line anti-malarial (ASAQ) for infants, toddlers and adults

⁷ Significant risk areas tested under this objective include service quality, monitoring and evaluation activities and procurement and supply chain.

1.5. Summary of Agreed Management Actions

The Secretariat will work with the Ministry of Health and partners to:

- Support efforts to improve program data availability and quality across the three disease programs. This will include a focus on the completion of key studies and surveys and the National Monitoring and Evaluation Framework.
- Strengthen coordination and complete mapping of donor contributions to key commodities at facility level across the three diseases.

The Secretariat will support the Principal Recipients to improve procurement, finance and asset management controls to safeguard Global Fund investments.

2. Background and Context

2.1. Overall Context

The Republic of South Sudan's history has been marked by instability and violence since its secession from the Republic of Sudan in 2011. Since 2017⁸, the country has been administratively divided into 32 States⁹ and the Abyei administrative area. The 32 states have their own councils, cabinet and government ministries, departments and agencies. South Sudan is a low-income country with an estimated population of 11.06 million people.¹⁰ More than 2.3 million people fled their homes due to the conflict in 2016; this includes 1.66 million internally displaced people (with 53% estimated to be children) and nearly 644,900 refugees in neighboring countries.¹¹

GDP per capita: **US\$283** (World Bank, 2016)

UNDP Human Development Index: **187 of 188** (2018)

Transparency International Corruption Perceptions Index: **178 of 180** (2018)

UNDP Gender Inequity Index: **187 of 189** (2017)

South Sudan is the most oil-dependent country in the world; oil accounts for the majority of exports and 60% of gross domestic product.¹² The share of health in government funding plummeted from 7% in 2012 to 1% in 2016, largely due to a fall in oil revenues. The health sector is predominantly externally funded. The health system is decentralized and based on four levels: community level primary health care units; primary health care centers; county and state hospitals; and national referral hospitals. Country-specific challenges are impacting the quality of services and hindering effective implementation across all three diseases. The inadequate capacity of human resource for health across the country is compounded by limited and irregular remuneration by the Ministry of Health. Health infrastructure at local, state and national levels is inadequate and frequently not fully functional; health facilities have been attacked and destroyed in some instances during heavy fighting in recent years, while community systems are either ineffective or non-existent.

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 under the Additional Safeguards 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 Sudan is:

 Focused: (Smaller portfolios, lower disease burden, lower mission risk)

 **Core: (Larger portfolios, higher disease burden, higher risk)**

 High Impact: (Very large portfolio, mission critical disease burden)

 **Challenging Operating Environment**

 **Additional Safeguard Policy**

⁸ On 14 January 2017, President Kiir issued a decree that increased the number of federal states from 28 to 32. <https://www.hrw.org/world-report/2018/country-chapters/south-sudan>

⁹ 10 former states are recognized by certain development partners

¹⁰ UN Population Division Estimate: <https://population.un.org/wpp/Download/Standard/Population/>

¹¹ <https://reliefweb.int/report/south-sudan/2016-south-sudan-humanitarian-needs-overview>

¹² World Bank 2016: <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=SS>

2.3. Global Fund Grants in South Sudan

The Global Fund has signed grants of over US\$462 million and disbursed over US\$421 million to South Sudan since 2005. The United Nations Development Programme (UNDP) implements the HIV (including health systems strengthening component) and TB grants, while Population Services International (PSI) implements the malaria grant. The active grants in the country are:

Principal Recipient	Grant Number	Component	Grant Period	Grant Signed Amount (US\$)	Grants Disbursed to date (US\$)
United Nations Development Programme	SSD-H-UNDP	HIV	January 2018 to December 2020	32,681,295	16,465,685
Population Service International	SSD-M-PSI	Malaria	January 2018 to December 2020	45,000,000	18,451,214
United Nations Development Programme	SSD-T-UNDP	TB	January 2018 to December 2020	9,000,000	3,302,503
Total				86,681,295	38,219,402

The country was placed under the Additional Safeguard Policy (ASP) as a direct consequence of ongoing insecurity, insufficient public accountability, as well as the rebuilding of systems, infrastructure and capacity after 21 years of conflict. To mitigate these risks, the Secretariat has put in place specific safeguards such as: the selection of Principal Recipients by the Global Fund; Local Fund Agent assessments of sub-recipients; procurement through international procurement agents (UNDP and PSI); and additional capacity assessments of the National Programs.

2.4. The Three Diseases



Malaria: Malaria is the leading cause of morbidity and mortality in South Sudan. It is a major public health issue and is endemic in all parts of South Sudan, with the entire population at risk. Malaria accounts for 45% of all visits to health facilities and 9% of all hospital admissions. It remains one of the biggest causes of illness and death in children under five. WHO estimates a decrease of 20-40% in malaria mortality rates in the period 2010-2015.

2.56m insecticide treated nets (ITNs) distributed in 2017-2018.

Increased coverage of intermittent preventive treatment in pregnancy, from **32%** in 2013 to **57%** in 2017 (against a 2016/17 target of 50%)¹³

3% decline in the ownership of at least one ITN per household – **66%** (2013) to **63%** (2017)¹⁴ against a target of 75%.

Increased percentage of children under 5 years receiving any ACT, from **20%** in 2013 to **61%** in 2017¹⁵ against a 2016/17 target of 60%



HIV/AIDS: HIV adult prevalence in the general population is estimated at 2.5%. Approximately 190,000 people are living with HIV, 91% of whom are adults (15+ years).¹⁶ The 2017 Integrated Biological and Behavioral Survey conducted amongst men who have sex with men indicated a HIV prevalence of 3.3% among this key population.

Progress against the UNAIDS 90-90-90 cascade is estimated at 24-16-83.¹⁷ Antiretroviral treatment coverage is low (estimated at 16% in 2018) and prevention of mother to child transmission coverage remains low at 56% in 2018.

190,000 estimated people living with HIV (2018)

9,900 AIDS-related deaths in 2018¹⁸

31,586 people living with HIV (PLHIV) on anti-retroviral treatment across 69 active anti-retroviral treatment sites (2018)¹⁹



Tuberculosis: No national TB prevalence survey has ever been conducted in South Sudan. The TB epidemiological status and trends are based on WHO modelling. TB case notification increased from 10,478 in 2016 to 14,371 in 2018 across 95 functional TB management units. TB treatment coverage (notified/estimated incidence) in 2017 was 56%, up from 54% in 2015 (WHO). Programmatic management of drug resistant TB in South Sudan began only in 2017 pilot phase. In 2017 and 2018, there were 15 and 53 drug-resistant tuberculosis (DRTB) cases notified, respectively, out of which 12 (80%) and 28 (53%) were enrolled on treatment.²⁰

TB cases notified in 2018: **14,371**

TB Treatment success rate: increased from **72%** in 2014 to **82%** in 2016

TB/HIV: Mortality figures increased from **6.6%** in 2014 to **13%** in 2016²¹

¹³ Malaria Strategic Plan 2014/15-2020/21 – Revised 2017

¹⁴ South Sudan Malaria Indicator Survey 2018

¹⁵ Secretariat Briefing Note NFM1 and NFM2, South Sudan Funding Request NFM1 2016-2018 and NFM2 2019-2021

¹⁶ <https://www.unaids.org/en/regionscountries/countries/southsudan> (2019)

¹⁷ <https://www.unaids.org/en/regionscountries/countries/southsudan> (data for 2018 used for % of people living with HIV who knew their status and % of people living with HIV who were on treatment. The third 90 comes from the 2018 PUDR.

¹⁸ <https://aidsinfo.unaids.org/>.

¹⁹ ¹⁹ <https://www.unaids.org/en/regionscountries/countries/southsudan> (2019) and Secretariat Briefing Note NFM1 and NFM2, South Sudan Funding Request NFM1 2016-2018 and NFM2 2019-2021

²⁰ ²⁰ Secretariat Briefing Note NFM1 and NFM2, South Sudan Funding Request NFM1 2016-2018 and NFM2 2019-2021

²¹ WHO TB Country Profile

2.5. Portfolio Performance

Grants in the country are generally exceeding expectations, as shown by the achievement rate of key mandatory coverage indicators in the country. The root causes for the zero rates of achievement on the malaria indicators are analyzed in sections 4.2 and 4.3 of this report.

Global Fund Key Indicator Achievements (December 2018) ²²			
Indicator – HIV/AIDS	Target	Actual	Achievement
% of sex workers that have received an HIV test during the period that know their results	30%	32%	107%
% of sex workers reached with HIV prevention programs – defined package of services	30%	63%	120%
% of other vulnerable populations reached with HIV prevention programs - defined package of services	17.3%	34%	120%
% of HIV positive pregnant women who received ART during pregnancy	38%	42%	111%
% of HIV exposed infants receiving a virologic test for HIV within 2 months of birth	15.2%	9.4%	62%
% of people living with HIV currently receiving antiretroviral therapy	15.4%	17%	113%
% of People Living with HIV on ART who had a Viral Load test in the last 12 months	20%	43%	120%
Indicator – TB	Target	Actual	Achievement
% of Laboratories showing adequate performance in EQA for smear microscopy among total of laboratories using smear tests	95%	82.7%	87%
% of registered new and relapse TB patients with documented HIV status	85%	94.8%	112%
% of HIV positive new and relapse TB patients on ART during TB treatment	85%	92.2%	108%
Number of TB cases with Rifampicin-resistant (RR-TB) and/or MDR-TB notified	35	36	103%
Number of cases with RR-TB and/or MDR-TB that began second-line treatment	35	21	60%
Number of notified cases of all forms of TB	6339	7446	117%
Indicator – Malaria	Target	Actual	Achievement
Proportion of population at risk potentially covered by long lasting insecticidal nets distributed	100%	146%	120%
Proportion of estimated malaria cases (presumed and confirmed) that received first line antimalarial treatment at public sector health facilities	80%	0%	0%
Proportion of confirmed malaria cases that received first-line antimalarial treatment in the community	80%	99.9%	120%
Proportion of estimated malaria cases (presumed and confirmed) that received first line anti-malarial treatment in the community	80%	96.5%	120%
Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national policy at public sector health facilities	75%	0%	0%
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	55.6%	62%	112%
Proportion of pregnant women attending antenatal clinics who received three or more doses of intermittent preventive treatment (IPTp) for malaria	26%	67.6%	120%
Exceeding Expectations	>100%		
Meet Expectations	90-100%		
Adequate	60-89%		
Inadequate but potential demonstrated	30-59%		
Unacceptable	<30%		

²² Global Fund Grant Rating Tool (Global Fund Performance Update Disbursement Report Q4 2018) for the three grants for the period July 2017 to December 2018; selected key grant performance indicators based on relevance and importance

2.6. Risk Appetite

Risk appetite has been developed at the organizational level using data from a cohort of 25 countries²³ representing most 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 have been reviewed for South Sudan and the portfolio is scheduled to have a CPR in Q4 2019.

The OIG compared the Secretariat's aggregated assessed risk levels (Q1 2019) for the key risk categories covered in the audit objectives for the South Sudan portfolio with the residual risk that exists based on OIG's assessment (Q2 2019), mapping risks to specific audit findings. Please refer to the table below:

Risk	Secretariat aggregated assessed risk level²⁵	Assessed residual risk, based on audit results	Relevant audit issues
National Program Governance and Grant Oversight	Very High	Very High	Finding 4.1
Strategic Data Quality & Availability (SDQA)	High	High	Finding 4.2
Grant related Fraud & Fiduciary	High	High	Finding 4.4
In-Country Supply Chain	Very High	Very High	Finding 4.5

South Sudan is an operating environment in which the risk levels are rated as very high for program quality, in-country supply chain and national program governance and grant oversight, whilst the remaining risk levels vary across the spectrum. The assessment of risk levels by the OIG and the Secretariat are aligned.

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 This is the aggregated risk levels for the three grants in South Sudan.

3. The Audit at a Glance

3.1. Objectives

The audit sought to provide assurance on:

- Whether grant implementation arrangements including governance, oversight and partner coordination are adequate to effectively achieve grant objectives.
- The adequacy and effectiveness of financial management and assurance over grant funds.
- Whether significant risks in the portfolio are effectively identified and mitigated.

3.2. Scope

The audit was performed in accordance with the methodology described in Annex B and covered the period from January 2017 to December 2018. The review covered the grants implemented by the Principal Recipients and key implementers including the Ministry of Health and other sub-recipients. Where applicable, the audit also considered the design of future arrangements for the implementation of grants in South Sudan. Due to the security situation in the country, the audit focused on activities in Juba, the capital of South Sudan, and did not review/visit health facilities outside of Juba.

Principal Recipient	Grant Number	Component	Grant Period	Grant Signed Amount (US\$)
United Nations Development Programme	SSD-H-UNDP	HIV	October 2015 to December 2017	40,705,633
			January 2018 to December 2020	32,681,295
Population Service International	SSD-M-PSI	Malaria	April 2015 to December 2017	74,013,291
			January 2018 to December 2020	45,000,000
United Nations Development Programme	SSD-T-UNDP	TB	July 2015 to December 2017	16,079,588
			January 2018 to December 2020	9,000,000
Total				217,479,807

Exclusion from scope

The United Nations General Assembly has adopted a framework known as the “single audit principle”, whereby the UN and its subsidiaries cannot consent to third parties accessing their books and records. All audits and investigations are conducted by the UN’s own oversight bodies. Accordingly, the OIG cannot provide assurance on activities or procurements directly implemented by UN agencies. However, all other activities (including the management of assets procured and transferred to sub recipients) and non-UN sub-recipient activities were part of the scope.

3.3. Progress on Previously Identified Issues

A 2015 OIG audit of Global Fund grants to South Sudan highlighted the following issues:

1. *Limited funding for the three diseases, coupled with difficulties related to operating in the country, have affected coverage of key affected populations and limited the country’s ability to fight the three diseases.*
The grants that were signed under the new funding

Previous relevant OIG audit work

[Audit of Global Fund Grants to the Republic of South Sudan, 2015](#)

model address the limited coverage of key affected population under the three diseases. However, the NFM2 grant allocation was lower than the NFM1 cycle and the government share of funding to the health sector decreased not only in proportion but also in absolute terms due to decreased oil prices. This in effect resulted in reduced investment in the three diseases and RSSH.

2. *Key activities that are critical to the overall success of funded programs have not been effectively implemented and key risks have not been effectively mitigated in South Sudan.* The current audit found that some key activities within the grants have not been implemented, including key staff recruitment and national surveys/studies. Combined with ongoing challenges, from partner coordination to the challenges of the working environment, this means that these underlying issues remain. The Secretariat reviewed the existing mechanism to ensure that key risks are effectively tracked and approved at the highest level. The Risk department developed the Integrated Risk Management module (tool) to track due dates of risk actions and an escalation process has been incorporated in the Risk Management Operational Policy Note. The South Sudan Country Team has mapped their risks and included risk mitigation and assurance measures in the tracking tool.
3. *Grant activities to strengthen health systems have not optimally supported the funded programs.* Since the audit, the Secretariat has updated its policies and guidelines on the use of Global Fund grants funds for construction and renovation projects. The Health System Strengthening Information Note was also revised to ensure that normative guidance from technical partners is referenced and incorporated within budget guidelines.
4. *The Secretariat has not tailored its grant making and operational processes to consider grants that are implemented in “challenging operating environments”.* The Secretariat launched the Challenging Operating Environment policy (COE) which was approved by the Board in April 2016.²⁶ The Policy identifies COE countries and outlines the broad principles for the Secretariat's engagement in those countries. It acknowledges that the Secretariat will develop an operational framework to implement the COE policy, applying flexibilities on a case-by-case basis. This has since been introduced; however, finding 4.3 identifies ongoing challenges with the application of flexibilities, specifically on the South Sudan malaria program. The current audit identifies opportunities for PRs to make decisions based on agreed risk appetite within a COE context.

²⁶ (Decision #GF/B35/03)

4. Findings

4.1. Risk mitigation actions have not been implemented, impacting the availability of strategic data to inform policy & effective programming

The availability of data is critical for the setting and monitoring of robust performance targets. Limited data availability and inadequate data quality to inform program implementation were identified as a risk under both NFM I & II grants. Data weaknesses identified in the Secretariat risk assessments include accuracy, quality, timeliness and completeness of both logistics and programmatic data. This impacts the quality of services being delivered, with insufficient consistent data available to assess trends and impact. For example, WHO has been unable to produce trend and impact analysis (on malaria cases and mortality) for South Sudan in the World Malaria reports for the past five years, and poor-quality data were reported to the Secretariat (and then rejected) for two malaria indicators in the country's progress update report (PUDR) for the period ended December 2018 (see section 2.5). To address the data quality challenges, risk mitigation actions have been designed by the Secretariat to be implemented by Principal Recipients and sub-recipients. While certain actions have been completed or are being implemented, other key initiatives have either been materially delayed or have not started. These include:

Delayed strengthening of the national Health Management Information System (HMIS): Decentralized reporting and transition under UNDP mandate, DHIS1.4 to DHIS2, were initially targeted for all County Health Directorates by December 2017. This target has however been revised to December 2020 following delays. A new costed roll-out plan was developed in Q4 2018. DHIS2 is a health management information system to manage strategic information and facilitate evidence-based decision making. Migration to this leading-edge system, that has been used in low and middle-income countries since 2006, will enable many benefits including the ability to send health data from places with no fixed line telephony or internet access via a simple cell phone. Some progress has been made, including training 63 monitoring and evaluation (M&E) officers. Equipment to facilitate their work has however not been provided to the M&E officers, and guidelines have not been disseminated. The inadequate funding and staffing at the M&E Directorate, sub-optimal functioning of HMIS and delayed roll-out of DHIS2 contributed to delayed HMIS reports in 2017 and 2018.

Lack of key data including national-level studies and health surveys: In addition to the studies (i.e. Therapeutic Efficacy Surveillance and the National Health Accounts) not completed and highlighted under finding 4.4:

- An AIDS Indicator Survey which was initially planned to be conducted under NFM1 has not commenced. The bilateral partner which was expected to contribute 50% of the cost of this survey withdrew its funding due to post-2016 conflict issues such as population displacement. The survey requires donor funding support to be implemented. HIV cascade analysis for the October - December 2018 cohort was delayed due to lengthy data analysis and report writing. The report was finally published in Q3 2019.
- A Vector Susceptibility Study commenced under NFM1 was suspended due to delayed administrative and procurement processes; the country plans to recommence the study in Q4 2019.
- A 2017 Antenatal Care sentinel surveillance report is yet to be published, and an HIV drug resistance survey planned for 2017 only commenced in Q4 2018, with the report scheduled for Q4 2019.
- The final report of the Service Availability and Readiness Assessment conducted in 2017/18 (and which includes the establishment of a master health facility list) is yet to be finalized (over 12 months delay).²⁷

Data Quality Reviews were incorporated into the GAVI-funded Health Facility Assessment (HFA) that took place in 2018 and Q1 2019, the report is however yet to be finalized. The HFA incorporated

data quality as well as service availability and readiness assessments in the nationwide review. Planned program quality reviews for the TB and HIV programs are yet to be completed, despite being scheduled to commence in 2019. The National Monitoring and Evaluation framework has also been delayed for 18 months and is yet to be finalized. The recruitment, training and deployment of 33 State TB/HIV, malaria and M&E Coordinators to facilitate improved quarterly supportive supervision and review monthly HMIS reports submitted by the County Health Teams has been delayed.

The delayed or non-commencement of key national surveys/studies and inadequate oversight by respective national disease programmes are primarily due to human resource capacity gaps, budgetary constraints and prolonged recruitment challenges at MoH. Four key MoH M&E positions (one Director and three Officers) remain vacant. Recruitment and retention of staff have been further hampered by the inability of MoH to make regular salary payments to staff and to agree long term working contracts until the recruitment exercise, which has been ongoing for over 12 months, is completed. This also explains why roll-out of DHIS2 has been delayed and data quality assessments were not conducted in 2017 and 2018. Wider country challenges, such as the 2016 conflict which led to displaced and inaccessible populations and loss of trained health workforce, contributed to the data quality challenges. Ongoing power supply and internet availability are also contributing factors. The Malaria Indicator Survey completed in 2018 will provide a basis for Malaria indicators, the Malaria Program Review and the Malaria National Strategic Plan Revision.

Consequently, the availability of strategic data to inform decision making and the development of policy, programmes and grants is limited. Grant interventions and implementation strategies might not adequately target populations with high disease burdens, including uniformed workers, internally displaced persons, refugee camps as well as returning civilians in and outside protected sites. Due to the delays in national level baseline studies and surveys, performance targets are not necessarily based on up to date evidence or strategic information, limiting the implementers' ability to effectively monitor and track grant performance. There is also a risk that program results reported to the Global Fund may not be reliable.

Agreed Management Action 1

The Secretariat, in collaboration with the Ministry of Health and partners, will support efforts to improve program data availability and quality across the three disease programs, by working with the Ministry of Health and other partners to:

- Prioritize completion of the following key national surveys and studies: Vector Susceptibility Survey, Antenatal Care sentinel surveillance report and the Service Availability and Readiness Assessment.
- Finalize the National Monitoring and Evaluation Framework for the health sector.

Owner: Mark Edington, Head of Grant Management Division

Due Date: 31 December 2020

4.2. Insufficient planning, monitoring and limited accountability over LLINs distribution

Malaria is endemic in South Sudan, with the entire population at risk of infection. It is the leading cause of morbidity and mortality, accounting for 45% of all visits to health facilities and 9% of all hospital admissions.²⁸ In fighting malaria in South Sudan, a key challenge is to ensure comprehensive costing of the malaria response at the outset to identify funding gaps. Uncertain population data due to the lack of a recent census and displacement of people have led to difficulties in program target setting and performance monitoring. Despite investments of US\$7.7 million on vector control, planning, monitoring and accountability issues for the mass campaign²⁹ for insecticide-treated nets could be improved:

Insufficient planning and monitoring of the mass campaign for insecticide-treated nets

Behavioral Change and Communication (BCC) activities designed to educate users before and during mass campaigns in 2017 and 2018 were not undertaken. This was due to weak collaboration with community actors and activities not being budgeted in the grant for the 2018-2020 period. In addition, the nets were distributed outside the malaria peak season, putting the campaign's effectiveness at risk; they were distributed in December whilst the peak malaria period is June - October. There was limited effective supervision during the mass distribution by the Principal Recipient, the National Malaria Control Program or the County Health Departments, in part due to the instability in certain states as well as an insufficient health workforce. Lessons learned, and root cause analysis of the campaign's impact have not been undertaken, despite the health management information system indicating a 3% drop in the distribution coverage of insecticide-treated nets.

The absence of BCC activities before and during the campaign impacted the awareness and usage of the nets. The utilization rate of the bed nets was 47% in 2018³⁰; malaria positivity was 67% in 2018 against a national target of 40%. About 684,000 bed nets were received in South Sudan in December 2017, with 597,000 of those distributed in 2018. The remaining 105,000 bed nets with an approximate value of US\$197,000 have been stored in containers at the central warehouse for over 18 months and have been subjected to adverse weather conditions (quality assurance testing was being undertaken on the bed nets at the time of the audit following a request to stop distribution from the Secretariat). The reasons for the delay in the bed net distribution in 2018 include an 18-month delay in signing the contract with one of the mass campaign's two implementing partners.

Limited use of flexibilities in the Challenging Operating Environment policy and accountability of insecticide-treated nets

In 2017, the Global Fund's Executive Grant Management Committee approved the use of flexibilities under the Global Fund's Challenging Operating Environment (COE) policy to improve absorption and impact of in-country investments. For the malaria grant in South Sudan, the flexibility approved permitted an alternative reporting mechanism in the form of a distribution report or state-level clearance certificate for distribution, reporting and verification mechanisms in community and mass distribution settings. Flexibilities were also utilized by outsourcing of bed net distribution to service providers including humanitarian agencies as opposed to sub-recipients.

The implementation of flexibilities, such as the use of third party monitors to effectively monitor and evaluate bed net distribution in conflict and hard to reach areas was not utilized. The absence of an agreed risk appetite on key areas such as losses of bed nets and accountability by the Principal Recipient has led to a cautious approach to the use of flexibilities by implementers.

²⁸ WHO World Malaria Report South Sudan

²⁹ Mass campaign is a free distribution of long lasting insecticide nets through multiple channels as a cost-effective way to rapidly achieve high and equitable coverage of the population.

³⁰ Malaria Indicator Survey, 2017

Agreed Management Action 2

The Secretariat in conjunction with the Ministry of Health and Principal Recipients will:

- Develop a time-bound action plan to improve the quality of future mass campaigns based on the findings and recommendations of the 2017/2018 MIS report.
- Ensure the LFA undertakes a review of accountability for LLIN distribution across the 2018 mass distribution.
- Design and agree on an approach to clarify the minimum level of evidence required to support flexibilities in the context of LLIN distribution.

Owner: Mark Edington, Head of Grant Management Division

Due Date: 31 December 2020

4.3. Weak internal controls over financial management, procurement and management of assets

The Secretariat has instituted financial management arrangements including a zero-cash policy, segregation of duties and regular financial audits to safeguard Global Fund resources in the country. Since the OIG's 2015 audit, fixed asset management processes have matured: assets are adequately labelled, designated custodians are documented, and vehicle logbooks are maintained. Despite the progress made in financial management, control gaps over procurement, asset management and sub-recipients, as well as non-compliance with Global Fund policies, were noted.

Non-compliance with Global Fund policies and guidelines

The Global Fund's operational policy manual indicates that International NGOs (INGOs) can charge up to 3% of Indirect Cost Recovery (ICR) on the procurement of health products and their associated costs. A rate of 7% was used by the INGO Principal Recipient as the Secretariat had not applied the latest operational policy note on ICR charges as part of the budgeting process prior to the grant agreement approval. As a result, 7% was charged on approximately US\$8.3 million of freight and insurance, overstating the ICR by US\$300k in 2017 and 2018. This occurred because the grant agreement signed with PSI in April 2015 did not incorporate the latest policy changes (approved in March 2015) and there was no Secretariat process check to ensure accuracy and alignment based on the latest operational policy note.

According to the Framework Agreement with the Global Fund, the Principal Recipient (PSI) is not required to have a dedicated bank account for Global Fund funds and the external auditor is expected to give assurance on the cash balance of the grants. The grant funds are commingled with funds from other donors. As a result, the external auditor could not express an opinion on the cash balances of the Principal Recipient and the OIG is not able to provide assurance on the bank balances of the Principal Recipient at headquarter or country levels.

Inadequate financial management

Payments without adequate supporting documents and non-competitive procurement practices were identified by the OIG at the Principal Recipient and sub-recipients (SRs) sampled for review. For example:

- Despite the use of the zero-cash policy at certain sub-recipients of both Principal Recipients, transactions amounting to US\$211k³¹ had either inadequate or no supporting documentation to justify the expenditure.
- Non-competitive procurements (or procurement that was not aligned with best practice) were identified in 48% of sampled transactions of Cordaid, a sub-recipient under UNDP. For example, the sub-recipient procured directly in lieu of obtaining quotations.³²

Inadequate oversight by the Principal Recipient, PSI and limited assurance from the Local Fund Agent on sub-recipient expenditures³³, which form 35% of overall expenditures, contributed to these gaps prior to 2018. The PR undertakes a direct disbursement of any activity above US\$100k to the SRs. When the activity is conducted, the PR verifies a sample of about 25% before the advance payment is cleared. However, despite the PR's review noting issues such as unsupported expenses, the sample size of the review was not increased to mitigate the risk. From 2018 onwards, PSI introduced a risk-based approach, commencing with a 100% review of all partner transactions and reducing the sample size on a risk basis.

Gaps in fixed assets management

Although there has been progress in fixed assets management, further improvement is required in asset management across both Principal Recipients. Grant assets worth US\$340k which were recorded in the asset register as being in Juba could not be physically verified by the OIG. Of this

³¹ US\$211k worth of expenses associated with the National Malaria Control Programme, NMCP (an SR under PSI)

³² Transactions valued at \$112,000

³³ Six monthly reviews by the LFA were stopped by the Secretariat as reliance was to be placed on external audit

total, PSI assets worth US\$87,000 were tracked but could not be physically verified. UNDP assets (mainly health equipment) amounting to US\$160k bore different serial numbers to those in the asset register. Quality control reviews over fixed assets need strengthening, and annual asset verification exercises should be executed independently of those who manage the assets on an ongoing basis.

Agreed Management Action 3

The Secretariat will support the Principal Recipients to improve procurement, finance and asset management controls to safeguard Global Fund investments. This includes ensuring:

- The PR updates the fixed asset register.
- LFA reviews the fixed asset register, including assets which the OIG was unable to identify (with recoverable amount if any).
- LFA six-monthly sub-recipient expenditure verification reviews.

Owner: Mark Edington, Head of Grant Management Division

Due Date: 31 October 2020

4.4. Gaps in implementation arrangements, governance, oversight and partner co-ordination have delayed the execution of key activities

The health sector in South Sudan is reliant on international donors, and partner coordination is challenging in the country. The Global Fund works closely with PEPFAR on HIV, and partners supporting the Health Pooled Fund on malaria. There are opportunities to enhance co-ordination to implement key country initiatives as well as for regular reporting and commodity distribution. While the Country Coordinating Mechanism (CCM) has made significant strides following a period from November 2015 to March 2017 when it was classified as non-compliant with eligibility requirements, issues remain on CCM funding and partner involvement.

CCM governance and funding

Effective oversight and governance mechanisms are required to ensure that implementation challenges are identified in a timely manner and that lessons learnt help correct programs throughout the implementation period. The country has an active CCM, supported by an oversight committee that meets regularly. The CCM successfully led the grant making processes for the new funding cycle (2018-2020) in South Sudan, resulting in the timely signing of the grant agreements in December 2017. However, some of the CCM's activities (mainly logistics) are funded by implementers, contravening the Global Fund's CCM funding policy, which stipulates that CCMs should not draw directly from approved grant funds to support CCM costs. The CCM has been experiencing challenges with sustainable funding from other partners, and one donor has cut funding to the CCM. Efforts by the CCM resource mobilization committee have not yielded significant results to cover all CCM needs. The OIG recognizes that the CCM has been coordinating partners beyond the Global Fund grants. Joint missions undertaken by CCM and partners also resulted in recovery of grants vehicles and assets that had been seized.

The adequacy of CCM governance and oversight is impacted by low levels of attendance at CCM meetings by members representing the bilateral constituencies, who attended only 33% (5 of 15) of the general meetings held in 2017 and 2018. Whilst a quorum was achieved for decision making, this impacts the effectiveness of the CCM's role in the execution of, and oversight over, funded programs. For example, bilateral donors are funding the Boma Health Initiative (BHI) and other health system strengthening interventions that play a significant role in achieving Global Fund objectives. Some of these key actors are however not always present at CCM meetings. Specific sectoral issues including coverage of interventions by various donors are therefore not tabled and addressed adequately.

Coordination gaps are impacting program effectiveness at the national and state levels

The Ministry of Health (MoH) has established coordination bodies to manage donor and partner efforts including the Health Sector Working Group, Health Clusters, NGO Forum and disease Technical Working Groups (TWG). Apart from the disease TWGs, attendance and frequency of the meetings of the various coordinating bodies were ad hoc in 2017 and 2018. The Terms of Reference for the various working groups have not been aligned to identify how they can support MoH, nor is there a mechanism to track action points, recommendations, or defined mechanisms to escalate key issues for decision-making. The CCM that oversees Global Fund programs in the country has limited links to the established coordination bodies at MoH. A consolidated overview of key partner interventions for better coordination and monitoring of commitments is yet to be developed, despite the Global Fund's Challenging Operating Environments Policy requiring the Secretariat to undertake donor mapping across key partners and implementers.

The absence of clear segregation of donor roles by state and activities has contributed to multiple deliveries for different commodities to 131 health facilities by the Global Fund, Gavi Alliance and the Health Pooled Fund. In addition to this challenge which is acknowledged by partners, parallel reporting systems are run by partners to the detriment of the National Health Information System (HMIS). This negatively impacts the timeliness, completeness and availability of data. Delays in partners/implementers confirming their coverage and support for the Boma Health Initiative have resulted in US\$1.4 million in funding in the malaria grant not being utilized. These weaknesses are due to coordination bodies at the MoH not functioning effectively. Wider government challenges on

irregular salary payments and extensive human resource challenges across the MoH also contributed to this issue.

Key interventions not completed due to limitations in Principal Recipient oversight of sub-recipient activities

Under the NFM1 implementation arrangements, WHO was contracted as a sub-recipient of a grant managed by Population Service International (PSI). PSI, as an international NGO, has limited ability to supervise and monitor interventions implemented by UN entities. Thus, it has been unable to obtain, review and verify financial and programmatic information from WHO within the stipulated timelines of the sub-recipient agreement. PSI was not able to validate completion by WHO of activities with associated expenditures amounting to US\$1.1 million. A number of key interventions that WHO were contractually obliged to execute in 2017 (NFM 1) were either delayed or not implemented despite funds being advanced for these activities. These include:

- Development of technical guidelines for Behavior Change Communication and printing of Emergency Preparedness and Response guidelines (EP&R) were not undertaken at the end of NFM1 (18 months late).
- WHO recommends that the efficacy of first- and second-line antimalarial treatments be tested at least once every 24 months at all sentinel sites. Although US\$290k was reported as expenditure incurred for Therapeutic Efficacy Surveillance, the study was not completed, and no report was produced as envisioned in the NFM1 targets. There are plans to reprogram funds within the NFM2 grant to complete this study (with PSI engaging potential service contractors directly) which is now rescheduled to Q4 2019 to correspond with the high malaria season and to ensure Ministry of Health has time to prepare.
- The establishment of National Health Accounts (NHA) was a key milestone in NFM1 for the country's health sector and the data was to be used for advocacy, resource mobilization, policy dialogue and development, as well as to facilitate evidence-based decision making. Expenditure of US\$160k was reported for the establishment of the NHA but the health accounts were not completed by end of NFM1. Preliminary findings were presented in Q4 2018 and inputs from stakeholders are being incorporated to produce the final report for the 2016/2017 NHA (20 months delay as at July 2019).

Under the NFM 2 period (2018 – 2020), the Global Fund has made US\$1.1 million available for the implementation of approved activities through WHO. PSI were given guidance by the Secretariat to engage with WHO to seek a move from an implementing partner (SR agreement) to a Technical Assistance Provider (to PSI) which WHO did not agree to. Following discussions between PSI and the Secretariat, the funds initially allocated to WHO is being reprogrammed with a view of appointing alternative service contractors. The reprogramming approvals have been undertaken in sequence, although discussions and final approvals are ongoing. The delays in reprogramming and challenges in agreeing the implementation arrangements have resulted in delays in implementation of activities originally scheduled under NFM1 and subsequently programmed for NFM2. Approved activities under NFM2 including Therapeutic Efficacy Study (supposed to have commenced in Q1 2019) and Vector Susceptibility Study (planned commencement was Q1 2018) were rescheduled to Q4 2019. As a result, key training including on clinical audit and epidemiological approach for malaria control have not been delivered.

Agreed Management Action 4

The Global Fund Secretariat will work with the Ministry of Health, the CCM, and key partners to:

- Develop a timebound Stakeholder Engagement and Coordination plan to strengthen the CCM's engagement with partners and other coordination structures.
- Develop a plan for the mapping and coordination of donor contributions to key commodities at facility level across the three diseases.

Owner: Mark Edington, Head of Grant Management Division

Due Date: 30 September 2020

4.5. Improvements needed in quantification, forecasting and supply planning to improve value for money and minimize both expiries and stock outs.

For drug commodity management, supply plans should be based on the latest available programmatic data and be subject to regular review for accuracy and adjustments. The Principal Recipients use quantification tools (with pre-set formulae) and have guidelines for forecasting and quantification. The first national forecasting and quantification exercise by key partners for anti-malarial commodities, RDTs and LLINs was performed in 2018. Supply plans are in place, and health commodities are procured from WHO pre-qualified suppliers.

Despite this, inconsistent use of forecasting assumptions was noted, including the absence of Global Fund-negotiated pooled procurement prices for commodity forecasting. Forecast accuracy on health commodities for HIV and TB is not reviewed to ensure adjustments are made within a reasonable time-frame. In addition, no cost/patient analysis, including the financial impact, has been performed for the transition to using tenofovir lamivudine dolutegravir (TLD), a single-pill HIV treatment.

Gaps in quantification and forecasting contributed to stock outs and expiries of key commodities. For example:

- Stock outs of malaria commodities were reported at 76% of health facilities in June 2018.³⁴
- At the time of the audit, six HIV commodities worth US\$220k were at risk of expiry within the following two months,³⁵ although OIG notes that of these, only \$31,000 expired with the remainder consumed.
- GeneXpert tests kits worth US\$130k were sent to Uganda in May 2018 because they were due to expire in April 2019. The stocks would not have been consumed due to the low number of GeneXpert machines in the country, with low levels of utilization. There is no clear process to ensure that South Sudan will receive adequate reimbursement for the kits. South Sudan had stocked out of GeneXpert kits at the time of the audit.

The Principal Recipient cancelled an order of 9,000 packs of Sulfadoxine-Pyrimethamine tablets due to a potential overstock in the country, and all 2018 orders for malaria rapid diagnostic tests scheduled for delivery in August and November 2018 were rescheduled to 2019.

In line with forecasting and quantification guidelines, the Principal Recipient is required to work with the Ministry of Health and partners to identify ways to collect logistics data, including consumption and morbidity data, to provide enough visibility to forecast key commodities. This is however yet to be fully implemented. An opportunity was identified by UNDP to work and learn from an in-country partner initiative, utilizing Chemonics consumption data through a call center monitoring operation. Key areas of action have been agreed between UNDP and Chemonics, but this is yet to be operationalized. Actions to enable the logistics management information system to support a flow of reliable consumption data have not been designed and implemented, contributing to the gaps in forecasting, quantification and supply planning. Through a PSM specialist and LMIS coordinator, UNDP has sought to address the consumption data challenges through site visits, training, storage practice assessments, data verification and partner access to the pharmaceutical supply chain software. The country has limited supply chain data, including consumption data, patient regime numbers and health facility stock status reports. The absence of a procurement and supply chain specialist at the Principal Recipient in 2017 and 2018, and the lack of forecasting and quantification training in the last two years, also contributed to the gaps identified above.

³⁴ Global Fund Progress Update Disbursement Report June 2018. This has been caused by the number of health facilities not previously included in the HMIS (as not previously recognized by the Ministry of Health and thus not included in the quantification exercise to allocate commodities to the State MOHs). In 2019, the Directorate of M&E Research Planning and Budgeting issued an official letter to the Director Generals at the State MOHs to identify these missing HFs that were not included in the HMIS, resulted in the number of HFs increasing from 1315 to 2327 currently in the DHIS2.

³⁵ June and July 2019

Agreed Management Action 5

The Secretariat, in collaboration with the Principal Recipients will:

- Strengthen the coordination of and by Technical Working Groups and ensure a review mechanism is established for quantification and forecasting purposes.
- Develop a strategy and action plan to strengthen the LMIS.

Owner: Mark Edington, Head of Grant Management Division

Due Date: 31 December 2020

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
<p>1. The Secretariat, in collaboration with the Ministry of Health and partners, will support efforts to improve program data availability and quality across the three disease programs, by working with the Ministry of Health and other partners to:</p> <ul style="list-style-type: none"> • Prioritize completion of the following key national surveys and studies: Vector Susceptibility Survey, Antenatal Care sentinel surveillance report and the Service Availability and Readiness Assessment. • Finalize the National Monitoring and Evaluation Framework for the health sector. 	31 December 2020	Mark Edington, Head Grant Management Division
<p>2. The Secretariat in conjunction with the Ministry of Health and Principal Recipients will:</p> <ul style="list-style-type: none"> • Develop a time-bound action plan to improve the quality of future mass campaigns based on the findings and recommendations of the 2017/2018 MIS report. • Ensure the LFA undertakes a review of accountability for LLIN distribution across the 2018 mass distribution. • Design and agree on an approach to clarify the minimum level of evidence required to support flexibilities in the context of LLIN distribution. 	31 December 2020	Mark Edington, Head Grant Management Division
<p>3. The Secretariat will support the Principal Recipients to improve procurement, finance and asset management controls to safeguard Global Fund investments. This includes ensuring:</p> <ul style="list-style-type: none"> • The PR updates the fixed asset register. • LFA review the fixed asset register, including assets the OIG were unable to identify (with recoverable amount if any). • LFA six monthly SR expenditure verification reviews. 	31 October 2020	Mark Edington, Head Grant Management Division
<p>4. The Global Fund Secretariat will work with the Ministry of Health, the CCM, and key partners to:</p> <ul style="list-style-type: none"> • Develop a timebound Stakeholder Engagement and Coordination plan to strengthen the CCM's engagement with partners and other coordination structures. • Develop a plan for the mapping and coordination of donor contributions to key commodities at facility level across the three diseases. 	30 September 2020	Mark Edington, Head Grant Management Division
<p>5. The Secretariat in collaboration with the Principal Recipients will:</p> <ul style="list-style-type: none"> • Strengthen the coordination of and by Technical Working Groups and ensure a review mechanism is established for quantification and forecasting purposes. • Develop a strategy and action plan to strengthen the LMIS. 	31 December 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 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 countries³⁶ 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 Committee³⁷ 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.

³⁶ 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.

³⁷ 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