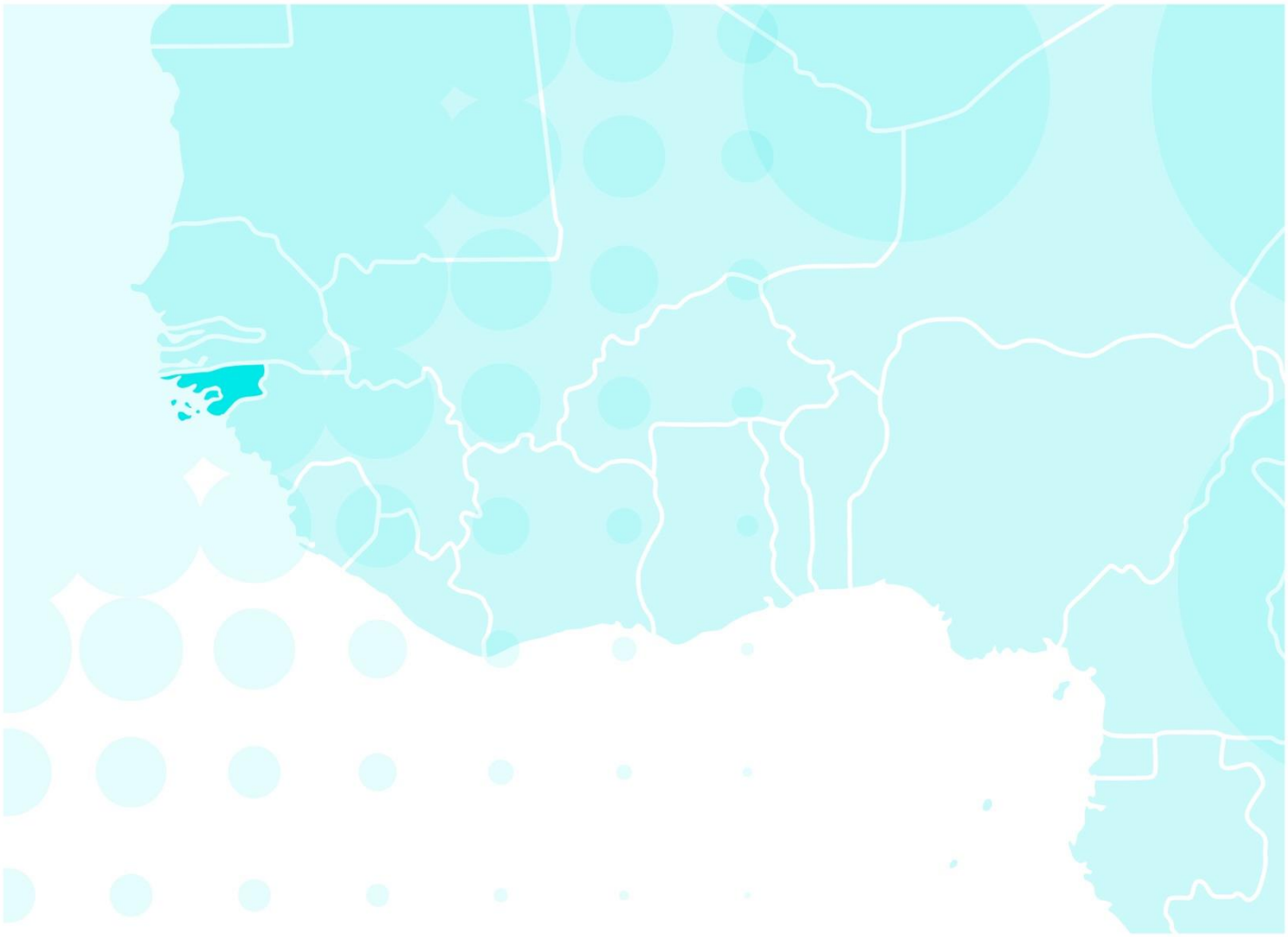

Audit Report

Global Fund Grants to the

Republic of Guinea-Bissau

GF-OIG-24-021
17 December 2024
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

The Republic of Guinea-Bissau is a low-income country, with a history of political, economic, and institutional fragility. A long period of political instability has resulted in depressed economic activity, deteriorating social conditions, and increased macroeconomic imbalances. Its GDP per capita and Human Development Index are among the lowest in the world, with poverty increasing in 2023. It has weak health systems, and especially for human resources for health. The portfolio is classified as a Challenging Operating Environment (COE) and has been subject to the Additional Safeguard Policy (ASP) since 2012.

Despite this context, there has been positive progress in some programmatic areas. Per UNAIDS 2023 estimates, HIV new infections have been declining and there has been an increase in HIV testing and antiretroviral therapy (ART) coverage.[1] Efforts have been made to roll out the health information management system DHIS2, and nationwide training on inventory and logistics management has been conducted. However, several significant issues remain, which are a consequence of wider health system weaknesses.

For the 2023 long-lasting insecticidal net (LLIN) mass campaign, nets distributed could not be fully traced back to beneficiaries in a sample of health areas, based on documentation made available to the OIG during the audit fieldwork, and the number of distributed nets has not been finalized, nine months after the campaign ended. This, and issues in the consistency of distribution, can limit the effectiveness of Global Fund investments and increase the risk of commodity diversion.

For HIV, weak treatment initiation and potential high loss to follow-up was noted at sites visited by the OIG: 51% of patients did not start treatment at the same site after receiving a positive result, leading to potentially high loss to follow up (46%). Gaps in national policies, delays in community health worker implementation, as well as weak data systems and data management, increase the risk of high loss to follow-up and lead to a lack of clarity regarding the number of patients on ART. Significant programmatic data quality issues were noted for key HIV and malaria indicators with variances of +/- 30%[2] noted at most of the 7 sites visited by the OIG. Thus, program implementation, data quality, and risk management for specific malaria and HIV interventions are **ineffective.**

Material stock-outs of key commodities, expiries, gaps in traceability, and risk of poor quality due to unsafe warehouse conditions were observed. The overall effectiveness and sustainability of the in-country supply chain is limited by gaps in national strategic direction and weak national institutions, within the context of fragile health systems and political instability. There was an ongoing project managed by the United Nations Development Programme (UNDP) to construct a new central medical warehouse (CECOME). Started in 2017, it has cost US$4.6 million to date and was only completed in May 2024, after significant delays due to poor strategic and operational project management. This led to the continued use of a warehouse that is unsuitable for safeguarding Global Fund commodities. Supply chain implementation and associated risk management are **ineffective.**

Well-designed financial management policies and manuals, along with complementary layers of oversight, were noted for the Ministry of Health grant. The Fiscal Agent's role has been strengthened to improve sub-recipient oversight. No material issues were noted in verifying fixed assets, and most

[1] The 1st 95 increasing from 58% to 75% and the 2nd 95 increasing from 57% to 86% between 2017 and 2022.
[2] As per the Global Fund guidelines, +/- 20% variances are indications of very poor data quality.

sampled expenses were adequately supported and within Global Fund budget requirements. However, some implementation gaps have resulted in a few isolated, moderate issues: €0.3 million of sampled expenses were not in line with budget requirements and there were instances of gaps in adequate supporting documents relating to sub-recipient advances. Issues with gaps in insurance coverage were also noted. The financial management and assurance mechanisms for safeguarding Global Fund resources are **partially effective.**

1.2 Key Achievements and Good Practices

Roll-out of nationwide stock management and logistics management system training

Nationwide stock management and logistics management information system (LMIS) training was conducted in Grant Cycle 6 (GC6)[3]. New LMIS tools were launched to improve Procurement and Supply Management data reporting, which started in 2024. Technical assistance to support a complete assessment of CECOME produced recommendations for the entity, going forward.

Strong trends in reducing new HIV infections and increasing HIV testing coverage

There has been a 56% decline in new infections since 2010. The estimated number of people living with HIV (PLHIV) who knew their status has also increased, from 58% (2017) to 75% (2022)

Well-designed financial management manuals and expenditure reviews under Ministry of Health (MOH) grant

The MOH has detailed manuals on financial management, procurement, and fixed assets. To mitigate financial risks, a Fiscal Agent (FA) has been in place on the portfolio since 2015. The FA reviews all expenditures and local procurements under the MOH grant. The role of the FA over sub-recipients was strengthened for GC6, as a part of a Secretariat-led action plan to respond to issues raised in the OIG West and Central Africa Advisory.[4] The MOH Program Management Unit (PMU) finance team, FA, and MOH PMU Internal Auditor conduct a trimonthly review of sub-recipient expenditures.[5] The MOH PMU and FA also conduct a joint annual asset verification. The OIG verified a sample of assets and noted no material issues. 98% of transactions sampled were within Global Fund budget requirements, and 88% were supported by adequate documentation.[6]

1.3 Key Issues and Risks

Limitations in oversight and controls for the 2023 LLIN mass campaign led to an inability to trace nets to intended beneficiaries and potentially reduced campaign effectiveness.

For the 2023 LLIN mass campaign, there was no supporting documentation to confirm whether nets were correctly delivered to beneficiaries in two of the three health areas sampled by the OIG (representing 82% of the LLINs sampled). The number of nets distributed has not yet been finalized, nine months after the end of the campaign. Distribution was inconsistent, with the ratio of two people

[3] GC6 covers the grant implementation period Jan 2021- Dec 2023
[4] OIG Advisory Report Grant implementation in Western and Central Africa (WCA), https://www.theglobalfund.org/media/8493/oig_gf-oig-19-013_report_en.pdf - accessed 31 May 2024
[5] The MOH PMU Internal Auditor review occurs after fiscal agent review as an additional check on supporting evidence and produces a regular report of issues which is shared with PMU management.
[6] Around 2% of expense items sampled by the OIG, valued at €0.3 million out of €7 million sampled, were spent by the MOH PMU outside of Global Fund budget requirements. This included the purchase of an item of furniture for senior ministry officials (€0.04m) and a severance payment to all PMU staff at the end of GC6 (€0.29m). In addition, there were some instances of sub-recipient advances being cleared after year end without appropriate supporting documentation, although the total value of these items was immaterial. The OIG also noted an issue with the purchase of office items beyond a no-objection threshold amount provided by the Global Fund Country Team. However, an approval for this expenditure was subsequently issued by the Global Fund Country Team in line with budget guidelines.

per net not routinely adhered to. This can limit the campaign's effectiveness and increase the risk of commodity diversion. The 2023 Malaria Indicator Survey (MIS) noted LLIN coverage at 77%,[7] despite the campaign having sufficient funding to achieve universal coverage.

Weak HIV treatment initiation and potentially high LTFU can hinder further progress.

For HIV, weak treatment initiation was noted at OIG sites visited; with 51% of patients not having started treatment after a positive result, leading to potentially 46% loss to follow-up (LTFU). There is a lack of clarity on the scale of LTFU or ART coverage, due to an inability to track patients across different health sites and general weaknesses in data systems. Gaps in national policies regarding LTFU, delays in providing community health workers to support patient follow-up, gaps in Human Resources for Health (HRH) and weak data systems increase the risk of high loss to follow-up and lead to a lack of clarity for patients on ART.

The national in-country supply chain and PSM entities are fragile, leading to material issues in stock availability, expiries, gaps in commodity traceability, and risks of reduced quality.

The audit found material stock-outs of key HIV and malaria commodities, as well as €0.9 million of HIV and TB commodity expiries at the central level. Gaps in commodity traceability at central and health facility level were noted, as well as an increased risk of poor product quality due to sub-optimal storage conditions. This has been caused by insufficient national strategic direction and weak national institutions, within the context of weak health systems and political instability. There were delays in the UNDP-managed CECOME warehouse construction project. Started in 2017, it has cost US$4.6 million to date and construction was completed only in May 2024. This has led to the continued use of a suboptimal warehouse that is not suitable for Global Fund commodities, risking the quality and security of Global Fund commodities.

Significant and persistent programmatic data inaccuracies from health facilities impacting ability to assess grant performance.

Significant programmatic data quality issues were noted for key HIV and malaria indicators. Variances of +/- 30% were found at most of the 7 visits visited by the OIG, when comparing DHIS2 results to primary records. Issues with completeness of malaria data were also identified. There are no approved data quality guidelines, or strong national technical working groups to drive progress in this area. There are also limitations in the national approach to review data quality, delayed use of available GC6 RSSH funding, and health facility challenges, with gaps in guidelines, staffing and training. The country's weak health system and country context also impact progress.

[7] Coverage being the proportion of households with one LLIN for two people. Per draft analysis provided by UNDP in August 2024, this coverage reduces to 63% when considering only bed-nets distributed during GC6.

1.4 Objectives, Ratings and Scope

The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on the adequacy and effectiveness of Global Fund grants to Guinea-Bissau. The audit's specific objectives, ratings and scope are outlined in the table below:

<table>
<tr><th>Objectives</th><th>Rating</th><th>Scope</th></tr>
<tr><td>The program implementation, data quality and risk management for specific malaria and HIV interventions to support the achievement of grant objectives.</td><td>Ineffective</td><td rowspan="3">Audit period: January 2021 to December 2023
Grants and implementers
Principal Recipients Ministry of Health and the United Nations Development Program.

Scope limitation
United Nations System organizations have generally adopted internal rules known as the “single audit principle”, whereby they are subject to their internal oversight mechanisms at the exclusion of any other. Nevertheless, the Global Fund has access for audit and investigation purposes to sub-recipients of these entities that are not themselves part of the UN System. Accordingly, while the OIG cannot provide assurance on activities and transactions directly implemented by these agencies, it can provide some assurance on the activities implemented through these sub-recipients and contractors.</td></tr>
<tr><td>Supply chain implementation and risk management to ensure the timely availability and accountability of commodities at all levels.</td><td>Ineffective</td></tr>
<tr><td>Financial management and assurance mechanisms for safeguarding Global Fund resources.</td><td>Partially effective</td></tr>
</table>

Details about the general audit rating classification can be found in Annex A of this report.

2. Background and Context

2.1 Country Context

Guinea-Bissau is classified as a Challenging Operating Environment (COE) and has been placed under the Additional Safeguard Policy since 2012 due to its fragile economic, political and security situation.[8] There have been four successful and 17 attempted or alleged coups d'etat since the country's independence in 1974.[9] Guinea-Bissau is a low-income country, with a growing budget deficit of 6.3% of GDP[10] which is reducing the available fiscal space for health.

The country suffers from weak health systems, especially regarding human resources (8 per 10,000 inhabitants against a target of 23 per 10,000 per inhabitants).[8] Health structure and general medical practitioner density stood at 0.7 and 0.9 per 10,000 inhabitants respectively, while inpatient bed distribution ranged from 0 to 13 per 10,000 inhabitants, below the WHO standard.[11]

Guinea-Bissau's national health system is divided into 11 health regions and 114 health zones.

Country data[12]	
Population	2.1 million (2022)
GDP per capita	US$775.8 (2022)
Corruption Perception Index	164 of 184 (2022)
UNDP Human Development Index	177 of 191 (2021)
Human Resources for Health	8 per 10,000 (2023)

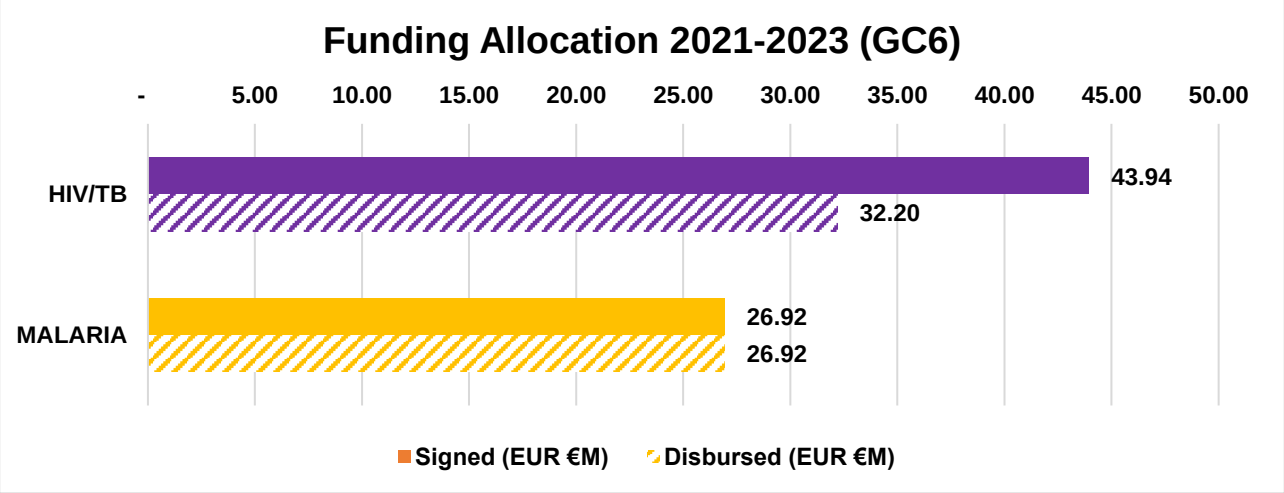
2.2 Global Fund Grants in Guinea-Bissau

Since 2002, the Global Fund has signed grants of over US$284 million and disbursed more than US$227 million to Guinea-Bissau. Active grants total €70.8 million[13] for Grant Cycle 6 (2020-2022) funding allocation period (and the corresponding January 2021 to December 2023 implementation period), of which 83% has been disbursed. The Ministry of Health is the Principal Recipient (PR) for HIV and tuberculosis grants, while the United Nations Development Programme (UNDP) manages the malaria grant. Both PRs implements the grants in partnership with the national programs for malaria, HIV and TB, and alongside sub-recipient organizations.[14] HIV and TB interventions, implemented as a combined grant, are coordinated, managed and supervised by the Principal

[8] https://www.theglobalfund.org/media/13695/gmd_additional-safeguard-policy_opn_en.pdf
[9] World Bank Country Profile, https://www.worldbank.org/en/country/guineabissau/overview - accessed on 21 June 2024
[10] World Bank Country database, World Bank Data - accessed on 25 March 2024
[11] WHO Harmonized Health Facility Assessment (HHFA) (2023) for Guinea Bissau
[12] UNDP data centre for HDI, UNDP HDI, Transparency International CPI index, Transparency International, Population data bases, City Population, WHO database, WHO Database, CIA Factbook – accessed on 21 June 2024
[13] HIV/TB grants include a C19RM component with an extended implementation period until 31 December 2025
[14] Other key sub-recipients for the malaria grant include; (i) Central DE Compras de Madicamentos Essenciais (CECOME); (ii) United Children Education Fund (UNICEF), (iii) Project BANDIM and (iv) Instituto Nacional de Saúde Pública da Guiné-Bissau (INASA), while for the HIV/TB grant, sub-recipients include;(i) PLAN International;(ii) Ajuda de Desenvolvimento de Povo para Povo (ADPP); (iii) ENDA

Recipient Program Management Unit (PMU) 'CG-PNDS' (Celula de Gestao do Programa Nacional de Desenvolvimento Sanitario (CG-PNDS)) in close partnership with HIV and TB programs.

Figure 1: Funding allocation 2020 -2022 implementation cycle (Jan 21-Dec 23)



2.3 The Three Diseases

HIV / AIDS (2023)

34,000 people are estimated living with HIV as of 2023, of whom 77% know their status and 64% are on treatment. This is 77% and 83% per the 1st and 2nd 95-95-95.

HIV prevalence estimated at 2.4% among the adult population (15-49 years old). The prevalence amongst female sex workers is 5.6%, for men who have sex with men is 3.3%, and injecting drug users are 3.5%.

Annual new infections decreased by 50% from 2,400 in 2012 to 1,200 in 2022.

AIDS-related deaths decreased by 43% from 2,100 in 2012 to 1,200 in 2022.

Only 60% of pregnant women who tested HIV-positive received ARVs in 2022.

Source: UNAIDS 2023 Report / Integrated Biological and Behavioural Surveillance (IBBS) 2022/ UNAIDS 2024 special analysis

TUBERCULOSIS (2023)

TB disease burden: Guinea-Bissau is among the WHO **30 high-burden countries for TB incidences per 100K** (ranks 16th globally).

Of the 7,600 estimated TB cases, only 39% are notified.

TB incidence increased and stagnated since 2005, from 351 to 361 per 100,000 people in 2022.

Guinea Bissau is among the WHO 30 high-burden countries for TB/HIV co-infection.

Mortality rate has decreased since 2012, from 78 per 100,000 to 54 in 2022.

Treatment success rate has remained below the WHO target of **90%** (75% of new TB cases in 2,490 cohort).

Source: WHO World TB Report 2023 / WHO TB Profile

MALARIA (2023)

Malaria is **endemic** across the country, with peak transmission during rainy season.

Malaria **prevalence increased**[15] across all age groups; from 0.7% in 2017 to 3.6% in 2020 for under 5 years, and from 1.5% in 2017 to 7.8% in 2020 for adults (over 5 years). However, per the latest MIS (2024), overall prevalence reduced to 3.1% in 2023.

WHO estimates **225,000 malaria cases** in 2023 (vs 207,000 cases in 2012, a **9% increase).** The estimated incidence rate reduced from 125 in 2012 to 64 in 2017, before increasing to 106 in 2022.

Estimated **malaria-related deaths** increased by 19%, from 862 in 2012 to 1,023 in 2022.

Source: WHO World Malaria Report 2023 / 2020 Malaria Indicator Survey (MIS) Report

[15] The Final 2023/4 Malaria Indicator Survey, provided in September 2024, noted a decline in malaria prevalence from 6% to 3%.

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

The Global Fund's Progress Update and Disbursement Request (PUDR) performance rating methodology assesses programmatic performance via alphabetic ratings, while financial performance is assessed via numerical ratings.

Comp	Grant	Principal Recipient	Total Signed (EUR)	Disbursement [16] (EUR)	(%)	Jun 21	Dec 21	Jun 22	Dec 22	Jun 23
	GNB-C-MOH	Ministry of Health (MOH)	43,942,535	32,195,685	73 %	B1	C5	C5	C3	C4
	GNB-M-UNDP	United Nations Development Programme (UNDP)	26,918,281	26,918,281	100 %	B1	C5	C5	C3	C3
TOTAL			**70,860,816**	**59,113,966**	**83%**					

3.2 Risk Appetite

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

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit issues
Programmatic and monitoring and evaluation	Malaria: program quality	**High**	**High**	4.2
	HIV: program quality	**High**	**High**	4.3
	M&E	**High**	**Very High**	4.1
Procurement and supply chain management	In-country supply chain	**Very High**	**Very High**	4.4, 4.5
Financial assurance framework and mechanism	Accounting & Financial Reporting by Countries	**Low**	**Low**	N/A
	Grant-related Fraud & Fiduciary	**Moderate**	**Moderate**	N/A

[16] Portfolio absorption figures are based on total disbursements processed for the 2020-2022 Implementation Period as of 25 March 2024, against the total signed amounts.

4. Findings

4.1 A weak health system, limited national direction and delayed RSSH implementation led to significant data inaccuracies, impacting program implementation of key activities

Data quality has been a persistent challenge, having already been flagged in the 2014 OIG audit. Despite constant investment in strengthening data systems, there has been slow progress in addressing poor programmatic data quality, leading to material data inaccuracies.

Guinea-Bissau is a challenging operating environment; its weak health system, most notably country data systems hinder sustained progress against the three diseases. There have been ongoing efforts from the Global Fund to strengthen data systems, with €2.7 million invested in Resilient and Sustainable Systems for Health (RSSH) activities for this area across GC5 and GC6. This has supported some good practices, including efforts under the malaria grant to expand DHIS2 coverage and support real-time data with the use of tablets. In addition, both the HIV and malaria programs conduct routine reviews of data at sub-national level. The HIV program conducts validation meetings at the regional level, and under the malaria grant there are joint data supervision reviews with UNDP, the national program and INASA, the National Public Health Institute responsible for data accuracy and completeness. However, these investments did not prevent the issues with programmatic data quality.

There were large[17] variances between DHIS2 reported results and primary records, in most sites visited (Table 1). In addition, there was low data completeness[18] for malaria. Data quality is a recurrent issue, not adequately addressed since the last OIG audit in 2014.[19]

Table 1: Data results from OIG site visits

Disease	Indicator	Sites with variances	Variances
Malaria	Number of pregnant women receiving IPT 3 doses +	5 of 5 (100%)	+ / - 30 %
	Confirmed malaria cases that received 1st line treatment at public sector health facilities	5 of 6 (83%)	+ / - 30 %
HIV	Total number of PLHIV on ART treatment	3 of 7 (43%)	+ / - 50 %

These data issues affect the ability of the Ministry of Health and the Global Fund to monitor and assess programmatic results and grant performance, corroborated in Finding 4.3 regarding the lack of quality data on patients on ART treatment. This reduces effective decision-making and risk management, as the magnitude and severity of issues are not fully known. The following factors are among the contributing causes of these issues.

Lack of national data quality guidelines and governance over programmatic data: There are no approved data quality guidelines or data management procedures. National-level technical working groups for DHIS2 and HMIS are not operational, and clear roles and responsibilities have not been defined.[20]

[17] Global Fund Operational Guidelines for Data Use & Improvement at Country Level classified data with >20% variances as very poor
[18] The June 2023 Progress Update (PU) noted a malaria data completeness rate of health facilities at 45%.
[19] The OIG 2014 audit identified similar issues with programmatic data, inadequate or ineffective supervision, gaps in data officer training, and incomplete data reported in DHIS2.
[20] These issues were noted in other independent assurance reviews, which were not resolved at the time of the OIG audit fieldwork.

DHIS2 validation checks not conducted: Despite DHIS2 being able to support user reviews of data quality and highlight issues, this functionality is not used. There was no evidence of data validation checks[21] being conducted by the national programs or INASA. There were no guidelines in place to establish data validation rules or to guide exception reporting.

Limited effectiveness and coverage of national Data Quality Control reviews (DQCs): National DQC reviews should be undertaken by national programs to validate data at lower levels. In the absence of national guidelines, the DQCs did not cover all key malaria indicators.[22] For malaria, DQCs conducted in 2022-2023 did not review DHIS2 reported data[23] and only covered 25% of facilities.[24] For HIV, only two DQCs were conducted between 2021-2023, also with limited coverage.[25]

Weak data management systems, tools, processes, and supervision at service delivery point: There were no guidelines for data collection, validation and reporting at any of the HIV or malaria sites visited by the OIG. For 67% (4 out of 6) of malaria sites, staff in charge of data management had not been trained on data management. In addition, 83% (5 of 6) of malaria sites were missing standard data recording and reporting tools, and 67% (4 of 6) used ad-hoc tools to record programmatic data. While supportive supervision did occur at all malaria sites, there was no evidence of written feedback at four of six sites, and no follow-up of recommendations could be evidenced at any sites. At 43% (3 out of 7) of HIV sites, there was no evidence of data validation checks at health facility level before reporting data, and no evidence of supportive supervision over data.

Generally weak health systems, and delays in utilizing RSSH funding for HMIS and Data: The weak health system context and political instability is a key limiting factor in progressing in this area. There has been instability in the main government institutions for data (INASA) following its restructure in 2022, and high staff turnover at both the Ministry of Health and INASA. There was also delayed use of available RSSH budgets for strengthening HMIS. As per the June 2023 Progress Update, only 49% and 66% of the RSSH HMIS budgets under the UNDP and MOH grants were utilized, meaning that key budgeted activities were not implemented in a timely manner. These include strengthening data monitoring through mobile technology, training regional staff on the use of data dashboards, and developing SOPs to conduct data-driven supervision. However, as of December 2023, RSSH HMIS budget utilization increased to 76% and 93% under the UNDP and MOH grants, highlighting increased implementation in the last six months of GC6.

Gaps in Global Fund Secretariat risk mitigation: All GC6 key mitigating actions established by the Global Fund Secretariat to reduce data risks were delayed and not completed during GC6, which ended in December 2023. This includes actions to strengthen leadership on HMIS and improve HMIS coverage. This allowed significant risks to persist.

[21] This includes establishing DHIS2 validation rules for malaria indicators, use of exception reporting and min-max outlier analysis.
[22] The Malaria DQC tool does not cover community testing and treatment indicators.
[23] The Malaria DQCs compared primary records to month summary reports held at health facility level rather than DHIS2 data.
[24] 37 out of 149 facilities (25%) had DQA undertaken in the period Jan 2022 to Dec 2023. The 2022 DQC has yet to be finalized and no DQC was conducted in 2023.
[25] 2021 DQC covered 41% of health facilities (63/152) and 2022 (April-June) DQC covered 34% (52/152)

Agreed Management Action 1

The Global Fund Secretariat will work with UNDP, and in cooperation with the INASA and the technical support providers, to strengthen data quality for HIV, TB and Malaria programs for improved completeness and quality of reporting and monitoring performance to:

A. Undertake a diagnostic review to identify the gaps and opportunities to improve the quality and use of HIV, TB and Malaria programmatic data to inform program decisions. This will include HIV patient care management data and loss to follow up data.

B. Develop a costed action plan to strengthen quality and use of data to improve program performance, with evidence of partial implementation achieved through the AMA timeline

OWNER: Head of Grant Management Division

DUE DATE: 31 December 2026

4.2 Sub-optimal implementation of 2023 LLIN mass campaign contributed to low coverage and reduced effectiveness

Limited supervision and weak controls led to sub-optimal implementation of the 2023 LLIN mass campaign, which impacted the campaign's effectiveness. Bed nets could not be traced to beneficiaries, and there was a lack of clarity in the number of nets being distributed, as well as inconsistencies in allocating nets to households.

Malaria is a significant health concern in Guinea-Bissau: it is one of the top ten causes of death[26] and is endemic. There was a 21% increase in estimated malaria deaths between 2018 and 2022. The use of long-lasting insecticidal nets (LLINs) is one of the main malaria prevention interventions under the UNDP malaria grant.[27] A national mass LLIN campaign was conducted in June 2023 with €5.3 million spent on distributing 1.3 million[28] nets to ensure universal coverage. This was conducted within a context of a very weak health system, poor infrastructure and with UNDP also supporting several other concurrent priority activities.

Household registration was conducted, with micro-planning at the regional level in preparation for the campaign. The Global Fund funded additional monitoring to provide assurance on the effectiveness of the campaign's implementation. A Malaria Indicator Survey (MIS) was carried out in November 2023[29] to provide insights into the campaign's effectiveness. However, material issues were noted in the campaign implementation.

Based on documentation provided to the OIG during audit fieldwork, 82% of the LLIN bed nets could not be traced to beneficiaries across the three health areas sampled by the OIG.[30] Per documentation availed to the OIG during audit fieldwork, implementers did not follow the beneficiary coupon system in all sampled health areas. The coupon system was designed to ensure nets are only provided to beneficiaries with a valid coupon.[31] There were also irregularities in documentation[32] in the third area, limiting the assurance the OIG can provide on nets being received by their intended beneficiaries.

The final number of LLIN nets distributed during the June 2023 campaign had not been finalized at the time of the OIG audit fieldwork. This was despite nine months having passed since the end of the campaign, and an expectation that data would have been finalized soon after the campaign. The national malaria program's final evaluation of the campaign had also not been completed, making it more difficult to assess its success. Reports from the Secretariat's additional monitoring provider noted inconsistent distribution of nets to beneficiaries, with the ratio of one net to two people not being followed.[33] These significant gaps in controls and oversight over distribution increase the risk of misuse and diversion[34].

[26] WHO global Database, https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death, accessed 3 April 2023
[27] 19% of the GC6 budget (€4.7 million) was budgeted for the 2023 LLIN mass campaign.
[28] Ministry of Heath - Programme National de Lutte contre le Paludisme (PNLP) distribution data
[29] The MIS was not finalized at the time of the audit fieldwork (March 2024) but a final version was given to the OIG in September 2024.
[30] The OIG sampled three health areas accounting for 75,000 LLIN nets, with 82% of LLINs in two health areas not being traceable to beneficiaries from reviewing available documentation stored at the health area level. After the OIG audit fieldwork, the OIG was provided with photographs of coupons that were distributed in the Contuboel health area by UNDP on September 19, 2024. The OIG did not find these coupons during the visit to the health area, and the health area personnel confirmed at the time of the OIG site visit that they had not utilized the coupons during the most recent LLIN distribution campaign. The OIG is unable to verify the accuracy and totality of these coupons remotely.
[31] Per mass campaign training guidelines, beneficiaries are entitled to acquire an LLIN only upon presenting a valid coupon that is issued during the process of household registration and this coupon is documented and stored by the provider.
[32] 20% of sampled coupons (6 out of 30) in this health area could not be tied back to the householder register as designed.
[33] Independent assurance reports indicated a distribution ratio of 2.9 people for 1 LLIN in sites visited by the monitoring provider and 2.7 people per 1 LLIN at the national level.
[34] LLINs were found for sale in local markets and a referral for potential misuse or diversion of LLINs funded by the Global Fund has been made to the OIG's investigation unit and screening team. The matter has been shared with the UNDP's Office of Audit and Investigations as per the existing Memorandum of Understanding.

The above issues contributed to lower-than-expected LLIN coverage.[35] Universal coverage was expected to be achieved through this campaign, with 1.3 million nets distributed to a population of 2.1 million. However, per the final 2023/24 Malaria Indicator Survey, LLIN coverage was only at 77%,. This increases the risk of increased malaria cases due to poor implementation of this key malaria prevention activity. A negative trend has already been observed for GC5 and GC6. Despite the mass campaigns being conducted every three years during GC5 and GC6, there has been an 88% increase in the estimated number of malaria cases, and a 67% increase in incidence rate[36] between 2017 and 2022.

Limited supervision, inaccuracies in distribution data, as well as gaps in physical security and measures to ensure traceability are among the factors contributing to this situation.

Limited campaign supervision and lack of operational implementation guidelines: There was inadequate supervision and oversight during distribution. Responsibility for supervision lay with national supervision teams, consisting of stakeholders from the National Malaria Program and UNDP. The Secretariat's monitoring provider highlighted no supervision over distribution at 36% of sites sampled.[37] This was corroborated by the lack of evidence of supervision noted at the health areas visited by the OIG. In addition, there were no detailed operational guidelines for implementation-level work, to guide health staff and volunteers during distribution.

Inaccurate and delayed campaign data: Responsibility for overseeing the compilation of distribution data and data entry in DHIS at all levels falls under the national supervision teams. However, there were gaps in supporting evidence for the distribution of nets between health regions and distribution points,[38] as well as inaccuracies in distribution data.[39] Due to data recording equipment failing and poor internet connectivity, monitoring reports noted issues with timely data entry at the end of each campaign activity day. This impacted data completeness.

Lack of additional measures to ensure traceability to intended beneficiaries, and gaps in physical security for LLINs: The main control to ensure LLINs are received by their intended beneficiaries is the coupon system:[31] there was no additional requirement for beneficiary signatures or fingerprints to record receipt. Thus, there was no safeguard if the coupon system failed to be implemented as designed. In addition, the Secretariat's monitoring provider noted that in 58% (69/119) of sites sampled, there was a lack of appropriate security and safety measures (such as doors/grids, padlocks or double keys, security personnel, and fire extinguishers) as per international good practise.

[35] Coverage being the proportion of households with one LLIN for two people.
[36] Malaria National Strategic Plan 2023 – 2027, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/malaria-incidence-(per-1-000-population-at-risk) - accessed 30 May 2024..
[37] This was noted at 44 out of the 119 sites sampled by the external assurance provider.
[38] At one health region sampled, 30% of nets reported as distributed to distribution points could not be traced to supporting documentation (representing s5,000 out of 18,000 nets)
[39] In an additional health region, there was a distribution point where the signed proof of delivery to the site indicated 2,035 nets were received, but distribution records show 3,400 nets were distributed (67% more nets distributed than received)

Agreed Management Action 2

The Global Fund Secretariat will work with UNDP and Ministry of Health to:

a. Strengthen the campaign methodology and supervision plan for next planned mass campaign in 2026, with a focus on supervision, security, and traceability through all campaign steps, including. training, household enumeration and ITN distribution.
b. Ensure the available devices procured through the GC6 grant are leveraged again to establish electronic data collection real-time monitoring of the distribution and ITN traceability in the 2026 mass campaign

OWNER: Head of Grant Management Division

DUE DATE: 30 November 2026

4.3 Positive HIV trends, but a lack of accurate data on treatment initiation and adherence could limit future progress

The proportions of people living with HIV who know their status, and those on antiretroviral therapy, have significantly increased over the last five years. However, delays in implementing community health worker (CHW) activities, data gaps, and service quality issues at health facilities are hampering progress on treatment initiation and adherence.

Guinea-Bissau has seen positive trends in key HIV programmatic indicators. There has been an estimated 56% decline in new infections since 2010. There have also been positive increases relating to 95-95-95 targets with the estimated number of people living with HIV (PLHIV) who knew their status increasing from 62% (2018) to 77% (2023), and the proportion of PLHIV who know their status and are on ART increasing from 68% (2018) to 83% (2023).[40] In addition, the national community health strategy (2021) was finalized to define the role of specialized CHWs to support treatment adherence.

There is however a lack of accurate information to assess the effectiveness of HIV treatment initiation and adherence. There have been no recent national assessments of treatment retention and loss to follow-up (LTFU) by the National HIV program. Patient records from the six facilities visited by the OIG indicate a high proportion (51%) of patients diagnosed with HIV but not starting HIV treatment at those sites. In addition, of patients who started ART (between January and March 2023), 26% stopped treatment before six months of treatment and 41% before 12 months at those same sites.[41] A previous (2021) study also indicated high levels of LTFU (46%). In the absence of a unique identifier and unreliable data systems, it is difficult to conclude if patients were enrolled in treatment at other sites than those visited, or continued treatment in other health facilities than where initiated.

Due to the above, the country cannot fully assess the adequacy and effectiveness of its HIV response and course correct as needed, resulting in a risk of progress stalling or reversing. National targets for ART coverage for GC6 were not met, impacting the effectiveness of the Global Fund's significant investments in HIV testing and treatment.[42] While HIV-related mortality cases have fallen, this achievement could be undermined in the absence of proper follow-up of patients.

The following root causes contribute to the gaps in linkage to care and LTFU:

Gaps in national policies, operational guidelines for LTFU and treatment initiation: The current national definition of LTFU is a patient absent for treatment 90 days after appointment (vs. 28 days as per WHO guidelines[43]). This can lead to delays in supporting patients and understates the level of LTFU. There are also no operational procedures for community-level workers to perform LTFU activities. In addition, training packages for CHWs and community activists do not include detailed guidance around these activities. None of the national documents that guide HIV treatment cover the approach for patients who do not initiate treatment, nor do they include details on the steps to be taken to ensure treatment initiation is conducted.[44] In addition, while there is a national policy on communication for behavioural change (May 2021), there is no information on HIV treatment and adherence, or on tackling stigma and discrimination, which negatively affects patient treatment-seeking behaviour.

[40] UNAIDS Country Profile, https://www.unaids.org/en/regionscountries/countries/guinea-bissau - accessed 21 June 2024 & UNAID data visualizer, UNAIDS special analysis 2024: https://aidsinfo.unaids.org/ - accessed 25 November 2024
[41] Due to gaps in data systems and records, the OIG cannot provide assurance if patient initiated or continued treatment at other sites.
[42] Validated June 2023 Progress Update - expenditure for HIV treatment care and support - €4.7 million & differentiated HIV testing services -€0.7 million
[43] WHO consolidated guidelines on person-centered HIV strategic information – https://www.who.int/publications- - page 56 – accessed 21 June 2024
[44] Patients who do not initiate treatment are not classified as LTFU, therefore no strategy is defined to link them to HIV care.

Delays in deployment of specialized CHWs to support LTFU activities, and low absorption of RSSH funding for community systems strengthening (CSS): CHWs play a critical role in supporting HIV treatment adherence. The Community Health Department of the Ministry of Health trained[45] 522 specialized CHWs between October 2022 and January 2023. Due to a lack of coordination between different Ministry of Health departments, there was an eight-month delay in finalizing tools and enablers for these workers: CHW tools were only finalized in September 2023. The CHWs only began work during the final quarter of GC6, meaning there was no CHW support for reducing LTFU for most of the grant cycle. Activities to support improved HIV treatment adherence were similarly delayed or not started, including the recruitment of female mediators to improve female representation in community worker cohorts, and social mobilization and sensitization activities. These delays are reflected in the delayed absorption of RSSH CSS funding under the MOH grant. Absorption was at 33% in June 2023, six months before the end of the grant, although this had increased to 50% by December 2023.

No national electronic patient case management system to track patients on treatment: There is a nationwide reliance on paper tools and manual processes to track patients, except for nine sites that use MS Access as an electronic database to record patient information. There is also no automatic mechanism to identify patients who miss appointments and trigger follow-up responses by health workers. It is not possible to track patients who transfer between sites, as there is no patient unique identifier or tracking system. While there is a national ART identifier (NIPS), a unique identifier for individual patients put on treatment, no controls are in place to ensure patients cannot be granted multiple NIPS at different sites.

Weaknesses in quality of service for patients at health facility level: Poor HIV quality of services was observed at the sites visited by the OIG, a result of human resource gaps. Three out of six sites had no doctors present, and in five out of six sites there were no psychologists to provide counselling. This meant that clinical support for HIV patients was dependent primarily on nurses. These gaps reflect a broader lack of qualified healthcare professionals in the country. At all six sites visited by the OIG, there were no guidelines on counseling for HIV treatment adherence, or for multi-month ART dispensing. At four out of six sites, there were no private spaces for counseling, impacting the quality of service experienced by patients. Four out of eight sites experienced stock-outs of first-line ART treatments[46] (see Finding 4.4), affecting the quality of, and access to, services to beneficiaries.

Agreed Management Action 1 aims to address the above issues related to data system and data quality including for HIV.

No Agreed Management Action was proposed by the Secretariat to cover additional technical support at high-volume ART sites to strengthen ART treatment initiation, adherence and loss to follow up activities. This is due to current funding constraints on the grant. However, the Secretariat aims to support this activity if additional funding or grant savings are identified during GC7.

[45] CHW training was funded by the Global Fund through C19RM funding.
[46] An additional two sites were visited to assess commodity availability and traceability. See Finding 4.3 for more details.

4.4 Fragile in-country supply chain and weak national PSM entities, including CECOME, led to unavailability of key commodities

As a challenging operating environment, Guinea-Bissau has weak supply chain systems, poor logistic data, and fragile national entities. While the Global Fund has allocated resources to strengthen these systems, these investments have not been effective in preventing material stock-outs, expiries, traceability gaps, and quality risks for key commodities.

In GC6, 41% (€24.6 million) of expenditure related to procurement and supply chain (PSM) costs. Global Fund commodities utilize the national supply chain, which includes the national regulatory body, CI-ARFAME, and the national warehouse entity, CECOME. However, in-country PSM systems remain very weak, linked to political instability. There is also a significant human resource challenge in terms of capacity and capability,[47] including a limited number of pharmacists.

Implementers spent €5.9 million on Resilient and Sustainable Systems for Health (RSSH) activities to strengthen PSM systems across the last two grant cycles, including the construction of a new central warehouse. These investments did generate some positive achievements. Nationwide stock management and Logistics Management Information Systems (LMIS) training were conducted during GC6. The Principal Recipients launched new LMIS tools to improve PSM data reporting.[48] There was also technical assistance to support an assessment of CECOME and community-based monitoring to report on stock availability. Despite these investments, several challenges persisted or emerged, linked to delayed warehouse construction and delays in using PSM-related RSSH funds under the MOH grant, with 62% absorption as of June 2023, 6 months before the end of the grant, although this increased to 159% by December 2023.

Table 2 - Stock outs at health facilities visited by OIG.

	Commodities	No of sites	% of sites visited	Average stock out (days)
HIV	HIV Tests	6/8	75%	46
	1st line adult (TLD)	4/8	50%	24
Malaria	Malaria tests	5/8	63%	25
	ACTs (all forms)	1/8	13%	39
	Malaria IPT	2/5	40%	9
	Artesunate inj.	4/7	57%	53

There were material stock-outs of HIV and malaria commodities for testing and treatment (see Table 2).[49] There were also expiries of HIV test kits and ARVs (€0.7 million) and drug-resistant TB medicines (€0.2 million) at central and regional warehouses. These stock-outs and expiries impacted treatment availability for beneficiaries (see Finding 4.3), contributing to HIV treatment gaps. Sites with stock-outs were high-burden sites, supporting 22% of all people on ARVs.[50] Malaria test kit stock-outs also occurred at high-burden sites that account for 17% of malaria cases.[51]

There were also unreconciled stock variances at the central warehouse for HIV and malaria commodities.[52] When tracing commodities from the central level to health facility dispensing points,

[47] 2024 WHO HHFA (harmonized health facility assessment) an average of 8 HRH per 10,000 compared to the WHO standard of 23
[48] The OIG noted evidence of the new LMIS tools being used in 2024, which will support improved PSM data collection and reporting in GC7. These activities were all funded by the Global Fund grants.
[49] The OIG observed stock-outs at health facility level where there were stock records to determine no stock availability. However, in all HIV sites and half of malaria sites, there were gaps in the availability of stock level information for key commodities. Thus, the OIG cannot provide assurance on whether there were further stock outs beyond what is included in Table 2.
[50] Using December 2023 DHIS 2 data
[51] Using January to December 2022 DHIS 2 data
[52] There was a 6% variance for HIV commodities, with a +/- €0.3 million variance for different commodities when comparing expected stock to actual. Smaller differences were noted for malaria.

33% of HIV and 9% of malaria commodities could not be traced to records at the dispensing point.[53] In addition, at the central warehouse, goods were stored in high temperatures, increasing the risk of poor medicine quality: no temperature and humidity monitoring system has been in place since June 2022.[54] Gaps in traceability significantly increase the likelihood of misuse and diversion. There is also a high risk of poor commodity quality, reducing medicine effectiveness for beneficiaries[55]. The above issues have been driven by several root causes, including the following.

Lack of national strategies and policies, weaknesses in key national PSM institutions and poor inventory management at service delivery point: There are no national supply chain strategies, national pharmaceutical policies, or nationally approved good storage practices to provide strategic direction for in-country supply chain management. The effectiveness of the national PSM committee is limited, and it does not routinely meet to discuss strategic PSM matters. There are also issues with the governance structure and financing model of CECOME, limiting its effectiveness and sustainability. An assessment was completed in 2023, but there is no approved action plan to implement its recommendations and transform its operating model.

CECOME also has issues with its systems, staffing, physical structure, and processes. The warehouse management system (MACS) is operated by one individual who has full access to the system, with no oversight or controls to prevent misuse.[56] There have been several labor strikes, impacting the distribution of commodities in 2022 and 2023, due to issues in timely payment of salaries by the National Government.[57] There are also no stock cards or insurance for HIV and TB commodities, putting Global Fund commodities at continued risk.[58] A key PSM risk mitigation was the construction of a new CECOME warehouse under the UNDP grant. However, this has been delayed since 2017 (see below). Service delivery point issues were also noted. There was a lack of availability and capacity of staff to support PSM processes, including a lack of trained pharmacists at all levels. In addition, at most sites visited by the OIG, non-compliance with good storage and inventory management practices was observed.[59]

Gaps in Global Fund Secretariat risk mitigation: No risk mitigating actions were set in GC6 to address the lack of national strategies or policies on in-country supply chain, despite their importance. However, the Secretariat did support the development of a national CECOME strategy, though this was not finalized. In addition, mitigating actions for the completion of the new warehouse and roll-out of a new e-LMIS were delayed, and not completed by the end of GC6, allowing risks to persist.

[53] The OIG could not conduct a similar check for TB commodities due to the lack of available data in the warehouse management system (MACS) and cannot provide assurance over the traceability of TB commodities.
[54] The risk did not materialize for malaria health products in 2023, as samples from the warehouse were shared with an external lab to confirm that the sampled malaria medication still comply with the quality requirements.
[55] UNDP has supported work to mitigate the risk of poor medicine quality, namely through quality control sample testing leveraging WHO pre-qualified laboratories with which UNDP has long term agreements work.
[56] The MACS system has issues with quality of reports produced (completeness and timeliness) affecting the monitor of commodities.
[57] This impacted the operations of CECOME and required Global Fund grants (under UNDP) to support emergency payments for workers to continue CECOME operations.
[58] An electrical fire occurred in February 2024, impacting the electrical systems and highlighting the continual risk to commodities.
[59] Non-compliance with good storage and inventory management practices noted for 5 out of 8 Malaria sites (63%), 6 out of 8 HIV sites (75%) and all lab sites (5 out of 5, 100%)

Agreed Management Action 3

The Global Fund Secretariat will support the Ministry of Health and country technical authorities including CECOME and ARFAME to develop a supply chain national strategy and advance the reform of CECOME as per the recommendations from ACAME.

OWNER: Head of Grant Management Division

DUE DATE: 30 June 2026

4.5 Gaps in project management and oversight by UNDP resulted in significant delays to complete new CECOME warehouse.

There have been significant delays in the completion of the new CECOME warehouse under the UNDP grant. This is linked to a lack of comprehensive planning, gaps in strategic and operational project management and oversight as a lack of dedicated technical expertise.

Since 2017, the Global Fund has provided financial support for the construction of a new central warehouse. As noted in finding 4.4, this was a key risk mitigation against PSM related risks. US$4.6 million was spent on this project between 2017-23 and further costs are expected. There have been multiple delays, with the initial 2019 completion date not being met. Twenty-one months elapsed between the delivery of the warehouse skeleton and the start of construction. In addition, construction was ongoing for 28 months and was only completed[60] in May 2024. These delays have led to the continual use of the current warehouse site during GC6 and the start of GC7. The current site is not fit for purpose for safeguarding Global Fund commodities, as noted in finding 4.4.[61] In addition, as there was no initial overall project budget, it cannot be confirmed whether the project has gone over budget. These issues were caused by the following root causes:

There was a lack of strategic project management at the project's inception. In 2017, no fully costed overall project plan for the CECOME warehouse was agreed amongst all key PSM stakeholders; in its absence, construction was approached in a piecemeal manner. No comprehensive approved budget was in place at inception to conduct routine budget vs expenditure analysis.[62] No transfer plan was agreed, nor timelines agreed to ensure a safe and efficient transfer of commodities between the old and new site. UNDP did not use project management tools or operate within approved milestones and timelines for most of the construction project.[63] Since August 2023, an internal project management tool has been used by UNDP to guide work. There was also no dedicated warehouse project manager in the UNDP team until August 2023. There were also gaps in the contract for the main construction firm hired by UNDP; despite several extensions being made to the existing construction contract, the legally agreed milestones and due dates of the project were not updated.[64]

There is a lack of Global Fund technical guidance for the planning, implementation, and management of construction projects. An advanced draft was produced but had not been finalized by March 2024. In addition, while there has been monitoring and follow-up by the Global Fund Secretariat on the CECOME project, this has not been effective in ensuring timely completion of the project.

Agreed Management Action 4
The Global Fund Secretariat will finalize and distribute global technical guidance on the planning, implementation, and management of "health product warehouse" related construction projects under Global Fund grants.
OWNER: Head of Supply Operations Department
DUE DATE: 30 June 2025

[60] 28 months is from January 2020 to May 2024, excluding 24 months due to significant COVID-19 impact (March 2020-March 2022). Including this COVID-19 period would increase the period to 52 months. This does not include the transition time to hand over between sites.
[61] Relating to structural safeguards for quality control and stock management
[62] No expected budget agreed to complete the end-to-end construction, transfer of commodities and establishment of the new warehouse in terms of structure, systems, tools and processes.
[63] No internal project tools with approved milestones and timelines were in place for 2017, 2018, 2020, 2021, 2022.
[64] For example, milestone 6 of the main warehouse construction project was initially agreed to be complete by December 2020 and was not updated subsequently in any additional updates to the contract with the construction firm.

Annex A: Audit Rating Classification and Methodology

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

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing and code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of its work.

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

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

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

Annex B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which fall within the Audit's scope. In addition, a narrative explanation is provided every Time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Guinea-Bissau: comparison of OIG and Secretariat risk levels

The updated Secretariat risk levels assessment (2024) aligns with the OIG audit rating except for:

Monitoring and evaluation – M&E: The Secretariat rates this risk as "High", and the sub-risks (i) Data Governance and Management as "high", (ii) Data Generation, Availability, and Quality as "very high" and (iii) Data Analysis and Use as "high". However, the OIG rates the risk overall as "very high" driven by a "very high" rating given to sub-risk (i). This is due to the significant issues raised in finding 4.1.