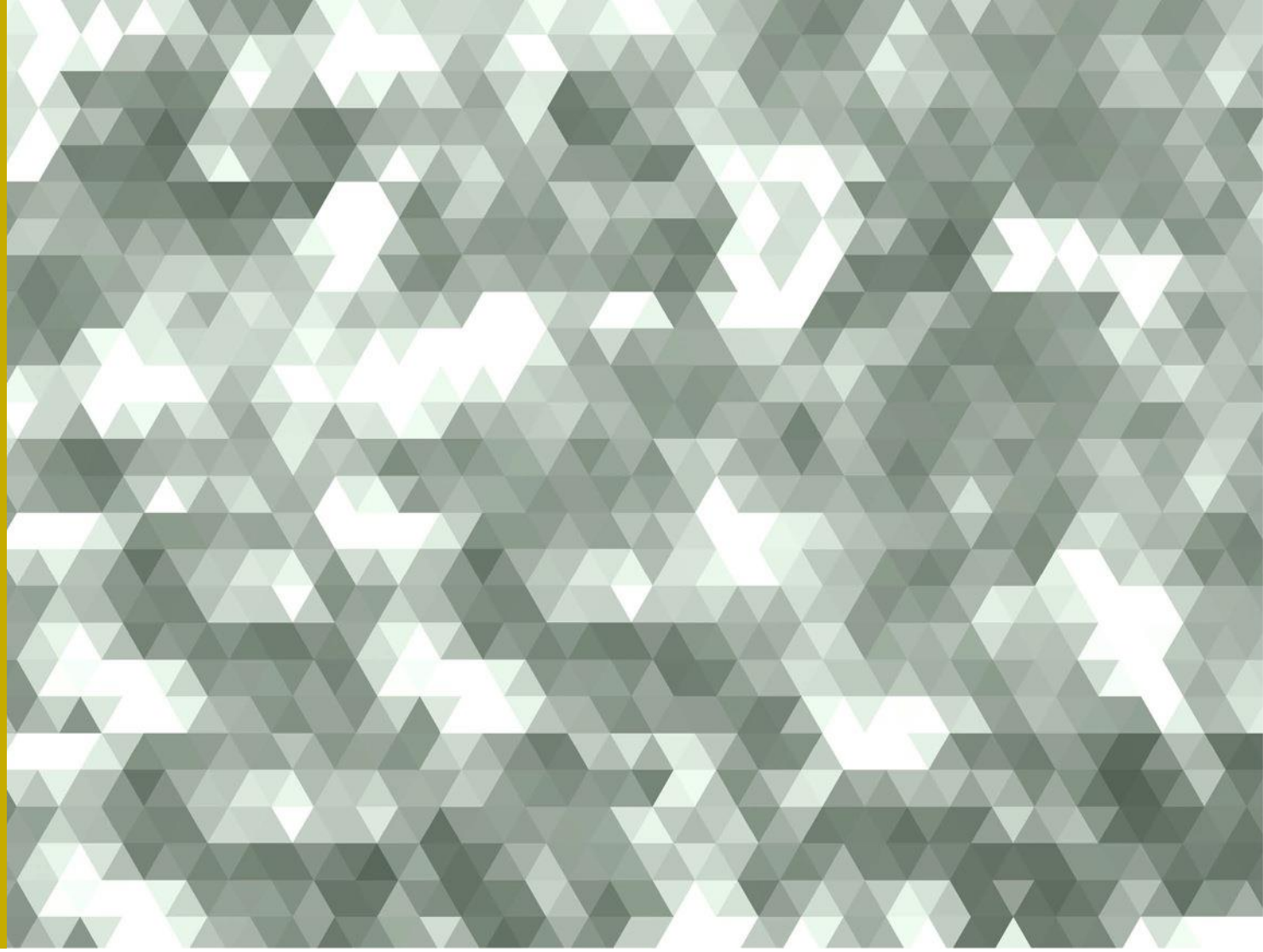

Audit Report

Global Fund Grants to the Federal Republic of Nigeria

GF-OIG-16-012
7 April 2016
Geneva, Switzerland

The Global Fund
Office of the Inspector General

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I. Background

Disease context
Nigeria is the most populous country in Africa with an estimated 175 million (2013)[1] inhabitants, of which approximately two-thirds live in areas classified as rural. Malaria is endemic in Nigeria with 76%[2] of the population living in areas of high malaria risk. Nigeria has the world's largest burden of malaria and accounts for 35% of global malaria mortality together with Democratic Republic of Congo.[3] HIV constitutes a major public health concern in Nigeria. The country has the second largest burden of HIV in Africa with an estimated 3.4 million people living with HIV in 2013.[4] This accounts for 9% of the global burden. Nigeria represents one of Africa's largest burden of tuberculosis (TB) with 600,000[5] people estimated to have TB at any one time. This accounts for 7% of the global TB burden. The high HIV prevalence in Nigeria is a major driver of the TB burden. A state level epidemiology analysis conducted by National Agency for the Control of AIDS (NACA) and supported by several donors revealed that the six states (Kaduna, Akwa Ibom, Imo, Rivers, Oyo and Lagos) that have 41% of the HIV burden and 42% of new HIV infections annually are also among the highest TB burden states.

Country context
Nigeria is a federal republic with 36 states and 774 Local Government Areas in addition to the Capital Federal Territory. The federal administrative system places significant authority at the state level for both the funding and delivery of health services. In 2014, the federal allocation to health was limited to 6% of the national budget and is predicted to decline in the future. As a result, 82% of the 2014 budget is for recurring expenditure. This means that there are minimal financial resources to make investments in health that could change the course of the three diseases. State level allocations for health vary between 3% and 22%. Key partners[6]' budgets for HIV and malaria are flat . The current financing gap for the three diseases is estimated at US$5 billion.[7]

In 2014, Nigeria was ranked 136 out of 182 countries in Transparency International's Corruption Perceptions Index. Since the creation of modern public administration in the country, there have been cases of official misuse of funds and resources.

In May 2015, there was a transition of power. After 16 years of the People's Democratic Party rule, Muhammadu Buhari from the political party "All Progressive Congress"(APC) won the presidential elections. The APC also won majorities in the Senate and House of Representatives and won 19 of the 28 governorships contested.

Global Fund context
The Global Fund has invested a total of 24 grants in Nigeria since 2003. As at June 2015 a total of US$1.43 billion has been disbursed for HIV (US$545m), malaria (US$708m), TB (US$155m) and Health Systems Strengthening (US$21m) programs.

The portfolio has two active malaria grants managed by two Principal Recipients: the National Malaria Elimination Program (NMEP) implements malaria treatment and prevention activities in the public sector, and the Society for Family Health (SFH) implements activities in the private sector. Three HIV/AIDS grants with an overall aim of scaling up gender-sensitive HIV/AIDS prevention, treatment, and care and support interventions for adults and children in Nigeria are managed by three Principal Recipients, the Association for Reproductive and Family Health (ARFH), NACA and

[1] World bank 2014 report
[2] WHO world malaria report 2015
[3] WHO world malaria report 2015
[4] UNGASS country progress report 2015
[5] WHO 2014 estimates
[6] Key partners for HIV and malaria include the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States President's Emergency Plan for Aids Relief (PEPFAR) and the President's Malaria Initiative (PMI).

[7] TB/HIV and malaria Concept Notes Gap analysis

the SFH. Two TB grants are managed by two Principal Recipients: the Association for Reproductive and Family Health (ARFH) responsible for the expansion of the DOTS[8] strategy and HIV/TB component, and the Institute of Human Virology Nigeria (IHVN) responsible for the Multi-Drug Resistant-TB component.

Despite significant investments in Nigeria, the Global Fund has faced a number of challenges leading to the following suboptimal grant performance:

- poor quality of health services including treatment disruptions;
- inadequate monitoring and evaluation including poor data quality;
- low financial absorption;
- fraud, corruption or misuse of funds;
- poor financial efficiency and reporting; and
- inadequate principal recipient governance and oversight.

The Global Fund has made efforts in the past two years to reduce the risk in the portfolio. This includes the following: categorizing the country into one of the newly-created high impact regions in the Grant Management Division; removing non-performing Principal Recipients; moving procurement activities for health commodities from Principal Recipients to the Global Fund Pooled Procurement Mechanism, which centrally procures and delivers health commodities on behalf of the Principal Recipient through independent procurement service agents; increasing assurance services by the Local Fund Agent over Principal Recipient activities and introducing recently a Fiduciary Agent for high risk grants.

These efforts, however, have resulted in minimal improvements in the risk profile of the portfolio, which has even deteriorated. NACA, which is Nigeria's largest implementer of Global Fund programs for HIV/AIDS, has moved according to the Global Fund's own portfolio risk assessment tool from a risk rating of 2.38 in 2013 to 2.60 in 2015. The Programmatic and Performance, Financial and Fiduciary Management, Health Services and Products categories have been consistently rated as red (high) for the past two years. NMEP, which is Nigeria's largest implementer of Global Fund programs for malaria had a risk rating of 2.60 in 2013 and has remained with the same risk profile in 2015. The Programmatic and Performance, Financial and Fiduciary Management, Governance and Oversight categories have also been consistently rated as red for the past two years. Health Services and Products have been rated as dark red (very high) since 2013.

In addition, there has been underperformance of some key grant performance indicators across the three diseases. For example:

- **Malaria:** For the period June 2013 to June 2014 only 41% of the target achieved for the number of mosquito nets distributed through public sector to the end users.
- **HIV/TB:** For a two-year period from July 2013 to June 2015, 8% of the year one annual target and 60% of the year two annual target was achieved for the number of estimated HIV positive incident TB cases that received treatment for TB and HIV; and
- **HIV:** For a two year period between July 2013 to June 2015 28% of the year one annual target and 10% of the year two annual target for the number of HIV-infected pregnant women who received antiretroviral drugs to reduce the risk for mother-to-child transmission). For the same period 6% of both year one and year two annual target for the number of infants born to HIV infected women who received an HIV test / PCR test within 2 months;

[8] The DOTS (directly observed treatment, short-course) strategy is the tuberculosis control strategy given recommended by the World Health organization. It includes five main components: government commitment, case detection, standardized treatment, drug supply, standardized recording and reporting system.

II. Scope and Rating

Scope

The Office of the Inspector General (OIG) assessed Global Fund grants to the Republic of Nigeria including:

1. the **effectiveness of the implementation arrangements** of Global Fund grants;
2. the **design and effectiveness** of the Global Fund risk management framework for Nigeria;
3. the **design and the effectiveness of internal control environment** in safeguarding Global Fund resources, covering:

    a) Financial and Fiduciary matters
    b) Procurement and supply chain management
    c) Program management.

The audit focused on the existing active grants analyzing the grant activities and transactions for the period January 2013 to June 2015. The audit took place in Abuja and six additional states with a noted high disease burden: Lagos, Abia, Oyo, Akwa Ibom, Osun and Anambra. The audit included site visits to projects/programs of Principal Recipients, sub-recipients and other implementing entities including selected health facilities, treatment centers, warehouses, stores, as appropriate.

The OIG visited 42 health and 10 storage facilities and covered the following Global Fund grants:

Principal Recipient	Grant Number	Grant Status	Grant Period	Committed Amount	Disbursed Amount
National Agency for Control of AIDS	NGA-H-NACA	Active	1-Jul-2010 to 31-Dec-2015	$392,105,141	$297,111,840.
Society for Family Health	NGA-809-G11-M	Financially Closed	1-Aug-2009 31-Jan-2015	$198,827,687	$198,827,687
National Malaria Control Program, Ministry of Health of Nigeria	NGA-809-G14-M	Financially Closed	1-Nov-2009 31-Jan-2015	$273,611,217	$273,611,217
Society for Family Health	NGA-M-SFH	Active	1-Feb-2015 31-Dec-2016	$77,163,334	$9,476,837
National Malaria Elimination Program, Ministry of Health of Nigeria	NGA-M-NMEP	Active	1-Feb-2015 31-Dec-2016	$183,362,943	$28,861,515
Association For Reproductive And Family Health	NGA-T-ARFH	Active	1-Jul-2010 31-Dec-2015	$95,017,439	$81,095,442
Total OIG Audit Coverage				**$1,220,087,761**	**$888,984,538**

Rating[9]

Below are the OIG's overall ratings of the implementation of the Global Fund grants to Nigeria:

Audit objectives	**Rating**	**Reference to findings**
1. Design and the effectiveness of internal control environment		
1.1 Procurement and supply chain management	Ineffective	1.1
1.2 Financial management	Ineffective	1.2
1.3 Program management	Ineffective	1.3
2. Design and effectiveness of Global Fund risk management framework for Nigeria	Ineffective	2
3. Effectiveness of implementation arrangements for Global Fund grants in Nigeria	Partial Plan to become Effective	3

[9] See Annex A for the rating definitions.

III. Executive Summary

The Global Fund has disbursed more than US$1.4 billion in Nigeria since 2003. Nigeria currently represents the Global Fund's largest portfolio with a total of US$1.1 billion allocated to fighting the three diseases for 2014-16.

Global Fund programs to date have contributed to 750,000 people living with HIV/AIDS currently on antiretroviral therapy and 310,000 new smear-positive TB cases detected and treated. In addition, 93.4 million insecticide-treated mosquito nets have been distributed to prevent the spread of malaria.
However, despite significant investments in Nigeria, the Global Fund has faced a number of challenges, including grants not achieving impact targets, poor quality of health services, treatment disruptions and fraud, corruption and misuse of funds.

Despite the efforts made by the Secretariat and over US$800 million disbursed to the country in the past four years, major deficiencies in the internal control environment persist in the portfolio. In addition, substantial reforms are required to the Global Fund's risk management framework and the current grant implementation arrangements in Nigeria in order to achieve the Global Fund strategic objectives.

The OIG found that the internal control environment supporting the Global Fund grants to NACA and NMEP present significant issues for procurement and supply chain management. In addition major issues were also identified under financial, fiduciary and program management. As such a number of the exceptions identified during the audit have been referred to the OIG Investigations Unit.

Procurement of health and non-health commodities
NACA and NMEP do not monitor health commodity orders coming from the Global Fund Pooled Procurement Mechanism and delivered to the central medical store in Lagos. This has resulted in discrepancies in antiretroviral drugs deliveries of US$ 3.7 million between orders through the Pooled Procurement Mechanism recorded by the Secretariat on behalf of NACA and the deliveries recorded in the central medical store stock records, from 2013 to September 2015. Discrepancies of US$ 0.5 million in artemisinin-based combination therapy drugs ordered through the mechanism and delivered to the central medical store were also identified for NMEP.

NACA's processes and controls for the procurement of non-health services and commodities through a procurement agent are inadequate. The OIG identified payments amounting to US$20 million made to a procurement agent without confirmation of services rendered or goods delivered. Other weaknesses noted in procurement included the failure to competitively tender several contracts that met the required thresholds. The total value of such contracts reviewed in the audit is approximately US$5 million.

Supply chain management
As 70% of the total grant budget for the entire Nigeria portfolio between 2013 to 2014 (US$350 million) is allocated to the procurement and distribution of health commodities, this area is critical for the success of the Global Fund-supported programs in order to reach patients and achieve impact. An estimated 15% of this amount is spent on distribution costs (US$149 million) for which controls were found to be inadequate.

Significant weaknesses exist in supply chain management, including a lack of effective procedures and controls over inventory management and distribution from central medical stores to the health facilities. These led to stock outs of critical medicines such as antiretroviral drugs used in the treatment of HIV infections and artemisinin-based combination therapies used for the treatment of malaria at all 42 high volume health facilities visited by the OIG. Some of the stocks were for periods as long as 8 months, with a direct impact on health service delivery. In addition, HIV commodities

worth US$5.4 million had expired in the last two years and 35 tons of expired HIV commodities, accumulated since 2005, had not been appropriately destroyed.

Financial and fiduciary management
The Nigeria portfolio has historically faced significant challenges around financial and fiduciary management. This has also led to a number of OIG investigations and recoveries of grant funds in the past years. In response to this, the Secretariat introduced a Fiduciary Agent in May 2015 as an additional control mechanism over financial and fiduciary management as well as to build the capacity of the current Principal Recipient to manage finances in accordance with the Global Fund requirements.

Whilst the OIG audit noted minor improvements in the processes for financial and fiduciary management since the introduction of the agent, financial management controls were found to be inadequate and ineffective with a general lack of financial discipline applied at the Principal Recipient level. Significant issues were identified during the audit for human resources management, payment approval processes, and advance management. This resulted in a total of US$7.65 million in unsupported expenditures.

Program management
Significant weaknesses exist in the internal controls around data collection and reporting processes. This resulted in material data inaccuracies identified (more than 10% of data errors) between the data recorded at the facility level and data reported to the state coordinator that is then aggregated and reported to the Global Fund. The issues identified were mainly for the HIV and malaria programs. Good practice was observed on data recorded for the TB programs.

The OIG noted major gaps in the effectiveness of monitoring and evaluation over program activities. There is no comprehensive analysis on capacity, volume of patients treated, type of treatment and services provided by the health facilities to support the supervision plans in place for the malaria and HIV programs. Supervisory visits often are either not conducted as per the supervision plans or not adequately documented. Action plans on issues identified during visits are not monitored, resulting in many programmatic issues that are not adequately resolved in a timely manner.

The Global Fund's risk management framework for Nigeria
Whilst Nigeria is classified as a high risk portfolio and represents the largest portfolio by allocation for the Global Fund, the OIG found that the organization's approach to risk identification has been inadequate and reactive. This has led to insufficient differentiation to identify, mitigate and monitor the risks. As a result key issues impacting the achievement of grant objectives such as significant treatment disruptions and stock outs have remained unresolved over time due to weak controls over procurement and supply chain management.

For example, one of the main objectives of Global Fund-supported programs in Nigeria is to procure and deliver health products to patients. Although the Secretariat introduced the Pooled Procurement Mechanism to the Nigeria portfolio, limited preventative controls are in place at the Secretariat and country level to ensure that drugs procured through the mechanism are actually delivered to the central medical stores and subsequently distributed to state medical stores and health facilities. The OIG also noted that the Nigeria Country Team does not have a dedicated Procurement and Supply Chain specialist impacting the Secretariat's ability to monitor and detect issues around supply and ultimately delivery of health commodities to patients.

Despite the strategic importance of the Nigeria portfolio to the Global Fund and the goals and targets for 2012 – 2016, Global Fund senior management's past monitoring of the Nigeria portfolio performance has been limited and ad-hoc, resulting in key issues such as low absorption not being actively tackled until recently.

Effectiveness of current implementation arrangements for Global Fund grants

At the heart of most of the significant challenges and limited progress in the Nigeria portfolio lies ineffective grant implementation arrangements which have affected the accountability, oversight and impact of the programs over the long term. Although health care delivery has been fully devolved to the state level governments, Global Fund-supported programs are currently implemented at the national level through federal and parastatal entities.

The current federal government implementers, NACA for the HIV program and NMEP for malaria, have no authority over the state governments and their ministries of health. The States have complete administrative and financial autonomy in resource generation and expenditure management. This leaves NMEP as a program under the Federal Minister of Health with limited authority over state health structures and NACA and other non-governmental organizations with even less.

Global Fund-supported programs are managed by the Principal Recipient from a central level through a wide range of sub-recipients and a vast geographical area with limited infrastructure and security. As a result, oversight functions for supply chain management, finance and monitoring and the evaluation of program activities are inadequate and ineffective. Oversight functions need to be closer to actual service delivery areas for the effective monitoring and evaluation of program activities and timely resolution of issues identified.

The lack of accountability and oversight of the Principal Recipient over the local and state governments and program activities as a result of the current grant implementation arrangements is evident by the significant and material internal controls issues identified by the OIG during this audit. Whilst the current implementation arrangements and the associated challenges have existed since the first Global Fund investments to the Republic of Nigeria in 2003, the Secretariat has only recently flagged this risk, in May 2015. Since then, the Secretariat has decided to pilot a state level approach in Nigeria starting early 2016 and has commenced discussions with several state authorities although no agreements had yet been concluded at the time of writing.

IV. Findings and Agreed Management Actions

1. Design and the effectiveness of Internal Control Environment

1.1 Internal controls over procurement and supply chain management

1.1.1 Inadequate and ineffective controls over procurement of health and non-health commodities

Inadequate controls over procurement processes resulted in US$4.2 million of variances between Pooled Procurement Mechanism orders and deliveries to the central medical stores. In addition, NACA made payments of US$20 million to suppliers without confirmation of delivery.

Since the beginning of the grants, procurement of health and non-health commodities has represented a significant risk for the Nigeria grant portfolio. In 2013, the Secretariat took measures to reduce some of the risks through the introduction of the Global Fund Pooled Procurement Mechanism. The Secretariat also introduced additional controls over the procurement of non-health commodities, including the Local Fund Agent as part of the procurement committee to ensure that all contracts go through a transparent and competitive process. Despite these controls, significant weaknesses exist over the procurement of health and non-health commodities.

a) Pooled Procurement Mechanism deliveries
NACA and NMEP do not monitor health commodity orders that come from the Global Fund Pooled Procurement Mechanism to the central medical store in Lagos. Based on a reconciliation of all orders recorded by the Secretariat from January 2013 to September 2015 and the deliveries recorded in the central medical store stock records, the OIG identified US$3.7 million in differences for antiretroviral drugs. At the time of the audit, no explanation for the differences could be provided by NACA. After the end of the audit, NACA indicated that the stock was being held in a different medical store; however, the evidence provided to support this was not adequate. In addition, US$ 0.5 million for artemisinin-based combination therapies could also not be accounted for by the NMEP. At the time of the audit, no explanation for the differences was received from the Principal Recipients.

b) Payments made to suppliers for the non-health procurements
Principal Recipients in Nigeria outsource the procurement of non-health services (including the maintenance of equipment) and commodities to a procurement agent. In the case of NACA, the procurement of non-health services and goods accounts for US$54 million of the grant budget. NACA, and in some cases the Global Fund on behalf of NACA, makes working capital advances to these suppliers to procure the services and commodities needed to deliver the grant activities. The clearance of these advances, totaling US$20 million, is made by NACA without confirmation that the goods or services have been delivered.

c) Non-compliance with procurement policies
Internal controls over procurement processes are not effective. For example, the OIG noted that:

- NACA and NMEP procurements worth US$4 million were not compliant with the implementers' own procurement policies. For example, contracts exceeding N2, 500,000[10] (i.e. around US$) 3,000 are required to go through a competitive process; however, the OIG noted instances when

[10] Foreign exchange rate applicable for the January 2013 to December 2013 was 160 Naira to 1 US Dollar, 165 Naira to 1 US Dollar for January 2014 to December 2014 and 167 Naira to 1 US Dollar for the January 2015 to June 2015 period.

this practice had not been followed. Non-competitive and non-transparent procurement practices were also identified, such as suppliers being awarded large contracts without approval from the tender evaluation committee;

- For procurements worth US$0.9 million related to NMEP and US$0.15 million related to NACA, contract adjustments were made after the approval of the procurement committee without any explanation or evidence of approval by the committee.

1.1.2 Inadequate controls over distribution, inventory management and storage

Inadequate controls over the distribution of health commodities for HIV and malaria programs resulted in stock-outs at all 42 health facilities visited by the OIG for periods as long as 8 months. In addition, inadequate inventory management also resulted in expired HIV commodities worth US$5.4 million in the last 2 years and 35 tons of expired commodities accumulated since 2005 that were not appropriately disposed of.

The OIG analysis of the end-to-end supply chain management system for health and non-health commodities showed significant internal control weaknesses with no effective procedures and controls over inventory management and distribution. These issues were particularly relevant to NACA and NMEP. Improvements around the distribution and inventory management processes are also necessary for non-governmental organizations such as SFH and ARFH to ensure the delivery of health services and products to patients at the health facilities.

As 70% of the total grant budget for the Nigeria portfolio (US$350 million) is allocated to the procurement and distribution of health commodities, this area is critical for the success of the Global Fund-supported programs in order to reach patients and achieve impact. An estimated 15% of this amount is spent on distribution costs (US$149 million) for which controls are inadequate for NACA and NMEP.

a) Distribution of health commodities

The distribution of the health commodities is outsourced by the Principal Recipients to third party logistics providers in charge of delivering the commodities to the health facilities. NACA and NMEP do not perform adequate monitoring over the distribution of health commodities from the central medical stores to the state medical stores and finally to the health facilities. In addition, the capacity of the logistic providers is not regularly assessed and coordination opportunities between programs or with other donors are not explored.

- **Monitoring of health commodities deliveries:** NACA and NMEP only perform sample calls to health facilities to confirm that deliveries have taken place; however, they do not perform any reconciliation between the proof of deliveries sent by the third party logistics and the approved distribution matrix. This is despite having received complaints from health facilities that commodities were either not received at all or not in accordance with the order. There is no tracking of commodities dispatched and delivered based on batch numbers. Delivery reports from the logistic providers do not facilitate the reconciliation process. For example, dates and quantities delivered are often blank, and references to the orders requested are not always documented. In addition, the logistics providers do not provide a “lost commodity” report as requested in the contracts with NACA and NMEP.

- **Lack of coordination:** No evidence of an assessment has been made to determine whether there are opportunities to coordinate the current logistics arrangements between other donors like PEPFAR and Principal Recipients like NACA and ARFH for the HIV and TB commodities. HIV and TB commodities are currently delivered to the central medical store in Lagos and are

largely distributed to the same states and health facilities by separate logistic providers without coordination.

The lack of monitoring over the distribution of health commodities by NMEP and NACA led to significant variances between stock requested on the resupply matrix by the health facility and the stock actually delivered. This was the case for all states and facilities visited by the OIG.

In addition, stock-outs were observed at all of the 42 health facilities across the seven states visited by the OIG. The stock-outs were mainly related to HIV and malaria programs, and were for critical health commodities such as antiretroviral drugs, reagents and artemisinin-based combination therapy. For example, in St Luke General Hospital with an estimated 7,000 patients currently on treatment, antiretroviral drugs were out of stock for a period of two months and reagents for three and a half months. The Eket Immanuel General Hospital, which has over 8,000 patients currently on treatment, also had a stock-out of paediatric antiretroviral commodities for 2.5 months.

As the sites selected were responsible for treating high volumes of patients, the stock-outs would have potentially affected a significant number of patients without treatment for as long as eight months. For example, in Akwa Ibom, based on the four sites visited (Eket Immunel General Hospital, Ipke Annang General Hospital, St. Mary's Hospital and St Luke) and inspection of patient registers, the OIG estimated that approximately 1276 patients were impacted by the stock-outs of HIV antiretroviral drugs and reagents.

b) Inventory management

Across all the implementers audited, the OIG noted significant weaknesses related to the inventory management of health commodities. Poor controls around drugs management, storage, handling, insurance and disposal of expired commodities were noted.

- **Drugs management:** There are insufficient controls at the central and state medical stores to ensure that drugs are managed and distributed according to their expiry dates. The Principal Recipients also do not adequately monitor the reception and distribution of drugs at the medical stores to ensure that drugs received by end-users are within the expiry timelines. Both the central and medical stores use the First-in First-out method which does not always align with the expiry date of health commodities. This was demonstrated by several batches of deliveries made to the central medical store for TB drugs that had earlier expiry dates than batches received before. As a result, TB drugs, for which ARFH was the responsible implementer, worth US$0.5 million were delivered at the central medical store in 2012 that have not been used and are due to expire in March 2016. In addition, the OIG identified NMEP malaria commodities with only 3 months remaining shelf life at all state medical stores visited, although the shelf life at delivery was 20 months. In both cases, the short remaining shelf life presents a significant risk for these drugs to expire before they are delivered to the final users. The poor management of drugs at the central medical store also resulted in US$5.4 million worth of expired HIV lab reagents over the past two years, for which NACA is the responsible implementer.

- **Disposal of expired commodities** – The central and state medical stores currently do not have processes and controls to ensure that expired commodities are disposed of in a timely manner and within the guidelines recommended by the WHO. Principal Recipients are not able to control or influence this process due to the Federal and State ministries of Health being independent of NACA and NMEP. As a result, the OIG noted 20 tons of expired HIV commodities at the central medical store, most of which were Global Fund purchased commodities and 15 tons at the state medical stores which have accumulated since 2005. The value of those commodities couldn't be calculated due to the state these drugs were stored.

- **Quality assurance and control:** The processes and controls for quality assurance and control require improvement, with key exceptions identified for TB and malaria commodities. For example, there is no evidence of sample collection or testing performed on TB drugs for which

ARFH is the responsible implementer, although a protocol for sample collection is in place and funds were allocated to quality control in the new grant. In addition, whilst sample collection for quality testing is performed by NMEP for artemisinin-based combination therapies (and malaria rapid diagnostic tests at the central medical store level, this is not performed throughout the supply including at the health facility level;

- **Storage & handling:** Storage conditions across the central and state medical stores visited were poor and not in accordance with WHO guidelines. For example, there is limited space available at the central medical store for the storage of TB drugs, resulting in the drugs being stored in rooms that do not have any cooling mechanisms. This can compromise the quality of the drugs and the implementer's ability to maintain the correct buffer stock levels. There are no generators in place at the state and zonal medical stores to maintain electricity supply and cooling in the event of power cuts. The Principal Recipients have limited control over the conditions of the medical stores, as they fall under the control of the Federal and State Ministries of Health.

- **Insurance:** Insurance over health commodities is inadequate at the central medical store and inconsistent from one state medical store to another. Malaria commodities at the central medical store were worth approximately US$5 million are not covered by insurance. Based on follow up discussions with the Principal Recipient, this was because there is no formal policy that governs insurance for health commodities. This is despite the fact that insurance over material assets is a requirement of the grant agreement.

1.2 Internal controls over financial and fiduciary management

Inadequate and ineffective financial and fiduciary management. Lack of financial discipline at the implementer's level

Inadequate financial management controls and a lack of financial discipline at the implementer level have resulted in US$7.65 million of unsupported expenditures, including irregular human resource payments and unreconciled project advances. Monitoring of sub-recipient expenditures is also insufficient.

Financial and fiduciary management has been identified by the Global Fund as a critical process to ensure the achievement of grant objectives. The Nigeria portfolio has historically faced significant challenges around financial and fiduciary management with a lack of people, processes and systems, resulting in a weak internal control environment. This has also led to a number of OIG investigations and recovery of grant funds.

a) Human Resources (HR)

Between January 2013 and June 2015, the Global Fund allocated more than US$25 million for the employment of 152 staff for NACA and NMEP.
Controls over the appointment, compensation and termination of employees at the Principal Recipient level are not effective. Deficiencies related to human resources include:

- Payments were made to 28 NMEP staff in 2014 amounting to US$ 197,000, and 8 NMEP staff in 2013 amounting to US$ 70,000 without employment contracts. These payments were not in the approved Global Fund grant budget.
- Top-up payments to 20 NMEP staff in 2013 amounting to US$103,000, and 16 NMEP staff in 2013 amounting to US$56,000 were not supported by valid contracts and were not in the Global Fund approved budget. In addition, NACA did not have a documented policy on payment of top-ups or contracts with the employees showing how many top-ups they were each entitled to. Furthermore, the OIG noted 12 employees for whom the percentage of top-up pay was higher than the specified rate in the approved Global Fund budget, with variances ranging between 10 and 20%. The total payments, however, did not exceed the overall approved budget for top-up payments;
- Employee benefits such as a car (US$17,000 per senior manager at SFH), housing (US$1,500 per employee at ARFH), top-up payments and performance bonuses (US$61,000 for SFH and 13th bonus cheque for NMEP) are not documented in the employee contracts and monthly payroll slips.

This led to unsupported HR payments of **US$0.8 million** most of which related to the Principal Recipient NMEP. The OIG noted, however, that for all implementers audited, the overall HR expenditure was within the approved Global Fund budget.

b) Payment approval process

Across all the implementers audited, there are ineffective controls to ensure that payments for grant expenditures are valid and accurate. In the case of NACA, finance manuals are not clear on the supporting documentation required to approve and process payments for grant expenditure. In addition, the finance manual has no thresholds for the approval of payments. As a result, the OIG noted insufficient documentation to support the validity and accuracy of payments amounting to **US$4.1 million** for travel, training, administration, planning and monitoring costs (**US$3.7 million** of these expenses related to NACA). In these cases, payments were approved and processed by the Principal Recipient although no supplier invoices or confirmation from third parties could be obtained to validate the payments. In addition, payment of **US$1.6 million** occurred for expenses

that were not in the approved grant budgets and work plans. Similar exceptions were identified for NMEP and ARFH, although these were not deemed material.

c) Advance management

The controls in place over the payment and reconciliation of project and staff advances are ineffective. NACA and NMEP do not have a policy that defines when a project or staff advance can be made, the maximum amount of advances that can be provided to staff or consultants and what levels of approval are required to make the advance. The policies do, however, define that all project and staff advances must be retired within two weeks of the advance being made. For NMEP, the OIG identified **US$0.7 million** of advances that had not been retired since 2013. At the end of 2014 the outstanding advances were reduced to **US$0.25 million**. A further **US$0.2 million** was identified as outstanding from 2014 for NACA.

d) Sub-recipient expenditure

Across all implementers reviewed, the Principal Recipients have weak monitoring over the sub-recipients' expenditures Reviews of sub-recipient expenditures are either not performed or, when they were, there was insufficient information to validate the accuracy and completeness of the reported amounts. Sub-recipient quarterly expenditure reports do not provide a detailed breakdown of expenditures by cost category and transaction. Only summary sheets are provided with lump sums amounts. In addition, the expenditure reports are not accompanied by general ledgers or copies of bank statements to perform meaningful analysis or validation.

See Section 1.3 for Agreed Management Actions.

1.3 Internal controls over program management

Inadequate and ineffective controls over data and lack of monitoring of programs activities.

Processes and controls around data collection and reporting are ineffective leading to inaccurate reporting and poorly informed decision-making. Monitoring and evaluation of program activities is insufficient and not documented.

a) Data Quality

Significant weaknesses exist in the internal controls around programmatic data quality resulting in material data inaccuracies identified (more than 10% data errors) for the majority of sites visited. For both the malaria and HIV programs implemented by NMEP and NACA, respectively, discrepancies were identified between the data recorded at the facility level and data reported to the state coordinator that are then aggregated and reported to the Global Fund for all visited facilities.

There were a number of facilities where the data recorded are over and/or understated. For example, in November 2013 at Ikot Abasi General Hospital in Akwa Ibom state, data in the records at the facility were greater than that reported at the state and central level by 763 patients.

In addition, there were several instances where no data were recorded at the facility level despite treatment being provided to patients during that period. For example, in the primary health care facility in West Itam facility of Akwa Ibom state, no data were recorded between October 2013 and December 2014. Data records were also missing for as long as 6 months in large facilities such as St Lukes, Eket Immanuel of Akwa Ibom state and Amachara General Hospital and New Era of Abia state.

The data discrepancies identified can be attributed to a lack of clarity on how the data should be recorded at the facility level, and the fact that tools and documents provided by implementers to record data are not being used by the health facility. Both of these root causes highlight the need for more focused and practical training on the use of tools and documents provided by implementers and the related data recording requirements at health facilities. Below are details of the exceptions identified by the OIG:

Tools to record data are not used

- In 80% of the visited facilities in the malaria program, the sections of the data registers which related to the patient test results and the type of artemisinin-based combination therapies (ACTs) administered by the facility were left blank. These are the most critical data points for malaria treatment. In 25% of the facilities visited under SFH, the data registers were not available for inspection.
- In 62% of health facilities, HIV patient care cards were incomplete with patient details and health records not maintained. This issue was more pronounced in the Federal Capital of Abuja, Abia and Shomolu General Hospital in Lagos.
- Across all HIV health facilities visited, the quality of documents and tools for recording HIV care, treatment management and monitoring is poor. For example, patient registers were missing at St Luke's and Dried Blood Spot Forms were not available. In addition, pre-antiretroviral therapy and regular registers were not completed in Lagos, Abia and extensively in Akwa Ibom with key information such as patient information, test results and treatment administered to the patient missing from the form.

- In many of the general hospitals and health facilities visited, the OIG observed that there were insufficient HIV tools and summary forms to cater for the volume of patients. In addition, the quality of printed tools across all facilities was poor (the printing was smudged so the criteria or question of the form could not be easily read and there was insufficient space to capture the patient details) thereby making it difficult for the health facilities and hospitals to capture data correctly. These tools and documents were not supplied by NACA but by other organizations.

Non-compliance with data recording methodology

- Visited facilities under NMEP record the patient before testing for malaria. Therefore, in the case of a negative test, the patient is still reported to the state coordinator as a treated case.
- Documentation and referrals of clients clinically screened for TB was inadequate in 30% of the visited health facilities. For example default tracker could not be evidenced for 10 out of 13 facilities visited for ARFH.
- Discrepancies existed between health facilities and the sub-recipient on how to count and record the total number of current patients including subtracting 'losses' e.g. the number of people who died, transferred out, lost to follow up and stopped treatment.
- Most facilities visited in Abuja, FCT and Akwa Ibom, did not have any records of client referrals from community outreach activities. Documentation for HIV counseling performed was also poor. For example in Wuse General Hospital in FCT and St Mary's in Akwa Ibom, no patient intake forms have been available at the facility since August 2015.
- The reconciliation process of Prevention of Mother to Child Transmission prophylaxis data in antenatal clinic and labor wards and pharmacies was not clear. The OIG observed that between the sub-recipients AIDS Prevention Initiative in Nigeria and the health facilities, there was no consensus on how to record women on prophylaxis and therefore this data was not being recorded.

In this context, the OIG also observed several best practices on data recorded for the TB programs implemented by ARFH. Data recorded at the facility level and reported at the state and central levels were largely consistent and there were little or no exceptions related to key data being captured.

Monitoring and evaluation

Across all implementers audited, the OIG noted significant gaps in the effectiveness of monitoring and evaluation over program activities.

Supervision plans
A comprehensive analysis on capacity, volume of patients treated, type of treatment and services provided by the health facility or hospital, is not performed to support the supervision plans in place for both NACA and NMEP.

Supervision visits
In the case of NACA and NMEP and the associated sub-recipients, the OIG noted that supervisory visits were not always conducted as per the supervision plan. In addition, supervisory visits conducted were not adequately documented and action plans and monitoring of issues identified during visits is not performed:

- **NMEP** - NMEP only conducts health facility supervision visits when they perform the Data Quality visits. Facilities which have very high volumes of patients, such as Ifako-Ijaye General Hospital in Lagos, Olugunna State Hospital in Osun state and Jaja Clinic- University of Ibadan in Oyo state, among others, have not been visited by the sub-recipient or Principal Recipient in as long as 30 months. Alternatively, where visits may have been performed, adequate records or evidence are not maintained.

- **NACA** –supervision visits conducted by the sub-recipient for HIV/AIDS facilities are not documented. The OIG therefore could not obtain assurance that supervision visits are conducted in accordance with NACA's supervision plan. Supervision reports for visits conducted by NACA itself were not site specific, making it difficult to track and monitor the issues identified. The programmatic issues identified were also not specific with only anecdotal evidence quoted. As a result, the supervision visit did not translate into effective detection and resolution of issues for health facilities visited. For example, frequent equipment breakdowns were flagged over a period of three years. In addition, CD4 and hematology machines and poor maintenance were identified, but no action plans were initiated to resolve them, resulting in the unavailability of hematology reagents in 46% of the health facilities visited. These issues were identified for Isolo and Epe General Hospital in Osun state, New Era and Amachara General Hospital in Abia state and St. Lukes and St. Mary's in Akwa Ibom, and other facilities.

In addition, the OIG noted that data verification exercises for Semester 2 of 2014 and Semester 1 of 2015 had not been conducted by NACA. There was also no oversight and supervision performed for states with security challenges since 2012 (Borno, Yobe, and Adamawa).

Agreed Management Action 1
The Secretariat will assess the amount to be sought for recovery from Principal Recipients based on the internal control deficiencies identified by the OIG audit and refer relevant expenditures identified as non-compliant with the Standard Terms and Conditions of the relevant Global Fund Program grant to the Recoveries Committee.

Owner: Mark Edington, Head Grant Management Division

Implementation date:30 September 2016

Agreed Management Action 2
The Secretariat will assess the internal control deficiencies identified by the OIG audit and determine non-compliant areas that require further review (e.g. by the Local Fund Agent). The Secretariat will refer any relevant issues from the reviews' findings to the OIG investigations department.

Owner: Mark Edington, Head Grant Management Division

Implementation date: 30 June 2016

Agreed Management Action 3
The Secretariat (Grant Management in collaboration with Finance and Risk Management) will conduct a capacity assessment relating to Government of Nigeria Principal Recipients. The capacity assessment will include the internal control environment (governance and oversight, financial and fiduciary management, health services and products and program management) as well as an assessment on the implementers' ability to deliver key grant objectives under the Global Fund grants to Nigeria.

Owner: Mark Edington, Head Grant Management Division

Implementation date: 30 June 2016

Agreed Management Action 4
Based on the outcome of the capacity assessment, the Secretariat will take the necessary measures to introduce additional controls and consider alternative implementation arrangements for key processes to ensure that key risks in the portfolio are adequately mitigated and the achievement of grant objectives under the Global Fund grants Nigeria.

Owner: Mark Edington, Head Grant Management Division

Implementation date: 31 December 2016

2. Design and effectiveness of the Global Fund risk management framework for Nigeria

Inadequate risk management and ineffective assurance framework to monitor Global Fund grants in Nigeria.

The Global Fund has not adequately identified and assessed key risks in the Nigeria portfolio. This has led to insufficient differentiation to mitigate the risks and key issues remaining unresolved over time.

a. The Global Fund's approach to risk identification for the Nigeria portfolio has been inadequate and reactive. This has led to risk mitigation initiatives which are ineffective in addressing the risks in the portfolio and which have been implemented in a fragmented manner.

Although Nigeria is classified as a high risk portfolio which represents the largest allocation for the Global Fund, the organization's approach to risk identification has been inadequate and reactive. This has led to significant risks affecting the achievement of grant objectives that have not been fully identified and prioritized.

For example, one of the main objectives of Global Fund-supported programs in Nigeria is to procure and deliver health products to patients (health commodities procurement and distribution represented US$350 million for the last two years, accounting for almost 70% of the total value of grants). In response to several prior OIG investigations and fraud allegations around the procurement of health commodities, the Country Team introduced the Global Fund Pooled Procured Mechanism for the procurement of health commodities across the portfolio. However, the supply chain management risk had not been fully identified. This risk is currently noted as a medium risk in the QUART[11] risk assessment for NACA, despite significant treatment disruptions and stock-outs. This is the same for SFH's QUART. As a result of the limited preventative and detective controls in place at the Secretariat and the country level to ensure that drugs procured through Pooled Procured Mechanism are actually delivered to the central medical stores and subsequently to state medical stores and health facilities, the OIG found stock-outs of critical commodities such as antiretroviral drugs and artemisinin-based combination therapies in all of the 42 facilities visited. Some of these stock-outs existed for as long as eight months.

In 2014, the Secretariat launched a US$21 million supply chain integration project for Nigeria which was meant to address the current issues around supply chain. However, this is a long term project which is only expected to yield results in the next three years. Given the significance of the procurement and distribution of health commodities for the end-user, risk mitigation for an area like supply chain management has also not been adequately prioritized. Sufficient balance between long term strategic solutions versus short term remediation to get critical medicines to patients is needed.

Similarly the quality of data recording and reporting has been a long standing issue in Nigeria. Whilst the Secretariat has invested US$21 million to merge the health information systems in the country in the long term, along with a number of other initiatives, there are limited short term interventions underway at the health facility and state levels. These initiatives are designed to improve data collection and recording, such ensuring that health facilities have registers so that they can record data.

[1111] QUARTs is the operational risk assessment tool used by the by the Global Fund Secretariat's Country Teams in order to establish a proper annual action plan to address/ mitigate the assessed/ identified risks.

In addition, the OIG noted that risk mitigation and monitoring initiatives deployed by the Secretariat have been implemented in a fragmented and ineffective manner. For example, in 2014 the Secretariat engaged the Local Fund Agent to review all HR and procurement policies for Principal Recipients; however, there was no requirement for the agent to assess the alignment of the policies with the Nigerian national or Global Fund guidelines. This resulted in the Principal Recipient choosing HR and procurement practices on an arbitrary basis, for examples, thresholds for procurement contracts having to go through a competitive process, allocation of overheads policy, travel allowances and 13th salary (or bonus) schemes. Similarly the Secretariat performed reviews over Principal Recipient financial manuals; however, the manuals are still inadequate with no defined thresholds for approval of payments as well as no defined policy on supporting documentation required for payments. As a result, the OIG noted insufficient documentation to support the validity and accuracy of payments amounting to US$4.1 million for travel, training, administration, planning and monitoring costs.

Despite the significant initiatives underway to address the risks and challenges in the Nigeria portfolio by the Secretariat, the fragmented approach to risk mitigation measures has also led to gaps. For example, the issue of stock-outs has been consistently identified in QUART reports, Country Coordinating Mechanism oversight committee reports and by the Principal Recipient (although not on a timely basis). However, limited measures have been taken to address this issue and reduce treatment disruptions. The same can be said for the issues around advance management and payroll which have been flagged by the Local Fund Agent, the Internal Audit and External Audit functions.

b. The Global Fund has not sufficiently differentiated the Nigeria portfolio in terms of people and processes to address the risks in Nigeria portfolio.

Nigeria represents the biggest portfolio for the Global Fund with 9% of the current allocation and a total of US$ 1.4 billion in disbursements since 2003. It is also classified by the Global Fund as one of the top ten riskiest countries in the world to operate it.[12] The environment is highly complex with one Federal government, 36 states, and 774 local government areas, which operate independently from the Federal Government. There are 23,000 health facilities in Nigeria catering for an estimated 175 million people. In addition, the country is exposed to significant security issues with militant Islamist terror group Boko Haram occupying most of the North Eastern States in Nigeria, making health programs difficult to implement in these areas. It is therefore critical that the Secretariat tailors the level of resources (e.g., staff quality and quantity) and the nature of the processes in order to effectively monitor the risks at the country level.

People

Whist there have been increases in staff to the Nigeria portfolio over the past five years, the current allocation of human resources does not allow for effective identification, mitigation and monitoring of the risks. One of the main objectives of Global Fund grants to Nigeria is to procure and distribute health commodities to health facilities. Although more than US$350 million have been budgeted in health procurement over the last two years, the Nigeria Country Team does not have a dedicated Procurement and Supply Chain specialist.

The Nigeria portfolio is an intensive and busy portfolio with grant-making, budget setting and grant monitoring required for five Principal Recipients, more than 30 sub-recipients and over 45 sub-sub-recipients. The Principal Recipients have historically had, and still have, very low capacity in financial and fiduciary management, resulting in an increased need for financial monitoring and

[12] The Global Fund uses and External Risk Indicator system to measure the risk profile of a country.

oversight. However, within the Nigeria Country Team there is only one Finance Officer in charge of the US$460 million that has been disbursed over the last two years to five implementers.

The relatively limited Secretariat resources allocated to the Nigeria Country Team, in relation to the size and complexity of the portfolio, may increase the exposure to operational risk.

Processes

Based on OIG interviews as well as an analysis of deliverables and outputs of the Country Team efforts, a significant amount of focus is placed on operational grant management processes and firefighting issues which arise frequently in the portfolio. As a result, the Country Teams' efforts have largely been tactical in nature and focused on immediate problem-solving without much time spent on analyzing the root causes of the problems experienced in the country. There has been limited time for long term strategic thinking and improving key objectives and enabling processes in the portfolio to achieve impact. This has led to ineffective monitoring activities performed by the Secretariat and limited success in the resolution of issues impacting the portfolio, despite the significant amount of effort and time invested by the Country Team.

The Nigeria Country Team, comprising seven members, visits the country on average every month for a period of one week. During the visits, they interact mainly with the Principal Recipients and the Local Fund Agent. Meetings are sometimes also held with partners, and the Fund Portfolio Manager regularly meets with the Ministry of Health. Yet, despite this significant interaction, little progress has been made in addressing persistent issues in the portfolio that date back several years, including stock-outs at health facilities, expired commodities, non-transparent and competitive procurement processes, delays in implementation of activities and inadequate data quality.

In this context, Global Fund senior management involvement in the Nigeria portfolio to date has also been very limited, although a large scale-up has been noted since June 2015. Despite the strategic importance of the Nigeria portfolio, monitoring of its performance has been ad-hoc. As a result, key issues such as low absorption have not been tackled in a focused manner until recently. Despite investments of more than US$800 million in the past four years, the lack of strategic focus applied to the implementation of the approved program strategies on the Nigeria portfolio by the Global Fund has led to a situation where the issues now and those from four years ago are largely the same. This is coupled with suboptimal performance on key grant indicators.

Furthermore, the OIG's inspection of the Secretariat management letters to the Principal Recipients in Nigeria noted that key matters are inconsistently addressed, despite having been flagged by the internal audit, external audit functions, the Local Fund Agent and the Country Coordinating Mechanism. For example, issues around accuracy and completeness of financial reporting, advance management, irregular HR practices and stock-outs have frequently been raised by the various assurance providers; yet, they have not always been followed through in the management letters from the Secretariat to the Principal Recipient. The Secretariat also does not have guidelines or an approach for the Country Team to escalate issues or to hold the Principal Recipients accountable for repeated persistent non-performance or non-compliance.

Through the evolution of the Nigeria portfolio, the Secretariat has become significantly overly reliant on secondary information from the Principal Recipients and Local Fund Agent. Despite the significant amount of time invested in the country, only three states have been visited by the Secretariat in the last two years as well as a limited number of health facilities in the Federal Capital Territory and the central medical store in Lagos, leading to insufficient information on how Global Fund programs are implemented across the Nigeria portfolio. In addition, the Secretariat has not performed any independent reviews through its risk management function to assess the implementation of programs and the assurance framework.

c. Inadequate design and operational effectiveness of the assurance framework to monitor risks at the country level

Design
The Global Fund spends US$4.7 million annually on assurance over its grants to Nigeria. Whilst the assurance spend appears to be commensurate with the risk in the portfolio, the OIG found that the actual assurance activities are not aligned with the risks in the portfolio.

For example, the assurance budget for procurement and supply chain activities has been under 10% for the last 3 years, although procurement, storage and distribution of drugs represent approximately 70% of the total grants for Nigeria. More than 85% of the current assurance budget is spent on financial and fiduciary risks, with very little focus on programmatic assurance over the implementation of grant activities (quality of health services and products, data quality, timely implementation and coordination of program activities).

The Secretariat doesn't have a consolidated assurance plan for the Nigeria portfolio. This would give a holistic view of the grant objectives, the associated risks and the controls in place to mitigate those risks. In the absence of this consolidated view, there are overlaps between various assurance providers; for example, the scope of the work performed by External Audit, Internal Audit and the Local Fund Agent is mainly on financial and fiduciary management.

In addition, there are also gaps in assurance over key processes and controls. For example, the Local Fund Agent sits on the procurement committee to ensure competitive processes are followed by the Principal Recipient, but there is no control in place to ensure that all procurement contracts go through a competitive process and are in accordance with the terms and conditions approved by the procurement committee. This led to US$4 million of supplier contracts that did not go through a competitive and transparent process and US$0.9 million of adjustments made to supplier contracts after the approval of the procurement committee.

Operational Effectiveness
The OIG analysis of the reports by the various assurance providers also highlighted some issues around the operational effectiveness of the current assurance framework.

Specifically, the assessment of internal audits across all the Principal Recipients reviewed, showed that these functions were not sufficiently staffed to cover the key activities. For example, NMEP had only two internal audit staff for most of 2013 and 2014 who are expected to cover activities across 16 sub-recipients and 24 States. As a result, key areas such as programmatic performance and health services and products were not covered in the scope of work of the function. Internal audit reports across all Principal Recipients reviewed are focused mainly on financial and fiduciary management risks.

In addition, across all the assurance providers, there is no systematic monitoring and tracking of issues identified to ensure that the appropriate action is taken to resolve the issues. As a result, issues such as long outstanding project advances, inadequate processes and controls for payroll, unsupported expenditure were identified across several reports for the Local Fund Agent, External Audit and Internal Audit.

The Secretariat has made efforts in 2015 to improve the assurance framework in country. This has included the appointment of international audit firms as external auditors for the Principal Recipients and request for interim audited financial statements to be performed. In addition, the Secretariat has revised requirements for Internal Audit functions with additional budget granted for Internal Audit staff.

Agreed Management Action 5
In conjunction with the Risk Management department, the Grant Management Division will develop and implement a consolidated risk and assurance plan for the Nigeria portfolio. This plan will at a minimum:

- include a holistic view of the grant objectives and the associated risks to the achievement of those objectives and provide an analysis of the current controls in place and evaluate any additional controls that need to be in place to mitigate the risks
- detail the current and the desired level of assurance by the Country Team and outsourced assurance providers to monitor the risks and rank these risks in terms of materiality (qualitative and quantitative against the grant objectives)

Owner: Mark Edington, Head of Grant Management
Implementation date: 31 December 2016

Agreed Management Action 6
The Secretariat will perform an assessment of its short term and long term plans for the Nigeria portfolio in order to ensure the achievement of grant objectives under the Global Fund grants to Nigeria. This will include the key strategic and operational activities that need to be performed by the Nigeria Global Fund Country Team. Based on this assessment, Secretariat will evaluate the current composition of the Nigeria Country Team against and where necessary make adjustments to the Country Team composition to ensure that there is adequate personnel to oversee the implementation, monitoring and oversight over key grant objectives and risks.

Owner: Mark Edington, Head of Grant Management
Implementation date: 30 September 2016

3. Effectiveness of the current implementation arrangements

The effectiveness of the Global Fund supported programs under the current implementation arrangements

Although health care delivery has been fully devolved to the state level governments, Global Fund-supported programs are implemented at the national level through federal and parastatal entities. This affects the accountability, oversight and impact of the programs in the long term.

NACA, the national public implementer for the HIV program is a presidential agency that implements Global Fund-supported programs through eight non-governmental organizations and three federal agencies. However, it has no control over health care delivery services, which are the responsibility of the individual state health authorities. NACA has no formal reporting line with the Federal Ministry of Health or the States Minister of Health. NMEP, the public implementer for the malaria program, is a program within the Federal Ministry of Health. It implements the malaria program using nine local non-governmental organizations as sub-recipients and has sub-recipient agreements with six out of 24 states that are part of the Global Fund programs.

Whilst Global Fund investments to date have managed to reduce the spread of the three diseases in the country, a "business as usual" approach will not achieve the necessary impact to materially change the trajectory of the three diseases and end the epidemics. Several of grants are not currently achieving their performance targets and many delays occur in the implementation of program activities.

Accountability: The current federal government implementers, NACA for the HIV program and NMEP for malaria, have no authority over the state governments and their ministries of health. The States have complete administrative and financial autonomy in resource generation and expenditure management. The Local Government Authority, in charge of the primary health facilities, reports to the State Ministry of Health. This leaves NMEP, as a program of the Federal Minister of Health, with limited authority over state health structures, and NACA and other non-governmental organizations with even less. This has resulted in the states and local governments having no accountability for the implementation of Global Fund programs.

Oversight: Global Fund-supported programs are managed by the Principal Recipients from the center through a wide range of sub-recipients, most of whom have no authority over health facilities and a vast geographical area with limited infrastructure and security. As a result, oversight functions for supply chain management, finance and monitoring and evaluation of program activities are inadequate and ineffective. Oversight functions need to be closer to actual service delivery areas for the effective monitoring and evaluation of program activities and timely resolution of issues identified.

The lack of accountability and oversight of the Principal Recipients over the local and state governments and program activities, as a result of the current grant implementation arrangements, is evidenced by the significant internal controls issues identified for NACA and NMEP, as noted under Section 3, Finding 1 of this report.

- Issues were noted around supply chain management where Principal Recipients have no accountability and oversight for the receipt, inventory management and dispatch of health commodities to and from medical stores.

- Principal Recipients have limited influence over data quality from the health facility level to the state and central levels, as the tools and systems for data recording, reporting and monitoring are owned by the State and Federal Ministries of Health which NACA and NMEP do not have any influence over.

- Similarly the ability of Principal Recipients to follow up and resolve issues identified during their supervision visits is limited, as they do not have authority over the health facilities or Local Government Authorities to escalate and manage non-performance.

Capacity Building: The implementation of the grants through federal programs has limited the Global Fund's ability to build capacity around people, processes, systems and assets in the country. Investments to date have mainly contributed to the development of capacity at the federal level (in Abuja). For example, under NMEP, more than US$20 million has been invested in the last two years to develop their capacity as an implementer. However, these investments have limited impact on the capacity of the states, leaving them with inadequate structures to effectively manage Global Fund grants. In the long run, this arrangement may affect the ability of the states to carry out their health mandate which can negatively impact any progress made by Global Fund programs on the three diseases.

Whilst the current implementation arrangements and the associated challenges have existed since the first Global Fund investments to the Republic of Nigeria in 2003, the Secretariat has only recently highlighted this risk, in May 2015. Since this, the Secretariat has decided to pilot a state level approach in Nigeria starting early 2016 and has commenced discussions with several state authorities although no agreements have been concluded.

Agreed Management Action 7
The Secretariat will develop an implementation plan for Nigeria with involvement and sign off from executive management at the Secretariat. The plan should, as a minimum, contain the following:
- Analysis of the current situation and clear plan with milestones and deadlines;
- Analysis of options to work with State Governments being Principal Recipients of the Global Fund for high burden states and as sub-recipients for the low burden states or the ones with low capacity;
- Analysis of options to consolidate the remaining functions at federal level (coordination, regulation, resource mobilization, reporting);

Owner: Mark Edington, Head of Grant Management
Implementation date: 31 December 2016

V. Table of Agreed Actions

#	Category	Agreed Management Action	Target date	Owner
1	Design and the effectiveness of Internal Control Environment	The Secretariat will assess the amount to be sought for recovery from Principal Recipients based on the internal control deficiencies identified by the OIG audit and refer relevant expenditures identified as non-compliant with the Standard Terms and Conditions of the relevant Global Fund Program grant to the Recoveries Committee.	31 September 2016	Mark Edington, Head of Grant Management
2	Design and the effectiveness of Internal Control Environment	The Secretariat will assess the internal control deficiencies identified by the OIG audit and determine non-compliant areas that require further review (e.g. by the Local Fund Agent). The Secretariat will refer any relevant issues from the reviews' findings to the OIG investigations department.	30 June 2016	Mark Edington, Head of Grant Management
3	Design and the effectiveness of Internal Control Environment	The Secretariat (Grant Management in collaboration with Finance and Risk Management) will conduct a capacity assessment relating to Government of Nigeria Principal Recipients. The capacity assessment will include the internal control environment (governance and oversight, financial and fiduciary management, health services and products and program management) as well as an assessment on the implementers' ability to deliver key grant objectives under the Global Fund grants to Nigeria.	30 June 2016	Mark Edington, Head of Grant Management
4	Design and the effectiveness of Internal Control Environment	Based on the outcome of the capacity assessment, the Secretariat will take the necessary measures to introduce additional controls and consider alternative implementation arrangements for key processes to ensure that key risks in the portfolio are adequately mitigated and the achievement of grant objectives under the Global Fund grants Nigeria.	31 December 2016	Mark Edington, Head of Grant Management
5	Design and effectiveness of the Global Fund risk management	In conjunction with the Risk Management department, the Grant Management Division will develop and implement a	31 December 2016	Mark Edington, Head of Grant Management

	framework for Nigeria	consolidated risk and assurance plan for the Nigeria portfolio. This plan will at a minimum: ▪ include a holistic view of the grant objectives and the associated risks to the achievement of those objectives and provide an analysis of the current controls in place and evaluate any additional controls that need to be in place to mitigate the risks ▪ detail the current and the desired level of assurance by the Country Team and outsourced assurance providers to monitor the risks and rank these risks in terms of materiality (qualitative and quantitative against the grant objectives)		
6		The Secretariat will perform an assessment of its short term and long term plans for the Nigeria portfolio in order to ensure the achievement of grant objectives under the Global Fund grants to Nigeria. This will include the key strategic and operational activities that need to be performed by the Nigeria Global Fund Country Team. Based on this assessment, Secretariat will evaluate the current composition of the Nigeria Country Team against and where necessary make adjustments to the Country Team composition to ensure that there is adequate personnel to oversee the implementation, monitoring and oversight over key grant objectives and risks.	30 September 2016	Mark Edington, Head of Grant Management
7	Effectiveness of the current implementation arrangements	The Secretariat will develop an implementation plan for Nigeria with involvement and sign off from executive management at the Secretariat. The plan should, as a minimum, contain the following: ▪ Analysis of the current situation and clear plan with milestones and deadlines; ▪ Analysis of options to work with State Governments being Principal Recipients of the Global Fund for high burden states and as sub-recipients for the low burden states or the ones with low capacity; ▪ Analysis of options to consolidate the remaining functions at federal level (coordination, regulation, resource mobilization, reporting).	31 December 2016	Mark Edington, Head of Grant Management

Annex A: General Audit Rating Classification

Highly Effective	**No significant issues noted**. Internal controls, governance and risk management processes were adequate, appropriate, and effective to provide assurance that objectives should be met.
Generally Effective	**Some significant issues noted but not material to the overall achievement of the strategic objective within the audited environment.** Generally, internal controls, governance and risk management processes were adequate, appropriate, and effective. However, there is room to improve.
Full Plan to Become Effective	**Multiple significant and/or (a) material issue(s) noted. However, a full SMART (*Specific, Measurable, Achievable, Realistic* and *Time-bound)* plan to address the issues was in place** at the time audit Terms of Reference were shared with the auditee. If implemented, this plan should ensure adequate, appropriate, and effective internal controls, governance and risk management processes.
Partial Plan to Become Effective	**Multiple significant and/or (a) material issue(s) noted. However, a partial SMART plan to address the issues was in place** at the time audit Terms of Reference were shared with the auditee. If implemented, this plan should improve internal controls, governance and risk management processes.
Ineffective	**Multiple significant and/or (a) material issue(s) noted.** Internal controls, governance and risk management processes were not adequate, appropriate, or effective. They do not provide assurance that objectives will be met**. No plan to address the issues was in place** at the time audit Terms of Reference were shared with the auditee.

Annex B: Methodology

The Office of the Inspector General (OIG) performs its 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 also help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing takes place 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 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.