Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

Issue 375: 18 March 2020

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BY DJESIKA AMENDAH

The Global Fund Board has allocated $43.3 million in additional funding for portfolio optimization to several Global Fund grants, including Kosovo (HIV/AIDS), the Middle East Response (integrated), Namibia (Malaria), Nigeria (Malaria), South Sudan (Tuberculosis), and Zambia (TB/HIV).

5. ANALYSIS and COMMENTARY: State Principal Recipients' find ways to improve Global Fund grant absorption

BY ANN ITHIBU

Malawi, Sierra Leone and Uganda are three African countries with varying disease burdens, Global Fund grant allocations, and operating environments. However, the state Principal Recipients, who manage most of the Global Fund grants in the three countries, face similar challenges spending their Global Fund allocations fully. These challenges include lengthy government approval processes and capacity gaps within the implementers. This article explains some of the strategies the three countries have come up with to improve their absorption of funds.

6. ANALYSIS: Supreme audit institutions of Ghana, Kenya, and Rwanda vary in their external audit performance of Global Fund grants

BY SAMUEL MUNIU

The Global Fund requires annual audits of its grants, with countries' own 'supreme audit institutions' (SAIs) as the preferred auditors of grants managed by state Principal Recipients. The supreme audit institutions of Ghana, Kenya, and Rwanda are among the few SAIs that already conduct annual audits of Global Fund grants in sub-Saharan Africa. These three SAIs, however, vary in their external audit performance.

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1. NEWS and ANALYSIS: "As the world shuts down due to Covid-19…"

Aidspan's health-economist Board member urges more HIV treatment in the era of the latest coronavirus

Alan Whiteside **18 March 2020**

On 27 December 2019, a doctor in Hubei province in China noticed four unusual cases of pneumonia, three from the same family. He notified the local Centres for Disease Control the following day. In short order, all the relevant Chinese authorities and the World Health Organization were informed.

The retrovirus causing the disease was identified in early January. By January 13, the first test kits were available. China began shutting down cities, placing people in mandatory quarantine, and banning travel. By March 16, the country had 81,020 reported cases. (All the figures in this article, unless otherwise stated, are taken from the Johns Hopkins Covida website: coronavirus.jhu.edu/map.html, on 16 March 2020. The website is constantly updated.) It is instructive that there have been 67,798 confirmed cases in Hubei; 3,099 deaths and 55,094 people who have recovered. There are relatively few new cases being reported from China in mid-March (a total of 29 in China on March 16, compared to 13,784 in the rest of the world, according to WHO).

The focus of the epidemic then moved westwards, first to Iran with (as of March 18) over 16,000 cases, then Italy with more than 31,000 cases. The epidemic has taken hold across the western world and North America with the number of cases ranging from 596 in Canada to 11,826 in Spain. The situation is fluid and the number of cases continues to climb.

Central and South America generally report fewer cases and the region is probably some weeks behind the rest of west. The data from sub-Saharan Africa are a puzzle. The Lancet published a comment on February 27 warning of the "**Looming threat of COVID-19 infection in Africa: act collectively, and fast".** It suggested "Because of the high volume of air traffic and trade between China and Africa, Africa is at a high risk for the introduction and spread of the novel coronavirus". This does not seem to have materialised to date.

At the moment the largest African COVID-19 epidemic is in Egypt, with 'only' 196 cases, followed by South Africa, with 85 reported cases; next comes Algeria, with 60 cases, followed by Senegal, with 26 reported cases. At the time of writing all other African countries that report cases had fewer than 10 cases each, and a number had none. Why is this?

Possible answers are:

- The continent and countries are behind in terms of the spread of the epidemic and cases have not developed;
- There is a failure to report cases, especially since many countries have weak health-care systems, inadequate surveillance and little laboratory capacity as well as limited public health infrastructure;
- Conditions in parts of Africa are less conducive to the spread of the epidemic, for example, it may not spread as easily in hot environments.

What does this have to do with HIV and AIDS? Both COVID-19 and AIDS are caused by retroviruses. The diseases spread into the human population through zoonotic transmission: chimpanzees and sooty mangabey monkeys in the case of AIDS, and probably bats to

pangolins to humans in the case of COVID-19. In both instances the animals were a food source, and transmission probably took place in markets.

The first cases of AIDS were seen in 1981 but the virus was only identified in 1983. It spread across the world with alarming speed. It was not until 1996 that the first effective medical treatments were developed. In the past 40 years there has been much progress. People who are infected can, if they obtain and are adherent to drugs, live normal lives. Prevention remains a challenge. However, the world knows how transmission occurs and how it can be prevented. Key populations can be identified, and the interventions targeted. Although there is still no vaccine or cure, the scientific response to AIDS, especially in virology and immunology, was rapid. This laid some groundwork for the knowledge about and response to COVID-19.

There are, however, significant differences. The first is in transmission: HIV is not easily transmitted; it must be introduced through body fluids into a person's body. The main modes of transmission are unprotected sexual intercourse, contaminated blood or blood products, and breast feeding. The use of drugs for AIDS treatment are effective at preventing transmission. COVID-19 is far more infectious and is spread through coughing, sneezing and transfer of the virus from surfaces, mostly via hands-to-face, into a patient.

The advances in epidemiology have been valuable in informing the global response and bringing the COVID-19 outbreak under control in some parts of the world (as now seems to be the case in China, South Korea, Taiwan and Singapore). The Chinese authorities decided the most appropriate response was to shut down Wuhan city. The restrictions on movement were extended across the country through a mandatory national holiday which effectively prevented people from travelling. There was extensive contact tracing.

The second difference: HIV takes years to develop into AIDS. COVID-19 has a short incubation period, generally less than two weeks. Most of those infected will experience few symptoms and may not even know they were affected (though could still have been infectious and unknowingly transmitted the virus to others). The severity of the epidemic increases with the age of those infected. The Chinese CDC reported 2.3% of all the people with confirmed cases of COVID-19 in China died. The fatality rate rose to 14.8% in people over 80; the fatality rate was 1.3% in the 50- to 60-year-old cohort; 0.4% in 40-year olds; 0.2% in the 10- to 39-year-olds; and negligible for children under 10. (Sharon Begley, 'Who is getting sick, and how sick? A breakdown of coronavirus risk by demographic factors', Statnews https://www.statnews.com/2020/03/03/who-is-getting-sick-and-how-sick-a-breakdown-of-coronavirus-risk-by-demographic-factors accessed 16th March 2020)

It seems the reason older people are more likely to fall ill, require medical interventions and die is due to co-morbidities. Put simply, this is the presence of other diseases, a weaker immune system, or simply worse overall health (and in China perhaps the high prevalence of smoking). The diseases associated with these co-morbidities that are mentioned in the literature to date are mainly non-communicable. They include hypertension, diabetes, respiratory system disease, and cardiovascular disease. (Yang J, Zheng Y, Gou X, Pu K, Chen Z, Guo Q, Ji R, Wang H, Wang Y, Zhou Y, Prevalence of comorbidities in the novel Wuhan coronavirus (COVID-19) infection: a systematic review and meta-analysis,

International Journal of Infectious Diseases (2020), doi: https://doi.org/10.1016/j.ijid.2020.03.017 accessed 16th March 2020.)

The issue of HIV and COVID-19 co-morbidity has received little attention to date. This is because we have not yet seen significant cases in places with a high HIV burden. There has been only one set of guidance disseminated on this, from the Southern African HIV Clinicians' Society, which says: "At the moment, very little is known about the interaction between HIV and COVID-19. Nonetheless, some reasonable assumptions based on experience with other infections, such as influenza, can be made with regard to immune-suppressed individuals." (This should be available on their website, https://sahivsoc.org) Essentially their advice is that HIV-infected people who are on treatment probably should not worry. The greatest concern must be for those who are HIV positive and not on treatment, especially those with TB. They and their health-care providers should focus on getting people tested and on treatment. More research and thinking needs to be done on this.

There is very little further information at this stage. Aidspan will monitor this and ensure we provide updates on the status of the COVID-19 epidemic in areas where HIV is a concern and on possible interactions.

On March 4, the Global Fund released a guidance note in response to COVID-19: "Working within its mandate to fight HIV, TB and malaria and to strengthen systems for health, the Global Fund is encouraging countries to reprogram savings from existing grants and to redeploy underutilized resources to mitigate the potential negative consequences of COVID-19 on health and health systems. In exceptional cases, countries may be able to reprogram funding from existing grants to COVID-19 response." (https://www.theglobalfund.org/en/news/2020-03-04-global-fund-issues-new-guidance-in-response-to-covid-19/)

Peter Sands, the Global Fund's Executive Director, said that the Fund is committed to a pragmatic and flexible approach in supporting countries. Quite how this will fit with the mission of ending HIV, TB and malaria is unclear. As the South African guidance notes, getting HIV-positive people on treatment for HIV is in itself protection against COVID-19. This is a rapidly evolving situation of great global concern.

Alan Whiteside OBE, DEcon, is an academic and a member of the AIDSPAN board, with 30 years' experience working in the field of HIV and AIDS.

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2. NEWS: Is it possible to contain and treat widespread COVID-19 infection in Africa?

Can developing countries "flatten the curve", especially in the presence of large numbers of people already infected with HIV and TB?

Adèle Sulcas **18 March 2020**

On March 16, at the World Health Organization's most recent COVID-19 press conference in Geneva, WHO Director-General Dr. Tedros Adhanom Ghebreyesus said: "As the virus moves to low-income countries, we're deeply concerned about the impact it could have among populations with high HIV prevalence, or among malnourished children."

For countries with high burdens of HIV and/or tuberculosis, COVID-19 is an enormous public health concern. Yet as of this writing, there is very little global guidance available on how countries should – from a clinical point of view – manage this multiple burden, beyond sticking with current treatment regimes.

Some information available on HIV- and COVID-19 co-infection comes from South Africa's National Institute for Communicable Diseases (NICD), which has just released guidelines "about the importance of continuing to take ARV treatments and stay healthy," Dr Lynn Morris, Director of the NICD, said. "For most people, the [COVID-19] infection is mild and does not involve hospitalization," Morris told the GFO in an email. "They will completely clear the virus after a few weeks." But, she said, "we don't know how COVID-19 will impact South Africans who are living with HIV and TB."

"For those who do not know their HIV status," Morris also said, "we recommend getting tested and tak[ing] ARVs if needed, as they restore immune function, which will help to fight COVID-19."

The clinical interactions between COVID-19 and HIV in a co-infected individual have not been fully explored (noted also by Professor Alan Whiteside in a separate article in this GFO), and not much discussed in the public domain – understandable given the short history of COVID-19, with scientists and medical professionals around the world working around the clock to care for patients and research treatments and vaccines.

What has been specified in many global forums is that some 'co-morbidities' – certain pre-existing underlying conditions such as respiratory illnesses or cardiovascular disease – are likely to make people more susceptible to or worsen the effects of COVID-19 infection. It has also been clearly stated by public health authorities around the globe (in addition to the NICD) that people whose immune systems are compromised may be more susceptible to infection with COVID-19 – clearly the case for people living with HIV and for many people living with TB, or both, as well.

Logically, therefore, countries with high burdens of HIV and TB in their populations (frequently the case in sub-Saharan Africa, and most countries in the region implementing Global Fund-financed programs against these diseases) are likely to face even greater challenges if their health systems need to cope with widespread COVID-19 outbreaks. And

yet this issue has not been explicitly addressed in the affected countries' mass communications around COVID-19 so far.

Health systems' ability to contain COVID-19

In addition, the same high-HIV- and TB-burden countries are the ones most likely to have public health systems that are less able to cope with extraordinary public health crises compared to the health systems of 'rich', developed nations, such as those in Europe currently grappling with an upsurge in COVID-19 cases – because in general developing countries lack the systems, and the levels of finance, medicines, equipment and the sheer numbers of medical professionals required to deal with infectious disease outbreaks on a vast scale.

A hopeful counter-argument to this is that some of these countries with comparatively weak health systems are the same countries that have, mostly, successfully fought (if not yet vanquished) the virulent Ebola outbreaks that have affected mainly West Africa in recent years – Democratic Republic of Congo, Gabon, Guinea, Ivory Coast, Sierra Leone, Liberia, Mali, and Nigeria. The World Health Organization called the 2014-2016 Ebola epidemic the "the largest and most complex Ebola outbreak since the virus was first discovered in 1976", and the countries that were hardest hit have as a result developed expertise and systems to screen for infections and manage virulently transmissible diseases.

Dr Aaron Aruna, the Ministry of Public Health Director of the Fight Against Diseases in the DRC told WHO in February that having their Ebola screening in place "made it easy for us to start screening for coronavirus disease." Dr Gervais Folefack Tengomo, WHO's Incident Manager for COVID-19 in the DRC said, "It is helpful that a lot of the infrastructure needed to diagnose, isolate and treat severe cases is already in place due to Ebola." A U.S citizen who has recently travelled in more than five African countries told the GFO that she was impressed with the systems the African countries she had visited had in place for systematic temperature screening and interviews about passengers' prior travels at borders and at airports – something that at that time, at least, was not routine in the United States (this has since changed).

Clinical care

What remains challenging for many African countries is how to adequately care for people who are ill with COVID-19, if they test positive for it. In Nigeria, after the first case of COVID-19 was reported there last week, the country's leading public health official, Chikwe Ihekweazu, the Director-General of the Nigeria Centre for Disease Control, said the biggest risk for his country was its ability to provide adequate clinical care, in the event that the virus spreads widely through the population. Acknowledging that even though the proportion of infections that lead to "severe" illness is relatively small (taking China, with more than 80,000 confirmed infections, as the base case), Ihekweazu said that "the absolute numbers will be fairly significant if transmission really gets a foothold in a context like Nigeria".

Many other African countries have similar contexts. Though the numbers of reported infections of COVID-19 in Africa remain relatively low on a per-country basis (most African countries have under 100 tested-and-confirmed infections each, with the exception of Egypt at 196 reported cases, as of March 18), many experts suspect that this may just be the spark before the wildfire. And they emphasize that it is containment at this point in an epidemic that makes all the difference.

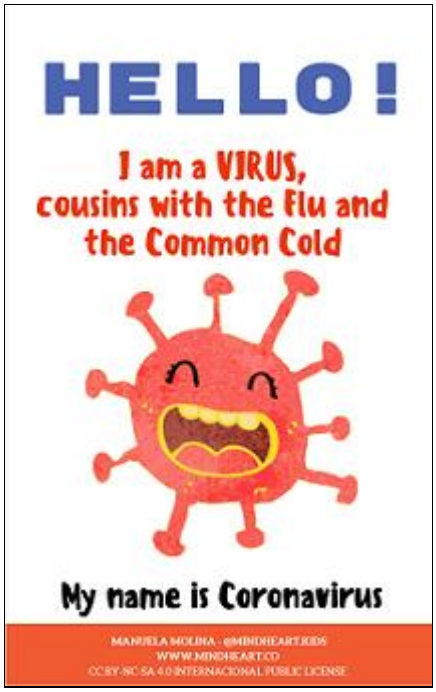
Dr Anthony Fauci, the Director of the United States' National Institute for Allergies and Infectious Diseases (NIAID), emphasized in his words to the U.S. public on March 16 (accompanying President Donald Trump's televised address in which he declared a 'national emergency' regarding COVID-19), that it is at this point in an epidemic when one often thinks that measures being taken are too extreme. And retrospectively, he said, that they always seem to fall short. "I think we should really be overly aggressive and get criticized for overreacting," he told NBC News.

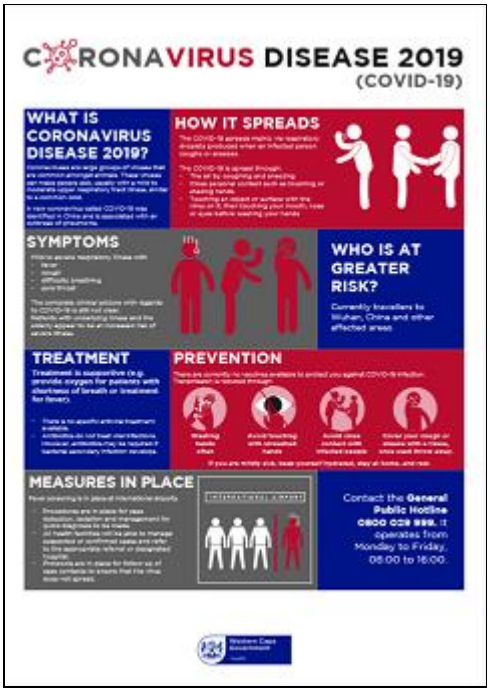
Like Ihekweazu, Fauci's main concern is grounded in an anticipated shortage of medical equipment – insufficient ventilators and access to oxygen therapy for those who need it – should COVID-19 really take hold. "So our best bet," he said, "is really to focus as hard as we can on early detection."

Dr Tedros's oft-repeated injunction to "test, test, test" is at once reassuring and aspirational, given many countries' limited diagnostic capacities and decisions to test people for COVID-19 only in the presence of symptoms. For African leaders, medical professionals and anxious members of the public, how to tread the line between effective prevention and control of COVID-19, and the limitations of their socioeconomic realities, is a pressing question that requires an urgent – and global – response.

Some COVID-19 tools and resources:

- WHO's daily COVID-19 Situation Reports
- Johns Hopkins University's Coronavirus resource centre (with frequently updated interactive maps and visuals)
- WHO's online 'Responding to COVID-19' courses in WHO's official languages (Arabic, Chinese, English, French, Russian, Spanish)
- WHO's online 'Responding to COVID-19' courses in additional national languages (Japanese, Bahasa Indonesian, Portuguese, Italian, Turkish, Vietnamese)
- 'Critical preparedness, readiness and response actions for COVID-19,' WHO Interim Guidance (16 March 2020)
- South Africa's Department of Health coronavirus website: https://sacoronavirus.co.za/
- South Africa's National Institute for Communicable Diseases
- WHO's 'Mental Health and Psychosocial Considerations during COVID-19 outbreak'
- Child-friendly explanation of coronavirus; see image below (left)
- COVID-19 basic prevention poster for the broader public (South African Department of Health); see image below (right)





Left: Child-friendly COVID-19 explanation; right: South African COVID-19 public information poster

Editor's note: The GFO will continue to report on COVID-19 in future editions, especially with regard to the interactions between COVID-19 and HIV/TB, as well as implementing countries' efforts to deal with the concurrent pandemics.

Further reading:

- Dr Tedros's opening remarks at WHO's March 16 press conference on COVID-19
- 'Anticipating Coronavirus in West Africa,' interview with Chikwe Ihekweazu, Director-General of Nigeria's Centre for Disease Control, from 'Think Global Health" (3 March 2020)
- Global Fund Executive Director Peter Sands' blog, 'COVID-19 threatens the marginalized and the poor more than anyone'.

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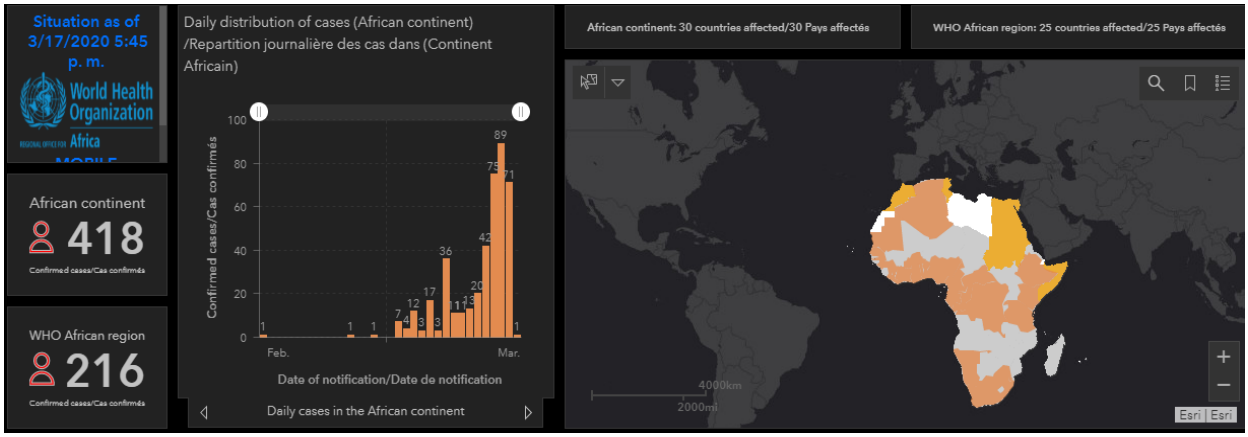
3. NEWS: As COVID-19 takes hold in Africa, will the Global Fund adjust its application windows for 2020-2022 funding requests?

Widespread travel and meeting restrictions inhibit adequate consultation in development of funding requests

Aidspan staff **18 March 2020**

Countries in the West and Central Africa region face major challenges in developing concept notes for their next Global Fund grant applications, in the context of the rapid spread of the COVID-19 virus.

Figure 1: Mapping COVID-19 in Africa; image from 17 March 2020



Source: WHO website

While the African continent initially appeared to be relatively spared by the coronavirus, the surge of cases in recent days raises fears of rapid expansion in the coming weeks. The three Maghreb countries (Morocco with 44 cases, Tunisia with 24 cases, Algeria with 60 cases), which are among the most affected so far, are trying to limit the spread and have already closed their air borders, particularly to travellers coming from Europe. Following the discovery of new cases in the Democratic Republic of Congo, in Ethiopia, South Africa, Senegal, and more recently in Côte d'Ivoire, Rwanda, Kenya, and Benin, African countries are taking strong preventive measures: quarantines, bans on meetings, religious holidays, closure of places of worship, schools and universities, cancellation of visas, quarantine of citizens from countries affected by COVID-19 and closure of air borders in some cases.

As a result, many consultants to Global Fund grants were unable to travel to the African countries where they were due to work, because of their nationality or place of residence, especially experts from Europe (France, Germany and Italy).

Since the beginning of the week, the main technical assistance providers involved in supporting Ministries of Health in the preparation of funding requests have suspended their activities, whether Expertise France, a major provider of technical assistance (TA) in the region, or UNAIDS, Roll Back Malaria, and WHO. The TA providers and consultancy firms are now repatriating the consultants still present in the field and asking them to continue their remote support.

This remote coordination will undoubtedly change the nature of the country dialogue process, which is also made impossible by the fact that many countries are not allowed to organise meetings and workshops. Inclusive and in-depth discussions will therefore be almost impossible and meaningful collaboration between consultants and programmes, CCMs and national stakeholders involved in the fight against pandemics is proving very difficult.

Moreover, the ministries in these countries are now very focused on the containment of COVID-19, and it will be hard to mobilize the Ministry of Health staff needed to prevent epidemics in general, including for the three diseases, in the country-dialogue process, at a time when preventing the spread of the coronavirus is the priority of the ministries of health.

Status of funding requests

With respect to Global Fund funding requests for the March window (Window 1 of three in 2020, for the Global Fund's 2020-2022 allocations), requests are almost complete (the deadline for submission in this window is 23 March), and countries are entering the home stretch: integration of comments and suggestions from Global Fund country teams, validation by national authorities of strategic choices, discussions around co-financing (amount and activities covered). The hasty return of the consultants to their countries of origin has deprived the recipient countries of their support at this critical phase, since most of the decisions taken at this stage are key under close scrutiny by the TRP: co-financing and implementation modalities (choice of Principal Recipients, among others).

But the situation is even more delicate for countries whose funding requests must be submitted by the May window (Window 2, with a submission deadline of 25 May), as almost all the consultants (except national experts) who were supposed to support the countries in the preparation of their funding requests have been sent back home.

Apart from the March 4 'New Guidance in Response to COVID-19' update published on the Global Fund website, we have not seen any real discussion coming out of the Global Fund on what comes next for countries' funding requests, in light of the coronavirus's disruption of countries' 'normal' functioning. Even if the decision has already been made to organise a virtual Technical Review Panel (TRP) review of funding requests for Window 1 (the TRP session for Window 1 was originally scheduled for April 29 to May 11), it is most likely that the process of writing funding requests will from now on be very chaotic, and is unlikely to be able to respect any of the Global Fund's principles of transparent, inclusive and comprehensive country dialogue given the difficulties raised by countries' restrictions on meetings and people's movements.

It is clear that the Secretariat is concerned about a delay in the submission of concept notes in Window 2 (as any delay means that there will not be enough time to properly conduct the whole funding request process until the grant agreements are signed before the end of December). While the Global Fund is keen to avoid disruption of services or extremely time-consuming extensions, there is a real risk that funding applications will not meet the necessary quality criteria and will be the result of a very limited consultation process.

Conclusion

The capacity of recipient countries to submit high-quality applications that are approved by the TRP is now the key concern of this discussion. This capacity is all the more necessary as the amounts allocated to the recipient countries in the 2020-2022 allocations are much higher than in the current period, and require a real discussion - especially on resilient and sustainable health systems and the most efficient strategies to eliminate the three diseases.

The African constituencies on the Global Fund Board, aware of what is at stake for their region, have taken the lead, and have developed a statement that is expected to be released today. The statement underscores the unique context in which the fight against coronavirus is taking place, highlighting the efforts made by ministries of health on this continent with still fragile health systems to contain the virus. Finally, the statement requests that the Secretariat propose flexibility measures to allow countries to submit their requests under favorable conditions: By postponing Window 1 (with the March 23 submission deadline) by a few weeks (up to a month), by postponing submissions for Window 2 to the submission deadline date originally scheduled for Window 3 (from May 25 to August 30), and by discussing now the possible extensions of grants from the current funding period to the first quarter of 2021, in order to give countries time to complete the grant negotiation process.

The topic will certainly be addressed at the Global Fund's next Strategy Committee session, which is scheduled to take place virtually on Thursday 19 and Friday 20 March.

The Global Fund Observer and the Observateur du Fonds Mondial will continue to report on this critical issue in upcoming editions. Please send any comments or questions in this regard to info@aidspan.org with "Global Fund and COVID-19" in the subject line.

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4. ANALYSIS: Global Fund has allocated an additional $43.3 million to existing grants in several countries

Funding for portfolio optimization goes to Kosovo, Middle East Response, Namibia, Nigeria, South Sudan, and Zambia

Djesika Amendah **18 March 2020**

The Global Fund Board has approved the Secretariat's recommendation to allocate $43.3 million in additional funding to several countries and grants. These countries and the funded disease components are, in alphabetical order, Kosovo (HIV/AIDS), Namibia (Malaria), Nigeria (Malaria), South Sudan (Tuberculosis), and Zambia (TB/HIV). The Middle East Response has also received more funding as an integrated grant, which is "a grant composed of individual country allocations" for Iraq, Syria, Yemen, and for Syrian refugees and vulnerable populations in Jordan and Lebanon. According to the Global Fund explorer, Jordan and Lebanon do not have ongoing grants.

These additional funds come mostly from unutilized funds within grants, often because of countries' lower-than anticipated rate of funds' absorption. Countries' absorption rates are monitored by the Secretariat. The Global Fund calls the process of reallocating unutilized funds to other countries and grants 'portfolio optimization'. The aim of portfolio optimization is to fully utilize all funds within an allocation cycle, while enabling countries that are on track to use 100% of their grants to optimize their programming by adding additional interventions that were not originally funded. The grants funded with this Board decision

were listed under Unfunded Quality Demand (UQD), which is a registry of activities that could not be funded with the countries' original respective country allocations.

Except in Kosovo, most of this additional funding goes to procure and distribute health commodities and equipment.

Editor's note: The additional funding to Kosovo was in Euros and that of the other countries in US$. We converted the Euros into $ using the exchange rate of $1.1 for one Euro, to obtain the amount for the total additional allocation in a single currency.

Table 1: Secretariat's Recommendation on Additional Funding to Finance UQD from the 2017-2019 Allocation Period

Applicant/ Currency	Disease Component	Grant Name	Previously Approved Program Budget	Recommended Additional Funding	Revised Program Budget
Kosovo/ EUR	HIV/AIDS	QNA-H-CDF	1,445,502	112,010	1,557,512
Middle East Response/ USD	Integrated	QSF-Z-IOM	36,408,367	4,940,702	41,349,069
Namibia/ USD	Malaria	NAM-M-MOH	2,370,582	699,999	3,070,581
Nigeria/ USD	Malaria	NGA-M-CRS	269,171,930	17,785,081	286,957,011
Nigeria/ USD	Malaria	NGA-M-NMEP	14,148,926	7,614,919	21,763,845
South Sudan/ USD	Tuberculosis	SSD-T-UNDP	9,000,000	2,351,204	11,351,204
Zambia USD	TB/HIV	ZMB-C-MOH	137,984,476	9,788,461	147,772,937
Total* *USD*			*470,674,333**	*43,303,577**	*513,977,910**

Source: Report of the Secretariat's Grant Approvals Committee

**Note: Aidspan used Euro 1.1 = US$1 as the average exchange rate (from Oanda.com). This number is not endorsed by the Global Fund Secretariat.*

Details of the approved grants

In Kosovo, human rights-related barriers to HIV services:

Kosovo is a middle-income country preparing to transition from Global Fund support. The Principal Recipient (PR) is called the Community Development Fund; it manages the country's HIV and TB grants. (Kosovo does not have a malaria grant). The additional EUR112,010 will support Kosovo's HIV grant, specifically activities to reduce human rights-

related barriers to HIV services, community responses, and systems for social mobilization, building community linkages, collaboration, and coordination. These funds will also pay for capacity building for community health workers.

Bednets in Yemen and digital X-ray machines in Iraq for internally displaced and refugees

The Middle East Response is a grant offering services to populations in five fragile countries affected by conflict and humanitarian crises. The PR for this grant is the International Organization for Migration (IOM). The additional $4,940,702 will be used in two countries: Yemen and Iraq.

In Yemen, this grant will fund the procurement and distribution of 1.6-million long-lasting insecticidal nets (LLINs) for mass campaigns, and for refugees and IDPs in high malaria transmission areas. In Iraq, the grant will fund the procurement of four digital X-ray machines for TB facilities, to help increase TB case notification and reach grant targets.

Bednets in Namibia for those who live in zinc structures

Namibia is an upper-middle-income country that aims to eliminate malaria by 2020, according to the World Health Organization. Nevertheless, malaria transmission occurs year-round in some regions of Namibia. The $699,999 additional funding aims to purchase 175,000 LLINs for the at-risk population who live in zinc-structure housing. Namibia has emphasized Indoor Residual Spraying for vector control to fight malaria, but this method does not work well for houses built with zinc. Thus, the need for bednets for the people who live in those structures and are at risk of malaria.

Seasonal malaria chemoprevention for under five-year-old children in four states in Nigeria

The additional $25.4 million will help fight malaria in Nigeria, the highest malaria-burden country in the world, according to the 2019 World Health Organization (WHO) Malaria report.

These funds aim to provide seasonal malaria chemoprevention (SMC) to children under five years old in the four states of Borno, Kano, Katsina, and Yobe in 2020, in the north of Nigeria. According to the WHO, SMC consists of giving full treatment of antimalarial medicine to children living in areas of highly seasonal transmission during the malaria season, using an 'intermittent' treatment protocol.

The National Malaria Elimination Program of the Federal Ministry of Health will be in charge of these SMC activities in Borno State. Catholic Relief Services, the malaria International Non-Governmental Organization PR, will work in Kano, Katsina and Yobe States.

South Sudan: more TB medications and some other interventions

South Sudan is designated by the Global Fund as a Challenging Operating Environment, and the United Nations Development Program is the PR. This additional funding aims to support the country's TB program; the $2,351,204 will help procure and distribute medications for first-line and second-line anti-TB drugs. In addition, the investment will support increased

case-finding and treatment interventions, optimize utilization of diagnostic devices, support outreach and motivation of community health workers, and strengthen the nascent multidrug-resistant TB (MDR-TB) program.

Zambia: HIV differentiated service delivery, 126-million condoms, and TB drugs

The Ministry of Health of Zambia will be responsible for the additional $9,788,461 in additional funding. These funds aim to bolster differentiated ART service delivery. According to the WHO, differentiated service delivery of HIV care "simplifies and adapts HIV services at all levels of care to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system." For example, differentiated service delivery allows in some contexts that persons living with HIV receive their medications quarterly at the community level without having to go to a health facility.

This funding will also procure 126 million condoms in 2020, and medicines for TB patients who are resistant to the multidrug- or rifampicin medicines for TB patients, also in 2020.

No Funding for Angola

The Grant Approvals Committee (GAC) recommended to the Board not to approve Angola's request for additional funding for its Resilient and Sustainable Systems for Health (RSSH) grant, in the amount of $5.3 million. Several reasons underlie this recommendation.

The Office of the Inspector General has audited the grants in Angola in 2019, and has reported the following findings: (i) poor data quality hampering reliable measurement of performance and impact; (ii) lack of country prioritization and ownership on programmatic performance; (iii) failure to fulfill Government commitments impacting Global Fund programs; and (iv) key structural bottlenecks impacting implementation of Global Fund grants.

The Secretariat had similar findings during its Country Portfolio Review, and made some strategic decisions. Among them are applying additional safeguard measures, choosing a United Nations entity as PR to manage the remaining funds in the grants, and withholding Angola's 2020-2022 allocation while sorting out these issues.

Way forward

The GAC will continue with optimization of the portfolio as more funding becomes available in 2020.

Editor's note: The information for this article comes from GF/B42/EDP04 (Electronic Report to the Board - Report of the Secretariat's Grant Approvals Committee: Decision on the Secretariat's Recommendation on Additional Funding to Finance Unfunded Quality Demand

from the 2017-2019 Allocation Period). This document is not available on the Global Fund's website.

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5. ANALYSIS AND COMMENTARY: State Principal Recipients' find ways to improve Global Fund grant absorption

Strategies include strengthening capacity of the state PRs and engaging top-level management

Ann Ithibu **18 March 2020**

Low absorption of Global Fund grants has been a long-standing challenge among recipient countries, especially those in sub-Saharan Africa. Previously, the Global Fund had estimated that countries failed to use close to $1.1 billion from the 2014-2016 allocation period. Discussions on the absorption of Global Fund resources are therefore likely to take center stage in the coming months as most countries draw closer to the end of their grants for the 2017-2019 allocation period, by the end of December 2020 or mid-2021.

The Global Fund and implementing countries have had to come up with strategies in the current implementation period, 2018 to 2020, to address the bottlenecks to effective absorption of funds, whether at the Secretariat- or country level, and ensure that countries use all their available funding. In this article, we highlight impediments to the absorption of Global Fund grants in three sub-Saharan African countries (Malawi, Sierra Leone, and Uganda) and the strategies that these countries have put in place to address them.

Editor's note: In July 2019 the GFO published a desk review on the challenges at Global Fund Secretariat and implementer levels found to impede absorption.

Data for this article comes from publicly available information and documents from the Global Fund website, a literature review, and interviews with officials from state Principal Recipients (PRs) from the three countries as well as from the Uganda Country Coordinating Mechanism (CCM). The State PRs include Malawi's Ministry of Health (MOH), Sierra Leone's Ministry of Health and Sanitation (MOHS), and Uganda's Ministry of Finance, Planning and Economic Development (MOFPED). Sierra Leone has another state PR, the National AIDS Secretariat, which was not interviewed for this analysis.

The three countries vary in disease burden and size of allocation

The countries vary in the Global Fund's portfolio categorization, size of the allocation and operating environment. Malawi and Uganda are high impact countries i.e. they have a large portfolio and a mission-critical burden, whereas Sierra Leone is a core country (larger portfolios, higher disease burden, and higher risk). The Global Fund also classifies Sierra Leone as a challenging operating environment (COE) as the country is still in recovery from

the 2014 Ebola outbreak. It has instituted additional safeguards, including a fiscal agent and limited cash policy, to strengthen fiscal and oversight controls in Sierra Leone.

State PRs are managing most of the current grants in the three countries: 85% in Malawi, 95% in Sierra Leone and 93% in Uganda (Table 1). The State PRs have established units to manage the grants that bear different names depending on the country: Program Management Unit (PMU) in Malawi, Funds Coordination Unit (FCU) in Uganda, and Integrated Health Projects Administration Unit (IHPAU) in Sierra Leone.

Table 1: Type of Principal Recipient for active Global Fund grants in Malawi, Sierra Leone and Uganda

Country	Principal Recipient	Grant number	Signed amount ($)	Proportion (%) of the total grants
Malawi	**State PR**	**Ministry of Health**	**394,382,867**	**85%**
	Non-state PRs	Action Aid Malawi World Vision Malawi	69,654,963	15%
Total			464,037,830	
Sierra Leone	**State PR**	**Ministry of Health and Sanitation (MOHS)** **National AIDS Secretariat**	**93,011,179**	**95%**
	Non-state PR	Catholic Relief Services (CRS)	5,313,275	5%
Total			98,324,454	
Uganda	**State PR**	**Ministry of Finance, Planning and Economic Development (MoFPED)**	**463,867,429**	**93%**
	Non-state PR	The AIDS Support Organisation (TASO)	35,559,886	7%
Total			**499,427,315**	

Source: ***Global Fund Data Explorer***

Note: The Sierra Leone MOHS grant runs between July 2018 and June 2021 whereas the other state grants run from January 2018 to December 2020

State PRs spent most of their funds in 2015-2017

Absorptive capacity measures the percentage of actual expenditure compared to the total grant budget, according to the Global Fund. During the 2015-2017 implementation period, the Malawi MOH absorbed 81% of the HIV/TB grant and only 65% of the malaria grant. Uganda's MOFPED, on the other hand, spent 102% of the HIV grant, 97% of the TB grant, and 93% of the malaria grant, as shared by the MOFPED official. The Sierra Leone MOHS spent 77% of a multi-component (TB, malaria, and health-systems strengthening) grant.

The three countries face similar impediments to funds absorption

The state PRs from the three countries highlighted the impediments to absorption within their country contexts. Some of the challenges are common to all three countries. First, the state PRs noted that lengthy government approval processes, such as for procurement, often delay the implementation of grant activities.

Second, gaps in implementers' capacity, at the national and sub-national levels, affect the absorption of grants in the three countries. These gaps often manifest as delays in initiating activities at the state-SR level (Uganda); delayed submission of reports, disbursement requests, and relevant documentation such as procurement plans by the implementers (Malawi and Sierra Leone); and ineligible expenses (Sierra Leone). Attrition within implementers' staff has contributed to the capacity gaps (Sierra Leone and Uganda).

Third, the state PRs from the three countries have also ended up with unspent funds due to savings and exchange-rate gains. The three countries made significant savings from a fall in the exchange rate (Sierra Leone) and overbudgeting or fall in global prices (all).

Lastly, the Global Fund additional safeguards often delay the implementation of grant activities in Sierra Leone. The safeguards include the 'limited cash' policy (where the PR makes direct payments to vendors, for goods and services, rather than transferring funds to SRs for this purpose) and putting in place a fiscal agent - contracted by the Global fund to minimize risk of fraud, misuse of grant funds and ineligible expenditures. For instance, the limited-cash policy affects the payment of salaries to community health workers (CHWs) due to the limited penetration of mobile money and banking services. Similarly, Malawi, which is not under the additional safeguards policy but has a fiscal agent in place, noted that delayed approvals by the fiscal agent led to delayed implementation of the grants' activities.

Other bottlenecks that are unique to each of the countries include frequent in-country missions by the Global Fund Country Teams that often pull the implementer's attention away from the execution of grant activities (Malawi), fear of incurring ineligible expenses (Sierra Leone), weak implementation arrangements (Sierra Leone), rigidity in Global Fund compliance standards (Sierra Leone) and failure to engage the top management of ministries serving as either PRs or SRs, which made it difficult to troubleshoot when bottlenecks arose (Uganda).

Strategies to address bottlenecks

The state PRs have come up with strategies to address the bottlenecks described above:

Leveraging the budgeting flexibilities

The state PRs in Malawi and Sierra Leone are taking advantage of the budgeting flexibilities accorded by the Global Fund to move funds from one intervention area to another for smoother implementation of grant activities. PRs can make changes of less than 15% of the total budget for any standard intervention or less than a 5% increase for any discretionary costs such as human resources or travel-related costs, without prior written approval from the Global Fund. Sierra Leone's IHPAU, in particular, reported that budgeting flexibilities have made it easier to move funds to more impactful modules; such flexibilities may be due to their COE status. The Malawi PMU has prioritized prompt reprogramming of savings in line with the Global Fund's budgeting guidelines.

Commoditization of the grant

A 2019 analysis by the Global Fund showed that commoditized grants have higher absorption rates as compared to their less commoditized counterparts. Uganda and Malawi have allocated 90% and 85% of their current grants, respectively, to the procurement of health commodities. However, for Uganda, commoditization of the grants was a way of minimizing stock outs. The MOFPED explained that since procurement has been made easier by the Pooled Procurement Mechanism (PPM), grant absorption has increased. Closely related to this, Uganda established a Health Commodities and Supply Chain Management task force in Uganda, which brings together development partners and the government to review quantification and forecasting, procurement, and distribution of health commodities. This engagement at the task-force level has helped improve donor confidence and hasten approvals in the procurement process.

Engagement of top leadership of state PRs and SRs

The Malawi and Uganda state PRs are engaging top leadership within the relevant ministries to enhance smoother implementation of the Global Fund grants. The Malawi MOH, for instance, holds a monthly one-hour grant-management meeting headed by the Secretary of Health, where they discuss issues that the implementers have been unable to solve. Malawi also holds a bi-weekly grant implementation meeting with the Chief of Health Services in the MOH, who is responsible for technical issues, where the implementers report on both technical and financial absorption. The Uganda MOFPED (which oversees the grant funds), and MOH (which implements the grant activities) hold a monthly meeting which is chaired by the Permanent Secretary (PS) of Health. The grant managers within the MOH provide updates on grant implementation including the challenges and bottlenecks they are facing.

Strengthening capacity of implementers and grant management units

Sierra Leone has prioritized building knowledge within the IHPAU and implementers' staff on the Global Fund budgeting requirements to reduce ineligible expenses. The country has also brought on board a consultant to help revise the grant's financial manual and simplify the financial processes related to grant management.

The grant management units have also recruited specialists to help in monitoring grant implementation: both IHPAU and PMU recruited a procurement specialist to help monitor procurement processes. The Gates Foundation supports the procurement officer in Malawi's PMU, whose roles include tracking global-market and price trends for health commodities. MOFPED's FCU includes specialists in finance, procurement, monitoring and evaluation, and communication and change management.

Frequent reporting by the SRs and disease programs

The Malawi PMU requires each of the SRs and disease programs to submit quarterly and six-monthly work plans and budgets. It also requires that the different entities report absorption at the module and activity level, unlike before, when they would review the budget and expenditures at a high level. The PMU also holds quarterly review meetings, which promote increased peer engagement and accountability among the implementers.

Active monitoring by the CCM

CCMs also play a critical role in identifying low absorption, bottlenecks, and ensuring that the implementers take well-timed corrective measures. The Uganda CCM representative noted that they have mainstreamed absorption discussions during all the quarterly CCM meetings. The Uganda CCM representative also noted that they have a vibrant Secretariat, which analyses data from the PR reports and closely monitors absorption. The CCM also pushes the PRs to prepare acceleration plans to catch up on delayed activities. At the time of the GFO's interview with the Uganda CCM, they were leading a reprioritization consultation process with the Country Team and relevant in-country stakeholders.

Others

Sierra Leone's MOHS has integrated TB, malaria, and health systems strengthening into one grant to ease the administrative burden and allow for the swift reallocation of funds. The IHPAU has also enlisted pre-qualified suppliers, with a one-year performance-based contract for administrative-related costs, which has reduced delays that often result from tendering processes. Uganda's MOFPED also noted that they have improved continuous engagement and communication between the various stakeholders including the CCM, implementers, the Global Fund Country Team, and other development partners, which has helped improve the implementation of grants.

Global Fund support

The state PRs from the three countries all said that the Global Fund has been responsive and has supported them in implementing these strategies. They noted that they have regular meetings with the Global Fund team. For Uganda, this meeting is called the 'enhanced grant review meeting', where the implementers and the Country Team, after each reporting period (which is usually after every six months), review the PR's Progress Update and Disbursement Request (PUDR), identify challenges and devise a way forward. Sierra Leone's IHPAU also

noted that they host quarterly Global Fund missions, which provide a platform to discuss challenges and possible solutions.

However, the Malawi PIU noted that there had been delays by the Global Fund country team in approving one reprogramming request submitted by the PIU. The PIU also explained that the Global Fund conducts many in-country missions, which draw grant implementers' attention and time away from actual implementation. The PIU explained that currently, the Global Fund holds four finance missions, two to three procurement missions, one supply chain mission and two M&E missions in Malawi – a minimum of nine missions – every year. They called for the Global Fund to reduce the number of country missions and to communicate the schedule for these well in advance.

Strategies seem to be working as absorption increases

The state PRs from the three countries attested that absorption has improved for the current grants. In fact, the Malawi PIU noted that the absorption rate at the time of the interview was the best they have had so far within any grant, at that stage of implementation. Malawi's MOH spent 67% and 93% of the budgeted amount for the period 2018 and 2019 under the HIV/TB and malaria grants, respectively, according to the PMU. Cumulatively, the Malawi MOH has now spent 40% of the HIV/TB grant (compared to an expected absorption of 59%) and 77% of the malaria grant (compared to an expected 84%).

Uganda, at 30 June 2019, had spent 60.1% of its HIV grant (compared to an expected absorption of 66%, according to the grant budget downloaded from the Global Fund website), 80.3% of the TB grant (compared to 62%) and 17.8% of the malaria grant (compared to 92%). The MOFPED explained that malaria had a lower absorption rate because the insecticide-treated nets mass distribution campaign, which is a major component of the malaria grant, has not yet taken place. As of June 2019, the Sierra Leone MOHS had spent 63% of the budget for the first year of the HIV/TB grant. This proportion accounts for 23.3% of the total grant whereas 37% of the total grant was expected to have been spent by the end of the first year. The Malawi MOH and Uganda MOFPED grants end in December 2020 while that of Sierra Leone's MOHS ends in June 2021.

Editor's note: The GFO will publish an article highlighting the strategies the Global Fund has put in place to address the absorption challenges in an upcoming issue.

Further reading:

- From GFO Issue 360, 10 July 2019, 'Challenges at Global Fund Secretariat and implementer levels found to impede grant absorption'
- From GFO Issue 333, 21 March 2018, 'A success story: Global Fund grants in Burkina Faso show significantly increased absorption rates'
- From GFO Issue 321, 4 October 2017, 'Identifying Secretariat-level impediments to full absorption of Global Fund money'

From GFO Issue 320, 20 September 2017, 'Identifying and solving country-level impediments to full absorption of Global Fund money'

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6. ANALYSIS: Supreme audit institutions of Ghana, Kenya, and Rwanda vary in their external audit performance of Global Fund grants

Ghanaian and Kenyan SAIs rated higher than the Rwandan SAI on external audit

Samuel Muniu **18 March 2020**

The Global Fund requires annual audits of its grants as a critical component of its risk and assurance framework. In Ghana, Kenya, and Rwanda it is the responsibility of each country's supreme audit institution (SAI) to audit the Global Fund grants managed by state Principal Recipients (PRs). However, the performance of the three SAIs varies, according to the Public Expenditure and Financial Accountability (PEFA) program assessments. The PEFA program rates the SAIs of Ghana and Kenya higher compared to the SAI of Rwanda on the overall external audit performance.

SAIs are constitution-mandated government audit agencies responsible for auditing government revenue and spending. According to the new Guidelines for Annual Audit of Global Fund Grants published in November 2019, supreme audit institutions are the preferred auditors for Global Fund grants managed by state Principle Recipients (PRs). The Global Fund expected grant-recipient countries to start implementing the new audit guidelines beginning with the reporting period that ended on 31 December 2019. The new guidelines for annual audit of Global Fund grants require SAIs to be 'accredited as meeting required standards by any relevant authority which is qualified to assess work standards.' In this article, we evaluate the SAIs of Ghana, Kenya, and Rwanda in terms of whether they meet international audit standards.

We obtained data on the characteristics of external audits of the Ghanaian, Kenyan, and Rwandan SAIs from the latest publicly available Public Expenditure and Financial Accountability (PEFA) program reports. The PEFA program was established in 2001 by international development partners to provide a framework for assessing countries' public financial management (PFM) performance for the last three completed fiscal years. For Ghana and Rwanda, we relied on the PEFA Performance Assessment Report for Ghana published in 2018 and the PEFA Assessment Report for Rwanda published in 2017.

For Kenya, we relied on the 2018 PEFA report for Makueni County, since the country report of 2019 was not publicly available but the Kenyan SAI audited Makueni County—one of the 47 county governments of Kenya. Just as with the other Counties of Kenya, Makueni County has its own semi-autonomous government, with an executive headed by a directly elected Governor and a County Assembly. The Constitution of Kenya requires the Auditor-General,

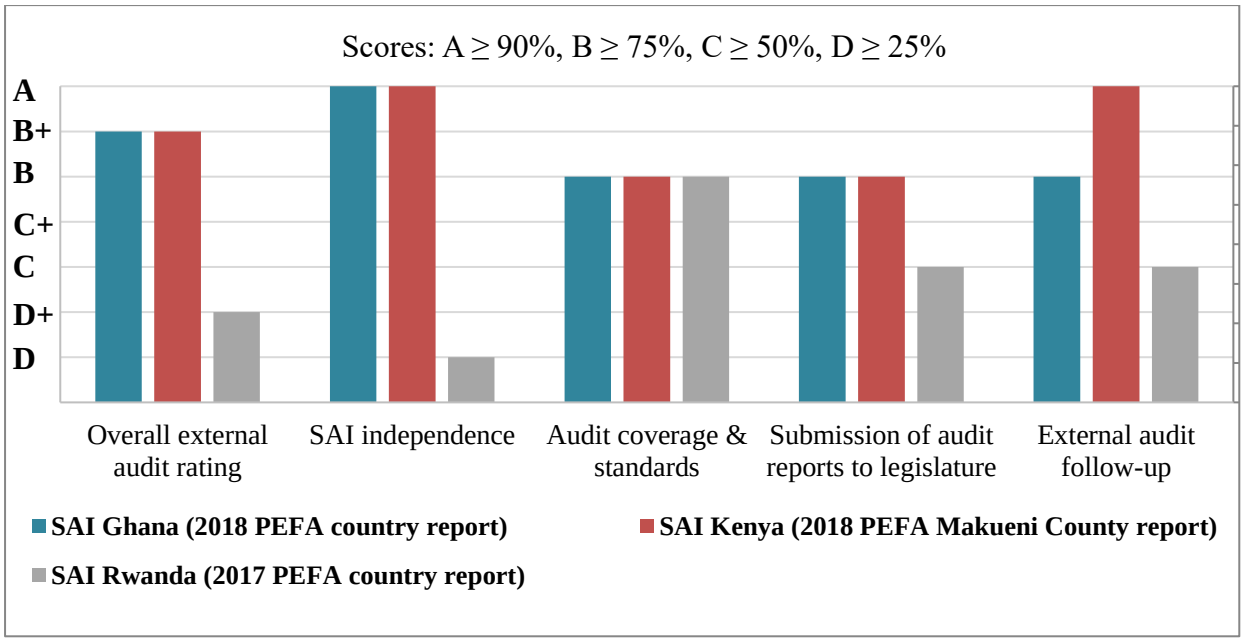
the head of SAI, to audit the accounts of Makueni County government, and report the findings to the Senate (one of the Houses of Parliament) and the Makueni County Assembly.

We extracted data on external scrutiny and audit, one of the seven pillars of the PEFA program. Specifically, we obtained assessments on each SAI's independence, audit coverage and standards, submission of audit reports to the legislature, and external audit follow-up. All these are core auditing standards of the International Organization of Supreme Audit Institutions (INTOSAI), the international body that sets best practices and auditing standards for SAIs (see GFO October 2019 article on the strengths of three SAIs).

Ghanaian and Kenyan SAIs' independence rated higher than Rwandan SAI's

Independence of SAIs is paramount for the work they perform and guarantees their transparency and integrity. According to the PEFA's Framework for assessing public financial management, SAI's independence is demonstrated by the non-interference in the functioning of an SAI by the executive arm of government – regarding the appointment and removal of the head of the SAI, the planning and implementation of audit work, publication of audit reports, and the approval and disbursement of the budget of an SAI. An SAI's independence guarantees its unrestricted and timely access to records, documentation, and information. According to PEFA assessments, the Ghanaian and Kenyan SAIs are independent, whereas the Rwanda SAI is partially independent.

Figure 1: Supreme audit institution performance as per the Public Expenditure and Financial Accountability (PEFA) performance assessment



Source: Aidspan, using data from the Public Expenditure and Financial Accountability (PEFA) reports

The SAIs of Ghana, Kenya, and Rwanda are independent offices enshrined in their respective constitutions. According to the PEFA assessments, the appointment and termination process for the heads of SAIs of Ghana, Kenya, and Rwanda are prescribed in their respective constitutions and laws. In Ghana, the President, in consultation with the Council of State,

appoints the Auditor-General. The process of removal of the Auditor-General from the office follows a similarly rigorous process as the removal of a High Court Judge. The Chief Justice must constitute a panel to investigate the Auditor-General and offer a recommendation for his or her removal from office. The tenure of the Auditor-General of Ghana expires upon the person attaining the age of 60. Furthermore, the Auditor-General's salary is a charge on the Consolidated Fund (the chief account of government).

In Kenya and Rwanda, the Parliament approves the appointment of the Auditor-General. In Kenya, the President nominates and appoints the Auditor-General with the approval of the National Assembly (one of the Houses of Parliament) for a non-renewable tenure of eight years. The process of removal of the Auditor-General of Kenya from office involves presenting a petition the National Assembly, which , when satisfied with facts presented, sends the petition to the President. Upon receiving the petition, the President constitutes a tribunal to investigate the Auditor-General and make binding recommendations to the President. In Rwanda, the President appoints the Auditor-General with approval of the Senate (one of the Chambers of the Parliament) for a term of five years, which is renewable only once. However, the President has the power to remove the Auditor-General of Rwanda from office, through a Presidential Order and the submission of a notice to both Chambers of the Parliament.

As independent offices, the three SAIs perform their functions without direction from any person or authority, and they independently plan, execute, and publicize their reports. Also, they all have unrestricted access to all records, documentation—including computerized and electronic documents—and information. The Ghanaian and Kenyan SAIs enjoy financial independence, though it is not absolute. In Ghana, the SAI does not receive budget ceilings from the Ministry of Finance but rather negotiates its budget. Additionally, the release of funds to the Ghanaian SAI is done in a timely way. In Kenya, the National Treasury reviews the SAI's budget before submitting it Parliament for approval. The Constitution of Kenya requires the Parliament to allocate adequate funds to the SAI. In Rwanda, however, the financial independence of the SAI is undermined by the fact that the Ministry of Finance and Economic Planning scrutinizes and sets the SAI's budget ceilings, and may delay releasing funds to the SAI, thus compromising the overall independence of the SAI.

The three SAIs' audits cover more than 75% of government expenditure and follow international auditing standards

The SAIs of Ghana, Kenya, and Rwanda have a broad mandate to audit all public funds, including that of the Global Fund grants managed by state PRs. The audit mandate of the three SAIs is provided in the countries' respective Constitutions and laws. However, according to the PEFA program, the audits of the three SAIs cover most (over 75%) of government expenditure. The Ghanaian SAI audited over 95% of government expenditure for the 2014-2016 financial year. The Kenyan SAI audits all public entities except those not connected to the Integrated Financial Management Information System (IFMIS), an automated system for financial data recording, tracking, and information management. The Rwandan SAI audited 81% of government expenditure for the 2013/14 fiscal year. All three SAIs conduct audits which adhere to the International Organization of Supreme Audit Institutions' auditing standards, and so are in line with international auditing standards.

Ghana and Kenya's SAIs perform better than Rwandan SAI in meeting legislature deadline

The three SAIs differ on the timeliness of audit report submission to the legislature, with the Ghanaian and Kenyan SAIs performing better than the Rwandan SAI. The Ghanaian SAI submitted audit reports on time (by 30 June), meeting the submission deadline for the 2014 and 2016 financial years; the audit report for the 2015 financial year was submitted to the legislature two and a half months late. This was a result of disagreement on whose responsibility it was, between the incoming and outgoing Deputy Directors, to sign the audited financial statement.

In Kenya, the SAI met the audit report submission deadline, as it submitted its report to the Senate and County Assembly of Makueni less than six months after receiving annual financial statements for the fiscal years 2013/14 through to 2015/16. In Rwanda, the SAI submitted to Parliament the Audit Reports for financial years 2012/13 and 2013/14 on time, which was on 30 April. However, the Rwandan SAI submitted some of the Audit Reports for the 2011/12 fiscal year on 11 May 2013 to the Parliament, which was outside the set deadline.

Kenyan SAI performs better than the Ghanaian and Rwandan SAIs on follow-up on the implementation of audit recommendations

According to the PEFA performance assessment, the Kenyan SAI performs higher on their follow-up on the audited agencies' implementation of their audit recommendations compared to the Ghanaian and Rwandan SAIs. In Kenya, the National Treasury (the equivalent of Ministry of Finance) has a template on its website for reporting actions taken in response to audit recommendations, and the SAI provides progress on audit issues raised in its subsequent audit reports. For the financial years 2013/14 through to 2015/16, the Kenyan SAI provided progress on audit issues raised an appendix in the audit reports.

The Ghanaian SAI keeps an audit follow-up file for each audited entity to track progress on the implementation of audit recommendations. There are a few instances in which audit findings were not implemented in Ghana. For example, out of eight significant audit findings for the 2015 financial year, the Ministries, Departments, and Agencies (MDAs) had not implemented two of them by 2016. Similarly, the Rwandan SAI tracks progress in the implementation of audit recommendations and includes their findings in the following year's audit report. The SAI of Rwanda, however, reported that not all audit recommendations were fully implemented for financial years 2012/13 through to 2014/15.

Further reading:

- *Global Fund 2019 report, 'Guidelines for Annual Audit of Global Fund Grants'*
- *GFO 366 article, 22 October 2019, 'Aidspan examines the strengths of Supreme Audit Institutions in Ghana, Kenya, and Rwanda'*
- *PEFA program 2016 report, 'Framework for assessing public financial management'*
- *PEFA program 2018 Ghana report, 'PEFA Performance Assessment Report for Ghana'*

- *PEFA program 2017 Rwanda report, 'PEFA Assessment Report for Rwanda'*
- *PEFA program 2018 Makueni County report, 'PEFA report for Makueni County'*

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