The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Office of the Inspector General

Audit of Global Fund Grants to the Republic of India

GF-OIG-13-011
24 April 2013

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A. EXECUTIVE SUMMARY

Nine grants audited

Grants reviewed USD 908 million with USD 767 million disbursed

1. As part of its 2012 work plan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to India from 17 September to 6 December 2012. The audit focused on five implementers, the Country Coordinating Mechanism, the Local Fund Agent and the Global Fund Secretariat. The grants under review totaled USD 834 million, of which USD 733 million had been disbursed by November 2012.

A.1 Key Findings

Grant oversight complicated by geographical spread

CCM should operationalize oversight plan

2. Oversight of grants in India is complicated by the large geographic area over which Global Fund-supported programs are implemented and the decentralization of health services from the central to the state level. At the time of OIG audit, the Country Coordinating Mechanism had not operationalized its oversight plan. The OIG also noted significant delays by Principal Recipients in signing grant agreements and processing of reports as a precursor to disbursements by the Global Fund. Having a single, centralized Country Coordinating Mechanism in a country as vast as India requires a carefully tailored oversight plan.

Secretariat should ensure compliance with conditions in the grant agreement

3. The audit team observed several instances of non-compliance with conditions in the grant agreement and management letters, e.g., the lack of timely reconciliations between advances and financial reports, which resulted in qualified external audit opinions for the year 2010-2011 and thus impacted the effectiveness of systems put in place by the Global Fund to safeguard grant resources.

Proper books of account not maintained

4. The government implementers did not maintain updated ledgers, which resulted in a failure to link expenditures to financial reports provided to the Global Fund and external auditors. The Principal Recipient's financial statements were qualified by the external auditor because material advances to suppliers were not correctly recorded. The Global Fund Secretariat has entered into dialog with the Principal Recipients and the Comptroller and Auditor General of India to address audit qualifications. The Secretariat should also ensure that variances are investigated and resolved and books of account updated.

Ineligible expenses worth USD 1.1 million noted

5. This report includes a table (Annex 4) of ineligible expenses totaling USD 1.139 million. It is for the Global Fund Secretariat to determine whether the amounts documented should be recovered.

Non adherence to treatment guidelines

6. The audit noted good practices across the three disease programs. However, the audit team observed a failure to adhere to treatment guidelines, complete treatment records, and actively monitor progress of multi-drug resistant tuberculosis patients during treatment. The National Tuberculosis Program should strengthen supervision at the state level.

Stock out of ACTs and RDTs

7. The Malaria Program faced stock outs of Artemisinin-combination therapy and rapid diagnostic tests at the peripheral level caused by delays in procurement.

Poor quality of TB services in the private sector

8. The National Tuberculosis Program faces a serious challenge of ensuring adherence by private sector providers to national tuberculosis guidelines in diagnosis, treatment and follow-up of patients. Gaps in the quality of treatment in the private sector resulted in difficulties in the effective control of tuberculosis and multi-drug resistant tuberculosis.

Programs should address procurement delays

9. Procurement of commodities for the diseases has been outsourced to a procurement agent. Significant delays in completing procurement affected the availability of commodities. Some of the medicines selected for tuberculosis treatment are in conformance with national treatment guidelines but not World Health Organization recommendations.

A.2 Conclusion

Major improvements needed

10. The OIG concludes that **major improvements are needed** in the management and implementation of Global Fund grants. This means that "Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives would be met."

Two critical recommendations on timely delivery of medicines and qualified external audit reports

11. The OIG offers nine recommendations, of which two are rated "Very High", requiring that urgent action be taken to ensure that quality assured drugs are purchased and made available to patients and that external audit findings are addressed rapidly. The remaining seven recommendations are "High" priority. The audit team worked closely with the Global Fund Secretariat in drafting and finalizing this report.

A.3 Actions Subsequent to the Audit

Mitigating actions taken by Secretariat and in-country stakeholders

12. A number of actions have already been taken to address the risks that emerged from the audit findings. These include:

- Substitution of conditions precedent and special conditions in nine grants with a streamlined set of enforceable conditions that reflect the programmatic and financial requirements and risk areas of each program;
- Determination of exact cash balances for all Principal Recipients in India. This process is on-going with exact cash balances to be determined prior to signing or closing further grants;
- Determination of what ineligible expenses identified by the OIG in Annex 4 should be disallowed. This exercise is nearing completion; and
- Engagement with the India Planning Commission and Comptroller and Auditor General to ensure more effective and efficient Global Fund investment in India's fight against the three diseases.

B. MESSAGE FROM THE EXECUTIVE DIRECTOR OF THE GLOBAL FUND

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MESSAGE FROM THE EXECUTIVE DIRECTOR

I would like to thank the Office of the Inspector General for its thorough and insightful work on the diagnostic review of Global Fund grants to the Republic of India.

The audit was carried out from 17 September to 6 December 2012 and covered grants totalling US$ 834 million, of which US$ 733 million had been disbursed by November 2012.

It focused on grants implemented between 2008 and 2012 for three Principal Recipients, who together were responsible for 16 grants: the Ministry of Finance, the Tata Institute of Social Sciences and the India HIV AIDS Alliance.

The Office of the Inspector General found that major improvements are needed in the management and implementation of Global Fund grants and that controls evaluated were unlikely to provide reasonable assurance that risks are being well managed.

Ineligible expenses totalling US$1.139 million were identified. The Global Fund Secretariat is in the process of determining how much of the amounts documented should be recovered.

While the audit encountered good practices across the three disease programs it also identified a failure to adhere to treatment guidelines, complete treatment records and actively monitor progress of MDR-TB patients during treatment.

In addition, the national TB program faces a serious challenge in ensuring that private sector providers follow national guidelines in diagnosis, treatment and follow-up of patients. It emerged that some medicines selected for tuberculosis treatment are not in conformity with World Health Organization recommendations.

The Office of the Inspector General concluded that improving the quality of services in the private sector is critical to control MDR-TB. It also found that data and reporting systems were not sufficiently reliable to yield accurate information.

The malaria program also faced stock outs of antimalarial drugs and rapid diagnostic test kits in the north eastern region of India as a result of procurement delays.

The audit identified eight instances of non-compliance with the conditions in the grant agreements, including a finding that the procurement of drugs in 2010 did not comply with Global Fund quality assurance requirements.

Accounting ledgers were not maintained by government implementers, which resulted in the Comptroller and Auditor General issuing qualified opinions in its audit reports. The audit identified a number of cases of un-reconciled balances and variances between books of account and financial reports of government implementers.

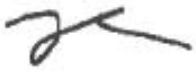
The audit makes nine recommendations, two of which are rated as "very high" priority. The first of these requires that procurement delays be addressed to ensure timely delivery of antimalarial drugs and rapid diagnostic tests to facilities in the northeast of the country supported by Global Fund grants; the second very high priority recommendation calls for external audit findings to be addressed quickly.

Following completion of the audit, the Global Fund has engaged with the India Planning Commission and Comptroller and Auditor General to ensure more effective and efficient Global Fund investment in India's fight against the three diseases.

Conditions precedent and special conditions in nine grants have been substituted with a streamlined set of enforceable conditions reflecting the programmatic and financial requirements and risk areas of each program.

Audits by the Office of the Inspector General are an essential form of quality control for the Global Fund. The Office of the Inspector General plays an indispensable role in helping us all achieve our mission of effectively investing the world's money to save lives.

Yours sincerely



C. AUDIT OBJECTIVES AND SCOPE

C.1 Audit Objectives

Audit assessed adequacy and effectiveness of controls

14. The audit objectives were to assess the adequacy and effectiveness of oversight arrangements in place to ensure that:

- Grant programs were implemented as planned and in line with national guidelines and that systems were in place to accurately report grant performance;
- Quality assured health products were available to ensure continuity of care to intended recipients; and
- Fiduciary and financial controls were in place to ensure best use of funds

Opportunities to strengthen grants

An important focus of this audit was to identify opportunities to strengthen oversight to grants.

Multi-skilled team deployed

15. The OIG deployed a multi-skilled team comprising financial auditors, a public health specialist, and a procurement and supply management specialist, each of whom participated in various stages of the audit.

C.2 Audit Scope

Audit examined operations of main grant stakeholders

16. The audit focused on the grants implemented between 2008 and 2012 for three Principal Recipients (PRs):

- The Ministry of Finance which had three implementers (the National AIDS Control Organization NACO, the National Vector Borne Disease Program NVBDCP, and the Central Tuberculosis Division CTD;

Three PRs were implementing the ten grants tested

- The Tata Institute of Social Sciences (TISS); and
- The India HIV AIDS Alliance (IHAA).

17. The three PRs audited were responsible for sixteen grants totaling USD 1,014 million (see Annex 3; which shows the ten grants covered by the audit). The total India grant portfolio was USD 1,134 million. The audit also covered the Country Coordinating Mechanism (CCM); the Local Fund Agent (LFA) and the Global Fund Secretariat.

Field visits in four states and 24 program sites

18. The audit covered program activities at the central level as well as a sample of 24 program sites in the states of Arunachal Pradesh, Maharashtra, Tamil Nadu and Bihar. The selection was based on a risk analysis of all 12 implementers of Global Fund grants in India, prior work done by the LFA, and the materiality of grants. The selection of states focused on those with the highest disease burden while ensuring coverage of the various geographic regions of the country.

D. OVERVIEW

D.1 Background to the Grants

Global Fund provides country-wide support for HIV and MDR-TB

Support to specific states for TB and malaria

19. India has a population of more than 1.2 billion spread over 3.1 million square kilometers and comprises 28 states and seven union territories. The Global Fund provides countrywide support for HIV and multi-drug-resistant tuberculosis (MDR-TB), with support to the TB and malaria programs provided to eight and seven states respectively. Grant programs are implemented by 12 implementers, including government agencies, Civil Society Organizations, the private sector company Infrastructure Leasing & Financial Services Educational and Technology Services, Limited (IL&FS ETS)[1] and a University (the Tata Institute of Social Sciences).

Challenges to program implementation

20. The health sector in India faces the following challenges that are important to bear in mind when reading this report:

- Decentralization of implementation of public sector health programs to state governments which have varying capacities and levels of program ownership;
- Insufficient staffing at state-level for program and clinical personnel due to high staff attrition and delays in recruitment;
- Sub-optimal supply chain arrangements for pharmaceuticals in the North-Eastern region of the country due to its remoteness; and
- The need for different implementation strategies for reaching vulnerable and most-at-risk populations in different states due to varying epidemiological settings.

D.2 Actions Subsequent to the Audit

Briefings provided in New Delhi to relevant stakeholders

21. Exit debrief meetings were held at the end of the audit fieldwork with stakeholders to discuss all findings in detail to ensure that the findings reported were factual and proposed recommendations were appropriate.

22. Subsequent to the audit, the Global Fund Secretariat undertook a number of steps to address some of the audit teams preliminary findings:

- Substitution of conditions precedent and special conditions in nine grants with a streamlined set of enforceable conditions that reflect the programmatic and financial requirements and risk areas of each program;
- Determination of exact cash balances for all Principal Recipients in India. This process is ongoing with exact cash balances to be determined prior to further grant signature or closure;
- Determination of what ineligible expenses identified by the OIG in Annex 4 should be disallowed. This exercise is nearing completion; and
- Engagement with the India Planning Commission and Comptroller and Auditor General (CAG) to ensure more effective and efficient Global Fund investment in India's fight against the three diseases.

[1] The social infrastructure arm of Infrastructure Leasing & Financial Services Limited.

E. OVERSIGHT AND GOVERNANCE

Some Improvement Needed	CCM oversight can be further strengthened to support program implementation, especially with regard to timely grant initiation and reporting to the Global Fund.

CCM oversees the grant-funded programs

LFA verifies grant program implementation

23. As part of the Global Fund grant architecture, a single central Country Coordinating Mechanism (CCM) oversees the Global Fund-supported programs and a Local Fund Agent (LFA) verifies grant program implementation for the Global Fund Secretariat; these oversight measures are critical to good fiduciary and program management.

24. Grant oversight in India is complicated by the large geographical area in which Global Fund-supported programs are implemented. It is further complicated by the decentralization of health services from the central to the state level, staff in which have varying capacities.

E.1 Country Coordinating Mechanism

25. The CCM is a country-level public-private partnership that has performed well in coordinating the development of grant proposals based on national priorities and needs and in nominating PRs. However, the CCM had scope for improving the oversight of implementation of Global Fund-supported grants.

CCM oversight committee and plan in place but not operational

26. The CCM approved its oversight plan and appointed an oversight committee in May 2011 and February 2012 respectively. With the exception of a single meeting held on 27 April 2012, planned oversight activities did not take place due to insufficient CCM funding.

27. The CCM could have done more to support PRs in overcoming the challenges they faced during grant implementation, e.g., the resolution of the delays of more than one year between grant approval and signing for government-related grants.

Extensive delays in grant signing and disbursement

28. CCM oversight could also have helped resolve delays by PRs in submitting periodic reports to the Global Fund to trigger disbursements. The turn-around time for processing disbursements was between 130 and 560 days, which adversely affected timely disbursements. This was caused by inadequate PR capacity to prepare quality reports for presentation to the LFA for verification.

E.2 Local Fund Agent

LFA has good understanding of grant-related risks

29. The LFA (PricewaterhouseCoopers) provides independent oversight of the implementation of program activities. The LFA has a good understanding of grant-related risk as reflected in its country risk assessment.

E.3 Global Fund Secretariat

The Secretariat is responding to oversight challenges

30. The Secretariat is aware of the oversight challenges presented by the complexities in the India grant portfolio. The Global Fund Secretariat has responded to these challenges by:

- Reducing the amounts to be disbursed to Principal Recipients in response to qualified amounts in external auditor reports;

- Increasing its engagement with the Office of the (CAG) so that external audit meets Global Fund requirements;
- Commissioning the LFA to undertake spot audits in order to keep sight of implementation at the peripheral level; and
- Commissioning a Data Quality Audit of the TB program to inform the Phase II approval process.

Recommendation 1 (High)

i. The CCM should implement its oversight plan by operationalizing the oversight committees. In particular the CCM should enter into dialog with the Government to establish a solution to the delays in initiating grants, and mobilize technical assistance to support PRs in the preparation of timely reports; and

ii. The CCM should put in place tailored approaches to oversight for different grants and different states/regions given the decentralized nature of programs in India.

F. GRANT MANAGEMENT

Critical	There was non-compliance with conditions in the grant agreements, including the procurement of drugs in 2010, which did not comply with Global Fund quality assurance requirements. Accounting ledgers were not maintained by government implementers, which resulted in qualified external audit opinions for the year ended 2010-2011.

Non-compliance with conditions stipulated in the grant agreement

31. The grant agreement contains conditions to safeguard grant resources and address key risks identified in the grant portfolio. There were eight instances of non-compliance with the grant agreements: Two by NVBDCP, one by the Revised National TB Control Program (RNTCP), three by NACO, one by IHAA and one by TISS.

TB procurement did not meet Global Fund quality assurance requirements

32. Non-compliance with grant agreements contributed to key risks. For example, in 2010 the government procurement agent RITES Ltd. procured four first-line TB drugs, three of which did not meet Global Fund Quality Assurance (QA) requirements.[2] In the Procurement and Supply Management Plan agreed between RNTCP and the Global Fund, the Program agreed to procure WHO-recommended drug formulations and diagnostics.

External audits did not meet Global Fund requirements

33. The Global Fund Secretariat relies on external audits of grant recipients for assurance over program implementation. The audit reports for government PRs issued by the CAG did not meet Global Fund minimum requirements. For example, the reports did not contain summary financial statements, which would have allowed the Global Fund to accurately track receipt and use of funds.

The financial statements have material qualified audit opinions

34. In addition, the audit reports for NACO, NVBDCP and CTD for the year ended 31 March 2011 were qualified on the following grounds:

- Ineligible expenditure relating to advances to the procurement agent;
- The use of grant funds to pay taxes; and
- Differences between statements of expenditure (SOEs) and PR books of account.

Qualified amounts ranged from USD 170,000 to USD 37.2 million.

Secretariat is seeking solutions to audit qualifications

35. The Global Fund Secretariat has requested that the PRs resolve the issues identified, and has initiated discussions with the CAG about the possibility of re-opening the audit process to certify financial statements.

External audit recommendations not consistently implemented

36. External audit recommendations have not always been implemented by PRs, which is a missed opportunity to strengthen the program control environment.

Accounting ledgers have not been maintained

37. Accounting ledgers were not maintained by the government implementers. In consequence, the CAG issued qualified opinions in its audit reports. The audit identified the following cases of unreconciled balances and variances between the books of accounts and financial reports of government implementers:

- Variances between PUDRs submitted by the PR and those verified by

[2] The prequalified drug was H-300 tablet. There were two Indian manufacturers prequalified by WHO. The non-prequalified drugs purchased were S-150 capsule; R-150 capsule and E-600 tablet.

Variances between books of account and financial statements

the LFA at 31 March 2012 amounted to USD 8.1 million (Round 2 RCC) and USD 28.5 million (Round 4 RCC), respectively. These were due to differences noted by the LFA that were not subsequently reflected in PR books as well as differences in methods used in converting Indian Rupees into USD for reporting purposes. The current audit observed similar variances with respect to the accounts provided by CTD to the OIG, which were different from those accounts verified and submitted by the LFA to the Global Fund.

- Variances between books of account and the audited financial statements in Arunachal Pradesh (32% under-reported), Assam (14% over-reported), and the Mizoram malaria programs (30% under-reported).
- The SOEs at state level were different (4%) from those in the records at the center for the period under review (e.g., in the Arunachal Pradesh malaria program).

Advances to third parties not reconciled

- Advances to RITES, which remained unreconciled to the government's books of accounts (e.g., NVBDCP did not have information on its unliquidated advances to RITES, and NACO had not reconciled USD 30.4m of the USD 101.8m disbursed to RITES).

Malaria program unable to provide closing balance to Round 4 grant

- NVBDCP was unable to provide a reliable closing balance for the Round 4 Malaria grant at 30 June 2010. The USD 3.8m noted in the report to the Global Fund was an estimate and could not be validated.

Transactions worth USD 1.1 m not in the Global Fund-approved budget

38. The audit identified transactions spent on activities that were not part of the grant budget. These totaled USD 110,081 (Central Tuberculosis Division)[3] and USD 1.029 million (Tamil Nadu State AIDS Control Society; see Annex 4 for details). While these transactions were health-related, they were not approved by the Global Fund.

Recommendation 2 (High)
The Global Fund Secretariat should continue to enforce grant agreement conditions relating to Quality Assurance of Pharmaceuticals and Diagnostic Products to ensure grant funds are not used to procure TB and malaria medicines that are in breach of the Global Fund Quality Assurance policy.

Recommendation 3 (Very High)
Principal Recipients should consistently address exceptions noted by the external auditors so as to strengthen the control environment within which grants are implemented.

Recommendation 4 (High)
i. PRs should maintain proper books of account. All variances and unreconciled balances should be examined and books of account updated. Advances to third parties should be reconciled to books of account.
ii. The Global Fund Secretariat should determine whether the expenditures documented as ineligible in Annex 4 should be recovered.

[3] The funds were used for program-related activities although they had been budgeted for under a different grant.

G. PROGRAM IMPLEMENTATION

Critical	Improving the quality of services in the private sector is critical to the control of MDR-TB. There is a need to attend to the quality MDR-TB services with regard to adherence to national guidelines. Data and reporting systems were not sufficiently reliable to yield accurate information.

G.1 Tuberculosis Program

India classified as high burden for TB and MDR-TB

39. India is classified as high burden for both TB and MDR-TB. In 2011, India had the highest TB burden globally, with an estimated 2 to 2.5 million new cases. This accounts for one fifth of global incidence.[4]

Universal DOTS coverage since 2006

40. Universal DOTS coverage has been in effect since March 2006. The impact measures of incidence, prevalence, and mortality have improved significantly since 2002, with steadily declining rates and with 2012 national targets being met. At sites visited, all patients received at least one sputum examination result prior to initiation of treatment.

High scale-up of MDR-TB Program but with gaps in quality of service

41. There were, however, shortcomings with regard to the quality of services, particularly adherence to treatment guidelines. Staff did not consistently follow treatment weight bands and moved patients from the intensive treatment phase into the continuation phase without confirmatory sputum tests. This was observed by RNTCP during its supervisory visits in June 2012, but remained unaddressed at the time of the audit.

Insufficient monitoring of patients

42. Patient records at TB treatment sites visited in Bihar State in November 2012 had incomplete medication schedules; in consequence the quality of care for these patients could not be verified. RNTCP management explained that since services at sites visited had only been set up in January 2012, services were not yet fully implemented. At none of the sites visited were there mechanisms to actively monitor progress of MDR-TB patients during treatment.

Inconsistent quality of service among private providers

43. Approximately 30,000 patients undergo re-treatment annually; nearly half of them have been previously treated by private practitioners. The national TB program faces a serious challenge of ensuring adherence by private sector providers to national TB guidelines in diagnosis, treatment and follow-up of patients. Gaps in the quality of treatment in the private sector result in difficulties in the effective control of MDR-TB. Of approximately 5.2% of GDP financing towards health, it is estimated that 4.3% is private and 0.9% public.[5]

TB drugs selected risk non-adherence

44. The TB program did not select Fixed-Dose Combination (FDC) drugs for DOTS and in consequence missed out on their advantages (e.g., ensuring quality, and improving patient compliance/adherence). The risk of non-adherence is especially high during the four-month continuation phase when patients take home blisters of four different drugs.

[4] Global Tuberculosis Report 2012, World Health Organization
[5] "Meeting people's health needs"- a presentation by NRHM. www.mohfw.nic.in/NRHM/presentations.htm.

DOTS treatment follows 3 times weekly schedule

45. TB treatment in India is administered in an intermittent three-dose-per-week schedule. A daily DOTS schedule is strongly recommended by the WHO to improve outcomes and reduce the risk of developing resistance. In addition, daily DOTS with FDCs would result in a lower pill burden for patients.[6] RNTCP management explained that the policy supporting an intermittent regimen was based on "scientific evidence of comparable outcomes with the daily regimen." However, the OIG was not provided with documentation to support this explanation.

Risk of under-dosing

46. Comparison of daily DOTS [7] with the current intermittent treatment regimen, shows a potential important under-dosing of rifampicin. This raises the risk of failure to achieve and sustain therapeutic levels of the main bactericidal component during the TB treatment course, especially for body weights at or below 60 kg (3 caps of 450 mg per week versus the standard 600 mg per day). See Recommendation 2.

Recommendation 2 (High)
Please refer to Recommendation 2 above, which is relevant to these findings.

G.2 Malaria Program

Malaria epidemic concentrated in 20% of land area

47. Eighty per cent of the malaria burden in India is concentrated in approximately 20% of the land area, particularly in hilly and remote areas in which minority "tribal" populations live.

LLIN distribution was well managed

48. Good practices in the malaria program included a well-organized and documented process for Long Lasting Insecticidal Net (LLIN) distribution accompanied with appropriate behavior change communication to ensure their proper use. "Accredited Social Health Activists" (ASHA) had been trained to administer ACTs only for confirmed *Plasmodium falciparum* cases.

No government-provided RDTs in public facilities visited

49. National policy provides for the use of bivalent rapid diagnostic tests (RDTs) for diagnosis of *P. falciparum* and *P. vivax* cases in remote areas and at locations where microscopy results are not available within 24 hours. Three sites visited were remote and had a five- to six-day turnaround time for microscopy results; however, RDTs were not available.

No adult ACTs in stock at sites visited in Arunachal Pradesh

50. Three of the five treatment sites visited[8,9] did not have any ACTs in stock. The two facilities that did stock ACTs had only infant and 9-14 year doses available. This was caused by procurement delays at the central government level; the stock-outs had lasted ten months.

Malaria treatment records not well maintained

51. The audit team documented weaknesses in recording data due to delays in distributing updated registers and report formats and providing training. The lack of proper registers resulted in incomplete data and inconsistencies in the data recorded. There was no evidence of data quality review by district, state, or central staff. The malaria

[6] Depending on body weight: 2 (< 40kg), 3 (40-54 kg), 4 (55-70 kg) and 5 (>71 kg) FDC tablets per day
[7] As defined by the WHO in "Treatment of Tuberculosis: guidelines for national programs", 4th Edition, 2010
[8] The sites visited were Naharlagun State Hospital, Pasighat General Hospital, Ruksin Primary Health Centre, Ngorlung Sub Centre, and Bilat Primary Health Centre.
[9] Sites visited were in Arunachal Pradesh, a malaria-endemic State

program intends to recruit additional Malaria Technical Supervisors to supervise program implementation at peripheral levels.

Malaria drug selection does not meet Global Fund Quality Assurance requirements

52. The present national guidelines prescribe the use of an Artemisinin-based Combination Therapy (ACT) drug that includes sulfadoxine-pyrimethamine. The drug formulation does not meet the requirements of Global Fund's quality assurance policy. With Global Fund approval, funds budgeted for drugs were reprogrammed to LLINs with the understanding that the Malaria program would identify alternative funding to fill the gap. At the time of the audit (17 September to 06 December 2012), there had not been RDTs or ACTs in Arunachal Pradesh since February 2012, with the exception of those for the 0-1 year age group. In consequence, performance of Malaria grants did not meet treatment performance targets. At 31 March 2012, the relevant performance against program targets was:

- 8% for the number of fever cases tested with RDT by ASHA; and
- 7% for the number of *P. falciparum* cases treated with ACT by ASHA.

G.3 HIV/AIDS Program

HIV/AIDS program generally performing well

53. India has an estimated 2.27 million people living with HIV. At the sites visited, a CD4 count was done prior to initiation of treatment. The average baseline CD4+ count at the time of antiretroviral therapy (ART) registration had increased from 147 in 2009 to 202 in 2012. There was continuous availability of drugs and delivery of counseling and testing services and ART services at the sites visited. In the states visited, monthly district HIV coordination meetings took place with Integrated Counseling and Testing Center (ICTC) and ART counselors, medical officers, and other relevant staff.

Low level of HIV testing among TB patients in lower prevalence States

54. The percentage of TB patients tested for HIV has improved substantially in high prevalence states. In many other states, however, this remains low, ranging from 20% in Bihar to 62% in Haryana. This is mirrored by the proportion of HIV infected patients who are treated with ART (11% in Bihar and 73% in Haryana).

Tuberculosis sites not recording ARV status or treatment

55. HIV-TB integration can also be strengthened. None of the TB (DOTS or DOTS+) treatment sites visited were recording ARV regimens in TB patient cards or registers. No MDR-TB treatment sites visited were recording HIV status; patient cards and registers did not have a provision for noting this.

Recommendation 5 (High)
The RNTCP should undertake regular, scheduled monitoring and supervision visits at state level, with an emphasis on early detection and follow-up of defaulters.

Recommendation 6 (High)
i. The NVBDCP should accelerate recruitment, orientation and deployment of Malaria Technical Supervisors to ensure compliance with malaria treatment guidelines.
ii. NVBDCP should make pre-printed registers and forms available at all facilities and all providers should be trained on the use of the updated tools.

Recommendation 7 (Very High)
The national program should work with the procurement agent, RITES Ltd., to address procurement delays. This should ensure timely delivery of antimalarials and RDTs to community health workers and at health facilities in the North-Eastern region supported by Global Fund grants.

Recommendation 8 (High)
Informed by this analysis, MDR-TB co-treatment coordination should be implemented with the scale up of DOTS+. The HIV/TB National Working Group should determine what measures it can put in place to ensure uniform implementation of the national policy on HIV/TB collaboration, and then proceed to implement these measures.

H. PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

Major Improvement Needed	Procurement of commodities has been outsourced to a government procurement agent to mitigate risk. There have been significant delays in procurement which have resulted in stock outs. Procurement delays are due to administrative bottlenecks. Drugs selected for tuberculosis treatment did not always comply with WHO guidance.

No single legal authority on procurement in India

56. At the time of the audit the central procurement law was in draft form; as a result there was no single legal authority on procurement in India. There was no procedural framework to regulate public procurement by central government ministries or guide decentralized procurement across the states.

Delayed procurement affected availability of commodities

57. A capacity assessment of RITES commissioned by the Global Fund Secretariat showed that delays in the procurement processes were partially attributable to insufficient capacity at RITES.

58. The average procurement cycle at the central level (initiation of tender to award of contract) was 190 days. There were no set timelines to guide the execution of procurement, resulting in procedural delays at various stages. These delays affected the timely availability of medicines, health products and equipment such as streptomycin injection (five month delay), HIV rapid test kits (eight months), CD4 machines (five months), and LLINs (one year).

Recommendation 9 (High)
Future contracts between Ministry of Health and RITES Ltd. with procurement agents should contain clauses about specific timelines related to agreed procurement plans. RITES should take appropriate management actions to implement such clauses in order to ensure timelines are consistent with good procurement practices and international standards.

ANNEXES

Annex 1: Abbreviations

ACT	Artemisinin Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
CAG	Comptroller and Auditor General
CHCs	Community Health Centers
CCM	Country Coordinating Mechanism
CTD	Central Tuberculosis Division
DOTs	Directly Observed Treatment Short course
FDC	Fixed-Dose Combinations
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counseling and Testing Center
IHAA	India HIV AIDS Alliance
LFA	Local Fund Agent
LLINs	Long Lasting Insecticidal Nets
MDR	Multi-Drug Resistant Tuberculosis
NACO	National AIDS Control Organization
NPC	National Planning Commission
M&E	Monitoring and Evaluation
MTS	Malaria Technical Supervisors
NVBDCP	National Vector Borne Disease Program
OIG	Office of the Inspector General
PLWHA	Persons Living With HIV AIDS
PR	Principal Recipient
PUDR	Progress Update Disbursement Request
QA	Quality Assurance
RCC	Rolling Continuing Channel
RDT	Rapid Diagnostic Tests
RNTCP	Revised National TB Control Program
SoE	Statement of Expenditure
SR	Sub-recipient
TB	Tuberculosis
TISS	Tata Institute of Social Sciences
USD	United States Dollars
WHO	World Health Organization

Annex 2: Classification of Audit Findings and Recommendations

Rating of Functional Areas: Each functional area reviewed (e.g., financial management) is rated as follows:

Effective	Controls evaluated were adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Some Improvement Needed	Some specific control weaknesses were noted; generally however, controls evaluated were adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Major Improvement Needed	Numerous control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Not Satisfactory	Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and the Global Fund's strategic objectives should be met.
Critical	An absence of or fundamental weakness in one or more key controls, or a serious non-compliance. Non-mitigation will jeopardize the achievement of the Global Fund's strategic objectives. It requires urgent attention.

Implementation and Prioritization of Audit Recommendations: The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. While the CCM and the recipients of grants bear the responsibility to implement specific recommendations, it is the responsibility of the Global Fund Secretariat to ensure that this takes place as part of their mandate to manage grants effectively. Audit recommendations are prioritized as follows to assist management in deciding on the order in which recommendations should be implemented:

Very High	An absence of or fundamental weakness in a key control, or a serious non-compliance. Non-mitigation will jeopardize the achievement of the objectives of the Global Fund. It requires urgent attention.
High	A key control evaluated was not adequate, appropriate, or effective. It is unlikely that the control will manage risk and meet objectives. It requires immediate attention.
Medium	A specific key control weakness was noted. It is possible that this control will not manage risk and meet objectives. It requires attention within a reasonable period.
Low	A specific control weakness was noted in a non-critical area that, if left unattended, will not manage risk and meet objectives. It requires attention in the medium term.

Letter to Management: The implementation of all audit recommendations would significantly mitigate the risks and strengthen the internal control environment in which the programs operate. Audit findings classified 'Medium' and 'Low' have been reported separately in a Letter to Management. When such isolated findings in aggregate constitute a significant risk, this is mentioned in the report and in our conclusion. Though these findings and recommendations do not necessarily warrant immediate action, they represent specific key control weaknesses which should be addressed in a reasonable time period. If these deficiencies are not addressed, risks will not be managed appropriately.

Annex 3: Grants under Review[10]

Principal Recipient	Grant	Grant Commitments (USD million)	Disbursed (USD million)	Stage of Grant
National AIDS Control Organization	R2 RCC	234.768	212.440	Phase 1
	R4 RCC	301.726	301.156	Phase 1
	R7	22.885	15.194	Phase 2
India HIV/AIDS Alliance	R9	7.539	7.539	Phase 1
Tata Institute of Social Sciences	R7	15.914	13.358	Phase 2
Total HIV		**582.832**	**549.687**	
Revised National TB Control Program	R2	83.624	85.705	Phase 1
	R4	19.114	19.114	Closed
	R9	45.188	12.880	Phase 1
Total TB		**171.987**	**117.699**	
National Vector Borne Disease Control Programme	R4	56.225	56.225	In closing
	R9	23.408	10.293	Phase 1
Total Malaria		**79.633**	**66.518**	
Total		**810.391**	**733.904**	

Summary of grants and commitment as at 1 November 2012

Annex 4: Summary of Ineligible Expenditure (USD)

Particulars	NACO	CTD	Total
Salaries of staff (National Rural Health Mission)	1,029,700	-	1,029,700
Renovation of government medical store depots (Round 4 activity) charged to Round 2 grants	-	110,081	110,081
Total	**1,029,700**	**110,081**	**1,139,781**

[10] The audit covered samples of expenditure; not the totality.

Annex 5: Recommendations and Management Action Plan

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
Oversight and Governance	***Recommendation 1 (High):*** i. The CCM should implement its oversight plan by operationalizing the oversight committees. In particular, the CCM should enter into dialog with the Government to establish a solution to the delays in initiating grants, and mobilize technical assistance to support PRs in the preparation of timely reports. ii. The CCM should put in place tailored approaches to oversight for different grants and different states/regions given the decentralized	i. The Global Fund Secretariat will monitor and follow-up implementation of this audit recommendation. Higher level interventions maybe required to avoid delays in grant signing. ii. Given the existence of three government-led national programs to fight the respective diseases: NACP, NVBDCP and RNTCP – the creation of a decentralized CCM model may not be feasible. Moreover, the operational costs of such a move would be high.	i. In fact India CCM has already operationalized the oversight plan by forming the committee and got approval in the CCM meeting held on 29 Dec 2011. Further the oversight committee had one meeting on 27 Mar 2012 as per the oversight plan. Meanwhile, the extended term of India CCM has come to an end during mid 2012, and it has been reconstituted with the new members as per the ToR for the next two-year term i.e. 2012–14. Now, the reconstitution of oversight committee with the new members is under process. Moreover during the phase 2 renewals, the members of oversight committee provided technical inputs and also in the areas of aid effectiveness in the	India CCM	CCM: The nomination for new Committee will be over by 31 Mar 2013. But the implement-tation of CCM activities depends on the availability of CCM funding.

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	nature of programs in India.		proposal. As per the OIG recommendation, implementing oversight plan and operationalizing oversight committee needs financial resources. But the GF Secretariat has not approved the last term expenditure reports of India CCM and also not provided the template for submission of CCM fund request for next term i.e. 2012 - 14. India CCM is now requesting the GF to provide the CCM Fund to India CCM as soon as possible for scaling up India CCM activities. ii. We would like to stress upon the fact that the decentralization of CCM in India is not advisable in the sense that it would lead to	The Global Fund Secretariat The Global Fund Secretariat	

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			miscommunications, delay in decision-making and instigate conflicts. Therefore we would strongly recommend for a single national CCM for India. *Global Fund Secretariat comment: Further CCM funding is dependent on removal of the CCM Secretariat from NACO, a grant implementer.*		
Grant Management	***Recommendation 2 (High):*** The Global Fund Secretariat should continue to enforce grant agreement conditions relating to Quality Assurance of Pharmaceuticals and Diagnostic Products to ensure grant funds are not used to procure TB and malaria medicines that are in breach of the Global Fund Quality	The Global Fund Secretariat has included appropriate conditions in the Grant agreement to ensure compliance with its Quality Assurance policies. If the conditions are not met, Grant funds are de-committed accordingly. The Global Fund Secretariat will not approve disbursement requests or portions thereof if the PR (or in India's case, government implementer) is not	RNTCP ensures that GF supported procurements meets the quality assurance norms of GF. The use of ACT-SP in the national malaria program is as per 'National Drug Policy of Govt. of India' which is decided by highest Technical Body known as Technical Advisory Committee (TAC). All policy decisions are evidence based.	CTD/ RNTCP NVBDCP	Will start from FY 2013-14 Ongoing

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	Assurance policy.	complying with the Global Fund's Quality Assurance policies for pharmaceuticals and/or diagnostic products.	As communicated, country has well established stringent controlling authority i.e. Drug Controller General (India) – DCG (I) for ensuring quality control of all Pharmaceuticals being produced and used in the country. GMP is essential component for registration of Pharmaceuticals including antimalarials. It would be worth mentioning here that a letter was written by Concerned Joint Secretary, Ministry of Health Government of India GF and the response to this is still awaited from GF. It is further reiterated that country uses quality drug under all program including National Vector Borne Disease Control Programme. The efficacy of antimalarial drugs including presently used ACT –SP is being monitored regularly and as and when there will be		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
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			indication for change of ACT, country would use alternative ACT. Accordingly TAC has recommended in its meeting held on 30th January'13 to use ACT –AL in 7 North East Sates and process has been initiated for replacing ACT-SP with ACT-AL in the North East Sates which are presently being covered under GFATM supported "Intensified Malaria Control Project -II (IMCP-II)". With regard to Rapid Diagnostic Test, Technical Specification includes clause of WHO recommended Diagnostic test. National Institute of Malaria Research – ICMR is carrying out Quality Assurance (QA) of Malaria-RDT in the country and process has been initiated for accreditation of NIMR laboratory for QA of malaria RDT by WHO in collaboration		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
			of Global Fund. *Global Fund Secretariat comment: QAP compliance will be enforced on an ongoing basis.*		
	Recommendation 3 (Very High): Principal Recipients should consistently address exceptions noted by the external auditors so as to strengthen the control environment within which grants are implemented.	The Global Fund Secretariat will continue to collaborate with India's Controller and Auditor General to ensure that future external audits of government implementing agencies meet the requirements of the Global Fund.	Based on the findings of OIG, PR (CTD) will take up this issue with CAG through proper channel. Department of AIDS (DAC) will address all the issues raised by C&AG and place the accounts for their audit accordingly. There is a mechanism already existing by external Audit by CAG.	NVBDCP	Annually
	Recommendation 4 (High): i. PRs should maintain proper books of account. All variances and	The Global Fund Secretariat will: • Assess PRs' (and government implementing agencies') limitations in	Noted by CTD. The adjustment if any will be done in consultation with the GF Fund Portfolio Manager. <u>DAC/NACO Comments</u>		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	unreconciled balances should be examined and books of account updated. Advances to third parties should be reconciled to books of account. ii. The Global Fund Secretariat should determine whether the expenditures documented as ineligible in Annex 4.	maintaining proper books of accounts acceptable to the Global Fund and work with them to ensure that accurate and timely financial reports are generated from their financial systems. • Identify weaknesses in the timely reconciliation of procurement invoices with actual reported expenses and develop recommendations to resolve issues resulting in qualified audit opinions. • Clarify the status of the potentially ineligible expenses listed in Annex 4. As of 25 February 2013, it appears that the last 4 expense lines have already been adjusted in the respective grant budgets. We are clarifying potential reversal of the first line and request additional information	(i)(a) At present sanction wise claims are submitted through e compilation excel sheet and the audit is conducted on the basis of consolidated excel sheet and all attachment in original. (i)(b) From Financial Year 2013-14 and onwards, a separate module for disbursement claims will be developed and implemented through computerized Project Financial Management System (CPFMS) software package and the same shall be got audited by C&AG in the CPFMS generated reports. (iii) An exhaustive exercise has already been done to obtain complete documentation from Procurement agents and necessary adjustment has been passed for most of the outstanding advances released till 2011-12 and those	NVBDCP (PR/SR)	On going

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		regarding attribution by grant, breakdown and time frame for incurrence by NACO of the listed amount (US $1,029,700).	adjustments shall be placed before the audit for obtaining unqualified audits reports. (iv) Regarding ineligible expenditure of USD 1,029,700 under RCC_II (Grant no. IDA-202-G02-H). It has been confirmed that the TNSACS has received the grants from NRHM. An amount of USD 1029700 will be adjusted in the next PU/DR. Agreed and implemented *Global Fund Secretariat comment: The outstanding issues will be cleared by the time of the subsequent Round 2 and Round 4 RCC grant extension signings with NACO, anticipated in June 2013, and the TB SSF extensions, to be signed by October 2013.*		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
Program Implementation	***Recommendation 5 (High):*** The RNTCP should undertake regular, scheduled monitoring and supervision visits at state level, with an emphasis on early detection and follow-up of defaulters.	The Secretariat agrees and will monitor this situation.	The monitoring and evaluation visits are being taken regularly both at the level of state and center. Efforts are also being undertaken to improve the quality of Monitoring and evaluation.	RNTCP	Already started
	Recommendation 6 (High): i. The NVBDCP should accelerate recruitment, orientation and deployment of Malaria Technical Supervisors to ensure compliance with malaria treatment guidelines. ii. NVBCP should make pre-printed registers and forms available at all	The CT raised these issues in the most recent management letter to NVBDCP and will be monitoring implementation following Phase 2 grant signing.	The matters has been taken with SR's .At present out of 258 MTS 231 (as in March 2013) are in position. However attrition due to various reasons are unavoidable. All MTS recruited are given training after the recruitment. Majority of the SRs are already implementing. It will be monitored for complete implementation. Accordingly, SR's has been instructed and	NVBDCP (PR/SR)	On going

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
	facilities and all providers should be trained on the use of the updated tools.		budget provision has been made. *Global Fund Secretariat comment: The Global Fund will assess compliance during its review of NVBDCPs forthcoming progress update, no later than September 2013.*		
	Recommendation 7 (Very High): The national program should work with the procurement agent, RITES Ltd., to address procurement delays. This should ensure timely delivery of antimalarials and RDTs to community health workers and at health facilities in the North-Eastern region supported by Global Fund grants.	There were significant delays in many of the early tenders floated by RITES in 2010. Reasons cited included: - Incorrect technical specifications provided by the PR resulting in queries raised by potential bidders followed by BID amendments. - Bidder complaints related to inefficiencies in the operations of RITES (e.g. evaluation report took 40 days). The LFA informed us that later in the first cycle of	CTD Comments: The program and the EPW of MoHFW are taking up these matters with RITES for the needful. DAC's Response: 1. Technical Specifications are approved by a Technical Specifications Committee and there have been no significant delays due to technical specifications 2. DAC has pro-actively addressed delays in procurement cycles by RITES from 2011 onwards	NVBDCP	Ongoing

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		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		procurements and in the second cycle – 2011 – NACO appeared to have addressed these delays. - Significant time is spent on follow-up of incomplete submission of bids (in requesting missing or additional documentation). - Long administrative delays in the process of having bid evaluation reports approved by the respective clients – NACO, NVBDCP, CTD, and EPW. o EPW needs to call upon 2 different committees, clinical and financial for evaluation of BID report. o The committees do not involve the respective PRs (government implementers). Hence urgency is not communicated. o For NACO, this has now been addressed with tender periods having been reduced 30	3. DAC has prescribed systems for approval and processing of BER reports and ensures speedy disposal of concluded contracts 4. DAC has prescribed procedures for tenders based on World Banks guidelines and is time bound 5. For future selection of procurement agent/s, DAC has incorporated timelines for every step of procurement cycle and has factored in penalties for delays in each of the steps All efforts are being done for ensuring timely procurement. Ministry of Health and Family Welfare (MO&FW) has extended the contract period of Procurement Agency i.e. RITES. EPW of MOH&FW and Programme is closely working		

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		days to 8 days. o For NVBDCP and CTD, the issue remains outstanding. (In 2010, for procurement of anti-TB drugs, this process took 157 days). o Finally, EPW informed RITES that they do not consider themselves 'approving' the bid evaluation report but approving payment for the same. Based on this information, it seems likely that such delays will continue in future procurements through EPW. Hence, while we may recommend that RITES streamline its procedures, we should recognize that most of the bottlenecks occur at the ministerial level. This will be communicated to the Government of India and CCM Planning Commission and MoHFW during the Country	with procurement agency to address any issue and clarification raised by them. However to come over unforeseen circumstance affecting procurement process, NVBDCP is also exploring the alternative procurement method i.e. Voluntary Pooled Procurement (VPP) through GFATM for the Intensified Malaria Control Project and for the immediate supply, NVBDCP is also exploring emergency procurement of diagnostics and pharmaceuticals till the routine Procurement / VPP materializes. *Global Fund Secretariat comment: The Global Fund will seek to operationalize VPP for NVBCP by December 2013.*		

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		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		Team's visit to the country in early March 2013.			
	Recommendation 8 (High): Informed by this analysis, MDR-TB co-treatment coordination should be implemented with the scale up of DOTS+. The HIV/TB National Working Group should determine what measures it can put in place to ensure uniform implementation of the national policy on HIV/TB collaboration, and then proceed to implement these measures.	HIV/TB collaboration is indeed a weak spot in the national response. The Secretariat will monitor progress on this issue, as well as the main priorities in the fight against the three diseases, including: 1. Strengthening focused HIV prevention among vulnerable groups; 2. Ensuring antiretroviral treatment coverage to all eligible patients; 3. Facilitating scaled-up TB case-finding, referral and treatment in the states most affected by new onset and drug resistant forms of the disease. 4. Ensuring adequate vector control and artemisinin based combination therapy in districts of the country with a high annual malaria parasite incidence. This includes 100% LLIN coverage and 80%	<u>CTD Comments:</u> The Findings of OIG will be submitted to the National Technical working group-TB/HIV for taking appropriate actions. However RNTCP monitors the TB/HIV linkages closely. In the 12th FYP program has made a provision for the recruitment of Senior DOTS + TB HIV supervisor at district level who will look for the TB HIV services. This is to inform that 100% of the districts have been covered by PMDT services in the country as on March 2013. <u>DAC/NACO Comments:</u> MDR-TB co-treatment coordination with the scale up of DOTS+, will be put up as an agenda in the next meeting of the HIV-TB National Working	Basic Services Division, NACO and Central TB Division, RNTCP	June 2013

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		diagnostic and treatment coverage by 2015. While pursing these goals, we will address four structural issues through actions tailored to each program: 1. Insufficient programmatic data quality that can lead to incorrect public health decisions; 2. Weaknesses in financial reporting and audit compliance that have resulted in disbursement disallowances and other financial losses to the grant programs; 3. Inadequate quality assurance of pharmaceuticals and diagnostic products that result in drug resistance and poor treatment outcomes; and 4. Governance and capacity	Group and necessary measures to be undertaken will be identified in the 1st quarter of 2013 Logistics management, with the help of an agency – SAMS, is in place to ensure availability of medicines and diagnostics at all health facilities. The technical requirement is calculated based on the epidemiological situation, deployment reserve & buffer stock as well as consumption pattern for drugs and diagnostics. NVBDCP envisages to achieve universal coverage with respect to diagnosis and , treatment of cases and vector control through LLIN *Global Fund Secretariat comment: The Global Fund will support efforts by NVBDCP to strengthen*	NVBDCP	

Section	Recommendation	Response and Action Plan		Responsible Parties	Due Date
		Global Fund Secretariat (Responsible for ensuring that the recommendation is implemented)	**Country Coordinating Mechanism and Principal Recipients (Responsible for the actual implementation of the recommendation)**		
		issues characterized by conflicts of interest and restricted information flow.	*logistics management on an ongoing basis. An Emergency procurement of health products is being arranged through WHO in May-June 2013.*		
PSM	***Recommendation 9 (High):*** Future contracts between Ministry of Health and RITES Ltd. with procurement agents should contain clauses about specific timelines related to agreed procurement plans. RITES should take appropriate management actions to implement such clauses in order to ensure timelines are consistent with good procurement practices and international standards.	NACO issues new tenders for procurement agent services for all three Global fund-supported disease portfolios. The Secretariat will review the new contracts so as to ensure their timelines are consistent with good procurement practices and international standards.	For future selection of procurement agent/s for procurement of goods/services using Global Fund resources, DAC has incorporated timelines for every step of procurement cycle and has factored in penalties for delays in each of the steps *Global Fund Secretariat comment: We await final selection of a procurement agent by June 2013.*	DAC	Ongoing