



THE OFFICE OF THE INSPECTOR GENERAL



The Global Fund to Fight AIDS, Tuberculosis and Malaria

Audit of Global Fund Grants to Zanzibar

Report

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EXECUTIVE SUMMARY

Introduction

1. As part of its 2012 workplan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to Zanzibar from 11 June to 13 July 2012. The audit focused on two grants (Round 6 HIV and Round 8 Malaria) totaling USD 8,816,103, of which USD 5,004,612 had been disbursed from December 2007 (the inception date of the HIV grant) to May 2012. The Principal Recipient was the Ministry of Health and Social Welfare implementing through the Zanzibar Malaria Control Program and the Zanzibar AIDS Control Program.

2. The OIG audit focused on grants from Round 6 onward, with a limited review of two earlier grants, Round 3 Tuberculosis and Round 4 Malaria, requested by the Global Fund Secretariat due to concerns over unsupported and ineligible expenditure that had been previously highlighted by the Local Fund Agent.

3. There was scope for improvement in several areas including: (i) human resource capacity; (ii) oversight of program activities by the Zanzibar Global Fund Country Coordinating Mechanism; (iii) internal controls and financial monitoring; (iv) forecasting and quantification of health products; and (v) monitoring and evaluation system for program activities.

4. The OIG offers 13 “critical” and 11 “important” recommendations to mitigate the control weaknesses identified. Twelve other recommendations are contained in a letter to management, which addresses less significant control weaknesses or areas of non-compliance.

Governance and Oversight

5. There was scope for the Country Coordinating Mechanism to strengthen its oversight of the grants by (a) obtaining the necessary funding and support to set up a fully-fledged Secretariat to coordinate its activities; and (b) reconstituting the oversight committee and implementing the oversight plan developed. The terms of reference for external auditors required improvement to enhance the relevance and quality of audits carried out. Given that Global Fund resources flow to public sector entities, external audit arrangements should be made in consultation with the office of the Controller and Auditor General of Zanzibar which has the overall mandate to provide assurance over the proper utilization of public funds in Zanzibar. It is critical that the internal audit function remains independent of management and focuses on review of internal control systems.

6. While the quality of the Local Fund Agent deliverables was generally adequate, the OIG noted a few areas of concern. For instance, the initial positive capacity assessment of the Principal Recipient was at odds with the findings of the OIG. There was no evidence that the Local Fund Agent had reviewed the external audit arrangements for the grants and advised the Global Fund on their acceptability.

7. The Global Fund Secretariat could have taken steps to better manage the grant start-up and closure processes. The Principal Recipient continued to spend money following the end of the Round 4 grant in June 2009 without the approval of the Global Fund Secretariat (the grant closure plan had not been finalized at the time of the audit). This resulted in the Principal Recipient incurring USD 212,490 of ineligible expenditure.

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Procurement and Supplies Management

8. Procurement of health products for the malaria program was carried out through the Voluntary Pooled Procurement mechanism, while HIV health commodities were procured through a memorandum of understanding with the Medical Stores Department of mainland Tanzania.

9. The Principal Recipient had scope for improving internal controls to ensure compliance with procurement regulations. At the time of transition to Voluntary Pooled Procurement, a purchase order, justified as an emergency due to imminent stock out, took place despite an adequate pipeline order underway. The bid evaluation criteria qualified only one supplier who was awarded the bid. The goods arrived one year later, well after the arrival of the order in the pipeline.

10. The Principal Recipient faced quantification challenges and the stock data maintained had inherent limitations making it difficult to consistently establish the quantity and expiry dates of stock at health facility level. OIG field visits recorded both over- and under-stock situations at different facilities. Stock outs and expiries were noted at the central level for both the malaria and HIV programs. The HIV program, in particular, suffered due to delays of up to twelve months in fulfilling orders for opportunistic infection and sexually transmitted infection medicines.

11. The introduction of a pull system for logistics management had improved this situation; however, this was limited to 19 out of 156 health facilities at the time of the audit. The Principal Recipient would greatly benefit from hiring/training logistician(s) to have in-house capacity for accurate quantification of health commodities and to roll out the pull system across Zanzibar.

12. Lot testing of rapid diagnostic tests for malaria, post market surveillance and batch tracking of medicines in use in the public sector had not taken place at the time of the audit. In the medium term, the Zanzibar Food and Drug Board should be encouraged to carry out this regulatory role. In the short term, other options such as the Tanzania Food and Drug Authority and Ifakara Laboratories on the Tanzania mainland should be considered for quality assurance services.

Financial Management

13. There was an urgent need for improvement in financial management and internal controls related to financial management in both the Malaria and HIV programs, particularly concerning expenditure not in line with the approved workplan and budget, budget monitoring and reporting. The audit findings point to a need for the Principal Recipient to recruit qualified accountants for the malaria program.

14. The audit documented amounts totaling approximately USD 387,862 in ineligible expenditure that should be refunded to the programs, and an amount of USD 62,413 in insufficiently supported or undocumented expenditure that should be refunded unless supporting documentation is made available to the Global Fund.

Public Health Program Implementation

15. An effective malaria control program had reduced the case load in Zanzibar with a limited annual seasonal increase. The malaria infection rate at community level had declined from more than 10% in 2005 to less than 1% in 2010. The incidence of new malaria episodes had decreased from 16/1,000 to 2/1,000 in children under five and from 4/1,000 to 2/1,000 in the age groups above five. The absolute number of confirmed malaria cases in all age

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groups had declined from 7,013 to 2,715 cases and from 247 deaths in 2005 to no reported deaths in 2010.

16. Malaria medicines were widely available, and the OIG documented good case management, diagnosis by microscopy and rapid tests. Vector control in homes through indoor residual spraying and distribution of long-lasting impregnated nets were done at a high level. However, the danger of malaria re-introduction remained. There is a need for early case detection, e.g., using a Geographical Information System, which would survey all grouped cases and facilitate early intervention.

17. Zanzibar had a concentrated HIV epidemic. The mean prevalence rate among the general population was 0.6% with higher prevalence rates among the key populations. The prevalence in urban areas was significantly higher than in rural areas. Women, especially those in the age group 15-49 years, had higher HIV infection rates (0.9%) than men (0.2%). About 8,000 Zanzibaris were estimated to be living with HIV/AIDS.

18. Care and treatment for patients was in line with international best practice, with antiretrovirals available in the ten facilities providing HIV care and treatment services. However, there had been frequent and prolonged stock-outs of opportunistic infection and sexually transmitted infection medicines across health facilities including at Mnazi Mmoja, the main referral hospital (with 3,907 HIV+ patients under care), which had no opportunistic infection drugs for at least eight months. This compromised the treatment of people living with HIV/AIDS. Prevention and treatment activities for the key populations with high prevalence were difficult to implement, given continued stigma against these groups. More direct involvement of peers from these groups in behavior change communication should be considered.

19. TB patients form an additional high prevalence sub-group with an HIV prevalence rate of 15.2%. While policy guidelines were developed to ensure that TB patients were screened for HIV and vice versa, these should be followed more consistently. Efforts should be made for a more efficient tuberculosis screening program including culture, which would provide more accurate diagnosis.

Prioritization of audit recommendations

20. To address the areas for improvement identified in this report, the recommendations have been prioritized as:

- **Critical**: There is a material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization interests, erode internal controls, or jeopardize the achievement of aims and objectives. It requires immediate attention by senior management; and
- **Important**: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

21. This report includes tables (see "Financial Management and Controls") that identify a total amount of USD 450,275 that was not used in line with the grant agreement and/or adequately supported. The OIG recommends that the funds are repaid by the PR.

Overall conclusion

22. The programs were generally well managed and demonstrated an impressive public health impact. However, there was a risk that this success may be undermined by lapses in oversight and weak control systems. Financial management required particular attention, with an urgent need to improve the capacity at both Principal and Sub-Recipient levels. Procurement and supply chain management needed to put in place controls to avoid repeated stock-outs and expiries of drugs. Grant oversight arrangements had scope for improvement, particularly in strengthening the Country Coordinating Mechanism and redefining the role of assurance providers such as external and internal auditors.

23. Based on the findings in this audit, the OIG considered the controls in place over the implementation of public health programming in Zanzibar effective. However, controls over procurement and supplies management, financial management and governance and oversight over Global Fund-supported programs were not satisfactory. Overall, the OIG was not able to provide the Global Fund Board with reasonable assurance over the effectiveness of controls in place at the time of the audit to manage the risks impacting the Global Fund-supported programs in Zanzibar.

MESSAGE FROM THE GENERAL MANAGER OF THE GLOBAL FUND



10 YEARS
OF IMPACT

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22 October 2012

MESSAGE FROM THE GENERAL MANAGER

I would like to thank the Office of the Inspector General for its thorough and insightful work on the audit of Global Fund grants to Zanzibar.

The audit's fieldwork was carried out from June 11 to July 13, 2012 and covered two grants (Round 6 HIV and Round 8 Malaria), totalling US\$ 8,816,103 - of which US\$ 5,004,612 had been disbursed from December 2007 (the inception date of the HIV grant) to May 2012. At the Global Fund Secretariat's request, the audit team also conducted a limited review of two earlier grants, Round 3 Tuberculosis and Round 4 Malaria.

The audit found a number of achievements in Zanzibar in the fight against AIDS, tuberculosis and malaria. The programs were generally well managed and demonstrated an impressive public health impact, according to the audit report. Malaria infection rates at community level declined from more than 10% in 2005 to less than 1% in 2010. The number of deaths caused by malaria declined from 247 in 2005 to no reported deaths in 2010. Care and treatment for patients was in line with international best practice, with antiretroviral medication available in all facilities providing HIV care and treatment services.

There is, however, scope for improvement in several areas. There were frequent and prolonged stock-outs of opportunistic infection and sexually transmitted infection medicines. In addition, attention is required concerning human resources capacity, oversight of program activities, internal controls and financial monitoring, and the monitoring and evaluation system for program activities. To address these issues, the report presents 24 recommendations.

The audit also identified US\$ 450,275 in expenditures not used in line with the grant agreement and/or not adequately supported. The report recommends the recovery of the funds from the Principal Recipient, the Ministry of Health and Social Welfare.

Audit reports 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

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM



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Ref: No. OMPR/A.10/C.17/ZGFCCM/VOL.V

Date: 26 September 2012

**Mr. John Parsons
Inspector General**

REF: FIRST DRAFT AUDIT REPORT ON GLOBAL FUND GRANTS TO ZANZIBAR

I have the honour to refer you to your letter referenced OIG/JP-12/202 dated 27th August, 2012 concerning the above mentioned subject.

We are pleased to inform you that we have critically reviewed the OIG's audit observations and have consolidated our responses which are attached herewith. Please also note that all the documents that support the ZGFCCM expenditures (for US\$ 15,430) that were not found during the time of audit survey have been located and are now ready for inspection and verification.

We take this opportunity to express our appreciations to the Audit team for the support extended to Zanzibar during the audit survey. We also wish to register our appreciations to the GF mission to Zanzibar which took place from 22nd to 24th September, 2012. The discussions of the mission and ZGFCCM and of PRs were very useful and will definitely help us in the management of grants.

We thank you for your continued support and cooperation.

Yours Sincerely

**Dr. Khalid S Mohamed
PRINCIPAL SECRETARY/ZGFCCM CHAIR
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OVERVIEW

Audit Objectives

24. The objectives of this audit were to assess the adequacy and effectiveness of the controls in place to ensure:

- Achievement of value for money from funds spent;
- Accomplishment of programmatic objectives including quality of service provision;
- Compliance with Global Fund grant agreements, related policies and procedures, and relevant laws and regulations;
- Safeguarding of grant assets against loss, misuse or abuse; and that
- Risks were effectively managed.

In undertaking this audit an important focus was to identify opportunities to strengthen grant management.

Audit Scope

25. The audit examined the operations of the Principal Recipient (PR), the interactions with its Sub-Recipients (SRs) and implementing partners, the supply chain for goods and services purchased with the Global Fund grant funds, and the oversight functions of the Zanzibar Global Fund Country Coordinating Mechanism (ZGFCCM), the Local Fund Agent (LFA) and the Global Fund Secretariat. The PR was the Ministry of Health and Social Welfare (MOHSW) implementing through the Zanzibar Malaria Control Program (ZMCP) and Zanzibar AIDS Control Program (ZACP). ZMCP had five SRs – Zanzibar Association for Medical Laboratory Scientific Officers (ZAMELSO), Zanzibar Association for Children Advancement (ZACA), TUISHI, Care & Share Organisation and Zanzibar Association for Farmers and Fishermen Development (ZAFFIDE). ZACP had only one SR - Center for Counselling, Nutrition and Health Care (COUNSENUTH). Program implementation and expenditure at the SR level accounted for only 4% of total disbursements spent.

26. The OIG audit focused on grants from Round 6 onward (Table 1), with a limited review of two earlier grants, Round 3 TB and Round 4 Malaria, requested by the Global Fund Secretariat due to specific concerns over unsupported and ineligible expenditure that had been previously highlighted by the LFA. This limited review focused on the problem areas previously identified as well as expenditure incurred after the end of the grant periods for the two grants. The Round 3 TB and Round 4 Malaria grants were due to end on 30 November 2009 and 30 June 2009 respectively; however, neither grant had been closed due to these pending issues. The audit sampled 80% of direct PR expenditure from December 2007 to May 2012.

Disease & Round	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
HIV Round 6	MOHSW	ZAN-607-G05-H	3,394,651	2,093,974
Malaria Round 8	MOHSW	ZAN-809-G07-M	5,421,452	2,910,638
Total			8,816,103	5,004,612

Table 1: Global Fund grants to Zanzibar audited by the OIG (Source: Global Fund website, 6 July 2012)

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27. The OIG used several approaches in conducting its work including: holding discussions with program personnel and relevant stakeholders, review of grant program documents including monitoring/supervision reports, review of relevant surveys and disease-specific reviews, examination of supporting documentation for grant expenditure, as well as programmatic and financial progress reports.

28. In addition to audit tests carried out at the central level, the audit team visited a sample of program sites at district and community (Shehia) levels on Unguja and Pemba islands. The audit team carried out tests and made observations on the quality of service at district hospitals and laboratories, Primary Health Care Units/Centers (PHCU/C), and storage facilities and had focus group discussions with People Living with HIV/AIDS (PLHIV).

Implementation and Prioritization of Audit Recommendations

29. 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.

30. The recommendations have been prioritized as follows to assist management in deciding on the order in which recommendations should be implemented:

(a) **Critical**: There is a material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization interests, erode internal controls, or jeopardize the achievement of aims and objectives. It requires immediate attention by senior management.

(b) **Important**: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

(c) **Desirable**: There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of good practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

Letter to Management

31. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. However, not all audit observations have the same urgency or priority. Audit findings deemed 'desirable' have been reported separately in a Letter to Management. This "Letter to Management" lists audit findings that constitute a less significant control weakness or noncompliance within the system, which require remedial action within an appropriate timescale. The adoption of best practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs. Though these findings and recommendations do not warrant immediate action, their implementation would help to strengthen the overall control environment for Global Fund-supported programs. The OIG would expect Management at the Global Fund Secretariat and/or the PR to follow up as appropriate.

OVERSIGHT

There is scope for the ZGFCCM to strengthen its oversight of the grants by (a) obtaining the necessary funding and support to set up a fully-fledged Secretariat to coordinate its activities; and (b) reconstituting the oversight committee and implementing the oversight plan developed. The terms of reference for external auditors requires improvement to improve the relevance and quality of audits carried out. Given that Global Fund resources flow to public sector entities, the external audit arrangements should be made in consultation with the office of the Controller and Auditor General of Zanzibar, which has the overall mandate to provide assurance over the proper utilization of public funds in Zanzibar. There is also a need for the internal audit function to remain independent and focus on the review of internal control systems.

Country Coordinating Mechanism

32. The ZGFCCM membership was renewed in December 2011 and complied with Global Fund regulations. However, in the absence of a fully-fledged Secretariat to coordinate its activities, the ZGFCCM had struggled to fulfill its oversight mandate. ZGFCCM meetings were not held on a regular basis hence limiting its effectiveness. The oversight committee was no longer functional and needed to be reconstituted as its official members were no longer on the ZGFCCM. An oversight plan had been developed but it had not been adopted for implementation. As a result, no supervisory visits had been undertaken.

33. The ZGFCCM was guided by its bylaws, governance and operational manuals. However, these needed to be updated to reflect Global Fund policy changes. There was also scope to combine the governance and operational manuals as they were similar in nature.

34. There was scope to improve the sharing of information and communication between the programs and the ZGFCCM Secretariat, as key information concerning the grants, including progress reports, was not routinely shared. The ZGFCCM could explore options to enhance information sharing such as participation in the LFA debriefs following the conclusion of the verification exercises.

35. The ZGFCCM had received USD 40,000 to support CCM activities in May 2009. At the time of the audit in June 2012, expenditure amounting to USD 28,067 had been incurred. However, due to a poor filing system, the OIG was not provided with supporting documents for expenses amounting to USD 15,430 (55% of total expenditure). These amounts should be refunded unless supporting documentation is made available to the Global Fund.

Local Fund Agent

36. PricewaterhouseCoopers had served as the LFA from the beginning of the grant programs in Zanzibar in 2003, working on both the Tanzania mainland and Zanzibar grants. The LFA had a dedicated manager to manage the Zanzibar portfolio with a supporting pool of experts for Monitoring and Evaluation, and Procurement and Supply Chain Management (PSM). It was based in Tanzania mainland, flying in to Zanzibar periodically.

37. The LFA had experienced frequent changes in key staff at manager level overseeing the Zanzibar grants. There were instances of late reporting of the progress update and disbursement requests (PU/DRs) due to the incompleteness of information received from the PR. There was scope for the LFA to notify the Global Fund whenever such challenges were faced to allow for quicker resolution.

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38. While the quality of the LFA deliverables was generally adequate, the OIG noted a few areas of concern. For instance, whereas the LFA's initial PR capacity assessment in 2010 rated the Financial Management Systems and PSM areas as "adequate" (B1 rating), the OIG noted that these were both areas of major concern with significant capacity gaps and internal control weaknesses. The OIG recognizes that some of the issues were highlighted by the LFA in subsequent PU/DRs and that these areas were downgraded to B2 ratings in subsequent capacity assessments of the TB Round 10 and Malaria Round 8 Phase 2 grants.

39. There was no evidence that the LFA had reviewed the external audit arrangements for the grants and advised the Global Fund on their acceptability. The OIG noted that no audit plans had been prepared by the PR which was reflected in persistent delays in submission of audit reports by both programs.

The Principal Recipient (MOHSW)

40. The MOHSW implemented the Global Fund grants through two programs: ZMCP and ZACP. Oversight was provided by the Principal Secretary, who is the accounting officer for the MOHSW, supported by the Director General and Director of Preventive Services.

41. The programs were supported by other MOHSW departments such as the Procurement Management Unit (PMU), responsible for the coordination of all procurement activities, and the Central Medical Stores (CMS), responsible for forecasting of essential medicines, clearing, storage and distribution of commodities. There was scope to improve the effectiveness of coordination between the programs and these departments.

Assurance Providers

External Audit

42. The external audit function for all public entities including the MOHSW was under the mandate of the Controller and Auditor General (CAG) of Zanzibar. The CAG carried out the external audits for ZACP. However, a private audit firm appointed by the program performed the external audit of ZMCP for the financial period ending 30 June 2009.

43. There was no evidence that the terms of reference for the external auditors were approved by the Global Fund as per the grant agreement. The CAG audit reports included management reports with findings and recommendations to address weaknesses in internal controls and areas of non-compliance with grant agreements. Further, the recommendations made by the external auditor in its report for the round 4 grant for the period ended 30 June 2009 had not been implemented as similar findings, e.g., accountability for working advances, post-expenditure approval, controls over cash were noted during the audit.

44. There was scope for the PR to improve compliance with the grant audit requirements. The submission of the audit report did not meet the six month deadline required by the Global Fund guidelines and the three month period after the financial year end to submit the financial statements for audit by the CAG as required by the Public Finance Act No. 12 of 2005 section 24(2). At the time of the audit, the ZACP audits for the financial years ending June 2010 and 2011 had not been finalized.

45. The external audit firm for ZMCP performed consultancy engagements for ZMCP in addition to the audit, which impaired its independence.

Internal Audit

46. The MOHSW internal audit function was located in the finance section of the Directorate of Planning, Policy and Finance. It was part of management internal control mechanisms (auditors had to sign off on all expenditure requisitions) and thus did not provide an independent assurance on the effectiveness of the internal controls.

Recommendation 1 (Critical)

The ZGFCCM urgently needs to improve its operations. In particular it should:

- (a) Reconstitute the oversight committee and adopt the oversight plan. Consideration should also be made for other technical working groups that may be required to further support the ZGFCCM's oversight functions;*
- (b) Ensure meetings are held regularly and decision points are followed through. The ZGFCCM may consider including a provision in the by-laws to replace any members who consistently fail to attend meetings;*
- (c) Seek operating funds and opportunities for technical capacity building to strengthen the ZGFCCM Secretariat. The Secretariat staff should include an administrative/accounts assistant charged with accounting responsibilities;*
- (d) Ensure that proper records for ZGFCCM expenditure are maintained. Supporting documents not availed to the OIG should be located and financial reports submitted to the Global Fund to enable the ZGFCCM to access further funding for its activities. Unless documented, the unsupported expenditure of USD 15,430 should be refunded;*
- (e) Ensure that the PR routinely provides the ZGFCCM with grant information, e.g., PU/DRs and external audit reports; and*
- (f) Update the ZGFCCM policy manuals to reflect Global Fund policy changes. Consideration should be made for consolidation of the various guidelines (operational and governance manuals) into a single manual.*

Recommendation 2 (Critical)

The PR should ensure that:

- (a) The grant start up and closure process is properly managed to minimize the risk of misuse of grant funds;*
- (b) The external auditor selection and development of audit terms of reference (TOR) is done at the Ministry level in consultation with the office of the CAG instead of the programs to enhance independence. Further, the external auditor and its TOR should be approved by the Global Fund Secretariat;*
- (c) It prepares and submits an audit plan for approval; and*
- (d) It prepares and implements action plans to address the areas of weakness identified by the external auditors. Progress in implementation should be tracked and reported on by the LFA.*

Recommendation 3 (Important)

The PR should ensure that its internal audit function is independent and performs regular internal audits to strengthen internal controls over the grant programs. Audits should be risk-based and include grant compliance.

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

Procurement of health products for the malaria program was carried out through the Voluntary Pooled Procurement (VPP) system, while the HIV health commodities were procured through the Medical Stores Department (MSD) of the Tanzania mainland guided by a Memorandum of Understanding (MOU). There were weaknesses in product quantification and the stock data maintained had inherent limitations making it difficult to establish the quantity and validity of stock at health facility level. Stock outs of malaria drugs (ACTs) and expiries of antiretroviral drugs were noted at the Central level but the extent of this problem could not be established at the health facility level. During the field visits, the OIG noted cases of over and under stocking of drugs at different facilities. The HIV program in particular had experienced shortages due to delays of up to twelve months by MSD in fulfilling orders for opportunistic infection and sexually transmitted disease medicines.

Malaria program

Quantification of malaria rapid diagnostic tests

47. There was scope for improvement in quantification. The PSM plan approved by the Global Fund for Round 8 included more than 800,000 malaria rapid diagnostic tests (mRDTs) per annum for the period 2012-15 (846,403 mRDTs for 2012). However, based on available consumption and distribution data, these quantities were four times higher than the actual requirements which ranged between 200,000-250,000 mRDTs per annum (actual consumption for 2011 was 187,586).

Recommendation 4 (Critical)

The PR should update the Round 8 PSM plan to reflect current consumption data. This will result in procurement savings, which present an opportunity for reprogramming to address unmet program needs.

Artemisinin-based Combination Therapy (ACT) stock

48. The audit team verified the inventory of ACT at the CMS Warehouse in Unguja and noted two dosages of ACT that had been out of stock at CMS warehouse for more than eight months. For the ACTs in stock, the balances were too low to function as an effective central warehouse buffer stock.

Date of last stock movement	ACT Dosage	Balance at CMS
28/10/2011	25mg/67.5 (<5yrs)	nil
25/04/2012	50mg/135mg (9-17 kg)	143
10/11/2011	100mg/270mg (18-35kg)	nil
25/04/2012	100mg/270mg (>36kg)	91

49. During the field visits, the audit team noted inconsistencies in the availability of ACTs at health facilities. For instance, at the Junguni PHCU (Wete, Pemba), there were cases of malaria but no ACTs. During the same period, a team from the U.S. President's Malaria Initiative (PMI) visiting Kombeni, Chaani Kikobweni and Bwefumu PHCUs noted that those facilities had over 10, 22 and 34 years' stock of ACTs respectively, based on their consumption pattern (and with a remaining shelf life of only 1 year).

Recommendation 5 (Critical)

The PR should ensure that:

- (a) Immediate stock reconciliation with CMS and health facilities is carried out to verify quantities in stock and quantities on order and redistribute stock, taking into account the remaining shelf life;*
- (b) Re-order levels based on consumption patterns are established and a mechanism put in place to ensure that replenishment orders are made when stocks reach the pre-determined re-order levels; and*
- (c) Regular joint meetings (e.g., quarterly) between CMS and program coordinators are held to discuss stock status (quantity and validity). Meeting minutes should document pending actions and the responsible parties, whenever there are issues to be addressed.*

Inventory Management

50. The PR did not have approved Standard Operating Procedures for storage and distribution as required in the grant agreement as a condition precedent.

51. The CMS had a manual inventory management system using bin tally cards and ledger books. Given the high volume of commodities handled and the number of health facilities that the CMS services, the manual system did not provide an efficient system of inventory management.

52. Due to capacity constraints, CMS distributed products to hospitals and health facilities on a push system to create space for other incoming goods. This mode of delivery had inherent drawbacks as needs in health facilities varied significantly. As a result, there were instances where some items, e.g., ACTs were in excess of demand at facility level while shortages occurred in others.

53. Multiple modes were used for distributing supplies. Products were distributed through either CMS and the Zonal Medical Store of Pemba, or directly to health facilities, Zonal materials officers, Zanzibar Integrated Logistics System store and/or program coordinators. Products were further distributed from these points to hospitals, PHCUs and/or implementing sites. The quantities distributed through the different channels were not reconciled, hence limiting the usefulness of stock data captured in informing management decisions.

Recommendation 6 (Important)

The PR should:

- (a) Review and expedite finalization of the Standard Operating Procedures for storage and distribution at CMS. Ideally, these need to be implemented before migration into the new warehouse in Maruhubi due for completion in August 2012;*
- (b) Establish a computerized inventory system for the new warehouse. CMS Management should initiate training for its staff in computerized inventory management;*
- (c) Centralize all issues and distributions through the new warehouse; and*
- (d) Maintain a proper filing system, e.g., using product movement sheets, to track and account for all products issued for distribution. The filing system adopted should allow for full reconciliation at the central level (CMS).*

Quality Assurance and Control

54. Zanzibar Food and Drug Board (ZFDB) was the national drug regulatory authority responsible for ensuring that all pharmaceutical products and other medical supplies procured met the quality standards under the Zanzibar Food, Drugs and Cosmetics Act No. 2 of 2006. However, the ZFDB did not carry out lot testing for mRDTs or post market surveillance for medicines in the public sector due to lack of capacity. There was no system in place for batch tracking of medicines.

Recommendation 7 (Critical)

The PR should ensure that:

- (a) The ZFDB carries out its role to quality assure pharmaceutical products. In the short term, options such as the Tanzania Food and Drug Authority and Ifakara Laboratories on the Tanzania mainland should be considered for quality assurance services; and*
- (b) Batch tracking of all medicines and other health products is instituted.*

Compliance with Grant Agreement

55. On 28 May 2010 the PR procured 300,000 mRDTs at a cost of USD 255,000 from Biocare Health Products. They were received on 7 March 2011. This procurement was flagged by the LFA as being non-compliant with the grant agreement which required that procurement of health products be done through VPP. At the time of the procurement, the PR's PSM plan had not yet been approved by the Global Fund as authorization to procure commodities.

56. The PR justified this procurement as an emergency order on the basis that at the time the program was facing an imminent stock-out situation. However, the OIG noted that at the time the 'emergency' order was made, there was a pipeline order that was more than adequate to meet the program's needs (125,125). This order was received on 6th August 2010 five weeks after the emergency order was initiated.

57. The mRDT tender evaluation process included criteria and conditions that were contained neither in the tender document nor in the technical specifications. The criteria specified the product brand, which effectively eliminated all other bidders as there was only one supplier (Biocare). There was no justification for the procurement of a specific brand.

58. The bid offers in the final evaluation ranged from USD 156,000 to USD 360,000 (TZS 540,000,000). Biocare had the fourth highest bid. From the available documentation it was not clear whether the mRDTs offered by other bidders were compliant with Global Fund guidelines.

Recommendation 8 (Important)

The PR should ensure that:

- (a) Provisions of the grant agreement for procurement of commodities are adhered to. Exceptions should be approved by the Global Fund before commitments are made;*
- (b) The technical specifications and descriptions of the health commodities are sufficiently general to allow all suppliers who meet Global Fund requirements to participate in tenders; and*
- (c) Procurement orders made take into account available stock and pipeline orders, if any.*

HIV program

Planning and Management

59. The considerable delays in delivery of supplies had resulted in stock outs of some of the most needed medicines at CMS and the health facilities. In 2011, this included opportunistic infection (OI) and sexually transmitted infection (STI) medicines which were out of stock for periods up to twelve months at the two major health facilities in Zanzibar (Mnazi Mmoja and Chake-Chake), which dealt with over 60% of all STI cases.

60. There was scope for more effective coordination to avoid delays in the execution of orders through various suppliers, especially the MSD. Due to poor coordination and the lack of defined responsibilities, between the program, PMU and CMS, follow-up of orders with MSD did not take place consistently.

61. There was a need to include sufficient specification in the MOU between the PR and MSD. For instance, there was no guidance on the prioritization of orders. As a result, MSD delivered the medicines and supplies to the PR at its discretion.

62. 100% advance payments were made to MSD including cost, insurance and freight charges of 20%, in accordance with the MOU. However, there was no monitoring of these advances to verify supplies received and outstanding orders.

Recommendation 9 (Critical)

The PR should ensure that:

- (a) Procurement planning and contract management responsibilities for the programs, PMU and CMS are clearly defined;*
- (b) Supplier agreements specify procurement needs with clearly defined timelines;*
- (c) Payment terms are better negotiated, e.g., avoiding, as far as possible, making 100% advance payments, renegotiating service charges and*
- (d) Advances paid to procurement agencies are monitored with verification carried out for all deliveries (quantity and quality as per specifications) prior to acceptance by the PR.*

Availability of medicines in facilities

63. Based on available records, there have been no stock-outs for antiretroviral (ARV) drugs on either island. This was consistent with the findings of the OIG team from the six health facilities visited and focus group discussions with 24 PLHIV (16 in Unguja and eight in Pemba) contacted through the Zanzibar people living with HIV and AIDS (ZAPHA+) organization. This was largely attributed to technical assistance provided by partners to improve quantification skills. However, this assistance was focused on Antiretroviral Therapy (ART).

64. On the other hand, the OIG noted frequent and prolonged stock-outs of OI and STI medicines across health facilities including at Mnazi Mmoja, the main referral hospital (with 3,907 HIV+ patients under care), which had no OI drugs for at least eight months. The lack of treatment for OIs and STIs not only endangers the lives of PLHIV but also undermines the credibility of the health system. Failure to treat OIs also has cost implications as it could lead to earlier than planned ARV treatment for PLHIV.

65. Stock in hand at the health facilities and pipeline orders were not taken into consideration appropriately. This was not a problem in the 19 facilities where the pull system had been implemented under the Integrated Logistics System.

Recommendation 10 (Critical)

The PR should ensure that:

- (a) Logisticians are trained to have in-house capacity to conduct accurate quantification of health commodities and facilitate the implementation of the pull system under the Integrated Logistics System across Zanzibar;*
- (b) Capacity building support focuses on the forecasting, quantification, storage and distribution activities for all health commodities; and*
- (c) Long term capacity building partnerships/programs rather than short term technical assistance engagements are sought.*

Expiry of HIV/AIDS medicines and supplies

66. Medicines and medical supplies were stored by CMS and distributed to public hospitals and health facilities. This includes an allocation of ARVs from Tanzania mainland stocks.

67. The OIG noted expired HIV medicines and laboratory diagnostics and reagents at the CMS warehouse in Unguja worth an estimated USD 18,138. This was mainly due to the lack of verification of commodities prior to acceptance, resulting in receipt of products with a short remaining shelf life.

68. This situation was worsened by the limitations in the information available to support management decisions since the information management tools used did not capture the inventory value and expiry dates.

Recommendation 11 (Critical)

The PR should ensure that:

- (a) The MOU clause requiring a minimum remaining shelf life of 80% for all drugs and reagents procured is enforced;*
- (b) A stock ledger that tracks supplies received and issued including their value (cost) and remaining shelf life is established;*
- (c) The First Expiring First Out (FEFO) system is applied consistently and regular assessments of remaining commodities are conducted to verify their validity for use; and*
- (d) Usage of stock at health facility level is monitored and, where necessary, redistributed to other health facilities or the CMS.*

FINANCIAL MANAGEMENT AND CONTROLS

There is scope for improvement in financial management and internal controls at both the Malaria (ZMCP) and HIV (ZACP) programs with an urgent need to improve controls over expenditure, budget monitoring and reporting. The audit findings point to a need for the Malaria program to recruit qualified accountants and for both programs to strengthen their financial oversight over Sub-Recipients, which generally have very limited capacity.

Closure of old grants (Malaria Round 4, TB Round 3)

69. The PR continued to spend the funds after the Round 4 grant ended in June 2009 (the grant closure plan had not been finalized at the time of the audit). In March 2010, the first disbursement for the Round 8 grant (denominated in EUR) was made to the Round 4 bank account denominated in USD, despite the Global Fund requirement to maintain separate bank accounts for different grants.

70. The PR also used the same account for both Round 4 and Round 8 from March 2010 until the time when a separate EUR account was opened for Round 8 in November 2010. The bank balance at the time was transferred to the new account and the Round 4 USD account was closed. However, the PR had not reconciled this account to determine how much related to each of the two grants.

71. The LFA notified the Global Fund Secretariat of the use of the same bank account in 2011 while verifying the Round 8 progress report for the period ending February 2011. Following the LFA review, the PR refunded USD 198,463.24 to the Global Fund representing the balance of Round 4 grant funds.

72. The OIG noted that from the expenditure incurred by the PR on the Round 4 grant after the grant end date, USD 212,490 was not related to grant activities. In addition an amount of EUR 25,467 relating to Round 4 remained in the Round 8 bank account while an amount of EUR 16,970 was paid from the Round 4 bank account for Round 8 activities. As at the time of the audit, an unspent amount of EUR 8,497 for Round 4 grant was still held by the PR. These amounts are refundable to the Global Fund (see Table A).

73. The OIG followed up on the status of unsupported expenditure of USD 124,534 charged to the Round 3 TB grant as previously reported by the LFA to the Global Fund Secretariat and confirmed that expenditure amounting to USD 33,929 remained unsupported (see Table B).

Recommendation 12 (Critical)

The PR should ensure that:

- (a) The grant start up and closure process is properly managed to minimize the risk of misuse of grant funds; and*
- (b) Accounting records are updated to reflect the actual position for the grants.*

Budgetary Control

74. There was scope for improvement in budgetary control. There were no periodic budget monitoring reports prepared for management to facilitate timely detection and correction of significant variances. For instance, in Phase 1 of Round 6, a total of USD 72,183 was spent on the strengthening of the College of Health Sciences' training facility versus a budget allocation of USD 49,299 representing a budget overrun of 46%. The PR did not seek Global Fund Secretariat approval for this budget overrun (see Table A).

75. In Phase 2 of the Round 6 HIV grant, the HR budgeted cost was USD 453,648 while the actual expenditure was USD 14,585. This unusual variance was due to the fact the PR had obtained funding for this activity from another donor due to a delay in disbursement of grants from the Global Fund. Budget revision and/or a reprogramming request from the Global Fund had not taken place.

76. Part of the reported expenditure for the Round 8 Malaria grant included EUR 11,566 for the clearance, storage and distribution of mRDT. However, this expenditure related to programs not supported by the Global Fund, and is therefore ineligible (see Table A).

Recommendation 13 (Important)

The PR should ensure that:

- (a) Budget monitoring reports are prepared periodically and significant variances followed up;*
- (b) Implementation of activities and expenditure for funds transferred to other units of the MOHSW, e.g., the College of Health Sciences are monitored; and*
- (c) The HR budget is reviewed and revised in light of complementary resources.*

Controls over expenditure

77. There was scope for strengthening the controls over expenditure at ZMCP. The following gaps were noted:

- The records kept by the cashier were inadequate as no documents were signed by the payees acknowledging receipt of cash.
- Cash withdrawn from the bank was kept in a safe until disbursed or spent. However, no records were kept indicating the value of cash kept in the safe at any particular time.
- The program settled more than half (55%) of its expenditure (excluding the direct payment by the Global Fund to VPP) by cash.
- While the requisitions of advances for expenditure were approved by both program and MOHSW management, there was no process to review and approve supporting documentation following implementation.
- There were concerns over the completeness of supporting documentation, especially for training activities, resulting in unsupported expenditure equivalent to USD 10,753 (see Table B).

78. For both programs, there was scope for improvement in the segregation of duties for bank withdrawals, payment for program expenditure, accounting for expenditure in books of account, report generation and other related functions to minimize the risk of error and/or fraud.

Recommendation 14 (Critical)

The PR should ensure that:

- (a) A petty cash book is introduced to record all cash withdrawals from the bank, payments and receipts. This should be balanced on a daily basis and undergo periodic spot checks to ascertain that the recorded cash balance matches with the physical cash in the safe;*
- (b) All cash advances are signed for by the receiving officer. These should be recorded as an advance against the receiving officer until proper accountability has been received;*
- (c) Cash payments are minimized by identifying transactions that can be settled by check/bank transfer. For instance, all major supplies could be procured centrally*

through approved suppliers. This should include payment for training and other venues, to the extent practicable;

(d) Supporting documents for expenditure are complete prior to approval of accountability; and

(e) There is effective segregation of duties so as to mitigate the risk of error and/or fraud.

Controls over procurement and consumption of fuel

79. The OIG noted that at ZMCP, fuel was procured from fuel stations in bulk and subsequently consumed through the issue of internal slips over a period of time for program activities. The following shortcomings were noted in this regard:

- There was no contract between the PR and fuel vendor for the fuel purchase;
- There was no documentary evidence available from the fuel vendors to support the program fuel consumption records;
- Fuel was provided to 38 vehicles, of which only 6 belonged to ZMCP. There was no evidence to support utilization of fuel in all the vehicles (see Table A for ineligible amount); and
- There were additional bulk quantities of fuel procured at the Pemba sub-office in cash but no records for its use were available for the OIG review.

Recommendation 15 (Critical)

The PR should ensure that:

(a) Agreements are signed with the major fuel vendors used. The agreements should include clauses with respect to payment modalities (by check/bank transfer) and provision of monthly statements for fuel procured and issued to different vehicles. This should include fuel procurement at the Pemba sub-office; and

(b) Vehicle log books are maintained to track fuel consumption by purpose/activity supported.

Need for consistency in currency conversion method

80. From December 2007 to May 2011, ZACP was using actual rates for conversion of the local currency (TZS) amount to USD for reporting purposes. However, the conversion method was changed in June 2011 to daily conversions using the Central Bank of Tanzania rate. This change was applied retrospectively to include the entire grant period from December 2007. Due to this change, the PR reported a cumulative exchange loss of USD 97,685.29 as at 31 May 2012 instead of USD 47,549.27 based on the original method.

81. ZACP maintained its books of account in USD instead of the local currency (TZS) which is the main spending currency. This meant that every transaction was translated to USD. This was both cumbersome and prone to error.

Recommendation 16 (Important)

The PR should ensure that:

(a) Books of accounts are maintained in the main spending currency (Tanzania Shillings) and translated into USD at an actual or average rate as defined in the Global Fund Guidelines for reporting purposes; and

(b) The exchange loss, as currently reflected, is corrected.

Human Resource

Consultancy fees paid to staff

82. The Malaria and HIV programs paid consultancy fees and other allowances such as meeting allowances, facilitation fees and overtime to its employees for regular duties such as data collection and assessments in addition to their regular salaries. Paying consultancy fees or allowances to an employee for carrying out activities similar to those already part of their job responsibilities, for which they are paid a salary results in double payment. The consultancy fees in question are ineligible expenditures and should be refunded to the Global Fund program (see Table A).

Top-up allowance for staff

83. Top-up allowances were part of the grant budget; however, the PR did not have a policy to guide the payment of those allowances. The OIG noted several weaknesses in the management of top-up allowances paid to ZMCP employees:

- The approved budget provided for top-up allowances for 33 employees; however, 42 employees were paid top-ups;
- For the quarter June to August 2010, the amount was paid twice resulting in excess payments of USD 6,079 (see Table A); and
- The top-up allowances were paid in cash.

Recommendation 17 (Critical)

The PR should ensure that:

- (a) Payments to staff are in accordance with established policy guidelines;*
- (b) A top up allowance policy is established and submitted to the ZGFCCM for approval. This should specify the rates to be paid and the specific positions entitled to the top-up allowances; and*
- (c) Top-up and other allowances are paid through employees' bank accounts to reduce cash payments and provide a better audit trail for payments made.*

Sub-Recipient Management

84. There were several examples of unsupported and ineligible expenditure incurred at SR level. COUNSENUETH, an SR under the Round 6 HIV grant, spent USD 2,166 (TZS 2,794,000) on supportive supervision visits that were not budgeted for under the grant. There was no supporting documentation for expenditure amounting to USD 2,013 and some cases where expenditure reported was higher than the actual amounts incurred (see Tables A and B).

85. ZACA, an SR under the Round 8 Malaria grant, spent EUR 982 on Post-Exposure Prophylaxis training for HIV/AIDS which is ineligible under the Malaria grant. There was no supporting documentation for expenditure amounting to EUR 217.

86. The following tables set out expenditure incurred by the PR and SRs that was either unsupported by documentation or ineligible (not in line with the grant agreement):

Audit of Global Fund Grants to Zanzibar

Table A: Expenditure not in line with the grant agreement

ZMCP (Malaria Round 8)	
Particulars	Amount (EUR)
Amount paid as consultancy fees, meeting allowance, overtime and facilitation fees to ZMCP employees	34,302
Expenditure relating to other programs charged to Global Fund grants	11,566
Double payment of top up allowance	6,079
Expenditure of fuel for vehicles other than ZMCP vehicles	4,194
Unspent Round 4 amount held in Round 8 account	8,497
SR expenditure incurred outside the approved budget (ZACA)	982
Total	65,620
USD equivalent	87,163
ZACP (HIV Round 6)	
Particulars	Amount (USD)
Amount paid as professional fees, meeting allowance and facilitation fees to ZACP employees	45,993
VAT paid (PR has VAT exemption and so this amount should be recoverable from the revenue authority)	7,893
Amount over paid to a vendor - Millennium Engineering Company	5,636
Amount paid to College of Health Science in excess of budget (46% budget overrun)	22,885
Amount paid by SR as allowance to MOHSW official	3,293
Over reporting of expenditure by SR to PR	343
SR expenditure incurred outside the approved budget (COUNSENUTH)	2,166
Total	88,209
ZMCP (Malaria Round 4)	
Particulars	Amount (USD)
Expenditure not related to grant activities	212,490
Total	212,490
GRAND TOTAL	387,862

Table B: Unsupported expenditure

ZMCP (Malaria Round 8)	
Particulars	Amount (USD)
Inadequate supporting documentation (EUR 8,095)	10,753
No supporting documentation – ZACA (EUR 217)	288
Total	11,041
ZACP (HIV Round 6)	
SR expenditure not supported by invoices	2,013
ZACP (TB Round 3)	
Supporting documentation not available (TZS 40,884,225)	33,929
ZGFCCM	
Supporting documentation not available	15,430
GRAND TOTAL	62,413

Recommendation 18 (Critical)

- (a) *The PR should ensure that all payments are properly justified and within the approved workplan and budget; and*
- (b) *The Global Fund Secretariat should assess the ineligible and undocumented amounts listed in Tables A and B, and seek refund from the PR as deemed appropriate.*

PROGRAM REVIEW

Malaria Program

The Zanzibar Malaria program is performing very well in terms of public health impact. Good practices noted included the availability of medicines, good case management, diagnosis by microscopy and use of rapid tests. Vector control in homes through in-door residual spraying and distribution of long-lasting impregnated nets were done at a high level. However, the danger of malaria re-introduction remained. There is a need for early case detection, e.g., using a detailed Geographical Information System, which would survey all grouped cases and facilitate early intervention.

Diagnosis and Quality assurance

87. In terms of access to diagnosis, Zanzibar had made tremendous strides. Parasitological diagnosis of malaria was made through rapid diagnostic tests (mRDTs) at all levels of health care and microscopy in a limited number of facilities. The availability of parasitological diagnostic tests had increased from about 15% before 2004 to 100% in 2007.¹ There was a reference laboratory at ZMCP performing microscopy quality assurance for public health facilities and selected private health facilities.

88. The internal quality assurance system was working well, with 10% of the negative slides and all the positive slides sent to and examined at the Central Laboratory. This included the 41 facilities (34 PHCU +, 4 PHCC and 3 district hospitals) where microscopy was done. There was no system in place to counter-check the mRDT results or their use by the PHCU Health Care Workers. Moreover, as the system was finding ever fewer positive results due to the low test positivity rates, the need to check the ability of microscopists to detect a positive result was important. This could be done through external quality assurance.

Recommendation 19 (Important)

The PR should implement a system:

- (a) Of external quality assurance whereby laboratories receive pre-confirmed slides from the Central Lab and are asked to verify both positive and negative slides; and*
- (b) To periodically countercheck the mRDT results against microscopy results and, considering the low test positivity rates, ensure that health workers are regularly trained to recognize positive results.*

Disease surveillance system and case detection

89. The OIG team witnessed the effectiveness of weekly mobile phone reporting complemented by the malaria case registers at the PHCUs. More sophisticated Health facilities (PHCCs, hospitals) were reporting through the national Health Management Information System.

90. Although malaria prevalence was at a low level, there was a need to investigate all grouped cases to intervene in all grouped cases in order to avoid spread of the disease to contact cases and to allow for surveillance of unknown malaria carriers in the patient's family or immediate community.

¹ Zanzibar Malaria Strategic Plan III 2012-2017 (draft)

91. Extensive case-finding was done once a month in "hot-spot" areas, e.g., during May and June 2012 the case detection team surveyed 11 communities (Shehia) representing 12,340 persons, with 92 new positive cases identified.

92. A good surveillance system needs both quick data transmission – which is in place – and rapid on-site response. However, during field visits the OIG noted that in various PHCUs in high-prevalence areas (like North-West Pemba), where a mean of 15 positive cases of malaria were declared each week, there was no evidence of any district or central team visiting the spot to investigate group cases.

Recommendation 20 (Important)

The PR should ensure that:

- (a) As Zanzibar moves from control toward elimination, there is a more proactive case detection activity, e.g. by using a detailed Geographical Information System, which would survey all grouped cases and facilitate early intervention; and*
- (b) High-risk malaria zones are identified for vector control as well as for potential outbreak intervention (mapping). Contingency plans (e.g., cleaning campaigns, treatment of mosquito breeding grounds) need to be developed and implemented in concert with the affected communities.*

HIV Program

The HIV epidemic in Zanzibar is concentrated with a prevalence rate of 0.6% in the general population. The key populations had higher infection rates (11-16%) as did women in the general population (0.9 vs. 0.2%). Care and treatment with ARVs was good but there were stock-outs of medicines for Opportunistic Infection treatment. The fight against the spread of HIV within the key populations was difficult in a conservative society with stigma against those engaging in conduct that was deemed socially unacceptable. Efforts to address these key populations would benefit from a more direct involvement of peers from these groups. For the general population, behavior change communication interventions will continue to play an important role going forward. Due to the strong linkage between TB and HIV, efforts should be made for a more efficient TB screening program with a greater emphasis on culture.

HIV testing and counseling

93. Health personnel from sites providing Provider Initiated Testing and Counseling (PITC) and VCT services had been trained on HIV testing and counseling using the National HIV testing and counseling guidelines.

94. The national HIV testing and counseling guidelines had been revised to incorporate PITC but other aspects such as Pediatric HIV, VCT, Key Populations and blood safety were not yet covered.

95. Diagnostic Testing and Counseling services were provided in 14 sites (nine in Unguja and five in Pemba). HIV testing services were also provided in hard-to-reach areas and during special events, such as World AIDS days. One regional "Gold Standard" VCT center was developed at Mnazi Mmoja hospital in Stone Town to serve as a model referral center.

96. Over a 6 year period, 196,368 people were tested for HIV² and of these 6,159 (3.1%) tested positive. There had been an increased uptake of VCT services especially with premarital testing which was advocated for by religious leaders. However, most health facilities did not have adequate infrastructure to allow comprehensive and confidential counseling and testing services.

Quality of care for PLHIV at Health facilities

97. The OIG team interviewed several patients at Mnazi Mmoja hospital, which delivers two-thirds of Zanzibar's HIV/AIDS treatment burden and found that the patients' opinion on quality of service was generally favorable. Patients were particularly happy with the simplified treatment and requirements for follow-up, as well as Voluntary Counseling and Testing (VCTs) and Care and Treatment Clinic/Centers (CTCs). For reasons of anonymity, many people came for consultation in Mnazi Mmoja from different areas including Pemba Island.

98. Mnazi Mmoja hospital was commended for having competent staff and innovative practices to meet different patients' needs, e.g., late afternoon outpatient clinic for key populations (KPs) in a bid to provide the patients with the desired privacy and anonymity.

99. However, the audit team noted a number of complaints over the attitude of health personnel towards PLHIV in the general health facilities, e.g., when attending emergency wards or outpatient clinics for purposes other than the need for ARV treatment. The negative

² Report for the period September 2004-July 2010: submitted on 5th September 2010 (ZACP)

attitude was particularly strong towards men having sex with men (MSM) and injecting drug users (IDUs).

Recommendation 21 (Important)

The PR should:

- (a) Revise the national HIV testing guidelines to include pediatric HIV, VCT and key populations;*
- (b) Advocate for the respect and confidentiality of HIV patients at the counseling and testing centers. Health care workers should be trained and sensitized on patient (PLHIV) rights; and*
- (c) Explore possibilities of replicating good practices in other health facilities, e.g., the late afternoon clinic at the Mnazi Mmoja hospital which makes it easier for KP members to access health services.*

Prevention of mother-to-child transmission (PMTCT) services

100. PMTCT services were first established in 2005 in Zanzibar. Of the 154 health facilities offering Reproductive and Child Health (RCH) services, 50 (32%) had integrated PMTCT services by 2009. Community sensitization sessions on PMTCT services were conducted through meetings for communities, religious leaders, traditional birth attendants and other influential district leaders.

101. PMTCT services had been affected by poor functioning of the referral system to respond to the HIV epidemic as well as weak linkages with the Health Management Information System.

102. While HIV screening among pregnant women was generally done well (85% of targeted pregnant women in Zanzibar were counseled and tested for HIV in 2009), there was scope for follow-up for appropriate care once HIV positivity had been confirmed. From the focus group discussions with PLHIV, it was noted that this was a bigger problem for women in the rural areas as those in the urban areas normally had some support from peers.

Recommendation 22 (Important)

The PR should:

- (a) Strengthen linkages between RCH personnel and PLHIV, e.g., through joint training sessions to discuss the issue of access to care for pregnant women and*
- (b) Establish a peer support system across Zanzibar to ensure access to care for pregnant women who discover their seropositivity.*

Behavior Change Communication

103. KP members reported instances they had experienced stigma, violence, legal prosecution and low condom usage due to group rape, low income, and less accessibility to condoms. Apart from the lack of protective laws for the KP, there were misconceptions and myths about harm reduction held by policy makers and the community.

104. In an attempt to counter this, several behavior change communication campaigns had been carried out. However, most information material was designed as one way (top-down) communication with little involvement of members of the key populations.

105. There was also concern that resource allocation to address KPs was not proportional to the magnitude of the infections among them, which is over twenty times higher than in the general population. Only 16.7% of outreach health education programs reach IDUs, and only

5.6% of programs reach female sex workers (FSWs) compared to 44.3% of the general population.³ Although KPs were recognized in the Round 6 proposal as important stakeholders, little money had been allocated directly to their representative associations to support any interventions at their level.

Recommendation 23 (Important)

The PR should involve KPs and organizations dealing with them, e.g., ZAPHA+ in the communication and development of strategies to ensure that their specific needs are addressed.

TB/HIV collaborative activities

106. TB and HIV policy guidelines were developed to ensure that TB patients were screened for HIV and vice versa. One center (Mnazi Mmoja) in Zanzibar provides TB/HIV services under one roof and all CTC staff had the capacity to screen for TB. However, the overall number of TB patients tested for HIV decreased from 98.2% in 2010 to 86% in 2011 due to unavailability of test kits in the centers. HIV patients were not consistently tested for TB.

107. Testing for TB was done using TB smears only. Owing to the fact that: (i) sensitivity of smear microscopy is only 50%, (ii) X-ray facilities in Zanzibar were few and often overbooked and (iii) TB culture needed special techniques and equipment which were only found in the TB national reference lab (in Pemba), there was a high risk of undetected TB.

Recommendation 24 (Important)

The PR should ensure that:

- (a) Test kits are regularly available so that all TB patients are tested for HIV. Considering the low number of patients, 100% testing should be an achievable goal;*
- (b) HIV patients are screened for TB; and*
- (c) Culture tests are done consistently for TB diagnosis and where there are confirmed cases people in close contact with the patients, such as the immediate family or surrounding community, are screened.*

³ Ministry of Health and Social Welfare, Situation response analysis of PMTCT, VCT and CCT services in Zanzibar, MOHSW, Final report, February 2010