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The Office of the Inspector General

Audit Report on Global Fund Grants to Tanzania

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Acronyms

ACTs	Artemisinin-based Combination Therapies
ADDOs	Accredited Drug Dispensary Outlets
AG	Accountant General
AIDS	Acquired-Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
APHTA	Association of Private Hospitals in Tanzania
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
CAG	Controller and Auditor General
CDC	Centers for Disease Control
CHAC	Community HIV and AIDs Coordinator
CSSC	Christian Social Services Commission
CTC	Care and Treatment Center (for HIV care)
CTC 2	Universal patient record for HIV care used in Tanzania
DACC	District AIDS Control Coordinator
DHMT	District Health Management Team
DSU	Diagnostic Services Unit of the MOHSW
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
GF	Global Fund for HIV/AIDS Tuberculosis and Malaria
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
ICB	International Competitive Bidding
ILS	Integrated Logistics System
IPTp	Intermittent Preventive Treatment in pregnancy
LFA	Local Fund Agent
LGAs	Local Government Authorities
LLINs	Long-Lasting Insecticide-treated Nets
LSHTM	London School of Hygiene and Tropical Medicine
LSR	Lead Sub Recipient
MEDA	Mennonite Economic Development Associates
M&E	Monitoring and Evaluation
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MSD	Medical Stores Department
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Program
NCB	National Competitive Bidding
NGO	Non-Governmental Organization
NIMR	National Institute of Medical Research
NMCP	National Malaria Control Program
NTLP	National Tuberculosis and Leprosy Program
OIs	Opportunistic Infections
OIG	Office of the Inspector General
PEPFAR	President's Emergency Plan for AIDS Relief

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PFA	Public Finance Act 2001 (Revised 2004)
PLWHA	Person Living with HIV and AIDS
PMI	President's Malaria Initiative
PMO-RALG	Prime Ministers Office-Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PMU	Procurement Management Unit of MOHSW
PR	Principal Recipient
PSI	Population Services International
PSM	Procurement and Supply Management
PWC	PricewaterhouseCoopers
RACC	Regional AIDS Control Coordinator
RMO	Regional Medical Officer
RHMT	Regional Health Management Team
R&R	Request and Report form
SCMS	Supply Chain Management Systems
S-P	Sulfadoxin Pyrimethamine
SR	Sub-recipient
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TAWG	Tanga AIDS Working Group
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
TNCM	Tanzania National Coordinating Mechanism
TOMSHA	Tanzania's Output Monitoring System for non-medical HIV and AIDS interventions – Monitoring system managed by TACAIDS
TZS	Tanzanian Shilling
UN	United Nations
UNOPS	United Nations Office for Project Services
US	United States
USAID	United States Agency for International Development
USD	United States Dollars
VCT	Voluntary Counseling and Testing for HIV
VCTC	Voluntary Counseling and Testing Center
WB	World Bank
WHO	World Health Organization

Executive Summary

Introduction

1. This report sets out findings and recommendations of the Office of the Inspector General's (OIG) audit of the Global Fund (GF) grants to Tanzania. The field work for the audit was carried out from January 19 to February 20, 2009.

Background

2. The audit of the Global Fund grants to Tanzania was conducted as part of the OIG work plan for 2009.

Audit Objectives and Scope

3. The overall objective of the audit was to provide assurance that the procurement, supply management, service delivery and financial management of GF grant programs for HIV/AIDS, HIV/Tuberculosis and Malaria were undertaken efficiently and effectively; that adequate controls exist to account for grant resources; and that there was effective program oversight of GF grants both within Tanzania and by the GF Secretariat. The OIG therefore deployed a multi-skill team comprising a public health specialist, a procurement and supply management specialist, and audit specialists.

4. The scope of the audit was limited to five GF grant programs being implemented by the following organizations: Ministry of Health and Social Welfare (MOHSW) and its national programs for HIV/AIDS, TB and Malaria¹, Prime Ministers Office-Regional Administration and Local Government (PMO-RALG), African Medical and Research Foundation (AMREF) and Tanzania Commission for AIDS (TACAIDS). In addition, the audit covered selected implementing partners of the afore-mentioned entities. Audit tests and program visits were carried out in eight districts in the regions of Kilimanjaro, Tanga and Iringa.

¹ National AIDS Control Program (NACP), National TB and Leprosy Program (NTLP) and the National Malaria Control Program (NMCP).

Summary Findings

5. This section briefly highlights the findings and conclusions arising from the audit; but detailed findings are contained in the rest of the report. It is therefore essential that this report is read in its entirety in order to comprehend fully the findings and the resulting recommendations of the audit.

6. The recommendations have been prioritized. However, the implementation of all recommendations is essential in mitigating identified risks and strengthening the internal control environment in which the programs operate. The prioritization has been done to assist management in deciding on the order in which recommendations should be implemented. The categorization of recommendations is as follows:

- (a) *High priority*: Material concern, fundamental control weakness or non compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization's interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management;
- (b) *Significant priority*: There is a control weakness or noncompliance within the system, which presents a significant risk and 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 control, or undermine achievement of aims and objectives; and
- (c) *Requires attention*: There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization's benefit

A. Program Achievements

7. Tanzania, with assistance of the GF and other development partners, has made impressive gains in scaling-up care and treatment for people living with HIV/AIDS. In February 2009, there were between 170,000 and 180,000 people on anti-retroviral therapy (ART). Further, a report of the last testing campaign in June 2008 stated that 4.8 million people have been tested for the human immunodeficiency virus (HIV). In addition, the effective use of paramedical staff has facilitated the decentralization of ART treatment services. In spite of these achievements, there are serious challenges facing the grant programs which need the attention of key stakeholders such as Tanzania National Coordinating Mechanism (TNCM), the MOHSW and the GF Secretariat.

B. Procurement and Supply Chain Management

Procurement

8. The Medical Stores Department (MSD) and the Procurement Management Unit (PMU) of the MOHSW which are responsible for procurement for the public sector grant recipients are expected to follow Tanzania's public procurement legislation and regulations which generally conform to Global Fund's procurement policies. OIG however found excessive delays in procurement for the programs due, principally, to capacity shortcomings of the above-named procurement entities, lack of coordination in procurement planning and the complex approval processes required in government departments.

9. Current procedures followed for quantification and forecasting of medicines have resulted in oversupply of artemether-lumefantrine, a fixed-dose artemisinin-based combination therapy (ACT) in the country. This oversupply has led to expired ACTs at all levels of the supply chain. The MOHSW should ensure that actual consumption data from health facilities are used in forecasting demand for medicines and other health supplies.

Supply Chain Management

10. MSD's Orion computerized inventory management system cannot be relied upon to provide MSD management and the MOHSW with accurate information to monitor and react to problems in the supply chain. MSD therefore needs better inventory software to enhance tracking and accountability of medicines and other health products at all levels of the supply chain. Also, stock management at service delivery levels was found to be deficient.

11. The Controller and Auditor General (CAG) has qualified the financial statements of MSD successively for two fiscal years. There are also missing quantities of ACTs in 2007; and the value of the loss confirmed by the LFA is USD 819,000². In addition, from review of external and internal audit reports, OIG noted that numerous internal control weaknesses and frauds committed were attributed to the Orion system. An audit of the Orion system was commissioned in October 2007 and the report was issued in September 2008, but during OIG's audit in February 2009, corrective measures had not been implemented. OIG was informed that the Orion audit report was being reviewed by the MOHSW.

Stock Outs

12. Laboratory reagents for haematology and biochemistry analyzers were out of stock in the health facilities visited by the OIG team. Also, stock outs of ACTs and ARV medicines were found at some health facilities visited by the OIG team. The MOHSW needs to monitor closely stock levels of medicines

² LFA report on the ACT Supply Review, Malaria Round 4, Tanzania, page 3; dated October 2008

and health products needed by the programs to ensure continuity of treatment.

Integrated Logistics System

13. The Integrated Logistics Management System (ILS) has been developed by the MOHSW to replace the system of periodic distribution of medicines and health supplies to health facilities on the basis of consumption estimates and disease prevalence commonly known as the "push system". The "push system" had contributed to oversupply and expired drugs. To replace the "push system" on a pilot basis, the ILS requires health facilities to request their supply needs based on an estimate of "assumed" consumption data. There are plans to integrate drugs for HIV/AIDS, TB and malaria if the pilot is successful. OIG however noted that the ILS does not require health facilities to report actual consumption of medicines and health supplies, but rather the "assumed" consumption which is calculated based on the sum of the opening balance of a stock item, stock received during the period, less any stock adjustments/losses and closing balance. This method of calculation takes no account of the possibilities of theft and inappropriate use of medicines and health supplies.

C. Service Delivery

HIV/AIDS Program

14. Tanzania, with assistance from development partners, has made impressive gains in providing care and treatment for people living with HIV/AIDS. The decentralization of treatment services is proceeding rapidly, aided by the decision authorizing paramedical staff to administer ART. However, the procedures for certifying HIV care facilities are not being followed as planned, and in some instances, inappropriate certifications are made. Treatment retention for patients on ART is not known, but in a small sample observed it was in line with the average in Africa. There is also lack of clarity in policy about the management of drugs and laboratory reagents that are not exclusively used for HIV care.

15. The two main instruments developed for monitoring HIV/AIDS in Tanzania, the CTC2 Database which is managed by the NACP and the Tanzania Output Monitoring System for non-medical HIV and AIDS interventions (TOMSHA) are not integrated with the National Health Information Management System (NHIMS) and the Tanzania Local Government Monitoring and Evaluation System.

HIV/TB Program

16. HIV/TB services are being rolled out successfully. HIV testing of new tuberculosis patients is almost universal. Tuberculosis screening of people testing positive for HIV is becoming more common but needs further attention to sustain the achievements. The process of certifying some tuberculosis

clinics to provide ART has just started. All these are positive developments that should be pursued.

Malaria Program

17. Malaria continues to be the most significant threat to health and life in Tanzania. The estimated yearly number of clinical cases of malaria is 10 to 12 million with between 15,000 to 20,000 deaths, primarily among children under five years old. The three-pronged strategy of bed-nets, treatment, and preventive medication during pregnancy has made some inroads on malaria prevalence. However, the achievements on Tanzania's mainland pale in comparison to the achievements in Zanzibar.

18. A national strategy for malaria vector control through the use of insecticide-treated bed nets was introduced with GF support using a system of cash vouchers to subsidize the purchase of nets. The strategy has not resulted in the targeted level of net coverage. The program is currently in a transition phase, continuing the voucher scheme while preparing bed-net mass distribution campaigns, initially for children and subsequently for all Tanzanians. Following the campaigns, the options for a subsidization system that ensures universal bed-net coverage will be explored.

D. Financial Management and Control

19. Financial reports (Progress Updates and Disbursement Requests) were not prepared and submitted in a timely manner by Principal Recipients (PRs) to the GF; and it was difficult to verify the accuracy and completeness, and establish the audit trail for these reports. The current reporting template does not allow the PR to declare USD 30 million of unspent balances OIG found being held in lead sub-recipients' bank accounts. The value of unspent grant funds in local currency depreciates over time leaving gaps in funding and resulting in curtailment of program activities.

20. OIG also noted that lack of coordination, information sharing and complex disbursement processes led to delays in sending grant funds to implementing organizations, resulting in delayed implementation of program activities. There is a need for the PR and lead sub-recipients (SRs) to monitor bottlenecks in the flow of funds to implementing organizations.

21. Some implementing organizations are incurring unnecessary exchange rate losses in converting local currency into foreign currency to pay both local and foreign suppliers. Foreign currency payments to local suppliers should be discouraged. And funds earmarked for approved procurement payable in foreign currency should be disbursed to lead SRs in foreign currency.

22. OIG found many internal control weaknesses in its review of grant receipts and expenditures at all grant implementing entities. These weaknesses can be attributed to inadequate supervision of accounting staff, workload issues,

high staff turnover and lack of relevant qualified and experienced finance/accounting staff to undertake routine financial control duties.

E. Institutional Arrangements, Governance and Program Oversight

23. There are multiple players involved in grant oversight in Tanzania with over-lapping responsibilities and inadequately defined roles and responsibilities that invariably leave gaps in ownership and fulfilment of grant oversight responsibilities. Thus, the PR and lead SRs need to strengthen monitoring of grant program achievements and performance. The complex institutional arrangements for grant implementation and oversight are illustrated in Annexes 3 and 4 of this report. OIG noted that the large influx of funds from donor-funded health program initiatives has overwhelmed the complex bureaucratic processes and procedures of public health sector implementing organizations such as the MOHSW. This has resulted in delays in procurement of goods and services for grant implementation that led to Tanzania forfeiting USD 7.6 million of unspent funds at the end of phase 1 for two grants, namely HIV/TB Round 3 and HIV/AIDS Round 4.

24. TACAIDS role as the substantive PR needs to be assessed by the Local Fund Agent (LFA) and corrective measures need to be identified and implemented to address its capacity gaps.

25. There is scope to increase both internal and external audit oversight to cover the entire supply chain for medicines and health products.

26. The Tanzania National Coordinating Mechanism needs to strengthen its oversight role by developing an oversight plan to guide its oversight responsibilities.

27. Given the size and complexity of the grant portfolio in Tanzania, there is scope for making the LFA's oversight work more "hands on" instead of being adhoc and reacting to negative incidents/events. The oversight work of the LFA should be informed by a risk assessment of the grant portfolio covering key implementing SRs and high risk areas of grant implementation.

28. The LFA data verification reports of February 2009 confirm the findings of the OIG team that there are serious problems in the reporting of performance indicator data for three of the five audited grants: Round 3 HIV/TB, Round 4 Malaria, and Round 4 HIV. The data verification studies were carried out by the LFA in 2008. These studies were the first of their kind as they were introduced by the GF in 2008. The studies were rigorous, but the fact that they were conducted quite late in the grant implementation process, limits their usefulness. The level of analysis used in the studies is acceptable to assess data quality, but it is insufficient to determine the causes of poor quality or to formulate recommendations on how to improve it. The data quality of the other two grants, Round 1 Malaria and Round 4 HIV (AMREF) is acceptable. It is evident that monitoring the quality of performance data has to start early in the

process of grant implementation and has to continue at regular intervals throughout.

29. The GF monitoring system in Tanzania is poorly aligned with national information systems, and often designed to specifically and exclusively collect GF grant performance data. It is labour-intensive, generates inaccurate data, and collects information that is often not very meaningful for tracking the grant results. Hence, the GF's Country Programs Cluster and the Monitoring and Evaluation Unit of the GF Secretariat should work with the TNCM to review the performance indicators for all GF grants to Tanzania with the objective to (a) reduce the number of indicators, (b) to aim the measurement process higher in the results chain, and (c) to achieve a better alignment of GF performance indicators with existing national monitoring indicators.

Overall Conclusion

30. OIG conclude that there are serious issues facing the grants to Tanzania, particularly, in the area supply chain management and financial and programmatic reporting.

31. For supply chain management, it is important that MSD's management and its Board ensure that controls needed to safeguard medicines and health products are in place, are effective, and are working at all levels of the supply chain, i.e. from receipt of goods by MSD to storage and eventual distribution down the supply chain to district stores and health facilities. Drawing on the CAG's report, OIG consider that unless corrective actions are taken to enhance the control environment and internal controls at MSD in particular, and at key levels of the supply chain, grant resources are at risk. Consequently, GF Round 8 grants to the Government of Tanzania should be conditioned on the country addressing the serious issues in supply chain management.

32. In the area of financial and programmatic reporting, OIG cannot give assurance on the accuracy of the financial and programmatic reports prepared by TACAIDS and submitted to the LFA. OIG found that there were no financial and programmatic reports available from implementing organizations/sub-recipients to confirm the figures reported. And there was no appropriate senior level PR management review before these reports were sent to the MOFEA for signature. Similarly, disbursement for Round 8 grants to the Government of Tanzania should be conditioned on addressing the capacity gaps of TACAIDS as a substantive PR, after its capacity has been assessed.

Summary of Tanzania and GF Secretariat Responses

33. Tanzania's detailed response to the audit recommendations and its management action plan to address the recommendations is attached as

Annex1. In addition, the GF Secretariat detailed response to the oversight recommendations and its management action plan is attached as Annex 2.

34. In its response, the GOT accepted most of the audit findings and stated that it would take appropriate corrective measures. Regarding the PSM weaknesses detailed in the PSM section of the report, the GOT noted that there are on-going actions to rectify the situation, such as changing the supply systems for medicines to health facilities from supply driven to demand driven, enhancing storage capacity at zonal level pursuant to a policy of decentralizing the activities of MSD. Furthermore, the GOT explained that Monitoring and Evaluation (M&E) weaknesses noted in the report are largely due to delayed revision of the national Health Management Information System (HMIS), resulting in the inability of the system to accommodate information needs of the new program interventions.

35. Similarly, in its overall response, the GF Secretariat's concurred with the findings and recommendations in the audit report. It stressed that it would work closely with the GOT and all stakeholders to address the issues raised by the OIG, particularly, in the areas of supply chain management and financial and programmatic reporting.

36. The GF Secretariat recognized that due to the massive scale up of health programs covering the three diseases, over the last five years, the health systems in Tanzania have been greatly stretched, resulting in several challenges in the following areas: (a) PSM; (b) Service Delivery; (c) Infrastructure, Human and Physical Resources; (d) Continuity/Sustainability of Treatment Services; and Coordination and Governance.

37. The Country Program Cluster emphasized that, in collaboration with other development partners, it has extensively worked to strengthen the Medical Store Department's storage and distribution capacity; and it has provided funding for other capacity-building activities including staff training. Further, following the loss of ACTs in 2007, it has instituted annual PSM reviews for ARVs and ACTs. But it acknowledged that given the massive scale-up in treatment programs requiring purchase and distribution of large volumes of medicines and health equipment, the PSM area still pose challenges and needs to be closely monitored.

38. The GF Secretariat said that service delivery is affected by the general shortage of personnel in the health sector which has particularly impacted health facilities in rural districts where infrastructure and physical resources are very limited. In the interim, it has supported a limited emergency hiring program to recruit health personnel for some rural districts. But the GF Secretariat said that to sustain scale-up and improve quality of service delivery, donor support for health systems strengthening component is critical.

39. With regards to sustainability of the programs, the GF Secretariat acknowledged the sustainability risk of the HIV/AIDs and malaria treatment

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programs if GF resources are not available. It has therefore brought this issue to the attention of GOT and its development partners.

Background

40. Between December 2002 and February 2009 total funds committed by the GF to HIV/AIDS, Tuberculosis (TB) and Malaria programs in Tanzania amounted to USD 820 million, of which USD 384 million had been disbursed as of February 23 2009. The GF has a portfolio of twelve grant agreements in Tanzania. The MOHSW as the lead Sub-Recipient (SR) for the public health sector implements its grants through three departments namely, the National AIDS Control Program (NACP) for HIV/AIDS; the National Tuberculosis and Leprosy and Program (NTLP) for Tuberculosis; and the National Malaria Control Program (NMCP) for Malaria. The three entities implement grant programs through regional and district level organizations (municipal and district councils) in the 21 regions and 122 districts of Tanzania.

41. Three of the twelve grants are implemented by three non-governmental organizations (NGO), namely, African Medical and Research Foundation (AMREF), Population Services International (PSI) and Pact Tanzania. Funds committed by TGF to the three grants amounted to USD 90 million.

42. The nine public sector managed grants require a substantial outlay in procurement of drugs, equipment and health supplies at the national level. To this end, the Government of Tanzania (GOT) mandated the Medical Stores Department (MSD), an autonomous organization under the MOHSW, to be responsible for procurement of medicines and health products. Service delivery under the public sector grants takes place in regional and district hospitals, health centers and dispensaries.

Objectives, Scope and Methodology

43. The overall objective of the audit was to provide assurance that the procurement, supply management and service delivery for GF grant programs in Tanzania were undertaken efficiently and effectively and that well functioning quality assurance arrangements are in place. Furthermore, the OIG's audit aims to provide reasonable assurance: (1) that there are adequate controls to account for grant resources; and (2) that there is effective program oversight of GF grants both within Tanzania and by the GF Secretariat.

44. The scope of the audit covered the following GF grant programs.

Disease & Round	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
Malaria Round 1	Ministry of Health and Social Welfare (MOHSW)	TNZ-102-G01-M	78,079,834	48,139,110
HIV/TB Round 3	Ministry of Finance & Economic Affairs (MOFEA)	TNZ-304-G03-C	83,466,904	34,538,952
HIV/AIDS Round 4	MOFEA	TNZ-405-G04-H	184,228,749	135,137,370
HIV/AIDS Round 4	African Medical and Research Foundation (AMREF)	TNZ-405-G07-H	25,201,730	15,871,814
Malaria Round 4	MOFEA	TNZ-405-G08-M	76,086,764	75,086,764
Totals			447,063,981	308,774,010

Table 1: GF grants to Tanzania audited by OIG (Source: GF website, February 2009)

45. The audit covered GF grant programs being implemented by the following lead SRs: Ministry of Health and Social Welfare (MOHSW) and its national programs for HIV/AIDS, TB and Malaria³, Prime Ministers Office-Regional Administration and Local Government (PMO-RALG), African Medical and Research Foundation (AMREF) and Tanzania Commission for AIDS (TACAIDS). The audit also covered AMREF as a PR for one of the HIV/AIDS Round 4 grants. In addition, the audit covered selected implementing partners of the afore-mentioned entities.. The audit sampled transactions from the initiation of the grant programs (i.e. 2003 to date).

46. The OIG used the following approaches to conduct its work: discussions with program and financial personnel of relevant grant recipients; review of grant program documents, monitoring/supervision reports, implementation and procurement plans, examination of supporting documents for grant expenditures as well as program and financial progress reports.

47. In addition, apart from audit tests carried out at the national/central level, the OIG team visited program and projects sites at regional, district and health facility levels in three regions: Kilimanjaro, Tanga, and Iringa. During the field visits the OIG team made observations and carried out tests at zonal drug stores, municipal and district councils, HIV care and treatment centers,

³ National AIDS Control Program (NACP), National TB and Leprosy Program (NTLP) and the National Malaria Control Program (NMCP).

hospitals, health centers, dispensaries and other service delivery units and community-based implementing organizations.

Procurement and Supply Chain Management

48. The health sector in Tanzania has benefited from increased donor programs with large procurement components to combat HIV/AIDS, Malaria and TB. About fifty percent of GF grant funds allocated to Tanzania are earmarked for procurement of medicines and health commodities. The scale-up of ART services for HIV/AIDS and national level adoption of ACTs for treatment of malaria has meant that increased quantities of ARVs, anti-malaria medicines, diagnostic agents and laboratory supplies and condoms have to be bought and supplied to health facilities. Procurement and Supply Management (PSM) for drugs and health commodities under GF grants is primarily the responsibility of the MSD, an autonomous unit under the MOHSW, and the Procurement Management Unit (PMU) of the MOHSW. While the MSD with its nine zonal stores/warehouses across the country is responsible for procurement, storage and distribution of drugs and health commodities under the grants, the PMU of the MOHSW handles mainly procurement contracts for Long Lasting Insecticide-treated Nets (LLINs) and service contracts for maintenance of laboratory equipment, for GF health programs. OIG also audited procurement of vehicles and equipment carried out by the civil society grant recipient, AMREF.

PSM capacity assessment

49. OIG established that while a PSM capacity assessment was done in 2004 for MSD, no such assessment was completed for the PMU of the MOHSW. The capacity assessment carried out for MSD was inadequate as it did not cover key PSM components such as logistics management and storage capacities at the district and service delivery points such as health centers and dispensaries. OIG also noted that PSM plans for the PMU of the MOHSW have not been reviewed and approved as required by GF policies and procedures.

50. GF grant programs in Tanzania have been beset by procurement and supply chain management challenges that have led to delays in implementation of program activities, resulting in unspent grant funds, lack of maintenance contracts for laboratory equipments, and stock outs of laboratory reagents for haematology and biochemistry analyzers. The imminent start of Round 8 grants which have large procurement components will put additional pressure on over-stretched PSM structures and systems.

51. Capacity strengthening activities have been ongoing at MSD supported by donors including the GF. Most recent support from the GF was in November 2007 with a USD 2.4 million disbursement to improve storage, provide equipment, upgrade the management information system and provide training. But these capacity strengthening activities have not been fully implemented because of slow and long-winding administrative processes.

Recommendation 1 (High)

A detailed assessment of procurement capacities of the MSD, the PMU and the supply chain at all key levels need to be carried out by the LFA before the onset of Round 8 grants.

Forecasting Demand for Medicines and Health Products

Current procedures for quantification and forecasting of medicines have resulted in oversupply and expiry of drugs.

52. Good forecasting of demand for medicines, test kits and other health supplies is important to ensure continuity of supply of these items for treatment programs, while mitigating the risks of oversupply resulting in the expiration of drugs. To this end, OIG assessed the adequacy of forecasting procedures used for Anti-retroviral drugs (ARVs) and for anti-malaria medicine artemether-lumefantrine, an artemisinin-based combination therapy (ACT).

Forecasting antiretroviral medicines for HIV/AIDS

53. Forecasting and quantification procedures were based on standard treatment guidelines and also involved a review of reports from district management teams as well as from disease surveillance monitoring and supervision reports. In addition, data on ARV issues to Care and Treatment Centers (CTCs) and stock on hand at the MSD central and zonal stores were taken into account. Further, forecasting was based on a desired total program supply pipeline of 15 months maximum and 9 months minimum stock levels⁴. The long supply pipeline is intended to accommodate long delays in the procurement process noted in the procurement section of this report and the logistics difficulties of distributing drugs in the country.

54. OIG however noted that for quantification of ARVs, existing stock levels for drugs in the district stores and in the CTCs were not taken into account to arrive at estimates of drug requirements. This has led to oversupply problems.

Forecasting anti-malaria medicines - ACTs

55. Similarly for malaria, standard treatment guidelines for ACTs are used as the base for forecasting and quantification by NMCP. This is adjusted as needed to reflect "assumed" consumption rather than actual consumption data.⁵ Account is also taken of information from staff monitoring and supervision reports, district malaria reports and analysis of service statistics. Also, interviews with in-country partners are conducted to learn of program requirements and future needs for anti-malaria treatment. Forecasting was

⁴ National Quantification of ARV Drugs and HIV Test Kits for 2008 – 2009, page 31

⁵USAID/Deliver Project, 'National Quantification Review for Anti-malarial Commodities/Program Management', 6-24th October 2008.

based on a desired total program supply pipeline of 12 months maximum and 8 months minimum stock levels of ACTs⁶.

56. Although quantification procedures for ACTs took into account stock levels at MSD and orders placed or expected arrivals, stock levels at health facilities were not considered before determining national estimates of demand. A national stock taking exercise was recommended to be done "as soon as possible to determine the stock status of the facilities to ensure that the next round of supplies is targeted to fill in the gaps for those weight bands in short supply"⁷. Field visits to validate data obtained from the quantification were not carried out. Finally, actual consumption data at health facilities were not collected and used for forecasting.

57. In OIG's view, the quantification for ACTs described above for a product with a two-year shelf-life and maintenance of a supply chain of 8 to 12 months is bound to result in a high level of expired drugs. However, the value of ACTs that OIG noted had expired during the audit was estimated at USD 130,000.

Recommendation 2 (High)

The quantification exercise must use actual consumption data at health facilities and take into account existing stock at all levels of the supply chain to arrive at good estimates of stock needs.

Recommendation 3 (High)

The MOHSW should review the current practice of maintaining the program supply chain for ACTs at a minimum 8 months and a maximum of 12 months of supply needs since these anti-malaria medicines have short-shelf lives. Further, the ARV supply pipeline of 15 months maximum and 9 months minimum stock levels should be reviewed to prevent oversupply.

Integrated Logistics System

Actual consumption data on medicines and health supplies are not reported by health facilities under the recently introduced Integrated Logistics System (ILS).

58. As stated above, data on actual consumption of medicines and health supplies if collected and reported to the national programs and MSD would help in justifying quarterly stock requirements of health facilities and improve forecasting of national demand requirements. OIG found that record-keeping for usage of medicines and health supplies was inadequate in most health facilities visited by the OIG team. Due to workload issues and staff shortage in the health facilities, stock ledgers are not routinely maintained and patient

⁶ USAID/Deliver Project, Technical Assistance Record page 4, October 2008

⁷ Ditto

registers are not regularly updated with medicines and supplies dispensed. This situation does not enhance accountability.

59. Until recently, because of lack of reliable actual consumption data, medicines and health supplies have been distributed to health facilities on the basis of consumption estimates and disease prevalence. This system of supplying medicines to health facilities has been described as the "push system". And it has resulted in overstocking and expiry of drugs on the shelves, together with stock imbalances between packages for different age and weight groups of patients (see service delivery section of this report).

60. The MOHSW in collaboration with its development partners has taken the initiative to rectify some of the weaknesses of the supply chain created by the "push system" by developing the ILS. The ILS requires health facilities to request their supply needs and report on their previous consumption quarterly using a Request and Report (R&R) form which would be sent to MSD zonal store/warehouse through the district medical office (DMO). There are plans to integrate drugs for HIV/AIDS, TB and malaria if the ongoing pilot phase is successful.

61. OIG, however, found that the R&R Form does not require facilities to report actual consumption of medicines and health supplies i.e. the quantity of medicines dispensed to patients during the reporting period. Consumption of each medicine or health product, as stated on the form, is calculated using a formula that adds the opening stock balance to the stock received during the period, less any stock adjustments/losses and closing balance to arrive at an estimated consumption. This system of calculating consumption does not take account of the risk of theft and misuse of drugs.

Recommendation 4 (Significant)

To enhance accountability for medicines and health supplies, the MOHSW should ensure that actual consumption data for ARV drugs, medicines for treatment of TB, malaria, opportunistic infections (OIs), and other health supplies are recorded and accounted for in stock ledgers and patient registers. These data should be reported in quarterly reports to both MSD and the national programs.

Procurement

The Medical Stores Department (MSD) and the Procurement Management Unit (PMU) of the MOHSW which are responsible for procurement for the public sector grant recipients are expected to follow Tanzania's public procurement legislation and regulations which, in general, conform to Global Fund's procurement policies. But there were long delays in procurement principally due to capacity shortcomings of the two entities responsible for procurement in the public health sector in Tanzania.

62. Audit criteria used by OIG was based on the expectation that procurement is carried out under the grants in an open, competitive transparent manner;

and that best value prices are paid for goods and services of assured quality. To this end, OIG audited procurement carried out by MSD for medicines, health products and civil works; by AMREF for vehicles and laboratory equipment; by the Procurement Management Unit (PMU) of MOHSW for contracted services; and by NMCP for bed-nets.

63. Procurement under GF grants was carried out according to Tanzania's Public Procurement Act of 2004 and the Public Procurement Regulations of 2005. Generally, OIG found that these procurement regulations conform to GF procurement policies. However, according to these national regulations framework contracts are only possible for a duration of one year and there are no provisions to expedite the process for emergency procurement when it is considered necessary. This limitation contributes to delays in procurement.

Procurement: Procurement Management Unit (PMU) of the MOHSW

64. Program officials responsible for HIV/AIDS, TB and Malaria cited delays in procurement as one of the key factors that affect timely program implementation. This is partly due to the lengthy national procurement processes and procedures, and the limited human resource capacity of the MOHSW's PMU to cope with increased donor inflows. According to a 2007 World Bank Report⁸, 60 percent of the MOHSW budget is used for procurement.

65. OIG noted the following weaknesses in its review of the operations of the PMU.

- (a) Continuing procurement backlogs;
- (b) Lack of prioritization of procurement activities in the annual procurement plan;
- (c) Inadequate monitoring of suppliers awarded contracts;
- (d) Unsatisfactory maintenance of contract documentation; and
- (e) As noted in the PSM capacity assessment section of this report, the PMU has been assigned the responsibility of procuring health commodities such as Long-Lasting Insecticide-treated Nets (LLINs) without prior PSM capacity assessment as required by GF policy.

Procurement: MSD

66. In its review of procurement of medicines, health products and civil works carried out by MSD, OIG found the following weaknesses:

- (a) Procurement of ARV medicine (Stavudine 40mg capsules) in 2005 from a manufacturer which had no WHO prequalification. The amount of the purchase was USD 469,000. MSD explained that this was an oversight as the purchase of these medicines was inadvertently included in a purchase

⁸ Mneney D and Kayani R. 'Developing a Workplan to Strengthen Procurement Capacity of the Ministry of Health and Social Welfare (MOHSW)'. World Bank Report, 2007.

order for GOT drugs financed with domestic funds which had different regulations.

- (b) Delays in procurement caused by late receipt of funds from the national programs, slow procurement procedures and poor communication between the national programs and MSD.

Procurement: AMFREF

67. OIG reviewed procurement of vehicles and laboratory equipment carried out by AMREF and found the following weaknesses:

- (a) Lack of standardized tender documents;
- (b) Sufficient time was not given to suppliers to bid as required by procurement regulations;
- (c) The preferred media for advertising international competitive tenders were national newspapers, and this limited competition to national suppliers.

68. OIG noted that AMREF have taken steps to address these shortcomings by strengthening the capacity of its procurement unit. And Recommendation 1 above addresses the capacity issues of both MSD and PMU.

Supply Chain Management

The Orion computerized inventory system cannot be relied upon to provide management with accurate information to monitor and react to problems in the supply chain.

Inventory Control and Stock Management at Medical Stores Department

69. In the health sector, a good inventory management system is essential in determining when to order stocks, quantities to be ordered and it assists health and procurement officials to maintain optimal stock levels to avoid stock outs or be confronted with significant oversupply situations of some medicines and health supplies. In the case of Tanzania, given the volume of procurements of medicines and health supplies under the grants, a well-functioning inventory control and management system is necessary to establish tracking and accounting for procurement, storage and distribution of medicines and other health products in the entire supply chain.

70. MSD uses a computerized inventory control and stock management system called Orion which was put into operation in 2001, prior to the inception and subsequent scale-up of GF and other donor programs in the country. OIG noted the following weaknesses some of which have also been documented in previous reviews⁹ of both the Orion system and MSD's stock management and supply chain.

- (a) Unreliability of the computerized system due to frequent downtimes;

⁹ PKF Consulting Ltd. Sept. 2008 Report on the Audit of the Orion System; and LFA ACT Review Report of Oct. 2008

- (b) The system allows deletion of transaction records without leaving an audit trail;
- (c) Issues and receipts of medicines and health supplies are not correctly recorded in the computerized system;
- (d) Medicines and health supplies bought with GF resources do not carry any value in the Orion system; a practice which does not facilitate valuation of stock on hand, and expired stocks or losses.
- (e) Medicines of significant value that could not be accounted for e.g. ACTs valued at USD 819,000 were found to be missing in 2007¹⁰;

71. The LFA in its review of missing ACTs cited the following weaknesses as contributory factors:

- (a) Weaknesses and capacity problems of the Orion system which has frequent downtimes that necessitate manual recordkeeping;
- (b) Manual records are not maintained when Orion system is off-line; and
- (c) Orion system is not updated with the manual records when the system is back on line.

72. Consequently, information from the computer system on stock receipts, issues and balances cannot be relied upon for decision-making. From a review of MSD internal audit reports¹¹, OIG noted that internal control weaknesses and theft detected and/or committed were facilitated by deficiencies in the Orion system and a weak control environment over stock at MSD. For instance, MSD's Internal Audit investigation report of October 2007 on missing/stolen medicines valued at USD 133,000 (163.2 million TZS) attributed the loss to the following weaknesses:

- (a) Unauthorized stock adjustments created in the Orion system to write off some of the stolen items;
- (b) Posting of fictitious issue vouchers;
- (c) Warehouse staff who were not aware of their responsibilities; and
- (d) Inadequate warehouse security.

The missing/stolen drugs noted above were not procured with GF resources.

73. OIG reviewed stock status reports generated by MSD's computerized inventory control system for a sample 125 health products including ARVs, ACTs and other health supplies. OIG noted stock adjustments that have been made without documented explanation and approval by MSD's senior management. Consequently, monitoring of controls over stock by MSD management is weakened, leading to lack of transparency and accountability. In OIG's view these unexplained stock adjustments expose medicines and health supplies to risk of theft and misuse. The table below shows a sample of medicines and health products from the MSD central store with major adjustments during 2008.

¹⁰ LFA report on the ACT Supply Review, Malaria Round 4, Tanzania, page 3; dated October 2008

¹¹ MSD Internal Audit Report on Investigation of Loss of Stock (Pharmaceuticals), 5th October 2007

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74. OIG calculated that 78 percent of the stock items reviewed had stock adjustments, but the reasons why they arose were not evident. As shown below, stock balances of antiretroviral combination drugs Lamivudine 150mg + Stavudine, and Zidovudine 300mg + Lamivudine were reduced (adjusted negatively) by 99 percent and 85 percent respectively to align with the low stock on hand at the end of 2008. Further, the antifungal medicine Fluconazole had a positive adjustment of 300 percent of stock in the books while biohazard bags had a positive adjustment of 17 times the available stock on hand at the end of 2008.

Drug	Unit	Stock at start of 2008	Receipts	Total issues	Stock adjustment	Expired	Goods in transit	Stock at end of 2008
Co-trimoxazole Tabs 400mg	1000T	9888	71606	42475	11665	0	0	50684
Ciprofloxacin Tabs 500mg	100T	4854	0	3265	-10	-1579	0	0
Fluconazole 150mg Tabs P10	Each	0	145000	39365	322888	0	0	428532
Nevirapine Tabs 200mg	60T	0	177657	124592	-44757	0	0	8308
Stavudine Caps 40mg	60T	4563	19633	73	-10396	-3911	0	9816
Zidovudine Oral Sol 10mg	100ml	140772	0	127419	-6750	-6541	0	62
Lamivudine 150mg + Stavudine	60T	148	508884	404061	-103367	-20	0	1584
Zidovudine 300mg + Lamivudine	60T	0	167285	109714	-48660	0	0	8911
Lamivudine 150 mg Tabs 3TC	60T	0	76385	79414	6418	0	0	3389
Nevirapine oral sol 50mg	100ml	2190	315865	146126	-1226	-45	-3600	167058
Biohazard bags (autoclave) 1	Pieces	22500	0	0	380000	0	0	402500
HIV Rapid test kit SD-Bioline	Kit/25	19681	0	47852	36791	0	0	8620
FACS Calibrite 3APC	P25	0	16	0	-16	0	0	0
Cryotube 2 mls	Pieces	924	0	115103	196881	0	0	82702
Male Latex condoms	P100	0	405000	126889	-58940	0	0	219171
R&R form	Book	500	0	0	-500	0	0	0

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Drug	Unit	Stock at start of 2008	Receipts	Total issues	Stock adjustment	Expired	Goods in transit	Stock at end of 2008
ACTs	180T	47698	98067	174080	27737	-502	2056	1724
ACTs	360T	59921	64732	99440	5773	-1362	1028	30652
ACTs	540T	23015	49377	56556	13856	-232	514	29974
ACTs	720T	42225	116312	179859	29449	-398	2056	9919

Table 2: Sample of stock adjustment from MSD Orion system (Source: MSD); Periodic Stock Movement Report Summary from Jan. to Dec. 2008 for GF (category B), printed on 13th February 2009.

75. MSD management said that the computerized inventory system and the reports it generated are unreliable. In OIG's view this explanation is unsatisfactory since a reliable inventory management system is essential to enhance accountability for medicines and health supplies procured with grant funds. Further, for sound decisions to be made on the supply chain, management needs accurate data. Also, if information generated from the system cannot be relied upon this compromises the quantification and forecasting exercise undertaken by the national programs.

Recommendation 5 (High)

Adjustments to stock on hand should be made only in cases of expired drugs, theft and damage. And all such adjustments should be explained, documented and subject to prior approval by MSD senior management and notification of MOHSW.

Recommendation 6 (Significant)

Medicines and health supplies bought with GF resources should be carried in MSD's inventory at cost to facilitate calculation of stock on hand, expired stocks, and to enhance accountability.

Recommendation 7 (High)

The MOHSW and MSD should consider seeking funding either to improve MSD's Orion system or replace it with a system that is more reliable and can enhance accountability of medicines and health supplies.

Stock levels of ACTs and ARV drugs in the Supply Chain

OIG observed oversupplies of ACTs and ARV drugs in the supply chain that have led to expiry of stocks.

76. OIG noted overstocking of ACTs and ARV drugs at the MSD central store and in some health facilities in Moshi, Tanga and Iringa regions visited by the OIG team. Overstocking of ACTs and ARVs medicines was mainly caused by inaccurate forecasts of the rate of consumption of these medicines at health

facilities. It has led to expiry of medicines resulting in waste of resources and congestion of limited storage space by expired drugs.

77. Review by OIG of MSD's stock movement report for four dosage categories of ACTs showed anti-malaria medicines that have expired as indicated in the table below.

Size of package	Months of stock on hand at 31/12/08	Months of stock including quantity on order/shipped at 29/1/09	Expired Stock at MSD warehouse on 31/12/08
180T	3.5	19	537
380T	5.6	17	3747
540T	9.6	10	819
720T	5.3	34	158

Table 3: Expired stock of ACTs at MSD on 31 December (Source: MSD records)

Also, stocks of ARVs and ACTs which OIG team found to have expired at the Iringa Regional Hospital are shown in the table below.

Drug	Pack	Date of expiry	Quantity expired
Triamune 40	60	09/2008	147
Abacavir Tabs 300 MG	60	12/2008	5
Nevimune Oral Suspension 9Syrup)	60	06/2007	3
Artemether-Lumefantrine	540	12/2008	13

Table 4: Expired drugs at Iringa Regional Hospital (Source: Iringa Regional Hospital inventory records)

78. Additionally, OIG found expired ACTs at some of the health facilities visited by the audit team in Moshi zone, namely, at the health centers in Pasua, Kiboriloni and Umbwe.

79. OIG also verified stock levels of a sample of ARV drugs at MSD central store and found that they exceeded established optimal levels necessary to maintain continued supply of these drugs to end users. The data presented below, obtained from MSD inventory records, showed that stock levels of some ARV drugs range from 17 to 96 months of supply needs. In OIG's view, stock levels of this magnitude take up storage space and could lead to unacceptable quantities of expired drugs in the supply chain.

Drug	Size of pack	Stock at 29/1/09	Months of stock
Didanosine Tabs 25mg (Ddl)	60T	874	8.0
Didanosine Tabs 100mg (Ddl)	60T	28,837	27.0
Efavirenz Tabs 50mg (Efv)	30T	116,267	96.9
Stavudine Tabs 15mg (d4T)	60T	13,679	33.7
Stavudine Tabs 20mg (d4T)	60T	5,718	21.4
Stavudine Oral Solution 1mg/ML	200ML	18,681	25.0
Nevirapine Oral Solution 10mg/	100ML	158,534	17.7
Zidovudine Tabs 100mg (AZT or ZDV)	100T	35,369	29.0
Stavudine+ Lamivudine + Nevirapine	60T	69,885	40.6
Efavirenz Tabs 600mg (Efv)	30T	714,924	8.9
Efavirenz Tabs 200mg (Efv)	90T	18,394	2.7
Lamivudine Oral Solution 10mg	100ML	236,127	4.7

Table 5: Stock levels of selected ARVs drugs at MSD central store on 29/1/09 (Source: MSD records)

80. OIG found inventory control and record-keeping to be poor in most health facilities visited. For example, at Majengo Health Center in Tanga region, OIG observed that staff were dispensing ACTs expiring in year 2010 instead of stock on hand that will expire in February and March 2009. Principles of first expiry first out (FEFO) and other good storage practices were not being complied with. Further, in Bombo Hospital in Tanga stock ledgers had not been updated since June 2008. Also, because of stock outs of R&R forms, orders for stock were made on blank sheets of paper.

81. At MSD's Iringa zonal warehouse, no reorder quantity levels have been established to minimize stock outs. And monthly stock count sheets were not kept to confirm that stock counts take place as per policy.

Recommendation 8 (Significant)

Senior management of MSD and MOHSW should monitor regularly the supply chain at all levels to ensure that slow-moving stocks which risk expiring are moved to facilities that could use them before they expire.

Recommendation 9 (High)

Accurate data on stock covering stock on hand, actual consumption, expected stock arrivals, losses and adjustments need to be collected and communicated to senior management of MSD and MOHSW on a regular basis to enable them to make informed decisions.

Recommendation 10 (Significant)

Staff at all levels of the supply chain need to be trained in basics of good inventory management and storage practices; and it is important that quality of inventory management at health facilities be monitored regularly by supervision teams from MOHSW.

Warehousing and Storage

Storage capacity is overstretched at all levels of the supply chain which affects the storage condition of medicines and risks compromising the efficacy of drugs.

82. MSD's storage facilities at its central store and zonal warehouses are stretched by the increased throughput of antiretroviral drugs and ACTs due to the scale up of treatment programs. Furthermore, the current policy of keeping minimum stock levels of 9 months for ARV drugs and 8 months of ACTs medicines further aggravates the storage problem. Although OIG found Moshi and Tanga zonal warehouses to be well built, both were operating at stock-holding capacity limits and were not properly organized to facilitate inventory tracking and management.

83. OIG however noted the efforts of MOHSW and MSD management to address the storage problem. For example, new warehouses have recently been built in Dodoma and Iringa regions. In addition, OIG learnt that MSD management has planned to increase storage capacity at the zonal warehouses in Mwanza, Mtwara and Dar es Salaam. However, the policy of keeping high stock levels of medicines, particularly ARV drugs, in the supply chain means that more storage capacity would be needed as the number of patients put on antiretroviral therapy grew.

84. All medicines and health supplies procured by MSD are delivered to the central store in Dar es Salaam. This practice increases congestion at the central store. MSD does not require suppliers to make deliveries of goods ordered directly to zonal warehouses even when suppliers operate nationwide. Further, international suppliers could be instructed to ship goods directly to zonal warehouses to ease storage constraints at the central store.

85. OIG found storage conditions for medicines and health supplies to be substandard in all health facilities visited in Tanga, Moshi and Iringa regions. OIG found stores which were not properly organized and well ventilated which could compromise the efficacy of drugs.

Recommendation 11 (Requires attention)

The MSD should consider shifting some deliveries of medicines and health supplies to zonal stores/warehouses to ease storage problems at the MSD central store.

Recommendation 12 (Significant)

The MOHSW should review the current practice of maintaining high stock levels in the supply chain to ease overstretched storage capacity at all levels of the supply chain.

Stock outs

Stock outs of ARV medicines, ACTs and laboratory reagents were found at some health facilities visited by the OIG team.

86. OIG found that laboratory reagents for biochemistry and haematology analyzers were out of stock in the care and treatment centers visited by the team. For example, stock-outs of reagents were noted at Iringa Regional Hospital and Tosamaganga District Hospital in Iringa Region and at Muheza District Hospital in Tanga Region. Hospital officials explained that they were obliged to obtain emergency supplies from their technical partners in order to carry out laboratory investigations among HIV/AIDS patients. Further, OIG learnt that haematology and biochemistry reagents procured for monitoring anti-retroviral treatment of HIV/AIDS patients are also utilized by non-HIV/AIDS services which is a contributory factor to the shortage of these reagents.

87. OIG also analyzed stock-outs of a sample of ARVs at the regional hospital in Iringa and the results obtained are shown below. OIG noted that some ARV drugs were out of stock for unreasonably long periods of time that ranged from two weeks to six months.

Drug	Date of stock-out	Date new order was received	Number of days out of stock
Efavirenz (200MG)	05/09/2008	28/10/2008	53
Efavirenz (200MG)	07/11/2008	15/01/2009	68
Zidovudine Tabs 300MG	18/10/2008	05/02/2009	131
Zidovudine Tabs 300MG	05/09/2008	08/09/2008	3
Stavudine Caps 30 MG	01/07/2007	10/07/2007	9
Stavudine Caps 40 MG	01/07/2007	23/08/2007	53
Syrup Lamivudine	02/10/2008	03/10/2008	1
Triomune Baby	04/07/2008	05/12/2008	180
Syrup Cotrimoxazole	14/03/2008	04/04/2008	19

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Syrup Cotrimoxazole	02/05/2008	06/05/2008	4
Syrup Cotrimoxazole	16/10/2008	28/10/2008	12
Syrup Cotrimoxazole	14/08/2009	15/08/2009	1
Zidovudine 100 MG	24/07/2008	28/10/2008	92
Caps Stavudine 30 MG	19/01/2009	05/02/2009	15

Table 6: Stock-outs of ARVs at Iringa Regional Hospital (Source:/Iringa Regional Hospital records)

88. Also, stockouts of ACTs for adults were observed by OIG in a sample of health facilities visited by the OIG team as shown in the table below.

Name of Health Facility	Stock situation of ACTs	Status of inventory records	Other observations
Mawenzi Regional Hospital, Kilimanjaro region	Frequent stock outs of ACTs	Stock ledgers not updated since May 2008	
Kiboriloni Dispensary, Kilimanjaro Region	Overstocking of ACTs	Stock ledger well kept	
Majengo Health Center , Kilimanjaro Region	Overstocking of some categories ACTs	ACT form completed; but orders of some stock made on blank paper instead of R&R form.	
Umbwe Health Center, Kilimanjaro Region	Overstocking of ACTs	No stock ledgers are maintained	Drugs for opportunistic infections and reagents are ordered on blank paper instead of R&R form
Pasua Health Center, Kilimanjaro region	Overstocking of ACTs	Stock Ledger maintained, but with no dates.	
MSD store/warehouse in Tanga Region	Stock out of ACTs for adults	Computerized inventory records	No manual backups are maintained for stock records
Bombo Regional Hospital, Tanga region	Stock out of ACTs for adults	Impressive computerized inventory system.	
Ngamiani Health Center	Stock out of ACTs for adults		R&R for malaria completed for Oct/Dec 08. Ordered in January but not yet replenished.
Makorora Health Center	Stock out of ACTs for adults	No stock ledgers kept or available.	Last order of ACTs was in Sept. 2008

Table 7: Stock situation of ACTs and status of inventory records in selected health facilities visited by OIG (Source: records at facilities visited)

Recommendation 13 (requires attention)

MOHSW should establish reorder quantity levels for medicines and health supplies to minimize stock-outs.

Service Delivery

HIV/AIDS

HIV infection is endemic in Tanzania at a relatively high level of prevalence but with a shifting socio-demographic profile. The response to HIV is almost predominantly funded by international organizations.

89. HIV infection in Tanzania is endemic with about six percent of the adult population living with the virus. This situation has been stable since the beginning of the decade. There is, however, considerable heterogeneity in HIV prevalence in the country. HIV prevalence in urban areas is almost twice the prevalence in rural areas. It is highest along the trucking routes and at the main border crossings to Zambia. It is highest in regions that have low male circumcision rates. It is highest among women in their early 30s and among men in their late 30s.¹²

90. Some shifts in this pattern are emerging. In 2003, wealthy and educated Tanzanians in urban areas had the highest HIV prevalence. In 2008, this HIV profile is gradually changing.¹³ The dynamics of this change are complex. HIV prevalence is related to the rate of new infection and to the survival of those already infected. A higher incidence of HIV infection among the poor, the uneducated, and the rural population may be partially hidden in the prevalence statistics because they have less access to testing and treatment and less chance of survival. An opposite effect may be observed in the gender distribution of HIV. There are about 40 percent more women than men living with HIV in Tanzania¹⁴, and OIG observed that women outnumbered men in the ART clinics by as many as four to one in some locations. Higher incidence and more access to treatment among women may act jointly to increase the gender imbalance in recorded HIV prevalence in Tanzania.

91. The financial resources for the response to HIV in Tanzania in the 2008/09 Fiscal Year are expected to be around 550 billion Tanzania Shillings (TZS) (about USD 423 million), 95 percent provided by international donors. The US Government and the GF are the largest financial contributors to the national response to HIV. In 2008, they accounted for 86 percent of all HIV program expenditures in the country. Not captured in these statistics is the international contribution to budget support and to the sector-wide health program assistance.¹⁵

¹² ASAP; The HIV epidemic in Tanzania Mainland. November 2008

¹³ ASAP; op. cit.

¹⁴ ASAP; op. cit.

¹⁵ TACAIDS; op.cit.

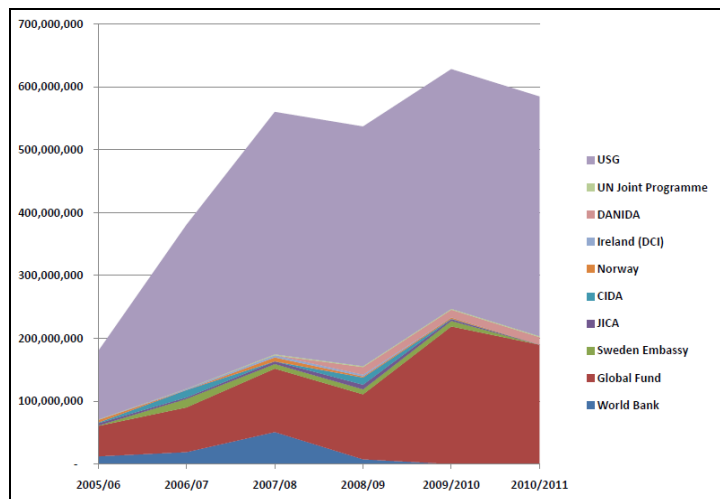


Figure 1: Evolution of donor support to HIV programs in Tanzania

HIV Care and Treatment

Tanzania, with assistance from development partners, has made impressive gains in providing care and treatment for people living with HIV. The decentralization of treatment services is proceeding rapidly, aided by the decision authorizing paramedical staff to administer ART. However, the procedures for certifying HIV care facilities are not being followed as planned, and some inappropriate certifications are made. Treatment retention for patients on ART is not known but in a small sample observed it was in line with the average in Africa. There is no clear policy directive about the management of drugs and laboratory reagents that are not exclusively used for HIV care.

92. In the Tanzanian HIV Care and Treatment Plan of 2003, the number of certified facilities providing HIV care was projected to reach 247 by 2008. By September 2007, 200 health facilities had been certified to provide ART, and an additional 500 were selected for ART roll-out. Certification of these 500 is on-going. Several of the health centers visited by the OIG team had just been certified or were about to be certified. The 2003 HIV Care and Treatment Plan projected 1.7 million clients under care by 2008, with 423,000 of them on ART.¹⁶ In 2005 the target for those on ART was reduced to 250,000. The actual result for those on ART in 2008 is between 170,000 and 180,000. Further downward adjustments of treatment targets were being made by the MOHSW at the time of the audit because of improved demand projection and lower than predicted HIV prevalence rate.

93. The expansion of the network of HIV treatment sites in Tanzania is an absolute necessity because (a) the cost of travel to the nearest site in rural areas is a major barrier to access and a main contributor to treatment non-

¹⁶ Government of Tanzania and Clinton Foundation; HIV/AIDS Care and Treatment Plan 2003-2008; Business Plan 4.0; September 2003

adherence;¹⁷ and (b) the original sites that were established after 2005 are hopelessly congested. The two hospitals visited by the OIG team in Tanga Region, Bombo Regional Hospital and Muheza District Hospital, provide ART to more than 2,000 patients each. This equates to more than 100 patients per day just for prescription refills, not counting all those who have not yet started ART and those who are newly arriving at the facility. From the patients' perspective it means a whole day of waiting each month just to get their repeat ARV prescription.

94. The decentralization and decongestion of services is made possible by a decision of the MOHSW authorising para-medical personnel (Assistant Medical Officers and Clinical Officers) to administer first-line ART. Although there is a severe shortage of health workers in the country, this delegation of treatment mitigates the worst of the human resources shortage on HIV care. Among the 14 HIV care sites visited by the OIG team, only two in Iringa Region and one in Kilimanjaro Region had human resource shortages severe enough to affect service provision. This, however, is not a representative sample. A joint presentation made by the heads of the Health and the AIDS Development Partner Groups in May 2008 reported that only 33 percent of public health posts in Tanzania are filled, and that the concentration of health workers responsible for HIV care leaves few staff behind to perform other routine health services.¹⁸

95. The process of certification of facilities for HIV care is well organized on paper. Certification can be on three levels, as an "Initiating Site" authorised to start ART, as a "Refilling Site" authorised to provide treatment that has been initiated elsewhere, and as an "Outreach Site" accommodating visiting teams from a nearby treatment center to provide on-site care for patients. Certification involves an initial visit by the NACP together with the District and Regional AIDS Coordinators. A structured assessment report is prepared and an improvement plan is developed for the facility, to be implemented over a three month period. A second visit then verifies the improvements and recommends certification. The OIG team however was unable to locate a single copy of an "improvement plan" either at the facility or at the District or Region for any of the six recently certified facilities visited. Some of these facilities were providing a remarkably good level of care. However two were in such a state of mismanagement and general disorganization, that the OIG team had concerns about their ability to provide adequate HIV care. This was signalled to the District Health Management Teams.

96. Anti-retroviral drugs were generally available in abundance in all HIV care facilities although there were serious supply management issues that needed to be addressed as detailed above in the supply chain management section of the report. Whenever shortages of drugs had been experienced in the past, the regional US-Government supported partners had usually acted quickly to

¹⁷ J. Cornell; Here we are far – I wonder if they hear us?: Draft report of a case study in Tanzania prepared for the WHO-Italian initiative on HIV/AIDS. (undated)

¹⁸ C Wainwright (Lead DPG Health) & E Jensen (Lead DPG AIDS); Strategic HIV Issues for the Development Partners' Group; May 2008

close the gaps. The issue of provision of Cotrimoxazole is more complex. The medication is dispensed free of charge to persons living with HIV who are not yet on ART in order to protect them from opportunistic infections. Most HIV positive patients on the tuberculosis registers are receiving Cotrimoxazole according to the register. In the HIV clinic registers, however, only a minority of patients were on this medication. Cotrimoxazole for HIV care is provided to the health facilities at no cost. However, Cotrimoxazole is also dispensed on a cost-recovery basis to patients with respiratory or urinary tract infection. Some facilities maintain separate stocks of the medication (one lot for people with HIV, one lot for others). Most of the time the first lot was exhausted unless it had been replenished by one of the US-funded partners. Muheza District Hospital kept a consolidated stock and claimed that it is paying for all the Cotrimoxazole it receives. According to the hospital pharmacist, the hospital dispenses the drug free of charge to people living with HIV and absorbs the cost in its general budget. In most facilities visited the predominant sense was confusion. There is a similar issue with Fluconazole, a medication with a similar double profile. Since Fluconazole, in contrast to Cotrimoxazole, is an expensive drug, it is even more often unavailable. Among the facilities visited, the OIG team only noted a significant stock of Fluconazole in the pharmacy store in one hospital (Same District Hospital).

97. The issue of laboratory equipment and reagents for CD4 counting, haematology profiles, and liver and renal function tests is also critical. None of these tests are essential but they are highly desirable for quality HIV care. Many of the hospitals visited had problems with maintaining the national standards of laboratory investigation. Equipment for CD4 counting was generally functioning, but there had been frequent shortages of reagents in the past year because of procurement delays noted in the procurement section of this report. Most of the time these supply gaps of reagents were bridged with emergency procurement by partners. The shortage of reagents was caused by bottlenecks and delays in the procurement process noted in the procurement section of this report. Automated haematology and biochemistry analyzers in several hospitals were not functioning. Some of the machines needed servicing, others were non-standard models for which no reagents were available in the country. In several facilities there was a stock-out of reagents. The situation observed in the seven Regional and District Hospitals visited during the audit is summarized in the following table.

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Hospital	CD4 Counter	Haematology Analyzer	Biochemistry Analyzer
Mawenzi Regional Hospital	Working	Working	Working
Bombo Regional Hospital	Working	Working	High volume: defective Stand-by: working
Iringa Regional Hospital	No reagents	No reagents	No 1: no reagents No 2: defective
Muheza District Hospital	Working	Working	No reagents
Same District Hospital	Working	No reference samples	Working but insufficient reagents
Tosamaganga District Hospital	Working	No reagents	Defective
Ilula District Hospital	No equipment	No reagents	No equipment

Table 8: Laboratory situation observed at the time of the audit (OIG field visit notes)

98. Despite these problems of supply management and clinic overcrowding, the OIG team observed a reasonably good level of care in most facilities visited. A meeting with a group of about 25 people living with HIV in Tanga confirmed this impression. Most of them had been on ART for more than three years. They appeared in good health, and they were satisfied with the service they received. The registers and the quarterly and monthly reports from the facilities visited indicated that people living with HIV who are not on ART visit the clinics infrequently unless they fall ill. The overcrowding and long waiting lines may be a factor. The main indicator of quality of care, however, is the treatment retention rate among those who started ART. This critical information can be obtained from the CTC database (see M&E section) but it is not yet being analyzed by the NACP on a national scale because of incomplete data and errors in reports received directly by NACP from treatment centers. OIG obtained the treatment retention analyses for Mawenzi Regional Hospital and Same District Hospital performed on the same database by EGPAF, a US-funded organization supporting HIV/AIDS services in Kilimanjaro Region. They indicate that after six months, nearly 90 percent of patients were still on treatment, after 12 months it was between 70 percent and 80 percent. These are data from just two hospitals and not national data, but they compare well with the average ART retention rates reported in other settings in Africa.¹⁹ The main reasons for non-retention are loss to follow-up and death.

Recommendation 14 (High)

The NACP should apply its instruments and procedures for the certification of HIV care and treatment sites more rigorously and include an assessment of the general quality of patient care in its certification criteria.

¹⁹ S Rosen, M Fox, C Gill; Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review; PLoS Medicine, Volume 4, Issue 10, October 2007

Recommendation 15 (Requires attention)

The MOHSW should develop clear guidelines for health facilities on how to manage drugs and supplies that are provided free of charge to patients with HIV/AIDS and that are at the same time dispensed to other patients on a cost recovery basis.

HIV Testing and Counseling

HIV testing and counseling, both voluntary and provider-initiated, is taking place in many different locations. In 2008, 37 percent of women and 27 percent of men reported that they had been tested at least once, 19 percent of both men and women within the last year. These are high testing rates and they are an impressive achievement. This information is collected in the Tanzania HIV and Malaria Indicator Survey (THMIS) and provides a much better indicator of performance than the numbers of tests counted for Global Fund performance monitoring.

99. HIV testing and counseling takes place in many different facilities and under many different circumstances in Tanzania. Many tests are performed during national testing campaigns. A report of the last testing campaign in June 2008 stated that 4.8 million people were tested. In addition, there are a large number of fixed and mobile voluntary counseling centers operating year-round in health facilities and by NGOs and community-based organizations. HIV testing and counseling initiated by health care staff also takes place in all tuberculosis clinics, in all ante-natal clinics, and on the wards and in the outpatient clinics of hospitals, health centers, and dispensaries.

100. HIV testing in Tanzania follows a national testing algorithm using three rapid tests for screening, confirmation, and resolution of indeterminate results (Bioline HIV 1/2®, Determine HIV 1/2®, and Uni-Gold Recombigen®). This algorithm is followed everywhere although some facilities visited by the OIG team were still using up remaining stock of the previously used screening test (Capillus®). The OIG team found that Uni-Gold tests were generally unavailable. The facilities reported that they had not received any supplies for more than a year and some had stopped ordering the test kits. Only Same District Hospital had a small supply of this kit, apparently supplied by the US-funded treatment partner. Consequently, most facilities were not able to positively diagnose HIV infection when there was a discordant result between the screening and confirmatory tests. OIG learnt that in situations like this some patients may be referred to a larger center or a private facility where there was the technology to test with Western Blot or with ELISA technology. It was not possible to confirm that this was actually done, but in any case it would mean additional costs to the client in terms of stress, transport, and possibly high laboratory fees.

101. Under the Round 3 HIV/TB Global Fund grant, AMREF is responsible for ensuring quality counseling and testing services in 33 districts of Tanzania. This involves the creation of new sites (infrastructure, equipment, and training), and the supervision of existing sites. The program had a rocky start

in the first two years with several inappropriate decisions being made in response to requests from Districts. (e.g. television sets and refrigerators were procured for sites that had no electricity). Since the beginning of year 3, AMREF started to assess the facilities before sending equipment, and has become more active in supervision.

102. HIV testing statistics are maintained by the District AIDS Control Coordinator (DACC) who prepares quarterly reports submitted to the Regional AIDS Control Coordinator (RACC), and to the GF Focal Coordinators in the MOHSW and the PMO-RALG. The DACC is also responsible for maintaining the supply of HIV rapid tests to the District and to distribute these tests to health facilities and NGOs. The Districts keep only summary statistics. The DACCs were able to show the OIG team some source reports from testing sites, but these were incomplete. The OIG team learnt that the DACCs collect these data from a number of known voluntary testing sites, but testing performed in Outpatient Departments, in Ante-Natal Clinics, and in Tuberculosis Clinics was not included. The indicator verification study of the LFA found the same situation. Here is an excerpt from the report: "Mwanza City reported a total of 10,745 clients to have been counselled and tested for HIV/AIDS. However, the City did not provide the breakdown of the reported results by individual VCTs to enable us compare the received results and reported results"

103. Furthermore, from the reported results it is not possible to differentiate newly tested individuals from those repeating their test because they are seeking a second or third opinion. It is important to keep track of the numbers of tests performed and of the number of positive screening tests for the purpose of quantification and supply management of test kits. But it is not useful for monitoring HIV prevention. More useful data on the coverage of HIV testing are generated by asking people if they ever have been tested in the periodic population surveys (e.g. the TDHS or the THMIS). In the 2007/08 THMIS, 37 percent of women reported that they had been tested for HIV, 19 percent within the last year. For men the proportion was 27 percent and 19 percent respectively.²⁰

Recommendation 16 (Significant)

The GF performance indicator for HIV counseling and testing should be changed by adopting the Tanzania National HIV indicator of the proportion of men and women who report that they were tested within the last 12 months and have received a result. MOHSW should consult with the TNCM and the Monitoring and Evaluation Unit of the GF Secretariat.

²⁰ TACAIDS & NBS; Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08; Preliminary Report; July 2008

Non-health sector HIV/AIDS programs

TACAIDS coordinates and monitors the non-health sector response to HIV in Tanzania. There is evidence of valuable work being done with Global Fund support in the areas of social mobilization and support for people living with HIV. Global Fund support to vulnerable children lacks strategic depth. It is primarily a program to deliver survival aid without addressing the institutional weakness of the social welfare sector in Tanzania or the systemic causes of childhood vulnerability to HIV.

104. The Government of Tanzania recognised early in the epidemic that a health sector response to HIV is insufficient to address the many challenges of HIV prevention and HIV/AIDS care and treatment.²¹ While GF grants have had a strong bias towards medical treatment, some of the funds were also programmed to address the social needs of people, and especially children, affected by HIV. Other international agencies have provided major support to non-health sector prevention and support programs, foremost among them the World Bank with its Multi-Sector AIDS Program grant.

105. The OIG team did not undertake extensive work on the components of the GF Round 4 HIV/AIDS grant that were used for programming outside the health sector. In the Districts visited, OIG interviewed the Community HIV and AIDS Coordinators. These are local employees of the Ministry of Community Development, Gender and Children who are involved in programming the part of the District allocation used for community mobilization, campaigns against stigma and discrimination, workplace HIV prevention program, and social support and protection for children made vulnerable by HIV. The OIG team also visited a community center operated by a regional NGO providing economic and social support to people living with HIV.

106. Although the audit found many instances where valuable work was being done, especially by, Tanga AIDS Working Group (TAWG), the NGO visited in Tanga, the OIG team also noted that the program of support to vulnerable children lacked in strategic depth and was primarily used to conduct a census of widows and orphans and to channel basic survival aid to them. While this is important, it does not do much to address the systemic issues and the child protection needs of children falling through the safety net of the traditional family welfare system that is increasingly stretched by the impact of the HIV epidemic. The OIG team was not able to meet with the Department of Social Welfare at national level despite many attempts to obtain an appointment. At the District level, the Department is not represented. From discussion with international partner organizations the OIG team concluded that the need for systemic strengthening of Government social support and welfare systems is an issue that is not well addressed in the TNCM grant applications to the GF. The Social Welfare Department of the MOHSW is not represented in the TNCM.

²¹ Prime Minister's Office; National Policy on HIV/AIDS; September 2001

Recommendation 17 (Significant)

The TNCM should strengthen the representation of partners engaged in the social sector response to HIV, especially partners who speak for the needs of children.

Monitoring the response to HIV/AIDS in Tanzania

TACAIDS monitors the national response to HIV in Tanzania with inputs from several sources, primarily the CTC2 database of the NACP and the TOMSHA data collection system managed by TACAIDS. Both are ambitious systems under construction. Both systems have very high resource requirements (in terms of time, effort, and money). The CTC2 database is highly dependent on international partner support. Both systems are stand-alone "vertical" information systems without links to the National Health Management Information System and the Regional Administration Monitoring and Evaluation System.

107. Two main instruments have been developed to monitor the response to HIV in Tanzania: The CTC2 Database managed by the NACP and the Tanzania Output Monitoring System for non-medical HIV and AIDS interventions (TOMSHA).²² Information from these two sources and from occasional surveys such as the TDHS and the THMIS is compiled by TACAIDS in an annual report that tracks 49 national HIV indicators.²³ Of the 37 process indicators monitored for the GF HIV/AIDS Round 3 and 4 grants, only 10 are part of the national HIV indicator set. The remaining 27 are being followed with a GF specific monitoring system.

The HIV Care and Treatment Database (CTC2)

108. The CTC2 Card is a universal patient record card maintained in the health facility for all patients in HIV care. It is updated at each visit, and the information is then transcribed into one of two ledgers, depending on whether the patient is on ART or not. Information from these ledgers is extracted monthly and quarterly into facility-based monthly and quarterly reports and sent via the DACC and the RACC to the NACP. A third quarterly report, the cohort report, was recently introduced but it was not yet in use in any of the facilities visited during the audit. In practice, very few of these monthly and quarterly reports reach the NACP in Dar es Salaam.

109. In addition to this paper-based record and reporting system, all hospitals have an electronic CTC2 data capture system for information from the CTC2 cards. This system was developed by the NACP and has been shared with the regional US Government-funded partners who use it and employ the data entry clerks. The database generates the monthly and quarterly reports required by the NACP for GF reporting purposes, but it also

²² TACAIDS: Guidelines for the Tanzania Output Monitoring System for non-medical HIV and AIDS interventions (TOMSHA), 2006.

²³ TACAIDS; Annual HIV Response Report for Tanzania Mainland HIV response 2006 – 2007; September 2008

generates the much more detailed reports required by the US Government PEPFAR initiative. The information extracted for the PEPFAR reports include monthly updated cohort analyses for ART retention. The reports are transmitted via internet to the partner office and to the NACP, or they are collected by the partner during supervision visits at the facility and then reach the NACP via the headquarters of the partner organization in Dar es Salaam. The information trails bypass the District and the Regional Health Management Teams who may or may not receive copies of these reports.

110. Maintaining the paper ledgers and the electronic database is very labour intensive. Small HIV clinics in Dispensaries and Health Centers visited by the OIG team had reasonably complete records, but many of the busy hospital clinics were falling behind in the manual ledger keeping and in preparing monthly and quarterly reports. The newly introduced cohort reports will add to their workload and there is a high risk that they will not be completed. The CTC2 cards and the electronic databases were generally more complete and up to date. Subsequently, as a result of OIG team's feedback on its findings to NACP, the facilities have been instructed that in principle they could abandon the paper ledgers if they had an assurance of security and back-up of electronic information. But in one facility (Same District Hospital) visited by the OIG team, the electronic server was infected with a virus and had not been used for over a week. The hospital was waiting for an IT Technician.

111. The monitoring and reporting system based on the CTC2 cards is sophisticated and powerful. The electronic database is capable of generating more information than is currently extracted by the NACP. In particular, it can generate ART retention cohort analyses. However the redundancy of maintaining both a paper-based and a computerised system in hospitals adds to staff workload and introduces additional data capture errors. The lack of involvement of the Districts and Regions in the data transmission and in the local exploitation of the data is a concern. A further concern is the complete dependence of the electronic system on the US-funded partner organization. The system is de-linked from the National Health Management Information System (NHMIS) which is planned to be developed to a similar level of sophistication by the MOHSW. The OIG team did not see any intersection between the NHMIS and the CTC2 data system at the point of data capture, during the process of data transmission, or at the point of data analysis. This creates a parallel system which does not rationalize the use of resources such as personnel and computer equipment.

The Tanzania Output Monitoring System for Non-Medical HIV and AIDS Interventions:

112. The TOMSHA system of collecting data on the response to HIV outside the health sector is managed by TACAIDS. It is a very ambitious and elaborate paper-based reporting system with several distinct paths of data transmission. It relies heavily on the participation of the Community HIV and AIDS Coordinators at District level to collect quarterly reports and channel

them to TACAIDS. TACAIDS claims that it receives reports at least once a year from 66 percent of organizations that have been trained in TOMSHA (cumulative 1,800 reports since 2007). However in interviews with five CHACs in Iringa, Tanga, and Kilimanjaro Region, the OIG team only identified two who were participating in TOMSHA reporting. Both of them stated that only about 20 percent of organizations in the district were submitting reports.

113. TOMSHA is a system under development. The effort required to bring it to a level where it can generate valid information is enormous. The main constraint to the system is that it relies on the participation of the CHACs who are agents of the Ministry of Community Development, Gender, and Children and report to the District Community Development Department and the District Executive Director. Their participation in TOMSHA reporting is quasi voluntary. There is a discussion about integrating TOMSHA in the Tanzania Local Government Monitoring and Evaluation System. Without this integration it will be very difficult for the system to fully develop and to survive in the long term.

Additional Monitoring and Evaluation Activities and Systems:

114. In its role as national coordinating agency for the response to HIV, TACAIDS tracks 49 HIV indicators through a number of different mechanisms. It reports annually on these indicators to national and international partners in a joint HIV response review. The indicators are discussed and adjusted at the time of the review. TACAIDS also commissions a periodic population-based survey, the Tanzania HIV and Malaria Indicator Survey, which is fashioned after the more extensive Demographic and Health Survey and covers the interim period between the DHS which are conducted every 4-5 years. Through the combination of these efforts, Tanzania has a good platform of information on which to track the national response to HIV.

115. In its role as the secretariat of the Tanzania National Coordinating Mechanism (TNCM) of the GF, TACAIDS receives and distributes the reports of the "Executive Dashboard" prepared by the University Computing Center. The Dashboard is assembled from financial, management, and program performance data submitted by the GF PRs to the University Computing Center. This information is processed into quarterly four page summaries of grant performance. Before presenting these summaries to the TNCM, they are reviewed by technical committees and any questions about validity and accuracy of the information are resolved. The OIG team examined three reports of September 2008 (HIV/TB Round 3, HIV Round 4, and Malaria Round 4). The report for HIV/TB Round 3 stated that 102,000 patients were maintained on ARV in the 33 districts covered under this grant, and more than 5 million people had been tested for HIV. These are two examples of implausible information on the Dashboard reports that were questioned by the OIG team. TACAIDS acknowledged that these data were incorrect and stated that they were due to errors that occurred when the Dashboard system was first introduced. They were noted at the time and have since been corrected.

Recommendation 18 (Significant)

The NACP should strengthen the national processes and capacities for collecting, entering, transmitting, and analysing data on HIV care by taking a stronger ownership of the CTC2 database at District, Regional, and National level. This effort should also include an effort of greater coordination and sharing of resources of the CTC2 data collection system with the National Health Information Management System.

Recommendation 19 (Significant)

The NACP should start generating and publishing ART cohort retention data from the electronic CTC2 database, even if this may initially only be possible for a few selected health care facilities.

Recommendation 20 (Significant)

TACAIDS should review the costs and the options of further developing TOMSHA as a stand-alone data collection and analysis system and give serious consideration to seeking the integration of TOMSHA in the Local Government Monitoring and Evaluation System.

Recommendation 21 (Significant)

The TNCM should enter into a discussion with the GF Monitoring and Evaluation Unit to achieve a greater alignment of GF grant performance indicators with national HIV indicators.

HIV and Tuberculosis Programs

TB/HIV services are being rolled out successfully. HIV testing of new tuberculosis patients is almost universal. Tuberculosis screening of people testing positive for HIV is becoming more common but it still needs to be introduced in many testing facilities. The process of certifying some tuberculosis clinics to provide ART has just started. All these are positive developments that should be pursued.

116. Diagnosis and treatment of tuberculosis is provided in specialised TB clinics located in hospitals and health centers. In some places this is just one room, in others it is a separate small building with a waiting room, clinical room, dispensary, microscopy room, and records room. The services are supervised by a District TB and Leprosy Control Coordinator. Although this was not subject to the audit, the services appeared to be functioning well.

117. All but one District visited by the OIG team had a District TB/HIV Coordinator. The deployment of these coordinators started in 2006. In most facilities the OIG team observed that all tuberculosis patients entered in the clinic registers had been tested for HIV. Those who tested positive were referred to the HIV treatment center and were placed on Cotrimoxazole prophylactic therapy in the TB clinic. This standard of good practice was achieved by most clinics visited, with few exceptions that we signalled to the District Health Management Teams.

118. The MOHSW has developed a five-point tuberculosis screening questionnaire for people testing positive for HIV. If there is a positive answer to any of the questions, the client is referred for further investigation to the TB clinic. The District TB/HIV Coordinator has the task of introducing this questionnaire to all sites where HIV testing is taking place. According to observations during the audit, this is work in progress. Some sites have the questionnaire and attach it to the patient file. Others say that it is used in counseling but it is not filled-in and filed, and in other sites the training of staff had not yet taken place.

119. Two tuberculosis clinics visited were in the process of being certified to provide ART to tuberculosis patients for the duration of their TB treatment. Both of those clinics were functioning well with a high tuberculosis patient load. Certifying them for the provision of ART would help decongest the HIV care center and would separate infectious tuberculosis patients from the immuno-compromised clients of the HIV clinic.

Recommendation 22 (Significant)

The universal implantation of the TB screening questionnaire in all HIV testing sites and the certification of selected tuberculosis clinics for ART are promising initiatives that should be pursued by the MOHSW.

The role of in-country technical partners in supporting HIV/AIDS Programs financed by the Global Fund

HIV care and treatment programs supported by the Global Fund in Tanzania are highly dependent on technical support and synergetic programming by the US Government-funded agencies under PEPFAR. The UNAIDS Technical Support Facility is underused and primarily called upon to assist in proposal writing. UNICEF provides essential technical and policy support to the TNCM and to the Department of Social Welfare of the MOHSW for improving programming for vulnerable children.

120. The WHO office in Tanzania is providing technical support to the National Tuberculosis and Leprosy Program for the implementation of the Round 6 Global Fund grant for tuberculosis programming. This grant was not covered in the audit. There is little involvement of the WHO TB officer in the Round 3 HIV/TB grant.

121. UNAIDS told the OIG team that its Regional Technical Support Facilities located in Nairobi and in Johannesburg are called upon frequently by the TNCM to assist in the development of GF proposals, but there is almost no demand for assistance in implementation. This is an issue of concern to UNAIDS and is being discussed at regional level. However, AMREF Tanzania reported that they had extensive support from the UNAIDS Technical Support Facility in Nairobi, especially for the development of the AMREF GF Program Monitoring and Evaluation Plan. This may be related to the fact that the

AMREF Headquarters in Kenya houses the UNAIDS Eastern African Technical Support Facility.

122. UNICEF is providing intensive support to the Social Welfare Department of the MOHSW for the implementation of the "Most Vulnerable Children" program component of the Round 4 HIV Grant. UNICEF also co-chairs the Development Partner Group on AIDS, and the UNICEF HIV officer is a member of the proposal drafting team for a Round 9 GF grant application. UNICEF's support to the Social Welfare Department on the national level includes support in developing national situation analyses and action plans for children. At the peripheral level UNICEF has selected seven pilot districts to build support for vulnerable children from the bottom upwards. At the level of the TNCM, UNICEF is trying to strengthen the influence of Social Welfare in a body that has traditionally had a strong health sector bias. UNICEF is quite critical of the program for children in the Round 4 HIV grant which is primarily focusing on direct service delivery rather than on addressing structural and systemic issues of child protection and vulnerability to HIV infection and to the impact of HIV.

123. The programme of rolling out HIV treatment under Round 4 of the GF is primarily supported by US Government-funded technical partners. At the central level, they provide support to planning, management, and supply issues. At the peripheral level, they are present in all regions of the country supporting all aspect of HIV treatment (drugs, laboratory reagents, staff training, information management, staff incentives, etc.). Without this support the high standards of HIV care and the level of absorption of the GF grant could not be maintained. While such synergy of programming has many positive aspects, it also creates an interdependence that can become a sustainability risk in the long term.

Recommendation 23 (Requires attention)

The PRs of GF grants for HIV in Tanzania should seek more active support from the UNAIDS Technical Support Facility for issues of grant implementation.

Recommendation 24 (Significant)

The MOHSW should engage with the international agencies providing support to the HIV treatment program to assure that this support places as much or more emphasis on local capacity and systems development as it places on achieving high levels of treatment outcomes.

Malaria

<p>Malaria continues to be the most significant threat to health and life in Tanzania. The three-pronged strategy of bed-nets, treatment, and preventive medication during pregnancy has made some inroads on malaria prevalence. However the achievements on Tanzania's mainland pale in comparison to the achievements in Zanzibar.</p>

124. Malaria is by far the single most important threat to health and survival in Tanzania. Malaria transmission occurs throughout the country all year round with seasonal peaks. The estimated yearly number of clinical cases of malaria is 10 to 12 million with between 15,000 to 20,000 deaths, primarily among children under five years old.²⁴

125. There have been some achievements in the reduction of malaria incidence in mainland Tanzania through the three-pronged strategy of promoting the use of insecticide-treated bed-nets (ITN), intermittent preventive malaria treatment of pregnant women (IPTp), and early treatment of malaria, most recently with Artemisinin-based Combination Therapy (ACT).

²⁵

126. However these results are not as impressive as those recorded in Zanzibar, where a combination of bed-net promotion, ACT, and indoor residual spraying (IRS) has brought malaria prevalence to near zero. (same source as above).

Malaria vector control through insecticide treated bed-nets

A national strategy for malaria vector control through the use of insecticide-treated bed nets was introduced with Global Fund support using a system of cash vouchers to subsidize the purchase of nets. The strategy has not resulted in the targeted level of net coverage. The program is currently in a transition phase, continuing the voucher scheme while preparing bed-net mass distribution campaigns, initially for children and subsequently for all Tanzanians. Following the campaigns, the options for a subsidization system that ensures continued universal bed-net coverage will be explored.

127. With financial support from the GF Round 1 malaria grant, Tanzania introduced a subsidy system for insecticide treated bed-nets using cash vouchers given to pregnant women to be redeemed at point of sales against the partial cost of a bed-net. About 7,000 retailers participate in the scheme. The choice of net is open (there are four net manufacturers in Tanzania). All nets are re-treatable polyester nets co-packaged with one dose of insecticide for treatment. Initially this provided protection for about six months, but it has since been replaced by another product which has a much longer duration of insecticide activity. The value of the voucher is fixed. It has been adjusted once and is currently at 3,250 TZS. Bed-net prices, on the other hand, have been increasing steadily and vary from location to location because of transport costs. Currently the voucher covers barely half of the retail cost of a bed-net. The increased cost of the net is the probable reason why the rate at

²⁴ WHO. World Malaria Report 2008; pp. 123-125

²⁵ National Malaria Control Program. Overview of household survey methods used in Tanzania, 2007-08 (undated)

which pregnant women exchanged the vouchers they received fell from 50 percent in 2007 to only 26 percent in 2008.²⁶

128. A second voucher scheme for infants was introduced somewhat later. It is administered under the same arrangement and is funded by the US President's Malaria Initiative.

129. The GF Round 1 malaria grant also included a budget to procure additional insecticide re-treatment kits to be distributed free of charge in child health clinics. Because of procedural delays these kits were never procured and changes in the voucher scheme has since made them somewhat redundant.

130. Under a continuation grant from the GF (for which implementation has not yet started), the voucher scheme is set to continue for another two years. But it will be radically changed. The plans are to make the vouchers redeemable only against polyethylene long-lasting nets of a standard size (which limits the choice to a single supplier). Instead of fixing the voucher value, the new scheme will fix the co-payment at TZS 500. This means the voucher value will have to be adjusted regularly, and that there will have to be a mechanism to adjust to the variable delivery costs to different regions of the country.

131. At the same time, the GF Round 1 continuation grant is meant to co-finance a country-wide mass distribution campaign for bed-nets to children under five years of age. The other participants in this campaign are the US President's Malaria Initiative (PMI) and the World Bank's Malaria Booster Program. There have been major delays in starting this campaign for a number of reasons. Mass distribution to children under five was piloted in one District in the East of the country and, under a different scheme in Tanga Region, both with funding from sources other than the GF. The campaigns boosted bed-net usage among children in the regions, but not to the desired level. The Red Cross is currently conducting catch-up campaigns in these areas.

132. Finally, Tanzania has obtained approval for a GF grant in Round 8 to finance a national mass distribution campaign to provide a bed-net for every sleeping space in the country. It is widely expected that this will completely destroy the local bed-net market for some time until new needs arise. By the time this mass campaign has been fully rolled out, the two-year GF support for the voucher scheme will have been exhausted. The NMCP plans to conduct a major study and organize a national consultation to develop a bed-net supply maintenance strategy to follow the campaign for universal coverage.

²⁶ IHRDC & LSHTM; Monitoring and Evaluation of the Tanzania National Voucher Scheme: Preliminary results from 2008 household and facility survey. 24 November, 2008

Recommendation 25 (Significant)

Because of the planned transition in the Tanzanian national bed-net strategy, the GF should adopt a monitoring approach that would allow sufficient flexibility to respond to the different stages of transition. In practice, this would mean Global Fund Secretariat participation in the regular national bed-net partnership meetings.

Monitoring the Tanzania Bed-net Strategy

The Tanzania bed-net strategy is closely monitored by MEDA, IHRDC, the LSHTM, and other actors. This produces a rich source of evidence upon which the strategy relies for adjustments and corrections. However, the number of surveys conducted by different partners and programs in recent years has been excessive. The number could be significantly reduced if research on malaria in Tanzania were better coordinated.

133. The bed-net strategy in Tanzania is closely monitored. The voucher distribution and re-imburement mechanism is monitored by the Mennonite Economic Development Associates (MEDA), the agency in charge of the voucher system. The names and addresses of the beneficiaries are entered on each voucher and on the stub in the voucher book. They are also recorded in a register kept in the ante-natal clinic. Redeemed vouchers are checked against the stubs and the registers. The monitoring system is administratively heavy, especially for nurses working in ante-natal clinics. In 2008, the program commissioned a study to ascertain the level of fraud in the voucher scheme. Investigators followed-up 568 vouchers given to pregnant women. If the woman whose name appeared on the voucher could not be traced, fraudulent issue of the voucher was suspected. The study concluded that 3 percent of the vouchers were "almost certainly misused", and another 6 percent "probably misused". This gives a total estimate of fraudulent use of the voucher scheme of 9 percent.²⁷

134. The GF Round 1 grant also includes support to monitoring the use of bed-nets by end-users and to researching the determinants of bed-net use. This component is contracted to the London School of Hygiene and Tropical Medicine (LSHTM) and to the Ifakara Health Research and Development Center (IHRDC). It includes qualitative studies of determinants and attitudes towards bed-nets, as well as household surveys looking at bed-net usage rates, voucher redemption rates, malaria incidence and the prevalence of anaemia. These rounds of surveys show that the usage rates of insecticide treated bed-nets by children and pregnant women are slowly creeping up, but that they remain low (29 percent and 22 percent respectively in 2008). They also record a consistent difference in net-use by socio-economic status, with the most wealthy having the highest net usage. Not necessarily causally related is the finding that the most wealthy have by far the lowest prevalence

²⁷ R Nathan, H Mponda, T Marchant, Y Sedekia & K Hanson. Tanzania National Voucher Scheme: Report on 2007/8 voucher tracking study. US President's Malaria Initiative, May 2008

of malaria parasites in their blood.²⁸ These are the results that are driving the review and revision of the national bed-net strategy.

135. While it is easy to get excited about the very impressive data collected and analyzed by the LSHTM and the IHRDC, there is another side of this coin. According to the Tanzania National Malaria Control Program, five separate malaria household surveys were conducted in the 12 month interval from October 2007 to September 2008. These surveys by different agencies covered a total of 82 Districts, some as many as four times. A total of 55 field teams interviewed more than 35,000 households, all of them exploring bed-net usage, and all of them generating similar results.²⁹ This is clearly not the most rational use of resources.

Recommendation 26 (Requires attention)

The NMCP should play a stronger role in coordinating malaria research by all actors in Tanzania in order to eliminate redundancies and increase the power of individual studies.

Malaria treatment in health facilities

First line treatment of malaria with artemisinin-based combination therapy (ACT) has become the norm in public health facilities in Tanzania. The treatment in the informal and private sector should now be improved, together with continued public education to assure timely treatment. Distortions in the supply chain of ACT are an issue of concern that needs urgent attention.

136. With the emergence of malaria resistance to Chloroquine during the 1990s, Tanzania changed its first line treatment to Sulfadoxin-Pyrimethamine (S-P) and then in 2004 to Artemether-Lumefantrine, one of the fixed dose ACT formulations. S-P continues to be used for intermittent preventive treatment in pregnancy (IPTp). Starting in 2005, with financial support of the three-year GF Round 4 grant for malaria, ACT treatment free of charge in public health facilities was rolled out.

137. The OIG team found that the records in almost all health facilities showed consistent use of ACT for the treatment of children with malaria. However two independent surveys of the National Malaria Control Program and the National Bureau of Statistics in 2008 found that only 13 percent of children under five received ACT within 24 hours of onset of malaria.³⁰ There are two factors to explain this discrepancy. Correct anti-malarial treatment depends not only on the use of an effective medication, but also on the timeliness of its use. Furthermore, many people seek treatment in pharmacy shops and private clinics. This fact is the basis of a strategy to create a network of private Accredited Drug Dispensary Outlets (ADDOs) in Tanzania.

²⁸ LSHTM & IHRDC. Monitoring and Evaluation of the Tanzania National Voucher Scheme: Preliminary results from 2008 household and facility survey. November 2008

²⁹ NMCP; Overview of household survey methods used in Tanzania, 2007-08 (undated)

³⁰ NMCP; Op.cit.

138. The main issues related to malaria treatment found by the OIG team relate to irregularities in the supply chain created by a system of distributing anti-malarial drugs to health facilities on the basis of consumption estimates rather than on the basis of real demand. This system is gradually being replaced. (see procurement section) The most common situation the OIG team observed was overstocking and expiry of drugs on the shelves, together with stock imbalances between packages for different age and weight groups of patients.

Recommendation 27 (Requires attention)

The NMCP should shift attention towards increasing the availability and use of ACT in the informal and private sector, together with continued public education to assure prompt treatment of malaria.

Monitoring malaria treatment in Tanzania

Information about the use of ACT as first line anti-malaria treatment in Tanzania is available from periodic surveys. There is, however, no system to monitor malaria treatment in Tanzania on a quarterly basis. Such a system should be part of a logistics system linking health service data to drug management information. It would go a long way to solving the current supply chain problems for ACT at the Regional, District, and Health Facility level.

139. Theoretically, a patient record and logistics system should provide instant access to information linking malaria diagnosis to treatment and drug consumption at the facility, district, regional, and national level. Presently, malaria treatment is reported monthly as part of the routine District reports to the National Health Management Information System, and the consumption of anti-malarial drugs is calculated by the District pharmacists as the difference between drugs received and drugs in stock. Muheza District provided the OIG team with electronic copies of their ACT Request and Requisition (R&R) forms covering one year. According to the information contained in these forms, 81,000 diagnoses of malaria had been made in health facilities in the District, while 157,000 doses of ACT malaria treatment had been consumed. Similar discrepancies were observed by the LFA during the data verification study. For instance Buzuruga Health Center (Mwanza City) reported 3,480 cases of malaria based on consumption data of ACTs, but the reviewers could only find 812 cases on record. The comments by the reviewers were:

“The reported consumption was based on the number of ACTs issued translated into number of patients treated; The difference between the reported results and verified number of patients registered during the period could either be due to the fact that clinicians sometimes forget to register some of the attended patients or some of the ACTs were not given to patients.”³¹

³¹ PricewaterhouseCoopers; LFA On-Site Data Verification Report; Ministry of Finance of the United Republic of Tanzania, Round 4 Malaria; February 2009

140. Periodic surveys such as the Tanzania Demographic Health Survey (TDHS) and the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) sample households to collect information about the incidence of fever, the prevalence of malaria parasites, and about the choices and timeliness of malaria treatment. The last TDHS was conducted in 2004/05, the last THMIS in 2007/08. These surveys do show an increasing trend in the correct use of ACT. However, at the facility or district level, the OIG team did not find any data collection instrument or reporting form that would allow facility-based monitoring of GF Performance Indicators such as "Number of children below five years receiving correct diagnosis and treatment of malaria according to national policy within 24 hours from onset of fever". The OIG team was not able to ascertain the origin of the performance data reported to the GF.

Recommendation 28 (Requires attention)

The MOHSW, in consultation with the TNCM, should ensure that Global Fund grants for the supply of ACT should include a performance monitoring framework that can be monitored with existing data tools and reports.

Recommendation 29 (Significant)

The MOHSW should rapidly develop a logistics and reporting system that could link morbidity data from health facilities with information about medication usage. Such a system should not be specific to malaria but cover all clinical activities in health facilities.

The role of in-country technical partners in supporting malaria programs financed by the Global Fund

The US Centers for Disease Control, supported with funds from the President's Malaria Initiative, provides the strongest international technical support to malaria control in Tanzania, including support to programs financed with Global Fund grants. The fact that the Global Fund has no representation in the technical partner meetings guiding malaria control in Tanzania is of concern in the face of the very dynamic program environment.

141. The largest international partners of the National Malaria Control Program in addition to the GF are the US Government through the President's Malaria Initiative and the World Bank through the Malaria Booster Program. The US Government has a strong technical presence through the Tanzania offices of the Centers for Disease Control. But several smaller partners, for instance the Swiss Tropical Institute (STI) provide substantive technical support to malaria control in Tanzania. The partners collaborate very closely and meet regularly in technical partner consultations. Key strategic decisions on malaria control strategies are reached jointly. There is a high level of interdependence among partners. For instance the planned bed-net campaign for children under five is co-funded by the US Government, the World Bank, and the Global Fund, in a way that nothing can be done unless all partners act in unison.

142. The country office of WHO was closely involved in supporting proposal development for GF Malaria proposals. The office also provided some initial support to the procurement of ACT through a special agreement between WHO and Novartis, the manufacturer of Artemether-Lumefantrine.

143. There is a pool of international technical staff involved in guiding the use of GF resources for malaria control in Tanzania. There are, however, a number of priority issues for the GF (for instance the supply chain for ACT), and there are a number of delicate issues that require rapid informed decision-making (for instance the development of the under-5 bed-net catch-up campaign).

The performance monitoring framework of the Global Fund's grants in Tanzania

144. The performance monitoring frameworks for GF grants in Tanzania often aim too low in the results chain, counting project outputs rather than focusing on outcomes. This results in too many indicators with the consequence of a decrease in quality and reliability of measurements. For example, two HIV grants audited, (Round 3 and Round 4-MOF) are monitored with a total of 37 process indicators (15+22). Among them are 10 indicators of number of people trained in various skills or procedures. These are useful indicators for a project that tracks resource inputs according to a traditional project management approach. For a funding program that is results-based the GF Secretariat needs to monitor outcomes at a higher level rather than continue to collect accounts of activities performed.

145. The GF monitoring system in Tanzania is poorly aligned with national information systems, and often designed to specifically and exclusively collect GF grant performance data. It is labour-intensive, generates inaccurate data, and collects information that is often not very meaningful for tracking the grant results. For instance, in the area of HIV/AIDS, Tanzania has a national monitoring system administered by TACAIDS. The system is based on 49 indicators that have been defined in collaboration with all national and international stakeholders, that are reviewed annually, and that are collected jointly. Many different organizations have an interest in this information and they invest considerable effort in controlling the quality of information. Of the 37 process indicators used to monitor the GF grants of round 3 and 4, only 10 are included in this list (3/15 for Round 3, and 7/22 for Round 4).

Recommendation 30 (Significant)

The MOHSW, in consultation with the TNCM, should work with the GF Country Programs Cluster and the Monitoring and Evaluation Unit of the GF Secretariat to review the performance indicators for all GF grants to Tanzania with the objective to (a) reduce the number of indicators, (b) to aim the measurement process higher in the results chain, and (c) to achieve a better alignment of GF performance indicators with existing national monitoring indicators.

Financial Management and Control

146. Of the five grants selected for audit, OIG examined disbursement of grant funds to PRs and selected SRs. In addition, OIG audited program expenditures and financial reporting of three program units of the MOHSW, namely, National AIDS Control Program (NACP), National Tuberculosis and Leprosy Program (NTLP) and National Malaria and Control Program (NMCP). Additionally, the OIG team audited grant expenditures and receipts of the following SRs: MSD, AMREF, TACAIDS and Christian Social Services Commission (CSSC).

Financial and programmatic reporting: Progress Updates and Disbursements Requests (PUDRs)

Progress Updates and Disbursement Requests (PUDRs) were not prepared and submitted in a timely manner by Principal Recipients to the Global Fund; and OIG found the sample of PUDRs it reviewed to be inaccurate, incomplete and with no audit trail.

147. Through a Memorandum of Understanding with TACAIDS the MOFEA delegated its PR functions which include financial reporting to TACAIDS. Financial reports are prepared semi-annually. OIG found that the financial report for Round 4 HIV/AIDS grant for the reporting period March 1 2008 through 31 August 2008 overstated program expenditures by USD 18 million dollars and understated cash on hand by the same amount. Although OIG found that the USD 18 million has not been spent on program activities by the MOHSW, the funds were considered to have been spent because they had been transferred into SR bank accounts by the PR (MOFEA). The current PUDR template is not suitable for a "pass through" PR like the MOFEA which is not an implementing entity. Disbursements by the MOFEA to its SRs e.g. MOHSW are considered as expenditures. Currently GF policies do not require MOFEA to report unspent balances in the accounts of its lead SRs.

148. OIG did not find evidence that the PR financial reports produced by TACAIDS Grants Coordinator were reviewed by TACAIDS Director of Finance before approval by the MOFEA.

149. In addition, OIG noted that as the substantive PR, TACAIDS does not keep copies of financial reports it receives from SRs such as MOHSW, NACP, and PMO-RALG. It was therefore difficult for the OIG to establish the audit trail and verify the source and accuracy of the figures reported for the sample of the PUDRs it reviewed. Further, the data on indicators could not be verified as OIG learnt that most of the data are collected through phone calls to peripheral facilities. The reason is that staff working in service delivery facilities are busy with heavy patient workloads given the general shortage of staff in the health sector; thus reports are not timely prepared.

150. Consequently, OIG noted that financial and progress reports are not submitted by the due dates as stipulated in the grant agreements. For instance, GF HIV/AIDS Round 4 report which was due on 31 August 2008 was submitted to the MOFEA on 12 December 2008 and GF HIV/TB Round 3 financial and progress report which was due on 15 December 2008 was submitted to the MOFEA on 16 January 2009. And by the end of OIG audit on 20 February 2009, the afore-mentioned reports had not been submitted to the GF because TACAIDS was still clearing queries raised by the LFA.

151. OIG also noted that implementing organizations report use different report templates which make consolidation difficult. Also, different cut-off dates or quarters are used. For example, while some entities report quarterly on calendar year basis others prepare their reports according to grant disbursement quarters.

152. For both Rounds 3 and 4 grants, OIG noted that annual reports, which are required to be submitted by the PR to GF three months after the grant year had not been submitted.

153. OIG was informed by the LFA that PUDRs received from MOFEA were usually incomplete and had errors and omissions. Further, the PUDRs lack audit trail and appropriate review by TACAIDS and MOFEA senior management for accuracy and completeness. OIG also learnt that LFA's scope is limited given the number of days allowed by GF for review of progress updates, considering the number of SRs and implementing organizations involved in a grant.

154. OIG learnt that because of the poor quality of PUDRs produced by the PR the LFA is usually obliged to do more work than is required by GF's scope of work to verify a PUDR. Through its own initiative, the LFA has decided to write management letters to explain issues noted during review of Tanzania's PUDRs because information requested in the current report format does not provide GF with adequate information for decision making.

155. On 24 February 2009, OIG reviewed a management letter that the LFA had drafted regarding the PUDR submitted by TACAIDS covering the six month period that ended on 31 August 2008 and found similar errors noted below.

- (a) USD 17.6 million out of USD 37.9 million of commitments reported had no supporting documentation;
- (b) SRs had huge cash balances that could be utilized for program implementation before disbursement of additional funds; the LFA would therefore recommend to GF to disburse USD17.6 million instead of USD 31.8 million requested by the PR;
- (c) Late disbursement of funds from MOFEA to SRs;
- (d) Unreliability of reported data as 60 percent of the data were collected through telephone calls;
- (e) Lack of audit trail is a problem in verifying the data reported;

- (f) Incorrect cash balance of zero reported at 31 August 2008 as the PR had not yet disbursed USD 12.8 million to SRs;
- (g) USD 2.4 million disbursed for capacity strengthening at MSD had not been utilized; and
- (h) Reported expenditures did not match the reporting period.

Recommendation 31 (High)

TACAIDS financial reporting capacity should be reviewed as part of its PR capacity assessment. As part of this assessment, the financial reporting capacity of all lead SRs which send their PUDRs to TACAIDS to be consolidated should also be assessed.

Recommendation 32 (Significant)

The PR should report in the PUDRs all large unspent bank balances in PR and SRs' bank accounts to provide the GF with adequate information to make grant disbursement decisions.

OIG learnt that GF Finance unit is in the process of revising the current PUDR reporting template to require lead SRs to report large unspent balances. OIG strongly encourages GF management to implement a revised PUDR to address the problem of large unspent balances in program bank accounts.

Disbursement of grant funds to SRs and implementing organizations

There were significant delays in disbursing grant funds received from the Global Fund to implementing organizations leading to delays in implementing program activities.

156. OIG reviewed the disbursement of grant funds from the Principal recipient, MOFEA, to lead SRs such as the MOHSW and PMO-RALG as delays in receipt of program funds by implementing organizations delay program delivery and affect achievement of program targets. Funds disbursed by GF are deposited into the development revenue account of the MOFEA held at the Bank of Tanzania (BOT). Funding requests from lead SRs are reviewed by TACAIDS, the substantive PR, and sent to the MOFEA which instructs BOT to transfer funds to recipients' accounts through the GOT finance system (exchequer system).

157. Analysis of flow of funds from the time funds were received/credited into the MOFEA's development revenue account to the time funds were transferred into sub-recipients' bank accounts showed that delays range from one week to eight months. Below is an analysis of delays in disbursements to SRs based on information received from the office of the Accountant General (AG).

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Round	Received by MOFEA			Released by MOFEA			Days Outstanding
	Date	USD	Equiv. TZS	Date	LSR	TZS	
GFR 1	8-Jul-05	2,847,000	2,880,774,038	24-Aug-05	MOHSW	2,880,774,038	47
	14-Sep-05	18,575,572	20,849,822,004	21-Feb-06	MOHSW	20,849,822,004	160
GFR 4	19-Sep-05	36,883,797	41,590,538,335	3-Oct-05	TACAIDS	2,250,016,080	14
GFR 4	19-Sep-05			24-Nov-05	PMO-RALG	6,621,813,589	66
GFR 4	19-Sep-05			5-Oct-05	MOHSW	29,923,346,777	16
GFR 4	19-Sep-05			11-Oct-05	PMO-RALG	2,196,584,280	22
GFR 4	19-Sep-05			20-Oct-05	MOL	598,777,610	31
GFR 4	14-Nov-06	17,734,887	22,926,984,441	14-Dec-06	MOHSW	22,926,984,441	30
GFR 4	14-Nov-06	13,153,352	16,730,562,601	8-Mar-07	PMO-RALG	7,068,873,994	114
GFR 4	14-Nov-06			30-Jan-07	TACAIDS	3,357,856,885	77
GFR 4	14-Nov-06			30-Mar-07	MOHSW	6,303,829,722	136
GFR 4	13-Jul-07	46,300,606	58,394,352,068	20-Jul-07	MOHSW	50,564,553,600	7
GFR 4	13-Jul-07			19-Sep-07	MOHSW	7,829,798,467	68
GFR 4	2-Jul-08	59,537,943	69,330,600,974	3-Sep-08	TACAIDS	1,172,270,874	63
GFR 4	2-Jul-08			14-Aug-08	MOHSW	52,463,296,402	43
GFR 4	2-Jul-08			5-Aug-08	PMO-RALG	732,881,445	34
GFR 4	13-Oct-08	20,884,977	25,027,211,444	27-Oct-08	MOHSW	25,027,211,444	14
GFR 3	9-May-06	10,757,342	13,146,393,519	2-Jun-06	TACAIDS	6,956,150,911	24
GFR 3	9-May-06			15-Jun-06	PMO-RALG	1,427,138,645	37
GFR 3	9-May-06			27-Jul-06	MOHSW	4,514,063,060	79
GFR 3	9-May-06			25-Sep-06	MOD	249,040,903	139
GFR 3	7-Jan-08	14,106,902	16,446,863,209	3-Mar-08	TACAIDS	7,982,920,063	56
GFR 3	7-Jan-08			30-Jan-08	MOHSW	6,039,748,207	23
GFR 3	7-Jan-08			31-Mar-08	PMO-RALG	2,170,316,658	84
GFR 3	7-Jan-08			17-Sep-08	MOD	253,878,282	254
GFR 3	2-Dec-08	20,259,538	25,245,874,245	28-Jan-09	MOHSW	22,250,662,000	57
GFR 3	2-Dec-08			Note 1	TACAIDS	2,454,594,196	80
GFR 3	2-Dec-08			Note 1	MOHSW	540,618,049	80

Table 9: Analysis of delays in disbursement of grant funds to SRs (Source: Office of the Accountant General records)

158. Officials in the Accountant General's department attributed the delays to the following factors.

- (a) Funds can only be released from the MOFEA upon receipt of release request from TACAIDS and/or lead SRs; and in the past such requests had not been received in a timely manner; and
- (b) At times information such as the GF Round or name of grant is not specified on the schedule of payments received from TACAIDS and this delays disbursement of funds.

159. From discussions with BOT officials, OIG learnt that disbursements received from GF do not specify MOFEA's development revenue account to be credited at the BOT. Hence, this usually requires BOT to write to MOFEA to request the relevant information. Therefore, crediting of grant funds to MOFEA's account at the BOT would depend on the timeliness of response

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from the MOFEA. Delays in the release of funds to MOFEA by BOT for selected GF disbursements are shown in the table below.

Grant Number	Amounts in USD	Date Disbursed by GF	Date Received by BOT	Date Released by BOT	Days before BOT Release
TZN-304-G03-C	2,570,173	28-Jun-05	29-Jun-05	8-Jul-05	9
	10,757,342	26-Apr-06	27-Apr-06	9-May-06	12
	20,259,538	18-Nov-08	20-Nov-08	2-Dec-08	12
TZN-405-G04-H	34,036,797	31-Aug-05	1-Sep-05	19-Sep-05	18
	13,153,352	14-Dec-06	15-Dec-06	11-Jan-07	27
	59,537,943	27-Jun-08	30-Jun-08	2-Jul-08	2
TZN-405-G08-M	18,575,572	27-Jul-05	3-Aug-05	14-Sep-05	42
	17,734,887	13-Oct-06	17-Oct-06	14-Nov-06	28
	20,884,977	1-Oct-08	3-Oct-08	13-Oct-08	10
TZN-607-509-T	7,699,656	25-Oct-07	29-Oct-07	28-Nov-07	30
	7,473,500	5-Dec-08	8-Dec-08	17-Dec-08	9
TZN-708-G10-M	5,161,417	23-Jun-08	24-Jun-08	2-Jul-08	8

Table 10: Analysis of delays in the disbursement funds from the BOT to the MOFEA (Source: BOT and GF records)

160. OIG also noted that on 2 July 2008, the MOFEA received USD 59.5 million for GF Round 4 HIV/AIDS grant implementation. Of the amount received, USD13.5 million (TZS15.6 billion) was earmarked to be transferred to PMO-RALG and the district councils. However, at the time of OIG's audit in February 2009, USD 12.8 million (TZS 14.9 billion) of this amount had not been released to PMO-RALG and the district/municipal councils. That is more than seven months after disbursement of funds by the GF.

161. OIG learnt that the district councils had not budgeted these funds in the government expenditure estimates for the financial year. And according to government financial regulations, these funds can only be allocated and spent after supplementary estimates are approved by parliament, a process which could take more than six months.

Recommendation 33 (Significant)

When grant funds have not been budgeted in government expenditure estimates, the PR should inform GF to defer disbursements pending in-country reallocations or approval of supplementary budgets by national authorities.

Recommendation 34 (Significant)

There is scope for improvement in coordination, communication and information-sharing among the key players namely, MOFEA, MOHSW, TACAIDS, PMO-RALG, TNCM and the LFA regarding removing bottlenecks to flow of funds to implementing organizations.

Recommendation 35 (Requires attention)

The PRs and lead SRs should explore with their banks for interest to accrue on large credit bank balances held in program bank accounts.

Exchange rate losses

Some implementing organizations are incurring unnecessary exchange rate losses in converting local currency into foreign currency to pay both local and foreign suppliers.
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162. The MOU that was signed between the MOFEA and lead SRs for Round 3, states that the lead SRs and relevant implementing partners shall open bank accounts in foreign currency and Tanzania shillings (TZS). The MOU also states that for approved procurement payable in foreign currency, the lead SRs and their implementing partners would receive disbursements from the MOFEA in foreign currency.

163. Contrary to what is stated in the MOU, OIG noted that grant implementing organizations such as MSD and AMREF obtain foreign currency at commercial rates on the local market to pay their suppliers. This results in exchange rate losses.

164. Also, the practice of keeping large unspent funds in local currency in bank accounts lead to depreciation in the value of the currency resulting in gaps in funding and consequently curtailment in the planned level of procurement or implementation of program activities.

Recommendation 36 (High)

As provided for in the MOU signed between MOFEA, as the PR, and the lead SRs, funds earmarked for approved procurement payable in foreign currency should be disbursed to the lead SRs and SRs in foreign currency so as to avoid losses which could arise due to unfavourable movement in exchange rates. The MOFEA, AMREF, TACAIDS, MOHSW and MSD should consult and agree on how this recommendation will be implemented.

Compliance with tax exemption provisions of grant agreements

Contrary to the grant agreements Implementing Organizations are paying value added tax (VAT) on goods and services procured with grant funds.

165. OIG found that implementing organizations such as MSD, NACP, PMO-RALG, NMCP, NTLP and TACAIDS have paid Value Added Tax (VAT) and duties on goods and/or services in contravention of GF grant agreements. For example, for three payments for goods and services reviewed by OIG, MSD had paid USD 98,000 in VAT and import duty. OIG found that implementing organizations have found it cumbersome to process tax exemptions waivers for numerous local purchases that they considered to be small in value.

166. Using grant funds to pay taxes implies that less program funds are used to buy bednets, medicines and supplies needed by patients, or fewer number of health workers are trained for health facilities.

Recommendation 37 (Requires attention)

The PR (MOFEA) and lead SRs should ensure that implementing organizations obtain VAT exemption waivers for procurement of goods and services under the grants.

Recommendation 38 (Requires attention)

To facilitate the recovery of taxes paid on locally purchased goods and services, SRs should consider opening a VAT control account in their accounting books into which VAT paid for each transaction using GF resources is debited. Periodically, either monthly or quarterly, implementing organizations should then compile total VAT paid per the control account, support the return with paid invoices and submit a claim to the revenue authorities for a refund. The PR (MOFEA) should facilitate this process.

Recommendation 39 (Requires attention)

For VAT paid since inception of the grants, lead SRs and implementing organizations should compile a list of such payments and seek a refund from the revenue authorities. This list should be verified by the LFA during its semi-annual verification of implementation.

Recommendation 40 (Requires attention)

The PR (MOFEA) and lead SRs should ensure compliance with GF grant agreement provisions of tax exemption for purchase of any goods or service using grant funds. Taxes paid by SRs should not be billed to GF. And all taxes paid with grant funds should be calculated and paid back by the GOT into grant bank accounts.

Other Matters

167. OIG found that under the Malaria Rd 1 grant program, approximately USD 82,000 had been incurred in bank charges on the foreign exchange bank

account maintained by NMCP at the National Microfinance Bank. In OIG's view, the rate of 0.25 percent applied/deducted by the bank as fees for each disbursement received from the GF is excessive; and NMCP management should negotiate with the bank for better terms.

168. As part of the negotiations leading to the grant agreement between the GF and the PR it was agreed that MSD, as the entity responsible for procurement of medicines and health supplies, would charge the grant 8 percent of the cost of procurement as administrative fee to cover its overhead. However, OIG noted that MSD has been charging administrative fees that range from 8 percent to 161 percent of the cost of products purchased. MSD needs to refund overcharging of its administrative fees.

169. OIG noted the following common internal control weaknesses at all SRs and implementing organizations audited. These audit findings noted by OIG have also been confirmed in annual audit reports of SRs and implementing organizations. The causes of these weaknesses could be attributed to inadequate supervision of accounting staff, workload issues, high staff turnover and paucity of adequately qualified finance/accounting staff.

- (a) Inter-program borrowing due to delayed receipts of grant funds;
- (b) Lack of proper accounting records;
- (c) Bank reconciliations were not being prepared and reviewed regularly;
- (d) Statutory deductions such as income and social security taxes were not deducted/paid to relevant authorities on time ;
- (e) Third party documents such as invoices not being cancelled to prevent possible re-use;
- (f) No participant list or activity reports to justify allowances paid during workshop/ training to prevent payment to invalid recipients;
- (g) Use of spreadsheet to record grant receipts and expenditures, rather than accounting software with appropriate controls;
- (h) Advances to staff and others not being accounted for before subsequent advances are disbursed;
- (i) Limited involvement of accountants in financial reporting; and
- (j) Fixed asset registers not maintained.

Recommendation 41 (Requires attention)

The NMCP should negotiate with its bank to provide a favourable rate for bank charges.

Recommendation 42 (Requires attention)

The GF Secretariat should ask the LFA to identify all instances where more than the agreed administrative fee of 8 percent has been charged; and MSD should refund excess payments into program bank accounts.

Recommendation 43 (Significant)

All PRs and lead SRs of GF grants should issue a management letter to all implementing organizations to prepare management action plans to address all the above-listed audit findings).

Recommendation 44 (Significant)

All PRs and lead SRs should follow up implementation of recommendations in the audit reports of its implementing partners.

Institutional Arrangements, Governance and Oversight

Institutional Arrangements

Absorptive capacity of grant implementing organizations

There have been delays in implementing grant programs, particularly in the public sector, due to low absorptive capacity of implementing organizations caused by complex bureaucratic processes and procedures.

170. One of the key GF fiduciary principles is to use national systems and processes to implement grant programs in recipient countries³². To this end, before grant agreements are signed an assessment is carried out of the PR's, systems and processes in the functional areas of Financial Management and Systems, PSM, M&E and institutional and programmatic arrangements. The results of the early assessments done in 2003 showed that the existing systems were adequate and could meet the demands of grant implementation. However as shown by the audit findings in both the PSM and Financial Management sections of this report, the national systems and processes are under severe strain. Similarly, Phase 2 assessment³³ of the Round 4 HIV in August 2007 noted issues of procurement delays, late disbursement of funds to SRs and concerns about the quality and timeliness of sub-recipients' financial and programmatic reporting.

171. OIG noted that influx of funds from donor-funded health program initiatives has overwhelmed the complex bureaucratic processes and procedures of public sector implementing organizations such as MOHSW. This has resulted in delays in procurement of goods and services for grant implementation that led to Tanzania forfeiting USD 7.6 million of unspent funds at the end of phase 1 for two grants, namely HIV/TB Round 3 and HIV/AIDS Round 4. As detailed in the financial management section above, there have been excessive delays in the release of funds to SRs and OIG found over USD 30 million grant funds left idle in bank accounts. Thus, in the case of Tanzania the GF principle of "promoting rapid release of funds to assist target populations"³⁴ is not being adhered to.

172. Implementation of some grants had not taken place in a timely manner due to inability of some PRs and SRs in meeting conditions precedent. For example, OIG noted that phase two disbursements were made in June 2008 for activities planned from July 2007 to March 2008.

173. As of February 2009, the lead SRs have not received disbursements for years four and five amounting to USD 41 million which had been

³²The Global Fund's Fiduciary Arrangements for Grant recipients, July 1 2003

³³ Grant Score Card for HIV Round 4 of August 2007

³⁴ Ditto

scheduled for disbursement in November 2008. The delay in receiving funds from the GF was due to late receipts of progress update and audit reports.

Recommendation 45 (High)

The PR (MOFEA) and MOHSW should assess whether current systems and processes will be able to cope with the increasing size of Tanzania's grant portfolio. Bottlenecks to grant implementation should be identified, such as long delays in disbursement of funds to SRs and other implementing organizations, and capacity constraints of MOHSW's Procurement Management Unit (PMU) need to be addressed to improve absorptive capacity of the grants.

Governance and Program Oversight

There are multiple players with overlapping responsibilities and inadequately defined roles and responsibilities that leave gaps in ownership, creating an environment of inadequate oversight and lack of accountability.

174. When Round 8 grants of Tanzania are approved, the country will have a grant portfolio of USD1.3 billion spread over thirteen grants. OIG noted that the geographical size of the country and its many administrative divisions which comprise 21 regions made up 121 districts pose both program implementation and oversight challenges. Further, there are five PRs and over 350 implementing organizations across the country.

175. OIG noted that there are multiple players involved in grant oversight in Tanzania with over-lapping responsibilities and inadequately defined roles and responsibilities that invariably leave gaps in ownership and fulfilment of grant oversight responsibilities.

176. The MOFEA is the Principal Recipient for eight grants while AMREF is PR for one grant and a lead SR for another grant; and the MOHSW, Population Services International (PSI), and PACT Tanzania are PRs for one grant each. The grant agreements signed by the GF with its PRs legally binds them to be responsible for programmatic results and financial accountability of the grants. In addition, the PR is responsible for program implementation, technical coordination, procurement and supply oversight, financial management as well as monitoring and reporting. OIG noted that in a Memorandum of Understanding (MOU) signed with TACAIDS in 2004 the MOFEA delegated its PR responsibilities to TACAIDS. But TACAIDS has not been assessed as PR, as required by GF policy.

177. Hence, another key player in the oversight of implementation of grants is TACAIDS. Established by an Act of Parliament in 2001, it is mandated to provide strategic leadership, coordination and monitoring of the national response to HIV/AIDS. It is a Government department under the Office of the Prime Minister. In addition to being a substantive PR and a lead SR for GF

Round 3 HIV-TB grant, it serves as the TNCM secretariat. The Permanent Secretary in the Office of the Prime Minister is the Chairman of the TNCM.

178. The MOHSW, as the largest lead SR of grant funds, has an important role to play in the oversight of grant resources and progress of grant implementation. The GF grant agreements stipulate that the oversight responsibilities of the PR for grant implementation and accountability are also shared by SRs. In addition, the Public Finance regulations mandate Ministries, Departments and Agencies (MDAs) to establish Internal Audit (IA) units. Hence, the MOHSW has an IA unit with a staff of eight auditors to provide oversight of MOHSW activities in the country.

179. OIG found that approximately fifty percent of grant resources are utilized for procurement. The MSD, an autonomous unit within the MOHSW, is responsible for procurement of pharmaceutical supplies, civil works, laboratory equipment and other health commodities. The Public Finance Regulations require MSD to establish an Internal Audit (IA) unit and, working in close collaboration with the Board of Trustees and management, all have vital oversight responsibilities of procurement and supply chain management.

180. The TNCM which replaced the GF Country Coordinating Mechanism in 2007 has oversight responsibility for all GF grants in addition to programs funded by other international and national donors. The TNCM Secretariat is currently hosted by TACAIDS.

181. The Controller and Auditor General (CAG) of Tanzania is also a key player in the oversight of GF grants in Tanzania. The CAG is the external auditor of MDAs, Regional Administration, Local Government Authorities and donor-funded projects. The CAG therefore conducts annual audits of the following entities implementing GF grant programs: MOHSW, PMO-RALG which includes District and Municipal Councils, TACAIDS, and other line ministries involved in grant program implementation.

Oversight Role of the Ministry of Finance and Economic Affairs

182. OIG noted that in an MOU signed in December 2004 with the six lead SRs for HIV-TB Round 3 grant, the MOFEA limited its role of PR to the following areas:

- (a) Request and disburse funds to the Public Sector Lead SRs;
- (b) Review semi-annual financial reports from TACAIDS;
- (c) Facilitate the audit function;
- (d) Report semi-annually to the Local Fund Agent (LFA); and
- (e) Participate in partnership meetings and planning activities;

183. OIG noted that the MOU signed with the six lead SRs delegated the MOFEA's other PR responsibilities to TACAIDS. OIG, however, did not find

184. OIG found that semi-annual financial reports submitted to the MOFEA had been signed without rigorous verification to detect inaccuracies. For example, OIG found that funds which are yet to be disbursed to implementing organizations by MOFEA had been reported as spent in semi-annual financial reports to GF. OIG therefore concluded that the MOFEA has very limited role in program oversight.

Recommendation 46 (Significant)

There is scope for MOFEA to increase its involvement in oversight of the grants. Hence consideration should be given to expanding the PR responsibilities of the MOFEA particularly in the area of financial oversight.

Oversight Role of TACAIDS

185. TACAIDS is the substantive PR in Tanzania for a total GF public health sector grant portfolio which will soon amount to USD 1.2 billion with the signing of Round 8 grants. Being the substantive PR, TACAIDS has the following additional responsibilities:

- (a) It is a lead SR for GF Round 3; and as lead SR it has its own oversight responsibilities towards its own implementing partners such as AMREF and the Christian Social Services Commission (CSSC);
- (b) It serves as the TNCM Secretariat and is therefore involved not only in the preparation and hosting of TNCM meetings, but, in addition, it has responsibility for reviewing of concept papers, developing proposals to be submitted to GF and selection of PRs and SRs under the Global Fund's call for proposals. TACAIDS provides the TNCM a GF Coordinator who serves as secretary to the TNCM, a TNCM Secretariat Monitoring Officer, a Grants Coordinator and an Administrative Secretary;
- (c) It is the coordinating body for HIV/AIDS in Tanzania and receives funding from the GOT domestic budget to implement its own programs; and
- (d) It is implementing grants program financed by other donors such as the World Bank, UNDP etc.

186. The parliamentary act establishing TACAIDS entrusted it with the following responsibilities, among others, as the national coordinating body for HIV AIDS in Tanzania:

- (a) To mobilize, disburse and monitor resources and ensure equitable distribution;
- (b) To monitor and evaluate all on-going HIV/AIDS activities;
- (c) To-coordinate all activities related to the management of the HIV/AIDS epidemic in Tanzania as per National Strategy;
- (d) To advise the government on all matters relating to HIV/AIDS control in Tanzania mainland; and

- (e) To identify obstacles to the implementation of HIV/AIDS, prevention and control policies, programs and ensure the implementation and attainment of programs, activities and targets.

187. As shown above, TACAIDS has enormous responsibilities to undertake and its multiple and sometimes conflicting roles as PR, lead SR, TNCM Secretariat, implementer of its own programs and its role as national HIV/AIDS coordinating mechanism is stretching its capacity, structures and systems to a breaking point that could well compromise quality of its PR outputs.

188. OIG also noted that TACAIDS' audit committee had been inactive since October 2007, but recently management has taken steps to reinstate its oversight role.

Recommendation 47 (Significant)

Global Fund's Country Programs Cluster should assess TACAIDS capacity as a substantive PR and corrective actions should be taken to address any gaps/weaknesses found.

Recommendation 48 (Significant)

TNCM should draw up conflict of interest policies to manage the conflicts of interest situations that TACAIDS is confronted with such as being a substantive PR, a lead SR and at the same time managing the process for screening and selection of SRs.

MOHSW Oversight of Grant Programs

189. The MOHSW is the largest recipient of grant funds for the public sector. GF grant funds are received by the MOHSW through the government's exchequer system from the MOFEA. Generally, GF program activities are implemented by the program units of the MOHSW, such as National AIDS Control Program (NACP), National Tuberculosis and Leprosy Program (NTLP) and Medical Stores Department (MSD). These implementing units of the MOHSW however maintain program bank accounts at commercial banks which are outside the government exchequer finance system.

190. Funds received by the MOHSW from the MOFEA are released by the Finance Unit of the MOHSW to its implementing program units subject to review and authorization from the MOHSW's Department of Policy and Planning (DPP). Payment vouchers (PVs) for disbursement of GF funds to program units are not initiated/prepared by the Finance Unit, but by the program accountant of DPP. After the PVs have been processed through the internal control system of the MOHSW, cheques are then issued by the Finance Unit of the MOHSW to the program units which deposit the funds into the commercial bank accounts maintained by these implementing units.

191. Semi-annual financial and technical progress reports are not reviewed by the Finance Unit of the MOHSW as these bank accounts are operated outside the government's finance/accounting (exchequer system). Furthermore, financial and technical progress reports are not routinely shared with the Finance Unit. OIG reviewed the financial statements of the MOHSW and found that the balances on the program units' bank accounts are not incorporated in the MOHSW annual financial statements as these funds remain outside the exchequer financial system.
192. The MOHSW has an Internal Audit (IA) unit as mandated by the Public Finance Regulations, but due to capacity limitations its oversight does not currently cover GF grants. OIG noted that the MOHSW has more than 200 auditable sites in the country receiving funds from the Government of Tanzania's domestic budget and from donors.
193. OIG found that the key challenge facing the MOHSW IA unit is lack of adequate staff with appropriate mix of skills. OIG noted that while the approved staffing level for the IA department is fourteen auditors, currently it has eight staff members who do not have the appropriate mix of skills needed to provide oversight of GF activities. Current staff are audit specialists. Other specialists or consultants could be hired to complement its existing staff as needed, but the OIG learnt that the IA unit lacks the necessary financial resources. Because of limited staff the IA's oversight work is limited in scope and coverage. OIG found that there were only two limited scope reviews that have been done for NACP and NTLP in 2006 and 2007.

Recommendation 49 (High)

There is a need for senior management of the MOHSW to closely monitor the activities of MSD and the supply chain at all levels.

Recommendation 50 (Significant)

There is a need to increase the scope of the MOHSW Finance Unit's involvement in grant monitoring through periodic coordination meetings with program managers as well as sharing of information and reports.

Recommendation 51 (High)

There is scope to increase MOHSW senior management's role in removing bottlenecks to grant implementation through monthly review of the level of unspent grant funds in program bank accounts.

Recommendation 52 (Significant)

The capacity of the MOHSW Internal Audit unit should be enhanced to enable it provide oversight of GF grants.

Oversight Role of Medical Stores Department

194. OIG assessed the adequacy of the oversight of MSD's operations by its Internal Audit unit. The IA unit had five staff members who, according to its annual audit plan, are required to perform investigations and audit work covering procurement, inventory/stock control, and financial management at the head office each year. In addition, the IA unit is tasked with auditing twice a year each of the nine zonal offices warehouses in the country. OIG noted that in 2008, the IA unit was able to complete six out of nine planned audits of the zonal warehouses. But only one audit was conducted instead of the two planned for each zonal store.

195. OIG found that MSD internal audits do not cover district drug stores and health facilities except in cases when its auditors conduct investigations. Further, as sub-recipient audits do not cover medicines and health supplies delivered to district and health facilities, this means that medicines and health supplies purchased with GF grants are devoid of audit oversight which increases the risk of loss.

196. OIG noted that in June 2008 the Audit Committee of the MSD Board of Trustees had instructed management to conduct a comprehensive staff needs assessment of the IA unit. At the time of OIG's audit visit the staff needs assessment had not been carried out.

197. OIG noted the following issues raised in two consecutive CAG audit reports on MSD for FY 2005/2006 and 2006/2007:

- (a) Non compliance with the Procurement Act No 21 of 2004 and its related regulations of 2005;
- (b) Payments made without contracts;
- (c) Goods in transit not delivered to MSD;
- (d) Goods not delivered to zonal warehouses;
- (e) Loss of cash at MSD;
- (f) Goods in transit amount over-stated;
- (g) Unnecessary additional payment to a supplier; and
- (h) Questionable payments for fuel.

198. The Board of Trustees of MSD which is responsible for governance and oversight of the operations of MSD has not been reconstituted after its term expired in November 2008. Some of the matters facing MSD that affect its operational effectiveness and would need the new board's attention include the following:

- (a) Reinstating the Audit Committee of the Board of Trustees to focus on addressing the issues which have led to the CAG issuing successively two qualified opinions on the 2005/2006 and 2006/2007 FY financial statements of MSD;
- (b) Revising the outdated legislation governing MSD activities/operations (MSD Act No. 13 of 1993) to bring it in line with the Public Procurement Act of 2004 and its regulations that have impacted the way MSD conducts its business;

- (c) Clarifying MSD's role, responsibilities and relationships with other public entities such as the MOHSW's Pharmaceutical Supply Unit (PSU);
- (d) Reviewing internal MSD regulations and policies regarding how it conducts business with different donors; and
- (e) Strengthening and capacitating the human resources of MSD to be able to face the massive inflow of donor funds for medicines and health supplies.

Recommendation 53 (High)

MOHSW should reinstitute the MSD Board of Trustees, as a matter of urgency, to give it the necessary direction and oversight of its activities.

Recommendation 54 (Significant)

The MOHSW should ensure that the MSD Act is revised to take into account changes in its operating environment, and to address the organization's relationships and/or arrangements with donors.

Recommendation 55 (Significant)

Audits conducted by MSD should follow the supply chain trail to drug stores in the districts.

Recommendation 56 (High)

The MOHSW and the MSD Board of Trustees should ensure that the IA unit of MSD has sufficient, qualified and experienced staff to carry out its work to provide adequate internal audit oversight of medicines and health supplies purchased and distributed under the grants.

PMO-RALG Oversight of Grant Programs

199. PMO-RALG as a lead SR for GF grants is responsible for providing oversight of grant funds disbursed to 133 local government entities which include regional administration, municipal and district councils implementing grant programs in the country. What follows are some of the responsibilities of PMO-RALG:

- (a) Budget grant program activities of the local government entities in the government's development budget estimates;
- (b) Monitor the implementation program activities of the municipal and district councils; and
- (c) Collect and review financial and programmatic reports received from the municipal and district councils, consolidate these reports and send them to TACAIDS;

200. OIG found that PMO-RALG responsibilities have not been effectively performed because the coordination office had only one staff member to undertake these duties.

Recommendation 57 (High)

The PMO-RALG should recruit additional program and accounting staff in its coordination office to support its grant program monitoring and reporting responsibilities.

Controller and Auditor General Oversight of Grants

There is scope for the CAG to increase his audit scope to cover the entire supply chain for medicines and health products.

201. According to the Public Finance Act of 2001 the Controller and Auditor General (CAG) of Tanzania is required to audit the accounts of all Ministries Departments and Agencies (MDAs) of the Government of Tanzania. The CAG therefore conducts annual audits of the following entities implementing GF grant programs: MOHSW, PMO-RALG which includes District and Municipal Councils, TACAIDS, and other line ministries involved in grant program implementation.

202. The OIG noted that the CAG has embarked on a program of building its capacity and enhancing its independence and effectiveness with the support of the Swedish National Audit Office (SNAO). OIG noted that the CAG has adopted a quality assurance review process for its audit work to ensure that its outputs are of high quality. In addition, there are plans to enhance the independence of its auditors by relocating them from the offices of its auditees to regional CAG offices.

203. OIG reviewed a sample of audit reports issued by the CAG and some of the recurring issues/findings in audit reports and confirmed from OIG review that act as constraints to grant implementation and performance are listed below.

- (a) Unspent grant funds due to inadequate capacity;
- (b) Anticipated grant receipts from GF are not included in government development budget estimates (Medium Term Expenditure Framework)
- (c) Difficulties of matching GF grant expenditures with work plans and budgets;
- (d) Incurring grant expenditures without budget; and
- (e) Co-mingling of GF financing with funds received from other donors.

Recommendation 58 (Requires attention)

There is scope for the CAG to increase his audit scope to cover the entire supply chain for medicines and health products.

TNCM Oversight of Grant Programs

204. To meet the challenges of scale up of programs in response to HIV/AIDS, TB and malaria in early 2007, the responsibilities and oversight role of the CCM in Tanzania was expanded to cover programs funded by all

international donors. To this end the CCM was renamed the Tanzania National Country Coordinating Mechanism (TNCM). With an executive committee of sixteen members it is less wieldy as the CCMs in some GF-supported countries which have a total membership of more than forty. To give it the appropriate authority to oversee grant programs, the Permanent Secretary in the Prime Minister's office is the Chairperson of the TNCM. OIG also noted that as per CCM guidelines, key constituencies including civil society and the private sector are adequately represented in the TNCM. The Vice-Chair of the TNCM is selected from the civil society constituency.

205. In addition, to increase its effectiveness, the TNCM has established a technical coordinating committee which provides technical advice to the TNCM in oversight of grant programs and preparation of grant proposals. The technical coordinating committee of the TNCM is constituted into four technical working groups covering the three diseases as well as avian influenza. A review of TNCM minutes showed that the introduction of the technical working groups has improved the TNCM oversight of implementation bottlenecks such as procurement delays, receipt of grant funds and disbursement to SRs.

206. Furthermore, the governance mechanism in Tanzania has been strengthened through the adoption of TNCM guidelines, introduction of the executive dashboard to assist in oversight of grant implementation, establishment of technical working groups to advise the TNCM, and studies undertaken to improve grant implementation.

207. OIG however noted that challenges and constraints to grant implementation had been detailed in the June 2008 consultancy report titled *Analysis of the Management and Financial Flows and Utilization of the Global Fund Grants in Tanzania*. This report was commissioned by TACAIDS on behalf of the TNCM. Some of the key constraints to grant implementation noted in the report are listed below:

- (a) Delays in procurement due to poor planning and lack of capacity of MOHSW's PMU;
- (b) Severe shortage of reagents;
- (c) Complex government financial disbursement procedures lead to delays in the release of funds to implementing organizations which affect program implementation;
- (d) Delays in the preparation of financial progress reports; and
- (e) Poor communication and coordination leading to long decision-making times.

208. OIG did not find Action Plans to address the issues and recommendations raised in the above-mentioned consultant report.

209. OIG also noted that the TNCM does not have an oversight plan to facilitate its oversight responsibilities of the increasing size of Tanzania's grant

portfolio. GF guidelines require the Country Coordinating Mechanism (CCM) to have an oversight plan which could help it focus on key risk areas and assist in assessing its oversight performance. OIG also noted that the TNCM as a group is yet to make visits to program sites to be acquainted with the implementation challenges facing its grants.

Recommendation 59 (Significant)

The TNCM should develop an oversight plan to facilitate its oversight responsibilities.

Recommendation 60 (Significant)

There is the need for the TNCM and lead SRs to assess the current level of staffing and resources for M&E activities given the increasing number of grants and the size of the portfolio.

LFA Oversight of Grant Programs

210. GF does not have a country presence, thus it relies on the Local Fund Agent (LFA) to provide oversight of its grants in recipient countries. The grant portfolio in Tanzania will be USD1.3 billion with the signing of Round 8. The LFA in Tanzania is PricewaterhouseCoopers. According to the LFA scope of work it is responsible for carrying out the following tasks for the GF.

- (a) Initial PR capacity assessment before grant signature;
- (b) Review of grant Progress Updates and Disbursement Requests (PUDRs) submitted by PRs, which in the case of Tanzania it is semi-annual for each grant;
- (c) Assessment of PR after the initial two years of grant implementation; and
- (d) On site data verification, a new monitoring tool introduced by the GF in 2008.

211. At times the LFA did influence the types of monitoring activity as was the case in 2007 when it found missing quantities of ACTs at the Medical Stores Department. Subsequently, the LFA advised the GF Secretariat that further follow on work was needed which made it possible to quantify the loss and identify the weaknesses that caused this incident.

212. As noted above, it is evident that the LFA oversight function is reactive, output-driven, time-specific and not a continuous monitoring activity. After outputs are delivered, there is limited incentive and no contractual obligation for the LFA to engage in on site monitoring work. Any monitoring activity is conditional on a work order agreed with the GF Secretariat.

213. But in OIG's view, given the size of the portfolio and the impending signing of Round 8 grants which have significant procurement components, the LFA oversight work in Tanzania needs to be more "hands-on" rather than reactive as it is currently the case. Also, OIG did not see any risk assessment of the grants in Tanzania that informs the LFA's oversight work to ensure that it is appropriately focused on key risk areas.

Recommendation 61 (Significant)

Given the size and complexity of the grant portfolio in Tanzania, there is scope for GF Country Programs Cluster to make the Tanzania LFA's oversight work more "hands on" instead of being adhoc and reacting to negative events in the field.

Recommendation 62 (Significant)

The GF Country Programs Cluster should ensure that the LFA oversight work in Tanzania is informed by a risk assessment done of the grant portfolio covering key implementing SRs and high risk areas of grant implementation.

The role of the local fund agent in program monitoring the quality of service and data reported by grant recipients

The LFA conducted a series of data verification studies in 2008 with assistance of contracted health specialists, but this is the only documented evidence of LFA involvement in monitoring service delivery. The on-site data verification is a new monitoring instrument introduced by the GF Secretariat. The reports of the data verification studies reveal serious problems of data quality for three of the five grants. The studies were rigorous, but the fact that they were conducted quite late in the grant implementation process, limits their usefulness. The level of analysis used in the studies is acceptable to assess data quality, but it is insufficient to determine the causes of poor quality or to formulate recommendations on how to improve it.

214. Section B1 of the LFA Manual³⁵ ("what LFA's do") is a generic summary of the terms of reference of an LFA. It engages LFAs in programmatic monitoring by requiring them to "review proposed indicators and targets for programmatic performance", and to "verify results against targets and expenditures". The OIG team were told by the LFA that it engaged public health specialists to monitor programs.

215. During the audit, the only programmatic monitoring reports provided by the LFA concerned initial recipient capacity assessments and special reports related to the issue of procurement and supply management of ACTs. The limited role of the LFA to monitor the services provided with GF support, due to limitation of its scope of work agreed with the GF Secretariat was acknowledged in meetings with the OIG team. The LFA representatives stated that public health specialists were contracted to assist in this task. After the field work, OIG team reviewed reports of data verification studies for each of the audited grants and the CVs of three health professionals who were involved in this exercise. The reports were dated February 2009 and were the only reports of this nature available, since this monitoring instrument was recently introduced by the GF Secretariat. The health professionals had high

³⁵ The Global Fund; LFA Manual, May 2008

level academic profiles, but only one of the three had any background in public health which is the main competence necessary for this task.

216. The data verification for each of the grants was conducted in a rigorous manner using a standardised procedure. The comparability of the results is high, but the somewhat mechanistic application of the methodology did not generate much understanding of the causes for data discrepancies or help to formulate appropriate recommendations. The recommendations are therefore superficial, asking for improved measurement performance when the constraints are clearly at the level of measurement systems.

217. For example, the verification report for the Round 4 Malaria grant notes that Bukoba District reported a total consumption of 22,339 tablets (or treatments?) of ACT between October 2007 and March 2008, while the National Malaria Control Program reported the quantity of 99,871 tablets (or treatments?) for Bukoba District for the same period. Mathematical error was cited as the primary reason for this discrepancy, but there are clearly more profound problems in reporting and data management.

218. In general, the LFA data verification reports confirm the findings of the OIG team that there are problems in the reporting of performance indicator data for three of the five audited grants: Round 3 HIV/TB, Round 4 Malaria, and Round 4 HIV (MOF). The data quality of the other two grants, Round 1 Malaria and Round 4 HIV (AMREF) is acceptable. It is evident that monitoring the quality of performance data has to start early in the process of grant implementation and has to continue at regular intervals throughout. Furthermore, when routine data verification studies show that there are major discrepancies between reported results and verifiable results, a more in-depth investigation needs to be conducted.

Recommendation 63 (High)

The GF Country Programs Cluster should ensure data verification is conducted regularly and routinely by the Local Fund Agent starting early in grant implementation.

Recommendation 64 (High)

When data verification studies reveal major problems of data quality, as found in Tanzania, GF Country Programs Cluster needs to ensure that they are followed up with a more detailed technical assessment that is able to diagnose the source of the problems and provide appropriate suggestions for solutions.

Recommendation 65 (Significant)

The GF Country Programs Cluster should review the role of the LFA in monitoring the quality of service delivery and make the necessary changes in the LFA terms of reference to assure that this task is performed adequately.

GF Secretariat Oversight of Grant Programs

219. OIG recognize that some of the challenges facing the grants to Tanzania detailed in this report had also been noted in GF Secretariat periodic performance reports. For example, the August 2007 Phase 2 assessment³⁶ of the Round 4 HIV grant noted issues of procurement delays, late disbursement of funds to SRs and concerns about the quality and timeliness of sub-recipients' financial and programmatic reporting. To address the aforementioned issues, the following corrective measures were proposed by the Secretariat.

- (a) Submission by the PR of a comprehensive procurement planning matrix for GF Secretariat approval;
- (b) PR's implementation of the M&E health systems strengthening tool to improve on quality of data generated and programmatic results reported; and
- (c) Submission by the PR to the GF of evidence of implementation of the HR capacity strengthening plan funded under GF Round 3 grant.

220. OIG noted that the remedial actions proposed by the Secretariat did not address quality issues regarding financial reporting by TACAIDS. Furthermore, the corrective measures proposed did not address the supply chain management issues noted in this audit report. OIG however recognize that subsequent to the ACT problems in Tanzania, the Country Programs Cluster, in December 2008 instructed the LFA to review the procurement and supply chain management systems for ARVs. In addition, in October 2008, the Country Programs Cluster asked the LFA to undertake a financial monitoring review of 22 selected Local Government Authorities (LGAs) and Regional Hospitals that receive funds under HIV/AIDS Round 4 and HIV/TB Round 3 grants. The results of this review indicate that ongoing monitoring of the LGAs is needed. OIG also learnt that the Country Programs Cluster will increase its LFA oversight budget for Tanzania from USD 0.6 million in 2008 to USD 1.3 million in 2009.

221. Some of the common weaknesses³⁷ mentioned in Tanzania's M&E systems strengthening workshop report in 2007, covering HIV/AIDS, TB and malaria are detailed below.

- (a) Lack of guidelines to ensure data quality;
- (b) Inadequate capacity at all levels in data management, processing, documentation, analysis and reporting;
- (c) Inadequate capacity at TACAIDS management unit;
- (d) No systematic feedback to sub-reporting entities concerning data quality;
- (e) Supervisory visits do not take place frequently enough; and
- (f) Small percentage of budget is allocated to M&E and over-reliance on donor funds to conduct M&E.

222. OIG did not find evidence of GF Secretariat regular monitoring of the progress of the implementation of the M&E improvement plan (road-map) which was prepared by the PR in October 2007 after Tanzania's self-assessment of its M&E systems. OIG learnt that finding the financial

³⁶ Grant Score Card for HIV Round 4 of August 2007

³⁷ HIV/AIDS, Malaria and TB Monitoring Evaluation Systems Assessment Report, 2007

resources to fund the M&E improvement plan has also been a challenge. Some in-country technical partners are funding some of the improvement activities while other systems strengthening activities have been earmarked for implementation under impending GF Round 8 grants.

Recommendation 66 (Requires attention)

The GF's Country Programs Cluster should draw more on the technical expertise of the GF M&E and Procurement units in its oversight of the grants in Tanzania.

Annex 1

Government of Tanzania Response to Recommendations and Management Action Plan

Prioritization of recommendations

a. High priority: Material concern, fundamental control weakness or non compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization’s interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management.

b. Significant priority: There is a control weakness or noncompliance within the system, which presents a significant risk and 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 control, or undermine achievement of aims and objectives.

c. Requires attention: There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization’s benefit.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
Procurement and Supply Management	<p>Recommendation 1 (High) A detailed assessment of procurement capacities of the MSD, the PMU and the supply chain at all key levels need to be carried out by the LFA before the onset of Round 8 grants.</p>	<p>MOHSW concurs with the recommendation.</p> <p>The MOHSW in realization of weakness of procurement capacity, in the year 2008 carried out assessment of the procurement capacities of the PMU at the MOHSW headquarters. The assessment was conducted in collaboration with the World Bank Tanzania Country Office, following the basket fund procurement audit reports submitted by American Procurement Company Inc (AMPROC) for the financial year 2004/2005, 2005/2006, 2006/2007 and</p>	See below	See below

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		<p>2007/2008.</p> <p>The report came-up with 12 recommendations. The recommendations are being implemented.</p> <p>The Development Partners agreed to assist the MOHSW to undertake the assignment. The Basket Fund Committee (BFC) meeting held on 19th February, 2009 agreed to hire a consultant who will undertake in house training for the PMU and supporting the procurement process.</p> <p>However, there is need for the LFA to conduct the assessment taking into account the above efforts undertaken by the MOHSW and Partners.</p> <p><u>GF Secretariat Comment on Country Response:</u></p> <p>The Cluster has taken note of the Country's response and would like to add a few comments regarding the LFA assessments as follows:</p> <p>The EAIO team has instituted Annual Procurement and Supply Management (PSM) reviews in Tanzania in view of the large Portfolio and potential risk given that over 60% of the grant funds are for procurement of health products.</p>	<p>LFA/EAIO Team</p>	<p>July 2009</p>

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		<p>The LFA is currently carrying out full blown assessments not only to cover round 8 grants specifically but to cover the overall capacity for Procurement and Supply Management. The 2009 ARV review (on-going) and the scheduled July 2009 ACT review will be undertaken as part of a wider overall review of the PSM system. The review will cover MSD, Ministry of Health PMU, and the general supply chain management systems. As with previous assessments, any assessments / reviews undertaken by partners will be taken into account. The outcome of these LFA reviews will determine any follow up detailed analysis or actions that will enable the implementation of the Tanzania grants. We deem these adequate to enable moving forward with round 8.</p>		
	<p>Recommendation 2 (Significant) The quantification exercise must use actual consumption data at health facilities and take into account existing stock at all levels of the supply chain to arrive at good estimates of stock needs.</p>	<p>The Ministry concurs with recommendation;</p> <ul style="list-style-type: none"> The next ACT, ARV and HIV test kits quantification will take into consideration existing stock at all levels of the pipeline. MOHSW in collaboration with PMO-RALG will instruct all District and Regional Medical Officers to ensure that health facilities conduct stocktaking on quarterly basis effective from July 2009. The stocktaking reports will be 	MOHSW	OCTOBER 2009

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		<p>submitted to MOHSW and MSD to facilitate stock tracking national wide.</p> <ul style="list-style-type: none"> As regards to ACT, quantification will also take into account contribution of other interventions in reduction in number of malaria cases especially when there will be a universal coverage of long lasting nets. 		
	<p>Recommendation 3 (High) The MOHSW should review the current practice of maintaining the program supply chain for ACTs at a minimum 8 months and a maximum of 12 months of supply needs since these anti-malaria medicines have short-shelf lives. Further, the ARV supply pipeline of 15 months maximum and 9 months minimum stock levels should be reviewed to prevent oversupply.</p>	<p>The Ministry concurs with recommendation; The ACT and ARV minimum and maximum months of stock in supply chain will be reviewed before the next procurement is done. The review of minimum and maximum stock levels will take into account MSD procurement lead time, supplier delivery schedules and scale-up of ART program.</p>	MOHSW	December 2009
	<p>Recommendation 4 (Significant) To enhance accountability for medicines and health supplies, the MOHSW should ensure that actual consumption data for ARV drugs, medicines for treatment of TB, malaria, opportunistic infections (OIs), and other health supplies are recorded and accounted for in stock ledgers and patient registers. These data should be reported in quarterly reports to both MSD and the</p>	<p>MOHSW concurs with the recommendation MOHSW has already instructed MSD to distribute medicines and medical supplies along with management tools (stores ledgers, dispensing and patient registers) to ensure that each health facility has the tools. MOHSW will issue a circular to remind District and Regional Medical Officers to ensure that health facilities properly maintain stock records. MOHSW in collaboration with PMO-RALG will ensure that Regional and</p>	MOHSW	October 2009

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	national programs.	Council Health Management Teams (RHMT & CHMT) conduct routine supportive supervision to health facilities under their jurisdiction to make sure that the facilities properly maintain stock records.		
	<p>Recommendation 5 (High) Adjustments to stock on hand should be made only in cases of expired drugs, theft and damage. And all such adjustments should be explained, documented and subject to prior approval by MSD senior management and notification of MOHSW.</p>	<p>MSD concurs with the recommendation. Effective from July 2009 all adjustments will be done only after approval of MSD senior management. In case of theft, damage and expiry, adjustments will be reported to the MSD Board of Trustees for approval and submitted to MOHSW for appropriate action.</p>	MSD	October 2009
	<p>Recommendation 6 (Significant) Medicines and health supplies bought with GF resources should be carried in MSD's inventory at cost to facilitate calculation of stock on hand, expired stocks, and to enhance accountability.</p>	<p>MSD concurs with the recommendation.</p> <p>Medicines, medical supplies, reagents and equipment bought with GF resources are recorded in MSD stock at cost when received at MSD warehouse. The stocks are immediately charged to the Donor's account in accordance to the existing MoU. The stocks are then carried at zero values in the ledger to facilitate free distribution to beneficiaries.</p> <p>Currently, the ORION system is unable to accommodate the recommendation. MSD will be able to comply with the recommendation after the system upgrading or replacement.</p>	MSD	December 2010

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	<p>Recommendation 7 (High) The MOHSW and MSD should consider seeking funding either to improve MSD's Orion system or replace it with a system that is more reliable and can enhance accountability of medicines and health supplies.</p>	<p>MOHSW and MSD concur with recommendation.</p> <p>MOHSW will make a decision on the PKF audit report and direct MSD on the appropriate action to be taken as regards to upgrading/replacement of the Enterprise Resources Planning (ERP) system.</p> <p>MSD has set aside funds for upgrading/replacement of current ERP (ORION) System in the 2009/10 budget. The upgrading/replacement has been estimated to take not less 18 months.</p>	<p>MOHSW</p> <p>MSD</p>	<p>June 2009</p> <p>December 2010</p>
	<p>Recommendation 8 (Significant) Senior management of MSD and MOHSW should monitor regularly the supply chain at all levels to ensure that slow-moving stocks which risk expiring are moved to facilities that could use them before they expire.</p>	<p>MOHSW and MSD concur with the recommendation</p> <p>MOHSW in collaboration with PMO-RALG will ensure that health facilities conduct stocktaking on quarterly basis effective from July 2009. The health facilities will prepare reports indicating stock levels, slow moving and near expiry items. The stocktaking reports will be submitted to MOHSW and MSD to facilitate stock tracking nation-wide and redistribution.</p> <p>MSD will build capacity of inventory analysts to enhance inventory management of medicines, medical supplies, reagents and equipment. In</p>	<p>MOHSW</p> <p>MSD</p>	<p>October 2009</p> <p>July 2009</p>

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		<p>addition, two stock verifiers charged with regular monitoring of stocks at all levels of MSD will be recruited. Furthermore all Zonal Managers are required to prepare monthly stock reports indicating slow moving, near to expire and dormant stocks, and submit to MSD headquarters. This will enable MSD management to make informed decision.</p>		
	<p>Recommendation 9 (High) Accurate data on stock covering stock on hand, actual consumption, expected stock arrivals, losses and adjustments need to be collected and communicated to senior management of MSD and MOHSW on a regular basis to enable them to make informed decisions.</p>	<p>MOHSW and MSD concur with the recommendation. MOHSW in collaboration with PMO-RALG will issue a circular to District and Regional Medical Officers to submit timely and accurate data on stock on hand, consumption, losses and adjustments from health facilities under their jurisdiction to MOHSW and MSD</p> <p>MSD will ensure that Zonal medical stores adhere to established re-order levels.</p>	<p>MOHSW</p> <p>MSD</p>	<p>July, 2009</p> <p>July 2009</p>
	<p>Recommendation 10 (Significant) Staff at all levels of the supply chain need to be trained in basics of good inventory management and storage practices; and it is important that quality of inventory management at health facilities be monitored regularly by supervision teams from MOHSW.</p>	<p>MOHSW concurs with the recommendation. MOHSW in collaboration with PMO-RALG will facilitate the regions to provide capacity building on basics of good inventory management and storage practices to health workers involved in the management of medicines, medical supplies and reagents. In</p>	<p>MOHSW</p>	<p>October 2010</p>

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		<p>addition, RHMT and CHMT will be required to routinely conduct supervision in health facilities under their jurisdiction to ensure that the facilities adhere to good inventory and storage practices.</p>		
	<p>Recommendation 11 (Requires attention) The MSD should consider shifting some deliveries of medicines and health supplies to zonal stores/warehouses to ease storage problems at the MSD central store.</p>	<p>MSD concur with the recommendation. As part of Implementation of MTSP 2007 - 2013, MSD is decentralizing most of activities to Zonal stores. Currently management is implementing capacity building programs in terms of staffing, ICT systems and warehousing so that zonal stores are able to receive goods from suppliers.</p> <p>MSD is expanding its storage facilities in all zones by constructing new warehouses. So far three Zonal Medical Stores namely Moshi, Iringa and Mwanza have increased storage capacity. In the interim MSD central warehouse receives and transfers consignments to zonal stores.</p> <p>MSD has prepared five year human resource plan to address among other things, staffing of Zonal Stores to enable them to take up new roles.</p>	MSD	December, 2010
	<p>Recommendation 12 (Significant) The MOHSW should review the current practice of maintaining high stock levels in the supply chain to ease overstretched storage capacity at all levels of the supply chain.</p>	<p>MOHSW concurs with the recommendation.</p> <p>MOHSW will institute ordering system in all health facilities using Integrated Logistics System (ILS) to ensure that health facilities order their requirements from MSD according to</p>	MOHSW	June 2010

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		needs including ACT and ARV. RHMT and CHMT will be required to routinely conduct supervision in health facilities to make sure that facilities place their orders timely and accurately.		
	<p>Recommendation 13 (Requires attention) MOHSW should establish reorder quantity levels for medicines and health supplies to minimize stock-outs.</p>	<p>MOHSW concurs with the recommendation</p> <p>MOHSW in collaboration with PMO-RALG will provide capacity building at regional level. In-turn, the regional level will facilitate health facilities to maintain appropriate stock levels to avoid overstocking and stock-outs. On the other hand MSD will adhere to established stock reorder level.</p>	MOHSW	June 2010
Service Delivery: HIV/AIDS	<p>Recommendation 14 (High) The NACP should apply its instruments and procedures for the certification of HIV care and treatment sites more rigorously and include an assessment of the general quality of patient care in its certification criteria.</p>	<p>The National AIDS Control Programme shall continue to use the existing tools for assessment more rigorously and ensure each level of implementation keep the assessment reports for subsequent follow-up and supportive supervision and clinical mentoring. In addition, NACP is finalizing development of Quality Improvement Guidelines for patients' care which will be in use from early next year 2010.</p> <p>In this regard, the NACP is strengthening the procedures for certification of HIV care and treatment sites by;</p> <ul style="list-style-type: none"> • Ensure feedback on the implementation of the strengthening plan as agreed 	MOHSW/PMO RALG	On going

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		<p>during the assessment on monthly basis to the relevant authority (DHMT, RHMT and national level).</p> <ul style="list-style-type: none"> • Structured supportive supervision and clinical mentorship • Stress the importance of filing and proper record keeping at all levels of healthcare delivery systems 		
	<p>Recommendation 15 (Requires attention) The MOHSW should develop clear guidelines for health facilities on how to manage drugs and supplies that are provided free of charge to patients with HIV/AIDS and that are at the same time dispensed to other patients on a cost recovery basis.</p>	<p>The MOHSW will develop clear Guidelines in consultation with all key stakeholders to provide instructions to health care workers on the management drugs and supplies provided through donor support including Global Fund.</p>	MOHSW	March 2010
	<p>Recommendation 16 (Significant) The GF performance indicator for HIV counseling and testing should be changed by adopting the Tanzania National HIV indicator of the proportion of men and women who report that they were tested within the last 12 months and have received a result. MOHSW should consult with the TNCM and the Monitoring and Evaluation Unit of the GF Secretariat.</p>	<p>The MOHSW concurs with recommendation. Implementation will commence after consultation with TNCM and GF, Geneva on the change of indicator and the reporting period</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>This will be reviewed by the East Africa and India Ocean (EAIO) Team in consultation with</p>	<p>MOHSW/ TNCM</p> <p>EAIO Team / GF M & E Unit</p>	<p>September 2009</p> <p>On-going</p>

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		the GF M & E Unit and appropriate decisions made regarding the indicator to adopt.		
	<p>Recommendation 17 (Significant) The TNCM should strengthen the representation of partners engaged in the social sector response to HIV, especially partners who speak for the needs of children.</p>	<p>The representation in the TNCM is by institution. Department of Social Welfare (DSW) is a department under the MOHSW. MOHSW is represented in the Executive Committee of TNCM by Permanent Secretary (PS). Other MVC stakeholders (Pact) are also members of HIV/AIDS Technical Working Group of TNCM. Moreover, TNCM shall co-opt more members who represent the interest of children when need arises.</p>	MOHSW, TNCM	Done
	<p>Recommendation 18 (Significant) The NACP should strengthen the national processes and capacities for collecting, entering, transmitting, and analysing data on HIV care by taking a stronger ownership of the CTC2 database at District, Regional, and National level. This effort should also include an effort of greater coordination and sharing of resources of the CTC2 data collection system with the National Health Information Management System.</p>	<p>The MOHSW is currently strengthening the data management and flow by putting in place the following measures:</p> <ul style="list-style-type: none"> - Assessment of the existing care and treatment monitoring and evaluation system in June 2009 through fielding consultants to find out factors which hinder HIV care routine recording, data summarization/aggregation, data flow and use. This activity will come up with action oriented recommendation for strengthening the system. Mean while the MOHSW: - Has issued a circular to Regions and Districts reminding them on data management at their respective levels. - Is reviewing Terms of Reference/Memorandum of Understanding) regarding regionalization and 	MOHSW	December 2009

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		<p>data management (collecting, entering, transmitting and analysing).</p> <ul style="list-style-type: none"> -Is harmonizing paper based and electronic training materials on data management for HIV care to develop one comprehensive training materials that will facilitate capacity building at all levels - Is reviewing its HMIS to make it more comprehensive to capture data for various programmes including HIV/AIDS. - Is reviewing job descriptions and qualifications for RACCs and DACCs to strengthen coordination and data management at regional and district levels. 		
	<p>Recommendation 19 (Significant) The NACP should start generating and publishing ART cohort retention data from the electronic CTC2 database, even if this may initially only be possible for a few selected health care facilities.</p>	<p>The MOHSW concurs with the recommendation. The NACP will start developing and publish ART cohort retention data from the electronic CTC2 database from selected health care facilities. This will be part of the "Implementation of HIV/AIDS care and treatment services in Tanzania, report number 2.</p>	MOHSW	December 2009
	<p>Recommendation 20 (Significant) TACAIDS should review the costs and the options of further developing TOMSHA as a stand-alone data collection and analysis system and give serious consideration to seeking the integration of TOMSHA in the Local Government Monitoring and Evaluation System.</p>	<p>TOMSHA was designed to be integrated into Local Government M&E System (LGMD). A Consultancy to develop a module for integration into LGMD has been Advertised and Tender evaluation will be completed by July 2009. Re-training of implementers is scheduled to start second quarter of 2010</p>	TACAIDS	June 2011

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	<p>Recommendation 21 (Significant) The TNCM should enter into a discussion with the GF Monitoring and Evaluation Unit to achieve a greater alignment of GF grant performance indicators with national HIV indicators.</p>	<p>Recommendation is accepted.</p> <p>National Indicators will be adopted for GF Grant performance M&E subject to agreement with GF Secretariat, Geneva. It is proposed that this should be done together with synchronization of the reporting periods of Government and GF grants. Communication has already been submitted to GF Geneva; meanwhile National Consultation is going on.</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>The process of harmonization and alignment of indicators is an on-going process. The Round 8 M & E plans and performance Frameworks negotiation will be the starting point moving forward. However, the process will be reinforced during the scheduled MESS self assessment Tool workshop scheduled for October 2009. The EAIO Team and GF Secretariat M & E staff will attend the work shop as co-facilitators and also to engage all stakeholders /partners who will be participating in the workshop.</p>	<p>TNCM Secretariat</p> <p>EAIO Team / GF M & E Unit</p>	<p>December 2009</p> <p>On-going</p>
HIV-TB	Recommendation 22 (Significant)	The Ministry agrees with the recommendation.	MOHSW	On going

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	<p>The universal implantation of the TB screening questionnaire in all HIV testing sites and the certification of selected tuberculosis clinics for ART are promising initiatives that should be pursued by the MOHSW.</p>	<p>All partners have already adapted the TB screening tool. All major TB clinics are now approved to provide ART in close collaboration with the Care and Treatment Clinics (CTC). Other actions include:</p> <ol style="list-style-type: none"> 1. The MOHSW is scaling up the collaborative TB/HIV activities by conducting trainings to all HIV testing sites based Health Care Workers in phases. The emphasis of the training includes the use of TB screening questionnaire. 2. There is on-going supportive supervision to Regional and Council Health Management teams in order to build their capacity to enable them conduct supervision in their health care facilities providing HIV care and treatment services. 		
	<p>Recommendation 23 (Requires attention) The PRs of GF grants for HIV in Tanzania should seek more active support from the UNAIDS Technical Support Facility for issues of grant implementation.</p>	<p>Recommendation is accepted. Tanzania has developed a National Technical Support Plan with TA from UNAIDS. Two priority areas have been identified from the Technical Support Plan namely;</p> <ol style="list-style-type: none"> 1. Financial Management 2. Monitoring and Evaluation <p>Tanzania has received UNAIDS TSF support in the following activities;</p>	<p>MOHSW/ TACAIDS</p>	<p>September 2009</p>

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		<ol style="list-style-type: none"> 1. Analysis of the management, financial flows and utilization of the GF grants in Tanzania (2008) 2. Preparation of GFR3 RCC proposal (2009) 3. Programmatic and Financial Gap analysis for GFR9 proposal (2009) 4. Development of a costed Prevention Strategy 5. Preparation of GFR9 proposal (2009) 		
	<p>Recommendation 24 (Significant) The MOHSW should engage with the international agencies providing support to the HIV treatment program to assure that this support places as much or more emphasis on local capacity and systems development as it places on achieving high levels of treatment outcomes.</p>	<p>The MOHSW will review Terms of Reference/Memorandum of Understanding with HIV care and treatment regional implementing partners regarding local capacity and system development and strengthening.</p>	MOHSW	December 2009
<p>Service Delivery: Malaria</p>	<p>Recommendation 25 (Significant) Because of the planned transition in the Tanzanian national bed-net strategy, the GF should adopt a monitoring approach that would allow sufficient flexibility to respond to the different stages of transition. In practice, this would mean Global Fund Secretariat participation in the regular national bed-net partnership meetings.</p>	<p>The Global Fund will be invited to attend NATNET Steering meeting which are held quarterly. Their attendance to be decided by the GF Secretariat.</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>The EAIO Team is engaged in coordination</p>	<p>MOHSW</p> <p>EAIO Team</p>	<p>On going</p> <p>On-going</p>

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		<p>/harmonization and joint funding arrangements for the bed nets program. Currently, the WB, PMI and TGF are involved in joint purchase of 7.2 M bed nets for the Under Five (U5) LLINs Campaign. Several meetings have taken place including high level meetings between PMI, WB and GF.</p> <p>The LFA has been and will continue to attend the NATNET Steering meeting which are held quarterly. The EAIO Team will endeavour to attend the meetings whenever possible.</p>		
	<p>Recommendation 26 (Requires attention) The NMCP should play a stronger role in coordinating malaria research by all actors in Tanzania in order to eliminate redundancies and increase the power of individual studies.</p>	<p>In Tanzania the National Institute for Medical Research (NIMR) has the legal mandate to coordinate all health research in Tanzania. There is an annual forum (The National Essential Health Research Forum) whereby NMCP pre-identified malaria research topics are presented and shared. NIMR may then allocate resources for research. The MOHSW will therefore instruct NIMR to take a proactive role in coordinating the different researches so as avoid such duplication and hence obtaining value for money.</p> <p>The concern addressed in this report relates to uncoordinated surveys done by different institutions all targeting on the use of nets, malaria parasite prevalence etc. NMCP has</p>	MOHSW	July 2009

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		already taken action by calling a meeting of all parties to harmonize malaria M&E surveys for the next 5 yrs		
	<p>Recommendation 27 (Requires attention) The NMCP should shift attention towards increasing the availability and use of ACT in the informal and private sector, together with continued public education to assure prompt treatment of malaria.</p>	<p>Availability and use of ACTs to the informal and private sector is being addressed in GFR 7 and AMFm proposals. It is envisaged that in the 1st quarter of 2010 private health facilities and Accredited Dispensing Outlet will start selling affordable ACTs.</p>	MOHSW	March 2010
	<p>Recommendation 28 (Requires attention) The MOHSW, in consultation with the TNCM, should ensure that Global Fund grants for the supply of ACT should include a performance monitoring framework that can be monitored with existing data tools and reports.</p>	<p>ACTs are monitored with the existing HMIS tools which are the Reporting and Requisition (R&R) forms and the patient registers (HMIS Book 2) available in all health facilities. Health Facilities reports on ACT consumption on quarterly basis.</p> <p>The challenge has been the sending of these forms on a regular basis to NMCP and HIMS. This issue has been addressed in GFR4 and PMI support whereby all health facilities will be pulling ACT by end of 2009, where reporting is mandatory. GFR9- HSS also addresses the issue on monitoring.</p>	MOHSW	On going
Service Delivery: General	<p>Recommendation 29 (Significant) The MOHSW should rapidly develop a logistics and reporting system that could link morbidity data from health facilities with information about medication usage. Such a system should not be specific to malaria but cover all clinical activities in</p>	<p>The MOHSW has already finalized and shared with partners a proposal to computerise HMIS. The system will facilitate analysis of all health data including morbidity from health facilities.</p>	MOHSW	December 2011

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management and control	TACAIDS financial reporting capacity should be reviewed as part of its PR capacity assessment. As part of this assessment, the financial reporting capacity of all lead SRs which send their PUDRs to TACAIDS to be consolidated should also be assessed.	<p>the capacity of TACAIDS and other LSRs which submit PUDRs to TACAIDS.</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>This is being undertaken under the Round 8 LFA Assessment. The review will involve assessing TACAIDS's coordination role. Note that the actual implementation of the programs is undertaken by the Lead Sub-Recipients (SRs) and Sub-SRs such as MOHSW, MSD, NMCP, NTLP, NACP etc.</p>	LFA/EAIO Team	September 2009
	<p>Recommendation 32 (Significant) The PR should report in the PUDRs all large unspent bank balances in the PR and SRs' bank accounts to provide the GF adequate information to make grant disbursement decisions.</p> <p>OIG learnt that GF Finance unit is in the process of revising the current PUDR reporting template to require lead SRs to report large unspent balances. OIG strongly encourages GF management to implement a revised PUDR to address the</p>	<p>Recommendation is accepted.</p> <p>Tanzania is willing to implement according to revised Progress Update and Disbursement Request (PUDR)</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>This will be reviewed at the Country Programs Cluster level in coordination with the GF</p>	LFA/EAIO Team	December 2009

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	problem of large unspent balances in program bank accounts.	Secretariat Finance Unit who are charged with the responsibility of designing the PU/DR forms (change of the PU/DR forms has a wider Cluster wide implication). The EAIO Team will follow up on final decisions and recommendations made at the GF Secretariat level.		
	Recommendation 33 (Significant) When grant funds have not been budgeted in government expenditure estimates, the PR should inform GF to defer disbursements pending in-country reallocations or approval of supplementary budgets by national authorities.	Recommendation is accepted. GF grants will be budgeted in the Gov't MTEF estimates. In case the country receives excess GF funds than estimated, the country will inform the GF Secretariat.	MOFEA, PMORALG	
	Recommendation 34 (Significant) There is scope for improvement in coordination, communication and information-sharing among the key players namely, MOFEA, MOHSW, TACAIDS, PMORALG, TNCM and the LFA regarding removing bottlenecks to flow of funds to implementing organizations.	Tanzania concurs with recommendation. Efforts to remove bottlenecks to the flow of funds are on going through; <ul style="list-style-type: none"> • Conducting quarterly technical meetings of all key players • Making follow-ups on recommendations of the meetings 	MOFEA, MOHSW, TACAIDS, PMORALG, TNCM, LFA	On going
	Recommendation 35 (Requires attention) The PRs and lead SRs should explore with their banks for interest to accrue on large credit bank balances held in program bank	Tanzania concurs with auditors recommendations. TNCM will instruct all PRs and LSRs to explore the recommendation	TNCM	July, 2009

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	accounts.			
	<p>Recommendation 36 (High) As provided for in the MOU signed between MOFEA, as the PR, and the lead SRs, funds earmarked for approved procurement payable in foreign currency should be disbursed to the lead SRs and SRs in foreign currency so as to avoid losses which could arise due to unfavourable movement in exchange rates. The MOFEA, AMREF, TACAIDS, MOHSW and MSD should consult and agree on how this recommendation will be implemented.</p>	<p>Recommendation accepted; MOFEA will organize a discussion with SRs and LSRs on how to implement the recommendation. Members of BOT and CAG will also be invited.</p>	MOFEA	September 2009
	<p>Recommendation 37 (Requires attention) The PR (MOFEA) and lead SRs should ensure that implementing organizations obtain VAT exemption waivers for procurement of goods and services under the grants.</p>	<p>Recommendation accepted. MOFEA will provide guidance to facilitate to obtain VAT exemption waivers for procurement of goods.</p>	MOFEA	December 2009
	<p>Recommendation 38 (Requires attention) To facilitate the recovery of taxes paid on locally purchased goods and services, SRs should consider opening a VAT control account in their accounting books into which VAT paid for each transaction using GF resources is debited. Periodically, either monthly or quarterly, implementing organizations should then compile total VAT paid per the control account, support</p>	<p>Recommendation accepted. MOFEA will facilitate the process.</p>	MOFEA	On going

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	the return with paid invoices and submit a claim to the revenue authorities for a refund. The PR (MOFEA) should facilitate this process.			
	Recommendation 39 (Requires attention) For VAT paid since inception of the grants, lead SRs and implementing organizations should compile a list of such payments and seek a refund from the revenue authorities. This list should be verified by the LFA during its semi-annual verification of implementation.	Recommendation accepted. TNCM will issue an official letter to PRs to facilitate compilation of a list of VAT paid since inception of all grants.	TNCM	June 30, 2009.
	Recommendation 40 (Requires attention) The PR (MOFEA) and lead SRs should ensure compliance with GF grant agreement provisions of tax exemption for purchase of any goods or service using grant funds. Taxes paid by SRs should not be billed to GF. And all taxes paid with grant funds should be calculated and paid back by the GOT into grant bank accounts.	MOFEA is consulting with Gov't agencies on the possibility of implementing the recommendation .	MOFEA	
	Recommendation 41(Requires attention) The NMCP should negotiate with its bank to provide a favourable rate for bank charges.	The negotiations have begun.	MOHSW	July 2010
	Recommendation 42 (Requires attention) The GF Secretariat should ask the LFA to identify all instances where more than the	MSD will work together with LFA to identify such incidences and implement per OIG recommendations.	MOHSW/MSD	June 30, 2009.

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	agreed administrative fee of 8 percent has been charged; and MSD should refund excess payments into program bank accounts.	<p><u>GF Secretariat Comment on Country response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>The EAIO Team will request the LFA to review and report their findings</p>	LFA/EAIO Team	July/August 2009
	<p>Recommendation 43 (Significant) All PRs and lead SRs of GF grants should issue a management letter to all implementing organizations to prepare management action plans to address all the above-listed audit findings.</p>	TNCM will instruct PRs and LSRs to issue circulars requiring all implementing organizations to prepare Management Action Plans on audit findings as per recommendations.	TNCM	June 2009
	<p>Recommendation 44 (Significant) All PRs and lead SRs should follow up implementation of recommendations in the audit reports of its implementing partners.</p>	All PRs and Lead PRs will make follow up on implementation of recommendations	MOFEA/ MOHSW/PMO RALG/TACAIDS	On going as per individual action plan
Institutional arrangements, governance and oversight	<p>Recommendation 45 (High) The PR (MOFEA) and MOHSW should assess whether current systems and processes will be able to cope with the increasing size of Tanzania's grant portfolio. Bottlenecks to grant implementation should be identified, such as long delays in disbursement of funds to SRs and other implementing organizations, and capacity constraints of MOHSW's Procurement</p>	<p>Recommendation is accepted.</p> <p>The assessment will be conducted and act according to results of assessment</p>	MOHSW/ MOFEA	July 2009

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	Management Unit (PMU) need to be addressed to improve absorptive capacity of the grants.			
	<p>Recommendation 46 (Significant) There is scope for MOFEA to increase its involvement in oversight of the grants. Hence consideration should be given to expanding the PR responsibilities of the MOFEA particularly in the area of financial oversight.</p>	<p>MOFEA is in the process of strengthening the GF grant activities by;</p> <ul style="list-style-type: none"> • Recruit 5 personnel who will be responsible for GF grant activities • Develop financial oversight grant management plan 	MOFEA	December 2009
	<p>Recommendation 47 (Significant) Global Fund's Country Programs Cluster should assess TACAIDS capacity as a substantive PR and corrective actions should be taken to address any gaps/weaknesses found.</p>	<p>Recommendation is accepted.</p> <p><u>GF Secretariat Comment on Country Response:</u> The Cluster has taken note of the recommendation and country response.</p> <p>As already mentioned above, this is being undertaken under the Round 8 LFA Assessment. The review will involve assessing TACAIDS's coordination role. Note that the actual implementation of the programs is undertaken by the Lead Sub-Recipients (SRs) and Sub-SRs such as MOHSW, MSD, NMCP, NTLF, NACP etc. The capacities of these entities are likewise being assessed.</p> <p>The Annual PSM assessment will continue to assess any incremental capacity needs due to</p>	LFA/EAIO Team	September 2009

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		new grants/increasing implementation challenges.		
	Recommendation 48 (Significant) TNCM should draw up conflict of interest polices to manage the conflicts of interest situations that TACAIDS is confronted with such as being a substantive PR, a lead SR and at the same time managing the process for screening and selection of SRs.	TNCM concurs with recommendation; TNCM will review conflict of interest policies. This subject will be presented in the ordinary meeting scheduled on 23 rd July 2009	TACAIDS	September 2009
	Recommendation 49 (High) There is a need for senior management of the MOHSW to closely monitor the activities of MSD and the supply chain at all levels.	MOHSW concurs with the recommendation MOHSW will monitor MSD performance by requesting it to submit quarterly reports on procurement, storage and distribution. In addition, MOHSW will conduct meetings with MSD Management to discuss the quarterly reports with a view of improving provision of services to health facilities.	MOHSW	October 2009
	Recommendation 50 (Significant) There is a need to increase the scope of the MOHSW Finance Unit's involvement in grant monitoring through periodic coordination meetings with program managers as well as sharing of information and reports.	MOHSW has decided to centralize accounts department where all programme accountants are working under the head of finance unit of the MOHSW	MOHSW	On going
	Recommendation 51 (High) There is scope to increase MOHSW senior management's role in removing	Recommendation is accepted The Internal Audit Unit conducted routine audit	MOHSW	On going

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	bottlenecks to grant implementation through monthly review of the level of unspent grant funds in program bank accounts.	in February/March 2009 and recommended to the senior management of MOHSW to instruct Programmes to submit bank reconciliation statements on monthly basis.		
	Recommendation 52 (Significant) The capacity of the MOHSW Internal Audit unit should be enhanced to enable it provide oversight of GF grants.	The Gov't of Tanzania established the Internal Audit Unit in September 2006. The Gov't through MOFEA has set aside funds for capacity building of Internal Auditors of Ministries and Departments. Recruitment of staff is done annually. The MOHSW has communicated with the MOFEA requesting for additional staff to fill the gap of 6 internal auditors.	MOHSW/ MOFEA	December 2009
	Recommendation 53 (High) MOHSW should reinstitute the MSD Board of Trustees, as a matter of urgency, to give it the necessary direction and oversight of its activities.	MOHSW concurs with the recommendation MOHSW has already undertaken the vetting of the Board Members. Appointment of the members is underway	MOHSW	July 2009
	Recommendation 54 Significant) The MOHSW should ensure that the MSD Act is revised to take into account changes in its operating environment, and to address the organization's relationships and/or arrangements with donors.	MOHSW concurs with the recommendation The revision process of the MSD Act and its Regulations has already been initiated. Relationship of MSD with the donor community has been addressed in the proposed amendment of the Act.	MOHSW	December 2009
	Recommendation 55 (Significant)	According to the existing operational setup of	MOHSW/	On going

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	Audits conducted by MSD should follow the supply chain trail to drug stores in the districts.	MSD, its responsibility is limited to delivering goods to the district level. The District medical stores belong to the Local Government Authority (LGA) which are above jurisdiction of MSD. Audit of these SRs covers all aspects including medicines and related supplies to districts and health facilities, and is done by Internal Audit Unit of the MOHSW and CAG.	PMO-RALG	
	Recommendation 56 (High) The MOHSW and the MSD Board of Trustees should ensure that the IA unit of MSD has sufficient, qualified and experienced staff to carry out its work to provide adequate internal audit oversight of medicines and health supplies purchased and distributed under the grants.	MOHSW and MSD concur with the recommendation. MSD Management commissioned PKF TANZANIA, a consulting firm to prepare a Five Year Human Resource Plan to support the implementation Medium term strategic plan. The draft plan has already been submitted to the Management. The staff needs for the Internal Audit Unit has been in the Plan and Budget for 2009/2010.	MSD	October 2009
	Recommendation 57 (High) The PMO-RALG should recruit additional program and accounting staff in its coordination office to support its grant program monitoring and reporting responsibilities.	PMO-RALG has assigned Assistant Director to lead the team of officers dealing with GF activities in the Ministry. Furthermore, 4 Officers have been allocated to assist the GF coordinator; <ul style="list-style-type: none"> • 1 Planner for Monitoring and Reporting • 1 Economist for Budgeting • 2 Accountants for Financial Management and accountability in the Ministry and 	PMORALG	On going

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		Local Government Authorities.		
	Recommendation 58 (Requires attention) There is scope for the CAG to increase his audit scope to cover the entire supply chain for medicines and health products.	Recommendation is accepted	CAG	On going
	Recommendation 59 (Significant) The TNCM should develop an oversight plan to facilitate its oversight responsibilities.	TNCM concurs with recommendation will develop and oversight plan. This subject will be presented in the ordinary meeting scheduled on 23 rd July 2009	TNCM	July 2009
	Recommendation 60 (Significant) There is the need for the TNCM and lead SRs to assess the current level of staffing and resources for M&E activities given the increasing number of grants and the size of the portfolio.	Recommendation is accepted. TNCM will request TA support from UNAIDS TSF to conduct assessment as requested. All PRs and SRs will implement according to the assessment results	TNCM	September 2009

Annex 2

Global Fund Secretariat’s Response to Recommendations and Management Action Plan

Prioritization of recommendations

a. High priority: Material concern, fundamental control weakness or non compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization’s interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management.

b. Significant priority: There is a control weakness or noncompliance within the system, which presents a significant risk and 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 control, or undermine achievement of aims and objectives.

c. Requires attention: There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization’s benefit.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
Oversight	<p>Recommendation 61 (Significant) Given the size and complexity of the grant portfolio in Tanzania, there is scope for GF Country Programs Cluster to make the Tanzania LFA’s oversight work more “hands on” instead of being adhoc and reacting to negative events in the field.</p>	<p>We concur with the recommendation: The EAIO Team has recognized and proactively increased the LFA’s scope of work over the years. The 2009 LFA budget has taken account of the increase in value of the Tanzania portfolio (from 0.6 Billion to 1.3 Billion with Round 8 signature). The LFA Budget for 2009 is US 1.3 Million, almost double the 2008 budget. The LFA scope of work will cover key risks including among others, the following: a) Procurement and Supply Management systems; Annual reviews (to include ACT and ARV Supply Chain Management reviews) - The reviews are already being undertaken (2008 ACT and ARV</p>	EAIO Team (Team Leader and FPM)	Ongoing Formalities with LFA to be completed by 30 June 2009

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		<p>reviews) and the soon to be concluded 2009 ARV review to be followed by an ACT review in June / July 2009. Both reviews take into account the wider PSM systems;</p> <p>b) Monitoring & Evaluation (M & E): Annual Assessments to include the two year Monitoring and Evaluation Systems Strengthening (MESS) Self Assessments by stakeholders with mid-term reviews; scheduled Progress reviews during PU/DR reviews (twice a year per grant); Annual OSDVs per grant; Data Quality Audits (DAQs) by external consultants in coordination with the GF M & E Team. The TORs are reviewed in consultation with GF M & E Teams.</p> <p>c) Financial Management systems: Annual reviews to monitor & mitigate potential financial risks - this has already been proactively undertaken by the EAIO Team with the financial monitoring review by LFA in October 2008 of 22 selected Local Government Authorities (LGAs) and Regional Hospitals out of the 67 LGAs and Regional Hospitals that receive funds from the Global fund under the MOF grants.</p> <p>d) Other services including ongoing capacity assessment of sub-recipients and supporting infrastructure.</p> <p>The EAIO Team notes that Human Resources constraints and sustainability for ARV & ACT Treatment remain major challenges given massive scale up. This is evident in the complete switch of the malaria treatment policy to ACT and the success of the National HIV testing campaign (over 3.6 million people tested). The main ARV and ACT grants will end between 2009 and 2011. PEPFAR and the GF are currently the main funders collaborating on the ARV front. Quality treatment is critical to effectively manage cost associated with switching treatment to second line drugs.</p>		

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>Recommendation 62 (Significant) The GF Country Programs Cluster should ensure that the LFA oversight work in Tanzania is informed by a risk assessment done of the grant portfolio covering key implementing SRs and high risk areas of grant implementation.</p>	<p>We concur with the Recommendation: The EAIO Team recognizes the big Grant Portfolio of Tanzania and the corresponding Potential risk that goes with it. In addition to the LFA's main scope of work (PR capacity assessments, PU/DR reviews, Phase 2 / RCC assessments, OSDV, etc) the LFA scope of work has been expanded to include assessment of the following potential risks:</p> <ul style="list-style-type: none"> a) Procurement & Supply Management (PSM - Annual reviews) b) Financial Management (Annual Financial monitoring of lead SRs) c) Quality Service Delivery/M & E reviews / assessments d) Cost effectiveness - value for money audits <p>These are already being undertaken with some reviews done in 2008 and follow up reviews already started for 2009 (PSM). A comprehensive Work Order / plan for the LFA review of the overall Tanzania Portfolio has been agreed upon (will focus on Key Sub-Recipients -SRs and high risk areas of the Portfolio).</p>	EAIO Team - FPM to take the lead.	July 2009
	<p>Recommendation 63 (High) The GF Country Programs Cluster should ensure that data verification is conducted regularly and routinely by the Local Fund Agent starting early in grant implementation.</p>	<p>We concur with the recommendation: As already mentioned under Recommendation 61, a number of on site M & E audits checks will be regularly conducted during the course of the year. These include the regular PU/DR reviews by LFA (twice a year per grant); the annual OSDV per grant (with wider sample scope over one year period); the two year MESS self assessment (with mid-term review; regular grant renewal assessment (New Rounds, phase 2/RCC); and DQA by external consultants. The DQA is also a new GF initiative that was successfully operationalized in Rwanda in 2008 and is expected to be rolled out in Tanzania for the first time in 2009 (in coordination with the GF M & E team).</p>	EAIO Team - FPM to take the lead.	Ongoing Formalities with LFA to be completed by 30 June 2009

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>Recommendation 64 (High) When data verification studies reveal major problems of data quality, as found in Tanzania, GF Country Programs Cluster needs to ensure that they are followed up with a more detailed technical assessment that is able to diagnose the source of the problems and provide appropriate suggestions for solutions.</p>	<p>We concur with the recommendation The EAIO Team will recommend additional follow up actions / M & E checks as a result of the above mentioned M & E reviews resulting in Data quality issues including taking into consideration other country contextual information received. The LFA will be proactively involved in gathering and analyzing such information, following up and recommending potential actions for approval by the GF. The M & E Team of the GF will be involved to provide technical advice. The OSDV reports for example are analyzed by the EAIO team and the M & E support team. The OSDV recommendations for improvement (actions), will be communicated to the PR for review in consultation with country stake holders and a plan of action to mitigate indentified weaknesses will be provided to the GF /LFA for follow up.</p>	EAIO Team - FPM to take the lead	On-Going Formalities with LFA to be completed by 30 June 2009
	<p>Recommendation 65 (Significant) The GF Country Programs Cluster should review the role of the LFA in monitoring the quality of service delivery and make the necessary changes in the LFA terms of reference to assure that this task is performed adequately.</p>	<p>We concur with the recommendation: The EAIO Team has identified the quality of service as one of the key risks to the GF portfolio in Tanzania given the complexity and scale of the treatment programs. As already indicated above, the LFA Work order budgets' have taken into account the increasing Portfolio and potential risks. The LFA has therefore been given a wider scope of review (including wider sample taking) both during progress review (PU/DR) and OSDV which will be undertaken annually for all grants with a one year sample base scope. The TORs for the OSDV is reviewed with input from the GF M & E support Team. The GF will also seek to enhance collaboration with key technical partners including CDC, Stop TB, USAID (PEPFAR/PMI), WHO and UNAIDS to provide the necessary support to complement and enhance the work of the LFA.</p>	EAIO Team - FPM to take the lead	On-Going Formalities with LFA to be completed by 30 June 2009

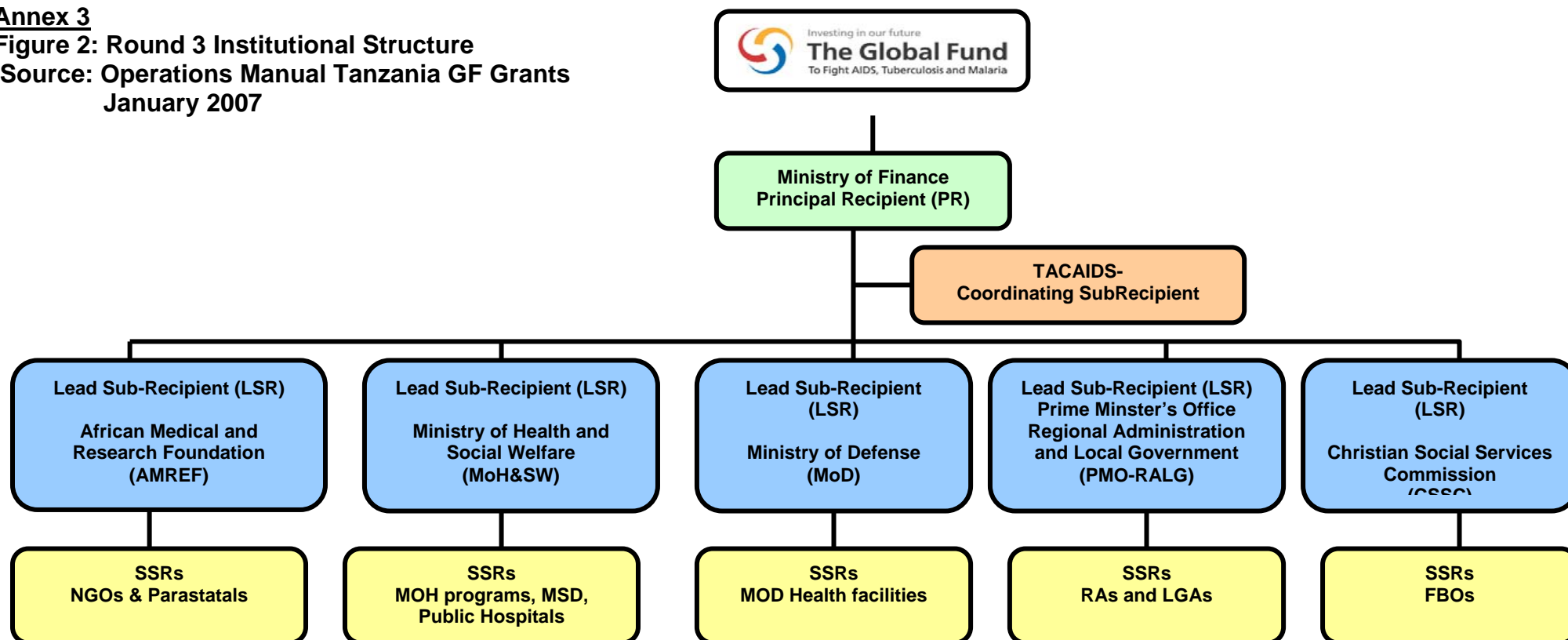
Audit Report on Global Fund's Grants to Tanzania

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>Recommendation 66 (Requires attention) The GF's Country Programs Cluster should draw more on the technical expertise of the GF M&E and Procurement units in its oversight of the grants in Tanzania.</p>	<p>We concur with the recommendation: The EAIO Team has actively engaged other teams including the Procurement and M&E on monitoring missions to provide the relevant technical experience and oversight to grants. We will continue engaging the Procurement Department of the Global Fund in Procurement matters including reviews and oversight on PSM matters. Likewise, we shall continue to involve the Global Fund M & E Team on M & E matters. The GF Secretariat must ensure that there is appropriate level of technical staffing in the support departments to cater for the requirements of an expanding portfolio. EAIO Team will also stress the need for more structured support from technical partners.</p>	<p>EAIO Team - FPM to take the lead</p>	<p>On-Going Formalities with Support Teams to be completed by 30 June 2009</p>

Annex 3

Figure 2: Round 3 Institutional Structure

Source: Operations Manual Tanzania GF Grants
January 2007



Annex 4

Figure 3: Round 4 Institutional Structure
 Source: Operations manual for Tanzania GF Grants
 January 2007

