



Audit Report

Audit of Global Fund Grants to the United Republic of Tanzania (mainland)

GF-OIG-16-002
8 February 2016
Geneva, Switzerland

Table of Contents

I.	Background	3
II.	Scope and Rating.....	6
III.	Executive Summary	7
IV.	Findings and Agreed Actions	10
V.	Table of Agreed Actions	25
	Annex A: General Audit Rating Classification	28
	Annex B: Methodology.....	29

I. Background

The United Republic of Tanzania, the thirteenth largest country in Africa, is a low-income country with an average annual Gross Domestic Product growth rate of 7% over the past decade. However, this growth rate has not resulted in commensurate poverty reduction, with the country's Human Development Index ranking falling by seven positions in 2013.¹ Tanzania's political and security situation remains stable.

The Tanzania health system is organized into four main levels at district, regional, zonal and national levels). Each level has a network of hospitals, health centres, dispensaries and village health services. The country has over 8,215 healthcare facilities, 79% of which are government run, 13% faith-based and voluntary, and 8% privately owned.² The health status of the Tanzania population has continued to improve in recent years, evidenced by the improvement of life expectancy at birth. However, HIV and malaria remain major health concerns in the country.

The three diseases in Tanzania

HIV

Tanzania accounts for 4.63 percent of the global HIV burden, ranking seventh in the world. The country has an estimated 1.5 million people living with HIV, 28% of whom are children aged less than 15 years. Tanzania has made great headway in the control and treatment of HIV/AIDS as shown below:

- Based on the 2015 Spectrum data³, the proportion of children under 15 living with HIV is expected to fall from 10 to 6% from 2014 to 2020.
- In the country's third Health Sector HIV and AIDS Strategic Plan (2013 – 2017), baseline HIV incidence is 0.32 (2012) with a target of 0.16 by 2017.
- Progress has been registered in scaling up access to treatment and prevention with 73% of patients living with HIV having access to treatment based on the pre-2013 eligibility criteria (CD4-350). The number of people on antiretroviral therapy as of July 2015 is 703,589.

However, HIV prevalence among key affected populations remains high: 26% (14%-37%) in female sex workers; 25% (18-35%) among men who have sex with men; and 36% (22%-43%) among people who inject drugs. The country's HIV prevalence is also high in eight of its regions.⁴

Malaria

Tanzania is the fourth largest population at risk of malaria in the world.⁵ Approximately 44 million people (90% of the population) live in areas where there is malaria. The country has made significant progress in reducing its malaria burden as demonstrated by the following:

- Malaria prevalence in children under five decreased from 18 percent in 2007 to 9.5 percent in 2012. However, this remains slightly behind the 5% target set by the country for 2016.⁶

¹ Tanzania Human Development Report 2014, UNDP.

² HSSP IV – 2015 – 2020.

³ An analytical data tool developed to support policy decisions concerning public health. Spectrum includes modules for HIV estimates and projectors.

⁴ The National AIDS Control Program's Consensus estimates on key population size and HIV prevalence, July 2014.

⁵ Global Fund Allocation Data Base.

⁶ 2012 THMIS 2012 indicator survey.

- Deaths caused by malaria reduced by 71% from 41/100,000 in 2004 to 12/100,000 in 2014.⁷

However, the disease remains a major public health problem accounting for 40% of the outpatient cases and about 36% of all deaths of Tanzanian children under five years. The country's malaria strategic plan aims to reduce its malaria prevalence to 5% by 2016 and below 1% by 2020.

Tuberculosis

Tanzania accounts for 1% of the tuberculosis (TB) global burden and ranks 18th among the 22 high burden countries. The country's treatment success rate for smear positive TB cases increased from 85 percent in 2008 to 89 percent in 2012. However, the country's case detection of new smear-positive adults has been found to be markedly lower (42-54%) than previously reported in the yearly global TB report published by the World Health Organization (77%) and the Millennium Development Goal target of 70%. This implies that although TB patients are having positive treatment outcomes, not enough people who have tuberculosis are being diagnosed. This increases the number of patients who will need treatment in the future and has implications for funding tuberculosis drugs.

Global Fund support in Tanzania

Global Fund grants to the United Republic of Tanzania are allocated separately between the Tanzania mainland and Zanzibar. Since the Global Fund first started funding in Tanzania (mainland) in 2002, a total of 15 grants amounting to USD 1.6 billion have been signed, of which USD 1.3 billion had been disbursed to the country at the time of the audit. The active grants in the period under audit (from January 2013 and June 2015) were:⁸

Grant Number	Principal Recipient	Grant end date	Signed USD	Disbursed USD
TNZ-405-G06-H	Population Services International	31-Dec-16	61,192,309	44,729,265
TNZ-809-G13-H	Ministry of Finance	31-Dec-15	547,010,319	425,527,874
TNZ-M-MOFEA	Ministry of Finance	30-Jun-16	266,808,969	138,459,976
TNZ-607-G09-T	Ministry of Finance	30-Jun-15	33,905,091	33,905,091
TNZ-911-G14-S	Ministry of Finance	30-Apr-16	121,127,608	103,432,448
Grand Total			1,030,044,296	746,054,654

The country's allocation for 2014-16 amounts to USD 711.1 million⁹ and is split as follows:

- an HIV program for USD 462 million (grant agreement signed) including incentive funding of USD 78.6 million;
- a tuberculosis program for USD 26 million (grant agreement signed);
- a malaria program for USD 185 million (in the grant making process); and
- a health system strengthening program for USD 36 million (in grant making process).

The Global Fund's Pooled Procurement Mechanism procures all health commodities with the exception of tuberculosis drugs and laboratory re-agents, which are bought by the Global Drug

⁷ 2004-2014 Health Management Information System survey.

⁸ Global Fund System data at 22 June 2015

⁹ The amount does not include incentive funding under the malaria and health system strengthening grants amounting to US\$ 27.71m.

Facility and the Medical Stores Department respectively. The Pooled Procurement Mechanism has secured quality assured products at lower prices than previously obtained and in a timely manner. In accordance with the grant agreement, the Tanzania Food and Drugs Authority quality assures health products.

II. Scope and Rating

Scope

This audit was undertaken according to the Office of Inspector General (OIG)'s risk-based audit plan for 2015. This follows an audit undertaken by the OIG in 2009. Through this audit, the OIG seeks to provide independent assurance to the Board on the adequacy and effectiveness of current grant implementation arrangements in ensuring that:

- (i) patients/clients have access to quality-assured drugs in a timely manner;
- (ii) accurate and timely data is available to support decision making; and
- (iii) available grant funds are spent in an economic, efficient and effective manner.

The audit covered:

- Global Fund grants to Tanzania mainland but not Zanzibar, which has a separate grant allocation;
- the four active grants managed and implemented by the Tanzania Ministry of Finance which represents 94 percent of total active grant amounts at the time of the audit;
- visits to 10 sub-recipients and sub-sub-recipients;
- field visits to 55 hospitals and facilities, the central Medical Store Department and its four zonal warehouses, and two District Medical Offices; and
- site visits to 50 houses for health workers (in construction) and three universities (renovations) under the health system strengthening grant.

The audit did not cover the active grant implemented by Population Services International that accounts for about 6% of the total active grant amounts at the time of the audit.

Audit of Tanzania (mainland) grants by the OIG Audit

In 2009, the OIG undertook an audit of the Global Fund grants to Tanzania. This audit has validated the status of the implementation of recommendations from the relevant report in addressing issues identified in 2009.

Rating¹⁰

Operational Risks	Rating	Reference to findings
Programmatic and Performance: accurate and timely data is available to support decision making	Partial Plan to Become Effective	IV.2, IV.3
Financial and Fiduciary: available grant funds are spent in an economic, efficient and effective manner	Ineffective	IV.4, IV.5
Health Services and Products: patients/clients have access to quality-assured drugs in a timely manner	Partial Plan to Become Effective	IV.1
Governance, Oversight and Management: adequacy and effectiveness of current grant implementation arrangements	Ineffective	IV.5

¹⁰ See Annex A for the rating definitions.

III. Executive Summary

The Republic of Tanzania is one of the biggest recipients of Global Fund grants with USD 1.8 billion received to date. The country has made great headway on the control and treatment of AIDS, tuberculosis and malaria with a decrease in related incidence since 2000 by 72%, 31% and 72% respectively. The death rates for the three diseases have also fallen by 68%, 29% and 64% respectively.¹¹ The audit of grants in Tanzania mainland sought to provide independent assurance to the Board on the adequacy and effectiveness of current grant implementation arrangements with three specific objectives in mind.

Patients/clients have access to quality-assured drugs in a timely manner

Approximately 80% of grant funds are spent on the procurement, storage and distribution of health commodities. The Global Fund's Pooled Procurement Mechanism, used to buy most of the health products, has significantly improved procurement timelines and reduced commodity prices. This has also eliminated antiretroviral treatment stock-outs thereby reducing the need for PEPFAR (the United States President's Emergency Plan for AIDS Relief) emergency commodity support. The volume of commodities supported by the country's supply chain management system has significantly increased,¹² but has not kept pace with the country's scale up under the three diseases. As was the case in the last OIG audit in 2009, the country's supply chain management system remains ineffective in delivering health products to patients and accounting for commodities received especially in light of the country's rapid expansion of people on treatment.

The distribution of health products by the Medical Stores Department has been affected by the government's failure to meet its financial obligations. The 2015 audit identified stock-outs of health products of varying magnitudes at different levels of the supply chain caused by inadequate planning and coordination by key stakeholders (e.g. the Medical Stores Department, Ministry of Health and facilities) in making appropriate distribution decisions. As was noted in the last audit, there were also unexplained stock differences throughout the supply chain. For example, the audit noted:

- differences between stock dispatched by the Pooled Procurement Mechanism and recorded as received at Medical Stores Department valued at USD 1.55 million;
- a lack of proper records at regional/district medical offices that distribute 50% of all health commodities which has resulted in poor accountability for commodities that they manage; and
- unexplained differences ranging between 40-50% between the quantity of malaria and HIV test kits and anti-malaria medicines reported as delivered by the Medical Stores Department and accounted for by the district medical offices/facilities.

At the time of the audit, the Secretariat alongside country partners was reviewing the Medical Stores Department to find solutions to the challenges of storing and distributing commodities. However, this alone will not address all the supply chain challenges noted especially at the facility level. Therefore, the audit concludes that there is a **partial plan to become effective** in addressing health services and products risk.

Available grant funds are spent in an economic, efficient and effective manner

The OIG identified lapses in key fiduciary controls over procurement, the management of advances and contract management. This partly explains the USD 9.6 million of unsupported

¹¹ The Global Fund Results Report 2015, p. 25.

¹² Number of people on antiretroviral treatment supported from some 170,000 (2009) to over 700,000 (2015).

costs that have been identified in this audit. The Global Fund investment towards the health system strengthening grant¹³ has contributed to improvements in health care delivery especially with regard to building human resource capacity but has not been fully optimized in light of:

- Significant reductions (an average of 50%) noted in the scope of planned constructions without a corresponding reduction in budget. This reflects a higher cost per activity than planned and raises questions about whether the best value was obtained on investments made.
- Questioned rationale of health system strengthening investments (e.g. the use of most of the budget for construction that benefit a relatively small segment of the population and use of program funds to mainly sponsor post graduate courses when the country's critical human resource gap is at lower levels).

The financial and fiduciary area is therefore rated as **ineffective**.

The case has also been referred to the Office of the Inspector General's Investigations Unit for further review.

Accurate and timely data is available to support decision making

Tanzania's alignment of its antiretroviral policy to the latest guidance from the World Health Organization has increased the number of patients¹⁴ and will result in a treatment funding gap of at least USD 232 million by 2017.¹⁵ In consequence, the Global Fund is 'front loading' commodities planned for 2016/17 to 2015 to address current medicine shortages. The government's proposed mechanisms to raise additional funding may not be effective in the short to medium term. If unaddressed, this funding gap will result in treatment disruption and will affect the gains made in the HIV program.

As the country scales up its fight against the three diseases, the country is facing challenges in operationalizing its policies. This has affected patients' access to quality treatment and has a potential adverse effect on the achievement of program objectives:

- While Tanzania has put 47% of its people living with HIV on antiretroviral treatment, it has a relatively high attrition rate with 23% and 19.5% of adults and children respectively abandoning treatment 12 months after initiation.¹⁶ Mechanisms in place for identifying and transitioning eligible patients from the first to second line antiretroviral treatment remain inadequate.
- Contrary to the country's national treatment guidelines for malaria, 51% of patients are treated for malaria without a confirmed diagnosis and/or with negative results.
- Commodities distributed under the private sector Co-Payment Mechanism¹⁷ are sold at the time of the audit at prices higher than recommended (i.e. Tshs 3000 against Tshs 750) and mechanisms in place are inadequate in ensuring that subsidized medicines are distributed in malaria endemic areas.

The implementation of the district health information system and electronic Logistic Management Information System have significantly increased the data reporting rate by facilities. However, data quality has not received equivalent emphasis with poor record keeping noted in most of the facilities visited. The management information system is also still

¹³ Construction of additional warehouses and staff houses in hard to reach areas, strengthening the health management information system, training health workers etc.

¹⁴ Anticipated to increase by 390,000 by 2017 (ARV and laboratory quantification, National Aids Control Program, June 15th, 2015).

¹⁵ With a CD4 count of 350.

¹⁶ Twelve months after initiation (June 2015 progress report).

¹⁷ The Co-payment Mechanism is a financing model used by the Global Fund, to expand access to artemisinin-based combination therapies (ACTs), in the private sector.

unable to report on key malaria indicators. As detailed in the findings, multiple logistics management information systems have been rolled out since the 2009 OIG audit but they remained inefficient and ineffective in accounting for stock and supporting logistics management.

The Global Fund, together with government and other development partners, has made considerable investments in training and supervision in order to support the translation of policy into practice, and to ensure quality service delivery and data quality. However, supervision and training undertaken by multiple entities (i.e. national programs, regional and district personnel) is not well planned and coordinated and, consequently, remains ineffective in creating the desired impact. There is therefore a **partial plan to become effective** in managing programmatic and performance-related risk.

Adequacy and effectiveness of current grant implementation arrangements

As previously noted in the 2009 OIG audit, lapses in the Principal Recipient's execution of its role have created a weak control environment within which grants are implemented. The program management units set up under the Ministries of Finance and Health to manage and oversee programs have overlapping roles and are not fully executing their terms of reference. Oversight by the Tanzania National Coordinating Mechanism has been strengthened by the newly formed oversight committee. However, the Country Coordinating Mechanism is yet to provide effective oversight over the Principal Recipients. There were delays in the disbursement of grant funds to implementers (on average 150 days) which affected implementation. Progress reports were also submitted late to the Global Fund and many management actions communicated by the Secretariat have not been implemented. The audit also noted that controls put in place by the Secretariat to strengthen internal control were overridden. Therefore, governance, oversight, and management is rated as **ineffective**.

IV. Findings and Agreed Actions

IV.1	<i>Supply chain management system unable to effectively support commodity distribution</i>	Country Team Level	
------	---	-------------------------------	--

The country’s supply chain management system does not support the effective delivery of health products to patients and cannot fully account for commodities received.

Health products and related costs account for approximately 80% of the Global Fund grants to Tanzania. The Global Fund’s Pooled Procurement Mechanism procures, and the Medical Stores Department stores and distributes, most health commodities.¹⁸ As has been reported in several prior reports (including the 2009 OIG audit),¹⁹ Tanzania’s supply chain management system does not effectively deliver commodities to patients and is unable to fully account for available commodities. Interventions by the Global Fund, USAID, World Bank, Denmark’s Development Cooperation, and World Health Organization ²⁰ have not completely resolved the pertinent issues prevalent in the supply chain.

Stock outs of key commodities: There are stock-outs of varying magnitudes of key commodities at all levels. For example, in 2015, HIV test kits ran out for periods of up to three months at the central warehouse. The three warehouses visited had at least six instances of stock-outs of malaria and HIV test kits that lasted between one – two months in the 2014-15 period.²¹ Buffer stocks are not respected at all levels as mitigation against the risk of stock-outs. This occurrence of stock-outs is caused by the following:

- Distribution decisions by the Medical Stores Department are not always informed by requests from facilities: Commodities received under the funded programs are treated as donations that must be distributed quickly due to storage constraints²² and this is often without guidance from national programs and/or requests from zones and/or facilities to ensure they reach target areas/populations. The OIG audit noted that:
 - Only 40% of antimalarial medicines and HIV and malaria test kit orders by three zonal warehouses visited were filled. The artemisinin-based combination therapy order filling rate at February 2015 was 60%.
 - Only 25% of zonal warehouse requests for antimalarial medicine were honored while Dar es Salaam had received 300% of its request in one period. Dar es Salaam also received five times more test kits than requested while two zones did not receive their requests and one zone that had not submitted a request received stock.
- Partial delivery arrangements to facilities: The Medical Stores Department only delivers about 50% of commodities directly to facilities, with the rest left to regional/ district medical offices for further distribution. Facilities must collect these commodities from the region/ district and may not be able to do so in a timely manner due to the lack of funds for transportation.

¹⁸ With the exception of laboratory reagents that are procured by Medical Stores Department and bed nets are distributed by the Ministry of Health.

¹⁹ Including internal and external audits.

²⁰ Interventions include building of warehouses, fleet acquisition, installation of logistics management systems, etc. The health project component of Big Results Now (BRN), a national initiative to accelerate Tanzania’s development, includes strengthening procurement and supply chain management at primary health care level.

²¹ These stock outs were caused by inadequate capacity at facility level to use available data guide the ordering process, changes in the HIV treatment algorithm resulting in shortages/over stocking during the transition period and full roll out of the Option B+ which depleted buffer stocks at the central level.

²² Due to storage constraints.

- **Delays in distribution of commodities:** The Medical Stores Department takes an average of 65 days against the stipulated 21-day target to distribute antiretroviral opportunistic infection medicines and laboratory commodities after a request is received. The Medical Stores Department has attributed this to the lack of adequate working capital to effectively execute its mandate.
- **Program inputs used to diagnose and treat other diseases:** Program commodities such as antibiotics and laboratory reagents are not only used to diagnose and treat the three diseases, but often run out because they also cover other diseases. This typically happens when there are delays in the government's provision of essential medicines/commodities.

Expiry of health commodities: Expired health commodities were noted at the different levels of the supply chain. While the magnitude of the expired drugs cannot be quantified due to the lack of required data, the value of expired drugs related to vertical programs at the Medical Stores Department increased by 220% (Tshs 750 million to Tshs 2.4 billion) in the years 2013/14 to 2014/15. Tshs 444.67 million of this amount relates to Global Fund commodities.²³ Staff at the facility level lack adequate skills to effectively track and report expiries. The expiry of drugs has been partly attributed to:

- receiving unplanned donations especially when the Medical Stores Department is already holding stock;
- inability to maximize the use of the logistics system to alert management when commodities are about to expire;
- failure by facility staff to adhere to a first-expired-first-out principle; and
- The Medical Stores Department taking delivery of laboratory reagents that do not meet its 80% prescribed shelf life. For instance, nine instances were identified in the period under audit where the shelf life of the laboratory reagents averaged 50%.

Unexplained stock differences throughout the supply chain. The audit identified unexplained stock differences of varying magnitudes that are prevalent at the different levels of the supply chain. Unexplained and unauthorized stock record adjustments are made to correct stock positions across the supply chain and this exposes commodities to the risk of theft. These issues were previously identified in the 2009 OIG audit report as well as internal and external audit reports, but remained unaddressed at the time of the audit. The table below summarizes the stock differences noted during the audit:

Stock differences	Details
Between dispatches from the Global Fund's Pooled Procurement Mechanism and stocks recorded as received by the central warehouse.	Antimalarial medicines and malaria test kits and antiretroviral medicines valued at USD 1.55 million in the period under audit (2013-2015). This happened at the Medical Stores Department.
At regional/ district medical offices (About 50% of all deliveries made by the Medical Stores Department)	Based on the OIG's sample of regional/district medical offices visited, the audit noted that they do not maintain proper stock records and are therefore unable to account for the commodities that are left in their custody (50% of commodities distributed). For instance, based on available data, there are unexplained differences (40-50%) between quantities of HIV test kits reported as delivered by the Medical Stores Department and accounted for by the district medical offices/ facilities.

²³ Medical Stores Department records.

Between commodities issued by zonal warehouses and quantities received at facilities	The audit reviewed six orders from zonal warehouses to facilities and all six samples had differences (shortages) averaging 60% and 53% between quantities recorded as dispatched and received for antimalarial medicines and for test kits, respectively.
Between the stocks received at the facility and what is recorded as dispensed to patients.	From the 55 facilities visited, the audit noted average differences of 64% and 52% between stocks received at facility level and quantities dispensed/used by patients or remaining in inventory for antimalarial medicines and for malaria test kits, respectively. Some facilities visited had differences of up to 95% of stock received.

In order to get a better understanding of the causes and extent of these unexplained stock differences, this issue has been referred for further investigation.

The challenges in the supply chain management system are attributed to:

- i. ***Inadequate ownership, coordination and/or accountability for health commodities*** by the Ministry of Health, the Medical Stores Department, local government and facilities: There is inadequate oversight of commodities by the Ministry of Health and local government in ensuring that commodities received reach intended beneficiaries and are accounted for throughout the supply chain. The coordination of key stakeholders in the supply chain is also inadequate. Delivery decisions do not take into account the Medical Stores Department's storage capacity and distribution is not appropriately informed and managed. The roles of the different stakeholders in storing, distributing, dispensing and accounting for health commodities are defined but not effectively executed. Staff are not held accountable for lapses in their roles by their managers.
- ii. ***Limitations in the Medical Stores Department's ability to meet its financial obligations*** due to the Government's failure to pay to the Medical Stores Department. According to the Medical Stores Department's 2013 financial statements, the Government's debt amounted to USD 58 million. The debt has been caused by, among other things, the government's failure to pay the 12% counterpart funding for the distribution of commodities under the three funded disease programs. In other cases, funds were not provided to cover logistics for donations related to vertical programs and the Medical Stores Department has had to rely on the government to cover these costs. As a consequence, the Medical Stores Department is unable to either deliver effectively on its own or to meet its obligations to other delivery providers (e.g. pay suppliers, customs, demurrage and inspection fees) in a timely manner. The Principal Recipient has committed to pay the Government debt in the 2016/17 budget.
- iii. ***Inefficient and ineffective logistics management information systems*** in accounting for stock and supporting logistics management: Multiple information systems (Epicor 9, eLMIS, ILS Gateway and SMS4life) have been rolled out since the 2009 OIG audit for different purposes. Tanzania's eHealth strategic objectives now provide for a uniform e-platform, looking to integrate co-existing multiple systems (e.g. the eLMIS with Epicor 9). The audit questions the effectiveness of procedures followed in identifying systems required to support supply management, due to the following:
 - Although developed for different purposes and meant to be complementary, some of the developed systems have duplicative functions, e.g. the SMS4life and ILS gateway (costing USD 600,000 and 60,000 annually, respectively) collect

similar information. There are plans to discontinue SMS4life under the new grants.

- There is limited interface among available systems and information is fragmented across multiple systems. As a consequence, there is poor visibility of stock across the supply chain, which affects stakeholders' decision making.
 - Logistics systems also do not interface with case management systems and this is a missed opportunity to check data integrity. For instance, the audit compared the volume of antiretroviral medicines distributed against the number of patients on antiretroviral treatment in one quarter, for the three zones visited, and noted that there was an over distribution of 30-50%, even after considering the buffer.
 - The Medical Stores Department's system (Epicor 9) generates inaccurate data, including negative stock balances. Other system deficiencies noted include users' ability to delete transactions from the system without a trace. These findings are similar to those related to the previous system the Medical Stores Department had in place (Orion) in the 2009 OIG audit.
- iv. **Limited human resource capacity (numbers and skills):** Facilities' ability to maintain proper stock records was affected by staff shortages and inadequate skills. In consequence, they were unable to account for commodities under their custody. For instance, only 28 out of 55 facilities visited maintained stock records for antimalarial medicines and test kits. Moreover, even the 28 facilities with records also had challenges in maintaining proper stock records. For instance, 26 facilities had inaccurate entries in their bin cards while 15 facilities had not updated their bin cards.

Agreed management action 1: The Secretariat and key country stakeholders have instituted a review of the Medical Stores Department to find solutions to the challenges it faces in storing and distributing commodities. The Secretariat will support the government and partners to develop an operational plan based on the findings of this review. Additionally, recognizing that the overall improvements of commodities' flow through the supply chain are critical for improved service delivery, a separate operational plan will be developed and agreed upon between the Secretariat, the government and partners with a view of improving the overall accountability throughout the supply chain.

Owner: Head of Grant Management

Target Date: 31 December 2016

IV.2	<i>Scale up of HIV testing and treatment likely to affect continuity of services</i>	Executive Level	
------	---	------------------------	--

Limitations in effective planning and implementation of program scale up affecting patients' ability to access quality treatment.

Tanzania has aligned its antiretroviral therapy policies to the latest diagnosis and treatment guidance from the World Health Organization and UNAIDS.²⁴ While this has increased the number of people that qualify for HIV treatment, it also has resulted in a marked increase in funding needed to support the scale up. Because this additional funding is not readily available, this may result in treatment disruption in the medium to long term and curtail the gains registered in the past against the diseases. Significant questions exist about the effectiveness of planning to ensure that critical factors for successful scale ups are in place prior to changing policies.

The National AIDS Control Program estimates that the number of patients who need treatment will increase by about 390,000 patients by 2017 as a result of the change of eligibility criteria from CD4 Count 350 to 500 and without considering the effect of other policy changes. This has implications for:

- ***Health commodities required for diagnosis and treatment.*** The documented funding gap at the time of the audit (August 2015) for only medicines and laboratory reagents until December 2017 if the country remained at CD4 count 350 was USD 232 million. The gap will increase to USD 328 million if the CD4 count 500 is applied. If the funding gap is not filled, this will result in commodity shortages by as early as mid-2016 due to increased consumption of medicines that will exhaust available stock in a much shorter time frame.
- ***Health systems' ability to effectively support the scale up*** in areas such as human resources, storage and distribution and data management. At the time of the audit, greater concern was rightly placed on the need to cover commodities. No consideration has been given to the additional funding that is necessary to prepare health systems (e.g. the logistics management system to deliver services to the increased patient numbers). Unless addressed, this scale up will increase the challenges the country is facing in its health systems, including its fragile supply chain management.

The Country Coordinating Mechanism has been able to mobilize approximately 15% of the funding gap. However, challenges remain in covering the rest of the commodity related funding gap at the time of the audit:

- The government, as the main funder of the Ministry of Health budget, may not be able to cover the gap. It has not met its commitment to purchase antiretroviral medicines in 2014/2015. The government's proposed initiatives to raise additional funding through the AIDS Trust Fund, domestic financing strategy and the National Health Insurance Scheme are unlikely to materialize in the short term.
- While more than 95% of the total HIV and TB funding between 2011 and 2015 has been from external sources, there are also challenges in mobilizing resources from the government's traditional funders. For instance, under the New Funding Model, the funding allocation for Tanzania is unable to cover its need allocation. This is in light of

²⁴ These include (i) changing eligibility criteria for treatment from CD4 count 350 to 500; (ii) universal treatment for expectant mothers living with HIV for life regardless of their CD4 count (option B+); and (iii) diagnosis of 90% of people with HIV, treating 90% of people diagnosed with HIV and achieving undetectable viral load in 90% of people on treatment (90-90-90 target by 2020). The 2015 WHO guidelines on HIV treatment had not been implemented at the time of the audit.

the fact that the Global Fund is already one of the largest funders of HIV treatment in the country.

The funding gap and other issues in this audit raise questions about the Country Coordinating Mechanism's effectiveness in mobilizing funds; coordinating government and development partners' responses to the three diseases; prioritizing resources; and ensuring effective utilization of available resources.

As the World Health Organization revises its guidelines in 2015 calling for universal coverage of all HIV clients, this has implications for available funding to cover the response:

- Like Tanzania, most high disease burden countries remain heavily dependent on international funding to cover the response. For instance in 33 countries in sub-Saharan Africa, 26 receive more than half of HIV funding from international sources, including 19 that depend on external sources for at least 75% of HIV-related spending.²⁵
- Most countries are unable to raise domestic funding to cover the funding gap. The UNAIDS Treatment 2015 report notes that only six countries in Africa have met the Abuja Declaration target of allocating 15% of national public sector spending on health.

This raises questions on the effectiveness of the country's financial planning for scale ups to ensure that the adoption of latest treatment guidelines can be funded. For example, countries should demonstrate their ability to shoulder the resultant financial burden through counterpart funding.²⁶ This is consistent with the strategic direction of the Board and the organization's vision to have countries have ownership for the health of their populations. However, the audit noted that there are challenges associated with this difficult (yet right) journey, given the limitations governments have with raising funds.

Agreed management action 2:

The Secretariat working in concert with partners will engage with governments in five countries including Tanzania to analyze the gaps in funding due to scale-up following the latest normative guidance from the WHO on testing and treatment for HIV, which may have implications for the continuity of treatment for existing patients. Accordingly, the Secretariat in collaboration with partners will encourage governments to develop action plans and monitor the implementation of the plans to address such gaps, including considering the possibility of increased government financing.

Owner: Head of Strategy Investment and Impact

Target Date: 31 December 2016

²⁵ Treatment 2015, UNAIDS.

²⁶ Fifteen percent of disbursements under the new funding model are tied to government's ability to meet commitments made. However the investments do not necessarily have to be in areas that directly benefit programs funded by the Global Fund.

IV.3	<i>Operational challenges affecting patients' access to appropriate treatment</i>	Country Team Level	
------	--	-------------------------------	--

Challenges in operationalization of policies affecting patients' access to quality treatment, with potential adverse effect on programs' achievement of impact under the HIV program and/or efficient attainment of impact for malaria.

The Global Fund has contributed to the scaling up of key interventions with significant gains registered across the three disease programs. However, programs are facing challenges in enforcing treatment guidelines, retaining patients on treatment, and regulating funded program interventions so that they reach intended beneficiaries. These factors are affecting patients' ability to access quality treatment and therefore directly impact the effectiveness of funded programs. They have also created inefficiencies in the programs.

Retention of HIV patients on appropriate treatment: Tanzania has put 47% of people living with HIV on antiretroviral treatment with CD4 350 criteria.²⁷ However, the following gaps noted in the audit may limit the effectiveness of the antiretroviral therapy intervention:

- **Relatively high HIV attrition rate:** The June 2015 progress report to the Global Fund noted that only 76.7% and 80.5% of adults and children, respectively, with known HIV remain on treatment 12 months after initiation.²⁸ The high attrition rate includes clients that pass away, opt out of treatment and those clients that self-transfer to other treatment sites. The program's community based follow-up mechanism has had limited effectiveness in ensuring patients lost to follow-up are identified and retained on treatment. This calls for a proper analysis of the underlying causes for patients leaving their treatment in order to develop an effective strategy to address the attrition.
- **Relatively low rate at which eligible patients graduate from first to second line antiretroviral medicines** i.e. 2% against the expected 6% rate, in light of the fact that the antiretroviral program has been in place for over 10 years. This raises questions on the effectiveness of mechanisms in place to identify and change treatment regimens for patients experiencing adverse side effects to medication (drug toxicity) or those whose medications are not effectively controlling HIV (regimen failure). This was identified by the national program since 2012 and has been attributed to:
 - lack of confidence by clinicians to identify treatment failure and switch patients to second line of treatment;
 - unavailability of second line treatment regimens with low toxicity; and
 - inadequate HIV viral load testing.

During field visits, the audit noted that some patients collect their medication without consulting a doctor and this raises questions of whether clinicians perform the required clinical and laboratory monitoring to inform patients' treatment plans.

Treatment of malaria without confirmed diagnosis: The national treatment guidelines for malaria have not been consistently enforced, resulting in patients being treated for malaria without confirmatory diagnosis:

- Data from the Ministry of Health's management information system shows that 51% of patients are treated without confirmatory testing for malaria and/or after negative laboratory results despite nationwide rollout of malaria test kits over 2013/14. Data

²⁷ The United State Government through PEPFAR is supporting programs that address linkages between testing and treatment, retention, and VL scale-up.

²⁸ The National AIDS Control Program puts the rate of patients lost to follow-up at 30%.

collected from 18 facilities visited during the audit showed that 78% of patients are treated with antimalarial medicines without testing and/or with negative results.²⁹

- The sale of antimalarial medicines through the private sector's Co-Payment Mechanism without including rapid test diagnosis in the program also encourages the treatment of malaria without proper diagnosis.

The treatment of patients without confirmatory diagnosis not only raises the risk of development of drug resistance but also represents inefficient use of medicines. Consumption data is the key factor used in quantifying antimalarial medicine and test kit requirements; yet it is well known that consumption rates are much higher/lower than the real need for medicines and test kits respectively. Consequently, more antimalarial medicines and less test kits than required are procured.

Subsidized antimalarial medicines not accessible and affordable: Controls over the private sector Co-Payment Mechanism were inadequate to support the achievement of its objectives with regard to the availability, affordability and accessibility of subsidized antimalarial medicines in private health facilities, pharmacies and drug outlets. The OIG audit noted that:

- Medicines are sold above the recommended price, i.e. between Tshs 2,000-4,000 (USD 0.9 – 1.8) and not Tshs 750 (USD 0.34). No mechanism had been set up at the time of this audit to regulate the prices at which subsidized antimalarial medicines are sold in the market.
- There is limited instituted mechanism to ensure that the subsidized medicines are distributed outside the big cities to reach malaria endemic areas. This would ensure that the medicines are available and accessible in the areas where there is greatest need.

Inadequate regulation of charges to patients for antimalarial medicines: Contrary to the Global Fund expectation that medicines are distributed free of charge, the audit noted that in 49 out of the 52 facilities visited, patients suffering from malaria are required to make a contribution towards their treatment. This is in line with a cost sharing agreement established by the government. However, the audit raised the following concerns:

- The country's cost sharing arrangement has not provided guidance on what charges can be levied and, as a consequence, rates vary significantly across facilities, i.e. from Tshs 500 to Tshs 2,000 (USD 30 cents to USD 1.30), which according to the Principal Recipient, councils have been mandated to set the price.
- Contrary to provisions in the grant agreement, there is also no mechanism to track and report on the income generated through this cost sharing arrangement and to ensure that funds raised are used to support program activities. After the audit, the MoHSW has initiated to reinforce the implementation of the cost sharing policy and has requested hospitals and councils not to charge for essential medicines received from the Global Fund.

The underlying causes of the issues noted above are:

- i. ***Inadequate ownership of the Co-Payment Mechanism program:*** Although the co-payment mechanism targets the private sector, it is managed under the public sector through the Principal Recipient Ministry of Finance while some functions were delegated to the National Malaria Control Program. As is the case in similar arrangements in other countries, this implementation arrangement creates a challenge of inadequate ownership of the program. In the case of Tanzania, there is a gap in the

²⁹ Facilities did not readily have the information required to make the computations.

day-to-day management of this arrangement since responsibility for its implementation has been delegated to a task force whose role should be principally one of oversight.

ii. ***Ineffective quality improvement programs at national, regional, district and facility levels*** to identify and address quality of service issues. The issues above raise questions on the effectiveness of training and supervision in supporting the translation of policy into practice and ensuring quality service delivery. Most grant funds related to training and supervision go towards the payment of travel related costs, which have had numerous audit queries from this and other audits/reviews (see finding number 5). The audit also noted that:

- Supervision is undertaken by multiple entities, specifically national programs, regional and district personnel that lack clear objectives. Supervision tools are inadequate in supporting the identification of key issues at service delivery level. There are no linkages between the different visits, which is a missed opportunity to build prior work. Supervision visits are infrequent and less than the four per year envisaged in plans. Feedback is rarely provided to facilities and, when provided, reports are limited in content and do not address key issues that facilities grapple with.
- Training plans are not informed by a proper needs assessment that considers the weaknesses identified at service delivery level. The audit also noted that the approved training plan is not always adhered to with regard to the number of people trained, days over which trainings happen, etc. The preferred mode of training has been workshops as opposed to 'on-the-job' training. This not only takes limited human resources away from their duty stations, but also lacks the hands-on resolution of problems health workers may face.

Agreed management action 3: The grants that have been signed and/or will be signed under the new funding model are an opportunity for the Secretariat to work with in-country stakeholders (including technical partners) to find solutions to the quality of service issues that are affecting the grants. Specifically, the Secretariat will:

- Work with in country stakeholders to ensure that the quantification and forecasting of malaria medicines and test kits is revisited before additional investments are made. Different quantification methods will be applied and results triangulated to ensure an optimal result.
- Ensure that the Principal Recipient identifies a suitable entity to manage the Co-Payment Mechanism.
- Ensure that the Principal Recipient prepares a supervision and training plan that details the objectives of different types of training and supervision that will be undertaken, specifically addressing the quality of services that are found to be sub-optimal, i.e. the retention of patients on treatment and treatment of malaria patients without diagnosis.

Owner: Head of Grant Management

Target Date: 30 September 2016

IV.4	<i>Health system strengthening interventions in the funded programs not optimized</i>	Executive level	
------	--	------------------------	--

Effectiveness of Health System Strengthening grant in supporting three diseases questionable in light of prevalent challenges in country systems

Through a separate grant, the Global Fund has invested USD 121 million towards health system strengthening in human resources, monitoring and evaluation, procurement and supply chain management and leadership and management. While the investment has contributed to improving health care delivery in Tanzania, the audit raises questions around the prioritization of investments made in light of the country context and adequacy of controls in ensuring best value for money from the investments.

Rationale of health system strengthening investments made: In a country like Tanzania that has significant and diverse health system related issues, the greatest challenge lies with prioritizing the limited resource envelope. The OIG notes that funded programs were not implemented as proposed and therefore, in light of the country context, it remains questionable if they have created the intended effect. The audit also questions the effectiveness of Secretariat processes in ensuring that implemented grants remained aligned to the approved proposal:

- **National targets for health workers trained met before increasing the capacity of training institutions:** The rationale provided for renovating regional hospitals and training institutions was to increase their production capacity by 30% and thereby support the country in meeting its target of health workers trained. However, the target related to health workers trained has been exceeded (110%) even before the planned upgrades to training institutions are completed. This raises the question of whether the renovations were necessary in reaching the targets for health workers trained.³⁰
- **Sponsoring post graduate courses when Tanzania’s critical human resource gap is at lower levels:** Priorities and targets for courses sponsored under the health system strengthening grant were not clearly defined during grant negotiations in order to ensure that they address critical human resource gaps in the country’s context. Consequently, grant funds were used to sponsor 451 post-graduate degrees in a bid to increase skilled practitioners in secondary and tertiary services delivery when the real need was at lower levels given the low national average ratio of clinicians and nurses per 10,000 population (7.74 against the World Health Organization’s recommended 22.8 ratio). The audit therefore questions the rationale behind the courses that were prioritized for sponsorship especially in light of the critical human resource gaps in the country.³¹

Deficiencies in designing/ planning impacted effectiveness of interventions: Planning for activities that were critical to the overall success of the health system strengthening grant was inadequate and, as a result, once implementation was underway, the programs faced challenges in meeting the outputs proposed to and approved by the Global Fund’s Technical Review Panel.

- **Counterpart funding did not materialize:** The 40% counterpart financing towards the construction of staff houses did not materialize and this and the increased costs of construction contributed to the reduced scope of staff houses constructed from 700 to 480 houses. This raises questions about whether prior to the submission of the proposal,

³⁰ The country has set a new target i.e. enrolling 15,000 students by 2020.

³¹ PEPFAR is supporting programs that address linkages between testing and treatment, retention, and viral load scale-up.

firm commitments were obtained from the government to cover the gap. The OIG audit also did not see evidence that this commitment was followed up during grant implementation.³²

- Sustainability of funded activities not envisaged for some activities: Consideration was not given to how funded activities would be maintained/ sustained after the grant ended as listed below:
 - Students, tutors and health care workers trained and recruited under the grant could not be easily absorbed into the government structure due to the lack of employment permits. At the time of the audit, 27% (20 out of 74) of students under one implementer remained unemployed one year after they graduated due to the lack of employment permits. Prior arrangements were not made for the transfer of health workers from grants to the government structures and as a result, salaries were paid from grant funds during the bridging period.³³ These workers were also recruited at higher salary rates than government scales in order to attract them to work in hard to reach areas. However, this created other challenges involving the willingness to receive a lower salary at the time of the transfer to government.
 - No funding arrangements were made for the maintenance of constructed buildings. For instance, at the time of the audit, zonal warehouses were facing challenges in paying the increased electricity bill for cooling the newly constructed warehouses.³⁴ The monthly electricity bill at one of the three zonal warehouses visited increased by 1650%, from Tshs 800,000 (USD 376) to Tshs 14 million (USD 6,785).
- Changes in construction designs affected outputs: Changes in construction design/plans after the Technical Review Panel's approval of the proposals increased construction costs and this significantly reduced planned outputs:
 - The change in warehouse design resulted in a reduction in storage space than had been initially planned. However, storage space remains a critical challenge to funded programs.
 - Changes from proposed staff house designs increased costs per house by USD 21,000 and USD 10,000 under Phase 1 and 2 respectively. This contributed to the reduction of the number of houses that could be constructed within the available budget from 700 to 480 houses.
 - Deficient construction designs, discrepancies between staff house drawings and the bills of quantities and extension of contract duration resulted in cost overruns of Tshs 408 million (USD 198,000).³⁵
- Significant delays in the completion of grant activities: Four years into the grant and seven months before the grant end date (30 April 2016), almost 75% of the planned constructions are incomplete (see table below). At the time of the audit, only 920 out of 2253 (40%) under-graduates had been recruited under the grant. This calls into question the adequacy of planning to ensure that activities were undertaken on schedule.

Questionable value for money on health system strengthening investments:

There has been a significant reduction in the scope of planned interventions without a

³² The TRP was informed that government would not be able to honor its commitment due to the timing of government's budget approval. No action was taken to include this commitment in the subsequent government budgets.

³³ Contracts had to be extended under the grant as negotiations for the transfer of these staff to government happened.

³⁴ Increases in the electricity bills have been included in MSD's budget.

³⁵ Designs did not cater for the differences in terrain in areas where construction would happen.

corresponding reduction in budget. This reflects a higher cost per activity than was planned and budgeted and raises questions about whether best value has been obtained on the investments made.

HSS Interventions	Proposed and approved scope by TRP	Estimated for completion by 30 April 2016	Percentage reduction in scope	Completed at time of audit
Training institutions /Schools	9/36	7/27	22%/25%	3
Regional hospitals	21	10	52%	0
Staff houses	700	480	31%	229
Warehouse ³⁶	24,000 sqm (96,000 cubic meters)	9,807 sqm (88,283 cubic meters)	59% (10%)	9,807 sqm (88,283 cubic meters)
Undergraduates	2,252	920	59%	725

Inadequate measurement of health system strengthening progress: The performance framework for this grant did not track progress on some of the key activities. Consequently:

- Grant ratings and progress on implementation are disconnected. For instance, the grant has an A2 rating (meeting expectations), yet most key interventions (constructions which account for significant spending under this grant) were significantly behind schedule at the time of the audit.
- Whilst underlying indicator targets may be met, the related expected performance improvements in the health system may still not be achieved. For example, while the monitoring and evaluation indicator related to the number of facilities reporting under the Health Management Information System has been met, data quality remains a well acknowledged problem. The system is also still unable to generate data on key malaria indicators.³⁷

The issues above point to a number of weaknesses:

- Greater clarity on Global Fund strategy with regard to health system strengthening:** The Global Fund has not defined its priorities with regard to funding health system strengthening and therefore lacks effective guidance on what interventions it considers critical for its achievement of impact. An information note released by the Secretariat in 2015 provides generic guidance and is inadequate in supporting stakeholders in prioritizing between competing needs at country, technical review panel and Secretariat level.
- Lack of effective guidance on health system strengthening:** The Secretariat lacks effective guidance on the unique risks and challenges that health system strengthening activities present, such as the management of construction projects under HSS. This covers key areas from planning, overseeing implementation and monitoring activities.

Agreed management action 4: The Secretariat will provide specific operational guidance to clarify the requirements for planning, overseeing and monitoring construction and renovation projects in order to identify and mitigate typical risks inherent in such activities, including sustainability following completion of the infrastructure improvement activity.

Owner: Head of Program Finance and Controlling

Target Date: 31 March 2017

³⁶ While the square meters decreased, there is increased volume since the new warehouses are 5 meters higher than original stores.

³⁷ Proxy data is still used to report on two malaria key indicators (i.e. the number of suspected malaria cases tested in public health facilities and the number of patients diagnosed with malaria receiving ACT treatment).

IV.5	<i>Inadequate financial and fiduciary controls resulting in lost program funds</i>	Country Team Level	
------	---	-------------------------------	--

Inadequate management and oversight affecting the timely receipt and disbursement of funds and thereby delaying program implementation and affecting the proper accountability of funds.

The Ministry of Finance is the Principal Recipient of about 90% of grant funds in Tanzania. It has delegated the management and implementation of grants primarily to the Ministry of Health. However, the audit noted that the implementation and oversight arrangements both by the Country Coordinating Mechanism and the Principal Recipient are currently inadequate to support the effective implementation of funded programs.

Delayed disbursement of funds to implementers: As noted in the 2009 OIG audit and other reports, there are significant delays in the disbursement of funds by the Principal Recipient to implementing entities. This affects timely program implementation. For example, the National Tuberculosis Program received funding three days after the grant end date and could not implement planned activities. This also has delayed the start of procurement processes and contributed to the low absorption of funds.

Unsupported expenditures: The audit identified unsupported costs amounting to USD 9.6 million related to transactions that were:

- Incurred without appropriate supporting documentation amounting to USD 9,350,116; and
- Ineligible amounting to USD 617,165. This was related to payments that were not in the budget e.g. the purchase of gym equipment (USD 218,568), payment of allowances that were not in line with the relevant government policies (USD 337,258) and value added taxes paid with grant funds (USD 61,339).

In order to get a better understanding of the causes and extent of these costs, this issue has been referred for further investigation.

Poor controls over the recovery of program funds: Some schools received school fees for students from the grants in December 2014 and also obtained paid duplicative fees from the same students. No refunds had been made to the students or to the funded program at the time of the audit.³⁸ The OIG audit also identified delayed recovery of program funds amounting to USD 1.35 million relating to:

- Advances to a contractor for construction that was terminated amounting to Tshs 480m (USD 217,000) in May 2014. The program did not recover funds from the contractor's performance guarantee. The guarantee expired in 2015;
- An insurance claim by the Medical Stores Department amounting to USD 0.5 million for antiretroviral medicines that were lost in transit in 2013. At the time of the audit, the status of this claim was unknown ;
- Unutilized funds by the Medical Stores Department related to the construction of the warehouses under the health system strengthening grant amounting to USD 0.2 million;³⁹ and

³⁸ Subsequent to the audit, 12 out of 13 schools have refunded fees paid to students. The last school has committed to effect refunds before June 2016.

³⁹ This was paid to the Ministry of Health subsequent to the audit.

- The inflation of a contract price related to bed net distribution by USD 150,000 (i.e. the amount entered into the contract differed from the financial award price).⁴⁰

Inadequate management of advances: At the time of the audit, the advances which had not been accounted for amounted to USD 0.3 million. The OIG audit identified several issues related to advances:

- Advances were made in cash to staff, sometimes up to six months before commencement of intended activities.
- Staff accounted for advances several months after the activity had taken place, which is contrary to the 10 days stipulated by the government policy.
- Ten out of the 11 entities audited lacked effective mechanisms for tracking cash advances. Advances were expensed upon payment and the entities lacked advance ledgers to track outstanding amounts.

Inadequate procurement processes for non-health products: There were significant procurement delays (up to one year) noted with the procurement of non-health commodities. The processes followed in purchasing non-health products did not provide for sufficient competition:

- Restrictive tendering was consistently followed for all construction related transactions sampled irrespective of amounts involved (USD 0.3 – 1.9 million). This not only limits the number of possible bids but in the absence of a list of prequalified suppliers, calls into question the basis for selecting potential bidders. In one case, the selected contractor did not have the requisite prequalification from the Contractors Registration Board. The audit also noted that evaluators usually introduce new technical criteria and/or interpret set criteria differently and as a result disqualify all bidders except one at the technical stage. The sole financial bid was then accepted without adequate documentation if the bid represented best value for money.
- The Medical Stores Department does not respect the terms of the two year framework contract it signs. Once signed, the department issues orders worth the total value of the two-year contract and thereafter amends the contract to supply volumes of up to 500% more than the original contract sum. This amendment typically happened before even the first order is delivered, which defeats the purpose of having a framework. The department may have been able to negotiate better prices if it had tendered the full volume of commodities up front.

Inadequate contract management: In addition to the issues raised under section 4 of this report, the audit identified instances of poor contract management:

- Budget overruns under several contracts are addressed by reducing the scope of work as was noted with the Tshs 600 million (USD 400,000) budget overrun on the Mtwara construction.
- Programs do not have any security on advances made to contractors because guarantees presented are allowed to expire before the completion of the work. The programs normally make up front payments to contractors of up to 15% of the contract sum.
- Supervision of civil works is inadequate in some constructions and this resulted in substandard construction work as was noted at the Hubert Kariuki School. Recommendations by the Country Team to strengthen supervision have not been implemented by the recipients.

The issues in this report raise questions around the adequacy and effectiveness of the Ministry of Finance in executing its mandate as Principal Recipient. Two Program Management Units have been set up within the Ministry of Finance and the Ministry of Health to manage the

⁴⁰ The implementer has subsequently acknowledged that the increase in price was an error.

funds and provide oversight to the implementation of the program activities. The audit noted that the two units have overlapping terms of reference and even then, do not effectively perform the roles described in their terms of reference.

As previously noted in the 2009 OIG audit and as noted below, lapses in the Principal Recipient's execution of its role have weakened the control environment within which grants are implemented and the efficiency and effectiveness of funded programs:

- Delayed disbursement of funds from the Global Fund due to unfulfilled conditions precedent to disbursement, late submission of reports to the Global Fund and tardy resolution of management actions.
- Delayed disbursement of funds to implementers due to lengthy government processes for disbursing program funds to implementers. It takes on average 150 days for funds received from the Global Fund to be transferred to implementers.
- Inadequate management of available funds as evidenced by the unsupported expenditures;
- Inadequate implementation arrangements in supporting program implementation. For example, the retention of control by the Ministry of Health headquarters over the funded programs when programs are implemented in a decentralized setting disempowers local governments that are primarily responsible for service delivery.
- Ineffective oversight of implementers resulting in weaknesses in the latter's internal controls as has been noted in the procurement of non-health products and weaknesses in the supply chain management system.
- Limited effectiveness of the assurance mechanisms in identifying and mitigating key risks to effective program implementation. In cases where issues have been identified, recommendations have not been implemented in a timely manner. For example, proposals by the Secretariat to reduce costs of construction have not been implemented by the Principal Recipient.

Agreed management action 5:

The Secretariat will request the Country Coordinating Mechanism to prepare a time bound action plan showing how the country's implementation arrangements will be streamlined and strengthened in order to support the effective implementation of funded programs. This will include and not be limited to strengthening:

- (i) The capacity of the Principal Recipient to effectively execute its mandate;
- (ii) Oversight of the delegated authority to sub-recipients and sub-sub recipients (especially Ministry of Health and Prime Minister's Office Regional Administration and Local Governments); and
- (iii) The Principal Recipient's risk management and assurance framework over the funded programs.

Owner: Head of Grant Management

Target Date: 30 June 2016

Agreed management action 6: The Secretariat will review the findings relating to loss of assets and funds not accounted for and make proposals to the Recoveries Committee on a way forward.

Owner: Head of Grant Management

Target Date: 30 June 2016

V. Table of Agreed Actions

No.	Category	Agreed Action	Target date and owner
1	Supply chain management system unable to effectively support commodity distribution	The Secretariat and key country stakeholders have instituted a review of the Medical Stores Department to find solutions to the challenges it faces in storing and distributing commodities. The Secretariat will support the government and partners to develop an operational plan based on the findings of this review. Additionally, recognizing that the overall improvements of commodities' flow through the supply chain are critical for improved service delivery, a separate operational plan will be developed and agreed upon between the Secretariat, the government and partners with a view of improving the overall accountability throughout the supply chain.	Head of Grant Management 31 December 2016
2	Scale up of HIV testing and treatment likely to affect continuity of services	The Secretariat working in concert with partners will engage with governments in five countries including Tanzania to analyze the gaps in funding due to scale-up following the latest normative guidance from the WHO on testing and treatment for HIV, which may have implications for the continuity of treatment for existing patients. Accordingly, the Secretariat in collaboration with partners will encourage governments to develop action plans and monitor the implementation of the plans to address such gaps, including considering the possibility of increased government financing.	Head of Strategy Investment and Impact 31 December 2016
3	Scale up of HIV testing and treatment likely to affect continuity of services	The grants that have been signed and/or will be signed under the new funding model are an opportunity for the Secretariat to work with in-country stakeholders (including technical partners) to find solutions to the quality of service issues that are affecting the grants. Specifically, the Secretariat will: <ul style="list-style-type: none"> • Work with in country stakeholders to ensure that the 	Head of Grant Management 30 September 2016

		<p>quantification and forecasting of malaria medicines and test kits is revisited before additional investments are made. Different quantification methods will be applied and results triangulated to ensure an optimal result.</p> <ul style="list-style-type: none"> • Ensure that the Principal Recipient identifies a suitable entity to manage the Co-Payment Mechanism. • Ensure that the Principal Recipient prepares a supervision and training plan that details the objectives of different types of training and supervision that will be undertaken, specifically addressing the quality of services that are found to be sub-optimal, i.e. the retention of patients on treatment and treatment of malaria patients without diagnosis. 	
4	Health system strengthening interventions in the funded programs not optimized	The Secretariat will provide specific operational guidance to clarify the requirements for planning, overseeing and monitoring construction and renovation projects in order to identify and mitigate typical risks inherent in such activities, including sustainability following completion of the infrastructure improvement activity	<p>Head of Program Finance and Controlling</p> <p>31 March 2017</p>
5	Inadequate financial and fiduciary controls resulting in lost program funds	<p>The Secretariat will request the Country Coordinating Mechanism to prepare a time bound action plan showing how the country's implementation arrangements will be streamlined and strengthened in order to support the effective implementation of funded programs. This will include and not be limited to strengthening:</p> <ul style="list-style-type: none"> • The capacity of the Principal Recipient to effectively execute its mandate; • Oversight of the delegated authority to sub-recipients and sub-sub recipients (especially Ministry of Health and Prime Minister's Office Regional Administration and Local Governments); and 	<p>Head of Grant Management</p> <p>30 June 2016</p>

		<ul style="list-style-type: none"> The Principal Recipient's risk management and assurance framework over the funded programs. 	
6	Inadequate financial and fiduciary controls resulting in lost program funds	The Secretariat will review the findings relating to loss of assets and funds not accounted for and make proposals to the Recoveries Committee on a way forward.	Head of Grant Management 30 June 2016

Annex A: General Audit Rating Classification

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

Annex B: Methodology

The Office of the Inspector General (OIG) performs its audits in accordance with the global Institute of Internal Auditors' (IIA) definition of internal auditing, international standards for the professional practice of internal auditing (Standards) and code of ethics. These Standards help ensure the quality and professionalism of the OIG's work.

The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These help our auditors to provide high quality professional work, and to operate efficiently and effectively. They also help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing takes place across the Global Fund as well as of grant recipients, and is used to provide specific assessments of the different areas of the organization's' activities. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.