

Our ref: OGM/GJ/JP

19 April, 2012

MESSAGE FROM THE GENERAL MANAGER AND INSPECTOR GENERAL

Audit Reports and Diagnostic Review issued by the Global Fund's Office of the Inspector General on 20 April 2012

Dear Reader:

Today the Global Fund has released three audit reports and one diagnostic review. These audits and reviews are part of the Global Fund's well established and consistent quality assurance process which seeks to ensure that grant money is used as effectively and efficiently as possible.

The reports are:

- [Audit Reports](#): Ethiopia, Kenya and Uzbekistan;
- [Diagnostic Review](#): Cuba.

While diagnostic reviews and audits serve similar purposes—they provide the Global Fund with an opportunity both to learn and to improve the way it does its business—there are certain important differences between them.

Audits take an historical perspective and comprehensively review grant implementation over time to substantiate whether grant funds have been used for the purpose intended and to provide assurance that grant funds are used wisely to save lives.

Diagnostic reviews look at the grants at a given point in time to identify the key risks to which grant programs are exposed. They provide recommendations to mitigate the risks identified.

The audit reports in the current release are 'legacy' reports, which relate to grants signed as far back as 2004 and to audits performed in 2009 and 2010. Many of the findings relate to weaknesses in grant management and oversight during the early years of the Global Fund that have been identified before, including in the High Level Panel Report and in other audit reports by the Office of the Inspector General. Many findings are already being addressed.

The diagnostic review in this release was performed in late 2011. It points to areas for improvement in managing Global Fund support. It also demonstrates solid achievements and good grant management practices.

Each report published today includes a concrete time-bound management plan of action that indicates how the findings will be addressed and the recommendations implemented. We both applaud the considerable progress that has already been made to improve grant management in response to the recommendations offered by the Global Fund's Office of the Inspector General.

Gabriel Jaramillo



John Parsons





THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

**Audit of Global Fund Grants to the Federal Democratic Republic
of Ethiopia**

**GF-OIG-10-014 revised
14 May 2012**

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NB: This revised version of the report first issued on 20 April 2012 contains the CCM response to Recommendation 35 that had not been included in the original. It was received by the OIG on 02 May 2012.

EXECUTIVE SUMMARY

Introduction

1. The Office of the Inspector General (OIG) as part of its 2010 work plan, conducted an audit of the Global Fund grants to Ethiopia. The purpose of this audit was to provide assurance that Global Fund resources have been spent wisely to save lives in Ethiopia.

2. The audit covered all 10 Global Fund grants, and 4 PRs, from Rounds 1 to 8, which totaled USD1,306 million, distributed as follows between PRs and diseases:

Principal Recipient	Disease	USD Million
Federal Ministry of Health (FMOH)	Malaria & TB	404
HIV/AIDS Prevention and Control Office (HAPCO)	HIV	879
Ethiopian Interfaith Forum for Development Dialogue and Action (EIFDDA)	HIV	14
Network of Networks of HIV Positives in Ethiopia (NEP+)	HIV	9
Total		1,306

Table 1: Grant Portfolio by PR as at November 2010

At the time of the audit, in November 2010, the total amount disbursed under these grants was USD947 million, which represented 73% of the total grants.

HIV Program

3. Notable HIV program achievements for each PR included:

- **HAPCO:** After launching the free ART program, the estimated number of patients who started treatment increased from 8,226 in 2005 to 268,934 in 2009¹. HCT uptake has increased from about 500,000 in 2004 to 9.4 million in 2009². Health facilities (HFs) providing ART reached 517 in December 2009 from 93 in 2005³.
- **EIFDDA:** In 2010, in line with targets, 31,702 orphans and vulnerable children (OVC) received educational support, 12,844 OVCs received food, shelter and clothing support, and 2,936 siblings and guardians received income generation activities (IGA) support⁴.
- **NEP+:** 126,967 PLHIVs received treatment literacy and adherence education, which exceeded the target by 19%; and 15,135 PLHIVs received community and home-based care (HBC) compared to the target of 11,270.

¹ HIV Multi-Sectoral HIV/AIDS response, Annual Monitoring and Evaluation Report (July 2008 - June 2009)

² HAPCO Round 2 HIV RCC grant PUDR at 31 December 2010

³ UNAIDS UNGASS Report issued on 30 June 2010

⁴ EIFDDA Round 7 HIV grant PUDR at 31 December 2010

HIV Service Delivery - HAPCO

Construction of new health centers

4. For Rounds 4 and 7, as part of the strategy to expand entry points to ART, VCT, PMTCT, TB/HIV and STIs, a total USD83,344,534 was committed to renovate 550 existing HFs to provide VCT, PMTCT and ART services. In addition, USD 24,196,552 was provided for constructing and renovating health posts in the regions. During the audit, the OIG noted that 1,309 new health centers (HCs) had been constructed using Global Fund resources against the budget line for renovation of HFs and construction of Health Posts. A total of USD165,393,027 was spent for this purpose, resulting in over expenditure of USD57,851,941 against the approved budget for this budget line.

5. The budgets intended to finance other activities (e.g. OI drugs, ARVs, HMIS implementation, and prevention activities) were used to finance this over expenditure. This impacted program results; for example, the indicator for 'Number of patients who received prophylaxis and treatment for OI' was reported to be 74% of target⁵. Also, a review of the implementation of the PSM plans revealed that many of the planned OI drugs were not procured⁶ and the supply and availability of OI drugs was observed to be insufficient in all the regions, zones, and woredas (districts) visited.

6. There was no formal approval from the Global Fund to expand grant activities for the construction of new HCs. Further, the TRP did not review and approve this material change to the scope and scale of the proposal originally approved, and the performance frameworks were not revised to reflect this significant reallocation of funds. The Global Fund Secretariat was aware, however, of the nature and extent of the HC construction activities and had contracted reviews in 2009 and 2010 to evaluate the HC construction projects funded by the Global Fund. A HC construction proposal had been presented to the TRP for approval under Round 5 and 6 but was not recommended for approval by the TRP for a number of programmatic and budget reasons.

7. Similarly, for Malaria R8, USD6.97 million was reprogrammed from indoor residual spraying to HC construction without the necessary formal approvals being obtained. The OIG recommended that HAPCO and the FMOH ensure that the necessary formal Global Fund approvals are obtained before any material reprogramming of grant activities takes place in the future.

HC construction quality issues

8. The OIG visited 77 sites of newly constructed HCs and observed significant deficiencies:

- 71% of the sites visited did not have access to water; 32% did not have functioning toilet facilities; 53% had major cracks in the floors; and 19% had leaking roofs.

⁵ETH-405-G04-H Grant Performance Report, updated 7 July 2011

⁶ As of March 2011 only USD0.882 M had been spent out of USD6.066 M provided in the Round 4 HIV budget

- Only 14% of the HCs had equipment such as microscopes and delivery beds; only 12% had functional drug stores; and none of the laboratories had work surfaces.

9. The OIG recommended that HAPCO should seek to rectify the defects of the HCs constructed so as to ensure the proper provision of health services related to HIV, TB and Malaria.

PMTCT and Pediatric ART

10. Of the 46 HFs visited, fully functional services for preventing mother-to-child transmission (PMTCT) were observed in only 12 HFs. The weak implementation of PMTCT was in particular affected by low ANC coverage which stands at around 28%. Pediatric ART and prophylaxis for diarrhea and pneumonia was only available at hospitals, and not at any of the HCs visited. The OIG recommended that HAPCO commission a study to identify specific causes for the weak implementation of PMTCT and the poor ANC coverage.

Inadequate supervision of HEWs

11. The HEWs conduct various activities and interventions in the community for the HIV grants, as well as for the malaria and TB grants. The OIG noted that there was inadequate supervision of the HEWs by the HEW supervisors and HCs, and recommended that regular supportive supervision be provided, along with monitoring of deliverables.

HIV Service Delivery - EIFDDA and NEP+

12. As a result of visits to SRs and SSRs of EIFDDA and NEP+ implementing activities for HBC for PLHIVs, OVC care and support, and IGA support for PLHIVs and OVC guardians, the OIG identified the need for the implementation of:

- Guidelines and criteria for conducting activities
- Standardized training
- Proper record keeping for the activities

13. The OIG also made recommendations to both EIFDDA and NEP+ aimed at strengthening systems for supervision of the activities implemented by the SRs and SSRs by developing and implementing guidelines and checklists.

Malaria and Tuberculosis Programs

Malaria Service Delivery

14. Malaria program achievements included:
- In areas heavily affected by malaria, 7.8 million houses were sprayed with insecticides in the 12 months to June 2010, which exceeded targets by 34%.
 - More than 33 million LLINs³ had been distributed to people at risk of malaria over the last 7 years which was close to the target of 33.8 million.

- Over 172 district level program managers⁷ were trained on malaria prevention, control, and monitoring and evaluation, which was 108% of target.

Microscopy diagnosis quality issues

15. From visits to 46 HF's, the OIG noted that there was often a lack of running water and some microscopes were in a poor condition, which affected the quality of microscopy diagnosis for both malaria and TB. Additionally, internal and external quality assurance had not been properly implemented in many HF's visited.

Poor implementation of case management national guidelines

16. It was observed that none of the medical doctors and clinical nurses in the 46 HF's visited were trained in malaria case management as per national guidelines.

Long-lasting insecticidal nets (LLINs)

17. During visits to health posts, the OIG noted there was a lack of monitoring to ensure that LLINs were being used in households, and there was no strategy for the replacement of LLINs nearing their expiry period.

Indoor residual spraying (IRS)

18. The OIG noted there was a need to:
- Establish a system for on-site quality checks during IRS.
 - Commission a study on the status of resistance to DDT used in IRS, as planned under the National Malaria Strategic Plan (NMSP).
 - Disseminate to the implementation level the guidelines that have been developed at the federal level for storage, transport, and application of insecticides.

Active surveillance and epidemic control

19. The OIG recommended that the FMOH implement an active surveillance and epidemic control system as envisaged under the NMSP.

Tuberculosis Service Delivery

20. Though there had been some improvements in TB grant performance, many targets had not been met.

Case detection challenges

21. The OIG noted the following issues affecting case detection:
- For many TB suspects, the long distance to HC's limited access to sputum microscopy services. Also, civil society and private healthcare providers were not involved in the TB referral system although they are often the only institutions providing health services to the community in hard-to-reach areas.

⁷ MoH Round 4 Malaria grant PUDR at 30 June 2010

- Referral of pulmonary TB suspects by HEWs was not taking place in some of the 46 HFs visited. Also, where HEWs did refer suspects for sputum microscopy, in some cases they did not follow-up on the results.
- There was inadequate information at HFs on pulmonary TB, its harm, and the services available.

Treatment regimen for TB

22. The OIG recommended:

- Inclusion of Rifampicin in the continuation phase of the DOTS regimen as recommended in WHO guidance⁸.
- Providing each patient with a fixed dose combination in a box for each patient in order to ensure uninterrupted access to the complete course of treatment.
- Training for healthcare staff treating TB patients on identifying side effects and necessary remedial actions.

Impediments to DOTS

23. Due to long distances, it was difficult for some TB patients to travel every day to the HF to take the daily dose under supervision. For the continuation phase, patients were given drugs for a week or fortnight, and there was no system for verifying whether the patient had indeed taken the drugs. Also, a system for monitoring defaulters was only evident at 3 of 46 HFs visited where HEWs were involved in DOTS.

Multi-drug resistant tuberculosis (MDR-TB)

24. Though there was a MDR-TB diagnostic algorithm at the federal level, of the 36 HFs visited, the health officers/doctors were only aware of the MDR-TB strategy in 3 regional hospitals.

HIV-TB coordination

25. Better coordination in HIV clinics as compared to the poor coordination in TB clinics was observed on field visits. There was a lack of standardized formats for referral and feedback between the TB and HIV clinics. In all the health posts visited, none of the HEWs were trained in HIV-TB coordination.

Monitoring and Evaluation

26. For HAPCO, the OIG noted that grant work plans were not effectively cascaded to regions, zones and woredas; and also that program reports generated and analyzed at the woredas and zones were not forwarded to the regional or federal offices. The OIG recommended that HAPCO should:

- Ensure that the work plans at regional, zone, and woreda levels incorporate the objectives, activities, and sub-activities listed in the HAPCO work plans for the Global Fund grants.

⁸ http://www.who.int/tb/publications/2008/who_htm_tb_2008_401_eng.pdf

- Put in place a mechanism for monitoring the implementation of activities in the grant work plans and strategic plans.
- As part of strategic planning and review, undertake a mapping of stakeholders and their areas of implementation.

27. The need to improve data collection and reporting was noted for HAPCO, EIFDDA and NEP+, as well as a need to standardize systems and processes for data validation at EIFDDA and NEP+

28. Additionally, for the FMOH, EIFDDA and NEP+, the OIG made several recommendations regarding the need to revise indicators to ensure greater clarity, and also include additional indicators to improve the measurement of interventions.

Financial Management

Ineligible expenditure

29. The OIG noted that HAPCO had charged a total of USD6 million of ineligible expenses to the grant programs, which included USD4.7 million of VAT on payments for the construction of HCs expensed to Round 4. The PR did, however, make a correcting adjustment for this VAT amount during the finalization of the OIG audit. Also, the FMOH as SR, wrongly included USD11 million in statements of expenditure submitted to HAPCO, as this amount had not yet been liquidated by the implementers. Recommendations were made to HAPCO to recover ineligible expenditure to the Global Fund accounts, and ensure proper verification of statements of expenditure in the future to confirm the validity of amounts reported.

Long-outstanding advances

30. For both the FMOH and HAPCO, the OIG noted instances where advances were outstanding for long periods. For example, an advance of USD6.3m by HAPCO to PFSA in April 2009 was still outstanding in November 2010. Additionally, advances were noted to be outstanding for grants that had expired; in particular, for Round 4 HIV, over USD5.5 million was advanced by HAPCO to the FMOH and was still outstanding by February 2011 although the grant expired in August 2010. A total of USD112k of advances by the FMOH to various regions and SRs was also found to be outstanding for expired grants (TB Round 1 and Malaria Round 2). The OIG recommended timelier monitoring and follow up of outstanding advances, and refund to the Global Fund of USD5.5 million related to expired grants.

Weaknesses in accounting systems at the FMOH

31. The FMOH's financial records for the grants were maintained using Excel spreadsheets instead of a suitable accounting software package. Also key reconciliations relating to cash and bank, and program disbursements were not regularly prepared and reviewed.

Improvement needed in budget preparation and monitoring at HAPCO

32. The PR prepared budgets by allocating lump-sum amounts to different work-plan activities. Also, periodic budget monitoring reports were not prepared and reviewed by management. The OIG recommended that HAPCO prepare activity-

based budgets, along with detailed supporting calculations including unit types, unit costs, and assumptions; and also prepare and review budget monitoring reports on at least a monthly basis, in order to identify and follow up on unexpected deviations.

Delayed annual audits of PR and SR financial statements

33. For the FMOH and HAPCO, the annual audits of program revenues and expenditures for various grants were not carried out on a timely basis, with delays of up to 9 months for HAPCO and over 21 months for the FMOH in some cases. The OIG recommended that the PRs ensure that the PR and SR books of account and financial statements should be made ready for audit on a timely basis and that the external auditor reduce the time taken on the external audit by performing interim audits before the financial year end and adopting a risk-based approach to auditing regions and SRs.

Inadequacies in internal audit

34. For HAPCO, the OIG noted that the internal audit function lacked organizational independence, as well as a system to ensure appropriate remedial actions are taken in response to audit recommendations. For EIFDDA, the internal audit function had very limited human resources and technical capacity. For both these organizations, the scope of the internal audit work did not include all high-risk areas.

Grant closure long overdue

35. The OIG noted that the TB Round 1 grant expired on 31 January 2009 and Malaria Round 2 grant expired on 31 March 2009. However, at the time of the OIG audit, nearly two years had elapsed and the grant closure for these grants was still incomplete.

Weak financial management by EIFDDA SR

36. The Ethiopian Muslim Development Agency (EMDA) received USD2 million from EIFDDA to undertake social mobilization and OVC support activities. The OIG observed significant financial and operational weaknesses at this SR, in particular proper books of accounts had not been maintained and controls over cash and bank were inadequate. The OIG recommended that EIFDDA ensure that EMDA addresses the many financial management issues noted, and should consider withholding funding to EMDA until this has been accomplished.

PR Governance

Strengthening PR boards

37. The OIG recommended that the boards of HAPCO, EIFDDA and NEP+:
- Establish a conflict of interest policy to ensure that board members who are also on the boards of SRs exclude themselves from board deliberations and decisions relating to their respective organizations.
 - Consider setting up board committees to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up.

Procurement and Supply Management

Planning, forecasting and logistics

38. The PFSA had received considerable support from several donors which had greatly enhanced forecasting and logistics for ARVs. Malaria and TB pharmaceuticals, however, were still mainly managed through the respective departments at the FMOH, and program targets were largely used to determine what to procure as virtually no consumption reports were collected from treatment centers. It was envisaged that the forecasting for the malaria and TB programs would be handed over to PFSA, and in August 2010, with support from USAID/SCMS, the PFSA conducted a national forecasting and quantification exercise covering the TB and Malaria programs.

39. For two HIV grants and one TB grant, the OIG compared actual quantities procured against PSM plans and observed significant variations, indicating poor planning and forecasting, which was mainly because the results of the new donor-supported systems and exercises had not yet been incorporated into the PSM plans. In the facilities visited, significant overstocking and stock outs of some medicines were observed, despite the existence of established minimum and maximum stock level for all medicines. The OIG made recommendations regarding the need to:

- Ensure PSM plans are updated to reflect the results of donor supported forecasting and quantification systems.
- Adhere to approved PSM plans.
- Monitor adherence to the established minimum and maximum stock levels.
- Complete the implementation of an effective logistics management information system for TB and malaria health products.

Delays in procurement

40. For 60% of the OIG sample of 144 items procured by PFSA under Global Fund grants, it was noted that the goods were not delivered within 6 months after the commencement of the bidding process, as stipulated in the PSM plans. The OIG stressed the need to: enhance the planning and execution of procurement activities; improve coordination with PRs; and better manage contracts to ensure improved and timelier performance by suppliers.

Quality assurance

41. Quality monitoring was only conducted via visual inspection, with only suspected samples being subjected to laboratory testing. The OIG recommended routine random sampling and testing from different points in the distribution chain as required by Global Fund policy. The implementation of a system for the tracking of medicines by batches was also recommended.

Grant Oversight

Country Coordinating Mechanism

42. The OIG noted aspects of the following CCM processes that needed improvement:

Aspect for improvement	Action proposed
Members representing CSOs were admitted to the CCM mainly on the basis of letters of introduction from their respective organizations.	CCM membership - CCM members representing non-government constituencies should be selected by their own constituency based on a documented, transparent process, developed within each constituency.
There was a lack of evidence that the concept notes solicited from the public were considered for inclusion in proposals.	Proposal development - The CCM should coordinate the development of funding applications through transparent and documented processes that engage a broad range of stakeholders.
The Ethiopia CCM guidelines state that the PR for malaria and TB grants will remain the FMOH.	PR selection - The CCM should document a transparent process for the nomination of all new and continuing PRs based on clearly defined and objective criteria.
Important examples were noted where program activities were not implemented as planned.	Program oversight - The CCM should oversee the performance of PRs to ensure that they achieve the agreed targets of the programs they are implementing.

Table 2: CCM Processes with Aspects for Improvement

Local Fund Agent

43. The OIG noted a number of important areas for improvement for the LFA:
- There was no evidence that the LFA had reviewed the PRs' external audit arrangements applicable to the Global Fund grants and advised the Global Fund on their acceptability.
 - The LFA did not have an adequate documentation system for work performed or for quality assurance.
 - With regard to the LFA's PUDR review work:
 - i. The LFA's verification procedures failed to detect some significant amounts that were wrongly included in statements of expenditure, and did not include verification of the proper distribution of commodities to the ultimate recipients.
 - ii. The LFA did not reconcile the financial information in the PUDRs to the PR accounting records prior to submission to Global Fund as was the case for the grant to EIFDDA.
 - iii. There was a lack of analysis provided by the LFA on variances between the forecast and budget.

Global Fund Secretariat

44. The OIG recommended that the Global Fund Secretariat should:
- Ensure that Global Fund policies are properly followed for adjustments to grant programs, including: formal approval of all material budget changes; referral of material program activity changes to the TRP for review; and appropriate amendment of the grant agreement.

Audit of Global Fund Grants to Ethiopia

- Follow up on the implementation of the memorandum of understanding that ensures alignment of Global Fund grant work plans with those funded by PEPFAR. The OIG noted instances of duplication of funding with PEPFAR with respect to support to PFSA for distribution of commodities.
- Ensure the LFA reviews the Principal Recipients' audit arrangements and advises the Global Fund on their acceptability.
- For significant variances between forecast expenditure and budget in PUDRs:
 - i. Ensure the PR specifies the factors that are the major drivers of the deviation.
 - ii. Ensure the LFA provides analysis and comments on the variance.

Amounts Recommended for Refund to the Global Fund

45. The OIG has recommended the following amounts for refund:

PR	Description	Amount USD	Report Ref.
HAPCO	Outstanding advances related to the expired Round 4 grant	5,591,015	Paragraph 130 Page 40
HAPCO	VAT and other ineligible expenses charged to the grant programs	1,323,627	Table 13 Page 39
FMOH	Outstanding advances to various regions and SRs related to the expired grants: Malaria Round 2 and TB Round 1	112,287	Table 9 Page 29
Total		7,026,929	

Table 3: Amounts Recommended for Refund to the Global Fund

Overall Conclusion

46. The Global Fund grants have been successful in increasing coverage for the three diseases. At the time of audit, there was weak implementation of PMTCT reflected in poor performance against grant targets. A total of USD165,393,027 was spent on Health Centre construction, resulting in over expenditure of USD57,851,941 or 54% against the approved budget for health facility renovation. There was inadequate control in place to assure quality and effective use of the constructed health facilities. From the audit findings, the OIG could not provide assurance that oversight arrangements ensured that grant funds are used for the purpose intended.

MESSAGE FROM THE GENERAL MANAGER



10 YEARS
OF IMPACT

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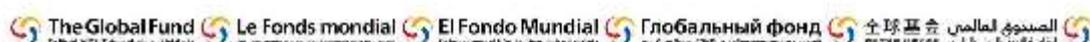
MESSAGE FROM THE GENERAL MANAGER

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

The audit was conducted in 2010 and early 2011 and covers grants made from Rounds 1 through 8 worth a total of USD 1.3 billion. The report outlines broad advances in Ethiopia for the treatment and prevention of HIV, such as starting more than 240,000 patients on anti-retroviral treatment, distributing more than 33 million insecticide-treated nets to prevent malaria, and constructing hundreds of new health centers to dramatically increase entry points for effective treatment and prevention.

The report also cites concerns about over-expenditures on the approved budgets for construction of new health centers and the functionality at some of those sites. The report cites insufficient programmatic, budgeting and oversight supervision for construction of that magnitude. The Secretariat was aware that health center construction activities were over budget and agrees with the Office of the Inspector General that the documentation should have been formalized in a better way.

The audit includes an action plan of 88 detailed recommendations for improvements in making the grants more effective, and a table that shows the status of progress on each recommended action. Many of the recommended actions are already complete. In March, 2012, the Secretariat was informed that 73 of 77 health centers visited by the Office of the Inspector General had been provisionally accepted, with construction problems rectified. The Global Fund Secretariat has made a detailed list of responses to issues raised in the audit report, and that list is included as Annex#2.



I am confident that with our new emphasis on risk management and grant management, we will have appropriate procedures in place to address and resolve in a timely way the issues raised in this report by the Office of the Inspector General.

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

Yours sincerely,



MESSAGE FROM THE COUNTRY COORDINATING MECHANISM



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March 06, 2012

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Dear Mr. Parsons,

Subject: CCM Ethiopia, Responses/Reactions to the Country Audit of OIG Final Draft Report

Kindly refer to your letter of 28 February 2012, Ref. No. OIG/OP/12/02600 with the attached final draft report on the above mentioned subject.

The Country Coordinating Mechanism of Ethiopia (CCME) is pleased to submit Responses to OIG Final Draft Report/country audit, for your kind attention and consideration.

All comments and recommendations, with particular attention to the revised recommendations, have been reviewed critically by PRs-Ethiopia and CCME members at the urgent meeting of 05 March 2012.

The CCME members also emphasized that the processes have been transparent, participatory and educational with a lot of lessons to learn from.

On behalf of the Government of Ethiopia, CCME members and on my own behalf as the Vice Chair of CCME, I would very much appreciate your positive response as a matter of importance to fight HIV/AIDS, TB and Malaria.

In general, the CCME members very much appreciated your valuable revision of some of the recommendations which were discussed with necessary attention and hope for your continued support and assistance as always.

Sincerely,

Meshesha Shewaraga (Dr.)
Executive Director



- c.c.
- Mr. Linden Marr-St., Regional Team Leader, East Africa and Indian Ocean
 - Mr. Christian Thurasingham, Fund Portfolio Manager, East Africa and Indian Ocean

BACKGROUND

Grant Portfolio

47. At the time of the audit, between November 2010 and March 2011, the total approved funding to Ethiopia amounted to USD1,306 million as detailed in the following table:

Round	Disease	Principal Recipient	Grant Amount (USD)	Status
1	Tuberculosis	FMOH	26,980,649	Phase II
2	Malaria	FMOH	73,875,211	Phase II
2	HIV/AIDS	HAPCO	435,001,702	RCC I
4	HIV/AIDS	HAPCO	401,905,883	Phase II
5	Malaria	FMOH	140,687,413	Phase II
6	Tuberculosis	FMOH	29,539,816	Phase II
7	HIV/AIDS	NEP+	9,487,078	Phase I
7	HIV/AIDS	HAPCO	41,666,516	Phase I
7	HIV/AIDS	EIFDDA	13,802,195	Phase I
8	Malaria	FMOH	133,089,526	Phase I
Total			1,306,035,989	

Table 4: Grant Portfolio as at November 2010

Audit Timing and Approach

48. The Office of the Inspector General (OIG) as part of its 2010 work plan, conducted an audit of the Global Fund grants to Ethiopia.

Audit Objectives

49. The objectives of this audit were to:
- I. Assess the adequacy and effectiveness of the management and implementation of grants.
 - II. Measure the soundness of systems in place to safeguard Global Fund resources.
 - III. Confirm compliance with Global Fund grant agreements, related policies and procedures, and the relevant laws and regulations.
 - IV. Verify whether program funds are used economically, efficiently and effectively.
 - V. Make recommendations to strengthen the management of the Global Fund grants.

Audit Scope

50. The OIG audit covered all the active and closed grants since the inception of the Global Fund-supported programs in Ethiopia. It covered all the entities involved in program implementation and oversight, i.e. principal recipients (PRs), sub-recipients (SRs), Country Coordinating Mechanism (CCM), and the Local Fund Agent (LFA); and also covered the following functional areas: (i) finance and administration; (ii) procurement and supply chain management; (iii) programmatic management and (iv) program oversight. The audit field work covered 22 SRs, 6 regions, 24 zones and 58 woredas. The areas visited by the OIG were selected on the basis of materiality of grant funds received and geographic diversity.

51. UNICEF provided procurement agency services to the grant programs for health product procurements totaling USD220 million. The OIG did not have access to UNICEF's procurement records for the audit because of the limitation imposed by the United Nations 'single audit principle'. The audit work for these procurements was therefore limited to delivery documentation available at the PR's premises.

Audit Methodology

52. Using a risk-based approach, the OIG evaluated the adequacy of the design of key internal controls and conducted extensive substantive testing of samples in order to conclude upon the correctness and validity of transactions, as well as obtain evidence regarding the effective and efficient operation of the internal controls. The OIG deployed a multi-skilled team comprising financial auditors, public health and programmer specialists, procurement supply management specialists and engineers. The OIG also reviewed the quality of service delivery and the reliability of results reporting.

Prioritization of Audit Recommendations

53. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. The recommendations have been prioritized so as 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 interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management; and
- (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.

Events after the Audit Field Work

54. The Global Fund Secretariat has notified the OIG of certain actions taken to improve implementation arrangements for grants in Ethiopia that have been taken

since completion of the audit field work in March 2011. These actions, which have not been independently reviewed, should be taken into consideration in taking action on the recommendations contained in this report. The key actions taken in addressing grant related risks include:

- (a) The Global Fund Secretariat undertook a mid-term evaluation of the LFA-UNOPS. The LFA was encouraged to strengthen its financial and PMAS capabilities, and at the same time was notified about the intention of the Secretariat to explore the market and potentially, re-tender the LFA services;
- (b) A TB prevalence survey has been concluded;
- (c) To address delays in liquidation of advances to SRs and regions, HAPCO has put in place a tool to monitor on a monthly basis the “stock” of advances to SRs. This tool is informed by SoEs submitted from the different levels of implementation, verified by the Accountant and the Finance Manager in the region. In addition, the Secretariat is proposing a policy to encourage timely retirement where advances over 6 months old will be reversed in the PUDR and treated as ineligible until subsequently cleared.
- (d) The Secretariat has engaged with the Audit Service Corporation to identify ways to speed up the audit process without compromising the quality of the audit as well as to bring the scope of work into line with Global Fund requirements. The suggested solutions, including rotational sampling of regions and a tailored opinion referring to the Global Fund grant agreement, have been favorably received and should possibly be implemented from the 2011 audit.

MALARIA AND TUBERCULOSIS GRANTS

Federal Ministry of Health

55. The Federal Ministry of Health (FMOH) is the principal recipient for the malaria and tuberculosis grants. The PR has representation in the federal regions and urban administrations through the Regional Health Bureaux. Each region consists of various zones and woredas (districts) through which the various work-plan activities are implemented. The Ministry is also a sub-recipient of the HIV/AIDS grants managed by HAPCO.

56. The FMOH liaises with various donors for resource mobilization in the implementation of the Health Sector Development Plan (currently HSDP IV is under-implementation). At the federal level, there is the Joint Consultative Forum and Joint Coordinating Committee which comprise of FMOH management, Heads of Agencies and in-country Heads of donor partners which focus on technical assistance issues within the health sector.

57. At the time of the audit, a total of USD326 million had been disbursed to the PR for the five approved grants as summarized in the table below.

Disease	Grant Number	Budget USD	Disbursed USD	% Disbursed	Rating
Malaria	ETH-202-G02-M-00	73,875,211	73,875,211	100%	A1
	ETH-506-G05-M	140,687,413	132,290,767	94%	B1
	ETH-809-G10-M	133,089,526	72,178,615	54%	NR
	Sub-total	347,652,150	278,344,593	80%	
TB	ETH-102-G01-T-0	26,980,649	26,980,649	100%	B1
	ETH-607-G06-T	29,539,816	20,602,375	70%	NR
	Sub-Total	56,520,465	47,583,024	84%	
Grand total		404,172,615	325,927,616	81%	

Table 5: Summary of Grants Received by FMOH

Source: The Global Fund website as at 16th November 2010

Malaria Grants

58. An estimated 68% of the Ethiopian population live in areas of altitude below 2000m and are considered to be at risk of malaria. The Malaria Prevention and Control Programme within Ethiopia is guided by the National Strategic Plan for Malaria Prevention and Control which takes into consideration three key aspects that include; (i) early diagnosis and effective treatment, (ii) selective vector control and (iii) epidemic prevention and control.

59. In 2005, the Ethiopian Federal Ministry of Health (FMOH) and its partners began to massively scale-up malaria prevention and control interventions in order to make significant progress on disease morbidity and mortality. The 2007 Malaria

Indicator Survey (MIS) results demonstrated that great progress was attained as seen by a significant decrease in malaria morbidity and mortality.

60. The program supported by the Rounds 2 and 5 malaria grants aims to reduce malaria-related sickness and death in the population at risk using an integrated approach: preventive measures in vector-targeted interventions through insecticide-treated bed nets, surveillance and treatment measures to reduce malaria transmission in relatively stable and malaria-free regions; control of epidemic outbreaks in areas where transmission is unstable; and support for communities in recognizing and treating the disease early before it causes harm.

61. The overall goal of the program supported by the Round 8 malaria grant is to set up Ethiopia's epidemiological, strategic and service delivery environment for the pre-elimination phase according to criteria set by Roll Back Malaria. Planned activities include the procurement and distribution of long-lasting insecticide-treated bed nets, implementation of indoor residual spraying through a Health Extension Program, the establishment and/or strengthening of sentinel malaria surveillance sites, and training for health extension workers and health center staff.

62. The funds received by the PR in relation to malaria grants have been spent in the following broad categories:

Spending Entity	Round 2 USD	Round 5 USD	Round 8 USD	Total USD	% of Total
UNICEF	39,747,548	83,763,492	33,362,027	156,873,067	65%
PR Expenditure	26,036,565	15,243,163	7,218,062	48,497,790	20%
Federal Regions	7,498,234	9,009,988	9,280,433	25,788,655	10%
PFSA	-	6,530,635	437,483	6,968,118	3%
SRs	453,800	1,154,093	2,776,346	4,384,239	2%
Total	73,736,147	115,701,371	53,074,351	242,511,869	100%

Table 6: Analysis of Funds Spent by Entity as at 31 October 2010

63. The OIG visited 6 regions, selected based on amounts disbursed and assessed risk: Oromia, Amhara, Tigray, SNNPR, Gambella and Somali. In addition, 4 SRs were visited: EHNRI, Malaria Consortium, Anti Malaria Association and Population Services International.

Service Delivery

Diagnosis

64. From visits to 8 hospitals and 38 HCs, the OIG noted that:
- I. Some microscopes were not up to the standards required for quality diagnosis, as lenses were not clean, mounts were not functioning properly, or bulbs needed replacement (as seen at Dire Dawa HC and Kara Mara hospital in Jijiga).
 - II. There was a lack of running water in many facilities, which was noted to be a factor affecting smear quality.

- III. All the laboratory technicians were trained once on joining but no refresher training was planned in any of the health facilities.
- IV. Internal quality assurance (IQA) was undertaken in all 8 hospitals visited and in 18 of the 38 HCs visited. External quality assurance (EQA), though planned, was evident in only 4 hospitals and 6 HCs. Documentary evidence of IQA/EQA was seen in 2 hospitals.

Note: this issue also applies to tuberculosis diagnosis.

Recommendation 1 (Significant priority)

To improve the quality of malaria and tuberculosis diagnosis, the FMOH should ensure:

- (a) Microscopes are maintained in proper functioning order.*
- (b) Running water is available in the health facilities.*
- (c) Refresher training is provided to laboratory technicians based on a needs assessment.*
- (d) Internal and external quality assurance of the health facility laboratories is conducted as planned and is duly documented.*

Case management

65. It was observed that none of the medical doctors and clinical nurses in the health facilities visited was trained in malaria case management as per national guidelines. This is particularly risky in malaria zones and would affect malaria control activities if standardized protocols are not followed uniformly. It was also observed at most of the health posts that HEWs could not confidently elucidate the criteria for identifying and referring suspected complicated malaria cases.

66. It was observed in Durbete health center in South Achefer woreda in Amhara region that, due to a stock out, the health center had to purchase ACTs from the market and charge patients for them at a commercial rate.

Recommendation 2 (Significant priority)

The FMOH should improve the quality of malaria case management by:

- (a) Providing training for staff of the health facilities on malaria control activities; especially medical doctors and clinical nurses who handle the outpatient departments. The training protocol and system laid out in the national malaria guidelines should be implemented rigorously.*
- (b) Providing training for HEWs on identification and referral of complicated malaria cases.*
- (c) Ensuring stock outs of malaria drugs are avoided, and improvements are made to drug forecasting and supply systems as necessary.*

Long-lasting insecticidal nets (LLINs)

67. During visits to health posts, the OIG noted:

- I. There was a lack of monitoring to ensure that LLINs are indeed being used in the household.

- II. There was a lack of an established strategy for the replacement of LLINs which are nearing their expiry period.

Recommendation 3 (Significant priority)

With regard to LLINs, the FMOH should:

- (a) *Ensure LLIN utilization monitoring activities are undertaken to make sure that LLINs are indeed being used in the household. This could be a regular task for the HEWs with support from health centers and health extension supervisors.*
- (b) *Ensure a strategy is established for the replacement of the LLINs which are nearing their expiry period. This could begin with collection of data on the need for replacement of LLINs through the HEWs.*

Indoor residual spraying (IRS)

68. From review of IRS activities, the OIG noted:

- I. There was no systematic quality check for the IRS conducted.
- II. There was a lack of clarity on: per diem amount to be paid to the IRS volunteers; other operational costs related to IRS; and which budget head these amounts should be charged to.
- III. There was no system in place for assessing the resistance status to DDT. This assessment is crucial for sustained efficacy of IRS activity.
- IV. Guidelines were developed at the federal level for the storage, transport, and application of insecticides but these had not been properly disseminated to the implementation level. It was observed at most of the sites visited that there was no awareness of these protocols.

Recommendation 4 (Significant priority)

With regard to IRS, the FMOH should:

- (a) *Ensure a system is in place for on-site quality check during IRS.*
- (b) *Provide guidance on appropriate and reasonable costs related to IRS. These should include per diem and contracting fees. The budget lines to be charged against the grant should be clarified as well.*
- (c) *Commission a study on the status of resistance to DDT used in IRS, as planned under the National Malaria Strategic Plan.*
- (d) *Disseminate to the implementation level the guidelines that have been developed at the federal level for storage, transport, and application of insecticides.*

Active surveillance and epidemic control

69. The active surveillance and epidemic control system envisaged in the National Malaria Strategic Plan is an important system to monitor the impact and progress of malaria control activities and also gather an evidence base for institutionalizing appropriate and effective interventions. The OIG noted, however, that this system was not implemented in any of the regions visited. Though this

activity is not listed in the activities under the Global Fund-FMOH work plan for malaria grants, this particular system has an important bearing on grant performance.

Recommendation 5 (Significant priority)

The FMOH should implement an active surveillance and epidemic control system at the Federal and regional levels as envisaged under the National Malaria Strategic Plan.

Supervision of health extension workers (HEWs)

70. The Health Extension Program supports malaria prevention and control activities in the community. At the time of the OIG audit, the HEWs had to deliver 16 service packages in the community. The OIG noted that there was a lack of regular supportive supervision provided to the HEWs by the HEW supervisors and health centers. This was mentioned to be a problem by the majority of the HEWs interviewed, and there were no supervisory visit records or feedback in evidence. Note: this issue also applies to tuberculosis grant activities.

Recommendation 6 (Significant priority)

With regard to the supervision of health extension workers, the FMOH should ensure:

- (a) Systematic supportive supervision is provided by the HEW supervisors and health centers to the HEWs undertaking the Global Fund grant-funded program activities and interventions in the community.*
- (b) Basic tools for HEWs to record tasks carried out. The same tools would be used to record monitoring and supervisory remarks.*

Monitoring and Evaluation

71. Details of activities on BCC are not provided in sufficient detail in the work plans for malaria and TB grants beyond organizing community meetings and production and use of IEC material. The LFA, in one of its onsite data verification (OSDV) reports, has recommended that the malaria program should write a BCC plan into its overall work plan.

Recommendation 7 (Significant priority)

The malaria and TB programs should implement the LFA's recommendation to write BCC plans into their national activity plans, along with suitable output and outcome measures to monitor progress. The BCC work plans for malaria and TB grants should flow from these national activity plans.

72. The OIG reviewed a sample of reports from RHBs and noted two output indicators were not clearly defined or commonly understood, leading to erratic and possibly erroneous reporting:

- I. 'Number of health facilities reporting no stock out of antimalarials' is reported as 100% by some and 0% by others; both are taken to represent no stock out. This is a negatively-worded indicator that requires special care to ensure that peripheral reporting entities clearly understand its interpretation.

- II. 'Number of facilities with RDT and reagents' is often reported in a descriptive manner. Confusion regarding the indicator on RDT and reagents stems from the lack of a clear and common understanding. The corresponding indicator in the M&E toolkit of the Global Fund is 'Number of facilities with RDT and/or reagents'.

Recommendation 8 (Significant priority)

In order to ensure correct data collection and reporting on the two output indicators: 'Number of health facilities reporting no stock out of antimalarials' and 'Number of facilities with RDT and reagents', the FMOH should ensure that the M&E plan includes clear descriptions of numerators and denominators, and detailed instructions for reporting.

73. The results for the indicator on LLIN distribution ('Number of LLINs distributed') are reported before distribution actually takes place. The distribution plan developed by the RHBs and woredas and the data on consignments of LLINs provided by the regional office of the procurement agency is reported to the Global Fund as distribution to households having been completed. Data from distribution registers maintained at village health post levels are not used for the purpose of this reporting.

Recommendation 9 (Significant priority)

The FMOH should ensure that the data for reporting the indicator 'Number of LLINs distributed' is aggregated from LLIN distribution registers.

Tuberculosis Grants

74. In regard to Tuberculosis, Ethiopia ranks 7th among the TB high burden countries in the world and among the top three in Africa with regard to estimated number of incident cases of TB. The prevalence rate for all forms of TB in the country is estimated at 579 per 100,000, with the mortality rate due to TB estimated at 92 per 100,000⁹.

75. The overall goal of the program supported by the Round 1 TB grant was to increase the case detection rate for smear-positive pulmonary TB cases and to increase the treatment success rate for newly detected smear-positive pulmonary TB cases. The program supported by the Round 6 TB grant aims: to interrupt transmission of the infection; reduce TB-related sickness and death; prevent the spread of drug resistance; reduce the burden of TB among people living with HIV and AIDS and the general population; and reduce HIV prevalence among TB patients.

76. The funds disbursed to the PR were utilized by the following entities as summarized in Table 7.

77. The OIG visited 5 regions based on amounts disbursed and assessed risk: Oromia, Amhara, Tigray, SNNPR and Somali. In addition, St. Peter's Hospital in Addis Ababa was visited, which is the main TB referral hospital in the country.

⁹ 2009 Global Tuberculosis Control Report

Spending Entity	TB-R1 (USD)	TB-R6 (USD)	Total (USD)	%age
PR Expenditure	20,627,375	1,713,126	22,340,501	51.0%
Federal Regions	1,766,747	4,582,221	6,348,968	15.0%
PFSA	4,367,468	8,314,865	12,682,333	29.0%
SRs and Institutions	83,484	1,919,671	2,003,155	4.7%
Others (WHO, GLC)	71,851	50,000	121,851	0.3%
Total	26,916,925	16,579,882	43,496,808	100.0%

Table 7: Analysis of Funds Spent by Entity as at 30 November 2010

Service Delivery

Diagnosis

78. Best practice in case detection was observed in Adama woreda of the Oromia zone, where the HEW accompanied the TB suspects to the health center and ensured that they underwent sputum microscopy. The HEW also provided DOTS to the diagnosed TB patient and ensured follow-up sputum examinations. More generally, referral of pulmonary TB suspects (the main target of the program) by HEWs was strong in some areas but lacking in others. In 20 health posts and health centers out of the 42 visited, the HEWs followed-up on the referral of TB suspects and ensured initiation of treatment of those detected with TB, while in the rest, the HEWs did refer suspects for sputum microscopy but did not follow-up on the results.

79. Additionally, the OIG noted that the following processes that would ensure adequate CDR were not in place:

- I. The private sector is not actively involved. Civil society and private healthcare providers are often the only institutions providing health services to the community in hard-to-reach areas and so it is crucial to involve them in the referral system.
- II. The health centers are, in many instances, beyond normal reach of the TB suspect, which limits access to sputum microscopy services. For the majority of TB patients interviewed, the common complaint was accessibility of the HC due to long distances. This made it difficult for the TB suspect to travel to the HC two days in a row to submit consecutive sputum samples as required.
- III. There is inadequate information at health facilities in the community on pulmonary TB, its harm, and the services available.

Recommendation 10 (Significant priority)

The FMOH should improve TB diagnosis and referral by:

- (a) Training HEWs in identification of pulmonary TB suspects and their referral to the nearest health center.*
- (b) Disseminating standard referral and feedback formats to the HEWs to improve documentation and follow up of referrals.*

- (c) *Encouraging partnerships with civil society and private sector healthcare providers for TB referral.*
- (d) *Conducting operational research of ‘sputum collection and transportation’ arrangements using CHWs, HEWs, civil society volunteers, and private healthcare providers to bridge the access gap caused by geographical distances; and based on this research, develop national guidelines for sputum collection and transportation, specific to each of the volunteers mentioned.*
- (e) *Ensuring there is adequate information at health facilities in the community on pulmonary TB, its harm, and the services available.*

Treatment regimen for TB

80. From review of the treatment system followed for TB in Ethiopia, the OIG noted:

- I. Rifampicin was not included in the continuation phase of the DOTS regimen, which is contrary to global practice¹⁰.
- II. Unlike the fixed dose combination provided in a box for each patient in TB control programs globally, medicine was instead provided in individual strips for each drug category, which makes the system prone to stock outs and mismatches as there would be several patients at a time in the initial and continuation phases.
- III. Information on side effects and remedial actions to be taken was not adequately disseminated at all the HFs.
- IV. Treatment regimen SOPs were not uniformly available at all H

Recommendation 11 (Significant priority)

With regard to the treatment regimen for TB, the FMOH should ensure:

- (a) *Rifampicin is included in the continuation phase of the DOTS regimen.*
- (b) *Each patient has uninterrupted access to the complete course of anti-TB treatment by placing all the drugs for each patient in a box at the start of the treatment.*
- (c) *All the staff concerned with treatment of TB patients are trained on identifying side effects and the subsequent necessary remedial actions.*
- (d) *SOPs for treatment regimen are displayed at all the HFs.*

Directly observed treatment

81. During the initial phase of DOTS, patients are expected to travel to the health facility every day to receive drugs under the supervision of staff at the facility. Across the country, a person has to travel more than 20 km on average to access the nearest government health facility. This makes it difficult for a TB patient to travel every day to take the daily dose under supervision. This increases the risk of patients defaulting once they start feeling well.

¹⁰ WHO Handbook for Implementing Stop TB Strategy - 16 April 2008

82. For the continuation phase, patients were handed over drugs for a week or fortnight, and there was no system for verifying whether the patient had indeed taken the drugs.

83. The treatment card carried by the patient does not have any record of the progress of treatment and daily drug intake.

84. The OIG noted that no strategy for default retrieval was available with any of the program managers interviewed at the region, zone, and woreda levels. Default retrieval is a very important activity in a TB control program as it determines the capacity of the health system and the program to ensure DOTS and prevent an important cause of MDR-TB incidence. A system for default retrieval was only evident at 3 of 46 HFs visited where HEWs were involved in DOTS. It was explained that on initiation of treatment, contact information of a relative, friend or prominent person from the community is recorded and if the patient does not turn up for DOTS as scheduled then the information is passed on to the HEW and the patient's house is visited.

85. At the HFs visited, it was noted that no address is recorded when recording the patient information in the laboratory register for sputum examination, just name and village number. This was the only information that was taken forward to the TB treatment register.

Recommendation 12 (Significant priority)

With regard to DOTS, the FMOH should:

- (a) Seek to assign to HEWs the task of providing DOTS to the TB patients living in their coverage area. This is being piloted in a few Woredas of Oromia and could be included in future HEW training. Additionally, as a way of ensuring treatment compliance, seek to give priority to the patient's preferences such that the DOTS provider could also be a CHW, or other person from the community with whom the patient is comfortable.*
- (b) Until a more comprehensive system is developed:*
 - i. Ensure the treatment card carried by the patient includes a record of the daily dose intake, for example via a tick mark.*
 - ii. For the continuation phase, where patients are given drugs for a week or fortnight, ensure empty blister packs are retrieved from the patient during their subsequent visit to the health center to provide some evidence that medicines have been consumed.*
- (c) Ensure a comprehensive default retrieval framework is developed at the federal level with scope for local variations and innovations within the broader framework.*
- (d) Ensure health facility staff are trained on appropriate address recording procedures to enable the patients to be located in case of default. This information should be verified during supervisory visits.*

Multi-drug resistant tuberculosis (MDR-TB)

86. There was a MDR-TB diagnostic algorithm at the federal level but, of the 36 health centers and hospitals visited, it was observed in only 3 regional hospitals that the health officers/doctors were aware of the MDR-TB strategy. The reason

cited by program managers at the regional, zone, and Woreda levels was that in the absence of adequate culture and DST facilities it is of no use to develop a diagnostic algorithm.

87. The OIG noted that there was a plan to establish MDR-TB culture and DST centers in some regions to increase accessibility of services. There was, however, no specific initiative to partner with the private sector to provide MDR-TB diagnosis facilities and services. A few major private sector institutions had expressed interest in partnering with the public sector to help establish these services.

Recommendation 13 (Significant priority)

In addition to the current effort to increase the MDR TB cohort, the FMOH should:

- (a) Identify the number of possible MDR-TB suspects by assessing the treatment and re-treatment failure data. This data would help in assessing the local need for culture and DST facilities.*
- (b) Consider undertaking IEC/BCC activities to educate the community on the reasons for MDR-TB in order to create awareness regarding the necessity to comply with the complete course and undertake regular follow up sputum examinations.*
- (c) Complete the process of establishing culture and DST facilities at the sites identified by the FMOH.*
- (d) Initiate a dialogue with the private healthcare providers to establish partnerships for creating culture and DST facilities.*

HIV-TB coordination

88. The HIV-TB coordination system is based on evidence of the need for such a coordination, which is indicated by the number of cross referrals between the TB and HIV clinics. The availability of such evidence is, however, affected by the lack of standardized formats for referral and feedback between the TB and HIV clinics.

89. Better coordination from the HIV clinic as compared to the poor coordination from the TB clinic was observed from field visits to Zewditu Hospital in Addis Ababa, Kara Mara hospital in Somali, Dil Chora hospital in Dire Dawa, where the HIV clinics undertook prompt referrals to the TB clinics but the reverse was not done regularly. None of the HEWs were trained in HIV-TB coordination in any of the health posts visited.

Recommendation 14 (Significant priority)

To improve TB-HIV collaboration, the FMOH should undertake the following actions:

- (a) Develop and implement HIV-TB coordination protocols along with appropriate training. In particular, HEWs should be trained to identify suspected HIV co-infection in TB patients and TB co-infection in HIV patients to ensure referral to the respective clinics for diagnosing HIV-TB co-infection.*
- (b) Standardize checklists, feedback systems, and documentation.*

- (c) *Ensure the HEWs and the health facility staff play a more active role in communicating to communities the preventive strategies regarding TB and HIV.*

Monitoring and Evaluation

90. Estimates of new smear positive (NSP) cases, which function as denominators for the number of NSP cases detected, are different in the performance framework for Round 6, Phase II grant and in national targets found in HSDP III and IV. Similarly the targets are very different. These discrepancies are presented in the table below. The estimates used in the performance framework of phase II of the Round 6 grant are lower than those in the national plans, which would result in higher case detection rates to be reported to the Global Fund.

Document/Plan	Target	Denominator Used (# estimated NSP Cases)
HSDP III	88,595 (66%) (2009-'10, EFY 2002)	134,213
HSDP IV	18,026 (24%) ¹¹ (2010-'11), EFY 2003)	139,235
Global Fund Round 6 Phase II grant:	64,981 (60%) ¹² Year 3 (2010)	108,301
	80,004 (65%) ¹³ Year 4 (2011)	123,083

Table 8: Targets and Denominators for NSP Case Detection

Recommendation 15 (High priority)

The TB Program should review its targets for the Round 6, Phase II grant, as well as the calculation of the indicator for the number of NSP cases detected, and align them with national plans in accordance with the Government's policy of one plan, one budget and one M&E system. Such an effort will enable better interpretation of reported data and will give a clearer picture of the grant's contribution to national goals.

91. Aspects of knowledge, attitudes and practices (KAP) related to TB care seeking and treatment adherence were not included as outcome indicators. Despite a KAP survey being planned in the grant program¹⁴, the lack of indicators on aspects of care seeking puts the achievement of case-detection targets at risk. .

Recommendation 16 (Significant priority)

The TB program is encouraged to make use of Round 6, Phase II to include the findings of the KAP survey to reprogram its interventions accordingly and also plan for a follow-up KAP survey at the end of 2012 (Year 5 of the grant). Information on key attitudes and practices (such as knowledge about TB and timely care

¹¹ The target for EFY 2003 was revised based on national performance during EFY 2002

¹² The percentage value is taken from the target for the indicator "Percentage of NSP Pulmonary TB cases detected country wide each year per 100,000 population" and the number value from the target for the indicator "Number of NSP cases detected", both from the Round 6 Phase II Performance Framework

¹³ Ibid

¹⁴ The KAP survey was underway as part of the TB Prevalence survey, as per PUDR July to December 2009.

seeking for cough) will provide insights for program managers to understand and interpret trends in case detection rates and take remedial action.

Financial Management

92. The OIG noted that funds relating to Malaria Round 8 amounting to USD 6,972,986 were reprogrammed from indoor residual spraying to health center construction without obtaining the appropriate approval of the Global Fund Secretariat.

Recommendation 17 (High priority)

The FMOH should ensure that in future all material reprogramming is undertaken in accordance with the requirements of the Global Fund Secretariat, as indicated in the grant agreement.

93. The OIG noted that USD3,426,401 of TB Round 6 grant funds were lent to the Malaria Round 5 program from July 2009 to July 2010. This adversely impacts on the timely implementation of work-plan activities for the program that lends the funds.

Recommendation 18 (High priority)

The FMOH should ensure that inter-grant borrowings are avoided and that disbursement requests are aligned to the timing of activity implementation.

94. The OIG noted that the TB Round 1 grant expired on 31 January 2009 and Malaria Round 2 grant expired on 31st March 2009. However, at the time of the OIG review, a period of approximately two years had elapsed and the grant closure for these grants was still incomplete.

Recommendation 19 (High priority)

The FMOH should undertake to close-off all grants that have expired.

95. The OIG noted several important areas where improvements are needed in the PR's financial management:

- I. Although FMOH uses Peach Tree accounting software for the statutory transactions of the Ministry, the transactions relating to Global Fund programs have been maintained using Excel spreadsheets since the commencement of grants. The use of spreadsheets does not provide an audit trail and is prone to errors.
- II. Key reconciliations relating to cash and bank, and program disbursements were not regularly prepared and reviewed. Such reconciliations are necessary to ensure the timely detection of any errors and omissions. The OIG noted several differences between disbursements from FMOH to regions, regions to zones and zones to woredas.
- III. USD250,000 from the Malaria Round 8 grant was disbursed to Ethiopian Pediatrics Society which was implementing GAVI Alliance programs and not Global Fund program activities. The PR explained

that this was a mistake as the funds were supposed to be paid from the GAVI bank account.

- IV. For the distribution of commodities by UNICEF, particularly bed nets, the FMOH did not keep records of proof of delivery to the ultimate recipients. Records of delivery of commodities worth USD33 million could only be provided to the OIG by the PR after a long period of reconciliation with UNICEF.
- V. During the review of advances to various regions and SRs, the OIG noted long outstanding advances relating to various regions, sub-recipients and institutions. In addition, some of the outstanding balances related to grants that have expired as summarized below:

Region/SR/Institution	Grant	Amount (ETB)
Beni-Shangul Region	ML-R2	496,874
	TB-R1	63,481
Addis Ababa University/Institute of Pathology	ML-R2	60,715
Addis Ababa University/School of Journalism and Communication	ML-R2	20,553
Ethiopia Health Nutrition Research Institute	ML-R2	63,584
DACA	ML-R2	232,482
Addis Ababa Region	TB-R1	159,772
Bahir Dar University	TB-R1	25,409
Total in ETB		1,122,870
Total in USD		USD112,287

Table 9: Outstanding Advances Related to Expired Grants

Recommendation 20 (High priority)

The FMOH should:

- (a) *Ensure that Global Fund grant transactions are recorded in a robust accounting package, in order to provide an appropriate audit trail, better data integrity and security, and improved reporting.*
- (b) *Ensure the reconciliations for cash and bank, and program disbursements are regularly prepared and reviewed, and all reconciling items are properly followed up. This is particularly important for key accounts such as UNICEF and PFSA. Additionally, training and capacity building on record keeping should be provided at the FMOH, regions, zones and woredas as necessary to ensure all ledgers are properly maintained and reconciled.*
- (c) *Ensure the funds disbursed to Ethiopian Pediatrics Society are returned to the Global Fund program bank account and are used only for the activities approved in the Malaria R8 work plans.*
- (d) *Keep records of the proof of delivery to the ultimate recipients for the distribution of commodities, such as bed nets distributed by UNICEF.*
- (e) *Strengthen controls over the disbursement process to ensure the correct bank accounts are used to make disbursements.*

- (f) *Follow-up and liquidate all long-outstanding advances.*
- (g) *Refund to the Global Fund the total of USD112,287 of outstanding advances to various regions and SRs related to the expired grants: Malaria Round 2 and TB Round 1.*

96. The external audits for the various grants were not carried out in a timely manner as required by the grant agreements. This may lead to delayed approval of future disbursements since external audit reports are a key consideration in disbursement approval. Examples of delays include the following:

Grant	Review for period ended	Date of audit report	Delay (months)
ETH-202-G02-M-00	July 2007	August 2008	11 months
ETH-202-G02-M-00	July 2008	April 2010	22 months
ETH-506-G05-M	July 2008	March 2010	21 months
All grants	July 2009	Pending at the time of OIG review	Over 21 months overdue

Table 10: Delays in Presentation of External Audit Reports

Recommendation 21 (High priority)

The FMOH should consider the following actions to ensure more timely annual financial audits:

- (a) *Ensure that books of account at the PR and SRs, and the financial statements, are ready for audit on a timely basis.*
- (b) *Hold discussions with the Audit Services Corporation to explore the possibility of:*
 - i. *Carrying out interim audits before the financial year end so that a smaller, more manageable scope of work is left at the end of the year.*
 - ii. *Adopting a risk-based approach whereby audit effort is focused on regions and SRs that are assessed as higher risk. Audit of lower-risk entities and regions could be carried out on a rotational basis.*

HIV/AIDS GRANTS

Introduction

97. The first two cases of HIV in Ethiopia were reported in 1986. The epidemic spread rapidly prompting the Government of Ethiopia to declare it as a public health emergency in 2002. The Ethiopia single point estimate in 2009 showed that the national HIV prevalence was 2.3% which varied depending on setting (urban 7.7%; rural 0.9%) and gender (female 2.8%; male 1.8%). Recent estimates show that 1.1 million people are living with HIV/AIDS, out of whom 336,160 are eligible for ART. With an incidence rate of 0.28%, the number of new infections in 2009 was about 131,145. The estimated number of HIV positive pregnant women was 84,189 and 855,720 orphans were estimated as a result of losing at least one parent to AIDS¹⁵.

98. While no recent studies have been carried out to identify the sexual behaviors of most at risk populations and their potential to further spread the epidemic, available information shows that the epidemic is concentrated among: commercial sex workers; uniformed forces; long distance drivers; discordant couples; displaced people and refugees; migrant workers; day laborers; high school and university students; and out-of-school youth.

99. The Government of Ethiopia has taken steps to establish a framework within which to combat the epidemic: a National HIV/AIDS Policy was adopted in 1998; Federal and Regional HIV/AIDS prevention and control offices were set up, and two strategic plans multi-sectoral HIV/AIDS response have been developed (SPM I for 2004-2008 and SPM II for 2010-2014).

100. Ethiopia has so far received Global Fund HIV/AIDS Rounds 2, 4 and 7 grants. HAPCO was selected as the sole PR for Rounds 2 and 4. HAPCO, NEP+ and EIFDDA are the PRs for the Round 7 grant under a dual-track financing initiative.

HIV/AIDS Prevention and Control Office

101. The HIV/AIDS Prevention and Control Office (HAPCO) was established by proclamation in June 2002 to coordinate the multi-sectoral response to HIV/AIDS in Ethiopia. Global Fund grant activities are implemented at the different levels of the federal government structure i.e. federal, regional, zone, woreda, and village levels. In each of the regions there is a regional HAPCO, some of which are integrated into the regional health bureaux (RHBs) while others are separate.

102. With respect to the three HIV grants received by HAPCO: the Round 2 grant is now under RCC; the Round 4 grant end-date was extended by six months to August 2010; and the Phase 1 of the Round 7 grant ended in December 2010. The amounts granted and disbursed for each of these grants were as follows:

Rd	Grant Number	Budget USD	Disbursed USD	% Disbursed	Rating
2*	ETH-202-G03-H-00	435,001,702	186,154,785	43%	N/A

¹⁵ Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS - March 2010

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4	ETH-405-G04-H	401,905,883	377,068,575	94%	A2
7	ETH-708-G08-H	41,666,516	35,805,861	86%	B1
	Total	878,574,101	599,029,221	68%	

Table 11: Summary of Grants Received by HAPCO

Source: The Global Fund website as at 16th November 2010

*Includes RCC grant

103. The overall goal of the program supported by the Round 2 HIV/AIDS grant is to reduce the spread and impact of HIV and AIDS through an integrated approach including: epidemiological surveillance and operational research; treatment, care and support services; blood safety and universal precautions; information, education and communication; condom promotion, distribution and social marketing; and health sector capacity building. The program supported by the Round 4 HIV/AIDS grant focused on increasing access to treatment care and support services and strengthening preventive services by accelerating information, education and communication activities, with a special focus on women and youth. The program supported by the Round 7 HIV/AIDS grant aimed to reduce the number of infants born to HIV-infected mothers, through the strengthening of Ethiopia's prevention of mother-to-child transmission of HIV program.

104. Of the total of USD599,029,221 received by the PR from the Global Fund, a total of USD535,830,363 (89%) was disbursed by the PR to SRs as shown in the following table:

Sub Recipient	R2 (+RCC) USD	R4 USD	R7 USD	Total USD	%
Regional HAPCOs and RBHs	46,493,380	100,440,224	11,030,039	157,963,643	29%
Govt Organizations	1,551,317	2,596,615	755,100	4,903,032	1%
NGOs	1,578,082	4,956,557	-	6,534,639	1%
FMOH	57,989,235	126,459,818	17,526,423	201,975,476	38%
UNICEF	5,858,880	57,103,135	-	62,962,015	12%
DACA	4,162,961	5,485,600	-	9,648,561	2%
EHNRI	3,412,188	2,093,307	-	5,505,495	1%
PSCM	6,257,847	-	-	6,257,847	1%
PFSA	-	73,747,118	6,332,537	80,079,655	15%
Total	127,303,890	372,882,374	35,644,099	535,830,363	100%

Table 12: Amounts Disbursed to SRs by HAPCO as at November 2010

105. The following SRs were visited as part of the OIG audit: FMOH; DACA; EHNRI; PFSA; five RBHs; Federal Ministry of Youth and Sports; and National Coalition of Women against HIV/AIDS.

Service Delivery

Construction of new health centers

106. The construction of new health centers (HCs) was part of an effort by the Government of Ethiopia to expand access to health services by constructing 2,632 new HCs. At the time of the audit, it was reported that 2,333 HCs had been constructed, of which 1,042 were funded by local government and 1,291 using Global Fund resources.

107. Included in the Round 4 and 7 grant proposals was an activity to ‘integrate VCT services in selected health centers’. This was part of the strategy to ‘expand entry points to ART, VCT, PMTCT, TB/HIV and STIs’. After proposal approval and grant negotiations, a total USD83,344,534 was committed to renovate 550 existing health facilities to provide VCT, PMTCT and ART services. In addition, USD 24,196,552 was provided for constructing and renovating health posts in the regions. The target of 550 facilities to be renovated to provide VCT, ART, and PMTCT services was included as an indicator in the grant performance framework.

108. The 1,291 new HCs constructed using Global Fund resources were charged to the budget line for renovation of health facilities, which represented 138% more HCs than the number that was planned for renovation. A total of USD165,393,027¹⁶ was spent for this purpose, resulting in over expenditure of USD57,851,941 or 54% against the approved budget for health facility renovation. The budgets intended to finance other activities (e.g. OI drugs, ARVs, HMIS implementation, and prevention activities) were used to finance this over expenditure.

No formal processes were followed for revising grant budget and work plans

109. Despite the materiality of the changes made to the grant budgets and work plans, the OIG noted that:

- There was no formal approval by the Global Fund to expand grant activities for the construction of new HCs;
- The TRP did not review and approve this material change to the scope and scale of the proposal originally approved; and
- The performance frameworks were not revised to reflect this significant reallocation of funds.

110. The Global Fund Secretariat was aware, however, of the nature and extent of the HC construction activities. This was evident from documentation reviewed by the OIG:

- I. The grant performance report for Round 4 end of Phase 1 stated “the Cluster cautions against rapid scale-up in physical infrastructure without supporting human resources and other related services”¹⁷.
- II. The Secretariat contracted a consultant to evaluate the HC construction projects and a report was submitted in July 2009. This report stated that

¹⁶ This amount includes approximately USD 5,1m that the Principal Recipient recognized as a gain in foreign exchange. This exchange gain does not represent funds disbursed by the Global Fund.

¹⁷ ETH-405-G04-H grant score care dated 15 February 2009

“Under this grant, a total of 500 HC’s were started and partly completed through GTZ-IS as implementation agent. A further 891 HC’s have been planned and are in progress through the coordination of the Federal Ministry of Health Project Management Unit (FMOH-PMU).”¹⁸ In their report, the LFA reported that Euro 59,929,111 (approximately USD 79,189,700¹⁹) had been spent on the project as at 30 April 2009.

- III. The Secretariat requested the LFA to undertake another review of HC construction in 2010 and the LFA’s report, submitted in October 2010, was entitled ‘Evaluation of Health Center Construction Project Funded by the Global Fund’. The LFA reported that since the previous assessment conducted in 2009, the PR had further completed 895 HCs, but that only approximately 30% of the completed ones were fully operational due to lack of electricity, water, equipment, medicine and human resources. The LFA also reported that at the time of the review the Global Fund had disbursed USD130,723,374 towards the project²⁰.

TRP concerns regarding HC construction

111. A construction proposal was presented to the TRP for approval under Round 5 and 6 but was not recommended for approval by the TRP for a number of reasons, which included:

- I. The TRP could not link HC construction to the scale-up of coverage of ART, VCT and PMTCT given the complexity of similar programs being implemented already by various partners.
- II. The construction costs for the HC renovation work plan were unrealistic.
- III. The proposal focused exclusively on the supply of health care services without giving consideration to their utilization i.e. whether there was a demand for them.

Impact on the achievement of grant objectives

112. By reviewing expenditure lines in the PR’s general ledger, the OIG noted significant under spending on OI drugs, ARVs, HMIS implementation, and prevention activities. This impacted program results; for example, the indicator for ‘Number of patients who received prophylaxis and treatment for OI’ was reported as just 74% of target²¹. Many of the planned OI drugs had not been procured.²²

Construction quality issues

113. The OIG noted that many of the HCs constructed were not functional, and where they were functional, there was an absence of documentation to demonstrate that the facilities renovated provided VCT, ART and PMTCT services,

¹⁸ Evaluation of Ethiopian Health Center projects funded by Global Fund, April 2009

¹⁹ Oanda.com exchange rate for 30 April 2009

²⁰ Evaluation of Health Centre Expansion Project Funded by the Global Fund September, 2010

²¹ ETH-405-G04-H Grant Performance Report, updated 7 July 2011

²² As of March 2011 only USD0.882 M had been spent out of USD6.066 M provided in the Round 4 HIV budget

or those related to Malaria and TB. The OIG visited 77 newly constructed HCs²³ and observed the following significant deficiencies in infrastructure and equipment:

- 71% of the sites visited did not have access to water; 32% did not have functioning toilet facilities; 53% had major cracks in the floors; and 19% had leaking roofs.
- Only 14% of the HCs had equipment such as microscopes and delivery beds; only 12% had functional drug stores; and none of the laboratories had work surfaces.

114. The OIG identified a number of factors that contributed to these deficiencies:

- Contractors failed to perform work to the required contract standard. As a result, several contractors were issued with multiple warning letters and about 55 contractors had their contracts terminated.
- Insufficient site supervision, given that in some cases supervisors were in charge of 15 to 30 sites.
- Insufficient alignment to the non-structural requirements for functional HCs, such as qualified human resources, water, and electricity.

Recommendation 22 (High priority)

HAPCO should:

- (a) Ensure formal Global Fund approval is obtained before making any material changes to grant budget and work plans in the future.*
- (b) Seek to rectify the defects of the health centers constructed so as to ensure the proper provision of health services, including those related to HIV, TB and Malaria.*

Recommendation 23 (High priority)

As a lesson learned the Global Fund Secretariat should in the future ensure all Global Fund policies and procedures are followed with regard to changes to implementation plans. In particular, the Global Fund Secretariat should:

- (a) Formally approve all material budget changes during grant implementation. In practice, material budget changes are now typically defined as any amount greater than 10% of the annual approved service delivery area budget line or an absolute threshold to be determined in the context of the grant by the Country Team²⁴.*
- (b) Refer to the TRP for review any:*
 - i. Material change to the scope and/or scale of a Performance Framework which shifts the balance of program activities²⁵.*
 - ii. Significant change to targets for an output indicator that measures health system strengthening, such as infrastructure*

²³ This was a representative sample agreed with the PR to include all regions, both remote sites and those near urban dwellings, and health centres at different stages of completion. Ministry staff later visited each of the sites to validate the OIG's findings.

²⁴ Paragraph 30, Guidelines for Budgeting in Global Fund Grants (version 15 August 2011)

²⁵ Paragraph 6, OPN on Changes to Scope and or Scale of Performance Frameworks (Issued 12 July 2011)

construction/rehabilitation, if such activities are a key component of the proposal²⁶.

- (c) *Ensure appropriate amendment is made to the grant agreement in cases where the changes in implementation plans will lead to substantive changes to the budget and performance framework²⁷.*

Availability of OI drugs

115. The supply and availability of opportunistic infection (OI) drugs was insufficient in all the regions, zones, and woredas visited. Of the 46 health facilities visited, only 3 hospitals had a supply of all OI drugs, and 11 HCs had only one or two OI drugs in stock.

Recommendation 24 (High priority)

HAPCO should ensure that OI drugs are available in hospitals and health centers. The procurement and supply management arrangements for OI drugs should be strengthened as necessary. Consideration could be given to enhancing coordination with the civil society players, such as EIFDDA and NEP+, to monitor and report forecasting and supply challenges.

Supervision of health extension workers (HEWs)

116. The activities of HEWs were observed in the 32 health posts visited. At all the sites, there was a lack of on-site support and supervision by the HEW supervisors and health centers, though there was evidence of support and supervision by the international agencies working in the area. At 19 of these health posts, there was a lack of sufficient documentation of community conversations and other advocacy activities undertaken by HEWs.

Recommendation 25 (Significant priority)

HAPCO should ensure:

- (a) *Systematic supportive supervision is provided to the HEWs with regard to the planned interventions.*
- (b) *Activities carried out by HEWs are broken-down in sufficient detail, along with expected deliverables for each activity, to enable their close supervision and monitoring.*
- (c) *Adequate documentation of community conversations and other advocacy activities undertaken by HEWs to enable systematic monitoring.*

Treatment adherence

117. At the community level, HEWs and civil society organizations are mandated to undertake treatment adherence activities. Grant funding was also provided for training of clinical mentors on adherence services. All six regional hospitals visited had a system wherein PLHIV support groups were affiliated with the ART center to

²⁶ Paragraph 9 (vi), OPN on Changes to Scope and or Scale of Performance Frameworks (Issued 12 July 2011)

²⁷ Section IV.10.1, Operational Guide, The Key to Global Fund Policies and Processes (version 15 August 2011)

undertake treatment adherence activities. For the other health facilities visited, treatment adherence activities were not linked with community outreach activities in 15 of the 42 facilities.

Recommendation 26 (Significant priority)

HAPCO should ensure that treatment adherence, which starts at the facility level, is systematically linked with HEW activities and has strategic involvement of CHWs and PLHIV volunteers.

Preventing mother-to-child transmission (PMTCT)

118. Of the 46 health facilities visited, fully functional PMTCT services (including counseling and HIV testing) were observed in only 12 health facilities, which included 6 regional hospitals and 6 health centers. Furthermore, it was observed in 2 of the regional hospitals (Somali and Dire Dawa) that the PMTCT services were provided in a crowded room without much privacy.

119. Program officers interviewed explained that the weak implementation of PMTCT was primarily due to low ANC coverage which stands at around 28%. The OIG noted weak coordination and linkages between PMTCT, ANC, and ART centers in all but 2 of the health facilities visited. This was seen by a lack of standardized forms to be used by the respective centers for patient referral and to provide feedback on the status of patients.

120. There is a lack of adequate supervision from the regional HAPCO and RHBs, though regular coordination and supervision has been provided by the international agencies working in HIV in the area (primarily ICAP).

Recommendation 27 (High priority)

HAPCO should:

- (a) Commission a study to suggest steps to improve ANC coverage and PMTCT implementation.*
- (b) Ensure the quality of PMTCT services is standardized through the development of guidelines, as well as the provision of supportive supervision.*

Pediatric ART and prophylaxis

121. During visits to 38 HCs and 8 hospitals, evidence of Pediatric ART and prophylaxis for diarrhea and pneumonia with Cotrimoxazole and other highly effective interventions was available only at the hospitals. This coverage of pediatric ART is not sufficient to address the current need in the country.

Recommendation 28 (High priority)

HAPCO should ensure the availability of pediatric ART and Cotrimoxazole prophylaxis alongside adult ART services at HCs.

Monitoring and Evaluation

122. The OIG noted that Global Fund-approved work plans were not effectively cascaded to the regions, zones and woredas; and also that the program reports generated and analyzed at the woredas and zones were not forwarded to the regional or federal offices. In line with the principle of national ownership, the indicators in the grant performance frameworks were not tied to Global Fund grant activities. There is still a need, however, to maintain a record of implementation of planned activities to enable monitoring and linkage between how grant funds have been used and the national program outcomes.

Recommendation 29 (High priority)

In its role as PR and national coordinator for HIV programs, HAPCO should:

- (a) Ensure that the work plans at regional, zone, and woreda levels incorporate the objectives, activities, and sub-activities listed in the HAPCO work plans for the Global Fund grants.*
- (b) Put in place a mechanism for monitoring the implementation of activities in the grant work plans and strategic plans.*
- (c) As part of strategic planning and review, undertake a mapping of stakeholders and their areas of implementation.*

123. PEPFAR contracted Management Sciences for Health (MSH) to provide technical assistance to about 350 ART facilities. The data collection format used by MSH is different from the one used by HAPCO, as data requirements of PEPFAR differ slightly from those of the FMOH/HAPCO. This creates a parallel reporting system and as such a duplication of effort at peripheral levels. Some of the differing requirements noted were:

- I. Age disaggregation of cohort survival rates (disaggregated by under 15 years and 15 years and above for PEPFAR; no age disaggregation for FMOH).
- II. Age limit for infants with HIV (under 18 months for FMOH and under 12 months for PEPFAR).
- III. Number of those who stopped ART due to side effects (not required by FMOH).

Recommendation 30 (Significant priority)

HAPCO should initiate dialogue with MSH in order to reconcile the two sets of reporting requirements for ART facilities and eliminate the parallel reporting process.

Data quality

124. While the data at most sites visited was recorded accurately, the OIG noted aggregation errors at all levels except between the RHBs and FMOH. These disparities at the peripheral level had been identified in the OSDV reports reviewed and were within the 10% margin of error, and thus were rated 'A'. It is necessary, however, to minimize the incidence of aggregation errors to avoid potentially larger errors occurring in the future.

Recommendation 31 (Significant priority)

HAPCO should work towards eliminating aggregation errors, especially at the peripheral levels from patient registers in health facilities and woredas.

125. In the field, it was noted that data was often collected by RHBs directly from facilities over the phone. It was explained that this enabled RHBs to obtain updated information without having to wait for the transmission of data through the routine HMIS. With this method of data collection the process of data review and feedback to the health centers is skipped, raising the risk of weakening the HMIS.

Recommendation 32 (Significant priority)

HAPCO should discourage the practice of collecting data over the telephone and put in place mechanisms for timely data reporting from health facilities in order to strengthen the quality of data at all levels.

Financial Management

126. The OIG noted instances where the PR and SRs had expensed VAT and other ineligible expenses to the grant programs:

Entity	Amount USD	Comment
HAPCO-PR Expenditure	283,830	VAT charged to Global Fund programs from 2004-2010
Drug Administration and Control Agency	631,662	VAT charged to Global Fund programs from 2004-2010
Ministry of Youth and Sports	342,927	VAT charged and other ineligible expenses charged to program
National Coalition of Women Against HIV	65,208	VAT charged and other ineligible expenses charged to program
Total	1,323,627	

Table 13: VAT and Other Ineligible Expenses Charged to the Grant Programs

127. Additionally, approximately USD4.7 million of VAT was expensed to Round 4, relating to payments for the construction of HCs. This amount was expensed despite it being a receivable from the Federal Ministry of Finance and Economic Development. The PR did, however, make a correcting adjustment for this amount during the finalization of the OIG audit.

Recommendation 33 (High priority)

HAPCO should:

- (a) Take measures to recover the USD1,323,627 of funds spent on ineligible expenditure and return them to the Global Fund program accounts for grants that are still active, or directly to the Global Fund for grants that are closed.*
- (b) Ensure VAT, and other ineligible expenditure, is not charged to the grant programs in the future.*

128. The OIG noted scope for improvement in budget preparation and monitoring:

- I. During the budget preparation process by the PR, detailed activity-based budgets with unit costs, unit types, and notes for justification had not been provided. Lump-sum amounts had been allocated to different work-plan activities. This may lead to under/over-estimation and make budget implementation for the specific activities difficult.
- II. The chart of accounts in the accounting system was not matched to the different work plans and budgets in the signed grant agreements. This leads to difficulty in preparation of budget monitoring reports, such as budget versus actual reports.
- III. Periodic budget monitoring reports had not been prepared and reviewed by management of the PR. Absence of regular budget monitoring means that unexpected budget variances may not be detected and addressed on a timely basis.

Recommendation 34 (High priority)

In order to improve controls for budget preparation and monitoring, HAPCO should:

- (a) Enhance budget control and monitoring by ensuring the preparation of activity-based budgets, along with detailed supporting calculations including unit types, unit costs, and assumptions.*
- (b) Ensure that the charts of accounts in the accounting system is able to adequately capture and report the budgets and expenditures related to the approved grant budgets and work plans.*
- (c) Prepare and review budget and work plan monitoring reports on at least a monthly basis in order to identify and follow up on unexpected deviations.*

129. Advances made to SRs are settled through statements of expenditure (SOEs). The supporting documents to these SOEs are retained by the SRs and are not verified by the PR. The OIG noted one case where the FMOH wrongly included USD11 million in SOEs submitted to the PR, as this amount had not been liquidated by the implementers at the time. Additionally, the OIG noted instances where advances were outstanding for long periods:

- An advance made to PFSA in April 2009 worth USD6.3m was still outstanding by November 2010, 17 months later.
- For Round 4, USD121 million was advanced to the FMOH out of which USD 5.5m was still un-liquidated by February 2011 although the grant expired in August 2010.
- For Round 4, USD 3,187,500 was advanced to PFSA for the procurement of vehicles and was still outstanding by February 2011 although the grant expired in August 2010. The procurement of vehicles was also included in the grant closure plan.

130. In August 2010 when the Round 4 grant ended, HAPCO submitted a grant closure plan to the Global Fund. In the plan the PR proposed to undertake grant closure activities worth USD 9,115,592.72 out of which the Global Fund Secretariat

only approved expenditure of USD 3,524,577.41. The Round 4 balance of USD 5,591,015.31, inclusive of USD 3,187,500 for purchase of motor vehicles, is refundable to the Global Fund.

Recommendation 35 (High priority)

In order to ensure the proper management of advances, HAPCO should:

- (a) Verify SOEs submitted by SRs to confirm the validity of amounts reported and adequacy of the supporting documentation.*
- (b) Monitor outstanding advances to SRs and follow up on a timely basis.*
- (c) Refund to the Global Fund, the Round 4 grant balance of USD 5,591,015.31.*

131. The Global Fund grant agreements require the PR to present an audit report for the annual financial audit of program expenditures within 6 months of the end of the financial year audited. The PR has, however, consistently failed to ensure these audit reports were ready for presentation to the Global Fund on time, as shown in the table below:

Year Ended	Due date	Date Audit Report Signed	Days Late	Months Late
07-Jul-04	07-Jan-05	02-Aug-05	207	7 months
07-Jul-05	07-Jan-06	13-Jun-06	157	5.2 months
07-Jul-06	07-Jan-07	04-Sep-07	240	8 months
07-Jul-07	07-Jan-08	13-Oct-08	280	9.3 months
07-Jul-08	07-Jan-09	22-Sep-09	258	8.6 months
07-Jul-09	07-Jan-10	06-Aug-10	211	7 months

Table 14: Delays in Presentation of External Audit Reports

132. The OIG noted a combination of factors contributing to delays in the annual financial audits, in particular:

- On the part of the PR and SR, delays in the preparation of the books of account and financial statements for presentation to the external auditor, the Audit Services Corporation (ASC)
- On the part of the ASC, delays in completion of audit work due to the large volume of work to be undertaken. In particular, all regions and SRs are audited as part of each annual audit.

Recommendation 36 (High priority)

HAPCO should consider the following actions to ensure more timely annual financial audits:

- (a) Ensure that books of account at the PR and SRs, and the financial statements, are ready for audit on a timely basis.*
- (b) Hold discussions with the Audit Services Corporation to explore the possibility of:*
 - i. Carrying out interim audits before the financial year end so that a smaller, more manageable scope of work is left at the end of the year.*

- ii. Adopting a risk-based approach whereby audit effort is focused on regions and SRs that are assessed as higher risk. Audit of lower risk entities and regions could be carried out on a rotational basis.*

133. The OIG noted the following inadequacies in the internal audit function of HAPCO:

- I. The internal audit function exists within the Directorate of Quality and Compliance and reports to the Director General, with no functional reporting relationship to the Board of HAPCO in order to ensure organizational independence.
- II. While the internal audit function carries out risk assessments in order to prioritize audit work, the regions are not included in the risk assessments although they receive a significant portion of funding from the PR. Further, the institutions FMOH and PFSA were assessed as high risk for audit purposes but were not included in the audit plan.
- III. The internal audit recommendations do not result in: agreed remedial actions by the management of the audited organizations; the deadlines for implementation of the actions; and the parties responsible for carrying out the actions.

Recommendation 37 (Significant priority)

HAPCO should consider the following actions in order to enhance the effectiveness of the internal audit function:

- (a) In accordance with best practice and to achieve organizational independence, ensure the internal audit function reports functionally to the Board, with administrative reporting to the Director General.*
- (b) Ensure the regions are included in the internal audit risk assessment. All institutions and regions assessed to be high risk should be included in the audit plan, with additional internal audit resources being provided as necessary to ensure completion of the plan.*
- (c) Ensure internal audit reports include the following elements in response to each recommendation: remedial actions; persons responsible to carry out the actions; and deadlines for completion of actions. The internal audit function should follow up to ensure remedial actions have been effectively implemented.*

PR Governance

134. The OIG noted a number of areas where there is scope for enhancement of governance at the PR:

- I. The proclamation that established HAPCO included the powers and duties of the Board, which is appointed by the Prime Minister. In the Proclamation, HAPCO is required to report to the FMOH. The FMOH is, however, HAPCO's biggest SR, and the Chair of the Board of HAPCO is also the head of the FMOH. In this situation, the interests of the SR could override those of the PR and adversely affect grant implementation. The OIG noted that the Board did not have a conflict of interest policy.
- II. The Board of HAPCO is required by proclamation to meet on a monthly basis; however, only two board meetings were held in 2010.
- III. The Board of HAPCO had not established any board committees to focus on specific areas such as finance, audit, programs, or governance.

Recommendation 38 (High priority)

In order to enhance governance, the HAPCO Board should:

- (a) Ensure a conflict of interest policy is established for the Board in order to ensure that the interests of the PR prevail in Board decision making.*
- (b) Ensure board meetings are held on a monthly basis as stipulated in the Proclamation. This will ensure that important program performance issues are discussed and dealt with by the Board in a timely manner.*
- (c) Consider establishing board committees based on the needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up.*

Ethiopian Interfaith Forum for Development Dialogue and Action

135. The Ethiopian Interfaith Forum for Development Dialogue and Action (EIFDDA) is an alliance of faith-based organizations (FBOs) that was established in 2002 to coordinate the efforts of FBOs in Ethiopia. In 2006 EIFDDA was formally registered as a local civil society organization (CSO). EIFDDA has a membership of 19 FBOs.

136. EIFDDA has so far signed one grant agreement as PR, which was for Round 7 HIV/AIDS. Phase 1 commenced on 1 January 2009 and ended on 31 December 2010. By the end of the OIG fieldwork review on 11th February 2011, EIFDDA was awaiting the signing of the phase 2 grant agreement. EIFDDA served as a SR of HAPCO under the Round 4 HIV/AIDS grant. The objective of funds from HAPCO was to build EIFDDA capacity in preparation of its role as PR under round 7 HIV/AIDS grants. The following table highlights the amount granted and total disbursed to EIFDDA by the Global Fund under Round 7:

Audit of Global Fund Grants to Ethiopia

Round	Grant Number	Budget USD	Disbursed USD	% Disbursed	Rating
7	ETH-708-G09H	13,802,195	13,802,195	100	A2

Table 15: Summary of Grant Received by EIFDDA

Source: The Global Fund website as at 16th November 2010

137. The objectives of the Round 7 grant implemented by EIFDDA are to: enhance community ownership and response to HIV/AIDS; increased holistic support for OVC; and strengthen the implementation capacity of FBOs.

138. The PR selected nine FBOs as SRs under the Round 7 HIV/AIDS grant. Of the total of USD13,802,195 received by the PR from the Global Fund, a total of USD13,191,155 (96%) was disbursed by the PR to the SRs as shown in the following table:

Sub Recipient	Amount USD	%
Ethiopian Orthodox Church Development and Inter-Church Aid Commission (EOC-DICAC)	3,863,339	29.3%
Ethiopian Orthodox Church Child and Family Affairs Organization (EOC-CFAO)	2,142,168	16.2%
Ethiopian Muslim Development Agency (EMDA)	2,089,418	15.8%
Ethiopian Kale Heywet Church (EKHC)	1,424,273	10.8%
Ethiopian Evangelical Church Mekane Yesus (EECMY)	1,378,221	10.4%
Ethiopian Catholic Secretariat (ECS)	824,700	6.3%
Ethiopian Muslims Relief and Development Association (EMRDA)	722,132	5.5%
Meserete Kristos Church Relief and Development Association	394,413	3.0%
Ethiopian Mulu Wongel Amagnoch Church Development Organization (EMWACDO)	352,491	2.7%
Total	13,191,155	100%

Table 16: Amounts Disbursed to SRs by EIFDDA as at November 2010

139. The SRs reviewed during the audit were: EOC-DICAC; EOC-CFAO; EMDA; EKHC; and EECMY.

Service Delivery

140. The operational areas allocated for social mobilization activities (i.e. community conversations sites) and OVC support activities were distinct and far apart, although these activities were meant to be complimentary. It is expected that communities sensitized through community conversations adopt and support OVCs that were initiated into the Global Fund program. The absence of alignment raises the risk that investment into community conversations may not be optimized.

141. HAPCO, the national HIV/AIDS coordinating body, allocated the program activities and operational areas. The OIG noted that only one coordination meeting, between EIFDDA and HAPCO for Round 7 grants, was held within the 19 months of program implementation. Inadequate interface and coordination could partly explain the program implementation disparities and challenges highlighted above.

Recommendation 39 (Significant priority)

EIFDDA should ensure:

- (a) *Alignment of social mobilization activities (i.e. community conversations sites) and OVC support activities such that communities sensitized through community conversations adopt and support OVCs that were initiated into the Global Fund funded program.*
- (b) *Adequate coordination with HAPCO through periodic coordination meetings to address program implementation disparities and challenges such as the lack of alignment of social mobilization activities and OVC support activities.*

OVC care and support

142. The care provided by the volunteers is of good quality as was observed at all the sites visited. However, there is a lack of uniformity in implementation strategies and a lack of controls over program activities:

- I. The selection criteria followed by SRs varied with each SR. At some sites (EKHC, EMWACDO, ECS, EOC-CFAO) the checklists were provided by the SR while at others (EMDA, EMRDA) the selection criteria was distinct for each site with the local religious leaders and members developing their own criteria.
- II. In some cases there were no records maintained by the SRs to support the OVC selection processes and the OIG was not able to determine whether the children supported were actually OVCs.
- III. The PR did not verify the number of OVCs reported by SRs.
- IV. The amount provided for educational and nutritional support varied from site to site with a range of ETB120 per quarter to ETB430 per quarter. In some sites the support was provided in cash while in others it was in kind.

Recommendation 40 (Significant priority)

EIFDDA should improve the performance of OVC care and support by:

- (a) *Disseminating the guidelines and criteria to be used for the selection of OVCs, while allowing for variations to accommodate local needs.*
- (b) *Ensuring records supporting the OVC selection processes are properly maintained by the SRs.*
- (c) *Implementing a mechanism to verify the number of OVCs reported by SRs.*
- (d) *Providing guidance on amounts to be given for educational and nutritional support, and whether this is to be provided in cash or in kind.*

Income generation activities (IGA) for guardians of OVCs

143. IGA support to OVC guardians is intended to ensure long-term financial security for the OVCs. The following observations arose from visits to 11 IGA supported sites:

- I. In 7 sites the selection criteria for IGA support was locally devised with no involvement of the SR/PR.
- II. In 5 sites the amount of seed money varied from ETB 2,500 to ETB 3,200.
- III. The federal microfinance training institute for vocational training was enlisted in only 3 sites due to its limited presence in the woredas. In other areas local agencies were contracted, which resulted in a lack of standardization in training protocols as well as training quality.
- IV. At all the sites visited, there were no processes for documenting IGA activities, i.e. a lack of books of account, and stock and cash records.

Recommendation 41 (Significant priority)

EIFDDA should:

- (a) *Disseminate selection criteria for IGA support and guidance on amounts to be given as seed money, while allowing variations to accommodate local needs.*
- (b) *Ensure standardization of vocational training protocols as well as training quality.*
- (c) *Ensure standardization of processes for documenting IGA activities, including books of account, and stock and cash records.*

Monitoring and Evaluation

144. Aspects of support within the indicator in the performance framework: 'Number of OVCs receiving subsidies for food, shelter, clothing and health', fall within a single "type" of support among those outlined by the M&E plan, and the data is therefore not disaggregated. Owing to the lack of disaggregation, the OIG could not establish the number of times an OVC received support within a reporting period and the aspects of support received by the OVC. While there have been attempts by several organizations to standardize indicators related to OVC support, there is no consensus yet on this issue.

Recommendation 42 (Significant priority)

EIFDDA should obtain the necessary technical assistance to develop a "minimum essential package" of support to OVCs, and the frequency of its provision. It will then be possible to revisit indicators and targets in the light of this package, and also provide clarity to implementers on the reporting of this set of data.

145. The PR work plan and budget provided for development of M&E software. It was envisaged that this software would greatly improve programmatic reporting between the PR and SRs. At the time of the OIG audit, this software was still not functional and had therefore not been put to use by the end of phase 1.

Recommendation 43 (Significant priority)

EIFDDA should obtain necessary technical assistance to ensure that the M&E software is fully functional and put to the use intended.

146. The OIG noted from visits to 6 SRs and 14 SSRs:
- I. The frequency of reporting by 6 SSRs was biannual instead of quarterly as mandated by EIFDDA. This results in less frequent review, data validation and follow-up action.
 - II. Quality of data collection was poor for half of the SRs and SSRs visited, with a lack of uniformity of data collection formats.
 - III. Errors in the reporting, especially at the SSR level, and the timeliness of submission of reports was a challenge for the remotely located SSRs.

Recommendation 44 (Significant priority)

With respect to data quality, EIFDDA should ensure:

- (a) Mandated quarterly reporting cycles are observed for all SRs and SSRs.*
- (b) Uniform data collection formats are used across all the SRs and SSRs. Data collection should be closely supervised and technical assistance provided by EIFDDA and SRs when needed.*
- (c) Timely and accurate reporting by all SRs and SSRs, with supportive supervision being provided by EIFDDA and SRs as necessary.*

147. From visits to 6 SRs and 14 SSRs, the OIG noted that there was no comprehensive system for data validation from EIFDDA level to the SSR level. Though data validation is undertaken regularly on receipt of the reports at the EIFDDA level, this regularity is lacking at the SR and SSR levels. Further, the review at the EIFDDA level is limited mainly to desk review with clarification and feedback by telephone, which does not satisfy the need for verification of the data collection mechanisms and validity of the reports submitted.

Recommendation 45 (Significant priority)

The EIFDDA should ensure:

- (a) Uniform and standardized systems and processes for data validation are put in place at PR, SR and SSR levels.*
- (b) Data validation includes visits as necessary to verify data collection mechanisms and validity of the reports submitted.*

Program and Financial Management

148. EIFDDA set-up a Global Fund HIV taskforce in order to oversee the implementation of the Global Fund work plan and review SR performance. The OIG found no evidence that the task force had reviewed the performance of the SRs. Also, the task force undertook just two meetings, on 22nd Apr 2010 and 26th Nov 2010, despite a requirement in the requirement in the EIFDDA grant implementation manual that the task force should meet monthly.

Recommendation 46 (High priority)

EIFDDA should ensure the Global Fund HIV taskforce is effective in overseeing the implementation of the Global Fund work plan and reviewing SR performance. This taskforce should meet monthly, as required by the EIFDDA grant implementation manual.

149. The OIG reviewed the systems for supervision at the EIFDDA and for 6 SRs and 14 SSRs, and noted that there was no systematic program for supervising the SRs and SSRs at a regular frequency from EIFDAA. At the SR and SSR level there was a gap in uniform checklists being used in 3 SRs and 8 SSRs. The documentation aspect of supervision was found to be weak with no written feedback provided at the SR and SSR levels

Recommendation 47 (Significant priority)

The EIFDDA should improve supervision by:

- (a) *Developing a standardized system of supervision including uniform checklists and feedback protocols to be used by all the SRs and SSRs.*
- (b) *Ensuring of all aspects of supervision are properly documented at the SR and SSR levels.*

150. EIFDDA uses Peachtree accounting software. The OIG noted, however, that due to the limited skills and lack of training of the finance staff this software has not been fully exploited. The OIG specifically noted the following:

- I. Controls need to be enhanced regarding system access authorizations and also the ability of the system to provide an audit trail.
- II. The system was not being used for budget monitoring; instead the PR was performing a manual comparison of work plans to actual expenditure, for which there was no evidence of review to ensure against errors and omissions.
- III. There was no evidence that the transactions input to the system were reviewed for accuracy and completeness before posting. In particular, the total expenditure figures reported in all of the PUDRs prepared by the PR were not in agreement with the expenditure per the PR accounting system, and management explained that a cause of differences was the erroneous posting of transactions.

Reporting period	PUDR Expenditure USD	General ledger expenditure USD	Difference USD
1 Jan 09 - 30 Jun 09	2,074,302	2,770,564	(696,262)
1 Jul 09 - 31 Dec 09	2,088,650	1,611,757	476,893
1 Jan 10 - 30 Jun 10	4,559,322	4,407,003	152,319

Table 17: Expenditure Differences between PUDRs and General Ledger

Recommendation 48 (High priority)

With regard to the accounting software, EIFDDA should ensure:

- (a) *Access controls are properly set up, including passwords and user profiles.*
- (b) *Audit trail capabilities of the software are fully enabled.*
- (c) *Implementation of budget monitoring using the software. In the meantime, any manually prepared budget versus actual analysis should be reviewed to ensure against errors and omissions.*

- (d) *All transactions input to the system are reviewed for accuracy and completeness before posting.*
- (e) *Expenditure reported in the PUDR is always reconciled to the expenditure per the accounting system.*

151. EIFDDA's grant implementation manual includes the requirement for the PR to orient SRs on the Global Fund guidelines for annual external audits and jointly develop a plan of how the SR audits will be undertaken. There was no evidence that this plan was developed. Furthermore, the manual requires the PR to withhold disbursements where an SR has not completed the external audit within the defined time; however, the PR continued to make disbursements to SRs in cases where external audits were not completed on time.

Recommendation 49 (High priority)

EIFDDA should:

- (a) *Orient SRs on the Global Fund guidelines for annual external audits and develop a plan with the SRs for how the audits will be undertaken.*
- (b) *Withhold disbursements to an SR where the external audit for this SR has not been completed within the defined time.*

152. The PR only has one internal auditor. The scope of the internal auditor's work is limited to financial transaction reviews, and covers all of the EIFDDA programs, including Global Fund programs. The OIG noted there was no internal audit plan, and audit programs were not used for the internal audit reviews. In addition, there was no proper documentation of the internal audit work performed.

Recommendation 50 (Significant priority)

- (a) *EIFDDA should consider enhancing the effectiveness of the internal audit function by:*
 - i. *Implementing an internal audit charter approved by the Board, and covering the purpose, authority and responsibility of the internal audit function.*
 - ii. *Ensuring the establishment of a risk-based internal audit plan that includes coverage of important areas such as program implementation.*
 - iii. *Encouraging the implementation of professional standards such as the authoritative guidance of the Institute of Internal Auditors.*
- (b) *EIFDDA should ensure that internal audit work performed is guided by audit programs and is properly recorded in work papers.*

Financial management by SRs

153. The Ethiopia Muslim Development Agency (EMDA) received 16% of the total grant funds disbursed to the PR. The key activities undertaken by EMDA were social mobilization and OVC support (educational support, food and IGA). The OIG review of EMDA revealed significant financial and operational weaknesses as highlighted below:

- I. The SR did not maintain proper books of accounts. Expenditures reported in the financial reports for the year to December 2009 were not sufficiently supported. USD295,984 had no supporting documentation.
- II. The SR figures reported in the six-month financial report to June 2010 did not agree with the SR ledgers. The financial report was overstated by USD205,444.
- III. The record filing and maintenance was poor and some documents were damaged.
- IV. No bank reconciliations were prepared for the entire period of administering the grant.
- V. The bank account was commingled. The SR maintained one single bank account for all funds including Global Fund grants.
- VI. To undertake field activities in the different woredas, program staff carried cash or funds were transferred to their personal bank accounts. Such practices increase the risk of loss of grant funds.
- VII. Control over advances to staff was found to be inadequate. In particular, no advance ledger was maintained for these advances.
- VIII. The SR had no policy on per diems paid to staff for field activities. The SR had no standard per diem rate and per diems were paid ad hoc and varied from time to time. Sometimes staff was paid per diems for up to 30 days.
- IX. There was no evidence of budget monitoring and control. The SR did not monitor actual expenditures against the budget. Budget to actual variance reports were not prepared.
- X. There was no evidence to support the OVC figures reported in the EMDA program reports from Somali Region.
- XI. Even though required to report quarterly, the SR only reported semi-annually to the PR.
- XII. Financial reports to the PR for the year 2009 were not in the required format and lacked key information such as amounts spent per activity.

Recommendation 51 (High priority)

EIFDDA should ensure that EMDA addresses the many financial management issues noted during the OIG audit, and should consider withholding funding to EMDA until this has been accomplished. In particular, the SR should return to EIFDDA the USD295,984 of expenditure that was found to have no supporting documentation, and the funds should be returned to the grant bank account. In addition corrective action should be taken by EIFDDA to ensure:

- (a) Adequate supporting documentation for expenditure, and adequate filing system.*
- (b) Accurate and timely financial reporting, using required formats.*
- (c) Preparation of bank reconciliations.*

- (d) *Maintenance of Global Fund grant funds in a separate bank account.*
- (e) *Improved controls over cash handled by program staff and advances to staff.*
- (f) *Introduction of a policy for per diems.*
- (g) *Improved budget monitoring and control.*

154. For the Ethiopian Orthodox Church Development and Inter-Church Aid Commission (EOC-DICAC), the OIG noted outstanding staff advances for periods ranging from 159 days to 524 days. Also, this SR had not undertaken a reconciliation of advances to SSRs, funds accounted for by SSRs, and available cash book and bank balances. As at 30 June 2010, a total of USD1,566,120 from all SSRs was not reconciled despite the closure of Phase 1 of the grant.

Recommendation 52 (High priority)

EIFDDA should ensure that EOC-DICAC:

- (a) *Follows up and ensures proper liquidation of all outstanding staff advances.*
- (b) *Performed a reconciliation of advances to SSRs, funds accounted for by SSRs, and available cash book and bank balances. All outstanding advances should be followed up and properly liquidated.*

PR Governance

155. The EIFDDA constitution mandates the Organization's Board of Directors to oversee the performance of the organization including Global Fund programs. Nine of the board members are executive directors of SRs under the Global Fund program. This affects the Board's independence and objectivity with regard to Global Fund grant program oversight. Furthermore, there were no policies in place to guide the Board on how to address conflicts of interest, and the OIG found no evidence that board members had declared their conflict of interest and excluded themselves from board deliberations and decisions relating to their respective organizations.

156. The OIG noted that no board committees had been set-up to deal with the various functional aspects of the organization such as finance, audit or program management. Without such committees there is a risk that matters of a technical nature may not receive due attention or that Board decisions and recommendations may not receive due follow-up. As examples:

- In June 2009 the EIFDDA board recommended the revision of finance and procedures manual to include the need for board approval before management open a bank account. This revision had not been done by the time of the OIG audit and there was no evidence of follow-up of this matter.
- The EIFDDA board discussion of the external audit report and financial statements for the year ended 31 December 2009 did not include agreement of actions to ensure the problems noted were prevented from occurring in future years.

Recommendation 53 (High priority)

The EIFDDA Board should:

- (a) *Include in its bylaws a conflict of interest policy to ensure that perceived or real conflicts of interest are dealt with appropriately. This should include the need for board members who are also on the boards of SRs to declare their conflicts of interest and exclude themselves from board deliberations and decisions relating to their respective organizations.*
- (b) *Consider establishing board committees based on the needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up.*

Network of Networks of HIV Positives in Ethiopia

157. Network of Networks of HIV Positives in Ethiopia (NEP+) is an umbrella organization of PLHIV networks and associations. NEP+ was considered as a step forward towards the pace of addressing the challenge of the epidemic, especially through strengthening the collective voices of PLHIV as part of the global network and meaningful involvement of people living with HIV/AIDS and greater involvement of PLHIV at the national, regional, and international level.

158. NEP+ was established in October 2004 to strengthen the capacity and relay collective voices to people who are HIV positive. So far the network has assisted the establishment of six regional networks and a special network of positive women in Ethiopia. The PR has 14 members who include; Dawn of Hope, Mekedim, National Networks of Positive Women and a member network group in each of the 11 regions.

159. The first grant received by the NEP+ as a PR related to Round 7 for the grant period April 2009 to March 2011. The following table highlights the amount granted and total disbursed to NEP+ by the Global Fund:

Round	Grant Number	Budget USD	Disbursed USD	% Disbursed	Rating
7	ETH-708-G07-H	9,487,078	8,695,918	92%	A2

Table 18: Summary of Grant Received by NEP+

Source: The Global Fund website as at 16th November 2010

160. The objectives of the Round 7 grant implemented by NEP+ are to: increase the coverage and adherence to ARV for PLHIV; reduce the vulnerability and mitigate the impacts of HIV/AIDS for PLHIV and their families; and strengthen the implementation capacity of PLHIV associations. The major areas of intervention for the grant are: adherence training; home based care programs; income generating activities for PLHIV and their families, and nutritional support.

161. Of the total of USD 8,695,918 received by the PR from the Global Fund, a total of USD 7,437,056 (78%) was disbursed by the PR to SRs as shown in the following table:

Sub Recipient	Round 7 (USD)	%
World Food Programme (WFP)	2,157,427	29.0%
Amhara Network	1,351,623	18.2%
Oromia Network	1,044,145	14.0%
SNNPR Network	668,339	9.0%
Addis Network	658,859	8.9%
Tigray Network	347,887	4.7%
Harar Network	229,314	3.1%
Dire Dawa Network	205,608	2.8%
Somali Network	180,851	2.4%
Afar Network	160,886	2.2%
Beni-Shangul Network	146,978	2.0%
Gambella Network	126,794	1.7%
Dawn Of Hope - National Association	72,803	1.0%
National Networks of Positive Women	53,598	0.7%
Mekedim Ethiopia National Association	31,944	0.4%
Total Disbursements to SRs	7,437,056	100%

Table 19: Amounts Disbursed to SRs by NEP+ as at November 2010

162. The OIG carried out visits to some of the SRs on the basis of amounts disbursed and assessment of risk. The SRs visited included; Implementing Partners of WFP in Tigray and Oromia Regions, Amhara Network, Oromia Network, SNNPR Network, Addis Network and Tigray Network.

Service Delivery

Treatment literacy and adherence education (TLAE)

163. All the four sites implementing Treatment Literacy and Adherence Education (TLAE) were visited by the OIG. It was found that community awareness activities were conducted by each SSR and community responses showed good dissemination of knowledge. Gaps were noted in the involvement of the private healthcare providers and civil society organizations, although this had been planned. There was no initiative to sensitize and train the private healthcare providers in any of the SSRs visited in the four sites. Media involvement was observed at only one site (Addis Ababa) and not in any other.

Recommendation 54 (Significant priority)

NEP+ should disseminate all the activities and processes of TLAE as indicated in the grant work plan, and in particular, ensure the involvement of private healthcare providers and civil society organizations. NEP+ and the SRs should monitor and supervise implementation of the TLAE activities.

Community and home-based care (HBC)

164. It was observed at all the 13 SSRs providing HBC that the quality of service provided by the volunteers was good with most of the volunteers (PLHIVs themselves) made effort to establish a bond with the PLHIV and family. Supportive supervision provided to the volunteers was, however, weak for most of the sites visited, with regular site visits being undertaken for only 4 SSRs.

165. The OIG also noted that there was inadequate replenishment of medical and non-medical kits with the volunteers creating a hurdle in providing services. The training provided to the volunteers was not standardized and only 3 of the 18 volunteers visited had a copy of the training manual. Documentation of the activities undertaken by the care providers was non-existent in most of the places visited with only 2 care providers listing down activities and issues.

Recommendation 55 (Significant priority)

NEP+ should improve the quality of community and home-based care (HBC) services by ensuring:

- (a) HBC sites receive regular supportive supervision from the SSRs and SRs.*
- (b) Medical and non-medical kits are replenished on a timely basis.*
- (c) A standardized training protocol is developed and disseminated for the volunteers.*
- (d) Training is undertaken by master trainers and training manuals are provided to the volunteers trained.*
- (e) Templates and necessary training are provided to the volunteers to ensure activities undertaken are properly documented.*

Income generation activities

166. IGA activities were visited at eight sites. The OIG noted the following:

- I. There was no standardized training strategy being used by the SSRs for the IGA beneficiaries.
- II. The criteria for selecting PLHIV as IGA beneficiaries differed between SSRs with just three IGA sites showing evidence of standardized selection criteria being used.
- III. The seed money provided to the beneficiaries varied from 2800 ETB to 3400 ETB.
- IV. For all of the sites visited, there were no books and records maintained for the IGA businesses being conducted.

Recommendation 56 (Significant priority)

NEP+ should improve the quality of IGA activities by:

- (a) Developing and disseminating standardized training protocols for IGA beneficiaries in conjunction with the Federal Microfinance Institute.*
- (b) Disseminating and ensuring implementation of selection criteria for IGA beneficiaries.*
- (c) Developing criteria for determining seed money distributed to the beneficiaries on the basis of local need. Variations in seed money distribution should be adequately explained and documented.*
- (d) Disseminating appropriate templates for day-to-day business management and bookkeeping.*

Monitoring and Evaluation

Quality of performance frameworks

167. The extent of integration/overlap between the beneficiaries of the four streams of interventions for care and support of PLHIVs (adherence education, home-based care, food and other support, and income generation activities) is not clear from the indicator statements in the performance framework or from their data collection methods.

168. The four streams of interventions need to be delivered as an integrated package to a pre-determined target PLHIV population. The entire target population would receive adherence education, and subsets thereof would receive the other interventions, based on mapping of need and opportunities among target PLHIVs. The overall intent of this integration is to reach the program outcome which is the survival and well-being of PLHIVs and avoid piece-meal delivery of services to beneficiaries.

Recommendation 57 (Significant priority)

NEP+ should revise its data collection and reporting formats to reflect the integration between the four streams of interventions for care and support of PLHIVs (adherence education, home-based care, food and other support, and income generation activities). For example, individual beneficiary forms, such as ones being used currently for IGA beneficiaries, could be developed to collect data for PLHIVs that receive any intervention additional to adherence education. At the supervisor and project levels, lists of beneficiaries could be developed to map out who is receiving what intervention.

169. The indicator on adherence education for ART ('Number of people reached through adherence education') includes, by definition, those on ART and others in their families and communities. Data collection and recording formats do not provide for eliminating the possibility of delivering this intervention to the same persons more than once. The M&E manual of NEP+, however, stipulates that a person can be counted as a beneficiary only once a year.

170. The wording of this indicator and the data collected do not make it possible to tease out the number of PLHIVs reached through this intervention. This assumes significance from the fact that this is the only indicator related to the second half of Objective 3 of the grant: 'Increase coverage and adherence to ART in 40 woredas in major regions'. Data collection instruments also do not help avoid double counting of PLHIVs receiving adherence education more than once during the same reporting period.

Recommendation 58 (Significant priority)

NEP+ should:

- (a) During the next opportunity for revision, ensure the indicator on adherence education for ART ('Number of people reached through adherence education') is reworded to specify the numbers of PLHIVs reached through adherence education in order to provide a clearer picture of coverage.*
- (b) Revise data collection formats to include the reporting of the numbers of PLHIVs reached through this intervention. This data should ideally be incorporated into individual PLHIV forms.*

- (c) *Consider stipulating the number of household members to be reached for every PLHIV and their relationship to the latter.*

171. The performance framework does not have any outcome indicator specific to NEP+ interventions. The NEP+ interventions are intended to contribute to progress in the two impact indicators: (i) Prevalence among sexually active population; and (ii) 12-month survival of HIV positive adults and children on ART. Target populations for all of its interventions put together form about 20% of the total HIV positives that are targeted for the impact indicators; hence even a strong contribution from NEP+'s interventions could be masked by a downward trend in the remaining 80% not reached by NEP+. As an organization, NEP+ would benefit from tracking the outcome of its interventions within its overall M&E framework.

Recommendation 59 (Significant priority)

NEP+ should consider the inclusion of outcome indicators that track the outcome of its interventions within its overall M&E framework, and thus provide a measure of NEP+'s contributions to the national-level outcomes.

172. A key capacity investment in SRs and implementing entities is supportive supervision with the view to improving the quality of activities as well as data. However, this is not reflected in the performance framework as an indicator. Findings related to data quality point to the need for more focused and more frequent supervision by the PR and by SRs to implementing entities.

Recommendation 60 (Significant priority)

NEP+ should consider setting targets for supervisory visits and the content of the visits, and thus intensify the supervisory function from both the PR and SR levels.

Data quality

173. The OIG noted that there were data collection quality issues at some SSRs, especially in the areas of IGA and OVCs. Also, on review of 7 SR reports, data aggregation mistakes were noted in 4 cases, while incomplete reports were noted in 3 cases. More generally, the timeliness of submission of reports was a challenge for the remotely located SSRs. There were no formats in the grant implementation manual for data collection and reporting, and it was observed that there was no standardized template for reporting being consistently used across SRs and SSRs.

Recommendation 61 (Significant priority)

The NEP+ should ensure:

- (a) *Data collection is closely supervised and technical assistance is provided by SRs and NEP+ when needed.*
- (b) *Timely and accurate reporting by all SRs and SSRs, with supportive supervision from NEP+ and SRs as necessary.*
- (c) *An appropriate level of standardization of data collection and reporting formats is implemented across all the SRs and SSRs, with the necessary guidance on this included in the grant implementation manual.*

174. The data validation system of NEP+ included desk review, telephone recall and validation, and surprise visits. From visits to 8 SRs and 16 SSRs, the OIG noted

that a systematic approach to data validation was lacking at the SR and SSR levels, and also there was poor documentation of the data validation activities.

Recommendation 62 (Significant priority)

The NEP+ should ensure:

- (a) Uniform and standardized systems and processes for data validation are put in place at PR, SR and SSR levels.*
- (b) A comprehensive system of detailed documentation of all the data validation undertaken is established at all levels, with suitable templates developed and disseminated.*

Program and Financial Management

175. The OIG noted that the NEP+ grant implementation manual does not include criteria by which SRs and SSRs are to be identified, selected and assessed

Recommendation 63 (Significant priority)

NEP+ should include in the grant implementation manual, criteria for:

- (a) Identification, selection and assessment of SR and SSRs.*
- (b) How grants programs and funds are to be allocated.*

176. The OIG noted that there is no mechanism in place to ensure linkage between programmatic and financial results that are submitted to the PR on a quarterly basis. For example:

- At the Addis Network of PLHIV, the OIG noted inconsistencies in reporting, such as the number of people obtaining start-up capital in a quarter being quantified in the programmatic report but no amounts relating to that indicator appeared in the financial report.
- Number of PLHIV receiving financial support relating to funeral costs was quantified but no cost equivalent was reported in the financial reports.

Recommendation 64 (High priority)

The NEP+ monitoring and finance units should work together to ensure that their reports are well linked with respect to the indicators per the work plan to avoid inconsistencies in reporting and to ensure that all financial resources have been well accounted for and that disbursements are made based on correct reporting.

177. The OIG reviewed the systems for supervision at the NEP+ headquarters and for 8 SRs and 16 SSRs. The OIG noted that the frequency of supervision varied, particularly at the SR level. The supervisory checklists used at all levels were not standardized, and there was no uniform approach to following up the issues raised during supervision.

Recommendation 65 (Significant priority)

The NEP+ should improve supervision by:

- (a) Developing and implementing guidelines for supervision across all levels (PR, SR and SSR).*

- (b) *Disseminating checklists to guide the standardized documentation and follow up of supervision actions.*

178. Program implementation has been adversely impacted by high turnover of staff, especially at the SR and SSR levels. Of the 8 SRs visited, 5 reported that more than 2 staff (of the 4 supported by Global Fund funding) had resigned in the past year, while 10 of the 16 SSRs highlighted that at least 2 staff (of the 4 supported by Global Fund funding) had left their jobs in the past year. It was also noted that there was a low percentage of PLHIVs among the staff at all levels (PR, SR and SSR).

Recommendation 66 (Significant priority)

NEP+ should review the root causes of the high staff turnover and implement actions that will mitigate the high turnover at the various levels. Further, NEP+ should consider ways of encouraging more PLHIVs to join the network.

179. Capacity building funds have been used to enhance the technical and administrative competency of NEP+, SRs and SSRs. The OIG noted that there was a lack of comprehensive strategy in utilizing the capacity building funds to achieve maximum output. Also, no guidance was provided in the grant implementation manual for how capacity gaps should be identified and addressed. The PR and SRs expressed that the funds allocated under this component were inadequate to meet the human resource and infrastructure needs, especially given the challenges of staff turnover.

Recommendation 67 (Significant priority)

In relation to capacity building, NEP+ should:

- (a) *Ensure that priority areas for the utilization of capacity building funds are identified in consultation and regular dialogue between the PRs, SRs and SSRs.*
- (b) *Include guidance in the grant implementation manual regarding how capacity gaps should be identified and addressed.*
- (c) *Critically assess the shortfalls in the capacity building funds, identify the need for additional capacity building funds, and include this additional requirement in future proposals.*

PR Governance

180. The OIG noted opportunities for improvement in PR governance:

- Some of the board members of NEP+ also serve on the boards of SRs or SSRs. There was no evidence that the Board had a conflict of interest policy. This may affect the independence and objectivity with which the board members execute their roles and also potentially give rise to conflict of interest.
- As evidenced in the NEP+ board minutes, there was only minimal discussion of issues pertaining to grant performance, financial reporting, and internal control weaknesses as reported by external and internal auditors.

Recommendation 68 (High priority)

The NEP+ Board should:

- (a) *Establish a conflict of interest policy to ensure that perceived or real conflicts of interest are dealt with appropriately. This should include the need for board members who are also on the boards of SRs to declare their conflicts of interest and exclude themselves from board deliberations and decisions relating to their respective organizations.*
- (b) *Consider setting up board committees based on the needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up*

PROCUREMENT AND SUPPLIES MANAGEMENT

Pharmaceutical Fund and Supply Agency

181. The Pharmaceutical Fund and Supply Agency (PFSA) was formed by government proclamation, number 553/2007, in September 2007 with the mandate to be the sole provider of forecasting, procurement, storage, inventory management and distribution of pharmaceuticals to the public health sector. Prior to this, procurement and supply management (PSM) activities were undertaken by departments within the FMOH.

182. In Ethiopia, public procurement is regulated by: (i) Financial Proclamation 57/1996 which constitutes the Procurement Law; (ii) Financial Regulation 17/1997 issued by the Council of Ministers; and (iii) Ministry of Finance and Economic Development procurement directives. PFSA's procurement guidelines are based on these directives. The procurement directorate at PFSA has 19 staff who are well trained in procurement with clearly defined job descriptions.

183. According to Proclamation 553/2007, the PFSA should have a board of directors that oversees and guides its operations. This board, however, has not yet been set up and currently the PFSA is just reporting to the FMOH.

Recommendation 69 (High priority)

The PFSA Board of Directors should be set up to oversee the activities of PFSA as stipulated in the Proclamation 553/2007 that established PFSA.

Quantification and Forecasting

184. The PFSA has received considerable support from several donors, particularly SCMS, which has greatly enhanced forecasting for ARVs through the establishment of a system for data collection and aggregation.

185. Malaria and TB pharmaceuticals, however, were still mainly managed through the respective departments at the FMOH, which had not received training in forecasting and quantification. The OIG noted that medicines distributed to the service delivery point level were not tracked, with virtually no consumption reports collected from treatment centers, especially for anti-malaria medicines. In the absence of consumption data, program targets were mainly used to determine what to procure.

186. It was envisaged that the forecasting for the malaria and TB programs would eventually be handed over to PFSA through implementation of the integrated pharmaceutical logistics system, and in August 2010, with support from USAID/SCMS, PFSA conducted a national forecasting and quantification exercise covering the HIV/AIDS, TB and malaria programs. The forecasting and quantification procedures used were based on standard treatment guidelines for the three diseases and involved extensive consultations with the various experts within Ethiopia. At the time of the audit, the results of this quantification exercise were yet to be finalized.

187. For two HIV grants and one TB grant, a comparison of quantities per PSM plans and the actual quantities procured showed significant variations in terms of:

over procurement, under procurement, and unplanned procurement (see table below for details). This non adherence to PSM plans indicated poor planning and forecasting, which was mainly because the results of the new donor-supported systems and exercises had not yet been incorporated into the PSM plans.

	Round 7 HIV/AIDs Phase 1		Round 6 TB Phase 2		Round 4 HIV/AIDs Phase 1	
	No. of items	Average % deviation from planned	No. of items	Average % deviation from planned	No. of items	Average % deviation from planned
Less procured	4	64%	6	58%	15	100%
Excess procured	1	193%	9	378%	8	8588%
Not procured	0	0	0	0	3	0
Unplanned	0	0	0	0	43	0

Table 20: Comparison of PSM Plans versus Actual Quantities Procured

Recommendation 70 (High priority)

The PFSA should ensure:

- (a) *PSM plans are updated to reflect the results of donor supported forecasting and quantification systems, and in particular, the results of the national forecasting and quantification exercise covering the HIV/AIDS, TB and malaria programs conducted with support from USAID/SCMS.*
- (b) *Procurement for Global Fund grant programs is carried out in accordance with the approved PSM plans.*
- (c) *Adequate technical capacity is institutionalized at the forecasting and quantification directorate level to enable PFSA to independently conduct accurate and reliable forecasting and quantification, and thereby ensure that the initiatives introduced by donors are sustainable.*

Procurement

188. UNICEF provided procurement agency services to the grant programs for health product procurements totaling USD220 million. At the time of the audit, PFSA had largely taken over responsibility for procurement and had undertaken procurements totaling USD70 million for the grant programs. The OIG did not have access to UNICEF’s procurement records for the audit because of the limitation imposed by the United Nations ‘single audit principle’. The audit work for these procurements was therefore limited to delivery documentation available at the PR’s premises.

189. Procurement of finished pharmaceutical products for HIV/AIDS, TB and malaria using Global Fund resources is only via limited international bidding because only certain manufacturers are eligible as defined by the Global Fund quality assurance policy. Only companies listed on the Global Fund website are invited to participate in the bidding process through their representatives in Addis Ababa.

190. The PFSA has agreements with HAPCO to conduct procurement which specify what will be procured, the quantities and the period over which they should be procured. However, there are no formal agreements between the PFSA and the FMOH, as the PFSA is regarded as being part of the FMOH. Whenever

procurement is needed, the malaria and TB program managers at the FMOH submit requests to PFSA. This process results in a less timely procurement as there are no clear procurement plans to guide the process and bidding cannot start without the procurement request.

191. The tender committee at PFSA comprises of four PFSA staff and one expert from the public procurement office. At least four members of the committee need to be present for procurement evaluation decisions to be made.

192. The OIG noted that the procurement of laboratory reagents and equipment that was supposed to be via international competitive bidding was just advertised locally in the Ethiopian Herald newspaper, which limits participants to international companies with local agents. According to the public procurement directive, this bid advertisement should be made accessible to the international media.

Recommendation 71 (High priority)

The PFSA should:

- (a) Facilitate proper procurement planning by working with the FMOH to ensure detailed agreements are in place at the beginning of the program implementation period that specify what needs to be procured and clearly define the timelines.*
- (b) Consider enhancing tender committee impartiality and objectivity through:*
 - Increasing external representation in the tender committee to ensure the committee is broad-based.*
 - Introducing a procedure for the tenure of committee membership to ensure that membership changes on a regular basis.*
- (c) Ensure the advertisement of international competitive bidding tenders should be done as stipulated in the public procurement directive to ensure that the process is competitive and that the lowest prices are obtained. A website should be developed and used for this purpose.*

193. According to the PSM plans, goods should be delivered within six months of the commencement of the bidding process. Analysis conducted by the OIG on 144 items procured by PFSA under Global Fund grants shows that 60% of the items were delivered more than six months after commencement of the bidding process. One reason cited for the long lead time were delays in disbursement of funds to the PFSA account by the PRs which has to be done for contracts to be issued to suppliers and purchase orders to be placed.

194. Additionally, for 141 items sampled, 37% were delivered over six months after the purchase order was issued, even though the normal duration of this step of the procurement process is 12 weeks according to the PSM plans.

Recommendation 72 (High priority)

In order to avoid potential supply interruption and stock outs due to long procurement lead times, the PFSA should enhance:

- (a) Planning and execution of procurement activities, including careful coordination with PRs to ensure disbursement of funds to the PFSA account on a timely basis.*

- (b) *Contract management procedures to ensure improved performance by suppliers whereby goods are delivered within a reasonable time after submission of a purchase order. This should also be utilized to ensure shorter lead times.*

Quality Assurance

195. The Food, Medicines and Health Administration and Control Authority (FMHACA) is mandated to ensure that all drugs within the country are of standard quality and post-distribution surveillance is conducted on an on-going basis to mitigate risk of substandard products being provided to the patients. The OIG noted that:

- I. Quality monitoring was only conducted via visual inspection and only suspected samples were subjected to laboratory confirmatory tests. Routine random sampling and testing from the different points within the distribution chain was never conducted.
- II. Tracking of medicines by batches was also not conducted hence in case of product recalls, it would be hard to trace where and when they were distributed. Medicines were issued from the warehouses to the facilities on the basis of expiry dates only.
- III. Only 1 of the 12 health facilities visited had an expired medicines register. Also, destruction of expired drugs took a long time to be done (five years in some hospitals) and the quantity expired was not quantified by period hence wastage level was not monitored.

Recommendation 73 (High priority)

The drug regulatory authority, FMHACA, should:

- (a) *Ensure that, in accordance with Global Fund quality assurance policy, random samples of finished pharmaceutical products are obtained at different points in the supply chain (from initial receipt of the products in country to delivery to end-users) for the purpose of monitoring their quality. Such samples must be sent for quality control testing to one of the following laboratories for Quality Control testing: a laboratory prequalified by the WHO Prequalification Programme; an National Drug Regulatory Authority (NDRA) or NDRA-Recognized Laboratory that meets one of the following criteria: Prequalified by WHO Prequalification Programme, or Accredited in accordance with ISO17025; or a laboratory contracted by the Global Fund..*
- (b) *Implement a system for the tracking of medicines by batches.*
- (c) *Implement pharmaceutical waste disposal guidelines to ensure that health facilities dispose of expired stocks in-line with internationally recognized standards on a timely basis.*
- (d) *Ensure expired medicines registers are maintained at the health facilities and wastage levels are monitored.*

Inventory Management and Distribution

196. At the PFSA hubs, there was a computerized inventory management system for managing stock, though not all hubs had started using the system as at the time of the OIG visit, as noted at Mekele hub in Tigray Region. The RHB warehouses were using manual records, which were up-to-date at the time of the visit. The health facilities were using a combination of manual records and a computerized system donated by the USAID-DELIVER project. ARVs had a web-based system that was updated by SCMS seconded personnel who received orders and reports from the health facilities and uploaded them onto the system. The data were aggregated centrally and orders filled accordingly.

197. The distribution channel for ARVs was quite well organized, having received support from development partners, especially USAID DELIVER project, SCMS and MSH/SPS program. There was no reporting mechanism for anti-malaria medicines and RDTs in the regions visited. Consumption reports for TB medicines were usually submitted by the zones and woredas but the reporting rate from the regions to the central level was inconsistent. The distribution of anti-malaria and TB medicines was conducted by the RHB warehouses via a push system. Despite the existence of fixed resupply periods for malaria and TB commodities on a quarterly basis, there were no clear distribution schedules to the regions, zones, and service delivery points. This predisposed the health facilities to supply interruption due to irregular delivery intervals.

198. In the facilities visited, significant overstocking and stock outs of some medicines were observed, as tabulated in Annex 3. Despite the establishment of minimum and maximum stock level for all medicines, these were not strictly observed.

Recommendation 74 (High priority)

The PFSA should:

- (a) Work with malaria and TB program managers to establish regular delivery schedules for TB and malaria health products.*
- (b) Implement a redistribution mechanism between health facilities to ensure that excess medicines are redistributed to where they are needed thus alleviating incidents of expiry or stock out.*
- (c) Monitor adherence to the established minimum and maximum stock levels to ensure that health facilities are not at risk of stock outs or expiries.*
- (d) Complete the implementation of an efficient logistics management information system for TB and malaria health products to ensure that health facility demand is served on time and consumption trends are monitored to detect and avoid stock outs or overstocking.*

Storage

199. For the health facilities visited, storage areas for the medicines procured under the grants varied in level of organization, adherence to proper storage practices and use of automated systems. Most facilities lacked adequate space, and storage media such as pallets and racks. In some hubs, commodities were stored in the corridors due to lack of space. The OIG observed that temperatures were not monitored, even in areas that are prone to hot weather. The Mekele

District Hospital store did not have racks or an organized storage system. At the Kaliti 2 hub, appropriate handling of commodities in the warehouses using the provided forklifts and storing on racks with pallets was not evident. In Saris store, Nevirapine tablets cartons were stacked next to Sodium Hypochlorite jars, which are supposed to be stored away from liquids.

Recommendation 75 (High priority)

The PFSA should ensure:

- (a) Appropriate racking and other storage media are provided to the facilities in order to facilitate proper storage of health products. In particular, direct storage on the floor as observed in some facilities may lead to products being damaged by moisture hence pallets should be used. Correct handling equipment reduces the risk of injury to workers and damage to stock. Stock organization on shelves and pallets enhances accessibility which facilitates use of first in first out (FIFO) and first expiry first out (FEFO) issuing systems.*
- (b) Temperature monitoring in storage areas is introduced in order to maintain optimum storage conditions.*

Rational Drug Use

200. Despite the existence of national standard treatment guidelines and essential medicines lists, Ethiopia has not yet conducted any drug utilization studies to evaluate the level or extent of irrational prescribing or non-adherence to treatment guidelines.

Recommendation 76 (Significant priority)

The PFSA, through the directorate in charge of rational drug use, should conduct a national drug utilization study to identify the magnitude of irrational use of medicines within Ethiopia.

GRANT OVERSIGHT

Country Coordinating Mechanism

201. Country Coordinating Mechanisms (CCMs) are central to the Global Fund's commitment to local ownership and participatory decision-making. The Global Fund has produced guidelines and requirements for CCMs regarding their role in Global Fund processes.

CCM Membership

202. According to Global Fund requirements, CCM members representing non-government constituencies must be selected by their own constituency based on a documented, transparent process, developed within each constituency. For the Ethiopia CCM, the OIG noted that the members representing CSOs were admitted to the CCM on the basis of:

- I. A letter and minutes from the organization's management (NEP+).
- II. A letter of introduction from the organization's executive board (EIFDDA and CDRA).
- III. CCM guidelines, which stipulate that CDRA will represent civil society organizations.

203. There was no evidence that persons living with HIV/AIDS, or affected by TB and malaria were included on the CCM.

Recommendation 77 (High priority)

With regard to CCM membership, the CCM should ensure:

- (a) All CCM members representing non-government constituencies are selected by their own constituencies based on a documented, transparent process, developed within each constituency. This requirement should apply to all non-government members including those members representing people living with or affected by the three diseases.*
- (b) Membership is in evidence of people living with HIV and of people affected by TB or malaria (where funding is requested or has previously been approved for the respective disease). People affected by TB or malaria include people who have lived with these diseases in the past or who come from communities where the diseases are endemic.*

Proposal Development

204. The Global Fund guidelines require that CCMs coordinate the development of funding applications through transparent and documented processes that engage a broad range of stakeholders. To this effect, through newspaper advertisements, the Ethiopia CCM solicits concept notes from the public for inclusion in proposals for funding. For the Round 7 HIV grant, the concept notes from the selected PRs, NEP+ and EIFDDA, were selected for inclusion in the proposal; however, the OIG did not see evidence that other submissions were considered.

205. In developing funding applications, the CCM is expected to base funding requests on identified financial gaps in national programs. The OIG noted, however, that for the funding gaps of USD812m in the Round 7 HIV proposals and USD50m in the Round 8 Malaria proposal there was no supporting information to show how these funding gaps had been derived.

Recommendation 78 (High priority)

In the development of funding applications, the CCM should:

- (a) Clearly document the processes followed to engage a broad range of stakeholders (including CCM members and non-members) in the solicitation and the review of activities to be included in the application.*
- (b) Ensure that a review of the stakeholders and their interventions is undertaken as part of the national health strategic process, which should include calculation of the existing funding and funding gaps. These funding gaps would then be the basis for activities and budgets presented in proposals to the Global Fund.*

PR Selection

206. The Global Fund requires all CCMs to document a transparent process for the nomination of all new and continuing PRs based on clearly defined and objective criteria. The Ethiopia CCM guidelines state, however, that: 'The PR shall remain the Federal Ministry of Health for Malaria and Tuberculosis'. This criterion automatically excludes the possibility of other PR candidates being considered, and also rules out dual-track financing whereby both government and non-government PRs are nominated for each disease program.

Recommendation 79 (High priority)

For the malaria and TB programs, the CCM should ensure a transparent and well documented PR nomination process that considers more than one PR candidate and enables the consideration of non-government PRs and dual-track financing.

Program Oversight

207. Once Global Fund financing is secured, the most important function of the CCM is oversight. The CCM oversees the performance of PRs to ensure that they achieve the agreed targets of the programs they are implementing. The OIG noted instances, however, where program activities were not implemented as planned, which negatively affected the achievement of agreed performance targets:

- I. Significant amounts of the HIV grants (Rounds 2 and 4) were reprogrammed from intended purpose to construction of health centers.
- II. There were notable delays in disbursement of funds as a result of the failure to present audit reports for the Government PRs.
- III. Drugs for STI and OI were not procured as planned and there was evidence of stock outs at many of the sites visited.
- IV. USD3.4 million of TB grant funds were lent to the Malaria program for one year during which time the planned TB program activities were not undertaken.

208. The CCM set up teams to conduct site visits to program areas. The OIG noted, however, that since 2008 only two site visits have been undertaken, although the CCM intention was for there to be at least 6 visits per year.

Recommendation 80 (High priority)

The CCM should strengthen its oversight function in order to ensure program activities are implemented on time and agreed performance targets are met. In particular, the CCM should:

- (a) Anticipate and proactively identify implementation challenges, and meet with PRs and SRs regularly to discuss challenges and facilitate solutions before performance is affected. Particular attention should be paid to: procurement and distribution of pharmaceuticals to avoid the risk of stock outs; external audit planning and execution to avoid delays in presenting audit reports; and proposed reprogramming to ensure required procedures are followed.*
- (b) Consider setting up appropriate committees to support the CCM in effectively undertaking its oversight responsibilities.*
- (c) Ensure that the intended number of site visits are undertaken in order to obtain first-hand information on program activities and quality of services.*

Local Fund Agent

209. KPMG served as LFA from the inception of grants in Ethiopia until the end of 2008, when UNOPS was selected to replace KPMG. UNOPS began office set up in January 2009 with an initial four fulltime staff in-country and scaled up to six later in the year. The team was comprised of a team leader, PSM expert, financial management expert, financial associate, M&E expert and a health programmatic specialist. The team is also supported by the LFA Coordination Office in Geneva and UNOPS Africa Office in Johannesburg.

210. The OIG noted several important aspects of the LFA's PUDR review work where improvement was needed:

- I. With regard to the LFA's verification procedures:
 - a. Significant amounts were wrongly included in statements of expenditure reported by the FMOH as SR to HAPCO:
 - USD11 million that related to amounts advanced to implementers that had not yet been liquidated.
 - USD4.7 million of VAT was included in construction payments.
 - b. For the distribution of commodities by UNICEF, particularly bed nets, the FMOH did not keep records of proof of delivery to the ultimate recipients. Records of delivery of commodities worth USD33 million could only be provided to the OIG by the PR after a long period of reconciliation with UNICEF.
 - c. In the PUDR for March to August 2009 for HAPCO Round 4, the PR reported 368 health centers completed and the LFA reported that they verified 538 health centers; however, the LFA had compiled this figure from RHB reports without verifying their accuracy.

- II. The LFA did not reconcile the financial information in the PUDRs to the PR accounting records prior to submission to Global Fund as was the case for the grant to EIFDDA.
- III. In November 2009, HAPCO submitted a Round 4 grant disbursement request with the forecast amount equal to the grant balance of USD158 million. The LFA recommended this amount for disbursement even though the grant budget for the remaining period of the grant was just USD57.7 million. There was no analysis provided by the LFA on the variance between the forecast and budget to show how this significant amount of funds could be utilized in the time remaining.

Recommendation 81 (High priority)

With regard to PUDR reviews, the LFA should:

- (a) *Verify programmatic and financial information using an approach that takes into account the country and grant risks. In particular, the LFA should:*
 - *Check the supporting documentation of expenditures reported in statements of expenditure to ensure the expenditures are valid and are properly supported, including with proof of delivery where applicable.*
 - *Verify the reliability and accuracy of programmatic information reported.*
- (b) *Ensure the financial information in the PUDRs has been correctly extracted from the PR's accounting records.*
- (c) *Verify the reasonableness of the forecast amount based on program performance, absorption capacity, any major changes to the work plan, any major unit price changes, cash balances at the SR level, the likelihood of existing commitments requiring cash during the forecasted period and any macroeconomic factors. The LFA should comment on variance between the forecasted expenditures and the latest approved budget.*

211. As part of the repeat PR assessment of the FMOH, the LFA rated the Financial Management Systems functional area as B1 (adequate); however, the OIG noted that significant capacity gaps existed given that the PR's financial records for the grants were maintained using Excel spreadsheets instead of a suitable accounting software package, and also key reconciliations relating to cash and bank, and program disbursements were not regularly prepared and reviewed.

Recommendation 82 (High priority)

With regard to PR assessments, the LFA should ensure that assessment conclusions from the review of the Financial Management Systems functional area clearly identify capacity gaps that represent a risk to successful grant implementation. The LFA should also make specific, realistic and timely recommendations as to how the PR may resolve or overcome the capacity gaps identified during the assessment.

212. There was no evidence that the LFA had reviewed the external audit arrangements applicable to the Global Fund grants and advised the Global Fund on their acceptability. Furthermore, the OIG noted that no audit plans for 2010 had

been prepared by the PRs, despite the historical delays in submission of audit reports by all PRs.

Recommendation 83 (High priority)

The LFA should review the external audit arrangements applicable to the Global Fund grants and advise the Global Fund on their acceptability, and in particular, should ensure the PRs have an audit plan for the PR and SR audits that sets out the scheduling of the audits with a timeline for the audit reports. The LFA should monitor the deliverables based on these plans.

213. The LFA did not provide the Global Fund with information on the linkage between programmatic and financial results, although this is required as part of the LFA's reviews of Enhanced Financial Reporting (EFR) and On-site Data Verification (OSDV).

Recommendation 84 (High priority)

The LFA should monitor financial management and performance, and program performance and link the two components. In particular:

- (a) As part of the LFA review of the EFR template, the LFA should comment on the explanation of variances in expenditure provided by the PR in the template, focusing particularly on the explanation by the PR of the link between the programmatic results for the same period and the financial information related to those programmatic results.*
- (b) The LFA's OSDV report should include description of discrepancies between programmatic results and other sources of information such as financial and inventory data.*

214. The OIG noted that the LFA did not have a well-developed documentation system for work performed and for quality assurance. In particular, there was no documentation of the procedures carried out by the LFA finance team or the results of the work performed.

Recommendation 85 (High priority)

- (a) The LFA should ensure that work programs and the results of the work performed are properly documented and adequately support conclusions drawn and recommendations made.*
- (b) The LFA's internal quality assurance process should be properly documented and should ensure that the tasks undertaken and products delivered to the Global Fund are of an acceptable quality.*

PR External Audit Arrangements

215. The LFA did not provide a review of the audit arrangements for the PRs and SRs as required by Global Fund policy. Furthermore, weaknesses were noted in the audit deliverables of NEP+.

Recommendation 86 (High priority)

The Global Fund Secretariat should:

- (a) Ensure the LFA reviews the PRs' audit arrangements and advises the Global Fund on their acceptability.*

- (b) *Approve the PRs' audit arrangements if they are found to be in line with the Global Fund requirements.*

Ongoing Progress Updates and Disbursement Requests

216. From review of PUDRs, the OIG noted that:

- I. For the Round 4 HIV grant PUDR for 1 September 2009 to 28 February 2010, the LFA recommended the disbursement of the PR's request for the full amount of the remaining grant balance of USD158 million. The grant budget for the remaining period of the grant was, however, just USD57.7 million, and no analysis was provided by the LFA on the significant variance between the forecast and budget.
- II. For the Round 4 HIV grant PUDR for 1 September 2008 to 31 May 2009, HAPCO requested USD140.8 million; of which USD82.5 million was disbursed while USD49.6 million was withheld pending the submission of a completion certificate for health center renovation works undertaken by GTZ. At the time of the OIG audit in November 2010, the certificate had not yet been provided to the Global Fund, although the previously withheld funds were released.
- III. For the Round 4 HIV grant PUDR for 1 September 2007 to 31 May 2008, it was written that due to a reduction in the price of ARVs, savings of USD59.7 million were realized. There was no documentation, however, of how this saving was treated in subsequent disbursements, although there should have been a reduction the overall grant budget or a formal reprogramming.

Recommendation 88 (High priority)

The Global Fund Secretariat should:

- (a) *In the case of a significant variance between forecast expenditures and budget:*
 - i. *Ensure the PR specifies the factors that are the major drivers of the deviation and their impact on the variance (in terms of specific amounts).*
 - ii. *Request an updated work plan and budget from the PR.*
 - iii. *Ensure the LFA verifies the reasonableness of the forecast amount based on program performance, absorption capacity, any major changes to the work plan, any major unit price changes, cash balances at the SR level, the likelihood of existing commitments requiring cash during the forecasted period and any macroeconomic factors.*
 - iv. *Ensure the LFA provides analysis and comments on the variance between the forecasted expenditures and the latest approved budget.*
- (b) *Ensure that the PR has met the conditions specified in the LFA's disbursement recommendation, before disbursing requested amounts that have been withheld conditionally.*

- (c) *Ensure overall grant budget is reduced or appropriate reprogramming is undertaken, in cases where significant grant budget savings are realized.*

Working with Partners

217. In 2009, the Global Fund Secretariat requested that the PR, HAPCO, align its Global Fund grant work plans with those funded by PEPFAR. As part of ensuring this alignment, a memorandum of understanding was signed by the Minister of Health and US Ambassador for Ethiopia. There was, however, no evidence of the implementation of this memorandum as neither the Ministry of Health nor HAPCO could provide details of how Global Fund grant activities are coordinated with those funded by PEPFAR. Further, the OIG noted the following cases of duplication:

- I. PFSA drew a commission of 7% of procurement value from Global Fund grants to cover the distribution of commodities. It was evident that the same activities were paid for by the PEPFAR through their implementing partners.
- II. Development partners including PEPFAR were undertaking capacity development activities for PFSA including warehouse construction and purchase of vehicles and equipment. These activities were also included in the Round 7 HIV grant funded by the Global Fund. There was no evidence of harmonization of these efforts to avoid duplication.

Recommendation 87 (High priority)

The Global Fund Secretariat should:

- (a) *Follow up on the implementation of the memorandum of understanding that ensures alignment of Global Fund grant work plans with those funded by PEPFAR, and in particular obtain details of how Global Fund grant activities are coordinated with those funded by PEPFAR.*
- (b) *Ensure that the Global Fund grant-funded support to PFSA, for distribution of commodities and capacity development, is harmonized with other development partners to avoid duplication of funding.*

Global Fund Secretariat

218. The Global Fund Secretariat is responsible for grant oversight. The objectives of this oversight include adjusting grants to respond to country needs and program realities, and ensuring program implementation is consistent with Global Fund policy. As noted in paragraphs 106 to 114 significant adjustments were made to the Rounds 4 and 6 HIV, and Round 8 Malaria grants by diverting grant funds to the construction of new HCs, for which the Global Fund Secretariat did not ensure that Global Fund policies were properly followed. Further, the programmatic soundness of the adjustments is questionable given the TRP had not given approval for proposals for similar activities under Rounds 5 and 6. Recommendation 23 of this report addresses this finding.

ANNEXES

Annex 1: Abbreviations

ACT	Artemisinin Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDR	Case Detection Rate
CHW	Community Health Worker
CSO	Civil Society Organization
DACA	Drug Administration and Control Authority
DDT	Dichlorodiphenyltrichloroethane
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment - Short course
DST	Drug Susceptibility Test
ECS	Ethiopian Catholic Secretariat
EECMY	Ethiopian Evangelical Church Mekane Yesus
EFR	Enhanced Financial Reporting
EFY	Ethiopian Fiscal Year
EHNRI	Ethiopian Health and Nutrition Research Institute
EIFDDA	Ethiopian Interfaith Forum for Development Dialogue and Action
EKHC	Ethiopian Kale Heywet Church
EMDA	Ethiopian Muslim Development Agency
EMRDA	Ethiopian Muslims Relief and Development Association
EMSAP	Ethiopian Multi-Sectoral HIV/AIDS Prevention and Control Project
EMWACDO	Ethiopian Mulu Wongel Amagnoch Church Development Organization
EOC-CFAO	Ethiopian Orthodox Church Child and Family Affairs Organization
EOC-DICAC	Ethiopian Orthodox Church Development and Inter-Church Aid Commission
EQA	External Quality Assurance
ETB	Ethiopian Birr
FBO	Faith-Based Organization
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GLC	Green Light Committee
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-Based Care
HC	Health Centre
HCT	HIV Counseling and Testing
HEW	Health Extension Workers
HF	Health Facility

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HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Program
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education, Communication
IGA	Income Generation Activities
IQA	Internal Quality Assurance
IRS	Indoor Residual Spraying
KAP	Knowledge, Attitudes and Practices
LFA	Local Fund Agent
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant TB
MIS	Malaria Indicator Survey
MSH	Management Sciences for Health
NEP+	Network of Networks of HIV Positives in Ethiopia
NGO	Non-governmental Organization
NMSP	National Malaria Strategic Plan
NR	Not Rated
NSP	New Smear Positive
OI	Opportunistic Infection
OSDV	On-Site Data Verification
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PLHIV	People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
PR	Principal Recipient
PUDR	Progress Update and Disbursement Report
RCC	Rolling Continuation Channel
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities, and People's Region
SOE	Statement of Expenditure
SOP	Standard Operating Procedure
SPM	Strategic Plan for Multi-Sectoral HIV/AIDS Response
SR	Sub Recipient
SSR	Sub-Sub Recipient
STI	Sexually Transmitted Infection
TB	Tuberculosis
TLAE	Treatment Literacy and Adherence Education
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
VAT	Value Added Tax
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization

Annex 2: Overall Comments from Division Head, Grant Management



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16 April 2012

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Subject: Country Audit of the Global Fund Grants in Ethiopia

The Secretariat would like to thank the Office of the Inspector General (OIG) for its collaboration during the audit of the grant agreements concluded between Ethiopia and the Global Fund. This letter provides a brief summary of the contextual background, key achievements, and also highlights specific actions the Secretariat, the Ethiopian Coordinating Mechanism (ECM) and the Principal Recipients have taken or will take to address the key risks in the Global Fund Portfolio.

The Secretariat, the Local Fund Agent (LFA), and Principal Recipients have already started implementing recommendations in the key areas requiring special attention of the PRs: this includes financial and grant management and oversight. In relation to the perceived risks, the LFA has also made substantive improvements in the quality of deliverables and size of their team. The Secretariat will continue working closely with all parties to monitor the implementation of agreed-upon audit recommendations.

A. Contextual Background

Ethiopia's portfolio of approved Global Fund grants to date totals US\$1.32 billion of which US\$ 1.14 billion has been disbursed. To date the Global Fund's investments, with the support of the Government of Ethiopia and partners, have contributed significantly to the total results reported to date such as:

- Provision of anti-retroviral treatment for 241,424 people;
- Cumulative distribution of 33 million long-lasting insecticide-treated nets; and
- New smear-positive pulmonary TB cases treated – 26,942.

B. Summary of Key Recommendations and actions by the Secretariat

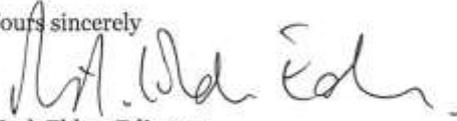
Challenges and key risks identified by the OIG	Secretariat comments and measures to address the identified risks
Health Center Budgets	<p>The Secretariat notes that the OIG reported US\$57,851,941 of over-expenditure. As noted in the OIG report, the Secretariat was aware of the reclassification of health center construction activities and agrees that the documentation should have been better formalized. The Secretariat will work with the CCM, PR, and in-country stakeholders to address this issue.</p>
Health Center construction quality issues	<p>The Secretariat acknowledges the issues cited in the OIG report including access to water, and the quality of construction of the health centers. The Secretariat will be following up with the Federal Ministry of Health (FMOH) to ensure that all HCs are completed in accordance with the minimum standards of the FMOH. In March 2012, the Secretariat was informed that 73 of the 77 health centers visited by the OIG were provisionally accepted, with faults including roof leakages rectified. The LFA has been requested to verify the information. The Secretariat will request the CCM to ensure that all defects are rectified.</p> <p>With regard to the provision of HCs with equipment and their future use, the Secretariat has been informed of the delivery of medical equipment to approximately 2104 health centers. The Secretariat has requested the LFA to work with the CCM and the Principal Recipient, The HIV/AIDS Prevention and Control Office (HAPCO), to verify the following a) the number of HCs in good working condition; b) the number of HCs that are fully equipped; and c) the number of HCs that are in regular use.</p> <p>The Secretariat also acknowledges the concerns cited in the OIG report regarding the absence of water in a high percentage of HCs. However, the Secretariat notes that at the time of the audit, a large number of HCs were freshly established and were not yet connected to water supply. In addition, the structure of the buildings allows for capture of rain water from the roof surface and FMOH has plans to exploit this source of supply. As mentioned above the Secretariat will, with the collaboration of the FMOH, CCM, and partners, monitor the usability of the HCs to ensure compliance with FMOH minimum standards for HCs.</p>

Challenges and key risks identified by the OIG	Secretariat comments and measures to address the identified risks
Budget vs. Expenditure for Health Center construction	The Secretariat notes the ETB/USD exchange rates used to derive the USD value for the construction of HCs. Given the broad range of fluctuation in the ETB/USD rate (from 8.2 ETB/USD in January 2004 to 16.2 ETB/USD in December 2010), the Secretariat will work closely with the PR and OIG to validate and make the necessary adjustments.
Quality of LFA Services	<p>During the OIG debrief of the findings in March 2011 significant concerns were raised regarding the staffing level of the LFA team, particularly in the area of financial management given the large size of the Ethiopia grant portfolio. In March 2011 the Secretariat carried out a mid-term evaluation of the LFA which highlighted a number of areas for improvement. As a result the LFA has since made significant improvements including:</p> <ul style="list-style-type: none"> • Establishing a central coordination and oversight function to improve and standardize the quality of key outputs; and • Hiring eight additional financial analysts to strengthen the LFA's financial oversight of the grants. <p>A second review will be conducted in September 2012 to monitor the progress and to facilitate a continued improvement of delivery and output.</p> <p>The Secretariat has broadened the scope of work for the LFA in 2012 to further mitigate risk, resulting in a budget increase of 56% between 2011 and 2012.</p>
Obtaining Necessary Approvals for Material Reprogramming	The Secretariat acknowledges that, with the evolution of Secretariat policies regarding material reprogramming, it is critical that all PRs are made aware of the need for written approval for all material reprogramming. As per the Secretariat's Operational Policy Manual, material reprogramming is defined as a change of more than 10% of the annual approved service delivery area (SDA) budget line or an absolute threshold as defined by the Country Team. The LFA has been requested to conduct their reviews using these benchmarks.

Challenges and key risks identified by the OIG	Secretariat comments and measures to address the identified risks
Timeliness of Audit Reports	<p>The Secretariat acknowledges that audit reports from FMOH are routinely delayed. Following in-country discussions with both FMOH and the Audit Services Corporation of the Ethiopian Government a modified audit plan has been agreed upon that should reduce the delays in the preparation and finalization of the annual audit report.</p> <p>However, a key challenge still remains as FMOH has a shortage of skilled Finance staff and this is likely to delay the preparation of financial accounts. The Secretariat is working with partners and FMOH to support the PRs' request for funding additional staff.</p>
Completing closure of grants that have expired	<p>The Secretariat acknowledges that there are five expired grants that are at various stages of closure. These are the Round 1 TB, Round 2 Malaria, and Round 5 Malaria grants with FMOH and the Round 4 and Round 7 HIV/AIDS grants with HAPCO. The Secretariat will work closely with the PRs, CCM, and LFA to encourage a timely closure of these grants and a refund of any relevant funds.</p>
Amounts recommended for refund by the OIG	<p>The OIG reported a total of US\$7,026,929 as ineligible and or unaccounted for. The figures include:</p> <ul style="list-style-type: none"> • HAPCO – VAT and other ineligible expenses charged to the grant programs (US\$1,323,627); • HAPCO – Outstanding advances related to the expired Round 4 grant (US\$5,591,015); and • FMOH – Outstanding advances to various regions and SRs related to the expired grants: Malaria Round 2 and TB Round 1 (US\$112,287). <p>The Secretariat will work closely with the OIG and the PRs to ensure recovery of all ineligible and unaccounted for funds.</p>
Proposed refund of US\$1,323,627 of VAT expenses charged to grants by HAPCO and its sub-recipients	<p>The Secretariat acknowledges that a total of US\$1,323,627 of VAT expenses was incurred by HAPCO and its sub-recipients between 2004 and 2010.</p> <p>The PR informed the Secretariat that it has recovered US\$982,384 thus far and is in the process of claiming the balance from the Revenue Authorities.</p> <p>The Secretariat will ask the LFA to review and confirm the tax refunds.</p>

The Secretariat thanks the Office of the Inspector General for the completion of this report and is looking forward to a constructive engagement on matters raised in this letter.

Yours sincerely



Mark Eldon-Edington
Division Head
Grant Management Division

Annex 3: Incidence of Overstocking and Stock-Outs

Hospital	Item description	Quantity on Hand	Average Monthly Consumption	Months of Stock	Stock status
Sheshamane	Ethambutol 400mg + Isoniazid 150mg tabs	0	896		Stock out
	Isoniazid 300mg tabs	15,488	1,226	12.63	Overstocked
	AZT 60mg/3TC 30mg/NVP 50mg	3,000	60	50	Overstocked
	RHZE tabs	8,064	1,456	5.54	Overstocked
	Efavirenz 100mg caps	0	270		Stock out
Yirgalem	Ethambutol 400mg + Isoniazid 150mg tabs	0	896		Stock out
	Rifampicin 150mg + Isoniazid 75mg	0	224		Stock out
	LPV/R 80mg/20mg Oral suspension	0	3		Stock out
	Isoniazid 100mg tabs	4,816	333	14.46	Overstocked
	D4T 30mg/3TC 150mg/NVP 200mg	5220	850	6.14	Overstocked
	D4T 15mg/3TC 75mg/NVP 100mg	45,540	7,400	6.15	Overstocked
	D4T 6mg/3TC 30mg	2,040	180	11.33	Overstocked
	AZT 100mg	1100	200	5.5	Overstocked
	AZT 10mg/ml	48	1	48	Overstocked
	AZT 300mg	1050	75	14	Overstocked
	Streptomycin Inj	400	25	16	Overstocked
	Cotrimoxazole tabs	86,500	2,866	30.18	Overstocked
	Awassa Referral	Abacavir 300mg tabs	0	1480	
EFV 200mg caps		4050	90	45	Overstocked
DDI 250mg tabs		0	410		Stock out
D4T 30mg/3TC 150mg/NVP 200mg tabs		79,020	12,960	6.10	Overstocked
D4T 30mg/3TC 150mg tabs		42,660	3,420	12.47	Overstocked
3TC 150mg tabs		0	14,880		Stock out
NVP 200mg tabs		17,640	1,480	11.92	Overstocked
Wukro Woreda	LPV/R 200mg/50mg tabs	0	80		Stock out
	NVP 200mg	0	400		Stock out
	EFV 600mg tabs	5,400	200	27.30	Overstocked

Record of stock status at selected sites as at 30 November 2010

Annex 4: Recommendations and Action Plan

Country Response and Action Plan to OIG Recommendations/Ethiopia, 03 February 2012

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>Recommendation 1 (Significant priority) To improve the quality of malaria and tuberculosis diagnosis, the FMOH should ensure: (a) Microscopes are maintained in proper functioning order.</p>	<p>EHNRI in collaboration with regional labs has been giving due emphasis on preventive maintenance of the microscopes through incorporating basic preventive maintenance skills into the basic and refresher training packages for laboratory technicians throughout the country. Such skills on basic preventive maintenance of microscopes can address most of the problems observed in some health facilities during the audit regarding microscope status.</p> <p>Action plan</p> <ul style="list-style-type: none"> ➤ EHNRI will continue to further strengthen and intensify its efforts in building the skills of lab technicians on basic preventive maintenance of microscopes (and other lab equipment) 	<p>EHNRI/RHBs</p>	<p>2012</p>
<p>(b) Running water is available in the health facilities.</p>	<p>b) The government has developed Water Supply and Sanitation Strategy whose principal objective is to secure basis for the provision of sustainable, efficient, reliable, affordable and users-acceptable WSS services to the Ethiopian people, including livestock watering, in line with the goals and objectives of relevant national and regional development policies. Water Supply Development Program, a development program with 15 years planning period ranging from 2002-2016 has been implemented in three phases (universal access plan/UAP). The national coverage of potable drinking water is at 73.3% and by the end of EFY 2007 (2014/15), it will reach at 98.5%. On</p>	<p>FMOH & Ministry of Water & Energy</p>	<p>On-going</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	<p>yearly basis, the government allocates significant capital budget; the government in partnership with Watsan Development Partners has developed WASH (water, hygiene & sanitation) program that also mobilizes significant budget to increase access to potable water. Ensuring availability of running water in all health facilities has been given due emphasis by FMOH along with the expansion of health facilities. (refer to website of Ministry of Water and Energy/Ethiopia: http://www.mowr.gov.et)</p> <p>Action plan</p> <ul style="list-style-type: none"> ➤ To follow up with Ministry of Water & Energy implementation of UAP. 		
<p>(c) Refresher training is provided to laboratory technicians based on a needs assessment</p>	<p>c) There is a national guideline for diagnosis of malaria, and trainings have been conducted from federal to district level every year and currently EHNRI at national level is conducting an assessment to provide training based on need assessment. EHNRI has developed the necessary guidelines and manuals for laboratory trainings pertinent to Malaria and TB. TOTs were provided to the Regional labs to facilitate regular refresher training rollouts. Many regions, in collaboration with partners, have also conducted basic trainings for facilities.</p> <p>Action plan</p> <ul style="list-style-type: none"> ➤ EHNRI will continue its support for the regions and branch laboratories to cover all health facilities in a shortest period of time. 	<p>EHNRI/Regional Laboratories</p>	<p>On-going</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>(d) Internal and external quality assurance of the health facility laboratories is conducted as planned and is duly documented.</p>	<p>d) In the national laboratory master plan there is an adequate provision for Internal Quality Control (IQC) and External Quality Assessment (EQA). As a result of this EHNRI and Regional Labs have been working to implement Internal Quality Control (IQC) and External Quality Assessment (EQA) programs at all laboratories nationwide.</p> <p>National TOTs have been provided to regional laboratories by ENHRI and in turn the regional laboratories have been cascading the trainings to branch laboratories.</p> <p>Action plan</p> <p>In the future documentation of quality assurances will be improved by regular follow up and supervision by regional and branch laboratories.</p>	<p>EHNRI/Regional labs</p>	<p>On-going</p>
<p>Recommendation 2 (Significant priority) The FMOH should improve the quality of malaria case management by: (a) Providing training for staff of the health facilities on malaria control activities; especially medical doctors and clinical nurses who handle the outpatient departments. The training protocol and system laid out in the national malaria guidelines should be</p>	<p>a) There is a focus on malaria during pre-service and in-service trainings and there is a strong system to build the health workers capacity at regional and hospital level on malaria diagnosis and treatment, as a result repeated trainings have been provided to health professionals on malaria diagnosis and treatment at regional level as per the national guideline. Since July 2009 to June 2011 a total of 8857 health workers have been trained on malaria diagnosis and treatment. However, as a result of the high service expansion in the country, still there is a need to train more health workers.</p> <p>Action plan</p> <p>We have planned to train HF professionals on malaria prevention and control, including severe case management and surveillance according to the national guidelines in 4 rounds at the beginning of 2012.</p>	<p>FMOH/RHBs</p>	<p>January 2012</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>implemented rigorously.</p> <p>(b) Providing training for HEWs on identification and referral of complicated malaria cases.</p> <p>(c) Ensuring stock outs of malaria drugs are avoided, and improvements are made to drug forecasting and supply systems as necessary.</p>	<p>b) Trainings to HEWs have been provided at different times since its establishment. Recently Integrated refresher training has been rolled out in 2011 in all regions in the country and identification and referral of complicated malaria cases have been addressed.</p> <p>c) At the national level there is no stock out of ACT. Drugs are distributed to regions based on morbidity data at the national level. In the Amhara region where the actual problem was observed, from Feb 2009 to Nov 2011 a total of 5,552,073 amount of ACT treatment dose have been distributed over the last 2 years from the national stock. Though at local/facility level problems might be encountered due to different reasons like geographical access and transport problems. However, PFSA has a forecasting and supply management system for drug procurement, distribution and stock out tracking.</p>		

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>Recommendation 3 (Significant priority) With regard to LLINs, the FMOH should:</p> <p>(a) Ensure LLIN utilization monitoring activities are undertaken to make sure that LLINs are indeed being used in the household. This could be a regular task for the HEWs with support from health centers and health extension supervisors.</p> <p>(b) Ensure a strategy is established for the replacement of the LLINs which are nearing their expiry period. This could begin with collection of data on the need for replacement of LLINs through the HEWs.</p>	<p>(a) To ensure utilization of LLINs a tracking mechanism is clearly set in the National LLINs Strategic Plan (2008-12). In this document a guiding format is developed to be used by HEWs during house to house visit to monitor the use of LLINs by the beneficiaries. The HEWs are required to observe whether LLINs were hang to the sleeping places or not, presence of holes in the nets, who was sleeping under the net and demonstrating correct use of LLINs and finally asking if they have any problem and negotiate for possible solutions. In addition, to increase the utilization of LLINs emphasis is given, and the HEP has included LLINs utilization as one of the pre-requisite for model household graduation.</p> <p>(b) LLIN replacement scheme (keep up strategy) is well stated in the national strategic plan. The number of LLINs required for replacement in each kebele will be collected by HEWs. This will lead to bottom-up approach to reflect accurate LLIN requirement. In addition, Woreda/district micro-planning is based on the HEWs database and the replacement is considered and addressed during this process.</p> <p>Action plan</p> <ul style="list-style-type: none"> Emphasis will be given for collection of data on the need for replacement of LLINs through the HEWs during IRT training follow up. 	FMOH/RHBs	Ongoing
<p>Recommendation 4 (Significant priority) With regard to IRS, the FMOH should:</p> <p>(a) Ensure a system is in</p>	<p>a) Every year, comprehensive Malariology training is conducted to significant number of district level malaria experts to equip districts with vector control activities; which again helps to train spray men to the standard. In addition onsite supervision is conducted by trained malaria</p>	FMOH/RHBs	Ongoing

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>place for on-site quality check during IRS.</p> <p>(b) Provide guidance on appropriate and reasonable costs related to IRS. These should include per diem and contracting fees. The budget lines to be charged against the grant should be clarified as well.</p> <p>(c) Commission a study on the status of resistance to DDT used in IRS, as planned under the National Malaria Strategic Plan.</p> <p>(d) Disseminate to the implementation level the guidelines that have been developed at the federal level for storage, transport, and application of insecticides.</p>	<p>technicians at the Woreda level.</p> <p>b) The payment for IRS operation is based on the country's finance and economy rules and regulations though there might be some regional payment variations due to hardship allowances especially in the hard to reach areas of the country like Somali, Afar, and Gambella; and this variation of payment is in accordance with financial regulation of the country and regional states.</p> <p>c) Insecticide resistance studies were conducted at different times in the country. As a result, Federal Ministry of Health replaced DDT by Deltamethrine by December, 2009. In addition insecticide resistance management strategy development is on progress.</p> <p>d) There is a training manual for insecticide residual spraying (revised April 2011) which has been disseminated to the Woreda level and the guidelines are available at the institution level (HCs and district health office information centres).</p>		
<p>Recommendation 5 (Significant priority)</p> <p>The FMOH should implement an active surveillance and epidemic control system at the Federal and regional levels as envisaged under the National Malaria Strategic Plan</p>	<p>The country has a guiding document, malaria epidemic preparedness and control guideline. Malaria epidemic monitoring chart is also used at facility level to monitor the occurrence of epidemics. In addition community based surveillance system is in place in Ethiopia and currently the country has established an innovative strategy to scale up health service delivery system at grass root level through Health Development Army (HDA) which could in turn strengthens malaria surveillance system by early</p>	FMOH/EHNRI/PHEM	Already addressed

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	identification and notification of cases at village level.		
<p>Recommendation 6 (Significant priority)</p> <p>With regard to the supervision of health extension workers, the FMOH should ensure:</p> <p>(a) Systematic supportive supervision is provided by the HEW supervisors and health centers to the HEWs undertaking the Global Fund grant-funded program activities and interventions in the community.</p> <p>(b) Basic tools for HEWs to record tasks carried out. The same tools would be used to record monitoring and supervisory remarks.</p>	<p>a) Starting from the establishment of the health extension program, there has been a system to support HEWs by assigning HEW supervisors at the HC level to support HEWs on weekly basis for all HEW packages including GF grant funded program activities. To strengthen the system currently the technical support to HEW has been closely attached to health centres; a health center and 5 satellite health posts constitute primary healthcare unit/PHCU/ - these 5 health posts are administratively responsible to the health center. In addition the HDA strategy is in place to support the supportive supervision at the PHCU level.</p> <p>b) This comment is totally unacceptable. The national Health Sector Development Program gives special attention to the health extension packages (HEP) and since its establishment the strategy is focused to address 16 health extension program packages at the community level and each package has clear targets and indicators with timelines. The activities are broken down and are geared to create model families who are capable of producing their own health for this the strategy has its own model family graduation criteria.</p> <p>To strengthen and monitor the activities at the community</p>	FMOH/RHBs	Addressed

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	<p>level clearly demarcated roles and responsibilities are set at federal, regional, zonal, woreda, health centres and health post levels with full government commitment. And the roles and responsibilities of HEWs are explicitly indicated in detail with clear deliverables in the document.</p> <p>In addition currently the integrated refresher training has also clearly addressed the responsibilities and deliverables from the HEWs for each package including malaria.</p>		
<p>Recommendation 7 (Significant priority) The malaria and TB programs should implement the LFA’s recommendation to write BCC plans into their national activity plans, along with suitable output and outcome measures to monitor progress. The BCC work plans for malaria and TB grants should flow from these national activity plans</p>	<p>To support and strengthen the utilization of health interventions IEC/BCC plan is incorporated into the national strategic plan for malaria with clear objectives, targets and key outcome indicators and activities. In addition the process indicators are addressed in the M and E strategic plan while the outcome indicators are addressed by surveys like Malaria Indicator Survey and Demographic & Health Survey. Community Empowerment and Mobilization is one of the major strategy indicated in the plan to achieve the health-related MDGs and BCC activities are implemented accordingly.</p>	FMOH/RHBs	
<p>Recommendation 8 (Significant priority) In order to ensure correct data collection and reporting on the two output indicators: ‘Number of health facilities reporting no stock out of antimalarials’ and ‘Number of facilities with RDT and reagents’, the FMOH should ensure that the M&E plan</p>	<p>In the national malaria M&E strategic plan (2010-2015), the process indicators to monitor stock status of RDT and ACT at facility level are Number of health facilities that reported RDT stock out for more than three weeks and Number of health facilities that reported ACT stock out for more than three weeks, respectively. These two indicators are absolute numbers and both are positively worded.</p> <p>Therefore, in the future, we will review these indicators with detailed instructions as per the comment and provide training for health managers and workers in malarias areas</p>	FMOH	

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
includes clear descriptions of numerators and denominators, and detailed instructions for reporting.	so that the coherence of the report will be maintained.		
<p>Recommendation 9 (Significant priority) The FMOH should ensure that the data for reporting the indicator ‘Number of LLINs distributed’ is aggregated from LLIN distribution registers.</p>	<p>There is a National LLINs Strategic Plan (2008-12) and LLINs Distribution Registry for Tracking Final Destination of Nets including mechanisms of monitoring their use by beneficiaries. However, most of the LLIN distribution mechanism in the country was using campaigns to address households in the malaria areas without nets. During the process LLIN batch and net number is registered using the standard registration format. To prevent misuse like selling of LLINs the cover is torn out during distribution and only the naked LLIN is provided to the consumers and its uptake is monitored according to the format indicated in the LLINs Strategic Plan.</p> <p>Action plan</p> <ul style="list-style-type: none"> To further strengthen this, focus will be given during the subsequent integrated refresher trainings and in the Health Development Army (HDA) activities. 	FMOH/RHBs	On-going
<p>Recommendation 10 (Significant priority) The FMOH should improve TB diagnosis and referral by: a. Training HEWs in identification of pulmonary TB suspects and their referral to the nearest health center.</p>	<p>a. The best practices observed with regards to the implementation of community TB care (CTBC) using HEWs in Adama Woreda at the time of the Audit is being scaled up throughout the country. The plan is to complete the nationwide scale up over the coming three years. To ensure the implementation of CTBC through the maximum use of HEWs, Federal Ministry of Health has developed a comprehensive Integrated Refresher Training (IRT) program for all HEWs in the country. The TB/HIV module of the IRT addresses all the components</p>	FMOH(Agrarian, Pastoralist and Urban HPDPDs) and all RHBs	September 2013

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	<p>of TB suspect identification; referral and Provision of DOTS after diagnosis. The HEWs also ensure the TB patients submit follow up sputum specimen during treatment.</p> <p>Action plan:</p> <ul style="list-style-type: none"> ➤ All HEWs will be trained on TB/HIV Module of the IRT and CTBC implementation will be scale-up nation-wide by the end of 2013. 		
<p>b. Disseminating standard referral and feedback formats to the HEWs to improve documentation and follow up of referrals.</p>	<p>b. The Standard TB suspects' referral and feedback formats have been prepared and being disseminated as recommended. In fact, such formats have been disseminated to the districts where the CTBC was piloted even at the time of the audit. The standard TB suspect identification and referral formats include the TB suspects Registration logbook (to document and follow the TB suspects identified and referred to HC) and TB suspect referral form.</p>	<p>FMOH/RHBs</p>	
<p>c. Encouraging partnerships with civil society and private sector healthcare providers for TB referral.</p>	<p>c. Health facilities run by NGOs provide DOTS services as public health facilities do. PPM-DOTS service has been launched in Ethiopia in 2006 and since then, private health facilities are actively involved in TB Prevention, Suspect Identification and referral, Diagnosis and treatment of TB as per the national guidelines. Currently, 317 private HFs are actively engaged in provision of full packages of TB suspect identification, diagnosis and treatment as well as referral. The Ministry in collaboration with its development partners is further expanding PPM-DOTS services and collaboration of the private health sector in TB Prevention and Control. Nationally the plan is to have 1000 PPM-DOTS Sites at the end of 2015. Currently, an assessment of private-for-profit lower clinics and rural drug vendors to be engaged</p>	<p>FMOH/RHBs</p>	<p>By 2015, 1000 private HFs will be engaged in PPM-DOTS service</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	<p>in TB suspect identification and early referral is completed and strategy to formally engage these private facilities is being finalized.</p>		
<p>d. Conducting operational research of ‘sputum collection and transportation’ arrangements using CHWs, HEWs, civil society volunteers, and private healthcare providers to bridge the access gap caused by geographical distances; and based on this research, develop national guidelines for sputum collection and transportation, specific to each of the volunteers mentioned.</p>	<p>d. Currently, the geographic coverage of DOTS reaches 100% whereas the Health Facility coverage is 95%. According to the national DOTS facility assessment made in February 2011, 110 hospitals out of 119 hospitals (92%) and 2,367 health centers out of 2,480 health centers (95%) are implementing DOTS services. In addition, TB treatment follow up under the DOTS strategy is given in 2,100 health posts across the country; 15% of total existing health posts. Overall, there are 4,577 DOTS centers in which DOTS coverage among government hospitals and health centers reached to 95%, up from 92% in 2010. From the recent assessment, 1,596 (64%) out of a total 2,478 public-DOT facilities and 280 (63%) out of a total 317 PPM-DOT facilities have AFB diagnostic services. Overall, there are 1,876 TB diagnostic centers with AFB microscopy in the country. In order to further expand access and improve quality of TB control in Ethiopia, the government in collaboration with partners innovatively engaged the private sector in TB care and currently there are a total of 317 PPM-DOTS facilities nationwide (44 hospitals, 149 higher clinics, 95 medium clinics and 29 lower clinics) which are owned and run by NGOs and other private sector organizations and institutions. Furthermore, according to the KAP survey conducted along with the National TB Prevalence survey, 91% of the TB Suspects live within 10 Km radius of TB diagnostic Public Health facilities. The National strategy is therefore, to further expand DOTS services and improve access to TB Diagnostic services (public, private-for-profit, private-not for-profit). However,</p>	<p>FMOH/RHBs</p>	

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	sputum collection and transportation of fixed sputum slides using HEWs might be considered in exceptional geographic areas where the access to diagnostic health facilities is sub-optimal due to geographic barriers until optimal access is ensured.		
e. Ensuring there is adequate information at health facilities in the community on pulmonary TB, its harm, and the services available.	<p>e. FMOH in collaboration with its development partners has been producing and disseminating different IEC/BCC materials on TB to the health facilities to ensure availability of adequate information on TB. The availability and utilization of these IEC/BCC materials at health facilities and in the community is also being checked during supportive supervision visits. There might be irregularities in the availability of adequate information on TB as well noted during the audit visits. The FMOH will continue to produce and avail essential IEC/BCC materials on TB so that the community becomes well informed on TB Prevention and control in the country. Moreover, improving communities' awareness on TB and increased social mobilization against TB has been given due emphasis through implementation of CTBC and through maximum use of the Health Development Army (HDA).</p> <p>Action Plan:</p> <ul style="list-style-type: none"> ➤ Produce and avail IEC/BCC materials on TB at health facilities ➤ Implementing CTBC and improve information on TB at community level through conducting TB ACSM using the HDA 	FMOH/RHBs in collaboration with Partners	Continuous
Recommendation 11 With regard to the treatment regimen for TB, the FMOH should ensure:	a. TB treatment regimen shift from EH- based continuation phase to RH-based continuation phase as per the WHO's 2010 recommendation has been launched in Ethiopia since September 2010. The regimen shift has been implemented in a phased	FMOH	Completed

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
(a) Rifampicin is included in the continuation phase of the DOTS regimen.	manner starting at Urban areas and subsequently to major Agrarian regions and finally to the pastoral regions of the country. Therefore, the recommendation is well addressed and Rifampicin is already included in the continuation phase and nation-wide TB treatment regimen shift as per the WHO's recommendation is completed.		
(b) Each patient has uninterrupted access to the complete course of anti-TB treatment by placing all the drugs for each patient in a box at the start of the treatment.	<p>b. The observations noted during the audit visits regarding the availability and provision of anti-TB drugs in individual blisters of FDCs and loose drugs to the TB patients is correct and so far the country has been procuring anti-TB drugs in individual blister packs of FDC drugs and loose drug formulations. However, there were no any major anti-TB drugs stock outs or drug interruptions due to stock outs in the country. The TB treatment outcome in the country, which is highly affected of course by drug stock outs and interruptions, has been maintained at optimal levels of 84% Treatment Success Rate for over the last 5 years. The role of TB patient drug kits to avoid TB treatment interruptions due to stock out of anti-TB drugs is well recognized and hence, FMOH has decided to procure TB patient drug-kits starting from 2012, using R10 TB grant.</p> <p>Action plan:</p> <ul style="list-style-type: none"> ➤ Procure TB patient drug Kits starting from 2012 using GF TB Grant Round 10 ➤ Integration of TB drugs and supplies management system in to the Integrated Pharmaceuticals Logistics System (IPLS) 	FMOH and PFSA	Starting from 2012
(c) All the staff concerned with treatment of TB patients are trained on	c. Identification and management of anti-TB drug side-effects is part and parcel of the trainings on TB DOTS and TB treatment for general health workers. All health	FMOH/RHBs/Partners	Continuous

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>identifying side effects and the subsequent necessary remedial actions.</p>	<p>facility TB focal persons have received basic trainings on TB DOTS and hence well acquainted with identification and management of anti-TB drugs side-effects. Besides, the common anti-TB drugs side-effects and their management is clearly described in the national TBL and TB/HIV Prevention and Control Program manual. However, due to the existent high trained staffs' turnover, the staff working in TB Clinics in some of the health facilities might not have received such basic trainings and might not be well informed. To further improve the skills of the staffs concerned with treatment of TB including the HEWs on identification and management of side-effects of Anti-TB drugs, FMOH has developed a revised comprehensive TBL and TB/HIV training material for general health workers (GHWs) and IRT for HEWs.</p> <p>Action Plan:</p> <ul style="list-style-type: none"> ➤ Train relevant Health Workers on comprehensive TBL and TB/HIV training material ➤ Train HEWs on IRT as stated above in response to Recommendation 10(f). 		
<p>(d) SOPs for treatment regimen are displayed at all the HFs.</p>	<p>d. This recommendation is well accepted and actually inline with the NTP's plan. TB job aids including diagnostic and treatment algorithms are being distributed to all DOTS facilities. The availability of these job aids at the health facilities will be checked and ensured during supportive supervision visits.</p> <p>Action Plan:</p> <ul style="list-style-type: none"> ➤ Avail TB Job aids (diagnostic and treatment algorithms) at all TB DOTS HFs ➤ Ensure their availability during integrated supportive 	<p>FMOH/RHBs</p>	<p>Continuously</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	supervisions		
<p>Recommendation 12. With regard to DOTS, the FMOH should:</p> <p>(a) Seek to assign to HEWs the task of providing DOTS to the TB patients living in their coverage area. This is being piloted in a few Woredas of Oromia and could be included in the future HEWs training. Additionally, as a way of ensuring treatment compliance, seek to give priority to the patient's preferences such that the DOTS provider could also be a CHW, or other person from the community with whom the patient is comfortable.</p>	<p>a. Currently, implementation of CTBC and Community TB DOTS program where HEWs provide TB DOTS and supervise TB treatment at Health Posts is being scaled up at national level. The provision of TB DOTS at community level (Health posts or at patients home) is an essential component of CTBC. To effect DOTS provision at HPs, HEWs are responsible to supervise the daily doses. But, to provide DOTS at patients' home during the continuation phase of treatment, TB Treatment supporters (TTS) are being identified and trained either GHWs at TB clinics or HEWs. These TB treatment supporters are identified by the patient from household members, CHWs or community volunteers. Therefore, this recommendation is also well noted and being scaled up nationally.</p> <p>Action plan:</p> <ul style="list-style-type: none"> ➤ Scale up CTBC implementation nationwide by the end of 2013 	FMOH/RHBs	September 2013
<p>(b) Until a more comprehensive system is developed:</p> <p>i. Ensure the treatment card carried by the patient includes a record of the daily dose intake, for example via a tick mark.</p> <p>ii. For the continuation phase, where patients are given drugs for a week or fortnight, ensure</p>	<p>b. The TB treatment card has daily observation chart to be checked by the TB DOTS service provider at HCs, HEWs and TTS at community level whether the daily doses are taken by the patient. The treatment of TB during continuation phase is currently provided under direct observation of a trained designated TB treatment supporter (could be HCWs at DOTS HF, HEW, community volunteer, CHW).</p>	FMOH/RHBs	Completed

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>empty blister packs are retrieved from the patient during their subsequent visit to the health center to provide some evidence that medicines have been consumed.</p>			
<p>(c) Ensure a comprehensive default retrieval framework is developed at the federal level with scope for local variations and innovations within the broader framework.</p>	<p>c. TB defaulter tracing framework is provided by TBL and TB/HIV Prevention and Control Manual and the role of HEWs in defaulters tracing is clearly articulated in the Community TB Implementation Guideline. Furthermore, TB defaulter tracing is addressed using the Community TB care scale up, strengthening HP and HCs linkages and use of Health Development Army (HDA). As the CTBC implementation is scaled up nation-wide and with HDA rollout, retrieval mechanism will be strengthened and the TB treatment defaulters' rate will be significantly reduced.</p> <p>Action Plan:</p> <ul style="list-style-type: none"> ➤ Address TB Defaulters retrieval by implementing CTBC as per the implementation guideline, use of HDA and strengthening HP-HC Linkages 	<p>FMOH (HPDP Directorates) and RHBs</p>	<p>Already addressed in NTP Manual, CTBC Implementation Guideline</p>
<p>(d) Ensure health facility staffs are trained on appropriate address recording procedures to enable the patients to be located in case of default. This information should be verified during supervisory</p>	<p>d. Ensuring proper recording and reporting of TB patients at HF is part of the training package for GHWs in the training material. Moreover, clear instructions on how to complete the Unit TB register which includes separate columns for recording the patients' addresses and TB patient's contact person's address are provided on the first pages of the unit TB register. Ensuring proper recording of the patient's correct address on</p>	<p>FMOH (All HPDP Directorates) and RHBs</p>	<p>Already being addressed</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
visits.	<p>the Unit TB register is very essential and is being checked during supervisory visits as recommended.</p> <p>Action Plan:</p> <ul style="list-style-type: none"> ➤ Training GHWs on comprehensive TBL and TB/HIV Training manual and ensuring proper recording of TB patients' information on Unit TB Registers through supportive supervisions 		
<p>Recommendation 13: (a) Identify the number of possible MDR-TB suspects by assessing the treatment and re-treatment failure data. This data would help in assessing the local need for culture and DST facilities.</p>	<p>a. Currently, the possible MDR-TB suspects at national level have been estimated and plan finalized to provide Culture and DST services through sputum sample transport system and lab networking. National MDR-TB Prevalence survey is being undertaken by EHNRI.</p>	FMOH	Completed
<p>(b) Consider undertaking IEC/BCC activities to educate the community on the reasons for MDR-TB in order to create awareness regarding the necessity to comply with the complete course and undertake regular follow up sputum examinations.</p>	<p>b. This recommendation is well noted and already being addressed by CTBC and HDA implementation. Furthermore, national TBL and TB/HIV ACSM strategy has been developed and all aspects of Advocacy, communication and social mobilization on MDR TB is part of the strategy.</p>	FMOH/RHBs/Partners	Ongoing
<p>(c) Complete the process of establishing culture and DST facilities at the sites identified by the FMOH</p>	<p>c. Currently there are 2 referral labs providing Culture and DST, and by 2012 we will have 5 additional labs. The facility renovations and installation of all the required equipments are also finalized.</p>	FMOH/EHNRI	End of 2012

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(d) Initiate a dialogue with the private healthcare providers to establish partnerships for creating culture and DST facilities.	d. Currently one private lab is providing Culture and DST services and reporting to the national program. The same approach will continue to engage more private labs in provision of culture and DST. The challenge in engaging the private labs in TB Culture and DST will be the cost implications to the patients as the private labs are profit making.	FMOH/EHNRI	Ongoing
<p>Recommendation 14 (Significant priority) To improve TB-HIV collaboration, the FMOH should undertake the following actions:</p> <p>(a) Develop and implement HIV-TB coordination protocols along with appropriate training. In particular, HEWs should be trained to identify suspected HIV co-infection in TB patients and TB co-infection in HIV patients to ensure referral to the respective clinics for diagnosing HIV-TB co-infection.</p>	a. TB/HIV Collaborative activities are coordinated as per the national TBL and TB/HIV Program guideline. HEWs are trained on IRT which has TB/HIV module. The HEWs will advise all TB patients on treatment to undergo HIV tests and HIV positive individuals who have disclosed their HIV status to the HEWs to undergo regular screening for TB symptoms at the HCs.	FMOH/RHBs	Ongoing
(b) Standardize checklists, feedback systems, and documentation.	b. There is standardized referral and feedback form for HIV/TB co-infected individuals.	FMOH/RHBs	Addressed
(c) Ensure the HEWs and the	c. Communicating to communities the preventive	FMOH/RHBs	On-going

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<p>health facility staffs play a more active role in communicating to communities the preventive strategies regarding TB and HIV.</p>	<p>strategies regarding TB and HIV is part of the package of HEP. Moreover, communities are reached with prevention messages through the HP-HC linkages and HDA</p>		
<p>Recommendation 15: The TB Program should review its targets for the Round 6, Phase II grant, as well as the calculation of the indicator for the number of NSP cases detected, and align them with national plans in accordance with the Government’s policy of one plan, one budget and one M&E system. Such an effort will enable better interpretation of reported data and will give a clearer picture of the grant’s contribution to national goals</p>	<p>The estimated number of New Smear Positive TB cases used in national target for case detection rate (CDR) in HSDP III (2002 EFY or 2009/10) is 129,740 and the target for the same year is to reach a CDR of 50%. This estimate is based on the WHO’s 2009 estimate. However, since WHO has stopped publishing country estimates for New Smear Positive TB cases since 2010, the 2009 WHO estimate was used to determine the estimated number of New smear positive TB cases for the year 2003 EFY (HSDP IV). Accordingly, the denominator used for HSDP IV target for NSP is 133,573 and the target for the same year in HSDP IV first year (2003 EFY) is to detect 58.7% of the estimated NSP TB cases (See the Health and Health Related Indicators, 2002 EFY edition and HSDP IV 2003 EFY Annual Performance report). Based on this, the estimated number of NSP TB cases for the 2003 EFY is 133,573. Therefore, the denominators for HSDP III and HSDP IV indicated in the Audit report (Table 8, pp 27 of draft audit report) are not similar with the national documents.</p> <p>The outcome indicator used in the performance framework for GF Round 6 phase II Grant is the NSP TB Case Notification Rate per 100000 populations (percentage of New Smear Positive TB cases detected each year per 100,000 populations), not NSP Case Detection Rate. Therefore, computing for estimated number of NSP TB cases from the targets given in the performance framework</p>	<p>FMOH</p>	<p>December 2012</p>

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	<p>for the respective years is not required. The national TB survey (the first of its kind in the continent) was conducted in 2011; it is now in preparation for dissemination.</p> <p>Action Plan:</p> <p>Following dissemination of the national TB prevalence Survey targets will be revised.</p>		
<p>Recommendation 16: The TB program is encouraged to make use of Round 6, Phase II to include the findings of the KAP survey to reprogram its interventions accordingly and also plan for a follow-up KAP survey at the end of 2012 (Year 5 of the grant). Information on key attitudes and practices (such as knowledge about TB and timely care seeking for cough) will provide insights for program managers to understand and interpret trends in case detection rates and take remedial action.</p>	<p>The national KAP survey result is just released on 15th of December 2011 and the national TB program is reviewing the findings to see if there are any implications to the planned interventions. After critically reviewing the findings, FMOH will consider re-programming as per this recommendation.</p> <p>However, there is no any plan to conduct follow-up KAP survey at the end of 2012. This is due to the fact that it requires a reasonably longer time period to see the intended changes over time on health attitudes and practices as a result of change in knowledge of the community.</p> <p>Therefore, the plan is to conduct follow up KAP survey using GF R10 grant to see on the trends in changes in KAP and the impact of the interventions being made.</p>	FMOH	
<p>Recommendation 17 (High priority) The FMOH should ensure</p>	<p>When we reprogrammed budget intended for DDT (insecticide) warehouse to health center project considering the two are in the same cost center. By then,</p>		

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<p>that in future all material reprogramming is undertaken in accordance with the requirements of the Global Fund Secretariat, as indicated in the grant agreement.</p>	<p>there was no percentage set that limits material reprogramming before October 2010. However, the reprogramming was done according to the procedure of the Global Fund and has been approved by the CCM/E. But communicating this to the GF Secretariat for approval was made lately. Thus, in the future, the FMOH will ensure that all steps are completed before implementing the reprograms.</p> <p>Action Plan: Letter of notification will be issued to federal institutions, regional health bureaus and SRs advising them not to make any material reprogramming without getting preapproval from the GF.</p>	FMOH	January 2012
<p>Recommendation 18 (High priority) The FMOH should ensure that inter-grant borrowings are avoided and that disbursement requests are aligned to the timing of activity implementation.</p>	<p>The PR will avoid inter-grant borrowings/lending. However, as GF programs are fighting with the most life-devastating diseases, the PR still suggests if inter-grant borrowings/lending could be allowed in unforeseen circumstances as far as the purpose is for those activities already agreed upon by both the GF and the PR.</p> <p>Action Plan: Letter of notification will be issued to federal institutions, regional health bureaus and SRs advising them not to authorize inter-grant borrowings/lending.</p>	FMOH	January 2012
<p>Recommendation 19 (High priority) The FMOH should undertake to close-off all grants that have expired.</p>	<p>The PR/FMOH is working to close the grants in consultation with the GF Secretariat.</p> <p>Action Plan: The closure of the expired grants will be concluded shortly.</p>	FMOH with Secretariat	March 2012
<p>Recommendation 20 (High priority)</p>	<p>(a) The FMOH has noted the issue and has already introduced Peachtree Accounting software for recording of</p>		

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>The FMOH should:</p> <p>a) Ensure that Global Fund grant transactions are recorded in a robust accounting package, in order to provide an appropriate audit trail, better data integrity and security, and improved reporting.</p> <p>(b) Ensure the reconciliations for cash and bank, and program disbursements are regularly prepared and reviewed, and all reconciling items are properly followed up. This is particularly important for key accounts such as UNICEF and PFSA. Additionally, training and capacity building on record keeping should be provided at the FMOH, regions, zones and woredas as necessary to ensure all ledgers are properly maintained and reconciled.</p> <p>(c) Ensure the funds disbursed to Ethiopian Paediatrics Society are returned to the Global Fund</p>	<p>all GF financial transactions since July 8, 2010.</p> <p>Action Plan: The system will be strengthened taking into consideration the new system being under test at national level.</p> <p>(b) The PR always performs cash and bank reconciliations. Balance reconciliation with PFSA is regularly underway. Balance reconciliation with UNICEF is also done but still need to be improved. Capacity building training to FMOH accountants is being undertaken at national level at MoFED. Moreover, at the Federal Office, four technical assistances are hired to build the capacity of finance staff and to improve the financial management system. Similar training to regions, zones and woredas has also been given by a consulting firm named ABCON PLC. In this regard, the PR is reviewing the performance of the consultant and the impact of its involvement. Areas that need additional intervention will also be assessed and addressed.</p> <p>Action Plan: The reconciliation of cash and advance balances will be continued by focusing on improvements.</p> <p>(c) The payment that was made to the Ethiopian Paediatrics Association was in the form of refundable from GAVI and therefore has already been reimbursed to GF.</p> <p>Action Plan: Already performed.</p>	<p>FMOH</p> <p>FMOH</p> <p>FMOH</p> <p>FMOH</p>	<p>Done</p> <p>Ongoing</p> <p>Done</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

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<p>program bank account and are used only for the activities approved in the Malaria R8 work plans.</p> <p>(d) Keep records of the proof of delivery to the ultimate recipients for the distribution of commodities, such as bed nets distributed by UNICEF.</p> <p>(e) Strengthen controls over the disbursement process to ensure the correct bank accounts are used to make disbursements.</p> <p>(f) Follow-up and liquidate all long-outstanding advances.</p> <p>(g) Refund to the Global Fund the total of USD112,287 of outstanding advances to various regions and SRs related to the expired</p>	<p>(d) Comment accepted and will be implemented accordingly.</p> <p>Action Plan: The PR will put in place a system that proofs the delivery of commodities to the ultimate recipients.</p> <p>(e) The PR is always aware of the need of control over the correctness of bank accounts. So, the PR will continue ensuring as suggested.</p> <p>Action Plan: The control system over disbursements that are made through banks will be more strengthened and adhered to.</p> <p>(f) The management of the PR has already introduced a bi-weekly meeting where the liquidation status of all disbursements and all grants are discussed on and necessary decisions are made on the problem areas.</p> <p>Action Plan: The PR will take necessary legal actions on all long outstanding advances.</p> <p>(g) Out of the mentioned amount for refund, USD 54,005 was utilized before the expiry of the grants but the SoEs lately arrived from regions due to communication problems (see Document 1 for the expenditure of USD 54,000); USD 15,977 that is said to be the outstanding balance with Addis Ababa University under TB Round 1 is not correct as the PR has never disbursed fund to the university from TB Round 1 grant. Thus, the PR agrees to</p>	<p>FMoH</p> <p>FMoH</p> <p>FMoH</p> <p>FMoH and regions</p>	

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
grants: Malaria Round 2 and TB Round 1.	refund GF the remaining balance amounting to USD 96,307 only. Action Plan: Once agreed with the OIG/GF on the refundable amount, the PR will shortly make the refund soon.		
<p>Recommendation 21 (High priority) The FMOH should consider the following actions to ensure more timely annual financial audits:</p> <p>(a) Ensure that books of account at the PR and SRs, and the financial statements, are ready for audit on a timely basis.</p> <p>(b) Hold discussions with the Audit Services Corporation to explore the possibility of:</p> <p>iii. Carrying out interim audits before the financial year end so that a smaller, more manageable scope of work is left at the end of the year.</p> <p>iv. Adopting a risk-based approach whereby audit effort is focused on regions and SRs that are assessed as higher risk. Audit of lower-risk entities and regions could be carried out on a rotational basis.</p>	<p>The PR has accepted the recommendation and:</p> <p>(a) Already deployed its staff members to ensure the readiness of financial statements at all levels for the years ended 7 July 2010 and 7 July 2011.</p> <p>Action Plan: Pre-audit preparations will be always made ahead of the auditing time.</p> <p>(b) held discussion with the Office of Federal Auditor General (OFAG) and Audit Services Corporation (ASC) early August 2011 and agreed to:</p> <p>iii. Undertake interim audits as recommended;</p> <p>iv. Adopt a risk-based approach and auditing on rotational basis of those entities at lower risk. In this regard, the ToR for the two years audit is already submitted to the ASC and to the GF/LFA for comments.</p> <p>Action Plan: The PR seeks comments from the GF/LFA and the ASC on the audit ToR that is already submitted and will act accordingly.</p>	FMOH	

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<p>Recommendation 22 (High priority) HAPCO should: (a) Ensure formal Global Fund approval is obtained before making any material changes to grant budget and work plans in the future. (b) Seek to rectify the defects of the health centers constructed so as to ensure the proper provision of health services, including those related to HIV, TB and Malaria.</p>	<p>There was no limit to materiality reprogramming prior to October 2010. When need arises, prior to any change above the 10% of the budget of a given SDA , HAPCO will request formal reprogramming through the CCM and will implement it provided that it was approved by the GF Secretariat and TRP.</p> <p>With the support of the GF HIV grants 1309 health centres have been constructed. Out of these 1126 (85.1%) were provisionally accepted whereby most of them started to provide services. There is a one year defect liability period (guarantee) for which 2.5% of the contractor’s payment is withheld. If there are any defects within one year period, the contractor will rectify. For instance, from the visited 77 health centers by the OIG Auditors, at the time of visit, none of the health centers had been subjected to the final acceptance. At the time of writing this response, of the 77 health centres visited, 73 have provisionally accepted of which 51 have in mean time undergone successfully the Final Acceptance. That means that cracks and roof leakages have been rectified. The remaining 196 will be provisionally accepted by June 2012. Most of the cracks and roof leakages identified by the OIG team were rectified by PMU/FMOH and the contractors. Most of the required equipment for 2594 health centres was procured in the past few years with the fund obtained from development partners - MDG pooled fund, PBS/MDTF-World Bank, GAVI and others. So far PFSA has distributed medical equipment for about 2104) newly constructed health centres.</p> <p>The HC construction project management unit in the MOH has a quality control tool with clear indicators of quality. In</p>		

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	<p>HCs might be electrified). All these efforts will ensure the availability of clean running water and power supply in the health centers.</p>		
<p>Recommendation 23 (High priority) As a lesson learned the Global Fund Secretariat should in the future ensure all Global Fund policies and procedures are followed with regard to changes to implementation plans. In particular, the Global Fund Secretariat should:</p> <p>(a) Formally approve all material budget changes during grant implementation. In practice, material budget changes are now typically defined as any amount greater than 10% of the annual approved service delivery area budget line or an absolute threshold to be determined in the context of the grant by the Country Team (Paragraph 30, Guidelines for Budgeting in Global Fund Grants (version</p>	<p>CCM/E and the PRs will follow this reprogramming procedure whenever they have such request.</p>		

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>15 August 2011)).</p> <p>(b) Refer to the TRP for review any:</p> <p>i. Material change to the scope and/or scale of a Performance Framework which shifts the balance of program activities (Paragraph 6, OPN on Changes to Scope and or Scale of Performance Frameworks (Issued 12 July 2011)).</p> <p>ii. Significant change to targets for an output indicator that measures health system strengthening, such as infrastructure construction/rehabilitation, if such activities are a key component of the proposal (Paragraph 9 (vi), OPN on Changes to Scope and or Scale of Performance Frameworks (Issued 12 July 2011)).</p> <p>(c) Ensure appropriate amendment is made to the grant agreement in cases where the changes in implementation plans will lead to substantive changes</p>			

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>to the budget and performance framework (Section IV.10.1, Operational Guide, The Key to Global Fund Policies and Processes (version 15 August 2011)).</p>			
<p>Recommendation 24 (Significant priority) HAPCO should ensure that OI drugs are available in hospitals and health centers. The procurement and supply management arrangements for OI drugs should be strengthened as necessary. Consideration could be given to enhancing coordination with the civil society players, such as EIFDDA and NEP+, to monitor and report forecasting and supply challenges.</p>	<p>At the time of the OIG audit OI drug procurement, which worth about US 11 Million was on process. The procured OI and STI drugs were distributed immediately and the problem was addressed. Joint quantification of ARV drugs, OI drugs and Health commodities was done in August 2010. Based on this the PSM plan was revised and approved by the GF Secretariat. Following this additional procurement of OI drugs, which worth US14.5 million, is initiated. In the quantification MOH, PFSA, health professionals working in the health facilities, Regional Health bureaus, CDC, USAID, SCMS, PEPFAR, WHO and other relevant stakeholders participated. Furthermore, the multi-tier distribution system has been reviewed and PFSA arranged an integrated distribution for all health commodities and drugs including drugs for OI which will address the stock out of OI drugs.</p> <p>Action Plan</p> <ul style="list-style-type: none"> i) Strengthen the drug and therapeutic committee in each health facilities so as to know the actual needs and improve the pull system. ii) Extend the Integrated pharmaceutical logistic system (ILPS) implementation from 200 HF to all ART sites by 2012 and to non-ART sites by mid 2013 through building the capacity of health facilities. iii) Update Quantification documents annually and 	<p>PFSA</p> <p>PFSA</p> <p>PFSA</p>	<p>June 2012</p> <p>2012 and 2013</p> <p>March 2012</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	revise procurement supply management plan of drugs including OI.		
<p>Recommendation 25 (Significant priority) HAPCO should ensure:</p> <p>(a) Systematic supportive supervision is provided to the HEWs with regard to the planned interventions.</p> <p>(b) Activities carried out by HEWs are broken-down in sufficient detail, along with expected deliverables for each activity, to enable their close supervision and monitoring.</p> <p>(c) Adequate documentation of community conversations and other advocacy activities undertaken by HEWs to enable systematic monitoring.</p>	<p>Ministry of Health has currently redesigned the process and given the supervision mandate to each health center. The health professionals in each health center have Shared their respective satellite health posts. Each health center is providing supportive supervision every week to their five satellite health posts where the HEWS are deployed. The overall process is over sighted according to Shared tasks at federal, regional, zonal and woreda levels based on standard agreed upon supervision checklists. There has been system for documenting community Conversations and to further strengthen the system a community information system has also been Developed and piloted. When HEWs are deployed they are provided with Health extension implementation manual which clearly depicts what to do and how to do the expected deliverables.</p> <p>Action plan</p> <p>a) All health posts, where health extension workers base, will be supervised by the health centers by the new supervision arrangement, which was discussed above, by end of 2012</p> <p>b) refer to response to recommendation 60</p> <p>c) Implement the new piloted CIS in full scale in all regions.</p>	<p>Health promotion and Disease Prevention Directorate, FMOH</p> <p>Plan and M&E directorate, FHAPCO.</p>	<p>December 2012</p> <p>March 2012</p>
<p>Recommendation 26 (Significant priority)</p>	Ministry of Health has designed and started implementing a		

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>HAPCO should ensure that treatment adherence, which starts at the facility level, is systematically linked with HEW activities and has strategic involvement of CHWs and PLHIV volunteers.</p>	<p>29 days integrated refresher training (IRT) for HEWs which has four phases (HIV/AIDS & TB; MNCH, ICCM and EPI and First aids). The HIV/AIDS and TB component of the training is a six days training and focuses on HIV/AIDS and TB prevention , care and treatment education including, referral for counseling & testing, TB suspected individuals, adherence education etc. Community promoters or facilitators were trained with the grants. Recently the government initiated a new approach called health development army whereby 150- 200 households are trained as leaders of the one to five communities networking approach to create demand and maximize service utilization including HIV services.</p> <p>To improve counseling and treatment adherence HIV positive women support group were established in many urban health facilities and also expert patients (PLHIV) were recruited in a good number of health facilities.</p> <p>Action plan</p> <ul style="list-style-type: none"> ➤ Strengthen the already in place system of adherence education and defaulter tracing through involving HEWs, community volunteers, Health development army , women support group and PLHIV. 	<p>Health promotion and Disease prevention Directorate of the nine regional state and two city administration health Bureaus.</p>	<p>On progress</p>
<p>Recommendation 27 (High priority) HAPCO should:</p> <p>(a) Commission a study to suggest steps to improve ANC coverage and PMTCT implementation.</p> <p>(b) Ensure the quality of</p>	<p>HAPCO had already commissioned universities to undertake a study on bottlenecks for PMTCT. Until then concerted efforts are under way. To this effect an Accelerated PMTCT plan was launched on 4th December 2011 prior to the opening ceremony of the 16th ICASA Conference The country has adopted the 2010 WHO PMTCT guideline. Provision of training on the new guideline and implementation based on this guideline has been started.</p>		

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>PMTCT services is standardized through the development of guidelines, as well as the provision of supportive supervision.</p>	<p>Action plan</p> <ul style="list-style-type: none"> ➤ Accomplish the ongoing study and revise the accelerated action plan accordingly. ➤ Supervise the implementation of the new PMTCT guideline in all PMTCT service delivery sites. 	<p>FMOH/HAPCO</p> <p>FMOH/RHBs</p>	<p>December 2012</p> <p>continuous</p>
<p>Recommendation 28 (High priority) HAPCO should ensure the availability of pediatric ART and Cotrimoxazole prophylaxis alongside adult ART services at HCs.</p>	<p>As described above as a response to recommendation # 24, Joint quantification of ARV drugs, OI drugs, STI drugs, IP materials and rapid test kits was done in August 2010. In this exercise pediatric ARV and co-trimoxazole prophylaxis were included. The PSM plan of the RCC grant was amended and approved the GF Secretariat accordingly. Previously Co-trimoxazole for prophylaxis was procured by PEPFAR and GF grant while pediatric ARVs were covered by Clinton health Initiatives. Currently there is adequate stock of pediatric ARV drugs and co-trimoxazole.</p> <p>Action plan</p> <ul style="list-style-type: none"> ➤ Pediatric ARV drugs and Co-trimoxazole Prophylaxis will be made available to all ART sites as part of the Integrated Health commodities and drug distribution system. 	<p>PFSA & FMOH</p>	<p>July 2012</p>
<p>Recommendation 29 (High priority) In its role as PR and national coordinator for HIV programs, HAPCO should: (a) Ensure that the work plans at regional, zone, and woreda levels incorporate the objectives, activities,</p>	<p>The Work plan and grant agreement entered between FHPACO and Regions had indicated clearly the objectives, SDAs and activities. When regions cascade these into zones and Woredas some regions have been incorporating the objectives, SDAs and activities while other have not done. To address this and strengthen M&E of the grants a training was given to 63 staff of regional health Bureaus and RHAPCOs from 2 - 4 November 2011.</p>		

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<p>eliminating aggregation errors, especially at the peripheral levels from patient registers in health facilities and woredas.</p>	<p>bureaus and ministry of health. The aggregation module has been tested and evaluated. For this purpose: 1456 computers were purchased and distributed and the procurement of 4172 computers underway. Data quality checking system has been in place; as a result each health facility has established performance review team that checks data quality every fifteen days. The woreda health office and regional health bureaus are supervising the process according to the module Electronic HMIS is also on pilot phase- It is piloted in Addis Abba and Oromia and now it is under revision based on the pilot finding.</p> <p>Action plan</p> <ul style="list-style-type: none"> Implement fully the data quality checking system in all health facilities. 	<p>HMIS case team, FMOH</p>	<p>June, 2012</p>
<p>Recommendation 32 (Significant priority) HAPCO should discourage the practice of collecting data over the telephone and put in place mechanisms for timely data reporting from health facilities in order to strengthen the quality of data at all levels.</p>	<p>The comment is well accepted. As part of institutionalizing HMIS, three hundred generic Health Informatics Technicians were graduated after completing a three years of training and deployed in health facilities. In addition 3424 are on training all of whom will graduate by 2013. This will greatly improve data collection, compilation, timely reporting and avoids use of telephone for data collection. More over schedule of submitting report at each level has been stated in the HMIS guideline</p>	<p>HMIS case team, FMOH</p>	<p>On progress</p>
<p>Recommendation 33 (High priority) HAPCO should: (a) Take measures to recover the USD1,323,627 of funds spent on ineligible expenditure and return them</p>	<p>Out of the USD 1,323,627 stated as ineligible expenditure, USD 982,384 (ETB 9,823,841) was recovered so far and returned to the HAPCO Global fund account. The remaining (USD 341,243) ineligible expenditures is in two SRs and HAPCO is currently on process to collect these from the Ministry of Women, Children and Youth Affairs and National Women’s Coalition Against HIV/AIDS</p>		

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<p>to the Global Fund program accounts for grants that are still active, or directly to the Global Fund for grants that are closed. (b) Ensure VAT, and other ineligible expenditure, is not charged to the grant programs in the future.</p>	<p>The Grants are free of VAT, but the working modality is on reimbursement from the Ministry of Finance and Economic Development (MOFED) on a monthly basis. All implementers have been communicated not to charge VAT to the grant programs. Starting from July 2010 VAT payment is being recorded as a receivable and request for reimbursement is being presented to MOFED on monthly basis</p> <p>Action Plan a) To use USD 1,323, 627 to implement Community system and MARP related activities of the RCC grant. b) Follow SRs to record VAT as receivable and collect monthly from MOFED as reimbursement.</p>	<p>Administration and Finance Directorate, HAPCO</p> <p>HAPCO, SR and SSRs.</p>	<p>31 May 2012</p> <p>December2012.</p> <p>Continuous process</p>
<p>Recommendation 34 (High priority) In order to improve controls for budget preparation and monitoring, HAPCO should: (a) Enhance budget control and monitoring by ensuring the preparation of activity-based budgets, along with detailed supporting calculations including unit types, unit costs, and assumptions. (b) Ensure that the charts of accounts in the accounting system is able to adequately capture and report the</p>	<p>There was activity based budget, but no adequate budget control on implementation. Training was given twice on budget control and recording expenditures based on the cost category in the approved grant. The detail activity cost of the cascaded activities and approved training plan of the RCC phase 1 year 3 (2011 plan) along with all cost breakdowns were shared to SRs and also were oriented in the November 2011 training. As per the cost category in the RCC grant the chart of accounts was already modified and started the implementation to adequately capture and report the budgets and related expenditures for the approved RCC grant.</p> <p>Action plan a) Ensure the availability of fund for the specific</p>	<p>Administration and</p>	

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>budgets and expenditures related to the approved grant budgets and work plans.</p> <p>(c) Prepare and review budget and work plan monitoring reports on at least a monthly basis in order to identify and follow up on unexpected deviations.</p>	<p>activity in the approved work plan and budget prior to implementation.</p> <p>b) Review monthly the expenditure for the Implemented activities against budget in the approved work plan.</p> <p>c) Prepare a report on periodic review of budget monitoring reports by the PR and share to the PGMC, Director General and Deputy Director General of HAPCO. Copy of recommendation 33 though not related</p>	<p>Finance Directorate, HAPCO</p> <p>HAPCO, SR and SSRs.</p>	<p>Continuous process</p>
<p>Recommendation 35 (High priority)</p> <p>In order to ensure the proper management of advances, HAPCO should:</p> <p>(a) Verify SOEs submitted by SRs to confirm the validity of amounts reported and adequacy of the supporting documentation.</p> <p>(b) Monitor outstanding advances to SRs and follow up on a timely basis.</p> <p>(c) Refund to the Global Fund, the Round 4 grant balance of USD</p>	<p>HAPCO recruited additional accountants to strengthen the verification of SOR submitted by partners.</p> <p>Action plan</p> <p>a) HAPCO will do verification on all SOE received from SRS at the Federal and sample verification on SOE collected from regions.</p> <p>b) Aging analysis will be done by the finance section of the PR, SRs and SSR s monthly and will be presented to the management bodies of the PR, SR and SSRs to address bottle necks and speed up the implementation, utilization and settlement of advances.</p> <p>c) Will refund US\$ 5,591,051 which was not approved in the R4 grant closure plan.</p>	<p>HAPCO (Finance and Admin.), SRs and SSRs.</p>	<p>March 2012</p> <p>April, 2012</p>

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
5,591,015.31.			
<p>Recommendation 36 (High priority) HAPCO should consider the following actions to ensure more timely annual financial audits:</p> <p>(a) Ensure that books of account at the PR and SRs, and the financial statements, are ready for audit on a timely basis.</p> <p>(c) Hold discussions with the Audit Services Corporation to explore the possibility of:</p> <p>i. Carrying out interim audits before the financial year end so that a smaller, more manageable scope of work is left at the end of the year.</p> <p>ii. Adopting a risk-based approach whereby audit effort is focused on regions and SRs that are assessed as higher risk. Audit of lower risk entities and regions could be carried out on a rotational basis.</p>	<p>Discussion with the Audit Service Corporation was held in the presence of the Federal Auditor General early August 2011 and consensus was reached to conduct an audit by adopting a risk-based approach and audit of lower risk entities and regions could be audited on a rotational basis.</p> <p>Action Plan</p> <ul style="list-style-type: none"> ➤ Starting from the year 2011/12, by strengthening the finance unit of PRs and SRs, financial statement will be prepared and submitted to the external audit within three months. 	<p>HAPCO(Finance &Administration directorate)</p>	<p>For the year ended July 8, 2012.</p>
Recommendation 37			

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<p>(Significant priority) HAPCO should consider the following actions in order to enhance the effectiveness of the internal audit function: (a) In accordance with best practice and to achieve organizational independence, ensure the internal audit function reports functionally to the Board, with administrative reporting to the Director General. (b) Ensure the regions are included in the internal audit risk assessment. All institutions and regions assessed to be high risk should be included in the audit plan, with additional internal audit resources being provided as necessary to ensure completion of the plan. (c) Ensure internal audit reports include the following elements in response to each recommendation: remedial actions; persons responsible to carry out the actions; and deadlines for completion of actions. The internal audit</p>	<p>According to the Federal Government of Ethiopia Financial Administration Proclamation No. 648/2009 Article 7 Sub Article 1(a), “the internal audit of public bodies shall be responsible for submitting audit reports to the head of the public body and to the Ministry of Finance and Economic development.” As HAPCO is a public body, the internal audit will be accountable to the Director General of HAPCO. (Refer Financial Administration Proclamation No 648/2009) Action plan a) The internal audit will incorporate regions and institutions on its risk assessment. Based on the assessment, high risk institutions and regions will be included in the annual internal audit plan. The internal audit will be strengthened further by deploying necessary human resources to ensure the completion of the plan. b) The action plan will be prepared and follow up will be made as per the recommendation starting from now onwards.</p>	<p>HAPCO (Internal Audit)</p>	<p>January,2012</p>

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<p>function should follow up to ensure remedial actions have been effectively implemented.</p>			
<p>Recommendation 38 (High priority) In order to enhance governance, the HAPCO Board should: (a) Ensure a conflict of interest policy is established for the Board in order to ensure that the interests of the PR prevail in Board decision making. (b) Ensure board meetings are held on a monthly basis as stipulated in the Proclamation. This will ensure that important program performance issues are discussed and dealt with by the Board in a timely manner. (c) Consider establishing board committees based on the needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure</p>	<p>The board at national level is not involved in allocating global fund resources; it oversees the overall multi-sectoral HIV/AIDS response. The power and duty of the management board as stated in the proclamation 276/2002 does not require the establishment of separate technical committees under the board. Discussion is undergoing to revise the frequency of meeting from monthly to three times per year. It is the CCM that will oversee the implementation of the grants. The CCM has also the policy on management of conflict of interest. (Refer to the proclamation 276/2002)</p> <p>Action plan</p> <p>Board Meetings will be convened two to three times per year.</p>		

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up.</p>			
<p>Recommendation 39 (Significant priority) EIFDDA should ensure: (a) Alignment of social mobilization activities (i.e. community conversations sites) and OVC support activities such that communities sensitized through community conversations adopt and support OVCs that were initiated into the Global Fund funded program. (b) Adequate coordination with HAPCO through periodic coordination meetings to address program implementation disparities and challenges such as the lack of alignment of social mobilization activities and OVC support activities.</p>	<p>In its phase II plan EIFDDA did the alignment and all OVC support districts now have Community Conversations except very few OVC support districts that don't have community conversation.</p> <ul style="list-style-type: none"> • HAPCO is involved in review meetings of EIFDDA Global Fund program and involved in all OVC committees at districts level <p>Action Point</p> <ul style="list-style-type: none"> ➤ Continued follow up and constant improvement of the coordination with HAPCO is in progress 	<p>Done by EIFDDA Global Fund Program Manager</p>	<p>Completed and the follow up is a continuous work</p>
<p>Recommendation 40 (Significant priority)</p>	<ul style="list-style-type: none"> • EIFDDA developed Project Implementation Manual (PIM) with standard criteria for OVC selection and disseminated 	<p>Done by EIFDDA Global Fund Program Manager</p>	<p>Completed</p>

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>EIFDDA should improve the performance of OVC care and support by:</p> <p>(a) Disseminating the guidelines and criteria to be used for the selection of OVCs, while allowing for variations to accommodate local needs.</p> <p>(b) Ensuring records supporting the OVC selection processes are properly maintained by the SRs.</p> <p>(c) Implementing a mechanism to verify the number of OVCs reported by SRs.</p> <p>(d) Providing guidance on amounts to be given for educational and nutritional support, and whether this is to be provided in cash or in kind.</p>	<p>to all SRs and SSRs.</p> <ul style="list-style-type: none"> • All SRs and SSRs were informed in record keeping of the selection process of OVC and it has been improved in 2011. • Onsite data verification formats were developed by EIFDDA and are on use currently as part of M&E • OVC service standard and quality improvement guideline was adopted by EIFDDA and addressed the kind of support to be given to the OVC. Three days training was also given to all SRs and SSRs. 	<p>and M&E Service Head</p>	
<p>Recommendation 41 (Significant priority) EIFDDA should:</p> <p>(a) Disseminate selection criteria for IGA support and guidance on amounts to be given as seed money, while allowing variations to accommodate local needs.</p>	<ul style="list-style-type: none"> • The PIM developed to standardize the Global Fund Program in EIFDDA addressed the selection criteria for IGA beneficiaries. • The amount allocated for IGA is specified in the project proposal already. • All the business skill trainings are recommended to all SRs to be conducted with the government small and micro-enterprise office 	<p>EIFDDA Global Fund Program Manager and M&E Service Head</p>	<p>Recommendation d & e are completed and preparation of account books, stocks and cash-records shall be completed by February 28,2012</p>

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>(b) Ensure standardization of vocational training protocols as well as training quality. (c) Ensure standardization of processes for documenting IGA activities, including books of account, and stock and cash records.</p>	<ul style="list-style-type: none"> • Keeping the standard records of the IGA have been agreed with the all SRs and made as part of the agreement issue in phase II. <p>EIFDDA is preparing books of account, stock and cash records.</p> <p>Action Points</p> <ul style="list-style-type: none"> ➤ Preparation of account books and stock and cash records 		
<p>Recommendation 42 (Significant priority) EIFDDA should obtain the necessary technical assistance to develop a “minimum essential package” of support to OVCs, and the frequency of its provision. It will then be possible to revisit indicators and targets in the light of this package, and also provide clarity to implementers on the reporting of this set of data.</p>	<p>The quality standard and improvement guideline adopted by EIFDDA defined the critical minimum activities and packages to address the OVC needs and disseminated to all SRs. SRs and SSRs were also trained on this in 2011.</p>	<p>Done by EIFDDA Global Fund Program Manager and M&E Service Head</p>	<p>Completed</p>
<p>Recommendation 43 (Significant priority) EIFDDA should obtain necessary technical assistance to ensure that the M&E software is fully functional and put to the use intended.</p>	<p>The M&E software, especially the data base system was put in place and now it is made functional with entry of updated information of beneficiaries and activities. Reports are generated in SRs with more than 80% of the data in all SRs Regular follow up is planned to be made</p> <p>Action Plan</p>	<p>EIFDDA M&E Service Head</p>	<p>Completed and the full functionality will be followed up to March 31, 2012.</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>Recommendation 44 (Significant priority) With respect to data quality, EIFDDA should ensure: (a) Mandated quarterly reporting cycles are observed for all SRs and SSRs. (b) Uniform data collection formats are used across all the SRs and SSRs. Data collection should be closely supervised and technical assistance provided by EIFDDA and SRs when needed. (c) Timely and accurate reporting by all SRs and SSRs, with supportive supervision being provided by EIFDDA and SRs as necessary.</p>	<p>➤ Follow up of the functionality of the system</p> <ul style="list-style-type: none"> • The quarterly reporting schedule was made part of the phase II agreement document EIFDDA entered with the SRs and there is an improvement in January to June 2011 reporting period. • Standard data reporting formats were distributed to all SRs and SSRs as an annex of the agreement document in phase II • Reporting deadlines were also agreed as part of the agreement document. In 2011 supportive supervisions to SRs and SSRs have been made. The reporting in 2011 improved very well. • All SRs have strengthened their M&E for their SSRs Additionally EIFDDA hired two additional M&E staff 	<p>Done by EIFDDA M&E Service Head</p>	<p>Completed</p>
<p>Recommendation 45 (Significant priority) The EIFDDA should ensure: (a) Uniform and standardized systems and processes for data validation are put in place at PR, SR and SSR levels. (b) Data validation includes visits as necessary to verify data collection mechanisms</p>	<p>Routine data quality verification tool was developed and piloted Data validations and verifications were made as part of the routine M&E in EIFDDA and these have been started in 2011 intensively by EIFDDA at SRs and SSRs level.</p>	<p>Done by EIFDDA M&E Service Head</p>	<p>completed</p>

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and validity of the reports submitted.			
<p>Recommendation 46 (High priority) EIFDDA should ensure the Global Fund HIV taskforce is effective in overseeing the implementation of the Global Fund work plan and reviewing SR performance. This taskforce should meet monthly, as required by the EIFDDA grant implementation manual.</p>	<p>The Task force doesn't have this mandate of overseeing the in 2011 the Task force developed annual meeting plan and meets every month.</p>	<p>EIFDDA Global Fund Program Manager and M&E Service Head</p>	<p>Completed</p>
<p>Recommendation 47 (Significant priority) The EIFDDA should improve supervision by: (a) Developing a standardized system of supervision including uniform checklists and feedback protocols to be used by all the SRs and SSRs. (b) Ensuring of all aspects of supervision are properly documented at the SR and SSR levels.</p>	<p>All SRs developed their M&E plan and submitted to EIFDDA M&E visits were included in the performance indicators of the Global Fund and all SRs are properly documenting and reporting to EIFDDA in phase II.</p> <p>Action Point</p> <ul style="list-style-type: none"> ➤ Standard M&E checklists with feedback forms will be developed by EIFDDA and disseminated to all SRs. 	<p>EIFDDA M&E Service Head</p>	<p>March 31,2012</p>
<p>Recommendation 48 (High priority) With regard to the accounting software, EIFDDA</p>	<ul style="list-style-type: none"> • EIFDDA uses user profile and password in Peachtree accounting software. • All transactions are reviewed by the Finance and 	<p>Done by EIFDDA Administration and Finance department Head</p>	<p>March 31,2012</p>

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<p>should ensure:</p> <p>(a) Access controls are properly set up, including passwords and user profiles.</p> <p>(b) Audit trail capabilities of the software are fully enabled.</p> <p>(c) Implementation of budget monitoring using the software. In the meantime, any manually prepared budget versus actual analysis should be reviewed to ensure against errors and omissions.</p> <p>(d) All transactions input to the system are reviewed for accuracy and completeness before posting.</p> <p>(e) Expenditure reported in the PUDR is always reconciled to the expenditure per the accounting system.</p>	<p>administration department head before posting to the software.</p> <ul style="list-style-type: none"> • Expenditure in the PUDR are reconciled at EIFDDA level and the report from SRs Also Checked against the financial document subsequently <p>Action Point</p> <ul style="list-style-type: none"> ➤ Budget monitoring and Budget performance report will be started as of 2012 budget year in accounting software 		
<p>Recommendation 49 (High priority)</p> <p>EIFDDA should:</p> <p>(a) Orient SRs on the Global Fund guidelines for annual external audits and develop a plan with the SRs for how the audits will be undertaken.</p> <p>(b) Withhold disbursements</p>	<p>SRs were oriented in review meetings in 2011 and plans are developed and submitted to Global Fund.</p> <p>Withholding transfer is agreed for those who don't meet the agreed deadline in the plan but in 2011 all undertook as per their plan.</p>	<p>Done By EIFDDA management</p>	<p>Completed</p>

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to an SR where the external audit for this SR has not been completed within the defined time.			
<p>Recommendation 50 (Significant priority) (a) EIFDDA should consider enhancing the effectiveness of the internal audit function by:</p> <ul style="list-style-type: none"> i. Implementing an internal audit charter approved by the Board, and covering the purpose, authority and responsibility of the internal audit function. ii. Ensuring the establishment of a risk-based internal audit plan that includes coverage of important areas such as program implementation. iii. Encouraging the implementation of professional standards such as the authoritative guidance of the Institute of Internal Auditors. <p>(b) EIFDDA should ensure that internal audit work performed is guided by audit programs and is properly</p>	<p>EIFDDA developed draft Audit manual assisted by UNAIDs/ TFS for and it will be approved by Board on the next Board meeting and all issues on the internal audit process will be addressed within the manual framework.</p> <ul style="list-style-type: none"> • The risk based audit plan was developed and submitted already. • Comment on maintaining professional standard is accepted and will be addressed when the audit manual development is completed <p>Action Points</p> <ul style="list-style-type: none"> ➤ Finalization of the draft Audit Plan with Board approval ➤ Maintain professional standard for Audit with the audit manual 	EIFDDA Management and internal Auditor	March 31,2012

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
recorded in work papers.			
<p>Recommendation 51 (High priority) EIFDDA should ensure that EMDA addresses the many financial management issues noted during the OIG audit, and should consider withholding funding to EMDA until this has been accomplished. In particular, the SR should return to EIFDDA the USD295,984 of expenditure that was found to have no supporting documentation, and the funds should be returned to the grant bank account. In addition corrective action should be taken by EIFDDA to ensure:</p> <ul style="list-style-type: none"> (a) Adequate supporting documentation for expenditure, and adequate filing system. (b) Accurate and timely financial reporting, using required formats. (c) Preparation of bank reconciliations. (d) Maintenance of Global Fund grant funds in a separate bank account. 		The supporting document and expenditure of EMDA was settled for the amount stated on recommendation	Completed

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<p>(e) Improved controls over cash handled by program staff and advances to staff. (f) Introduction of a policy for per diems. (g) Improved budget monitoring and control.</p>			
<p>Recommendation 52 (High priority) EIFDDA should ensure that EOC-DICAC: (a) Follows up and ensures proper liquidation of all outstanding staff advances. (b) Performed a reconciliation of advances to SSRs, funds accounted for by SSRs, and available cash book and bank balances. All outstanding advances should be followed up and properly liquidated.</p>	<p>To strength the Financial system, EIFDDA permitted additional finance staff to be employed by EMDA</p>		<p>Completed</p>
<p>Recommendation 53 (High priority) The EIFDDA Board should: (a) Include in its bylaws a conflict of interest policy to ensure that perceived or real conflicts of interest are dealt with appropriately. This should include the need for</p>	<p>EIFDDA has started the detail capacity assessment together with UNAIDS and the revision of manuals and guidelines will be dealt in the process.</p> <p>Action points</p>	<p>EIFDDA board and Executive Director</p>	<p>June 30, 2012</p>

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<p>board members who are also on the boards of SRs to declare their conflicts of interest and exclude themselves from board deliberations and decisions relating to their respective organizations.</p> <p>(d) Consider establishing board committees based on the needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up.</p>	<ul style="list-style-type: none"> • Finalization of the revision of the governance manual with the support of UNAIDS/TSF • Establish technical committee for program and finance by the Board 		
<p>Recommendation 54 (Significant priority) NEP+ should disseminate all the activities and processes of TLAE as indicated in the grant work plan, and in particular, ensure the involvement of private healthcare providers and civil society organizations. NEP+</p>	<p>The activities of Treatment Literacy and Adherence Education (TLAE) are being implemented in the private health care facilities as awareness creation service is being delivered there by TLAE promoters eg. Asser Hospital in Awassa.</p> <p>However, NEP+ agreed to make official the process through agreements/evidences.</p>	M&E Manager	March 31, 2012

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and the SRs should monitor and supervise implementation of the TLAE activities.			
<p>Recommendation 55 (Significant priority) NEP+ should improve the quality of community and home-based care (HBC) services by ensuring:</p> <p>(a) HBC sites receive regular supportive supervision from the SSRs and SRs. (b) Medical and non-medical kits are replenished on a timely basis. (c) A standardized training protocol is developed and disseminated for the volunteers. (d) Training is undertaken by master trainers and training manuals are provided to the volunteers trained. (e) Templates and necessary training are provided to the volunteers to ensure activities undertaken are properly documented.</p>	<p>(a) The supportive supervision is being done but not documented. Thus, the NEP+ planned to develop checklist which will be used at the SSR level to document the on-site supportive supervision.</p> <p>(b) The NEP+ recognizes that there was delay in procurement and disbursement of the HBC medical kits but not with the non-medical kits. The NEP+ recognises that there was delay in procurement of the medical kits.</p> <p>(c) The NEP+ has started to use the grant fund to develop audio-video interactive training material to be used as a standard and self update. Do all volunteers have access to audio-video capabilities?</p> <p>(d) Done: Delivering trainings by a master trainer and delivering training manual has been made the culture of NEP+ since the first draft recommendation of the OIG. This can be evidenced during the delivery of the palliative community home based care training to officers and providers.</p> <p>(e) The templates are available with the SRs/SSRs and NEP+ will make sure that all activities are recorded during supportive supervision.</p>	<p>M&E Manager</p> <p>Grant Manager</p> <p>Grant Manager</p> <p>Done</p> <p>M&E Manager</p>	<p>March 31, 2012</p> <p>Regularly</p> <p>March 31, 2012</p> <p>-</p> <p>March 31, 2012</p>

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<p>streams of interventions for care and support of PLHIVs (adherence education, home-based care, food and other support, and income generation activities). For example, individual beneficiary forms, such as ones being used currently for IGA beneficiaries, could be developed to collect data for PLHIVs that receive any intervention additional to adherence education. At the supervisor and project levels, lists of beneficiaries could be developed to map out who is receiving what intervention.</p>	<p>within the available grant services(IGA, Comaunity based Palliative Care, Food and Nutrition support, etc)”</p>		
<p>Recommendation 58 (Significant priority) NEP+ should: (a) During the next opportunity for revision, ensure the indicator on adherence education for ART (‘Number of people reached through adherence education’) is reworded to specify the numbers of PLHIVs reached through adherence education in order to provide a clearer picture of coverage.</p>	<p>(a) The objective of the TLAE reads as “Treatment Literacy and Adherence Education (TLAE) for PLHIVs, families and communities” which implies that it is to reach both the PLHIVs and the general population. The intention is that the PLHIVs will adhere to treatment and community members will be supportive to PLHIVs to be able to adhere to their treatment.</p> <p>(b) N/A because the objective of the TLAE is as stated above.</p>	-	-

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<p>(b) Revise data collection formats to include the reporting of the numbers of PLHIVs reached through this intervention. This data should ideally be incorporated into individual PLHIV forms.</p> <p>(c) Consider stipulating the number of household members to be reached for every PLHIV and their relationship to the latter.</p>	<p>(c) N/A because the objective of the TLAE is as stated above.</p>	<p>-</p> <p>-</p>	<p>-</p> <p>-</p>
<p>Recommendation 59 (Significant priority) NEP+ should consider the inclusion of outcome indicators that track the outcome of its interventions within its overall M&E framework, and thus provide a measure of NEP+'s contributions to the national-level outcomes.</p>	<p>The NEP+ has set two outcome indicators during this phase-2 grant agreement.</p> <ul style="list-style-type: none"> • Percentage of new clients with BMI <18.5 who have BMI >18.5 after six months of treatment and nutrition support • Percentage of PLHIV trained in business skills, obtained start-up capital and still have their own business six months after the initiation of the business activity 	<p>Done</p>	<p>-</p>
<p>Recommendation 60 (Significant priority) NEP+ should consider setting targets for supervisory visits and the content of the visits, and thus intensify the supervisory function from both the PR and SR levels.</p>	<p>The NEP+ will set a clearer target for the supervisory visits and communicate down to the SRs/SSRs.</p>	<p>M&E Manager</p>	<p>March 31, 2012</p>

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<p>Recommendation 61 (Significant priority) The NEP+ should ensure:</p> <p>(a) Data collection is closely supervised and technical assistance is provided by SRs and NEP+ when needed.</p> <p>(b) Timely and accurate reporting by all SRs and SSRs, with supportive supervision from NEP+ and SRs as necessary.</p> <p>(c) An appropriate level of standardization of data collection and reporting formats is implemented across all the SRs and SSRs, with the necessary guidance on this included in the grant implementation manual.</p>	<p>(a) Done: There is a practice for data quality check during supportive supervision. Reports are taken and the way it compiled will be analyzed; verification will done sample bases whether services are received or not during the SS.</p> <p>(b) Done: NEP+ has set an indicator on the timeliness of the reports during the phase-2 grant agreement</p> <p>(c) Done:</p>	<p>-</p> <p>-</p> <p>-</p>	<p>-</p> <p>-</p> <p>-</p>
<p>Recommendation 62 (Significant priority) The NEP+ should ensure:</p> <p>(a) Uniform and standardized systems and processes for data validation are put in place at PR, SR and SSR levels.</p> <p>(b) A comprehensive system of detailed documentation of all the data validation undertaken is established at</p>	<p>Done:</p> <p>(a) At the PR and SR level there is data base system with data validation rule on some aspects of the data recorded and reported. Moreover, the PR and SRs are conducting data quality checking during supportive supervision on regular bases. It was also intended that PR will use the internal auditor for further verification on a sample bases and based on the findings of supportive supervision.</p> <p>(b) NEP+ will make sure that data quality checks are well</p>		

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
all levels, with suitable templates developed and disseminated.	documented.		
<p>Recommendation 63 (Significant priority) NEP+ should include in the grant implementation manual, criteria for:</p> <p>(a) Identification, selection and assessment of SR and SSRs. (b) How grants programs and funds are to be allocated.</p>	<p>(a) NEP+ will refine its criteria for identification, selection and assessment of SRs and SSRs</p> <p>Done: (b) There are two answers provided in the grant manual for the question regarding how grant funds are to be allocated:</p> <ul style="list-style-type: none"> i. Based on pre-determined criteria (which includes proportion of positive population in the regions; Mandate of the entities; and capacity to implement) ii. NEP+ may call for proposal based on the direction from its Board) 	NEP+ M&E Manager	31st March 2012
<p>Recommendation 64 (High priority) The NEP+ monitoring and finance units should work together to ensure that their reports are well linked with respect to the indicators per the work plan to avoid inconsistencies in reporting and to ensure that all financial resources have been well accounted for and that disbursements are made based on correct reporting.</p>	<p>Done: The NEP+ has developed and distributed a template which requires the SRs/SSRs to analyse both physical targets as well as financial plan versus actual performance and variances in a single sheet.</p>	-	-
<p>Recommendation 65 (Significant priority)</p>			

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>SRs and SSRs. (b) Include guidance in the grant implementation manual regarding how capacity gaps should be identified and addressed. (c) Critically assess the shortfalls in the capacity building funds, identify the need for additional capacity building funds, and include this additional requirement in future proposals.</p>	<p>manual so that it will include how capacity gaps are assessed and how those gaps are addressed. (c) The NEP+ will conduct capacity assessment so that the capacity building budget is evidence based</p>	<p>Grant Manager Program and Admin & Finance Managers</p>	<p>March 31, 2012 June 30, 2012</p>
<p>Recommendation 68 (High priority) The NEP+ Board should: (a) Establish a conflict of interest policy to ensure that perceived or real conflicts of interest are dealt with appropriately. This should include the need for board members who are also on the boards of SRs to declare their conflicts of interest and exclude themselves from board deliberations and decisions relating to their respective organizations. (b) Consider setting up board committees based on the</p>	<p>(a) In interest of promoting greater Involvement of PLHIVs, most of the NEP+ Board members are from constituencies and they are SRs. In order to avoid conflict of interest, NEP+ will develop a policy that requires a Board member whose issue is being discussed to remove himself/herself from the meeting during that specific agenda. (b) Based on the preliminary draft, NEP+ has already proposed the sub-committees to the Board and waiting decision of the Board on the issue.</p>	<p>NEP+ Board & Executive Director Executive Director</p>	<p>March 31, 2012 March 31, 2012</p>

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<p>needs of the Board, such as committees for finance, audit, programs, or governance. These specialist committees, comprised of individuals with appropriate expertise, can help to ensure that matters of a technical nature receive due attention, and that Board decisions and recommendations receive due follow-up</p>			
<p>Recommendation 69 (High priority) The PFSA Board of Directors should be set up to oversee the activities of PFSA as stipulated in the Proclamation 553/2007 that established PFSA.</p>	<p>Board of Directors was already assigned.</p>	<p>NA</p>	<p>NA</p>
<p>Recommendation 70 (High priority) The PFSA should ensure: (a) PSM plans are updated to reflect the results of donor supported forecasting and quantification systems, and in particular, the results of the national forecasting and quantification exercise covering the HIV/AIDS, TB and malaria programs</p>	<p>The recent Joint quantification of ARV drugs, OI drugs, STI drugs and health commodities such as rapid test kits, IP materials etc was done in August 2011. As part of this exercise and during the RCC phase 2 preparation, the contribution of partners was worked out. What PEPFAR and GF will support is clearly indicated in the GF- PEPFAR support matrix for 2012. According to this the PSM plan for the HIV RCC grants was updated. As annual updating of the quantification document is required, a joint meeting is called for February 2012. PFSA is also on preparation to take over the</p>		

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conducted with support from USAID/SCMS.	quantification of anti malaria and TB drugs for which joint quantification exercise is scheduled for March 2012, so that PSM plan can be updated. Action plan Conduct the Joint quantification of anti malaria and TB drugs with the involvement of stakeholders and update the PSM plan.	Health promotion and disease prevention Directorate, PFSA (Forecasting and Capacity Building Directorate)	March 2012
(b) Procurement for Global Fund grant programs is carried out in accordance with the approved PSM plans.	PFSA has already started to stick and adhere to the approved PSM plan that it had received from the PRs. Whenever there is a need to adjust, it will request the PRs and implement following approval.	PFSA (Forecasting and Capacity building, Pharmaceuticals & Medical Supplies Procurement and Storage & Distribution directorate)	Beginning from January 2012
(c) Adequate technical capacity is institutionalized at the forecasting and quantification directorate level to enable PFSA to independently conduct accurate and reliable forecasting and quantification, and thereby ensure that the initiatives introduced by donors are sustainable.	Knowledge transfer from development partners seconded high calibre staffs to PFSA permanent staff is at its maturity stage and most of the staff have developed the required skill for the forecasting and quantification. Action plan Accomplish the development of technical skill for conducting the forecasting and quantification fully with the staff of PFSA.	PFSA (Forecasting and Capacity Building Directorate)	March 2012
Recommendation 71 (High priority) The PFSA should: (a) Facilitate proper procurement planning by	Action plan FMoH will give full documents along with the approved procurement plan to pursue the procurement and PFSA in turn carries out procurement, storage and distribution of	MOH and PFSA	

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>working with the FMOH to ensure detailed agreements are in place at the beginning of the program implementation period that specify what needs to be procured and clearly define the timelines.</p>	<p>commodities and submits regular logistical and financial reports.</p>		
<p>(b) Consider enhancing tender committee impartiality and objectivity through:</p> <ul style="list-style-type: none"> ▫ Increasing external representation in the tender committee to ensure the committee is broad-based. ▫ Introducing a procedure for the tenure of committee membership to ensure that membership changes on a regular basis 	<p>PFSA is established by law to procure and distribute health commodities using its own RDF as well as financial assistance obtained from development partners. Hence, as per rules and regulations of the country’s public procurement it has got a tender committee composed of relevant bodies of the Agency. Therefore we believe tender committee impartiality cannot be ensured by including external representation, and or membership rotation rather by putting in place principles and procedure of good governance in procurement (which is in place at PFSA). (refer to the Ethiopian Federal Government Procurement & Property Administration Proclamation No 649/2009 ..\financial.zip)</p>		
<p>(c) Ensure the advertisement of international competitive bidding tenders should be done as stipulated in the public procurement directive to ensure that the process is competitive and that the lowest prices are obtained. A website should be developed and used for this purpose</p>	<p>In fact procurement for Global Fund grant program including HIV/AIDS, TB and Malaria health commodities are supposed to be in accordance with the Global Fund quality assurance policy. Hence prequalified suppliers included in the Global Fund quality assurance profile are invited on a limited international procurement modality which does not require advertisement (we use invitation letter to the respective potential suppliers). PFSA has already developed its own web site and is now on the testing stage. One of the deliverables from the web site is provision of General Procurement Notice (GPN) and Specific Procurement Notice (SPN) information for all</p>		

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	<p>interested parties during open international competitive bidding (ICB).</p> <p>Action Plan Accomplish the testing of website and make it function soon.</p>	PFSA (Plan, Monitoring and MIS Directorate)	End of March 2012
<p>Recommendation 72 (High priority) In order to avoid potential supply interruption and stock outs due to long procurement lead times, the PFSA should enhance: (a) Planning and execution of procurement activities, including careful coordination with PRs to ensure disbursement of funds to the PFSA account on a timely basis.</p>	<p>The Procurement and Supply management coordination committee was revitalized in June 2011 and started to meet monthly so as to coordinate the planning, procurement and address any stock outs. The PSM coordinating committee members were drawn from MOH, HAPCO, PFSA, CDC, USAID, SCMS and Clinton Foundation.</p> <p>Action plan Continue to use this PSM coordinating committee to harmonize the planning and procurement of the drugs and health commodities in the PSM plan of the PRS.</p>	PFSA and PSM coordinating committee	It is a Continuous intervention
<p>(b) Contract management procedures to ensure improved performance by suppliers whereby goods are delivered within a reasonable time after submission of a purchase order. This should also be utilized to ensure shorter lead times.</p>	<p>Contract management procedure is in place. But because of force majeure, there are times that the suppliers underperformance or none performance of the supplier's extended lead-time to receive the products may be required. In fact to ensure strategic and collaborative business relationship PFSA conducts annual consultative meeting with suppliers, where by problems encountered between suppliers and PFSA is one of the discussion points.</p> <p>Action plan Stick to contract management procedures and accept any changes due force majeure.</p>	PFSA (Pharmaceuticals & Medical Supplies Procurement Directorate)	It is a Continuous effort

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>Recommendation 73 (High priority) The drug regulatory authority, FMHACA, should: (a) Ensure that, in accordance with Global Fund quality assurance policy, random samples of finished pharmaceutical products are obtained at different points in the supply chain (from initial receipt of the products in country to delivery to end-users) for the purpose of monitoring their quality. Such samples must be sent for quality control testing to one of the following laboratories for Quality Control testing: a laboratory prequalified by the WHO Prequalification Programme; an National Drug Regulatory Authority (NDRA) or NDRA-Recognized Laboratory that meets one of the following criteria: Prequalified by WHO Prequalification Programme, or Accredited in accordance with ISO17025; or a laboratory contracted by the Global Fund.</p>	<p>Recently the QC lab of the Authority was accredited in accordance with ISO 170125 with the assistance of USP/PQM (USAID) and all the tests will be carried out in this lab.</p> <p>Post marketing Surveillance on selected ARV Drugs, OI Drugs, Anti-Malarial Drugs, and Condom has been undertaken using USAID (USP/PQM -PEPFAR) assistance annually.</p> <p>The frequency of laboratory base PMS (ARV. OI, Anti-malarial and others) will be increased to 4 times a year in order to increase the testing coverage from different points of the supply chain.</p> <p>Action Plan</p> <ul style="list-style-type: none"> ➤ The Authority is planning and going to take random samples from finished pharmaceutical actual consignment for laboratory testing starting from port of entry. ➤ Strengthening the QC lab (logistical and human resources). 	<p>FMHACA,</p> <ul style="list-style-type: none"> • Inspection and Surveillance Directorate, • Branch Office (Ports of Entry) • Product Quality Assessment Directorate 	<p>2012</p>
<p>(b) Implement a system for</p>	<p>Recommendation well taken. The regulatory Authority has</p>	<p>FMHACA</p>	

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
the tracking of medicines by batches.	<p>been enforcing batch tracking to control Diversion and for ease recall of products with quality defect, efficacy and safety problems. EFMHACA, Regional and District regulatory body will intensively enforce the batch tracking system in the supply chain including in PFSA</p> <p>To materialize this capacity of the regulatory activities at federal, regional and district level will be strengthened.</p>		
(c) Implement pharmaceutical waste disposal guidelines to ensure that health facilities dispose of expired stocks in-line with internationally recognized standards on a timely basis.	<p>The Authority and regulatory bodies at different levels have been disposing expired drugs in accordance with old methods and directives. Currently the Authority (country) has developed directive and implementation framework for proper disposal of pharmaceutical wastes. Various efforts are underway to mobilize resources to obtain appropriate disposal facilities including medium temperature incinerators for use at different level.</p> <p>Action Plan</p> <ul style="list-style-type: none"> ➤ EFMHACA, Regional and district regulatory bodies will ensure timely and proper disposal of pharmaceutical wastes in health institutions; 	<ul style="list-style-type: none"> • FMHACA <ul style="list-style-type: none"> ○ Inspection and Surveillance Directorate ○ Branch Offices • Regional Regulatory bodies • District regulatory Units 	2012
(d) Ensure expired medicines registers are maintained at the health facilities and wastage levels are monitored.	<p>It is regulatory requirements that expired drugs have to be immediately segregated & registered, and the institution has to apply to the nearby regulatory body along with the list of expired products.</p> <p>The regulatory body at different level including Federal, Regional and District regulatory will be strengthened and undertake regular inspection and monitoring of the supply management and proper use (prescribing, dispensing and patient use) as per the STGs.</p>	<ul style="list-style-type: none"> • FMHACA <ul style="list-style-type: none"> ○ Inspection and Surveillance Directorate ○ Branch Offices • Regional Regulatory bodies • District regulatory Units 	2012

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Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>Recommendation 74 (High priority) The PFSA should: (a) Work with malaria and TB program managers to establish regular delivery schedules for TB and malaria health products.</p>	<p>PFSA and malaria & TB program managers are working in close collaboration to establish regular delivery schedule. As a result the commodities and drugs for malaria and TB will be distributed as part of the holistic integrated pharmaceutical and health products distribution package.</p> <p>Action plan Strengthen the new initiative of integrated pharmaceutical and health products distribution approach including for TB and malaria programs.</p>	<p>PR, PFSA (Storage & Distribution Directorate)</p>	
<p>(b) Implement a redistribution mechanism between health facilities to ensure that excess medicines are redistributed to where they are needed thus alleviating incidents of expiry or stock out.</p>	<p>The system is in place, but for one reason or the other it is not potent.</p> <p>Action plan PFSA will make this system work through strengthening its IPLS.</p>	<p>PFSA (Branches) and Health Facilities</p>	<p>It is a Continuous effort</p>
<p>(c) Monitor adherence to the established minimum and maximum stock levels to ensure that health facilities are not at risk of stock outs or expiries.</p>	<p>There is a well established system of minimum and maximum stock levels for HIV commodities and drugs which is six months as minimum and 13 months as maximum.</p> <p>Action plan PFSA will strengthen the minimum and maximum stock levels of ant TB and malaria drugs and commodities.</p>	<p>PFSA (Branches)</p>	<p>It is a Continuous effort</p>
<p>(d) Complete the implementation of an efficient logistics management information system for TB and malaria health products to ensure that health facility demand is</p>	<p>Required LMIS format is already developed and printed. Distribution to health facilities has been started since July 2011. Furthermore, orientation on how to utilize the system is being delivered to public health facilities.</p>	<p>PFSA (Forecasting & Capacity Building, Storage & Distribution Directorate and Branches)</p>	<p>It is a Continuous effort</p>

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<p>served on time and consumption trends are monitored to detect and avoid stock outs or overstocking.</p>			
<p>Recommendation 75 (High priority) The PFSA should ensure: (a) Appropriate racking and other storage media are provided to the facilities in order to facilitate proper storage of health products. In particular, direct storage on the floor as observed in some facilities may lead to products being damaged by moisture hence pallets should be used. Correct handling equipment reduces the risk of injury to workers and damage to stock. Stock organization on shelves and pallets enhances accessibility which facilitates use of first in first out (FIFO) and first expiry first out (FEFO) issuing systems. (b) Temperature monitoring in storage areas is introduced in order to maintain optimum</p>	<p>PFSA has succeeded in supplying shelves, ladders, fire extinguishers, pallets, computers and the IPLS trainings with support from development partners. As a result most of the identified problems were addressed in the last six months. Action Plan. PFSA will further continue working to address these issues in close collaboration with DPs.</p>	<p>PFSA (Forecasting & Capacity Building Directorate)</p>	<p>End of 2014</p>

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storage conditions.			
<p>Recommendation 76 (Significant priority) The PFSA, through the directorate in charge of rational drug use, should conduct a national drug utilization study to identify the magnitude of irrational use of medicines within Ethiopia.</p>	<p>PFSA has a plan to conduct a study on a rational drug use along with stakeholders every two years.</p> <p>Action plan PFSA will conduct the rational use drug study in the coming Ethiopian fiscal year.</p>	PFSA (Forecasting & Capacity Building Directorate)	Mid 2013
<p>Recommendation 77 (High priority) With regard to CCM membership, the CCM should ensure: (a) All CCM members representing non-government constituencies are selected by their own constituencies based on a documented, transparent process, developed within each constituency. This requirement should apply to all non-government members including those members representing people living with or affected by the three diseases. (b) Membership is in evidence of people living</p>	<p>Civil society representatives are selected from umbrella organizations which represent each constituency registered at Federal and regional levels. These umbrella organizations have their own general assemblies to which all constituencies have representatives. These assemblies are the highest decision making organs and meet in a defined period of time annually. Assemblies nominate board of directors/executive Boards who will oversee policy issue.</p> <p>Hence members to the CCM/E are selected by the board of directors/executive Boards, which is considered to represent the interest of its members. Such decision is communicated to CCM/E accompanied by Minutes of the board with an official covering letter. Therefore the CCM/E believes members who are delegated through this process are selected transparently and represent the interest of their respective constituencies. The CCM/E has made it a procedure that each elected CSO representative shall have mechanism of reporting back to its respective</p>	CCM/E Secretariat	30 March 2012

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<p>with HIV and of people affected by TB or malaria (where funding is requested or has previously been approved for the respective disease). People affected by TB or malaria include people who have lived with these diseases in the past or who come from communities where the diseases are endemic.</p>	<p>constituencies.</p> <p>In light of the foregoing, therefore, the CCM/E would find it difficult to implement the recommendation of the OIG that calls for the CCM/E to ensure the selection process for the membership of the CCM/E starts at grass root level, mainly on due to the big size and number of constituencies that have to be dealt with. Moreover, the CCM/E believes that the general assembly and its Board of Directors/executive Boards fully represent the interest of their constituencies.</p> <p>Action plan: CCM/E shall ensure that all representatives of civil societies are nominated by board of directors/executive Boards according to their constitutions in a transparent way evidenced by appropriate documentation and communicated to constituencies in an appropriate medium.</p> <p>Among the People living with the diseases, HIV is well represented by NEP+. As to the other disease areas, attempts have been made even if inclusion of malaria and TB affected representatives has been found out to be difficult due to the nature of the diseases and organizational set up that cater for the interest of such groups.</p> <p>Action plan: Despite the above mentioned inherent challenges, the CCM will further try to track and include malaria or TB representative</p>		
<p>Recommendation 78 (High priority) In the development of funding applications, the</p>	<p>In the preparation of all previous proposals in the preceding rounds, the CCM/E has put in place mechanisms for transparent and broad-based engagement and inclusion of stakeholders in solicitation of inputs, identification of</p>	<p>CCM/E Secretariat</p>	<p>30 March 2012</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
<p>CCM should:</p> <p>(a) Clearly document the processes followed to engage a broad range of stakeholders (including CCM members and non-members) in the solicitation and the review of activities to be included in the application.</p> <p>(b) Ensure that a review of the stakeholders and their interventions is undertaken as part of the national health strategic process, which should include calculation of the existing funding and funding gaps. These funding gaps would then be the basis for activities and budgets presented in proposals to the Global Fund.</p>	<p>gaps, review and enrichment of draft proposals before formal submission to the CCM/E and eventually to the Global Fund Secretariat.</p> <p>Action plan: CCM/E Secretariat to strengthen its documentation capacity of the process and outputs of the solicitation and review of proposals.</p> <p>Action plan: Undertake mapping of stakeholders and their interventions in relation to the three diseases</p>	<p>CCM/E and Secretariat</p>	<p>30 June 2012</p>
<p>Recommendation 79 (High priority)</p> <p>For the malaria and TB programs, the CCM should ensure a transparent and well documented PR nomination process that considers more than one PR candidate and enables the consideration of non-government PRs and dual-track financing.</p>	<p>CCM/E has been implementing the criteria for the section of PR for the three diseases, which emphasizes among others, the administrative capacity for fund management and availability of structural and technical to provide appropriate services in the ground. All previous invitations for proposal development and concept note submission have been publicly announced and same procedure will be maintained for future rounds.</p> <p>Action plan:</p> <ul style="list-style-type: none"> • CCM/E shall review the existing criteria for PR selection • Dual track financing will be taken in to consideration in the upcoming grant applications with due regard to the 	<p>CCM/E</p>	<p>30 March 2012</p>

Recommendation	Country Response and Action Plan	Responsible Person	Expected Completion Date
	financial administration and service delivery technical and structural capacity.		
<p>Recommendation 80 (High priority) The CCM should strengthen its oversight function in order to ensure program activities are implemented on time and agreed performance targets are met. In particular, the CCM should:</p> <p>(a) Anticipate and proactively identify implementation challenges, and meet with PRs and SRs regularly to discuss challenges and facilitate solutions before performance is affected. Particular attention should be paid to: procurement and distribution of pharmaceuticals to avoid the risk of stock outs; external audit planning and execution to avoid delays in presenting audit reports; and proposed reprogramming to ensure required procedures are followed.</p> <p>(b) Consider setting up appropriate committees to support the CCM in effectively undertaking its</p>	<p>The CCM/E concedes that in the last two years the frequency of over-sight visits were not sufficiently conducted due to over-stretch and engagement in other competing official responsibilities of members with their routine activities and financial constraints to cover DSA and logistical costs for some members.</p> <p>CCM/E has already identified the challenges for the inadequate oversight performance and has come-up with the following solutions</p> <p>Action plan:</p> <ol style="list-style-type: none"> 1. the composition of each team should revised and an oversight schedule shall developed in consultation with teams 2. For the transitional period until GF authorizes the disbursement of basic fund, which the CCM/E shall submit an application for within few weeks, Bi/multi-lateral agencies will provide financial and logistic support for field missions. 3. CCM/E Secretariat shall be responsible for the coordination of each mission, including communication with target regions (PR, SR, SSR), organization of logistics and facilitation of DSA payments...etc <p>Efforts will be made to align mission programs with other Health sector review missions, if found to be advantageous.</p>		16 April 2012

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oversight responsibilities. (c) Ensure that the intended number of site visits are undertaken in order to obtain first-hand information on program activities and quality of services.			