



The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Office of the Inspector General

Diagnostic Review of Global Fund Grants to the Kingdom of Thailand

GF-OIG-13-010
3 May 2013

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A. Executive Summary

Six grants reviewed totaled USD 116 million

USD 64 million had been disbursed at the date of the review

Good practices noted included:

HIV treatment fully integrated in the national health care system
Innovative community-led HIV prevention programs
Functional procurement monitoring

Risks identified included:

- Sustainability of treatment for uninsured populations
- Supply bottlenecks due to long procurement
- Financial oversight

1. This diagnostic review of the active Global Fund grants to the Kingdom of Thailand sought to identify and share good practices, identify key risks to which the grant programs were exposed, and make recommendations for risk mitigation where weaknesses and gaps were found.

2. Of the thirteen grants made to Thailand since 2003, the review focused on six active single stream funding grants. The total budget for the grants reviewed was USD 116 million of which USD 64 million had been disbursed at the time of the review. The fieldwork for the review took place from mid-November to mid-December 2012.

3. The diagnostic review noted many good practices, as illustrated by examples cited in the report. Key good practices included:

- a. The roll-out of nationally-funded HIV treatment that was fully integrated in the national health care system¹;
- b. An approach to social support of vulnerable children that was aligned with the national child protection policy;
- c. Many examples of innovative and creative community-led HIV prevention programs among key affected populations² that were implemented despite limitations created by the general political context;³ and
- d. A functional approach to procurement monitoring and efficient management of the supply chain for procured goods.

Risks identified

4. Notwithstanding this, a number of risks were identified that could impede the achievement of grant-funded program objectives unless mitigated. In particular, the review identified risks to the efficiency and sustainability of grant-funded support for HIV and first-line tuberculosis treatment of migrants and uninsured populations.

5. The diagnostic review identified a number of risks relating to the six active grants under review; in particular:

- HIV and tuberculosis treatment targeting the uninsured population is not sustainable due to a lack of integration with the national health system;
- HIV prevention and care services provided by civil society and by government institutions are not sustainable;
- Information collected for program monitoring or management is not always essential and may be duplicative;

¹ Please note that this does not include the uninsured population (such as migrant workers from neighboring countries, international refugees); this has been raised as a risk under section G.

² Men who have sex with men, female sex workers, injecting drug users, and non-Thai citizens

³ For example, the diagnostic review observed effective harm reduction programs for people who inject drugs despite a general policy that defined drug use as a criminal justice rather than a public health issue.

- Certain programs are not well-designed, are based on invalid assumptions or are out of date;
- The process used to procure goods through the Global Fund's Voluntary Pooled Procurement mechanism does not provide optimal results;
- The financial oversight of grant programs by PRs and SRs is not effective; and
- There is poor financial management capacity, including financial controls and financial management practices.

6. An additional risk, which was not covered in detail in this diagnostic review but is important in the Thai context, is the emergence of Artemisinin-resistant malaria in the western and eastern border areas of the country (see paragraph 24).

Key Mitigating Actions

7. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. While the Country Coordinating Mechanism and the recipients of grants bear the responsibility to implement specific recommendations, it is the responsibility of the Global Fund Secretariat to ensure that this takes place as part of their mandate to manage grants effectively.

8. In response to risks in the areas of program design, implementation and monitoring, the relevant stakeholders have agreed to:

Mitigating actions agreed upon by stakeholders include:

- Accelerating task-shifting for HIV testing to the community level
- Reviewing procurement planning to shorten lead times
- Strengthening financial oversight and internal controls

- Accelerate task-shifting for HIV testing to the community level and the roll-out of rapid (same-hour) HIV testing services;
- Coordinate and monitor grant-supported activities of civil society organizations with services provided by government agencies for key affected populations;
- Reprogram (without scaling down) the grant for HIV prevention among people who inject drugs in order to put stronger focus on documenting the effectiveness of harm reduction and on advocacy; and
- In collaboration with community members, review and simplify data collection forms and registers for community work.

9. With regard to Procurement and Supply Management, the Global Fund Secretariat has agreed to review its procurement planning and processes in order to shorten the lead times for procurement carried out through the Voluntary Pooled Procurement mechanism.

10. Regarding financial management, the relevant stakeholders have agreed to strengthen financial controls and seek additional resources for oversight of Sub-recipients.

B. Message from the Executive Director of the Global Fund



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3 May 2013

MESSAGE FROM THE EXECUTIVE DIRECTOR

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

The review focused on six active single-stream funding grants worth US\$116 million, of which US\$64 million had been disbursed at the time of the review. Fieldwork for the review was conducted from mid-November to mid-December 2012.

Principal Recipients reviewed were the Ministry of Public Health's Department of Disease Control, the Raks Thai Foundation, Population Services International (PSI) and the AIDS Access Foundation.

The review found many good practices including nationally-funded HIV treatment that was fully integrated in the national health care system; many examples of innovative and creative community-led HIV prevention programs among key affected populations; and efficient management of the supply chain for procured goods.

However a number of risks were identified that could stand in the way of achieving grant-funded program objectives unless they are addressed. A particular risk concerns the efficiency and sustainability of grant-funded support for HIV and first-line tuberculosis treatment of migrants and uninsured populations.

In addition, the review found that HIV prevention and care services provided by civil society and by government institutions are not sustainable while financial oversight of grant programs by Principal Recipients and Sub-recipients is ineffective.

It also concluded that financial management capacity -- including financial controls - is poor and that the process used to procure goods through the Global Fund's Pooled Procurement mechanism is not giving the best results.

The review makes 10 recommendations to relevant stakeholders and, in response, they have agreed to a number of actions. These include, among other steps, accelerating a shift to the community level of HIV testing; introduction of rapid HIV testing services; and reprogramming the grant for HIV prevention among injecting drug users in order to put a stronger focus on documenting the effectiveness of harm reduction.

Relevant stakeholders have also agreed to strengthen financial controls and seek additional resources for oversight of Sub-recipients.


Meanwhile, the Global Fund Secretariat has agreed to review its procurement planning and processes in order to shorten lead times for procurement carried out through the Voluntary Pooled Procurement mechanism.

An additional risk, which was not covered in detail in the diagnostic review, is the emergence of artemisinin-resistant malaria in the western and eastern border areas of Thailand.

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

Yours sincerely,



C. Message from the Country Coordinating Mechanism

CCM THAILAND
COUNTRY COORDINATING MECHANISM

Country Coordinating Mechanism, Thailand
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Our Ref. CCM 099/2013

19 April B.E. 2556 (2013)

Dr. Elmar Vinh-Thomas
The Global Fund Director of Audit
The Global Fund to Fight AIDS, Tuberculosis and Malaria,
Chemin de Blandonnet 8,
1214 Vernier-Geneva, Switzerland

Dear Dr. Elmar Vinh-Thomas,

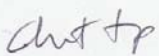
Subject: Feedback to Diagnosis Review of The Global Fund Grants to The Kingdom of Thailand

Since the Global Fund has been established in 2002, Thailand is one of 151 countries which received good collaboration with the Global fund and another partner in providing HIV/AIDS Tuberculosis and Malaria prevention and treatment support. Even as the Thai government by the Ministry of Public Health has a strong public health policy to provide all Thai people to access health services throughout the country but it still have the country gap such as people in high-risk group, marginalized and vulnerable populations including non -Thai and migrant. Towards ASEAN Economic Community in 2015, Thailand is strongly supported to the initiative of the regional proposal that it will be beneficial for the peoples in this region in order to access health care and services adequately.

In occasional of Office of Inspector General (OIG) had conducted the diagnostic review of the Global Fund grants in Thailand during mid - November until mid - December 2012. We are greatly appreciative of the expertly performed by the OIG team during the diagnostic review procedure as well as for the valuable observations and recommendations, which will be taken in to our efficiency and accountability implemented with a set of programmatic and financial management of the Principal Recipients in Thailand.

On behalf of CCM Thailand and all the partners, We would like to express our deep gratitude to the OIG team were reflected in grant implementation and all key findings which will be resulted to improve our grant management in Thailand.

Yours sincerely,

for 
Dr. Narong Sahameapat
Permanent Secretary as CCM Chair

cc: CCM member, PRs, FPM and LFA

D. Introduction

Aim of review to identify good practices and key risks

Review team consisted of public health, procurement and financial experts

The review focused on six active “single stream funding” grants to four PRs

11. As part of its 2012 plan, the Office of the Inspector General (OIG) undertook a diagnostic review of the active Global Fund grants to Thailand. This review sought to:

- Identify and share good practices; and
- Identify and report the key risks to which the grant programs are exposed, along with recommendations aimed at ensuring the risks are adequately mitigated.

12. A diagnostic review is different from a country audit in that no overall opinions are expressed and no assurance is provided regarding how grant funds were spent. The team for the diagnostic review included technical experts in public health, financial management, and procurement and supply chain management. The fieldwork for the diagnostic review was conducted from 12 November to 13 December 2012.

Scope

13. The Principal Recipients (PR) reviewed were the Ministry of Public Health’s Department of Disease Control (DDC), the Raks Thai Foundation (RTF), Population Services International (PSI), and the AIDS Access Foundation (ACCESS).

14. Of the thirteen grants made to Thailand since 2003, the review focused on six active single stream funding (SSF) grants. The Ministry of Public Health through its Department of Disease Control (DDC) is the PR for three grants, one for each disease. Three additional grants for HIV prevention, treatment and social support were awarded to the Raks Thai Foundation to serve international migrants and other non-insured populations, Population Services International for people who inject drugs, and the AIDS Access Foundation for vulnerable children, including those affected by HIV.

15.

PR	Disease	Grant	Total Committed Grant Amount	Total Disbursed to 22 Nov 2012
DDC	HIV	THA-H-DDC	39,390,514	21,306,987
DDC	Malaria	THA-M-DDC	29,203,469	16,347,131
DDC	TB	THA-T-DDC	20,737,722	11,736,660
Raks Thai Foundation	HIV	THA-H-RTF	11,222,249	6,482,063
Population Services International	HIV	THA-H-PSI	8,091,530	4,402,311
AIDS Access Foundation	HIV	THA-H-ACC	7,425,584	3,742,645
		Total (USD)	116,071,068	64,017,797

Diagnostic Review of Global Fund Grants to Thailand

Very large number of SRs and SSRs

16. The national disease programs⁴ are Sub-recipients (SRs) under the three grants with responsibilities for technical assistance and program implementation. An additional 26 SRs of the three grants managed by the DDC include government departments, research institutions, and national NGOs. Implementation of the grant-supported programs was undertaken by 199 Sub-sub-recipients (SSRs), including Regional Offices of Disease Prevention and Control, Regional Health Promotion Centers, Provincial Health Offices and local non-governmental organizations (NGOs).

17. The three civil society sector PRs (RTF, PSI and ACCESS) implemented programs through a total of 26 SRs, 56 SSRs and a number of Implementing Agencies (IAs), primarily national and international NGOs.

18. Program risks for a number of interventions supported by the Global Fund were not included in the diagnostic review because they were already identified in recent evaluations and were the subject of reprogramming discussions at the time of the diagnostic review. This included the control of MDR/XDR tuberculosis, the containment of Artemisinin-resistant malaria, and HIV prevention among men who have sex with men and female sex workers.

Health context

Thai citizens are covered by public health insurance that includes HIV care

19. Governance of and budget authority over health services is decentralized to the 76 provinces. Thai citizens are covered by public health insurance, the large majority under the Universal Coverage (UC) scheme administered by the National Health Security Office (NHSO).

HIV

Declining trend in national HIV prevalence not observed in MSM, FSW and IDU

20. The epidemic of HIV in Thailand was initially driven by injecting drug use and evolved into an epidemic of sexually transmitted HIV. An effective national response resulted in a rapid decline in national HIV prevalence; however, this trend was not observed among men who have sex with men (MSM), female sex workers (FSWs), transgender individuals, and people who inject drugs (IDUs). At the time of the review in December 2012, about 490,000 people were estimated to be living with HIV,⁵ with about 225,000 on antiretroviral therapy (ART) treated in almost 1,000 health care facilities throughout the country. About 10,000 new HIV infections are projected to occur each year with about two-thirds among MSM, FSWs and clients, and IDUs; the remaining third through transmission among partners in heterosexual relationships.⁶ The national response to HIV in Thailand was guided by a five-year national strategy launched in June 2012 named "Thailand Getting to Zero". The National AIDS Management Center of the Ministry of Public Health was responsible for guiding implementation, while the Bureau for AIDS and STIs (BATS) was responsible for the health sector response.

21. Since 2007, HIV care has been included under Universal Coverage; however, this is not offered to migrant workers, international

⁴ The National AIDS Management Center and the Bureau for AIDS and STIs for HIV, the Bureau for Vector-Borne Diseases for malaria, and the Bureau of Tuberculosis for tuberculosis

⁵ UNAIDS World AIDS Report 2012.

⁶ Thailand AIDS Response Progress Report 2012.

Case detection and treatment for migrants and other uninsured populations is a challenge

refugees, and to stateless Thai residents in border areas.

Tuberculosis

22. Although the prevalence rate of tuberculosis in Thailand is high (161 per 100,000 people in 2011), it is considerably lower than in the neighboring countries that account for most migration to Thailand.⁷ An estimated 130,000 people in Thailand suffer from tuberculosis, with about 94,000 new cases each year.⁸

23. The national response to tuberculosis is guided by a ten-year strategy (2006-2015) under the responsibility of the Bureau of Tuberculosis (BTB) of the DDC. First- and second-line treatment for tuberculosis is paid for by the NHSO (with the exception of migrant and other uninsured populations). One of the main challenges for tuberculosis control in Thailand consists of ensuring continued case detection and treatment for migrants and other uninsured populations. In addition to the public sector, tuberculosis is also treated in private hospitals that often neither follow national treatment guidelines, nor comply with case notification. This was an issue particularly in the Bangkok Metropolitan Area. It has contributed to high treatment default rates and the absence of reliable national information on all forms of TB including MDR/XDR tuberculosis.⁹

Emergence and spread of Artemisinin-resistant malaria

Malaria

24. Historically, malaria has been a major health problem in Thailand; however, efforts to control the disease have resulted in the WHO classifying the country as one of only five countries in South East Asia that have registered a decrease in malaria incidence of 75% or more between 2000 and 2011.¹⁰ Malaria incidence has since become localized, primarily in border areas and the extreme south of the country. The national effort towards malaria elimination is guided by a ten-year strategy (2011-2020).

25. One of the main challenges to malaria elimination is the cross-border movement of migrants and refugees and the security situation in the South, restricting public health worker access to highly endemic districts. Almost two thirds of malaria cases recorded in 2010 were among refugees and short-term migrants.¹¹ Another challenge is the emergence of Artemisinin-resistant malaria in the Thai-Cambodia border area, which has spread to high incidence areas on the Thai-Myanmar border.¹²

⁷ For example, Cambodia 660/100,000; Myanmar 525/100,000 (WHO TB database accessed Nov. 2012)

⁸ A second national TB prevalence survey is on-going and its results should be considered as soon as possible.

⁹ A recent GLC report (dated October 2012) also raises concerns about the quality of MDR-TB treatment.

¹⁰ WHO World Malaria Report 2012,

http://www.who.int/malaria/publications/world_malaria_report_2012/en/index.html

¹¹ So-called "M2 migrants" who have spent less than six months in Thailand

¹² Phyo A.P. *Emergence of Artemisinin-resistant malaria on the western border of Thailand*; Lancet, Apr. 2012

E. Grant Implementation

Oversight arrangements conform to Global Fund model	<p>26. The Global Fund grant oversight arrangements included the following key aspects:</p> <ul style="list-style-type: none">(i) The Country Coordinating Mechanism (CCM) is responsible for overseeing Global Fund-supported grant programs;(ii) The PRs are responsible for ongoing programmatic and financial monitoring of grant implementation activities by SRs and other implementing organizations;(iii) The Local Fund Agent (LFA), KPMG, provides independent verification of program progress and financial accountability; and(iv) The Global Fund Secretariat manages the grants and monitors performance.
Need for CCM oversight plan and requisite funding	<p>27. Following the reform¹³ of the CCM in 2011, an oversight committee¹⁴ was established to support the CCM's oversight work. However, this was not active at the time of the diagnostic review in December 2012. An oversight plan has not been finalized. The review found that there was a need to strengthen the CCM's oversight over grant programs and to secure the requisite funding to exercise this responsibility.</p>
Scope to improve the LFA's programmatic oversight	<p>28. The LFA oversight function is exercised almost exclusively by finance specialists with limited capacity to analyze programmatic information.</p>
Programmatic monitoring and reporting challenges due to the large number of SRs and SSRs	<p>29. The large number of SRs and SSRs pose financial and programmatic monitoring and reporting challenges to the PRs and SRs.</p> <p>30. DDC and ACCESS maintained separate grant bank accounts for grant receipts and disbursements. RTF used a dedicated grant bank account for receipts, but used its corporate bank accounts for grant disbursements. PSI received funds in a dedicated account at its Global Head Office. Funds were transferred from the dedicated bank account to its corporate account based on actual expenses incurred by PSI Thailand on a monthly basis. Joint signatories were required by all grant recipients for disbursements. The PRs used accounting software for financial management.</p>
Use of the Global Fund's VPP mechanism	<p>31. The national programs¹⁵ were responsible for coordinating quantification of medicines and health supplies purchased with grant funds.</p> <p>32. Grant-financed ARVs, ACTs, RDTs and LLINs were procured using the Global Fund's Voluntary Pooled Procurement (VPP) mechanism. Anti-tuberculosis medicines were purchased internationally from WHO-prequalified suppliers through the Global Drug Facility. ARVs were earmarked for 2,300 uninsured individuals through a program</p>

¹³ With technical assistance from Grant Management Solutions.

¹⁴ Supported by three technical working groups for HIV, TB, Malaria.

¹⁵ BATS, BTB and BVBD were responsible for quantification of pharmaceuticals and health products.

referred to as “BATS Care”¹⁶ and 3,500 patients enrolled in two ART cohort studies in Thailand. Anti-tuberculosis medicines were earmarked for uninsured patients attending participating hospitals.¹⁷ The anti-malaria health products were earmarked for populations (both Thai and non-Thai) in highly endemic communities in 43 provinces through the Bureau of Vector-Borne Disease (BVBD) of the DDC and for people living in and around refugee camps through a program implemented by NGOs.

33. The Government Pharmaceutical Organization (GPO),¹⁸ a public-private entity, was sub-contracted for storage, inventory management and distribution of ARVs to 345 public hospitals and health centers participating in BATS care. The BTB and the BVBD were responsible for storage and distribution of grant-financed anti-tuberculosis drugs and anti-malaria commodities.

¹⁶ Representatives of NGOs working with migrants told the review team that they estimated that approximately 10,000 people were in a waiting line to access “BATS Care” (also sometimes referred to as “National Access to Antiretroviral Program for HIV and AIDS (NAPHA) Extension”)

¹⁷ 252 hospitals for first line treatment and 26 hospitals for second line (targets change over the course of the grant).

¹⁸ The GPO managed the government-financed national procurement and distribution system.

F. Good Practices

Sustainable universal access to HIV treatment is an achievable goal

34. The diagnostic review team observed many examples of good program management and related practices, including:

- More than 225,000 people living with HIV in Thailand were receiving ART free at the point of service,¹⁹ funded entirely with domestic resources. Notwithstanding the treatment gaps for uninsured migrants and ethnic minorities, this indicated that sustainable universal access to HIV treatment is an achievable goal in Thailand;
- Social protection for vulnerable children and their families²⁰ was based on national child protection legislation implemented under the guidance of Provincial Child Protection Committees that was “AIDS-sensitive rather than AIDS-targeted”;²¹
- The DDC employed a standard procurement tracking tool for HIV, tuberculosis and malaria commodities to monitor each step of the procurement process, facilitating follow-up and analysis in the case of delays or supply bottlenecks;
- Local procurement contracts established by all PRs included in-country transport and delivery to SRs;
- Effective opioid substitution therapy was provided to more than 300 clients in Chiang Mai as part of comprehensive ambulatory substance-abuse services for the treatment of opioid, alcohol, tobacco, amphetamine and other addictions.²² Despite challenges to implementing harm reduction programs on a comprehensive basis in Thailand, the services provided at the specific centers visited by the review team were of a very high quality; and
- A drop-in center for male and female sex workers visited by the review team in an entertainment district of Bangkok²³ was found to provide HIV prevention services that were well adapted to the needs and the profile of the population served.

¹⁹ UNAIDS Thailand AIDS Response Progress Report 2012: Status at a glance (31 Mar 2012).

²⁰ Supported by the Global Fund grants to ACCESS and to the DDC.

²¹ Joint Learning Initiative on Children and HIV/AIDS. *Home Truths: Facing the facts on children, AIDS, and poverty*. 2009

²² By the Fah Mai Clinic, a community extension facility of the Thanyarak Institute under the Department of Medical Services.

²³ Operated by the organization SWING, SSR under the grant to DDC.

G. Risks

Risk 1. Global Fund support for HIV and tuberculosis treatment targeting the uninsured population is not sustainable due to a lack of integration with the national health system

Support for HIV and tuberculosis treatment for uninsured population not sustainable

35. Since 2007, HIV/AIDS care has been included under Universal Coverage and the NHSO has become responsible for about two thirds of all public expenditure on HIV in Thailand.²⁴ This coverage was, however, not offered to migrant workers from neighboring countries, international refugees residing in camps, and to stateless Thai residents belonging to ethnic minority groups residing in border areas.²⁵ Although these populations are by their nature difficult to quantify, together these groups constitute approximately 5-6% of the total population in Thailand; untreated, they can become an important source of transmission given their marginalized status and mobility.

36. The exclusion is primarily maintained because national immigration policies did not incorporate public health concerns. Although there were no indications that these policies would change in the short to medium term, migration patterns will be affected with the creation of the Asian Economic Community (expected in 2015).

Drugs for the treatment programs supported by the Global Fund were procured and managed outside the national system

37. Drugs for the treatment programs supported by the Global Fund were procured and managed outside the national system. These drugs had different formulations, different packaging and a different appearance to the drugs dispensed to the insured population. ARVs procured for the program under VPP, for instance, did not include fixed dose combination drugs, which are important to reducing pill burden, improving quality of life and improving treatment adherence for ART patients.

Separate supply chains for the small proportion of drugs procured under the grants

38. The additional effort of maintaining separate supply chains for the small proportion of drugs procured under the Global Fund grants has affected both grant implementers and oversight entities.²⁶ For first-line tuberculosis drugs most facilities chose not to prescribe these drugs and instead provided national drugs (which are not prequalified), absorbing the costs for treating uninsured patients in their operating budget or passing them on to the NHSO.

39. Because of the different formulations and presentations, the drugs could not be easily interchanged in case of supply bottlenecks. When they were interchanged, there were risks of dispensing errors and risk of non-adherence among patients who might have difficulties changing their routine of taking tablets of a certain appearance in usual quantities at specific times. This is a treatment quality risk.

40. There was no strategy for the integration of these two supply

²⁴ In 2011, the NHSO received THB 3 billion (USD 95 million), 65% of the national budget allocation for the response to HIV (Source: ASEAN Institute for Health Development: 2011)

²⁵ Migrant workers who were registered by the Ministry of Labor could buy coverage under the NHSO health insurance for about USD 60 per year, but this did not cover antiretroviral treatment

²⁶ From the dispensing hospital to the Global Fund Secretariat

Seek opportunities to integrate Global Fund support

systems, which further increased sustainability risk, even if the treatment gaps are covered by future Global Fund grants.

Recommendation 1: *The CCM and the DDC should assess the feasibility for removing barriers that prevent the integration of the Global Fund support for HIV and tuberculosis treatment in the national health system.*

Risk 2. HIV prevention and care services provided by civil society and by government institutions are not sustainable

Institutional separation of HIV prevention, HIV testing, and HIV treatment

Weaknesses in the links between services provided by NGOs and the public sector

41. About 60% of people starting ART in 2011 had a CD4 count of less than 100, i.e. they were at a relatively advanced stage of disease with a lower survival rate.²⁷ This indicated that access to ART was limited by insufficient use of HIV testing services. Reasons included the institutional separation of HIV prevention, HIV testing, and HIV treatment, and infrequent HIV testing outreach services in the community.

42. Weaknesses in the links between HIV prevention and care were particularly pronounced for key affected populations. Structural barriers preventing access to services were observed in program areas supported by the Global Fund. For example, there was no assurance that non-Thai citizens referred to health services by community organizations because of symptoms of sexually transmitted infection (STI) actually received treatment. Similarly, in some provinces including the Bangkok Metropolitan Area, there were insufficient linkages between social protection services for vulnerable children provided by the Ministry of Social Development and Human Security under the grant to DDC, and the community diagnosis and development activities for these children under the grant to ACCESS. The observed weaknesses in the links between public sector and civil society contributions are a risk to the effectiveness and sustainability of the national response to HIV and its ability to control the spread of HIV.

Slowness in introducing rapid HIV testing and shifting tasks of HIV counseling and testing to the community level

43. A contributing factor limiting access of key affected populations to HIV testing and treatment was the reluctance of the Thai DDC to adopt the introduction of rapid (same-hour) HIV testing and to shift the tasks of HIV counseling and testing to the community level. Outreach clinics operated by health services in community sites had started to provide HIV screening using same-hour tests, but confirmation still required enzyme-linked immunosorbent assay. Confirmed results of tests were therefore only available after several days. HIV testing services providing same-day results were being piloted under a USAID-supported pilot project for HIV prevention among male and transgender sex workers with good results.²⁸

Recommendation 2: *The CCM should monitor the coordination of grant-supported activities implemented by civil society organizations*

²⁷ Thailand's AIDS Response Progress Report 2012

²⁸ After only one month of operation, the testing site of the organization "Sisters" in Pataya providing HIV testing with same-day results achieved a level of about 40 tests per month, while more established sites for the same population using the standard protocol of rapid test screening and ELISA confirmation saw no growth and continued to test less than 10 clients per month over the same period. (FHI, Midterm assessment of VCT pilot project, February 2012)

with services provided to the same populations by government agencies. The CCM should create a regular forum in which weaknesses in the links between civil society and government services can be discussed and resolved.

Recommendation 3: *The CCM should work with technical partners to accelerate the adoption of task-shifting of HIV counseling and testing to the community level and to introduce rapid (same-hour) HIV testing services.*

Collection of information that is not essential for program monitoring or management

Risk 3. Information collected for program monitoring or management is not always essential and may be duplicative

44. The diagnostic review noted instances of the application of data collection instruments in all grants that either duplicated information that was available through national information systems or that collected information that was unnecessarily detailed for the purposes of grant monitoring or management. Examples include (list not exhaustive):

- Health facilities providing tuberculosis services maintained tuberculosis registers and patient cards according to international standards. Facilities participating in the Community-based Intensified Case Finding (ICF) program submitted three additional forms to the PR.²⁹ Hospitals in which the grant-supported program for Isoniazid Preventive Treatment in children was implemented, used an additional three-page form.
- The peer educator monitoring forms maintained by Rainbow Sky Association of Thailand for HIV prevention among MSM were three pages long and included a large number of questions about the profile and the behavior of clients that were never analyzed.
- Child Action Groups spent more than 50% of their time during meetings and outreach activity on the task of completing forms, particularly forms and documentation to provide proof of their activities.
- The migrant HIV prevention program managed by RTF had a total of 32 different data collection instruments for nine output indicators in the performance framework.

Some data collection was invasive and time-consuming

45. Grant implementers stated that data collection was invasive and time consuming. It interfered with the process of gaining the trust of people who are often stigmatized and suffer discrimination and interfered with transferring ownership of the prevention effort to communities. We noted instances in which data collection breached medical ethics and confidentiality.³⁰

Unnecessary effort to avoid duplicate counting of people trained

46. The Global Fund requirement to avoid “repeat counting” of people reached through education activities was translated into rigorous exercises to remove “duplicates” from reported results. To combat this, “Unique Identifier Codes” were introduced in the HIV prevention programs for men who have sex with men and for injecting drug users. This helped to provide some level of confidentiality in the effort to avoid

²⁹ Named SSF-1 to SSF-3

³⁰ For example, the referral slips for STI services collected and maintained as documented proof of performance in a migrant drop-in center visited in Bangkok identified people suffering specific STIs by name and address.

duplicate counting; however, the code could easily be broken, exposing clients to unnecessary risk.

47. A second contributing factor was a misunderstanding of the concept of “target population”. Defining target populations provides focus to a strategy. Having defined target populations should not result in rationing access to services. The HIV prevention program for migrant workers, for instance, defined certain nationalities, age groups and professional groups as their main target. Services provided to persons outside this target during outreach work or in drop-in centers were not considered to contribute to performance and were either refused or not reported because of fear that they would be discounted by the LFA during data verification.³¹

Recommendation 4: *The PRs should review and simplify data collection forms and registers in collaboration with their Sub-recipients and partners, focusing on collecting essential program monitoring and management control data in a way that is acceptable to all stakeholders and where possible, in line with the national programs. Supportive supervision should be strengthened in order to improve data quality.*

Recommendation 5: *The Global Fund Secretariat should review the need to avoid “repeat counting” of beneficiaries in programs for community systems strengthening, and instead focus on monitoring the total number and the quality of client contacts. Data collection protocols and instruments used for this purpose should be reviewed by an ethics committee to ensure confidentiality.*

Risk 4. Certain programs are not well-designed, are based on invalid assumptions or are out of date

48. The external evaluation of grant-supported HIV prevention among men who have sex with men, female sex workers and people who inject drugs made many recommendations on how to improve program effectiveness.³² The main recommendations address program design issues that have become apparent because assumptions made at the time of program inception were found to be invalid, or have become dated due to social and epidemiological change. Reprogramming grant support for HIV prevention among MSM and FSW under the DDC was already being negotiated; however, there is an equally important need to review the program approach to harm reduction under the grant to PSI.

49. The grant proposal for the support of harm reduction among people who inject drugs was developed in 2007/8 under the assumption that Thailand would adopt a national harm reduction policy and would move towards adopting a public health approach to the issue of drug use. This was indeed happening in the locations visited by the review team in Chiang Mai (Fah Mai clinic). However, this was not the case for all

Need to review approach to harm reduction under the grant to PSI

Need to place greater focus on documenting benefits of harm

³¹ For DDC, this actually occurred as documented in the LFA Phase 2 Data Quality Assessment of THA-102-G01-H (January 2011), in which the LFA proposed a downgrading of the grant performance because many people reached through workplace HIV education targeting out-of-school young people were not within the targeted age group of 12-24.

³² Institute for Population and Social Research, Mahidol University. *Evaluation of HIV programs among female sex workers, people who inject drugs, and men who have sex with men.* Draft Report 2012

reduction

Need to advocate for policy change

locations and all harm reduction strategies. For example, site visits in Bangkok and the evidence cited in the evaluation report indicate that a national roll-out of needle exchange services, while technically feasible, does not currently have enough support. There is therefore a need to review the program and place a much stronger focus on activities to document the benefits of harm reduction in the Thai context and to advocate for policy change.

Need for review and adjustment of the output indicators for community-based activities

50. For other grant-supported community programs,³³ the review team found instances of output indicators that were either inappropriately formulated, inappropriately interpreted or had unachievable targets. For example:

- Community participation in tuberculosis control was integrated into the SSF grant to DDC through sub-grants to a number of civil society SRs focusing on Intensified Case Finding (ICF) and community DOTS support. The output target for ICF among marginalized populations was determined on the basis of tuberculosis prevalence estimates in groups that were not comparable with the targeted population. Community DOTS support was only programmed for people with smear positive tuberculosis on the basis of a budgetary and public health rationale.³⁴
- Working at the community level requires responsiveness to community concerns and priorities in order to maintain credibility and trust. Excluding people with smear-negative tuberculosis from DOTS support is likely to create dissonances in tuberculosis education.
- The output indicator for STI treatment among migrants had a target that required evidence of completed treatment. Although the PR was achieving the target in terms of number of people referred, grant performance was based on monitoring the number of people treated. STI treatment, however, was not provided nor financially supported under the grant agreement. In addition, the documentation collected and filed by the implementing agencies as proof of their target achievement was in violation of standards of medical confidentiality.³⁵
- The community activities in support of vulnerable children under the grant to ACCESS, such as peer group meetings and youth camps, had strictly defined targets of numbers and types of children who could attend. Implementing agencies worked diligently to achieve these targets for each activity, even if they considered them inappropriate. In some communities, for instance, the work with highly marginalized children should be conducted in smaller groups where these children could feel safe and protected, or it should include older individuals who are key reference persons for these children. The implementing agencies feared that any deviation from the target would result in lower performance scores and budget cuts.

³³ Such as HIV prevention among migrants, ICF of tuberculosis among vulnerable populations and community mobilization for the rights and protection of vulnerable children

³⁴ While smear negative cases of tuberculosis are “not infectious” and from a purely technical public health viewpoint, their successful treatment is of lower priority, this is not normally acceptable to families and communities

³⁵ Program management files maintained by the SSRs included copies of referral slips containing full personal identification (substantiated by a copy of the ID card), as well as the diagnosis and the treatment prescribed.

Recommendation 6: *The CCM and PSI should review and revise as necessary (but not scale down) HIV prevention protocols for people who inject drugs. This reprogramming should be guided by the findings and recommendations of the external evaluation. The output performance framework and Procurement and Supplies Management plan should be adjusted accordingly.*

Recommendation 7: *The CCM and the PRs should systematically review all output indicators for community-based program activities that showed significant under- or over-performance after the first year of implementation. Where this is found to be related to invalid assumptions in target setting, indicator definition or program design, the target or indicator definition should be adjusted.*

Risk 5. The process used to procure goods through the Global Fund's Voluntary Pooled Procurement mechanism does not provide optimal results

Long procurement cycle led to receipt of bed nets after the season peaked

51. The average lead time for procurement through the VPP mechanism was 10.4 months.³⁶ The VPP guidelines recommend an average procurement lead time of six to eight months. Factors that contributed to increased lead-times included (i) purchase orders issued only after the receipt of grant funds, and (ii) the need for the PR to obtain approval from the Global Fund Secretariat where unit price quotations obtained through VPP exceeded reference prices in the approved PSM plan. The long procurement cycle led to receipt of bed-nets and retreatment kits after the peak of the malaria season,³⁷ as well as to a stock-out of Artesunate tablets requiring an emergency order.

Recommendation 8: *To reduce lead times for procurement, the DDC should:*

- *Request price quotations from the Global Fund's Procurement Services Support team before receipt of grant funds, as recommended in the VPP guidelines;*
- *Review the Year 2 forecasts for health products based on updated stock balance information and an expected delivery time of ten months for VPP orders. When there is a likelihood of stock-outs, the PR should consider splitting the order to VPP into an emergency and a regular purchase order; and*
- *Seek clarification from the Global Fund Secretariat about the conditions under which an additional approval of procurement must be obtained when the VPP price quotation exceeds the budgeted cost.*

Risk 6. The financial oversight of grant programs by PRs and SRs is not effective

Need to adopt a risk-based approach for financial oversight of the large number of

52. Financial monitoring plans over SRs and SSRs prepared by the PR and SRs, respectively, were not risk-based. Oversight plans did not always focus on those implementing organizations that managed substantial grant funds. In particular:

³⁶ Analysis of last eight purchase orders for malaria and HIV health products issued in SSF Year 1 documented a lead-time ranging from 6.4 to 14.6 months between placing the order and receipt in Thailand

³⁷ Purchase order 0993-ITN-VPP-0035 for LLINs and for deltamethrin bed net retreatment tablets

grant implementers

- Some PRs only conducted financial monitoring visits once a year,³⁸ a practice that did not provide early warning signs of potential problems that could be corrected.
- One SR covered a limited number of its SSRs.³⁹ Another SR did not conduct financial monitoring of its implementing organizations due to lack of budget.⁴⁰
- Documented checklists and testing sheets to facilitate monitoring visits were either not available or required improvement.
- One SR did not formally communicate the findings and recommendations from financial monitoring visits to its SSRs. There were no established procedures for following up the status of implementation of recommendations from monitoring visits.⁴¹

Recommendation 9: *The PRs and SRs should:*

- *Adopt a risk-based approach to planning and conducting financial monitoring visits, considering factors such as disbursement amounts, findings from previous monitoring visits, and external and internal audit findings;*
- *Calculate budgetary needs to implement financial monitoring plans and negotiate with the grantors for necessary funding; and*
- *Prepare/improve and implement tools for financial oversight staff to assist them during monitoring visits, including a mechanism to track and monitor the implementation of recommendations made. Training should be provided to finance staff on supportive supervision.*

Risk 7. There is poor financial management capacity, including financial controls and financial management practices

Scope to strengthen financial management capacity of implementers

53. There had been no documented financial management capacity assessments of SRs and SSRs in our sample that would have allowed them to address any capacity weaknesses. The review team noted challenges, particularly among SSRs, in recruiting and retaining accounting staff. This situation sometimes resulted in late submission of financial reports. Many SSRs maintained accounting records using Excel spread-sheets⁴² and/or did not have finance staff⁴³ available to prepare financial reports. Multiple revisions of financial reports were required due to errors.

Need to address root causes of financial control weaknesses

54. Weaknesses in financial controls observed among implementing organizations included:

³⁸ DDC and RTF

³⁹ SR BVBD conducted financial monitoring of only 7 SSRs out of its 54 SSRs. These 7 SSRs only constituted 8% of the total disbursement to all SSRs during Oct'11 to Sep'12.

⁴⁰ BTB did not conduct financial monitoring visits for any of its 17 SSRs as there was no budget allocated for this purpose

⁴¹ SR BATS did not formally communicate the findings and recommendations from financial monitoring visits to any of the 57 SSRs visited during Oct'11 to Sep'12.

⁴² 29 out of 49 SSRs of BATS, Planned Parenthood Association of Thailand, World Vision Foundation Thailand and BTB relied on Excel spreadsheets to maintain their accounts.

⁴³ 68 out of 71 SSRs of BTB and BVBD did not have a finance staff to prepare the periodic financial reports submitted to the SR.

- Accounting staff sharing a single user name and password to access the accounting software, making it difficult to identify who had used the software;⁴⁴
- No restrictions on accounting staff accessing, editing and deleting grant transactions;⁴⁵
- A failure to close the accounting system periodically to prevent irregular transactions from being entered after the submission of financial reports, which could lead to unauthorized changes to financial records in prior periods;⁴⁶ and
- Delays in entering transactions in the accounting system, resulting in incomplete/inaccurate books of account. Key contributing factors included inadequate staff capacity and inadequate mastery of the accounting software.

Recommendation 10: *The PRs and SRs should assess the financial management capacity of both new and existing implementing organizations and SSRs in the following areas: Accounting systems, policies and procedures, personnel and Information Technology. Following this, the PRs and SRs should develop and implement action plans to address any gaps found.*

⁴⁴ PR Access, SR BATS, Planned Parenthood Association of Thailand

⁴⁵ PRs DDC and Access and SRs BVBD, BTB, BATS, Thai National AIDS Foundation

⁴⁶ PRs DDC and Access and SRs BVBD, BTB, Thai National AIDS Foundation

Annex 1: Abbreviations

ACCESS	AIDS Access Foundation
ACT	Artemisinin-based combination therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BATS	Bureau of AIDS and Sexually Transmitted Infections
BTB	Bureau of Tuberculosis
BVBD	Bureau of Vector-borne Diseases
DDC	Department of Disease Control
DOTS	Directly Observed Treatment, Short course
GPO	Government Pharmaceutical Organization
HIV	Human Immunodeficiency Virus
ICF	Intensified Case Finding
IDU	Injecting Drug Users
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MDR-TB	Multi-Drug Resistant Tuberculosis
NGO	Non-Governmental Organization
NHSO	National Health Security Office
OIG	Office of the Inspector General (of the Global Fund)
PR	Principal Recipient
PSI	Population Services International
PSM	Procurement and Supplies Management
RTF	Raks Thai Foundation
SR	Sub-recipient
SSF	Single Stream Funding
SSR	Sub-sub-recipient
STI	Sexually Transmitted Infection
THB	Thai Baht
TNAF	Thai National AIDS Foundation
USAID	United States Agency for International Development
USD	United States Dollar
VPP	Voluntary Pooled Procurement
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant Tuberculosis

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Annex 2: Recommendations and Management Action Plan

Risk	Recommendation	Comments and Agreed Actions	Responsible Party	Due Date
Program				
1. Risk that the Global Fund support for HIV and tuberculosis treatment targeting the uninsured population is neither efficient nor sustainable	Recommendation 1: <i>The CCM and the DDC should assess the feasibility for removing barriers that prevent the integration of the Global Fund support for HIV and tuberculosis treatment in the national health system.</i>	HIV: the assessment will be done on the issue of ; <ul style="list-style-type: none"> • ART for migrants • HIV prevention among FSW, MSM and PWID TB: the assessment will be done on the issue of ; <ul style="list-style-type: none"> • Distribution system of anti-TB drugs 	<ul style="list-style-type: none"> • PR-DDC, • NAMc/Bureau of AIDS, • Bureau of Tuberculosis 	May 2013
2. Risk that HIV prevention and care services provided by civil society and by government institutions are not sustainable	Recommendation 2: <i>The CCM should monitor the coordination of grant-supported activities implemented by civil society organizations with services provided to the same populations by government agencies. The CCM should create a regular forum in which weaknesses in the links between civil society and government services can be discussed and resolved.</i>	<ul style="list-style-type: none"> • The oversight plan being developed will include the coordination of grant-supported activities implemented. • CCM in collaboration with PRs will organize the regular meeting forum between civil society and government. 	<ul style="list-style-type: none"> • CCM, • Oversight committee, • PRs 	June 2013
	Recommendation 3: <i>The CCM should work with technical partners to accelerate the adoption of task-shifting of HIV counseling and testing to the community level and to introduce rapid (same-hour) HIV testing services.</i>	<ul style="list-style-type: none"> – The national consultation on strategic use of ARV in august 2012 has pointed out the issue of task-shifting of HCT to the community. – The formulation of policy will be developed and proposed to the National AIDS Committee in June 2013. 	NAMc/BATS PR-PSI	June 2013
M&E				
3. Risk that information collected for program monitoring or management is	Recommendation 4: <i>The PRs should review and simplify data collection forms and registers in collaboration with their Sub-recipients and partners, focusing on</i>	<ol style="list-style-type: none"> 1. In year 2 SSF, PR-DDC will perform as OIG recommend – PR-DDC will review and simplify data collection forms with SRs, SSRs, of all 3 SSF grants and 	1. PR – DDC, SRs, SSRs, IA	1. (PR-DDC) Within Quarter 7-8 of 2013 (April-

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<p>not always essential and could be obtained from the national health information system</p>	<p><i>collecting essential program monitoring and management control data in a way that is acceptable to all stakeholders and where possible, in line with the national programs. Supportive supervision should be strengthened in order to improve data quality.</i></p>	<p>especially with particular SRs which are the national program i.e. Bureau of AIDS, National AIDS Management Center, Bureau of Tuberculosis and Bureau of Vector Borne Diseases.</p> <ul style="list-style-type: none"> - IA (Hospital), SSRs and SRs will be trained regarding method of using program and data collection forms linked with the national health information. - PR and SR will conduct site visit at SR, SSR and IA levels in order to strengthen data quality of all levels using RDQA at least twice a year, by using RDQA method. <p>2. Raks Thai Foundation needs to discuss with the Global Fund Portfolio Manager of Thailand and SR to simplify data collection forms and registers. The data collection forms developed for the program are based on the requirement of the Global Fund on data disaggregation by nationalities, ages, gender, as well as on target attendance assuring for each activity.</p> <p>3. (ACCESS) Child Action Groups (CAG) are considered a crucial mechanism to carry out community-based services for vulnerable children. Therefore, it was agreed amongst PR (ACCESS), SRs, and SSRs to have a measure to support CAGs to run activities, rather than spending too much time to deal with financial and programmatic documents. However, PR-ACCESS has to share the concern to its SRs and SSRs to find solutions together. Actions to be taken are:</p> <ul style="list-style-type: none"> • Consultation meeting with the SRs and SSRs. • Focus group discussion with representatives of CAGs in 4 regions (North, Northeast, South, and Central region), including SRs and SSRs. • Meeting with SRs/SSRs to conclude solving 	<p>2. Raks Thai Foundation, Global Fund Portfolio Manager of Thailand</p> <p>3. PR-ACCESS, SRs, and SSRs</p>	<p>September 2013)</p> <p>2. (Raks Thai) Quarter 7 onwards</p> <p>3. (ACCESS) December 2012 – February 2013 (completed)</p> <ul style="list-style-type: none"> • Consultation meeting with the SRs and SSRs. • Focus group discussion with representatives of CAGs in 4 regions (North, Northeast, South, and Central region), including SRs
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		<p>measures.</p> <p>All of these activities were already completed. It was founded that CAGs were confused about the programmatic documents and the supporting documents required for the financial purpose.</p> <p>For the programmatic documents, mostly they are data collection forms to assist CAGs to analyze OVC's situation for planning and designing activities, and following up the cases. Despite the fact there are 4 forms that CAGs have to fill in and/or use to collect data, they are not required to fill in all at once. The forms will be completed when each activity takes place, 2-5 activities in each quarter depending on the work plan.</p> <p>For the financial supporting documents, PR, SRs, and SSRs agreed to simplify the forms and minimize the number of the forms. Forms (e.g. meeting's registration forms, per dium's receipt vouchers, etc.) have to be prepared for CAGs by SSRs.</p> <p>SRs and SSRs have to communicate with CAGs about these forms and stand by to provide assistance or clarification when needed.</p> <p>PR and its SRs and SSRs have a plan to listen to CAGs' comments and assess the situation together again.</p>		<p>and SSRs.</p> <ul style="list-style-type: none"> •Meeting with SRs/SSRs to conclude solving measures. <p>By September 2013</p> <ul style="list-style-type: none"> •Feedback from CAGs after the adjustment
	<p>Recommendation 5: <i>The Global Fund Secretariat should review the need to avoid "repeat counting" of beneficiaries in programs for community systems strengthening, and instead focus on monitoring the total number and the quality of client contacts. Data collection protocols</i></p>	<ol style="list-style-type: none"> 1. PR – DDC welcomes OIG recommendation and will discuss with the GF secretariat as recommended. 2. Raks Thai Foundation developed MIS program 	<ol style="list-style-type: none"> 1.PR – DDC, GF Secretariat 2.Raks Thai 	<ol style="list-style-type: none"> 1. (PR-DDC) Within Quarter 7-8 of 2013 (April-September 2013) 2. (Raks Thai)

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	<i>and instruments used for this purpose should be reviewed by an ethics committee to ensure confidentiality.</i>	<p>database by having program access authorization. The supporting documents related to the beneficiaries are kept by the program sites and required for security and confidentiality.</p> <p>3. PR-PSI agrees and supports the recommendation to eliminate the need to separate 'double-counting' and focus on retention in program services and increasing frequency of contacts with clients.</p>	<p>Foundation,</p> <p>PSI</p>	<p>Quarter 7 onwards</p>
4. Risk that certain programs are not well-designed, are based on invalid assumptions or are out of date	Recommendation 6: <i>The CCM and PSI should review and revise as necessary (but not scale down) HIV prevention protocols for people who inject drugs. This reprogramming should be guided by the findings and recommendations of the external evaluation. The output performance framework and Procurement and Supplies Management plan should be adjusted accordingly.</i>	CCM agree with OIG recommendation; CCM and PR-PSI will review and the revision of the program for PWID will be utilizing the result from as inputs	CCM (TC-HIV), PR-PSI	June 2013
	Recommendation 7: <i>The CCM and the PRs should systematically review all output indicators for community-based program activities that showed significant under- or over-performance after the first year of implementation. Where this is found to be related to invalid assumptions in target setting, indicator definition or program design, the target or indicator definition should be adjusted.</i>	<ul style="list-style-type: none"> PRs will review their performance of the first year of implementation. <p>PRs will share the finding revision to the oversight committee and the target setting for each program will be revised in terms of the target or indicator definition</p>	<ul style="list-style-type: none"> PR-DDC PR-PSI PR-RTF PR-ACCESS CCM Oversight Committee PRs 	As mentioned in the comments
PSM				
5. Risk that the process used to procure goods through the Global Fund's Voluntary	Recommendation 8: <i>To reduce lead times for procurement, the DDC should:</i> - Request price quotations from the Global Fund's Procurement	<ul style="list-style-type: none"> In year 2, before receipt of grant fund, PR DDC will submit the official letter request to The Global Fund to purchase the drugs by VPP method since January 2013. 	PR – DDC and FPM Thailand	As mentioned in the comment

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<p>Pooled Procurement mechanism does not provide optimal results</p>	<p><i>Services Support team before receipt of grant funds, as recommended in the VPP guidelines;</i></p> <ul style="list-style-type: none"> - <i>Review the Year 2 forecasts for health products based on updated stock balance information and an expected delivery time of ten months for VPP orders. When there is a likelihood of stock-outs, the PR should consider splitting the order to VPP into an emergency and a regular purchase order; and</i> - <i>Seek clarification from the Global Fund Secretariat about the conditions under which an additional approval of procurement must be obtained when the VPP price quotation exceeds the budgeted cost</i> 	<ul style="list-style-type: none"> • In year 2 of HIV-SSF Grant (Oct 12 – Sep 13) PR has split purchase order of ARV drug order to prevent stock out and long lead time for delivery as recommended since Jan 2013. • PR DDC agrees with OIG recommendation. <p>It is worth to note here that there is no risk of anti-TB and anti-Malarials stock out.</p>		
Financial Management				
<p>6. Risk that the financial oversight of grant programs by PRs and SRs is not effective</p>	<p>55. Recommendation 9: <i>The PRs and SRs should:</i></p> <ul style="list-style-type: none"> • <i>Adopt a risk-based approach to planning and conducting financial monitoring visits, considering factors such as disbursement amounts, findings from previous monitoring visits, and external and internal audit findings;</i> • <i>Calculate budgetary needs to implement financial monitoring plans and negotiate with the grantors for necessary funding; and</i> • <i>Prepare/improve and implement tools for financial oversight staff</i> 	<p>The PR-DDC and SRs agree with the recommendation to adopt a risk-based approach as recommended. The financial monitoring visits will be conducted every 3 month at the SRs and/or SSRs which are high risk and every 6 month for the SR and SSR which are low risk.</p> <p>By the Work Plan adjustment and saving carried over from year 1, budget for implementing financial monitoring plans is adequate.</p> <p>Financial tools will be reviewed and provide to PR's financial oversight staff to assist them during monitoring visits as recommended. Capacity building the finance staff on supportive supervision will be provided. In addition, PR will analyze the strange and weakness and train to</p>	<p>PR-DDC and SR</p>	<p>Start from Quarter 6 onwards</p>

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	<p><i>to assist them during monitoring visits, including a mechanism to track and monitor the implementation of recommendations made. Training should be provided to finance staff on supportive supervision.</i></p>	<p>improve the management and potential of the finance staff</p> <p>Raks Thai Foundation fully agrees on the recommendations and will act as follow:</p> <ul style="list-style-type: none"> - Planning and conducting monitoring visits by considering all risk factors of SRs and SSRs; - Increasing financial support for PR, SRs and SSRs on their monitoring visit and training. This will be requested to the Global Fund during the grant reprogramming; and - Improve and implement monitoring tools for financial and programmatic oversight. <p>PR-PSI has already initiated such efforts and continues to strive for improvements in financial management. PR-PSI has developed a risk management strategy; site visits and internal and external audits are regularly conducted; finance management trainings have been delivered and additional trainings are planned for the future; PSI HQ provides a wide range of financial, procurement, operational, research and SR monitoring management tools.</p>	<p>Raks Thai Foundation, Global Fund Portfolio Manager of Thailand</p> <p>PR-PSI</p>	<p>Quarter 7 onwards</p>
<p>7. Risk that there is poor financial management capacity, including financial controls and financial management practices</p>	<p>Recommendation 10: <i>The PRs and SRs should assess the financial management capacity of both new and existing implementing organizations and SSRs in the following areas: Accounting systems, policies and procedures, personnel and Information Technology. Following this, the PRs and SRs should develop and implement action plans to address any gaps found.</i></p>	<p>1. (PR-DDC) Before starting implementation of HIV, TB and Malaria SSF grant, PR-DDC has assessed the SRs of three grants on 4 areas: programmatic, financial management system, procurement and supply management system, M&E including data management.</p> <p>In Part 2 of General Agreement and Conditions item 10 in the Program Grant Agreement between the PR and the SRs, the PR has informed the SRs to assess the SSRs for the capacity to carry out the Program activities before supported the fund. During the implementation of year 1 the PR has conducted internal auditing to monitor and audit the document all 4 areas of the SRs: programmatic, financial management system, procurement and supply</p>	<p>PR-DDC</p>	<p>(PR-DDC) The SR assessment will be reviewed and provide capacity building as needed started from Q7 (Apr 2013)</p>

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		<p>management system, and data management in quarter 3 -4 and planned to continue the internal auditing every 6 months. Regarding accounting system, PR has installed the accounting software to some SRs which did not have the accounting software, trained and followed up to ensure the understanding and can develop the report from the accounting software. The PR has informed the SRs to hire the qualified financial staff as recommended by OIG</p> <p>2. (PR-ACCESS) At the PR level, PR-ACCESS agreed to take the OIG’s recommendation to improve the internal financial control by</p> <ul style="list-style-type: none"> •differentiating user names and passwords for users and authorizers to access the accounting software and/or edit the data. •Closing the accounting system periodically. <p>At the SRs/SSRs level, PR-ACCESS will have a discussion with SRs to identify gaps in the capacity of SSRs in the financial control. Primarily, assumption from the SSRs are:</p> <ul style="list-style-type: none"> •Insufficiency of finance/accounting staff at the SSRs level, in terms of number and capacity. •Limited number of SSRs’ staff (2 staff per SSRs responsible for a large number of CAGs) •Lack of proper job handover to new finance/accounting staff at the SSR level. •Inadequate explanation of the GF’s financial requirements provided to the finance/accounting staff of SSRs. •Complication of the financial report that SSRs have to report to SRs. <p>However, these are assumptions reflected by a number of SRs. PR-ACCESS has to seek more information and identify measures to address the financial control capacity at the SSR level with the SRs’ support.</p>	<p>PR-ACCESS</p>	<p>March – May 2013</p> <ul style="list-style-type: none"> •PR-ACCESS to improve the authorized access to the accounting system, and to improve the accounting data entry and accounting close on a regular basis and on a timely basis. <p>May – July 2013</p> <ul style="list-style-type: none"> •Finalize gaps in the capacity of the SSRs in financial management and identify agreed solution measures with SRs and SSRs.
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		<p>PR-PSI has thoroughly reviewed and assessed SR and SSR capacity in the recommended areas already. In addition, PR-PSI uses the Technical Support Management Plan (developed internally) to provide support and track performance of SRs and SSRs.</p>	<p>PR-PSI</p>	<p>July – August 2013 <ul style="list-style-type: none"> •Consult with the GF for the possibility to adjust the budget if more finance/accounting staff required at the SSR level. </p>
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