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The Global Fund

To Fight AIDS, Tuberculosis and Malaria

The Office of the Inspector General

Country Audit of Global Fund Grants to Cambodia

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Acronyms

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Antiretroviral
BBC	British Broadcasting Corporation
BCC	Behavioural Change Communication
BEC	Bid Evaluation Committee
BMGF	Bill and Melinda Gates Foundation
CATA	Cambodia Anti Tuberculosis Association
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CCC	Country Coordinating Committee
CCCSC	Country Coordinating Committee Sub Committee
CDC	Centers for Disease Control
CENAT	National Centre for Tuberculosis and Leprosy Control
CHAI	Clinton Foundation for HIV/AIDS Initiative
CIPLA	The Chemical, Industrial and Pharmaceutical Laboratories
CMS	Central Medical Store
CNM	National Centre for Parasitology Entomology and Malaria Control
CoI	Conflict of Interest
CP	Conditions Precedent
CPE	Cambodia Pharmaceutical Enterprises
CPN+	Cambodian People Living with HIV/AIDS Network
CRC	Cambodia Red Cross
CQ + SP	Chloroquine and Sulphadoxypyremethamine
CV	Curriculum Vitae
DDF	Department of Drug and Food
DFID	Department for International Development
DID	Drug Information Database
DOTS	Direct Observed Treatment / Therapy
DPHI	Department of Planning and Health Information
DR	Disbursement Request
DU	Drug Users
EDAT	Early diagnosis and treatment
EDB	Essential Drugs Bureau
EML	Essential Medicines List
FPM	Fund Portfolio Manager
GAVI	Global Alliance for Vaccine and Immunization
GDF	Global Drug Facility
GFATM	Global Fund to Fight HIV/AIDS Tuberculosis and Malaria
GMS	Global Management Solutions
HEAD	Health and Development Alliance
HIS	Health Information System
HIV	Human Immunodeficiency Virus

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HR	Human Resource
HSP	Health Sector Strategic Plan
HSS	Health Systems Strengthening
HSSP	Health Sector Support Project
IBN	Impregnated Bed Nets
ICB	International Competitive Bidding
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IFB	Invitation For Bid
IRS	Insecticide Residential Spray
IT	Information Technology
JAPR	Joint Annual Performance Review
JICA	Japan International Cooperation Agency
KHANA	Khmer HIV/AIDS National Alliance
KHATT	Khmer HIV Training Team
LFA	Local Fund Agent
LLIMN	Long-Lasting Insecticide Treated Mosquito Net
LLIN	Long Lasting Insecticide Treated Nets
LMIS	Logistics Management Information System
MBPI	Merit Based Performance Incentive
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR	Multi-Drug Resistant
MDR TB	Multi-Drug Resistant Tuberculosis
MDM	Medicins du Monde
MMM	Mundol Mith chuoy Mith (Friends Helping Friends)
MOA	Memorandum of Agreement
MOEF	Ministry of Economy and Finance
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
MOU	Memorandum of Understanding
NAA	National AIDS Authority
NAP	National AIDS Program
NCB	National Competitive Bidding
NCHADS	National Centre for HIV/AIDS, Dermatology and STI
NDP	National Drug Policy
NGO	Non-Governmental Organization
NLDQC	National Laboratory for Drug Quality Control
NTP	National TB Programme
OD	Operational District
OI	Opportunistic Infection
OIG	Office of the Inspector General
OJT	On the Job Training
OP	Operational Plan
OVC	Orphans and Vulnerable Children
OSDV	On Site Data Verification

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PAO	Provincial AIDS Office
PFD	Partners for Development
PFHD	Partner for Health and Development
PLWHA	People Living With HIV and AIDS
PMG	Priority Mission Group
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Project Monitoring Unit
PR	Principal Recipient
PRTRT	Principal Recipient Technical Review Team
PSF	Pharmaciens Sans Frontiere
PSI	Population Services International Cambodia
PSM	Procurement and Supply Chain Management
PSRP	Poverty Reduction Strategic Plan
PUDR	Project Update Disbursement Request
QC	Quality Control
QA	Quality Assurance
RCC	Rolling Continuation Channel
RDT	Rapid Diagnostic Test Kits
REDA	Rural Economic Development Association
RFQ	Request For Quotation
RHAC	Reproductive Health Association of Cambodia
RGC	Royal Government of Cambodia
SCC	Salvation Centre Cambodia
SEAD	Sharing Experience for Adapted Development
SHCH	Sihanouk Hospital Centre of Hope
SOP	Standard Operating Procedures
SR	Sub Recipient
STG	Standard Treatment Guidelines
SSR	Sub Sub Recipient
STI	Swiss Tropical Institute
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach Programme
SWIM	Sector Wide Management
TA	Technical Assistance
TB	Tuberculosis
TGF/GF	The Global Fund To Fight AIDS Tuberculosis and Malaria
TGFATM	The Global Fund to Fight AIDS, TB and Malaria
TOR	Terms of Reference
TRP	Technical Review Panel
TRT	Technical Review Team
TWG	Technical Working Group
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations International Children Education Fund
USAID	United States Agency for International Development
US\$	United States Dollars

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USP	University of the South Pacific
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
VCCT	Voluntary Confidential Counselling and Testing
VMW	Village Malaria Worker
VPP	Voluntary Pooled Procurement
WHO	World Health Organization
WHOPES	WHO Pesticide Evaluation Scheme
XDR	Extensive -Drug Resistant

Executive Summary

Introduction

1. The Office of Inspector General (OIG), as part of its 2009 work plan, carried out the audit of the Global Fund grants to Cambodia. The purpose of the audit was to assess the adequacy of the internal control and programmatic processes in managing the Global Fund grants in Cambodia. The audit objectives were to:

- a) assess efficiency and effectiveness in the management and operations of grants;
- b) measure the soundness of systems, policies and procedures in safeguarding Global Fund resources; and
- c) assess the effectiveness of established mechanisms/controls to safeguard Global Fund resources in Cambodia;

2. The audit covered all the Global Fund grants to the Country whose details are shown in the table below:

Round	Component	Grant Number	Grant amount	Disbursed
Ministry of Health (MOH) of the Royal Government of Cambodia				
1	HIV/AIDS	CAM-102-G01-H-0	14,701,497	14,701,497
2	HIV/AIDS	CAM-202-G02-H-0	14,765,625	14,583,357
2	Malaria	CAM-202-G03-M-0	9,730,345.00	9,683,872.00
2	TB	CAM-202-G04-T-0	6,169,733.00	6,169,732.00
4	HIV/AIDS	CAM-405-G05-H	36,546,134	33,045,355
4	Malaria	CAM-405-G06-M	9,857,891	9,072,273
5	HIV/AIDS	CAM-506-G07-H	34,963,654	25,063,560
5	HSS	CAM-506-G08-S	4,698,327	2,872,691
5	TB	CAM-506-G09-T	9,022,696	6,194,851
6	MOH	CAM-607-G10-M	13,105,131	11,601,812
		10 grants	153,561,033	132,989,000
National Centre for HIV/AIDS, Dermatology and STI (NCHADS)				
7	HIV/AIDS	CAM-102-G04-H-00	23,857,767	14,783,462
		1 grant	23,857,767	14,783,462
National Centre for Parasitology, Entomology and Malaria Control (CNM)				
RCC	Malaria	CAM-202-G03-M	17,539,174	5,519,604
		1 grant	17,539,174	5,519,604
The National Centre for Tuberculosis and Leprosy Control (CENAT)				
R7	TB	CAM-708-G12-T	7,597,209	3,798,118
		1 grant	7,597,209	3,798,118
		Total 13 grants	202,555,183	157,090,184

Table 1: Summary of grants Source: The Global Fund website

Scope

3. The audit covered the operations of the Principal Recipients (PRs) and their interactions with their SRs and the oversight by the Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA) and the Global Fund Secretariat. The audit covered:

- (a) *Compliance* of the grant structures, systems and processes with the grant agreement; laid down policies, procedures and guidelines and country laws;
- (b) *Internal control* where the adequacy of the structures and systems were assessed in safeguarding grant assets against possible misuse and abuse;
- (c) *Financial review* to ensure that funds were utilized in accordance with the grant agreements and that value for money was derived from money spent; and
- (d) *Grant management* i.e. obtaining assurance that the systems, processes and controls in place are efficient and effective in supporting the achievement of grant objectives.

Summary of findings

4. This section briefly highlights the achievements, findings and conclusions arising from the audit. The detailed findings are contained in the rest of the report. It is, however, essential that this report is read in its entirety in order to comprehend fully the approach to, and findings of the OIG's work.

Achievements and challenges

5. The MOH also achieved some success in relation to the procurement and supply chain management for the HIV/AIDS program e.g. (i) pooling ARV procurements and obtaining discounts on purchases and assurance of quality; (ii) taking initiatives to improve the performance of pharmacovigilance activities to detect, assess, understand and prevent any side effects of medications; and (iii) having well defined distribution and storage channels.

6. However, the MOH's achievements were constrained by (i) the Ministry's lack of capacity to manage programs especially as the number of grants increased; (ii) delayed reporting by SRs thus affecting the reporting to the Global Fund and affecting disbursements; and (iii) delays in procurements by some SRs which resulted in slow program implementation and low absorption of funds.

7. NCHADS was able to achieve success in program implementation through (i) the "100% condom use program" in 24 provinces reaching more than 90% of entertainment workers; (ii) Home and community based care for people living with HIV being scaled up to cover 657 health centres in 20 provinces; (iii) Anti Retroviral Therapy (ART) and Opportunistic Infection (OI) services expanded to 51 sites in 20 provinces (31,999 people were receiving ART including 3,067 children). NCHADS however had a slow start up mainly caused by a delay in (i) the selection of the SRs; (ii) preparing and finalizing the PSM plan; and (iii) The presence of counterfeit drugs.

8. CNM achieved some success in the fight against malaria with (i) the Malaria incidence rate declining from 7.5 per 1,000 in 2004 to 4.1 per 1,000 in 2008; the Malaria mortality rate declining from 2.8 per 100,000 in 2004 to 1.4 per 100,000 in 2008; the Village Malaria Worker (VMW) program expanding from 2 to 10 provinces; the level of public awareness of proper treatment procedures increasing

from 47% in 2004 to 72% in 2008; and CNM having a well-defined storage and distribution system.

9. However, CNM's achievements in implementing Global Fund programs were constrained by (i) frequent changes to the national treatment guidelines for malaria creating challenges in the forecasting/quantification of drugs; CNM having difficulty in finding a WHO prequalified supplier for Artesunate and Mefloquine (A+M) co-blister; the high presence of counterfeit drugs which contributed to the high drug resistance; and the low number of cases of malaria treated at public sector health facilities continued to be low which meant that the targets were not going to be met.

10. The Global Fund contributed to the success of the TB program in 2008 as demonstrated by (i) the TB cure rate being 91% against the 2008 target of 85%; the case detection rate of smear positive pulmonary TB was 69% against the 2008 target of 70%; (iii) Basic DOTS reached 100% health centre coverage; (iv) Community DOTS was expanded to cover 506 health centres; (v) Public/private DOTS expanded to 11 provinces; and (vi) TB/HIV collaboration program expanded to 57 ODs.

11. However, CENAT's achievements in implementing Global Fund grants were constrained by (i) the lack of skilled human resource and capacity at lower levels; (ii) ineffective treatment of Multi-Drug Resistant (MDR) cases; and (iii) ineffective collaboration between the HIV and TB programs work.

Control environment within which the programs were implemented

12. The OIG noted that as the Global Fund support increased, there was a gradual reduction in the government and other partner support. This was contrary to the Global Fund principle that requires recipients to treat its funds as additional to the host country resources and from other external sources to fight the three diseases. Excessive reliance on one partner, the Global Fund in this case, could put at risk the entity's strategy in the event that assistance is no longer available.

13. All four PRs established parallel structures from the national ones to manage the programs funded by the Global Fund. These parallel structures led to a duplication of roles throughout the entities audited. The creation of parallel structures goes against the grain of the Global Fund principles and the Paris Declaration that call for the use of national systems.

14. At the time of the audit, there was no capacity building and /or transition plan for transitioning the program from the parallel structures to the national ones. The OIG also noted a gradual movement of staff from government positions to equivalent positions under the Global Fund programs because the latter offered better remuneration scales. To the extent possible, all the PRs should put in place plans to transition back to national systems.

15. The OIG noted that recruitment by the PRs was driven by the availability of funding and by the requirements of the work load. Staff were recruited for each grant and not in order to address work load. A job evaluation should be undertaken to assess the available skills in the government structures to carry out different functions and what additional skills are required to deliver the programs funded by the Global Fund. It should also cover amalgamating the different roles that are duplicated by grant into the appropriate number of jobs required to deliver the Global Fund grants.

16. The OIG noted that there was poor delegation of authority within all the PR structures. This was evidenced by the directors having to authorise most, if not all, the transactions incurred. Directors were therefore involved in menial tasks. Their time could have been put to better use. Effective delegation of authority increases teamwork, productivity, and provides staff with the opportunity to develop their professional knowledge and skills. It also increases morale.

17. The staff incentives paid by the different PRs were not harmonised with those of other institutions in the ministry. The salaries paid to contract staff were significantly higher than those paid to government staff employed in the same institution. This caused distortions in the government structures within the various institutions as staff moved from government positions to the more lucrative contract positions. The incentives paid were also much higher than those paid by other donors.

18. A government decree in April 2008 required that all Development Partners (DPs) including the Global Fund to align their practices on salary supplements with the Merit-Based Performance Incentive (MBPI) ¹ scheme. The RGC subsequently terminated the MBPI for civil servants from 1 January 2010 while at the same time allowing the DPs to continue paying salary supplements according to the practices employed prior to 1 January 2010. This caused confusion since the earlier decree had required alignment of such supplements. At the time of the audit, the DPs were still in dialogue with the RGC on a way forward. The OIG recommends that all PRs stop payment of salary incentives until this dialogue has come to a conclusion.

19. All the PRs made most of their payments in cash and not through the bank system. This raised the risk of misappropriation of the money. The OIG has recommended that the practice of payment for goods, services and salaries in cash should stop.

20. The OIG noted consistent failure by the PR and the SRs to comply with approved work plans and budgets. The OIG did not see evidence of the Ministry obtaining approval for expenditure that was not in the approved budget. As a

¹ The MBPI initiative is designed to provide an incentive to personnel in positions that are critical to the attainment of the government's mission, as well as to rationalise the current arrangement of ad hoc salary supplements. It was meant to provide transparency and consistency in the remuneration of RGC staff while placing an emphasis on developing a performance culture by establishing a linkage between the provision of financial incentives and the setting and monitoring of performance goals.

result, expenditure amounting to US\$ 185,690 that was not in line with approved work plans should be refunded to the Global Fund.

PR program management

21. An overview of all grants to date revealed that the Country Coordinating Committee (CCC) has treated all grants separately i.e. as a one off and not as part of one national program for any one disease. The focus by the CCC as presented through the proposals to date had been almost solely focused on ‘what’ should be funded and monitored to the relative neglect of ‘how’ to best go about working strategically and harmonising the grants with other programs already in place in the government. The administration and management of these grants also became cumbersome as the number of grants grew. The Ministry’s grants should be consolidated by disease. This will increase the synergies across the grants for the different diseases and reduce administrative work load.

22. Cambodia was one of the few countries which were successful with their grant applications for the Health System Strengthening (HSS) under Round 5. The wider health sector context within which Round 5 is functioning is one of a dynamic leadership and is results oriented. However, it was difficult to ascertain what useful, sustainable impact the Round 5 HSS was having, how efficiently the funds were being used to strengthen health systems and what contribution the HSS had made to the results in the wider health sector. This was because most of the HSS grant indicators were not related to the 15 core national health sector indicators.

23. Cambodia has a high resistance rate for anti-malarial drugs putting it in peculiar situation since it requires special drug combinations. This prompted the special procurement of artesunate and mefloquine for which there is no WHO pre-qualified manufacturer. With the approval of the Global Fund, co-blisters from non WHO prequalified manufacturers have been procured. This resulted in episodes of ACT shortages since 2006 and these will be experienced until a permanent solution is found to the supply of ACTs that specifically address the complex malaria treatment requirements in Cambodia.

24. The OIG reviewed the procurement of nets and noted that CNM (the PR) had not in the past used generic LLIN technical specifications. There was therefore no competition and CNM depended on a single supplier. In a letter to CNM, the Global Fund advised that the net specifications were fairly specific and would not allow for competition amongst all WHO Pesticide Evaluation Scheme (WHOPES) recommended LLINs. This resulted in the delay of procurement activities for LLINs.

Systems that support program implementation

25. There was no alignment with the national Monitoring & Evaluation (M&E) system. All the PRs established parallel systems and structures for M&E including the associated functions of data collection and analysis. The OIG also noted that these parallel systems came with excessive provision of technical assistance (TA)

posts for M&E. This TA was not contributing to strengthening the national M&E system but was supporting contract staff that should have had the requisite skills at the time they were recruited.

26. The indicators that were developed for the Global Fund grants were additional to other indicators in place within the health sector i.e. the Health Information System (HIS) indicators, those for the national disease programs and also required by other DPs. These indicators were established without consulting the DPHI which is the government department responsible for the planning and setting of indicators.

27. Clear policies, strategies and guidelines exist in support of equitable, accessible, quality service delivery. However, it is common for patients to be charged for what should be 'free' drugs and commodities in the public sector. The public has little confidence in public sector delivery and uses the private sector extensively. Salaries were also noted to be low and some health facilities were understaffed resulting in poor quality of service delivery.

28. The term has been described as meeting a four-tier hierarchy of capacity i.e. (i) structures, systems and roles; (ii) staff and facilities; (iii) skills; and (iv) tools. All too often the focus of capacity development was on the latter two i.e. skills development training and developing guidelines and other documents. In the case of training, this translated into numerous training sessions in meetings, workshops, courses and attendance at overseas conferences. There had also been no effectiveness or impact evaluation of all this training or of the extensive use of technical assistance (TA).

29. The OIG saw no evidence of on-the-job mentoring or of institutional capacity development. While there was the occasional example of quality TA, it has tended to be in the form of 'doers' rather than mentors. It also seemed to have had little influence on strengthening the ministry as an institution. Rather it benefited just one of the 3 diseases or worse still just one of the Global Fund grants.

30. The OIG carried out field visits as part of the audit and noted the following:

- (a) Health products that should have been provided free of charge e.g. nets were sometimes being sold to the public;
- (b) Some of the nets that had been distributed were not in use;
- (c) Some of the condoms that were distributed by PSI were sold at prices that were higher than the recommended retail price;
- (d) There were no bin cards maintained by the stores at regional level. At the service delivery centers, stock registers were not maintained. Records of lost and damaged drugs were not maintained by the service delivery centers;
- (e) Expired drugs had been delivered to a health centre; and
- (f) There was no written policy or guidelines for disposal of expired drugs. However, expired drugs were kept separately from un-expired drugs. Nonetheless, expired drugs, if not destroyed promptly, may be issued to

unsuspecting patients or may be released into the market (especially to the private sector).

Procurement and Supply Chain Management

31. Cambodia public sector lacks a defined procurement legal framework and policies for use by the public institutions. The Global Integrity report (2008) identified major weaknesses on the effectiveness of the public procurement process suggesting that the operating environment within which public procurements were undertaken was prone to fraud and corruption.

32. The procurement guidelines developed for Global Fund procurements made no reference to any national guidelines for procurement nor the Ministry of Economy and Finance (MOEF) rules and regulations (including a sub decree of 2006). These guidelines were inadequate to effectively support the Global Fund grant procurements. They lacked clarity and depth of detail for experience and knowledge of public procurement and did not represent procurement best practices. The Ministry had plans to review the guidelines to bring them into line with best practices but there was insufficient capacity within the Ministry to do so.

33. The establishment of procurement units with the PR and SRs resulted in a fragmentation of procurement activities. Across all the four PRs, there was weak procurement planning, lack of procurement and contract management capacity, lack of transparency in some procurement processes. Value for money was not being achieved for some purchases and procurement practices were focused on national competitive bidding methods using local agents.

34. Contracts awarded for procurement of goods and services (health products, non-health products, services and civil works) did not, in the majority of cases, conform to formal written procurement guidelines and best practice. Procurement processes were not open, competitive and transparent. Goods and services of assured quality were not always obtained at the lowest possible prices.

35. Cambodia has a high prevalence of counterfeit and substandard drugs. This includes Artemisinin-based Combination Therapies (ACT) and Opportunistic Infection (OIs). A University of the South Pacific (USP) report of June 2009 showed that 27% of Artesunate being distributed in Cambodia was counterfeit. A similarly high percentage was reported for some OIs. The laws that would help curb the proliferation of counterfeit and substandard drugs were in place but law enforcement was weak. Urgent action is needed to address this problem.

Country Coordination Mechanism - Country Coordinating Committee

36. The OIG noted that there were no guidelines in place to guide the nomination process for PRs until Round 7. After Round 7, guidelines were developed were not consistently applied from Round to Round. There was no evidence that the CCC followed due diligence of the PRs' capacity. In the period when there were no procedures and criteria for PR nominations, the CCC nominated the MOH to be PR

i.e. up to and including Round 6. Thereafter, the final selection of the PRs was made through voting by the CCC.

37. The CCC is also required to facilitate linkages and consistency between Global Fund assistance and other development and health assistance programs in support of national priorities. The OIG's review of CCC minutes presented no evidence of discussion or review of programs funded by other development partners for HIV/AIDS, malaria, TB or health systems strengthening. In practice this audit revealed numerous instances of divergence from the national structures and non alignment of the Global Fund programs to those implemented by other partners. There was no evidence of any effort being made to harmonise the activities of various programs run by the PRs.

Local Fund Agent

38. The work of KPMG as LFA since the inception of Global Fund grants till the end of September 2008 could not be fully reviewed as the OIG was not granted access to the work papers. Many of the issues identified in the OIG's audit should have been picked up by KPMG. KPMG also performed external audits of SRs which in the OIG's view represented a conflict of interest.

39. The Swiss Tropical Institute (STI) is the current LFA for the Global Fund grants to Cambodia. STI as a public health institute has a strong programmatic background and resources and the work in Cambodia reflected this. However, they had limited skill and experience in procurement and finance. The OIG noted that there was no risk assessment done either at the country or grant level. Failure to undertake review work with a risk management perspective, may lead to significant weaknesses not being identified by the LFA.

40. Quality assurance policies and procedures were not evident from OIG's review of the work carried out by the current LFA. The STI lacked standard work procedures; there was no evidence of work planning; processes for allocation of staff, documenting data verifications, documenting of internal meetings; documenting of findings and conclusions or evidence of review and quality assurance, in country or from Basel.

The Global Fund Secretariat

41. The Global Fund Secretariat oversees program management by ensuring that both the Global Fund and PRs adhere to the provisions of grant agreements. The OIG noted the following cases where non-compliance to grant agreements provisions was not followed by action from the Secretariat to enforce compliance.

42. Arguably, some of the issues identified by the OIG during the audit reflect the effectiveness of the Global Fund Secretariat in providing oversight in the past over grant implementation. These include the type of indicators that the country was allowed to have, creation of parallel and duplicative structures to the national

structures, the frequent unapproved budget allocations, failure to follow up program income, weaknesses in PSM arrangements etc.

43. The OIG however noted that in the recent past, there was marked improvement in the LFA and Secretariat oversight over the grants in Cambodia. This has resulted in significant changes that have strengthened the control environment within which the programs were being implemented.

44. The salary supplements and incentives paid to Government staff were stopped as of the 1 January 2010. The impact of the termination of salary supplements/incentives is that there will be low morale, more staff losses in the public sector, a lower quality of performance and an increase in corruption. The Global Fund Secretariat should discuss with development partners what the health sector response should be to mitigate the risk to grant implementation by the sudden announcement of the discontinuation of the salary supplements and incentives.

Report Structure

45. This report is presented by functional areas such as the environment within which programs were implemented; grant management by PR; systems that support program management; procurement and supply management; and oversight functions. The functional areas may be broken down into specific functional areas. Good internal control practices or significant achievements found during the audit are mentioned in the report, but they are not discussed in depth given that the purpose of the audit was to identify significant risks and issues that needed to be addressed.

46. The recommendations have been prioritized. However, the implementation of all recommendations is essential in mitigating identified risks and strengthening the internal control environment in which the programs operate.

The prioritization has been done to assist management in deciding on the order in which recommendations should be implemented. The categorization of recommendations is as follows:

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

systems, procedures and risk management for the benefit of the management of the grant programs.

Introduction

Situation analysis

HIV/AIDS

47. Cambodia has a generalized epidemic and one of the highest prevalence rates in Asia. Following a peak of 3% in 1997, prevalence rates among people 15-49 years old declined to 2.1% in 2002 and to 1.6% in 2005². While the epidemic appeared to have stabilized, the number of people with AIDS needing antiretroviral therapy has increased over the years.

48. Cambodia's HIV/AIDS epidemic has spread primarily through heterosexual transmission and has revolved largely around the sex trade. Although Cambodia is one of the poorest countries in the world, extraordinary HIV prevention and control efforts exerted by the Royal Government of Cambodia and its partners have helped to reduce the spread of HIV.

49. Though prevalence among the general population has continued to decline, groups that engage in high-risk behaviors have continued to threaten Cambodia's success in fighting HIV/AIDS. Significantly, a low prevalence rate in the general population continues to mask far higher prevalence rates in certain sub-populations, such as injecting drug users, people in prostitution, men who have sex with men, karaoke hostesses and beer girls, and mobile and migrant populations.

Malaria

50. Malaria is a major concern for people living in Cambodia's hilly forested environments and forest fringes. The number of reported malaria cases decreased gradually between 1993 and 2003. However, in 2003 the reported number of treated cases, severe cases and deaths started to increase again. This apparent increase was partly attributed to improving access to public health facilities in remote areas because of improved infrastructure, improved referral systems and more regular and reliable reporting.

51. There has been great concern about the high level of multidrug resistance present in affected areas. Strains of *P. falciparum* are resistant to most antimalarial drugs, and the quality and usage pattern of antimalarial drugs are suboptimal. Recent studies show that counterfeit and substandard drugs are prevalent in Cambodia. Furthermore, a survey of antimalarial drug use in 2002 showed problems of delayed treatment-seeking behaviour, widespread use of many antimalarial drugs for the same malaria episode and non-adherence to malaria treatment.

² HIV sentinel surveillance, Ministry of Health/National Center for HIV/AIDS, Dermatology and Sexually Transmitted Infections (NCHADS))

52. The main focus of the National Malaria Control Program (NMCP) is to strengthen clinical management of malaria cases, provide surveillance and health education and promote the use of ITNs. Good-quality drugs and improvement in treatment access and patient compliance also are essential to combat the emergence and spread of resistant strains of *P. falciparum*.

Tuberculosis

53. Cambodia ranks 21st on the list of 22 high-burden tuberculosis (TB) countries in the world. An estimated 64 percent of Cambodians are infected with TB, and a substantial number of cases remain undetected. In 2007, around 13,000 Cambodians died from the disease. There were almost 71,000 new TB cases in Cambodia in 2006, with an estimated incidence rate of 495 cases per 100,000 population.

54. The National TB Control Program (NTCP) began DOTS (the internationally recommended strategy for TB control) implementation in 1994 and by 2004, DOTS coverage reached 100 percent. Although there is a high burden of disease, the TB situation in Cambodia has remained relatively stable over the past five years. The country has maintained a TB case detection rate of around 60 percent and a treatment success rate of more than 90 percent, although cure rates vary dramatically across provinces. Case detection has fallen after reaching 68 percent in 2005. It is not clear if the decline is due to a drop in incidence or problems with case finding. Increasing the participation of community members to refer and supervise TB patients and collaborating with the private sector will likely improve case finding.

55. The 2009 World Health Organization (WHO) Global TB Report estimated that there were only 94 cases of multidrug-resistant (MDR) TB in Cambodia, although preliminary results from the ongoing second National Tuberculosis Drug Resistance Survey show that cases of MDR-TB have appeared and around 60 patients are being treated for MDR-TB. HIV prevalence among new TB cases is 7.8 percent, very high compared with the national HIV prevalence of 0.8 percent. HIV co-infection among new cases is also high compared with the WHO regional average but just below the average of 11.0 percent for high-burden countries.

Interventions by the Global Fund

56. The Global Fund has provided funding to the Royal Government of Cambodia since 2003. The Ministry of Health has been the PR for Rounds 1-6, managing at one point a total of 10 grants worth US\$ 154.5 million. In 2005, the CCC noted that the growing size of the grants had strained Ministry's capacity and a decision was made to appoint the three Ministry institutions central to fighting the three diseases as PRs. In 2007, the MOH alongside its National Centre for HIV/AIDS, Dermatology and STI (NCHADS), National Centre for Parasitology, Entomology and Malaria Control (CNM) and the National Centre for Tuberculosis and Leprosy Control (CENAT) became PRs for Rounds 7 and 9 and a RCC.

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Ministry of Health

57. The MOH signed the first grant agreement under Round 1 with the Global Fund for HIV/AIDS on 27 January 2003. The MOH subsequently received 9 other grants, 8 for the 3 diseases and one for HSS. The table below provides a summary of the grants managed by the Ministry at the time of the audit.

Round	Disease	Status	Total grant amount (\$)	Total disbursed	Total spent
1	H	Closed	14,701,497	14,701,497	14,574,179
2	H/M/T	Closed	30,665,703	30,578,062	30,416,705
4	H/M	Phase II	46,404,025	42,117,628	28,176,819
5	H/HSS/T	Phase II	48,684,677	34,131,102	25,439,384
6	M	Phase I ending	13,105,131	11,601,812	5,097,808
	Total		153,561,033	132,989,000	103,704,895

58. The grants received from the Global Fund were for the following activities :

Intervention	Activities
HIV/AIDS	<ul style="list-style-type: none">• Prevention of HIV and care and management of HIV and of AIDS• Sexually transmitted infection (STI) prevention and management• Management of drugs and other commodities
Malaria	<ul style="list-style-type: none">• Malaria Behavioural Change Communication (BCC) and health education• Distribution of Impregnated Bed Nets (IBN) and re-impregnation• Early diagnosis and treatment• Strengthening the institutional capacity of CNM
Tuberculosis	<ul style="list-style-type: none">• The expansion of community Directly Observed Therapy (DOTS)• The expansion of DOTS health center• Health education
HSS	<ul style="list-style-type: none">• Strengthening forecasting, assessment of needs, timely provision of drugs, vaccines & medical supplies, procurement process, storage and distribution systems• Strengthening (i) Sector wide management (SWIM), (ii) Existing planning and M&E processes & mechanisms; (iii) Technical planning capacities for managers at central, provincial and district levels

Achievements and challenges

59. The MOH achieved some success in the implementation of the HIV/AIDS program as reflected in the performance results published in the 2008 Joint Annual Performance Review (JAPR) as detailed below:

- (a) The Ministry carried out pooled procurements for ARVs for all its SRs and obtained discounts on purchases and assurance of quality;
- (b) The Ministry also initiated the performance of pharmacovigilance activities to detect, assess, understand and prevent any side effects of medications; and;

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- (c) Channels for distribution and storage were well defined. The logistics management information system was strengthened through the implementation of drug inventory databases and streamlining and the Essential Drug Bureau handing over the order processing function to Central Medical Stores.

60. However, the MOH's achievements were constrained by:

- (a) The Ministry lacking the requisite capacity to manage programs especially as the number of grants increased. This necessitated the recruitment of additional international technical assistance consultants and local staff to fill identified gaps.
- (b) Some SRs failing to comply with the reporting requirements resulting in delays in reporting to the Global Fund and thus affecting timely disbursements.
- (c) Delays in procurements by some SRs which resulted in slow program implementation and low absorption of funds.

National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS)

61. The National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) is a semi-autonomous institution within the MOH. It falls under the MOH Director General of Health Services. NCHADS was established in 1998 following the amalgamation of the National Aids Programme (NAP) and the National STD and Dermatology Clinic. NCHADS operates in the 24 provinces in the country.

62. NCHADS' primary purpose is to respond to the HIV/AIDS epidemic through the implementation of the HIV/AIDS strategic plan. On HIV/AIDS the functions of NCHADS include (i) policy development programme planning and evaluation; (ii) management, provincial support, coordination with other partners in the health sector; (iii) development of guidelines; (iv) epidemiology, behaviour and effective STD/HIV/AIDS prevention; and (v) care, information and implementation.

63. NCHADS' operational plan falls within the comprehensive annual health sector plan and cascades down to disease specific plans and provincial and district operational plans. These plans were available at NCHADS as well as at all health facilities visited. The health facilities had relevant up-to-date treatment and other guidelines. NCHADS also has a well defined storage and distribution system.

64. Prior to being appointed as PR, NCHADS was an SR of the MOH under Rounds 1, 2, 4, and 5. The table below provides an analysis of grants managed by NCHADS as PR and SR as at 31 October 2009:

	SR				PR
	Round 1 US\$	Round 2 US\$	Round 4 US\$	Round 5 US\$	Round 7 US\$
Period	1.8.2003 - 31.8.2006	1.1.2004 - 31.12.2008	1.9.2005 - 31.8.2010	1.9.2006 - 30.9.2011	4.12.2008 - 30.11.2010
Status	Closed	Closed	Ongoing	Ongoing	Ongoing

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Total budget	3,545,101	2,385,158	20,063,675	3,304,177	23,857,767
Funds received	2,907,562	1,489,288	3,042,868	1,668,116	14,783,761
Interest received					6,268
Fund spent	2,623,821	1,458,030	2,859,868	1,595,511	6,956,295
Balance	283,741(R)	31,258(R)	194,485	130,543	6,943,447
	(R) - refunded to PR				

Source: NCHADS records

Achievements and challenges

65. NCHADS' pace of the project implementation in the first 2 quarters of Round 7 was slow as evidenced by the low target achievement rates and the low disbursements. The slow start up was caused by a delay in (i) the selection of the SRs; and (ii) preparing and finalizing the procurement and supply management plan and subsequently its ability to purchase program inputs. NCHADS entered into agreements with 17 SRs. These SRs have been instrumental in accelerating the pace of program implementation. At the time of the audit, US\$ 5,726,838 had been transferred to SRs.

66. Despite these setbacks, NCHADS was able to achieve success in program implementation. The 2008 Ministry of Health JAPR conducted in 2008 showed that:

- (a) The "100% condom use program" covered 24 provinces reaching more than 90% of "entertainment" workers;
- (b) Home & community based care for people living with HIV scaled up to cover 657 health centres in 20 provinces;
- (c) OI/ Anti Retroviral Therapy (ART) services expanded to 51 sites in 20 provinces; and
- (d) 31,999 people were receiving ART including 3,067 children.

67. However, at the time of the audit, the program was still behind schedule with regard to the following targets:

Activities	Target	Achieved	%
Number of Injecting Drug Users (IDU) reached by Needles Syringe Programme	600	25	4
Number of dependent Drug Users (DU) enrolled on methadone programme per year	25	0	0
Number of people trained on Orphans and Vulnerable Children (OVC) care	75	37	50
Number of OVC households receiving nutritional support	1909	1295	68

Source: PUDR number 1

68. NCHADS' achievements in implementing Global Fund programs were constrained by the following challenges:

- (a) Unavailability of qualified consultants for TA. NCHADS had failed to find suitably qualified M&E expert and procurement candidates;
- (b) As a new PR, NCHADS was learning to manage the large number of SRs under its fold; and

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- (c) The presence of counterfeit drugs. A recent study carried out in Cambodia revealed that up to 27% of ACTs in the market were fake.

The National Centre for Parasitology, Entomology and Malaria Control (CNM)

69. The National Centre for Parasitology, Entomology and Malaria Control (CNM) was established in 1984. CNM is a semi-autonomous institution within the MOH. CNM's director reports to the Director General Health Services. CNM is responsible for controlling vector borne diseases with its key functions as (i) conducting research; (ii) implementation, monitoring and evaluation of disease control programmes; and (iii) training and supervision of health staff.

70. CNM was an SR to the MOH under Round 2, 4 and 6. CNM became a PR under the RCC grant and was also approved as the PR for the Round 9 Malaria grant. The objectives of the programs funded by the Global Fund were to:

- (a) Increase community awareness and care-taking practices on malaria prevention and control;
- (b) Improve access to preventive measures with a focus on bed net distribution and re-treatment;
- (c) Increase access to early diagnosis and treatment for malaria throughout the country;
- (d) Strengthen the institutional capacity of the national malaria control program at all levels; and
- (e) Halt the development and prevent the spread of anti-malarial drug resistance.

71. The table below provides a summary of the grants managed by CNM at the time of the audit:

	SR			PR	Total US\$
	Round 2 US\$	Round 4 US\$	Round 6 US\$	RCC US\$	
Status	Closed	Ongoing	Ongoing	Ongoing	
Grant income	3,977,705	3,832,508	6,587,609	5,519,604	19,917,425
Grant expenditure	4,072,204	2,917,731	5,439,299	175,689	12,604,923
	-	914,777	1,148,310	5,343,915	7,407,002

Achievements and challenges

72. CNM achieved some success in the fight against malaria since the commencement of the Global Fund grants as reflected in the following results:

- (a) The Malaria incidence rate declined from 7.5 per 1,000 in 2004 to 4.1 per 1,000 in 2008;
- (b) The Malaria mortality rate declined from 2.8 per 100,000 in 2004 to 1.4 per 100,000 in 2008;
- (c) The Village Malaria Worker (VMW) program expanded from 2 to 10 provinces;

- (d) The level of public awareness of proper treatment procedures increased from 47% in 2004 to 72% in 2008; and
- (e) CNM has a well defined storage and distribution system and also has an approved PSM plan for the RCC grant.

73. However, CNM's achievements in implementing Global Fund programs were constrained by the following challenges:

- (a) There were frequent changes in national treatment guidelines for malaria. This presented challenges to the forecasting/quantification of drugs and created the need to continuously retrain treatment providers;
- (b) CNM had difficulty in finding a WHO prequalified supplier for Artesunate and Mefloquine (A+M) co-blister;
- (c) The country had a high presence of counterfeit drugs which contributed to the high drug resistance. A recent study into the existence of counterfeit drugs in Cambodia showed that up to 27% of malaria drugs in the market were fake; and
- (d) The number of cases of malaria treated at public sector health facilities continued to be low and not meet targets. The number of cases of malaria treated per 1,000 population at public sector health facilities in 2008 was 4.1 against a target of 6.5. Malaria patients continued to go to the user-friendly private sector for treatment instead of getting free treatment at public sector health facilities.

National Centre for Tuberculosis and Leprosy Control (CENAT)

74. The National Centre for Tuberculosis and Leprosy Control (CENAT) was established in 1980. CENAT is a semi-autonomous institution within the MOH. CENAT's director reports to the Director General Health Services. The National Tuberculosis Program (NTP) operates under the responsibility of CENAT. CENAT received its first Global Fund grant under Round 2 as an SR of MOH. This grant was closed in June 2009. Since this initial grant, CENAT has accessed grants under Round 5 as an SR and under Round 7 as a PR.

75. The goal of the Global Fund Round 7 TB program was to reduce morbidity and mortality due to tuberculosis and is in line with the Cambodia Millennium Development Goals and the Stop TB Strategy. The key objectives of the programs funded by the Global Fund were to:

- (a) ensure high quality tuberculosis services nationwide;
- (b) strengthen DOTS activities in health centers and TB units;
- (c) expand DOTS services and bring them close to patients;
- (d) improve awareness and knowledge on TB through appropriate communication activities;
- (e) strengthen the monitoring and evaluation system; and
- (f) address emerging priorities, including TB/HIV and MDR-TB.

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76. The table below provides a summary of CENAT's funds flow analysis as at 31 October 2009:

	SR		PR	Total US\$
	Round 2 US\$	Round 5 US\$	Round 7 US\$	
Status	Closed	Ongoing	Ongoing	
Grant income	5,778,597	2,918,216.51	3,363,864.00	12,060,677.51
Grant expenditure	5,778,597	2,478,528.55	791,525.11	9,048,650.66
Balances	-	439,687.96	2,572,338.89	3,012,026.85

Achievements and challenges

77. Since the commencement of the Global Fund grants, CENAT achieved some success in the fight against TB as shown below:

- (a) There was an increase in case detection rate from 64% in 2004 to 69% in 2008;
- (b) CENAT had a treatment success rate of 94% in 2008;
- (c) There was an increase in the number of new smear positive cases detected and registered under DOTS from 18,978 to 19,860 in 2008; and
- (d) CENAT retained the services of CMS for the storage and distribution of its products.

78. The Global Fund contributed to the success of the TB program in the health sector performance in 2008 as demonstrated the following:

- (a) The TB cure rate was 91% against the 2008 target of 85%;
- (b) The case detection of smear positive pulmonary TB sat at 69% against the 2008 target of 70%;
- (c) Basic DOTS reached 100% health centre coverage;
- (d) Community DOTS was expanded to cover 506 health centres;
- (e) Public/private DOTS expanded to 11 provinces; and
- (f) TB/HIV collaboration program expanded to 57 ODs.

79. However, CENAT's achievements in implementing Global Fund grants were constrained by the following challenges:

- (a) The lack of skilled human resource and capacity at lower levels;
- (b) ineffective treatment of Multi-Drug Resistant (MDR) cases; and
- (c) ineffective collaboration between the HIV and TB programs.

Control environment within which programs were implemented

80. This section of the report considers the control environment within which program implementation was undertaken. Issues that emerged during the OIG audit are mostly generic to, or cut across, all 4 PRs. To avoid repetition of key issues across all the PRs, this section highlights the internal control issues that cut across all the PRs. The subsequent sections address those issues that were unique to particular PRs. The senior management of the Ministry of Health should ensure that these recommendations are implemented by each of the PRs.

Institutional arrangements**Sustainability of programs**

As the Global Fund support increased, there was a gradual reduction in the government and other development partner support. This was contrary to the Global Fund principle that requires recipients to treat its funds as additional to the host country resources and from other external sources to fight the three diseases. Excessive reliance on one partner, the Global Fund in this case, puts at risk the entity's strategy in the event that assistance is no longer available.

81. The Global Fund requires recipients to treat its funds as additional to the host country resources and from other external sources to fight the three diseases. However, as the Global Fund support increased, there has been a gradual reduction in government and other partner support. This invariably increased the level of dependence on the Global Fund to finance programs. Excessive reliance on one partner, Global Fund in this case, creates risks and could be detrimental to an entity's strategy in the event that this assistance is no longer available.

82. The table below illustrates NCHADS' funding trend:

Year	2007		2009		% increased/ (decreased)
	US\$ m	%	US\$ m	%	
Total Budget	10.58	100	15.18	100	44
Government contribution	0.62	6	0.36	2	(40)
Other support	4.65	44	3.49	23	(25)
The Global Fund	5.31	50	11.32	75	113

83. The table below illustrates CENAT's funding trend:

Source of funding	2005	2006	2007	2008	2009	2010
	US\$000	US\$000	US\$000	US\$000	US\$000	US\$000
Domestic sources	823	863	975	1,000	1,050	1,100
World Bank	407	428	643	580	-	-
JICA	350	350	350	350	200	-
Government of Japan	750	750	-	-	-	-
WHO	560	60	60	60	60	60

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Source of funding	2005	2006	2007	2008	2009	2010
	US\$000	US\$000	US\$000	US\$000	US\$000	US\$000
USAID	2,700	1,800	1,970	2,400	2,000	2,000
TB-CAP	-	-	616	616	900	-
Total non-GF resources	5,590	5,590	2,646	3,076	2,960	3,160
Global Fund	1,523	1,037	1,579	2,827	6,712	6,809
Percentage of GF	21	16	37	48	67	68

84. The table below shows CNM's funding trend:

Source of funding	2006	2007	2008	2009	2010	2011
	US\$	US\$	US\$	US\$	US\$	US\$
Domestic sources	2,958	2,375	2,177	3,800	4,174	4,089
WHO/USAID	500	500	500	500	500	500
Department for International Development (DFID)	51	107	276	275	275	275
Bill & Melinda Gates Foundation	-	-	-	7,440	2,060	-
Total non-GF resources	3,509	2,982	2,953	12,015	7,010	4,864
Global Fund (incl. Round 9)	2,551	3,948	9,554	12,702	12,975	39,667
Percentage of GF of total	42%	57%	76%	51%	65%	89%

Recommendation 1 (High)

CNM, CENAT and NCHADS should under the leadership of the MOH develop a sustainability plan with strategies to address the reduction of funding by government and other DPs. The sustainability plan should tackle how the three can leverage additional funding. It should be discussed with stakeholders such as donors, MoH, and MOEF with a view of getting buy-in and alternative sources of funding.

Oversight

The four PRs had nonexistent/ineffective oversight structures over the programs funded by the Global Fund. The MOH created a Technical Review Team to oversee the program activities but its scope did not cover the Health Support Strengthening grant. There was no evidence of the MOH providing oversight to the programs run by NCHADS, CENAT and CNM. The effectiveness of the management teams of the all the four PRs in providing program oversight was affected by their inadequate delegation of tasks, micromanagement of functions e.g. procurement etc.

85. The three new PRs i.e. NCHADS, CENAT and CNM are semi-autonomous institutions within the MOH. They are headed by directors who report to the Director General of Health Services in the MOH. However, the OIG did not see evidence of the MOH providing oversight over these organisations' activities nor program implementation funded by the Global Fund. As is common practice in most ministries the world over, there were no management committees in place to oversee the respective institutions' strategies, program implementation, human resources, funding etc. Consequently, there is inadequate oversight over the management and programs of these entities.

Recommendation 2 (High)

The MOH should establish an oversight body for the three institutions responsible for the implementation of Global Fund programs. This body should meet regularly to oversee the respective institutions' strategies, governance matters, operations and overall program performance. The MOH should develop comprehensive guidelines that define the various oversight activities like supervision, providing advice, monitoring, coordinating and supporting the management team.

86. All the PRs established Bid Evaluation Committees (BEC) in line with the procurement guidelines to provide oversight over the procurement and supply chain management processes. In all cases, these committees mainly consisted of the PR senior management team. However, the OIG noted from the review of a sample of procurements that the PR management through the BEC micromanaged procurement activities. The roles and responsibilities of the staff and technical assistance in the procurement department were often dominated by the activities of the BEC. For example, the OIG saw evidence of the BEC influencing tender awards e.g. by changing the tender evaluation criteria.

Recommendation 3 (High)

The BEC's mode of operation should be redefined in order to elevate it from procurements operations to providing oversight over the procurement and supply chain management processes. This should include a change of the name of the committee from BEC to the "PR Tender Committee" in order to remove any role confusion that may arise out of its current title. Their role should be supervisory, advisory, monitoring, coordinating and supportive.

Structures established to manage the programs

All four PRs established parallel structures from the national ones to manage the programs funded by the Global Fund, which goes against the grain of the Global Fund principles and the Paris Declaration. At the time of the audit, there was no capacity building and /or transition plan for transitioning the program from the parallel structures to the national ones. To the extent possible, all the PRs should put in place plans to transition back to national systems.

87. All four PRs had established parallel structures from the national ones to manage the programs funded by the Global Fund. While the senior management teams were the same for government and the Global Fund programs, the roles were split between government and Global Fund specific work at the lower functional levels. For example, the finance and administration function for government was separate from that of the programs funded by the Global Fund.

88. All the PRs had two procurement units in place i.e. a government one as approved by the MOH and another one for managing the program funded by the Global Fund. The reporting structures of the two procurement functions were different with two sets of staff undertaking procurement. The OIG did not see evidence of any coordination or information sharing between the two teams. These parallel structures affected the efficiency and effectiveness with which

procurement activities were undertaken e.g. there was no pooling of procurement of common items in order to benefit from economies of scale.

89. These parallel structures led to a duplication of roles throughout the organisations audited. The OIG also noted a gradual movement of staff from government positions to equivalent positions under the Global Fund programs because the latter offered better remuneration scales. This weakened the government structures. Because the Global Fund positions are for defined periods, this also raised the risk that these entities may lose valuable skilled staff in the event that the Global Fund grants come to an end.

90. The creation of parallel systems goes against the grain of the Global Fund principles that advocate for the use of national systems and the Paris Declaration that refers to the need to *'Avoid, to the maximum extent possible, creating dedicated structures for day-to-day management and implementation of aid-financed projects and programmes'*.

91. There was limited alignment of donor programs with Cambodian institutions and procedures. According to the 2006 OECD harmonization and alignment baseline survey, there were at least nine different 'project implementation units' in the health sector³. Target 6 in the Declaration is to reduce by two-thirds the stock of parallel PMUs⁴. While the PRs/ SRs were set up prior to the 2005 Declaration, there was no indication of any move to dismantle the parallel structures. In fact, the three newly appointed PRs followed the Ministry example and established more parallel structures.

92. At the time of the audit, there was no capacity building and /or transition plan for transitioning the program from the parallel structures to the national ones. Because most of the staff handling program work related to the Global Fund were contract staff/ international technical advisors, it created a dependency on experts for the delivery of the programs. The OIG also did not see evidence of capacity building of staff within the national structures to take over the roles undertaken by the experts. These parallel systems therefore came at an extra financial and dependency cost to the programs, the benefit of which would be short-lived once they are removed.

93. Another example is the financial management policies and procedures in place for all the PRs. All PRs developed and used financial policies and procedures for Global Fund programs that are different from government policies and procedures. While the government policies and procedures were deemed to be inadequate at the start of the Global Fund program, there were no efforts to improve these. The PRs developed their own guidelines which did not necessarily address the weaknesses identified in the government ones and resulted in the weakening of checks and balances normally embedded in the government structures.

³ DPHI 2007 Strategic framework for health financing. Department for Planning and Health Information, Ministry of Health

⁴ OECD/DAC Paris Declaration on Aid Effectiveness, High Level Forum 28 February - 2 March 2005, Paris

Recommendation 4 (High)

To the extent possible, all the PRs should use national structures, systems and procedures for implementation of program activities. In cases where parallel systems have to be established due to inadequate capacity in the Ministry, these structures should be for a defined period of time with relevant capacity building and transition plans for the eventual transitioning back to national structures. Any skills gaps within the government structure should also be addressed by training existing staff or recruiting suitable staff to fill vacant positions.

Internal audit

94. Most of the PRs i.e. CENAT, NCHADS and CNM did not have internal audit functions in place. While the MOH had an internal audit department, its audits were restricted to the transactions incurred from government funds and did not cover activities funded by the Global Fund. Although having internal audit is not a mandatory requirement from the Global Fund, it helps strengthen the control environment within which programs are implemented. This is especially commended since all the PRs have SRs and regional offices that an internal audit unit should periodically visit.

Recommendation 5 (Significant)

CNM, CENAT and NCHADS should consider establishing internal audit functions to review SRs and program implementation in the regions. For the Ministry of Health, the internal audit work undertaken by the government auditors should cover the activities funded by the Global Fund.

Human resource management

Staff were recruited for each grant and not in order to address work load. There was also poor delegation of authority within all the PR structures. A job evaluation should be undertaken to assess the available skills in the government structures to carry out different functions and what additional skills are required to deliver the programs funded by the Global Fund.

95. The OIG noted that all the PRs had weak human resources functions as evidenced by inadequate policies and practices around the recruitment, task allocation and appraisal of staff.

96. All PRs recruited staff by grant and not in order to address work load. Recruitment was driven by funding availability and not to address work load. For example there was a project co-coordinator, M&E, procurement and supply management and finance staff for each of the Rounds for each PR. This was in addition to the directors and vice directors for each of the respective institutions responsible for Global Fund grants.

Recommendation 6 (High)

The MOH should retain the services of a human resources expert to undertake a job evaluation⁵. The objective of this will be to assess the available skills in the government structure and to identify what additional skills are required to deliver the programs funded by the Global Fund. It should also cover amalgamating the different roles that are duplicated by grant into a reasonable number of jobs required to deliver the Global Fund grants.

97. The human resource policies were inadequate to guide key areas such as recruitment, performance evaluation, recruitment and promotion. The OIG noted instances where the human resource practices did not follow best practice. For example, there was no requirement to disclose any potential conflicts of interest as part of the recruitment process. This resulted in relatives of staff in key positions being recruited in all the PRs.

98. The OIG's review of the job descriptions also revealed that they did not reflect the actual roles and responsibilities that staff were undertaking. Some staff had similar job descriptions for different functions e.g. the MOH planning officer and the M&E officer had similar job descriptions. At NCHADS, the job descriptions for accounting staff included procurement roles and vice versa. For CNM and CENAT, the descriptions of procurement staff contained human resource tasks. The failure to define the functions, roles and responsibilities of staff in their different capacities created confusion among the staff. Job descriptions should be clear and understandable especially if they are to be used as benchmarks for the evaluation of staff.

99. The OIG also noted that there was poor delegation of authority within all the PR structures. This was evidenced by the directors having to authorise most, if not all, the transactions. Directors were therefore involved in menial tasks like signing training instructions, approving goods received notes, approving petty cash supporting vouchers. Their time could have been put to better use. Effective delegation of authority would increase teamwork and provide staff with the opportunity to develop their professional knowledge and skills, give them personal satisfaction and increase morale.

Recommendation 7 (Significant)

(a) In order to strengthen the control environment within which the programs are being implemented, the management of all the PRs must:

- support the development and enforcement of appropriate human capital policies for hiring, training, evaluating, counseling, advancing, compensating and disciplining personnel;*
- clearly define and delegate areas of authority, responsibility and reporting throughout the different institutions; and*
- ensure personnel appointed possess and maintain the proper knowledge and skills to perform their assigned duties.*

⁵ Job evaluation is a systematic process that you can use to determine the relative level, importance, complexity, and value of each job in your organization.

- (b) *The job descriptions for all staff should be reviewed and should :*
- reflect in detail the different responsibilities that are executed by the people in those positions. Performance should be measured against the job descriptions issued;*
 - show who a staff member is responsible to and who they should be reporting to. While this may be reflected on the organization chart, it should also be mentioned in the job description for clarity;*
 - be signed by a management level member of staff and the jobholder as evidence of commitment to meeting the terms that have been laid out; and*
 - be reviewed at the time of renewing the contracts for staff to ensure that they are up to date and reflect any changes in work that may have arisen over time and such revisions should follow the RGC guidelines.*

Staff salaries

The salaries paid to contract staff were significantly higher than those paid to government staff employed in the same institution. The staff incentives differed by PR and were not harmonised with those paid by other donors thus causing distortions in the government structures. A government decree in April 2008 required that all Development Partners (DPs) including the Global Fund to align their practices on salary supplements with the Merit-Based Performance Incentive (MBPI) scheme. At the time of the audit, the DPs were still in dialogue with the RGC on this matter.

100. The OIG noted that the staff incentives paid by the different PRs were not harmonised with those of other entities in the ministry. The salaries paid to contract staff working on Global Fund programs are significantly higher than those paid to government staff employed in the same institution. The incentives paid are also much higher than those paid by other donors. This causes distortions in the government structures within the various institutions as some staff have moved from government positions to the more lucrative contract positions.

101. A government decree (sub-decree 29) in April 2008 required that all Development Partners (DPs) align their practices on salary supplements with the Merit-Based Performance Incentive (MBPI) scheme. The MBPI initiative is designed to provide an incentive to personnel in positions that are critical to the attainment of the government's mission, as well as to rationalise the current arrangement of ad hoc salary supplements. This was to provide transparency and consistency in the remuneration of RGC staff while placing an emphasis on developing a performance culture by establishing a linkage between the provision of financial incentives and the setting and monitoring of performance goals.

102. The Global Fund agreed with the Government that this alignment would take place over the period of two years. In December 2009, the RGC decided to terminate the MBPI for civil servants from 1 January 2010 onwards (sub-decree 206). The following day, the Deputy Prime Minister sent a letter to the DPs stressing that in addition to terminating the MBPI, the termination also applied to

“salary supplements” or “supplemental allowances” and “all other such incentives /schemes” or “other similar pay incentive schemes”, from the end of 2009 “irrespective of the funding sources.”

103. A number of key multilateral and bilateral DPs complied with the directive that all salary supplements should be stopped. The partners called for the opening of a dialogue with the RGC on the matter since it was likely to have “adverse humanitarian consequences on vulnerable groups in key sectors”. This response was supported by the Global Fund. In response to the DPs, the DPM indicated that a new modality was guided by the principle of “daily operational cost” would be established “to replace existing salary supplementations and allowances”. He added that until the new modality was in place, “payment of salary supplementations shall be allowed to continue according to the practices employed prior to 1 January 2010”.

104. This caused confusion since all salary supplements schemes were supposed to have been aligned with the sub-decree 29. This sub-decree had been now nullified and no other clarification had been provided. There was therefore no basis on which salary supplements payments could be maintained. The DPs were still in dialogue with the RGC at the time of writing this report. In the absence of consensus on the matter, the Global Fund in line with the grant agreements should ensure that PRs comply with the laws of the country until such time that agreement on salaries is arrived at.

Recommendation 8 (High)

In line with the RGC decree, all PRs should stop payment of salary incentives until such a time that resolution has been found to the current situation. Once the new modality is in place, consideration should be given to making back payments to affected staff.

Compliance with the grant agreement

There were some instances noted of the four PRs’ non compliance with the Global Fund grant agreement and the applicable laws and regulations. All PRs should comply with the grant conditions and the RGC laws as this will ensure that the conditions put in place to safeguard the Global Fund assets are operational.

105. The grant agreement requires PRs to comply with the grant agreement and the laws and regulations of Cambodia. The conditions stipulated in the grant agreement ensure that the control environment is adequate to safeguard Global Fund investments. The OIG’s review of PR compliance with the grant agreement identified the following issues.

Taxes

106. Article 4 of all Global Fund grant agreements stipulates that all assistance financed under the agreement should be free from all taxes, customs duties, tariffs, import duties and VAT. There was no evidence seen of PRs following up tax

exemption status with the Government. The OIG noted that VAT was paid for all purchases at the Ministry and SR level. The use of program activities for the payment of taxes reduces the funds available for fighting the three diseases.

107. None of the PRs deducted withholding tax from the salaries and services paid in line with the government regulations. This was despite having received clarification from the Ministry of Economy and Finance about the need to withhold taxes on salaries, rent and consultants' fees. This can result in penalties.

Insurance of assets

108. With the exception of cars, the PRs had not insured their assets procured under the grants. The grant agreement stipulates that the "PR shall maintain where available at reasonable cost, all risk property insurance on program assets and comprehensive general liability insurance with financially sound and reputable insurance company. The insurance coverage shall be consistent with that held by similar entities engaged in similar businesses". Failure to insure assets exposes the Global Fund assets to risk of loss.

External auditors

109. The grant agreement stipulates that PRs should have its books of account audited and a report presented to the Global Fund within six months of the year end. The MOH appointed external auditors to carry out audits on both the PRs and the SRs. However, these were late. For example, at the time of the OIG audit that is December 2009, the audits for 2008 had not yet been completed.

110. In the case of CENAT, the process to identify auditors had not started despite the program having been under implementation for over a year. The grant agreement provides that the PR should notify the Global Fund of the selection of an independent external auditor not later than three months after grant starting date.

111. At the time of the audit i.e. December 2009, NCHADS had also not submitted the 2009 SR audit plan to the LFA as is required under the terms of the agreement. The OIG also noted that between 2003 and 2005, NCHADS was audited by KPMG. At this time, KPMG was also the LFA for Cambodia which created a conflict of interest.

The Global Fund was alerted of this conflict of interest as required in cases where LFAs are to be appointed as the auditors. KPMG was no longer the LFA at the time of the audit.

112. At the time of the audit, CNM had not put external audit arrangements in place for the programs funded by the Global Fund. In the past, CNM was audited by the National Audit Authority and their coverage was only of government funded projects.

Submission of reports

113. The grant agreement requires that the PR submits its quarterly reports within 45 days and an annual report to the Global Fund within 90 days of the period end. However, all the PRs submitted their periodic reports to the Global Fund beyond the due dates required by the grant agreement. In consequence, delayed reporting affected the Global Fund's ability to release timely disbursements. For example at the time of the audit (December 2009), the MOH had not submitted the final Round 2 cash statement that was due on 30 September 2009 and the final periodic progress report due on 15 February 2009.

Recommendation 9 (High)

The PRs should comply with the conditions stipulated in the grant agreement. This will strengthen the control environment within which Global Fund programs are implemented. Specifically, the PRs should:

- (a) seek exemption from the payment of taxes for all Global Fund activities and communicate this to all implementers. Efforts should be made to recover taxes paid so far from the tax authorities;*
- (b) open VAT control accounts in the accounting records in order to facilitate the accumulation of VAT costs and for the recovery of VAT*
- (c) withhold relevant taxes from payments of services in accordance with the relevant government laws;*
- (d) insure program assets against loss;*
- (e) ensure that their quarterly and annual reports are submitted on time since this affects the Global Fund's decision making; and*
- (f) ensure that external audits are planned and undertaken in a timely manner.*

Financial management

The financial management systems within which the programs are implemented were inadequate to safeguard Global Fund resources. All PRs effected most payments in cash raising the risk of loss and/or misappropriation of funds. Budgeting as a cost control mechanism was not functional with numerous budget reallocations happening in the life of the grant resulting in funds being used on activities that they were not intended to be spent on.

Cash transactions

114. All the PRs made most of their payments in cash and not through the bank system. Examples of the typical payments effected in cash were salary payments and payments for goods purchased. Payment of most goods and services in cash meant that large cash balances had to be withdrawn from the bank and/or held in order to meet obligations. This raised the risk of misappropriation or theft of the money. The OIG established that other development partners made payments by bank transfer.

Recommendation 10 (High)

The practice of payment for goods and services in cash must be stopped. The PRs should establish a threshold for payments in cash with all other payments effected through the banking system. All salaries should be paid through the bank.

Budgeting

115. The OIG noted that there were frequent budget reallocations where funds from one budget line were moved to cover other costs. In some instances, the budget was changed to cover items that were not included in the approved budgets by the Global Fund. For example savings from monitoring and evaluation were reallocated to workshop and training, general operating costs and consultancy services.

116. The need to frequently adjust budgets points to an ineffective budget preparation and review system. It also defeats the purpose of budgeting as a cost control mechanism. Because of the frequent changes to the budget, the Ministry had so many adjusted budgets that they could not provide the OIG team with the approved Global Fund budget. It also resulted in instances of ineligible expenditure noted.

Recommendation 11 (High)

The PRs should strengthen its budgeting framework to cover proper preparation (backed by proper work plans and reasonable costs) eligible expenditure per grant agreement and proposal, cost ceilings, budgetary reallocation justification, reviews and approvals etc.

Sub Recipient and Sub SR management

All the PRs implement some of the program activities through SRs and SSRs. These PRs did not have policies and procedures to guide SR management. In some cases, there were no criteria in place for the selection of SRs and SSRs; no capacity assessments were undertaken for SRs to confirm their ability to implement activities; there were no documented criteria for determination the amounts to be disbursed; no advance ledger accounts were maintained for disbursements; and there were no mechanisms in place to monitor performance and ensure regular reporting by the SRs.

117. The PRs and SRs are responsible for selecting the SRs/ SSRs respectively through which Program activities will be implemented. The OIG noted instances where a proper process for identification of the SRs was not followed. There was also no assessment of the capacity of the SRs at the start of the grant. The OIG's review revealed that most of the SRs had significant capacity weaknesses, but no capacity building was undertaken to enable them implement the programs better.

118. Most of the PRs and SRs expensed the monies advanced to SRs upon disbursement. There was no system at the PR to track disbursements made to the SRs against the accountabilities received. It was therefore impossible for the PR to

determine amounts unspent at any one point and to claim and follow up outstanding balances with the SRs. The PRs/ SRs also did not have a proper monitoring framework through which to monitor their sub recipients.

Recommendation 12 (significant)

(a) *The PR should develop policies and procedures to guide SRs on how program funds should be managed. The policies and procedures should cover disbursement and accountability, programmatic and financial reporting (including formats), budget tracking and analysis, maintenance of accounting records monitoring and inspection of SR performance, guidance on internal and external auditing etc. The PR should periodically visit SRs and assess their performance against the guidance laid out in the manual.*

(b) *The PR should use a well documented process for identification of potential SRs. These should be assessed for both programmatic and financial management capacity in order to identify gaps that would affect program implementation. These assessments will provide useful information on the strength of the institutional, financial and management systems of the potential SR. Assessments also aid the PR in identifying capacity gaps and institutional weaknesses of the potential sub-recipient for effective and rational decision making.*

(c) *All PRs/ SRs with sub recipients should institute a proper monitoring framework that covers:*

- *Well defined indicators and targets for SRs;*
- *Plans detailing when, how and whom monitoring will be undertaken;*
- *Methods of data collection, verification and accumulation for reporting;*
- *Site visits plans for SRs covering financial and programmatic aspects;*
- *Follow up of findings and provision of feedback to SRs;*
- *Comparison of programmatic and financial data etc.*

Ministry of Health

Institutional arrangements

119. The Ministry established a PMU to manage the program activities related to the Global Fund. At one point there were 30 staff of whom 5-6 were government employees. The PMU which was created outside the national structures is a parallel structure which goes against the Global Fund principles that encourage the use of national structures.

120. The Ministry established a Technical Review Team (TRT) that provided technical oversight of program implementation. Its activities included following up findings of the semi-annual and annual progress reports from the SRs. However the terms of reference of the TRT were not amended to incorporate the HSS grants once it was signed in 2006. As a result, there was no oversight provided over the HSS grant implemented by the Ministry. As a result, incorrect information provided to the Global Fund with regard to meeting of targets went undetected.

Recommendation 13 (Requires attention)

The Ministry should strengthen the oversight of the HSS grant by amending the terms of reference of the TRT to cover the HSS grant. The results of the HSS should be reviewed and approved by this Team before they are transmitted to the Global Fund.

Financial management

121. The grant agreement stipulates that all funds provided by the Global Fund should be used in accordance with the approved grant agreement. Exceptions to this should be with the prior approval of the Global fund. The OIG noted consistent failure by the PR and the SRs to comply with approved work plans and budgets. The OIG did not see evidence of the Ministry obtaining approval for expenditure that was not in the approved budget. As a result, the following expenditure that was not in line with approved work plans should be refunded to the Global Fund:

Rounds	Description	Amount (US\$)
Various	Consultants for Phase II applications	47,046
Round 1	Technical Assistance Consultant-MoSVY	80,191
Round 1	Database consultant	48,300
Rounds 4 and 6	Reimbursement for purchasing Laptop Computer	5,457
Rounds 4 and 6	Procurement of mobile phones for senior management	3,590
Rounds 4 and 6	Procurement of mobile phones, video camera	1,106
Total		185,690

Recommendation 14 (High)

The Ministry management should ensure that all expenditure incurred is in line with the approved budget. Exceptions to the budget should only be made with the

prior approval of the Global Fund. Expenditure incurred out of the budget without prior Global Fund approval should be refunded.

122. The PR and SRs procured a substantial number of computers, motorcycles, bicycles and motor vehicles e.g. under Rounds 1 and 2 alone, this totalled to US\$ 3,352,718. However, the PR did not maintain a comprehensive register of all the assets procured. The Ministry did not carry out periodic physical verification of assets raising the risk of loss and misuse.

Recommendation 15 (Significant)

The PR should maintain a comprehensive register of all the assets purchased with Global Fund grants. A physical verification exercise should be conducted periodically to ascertain the existence and condition of program assets.

Sub Recipient Management

123. The Ministry implemented the programs funded by the Global Fund through 32 SRs i.e. 9 government organisations/ national programs, 13 international organisations and 10 local non governmental organisations. The Ministry disbursed at least 61% of the grant funds from the Global Fund to SRs. The OIG did not see any criteria followed nor a proper process being followed by the MOH in the selection of SRs from Round 1-6. There were also no documented criteria on how the Ministry determined the level of funding for SRs.

124. The Ministry's oversight of SRs was inadequate as evidenced by the inadequate guidance to SRs on program implementation. There was no evidence of the Ministry following up compliance by the SRs with mandatory systems, policies and procedures. This resulted in significant internal control weaknesses at SR/SSR level. This undermined the ability of the SRs to safeguard resources and as a result exposed the GF resources to loss, mismanagement and/or misuse.

125. As part of the audit, the OIG visited 10 of the 32 Ministry SRs. The internal control weaknesses noted across the SRs are listed below.

- (a) there were weak cash management controls as evidenced by the large cash balances held by some SRs e.g. SEAD and KHANA. SRs did not have guidance on the levels of cash they could hold;
- (b) contrary to the government laws, the SRs did not withhold taxes on salary, consultants' fees and rent payments;
- (c) lack of proper human resource policies and procedures resulting in the recruitment of staff with inadequate qualifications/experience/skill. Most of the SRs did not have job descriptions for staff positions and personnel files were not maintained;
- (d) there were inadequate fixed asset controls as evidenced by the lack of insurance over assets. The OIG noted that some SRs i.e. RHAC, SHCH, DDF and DPHI) had lost assets for which no recovery was possible. There were no procedures in place to guide the use maintenance and follow up of assets acquired during closed Rounds;

- (e) budgeting as a control mechanism was not operational at most SRs. SR budgets were heavily 'padded' and these resulted in frequent reallocation of budget 'savings';
- (f) there was inadequate recording and reporting of other income incidental to program activities. This income was sometimes used without requisite authorization;
- (g) procurements were made without following laid down procedures and best practice. In such cases, purchases could not be said to be 'open and transparent'; and
- (h) SRs an unlicensed version of "QuickBooks" accounting software. The staff did not receive the requisite training on how to use the software. As a result many SRs continued to use MS Excel spreadsheets. Maintaining manual books of account raises the risk of errors in recording, processing and reporting transactions as well as a lack of "checks and balances" in the processing of data. These also often results in errors going undetected.

Recommendation 16 (Significant)

The Ministry should strengthen its monitoring function on SRs in order to mitigate the above noted internal control weaknesses.

Findings specific to SRs visited

Khmer HIV/AIDS National Alliance (KHANA)

126. KHANA implements its activities through 50 SSRs. The OIG noted that assessment of the financial and programmatic capacity of these SSRs was not conducted prior to disbursement of funds. This raised that risk that the SRs may lack the capacity to implement program activities. KHANA was also unable to identify the entities that would have benefited from closer supervision and capacity building. The OIG noted that some of KHANA's SSRs were unable to maintain up to date financial records and this affected their ability to submit timely financial and technical progress reports to this SR.

127. KHANA had a plan to provide technical support to 29 out of its 50 SRs. The OIG's audit questioned the basis of the planned technical support since assessments were not undertaken. KHANA did not undertake visits to all its SSRs to assess the implementation of program activities and verify the systems, records and results reported in regard to Global Fund activities. At the time of the audit, some SSRs had not been visited for over two years e.g. Salvation Centre Cambodia (SCC) which was last visited in February 2007 and Rural Economic Development Association (REDA) in July 2007.

Pharmaciens Sans Frontieres (PSF)

128. PSF is an international NGO created in 1985 with its headquarters in France. PSF is registered with the MOFA and is one of the key MOH SRs under different Rounds. The PSF country coordinator reports to its headquarters on a monthly basis. The OIG did not see any evidence of oversight provided by the headquarters

of the program activities implemented at the country level. The OIG also did not see evidence of the PR's review of PSF's systems except on one occasion to clarify certain points about the 2008 audit report. Consequently, there was no evidence of adequate oversight over PSF's management and programs.

129. PSF sought to improve access to quality drugs for the most vulnerable populations. The effectiveness of PSF in distributing drugs was constrained by delays in receiving drugs. For example UNICEF was contracted to procure ARV drugs under Round 2 which closed in June 2008. These ARVs were only received for distribution in the last week of November 2009.

130. The OIG's visit to PSF revealed that the financial management systems at PSF were inadequate as detailed below:

- (a) PSF paid per diems in addition to paying for accommodation for staff for a staff retreat. This was unreasonable from two aspects (i) the payment of per diems covered accommodation and therefore the payment of both represents an overpayment to staff; and (ii) The costs of attending a staff retreat should not be charged to the Global Fund. Charges should only be to the extent that the staff retreat was for program activities related to the Global Fund.
- (b) The OIG noted that the laboratory test charges charged by and paid to the Pasteur Institute of Cambodia through its partner SEADO were not checked against the price quoted in the contract.
- (c) The total cost of the rent for the country coordinator's house (monthly US\$ 700) was charged to the Global Fund from April 2008 to the time of the audit. However, this was contrary to his contract that stipulated that the Global Fund would cover 50% of the rent. The excess charge to the Global Fund of US\$ 7,000 should be refunded.
- (d) PSF's Finance department paid for training expenses without obtaining verification from the program department that the activities had taken place.
- (e) The OIG noted several instances of inter grant borrowings without the approval of the PR. This raised the risk that funds may not have been available when needed to implement program activities.
- (f) The OIG noted that generic costs such as rent, salary of common staff, utilities were allocated to the Global Fund grants in an arbitrary manner. PSF could not justify the basis for allocation of costs by grant.

131. The OIG also reviewed PSF's procurement and logistics management systems and noted the following issues:

- (a) PSF had disposed of expired drugs financed by the Global Fund without obtaining approval from the MOH. This comprised of 17 items with a total value of US\$ 16,150.81;

- (b) PSF lent 30,000 (150mg) Lamivudine tablets and 600 units of Zidovudine (300mg) financed by the Global Fund grant to a NGO, ESTHER on 1 December 2008. These drugs costing US\$ 4,614 were subsequently recorded as a donation on 6 February 2009. This 'donation' was without approval of the PR; and
- (c) PSF maintained only one inventory record for drugs received under the programs funded by the Global Fund. PSF could not account for the drugs under the different grants.

Recommendation 17 (High)

The Ministry of Health should follow up and seek resolution of the financial and procurement and logistics management matters raised above making reimbursements where indicated.

Population Services International Cambodia (PSI)

132. PSI was an SR to the MOH under the Malaria grants. The OIG noted the following from its review of PSI:

- (a) PSI is permitted to charge procurement fees (5%) on procurements it makes on behalf of the program. The OIG however noted that PSI made a claim of US\$ 12,074.50 against program funds for a procurement that they did not undertake. This procurement was undertaken by CNM. This amount should be refunded.
- (b) Furthermore, PSI has in the past charged headquarter overheads and procurement fees at the rate of 12% and 5% respectively. Effective from 2009, there was a revision in the headquarters overheads and procurement rates to 10% and 3% respectively. However PSI continued to charge the old rates for Rounds 5 and 7. Reimbursements need to be made.
- (c) The OIG noted that at the time of the audit, PSI was holding US\$ 790,803 in income from program activities. The income generated was US\$ 1,362,467 to which expenditure worth US\$ 571,664 was charged to leave the balance above. This money was not placed in an interest generating bank account. This income was reported to the Ministry as part of the periodic reports.

133. The OIG's review of PSI's procurements revealed the following:

- (a) There were procurements undertaken that were not transparent. Bids were awarded to a single bidder without advertising. For example the procurement of condoms and lubricants was single sourced from Thai Nippon Rubber Industry Company Limited under Round 1 and under Round 4, bed nets were single sourced from Vestergaard;
- (b) Advance payments amounting to US\$ 57,703 were made for the procurement of two lots of Paracheck under Round 2 which is contrary to the procurement guidelines V8;
- (c) A vendor data base was not maintained. The OIG could not therefore not assess the transparency with which suppliers were shortlisted for RFQs;
- (d) The short listing of suppliers was not based on predetermined criteria;

- (e) The performance evaluation of suppliers had not been not documented; and
- (f) The bid evaluation reports were not comprehensive i.e. they did not include adequate information about the evaluation process and how results were arrived at.

Recommendation 18 (High)

- (a) *PSI management should ensure adherence to the procurement guidelines in place. PSI should also refund the procurement fees amounting to US\$ 12,074 charged to the Global Fund grants for procurements that were made by CNM.*
- (b) *The headquarters overhead and procurement fees should be charged in accordance with the approved rates. Any excess amount charged under Round 5 and 7 should be adjusted from future billings.*
- (c) *PSI should prepare a plan for approval on how the funds incidental to program activities will be used. The PR should then present a plan to the Global Fund through the LFA on how these funds will be used.*

Cambodian People Living with HIV/AIDS Network (CPN+)

134. CPN+ is a SR of the MOH under Round 4 and is also an NCHADS SR under the Round 7 grant. The OIG's visit to CPN+ revealed the following:

- (a) CPN+ retained the services of the Khmer HIV Training Team (KHATT) to train its network members. However, the selection of consultants did not follow the procurement guidelines. The OIG also noted that KHATT was not a registered entity and that payments were made to the training team in cash.
- (b) CPN+ has 5 finance staff, with 2 covering the MOH Round 4 grant and 2 covering the NCHADS Round 7 grant. A finance manager oversees the functions of the four finance staff. The OIG noted that that CPN+'s recruitment of staff in the finance function was by grant and not driven by the volume of work. As a result, one of the two staff covering the Round 4 grant had limited knowledge of the accounting system and the Global Fund programs.
- (c) CPN+ did not maintain personal files on its staff.

Recommendation 19 (Significant)

- (a) *CPN+ should follow procurement guidelines in the identification of service providers to ensure that the program gets value for money for its investments. To the extent possible, the organisation should only contract with registered service providers since this protects CPN+ should any disputes arise. Additionally, payments to all service providers should be made through the bank.*
- (b) *CPN+ should review its staff requirement in the finance section in light of the volume of work rather than hiring staff by grant.*

BBC World Service Trust (BBC)

135. The BBC has a Memorandum of Understanding (MOU) with the Ministry for HIV prevention through behaviour change communications using mass media. The BBC is required to submit quarterly program reports to the Ministry of Foreign Affairs (MOFA) and annual financial reports within 90 days of closing the accounts or fiscal year to both the MOEF and MOFA. However, no such reports were submitted by the BBC to either ministry.

136. The OIG noted that the BBC budget included an overhead cost (headquarter cost) amounting to US\$ 279,000 for its Round 5 activities under HIV/AIDS grant. This was included within various budget lines and was not explicitly identified in the budget. The BBC Trust sought and received approval from the Global Fund for the costs to remain hidden under the different activities in the budgets. The resultant expenditure reported in the financial statements were overstated by the Headquarter costs.

Recommendation 20 (Significant)

Further disbursement of funds by the Ministry to its SRs should be tied to the meeting of key indicators like reporting. The BBC should comply with the reporting requirements in the MOU. With future grants signed with the BBC, the overhead cost should be shown separately in the budget in order to give the actual picture of the cost of activities in the financial statements.

Program management

Effect of Rounds based grants

137. An overview of all grants to date revealed that the CCC had treated all grants separately i.e. as a “one off” and not as part of one national program for any one disease. A review of the different disease interventions under the various grants revealed that they had similar objectives with many interfaces. The administration and management of these grants became cumbersome as the number of grants grew. This resulted in the Ministry recruiting staff to administer each grant and causing the administrative overhead costs to increase accordingly.

138. There was also a feeling in country that the Global Fund guidance, rules and regulations had changing over time as the organisation has evolved. To some in Cambodia the Global Fund had become very complex in its policies and procedures. This further complicated the work of the PR when they had multiple grants for the same disease.

139. The focus by the CCC as presented through the proposals to date was almost solely focused on ‘what’ should be funded and monitored to the relative neglect of ‘how’ to best go about working strategically and harmonising the grants with other programs already in place in the government. This was partially addressed by moving the PR-ship from the Ministry of Health to the relevant national programs.

Recommendation 21 (High)

The Ministry's grants should be consolidated by disease. This will increase the synergies across the grants for the different diseases and reduce the administrative work load i.e. by reducing the number of reports required, harmonizing monitoring and evaluation requirements etc.

Health Systems Strengthening

140. Round 5 in 2005 was the only year when there was a separate window for HSS in addition to the 3 diseases. Cambodia was one of the few countries which were successful with their grant applications. The HSS grant amount was US\$ 5,015,741 over 5 years. The goal of the program was *"to increase the efficiency and effectiveness of TB, Malaria and HIV/AIDS interventions by improving identification and strengthening of complementarities and potential efficiency gains between them and across the health system"*. The Round 5 grant is now in Phase II.

141. The MOH stakeholders felt that the consultant that wrote the HSS proposal did not consult them adequately and this affected the Ministry's ownership of the grant once it was underway. For example, the Department of Drugs and Food (DDF) was allocated the responsibility for implementing objective 6 i.e. *to strengthen the procurement process to ensure the timely provision of the required quantities of drugs, vaccines and medical supplies to all health service providers which meet agreed quality standards*. However this department was not responsible for procurement related tasks in the MOH.

142. The MOH had 3 SRs under the HSS grant namely the Ministry's two departments i.e. the Department of Planning and Health Information (DPHI) and the DDF and an NGO, MEDiCAM. While the relevance and role of DPHI and DDF as SRs was clear, MEDiCAM's role was less clear. The OIG noted that the HSS performance data is verified by MEDiCAM. This information was provided to an NGO for verification yet it was not provided to the Ministry's TRT for review. The Ministry's TRT reviewed all other Global Fund grant related information.

143. The wider health sector context within which Round 5 was functioning was one of a dynamic results oriented leadership. The joint annual performance review used 15 core indicators and in 2008 some targets were reached with others lagging slightly behind. For example:

- (a) The average number of new case consultations per inhabitant reached its 2008 target of 0.50; with the target of 1.1 for children under the age of 5 years also being reached;
- (b) Coverage of health centres implementing IMCI-CS reached 69%, higher than the 65% target;
- (c) The percentage of private entities such as pharmacies and maternity clinics licensed reached 56% against the 2008 target of 50%;
- (d) The percentage of essential drug stock-outs at health centres (15 marker drugs) was 12.8% against the 2008 target of 10%; and

- (e) The percentage of provincial health departments who received feedback on HIS from MoH was 40% against the 2008 target of 60%.

144. However, it was difficult to ascertain what useful, sustainable impact the Round 5 HSS was having, how efficiently the funds were being used to strengthen health systems and what contribution the HSS grant had made to the results referred to above. This was because the MOH reports lack information on impact/outcome indicators and the analysis of programmatic and financial variances⁶ was unclear.

145. This was also because most of the HSS grant indicators were not related to the 15 core national health sector indicators referred to earlier. For example, the HSS' objective 2 was *"to strengthen the implementation of the MOH's existing operational planning, monitoring and evaluation processes and mechanisms at the central, provincial and district levels"*. If this objective was being addressed appropriately, one would expect that there should have been an alignment of the fragmented M&E monitoring systems and a sound national M&E framework would be falling in place. However, the HSS grant was already in Phase II without any progress being registered on this objective.

146. The proposal made a provision for WHO to provide technical assistance worth US\$ 0.75 million. However, contrary to the agreement between the Ministry and WHO, the Ministry had only received two technical progress reports at the time of the audit.

Recommendation 22 (Significant)

(a) *The implementation of this and any future HSS grant implementation framework needs to be revisited in order for it to have a meaningful impact in the health sector. This should be developed with the full involvement of key stakeholders in the health sector and build on the activities that are already underway in the country.*

(b) *In order to have a successful grant implementation, the Ministry should scale up its HSS related activities.*

(c) *Oversight over the HSS grant should be strengthened which among other things should include forming part of the TRT's oversight agenda. There is a need for HSS expertise in the CCC and the TRT to provide the appropriate oversight at these levels.*

Procurement and supply management

Policies and procedures

147. The Ministry established a procurement unit to focus on grant procurements relating to health products for Rounds 1, 2, 4, 5 and 6. This unit worked

⁶ See for example the GFATM Round 5 Phase II assessment report, 12 August 2008

independently of the MOH Procurement Bureau, and was therefore another parallel procurement system. There was no evidence of any collaboration in procurement activities between the MOH PR unit and the bureau. In fact it was not possible for the audit team to get access to the MOH Procurement Bureau because the two entities were separate and the latter was not undertaking any work related to the Global Fund.

148. During the initial years of the grants there was a high staff turnover in this procurement unit. This has stabilised with the hiring of more contract staff through the financial support of the Global Fund. The staff turnover affected the Ministry's capacity thus causing delays in procurement related decisions that needed to be made and affected the start of procurement processes. Procurement of pharmaceuticals was decentralized for Round 2 for some time to SRs such as PSI, Sihanouk Hospital Center of Hope (SHCH), CNM, NCHADS. This was later reversed due to a lack of capacity in these SRs. Despite all these challenges, the MOH PR was able to provide all commodities in the required quantities for program implementation.

149. The unit received procurement related technical assistance to build capacity. This was initially through a United Nations Development Programme (UNDP) procurement consultant. This contract ended June 2004 and another consultant was provided under the Global Fund supported program under a contract ending in August 2009. Although funds are still available to support technical assistance, the Ministry decided not to fill the vacant TA position because of the short length of the remaining grant period. This was despite having key tasks that are incomplete e.g. the finalisation of procurement policies and procedures.

150. The current procurement unit staff have gained some experience since the inception of the grants. However, this capacity was not sustainable since most of them were contract staff and therefore not part of the national institution. The OIG noted that the unit lacked capacity in the following aspects:

- (a) Contract management;
- (b) There were no standard operating procedures (SOPs) for key procurement processes;
- (c) The procurement matrix was inadequate for forward planning; and
- (d) The Unit had not developed tools for monitoring supplier performance.

This resulted in procedures not being standardized, emergency procurements and some suppliers not delivering on time.

151. Focal points were appointed to oversee product categories namely (i) ARVS/OIs, medical equipment, consumables and reagents; (ii) TB and anti malarial; (iii) office furniture and equipment; and (iv) price and quality reporting activities. The OIG did not see evidence of the involvement of the focal points in tender evaluations which was a missed opportunity to use their expertise in the tender process.

152. There were no personnel assigned to oversee contracts with third parties. For example a contract for technical assistance was signed with WHO for the HSS grant. US\$ 785,000 was disbursed to WHO based on an agreement that two full time WHO consultants would be provided to the MOH Department of Planning and Health Information (DPHI) and Department of Drug and Foods (DDF). However, the OIG noted that the consultants did not work full time in their assigned departments. Furthermore, only 2 of the required 12 technical reports were provided by WHO during Phase I of the grant. WHO also did not provide the external audit reports and income and expenditure reports as required in the contract signed with the Ministry. Despite this weak performance during Phase 1, the Ministry went ahead in signing another contract with WHO for US\$ 1,014,450 for Phase II.

153. The procurement of non-health commodities remained the responsibility of the SRs. The agreements signed between the Ministry and its SRs called for the direct involvement of the Ministry in the SRs' procurements. However, the OIG's review of the work done at the SR level e.g. CNM, CENAT and NCHADS showed that the PR involvement was limited and therefore inadequate.

154. Public sector pharmaceuticals were procured through a single preferred local provider until 2002 when an open tendering process was introduced. As a result, until then, there were no clear national procurement rules and regulations to guide the procurement process. The procurements for both the Ministry and its SRs were guided by Procurement Guidelines Version 8.

155. These guidelines were developed by the PR and at the time of the audit had undergone many revisions. At the time of the audit, the Ministry indicated that it had plans to further revise the guidelines because they lacked clarity and depth of content. The development of 8 and soon to be 9 versions of the procurement policies was a waste of time and money since after so many revisions, the policies remained inadequate. The frequent changes to and the lack of finalised the procurement processes contributed to the operational challenges in the procurement environment.

Recommendation 23 (Significant)

(a) *The Ministry should engage TA for the remaining period with specific tasks to be completed. Priority areas might be finalization of the procurement guidelines, guidelines for the handling of expired stock and on the job training (OJT) for PR and SR procurement staff on procurement best practices, development of SOPs for key procurement processes, development of supplier contract management tools etc.*

(b) *Parameters for measuring performance should be agreed upon and the disbursement of funds should be tied to meeting specific agreed upon milestones.*

(c) *Management should identify a focal point in the Ministry of Health coordinate the technical assistance provided by WHO and ensure compliance with the conditions of the contract that are stipulated in the signed contract with the*

Ministry of Health. The TRT should, when reviewing the HSS grant, also provide oversight of the performance of WHO.

Procurement processes

156. The Ministry prepared procurement and supply management plans. However, procurement planning and forward planning remained an area of weakness as evidenced by the fact that the Ministry procured most program inputs on an emergency basis. Because these procurements were undertaken as emergencies, the procurement guidelines were not followed most of the time. This resulted in the inappropriate identification and selection of suppliers.

157. The OIG noted that there was inadequate coordination of quantities to be procured by the Ministry. This resulted in the tender quantities having to be changed during the tender process. For example the procurement of ARVs in May 2006 had several revisions to the items and quantities contained in the bid documents. These included some SRs revising quantities; NCHADS cancelling the purchase of 2nd line drugs after receiving some from Clinton Foundation for HIV/Aids Initiative (CHAI); CARE and SHCH revising their requirements etc.

158. A review of the procurement processes of the MOH showed that some contracts awarded for the procurement of health products did not conform to formal written procurement guidelines and best practices. For example high value procurements i.e. with amounts over US\$ 100,000 were effected through the Request for Quotation (RFQ) which is not in line with the procurement guidelines V8. The explanation provided was that the Global Fund had approved the use of RFQs instead of the appropriate National Competitive Bidding (NCB) or International Competitive Bidding (ICB). To verify this information, the OIG was only provided with evidence of approval of only one urgent procurement of ARVs. The OIG also noted that the high value procurements were not secured with bid and performance guarantees and bonds.

159. The OIG sought but was not provided with all the tender documents for the sample of procurements selected. Examples of documents that were not provided included bid opening minutes, good received notes and purchase orders. The tender process reports i.e. bid opening minutes, technical and financial evaluation of bids were documented as one report thus resulting in the loss of a lot of detail. The report did not contain adequate details of the process to demonstrate that the processes were open and transparent.

160. The OIG also noted that where the NCB method was used, the Ministry contacted the local agents of potential suppliers. However there was a misinterpretation of the concept of 'agents' by the Ministry. The award of contracts was made with the agent and not the principal bidder. This was done on the basis of a power of attorney given to the agent to enable them to sign the contract on behalf of the principal bidder. This transferred the contractual obligations from the principal bidder to the local agent.

161. In the paragraphs below, the OIG provides the outcome of its review of two Ministry procurements that did not conform to guidelines and best practices. The Round 1, 2 and 4 procurements were pooled in 2006 to purchase health products valued at US\$ 1,697,141.50. The OIG reviewed this procurement and noted the following:

- (a) The method of procurement followed was a RFQ to seven companies. The Bid opening date was 3 May 2006 but the RFQ stated 2 May 2006;
- (b) An additional bid was received from MSD on 13 May 2006. This bid was accepted and opened for evaluation despite being late and having been sent by e-mail and not courier as required in the RFQ;
- (c) No bid security and performance security was requested;
- (d) The bid evaluation report did not given the results of the evaluations undertaken of product quality, delivery time and compliance with terms and conditions of the PR;
- (e) The contract was awarded to MEGA and signed on 7 July 2006 yet there was no evidence in the file to show that MEGA had been invited to participate in the tender in the first place; and
- (f) Notification of award and delivery status information was not available on the file.

162. Under the Round 5 grant, TB drugs were procured in March 2009 and the OIG review identified the following:

- (a) The RFQ was sent out on 04/05/09 without a closing time for submission of the RFQ. It was not indicated that these should be sealed quotes as per procurement guidelines requirement;
- (b) The bid opening and evaluation report was done on 5 May 2009 which was only one day after the RFQ was sent out;
- (c) The evaluation criteria did not conform to the RFQ in respect to specifications/technical requirements relating to shelf lives offered. The RFQ required that bidders notify the PR if shelf life offered was going to be less than 18 months. The bidders offered products with shelf lives of between 24 months to 5 years. The CENAT Director recommended a 3 year shelf life for tablets during evaluation and this resulted in Sandoz and Macleods being declared non-compliant by offering items with a shelf life of 2 years.
- (d) The notification of and contract award was made to Biogen yet this was an agent for Macleods. This transferred the contractual obligations to deliver from Macleods the principal bidder to Biogen the local agent;
- (e) There were amendments made to the quotations i.e. an increase in the quantities for streptomycin injection, H2O for injections and an increase of rifampicin/pyrazinamide/isoniazid/ethambutol. This increased the contract amount by US\$ 44,714.23.

Recommendation 24 (Significant)

The Ministry (PMU management) through the BEC should enforce adherence to the laid down procurement guidelines. Exceptions should be justified to and approved by the BEC.

Ministry support to the SR

163. The PR and NCHADS developed a joint procurement matrix for ARVs and OIs. The matrix for ARVs was approved in July 2009 and the one for OIs was awaiting feedback from the Global Fund after submission of clarifications on the quantification tool used. The procurement of ARVs and OI drugs for SRs was coordinated by the MOH PR and the procurement process is centralized in the Ministry.

164. The procurement of non-health commodities remained fragmented across the Ministry and its SRs. Consolidation of procurements started but had remained an uncompleted activity for a long time. There were no clear guidelines and defined timelines for the consolidation process. The current arrangement of rotation of coordination among the MOH PR, CNM, NCHADS and CENAT was not effective or efficient. The PR/SR meetings did not adequately address the PSM challenges e.g. delays in delivery of program inputs, potential of stock outs, short dated and expired stocks at SRs etc.

165. SR procurement and supply management activities were supervised by the Ministry. There was no evidence of active supervision, other than attending bid opening and evaluation meetings for national program procurements. There was evidence of problems at different SRs which remained unaddressed and to which the Ministry remains oblivious. Examples are provided below:

- (a) On 22 May 2006, MDM wrote to the TA expressing concerns about NCHADS procurement responsibility. Every time they submitted a request for 2nd line ARVs, NCHADS did not order them. MDM anticipated some stock problems because of this and needed advice on how their 2nd line procurement plan would be effectively followed;
- (b) SHCH wrote to the PR highlighting that they had drugs that were likely to expire because they had been supplied by the Ministry with a very short shelf life;
- (c) PSF had written to the Ministry on several occasions raising concerns about delays in the receipt of drugs, and stock out of drugs at several locations.

Recommendation 25 (Significant)

The Ministry's support to the SR in the area of procurement and supply chain management should be strengthened. The BEC should take overall responsibility for coordination as well as the oversight of the Ministry and SR procurement activities.

National Centre for HIV/AIDS, Dermatology and STI

Institutional aspects

166. NCHADS is headed by a director appointed directly by the MOH. Under the leadership of the director, NCHADS divided into a technical bureau and an administration and finance bureau. The former undertakes the technical and service delivery related responsibilities of NCHADS while the latter exercises financial control and undertakes administrative processes, including logistics and procurement.

167. NCHADS had established a 'Global Fund' core unit team consisting of 12 staff including the director, deputy directors, senior finance officer and the senior PSM officer. The staff within the Global Fund unit reported to their technical heads as per the NCHADS organizational structure whereas their activities were coordinated by a Global Fund coordinator who reported to the director.

Financial management

168. NCHADS followed the financial policies and procedures approved by MOH and maintained proper books of account to facilitate reporting in accordance with timelines agreed with the Global Fund. Financial transactions were posted into "QuickBooks" accounting software to produce financial reports. PUDRs were prepared in MS Excel using figures reported by the accounting software. The finance department regularly reconciled accounting information reported in the PUDR with NCHADS' financial records.

169. As of December 2009, the OIG noted that the funds from the Global Fund were used to pay salary incentives for 68 government staff (including 12 staff core to the program). In addition, 82 staff were contracted for grant implementation and another 717 provincial level staff received salary incentives as part of the Global Fund program. The OIG reviewed the conditions under which the Global Fund paid incentives to over 800 people and noted that salary incentives were paid to staff that were not necessarily involved in the program funded by the Global Fund. All NCHADS staff received allowances irrespective of whether they were involved in implementing programs funded by the Global Fund or not e.g. the payment of incentives amounting to US\$ 2,340 to four staff of Research unit for Quarter 1. In other instances, some government staff changed to Global Fund grant programs were engaged in the programs implemented by other agencies. NCHADS was unable to provide the OIG with justification of allocation of cost by donor.

170. All salary incentive payments to staff including provincial staff were made in cash. The heads of departments were involved in the distribution of salary at the NCHADS head office. At provincial level, staff withdrew the cash from the

bank in Phnom Penh and carried it to the province to staff. This raised the risk of loss through misappropriation/ theft.

Recommendation 26 (High)

(a) *NCHADS should review and align its payment of salaries to the Government policy on salary incentives. No further top up payments should be made to government employees until there is agreement between the Government and the development partners.*

(b) *In the mean time, NCHADS should prepare a justification for the payment of salary incentives for review by the LFA and approval by the Global Fund. The payment of incentives should be in line with the whatever scheme is agreed between the RGC and the development partners and be to the extent to which contributions are made by staff to the programs funded by the Global Fund.*

(c) *In the event that payment of salary incentives is agreed upon, the payment of salaries in cash should stop with immediate effect. Arrangements should be made for salary to be paid into staff bank accounts.*

171. NCHADS maintained an imprest petty cash float with a limit of US\$ 2,000 at two locations at its head office. The OIG noted that one of the cashiers carried the money to her house every day citing security reasons which exposed the funds to an even greater risk of loss.

Recommendation 27 (High)

The removal of petty cash from the office should stop with immediate effect. NCHADS should institute mechanisms to ensure security of petty cash in the office.

172. The OIG's review of advances revealed two areas where the provisions of the financial guidelines were not followed thus weakening the control environment within which advances were made. Advances were provided to staff without them having settled earlier advances taken. The guidelines also provided for liquidation of advances within two weeks of the activities having taken place. However advances were in many instances liquidated past their due date.

Recommendation 28 (Significant)

NCHADS should ensure that advances are liquidated on time. Furthermore, there should be strict adherence to the requirement that staff with outstanding accountabilities do not receive additional advances except in unavoidable circumstances with proper justification documented.

173. A fixed assets register was maintained to record the assets procured from the Global Fund grants. However, the OIG noted that physical verification of the fixed assets was not conducted.

At the time of the audit, one grant motorcycle had been stolen but since it had not been insured, no recovery could be made. The NCHADS policy provided for the

recovery of the asset from the responsible staff member. However, this too did not happen.

Recommendation 29 (Significant)

NCHADS should carry out periodic fixed asset physical verifications. The assets register should be updated with the results of the verification exercise.

174. The OIG reviewed the training undertaken by NCHADS and noted that NCHADS followed the training curriculum approved by the MOH. The curriculum approved by the MOH provided for the reasonable number of days over which training should happen. This was also included in NCHADS annual work plan. However, the OIG noted that the numbers trained were much higher than those in the budget. For example the two week OI/ARV training was provided for 5 consecutive months to the same 30 staff which was in the OIG's view was unreasonable.

175. NCHADS budgeted and paid for the cost of training based on financial guidelines approved by the MOH. The OIG noted that in addition to receiving salary incentives from grant funds, staff also received allowances to attend the trainings. For example, the NCHADS director and his deputy directors received an honorarium of US\$ 50 each for attending the opening and closing ceremonies of the trainings. Facilitators and logistics personnel on the payroll funded by the Global Fund also received facilitation allowances for trainings they undertook as part of their jobs.

176. One of management's fundamental responsibilities is to develop and maintain an effective internal control environment which prevents or is able to detect significant weaknesses that may result in waste, fraud, and mismanagement. However, the issue as highlighted above requires more attention to be given by the management to enhance an effective management control system.

Recommendation 30 (High)

NCHADS management should strengthen the control environment within which program activities are undertaken. Staff should not receive allowances for undertaking tasks that are part of their jobs.

Sub Recipient management

177. NCHADS has 17 SRs under Round 7 that are charged with implementing about 82% of the program activities funded by the Global Fund. NCHADS also provides funds to all 24 provinces to support the Provincial AIDS Office (PAO) in accordance with the approved work plan.

178. The OIG noted that there were no mechanisms in place to actively monitor implementation of SR activities. At the time of the audit:

- (a) Guidelines for the review and monitoring of the activities of SRs/ SSRs had not yet been developed;
- (b) SR planning and monitoring visits by the M&E department were inadequate as evidenced by only 6 out of 17 SRs having been visited in the one year of program implementation;
- (c) The M&E department had not made any visits to the provinces since the inception of the program. The department placed reliance on the monthly reports submitted by the provinces.
- (d) NCHADS did not provide feedback to its SRs; and
- (e) An SR capacity development plan had not yet been developed.

179. OIG also conducted visits to five of NCHADS' SRs. NCHADS' oversight of SRs was noted to be inadequate as evidenced by lack of guidance to SRs on the mandatory systems, policies and procedures that SRs should have. This resulted in significant internal control weaknesses at SR/SSR level. This undermined the ability of the SRs to safeguard resources and as a result exposed the GF resources to loss, mismanagement and/or misuse.

180. The internal control weaknesses noted across the SRs are listed below:

- (a) almost all the SRs paid salary to their staff in cash;
- (b) contrary to the government laws, the SRs did not withhold taxes on salary, consultants' fees and rent payments;
- (c) program assets were not insured;
- (d) budgeting as a control mechanism was not operational at most SRs. SR budgets were heavily 'padded' and these resulted in frequent reallocation of budget 'savings';
- (e) SRs did not assess the capacity of SSRs for program implementation; and
- (f) SRs had acquired an unlicensed version of "QuickBooks" accounting software. The staff did not receive the requisite training on how to use the software.

181. The OIG's visit to CPN+ revealed that a driver was hired and the salary paid from June 2009 onwards but the vehicle he was to drive had not been received even at the time of the audit (December 2009). The OIG also noted that assets were procured and delivered by NCHADS to CPN+ for distribution. These assets had remained in the stores for more than 4 months and some of these assets with a value of US\$ 9,780 were stolen from the stores. These assets had not been insured. The security company agreed to replace all the stolen assets but at the time of the audit only assets with a value of US\$ 5,840 had been replaced. CPN+ should follow up the outstanding asset balances from the insurance company.

Procurement and supply management

182. NCHADS had been purchasing health and non health products for the HIV/AIDS program since Round 1. However, the procurement of the ARVs remained the responsibility of the MOH for all Rounds. NCHADS was also responsible for purchasing products for CHAI and the Centre for Disease Control (CDC) and had accumulated procurement experience.

183. NCHADS had two procurement units i.e. a government one as approved by the MOH and another one for managing the program funded by the Global Fund. The procurement function in the government structure fell under finance and the one funded by the Global Fund fell under the NCHADS director. The staff and procurement activities for Rounds 1, 2 and 5 were independent of the ones relating to Round 7. There was no coordination between the two teams creating an information gap and the absence of experience sharing. This resulted in parallel procurement activities with no pooling of procurements by grant.

184. All senior procurement positions in the two units were vacant at the time of the audit. Under the government structure, the post of the chief of procurement had not been filled at the time of the audit. The reason provided for this was that the Minister of Health had to make the appointment personally. The perception at NCHADS was that there was no need to fill the chief of procurement position because the work load was low. Under the Global Fund structure, the highest position was a senior procurement officer. This position was at a lower level than for other decision making staff in NCHADS. The lack of a senior procurement official is likely to have contributed to the compromised procurement related decision making.

185. At the time of the audit, NCHADS had recruited national officers in fulfilment of Conditions Precedent to disbursement for Round 7 but the recruitment for an international TA was unsuccessful. This was attributed to the TORs that called for a person with both finance and procurement skills. However, NCHADS had not identified someone with the requisite experience and knowledge of the two areas.

Recommendation 31 (High)

The NCHADS management should identify a senior official to head the procurement unit in order to ensure better planning, organizing, staffing, directing and controlling of the procurement function. Their role should cover ensuring coordination with the MOH Procurement Bureau to ensure that there are no duplications and to identify ways in which synergies can be obtained. All vacant positions should also be filled.

Planning

186. The Global Fund guidelines required that all PRs prepare a PSM plan. At the time of the audit, NCHADS did not have an approved PSM plan for the Round 7 grant although the grant was already one year into implementation. The FPM approved the procurements for Round 7 without having a PSM plan in place based on the notion that the PSM activities were adequately covered in all the other documents. The OIG reviewed NCHADS' draft PSM plan and noted that it was inadequate in supporting certain PSM activities⁷ since it lacked key information on the areas like quality assurance, storage and distribution etc.

⁷ REF:2_1_3 Review of PSM and PR procurement capacity- NCHADS

187. The preparation of the PSM plan should not be to just meet a Global Fund requirement but also to assist NCHADS to:

- (a) consolidate program inputs for greater economies of scale;
- (b) anticipate and resolve potential problems;
- (c) arrange logistical aspects e.g. storage;
- (d) assess its PSM performance measured against the plan;
- (e) have better workload planning and scheduling especially for the different types of procurement etc.

188. NCHADS had a condition precedent to disbursements requiring it to prepare a joint PSM plan and procurement matrix with the MOH PR for all HIV grants by 15 August 2009. At the time of the audit, the ARVs matrix for ARVs had been approved. The OI one was pending clearance of concerns raised by the Global Fund that the estimated prices were higher than international reference prices. At the time of the audit, explanations had been submitted to the Global Fund and NCHADS awaited feedback. NCHADS did not envisage that the delay in the finalization of the matrix would affect the program since there were adequate stocks of drugs.

189. NCHADS developed a consolidated list of non-health products for 2009 for all of Round 7 requirements, including SR requirements. This was approved by the Global Fund through an implementation letter of 7 July 2009 for procurement to start. A procurement implementation instruction had been issued to SRs.

190. At the time of the audit, NCHADS had initiated the request to use the Voluntary Pooled Procurement (VPP) initiative for procurement of laboratory consumables. The list of the technical specifications for the items had been submitted to the Global Fund and NCHADS was waiting for the quotation in order to proceed with the procurement.

Recommendation 32 (Significant)

NCHADS should finalise the PSM for Round 7 to ensure that PSM activities are well planned for. A subsequent activity plan should be developed and PSM performance reports against the plan developed on a regular basis.

Forecasting and quantification

191. NCHADS was responsible for forecasting and quantification of ARVs and OIs for the HIV/AIDS program in Cambodia. The forecasting and quantification of ARVs followed the morbidity based method and was supported by CHAI. The OIG requested but was not provided with the ARV quantification tool or process.

192. The OIG reviewed the definition of OIs was and found it to be very broad. Because of this, the list contained drugs that would not typically be included on this list. The list comprised of the typical OI drugs, STI drugs and common drugs for treating ARV side effects. The inclusion of common drugs in the drug list raised the risk of duplication of procurements with the national budget procurements.

This risk was exemplified by the lack of procurement coordination between the MOH Procurement Bureau and grant PRs. In addition some of the purchases of common drugs were for small quantities and these tended to be expensive.

193. The basis for forecasting and quantification of OIs was the consumption method i.e. using the previous year's consumption data. The responsibility of collecting consumption data lay with the NCHADS' logistics unit. The logistics unit's data collection, validation and analysis processes were in the OIG's view inadequate to enable accurate forecasting and quantification. There was also no mechanism in place to oversee this process to ensure that it was properly done.

Recommendations 33 (Significant)

NCHADS should strengthen its logistics systems to ensure that accurate and timely information is available to support the forecasting and quantification process. In developing the OI drug list, NCHADS should liaise with the MOH Procurement Bureau to ensure that there are no duplications in the drugs procured and to explore opportunities for pooled procurement.

Storage and distribution

194. The NCHADS logistics unit was comprised of 8 staff i.e. 5 government employees and 3 under contract under Global Fund activities. ARVs were kept in 2 different stock locations i.e. at NCHADS and at Central Medical Stores (CMS). The stocks held at NCHADS included drugs and diagnostics from CDC, CHAI and the Global Fund.

195. The OIG's review of NCHADS' distribution system revealed that:

- (a) NCHADS did not have vehicles for deliveries. Therefore, the ART sites had to collect orders from NCHADS;
- (b) the lead time for deliveries was up to 2 months;
- (c) NCHADS had established an independent distribution system from the national system i.e. the CMS system; and
- (d) ARVs returned from ART sites were stored in the NCHADS warehouse. The records for recalled items were not adequate to account for the stock movements.

Recommendation 34 (High)

In line with the Global Fund principles and to the extent possible, the Ministry should use national structures, systems and procedures i.e. CMS for logistics and storage. NCHADS should assess and contribute towards strengthening capacity gaps at CMS instead of setting up duplicative structures.

196. NCHADS used two systems for its logistics management i.e. MS Excel and Peach Tree software. Quarterly reports prepared were able to track stock movements and balances e.g. ARV stock status report for the quarter per funding source. However, maintaining of records in MS Excel raised the risk of errors in recording, processing and reporting transactions as well as having a lack of checks and balances in the processing of data.

197. With regard to the Peach Tree software, the OIG noted the following:
- (a) NCHADS had an unlicensed version of the Peach Tree software. As a result, NCHADS did not have any documentation about the software e.g. a software user manual, SOPs for the use of the software and a software training manual.
 - (b) The information technology department was unable to offer any backup support to the software because of the lack of a license.
 - (c) Due to its inability to offer training to its staff, NCHADS transferred its responsibility to train staff by making it a requirement for all recruited staff to have training in the Peach Tree system.
 - (d) The software could not produce critical logistical information e.g. expiry profiles and slow moving items profile. The system also could not be adjusted to provide this information since it cannot be amended.
 - (e) Staff were unable to print distribution lists for the last quarter from the system for each ART site.

198. The use of unlicensed software is illegal. Also pirated software has no guarantee, warranty or refund policy. As a result should it stop working, the money paid for that software goes to waste. Pirated software normally has bugs and in other cases has been known to have viruses, Trojans or spy ware thus exposing the users to associated risks. They are also hard to setup, do not come with the requisite training and one cannot get access to any critical updates. It also cannot be amended to suit the purchaser's circumstances.

Recommendation 35 (Significant)

NCHADS management should obtain a licensed version of the Peach Tree software. The genuine software will be more costly but will be legal and come with a number of benefits such as access to updates and full support and help. It will also ensure the security of data and the integrity of the information systems is guaranteed.

Procurement processes

199. NCHADS' procurement processes were guided by the Procurement Guidelines Version 8. NCHADS has procured through different channels e.g. through UNICEF under Round 2 and often directly from the market. The procurement guidelines provided for at least 3 quotations to be obtained for all procurements above US\$ 5,000 and below US\$ 100,000. However, NCHADS did not maintain a list of approved vendors. In its absence the selection of prospective vendors to provide quotations was not clear.

200. The OIG also noted exceptions to the use of RFQ method as required in the procurement guidelines. In most cases where the RFQ method was used, only one vendor met all the technical specifications thus resulting in the disqualification of the other bids. In such instances, this bidder was awarded the contract even though the quoted price was usually comparatively higher. The frequency with which this happens points to either NCHADS not adequately researching potential

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suppliers before sending out its RFQs or this was a deliberate attempt to procure from particular suppliers.

Examples of this are provided in the table below:

Ref No	Description of goods	Amount US\$	Remarks
DV05/0251	Prevention package-STI management -Supplies- Lab and Medical Equipments	54,319	Medicom awarded the contract having been the only one that met the technical specifications out of four bids.
DV06/0217	Continuum of care-VCCT Equipment -Lab Equipments	53,912	NCHADS awarded to the purchase of spectrophotometer to Medicom. The other 7 items in the bid. Out of the four bidders, this supplier was the only one that complied with the technical specifications of the items that they were awarded.
DV06/013	PCM - Logistic & Supply Management - Equipment & Furniture - Lab Equipment	85,272	12 bid documents were distributed but only five firms (all from Cambodia) submitted bids. Out of the 5 bidders only Medicom met the technical specification.

201. For procurements above US\$ 100,000, the preferred procurement method was ICB/NCB. However, these guidelines were not always adhered to. For example the identification of contractors for civil works (reference number DV-08-0006) in 5 referral hospitals amounting to US\$ 214,067 did not follow ICB/ NCB. The RFQ method was followed.

202. The OIG also noted that NCHADS split contracts into smaller lots to avoid ICB and having to get approval from the MOH Secretary of State. For example the procurement of 11 haematology analysers and 122,000 reagents (Ref. DV07/005) amounting to US\$115,522 under the Round 2 Phase 1 grant was split into two smaller lots of US\$ 77,016 and US\$ 38,506. Contracts were entered into with the same supplier on 27 and 29 December 2005 respectively. The haematology analysers were delivered by the supplier after 134 days against 90 days agreed in the contract.

203. The timeframe allowed for the procurement process was too short. This did not allow potential suppliers adequate time to prepare proper bids and inevitably acted as a deterrent to effective competition. For example the whole procurement process for the haematology analysers referred to above happened between 26 and 29 December 2005.

204. The OIG noted that there was no mechanism in place to ensure that the products delivered complied with the technical specifications of the bid and order. This was especially the case for office and medical equipment received i.e. Ref.DV07/005. The OIG also noted that a certificate of origin was not provided to support the equipment supplied in most cases. The certificate of origin provides third party evidence that the products supplied comply with the technical specifications.

205. In the case of construction works under Round 1 where US\$ 230,913.35 was paid to Khmer Sang Sorng Co. Ltd., the contractor, for construction of 6 new buildings, NCHADS did not retain the services of an independent engineer to supervise the construction and verify works and related payments. However, NCHADS had hired an independent engineer named Prak Naly, for the supervision of construction works carried out under Round 2 and Round 5.

206. The OIG reviewed the records maintained by NCAHDS in support of the procurements undertaken and noted that the purchase orders were made in the name one company but the resultant invoice for payment came from a different company.

Examples were (i) the purchase of furniture (DV/09/0600) where the purchase order was to Leecho Furniture but the invoice was from furniture shop and payment made to Leecho shop Moving Furniture; and (ii) the purchase of toner (DV05/0181) where the purchase order was to Narita Distribution Cambodia and the invoice was received from Narita IT Cambodia. Subsequent clarification from the management revealed that they were associated parties and well known to NCHADS, accordingly the names might have been different while recording the entries.

Recommendation 36 (High)

NCHADS' management should enforce strict adherence to the procurement guidelines. Any deviation in the name of supplier against the purchase order should be properly justified and documented. Potential procurement irregularities should be investigated by the relevant authorities.

National Centre for Parasitology, Entomology and Malaria Control

Malaria

207. One question in the evaluation undertaken in 2008 of the Global Fund support for malaria since 2004 was ‘Has increased malaria funding led to a reduction in the burden of disease?’ The conclusion was that there had been a significant improvement in malaria prevention and treatment. In particular there were increases in the population at risk with access to early diagnosis and treatment through the availability of community based village malaria workers and in impregnated bed nets coverage⁸. Additionally, the review of health sector performance in 2008 showed that⁹ (i) Malaria mortality declined from 2.8/100,000 in 2004 to 1.4/100,000 in 2008; and (ii) Malaria incidence declined from 7.5/1,000 in 2004 to 4.1/1,000 in 2008.

208. However, one result from the 2007 Cambodia malaria survey was that while there was an improvement in awareness about correct treatment, from 47% in 2004 to 72% in 2007, ‘behaviour does not seem to be keeping pace with knowledge judged by low ITN use and the high use of inappropriate malaria treatment in the private sector’^{10 11}. In the late 1990’s it was estimated that 80% people bought their malaria drugs in the private sector, the 2007 survey showed that this had only dropped to 70%. Indeed, in 2008 the number of cases of malaria treated at public sector health facilities was only 4.1 per 1,000 population¹².

209. There were however some challenges noted in relation to quality service delivery. These were (i) the emergence of artemisinin resistance on the Cambodia-Thai border; (ii) the movement of mobile populations from non-endemic areas into forests which are highly endemic; (iii) there are known to be a number of counterfeit anti-malarial tablets in the private sector; and (iv) in 2008 there were delays in the provision of ACT’s through UNITAID and of LLIN’s through the Global Fund. (This is covered in the section on procurement and supplies management).

Financial management

210. CNM staff often attended international conferences and workshops and these meetings were mostly funded by the Global Fund. The OIG noted that the number of conferences/ workshops attended by CNM staff was high. For instance, during 2008, over 20 overseas workshops and conferences were attended by various CNM staff. This amounted to an average of one conference attended every

⁸ Dr Kheng Sim, Five year evaluation of the Global Fund Study: malaria report and data. Power point presentation, 28 August 2008. CNM

⁹ DPHI Report: Joint annual performance review of health sector 2008. Department of Planning and Health Information, MOH April 2009

¹⁰ CNM. Program implementation and achievements made in 2008. Power point presentation, National Malaria Conference, 23-24 June 2009

¹¹ Cambodia Malaria Survey 2007. Draft report 2008

¹² DPHI Report: Joint annual performance review of health sector 2008. Department of Planning and Health Information, MOH April 2009

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three weeks. The amount of time spent away from core program activities was significant and affected the effectiveness of the program since staff were not available to implement program activities.

Recommendation 37 (Requires attention)

CNM should submit to the Global Fund on an annual basis the schedule for workshops and international workshops for approval. This will ensure that program funds are used to fight Malaria and that staff are available to implement program activities.

211. CNM incurred ineligible expenses amounting to US\$ 17,942. The table below summarises the transactions that were not in the approved work plan and for which prior Secretariat approval was not sought. With the exception of cell phones and the coffeemaker, all the items below were classified under general operating expenses in the accounting records, yet they were fixed asset purchases. This classification was misleading and facilitated such purchases even though they were not budgeted for.

Date	Voucher reference	Description	Amount (US\$)	Comments
24 Jul 2008	CDVR6 08/92	Purchase of cell phones	3,440	Budget was for 2 mobile phones each costing \$80 to assist in field work. Instead, 4 mobile phones each costing \$860 were purchased for senior management
2 Jun 2008	CDV08/52	Purchase of coffee maker	1,590	Not in budget. CNM has several water dispensers on site and did not need to purchase a coffee maker.
10 Sep 2008	CDV 08/98	Rebuild CNM LAN	9,900	Item not in budget/ work plan
4 Oct 2008	PCPV08/41	Renovation of IT room	420	Item not in budget/ work plan
23 Jul 2008 21 Jul 2008 16 Dec 2008 11 Aug 2008	CDV 08/84 CDV 08/82 PCPV08/120 PCPV08/103	Décor in Director's office	2,592	Items not in budget/ work plan
			17,942	

Recommendation 38 (High)

CNM management should ensure that all expenditure is appropriately classified in the financial records in order to provide an accurate financial position for decision making. All ineligible costs identified above should be refunded.

Sub recipient management

212. CNM implemented programmes and also sub-grants to SRs and SSRs to implement on its behalf. Overall, 75% of grant expenditure to-date was by CNM and 25% by SRs and SSRs including those provinces. A review of the activities

conducted by the SRs and SSRs revealed that their activities were in some instances similar to those conducted by CNM. In other instances, the SRs used CNM resources to conduct their activities. For instance, under Round 4, ASSAR an SSR was responsible for distributing Long Lasting Insecticide Treated Nets (LLIN) and basic education. These activities were conducted by CNM thus bringing into question the need to have an SSR as a ‘middleman’ and justifying the additional costs that came with it.

Recommendation 39 (High)

Given the vast nature of the CNM/MOH network, administrative costs of the programs could be reduced by maximizing the use of existing resources.

Procurement and supply management

PSM arrangements

213. CNM had a procurement department in place that was responsible for procurement and logistics management. CNM was responsible for procuring both health and non-health commodities for Rounds 2, 4 and 6 where it was an SR under the supervision of the MOH. For the RCC grant, CNM was procuring as a PR and was responsible for supervising the procurement of its SRs.

214. The OIG reviewed the skills and experience of staff responsible for CNM’s procurement and logistics management function. It is commendable that the department had two pharmacists who provided the relevant expertise to the procurement process. However, the procurement and logistics unit lacked staff with proper qualifications in procurement or logistics. Some staff did not have the requisite qualifications and expertise for the positions they held. These staff relied on their past procurement related experience to perform their work.

215. In practice the positions in procurement and logistics department did not were lower than staff levels illustrated in CNM’s organogram. There were also key functions that were not catered for in this department i.e. forecasting and quantification, contract management and shipping and forwarding. The shipping and forwarding function was included in the logistics management assistant’s job description as ‘arranging the documents of imported drugs from overseas suppliers and pertaining with other institution in government’. This did not reflect the work that is required in this important function. There was no focal point for liaison and coordination with MOH. There was no one assigned the responsibility of supervising logistics. This left logistics management functions like tracking of expired drugs, slow moving items, stock levels, losses, adjustments etc poorly managed.

216. The job descriptions of various staff in the procurement and logistics department contained both gaps and overlaps. They did not reflect the work that the different staff were involved in and did not separate roles and responsibilities among the staff. The descriptions mixed up the functions of finance, procurement and logistics management.

217. The OIG's review of the PSM plan revealed that the plan was adequate except for the quality assurance aspects that were not elaborated well in the plan. The plan was also silent on how CNM would have its pharmaceuticals tested at a WHO-prequalified laboratory. This was especially important since CNM procured ACTs from a non- WHO prequalified suppliers thus raising the risk of compromised products. The University of the South Pacific data quality program provided some QA monitoring but this did not cover all the batches as is required under the Global Fund QA policy. There was also no defined product recall process in the event that CNM identified product quality problems after distribution.

218. These gaps were identified during the PSM plan development for the RCC grant and the subsequent LFA assessment of this grant. CNM had made its proposal for TA in this area but this was not approved by the Technical Review Panel (TRP). However, there was a provision for a long term international TA on procurement under a containment project approved by Bill and Melinda Gates Foundation (BMGF). As CNM moves away from parallel systems back to the national systems, such assistance would go a long way in strengthening the national systems and benefit all the donors.

Recommendation 40 (High)

CNM should strengthen its capacity especially in forecasting and quantification, contract management, shipping and forwarding and logistics management.

Forecasting and quantification activities

219. The responsibility for forecasting and quantification of ACTs lay with CNM's logistics unit. A team with epidemiology, technical, program and logistics skills were involved in the forecasting and quantification. The primary method used for forecasting and quantification of ACTs was the morbidity method. The consumption method was used to confirm the estimates. The Standard Treatment Guidelines (STGs) for malaria have changed every two years based on the resistance study results.

220. However, the change in treatment protocols and the poor Logistics Management Information Systems (LMIS) had in the past contributed to inaccuracies in the morbidity and consumption methods and created forecasting problems. The Clinton Foundation was providing support through a quantification tool called MALCOLM. Staff in the logistics unit had received training and it is expected that this would result in more accurate forecasting and quantification for ACTs in the future.

221. The Impregnated Bed Nets (IBN) Unit was responsible for the forecasting and quantification of bed nets and respective insecticides for Insecticide Residential Spray (IRS) and bed nets retreatment. The On Site Data Verification (OSDV) report of July 2009 raised concern that CNM's data collection and management of the distribution of LLINs was poor. This affected the accurate forecasting and quantification of nets.

Recommendation 41 (Significant)

CNM should improve LMIS for nets to improve the quality data used for forecasting.

Procurement processes

222. Cambodia has a high resistance rate for anti-malarial drugs putting it in peculiar situation since it requires special drug combinations. This prompted the special procurement of artesunate and mefloquine for which there is no WHO pre-qualified manufacturer.

223. With Global Fund clearance, CNM contracted Cambodia Pharmaceutical Enterprises (CPE) to re-package the artesunate and mefloquine into a co-blister until 2008. Again with the Global Fund CNM then procured co-blisters from CIPLA but this too was not from a WHO prequalified manufacturer. The use of manufacturers that are not pre-qualified raised the risk of compromised product. There were also episodes of ACTs shortages since 2006 and these will continue until CNM finds a permanent solution to the supply of ACTs that specifically address the complex requirements for malaria treatment in Cambodia.

224. The country faced the challenge of identifying a WHO pre-qualified manufacturer that is willing to produce the special combination. There is enough business for ACT manufacturers in the production of generic ACT combinations and unless it makes good business sense, it may not be lucrative to manufacture small quantities of a special combination for a few countries. The Global Fund has given CNM up to June 2010 to get a WHO pre-qualified supplier for the artesunate and mefloquine co-blister.

Recommendation 42 (High)

CNM should continue to engage stakeholders to find permanent solutions to the underlying factors that are causing the acceleration of drug resistance.

225. The OIG reviewed the procurement of bed nets and noted that CNM had in the past not used generic LLIN technical specifications, and had become dependant on a single supplier (Sophanna) i.e. there was no competition. In a letter to CNM, the Global Fund advised CNM that the net specifications were fairly specific and would not allow for competition amongst all WHO Pesticide Evaluation Scheme (WHOPES) recommended LLINs. This resulted in the delay of procurement activities for LLINs. CNM then wrote to the Global Fund asking for the approval to customize their technical specifications to “hammock” nets which could only be provided by one supplier.

Recommendation 43 (High)

CNM should develop generic LLIN specifications in line with procurement best practice for approval by the BEC. The technical specifications should result in fair and open competition amongst all WHOPES nets.

226. CNM did not follow procurement guidelines in the procurement of nets. The procurement of nets was not tendered in line with the procurement guidelines and best practice and so was not open, transparent and competitive. Instead, CNM extended a closed contract it had with Sophanna. This was approved by the Secretary of State¹³.

227. The OIG noted that the constitution of the tender evaluation committee was inappropriate on those occasions when it met without a relevant technical representative. For example, for the evaluation of Rapid Diagnostic Test Kits (RDTs)¹⁴, there were no technical experts assigned to the evaluation committee to provide technical inputs to the evaluation processes. Other matters noted related to this tender were the lack of a price comparison between Mission Pharma's offer and international prices. Where only one bid met the technical requirements, this should have been done as a matter of principle. The performance security of 2% was a tender requirement that was not enforced.

228. CNM's procurement processes were targeting agents and distributors and were not directed at manufacturers. This was driven by use of the NCB method which attracted local distributors and agents. This created a 'middleman' which inevitably resulted in additional charges and increased the total costs for products. CNM also misinterpreted the agency concept where the issuance of a letter of attorney to an agent was construed wrongly to mean the transfer of the contract from the principal company to the agent. For example Pharmacie Sophanna had been contracted twice by CNM for Beijing Holley-Cotech Pharmaceuticals Co. Ltd. awards of contract. This transfers the contractual obligations from Beijing Holley Cotec Pharmaceuticals Co. Ltd to Sophanna. This was also identified between Mission Pharma and GreatPharma contracts. .

229. The OIG noted anomalies in a case involving procurement of flip charts by CNM. Quotations were obtained from five potential suppliers including Cam Digital Publishing Co. Ltd and Sunway Publishing. The contract was awarded to Cam Digital Publishing Co. Ltd on the basis of lowest rate offered. Cam-Digital Publishing Co. Ltd sent CNM a letter requesting for their payment to be made to a Mr Chhum Sokhoeun. However, the stamp on that authorization letter was for another bidder, Sunway Publishing Shop. This indicated that the two bidders may be the same person or may be connected in some way. This also indicated that the review of supporting documents before payments were made by the Finance department was not comprehensive.

230. Other internal control weaknesses noted from the review of a sample of procurement processes were:

- (a) CNM's procurement planning was inadequate to allow the pooling of the procurement of similar products to benefit from economies of scale. Poor planning often also resulted in CNM having to undertake emergency procurement which did not follow procedures.

¹³ REF: Mosq Nets GFATM/CNM/Mos.Ins/02

¹⁴ REF : GFATM/CNM/RDT.RII.Phase2/011

- (b) The issuing of tenders on an emergency basis resulted in the setting of tight deadlines e.g. one week for bidders to prepare competitive bids. This may have contributed to the low bid submission rate (as low as 14%) despite the large number of tender documents issued.
- (c) Instances were noted where the criteria used to evaluate bids differed from that in the bidding documents e.g. the criteria to be used in evaluating the tenders for nets were changed during the evaluation.
- (d) CNM did not have an approved list of suppliers for use in the national shopping procurement method. This left the process prone to abuse and manipulation by the staff and management involved in the identification of suppliers.
- (e) CNM did not enforce performance securities for high value contracts as required by the procurement guidelines. CNM could not provide performance securities for sampled contracts. Performance securities ensure that suppliers perform their obligations as set out in the contract.
- (f) CNM had a good practice of advertising tenders in local newspapers and this created a reasonable level of interest among mostly local suppliers e.g. bid number GFTAM/CNM/Mos.Ins./02 received 10 bids. On the other hand, there had limited interest generated from international companies. The OIG questions whether enough was done to attract international companies.
- (g) CNM set unrealistic bid validity periods and delivery dates for their suppliers. CNM set a bid validity period of 45 days that it could not abide by resulting in CNM having to request for extensions. Suppliers were given 60 days to deliver from the date of contract signing. This was also rarely met resulting in suppliers requesting to extend the delivery time.
- (h) The tender reports prepared by CNM were not comprehensive. They did not contain bid opening minutes. The details provided in the combined bid opening and bid evaluation reports did not demonstrate the required level of transparency of the processes. Fraudulent processes can go undetected with such shortcomings.

Recommendation 44 (High)

CNM should put in place measures that ensure that procurement guidelines are adhered to all the times. SOPs should be put in place to provide guidance on various procurement processes e.g. on pre-qualifying suppliers.

Storage and distribution

231. CMS was responsible for the storage and distribution of commodities. It was reported in the WHO studies for RDTs that there were disruptions in the cold chain for RDTs especially in the private sector. This was also supported by the LFA OSDV for the private sector.

During the audit field visits it was also established that there are inadequate cold chain facilities in the supply chain. There was no defined system for temperature monitoring at the different levels.

Recommendation 45 (Significant)

CNM should liaise with CMS to minimise disruption of cold chain during distribution of RDTs and the OD pharmacists to ensure there are appropriate cold storage facilities in the districts to maintain appropriate storage temperatures for RDTs.

The National Centre for Tuberculosis and Leprosy Control**Financial management**

232. The OIG's review of advances revealed two areas where the provisions of the financial guidelines were not followed thus weakening the control environment within which advances were made. Advances were provided to staff without them having settled earlier advances taken. The guidelines provided for liquidation of advances within two weeks of the activities having been taken. However advances were in many instances liquidated past their due date. Examples of such delays are detailed in the table below:

Disbursement date	Particulars	Settlement date
9.4.2009	Active Case Finding Preparation Visit at OD Kg Tralach, Kg Chhnang Province from 7-12 September 2009	5.10.2009
28.8.2009	Active Case Finding Preparation Visit at OD Sampov Meas, Pursat Province from 31 Aug-5 Sep 2009	5.10.2009
19.8.2009	Regional Meeting for Grant Recipient Countries, Mongolia from 3-5 September 2009	20.10.2009
28.8.2009	Active Case Finding Preparation Visit at OD Angkor Chum, Siem Reap Province from 31 Aug-5 Sep 09	20.10.2009
9.4.2009	Active Case Finding Preparation Visit at OD Korng Pisey, Kg Speu Province from 7-12 September 2009	30.10.2009

233. The advance management system in CENAT was also not integrated in the QuickBooks accounting system. Individual advance registers were not maintained and there was no ageing analysis of the outstanding advances. This resulted in staff with outstanding advances receiving further advances and delays in settlement of advances. This resulted in delays in settlement of advances. There was no information available for follow up by management e.g. the advance of US\$ 682 taken on 7 May 2009 for TB/HIV quarterly meeting was not used and only got refunded two months later i.e. on 23 July 2009.

Recommendation 46 (Significant)

CENAT should strengthen its advances management processes by ensuring adherence to the financial guidelines. Specifically, there should be strict adherence to the requirement that staff with outstanding accountabilities for prior advances do not receive additional advances.

234. The OIG audit covered the training undertaken by CENAT. CENAT budgeted and paid for the cost of training based on financial guidelines approved by the MOH. The OIG's audit revealed the following issues related to training:

- (a) CENAT staff received allowances to attend the trainings in Phnom Penh. For example, the NCHADS director and his deputy directors received an honorarium of US\$ 50 each for attending the opening and closing ceremonies of the trainings.
- (b) Facilitators e.g. the logistics personnel on the payroll funded by the Global Fund also received facilitation allowances for trainings they undertook as part of their jobs.
- (c) Per diems were paid to staff to attend trainings that were conducted in Phnom Penh, where the staff are based.

Recommendation 47 (High)

CENAT management should strengthen the environment within which program activities are undertaken. Staff should not receive allowances for undertaking tasks that are part of their jobs except in exceptional circumstances. .

235. CENAT staff attended a conference on lung health “39th Union World Conference on Lung Health” in France during 2008. The conference was specifically targeted to the health care professionals interested in TB, HIV/AIDS, asthma and other lung diseases. However, the team attending the conference also included finance personnel. The costs incurred by the finance personnel to attend this conference amounted to US\$ 7,400. There is no need programmatically for them to attend.

Recommendation 48 (Significant)

CENAT should ensure that the composition of teams attending international conferences is reflective of program requirements. Capacity building and training of employees which are essential to the growth and sustainability of the organization need be adequately planned and be based on the need of the staff and the job profile. This would benefit the staff and the organization both in terms of gaining knowledge and value for money spent.

236. CENAT purchased 4 new printers in September 2009 which were not in use and kept in the store. Almost all of the project staff were equipped with printers e.g. there were 6 printers and 1 multifunctional printer for just 8 finance staff. Additionally, all staff had laptops alongside their desktops. The laptops were only being used during field work. The purchase of unnecessary equipment represents waste of program funds that could have been put to better use fighting the diseases.

Recommendation 49 (Significant)

Fixed assets procured using Global Fund grants should be based on actual need in order to enable efficient conduct of program activities and not on the basis of budget approved by Global Fund.

The cost of assets budgeted but not necessarily required by the organization should be used on other productive activities.

Sub Recipient management

237. CENAT sub-granted some of its implementation to SRs and SSRs. Overall, under Round 2 and 5, more than 75% of the grant expenditure to-date was incurred by CENAT and under Round 7 around 70% of the expenditure to date had been incurred by SRs.

238. Under Round 7, CENAT was conducting the Global Fund activities through 11 SRs. During the capacity assessment of those 11 SRs, 2 Health and Development Alliance (HEAD) and Cambodia Anti Tuberculosis Association (CATA) were identified as relatively new with limited experience. Specifically, in case of CATA procurement activities were conducted by CENAT itself. The OIG was not provided with a capacity building plan for these SRs. There was also no evidence of CENAT having carried out any monitoring visit to CATA. During its field visit to the HEAD, the OIG noted that this SR did not have any TB related experience and therefore could not establish the value added of this SR to the TB program.

Procurement and supply management

239. CENAT was responsible for the procurement of non- health commodities under Rounds 2 and 5 when it was an SR. Procurement of TB drugs was the responsibility of the MOH. Under Round 7 CENAT as PR took on the responsibility for procuring grant commodities and the coordination of procurements for its SRs. Direct procurement through Global Drug Facility (GDF) was used for the procurement of first line adult anti TB drugs. The procurement values were within the budget and the full budget amount was covered by a single procurement.

240. The number of responsible staff was adequate for the level of planned procurement activities but this was not the case for the supply chain management. The OIG was concerned that CENAT's chief of procurement was also the human resource manager reducing the amount of time dedicated to these two important functions.

241. The OIG reviewed the forecasting and quantification process for TB drugs and noted that there were no guidelines in place on forecasting and quantification processes. There was no evidence that the data and forecasting and quantification processes were validated. The primary forecasting method used was the consumption method. There was no active logistics management by CENAT thus the data submitted by health facilities could not be totally relied on for accurate forecasting. No shortages had been documented because there is always a buffer stock of 9-12 months.

Recommendation 50 (Significant)

(a) *CENAT should carry out active logistics activities including verification of data from health facilities, collection of stock status reports from CMS, tracking expiry dates of supplies in the supply chain.*

(b) *CENAT should develop and implement forecasting and quantification guidelines to be used by the forecasting and quantification team.*

242. The OIG reviewed one of the procurement processes for health products (x-ray films and accessories) undertaken by CENAT and it revealed the following:

- (a) The method followed was the NCB in accordance with the procurement guidelines. The venue for the bid opening was not specified in the invitation for bids. The mode of submission of bids i.e. email, post, courier, hand delivery was not specified in the bids. The bid documents did not mention that bids submitted after deadline would not be accepted.
- (b) The bid security was for the 5% which is on the high side.
- (c) Shipping instructions were inadequate for international procurement.
- (d) Time for bid opening was postponed to 4.30pm on same day "due to conflict of the meeting" in non compliance with the instructions in the bidding documents.
- (e) Report did not show item by item evaluation as per bidding documents. Evaluation criteria changed from item-by-item to lot during evaluation due to small size of contract.

Recommendation 52 (Significant)

(a) *CENAT should review the bidding documents to bring them in line with best practices and give potential bidders enough information to make decisions on whether or not to participate in the tender.*

(b) *CENAT should bring bid securities down to the recommended 2% and concentrate on the management of the contracts rather than use a high bid security of 5% as the deterrent measure.*

Systems that support program implementation

243. Issues that emerged during the public health aspect of the OIG audit were mostly generic to, or cut across, all 4 PRs. This is because all 4 PRs are part of one institution, the MOH. Because the public health findings are not specific to each PR and to avoid repetition, the findings are given in the following sections of M&E, quality of service delivery, technical/management capacity and role of in-country partners and coordination, rather than under each PR.

Disease specific aspects

Malaria

244. CNM achieved some success in the fight against malaria with (i) the Malaria incidence rate declining from 7.5 per 1,000 in 2004 to 4.1 per 1,000 in 2008; the Malaria mortality rate declining from 2.8 per 100,000 in 2004 to 1.4 per 100,000 in 2008; the Village Malaria Worker (VMW) program expanding from 2 to 10 provinces; the level of public awareness of proper treatment procedures increasing from 47% in 2004 to 72% in 2008; and CNM having a well defined storage and distribution system.

245. A key question in the evaluation undertaken in 2008 of GFATM support for malaria since 2004 was ‘Has increased malaria funding led to a reduction in the burden of disease?’ The conclusion was that there had been a significant improvement in malaria prevention and treatment. In particular there were increases in the population at risk with access to early diagnosis and treatment through the availability of community based village malaria workers and in impregnated bed net coverage¹⁵. Additionally, the review of health sector performance in 2008 showed that¹⁶ (i) Malaria mortality declined from 2.8/100,000 in 2004 to 1.4/100,000 in 2008; and (ii) Malaria incidence declined from 7.5/1,000 in 2004 to 4.1/1,000 in 2008.

246. However, one result from the 2007 Cambodia malaria survey was that while there was an improvement in awareness about correct treatment, from 47% in 2004 to 72% in 2007, ‘behaviour does not seem to be keeping pace with knowledge judged by low ITN use and the high use of inappropriate malaria treatment in the private sector’^{17 18}. In the late 1990’s it was estimated that 80% people bought their malaria drugs in private sector. The 2007 survey showed that this had only dropped to 70%. Indeed, in 2008 the number of cases of malaria treated at public sector health facilities was only 4.1 per 1,000 population¹⁹.

¹⁵ Dr Kheng Sim, Five year evaluation of the Global Fund Study: malaria report and data. Power point presentation, 28 August 2008. CNM

¹⁶ DPHI Report: Joint annual performance review of health sector 2008. Department of Planning and Health Information, MOH April 2009

¹⁷ CNM. Program implementation and achievements made in 2008. Power point presentation, National Malaria Conference, 23-24 June 2009

¹⁸ Cambodia Malaria Survey 2007. Draft report 2008

¹⁹ DPHI Report: Joint annual performance review of health sector 2008. Department of Planning and Health Information, MOH April 2009

247. There were however some challenges noted to quality service delivery. These were;

- I. the emergence of artemisinin resistance on the Cambodia-Thai border;
- II. the movement of mobile populations from non-endemic areas into forests which are highly endemic; (iii) there are known to be a number of counterfeit anti-malarial tablets in the private sector; and
- III. in 2008 there were delays in the provision of ACT's through UNITAID and of LLIN's through GFATM. (This is covered in the section on procurement and supply chain management).

HIV and AIDS

248. The MOH achieved some success in the implementation of the HIV/AIDS program e.g. (i) Pooling ARV procurements and obtaining discounts on purchases and assurance of quality; (ii) Initiating the performance of pharmacovigilance activities to detect, assess, understand and prevent any side effects of drugs; and (iii) having well defined distribution and storage channels.

249. NCHADS was able to achieve success in program implementation e.g. (i) the "100% condom use program" in 24 provinces reaching more than 90% of entertainment workers; (ii) Home & community based care for people living with HIV scaled up to cover 657 health centres in 20 provinces; (iii) OI/ Anti Retroviral Therapy (ART) services expanded to 51 sites in 20 provinces; and (iv) 31,999 people were receiving ART including 3,067 children. NCHADS' however had a slow start up mainly caused by a delay in (i) the selection of the SRs; (ii) preparing and finalizing the PSM plan; and (iii) The presence of counterfeit drugs.

250. Worldwide there is concern that now treatment is available for HIV and AIDS, prevention is being/will be relatively neglected. During the audit this concern was confirmed. The OIG was given conflicting information on whom, if anyone, between the NAA and MOH/ NCHADS had the lead responsibility for preventive work. There was no evidence that the general population was kept sufficiently informed, even on the build up to, and on World AIDS Day, when some members of the OIG were on field visits.

251. There were reports of insufficient and poor quality HIV preventive work, except on a one-to-one basis during counselling sessions and sometimes on a peer basis among the current 3 at risk groups. While the epidemic was currently among the 3 high risk groups, the general public especially young people needed their awareness levels to be kept high. The epidemic was not known to be generalized but as members of the public used the private sector so much, even good sentinel surveillance would miss cases.

252. The 100% condom use program under Rounds 4 and 7 was impressive but it was only targeted at the high risk groups. Both the national disease program and PSI were promoting the program. Under the latter some bosses of 'entertainment houses' buy the PSI subsidised condoms and then give them 'free' to clients. The

cost is included in the price for a room. However this raised the question 'does this mean price for room has gone up and is a deterrent for some people and do some negotiate to get price down without the inclusion of the 'free' condom?

253. During field visits one OIG group stopped at random at market stalls at commune level and at provincial capital markets to ascertain the availability and price of condoms on the market. No condoms were found for sale at communal level but were reasonably available in provincial level markets. The group also asked about the availability of free condoms in health facilities. They were only available through the family planning/birth spacing program where free condoms were provided.

254. If a client was found to have a sexually transmitted disease at a public sector health facility s/he could ask for free condoms but they would have to be obtained from the supply for family planning. This could be interpreted as you have to get an infection before you can get a free condom which is too late! The international and local evidence base for the greater availability of free condoms needs to be examined as does the need for the better marketing of condoms at commune level.

255. The use of the term 'home based care' for HIV and AIDS supported by the Global Fund was misleading. It was not palliative care but only helped people at community and health centre levels get referrals, supported follow-up of adherence to treatment and for the supply of medical kits for home use. Palliative care was not covered in the approved work plan and so only appears to be provided at the hospital level for terminal stages of cancer and AIDS through Doulers sans Frontieres. This was a missed opportunity for Cambodia to develop a national palliative care program.

256. Finally, it was very difficult to get reports on CD4 count levels that had been recorded during the past 6 months in the capital city. Grant funds were spent on buying equipment, which some might use as an output indicator. But this could not be tied to any result i.e. what the CD levels of patients were and how these were affecting those on treatment. The OIG was informed that no CD4 counts had been done recently because there was a problem with the supply of reagents; and that the same applied to doing viral loads.

Recommendation 53 (Significant)

(a) NCHADS and the NAA together should review the quality, type and amount of preventive work done, especially among the general population and agree what is needed in the future, how best to do it and who will do it. The outcome of this review should be considered by the CCM and reflected in future grant proposals.

(b) Apart from for the most at risk target groups, free condoms are promoted as a family planning/birth spacing commodity. NCHADS should review the need for a greater availability of free condoms. Private sector vendors should be encouraged to get their supplies out to commune level.

(c) There has been a missed opportunity to develop a community palliative care program with Global Fund support. NCHADS to review and have a position or

policy on whether palliative care for AIDS patients that would also benefit cancer patients should or should not be a MOH program

TB

257. The Global Fund contributed to the success of the TB program in the health sector performance in 2008 as demonstrated by (i) the TB cure rate being 91% against the 2008 target of 85%; the case detection of smear positive pulmonary TB sat at 69% against the 2008 target of 70%; (iii) Basic DOTS reached 100% health centre coverage; (iv) Community DOTS was expanded to cover 506 health centres; (v) Public/private DOTS expanded to 11 provinces; and (vi) TB/HIV collaboration program expanded to 57 ODs.

258. TB had a very specific challenge in that it has fewer and fewer development partners supporting it. Unlike HIV and AIDS or even malaria TB is not a popular subject. So while there are risks associated with the increasing reliance on Global Fund grants for all 3 diseases, it is particularly relevant for TB. In 2009 all drugs for TB were obtained through Global Fund grants. There were government budget funds for TB drugs but when Global Fund monies became available then the government funds were re-allocated for necessary non-TB drugs.

259. In 2001 a survey about TB found that there was no MDR. At the time of the audit, the ministry was awaiting the results of a repeat survey in 2009. The indications are that MDR may be at about 1.5%. This has implications for both drug use and the quality of monitoring that patients take their drugs regularly and complete their drug regime(s).

260. At the community levels there was an increasing number of volunteer DOTS watchers. Their key task was to collect TB drugs on a weekly basis from their health centre and go either to a TB patient's home daily and watch the taking of drugs or for the patient to come to the home of the DOTS watcher and take their drugs under supervision.

261. There were also volunteer community DOTS supporters. These people worked with village health support groups mainly on helping potential patients gain access for investigation and treatment. Both community and volunteer DOTS supporters/ watchers were included in the approved work plan. The justification for having such supporters just for one disease in addition to the DOTS watchers was unclear. Both types of DOTS workers got per diems, paid out of Global Fund grants, for attending meetings and training sessions at health centres.

Recommendation 54 (Requires attention)

CENAT with MOH should review the justification for having DOTS supporters (as well as DOTS watchers).

HIV/TB

262. As the number of health workers who had been trained to take blood increased so did TB/HIV testing. A TB patient could get the result of their HIV test results the next day, but only if they returned to the health facility. From the OIGs discussions in health facilities it seemed that the quality of the system for follow-up of patients who were tested and were HIV+ and did not return for their result needed strengthening. Theoretically a health worker should have visited the person at home if they did not attend for their result but no evidence was found to show this is actually happening.

263. There was also some indication that HIV or AIDS patients who needed to be tested for TB, never were because they find it difficult to produce sputum and they were then not x-rayed.

Recommendation 55 (Significant)

The Ministry should review and strengthen the systems for the follow-up of patients tested for HIV who do not collect their results and of those HIV or AIDS patients who need testing for TB.

The health system context

Cambodia was one of the few countries which were successful with their grant applications for the Health System Strengthening (HSS) under Round 5. The wider health sector context within which Round 5 is functioning is one of a dynamic leadership and is results oriented. However, it was difficult to ascertain what useful, sustainable impact the Round 5 HSS was having, how efficiently the funds were being used to strengthen health systems and what contribution the HSS had made to the results in the wider health sector. This was because most of the HSS grant indicators were not related to the 15 core national health sector indicators.

264. Cambodia was one of the few countries that was successful with its applications to the Global Fund for HSS support. It was therefore judged important during the audit to consider the wider context of the Cambodian health system. Intensive work started 1992/3 to re-build the health system following the devastating genocide under the Khmer Rouge. A particular focus was on developing capacity, systems and services. Overall, Cambodia has made tremendous strides forward and can now be said to be in a health development phase rather than in a post conflict era. Indeed its openness to trying innovative approaches and obtaining the evidence base for scale up to address equity and access to services by the poor are impressively ahead of many other developing countries.

265. JAPRs²⁰ were undertaken annually since 2001. These JAPRs have specific emphases every year with the March 2009 review of 2008 focussing on

²⁰ A JAPR is a sector wide forum to assess achievements of the previous year, examine constraints to implementation and identify priorities for the coming year.

reproductive, maternal, newborn and child health, communicable and non-communicable diseases and health systems strengthening. Among other things, this report noted that:

- (a) There was a clear policy direction in health since 2003. The current guiding document was the Health Sector Strategic Plan 2008 - 2015. Reducing HIV/AIDS, malaria & TB morbidity & mortality was a strategic priority in the plan. There were also annual operational plans and a 3 year rolling plan for 2010 - 2012;
- (b) MOH was specifically in charge, of among other things, 'combating HIV/AIDS, malaria and TB';
- (c) There were a number of sound systems e.g. the planning & health information while others were fragmented e.g. the M&E;
- (d) There was no human resource retention strategy. Salaries were very low
- (e) The use of the private sector was very prevalent, with high levels of "out-of-pocket" expenditure, even in cases where there were free services and commodities;
- (f) As of 2009, licensed private practitioners were required to use/contribute to the national health information system;
- (g) There was much rhetoric about harmonisation and alignment among international stakeholders. However, the report noted that external support was still mainly in the form of individual projects and was causing serious financial imbalances and/or distortions; and
- (h) There were risks associated with increasing reliance on the Global Fund grants.

266. Health systems strengthening means different things to different people, not just in Cambodia but worldwide. However, there is an emerging international consensus that health systems aim to help ensure that the institutional culture and management arrangements facilitate the attempts of managers and implementers to make effective decisions, provide quality services and undertake their work properly. They therefore focus on processes, roles, structures and specific systems.

267. Once these issues are strengthened it enables the effective use of facilities and of staff who can then more effectively use their skills and tools. Increased funds for the prevention and control of the three diseases will not help achieve the desired outcomes and impact if shortcomings in the health system systematically undermine individuals' attempts to work properly²¹. Of some concern is that the HSS in the Round 9 HIV/AIDS did not reflect this thinking. It was not going to strengthen institutional and management needs in the ministry as it was directed at NGOs. This issue should be considered in future grant proposals.

²¹ Stephanie Simmonds 2008 Institutional factors and HIV/AIDS, TB and Malaria. International Journal of Health Planning and Management, 23:139-151

Monitoring and evaluation

There was no alignment with the national Monitoring & Evaluation (M&E) system. All the PRs established parallel systems and structures for M&E including the associated functions of data collection and analysis. The OIG also noted that these parallel systems came with excessive provision of technical assistance (TA) posts for M&E. This TA was not contributing to strengthening the national M&E system but was supporting contract staff that should have had the requisite skills at the time they were recruited.

268. The national HIS used a variety of tools for planning and for M&E. These included routine data collected monthly in the HIS form, the JAPR, the annual operational plan, the national strategic plan, national surveys and the MDGs. Because of the economic recession the Ministry of Planning recently gave all ministries the opportunity to revise their MDG targets. The MOH changed the maternal mortality ratio from the original 2015 target of 140 per 100,000 live births to 250 per 100,000. The other health targets including those related to the 3 diseases all stayed the same.

269. When monitoring performance and evaluating the scale-up for better health the MOH Department of Planning and Health Information (DPHI) had identified a number of issues that need addressing²²:

- (a) There were too many indicators in addition to the core national health indicators. For example there are indicators required by national health programs, the Global Fund, GAVI, MDGs and other global health initiatives;
- (b) There were fragmented data collection tools;
- (c) There were weaknesses in data quality;
- (d) The Ministry had inadequate capacity in data analysis; and
- (e) There was poor data utilization and dissemination.

270. The Round 1 was not signed until 2003 and following a performance assessment a few months later the MOH came under pressure from the Global Fund Secretariat because it was behind on achieving set targets. The national M&E system was judged as being weak and also because additional indicators needed to be monitored, the MOH PR decided it would take too long to strengthen the national M&E system.

271. The Ministry opted to create its own M&E unit. This was in parallel to the DPHI where M&E is a routine function. This was an example of implementation pressure versus capacity building and of a wasted opportunity. The Global Fund resources have therefore contributed towards fragmenting and not building the national system.

²² Lo Veasnakiry 2008 Monitoring performance and evaluation of the scale-up for better health. Power point presentation at Ratnak meeting, Department for Planning and Health Information, Ministry of Health

272. M&E was further fragmented under the Round 7 HIV/AIDS and TB grants and the 2007 RCC malaria grant when each of the 3 disease institutions became PRs. As PR, each of these institutions proposed and got a TA post for M&E. The extravagance in the support of M&E posts was further exemplified in the MOH DDF. DDF as an SR under Rounds 5 and 6 had an M&E person for each of the 2 Rounds.

273. The creation and financing of posts outside the national system was in the OIGs view unjustified and a waste of money. There should only be a need for one TA post for M&E, which should be in the DPHI. The savings can then be spent on strengthening the national HIS and M&E systems, and the alignment of the information required for, and the M&E undertaken by, the national disease programs and by the Global Fund.

274. The OIG also noted that most performance monitoring frameworks for Global Fund grants had a number of indicators that were additional to and/or different from the HIS indicators, those for the national disease programs and also those relating to the health systems strengthening. For example:

- (a) For HIV/AIDS, there were 4 national indicators in the HIS form. NCHADS had 46 indicators. The Global Fund Round 5 grant had 14 indicators, 4 of which were part of NCHADS' 46 indicators and 10 were which specifically set for the Global Fund;
- (b) For TB, there were 3 indicators in the HIS form. CENAT had 5 indicators. The Global Fund Round 7 grant had 19 indicators of which only 2 are tied to CENAT's 5 indicators;
- (c) For Malaria, the HIS form had 4 indicators. CNM had 9 indicators and the Global Fund Round 9 grant had 11 additional indicators; and
- (d) For the HSS grant, there are 15 national HSS indicators used for the JAPR. The Round 5 HSS Phase 1 had 18 indicators, none of which were the same as the 15 national indicators. An opportunity was available during the design of Phase II to better align these indicators but it was not taken up. Furthermore, new additional indicators have been added to the 18 indicators bringing the total to now 25 indicators. Again none of the 25 were tied to the 15 national indicators.

275. The indicators were mainly project type output indicators tracking inputs rather than performance related outcomes. Most service delivery ones were quantitative, there were few qualitative indicators for example on bed/hammock net use, on who was buying socially marketed products or tracking changes in ways of working and in clinical practices. The Global Fund was blamed for having many additional indicators because "it needed to closely monitor performance".

276. The quality of TA and Global Fund advice on indicators was also of questionable quality as evidenced by the indicators that the country was allowed to take on. For example there was a Round 9 indicator on incidence rather than prevalence of HIV infections in the proposal sent to Geneva and some Round 5 HSS strategies and their indicators were not relevant to the actual situation and needs as noted previously. Furthermore, the DPHI was not been consulted on the planning of, or setting of indicators for, the Phase I Global Fund grant. Under

Phase 2, the Global Fund requested the CCC to form a working group consisting of WHO, DPHI, DDF, WB and MOH (PR) to agree on the indicators. The Global Fund needed to revisit 'how' the monitoring is done and to ensure better alignment.

277. Not only was there a parallel M&E system and additional M&E indicators but the PRs also had their own set of M&E guidelines for the 3 diseases²³. This was in addition to the three disease specific ones in place. For HIV and AIDS the National AIDS Authority (NAA) also had M&E guidelines²⁴. These were also developed because in the early days, the assessments undertaken pointed to there not being relevant national guidelines.

278. At the national program level, there were usually 1-2 people per grant collecting information and well paid from the Global Fund resources. At the provincial level there were 1-2 staff for the national HIS. In most cases, there was only one overworked person collecting data without receiving any financial incentive. At the operational district level there were many development partners/initiatives requiring/collecting additional information e.g. Global Fund, GAVI, UNICEF and SRs.

279. This meant, among other things, that there were parallel systems for the collection and analysis of data and that it was time consuming to avoid double counting. At the health centre level staff shortages meant that staff were overworked often resulting in poor quality data inputs. The DPHI estimated that on average about 20% of mistakes in the HIS data got through to it at the central level.

280. The above issues in M&E highlight that while the Global Fund was a signatory to the Paris Declaration²⁵ and has a principle of using national systems in practice alignment and harmonization were not happening. Recently central government asked each line ministry how many M&E systems it had and why. Successes in achieving results in fighting the 3 diseases were at a cost of weakening the national planning, M&E and decision making systems and processes.

Recommendation 56 (High)

(a) *The 3 TA posts for M&E for the 3 diseases should be reduced to one and the savings re-programmed towards: (i) the development of a sound national health M&E framework that development partners can align with; (ii) the development of one set of national M&E guidelines; and (iii) the alignment of the information required for, and the M&E undertaken by, the national disease programs and by the Global Fund. It is further recommended that the one M&E post be in the DPHI.*

(b) *In discussion with the DPHI all contracted and government staff posts for M&E in the MOH-PR and in SRs and in provincial health offices solely working on*

²³ The Communicable Disease Department, The Office of the Principal Recipient for the Global Fund to fight AIDS, TB and Malaria, *Monitoring and Evaluation Guidelines For HIV/AIDS, Malaria and Tuberculosis* GFATM's Grant Recipient Program. 3rd edition, May 2006

²⁴ NAA, National HIV/AIDS Monitoring and Evaluation Guidelines, National AIDS Authority, July 2007

²⁵ OECD/DAC Paris Declaration on Aid Effectiveness, High Level Forum 28 February - 2 March 2005, Paris

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Global Fund grants should be rationalized and any remaining posts be allocated to DPHI to work on both the national M&E and on data collection and analysis still required for global initiatives.

(c) Future proposals to the Global Fund should limit the number of output type indicators and indicators additional to the strengthened national M&E framework.

(d) The Global Fund Secretariat should review ‘how’ it monitors and rewards performance so that it is more closely aligned to national systems and processes.

Quality of service delivery

Clear policies, strategies and guidelines exist in support of equitable, accessible, quality service delivery. But out-of-pocket expenditure in the health sector is common, with charges being made sometimes for ‘free’ drugs and commodities in the public sector. There is also extensive use of the private sector. Salaries are low and some health facilities are understaffed thus affecting the quality of service quality.

281. The factors common to successful performance in communicable disease programs including HIV, malaria and TB identified during the 2009 JAPR of 2008 were²⁶:

- (a) Political commitment;
- (b) Clear policies and strategies;
- (c) Strong leadership and ownership;
- (d) Effective technical working groups that regularly design and update guidelines;
- (e) Good collaboration with development partners; and
- (f) Adequate funding for some communicable diseases to date.

282. There were reports of varying quality of service delivery. This was generally attributed to the low salaries which resulted in understaffing of health facilities especially at health centre level. This meant that the staff present were heavily overworked often resulting in low quality of service delivery. Shortcomings in service delivery were compounded and can also be attributed to poorly equipped health centres, stock outs of drugs and supplies and the evidence of use of expired drugs.

283. The situation got worse as to supplement their salaries a number of health workers practiced under-the-table charging for drugs and commodities that should have been free. The OIG obtained evidence of charging for public sector bed nets. There were also reports of charges for consultations, drugs, laboratory tests and for x-rays, especially under the TB program.

284. Cambodia has a very high level of private, “out-of-pocket” household spending that accounts for approximately two-thirds of all health expenditure, or

²⁶ DPHI Report: Joint annual performance review of health sector 2008. Department of Planning and Health Information, MOH April 2009

approximately US\$ 25 per capita per year²⁷. A report in 2000 by OXFAM found that people were getting into serious debt because of these ‘under-the-table’ charges. In a poor country like Cambodia such high levels of out-of pocket expenditure are of great concern as they affect equity and universal access to health care.

285. The extensive use of the private sector was also noted to be further affecting access to free services and commodities. There are varying reasons for this;

- I. some attributed this to the view that the private sector is more user-friendly;
- II. others felt that the smaller queues of people in the private sector was a factor;
- III. to others it was the opening times of private sector practitioners that were more convenient; and
- IV. to others, private clinics were physically located closer to people’s homes and/or people felt they are treated more as clients. The last issue was recognised by the MOH to the extent that in the 2003 - 2007 National Health Strategic Plan had a strategy ‘to change for the better the attitudes of health providers’.

286. There were supervision check lists for each of the 3 diseases in place to monitor quality. But during discussions it became evident that they are not always used. Furthermore, when supervision had taken place there was no evidence of provision of feedback provided after a supervision visit nor were findings followed up subsequently.

287. The institutions central to the three disease i.e. NCHADS, CNM and CENAT had produced various guidelines to help ensure the effectiveness and quality of work. NCHADS in particular has useful ones on issues such as counselling and quality control and use of antiretroviral therapy²⁸. Some of the various guidelines were available in health facilities visited by the OIG.

288. The OIG noted that all 3 institutions did their own health education Behavioural Change Communication (BCC) with generous budgets allocated for these activities. However, this BCC was unlikely to have much impact and/or be cost effective because it was so fragmented and because of the lack of relevant expertise. Guiding staff is relatively easy when compared to guiding or advising the general public and at risk groups to make changes in practices. Providing the knowledge or awareness of people about crucial issues to prevent and control diseases is relatively easy but taking this further, to change people’s attitudes and practices, takes greater professional expertise.

289. The TB and the malaria programs both used volunteers. There had been no evaluation undertaken to date to assess the effectiveness or quality of their work.

²⁷ DPHI 2007 Strategic framework for health financing. Department for Planning and Health Information, Ministry of Health

²⁸ NCHADS 2007 Standard operating procedures for quality improvement for HIV counselling and quality control for HIV testing and also 2007 National guidelines for the use of paediatric antiretroviral therapy in Cambodia

It was difficult to find people that can afford to be volunteers in poor countries like Cambodia and so one has to ask what is in it for them. Both the malaria and TB volunteers had access to public sector drugs which are meant to be dispensed free of charge to patients. There was a likelihood that these were given with an 'under the table' charge already alluded to as well as the possibility of these drugs making their way to private sector vendors. Private sector vendors stated that they bought supplies from the public sector. While it would be wrong to attribute this to any one type of health worker such as volunteers, the possibility exists.

Recommendation 57 (Requires attention)

(a) MOH should develop strategies to ensure that free drugs and commodities are exactly that for the targeted end user. There is also a need to work actively at building the public's confidence in the public sector service delivery.

(b) Supervision check lists for the 3 diseases need to show what action was needed following a supervision visit and provide for the follow-up of salient issues.

Social marketing under malaria and HIV grants

290. Global Fund grants supported the social marketing of bed nets, condoms and a malaria treatment pill. For malaria this was in collaboration with other donors through the NGO specialist in social marketing, PSI. PSI was also doing the condom social marketing. International evidence on the effectiveness of social marketing has been mixed.

291. Prior to inclusion in Global Fund grant proposals there was no evidence of any rigorous examination of the relevance and pros and cons of social marketing initiatives in poor countries like Cambodia.

MOH and especially the relevant disease institutes needed to better demonstrate that they were in the 'driving seat' and question initiatives that were driven by social marketers.

292. The MOH stopped the social marketing of nets following the 2007 malaria survey. The survey found that only 2% of the markets through the social marketing channel were reaching the population at risk. Furthermore, PSI was not reporting on end-users. PSI reported on the commodities provided to the wholesalers. It was not known who was buying the commodities and at what price.

Recommendation 58 (Requires attention)

(a) The Global Fund Secretariat should consider, in the light of international evidence, the validity of the use of public funds for social marketing in poor countries, especially of bed nets, where it is also enabling free drugs and commodities to be supplied.

(b) MOH should consider and develop a position or policy on social marketing in the health sector. This should include putting mechanisms in place to ensure that the products reach their intended beneficiaries.

Technical/management capacity

293. As with health systems strengthening ‘capacity building’ means different things to different people. The term has been described as meeting a four-tier hierarchy of capacity needs that must be considered if investments in development are to pay off. The 4 tiers are:

- I. structures, systems and roles;
- II. staff and facilities;
- III. skills; and
- IV. tools²⁹.

All too often the focus of capacity development is on the latter two i.e. skills development training and developing guidelines and other documents.

294. Large sums of money were set against the ‘training’ line in Global Fund grants in Cambodia. This ‘training’ took the form of strengthening individual capacity through a proliferation of meetings, workshops, courses and attending overseas conferences, all with per diem and other costs covered. Undoubtedly, some training was needed since there are always new developments, for example, in disease management, service delivery and health system management.

295. The OIG noted that training was taking place in a vacuum. This is so because:

- (a) There was no MOH capacity development/continuing education/training strategy or plan;
- (b) No-one had responsibility for maintaining the bigger picture of training and its rationalisation in the Ministry;
- (c) There was little coordination of training funded by development partners, especially at the service delivery level;
- (d) Not all training was included in any annual operational plan; and
- (e) There was no outcome or impact evaluation of any of the training to date. There were also no evaluations or assessments of the quality of the trainers and the approaches they use.

296. Furthermore, the OIG heard no mention of on-the-job mentoring or of institutional capacity development. This was of some concern given the large amount of short and long term TA provided to date through the Global Fund grants. As highlighted in the section on M&E all 3 disease programs have a post for an international full time TA consultant. In addition there were similar posts for the finance and procurement functions.

297. The OIG noted that the TA was provided to contract staff who should have been recruited with the requisite qualifications to do the work they were contracted to do. It was also questionable what impact some of the international TAs would provide say in finance which was a fairly straight forward function. This

²⁹ Christopher Potter and Richard Brough. 2004. Systemic capacity building: a hierarchy of needs. Health Policy and Planning; 19(5): 336 - 345

was a waste of money if it did not contribute to the building of national structures but instead contributed to fragmentation.

298. While the OIG noted examples of quality TA, it has tended to be in the form of ‘doers’ rather than mentors. It does not appear to have had much influence on strengthening the Ministry as an institution. Rather it benefited just one of the 3 diseases or worse just one of the Global Fund grants. In the early days of proposal writing the process to ensure ownership of grants was very weak. The R5 HSS is a prime example of this. More recently, consultants seem to be more consultative and PRs, if not the ministry as an institution, seem to fully own proposals.

299. When the OIG asked why TA was still needed to write Global Fund proposals, one member of MOH senior management replied that they were not mandated to sit for 2-3 months to write a Global Fund proposal. This highlights the country perception of the proposal writing process and provides a good reason to move towards national disease strategy support.

300. As with training, no one was maintaining the bigger picture of all TA in the ministry and its rationalisation and justification. There did not seem to be much coordination of the provision of TA among development partners. In 2007 the MOEF produced standard operating procedures on TA. But no copy was made available to the OIG team or reference made to the procedures in the MOH. Finally, some people made reference at times to full time TA not working full time in the ministry. For example, WHO consultants have a desk in the MOH but they also spend quite a lot of time at the WHO office, often with a desk there as well.

Recommendation 59 (High)

(a) *The Ministry should undertake an outcome or impact evaluation of the different types of training supported by the Global Fund to date commissioned from an independent evaluator.*

(b) *The Ministry should reduce the extent to which Global Fund supported capacity building or ‘training’ is taking place in a vacuum by ensuring that it targets the strengthening of national human resource systems and processes.*

(c) *The Ministry should undertake a joint MOH/donor evaluation of TA provided in the last decade and with the MOH establish a process to ensure coordination of all TA in the MOH, the objectives of, and approaches used to, develop capacity and the monitoring and evaluation of the quality of TA.*

301. There were three other aspects of technical/management capacity that arose during the audit. The first was that of PR capacity, the second was about the capacity of NGOs as SRs and SSRs. The third, the use of financial incentives to boost morale and performance is reported in the section relating to oversight.

302. Firstly regarding MOH PR capacity, it was earlier mentioned that in 2005 the MOH PR was managing 10 grants worth US\$153.5 million and it was noticed that this was straining the absorptive capacity of the PR. What was not clear was the extent of a rigorous analysis of the reasons for the stretched capacity and of

options for the way forward. All that is obvious was that from 2007 onwards 3 new PRS were appointed.

303. So there are now 4 PRs all within one institution, which to some gives an impression of fragmentation and is not cost-efficient as there is duplication of tasks and roles and there are few systems common to all the PRs. In addition it means that the MOH as an institution is less in the driving seat and power is being re-distributed depending on the size of a grant. Some partners describe HIV and AIDS as a sector with disproportionate amounts of money and power.

304. Secondly, it was clear that some NGOs were following the money and did not have a comparative advantage or strength in whatever subject for which they were a SR or SSR. There was little evidence of a rigorous assessment of any proposed SR or SSR by either a prospective PR or by the CCC. Where lack of capacity was recognised at the time of selection, grant proposals often remarked that some funds would be used for capacity development during the course of the grant implementation. But this rarely happened.

Recommendation 60 (High)

(a) *MOH with the CCC and Global Fund Secretariat should examine the impact of having 4 PRs within one government institution and decide whether consolidation of the PRs is needed to reduce fragmentation and cost-inefficiencies and strengthen the leadership role of the ministry.*

(b) *The process for identifying SRs for program implementation should be strengthened across all PRs. Where inexperienced NGOs are chosen as SRs, there should be good justification for their selection e.g. showing they have comparative advantage to deliver particular services and capacity building should be provided to address noted weaknesses.*

Coordination

305. The main issue related to coordination was that Global Fund proposals (Rounds based, the RCC and Phase 2) bypass and were not coordinated with key MOH technical/management structures such as the Health Sector Working Group, the Health Sector Steering Committee, the Director General of Health, and the DPHI. In fact a parallel planning system, decision making process and coordination mechanism was in place. Any draft Global Fund proposal was scrutinised by a group especially formed for the Global Fund, the TRT and then seen by the CCC sub-committee and finally endorsed by the CCC but with little questioning of assumptions in the process. Other non Global Fund proposals were vetted by the technical working group for health (TWG-H) and then sent on to the Health Sector Steering Committee.

306. There were regular quarterly PR-SR meetings for which minutes were available. Some of the minutes were comprehensive. However, none of them showed evidence of what action had been taken following any information reported nor was there any evidence of action taken reported and recorded in the minutes of the next meeting.

Recommendation 61 (Significant)

The CCC and MOH should review the planning and decision making processes related to Global Fund proposals, including Rounds and RCCs and any Phase II to better align technical and decision making processes with those of the Ministry.

Role of in-country partners

Capacity building has mainly been about strengthening the capacity of individuals through numerous training sessions in the guise of meetings, workshops, courses and attending overseas conferences. OIG heard no mention of on-the-job mentoring or of institutional capacity development. There has also been no effectiveness or impact evaluation of all this training or of the extensive use of TA. In-country partners are numerous and very supportive.

307. Cambodia has numerous public sector, private not-for-profit and private-for-profit partners in health. For the most part all are very supportive, especially the bilateral and multilateral donors. The private-for-profit is working increasingly with the MOH through partnerships and since end 2009 on using the HIS on a monthly basis. However, sometimes conflicts of interest arise.

308. An example of such a conflict of interest is the relationship with WHO as an in-country partner. WHO sits as a co-chair on the CCC. A WHO consultant wrote the Round 5 HSS proposal. This consultant wrote into the proposal some US\$ 750,000 of TA for use through WHO. Once the grant was signed, WHO could not be an SR to the Ministry because of WHO's status with the MOH. The Ministry was therefore unable to adequately monitor or supervise performance. According to the TA terms, the WHO's consultants were supposed to be stationed at the Ministry full time but they were rarely at the Ministry.

309. There was no clause in the agreement signed with WHO about who was to supervise their work. WHO did not provide the Ministry with technical progress reports as required in the agreement. Despite this poor performance, WHO was awarded a bigger TA contract under Phase II of the HSS grant. A recommendation to address this matter has already been raised.

Field visit findings

310. The OIG visited three families in Krong village that received LLINs from the Krang Lvea HC. One family informed the OIG that they were charged 2,000 Riel for the two nets given to them. The director of Krang Lvea HC admitted that VHWs were charging families 1,000 Riels for each net. None of the families had opened their nets and they continued to use their old bed nets. All the families informed the OIG that they would continue to use their old nets until they got torn.

311. The OIG also noted an instance in Krang Lvea HC where 870 units of expired drugs (rifam/isoniazide/pyrazinamide - 150 + 75 mg) meant for TB treatment had been delivered. The expiry date was February 2009 but 400 units were issued on

31 March 2009 and another 470 units on 15 April 2009. This was followed up at CENAT who could not explain why this occurred.

312. PSI distributed condoms called 'Number 1' for sale. These condoms were being sold in village markets at a price higher than the retail price for which it should be sold. The OIG purchased a Number 1 condom at Sras Srang Pharmacy, Trapeang Bei Village, Psar Chnang for 1,000 Riels whereas the recommended retail price was 500 Riel. The OIG was also bought another "Number 1" condom at Sochenda Pharmacy, Kampong Sala Lek Pram Village, Tralach District for 800 Riel whereas the recommended retail price is 300 Riel.

Procurement and supply chain management

National regulatory structures

313. The key PSM structures in Cambodia were Department of Drug and Food (DDF), the Central Medical Store (CMS), the National Laboratory for Drug Quality Control (NLDQC), the Procurement Bureau and the faculty of pharmacy. The OIG noted that each of the PRs i.e. MOH, NCHADS, CNM and CENAT set up their own procurement units and the MOH Procurement Bureau was not used in the procurement of products funded by the Global Fund.

314. The responsibilities for the units with the procurement mandate in Cambodia are given in the table below:

UNIT	Key responsibilities
DDF	Regulatory authority under the Director General Health. The bureaus under the DDF are registration and cosmetics, essential drug, pharmaceutical trade, drug regulation and food safety. Responsible for monitoring and evaluation of the strategic framework and annual operational plans
NLDQC	Drug analysis and technical advise on suspect pharmaceuticals; educate industry on how to improve quality QA obligations during drug manufacturing
CMS	Receiving storage and distribution of drug supplies to public outlets medical supplies; hospital equipment
MOH Procurement Bureau	Coordinating and administering pharmaceutical procurement orders for the public
PR procurement unit	Responsible for procurement of grant commodities. MOH PR is responsible for all grant pharmaceutical procurements
Faculty of pharmacy	Responsible for education of pharmacists and pharmacy assistants

315. The PSM arrangements in Cambodia were guided by the National Drug Policy (NDP 1995). The pharmaceutical sector developed its Pharmaceutical Strategic Plan (2005 to 2010) to support PSM activities with three year rolling plans and annual operational plans in place to guide the planned activities. At the time of the audit, DDF had not started the process of developing the next Pharmaceutical Strategic Plan. Without this there was a risk that pharmaceutical activities may not be coordinated in future.

316. The OIG reviewed the progress of implementation against the strategic, three year and annual plans and noted that there was limited progress being made on implementing the aspects contained in these plans. DDF attributed this to the lack of funding and support for its work. However, the OIG's assessment was that DDF was now focusing on Global Fund activities and was not discharging its primary responsibility.

317. The regulation of this sector remained problematic as evidenced by the following:

- (a) Whilst there were clear procurement guidelines and processes in the public sector and a strategic framework existed, there was insufficient monitoring and evaluation of the strategic framework and the application of guidelines and set processes.
- (b) While strengthening of the pharmaceutical sectors had been effective, law enforcement by the few inspectors remained a problem.
- (c) Shortages of essential drugs in the public sector were still reported.
- (d) At the time of the audit, drug registration was lagging behind imports resulting in the need to use temporary registration codes. There was no system in place to follow up and complete this process.
- (e) Counterfeit drugs remained a problem in Cambodia³⁰.

Product selection

318. The Essential Medicines Concept was being adhered to by all three national programs i.e. malaria, TB, HIV and AIDS. The selection of pharmaceutical products by all programs was based on the Essential Medicines List (EML). The PRs had to seek approval from the DDF for any procurement of medicines not on the EML. The 5th edition of the EML was in use at the time of the audit and the DDF was in the process of finalising the 6th edition of the EML.

National quantification of commodities

319. The national quantification of essential medicines was coordinated by the Essential Drugs Bureau (EDB) of the DDF. The 7 national hospitals also submitted their annual requirements of essential medicines to the EDB for review and approval. The consolidated quantities of essential medicines list was forwarded to MOH Procurement Bureau for procurement to be arranged. There was no validation of consumption based method with the morbidity method based on epidemiological data. Under the R5 HSS staff from different levels of the supply chain were trained in forecasting and quantification of medicines needs and procurement of health products.

320. The OIG noted that the programs funded by the Global Fund did not use the resources that were available in the national structures. All the 4 PRs set up parallel systems outside the national systems for quantification of program commodities.

Procurement legal framework

Cambodia public sector lacks a defined procurement legal framework and policies for use by the public institutions. The Global Integrity report (2008) identified major weaknesses on the effectiveness of the public procurement process suggesting that the operating environment within which public procurements were undertaken was prone to fraud and corruption.

³⁰ REF: 2.1.4.1 Review of level of counterfeit drugs in Cambodia CNM

321. The Royal Government of Cambodia lacked a defined procurement legal framework and policies for use by the public institutions. What was available was the Sub-decree on Public Procurement, rules and regulations, dated 2006 and guidelines. The status of enforcement of the sub decree issued by the Royal Government of Cambodia was not clear. The OIG held discussions with various PR staff and none appeared to have awareness that it existed.

322. The Global Integrity report (2008)³¹ reviewed the effectiveness of the public procurement process (based on the 2006 sub-decree and GF procurement requirements). The issues raised by this report were:

- (a) There were no regulations addressing conflicts of interest for public procurement officials;
- (b) There was no mandatory professional training for public procurement officials;
- (c) By law, there was no mechanism that monitored the assets, incomes and spending habits of public procurement officials;
- (d) By law, companies found guilty of major violations of procurement regulations (i.e. bribery) were not prohibited from participating in future procurement bids;
- (e) By law, citizens could not access public procurement regulations;
- (f) In practice, major public procurements were not effectively advertised; and
- (g) In practice, citizens could not access the results of major public procurement bids.

323. The above issues painted a picture of the procurement environment within which the programs funded by the Global Fund were being implemented. The lack of an operational procurement legal framework raised the risk that the procurement operating environment would be prone to fraud and corruption. In 2006, the World Bank suspended loans to Cambodia due to allegations of corrupt procurement practices under land management and administration, infrastructure, and the water supply and sanitation projects. Whilst this was not a health program related issue it helps to paint the operational context within Cambodia.

324. The MOH developed procurement guidelines for Global Fund procurements based on World Bank guidelines. These were developed with the assistance of procurement TA obtained through Global Fund grants. The guidelines had no reference to any national guidelines for procurement nor the MOEF rules and regulations (including the sub decree of 2006). The 4 PRs were not aware of the availability of such documents and none of the documents could be accessed during the audit.

325. The procurement guidelines in use were Version 8 of 2006. These guidelines were being used by all PRs and SRs. At the time of the audit, the OIG was informed that the MOH had plans to review the guidelines. There was however no capacity within the MOH to review the guidelines.

³¹ Global Integrity report: <http://report.globalintegrity.org/Cambodia/2008>

326. A review of the guidelines revealed that they were inadequate to effectively support grant procurements. This weakness was amplified by the emerging issues identified through the review of a sample of procurements by all PRs and some SRs. The guidelines lacked clarity and depth of detail to meet the needs of current procurement staff skills, experience and knowledge of public procurement. They did not demonstrate procurement best practices.

327. There were no SOPs for key procurement processes thus procurement procedures were not standardized, ineffective procedures were used and there was no basis for training procurement staff.

328. All the above contributed to the contracts awarded for procurement of goods and services (health products, non-health products, services and civil works), in the majority of cases, not conforming to formal written procurement guidelines and best practice. Procurement processes were not open, competitive and transparent. Goods and services of assured quality were not always obtained at the lowest possible prices.

Institutional arrangements

The establishment of procurement units with the PR and SRs resulted in a fragmentation of procurement activities. Across all the four PRs, there was weak procurement planning, lack of procurement and contract management capacity, lack of transparency in some procurement processes. Value for money was not being achieved for some purchases and procurement practices were focused on national competitive bidding methods using local agents.

329. The MOH was at the centre of procurement of pharmaceuticals from the inception of the Global Fund programs in 2003. There was no coordination with the MOH Procurement Bureau. This resulted in two parallel and independent procurement structures within the same ministry. The establishment of the procurement units within the PRs and SRs further fragmented the procurement structures.

330. This resulted in isolated procurements with no pooling to reap economies of scale, the inability to negotiate better prices for grant procurements, increased administration costs arising from the duplicative structures set up etc. Across all the four PRs, the OIG noted weak procurement planning, lack of procurement and contract management capacity, lack of transparency in some procurement processes, value for money not being achieved for some procurements and PR procurement practices which did not follow best practice.

331. There was no evidence of involvement of MOH PR management in the procurement of SRs. Evidence showed that communications and decisions were between the Secretary for State and the SRs, i.e. CNM, CENAT and NCHADS. This was contrary to the requirement that the PR oversees SR procurements.

Recommendation 62 (High)

(a) *To the extent possible, all the PRs should use national PSM structures, systems and procedures for implementation of program activities. In cases where parallel systems have to be established due to inadequate capacity in the Ministry, these structures should be for a defined period of time with relevant capacity building and transition plans for the eventual transitioning back to national structures. Any skills gaps within the government structure should also be addressed by training existing staff or recruiting suitable staff to fill vacant positions.*

(b) *The procurement matrix should be completed and all procurements should be pooled to reap economies of scale. This process should be spearheaded by the MOH Procurement Bureau. In the event that the Bureau lacks capacity, a third party procurement agent should be identified in the short/medium term to support the process and build the capacity of the Bureau.*

(c) *The Ministry should spearhead the development of SOPs for key procurement processes to ensure processes are standardized and efficient.*

Receiving, storage and distribution

332. The Global Fund provided CMS with 3 vehicles, 2 forklifts, racking material and plastic pallets to improve its storage and distribution capacity. Receiving bays at the new warehouse were also renovated to improve materials handling capacity.

333. The receiving, storage and distribution systems of health commodities were well defined. However the existing distribution and storage channels were not functioning properly and were not reliable. The existing inventory management and storage facilities as well as temperature-monitoring systems were not adequate to assure efficacy of drugs received by end users/final beneficiaries.

334. The CMS was at the centre of these receiving, storage and distribution activities for health commodities for the grants. CMS had adequate and appropriate storage space for the grant medicines, including cold storage facilities. There was however no connection to the logistics system NATDID at the new warehouse. The system was installed at the old warehouse thus delaying processing of orders because all the data capturing was done at the old warehouse and relevant documents were then physically moved to the new warehouse for order picking, assembling and dispatch. This resulted in operational inefficiency caused by the lack of the NATDID system at the new warehouse.

335. A review of the logistics system revealed the following generic weaknesses. These were highlighted in various assessments of the grant as well as the WHO July 2005 report 'Towards a responsive HIV/AIDS system in Cambodia'. It was also confirmed during the OIG field visits:

- (a) Inadequate and inappropriate storage space at OD and health facility level;
- (b) Poor storage and distribution practices at health facilities and ODs despite the availability of guidelines for the storage of essential medicines and other health products;

- (c) Expired drugs and test kits in the supply chain;
- (d) Issuing of expired medicines to patients at health facilities;
- (e) leakages of drugs in the supply chain;
- (f) Lack of logistics management support to health facilities; and
- (g) Shortages and stock outs of general and grant commodities.

336. The CMS used quarterly scheduled deliveries to all the provinces of Cambodia. The distribution of grant commodities was done together with the general commodities. The procedure for placing emergency orders was complex thus not being used by health facilities. Feedback from the provinces indicated that CMS did not always deliver on time. The current order processing system from OD to CMS was bureaucratic and time consuming. The ordering process was reviewed by CMS but without any real change³². The CMS also did not have a policy for the delivery of emergency orders.

337. The OIG undertook a review of CMS' capacity and noted that past reviews have indicated that CMS lacked inadequate managerial capacity in terms of numbers and qualifications³³. Their staff capacity was improved by the Global Fund support through the contracting of 21 contract staff bringing the total staff compliment to 43. The OIG review's review of the management capacity revealed the following:

- (a) CMS did not have a strategic plan. CMS annual operational plans were based on the MOH strategic plans.
- (b) At the time of the audit, there were some vacant positions e.g. receiving supervisor, essential drugs supervisor, program supervisor and packaging and distribution supervisor.
- (c) Some key functions were not catered for in the CMS organogram e.g. there was no position at CMS for quality assurance.
- (d) Some staff were managing more than one function. For example the deputy chief of the administrative/finance bureau was also the supervisor for packing/distribution unit. The chief of the technical bureau was also the supervisor for the national programme unit. The deputy chief of the technical bureau is also the supervisor for the essential drugs unit.
- (e) A review of the CVs of CMS's top management at CMS revealed that some of the managers did not have the relevant qualifications to manage this institution³⁴. While having several years of experience may make up for the lack of qualifications in operational management, the managers were not well placed to provide strategic direction.

Recommendation 63 (High)

- (a) *The Ministry of Health should strengthen the stock management at CMS, provincial and OD level and improve storage facilities; provide written guidelines on all aspects of stock management; and improve supervision.*

³² REF: 2.1.5.1 Order Processing MOH

³³ REF: 2.1.3 Review of CMS managerial capacity -CMS

³⁴ REF: 2.1.3.1 Review of Management team CVs- CMS

- (b) *The managerial capacity of the staff at CMS should be strengthened to provide strategic direction to the institution.*
- (c) *Drugs that are susceptible to expiry should be issued first by the stores to avoid the financial losses that occur due to the expiry of the drugs.*
- (d) *The procedures for the disposal of the expired drugs should be initiated at the earliest opportunity once drugs have expired and measures should be taken not to issue expired drugs to patients.*

Logistics Management Information Systems

338. The MOH implemented a data inventory database at the national, provincial and operational district level, namely NATDID, PRODID and ODID respectively. The LMS through NATDID, PRODID and ODDIT was adequate to support logistics for programs commodities.

339. The system became operational in 2007. The key functions of the system were screening the health facility/OD requests, inventory management at OD pharmacies and generating OD requests to CMS. At the time of the audit, not all ODs had ODID installed due to cable connection challenges and lack of regular electricity, computers, internet access and trained staff. The health facility level used a manual bin card system and reported monthly or quarterly depending on the accessibility to respective OD pharmacies.

340. The DID was able to produce inventory reports, track product receipts, inventory movements and shipments to the ODs at CMS. At OD level, it tracked stock on hand at the OD stores, usage at service delivery sites, and made order requests and usage reporting to the CMS.

341. Evidence from the field visits carried out during the audit and by the LFA shows that there is underutilisation of the DID system. Expired stock was found at health facilities despite the availability of an automatic pop-up built in the system to warn of goods at risk of expiry, shortage etc. Shortages and stock outs for both general and program specific products were also reported. There was no defined system for reports and data analysis and decision making based on the reports generated from the system.

Recommendation 64 (Significant)

Proper training should be provided to staff to be able to fully utilise the DID systems to track expiry dates of the drugs, shortages, and stock outs.

Quality assurance systems

342. Cambodia has a high prevalence of counterfeit and substandard drugs including ACTs and OIs. The USP DQI report of June 2009 showed that there is a 27% level of counterfeit artesunate in both the public and private sector in Cambodia. A similarly high percentage was reported for some OI drugs. The OIG noted that there were laws to help curb proliferation of counterfeit and substandard drugs were in place but law enforcement was weak. Unless there is a

effective law enforcement, other controls would not be effective as counterfeit drugs are readily available. An inter-ministerial committee on counterfeit and sub-standard drugs had been set up to help in the fight against counterfeit and sub standard drugs. Pharmacovigilance activities were in their infancy.

343. The NLDQC was at the centre of the medicines quality assurance system in Cambodia. It had built capacity to analyse medicines through the support from the Global Fund and the USP DQI. NLDQC issued a certificate of analysis per batch analysed. USP had been providing reagents and incentives for the QA of ACTs since 2003. The Global Fund provided laboratory equipment for mini laboratories and funding for sampling at sentinel sites since 2008 under the R5 HSS grant. Global Fund QA support covered OIs and TB drugs. The NLDQC had no capacity to analyse ARVs and it was assumed that the quality was good since ARVs were from WHO-Prequalified manufacturers.

344. The Global Fund requires that medicines be tested by a WHO prequalified laboratory or an ISO 17025 certified laboratory. The NLDQC has none of the two. The Global Fund allowed Cambodia to use its NLDQC until the end of 2009 and a regional laboratory in Thailand was identified for use from January 2010.

345. The CMS liaised with NLDQC for the sampling of received products. The OIG noted with concern that stocks were not quarantined during the QC period. There was also inadequate QA support at the health facility level due to lack of qualified staff.

346. The Global Fund had approved in September 2009 guidelines for handling expired medicines in the public sector. The guidelines were based on WHO guidelines but lacked specific and relevant guidance applicable to Cambodia. The approved guidelines had not been printed and distributed for use at the time of the audit.

347. A final version of the drug quality assurance system in Cambodia was developed for the grant health products. Implementation of the system had not started during the time of the audit due to lack of funding.

Recommendation 65 (Significant)

- (a) *The Ministry of Health should follow up and finalise the selection of the outsourced WHO-prequalified laboratory for pharmaceuticals. Necessary arrangements should be put in place to facilitate the transfer of the samples to the identified laboratory and the receiving of report from the laboratory. MOH should mobilise resources for NLDQC to start working on the WHO pre-qualification or ISO certification of the laboratory*
- (b) *All PRs should put measures in place for qualified and relevant professional experts to carry out, document and approve post- shipment inspections of drug related consignments.*
- (c) *All PRs should Implement the GF approved guidelines for handling expired medicines and distribute to the provincial, ODs and health centre level.*

Field visit findings

348. The OIG visited 10 provincial health departments, 10 ODs, 2 referral hospitals and 8 health centres and the findings relating to storage and distribution were as follows:

- (a) Bin cards were not maintained at the stores. It was therefore difficult to maintain adequate records regarding utilisation of drugs.
- (b) At the service delivery centres, stock registers were not maintained. However, the physical verification of inventory items were carried out twice a month and a report generated.
- (c) The record of lost and damaged drugs was not maintained by the service delivery centres. As a result, remedial actions could not be taken to prevent subsequent occurrences. In addition, with no mechanism in place to identify the exact reasons for losses, the likelihood of recurrence was high.
- (d) During its field visits the OIG noted that there were no guidelines were not available at the PHD and OD. However, expired drugs were kept separately from un-expired drugs. Nonetheless, expired drugs, if not destroyed promptly, may be issued to unsuspecting patients or may be released into the market (especially to the private sector).
- (e) There were outstanding queries from the ministry auditors, PHD and OD (wherever applicable) but with no evidence of actions taken to address these.

Oversight

Background

349. The Global Fund's fiduciary arrangements for grant recipients comprised of Principal Recipients (PRs) and sub-recipients (SRs) and sub SRs (SSRs) implementing the programs. The program implementation was overseen by a Country Coordinating Committee (CCC). The Local Fund Agent (LFA) provided assurance to the Global Fund Secretariat on the implementation of grant programs. These fiduciary arrangements place reliance on effective oversight arrangements.

Country Coordination Committee

Composition

350. In 2003, the CCC in Cambodia was established as part of the Global Fund requirements following application for Round 1 grants. At the time of the audit, the CCC had successfully accessed over 13 grants from the Global Fund under the different Rounds i.e. proposals submitted for Rounds 1, 2, 4, 5, 6, 7 and 9. It was also able to secure a Rolling Continuation Channel (RCC) grant. The CCC was also successful in its application for Phase II funding. Since formation of the CCC, the grant implementation environment changed especially with the increased number of grants, transition of PRship from the MOH to the three disease institutions. This called for greater oversight.

351. The CCC between 2002 and mid 2009 comprised of 29 members with 11 members from government, 1 from the academic/education sector, 6 from NGOs and CBOs, 1 from People Living with Diseases, 9 from bilateral or multi-/bilateral development partners, and 1 from the private sector. The CCC was chaired by the Minister of Health and included representation from the PRs and SRs.

352. The CCC was dissolved in November 2009 to make way for a new CCC. The CCC was reconstituted to make it more transparent, balanced and to strengthen oversight of the Global Fund programs in the country. There was no CCC in place at the time of the audit. A new CCC was reconstituted effective 11 November 2009 but its members have not elected a chair and vice chair.

353. The new CCC comprised of 6 members from government, 2 from the academic/education sector, 3 from NGOs and CBOs, 3 from People Living with Diseases, 1 from religious/faith-based organizations, 4 from bilateral or multi-/bilateral development partners, and 1 person from the private sector. During the audit the new CCC held a retreat at which the CCC governance manual, conflict of interest policy and oversight plan were drafted.

354. The CCC had a Secretariat that manages its day to day activities. On top of this, the CCC secretariat was involved in providing oversight and the provision of

support to the committees. However, the staffing available to the CCC Secretariat were inadequate to effectively undertake the work delegated to this office.

Recommendation 66 (High)

d) *The CCC should consider co-opting a health system expert on its technical committees. Such a person would provide insight on the integration and alignment of the 3 diseases into the national health systems and the strengthening of the overall health system of the country.*

e) *The CCM should operationalise the CCC manual, conflict of interest policy and the oversight plan.*

f) *The CCC should strengthen its Secretariat capacity so that it can provide effective support to the CCC and its committees in its oversight functions by increasing the level of staffing and enhancing skills and expertise.*

Performance of its roles

There were no guidelines in place to guide the nomination process for PRs until Round 7. After Round 7, guidelines were developed were not consistently applied from Round to Round. There was no evidence that the CCC followed due diligence of the PRs' capacity. In the period when there were no procedures and criteria for PR nominations, the CCC nominated the MOH to be PR i.e. up to and including Round 6. Thereafter, the final selection of the PRs was made through voting by the CCC.

355. The CCC was mandated to coordinate the preparation and submission of proposals to the Global Fund for funding. From the review of CCC minutes since mid 2007 the former CCC mainly discussed issues relating to proposal preparation and Phase II applications, selection of PRs and SRs, and the need to reconstitute the CCC. There was no evidence that the CCC fulfilled the critical role of providing oversight over the implementation of program activities funded by the Global Fund.

356. In nominating PRs, the CCC was required to put in place and maintain a transparent, documented process. The OIG noted that there were no guidelines in place to guide the nomination process for PRs until Round 7. The CCM is commended for having developed these guidelines for the nomination of Round 7 PRs but the OIG noted that the criteria for the nomination of PR changed from Round to Round. There was also no evidence that the CCC undertook due diligence in reviewing the capacity of the PRs that were nominated.

357. In the period when there were no procedures and criteria for PR nominations, the CCC nominated the MOH to be PR i.e. up to and including Round 6. Once this became a requirement under the six minimum eligibility criteria, it was addressed by the CCC. Thereafter, the final selection of the PRs was made through voting by the CCC.

358. The CCC was required to oversee program implementation. The former CCC delegated its authority to review PUDRs and semi-annual reports including the

reprogramming and budget realignment requests to the CCCSC. The CCCSC reported to the CCC on the performance of the PRs periodically. The OIG noted that all PUDRs, reprogramming and budget realignment requests, and semi annual reports submitted by the PRs were not always discussed in the CCCSC meetings but circulated by email to members for comments and approved thereafter. These documents were also not presented to the CCC for ratification and approval undermining the oversight role of the CCC.

Recommendation 67 (High)

(a) *The CCC should develop and communicate the process by which PRs are nominated to be PR. The selection criteria should be fixed and included in the governance manual and regularly reviewed.*

(b) *The draft conflict of interest policy should be approved and implemented by the CCC. Any possible conflict of interest should be declared by CCC members who should opt out of decision making where such conflict arise.*

(c) *The oversight role of the CCC over grant implementation should be strengthened through the appointment of an oversight subcommittee. The formation of separate sub committees to review financial performance and programmatic performance would further enhance the effectiveness of the CCC. The CCC should review the grant implementation and approve the performance in its full meeting based on recommendations provided by its sub committees on reviews carried on PUDRs, semi-annual report. Such reviews should include review of audits reports and management letters.*

359. The CCC is also required to facilitate linkages and consistency between Global Fund assistance and other development and health assistance programs in support of national priorities. The OIG's review of CCC minutes presented no evidence of discussion or review of programs funded by other development partners for HIV/AIDS, malaria, TB or health systems strengthening. In fact this audit revealed numerous instances of the divergences from the national structures and non alignment of the Global Fund programs to those implemented by other partners. There was no evidence of any effort being made to harmonise the activities of various programs run by the PRs.

Recommendation 68 (Significant)

The CCC should ensure that Global Fund programs are complimentary to the programs funded by the RGC and the other development partners. This should be demonstrated at proposal formulation as well as throughout the life of the grants.

360. The OIG noted that the TRT which was involved in the review of the proposals did not have a finance expert to review the grant budgets prior to approval by the CCC and submission to the Global Fund. This resulted in the presentation and approval of inflated budgets. The inflated budgets resulted in waste of program funds e.g. as seen in CENAT where staff had a two computers at their disposal for work and to the frequent reprogramming of the so called budget 'savings'. Furthermore, NCHADS used frequent reprogramming to regularize

unbudgeted expenditure. This was done by reallocation of savings from drug procurements worth US\$ 115,000 to civil works.

361. The budget reallocation requests are submitted by the PRs to the CCCSC for approval not on a quarterly basis but as and when required. The budget reallocation process had been a major concern of the members of the CCCSC since they often came in late with very little time allowed for review and analysis. Furthermore, most approvals were provided by email and did not allow for a discussion on the conditions under which the reallocations arose. Because there were many budget reallocations happening at the same time, the program activities in some instances moved significantly away from the originally approved budget and at the time of the audit, some PRs could not tell what the original approved budget was.

362. Conflict of interest arose from the PRs also being part of the CCCSC. These PRs and SRs were involved in approving the very requests they had submitted.

Recommendation 69 (High)

(a) *The CCC should constitute a finance committee to review the budgets submitted as part of the proposals submitted to the Global Fund. This committee should be responsible for the review of request for budget reallocations. Budget reallocation guidelines should be developed to guide these processes.*

(b) *The CCCSC should be reconstituted to remove the PRs since this raises conflicts of interest.*

Local Fund Agent

363. The LFA is a crucial part of the Global Fund's system of oversight and risk management. KPMG USA was the LFA since the inception of the grants to Cambodia in 2003. After the LFA retender process, KPMG was replaced by the Swiss Tropical Institute from September 2008.

KPMG

The work of KPMG as LFA since the inception of Global Fund grants till the end of September 2008 could not be fully reviewed as OIG was not granted access to the work papers. KPMG did not undertake its review of the Global Fund grants in Cambodia from a risk management perspective, looking at both grant risk and country risk characteristics and materiality. Many of the challenges identified in the OIG's audit should have been picked up by KPMG. KPMG also performed external audits of SRs which represented a conflict of interest.

364. KPMG Cambodia performed in country work on instructions received from KPMG USA. The work orders issued by the Global Fund were not shared by KPMG USA with KPMG Cambodia. KPMG Cambodia undertook the work and submitted draft reports to KPMG USA for finalization and submission to the Global Fund Secretariat.

365. The OIG noted that KPMG Cambodia performed the audit of some SRs between 2003 and 2007 when it was also the LFA. In the OIG's view this created a conflict of interest. KPMG states that it obtained Global Fund clearance before undertaking these services because the audits were for non-Global Fund projects.

366. The OIG requested and was denied the OIG access to their working papers. The OIG was therefore not able to assess the quality of work undertaken under the team and the basis of the assurance provided by the LFA to the Global Fund. The OIG however noted that there were a number of issues that should have been identified by the LFA and flagged to the Global Fund Secretariat such as:

- (a) The padding of budgets that is a key task for LFAs during grant negotiations was not identified;
- (b) Frequent budget reallocations: at the time of the audit, there had been so many reallocations and some PRs had lost track of what was the initial approved budgets;
- (c) Effecting of payments in cash as opposed to using the banking system;
- (d) Inappropriate indicators for grants etc.

367. The OIG also noted that there was no effective handover from KPMG to STI. This affected STI's ability to 'hit the ground running'. STI was not privy to KPMG's working papers in order to understand their new client better.

Swiss Tropical Institute (STI)

The Swiss Tropical Institute (STI) is the current LFA for the Global Fund grants to Cambodia. STI as a public health institute has a strong programmatic background and resources and the work in Cambodia reflected this. However, they had limited skill and experience in procurement and finance. The OIG noted that there was no risk assessment done either at the country or grant level. Failure to undertake review work with a risk management perspective, may lead to significant weaknesses not being identified by the LFA. There was also no evidence of quality assurance of the LFA by the Central Coordination Team.

368. The Swiss Tropical Institute (STI) is the current LFA for the Global Fund grants to Cambodia. The Global Fund signed a contract for the LFA arrangement with STI headquarters based in Basel, Switzerland. STI has a country office in Cambodia to perform the LFA functions for the grants in Cambodia. STI is in the process of being registered as a legal entity in Cambodia and has submitted the required documents to the relevant authority.

369. STI as a public health institute has a very strong programmatic background and resources and the work in Cambodia reflected this. There were key procurement challenges in the country but STI did not have resident procurement expertise with support only being provided from Bangkok and Basel. This arrangement was approved by the Global Fund. The finance staff demonstrated high commitment to their work but they lacked the requisite experience in the operations of the Global Fund. This position was further aggravated by the lack of a proper handover from the previous LFA.

370. The OIG through discussion with the country head of STI noted that there was poor communication between STI Basel and Cambodia in relation to oversight of the work performed in country. Clear instructions were not provided by STI Basel to STI Cambodia on work to be done creating confusion among the team members.

371. The OIG also noted that there was conflict of interest STIs M&E staff were involved in the PR assessment under Round 7. The same staff had developed the proposal for TB Round 7 as consultants. The LFA stated that clearance had been obtained from the Global Fund secretariat on the COI.

Recommendation 69 (High)

Clear communication should be established between STI at Basel and country offices to ensure an effective working environment and quality of work. To enhance the skills of the staff working on Global Fund grants regular training should be given on finance and procurement

372. The LFA Manual required that reviews are undertaken from a risk management perspective, looking at both grant risk and country risk characteristics and materiality. The LFA was also required to take into account trends in the PR's progress reported over time and mitigating factors where specific targets have not been met. During the review of the work done by the LFA, the OIG noted that there was no risk assessment done either at the country or grant level. Failure to undertake review work with a risk management perspective, may lead to significant weaknesses not being identified by the LFA.

Recommendation 70 (Significant)

The LFA should make an assessment of risks that are likely to result in failure to implement grant programs or result in errors and fraud. This should be a key guiding document in the design of activities to be undertaken for verification of implementation and capacity assessments.

373. STI lacked standard work procedures to be followed for different work to be conducted e.g. planning of work; allocation of staff members; documentation of data verification; documentation of internal meetings; documentation of findings; conclusions and evidence of review and quality assurance, in country or from Basel. For example there was no evidence for review of conditions precedent relating to the first disbursement as no working paper file was maintained for the Round 7 TB and RCC grants. Additionally for TB Round 7, the PR assessment carried out by the LFA did not have any supporting documents and there were no working paper files maintained.

374. Quality assurance policies and procedures were not evident from the OIG's review of the work carried out by the LFA and or from discussion with the country head. Absence of proper quality assurance policies and procedures poses a serious

risk for implementation of the Global Fund grants and the assurance Global Fund can place on the quality of STI's work.

Recommendation 71 (High)

Quality assurance policies and procedures should be developed and implemented in the country for work performed by the LFA. The regular review of work by the Country Head and by Basel would provide additional assurance on the work performed and on the reliance that can be placed on reports submitted to the Global Fund.

Global Fund Secretariat

375. Cambodia is a very poor country with correspondingly low salaries paid to civil servants. Salary supplementation and the payment of financial incentives are internationally well known mechanisms which seek to retain public sector personnel and to boost performance. For a few Global Fund grants in Cambodia, up to 50% of the budget goes on human resources. Certainly for other grants the combined costs of human resources and training also amounted to 50% or more of the budget. Salary costs are for contract staff. There is also salary supplement and financial incentives, all mostly for central level staff.

376. Other development partners also pay incentives. The problem with the Global Fund incentives is the high levels that the Geneva Secretariat agreed to. For example, during the audit the OIG established that the DPHI had 3 sources of incentives, the Health Sector Support Project 2 (HSSP 2) a multi donor funded program, GAVI and the Global Fund.

377. HSSP2 set very reasonable levels based on the UK Department for International Development experience of paying incentives in the health sector at provincial level. GAVI was following the HSSP2 levels. But the Global Fund levels were in the view of many partners unreasonably high compared to HSSP2 salaries. According to a member of the MOH top management the Global Fund set high incentive levels as it wanted to have the highest possible capacity and motivation of staff working on its programs. Interestingly at the provincial level the Global Fund incentives were reasonable. There it was more a case of who was and who was not receiving the incentives for doing similar work.

378. One OIG recommendation was likely to have been for the Global Fund to reduce incentive levels it has agreed to and align them with HSSP2 and to work with the MOH on developing a staff retention package. However towards the end of the audit the Prime Minister issued a sub-decree³⁵ followed up by a letter³⁶ from the Minister of Economic and Finance to the World Bank stating that throughout government all salary supplements and incentives were to be stopped as of the 1st January 2010. The reasons for this were unclear. It also did not cover NGOs. So during the last few days of the audit the Global Fund Secretariat was discussing

³⁵ Prime Minister, Sub-Decree on Ending of Priority Mission Package and Merit-Based Performance Incentive No: 206 ANKr.BK, 3 December 2009, Royal Government of Cambodia

³⁶ MEF, Royal Government of Cambodia's Decision on the Termination of Merit-Based Performance Incentive

with development partners what the health sector response should be. A possible impact of the termination of salary supplements/incentives is that there will be low morale, more staff losses in the public sector, a lower quality of performance and an increase in corruption.

Recommendation 72 (High)

Global Fund needs to align its response to the sub-decree and letter on the termination of salary supplements and incentives with other donors and evaluate the impact it would have on the grant implementation.

379. The Global Fund Secretariat oversees program management by ensuring that both the Global Fund and PRs adhere to the provisions of grant agreements. The OIG noted the following cases where non-compliance to grant agreements provisions was not followed by action from the Secretariat to enforce compliance.

380. Arguably, some of the issues identified by the OIG during the audit reflect the effectiveness of the Global Fund Secretariat in providing oversight in the past over grant implementation. These include the type of indicators that the country was allowed to have, creation of parallel and duplicative structures to the national structures, the frequent unapproved budget allocations, failure to follow up program income, weaknesses in PSM arrangements etc.

381. The OIG however commends the marked improvement in the LFA and Secretariat oversight over the grants that was noted in the recent past. This has resulted in significant changes that have strengthened the control environment within which the programs were being implemented.

Annex 1: Recommendations and Action Plan

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>Recommendation 1 (High) CNM, CENAT and NCHADS should under the leadership of the MOH develop a sustainability plan with strategies to address the reduction of funding by government and other DPs. The sustainability plan should tackle how the three can leverage additional funding. It should be discussed with stakeholders such as donors, MoH, and MOEF with a view of getting buy-in and alternative sources of funding</p>	<p>All respondents concur with the need to integrate disease programs with MoH to ensure sustainability of action. However, in practice, the reality remains driven by the GFATM's funding configuration which favours direct funding of disease vertical programs as Principal Recipients in parallel with MoH management.</p> <p>Very important but the national programs have little control over it. Developing a sustainability plan is possible but national programs cannot be held accountable for its implementation.</p> <p>The Secretariat will also raise this issue with the MoEF and the Development Partners.</p> <p><u>Secretariat comment</u></p> <p>We agree with the country response that a sustainability plan as such will not address the issues listed by the OIG. This should be an ongoing multi-stakeholder process led by the MoH.</p>	<p>MoH and disease programs through national planning Processes CCC and PR coordination group</p>	<p>Future Round based applications for funding.</p>	<p>The Secretariat should ensure that dialogue on this matter is held.</p>

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>Recommendation 2 (High) The MOH should establish an oversight body for the three institutions responsible for the implementation of Global Fund programs. This body should meet regularly to oversee the respective institutions' strategies, governance matters, operations and overall program performance. The MOH should develop comprehensive guidelines that define the various oversight activities like supervision, providing advice, monitoring, coordinating and supporting the management team.</p>	<p>Agree with principle but it needs to extend beyond GF supported programs. However, it is difficult for GF to enforce an overarching body. We recommend increasing/ strengthening the capacity of the CCC oversight committee, which has recently been established by the CCC, to oversee the Global Fund programs. MOH should review existing oversight mechanisms and strengthen them.</p> <p><u>Secretariat comment</u></p> <p>We agree with the country response that instead of establishing a new body the country needs to continue empowering and strengthening the TWG-H and sub-TWGs and TWG on HIV/AIDS as well as supporting the AOP and JAPR processes.</p>	MOH or CCC	1 year	
<p>Recommendation 3 (High) The BEC's mode of operation should be redefined in order to elevate it from procurements operations to providing oversight over the procurement and supply chain management processes. This should include a change of the name of the committee from</p>	<p>Agree in principle. However, the PR tender committee should be a representative of all constituencies involved in the procurement, namely the government and non government agencies.</p>	MoH, CCC, PRs	within 1 year	Subsequent to the audit, the Global Fund in collaboration with country partners undertook a country procurement profile. It resulted in additional concrete recommendations

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<i>BEC to the “PR Tender Committee” in order to remove any role confusion that may arise out of its current title. Their role should be supervisory, advisory, monitoring, coordinating and supportive.</i>	<p><u>Secretariat comment</u></p> <p><i>The idea of having a standing committee under the CCC might be a good option. Hence, the timeline proposed by the CCC is reasonable.</i></p>			<i>which if implemented will further strengthen the procurement control environment.</i>
<p>Recommendation 4 (High)</p> <p><i>To the extent possible, all the PRS should use national structures, systems and procedures for implementation of program activities. In cases where parallel systems have to be established due to inadequate capacity in the Ministry, these structures should be for a defined period of time with relevant capacity building and transition plans for the eventual transitioning back to national structures. Any skills gaps within the government structure should also be addressed by training existing staff or recruiting suitable staff to fill vacant positions.</i></p>	<p><i>Agree in principle. Transition plans should be developed. However, due to the weak capacities of the national procurement and financial procedures we believe this may take time to implement.</i></p> <p><u>Secretariat comment</u></p> <p><i>Priority Operating Cost scheme (POC) has recently been approved by the Prime Minister. At this point, the detailed modalities of implementation are not yet completed. According to the Round 9 PGAs, the PRs are requested to submit an updated HR manual for the CAM portfolio along with the revised budgets by the end of this year.</i></p>	<i>PRs under the leadership of MOH</i>	<i>Transition plan with milestones should be developed by the end of 2010.</i>	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
Recommendation 5 (Significant) CNM, CENAT and NCHADS should consider establishing internal audit functions to review SRs and program implementation in the regions. For the Ministry of Health, the internal audit work undertaken by the government auditors should cover the activities funded by the Global Fund.	Agree	PRs and MOH	December 2010	
Recommendation 6 (High) The MOH should retain the services of a human resources expert to undertake a job evaluation ³⁷ . The objective of this will be to assess the available skills in the government structure and to identify what additional skills are required to deliver the programs funded by the Global Fund. It should also cover amalgamating the different roles that are duplicated by grant into a reasonable number of jobs required to deliver the Global Fund grants.	<p>PR-MoH together with disease program PRs are of the opinion that HR policy should follow the framework of public administration reform as a whole. For its part, the MoH agrees to retain the services of a human resources expert to undertake further consultation regarding job evaluation.</p> <p>Agree. The issue will be addressed when transitioning to the SSF. All PRs will have one grant. In addition there is a continuing effort to improve the HR management through public administration reform and thus we believe it would be appropriate to undertake this evaluation in the framework of PAR.</p>	PRs and MOH	According to timelines and milestones of PAR	

³⁷ Job evaluation is a systematic process that you can use to determine the relative level, importance, complexity, and value of each job in your organization.

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
	<p><u>Secretariat comment</u></p> <p>The updated HR manual will contain sections on the POC for public servants, procedures for contractual staff and national/international consultants (short and long-term). As for the job evaluation, we believe it cannot be an one-off exercise as we (LFA) need (and we do) to conduct such assessment of the PR HR needs every time we have a grant coming in or closing out.</p>			
<p>Recommendation 7 (Significant)</p> <p>(a) In order to strengthen the control environment within which the programs are being implemented, the management of all the PRs must:</p> <ul style="list-style-type: none"> • support the development and enforcement of appropriate human capital policies for hiring, training, evaluating, counseling, advancing, compensating and disciplining personnel; • clearly define and delegate areas of authority, responsibility and reporting 	<p>Agree. Performance and accountability framework is now being developed by the Government. From 1 July 2010 the Government is planning to use POC as a temporary tool for performance based management of Government staff. The Government is also committed to complete the compensation reform by 2013.</p> <p>Also see Secretariat comment above</p>	MOH	According to timelines and milestones of PAR	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>throughout the different institutions; and</p> <ul style="list-style-type: none"> • ensure personnel appointed possess and maintain the proper knowledge and skills to perform their assigned duties. <p>(b) The job descriptions for all staff should be reviewed and should :</p> <ul style="list-style-type: none"> • reflect in detail the different responsibilities that are executed by the people in those positions. Performance should be measured against the job descriptions issued; • show who a staff member is responsible to and who they should be reporting to. While this may be reflected on the organization chart, it should also be mentioned in the job description for clarity; • be signed by a management level member of staff and the jobholder as evidence of commitment to meeting the terms that have been laid 				

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>out; and</p> <ul style="list-style-type: none"> be reviewed at the time of renewing the contracts for staff to ensure that they are up to date and reflect any changes in work that may have arisen over time and such revisions should follow the RGC guidelines. 				
<p>Recommendation 8 (High) In line with the RGC decree, all PRs should stop payment of salary incentives until such a time that resolution has been found to the current situation. Once the new modality is in place, consideration should be given to making back payments to affected staff.</p>	<p>Agree. Payment of incentives is currently on hold (from January 1, 2010) until a new incentive system (Priority Operating Costs) is put in place.</p> <p><u>Secretariat comment</u></p> <p>We stopped payments to public servants in January 2010. After the POC decree was approved in July 2010, the PRs were authorized to retroactively pay for Jan-June 2010 and requested to align their payments to public servants to POC scheme starting from July 1. Currently, there are no payments to the public servants. In order to start POC payments, the PR are required to fulfill the above conditions listed in the R9 PGA.</p>	All PRs	According to the POC development and implementation agenda	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>Recommendation 9 (High) The PRs should comply with the conditions stipulated in the grant agreement. This will strengthen the control environment within which Global Fund programs are implemented. Specifically, the PRs should:</p> <p>(a) seek exemption from the payment of taxes for all Global Fund activities and communicate this to all implementers. Efforts should be made to recover taxes paid so far from the tax authorities;</p> <p>(b) open VAT control accounts in the accounting records in order to facilitate the accumulation of VAT costs and for the recovery of VAT</p> <p>(c) withhold relevant taxes from payments of services in accordance with the relevant government laws;</p> <p>(d) insure program assets against loss;</p> <p>(e) ensure that their quarterly and annual reports are submitted on time since this affects the Global Fund's</p>	<p>(a) PR MOH, despite its efforts, has not been able to get VAT exemption. GFATM to directly discuss the matter with MEF in order to get matter resolved. (b) Subject to the above exemption the VAT control accounts should be implemented.</p> <p>(c) Agree. Taxes on salaries and services will be paid in line with government regulations.</p> <p>(d), (e) and (f) Agree</p> <p><u>Secretariat comment</u></p> <p>We have asked the PRs to provide us with the copies of their communication with the MEF. Based on our review of these letters, we will determine if the issue needs to be brought up to the MEF by the Regional Team.</p> <p>Regarding point c: we have not received advice from legal counsel in Cambodia as to whether the PRs are in fact required under local law to withhold taxes as described in paragraph (c). We would need to obtain such advice before imposing a specific requirement for PR's to comply with this recommendation.</p>	All PRs	Immediately	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>decision making; and (f) ensure that external audits are planned and undertaken in a timely manner.</p>				
<p>Recommendation 10 (High) The practice of payment for goods and services in cash must be stopped. The PRs should establish a threshold for payments in cash with all other payments effected through the banking system. All salaries should be paid through the bank.</p>	<p>The practice of wire transfer payments is increasing in Cambodia as the country's banking system develops. The situation in the capital and major cities is certainly ahead of rural areas however, making it difficult to avoid cash payment when SR or SSRs implement activities in peripheral areas. However, a trend towards electronic payments in the MoH and other national government entities gives cause for optimism that this recommendation will, with time, be addressed.</p> <p>Agree. All payments should be made through bank accounts except in exceptional circumstances or if its payment out of petty cash. PR should determine what amounts should be held as petty cash and what should be paid using petty cash.</p> <p>Insignificant individual incentive payments e.g. incentives to community health workers could be paid in cash below district level. However, there should be no cash transactions from the PR offices down to the Provinces/Districts.</p>	All PRs	Immediately	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>Recommendation 12 (significant)</p> <p>(a) The PR should develop policies and procedures to guide SRs on how program funds should be managed. The policies and procedures should cover disbursement and accountability, programmatic and financial reporting (including formats), budget tracking and analysis, maintenance of accounting records monitoring and inspection of SR performance, guidance on internal and external auditing etc. The PR should periodically visit SRs and assess their performance against the guidance laid out in the manual.</p> <p>(b) The PR should use a well documented process for identification of potential SRs. These should be assessed for both programmatic and financial management capacity in order to identify gaps that would affect program implementation. These assessments will provide useful information on the strength of the institutional, financial and management systems of the</p>	<p>(a) Agree.</p> <p>(b) Additional requirements for better management of the program funds shall be incorporated in the amendments. We note that SR selection is done at proposal development stage by the CCM. However the PR should conduct comprehensive capacity assessments of the SRs and address the financial and programmatic gaps including change of SRs</p> <p>(c) Actions such as: developing policies and procedures to train SRs; developing SOPs to monitor SRs performance have started.</p> <p><u>Secretariat comment</u></p> <ul style="list-style-type: none"> SR Management manual is currently being developed by the PR. Should be completed before the end of the year. The CCC may nominate SRs based on agreed criteria. However, each PR is solely responsible for selecting and contracting SRs, given that the PR will be fully liable for the acts and omissions of each SR with respect to the Program. SOPs for monitoring of SRs' 	PRs and CCC	6 months	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>potential SR. Assessments also aid the PR in identifying capacity gaps and institutional weaknesses of the potential sub-recipient for effective and rational decision making.</p> <p>(c) All PRs/ SRs with sub recipients should institute a proper monitoring framework that covers:</p> <ul style="list-style-type: none"> • Well defined indicators and targets for SRs; • Plans detailing when, how and whom monitoring will be undertaken; • Methods of data collection, verification and accumulation for reporting; • Site visits plans for SRs covering financial and programmatic aspects; • Follow up of findings and provision of feedback to SRs; • Comparison of programmatic and financial data etc. 	<p>performance under development.</p>			
<p>Recommendation 13 (Requires attention) The Ministry should strengthen</p>	<p>Mechanisms have recently been put in place to identify strategic priorities ahead of HSS grant proposal, mostly by addressing them</p>	<p>CCC and appending Proposal</p>	<p>Immediately (as for ongoing Round 10</p>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p><i>the oversight of the HSS grant by amending the terms of reference of the TRT to cover the HSS grant. The results of the HSS should be reviewed and approved by this Team before they are transmitted to the Global Fund.</i></p>	<p><i>within the TWG-H. At the time of proposal development, the newly established Proposal Development Committee (a subcommittee of the CCC) has identified available peer reviewers for health system strengthening who are familiar both with the GFATM requirements and with the MoH and current Government Health Sector Strategic Plan. The shortcomings observed for Round 9 are being overcome for the current Round 10 proposal development.</i></p> <p><i>Agree. However, the Regional Team notes that Cambodia is being considered as a pilot country for HSS funding platform Track (Area) 1 and hence the MoH in cooperation with the key partners will be looking at the possibilities to streamline the oversight of HSS grants of the GF, GAVI and WB through the efforts on harmonization and alignment of processes and procedures envisaged in the principles of the joint platform. Moreover, the Regional Team is planning to address the weaknesses in the MoH's oversight role in the HSS grant implementation during the consolidation of Round 9 HSS with Round 5 HSS in June 2010.</i></p> <p><u>Secretariat Comment</u></p> <p><i>A TRT has been established to provide oversight over the implementation of the</i></p>	<p><i>Development Committee and Oversight Committee</i></p>	<p><i>proposal development)</i></p>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
	<i>HSS grants.</i>			
Recommendation 14 (High) <i>The Ministry management should ensure that all expenditure incurred is in line with the approved budget. Exceptions to the budget should only be made with the prior approval of the Global Fund. Expenditure incurred out of the budget without prior Global Fund approval should be refunded.</i>	<i>The Ministry respectfully requests that the GFATM reconsider its recommendation to refund amounts for these expenditures as the guidelines were not clear regarding the budget approval process in the early rounds.</i> <i>Agree. The LFA will be requested to regularly monitor the expenditures</i> <u>Secretariat comment</u> <i>We agree with the country response and explanations for point 1-3. However, for point 4-5 the PR failed to provide sufficient justification and we propose that the final report maintain our requirement to reimburse for point 4-5.</i>	<i>PR(MOH)</i>	<i>Immediately</i>	
Recommendation 15 (Significant) <i>The PR should maintain a comprehensive register of all the assets purchased with Global Fund grants. A physical verification exercise should be conducted periodically to ascertain the existence and condition of program assets.</i>	<i>Agree. This issue is included in the Grant Agreement as a special term and LFA verifies that the PRs are compliant with the ST</i> <u>Secretariat comment</u> <i>There is a condition on assets in Round 9 Malaria PGA. For other PRs, the GF is following as management action.</i>	<i>PR MOH (but relevant for other PRs as well)</i>	<i>Ongoing</i>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
Recommendation 16 (Significant) <i>The Ministry should strengthen its monitoring function on SRs in order to mitigate the internal control weaknesses.</i>	Agree.	PR MOH	Immediate	
Recommendation 17 (High) <i>The Ministry of Health should follow up and seek resolution of the financial and procurement and logistics management matters raised above making reimbursements where indicated.</i>	Agree.	PR-MoH, KHANA, PSF	According to above timelines	
Recommendation 18 (High) (a) <i>PSI management should ensure adherence to the procurement guidelines in place. PSI should also refund the procurement fees amounting to US\$ 12,074 charged to the Global Fund grants for procurements that were made by CNM.</i> (b) <i>The headquarters overhead and procurement fees should be charged in accordance with</i>	(a) <i>Procurement fees inadvertently charged will be refunded.</i> (b) <i>The 10% HQ fees and 7% procurement fees is still being negotiated at HQ levels and will be addressed once agreement is reached</i> (c) <i>Agree. In September 2009, the Regional Team requested the PRs in Cambodia to improve their reporting of PI in order to ensure that the SRs report on actual (not projected) PI and request the use of</i>	GF, PSI, PRs	6 months	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>the approved rates. Any excess amount charged under Round 5 and 7 should be adjusted from future billings.</p> <p>a. PSI should prepare a plan for approval on how the funds incidental to program activities will be used. The PR should then present a plan to the Global Fund through the LFA on how these funds will be used.</p>	<p>PI prospectively. Following this intervention, PSI in the latest round of PU/DRs submitted its report on generated PI along with the request to use these funds in the next period for Global Fund review and approval.</p> <p><u>Secretariat comment</u></p> <p>We confirm that the PSI has already returned the funds in question.</p> <p>The Global Fund has included a special condition in a number of grants which states words to the effect that PSI's Headquarter Management Fees are being reviewed by the Global Fund and may be retroactively reduced from the grant start date. The Rounds 5 and 7 Grant Agreement with the MOH did not include a requirement for the MOH to include an equivalent condition in its Sub-recipient Agreement with PSI. However, such provision is included in Rd 9 grant agreements.</p>			
<p>Recommendation 19 (Significant)</p> <p>a. CPN+ should follow procurement guidelines in the</p>	Agree	PRs MoH and NCHADS, CPN+	Immediately	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>identification of service providers to ensure that the program gets value for money for its investments. To the extent possible, the organisation should only contract with registered service providers since this protects CPN+ should any disputes arise. Additionally, payments to all service providers should be made through the bank.</p> <p>CPN+ should review its staff requirement in the finance section in light of the volume of work rather than hiring staff.</p>				
<p>Recommendation 20 (Significant) Further disbursement of funds by the Ministry to its SRs should be tied to the meeting of key indicators like reporting. The BBC should comply with the reporting requirements in the MOU. With future grants signed with the BBC, the overhead cost should be shown separately in the budget in order to give the actual picture of the cost of activities in the financial statements.</p>	<p>Agree</p> <p><u>Secretariat comment</u></p> <p>BBC was directed by the PR and received approval from the Global Fund to conceal the overhead costs..</p>	<p>PR MOH and BBC</p>	<p>Immediately</p>	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>Recommendation 21 (High) The Ministry's grants should be consolidated by disease. This will increase the synergies across the grants for the different diseases and reduce the administrative work load i.e. by reducing the number of reports required, harmonizing monitoring and evaluation requirements etc.</p>	<p>Agree. The recommendation is well taken and a reconfiguration of disease specific grants cutting across all rounds is being designed.</p> <p><u>Secretariat Comment</u></p> <p>Consolidation through SSF was completed for HSS and Malaria and is ongoing for HIV. R7 TB will be consolidated with R10 TB if it is successful.</p>	<p>MOH, PRs</p>	<p>During Round 9 negotiations for HIV, Malaria and HSS. CCC has informed the Secretariat that the country is planning to apply for Round 10 TB as a SSF proposal.</p>	
<p>Recommendation 22 (Significant) (a) The implementation of this and any future HSS grant implementation framework needs to be revisited in order for it to have a meaningful impact in the health sector. This should be developed with the full involvement of key stakeholders in the health sector and build on the activities that are already underway in the country.</p> <p>(b) In order to have a successful grant implementation, the Ministry should scale up its HSS</p>	<p>All PRs are in agreement with the suggested response of the auditors.</p> <p>(a) Grant negotiations for Round 9 HSS will be conducted in close consultation with the key stakeholders and partners (WHO, HSSP-2 partners, WHO-HMN). The implementation modalities will also reflect the imminent piloting of HSS funding platform in Cambodia.</p> <p>(b) Ministry of Health with support from the in-country health partners is planning to apply for HSS grant for Round 10 as part of Round 10 TB proposal. Moreover, this application will be a SSF proposal which means that the TRP will be able to review</p>	<p>MoH, development partners, PR MoH, CCC</p>	<p>For Round 9 grant signing in July 2010 6 months for oversight</p>	

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<p>related activities.</p> <p>Oversight over the HSS grant should be strengthened which among other things should include forming part of the TRT's oversight agenda. There is a need for HSS expertise in the CCC and the TRT to provide the appropriate oversight at these levels</p>	<p>and analyze the Round 10 proposal in light of the available funding and approved activities under the consolidated Round 9/Round 5 HSS grant.</p> <p>(c) Recognizing the need to improve the CCC oversight functions, the CCC has recently established the Technical Working Groups for HIV, Malaria and TB/HSS with the task to provide technical input to the CCC oversight activities as well as to support proposal development.</p> <p><u>Secretariat comment</u></p> <p>The SSF for HSS was negotiated with active involvement of all the partners. Moreover, some elements of the joint HSS platform has been considered during grant negotiations.</p>			
<p>Recommendation 23 (Significant) (a) The Ministry should engage TA for the remaining period with</p>	<p>(a) Agree.</p>	<p>MOH, PRs</p>	<p>6 months</p>	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p><i>specific tasks to be completed. Priority areas might be finalization of the procurement guidelines, guidelines for the handling of expired stock and on the job training (OJT) for PR and SR procurement staff on procurement best practices, development of SOPs for key procurement processes, development of supplier contract management tools etc.</i></p> <p><i>(b) The Ministry should revisit the contract with WHO. Parameters for measuring performance should be agreed upon and the disbursement of funds should be tied to meeting specific agreed upon milestones.</i></p> <p><i>(c) Management should identify a focal point in the Ministry of Health coordinate the technical assistance provided by WHO and ensure compliance with the conditions of the contract that are stipulated in the signed contract with the</i></p>	<p><i>(b) WHO staff work both at the Ministry and at WHO Offices and not contracted to work solely with GFATM and former FPM was aware of this arrangement.</i></p> <p><i>(b) The Regional Team discussed this with the Partnership Unit and is of opinion that the Ministry at this point would not be able to revisit the contract with WHO Cambodia due to the fact that the proposed changes most probably would not be acceptable to the WHO Legal Department”.</i></p> <p><i>(c) DDF and DPHI who have signed the Phase 2 contracts with WHO will be responsible for ensuring compliance with contract terms.</i></p> <p><i>(c). Agree. Moreover, the Regional Team is planning to discuss the issue of the WHO TA oversight with WPRO.</i></p> <p><u><i>Secretariat comment</i></u></p>			

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
Ministry of Health. The TRT should, when reviewing the HSS grant, also provide oversight of the performance of WHO.	<p>In agreement with a.</p> <p>For b, we note that the Phase 2 MoU between the SRs and WHO in Cambodia was signed only after it had been reviewed, commented on and greenlighted by a GF Legal Office. Given that the contract has been signed by both parties, we suspect it would be difficult to get WHO's approval to amend it at this stage, particularly the method of payment. However, the PR may nonetheless try to negotiate an amendment to the reporting requirements in the contract to allow for greater scrutiny of WHO's performance.</p>			
Recommendation 24 (Significant) The Ministry (PMU management) through the BEC should enforce adherence to the laid down procurement guidelines. Exceptions should be justified to and approved by the BEC.	<p>Agree.</p> <p><u>Secretariat comment</u></p> <p>We believe that what is lacking in the system is a set of SOPs on procurement and these are going to be developed soon.</p>	PR MoH	Immediately	
Recommendation 25 (Significant) The Ministry's support to the SR in the area of procurement and supply chain management should be strengthened. The BEC should	<p>Agree.</p> <p>However, we note that ideally the proposed PR tender committee should ideally be formed outside the Ministry of Health.</p>	PR MOH for strengthening of SR procurement management MOH , CCC,	6 months	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
take overall responsibility for coordination as well as the oversight of the Ministry and SR procurement activities.		PRs for BEC		
<p>Recommendation 26 (High)</p> <p>(a) NCHADS should review and align its payment of salaries to the Government policy on salary incentives. No further top up payments should be made to government employees until there is agreement between the Government and the development partners.</p> <p>(b) In the mean time, NCHADS should prepare a justification for the payment of salary incentives for review by the LFA and approval by the Global Fund. The payment of incentives should be in line with the whatever scheme is agreed between the RGC and the development partners and be to the extent to which contributions are made by staff to the programs funded by the Global Fund.</p> <p>(c) In the event that payment</p>	<p>(a),(b) Agree (details see above in recommendation 8)</p> <p>(c) Agree. PR to establish a Bank transfer</p>	PR NCHADS	<p>As per timeline and milestones of PAR</p> <p>Immediately</p>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<i>of salary incentives is agreed upon, the payment of salaries in cash should stop with immediate effect. Arrangements should be made for salary to be paid into staff bank accounts.</i>	<i>system up to the district level, however it recommends that incentives below the district level which are not material could be paid by cash.</i>	<i>PR NCHADS</i>	<i>Immediately</i>	
Recommendation 27 (High) <i>The removal of petty cash from the office should stop with immediate effect. NCHADS should institute mechanisms to ensure security of petty cash in the office.</i>	<i>Agree. The management of petty cash has been resolved by procuring a safe.</i>	<i>PR NCHADS</i>	<i>Immediately</i>	
Recommendation 28 (Significant) <i>NCHADS should ensure that advances are liquidated on time. Furthermore, there should be strict adherence to the requirement that staff with outstanding accountabilities do not receive additional advances except in unavoidable circumstances with proper</i>	<i>Agree.</i>	<i>PR NCHADS</i>	<i>Immediately</i>	

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<i>justification documented.</i>				
Recommendation 29 (Significant) <i>NCHADS should carry out periodic fixed asset physical verifications. The assets register should be updated with the results of the verification exercise.</i>	<i>Agree. This will be followed up on as part of the standard terms and conditions in the Grant Agreement.</i>	<i>PR NCHADS</i>	<i>Ongoing</i>	
Recommendation 30 (High) <i>NCHADS management should strengthen the control environment within which program activities are undertaken. Staff should not receive allowances for undertaking tasks that are part of their jobs.</i>	<i>Agree in principle that it needs to improve the financial management systems</i> <u>Secretariat comment</u> <i>The Rd 9 agreements require the PR to submit an updated HR manual which shows the criteria and methodology for making any payments to employees and consultants.</i>	<i>PR NCHADS</i>	<i>Ongoing</i>	
Recommendation 31 (High) <i>The NCHADS management should identify a senior official to head the procurement unit in order to ensure better planning, organizing, staffing, directing and controlling of the procurement function. Their role should cover ensuring coordination with the MOH Procurement Bureau to</i>	<i>Agree (also refer to recommendations 3 and 23)</i> <u>Secretariat comment</u> <i>The PR NCHADS management structure will be reviewed in the coming weeks for Round 9 grant negotiations. We will follow up with the PR that they complete recruitment for vacant posts asap.</i>	<i>PR NCHADS</i>	<i>Prior to Round 9 grant signing</i>	

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ensure that there are no duplications and to identify ways in which synergies can be obtained. All vacant positions should also be filled.				
Recommendation 32 (Significant) NCHADS should finalise the PSM for Round 7 to ensure that PSM activities are well planned for. A subsequent activity plan should be developed and PSM performance reports against the plan developed on a regular basis.	Subsequently completed. <u>Secretariat comment</u> In full agreement with the statement. The PSM plan for Round 7 HIV Phase 1 is fully approved.	PR NCHADS	Completed	
Recommendations 33 (Significant) NCHADS should strengthen its logistics systems to ensure that accurate and timely information is available to support the forecasting and quantification process. In developing the OI drug list, NCHADS should liaise with the MOH Procurement Bureau to ensure that there are no duplications in the drugs procured and to explore opportunities for	Agree. The PR NCHADS has developed a forecasting tool for OI as part of the Global Fund requirement to improve the quantification of OI drugs and avoid duplication between the PR. We, however, acknowledge the fact that this tool still needs to be improved. <u>Secretariat comment</u> We have requested an updated OI quantification tool for Round 9 HIV negotiations.	PR NCHADS, MoH	6 months	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<i>pooled procurement.</i>				
Recommendation 34 (High) <i>In line with the Global Fund principles and to the extent possible, the Ministry should use national structures, systems and procedures i.e. CMS for logistics and storage. NCHADS should assess and contribute towards strengthening capacity gaps at CMS instead of setting up duplicative structures.</i>	Agree <u>Secretariat comment</u> <i>We confirm this statement. All ARV and OI drugs are stored at the CMS and distributed thru the national distribution supply chain.</i>	<i>PR NCHADS and CMS</i>	<i>6 months</i>	
Recommendation 35 (Significant) <i>NCHADS management should obtain a licensed version of the Peach Tree software. The genuine software will be more costly but will be legal and come with a number of benefits such as access to updates and full support and help. It will also ensure the security of data and the integrity of the information systems is guaranteed.</i>	Agree	<i>PR NCHADS</i>	<i>3 months</i>	
Recommendation 36 (High)	Agree	<i>PR NCHADS</i>	<i>Immediately</i>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
NCHADS' management should enforce strict adherence to the procurement guidelines. Any deviation in the name of supplier against the purchase order should be properly justified and documented. Potential procurement irregularities should be investigated by the relevant authorities.				
Recommendation 37 (Requires attention) CNM should submit to the Global Fund on an annual basis the schedule for workshops and international workshops for approval. This will ensure that program funds are used to fight Malaria and that staff are available to implement program activities.	Agree <u>Secretariat comment</u> It is a special condition for Round 9 grants.	PR CNM	Immediately	
Recommendation 38 (High) CNM management should ensure that all expenditure is appropriately classified in the financial records in order to provide an accurate financial position for decision making. All ineligible costs identified above	Agree <u>Secretariat comment</u> We believe that the below expenditures were important for CNM and hence can be justified as minor reallocation of costs under office supplies budget categories.	PR CNM	Immediately	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments										
<i>should be refunded</i>	<table border="1"> <tr> <td>10 Sep 2008</td><td>CDV 08/98</td><td>Rebuild CNM LAN</td><td>9,900</td><td>Item not in budget/ work plan</td></tr> <tr> <td>4 Oct 2008</td><td>PCPV 08/41</td><td>Renovation of IT room</td><td>420</td><td>Item not in budget/ work plan</td></tr> </table> <p><i>For the rest we rely on the OIG assessment of the PR response.</i></p>	10 Sep 2008	CDV 08/98	Rebuild CNM LAN	9,900	Item not in budget/ work plan	4 Oct 2008	PCPV 08/41	Renovation of IT room	420	Item not in budget/ work plan			
10 Sep 2008	CDV 08/98	Rebuild CNM LAN	9,900	Item not in budget/ work plan										
4 Oct 2008	PCPV 08/41	Renovation of IT room	420	Item not in budget/ work plan										
Recommendation 39 (High) <i>Given the vast nature of the CNM/MOH network, administrative costs of the programs could be reduced by maximizing the use of existing resources.</i>	Agree	PR CNM, MOH	Immediately											
Recommendation 40 (High) <i>CNM should strengthen its capacity especially in forecasting and quantification, contract management, shipping and forwarding and logistics management.</i>	<p>Agree. Following the Global Fund requirement to improve the ACT and LLIN quantification, the PR CNM with support from CHAI has already developed an ACT forecasting tool. LLIN forecasting methodology will also be updated prior to Round 9 grant signing</p> <p><u>Secretariat comment</u></p> <p>We confirm that for Round 9 grant negotiations the PR CNM submitted an updated quantification tools for the</p>	PR CNM	Immediately											

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
	<i>products listed. These tools were reviewed by the LFA and GF and found to be appropriate.</i>			
Recommendation 41 (Significant) <i>CNM should improve LMIS for nets to improve the quality data used for forecasting.</i>	<i>Agree</i>	<i>PR CNM</i>	<i>December 2010</i>	
Recommendation 42 (High) <i>CNM should continue to engage stakeholders to find permanent solutions to the underlying factors that are causing the acceleration of drug resistance.</i> <i>(a)</i>	<i>Agree</i> <i>The Secretariat will monitor approval process.</i> <u>Secretariat comment</u> <i>We agree with the response. CNM and partners are doing their best to find solution to the problem.</i>	<i>PR CNM</i>	<i>Ongoing</i>	
Recommendation 43 (High) <i>CNM should develop generic LLIN specifications in line with procurement best practice for approval by the BEC. The technical specifications should result in fair and open competition amongst all WHOPES nets.</i>	<i>Completed. We have already approved the generic specifications submitted by CNM in January 2010 and procurement is ongoing through WHO procurement.</i> <u>Secretariat comment</u> <i>We confirm the CNM's statement. They have changed the technical specifications and procured WHOPES nets.</i>	<i>PR CNM</i>	<i>Completed</i>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
Recommendation 44 (High) CNM should put in place measures that ensure that procurement guidelines are adhered to all the times. SOPs should be put in place to provide guidance on various procurement processes e.g. on pre-qualifying suppliers.	Agree <u>Secretariat comment</u> As above, SOPs will be developed in accordance with the SC in Round 9.	PR CNM	December 2010	
Recommendation 45 (Significant) CNM should liaise with CMS to minimise disruption of cold chain during distribution of RDTs and the OD pharmacists to ensure there are appropriate cold storage facilities in the districts to maintain appropriate storage temperatures for RDTs.	Agree <u>Secretariat comment</u> We agree but want to add that as per our knowledge the RDTs we buy in Cambodia do not require cold chain.	PR CNM	Immediately	
Recommendation 46 (Significant) CENAT should strengthen its advances management processes by ensuring adherence to the financial guidelines. Specifically, there should be strict adherence to the requirement that staff with outstanding accountabilities for prior advances do not receive	Agree	PR CENAT	Immediately	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<i>additional advances.</i>				
Recommendation 47 (High) CENAT management should strengthen the environment within which program activities are undertaken. Staff should not receive allowances for undertaking tasks that are part of their jobs except in exceptional circumstances	<p>Agree. CENAT prefers to wait for the Sub-decree on Priority Operating Costs (POC) from the RGC, and will follow the Sub-decree's recommendations.</p> <p><u>Secretariat comment</u></p> <p>As above, we need to update the HR policies to include POC for civil servants.</p>	PR CENAT	Immediately and according to CAR timeline for POC Sub Decree to be in force.	
Recommendation 48 (Significant) CENAT should ensure that the composition of teams attending international conferences is reflective of program requirements. Capacity building and training of employees which are essential to the growth and sustainability of the organization need be adequately planned and be based on the need of the staff and the job profile. This would benefit the staff and the organization both in terms of gaining knowledge and value for money spent.	<p>Agree. The composition of teams for international conferences is based on program requirements. Staff from finance are included (as a member of the Senior Management Team) to understand the financial implications of starting innovative activities and to provide sound advice on efficient budgeting for specific goods and services (VFM) which will benefit the organization and the donor.</p> <p><u>Secretariat comment</u></p> <p>Financial and budgetary issues are regularly discussed at the international forums on TB during special sessions. It is difficult to comment on the response without having detailed information on the conference.</p>	PR CENAT	Immediately	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>Recommendation 49 (Significant) <i>Fixed assets procured using Global Fund grants should be based on actual need in order to enable efficient conduct of program activities and not on the basis of budget approved by Global Fund. The cost of assets budgeted but not necessarily required by the organization should be used on other productive activities.</i></p>	<p><i>Agree. Bulk procurement of goods such as printers, etc. is preferred, as it results in overall savings, and will be delivered to different destinations, according to the distribution plan.</i></p>	PR CENAT	Immediately	
<p>Recommendation 50 (Significant) <i>(a) CENAT should carry out active logistics activities including verification of data from health facilities, collection of stock status reports from CMS, tracking expiry dates of supplies in the supply chain.</i> <i>(b) CENAT should develop and implement forecasting and quantification guidelines to be used by the forecasting and quantification team.</i></p>	<p><i>Agree</i></p> <p><u>Secretariat comment</u></p> <p><i>We agree with the point on quantification. The tools for quantification are standard and were developed by WHO and IUATLD.</i></p>	PR CENAT	December 2010	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
Recommendation 51 (Significant) (c) CENAT should review the bidding documents to bring them in line with best practices and give potential bidders enough information to make decisions on whether or not to participate in the tender. (d) CENAT should bring bid securities down to the recommended 2% and concentrate on the management of the contracts rather than use a high bid security of 5% as the deterrent measure.	Agree.	PR CENAT	Immediately	
Recommendation 52 (Significant) (a) NCHADS and the NAA together should review the quality, type and amount of preventive work done, especially among the general population and agree what is needed in the future, how best to do it and who will do it. The outcome of this review should be considered by the CCM and reflected in future grant proposals.	(a) Agree. (b) & (c) Agree. <u>Secretariat comment</u> In full agreement.	(a) NCHADS, NAA, CCC and TRP to ensure compliance (b) NCHADS (c) NCHADS and MoH	(a) Future grant proposal (b) Ongoing (c) Ongoing	

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<p>(b) Apart from for the most at risk target groups, free condoms are promoted as a family planning/birth spacing commodity. NCHADS should review the need for a greater availability of free condoms. Private sector vendors should be encouraged to get their supplies out to commune level.</p> <p>(c) There has been a missed opportunity to develop a community palliative care program with Global Fund support. NCHADS to review and have a position or policy on whether palliative care for AIDS patients that would also benefit cancer patients should or should not be a MOH program</p>				
<p>Recommendation 53 (Requires attention) CENAT with MOH should review the justification for having DOTS supporters (as well as DOTS</p>	<p>Agree</p> <p><u>Secretariat comment</u></p> <p>We can confirm this statement. The only</p>	<p>PR CENAT, MoH</p>	<p>3 months</p>	

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watchers).	volunteers for TB program are the DOTS-watchers, as per the national strategy.			
Recommendation 54 (Significant) The Ministry should review and strengthen the systems for the follow-up of patients tested for HIV who do not collect their results and of those HIV or AIDS patients who need testing for TB.	Agree.	PR NCHADS and MOH	6 months	
Recommendation 55 (High) (a) The 3 TA posts for M&E for the 3 diseases should be reduced to one and the savings re-programmed towards: (i) the development of a sound national health M&E framework that development partners can align with; (ii) the development of one set of national M&E guidelines; and (iii) the alignment of the information required for, and the M&E undertaken by, the national disease programs and by the Global Fund. It is further recommended that the one M&E post be in the DPHI. (b) In discussion with the DPHI all contracted and government	(a) This is based on country needs and we suggest that instead of reprogramming the savings, additional funds are channelled towards (i), (ii) and (iii). (b) Agree, however the remaining posts may need to be allocated to the three National Programs for HIV, TB and Malaria in addition to DPHI (c) Most of the grants in Cambodia are in the process of being consolidated into single stream. This will already rationalize the number of indicators in these grants. (d) GF system of monitoring and rewarding performance is rooted in and dependent on good/strong national M&E systems. GF has been supporting strengthening of National M&E systems through funding the M&E action plans in order to better align with national systems where these are weak	CCC and the PR MOH, PR CNM, PR CENAT & PR NCHADS	a 1 year following the transition to SSF	

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<p>staff posts for M&E in the MOH-PR and in SRs and in provincial health offices solely working on Global Fund grants should be rationalized and any remaining posts be allocated to DPHI to work on both the national M&E and on data collection and analysis still required for global initiatives.</p> <p>(c) Future proposals to the Global Fund should limit the number of output type indicators and indicators additional to the strengthened national M&E framework.</p> <p>(d) The Global Fund Secretariat should review 'how' it monitors and rewards performance so that it is more closely aligned to national systems and processes.</p>	<p><u>Secretariat comment</u></p> <p>We would agree with the recommendation for having 1 TA for M&E for the 3 diseases but only when the integrated monitoring for health system is fully developed, which may be in 3-5 years.</p>			
<p>Recommendation 56 (Requires attention)</p> <p>(a) MOH should develop strategies to ensure that free drugs and commodities are exactly that for the targeted end user. There is also a need to work actively at building the public's</p>	<p>(a) Agree (b) Agree (c) Agree</p>	MOH, all disease PRs,	1 year	

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<p>confidence in the public sector service delivery.</p> <p>(b) Supervision check lists for the 3 diseases need to show what action was needed following a supervision visit and provide for the follow-up of salient issues.</p> <p>(c) The consolidation of all health education/BCC work in one MOH department should be considered.</p>	<p><u>Secretariat comment</u></p> <p>We will follow up on this with the MoH/PRs.</p>			
<p>Recommendation 57 (Requires attention)</p> <p>(a) The Global Fund Secretariat should consider, in the light of international evidence, the validity of the use of public funds for social marketing in poor countries, especially of bed nets, where it is also enabling free drugs and commodities to be supplied.</p> <p>(b) MOH should consider and develop a position or policy on social marketing in the health sector. This should include putting mechanisms in place to ensure that the products reach their intended beneficiaries.</p>	<p>(a) Agree in principle but believe that this should be addressed to the SPE Cluster and not to the country. Regarding social marketing in Cambodia, we have recently received two reports from DFID/USAID commissioned evaluations of social marketing in Cambodia. Both studies showed positive impact of social marketing programmes against the programme objectives (reports are available if needed).</p> <p>(b). Agree</p> <p><u>Secretariat comment</u></p> <p>We will follow up on this with the PR NCHADS.</p>	<p>MOH, PRs, technical partners</p>	<p>1 year</p>	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>Recommendation 58 (High)</p> <p>(a) The Ministry should undertake an outcome or impact evaluation of the different types of training supported by the Global Fund to date commissioned from an independent evaluator.</p> <p>(b) The Ministry should reduce the extent to which Global Fund supported capacity building or 'training' is taking place in a vacuum by ensuring that it targets the strengthening of national human resource systems and processes.</p> <p>(c) The Ministry should undertake a joint MOH/donor evaluation of TA provided in the last decade and with the MOH establish a process to ensure coordination of all TA in the MOH, the objectives of, and approaches used to, develop capacity and the monitoring and evaluation of the quality of TA.</p>	<p>(a). Agree., (b). Agree (c). Agree.</p> <p><u>Secretariat comment</u></p> <p><i>In full agreement with the timeline as well.</i></p>	MOH, PRs of the 3 diseasesw, CCC	June 2011	
<p>Recommendation 59 (High)</p> <p>(a) MOH with the CCC and Global Fund Secretariat should examine the impact of having 4</p>	<p>(a) Agree in principle and the PRs and MOH will discuss with the CCC regarding consolidation of the PRs.</p> <p>(b) Agree</p>	(MOH, PRs and CCC	New proposal submission	

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Recommendations	Response and Action	Responsible	Completion Date	The OIG comments
<p>PRs within one government institution and decide whether consolidation of the PRs is needed to reduce fragmentation and cost-inefficiencies and strengthen the leadership role of the ministry.</p> <p>(b) The process for identifying SRs for program implementation should be strengthened across all PRs. Where inexperienced NGOs are chosen as SRs, there should be good justification for their selection e.g. showing they have comparative advantage to deliver particular services and capacity building should be provided to address noted weaknesses.</p>				
<p>Recommendation 60 (Significant)</p> <p>The CCC and MOH should review the planning and decision making processes related to Global Fund proposals, including Rounds and RCCs and any Phase II to better align technical and decision making processes with those of the Ministry.</p>	<p>Agree. However it is the responsibility of the CCC through its newly established Proposal Development Committee to ensure that proposals are being developed in line with government health strategic documents.</p> <p><u>Secretariat comment</u></p> <p>We agree with the statement. We noticed a good progress in the proposal development process for R10.</p>	CCC with MOH	From new proposal submission	

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<i>Recommendations</i>	<i>Response and Action</i>	<i>Responsible</i>	<i>Completion Date</i>	<i>The OIG comments</i>
<p>Recommendation 61 (High)</p> <p>(a) To the extent possible, all the PRs should use national PSM structures, systems and procedures for implementation of program activities. In cases where parallel systems have to be established due to inadequate capacity in the Ministry, these structures should be for a defined period of time with relevant capacity building and transition plans for the eventual transitioning back to national structures. Any skills gaps within the government structure should also be addressed by training existing staff or recruiting suitable staff to fill vacant positions.</p> <p>(b) The procurement matrix should be completed and all procurements should be pooled to reap economies of scale. This process should be spearheaded by the MOH Procurement Bureau. In the event that the Bureau lacks capacity, a third party procurement agent should be identified in the short/medium</p>	<p>Agree: It is expected that with the completion of the Country Profile, this would indicate which areas in the national system require further strengthening. However we note that there needs to be a balance between the PBF principle and the risk that weak National systems may impact on the delivery of services and this may take some time to address. Finally, it should be noted that the PSM structures in use by the PRs are mainly the National ones i.e. treatment guidelines, Management Information Systems, Storage and warehousing, distribution systems etc.</p> <p><u>Secretariat comment</u></p> <p>As in our first feedback, we are not in support for immediate transfer of all procurement to the MOH Procurement Bureau. GF and partners are discussing the ways to strengthen this unit and may be at some point in 5-7 years this unit will be able to take the entire procurement under its umbrella. In the meantime, we recommend to continue working on strengthening the national systems through our support to DDF, CMS, PR Procurement Units. We will also use the country profile and the plan of action to monitor the developments</p>	MOH, all disease PRs and CCC	Ongoing	

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term to support the process and build the capacity of the Bureau. (c) The Ministry should spearhead the development of SOPs for key procurement processes to ensure processes are standardized and efficient.	in this area.			
Recommendation 62 (High) (a) The Ministry of Health should strengthen the stock management at CMS, provincial and OD level and improve storage facilities; provide written guidelines on all aspects of stock management; and improve supervision. (b) The managerial capacity of the staff at CMS should be strengthened to provide strategic direction to the institution. (c) Drugs that are susceptible to expiry should be issued first by the stores to avoid the financial losses that occur due to the expiry of the drugs. (d) The procedures for the disposal of the expired drugs	Agree: The Country Profile just finalised will form a strong basis for strengthening these areas as it captures adequately all these. The LFA will be requested to review the Standard Operating Procedures for management of pharmaceutical and health products to ensure that these areas are addressed, and then the PR to follow up with operationalization of the SoPs during the Round 9 Negotiations, including the need to budget for the strengthening of these areas. <u>Secretariat comment</u> Based on the country profile assessment, the GF requested the PR MoH and CNM to include into Round 9 Malaria and HSS grants some funds for improvement of storage conditions at peripheral level. We have also included condition on improvement of LMIS.	MOH with all disease PRs	6 months	

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<i>should be initiated at the earliest opportunity once drugs have expired and measures should be taken not to issue expired drugs to patients.</i>				
Recommendation 63 (Significant) <i>Proper training should be provided to staff to be able to fully utilise the DID systems to track expiry dates of the drugs, shortages, and stock outs.</i>	Agree	PRs	Immediately	
Recommendation 64 (Significant) (a) <i>The Ministry of Health should follow up and finalise the selection of the outsourced WHO-prequalified laboratory for pharmaceuticals. Necessary arrangements should be put in place to facilitate the transfer of the samples to the identified laboratory and the receiving of report from the laboratory. MOH should mobilise resources</i>	(a) Agree. MOH is in the process of selecting a WHO pre qualified laboratory (b) and (c) Agree <u>Secretariat comment</u> <i>QC laboratory has just been selected through a competitive bidding. The PR MoH will sign the contract and start working with this laboratory soon. The plan is to sample products for the portfolio and not only for the MoH PR.</i>	MOH and PRs	6 months	

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<p>for NLDQC to start working on the WHO pre-qualification or ISO certification of the laboratory</p> <p>(b) All PRs should put measures in place for qualified and relevant professional experts to carry out, document and approve post-shipment inspections of drug related consignments.</p> <p>(c) All PRs should Implement the GF approved guidelines for handling expired medicines and distribute to the provincial, ODs and health centre level.</p>				
<p>Recommendation 65 (High)</p> <p>(a) The CCC should consider co-opting a health system expert on its technical committees. Such a person would provide insight on the integration and alignment of the 3 diseases into the national health systems and the strengthening of the overall health system of the country.</p> <p>(b) The CCC should operationalise the CCC manual,</p>	<p>(a) The CCC is of the view that the regular technical support it is availing would be an effective solution to strengthen the overall health systems rather than hiring of one health system expert co-opted as a full time advisor because of the expertise required for alignment of diseases programs.</p> <p>(b) The CCC conflict of interest chapter was approved in January and is currently being operationalised.</p> <p>(c) The CCC recently submitted their</p>	CCC	Completed	

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<p>conflict of interest policy and the oversight plan.</p> <p>(c) The CCC should strengthen its Secretariat capacity so that it can provide effective support to the CCC and its committees in its oversight functions by increasing the level of staffing and enhancing skills and expertise.</p>	<p>CCM funding request under the extended funding channel for recruitment of additional staffing to strengthen the CCC Sec and CCC oversight functioning.</p>			
<p>Recommendation 66 (High)</p> <p>(a) The CCC should develop and communicate the process by which PRs are nominated to be PR. The selection criteria should be fixed and included in the governance manual and regularly reviewed.</p> <p>(b) The draft conflict of interest policy should be approved and implemented by the CCC. Any possible conflict of interest should be declared by CCC members who should opt out of decision making where such conflict arise.</p> <p>(c) The oversight role of the CCC over grant implementation should be strengthened through the appointment of an oversight sub committee. The formation of</p>	<p>(a) The selection criteria for selection of PRs have been included in the new CCC governance manual and endorsed by the CCC</p> <p>(b) The conflict of interest provisions in the new CCC Governance manual have already been approved by the CCC members.</p> <p>(c) The oversight committee now operate in line with the recommendation</p>	CCC	Completed	

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<i>separate sub committees to review financial performance and programmatic performance would further enhance the effectiveness of the CCC. The CCC should review the grant implementation and approve the performance in its full meeting based on recommendations provided by its sub committees on reviews carried on PUDRs, semi-annual report. Such reviews should include review of audits reports and management letters.</i>				
Recommendation 67 (Significant) <i>The CCC should ensure that Global Fund programs are complimentary to the programs funded by the RGC and the other development partners. This should be demonstrated at proposal formulation as well as throughout the life of the grants.</i>	<i>Agree. The CCC on its own does not have the capacity to ensure alignment and complementarity with program funded by the RGC and other development partners. The lead donor facilitator for health in Cambodia acts as a broker for proper inter-agency program planning and alignment with the RGC strategic and programmatic directions.</i>	<i>CCC and Health Development Partners</i>	<i>During the next Round based funding request</i>	
Recommendation 68 (High) <i>(a) The CCC should constitute a finance committee to review the budgets submitted as</i>	<i>The financial aspects of the grant proposal will be covered during the time of the proposal development which will be reviewed by the newly constituted proposal</i>	<i>CCC</i>	<i>Completed</i>	

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<p>part of the proposals submitted to the Global Fund. This committee should be responsible for the review of request for budget reallocations. Budget reallocation guidelines should be developed to guide these processes.</p> <p>(b) The CCCSC should be reconstituted to remove the PRs since this raises conflicts of interest</p>	<p>Development Committee. With the Oversight Committee in place, it is under its mandate to review the financial aspect of grant implementation. Completed. The former CCC Sub Committee has been replaced by an Oversight Committee free of conflict of interest and no PR inclusion.</p>			
<p>Recommendation 69 (High) Clear communication should be established between STI at Basel and country offices to ensure an effective working environment and quality of work. To enhance the skills of the staff working on Global Fund grants regular training should be given on finance and procurement</p>	<p>We fully agree with the importance of clear communication channels and will continue to make efforts to improve them. As mentioned under point 4, Skype conference calls take place regularly.</p> <p>In-country finance staff is now more experienced with Global Fund operations, being able to provide the detailed review requested by the Finance staff of the Global Fund, especially since the Round 9 regional workshop, where close collaboration occurred between the two institutions; in addition, the coming training in Finance by Global Fund in November</p>	STI	A continuous training budget is available for 2010 and is used.	

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	<p>2010 should also strengthen their capacity;</p> <p>Until today no proper handover from KPMG to Swiss TPH has taken place.</p>			
<p>Recommendation 70 (Significant)</p> <p>The LFA should make an assessment of risks that are likely to result in failure to implement grant programs or result in errors and fraud. This should be a key guiding document in the design of activities to be undertaken for verification of implementation and capacity assessments.</p>	<p>It is correct that a fully fledged risk assessment has not been undertaken. However, the Global Fund has no coherent approach to risk assessment and there is no general framework respectively specific guidelines for LFAs on how to conduct a risk assessment. For example shall a risk assessment have a country focus, a program focus or a PR focus? Key documents such as the PR assessment template or the phase 2 review template entail some questions relating to a risk assessment. These questions are however not consolidated through a general risk assessment approach.</p>			
<p>Recommendation 71 (High)</p> <p>Quality assurance policies and procedures should be</p>	<p>The Swiss TPH has a quality assurance policy in place which includes for</p>	STI	Since December 2009, the Cambodia	

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<p>developed and implemented in the country for work performed by the LFA. The regular review of work by the Country Head and by Basel would provide additional assurance on the work performed and on the reliance that can be placed on reports submitted to the Global Fund.</p>	<p>example a checklist for PU/DR reviews as well as peer-review reading by senior staff. Indeed typically every report/document which is submitted to TGF undergoes a quality review. Feedback and comments from Swiss TPH headquarters in Basel, as evidence of review and quality assurance, were provided - perhaps with the exception of initial reports, where HQ staff has been involved in PR assessments itself have been provided throughout 2009 (and continue to be provided in 2010).</p> <p>It is correct that SCIH did not have specific standard work procedures for all task executed by the LFA. However, HQ and the local office relied on Global Fund instructions and the large experience of the head of office, who applied most procedures she has been used to with her previous employer.</p> <p>Regular Skype conference calls of up to one hour take place on a bi-weekly basis since April 2009. Minutes of these conference calls are available.</p>		<p>Office of the Swiss TPH has updated and re-designed templates for working procedures and thus for quality assurance (based on pre-existing Swiss TPH templates). There is now</p> <ul style="list-style-type: none"> - Work planning sheet, including staff allocation for tasks; and - Documenting procedure for PU/DR and PR capacity assessment. 	

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	<p><i>To further harmonize approaches, the Swiss TPH has recruited since fall 2009 a quality assurance officer, whose task is to standardize approaches across the different countries where Swiss TPH is the LFA.</i></p> <p><i>Cambodia Office has now templates. Work planning sheet, including staff allocation for tasks; and documenting procedure for PU/DR and PR capacity assessment are now in place in Phnom Penh.</i></p>			
<p>Recommendation 72 (High) <i>Global Fund needs to align its response to the sub-decree and letter on the termination of salary supplements and incentives with other donors and evaluate the impact it would have on the grant implementation.</i></p>	<p><i>See Secretariat comment under Recommendation 8</i></p>			