



## Audit Report

# Global Fund Grants to the Republic of Uzbekistan

GF-OIG-16-01  
19 January 2016  
Geneva, Switzerland

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# I. Background

## Country context

The Republic of Uzbekistan is a landlocked country in Central Asia, comprising 12 regions, the autonomous Republic of Karakalpakstan, and the capital city of Tashkent.<sup>1</sup> In 2015, Uzbekistan had an estimated population of 31 million.<sup>2</sup>

The World Bank classified Uzbekistan as a lower middle income country with a gross national income of USD 2,090 per capita in 2014.<sup>3</sup> In 2013, total health expenditure was USD 120 per capita, representing 6.1% of the gross domestic product.<sup>4</sup> The country ranks 114<sup>th</sup> out of 188 countries in the 2015 United Nations Development Program's Human Development Index.<sup>5</sup>

## Disease context

### HIV/AIDS

In 2013, Uzbekistan had an estimated 35,000 people living with HIV representing 1.7% of the burden in the World Health Organization (WHO) European Region, indicating HIV prevalence of 0.1% in the general population. A higher prevalence exists in key affected populations (7.3% among people who inject drugs, 3.3% among men who have sex with men, and 2.1% among female sex workers). HIV infections continue to rise with an estimated 14.1 new cases per 100,000 people in 2013 (compared to 7.8 new cases in the WHO European Region).<sup>6</sup>

Between 2011 and 2014, the number of people on antiretroviral therapy (ART) has increased from about 3,200 to 12,000. However, this corresponds to only about 34% of people who are eligible for therapy. Between 2008 and 2014, the country tripled HIV testing to about 3 million tests per year. This mostly focused on specific population groups but only partially on the key affected populations mentioned above.<sup>7, 8</sup>

### Tuberculosis

Uzbekistan is one of the tuberculosis (TB) high priority countries in the WHO European Region. In 2013, the country had an estimated 35,000 cases of TB (representing 7.6% of the burden in the WHO European Region), indicating TB prevalence of 120 cases per 100,000 people (compared to 51 cases in the WHO European Region). A total of 22,140 TB cases were enrolled in treatment in 2013. Incidence of new TB cases was 80 cases per 100,000 people (compared to 39 cases in the WHO European Region) in 2013. Although TB prevalence, incidence and mortality indicators are higher than overall in the region, they show a decline in the last ten years. In 2014, the treatment success rate was 73% for new TB cases under Directly Observed Treatment, Short-Course (DOTS) treatment. As many as 98% of TB patients were screened for HIV.<sup>9</sup>

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<sup>1</sup> Referred to in the report as 14 regions in total

<sup>2</sup> <http://data.worldbank.org/country/uzbekistan>

<sup>3</sup> <http://data.worldbank.org/country/uzbekistan>

<sup>4</sup> <http://databank.worldbank.org/data>

<sup>5</sup> [http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/UZB.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/UZB.pdf)

<sup>6</sup> <http://apps.who.int/gho/data/node.country.country-UZB> , <http://apps.who.int/gho/data/node.main.620> ;

<http://data.worldbank.org/country/uzbekistan> , HIV triangulation data analysis in Republic of Uzbekistan (UNAIDS, 2014)

<sup>7</sup> <http://data.worldbank.org/country/uzbekistan> ; HIV concept note (15 July 2015)

<sup>8</sup> HIV testing mostly focuses on population groups such as pregnant women, newlywed couples, medical personnel, and migrant workers. However, it also targets people living with diseases and key affected populations (e.g. people who inject drugs, men who have sex with men, and sex workers).

<sup>9</sup> WHO 2014 Tuberculosis report; <http://apps.who.int/gho/data/node.country.country-UZB> ;

[https://extranet.who.int/sree/Reports?op=Replet&name=/WHO\\_HQ\\_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UZ&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UZ&outtype=html) ; Republican DOTS Center summary data on TB cases in 2013; progress update and disbursement request report for grant UZB-809-G05-T (July-December 2014)

Uzbekistan is among the WHO European Region countries with the highest multidrug-resistant tuberculosis (MDR-TB) burden. In 2013, the country had an estimated 7,900 cases of MDR-TB (representing 2.6% of the global burden or 10.4% of the burden in the WHO European Region). In 2014, a total of 3,964 MDR-TB cases were enrolled in treatment. Out of all MDR-TB cases in Uzbekistan, approximately 5% are estimated to be extensively drug-resistant tuberculosis (XDR-TB). In 2012, the treatment success rate was 53% for MDR-TB cases and 13% for XDR-TB cases.<sup>10</sup>

In Uzbekistan, separate treatment protocols exist between the Republican DOTS Center (the Global Fund's Principal Recipient), using WHO-recommended DOTS methodology, and the National Institute of Phthisiatry and Pulmonology (a key coordinating body for TB in the country), which also uses a non-DOTS approach to treatment.

## Malaria

Prior to World War II, malaria was one of the most prevalent diseases in Uzbekistan, affecting 80% of the population. Subsequent eradication programs largely succeeded but the country remained vulnerable to the resumption of malaria transmission with sporadic cases reported, particularly along the borders with Afghanistan and Tajikistan. Between 2005 and 2006, about 60 locally transmitted cases were registered per year. Since 2011, no locally transmitted cases have been reported.<sup>11</sup>

The country supports a malaria elimination program concentrating on vector control and monitoring of malaria situation, and is preparing to receive a WHO malaria elimination certificate.

## Funding context

Between 2004 and 2015, the Global Fund signed seven grants with Uzbekistan totaling USD 143 million, of which USD 117 million has been disbursed as of 30 June 2015. Three grants are currently active, one for each disease.

The Global Fund allocation to Uzbekistan for 2014-2017 totals USD 64 million. In 2015, the country submitted concept notes for HIV, TB and malaria components. The HIV and the TB grants are at the grant making stage.<sup>12</sup> The malaria concept note was not entirely supported by the Global Fund but some technical cooperation activities and an incentive reward for obtaining malaria elimination certification will be funded from the allocation.

The national and local governments are the primary funding sources for the three diseases in Uzbekistan, and the Global Fund has been the principal external donor. In 2014, the Government of Uzbekistan funded approximately 53% of HIV, 83% of TB and 82% of malaria interventions, while the Global Fund financed approximately 37% of HIV, 13% of TB and 18% of malaria interventions.<sup>13</sup> Other donors include United Nations agencies, specifically the WHO, Joint United Nations Program on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime. The United States of America and German development agencies provide primarily technical assistance. Médecins Sans Frontières (MSF) supports the TB program, particularly for Karakalpakstan.

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<sup>10</sup> WHO 2014 Tuberculosis report; <http://apps.who.int/gho/data/node.country.country-UZB> ; [https://extranet.who.int/sree/Reports?op=Replet&name=/WHO\\_HQ\\_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UZ&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UZ&outtype=html) ; progress update and disbursement request report for grant UZB-809-G05-T (July-December 2014); Multidrug-resistant tuberculosis in Uzbekistan: results of a nationwide survey, 2010 to 2011 (www.eurosurveillance.org)

<sup>11</sup> Malaria concept note (1 June 2015)

<sup>12</sup> The grants have been conceptually endorsed by the Global Fund and are at the grant making stage to finalize risk mitigation measures and implementation arrangements.

<sup>13</sup> TB concept note (30 January 2015), Malaria concept note (1 June 2015), HIV concept note (15 July 2015)

## II. Scope and Rating

### 01 Audit Objective

The objective of the audit of Global Fund grants to the Republic of Uzbekistan was to assess whether:

- the governance and implementation arrangements for Global Fund grants are appropriate and effective in achieving grant objectives;
- the health products and services for HIV and TB programs are freely accessible and delivered to patients in good quality and quantity;
- the program data management systems are adequate and effective for the timely and accurate reporting of health data related to the Global Fund grants; and
- the financial management systems have adequate and effective controls, ensuring effectual use of the Global Fund monies for grant objectives.

### 02 Audit Scope

The audit mainly focused on the period from January 2013 to June 2015 and the active HIV and TB grants (97% of the value of all active grants):

- UZB-H-UNDP, implemented by the United Nations Development Program (UNDP), as the Principal Recipient, and the Republican Center to Fight AIDS (RCAIDS), as the main sub-recipient; and
- UZB-809-Go5-T, implemented by the Republican DOTS Center, as the Principal Recipient.

The OIG assessed the overall grant implementation arrangements at the UNDP level and audited sampled operations of UNDP sub-recipients. Due to the “single audit principle”<sup>14</sup> in place for grants to UNDP and the OIG’s limited access to UNDP books and records, the OIG did not carry out a complete audit of UNDP operations. However, this audit was undertaken in cooperation with the UNDP Office of Audit and Investigations (OAI), which audited UNDP’s Principal Recipient operations from January 2014 to June 2015. The OIG and OAI teams collaborated throughout all stages of the audit, and the OAI findings were considered and incorporated in the OIG audit findings.

The OIG visited 23 selected program sites in four (out of 14) regions including regional AIDS centers, non-governmental organizations (NGOs) coordinating HIV outreach workers, HIV “trust cabinets” and “friendly cabinets”,<sup>15</sup> ART clinics, TB/MDR-TB hospitals, dispensaries and health facilities.

The four regions selected for the review represent 43% of prevention services coverage to key affected populations<sup>16</sup> and 50% of patients treated under the HIV grant in 2014, as well as 35% of TB cases of all forms notified and 33% of MDR-TB cases enrolled in treatment in the country during 2014.

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<sup>14</sup> In accordance with the United Nations General Assembly resolutions and the grant agreements with UNDP, audits and investigations of UNDP are carried out by the OAI.

<sup>15</sup> “Trust cabinets” focus on HIV prevention services to key affected populations, while “friendly cabinets” also undertake diagnostic and treatment of other sexually transmitted infections.

<sup>16</sup> The percentage represents the share of key affected population members in the four regions out of all members reached with HIV prevention services under grant during 2014.

### 03 Rating<sup>17</sup>

| <b>Operational Risks</b>             | <b>Rating</b>                 | <b>Reference to findings</b> |
|--------------------------------------|-------------------------------|------------------------------|
| Governance, Oversight and Management | Full plan to become effective | IV.1, IV.2                   |
| Programmatic and Performance         | Full plan to become effective | IV.2, IV.3                   |
| Financial and Fiduciary              | Generally effective           | No significant findings      |
| Health Services and Products         | Full plan to become effective | IV.2, IV.4                   |

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<sup>17</sup> See Annex A for the rating definition

### III. Executive Summary

With a total population of 31 million, Uzbekistan has 7.6% of the TB burden and 1.7% of the HIV burden in the WHO European Region. MDR-TB is a particularly major issue in Uzbekistan, with 23% of new TB cases (5<sup>th</sup> highest rank in the world) and 62% of retreated cases (2<sup>nd</sup> highest rank in the world) estimated to be MDR-TB.<sup>18</sup>

The country has demonstrated significant commitment towards the three disease programs. With malaria affecting 80% of the population post-World War II, Uzbekistan has progressed with no reports of local malaria transmissions since 2011. While the Global Fund has supported Uzbekistan with seven grants totaling USD 143 million, mainly for TB and HIV, national funds cover approximately 53% of HIV, 83% of TB and 82% of malaria interventions.

#### Governance, oversight and management risks

Although both the HIV and TB grant implementing entities have sound capacities, particular challenges were noted in the HIV grant implementation. There have been multiple revisions to concept notes, and consequently several short-term grant extensions, periodic service interruptions and ambiguity in implementation arrangements, including in the respective roles of implementers.

Regarding governance arrangements, the Country Coordinating Mechanism (CCM) was rated as partially compliant in the last External Performance Assessment conducted in 2014 by the Global Fund. Although the CCM has since improved some of its procedures, it has yet to implement most of the measures in its Improvement Plan agreed following the assessment. The OIG found that the CCM has played a limited role in resolving various key portfolio issues such as the different approaches to TB treatment, lack of automated drug management systems, or failure to submit a comprehensive HIV concept note without multiple revisions. On these issues, the CCM lacked an adequate coordination effort between different stakeholders. The CCM needs to strengthen its decision-making procedures through better information to and feedback from its members. It needs to further diversify its membership, and improve its oversight and follow-up mechanisms.

The Global Fund Country Team has been active in managing grant risks and relationships with in-country counterparts, and addressing grant implementation challenges. It has developed a time-bound action plan to address key portfolio risks. In particular, it has ensured alternative arrangements to minimize service interruptions, secured technical assistance to address concept note issues, and is closely following up on the implementation of the CCM Improvement Plan and strengthening of CCM Secretariat staff. Therefore, the Secretariat's management of governance, oversight and management risks is rated as having a **full plan to become effective**.

#### Programmatic and performance risks

The Ministry of Health is responsible for developing a new health management information system, but the project's funding sources and timelines are not currently known. Despite this, program data collection, aggregation and reporting processes were generally well designed and effective, with exceptions found in two out of 13 program facilities visited by the OIG. This was consistent with the results of the latest on-site data verifications by the Local Fund Agent, where data was found to be of good quality for all three diseases. The frequency and coverage of the program monitoring visits, and the quality of monitoring reports were generally satisfactory with follow-up mechanisms in place.

For the TB grant, while there is a moderate decline in the epidemics, the country has not adequately addressed the causes of its high prevalence of MDR-TB. Previous studies have identified various contributing causes including the fact that the WHO-recommended DOTS methodology for TB treatment was only partially adopted. The national counterparts need to make decisions to address the underlying causes.

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<sup>18</sup> WHO 2014 Tuberculosis report; <http://apps.who.int/gho/data/node.main.620>

The Country Team has targeted its assurance activities over program data and has actively monitored program performance. Taking into account its efforts to advocate DOTS methodology through multiple forums and address the periodic service interruptions in the HIV grant, the Secretariat's management of programmatic and performance risks is rated as having a **full plan to become effective**.

#### Health services and products risks

Access to HIV and TB treatment services is generally uniform and provided in all regions. However, TB treatment services combine DOTS methodology with older approaches to treatment involving prolonged hospitalization, impairing overall program effectiveness. Access to HIV prevention services is limited to certain regions for some of the key affected population groups because local authorities in some regions do not approve of sub-recipients.

Patient access to health products under HIV and TB grants improved between the beginning and the end of the period under audit. Implementing entities have registered improvements in the supply chain management, particularly in logistics and drug quality assurance. However, gaps in storage conditions were identified in nine out of 20 storage facilities visited by the OIG. Periodic stock-outs of up to one to two months for main HIV and TB drugs were identified in five out of 10 treatment facilities visited by the OIG, leading to treatment disruptions. Stock-outs were also found through program monitoring visits and by the Local Fund Agent. Stock-outs identified by the OIG were primarily caused by the lack of automated drug management systems in the country coupled with absence of buffer stocks in the regional health facilities.

The Country Team has effectively used assurance mechanisms, including regular "stock-out risk analysis" to improve access to health products and services. It has steered supply chain improvement plans, advocated DOTS methodology and made alternative arrangements for the HIV prevention services. Considering its ongoing plan to address service availability and supply chain issues, the Secretariat's management of health services and products risks is rated as having a **full plan to become effective**.

#### Financial and fiduciary risks

The general financial controls at the TB grant Principal Recipient and the main HIV grant sub-recipient, including procurement and asset management controls, were tested and found to be satisfactory. The Office of Audit and Investigations conducted an audit of UNDP simultaneously with the OIG audit. Their report has not raised any significant issues in the UNDP's own financial management. However, areas for improvement have been identified by the OIG relating to more efficient disbursements, but these did not present material financial risks.

The Country Team has targeted its financial and procurement assurance activities. All drug procurements are managed through centralized Global Fund or UNDP procurement mechanisms, with significant additional procurement reviews by the Country Team to address any gaps in local procurements. Overall, the Secretariat's management of financial and fiduciary risks is rated as **generally effective**.



## IV. Findings and Agreed Management Actions

### 01 Governance arrangements

**The CCM should provide more effective governance over Global Fund grants by proactively identifying and managing key issues and challenges.**

The CCMs are central to the Global Fund's commitment to local ownership and participatory decision-making. In addition to developing concept notes and overseeing grant implementation, they have an active role in engaging stakeholders, aligning Global Fund grants with other national health programs, and contributing towards national strategy discussions.<sup>19</sup> The OIG's review of the CCM's work in Uzbekistan during 2014-2015 found that it has primarily served as a formal decision making body on Global Fund related issues. However, the CCM's role in identifying and addressing cross-cutting issues in grant implementation has been limited. For example:

#### Non-DOTS approach to TB treatment

- The two principal coordinating bodies for TB in the country follow different treatment protocols. The Republican DOTS Center (the Global Fund's Principal Recipient) follows WHO-recommended DOTS methodology. However, the National Institute of Phthisiatry and Pulmonology, which supervises the overall network of TB hospitals in the country, also prescribes older non-DOTS approaches to treatment. Around 85% of TB cases are treated in hospitals for prolonged periods, leading to risk of patient infection with other strains of TB, as opposed to earlier transition to home-based treatment that is recommended by WHO. At the time of the audit, the Republican DOTS Center and the National Institute had plans to establish a memorandum of cooperation to clarify their roles and responsibilities, and move towards universal DOTS treatment in 2017. However, despite the Global Fund communications, the CCM has not adequately discussed this issue. It needs to propose timely solutions and hold appropriate national forums for decision-making.

#### Lack of automated systems in drug management

- As detailed in finding 04, both the national HIV and TB programs use manual tools for health product quantification and distribution, which are not ideal for sufficiently monitoring drug stock levels across the country. This has contributed to periodic drug stock-outs in regional and local health facilities and treatment disruptions, as detailed in finding 04. The CCM has not addressed this issue, despite regular flagging by the Global Fund.

#### Iterations of HIV concept notes

- The CCM has not ensured a comprehensive quality control of the HIV concept notes prior to their submission to the Global Fund. For the HIV program, in 2014-2015 the country submitted one reprogramming request followed by three different versions of the concept note because previous versions required significant improvement. The last version was endorsed by the Global Fund in November 2015.

The possible root causes of the limited CCM effectiveness are weaknesses in its decision-making procedures, membership, and oversight activities:

#### *Gaps in decision-making process*

- The CCM's decision-making process is not always fully informed and inclusive due to procedural gaps. These include:

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<sup>19</sup> <http://www.theglobalfund.org/en/ccm>

- CCM members were given short notice for meetings. For the last two CCM meetings in 2015, CCM members were notified two days ahead of time. Members did not have sufficient time to review the background documents, which were provided only in Russian;
- Not all critical documents were circulated to relevant members. For example, for three of the five meetings in 2014-2015, documents were sent only to “working group” members and not to all CCM members; and
- meeting minutes were finalized on the same day as the meeting with limited time to incorporate members’ feedback in the meeting minutes.

All CCM decisions in 2014-2015 were made unanimously through open voting. However, a number of CCM members told the OIG that anonymous voting might lead to different and more representative voting outcomes.

### *CCM membership*

- The CCM represents most of the Global Fund required constituencies, except that it does not yet include members to represent people who have had TB, and the various HIV key affected populations. These constituencies are currently not represented although the TB grant is the largest among the three diseases. Additionally, MDR-TB is a major challenge in Uzbekistan, and HIV prevention, treatment, care and support for the key affected populations is the priority of the HIV grant. The external performance assessment of the CCM in September 2014 rated it as “partially compliant” with these membership requirements. These were included in the CCM performance improvement plan.

The CCM has not established a process for the membership rotation of civil society organization, NGO and international organization members. The CCM has had a limited change of members from these constituencies, with membership lasting an average of eight years. A rotation policy would promote a decrease in the average membership period and balance the continuity in the CCM with manifest objectivity and change.

### *Limited oversight function*

- The CCM’s oversight function was largely limited to regional oversight visits and did not entail general grant oversight. The Principal Recipients provided narrative grant updates to the Minister of Health. However, the CCM did not monitor grant milestones and key results, which would require it to take high level coordinating actions. For example, the prisons overseen by the Ministry of Internal Affairs have a considerably lower TB treatment success rate than other hospitals in the country. In 2014, the prisons had a 49% success rate compared to 73% in hospitals. This issue has not been reviewed by the CCM, although it has a coordinating role between various sectors and ministries.

The CCM undertakes oversight visits to program sites, covering all 14 regions and all disease components every year. However, the oversight reports reviewed by the OIG were of mixed quality and did not include specific recommendations. The CCM summarized visit results only on an annual basis and only provided Principal Recipients with informal feedback. This could deter critical issues such as drug stock-outs or prevention service accessibility issues from being addressed on a timely basis.

The external performance assessment of the CCM in September 2014 also identified some of the procedural issues noted above and resulted in a CCM performance improvement plan. The implementation of this plan has experienced delays. According to the Global Fund Secretariat progress review in September 2015, only two out of 14 recommendations were confirmed as completed.

**Agreed Management Action 1:** The Global Fund Secretariat will ensure that the CCM Improvement Plan and the governance is strengthened through the following actions:

- development of procedures to require that the CCM Secretariat openly shares information, notifies members of meetings on a timely basis, and includes members' feedback in CCM minutes and decisions; and
- development of procedures for systematic review of grant performance information by the CCM or its Oversight Committee, including following up on key issues.

**Owner:** Head of Grant Management

**Target Date:** 31 December 2016

## 02 Implementation arrangements for the HIV grant

### **The HIV grant requires improved planning and coordination for transitioning towards stability and cost-effectiveness.**

The current HIV grant, which has been extended until 30 June 2016, is implemented by UNDP and its ten sub-recipients, of which the Republican Center to Fight AIDS (RCAIDS) is the main sub-recipient. RCAIDS is in charge of 14 regional AIDS centers and HIV health facility network. The HIV concept note submitted under the new funding model propose RCAIDS as the Principal Recipient. RCAIDS is currently undergoing capacity strengthening following the approval of the capacity-building plan by the Global Fund.

There have been significant issues in the implementation of the current HIV grant, which have resulted in an adverse impact on services to target beneficiaries as well as certain duplication of efforts:

#### Short-term implementation arrangements reducing service coverage

Some grant performance issues and implementation challenges in 2013 led the Global Fund to reject the second phase of the current HIV grant, as well as multiple revisions in the HIV concept note in 2014-2015. As a result, there have been several short-term grant extensions. As per local regulations, every grant extension requires new legal approval of sub-recipient candidates by the local authorities. The short-term extensions have resulted in the need to seek short-term approvals. Waiting for approval from local authorities has led to delays of six to nine months in 2013-2014 and two months in 2015. Such delays contributed to the departure of about one third of outreach workers during 2014-2015 and led to the periodic interruption of services by the sub-recipients, including for up to six months in 2014. Target beneficiaries remained without services such as counselling on HIV transmission, psycho-social support to HIV positive patients, anti-stigma training, and distribution of condoms and syringes.

In 2013-2014, the local authorities did not approve a number of NGO sub-recipient candidates. This limited the access to services of some key affected population groups in certain geographical areas. HIV prevention services were reduced to ten regions for female sex workers and to three regions for men who have sex with men.

#### Delays in disbursements to sub-recipients put the continuity of grant implementation at risk

UNDP's policy of disbursements to sub-recipients was not sufficiently flexible or adapted to the grant implementation environment. In 2014-2015, the sub-recipients received the disbursements with delays between 3 weeks and 6 months. The reasons included:

- the above-mentioned delays in the annual sub-recipient approvals by the local authorities;
- the local authorities require between two weeks and several months to approve the release of the quarterly disbursement to local sub-recipient organizations; and
- NGO sub-recipients' own delays in justifying earlier disbursements.

Due to these reasons and the fact that UNDP made disbursements on a quarterly rather than a bi-annual or yearly basis, and without any buffer funds, the delays were experienced every quarter (except for one bi-annual disbursement in 2014). This had a particularly adverse impact on NGO sub-recipients with no other sources of funds and resulted in salary delays to sub-recipient staff and outreach workers, difficulties in covering running expenses, and delays in training and grant monitoring activities. It contributed also to the departure of about one third of outreach workers during 2014-2015.

### Gaps in coordination and effectiveness

The current grant implementation arrangements have also experienced some coordination challenges. The implementation of the cost-sharing agreement, according to which the government was to provide a total of USD 2 million to UNDP during 2013-2014 for procurement of antiretroviral (ARV) drugs has been delayed for more than a year due to administrative issues. This could lead to drug stock-outs in the health facilities supported by the government.

As UNDP is an interim Principal Recipient, the current grant also presents higher costs for various grant activities, as well as some parallel structures and duplications of efforts between UNDP and RCAIDS.

**Agreed Management Action 2:** The Secretariat, with support of the CCM and both the current and prospective Principal Recipients, will implement a set of intermediate and long-term actions to facilitate the HIV prevention and treatment activities. These will include, in particular:

- ensuring a smooth transition to the revised implementation arrangements under the new funding model, including assessing the capacity of new implementers;
- exploring alternative disbursement arrangements to ensure uninterrupted cash flow to sub-recipients; and
- contracting additional sub-recipients to provide essential services to key populations including female sex workers and men who have sex with men.

**Owner:** Head of Grant Management

**Target Date:** 31 December 2016

## 03 Multidrug-resistant tuberculosis

**The country has not adequately addressed the reasons for its high prevalence of multidrug-resistant tuberculosis.**

Uzbekistan is among the countries that have the highest shares of MDR-TB cases among all TB cases in the country. According to the 2011 TB drug resistance survey, 23% of new TB cases (5<sup>th</sup> highest rank in the world) and 62% of retreated cases (2<sup>nd</sup> highest rank in the world) are estimated to be MDR-TB. From 2005 to 2013, the number of confirmed MDR-TB cases in the country has increased 35 times, though this can also be attributed to improved diagnosis. Approximately 5% of the MDR-TB cases are estimated to be extensively drug-resistant tuberculosis (XDR-TB), and this percentage is increasing.<sup>20</sup>

MDR-TB and XDR-TB are very difficult and expensive to treat, and treatment often results in serious side effects for patients. In 2012, the treatment success rate in the country was 53% for MDR-TB cases and only 13% for XDR-TB cases.<sup>21</sup> Patients with MDR-TB and XDR-TB who are not treated have a high risk of infecting others with these strains of TB.

Previous studies by the WHO, the Global Fund and in-country partners have identified potential factors for this exceptionally high spread of MDR-TB in Uzbekistan. Some of the key factors, also observed by the OIG, include TB treatment service delivery issues, low adherence to treatment by MDR-TB patients, and the practice of combining DOTS methodology with older treatment approaches. For instance:

- a high percentage of TB cases (currently around 85%) are treated in hospitals for prolonged periods, leading to the risk of infecting patients with MDR-TB or XDR-TB, as opposed to home-based treatment that is recommended by WHO and the Global Fund; and
- the existing practice where successfully treated TB patients are periodically readmitted to hospitals for non-DOTS “post-treatment prophylaxis” to avoid relapse of TB in them. However, this practice exposes these patients to the risk of drug resistance or re-infection with MDR-TB or XDR-TB.

Although the national TB program has made some progress in the prevention, diagnosis and treatment of MDR-TB and XDR-TB, it has not revised some of the existing practices in TB treatment that may be counterproductive to the reduction of MDR-TB prevalence in Uzbekistan.

The issues related to the high MDR-TB prevalence were also raised during the TB concept note, review by the Global Fund Technical Review Panel, and are being followed up by the Country Team. These have taken into account in the main objectives of the upcoming TB grant to Uzbekistan as well as in the new regional grant for the Eastern Europe and Central Asia region on strengthening health systems for effective TB and drug-resistant TB control.

**Agreed Management Action 3:** To address the high MDR-TB prevalence in Uzbekistan, the Secretariat will incorporate the necessary actions in response to the Technical Review Panel recommendations in the grant agreement and performance framework.

**Owner:** Head of Grant Management

**Target Date:** 30 June 2016

<sup>20</sup> WHO 2014 Tuberculosis report; [http://apps.who.int/iris/bitstream/10665/137095/1/WHO\\_HQ\\_TB\\_2014.12\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/137095/1/WHO_HQ_TB_2014.12_eng.pdf) ; Multidrug-resistant tuberculosis in Uzbekistan: results of a nationwide survey, 2010 to 2011 (www.eurosurveillance.org)

<sup>21</sup> WHO 2014 Tuberculosis report

## 04 Access to health products

### **HIV and TB programs require solutions for uninterrupted drug supply throughout the supply chain.**

The OIG audit identified stock-outs of a number of significant ARV and TB drugs, which lasted between one to two months and for which drug replacements were not available in five out of ten (50%) treatment facilities visited. Periodic stock-outs of significant drugs were also identified through program monitoring visits and Local Fund Agent reviews. Stock-outs lead to treatment disruptions leading to advanced stages of disease or drug resistance in patients.

One of the key factors that caused the stock-outs was because both the national HIV and TB programs use manual tools for drug quantification and distribution, which require continuous maintenance to ensure the data is up to date. Manual tools are not ideal for monitoring drug stock levels across the country. This issue has been repeatedly flagged by the Global Fund Country Team to in-country implementing partners. The TB program is piloting an automated system only for second line TB drugs. At the same time, the government has not authorized the use of the Global Fund recommended eTB Manager system to manage TB cases. The Ministry of Health is responsible for developing a new health management information system, but the project's funding sources and timelines are not known.

Another contributing factor to stock-outs is the fact that the regional AIDS centers and regional TB hospitals managed drug stocks only for their registered patients but maintained no buffer stocks, although this was required by their procedures. The regional facilities visited by the OIG did not have buffer stocks.

In order to mitigate stock-out risks, the Country Team now requires the Principal Recipients to undertake stock-out risk analysis on a bi-annual basis for the HIV program and on a quarterly basis for the TB program. Those analysis are also reviewed by the Local Fund Agent. However, the unavailability of automated systems together with the absence of buffer stocks are some of the key underlying causes that need to be addressed to minimize treatment disruptions.

**Agreed Management Action 4:** The Secretariat, through support of the Ministry of Health, the Principal Recipients and other program partners, will further streamline uninterrupted ARV and TB drug supply for patients in short and long term. This will include:

- regularly monitoring drug stocks at all levels and exploring the possibility of introducing automatic supply chain management systems; and
- ensuring buffer stocks are used throughout the supply chain, and ensuring that drug orders are based on actual need.

**Owner:** Head of Grant Management

**Target Date:** 31 December 2016

## V. Table of Agreed Actions

| #  | Category                                   | Agreed Management Action   | Target date      | Owner                    |
|----|--|--|------------------|--------------------------|
| 1. | Governance, oversight and management risks | <p>The Global Fund Secretariat will ensure that the CCM Improvement Plan and the governance is strengthened through the following actions:</p> <ul style="list-style-type: none"> <li>• development of procedures to require that the CCM Secretariat openly shares information, notifies members of meetings on a timely basis, and includes members' feedback in CCM minutes and decisions; and</li> <li>• development of procedures for systematic review of grant performance information by the CCM or its Oversight Committee, including following up on key issues.</li> </ul>  | 31 December 2016 | Head of Grant Management |
| 2. | Governance, oversight and management risks | <p>The Secretariat, with support of the CCM and both the current and prospective Principal Recipients, will implement a set of intermediate and long-term actions to facilitate the HIV prevention and treatment activities. These will include, in particular:</p> <ul style="list-style-type: none"> <li>• ensuring a smooth transition to the revised implementation arrangements under the new funding model, including assessing the capacity of new implementers;</li> <li>• exploring alternative disbursement arrangements to ensure uninterrupted cash flow to sub-recipients; and</li> <li>• contracting additional sub-recipients to provide essential services to key populations including female sex workers and men who have sex with men.</li> </ul> | 31 December 2016 | Head of Grant Management |
| 3. | Programmatic and performance risks         | To address the high MDR-TB prevalence in Uzbekistan, the Secretariat will incorporate the necessary actions in response to the Technical Review Panel recommendations in the grant agreement and performance framework.  | 30 June 2016     | Head of Grant Management |
| 4. | Health services and products risks         | <p>The Secretariat, through support of the Ministry of Health, the Principal Recipients and other program partners, will further streamline uninterrupted ARV and TB drug supply for patients in short and long term. This will include:</p> <ul style="list-style-type: none"> <li>• regularly monitoring drug stocks at all levels and exploring the possibility of introducing automatic supply chain management systems; and</li> <li>• ensuring buffer stocks are used throughout the supply chain, and ensuring that drug orders are based on actual need.</li> </ul>  | 31 December 2016 | Head of Grant Management |



## Annex A General Audit Rating Classification

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

## Annex B: Methodology

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

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

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

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

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