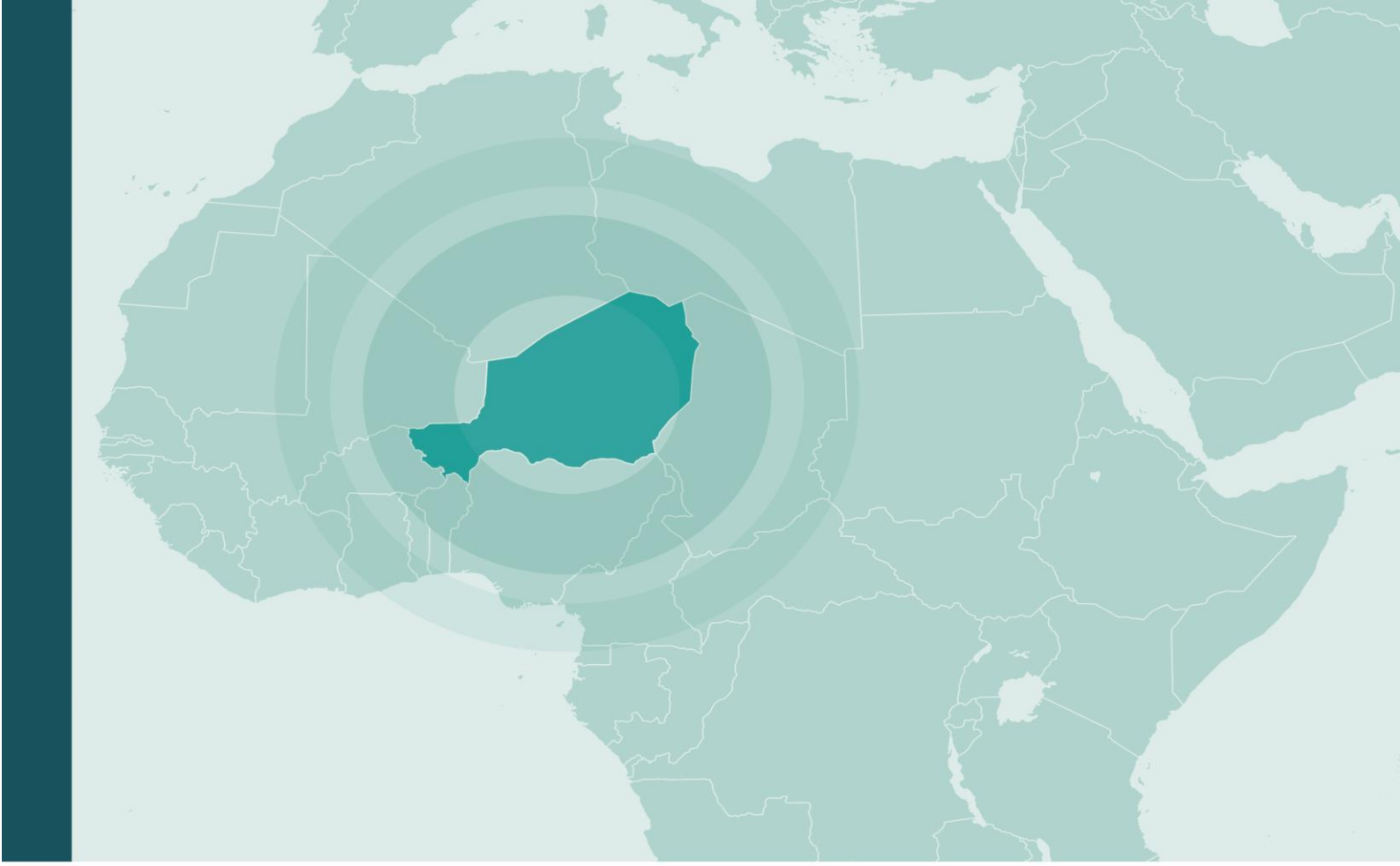

AUDIT REPORT

Global Fund Grants in the Republic of Niger

GF-OIG-23-005
28 March 2023
Geneva, Switzerland

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1. Executive Summary

1.1 Opinion

According to the United Nations Development Program,[1] Niger is ranked among the top three lowest human development scorers in the world. The Global Fund has classified Niger as a Challenging Operating Environment (COE) since 2016 because of its volatile political and security situation. Malaria is endemic and its burden is among the highest 11 in the world while tuberculosis (TB) and HIV have a high burden.[2] In addition to the three diseases, acute malnutrition is a major threat to children in Niger. Despite this challenging context and the recent impact of COVID-19, Niger has made good progress in the fight against the three diseases. In particular, the incidence and mortality rate of malaria and tuberculosis reduced significantly between 2012 and 2021.

The malaria interventions cost, accounting for 59% of the overall New Funding Model Three (NFM3) investment, shows good performance regarding case management, vector control and drug preventive therapy[3] for targeted children, even if assigned targets are not fully met. Of the confirmed malaria cases between 2021 and 2022, 85% were treated according to national malaria treatment guidelines. Other key interventions such as drug preventive therapy for pregnant women still need to be improved. Investigations into the rising number of malaria cases and deaths since 2017 were completed in December 2022. Most planned grant activities for HIV, TB and COVID-19 were only partially or not implemented during the period under review. In response, greater accountability for implementers is needed alongside strengthening of the grant management unit (UGS) within the Ministry of Health. The OIG noted limited progress in improving the quality of HIV services and data reporting since the last audit in 2018. While mitigation measures were identified, implementation has been slow. Implementation arrangements at the Ministry of Health, as well as the design and implementation of key program interventions **need significant improvement**.

Most key health products were available at central and peripheral levels in 2021 and 2022 thanks to improved quantification processes, timely execution of the procurement plan and increased distribution capacity of the central medical store. The level of expiries remains disproportionately higher for HIV commodities compared to the cost of actual ARV needs. Despite investments to improve storage conditions, drug quality could still be compromised because of sub-optimal storage conditions in the main warehouses. Furthermore, inventory management processes are inadequate to ensure visibility on drugs throughout the supply chain. Design and implementation of measures to ensure availability of quality-assured health commodities, efficiency, and accountability across the supply chain is **partially effective.**

Internal controls and assurance mechanisms for Principal Recipients have proved effective in preventing and detecting non-compliant transactions. However, financial absorption by the government Principal Recipient remains low (29%)[4] after 18 months of implementation due to various factors including slow disbursement to implementers, insufficient planning and coordination capacity of the UGS and the long turnaround time for expenditure validation. The Country Team did not leverage enough the financial flexibilities to maximize the use of Global Fund grants. Implementers' financial management system and the assurance mechanism to mitigate financial and fiduciary risks is **partially effective.**

[1] Human development Index report 2021/2022
[2] Global Fund Eligibility list 2022
[3] Refers to the Seasonal Malaria Chemoprevention (SMC). SMC is designed to protect children by clearing existing infections and preventing malaria infections during the season of greatest risk. This is achieved through the monthly administration of antimalarial medicines for as long as the rainy season lasts.
[4] This financial absorption rate refers to the HIV grant which includes C19RM grant, allocated in November 2021.

1.2 Key Achievements and Good Practices

Good performance of malaria program results and significant decrease in malaria burden in the past 10 years

From 2012 to 2021, malaria incidence in Niger reduced by 31% while the malaria case fatality rate reduced by 66% during the same period. Regarding case management, 93% of suspected malaria cases were tested in health facilities and communities from January 2021 to June 2022 and 85%[5] of confirmed malaria cases were treated according to national malaria treatment guidelines. In terms of prevention, vector control interventions also showed satisfactory results with utilization rate for bed nets exceeding 86% and coverage for preventive therapy of children under five at about 74%[6] in 2021. Despite these improvements over the last 10 years, the number of malaria cases and deaths have significantly increased since 2017. The investigations recommended by the Technical Review Panel to identify the root causes for this rise was completed and discussed in December 2022 with stakeholders. Additional analyses are planned to be completed in February 2023.

Availability of key health products enables good case management

In most heath facilities visited, key health products for the three diseases were continuously available from 2021 through to October 2022, except for HIV rapid diagnosis tests, viral load reagents and drugs for severe malaria cases. This achievement reflects the combined effect of improved quantification processes, timely execution of procurement plans and the increased distribution capacity of the central medical store.

1.3 Key Issues and Risks

Limited progress achieved to improve HIV quality of care and data reporting

Data on patients known to be under antiretroviral therapy (ART) is still not reliable due to poor maintenance of patient files. This issue was also flagged in the 2018 OIG audit. A high number of patients are lost to follow up (35% in 2019)[7] due to missing identification and tracking mechanisms in 66% of the health facilities visited. A significant proportion of ART patients (3 of 10 on average) do not observe the requirement of 12 months therapy as per national HIV treatment guidelines, reducing the chance of treatment success. Mitigation measures to improve the quality of service were identified but implementation is behind schedule. For prevention of mother to child transmission (PMTCT), the treatment cascade is poor with less than half of pregnant women tested for HIV in 2021 and 2022. This is due to the government's failure to uphold its commitment to procure rapid tests for HIV diagnosis.

Improvement needed for key components of in-country supply chain

Storage conditions in the warehouses visited did not guarantee drug quality during the audit period. Temperatures in warehouses exceeded the recommended level for at least three months because of non-operational cooling systems at the time of the audit. This could have compromised drug quality that went undetected since quality controls have been absent since the end of 2020. Furthermore, the inventory management process is sub-optimal in central warehouses. The inventory management software (SAGE) used at the central level is not updated to ensure better traceability of drugs and accurate reporting for stock monitoring. Most health facilities are still not reporting the required logistic data, despite training and the provision of collection tools. This reflects weak governance and poor monitoring and supervision, which undermines the accuracy of drug quantification.

Low HIV and TB grant absorption suggests grant activities are either partially, or entirely not being implemented

As of the end of June 2022, the absorption of HIV and TB grants, during the current funding cycle, is low (respectively 29% and 24%) due to various factors including the insufficient capacity of the Principal Recipient to plan and coordinate implementation of the workplan, the slow disbursement of funds from the Principal Recipient (UGS) to implementers,

[5] The treatment rate could be much higher if severe malaria cases (7% on average) are deducted from the number of confirmed malaria cases.
[6] As per SMC campaign 2021 report, 3.2 million children under five were treated across the four rounds against a target of 4.3 million.
[7] Figure from 2019 lost to follow up review report. No reliable information on HIV patient retention rate is available for 2022 / 2021 due to the lack of an identification mechanism for patients lost to follow up in most ART clinics.

unenforced accountability mechanisms and delayed validation of expenditures. At the time of the audit, only some of these root causes were addressed.

1.4 Objectives, Ratings and Scope

The audit's overall objective was to provide reasonable assurance on the adequacy, effectiveness, and efficiency of Global Fund Grants to the Republic of Niger. Specifically, the objectives in the table below were assessed.

Objectives	Rating	Scope
The existing implementation arrangement at the Ministry of Health, as well as the design and implementation of key program interventions particularly: the quality of services and the health information management system.	**Needs significant improvement**	**Audit period** January 2019 to June 2022 **Grants and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund supported programs. **Scope exclusion** TB diagnosis and treatment
The design and implementation of mitigation measures to ensure continuous availability of quality-assured health commodities, efficiency, and accountability across the supply chain.	**Partially effective**	
Implementers' financial management system, as well as an assurance mechanism to mitigate financial and fiduciary risks and to allow efficient implementation of grant activities.	**Partially effective**	

The audit team visited 16 health facilities and hospitals in Niger and four district depots located in three regions, as well as warehouses managed by the central medical store (ONPPC). The regions visited account for 51% of patients under antiretroviral therapy, 38% of notified TB cases and 46% of all malaria cases in the country.

Details about the general audit rating classification can be found in Annex A of this report.

2. Background and Context

2.1 Country Context

Niger is a landlocked country in the Sahel region that, according to the United Nations Development Program, is ranked among the top three lowest human development score in the world.[8] Its population of 25 million people is growing at 4% a year, one of the highest in the world. On average, a woman in Niger has 6.2 children during her lifetime.

The rainy season is short with increasingly irregular rainfall. Rising temperatures, desertification, and ever more frequent climate shocks undermine progress. Epidemics and conflict in three neighbouring countries aggravate Niger's already challenging environment.

These conditions resulted in more than 4.4 million people becoming acutely[9] food insecure during the "lean season"[10] in 2022, representing over 17% of the population. About 6.8 million people are chronically food insecure.[11]

Despite its continuous GDP growth since 2000, GDP contribution to health is relatively low (6% in 2019). The country has a shortage of health workers with 0.04 physicians per 1,000 people against a World Health Organization standard of one per 1,000 people.[12]

Country data[13]	
Population	25.2 million
GDP per capita	US$595
Corruption Perception Index	124 of 180
UNDP Human Development Index	189 of 191
Government spending on health (% of GDP in 2019)	6%

[8] United Nations Development Programme 2021/2022 report

[9] Acute food insecurity is when a person's inability to consume adequate food puts their lives or livelihoods in immediate danger. (Definition by World Food Programme)

[10] The period between harvests that lasts from May to August

[11] World Food Programme Niger

[12] World Bank database, 2016

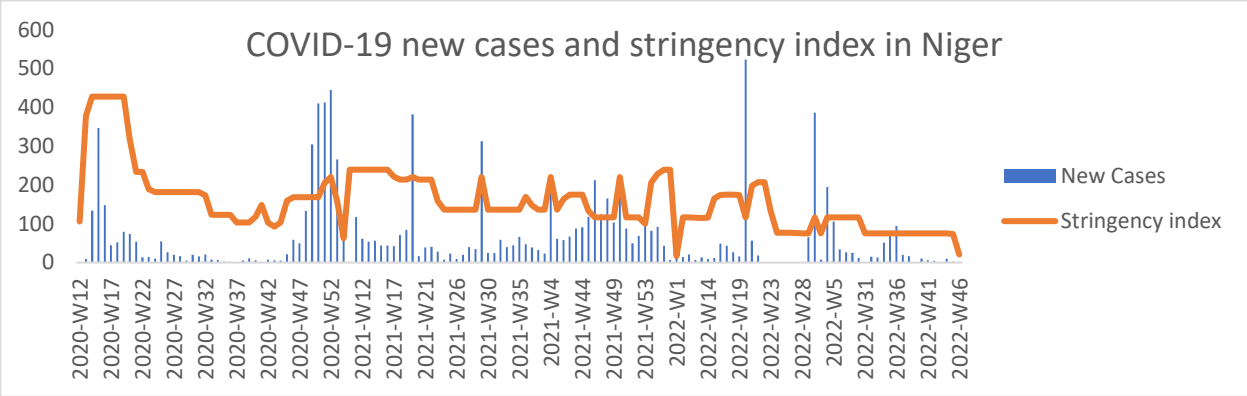
[13] Sources: population, GDP, Health expenditure from World Bank Database; Corruption Perception Index by Transparency International; Human Development Index by UNDP; all accessed on 11 November 2022

2.2 COVID-19 Situation

Since April 2020, Niger has taken stringent containment measures to slow the spread of the virus, including lockdowns and curfews. From the start of the pandemic until 15 July 2022, the case fatality rate stood at 3%.[14]

COVID-19 statistics (11.11.22)
- Confirmed cases – 9.931
- Deaths – 312
- Recovered – 8.890

Figure 1: COVID-19 cases and stringency index[15]



2.3 Global Fund Grants in the Republic of Niger

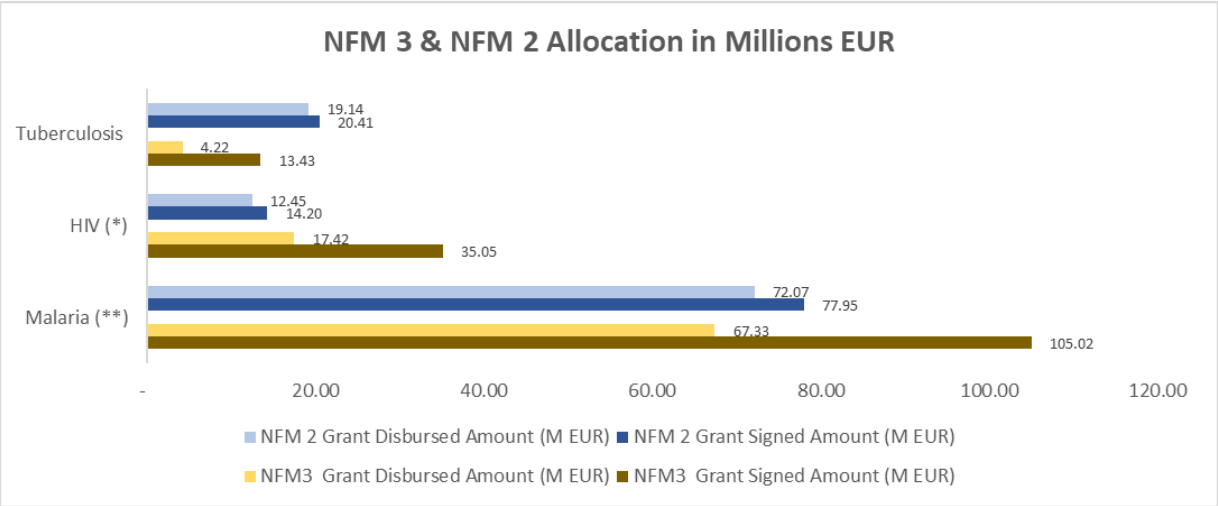
Since 2004 the Global Fund has signed over US$547.87 million and disbursed more than US$462.99 million to Niger as of November 2022.[16] Active grants total €153.50 million[17] of which 58% was disbursed for the 2021 to 2024 funding allocation period.[18]

Disease component	Principal Recipients	Sub-recipients Civil Society	Sub-recipients Public sector
HIV / AIDS	The Ministry of Public Health, Population and Social Affairs	PLAN Niger ONEN RENIP+ SONGES	National AIDS and Hepatitis control program (PNLSH)
TUBERCULOSIS	The Ministry of Public Health, Population and Social Affairs	PLAN Niger ONEN	National TB control program (PNLT)
MALARIA	Catholic Relief Services (CRS) – United States Conference of Catholic Bishops (CRS Niger)	None	National Malaria control programme (PNLP)

[14] University of Oxford Our world in data Accessed on 11 November 2022
[15] University of Oxford Our world in data Accessed on 11 November 2022. Covid Cases numbers: Our world in data
[16] The Global Fund's Data Explorer, accessed on 11 November 2022
[17] All Global Fund grants are signed in USD except for fourteen countries which use XOF/XAF as currency. For these countries, grant amount, disbursement and reporting are made in Euro given that the XAF/XOF is pegged to the Euro.
[18] Figures are from Grant Operating System (GOS), accessed on 11 November 2022.

In NFM3 grant funding, 51% goes towards procuring medicines, health products and equipment. The central medical store is responsible for storing and distributing medicines and health products related to Global Fund grants.

Figure 2: Funding allocations, prior and current funding cycles (as of September 2022)[19]



(*) HIV NFM3 grant €35.05 million is made up of C19RM (€10.82 million), HIV allocation (€15.66 million) and RSSH (€8.57 million). (**) Malaria NFM3 grant (€105.02 million) includes C19RM (€13.89 million) and malaria allocation (€91.13 million).

[19] Figures are from Grant Operating System (GOS), accessed on 11 November 2022.

2.4 The Three Diseases

HIV / AIDS (2021)	TUBERCULOSIS (2021)	MALARIA (2021)
30,000 people are living with HIV as of 2021, of whom 81% know their status and are on treatment.[20] **Annual new infections decreased by 17%** from 1,200 in 2010 to 1,000 in 2021. **AIDS-related deaths decreased by 54%** from 2,200 in 2010 to 1,000 in 2021. **Only 40% of pregnant women** who tested HIV positive received ARVs in 2021. *Source:* UNAIDS – Niger fact sheet (accessed on 16 November 2022)	**Of the 20,136** estimated TB cases, only 64% are notified. **TB incidence has declined** since 2010, from 191 to 79 per 100,000 people in 2021. **Mortality rate has decreased** since 2010, from 58 per 100,000 to 13 in 2021. **Treatment success rate** has remained close to the WHO target of **90%** (84% of new TB cases in 2020 cohort). *Source:* Niger TB country profile 2021 (Accessed on 19 December 2022)	Malaria is **endemic** across the country with peak transmission during rainy season. WHO estimated **8.2m malaria cases** in 2021 (vs 6.8m in 2010), with 3.2m cases treated with ACT (vs. 2.9m in 2018). Malaria rapid diagnosis test is the main method of confirmation with 5.6m tests carried out in 2021 against 1.6m in 2011. Estimated **malaria-related deaths** slightly decreased by 6%, from 26,471 in 2010 to 24,997 in 2021. *Source:* World Malaria Report 2022

[20] The reliability of data on HIV treatment cascade is not confirmed as indicated in finding 4.2

3. Portfolio Risk and Performance Snapshot

Historically, Global Fund grants in Niger have a moderate performance against targets, as shown below.[21]

NFM2 Allocation (2018-2020)

Grant Name	Component Name	PR Name	Total Budget Euro	Grant rating S1 2018	S2 2018	S1 2019	S2 2019	S1 2020	S2 2020	S1 2021	S2 2021
NER-H-CNCTRN	HIV/AIDS	Cellule Nationale de Coordination Technique de la Riposte Nationale au Sida et aux Hépatites	14,203,325	B2	B2	B2	B2	B2	B2	N/A	
NER-M-CRS	Malaria	Catholic Relief Services - United States Conference of Catholic Bishops	77,951,569	A1	A2	B1	B1	B1	B1	N/A	
NER-T-MSP[22]	Tuberculosis	Ministry of Public Health, Population and Social Affairs	20,411,821	N/A		B1	B1	B1	B1	B1	C
Total			**112,566,715**								

NFM3 Allocation (2021-2023)

Grant Name	Component Name	PR Name	Total Budget Euro	Grant rating[23] S2 2018	S1 2019	S2 2019	S1 2020	S2 2020	S1 2021	S2 2021	S1 2022
NER-H-MSP	HIV/AIDS	Ministry of Public Health, Population and Social Affairs	35,049,005	N/A					B1	C5	D5
NER-M-CRS	Malaria	Catholic Relief Services - United States Conference of Catholic Bishops	105,022,607	N/A					A2	B5	B3
NER-T-MSP	Tuberculosis	Ministry of Public Health, Population and Social Affairs	13,432,053	N/A							C5
Total			**153,503,665**								

[21] Blank periods represent different implementation periods between the grants

3.1 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels in key categories covered in the audit objectives with the residual risk based on OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanation of differences are detailed in Annex B.

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit issues
Programmatic and Monitoring and evaluation	HIV: program quality	**High**	**High**	4.1
	Malaria: program quality	**Moderate**	**Moderate**	4.2
Procurement and supply chain management	In-country supply chain	**High**	**Moderate**	4.3
Financial assurance framework and mechanism	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	4.4

4. Findings

4.1 Findings and recommendations from investigation into the increasing number of malaria cases and deaths in Niger need to be addressed to ensure improved impact of interventions in the next funding cycle

The good performance of malaria programs supported by the Global Fund over the last 10 years has helped to significantly decrease Niger's malaria burden. However, the surge in cases and deaths since 2017 needs to be investigated and adaptive measures considered for responding to challenges identified through the investigation.

When WHO identified the 11 countries that bear 70% of the global malaria burden in 2017, Niger was positioned as eighth. All 11 countries were classified as High Burden to High Impact (HBHI) countries[22] to attract additional support and resources in the fight against malaria. Measures are meant to accelerate the reduction of malaria incidence and mortality through enhanced political will, use of data for action and better guidance and coordination.

As an HBHI country, Niger's malaria national disease programme (PNLP) received significant assistance from various technical and development partners. In the current funding cycle, the Global Fund invests more than €91 million in malaria programs, which amounts to 59% of Niger's total allocation.

This support has contributed to the significant decrease in Niger's malaria burden in recent years. From 2012 to 2021, incidence per 1,000 inhabitants decreased by 31%[23] and the case fatality rate[24] fell from 4.8% to 1.47% over the same period. These achievements reflected increased coverage for prevention and case management over time.

Reversing the surge of malaria cases and deaths requires first understanding the root causes

Despite the progress noted above, confirmed and presumed malaria cases increased by 70% between 2017 and 2021 (from 2.8 million[25] to 4.5 million[26]). The number of severe malaria cases also surged by 150% in the same period, while the number of deaths increased by 153%.[27] It is worth noting that this increasing trend in malaria cases and deaths is common in 10 of the 11 HBHI countries.[28]

Considering this rise, the Technical Review Panel (TRP) recommended a retrospective analysis to investigate root causes by end of 2021, but it later granted a one-year waiver due to the COVID-19 context. The investigation was completed and discussed in December 2022. Its outcomes are expected to be leveraged to inform interventions for the upcoming funding cycle.

[22] High Burden to High Impact (HBHI)
[23] Incidence for general population decreased from 282 in 2012 to 195 per 1,000 population at risk (PNLP report)
[24] The case fatality rate measures the proportion of deaths among identified confirmed malaria cases
[25] Malaria world report 2021, page 239
[26] Routine data reported in DHIS 2
[27] From 2,316 in 2017 to 5,849 in 2020 before declining to 4,430 in 2021 – Malaria World Report 2022, page 290
[28] Malaria world report 2021, page xix

While coverage of key interventions is good, impact of drug-based prevention intervention[29] (SMC) for children under five does not show a steadily declining trend in the number of severe malaria cases.

Case management[30] in Niger has shown good performance. About 93% of suspected cases were tested in health facilities and communities, and 85%[31] cases were treated respectively according to national malaria treatment guidelines.[32] These results were possible given the continuous availability of anti-malaria drugs and rapid diagnosis tests at both central and peripheral levels. Malaria data reporting also improved. The completeness of reporting reached 96% in 2022. In the 10 health facilities visited, the quality of reported data was reasonable. Variances between primary source data and reported data do not exceed +/- 5%.

For malaria prevention, Niger primarily relies on bed nets. The latest national malaria indicators survey conducted in 2021 shows good results: bed net use varies between 78% and 90% depending on target population, and 96% of households possess at least one net. Preventive malaria drugs are also provided to children under five years old: 74% received the full required preventive therapy during the 2021 campaign.

Despite this coverage, the number of severe malaria cases for children under five does not follow a steadily declining trend as expected. It increased from 147,983 in 2019 to 189,067 in 2020 and then declined some to 157,693[33] in 2021. Due to the improved quality of data noted in 2020 and 2021, the retrospective analysis could not draw conclusions for the period prior to 2020.

Draft Management Action 1
The Retrospective Analysis has been completed for Niger in December 2022. The impact analysis of SMC has been included in the Retrospective Analysis. The report is available and the information is being used by the CCM and NMCP to inform the next funding cycle's interventions. No further Management Action necessary.
OWNER: N/A
DUE DATE: N/A

[29] This intervention refers to the Seasonal Malaria Chemoprevention (SMC). SMC is designed to protect children by clearing existing infections and preventing malaria infections during the season of greatest risk. This is achieved through the monthly administration of antimalarial medicines, usually sulfadoxine-pyrimethamine plus amodiaquine (SP+AQ), for as long as the rainy season lasts.
[30] Data from the country health information management system (DHIS2)
[31] Specifically, 85% confirmed cases and 97% of confirmed cases were treated from 2021 to June 2022 respectively in health facilities and communities. Cases treated in the communities account for to 5% of overall reported treated cases.
[32] Recorded from January 2021 to June 2022. The treatment rate could be much higher if severe malaria cases (7% on average) are deducted from the number of confirmed malaria cases.
[33] PNLP routine data report

4.2 Limited progress has been achieved in improving HIV quality of care and data reporting

Issues with HIV interventions that the OIG identified in 2018 remain unaddressed. These include unreliable data on ART patients, a high rate of lost to follow up patients, low viral load coverage and the poor cascade of PMTCT. Mitigation measures are planned, but implementation has been slow.

In the current cycle, about 10% (€15.7 million) of Niger's €153 million grants are directly invested in HIV interventions. This reflects the country's low HIV prevalence rate (0.2%) compared to the average for UNAIDS West and Central Africa region (1.3%). Niger has struggled to make further progress against HIV, particularly with case management for HIV patients on treatment. In some areas, the situation has worsened since 2018 when the OIG conducted its last audit.

Quality of HIV care and data needs significant improvement to improve HIV outcomes

The OIG identified the issues below that need addressing to improve HIV outcomes in Niger.

- *Unreliable data of patients under antiretroviral therapy (ART) cohort:* The OIG was unable to reconcile the number of patients in the nine ART clinics visited because patient files were not up to date. In the absence of proper records, it was not possible to classify patients by ARV regimen either. Previous reviews from partners[34] found that the number of patients under ART was overestimated by 35%. These data issues call into question the reliability of data in DHIS2, which the OIG highlighted in its 2018 audit.
- *Ineffective monitoring mechanism to track HIV patients no longer undergoing treatment:* Six of the nine ART clinics visited (accounting for 16% of overall ART patients) lacked a system to identify and track patients no longer undergoing treatment ("lost to follow up"). As a result, a reliable rate of lost to follow up patients (LFTU) for 2021/2022 is not available and it was not possible to determine whether the high LFTU rate observed in the 2017–2018 ART patients' cohort (35%)[35] has improved.
- *Low observance of ARV therapy:* On average, three of 10 patients in the nine ART clinics visited took less than the recommended 12 months[36] of treatment. This lack of adherence undermines the effectiveness of treatment and increases the risk of drug resistance.
- *Low coverage of viral load monitoring:*[37] Less than 15% of patients from the 26 prioritized ART clinics have performed a viral load test during the first semester of 2022. Of those tested, 64% have their viral load suppressed against a UNAIDS target of 95%. The highlighted low viral load coverage reflects weaknesses in the laboratory network and lack of systematic prescriptions for viral load testing by clinicians.

Corrective actions have been planned to address these issues with a focus on the 26 high-volume ART clinics that account for 80% of patients. However, implementation has been delayed. The OIG noted that materials and equipment have yet to be delivered against the agreed deadline for the last quarter of 2021. Similarly, planned supervision as well

[34] Report on the audit of the number of ART patients and stock of health products – 2018 (Expertise France and Solthis)
[35] Report on challenges about ART lost to follow up patients issued in 2019 by the PNLSH (page 14)
[36] ARV therapy is a lifelong treatment which requires daily medication. In practice, patients are provided one-month consumption of ARVs, which are renewed at each monthly consultation.
[37] The HIV viral load monitoring is meant to determine whether the treatment is effective. It enables early and accurate detection of treatment failure before immunologic decline.

as activities to track lost to follow up patients have not started. This is mainly due to delayed procurement processes at the Ministry of Health.

Improvement needed to ensure activities to prevent mother to child transmission have lasting impact

There remains a poor cascade of prevention of mother to child transmission (PMTCT)[38] in programs. The OIG's observations were similar to those in the 2018 audit.

- *PMTCT testing coverage is low:* Less than 25% of pregnant women who came for antenatal consultations were tested for HIV in 2021 and during the first semester of 2022. This is due to recurring stock-out of HIV rapid tests, a prerequisite for successful PMTCT. The Government of Niger is expected to procure tests as part of its co-financing agreement but has failed to meet this commitment since the beginning of the current implementation period (2021 – 2023). After discussions with the Secretariat in October 2022, the Ministry of Health committed once again to procuring HIV tests as soon as possible.
- *Linkage from HIV testing to treatment remains low:* Out of 2,681 pregnant women who tested HIV positive from January 2021 to June 2022, only 40% were put on treatment. This reflects the disruption of services from antenatal consultations to maternity care services, to antiretroviral clinics. Supervisions are also ineffective since they do not cover the cascade and are rather limited to verifying the availability of HIV rapid tests.
- *Coverage of early diagnosis of newborns from HIV positive mothers is low:* Only 3% of those infants exposed to HIV were tested before two months age in the first semester of 2022 due to poor linkages of care between maternity wards and laboratories.

As a result of this weak performance, the rate of mother to child HIV transmission remains high at 26%.[39] A PMTCT strategic improvement plan was developed and agreed with the Global Fund in 2022, but it has yet to be implemented.

Need to strengthen TB/HIV co-infection management to reduce mortality

While the mortality rate of co-infected TB/HIV patients reduced from 19% in 2020 to 14% in 2021, it remains insufficient compared to global targets.[40] About 68% of TB patients who tested HIV positive were put under antiretroviral therapy against a grant target of 98% in 2021. There is currently no system to track TB screening among patients under antiretroviral treatment in Niger.

These challenges reflect insufficient collaboration between the TB and HIV disease programs. For example, the OIG noted irregular coordination meetings. There was only one joint supervision conducted since the beginning of the current funding cycle, as well as a missing coordination framework at the regional level. At the health facilities level, 121 of 262 TB testing and treatment centres (CDT) were trained to manage "one stop shop" services for TB/HIV. While these efforts are substantial, they remain insufficient to improve coverage.

Limited impact of interventions for key populations to significantly reduce new infections[41]

Considering the current estimates for key populations[42] by UNAIDS**,** the coverage of prevention and testing interventions (below 10%) is too low to achieve meaningful impact. In addition, prevention and testing activities for imprisoned populations started in the first semester of 2022, but outreach activities only covered 1% of the targeted population.

[38] Data reported in this section comes from the country health information management system (DHIS2)
[39] UNAIDS fact sheet accessed on 15 November 2022
[40] United Nations Member States committed to reaching 90% of all people with TB with preventive or therapeutic treatment and achieving 90% treatment success for all people diagnosed with TB (https://www.unaids.org/sites/default/files/media_asset/tb-and-hiv_en.pdf)
[41] New infections were stable at 1,100 from 2017 to 2020 before a slight decline to 1,000 in 2021 (UNAIDS website)
[42] These include men who have sex with men, female sex workers and incarcerated populations.

Root causes for this low coverage include the funding gap for prevention activities, the lack of accurate size estimation for key populations across the country, the late normalization of HIV testing outside the capital city (Niamey) and the delayed implementation of an HIV differentiated testing approach.[43]

Draft Management Action 2
The Secretariat in conjunction with the Ministry of Health and partners will ensure that: (a) An ART register that allows for the monitoring the ART cohort, including adherence to treatment, tracking of LTFU and retention in care, specific treatment regimen, etc., is validated and deployed in the high volume ART sites representing over 80% of the cohort. (b) High burden PMTCT sites supported through the strategic initiative TA are strengthened to provide quality PMTCT services through the implementation of a package of interventions including refresher trainings for health providers and PMTCT/HIV focal points on basic integration of PMTCT services in prenatal consultation and mentoring of health providers by a pool of PMTCT mentors.
OWNER: Head of Grant Management Division
DUE DATE: 30 September 2024

[43] HIV differentiated testing aims to increase efficiency, effectiveness and equity, and to find the highest number of positive cases with the lowest number of tests. It helps identify people who, for multiple reasons, do not readily access routine or standard service. It includes self-testing, index testing.

4.3 Niger has made significant progress on drug availability, but key components of its supply chain still need improvement

Most key health commodities were available in the current implementation period, despite challenges with storage conditions at the central level. Better supply chain coordination for HIV products and more sustainable storage for commodities need to be considered to maximize impact and ensure continuity of service.

Niger developed a supply chain strategic plan for 2019-2023 to respond to the challenges identified during the 2018 audit. Implementation has involved technical assistance partners, which has helped to strengthen the capacity of national programmes and to make quantification exercises more robust for the three diseases. Although it should be noted that consumption data is not yet available and HIV data is unreliable.

The procurement of health products for malaria was completed in 2021 and 2022 on a timely basis. The Global Fund and partners strengthened the distribution capacity of the central medical store (ONPPC) by extending its truck fleet from three in 2018 to 15 in 2022. This allowed ONPPC to execute its distribution plan to supply district warehouses and national/regional referral hospitals in a timely manner. Supervision is now carried out more frequently at the peripheral level for commodity management, but quality still needs improvement.

As a result of these combined efforts, key health commodities for the three diseases,[44] with some exceptions,[45] were continuously available since 2021, at both the central level and the 16 health facilities visited. Reviews from other partners[46] with larger samples are in line with the OIG's observations on antimalarial drugs. This is a key achievement that shows significant progress from the 2018 audit when the OIG noted recurring stock-out of health products across the three diseases.

Yet despite this significant progress, improvement is still needed on effectiveness and efficiency of storage, coordination, and oversight of the in-country supply chain for HIV, as well as for logistics data management.

Limited flow of information and coordination in the supply chain for HIV commodities led to expiries and shortages

Strengthening the capacity of the HIV national programme (PNLSH) remains a significant challenge. The quantification process is handled by an international technical assistance partner with limited PNLSH involvement, and product specification errors are still made when using the Global Fund's pool procurement system (Wambo). The supply chain officer in the national programme has access to Wambo and is also approving the quantity of health products to be distributed by the ONPPC to health facilities. However, an effective monitoring mechanism is not in place to monitor ordered products, existing stock levels, or forecasted and distributed quantities of commodities. Without this monitoring mechanism and in the absence of reliable data on the number of ART patients, implementers cannot anticipate potential stock-outs or over-stock. The OIG noted the following issues:

[44] The tracer health products include: the two main first line ARVs supporting at least 80% of ART patients (TDF / 3TC / EFV and TDF / 3TC / DTG), the anti-malaria first line drugs Artemether-Lumefantrine ALu (four formulations), the malaria rapid diagnosis test, the first line treatment of severe malaria (Artesunate injectable 60mg), the two key first line TB drugs (RHZE 150+75+400+275mg and RH 150+75mg).

[45] Exceptions include reagents for viral load reagents, HIV rapid test determine for HIV. Regarding malaria, there was stock-out of malaria rapid test and at least one formulation of anti-malaria drugs in few health facilities but these did not end up in treatment interruption. 70% of visited HF run out of artesunate injectable for at least 30 days due to funding gap for this product.

[46] PMI end user verification report: On day of visit in February 2021, 98% of 65 surveyed health facilities had at least one anti-malaria drug formulation and 14% were out of stock of malaria diagnosis rapid test.

- Shortage of four key ARVs (less than one month consumption)[47] were observed at both the central level and in most health facilities visited. This could lead ART clinics to inappropriately shift patients from one ARV regimen to another, increasing the risk that patients do not properly observe treatments.
- ARVs worth US$1.2 million expired between 2020 and 2022. This amount represents 29% of ARVs procured in the previous funding cycle (2018-2020). One type of ARV[48] accounts for 46% of the value of expiries. This is partly due to the transition to a new ARV regimen in line with WHO recommendations.

Limited consideration for the sustainability of warehouse investments and persistently inadequate storage conditions

In the past, health products were kept in ONPPC warehouses that did not guarantee adequate storage conditions. As an alternative solution, some malaria health products and all TB and HIV commodities are currently stored in privately rented warehouses that are undergoing renovation. While the OIG noted some improvement in the storage conditions, two issues still require attention.

- *High temperatures*: Due to non-operational cooling systems, temperatures in warehouses exceeded the recommended 30°C level for at least three months. Temperatures were not systematically measured and monitored, and deviations from the recommended threshold were not acted on. This could have compromised drug quality that went undetected given that quality controls have been absent since end of 2020 and contracting was delayed for the WHO-approved lab to carry out tests. Spoiled drugs can lead to treatment failure and significant side effects for patients.
- *Sub-optimal inventory management:* SAGE is the electronic inventory management system used by ONPPC, the central medical store. Data in SAGE is often obsolete due to issues around the continuous availability of internet connectivity. From a sample of records, the OIG noted that it took between three and six months to post issued inventories in SAGE. As a result, ONPPC is unable to generate accurate and complete stock analysis. The warehouse management strategy, "First Expiry First Out," is not systematically respected while issuing products to health facilities. This increases the risk of expiries. In other instances, products close to expiry date (less than 10 days) were distributed to health facilities without adequate notification of this risk.

At the end of September 2022, the Global Fund invested up to €1.08 million to rent and renovate private warehouses. This is because the central medical store's warehouses are not operational despite a renovation attempt in the previous funding cycle. While the OIG does not question the current storage investment approach as a short-term solution, it is worth noting that it does not support the strengthening of the existing weak health system in the long term. Discussion is ongoing between the Global Fund Secretariat and in-country stakeholders, but a decision is yet to be made on the strategy to move from the temporary storage solution to a more sustainable option, such as the acquisition of a government-owned warehouse. Furthermore, the Global Fund is putting in place a new contracting model to allow the billing of incurred costs by the ONPPC, which is responsible for managing the rented warehouses.

Limited availability and use of logistics data

Niger continues to struggle to improve the visibility of stock levels and consumption data at peripheral levels due to its dysfunctional logistics information management system (LMIS). Despite training and distribution of LMIS tools, data collection from health facilities remains ineffective. This failure is due to multiple factors including the lack of a centrally accountable LMIS team in Niger's Directorate of Pharmacy and Traditional Medicine (DPMT) to coordinate and monitor LMIS implementation. The DHIS2[49] is also not leveraged to collect logistics information even though a module is available for this purpose. Of the visited health facilities, 86% did not regularly record stock information for

[47] This includes the ARV Dolutegravir/Lamivudine/Tenofovir (TLD) which is replacing the molecule used for treating about 80% of HIV patients, two newborn ARV prophylaxis (Nevirapine and Zidovidune) as well as a second line ARV (Lopinavir/ Ritonavir)
[48] Tenofovir/ Lamuvidine/Efavirenz 300/300/600mg
[49] DHIS2 is an open source, web-based platform most used as a health management information system (HMIS).

all products in 2022 due to various contributing factors including limited staffing. Up-to-date records are necessary for effective stock monitoring, timely fixes to stock-outs and an accurate quantification process.

Draft Management Action 3
The Secretariat will work with the Ministry of Health, partners and implementers to: (a) Set up a Logistics Management Unit within the MoH's Directorate of Pharmacy (currently being moved into a newly established Pharma Regulatory Agency) to strengthen governance and supervision of the LMIS monitoring HIV program commodities management. (b) Address identified gaps in storage conditions and inventory management at central level.
OWNER: Head of Grant Management Division
DUE DATE: 30 June 2024

4.4 Niger needs to improve its grant absorption rate and leverage COE flexibilities across the portfolio

The internal control system and the Global Fund's assurance mechanisms for Principal Recipients are effective in preventing and detecting transaction and procurement irregularities. However, the financial absorption of grants remains low after 18 months of implementation and COE flexibilities are not sufficiently leveraged.

Overall, both Principal Recipients enforce adequate financial management processes and procedures. In addition to the assurance provided by the Local Fund Agent (LFA) and external auditors, the Global Fund has appointed a Fiscal Agent to perform prior and post verification on 100% of transactions and to observe procurement processes in the Grant Management Unit.

As part of this audit, the OIG verified 35% of expenditures[50] incurred from January 2019 to June 2022 and did not identify material gaps. This result confirms that the internal control systems and assurance mechanisms of Principal Recipients are working well enough to prevent and detect irregularities on procurement and expenditure.

There is room for improvement, however, in the Grant Management Unit (UGS) within the Ministry of Health. Specifically, the archiving system for supporting documents is inadequate. Regarding promotion of ethical behaviour and fraud awareness communication, draft policies exist but they are still pending final approval.

Low financial absorption for government grants slows down the implementation of grant activities

Catholic Relief Services, the civil society Principal Recipient, recorded financial absorption of 80% for malaria/C19RM from January 2021 to June 2022. The government Principal Recipient absorbed just 37% of allocated funds (HIV and RSSH interventions) during the same period. For the tuberculosis grant which started in January 2022, financial absorption was 24% in the first six months of implementation. The absorption of C19RM, including the HIV grant, is much lower at 5%. This low absorption suggests that grant activities have experienced delays or are not implemented at all. The OIG saw evidence of this during the audit, as outlined below:

- *Delayed implementation of the 26 HIV high volume sites project*. This could have accelerated the improvement of quality of service to 80% of patients under antiretroviral therapy (see finding 4.2).

- *Activities meant to strengthen the laboratory network were not implemented on a timely basis*. These are key to increasing the low coverage of HIV viral load monitoring and early infant diagnosis. as well as to improve PMTCT performance.

- *Delayed implementation of HIV differentiated testing*. This could have raised the rate of tested key populations, thereby helping to identify new HIV cases and reduce their risk of infection.

- *Rehabilitation of three regional warehouses has not started*, which could have improved drug storage conditions.

In terms of root causes, the insufficient capacity of the UGS to plan, monitor and coordinate the implementation of its annual workplan has contributed to the low absorption. The workplan is not specific about the target timelines and does not contain key information to allow proper monitoring. Coordination with implementers is also challenging in the absence of defined accountability and the lack of a framework to identify and address bottlenecks on a timely

[50] The OIG sample does not include transactions already identified

basis. Significant delays were noted in the procurement of non-health products and services: 96% and 63% of planned procurements respectively in 2022 and 2021 were either not or only partially executed with a value of €5.6 million. The OIG noted that procurement processes took up to 10 months for completion in some instances. The lack of a procurement specialist in the UGS since March 2022, and the poor performance of the former specialist contributed to these delays. The OIG also noted delayed submission of terms of reference from implementers to trigger the procurement process.

COVID-19 travel restrictions prevented the Country Team from better assessing implementation bottlenecks and identifying mitigation measures in a timely manner. For example, it took almost 15 months for the Secretariat to propose a solution to address the slow disbursement of funds to sub-implementers,[51] one of the main contributors to low absorption.

The validation of expenditures is time-consuming and impacts fund absorption. The OIG found that 60% of expenditure or request for payments submitted every quarter by the UGS could not be approved by the Fiscal Agent on the first Principal Recipient submission. Most are due to incomplete or inconsistent supporting documents, which can take up to two months for implementers to address and to get the payment validated. No remediation plan had been proposed by any of the parties involved at the time of the audit. While Fiscal Agent oversight is key to managing fraud risks in the country, the approach needs to be risk-based and carefully balanced against delivery risks.

Financial flexibilities could be further leveraged

Countries with Challenging Operating Environment52 status, like Niger, may benefit from certain grant flexibilities that can be granted by the Global Fund, including a differentiated approach for supporting document requirements and procurement within the country. Given the known insecurities and challenging conditions in some areas, further leveraging of these flexibilities could improve timely implementation of activities in certain areas.

Draft Management Action 4
The Secretariat will work with implementers to define KPIs at the level of the MoH PMU to monitor the efficiency of financial and non-health procurement processes.
OWNER: Head of Grant Management Division
DUE DATE: 30 April 2024

[51] These include sub-recipients and Ministry of Health entities, central and regional directorates.
[52] The Challenging Operating Environments policy (COEs) aims at improving effectiveness in COEs through innovation, increased flexibility and partnership.

Annex A: Audit Rating Classification and Methodology

Effective	**No issues or few minor issues noted**. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	**Moderate issues noted**. Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Needs significant improvement	**One or few significant issues noted**. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met.
Ineffective	**Multiple significant and/or (a) material issue(s) noted.** Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised**.**

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing 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 documents help safeguard the independence of the OIG's auditors and the integrity of its work.

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 is used to provide specific assessments of these different areas. 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.

Annex B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which fall within the Audit's scope. In addition, a narrative explanation is provided every Time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Niger: comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit rating except for supply chain. The OIG rating (moderate) considers the ultimate goals of supply chain which are around quality assured drugs availability, efficiencies and accountability. Based on OIG findings in the report, these three objectives are not severely compromised.