THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Audit of Global Fund Grants to the Republic of Chad

Report

GF-OIG-10-017
11 December 2012

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EXECUTIVE SUMMARY

Introduction

1. In November 2010, the OIG undertook an audit of Global Fund grants to the Republic of Chad as part of its 2010 work plan. The purpose of the audit was to assess whether Global Fund grant funds had been used wisely to save lives in Chad and to make recommendations to strengthen the management of the grants.

2. This audit covered Global Fund grants to Chad for the period of March 2008 to October 2010. Supporting documentation was not available from transactions prior to 2008 because all hard copies and electronic files were reportedly destroyed in an attack related to the country's civil war in February 2008. The Audit therefore covered 56 percent (USD 17,616,000) of the total USD 31 million disbursed by the Global Fund under Rounds 2 and 8 TB, Rounds 3 and 8 HIV/AIDS, and the Round 7 Malaria grant.

Overall conclusion

3. The audit highlighted areas with significant scope for improvement in financial management and procurement and supply management. Oversight by the Local Fund Agent and the external auditor requires an innovative approach to address Chad's lack of basic infrastructure. There had been limited programmatic achievement at the time of the audit because malaria program implementation had only recently begun and the November 2006 suspension of the HIV/AIDS and TB programs had been lifted only in August 2007.

4. Based on the findings in this audit, the OIG is not able to provide the Global Fund Board with reasonable assurance over the effectiveness of controls in place at the time of the audit to manage the key risks impacting the Global Fund-supported programs and operations.

Grant Management

5. Drug logistics and distribution were hindered by Chad's lack of basic infrastructure at the provincial and district levels. Internal controls such as adequate accounting systems and procedures, bank reconciliation processes, and asset management require important capacity input with respect to Principal Recipients UNAD and AMASOT.

Grant Oversight

6. The Local Fund Agent, the Swiss Tropical and Public Health Institute, should pay increased attention to analyzing the root cause of problems faced by the program and provide innovative suggestions and recommendations. The LFA needs to strengthen its capacity to oversee the financial management and procurement and supply management of the programs.

7. The Country Coordinating Mechanism (CCM) meets minimum oversight expectations and shows room for improvement.

Service Delivery

8. The current context of health service provision raises several areas for improvement that transcend the Global Fund-supported grants but affect their implementation and management. Three main areas of need for greater capacity stand out.

9. The health care system should be able to deliver quality patient care and ensure systematic and professional follow-up. To achieve this, the health care system needs strengthening to prevent: Systemic stock-outs or near-stock-outs of drugs, tests and laboratory reagents; low adherence to TB and AIDS treatment; and insufficiently decentralized services.

10. The health care system should be able to provide drugs and bed nets that are high quality and affordable to the consumer. At the time of the audit, storage and distribution needed greater quality controls and prescriptions were not always in line with protocols and were subject to user charges.

11. The health care system should be able to assure coordinated interventions after community sensitization. At the time of the audit, there was scope for improvement in the long-lasting insecticidal net distribution arrangements.

12. The PRs, together with their SRs, should draft a transition strategy for handing grant programs to the state that includes clear milestones for capacity building. There is a need for substantial additional technical assistance, which should preferably be hands-on and in-country.

Events Subsequent to the Audit

13. In June 2012, the external audit reports on the malaria Sub-Recipients (Programme National de Lutte contre le Paludisme and the Centrale Pharmaceutique d'Achat) for the period March 2009 to September 2010 was made available to the Global Fund Secretariat. The Global Fund Secretariat has asked UNDP, the Principal Recipient for malaria, to cease all disbursements to these Sub-Recipients pending clarification and resolution of the issues noted in the audit reports.

14. The Chad CCM informed OIG that since the OIG debrief meeting on 30 November 2010, there has been much progress achieved in relation to the OIG draft report observations and recommendations such as:

- Strengthening the supervision of funding provided to the SRs, revision of the procedures manuals of the 4 PRs, and establishment of a capacity building process;
- A small team was set up under the supervision of the CCM to resolve the issues regarding the synchronization of management software;
- The reliability and quality of data has been improved through the review of tools to collect data (registers, sheets, cards, etc); the setting-up of a tool for data processing centrally; a better organized verification of quarterly reports and the training of agents to use the new tools during supervision;
- In order to avoid shortages of drugs and other health products, corrective measures were taken by transferring the anti-TB stock management from NTP to CPA, training of PRA managers on the management of anti-TB materials; forecasting the purchase of anti-TB materials in the state budget; strengthening of the logistics capacity of the CPA through the purchase of a refrigeration vehicle and the enlargement of warehouse; improving follow-up of medicine ordering through phone-calls; continuing training during supervision and the review of the NTP Technical Guide with a treatment outline of six months;
- In order to solve the issue of uncertainty over the number of patients under ARV which included deceased, missing or transferred patients, improved data-collecting tools had been developed and used since 2011. Staff had also been trained to use these tools.

15. The OIG has not yet validated the success of these initiatives.

16. Recently, a suspected case of fraud has been reported and has been referred to the investigations unit of the OIG.

MESSAGE FROM THE GENERAL MANAGER

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

10 YEARS OF IMPACT

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MESSAGE FROM THE GENERAL MANAGER

I would like to thank the Office of the Inspector General for its thorough and insightful work on the audit of Global Fund grants to the Republic of Chad.

The audit was carried out in November 2010 and covered Global Fund grants to Chad for the period of March 2008 to October 2010. The Audit covered 56 per cent (US$17,616,000) of the total US$31 million disbursed by the Global Fund. Supporting documentation was not available from transactions prior to 2008 because all hard copies and electronic files were reportedly destroyed in an attack related to the country's civil war in February 2008.

Programmatic achievement at the time of the audit was limited because malaria program implementation had only recently begun and the November 2006 suspension of the HIV/AIDS and TB programs had been lifted only in August 2007.

The audit highlighted areas with significant scope for improvement in financial management and procurement and supply management. Oversight by the Local Fund Agent and the external auditor requires an innovative approach to address Chad's lack of basic infrastructure. The report makes 28 recommendations, 7 of them categorized as Critical, for action by management in the areas of oversight, financial management, procurement and supply chain management, and program implementation and service delivery.

In June 2012, the Global Fund Secretariat asked the United Nations Development Programme (UNDP), the Principal Recipient for malaria, to cease disbursements to two Sub-Recipients pending clarification and resolution of issues raised in external audit reports. The Country Coordinating Mechanism for Chad has informed the Office of the Inspector General that following a debriefing in November 2010 it has made progress in response to recommendations in a draft of the audit report. Actions taken include strengthening supervision of funding given to Sub-Recipients, revisions of procedures manuals for the 4 Principal Recipients and the establishment of a capacity-building process.

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

Yours sincerely

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM

The CCM did not submit an overall message for inclusion in this report. However, the CCM's response to the recommendations offered forms an integral part of the management action plan (Annex 3).

OVERVIEW

Audit Objectives

17. The purpose of the audit was to assess whether the Global Fund grant funds have been used wisely to save lives in Chad. The objectives of this audit were to assess the adequacy and effectiveness of the controls in place to ensure:

- Achievement of value for money from funds spent;
- Accomplishment of programmatic objectives including quality of service provision;
- Compliance with Global Fund grant agreements, related policies and procedures, and relevant laws and regulations;
- Safeguarding of grant assets against loss, misuse or abuse; and that
- Risks were effectively managed.

In undertaking this audit an important focus was to identify opportunities to strengthen grant management.

Grant suspension in 2006

18. In November 2006, the Global Fund had suspended its Tuberculosis Round 2 and HIV Round 3 programs due to serious financial irregularities and mismanagement discovered by the Global Fund Secretariat during a mission to Chad in November 2006. External and internal audits of the PR for both programs, the Fonds de Soutien aux Activités en Matière de Population (FOSAP), raised similar concerns. The suspension was followed by a forensic investigation conducted by an audit firm under the supervision of the OIG.

19. The investigation reviewed the Central d'Achat Pharmaceutique (CPA) and the Hôpital General de Reference Nationale (HGRN) and concluded the following:

- The full cost of the administrative charges imposed by the CPA was not openly and transparently disclosed to FOSAP. As a result, FOSAP had to bear a disproportionate amount of the total cost of administrative expenses incurred by the CPA;
- The prices paid to the CPA by FOSAP for pharmaceutical supplies were inflated, on average by 40 to 50 percent, which amounted to a cumulative loss of USD 240,000 to the programs or approximately 25 percent of the total value of pharmaceutical supplies procured from the CPA;
- There was strong evidence to suggest that the lack of adequate controls and financial accounting systems at the HGRN resulted in mismanagement of Global Fund resources; and
- There was a high probability that pharmaceutical supplies were double counted and simultaneously reported as supplies purchased for the Global Fund and for other customers of the CPA. This was rendered possible by the lack of adequate controls in accounting for stocks.

20. In May 2007, the Global Fund informed the CCM and government of Chad of the results of the investigation and the requirements that needed to be met for funding to continue. These included: 1) Recovery of misused funds from the National AIDS Program (PNLS), the CPA and HGRN; 2) Improvement of CCM capacity; 3) Clarification of the relationship between FOSAP and the CCM; 4) Disbursement through a fiduciary agent; and 5) LFA assessment of the CPA prior to any contract being signed between the PR and the CPA. In August 2007, the suspension was lifted.

21. OIG follow-up on these conditions showed that four of the five had been fully implemented. The OIG noted that the LFA assessment of the CPA was done a few weeks before the audit started rather than before the contract was signed with the CPA. The assessment did not include a review of the contract between the CPA and the PR.

Grant Portfolio and Institutional Arrangements

22. As of the time of the audit, the Global Fund had approved USD 96 million in funding to Chad, with USD 31 million having been disbursed. The Global Fund grant portfolio in Chad was as follows:

Diseases	Round	Principal Recipient	Amount Committed, USD	Disbursement, in USD	Status
HIV/AIDS	3	FOSAP	17,783,344	13,385,483	Phase II
	8	FOSAP	21,465,096	3,759,141	Phase I
	8	AMASOT	6,088,779	1,966,605	Phase I
	8	UNAD	7,297,019	1,071,190	Phase I
TB	2	FOSAP	3,039,321	2,398,019	Phase II
	8	FOSAP	4,123,130	432,442	Phase I
Malaria	7	UNDP	10,477,631	8,341,280	Phase I
Total			**70,274,320**	**31,354,160**	
	9	UNDP	26,107,482	18,843,262*)	Signed Nov 2010
			96,381,802	50,197,422	

*) This amount was disbursed on 11 November 2010 therefore it was not included in the audit scope.
[Table 1: Source Global Fund Web Site, November 2010]

Scope and methodology

23. The audit covered all Global Fund grant programs in Chad with respect to their management, governance and operations, including the PRs, the CCM, the LFA, Sub-recipients (SRs) and other entities involved in implementing the programs.

24. The OIG chose to review FOSAP as PR for the Round 3 and 8 HIV/AIDS and Round 2 and 8 TB programs, as well as two of its SRs. The OIG reviewed two Principal Recipients for Round 8 HIV/AIDS, the National Union of Diocesan Associations (UNAD) and the Association of Social Marketing in Chad (AMASOT). These did not have SRs at the time of the review. The audit of the United Nations Development Program (UNDP) as PR for the Round 7 malaria program was carried out separately by UNDP's internal audit department, but the OIG selected two SRs for review, the CPA and the National Malaria Program (PNLP).

Audit scope limitation

25. The OIG review covered the period from March 2008 to October 2010. Supporting documentation, including financial documents, was not available for transactions prior to 2008 as it was destroyed in the civil war in February 2008.[1] The missing documentation (i.e. expenditure vouchers) included Round 2 TB and Round 3 HIV/AIDS totaling USD 7,482,200 or 47 per cent of the total disbursement for these 2 grants.

26. The review did not include expenditures incurred by UNDP, which represented 75 percent of the total grant funds disbursed under the Round 7 malaria grant, i.e., USD 6,255,960.

27. This audit therefore covered USD 17,616,000, or 56 percent of the USD 31 million in total Global Fund disbursements to Chad as of the date of the audit. The OIG sampled an average of 20 percent of total expenditures for each entity selected for review.

Prioritization of Audit Recommendations

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

29. The recommendations have been prioritized as follows to assist management in deciding on the order in which recommendations should be implemented:

- **Critical:** There is a material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization interests, erode internal controls, or jeopardize the achievement of aims and objectives. It requires immediate attention by senior management.
- **Important:** There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.
- **Desirable:** There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of good practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

30. This report presents detailed audit findings and a total of **28** recommendations categorized as **Critical (7)** and **Important (21)** for action by management in the areas of oversight, financial management, procurement and supply chain management, and program implementation & service delivery. Recommendations classified as "Desirable" have been provided in a separate management letter and they do not feature in this report.

[1] See mission report of FPM dated September 2010 and letter of acknowledgment from local authorities.

OVERSIGHT AND GOVERNANCE

Background

31. As part of the Global Fund grant architecture, Global Fund-supported programs are overseen by a CCM in each country. Principal Recipients are responsible for overseeing their SRs. The LFA provides assurance to the Global Fund Secretariat on the implementation of grant programs. The Global Fund Secretariat relies on these oversight arrangements being effective to properly manage the Global Fund grants.

Country Coordination Mechanism

32. The OIG observed good practices on the part of the CCM, such as independence of the CCM Chair, active participation by civil society, a high level of commitment on the part of the CCM Secretariat, transparent processes for the preparation of meeting minutes and independent review of PR candidate capacity for Round 10 based on lessons learned from Round 9.

Roles of the CCM

33. The CCM was successful in its proposals to the Global Fund for Rounds 2, 3, 7, 8 and 9, with the total amount of approved funding for these programs coming to USD 96 million. Furthermore, the CCM has performed its roles of regular oversight and suggested actions for improvement.

34. The OIG attended some CCM meetings and observed that civil society organizations actively participated in discussion. The OIG also noted excellent contribution of the established expert subcommittees in decision making. However, the OIG also noted that in some cases, expert subcommittee recommendations were rejected by the CCM.

35. The CCM Secretariat worked well given its limited staff resources. The CCM meeting minutes were well elaborated and organized.

36. The following aspects of CCM governance had scope for improvement:

- The CCM should continue to strengthen PR management capacities and to elaborate strategic plans for the improvement of capacity of potential PRs;
- The CCM should take a more active oversight role regarding actions taken by the existing PRs to avoid stock out and expired drugs, drug procurement and distribution, SR managements, PR budgets and reporting mechanisms;
- The CCM should strengthen its conflict of interest policy. Some of the CCM members are representatives of PRs or SRs and the CCM Chair also acts as Minister of Health;
- Due to the increase in the number of PRs, there is a need to establish a PR coordination committee, supervision or field visit plans and a PR monitoring tool and communication strategy;
- The CCM manuals are in place but need to be updated and further socialization of CCM members to have a clear understanding of the CCM manual is advisable;
- Coordination and collaboration should be strengthened with other health partners that are not involved in Global Fund program implementation;
- The current practice of selection of SRs by the CCM should be reconsidered;
- The CCM should ensure funding for the CCM Secretariat from the Global Fund and other sources;
- Clear terms of reference (TOR) and task distributions for new CCM Secretariat staff should be established; and

- The CCM should conduct a self-assessment regularly.

Recommendation 1 (Important)
The CCM should:
a) Strengthen program oversight with respect to procurement and supply management, specifically procurement, stock and distribution of drugs, regular field visits, data collection and monitoring, PR management of grants and the development of an action plan to strengthen PR capacity;
b) Reduce the risk of conflicts of interest by ensuring that the PRs and SRs do not have a role in CCM decision making with respect to their own activities and by ensuring that the decisions of the CCM Chair are not influenced by his role as Minister of Health and supervisor of the three national disease programs;
c) Consider involving the PRs in the selection process of the SRs, as they will be accountable for the actions of the SRs;
d) Secure the strong commitment and support of development partners and strengthen collaboration with health partners that are not involved in the Global Fund programs; and
e) Update the CCM procedural manual on a regular basis and develop a PR monitoring tool and communications strategy.

Recommendation 2 (Important)
The CCM should mitigate the risk that the role of expert subcommittees will be undermined by the strong influence of particular groups with representation on the CCM. This could be achieved by, for example, delegation of decision-making authority to the expert groups based on their expertise.

Local Fund Agent

37. Swiss TPH has been the LFA since the inception of the first grants to Chad in March 2004. Swiss TPH had reviewed 53 progress update/disbursement reports (PU/DRs), conducted 38 PR assessments and undertaken 10 on-site data verifications (OSDVs). The extensive OIG investigation of the Chad grant portfolio in 2006 was initiated as a result of a thorough review by the LFA of the external and internal audit reports.

38. The LFA has regularly provided recommendations to improve program implementation to the Global Fund, but there is no evidence to establish that these recommendations have been implemented by the PRs due to the absence of a sufficient monitoring mechanism. There was no system in place to verify that all LFA recommendations were followed up and that any action taken was reported. Important LFA recommendations were not promptly followed, such as the LFA's repeated observation of the need for technical assistance in-country.

39. This OIG audit showed that weaknesses in PR and SR internal controls that were previously identified by the LFA continued to exist. This indicates insufficient follow-up by the PRs and/or the Global Fund Secretariat. However, the OIG did not see evidence that the LFA tried to establish why the recommendations were not implemented or identified the root causes of the recurrent problems identified. The LFA did not use a risk-based approach to oversight, or proactively provide guidance on how to implement solutions to the shortcomings noted.

40. The LFA did not fully review the role of the fiduciary agent with respect to the transfer of competence to the PR. The OIG also observed that implementation of Conditions Precedent (CPs), for example those related to SR capacities, were not adequately assessed.[2]

41. The LFA finalized its risk assessment[3] to identify priorities only after the audit was completed. The LFA informed the OIG that the Global Fund Secretariat had not asked for this to be done previously. In the absence of a country risk assessment, the LFA could not have identified issues arising from weak country infrastructure and lack of capacity to implement the program.

42. The OIG reviewed the report of the LFA review of the UNAD PU/DR for Quarter 3 of 2010. The OIG noted an improvement in the LFA's approach in its review of this assessment.

Recommendation 3 (Critical)
Given the complexity of the LFA's role in Chad, the Global Fund Secretariat should:

a) *Ensure that the current LFA has adequate capacity to oversee grant implementation, in particular in the areas of financial management and PSM; and*
b) *Request that the LFA reassess the minimum internal control requirements for the existing PRs and SRs.*
c) *Ensure that the LFA prioritizes the review of the capacity-building processes.*

Role of development partners

43. Most of the development partners are CCM members. The OIG observed that developments partners played significant roles in supporting Global Fund program implementation, including strengthening of the CCM, and providing technical assistance to PRs for implementing Conditions Precedent.

44. The main concern of development partners is the need for the Global Fund Secretariat to understand the country context, such as the lack of PR capacity to meet Global Fund requirements.

The Global Fund Secretariat

45. Overall, the Global Fund Secretariat has done well in overseeing grant implementation. It has undertaken regular visits to the country and provided regular feedback. However, the OIG observed some scope for improvement in communication.

46. Most of the country stakeholders that the OIG interviewed did not fully understand the Global Fund's Additional Safeguards Policy (ASP)[4] and as a result, felt that the Global Fund Secretariat imposed its own requirements in contradiction of the principle of country ownership; for example, the Global Fund's appointment of UNDP as PR for Round 9 in spite of the CCM's initial disagreement. The LFA's evaluation revealed the weaknesses in

[2] For example, for Round 3 HIV, the LFA was asked to review the CP related to the disbursement of funds to SRs in order to establish whether there was evidence of satisfactory staffing, competences and capacities as well as the existence of appropriate and robust financial management systems at the SR level. The LFA concluded that the CP was fulfilled but the OIG audit showed that there was a serious lack of capacity at SR level, in particular at Ministry of Public Health SRs.
[3] The formal Global Fund risk assessment tool was in place only from September 2010. The LFA, upon Secretariat request, completed the risk assessment for the four PRs in February 2011.
[4] For details on this policy, please see the Global Fund's "Core Operational Policy Manual, available on-line. The ASP is explained on pp.139ff. At the time of the audit, ASP had been invoked due to the on-going tension at the time of Round 7 grant signing and significant concerns about governance. Furthermore, the LFA's assessment of the PRs proposed by the CCM determined that UNDP was the only entity with adequate capacity to implement the programs. In the application of ASP, the Secretariat decided to appoint UNDP as PR for the malaria grants.

programmatic and financial management capacities of the proposed PR for Round 9. Therefore, the CCM with support from the Global Fund Secretariat, finally decided to select UNDP which was already managing the Round 7 grant.

47. The CCM was concerned that it did not receive all documents needed to supervise program implementation, such as PU/DRs, management letters to PRs and grant agreements.

48. The OIG observed that the Global Fund Secretariat did not conduct sufficient field visits when visiting the country, justified by the security situation in Chad. This concern was also raised by some stakeholders, who indicated that Secretariat visits were mainly in N'Djamena city.

Internal Audit

49. OIG review of the institutional arrangements and oversight function showed that there was no dedicated internal audit unit at AMASOT or UNAD. FOSAP had a dedicated internal audit unit, which needed to be strengthened to provide appropriate support to the programs. Its function was limited to receipt of SR supporting documentation but not evaluation of its adequacy and accuracy or whether SRs are following proper procedures. Furthermore, FOSAP's internal audit function required:

- A mechanism to monitor SR implementation of audit recommendations;
- An audit plan that covers the SRs; and
- Comprehensive recommendations.

Recommendation 4 (Important)

To improve internal controls at the PRs, the Global Fund Secretariat should assess:

a) Whether the PRs should implement separate internal audit functions or outsource these to an independent audit entity; and

b) The possibility of collaboration with the government's internal audit department.

OVERALL CONTROL ENVIRONMENT

50. Of the USD 96 million in grant funds approved by the Global Fund, USD 31 million had been disbursed to four PRs at the time of the audit. The audit team reviewed approx. 20% of the expenditures of each the following PRs and SRs:

- Fonds de Soutien aux Activités en Matière de Population (FOSAP, a PR)
- Union Nationale des Associations Diocésaines (UNAD, PR)
- Association pour le Marketing Social au Tchad (AMASOT, PR)
- Programme National de Lutte contre le Paludisme (PNLP, SR)
- Programme National de Lutte contre la Tuberculose (PNLT, SR)
- Conseil National de Lutte contre le Sida (CNLS, SR)
- Centrale Pharmaceutique d'Achat (CPA, SR)

51. This section of the report presents findings in relation to the general control environment within which program implementation took place.

Compliance with the Grant Agreements

52. The OIG's review of compliance with the terms and conditions stipulated in the grant agreements showed common instances of non-compliance:

- Global Fund approval of the external auditor. Neither UNAD nor AMASOT requested Global Fund approval of the external auditors or provided the Global Fund with the SR annual audit plan as required by the grant agreements;
- Funds maintained in interest-bearing accounts. The grant agreements encourage the PR to keep program funds in interest-bearing accounts to the extent practicable, but this expectation had not been followed by AMASOT or CPA;
- Timely submission of annual audit reports. FOSAP audit reports for Rounds 2 and 3 for the years ending 31 December 2008 and 31 December 2009 were not made available until September 2010. As per Article 13 of the grant agreements, these reports should have been submitted within six months of the period end; and
- Timely processing of close-out audits. The FOSAP close-out audits for both Rounds 2 and 3, due 30 April 2010 and 31 July 2010, respectively, had yet to be completed at the time of the audit.

Recommendation 5 (Critical)
FOSAP, UNAD, AMASOT and CPA should comply with all terms and conditions of the grant agreements, and in particular should ensure that all selected external auditors are communicated to and approved by the Global Fund Secretariat, external auditors' reports are submitted to the Global Fund not later than 6 months from the close of the financial year and the close-out audit reports for Rounds 2 and 3 are completed and submitted to the Global Fund.

Government Contribution

53. In line with the Global Fund principle of counter-part funding, the government of Chad is committed to providing an annual contribution for procurement of drugs for the three diseases. However, this contribution did not always taken place as planned.

- The Procurement and Supply Management plan (PSM Plan) for TB anticipated a government participation of 15 percent of the cost of purchase of the drugs, which in 2009 would have been XAF 67 million. The actual contribution was only XAF 54 million; and
- The contribution of the Global Fund towards the procurement of antiretroviral drugs (ARVs) was estimated at XAF 851 million, sufficient to treat approx. 7,500 of the 32,000

persons living with HIV in Chad in 2009 and 2010. The government of Chad procured XAF 610 million of ARVs during this same period. This means that the government of Chad supported ARVs for approx. 5,400 persons, leaving approx. 19,600 uncovered by the program.
- The OIG did not receive information on the amount of contribution by the Government toward the malaria program.

Recommendation 6 (Important)
The Global Fund program is meant to support or fill the gaps left by the three national disease programs. The CCM is encouraged to continuously monitor and engage in advocacy to ensure the adequacy and continuity of government and development partner participation in fighting the three diseases.

Accounting and Information System

54. The OIG noted room for improvement in accounting and information systems, such as the need to ensure the reliability of accounting software, to establish an adequate accounting manual and to ensure that bank reconciliation statements are prepared and reviewed and adequate back-up procedures are in place.

55. The following aspects of the existing accounting systems should be improved:
- FOSAP used a TOMPRO accounting system that was configured in a mono-project manner and could only be used by one user. This resulted in Round 2 and 3 accounts being maintained in one database. Moreover, the software was underutilized. The budget, purchases and engagements functions were not fully used. Furthermore, Round 8 records were maintained in MS Excel, which poses a significant risk of errors;
- UNAD used a SAGE SAARI 100 system, which has limited functionality in terms of carrying out certain financial analyses. For example, the software does not reject the processing of expenses over budget, and allows the possibility to change a transaction that has been posted;
- AMASOT used SUNSYSTEM, which has limited functionality with respect to certain financial analyses. For example, the software does not reject processing of expenses over budget. The system has some good functionality, which, however, needed to be configured (e.g., for tracking fixed assets, procurement, variance analysis and stock management); and
- PNLP maintained its financial management information in MS Excel spreadsheets. These Excel tables were not backed up in any way and were susceptible to manipulation and human error.

56. The OIG observed a need for FOSAP, CNLS and PNLT to establish a reliable accounting manual.

57. FOSAP's current accounting manual was prepared by the fiduciary agent contracted by the program. The current procedures manual[6] required improvements in:
- The description of the TORs to ensure clear accountability at each level. The role of the Finance Assistant and the Finance Manager were overlapping;
- Covering key aspects of the program such as drug procurement, SR management and oversight, and program implementation; and

[6] The Global Fund Secretariat notes that the conditions under the Phase 2 renewals for the Round 8 HIV and TB grants include, *inter alia*, the requirement for the PRs to update the Procedures Manuals and accounting procedures. This is being done with the assistance of Finance TA and will be further supported by the Fiduciary Agent.

- Customizing the SR manual based on their organizational structures and having it cover areas such as drug distribution and data collection at the grassroots levels.

58. CNLS and PNLT did not have an adequate, comprehensive procedures manual covering operations, administrative and financial transactions. The OIG observed that the current manual provided by FOSAP was not consistent with the size and nature of these disease programs' operations:

- Key procedures performed by each officer in the execution of daily responsibilities were not clearly spelled out in job descriptions; and
- The stock management section of the procedures manual did not clearly indicate the distribution channels for medical products (ARVs and anti-tuberculosis drugs).

59. UNAD did not apply any ceiling or threshold of amount on check signatory authority. The existing procedure required the signatures of any two of the three authorized signatories to issue checks. One authorized signatory, the Board Chair, did not reside in N'Djamena. A value threshold should be established to ensure that the Board Chair is made aware of significant transactions.

60. The PNLT and CNLS did not have a mechanism in place to prepare bank reconciliation statements.

61. None of the PRs and SRs audited had adequate back-up procedures in place. For example:

- FOSAP indicated that accounting information from before 2008 was unavailable as a result of the destruction of assets in February 2008 during the civil war and the loss of the computer containing the financial information. FOSAP still had no data backup mechanism in place at the time of the audit; and
- AMASOT and UNAD performed the daily back-up to an external hard drive, but did not store the back-up drives in off-site locations. Back-up drives were kept by their Finance Officers and brought to work daily.

62. OIG review of payment processes at FOSAP and AMASOT showed that checks were made out to individuals rather than the entities with which the organizations deal. This practice poses the risk that the payments will not be received by intended beneficiaries. The checks issued were not crossed to prevent non-intended beneficiaries from cashing them.

Recommendation 7 (Important)

To achieve an acceptable level of internal control of accounting information and systems, the Global Fund should ensure that AMASOT, UNAD, FOSAP and the SRs:

a) Review their current procedures manuals and incorporate processes that are relevant to their operations. This review should cover areas such as procurement, budgeting and monitoring, human resources, quality assurance of drugs, administration and logistics. Clear job descriptions should be provided in order to avoid conflicting or overlapping roles;

b) Configure and/or upgrade current accounting software to support multi-project functions appropriate for the complex programs managed. This configuration should also cover procurement and budgeting. Effective accounting software should be used in place of Excel spreadsheets;

c) Formalize the processes and procedures for data back-up and put appropriate controls in place; and

d) Issue checks only to the authorized beneficiary and use crossed checks whenever possible. Documented justification should be provided where crossed checks cannot be used.

Recommendation 8 (Critical)
Given that financial capacity should have been assessed by the LFA in the early stages of PR selection, the OIG encourages the Global Fund Secretariat to ask the LFA to reassess the existence of adequate internal controls for each PR, including the accounting systems used, during its PU/DR verifications. A minimum standard of acceptability should be ensured or capacities built to meet such a minimum standard. The minimum standard should include, but not be limited to:

- *An adequate accounting system used by each PR;*
- *Adequate control of payment processes, included bank reconciliation processes;*
- *Adequate control of cash payments and training activity;*
- *Adequate procurement processes;*
- *Adequate accounting procedures; and*
- *An adequate system for tracking and maintaining financial information and documentation.*

Asset Management

63. The OIG observed that for all PRs and SRs reviewed, there were systematic weaknesses in fixed asset management.

Recommendation 9 (Important)
The Global Fund Secretariat should ensure that the PRs and SRs implement proper systems for managing assets by:

a) Implementing adequate asset management manuals;
b) Using the asset management functions of their accounting software and establishing proper fixed assets registers;
c) Reviewing and strengthening procedures to control assets by establishing monthly reconciliations between asset registers and general ledgers;
d) Implementing controls over movement of assets in and out of the Global Fund programs;
e) Monitoring the use of assets assigned to staff and ensuring that assets are properly cared for;
f) Implementing procedures over handling of log books; and
g) Implementing CAPEX reconciliation with proper follow-up through the use of procurement systems.

Human Resources

64. The OIG review showed that the human resources capacities of the PRs and SRs needed to be strengthened. They require adequate human resources policies and procedures, should train program staff regarding Global Fund process and procedures, ensure continuous staff development and ensure adequate documentation of staff recruitment and changes.

Recommendation 10 (Important)
The Global Fund Secretariat should ensure that PRs and SRs establish adequate human resources policies and procedures, including training requirements where necessary.

FONDS DE SOUTIEN AUX ACTIVITES EN MATIERE DE POPULATION

Background

65. The Fonds de Soutien aux Activités en Matière de Population (FOSAP) is an arm of the government that was established by the Ministry of Planning to aid in social programs. The CCM chose it as PR with the goal that it would work with two national disease programs (HIV & TB) in the implementation of Global Fund grant programs in order to ensure reliable management of funds. The Global Fund grant programs are implemented at the central level by FOSAP and the national disease programs. FOSAP was the only PR during the implementation of Round 2 TB and Round 3 HIV/AIDS program until 2008, and continued to be the PR for the Round 8 TB and HIV/AIDS programs.

Governance and Oversight Function

66. FOSAP has a Board of Directors and internal and external audit functions in addition to the Global Fund grant oversight structures. These bodies are expected to play their oversight roles with sufficient assurance of independence. The OIG, however, noted the following:

- The OIG observed that some members of the Board of FOSAP were SRs of the Global Fund-supported programs[8], raising (potential) conflict-of-interest issues. In addition, FOSAP's SR selection committee included representatives of the national disease programs, which were themselves SRs. FOSAP and the national disease programs all signed the agreements with selected SRs; and
- FOSAP's Board of Directors did not hold quarterly meetings as per its statutes. For example, in 2007 only one meeting was held and in 2009 only three meetings were held.

67. The OIG observed a need for timely follow-up on external auditor recommendations. The external auditor, Cabinet FIDUSAO, in its review for the periods ending 31 March 2009 and 30 September 2009 observed weaknesses in FOSAP's accounting processes, for example differences in personnel accounts, expenses not presented per category and inaccurate financial statements produced by the system.

68. The OIG observed that grant close-out plans were prepared 4 to 5 months after the closure time. These should be prepared in a more timely fashion.

Recommendation 11 (Important)

The Global Fund should ascertain that FOSAP strengthens program implementation through strong oversight and governance structures by:

a) Putting in place conflict-of-interest procedures and reviewing SR selection procedures. FOSAP's Board of Directors should meet quarterly.

b) Preparing and submitting grant close-out plans at least 3 months before the grant closure date. This work should be done at the PR and SR level in order to determine how to maintain ongoing programs and their funding requirements.

Sub-recipient monitoring

69. The OIG review highlighted the following areas for improvement in SR monitoring:

[8] PNLS, PSLS and Projet Population et Lutte contre SIDA (PPLS)

- Internal and external auditors should review SRs in the normal course of their reviews;
- A proper accounting system should be put in place, in particular for the national disease programs;
- SR staff should be adequately trained in Global Fund requirements and procedures. (The OIG noted that the delay in activities in 2010 was due to a lack of understanding of the requirements of Conditions Precedent);
- The procedural manual provided by the PR should be customized to the relevant SR structures; and
- Both financial and programmatic reporting tools and formats should be standardized.

Recommendation 12 (Important)

The Global Fund Secretariat should ensure that FOSAP:

a) Strengthens the monitoring of SRs through SR audits by the internal and external auditors;
b) Strengthens the accounting and financial management of SRs;
c) Trains staff in the policies and procedures of the Global Fund; and
d) Standardizes reporting tools and budget monitoring.

Budget and reporting

70. The OIG found some instances of inconsistencies in reporting, such as:

- Reported expenses did not match with the accounting data. For example, an expenditure of USD 147,874 was reported in the PU/DR for Q13, which was higher than the expenditure of USD 146,435 that was recorded in the accounting system;
- The reported bank balance in the cash reconciliation sheet (Section 2) was consistent with neither the accounting balance nor the bank statement for the period covered; and
- The explanations on budget variances were not always consistent or coherent. For example, in PU/DR 10 for the TB grant program, a variance of USD 297,271 was explained by the fact that the time between the first disbursement and the end of the quarter was not enough to absorb the cash that was budgeted.

71. The OIG noted that there was no mechanism to validate expense budget lines before an expense was charged to the budget.

Recommendation 13 (Important)

The Global Fund Secretariat should ensure that FOSAP establishes a mechanism for quality control review of PU/DRs and EFRs before sending them to the Global Fund. Each figure should be reconciled to accounts and any difference clearly explained. A proper budgetary monitoring mechanism should be put in place. The LFA should follow up to determine if refunds are required.

Payment process

72. A review of payment processes showed the following:

- The PR has engaged in inter-grant borrowing between the HIV and TB programs to meet payments when there was a cash flow problem;
- Bank reconciliation statements were not prepared for all months and the reconciled balances in some cases did not agreed with bank balances. There was no reconciliation statement for October 2008. Reconciliation for the TB account was not reviewed from June to December 2009. There has been an unresolved discrepancy in

the accounts of XAF 1.6 million (USD 3,149)[9] since June 2008 stemming from a TB expense paid through the HIV account for which the entry had not been reversed; and

- In fulfillment of one of the recommendations stemming from the special investigation, a fiduciary agent (GTZ) was appointed to assist in financial management of FOSAP and build its capacity. While reviewing supporting documents for payment of technical assistance done by GTZ, we found the following:
  - It was unclear that all GTZ employees were physically present. The OIG understands that only two out of three GTZ employees were actually working with FOSAP. The administrative expert was not available during the duration of the contract;
  - The knowledge transfer from technical assistance to the financial expert did not take place despite an extension of six months from initial contract through September 2009; and
  - The signed fiduciary agent contract did not clearly state controls to be performed over the technical assistance and transferred all administrative and financial rights regarding technical assistance to the FOSAP/PR.

Recommendation 14 (Important)
To improve payment processes FOSAP should:

a) Prepare and review bank reconciliations on a monthly basis. Longstanding items should be analyzed, followed up and cleared regularly;
b) Avoid inter-grant borrowing in accordance with the grant agreement;
c) Reimburse the amount of XAF 1.6 million relating to inter-grant borrowing from the TB program to the HIV program;
d) Increase effectiveness of the technical assistance activities by prioritizing the capacity building of existing program staff and ensuring the monitoring and evaluation by the LFA and CCM in order to ensure that objectives met; and
e) Ensure that contracts for the provision of technical assistance include detailed and clear TORs on how the transfer of knowledge should take place and the criteria for justification and evaluation of results. The LFA should ensure that the technical assistance complies with the agreed TORs.

Margins on FOSAP drugs

73. The contract with FOSAP indicated that the CPA was to invoice FOSAP based on the supplier's invoice, cost of transit and 9 percent based on CIP (Carriage and Insurance Paid to) and or CIP N'Djamena. However, CPA charged 10 percent on CIF (cost, insurance and freight) without charging for the cost of transit. There was an inconsistency between the CPA-FOSAP contract and the PSM Plan on the obligatory charges to be billed to FOSAP. According to FOSAP, forwarding agent's invoices reach the CPA with extensive delay, hence an additional 1% is invoiced as an estimation of the transit charges (the 10% included 1% of transit charges and 9 % of the agreement).

Recommendation 15 (Important)
FOSAP and the CPA should review their contract and have the same understanding of the terms of the contract. For the execution of the contract to date, any over- or under-charge should be refunded to the appropriate party.

[9] The exchange rate applied in this report is USD 1 to XAF 508.04 (http://www.oanda.com; 30 November 2010).

ASSOCIATION POUR LE MARKETING SOCIAL AU TCHAD

Background

74. The Association pour le Marketing Social au Tchad (AMASOT) was one of the three PRs for the Round 8 HIV grant program. The Global Fund approved a grant of USD 6.1 million to AMASOT, of which USD 2 million had been disbursed by the Global Fund as of October 2010. This grant represents 11.5 per cent of the total of Global Fund HIV grant funds to Chad at the time of the audit. AMASOT had no previous experience managing Global Fund-supported programs; its annual average budget has doubled with the Global Fund program funds.

75. The main objectives of AMASOT were to strengthen social mobilization and communication in the fight against HIV, AIDS and STI and to strengthen the fight against HIV/AIDS in the workplace.

76. AMASOT had sub-contracted specialized organizations to implement planned activities. AMASOT is primarily responsible for the coordination, management of SRs and monitoring and reporting of results.

77. At the time of the OIG review, no major results had been registered from the various regions due to delays in making the first disbursement of grant funds because of unmet Conditions Precedent. Disbursements to SRs were made at the end of the third quarter of 2010. The first programmatic reports were due by the end of the fourth quarter of 2010.

Financial management

Restriction on Global Fund Monies

78. In reviewing bank reconciliation statements, the audit team noted that a bank used by AMASOT had placed a restriction on XAF 227 million of grant funds. Management explained this as a court restriction relating to on-going litigation with a former supplier. The OIG received no supporting documents to support this claim. This contravened Article 6 (a) of the Standard Terms and Conditions of the Grant Agreement.

Recommendation 16 (Critical)
The Global Fund Secretariat should ensure that:

a) AMASOT remains in compliance with the terms and conditions of the Grant Agreement, ensuring that program funds are always available for program purposes; and
b) The LFA verifies the status of the program funds restricted by the bank.

Payment Processes, Budget Control

79. The OIG review of payment processes showed the following:

I. There were repeated small expenditures over and above budget lines that had not received prior approval from the Global Fund Secretariat [see table below];
II. Budget variances were not reviewed by management. No corrective action was being taken for variances in the budget monitoring report. No documented review was made of budget monitoring reports;
III. Checks were not issued serially and cancelled checks were not maintained for proper accountability;

IV. There were inadequate supporting documents for payments[11]; and
V. Unbudgeted indemnities were paid to personnel without prior authorization from the Global Fund.

Budget Line	Description	Budget	Expenses	Over budget (FCFA)	Percentage overspent
F11030807	Sécurité	1,081,017	2,205,131	1,124,114	203.99%
F11030400	Assurance véhicules	2,000,669	3,148,216	1,147,547	157.36%
F11030809	Electricité-eau	1,199,089	1,856,220	657,131	154.80%
F11030200	Acquisition d'un équipement VS	8,000,052	9,235,500	1,235,448	115.44%
F01030303	Achat Mat. de sono. UVF	6,598,927	7,375,000	776,073	111.76%
F11020100	Acquisition de 2 véhicules 4x4	24,000,155	26,372,500	2,372,345	109.88%
F01020704	Impress. guide de conversation	3,279,785	3,374,300	94,515	102.88%
	Total			**7,407,173**	

Recommendation 17 (Important)
AMASOT should:
a) Comply with Global Fund budget approval requirements. The PR should request postfacto *approval on budget overruns or refund these to the program (XAF 7,407,173);*
b) Comply with the Global Fund's budget guidelines;
c) Serially issue checks and retain cancelled checks for proper follow-up; and
d) Do business only with registered companies.

[11] For example, Per diems paid to media houses: The stamp or invoice from the various media houses was not obtained. An attendance list and contact details of participants was not seen. No report was attached to the expense. This involved two transactions amounting to FCFA 260,000 and FCFA 430,000.

UNITED NATIONS DEVELOPMENT PROGRAMME

Background

80. The United Nations Development Programme (UNDP) was PR for the Round 7 and Round 9 malaria grants and has managed the purchase of both insecticide-treated mosquito nets and antimalarial medication. It worked particularly with PNLP for program implementation and the CPA for stocking and distribution of antimalarial drugs. The aim of the Round 7 program included patient care, which consisted of artemisinin-based combination therapy (ACT), improved diagnosis and preventive measures, in particular long lasting insecticide-impregnated bed nets (LLINs), and preventive treatment for pregnant women.

81. The Global Fund Secretariat selected UNDP as PR after having decided to apply the ASP in Chad, and since no other CCM-nominated PR was found to have the appropriate programmatic and financial management capacity following LFA assessment.

82. The UNDP portfolio represented 38 percent of the total of Global Fund grant funds approved for Chad, with USD 36 million approved and USD 8.3 million disbursed at the time of the audit:

Round	Status	Grant amount (USD)	Disbursed (USD)
7	Phase I	10,477,631	8,341,280
9	Signed Nov 2010	26,107,482	--
Total		36,585,113	8,341,280

83. Under Round 7, UNDP implemented grant activities through SRs, contracting four SRs[13] that received material amounts of funding to support implementation. The total budget to be disbursed to SRs was USD 2,578,887 (25% of the total Round 7, Phase 1 budget at the time of the audit). The Round 9 malaria grant was signed after the field audit ended.

84. The national malaria control program, PNLP, was created under the auspices of the Ministry of Public Health to coordinate and assess the effects of the programs fighting malaria in Chad. It was involved in a number of activities aimed at reducing the prevalence rate and acted as an SR under UNDP.

Scope of the audit

85. Since expenditures incurred directly by UNDP were subject to UNDP's internal and external audits, they were not covered by the OIG audit, which instead reviewed two SRs contracted by UNDP. The UNDP Office of Audit and Investigation (OAI) conducted two audits of their offices in Chad in 2009 and 2010, which covered the periods of 1 January to 31 October 2009 and 1 November 2009 to 30 September 2010, respectively.

UNDP Procurement Cost

86. The LFA noted that the unit price of UNDP procurement through UNICEF is generally high[14] compared to prices in other countries. According to UNDP OAI, during its

[13] CPA, PNLP, UNICEF, and WHO
[14] LFA assessment, 24 November 2010 and email from LFA to UNDP Copenhagen 24 January 2011.

own audit fieldwork OAI attempted to compare the prices of drugs bought by UNDP and other PRs in the region using data from PQR. The comparative analyses was inconclusive for the following reasons: (1) Each PR purchased a different quantity of drugs form different sources at a different time which potentially affected the unit cost; (2) inconsistency of the data in the PQR: for instance, some PRs included transport cost while others did not. In 2011, the UNDP Procurement Support Office conducted analyses of the PQR. Although the review concluded that UNDP through the Long Term Agreement with UNICEF purchased at competitive prices, the quality of the information of the PQR poses a number of challenges for a comprehensive review.

UNDP Sub-Recipients

87. The OIG reviewed the two UNDP SRs during its audit.

Programme National de Lutte contre le Paludisme (PNLP)

Field visit and distribution of mosquito nets

88. The OIG visited seven health centers and hospitals within the N'Djamena Centre and N'djamena Sud Regions with the objective of following the distribution channels of both antimalarial drugs and insecticide-impregnated mosquito nets.

89. The antimalarial drugs and mosquito nets were distributed to health centers without prior training of the officers in charge as to the handling, recording and management of stocks received. This resulted in insufficient handling and recording of stocks of both medication and mosquito nets. According to the UNDP, the trainings that had been carried out were dependent on the financial request to UNDP by NMCP. The Trainings during the audit period allowed information to be gathered for the benefit of the Global Fund's PUDRs.

90. A review of the stock sheets at N'Djamena PRA (Pharmacies Régionales d'Approvisionnement) indicated that there was a loss of about 147 mosquito nets. There were no supporting documents or sign-offs by recipients of such nets. According to UNDP, the management of mosquito nets at the N'Djamena PRA [regional supply pharmacy] was documented in the stock management file and in the transporter's detailed activity report of August 2010. These indicated that a bundle of 100 LLINs and 47 units were missing at the final count.

91. PRA N'Djamena received an amount of USD 56,000 (XAF 28 million) from CPA to cover the cost of distribution of medical products and mosquito nets to the health centers. However, only the mosquito nets were distributed to the health centers, while medical products were sent to the district centers (administrative). The health centers had to retrieve the medical products at their own cost. The amount allocated was not used in full.

La Centrale Pharmaceutique d'Achat (CPA)

92. CPA was responsible for the purchase of most of the drugs under the grant programs, except for the malaria program, for which UNDP procured. Its roles included warehousing, managing stocks, and distribution.

Governance and Accountability

93. The CPA had a documented procedures manual which had been in use since 2006. The manual has not been reviewed and revised and, as a result, there were no clear guidelines for newly created positions such as deputy manager, debt collector, IT, merchant or manager for program inventory.

94. The procedures manual covered some conflict-of-interest issues. However, it did not require key management personnel to sign off annually on conflict-of-interest declarations. There was no documentation to show that the conflict-of-interest provisions of the manual were being followed.

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

Introduction

95. Grant funds for procurement and supply management (PSM) activities represented 67 per cent of the total grant funds allocated to Chad. Therefore, the risk associated with procurement and supply management may be higher than non-procurement areas, and the effort to mitigate such risks should have been prioritized. Unfortunately, the LFA did not provide an actionable recommendation in the PR assessment, e.g., a rapid assessment on PSM similar to the one completed a few days before the audit started.[16] It would have been useful to have this assessment completed earlier, given that the Global Fund had provided funding to Chad for over five years.

96. Capacity building of the health system in Chad, including the procurement and supply management system, depended on support from the Government of Chad, and from development partners, among them the Global Fund. The purpose of Global Fund support was to serve as an additional resource to national health funding. Strengthening the health system relies heavily on the commitment of the Government of Chad.

PSM Institutional Arrangement

97. Each of the three national programs within the Ministry of Health, together with the Ad Hoc committee, was responsible for the selection and quantification of drugs and health products. The list of products to be procured was submitted to the respective PR. The CPA[17] procured HIV/AIDS drugs, the Global Drug Facility (GDF) TB drugs, and UNDP procured antimalarial drugs and health products.

98. The CPA received and stored drugs and health product at the central level. The PRAs performed these tasks at the regional level. The PRAs pick up drugs and health products at the CPA's premises two times a year and distribute them to the district level on a monthly basis.

99. At the time of the audit, the supply chain and distribution were divided between the CPA and the Regional Directorates of Health, as follows:

- The CPA was responsible for storage at the central level (N'Djamena);
- The related program was responsible for the quantification of the need;
- The Regional Directorates of Health of the Ministry of Health were responsible for regional distributions to (a) PRAs, (b) health districts, (c) hospitals, and (d) sites of drug distribution. In addition, data collection started from the peripheral drug distribution sites and ended at the central level[18];
- Instead of the regional councils, the PRAs, under the supervision of the regional representatives, are responsible for the distribution chain on a regional scale;
- FOSAP was responsible for procurement oversight of TB drugs. The Global Drug Facility (GDF) was used as the procurement agent; and
- UNDP was responsible for procurement oversight and management for the majority of malaria related health products. UNICEF was used as the procurement agent.

100. Most of the staff at the PRs and SRs included MOH staff members that were newly responsible for Global Fund PSM activities. The program did not have a mechanism in place

[16] Evaluation rapide du système de gestion des médicaments et produits médicaux au Tchad, Swiss TPH, Dr Bruno Viana, , Dr Kaspar WYSS et Dr Bruno CLARY, 28 octobre 2010. [Rapid PSM Assessment of drugs and health products in Chad]
[17] CPA (Central d'Achat Pharmaceutique) is the procurement and distribution agent for drugs of the Government of Chad at the Central Level.
[18] PSM Plan Phase 2, TB - TCD-202-G01-T-00 Table 2: Monitoring and evaluation process, page 27

to ensure an adequate archiving system or a hand-over process to address staff turnover. For example, during the audit, the OIG did not receive any information on PSM, such as inventory records or drug movement records, for the period 2004–2009.

Recommendation 18 (Important):
To improve the procurement process, the Global Fund Secretariat should ensure that PRs and SRs establish guidelines on the archiving process and the process of handing over documentation when there is staff turnover.

101. Good practices observed at the central level (the CPA) include the following:

I. Since 1 January 2010, the CPA has improved its inventory management system, including putting in place stock cards for each product and each batch of products, which were made in parallel with the computer tracking system at the CPA;
II. The CPA assigned a pharmacist to manage and monitor the drugs belonging to the program;
III. The procurement manual was adequate and included the process of pre-qualifying suppliers and the requirement to order drugs only upon approval from the respective PR;
IV. Multi-disciplinary committee members for the receipt of the drugs;
V. Adequate storage conditions; and
VI. Implementation of quality control mechanisms by an independent/WHO prequalified laboratory for drugs arriving in the country.

102. While the OIG was satisfied that the procurement and inventory management at the level of the CPA was adequate, the good practices noted above were not consistent at the district level, particularly related to distribution. The main reasons for these gaps were the lack of a clear distribution of responsibility or TORs between the central and district levels and inadequate infrastructure and resources at the district level. For example, there were stock-outs at the district level due to the lack of transportation to pick up the drugs, despite the fact that the drugs were available at the central level.

Recommendation 19 (Important):

The Global Fund Secretariat should:
a) Engage with the MOH to clarify the role of PRAs at the provincial and district levels to ensure integration of the Global Fund-supported activities.[19]
b) Request the respective PRs to re-define the contract between the CPA, PRA and PRs to ensure a clear TOR, responsibility and accountability and incentives in distribution.

Quality Control

103. Overall, the programs complied with the requirement of having quality control on arrival for the majority of drugs funded by the program, except for the anti-TB drugs procured by the GDF. GDF provided certificates of the laboratory analysis of batch manufacturers for some products.

104. Furthermore, in the case of anti-malaria drugs procured by UNDP, in one case, drugs were distributed before receiving the result of the independent quality control laboratory. As a result, when the results showed that some batches were defective, the CCM requested that the defective products that had been distributed be recalled, though some drugs had been consumed prior to the retrieval.

[19] The agreement between UNDP and CPA already delineates the responsibilities of distribution from central to districts and service delivery.

105. According to UNDP, there was no analysis of quality control for each batch of each product upon arrival. The anti-malarial drugs mentioned above came from a source which had been pre-approved by WHO and only a percentage of this type of products is verified upon arrival. It further stated that the samples tested were taken at the peripheral level, which is a benefit for the program in monitoring the quality of medications. Verification and comparison of the tests carried out on the samples taken and those kept by the manufacturer had led to the conclusion that the problem of quality was linked to the storage and distribution conditions in the interior of the country. In the meantime, several mitigating measures had been taken within the context of quality assurance (Chad QA policy).

Data Collection System

106. The review of data collection demonstrated inconsistent data collection processes at all levels. For example, the number of patients registered on ART did not match average drug consumption and monthly consumption was not accurate due to absent or non-standard tools. In most cases, the OIG did not see sufficient supporting documents to support data provided to the central level, or regular reconciliation to ensure the validity of data.

107. The OIG calculated the average number of ARTs distributed per month by the CPA to treatment centers and hospitals between January and October 2010. Taking into account distribution information provided by the CPA, the CPA distributed approx. 17,500 ARTs in an average month. However, the program reported more than 35,000 PLWHA on ART (see Annex 2). The OIG calculation was similar to the WHO report in May 2009[20], which reported that there were 17,024 PLWHA on ART.

Recommendation 20 (Critical):

To improve the data collection process, the Global Fund Secretariat should ask that:

a) *The entities involved in PSM design and implement a system to collect data on consumption and stocks of health commodities at sites on the entire chain of drug distribution at all levels of the health pyramid (central, regional and peripheral) in order to have full traceability of products funded by the Global Fund;*
b) *Partners build capacity at all levels through training for existing collection tools;*
c) *The entities involved in PSM standardize and simplify the collection tools already in place and design and implement a manual of procedures and methodology of data collection, with a clear definition of terms, functions and activities of each;*
d) *The Ministry of Health ensures a system of validation of published data which are used for the quantification of needs at the Ministry of Health;*
e) *The PRs checks the validity of data received from the SRs; and*
f) *The LFA improves its verification approach to the accuracy of all data transmitted by the PRs.*

PSM Plan

108. The OIG's review of the PSM plan showed inconsistencies between the PSM plan[21] and the supply chain of drugs in practice. According to the PSM plan, the CPA was responsible for the overall supply chain of drugs. However, at the time of the audit responsibility for the supply chain and distribution was divided between the CPA and the Regional Directorates of Health. This was due to incomplete coordination between implementers and the Ministry of Health.

[20] Consommation des Antirétroviraux enquête 2009, OMS
[21] See PSM plans : Phase 2 TB TCD-202-G01-T-00, September 2008, page 27; Malaria Phase 1 Round 7 (May 2009 (updated 17 February 2012) page 31; HIV Phase 1 Round 3, 12 January 2006, page 16; HIV Phase 2 Round 3 ((January 2009) page 31, and HIV Phase 1 Round 8 (October 2010 page 15.

109. The allocation of funds to the PRA level (per the contract between the PR and the CPA) did not take place, despite the PSM plan's providing a detailed calculation of the costs of the CPA[22], including the percentage of the cost to be reimbursed to the PRAs. Instead, the calculation of the CPA's cost was based on the existing contract between the CPA and the FOSAP.

Recommendation 21 (Important):

The Global Fund Secretariat should ensure that:

a) *The contract between the PR and the CPA should be reviewed by the LFA and approved by the Secretariat before it is implemented (as per the investigation recommendation from 2007);*
b) *The LFA verifies implementation of activities under the PSM plan and provides periodic updates (especially for the fees charged by the CPA); and*
c) *The LFA should verify the completeness of the PSM plans in accordance with the Global Fund requirements (especially for the effective implementation of quality control of anti-TB drugs on arrival).*

Procurement and Supply Management Cycle

110. With respect to non-health products, the OIG's visit to the National Malaria Program observed the following:

- Laptop computers procured did not consider the specifications required for the francophone country. The laptops were procured with a QWERTY keyboard, though laptops with AZERTY keyboards should have been procured;
- Radio communication devices for twelve sites were delivered to the National Malaria Program without adequate accessories. As a result, these radio communication devices were not used during the 18-month period following the inception of the phase 1 Round 7 grant; and
- The satellite link (V Sun) installed to establish communication between the Program and the sites only functioned for one week[23] following installation and had been nonfunctioning for 18 months when the audit took place. As a result, the intended objective of improving data collection had not been achieved at the time of the audit.

Recommendation 22 (Important):

The Global Fund Secretariat should request that the Malaria program ensures that:

a) *The satellite equipment is appropriately registered to render the satellite link functional;*
b) *Programs should clearly specify the technical specifications of products and non-medical services they need to the PR in writing;*
c) *The PR or buyer should comply with the specific demands and technical specifications provided by the program (or SR) for goods and for services purchased;*
d) *The PR and the buyer should provide products and services that are complete and in working order and should ensure the functionality of the products on the ground; and*
e) *The LFA should, in its review, monitor compliance with technical specifications, implementation and functionality in the field of products purchased by PRs.*

[22] PSM Plan Phase II HIV Grant TCD-304-G02-H, table 1, page 12 (September 2007-July 2010)
[23] UNDP informed the OIG that the non-functioning equipment was due to the government's not having provided support in registering the devices.

Quantification and estimation of need

111. The three national programs were responsible for the quantification and need estimation for health products; however, the methods and tools used for quantification varied. Good practice would have seen multidisciplinary committees involved in quantification to ensure appropriate input to improve calculations.

112. The OIG did not receive a response to its request for basic information to support the quantification process from each program, such as (1) the number of patients already on treatment, (2) targets, (3) stocks available in the country and procurement in progress, (4) availability of financial resources; and (5) expected safety stock.

113. The OIG noted instances where anti-malaria drugs and bed nets were received after the malaria season had ended[24].

Recommendation 23 (Critical):
The Global Fund Secretariat should ensure that the PRs establish a multidisciplinary committee with TORs that include the quantification of need. The membership of this committee should include all stakeholders and partners (programs, CPA, regional warehouse, donors, etc.) The committee should be involved in monitoring the overall PSM cycle, including the procurement process by the PR and the CPA. The following data and information should be provided to the committee:

- *Stocks at different levels of the supply chain;*
- *Orders under way;*
- *Expected arrival of on-going procurement;*
- *Number of patients under treatment/to be put on treatment;*
- *The policy concerning buffer stock at each level of the supply chain; and*
- *Any other relevant information known at the time of the meeting of the committee.*

Distribution

114. Distribution to the level of health facilities where treatment took place had scope for improvement given the multiplicity of actors and a non-integrated system. In addition, neither the CPA nor the PRAs had the necessary means of transport to ensure delivery of products to sites; orders not collected at the central levels caused delays and stock-outs. For example, an order for TB products had been pending and awaiting pickup at the CPA for more than 4 months at the time of the audit.

Recommendation 24 (Important)
The Global Fund should ensure that:

a) *The PRs improve the availability of drugs by designing and implementing an integrated system of distribution of health commodities to the treatment sites; and*
b) *The CPA strengthens its capacity in logistics and transportation.*

Field Visit observations

115. During field visits to three provinces and seven districts, the OIG observed the following areas for improvement:

[24] For example, bed nets procured arrived in Chad in January 2010. The malaria season is from August to October.

- At the main hospital visited, the OIG noted good practices, including complete inventory records and proper storage of products that are secured in locked metal cabinets. However, other sites visited lacked these practices;
- With respect to inventory management, there was a need to establish stock cards;
- With respect to the distribution system, there was a need to clarify the roles of each party (e.g. CPA, PRAs). There was also a need to ensure the availability of drug transportation to treatment sites and to evaluate the possibility of integrating the system between the CPA, PRAs and the district level;
- Drugs with adequate safety stocks should be available at different levels of implementation;[25]
- The monitoring of expired drugs, data collection with respect to stock status and monthly consumption monitoring was unreliable due to a lack of standard data collection procedures. This caused inaccuracies in the data reported;
- The OIG noted numerous expired medicines and health products during its field visits at all levels of the distribution chain, in particular ARV medicines, tests and reagents;
- Storage conditions, in particular at the distribution sites, were inadequate. For example, the temperature of most local storage was much higher than 30°C, while most of the drugs required storage at 30°C or below;
- Global Fund-supported drugs were distributed for free and thus did not provide an income to warehouses visited (in contrast with non-Global Fund-supported drugs). Therefore some of the district warehouses that the OIG visited did not want to invest resources in properly managing the program drugs; and
- The OIG found merchants in the markets of N'Djamena and Moundou and in N'djamena pharmacies who sold bed nets similar in appearance to those procured under the Global Fund-supported programs and ARV drugs bought under the Global Fund-supported program (based on their batch number).[26]

Recommendation 25 (Important)
The Global Fund should ensure that:
The PRs improve the PSM process by improving storage, putting in place stock cards, preventing stock-outs, the risk of overstock and expired products and ensuring traceability of inventory at all levels of the health system. This should include:

- *Developing and implementing a policy of safety buffer stock at all levels of the supply chain for products supported by the Global Fund; and*
- *Ensuring that implementers and SRs improve the collection of consumption data, and ensuring the reliability of these data in order to reduce the number of stock outs and patient usage of expired products.*

[25] The OIG noted numerous stock outs of medicines and health products, in particular stock outs of ACTs, laboratory reagents and consumables. During its field visits, the OIG noted the following: (i) stock outs of products throughout the distribution chain in the country (CPA, PRA, hospitals and health centers); (ii) during the CCM meeting held on 12 November 2011, it was announced that nearly 100 per cent of the Project Palat sites in 14 districts in 4 regions had stock outs of anti-malarial medicines; (iii) during the OIG's visit to the TRI health center on the grounds of the Moundou Hospital, the report for the month of September 2010 documented stock outs of ASAQ adult and adolescent stock; and (iv) during the OIG's visit to the Keloo Hospital, the OIG noted the stock out of RDTs and laboratory consumables.

[26] Example : EFAVIRENZ 600mg B/60 cp, Lot No. KW9C26 (05/2009 – 04/2012), Product and lot FM delivered by CPA (Order No. 008865 ARV/Ref FA090492) to the PSLS on 26 Aug. 2009.

SERVICE DELIVERY, MONITORING AND REPORTING

Malaria

116. Malaria has typically been at the top of the list of causes of hospital admissions and, in combination with anemia, is the cause of 30 percent of hospital mortalities.[27] Reports on malaria morbidity and mortality at the population level had been unreliable prior to the time of the audit, because only an estimated 30 percent of the population had access to health facilities and because diagnosis tended to be symptomatic. Data provided by PALAT gave a more accurate depiction of the relative widespread nature of malaria in districts covered by PALAT in its first year.

117. Round 9 malaria expanded targeted LLIN distribution (from Round 7) to mass distribution. The two rounds together have substantial potential, if well implemented, to address a significant cause of the country's morbidity and mortality. In addition, as malaria diagnosis and treatment occurs free of charge to patients, there is the potential to attract patients who could otherwise not afford the services. In Round 7, the goal of wider use of services was the reason for linking bednet allocation to the use of antenatal and vaccination services.

118. In 2005, a policy was adopted to shift to artemisinin combination therapy (ACT) after Chloroquine resistance had been convincingly established. However, the 2009 National Strategy – written just before the start of PALAT - noted that:

> 'Despite the adoption of this novel policy in 2005, Chloroquine that was withdrawn has continued to circulate and is being prescribed in both public and private health facilities. The poor availability and the poor access to ACT are the main causes of this situation. Indeed, only where UNICEF and NGOs deliver them freely or at an affordable price are ACTs available. That is the case in only 4 or 5 out of the country's 72 districts. In the remainder of the country ACTs are available only at exorbitant prices and thus are accessible only to a small proportion of the population.'[28]

119. According to UNDP, Round 7 was a progressive project which had made it possible to cover, at the time of the audit, 14 districts in Year 1 and 31 sanitation districts in Year 2. Over the 5 years, the project was expected to cover the 56 districts of Chad and therefore it was deemed normal that certain clinics did not benefit from ACTs at the time of the audit.

120. In its last reporting period of July-September 2010, the PR achieved a satisfactory level of performance of 67 per cent on average and 65 per cent for the Top Ten indicators. However, the ACT stock-outs at the time of the OIG visit will inevitably be reflected in subsequent results. UNDP explained that at time of the audit, 50% of the 2011 PALAT [Support Project for the Fight Against Malaria in Chad] order of ACTs had been received and hence this would minimize stock-outs. The project was waiting for the quality control results of the samples taken for analysis and distribution in the clinics.

Tuberculosis

121. The results of Round 2 TB were unclear, in part because the staff of the National Program were replaced after the 2006/7 suspension. Round 8 began on February 2010 and had not reported on the majority of its indicators at the time of the audit. A significant gap in the design of Round 8 is that there was no community sensitization and little involvement by the over 600 health centers which were the pillars of the country's health system. (Round 10 was designed to fill these and other gaps but was not recommended for funding by the Global

[27] Annuaire de Statistiques Sanitaires du Chad (2007). Data for PALAT for the period March-October 2010 indicate that as much as 80% of child mortality (under-fives) in project districts is attributed to malaria.
[28] Source: PNLP Plan Stratégique National 2009-2013 'Faire reculer le paludisme' au Tchad.

Fund's TRP.) A first step towards decentralization was envisaged in Round 8, with all supervision done 'en cascade', with a focus on the regional level. At the time of the OIG visit, however, headquarters staff were still making rounds through the country.

122. The PR explained that at the time of the audit, the supervisions carried out and reported were part of Round 2, which had planned the supervision of the central level until the health districts. However, during Round 8, decentralization of supervision had had been done and the supervision of the central level was limited to the regional level while the supervision of health districts was carried out by the regional level.

123. The objectives of the Round 8 TB grant were:

I. Spreading the DOTS strategy coverage from 46 percent (26 districts) to 85 percent (48 districts) and improving its quality in all structures of tuberculosis management;
II. Developing TB/HIV collaboration and MDRTB survey and prevention activities; and
III. Promoting operational research activities.

124. With respect to the key TB indicators,[29] in 2009, the case detection rate stood at 37 percent (8,651 cases identified out of 23,112 expected); the rate of detection of smear positive cases was 26 percent (3,820 cases detected out of 14,769 expected); and the treatment success rate for 2008 was below 30 per cent. The combined effect of poor detection and poor treatment results is that only one out of nine TB infected persons is both identified and successfully treated. This raises the question of whether performance is suboptimal, reporting is insufficient or both are poor.

125. The OIG noted a tendency to report only on TB cases for which there had been follow-up (3,670 in 2008), which tended to make results look better than they were. However, as the PNT's 2009 Annual Report correctly emphasizes:

> 'Sur 7,195 tuberculeux tous cas confondus dépistés en 2008, seuls 3,670 malades ont été suivis pendant toute la durée de leur traitement et ont été évalués à la fin traitement en 2009. Par contre, 3,525 n'ont pas été évalués et sont restés sans issus, ce qui représente 48,99 % des non évalues ou sans issus.'

126. The fact that nearly half of all cases detected end up as 'not evaluated or without a known outcome' reflects the inability at the time of the audit of the system to provide follow up on patients and report on them, case by case. The group thus contains both 'real' defaulters (perdus de vue) as well as those lost to reporting, whose outcome is unknown. As the reported default rate is 28 percent (917 persons in 2008), the conclusion is that for 62 percent (3,525 plus 917) of the total of 7,195 cases identified in 2008, the outcome was unknown.

127. It is possible that among the 'sans issus', there are in fact patients who successfully completed treatment. It is also possible that the smear positive cases have had a better outcome. (The GDF mission report of November 2009 cites for this group a cure rate of 31.5 percent, which in the latest portfolio survey is mistakenly given as the treatment success rate.) Whether it is performance, facility-level register maintenance and reporting, or a mixture of both which is inadequate is difficult to confirm without further evidence, but is likely a mixture of both.

128. Stock outs clearly are a key factor in contributing to poor outcomes. As the head of the National Program noted, 'Usually one or more drugs are out of stock and prescribers then have to adapt'. (The OIG witnessed this firsthand during its field visits.) Current treatment duration is still eight months, with hospital admission for the first two months.

[29] Programme National de Lutte contre la Tuberculose, Rapport Annuel 2009

The shift to Fixed Dose Combination therapy and to a shorter treatment duration of six months was due in 2011.[30]

HIV/AIDS

129. HIV/AIDS prevalence in 2005 stood at 3.3 percent, with a higher urban rate (7 percent) and lower rural prevalence (2.3 percent). More recent data from five sentinel sites also showed significant prevalence differences, ranging from 0.8 percent in Mao to nearly 10 percent in Bol. Data from HIV testing centers at the time of the audit were alarming; in some centers 20-25 percent of self-referrals tested positive31. The estimated total number of seropositive adults and children stood at 210,000. Of every three persons reported as living with HIV/AIDS, two were women32. According to the CCM, in some centers most patients are either encouraged to attend by the health service or go there by themselves following symptoms. In these circumstances, it is clear that the probability that these patient's results will be positive is higher compared to other patients.

130. The number of patients on ARVs was uncertain. National authorities stated that the number was well over 32,000 patients, consistent with the latest UNGASS report. The OIG believes that this included substantial over-reporting; reports at the time of the audit did not control for defaulters, dead and transferred patients. With respect to HIV/AIDS, as with TB, stock outs or near-stock outs were a factor in poor service performance. The OIG witnessed how patients on ARVs were routinely given only one month's supply of ARVs even if they had travelled far.

131. The Round 8 grant was awarded to three PRs:

- AMASOT: HIV prevention;
- FOSAP: HIV/AIDS health care; and
- UNAD: HIV/AIDS mitigation, care and support.

132. High risk groups had not been included in Round 3 or in Round 8. Round 8 implementation did not begin until the fourth quarter of its first year because disbursements to SRs were delayed. Therefore, the OIG cannot report on substantial achievements.

Unrealistic Proposals

133. Proposals to the Global Fund have aimed high, in line with national strategies. However, proposals for the various rounds have aimed high to the point of being unrealistic[33]. Specifically, proposals have overrated the competence and capacity of the health system to reach ambitious targets. PR selection was not confirmed until proposals were far advanced, and PRs were not always party to last-minute changes in the proposal. In the opinion of the OIG, over-ambitious proposals should in future be avoided. The TB and HIV/AIDS programs suffered from the 2006/7 suspension, and the malaria program is still in an early phase. Therefore, all three programs have few achievements to report. In addition, standard Global Fund tools meant to limit risk have delayed the start of the Round 8 programs.

[30] The use of Fixed Dose Combination (FDC) tablets greatly contributes to rational drug use and assists in effective DOTS implementation and expansion. FDC tablets reduce the number of tablets a patient needs to take, while avoiding mono-therapy and thereby reducing the risks of developing Multidrug-Resistant TB.
[31] Data: APMS, October 2010.
[32] Source: UNAIDS 2010 UNGASS report.
[33] This is seen in particular with respect to (i) TB cased detection and treatment success rates, (ii) PMTCT targets, and (iii) the estimation of ARV needs.

Recommendation 26 (Important)
The Global Fund Secretariat should:

a) *Renegotiate/reprogram proposals that carry a clear risk of being too ambitious, and consider a referral back to the Technical Review Panel. This is particularly important when targets are based on inaccurate data;*
b) *Encourage PRs to sign only those grant agreements which they, in consensus with National Programs, have vetted as feasible to implement and achieve; and*
c) *Reconsider the performance framework in for existing grants to capture realistic targets (e.g. for PMTCT and condom sales.)*

Conditions Precedent

134. The three Round 8 HIV PRs found it difficult to meet Conditions Precedent in a timely way, which was a major factor contributing to the late startup of the programs. AMASOT and UNAD had to address eleven Conditions Precedent, and FOSAP had to address 15.

Recommendation 27 (Important)
The Global Fund should:

a) *For future grants, follow the Operational Policy Note of October 2010, which states that conditions should be shared with the PR before grant signature. In the case of Chad, conditions should not only be shared but be thoroughly discussed and actions on their fulfillment agreed before grant signature; and*
b) *Facilitate Technical Assistance for the start-up phase of new rounds to address Conditions Precedent. Such TA should preferably be based in-country.*

Data collection, quality assurance and reporting

135. Currently, only the malaria program can fulfill the Global Fund's reporting requirements. However, this is at the price of creating a parallel data collection and reporting system, which will not be easily sustained once the malaria program goes to scale. Fundamental problems in data collection and reporting are seen in the entire health care system. The OIG sees the need to address the three root causes of insufficient reporting.

136. Routine reporting is activity-based. The routine data collection of Chad's health institutions is oriented towards production of an annual report. Data are recorded on a monthly basis, in the form of activities. For example, reports include the number of tests done and the number of cases with uncomplicated malaria. The system is not patient-oriented and is insufficient for illnesses that require individual monitoring over time, such as TB and HIV/AIDS. For these illnesses, special data collection instruments have been designed. These instruments, however, are not incorporated into the above basic formats, and their use is not enforced.

137. Lack of data collection instruments and lack of consensus on their use. For both TB and HIV/AIDS, registers that show the current status of each and every patient are not routinely used, even though the tools exist. Health care providers use a variety of registers marked 'patients on ARVs', 'second line treatment', 'co-infection', and so on, as in Moundou's Hôpital de Jour. Individual patient files are generally well kept and are easily retrievable as each patient has a code. Data are only retrievable, however, by the individual health care provider who knows his or her way around his or her own 'system'. Even within a single health care institution, 'systems' vary as providers are not necessarily coordinating with each other. In some large institutions, such as N'Djamena's General Hospital, the majority of the specialist doctors are ARV prescribers but are unaware of each other's 'systems'.

138. Lack of individual and institutional motivation. The perspective of individual health care providers is that the compilation and analysis of activities in the form of results is

not part of their job description. Ndjamena-based headquarters staff visit institutions and collect data themselves, which is not an easy task given the size of the country and the conditions of its roads. Institutions are reminded through telephone calls to forward their data to the central level.[34] For the PR, this requires district staff to travel at least to the three main prescribers – at regional, district and hospital level - to get data on ARV use.[35]

139. These root causes of poor reporting are documented, *inter alia*, by the LFA in its On-Site Data Verification reports. There have been attempts to address the above root causes, notably the lack of data collection instruments. New instruments have been designed, and training given in their use. Training, however, has not resulted in consensus on use of the instruments. More specifically, the third cause (lack of motivation) has been insufficiently addressed. A persistent problem of absent registers and forms has not been addressed.

140. The problem of stationary and registers exists also for routine health data. The OIG visited the DSIS, the national institution that collects and analyzes health data for the Ministry's Annual Report. Forms for monthly reports of health centers and hospitals at the time of the visit had been out of stock for seven months, since March 2010.

141. This is different for the malaria program, where incentives are given for data collection and analysis. A coherent set of interventions and the instruments to report on them exists, which translates the national strategy 2009-2013 into concrete actions and results. Registers and forms are delivered even at the peripheral level. A crucial role is played by so-called focal points: District level staff who personally take care that all reports that are compiled are mailed on a regular basis to reach the PNLP program in N'Djamena where they are entered in a national database. In the 5th trimester of Round 7, data from all 268 health centers in the project districts were available.

142. However, PALAT's parallel approach will be less appropriate when the program goes to scale and covers the entire country. Even though the seriousness of malaria warrants special attention, a parallel, incentive-based program should be avoided.

Indicators

143. The programs in Chad have scope for improvement in the quality of indicators and in data collection and reporting. The OIG found multiple causes for not reporting indicators. The main underlying problem was that at the time of the audit there was insufficient motivation to report on institutional performance. In addition, some non-reporting was due to difficulties in interpreting the indicator. For the Round 8 Phase 1 HIV grant to FOSAP, non-reporting occurred largely because indicators were tied to Global Fund funding (as was the indicator of blood security).

144. Some indicators give a misleading sense of security. An example is PALAT's Indicator 1.1 – Number and % of healthcare facilities that have not once reported a stock shortage of recommended anti-malarial drugs. The indicator was reported on at the time of the ACT stock out starting in September–October 2010. As a result, 85 percent of the facilities were out of ASAQ[36] in that period[37]. However, the stock out was not recognized because the calculation was done at the district level, and as averages were taken, facilities with stock obscured the fact that other facilities were out of stock. Also, the indicator does not consider when a facility is nearly out of stock and must urgently re-stock. The indicator needs rephrasing to become of operational use.

[34] Personal communication, Dr Abbas Moustapha, CNLS; idem Avelle Bilal Oyna, APMS.
[35] The Délégué Sanitaire Régional, the Médecin chef de District Sanitaire and the Médecin chef d'Hôpital.
[36] Fixed dose combination of Artesunate and Amodiaquine
[37] Source: PNLP, personal communication.

145. Some indicators lack a time dimension. The issue of timing and timeliness plays out in several domains. Three examples where indicators should include timeliness are given below.

a) *Timeliness of school fees*. If school fees are not paid on time, the child cannot enroll or is sent home. At the time of the OIG visit in November 2010, the first school term was well under way. The PR, however, had to await approval from the portfolio manager to disburse to SRs, since contracts with SRs had not been finalized. To correct this issue, indicator 2.4 - Number of orphans and vulnerable children aged 0-17 years who receive support for schooling – could simply have the words 'on time' added to it.
b) *Timeliness of ACTs and bednets*. Because malaria is a seasonal disease, the arrival of certain goods must occur ahead of the season for optimal effect. This rule has on several occasions not been achieved by the PALAT program, as explained in the PSM section of this report. The indicators would be more meaningful if the element of timeliness is captured.
c) *Timeliness and sequence of events in campaigns*. Education must closely correspond with interventions, particularly where it concerns a new set of interventions or a targeted campaign, as was the case for bednet distribution. The evidence shows that a communication strategy has been finalized but was not implemented in time for bednet distribution in Round 7 malaria. As the indicator simply was 'number of bednets freely distributed', it did not address proper targeting with correct information on use. The indicator, in other words, is disconnected from good practice and may even encourage poor practice.

146. Certain indicators were phrased in the negative, highlighting what is not wanted. An example is '% of infants born to HIV infected mothers who are infected'. The aim of the program is to have infants who are sero-negative (non-infected).

147. Some indicator targets are unrealistic. An example from the Round 7 Malaria grant is the indicators that depend on repeat antenatal control visits. While CPN1 is nearly 53 percent, the repeat visit (CPN2 and higher) is below 2 percent[38]. It is unlikely that the 'percent of pregnant women on Intermittent Preventive Treatment (IPT) according to national policy' can increase by an average 10-20 percent per year to reach 80 percent in year 5. UNICEF's performance for this indicator has been at 20 percent. The indicator needs to be reformulated and reward continued increases, without giving absolute targets.

148. A functioning health information system is the basis for improvement, and the absence of such a system means that data collection is a permanent struggle. Generally this has resulted in under-reporting. An example of over-reporting is below.

149. The indicator 'Number of adults and children with advanced HIV infection currently receiving antiretroviral therapy' stood out in all reports because it was one of the few that seemed to be performing. However, the OIG found it to be over-reported, for reasons similar to what was said above for TB patients. The phrase 'currently' was interpreted to mean 'active files'. Practitioners readily admitted that their reported numbers included defaulters, dead and transferred patients (Paragraphs 104-105 refer.)

150. It has been impossible to report on a key impact indicator of Round 3 HIV: '% of adults and children with HIV known to be on treatment 12 months after initiation'. Information on this indicator would require a search through all patient files and thus an extensive visit to all ARV individual prescribers. It would also require consensus on the concept of 'being on treatment'. The 2009 UNGASS report for Chad gives a proportion of 47 percent for this indicator, based on a study the results of which are yet to be published. This

[38] Source: DSIS 2007.

result, if confirmed, would indicate that over half of all patients who started treatment after one year have either died, have defaulted or have been allowed to interrupt treatment. All of these possibilities have serious implications.

Recommendation 28 (Critical)
The Global Fund Secretariat should:

a) *Rephrase and refine indicators for clarity and reasonableness in the context of Chad; and*
b) *Work with the PRs to improve routine data collection systems.*