



THE OFFICE OF THE INSPECTOR GENERAL



The Global Fund to Fight AIDS, Tuberculosis and Malaria

Audit of Global Fund Grants to the Republic of Senegal

Report

GF-OIG-11-007

7 September 2012

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

MESSAGE FROM THE GENERAL MANAGER OF THE GLOBAL FUND ... 4

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM 6

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM 7

AUDIT OVERVIEW 8

OVERSIGHT AND GOVERNANCE..... 10

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT 13

FINANCIAL MANAGEMENT AND CONTROLS..... 21

PROGRAM REVIEW 26

ANNEXES

- Annex 1: Abbreviations
- Annex 2: Summary of Grants to Senegal
- Annex 3: Background and Context
- Annex 4: Recommendations and Management Action Plan

EXECUTIVE SUMMARY

Introduction

1. As part of its 2011 work plan, the Office of the Inspector General (OIG) carried out an audit of the Global Fund grants to the Republic of Senegal. The field work for the audit was carried out from 15 August to 4 October 2011. The Global Fund managed a portfolio of eleven grants whose total value, at the time of the audit, was USD 139.8 million of which USD 99 million had been disbursed from 1 April 2003 (the inception date of the first grant) to 15 July 2011. The audit covered eight out of the eleven grants of the Senegal grant portfolio (see Annex 2).

2. The five Principal Recipients in Senegal were the National AIDS Commission, the Alliance Nationale de Lutte Contre le SIDA, the National Malaria Control Program, the National Tuberculosis Control Program, and the National AIDS Control Program. The key Sub-Recipients of the grant programs were national and regional hospitals, district health centers, health posts and Civil Society Organizations, as well as the Central Medical Stores (Pharmacie Nationale d'Approvisionnement).

Governance and Program Oversight

3. The Country Coordinating Mechanism has evolved to play a strong role in grant oversight. However, there was scope for the CCM to involve national oversight institutions such as the Auditor General (Cour des Comptes) to carry out regular audits and reviews of the Global Fund-supported programs in Senegal.

4. There was scope for the Global Fund Secretariat to work with the PRs to avoid implementation gaps such as those experienced in the transition from Phase 1 to Phase 2 of the Round 7 tuberculosis and malaria grants, which at the end of the audit in September 2011 were delayed by seven and twelve months, respectively.

5. There was a need for the Local Fund Agent to review its staffing, which was strained due to workload issues resulting from the increasing size of the grant portfolio. In addition, there was scope for the LFA to provide briefings on its findings in order to seek feedback from Principal Recipients before submitting reports to the Global Fund Secretariat.

The Public Health Response

6. Senegal has a concentrated HIV epidemic, stabilized below one percent at the national level. The most vulnerable groups are female sex workers and men who have sex with men among whom one in five is living with HIV. Treatment and prevention of mother-to-child transmission was available throughout the country, with specialized clinics providing health services. Antiretroviral treatment and treatment of opportunistic infections was free of charge. However, the increasing stigmatization of sexual minorities and female sex workers was an area of concern.

7. With an estimated tuberculosis prevalence of 545 per 100,000, Senegal is in the mid-range of African countries in terms of its tuberculosis burden. The National Tuberculosis Program has made advances in improving treatment success rates, although progress on the case detection rate was stagnating. Collaboration with community-based organizations in 32 out of 69 districts has shown promising improvement in cure rates and increased treatment adherence.

8. There was scope for improvement in the diagnosis and treatment of multi-drug resistant tuberculosis. At the time of the audit, only patients who could travel to the National Tuberculosis Reference Laboratory in Dakar were tested for drug resistance, and only those

Audit of Global Fund Grants to Senegal

who lived within daily commuting distance from three urban health centers in Dakar could access treatment.

9. Reported cases of malaria in Senegal fell from more than 1.5 million in 2006 to 174,000 in 2009. The main reason was a change in the case definition, with only laboratory-confirmed cases reported after 2008. There was some evidence of a real decrease in malaria incidence, although it was difficult to confirm this because of a data retention strike by health workers since 2010.

10. National guidelines for diagnosis and treatment of malaria required parasitological confirmation and treatment with Artemisinin-based Combination Therapy for all cases of uncomplicated malaria. This protocol was strictly adhered to in all clinics visited by the audit team. Rapid Diagnostic Tests and ACTs were available free of charge. However, bed-nets for routine distribution to pregnant women had been out of stock in all clinics visited.

Procurement and Supply Chain Management

11. There was a well-managed supply of ARVs. No major stock-outs were observed or reported. However, there was scope for the National AIDS Commission to strengthen its monitoring of and control over the distribution and consumption of drugs for treatment of opportunistic infections.

12. There was a regular supply of anti-tuberculosis drugs. No major stock-outs were noted.

13. There has been a continuous supply of ACTs since 2006. Rapid diagnostic tests were introduced successfully and were available in all health facilities visited by the audit team. However, there was scope to improve quantification of ACTs and diagnostic tests. In all facilities visited during the audit, adult dosage forms of ACTs were over-stocked while pediatric dosage forms were in short supply. Infant dosage forms were out of stock in most health facilities. Morbidity data have been withheld by striking health workers and consumption data were not collected along the supply chain.

14. There was scope to improve the Central Medical Stores' pharmaceutical logistics management information system, and its storage and distribution practices at both the central level and at its regional stores to meet the standards of good practice.

Financial Management

15. The audit team noted scope for improvement in financial management across all organizations audited. The audit findings should be addressed by (a) ensuring that financial controls are consistently applied to manage all key risks; (b) adopting relevant financial and operations manuals for Sub-Recipients that specify what supporting documentation is required for the justification of program costs relating to community health worker/field-level activities, transportation, field supervision, training, meetings, purchase of gasoline, etc.; and (c) ensuring supportive supervision of implementing entities by Principal Recipients.

Overall Conclusion

16. Governance and Program Oversight: The Country Coordinating Mechanism was active in grant oversight; however, there was scope to include national assurance institutions. The increasing size of the portfolio had resulted in delays in LFA reviews. There was scope for the Global Fund Secretariat to take steps to prevent long funding gaps between Phase 1 and Phase 2 of its Senegal portfolio. The OIG concludes that grant oversight was generally satisfactory, although further efforts are needed to strengthen its effectiveness.

Audit of Global Fund Grants to Senegal

17. **Program Review:** There have been good programmatic achievements in Senegal, particularly in the national response to HIV/AIDS and malaria. Steady progress was being made in tuberculosis treatment and control, although there was scope for improvement in the diagnosis and treatment of MDR-TB. Programs supported by the Global Fund were generally well managed and outcomes generally satisfactory.

18. **Procurement and Supplies Management:** While there was a regular supply of ARVs, anti-malaria drugs, anti-TB medicines and health products, there were stock-outs of bed-nets for routine distribution to pregnant women. The audit observed scope for improvement in drug management, distribution and storage at the Central Medical Stores. The OIG concludes that Procurement and Supplies Management was partially satisfactory, with further efforts needed to strengthen this area.

19. **Financial Management:** Controls to manage key financial risks were not applied consistently by grant recipients, particularly at the Sub-Recipient level. If these shortcomings are not addressed this may put grant funds at risk. The OIG concludes that there is scope for the Global Fund Secretariat to work with the Principal Recipients to strengthen financial management capacity of sub-recipients, and for Principal Recipients to provide an increased level of financial oversight and supportive supervision of sub-recipients. Financial management was partially satisfactory.

20. While internal control requires considerable strengthening, taken overall, the OIG was able to give reasonable assurance that oversight arrangements ensured that grant funds had been used for the purpose intended and that value for money had been secured. Key areas for improvement are detailed in the body of the report. Firm commitments have been made by stakeholders to take action to mitigate the risks identified. The OIG offers 14 recommendations categorized as “Critical”, 15 categorized as “Important” and six as “Desirable”.¹

Events Subsequent to the Audit

21. The following has taken place since the audit:

- a) The Round 7 Phase 2 of the TB grant has been consolidated with the Round 10 TB grant into a new TB single stream funding grant.
- b) The Round 7 Phase 2 malaria grant has been consolidated with the Round 10 malaria grant into a new Malaria SSF grant.
- c) The National Tuberculosis Program will procure drugs and health products through the Global Drug Facility. Storage and distribution will be handled by the Central Medical Stores.
- d) The National Malaria Program will procure drugs and health products through the Voluntary Pooled Procurement mechanism. Storage and distribution will be handled by the Central Medical Stores.

¹ Please see the Audit Overview section for a definition of these categories.

MESSAGE FROM THE GENERAL MANAGER OF THE GLOBAL FUND



Gabriel Jaramillo, General Manager

gabriel.jaramillo@theglobalfund.org
www.theglobalfund.org

T +41 58 791 1842
F +41 58 791 1641

Chemin de Blandonnet 8
1214 Vernier, Geneva
Switzerland

Our ref: OGM/GJ/JK/2012.09.07-SENEGAL

7 September 2012

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 Senegal.

The audit's field work was carried out from August 15 to October 4, 2011. At that time, the Global Fund had eleven grants in Senegal, totalling US\$ 139.8 million, of which US\$ 99 million had been disbursed between April 1, 2003 and July 15, 2011. The audit covered eight of the eleven grants.

Senegal has a concentrated HIV and AIDS epidemic, stabilized at less than one percent. The most vulnerable groups are female sex workers and men who have sex with men. The country is in the mid-range in Africa in terms of tuberculosis burden, with an estimated prevalence of 545 per 100,000. Reported cases of malaria fell from more than 1.5 million in 2006 to 174,000 in 2009. The main reason for that was a change in the case definition, with only laboratory-confirmed cases reported after 2008, but there is also evidence of a real decrease in malaria incidence.

The audit identified good achievements in the national response against the three diseases. Health services for the prevention of HIV transmission from mother to child are available throughout the country. Antiretroviral therapy is also available, and free of charge. Treatment success rates of tuberculosis have improved. For malaria, all clinics visited by the audit team adopted the national protocol, which requires parasitological confirmation and treatment with Artemisinin-based Combination Therapy for all uncomplicated cases. Procurement and supplies management have also been successful, with medicine for the three diseases and health products regularly available for the patients.

There is scope for improvement, according to the audit report, on diagnosis and treatment of Multi-drug Resistant Tuberculosis, as well as on routine distribution of insecticide-treated nets, which were out of stock in all clinics visited by the audit team. The National AIDS Commission also needs to strengthen monitoring and control of distribution and consumption of drugs for treatment of opportunistic infections. Financial management requires attention in all audited organizations. In order to address such challenges, the report presents 35 recommendations.

Audit of Global Fund Grants to Senegal

Following the audit, Round 7 and Round 10 tuberculosis and malaria grants have been consolidated into single streams of funding. Senegal has also implemented changes to improve procurement, storage, and distribution of drugs and health products.

Even though internal control requires considerable strengthening, overall, the Office of the Inspector General concluded that oversight arrangements in Senegal ensured that funds in the audited grants had been used for the intended purpose and that value for money had been secured.

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

Republique du Sénégal

Un peuple - Un But - Une Foi

Country Coordinating Mechanism (CCM) / Fonds Mondial Sénégal
Commission Nationale de Coordination du Fonds mondial de lutte contre le SIDA, la Tuberculose et le Paludisme

Dakar, le 31 août 2012

Votre Réf : OIG/JP_12/199
Notre Réf : 103/CCM/DB/0812

Objet : Version Finale du Rapport d'audit des subventions du Fonds Mondial au Sénégal

Monsieur l'Inspecteur Général,

Nous accusons réception des conclusions du rapport d'audit des subventions du Fonds Mondial au Sénégal, et avons pris bonne note des recommandations.

Le CCM Sénégal a pris contact avec les différentes parties intéressées par les recommandations, et travaillera en étroite collaboration avec ces dernières pour la mise en œuvre des dites recommandations.

En vous remerciant de votre collaboration, je vous prie d'agréer, **Monsieur l'Inspecteur Général**, l'assurance de ma parfaite considération.

PROFESSEUR DOUDOU BÂ
Président du CCM Sénégal

Monsieur John PARSONS
Inspecteur Général / Bureau de l'OIG
Fonds Mondial de lutte contre le Sida, la Tuberculose et le Paludisme
Chemin de Blandonnet 8 | 1214 Vernier - Geneva, Switzerland

Genève, SUISSE /

Cc :

- ✓ M Gabriel Jaramillo, Directeur Général
- ✓ Dr DebreworkZewdie, Directrice Général adjointe
- ✓ Mr Mark Eldon-Edington, Directeur Gestion des subventions
- ✓ M CeesKlumper, Chef de Gestion des Risques
- ✓ M LelioMarmona, Chef de département Afrique & Moyen Orient
- ✓ Mme Tina Draser, Directrice Régionale
- ✓ Dr Lyne Soucy, Gestionnaire de Portefeuille
- ✓ M OrenGinzburg, Chef de département Appui à la gestion des subventions
- ✓ Mme Gülen Newton, Directrice Département Légal
- ✓ Dr Elmar Vinh-Thomas, Directeur d'Audit
- ✓ Mme Dominique Guinot, Chef d'équipe, Swiss TPH, LFA
- ✓ Dr IbraNdoye, Sec Ex CNLS
- ✓ Mme MagatteMbodj, Dir Ex ANCS
- ✓ Dr Mady Bâ, Coordinatrice PNLP
- ✓ Dr Marie Sarr, Coordinatrice PNT
- ✓ Dr Abdoulaye Sidibé Wade, Chef DLSI
- ✓ Mr Ibrahima Keita, Vice-Président CCM



Secrétariat du CCM Sénégal / FM STP, sis à l'OMS, AlmadiesNgor Extension Zone 10 Lot n°19,
Email : stccmsenegal@yahoo.fr ; Tél / Fax : 221 33 810 18 97 ; BP : 8363 Yoff / 4039 Dakar - NINEA : 44406580Y9

Audit of Global Fund Grants to Senegal

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM

Dakar, 31 August 2012

Your Ref: OIG/JP_12/199
Our Ref: 103/CCM/DB/0812

Subject: Final version of the Audit Report on the Global Fund Grants to Senegal

Dear Inspector General,

We acknowledge receipt of the conclusions from the report on the Global Fund Grants to Senegal, and have taken note of the recommendations.

The Senegal CCM has contacted the different parties involved in the recommendations and will work in closely with them in order to put these recommendations in place.

We would like to thank you for your cooperation.

Please accept the assurances of our highest consideration,

PROFESSOR DOUDOU BÂ
Senegal CCM Chair

Mr. John Parsons
Inspector General
The Global Fund to fight AIDS, Tuberculosis and Malaria
Chemin de Blandonnet 8/1214 Geneva, Switzerland

*Informal translation of letter from Senegal CCM

Audit of Global Fund Grants to Senegal

AUDIT OVERVIEW

Audit Objectives

22. The objectives of this audit were to assess the adequacy and effectiveness of the controls in place to ensure:

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

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

Audit Scope

23. The audit looked at the operations of the Principal Recipients (PRs), their interactions with their Sub-Recipients (SRs) and implementing partners, the supply chain for the goods and services purchased with the Global Fund Grant funds, and the oversight functions of the Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA) and the Global Fund Secretariat. The five Principal Recipients were the National AIDS Commission (CNLS), the National Alliance to Fight AIDS (ANCS), the National Malaria Control Program (PNLP), the National Tuberculosis Control Program (PNT), and the National AIDS Control Program (DLSI).

24. The audit covered eight Global Fund grants to Senegal (three Round 1 grants had been closed). The audit sampled transactions from January 2006 to June 2011.

Disease & Round	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
HIV Round 1	CNLS	SNG-102-G01-H	8,807,959	8,748,915
HIV Round 1	ANCS	SNG-102-G04-H	2,906,326	2,906,326
HIV Round 6	CNLS	SNG-607-G05-H	10,726,141	10,726,141
HIV Round 6	ANCS	SNG-607-G06-H	6,215,816	6,215,816
HIV Round S	CNLS	SNG-S10-G09-H	23,232,616	14,117,790
HIV Round S	ANCS	SNG-S10-G10-H	12,389,339	4,171,574
HIV Round S	DLSI	SNG-S10-G11-H	13,083,990	3,836,262
Subtotal			77,362,187	50,722,824
Malaria Round 1	PNLP	SNG-102-G02-M	1,526,770	1,526,770
Malaria Round 4	PNLP	SNG-405-G03-M	28,778,260	24,173,981
Malaria Round 7	PNLP	SNG-708-G07-M	27,974,550	19,139,145
Subtotal			58,279,580	44,839,896

Audit of Global Fund Grants to Senegal

Tuberculosis Round 7	PNT	SNG-708-G08-T	4,203,585	3,632,384
Subtotal			4,203,585	3,632,384
Total			139,845,352	99,195,104

Table 1: Global Fund grants to Senegal audited by the OIG (Source: Global Fund website, July 2011)

25. The Office of the Inspector General (OIG) used the following approaches to conduct its work: Discussions with program and financial personnel of relevant grant recipients, review of grant program documents, monitoring/supervision reports, implementation and procurement plans, examination of supporting documents for grant expenditures as well as program and financial progress reports.

26. In addition to audit tests carried out at the national/central level, the OIG team visited program sites at regional, district and peripheral levels in five regions (Dakar, Thiès, Louga, St Louis and Ziguinchor). During the field visits the OIG team carried out tests and made observations at national and regional hospitals, district health centers, health posts, as well as at regional and district pharmacies. The OIG team also visited clinical, prevention and patient support programs managed by civil society and community-based organizations and conducted focus group discussions with program beneficiaries.

Scope limitation

27. The audit team did not assess the quality of clinical data because there was a data retention strike by health workers since the first quarter of 2010. This was due to a labor dispute with national authorities. Once the strike has ended, the CNLS/DLSI will need to collect and verify outstanding data that can then be assessed in an on-site data verification carried out by the LFA.

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

- a) 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.
- b) Significant: 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.
- c) 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.

OVERSIGHT AND GOVERNANCE

The CCM has evolved to play a strong role in grant oversight. Support from the CCM Secretariat could be strengthened further. There is scope for improving the way in which the Local Fund Agent exercises its role, scope for improved follow-up on internal and external audit recommendations and in the timeliness of Secretariat responses to country needs.

Country Coordinating Mechanism

29. From the inception of the grants in April 2003 to the end of 2004, the CCM held few meetings and did not actively exercise its oversight role. In 2005, the CCM was restructured and a new Chair elected from the academic sector to replace the MOH representative. CCM membership complied with Global Fund requirements. Representatives of PRs are voting members on the CCM, with any conflict of interest mitigated by conflict of interest policies and procedures.

30. The CCM was active, has held regular meetings and has undertaken at least two supervisory field visits to monitor program implementation, leading to the satisfaction of national program and development partner officials interviewed. The establishment of a CCM sub-committee for technical oversight strengthened the CCM's oversight of the grant programs. The effectiveness of CCM meetings had improved because of the preparatory work and analyses of issues done by the technical sub-committee. Further, the CCM's technical oversight sub-committee had used a program monitoring dashboard to produce analyses of grant recipients' programmatic reports. This facilitated the CCM's program oversight role.

31. In addition to funding from the Global Fund, the CCM has received financial and technical support from other development partners. The World Health Organization (WHO) provides office space for the CCM Secretariat and has assigned a senior staff member who serves as Coordinator of the CCM Secretariat. USAID, the European Union and Cooperation Française have provided financing/technical support for specific CCM activities such as the salary survey of principal recipients and provision of equipment and furniture for the CCM Secretariat.

32. The staffing of the CCM Secretariat may need to be expanded. With the onset of Global Fund Round 10 programs the number of PRs will increase from five to seven, with the addition of Plan Senegal and IntraHealth. The CCM intends to recruit a staff person to support the use of the dashboard to monitor program progress.

Global Fund Secretariat

33. The Senegal grant portfolio has adversely been impacted by delays in the Global Fund Secretariat's grant management processes, procedures and decision-making. For example, during the audit field work in August and September 2011, the Malaria and TB grants had been inactive for 12 months (August 2010 to August 2011) and seven months (January to August 2011), respectively, because the grant agreements for Phase 2 had not yet been signed. This gap has been particularly difficult for Senegal because of the high level of dependence of the tuberculosis program on Global Fund support. Similarly, as already noted above, the implementation of the Global Fund grant for Health Systems Strengthening (HSS) program was delayed by more than one year because of the long process of validation of the procurement plan.

34. PR and CCM officials provided evidence of the lack of a timely response from the Global Fund Secretariat to requests for information and official communication regarding issues relating to the grants.

Local Fund Agent

35. The Swiss Tropical Institute has reinforced its country presence by relocating its team Leader from Europe to Dakar in September 2011. It has previous LFA experience in the country and has maintained good grant management and oversight documentation. However, STI's performance of the LFA oversight role has been affected by the following country context and its working methods:

- a) Increasing workload due to the size of the grant portfolio (from five to seven PRs) that has sometimes resulted in delays in its reviews;
- a) Inter-personal and communication styles of LFA team members that could be more consistently professional;
- b) Greater scope for validating its findings with PRs (e.g., the 2010 Procurement review of the PNLP);
- c) A need to ensure the appropriate context to issues raised in reports and referrals to the Global Fund secretariat; and
- d) A need to ensure that issues that are not material are represented appropriately in reports and referrals to the Global Fund Secretariat.

36. Acting on these observations will allow the LFA in future to apprise the Global Fund of some of the issues raised in this report in a timelier manner, and ensure stronger grant management.

Recommendation 1 (Critical)

The Global Fund Secretariat should ensure that the LFA addresses the above areas for improvement by:

- a) Increasing its staffing level to match the grant portfolio workload;*
- b) Instituting a policy on inter-personal and communication styles of LFA team members;*
- c) Adopting a standard operating procedure of providing briefings on its findings to the PR(s) to seek feedback prior to submitting reports to the Global Fund Secretariat;*
- d) Adopting a policy of providing appropriate context to issues raised in its reports and referrals to the Global Fund Secretariat; and*
- e) Adopting a policy of focusing on significant issues in its reports and referrals to the Global Fund Secretariat.*

Other Assurance Providers

Internal Audit

37. Four out of five PRs, PNLP excepted, had internal auditors who provided financial assurance regarding the grant programs. A review of a sample of internal audit reports showed the same financial management weaknesses at implementing organizations that are detailed in the financial management section of this report.

National Assurance Functions (Corps de contrôle de l'état)

38. The national assurance functions (the Cour des Comptes, the Inspection Générale and the Agence de Régulation des Marchés Publics, ARMP) have responsibilities for auditing all Ministries, Departments and Agencies of the Government of Senegal but have played a limited oversight role over the grant programs due in part to inadequate staff strength and budget. The CNLS has been audited by the Inspection Générale, while the PNLP has been audited by the Cour des Comptes. The review documents seen by the audit team raised mainly procedural issues.

Audit of Global Fund Grants to Senegal

The national procurement law gave the ARMP oversight over all procurement carried out by public sector entities, including four of the five PRs, viz. the CNLS, PNLP, PNT and DLSI. The Central Medical Store, the Pharmacie Nationale d'Approvisionnement (PNA), which served as the procurement agent for CNLS, PNLP and DLSI for medicines and health supplies was also subject to the oversight of the ARMP. Due to the size of its budget, the CNLS was audited by the ARMP in 2008, 2009, and 2010 (it reviewed tenders for procurement of medicines and health products as well as non-health related procurement, for example, construction). Given the audit findings in the PSM section of this report, there is scope for improvement in the oversight carried out.

Recommendation 2 (Important)

The Global Fund Secretariat should work with the CCM to ensure that:

- a) The Auditor General regularly conducts quality audits and/or reviews of Global Fund-supported activities in Senegal;*
- b) All PRs undertake internal audits, deliver high quality reports and act on their recommendations to meet Global Fund requirements; and*
- c) The ARMP strengthens its oversight over procurement to address the findings in this report.*

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

There was scope for improvement in procurement and supply chain management at the PRs and the Central Medical Stores (PNA). These can be addressed through (a) improved procedures for quantification of drugs for opportunistic infections; (b) improved guidelines for the management of anti-malarial drugs through collection of average monthly consumption data in relation to morbidity; and (c) improvement of the drug logistics management information system at the PNA.

HIV

Quantification and Distribution

39. All health facilities visited were fully stocked with ARVs in appropriate quantities. No stock-outs were observed or reported in any of the pharmacies visited, which implies that quantification of ARVs is appropriate to the demand. Rapid HIV tests were available in all facilities visited. There were, however, frequent reports of stock-outs of reagents for CD4 analysis, related to the fact that many different types of CD4 analyzers are in use, each with its own specific requirement.

40. There was no system for the rational quantification of drugs for opportunistic infections (OI drugs). The approved quantities of some OI drugs in the PSM plan were modified to fit the budget after price quotations were obtained. The quantity of Fluconazole, for instance, was reduced by 215 percent, while the quantity of Metronidazole was increased by 68 percent.

41. The OIG was not able to establish whether the quantities of OI drugs procured and distributed related to the active case load of patients in HIV clinics in the different regions of the country. While the supply of ARVs to treatment facilities is controlled by the PRA pharmacist using accurate information of the active patient cohort, OI drugs are distributed without verifiable justification. The consumption of these drugs is not tracked by the PRA, resulting in an absence of data for estimating resupply needs.

Procurement

42. The PNA procured ARVs, OI drugs, and laboratory reagents on behalf of the CNLS, while the CNLS procured medical and laboratory equipment. Up to 2009, the CNLS followed World Bank procurement procedures authorized by the National Public Procurement Authority (DCMP). However, from 2010 the CNLS started following the regulations of the national procurement law. The CNLS had not updated its procurement planning tool to fit the requirements and procedures of the national procurement law and continued to use the procurement planning tool for World Bank procurement procedures.

43. Tender files kept by the CNLS did not include receiving reports or delivery receipts for procured equipment since the CNLS manual of standard operating procedures did not clearly require this proof of delivery. There are risks associated with inadequate controls in the receiving process of sophisticated equipment that is directly delivered to health facilities.

Recommendation 3 (Critical)

The Global Fund Secretariat should ensure that CNLS, in collaboration with the DLSI and the PNA, establishes quantification and distribution procedures based on the reported

Audit of Global Fund Grants to Senegal

incidence of specific opportunistic infections (OIs) and the anticipated patient load in each region.

Recommendation 4 (Critical)

The Global Fund Secretariat should ensure that CNLS a) updates its current procurement planning tool, b) provides an annual procurement plan to the PNA, and c) develops a time-bound procurement schedule for drugs and reagents procured by the PNA, which should be included in the CNLS-PNA memorandum of understanding in order to allow both parties to plan and monitor procurement.

Recommendation 5 (Critical)

The Global Fund Secretariat should ensure that the CNLS Procurement Unit establishes a system for logging receipts (e.g., receiving reports or delivery receipt that include the technical specifications of each major item). This system should include routine certification by the receiving laboratory or health facility that the received equipment has the agreed specifications and was installed as agreed with the supplier.

Tuberculosis

Quantification and Distribution

44. No major concerns regarding quantification were identified. However, problems of coordination in procurement planning and a very long delay in the 2009 international tender by PNA (16 months) led to some shortages and a stock-out of sputum cups in 2010, which was addressed through two orders by the PNT from the Global Drug Facility (GDF) in 2009 and 2010.

Procurement²

45. An irregularity was noted during the audit of PNT procurement. Two contracts were awarded to the supplier “Technologies Services” within one month following “restricted national consultations” (CRN; see table). This procedure is allowed under the national procurement law for orders up to a value of CFA 15 million (approximately USD 30,000). The division into two lots constitutes a split procurement. It should be noted that these procedures were launched by the fiduciary agent, the Compagnie Internationale de Conseil et d'Expertise (CICE) who was administratively responsible for the PNT up to the end of 2010.

Product description	Award date	Procurement method	Amount awarded (CFA)	Order date
Reagents and laboratory supplies and materials (No. 11)	23-Aug-09	CRN	14,980,000	31-Aug-09
Reagents and laboratory supplies and materials (No. 12)	28-Sep-09	CRN	12,110,000	29-Sep-09
Total			27,090,000	

Malaria

Quantification and Distribution

² For the new TB single stream funding grant that consolidated Round 7 and 10 grants, the PNT will procure drugs and health products through the Global Drug Facility. However, storage and distribution will be handled by the PNA.

46. The OIG audit team took note of two major quantification exercises for ACTs: (i) A quantification in 2006 using the tools of the RBM initiative that led to a major over-estimation of need and an expiry of about 30 percent of ACTs (ASAQ); and (ii) A quantification exercise during Phase 1 of the Round 7 Global Fund grant based on morbidity data collected by the PNLN over a period of 12 to 18 months. Following this, quantifications of ACTs and RDTs were to be adjusted according to data of the quarterly malaria reviews. However, due to the data retention strike of health workers in early 2010, no new data have become available since January 2010.

47. In June 2011, the PNLN conducted a workshop in Thiès to determine the needs for the 2011 malaria season (September – January). The quantities calculated at this workshop were based on 2009 morbidity data, the latest data available. The OIG audit found that this quantification did not satisfy the needs of the health facilities visited. In all facilities visited during the audit, adult dosage forms of ACTs were over-stocked while pediatric dosage forms were in short supply. The smallest (infant) dosage form was out of stock in most facilities, and the ACT formulations for children and adolescents had expiry dates in October 2011.

48. In 2007, the PNLN established management procedures for anti-malarial drugs in district and health facility pharmacies, based on Average Monthly Consumption (AMC). However, only one pharmacy visited by the OIG audit team calculated up-to-date AMC data based on its own initiative (Ziguinchor District Pharmacy). Most of the pharmacies visited were unfamiliar with the concept.

49. The PNA prepares a weekly stock report of ACTs at the PNA and PRA levels, but it does not calculate or publish monthly AMC data at the central or the regional level. Furthermore, the communication between the PNA and the PNLN is mostly informal (e.g., the OIG audit team did not find any formal response of the PNLN to the PNA regarding the weekly stock reports).

Procurement

50. The PNA is responsible for the procurement³ of RDTs, ACTs and bed nets. The OIG audit team noted that collaboration between the PNLN and the PNA had scope for improvement. Findings that affected procurement and distribution of malaria program commodities and thus posed a risk to Global Fund-supported programs, included the following:

- a) The PNA management fee for the handling of PNLN products procured with Global Fund support had not been paid. At the time of the audit the outstanding balance was EUR 552,103;
- b) Information exchange between PNA and PNLN was inadequate. For example, the PNA shipped six months' stock of ACTs for the 2011 malaria season as requested by PNLN. However, several of the ACT batches shipped in August had an expiry date of October. The PRA managers nevertheless distributed them to the District level; and
- c) The PRAs provided insufficient information about ACTs to health facilities. For example, the pharmacists in two health facilities in Ziguinchor District visited by the OIG audit did not know that the ACT syrup for infants which was out of stock had been replaced with dispersible tablets and had not ordered the new products.

Recommendation 6 (Critical)

The Global Fund Secretariat should ensure that PNLN reviews and revises its guidelines for the management of anti-malarial drugs in district and health facility pharmacies and

³ For the new malaria single stream funding grant that consolidated Round 7 and 10 grants, the PNLN will procure drugs and health products through the Voluntary Pooled Procurement mechanism. However, storage and distribution will be handled by the PNA.

assure, through close formative supervision, that the guidelines are understood and implemented and that AMC data are collected and analyzed at all levels in relation to morbidity data.

Recommendation 7 (Critical)

The Global Fund Secretariat should ensure that the PNLP and the PNA organize formal monthly coordination meetings focused on the following areas: The monthly stock position of malaria supplies, trends in consumption at national and regional level, levels of expired drugs and RDTs, stock-out situations and deliveries during the month.

Recommendation 8 (Critical)

The CCM should ensure that the PNLP and the PNA collaborate professionally on issues of storage and distribution of malaria program commodities.

Procurement and Supply Chain Management by the Pharmacie Nationale d'Approvisionnement

Procurement

51. The PNA is a SR for four PRs in Senegal (CNLS, PNLP, PNT and DLSI), in charge of drug procurement, storage and distribution. Each PR has signed a memorandum of understanding with the PNA describing the rights and obligations of both parties.

52. The PNA procurement unit was responsible for monitoring the compliance of all PNA procurement actions with the national procurement law. It had one staff person responsible for coordinating procurement with the grant programs. The PNA lacked a standard planning tool that would assist it in timing procurement actions to meet deadlines for pharmaceutical and health product delivery.

53. The PNA procured HIV program drugs and reagents every two years for a planned coverage of 30 months. The tender (AOI PNA ARV N°4/2010) was the first PNA international tender entirely managed under the new national procurement law. The process took almost nine months (tender notice on 10 June 2010 and DCMP contracts approval on 1 March 2011). The main bottleneck related to contract being signed by PNA and sent to suppliers for signature. Suppliers took over a month to respond. There was no procedure in place for the PNA to follow-up with the suppliers in order to achieve a timely response. A further complication was that the national procurement law did not allow the specification of a minimum level below which the supplier could not assure delivery. There is therefore a risk that suppliers may refuse to sign contracts that do not offer them sufficient economic returns, and the PNA would be obliged to reassign the contract to the second-ranked bidder.

Recommendation 9 (Critical)

The Global Fund Secretariat should ensure that PNA develops a planning tool that reflects all steps of the procurement process as well as the minimum time necessary for each step under the national procurement law.

Recommendation 10 (Important)

The Global Fund Secretariat should ensure that PNA considers assigning additional staff to reinforce its procurement unit in order to respond to the increasing business from development partners. In addition, the PNA should institute a policy of following up suppliers in order to shorten delays for obtaining DCMP approval of PNA contracts.

Analysis of the procurement of malaria program commodities: Tender Number 2008 for antimalarials (PNLP)

54. Because the national procurement law adopted in 2008 had several requirements which constrained the procurement of pharmaceuticals, the PNA lobbied the regulatory authorities (DCMP and ARMP) to obtain special dispensations for pharmaceutical procurement.

55. The PNA was selected as the procurement agent for the PNLP at the start of the Round 7 and of Phase 2 of the Round 4 malaria grants. In 2008, the PNA initiated a major procurement action for the Global Fund-supported malaria program: Tender Number 2008 (Anti-malarial PNLP). In June 2010, the newly appointed LFA was asked to conduct a procurement review of the above-mentioned tender. This review raised concerns about the following possible irregularities: (1) non-registration of the tender by the DCMP; (2) restrictive technical specifications for the RDTs and the bednets; and (3) splitting of the bednet contracts between two suppliers. In response, the procurement of 2.5 million RDTs and 350,0000 bed-nets included in this tender was stopped by the Global Fund Secretariat, and the invoices for some commodities already received were not paid (under the agreement, payment was to be made directly by the Global Fund).⁴

56. The audit team reviewed the 2008 anti-malaria procurement action to confirm possible irregularities and noted that: (a) the tender was validated by the DCMP, but the contract with suppliers were not because the PNA could not provide a certificate of existence of credit as it did not have sufficient funds in its bank account; (b) the technical specifications for the bed-nets and the RDTs were done according to “national preference” and not intended to limit competition; and (c) although the splitting of the bed-net contract between two suppliers resulted in EUR 417,691 additional costs to the grant, this followed established practice of the PNA and the audit team did not find evidence that it was done with the intent of financial gain.

Recommendation 11 (Important)

For future procurement actions, the Global Fund Secretariat should ensure that all PRs clearly state their technical specifications for key products that carry a high risk (large volume and/or high cost), and have them formally reviewed by the LFA and approved by the Global Fund Secretariat prior to inclusion in the tender document.

⁴ The OIG learned that the Global Fund Secretariat made payments to Vestergaard Frandsen and Toyota Tsusho Corp in 2012.

Audit of Global Fund Grants to Senegal

Storage and Inventory Management

57. The central warehouse buildings were constructed in 1954. At the time of the audit, they were overcrowded with stock. Cartons were piled without storage racks and there was no control of temperature and humidity. Tests of selected stock by the audit team found that expired drugs were mixed with active stock, and quantities posted on the stock cards were significantly different from those listed in the stock management software as shown in the following table.

Product Code	Product Description	Stock on hand per stock card	Stock on-hand per inventory management software
040710 PMI	Artemether + Lumefantrine (20+120) mg adult tablets	97,797	51,435
040712 PMI	Artemether + Lumefantrine (20+120) mg dispersible tablets for children	68,995	57,401
030117	Efavirenz 600 mg	6,910	2,670
031800	Lopinavir 200mmg /Ritonavir 50 mg	2,071	13,162
020221	Isoniazid 100 mg tablets b/672	111	111
020501	Rifampicin + Isoniazid + Pyrazinamide + Ethambutol (150+75+400+275) b/672	703	2,871
PNT01	Streptomycin 1g inj.	360	360

58. The electronic PNA drug management system used Enterprise Resource Planning (ERP) software SAGE 100. It was installed on a server in Dakar to which all PRAs had client access. During the field visits, the OIG audit team observed that some PRAs had good access to the server, while access for some PRAs was limited to 25-50 percent of their working hours. At the PRA in Ziguinchor it took one hour to print a stock inventory from the on-line database, while in Thiès it was not possible to access the server because of an internet interruption.

Stock Management at Central Level

59. The OIG audit team identified the following weaknesses in the PNA drug management system at the central level.

- a) The drugs were managed by product instead of by batches. This led to the same item being found in different places in the stock area;
- b) There was no routine procedure to generate weekly national stock reports with batch numbers and expiry dates per type of product;
- c) There was no system to collect and analyze distribution figures to show trends in drug consumption at national and regional levels;
- d) It was not possible to generate a report of stocks bought with financing from different sources (programs or donors);
- e) The drug management information system's database had not been audited;
- f) The drug management information system was not able to track medicines and health supplies from the central level to the health facility; and
- g) The PNA Information Technology (IT) department was segregated from other services, creating a barrier to internal development.

60. The management of HIV program commodities was very cumbersome. The system generated stock issue vouchers that were signed by the health facilities. These vouchers include neither the batch number nor the expiry date. The issue vouchers were sent each

Audit of Global Fund Grants to Senegal

month to the central level at the PNA where the pharmacist in charge of grant program supplies prepared a report to the CNLS reflecting the quantities of stock that was reported as issued by the PRAs. This process occupied about half of the working time of the pharmacist.

Stock Management at Regional Level

61. The four PRAs visited by the OIG audit team were not equipped with adequate storage racks. Although there were efforts to modernize some PRAs (Kaolack, Matam, Tambacounda) there was no investment plan to equip and standardize the network of PRAs.

62. The PNA had not established standardized and harmonized pharmaceutical and technical procedures for its central and regional stores.

63. At the Ziguinchor PRA, stock cards had not been updated for more than four months. Archives were not maintained and it was not possible, for example, to retrieve a record of issues of OI drugs for 2009. PRAs did not calculate average monthly consumption and did not keep data on the movement of key medicines and health supplies, including ACTs and RDTs. Stock movements of the PRAs were maintained on the server in Dakar and removed each year to create storage space. It was therefore not possible, for example, to track the consumption of ACTs in a specific region and triangulate it with the malaria morbidity data from the health information system.

Recommendation 12 (Important)

The Global Fund Secretariat should ensure that PNA ensures a minimum standard for basic equipment in PNA and PRA warehouses to ensure good storage and distribution practices. It should engage with the Ministry of Health (MOH) to ensure that the PNA drafts a business development and financing plan for a new central medical store to assure long-term quality storage of drugs and health products.

Recommendation 13 (Desirable)

The Global Fund Secretariat should work with the MOH to ensure that PNA considers seeking expert advice/technical assistance to redesign its electronic network architecture, for example, to allow each PRA to maintain its own database locally, with the PNA able to access it from the central level.

Recommendation 14 (Critical)

The Global Fund Secretariat should ensure that PNA develops standard operating procedures to ensure compliance with good inventory management practices across its central and regional stores.

Distribution

64. There were challenges facing the PNA in the distribution of OI drugs and ACTs. There was no tracking system at PNA and PRA level to monitor the flow of OI drugs. All OI drugs procured with Global Fund support can also be found in the in the list of essential drugs sold by the PNA to its clients. From 2011, following a DLSI supervision visit, the PRAs started to physically separate the stock of OI drugs to be distributed free of charge from the stock of essential medicines for sale. Some health facilities were unaware of the availability of the free OI drugs. The OIG audit team encountered some health facilities without any OI drugs, and others with large stocks of some OI drugs.

65. There was no formal procedure to guide the distribution of ACTs. The six-month supply for the malaria season 2011/2012 was distributed to District pharmacies with some batches expiring within the first two months of the season.

Recommendation 15 (Critical)

The Global Fund Secretariat should ensure that the PRs and the PNA establish a formal system of coordination to assure that the supply and delivery of drugs and reagents are closely linked to forecast patient loads.

Quality control

66. The National Laboratory for Drug Quality Control (LNCM) did not have an ISO 17025 certification nor was it WHO prequalified, which it is expected to gain shortly following WHO inspection in early 2011. The OIG noted that in general drugs procured with Global Fund support had been found to be of good quality. There had been some findings of moisture, but this had not affected their therapeutic effectiveness. The audit team was not able to obtain detailed information on the trends of analyses made by the LNCM by batches received and variation in quality by supplier and manufacturer.

Recommendation 16 (Critical)

The Global Fund Secretariat should work with the MOH to accelerate the accreditation of the LNCM to provide quality control services as per Global Fund Quality Assurance requirements.

FINANCIAL MANAGEMENT AND CONTROLS

The audit identified scope for improvement in financial management across all organizations audited (PRs, SRs and implementing organizations). These can be addressed by putting in place (a) relevant financial and operational manuals to guide the financial activities of SRs; (b) appropriate training of SR staff by the PR; and (c) supportive supervision of implementing entities by Principal Recipients.

67. The OIG audited grant receipts, expenditures and financial reporting of five PRs, namely, CNLS, ANCS, PNLP, PNT and DLSI. In addition, the OIG team audited grant expenditures and receipts of selected SRs and implementing partners of the above PRs, namely, Pronalin, the Bacteriology and Virology Laboratory at Dantec Hospital in Dakar (LBV), the Hope for African Children Initiative (HACI), ENDA Santé and selected Regional and District Health Services and Civil Society Organizations.

Common Areas for Improvement in Financial Management and Internal Control at all PRs and SRs

68. The OIG noted common areas for improvement in financial management and control at grant implementing organizations audited (PRs, SRs and implementing organizations). All the PRs should prepare management action plans to address the following common findings:

- a) There was scope for the PRs to adopt a Code of Ethics and Professional Conduct for staff of the PR, SRs and other implementing entities in order to enhance the control environment within which the grants operate. Further, anti-fraud policies were needed for dissemination among implementing entities;
- b) Accounting transactions (payment vouchers and supporting documentation) of various donors needed to be differentiated to facilitate allocation of expenditures to their respective grant budgets;
- c) In some cases, the OIG could not verify that program managers had reviewed payment vouchers and accompanying invoices before payment due to absence of required signatures;
- d) There was scope to put in place adequate supporting documentation for some expenditures made by SRs and CBOs for program costs relating to community health worker/field-level activities, transportation, field supervision, training, meetings, purchase of gasoline etc. The underlying cause was that SRs required relevant and appropriate financial and operations manuals that specified supporting documents required for justification of these types of expenditures;
- e) There were occasions of inter-grant borrowing of funds due to delayed receipts of grant funds; and
- f) The audit team found lack of evidence of competitive bidding or price comparisons for some purchases of goods/services.

Recommendation 17 (Important)

The Global Fund Secretariat should ensure that all PRs and SRs address the following recommendations:

- a) *The PRs should adopt a Code of Ethics and Professional Conduct for PR staff and staff of implementing entities (SRs, Non-Governmental Organization and CBOs) in order to enhance the control environment within which the grants operate. Anti-fraud policies should be adopted and disseminated among implementing entities.*
- b) *To enhance the control environment, payment vouchers and supporting documentation of various donors should be differentiated by labeling/stamping accounting documentation to facilitate allocation of expenditures to respective grant budgets.*
- c) *Program managers should ensure that documents reviewed by them are signed and dated.*

Audit of Global Fund Grants to Senegal

- d) *The PRs should ensure that SRs have Operations and Procedures Manuals that specify in detail the type of supporting documentation required for justification of expenditures relating to community health worker/field-level activities, transportation, field supervision, training, meetings, purchase of gasoline, etc.*
- e) *PRs should ensure they have up-to-date financial and operations manuals that provide guidance on period–end closing procedures.*
- f) *The PR, SRs and grant implementing organizations need to show evidence in supporting documentation attached to payment vouchers that value for money has been obtained for goods and services by ensuring that transparent competitive bidding takes place (as established in financial and operations manuals) before goods and services are procured.*
- g) *PRs and SRs should strengthen control over grant program assets by ensuring that fixed asset registers and records are updated at least annually.*

ANCS (Rounds 6 and 9 HIV/AIDS Program)

69. The OIG noted the following areas for improvement in financial management and internal control in the audit of ANCS.

- a) Putting in place adequate segregation of duties regarding purchasing in the responsibilities assigned to the Administrative and Finance Manager was essential;
- b) Regular performance of back-ups of accounting data needed to happen. In addition, there was no formal policy for off-site storage of backed-up data to mitigate the risk of loss of important data in case of a fire or a natural disaster;
- c) Limitations existed in the QuickBooks accounting software, such as its inability to handle more than nine figures or perform routine closing of the accounting period;
- d) Advances made to staff for implementation of program activities needed to be liquidated before the deadlines established for justification of the advances;
- e) New equipment stored in the office of the PR had yet to be entered in the fixed asset register, and consistently be assigned unique identifying codes to facilitate control and accounting of program assets;
- f) On-site financial reviews of SRs took place only once a year instead of quarterly as prescribed in ANCS internal regulations;
- g) Purchase of computer equipment amounting to CFA 25 million (USD 50,000) in 2008 required evidence of open and advertised competitive bidding per the PR's internal regulations; and
- h) Adequate supporting documentation attached to CFA 6 million (USD 12,000) in overhead charges needed to be made available.

Recommendation 18 (Important)

The Global Fund Secretariat should ensure that ANCS addresses the above audit findings by ensuring that:

- a) *Incompatible duties performed by the Finance and Administrative Manager are assigned to another staff member;*
- b) *A policy for back-up and storage of accounting data is adopted and implemented;*
- c) *The current limitations of its accounting software is corrected;*
- d) *Advances to staff are liquidated according to established deadlines;*
- e) *New equipment in the custody of the logistician is included in the fixed asset register; and all fixed assets are assigned unique identification codes;*
- f) *On-site financial oversight of program activities of SRs is carried out per its regulations;*
- g) *The PR strengthens its controls over purchasing by implementing Recommendation 35f above; and*
- h) *The PR provides adequate documentation and justification for the CFA 6 million overhead payments.*

PNLP (Rounds 4 and 7 Malaria Program)

70. The OIG noted the following scope for improvement in financial management and internal control in the audit of PNLN:

- a) Inter-grant borrowing of funds took place due to delayed receipts of grant funds;
- b) Stronger controls were needed over gasoline purchases for program vehicles in 2008;
- c) Insufficient supporting documentation was in place for per diems paid to participants for some training events that took place in 2008;
- d) Purchase of T-shirts for CFA 7.3 million (USD 14,600) for media events in 2009 did not conform to the established policies of the PR;
- e) Payment vouchers and supporting documentation were not archived in a chronological manner to facilitate retrieval of accounting documents;
- f) A spreadsheet (Microsoft Excel) was used to monitor grant budgets against expenditures instead of the accounting software's budget control module, which had not been activated;
- g) Insufficient supporting documentation was available for CFA 19.6 million (USD 39,000) of grant funds advanced to Sub-recipient Médecins Sans Blouse; and
- h) Insufficient supporting documentation was available for CFA 44.6 million (USD 89,000) of grant funds advanced to Sub-recipient Management Sciences for Health.

Recommendation 19 (Important)

The Global Fund Secretariat should ensure that PNLN addresses the above audit findings by ensuring that:

- a) *Inter-grant borrowing of funds ceases and balances are repaid to original grants;*
- b) *Existing policies and controls over gasoline purchases are reviewed and strengthened;*
- c) *Adequate supporting documentation is maintained for payments to participants for training events;*
- d) *It complies with its internal regulations for purchase of non-health related goods and services;*
- e) *Payment vouchers and supporting documentation are archived in a chronological manner to facilitate retrieval of accounting documents;*
- f) *The budget control module of the accounting software is activated to facilitate budgetary control;*
- g) *Grant funds advanced to the association Médecins Sans Blouse are accounted for or repaid to PNLN; and*
- h) *Grant funds advanced to the NGO MSH are accounted for or repaid to PNLN.*

PNT (Round 7 Tuberculosis Program)

71. The OIG noted the following scope for improvement in financial management and internal control in the audit of PNT:

- a) Agreements with Sub-recipients required additional information such as date of the agreement, duration and amount of the grant;
- b) Grant funds advanced to the District Health Services for program implementation were liquidated late; and
- c) Putting in place adequate segregation of duties in the responsibilities assigned to the PR cashier.

Recommendation 20 (Important)

The Global Fund Secretariat should ensure that PNT addresses the above audit findings by ensuring that:

- a) *Sub-grant agreements are rewritten to include relevant information such as date of the agreement, duration and amount of the grant;*

Audit of Global Fund Grants to Senegal

- b) *Advances made to the District Health Services are liquidated according to established deadlines; and*
- c) *Incompatible duties of the cashier are assigned to another staff member.*

DLSI (Round 9 HSS Program)

72. The OIG noted scope for improvement in financial management and internal controls in the audit of DLSI, as follows:

- a) *Written procedures in the financial and operations manual for month-end closing of grant accounts were not on file;*
- b) *Annual verification of fixed assets was needed to update the register of grant program assets;*
- c) *Putting in place adequate segregation of duties of the responsibilities assigned to the Finance Manager at the SR Pronalin was required; and*
- d) *Payment vouchers and supporting documentation for Rounds 1 and 6 grants needed to be retrieved from the custody of SRs for archiving after the end of the grants.*

Recommendation 21 (Important)

The Global Fund Secretariat should ensure that DLSI addresses the above audit findings by ensuring that:

- a) *Its financial and operations manual include procedures for month-end closing of grant accounts;*
- b) *An annual count of fixed assets is done to update the register of grant program assets;*
- c) *Incompatible duties of the Finance Manager are assigned to another staff member to assure adequate segregation of duties; and*
- d) *Payment vouchers and supporting documentation are retrieved and retained according to the provisions of the grant agreement with the Global Fund.*

CNLS (Rounds 6 and 9 HIV/AIDS Program)

73. The OIG noted scope for improvement in financial management and internal controls in the audit of CNLS, as follows:

- a) *Purchase of office furniture amounting to CFA 17.9 million (USD 36,000) in 2008 needed to demonstrate open and advertised competitive bidding as required by the PR's internal regulations;*
- b) *Purchase of computer equipment needed to meet the required technical specifications of the purchase order; and*
- c) *Procurement contracts had not been established for some purchases that exceeded CFA 5 million (USD 10,000) as required by CNLS internal regulations.*

Recommendation 22 (Important)

The Global Fund Secretariat should ensure that CNLS addresses the above audit findings by ensuring that:

- a) *The PR strengthens its controls over purchasing; and*
- b) *Procurement contracts are established for purchases exceeding CFA 5 million as required by its internal regulations.*

SR Financial Management

74. The OIG noted the following areas for improvement in financial management and internal control in the audit of HACI and SWAA, sub-Recipients of ANCS:

Audit of Global Fund Grants to Senegal

- a) Payment of transportation expenses to two operational and finance staff members who were not participants in workshops that took place in between 2007 and 2009 (HACI); and
- b) Inadequate supporting documentation for per diem paid to participants for some training events that took place in 2008 and 2009.

Recommendation 23 (Important)

The Global Fund Secretariat should ensure that ANCS ensures that HACI addresses the above audit findings by ensuring that:

- a) Policies are established in financial and operations manuals regarding per diem eligibility for operational staff who provide support functions for training events; and*
- b) The PR addresses the above finding by implementing the Recommendation above.*

Oversight over Sub-Recipients

75. Supportive supervision provided by the PRs and the decentralized services of the MOH (Regional and District Health Services) have been adversely affected by the funding gaps in the malaria and TB grant programs. The PNLN and PNT supervision costs were budgeted under the Round 7 malaria and TB grants that had funding gaps of more than one year.

PROGRAM REVIEW

76. The OIG audit focused on reviewing the adequacy and effectiveness of the controls in place to ensure that grant monies are spent appropriately. Although we did not perform a technical programmatic evaluation, we reviewed the controls in place to deliver on the goals of the grant and to ensure that programmatic objectives are achieved.

The HIV/AIDS Program

Senegal has a vigorous and well-coordinated response to HIV involving state and civil society actors. The response is evidence-based and appropriately targeted.

HIV in Senegal

77. Senegal is experiencing a concentrated HIV epidemic that has stabilized at a national level below one percent with considerable regional variability. HIV transmission during heterosexual sex in the general population accounts for about 70 percent of HIV incidence.⁵ Two successive surveys in 2006 and 2010 reported a stable HIV prevalence among female sex workers around 19 percent. Available HIV prevalence data among men who have sex with men date back to a study in 2007 reporting a prevalence of 22 percent.⁶ A first study of HIV prevalence among drug users was being prepared at the time of the audit.⁷

78. Recent surveys report a high level of acceptance of people living with HIV among most population groups. The CNLS has actively advocated against discrimination of people living with HIV which has led to the passing of a law in 2010 that makes discrimination a criminal offence.⁸ Nevertheless, all the people living with HIV that the OIG team met in group sessions in Dakar, Mbour and Ziguinchor stated that they felt highly stigmatized, particularly female sex workers and men who have sex with men.

The National Response to HIV

79. By the end of 2009, more than 12,000 people in Senegal were receiving anti-retroviral treatment in more than 100 health facilities, covering approximately 70 percent of the estimated national treatment need.⁹ HIV counseling and testing was available at more than 500 sites and more than 100 health facilities throughout the country provided complete Prevention of Mother to Child Transmission (PMTCT) services. Clinics specialized in providing health care for men who have sex with men were operating in all but one region, and 36 health facilities throughout the country were providing registration and STI control services for female sex workers. There were eleven youth counseling centers (CCA) providing comprehensive sexual health services for adolescents.¹⁰ Anti-retroviral treatment and treatment of opportunistic infections is legislated to be free of charge. A high-level watchdog committee (Comité de veille et d'alerte) has been established to prevent human rights violations of the most vulnerable groups, notably female sex workers and men who have sex with men.

80. Senegal has a well-established and vigorous civil society response to HIV. Civil society organizations have a broad base of international financial and technical support and

⁵ UNAIDS; Mode of transmission study, 2010

⁶ <http://mc.manuscriptcentral.com/ac-phm-vcy>

⁷ ANRS; Enquête de prévalence et des pratiques à risques d'infection à VIH, VHB et VHC chez les usagers de drogues dans la région de Dakar (study protocol, Feb. 2011)

⁸ Loi N. 06/2009 relative au VIH et au Sida

⁹ Data for 2010 are incomplete and unreliable because of data retention by health staff

¹⁰ According to the definition used in Senegal, adolescence extends up to age 24.

are well represented in the CCM. By the end of 2009, a total of 46 associations of people living with HIV were active in the country.

HIV Prevention

81. The most common issue raised in the meetings with the associations of female sex workers was of increasing arrests and demands of bribes by the police. The monthly registration fee for sex workers of about one to two Euro (depending on location) was not considered a problem. In Dakar it covered the required laboratory exams. Drugs for the treatment of sexually transmitted infections (STIs) were generally available free of charge from ENDA Santé in Dakar. ENDA Santé also had a mobile clinic providing services to non-registered sex workers. In St. Louis, however, sex workers have to pay for STI treatment as well as high fees for routine quarterly laboratory exams at the Regional Laboratory.

82. In meetings with groups of men who have sex with men, the OIG mission was told of an increasingly hostile environment for gay men. Nevertheless, associations involved in peer led HIV education and condom promotion have emerged throughout the country. Health mediators in hospitals and health facilities specialized in treating men who have sex with men have greatly improved the access to health for this population. There was general agreement that social exclusion and the resulting clandestine nature of their sexual lives constituted the greatest risk for HIV infection among men who have sex with men.

Recommendation 24 (Desirable) (CNLS)

The Global Fund Secretariat should ensure that CNLS strengthens the collaboration between civil society organizations and public authorities to revalorize the registration cards for sex workers, making sure that paying monthly registration fees offers real advantages such as free examination and treatment of STIs and protection from arbitrary arrest by the police.

Recommendation 25 (Desirable) (ANCS)

The Global Fund Secretariat should ensure that ANCS seeks the support of the Global Fund Secretariat to provide institutional support to the emergent associations of men who have sex with men to allow them to effectively address the HIV risk associated with their clandestine status.

Clinical services for HIV treatment and PMTCT

83. The OIG mission visited eight HIV clinics and seven primary PMTCT sites in four regions of the country.¹¹ The staff members interviewed were well informed about the latest guidelines for HIV treatment and PMTCT and were correctly applying the diagnostic and treatment algorithms. Antiretroviral drugs were available in sufficient quantities and there were no reports of any shortages in the last 12 months.

84. A number of areas for improvement were, however, observed during the site visits:

- a) All HIV treatment sites visited had a stock of “drugs for opportunistic infections”. Some of these drugs were acquired from the Regional Pharmacy (PRA) under a program of providing these drugs free of charge with Global Fund support, others were obtained by donation from other sources, and some were bought in the local market with money from an association of people living with HIV that received a subsidy for the reimbursement of medical care from the Global Fund grant. The range of available drugs varied widely. Three out of eight clinics were out of stock of Cotrimoxazole. Although the care providers were reporting the incidence of opportunistic infections according to a list of eligible conditions provided by the DLSI, in all but two facilities the drugs were only

¹¹ Primary sites are PMTCT sites offering full services including obstetric delivery and post-delivery care.

- provided free of charge to patients if they were in stock.¹² Record-keeping¹³ in clinical and ante-natal registers was incomplete in all sites visited.
- b) Although all health care providers interviewed were familiar with the protocol for CD4 and viral load analysis, only a small minority of charts and registers showed that it was applied. The reason given in all instances was the non-availability of CD4 analyzers due to breakdown of equipment, lack of reagents or the fact that patients had to travel considerable distances to reach a facility with a CD4 analyzer. The only functioning site for viral load determination was the Bacteriology and Virology Laboratory at the Dantec Hospital (LBV) in Dakar. Although the laboratory stated that it was able to analyze viral loads on dried blood spot samples submitted on filter paper, none of the clinics and laboratories visited were aware of this possibility or had submitted such samples.
 - c) An algorithm for early diagnosis of HIV infection to children born to HIV positive mothers was available in all PMTCT sites visited. All of them had submitted filter papers with dried blood spots for testing to the LBV in Dakar. However, the registers in the laboratories revealed that this was neither done consistently, nor with the timing stipulated in the algorithm.

Recommendation 26 (Important) (CNLS and DLSI)

The Global Fund Secretariat should ensure that CNLS and DLSI assure frequent and close formative supervision of HIV clinical services (HIV care and PMTCT) with special attention to the maintenance of clinical and ante-natal registers.

Recommendation 27 (Critical) (CNLS and DLSI)

The Global Fund Secretariat should ensure that CNLS and DLSI improve the access to CD4 and Viral Load analysis in the country.

Recommendation 28 (Critical) (CNLS and DLSI)

The Global Fund Secretariat should ensure that CNLS and DLSI assure the consistent application of the algorithm for early diagnosis of HIV infection among children born to HIV positive mothers.

Social support for people living with HIV

85. The Global Fund contributes to the social support for people living with or affected by HIV in three ways: (a) medical care; (b) nutritional support; and (c) livelihood support. Medical care is primarily supported by the procurement of drugs for opportunistic infections under the grant to the CNLS. It is also supported with small grants to associations of people living with HIV under the grant to the ANCS administered by HACI as a sub-recipient. Nutritional and livelihood support are delivered by associations of people living with HIV as sub-sub-recipients of HACI. Based on visits to health facilities and discussions with groups of people living with HIV, the OIG noted the following:

- a) **Medical support**: Each association interviewed received a quarterly grant that is not able meet the medical needs of all its members. The quarterly grants received were exhausted in the first two or three weeks after which time the members have to fend for themselves. All groups of people living with HIV interviewed stated that medical care is their biggest household expense and their greatest worry. For example the group interviewed in Ziguinchor had 260 members, but the grant it received allowed it to make medical payments for only for 33 members each quarter.
- b) **Nutritional support**: The program is implemented by the associations of people living with HIV through the distribution of locally assembled food kits. It is not based on a

¹² A recommendation related to this observation is found under the heading of social support because it is part of a larger issue of the financing of health care of people living with HIV.

¹³ The clinics visited had changed the format of paper-based medical registers twice in the last two years and had struggled to transfer patient data from one register to another, usually with loss of information.

professional assessment of nutritional needs of the recipients, nor is it guided by existing guidelines for nutritional rehabilitation of people living with HIV. Group members interviewed said that the food allocation was generally used up within four to six days. Further, because of a long list of people qualifying for this assistance, a family would not receive a second kit for another 12 to 18 months.

- c) **Livelihood support:** The program was delivered through micro-credit grants to members of the associations of a value ranging between EUR 100 and 150. The programs had no savings or capital formation component to create a sustained means of livelihood. There was no attempt to leverage the money by using the grant as a guarantee with a micro-finance institution. Members interviewed stated that they used their grant for conducting business for a limited period of time, but had no savings or capital once the loan was repaid. Since there were many applicants, it took a year or longer to qualify for a second loan.

Recommendation 29 (Desirable) (CCM, CNLS, ANCS)

Looking forward, The Global Fund Secretariat should ensure that the CCM, CNLS and ANCS review the modalities of applying grant funds to the subsidy of medical care for people living with HIV. The current combination of input financing (through the procurement of drugs for opportunistic infections) and medical care grants to associations of people living with HIV is not effective. Other methods such as per capita payments to health facilities based on the patient load or contracting of health facilities should be considered. Initial costing studies of these types of approaches have already been conducted in Senegal.¹⁴

Recommendation 30 (Desirable) (ANCS)

Looking forward, the Global Fund Secretariat should ensure that the ANCS reviews the nutritional and livelihood programs for people living with HIV with the objective of refocusing these programs so that the nutrition support program addresses actual nutritional needs of the beneficiaries and the livelihood program is developed in collaboration with experienced micro-credit organizations within the framework of a savings and loan program designed to achieve capital formation.

¹⁴ ANA Canestri et al. Evaluation of the cost of medicines excluding antiretroviral for patients in Senegal (working progress) . Poster Exhibition: The XIV International AIDS Conference: Abstract No. TuPeE5163, 2003

Monitoring and Evaluation

86. The Performance Frameworks of the grants to the CNLS and to ANCS have eight common impact and outcome indicators that are derived from national data collection activities such as the DHS and ENCS surveys. At the output level, the ANCS grant follows twelve indicators and the CNLS grant eleven. The versions of the performance frameworks provided to the OIG were dated November 2010.

87. The main observation of the performance frameworks was a misinterpretation of the meaning of “number and percentage” in the target setting of many output indicators. Percentages, in all cases, were calculated with the target number as the denominator rather than the estimated population size in order to assess program coverage. Thus four annual cumulative indicators in the CNLS framework have a defined target of 100 percent at the end of each year, and six program cumulative indicators have a target of 100 percent at the end of the two-year grant. The situation is similar for the ANCS grant.

Recommendation 31 (Desirable) (CNLS, ANCS, Global Fund Secretariat)

CNLS, ANCS and the Global Fund Secretariat should jointly review the grant performance frameworks of the grants of both PRs and, where possible, define targets that are expressed as proportions in terms of population coverage estimates rather than in terms of target achievement.

Data Management and Quality

88. Performance data are collected in the form of standardized paper-based monthly reports by the UAR at the regional level, entered into an electronic database, and transmitted quarterly to the central level. Health service data are shared with the National Health Information System at the Regional level. Because of the data retention strike, complete data are only available up to the end of 2009, although some updated data were collected through “active data collection” by staff of the CNLS. Data for community-based activities reported by the ANCS are collected in a standardized format by the Sub-Recipients (SRs) and submitted to ANCS in quarterly reports. The data are verified during site visits by ANCS staff.

89. Two OSDVs were carried out in 2009 by the former Local Fund Agent (LFA). The reports, however, were not reliable because of sampling errors. An OSDV that had been planned in 2010 was postponed because of the data retention strike. There was no indication of any issues of data quality for community-level data. It is, however, difficult to assess the quality of clinical data because of the strike. The review noted the following areas of concern:

- a) There was no system in place to monitor the 12-month ART retention rate, which was one of five impact indicators. Once the CTA in Dakar has completed the transfer of all files to the electronic patient record system (ESOPE) this information will become available on a routine basis for the approximately 1,600 adults on ART followed at this facility. However, will not reflect national data.
- b) The summary data extracted from the 2009 HIV treatment database and provided by the PNLs to the OIG lists the annual incidence of opportunistic infections for each Region. This is one of the Global Fund output indicators. When computed in relation to the number of HIV positive patients followed in each Region, the incidence ranges from zero percent (no opportunistic infections) in Kolda and Sédhiou to about 50 percent in Diourbel, Fatick and Tambacounda. This is unlikely to be accurate.
- c) During random reviews of registers and charts by the OIG audit team in eight HIV clinics, we found various non-standardized approaches to tracking patients lost to follow-up, most of them based on personal knowledge and engagement by the social worker or clinical staff. In three clinics, we examined at least one random chart of a

patient who had missed at least one appointment but who was still kept on the list of active patients.

Capacity Building

90. Training activities represent about eight percent of the CNLS budget and six percent of the ANCS budget. All community-based groups and associations met by the OIG team confirmed that they received essential training and technical support from ANCS and from SRs such as HACI and ENDA Santé. The clinical staff interviewed during the site visits were well informed about treatment issues and protocols.

The Tuberculosis Program

The tuberculosis program is performing strongly in terms of increased treatment completion and success rates. There have been recent improvements in the diagnosis and care of TB/HIV co-infection. There are still major challenges in assuring the diagnosis and treatment of multi-drug resistant tuberculosis.

Tuberculosis in Senegal

91. According to the WHO, Senegal had between 29,000 and 43,000 new cases of tuberculosis in 2009, placing the country in the average range in Africa.¹⁵ 11,139 cases were detected and notified, (about 32 percent of the estimated burden). There is, however, a high level of uncertainty in the WHO estimate.

92. Seven percent of tuberculosis patients were HIV positive in 2009.¹⁶ Data from the 2010 PNT database suggest that this proportion is closer to 10 percent.¹⁷ The number of new cases of multi-drug resistant (MDR) tuberculosis in 2009 was estimated at 390 by WHO. A study in 2006 estimated the prevalence of MDR TB among all patients with sputum positive tuberculosis at 1.9 percent. A new study is planned for 2012.

The National Response to Tuberculosis

93. There are 78 diagnostic and treatment centers for tuberculosis located in referral health centers (CSR). An additional 15 health facilities provide laboratory diagnostic services. Treatment is decentralized to over 300 health posts, prison and military clinics. Treatment for MDR tuberculosis is currently provided on an outpatient basis in three health centers in Dakar. The rehabilitation of an inpatient treatment facility is nearing completion at the Fann Hospital. The national tuberculosis reference laboratory (LNR) is operated by the PNT. It provides supervision and quality control for microscopy services throughout the country and is also the only public laboratory providing sputum culture and drug sensitivity testing.¹⁸ Three regional laboratories are currently being established.

94. Treatment success rates have continued to increase steadily over the past five years, outpacing the average rate of increase on the African continent. About 84 percent of the 2008 cohort of patients with smear positive pulmonary tuberculosis were reported as treated successfully. Because of data retention, final results for the 2009 and 2010 cohorts are not available but partial data suggest that the treatment success rate for the first quarter cohort of 2010 has climbed to 86 percent¹⁹.

95. Under the Round 7 Global Fund grant, the PNT signed sub-recipient agreements with 32 selected districts which in turn contracted community-based organizations to participate in health promotion, case finding, tracing of defaulters and community-based supervision of DOTS. An analysis of the 2008 cohort results revealed that in these 32 districts a combined treatment success rate of 87 percent was achieved with a default rate of 5 percent. In the 37 remaining districts without community actors the treatment success was 76 percent and the default rate 13 percent.²⁰ In the newly negotiated Round 10 grant, the collaboration with

¹⁵ WHO; Global Tuberculosis Control 2010

¹⁶ *ibid.*

¹⁷ PNT; Tuberculosis database 2010 (7,650 TB patients tested, 408 HIV positive, plus 368 known persons living with HIV diagnosed with tuberculosis: $(408+368)/(7,650+368) = 9.7\%$)

¹⁸ Sputum culture and sensitivity testing is also performed in one private laboratory in Dakar and in the laboratory of the Institute Pasteur.

¹⁹ PNT database accessed August 2011.

²⁰ Global Fund Round 10 grant application (page 7)

community-based organizations will be implemented throughout the country under a grant managed by a civil society partner.

96. When the first phase of the Global Fund Round 7 grant ended after a three month extension in January 2011, the PNT was left with a cash balance of EUR 340,000 (after deducting accrued expenditures) and a forecasted cash requirement of EUR 620,000 for the next six months.²¹ The PNT therefore had to reduce its planned program activities. This created serious gaps in supervision and data verification and delayed the planned scale-up of the MDR TB program. The agreement for Phase 2 of the grant was signed in August 2011 but no disbursement to the PNT had yet been made at the time of the OIG mission.

Recommendation 32 (Important) (PNT, the LFA and the Secretariat)

The PNT, the LFA and the Global Fund Secretariat should work together to avoid implementation gaps such as the one experienced in the transition from Phase one to Phase two of the Round 7 TB grant.

Tuberculosis Diagnosis and Treatment

97. The OIG mission visited the tuberculosis clinics and the laboratories in seven Reference Health Centers. All except one CDT had copies of the most recent quarterly case notification and treatment outcome reports. The information in all reports was identical to the information obtained from the central PNT database. All except one laboratory (Ziguinchor) had copies of their last quality control showing good results in terms of accuracy of sputum microscopy. No major weaknesses were identified. The proportion of children on treatment or prophylaxis in several clinics was quite low, suggesting that there may have been gaps in contact tracing.

Tuberculosis and HIV Co-infection

98. The nurses in charge of the CDTs visited by the OIG mission were trained in HIV counseling and testing. The result of the HIV test is noted in the register and on the patient cards. National data for the first quarter of 2011 indicate that the HIV status of about 70 percent of tuberculosis patients is known, and that among those who are HIV positive about 85 percent are receiving Cotrimoxazole prophylaxis.²²

99. According to the registers and quarterly CDT reports, the proportion of co-infected patients receiving ART is low. In the national database for the first quarter of 2011, it was 46 percent. Dispensing ARVs for tuberculosis patients in the tuberculosis clinic, the so-called “one stop” service, is starting to be implemented. It is expected to improve the ART coverage among co-infected patients.

Multi-Drug Resistant Tuberculosis

100. Treatment of MDR Tuberculosis started late, with the first ten patients enrolled in treatment in 2010.²³ At the time of the OIG audit, 16 patients had been enrolled as out-patients in three health centers in Dakar. For tuberculosis patient living outside Dakar a diagnosis of MDR TB is near impossible since sputum samples for culture can only be collected from patients directly at the LNR. Even with this limitation, the LNR detected 41 cases of multi-resistant tuberculosis in 2010. Most patients with MDR TB in Senegal do not receive appropriate medical treatment, a situation that will change only very gradually, even

²¹ PUDR Period 9 (ending 31 January 2011)

²² The national data set for Q1 in 2011 is almost, but not fully, complete because of data retention by health staff.

²³ A few patients have been treated over the past five years at their own cost at Fann Hospital with non-standard drug regimes. The outcome of these treatments is not known.

Audit of Global Fund Grants to Senegal

after the in-patient facility has opened and after the target of enrolling 40 patients per year in MDR TB treatment has been reached.

Recommendation 33 (Critical) (PNT)

The Global Fund Secretariat should ensure that PNT accelerates the establishment of hospitalization services for MDR tuberculosis, the decentralized capacity for sputum cultures and drug sensitivity testing, and a system for sputum transport to the laboratories performing culture and drug sensitivity testing.

Monitoring and Evaluation (M&E)

101. At the time of the OIG audit, the performance framework for Phase 2 of the Round 7 tuberculosis grant was not yet validated. The OIG mission corresponded extensively with the M&E specialists of the PNT and of the Secretariat on evolving drafts of this framework. All issues raised by the OIG mission were addressed, or will be addressed at the time of consolidation of the Round 7 and the Round 10 grant.

Data Management and Quality

102. Quarterly paper-based reports are submitted from tuberculosis clinics to the PNT via the Health Regions. Reports of the activities of community-based organizations are collected by the Health Districts (the SRs) and transmitted to the PNT. Clinical data are verified in six-monthly regional data verification meetings. However, because of the programming gap between the Phase 1 and Phase 2 grant agreement, at the time of the audit no meetings had been held for more than one year. An OSDV was conducted in 2010 that found good data quality for clinical data but unreliable data for community activities.

103. Despite the data retention strike and the programming gap between the two phases of the Global Fund grant, the OIG mission did not identify any data quality issues at the level of the tuberculosis clinics with one exception: the information of the number of HIV/TB co-infected patients receiving ART was not always available or up to date. This finding is being addressed by the introduction of one-stop TB and HIV treatment. The OIG did not review community data because the transfer of responsibility for the support of community based organizations (CBOs) from the Districts to the Civil Society PR in the Round 10 grant would make this review obsolete.

The Malaria Program

Since its reorganization in 2006, the National Malaria Program in Senegal has achieved a high level of success. Because of the protracted negotiation process for the second phase agreement of the Round 7 grant, there has been no significant Global Fund support to malaria control in Senegal since mid-2010.

Malaria in Senegal

104. Reported cases of malaria fell precipitously from more than 1.5 million in 2006 to 174,000 in 2009.²⁴ The main reason was a change in the case definition. But even after adjusting for this change, a continued downward trend in malaria incidence is noticeable. Because of the data retention since 2010, the continuation of the trend cannot be confirmed. Anecdotal information suggests that the downward trend continues.

The National Response to Malaria

105. The National Malaria Program (PNLP) started a very ambitious malaria control program in 2006, including a mass distribution campaign for universal coverage that was still being rolled out at the time of the OIG audit. The impact of this program is well documented.²⁵ A network of sentinel health posts has been established in the north of the country submitting weekly malaria incidence reports as part of a strategy to eliminate local transmission of malaria in large parts of Senegal.

106. International financial support for the malaria strategy in Senegal tripled from about USD 10 million in 2005 to about USD 30 million in 2010, approaching the estimated requirement of about USD 40 million per year for the implementation of the national strategy. In 2009, the Global Fund contributed about a third of program funding. In 2010, the Global Fund contribution was less than 10 percent, as the first phase of the Round 7 grant came to an end in August 2010. By the end of the OIG field work in September 2011, the agreement for the second phase of the Round 7 malaria grant had not been signed.²⁶ The malaria program in Senegal has a broad base of international support and was therefore able to continue the implementation of its strategy, despite the interruption of financial support from the Global Fund.²⁷

Malaria Diagnosis and Treatment

107. The OIG mission visited seven Health Centers and two Health Posts. The national algorithm for malaria testing was strictly applied. Microscopy was rarely used, primarily for ante-natal clients and for hospitalized patients. All patient records reviewed showed that rapid diagnostic tests (RDT) or GE were used consistently.

108. Outpatient registers were generally not well kept. This has implications on the quality of data reported. Only about half of the ante-natal registers reviewed provided clear records of intermittent preventive treatment of malaria (IPT). In all ante-natal clinics, the column for bed-nets was systematically ticked even though there had not been any bed-nets available for distribution for over a year. The midwives stated that they marked this column when the woman said that she slept under a bed-net or when she received a prescription to buy a bed-net.

²⁴ Roll Back Malaria; Focus on Senegal, November 2010

²⁵ *ibid.*

²⁶ The Phase 2 Round 7 malaria grant was consolidated with the Round 10 malaria grant into a single stream of funding grant and was signed on 15 December 2012 with a start date of 1 January 2012.

²⁷ At the time of the audit in Sep 2011, the most recent disbursement had been made in March 2010

109. All pharmacies had ACTs in stock, generally in large quantities but with many lots close to expiry (September or October 2011). RDTs were in stock in all health facilities visited. Stock management of ACTs and RDTs was generally not as good as for other essential drugs (stock cards were not up to date, ACT packages for specific weight groups were not re-ordered when out of stock, etc.). In contrast to other essential drugs, there is no economic interest for the Health Committees²⁸ to order and dispense “free” RDTs and ACTs. Supervision by the PNLP and by Districts has focused very closely on the management of these inputs as well as on the maintenance of registers. Such supervision, however, was financed under the Round 7 Global Fund grant and has not taken place since the end of the Phase 1 in 2010.

Recommendation 34 (Important) (PNLP)

The Global Fund Secretariat should ensure that PNLP restarts an intensive schedule of formative supervision of health facilities with special attention to the stock management of RDTs and ACTs as well as to record keeping and verification of data.

Bednets

110. In 2009, Senegal organized the first national mass distribution of long-lasting insecticide-treated bed-nets (LLIN) for households with children under five, distributing 2,300,000 nets throughout the country. A post-campaign study conducted in 2010 reported that 82 percent of households had at least one LLIN.

111. In 2010 the PNLP adopted a strategy of universal bed-net coverage using the principle of “one bed – one net”. The PNLP estimates a need for 12 million nets over the strategy period (2011-2015) to support universal coverage.²⁹ Guidelines were issued in 2010 specifying the methodological approach to mass distributions as well as of continued routine free distribution of Long-Lasting Insecticide-treated bed-nets (LLINs) to pregnant women at the time of their first ante-natal visit.³⁰ Mass distribution of LLINs for universal coverage started in 2010. LLINs for routine distribution in ante-natal clinics, however, were not available in any of the Health Centers visited by the OIG and had not been available for more than one year.

112. Several partners have supported the PNLP with bed-nets over the past years including US PMI, the Islamic Development Bank (IDB), the World Bank and the Global Fund. Under Phase 1 of the Round 7 grant, the PNLP procured 1.4 million nets (out of 1.75 million planned). A further 1.2 million nets were included in the draft budget for Phase 2. The proposed budget for the Round 10 grant included a further 7.5 million LLINs, with 2.5 million in the first two years. At the time of the audit, only bed-nets from the PMI were available for the mass campaign, which were neither sufficient to achieve national coverage before the 2011 malaria season, nor to supply health facilities for routine ante-natal distribution.

Recommendation 35 (Important) (PNLP)

The Global Fund Secretariat should ensure that PNLP procures the planned bed-nets to complete the universal coverage campaign before the 2012 malaria season and restart the routine distribution of bed-nets in ante-natal clinics as quickly as possible.

²⁸ Health Centers are managed by committees, who usually employ the pharmacy manager and other auxiliary staff with the income from, *inter alia*, the sale of drugs.

²⁹ CCM 2010; Global Fund proposal for Round 10 malaria

³⁰ PNLP 2010; Guide Méthodologique pour la Couverture Universelle en MILDA

Audit of Global Fund Grants to Senegal

Monitoring and Evaluation

113. At the time of the audit, the Round 7 malaria grant did not have a validated performance framework.

Data Management and Quality

114. Data on malaria diagnosis, laboratory test results and treatment given were collected from the outpatient and hospital registers every month and compiled in a monthly malaria report by the nurse supervisor of the health facility. These reports also included data on IPT from the ante-natal clinic registers. The monthly reports were verified in quarterly regional meetings.

115. Since 2007, four OSDVs for the malaria program have been conducted, the latest in December 2010. This OSDV found that the reported number of patients with malaria symptoms who were tested was relatively reliable except in cases where entire registers were lost or destroyed. In general, the OIG mission found that systems were in place to collect valid data. However, because of the data retention strike and the Global Fund program gap, they could not be validated during the audit.

Capacity Building

116. At the time of the audit, a number of training activities supported by PMI were underway. No Global Fund-supported training or capacity-building activity had been implemented for more than one year.