



THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Diagnostic Review of Global Fund Grants to the Republic of The Gambia

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Table of Contents

Executive Summary3

Message from the General Manager of the Global Fund4

Message from the Country Coordinating Mechanism5

Introduction6

Risks9

Annex 1: Abbreviations30

Annex 2: Principal Recipients32

Annex 3: Recommendations and Action Plan33

Executive Summary

1. This diagnostic review of the Global Fund grants to the Republic of The Gambia (Gambia) sought to identify and share good practices, identify key risks to which grant programs were exposed, and make recommendations for risk mitigation where weaknesses and gaps were found in the current risk response.

2. The review covered all seven active grants to Gambia, totaling USD 59 million of which USD 48 million had been disbursed at the time of the review. Six Principal Recipients implemented grants: The National AIDS Secretariat, the National Malaria Control Program, the National Tuberculosis and Leprosy Control Program, the Medical Research Council, Catholic Relief Services and ActionAid International.

3. There was evidence of successful national responses to HIV and malaria and of treatment success of tuberculosis in Gambia. Some good practices were observed by the team during the course of the diagnostic review. Notwithstanding this, a number of risks were identified that may potentially impede the program unless they are mitigated. The OIG has offered 28 “High Priority” and 11 “Significant Recommendations”¹ to address these risks. Action plans in response to the report recommendations have been prepared by the Global Fund Secretariat, the Country Coordinating Mechanism and the Principal Recipients and are included as Annex 3.

Key Mitigating Actions Agreed Upon

4. In response to the risks identified, the stakeholders have committed to:

5. Ensuring that data for decision making are accurate. In particular, the CCM and PRs will ensure the quality of consumption data used for quantification and distribution of pharmaceuticals (especially ARVs and ACTs) and health supplies (condoms and bed nets). Data will be collected through national systems wherever possible, and care taken to avoid double counting.

6. Ensuring that procurement is in line with good practice. In particular, the PRs will consistently practice competitive selection and the CCM and PRs will ensure quality assurance in line with Global Fund requirements.

7. Ensuring that treatment is optimal and patients are reached. In particular, the CCM and PRs will ensure that ART for co-infected TB patients commences early and PRs should institute pharmacovigilance for drug safety. The reasons for declining ART retention will be examined and addressed.

8. Ensuring good financial management. In particular, PRs will retain and consistently follow good banking practices. Principal Recipients will strengthen oversight of SR financial management practices and the CCM and PRs will ensure accurate payments reach orphans and vulnerable children.

9. Ensuring high quality oversight. In particular, the CCM will ensure that Global Fund requirements concerning CCM membership and conflict of interest are met to ensure continued eligibility for funding and that oversight over the grant programs becomes routine.

¹ Definitions are at paragraph 14. Other recommendations which require attention are offered in a letter to management.

Message from the General Manager of the Global Fund



10 YEARS
OF IMPACT

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MESSAGE FROM THE GENERAL MANAGER

I would like to thank the Office of the Inspector General for its thorough and insightful work on the Diagnostic Review of the Global Fund Grants to the Republic of the Gambia.

The diagnostic review was conducted from November 14 to December 2, 2011, with additional fieldwork performed between January 24 and 30, 2012. It covered all seven active grants to Gambia, totalling US\$ 59 million, of which US\$ 48 million had been disbursed at the time of the review.

According to the review report, there is evidence of successful national responses to HIV, tuberculosis and malaria. Gambia has a national TB treatment success rate of 90%. The country also has in place a national strategic framework for health, and the grants' implementation has taken place in accordance with national and international normative guidelines. In addition, the review found that all financial management teams had in place sound systems of internal control to ensure proper segregation of duties.

Notwithstanding the good standards achieved, the review identified risks and challenges. Gambia has not met the targets related to the retention of patients on antiretroviral treatment of 89% for 2009 and 91% for 2010. In fact, ART retention declined from 86% in 2009 to 82% in 2010. The country had by June 2011 achieved only 60% of its intended target for initiating patients co-infected with HIV and TB on antiretroviral treatment. Some programs also presented risks of results being misrepresented due to double counting.

The review makes 39 recommendations, to ensure that data for decision making are accurate, that procurement is in line with good practices, that treatment is optimal and patients are reached, and that there is good financial management and high quality oversight.

The Global Fund Secretariat, the Country Coordinating Mechanism, and the principal recipients together have prepared action plans to implement the report recommendations. Some of the suggested measures are already in place.

Diagnostic reviews 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

Diagnostic Review of Global Fund Grants to The Gambia

Message from the Country Coordinating Mechanism

Gambia Country Coordinating Mechanism Permanent Secretariat
1st Floor
FIB Building,
Kairaba Avenue
July 26th, 2012

Mr John Parsons
Inspector General
The Global Fund

The Gambia's Final Comments on the OIG's Diagnostic Review Report on Global Fund Grants to the Gambia

The Gambia CCM with its Principal Recipients have reviewed both the draft and the final reports of the OIG's Diagnostic Review report on the Global Fund Grants to the Gambia and are quite satisfied with the report. The final report is true reflection of our grants and it has incorporated all our comments. We have taken note of all the issues raised and have started implementing some of the recommendations. We would like to assure you that the CCM and its Principal Recipients will endeavour to make sure all recommendations are implemented within the specified time indicated in the action plan.

On behalf of the entire CCM and our Principal Recipients, I would like to extend our sincere thanks and appreciation for the cooperation and the support during the entire exercise.

Yours sincerely,



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Madi Jobarteh
CCM Vice Chair

Cc: File
CCM Chair

Diagnostic Review of Global Fund Grants to The Gambia

Introduction

What was the review about?

10. As part of its 2011 plan, the OIG undertook a diagnostic review of the Global Fund grants to the Republic of The Gambia (Gambia). This review sought to:

- Identify and share good practices; and
- Identify key risks to which Global Fund grant programs were exposed and make recommendations for risk mitigation where weaknesses and gaps were found in the current risk response.

11. A diagnostic review is different from a country audit in that no overall opinions are provided and no assurance is provided regarding how grant funds were spent. The team for the diagnostic review included technical experts in public health, procurement and supply chain (PSM) management, and financial management. The main fieldwork for the diagnostic review was conducted from 14 November to 02 December 2011, with additional fieldwork performed on PSM from 24-30 January 2012.

12. Of the ten grants made to Gambia, the review covered the seven active grants, which totaled USD 59 million, with USD 48 million disbursed at the time of the review.² The Global Fund grant portfolio for Gambia was as follows³:

Round/ Disease	Grant – Principal Recipient	Grant Amount- USD	disbursed Amount- USD
R3 - Malaria	GMB-304-G02-M: The Department of State for Health of the Republic of the Gambia	14,794,704	14,794,704
R3 - HIV	GMB-304-G01-H: The National AIDS Secretariat of the Republic of the Gambia	14,563,907	14,563,907
R5 - TB	GMB-506-G03-T: Ministry of Health and Social welfare of the Government of the Republic of the Gambia	5,032,929	4,900,730
R6 - Malaria	GMB-607-G04-M: Ministry of Health and Social welfare of the Government of the Republic of the Gambia	11,585,193	11,585,193
R8 - HIV	GMB-809-G06-H: ActionAid The Gambia	5,570,264	4,085,982
R8 - HIV	GMB-809-G05-H: The National AIDS Secretariat of the Republic of the Gambia	16,452,860	12,203,196
SSF - TB	GMB-T-MRC: Medical Research Council (UK)	3,158,908	2,005,497

² The Global Fund website, November 2011.

³ The Global Fund website, 25 October 2011. See Annex 2 for a description of the PRs.

Diagnostic Review of Global Fund Grants to The Gambia

<i>SSF - TB</i>	<i>GMB-T-MOH: Ministry of Health and Social welfare of the Government of the Republic of the Gambia</i>	<i>3,746,019</i>	<i>2,726,490</i>
<i>SSF - Malaria</i>	<i>GMB-S10-G07-M: Ministry of Health and Social welfare of the Government of the Republic of the Gambia</i>	<i>15,230,821</i>	<i>12,188,007</i>
<i>SSF - Malaria</i>	<i>GMB-M-CRS: Catholic Relief Services</i>	<i>4,101,726</i>	<i>3,671,149</i>
<i>TOTAL</i>		<i>94,237,331</i>	<i>82,724,855</i>

What good practices were observed during this diagnostic review

13. The following is a list of good practices that were observed by the OIG team in the course of the diagnostic review. Since the review focused on the identification of risks, this list is neither exhaustive nor systematic.

- Gambia has in place a national strategic framework for health and a national M&E plan. National data collection tools exist, and implementation of health programs takes place through the national system with coordinated regional health teams;⁴
- Procurement policies, procedures and systems were in place for selection, procurement, storage, and distribution;
- Proper warehousing documents and inventory control for health products existed in the Central Medical Stores (CMS) and in ART Centers and Health Centers visited;
- Implementation of grant programs took place in accordance with national and international normative guidelines;
- Reliable financial accounting software packages were available for use and all financial records were kept in accordance with sound International Accounting Principles;
- Budget control mechanisms were being applied and accounting records were updated on a timely basis; and
- All financial management teams had in place sound systems of internal control to ensure proper segregation of duties.
- The OIG observed good stock coverage, with no ARV stock out in the CMS and in ART Centers (though some expiry) and no ACT stock out or expiry in the CMS;
- All eligible patients (HIV and TB) received Cotrimoxazole prophylactic treatment; and
- The PR (AAITG) acted promptly to procure additional condoms when it became apparent that shortages were imminent.

⁴ While the report demonstrates an urgent need to address the risks arising from having created parallel reporting systems for Global Fund grant-related activities, the frameworks and policies to allow for integration in national systems are in place. The OIG considers this a good practice.

Prioritization of
Audit
Recommendations

14. 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) High Priority recommendations – issues of material concern, fundamental control weakness or non-compliance which, if not effectively managed, present material risk and which may be highly detrimental to the organization’s interests and the achievement of aims and objectives. These recommendations require immediate attention by senior management.
- (b) Significant recommendations – control weaknesses or non-compliance which present significant risk and where management attention is required to remedy the situation within a reasonable period of time.

Risks

PROGRAM IMPLEMENTATION: HIV/AIDS

What were the specific risks related to the National AIDS Secretariat (NAS) as PR?

15. Gambia has almost 50% coverage of ART (2,253 PLWHA are on treatment out of an estimated 5,000 in need), and targets for VCT services have been achieved during the course of grant implementation. All eligible patients co-infected with HIV and TB receive Cotrimoxazole prophylactic treatment. Nonetheless, there are some areas of risk that should be addressed.

Data for Decision-making

16. There is a risk that it will not be possible to establish whether grant objectives have been achieved (and a risk that they may not be achieved) due to incomplete availability of baseline data and survey data for mid-course corrections.

17. Based on the results of the 2006 National Sentinel Survey (NSS), an estimated 2.8% of pregnant women in Gambia are HIV positive. The Global Fund Round 8 grant provided for an annual NSS among antenatal women aged 15–49 years at nine sentinel sites to evaluate the effect of the national HIV response on preventing new HIV infections in Gambia. Such surveys had not taken place, and would provide the best estimates of adult HIV prevalence to allow for mid-course corrections in implementation.

Antiretroviral Treatment Outcomes

18. If the cause of the decline in antiretroviral therapy (ART) retention is not identified and addressed, there may be a continued decline.

19. ART retention targets for 2009 (89%) and 2010 (91%) were not met, with ART retention declining from 86% in 2009 to 82% in 2010. This has been identified as a problem by the PR and the LFA. However, at the time of the review there had been no concrete actions to investigate and mitigate the cause of this decline.

Antiretroviral Pharmacovigilance

20. Without a strong pharmacovigilance system, there is a risk that the effectiveness of the ART program will be compromised by problems related to drug toxicity, drug tolerance and drug interactions.

21. The Round 8 grant provides funds for strengthening

antiretroviral (ARV) pharmacovigilance. These funds have been earmarked for training 40 public and private ART facility health care workers annually on monitoring and reporting adverse drug reactions. The National AIDS Secretariat (NAS) has a national ARV Pharmacovigilance Plan but requires guidelines or Standard Operating Procedures (SOP) that describe pharmacovigilance activities.

22. While twenty health care workers from 15 facilities were trained in October 2010, regular reporting and continued training on pharmacovigilance needed to be put in place at the time of the survey.

23. The National Pharmaceutical Service Laboratory was responsible for monitoring drug toxicity and safety. Its capacity to execute this function effectively should be formally assessed.

Parallel Reporting Systems

24. Reporting Global Fund grant-related indicators through reporting systems parallel to the national structures does not strengthen the Gambian HMIS.

25. At the time of the review, NAS was using parallel reporting systems to collect data specific to Global Fund-supported activities instead of utilizing existing national systems through the NAC. NAS country officers were mainly collating data from facilities and undertaking verification themselves, leaving the Regional AIDS Coordinators largely uninvolved.

26. The NAS National M&E Plan adequately captured grant-related indicators (in addition to other indicators of interest for monitoring the national response), thus obviating the need for a grant-specific data collection process.

27. Quarterly review meetings provide an opportunity for facilities to present data to the PR, regional teams and other facilities. There is scope for sharing detailed reports of findings from previous data quality audit exercises at these meetings.

Monitoring and Oversight

28. There is a risk that implementation and operations will be adversely affected by a lack of high-level guidance, oversight and accountability.

29. At the time of the review, NAC, the body that oversees NAS, had not met since 2006 to review

programmatic progress. There was no other entity responsible to oversee the implementation and performance of Global Fund-supported grants. There is scope for improving oversight through more regular oversight meetings.

What were the specific risks related to ActionAid International The Gambia (AAITG) as PR?

Availability of and Access to Condoms

30. There is a risk that the quantity of condoms provided by the grant is inadequate to ensure achievement of grant objectives and that condoms distributed do not reach the intended recipients, particularly MARPS.

31. The Sex Workers Intervention Project reported that they received at most two boxes of condoms monthly (each containing 7,200 condoms), which was insufficient for the group of sex workers they served. Volunteers interviewed noted that demand outstripped condom supply.

32. Sex workers interviewed at brothels and hotels reported that the packets of 140 “Global Fund” and Ministry of Health⁵ condoms were usually sold to them at GMD 150 (USD 5) each, going up to GMD 300 during periods of scarcity.

33. Condoms were distributed by the Gambia Family Planning Association (GFPA), an SR, with extensive experience in distribution, including a warehouse in each region.

34. At the time of the review, there was a need to develop a clear needs- or population-based distribution strategy or guideline for condoms. Most condoms were distributed by peer educators and community volunteers in their communities, with some brothels, family planning clinics, health facilities and institutions listed as outlets for distribution.

35. At the time of the review, AAITG needed to develop a clear quantification method that articulated assumptions made and detailed the coverage targets relating to commercial sex workers. AAITG’s quantification system for condoms was based on distribution data provided by the GFPA. This method may be appropriate for routine distribution to organizations and communities, but was not sufficient in targeting populations most at risk.

36. The forecast quantity of condoms in the PSM plan (1,000,000 male and 2,000 female condoms) was insufficient, a situation worsened by the delay in delivery encountered by VPP. An additional 500,000 condoms were

⁵ Condoms seen on site were MOH issue. The risk affects both government and Global Fund issued condoms.

Diagnostic Review of Global Fund Grants to The Gambia

ordered in July 2011. The forecast in the Phase 2 PSM plan does not appear sufficient. Based on current data, the cumulative indicator at the end of Phase 2 should not be lower than 3,300,000.

37. AAITG intends to investigate further the actual needs of MARPS and intends to train 254 sex workers as peer health educators by the end of Phase 1.

Double Counting

38. There is a risk that reported achievements for BCC misrepresent actual achievements due to double counting.

39. AAITG exceeded targets on indicators for BCC messaging using participatory approaches and life skills education. The OIG reviewed the Agency for Development of Women and Children, one of the SRs implementing BCC programming, to determine how activities and achievements were counted and reported.

40. There was significant double counting noted in the method used to count the number of people reached. Individuals were counted each time they received a message (up to five times, for example, through sensitization meetings organized in schools).

41. There is scope to improve the M&E plan to include guidelines to describe the content of the behavior change messages and improve monitoring to ensure that they are implemented per the plan.

PROGRAM IMPLEMENTATION: MALARIA

What were the specific risks related to the National Malaria Control Program (NMCP) as PR?

Data quality

42. There is a risk that the true achievement against targets will not be known at the end of the grant.

43. NMCP has underachieved the 'number of people presenting to health worker/village worker with fever who has a finger prick for malaria testing using RDTs' (28% of target as of April 2011), as well as the 'number of children under the age of five with uncomplicated malaria receiving antimalarials (ACTs) as per national guidelines' (17% of target). There are difficulties in collecting complete data from clinics and village health workers, as well as verifying data, in part due to the high workload of staff responsible for data collection. NMCP has taken steps to address this problem by hiring data entry clerks who will assist in completing registers and improve the quality of data in large facilities.

44. There is scope to develop standardized Data Quality Assessments (DQA) or Standard Operating Procedures (SOP) for data management. Such documents could guide data collection, transmission and reporting processes, including internal data quality audits and should form part of the M&E Plan.

What were the specific risks related to Catholic Relief Services (CRS) as PR?

Availability of Insecticide Treated Nets at RCH clinics

45. There is a risk that LLINs for routine distribution to pregnant mothers and children under five in reproductive and child health (RCH) clinics are not reaching intended recipients.

46. LLIN distribution to pregnant women and children under five was reviewed at Serrekunda hospital in the Western Region for the period of 1 September to 23 November 2011. This coincided with the period immediately following mass campaigns for LLIN distribution. RCH clinics were conducted every day from Monday to Friday. A review of the registers showed that 514 LLINs were given out in a ten day period (2-12 September), followed by 94 LLINs on 23 November (the day of the OIG visit). There was no distribution during the two month period between those dates.

47. The OIG examined the stock of LLINs available at the Kerewan Health Centre RCH clinic in North Bank Region. Their stock of 104 LLINs had been distributed during community outreach on the day of the OIG visit, leaving no nets on hand for subsequent RCH clinic days.

Behavior Change Communication

48. There is a risk that BCC output indicators bear little relation to the desired population-level effects.

49. CRS is responsible for the only nationwide malaria BCC intervention. CRS reported overachievement in BCC training indicators and underachievement in the number of visits by the Kabilo representatives to sensitize households and the number of peers reached by peer health educators in and out of schools. There was potential double counting of those reached by peer health educators.

50. The indicator measuring the number of visits made by Kabilo representatives does not indicate how many people were actually reached with BCC messages.

51. From the draft 2010-2011 MIS report (November 2011), the percentage of children sleeping under bed nets the night before the survey fell from 61% to 56%. The Western Region shows a decline from 61% to 49%. The percentage of pregnant women that slept under a bed net the night preceding the survey declined from 62% to 58% (with a decline to 29% in some regions).

52. Looking forward, several clarifications would be useful in redesigning the interventions implemented to have significant national effect:

- Establishing the geographical coverage of Kabilo representatives;
- Establishing how many households in total the program is designed to cover; and
- Establishing in how many schools the peer education program is implemented and what the population of each school is.

PROGRAM IMPLEMENTATION: TUBERCULOSIS

What were the specific risks related to the National Tuberculosis and Leprosy Program (NTLP) as PR?

53. Gambia has made impressive strides in the management of tuberculosis, with a national TB treatment success rate of 90%. All eligible patients co-infected with HIV and TB received Cotrimoxazole prophylactic treatment. Nonetheless, there were some areas of risk that should be addressed.

Antiretroviral Treatment and TB Co-Infection

54. There is a risk that difficulties in TB/HIV program integration will compromise treatment outcomes of co-infected patients.

55. The WHO recommends that ART should commence in all HIV-infected individuals with active tuberculosis irrespective of CD4 cell count. The NTLP did not meet targets on co-infected patients initiated on ART, reaching only 60% of the intended target by 30 June 2011.

56. At the time of the audit, 90% of TB patients that tested positive for HIV in September 2010 at the TB clinic in Serrekunda Health Centre had not commenced on ART per the patient records. Since Serrekunda Health Centre is not an ART center, TB patients who tested positive for HIV were referred to an ART center for initiation of ART. Most of the patients were referred appropriately. However, there was no feedback from the receiving facility on the status of the referred patients.

57. The process of determining the number of co-infected patients on ART from primary data collection tools is complicated. TB Inspection Officers have to match the number of the TB patients in the cohort with the number in the voluntary counseling and testing (VCT) register and check whether the patients have been recorded as having initiated ART in the register. This has resulted in calculation errors.

58. There is scope for improving record-keeping on HIV and ART status in TB treatment cards.

Regional Level Supervision

59. Given current management and M&E capacity at the regional level, there is a risk of compromised service and data quality. The capacity at the central level does not extend to the regions.

60. Thirty-one DOTS Centers have been established in Gambia, supervised by the NTLP which has built capacity for program management and M&E at the central level. However, the NTLP had no focal persons at the regional

Diagnostic Review of Global Fund Grants to The Gambia

level. The central level officers were responsible for collecting and verifying data from the facility level. As a result, there was insufficient time for supervision or in-depth review of data at the facility level.

Financial Management

What were the risks related to financial management?

Expenditure Claims

61. There is a risk of incorrect reporting of expenditures due to a lack of proper supporting documents and of written policies and procedures to control advance payments. In addition, there is a risk of claiming the same expenditure from more than one grant if supporting documents for expenditures funded by the Global Fund are not marked as paid.

62. NAS, NMCP and NTLF all had written policies and procedures for processing advances made to Regional AIDS Centers (RACs) and for submission of invoices and adjustments.

63. The dates of some invoices, in particular fuel receipts, did not correspond to the period for which the advance was made. The practice was to issue prepaid coupons to drivers for fuel; however, sufficient internal controls were not in place regarding their use. Payments were issued against pro forma invoices, which were undated, rather than against actual invoices.

64. Coordinators at the regional level paid locally based suppliers in cash, which creates risks and is not efficient in terms of value for money given that office supplies are divided among several regions.

65. Invoices were not stamped as "Paid." In addition, original third party documents (invoices, contracts, receipts, delivery notes, etc.) related to Global Fund expenses were not stamped with the Global Fund name/project code. Several PRs received funds from different donor organizations, and the Global Fund or its LFA did not have access to their books of account to ensure that the same expense was not charged to more than one donor.

Fixed Asset Register

66. There is a risk of omission or deletion of assets maintained in an Excel spreadsheet and there is a risk of misuse, theft, and damage if Fixed Asset Registers (FARs) are not reconciled with financial records or do not maintain sufficient information (e.g., voucher number, location, status of assets.)

67. Among the PRs reviewed, the OIG noted that:

- a) FARs were maintained in an Excel table and not in the FAR module of the accounting software;
- b) FARs did not contain important information such as

Diagnostic Review of Global Fund Grants to The Gambia

location, asset type, date of purchase and date of disposal. The voucher reference was typically absent. As a result it was difficult to reconcile the assets entered in the FAR with the Books of Account;

- c) No FAR hard copy was generated or signed by the person accountable for maintaining the FAR; and
- d) No physical verification reports were maintained. The OIG team was not able to confirm that physical verification of assets had been undertaken.

Internal Audit

68. In the absence of a dedicated internal audit function there is a risk that the implementation of programs is inadequately assured (NAS, NMCP and NTLP). In absence of a specific audit work plan, there is an additional risk that internal audit services are not fully utilized (NMCP, NTCP, NAS, AAITG and CRS).

69. CRS has appointed an internal auditor funded by the Global Fund. During the six months preceding the review, he undertook an internal audit of SRs for the HIV/AIDS grant for which CRS is SR and participated in CRS audits concerning expenses related to projects funded by other donors. The Internal Auditor did not have an approved audit work plan.

70. At the time of the review, NAS, NMCP and NTLP had not set up an internal audit function.

71. Despite a special condition in the grant agreements to establish an audit function at the NMCP and the NTLP by 31 October 2010, neither PR received clearance from government to do so. There have been discussions among the PRs, the Ministry of Health and the Ministry of Finance to outsource this function to the Gambian State Audit Office.

72. Terms of reference (TORs) for the Internal Auditor have been developed but need revision since they did not cover the auditable universe (including, e.g., procurement and administration).

Banking

73. There are a number of risks related to PR banking practices: There is a risk of loss of revenue for programs that use non-interest bearing accounts (AAITG); Checks issued without sufficient funds may bounce, which risks loss of goodwill and incurring of bank fees (CRS and NTLP); and there is a risk that bearer checks may be cashed by a third party (NMCP and NTLP).

Diagnostic Review of Global Fund Grants to The Gambia

74. Clause (a) (i) of Article 11 of the Grant Agreement requires AAITG to keep grant funds in a bank account which bears interest at a reasonable commercial rate. AAITG holds two bank accounts, one in GMD and the other in EUR. Neither account is interest-bearing.

75. Both CRS and NTLF at different times had negative bank balances in their books of account because checks were issued without verifying the bank balance.

76. NMCP and NTLF issued bearer checks. Payment with bearer checks does not ensure that the payment reaches the intended recipient.

What were the financial management risks related to Catholic Relief Services (CRS) as PR?

Cost Categorization

77. There is a risk that incorrect financial reporting may be submitted to the Global Fund in the absence of classification of expenditures directly in the accounting software. There is also a risk that common expenses are incorrectly charged to the Global Fund program.

78. CRS recorded its financial transactions in Sun accounting software. Required fields such as cost category, service and activity codes were not consistently completed, although the PR had made progress in completing the missing information during the most recent months reviewed.

79. Reports were generated in Excel from the accounting software, after which information on cost category, service delivery and activity codes was manually entered.

80. Expenses common to multiple projects should be allocated to project funding sources on a basis agreed by the donor(s). The OIG noted that allocations were not always appropriately made. The OIG also noted clerical mistakes related to vehicle cost allocation, which should be cross-checked by the finance department before entry.

Management of Sub-Recipients

81. There are a number of risks related to SR management: There is a risk that equal opportunity is not given to prospective SRs and that the prospective SRs with the best capacity are not chosen; there is a risk that SR reporting and monitoring is not timely, which may have an impact on quality and timeliness of implementation of activities of SRs; and there is a risk of loss of revenue due to use of non-interest-bearing bank accounts.

82. All four SRs in the malaria program under CRS

were SSRs when CRS was SR for HIV and were listed as SRs in the Round 9 proposal. CRS did not advertise or invite proposals from other capable organizations or carry out a comprehensive selection process. CRS's SR Management Manual does not include specific SR selection policies.

83. Article 15 of the SR agreements requires SRs to submit quarterly progress reports before the end of the month following the quarter. SRs are also required to submit monthly liquidations of expenditure. The OIG noted that SRs did not regularly submit monthly liquidations of expenditure and did not submit quarterly reports on a timely basis.

84. The Health Education Promotion and Development Organisation (an SR) holds grant funds in a non-interest-bearing account, contrary to the terms of its SR agreement.

What were the financial management risks related to ActionAid international The Gambia (AAITG) as PR?

Payments to Support Orphans and Vulnerable Children

85. There is a risk that amounts paid to schools and families to support orphans and vulnerable children (OVC) may be inaccurate and could include double payments unless internal controls are strengthened.

86. The operational guideline for the national OVC policy and framework has not been completed. The PR has been following guidelines established by the National OVC Steering Committee (the National OVC Guidelines), which operate at the national rather than organizational level.

87. The National OVC Guidelines could be further strengthened by:

- a) Including a provision for verification of details of care given OVC families at care centers;
- b) Adding a mechanism to ensure there is no double payment to schools and madrasas;
- c) Specifying the amount of support to be paid to schools or to parents;
- d) Specifying the mode of payment;
- e) Including a mechanism to ensure two payments are not made if two parents are registered;
- f) Adding a provision for situations in which school fees do not equal the fixed package amount; and
- g) Including a method to ensure that a recipient does not receive support from multiple sources.

88. Most of the payments to schools and families are in cash.

Financial Reporting

89. There is risk of over-reporting of expenditures in financial statements.

90. AAITG over-reported expenditures by GMD 4,397,908 (EUR 114,978) in its enhanced financial reports (EFRs) up to December 2010 because it counted disbursements to SRs as expenditures instead of counting only actual expenditures reported by SRs.

91. In some cases the opening cash balance reported in a Progress Updates/Disbursement Request (PU/DR) did not match with the closing balance in the PU/DR for the previous period.

Accounting system

92. There is risk of incorrect financial reporting if reports are generated from Excel spreadsheets rather than directly from the accounting software.

93. AAITG's accounting system does not currently generate information regarding advance payments, advances and imprests paid to staff, balances with SRs or payments to suppliers related to Global Fund grants directly from its accounting software. To generate Global Fund program-specific ledgers, all information is exported to spreadsheets containing entries pertaining to programs funded from other sources.

What were the financial management risks related to the National Malaria Control Program (NMCP) as PR?

Payment Vouchers

94. There is a risk that payments are not adequately supported.

95. The administration of payments can be improved by a) attaching supporting documentation when submitting for payment, b) ensuring that payments and deliveries are consistently made pursuant to existing contracts, and that c) payments are made pursuant to original rather than pro-forma invoices.

Accuracy of Reporting

96. There are risks that periodic reports on programmatic progress may be incorrect and that disbursements may be delayed due to variances in expenditures reported in PU/DRs and EFRs versus those recorded in the general ledger. There is also a risk that late submission of reports will delay disbursements and implementation.

97. The OIG noted variances in the figures reported in

Diagnostic Review of Global Fund Grants to The Gambia

PU/DRs and EFRs in comparison to the books of accounts, which the NMCP found difficult to explain or reconcile. PU/DRs and EFRs were frequently submitted late. Audit reports were submitted significantly past the six month deadline.

What was the financial management risk related to the National Tuberculosis and Leprosy Program (NTP) as PR?

Training

98. There is a risk of incorrect payments being made due to a lack of proper identification and contact information for training participants.

99. Training program vouchers could be improved by including identification details of participants. NTP indicated that they intend to include this information in future training.

Procurement and Supplies Management

What were the risks related to procurement and supplies management?

Consumption Data

100. There is a risk of stock-out, over-stocking and expiry of drugs due to the lack of reliable consumption data and a fully effective Logistics Management Information System (LMIS).

101. At the time of the review there was a need to strengthen the LMIS in order to improve the reliability of consumption data. This related to diagnostic tests, reagents and ARVs (NAS); to condoms (AAITG); to antituberculosis drugs (NLTP); and to LLINs and antimalarials (NMCP).

102. The LMIS had scope for improvement as follows:

- Systematically recording patients in the outpatient register;
- Consistently tracking physical stock dispensed to patients (daily dispensing forms had only been in use for a short time);
- Consistently monitoring data collection and stock levels at service delivery points; and
- Reliably managing stock and data collection concerning reagents and diagnostic kits at hospitals.

103. At the peripheral level, staff responsible for data collection should be trained in greater depth to record consumption data. In September 2010 a first training on LMIS use and standard operating procedures was held for regional medical store (RMS) and hospital staff. Thirty data entry clerks were recruited in October 2011 and trained in data management and collection. In both cases training lasted only one week.

104. There is scope for improvement in the monitoring undertaken by the PRs, the Regional Health Team and the heads of health facilities. An LMIS manager was hired in October 2011 at the CMS to consolidate data between the ART centers and the central level. The CMS team responsible for collecting and processing data has planned periodic supervision to check the adequacy of consumption data but requires sufficient logistical support.

Quality Assurance

105. There is a risk that drugs and commodities are procured without the required quality assurance.

106. There was no WHO-prequalified or ISO 17025-certified quality control laboratory in Gambia. A memorandum of understanding had been signed between the National Pharmaceutical Services (NPS) and the Centre for Quality Assurance of Medicines at North-West University in South Africa, but no samples had been sent to this laboratory at the

time of the review.

107. As a result the PRs (NMCP, NAS, NLTCP, AAITG) did not, at the time of the audit, perform quality control of pharmaceuticals as required by the Global Fund's Quality Assurance/Quality Control Policy.

108. Similarly, quality control of condoms procured did not take place (AAITG).

Procurement Practices

109. There are a number of risks related to the procurement practices among PRs:

- There is a risk that ACTs and other antimalarials do not meet the Global Fund's WHO prequalification requirements (NMCP);
- There is a risk that insufficiently planned procurement could adversely affect competition and result in a lack of offers from suitable bidders and increased procurement costs (NMCP, NAS);
- There is a risk that value for money is not assured due to an insufficiently transparent procurement process and the absence of competitive bidding (NMCP, MRC); and
- There is a control risk relating to segregation of duties for the procurement of medical equipment and consumables due to individuals simultaneously serving in multiple procurement functions (requisition, selection of suppliers, setting prices and other terms and conditions of procurement) (MRC).

110. There was no evidence of competition between prequalified suppliers in NMCP's open tender for the purchase of ACTs. Two manufacturers awarded contracts for the procurement of quinine tablets and sulfadoxine-pyrimethamine were not on the list of manufacturers authorized by the Global Fund.

111. NAS procurement regulations require a national competitive bidding process for contracts valued greater than GMD 500,000 (USD 17,857), but NAS adopted restricted bidding processes for these by claiming urgency.

112. For the LLINs procured by NMCP, an international supplier was rejected because it was not able to supply the LLINs within 90 days of receipt of an advance payment. The chosen supplier did not deliver part of the order on time. NMCP did not apply penalties. A longer delivery period would have allowed other bidders to participate.

113. Procurement by the MRC demonstrated the following areas for improvement:

- Single-source procurement without competitive selection;

Diagnostic Review of Global Fund Grants to The Gambia

- Purchase order forms that did not contain terms and conditions regarding freight charges, insurance, delivery period and penalty for delay or post-sale service;
- Payment processed on the basis of pro-forma invoices or invoices received via email rather than original invoices; and
- Bills of lading and entry and clearing agent bills that were not available for review. The MRC informed the OIG that these were with clearing agents because they were needed for clearing the materials from port.

114. NAS, NMCP, NTLN and MRC made advance payments to suppliers without seeking bank guarantees.

Quantification

115. There is a risk of inadequate stock coverage for ARVs and stock-outs, over-stocking and expiry of drugs due to poor quantification methods by NAS and NMCP.

NAS

116. NAS, in collaboration with NPS and CMS, was responsible for forecasting and quantification of all HIV/AIDS program health products, based on morbidity data.

117. The initial quantification proposed by NAS for Phase 1 of the Round 8 grant was subject to a study by a consultant before Global Fund approval. The resulting revision would have benefitted from clearer assumptions and better data collection. The initial PSM plan was revised twice in the first year of implementation due to poor forecasting. The last revision was approved by the Global Fund in January 2011.

118. The number of new adult patients in need of ART treatment was underestimated. Conversely, targets for delivery of PMTCT, counseling and treatment were not reached, since implementers faced difficulties in recruiting children for treatment and most pregnant women did not receive a complete course of ART prophylaxis due to home delivery. In addition, Gambia received a donation of pediatric ARVs from the West African Health Organization, which had a positive impact on stock coverage of ARVs for adults, but added to the overstocking of pediatric ARVs. This resulted in some ARVs expiring before use.

NMCP

119. The quantification of ACTs is also based on morbidity data.

120. The quantity of drugs delivered by the central level was well recorded on stock cards, but there was scope for improvement as follows in the quality assurance of 2011 consumption data reported by health facilities:

Diagnostic Review of Global Fund Grants to The Gambia

- Consolidation of stock data between the pharmacy at the health facility and the service delivery point;
- Recording of all patients who received treatment;
- Reconciliation of the number of patients treated with the number of ACT doses; and
- Supervision of data collection and monthly reporting.

121. The OIG found no evidence of leakage of ACTs from the public sector to private pharmacies, drug stores or informal market places in Gambia or nearby Senegalese locations.⁶ Leakage is partly mitigated by distinctive packaging.

What was the PSM risk related to the National AIDS Secretariat (NAS) as PR?

National Public Health Laboratory Supplies

122. There is a risk of poor stock coverage for diagnostic tests, reagents and equipment.

123. NAS and the National Public Health Laboratory (NPHL) faced difficulties in defining the technical specifications of laboratory equipment, leading to delays in delivery by the VPP procurement agent. The consumption data from the LMIS on tests kits and reagents were not consistently reliable. This led to inaccurate quantification of tests and reagents, which resulted in rationing for laboratories and treatment facilities.

124. Distribution procedures were not consistent with good practices leading to loss of stability. In addition, there was a lack of a maintenance service for laboratory equipment.

What was the PSM risk related to Catholic Relief Services (CRS) as PR?

Increased Malaria Morbidity and Mortality

125. There is a risk that those most in need of LLINs do not have access to them.

126. The OIG found that LLINs for routine distribution to children under one year and pregnant women were not available from 11 August 2011 to 15 October 2011, when LLINs procured by NMCP were received by CRS. As of 05 December 2011, the nets received had not been distributed. This was attributed by CRS staff to “the high workload of the healthcare team during the malaria season.” Peak malaria incidence in Gambia is from September to November.

127. The distribution of LLINs is monitored by NMCP, which checks the distribution registry monthly for health centers and community distribution points organized by CRS.

⁶ The OIG team visited ten Gambian drug storage facilities, pharmacies in Banjul, Serrekunda, Senegambia, Farafenni and Essau as well as markets (and pharmacies/health posts where present) in the following Senegalese locations close to the border: Karang, Samba Guèye, Toubakouta, Sokone and Kaolack.

Diagnostic Review of Global Fund Grants to The Gambia

What was the PSM risk related to ActionAid International The Gambia (AAITG) as PR?

Availability of Home-Based Care Kits

128. There is a risk of overpayment for, insufficient availability of and delay in the delivery of home-based care (HBC) kits.

129. The PSM plan specifies neither the contents of the HBC kits nor their quantity, the number of each type of kit (nurse kit, volunteer kit and family kit) or the unit cost. The quantification of HBC kits did not follow a clearly articulated methodology.

130. The HBC kits were procured by the VPP procurement agent. VPP is not the best modality for procuring certain items (scissors, small bags, cottons, etc.) for the HBC kits, especially if the specifications are not clearly defined. Procurement has suffered lengthy delays in the delivery of multiple components of the HBC.⁷ In addition, as acknowledged in the management action plan attached, the VPP price was high compared to the cost of these items in the local market.

⁷ The order for the items listed above took almost one year to complete through VPP.

Oversight

Is oversight adequate?

CCM Eligibility for Further Funding

131. There is a risk that the CCM will not be eligible for funding by the Global Fund in the absence of transparent selection of CCM members representing non-government constituencies and of a documented and transparent process for the selection and nomination of all new and continuing PRs based on clearly defined and objective criteria.

132. CCM members representing civil society are designated by an umbrella group of NGOs including local and international NGOs. However, not all NGOs working in the health sector in Gambia are included in this group. CCM bylaws name this umbrella group as responsible for selecting the CCM members representing civil society organizations. This is not in line with Global Fund requirements.

133. The CCM did not have a documented, transparent process for the nomination of PRs for Round 8. There was no evidence that the CCM advertised a call for interest in the national press, of the number of proposals received, regarding evaluations of the proposals or of the selection criteria and scoring system. The PR selection procedures are not detailed in the SOP developed by the CCM.

Conflict of Interest

134. There is a risk that potential conflict of interest situations related to the CCM are not effectively mitigated.

135. The CCM has established several committees, of which the Technical Committee is responsible for developing the programmatic component, assessing and consolidating proposals, responding to technical questions from the Global Fund Secretariat and facilitating access to information on implementation for the Oversight Committee. The Technical Committee has seven members, of which six are PRs.

136. There is no evidence that CCM members who are PRs or SRs have formally declared their interests.

Management of and Oversight over Grants

137. There is a risk that management and oversight over grants are insufficient.

138. In 2011 the CCM met seven times. Five of those meetings did not have a quorum. Important decisions were made without a quorum.

Diagnostic Review of Global Fund Grants to The Gambia

139. The CCM Oversight Committee was only recently created. At the time of the audit, there was no workplan for this committee or for the visits to be undertaken by its members.

140. CCM meeting minutes provided to the OIG were not signed. A review of the minutes reviewed showed that CCM discussions were rarely related to monitoring the progress of implementation and management of the grants by the PRs. There was no evidence that the CCM received copies of the PU/DRs submitted to the Global Fund.

Quality of Information

141. PricewaterhouseCoopers was the LFA from the inception of the Global Fund grants in Gambia until its replacement by the Swiss Tropical and Public Health Institute (Swiss TPH) in May 2011.

142. At the time of the review, only the M&E officer in the Swiss TPH team for Gambia was present in country. The OIG noted that there was significant turnover of financial officers. In January 2012, a new permanent finance officer was appointed, based in Senegal, to carry out the financial part of the LFA review.

143. There was no LFA review plan for PU/DRs or EFRs. Such a plan should include a risk assessment and tests to be undertaken during review. The OIG noted that the LFA's sampling methodology was based only on the size of transactions and took no account of the risks associated with cost categories.

Annex 1: Abbreviations

AAITG	ActionAid International The Gambia
AIDS	Acquired Immune Deficiency Syndrome
ADWAC	Agency for the Development of Women and Children
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CHBC	Community Home-Based Care
CPT	Cotrimoxazole Prophylactic Therapy
CHW	Community Health Worker
CSO	Civil Society Organization
CSW	Commercial Sex workers
CTX	Cotrimoxazole
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment, Short Course
DQA	Data Quality Assurance / Assessment / Audit
FBO	Faith-Based Organization
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBBSS	Integrated Biological and Behavioral Surveillance Survey
IPT	Isoniazid Preventive Therapy
LFA	Local Fund Agent
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MICS	Multi-Indicator Cluster Survey
MIS	Malaria Indicator Survey
MSM	Men who have sex with men
NAS	National AIDS Secretariat
NMCP	National Malaria Control Program
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NSS	National Sentinel Survey (for HIV)

Diagnostic Review of Global Fund Grants to The Gambia

NTLP	National Tuberculosis and Leprosy Control Program
OI	Opportunistic Infection
OIG	Office of the Inspector General
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/ AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PUDR	Progress Update and Disbursement Request
PR	Principal Recipient
PSM	Procurement and Supply Chain Management
RCC	Rolling Continuation Channel
SDA	Service Delivery Area
SR	Sub-Recipient
SSF	Single Stream Funding
SSR	Sub-Sub-Recipient
STI	Sexually Transmitted Infection
SOP	Standard Operating Procedure
TB	Tuberculosis
TBA	Traditional Birth Attendant
TPM	Total Preventive Maintenance
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USD	United States Dollars
UPS	Uninterruptible Power Supply
USAID	United States Agency for International Development
VAT	Value Added Tax
VCT	Voluntary Counseling and Testing
VHW	Village Health Worker
WHO	World Health Organization

Annex 2: Principal Recipients

ActionAid International The Gambia (AAITG)

ActionAid began operating in Gambia in 1979. It works with poor people to support their basic needs and rights. The key areas of focus are health, water, education and livelihoods. It trains local people to give medical help and supports mobile health teams with training, equipment and funds. AAITG was selected as the PR of a Global Fund Round 8 HIV/AIDS grant, charged with accelerating access to prevention, treatment, care and support services.

Medical Research Council (MRC)

The MRC was established in Gambia in 1947. Its research focuses on infectious diseases of concern to Gambia and Africa, with the aim of reducing the disease burden in the country and the developing world. The MRC was selected for a single stream of funding TB grant to strengthen and expand DOTS services in Gambia. The goal of the program is to control TB by reducing transmission, morbidity and mortality.

Catholic Relief Services (CRS)

Catholic Relief Services started operating in Gambia in 1964 and is making inroads in malaria and HIV/AIDS prevention and maternal and child nutrition. CRS was SR for Round 3 and 6 grants. It was selected for a malaria SSF grant. The SSF program aims to reduce malaria-related morbidity and mortality in six health regions, with the goal to reach pre-elimination stage by 2015. CRS plans to provide universal access to LLINs and scale up BCC activities.

National AIDS Secretariat (NAS)

The National AIDS Council (NAC), and its operational and administrative arm, the National HIV/AIDS Secretariat (NAS), were established in the Office of the President in 2002 to oversee the coordination and monitoring of the national HIV/AIDS response initiated through the HIV/AIDS Rapid Response Project. NAS is PR for a Round 8 HIV/AIDS grant. It works with nine SRs toward the goal of accelerating access to prevention, treatment, care and support services.

National Malaria Control Program (NMCP) and National Tuberculosis and Leprosy Program (NTLP)

The Ministry of Health and Social Welfare is PR for two malaria grants, one under Round 6 and one SSF. The National Malaria Control Program is its implementing arm. NMCP focuses on malaria diagnosis with microscopy and rapid diagnostic tests, treatment at health facilities, scaling up of home management and indoor residual spraying.

The National Tuberculosis and Leprosy Program implements one TB SSF grant that focuses on identification and treatment, increasing access to HIV counseling and testing and the introduction of the practical approach to lung health strategy. The PR implements its program activities through two SRs, the National Public Health Laboratory and the Child Fund.

Annex 3: Recommendations and Action Plan

Risk	Recommendation	Secretariat Comments	Responsible Party	Country Comments and Agreed Actions	Due Date
Program Implementation and Reporting					
National AIDS Secretariat					
<p><u>Service Delivery - Data for Decision Making</u></p> <p>There is a risk that it will not be possible to establish whether grant objectives have been achieved (and a risk that they will not be achieved) due to incomplete availability of baseline data and survey data for mid-course corrections.</p>	<p><u>Recommendation 1 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the National AIDS Secretariat:</p> <p>a) Develops specific detailed work plans for the surveys and evaluations scheduled. Each survey work plan should be ready and approved by NAS management at least 6 months before the scheduled start of the survey in order to provide enough time to deal with resource and capacity challenges that might threaten adherence to implementation timelines. The work plan and budget should include details on the following: survey sensitization, technical committee and stakeholder meetings and survey planning, ad-hoc human resource</p>	<p>Secretariat: Agreed with (a) – (c)</p> <p>As per the recently negotiated Phase 2 work plan:</p> <p>The Behavioural Surveillance Survey and Antenatal Sentinel Surveillance occur in Y3 and Y5.</p> <p>The Demography Health Survey, ART resistance and PLHIV survival survey occurs in Y3, while the MARPs survey occurs in Y5.</p>	<p>NAS</p>	<p>a. Action Taken: Taken For the purpose of implementing the BSS, PLHIV Survival, ART resistance, PMTCT Impact and MARP studies have been planned in Phase II budget. The NAS will recruit the services of a consultant(s) in which prior to any contractual agreement, the NAS will agree and sign a detailed work plan 6 months prior to the conduct of the study.</p> <p>b. Action Taken: For the National Sentinel Surveillance (NSS), the Ministry of Health (MOH) in collaboration with NAS in Phase I supported capacity building including mentoring at MRC for key personnel involved in NSS. In addition, NAS supported training of these key personnel on NSS implementation in Kenya in 2010. Following which, the NSS 2011 was</p>	<p>January 2013</p> <p>Immediately</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>engagement and training, procurement development and preparation of infrastructure, hardware and software resources, central and regional level trainings for technical and field workers, data collection and consolidation, data cleaning and analysis and results dissemination;</p> <p>b) Assigns focal person(s) in the department responsible for planning and implementing the surveys. The assigned officer should be mentored appropriately in survey management and implementation in order to monitor the survey as implemented by the consultants and ensure that project timelines are met. One option of provision of mentoring on survey management and implementation could be obtaining technical assistance from the Medical Research Council of the Gambia; and</p> <p>c) Recalculates the cost savings from the 2010 NSS that was not completed and uses the</p>			<p>conducted and coordinated by the national Monitoring & Evaluation Reference Group (MERG). The report of the 2011 NSS is available.</p> <p>Since the MOH is the technical lead in the implementation of the NSS, the NAS will therefore solicit from the Ministry to submit a detail work plan for review and approval of subsequent NSS.</p> <p>The M&E Specialist is the focal person for surveys and the NAS will continue to build capacity in survey management.</p> <p>c. Action Taken: No savings on the 2010 NSS, however, the study is budgeted in 2012.</p>	<p>NA</p>
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Diagnostic Review of Global Fund Grants to The Gambia

	savings to undertake future surveys.				
<p><u>Service Delivery - ART outcomes</u></p> <p>If the cause of the decline in antiretroviral therapy (ART) retention is not identified and addressed, there may be a continued decline.</p>	<p><u>Recommendation 2 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that NAS:</p> <p>a) Conducts an investigation into the cause of the decline in ART retention and institutes an action plan to correct the problem and strengthen the system to meet targets for 2012. This investigation should first start with an analysis of the components of the retention indicator; and</p> <p>b) Reviews the data used to calculate the figures reported and determines the reasons for the decline.</p>	<p>Secretariat: Agreed with (a) – (b)</p> <p>In Q4 2011 the Secretariat requested NAS to analyse the findings of the ART retention study. This work has been delayed due to the negotiation of the NAS R8 Phase 2 grant. In addition, the PR was asked to ensure that proper analysis is done with the next ART retention study. The decline in ART retention will be investigated and an action plan developed to address the decline.</p>	NAS	<p>a. Action Taken: NAS has agreed to include in the PLHIV Survival study to investigate the reasons for the decline in survival amongst PLHIV on treatment. Thus, a TOR has been developed, shared with the GF and incorporated comments from GF. The study will be conducted through a consultancy and the identified consultant is expected to submit a technical proposal for review and approval.</p> <p>b. Action Taken: The next ART study will investigate any decline in PLHIV survival.</p>	<p>December 2012</p> <p>December 2012</p>
<p><u>Service Delivery - ARV Pharmacovigilance Training and Reporting</u></p> <p>Without a strong pharmacovigilance system, there is a risk</p>	<p><u>Recommendation 3 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that NAS:</p> <p>a) Establishes a national ARV Pharmacovigilance Plan for ARV pharmacovigilance. This will</p>	<p>Secretariat: Agreed with (a) – (d)</p> <p>Note, the Pharmacovigilance training has not been included in the budget of NAS Phase 2 grant. As a result,</p>	NAS	<p>a. Action Taken: MOH has already started engaging WHO and other partners to mobilize support to strengthen the Pharmacovigilance system at the MOH-CMS.</p> <p>b. Action Taken: Under the phase II Malaria Grant development of National Pharmacovigilance</p>	<p>On going</p> <p>January 2013</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>that the effectiveness of the ART program will be compromised by problems related to drug toxicity, drug tolerance and drug interactions.</p>	<p>require the involvement of development partners (WHO) and the Uppsala International Drug Monitoring Centre;</p> <p>b) Conducts pharmacovigilance training after the availability of clear guidelines to match the trainings budgeted for in the Global Fund Round 8 program budget;</p> <p>c) Ensures that trainings are followed immediately by the implementation of adverse drug reaction reporting using standard data collection tools by the facility whose staffs have been trained on pharmacovigilance; and</p> <p>d) Assesses of the National Pharmaceutical Service laboratory capacity to monitor drug toxicities and drug safety.</p>	<p>NAS will identify savings or mobilize support from other partners.</p>		<p>guidelines is proposed.</p> <p>c. Action Taken: In addition, in Phase II, NAS will identify any possible savings and re-program for the training in Pharmacovigilance.</p> <p>d. Action Taken: Recommendations C and d are noted.</p>	<p>January 2013</p> <p>January 2013</p>
<p><u>Parallel Reporting Systems</u></p> <p>Reporting Global Fund grant-related indicators through reporting systems parallel to the national structures does not strengthen</p>	<p><u>Recommendation 4 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that NAS:</p> <p>a) Transmits data through the national system and involves the Regional AIDS Coordinators</p>	<p>Secretariat: Agreed with (a) – (c)</p> <p>The migration of reporting towards the national HMIS has been included as a Special Condition (SC) in the NAS R8 Phase 2 grant agreement to ensure that the parallel</p>	<p>NAS</p>	<p>a. Action Taken: Now all the reports are channeled through the national reporting system.</p> <p>b. Action Taken: NAS has trained the Regional AIDS Coordinators (RAC) in data verification and collating reports and are now</p>	<p>July 2012</p> <p>January 2013</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>the Gambian HMIS.</p>	<p>in collating and verifying data. The data should ideally be reported to the HMIS unit of the Department of Planning at the Ministry of Health and then shared with NAS. However, this reporting should not replace the periodic routine internal data quality audits and spot checks of facilities that the PR must conduct;</p> <p>b) Trains and mentors the Regional AIDS Coordinators;</p> <p>c) Shares quarterly reports of PR data quality audits that have been transmitted through the national system with facilities before review meetings. Review meetings should be forums for responses to data quality findings and other issues of program performance.</p>	<p>system is stopped and involves the Regional AIDS Coordinators in collating the data. Budget for the PR to collect data from central to facilities level has been removed from the grant budget. Funds have only been allocated for 6-monthly supervisions. Improved use of the HMIS will be monitored by the GF/LFA during Phase 2 implementation.</p>		<p>taking up this responsibility at regional level as part of their TOR.</p> <p>c. Action Taken: The PR will continue to share quarterly data quality audits with its partners during review meetings.</p>	<p>January 2013</p>
<p><u>Management Monitoring and Oversight</u></p> <p>There is a risk that implementation and operations will be adversely affected by a lack of high-level</p>	<p><u>Recommendation 5 (Critical)</u></p> <p>The Global Fund Secretariat should ensure that NAS, in collaboration with NAC:</p> <p>a) Establishes an active subcommittee to oversee implementation and performance on regular basis; and</p>	<p>Secretariat: Oversight of NAS is a highly political matter. Historically, NAC is inactive and dysfunctional. The Secretariat has previously requested that NAC be reactivated. This issue was discussed with the Prime Minister in January 2012 who</p>	<p>NAS in collaboration with NAC</p> <p>GF Secretariat</p>	<p>Management Response: As indicated in this report, the country does not have a Prime Minister. The Office of the President continues to be the oversight authority of the NAS. In this regard, the Secretary General is the direct line manager and a focal person has also been identified to address the day to day operations of</p>	

Diagnostic Review of Global Fund Grants to The Gambia

<p>guidance, oversight and accountability.</p>	<p>b) Provides regular progress reports, annual work plans, financial statements and audit reports to NAC.</p>	<p>indicated that a Bill of Act is at the level of Parliament to reactivate the NAC.</p> <p>The GF will continue to advocate for the NAC to be reactivated and/or a subcommittee created for oversight purposes.</p> <p>Secretariat Addendum: The Secretariat apologizes for the oversight. The meeting took place with the Vice-President of The Gambia, Dr Aja Isatou Njie-Saidy. The GF appreciates the nomination of a focal person in the Office of the President as a liaison with NAS. However, an active oversight structure would need to be established and operationalized with clear oversight and accountability lines. Such a structure would, in addition, ensure the multi-sectorial coordination of the HIV/AIDS response.</p>		<p>the NAS at the Office of the President. However, regarding enactment of the NAS Bill, a proposed draft Bill was submitted to this office and now awaiting for a response.</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

ActionAid International The Gambia					
<p><u>Service Delivery - Availability of and Access to Condoms</u></p> <p>There is a risk that the quantity of condoms provided by the grant is inadequate to ensure achievement of grant objectives and that the condoms distributed do not reach the intended recipients, particularly MARPS.</p>	<p><u>Recommendation 6 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that AAITG:</p> <p>a) Recalculates the condom needs for the country. This should be done in collaboration with UNFPA. AAITG should flood the target groups with the needed condoms in order to reduce the incentive for the condoms to be sold;</p> <p>b) Re-visits the target end users and outlets for condom distribution. The lists should include, to the extent possible, all the identified sites where sex workers (male or female) have been identified. This includes brothels, hotels, bars and market day centres in the different regions, tourist hotels with a significant presence of male sex workers or ‘bumsters’, military barracks and border posts;</p> <p>c) Carries out a monthly reconciliation of available</p>	<p>Secretariat:</p> <p>(a) Quantification of condoms has been reviewed for Phase 2 and a distribution plan has been developed by the PR as a condition for Phase 2, particularly in view of the new MARPs focus in Phase 2.</p> <p>(b) Review of outlets for condoms distribution has been completed and agreed for Phase 2 for a better focus on MARPs. Phase 2 had been reprogrammed to focus on MARPs activities. Phase 2 provides a specific focus on condoms distribution to MARPs.</p> <p>The PR has reviewed the mapping of locations/sites frequented by MARPs and ensures these sites</p>	<p>AAITG</p>	<p>a) Action Taken: Condoms requirement for high risk groups have been recalculated for Phase 2. PR will review the UNFPA consultancy Report on condom requirement for the Gambia and work with MOH, UNFPA, GFPA and other stakeholders to determine national requirements.</p> <p>b) Action Taken: PR has already put in place a Strategy to use Commercial Sex Workers as PHE for the distribution of condoms to MARPs in all settings</p> <p>c) Action Taken: Condoms for end user calculations has been done for Phase 2</p> <p>d) Action Taken: Strengthening of supervision and monitoring including SRs has commenced and is ongoing.</p> <p>e) Action Taken: PR has submitted the SR assessment report to the LFA for review and submission to GF for approval. PR has selected World View a new SR to implement and monitor the activities of MARPs.</p>	<p>September 2012 Begin implementation</p> <p>November 2011 and on-going</p> <p>November 2011 and on-going</p> <p>June 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>condoms in stock and amount distributed; and</p> <p>d) Strengthens its supervisory monitoring, including of SRs, by using random and periodic spot checks and phone calls to end users to ensure that condoms are reaching intended end users and are available free at points of access.</p>	<p>are regularly monitored for condoms, especially at pick periods.</p> <p>For MARPs activities, PR has to select a new SR based on experience and knowledge on the targeted populations in order to improve implementation and monitoring and evaluation.</p> <p>Secretariat: Agreed. In collaboration with the PRs the Secretariat will endeavor to negotiate, operationalize and implement (a) – (e)</p>	<p>AAITG</p>		
	<p><u>Recommendation 7 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that AAITG:</p> <p>a) Develops a scientifically founded methodology for quantification of condoms based on the needs of high-risk groups, with analysis of consumption and coverage goals clearly defined;</p> <p>b) Monitors the distribution chain for condoms, stock status at</p>				

Diagnostic Review of Global Fund Grants to The Gambia

	<p>each level and the collection of consumption data;</p> <p>c) Develops a more proactive strategy for the distribution of condoms, focusing on high-risk groups;</p> <p>d) Formulates clear objectives for the distribution of condoms for Phase 2 based on a detailed analysis of the distribution in Phase 1; and</p> <p>e) Considers establishing a buffer stock that could overcome any delay or failure in the sourcing of condoms</p>				
<p><u>Monitoring and Evaluation – Behavior Change Communication</u></p> <p>There is a risk that reported achievements for BCC misrepresent actual achievements due to double counting.</p>	<p><u>Recommendation 8 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that AAITG:</p> <p>a) Develops a comprehensive indicator protocol reference sheet that not only repeats the indicator definition information in the performance frameworks and the M&E Plan but also provides detailed explanation of how to collect the data, limitations and data quality issues for the indicator and actions and steps to be taken to</p>	<p>Secretariat: Agreed with (a) – (e)</p> <p>BCC activities and indicators have been reviewed by the PR for Phase 2 to mitigate the risk of double counting, especially at the SR level. A new database for data collection has been set up and SRs have been trained by the PR.</p>	AAITG	<p>a) Action Taken: The indicator protocol reference sheet will be developed and shared with all SRs.</p> <p>b) Action Taken: The indicators on Participatory approaches and life skills has been reviewed and refocused on specific population groups (young people) aged 15 – 35 years. The monitoring tools have been revised to address these concerns.</p> <p>c) Action Taken: The revised M&E tools developed in November 2011 and the HIV /AIDS message booklet developed in year 1 by PR and partners have addressed these</p>	30/09/12

Diagnostic Review of Global Fund Grants to The Gambia

	<p>address limitations. For example, the indicator for the number of people reached with BCC messages through participatory approach can include as a limitation the fact that the indicator captures the number of people reached at one time, during one event, meaning that the same people may be counted more than once. Actions taken to address this would be specific for the particular BCC approach utilized but will include in general, regular internal data quality audits to ensure reliability of data collection processes and a comparison of figures to the total number of people that could be possibly reached from the community or school;</p> <p>b) Shares with SRs and implementing agents the Indicator Protocol Reference Sheet;</p> <p>c) Ensures that the BCC indicators for participatory approaches and life skills education reported should be two types, one that counts the actual number of people reached (with</p>	<p>Data on BCC indicators will be collected through program monitoring reports of sub-recipients. The reports will be compiled and aggregated to obtain an overall measure of the reach of prevention programs. Facilitators' registers will be used to capture accurate data (name, DOB, sex and address) to avoid double counting.</p> <p>For participants in MARPs activities, the PR will use the Unique Identifier Code applied during the IBSS 2011 which already created codes for all participants.</p> <p>In Phase 2 the PR has planned regular data quality audits on a quarterly basis.</p>		<p>issues.</p> <p>The new data management procedures developed November 2011 and shared with all SRs have addressed the issue of data quality assurance. Quarterly data verification/audit is ongoing</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

	<p>minimal double counting) and another that counts the number of activities to indicate the intensity of BCC message programming and the amount of activity carried out by the field workers;</p> <p>d) Sets up clear written guidelines on the standard content of prevention messages that should be given in order to count individuals towards BCC targets; and</p> <p>e) Conducts regular internal data quality audits to provide assurance of the quality of data collected by its SRs.</p>				
National Malaria Control Program					
<p><u>Monitoring & Evaluation – Data Quality</u></p> <p>There is a risk that the true achievement against targets will not be known at the end of the grant.</p>	<p><u>Recommendation 9 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that NMCP:</p> <p>a) Investigates and elucidates the causes of poor data quality during monitoring visits and increases mentoring activities for village health workers on data collection and reporting;</p>	<p>Secretariat: Agreed with (a) – (b)</p> <p>The NMCP 2012 training plan includes further training/mentoring of Village health workers in reporting and data quality. The issues on data quality will also be addressed during the Malaria SSF Phase 2 review occurring</p>	<p>NMCP</p>	<p>(a) Action Taken: Investigates and elucidates the causes of poor data quality :</p> <p>During the OIG diagnostic review period, data collection and reporting was at the level of the basic health facilities and had not reach the village health workers; however PR planned to roll-out ACTs and RDTs to village health workers at community level. Village Health Workers will then be</p>	

Diagnostic Review of Global Fund Grants to The Gambia

	<p>b) Develops a standardized data quality assessment tool that will be shared with the Regional Health Teams as guidance for conducting data quality audits. NMCP should also develop a data quality assessment standard operating procedure or guidelines, these formers should describe how to use the DQA tool and the next steps to take when data quality issues are detected. All SOPs and tools should be shared with the Regional Health Teams. The focal persons at the regional health teams should also be trained on the use of the SOPs and DQA tool; and</p> <p>c) Develops an Indicator Protocol Reference Sheet that provides clarity with all indicators in terms of not only their definitions but also detailed description of data collection methods, persons responsible for data collection, limitations of the indicators and actions and steps taken to address indicator limitations.</p>	<p>in Q3 2012.</p>		<p>reporting routinely. Currently, PR is aware of the factors contributing to poor data quality at facility level and these include; (i) inadequate human resource, (ii) poor recording due to inadequate capacity and (iii) inadequate monitoring/mentoring at health facility level.</p> <p>Action Taken: (a)</p> <ul style="list-style-type: none"> • Hiring of additional data entry clerks in phase 2 • Strengthening supportive monitoring/mentoring at health facility level • Training of health workers and village health workers on data quality management <p>(b) Action Taken: Develop standardized data quality assessment tool. Already, the PR is using a standardized data collection tool which is shared with the regions. However, this tool will be further improved upon to address the identified data quality gap. SOPs and DQA guidelines will also be developed and shared with regions to ensure data quality. Training will be conducted for RHT and health facility staff on the revised harmonized data collection tool, SOPs and DQA</p>	<p>January, 2013</p> <p>On-going</p> <p>September, 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

				<p>guidelines.</p> <p>Action Taken: (b)</p> <ul style="list-style-type: none"> • Review and update of data collection tools • Development of SOPs and guide lines on DQA • Training of RHT and facility staffs on the SOPs and guidelines on DQA <p>(c) Action Taken: Develop Indicator Protocol Reference Sheet:</p> <p>Planned Action: This will be developed and shared with RHT and health facility staff.</p>	<p>August, 2012</p> <p>November, 2012</p> <p>December, 2012</p> <p>July, 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

Catholic Relief Services					
<p>Service Delivery – Availability</p> <p>There is a risk that LLINs for routine distribution to pregnant mothers and children under five in reproductive and child health (RCH) clinics are not reaching intended recipients.</p>	<p><u>Recommendation 10 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that CRS:</p> <p>a) Investigates the reasons for LLINs not being distributed routinely at the RCH clinics and provides a comprehensive report of this investigation to the Global Fund;</p> <p>b) Recalculates LLIN needs for routine bed net distribution at the clinics;</p> <p>c) Mentors malaria focal persons at the clinics on LLIN distribution and ensures that individuals are not given LLINs multiple times; and</p> <p>d) Does a quarterly comparison between RCH clinic visitations and LLINs distributed per quarter to detect aberrations.</p>	<p>Secretariat: Agreed (a) – (d)</p> <p>The issue and resolution of LLIN distribution to pregnant women and children under five has been highlighted in a Management Letter sent in May 2012.</p>	<p>CRS in collaboration with NMCP</p>	<p>a) Action Taken: The number of LLINs needed for distribution at RCH clinics has been calculated in March 2012 based on the estimated number of pregnant women and children under one year old expected per year in the general population.</p> <p>b) Action Taken: CRS Program staff have revisited the LLIN distribution plan and targeted beneficiaries with focal persons at all clinics in March 2012.</p> <p>c) The continued mentoring of a Malaria focal person for each clinic will depend on the Global Fund’s written approval of this activity as it has cost implications as it requires recruiting one LLIN distribution volunteer for each RCH clinic.</p> <p>d) Action Taken: In March 2012, CRS/The Gambia developed a tool to report quarterly comparison of the number of visitations to RCH clinics, number of LLIN distributed and balance of LLINs in each distribution point. The tool was subsequently integrated into the</p>	<p>Done March 2012</p> <p>Done March 2012</p> <p>A request for funding will be sent to the Global Fund for continued mentoring in August 2012.</p> <p>To begin implementation by July 31, 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

				M&E procedure manual and key staffs have been trained on its use. This tool will be used by the SRs in the quarter commencing July 2012.	
<p><u>Monitoring & Evaluation – Behavior Change Communication</u></p> <p>Although the latest malaria indicator survey (MIS) was conducted before the LLIN mass campaigns, there is a risk that assurance will not be obtained that BCC output indicators translate to the desired population-level effects.</p>	<p><u>Recommendation 11 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that:</p> <p>a) The following indicators are maintained for malaria BCC using the Kabilo approach:</p> <ol style="list-style-type: none"> 1. Number of people reached with malaria BCC messages using the Kabilo approach (as an indication of intervention coverage). The measurement of this additional indicator should also be introduced to the data collection tools used by the Kabilo reps to collect primary data; and 2. Number of visits by Kabilo representatives to sensitize households on appropriate action for malaria control and prevention; <p>b) CRS and its SRs are not</p>	<p>Secretariat: Agreed with (a) – (d)</p> <p>The recommendation on indicators and double counting will be further addressed and operationalized through the process of SSF Malaria Phase 2 review and grant negotiation occurring in Q3/4 2012.</p> <p>CRS should conduct smaller surveys before the next MIS. This should be considered in the Phase 2 budget.</p>	<p>CRS in collaboration with NMCP</p>	<p>a) Action Taken: The data collection tools for Kabilo representatives to track the number of individuals and households reached with BCC activities were revised to prevent double counting. In June 2012 SR staff were trained on how to use these tools. Also, guidelines were developed to ensure that these tools are used consistently by field coordinators.</p> <p>b) Action Taken: The tool used to track and aggregate total number of peers reached by Peer Health Educators (PHEs) was revised in April 2012. This tool shows the total number of peers reached against the total number of students in the school with each BCC message.</p> <p>c) Action Taken: CRS developed guidelines in April 2012 on how each data collection and reporting tool in the M&E system is used to ensure consistency in data collection and reporting.</p> <p>d) Action Planned: Beginning</p>	<p>Done June 2012</p> <p>Done April 2012</p> <p>Done April 2012</p> <p>August 31,</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>double counting when reporting the number of peers reached with peer education programs. Figures reported can be cross-checked with the maximum population of the schools where the programs are implemented for in-school programs;</p> <p>c) CRS develops and shares with its SRs an Indicator Protocol Reference Sheet that provides clarity with all indicators in terms of definitions and detailed description of data collection methods, persons responsible for data collection, limitations of the indicators and actions/steps taken to address indicator limitations; and</p> <p>d) CRS conducts smaller surveys to assess the effectiveness of programs implemented for malaria BCC.</p>			<p>August 2012, CRS will conduct Lots Quality Assurance Sampling (LQAS) survey every 12 months to assess the level of progress of indicators that are based on the general population.</p>	2012
National Tuberculosis and Leprosy Program					
<p><u>Service Delivery – Co-infected on ART</u></p> <p>There is a risk that difficulties in program integration will compromise</p>	<p><u>Recommendation 12 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that:</p> <p>a) TB Inspection Officers at</p>	<p>Secretariat: Agreed with (a) – (c)</p> <p>During Phase 1 of the NAS and NLTP grants, particular</p>	NTLP	<p>(a) Action Taken: Leprosy/TB Inspectors (LTIs) working in health facilities which also serve as ART centres have put in place a mechanism for following up co-infected patients. The LTIs who are also part of the HIV/AIDS care team, prepare a list of</p>	On going

Diagnostic Review of Global Fund Grants to The Gambia

<p>treatment outcomes of TB/HIV co-infected patients.</p>	<p>the TB clinics follow up with facilities where they have referred patients in order to updated patients' ART status promptly. This can be done via phone calls or visits to the receiving facility. This should also be followed up in quarterly monitoring/data verification visits by the regional teams and the PR;</p> <p>b) TB registers are redesigned to include columns for HIV status and ART status; and</p> <p>c) The NTLP Data Quality Assessment Checklist includes an assessment of completeness of data collection tools at facilities and is shared with the regional health teams.</p>	<p>efforts have been made to increase the collaboration between both PRs in HIV/TB co-infection work area. At central level, regular meetings have been established and a referral system for patients set up.</p> <p>The recommendations on TB/HIV co-infection are to be further addressed and operationalized through the process of SSF TB Phase 2 review and grant negotiation occurring in Q3/4 2012.</p>		<p>HIV-positive TB patients from the Provider-initiated HIV counseling and testing (PHCT) register for consultation and confirmation from the HIV care register in the ART clinic. This follow up is regularly done on a monthly basis and once the LTI confirms from the HIV care register that a co-infected case has been put on ART, it is promptly entered in the appropriate column of the PHCT register. The data is verified by the monitoring team by cross checking from both registers and then finally reported.</p> <p>Action Taken: For TB clinics located in health facilities which do not serve as ART centres, the follow up of co-infected patients at the nearest ART centre is mainly done by the LTI on a monthly basis through phone calls. To facilitate this process, NLTP will soon provide credit call units for all LTIs. The newly developed TB/HIV referral form has now been printed and distributed to facilitate the referral system of patients. The follow up is further reinforced by the Regional Leprosy/TB Control Officers (RLTCOs) through their monthly supervisory visits during which the co-infected patients referred for care are verified from the ART register. The RLTCOs</p>	<p>September-December 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

				<p>visit each ART centre where co-infected patients have been referred to confirm the number on ART and give feedback to the LTI.</p> <p>Action Taken: Moreover, the recently developed TB/HIV policy is expected to contribute to an increased uptake of ART among co-infected patients. The policy adopts the WHO 2010 policy on ART for HIV positive TB patients. Four Regional Leprosy/TB Control Officers (RLTCOs) have since been posted are actively working in their respective regions.</p> <p>Action Taken: (b). NLTP has developed and using a separate register for TB/HIV cases which covers HIV and ART status. The inclusion of the HIV and ART columns in the TB central register would be cumbersome and duplication of efforts.</p> <p>(c). with regards to data quality assessment checklist the PR will comply based on the recommendation made during grant agreement in phase two.</p>	On going
<p><u>Monitoring & Evaluation – Regional-Level Supervision</u> Absent management</p>	<p><u>Recommendation 13 (Significant Priority)</u> The Global Fund should ensure that the NTLP:</p> <p>a) Fast tracks the hiring of</p>	<p>Secretariat: Agreed with (a) – (b)</p>	NTLP	<p>a) Action taken: PR has agreed with GF comments on the need to get RLTCOs as it will help to strengthen monitoring and supervision at regional level, thereby improving the overall</p>	July-December 2012

Diagnostic Review of Global Fund Grants to The Gambia

<p>and M&E capacity at the regional level, there is a risk of compromised service and data quality, since the capacity at the central level is insufficient</p>	<p>TB Regional Officers. These officers should be the primary staff responsible for mentoring facility staff on implementation and service quality, receiving data to be transmitted to the national level, conducting routine data quality assessment exercises and ensuring appropriate referral and follow up of co-infected patients; and</p> <p>b) Establishes an appropriate feedback mechanism for issues that are raised from quarterly data verification exercises to the Regional teams and DOTS facilities. This should be in form of a comprehensive quarterly report on DQA from the PR that provides feedback on the DQA and facility visits</p>			<p>service delivery and data quality.</p> <p>The PR has started the process of recruiting two more RLTCOs who will be posted in the remaining two health regions URR and</p> <p>NBWR as soon as possible</p> <p>b) Action Taken: The PR has started the process in the current reporting period (January-June 2012) and would continue the process throughout its implementation period</p>	<p>January-December 2012</p>
Financial Management					
Common Risks					
<p><u>Stamping All Third-Party Supporting Documents</u></p> <p>There is a risk of incorrect reporting of expenditures due to a</p>	<p><u>Recommendation 14 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that PRs stamp all original invoices as "PAID", and start the policy of affixing the</p>	<p>Secretariat: Agreed.</p>	<p>All PRs</p>	<p>Action taken: NAS- This recommendation was implemented immediately after OIG debriefing and now all original invoices bear the stamp PAID.</p> <p>Action taken: NMCP has acquired</p>	<p>Immediately</p> <p>This is already being</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>lack of proper supporting documents and of written policies and procedures to control advance payments. In addition, there is a risk of claiming the same expenditure from more than one grant if supporting documents for expenditures funded by the Global Fund are not marked as paid.</p>	<p>Global Fund Grant Code Stamp on all the original supporting documents belonging to the Global Fund Grant. If the same expense is paid by several projects the stamp for each project should be mentioned in the original third party documents with the allocated amount mentioned in the invoice.</p>			<p>an official stamp with the Global Fund grant code which is being used to stamp PAID on all original supporting documents of a paid transaction.</p> <p>Action taken: NLTP has acquired an official stamp with the Global Fund grant code which is being used to stamp PAID on all original supporting documents of a paid transaction.</p> <p>Action taken: AAITG- PR has a stamp since Phase 1 and all invoices are stamp 'PAID' and in use.</p> <p>Action taken: CRS designed a Global Fund stamp in March 2012 and is using it to cancel original supporting documents for the Global Fund grant.</p>	<p>implemented</p> <p>Done</p> <p>Done</p> <p>March 2012</p>
<p><u>Fixed Assets Registers</u> There is a risk of omission or deletion of assets maintained in an Excel spreadsheet and there is a risk of misuse, theft, and damage if Fixed Asset Registers (FAR) are not reconciled with financial records or do not maintain sufficient information</p>	<p><u>Recommendation 15 (High Priority)</u> The Global Fund Secretariat should ensure that:</p> <p>a) All PRs maintain their FAR by using the FAR module in the accounting software;</p> <p>b) The FAR contains data such as identification number, details of location, payment voucher reference no., asset type, date of purchase and date of disposal, invoice and payment voucher, condition of asset, etc.;</p>	<p>Secretariat: Agreed with (a) - (c)</p> <p>At a minimum, the Secretariat recommends that the basic prescription is to have at least an annual asset count and tagging, verification by an independent auditor, and reconciliation of assets purchased per account codes to the register to ascertain</p>	<p>All PRs</p>		

Diagnostic Review of Global Fund Grants to The Gambia

(voucher number, location, status of assets.)	and c) The physical verification of assets procured under the Global Fund grants is carried out periodically by personnel independent of the asset management function. A report should be prepared for the attention of management showing actual quantities found and their physical status. The report should explain variances between physical stock and records and should be signed by the persons involved in the verification process.	completeness.			
<p><u>Institutional Management – Internal Audit Function</u></p> <p>In the absence of a dedicated internal audit function there is a risk that the implementation of programs is inadequately assured. (NAS, NMCP and NTLP)</p> <p>In absence of a</p>	<p><u>Recommendation 16 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that:</p> <p>a) NAS establishes an internal audit function and defines an audit charter explaining the position, role, responsibilities, authority, and mission of the internal audit function;</p> <p>b) NMCP and NTLP establish a memorandum of understanding with the Gambian State Audit Offices;</p>	<p>Secretariat:</p> <p>(a) NAS - Establishment of an audit function and development of an audit plan are Conditions Precedent in the Phase 2 Grant Agreement.</p> <p>(b) NMCP & NLTP – As documented in Management Letters and PR responses, this has been discussed with the Ministry of Finance who has agreed to provide the service to the Ministry of</p>	<p>a) NAS</p> <p>b) NMCP and NTLP</p> <p>c) NMCP, NTLP, NAS, AAITG and CRS</p> <p>d) CRS</p>	<p>a) Action Taken: NAS, in consultation with GF and as per OIG recommendation, NAS has contacted Ministry of Finance, and an internal audit plan has been received and shared with TGF.</p> <p>b)Action Taken: Arrangements are finalized with Ministry of Finance Audit Department. The Audit exercise will start in July, 2012</p> <p>c) Action Taken: An annual plan has been developed by the audit unit of the Ministry of Finance and this has been reviewed and approved by the Global</p>	<p>July 2012</p> <p>July 2012</p> <p>July 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>specific audit work plan, there is a risk that internal audit services are not fully utilized. (NMCP, NTCP, NAS, AAITG and CRS)</p>	<p>c) NMCP, NTLP, NAS, AAITG and CRS develop an annual audit plan that covers key business processes, risk, audits and the entities to be audited and the frequency and timing of the audits to be undertaken. The internal audit reports should be shared with the CCM; and</p> <p>d) CRS's Internal Auditor is only involved in projects funded by Global Fund.</p>	<p>Health's PRs (NMCP and NLTP). The Department of Audit of the Ministry of Finance has agreed to take the responsibility of the internal audit function of both the Malaria and TB grants. The Secretariat has reviewed the audit plan. The arrangement should become operational immediately and be assessed after 6 months, based on the review of the first internal audit reports, which should be shared with the LFA/GF.</p> <p>(c)CRS – the PR has been informed that the internal audit function should cover only GF funding. CRS will need to submit to the GF an internal audit plan for approval.</p> <p>These recommendations on internal audit are furthermore to be addressed and operationalized through the process of SSF Malaria and TB Phase 2 reviews (NMCP,CRS, NLTP)</p>		<p>Fund. Reports of the audit exercise will be shared with CCM.</p> <p>Action taken by TB/LP: Arrangements are finalized with Ministry of Finance Audit Department. The Audit exercise will start in July, 2012</p> <p>An annual plan has been developed by the audit unit of the Ministry of Finance and this has been reviewed and approved by the Global Fund. Reports of the audit exercise will be shared with CCM.</p> <p>Action taken: AAITG has already submitted an internal audit plan to the Global Fund.</p> <p>Action taken: CRS has developed an Internal Audit Plan in March 2012 and is currently being implemented for fiscal year 2012</p>	<p>July, 2012</p> <p>July, 2012</p> <p>Done</p> <p>March 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

		occurring in Q3/4 2012.			
<p>Banking</p> <p>There are a number of risks related to PR banking practices: There is a risk of loss of revenue for programs that use non-interest bearing accounts (AAITG); Checks issued without sufficient funds may bounce, which risks loss of goodwill and incurring of bank fees (CRS and NTLP); and there is a risk that bearer checks may be cashed by a third party (NMCP and NTLP).</p>	<p>Recommendation 17 (High Priority)</p> <p>The Global Fund Secretariat should ensure that:</p> <p>a) AAITG holds funds in an interest bearing account with a competitive rate;</p> <p>b) CRS and NTLP issue checks only after verification of cash balance in books of account to ensure that there is enough cash for payments. The cash balance verification should be included in the payment request approval; and</p> <p>c) NMCP and NTLP should use bearer checks only exceptionally. The reason for issuing bearer checks should be formally approved and documented.</p>	<p>Secretariat: Agreed with (a) – (c)</p> <p>Where practical, interest bearing accounts should be used. The use of bearer checks is discouraged and should be minimized.</p>	<p>a) AAITG</p> <p>b) CRS and NTLP</p> <p>c) NMCP and NTLP</p>	<p>Action Taken: Can we have more clarification on what the OIG is referring to? The NMCP/NLTP do not issue bearer checks which read pay to Mr. X or bearer what we issue are order checks which read pay to Mr. X.</p> <p>Action Taken: These order checks are issued only when absolutely necessary i.e the activity involves the payment of transport refunds or per diems.</p> <p>OIG Response to NMCP and NTLP : During its review, the OIG noted cases of bearer checks issued to suppliers.</p> <p>OIG would like to recall that a bearer check is equivalent to cash, hence there is always a control risk that same is cashed by a person other than the one to whom it was issued and may not reach the actual recipient from whom goods and services were received. NMCP and NTLP should ensure that all payments are done using crossed checks.</p> <p>Action Taken: The bank takes extra precautions by making call backs to</p>	<p>Done</p>

Diagnostic Review of Global Fund Grants to The Gambia

				<p>ensure that the person demanding the check is the right person.</p> <p>b)) This is noted</p> <p>Action Taken: Can we have more clarification on what the OIG is referring to? The NMCP/NLTP do not issue bearer checks which read pay to Mr. X or bearer what we issue are order checks which read pay to Mr. X.</p> <p>Action Taken: These order checks are issued only when absolutely necessary i.e the activity involves the payment of transport refunds or per diems.</p> <p>Action Taken: The bank takes extra precautions by making call backs to ensure that the person demanding the check is the right person.</p> <p>Action Taken: AAITG: We have consulted with our bank and the condition for holding an interest bearing account is to forego the gains on exchange rate for which PR thinks the latter is better.</p> <p>Management Response: CRS The credit balance in the local currency general ledger cash account was due to timing and was solely a book deficit. Since CRS refrained from presenting the checks to the payees</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

				<p>until after Dalasis were transferred into the bank account from CRS' dollar account, there never was an overdraft balance in the Dalasi bank account. The Country Program wrote the checks to ensure that expenses were recorded in the month incurred to comply with GAAP. In retrospect, the Country Program should have accrued the expenses using a liability account, rather than the cash account for that purpose.</p> <p>Action Taken: In the future, the CRS Country Program will:</p> <ul style="list-style-type: none"> a) Refrain from writing checks when doing so will create a book deficit in the cash account. b) Accrue for expenses using a liability account when there is insufficient cash in the local currency bank account at month-end. 	
<p><u>Expenditures Support</u> There is a risk of incorrect reporting of expenditures due to a lack of proper supporting documents and of written policies and procedures to control advance</p>	<p><u>Recommendation 18 (High Priority)</u> The Global Fund Secretariat should ensure that: a) NAS and NMCP develop cash policies and procedures for controlling advance payments, including processing of advance</p>	<p>Secretariat: Agreed. In collaboration with the PRs, (a) – (d) will be negotiated, operationalized and implemented.</p>	<ul style="list-style-type: none"> a) NAS and NMCP b) NAS, NMCP and NTLP c) NAS, NMCP and NTLP 	<ul style="list-style-type: none"> a) Action Taken: NAS has a written policy regarding advances made to staff (including RAC) and how those advances are retired. All advance retirements are properly supported. b) Action Taken: The RAC operational cost is categorize as 	<p>NA</p> <p>Aug 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>payments. In addition, there is a risk of claiming the same expenditure from more than one grant if supporting documents for expenditures funded by the Global Fund are not marked as paid.</p>	<p>payments to RACs;</p> <p>b) NAS, NMCP and NTLP make payments against appropriate supporting documents. They should establish a checklist that contains information and documents to be checked before the payment is made. The checklist should be among the supporting documents attached to the voucher;</p> <p>c) NAS, NMCP and NTLP centralize procurement and other expenses to reduce the cash component of advances to RACs; and</p> <p>d) NAS, NMCP and NTLP enter into contracts with fuel supply companies for the purchase of fuel to mitigate the risk of fuel payments being used for other than project activities.</p>			<p>petty cash and therefore in most instances are within the threshold for single sourcing.</p> <p>c) Action Taken: As per the OIG recommendations, NAS has now centralized procurement and other expenses to reduce the amount of cash handled by RAC as advances. In addition, all invoices paid are stamped as 'PAID' to avoid duplication of payments.</p>	<p>Aug 2012</p>
Catholic Relief Services					
<p><u>Institutional Management – Cost Category</u></p> <p>There is a risk that incorrect financial reporting might be submitted to the</p>	<p><u>Recommendation 19 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that CRS:</p> <p>a) Indicates the codes for cost category, service delivery and activity in the accounting</p>	<p>Secretariat: Agreed with (a) – (b)</p>	<p>CRS</p>	<p>Management Response:</p> <p>The OIG audit period covered all transactions from May 2010 to November 2011. During the audit, CRS informed the OIG that CRS developed T1 codes in Sun System for cost category and T7 codes for activities in</p>	<p>Completed December 2011</p>

Diagnostic Review of Global Fund Grants to The Gambia

<p>Global Fund in the absence of classification of expenditures directly in the accounting software. There is also a risk that common expenses are incorrectly charged to the Global Fund program.</p>	<p>software and does not manually complete the Excel sheet extracted from the software to generate the desired reports to be submitted to Global Fund; and</p> <p>b) Prepares the vehicle cost working sheet correctly and has the finance and accounts department cross-check the information submitted by the administration department before entering the data in the accounting system.</p>			<p>August 2010. For transactions that occurred before these codes were developed CRS had to manually input the T1 and T7 into the Excel extract. From August 2010, all transactions were coded except those that occurred outside the country.</p> <p>Action taken: None needed since from January 2012 all transactions have been coded including those that occur outside of Gambia.</p> <p>Action taken: The Vehicle Management System (VMS) report is being verified and signed by Finance before entry into Sun as of June 2012.</p>	<p>Completed December 2011</p> <p>Done June 2012</p>
<p><u>Management of Sub-Recipients</u></p> <p>There are a number of risks related to SR management: There is a risk that equal opportunity is not given to prospective SRs and that the prospective SRs with the best capacity are not chosen; there is a risk that SR reporting and monitoring is not timely, which may have an impact on</p>	<p><u>Recommendation 20 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that CRS:</p> <p>a) Implements the SR selection policy to be issued by the CCM;</p> <p>b) Establishes reporting mechanisms which ensure that all SRs submit their quarterly progress reports and monthly liquidations on time; and</p> <p>c) SRs (HePDO) maintain grant funds in interest-bearing accounts as far as practical.</p>	<p>Secretariat: Agreed with (a) – (c)</p> <p>The SR selection policy would need to be reviewed by the CCM and used by PRs when submitting new proposals.</p>	<p>CRS</p>	<p>a) Management Response: Once it has been developed and issued, CRS will follow the CCM SR Selection policy during the next opportunity. To ensure future compliance, in March 2012 CRS modified its SR management guide to include a section on transparent selection of SRs.</p> <p>b) Action taken: CRS received approval from the GF on May 31, 2012 to hire an accountant who will be responsible for management of SR reporting processes to ensure timely reporting and liquidation.</p> <p>c) Management Response: It is</p>	<p>In Progress</p> <p>Done May 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

quality and timeliness of implementation of activities of SRs; and there is a risk of loss of revenue due to use of non-interest-bearing bank accounts.				not practical to maintain grant funds in interest bearing accounts, since withdrawals of funds for program activities are very frequent and requires using cheques to pay third parties. Cheque payments are only possible with current accounts which do not attract interest income d) Action taken: In March 2012, CRS amended the section of the SR agreement that requires funds to be kept in an interest bearing accounts.	Done March 2012
ActionAid International The Gambia					
<u>OVC – Payments to Schools</u> There is a risk that amounts paid to schools and families to support orphans and vulnerable children (OVC) are inaccurate and include double payments.	<u>Recommendation 21 (High Priority)</u> The Global Fund Secretariat should ensure that AAITG: a) Develops an operational guideline under the national OVC policy and framework; and b) Issues payments only to schools and not to parents or families. AAITG should immediately stop the practice of payment in cash.	Secretariat: Agreed with (a) – (b)	AAITG	Action taken: The national OVC criteria and guidelines have been revised and in use since September 2011. All payments for OVC school fees for the academic year 2011/2012 were made directly to the schools by cheque.	
<u>Financial Reporting</u> There is risk of over-reporting of	<u>Recommendation 22 (Significant Priority)</u> The Global Fund Secretariat	Secretariat: Agreed with (a) – (b)	AAITG	Action taken: This recommendation conflicts with the principle of cash accounting and accrual - this means	

Diagnostic Review of Global Fund Grants to The Gambia

expenditures in financial statements.	<p>should ensure that AAITG:</p> <p>a) Reports actual expenditures incurred by the SRs instead of counting disbursements to SRs as expenditures in PU/DRs and EFRs; and</p> <p>b) Explains variances between opening cash balances and the closing cash balances for the previous period in PU/DRs.</p>	Through Management Letters and in-country engagements the PR has been informed that detailed and correct cost classifications are extremely important for adequate planning and management. The GF and LFA will verify during Phase		taking us back to the accrual principle. OIG Response to AAITG : Disbursements issued to the SRs should be accounted as advances and not as actual expenses. When financial reports (EFRs) are submitted to the Global Fund they should include only actual expenses incurred by the PR and its SRs. AAITG should ensure that EFRs include only PR and SRs actual expenditures.	
<p><u>Accounting System</u></p> <p>There is risk of incorrect financial reporting if reports are generated from Excel spreadsheets rather than directly from the accounting software.</p>	<p><u>Recommendation 23 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that AAITG reconfigures the Sun accounting system to directly generate the desired reports.</p>	Secretariat: Agreed	AAITG	Action taken: The system has been reconfigured to generate automated reports for the project.	
National AIDS Secretariat					
National Malaria Control Program					
<p><u>Support Payments and Vouchers</u></p> <p>There is a risk that voucher payments are not adequately controlled.</p>	<p><u>Recommendation 24 (Significant Priority)</u></p> <p>The Global Fund Secretariat should ensure that NMCP:</p> <p>a) Establishes a checklist that contains information and</p>	Secretariat: Agreed with (a) – (b)	NMCP	a) Action taken: This is noted and the checklist will be developed and will be attached to the PV among the other supporting documentation.	a) Aug 2012

Diagnostic Review of Global Fund Grants to The Gambia

	documents that must be checked before payment. The checklist should be among the supporting documents attached to the voucher; and b) Makes sure that contracts are signed before delivery of goods and invoices are required for the issuance of payment.			b) Planned Action: contracts will be signed before delivery of goods and invoices. Invoices will be required for the issuance of payments	b) Already in place
<u>Reporting Mechanism</u> There are risks that periodic reports on programmatic progress may be incorrect and that disbursements may be delayed due to variances in expenditures reported in PU/DRs and EFRs versus those recorded in the general ledger. There is also a risk that late submission of reports delays disbursements and activities.	<u>Recommendation 25 (Significant Priority)</u> The Global Fund Secretariat should ensure that NMCP: a) Ensures that PU/DRs and EFRs are properly reconciled to financial records before being submitted to the Global Fund. The over-reported amount of USD 7,374 should be refunded; and b) Follows the reporting guidelines for preparing PU/DRs, EFRs and external reports and ensures that these reports are submitted to the Global Fund on a timely basis.	Secretariat: Agreed with (a)-(b) The OIG should specify to which period the over-reported amount of USD 7,374 is related. The GF will ensure the amount is refunded by NMCP.	NMCP	a-b. Action taken noted however the OIG should be specific on the period of the said amount of USD 7,374. OIG Response to NMCP: In the EFR for the period 01/05/2010 to 31/12/2010, there was excess reporting of \$7,374.74 in comparison to expenditures recorded in General Ledger.	
National Tuberculosis and Leprosy Program					
<u>Training</u> There is a risk of	<u>Recommendation 26 (Significant Priority)</u>	Secretariat: Agreed In April 2012 the GF	NTLP	Planned Action: NLTP will develop an addendum to its procedures manual	July 2012

Diagnostic Review of Global Fund Grants to The Gambia

<p>incorrect payments being made due to a lack of proper identification and contact information for training participants.</p>	<p>The Global Fund Secretariat should ensure that NTLP obtains identification and contact information for of training participants and includes copies of participants' ID cards or their ID numbers as well as their contact numbers on the attendance list.</p>	<p>requested the NLTP to develop an addendum to its procedures manual dedicated to the organization of trainings (covering all steps from planning, implementation, documentation and evaluation phases).</p> <p>The training modules have been developed with the support of an experienced local. All these trainings are accompanied by a detailed training report which includes attendance lists, pre and post evaluation reports and training methodology.</p> <p>Furthermore, the training plan approved by GF specifies the organizer, title ,topic, purpose, if the training is in the approved work plan, criteria used to select participants, number of participants, number of days, cost of venue (total duration of the training) etc.</p>		<p>dedicated to the organization of trainings (covering all steps from planning, implementation, and documentation and evaluation phases).</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

Procurement and Supply Management					
Common Risks					
<p><u>Inadequate Stock Coverage Due to Poor LMIS</u></p> <p>There is a risk of stock-out, over-stocking and expiry of drugs due to the lack of reliable consumption data and an effective Logistics Management Information System (LMIS).</p>	<p><u>Recommendation 27 (High Priority)</u></p> <p>The Global Fund should ensure that:</p> <p>a) NAS, NMCP and NTLP maintain manual stock cards (with batch and expiry dates) at all levels of the supply chain, even if a computerized monitoring system is installed, operational and used, until such time that the LMIS is fully reliable;</p> <p>b) NMCP continues to deploy the 30 additional officers to assist health centers to collect consumption data;</p> <p>c) NAS, NMCP and NTLP plan and perform additional LMIS training sessions for users in ART centers, hospitals, RMS and regional health centers;</p> <p>d) NAS, NMCP and NTLP, in collaboration with CMS, organize monthly supervision missions by the manager of the CMS/LMIS and the National</p>	<p>Secretariat: Agreed. The issue of the lack of reliable consumption data and the LMIS is a key priority requiring additional focus.</p> <p>In collaboration with the PRs, the Secretariat will endeavor to negotiate, operationalize and implement (a) – (f).</p> <p>The strengthening of the LMIS was part of the PSM capacity building plan approved and budgeted in National PRs Rounds 8 and 9 grants. All National grants have contributed to the LMIS strengthening.</p> <p>Implementation of the national procurement system capacity-building plan is behind schedule due to lack of ownership by the different</p>	<p>a) NAS, NMCP and NTLP</p> <p>b) NMCP</p> <p>c) NAS, NMCP, NTLP and CMS</p> <p>d) NAS, NMCP and NTLP</p> <p>e) NAS, NMCP, NTLP and CMS</p> <p>f) NAS, NMCP, and NTLP</p>	<p>Action Taken: Maintaining manual stock cards alongside the computerized system is the current practice both at the CMS and the Regional Medical Stores and service delivery points will be maintained. The stock cards have been reviewed and updated and captures the batch numbers and expiry dates.</p> <p>Action Taken: Under the phase 2, NMCP has made provision to recruit additional 22 data entry clerks to support the functioning of the LMIS. The initial 30 data entry clerks been referred to were recruited under the CBS plan (Rounds 8 & 9) and deployed to health facilities.</p> <p>Action Taken: Training of health workers and data entry clerks on LMIS will be factored and budgeted for the under the different grants.</p> <p>Action Taken: Under the CBS plan, there is quarterly monitoring of the</p>	<p>On going</p> <p>During annual PR budget review</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>Public Health Laboratory (NPHL) and make a vehicle available for this purpose;</p> <p>e) NAS, NMCP and NTLP, in collaboration with CMS, ensure that each RMS checks the collection, reliability and transmission of consumption data at the health facility level; and</p> <p>f) NAS, NMCP and NTLP strengthen the supervision of data entry clerks by the PRs' monitoring and evaluation teams, regional health teams, facility officers in charge and head pharmacists.</p>	<p>PRs involved. All three PRs (NLTP, NAS and NMCP), as well as the Central Medical Store, should become accountable to the plan. The LMIS Taskforce should report monthly on the implementation status to the LFA/GF. Before the periodic review the PRs should demonstrate accelerated implementation of the plan.</p> <p>PR's will need to ensure that CMS/NPS provide updates on the development of the LMIS and provide minutes of the taskforce meetings.</p>		<p>LMIS at regional and health facility levels. As indicated in the CBS plan, the PRs will provide logistics to facilitate supervision.</p> <p>Action Taken: Provision of a monitoring vehicle for the CMS/LMIS will also be budgeted.</p> <p>Additionally, NMCP& NPS conducts quarterly monitoring on procurement and supply management at regional and health facility levels.</p> <p>Action Taken: PRs and NPS will ensure that the RHTs/RMS takes active oversight role in checking the data collection, reliability and transmission of consumption at the health facility level.</p> <p>Action Taken: All PRs during their supervisory visits with partners will collaborate with key staff of the RHT, OICs & Head of Pharmacy to conduct spot checks and provide on the job training and mentoring on issues emanating during data entry and data transmission.</p>	<p>July 2012</p> <p>January 2013</p> <p>From now on</p>
<p><u>Non-compliance with Global Fund Quality Assurance</u></p>	<p><u>Recommendation 28 (High Priority)</u> The Global Fund Secretariat</p>	<p>Secretariat: Agreed. The lack of required quality assurance of health products is a key issue requiring additional</p>	<p>a) NAS, NMCP, NTCP and</p>	<p>a. Action Taken: During the implementation of the CBS plan in phase I, quality assurance manual/& SOPs were developed</p>	

Diagnostic Review of Global Fund Grants to The Gambia

<p><u>Requirements</u></p> <p>There is a risk that drugs and commodities are procured without the required quality assurance</p>	<p>should ensure that:</p> <p>a) NAS, NMCP, NTCP and AAITG establish (under the leadership of NPS) a comprehensive quality assurance policy, including for the collection of samples for analysis and all measures to be taken along the supply chain, as well as for cases of non-conformity;</p> <p>b) NAS, NMCP, NTCP and AAITG submit a sampling plan and procedure including provision for the number of lots sampled, the sampling period in terms of storage months and the level of the supply chain where the collection will be made. The PRs should predict an implementation budget to be included in PSM Costs;</p> <p>c) NAS, NMCP, NTCP and AAITG select samples of drugs along the distribution chain and send them to a quality control laboratory that is WHO-prequalified or certified ISO 17025 (such as the one selected in South Africa);</p> <p>d) AAITG considers using VPP services to perform sampling and quality control of condoms</p>	<p>focus.</p> <p>In collaboration with the PRs, the Secretariat will endeavor to negotiate, operationalize and implement recommendations (a) – (f).</p> <p>A contract between NPS (Ministry of Health & Social Welfare) and North West University, South Africa concerning QC testing has been signed for all National PRs (NAS, NMCP and NLTP). In the NAS Phase 2 budget a line item has been introduced to support QC testing. SOPs on sampling of products are available at NPS level.</p>	<p>AAITG</p> <p>b) NAS, NMCP, NTCP and AAITG</p> <p>c) NAS, NMCP, NTCP and AAITG</p> <p>d) AAITG</p> <p>e) NAS, NMCP, and NTCP</p> <p>f) NAS</p>	<p>which specified collection of samples across the supply chain. Development of the GA policy is already planned in the CBS.</p> <p>b. Action Taken: The quality assurance manual/SOPs has clearly spelt out the sampling methods and procedures. Equally, a sampling plan has developed and shared with the Global Fund. The budget has been included in the phase II to cater for sampling and analysis.</p> <p>Action Taken: Currently, NPS in collaboration with PRs (NMCP & NLTP) has collected and sent samples of anti-malarials and anti-TB drugs to the North West University Lab in South Africa and the results has been received and shared with the LFA. ARVs will follow soon.</p> <p>c. Action Taken: The PRs will continue to request the delivery of certificate of pre-qualification and confirmation from the CMS as and when received from the manufacturer.</p> <p>Action Taken: PR will consult with NAS and Central Medical Stores to consider including condoms in their</p>	<p>April 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

	<p>before shipment;</p> <p>e) NAS, NMCP and NLTCP require from CMS at each delivery (if the product is listed as Global Fund-prequalified) a copy of the certificate of prequalification and confirmation that the product delivered comes from the prequalified manufacturing site; and</p> <p>f) NAS ensures, according to Global Fund requirements, that the management of procurement and supply for drugs meets the principles established in the Interagency Guideline “A quality system model for the Central d’Achats.”</p>			quality control tests.	
<p><u>Price and Quality Report (PQR) Form</u></p> <p>There is a risk of incorrect procurement information and lack of quality assurance.</p>	<p><u>Recommendation 29 (Significant Priority)</u></p> <p>The Global Fund should ensure that NAS and AAITG monitor the prices, quantities and delivery data entered in the PQR form by the VPP procurement agent and request that any errors be corrected.</p>	Secretariat: Agreed	NAS and AAITG	<p>Action Taken: NAS and AAITG are periodically monitoring PQR and will continue to do so and request for correction where noted.</p>	From June, 2012
<p><u>Procurement</u></p> <p>There is a risk that drugs procured, primarily ACTs but</p>	<p><u>Recommendation 30 (High Priority)</u></p> <p>The Global Fund Secretariat</p>	Secretariat: Agreed.	All PRs	<p>Planned Action Recommendation is agreed and will be implemented.</p> <p>Action Taken: NAS has been complying with the national</p>	Already in place

Diagnostic Review of Global Fund Grants to The Gambia

<p>also other antimalarial drugs, do not meet the Global Fund's WHO prequalification requirements. (NMCP)</p> <p>There is a risk that unplanned procurement could adversely affect competition and result in a lack of offers from suitable tenderers, the selection of inappropriate suppliers and increased procurement costs. (NMCP, NAS)</p> <p>There is a risk that value for money is not assured due to an insufficiently transparent procurement process and the absence of competitive bidding.</p>	<p>should ensure that:</p> <p>a) All PRs establish annual plans that include deadlines for each procurement step (TOR/specification, advertisement, receipt of bids, evaluation of bids, supplier notification, issuance of the purchase order, signature of the contract, delivery date, etc.) in order to avoid unplanned or emergency procurement;</p> <p>b) NMCP adapts procurement procedures to the specific requirements of the Global Fund by restricting bids for drugs and commodities to pre-qualified manufacturers and products and establishing a tender process that allows a higher number of suppliers to respond by increasing the specified delivery time where feasible;</p> <p>c) MRC and NAS comply with the procurement-related conditions of the grant agreements and ensure value for money for all procurement of goods and services. Single-source and restricted procurement should be the exception;</p>	<p>In collaboration with the PRs, the Secretariat will endeavor to negotiate, operationalize and implement (a) – (g).</p> <p>The Secretariat will ensure that the PRs procurement procedures are in line with the GF-specific requirements. The Secretariat is systematically requiring that the tender specifications are reviewed by the LFA before the bid is launched by the PR, to ensure that the process is in compliance with GF requirements.</p>		<p>procurement regulations and only uses single sourcing and restricted tendering in exceptional circumstances as recommended and will continue to ensure value for money.</p> <p>Action Taken: The NAS shall request for Bank guarantees in applicable contract where advance payments are required.</p> <p>Planned Action: Noted and this will be developed in collaboration with the other PRs</p> <p>Action Taken: NMCP has now adapted the procedures required by the global fund</p> <p>Action Taken: NMCP has adapted this strategy and uses three international media outlets to advertise for tenders namely: UNDB, Devex and Development Aid</p> <p>Action Taken: NMCP has now adapted these conditions in the contract and bidding document.</p> <p>g) Action Taken: This is noted and bank guaranties will be obtained before making any advance payments</p> <p>Action Taken: Procurement decisions are made by NMCP, however</p>	<p>Already in place</p> <p>Already in place</p> <p>This is already being implemented</p> <p>In Progress</p> <p>Already in place</p> <p>Already in place</p>
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Diagnostic Review of Global Fund Grants to The Gambia

<p>(NMCP, MRC); and There is a control risk relating to segregation of duties for the procurement of medical equipment and consumables due to individuals simultaneously serving in multiple procurement functions (requisition, selection of suppliers, setting prices and other terms and conditions of procurement) (MRC).</p>	<p>d) NMCP and MRC use an appropriate tender advertisement strategy to ensure healthy competition by advertising tenders in local and international newspapers and on international websites for competitive bidding; e) NMCP and MRC indicate all the terms and conditions regarding freight charges, insurance, delivery period, and penalty for delay in delivery and post-sale service in purchase orders; f) MRC segregates duties between the end user (the program unit) and the procurement department in order to increase transparency in procurement. The only role of the end user should be to provide product specifications to the procurement unit. g) NAS, NMCP, NTLP and MRC receive bank guaranties before making any advance payments in order to reduce the risk of financial loss to the Global Fund grant program or delay in implementation.</p>			<p>CRS provides specifications. CRS is working with NMCP to develop a detailed plan for all procurements affecting both PRs.</p> <p>Action Taken: MRC</p> <p>a) All procurement over £100 goes through a value for money assessment based on three quotes before a contract is awarded.</p> <p>b) MRC through the Shared Service Centre Ltd (UK) uses appropriate tender advertisement strategy for all requests based on the EU Directive Tender threshold. We will incorporate a limit for requirement for an open tender in our procurement manual.</p> <p>c) MRC now have detailed terms and condition of Purchase which is referred to in the Purchase order.</p> <p>d) The MRC has a Procurement Policy in place which requires is sufficiently transparent and enhances value for money. End Users only raise Orders for overseas orders of scientific product.</p> <p>e) This is noted but concerns relates to complexity of the market and concept of the overseas supplier market to African buyers. We try to minimize this risk by developing</p>	<p>Limit for open tender locally will be assessed by Sept. 2012.</p> <p>Already in place</p> <p>Already in place</p> <p>Dec 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

				business relationship with all potential long-term suppliers with the intention of having in place credit terms.	
<p><u>Quantification</u> There is a risk of inadequate stock coverage for ARVs and stock-outs, over-stocking and expiry of drugs due to poor quantification methods by NAS and NMCP.</p>	<p><u>Recommendation 31 (High Priority)</u> The Global Fund Secretariat should ensure that: a) NAS and NMCP develop a proper method of quantification and forecasting of ARVs, ACTs, RDTs and LLINs, based on consumption data that takes into account data for stock-outs and expired drugs, and implement this method once data collection is sufficient (paying attention to data and seasonal fluctuations in consumption for, e.g., malaria). NAS should formally establish the number of new patients (adults and children) to be treated per year after clearly defining the assumptions and using realistic targets and considering the fact that all HIV-positive TB patients are eligible for ART; b) NAS and NMCP temporarily overlap quantification methods during the period of transition to the</p>	<p>Secretariat: Agreed. In collaboration with the PRs, the Secretariat will endeavor to negotiate, operationalize and implement (a) – (f). NAS has been tracking patient’s medicine utilization from the patient records. Likewise, an inventory management system has also been put in place for non-health products purchased by the grant which is periodically verified. In addition, quarterly ARV reports are provided in the PUDR.</p>	<p>a) NAS and NMCP b) NAS and NMCP c) NAS d) NAS e) NAS f) NAS</p>	<p>a. Action Taken: Currently, there is a system of forecasting and quantification in place. However, this will be improved after the training on quantification as agreed in the CBS plan. b. Action Taken: NAS has agreed to this recommendation. c. Action Taken: NAS will follow up with CMS to monitor stock levels to prevent stock outs. d. Action Taken: NAS will comply with this recommendation. e. Action Taken: NAS will work with CMS to establish a delivery schedule. f. Action Taken: A data manager has been recruited by CMS to serve all the 3 PRs and resides under the CMS (a&b) NMCP has started using consumption data for the quantification of health products. Year 3 health products were quantified</p>	

Diagnostic Review of Global Fund Grants to The Gambia

	<p>new quantification method;</p> <p>c) NAS follows up on any possible gaps between targets and reality and monitors the impact of any differences on stock coverage;</p> <p>d) NAS improves and updates the table for inventory control to make it easier to understand and allow for more efficient reporting. NAS should track inventory and orders and take into account stock on hand, rational stock (anticipating expected expiration), estimated order quantities and adjusted consumption;</p> <p>e) NAS establishes a delivery schedule with the estimated number of months of consumption represented by each ARV drug; and</p> <p>f) NAS recruits a data manager to use and update these necessary tools.</p>			<p>using consumption data.</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

National AIDS Secretariat					
<p><u>National Health Supplies</u> <u>Public Laboratory</u></p> <p>Due to poor implementation of procurement and supply management activities related to diagnostic tests, reagents and equipment, there is a risk of poor stock coverage for these products.</p>	<p><u>Recommendation 32 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that NAS, in collaboration with the Ministry of Health and Social Welfare, reviews and updates the national laboratory and diagnostic policy. NAS should also:</p> <p>a) Develop a short-term plan to strengthen PSM for tests, laboratory reagents and medical equipment, which plan should include strengthening of the overall organization, development of human resources, capacity building for each component of the PSM, establishment of a system of distribution in compliance with logistics standards, harmonization of equipment, establishment of an efficient LMIS and addressing maintenance issues;</p> <p>b) Budget for the improvement of laboratory PSM capacity;</p> <p>c) Hire a technical assistant</p>	<p>Secretariat: Agreed.</p> <p>In collaboration with the PRs, the Secretariat will endeavor to negotiate, operationalize and implement (a) – (e).</p>	<p>NAS</p>	<p>Action Taken: Despite the National Public Laboratory Service provides valuable laboratory service for HIV response, it is important to note that its institutional capacity strengthening is not a sole responsibility of the NAS but rather the MOH. Therefore, the NAS cannot guarantee the implementation of these recommendations. In addition, the NAS management is with the view that these recommendations are misplaced.</p> <p>OIG Response to NAS: The tests and laboratory reagents were procured from the Global Fund grant and used for the purpose of the grant and implemented by the PR (NAS). It the responsibility of the PR, with the involvement and the collaboration of the MoH and NPLS to implement this recommendation, with which the Global Fund Secretariat is in agreement. If bottlenecks appear during the implementation of this recommendation, the PR should report them to the CCM and the Global Fund Secretariat in order to facilitate and to</p>	

Diagnostic Review of Global Fund Grants to The Gambia

	<p>to train staff once human resources are sufficient;</p> <p>d) Sign a memorandum of understanding outlining the functional and administrative relationship between the PR and the MOHSW (NPHL), the services to be provided and the update to the national laboratory and diagnostic policy; and</p> <p>e) Write a manual for medical equipment supply and develop capacity to procure non-health products.</p>			<p>find a solution for a smooth implementation.</p>	
Catholic Relief Services					
<p><u>Risk of Non-Availability of LLINs</u> There is a risk of non-availability or non-distribution of LLINs.</p>	<p><u>Recommendation 33 (High Priority)</u> The Global Fund Secretariat should ensure that the NMCP and CRS better monitor the availability and distribution of LLINs, for example by identifying focal persons for distribution at RCH clinics.</p>	<p>Secretariat: Agreed.</p> <p>The issue of distribution of LLINs has been highlighted in Management Letters sent in May 2012. The PRs have been requested to investigate the issue.</p> <p>The recommendation on LLINs will be further operationalized through the process of SSF Malaria Phase</p>	<p>CRS</p>	<p>Management response: NMCP is responsible for procurement of LLINs, however CRS provides specifications. Beginning August 2012, CRS will ensure that stock management issues regarding LLINs are included in regular consultations with NMCP.</p> <p>Action Planned: CRS will continue regular consultations with NMCP on LLIN procurement and document minutes and action points. CRS Program staff have revisited the LLIN distribution plan and targeted beneficiaries with focal persons at all clinics. The mentoring of a Malaria</p>	

Diagnostic Review of Global Fund Grants to The Gambia

		2 review occurring in Q3 2012.		focal person will depend on the recommendations by the LFA. a) Action taken: CRS has developed new tools to allow CRS and the partner SRs to track distribution of LLIN to beneficiaries and movement of LLINs between distribution points	
ActionAid International The Gambia					
<p><u>Procurement of HBC Kits</u></p> <p>There is a risk of overpayment for, insufficient availability of and delay in the delivery of home-based care (HBC) kits</p>	<p><u>Recommendation 34 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the AAITG:</p> <p>a) Considers the possibility of purchasing some simple components of the kits from the local market; and</p> <p>b) Links the quantity of HBC kits to the indicator “number of people provided with HBC and psychosocial support” and not to indicator 3, “number of people provided with care and support”.</p>	<p>Secretariat: During Phase 2 grant negotiation, it has been agreed with the PR that some components of the kits will be bought from the local market. This will save budget, as prices are much higher on the international market, and reduce lead time. The quantification has been reviewed in line with the indicator.</p>	AAITG	<p>a) Action taken: PR has purchase the HBC local items for phase 1 and will continue to procure the HBC local supplies for Phase II.</p> <p>b) Action taken: This is not applicable to Phase II because kits are allocated to the nurses and volunteers and not patients.</p> <p><u>OIG Response to AAITG :</u></p> <p>a) All HBC kit items were procured through VPP during Phase I, which was not the best modality for procuring certain items (scissors, small bags, cottons, etc.)</p> <p>b) The OIG noted that in the PSM plan specified neither the contents of the HBC kits nor their quantity, the number of each type of kit (nurse kit, volunteer kit and family kit) or the unit cost. The quantification of HBC kits did not follow a clearly articulated</p>	

Diagnostic Review of Global Fund Grants to The Gambia

				methodology. However, if the kits are allocated to the nurses and volunteers and not to the patients and confirmed by the Global Fund Secretariat then the indicator should be updated.	
Oversight					
Country Coordinating Mechanism					
<p><u>CCM Eligibility</u></p> <p>There is a risk that the CCM will not be eligible for funding by the Global Fund in the absence of transparent selection of CCM members representing non-government constituencies and of a documented and transparent process for the selection and nomination of all new and continuing PRs based on clearly defined and objective criteria.</p>	<p><u>Recommendation 35 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the CCM:</p> <p>a) Ensures that selection of the CCM members representing non-government constituencies is done by their own constituencies through a documented, transparent process developed within each constituency;</p> <p>b) Ensures that the CCM bylaws relating to membership from the NGO constituency are in line with a) above;</p> <p>c) Documents the PR selection process for Round 8 and the SSFs currently under way and updates the CCM Regulations Manual with a detailed procedure for PR selection. This procedure should describe the whole process</p>	<p>Secretariat: Agreed with (a) – (d).</p> <p>Appropriate governance by CCM is a key priority requiring additional focus by the GF, CCM and Partners.</p> <p>The CCM has been informed of the risk of non-compliance with the GF CCM guidelines and has reviewed its processes - selection of CCM members representing non-government constituencies have been re-conducted to ensure transparency and proper nomination by each constituency.</p>	CCM	<p>a) Action taken: The CCM has complied with guidelines on the selection of non-government members of the CCM and the current CCM members selection had followed the due process particularly the non- government constituencies</p> <p>b) Action taken: The CCM Bylaws were revised to reflect the Global fund requirements and guideline on the selection of NGO constituencies</p> <p>c) Action taken: The CCM has updated its governance instrument properly describing the PR selection process detailing every step that need to be taken.</p> <p>d) Action taken: The CCM is aware of the importance of good record keeping and have already found some missing documents such as</p>	<p>Done since March 2012</p> <p>Done since March 2012</p> <p>Done since March 2012</p> <p>Done since March 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>from the establishment of criteria for selection and advertisement of those criteria through the nomination of the PR, including the tools for evaluation; and</p> <p>d) Improves CCM record keeping and archiving and ensures that missing CCM documents are found and filed (e.g., meeting minutes and documents relating to the PR selection process and the CCM secretariat selection process). The CCM should establish a document hand-over process for changes in leadership.</p>			<p>past meeting minutes, secretariat staff selection process and the handing over notes. All these can be verify at the CCM Secretariat</p>	
<p><u>Conflict of Interest</u></p> <p>There is a risk that potential conflict-of-interest situations related to the CCM are not effectively mitigated.</p>	<p><u>Recommendation 36 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the CCM:</p> <p>a) Ensures that PRs and SRs that are CCM members do not take part in decisions affecting them, including those related to oversight, and selection or financing PRs or SRs;</p> <p>b) Increases the proportion of non-PRs on the Technical Committee; and</p> <p>c) Establishes a policy/guideline for selecting SRs</p>	<p>Secretariat: Agreed with (a) – (c).</p> <p>Conflict of interest with PR and SR members of the CCM has been discussed with the CCM. As a mitigation measure, the CCM has developed a conflict of interest policy. The policy requests PRs or SRs not to take part in decisions affecting them. In reality, the policy is not systematically</p>	<p>CCM</p>	<p>a) Action taken: The CCM have developed a Conflict of Interest Policy which is very explicit on PR/SR when it comes to matters affecting them. In addition the CCM Bylaw deterred PR/SR from becoming CCM Chair. Furthermore the CCM have established a committee called Ethic and Conflict of Interest Committee. CCM has resolved that with all these new initiative it would continue to monitor and deal with conflict of interest on case by case basis. All the current CCM has filled conflict of interest</p>	<p>Done since March 2012</p>

Diagnostic Review of Global Fund Grants to The Gambia

	<p>to be followed by PRs.</p>	<p>applied. The recommendation of the GF has been to avoid having PRs as members of the CCM, and particularly of Technical Committees.</p> <p>The Secretariat will continue to work closely with the CCM staff to ensure the CCM is compliant with all GF CCM requirements.</p>		<p>declaration form indicating that any time they are in conflict they will declare it.</p> <p>b) Action taken: The CCM agreed with the recommendation to increase the proportion of non-PRs on the Technical committee</p> <p>c) Action taken: Like the selection of PR, the CCM has clearly described in its revised bylaw the selection process of SRs and CCM is committed to make sure is applicable</p>	
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Diagnostic Review of Global Fund Grants to The Gambia

<p><u>Insufficient Management and Oversight</u></p> <p>There is a risk that management and oversight over grants are insufficient.</p>	<p><u>Recommendation 37 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the CCM:</p> <p>a) Establishes an annual work plan that includes the CCM meeting schedule, agenda for each meeting and the documents to be received from the PRs for each meeting;</p> <p>b) Ensures that the CCM Secretariat gives members sufficient advance notice of meetings (e.g., 2 weeks) and obtains their confirmation, either by email or by telephone, of attendance in advance in order to ensure a quorum;</p> <p>c) Does not take binding decisions in the absence of a quorum of members;</p> <p>d) Ensures that the meeting minutes capture all decisions, and that they are signed by the CCM Chair;</p> <p>e) Creates an oversight and field visit plan. The plan should be approved by two-thirds of the CCM members as described in the bylaws;</p> <p>f) Monitors grant</p>	<p>Secretariat: Agreed with (a) – (i).</p> <p>Appropriate governance by CCM is a key priority requiring additional focus by the GF, CCM and Partners.</p> <p>The Secretariat will continue to work closely with the CCM staff to ensure the CCM is compliant with all GF CCM requirements.</p>	<p>CCM</p>	<p>a) Action taken: The CCM has developed an annual work plan that includes dates of CCM meetings, Oversight meeting, Oversight review of the Dashboards, field visits as well as all activities on the budget performance framework are also capture in work plan. This is approved by the CCM as provided for in the CCM bylaws</p> <p>b) Action taken: Since the inauguration of the CCM the CCM secretariat now send letters 2 weeks-notice before any CCM meeting and also scanned copy of the letters are send by email to all members and these are all filled at the secretariat for future verifications.</p> <p>c) Action taken: The CCM decisions are based on consensus and the decision taking is governed by the provisions of the CCM governance instruments. It is in the CCM bylaw that if there is no quorum the CCM meeting should be postponed and another meeting be call within a week and members present will take a decision that will be binding.</p> <p>d) Action taken: The CCM</p>	<p>Done since March 2012</p> <p>Done since March 2012</p> <p>Done since March 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

	<p>implementation and PR activities by regularly reviewing grant management-related documents, including PU/DRs, PR audit reports and PR annual plans;</p> <p>g) Ensures the development, in collaboration with the PRs, of an internal audit plan for each PR. The internal audit reports should be submitted and reviewed by the oversight committee;</p> <p>h) Ensures continued regular LFA debriefs to the Oversight Committee; and</p> <p>i) Evaluates the performance of the CCM Secretariat on a regular basis, with participation of all CCM constituencies.</p>			<p>oversight committee reviews Dashboards, PR quarterly reports and management letters of PRs every quarter and present its recommendation to the CCM at the following scheduled CCM meeting</p> <p>e) Action taken: The LFA have started providing briefing to the Oversight committee</p> <p>f) Action taken: The CCM has evaluated the Executive Secretary and have included in the Bylaws that the Executive Secretary will be evaluated 2 times in a year and the CCM leadership is committed to ensure that the evaluations happen.</p>	<p>Done since March 2012</p> <p>Done since March 2012</p>
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Diagnostic Review of Global Fund Grants to The Gambia

Local Fund Agent					
<p><u>Quality of Information Reported to the Global Fund</u></p> <p>There is a risk that the Global Fund Secretariat will not get accurate information without an updated country risk analysis and thorough verification by the LFA.</p>	<p><u>Recommendation 38 (High Priority)</u></p> <p>The Global Fund Secretariat should ensure that the LFA:</p> <p>a) Undertakes an assessment of country and PR risks and develops a review plan that ensures coverage of the key risks identified. This should guide all LFA work;</p> <p>b) Adopts a sampling methodology during its reviews of PU/DR and EFRs by selecting representative samples from each reporting budget line to ensure better coverage; and</p> <p>c) Always provides the Secretariat with the causes or explanations for detected problems to allow for quick and appropriate action.</p>	<p>Secretariat:</p> <p>(a) The LFA has been requested to complete an updated Country Risk assessment in Q2 2012.</p> <p>(b) Agreed.</p> <p>(c) The current LFA cost proposal includes additional LFA human resources for completing key financial deliverables (e.g. additional consultants to be contracted for PUDRs).</p>	<p>LFA</p>	<p>a) In agreement with the Global Fund Secretariat, the PR Risk assessment will be conducted by 15 August 2012. It was initially planned in Q2 2012, however given the high work-load with several Periodic reviews for TB and Malaria, it was agreed to do it before the next PU/DRs in August 2012. This is one year after the previous risk assessment, which is deemed reasonable.</p> <p>b) Agreed. We have already used this approach for the PU/DRs reviewed in February 2012. A sample has been selected with includes transactions from each cost category.</p> <p>c) This recommendation is a bit vague. Swiss TPH has been consistently documenting explanations for detected problems. Whenever the explanations are not immediately available and require further verification (including field visit), the LFA considers preferable to take more time and pro-vide the Global Fund with sound information.</p>	<p>a) Next PR Risk assessment using Swiss TPH template should be completed by 15 August 2012</p> <p>b) Further document the sampling methodology for the next PU/DRs in August 2012</p>
	<p><u>Recommendation 39 (High Priority)</u></p> <p>The Global Fund Secretariat</p>	<p>(a) The GF and LFA will</p>	<p>The Global</p>		

Diagnostic Review of Global Fund Grants to The Gambia

	<p>should:</p> <p>(a) Monitor the compliance of PRs with grant agreements, conditions and other Global Fund requirements and ensure regular monitoring of these matters by the LFA;</p> <p>(b) Ensure consistency and agreement between documentation on PR compliance; and</p> <p>(c) Ensure that adherence to compliance matters is consistently reflected in disbursement decisions.</p>	<p>vigilantly monitor compliance of CPs, grant agreements and organizational requirements.</p> <p>(b) The formation of the Grant Management Support Department within the Grant Management Division will provide additional organizational focus on compliance and quality assurance.</p>	<p>Fund Secretariat</p>		
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