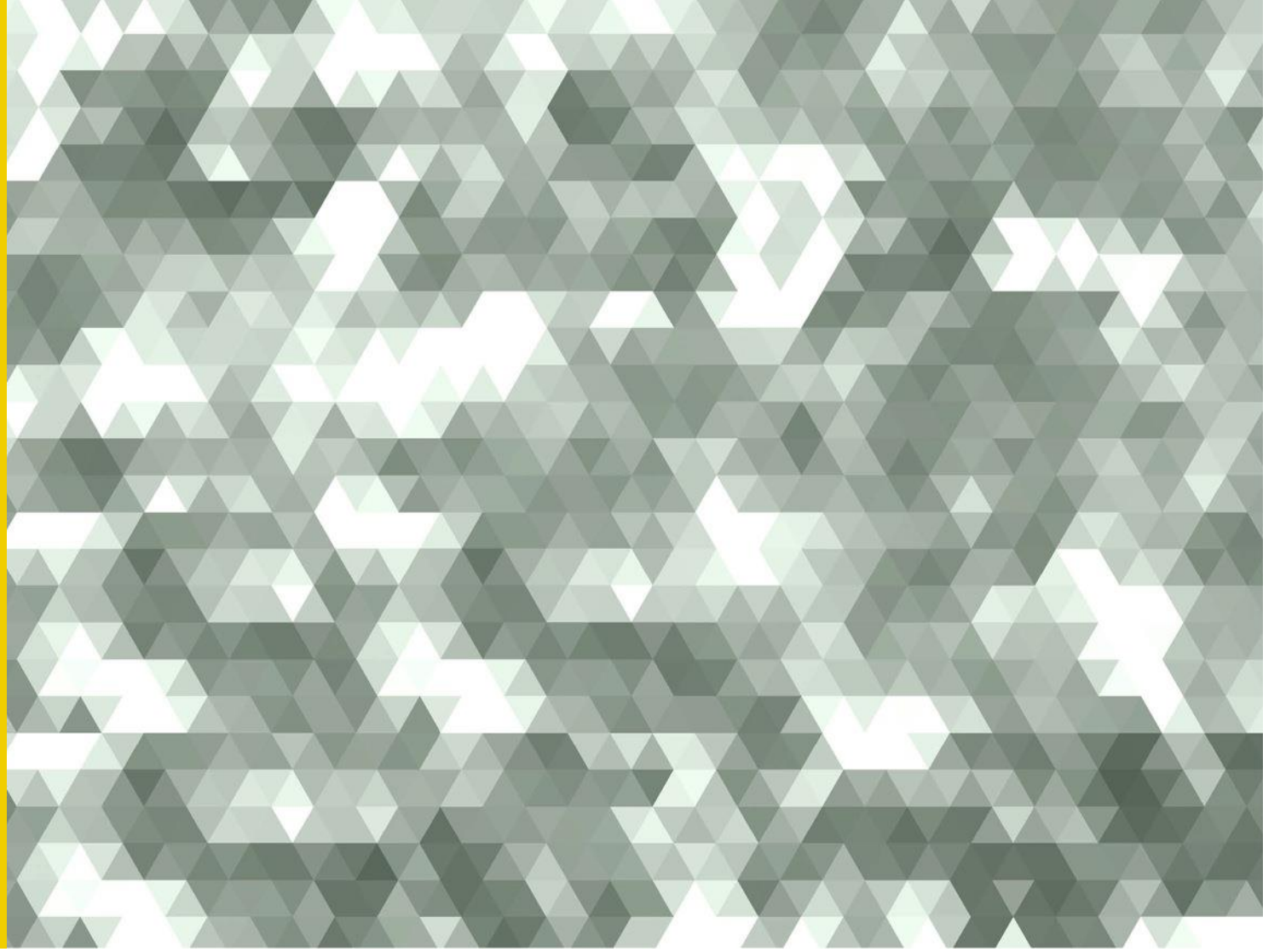

Audit Report

Global Fund Grants in the Republic of Niger

GF-OIG-18-016
3 September 2018
Geneva, Switzerland

The Global Fund
Office of the Inspector General

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Audit Report

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OIG investigations examine either allegations received of actual wrongdoing or follow up on intelligence of fraud or abuse that could compromise the Global Fund's mission to end the three epidemics. The OIG conducts administrative, not criminal, investigations. Its findings are based on facts and related analysis, which may include drawing reasonable inferences based upon established facts.

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1. Executive Summary

1.1. Opinion

Despite a challenging operating environment, Niger has made significant progress against the three diseases. The supply chain is able to distribute medicines, but fundamental gaps in the quantification, forecasting and stock monitoring processes still result in disruption of services. Many of the issues could be mitigated through more effective oversight, clear and binding accountability mechanisms, efficient use of available information and improved coordination between the various implementation partners, without material additional investment. This area "**needs significant improvement".**

The quality of the three programs has improved over the last two years, mainly on outreach of services and commodities, particularly for malaria. This has resulted in a material decline in mortality for malaria and HIV, with a 30% decline in malaria prevalence and mortality between 2010 and 2015[1]. However, challenges remain: material programmatic data inconsistencies, missing data records, weakness in the health care services and non-adherence to treatment guidelines. While these issues are to be expected in a challenging operating environment, the coverage, quality and coordination of supervision activities require improvements. The Global Fund and partners are supporting information systems improvements and solutions. Program mechanisms are currently **"partially effective"** in providing adequate quality of services to patients and reliable data for decision-making.

While extensive financial irregularities were identified in 2014, two new implementers were appointed, and assurances and controls over grant funds were expanded. These measures have significantly mitigated the financial risks in the malaria and HIV programs. For TB, while financial management risks have been mitigated, procurement activities still have some issues around transparency and competition. The financial systems and processes are therefore still "**partially effective"**.

1.2. Key Achievements and Good Practices

Progress in reducing disease burdens and improving access to services. Although Niger is one of the least developed countries in the world, Global Fund investments of US$240 million since 2004[2] have significantly contributed to achievements on all three diseases. The distribution of 4.5 million bed-nets, and the provision of malaria treatment and services in all health facilities have helped decrease malaria deaths by 30% between 2010 and 2015[3]. For HIV, prevention of mother to child transmission (PMTCT) services have been extended to over 186 health centers and district hospitals, and incidence has decreased from 102/100,000 in 2013 to 93/100,000 in 2016[4]. GeneXpert machines are available in all regions to strengthen the diagnosis of multi-drug resistant tuberculosis cases.

Improved financial controls to safeguard grant funds. Following the identification of major financial irregularities and refundable expenditures of approximately US$2.4 million in 2014[5], the Global Fund Secretariat instituted a number of safeguards to better manage grant funds. These included appointing two new Principal Recipients, introducing an international fiscal agent, instituting a zero cash policy, procuring malaria and HIV health commodities from the Pooled Procurement Mechanism, and enhancing the Local Fund Agent's scope.

[1] WHO World Malaria report 2016 Page 118; 119
[2] TheGlobalFund.org – Niger country overview
[3] WHO World Malaria report 2016 Page 118; 119.
[4] WHO World Malaria report 2017
[5] Approximately US$17 million were found to be non-compliant with internal procedures, out of which US$2.4 million were established to be overpriced or not utilized for grant purposes.

These measures have significantly mitigated financial risks, and no material irregularities were identified.

Increased funding to improve supply chain and data quality. The Global Fund and partners have supported various supply chain initiatives. For example, the World Bank financed a supply chain diagnosis to identify options for addressing weaknesses in delivering commodities to the last mile; the Global Fund has finance an audit of the central medical store and earmarked resources to expand storage capacities at the central medical store level; and funds have been allocated by partners to develop a logistics management information system and to provide technical assistance to better manage health commodities from central warehouse level to health facilities including community health workers. For program data, a TB focal person has been designated in each region and district health department. The Global Fund and partners are supporting the development of the District Health Information System (DHIS2), which has been rolled out in Niamey region.

1.3. Key Issues and Risks

Inadequate oversight over quantification and forecasting of health products. Weaknesses and errors in the quantification and forecasting processes were not identified or pre-empted, despite multiple layers of oversight by Principal Recipients, the Local Fund Agent, and the Global Fund's Country Team; these included, incorrect buffer stock assumptions, orders deviating from quantification results, delayed ordering with unrealistic delivery dates, and a failure to consider drug combinations or to exclude expiring drugs from available stock during the forecasting of needs. These issues have contributed to material and recurrent stockouts and expiries of essential TB and HIV commodities, leading to treatment disruptions and waste.

Weak use of data. For health procurements, all PRs in Niger use morbidity data to determine the quantity of medicines needed, rather than adjusting it based on consumption and stocks data, which is available but is not extracted and used from the tools and reports of the health facilities. Use of actual consumption and stocks data could better inform drug forecasts, contribute to lower levels of stockouts and expiries, and be used to triangulate patient numbers with other data to identify data anomalies or drug leakages.

Programatic data is also unreliable particularly for HIV and malaria. For HIV, nine out of 10 ART sites visited did not have patient registers which is the primary data source and the database used by the treatment centers to record and report all HIV indicators was not updated in three of the four health centers tested. Duplicative records and tools for HIV contributed to data gaps. For malaria, primary registers of care are not available and therefore cases reported cannot be verified in all the 12 sites visited. This has restricted the accuracy of reported treatments in all 12 sites visited. Over 70% of the health facilities visited had material discrepancies between facility-level records and patient numbers reported to districts.

Lack of national strategy including an absence of national guidelines for supply chain. There is no overarching framework document to guide supply chain processes, including roles and responsibilities for different actors involved in the supply chain. This has resulted in confusion and divergent practices, including the by-passing of regional pharmacists, arbitrary ordering, as well as siloed and uncoordinated distribution by the PRs. These issues have led to irrational and delayed deliveries which have further contributed to stockouts and expiries, and missed opportunities for cost efficiencies.

Coverage, quality and coordination of supervision activities to be improved. Despite multiple layers of oversight, the actual number and coverage of supervisory activities

are inadequate. There is limited coordination between supervisions conducted by grant implementers and regional health directorates. Increased coordination is needed to avoid duplications, maximize regional coverage, and ensure effective follow-up. Although well-designed, supervision guidelines and tools are not used at the regional or district levels, leading to inconsistent approaches to supervision reviews. These gaps impacted the delivery of activities such as such as weak prevention of mother-to-child transmission of HIV, the quality of HIV healthcare, and adherence with MDR-TB testing and malaria treatment protocols.

Transparency and competitiveness issues. Gaps were identified in the review of some grant procurements by Save the Children Federation, Inc. (SCF) due to a lack of compliance with procurement procedures.[6] These included missing evaluation criteria in bid documents, restricted tendering, fragmented procurements missing opportunities for economies of scale, and not invoking penalties upon delays. Besides financial implications, these issues contributed to delayed renovation of warehouses, with malaria and TB commodities being stored in temporary warehouses since December 2017, in inadequate storage conditions.

1.4. Rating

	Objective 1. Supply chain mechanisms in providing medicines to the patients for the three diseases procured through the Global Fund programs. **Needs significant improvement.**
	Objective 2. Program performance and oversight over grant activities and data processes and mechanisms to provide reliable data for decision-making. **Partially effective.**
	Objective 3. Financial controls in place over grant funds, including sub-recipient management. **Partially effective.**

1.5. Summary of Agreed Management Actions

The Global Fund Secretariat plans to work with the Government of Niger and partners to address the risks identified by the OIG through the following Agreed Management Actions:

- develop and implement guidance describing the process, roles and responsibilities, and data collection, reporting and supervision mechanisms, for the supply chain
- perform a root cause analysis of bottlenecks to quality supervisions across the three diseases and use its results to revise supervision processes, tools and operational plans
- review and revise the data collection tools, rationalizing data reporting requirements, and planning its rollout and training.

[6] Issues related to refurbishment of TB treatment centers and laboratories worth US$0.8 million and renovation of warehouses.

2. Background and Context

2.1. Overall Context

Niger is a low income country[7] with an estimated population of 21.5 million[8] and a poverty rate of 44.1%. The country is ranked 187 out of the 188 countries[9] in the 2016 United Nations Development Program (UNDP) Human Development Index (HDI) report. Transparency International's 2017 Corruption Perceptions Index ranks the country at 112 out of a total of 180 countries[10].

The Fragile States index[11] classifies the country as having limited institutional structures and poor infrastructure, which affects health service delivery. Niger has one of the lowest health care workforce ratios in the world with two health workers to 10,000 population[12] compared to a benchmark of 23 per 10,000 defined by the World Health Organization[13].

The country also has poor access to health services[14] (less than two core personnel and three Hospital beds per 10,000 population), volatile security environment and a heavy reliance on external financing (Government Health expenditure is 5% of GDP, covering only one third of Niger's health financing needs).

2.2. Differentiation Category for Country Audits: Niger

The Global Fund has classified the countries in which it finances programs into three overall portfolio categories: focused, core and high impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics. Countries can also be classed into two cross-cutting categories: Challenging Operating Environments and those under the Additional Safeguard Policy. Challenging Operating Environments are countries or regions characterized by weak governance, poor access to health services, and manmade or natural crises. The Additional Safeguard Policy is a set of extra measures that the Global Fund can choose to put in place to strengthen fiscal and oversight controls in a particularly risky environment.

Niger is:

	Focused: Smaller portfolios, lower disease burden, lower mission risk
X	**Core: Larger portfolios, higher disease burden, higher risk**
	High Impact: Very large portfolio, mission criticial disease burden

X	**Challenging Operating Environment**
X	**Additional Safeguard Policy**

As part of the Additional Safeguard Policy, a Fiscal Agent was introduced in 2013 together with a Zero Cash Policy applied to government implementers. Approximately 64% of Global Fund grants to Niger have been budgeted on health products (pharmaceutical, non-pharmaceutical and equipment) and supply/ delivery related costs for HIV, TB and malaria programs. The

[7] WorldBank - Income data in Niger
[8] WorldBank – Niger country overview
[9] UNDP – Human Development Index
[10] Transparency International – Niger country overview
[11] FundForPeace - Fragile States Index
[12] WHO - Health workforce aggregated data
[13] WHO - Tools and guidelines - Human Resources for Health
[14] Global Fund – Niger Health System Profile (TAP/HSS)

Global Fund's Pooled Procurment Mechanism is used to procure all malaria and HIV health commodities, while TB drugs are procured by SCF.

2.3. Global Fund Grants in the Country

The Global Fund has signed over US$248 million and disbursed US$220 million in the fight against HIV/AIDS, tuberculosis and malaria in Niger since 2004. The portfolio has the following grants:

Active grants	Principal Recipient	Disease component	Grant period	Signed amount EUR
NER-H-CISLS	Intersectoral coordination of the fight against STIs/ HIV/ AIDS (Coordination Intersectorielle de Lutte contre les IST/VIH/SIDA)	HIV/AIDS	July 2015 – December 2017	14,486,006
			January 2018 - December 2020 (new grant)	13,395,464
NER-T-SCF	Save the Children Federation, Inc.	Tuberculosis/HSS	January 2016 – December 2018	28,682,344
NER-M-CRS	Catholic Relief Services - United States Conference of Catholic Bishops	Malaria	May 2016 – December 2017	32,778,373
			January 2018 - December 2020 (new grant)	44,567,826
TOTAL (grants up to December 2017, new grants are not included)				**75,946,723**

The Global Fund also supports health system strengthening component as part of the tuberculosis grant. While two of these grants are managed by international non-governmental organizations, one grant is managed by a governmental entity.

The three Principal Recipients work in total with 10 sub-recipients including national entities under the Ministry of Health, and national/ international non-governmental organizations.

The Niger National Office of Pharmaceutical and Chemical Products (ONPPC) has been contracted by each of the Principal Recipients, for the storage and distribution of medicines and other health products.

2.4. The Three Diseases

HIV/AIDS: The Global Fund is the second largest donor for HIV, accounting for 30% of total HIV funding.

Half of new HIV infections are due to mother-to-child transmission: 57% in 2013 and 53% in 2014.

18,425 People currently on antiretroviral therapy[15]

HIV prevalence[16] (adult population): 0.4%

Adults and children living with HIV: 48,000

Malaria: The Global Fund is the largest donor for malaria, accounting for 46 % of total malaria funding.

Niger is characterized by stable endemicity which is accentuated by variable seasonal surges during the rainy season. 20.6 million people are at risk of malaria[17].

6,999,917 Insecticide-treated nets distributed in 2015 and 2016[18]

Estimated malaria cases[19] in 2016: 7,830,000
1.72% of global disease burden

Estimated malaria deaths in 2016: 2,226[20]

Tuberculosis: The Global Fund is the largest donor for TB, accounting for 63 % of total TB investments.

The Niger incidence rate (including HIV+TB) is estimated at 93 (60–132) per 100,000 inhabitants[21], declining from 113 (in 2010) and 102 (in 2014) per 100,000 inhabitants.

47,700 Laboratory-confirmed pulmonary TB detected and treated (cumulative) [15]

TB cases notified in 2016: 10,165[21]

Estimates of TB mortality in 2016 (both HIV-negative and HIV-positive): 4,400 [21]

[15] Progress Update Disbursement Request –HIV grant (2017 S2)
[16] UNAIDS – Niger country overview
[17] WHO World Malaria report 2017 Page 132
[18] WHO World Malaria report 2017 Page 113
[19] WHO World Malaria report 2017 Page 123 (Number of Cases – Point)
[20] WHO World Malaria report 2017 Page 158
[21] WHO Global TB report 2017 Appendix IV

3. The Audit at a Glance

3.1. Objectives

The audit sought to provide reasonable assurance as to whether the grants to the Republic of Niger are adequate and effective in supporting the achievement of impact in the country.

Specifically the audit assessed the effectiveness of:

- Supply chain mechanisms in providing medicines to the patients for the three diseases procured through the Global Fund programs;
- Program data processes and mechanisms to provide materially accurate, complete and timely data for the three diseases for decision-making;
- Oversight over grant activities and performance to identify and resolve issues in a timely manner;
- Financial controls in place over the TB grant, including sub-recipient management.[22]

3.2. Scope

The audit scope included all three active grants in Niger between January 2016 and December 2017. The audit covered three regions (Niamey, Maradi and Tahoua) accounting for 45% of the malaria burden, 63% of the HIV burden and 40% of the TB burden. The work included visits to integrated health facilities for HIV and/or PMTCT (17 sites), tuberculosis (10 sites) and malaria (12 sites). The team reviewed three central warehouses, two regional warehouses (Niamey, Tahoua), and 14 districts warehouses and pharmacies in hospitals and health facilities (Maradi, Tahoua). The OIG reviewed the financial controls in place, including sub-recipient management, for one grant (tuberculosis/ Health Systems Strenghthening).

3.3. Progress on Previously Identified Issues

Previous relevant OIG work

Assurance at Country Level: External Audit of Grant Recipients - Western Africa Regional Report GF-OIG-13-035.

Investigation of grants in Niger GF-OIG-14-022.

This is the first OIG audit of the Niger grants. Previously, an audit of the effectiveness of external assurance for West African countries had included Niger as one of the sample countries, concluding that major improvements were needed on the timeliness of external audit reports and management letters. Further, an investigation in 2014 noted non-compliant expenditures of US$17 million between 2005 and 2012, out of which US$2.4 million were deemed refundable to the Global Fund, due to weak internal controls and inadequate oversight of SRs by PRs, resulting in misuse of grant funds. To mitigate these risks, the Secretariat strengthened fiduciary controls by introducing an international fiscal agent, replacing the Principal Recipients for two out of three grants with International NGOs, implementing a Zero Cash Policy[23], and procuring malaria and HIV health commodities through the Pooled Procurement Mechanism (PPM). Some non-health procurements were also outsourced to UNOPS, and LFA scope of work for tender reviews was enhanced.

As a result of these changes, the financial risks have been significantly mitigated: OIG walkthroughs of sample financial transactions and our review of the financial control framework indicated low residual financial risk for the malaria and HIV grants, and financial management for these two grants was excluded from the fieldwork scope.

[22] Based on our risk assessment, for the procurement activities undertaken through the Global Fund's Pooled Procurement Mechanism and financial controls for the two remaining grants (HIV and Malaria), the Secretariat has implemented various layers of assurance over the expenditures including a Fiscal Agent.
[23] Under the zero cash policy, cash is not transferred to sub-recipients; instead, PRs make payments on behalf of the sub-recipient.

4. Findings

4.1. Weak oversight of the supply chain and limited use of data

Niger is a challenging operating environment with limited infrastructure. The Global Fund and other partners have supported the country in addressing some of the supply chain challenges. The World Bank has financed a diagnosis of the supply chain in Niger, which has identified options to address the gaps in delivering commodities up to the last mile. The Global Fund has earmarked resources to improve warehousing conditions and to expand storage capacities at the central medical store level, the *Office National Des Produits Pharmaceutiques et Chimiques* (ONPPC). Technical assistance has been funded at the ONPPC to support the management of health commodities and another one will support the Department of Pharmacy and Traditional Medicines to develop a logistics management information system. Pharmacists have also been appointed by the Ministry of Health in all eight regions to improve the verification of orders from districts and health facilities and overall supervision of facilities.

Despite these efforts, the supply chain has fundamental gaps and efficiency challenges which adversely impacted the availability of drugs and treatment of patients. Many of these issues could be mitigated with low additional investment, through more effective oversight, better use of available data and improved stock management mechanisms:

Weak oversight over quantification and forecasting activities: Weak controls over the forecasting and ordering process, combined with lack of clarity in roles and responsibilities for drug management, have led to errors and delays that contribute to persistent stock-outs and expiries. For example:

- In October 2016, despite validation of orders at all levels, TB drugs with sufficient buffer stocks were re-ordered while other essential drugs required were not ordered in sufficient quantities.[24]
- A six-month buffer stock was planned for in the 2015 quantification of TB drugs; however, the orders placed included only three months of buffer stock for adult drugs, and no buffer stock for pediatric drugs. The buffer stock used in the November 2016 quantification exercise for HIV drugs was only three months, which is not sufficient as per national guidelines and average order lead times;
- Drugs nearing their expiration date were not excluded from the available drugs total when placing future orders, leading to underestimated requirements; this was the case for three essential HIV medicines that were expected to expire in 2017[25] and all TB adult medicines that expired in 2017, contributing to stock outs.
- An order of TB drugs was placed late in April 2017 for an unrealistic delivery in June 2017 and the drugs were eventually delivered in October 2017.
- Emergency orders for combination drugs were not executed effectively. For example, two HIV drugs were ordered for quantities sufficient for 4 months and 12 months respectively, although they are prescribed in combination. The drug with higher stock could not be dispensed and has a high risk of expiry. For TB, two pediatric drugs were borrowed from Benin and Togo; however, in the absence of a third combination drug, which was not borrowed or procured, the two borrowed drugs could not be used. Instead, adult TB

[24] The audit found sufficient stocks of RHZE (1,633 boxes), however these were re-ordered unnecessarily. However, for RHZ, only 2 boxes were ordered, which represented 1% of the 2017 national need. Similarly for RH 60/60 mg, RH 60/30 mg, and RH 100mg, only 24%, 48% and 30% of 2017 national requirements respectively were ordered.
[25] AZT/3TC 60+30 mg stocks were expiring in June 2017; ABC/3TC/AZT in August 2017 and LPV/r 100+25 mg in Oct 2017, with drugs consumption estimated to be significantly lower than available stocks, but the expiring stocks were not excluded from drugs available.

pharmaceuticals were borrowed from Burkina Faso and Benin, for which the country already had enough drugs.

Improvements needed in supply chain management mechanisms: There is no national supply chain strategy and no overarching framework document describing Niger's supply chain including roles and responsibilities, human resource requirements, drugs flows, reporting channels, and decision-making mechanisms. This has resulted in divergent practices and inefficiencies. For example:

- Only the orders from HIV treatment centers go through the recently-appointed regional pharmacists. TB health centers place their orders at the district level, who then submit the order to the central level without passing through the regional pharmacists. Malaria orders are also placed at the district level, and drugs are replenished from the central level through a push system without any review or passing through the regions. This has contributed to cases of irrational deliveries to the facilities. For example:
    - In Q4 2017, the District Hospital of Guidan Roumdji ordered and received 2.5 years' consumption of ARVs, even though this drug was already overstocked at the District Store.
    - The Central Medical Store (ONPPC) distributed quantities of ARVs to two treatment centers which were more than the average annual consumption. However, during the same period, all three peripheral hospitals visited by the OIG had stock-outs for the same drug.
- For malaria, different re-ordering systems are used: three out of the six districts visited used a "push" system, two used a "pull" system, while one district applied a mixture of both systems; the latter resulted in the highest stockouts due to ambiguity of roles of health facility and district staff.
- Each PR has established its own distribution arrangements with the ONPPC. For HIV and TB products, order times and deliveries are not synchronized which translates to separate deliveries for each. With limited distribution capacity (ONPPC has three distribution trucks to manage all distributions to 72 districts), this affects both the cost efficiency and timeliness of distributions. Deliveries suffered an average delay of 31 days for the seven warehouses visited (24 days average delay for HIV, 36 days for TB, and over six months for some deliveries);
- ONPPC did not deliver to the locations as agreed in the contract with the PR, generally to avoid farther deliveries, due to their low distribution capacity. For example, HIV drugs were delivered to Maradi regional office as this was more accessible, instead of to the hospitals as per the contract. As a result, the drugs were stored in the office lobby with no climate or security controls.

These issues are symptomatic of inadequate quantification, ineffective drug procurement and supply chain management that contributed to the recurring stockouts and expiries, which in turn resulted in treatment disruptions:

- *Stock-outs of essential drugs:*
    - In March 2018, three out of four TB pediatric drugs were out of stock at the central level for several months.[26] This directly affects patient treatment, and in the absence of these essential drugs, other combination drugs, which were available, could not be given to patients.

[26] RHZ was stocked out since July-17 (8 months); RH 60/60mg since May-17 (10 months); and H 100mg since March-17 (12 months).

- Six of the seven TB health facilities visited in three regions had stock outs of the main pediatric drug and were unable to treat any child affected with TB. In the only health facility that had stock, the drug was due to expire in April 2018 and no supplies were in the pipeline.
- One of the seven facilities visited had a stock-out of the main adult TB drug, and therefore no adults could be put on treatment.
- For HIV, five out of 25 ARVs were out of stock at the central level at the end of December 2017. While four of these drugs can be replaced by other available drugs (although this requires patients to take more pills, which can adversely affect treatment adherence), the fifth drug had no available replacement.

- *Drug expiries*: In 2017, more than US$98,000 worth of TB drugs (approximately 30% of the average of actual expenses of health products in 2017) expired at ONPPC without being distributed, and more than US$235,000 of ARVs (approximately 25% of the average of actual expenses of health products in 2017) expired throughout the country. ONPPC had stocks of ARVs in excess of consumption requirements, and are expected to expire by June 2018 (totalling approximately US$70,000).

Available data not used for informing drugs quantification: To determine the quantity of medicines needed, all three PRs use morbidity data, rather than consumption data which is not readily available. However, the audit identified that consumption could be estimated from the available drugs logistics data[27] to better inform forecasts, which can contribute to lower stockouts and expiries. Morbidity data (number of patients) and logistics data (number of health products consumed) are not triangulated, which could also help to identify data anomalies, drug leakages, and treatment quality issues.

Agreed Management Action 1

The Principal Recipients and the Government of Niger, in coordination with key technical and financial partners will develop and implement an overarching guidance that describes the supply chain network (Warehouses and Transport) at all levels (from the central to the health facility level). This document must also include:

- Clear definition of roles and responsibilities of key actors involved in the national supply chain mechanism at all levels, especially for storage, distribution, ordering, and logistic data management;
- Clear definition of the process for data collection and reporting;
- Clear definition of the supply chain's supervision process.

Owner: Head, Grants Management Division

Due date: 31 December 2019

[27] Quarterly stock reports include opening and closing stocks, and supplies. This can be used to calculate quarterly consumption.

4.2. Deficiencies in quality of services and data due to inadequate supervision

Despite limited resources and infrastructure challenges, several positive practices exist in program management of services to patients. Prevention of mother to child transmission (PMTCT) services[28] has been extended to over 186 Health centers and District hospitals (996 PMTCT sites). Malaria diagnosis and treatment are carried out in all health facilities. With the support of the Global Fund, the country distributed over 4.5 million bed nets between 2010 and 2015. A 30% decline in malaria prevalence and mortality has been registered in Niger between 2010 and 2015[29]. For TB, GeneXpert machines are now available in all regions to strengthen the diagnosis of MDR-TB cases. One TB focal person has been designated in each regional and district health department, to improve the quality of program data. The Global Fund and several partners are also supporting the development of the District Health Information System (DHIS2), and the system has been rolled out in Niamey region.

However, there are gaps in program supervision:

Supervision arrangements need to be strengthened: The Global Fund supports supervision activities in Niger to ensure that quality health care is provided to patients and that data is accurately reported. There are two types of supervision reviews: a narrowly scoped, in-depth review of key service areas, conducted by the three national programs (PRs) for malaria and tuberculosis and by the CISLS for HIV, and an integrated supervision review by the Regional Health Directorates (DRSP) which has a wider but less detailed scope. However, these supervision reviews, particularly at the facility level are insufficient, particularly for the HIV and malaria programs:

- *Lack of coordination of supervision activities:* Although the Regional Health Directorates (DRSP) manage the health facilities their reviews do not include checking the implementation of corrective actions recommended previously by them or the PRs.
- *Weak coverage of activities:* The number of supervision activities performed has been limited. The grant detailed budget indicates that each each entity (National programs or Principal Recipient) should perform quarterly (HIV and tuberculosis) or bi-annually (malaria) supervision visits to regions, while the Regional Health Directorates (DRSP) should also supervise each district at least once per quarter. However:
    - for HIV only two supervision visits were performed in 2017 by the PR (CISLS);
    - for malaria, only one supervision visit covering each region was performed by the national program in 2017 and no supervisions of districts were performed by the Regional Health Directorate (DRSP) in 2017;
    - for TB, one national program supervision visit was carried out in the first half of 2017 in each region, and three additional supervision visits were performed in the second half of 2017;
    - for all programs, monthly supervision activities from districts to health facilities, and from facilities to individual health centers and community relays, were not performed in 2017, as required by the guidelines.
- *Tools are not disseminated: A*lthough supervision guidelines and tools generally exist, and are often quite detailed, these are not transmitted or used at the regional or district level, except for the TB program. This leads to inconsistent topics, issues and findings raised by the supervision activities.

These supervision and oversight gaps have contributed to the following programmatic issues:

[28] PMTCT, also known as prevention of vertical transmission, refers to interventions to prevent transmission of HIV from an HIV-positive mother to her infant during pregnancy, labour, delivery, or breastfeeding.
[29] WHO World Malaria report 2016 Page 118; 119

- *Limited effectiveness of PMTCT activities:* Half of all new HIV infections are from mother to child infections; however, the OIG found that PMTCT activities are not effective and in particular:
  - 32% of pregnant women seen for their pre-natal consultations, and 50% of mothers seen for post-natal consultation, were not tested for HIV[30], against a requirement of 100% coverage as per national guidelines;
  - 51% of HIV-positive pregnant women benefited from the tri-therapy at the national level[31], against a requirement of 100% as per national guidelines;
  - only 10% of the sites visited sent blood samples to the laboratories in 2017, although the guidelines require this to be done for each case;
  - Option B+[32], adopted by the country, is not available at all sites due to insufficient training and low task shifting from physicians to nurses and mid-wives;
  - only 18% of infants benefited from early detection testing in first half of 2017[33], since the viral load machines were not well-maintained and often unavailable.
- *Weak management of People Living with HIV (PLHIV) health care:* 40% of the patients initiated on treatment are lost to follow-up in six of the 10 visited sites, against a national target of 5% as per national guidelines. This high rate arises from multiple weaknesses in PLHIV care management. Only three out of the 10 sites visited reported working with community stakeholders. Patients are not provided with adequate therapeutic or treatment education (e.g. side-effects counselling is missing in four out of 12 sites visited), a requirement of national guidelines.
- *Insufficient TB care, especially paediatric services:* All health facilities visited except one had interrupted the TB paediatric treatment due to stock-outs of TB drugs. Nearly 50% of the sites did not comply with the guidelines for confirming MDR-TB cases with Gene-Xpert; this was due to the absence of test kits and poor sample collection.
- *Malaria treatment without compliance with the treatment guidelines:* The results of rapid diagnostic tests were not systematically recorded in the health registers for all the 12 health centers visited, increasing the risk of treatment without confirmed diagnosis. In one integrated health center, simple malaria cases were treated with a drug normally used only for severe cases. In all centers visited, the primary register was materially incomplete and its data could not be used, impacting the accuracy of the programmatic data.
- *Challenges in monitoring and evaluation systems:* Overall, programmatic data tends to be unreliable, particularly for HIV and malaria. For HIV, nine out of ten ART sites visited did not have registers to report the cohort data or patients lost to follow-up. Individual patient files are the primary source of information, which increases the risk of incorrect data reporting, especially in facilities with a high number of patients. The database in the health facilities used to report HIV indicators had not been updated in three of the four sites tested. For PMTCT, there is a need to streamline the tools: currently, five different registers and five separate monthly reports are filled by each PMTCT site regardless of level and volume of activities. As a result, these registers were not correctly completed in all PMTCT sites visited. In order to verify and clean up the number of HIV patients under treatment, Niger is currently conducting a cohort audit, but this is not a sustainable solution.
- *Malaria data is not accurate:* For all 12 sites visited, primary registers of care were not available, meaning that the malaria cases reported could not be verified. The primary data

[30] Revue Semestrielle des interventions PTME – Unité Sectorielle de Lutte contre le SIDA – 1er Semestre 2017
[31] idem
[32] Option B+ offers lifelong antiretroviral treatment to pregnant and breastfeeding women irrespective of CD4 count with the aim of preventing HIV transmission.
[33] Revue Semestrielle des interventions PTME – Unité Sectorielle de Lutte contre le SIDA – 1er Semestre 2017

records and treatment registers are materially incomplete for malaria at health facilities. When the number of cases diagnosed was compared with the number of patients treated, material discrepancies were identified in nine of the 12 health facilities visited.

Agreed Management Action 2

The Principal Recipients, the Government of Niger with support from partners will conduct a root cause analysis of bottlenecks to the implementation of quality supervisions across the three diseases.

Based on this analysis the Secretariat will engage stakeholders to review and revise the supervision processes and tools and work with the Ministry of Health to develop revised supervision and operational plans.

Owner: Head, Grant Management Division

Due date: 31 December 2019

Agreed Management Action 3

The Principal Recipients, the Government of Niger with support from partners will:

- As part of DHIS2 requirements, review and revise data collection tools and rationalize data reporting requirements and indicators;
- Develop a plan for rolling out and training on the revised tools and requirements.

Owner: Head, Grant Management Division

Due date: 31 December 2019

Table of Agreed Actions

Agreed Management Action	Target date	Owner
The Principal Recipients and the Government of Niger, in coordination with key technical and financial partners will develop and implement an overarching guidance that describe the supply chain network (Warehouses and Transport) at all levels (From the central to the health facility level). This must include: • Clear definition of roles and responsibilities of key actors involved in the national supply chain mechanism at all levels, especially for storage, distribution, ordering, and logistic data management; • Clear definition of the process for data collection and reporting; • Clear definition of the supply chain's supervision process.	31 December 2019	Head, Grant Management Division
The Principal Recipients, the Government of Niger with support from partners will conduct a root cause analysis of bottlenecks to the implementation of quality supervisions across the three diseases. Based on this analysis the Secretariat will engage stakeholders to review and revise the supervision processes and tools and work with the Ministry of Health to develop revised supervision and operational plans.	31 December 2019	Head, Grant Management Division
The Principal Recipients, the Government of Niger with support from partners will: • As part of DHIS2 requirements, review and revise data collection tools and rationalize data reporting requirements and indicators; • Develop a plan for rolling out and training on the revised tools and requirements.	31 December 2019	Head, Grant Management Division

Annex A: General Audit Rating Classification

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

Annex B: Methodology

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

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

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

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

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