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The Global Fund

To Fight AIDS, Tuberculosis and Malaria

The Office of the Inspector General

Country Audit of Global Fund Grants to Cameroon

Audit Report No: GF-OIG-09-010

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Acronyms

ACT	Artemisinin-based Combination Therapies
ACDI	Agence Canadienne pour le Développement International
ACT	Artemesinine combination therapy
AIDS	Acquired-Immune Deficiency Syndrome
AL	Artemether-lumefantrine
ANRS	Agence Nationale (française) de Recherche sur le SIDA
ARMP	Public Contract Regulatory Authority
ART	Anti-retroviral Therapy
ARV	Anti-Retrovirals
ASAQ	Artesunate-amodiaquine
BRS	Bank Reconciliation Statement
ASR	Agents Santé Relais
CAA	Caisse Autonome d'Amortissement/ Autonomous Sinking Fund
CI	CARE International
CAPR	Centres d'Approvisionnements Pharmaceutiques Régionaux
CARE	International NGO
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
CD4	White blood cell
CDC	Centers for Disease Control
CE	Central (province)
CENAME	National Essential Drugs and Medical supplies Procurement Centre
FCFA	Cameroon currency
CFU	Coordination and Follow up Unit
CHAI	Clinton HIV/AIDS Initiative
CHP	Care & Help Program
CNLS	Comité National de Lutte contre le SIDA
CRA	Community Relays Agent
CRIS	Country Response Information System
CSE	Contrôle Supérieur de l'Etat
CSPM-FM	Comité Spécial pour la Passation des Marchés/Fonds Mondial
CTA	Centre de Santé Agrée
CTG	Central Technical Group
DG	Directeur Général
DHS	Demographic Health Survey
DPM	Direction de la Pharmacie et du Médicament
EFV	Efavirenz
EN	Far North (province)
ESTHER	French NGO
FC	Fondation Clinton

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FDC	Fixed Dose Combination (tablet)
FS	Formations Sanitaires/Health Facility
GDF	Global Drug Facility
GF	Global Fund
GLC	Green Light Committee
GTP	Groupe Technique Provincial
GTZ	German Technical Cooperation
HAART	Highly Active Anti-retroviral Therapy
HF	Health Facility
HIMS	health Information and Management System
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno Deficiency Virus
HPLC	High Pressure Liquid Chromatography
IPT	Intermittent Preventive Therapy
IPT	Intermittent Preventive Therapy
IRESKO	The institute for Research, Socio-Economic Development and Communication
ITN	Insecticide Treated Net
KFW	German Financial Cooperation
LANACOME	Laboratoire National de Contrôle de Qualité des Médicaments et d'Expertise
LFA	Local Fund Agent
LLIN	Long Lasting Impregnated Net
LT	Littoral (province)
M&E	Monitoring and Evaluation
MDR	Multi Drug Resistance
MoPH	Ministry of Public health
MPH	Ministère de la Santé Publique
MSF	Médecins Sans Frontières
NACC	National Aids Control Committee
CNLS	National AIDS Control Program
NGO	Non-Governmental Organization
NHMIS	National Health Management Information System
PNLP	National Malaria Control Program
PNLT	National Tuberculosis Control Program
NW	North West (province)
OAPI	African Intellectual Property Organization
OCEAC	Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale
OI	Opportunistic Infection
OVC	Orphans and Children in Vulnerable Conditions

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PLWA	People living with AIDS
PLWHA	Person Living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PNLP	Programme National de Lutte contre le Paludisme
PNLT	Programme National de Lutte contre la Tuberculose
PR	Principal Recipient
PS	Permanent Secretary
PSM	Procurement and Supply Management
QA	Quality Assurance
QC	Quality Control
SP	Sulphadoxine-pyrimethamine
STI	Sexual Transmittable Disease
	Système National d'Approvisionnement en Médicaments et consommables Essentiels)
SYNAME	
TB	Tuberculosis
TDF	Tenofovir
TGF	The Global Fund
TS	Technical Secretariat
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNITAID	an international drug purchase facility , http://www.unitaid.eu
UPEC	Unité de Prise en Charge
VCT	Voluntary Counseling and Testing for HIV
VPP	Voluntary Pooled Procurement
WFP	World Food Programme
WHO	World Health Organization
WHOPES	WHO Pesticide Evaluation Scheme
WTO	World Trade Organization
YTD	Year to Date

I. Executive Summary

Introduction and overview

1. The Office of the Inspector General (OIG), as part of its 2009 work plan, carried out the audit of Global Fund grants to Cameroon. The objectives of the audit were to:
 - (a) assess the efficiency and effectiveness in the management and operations of grants;
 - (b) measure the soundness of systems, policies and procedures in safeguarding Global Fund resources;
 - (c) assess the effectiveness of established mechanisms/controls to safeguard the Global Fund resources in Cameroon; and
 - (d) assess any risks that Global Fund grants are exposed to and adequacy of measures taken to mitigate them.
2. The audit covered the six Global Fund grants during the period 2003 until September 2009 as detailed in the table below:

Grant	PRs	Status	Round	Approved Funding Phase 1 and 2 in US\$	Total Funds disbursed in US\$
HIV/AIDS					
CMR-304-G01-H	MoPH	Open	3	55,500,617	55,500,617
CMR-404-G04-H	Care International	Open	4	16,194,089	15,915,458
CMR-506-G05-H	MoPH	Open	5	14,878,144	6,555,458
Total HIV/AIDS				86,572,850	77,971,533
Malaria					
CMR-304-G02-M	MoPH	Open	3	31,781,187	29,881,464
CMR-506-G01-M	MoPH	Open	5	15,134,454	4,248,021
Total Malaria				46,915,641	34,129,485
TB					
CMR-304-G03-T	MoPH	Open	3	5,804,961	5,478,819
Total TB				5,804,961	5,478,819
Total				139,293,452	117,579,837

Source: Global Fund websites, September 2009

3. Subsequent to the audit, the Global Fund Board approved an additional US\$ 132 million for the Tuberculosis and Malaria grants under Round 9. The grant agreements will be signed over the next few months. The Round 3 HIV grant implemented by the Ministry of Public Health continued under a Continuation of Services (CoS) mechanism. Apart from this grant, there is no further funding for HIV which created significant challenges with continuing critical programs. Three grants also ended on 31 December 2009.

Scope and methodology

4. The audit covered all the six grants to Cameroon. It covered all aspects of the management and operations of the grant programs, i.e. the Principal Recipients (PRs), Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA), the Sub-Recipients (SRs) and any other organizations that may be involved in the operations of the Global Fund supported programs (e.g. the procurement agents).
5. In this regard, the audit covered:
 - (a) *Compliance*: whether structures, systems and processes complied with Global Fund policies, procedures and guidelines as well as country laws.
 - (b) *Internal control*: the review of the adequacy of the internal control structure of the entities that manage and implement Global Fund supported programs in ensuring that grant assets were safeguarded against possible misuse and abuse.
 - (c) *Financial review*: a financial review to provide assurance that value for money was obtained from the funds that were sent to the country. This entailed verifying whether program funds are used economically, efficiently and effectively.
 - (d) *Grant management*: obtaining assurance that the systems, processes and controls in place were efficient and effective in supporting the achievement of grant objectives.

Summary of findings

6. This section briefly highlights the findings and conclusions arising from the audit and the detailed findings are contained in the rest of the report. It is, however, essential that this report is read in its entirety in order to comprehend fully the approach to, and findings of OIG's work. The OIG audit covered the period from the inception of the grants in 2003 to September 2009. The OIG noted that the findings noted in this report have happened over the entire period audited. In cases where weaknesses were noted and remedial action taken over the course of the grants, this has been highlighted in the report with no recommendation made.

7. The recommendations have been prioritized. However, the implementation of all recommendations is essential in mitigating identified risks and strengthening the internal control environment in which the programs operate. The prioritization has been done to assist the Global Fund Secretariat and PR management in deciding on the order in which recommendations should be implemented. The categorization of recommendations is as follows:

- (a) *High priority*: Material concern, fundamental control weakness or non compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization's interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management;

- (b) *Significant priority*: There is a control weakness or noncompliance within the system, which presents a significant risk and management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal control, or undermine achievement of aims and objectives; and
- (c) *Requires attention*: There is minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization's benefit.

8. The former Minister of Health and three Permanent Secretaries responsible for HIV, Tuberculosis and Malaria were arrested in 2008 for allegations of mismanagement of government funds from the highly indebted poor countries (HIPC) initiative. When they held their respective positions, these officials were also responsible for implementing the programs funded by the Global Fund in Cameroon. The OIG sought to obtain the audit report which was the basis for the arrests in order to ascertain whether Global Fund investments were involved and whether they were exposed to any risk. The OIG was not provided with this report and is therefore unable to establish whether the report did in fact refer to the mismanagement of Global Fund resources.

Financial Management in MOPH

9. Although the OIG observed some examples of good practices applied by some PRs and SRs, there were a number of material deficiencies in the financial management control framework of the MOPH PRs and SRs in managing Global Fund grants. There were several areas identified where financial management controls need to be strengthened to ensure appropriate controls over the management of Global Fund grants. The recommendations should assist the PR and SRs in mitigating the financial risks that Global Fund grants may be exposed to.

10. The main weaknesses identified related to:
- (a) The three MOPH PRs had qualified audit opinions to their financial statements. The OIG noted that the issues that gave rise to the qualifications had not been addressed which resulted in further qualifications in subsequent years.
 - (b) There were inadequate financial management guidelines in all the MOPH PRs. Although there was a Procedures Manual in force, it was not comprehensive to provide guidance to the implementers of the program.
 - (c) There was no segregation of duties in the regional offices. Accountants were often signatories to the bank accounts. When there is inadequate segregation of duties, there needs to be a strong oversight function to ensure that irregularities do not arise. The OIG did not see evidence of such oversight.
 - (d) Proper books of accounts were not maintained. Bank reconciliations were not prepared on a timely basis and even when they were they contained long

outstanding reconciling items. None of the Programs had up-to-date financial records at the time of the audit. The filing systems were in disarray, thus making it impossible for the OIG to obtain all the documentation it requested to support payments. No reconciliations were prepared with the suppliers. This resulted in over payments. Also, the programs did not follow up on the recovery of long outstanding advances.

- (e) The accounting software was not able to consolidate the accounts of the regional offices. Consequently, the accounts of the entire Program were maintained by the Head Office. There were no backups of the accounting system. In one case, the system crashed, which resulted in all the information having to be reentered.
- (f) The interest income earned on the Program bank accounts was retained by the Caisse Autonome D’Amortissement (CAA). This is contrary to the grant agreement, which stipulates that income that is incidental to program activities should be recorded and used for program activities.
- (g) There were weak controls over assets as evidenced by the inability of Programs to reconcile their records to stock balances at the end of the year, lack of comprehensive asset registers, assets not being marked with unique numbers etc.
- (h) Top-up salaries were paid to staff without the requisite approval of the Global Fund Secretariat.

Programme National de Lutte contre le Paludisme (PNLP)

11. The procurement of mosquito nets did not follow international bidding as recommended by the manual. They were procured through national bidding and at higher prices than ruling prices in the market. Although the Program stated that this was done because of pending campaigns, the OIG noted instances where nets procured were stored for long periods of time without being distributed. Proper records were also not maintained for mosquito nets and at the time of the audit, the Program could not provide a breakdown of nets procured, distributed and balances held. At the time of the audit, the OIG observed a difference of about 62,780 outstanding mosquito nets between the technical report and distribution statistics. The distributed nets also required re-impregnation but there had been delays in purchasing the required chemical.

12. The OIG noted several conflicts of interest that were not disclosed as part of doing business. For example, the audit firm contracted to provide accounting services to PNLP belonged to the brother of the former PNLP Permanent Secretary. This transaction occurred when this Permanent Secretary still held office. The OIG also noted that one of the suppliers to PNLP was the wife of a staff member. There was no evidence that this relationship was not declared at the time of identifying the supplier. There was no guidance in place on how to handle conflicts of interest.

13. The OIG also noted that there were two pending law suits brought against the PNLN at the time of the audit. These related to unpaid social security deductions from staff and an unpaid vehicle repair bill.

14. The Program uses trained village workers to diagnose and treat patients at village level. The workers are allowed to charge 30% of the cost for treatment as their income. The cost for the treatment of malaria is fixed by the MOPH. Because of the drop in ACT prices the associated income to the village agents also fell. This was the rationale for increasing the charge from 10% to 30%. Still, it is considered inadequate. The program now faces the challenge of having to find suitable people to train and serve the population at the village level because the income for the service is considered too small.

Comité National de Lutte contre le SIDA

15. The OIG found an overpayment amounting to FCFA 1,549 million (US\$ 3.37 million)¹ which arose from the procurement agent (CENAME) invoicing CNLS at prices higher than the prices they had paid for the drugs. This amount should be recovered from CENAME (the national procurement agent for drugs). The Global Fund Secretariat has subsequent to the OIG audit held discussions with CNLS and reached an agreement that the overpayments to CENAME will be offset against future bills presented from CENAME. The implementation of this will be monitored by the Global Fund Secretariat.

16. As part of its commitment to HIV/AIDS, since 2007, the Government of Cameroon has subsidized tests for patients and reimbursed the cost to the hospitals or treatment centers for the cost of 4 types of tests. The OIG noted that since August 2008 the reimbursements to hospitals had stopped. The outstanding costs due to Hospitals amounted to FCFA 803 million (US\$ 1.75 million). The hospitals had therefore stopped providing subsidized tests which impacted the program since many patients cannot afford to pay for tests. These costs were subsequently paid after a new disbursement was received from the Global Fund at the end of the audit.

17. The OIG identified an apparent fraud in one of the hospitals where refunds for tests that had not been undertaken were being claimed. Some US\$ 52,000 needs to be recovered and the officials responsible investigated. The PR also needs to establish whether such fraudulent practice was taking place in other hospitals.

18. There was no mechanism in place for the Central Technical Group (CTG) to assess the reasonableness of ARV prices set by CENAME. Put differently, the Program paid prices without verifying that such prices were reasonable.

¹ US\$1 is equivalent to FCFA 459.60. This rate is used to convert equivalent of FCFA to US\$ for the whole relevant part of the report. Source <http://www.oanda.com> dated 30 September 2009.

19. The promotion of free antiretroviral treatment was supported at the community level by Community Relay Agents (CRA). These Agents also encouraged people to go for testing. However, for budgetary reasons, the financing for mobilization of people at the grass roots-level was suspended in November 2008.

National Tuberculosis Control Program (PNLT)

20. The National TB Control Program is well established with 207 facilities for diagnosis and treatment. There is no budget line in the MOH to cover the cost for TB drugs for the first and the second line. The actual supply and funding will however run out in 2009 and future supplies will be financed by the Global Fund program. In terms of service delivery, there is no structure to follow up drop outs. The preventive treatment of children under 5 in households with TB patients is not practiced. Although this is not a high priority for STOP TB, it is recommended by WHO. HIV testing for TB patients is increasingly being accepted (up to over 80%) and preventive treatment for tuberculosis for HIV infected persons is available.

21. The government should introduce a budget line for TB drugs to continue standard and multi-drug resistant treatment free of charge and to prepare for sustainable support with drugs after the Global Fund resources run out. The OIG recommends the development of practical guidelines for the preventive treatment for children under 5 in households of patients with tuberculosis. In the future, grant proposals the CCM should consider making the care of Multi-Drug Resistant (MDR) patients a cost-free part of the health infrastructure. A follow-up structure for drop-outs should be introduced in collaboration with the other programs and the MOH.

CARE Cameroon

22. CARE has a strong internal control environment in which the Programs are implemented. OIG's key findings in respect of CARE Cameroon related to the need to strengthen the management for Global Fund grants managed by SRs:

- (a) Assets were not physically identified and a fixed asset inventory check was not undertaken.
- (b) Manual processing of payroll using Excel sheets prior to recording in the books raised the risks of errors.
- (c) Supporting documents for payments made by the bank were not stamped "paid".

Procurement and Supply Management

23. Product selection for HIV/AIDS is adequately done although the demarcation between first- and second-line protocols is becoming blurred. The OIG observed that it would be helpful to streamline donor funding from different sources over the different treatment and prevention protocols and use a tracer code for the Global Fund in the procurement and supply management systems at different levels.

24. There was a need for discussion around product selection for Malaria, the OIG observed that the ACT selected in the Malaria Grants is not well tolerated. Clinics were diverting patients to other ACTs available in the market, notably the artemether-lumefantrine (AL) combination which has to be purchased by households.

25. In spite of the more recent PSM plan for the Malaria program describing in detail how quantities for ACT were calculated, the OIG noted the absence of a consistent and robust methodology for the quantification of needs that is, whether it be consumption-based, morbidity-based or a combination of the two. Obviously reliable inputs from the periphery are required on a routine basis for any of the methods. To underpin this stock management as well as morbidity data reporting systems were being implemented and strengthened at the time of the audit. The OIG observed stock outs, overstock/expired stock and rationing of supplies in some units during the audit. Such observations do signal that the system needs to be rigorously evaluated particularly given that multiple sources provide funding for the same product category.

26. Procurement of pharmaceuticals is done by the CENAME in a transparent manner. CENAME has adequate technical capacity (i.e. a sufficient number of persons with suitable qualifications) using pre-qualified suppliers conforming to agreed delivery times as applicable. The OIG observed that warehouses are locked, kept clean, dry and were maintained within acceptable temperature limits (air conditioning). Storage space at regional level is, however, limited. Procurement of health goods (non-pharma) conducted by one of the PRs experienced considerable delays. The quality control methodology available in Laboratoire National de Contrôle de Qualité des Médicaments et d'Expertise (LANACOME) to test quality of pharmaceuticals was found to be limited to basic tests (identification tests, wet chemistry, semi-quantitative tests for impurities and volumetric assays) e.g. they were sufficient to detect counterfeit or substandard products but insufficient to perform instrumental analysis e.g. HPLC to verify bio-equivalence or perform dissolution tests of solid oral products.

27. The OIG noted that health units were in general satisfied with the distribution system from CENAME level down to the periphery from where facilities collected their orders. A few were more critical on available stock levels and rationing of some supplies. The OIG's recommendations emphasize that a more strict control on remaining shelf lives in the supply chain is required. Implementation of a specific pharmaceutical inventory management system at central level needs to be considered with the possibility of exchanging information easily between the central level (CENAME) and regional stores (Government CAPRs) and to generate reliable reports automatically on a periodic basis.

Monitoring and Evaluation

28. The indicators for monitoring and evaluation include only a small number of impact indicators. The indicators usually do not contain a quality aspect and the

information collected for the impact indicators cannot be collected by the project in many instances or are not representative of the target population for the interventions.

29. The administrative structures for M&E comprise an operational technical secretariat covering the three programs. The Coordination and Follow-Up Unit (CFU) is the linking structure between the MOH and the three programs but is not operational. Key persons in the MOH were not aware of this function. Supervision at all levels was inadequate. The number of the planned supervisory visits was not followed and the time interval between visits was not respected.

30. The impact (+outcome) indicators should be adapted to the collection capacities of the program and the performance indicators should include at least one quality aspect. A closer collaboration between the structures for M&E is needed. This starts with collaboration between the programs at the community level. The CFU needs strengthening. The proposed supervisory visits envisaged in the M&E plans must be followed by sufficient qualified staff to provide the basis of a reliable monitoring and evaluation.

Oversight

CCM

31. The CCM has generally been functioning well following initiatives taken by various stakeholders to strengthen its roles and responsibility. Funding still remains a big challenge to ensure continuation of its activities, in particular to perform its supervisory and monitoring responsibilities for grant implementation.

32. The representation in the CCM may need to be reviewed to ensure that it remains balanced in order to ensure its effectiveness. The CCM did not have policies and procedures in place at the time of the audit to guide its operations. These should be put in place.

33. Cameroon has submitted proposals under Rounds 6, 7, 8 and 9 and its proposals have been unsuccessful. In such cases, the Global Fund guarantees continued treatment but cannot fund other activities. Unless the country can access funding from other sources, this will affect the progress of the programs in the country.

LFA

34. PricewaterhouseCoopers has been LFA for Cameroon since the inception of the grants. The OIG observed that PWC had delivered in quantitative terms on its contractual obligations. However, the OIG has concerns with the quality of work done by the LFA. The Global Fund's decision making is dependent on the work of the LFA and shortcomings in the LFAs performance potentially compromise decision making. Action

is needed to improve performance. Alternatively, consideration should be given to re-tendering the services.

Audit recommendations and the way forward

35. Based on comments and action plans prepared by the Country to address the audit recommendation, the OIG is pleased to acknowledge the effort and commitment of the Country to address the audit recommendations. Some of the actions have already been completed and many more are ongoing.

Report Structure

36. This report is presented by functional area such as grant management, program management, logistic and supply management, and oversight functions. The functional areas may be delineated into specific functional areas. Good internal control practices or significant achievements found during the audit are mentioned in the report, but they are not discussed in depth given that the purpose of the audit was to identify important risks and issues that needed to be addressed.

II Introduction

Background

37. Cameroon received the first three of six grants from the Global Fund in 2004. Cameroon has signed grant agreements amounting to US\$ 139 million. By September 2009, some US\$ 117 million (84%) of the total approved grant had been disbursed to the PRs. The MoPH is the PR for five out of six grants and one HIV/AIDS grant is implemented by Care International. Under the MoPH, two grants are implemented by the Comité National de Lutte contre le SIDA (CNLS), two grants by the Programme National de Lutte contre le Paludisme (PNLP) and one grant by the Programme National de Lutte contre la Tuberculose (PNLT).

38. Program activities have been integrated into the existing national interventions against the three diseases, which is consistent with Global Fund principles. The Government has shown its commitment in the fight against the three diseases and particularly in HIV/AIDS by contributing 50% of the cost, and paying the salaries of all MoH staff involved in implementing program activities. Cameroon has been unsuccessful in its application for further funding under Rounds 6, 7 and 8. Although the Global Fund has given assurances that there will not be any treatment disruptions, the shortfall in funding will definitely constrain any progress registered so far in the fight against the three diseases.

39. Since 2000, the Government has launched the Cameroon anti-corruption initiative called 'Opération Epervier' in an effort to combat corruption and improve the country's image to donors. This resulted in the arrest of the former Minister of Public Health, and the three Permanent Secretaries responsible for the MoPH's HIV/AIDS, Tuberculosis, and Malaria national programs. They have not yet been brought to trial.

40. The arrest of the former Minister and the three Permanent Secretaries affected program implementation, and particularly the Round 5 Malaria program. In order to improve grant performance, the Global Fund Secretariat and the development partners responded by:

- (i) appointing a program coordinator for the three national implementation units;
- (ii) mobilizing Partners (that is, UNAIDS, RBM and WHO) to support the PRs through the provision of technical assistance;
- (iii) reforming the CCM to ensure compliance with Global Fund requirements; and
- (iv) establishing a CCM Secretariat supported by Partners to strengthen CCM oversight.

Scope of the audit

41. The OIG audit covered all Global Fund grants made to Cameroon. It covered all aspects of the management, governance and operations of the grant programs - that is,

Principal Recipients, Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA), the Sub Recipients (SRs), and organizations that are involved in implementing, or providing oversight to, the programs financed by the Global Fund, such as CENAME (a procurement agent for Drugs) and the MoH Procurement Unit (CAA). These other organizations were reviewed to the extent that they were involved in the activities funded by the Global Fund program. Two SRs were selected for a detailed review namely CHP (Care & Help Program) and IRESCO (The Institute for Research, Socio-Economic Development and Communication).

42. The audit was scheduled for completion by 8 September 2009. However, based on the emerging findings of the audit, the exercise was extended until 15 October in order to provide a wider coverage of transactions at two PRs so as to address specific risks identified.

Audit scope limitation

43. Based on the OIG discussion with the Contrôle Supérieur de l'Etat (CSE), Cameroon's supreme audit agency, it emerged that the arrest of the former Minister of Public Health and several staff was in response to the initial audit undertaken by CSE. CSE could not provide any information on whether Global Fund resources were involved. However, they confirmed that the audit during this period covered all funds, including those from the Global Fund that were managed by the institutions responsible for the three diseases (PNLP, CNLS, PNLT) during that period.

44. The OIG requested but was unable to obtain access to the audit report that was the basis for the arrests of the former Minister and MOPH officials. The OIG's request was refused on the ground that the CSE report was intended solely for the President of Cameroon. In the absence of a full audit report, the OIG could not assess whether the risks that led to the alleged fraud were also prevalent in the programs funded by the Global Fund. This is of particular concern because the MOPH officials arrested were also directly responsible for implementing Global Fund programs. However, without access to the audit report the OIG was unable to establish whether the report did in fact refer to the mismanagement of Global Fund resources.

45. There was also substantial documentation that was not available for review during the audit especially relating to the period before 2008, as described in the various sections of the report that follow. At the time of finalizing this report, the Country provided these documents for review.

III. Ministry of Public Health - Malaria

Background

46. Malaria is the leading cause of morbidity and mortality in Cameroon. The disease accounts for 40 to 45% of medical consultations, 50% of morbidity and 40% of mortality among children under five, 30 to 40% of deaths in health facilities. It also represents 57% of hospitalization days and 26% of sick leave. Over two million cases of malaria are reported yearly from about 1,638 health facilities all over the country. The socio-economic impact of malaria in Cameroon is considerable. It consumes up to 40% of the annual health budget of households (Health Sector Strategy 2001-2010). It is also estimated that malaria-related economic loss represents a minimum of 1.3% of Cameroon's annual GNP.²

47. Despite all the resources that have been mobilized in recent years to control the malaria, it remains a major public health problem in Cameroon. In terms of morbidity, malaria affects all regions in Cameroon and accounts for 40.1% of morbidity among the general population. Children below the age of five have a minimum of two malaria episodes per year and older patients have a minimum of one episode each year. The majority of these patients are not treated in health facilities.

48. The malaria program has received US\$ 46.9 million through two grants from the Global Fund under Rounds 3 and 5. Both grants are directly implemented by the MOPH through PNLP. At the time of the audit, the Global Fund had disbursed US\$ 34 million (that is, 72% of the total grant). The Global Fund Secretariat recommended a "no go" for the second phase of the Round 5 grant based on poor program performance, weak grant management and inefficiencies related to the application of the drugs protocols. The CCM provided responses to the implementation gaps and weaknesses identified during Phase 1, resulting in the Board approving a "conditional go".

49. The conditions set under this "conditional go" were:

- (i) A need for approval by the Global Fund of a revised M&E plan before the second disbursement;
- (ii) A data quality audit after one year of program implementation;
- (iii) Approval by the Global Fund of a revised PSM plan; and
- (iv) A review by the country team of program implementation and human resources budgets one year after grant signature.

Implementation of these conditions was still under way at the time of the audit.

² MOPH Cameroon: procurement and supply management plan of malaria component of the 5th round

Achievements and challenges

50. Under the Round 3 repeat assessment, the LFA rated the PR as a B1. The PR had an A2 rating for program and financial management capacity; and a B1 rating for procurement and supply management and monitoring and evaluation. For the Round 5 Phase 2 assessment, the LFA rated this PR as a B2. However, this rating was revised by the Global Fund Secretariat to a C. This culminated in a conditional go for Phase 2 after the CCM made some commitments to address the capacity gaps.³

51. The Round 3 program was not performing well at the time of the audit, as evidenced by the fact that over half of the performance indicators showed an achievement rate below 65%. This situation was partly attributed to problems in the PSM processes. The areas noted that recorded reasonable performance were the following:

- (a) malaria patients were treated by trained persons with ACT;
- (b) women received intermittent preventive therapy (IPT); and
- (c) children under 5 were provided with impregnated bed nets. Under the Round 5 grant, the program was under performing until problems with procurement were sorted.
- (d) The M&E plan was also revised to tackle weak data quality.

52. *Standard Malaria diagnosis:* People have access to health facilities where proper diagnosis can be undertaken and treatment provided. Microscopes and trained laboratory staff were available in most health centers. The diagnosis and treatment of malaria is one of the major activities undertaken in the peripheral health facilities because the country is at risk, with a particularly high transmission during the humid and hot seasons. The microscope is still the major malaria diagnostic tool used at the health facility level. ACTs are usually available at the health facility and the treatment costs are fixed by the MOPH.

53. *Distribution of nets:* At the time of the audit, almost 2 million nets had been distributed. The OIG observed that some households in the vicinity of the health centres visited had received impregnated bed nets from the program. At the time of the audit, some of those nets had already been re-impregnated. The mothers interviewed by the OIG found the contribution of FCFA 200 (US\$ 0.5) for re-impregnation appropriate.

³ A1, the PRs capacities and systems exceed the minimum requirements; A2, the PR's capacities and systems fully satisfy minimum requirements; B1, Capacity gaps pose minor risks and strengthening measures can be completed concurrently with implementation; B2, Capacity gaps pose some manageable risks and certain strengthening measures must be completed before the first disbursement; C1 Capacity gaps pose major risks which cannot be addressed within three to six months. An alternative PR arrangement must be found for the initially approved two years of the grant while capacity strengthening measures may allow the nominated PR to be phased-in for the subsequent 3-5 years; C2, Capacity gaps pose major risks and necessary capacity strengthening does not appear feasible within the proposal period.

54. *Sentinel surveillance of resistance development*: Sentinel surveillance sites are established and well controlled. The resistance level against insecticides in one of the main vectors (*Anopheles Gambiense*) had been analyzed and a map indicating resistance of specific insecticides was prepared. Studies to identify resistance among patients against different treatment products are planned.

Institutional aspects

55. The Program was implemented by the PNLP, which was itself established in 1997. At the central level, PNLP is headed by a Permanent Secretary. At regional level, it is managed by a regional technical group headed by a coordinator. In relation to the Global Fund program, the PNLP reports to the Principal Recipient's Technical Secretariat of the three programs, which acts as a direct link between MOPH and the three programs. In addition to the Technical Secretariat which was exclusively established under the Global Fund Program, a coordination and Follow-up Unit (CFU) was established for all three diseases. At the central level, the program is implemented by a unit called CTG (Central Technical Group), at provincial level by RTGM (Regional Technical Group for Malaria) and at peripheral level by DU (District unit).

Internal and external audit

56. The OIG noted that there was no internal audit function within the PR. Although the introduction of an internal audit function is not a mandatory requirement under Global Fund rules, it is a good practice that helps strengthen the control environment in programs. This is particularly recommended for reviewing the program implementation in the regions.

57. The OIG reviewed the PR's 2007 and 2008 Round 3 audit reports and noted that most of the recommendations from the audits were not addressed and/or resolved. Failure to implement audit recommendations weakens the internal control environment in which programs operate. A review of the 2007 and 2008 audited accounts revealed that they contained a qualification on the basis of:

- (a) Unresolved issues from the 2007 audit. These arose from:
 - A suspense account on the special account opened at GTC BICEC for a total amount of FCFA 17,799,000 (US\$ 38,727); and
 - Advances made in 2007 that remained outstanding at the time of the 2008 audit i.e. advances to (i) a staff member advance for FCFA 23,309,000 (US\$ 50,716); and (ii) NGOs and district associations for FCFA 21,299,000 (US\$ 46,342); and NGOs and tertiary COSA for FCFA 29,405,000 (US\$ 63,979).
- (b) 2008 financial audit related qualifications. These arose from:
 - Lack of supporting documentation for FCFA 5,477,000 (US\$ 11,917) incurred by GTPs;
 - Failure to reconcile the physical stock to the records at the year end;

- Findings from the CNPS audit for the audit period May 2005 to June 2007 with key findings that revealed unsupported expenditure amounting to FCFA 145,822,000 (US\$ 317,280); and
- Costs amounting to FCFA 4,041,000 (US\$ 8,792) relating to the Round 3 grants that was charged to Round 5.

58. The 2008 Round 5 audit opinion qualified based on:

- (a) Outstanding 2007 audit qualifications that remained unresolved at the time of the 2008 audit;
- (b) an outstanding staff advance for FCFA 7,757,000 (US\$ 16,878); and
- (c) non confirmation by the CAA on the account balance.

Recommendation 1 (High)

- (a) *Consideration should be given to establishing an internal audit function.*
- (b) *The PR should implement the recommendations from external audit reports that remain outstanding. All outstanding advances should be accounted for or recoveries sought from individuals/entities that fail to liquidate advances taken within three months of receiving the draft report. Unsupported expenditure should also be recovered.*

Compliance with grant agreement

59. The Global Fund signed a grant agreement with the MOPH and these agreements require MOPH to comply not only with the conditions in the grant agreement as well as with the laws and regulations of Cameroon. This ensures that the measures put in place to safeguard the Global Fund assets are operational and therefore reduce the risks to which Global Fund resources may be exposed. Instances of non-compliance noted are highlighted below:

- (a) The grant agreement with the Global Fund requires that any interest earned on grant funds should be accounted for and used solely for program-related purposes. The OIG noted that interest income from the Round 3 special bank account was transferred into the CAA and utilized for non related Global Fund program activity without prior authorization from the Global Fund; and
- (b) The grant agreement provides that audit reports should be presented to the Global Fund within six months following the end of the relevant fiscal year. At the time of the audit (that is, September 2009), the final audit reports for the year ended 31 December 2008 for Rounds 3 and 5 were not available.

Recommendation 2 (Significant)

The PR should comply with the conditions stipulated in the grant agreement. The PR should provide a written explanation to the Global Fund about the transfer and use of funds by CAA. These funds should be refunded within three months of receiving the OIG report. In the future, the PR should seek Global Fund formal approval before using income incidental to program activities. PNLP should ensure that the audit reports are submitted on time.

Conflicts of Interest issues

60. The grant agreements require that the PR discloses the actual, apparent or potential conflict of interest directly to the Global Fund. The OIG observed that there was no conflict of interest policy in place within the MoPH. While having a conflict of interest does not constitute a malpractice, all conflicts should be disclosed and managed to ensure that the related risks arising from such relationships are mitigated. The OIG noted the following conflicts of interest that had not been disclosed: (i) One of the PNLP's suppliers is the wife of one of the PNLP's staff; and (ii) The former Permanent Secretary of PNLP is a brother of the owner of the accounting firm that PNLP contracted to validate transactions and confirm delivery of items procured. In this case, some of the transactions validated were undertaken by the Ex PNLP PS.

Recommendation 3 (High)

The PR -MoPH should establish a mechanism to address the conflicts of interest issue. This mechanism should include the requirement for each staff member to declare on a yearly basis any potential conflict of interest which may pose a risk to the organization. Procedures should be put in place to ensure that any transactions with conflicted parties are undertaken at arm's length.

Financial management

Payment of advances to staff

61. The program provides advances to staff for program implementation. The OIG noted that advances are not accounted for in a timely manner. The staff advances that were outstanding at the 31 December 2007 and 2008 were FCFA 41 million (US\$ 89,445) and FCFA 23 million (equivalent to US\$ 50,716) respectively. This was one of the reasons why the audit opinions for 2007 and 2008 were qualified.

Recommendation 4 (High)

The PR-MoPH should strengthen its monitoring of staff advances. All advances should be settled before additional advances are given. All outstanding advances should be cleared as soon as possible and recovery should be obtained from staff who fail to liquidate their advances.

Inventory

62. The OIG noted that the controls over undistributed mosquito nets were weak, as evidenced by failure to undertake periodic physical inventory counts. At the time of the audit, the OIG found that there was a difference of 62,780 mosquito nets, between the technical report (these are reports produced at the end of mosquito net distribution exercises by region and contain information on distribution modalities, quantity of mosquito nets distributed and undistributed etc) and distribution statistics (data

obtained from CTG). The OIG also noted that the nets did not have unique identification features to identify nets procured from grant funds (e.g. a logo or label), which increased the risk of pilferage.

Recommendation 5 (High)

The PR - MoPH need to ensure that physical inventory counts of nets should be undertaken periodically and physical counts reconciled with the records. Consideration should be given to having nets with unique identification features in order to reduce the risk of pilferage. The PR should provide the Global Fund Secretariat an explanation about the nets that remained unaccounted for at the time of the OIG audit.

63. In December 2005, the PS, through a Memorandum, brought a new policy into place requiring that the payment of benefits for an amount greater than or equal to 100,000 FCFA (US\$ 217.58) should be made by cheque. The OIG noted that this policy was not always followed with payments larger than US\$ 217 being made in cash.

There were several petty cash-related weaknesses noted. These included:

- (a) Petty cash was not kept in a safe;
- (b) The PR had not established petty cash ceilings; and
- (c) There were no spot cash counts undertaken.

64. An insurance claim reimbursement for one of the vehicles belonging to the program in October 2007 was paid into an account that did not belong to the Global Fund Program. This transaction was not disclosed in the accounting records of the Program. This amounted to FCFA 9,594,623 (US\$20,876), of which FCFA 7,000,000 (US\$15,230) was used to repair the vehicle. The balance of some FCFA 2,594,623 (US\$ 5,645) should be returned to the Global Fund program.

Verification of expenses

65. The OIG requested and did not receive some supporting documents amounting to FCFA 30,403,364 (US\$66,151). Various expenses were made from the grant on behalf of the CAA between January 2006 and February 2008 under the budget line "Support to the CAA" for which no support was provided. The key issues noted from the review were are provided below:

- (a) Absence of purchase orders and/or goods delivery notes for expenditure of various equipment and fuel amounting to FCFA 7 million or US\$ 15,319;
- (b) In line with best practice, absence of a list of households that benefitted from the impregnation of bed nets amounting to 1.5 million FCFA or US\$ 3,263.70;
- (c) Absence of invoices for payments related to administrative cost and vehicle maintenance for FCFA 1,134,940 or US\$ 2,469;
- (d) Mission expenses without mission orders for FCFA 2,014,000 or US\$4,382.07; and
- (e) Payment to CAA for some FCFA 30 million or US\$ 65,274 for special allowances and computer equipment without any specific approval from the Global Fund Secretariat.

Recommendation 6 (Significant)

All expenditure must be supported. All the issues noted above i.e. the absence of purchase orders, delivery notes, supporting documents to evidence receipt by beneficiaries, invoices etc should be addressed to strengthen the internal control environment in which the programs are implemented. The balance of funds from the insurance claim reimbursement of FCFA 2,594,623 (US\$ 5,645) should be returned to the Global Fund program.

Exposure to litigation against PNL

66. At the time of the audit, the OIG noted that there were two pending litigations against the program. Failure to resolve these two matters amicably may result in a loss of program funds. These related to:

- (a) non payment of the National Social Insurance Fund Contributions from March 2005 to March 2007 for FCFA 145,822,219 (US\$317,280). The payment of social security lies with the employer i.e. the MoPH. The Minister of Health has called on a tax expert to assist the PNL in this claim.
- (b) An outstanding claim by SIMCO and Sons Enterprise amounting to FCFA 2,115,000 (US\$4,601) for the repair of a program vehicle.

Recommendation 7 (Requires attention)

The MOPH should resolve the two pending cases of litigation against the program i.e. for non payment of the National Social Insurance Fund Contributions and outstanding claim by SIMCO and Sons Enterprise.

Review of procurement procedures

67. The procedure manual requires the Chief of Service for Procurement to prepare a procurement plan and monthly/quarterly reports on the status of contracts. The OIG requested and was not provided with the procurement plan or the monthly/quarterly reports. The only report provided was an extraction from the supplier statement of account which does not allow for the tracking of the progress of contracts.

68. The OIG selected 32 contracts for review. The OIG was not provided with information for 10 contracts amounting to FCFA 292,569,463 (US\$636,574). The OIG reviewed the files provided and noted the weaknesses detailed in the paragraphs below.

69. CENAME awarded two contracts for the sourcing of ACT. The first contract was initiated by CENAME, following an open international invitation to tender. The OIG reviewed all the documents relating to this procedure and noted the following:

- (a) The invitation to tender did not specify the assessment criteria (qualitative and quantitative) for tenders as prescribed in the Public Contracts Code; and
- (b) The procurement commission poorly analyzed discounts granted by the tendering organization, CIPLA, which proposed a 10% discount.

70. The second contract was awarded without an invitation to tender. This was an exceptional procedure authorized by the Prime Minister's Office. It was awarded in December 2008 for a total quantity of 10,116,000 combined ACT (IPCA Laboratoire 1 SANOFI AVENTIS). However, at the end of the audit, purchase orders for only 1,280,300 combinations had been placed from the SANOFI laboratory.

71. CENAME invoiced PNLN for the supply of SULFADOXINE (Round 3) and ACT (Round 5) amounting to FCFA 1.543 million (US\$ 3,357,267). The OIG requested and was only provided with invoices that amounted to FCFA 1.236 million (US\$ 2,689,295), with a difference of US\$ 667,972 still outstanding at the end of the audit.

Recommendation 8 (Significant)

The remaining invoices for the outstanding amount i.e. US\$ 667,972 should be located and reconciliation performed within three months of receiving the draft report. The LFA should conduct further verification of the missing contract and of the CENAME invoices to ensure that all invoices or contracts exist and are eligible for payment. The MOPH should seek reimbursement for all invoices that are not available.

Programmatic aspects

Prevention and treatment at the village level

72. Two of the major components (prevention and care) for malaria prevention are supported through the Global Fund. The Global Fund resources were utilized to (i) obtain information about the infection cycle and identify ways of preventing infections; and (ii) vector control.

73. The early diagnosis and treatment of malaria at the village level prevents sickness and keeps people at work. The finances from the Global Fund Round 3 grant contributed to both approaches through the supply of nets. Most of the 2 million bed nets (ITNS) were distributed during campaigns. Children under 5 who were not present during campaigns could still get their bed nets at a later date. The OIG however noted that the bed nets needed re-impregnation after 6 months. The supply of chemicals for re-impregnation was delayed. When the chemicals became available, the re-impregnation started slowly and at a cost of FCFA 200. This cost was borne by the beneficiaries. The interviews held by the OIG with some beneficiaries revealed that they found the rate charged for retreatment reasonable. In line with the WHO recommendations, the procurement of ITNs has been discouraged by the Global Fund.

Recommendation 9 (Significant)

PNLN should procure LLINs as opposed to ITNs in line with WHO recommendations.

Malaria detection and prevention approach at the village level

74. About 15,000 people at the village level were trained to visit households to inform people about the cycle of malaria transmission and how they could break the cycle. Those village workers were contracted by NGOs or directly with the PNLP. They reported their findings and the results of their work through the district to the region and then to the central level. To implement this activity in 2006, one contract from the central level with an NGO for each region was concluded. On the basis of these contracts, the work has continued for three more years. The payment for a single contract was at a rate of 50,000 FCFA per person per month with a transport allowance of FCFA 15,000 per month. The timeframe for the implementation of the approach was 5 months in 2007 and one month in 2008 and 2009.

75. The program has enabled people at the village level to diagnose malaria on the basis of clinical signs and treat the patients on the basis of a clinical algorithm. Rapid tests are to be introduced to improve the quality of the diagnosis. But there had been no discussion on how much should be paid to village workers for administering the rapid tests.

76. The treatment of village workers with the Artemisinin-based Combination Therapy was (ACT) financed through the Global Fund. The agent at the community level charged the patient following the recommended price fixed by the MOPH. The charge was 30% of the cost for treatment as their income. The cost for the treatment of malaria is fixed by the MOPH. The fall in ACT prices means that the income earned also decreases.

77. The biggest challenge has been to find appropriate people to train and serve the population at the village level because the income for providing the service is considered too small. Because of the fall in the cost of the drugs, the income of the village agents has continued to shrink. This was the rationale for increasing the charge from 10% to 30%. However, this is still considered inadequate.

78. In case the village of the patient infected with malaria is not covered with the village worker approach, the patient still has to go to the nearest health centre, where he/she will be tested through a blood test, which is still the standard diagnostic procedure in the country. The treatment in the health facilities is on the basis of the recommended ACT therapy at the subsidized cost. Women showing up for antenatal care are put on preventive therapy, if there is a risk for her health or that of the unborn child.

Recommendation 10 (Requires attention)

The MOPH needs to review and determine how the village approach can be sustained. This should include how agents can be remunerated to keep them engaged at the village level.

IV. Ministry of Public Health - HIV/AIDS Grants

Background

79. The high HIV prevalence of 5.1% among of the adult population aged between 15 to 49 years with a HIV infection puts Cameroon among the countries having a concentrated epidemic. HIV infection in Cameroon is a key public health problem. The national response to HIV/AIDS has received political support from the President of Cameroon since 1999 when the fight against HIV/AIDS was made one of the national priorities. The Government prepared a strategic plan for the fight against HIV/AIDS for the period 2006-2010. This plan is multi-sector-based and decentralized with the following key components:

- (a) universal access to prevention favouring specific priority target groups;
- (b) universal access to treatment and care for adults and children living with HIV;
- (c) protection and care for orphans and vulnerable children (OVC);
- (d) participation of a broad spectrum of actors of civil society;
- (e) epidemiological surveillance and promotion of research;
- (f) strengthening of coordination, partnership and monitoring and evaluation; and
- (g) the activities of the Global Fund contribute to all components.

80. In 2008, the estimated number of HIV-infected people was 543,294 with the proportion of men to women being 39:61. The basis for the estimation for 2008 was provided by 2,019 testing facilities for HIV which collected the number of HIV infections and reported them to the CNLS. This testing facility covered about 75% of the health infrastructure, and they tested 597,352 persons. The number of new infections for 2008 was 51,598 with the proportion of men to women as 41:59.

81. In 2008, an estimated 144,953 of the HIV infected persons were qualified for treatment, among them 60,344 men, 84,609 women and 8,232 children. At the end of 2008, 59,960 were undergoing treatment (i.e. 57,510 adults and 2,450 children). The number of people in need of treatment is rapidly increasing because over 50% of the newly detected cases qualify immediately for treatment.

82. The Global Fund is the major funding source for HIV/AIDS in Cameroon. Multilateral agencies fund 59% and bilateral agencies fund 12% of the total estimated cost of the fight against HIV/AIDS. The contribution of the government is 17% of the funding. International NGOs contribute 8% and the private sector 4% of the cost. The table below provides a list showing the different partners involved in the fight against HIV/AIDS and their areas of interventions:

UN Family	Other Donors
WFP: OVC WHO: Prevention, Access for treatment & care UNAIDS : Monitoring & Evaluation	ACDI: Prevention ANRS: Research CDC : Research Clinton Foundation : Prevention, treatment &

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UN Family	Other Donors
UNDP : Prevention, OVC UNESCO : Prevention UNFPA : Prevention UNHCR : Prevention UNICEF : Prevention	care ESTHER : Access for treatment & care GTZ : Prevention Access for treatment & care KFW : Prevention MSF : Access for treatment & care OCEAC : Prevention

83. The HIV/AIDS program has received funding from the Global Fund under Rounds 3, 4 and 5. MOPH is the PR, with CNLS as implementing agency for two grants under Rounds 3 and 5. CARE is the PR for the Round 4 grant that covers civil society activities. Out of total grant funds (i.e. US\$ 70 million), 62 million or 88% had been disbursed by the Global Fund by October 2009.

84. The distribution of the funds in 2007 gives an indicative allocation of funds across the different interventions in the Strategic Plan as shown in the table below. The cost of treatment was the biggest part of the budget. It is also the part with the highest potential for further growth. It is therefore important for the Government of Cameroon to start the discussion about how a more sustainable financing of the treatment and needed laboratory costs can be achieved. There is a need to also prioritize interventions and to adapt all components of the program and the finances according to set priorities.

Strategic components	2007	% of Spending
Universal access to prevention favouring specific priority target groups	5,234,251,590	29 %
Universal access to treatment and care for adults and children living with HIV	7,400,148,800	41 %
Protection and care for orphans and vulnerable children (OVC)	1,082,948,605	6 %
Seeking participation of different actors of the civil society	19,035,000	0.1 %
Epidemiological surveillance and promotion of research	180,491,434	1 %
Strengthening of coordination, partnership and monitoring and evaluation	4,132,267,985	22.9 %
Total	18,049,143,415	100 %

Source: Yearly report CNLS 2008

Achievements and challenges

The high HIV prevalence of 5.1% among the adult population aged between 15 to 49 years with an HIV infection puts Cameroon among the countries having a concentrated epidemic. The distribution of the infection is increasing from south to north with the highest concentration in urban areas and among women. The Government of Cameroon is contributing to the response to the pandemic but the major portion of such response is financed by external sources.

Achievements

85. The Round 3 and 5 grants were performing at A level and the Round 4 grant is performing at a B1 level. 54,429 people are on ARV treatment and 10,351 women received ARV prophylaxis.

86. The overall programmatic achievement for the Round 3 grant was satisfactory with some particularly good results in important 'people reached' indicators. The main success was the rapidly increasing number of patients showing up for treatment. This led to the Program halting two other components i.e the support to OVCs and the support through Community Relay Agents (CRA) at the community level when finances became strained.

87. The general performance of the Round 5 grant was satisfactory. Five out of 10 indicators exceeded their targets. The component for the prevention of transmission for pregnant women through ARV has shown greater acceptance with time, and the number of TB patients accepting HIV testing is also increasing.

Challenges

88. With the Government commitment to provide free ARVs and subsidized tests to the population, the number of tests and people in need of ARVs has increased rapidly. Unfortunately, the country has failed to obtain additional grants since Round 6. At the time of the audit, the grants were due to close (that is, by 31 December 2009) and the continuation of funding is for a maximum period of two years. There is a need for the country to ensure that the shortfall of funding does not affect continuity of service to patients.

Institutional aspects

89. The HIV/AIDS Program is implemented by CNLS, an independent body established by the MOPH in 1986. CNLS is headed by a Permanent Secretary. The program is implemented following a decentralized mechanism. At the central level, the CTG (Central Technical Group), which consists of 6 units, was established following with a GTP at the provincial level while at peripheral level there are Communal Correspondents and local committees.

90. The Program has only one internal auditor who is unable to adequately cover the review of program activities at various regions, NGOs and associations. This function does not have a budget line to cover its costs. The internal auditor actively participates in the operational activities of the program - that is, approval of invoices, goods received notes, etc. The work of the internal auditor did not cover SRs. External audit reports do not cover SRs either.

91. From the draft external audit report received during the last week of the last week of the OIG audit, the Program was due to receive a qualified opinion for 2008 for Round 3 based on the following:

- (a) Qualifications that related to 2007 but were still outstanding in 2008 mainly related to non reconciled items in the 2007 bank reconciliation statements;
- (b) There was a non-reconciled difference of FCFA 112 555,000 (US\$ 244,898) between the physical count and the records maintained of inventory at the year end; and
- (c) The bank interest received and charges made by the Caisse Autonome d'Amortissement were not recorded as required.

92. The qualifications for Round 5 related to:

- (a) Unrecorded program transactions totaling FCFA 80,165,000 (US\$ 174,423);
- (b) Purchase of ARVs worth FCFA 77,993,000 (US\$ 169,697) from the CENAME which was not recorded in the program records;
- (c) There was a non-reconciled difference between the physical count and the records maintained of inventory at the year end; and
- (d) Accounting treatment of bank interest received and charges made by the Caisse Autonome d'Amortissement were not recorded as required.

Recommendation 11 (Significant)

The PR should provide explanations to the Global Fund of all the outstanding issues raised in the audit report. This should be within three months of receiving the audit report. The LFA should review the explanations provided. Refunds should be sought for all unresolved matters.

Compliance with grant agreement

93. The Global Fund signed a grant agreement with the MOPH, which required MOPH to comply with the conditions set in the instrument as well as with the laws and regulations of Cameroon. This would ensure that the measures put in place to safeguard Global Fund assets are operational and therefore reduce the risks to which Global Fund resources are exposed. Instances of non-compliance noted are highlighted in the following paragraphs.

94. Article 7 of the Grant Agreement requires the PR to furnish the Global Fund with audit reports within six months after the end of the period under audit. Audit reports for the year ended 31 December 2008 for Rounds 3 and 5 were not yet available as at the date of the OIG review.

95. According to the provisions of Article 3 (b) of the Grant Agreement, any interest generated by grant funds shall be accounted for and used solely for Program purposes. The OIG observed that interest income generated by the special bank account (Round 3) had been transferred into the Autonomous Sinking Fund (CAA). The table below shows the interest amounts drawn by the CAA per year:

Year	Round 3 Currency FCFA (US\$)	Round 5 Currency FCFA (US\$)	Total Currency FCFA (US\$)
2007	2,691,111 (5,855)	992,882 (2,160)	3,683,993 (8,015)
2008	3,666,761 (7,978)	1,647,194 (3,584)	5,313,955 (11,562)
2009	480,263 (1,045)	160,178 (348)	640,441 (1,393)
Total	6,838,135 (14,878)	2,800,254 (6,093)	9,638,389 (20,971)

Recommendation 12 (Significant)

CNLS should comply with the provisions of the Grant Agreement. The CAA should reimburse interest income received between 2007 and 2009.

Financial management

Control over reimbursements for HIV/AIDS tests

96. As part of the Government commitment to HIV/AIDS, since 2007, the Government of Cameroon has subsidized the cost of tests for patients and reimbursed the cost to the hospitals. There were four types of tests for which fee subsidies were provided to HIV/AIDS patients. These were screening test, CD4 count test, treatment preparation test and follow-up test. Each GTP is required to review the invoices submitted by the each hospital or treatment center.

97. Good controls are needed to verify invoices before payments are effected and the verification should include an assurance that the number of patients tested as shown on the invoice corresponds to the eligible patients tested (that is, based on laboratory registration). However, this is not always the case. For example, at Hospital UPEC de Nylon in Douala, the verification of invoices was only conducted on 30 June 2009 for monthly invoices covering the period September 2008 until March 2009. For the Military Hospital in Douala, the monthly invoices for the period May 2008 to December 2008 were verified only in February 2009. In one hospital in Douala, the OIG found that the number of tests invoiced were more than the actual patients tested based on the list of tests carried out by the Hospital laboratory. From a four-month audit sample (September to December 2008), the OIG found differences of FCFA 2,047,500 (equivalent to US\$ 4,454). The OIG field visit to three hospitals in the Far North region did not reveal any discrepancies, and the verifications by the GTP were duly carried out.

98. The OIG further noted that the reimbursements to hospitals had been stopped since August 2008 until the time of the audit (September 2009). This was because CNLS had given priority to financing ARVs even though the budget for this activity was still unutilized. Consequently, testing ceased. The outstanding costs due to Hospitals about FCFA 803 million (US\$ 1.75 million) were subsequently paid following receipt of the fresh disbursement from the Global Fund at the end of the audit.

Recommendation 13 (High)

MOPH as PR should:

- (a) Strengthen the control over the reimbursement of the cost of testing by hospitals or health centers. The provincial coordinators should verify the correctness of invoices submitted by hospitals.*
- (b) Improve CNLS cash flow management to ensure that obligations to all third parties obligation are paid on a timely basis. The outstanding bills should be cleared.*

99. During the OIG visit to South West Region, the OIG found an apparently fraudulent request for reimbursement of laboratory testing expenditure by one hospital in Kumba. This hospital invoiced the Global Fund program for tests that were not undertaken by them but were undertaken by a private laboratory outside the Hospital. The costs of these tests had been fully paid by the patients.

100. Furthermore, the OIG noted that the hospital had also issued receipts to falsely imply that the patients paid their share of the test costs and that they had requested and received reimbursement from the Provincial Technical Groups. The Hospital also had a list that they claimed were patients that had done the tests at the Hospital Laboratory. This practice had been taking place since 2007. The OIG checked the tests claimed for January 2008 and noted that the Hospital had sent to the Provincial Technical Group a request for refund for 56 patients amounting to FCFA 1,008,000 (US\$ 2,193). A review of all claims made since 2007 should be undertaken and refunds sought. The OIG estimated that some US\$ 52,000 needs to be recovered given that this fraud would appear to have taken place over a two year period.

101. The Hospital director explained that the Hospital sent the patients to the external laboratory with which they had an agreement because at that time the machine had broken down. However, the Director could not provide the OIG with the agreement with the private laboratory. The OIG confirmed from the director of the private laboratory that no agreement existed with the hospital as alleged. The case was handed over to the Inspector General of the MOPH at the end of the audit for further investigation and to assess the extent to which this risk had materialized in other hospitals.

Recommendation 14 (High)

The PR should within three months of receiving the OIG report should:

- (a) check all requests for reimbursement paid to Kumba Hospital and should ask the Hospital to reimburse all tests performed by the external laboratory;*
- (b) report back to the Global Fund through the LFA on the outcome of the investigation at the hospital in Kumba; and*
- (c) undertake a verification exercise of all payments made to the entities that have requested to be reimbursed for HIV tests to ensure the correctness of the test numbers reported.*

Treasury

102. Verification and validation of invoices of biological tests and other tests by the medical care support units (UPEC/CTA) was not well executed. Payment of the invoices was not made on time e.g. payments had been pending since October 2008 until the audit (September 2009). There were also no controls over rejected and/or unapproved items.

103. The procedure manual discourages the maintenance of petty cash within the programs. However, significant amounts were withdrawn from the bank for workshops, reimbursement to health institutions that did not have bank accounts, payment of 'Agent Relais Communautaire' (ARC) etc and these resulted in large cash balances being held which raises the risk of loss.

Recommendation 15 (High)

CNLS should establish a mechanism that verifies invoices before payment and that keeps track of rejected items to avoid resubmission.

Human Resources

104. The Central Technical Group (CTG) does not have an exhaustive database for all employees of the Global Fund supported program. No verification is carried out by CTG to ensure that salaries paid at regional level are consistent with contracts. The applicable procedure manual of the CHP does not specify the required profile for some positions of responsibility in the organization. Personnel files at CNLS were damaged as a result of a flood and were being reconstructed at the time of the audit.

Recommendation 16 (Requires Attention)

CNLS should create an employee database for the Global Fund supported program including salaries and carry out a monthly check to monitor the payments made in the regions. Personnel files should be updated. CHP should amend the procedures manual to cover job profiles.

Inventory

105. In 2006 and 2007, medicines were delivered to CAPR and health units monthly. The quantities requested were based on statistical measures (drug attribution by the Program). Since 2008, orders were placed directly by CAPR to CENAME, which bills the Program. However, these orders were neither approved nor monitored by the Program. There was no global reconciliation of the treatment statistics to quantities purchased. This is necessary for proper forecasting.

Recommendation 17 (High)

- (a) CNLS should put in place a system for approval and monitoring of orders by the Regional Technical Group (RTG). RTG should also report to the CTG on orders placed.*
- (b) CHP should put in place a centralized monitoring process for drugs at the sensitization units and carry out monthly global reconciliations between treatment statistics and quantities distributed.*

Interaction between CNLS and SRs

106. CNLS does not maintain adequate budget control procedures that show payments against budget nor liquidations received against advances made. Following the OIG's recommendation, the CTG has begun reconstituting advances made to NGOs to identify the SRs with long outstanding advances. From the work done by the OIG, the following issues related to OVCs were noted:

- (a) Information provided by NGOs and Associations was not comprehensive and uniform e.g. nature and amount of assistance;
- (b) Some OVCs in the Central region received double assistance;
- (c) OVC lists did not contain information about the respective tutors; and
- (d) Other participants in the Program (PNS-OEV) did not provide regular information about activities in the regions that would enable the OVC database to be updated.

107. The terms of Agreement with NGOs and Associations for assistance to OVC do not specify the information required (tutor's name and address, nature and evaluation of the assistance, age of the OVC).

Recommendation 18 (High)

- (a) CNLS should put in place a budget control system based on an ageing analysis of advances.*
- (b) CNLS should request information from other actors on identified and assisted OVCs and define a period (monthly, quarterly, semi-annually, and yearly) for updating the OVC database.*
- (c) The CTG together with RTG should set guidelines on expected information from NGOs and Associations, and carry out monitoring visits.*

Information and accounting system

108. CNLS does not have accounting and payroll software. Both the accounts and payroll are managed on a MS Excel spreadsheet. In addition, the computer of the Head of Administration and Finance department, on which the accounts and payroll is processed, is not protected by an access code and the various data (accounting, financial and technical) are not backed up. CNLS uses a cash basis system of accounting which makes it difficult to track advances made and not accounted for and liabilities.

109. The procedure manual currently in use does not pay much attention to issues such as: (i) the definition of segregation of duties for each business process. For example, the manual does not segregate the tasks relating to supervising, storing, recording and control in the purchasing system; and (ii) the flow and control of information and data within the organization. There is no mention of documents produced for each transaction type and its process.

Recommendation 19 (Significant)

- (a) The Program should acquire a suitable accounting and payroll software. Data safeguarding procedures and access codes should be implemented.*
- (b) CHP should institute an advances ledger to enable the following up of monies that have not been liquidated.*
- (c) The sub-recipient (CHP) should amend the procedures manual taking into account the above-mentioned weaknesses and CHP's procedure should be harmonized with that of the PR.*

Government contribution

110. Government contributions amount to 50% of ARV drugs. The OIG noted that the Government's contribution throughout the Program lifespan varied considerably with contributions in some years exceeding the agreed upon contribution percentage threshold and in other years falling below. There were also delays in making the contribution.

Recommendation 20 (Requires Attention)

The Government of Cameroon should make its contributions available to the Program within a reasonable timeframe (quarterly, monthly) in order to avoid delays in the implementation of activities.

Verification of Data Quality

111. The OIG noted that the monthly statistics from the sensitization units e.g. number of sensitized/trained persons to administer voluntary AIDS screening tests, and treat STDs had only been verified once. The nature of the information to be provided by the units was not defined. Therefore, the units provided information that was inconsistent and not comprehensive.

Recommendation 21 (Significant)

CHP should put in place a process for the periodic validation of information from the sensitization units. These processes should deal with the nature of information (number of sensitized/trained persons who administer voluntary AIDS screening tests, and treat STDs, and the quantity of kits distributed). The outcome should be submitted to the head office.

Expenditure

112. The OIG noted that the procedures manual does not provide for the apportionment of costs related to program expenses. This could pose a risk of charging the Global Fund for expenditure relating to other funders.

113. The OIG did not receive supporting documentation for more than 50% (58 of 101) of the information requested. The expenditure for which the OIG did not receive supporting documentation amounted to FCFA 311,679.125 or US\$678,153. The OIG noted that the reason for not producing supporting documents in a timely manner was a poor filing system.

Recommendation 22 (Requires attention)

The PR's procedures manual should be updated to include cost apportionment criteria. CNLS should retain proper records to support all payments effected from program funds. The LFA should seek to control and verify the missing supporting documents. Unsupported expenditure should be recovered.

Control of the billing process from CENAME

114. CENAME makes international invitations to bid based on the needs expressed by the CNLS. CENAME's sales price is set by adding an overhead margin to the cost price as determined by the Ministry of Public Health. The OIG noted that there was no procedure in place at CTG to check prices set by CENAME. This resulted in CENAME over charging the Ministry of Health.

115. The OIG reviewed the ARV billing reconciliation for the period May 2007 to December 2008 undertaken by CENAME and noted that there was no proper verification of CENAME's invoices by CNLS before payments were effected. The OIG found that since 2007 there had been an overpayment of FCFA 1,549,000,000 (US\$ 3,370,322.) which now needs to be recovered. This arose because CENAME had been invoicing CNLS at prices higher than the prices they had paid for the drugs.

Recommendation 23 (High)

CNLS should monitor the conclusions of the bidding process (selected suppliers, given prices, etc.), obtain the goods received notes from Centres d'Approvisionnement Pharmaceutiques Régionaux (CAPR) and reconcile with invoices from CENAME, based on the statistics of "PLWHA" carry out overall consistency checks to verify the appropriateness of orders from CAPR. Monthly reconciliations should be performed between quantities supplied to CAPR, quantities supplied to support units, Centre de Santé Agrée (CTA) and the number of PLWHA treated.

Programmatic aspects

HIV/AIDS testing and treatment

116. The decision to provide cost free treatment for HIV infected persons and to subsidize the cost for related laboratory examinations has increased the number of people going for testing and accepting treatment. Since May 2007, ARV treatment has been free of charge. Before this, patients had to pay FCFA 6000 for a month's treatment. Since August 2008 costs for the different laboratory tests in connection with the ARV treatment have also been subsidized through the Global Fund program. The following table shows the actual cost participation:

	To be paid by the patient FCFA	Global Fund contribution FCFA
Screening test	500	
CD4 count test before treatment	2,500	7,500
Treatment preparation test	500	10,500
Follow up test	3,000	18,000

Promotion of HIV testing

117. The promotion of the cost-free antiretroviral treatment was supported at the community level by the Community Relay Agents (CRA). Because of their activities during the last year, many more people accepted testing. The easy access for patients to Voluntary Counseling and Testing (VCT) at a low cost participation of 500 FCFA for a HIV test also increased the number of patients accepting HIV testing. However, this successful mobilization component was suspended in November 2008 for budget reasons.

Procedures and cost to obtain treatment

118. Patients are registered in a treatment centre where further tests are undertaken at subsidized prices to find out whether their infection status has progressed and if they qualify for ARV treatment. The first test to find out up to what level the infection has already progressed is a subsidized CD4 count costing the patient 2,500 FCFA. If the CD4 count is below 350 and or clinical signs show a progression to AIDS, the patient is presented to the treatment committee of the centre. There the decision is taken to offer the patient ARV treatment. The further treatment preparation testing costs the patient 500 FCFA. After the testing, the patient is put under first line treatment.

119. If the patient's medical condition requires a treatment combination with Nivirapine, the patient has to undergo additional testing of his liver function after 2 weeks treatment with a lower dose of Nivirapine. The cost for this test of about 7,000 FCFA is not included in the cost participation decision of the MOPH, and the patient therefore has to pay.

120. In order to remain under treatment and as long as no exceptional events occur, the patient has to show up regularly once a month to obtain drugs and every six months

for the subsidized follow-up testing at a cost of 500 FCFA. As long as no resistance develops to the first-line treatment, he/she remains at the treatment centre and he/she is monitored after every six months.

121. If signs of resistance to the virus during the first line treatment evidenced by a reduction of the CD4 cells or through the appearance of opportunistic infections, the patient is referred to a better equipped (CD4 count) treatment facility. Those units are usually at a longer distance from the patient's residence. In this treatment facility the patient is put under second-line treatment, and is not sent back to his former treatment facility. The second-line treatment does not bear additional costs beside the standard 500 FCFA for the follow up testing. Higher cost may be incurred in the form of travel expenses due to the longer distance to the better qualified treatment centre. Scientific studies of resistance development against different drug regimes are still rudimentary in the country because laboratories are not sufficiently equipped to do more detailed viral investigations.

122. The AIDS patients are taken care of in 166 treatment Centres found all over the country. The lack of CD4 counting facilities is an important reason for the referral of the patient to the treatment facilities with CD4 count facilities to identify those that may need second line treatment. The need to change the treatment facility and having to travel longer distances to get treatment is one of the reasons for patients choose to discontinue treatment. The drop out rate is estimated at 10% of the patients registered at a treatment centre. Drop out rates are however higher in urban settings.

123. Community relief agents follow up lost patients and seek to increase their adherence to the therapy. The agents continued also to promote the Voluntary Counseling and Testing approach in the environment of the infected persons. However, as noted above successful component was stopped in November 2008, because of lack of funding which greatly affected the impact of the program.

124. At the time of the audit, treatment for all patients was provided even if stock outs occurred occasionally for single products. At the time of the audit, the ARV country stock was enough to last 6 months and no further funding was available under the Rounds 3 and 5 grants to fund further purchase. The country CCM requested the Global Fund to bridge support once that stock runs out through the Continuity of Services (COS) request. This request was approved subsequent to the OIG audit. Apart from this grant, there is no further funding for HIV which created significant challenges to maintain continuity of service for critical programs.

Data collection

125. There is no operational national health management information system in the MOPH for the collection and processing of data. The HIV/AIDS program (CNLS) has developed one to meets its needs i.e. collecting HIV infection related data through the peripheral health facilities, reporting and processing them through the district and

regional level up to the Central Technical Group (CTG). In order to ensure proper data processing, analysis and utilization, the Country Response Information System (CRIS) designed by UNAIDS is used to store all strategic information put together by the Planning, Monitoring Evaluation Unit of the National AIDS Control Committee.

126. No sentinel surveillance has been undertaken in the country since 2002. During the last investigation in 2002 only certain groups at risk were studied. The last reliable and representative results for the general population date from the Demographic Health Survey (DHS) of 2004. For reliable planning on prevention and care there is an urgent need to have more up to date information on the infection rate among the general population. Subsequent to the OIG audit, the Round 3 HIV grant implemented by the Ministry of Public Health received approval to continue under the Continuation of Services (CoS) mechanism. Apart from this grant, there is no further funding for HIV which created significant challenges with continuing critical programs.

Recommendation 24 (High)

- (a) A closer collaboration between MOPH structures for data processing of HIV/AIDS data should be initiated.*
- (b) A Sentinel surveillance survey is urgently needed, to get the baseline data needed for reliable planning of future interventions in prevention and care. Surveys should also be undertaken to evaluate program results and impact of the Global Fund supported program.*

V. Ministry of Public Health - Tuberculosis Grant

Background

127. Tuberculosis in Cameroon, as in many other African countries, is a public health problem with important economic consequences. This problem is worsening with the increasing number of HIV/AIDS patients, because over 40% of HIV infected persons also develop Tuberculosis. The recognition of this as a problem resulted in the National Tuberculosis Control Program (PNLT) becoming a priority for the MOPH. This resulted in support from the Global Fund for implementing the related tasks by the Central Technical Group for Tuberculosis (CTG).

128. In 2002, the National Tuberculosis Control Program (PNLT) was recognized as a priority by the Ministry of Public Health. Cameroon adheres to the universal initiative of WHO/UNAIDS as well as to the “Global Plan to Stop Tuberculosis”. In Cameroon treatment of TB is free of charge. The general objective of the PNLT is to progressively reduce the morbidity and mortality associated with the disease through the proper management of cases.

129. The Global Fund awarded Cameroon one grant in Round 3 amounting to US\$5.8 million, 93% of which has been disbursed by the Global Fund as of October 2009. MoPH is the PR with PNLT as the implementing unit.

Achievements and challenges

130. Overall, the Round 3 TB grant is performing well at A1 level with 21,119 new smear positive cases having been detected; 15,561 of new smear positive cases were successfully treated as a proportion of new cases detected. The program progressed well by achieving nearly 100% in all programmatic indicators, this includes diagnosis and treatment. The offer of VCT for all TB patients is well accepted and reaches over 80%.

131. However, as is the case with the HIV and Malaria programs, the TB control program in Cameroon is plagued by a lack of funding. The impact of this situation is described in the paragraphs that follow.

Institutional aspects

132. The PNLP was established by MOPH to deal with Tuberculosis. At the central level, the program is managed by PNLP, at the provincial level by Regional Technical Group Tuberculosis (RTGT), and at the peripheral level by Diagnostic and Treatment Centres (DTCs).

Compliance with the Grant Agreement

133. The Global Fund signed a grant agreement with the MOPH requiring MOPH to

comply with the conditions in the grant agreement and the laws and regulations of Cameroon. Instances of non compliance are highlighted below:

- (a) Article 20 of the current Agreement (Round 3) stipulates that the Program's fixed assets should be insured. However, some vehicles were not insured.
- (b) The OIG's review of external audit functions revealed that audit reports for Round 3 for the year ended 31 December 2008 were not available at the time of review (September 2009). The audit reports became available subsequent to the audit. Article 13 of the Grant Agreement requires the PR to furnish the Global Fund with audit reports within six months following the period under review.

Recommendation 25 (Requires attention)

The PR should comply with the conditions stipulated in the grant agreement. Specifically, vehicles should be insured and audit reports prepared within the stipulated deadline in the Grant Agreement.

Internal and external audit

134. The OIG noted that there was no internal audit function within the PR. Although having internal audit is not mandatory for programs funded by the Global Fund, it helps strengthen the control environment within which programs are implemented. This is commended particularly for reviewing program implementation in the regions given that regional units are not subject to regular reviews from the center. There is an Internal Control Department in place that is in practice responsible for budget control.

Recommendation 26 (Significant)

An internal auditor should be employed and a clear job description established that includes random and surprise checks of regional units. The internal auditor should adhere to the principle of independence and should be responsible for the development and implementation of an effective internal audit function.

135. The external auditor appointed by the PNLT had not finalized the report for 2008 at the time of the OIG audit. The draft report was received in the last week of audit which proposed a qualified opinion for year 2008 based on:

- (a) Unresolved issues from the 2007 audit report include the following:
 - Outstanding debtors from the 2007 audit; and
 - There were balances outstanding from the inter grant transactions that took place in 2007.
- (b) PNLT owed the National Fund of Social Insurance FCFA 64,292,000 (US\$ 139,887) arising from unpaid social contributions for the period October 2005 to March 2008.

Recommendation 27 (Significant)

The PR should provide explanations to the Global Fund of all the outstanding issues raised in the audit report. This should be within three months of receiving the audit

report. The LFA should review the explanations provided. Refunds should be sought for all unresolved matters.

Financial Management

Accounting system

136. The PNLT Management informed the OIG that the accounting system had crashed, resulting in the loss of data. The data was later entered manually, presenting some abnormalities e.g. the bank reconciliation statements for the period November 2004 to April 2007 were not in the TOMPRO system. The accounting software used by the Program (TOMPRO) was not functioning in the North, East and Adamaoua Regions. Accounting information for these regions was therefore posted at the CTG. The program did not have up-to-date accounting information (that is, in August 2009). Such information was only available as of 31 May 2009.

Recommendation 28 (Significant)

The process/procedure for PR back-ups should be formalized and appropriate controls put in place; the Program should ensure proper implementation of TOMPRO in the regions; and the accounting records should be kept up to date.

Programmatic aspects

Epidemiology

137. There were 25,125 estimated infections in 2008. The highest concentration of infections is still found in the two big cities: Douala with 19% and Yaoundé with 15% of the total number of infections in the country. The objectives of the PNLT corresponding to WHO recommendation to achieve a cure rate of 85% and to achieve a rate of lost patients below 5%.

Diagnostic

138. A patient suspected of having Tuberculosis on the basis of clinical signs is usually referred to one of the 207 Diagnostic and Treatment Centres in the country. A sputum examination is done at the cost of 1,000 FCFA. If the smear is positive the patient is put under standard DOTS treatment for 6 months. If the smear is negative but the suspicion of the existence of an infection with TB still persists and the patient is able and willing to pay, an X-ray (about 6,000 FCFA) at the nearest facility is recommended. The treatment is considered successful if after treatment 3 sputum smears are negative.

Treatment

139. The drugs for the treatment of Tuberculosis are free of charge. They are supplied by GDF. There is no budget line in the MOPH to cover the cost for TB drugs for

the first and the second line. The actual supply is running out and the program is prepared to buy the next supply with the funds provided through the Global Fund.

Absence of follow-up of patients dropping out

140. Patients are followed up during their treatment, but the number of patients dropping out is difficult to trace. Drop outs are more common in urban settings and range from 5% to 20%. There is a need to follow up on those patients to keep them under treatment to prevent the further spread of the disease and drug resistance.

Absence of free treatment for Multi-Drug Resistant TB

141. If after a treatment the sputum is still positive, the Tuberculosis of the patient is considered as drug resistant and is referred to one of the two referral facilities where bacterial cultures are feasible or to the GTZ project. If Multi Drug Resistant (MDR) tuberculosis is identified, the treatment with much more expensive drugs is administered free of charge through the GTZ project. The number of Multi Drug Resistant TB patients is estimated at about 120. It is estimated that 3 - 4 new infections are registered per month..

Lack of proper guidelines on preventive treatment

142. The preventive treatment of children under 5 in households with TB patients is not practiced. An existing guideline for the preventive treatment of children exists and should facilitate the application of standard processes, but it lacks clarity at the treatment centre.

Recommendation 29 (Significant)

- (a) *The care of Multi Drug Resistant (MDR) patients needs to be integrated into the structure of the MOPH and the treatment needs to be free of charge for the patients to keep them under treatment and to prevent a spread of the MDR tuberculosis strains.*
- (b) *The CCM should encourage the government to introduce a budget line for MDR TB drugs to continue the standard and the multi drug resistant treatment free of charge and to prepare for sustainable support with drugs after the support through external donors has run out.*
- (c) *The cost for diagnosis (e.g. X-ray) should be supported to prevent patients not coming for treatment because of their inability to pay the diagnostic costs.*
- (d) *The guidelines for the preventive treatment for children under 5 in households of patients with Tuberculosis should be reviewed to facilitate an easy and cost free access of those children for preventive treatment.*
- (e) *An approach should be developed together with the other programs, for community level involvement to follow up patients who fall out from treatment.*

Tuberculosis and HIV infections

143. The number of TB patients simultaneously infected with HIV is over 40%. The increasing number of HIV infections has led to an increasing number of Tuberculosis infections. Some of these new infections arise because of a re-appearance of an old Tuberculosis infection due to the weakening of the immune system, the others arise from a higher susceptibility level because of the weakened immune system of HIV infected persons.

144. The close interaction of both infections creates the need to combine interventions for both diseases. Therefore in all Diagnostic and Treatment Centres a combined Voluntary Counseling and testing facility was introduced. The offer for HIV testing was quickly accepted by the patients, and over 80% of patients accepted in some centers already received HIV testing as a complementary part of their Tuberculosis diagnosis.

145. The treatment priorities for TB and AIDS are followed by using a pragmatic approach. The treatment for tuberculosis is usually initiated first. After the TB treatment the patient is referred to a HIV/AIDS treatment unit for treatment with ARV. In collaboration with the Diagnostic and Treatment Unit of the TB program the doctor in the HIV treatment facility decides if the patient has to continue preventive treatment for tuberculosis after DOT's treatment has been successfully completed.

Recommendation 30 (Significant)

The VCT activities at the treatment facilities should be further strengthened to promote HIV prevention and to convince more TB patients to get tested for HIV.

VI. Ministry of Health - Cross cutting internal control weaknesses

146. The OIG identified some internal control issues that were cross cutting across the three Global Fund supported Programs. In order not to repeat them across all the three sections, these are summarized below. The MOPH Senior Management needs to ensure that these recommendations are implemented by each of the Programs.

Accounting and information system

147. The PR has its accounting policies elaborated in a manual. However, the procedures manual has its shortcomings e.g. it did not describe the roles of key staff in the organizational structure. The OIG also noted that the "inventory management" module of the manual did not provide procedures for the management and control of inventory like mosquito nets and drugs.

148. At the time of the audit i.e. September 2009, the OIG noted that accounting information on the Program was not up to date. The books of accounts had last been updated on 31 May 2009 and 30 April 2009 for Round 3 and Round 5 respectively. The Program did not maintain a proper filing system and document retrieval was difficult.

149. The use of the software TOMPRO was not fully operational. The software was non functional in some regions (North and East). The version in use by the program could not consolidate accounting information from various locations. Access rights were also not defined on TOMPRO. All accountants have unrestricted access to its applications. PNLN has neither IT staff, nor a maintenance contract for the IT equipment and the Project had not developed a data security policy.

Recommendation 31 (Significant)

The three Global Fund supported programs in the MOPH should:

- (a) Maintain up to date accounting records;*
- (b) Revise and update the Procedure Manual to ensure it adequately covers all program processes;*
- (c) Upgrade the accounting software (TOMPRO) to ensure that it is operational in all regions and locations and is also able to consolidate records across regions and locations. Access right to TOMPRO should be defined, taking into consideration the level and authority of users;*
- (d) Set up an IT department. Alternatively, the maintenance of the equipment and application software (TOMPRO) should be outsourced; and*
- (e) Should strengthen its filing and archiving of accounting records.*

Treasury

150. The OIG reviewed the controls over the PR's bank and cash function and noted the following:

- (a) Regional accountants also acted as cashiers and they were the sole signatories for some payment vouchers;
- (b) There was no evidence that petty cash counts were ever undertaken;
- (c) According to the manual, bank reconciliation statements (BRS) were supposed to be prepared and reviewed by the Head of Administration and Finance. A review of a sample of BRS revealed the following issues:
 - Some BRS covered periods exceeding a month;
 - Bank reconciliation statements were not signed by the person who prepared them;
 - There was no evidence of BRS having been reviewed by a senior official independent of the preparer;
 - There were long outstanding transactions in the BRS; and
 - There were differences between the account balance and the balance reflected in the bank reconciliation statements.

Recommendation 32 (Significant)

- (a) *Under the principle of segregation of duties, the person responsible for keeping cash should be different from the person who keeps the records and cash payment vouchers must be countersigned by a responsible individual.*
- (b) *The preparation of bank reconciliation statements should be on a monthly basis. Furthermore, they should be signed by the preparer and reviewed by an authorized person.*
- (c) *The minutes of petty cash count should be systematically established at the end of every month and kept safely.*
- (d) *Count sheets should be countersigned by an appropriate authority. A procedure establishing spot counts should be put in place.*
- (e) *All resources generated by the assets acquired with funds received from the Global Fund should be paid into the account entitled to receive the funds.*

Fixed Assets

151. The Programs did not have a fixed assets register. A draft register was under preparation based on the findings of an inventory check as of 31 December 2008. Only one fixed asset inventory check had been carried out since the beginning of the project. This is contrary to the procedure manual requirement which recommends that an inventory be carried out every year end.

152. A review of the fixed asset inventory revealed the following:

- (a) Assets were not tagged with a unique identification numbers and were not easily identifiable. Some assets only bear the mark “Round 3 CNLS”;
- (b) Information on the state and location of some assets was not listed; and
- (c) The condition of the assets was not noted.

Recommendation 33 (Significant)

- (a) The Global Fund supported Programs should prepare a comprehensive fixed asset register. Annual physical verification exercises should be undertaken and the assets register updated accordingly; and*
- (b) All assets should be marked with unique identification numbers. These numbers should be included in the assets register.*

Human Resources

153. Some civil servants seconded to working with the three Global Fund supported programs received special allowances as per Ministerial Order No 592MPS/CAB of 22 November 2004. This order requires that the corresponding expenses are charged to the budget of the PR. The ministerial order also requires that the special allowance should be approved by the Global Fund. The OIG was not provided with evidence of such approval. In addition, the OIG noted the following:

- (a) The absence of the Global Fund's formal approval on expenses (salary, vehicles) incurred by the National Committee of Roll Back Malaria; and*
- (b) Some senior staff of the PNLT (for example the Chief of Administrative and Financial Service and the Internal Controller) who are not involved in the day to day running of the program are paid by the PNL.*

154. A review of a sample of personnel files (both contractual and civil servants) revealed the absence of some documents such as curriculum vitae, references from past employees, proof of academic qualifications etc. The Program has no staff training policy on the procedures and practices of the Global Fund. There were also inconsistencies on the job profile for the head of regional units.

Recommendations 34 (Requires attention)

- (a) The Global Fund programs should obtain formal approval from the Global Fund before incurring expenditure that is outside the approved budget.*
- (b) A training program should be prepared and integrated in the action plan at the beginning of each year. Training should not be focused only on Global Fund policies but equally on specific aspects such as the use of the software TOMPRO;*
- (c) Personnel files should be updated, including the harmonization of staff job profiles.*

VII. PR of HIV/AIDS - Care Cameroon

Background

155. CARE International is the PR for the Round 4 HIV Grant with a grant of US\$16 million of which US\$15.9 has been disbursed by the Global Fund as of October 2009. This grant represented 12% of the total grants to Cameroon.

156. The program objectives include:

- (a) a mass media behavioral change communication program targeting youth (15-24 years) in both urban and rural areas and building the capacity of community and faith-based organizations to improve the effectiveness of their contribution to the fight against AIDS in Cameroon;
- (b) build the technical, management and organizational capacity of civil society organizations through a two-tier grant mechanism i.e. a small grant mechanism to fund the activities of Community-Based Organizations (CBOs); and
- (c) a larger grant mechanism for more established Non Governmental Organizations (NGOs) that will help in building the capacity of smaller NGOs.

157. The Round 3 grants ended subsequent to the OIG audit. At the time of reporting, the grants were being closed. Recommendations have been made despite CARE currently not having a role in program implementation. These are meant to strengthen the organization in the event that this organization works with the Global Fund in the future.

Achievements and challenges

158. The support to civil society through CARE is operating well. The majority of performance indicators are being met or exceeded. The prevention component for youth and the care component for people infected or affected by HIV are showing the best results. To maintain the good performance and to avoid delays a continued training program for the NGOs and regular supervision is recommended.

159. The performance of CARE is a good example of civil society management, along with some involvement of the private sector. The RCC and Round 9 proposals were not successful and this may affect the scaling up of activities.

Financial management

Financial control

160. Supporting documents for payments made by the bank are not labeled as “paid”. The project uses a cash basis of accounting, in consequence, its obligations are not disclosed in the accounts resulting of non reliable of its financial information.

Suppliers' invoices are monitored using spreadsheets, and there is a risk of double payment due to omission or errors on the spreadsheets.

Recommendation 35 (Requires attention)

Care should ensure that all supporting documents for bank payments are marked "paid".

Slow utilization of the budget

161. The OIG verified budget versus actual expenses, which highlighted a significant variance. The budget for quarters 2 to 4 of 2009 was US\$ 1,592,506, while expenses for the same period were US\$ 639,450. The OIG observed that the reason for the slow utilization of the budget was due to delay of verification of SR financial reports, which resulted in the delay of disbursement to SRs.

Recommendation 36 (High)

Care should ensure that timely verification of reports from SRs is undertaken so that disbursements are made on a timely basis.

Fixed assets

162. The accounting and financial procedures relating to the fixed assets requires that all assets acquired for the project be identified with a unique identification number. However the OIG noted that (i) the assets devoted to the project were not physically identified by a code; and (ii) fixed asset inventory sheets were not signed and approved by the people who participated in the count.

Recommendation 37(Significant)

Care should mark all assets with a unique identification number and these numbers should be registered in the fixed asset register.

Information system

163. The PR does not have a computerized system for managing the payroll. The payroll was managed in MS Excel prior to being recorded in the books. This created the significant risk of errors or omission as a result of the manual processing of payroll or errors during the transfer of data into the books.

Recommendation 38 (Requires attention)

Care should purchase a module for managing the payroll in the SAGA system (accounting software used by the PR).

IRESKO (Care Sub Recipient) management system review

164. The review of the sub-recipient IRESKO management system revealed the following:

- (a) The Organization uses a cash basis system of accounting which does not record advances and liabilities in the accounts. The back-up file does not make it possible to retrieve or export information from closed periods. Retrieval of data is made impossible because of the risk of losing current data. The prior period's accounts can only be consulted in hard copy. Also, there is no maintenance service provider for the accounting software.
- (b) Purchase requisitions are not systematically prepared in compliance with the procurement policy for high value purchases. Pro forma invoices and signed purchase orders were not available in the file relating to the contract for the installation of internet and intranet connections.

Recommendation 39 (Significant)

- (a) *IRESKO should put in place an accrual system of accounting.*
- (b) *IRESKO should reconfigure the software to meet the needs of the Program.*
- (c) *IRESKO should comply with the procurement policies.*

Programmatic aspects

165. The problem of HIV does not concern the health sector alone. There are important aspects that need the contribution of the whole society. The two main aspects of prevention of new HIV infections and care for those affected (e.g. children of infected persons) by the infection need to be taken care of by groups outside the health sector. Two major components of the programs contribute to prevention and care are partly financed through the National AIDS Control Program but an essential part is financed directly through the support of CARE acting as PR for channeling funds through civil society structures.

166. The component supported through the PNLS was also implemented through NGOs and CBOs active at the community level. They were taking care of orphans and Vulnerable Conditions (OVC). The estimated number of OVC needing assistance for 2007 was between 230,000 and 390,000. HIV infected persons in difficult conditions were also able to get support, if they were poor, unable to take care of themselves and unable to contribute to their laboratory costs which is essential for treatment with ARV. The support of OVC organized by the CNLS through NGOs, CBOs and social services of other government structures supported over 30,000 children through 5 major service packages covering aspects of schooling, nutrition, psycho-social support, medical support and legal support. The intervention was suspended at the end of 2008 for financial reasons.

167. The direct financial support of the Global Fund to civil society was mainly provided through a program with CARE. Local NGOs and CBOs. The major objective of

their support was to strengthen civil society (NGO) capacities for project implementation.

Identification of implementers

168. After an initial phase of training NGOs and CBOs in the preparation of project proposals, a call for proposals was launched in 2005. It resulted in the submission of 700 proposals from civil society. In a transparent process the proposals were screened and 55 CSOs were retained. Most of them are still ongoing.

169. An extensive manual clearly describing all steps from the project submission through the selection process until project implementation and reporting procedures was prepared by CARE.

170. There were major delays in implementing projects due to the weak management capacity of the NGOs and CBOs. In spite of preparation and clearly structured administrative steps many organizations could not meet the laid down criteria. Much support for the organizations is still needed during the whole implementation process. It was common to find projects implementing their activities long after their originally planned support phase had already ended.

171. The supervision of CARE during the implementation period was considered insufficient by some of the implementing NGOs visited. This is due to the big numbers of SRs i.e. more than 60 SRs with the limited number of staff for supervision.

Recommendation 40 (Requires attention)

To maintain good performance, CARE should undertake more regular monitoring visits of its SRs.

Involvement of CARE in for Round 9 proposal preparation

172. CARE contributed to the preparation of Round 9 submissions and was a prospective PR. This created tensions with other NGOs (mainly those representing PL WHA) which felt that this put CARE in a more favorable position in the process. CARE's involvement in the preparation of the Round 9 submission created a potential conflict of interest.

Recommendation 41 (Significant)

The CCM should develop guidelines for the process of identifying PRs. These should cover how the conflict of interest arising from prospective PRs being involved in proposal writing will be addressed. . The CCM Guidelines and minimum eligibility requirements currently address the issue of mitigating conflict of interest within the CCM specifically the role of CCM Chair and Vice Chair in relation to PR selection, PR renewal for Phase 2, reprogramming of grant funds and decisions that have a financial

impact on the PR. These should be taken into account in the CCMs conflict of interest policy and any related guidelines.

VIII. Disease-Specific Systems that Support Program Implementation

Procurement and supply management

173. The scope of the audit was aimed at PSM activities to Global Fund grant programs being implemented by the PR covering the three national disease control program divisions of the Ministry of Public Health, namely the National Committee to fight AIDS (CNLS), the National Malaria Control Program (PNLP) and the National Tuberculosis Control Program (NPLT). Procurement of medicines for the first two programs (Global Fund funded) is centralized and carried out by CENAME whereas the national TB program has outsourced procurement of pharmaceuticals to the GDF in Geneva (non Global Fund). Health supplies are procured by the three disease programs themselves (Global Fund).

174. In addition to observing PSM practices, testing systems, reviewing procurement documentation provided by the offices and conducting face to face discussions with executives at CENAME, the CAPR central and disease program officials in Yaoundé, visits were carried out to PR CARE and development partners. During one-week field visits the regional stores (CAPR), health facilities and CARE sub-recipients in 2 selected provinces were visited.

Context of PSM Cameroon

Pharmaceuticals

Pharmaceuticals required for implementation of the Global Fund HIV/AIDS grants (i.e. ARVs, OI/STI drugs and the Global Fund Malaria grants (ACTs and SP tablets for IPT) are procured through the National Essential Drugs Procurement System (SYNAME) to which CENAME is central. Accordingly, a formal Tender Board is instituted in the CENAME by the Office of the Prime Minister.

175. CENAME was set up in 1996 as a tri-partite body by the Government of Cameroon, the Government of Belgium, and the European Union (signed on 21 June 1996). It officially became a parastatal ('Etablissement Public Administratif de forme particulière') by presidential decree in 2005. CENAME became the sole organisation in the national procurement and supply system for essential drugs and diagnostic (lab) supplies to the 10 government owned 'Centres d'Approvisionnement Pharmaceutiques Régionaux' (CAPRs) and the larger hospitals at central and regional levels. SYNAME is the agency which manages the procurement and storage of vaccines for the national immunization program and donor funded medicines by CENAME and through its regional warehouse in Ngaoundéré and the CAPRs, ensures the continuity of supply to the periphery where services are provided.

176. The Prime Minister appoints the Chair of the Tender Board for the Procurement of Pharmaceuticals in CENAME for 2 years. Other members include a representative of the Ministry of Health and two representatives from CENAME. The procedure is formally described by CENAME in the Procurement Manual

Other Health and Non-Health Supplies

Health supplies are procured by the PRs following the Public Market Code. The Code, requiring competitive bidding, is managed by the Agency for Regulation of Public Markets. Public procurement listings are published in *Cameroon Tribune* (the governmental daily newspaper) and in the Journal of the public Contract Regulatory Agency.

177. The PRs under Global Fund grants assume the responsibility of procurement and distribution of all non-pharmaceuticals i.e. health supplies such as bed nets, insecticide for (re-) impregnation of bed nets, microscopes and other laboratory equipment and non-health goods (i.e. vehicles, bicycles, computers etc.) required for program implementation. All procurement activities by the PRs in this category using public funds are governed by the Public Market Code which, for grant implementation, is operationalized through the 'Comité Spécial pour la Passation des Marchés/Fonds Mondial' (CSPM/FM) under supervision of the Prime Ministers office. The contracted suppliers deliver health goods procured through international and national tendering (or direct purchase provided it is authorized by the Prime Minister), directly to the recipients in the provinces for further distribution to the districts.

178. The Comité Spécial pour la Passation des Marchés/Fonds Mondial (CSPM/FM) consists of seven members representing the Public Contract Regulatory Authority (ARMP), the Ministry of Finance and the Ministry of Public Health, and a secretary. The Chair is appointed from among its members. Additional expertise if required is added to technical sub commissions, which carry out administrative and technical evaluation of bids. Tender processes, amendments and negotiations are monitored and reported separately by an independent observer (that is, a private sector consultant appointed by the Prime Minister and a regulatory board.

Findings and recommendations

Product selection

Product selection for HIV/AIDS is adequately done although the line between the first and second line protocols is becoming blurred. The OIG observed that it would be helpful to streamline donor funding from different sources over the different treatment and prevention protocols and use a tracer code for the Global Fund in the procurement and supply management systems at different levels.

Product selection for malaria is currently being debated given that the choice of ACT in the Malaria grants is not well tolerated. Patients are therefore diverting to other ACTs available in the market, notably the artemether-lumefantrine (AL) combination. The recent switch in selection from co-pack to co-formulation needs to be rolled out firmly with vigilance and appropriate training of health cadre on rational drugs use to stop confusion about the preferred medicine to be used in the first line treatment of uncomplicated malaria. Alternatively the choice of ACT should be re-considered. There is also a need to standardize product codes and descriptions between the central procurement, and regional levels and recipients in the periphery.

For all pharmaceutical procurement an appropriate inventory management system that is able to link data from different levels efficiently and generate customized reports of standard data periodically should be given serious attention.

179. Cameroon has been a member of WTO since 1995. There are no immediate barriers in patent laws to buying and using generic versions of medicines. Product selection should in principle be matched to generic products that can be fully analysed by a Quality Control Laboratory (i.e. LANACOME or another qualified contract laboratory) using traceable references and validated methods following international recognised pharmacopoeias.

HIV

180. There is in general no great concern on product selection for HIV treatment or prevention since most is consolidated in evidence based first line treatment protocols using standard tri-therapy (CNLS edition 2007, currently being updated). In practical terms the selection is limited to products officially registered by the national drug regulatory authority (DPM). This restricts registration to the products pre-qualified by the WHO or those authorized for marketing by a stringent regulated authority.

181. Treatment of HIV patients is based on defined enrolment criteria following WHO and other applicable international guidance (HAART) and more than 98% of the drugs produced are 1st line protocols⁴. This is reflected in procurement of a restricted number of ARV molecules as separate molecules combined in a therapeutic regime and, if available, in co-formulation to reduce pill burden and promote adherence. Corresponding data obtained from the CENAME in August 2009 show that there is a fair rationalisation of selected 1st line products since 2004/05. Volumes distributed have doubled since 2007. The table below shows the distribution of ARVs over the years:

⁴ Overall 97, 9 % of the total number protocols is first line and 2,1 % is second line (CNLS Annual Report 2008)

The Global Fund-financed ARVs delivered by CENAME to CAPRs		
Year	Total quantities of ARVs distributed	No of ARV's to sustain first-line protocols
2009 (ytd)	682,707	12
2008	944,662	19
2007	748,651	23
2006	451,213	25
2005	347,109	27
2004	99,212	24

Table: Rationalisation and increase in volume of ARV's since 2004, data CENAME August 2009

182. In 2009, the most prescribed (and needed) ARVs funded by the Global Fund were limited to fixed dose combination tablets: lamivudine + stavudine + nevirapine 150/30/200mg, lamivudine + zidovudine + nevirapine 150/300/200mg, lamivudine + stavudine 150/30mg, lamivudine + zidovudine 150/300mg and 'loose' products to combine separately: efavirenz 600mg capsules, efavirenz 200mg capsules, nevirapine 200mg tablets and zidovudine 300mg tablets.

183. These products are multi-source and available from multiple WHO pre-qualified sources allowing competitive procurement. The PSM plan for HIV Round 3 has a few minor inaccuracies but corresponds to these needs. The tenders issued by CENAME reflect these products plus paediatric syrups procured from 2006 to 2008. The need for loose stavudine capsules 40mg and 30mg strengths and prescribing the 40mg stavudine strength in fixed dose combinations was discouraged and consequently phased out during 2008/09.

184. The relative increase in the need for second-line treatment has become more significant over the years⁵. Second-line and paediatric treatment protocols have been supported by CHAI /UNITAID since 2007 and commitment is given for another year (until 2011). The agreement between CHAI and CNLS reduced the need to procure paediatric formulations under the program.

185. There is a small but increasing number of TDF (tenofovir) prescriptions for treatment of more complicated (1st line) cases using 2nd line supplies donated (CHAI) and for those who can afford to pay for the relative expensive proprietary products Atripla® and Truvada®. CNLS is considering including use of generic tenofovir combinations into the 1st line treatment regimes but this doesn't impact on the Global Fund funding under existing grants.

186. The Global Fund Round 5 PSM plan annex 1A (revised) lists 2 ARVs for prevention of vertical transmission of HIV: nevirapine 200mg tablets and zidovudine 300mg tablets. UNICEF funds the prevention of mother to child transmission (PMTCT) ARV program

⁵ [... as life expectancy increases due to HAART in the first line] the proportion of adults on second line treatment increased from 0,6% in 2006 to 2.0% in 2008, children from 1,6% in 2006 to 4.4% in 2008 (CNLS Annual Report 2008).

which creates an overlap with lamivudine tablets, zidovudine tablets and lamivudine+zidovudine fixed dose combination tablets funded by the Global Fund.

187. CENAME publishes an ARV catalogue (order list) that should (but does not) mention the product code so that this coding can consistently be used to update the PSM plan product lists yearly and in communication with CNLS for 6 monthly quantification/forecasting of needs per treatment protocol. The same code appears on print-outs of stock positions ('état du stock réel') but here the pack size is not indicated, Linking standard codes to items in standard pack sizes and the approved shelf lives would be a first step in building a transparent and more efficient system. The same standardisation would help provincial coordination offices (GTPs) to monitor need and the distribution/inventory control of the Global Fund funded medicines by CAPRs and Formations Sanitaires (FS). The treatment protocol codes used in the CENAME order list do not correspond to the ones in the ART registers seen in the units, which leads to confusion.

188. Management of information and calculation of quantities is mostly, if not always, done by offices using multiple MS Excel sheets of different design. This makes oversight complicated. Ideally, standardisation of product selection should be computerized between the different entities and levels. There are several software programs available specifically designed for pharmaceutical inventory management of systems consisting of a central procurement unit with provincial stock locations and major hospitals. This allows for a linkage of real-time informatics. Affordable packages exist for public and not-for profit organisations and it is strongly recommended that this is considered for the management of the Global Fund funded programs in Cameroon.

189. CENAME started using specific codes in their computerized system (Sage) to identify products supplied by CHAI or UNICEF. All items in category 11 (=ARV) without this specific _FC or _UN code are then supposed to be Global Fund funded. It is sensible to start using a Global Fund code for those products mentioned in the approved PSM plans.

190. CNLS should strictly define for each treatment protocol which donor funding applies. In that way PSM plans can subsequently be agreed and annually updated with each of the funding sources. In doing so, it is recommended to use a Global Fund tracer code in the information management system used by CENAME and standardize the CENAME product codes in communication between the central level (CENAME, CNLS) but also at provincial (CAPR) and peripheral levels (Formations Sanitaires).

Malaria

191. There is a concern on the rationale and evidence base of product selection for 1st line malaria treatment under the Global Fund grant since the OIG observed that the ACT in the PSM plan i.e. artesunate-amodiaquine (ASAQ) is less preferred/tolerated than the artemether-lumefantrine (AL) products available in the market.

192. There had been discussions at national consensus meetings and consultancies to arrive at the choice of ASAQ as first line treatment of uncomplicated malaria. The amodiaquine component in the co-blister is not well tolerated by patients causing 'fatigue' and led to irrational drug use or simply rejection of the drug prescribed in the hospital/health centre. The patients then sought treatment outside the hospital or got no treatment. A national consensus meeting in July 2008 strongly recommended stopping the use of the co-blister and adopting the ASAQ fixed-dose combination (FDC) tablet. The ASAQ FDC has a slightly lower content of amodiaquine, which is believed to promote acceptability by the patient. ASAQ FDC, which has been available at a subsidized price from CENAME since June 2009, is likely to overcome this compliance problem to an extent.

193. In some of the private sector pharmacies visited in Yaoundé, the OIG observed a wide choice of branded products at prices between FCFA 2,000 and 4,000 per treatment. From field visits to hospitals, the OIG also observed a wide availability of anti-malarials (including ACTs) for which the patients would have to pay. For instance there were adult dose treatment packs of ASAQ and large stocks of artemether injections (for severe cases) and artesunate suppositories (in Pette Hospital) but few stocks of the subsidized product (particularly children/infant doses for 1st line treatment). From discussions the OIG learnt that these age groups were for the time being mostly treated with artemether-lumefantrine syrup (Dafra) payable at 2100FCFA per treatment (Tokombere Hospital). This reality is in contrast with the objective of subsidizing ASAQ to increase availability and provide wide access to affordable effective malaria treatment to the public (plus private sector and home based care). Because the co-packaged ASAQ is not preferred, the shift to ASAQ FDC may have had a delayed impact in late 2009 and into 2010.

194. From data obtained from CENAME, the OIG noted that there is bound to be waste due to un expected expiration of existing co-blister ASAQ treatment packs at CENAME. The last ACT tender (2009) done by CENAME was only for the AL product in different strengths and the use of AL has increased rapidly in preference to the subsidized ASAQ . Even at a higher selling price the preference for AL exceeds the demand for ASAQ. In terms of the objective defined in the second National Malaria Strategic Plan 2007-2010 (to reduce malaria related morbidity/mortality by 50% in the general population) that was adopted in 2008, the OIG therefore recommends that the PNLP should reconsider the current choice of ACT for subsidy by the Global Fund.

195. The monitoring of efficacy of ASAQ occurs at a low and small-scale level by the PNLP. The OIG noted that a pharmaco-vigilance unit to monitor safety and tolerability was being set up but was not functional at the time of the audit to support the choice of ASAQ as a first line drug.

196. The National Essential Drug List provided by the DMP include the ASAQ strength referring to the co-packaged product (and the AL tablets and syrup) but contrary to

what is reported in PSM plans (Round 5 revised and phase 2 'Plan GAS corrigé LFA GMS') does not yet include the fixed dose ASAQ combination tablet.

197. At peripheral level the OIG observed confusion between the different presentations (co-packs and co-formulations) of ASAQ product. One hospital pharmacy continued to use the stock card (and name) of ASAQ co-pack (CENAME item 2ASAQ_12_10 artésunate+amodiaquine 12+12 cp nick named 'douze douze') for the newly supplied ASAQ fixed dose combination (CENAME code 2ARLU_4 arthém-luméfan 20-120 mg, 6x4). This obviously makes inaccurate monitoring of stock and consumption per item code. To better standardize the different ACTs in particular the different ASAQ presentations it is recommended to standardize the CENAME product codes between the central level (CENAME, CNLS) but also at provincial (CAPR) and peripheral levels (FS).

198. To increase the traceability of Global Fund-financed ACT supplies from CENAME to CAPRs (or private sector wholesalers) and health facilities, it is recommended to implement a Global Fund tracer code in the information management system used by CENAME.

Product selection Tuberculosis (outside Global Fund grant)

199. Anti-TB drugs are funded and procured through the GDF and cleared, stored and distributed by CENAME. However, the PR intends to use its remaining budget to procure an order of anti-TB medicines under the Global Fund grant. The choice of first-line product is rational and standardized in conformance with WHO guidelines. Second-line TB drugs are going to be procured through the GLC. The drugs procured from pre-qualified sources have not been fully evaluated by the DPM but obtained a fast track waiver status for importation.

Recommendation 42 (High)

The MOPH should:

- (a) accelerate the updating of standard treatment guidelines, essential drug lists, order list (catalogues) and the National Drug Register using standard coding and define the applicable donor funding per standard treatment protocol to avoid overlaps or gaps in procurement;*
- (b) add a Global Fund tracer code to Global Fund funded products in the central procurement management system;*
- (c) standardize the product and protocol codes between the central level (CENAME, CNLS and PNLP) but also at provincial (CAPR and GTP) and peripheral levels (FS);*
- (d) consider implementation of a computerized Inventory Management System linking the central level with the periphery for standardisation of products in the supply chain; and*
- (e) ensure that the pharmaco-vigilance mechanisms and systems are in place to closely monitor the acceptance of ASAQ .*

Quantification

Although the more recent PSM plan for the Malaria program describes in detail how overall ACT quantities are calculated, the OIG noted that the absence of a consistent and robust methodology for quantification of needs based on consumption, or morbidity or a combination of the two. Obviously, reliable inputs from the periphery are required on a routine basis for any of the methods and stock management as well as morbidity data reporting systems are currently being implemented and strengthened.

The OIG observed stock outs, overstock/expired stock and rationing of supplies in some units during the audit. Such observations do signal that the system needs to be evaluated for its efficiency/effectiveness especially where multiple sources provide funding for the same product category. Furthermore there is little being reported on how quantification works in reality when procurement and supply is based on pre-financing of stocks by the CENAME in a PULL system. A PUSH system that uses pre-defined distribution schedules with direct payments of suppliers by the PR may have to be considered to simplify and stabilize the system and avoid both stock-outs of vital drugs and overstocks/waste.

200. CENAME executes tenders for Global Fund funded medicines that are selected and quantified by the PR. As an independent entity from the government owned provincial stores, the CENAME has a business relationship with its decentralized customers (PULL: empowering the periphery to make their own decisions about what and how much to order). Ideally the stocks at central level are continuously updated based on the preferences and sales/consumption in the districts and thus supply automatically balancing market demand. This consumption method functions well in principle for the generally available essential drugs and stabilizes over the years. For the Global Fund funded supplies the CENAME procures and pays the suppliers relying on the quantification done by the programs and returns an invoice to the program for supplies delivered to the CAPRs.

201. There is little incentive for health facility staff to apply appropriate procedures to develop a well-functioning requisition (order) or PULL system. This generates consumption patterns that poorly represent the real need. With free goods there is no financial implication for the recipients and end-users and this even leads to situations where demand may be inflated easily and stock outs as well as overstock/expiry are not reported back systematically.

202. In addition, quantifying ('ordering') products from CENAME by the PR and then funding that the CAPRs do not order as estimated may put pressure on the PR to pay for what was quantified i.e. forcing active distribution of remaining stock with a short remaining shelf life to CAPRs even if the deliveries were not meeting the real need (substitutions, obsolete stocks and expiries). Conversely instructing CENAME too late about distribution or CENAME slowing down procurement because of the need to pre-

finance stocks may become a fait accompli for the customer (rationing of supplies) who then seeks other ways to obtain essential supplies or is unable to provide the required service to the patient.

ARV / Consumption

203. Quantification is performed centrally by the CNLS and forwarded to CENAME for six-monthly procurement through international tendering to WHO pre-qualified sources. Delivery of Global Fund funded supplies from CENAME to CAPRs is based on PULL and is in principle traceable (signed delivery notes). However, without regular information i.e. feedback to CENAME on actual stock levels in the provinces (other than their warehouse in Ngaoundéré) and consumption of items by the health facilities in the districts the PULL system has shortcomings as it does not provide an adequate basis for quantification of needs further next semester. The incomplete or at best irregular supervision of stocks and expiries at CAPRs and actual consumption at the health facilities (by the districts officials and GTP offices) provides inadequate assurance in itself that historical issues by CAPRs provide an accurate basis for quantification and whether this meets the actual needs in the districts.

ACT / Consumption

204. National ACT needs for treatment of uncomplicated malaria per age group are estimated by the PNLP and CENAME. Fixed margins and treatment prices were set officially by MPH in 2007 for artemether-lumefantrine (AL) and artesunate-amodiaquine (ASAQ) combination treatments in both public sector⁶ and private profit and not-for-profit sectors⁷ (last updated in June 2009 for the ASAQ fixed dose combination tablet in the public sector⁸) they are funded (partly the Global Fund and partly by CENAME) and storage capacity available, determine the quantities of ACT which can be handled per year. Actual consumption in a PULL system is predominantly influenced by the choice of ACT medicine alternatives available. Without differentiating between ACTs and disentangling distribution of different ACTs⁹, past data is unlikely to represent the real need of ASAQ in the past years. In any case a rational product selection process (see above) is a pre-condition for the quantification step in the procurement cycle.

⁶ Décision No. 036/D/MSP/CAB du **5 Février 2007** fixant dans le secteur publique les prix des combinaisons thérapeutiques à base d'artémésinine utilisée par voie orale (ASAQ co-pack 140-400FCFA/treatment, AL fdc 280-600FCFA/treatment)

⁷ Convention **03 May 2007** entre la CENAME et le secteur privé pharmaceutique sur la mise à disposition des combinaisons thérapeutiques à base d'artémésinine (ACT) subventionnées (private for profit: ASAQ co-pack 235-665FCFA/treatment, AL fdc 470-1000FCFA/treatment, private not for profit: ASAQ co-pack 175-490FCFA/treatment, AL fdc 345-735FCFA/treatment)

⁸ Décision No. 540/D/MINSANTE/CAB du **12 Juin 2009** fixant dans le secteur publique les prix des différentes présentations de la combinaison fixe d'artesunate-amodiaquine utilisées dans le prise en charge du paludisme non compliqué (ASAQ fdc 70-200FCFA/treatment)

⁹ Until 2008 when stock of AL at CENAMA was exhausted an ACT order for AL was automatically split into 85% ASAQ and 25% AL (request the Global Fund).

ARV / Morbidity

205. Where compilation of morbidity data exists (e.g. for HIV treatment protocols in UPECs and CTA's) and these are systematically managed and analysed by the GTP offices, an adequate projection of needs, in terms of treatment protocols is increasingly being made available to the program - that is, CNLS. The OIG observed such data from the GTP in the central province. The team could see how provincial data was consolidated retrospectively in an overall national report (CNLS annual report 2008).

206. Analysis of data provided by CENAME shows, for example, that issues from CENAME to CAPRs of Triomune 30 (used in more than half of the standard treatment protocols for adults) are not reconcilable with the number of cases on treatment without real time stock data of this item (and the same item at 40mg strength) at each of the CAPRs.

ACT / Morbidity

207. The PSM plan for Round 5 phase 2 (draft) calculates the following need for ACTs based on morbidity (PNLP monitoring and evaluation data 2007 and 2008):

Age group	2009	2010	2011
1-11months	705,286	1,270,043	1,493,571
1-5 years	470,191	846,696	995,714
Sub-total	1,175,476	2,116,739	2,489,285
6 - 13 years	478,418	861,511	1,013,137
plus or = 14 years	888,490	1,599,948	1,881,539
Sub-total	1,366,908	2,461,459	2,894,676

208. It continues: "...due to budgetary constraints, 20% of drugs will be acquired using HIPC funds in Years 4 and 5. This means the total drugs foreseen to be acquired [for funding by the Global Fund] in the course of [phase 2 of Round 5] will be as follows":

Age group	2009	2010	2011
1-11months	705,286	1,016,034	1,194,857
1-5 years	470,191	677,357	796,571
6 - 13 years	478,418	689,209	810,510
plus or = 14 years	888,490	1,279,958	1,505,231
TOTAL	2,542,384	3,662,558	4,307,169

209. The above means that a total quantity of more than 10 million ACT treatments using fixed dose combinations will be procured over three years while having ACTs (co-packs) in stock at CENAME. This exceeds the annual quantity possibly by a factor of 2 estimated in the original PSM plan. The LFA assessment in October 2008 for an additional request for disbursement of excess funds for new stock of ACTs under the Round 5 grant via direct procurement highlighted the irrational basis for quantification without justifying need by using reliable morbidity data even though the program said it was based on past consumption and demand consistently exceeding available supplies (only 53% of CAPRs orders were satisfied although when broken down to ASAQ and AL it appears that this is more applicable to AL than to ASAQ).

210. Quantification starts with a rationalized product selection followed by matching past consumption data (if available) with prospective morbidity patterns. The consumption data are not reliable unless systems are standardized in terms of item code and product names throughout the supply chain. Stocks within shelf life and expired/consumption/short supplies also need to be accurately recorded in health facilities on a daily basis and monitored against case loads.

211. Monitoring and evaluation systems at the regional level are crucial to supervise and compile timely overviews for analysis at central level. A central coordination unit (CFU) which was called for in PSM plans was not functional yet. In future it must systematically start collecting and analysing morbidity data, interpret unmet needs and use it to validate or adjust estimated needs per province on a quarterly basis. A final procurement list should then be drawn up by CENAME or another procurement agent twice a year taking existing stocks in the supply chain into consideration.

Recommendation 43 (High)

The PR should:

- (a) improve stock control at health facilities starting with a better standardization of product codes and names with recording lot numbers and expiry dates on stock cards and in the computer systems of the CAPRs;*
- (b) implement routine regional supervision of pharmacies (HFs) and CAPRs to enable monthly reporting by the program of stocks, overstock/expiries, deliveries and back-orders to validate the need and consumption and thus justify deliveries to each CAPR;*
- (c) in a similar routine fashion consolidate morbidity data at the central level on monthly basis as function of an effective M&E system;*
- (d) provide the Procurement Agent with the projected quantities per standard item for forecasting of procurement and inform the CAPRs on their expected orders;*
- (e) monitor actual deliveries to CAPRs against expected orders, investigate discrepancies, and if necessary adjust the next projections; and*
- (f) consider implementation of a computerized Inventory Management System linking the central level with the periphery for real time data analysis and routine reporting on movement of stocks in the supply chain to support accurate quantification and timely forecasting.*

Procurement

Procurement of pharmaceuticals is carried out by CENAME in a transparent manner with adequate technical expertise (i.e. a sufficient number of persons with suitable qualifications) using pre-qualified suppliers conforming to agreed delivery times. Documentation of international tenders for ARVs and ACTs) was found to be complete and well archived.

The Quality Control function for medicines procured by CENAME for Global Fund grants is performed by LANACOME. The methodology available was found to be limited to basic tests (identification tests wet chemistry, semi-quantitative tests for impurities and volumetric assays) capable to e.g. detect counterfeit or substandard products but insufficiently equipped to perform instrumental analysis e.g. HPLC to verify bio-equivalence or perform dissolution tests of solid oral products (tablets, capsules and powder for paediatric suspensions) supplied by generic (or innovator) sources. New equipment has however recently arrived at LANACOME.

Procurement of health goods (non-pharma) conducted via the CSPM/FM by the PR (PNLP) was more concerned about low transparency in national tendering, use of a limited number of suppliers, missing justification for award of points in evaluations, potential conflicts of interest between officials and suppliers, lengthy procedures with delays of over 12 months, lack of a reliable management information system, inefficient distribution plans (bed nets and insecticide), poorly documented receipts and inspection of goods, and lack of qualification/maintenance aspects in procurement of equipment. In consequence such procurements are unlikely to achieve value for money.

ARV

212. CENAME is technically and administratively capable of conducting international tendering of medicines from qualified sources in a transparent and competitive manner. A formal Tenders Board is in place consisting of an appropriate number of members and with proper separation of responsibilities. Price evaluation by CENAME of the past tenders show that the price of EFV600 caps reduced by 48% (in line with international trends) but the price paid for the lamivudine-zidovudine-nevirapine combination tablet increased by 3%.

213. The appropriate time to launch a tender depends on available stocks at CENAME and at CAPRs. There is however no computerization of information flows between CENAME and CAPRs to make this process transparent and efficient. A pre-finance arrangement means that stocks of ARV, quantified by CNLS, are initially paid and

owned by CENAME. During distribution of these stocks, each order and delivery to CAPR is then invoiced to the CNLS after which CENAME is paid.

214. Ideally, the entity responsible for quantification (CNLS), which is also the centre which collects and compiles all consumption data and monitors morbidity statistics from the GTPs, would need to provide finance to CENAME at time of ordering (payment of suppliers/SGS inspections) so that CENAME can do the clearing/storage and distribution as per quantification by CNLS.

215. Alternatively, CENAME would own stock but then should integrate data on consumption per item at the provincial/district level into their system to ensure timely availability of the correct product quantities without overstocking. This is done for their generic range of essential drugs.

ACT

216. At this moment, the updated PSM plan i.e. Round 5 phase 2 stated that procurement of ACTs will be outsourced to the VPP/Partnership for Supply Chain Management to bypass the delays experienced in the first phase so that CENAME can focus on receipt and distribution of supplies through the CAPRs to the district levels.

217. CENAME is capable of performing procurement of medicines. This makes the choice of VPP an option but not the first priority. Because CENAME procures their medicines through international competitive bidding and receives the goods for distribution through CAPRs to Health Facilities, it appears that the mode of financing and payment is a priority to be addressed.

Health goods

218. From documentation provided by the PNLP office, the OIG observed several weaknesses with the procurement of health goods:

- (a) Direct procurement has been preferred on several occasions to purchase health goods (bed nets). Though direct procurement or requesting quotations from a limited number of local suppliers is a possibility in the Public Market Code (provided the Prime Minister's office authorizes), it poses a risk to competitiveness and transparency in procurement.
- (b) It was not clear for specific direct procurements whether samples had been received from suppliers for evaluation of offers against specification.
- (c) Several procurement actions have been delayed for over 12 months.
- (d) Tender evaluations have not always justified the award of points to one or another bidder which is not transparent.
- (e) Documentation provided was incomplete which prevents an in depth review of procurement processes.
- (f) Receipt of supplies and inspection of goods was not well documented.

Recommendation 44 (High)

- (a) *CENAME should ensure that the pre-qualification of products is linked to the manufacturing site (i.e. not only the name of the manufacturer) for that particular product in tender specifications.*
- (b) *The MOPH should*
- *provide reliable data summaries to CENAME of stock at all 10 CAPRs including remaining shelf lives when preparing a pharmaceutical tender;*
 - *reconsider the pre-finance arrangement with CENAME i.e. transfer of funds to CENAME at time of ordering and clearance/handling, receipt and distribution of supplies by CENAME (at re-evaluated margins) and CAPRs (at re-evaluated margins); and*
 - *Accelerate the building of capacity and development of technical capability at LANACOME to perform full testing of ARVs (including OI and STI drugs) and ACTs (including SP tablets) based on a statistically sound sampling plan. LANACOME should ensure that all procurements of health products are in line with the Global Fund Quality Assurance policies.*

219. Subsequent to the OIG audit, a presidential decree was signed on 30 November 2009 to reform CENAME's structural organisation and functions. An official communication from the Prime Minister dated 10 December 2009 authorised the MOPH to deal directly with CENAME for pharmaceutical products and health products and not through the PM.

Warehousing/Storage

The OIG observed that warehouses are kept locked, clean, dry and are maintained within acceptable temperature limits (air conditioning). Stocks are placed on shelves and from the stores visited did not see damaged products due to storage conditions or handling. CAPRs operate bulk sections and picking sections to provide unidirectional flow of goods and to ensure safety of stock.

220. Available rack space at CAPR level may become an issue in the future when safety stock needs to be increased. However, expired medicines are not always segregated from stock which is not good practice.

221. At CENAME and CAPRs, rotation of stock is implemented as well as procedures for periodic stock take. However, the OIG observed a few discrepancies between physical stock and theoretical stocks. This arose from poor recording, for example entering multiple batches as one lot number. Such practices make an effective recall procedure impossible.

222. Manual stock cards were in place but some cards inspected showed irregularities or missing dates. Inventory management systems are stand-alone or based on manually kept records, which complicates exchange of information between central and regional levels. In addition, some systems are poorly computerized (for example with limited functionality or lengthy procedures to retrieve data from the system).

Recommendation 45(Significant)

The MOPH should:

- (a) strengthen physical stock control (training) and supervision of recording daily information (in/out) on stock cards including lot numbers and expiry dates;*
- (b) strengthen systems for the tracking the expiry dates of drugs;*
- (c) destroy the expired stock from the general warehouse sections; and*
- (d) consider a new more specialized software system for inventory control of pharmaceutical supplies in all CAPRs with the possibility to exchange information easily to central level and generate periodic reports (in MS Excel).*

Distribution

Distribution of supplies functions well with timely deliveries with delivery notes accompanying the consignment to the recipient. Overall the OIG noted that units are in general satisfied by the distribution system from CENAME down to the CAPRs from where they collect their orders. A few were more critical on available stock levels and rationing of some supplies.

223. A consistent service level depends heavily on the actual stock positions at the CAPRs and CENAME and thus the 6 monthly quantification exercise at central level by the programs is important. This starts with accurate recording of receipts and consumption of all items at Health Facilities level to predict monthly, 2 monthly or (remote) 6 monthly, needs and efficient inventory control of product codes, lot numbers, quantities and expiration dates by the CAPRs.

224. The OIG observed that at both CENAME and CAPRs there is more control needed on the maximum shelf lives remaining before distribution of (free) medicines. This means that minimum; maximum, reorder levels (minimum plus buffer) and order frequencies must be related to average shelf lives of products ex CENAME (after import), especially for those products with shelf lives below 3 years for instance 24 or 18 months. The OIG did not observe any of this at CAPR or facility level.

225. In order to be able to better trace the Global Fund funded supplies distributed to peripheral levels, particularly where there are multiple donors, it is recommended firstly that the Global Fund Secretariat in future call for a logo (or possibly a hologram) to be added to packaging. This requirement would need to be incorporated in product specifications issued by procurement agents.

226. The OIG observed that delivery notes for ACT and ARV medicines ex CENAME were usually reconcilable with receipts in the CAPR system at provincial level; some hard copies may have been misplaced (CAPR Littoral) and the OIG noted a few small errors in entries which were resolved/explained (CAPR Extreme North). The collection of medicines from CAPR by Health Facilities was not always documented well by the hospital/health centres e.g. hand-written on the 'bon de commande' and often the quantities issued by CAPR were below the quantities requested (function of stock position). Rationing supplies can lead to inflating of need by hospitals but most likely short supplies resulting in unmet needs and eventually forcing hospitals to look for other sources and to charge fees to patients or deny services to them

227. The table below shows the yearly statistics of all ARV's distributed to CAPRs and the central hospitals. The data filtered for First-line standard protocols only are shown in the second table. Given the increase in case loads, the decreasing trend of the number of deliveries from 2005 to 2006, with a peaking demand in 2007 and again a decrease to 2008/09 signals that the supply chain has developed in the right direction i.e. more stable (less number of products, higher quantities) to adequately meet the increase in need/consumption covering the standard 1st line treatment protocols. The drawback is, however, that per product/shelf-life an optimum must be reached to avoid over supply, risk of leakage or waste due to expiry with subsequent stocks outs and emergency ordering in unanticipated crises.

	(all Global Fund ARV) i.e. except FC and UN or other coded product	(all Global Fund ARV) i.e. except FC and UN or other coded product
Year	Number of deliveries	Sum of quantities delivered
2009 (ytd)	710	687,707
2008	1,645	950,884
2007	1,926	750,165
2006	1,585	451,213
2005	1,900	347,109
2004	1,668	99,212

Table Deliveries to CAPRs since 2004 (all protocols) Data CENAME August 2009

Protocol	1st line protocols only	1st line protocols only
Year	Number of deliveries	Sum of quantities delivered
2009 (ytd)	356	332,346
2008	470	376,450
2007	511	186,982
2006	347	92,084
2005	460	62,663
2004	375	16,818

Table Deliveries to CAPRs since 2004 (1st line protocols only) Data CENAME August 2009

228. The OIG observed expired drugs during field trips in the Littoral province and the Extreme-North province. Some of the cases involved products donated by CHAI (e.g. efavirenz suspension) but a number of cases were traceable to lot numbers of drugs invoiced to the Global Fund: Product code 11LAMI10, lot number G70652 observed in CAPR Littoral; stock 772 bottles expired in May 2009 but was not removed from the store for either destruction or return to CENAME. This batch was delivered by CENAME late 2007 and during 2008 to CAPR LT (and several other CAPRs) but clearly exceeded the actual demand in Littoral province.

229. The explanation given was that the same product in a larger pack size (240ml bottle, donated by CHAI) was preferred and made this item obsolete. A quantity of 50 bottles of the same product batch was distributed to CAPR Extreme North in February 2009 with a short remaining shelf life of about 2-3 months only (facture FAAN000346 date 3 February).

230. Another case observed (and stock photographed: IMG_3058.jpg) in CAPR-LT concerned drugs with an extremely short shelf life remaining being distributed in large quantities from CENAME to the province in or just before February 2008 with the tablets due to expire in March 2008, i.e. 1 month later (item code 11LAMId4T40, lot number 1631132 and 1635641; quantities 1730, 103 and 91, facture FAAR001437 and - 1438). This fixed dose combination tablet manufactured by Ranbaxy was delivered to CENAME in or just before May 2007 (9,720 packs).

231. During field visits, the OIG was able to buy ARVs with Global Fund batch numbers in Yaoundé and Doula. The program coordinator had similar experiences.

Recommendation 46 (Requires attention)

The MOPH should:

- (a) plan for expansion of storage space at regional levels;*
- (b) implement a more strict control on remaining shelf lives (removal for destruction or documented return to CENAME); and*
- (c) consider implementing specialized software at CAPRs for better inventory control.*

Recommendation 47 (Significant)

The MOPH should investigate how ARVs had leaked into the private market and strengthen control over stocks.

Procurement of bed nets

232. The OIG observed that there were serious shortcoming in bed nets procurement and distribution by the PNLP in particular that the bed nets were funded by various donors of bed nets for the following:

- (a) *Absence of monitoring mechanism:* The PNLP did not maintain an updated monitoring system of bed nets procured, distributed and in stock. Furthermore, there was no control and monitoring of bed nets funded by various donors. In the absence of this monitoring, there was no assurance that bed nets procured, distributed and available in stock had been reconciled with the total bed nets procured or funded by various donors. Due to non availability of some data, the OIG could not reconcile the quantity of bed nets procured with the distribution list provided by PNLP.
- (b) *Non-competitive procurement and unrealistic bed net procurement forecast.* From the list of payments to the supplier related to the bed nets procured, the OIG indentified 22 procurement contracts for 2, 068, 000 bed nets (including LLINs). The OIG found that among the 22 contracts issued, six were issued without competitive or direct procurement to local suppliers. The PR explained that the reason for this was urgency to meet the distribution campaign. Another example of bad forecasts is illustrated by another case in Doula. Five contracts were issued by the PR stating that in total 359,000 bed nets would be delivered by contractors to the GTP of the Littoral (Douala) and the delivery cost was included in the price stated in the contract. However, the 166,000 bed nets were sent to other regions involving an additional transportation cost e.g. Contract 206/M/MSP/CAB/CTPS/05 established to purchase and to deliver 96,000 bed nets to the GTP in Doula for a total amount of FCFA 201,696,000 equivalent to US\$460,439; those bed nets were then sent the GTP in Extreme North region (Ngaoundéré) with an additional transportation cost of FCFA4, 259,215, equivalent to US9, 724.
- (c) *Non-competitive procurement process.* 14 bed nets procurements were undertaken following an international bidding process. However, the OIG observed that even though the tender was called an international tender, the advertisements were only issued in local newspapers. This resulted in selecting suppliers mainly from local companies and did not include the international suppliers or producers. Furthermore, the procurement processes were not transparent and did not guarantee a better quality and price. However, the OIG noted that the two recent procurements were correctly done.
- (d) *Delivery notes did not represent the real situation and the inspection of the quantity and the quality of bed nets was delayed:*
 - (i) Long delay of quality and quantity inspection, e.g. Contract 207/M/MSP/CAB/CTPS/05, 27,000 bed nets delivered in 17/01/2006 and 78,000 delivered in 17/07/2006. However the inspection was done only in 11/08/2006 or seven months after the first delivery.
 - (ii) Delivery note prepared did not represent the actual delivery location. e.g. Contract 0007/M/MSP/CAB/CTPS/05 to purchase 46,000 bed nets and delivered in three locations. These were 6,000 bed nets to Ngaoundéré, 25,000 bed nets to Maroua and 15,000 bed nets to Garoua.

However, only one delivery note was issued in Yaoundé, for the whole quantity. Therefore there was no assurance that these bed nets were actually delivered to the intended locations.

- (e) The contract was signed after order was in place. The OIG observed that the Malaria program had requested one supplier to ship 187,500 LLINs to the Extreme North region. However while this request was initiated in July 2009, OIG observed by October 2009 the contract had still not been signed by the PNLP, even though the contract had been signed by the supplier on 31 August 2009. This procurement again was done by direct procurement. From the letter of authorization request dated 9 March 2009 sent to the Prime Minister requesting his approval to go through direct procurement, the reason given was that the normal procurement process takes too long. However until the end of October no contract was issued and also no LLINs had been delivered by the supplier. The letter sent to the Prime Minister erroneously stated that this procurement was recommended by the LFA which was disputed by the LFA.
- (f) During its visit to Douala, the OIG noted that 50,000 non impregnated nets had been procured in May 2006 (contract 0030/M/MSP/CSPM/FM/06) through direct procurement for urgent reasons. The bed nets had not been distributed and 8,000 of these have been stolen. According to PNLP, they were not distributed because of non availability of funds for the impregnation.

Recommendation 48 (High)

The MOPH should

- (a) *set up a mechanism to maintain a transparent recording process for bed nets from various donors. This system should include and not be limited to: contract number, donor, name of the suppliers, bed nets specifications, amount paid, quantity, delivery date, location of distribution, etc.*
- (b) *establish a procurement plan. This should be in line with the work plan as agreed in the PSM plan and should also record all procurements done during the previous periods.*
- (c) *ensure that each procurement is in line with Global Fund policy i.e. transparent and competitive processes should be followed and value for money should be considered. International tenders should be properly advertised to ensure the coverage of each supplier and value for money.*
- (d) *ensure that for each delivery, the supplier issues one delivery note and each delivery note should be signed by both supplier and the recipient.*
- (e) *ensure that the inspection commission checks the quantity and the quality of the product. This should be done in a timely manner to prevent delays in program implementation.*

Monitoring and Evaluation

M&E Plans

233. For all three diseases, a plan for the M&E was prepared and for Malaria the plan was reviewed in 2009. The structure for all M&E activities follows the same concept. All data are collected at the periphery in different health structures. The Malaria program has the broadest access to over 1300 health facilities for the collection of their data, the HIV program has 166 treatment facilities reporting on ARV treatment and the TB program gets their information from 207 diagnostic and treatment centres.

234. The main objective of the data collection as it is implemented now is to satisfy the information needs of the Global Fund. For the 3 diseases supported by the Global Fund there is no other structure in the health sector collecting data.

235. The data collected at the peripheral health structure are reported to the district health services and from there to the regional health group. The experts for each disease in the regional health group are reporting the data to the corresponding Central Technical Group of the program. The incoming data are compiled at all levels. The final processing of the data is done at the central level. The results are shared with the MOPH.

Indicators

236. The indicators of the program proposals funded by the Global Fund are the basis for the preparation of the indicators for the Monitoring and Evaluation (M&E) plans. The majority of the indicators for the HIV/AIDS component of the Round 3 proposal are performance indicators. Only two impact indicators had been selected for the Round 5 proposal for HIV/AIDS. The other program components (Malaria and TB) as well as the civil society support have up to two impact indicators others are performance indicators.

237. Of the 12 selected impact/outcome indicators in all six project components, information is only available for the two indicators in the TB program. Data on these is easily collected through the program and gives valid information concerning the target population. The indicators for the other programs need adaptation and clearer specification concerning the target population.

HIV Indicators

238. The collection of information for the first impact indicator, “% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures)”, is done and its development can be followed up, because nearly all children and adult patients under treatment are known to the project and are followed up. If the drop out rate remains low, the indicator shows good progress of the program concerning survival of persons under treatment.

239. The second impact indicator, “% of infants born to HIV infected mothers who are infected”, is only valid for mothers accepting to be tested or mothers with a known HIV status and participating in the Prevention of Mother to Child Prevention component of the program. The indicator is therefore not valid for the whole population of newborns in Cameroon.

240. The third impact indicator, “% of HIV sero-prevalence among all newly registered TB patients”, is also only valid for the patients accepting to be tested and cannot be taken as representative of all TB patients. The confidentiality level for the indicator is improving with the acceptance level among the TB patients increasing for HIV testing, which in some health facilities has reached to over 80%.

Malaria Indicators

241. The first impact indicator of Round 3, “% of malaria related deaths among children under 5”, can only be collected for the children treated in a health facility reporting to the project or visited through health staff collaborating with the malaria program and reporting to it. Children not getting in contact with the health facilities and dying at home are not considered. It can however be collected through a population survey. However since such surveys have not taken place, no results can be reported on this indicator.

242. The second impact indicator, “Malaria specific maternal mortality rate”, can only be defined for pregnant women coming to the health facilities and indicating their pregnancy. Even if a mother dies in a health facility it is not easy to associate the reason for her death clearly to a malaria infection because death is often a consequence of a number of different diseases. Therefore it is even in health structures not easy to calculate a malaria specific mortality rate. Pregnant women not indicating or not aware of their pregnancy and women not coming to the health sector are left out in the calculation, and therefore the indicator not valid for all pregnant women. It is also difficult to measure because malaria confirmation is not systematic in high endemic countries like Cameroon. However, this too can be obtained through a population survey. Such a survey has not taken place.

243. The second impact indicator of Round 3 and the first impact indicator of Round 5, “Malaria case fatality rate”, can only be calculated for patients treated in a health facility reporting to the project or if they are visited through health staff collaborating with the malaria program and reporting to it, and if the patient stays in the health facility or is followed up after leaving the health facility. As mentioned before the identification of causes for death is difficult because a range of other diseases or a combination of conditions found in different diseases may be responsible for the death of a patient. The indicator found in the program is not valid for the general population in the country.

TB indicators

244. The impact indicators for the TB program, “TB case detection” and “Treatment success rate”, are indicators for which the information is collected through the program. They are precise and give a clear feed back of the achievements of the program. The first indicator needs a clarification indicating the relationship with the number of expected cases in the target population, as the relationship to the actual existing infection of the covered population is essentially influencing the value of the indicator. It is easier to detect TB cases in a population with a high infection rate rather than finding a TB patent in a population with a low infection rate.

245. The information for the two impact indicators for TB is collected through the project. They give clear information on the number of TB cases detected and the treatment success for the patients accepting treatment.

Civil Society Indicators

246. The results of the first impact indicator for the civil society support, “% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to2, 3, 5 years as program matures)”, are not collected through the program. They are only valid if the target population corresponds to the population covered through the HIV project (see above) is collecting data for the same indicator.

247. The information needed for the second impact indicator for the civil society support, “% of young woman and man aged 15-24 who are HIV infected”, is not collected by the program and is not available through the actual existing surveillance system. The data used as a baseline are taken from the last and only representative survey for the target group collected in 2004 in the DHS. There is no recent sentinel surveillance survey for the country.

248. The information needed to cover the outcome indicator for the civil society support, “% of young people aged 15-24 reporting the use of a condom the last time they had sex with a non regular sex partner”, is not collected through the projects supported. To confirm the results of the outcome indicator a representative study or a second generation sentinel surveillance for the target group would be needed. This study is not planned and the existing surveillance structures are not capturing second generation sentinel surveillance for the general population.

Performance indicators for all proposals

249. The remaining indicators for all three components HIV/AIDS, Malaria and TB are performance indicators looking for numbers or cumulative numbers of activities done, people trained or supported, persons reached with an intervention (e.g. counselling, diagnostic, treatment), facilities rehabilitated or equipped. No quality aspect of the interventions is expressed in the indicators.

250. The assumptions for the set targets are based on existing information from reliable sources. The targets set correspond directly to the indicators given by the program, and the work plans are related to the proposed indicators.

251. Through the regular reporting from the different levels and through the production of quarterly reports at the central level the M&E framework shows up the extent to which the target objectives were reached.

252. The reporting of the civil society component provides the same information in their quarterly reports showing the extent to which the objectives were reached.

Recommendation 49 (High)

- (a) *The MOPH should review its impact indicators with the view of developing more appropriate indicators, for which the information can be produced and controlled by the project, or which are available in the country from a reliable source. They have to indicate clearly for which target group they are valid.*
- (b) *The performance indicators usually expressed in numbers or percentage achieved, should include a quality component. (e.g. an indicator for the training of people in the information technology could include the program on which the persons are trained and the level up to which they need to be qualified at the end of the training. This level can be shown through successful test participation.)*

Administrative structures concerning M& E

The Principal Recipient's technical Secretariat

253. The Secretariat of the Principal Recipient (PR) is the direct link between the MOPH and the three programs (HIV/AIDS, Malaria, Tuberculosis) supported by the Global Fund. The functions in monitoring and evaluation are an important task taken care of by the PR Secretariat. The secretariat organizes regular coordination meetings with all three programs.

254. A closer collaboration for “developing synergies among all participating structures” for the implementing at the community level is needed. The option to develop a common approach to have access to the people at the community level is one essential option. Until now, all three components have had their own approaches in parallel to reach the target population at the community level.

Recommendation 50 (Significant)

The MoPH should strengthen collaboration for all three of the Global Fund supported programs at the community level in order to reach the target population .

Coordination and Follow up Unit (CFU).

255. The CFU is not just a linking structure between the MOPH and the three programs but it is part of the health system. In the framework of the implementation of the Global Fund activities, the MOPH put in place a Coordination and Follow up Unit (CFU). The Coordination and Follow up unit has two services: the Administrative, Financial and Logistic Coordination Service, and the Monitoring and Evaluation Service. The CFU receives all the reports from the programs concerned - that is, HIV/AIDS, Tuberculosis, and Malaria. The CFU works in close collaboration with the M&E unit of each program and they together decide on what indicator to collect for the follow up of activities programmed.

256. The Terms of Reference of the CFU M&E unit are:

- (a) Ensure coordination of the M&E activities of the three programs;
- (b) Establish and follow up performance contract with different actors; and
- (c) Ensure a link between the Principal Recipient and Programs for activities of the project.

257. The OIG could not confirm from the audit that there was collaboration between the Global Fund programs and other structures of the MOPH. During the site visit of the audit team and the discussions with different units of the MOPH responsible for data collection and processing, the OIG found that none was collaborating with the CFU. There were two main units dealing with issues of data reporting and processing. The monitoring body under the General Secretary of the MOPH and the health information body under the project and study division. They are in charge of collecting and processing data for the MOPH. Neither unit knew about the activities and data produced by the programs of the Global Fund. The intended purpose of the CFU is therefore not being met.

258. The restructuring of the MOPH following the 2010 - 2015 Health Sector Strategy should be used as an entry point to initiate more appropriate and effective coordination among relevant units at the MOPH and the programs supported by the Global Fund.

Recommendation 51 (Significant)

The MOPH should:

- (a) *Initiate and maintain close collaboration between specific units in the MOPH with the structures of the Global Fund funded programs to prepare the way for sustainability of the project activities after external funding has run out.*
- (b) *Provide capacity building support to those units in MOPH that will subsequently assume the functions of the Global Fund funded programs.*
- (c) *Review structures of the MOPH and of the Global Fund programs to prevent the development of parallel structures in MOPH and the programs supported by the Global Fund.*

Data collection and processing

259. The need for data to satisfy the indicators given by the Global Fund was the main reason for developing the M&E system for the three diseases HIV/AIDS, Malaria and TB. The collected data therefore supports the reports to the Global Fund.

260. The three disease programs are the main collectors of data in the health sector. They adapted the existing infrastructure at the peripheral, district and regional level and the capacity at those levels to collect data and process it appropriately to meet the reporting requirements of the Global Fund.

261. A structure within the MOPH to collect data from the peripheral is rudimentary. There are investigation capacities at the MOPH level to follow reported cases on some infectious diseases. The Health Information and Management System (HIMS) under the responsibility of a small unit Health Information body in the “projects and study division is not staffed and equipped to implement broad and regular collection of data for many different health issues. This unit has developed a project proposal showing the intended structure of a future data collection system within the MOPH. In a first effort the group has reviewed all forms for data collection and combined them. Those forms are not yet in use.

Recommendation 52 (Significant)

A closer collaboration and support to the structures of the MOPH in charge of data collection and processing is recommended, to prepare the structures to take over the program activities if external funding runs out.

Data quality assurance (Supervision)

262. Supervision is the major element of the data quality assurance and it is supposed to be regularly done. The central level should supervise all structures at the regional level at least two times a year. The regional level should supervise the district level at least four times a year, and the district should supervise their corresponding health units monthly.

263. All programs in the four regions supervised were asked to prepare a list of supervision visits since their interventions started. On the basis of the information received the regularity and coverage of the supervisory visits was reviewed as far as it was practical. The information came in late and not for the requested period. The number of reported supervisory visits for 2009 was lower than planned.

264. The review of the samples of the supervision reports showed they were of acceptable quality. The supervisors identified weaknesses and discussed them on the spot with the concerned persons. After the supervisory visit a list of recommendations was prepared. Some of the recommendations were followed up during the next supervision. This follow up was not standard and some results were not always mentioned in the next supervision report. Many of the proposed recommendations in

the reports were not specific and the time frame in which the problems were to be solved was missing.

265. The analysis of the reported supervision missions shows the most important weakness in the M&E system of all programs. The following essential points were observed:

- (a) The number of the planned supervisory visits did not correspond to the number of implemented supervisory visits in most programs;
- (b) The time lag between the supervisory visits i.e. three or six months was often not respected; and
- (c) Some facilities were not visited during each planned supervision period.

The main argument to excuse the shortcoming was the non availability of funds.

266. Among all programs the M&E activities were best followed in the Tuberculosis control programs. With their clear structure and limited number of aspects to check their supervisory visits were the easiest to implement. But even in this component it was not possible to undertake all supervisory visits planned. Here also the insufficient funding was given as the reason for not undertaking all planned supervisory visits.

267. The Malaria control program has a large number of facilities to be supervised. This is coupled with the length of the form that needs to be completed which suggests that a lot of time needs to be spent on supervision visits.

268. The HIV/AIDS component has the largest number of activities to be supervised (Treatment, PMTCT, care of orphans and persons living with HIV). The activities of those different groups cannot be covered in one supervision mission. Therefore, specific supervision missions are needed (as it is already done in some regions) to assess the different components of the program. For these supervision missions, sufficient qualified staff and funds are needed.

269. The Global Fund recommends that 5-10% of the grant funding is used on M&E. The PR is therefore responsible for allocation of an appropriate budget for M&E activities. The funds are available for strengthening the overall M&E system in terms of capacity, skills, tools etc. The funds can also be used to cover supervision but this should not be the primary purpose for the M&E funds set aside.

Recommendation 53 (High)

The importance of M&E in quality assurance of programs should be emphasized. The budgets for M&E should be reviewed and the administrative processes adapted to enable the program to undertake all planned supervisory visits.

Program reporting

270. The reporting structure and the content transmitted are designed to meet the requirements of the Global Fund. The reports correspond to the information and data

collected in line with the given periods for reporting. There are sometimes delays in the transmission of information from some health facilities in the covered area. The delays were caused by the inaccessibility to health facilities due to the rainy season etc.

Staff resources

271. There is a general lack of qualified staff in all three programs. In the treatment centres for the HIV patients the workload is seen as the major challenge. The number of patients eligible for treatment is growing rapidly as a consequence of the MOPH decision to provide ARVs free of cost (since May 2007) and to subsidize laboratory costs for test. However, the staff numbers are not increasing in proportion to the workload. This has led to high staff turnover.

272. The psychological stress for the staff working with patients suffering stigmatization was expressed as another challenge. There is no psychological support provided to staff members who work with these patients. All those conditions are contributing to the high staff turnover in the treatment facilities for HIV patients.

IX Oversight

Background

273. The Global Fund's fiduciary arrangements for grant recipients are comprised of Principal Recipients (PRs) and sub-recipients (SRs) implementing the programs. The implementers are overseen by a Country Coordinating Mechanism (CCM). A Local Fund Agent (LFA) provides assurance on programs to the Global Fund Secretariat on the implementation of grant programs. These fiduciary arrangements place reliance on effective oversight arrangements.

274. The entities responsible for oversight of Global Fund grant programs are:

- (a) Country Coordinating Mechanism (CCM);
- (b) Principal Recipients (PRs) over Sub-recipients (SRs);
- (c) Local Fund Agent (LFA); and
- (d) Global Fund Secretariat.

Country Coordination Mechanism

275. As per the Global Fund policy, the CCM:

- (a) coordinates the development of grant proposals to the Global Fund based on priority needs at the national level;
- (b) Selects one or more appropriate organization(s) to act as the Principal Recipient(s) (PR) for the Global Fund grant;
- (c) Monitors the implementation of activities under Global Fund approved programs, including approving major changes in implementation plans as necessary;
- (d) Evaluates the performance of these programs, including of PRs in implementing a program, and submits a request for continued funding prior to the end of the two years of initially approved financing from the Global Fund; and
- (e) Ensure linkages and consistency between Global Fund assistance and other development and health assistance programs in support of national priorities, such as PRS or SWAPs.

276. The Cameroon CCM was chaired by a member of the Office of the President of the Republic of Cameroon. The Cameroon CCM is comprised of 50 members with voting power and 5 members who are observers. This represented 2 % (1) from the academic or educational sector; 36% (20) from government; 13% (7) from NGOs/CBOs; 4% (2) from People Living with Diseases; 4% (2) from private sectors; 9% (5) from religious/faith-based organizations; 22% (12) from multi/bilateral development partners; 2% (1) from other; and 9%(5) from observers (represented from existing PRs). Through collaboration with the in country Development Partners, Grant Management Solutions has been contracted to provide technical assistance to the CCM especially with regard to oversight.

277. The CCM has submitted proposals to the Global Fund and over US\$136 million has been committed to Cameroon to fight the three diseases. The regular meetings were funded by the MoPH budget and meetings are held regularly. These meetings bring together a wide section of national and international partners directly and indirectly engaged with the fight against the three diseases. The Cameroon CCM reform started in early 2008 with support from development partners. This resulted in the establishment of the CCM Secretariat. The development partners have continued to help the CCM even at the time of the audit with the US Government providing consultants (GMS) to review the CCM oversight function.

278. The CCM has broad representation as is required by the Global Fund. However, the government dominates the CCM having 36% representation on the CCM. The CCM also did not have a clear definition of the role of observers, especially since they are the current PRs. The CCM has been involved in the selection SRs. In the OIG's view this should be a part of a PR's roles and responsibilities. The CCM should probably determine the criteria against which SRs are selected and then provide oversight of the process.

279. The recent establishment of a CCM Secretariat to manage its daily operation has greatly improved the meeting arrangements and document distribution. However, this important function is not sustainable since it does not generate its own funds and has to make payments e.g. pay for meeting room and DSA for participants. The Global Fund allocated US\$43,000 for the CCM secretariat but this had not been received at the time of the audit. The new CCM funding policy offers an expanded funding track which could resolve CCM Secretariat financial pressures.

280. Since its inception in 2004, the CCM has not developed any manuals to guide the operations of the CCM. At the time of the audit, these documents were being drafted.

Recommendation 54 (significant)

The Cameroon CCM should:

- (a) review the current composition of the CCM members to ensure that it remains balanced in order to ensure its effectiveness and to consider reducing the total number of members;*
- (b) should complete a comprehensive manual of policies and operational procedures and have it approved and implemented;*
- (c) working groups (e.g. governance, monitoring & evaluation), and ad hoc working groups (dealing with issues that arise) should be established in a transparent and participatory way;*
- (d) ensure that all CCM members understand their roles and responsibility and establish protocol to improve a communication line among the members;*
- (e) strengthen the functioning of CCM secretariat and seek funding for this important function; and*
- (f) consider rotating the chair among the different representative groups.*

281. The OIG observed that the CCM has not been effectively discharging its oversight role. While it is evident that the CCM members are aware of this responsibility, the CCM has not yet reached a consensus on how it plans to discharge this role in the future. There are various models of oversight as practiced by different countries that the Cameroon CCM can draw on. They are available on the Global Fund website.

Recommendation 55 (Significant)

Oversight by the CCM should be strengthened. The CCM should establish, document and implement an oversight work plan that it will follow in undertaking this important function. The CCM should consider establishing a technical sub committee in order to strengthen its oversight role.

282. Pursuant to Global Fund guidelines, important roles for a CCM include applying for funding under the Rounds based channel. The CCM coordinates the country's proposal development ensuring broad-based participation through a transparent call for proposals locally; and launches a competition and transparent calls for PRs and nominates one or more to implement the grant program. The OIG observed that the writing of the proposal for Round 9 was dominated by the current PRs under MOPH and CARE International with some assistance from development partners. However, from discussion with various NGOs/CBO, there was a limited participation or input from them. One main reason given was the short time given to provide input. For example, the material for the meeting on 23 February on the Round 9 budget proposal was distributed only one day before the meeting.

283. The OIG further observed that the selection process of PRs for Round 9 was not properly run. In particular, insufficient time was given for the submission of proposals. The advertisement was run on 25 May 2009 with a deadline for submission of 26 May 2009. However, the CCM secretariat indicated that the pre-advertisement had been done over 5 days through local radio station but this still did not provide sufficient time to prepare and submit a proposal. This resulted in the selected PRs for Round 9 being the organizations that were involved in the drafting of proposals.

284. The OIG further observed that the selection process of Round 9 PRs was done by the Ad hoc Committee represented from the CCM Members. The members of the selection process committee also included the three implementing units of MoPH which constitute the current PR. There was inconsistency or non standardization in the scoring system, i.e. there was no standard minimum scores of each candidate to be considered eligible. For the HIV PR for example, one candidate was not accepted as PR since the score obtained was 71 out of 76 while on the TB program, MOPH received 72/88 and was accepted as PR while an NGO received 70/88 and was not selected as PR.

Recommendation 56 (Significant)

(a) The CCM should develop guidelines for nominating candidates to act as PRs. These should cover how cases where organizations that are involved in providing support to the proposal writing process bid as potential PRs, whether the current PRs or

SRs should participate in the selection process, etc. These guidelines should also include the conflict of interest policy and a mechanism to ensure a transparent process.

- (b) *Furthermore, the CCM secretariat should strengthen the process of writing proposals especially the need to strengthen the participation of civil society or NGOs.*

285. The CCM has not been awarded other grants since Round 5 due to major shortcomings in the proposals. The country is in dire need of the funds i.e. taking into account the country's economic situation and the increase in the numbers of patients suffering from the three diseases. For Round 8, HIV for example, the Technical Review Panel (TRP) categorized the Cameroon proposal as category 3 i.e. "not recommended for funding in its current form but encouraged to resubmit following major revision".

286. The reasons given by the TRP were:

- (a) Although the program targets the rural youth and sexual minorities, the implementation of this is not adequately addressed in the text;
- (b) Inadequate explanation of program implementation;
- (c) The complementarities and additional with the Round 4 proposal is not adequately demonstrated;
- (d) 18 million euro are allocated for support to people living with HIV/AIDS and orphans and vulnerable children without a clear indication of how this will happen;
- (e) Round 7 weaknesses cited by the TRP are not adequately addressed, including fixed government contribution, how the vulnerable groups will be targeted, building on Round 4 and the M&E framework; and
- (f) The M&E framework has some weaknesses as outcome indicators had no targets, output indicators were not focused on the vulnerable groups, and indicators in the proposal were not aligned with those in the Performance Framework.

Recommendation 57 (Significant)

- (a) *The CCM in collaboration with county development partners should address the concerns raised by the TRP. Adequate time should be allocated to the proposal writing process with stakeholders consulted.*
- (b) *The CCM should liaise with the Global Fund Secretariat to see if there is a possibility of getting technical assistance to improve the quality of proposals.*

Local Fund Agent

287. The LFA is a crucial part of the Global Fund's system of oversight and risk management. PricewaterhouseCoopers (PwC) has been Cameroon's LFA since the inception of the grants. The LFA's key roles are to:

- (a) assess the key capacities and systems of PRs before grant signing and at other stages of grants implementation;

- (b) provide independent and continuous oversight through verification of implementation by grant recipients throughout the lifetime of a grant to make recommendations to the Global Fund on disbursement amounts and adjustment to grant implementation arrangement;
- (c) carry out on-site data verification visits;
- (d) review the CCM Request for Continued Funding for Phase 2 of the grant and make a recommendation on funding for year three onwards of the grant;
- (e) provide country updates on key issues and events that impact grant implementation and pose risks to grant resources; and
- (f) carry out other services as requested by the Global Fund such as support for country visits by the Global Fund staff and consultants, grant consolidation and closure.

288. PwC Cameroon employed 18 staff including a partner, staff and external consultants dedicated to the Global Fund LFA assignment. Since 2004, the LFA has undertaken 15 assessments and verified 51 PUDRS. LFA has conducted an adequate budget reviews during the PUDRS assessments was resulting in cost saving based on information provided to the OIG.

289. The OIG noted that the Global Fund Secretariat identified weaknesses in the LFA's work as far back as 2008. The Secretariat requested the LFA to change its quality control systems in early 2009 and in September 2009, requested the LFA to reorganize its leadership in order to allow for a more active engagement on the assignment and to provide better in depth analysis.

290. The OIG observed a disconnect between the OIG findings with generally positive LFA assessments as detailed below:

- (a) Overcharging of US\$ 3.3 million by CENAME since 2007. This was not in line with the LFA statement which stated that they checked transactions in detail, increased review scope, lowered its materiality level and made extensive use of experts. The LFA informed the OIG that its sample coverage was between 75% and 100%.
- (b) The LFA was not aware of the failure to reimburse hospitals for tests undertaken for more than a year and yet this significantly affected program implementation.
- (c) There were major weaknesses identified in the bank reconciliation processes across the three programs which went undetected.
- (d) The weakness of accounting systems at the three programs was not identified by the LFA.
- (e) Some instances which related to conflict of interest issues were not reported i.e. where the owner of the accounting firm hired by the PNLP is the brother of the Head of the PNLP.
- (f) Interest on income from the banks was transferred by the CAA and has never been reported to the Global Fund.
- (g) Issues surrounding the purchase and distribution of bed nets were not identified by the LFA.

291. The OIG observed the LFA did not undertake a risk assessment as part of its work. The review of budget by the LFA was focusing on reconciling the quarterly budgets to the annual budget, and not focusing on high risk area as mentioned above. The LFA reviewed the results of the external audit of each program and included their results in the assessment report. However, the LFA did not follow up the issues raised in these reports.

Recommendation 58 (High)

As part of its assignment planning, the LFA should carry out risk assessments of the environment within which the Global Fund supported programs are being implemented. Identified risks should form the basis of detailed work undertaken.

292. The independence of the LFA is critical to the Global Fund's fiduciary oversight model; therefore, potential or actual conflict of interest is treated with the utmost seriousness. In undertaking its work the LFA should at all times demonstrate professionalism, objectivity and independence. The OIG observed that during the LFA verification or assessment, instances were noted where the LFA had been involved in the operational activities. For example, the LFA assisted PNLP in preparing its reports to the Global Fund. The LFA informed the OIG that their responsibility was to highlight areas where there were errors in the PUDR which the PRs would then correct themselves.

293. Another example is the case where the former Minister of MoPH and the three Permanent Secretaries of the Global Fund programs were arrested and the Global Fund secretariat contacted the LFA to seek assurance that there was no risk posed to Global Fund resources. The information provided by the LFA to the Global Fund was not validated. Basically, the LFA relied on a government press notice that the funds misappropriated were for the HIPC initiative. The LFA's assurance was based on quarterly verification of implementation reviews undertaken that had not unearthed any evidence of misappropriation of funds. They also related that the PR's audit reports had not revealed any misappropriation of funds. However, the purpose of the audits is not to identify fraud.

Review of LFA Assessment Reports

294. Based on a review of various LFA reports to the Global Fund Secretariat, the OIG observed some inconsistencies, which point to questionable quality of work.

- (a) In general, the LFA did not undertake a systematic follow-up of issues or risks in assessment report was missing in subsequent assessments. For example, in LFA PSM assessment in 2004, this assessment stated "...a more detailed bed net distribution plan is requested...." the OIG found that there was no follow-up of this issue and it disappeared in the subsequent assessment report.
- (b) In some cases where 'weaknesses' were indicated in broad terms and there was no further information or elaboration of the weaknesses in the main body of the

- report.
- (c) There was a lack of evidence of effective follow up of issues raised previously in reports. For example the absence of a pharmaco-vigilance system was raised in the HIV Program assessment in 2004 and this was never picked up in subsequent assessments although it remained unresolved.
 - (d) Lack of proper quality control where the 'approved' version contained errors or copy/pasted titles from other reports or financial data presented in one table using 2 different currencies .

295. Furthermore, the OIG observed that in spite of desk review reports done by experts i.e. on long distance, the pharmaceutical back-up expertise was not adequate to support the LFA in country. For example, in the assessment of product selection, different types of ACT and differences between co-packaged and co-formulated ACTs, sampling/inspection procedures, quality assurance and quality control activities in Cameroon were not adequately addressed. The risk is for example that the LFA too easily uses broad assurances such as '....proven distribution system is established (drugs) at central and provincial level into which ARVs will be incorporated...' while in reality the LFA had not assessed inventory controls in-depth. Moreover, the OIG observed that the LFA which was based in Douala had not visited the provincial warehouse CAPR in Douala to verify practices, test stock keeping, and discuss constraints with them. The LFA stated that they are forced to resort to desk reviews due the budget constraints.

Recommendation 59 (High)

- (a) *The LFA team should institute an effective quality assurance process for all reports submitted to the Global Fund. Because of the assessed high risk associated with the operations of the country, the PWC central Team in Geneva should provide an independent layer of review to the reports submitted to the Secretariat.*
- (b) *LFA should follow-up risks identified from previous assessments.*
- (c) *The LFAs work should incorporate more frequent pharmaceutical/PSM expertise reviews e.g. at least once a year at least 2 weeks to cover all procurement and supply aspects cross cutting the three disease programs.*

296. The LFA team undertook some data verification at peripheral health centers and presented the results in their reports. Some of their data quality control visits were implemented by non-expert staff. The work mainly covered the consistency of the data reported. The explanation and the recommendations about how problems should be overcome were insufficient. The inadequate qualifications in M&E of the supervising staff in the LFA prevented a clear and detailed analysis of the weakness and errors of the data reported. Moreover the M&E expert did not participate in most of the visits. Proposals for specific activities in training or support for the improvement of the quality of the data were not given. The main reason for weak data reporting was not analyzed and has not been addressed by the LFA. The LFA responded that the budget for the M&E expert was only 3.5. days per grant with which is impossible to cover all the health centres selected.

Recommendation 60 (High)

- (a) *LFAs should use their expert staff for field supervision to prepare valid and appropriate recommendations to the programs.*
- (b) *LFAs should, after supervision of the programs by their experts, follow up the implementation of the recommended interventions to the programs and report on progress in their status reports.*

Recommendation 61 (High)

The Secretariat should review the performance of this LFA drawing on the outcome of the OIG's work and seek a clear action plan on how their performance can be strengthened. Alternatively, consideration should be given to re-tendering.

Role of Development Partners

297. Development partners (US Government, UNAIDS, RBM, WHO etc.) in Cameroon have been actively involved in supporting Global Fund Programs. These contributions have had a positive impact on the programs. For example, the US Embassy provided support toward the strengthening of the M&E unit of the three programs and the CCM.

298. The Global Fund Secretariat has actively mobilized partners (that is, UNAIDS, RBM and WHO) to support PRs through the provision of technical assistance. For example, the establishment of a CCM Secretariat was supported by Partners. The Grant Management Solutions (GMS) is concluding a series of in-country visits to address the major weaknesses noted in the field of Monitoring and Evaluation, especially for the remaining two active grants managed by CNLS and PNLP. Furthermore, the RBM and its Harmonization Working Group (HWG) are very active in supporting the strengthening of the PRs capacities and management systems for the newly approved Round 9 malaria grants and Stop TB and the TB Union are playing the same role for Tuberculosis domain.

299. The Round 5 Malaria program's performance after 18 months of implementation was poor and results were not appropriately documented. RBM financed a consultancy to identify the gaps and the problems. Following Phase 2 review, the Board approved a Conditional GO after the CCM provided responses to the implementation gaps and weaknesses identified during Phase 1.

300. A joint Global Fund/UNAIDS mission visited Yaoundé in February 2009. The joint mission provided an opportunity to address CCM issues. The CCM has since improved with a new active Secretariat.

301. Two proposals were submitted in Round 8 for HIV and TB components, but were not approved by the TRP. Since several grants are coming to an end, the CCM has worked hard on Round 9 proposals and other opportunities to avoid gaps in services. However, again, the Cameroon proposal was not accepted by the TRP.

The Global Fund Secretariat

302. Since the inception of the grant, there has been a frequent change of staff within the Secretariat responsible for Cameroon. The OIG observed that staff succession was not well planned. For example, there was a lack of proper hand over of documentation related to the grants. As result, some significant information was not available within the Secretariat.

303. The OIG noted that the Secretariat did not follow up on the issues raised by the External Auditors and the LFA. There was no mechanism in place to ensure that each audit recommendation or LFA recommendation was followed up to ensure that correct action has been taken to address the risks identified.

Recommendation 62 (Significant)

- (a) The Global Fund Secretariat should establish a hand over mechanism, including a requirement to ensure that all grant documents are properly handed over.*
- (b) A standardization of filing systems within the Secretariat to ensure that a change of staff will not affect the institutional memory.*
- (c) The Country Programs team should establish a monitoring mechanism for all recommendations to strengthen the program implementation.*

Appendix 1: Global Fund Secretariat comments and responses

Global Fund Secretariat comments and response to the Report of the Audit of the Global Fund Grants in Cameroon issued by the Office of the Inspector General (OIG)

Country Audit of Global Fund Grants to Cameroon

Background

Cameroon has a population of 20 million and bears a heavy burden of diseases due to HIV, TB and Malaria.

HIV prevalence in adults is estimated at 5.1% with 540,000 people living with HIV. It is estimated that 180,000 people are in need of treatment of which 74,000 patients were receiving ART at the end of 2009. We estimate that the cost of treatment is almost equally shared between the GF and domestic funding.

Malaria is highly endemic throughout the country and accounts for some 21,000 deaths each year. TB prevalence is estimated at 195 per 100 000. During 2009, 28 000 cases were detected and initiated treatment. Multi-drug resistance (MDR) is still limited with 29 cases identified in 2009.

Cameroon is among the few countries on the continent that has relative political and social stability though there are ongoing issues of political governance and democracy. It also has a good level of qualified human resources and relatively adequate infrastructures in the health sector relative to the region.

The Global Fund has committed just over US\$271m in Cameroon of which US\$119.8m has already been disbursed. Three Round 4 grants ended on 31 December 2009. The Round 3 HIV grant is currently being continued through a Continuation of Services extension until December 2011 and two Round 5 grants (HIV and Malaria) are active until 2011.

The Board recently approved two additional proposals in Round 9 for Tuberculosis and Malaria. These will be signed over the next few months. There is no funding for HIV beyond the CoS and the country will face significant challenges with continuing critical programmes without further funding.

There is a general perception of high levels of corruption in Cameroon. The country is ranked 146 in the 2009 Transparency International Index for this indicator. With this in mind, the Secretariat welcomes this more comprehensive audit of the portfolio of our investments in Cameroon. This will enhance our oversight and also point to weaknesses requiring further attention from the Secretariat.

Overall comments on the report

As indicated in the pre-audit briefings, the Secretariat has been aware of many of the weaknesses related to financial management as well as monitoring and evaluation and procurement system weaknesses in the Cameroon portfolio. This report provides more definition and detail and will greatly assist the Secretariat in addressing these weaknesses and further reducing risk in this environment. The Secretariat has found the review at the PR level particularly useful.

Remarks on Program management issues

The report outlines the fact that in order to improve overall grant performance, the Global Fund Secretariat had mobilized Partners to support the PRs through the provision of technical assistance. As this report will eventually become public it seems useful to highlight the different areas where this support was provided by the respective development partners and Agencies.

As an example of the above, Grant Management Solutions (GMS) is conducting a series of in-country visits to address the major weaknesses noted in the field of Monitoring and Evaluation (Data collection and processing, data quality assurance), especially for the remaining two (2) active grants managed by CNLS and PNLP.

The same applies to the newly approved Rd 9 malaria grant for which RBM and its Harmonization Working Group (HWG) are already very active in order to strengthen the PRs capacities and management systems. Stop TB and the TB UNION are already playing the same role in the tuberculosis domain.

The Regional Team will continue to monitor all these on-going activities in order to ensure that the positive trends towards appropriate grant management and good performance are maintained.

The report mentions the absence of an internal audit function. The Secretariat understanding is that this function does exist: Internal Controllers are in place in the programs. Our understanding is that the issue lies more with the reporting lines of these controllers that could hamper their independency in highlighting issues and their ability to ensure the enforcement of remedial actions.

Remarks on Procurement and supply management issues

Procurement and supply management has always been one of the critical areas in the implementation of program activities in Cameroon. Still bottlenecks are mainly linked to the administrative procedures in place rather than to the capacity of the National

Essential Drugs and Medical supplies Procurement Center (CENAME) itself that is relatively functional and efficient.

As remedial actions, the Regional Team has noted that (1) a presidential decree was signed on 30 November 2009 to reform the CENAME's structural organization and functions, and (2) an official communication from the Prime Minister Office (dated 10 Dec 2009) now authorize the MOPH to directly deal with CENAME for pharmaceutical and health products (and no more through the PM).

Another major concern raised during the OIG Mission in Cameroon and clearly captured in the report, relates to a 3.3 million overcharging by CENAME to the program (CNLS) through a system of advance payment for the purchase of ARVs. The Secretariat has already addressed this issue and concluded negotiations for these overpayments to be offset against amounts owed by the PR to CENAME for orders placed. The Regional Team is monitoring that actual payments due to CENAME are deducted from the amounts invoiced to the PR for pending payments. We will be able to provide more information on progress when making our second round of comments.

Remarks on Monitoring and Evaluation issues

Some possible contradictions are seen in the report with regard to the availability of a health information system at the MoH level. On the one hand the report describes reporting mechanisms but on the other hand states that there is no system. This could require clarifications.

Recommendations are made to implement GF-specific M&E systems. Our understanding is that GF recommends the development and use of national systems with focus on national targets. It is our approach that GF-funded programs report on national results.

Appendix 2: Some good practices

Details		PR/SR
1	Existence of an accounting and administrative procedure manual	CNLS,PNLP, PNLT, CARE, IRESCO
2	Limits to approval and authorization of payments	CNLS,PNLP, PNLT
3	Improvement of control of financial reports prepared by Associations	CARE
4	Support to Associations through communication or dissemination of financial and accounting procedures.	CARE
5	Organization chart, rules for delegation of authority and job sheets are clearly defined	CNLS,PNLP, PNLT, CARE, IRESCO, CHP
6	Regular consultation of the Steering Committee prior to important decisions	CARE
7	Existence of action plans	CNLS,PNLP, PNLT, CARE, IRESCO,CHP

Country Audit of Global Fund Grants to Cameroon

Appendix 3: Recommendations and Action Plan

Recommendations	Response and Action Plan	Action taken	Completion date	Responsible	The Global Fund Secretariat Comments	The OIG Comments
Recommendation 1 (High) a). Consideration should be given to establishing an internal audit function. b). The PR should implement the recommendations from external audit reports that remain outstanding. All outstanding advances should be accounted for or recoveries sought from individuals/entities that fail to liquidate advances taken within three months of receiving the draft report. Unsupported expenditure should also be recovered.	(a) The PR has taken note of this recommendation. The procedural manual is currently being revised, and the setting up of a system of internal audit is being taken into account in it. This manual will be available in six months' time. (b) The PR has taken note of this recommendation. The following measures have already been undertaken: As regards the interest income raised by the Autonomous Amortization Fund (AAF/CAA), the latter is the main access point for Global Fund financing in Cameroon. The Global Fund accounts held there are current accounts and not deposit accounts. On 22 June 2010 the Ministry of Public Health (MoPH) submitted letter N°D 30-733 to the Director General (DG) of the CAA. This gave rise to a working session during which the DG decided to bring the problem of repayment to the attention of the next meeting of the board of directors of the CAA, due to take place in December 2010. As regards advances made to third parties, up to 33.47 % (27,374,953 CFA francs) has already been recovered out of a total amount of 81,770,000 CFA francs. Coercive	Revise the Procedures Manual	31 January 2011	ST-BP Coordinator/ FM	The Secretariat has taken note of the PR's response and will follow up its implementation.	
		To send request to the CAA General Director	Completed (22 June 2010)	MOPH and MOF		
		Awaiting the decision from the Board of CAA which will have meeting in December 2010	31 March 2011	MOPH and MOF		
		Strengthen the control over supporting document otherwise refund by the relevant party	30 June 2011	Permanent Secretary of PNLP		
		Refund the non-justify balance by the Government of Cameroon.	30 June 2011	PR		
		To finalize the terms of negotiation with consulting firm	31 March 2011	Permanent Secretary of		

Country Audit of Global Fund Grants to Cameroon

Recommendations	Response and Action Plan	Action taken	Completion date	Responsible	The Global Fund Secretariat Comments	The OIG Comments
	measures are currently being stepped up in order to force all public sector and civil society debtors to provide justification, or failing that, to repay the sums received up to the end of this year. Beyond this time limit the government undertakes to include this debt in its budget for the fiscal year 2011 with a view to a commitment to payment at the end of the second quarter, because the Finance Act 2010 did not take this expenditure into account. Regarding the non- payment of social contributions amounting to a total of 145,822,219 CFA francs between March 2005 and 2007, we dispute that this amount needs to be repaid. The matter is being negotiated with a consulting firm in order to determine definitively the amount to be paid to the National Social Insurance Fund (NSIF) within a period of 3 months.	Clarify the situation with the CNPS, final payment to be settled.	31 March 2011	PNLP Permanent Secretary of PNL		
Recommendation 2 (Significant) The PR should comply with the conditions stipulated in the grant agreement. The PR should provide a written explanation to the Global Fund about the transfer and use of funds by CAA. These funds should be refunded within three months of receiving the OIG report. In the future, the PR should seek Global Fund formal approval before using income incidental to program	As regards the interest income raised by the CAA, the latter is the main access point for Global Fund financing in Cameroon. The Global Fund accounts held there are current accounts and not deposit accounts. On 22 June 2010 the MoPH submitted letter N°D 30-733 to the Director General (DG) of the CAA. This gave rise to a working session during which the DG decided to bring the problem of repayment to the	Awaiting the decision from the Board of CAA which will have a meeting in December 2010	31 March 2011	MOPH and MOF	The Secretariat has taken note of the PR's response and will follow up its implementation. With regard to annual audit the Regional Team (RT) is carefully monitoring PR's compliance.	

Country Audit of Global Fund Grants to Cameroon

Recommendations	Response and Action Plan	Action taken	Completion date	Responsible	The Global Fund Secretariat Comments	The OIG Comments
activities. PNLP should ensure that the audit reports are submitted on time.	attention of the next meeting of the board of directors of the CAA, due to take place in December 2010. Regarding the annual audits, the National Malaria Control Programme (PNLP) undertakes to carry out these audits and to produce the reports relating to them within the timescales laid down in the donation agreement.	To conduct audits of 2010 within the deadline as per grant agreement. Audit report to be available in 30 June 2011	30 June 2011	STBP Global Fund Coordinator	2009 audit reports submission due by 30 June 2010 are delayed, and the RT has already notified the MOH that disbursement of funds is frozen until this condition is met. The PR has now indicated that the 2009 Reports will be available 4th October 2010.	
Recommendation 3 (High) The PR -MoPH should establish a mechanism to address the conflicts of interest issue. This mechanism should include the requirement for each staff member to declare on a yearly basis any potential conflict of interest which may pose a risk to the organization. Procedures should be put in place to ensure that any transactions with conflicted parties are undertaken at arm's length.	The PR has taken note of this recommendation. A policy for managing conflicts of interest has been included in the procedural manual currently being revised, which will be available within a period of six months. However, as far as the conflicts of interest noted by the OIG are concerned, we should point out that at the end of each accounting year an audit firm other than that which gave accountancy support came to certify the accounts and the activities of the PNLP. This gave all the evidentiary value to the activities of the PNLP.	Revise the procedures manual	31 January 2011	STBP Global Fund Coordinator	The RT has also taken note of the PR response and will ensure that the suggested timelines is observed.	
Recommendation 4 (High) The PR-MoPH should strengthen its monitoring of staff advances. All advances should be settled before additional advances are given. All outstanding advances should be cleared as soon as possible and	PR takes note of this recommendation. The following actions have already been undertaken: - Since these are advances given to third parties for the start up of activities, 33.47% (27,374,953 CFA	Strengthen the control over supporting document otherwise refund by the relevant parties	30 June 2011	PNLP Permanent Secretary	The Secretariat takes note of the PR response and the progress made so far. The RT will follow up for full implementation of	

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recovery should be obtained from staff who fail to liquidate their advances.	francs) of the amount of 81,770,000 CFA francs has already been recovered. - Coercive measures are being increased in order to force public and private sector debtors to justify or reimburse any amounts received up to the end of the year. If this delay is missed, the government has committed to adding this debt to its budget for the 2011 fiscal year and make final payment by the end of the second quarter of 2011, in line with the Finance Law which only allows expenses budgeted in the current financial exercise.	Refund the non-justify balance by the Government of Cameroon.	30 June 2011	PR	this recommendation.	
Recommendation 5 (High) The PR - MoPH need to ensure that physical inventory counts of nets should be undertaken periodically and physical counts reconciled with the records. Consideration should be given to having nets with unique identification features in order to reduce the risk of pilferage. The PR should provide the Global Fund Secretariat an explanation about the nets that remained unaccounted for at the time of the OIG audit.	The observations regarding the management of mosquito net inventories concerning, on the one hand, a periodic inventory count and on the other hand, the identification thereof in order to differentiate nets acquired through Global Fund financing and those acquired using other funding (PTE) are exact. The PR takes these observations into consideration and they will be followed for future orders and distribution of mosquito nets. As for the difference registered of 62,780 nets, this is an inventory of 62,800 mosquito nets purchased	Recruit statisticians in the regions to monitor data and inventory. For future procurement of bed nets, to include Global Fund Logo in bed nets	Completed Next procurements	Permanent Secretary of PNLP VPP/Global Fund	The Secretariat has taken note of the recommendation together with the response provided by the PR.	

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	<p>using funding from PPTE and not from Global Fund as indicated by procurement contract number 0121/M/MINSANTE/CPM-EIF/08 dated August 27, 2008 (attached).</p> <p>The PR takes note of the recommendation which will insure a closer monitoring of inventories and a more rational distribution of mosquito nets. This recommendation will be implemented during the next distribution campaigns. Newly recruited statisticians will, in the future, monitor mosquito netting in the regions on a quarterly basis following distribution campaigns. Monitoring and follow-up procedures are included in the new procedures manual which is currently being revised. The explanation for 62,800 (rather than 62,780) mosquito nets appears above.</p> <p>The PR regrets the lack of a logo on the mosquito nets bought which is what caused the confusion during the audit. The inclusion of a logo will therefore be a priority when placing future orders. This will, however, mean an increased cost when purchasing mosquito nets in the future</p>					
Recommendation 6 (Significant) All expenditure must be supported. All the issues noted above i.e. the	Regarding the retention of cash in a safe, there is already a safe at the GTC offices and measures will be	To provide supporting documents	Done on 2 July 2010	SP PNLP	The Secretariat has taken note of the response provided	OIG acknowledges having

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absence of purchase orders, delivery notes, supporting documents to evidence receipt by beneficiaries, invoices etc should be addressed to strengthen the internal control environment in which the programs are implemented. The balance of funds from the insurance claim reimbursement of FCFA 2,594,623 (US\$ 5,645) should be returned to the Global Fund program.	<p>taken to secure funds in the regions as per OIG recommendations. The purchase of safes for the regions will be included in the 2011 Finance Act.</p> <ul style="list-style-type: none"> - As regards the determination of a ceiling for amounts to be retained in cash, the manual which is presently being revised sets a clear ceiling for cash in hand (200,000 CFA francs) - Regarding the checking of cash on hand, this was done, as indicated by the attachments (photocopies of the year end closing for each region except the GTC because the GTC has not yet held any form of cash. - The balance of 2,594,623 CFA francs (5,645 US\$) was transferred to the PNLP's Global Fund Program. <p>The support documents for the 30,403,364 CFA francs for which the OIG is requesting information result from a selection of cash vouchers which cannot be assigned to an expense, a movement of funds or an adjustment. Support documents for the amount of 13,712,950 F CFA are for expenses incurred in relation to the above mentioned 30,403,364 CFA francs. As for the difference of 16,690,414 the explanations are: Voucher No. 001 dated 05/12/2004 from the Eastern region is an accounting entry of 2,403,650 CFA francs. This is a data entry error. This is actually a voucher for the purchase of fuel for the amount of 449,300 CFA but when it was entered</p>	Transfer fund to the Global Fund program account-PNLP.	Done 2 July 2010	SP PNLP	by the PR. The Secretariat also notes that the OIG is already reviewing some of the PR supporting documents. The RT will follow up implementation of this recommendation including transfer of funds as mentioned by the PR.	<p>received supporting documents related to this recommendation attached to the County comment and action plan.</p> <p>The review of these documents is ongoing.</p>

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	<p>an error occurred and the amount on the voucher was incorrectly entered as 2,403,650 CFA francs (voucher number 001, attached). When the error was detected on 30/06/2005, an adjustment was made to correct the cash surplus for the difference between 2,403,650 CFA francs and 449,300 CFA francs or 1,954,350 CFA francs (voucher No.50 dated 30/06/05 attached).</p> <p>Voucher number 120 dated 03/11/06 from the Western region for an amount of 4,200,000 CFA francs is a transfer of funds from the region for the Central Technical Group which was used to pre-finance a mission to Geneva to participate in the WHO Extraordinary World Assembly and to the 11th Board of Directors meeting for "Roll Back Malaria". Expenses for this trip amounted to 3,360,000 CFA francs. These funds were reimbursed to the Western region by the Central Technical Group.</p> <p>This is voucher No.48 dated 31/05/2005 for 11,403,064 CFA francs and is an adjustment made strictly for accounting purposes. This amount is not an expense but rather it is an adjustment.</p> <p>As for voucher No.80 dated 24/11/05 from the Eastern region this is an accounting error and had been reversed on 30/11/05 on voucher No.82 for the same amount which results in the non-use of the funds for an expense (TOMPRO cash</p>					

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	<p>account dated 01/11/05 to 30/11/05 attached).</p> <p>Concerning the absence of a purchase order and delivery order in the amount of 7 million CFA francs for equipment and fuel purchases, purchase orders and delivery receipts are available for a total of 3,225,000 CFA francs are available. However, bowls, strainers, gloves and masks for an amount of 3,815,730 CFA francs were purchased as part of the mosquito netting impregnation campaign and the release forms for this impregnated material are available from the district health supervisors.</p> <p>The reimpregnation of mosquito netting was well documented during the implementation of the “Scaling up malaria prevention” project. The list of people who impregnated their mosquito nets is available to GTC. These lists were prepared by district and by region and were archived with PNLP. We attach a copy of the list for the Adamaoua region.</p> <p>Regarding the missing invoices for payments linked to administration and maintenance for an amount of 1,134,940 CFA francs, these documents are available and may be examined by the LFA.</p> <p>Regarding the mission cost for</p>					

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	<p>2,014,000 CFA francs without a mission order, the PR provides copies of the mission orders in question, as attachments for the OIG. However, it should be noted that for the supervisory mission in the Southwest for an amount of 643,000 CFA francs, the team prepared a mission order for all supervisors and clarified this with “accompanied by all members of the supervisory team” which may have given the impression there was no mission order for the other team members.</p> <p>Concerning payment to the CAA designated as special allowances and for IT equipment these were budgeted and approved by the Global Fund Secretariat in the action plan for the first and second year of Phase 1. The amount budgeted in the action plan is 23 million CFA francs and not 30 million CFA francs. Support documents for the amount of 22,684,338 CFA francs are available and are attached.</p> <p>The PR has made support documents available to the OIG for all expenses mentioned above.</p> <p>As for the balance of 2,594,623 CFA francs a transfer order has been made to credit the account of the PNL Global Fund in order to straighten out the situation.</p>					<p>On Payment to CAA and other parties outside the program, given that these payments were not directly related to the program, the OIG considers there is a need to have a formal approval to confirm that the nature of payment is acceptable by the Global</p>

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						<p>Fund Secretariat.</p> <p>The approval of the GF Secretariat on the annual workplan does not mean that they have approved unusual expenses such as examples provided by the OIG.</p>
<p>Recommendation 7 (Requires attention)</p> <p>The MOPH should resolve the two pending cases of litigation against the program i.e. for non payment of the National Social Insurance Fund Contributions and outstanding claim by SIMCO and Sons Enterprise.</p>	<p>PR takes note of this recommendation.</p> <p>As regards the non-payment of fringe benefits between March 2005 and 2007 for an amount of 145,822,219 CFA francs this is an adjustment that we are contesting. Negotiations are taking place with a consultancy firm to determine the exact amount to be paid to the NSIF within a period of 3 months.</p> <p>Claims made by SIMCO are being analyzed and checked. The PNLP resolves to pay this amount if the claims are judged to be founded.</p>	<p>Clarify the situation with CNPS, and settle the final payment under the closure plan</p>	<p>31 March 2011</p>	<p>PNLP Permanent Secretary</p>	<p>The RT will follow up implementation of this recommendation.</p>	

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Recommendation 8 (Significant) The remaining invoices for the outstanding amount i.e. US\$ 667,972 should be located and reconciliation performed within three months of receiving the draft report. The LFA should conduct further verification of the missing contract and of the CENAME invoices to ensure that all invoices or contracts exist and are eligible for payment. The MOPH should seek reimbursement for all invoices that are not available.	<p>Information regarding the 10 contracts for a total of 292,569,463 CFA francs are available at the PNLP and are attached.</p> <p>Quantitative and qualitative evaluation criteria of the offers that appear in the notice of invitation to tender (point 5) are detailed in the tender documents (pages 16 & 17 - article 12 of the Invitation to Tender, Special rules). The 10% remittal by the CIPLA was translated into financial values and taken into consideration in the final classification of the offers. The order was placed with SANOFI AVENTIS because the drugs offered by CIPLA were not approved in Cameroon at the time the order was passed.</p> <p>A private contract for an overall quantity of 10,116,000 treatments. The Health Ministry received 386,000 € with which it was able to purchase only 1,280,300 doses. A further purchase has not taken place due to a lack of funds.</p> <p>Invoices related to the difference of 667,972 USD or 307,232,175 CFA francs are available from the PNLP and are attached.</p> <p>Invoices related to the difference of 667,972 USD or 307,232,175 CFA francs are available from the PNLP and are attached.</p>	Send to Geneva all invoices could not provided to OIG during the audit.	Done	PNLP Permanent Secretary	The Secretariat takes note that the The OIG is still reviewing supporting documentation provided by the PR.	<p>The OIG acknowledges having received supporting documents related to this recommendation attached to the County comment and action plan.</p> <p>The review of these documents is ongoing.</p>

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Recommendation 9 (Significant) PNLP should procure LLINs as opposed to ITNs in line with WHO recommendations.	<p>PNLP Cameroon has been applying this recommendation since 2007. At the beginning of Round III of the “Scaling up for malaria prevention” project in November of 2005, production capacities for the manufacture of Long Lasting Insecticide Treated Nets (LLITN) were still quite low to meet the demand of the country.</p> <p>The PR was therefore forced to order conventional nets (to be reimpregnated every six months) to get the program started and this continued until the beginning of 2006.</p> <p>As of 2007 all orders placed by the PR under this program are LLITNs.</p>	Procure only LLIN bednets	Done since 2007	PNLP Permanent Secretary	The Rd 9 Malaria grant under negotiation at present, also observes this recommendation.	
Recommendation 10 (Requires attention) The MOPH needs to review and determine how the village approach can be sustained. This should include how agents can be remunerated to keep them engaged at the village level.	<p>Within the framework for the implementation of objective 4 which resulted from the communication of the “Scaling up Malaria Prevention” project, Round 3 of the Global Fund to Fight HIV, Tuberculosis and Malaria campaign an awareness raising mission on the prevention and care of malaria patients was planned.</p> <p>This advocacy campaign, via interpersonal communication took place through household visits in support of the mass communication campaign (adverts and mini radio programs). The mass communication was funded through PPTE funds.</p>	Organize a national consultation to integrate the community-based health system.	Done in Kribi from 14 to 17 September 2010	Director of Fight against Diseases	The Secretariat has taken note of the recommendation and the response provided.	

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	<p>The advocacy through interpersonal communication required preparation: The selection of interveners (invitations to tender published in the Cameroon Tribune, with well documented and transparent selection at all levels), contracting interveners, skills improvement through cascade training sessions, the supervision of activities at all levels, documentation).</p> <p>Thus, 8,101 (eight thousand one hundred and one) people across the country were involved in promoting the fight against malaria via interpersonal communications campaign through household visits. Table 1: Distribution by type of intervener (NGO/Associations and individuals) in household visits to promote the anti-malaria campaign</p> <p>This allowed 1,965,907 (one million nine hundred and sixty five thousand nine hundred and seven) households to be visited the locations of which are shown in the table below.</p> <p>In 2007, the PNLP also trained 15,500 community posts in the home care of malaria patients over and above the conducting of home visits. Problems related to the implementation of this strategy are presented in points 75 to 78 and in recommendation 11.</p>					

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	<p>The Ministry of Public Health has conducted a survey of all community posts in the health sector to evaluate remuneration needs and to choose a long term strategy for their motivation.</p> <p>The PR takes note of the recommendation and is aware of the need for community agents in the community who are able to handle, not only these three diseases but also the other so called neglected tropical diseases and a broader vaccination program. Funding (APOC Funds) is presently available for a detailed analysis of the integration of versatile community agents in the health system to avoid duplication.</p>					
<p>Recommendation 11 (Significant) The PR should provide explanations to the Global Fund of all the outstanding issues raised in the audit report. This should be within three months of receiving the audit report. The LFA should review the explanations provided. Refunds should be sought for all unresolved matters.</p>	<p>Two positions for internal auditors are planned (Appendix 8 page A36 of the procedures manual). Two internal auditors had already been recruited. One, however, resigned. The end of Round 3, which was to finance their hiring did not allow us to replace him. The Program would greatly wish to have a second internal auditor for the monitoring of program activities and suggests the financing of this position (salary and mission) be handled by COS during Round 5.</p> <p>These non-reconciled elements were reconciled before the end of the</p>	Send the 2009 Audit Report to Geneva	31 October 2010	PR Technical Secretariat Coordinator	The Secretariat takes note that the OIG is still reviewing supporting documentation provided by the PR.	<p>The OIG acknowledges having received supporting documents related to this recommendation attached to the County comment and action plan.</p> <p>The review of these documents is on going.</p>

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	<p>2008 audit. The current bank reconciliation statements no longer contain outstanding items from 2007 and 2008.</p> <p>The explanation for the difference of 112,555,000 f CFA can be found on page 14 of the audit report by Cabinet Mazars and consists of the VAT in an amount of 37,239 553 CFA francs (which, with good reason, does not appear on the physical inventory report) and a corrected amount of 25,776,578 CFA francs.</p> <p>These are expenses for the purchase of registers for an amount of 2,170,000 CFA francs and an invoice from CENAME for ARV for a total of 77,992,869 CFA francs which were accounted for in January of 2009.</p> <p>This amount is already included in the above observation of 80,165,000 CFA francs</p> <p>We feel that the answer is the same as point R91b in that this difference is explained on page 14 of the Cabinet Mazars report on the audit of accounts.</p> <p>These non-reconciled elements were from before the end of the 2008 audit. The current bank reconciliation statements no longer contain outstanding items from 2007 and 2008.</p>					

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Recommendation 12 (Significant) CNLS should comply with the provisions of the Grant Agreement. The CAA should reimburse interest income received between 2007 and 2009.	The delays in the selection of different candidates prolonged the completion of the audits. The PR will, however, ensure that the audits are completed on time. The Autonomous Amortization Fund (CAA) has been covered by the interpretation and implementation of this part of the Agreement.	Awaiting the decision from the Board of CAA which will have a meeting in December 2010	31 March 2011	MOPH and MOF	The RT has taken note of the PR's response and will follow up its implementation.	
Recommendation 13 (High) a). MOPH as PR should:- Strengthen the control over the reimbursement of the cost of testing by hospitals or health centers. The provincial coordinators should verify the correctness of invoices submitted by hospitals. b). Improve CNLS cash flow management to ensure that obligations to all third parties obligation are paid on a timely basis. The outstanding bills should be cleared.	The procedures manual correctly describes the verification mechanism on page 148. Payments are usually made following this verification process. Clear directives have been given to the GTR coordinators for a more complete verification of requests for reimbursement. This will reinforce verifications made on site while allowing good supervision.	Provide clear guidance to GTR coordinators on verification of request for reimbursement Proper verification of reimbursement requests Settle outstanding bills	Done Action Continue December 2010.	SP CNLS GTR Coordinators SP CNLS	The Secretariat has taken note of the recommendation and the response. At present there is no active HIV grant except for the continuity of services for PLWHAs. The RT will follow up implementation.	

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<p>Recommendation 14 (High) The PR should within three months of receiving the OIG report should:</p> <p>a). Check all requests for reimbursement paid to Kumba Hospital and should ask the Hospital to reimburse all tests performed by the external laboratory;</p> <p>b). Report back to the Global Fund through the LFA on the outcome of the investigation at the hospital in Kumba; and</p> <p>c). Undertake a verification exercise of all payments made to the entities that have requested to be reimbursed for HIV tests to ensure the correctness of the test numbers reported.</p>	<p>(a) An in-depth verification covering the entire period for which reimbursements to the hospital were made, has been completed. During this verification it was found that an amount of 17,420,000 CFA francs was incorrectly collected by the hospital. The person in charge of UPEC reimbursed the totality of the amount in question on 13/10/2009 to Global Fund CAA AIDS account No. 33111142001-59. He was removed from his position and the file has been referred to the competent authorities for follow-up, which no longer falls under the authority of the Minister of Public Health.</p> <p>(b) The Inspector General for the Minister of Public Health conducted an inspection of the UPEC Kumba. The regional coordinator also conducted a mission following the OIG mission. As a result of these two missions the amount of all reimbursements made by the GTR Kumba to this UPEC were reimbursed to the Global Fund account for GTA Buéa in date of October 13, 2009. Both audit reports were forwarded to the LFA.</p> <p>(c)- The Inspector General for the MoPH will conduct a verification mission and check the payments made in different the health centers which did patient testing.</p>	<p>Conduct mission for in-depth review on reimbursements request by UPEC Kumba</p> <p>Refund of overpayment</p>	<p>Done (2 mission has been completed, reports sent to Geneva)</p> <p>Done (all has been refunded)</p>	<p>GTR South-West Inspectorate General of Pharmaceutical Services</p> <p>Ex Hospital Director of Kumba District.</p>	<p>The RT will be following up progress to ensure full implementation.</p>	<p>The OIG is awaiting the result of action point (14 C) under this recommendation</p>

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Recommendation 15 (High) CNLS should establish a mechanism that verifies invoices before payment and that keeps track of rejected items to avoid resubmission.	The verification mechanism exists in the procedures manual. Clear directives have been given to the GTR coordinators for a more complete verification of requests for reimbursement. The reimbursement procedure has, however, been changed. A new approach to laboratory analysis grants was established which no longer includes reimbursements to health centers.	Establish a new approach to laboratory analysis subsidy which no longer includes direct reimbursements to health centers	In place since January 2010	SP CNLS	The Secretariat has taken note of the recommendation and the response.	
Recommendation 16 (Requires Attention) CNLS should create an employee database for the Global Fund supported program including salaries and carry out a monthly check to monitor the payments made in the regions. Personnel files should be updated. CHP should amend the procedures manual to cover job profiles.	The personnel of programs funded by the Global Fund consists of private sector administrators and support personnel (drivers, secretaries, maintenance staff) recruited from calls for candidates and a list with the names and positions occupied is in the Multi-sectoral Program for the Fight against AIDS (PMLS) procedures manual. Support agents are recruited and managed in the regions and their administrative records are filed. An electronic data bank including all personnel at the central and peripheral levels will be updated every year. CHP signed a contract with FIDA CONSEIL on December 8, 2009 for the review of its procedures manual in the aim of including all recommendations including those concerning the insertion of personnel profiles.	Put in place a personnel data base for CNLS Revise the procedures manual of CHP	Done 31 December 2010	SP CNLS CHP Executive Director	The Secretariat has taken note of the recommendation and the response.	

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Recommendation 17 (High) a). CNLS should put in place a system for approval and monitoring of orders by the Regional Technical Group (RTG). RTG should also report to the CTG on orders placed. b). CHP should put in place a centralized monitoring process for drugs at the sensitization units and carry out monthly global reconciliations between treatment statistics and quantities distributed.	(a) This has been implemented by CNLS with the various memorandums and support meetings. (b) CHP revised its inventory management system by developing tools which allow the central office to monitor inventories from purchase from CENAME to distribution to patients in sites and regional offices. This mechanism resulted in the development of a monthly activity summary in a column which allows for the comparison of the number of persons who were treated for STIs and the number of kits distributed at the various sites.	Strengthen the approval system and monitoring of orders by GTR Establish a monitoring list of activity which are integrated with monitoring of STI treatments kits	Done Done	SP CNLS CHP Executive Director	The RT will follow up actual implementation of this recommendation.	
Recommendation 18 (High) a). CNLS should put in place a budget control system based on an ageing analysis of advances. b). CNLS should request information from other actors on identified and assisted OVCs and define a period (monthly, quarterly, semi-annually, and yearly) for updating the OVC database. c). The CTG together with RTG should set guidelines on expected information from NGOs and Associations, and carry out monitoring visits.	At the beginning of the year a survey was conducted with each OVC being assisted so as to determine the specific needs of each. In this way, the nature and content of the support OVC packages are adjusted to the needs and expectations of OVCs. This differentiation in donations is proof of the targeting of support that OVCs receive from the PSN-OEV. Throughout the year, donations to OVCs are made in quarterly portions. Certain support, such as nutritional support, psychosocial support are constant in the quarterly packages and therefore appear several times when counting the number of times the OVC has received them during	Establish a coordination of activity to support OVCs at central and regional levels Disseminate the OVC summary support to all those	31 December 2010 Done (form is	SP CNLS SP CNLS	The RT will be following up actual implementation of this recommendation.	

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	<p>the year which gives the impression of a duplication of aid. Information on the tutors of OVCs is available and may be consulted in the regional data banks of the Regional Technical Groups and at the head offices of our partner NGOs.</p> <p>Advances to NGOs and Associations are monitored regularly through subsidiary accounts to the advance accounts for NGOs and Associations. Subsequent partial payments are dependent on a justification of previous funds received.</p>	involved in supporting OVCs	available in the monitoring and evaluation guidelines)			
<p>Recommendation 19 (Significant)</p> <p>a). The Program should acquire a suitable accounting and payroll software. Data safeguarding procedures and access codes should be implemented.</p> <p>b). CHP should institute an advances ledger to enable the following up of monies that have not been liquidated.</p> <p>c). The sub-recipient (CHP) should amend the procedures manual taking into account the above-mentioned weaknesses and CHP's procedure should be harmonized with that of the PR.</p>	<p>(a)GTC-CNLS definitely does have a TOMPRO accounting program. In addition, the program is in the process of acquiring a more advanced version of the software. Given the limited number of employees paid by the program, salaries are calculated using an Excel work sheet as required by law. NSIF and income auditors ensure the correct application of rates for tax withholdings and social contributions and the regularity of declarations and remittances.</p> <p>(b/c) CHP purchased an appropriate accounting software, that is to say TOMPRO WINDOW. The training of their personnel will follow.</p>	<p>Procure an updated accounting software TOMPRO for CNLS</p> <p>Procure TOMPRO accounting software for CHP</p> <p>Revise procedures manual of CHP</p>	<p>Done</p> <p>Done</p> <p>December 2010</p>	<p>SP CNLS</p> <p>CHP Executive Director</p> <p>CHP Executive Director</p>	The Secretariat has taken note of the recommendation together with the response provided by the PR.	

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	<p>CHP is preparing a general ledger for advances in order to monitor unpaid amounts.</p> <p>The CHP procedures manual is in the process of being revised and this revision will include a separate description for each operation including tasks related to verification, registering and the control of purchases, cash flow and data collection within the organization.</p>					
<p>Recommendation 20 (Requires Attention) The Government of Cameroon should make its contributions available to the Program within a reasonable timeframe (quarterly, monthly) in order to avoid delays in the implementation of activities.</p>	PR takes note of this recommendation.				The Secretariat has taken note of the recommendation together with the response provided by the PR.	
<p>Recommendation 21 (Significant) CHP should put in place a process for the periodic validation of information from the sensitization units. These processes should deal with the nature of information (number of sensitized/trained persons who administer voluntary AIDS screening tests, and treat STDs, and the quantity of kits distributed). The outcome should be submitted to the head office.</p>	CHP will reinforce and systemize the periodic (quarterly) quality control process and the concordance of data collected at intervention sites through consultants recruited for this purpose. This periodic validation procedure concerns the number of people having been screened for AIDS, those with STIs who have received treatment, drug and kit inventory management.	To conduct data quality audit in intervention sites	Ongoing	CHP Executive Director	The Secretariat has taken note of the recommendation together with the response provided by the PR.	

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Recommendation 22 (Requires attention) The PR's procedures manual should be updated to include cost apportionment criteria. CNLS should retain proper records to support all payments effected from program funds. The LFA should seek to control and verify the missing supporting documents. Unsupported expenditure should be recovered.	<p>Disbursement methods and eligible expenses for each funder are indicated in the manual. To date, there has been no confusion in the allocation of expenses to funders. Each funder has their own specific accounts in which the funds are kept.</p> <p>Support documents for the 58 items are available. These are for activities conducted in the regions. The time given to the complementary audit by accounting firm KMPG and the concomitance with the end of the audit by Cabinet Mazars did not facilitate getting access to GTC filing system to find the remaining documents.</p> <p>Expenses were incurred based on the action plan and budget approved by Global Fund and verified regularly by the LFA and external auditors. Receipts for expenses are filed and archived by program.</p>	Revise the procedures manual	31 January 2011	STBP Global Fund Coordinator	The RT will be following up actual implementation of this recommendation.	<p>The OIG acknowledges having received supporting documents related to this recommendation attached to the County comment and action plan.</p> <p>The review of these documents is on going.</p> <p>The OIG had extended its mission period but still did not receive these documents during the audit. This pointed to serious weakness in the filing system of the program.</p>
Recommendation 23 (High) CNLS should monitor the conclusions of the bidding process (selected suppliers, given prices, etc.), obtain the goods received notes from	In verifying the conformity of prices billed to CNLS and those from tender invites and products delivered to CAPR, the CENAME noticed an overpayment in the amount of	Establish a monitoring committee to review CENAME's stock management	December 2010	SP CNLS	The RT will be following up actual implementation of this recommendation.	The OIG acknowledges having received supporting

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Centres d'Approvisionnement Pharmaceutiques Régionaux (CAPR) and reconcile with invoices from CENAME, based on the statistics of "PLWHA" carry out overall consistency checks to verify the appropriateness of orders from CAPR. Monthly reconciliations should be performed between quantities supplied to CAPR, quantities supplied to support units, Centre de Santé Agrée (CTA) and the number of PLWHA treated.	<p>1,460,428,487 CFA francs. The PR demanded an independent CENAME/CNLS/KMPG audit which determined the overpayment to total 1,549,882,094 CFA francs. Bills for materials in the stated amount were addressed to CNLS by CENAME.</p> <p>This material was audited in 2010 in accordance with CNLS through the payment of the following invoices:</p> <ul style="list-style-type: none"> - January 2009 in an amount of 196,714,847 CFA francs - February 2009 in an amount of 604,227,846 CFA francs - April 2009 in an amount of 604,065,859 CFA francs - unpaid November 2006 in an amount of 1,791,193 CFA francs - partial payment of a bill from December 2009 in an amount of 143,082,349 CFA francs <p>Steps have been taken to implement this recommendation. The quantitative and qualitative requirements are done by the CNLS and a member of CNLS management sits on the ARV and reagent reception commission for product received by CENAME.</p> <p>At regional level (CAPR), the coordinators are members of the drug reception commission. All orders from health centers must first be approved by the coordinators in order to correlate between numbers ordered and patients treated.</p>	and invoices				<p>documents related to this recommendation attached to the County comment and action plan.</p> <p>The review of these documents is on going.</p>

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	Also, prices from the tender invites are now attached to the invoices sent by CENAME. A CNLS manager will, in the future, follow the tender invite procedure to completion.					
Recommendation 24 (High) a). A closer collaboration between MOPH structures for data processing of HIV/AIDS data should be initiated. b). A Sentinel surveillance survey is urgently needed, to get the baseline data needed for reliable planning of future interventions in prevention and care. Surveys should also be undertaken to evaluate program results and impact of the Global Fund supported program.	(a) While awaiting the improvements to the health system, particularly the computer system, data collected by the CNLS will now be sent to the National Epidemiology Committee who house the Anti-Disease Branch which is responsible for epidemiology monitoring nationally. The data will also be forwarded to the health information cells located at the Project Studies Division and which is mandated to centralize all health information across the country. (b) A sentinel survey of AIDS and syphilis in pregnant women was conducted in 2009, the results of which were made available in March 2010.	Transmit data collected by CNLS to the Department of Health Information and Epidemiology Department. Perform a survey on HIV sentinel and syphilis among pregnant women every two years	Immediate Done in 2009	SP CNLS SP CNLS	The Secretariat has taken note of the recommendation together with the response provided by the PR.	
Recommendation 25 (Requires attention) The PR should comply with the conditions stipulated in the grant agreement. Specifically, vehicles should be insured and audit reports prepared within the stipulated deadline in the Grant Agreement.	The Program takes note of this recommendation. The [line relative to] vehicle insurance was not logged in the name of the PNLT. The vehicles were insured from December 2007 until February 2010. The PNLT termination plan will serve to insure the vehicles until December 2010. The line regarding Audit activities also was not in the Tuberculosis action plan.	Subscribe to insurance contracts To request audits of 2010 within the time prescribed in the grant agreement. Report available at 30 June 2011	Done 30 June 2011	Permanent Secretary of GTC-TB STBP Global Fund Coordinator	The Secretariat takes note of the PR response and the progress made so far. The RT will follow up for full implementation.	

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Recommendation 26 (Significant) An internal auditor should be employed and a clear job description established that includes random and surprise checks of regional units. The internal auditor should adhere to the principle of independence and should be responsible for the development and implementation of an effective internal audit function.	The revised procedure manual includes an internal auditor for the program who will report to the Technical Secretariat of the Principal Beneficiary and not to the Program manager. The budget for Round 9 has a provision for this activity and its remuneration.	Revise and validate the procedures manual	31 January 2011	Coordinator of the Technical Secretariat of the PR	The Secretariat takes note of the PR response and the progress made so far. The RT will follow up for its full implementation in Rd 9.	
Recommendation 27 (Significant) The PR should provide explanations to the Global Fund of all the outstanding issues raised in the audit report. This should be within three months of receiving the audit report. The LFA should review the explanations provided. Refunds should be sought for all unresolved matters.	The auditor recommended rather that monies from PNLP be reported as auxiliary resources, which was done by the PNLP. The PNLP operating budget was included in the PNLP action plan as confirmed in their action plans for phases 1 and 2 of Round 3. (see appendix 1 of recommendation 7 for the Malaria component). The problem was submitted to a consulting firm who, following a tripartite meeting with the NSIF, reduced the amount of this 64 million CFA francs debt to 9 million. Settlement of this debt will take place following the Q20 disbursement. Of the 953,124 CFA francs debt, 28% for an amount of 273,704 CFA francs, has already been reimbursed. The PR commits to pursue the recovery of the remaining amount.	Refund the advance payments Refund the non-justify balance by the Government of Cameroon	31 March 2011 30 June 2011	Permanent Secretary of GTC-TB PR	The Secretariat takes note of the PR response and the progress made so far. The RT will follow up its implementation.	

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Recommendation 28 (Significant) The process/procedure for PR back-ups should be formalized and appropriate controls put in place; the Program should ensure proper implementation of TOMPRO in the regions; and the accounting records should be kept up to date.	<p>The PR takes note of this recommendation. Some regions had security problems with the software but the PR's bank reconciliations, even those done manually, are reliable because controls have been put in place by the GTC Director of Administrative Services and Finance and by the internal Controller. Entries from regions in which the program was destroyed by the virus have been managed on site by the program accountant at the GTC-TB.</p> <p>Accounting entries have been up to date since August of 2009. In addition, the program has since then:</p> <ul style="list-style-type: none"> - not only signed a contract with a certified TOMPRO dealer who will service the software - but also have a contract signed with an IT computer services provider. <p>As for the IT equipment, the certified TOMPRO agent will restore the base system once the termination plan is activated.</p> <p>Attachments: Recommendation 28 - Appendix 1: BC No. 183/BC/MINSANTEP/PNLT/GTC/SPM dated 23 April 2009 with the configuration, follow-up and maintenance of the TOMPRO software. Attachments: Recommendation 28 - Appendix 1: BC No.</p>	Enter the accounting data	Done	Permanent Secretary of GTC-TBC	The Secretariat has taken note of the recommendation together with the response provided by the PR. The RT will follow up its implementation through active grants.	

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	183/BC/MINSANTEP/PNLT/GTC/SPM dated 23 April 2009 with the configuration, follow-up and maintenance of the TOMPRO software.					
Recommendation 29 (Significant) a). The care of Multi Drug Resistant (MDR) patients needs to be integrated into the structure of the MOPH and the treatment needs to be free of charge for the patients to keep them under treatment and to prevent a spread of the MDR tuberculosis strains. b). The CCM should encourage the government to introduce a budget line for MDR TB drugs to continue the standard and the multi drug resistant treatment free of charge and to prepare for sustainable support with drugs after the support through external donors has run out. c). The cost for diagnosis (e.g. X-ray) should be supported to prevent patients not coming for treatment because of their inability to pay the diagnostic costs. d). The guidelines for the preventive treatment for children under 5 in households of patients with Tuberculosis should be reviewed to facilitate an easy and cost free	<p>The care of multi-resistant patients is included in the Ministry of Public Health PPTE funding for the years 2007, 2008 and 2009. In fact 783,562,962 CFA francs has been budgeted for in the PPTE funds for these three years for first and second line anti-tuberculosis drugs of which 65,040,000 CFA francs is strictly for second line drugs for the care of multi-resistant patients (MDR). A notice of Open International Invitation to Tender was issued by CENAME.</p> <p>Free treatment of multi-resistant patients is also a reality thanks to the support of the GTZ which assists the PNLT in their care.</p> <p>Since 2007 and with funding from the PPTE, the government of Cameroon established a consolidation program for the anti tuberculosis campaign and to reduce loss of life.</p>	<p>Integrate multi-resistant patients in the health system.</p> <p>Provide for free anti-TB treatment for MDR patients</p>	<p>Done since August 2010</p> <p>Done since January 2010</p>	<p>MOPH</p> <p>MOPH</p>	<p>The Secretariat has taken note of the recommendation together with the response provided by the PR.</p>	

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access of those children for preventive treatment. e). An approach should be developed together with the other programs, for community level involvement to follow up patients who fall out from treatment.						
Recommendation 30 (Significant) The VCT activities at the treatment facilities should be further strengthened to promote HIV prevention and to convince more TB patients to get tested for HIV.	HIV tests are done systematically with all tuberculosis patients after counseling and with their consent. 74% of all tuberculosis patients have been tested for HIV. 40% of Tuberculosis patients are HIV positive. This activity has also been improved through a ministerial note creating a working group on TB-HIV co-infection. This working group will benefit from WHO support.	Intensify the HIV counseling/testing among TB patients in the VCT	Done	Permanent Secretary GTC-TB	The Secretariat has taken note of the recommendation together with the response provided by the PR. The RT will follow up its implementation through active grants.	
Recommendation 31 (Significant) The three Global Fund supported programs in the MOPH should: a). Maintain up to date accounting records; b). Revise and update the Procedure Manual to ensure it adequately covers all program processes; c). Upgrade the accounting software (TOMPRO) to ensure that it is operational in all regions and locations and is also able to consolidate records across regions and locations. Access right to TOMPRO should be defined, taking into consideration the level and authority of users;	(a) The PNLT no longer has problems at this level. In fact the program receives a regional report once a month no later than the 5th of the following month. (b) This activity is in progress; The new manual will include the new requirements. (c) The acquisition of multi-project software, better adapted to our needs, has been budgeted for in Round 9. (d) The budget for archiving activities is included in the	Procure a new software for multi-project Strengthen capacity of financial staff on TOMPRO Review the procedures manual Outsource computer	Q1, Round 9 Q1 Round 9 31 January 2011 Upon receipt	Permanent Secretaries of PNLT, PNLP, CNLS Permanent secretaries PNLT, PNLP, CNLS PR Technical Secretariat Coordinator	The Secretariat has taken note of the recommendation together with the responses provided by the PR. The RT will be following up progress during grant closing activities and active grants implementation.	

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d). Set up an IT department. Alternatively, the maintenance of the equipment and application software (TOMPRO) should be outsourced; and e). Should strengthen its filing and archiving of accounting records.	termination plan and takes procedures for filing and archiving of documents into consideration.	maintenance Strengthen archiving system	of the Closure Plan Closure Plan	Permanent secretaries PNLT , PNLP, CNLS Permanent secretaries PNLT , PNLP, CNLS		
Recommendation 32 (Significant) a). Under the principle of segregation of duties, the person responsible for keeping cash should be different from the person who keeps the records and cash payment vouchers must be countersigned by a responsible individual. b). The preparation of bank reconciliation statements should be on a monthly basis. Furthermore, they should be signed by the preparer and reviewed by an authorized person. c). The minutes of petty cash count should be systematically established at the end of every month and kept safely. d). Count sheets should be countersigned by an appropriate authority. A procedure establishing spot counts should be put in place. e). All resources generated by the assets acquired with funds received from the Global Fund should be paid into the account entitled to receive the funds.	(a) The revised manual institutes the separation of responsibilities between an accountant and a cashier. Furthermore, it is part of the program routine to have cash expenditures authorized by the regional supervisor in addition to the accountant's signature. (b) This is applied to the PNLT by the accountant and the SAF Head. The PNLT has the TOMPRO cash account statements. (c) However the keeping of the accounts is covered in the revised manual. (d) This is applied by the PNLT through the inventory accountant, the SAF Chief and the Permanent Secretary. (e) The Autonomous Amortization Fund will be advised for the interpretation and implementation of this part of the Agreement, as it has done with other funders. It is	Review the procedures manual Review the procedures manual To send request to the General Director of CAA (Caisse Autonome d'Amortissement) Awaiting the decision of the CAA Board of Directors who will meet in December 2010	31 January 2011 31 January 2011 Done (22 June 2010) 31 March 2011	Technical Secretariat Coordinator Coordinator of Technical Secretariat MOPH and MOF MOPH and MOF	The Secretariat has taken note of the recommendation together with the response provided by the PR.	

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	something which was not discussed at the signing of the Agreement.					
Recommendation 33 (Significant) a). The Global Fund supported Programs should prepare a comprehensive fixed asset register. Annual physical verification exercises should be undertaken and the assets register updated accordingly; and b). All assets should be marked with unique identification numbers. These numbers should be included in the assets register.	Even though this disposition overlaps with inventory accounting it is included in the manual.	Review the procedures manual Conduct inventories stocktaking and record them in capital assets register	31 January 2011 Annual	ST-BP /GF Coordinator PS PNLP PS PNLT PS CNLS	The Secretariat has taken note of the recommendation together with the response provided by the PR.	
Recommendations 34 (Requires attention) a). The Global Fund programs should obtain formal approval from the Global Fund before incurring expenditure that is outside the approved budget. b). A training program should be prepared and integrated in the action plan at the beginning of each year. Training should not be focused only on Global Fund policies but equally on specific aspects such as the use of the software TOMPRO; c). Personnel files should be updated, including the harmonization of staff job profiles.	PR takes note of this recommendation. Steps will be taken right from the start of Round 9 to train the internal auditor and the accountants on TOMPRO.	To formally approve (written) action plans for grants and to be validated by the Global Fund Secretariat Training for internal auditors and accountants on TOMPRO	Round 9	Global Fund's Secretariat PS PNLP PS PNLT	The Secretariat has taken note of the recommendation together with the response provided by the PR.	
Recommendation 35 (Requires attention) Care should ensure that all	Our internal auditing (before payment, after entering in the accounts) is consistent, and to date	Establish a procedure to stamp 'paid' on paid	Already set up following	Charities Aid Foundation (CAF) -	The Secretariat takes note of the recommendations	

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supporting documents for bank payments are marked "paid".	external audits have not found any duplicate payment of invoices, nevertheless we acknowledge the advantages of the proposed improvement.	invoices.	the auditors' comment	Accountant	and responses provided by the PR (CARE). However since this Rd 4 grant ended on 31 December 2009, all follow up actions will be monitored during grant close out activities.	
Recommendation 36 (High) Care should ensure that timely verification of reports from SRs is undertaken so that disbursements are made on a timely basis.	A plan for speedier implementation on both the programmatic and the financial/administrative levels was proposed to the Global Fund at the beginning of 2009. By strengthening the teams responsible for oversight and auditing from April 2009, budget spending was brought back on track (almost all the money had been spent at the end of the project) and the scale of technical implementation by the sub-recipients had been significantly increased.	See action plan	Carried out in Phase 17 to Phase 19 of the project.	Management - Project leader	See comment on Recommendation 35 above.	
Recommendation 37(Significant) Care should mark all assets with a unique identification number and these numbers should be registered in the fixed asset register.	The equipment in the regional offices was already labelled and checked annually. Only the equipment in the national office did not carry individual identification - [because of the] permanent proximity of the logistics service	make an exhaustive record of all equipment, including the equipment in the national office. Have the inventory cards for each room signed by a logistics representative and by the person in	Done in January 2010 To be updated each time new acquisitions are made	CAF - Logistics service	See comment on Recommendation 35 above.	

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		charge of each room.				
Recommendation 38 (Requires attention) Care should purchase a module for managing the payroll in the SAGA system (accounting software used by the PR).	Discussions are taking place with our headquarters to establish the feasibility of setting up a payroll software package interfaced with the accounting software.	Decision to be finalized in relation to the procedure for issuing pay slips.	July 2010	(d) anagement - CAF with CARE France	See comment on Recommendation 35 above.	
Recommendation 39 (Significant) a). IRESCO should put in place an accrual system of accounting. b). IRESCO should reconfigure the software to meet the needs of the Program. c). IRESCO should comply with the procurement policies.	During the project the Institute for Research, Socio-economic Development and Communication (IRESCO) was given professional help in improving the parametering of its accounting software but the problems raised could only be partially resolved. Following the auditors' recommendations, IRESCO took the decision to purchase new software (TOMPRO) for the management of all new projects. These problems were indeed noticed during the first phase of the programme in compliance with purchasing procedures.	Acquisition of new software and technical support contract with a firm of chartered accountants for training purposes and for the maintenance of the software. Purchasing activities for the project already completed when the audit by the Office of the Inspector General (OIG) took place. Strict compliance with procedures will be maintained in the other projects.	August 2010	IRESCO coordinating group; accounting department	See comment on Recommendation 35 above.	

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Recommendation 40 (Requires attention) To maintain good performance, CARE should undertake more regular monitoring visits of its SRs.	A plan to speed up implementation on both the programmatic and administrative/financial levels was proposed to the Global Fund at the beginning of 2009. By strengthening the teams responsible for oversight and technical assistance from April 2009, technical implementation by the sub-recipients saw a significant increase in scale and the number of supervisory visits went up considerably (more than 115 sub-recipients received at least one visit offering oversight and/or technical assistance and about 40 of these were visited more than twice).	See action plan	Carried out in Phase 17 to Phase 19 of the project	Project leader Technical teams	See comment on Recommendation 35 above.	
Recommendation 41 (Significant) The CCM should develop guidelines for the process of identifying PRs. These should cover how the conflict of interest arising from prospective PRs being involved in proposal writing will be addressed. . The CCM Guidelines and minimum eligibility requirements currently address the issue of mitigating conflict of interest within the CCM specifically the role of CCM Chair and Vice Chair in relation to PR selection, PR renewal for Phase 2, reprogramming of grant funds and decisions that have a financial impact on the PR. These should be taken into account in the CCMs conflict of interest policy and any related guidelines.					The CCM had benefitted from the support and technical assistance of UNAIDS and Grant Management Solutions (GMS). Progress will be followed up with Rd 10 proposals.	
Recommendation 42 (High)	The National List of Essential Drugs	Revise the list of	Done on	Pharmaceuti	The RT has taken	

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<p>The MOPH should:</p> <p>a). Accelerate the updating of standard treatment guidelines, essential drug lists, order list (catalogues) and the National Drug Register using standard coding and define the applicable donor funding per standard treatment protocol to avoid overlaps or gaps in procurement;</p> <p>b). Add a Global Fund tracer code to Global Fund funded products in the central procurement management system;</p> <p>c). Standardize the product and protocol codes between the central level (CENAME, CNLS and PNLP) but also at provincial (CAPR and GTP) and peripheral levels (FS);</p> <p>d). Consider implementation of a computerized Inventory Management System linking the central level with the periphery for standardisation of products in the supply chain; and</p> <p>e). Ensure that the pharmacovigilance mechanisms and systems are in place to closely monitor the acceptance of ASAQ .</p>	<p>(LNME) was revised during a national consensus workshop in Kribi from the 2 to 4 June 2010. It will be distributed in no later than three months. The catalogues will be updated to reflect the LNME over the next 3 months. A codification of the catalogue, identifying the source of funding, is already in place at CENAME level. A code assigned to each product identifies the funding source, the lot number and the expiry date.</p> <p>In the next few days, an instruction from the MoPH will ask 10 CAPR to use the same code for products for all three programs. As for health centers an evaluation of their needs regarding computer equipment and training must be conducted.</p> <p>A national drug monitoring system has been implemented across the country to ensure the safe use of all medications used in Cameroon. Training sessions for professionals have been organised and others are in progress.</p>	essential drugs	June 2010	cal and Drugs' Director	<p>note of the recommendation together with the response provided by the PR. Progress made will be reviewed and followed up. The PSM Country Profile already reviewed and submitted by the LFA is certainly another mechanism to ensure appropriate measures are taken and proper procedures are in place.</p>	
		Disseminate list of essential drugs	31 Dec. 2010	Pharmaceutical and Drugs' Director		
		Update catalogue based on National List of Essential Drugs.	31 December 2010	Pharmaceutical and Drugs' Director		
		Codify the catalogue with identification of funding source	Done	Pharmaceutical and Drugs' Director		
		Instruction to the 10 GARP to use the same code for the drugs/non drugs of the three programs funded by the Global Fund.	31 October 2010	Pharmaceutical and Drugs' Director And DG CENAME		
		Establish a national drug Vigilance	Done	Ministry of Public Health		

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		system		Pharmaceutical and Drugs' Director		
Recommendation 43 (High) The PR should: a). Improve stock control at health facilities starting with a better standardization of product codes and names with recording lot numbers and expiry dates on stock cards and in the computer systems of the CAPRs; b). Implement routine regional supervision of pharmacies (HFs) and CAPRs to enable monthly reporting by the program of stocks, overstock/expiries, deliveries and back-orders to validate the need and consumption and thus justify deliveries to each CAPR; c). In a similar routine fashion consolidate morbidity data at the central level on monthly basis as function of an effective M&E system; d). Provide the Procurement Agent with the projected quantities per standard item for forecasting of procurement and inform the CAPRs on their expected orders; e). Monitor actual deliveries to	<p>A national manual for the management of essential drugs has been developed and adopted. The MoPH provided this manual to all SYNAME health structures for immediate and strict implementation. The manual names outlying health centers as those responsible for the management of essential drugs and regulates financial and technical management including supervision by the National Center.</p> <p>For codification (see explanation, CAPR recommendation 42). This may take place between now and the end of the year for other essential drugs.</p> <p>National and regional supervisory teams exist but their supervision is sporadic.</p> <p>Briefing cards on inventory management exist in the care centers for the anti-AIDS, Tuberculosis and Malaria programs. A group for the coordination of</p>	Develop and adopt the national manual for management of essential drugs	Done on the 03 May 2010	Pharmaceutical and Drugs' Director	The RT has taken note of the recommendation together with the response provided by the PR. Progress made will be reviewed and followed up. The PSM Country Profile already reviewed and submitted by the LFA is certainly another mechanism to ensure appropriate measures are taken and proper procedures in place.	

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CAPRs against expected orders, investigate discrepancies, and if necessary adjust the next projections; and f). Consider implementation of a computerized Inventory Management System linking the central level with the periphery for real time data analysis and routine reporting on movement of stocks in the supply chain to support accurate quantification and timely forecasting.	<p>supply was established in April 2010 with the support of the Clinton Foundation. The mission of this group is to quantify the needs of CAPRs and health centers according to morbidity data and actual consumption by the sites. It is presently being put into operation.</p> <p>An analysis of the implementation of a computerized management system which will permit the real-time monitoring of inventory movement across the supply chain is being commissioned. CENAME will forward the various product codes to CAPR. CAPR will then take responsibility for communicating these codes to their health centers in order to ensure greater traceability.</p>	<p>Establish a procurement coordination unit.</p> <p>Organize a national consultation on the implementation of a computerized management system to monitor real-time stock movements throughout the distribution chain.</p> <p>Transmit the differentiation of codifications of the products to the GARPs and to the health facilities.</p>	<p>Done on the April 2010</p> <p>31 December 2011.</p> <p>31 December 2011.</p>	<p>Pharmaceutical and Drugs' Director</p> <p>Pharmaceutical and Drugs' Director /DG CENAME</p> <p>DG CENAME</p>		
Recommendation 44 (High) a). CENAME should ensure that the pre-qualification of products is linked to the manufacturing site (i.e. not only the name of the	<p>(a) The PR takes note of this recommendation. It has, in fact, been implemented by the CENAME since its inception.</p> <p>(b) The PR takes note of this</p>	Pre-select the products based on the manufacturer's name and	Done	DG CENAME	The RT has taken note of the recommendation together with the response provided	

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<p>manufacturer) for that particular product in tender specifications.</p> <p>b). The MOPH should</p> <ul style="list-style-type: none"> provide reliable data summaries to CENAME of stock at all 10 CAPRs including remaining shelf lives when preparing a pharmaceutical tender; reconsider the pre-finance arrangement with CENAME i.e. transfer of funds to CENAME at time of ordering and clearance/handling, receipt and distribution of supplies by CENAME (at re-evaluated margins) and CAPRs (at re-evaluated margins); and Accelerate the building of capacity and development of technical capability at LANACOME to perform full testing of ARVs (including OI and STI drugs) and ACTs (including SP tablets) based on a statistically sound sampling plan. LANACOME should ensure that all procurements of health products are in line with the Global Fund Quality Assurance policies. 	<p>recommendation. Revised procedure manuals for the three programs will be submitted for approval to the Global Fund within the six months so that resources from the Global Fund and those of the Cameroon government are made available to CENAME as soon as the amount of the contract is known.</p> <p>Global Fund recommendations have already been implemented by LANACOME. They have:</p> <ul style="list-style-type: none"> qualified and well trained staff bespoke technical equipment available; updated reference information available; <p>ACT, ARV and drugs for opportunistic infections are part of the range of products that are controlled.</p>	<p>manufacturing site in the tender specifications.</p> <p>Review procedures manual</p> <p>Include ACTs, ARVs,</p>	<p>31 January 2011</p>	<p>Coordinator ST-BP /GF</p>	<p>by the PR. Progress made will be reviewed and followed up. The PSM Country Profile already reviewed and submitted by the LFA is certainly another mechanism to ensure appropriate measures are taken and proper procedures in place.</p>	

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		drugs for opportunistic infections and STIs in the list of controlled products.	Done	DG LANACOME		
Recommendation 45(Significant) The MOPH should: a). Strengthen physical stock control (training) and supervision of recording daily information (in/out) on stock cards including lot numbers and expiry dates; b). strengthen systems for the tracking the expiry dates of drugs; c). destroy the expired stock from the general warehouse sections; and d). Consider a new more specialized software system for inventory control of pharmaceutical supplies in all CAPRs with the possibility to exchange information easily to central level and generate periodic reports (in MS Excel).	<p>See explanations for recommendation No.43 concerning the Essential Drug Management Manual. This manual restates the role of each intervener in assuring an effective supply of essentials drugs, including the securing of inventories and community supervision. The implementation of the manual will be accompanied by training sessions.</p> <p>A MoPH directive from April 2010 requested the managers of all drug distribution centers and dispensaries have all outdated drugs destroyed and retain detailed reports on emergency destructions. The Manual also implements the standardized management of essential drugs throughout the 10 regions. Standardization of IT management will also be effective starting with the 10 CAPR. This standardization is essential because CAPRs will soon be required to act as subsidiaries to the CENAME.</p> <p>An estimate of the costs and preliminary training sessions is required to reach health centers.</p>	<p>Develop and adopt a national manual for management of essential drugs</p> <p>Train the staff to use the national manual management of essential drugs.</p> <p>Request all responsables of structures of</p>	<p>Done on the 03 May 2010</p> <p>31 December 2010</p> <p>Done</p>	<p>Director of Pharmacy and medicines</p> <p>Ministry of Public Health</p> <p>Ministry of Public</p>	<p>The RT has taken note of the recommendation together with the response provided by the PR. Progress made will be reviewed and followed up. The PSM Country Profile already reviewed and submitted by the LFA is certainly another mechanism to ensure appropriate measures are taken and proper procedures in place.</p>	

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		distribution and dispensing of medicines to systematically destroy all expired medicines.		Health		
Recommendation 46 (Requires attention) The MOPH should: a). Plan for expansion of storage space at regional levels; b). Implement a more strict control on remaining shelf lives (removal for destruction or documented return to CENAME); and c). Consider implementing specialized software at CAPRs for better inventory control.	The PR takes note of this recommendation and will make every effort to implement it. (e) funds have been set aside in the 2010 investment budget for the construction of annexes to 6 CAPRs. The program which is used by CENAME, several CAPRs and some major hospitals is SAGE-SAARI. Urgent enquires will be made to see if there is a better program available. If not, SAGE will be retained in all SYNAME public centers.	Construct additional buildings in 6 CAPR. To obtain information about the existence of a better tool than the SAGE-SAARI currently used by the CENAME and CAPRs and for the management of drug stocks.	31 December 2010 31 December 2010	Ministry of Public Health DG CENAME	The RT has taken note of the recommendation together with the response provided by the PR. Progress made will be reviewed and followed up. The PSM Country Profile already reviewed and submitted by the LFA is certainly another mechanism to ensure appropriate measures are taken and proper procedures in place.	
Recommendation 47 (Significant) The MOPH should investigate how ARVs had leaked into the private market and strengthen control over stocks.	The PR takes note of this recommendation. There are several hypotheses and products may come from all levels of the pyramid including patients. Specific measures for securing the products will be proposed. The Minister of Public Health created an ad hoc committee made up of representatives from CNLS, the MoPH and members of the PVVIH associations. The committee plays a	Create and implement an ADHOC committee responsible for monitoring and the oversight of ARVs and biochemistries.	Done	Ministry of Public Health	The RT will follow up implementation of this recommendation together with the response provided by the PR.	

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	surveillance role which allows identification and notification of the presence of ARV on the streets. Elsewhere, the Pharmacy and Drug Directorate of the Inspector General of Pharmaceutical Services is responsible for monitoring the UPECs and the CENAME. The anti-corruption committee is activated as soon as any information regarding the diversion of ARVs becomes available.					
Recommendation 48 (High) The MOPH should a). Set up a mechanism to maintain a transparent recording process for bed nets from various donors. This system should include and not be limited to: contract number, donor, name of the suppliers, bed nets specifications, amount paid, quantity, delivery date, location of distribution, etc. b). Establish a procurement plan. This should be in line with the work plan as agreed in the PSM plan and should also record all procurements done during the previous periods. c). Ensure that each procurement is in line with Global Fund policy i.e. transparent and competitive processes should be followed and value for money should be considered. International tenders should be properly advertised to ensure the coverage of each supplier and value for money. d). Ensure that for each delivery, the	The PR has taken note of the observations. As an immediate measure, the PR has opted for VPP (Voluntary Pooled Procurement) for the next purchase of mosquito nets in Round 9. In the future, the PR will forward the technical specifications and quantities to the Global Fund for the direct purchase of mosquito nets. Concerning the publication of international contracts, in Cameroon we have a Journal des Marchés (JDM)[Procurement Contracts Journal] which is produced by the l'Agence de Régulation de Marchés Publics (ARMP) [Government Contract Regulatory Agency]. This is the most objective and effective way to provide information regarding procurement contracts and it is published on the internet. We are presently exploring the possibility of publishing in other international journals. But we would like to point out the very high costs involved	Insert Global Fund's logo on the Nets for future procurement. Recruit statisticians in the regions to monitor inventory and data	Next Procurement Done	VPP/Global Fund PS PNLP	The Secretariat takes note of the PR response and the progress made so far. Follow up actions will be exercised through active grants.	

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supplier issues one delivery note and each delivery note should be signed by both supplier and the recipient. e). Ensure that the inspection commission checks the quantity and the quality of the product. This should be done in a timely manner to prevent delays in program implementation.	<p>which have never been budgeted for in any of the grants. The PR, however, takes note of the remark and will take any possible measures to ensure that international tender invitations be published in the same manner. Judging from your appreciation of the last two tender invitations which you felt were well conducted, this demonstrates our concern and goodwill to do better. We shall go through the VPP in the future for the purchase of these kind of supplies.</p> <p>PR takes note of this recommendation. Measures will be taken immediately. In fact, all our procurement is presently handled through the VPP system. Instructions, followed by memorandums will be given to all Ministry of Public Health managers involved in the implementation of the programs.</p>					
Recommendation 49 (High) a). The MOPH should review its impact indicators with the view of developing more appropriate indicators, for which the information can be produced and controlled by the project, or which are available in the country from a reliable source. They have to indicate clearly for which target group they are valid.	The implementation of series 3 of the project began in December 2004 and phase 2 in February 2007. This impact indicator for series 3 “% of malaria related deaths in children younger than 5 years” was taken from the document entitled “Monitoring and evaluation toolkit version 2006” published by the Global Fund. The reservations you made regarding the	Use of best suitable impact indicators for future projects.	Round 9	PS PNLP	The Secretariat takes note of the recommendation together with the response provided by the PR. The Secretariat wishes to reiterate that it has always recommended the	

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b). The performance indicators usually expressed in numbers or percentage achieved, should include a quality component. (e.g. an indicator for the training of people in the information technology could include the program on which the persons are trained and the level up to which they need to be qualified at the end of the training. This level can be shown through successful test participation.)	representivity of this indicator have already been raised in the document (see "Monitoring and evaluation toolkit version 2006" page 70) which was the reference when the project's performance framework was written. In the project evaluation follow-up plan the data for measuring this indicator will be collected during a survey of the general population, given the endemicity of malaria in Cameroon and in conformity with "Monitoring and evaluation toolkit version 2006". The PR regrets the fact that no national survey, other than the one done at the beginning of the project, has been conducted to date, despite the fact that surveys were planned as part of the implementation of the project. The second impact indicator for series 3 "the maternal mortality rate due to malaria" was also taken from the Global Fund's "Monitoring and evaluation toolkit version 2006". The project evaluation/follow-up plan provides for the collection of the data to measure this indicator through a survey of the health centers. The reservations you made regarding the representivity of this indicator have already been raised in the document (see "Monitoring and evaluation toolkit version 2006" page 70) which was the only reference when the project's performance framework was written.	Use of pre and post-tests to assess the training sessions.	Made (since the beginning of the Global Fund funding	PS PNLP PS PNLT PS CNLS	use of national systems and national targets.	

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	<p>(a) PR takes note of this recommendation. But at the same time would like to point out the difficulty of measuring indicators related to mortality which is specific to malaria and which is recognized in the literature (see "Monitoring and evaluation toolkit"). However, the observations of the auditors did not take into consideration the reference documents recommended by the Global Fund. The other impact indicators do not face any technical problem either from the point of view of their definition or their feasibility.</p> <p>The PR also recognizes that mortality, no matter the cause, is better evaluated through surveys of the general population than those done in health centers. But the evaluation of mortality attributed to malaria, through a retrospective verbal autopsy, lacks specificity, particularly in young children because it is true that malaria is not always confirmed in health centers (where diagnostic methods exist) and, even more so in the community which presently does not have any means of diagnosis. The method used to measure this indicator related to mortality attributed to malaria, will always have shortfalls: In the community we can better estimate general mortality but specific mortality (related to malaria) is very</p>	Conduct internal audit missions on data quality.	<p>in 2004)</p> <p>continued Action</p>	PS PNLP		

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	<p>difficult to estimate because there is presently no way to diagnose the disease in the community in Cameroon. In health centers, general mortality is poorly estimated because only those persons having visited the centers are taken into consideration (and they are not necessarily representative of the general population) but specific mortality (related to malaria) is better estimated because they have the means to diagnose the disease even if diagnostics are not systematic.</p> <p>However, to evaluate the impact of future projects, indicators which are less open to debate will be selected.</p> <p>(b) The PR has results indicators (output), effect indicators (outcome) and impact indicators. Results and effect indicators are collected routinely. But impact indicators cannot usually be collected in a routine follow-up. They are collected during surveys.</p> <p>Training sessions are evaluated with pre and post tests on the subject of the training. The performance of those trained is evaluated in the field during supervisions or quality monitoring of the activities for which they were trained. However, given the broad scope of quality, quality criteria are not always included in performance indicators of projects</p>					

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	during implementation. Quality is nonetheless not forgotten during activities for example the program has several quality control procedures for data which are used periodically during field visits. The quality of other project activities is evaluated during supervisory visits.					
Recommendation 50 (Significant) The MoPH should strengthen collaboration for all three of the Global Fund supported programs at the community level in order to reach the target population .	The Ministry of Public Health takes note of the recommendation and is aware of the need for versatile community agents in the communities who are able to handle, not only these three diseases but also activities related to the other so called neglected tropical diseases and a broader vaccination program. Funding (APOC Funds) is presently available for a detailed analysis of the integration of versatile community agents in the health system to avoid duplication. This funding is managed by the Anti Disease department who have already held workshops to reinforce the health system.	Organize a national consultation on the integration of health interventions in community-based. Develop an operational model integrating community-directed to be implemented.	Took place at Kribi from 14 to 17 September 2010 31 December 2012	Director of the fight against the disease. Director of the fight against the disease.	The Secretariat has taken note of the recommendation together with the response provided by the PR.	
Recommendation 51 (Significant) The MOPH should: a). Initiate and maintain close collaboration between specific units in the MOPH with the structures of the Global Fund funded programs to prepare the way for sustainability of the project activities after external funding has run out. b). Provide capacity building support	The follow-up group reports to the general secretariat of the Ministry of Public Health. It is responsible for the coordination of the Ministry activities. The structures that collect and process data within the MoPH are: The National Epidemiology Committee, the Health Information Group which is located in the Studies	Enhance the participation of program managers to coordinate weekly meetings of the General Secretariat of the Ministry of Public Health.	continued Action	PS CNLS PS PNLP PS PNLT		

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to those units in MOPH that will subsequently assume the functions of the Global Fund funded programs. c). Review structures of the MOPH and of the Global Fund programs to prevent the development of parallel structures in MOPH and the programs supported by the Global Fund.	<p>and Projects Division, and the epidemiology department which is located in the Anti Disease Division. The coordination and follow-up unit (UCS) which is referred to in the audit report is actually the Principal Recipient's technical secretariat. This is an element of the PR which coordinates the implementation of Global Fund activities with the intention of transmitting the data to the Fund Secretariat in the most expeditious way as possible. It also acts as the PR representative in all questions regarding the Global Fund. It assists existing structures within the Ministry of Public Health.</p> <p>In the future, Global Fund data collected by the programs will be forwarded to the Epidemiology Committee, to the epidemiology department and to the health information group which centralize all health information in the country. The Global Fund Principal Recipient's technical secretariat is not a parallel agency for the collection of MoPH data, because health programs, which have donors other than the Global Fund have to transmit their data to the epidemiology department and the health information group at the same time as they are transmitted to the Principal Recipient. In the desire for expeditiousness the principal recipient's technical secretariat</p>	<p>Write a proposal on Strengthening Health System (RSS) to be submitted to donors.</p> <p>Transmit data collected by the programs to the health information's cell and epidemiological service</p>	<p>August 2011</p> <p>continued Action</p>	<p>Director of the fight against the disease.</p> <p>PS CNLS PS PNLP PS PNLT</p>		

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	forwards data to the Global Fund following signing off by the PR, with the progress reports.					
Recommendation 52 (Significant) A closer collaboration and support to the structures of the MOPH in charge of data collection and processing is recommended, to prepare the structures to take over the program activities if external funding runs out.	PR takes note of this recommendation. This in fact is included in the improvements to the health system which are a priority for the Ministry of Public Health.	Write a proposal on Strengthening Health System (RSS) to be submitted to donors.	August 2011	Director of the fight against the disease.	The Secretariat has taken note of the recommendation together with the response provided by the PR.	
Recommendation 53 (High) The importance of M&E in quality assurance of programs should be emphasized. The budgets for M&E should be reviewed and the administrative processes adapted to enable the program to undertake all planned supervisory visits.	PR takes note of this recommendation. But it should be pointed out that during program reviews in going from one phase to another, supervision budgets have been cut drastically. Also, delays in the disbursement of funds often disturb the supervision calendar.	Allocate a sufficient budget for supervisions Extend the budgets of supervision in the case of delay in the implementation of activities.	Next Rounds Next Rounds	Global Fund's Secretariat Global Fund's Secretariat	The Secretariat takes note of the recommendation together with the response provided by the PR. The RT wishes to point out that during Phase 2 reviews, and upcoming grants, emphasis is on increasing M/E budget. Also delays in the disbursement of funds are mainly due to delays in the submission of reports by PRs together with failure to meet CPs.	
Recommendation 54 (significant)	(a) The current composition of the	- Elaborate the	October	CCM Chair	The Secretariat	

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<p>The Cameroon CCM should:</p> <p>a). Review the current composition of the CCM members to ensure that it remains balanced in order to ensure its effectiveness and to consider reducing the total number of members;</p> <p>b). Should complete a comprehensive manual of policies and operational procedures and have it approved and implemented;</p> <p>c). Working groups (e.g. governance, monitoring & evaluation), and ad hoc working groups (dealing with issues that arise) should be established in a transparent and participatory way;</p> <p>d). Ensure that all CCM members understand their roles and responsibility and establish protocol to improve a communication line among the members;</p> <p>e). Strengthen the functioning of CCM secretariat and seek funding for this important function; and</p> <p>f). Consider rotating the chair among the different representative groups.</p>	<p>Country Coordinating Mechanism (CCM) results from the reform carried out by the consultant appointed by UNAIDS in 2008; the CCM decided to increase its membership from 20 to 50. However, the balance of representation has been maintained (40% Government, 40% Civil Society, and 20% Development Partners). In the light of the new constitution and rules of procedure, the number of members could be reduced.</p> <p>(b) There is an ad hoc working group responsible for supporting the Technical Secretariat in all technical matters which are in the process of being formalised. Other working groups will be set up as and when financial resources become available (governance, monitoring-evaluation, oversight, communication, etc). An increase in the CCM's operating budget is required in order to carry out this type of work.</p>	<p>basic text of the CCM (Internal rules and regulation, Procedures Manual on administrative management and financial accounting, and conflict of interest management)</p> <p>- Arrange a meeting session from the CCM to endorse these documents</p> <p>- Lead a discussion on the possibility to reduce the number of members and consider this proposal at the new election of the CCM Members</p> <p>The Constitution has already been certified by the government and the completion of the other documents is in progress. These documents will be available on 31 July 2010.</p>	<p>2010</p> <p>Done</p>	<p>CCM Technical Secretariat and Ad-Hoc Group</p>	<p>takes note of the recommendation and the response provided.</p> <p>The RT will follow up implementation according to the timelines provided by the CCM.</p>	

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	<p>C) Other working groups will be established based on availability of financial resources (Governance, monitoring and evaluation, supervision, communication etc). These activities require an increase in the operational budget of the CCM</p> <p>(d) The members of the CCM have taken part in several sub-regional workshops organised by the development partners: West and Central Africa Regional Meeting on the operationalisation of Global Fund and UNAIDS Gender Equality Strategies, Dakar 26-28 January 2010, West and Central Africa CCM Workshop Dakar 10-11 February 2010, Workshop on the Strengthening of the Community System Dakar 13-14 May 2010.</p> <p>The purpose of the third task for Grant Management Solutions (GMS) will be to organise a workshop to enhance members' capacity to understand their role and their responsibilities. Enhancing the capacity of members requires significant financial resources, which the CCM does not yet have.</p>	<p>Request additional financial support to the Global Fund in related to the function of the CCM</p> <p>Subsequently, establish working groups and make them operational</p> <p>To organize workshops for capacity building of CCM members when the operational budget is approved and available</p> <p>To organize a workshop on capacity building of</p>	<p>November 2010</p> <p>February 2011</p> <p>February 2011</p> <p>February 2011</p>	<p>CCM Technical Secretariat</p> <p>CCM General Assembly</p> <p>CCM Technical and CCM Bureau</p>		

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	<p>e) The structural and functional organisation of the CCM is currently being reviewed. Once this review has been completed, it will be possible to seek additional funding more efficiently.</p> <p>(f) This principle will be integrated into the rules of procedure and the way in which it is implemented will be determined by the method of election chosen.</p>	<p>CCM Members with support from the GMS</p> <p>Finalization and adoption of documents of the CCM frameworks</p> <p>Review the technical secretariat and developing a fundraising strategy</p> <p>Develop 2011 action plan and mobilization of resources</p> <p>Develop and validate the internal rules and regulation</p>	<p>October 2010</p> <p>December 2010</p> <p>December 2010</p> <p>October 2010</p>	<p>'GMS' and CCM Technical Secretariat</p> <p>CCM Chair</p> <p>CCM Technical Secretariat</p> <p>Technical Secretariat</p> <p>CCM Chair</p>		

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Recommendation 55 (Significant) Oversight by the CCM should be strengthened. The CCM should establish, document and implement an oversight work plan that it will follow in undertaking this important function. The CCM should consider establishing a technical sub committee in order to strengthen its oversight role.	The work plan is being developed in the procedural manual; plans for a working group with responsibility for oversight have already been finalized. All these documents will be available on 31 July 2010.	Finalize the 2011-2012 bi-annual plan before seeking expanded operational funding for CCM	November 2010	CCM Technical Secretariat technique and ICN ad hoc working group	The Secretariat takes note of the recommendation and the response provided.	
Recommendation 56 (Significant) a). The CCM should develop guidelines for nominating candidates to act as PRs. These should cover how cases where organizations that are involved in providing support to the proposal writing process bid as potential PRs, whether the current PRs or SRs should participate in the selection process, etc. These guidelines should also include the conflict of interest policy and a mechanism to ensure a transparent process. b). Furthermore, the CCM secretariat should strengthen the process of writing proposals especially the need to strengthen the participation of civil society or NGOs.	(a) There will be an improved and better structured process of selecting Principal Recipients (PRs) in the procedural manual now being completed. However, it does not seem to us incompatible with this that the author or initiator of a proposal should be nominated as PR / SR (Sub recipient) by the CCM.	The PRs selection process has been approved and well formalized in the procedures manual. However, it does not seem inconsistent that the author or the initiator of a proposal is designated as PR / SR by the ICN. Increase the participation of civil society and NGOs (publication and distribution of invitations, participative consultations, drafting team extended, review committee, wide	Already done	CCM Technical Secretariat	The Secretariat takes note of the recommendation and the response provided.	

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	(b) The CCM publishes calls for proposals in the leading national daily newspaper; finalising the presentation of proposals is entrusted to qualified members of the CCM with the collaboration of technical partners and any other experts available.	dissemination of drafts of documents, involvement of development partners).	This participation has been strengthened during the proposal writing of round 10 and will be improved for future installments.	CCM Technical Secretariat		
Recommendation 57 (Significant) (a) The CCM in collaboration with county development partners should address the concerns raised by the TRP. Adequate time should be allocated to the proposal writing process with stakeholders consulted. (b) The CCM should liaise with the Global Fund Secretariat to see if there is a possibility of getting technical assistance to improve the quality of proposals.	<p>This assertion does not accord with reality. The CCM succeeded in obtaining funding for the malaria and TB components within the framework of Round 9.</p> <p>The points raised by the Technical Review Panel (TRP) were resolved at the time of the appeal following the rejection of the HIV proposal in Round 9.</p> <p>The CCM has taken note of these recommendations, and within the framework of the national proposal for Round 10, assistance with the CCM's request for help from a UNAIDS consultant and from the</p>	To consider	Recommendation already implemented	CCM meeting	The Secretariat takes note of the recommendation and the response provided.	

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incorporate more frequent pharmaceutical/PSM expertise reviews e.g. at least once a year at least 2 weeks to cover all procurement and supply aspects cross cutting the three disease programs.	c) This has been addressed as such visits took place and November 2009 and June 2010 respectively. However discussions will need to be held with the FPM as budget constraints imposed by the GF Secretariat limit the frequency and duration of the PSM expert's field visits.		On site visits complete ; discussions ongoing in order to ensure future visits		update reviews, Enhanced Financial Reports and OSDVs. The RT also believes that the LFA should recruit more PSM Experts. It is our understanding that the number of Experts available in that field, to cover PWC Portfolio with TGF, does not allow for more frequent field visits.	
Recommendation 60 (High) (a) LFAs should use their expert staff for field supervision to prepare valid and appropriate recommendations to the programs. (b) LFAs should, after supervision of the programs by their experts, follow up the implementation of the recommended interventions to the programs and report on progress in their status reports.	a) Experts (financial, "health & programmatic" PSM and "M&E") are systematically used for field visits. The budget imposed by the GF limits the duration that non-financial experts can actually stay on the field i.e. the budget for the "M&E" Expert for OSDV is 3 1/2 days per grant which is significantly insufficient considering the geographical spread of the health centres and expected coverage from the GF. In the light of the above, there is a need for the GF to review its budget allocation for field visits by experts. b) Noted. However in accordance with GF procedures, the GF Secretariat would need to		Complete and ongoing	LFA Team Leader and GF FPM	The Secretariat takes note of the recommendations and response provided. The Secretariat could discuss issues on budget allocations, but the LFA should also invest on qualified Experts especially in the M&E area, which is still the weakest link. Management letters are systematically	

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	document its decision on the LFA recommendation through a management letter to the PR in order to facilitate follow-up by the LFA in its subsequent report				issued and copied to LFA, following receipt of any important deliverables from the LFA, emphasis being on PU/DRs, and PR evaluation and assessments.	
Recommendation 61 (High) The Secretariat should review the performance of this LFA drawing on the outcome of the OIG's work and seek a clear action plan on how their performance can be strengthened. Alternatively, consideration should be given to re-tendering.					The LFA performance review is being regularly done through the LFA Performance Evaluation Tool (PET). In addition a more comprehensive review will be done at the occasion of the LFA mid-term evaluation (MTEs) that is supposed to take place between June and December 2010; Cameroon will be prioritized. In this context, not sure an additional review is necessary. Upon request of the Secretariat the LFA Team Leader was changed and the Team strengthened.	

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Recommendation 62 (Significant) (a) The Global Fund Secretariat should establish a hand over mechanism, including a requirement to ensure that all grant documents are properly handed over. (b) A standardization of filing systems within the Secretariat to ensure that a change of staff will not affect the institutional memory. (c) The Country Programs team should establish a monitoring mechanism for all recommendations to strengthen the program implementation.					On (a): The Secretariat accepts that it should improve on hand-over mechanisms. This is actually work in progress: the approach is to improve the quality and to ensure regular updates of country briefs and Grant Performance Reports (GPR). This area of improvement is actually included as objectives in the 2010 Dialogue (staff performance evaluation) system and should be assessed at the end of this year. Though not necessarily exclusive of a specific hand over document, the quality of these documents should play a key role in ensuring that the Secretariat appropriately documents its institutional memory.	

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					On (b): standardization is also work in progress at the Secretariat, though dependent on an improved IT system.	