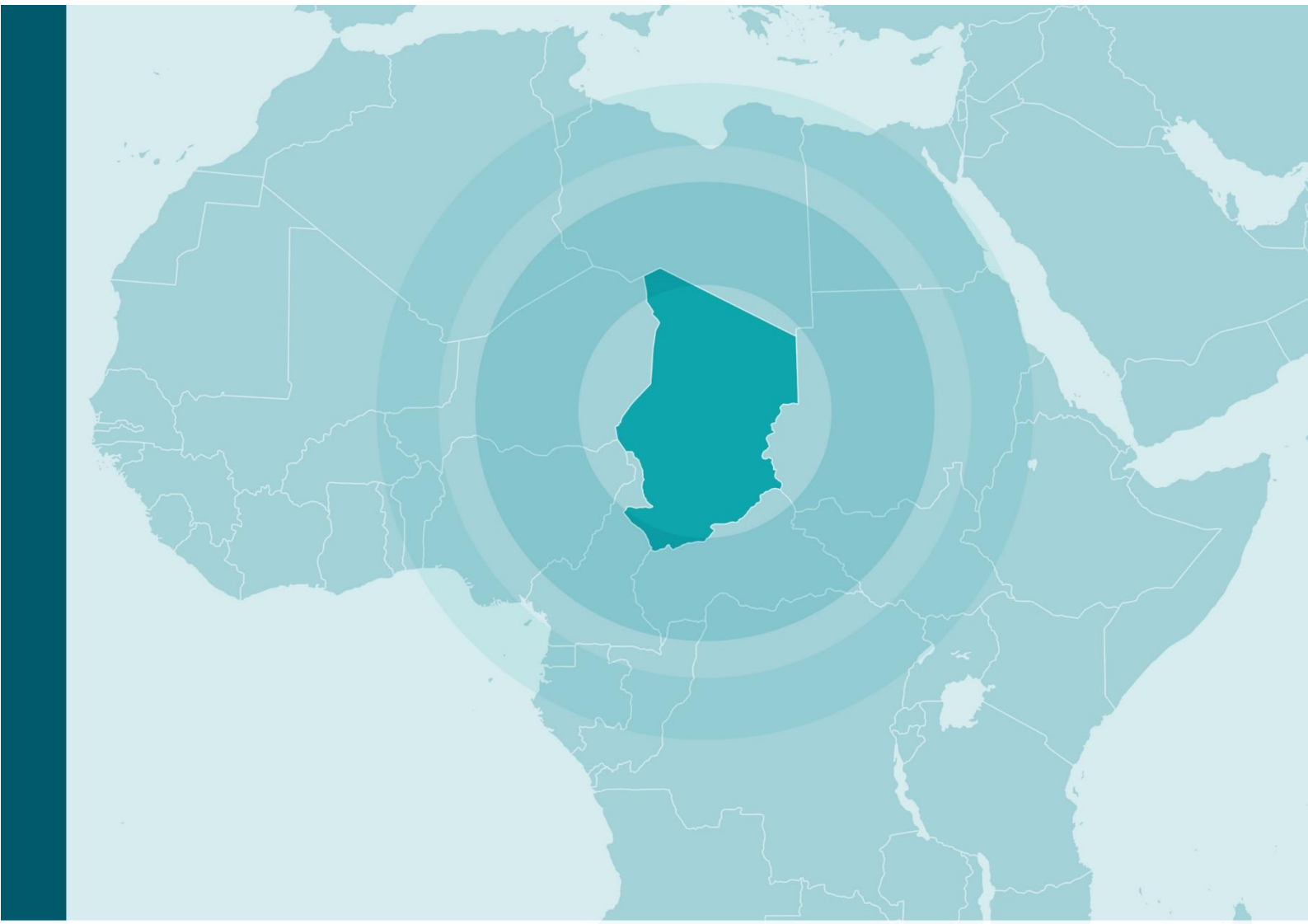

AUDIT REPORT

Global Fund Grants in the Republic of Chad

GF-OIG-23-001
22 February 2023
Geneva, Switzerland

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1. Executive Summary

1.1 Opinion

The Global Fund has classified Chad as a challenging operating environment with high political instability and security issues. This resulted in the Global Fund applying an Additional Safeguard Policy in 2009. Despite these difficulties, progress has been made in fighting the three diseases in Chad, and at the regional level. But many challenges remain, particularly in procurement and supply chain.

Over the last 10 years Chad progressed in the fight against the three diseases reducing both new infections and deaths. There are, however, key programmatic interventions for HIV and malaria that require attention to sustain impact. For HIV, the rate of viral load suppression was low. Likewise, the number of newborns from HIV positive mothers that are tested for HIV and put on treatment is low. Coverage for prevention of key affected populations (KAPs) is below grant targets. For malaria, community interventions were delayed, undermining coverage for this disease. As a result, the adequacy and effectiveness of key HIV interventions and community programs for malaria are rated as **partially effective.**

The distribution of Global Fund medicines using the in-country mechanism through the central medical store and 23 provincial medical stores is commendable. Yet, problems with quantification, ordering and distribution mechanisms have lead to frequent stock-outs and expiry of health commodities, impacting service delivery to beneficiaries. Furthermore, medicines distributed at peripheral levels have limited traceability and lack accountability. Efforts to improve the in-country supply chain with a transformation plan stagnated due to lack of funding and low government commitment. Therefore, the adequacy and effectiveness of the in-country supply chain arrangements to ensure the continuous availability of commodities and accountability at all levels **needs significant improvement**.

Overall, Chad is making improvements on grant management through the Secretariat and in-country oversight bodies. While the Project Management Unit and the Fiduciary Agents have significantly contributed to this progress, several issues are impacting their effectiveness. Therefore, the adequacy and effectiveness of grant implementation, as well as the oversight and assurance arrangements to address emerging risks – including monitoring and capacity-building activities – **needs significant improvement.**

1.2 Key Achievements and Good Practice

A joint effort among donors and partners to support the functioning of the Project Management Unit

The Project Management Unit (PMU) was established by the Ministry of Public Health and National Solidarity to oversee grant implementation with support from four donors: the Global Fund, GAVI, the Bill & Melinda Gates Foundation and ALIKO Dangoté, a private donor for polio programs. In addition, Expertise France, the French public international technical cooperation agency, provides technical support for governance, procurement, inventory management, monitoring and evaluation, finance and audit.

Programmatic achievements on the three diseases

Positive trends were noted in programmatic results, particularly in addressing some of the gaps identified during the last OIG audit in 2018. Progress was supported by an increase in funding of 47% (from €101 million to €149 million) for the funding allocation 2020-2022 (New Funding Model, or 'NFM' 3) compared to 2017-2019 (NFM 2) and a 10% (€92 million to €101 million) increase between NFM 2 and NFM 1.

- For **HIV,** new infection cases halved between 2010 and 2021 (from 7,100 to 3,500), a rate that surpasses regional and global trends. HIV deaths also fell by 29% (from 4,200 to 3,000). People living with HIV on antiretroviral treatment increased by 159% (from 31,919 in 2010 to 82,755 in 2021).

- For **malaria,** new cases have declined by 12% (23,352 per 100,000 people to 20,628) over the last 10 years (2010-2020), and death declined by 23% (from 99 per 1,000 people to 76). These results are despite an increase in estimated and confirmed malaria cases during this period. In 2020, nine million long-lasting insecticidal nets (LLINs) were distributed with the support of the Global Fund.

- **Tuberculosis (TB):** Incidence has slightly reduced by 2% from 2010 to 2020 (from 147 to 144 per 100,000 people). The TB treatment success rate has reached 80%, slightly below the global target of 90%.

1.3 Key Issues and Risks

Limited HIV interventions that undermine the quality of services

While the HIV program in Chad has made progress, it still has not fully achieved the grant objectives for the 2017-2019 (NFM 2) funding allocation, in particular the reduction of the death rate to 1,000 by 2022. While funding gaps representing 53% of the total need for NFM 2 may have contributed to this result, other factors are also undermining the quality of services as outlined below.

By 2021, 29% people living with HIV had undergone viral load testing, of which only 19% of the people living with HIV under treatment had suppressed their viral load, compared to the 95% target. Due to low viral load testing, the quality of HIV service for 71% of patients under antiretroviral treatment could not be determined, as treatment effectiveness could not be assessed. These gaps were partly due to the lack of standardized viral load procedures and guidelines, a weak sample transportation mechanism and the low utilization of GeneXpert diagnostic machines.

Coverage for prevention of mother to child transmission (PMTCT) sites is high, reaching 94% in 2021. While most pregnant women living with HIV have been tested and received pre-exposure medicines (HIV drugs for PMTCT), only 22% of exposed newborns of HIV positive mothers were tested for HIV. This is due in part to low integration of maternal and child health services with HIV services, as well as inadequate implementation of the integrated sample transport procedures for HIV testing and poor screening. Treatment initiation for children exposed to HIV when mothers had tested positive and on ART was weak and impacted results. Community interventions were limited in scope, undermining coverage as well.

Testing coverage for key affected populations (KAPs) reached only 12% (2,697 of 22,468 target) for prevention and 5% (1,028 of 22,468 target) for testing. Interventions also did not reach drug users. This outcome is due to the limited KAP coverage and prioritization in the existing grant.

Limited malaria community interventions

Similar to HIV, malaria grant objectives for the funding allocation 2017-2019 were not fully met and were also impacted by a funding gap of 58%. Out of the 23 regions in Chad, the malaria community intervention covered only three out of the target seven regions categorized as high malaria transmission in the NFM 3 funding request. There were also delays in the implementation of the current grant caused by the late selection of the principal recipient and sub recipients to implement the community intervention. The integration of community interventions for malaria with HIV and TB remains at an early stage.

Supply chain needs improvement to ensure the availability and traceability of drugs

Gaps in quantification, ordering and storage management have resulted in frequent stock-out for numerous critical malaria commodities and HIV tests that impacted quality of services. The lack of traceability resulted in weak accountability of distributed medicines at the peripheral levels due to the absence of stock cards or ordering documentation. Weak oversight from principal recipients contributed to this outcome. The Supply Chain Transformation Plan – a Global Fund initiative validated by the Ministry of Public Health and National Solidarity (MOPHNS) through different management committees in country to mitigate supply chain challenges – is stagnant due to poor governance and over reliance on Global Fund support.

Challenges with absorption capacity and general oversight that undermine effectiveness

The Project Management Unit (PMU) is ineffective at improving absorption capacity and remains highly dependent on technical assistance. The HIV and TB absorption rates for the funding allocation 2017-2019 were 65% and 69% respectively and there has been slow absorption in the current funding allocation (under 10% for the first half year of a three-year grant period for the HIV/TB grant and a year for the Malaria UNDP grant). Weak PMU oversight was also noted in the oversight of procurement and supply management (PSM).

Limited capacity-building that hinders program implementation

While the Fiduciary Agent effectively played its role in financial oversight, it led limited capacity-building activities despite this being a key responsibility. Implementation bottlenecks are not resolved in a timely way due to limited coordination between the Program Management Unit, Fiscal Agent, and Global Fund Country Team. The overall capacity-building plan executed by UNDP (the Principal Recipient) through the project PALAT remains ineffective, as was also noted in the 2018 audit. Implementation of the latest capacity-building plan remains delayed.

1.4 Objectives, Ratings and Scope

This audit was part of the Office of the Inspector General's 2022 work plan, approved by the Audit and Finance Committee in October 2021. The overall objective of the audit is to provide reasonable assurance to the Global Fund Board on grants in the Republic of Chad. Specifically, the audit assessed the adequacy and effectiveness of the objectives below.

Objective	Rating	Scope
Key HIV interventions: key affected population activities, PMTCT and viral load interventions, and community programs for malaria.	**Partially Effective**	**Audit period** July 2018 to June 2022 **Grants and implementers** The audit covered the Principal Recipients and Sub-Recipients of Global Fund supported programs. **Scope exclusion**[1] In line with the UN's Single Audit Principle, OIG did not audit UNDP expenditures and United Nations Sub-Recipients
In-country supply chain arrangements to ensure continuous availability of commodities and accountability at all levels.	**Needs significant improvement**	
Implementation, oversight, and assurance arrangements to address country emerging risks, including the Project Management Unit and Fiduciary Agent monitoring and capacity-building activities.	**Need significant improvement**	

Details about the general audit rating classification can be found in **Annex A** of this report.

Our auditors visited 15 health facilities and hospitals in the three largest provinces in Chad, as well as warehouses of the central medical store (CPA) and four provincial medical stores. Those health facilities that were visited account for 28% of notified TB- cases, 52% of patients under antiretroviral therapy and 35% of malaria cases.

[1] The United Nations General Assembly has adopted a series of resolutions and rules which create a framework known as the "Single Audit Principle." Under this framework, the United Nations and its subsidiaries do not consent to third parties accessing their books and records. All audits and investigations are conducted by the UN's own oversight bodies. The Global Fund Board and its committees have considered this assurance over funds managed by UNDP and other UN subsidiary bodies and rely on the assurance provided by these UN oversight bodies.

2. Background and Context

2.1 Overall Context

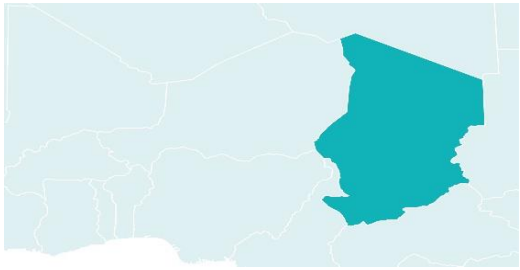
The Global Fund classified Chad as a challenging operating environment due to high political instability and security issues. As a landlocked Sahelian country, Chad's history has been marked by instability and violence, mostly from rebellions, terrorist groups and conflict in neighboring countries. Consequently, there is significant population movement on its eastern and northern borders and sporadic community conflict in some provinces.

The Global Fund Secretariat manages these risks under its Additional Safeguard Policy. This provides some operational flexibilities for the Country Team in terms of grant management, including for implementing partner selection and additional fiscal oversight, such as the appointment of a Fiduciary Agent.

Between 2000 and 2019, Chad's Human Development Index (HDI) value increased by 36%, from 0.293 to 0.398, positioning it at 187 out of 189 countries, with Chad ranked consistently among the lowest. As a low-income country under the World Bank classification, Chad also fell back into recession in 2020, with GDP contracting by an estimated 0.9% compared to the pre-pandemic projected growth rate of 4.8%.

The national health system operates at a central level with 23 regional levels, 138 district levels and 1,652 peripheral units. Due to the government's heavy involvement in the fight against terrorism in West and Central Africa, the national budget is dominated by military spending (16%) at the expense of other sectors, including education (12%) and health (4%).[2]

Country data[3]	
Population	16.91 million
GDP per capita	USD 696 (2021)
Transparency International Corruption Perception Index	164 of 180 (2021)
UNDP Human Development Index	187 of 189 (2019)
Gov't spending allocated to health expenditure (% of GDP)	4.4% (2019)



2.2 COVID-19 Situation

Since 2 April 2020, Chad took stringent containment measures to slow the spread of the virus, including lockdowns and curfews. Cumulatively, from the start of the pandemic until 5 August 2022, the case fatality rate has been 2.6%,[4] which is relatively high compared to Africa (2.1%) and worldwide (1.1%).

COVID-19 statistics
(04 August 2022)

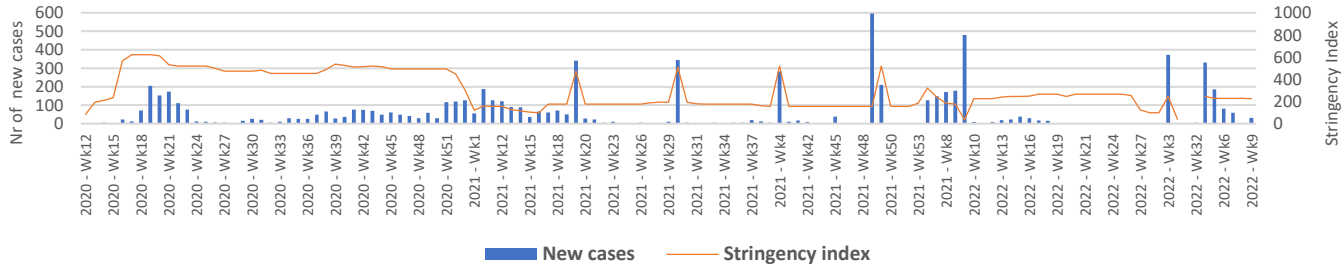
- Cases – 7,437
- Active cases – 2,370
- Recovered – 4,874
- Deaths – 193

[2] The Global Economy 2021

[3] Sources: population, GDP from WorldBank 2021; transparency corruption index from TICP 2021; health expenditure from The Global Economy 2021; all accessed 3 Aug 2022

[4] University of Oxford Our world in data Accessed on 4 August 2022

Figure 1: Weekly COVID-19 cases and stringency index in Chad[5]

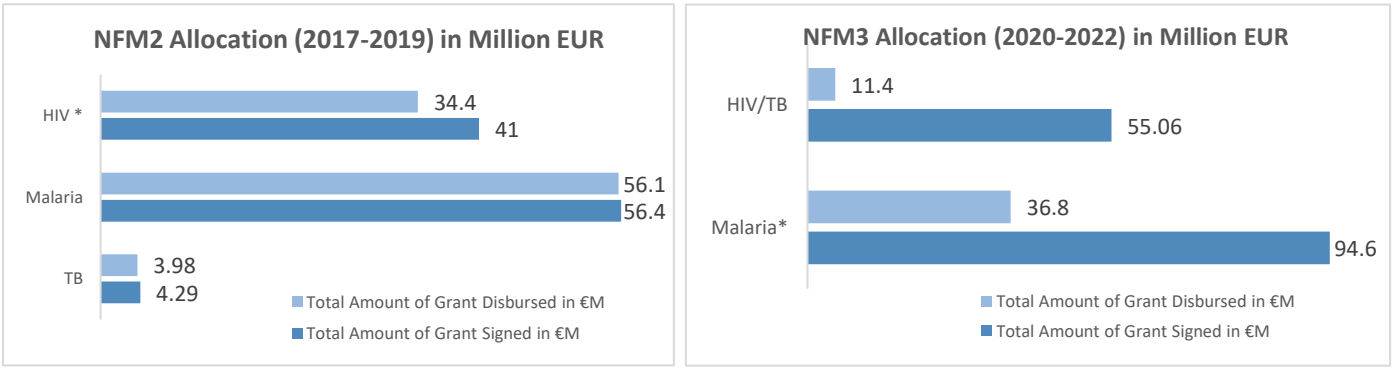


2.3 Global Fund Grants in Chad

Since 2005, the Global Fund has signed over US$557 million (€557.3 million) and disbursed over US$425 million (€425.2 million) to Chad[6]. Active grants total €149.7 million (US$149.6 million) for the 2020-2022 funding allocation (June 2021 to December 2024 implementation period), of which 28% has been disbursed. Full details on the grants can be found in the Global Fund's Data Explorer.

The Ministry of Public Health and National Solidarity is the principal recipient for HIV/TB and malaria, and UNDP (PALAT) act as co-principal recipients for malaria. Grants are implemented by sub-recipients including the *Conseil National de Lutte contre le Sida* (CNLS), *Programme Sectoriel de Lutte contre le Sida* (PSLS) for HIV, *Programme National de Lutte contre le Tuberculose* (PNT) for TB, the *Programme national de Lutte contre le Paludisme* (PNLP) for malaria and the *Bureau d'Appui au Système de Santé et environnement* (BASE) for community interventions.

Figure 2: Funding allocations, prior and current funding cycles (as of June 2022)[7]



Of NFM 3 grant funding, 60% goes towards procuring medicines and health products. The central medical store (CPA) and the provincial medical stores (PPAs) are responsible for storing and distributing them to health facilities (HFs) and hospitals.

[5] University of Oxford Our world in data Accessed on 4 August 2022

[6] Oanda Rate, 15 September 2022, USD 1 equivalent to EUR 1,00059

[7] Global Fund Data Explorer

2.4 The Three Diseases

HIV / AIDS	TUBERCULOSIS (TB)	MALARIA
110k people are living with HIV, of whom 79% know their status (vs 80% in the region). Among identified people living with HIV (PLHIV), 75% were on treatment (vs 78% in the region). **Annual new infections decreased by half since 2010,** from 7.1k newly infected people to 3.5k, making Chad the 11th highest in the region. **AIDS-related deaths reduced by 29%** from 4,200 in 2010 to 3,000 in 2020. **The epidemic is generalized.** Chad demonstrated a downward trend from 1.6% in 2010 to 1.1% in 2020, (vs 1.3% in the region), with higher prevalence in key populations[8] (13.8% among sex workers, 4.8% among MSM, and 5.2% among prisoners). *Source:* UNAIDS – Chad fact sheet	Chad is among the **50 high TB and TB/HIV burden countries**, with 24,000 estimated cases, of which 54% are notified. **TB incidence has slightly reduced by 2% since 2010**, from 147 to 144 per 100,000 people in 2020. 69% of TB patients have a **known-HIV status.** Of the 15% positive patients, 99% are enrolled in preventive treatment. **TB treatment success rate** is at 80%, putting it below the national target of 91%. In 2020, **MDR/RR-TB** was reported with 96 cases. *Source:* WHO TB Report 2021- Chad	Chad is the **15th largest contributor** to total malaria **deaths** globally. Chad carries **1.4%** of the **global malaria burden** and 2% of the mortality rate. There were **3,351 k** estimated malaria cases in 2020 **(+52% since 2010)**. Estimated **malaria-related deaths grew by 5%,** from 11,829 in 2010 to 12,415 in 2020. *Source:* Malaria World Report 2021

[8] Current prevention programs cover sex workers and men who have sex with men (MSM). In the context of Chad, MSM are also referred as "Personnes à risque" or "Populations at risk"

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Performance and grant ratings are shown below for NFM 2 Allocation (2017-2019) and NFM 3 Allocation (2020-2022).[9]

Funding allocation 2017-2019 (NFM 2)

Grant No.	Principal Recipient	Grant component	Grant Start Date	Grant End Date	Signed amount (€)[10]	Grant ratings						
						Jun 19	Dec 19	Jun 20	Dec 20	Jun 21	Dec 21	Jun 22
TCD-H-MOH	Ministry of Public Health and National Solidarity	HIV	1/1/2019	31/12/2021	41,010,934	B1	B1	B1	B1	B1	C	
TCD-M-UNDP	United Nations Development Program	Malaria	1/7/2018	30/06/2021	56,408,364	A2	B1	B1	B1	B1	N/A (1)	N/A (1)
TCD-T-MOH	Ministry of Public Health and National Solidarity	TB	1/1/2019	31/12/2021	4,291,907	B1	B1	B1	B1	B1	C	
Total					**101,711,205**							

Funding allocation 2020-2022 (NFM 3)

Grant No.	Principal Recipient	Grant component	Grant Start Date	Grant End Date	Signed amount (€)[10]	Grant ratings						
						Jun 19	Dec 19	Jun 20	Dec 20	Jun 21	Dec 21	Jun 22
TCD-C-MOH	Ministry of Public Health and National Solidarity	HIV/TB	1/1/2022	31/12/2024	55,058,145						N/A	
TCD-M-MOH	Ministry of Public Health and National Solidarity	Malaria	1/7/2021	30/06/2024	7,730,277						B	
	Ministry of Public Health and National Solidarity	C19RM	1/7/2021	30/06/2024	32,106,539							N/A (2)
TCD-M-UNDP	United Nations Development Program	Malaria	1/7/2021	30/06/2024	51,671,962						C-5	
	United Nations Development Program	C19RM	1/7/2021	30/06/2024	3,108,766							
Total					**149,675,690**							

[9] The B and C ratings in December 2021 PUDR applied the new rating system, equivalent to B1 ratings in the previous rating system. The N/A 1) due to end of the grant, and the N/A (2) is due to reporting not being yet due

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels – of key risk categories covered in the audit objectives for the Chad portfolio – with the residual risk that exists based on OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanation of differences are detailed in **Annex B** of this report.

Audit area	Risk category	Secretariat aggregated assessed risk level (March 2022)	Assessed residual risk based on audit results	Relevant audit issues
Program quality	HIV	**High**	**High**	Finding 4.1
	Malaria	**Moderate**	**Moderate**	Finding 4.1
In-country governance	In-country governance	**Moderate**	**Moderate**	Finding 4.3
Procurement and supply chain management	In-country supply chain	**Very High**	**Very High**	Finding 4.2
Financial assurance framework and mechanism	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	Finding 4.3
	Accounting and financial reporting	**Moderate**	**Moderate**	Finding 4.3

4. Findings

4.1 While programmatic performance has improved, gaps remain in key HIV and malaria interventions undermining program effectiveness

The HIV and malaria programs continue to demonstrate positive programmatic trends. However, progress on key HIV interventions like viral load suppression, coverage of early infant diagnosis and key populations remains low. The malaria community interventions are delayed and limited in scope, undermining their effectiveness.

Despite Chad's political, security and economic instability and low human development scores (ranked 187 of 189), HIV and malaria programs supported by the Global Fund have contributed to some positive trends. Over the past 10 years (2010-2020), during which the Additional Safeguard Policy was implemented, the number of HIV cases has been reduced by 0.5%, while new infections decreased by 51% and HIV deaths by 29%. Malaria also saw improvements with new cases and deaths reduced by 12% and by 23% respectively.

However, grant objectives in Global Fund-supported programs for HIV and malaria in Chad have only been partially achieved to date, limiting their impact. While funding gaps have undermined the quality of services, there are numerous other causes for the deficiencies reported. These include poor progress on viral load suppression, low PMTCT coverage on early infant diagnosis, limited interventions for HIV key populations and limited community interventions for malaria. These issues will continue to impact Global Fund investments in Chad if not addressed.

Low achievement of viral load suppression activities impact treatment effectiveness

Coverage for the viral load test intervention progressed from 1% of total HIV patients under ARV treatment in 2019 to 29% in 2021. This can be attributed to the GeneXpert scale-up from six in 2017 to 14 in 2019 and 31 in 2021. The suppression rate was 68% (16.8/24.8) or 19% of the total for PLHIV under treatment in 2021. While the GeneXpert machines are available in all provinces, the suppression rate remains below the country's 95% target and is lower than regional and global estimates.

This low achievement is mainly caused by weak in-country mechanisms for viral load suppression. The country has not finalized the national viral load intervention strategy, which has resulted in a lack of standardized procedures in 31 laboratories and viral load centers. The weak sample transportation mechanism and non-standardization of cartridge distribution have also contributed to the low access and achievement of viral load test targets.

Low coverage of early infant diagnosis intervention limit efforts to reduce PMTCT death rate

The prevention of mother to child transmission (PMTCT) coverage at the national level has increased significantly from 87% in 2019 to 89% in 2021. Results showed a 97% increase in the 13 provinces prioritized by the Global Fund, which is slightly higher than the 86% seen in provinces not covered. Yet, early detection of newborns exposed to HIV is still low, with only 22% of newborns tested for HIV in 2020 for all districts.

This situation is caused by weak follow-up of interventions for early detection of newborns exposed to HIV. Implementation is inadequate for the integrated sample transport approach for testing. Screening is also poor and initiation to treatment is weak. Other contributing factors include the prioritization of COVID-19 diagnosis over early HIV diagnosis using GeneXpert devices, low integration of maternal health services and limited PMTCT interventions at the community level.

Together, these factors have undermined efforts to reduce mortality and morbidity of children in Chad. The country still has the second highest maternal mortality in the world (860 deaths per 100,000 people) and ranks sixth among countries with the highest infant and child mortality rate, with 122 deaths per 1,000 live births[10].

Low coverage of HIV key populations has impacted the achievement of national testing and treatment targets

The HIV epidemic in Chad is generalized with high prevalence noted in key populations. There are an estimated 33,800 sex workers and 8,300 men having sex with men. As per the latest IBBS survey,[11] HIV prevalence among sex workers and men who have sex with men is high: 13% on average among sex workers, but as high as 47% in some provinces and 4.8% among MSM. Prevention and testing for these key populations is low. People at risk who have had an HIV test and received the result was only 59%. Only 12% (2,697 / 22,468) of those sex workers reached with HIV prevention program services were tested. And only 5% of sex workers (1,028/22,468) have received an HIV test and know the result. The estimated number of drug users is not yet part of the HIV prevention and testing intervention.[12]

The key populations are not all prioritized. For instance, there is no intervention for drug users under the current funding. Furthermore, there is a downward trend in country contribution based on commitment, which stood at 83% in 2019, 49% in 2020, and 44% in 2021. Only 39% of 2021 government commitments for HIV were met that year.

Delays in the implementation of malaria community interventions limit community contribution to testing and treatment of new cases

The UNDP (principal recipient) had started community interventions in two provinces in Chad under the 2014-2016 funding allocation. In the more recent funding allocation 2020-2022, the Global Fund supports a third province with the Ministry of Public Health and National Solidarity as the principal recipient. Malaria community interventions are critical for Chad due to its size, high malaria incidence and high number of refugees from neighboring countries.

However, community interventions are not fully effective due to significant delays in implementation. No sub-recipient for the third province had been contracted one year after grant signature. Community health workers were not paid for one year due to the additional justification required by the Fiscal Agent once transferred from UNDP to the Ministry of Public Health and National Solidarity. Malaria test kits had not been distributed either, making it difficult for community health workers to test for new malaria cases. Lastly, the malaria community interventions are not yet integrated with the HIV and TB community interventions. Altogether, these deficiencies undermined the effectiveness of community interventions for HIV, TB and malaria.

Agreed Management Action 1:
The Global Fund Secretariat will work with the principal recipients to address the identified key programmatic challenges by: a. Developing an action plan that aligns with national strategies to: (i) Increase access (demand and supply) to viral load testing and improve sample transportation mechanisms (ii) Respond to the delays in identification and testing of newborns exposed to HIV, and subsequent initiation on ART as required (iii) Increase coverage for key populations and extend coverage to prisoner and drug users (iv) Address delays in malaria community interventions and enhance integration across the three diseases

[10] UNICEF final report, Accélérer la Réponse au VIH/SIDA à travers un Système de Santé Résilient et Pérenne pour atteindre les cibles 90-90-90

[11] Chad IBBS survey, June 2021

12 TRP recommendations on NFM 2 and 3 to ensure prioritization of investment on Key Populations

b. The operationalization of the action plan as stipulated in part a
OWNER: Head of Grant Management Division
DUE DATE: (a) 31 December 2023 (b) 31 December 2024

4.2 Delayed implementation of the Supply Chain Transformation Plan led to poor quantification, impacting drug availability

The Supply Chain Transformation Plan finalized in 2019 has not been implemented due to poor governance, lack of monitoring, limited funding, as well as disruptions caused by the COVIDd-19 pandemic. As a result, key systemic challenges remain and have resulted in significant stock-outs at all levels and have limited drug traceability.

Programs supported by the Global Fund procure medicines through various procurement agents,[13] with distribution entrusted to national systems, central pharmacies (CPA) and 23 regional warehouses (PPAs). Distribution systems in sites visited by the OIG were assessed as adequate to monitor distributed drugs from CPAs (central level) to PPAs (regional level) and down to health facilities and hospitals.

The audit noted significant stock-outs of critical malaria medicines and expired HIV commodities due to weak quantification, distribution and supply chain monitoring. Stock-outs were noted during 2021 and 2022 at many of the 19 sites visited.

Disease	Description	Entity	Site number	Number of stock-outs	Average days of stock-out	Total days of stock-out
HIV	Testing	CPA	1	2	40	23 - 57
		PPA	3	6	40	10 -71
		Hospital & Health Facility	8	16	68	4 - 261
Malaria	Rapid test	CPA	1	1	145	145
		PPA	1	1	98	98 - 98
		Hospital & Health Facility	5	5	114	89 - 154
	Medicines	CPA	1	3	158	110 -197
		PPA	2	4	116	22 - 190
		Hospital & Health Facility	5	9	86	29 - 151

Delayed implementation of the transformation plan and limited oversight and monitoring of the supply chain are the main reasons for identified stock-outs.

Implementation of key activities for the Supply Chain Transformation Plan is delayed

The Global Fund has supported Chad in addressing its supply chain gaps by commissioning a supply chain diagnostic review that was finalized in 2018. This was complemented by other assessments commissioned by various donors. Based on these assessments, the Ministry of Public Health and National Solidarity approved a Supply Chain Transformation Plan (SCTP) in 2019 with a total budget of €18 million. Implementation of this plan has however been affected by lack of mobilized resources.

At the time of the audit, the plan was still missing key implementation elements: framework documents on resource mobilization, risk management, monitoring and evaluation, as well as annual implementation work plans. Of the €18 million budget required to implement the plan, only the Global Fund has mobilized €1.4 million and there is no clarity on resources from other partners. The Steering Committee established in 2019 to oversee the implementation had not

[13] Adult HIV antiretroviral drugs (Wambo), pediatric HIV antiretroviral (UNICEF), malaria medicines (UNDP) and TB medicines (GDF)

yet met at the time of the audit. There is also no regular implementation monitoring by the DGPL (*Direction General de la Pharmacie et Laboratoire*).

The quantification process lacked adequate data and tools, and did not benefit from effective oversight

So far during the funding allocations 2017- 2019 and 2020-2022, the process for HIV quantification has not relied on actual data for people living with HIV under treatment (ARVs). Instead, quantification relies on estimated consumption data. Consequently, the transition to a new regimen of ARV medicines used inconsistent estimated rates between the old and the new regimen,[14] which caused incorrect analyses of the monthly stock and procurement plan for the transition period (2021 -2022). This resulted in expiry of medicines for the old regimen (Viraday) in 2021 and low stock of Dolutegravir (TLD) in December 2021 and July 2022. While the expiries were not material and the new ARV regimen was available (though in low quantities), the gaps in quantification for HIV pose significant risk for future regimen changes.

Similar challenges were noted for TB quantification in 2022 because the tool used (QuanTB) did not include data for patients enrolled in the previous year (2021). This resulted in inaccurate stock and consumption data that then caused the underestimation of second-line drug needs. Unaddressed, this will likely cause low stock of second-line drugs in the first quarter of 2023.

Anti-malaria medicine quantification and annual buffer stocks are not updated regularly (at least annually) based on physical stock data. As a result, increases in consumption from a rise in malaria cases in 2021 compared to initial targets in 2021 (target NFM 2) absorbed the initial safety stock calculated in 2018. This caused significant stock-out in the second semester of 2021 at all levels, between 29 days to 197 days as shown in the table above.

Weak storage, inventory management and delayed distribution

Storage and system information capacity at CPAs and PPAs visited is limited. Sites showed insufficient logistics capacity, notably seen in the limited number of vehicles available for distribution. The various systems used (e.g. SAGE[15]) do not allow for proper monitoring of stock status, including multiple Excel tools for managing stocks for the three programs that are prone to error. This continues to negatively impact ordering and storage management, especially in the absence of specific stock management manuals. Storage conditions were also inadequate with high temperatures, limited space and weak internet connections that affected stock monitoring systems.

The absence of a written procedure and a harmonized distribution system has resulted in multiple distribution channels depending on the source of funding (Global Fund, the government or other partners). Consequently, distribution is inefficient with multiple deliveries in the same period noted from the CPA to the same PPA.

The delay in ordering malaria medicines was attributed to the delayed grant signature for the funding allocation 2020-2022 (NFM 3). The order was only completed in October 2021 when the grant was signed. This caused stock-outs of antimalarial drugs, from June 2021 until July 2022, at all levels of the supply chain for a period up to 197 days.

[14] The transition to Dolutegravir (TDF / 3TC / DTG) have varied between the 2020 NFM 2 quantification (20% Viraday / 70% DTG) and the 2021 NFM 3 quantification (50% DTG / 40% Viraday)

[15] The Semi-Automatic Ground Environment (SAGE) is an ERP information system used by the CPA and PPA to support accounting and stock management

Inadequate oversight and monitoring of supply chain at all levels

Supply chain oversight from steering committees is critical to ensure that programs achieve their intended results. However, OIG assessed this oversight, as well as the PMU's monitoring, as insufficient. OIG noted that the HIV program (PSLS) and PMU did not have the required data, such as monthly actual stock availability, to update quantification on a regular basis. PSLS and PMU also incorrectly estimated order dates and expected delivery dates that caused delivery delays.

For malaria, neither the PNLP nor UNDP had an alert mechanism or took sufficient action to avoid stock-outs. For example, stock-outs of malaria health products in 2021 were not identified at the end of 2020 because no alert was raised to place an urgent order in the first quarter of 2021.

Lack of training and supervisory visits at the health facility levels was also noted. Numerous health facilities did not have stock cards due to a lack of supply from principal recipients. This contributed to limited traceability of commodities at the peripheral level. There is also no capacity-building on stock management for PPAs and no training provided for stock managers. During visits to PPAs, the available budget under NFM 2 was not used to support computerized stock management.

Agreed Management Action 2:
The Global Fund Secretariat will work with the CCM and the Ministry of Health to accelerate the implementation of the Supply Chain Transformation Plan (SCTP), including establishing a dedicated project team and technical working group, and mobilizing technical assistance where appropriate to deliver on agreed upon components.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2023

4.3 In-country grant oversight mechanisms are properly designed but their effectiveness is limited

While the Project Management Unit is well designed, its governance and mechanisms to ensure sustainability need improvement. The Fiduciary Agent has limited capacity-building activity.

The Project Management Unit (PMU) was established to support the principal recipient, MOPHNS and oversee grant implementation for the three diseases. To provide financial oversight of PMU operations and improve their capacity, the Global Fund appointed a Fiduciary Agent in 2019. While these in-country oversight mechanisms are properly designed, various risks were identified during the audit that undermine their effectiveness.

1. Program Management Unit (PMU)

Well-designed governance and oversight over PMU's activities but limited effectiveness

The design of the PMU is adequate with an established governance system that includes a direct reporting line to the Minister of Health and program donors. Sufficient tools, systems, funds, and technical assistance are provided. The Ministry of Public Health and National Solidarity has established clear terms of reference and a clear reporting structure. Various committees have been established to further improve PMU governance, including a Steering Committee to discuss strategic challenges and bottlenecks to implementation, as well as an Audit Committee for overseeing implementation risks.

While these processes and systems exist in principle, OIG found that many are not implemented in practice. The Steering Committee and Audit Committee have provided limited oversight over the PMU. No reports on PMU challenges were brought to the attention of the Committees, internal audits were not regularly conducted, and the PMU has failed to provide monthly updates to the Minister of Health as agreed. KPIs for the current PMU were not finalized at the time of the audit, making it difficult for governance bodies, including donors, to assess its effectiveness. These gaps all undermine the PMU's effectiveness and its ability to conduct a supportive role.

While the main role of the PMU is to drive grant implementation, only 70% of the NFM 2 (2018-2021) funds have been spent (33% for HIV funds, and 31% for TB) at the end of NFM 2. For the funding allocation 2020-2022 (NFM 3), as of 30 June 2022, the absorption rate for the malaria component has been very low at 9%, which amounts to €25.6 million in unspent funding in one year of implementation. At the end of June 2022, the absorption rate in NFM 3 for component C (TB/HIV) was very low at just 7%, which amounts to €13.4 million. While it is not uncommon for grants to have low absorption in the first six months of implementation, it is important that the PMU address key challenges for low absorption in a timely manner. This should have been a lesson learned from the previous implementation period.

The PMU's procurement process is slow with limited supervision over sub-recipients and supply chain

The non-health product procurement process for the PMU was slow. At the time of the audit, 26% of activities in procurement plans from 2019 to 2021 had not been carried out. For the 2022 PNLP procurement plan, 90% of activities had not been implemented by June 2022. The contractual framework for sub-recipients is adequate with a clear definition of commitments with the principal recipient, as well as a manual of procedures to harmonize processes. Supervision and monitoring of sub-recipients in implementing activities was limited, and did not ensure the implementation of activities happened at this level. This has resulted in low absorption rates of sub-recipients for the two grant implementation periods. Gaps related to the PMU's limited oversight of supply chain arrangements were also noted in finding 4.2.

Staffing and sustainability challenges that undermine the PMU's effectiveness in overseeing grant implementation

Since the PMU was established in 2018, there has been no assessment of the adequacy of its current workforce to complete tasks and deliver on expectations. A long-term strategy for human resource sustainability is yet to be developed to reduce dependency on donor funding.

The MOPHNS approved 69 posts for the PMU, which it will gradually fill during grant implementation. The budget for PMU staff from the Global Fund is €10.2 million (€3.4 million for NFM 2 and €6.2 million for NFM 3) in the funding allocation for 2017-2019 and 2020-2022. Currently, 33 staff members are funded by donors with staff turnover at 33% since 2018 (16/49). Turnover has impacted reliable staffing for key positions including the administration and financial manager, coordinator, PSM manager and internal audit manager. Some positions have been vacant since 2021. This is due to the complexity of the process and ineffective communication and coordination with stakeholders.

The structure in the current funding arrangement is highly dependent on donor funds. In addition to funds allocated by the Global Fund, technical assistance is provided by Expertise France, a public international technical cooperation agency from France, in areas including governance, purchasing and inventory management, monitoring, and evaluation, finance and audit. Yet there has been a lack of strategic planning for the continuity of the PMU (eventually it is meant to integrate into the MOPHNS structure). Governance bodies have not established a succession and continuity plan to ensure sustainability in the event donor funding ends. In addition, the exit plan – which sets forth that technical assistance activities will end in 2025 – does not define timelines or key success indicators to determine at which level the achievement of these interventions will end technical assistance.

2. Fiduciary Agent oversight

Since 2019, a Fiduciary Agent (FA) has been in place to support the financial management of MOPHNS with a total cost of €0.85 million for the last three years (2019 to 2021). The Fiduciary Agent's primary role is to mitigate and address critical risks – including fraud, misappropriation, ineligible expenditures – and to conduct capacity-building. The FA has improved assurance to mitigate ineligible expenses, with support from the Local Fund Agent and external and internal audits. The FA terms of reference are well defined to support its mandates. While financial oversight has been adequate with immaterial ineligible expenditures identified, FA support for implementation and capacity-building could be enhanced, as noted below.

While financial oversight is adequate, improvement to the PMU's financial capacity is needed to increase grant absorption

The terms of reference clearly defines the Fiduciary Agent's role to ensure that the capacity of the principal recipient is strengthened through a time-bound, measurable capacity-building plan. However, there is limited evidence that the plan has been implemented. At the time of the audit, the capacity-building plan was not implemented. There was a delay of the Fiduciary Agent's review of the procedure manual, despite this being a key deliverable. Since this work has been delayed, it has resulted in some guidance gaps in daily activity, including delays in contractual processes.

For the period 2019-2021, there was a high rejection rate of supporting documents for reviewed transactions (over 30%). From a sample of 50 transactions, the average transaction processing time was more than 22 days between the date of receipt and approval, delaying PMU activities. The high number of rejections for sub-recipient expenditures and the long time to approve expenditures shows that the financial capacity of sub-recipients remains low.

Better engagement between implementers, the Fiduciary Agent and Secretariat is needed to address grant management bottlenecks

Implementers and the Fiduciary Agent have struggled to address key financial risks that become bottlenecks to grant implementation. This has resulted in delayed payments to several grant implementers with cascading impact on payments to CPAs and PPAs, as well as community interventions. Payments of approximately €1 million to CPAs and

PPAs for storage and distribution were delayed for more than one year because an invoicing mechanism could not be agreed between the PMU and Fiduciary Agent. Similarly, payments for community health workers have been delayed for more than 12 months because the Fiduciary Agent and PMU did not agree on the justification for payments.

The various long outstanding payments noted during the audit reflect the limited communication and coordination between the Fiduciary Agent, the PMU and the Global Fund Country Team. Despite the well-established evaluation processes for all these parties, timely follow-up on issues raised during prior reviews has not occurred.

Agreed Management Action 3:
The Global Fund Secretariat will work with the principal recipients to establish a Ministry of Health PMU monitoring mechanism, to increase efficiency of procurement processes and sub-recipient oversight, as well as to establish regular monitoring of capacity building implemented by UNDP.
OWNER: Head of Grant Management Division
DUE DATE: 30 June 2024

4.4 Delays in implementation of capacity building

Implementation of the overall capacity-building plan in UNDP project PALAT remains ineffective, limiting the effectiveness of the malaria program in implementing the grants.

Since 2009, UNDP has been a principal recipient for the malaria program through the project, *Le Projet d'Appui à la Lutte Antipaludique au Tchad* (PALAT). As a country subject to the Additional Safeguard Policy, the Global Fund expects the UNDP, as a principal recipient, to achieve two complementary objectives in Chad: program implementation and capacity-building. UNDP has developed the last Capacity Building Plan for the period 2021-2024 involving various national stakeholders, as well as technical partners in country. The plan was adequately designed with a detailed timetable, source of funding and performance indicators.

Failure to fully implement the current and previous capacity-building plan

Consistent with the findings of the 2018 OIG audit, UNDP's implementation of the capacity-building objective is ineffective. While the current plan was properly designed, less than 20% of planned capacity-building activities had been finalized. By this time, 70% of key activities amounting to €4.9 million should have been completed.

This is a recurring problem. The UNDP's capacity-building plans in 2017-2018 and 2019-2020 were also ineffectively implemented, with budget execution rates of 60% and 30% respectively. This low absorption rate can be attributed in varying degrees to weak approval processes, delays in recruiting staff and issues with establishing oversight committees. The implementation of the capacity-building plan is a complex exercise involving multiple stakeholders, including the Minster of Public Health and National Solidarity, and is very much dependent on the ability of both UNDP and MOPHS to prioritize these capacity-building activities. That being said, the main underlying driver is weak oversight, monitoring and follow-up by UNDP – the responsible entity for the capacity-building activities. There was no follow-up action or catch-up plan established to resolve these delays.

While the realization of the previous and current capacity plans is low, various activities have been implemented such as updating accounting procedures and configuration of DHIS. As a result, the capacity of the program in certain key areas – such as data collection for quantification and forecasting – remains low.

Agreed Management Action
See Agreed Management Action 3

Annex A: Audit rating classification and methodology

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

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing and code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct, and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of its work.

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

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

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

Annex B: Risk Appetite and Risk Ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework, setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are effectively assessed and mitigated.

Assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregate level in the eight key risk areas that fall within the audit's scope. In addition, a narrative explanation is provided every time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where there is no set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Chad: Comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit assessment.

Annex C: Summary of Stock-Outs in 19 Sites Visited

The OIG visited Central warehouse (CPA) three provincial medical stores (PPAs) and 15 health facilities and hospitals. Visits covered the period from 1 January 2021 to June 2022.

Disease	Description	Entity	Site number	Number of stock-outs	Average days of stock-outs	Total days of stock-outs
HIV	Testing	CPA	1	2	40	23 - 57
		PPA	3	6	40	10 -71
		Hospital & HF	8	16	68	4 - 261
	Medicines	CPA	1	1	23	23
		PPA	2	7	33	7 - 87
		Hospital & HF	3	6	97	24 - 261
Malaria	Rapid test	CPA	1	1	145	145
		PPA	1	1	98	98 - 98
		Hospital & HF	5	5	114	89 - 154
	Medicines	CPA	1	3	158	110 -197
		PPA	2	4	116	22 - 190
		Hospital & HF	5	9	86	29 - 151
Tuberculosis	First-line medicines	CPA				
		PPA	2	5	47	14 - 123
		Hospital & HF				
	Second-line medicines	CPA				
		PPA	1	4	73	25 - 140
		Hospital & HF	1	5	81	40 - 157