OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/SENEGAL'S ACTIVITIES UNDER THE PRESIDENT'S MALARIA INITIATIVE

AUDIT REPORT NO. 7-685-12-007-P
AUGUST 7, 2012

DAKAR, SENEGAL

Office of Inspector General

August 7, 2012

MEMORANDUM

TO: USAID/Senegal Mission Director, Henderson Patrick

FROM: Regional Inspector General/Dakar, Gerard Custer /s/

SUBJECT: Audit of USAID/Senegal's Activities Under the President's Malaria Initiative (Report No. 7-685-12-007-P)

This memorandum transmits our final report on the subject audit. We have considered carefully your comments on the draft report and have included them in their entirety (minus attachments) in Appendix II.

The report includes two recommendations. With the information you provided in your response to the draft report, we determined that final action has been taken on both recommendations and we consider Recommendations 1 and 2 closed upon report issuance.

I appreciate the cooperation and courtesy you extended to my staff during the audit.

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CONTENTS

Abbreviations

The following abbreviations appear in this report:

ACT	artemisinin-based combination therapy
FY	fiscal year
PMI	President's Malaria Initiative
RDT	rapid diagnostic test
RIG	Regional Inspector General

SUMMARY OF RESULTS

The United States launched the President's Malaria Initiative (PMI) in 2005 to reduce the effects of malaria in Africa. U.S. legislation extended PMI activities through the end of 2014. The U.S. Government implements PMI activities in 19 African countries and in Southeast Asia. The goal is to reduce malaria-related burden (morbidity and mortality) by 70 percent in targeted countries by 2015.[1] In Senegal, one of the African focus countries, USAID began implementing PMI activities in fiscal year (FY) 2007. The FY 2010 and 2011 budgets for the mission's PMI activities were $27.0 million and $24.5 million. During these years, the mission worked to implement activities through contracts, cooperative agreements, and task orders with 11 prime partners. Of those 11, USAID's Regional Inspector General in Dakar (RIG/Dakar) selected for audit the four partners and activities shown in the table below.

Audited Activities

Implementing Partner	Activities	Agreement/Task Order	
		Amount* ($ million)	Dates
ChildFund Senegal	Leads a consortium of international partners in the strengthening, expansion, and support of community health activities	12.7	7/2006-9/2011†
IntraHealth International	Provides technical support to clinical health-care providers in malaria, family planning, maternal, neonatal, and child health services.	6.9	6/2006-9/2011†
John Hopkins University	Provides support to increase the availability and use of long-lasting insecticide-treated bed nets via the NetWorks Project.	9.5	Washington-based cooperative agreement 9/2009-9/2014
RTI International	Provided indoor residual spraying to households to deter and kill residential mosquito populations.	15.3	Washington-based task order 9/2009-9/2011†

* Amount listed is obligations to date of only PMI funding for malaria activities.

† In September 2011, USAID/Senegal signed new agreements with both ChildFund Senegal and IntraHealth International. The ChildFund agreement is for 5 years and has a budget of $40 million, and the IntraHealth agreement is for 5 years and has a budget of $32 million. Both agreements include scopes of work beyond malaria prevention and treatment activities. Additionally, the mission is continuing indoor residual spraying through a Washington-based contract with Abt Associates; the USAID/Senegal budget for this activity in FY 2012 was $6 million.

The objective of the audit was to determine whether USAID/Senegal achieved its goals of increasing utilization of insecticide-treated bed nets, indoor residual spraying, treatment of malaria cases, and coverage of pregnant women with intermittent preventive treatment during FYs 2010 and 2011.

[1] President's Malaria Initiative, *Malaria Operational Plan Year Six–Fiscal Year 2012, Senegal,* November 11, 2011. For more information, see the President's Malaria Initiative Web site, www.pmi.gov.

The audit determined that the mission met its goals for PMI-related activities during FYs 2010 and 2011. Successes included spraying more than 490,000 structures to deter residential mosquito populations, providing more than 3 million bed nets to beneficiaries, including the completion of three phases of national distribution campaigns covering 10 of the 14 regions, and training more than 20,000 people on malaria prevention and treatment techniques. To prevent malaria in pregnant women, partners trained health-care personnel nationwide and informed the public of the risks of malaria during pregnancy. Senegal has seen improvement in malaria indicators since USAID/Senegal began PMI activities, such as an increase in the percentage of households with a bed net, the percentage of pregnant women and children sleeping under a bed net, and a decrease in the percentage of women of childbearing age with anemia. All of these successes occurred amid challenges. Since June 2010, a national strike by health-care workers has prevented the collection of certain data on services provided by the clinical health system in the country. Also in FY 2011, Senegal experienced repeated shortages of the drug needed for intermittent preventive treatment of malaria in pregnant women.

Notwithstanding the successes, the audit noted that partners were not adequately monitoring health facilities and beneficiaries under their purview (page 3). The audit found the facilities were out of drugs, used expired malaria tests, and lacked inventory controls, and recipients of bed nets did not always use them as prescribed.

To resolve these problems, RIG/Dakar recommends that USAID/Senegal:

1. Implement a plan to strengthen the monitoring of health huts by the ChildFund consortium (page 5).

2. Implement a plan to strengthen the monitoring of health facilities by IntraHealth International (page 5).

Detailed findings appear in the following section. Appendix I contains information on the scope and methodology. Management's comments are included in their entirety in Appendix II (minus attachments), and our evaluation of management comments is on page 6.

AUDIT FINDING

Partners Did Not Adequately Monitor Health Facilities

Senegal has a decentralized health system comprising 14 regions, each directed by a regional chief medical officer. The regions are further divided into 76 health districts in which district chief medical officers and health management teams oversee care, treatment, and prevention. Among these facilities are health posts, which exist in the larger population centers in each district. At the local level, more than 1,600 "functional"[2] health huts provide routine health services to roughly 19 percent of the country's population. Community health workers—in some cases supported by trained birth attendants and health educators—run the health huts with supervision from the nurse at the nearest health post. The medical commodities (medicines, supplies, etc.) that these workers dispense flow through the national distribution system from the central medical stores in Dakar to the 11 regional medical stores, to district health offices and health posts, and then to health huts.

Two of the four audited agreements were designed to improve services at different levels of the national system. IntraHealth provides technical assistance, training, and supervision to medical personnel at the health district and post levels; ChildFund provides technical assistance, training, and supervision to workers at health huts.

The mission's agreements with IntraHealth and ChildFund emphasize monitoring. The IntraHealth cooperative agreement states that dedicated staff "will travel frequently to provide supportive site visits," and, through these, supervise activities, strengthen accountability, and increase service quality at the district level, including health posts. The ChildFund agreement requires mentoring, monitoring, and supervision of health hut personnel. In addition, ChildFund's program management plan specifies that monitoring personnel are to "ensure timely and accurate monitoring [and] evaluation of program activities."

PMI activities that require monitoring include the storing and tracking of commodities. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* requires government agencies and their programs to institute internal controls to account for such assets properly. Examples include periodic counts and reconciliation of assets to inventory records, proper recording of transactions, and internal control policies and procedures that are documented and available for review.

In the two districts visited for the audit, the state of operations and discussions with beneficiaries revealed inadequate monitoring.

In Malème Hodar, site visits to the district health office and three health posts (two of which were promoted from health huts in late 2011) disclosed several control weaknesses. For example, at all four locations, there were expired artemisinin-based combination therapies (drugs known as ACTs). The drugs had expired several months earlier. It was difficult to

[2] A functional health hut has a trained community health worker (literacy is preferred but not required), regularly supervised by the chief nurse of the nearest health post, and the basic equipment and space needed to provide services.

determine how many or for how long the pharmacies were in possession of the expired drugs because none of the locations maintained accurate inventory records. All personnel stated that they had requested but not received new shipments of ACTs. In addition, at the district office, the audit found approximately 300 bed nets that had not been distributed as part of the 2011 national campaign. Mission officials stated that these nets were being held until the routine bed net distribution system becomes active.

In Guinguinéo, sites visited included the district health office, two health posts, and two health huts. Here, not only were accurate stock records for malaria commodities lacking, but also the only available rapid diagnostic tests (RDTs—blood tests used to diagnose malaria) had expired 4 months earlier. One health post nurse said she had used an expired RDT the morning of our visit without noticing the expiration date, December 2011, which was printed clearly on the top of the box. Additionally, 314 USAID-purchased bed nets that the mission believed had been distributed remained in the district warehouse. Results were similar at both health huts. One had only expired RDTs in stock and its children's dosages of ACTs had expired. At the other health hut, the consultation records showed that the community health worker had not consulted with any patients in more than a year. She stated this was because she had not received any stock, including malaria drugs and RDTs, in that time. She also said that instead of seeking treatment at the health hut, sick people from the village went to the "close by" health post, approximately 6 kilometers away.

During the site visits, we interviewed beneficiaries who had received bed nets and guidance on their use from USAID-funded partners during the 2011 national distribution campaign. The interviews made clear that use of bed nets varied greatly. In one village, of the 25 nets given to four families, none were being used correctly. In another village, 18 of the 31 donated nets were used correctly. In yet another village, all nine donated nets had been used the night before, in addition to other nets obtained by the families. In total, of the 88 nets donated by USAID during the 2011 national campaign that the audit tracked, 41 (47 percent) were hung and used the night before. The reason most often cited by recipients for not using the bed nets was that it was too hot to sleep under them. However, the temperature and climate in all the villages are the same due to their close proximity. The mission is continually working with all partners to promote the more effective and consistent use of bed nets.

In 2011, USAID/Senegal funded two evaluations related to the scope of this audit, one an assessment of the Senegalese central medical stores and the second a final evaluation of the Community Health Program implemented by the ChildFund consortium. The evaluations noted many of the same problems observed during this audit although the evaluations concerned health districts that the audit did not visit. The assessment of the medical stores noted a lack of formal, written inventory control mechanisms; storage weaknesses; the inability to quantify the commodity needs in the system; and a lack of proper oversight and monitoring. The Community Health Program evaluation raised concerns about the quality and effectiveness of the ChildFund consortium's monitoring at the health huts and recommended that program monitors receive additional training.

The evaluations indicate that the problems did not occur because the national distribution system lacked the proper resources. The assessment of the central medical stores stated that the Senegalese system did not lack qualified management personnel or funding. In addition, the report noted that the national system for distributing health-care commodities actually generates profits for health-care facilities. Furthermore, many times during the course of the audit, individuals with years of experience working with the national distribution system stated that it "used to work" and that "there is nothing wrong" with the design of the system, only with

ensuring it is managed properly. (To try to address these concerns, the mission began a new Health Systems Strengthening Program in FY 2012.) Essentially, when it comes to the USAID/Senegal PMI activities, the above-mentioned problems occurred because implementing partners did not adequately monitor health posts and health huts. The lack of supervision led to inconsistent operations and conduct by beneficiaries.

Without proper monitoring of the USAID-funded prevention and treatment activities, USAID/Senegal may not meet its overall PMI goals. In addition, the sustainability of the achievements could be in jeopardy. Given the mission's intention to begin using the national distribution system for routine distribution of nets, we are concerned—given the problems we observed with the distribution of commodities—that the system may not adequately ensure that bed nets are available for the intended beneficiaries.

Therefore, the audit makes the following recommendations.

Recommendation 1. *We recommend that USAID/Senegal, in conjunction with the ChildFund consortium, implement a plan to strengthen the supervision provided to health huts.*

Recommendation 2. *We recommend that USAID/Senegal, in conjunction with IntraHealth International, implement a plan to strengthen the supervision provided to district health facilities.*

EVALUATION OF MANAGEMENT COMMENTS

USAID agreed with both recommendations in the draft report. Having reviewed the actions taken by the mission and the supporting documentation provided, we have determined that final action has been taken on Recommendations 1 and 2, and we consider them closed upon issuance of this report. In addition, we have clarified the report based on the mission's comments. Our evaluation of management comments is shown below.

Recommendation 1. The mission agreed and has, in conjunction with the ChildFund consortium, instituted improvements to supervision activities. Specifically, all members of the consortium have participated in the establishment of improved supervisory visit guidelines and approaches. In addition, ChildFund established a plan for strengthening supervision, discussed it with the mission, and is implementing it. Accordingly, final action has been taken on this recommendation.

Recommendation 2. The mission agreed and has worked with IntraHealth to improve supervision activities. IntraHealth developed a plan of action on reinforcing supervision, discussed it with the mission, and is implementing it. Accordingly, final action has been taken on this recommendation.

SCOPE AND METHODOLOGY

Scope

RIG/Dakar conducted this audit in accordance with generally accepted government auditing standards.[3] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions, in accordance with our audit objective. We believe that the evidence provides that reasonable basis. The purpose of the audit was to determine whether USAID/Senegal's PMI activities were increasing utilization of insecticide-treated bed nets, indoor residual spraying, treatment of malaria cases, and coverage of pregnant women with intermittent preventive treatment.

The audit reviewed the activities of four of USAID/Senegal's primary partners during FYs 2010 and 2011. Two partners (John Hopkins University and RTI) had Washington-based implementing mechanisms (an agreement and an indefinite quantity contract, respectively), which the mission bought into for distributing bed nets and doing indoor residual spraying, and two (the ChildFund consortium and IntraHealth Inc.) had agreements with USAID/Senegal. Total PMI funding for these four activities as of June 13, 2012, was $44.4 million, of which $20.3 million was obligated for these four projects during FYs 2010 and 2011. In addition, the audit reviewed other activities and products funded by USAID/Senegal as they related to the audited indicators and activities. Fieldwork was conducted at USAID/Senegal in Dakar and at various other sites in-country from April 12 to May 16, 2012.

As part of the audit, the auditor assessed controls that the mission used to manage activities. These included (1) site visits conducted and documented to evaluate progress, (2) reviews of partner progress as reported in quarterly and annual reporting requirements, and (3) comparison of reported progress with planned progress, (4) the mission's own evaluations of progress, and (5) relevant USAID policies from the Automated Directives System and USAID/Senegal mission orders. Additionally, the auditor examined the mission's FY 2010 and FY 2011 annual self-assessment of management controls, which the mission is required to perform to comply with the Federal Managers' Financial Integrity Act of 1982,[4] to determine whether the assessment cited any relevant weaknesses that could affect the audit.

Methodology

To determine whether the mission was achieving its goals, the auditor interviewed officials from USAID/Senegal and the partners, Senegalese health-care providers, and beneficiaries. The auditor also reviewed USAID, partner, and beneficiary documents related to the activities. These documents included the contracts and cooperative agreements and associated modifications, mission and partner performance reporting tools and supporting documentation, partners' annual reports, and two evaluations funded by USAID/Senegal during the review period.

[3] *Government Auditing Standards*, December 2011 Revision (GAO-12-331G).
[4] Public Law 97-255, as codified in 31 United States Code 3512.

The audit focused on five performance indicators in the Performance Plan and Report to verify the accuracy and reliability of the reported performance data. The auditors interviewed mission and implementer staff members regarding processes for collecting, verifying, and reporting performance results. The auditor compared the results reported for the indicators with supporting documentation to determine whether the results met USAID's data quality standards. Based on the tests performed, the auditor found that the results met USAID's standards for validity and reliability.

In validating reported performance results, the auditor tested reported results on five performance indicators, checking the data reported during the period covered by the audit against records on file. The auditor selected a judgmental sample of items for testing. As a result, the results and overall conclusions are limited to the items tested and cannot be projected to the entire audit universe.

Initial meetings were conducted at the implementing partners' primary country offices in Dakar. Additional meetings took place at regional partner offices in and around the cities of Kaolack and Kaffrine. In the health districts of Malème Hodar and Guinguinéo, site visits were conducted to district health offices, health posts, and health huts. The auditor visited four villages where beneficiaries received health services and bed nets to consider the impact of the activities as well as the sustainability of that impact. In addition, the auditor visited two former soak pits used for the cleaning of insecticide spraying equipment and the warehouse in Kaolack used by Abt Associates. During these visits, the audit also verified that the partner was actually implementing selected activities.

MANAGEMENT COMMENTS

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FROM THE AMERICAN PEOPLE

MEMORANDUM

DATE: July 23, 2012

TO: Regional Inspector General/Dakar, Gerard Custer

FROM: Henderson Patrick, Mission Director, USAID/Senegal

REF: RIG/Dakar Draft Audit Report No. 7-685-12-00X-P

This memorandum transmits USAID/Senegal's management comments to the subject RIG/Dakar Draft Audit Report. Thank you for sharing the draft report and providing us the opportunity to offer clarifications and our response. We view audits as an opportunity to improve USAID health programming and accountability. Before addressing the two recommendations, we would like to take the opportunity to clarify some of the information presented in the report.

I. CLARIFICATIONS

- **Expired artemisinin combination therapies (ACTs) found in health facilities:** There are four forms of the drug that are prescribed based on age/weight bands. In all of the facilities that the auditors visited, it was only the infant form of the drug that was expired (the tablet form and/or the syrup form). All of the health care providers recognized that the ACTs were expired and in most cases had set them aside, though they had not actually removed them from their stock as is recommended. For the tablet form (Coartem), all tablets contain the same dose of medication and it is only the number of tablets that differs according to the age/weight band. Thus even though one form was unavailable, infants still could have been treated with valid (non-expired) drugs by cutting the appropriate number of pills from one of the larger treatments. This is often done to manage inconsistent drug availability.

- **Long lasting insecticide-treated nets (LLINs) found in storage at districts:** The audit report implies that the LLINs found at the district health offices had not been appropriately accounted for. USAID and NetWorks were aware that there was a stock of LLINs at the Maleme Hodar district office and this information was conveyed to the

auditors prior to the field visits (see document *"Quantité de MILDA disponibles par magasins de stockage dans les regions des phases 5-6"*). These nets were destined for distribution as part of the routine distribution system within Maleme Hodar district, and not for a mass campaign in other parts of the country as the audit report states. The routine system had not yet begun operating in Maleme Hodar at the time of the audit visit.

Conversely, the Mission was not aware that nets remained in Guinguineo district. Following the field visit, NetWorks personnel explained that these nets had been unclaimed during the initial distribution phase and that the district had requested to keep them in order to follow-up with the households for whom the nets were destined. NetWorks was under the impression that this had been done, but the district had not followed-through on this activity.

- **Evaluation of the Central Medical Stores:** The audit report makes reference to the USAID-funded assessment of the Central Medical Stores (CMS) conducted in 2011 and states that *"the evaluation(s)*[5] *noted many of the same problems observed during this audit; although the evaluation(s) concerned health districts that the audit team did not visit."* It should be clarified that the CMS evaluation only concerned the central and regional branches of the national supply system – this system does not extend to the district level or below. The audit, on the other hand, only examined the district and health facility levels. Health districts are clients of the CMS system, but there is no institutional relationship between the two.

  Further, while the CMS does indeed generate profits at the central level (as described in the assessment report), and health facilities charge fees for services and drugs/supplies under the country's cost recovery system, both ACTs and RDTs are provided free of charge to patients. Thus diagnosis and treatment of malaria do not generate any profits for the health system or the CMS and this is thought to be at least partially to blame for the lack of attention paid to ensuring a consistent supply.

In addition, the following points are important to understand the context in which the audit was conducted:

- **Transition between projects:** The audit was conducted just seven months after the start of USAID/Senegal's new five-year health strategy. For the two bilateral projects concerned there was a period of approximately six months of limited activities and close-out at the end of the award (March to September 2011). Subsequently, time was required for both projects to start up after their new awards were signed at the end of September. Thus when the auditors conducted field visits in May 2012, the new projects had only been operating for a few months.

5 This portion of the audit report refers to two evaluations – the CMS and the Community Health project.

- **Sites sampled:** USAID/Senegal recognizes that the RIG is severely constrained in its ability to conduct field visits on a scale that would be representative of all activities under review. Nevertheless, only two out of more than 1,600 health huts that USAID/Senegal supported during fiscal years 2010 and 2011 were actually visited during the course of the audit.

II. USAID/SENEGAL RESPONSE TO THE AUDIT FINDINGS AND RECOMMENDATIONS

Finding: *Partners did not adequately monitor health facilities*

Recommendation 1: *We recommend that USAID/Senegal, in conjunction with the ChildFund Consortium, implement a plan to strengthen the supervision provided to health huts.*

Recommendation 2: *We recommend that USAID/Senegal, in conjunction with IntraHealth International, implement a plan to strengthen supervision provided to district health facilities.*

USAID/Senegal's position on the finding and Recommendations 1 and 2: USAID/Senegal concurs with the finding that monitoring of health facilities was inadequate.

Ensuring consistent and quality supervision has been a longstanding problem in Senegal's health system. Poor performance due to a lack of responsibility on the part of health care workers, and lack of either sanctions for poor performance or reward for outstanding performance are contributing factors. Funds for supervision are specifically allocated in district budgets, but often go unused. In addition, the health worker unions have also instituted a boycott of supervision activities, reinforcing the longstanding data retention strike. USAID/Senegal has raised this issue repeatedly to the Ministry of Health in instances such as the annual Joint Portfolio Review and the semi-annual USAID/MOH health steering committee, but no significant changes have been implemented.

Supply chain management is also a longstanding and complicated problem. As the audit report notes, USAID/Senegal supported an assessment of the supply system in an effort to identify the root causes of stock shortages. The report revealed challenges at both the national and regional levels and USAID/Senegal has taken steps to address the most pressing problems under its new health strategy. The Health Systems Strengthening Program Component has two advisors placed at the CMS office to directly provide technical assistance, and the Health Services Improvement Program Component has an increased emphasis on logistical management at the district and health facility levels. In addition, a "push model" is being tested by the MOH Immunization Program whereby vaccines are delivered directly to health facilities on a monthly basis. If the pilot phase proves to be successful, USAID/Senegal will consider supporting the expansion of this model to other key commodities, including antimalarials and contraceptives.

While USAID/Senegal concedes that monitoring was inadequate, at the level of the health post we wish to clarify that this is largely beyond the control of the implementing partner. Whereas

ChildFund employed a staff of more than 200 field personnel, most of whom had the primary responsibility of "accompanying" communities in the functioning of their health huts, IntraHealth had only 10 regional advisors operating during the period that the audit covers. These advisors worked with the national programs (in particular the National Malaria Control Program, NMCP), regional and district management teams, and health facility personnel to support supervision to lower levels. This support included the revision of tools, provision of funding for field visits, and logistical support. However, IntraHealth had no direct authority over any of these actors and could only "make supervision happen" if the health system personnel were willing and able.

Lists of the rather extensive supervision activities implemented by IntraHealth and ChildFund during fiscal years 2010 and 2011 are provided in Attachments 1 and 2.

III. ACTION TAKEN/PLANNED

As noted in the draft audit report, the new USAID/Senegal health strategy came into effect in October 2011. The new strategy was developed after extensive consultation with the Ministry of Health, donors and other stakeholders. In addition, end of project evaluations were carried out and the new projects were developed to address specific challenges encountered under the previous program. In particular, the new projects include measures to address the issues of supervision and supply chain management. Some of the specific areas of focus relevant to this audit include the following:

Health Systems Strengthening (HSS) Program Component:

- Implemented by Abt Associates
- Sub-Component: Improved management, processes and system performance at the regional and district levels.
- Expected outcomes for this Program Component include:
    - Regional and district teams effectively monitor, assess, evaluate and report on program activities and performance
    - Pharmaceutical products and contraceptives managed well, with adequate forecasting, distribution and reporting to ensure stock is available at each facility

Health Services Improvement (HSI) Program Component:

- Implemented by IntraHealth International
- Sub-Component: Improved functioning of health services in public health posts, health centers and regional hospitals for related priority services
- Expected outcomes for this Program Component include:
    - Contraceptives, antimalarials, other drugs, and other products are available for use in the integrated package
    - Regular supervision is conducted at all levels (clinical and community)

Community Health (CH) Program Component:

- Implemented by ChildFund
- Sub-Component: Improved quality of and access to information, products, and services at health huts and outreach sites
- Expected outcomes for this Program Component include:
    - Community workers adequately trained, equipped, and supervised to provide quality services
    - Consistent availability of essential drugs and other health commodities at community service delivery sites

These three program components work closely together, with the HSS Component working at the national, regional and district levels to define policies, guidelines, and protocols, and the HSI and CH components focusing on implementation of these guidance and policies with health committees at all health centers, health posts, and health huts.

Following the audit field visit, USAID/Senegal took prompt action to address the problems that were identified. An initial meeting was held on May 2 with all of the health partners to provide feedback and discuss their roles in improving the situation. After the discussion draft was issued, USAID/Senegal called a meeting on May 23 with ChildFund, IntraHealth and the NMCP to discuss the specific audit findings related to supervision and to brainstorm potential solutions. Finally, on July 5 a follow-up meeting was held with ChildFund and IntraHealth to discuss their specific plans for strengthening supervision. The plans developed by each partner are included as Attachments 3 and 4.

At the community level, ChildFund has established a committee composed of representatives of all seven NGOs to review supervision practices and recommend improvements. The supervision checklist used for health huts has already been revised to make it simpler and more focused on key performance areas. The guide is in module format so that supervisors can focus on only one or two areas at each visit, with all modules being used over the course of a quarter. The module on stock management will be used at every visit to ensure that any problems in this critical area are promptly addressed. In addition, Community Development Agents will receive refresher training on how to implement quality supervision that specifically focuses on identifying weaknesses and following up on recommendations (planned for August). Finally, once the National Community Health Strategy is developed and adopted by the Ministry of Health, there will be greater focus on involving local authorities in the oversight and management of health huts. Since the time of the audit, the ChildFund consortium NGOs have conducted more than 3,000 supervision visits from zone offices to health huts in all 14 regions, with a renewed focus on quality.

At the clinical level, IntraHealth is expanding the “Tutorat Plus” approach that focuses on quality improvement and supportive supervision. Fifteen districts are already enrolled and by the end of the project’s third year, 65 of 76 health districts will be implementing this approach. IntraHealth is also putting greater emphasis on direct support for program supervision by the NMCP and districts (direct funding of their annual work plans), as well as logistics supervision in collaboration with the Division of Reproductive Health and the Regional Medical Stores. The pilot implementation of performance-based financing in three districts is in its start-up phase and

is also expected to improve supervision, since the achievement of the targeted results will require close monitoring. It must be noted, however, that it will be extremely challenging to strengthen supervision at the clinical level if the current supervision boycott by health worker unions continues. In the last quarter (April to June) IntraHealth supervised eight district management teams, 227 health facilities, 74 district drug depots, and 73 health center drug depots; the majority of these visits were done in May and June, after feedback on the audit results had been provided.

USAID/Senegal believes that adequate steps have been taken to address the problems identified by the audit, and that the supervision plans developed and being implemented respond to the audit recommendations. Therefore, **USAID/Senegal requests that Recommendations 1 and 2 be closed upon issuance of the final audit report**.

Attachments:

1. List of supervision visits conducted by IntraHealth during FY2010 and FY2011
2. List of supervision visits conducted by ChildFund during FY2010 and FY2011
3. IntraHealth plan to strengthen supervision
4. ChildFund plan to strengthen supervision

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