

COMBATTING CHILDHOOD COMMUNICABLE DISEASES  
PROJECT IN TOGO  
PROJECT NUMBER 698-0421.02

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PRELIMINARY REPORT - SURVEY AND ASSESSMENT

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16th August 1985

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16th August 1985

The Director,  
USAID,  
Lomé,  
Togo.

For the attention of Mr. R. Thomas, Project officer

Dear Sir,

COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT IN TOGO  
PROJECT NUMBER 698-0421.02

PRELIMINARY REPORT - SURVEY AND ASSESSMENT

We have completed our review and evaluation of the financial and commodity management system of the Combatting Childhood Communicable Diseases (CCCD) project in Togo. Our work was executed in accordance with the terms of reference of IQC number 681-0000-C-00-3154-00 work order number 10. This present report covers the following:

- i) evaluation of the existing system of financial and commodity control,
- ii) recommendations for improvements to these systems,
- iii) job descriptions for key project personnel,
- iv) training objectives and methodology.
- v) an overview of the main aspects of the new system.

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### WORK ALREADY COMPLETED

3. Our work on this first phase (evaluation and recommendation) was carried out in Togo between the 15 July and 2 August 1985. During this time our team engaged in discussion and meetings with members of the project's senior management staff from both the Government of Togo (GOT) and the United States Agency for International Development (USAID) and with field staff responsible for implementing the activities. Project papers, the project agreement and project appraisals were reviewed. Several hospitals and health clinics were visited in the towns of Kara and Sokode, and in and around the capital, Lomé. Storage points for vaccine, chloroquine tablets and oral rehydration salts (ORS) were visited in Lomé, Kara and Sokode. We interviewed the project chief accountant and inspected the accounting records held in Lomé. Towards the end of our team's three week stay in Togo they met with the Director General of the Sante Publique to discuss the proposed modifications to the system.

### WORK STILL TO BE DONE

4. In order to facilitate the implementation of the modifications to the system which we have proposed, we will be preparing during the second phase of our mission a systems manual which will be distributed to the members of the project staff. The manual will serve as a "How To" reference document. This manual, for which several sections are already in a "first idea" status, will be fully developed over the next few weeks in close collaboration with project staff. The final phase of the mission will be the introduction of the manual and revised documentation to the project staff.

### CONSIDERATIONS WHICH HAVE NOT BEEN INCLUDED IN THIS REPORT

5. A report prepared by Mr. Marty Makinen in May 1985 entitled "Togo/CCCD Financial and Economic Consultancy Report 1985" referred to the acceptance by GOT of the principal of self financing of CCCD activities by villages after the project officially ends in 1987.

Our systems do not cover receipts from self financing activities as we are informed that it is GO'T policy for these important activities to be handled entirely at village level.

#### PROJECT ACCOUNTING

6. The project accounts are maintained by Mr. Tsevi who is the secretary to Dr. Karsa at the Division of Epidemiology. Double entry bookkeeping is not used and the accounts consist solely of a register of payments. The register, which is divided into three sections to provide minimal budget analysis, records details of payment voucher number, cheque number, amount paid and a description of the expense. We list below the major shortcomings which came to our attention:

- i) there is no petty cash book: cash drawn from the bank for specific approved expenditure but not spent immediately, is not recorded. This means that there are uncontrolled amounts of cash in existence which may be used for non project purposes,
- ii) there is no bank book to record check payments, receipts, or other bank originated transactions as and when they occur,
- iii) expenditures are only recorded in the register of payments after they have been approved by USAID. At the time of our visit no entry had been made in the register since the end of May 1985. Delays in recording project expenditure increase the risk of manipulation of expense documentation,
- iv) since the project began in April 1983 bank statements have never been received by the accountant and therefore bank reconciliations have not been prepared. We called for the bank statements and compared the balance at 26th July 1985 with the expense report at 29th July 1985. We noted that the actual bank balance was less than the amount reported by FCFA 260.907. This difference must be reconciled as soon as possible.

- v) expense documentation bears no evidence of having been subjected to basic accounting controls such as correctness of calculations and additions and that goods and services invoiced have been received. Supporting expense vouchers are not cancelled by a paid stamp,
- vi) no formal accounting documentation is used in respect of cheque payments, cash payments, or requests by project management for approval to expend project funds,
- vii) project management does not have access to budgets. This deprives them of the ability to monitor physical progress reports against actual line item expenditure, and of the ability to constructively plan ahead,
- viii) there are no registers to record committed funds. Committed funds are defined either as orders placed but not fulfilled, or as invoices received but not yet paid.
- ix) there is a lack of formal feedback to project management from the Lomé office of USAID in respect of purchases made on their behalf. This is particularly important in respect of asset purchases where the information on the asset has to be recorded in the asset register.

7. Although not a system weakness, we noted that the procedures for approving project expenditures were long: in one instance the time between the original request for funds and the drawing of funds from the bank was 29 days. There is a very real need for the method by which project funds are liberated to be speeded up so that project management in Lomé may respond quickly to the immediate need of requests for supplies from the interior. We received several reports of shortages of pencils and paper which hindered the execution of specific tasks.

8. We recommend that the present system of accounting for project funds be improved in the following ways:

- i) introduction of proper cash and bank books to record expenditures made as and when they occur, and that these books of prime entry be balanced and reconciled on a monthly basis,
- ii) the preparation, on a regular monthly basis, of a reconciliation between the bank statement and the bank book,
- iii) the introduction of formal documentation in respect of cash and bank payments, and requests for approval to expend project funds,
- iv) the introduction of rubber stamps to indicate the various controls which have been exercised over project expenditures,
- v) the preparation of reports to provide project management with information on the availability of project funds,
- vi) the introduction of appropriate registers to record and control committed project funds: one to show goods and services which have been ordered but for which the invoice has not yet been received; the other to show invoices received which have not been paid,
- vii) that where assets are purchased directly by USAID on behalf of the project, the project accountant should be formally notified so that he may update his asset register.

9. We recommend that a system of single entry bookkeeping be implemented for the following reasons:

- i) the volume of transactions is low,
- ii) transactions are mostly expenditure,
- iii) the person responsible for the project accounting has no formal training in either bookkeeping or accounting. It would be unreasonable to expect him to master the principles of double entry bookkeeping in an acceptably short period of time given the low volume of project transactions.

#### PROJECT ASSET CONTROL

10. We noted the following shortcomings in project asset control:

- i) the records used to control project assets are inadequate. The asset register we saw related only to vehicles and contained information only in respect of the licence plate number and the centre where the vehicle was located; there was no information in respect of the date of purchase or the person to whom responsibility for the vehicle had been given. We saw no register for other project assets such as office equipment, refrigerators and freezers,
- ii) the assets themselves are not formally marked by the project to enable their subsequent identification.

We recommend that:

- i) registers be drawn up and introduced to record and control project assets,
- ii) a permanent (indelible marker or etching) code number be affixed to each asset to enable it to be subsequently identified.

## EXPENDABLE COMMODITY CONTROL - GENERAL

11. In the course of our visit we met with the national project managers and their staff with the exception of Mme Hounzah of the Mother and Child Division whom we are told deals with all aspects of oral rehydration activities. We hope to meet with her during our next visit to Lomé.

12. Control is required over the following types of expendable commodity:

vaccines

chloroquine tablets

oral rehydration salts (ORS)

gasolene and kerosene for vehicles and refrigerators

general supplies - needles, syringes, wicks and lamps for

kerosene refrigerators, accounting supplies, files, pencils and paper

We found that in general the controls which have been established over these commodities are at best patchy and at worst non-existent. Under the present circumstances it would be a difficult and time consuming task for project staff to produce a complete and justified reconciliation of commodity (vaccine, chloroquine and ORS) usage. It would appear that project personnel at all levels have often been left to design their own systems to handle requisition, receipt and distribution procedures. We did however find that standard forms had been introduced for the purpose of reporting the monthly usage of the three medical commodities. We noted however that procedures for obtaining the information to include in the reports was generally uncontrolled and that several different methods were in use, each with a different degree of efficiency and accuracy. From a review of the reports which had been sent back to the divisions at Lomé we found that:

i) many subdivisions sanitaires were not sending in reports,

ii) those that were sent in often contained errors.

3. Enquiry at the national level revealed that follow up of medical centres and dispensaries who did not send in their reports

was poor. Reports of usage are required for two important reasons, to provide statistics against which to measure project success and to provide usage figures for national level staff to assess stock requirements. Consequently we recommend that attention be given to procedures

for ensuring the receipt in Lomé of complete and accurate reports.

#### PERSONNEL

14. A remark we heard on several occasions during our visit was that there was a severe shortage of personnel. We learned of several instances where, according to government policy, experienced personnel who had been working on project activities for some time had been retired but had not been replaced. In only one instance (CHR Sokode) did we find that the principal doctor had assigned one person to supervise full time one of the project's three main activities. In all of the other hospitals and medical centres we visited the persons assigned to the project had other responsibilities which meant that they could not devote the necessary time to the project. We are of the opinion that the project would benefit greatly if the responsibility for the different aspects of the project be specifically attached to particular staff members of the subdivisions sanitaires and medical centres. The number of persons dealing with project activities in a particular subdivision or centre should be in line with the volume of these activities. In this way the larger centres may warrant the allocation of more than one person. National project managers should assess the work load of all staff currently employed on project activities and make appropriate recommendations.

15. Similar problems exist at the national level. We strongly recommend that at least one person be freed from other duties and should be made available full time to control project activities and ensure the correct implementation of procedures. It is certain that, with effect from the start of the training sessions, a full time co-ordinator should be designated to oversee the introduction of the new systems.

16. In all cases the persons detached should have clear instructions as to their responsibilities. The identification and designation of staff should have been effected prior to the start of the series of courses we shall give on the new systems and procedures.

## VACCINE SUPPLIES

### STORAGE

17. Vaccines are currently stored in three different places in Lomé: depot de TogoPharma, the offices of the Division de Epidemiology and at the Bureau Annexe of the Division de Epidemiology on the Boulevard Circulaire. The conditions of storage are not ideal in that it is possible for unauthorised persons to gain access to the storage area at two of the locations. In addition to this security problem the existence of stock in three different places makes it necessary to triple the control registers and to use more personnel to supervise the locations.

18. We recommend that all stores of vaccines be concentrated in the cold store of the Departement de la Santé at the TogoPharma depot. We understand that the reason why this has not already been done is because there are no electrical outlets for the freezers. We are informed that steps have been taken to arrange the installation of power points and that when this is done all vaccines will be stored at the Togopharma cold store. We recommend that this matter be treated as one of urgency.

### CONTROL OVER RECEIPTS AND ISSUES OF VACCINES AT LOME

19. Control over receipts and issues of vaccines is weak. Two registers of stock movements (one for goods in and another for goods out) are maintained at the Bureau Annexe. We understand that these registers cover all stock movements from all three of the stock locations but we were unable to verify this in the time

available to us. We noted the following system shortcomings:

- i) there are no stock cards in use which permit the quantities of vaccine in stock at any point in time to be known,
- ii) there is no formal documentation (i.e. goods received note) in use to record the initial receipts of vaccines,
- iii) there is no formal documentation (i.e. goods delivery note) in use to record the issue of vaccines. Currently a photocopy of the informal requisition is used which is expensive and inconvenient,
- iv) there is no formal system for authorizing the destruction of date expired vaccines.
- v) inventory procedures are ill defined, are carried out infrequently, and the results are not communicated to project management.

20. We recommend:

- i) the introduction of formal preprinted documentation to be used for the receipt and delivery of vaccines, and to authorize the destruction of date expired vaccines,
- ii) the maintenance of stock cards for each separate receipt of vaccine. This will facilitate control over batch numbers and peremption dates,
- iii) improvements be made to the format of the registers of vaccines received and delivered,
- iv) arrangements for inventory procedures be formalized. Inventories should be carried out according to a fixed calendar, and the results should be communicated to project management.

The adoption of the above recommendations will ensure that complete control is established over all receipts and issues and will permit project management to supervise vaccine handling, and operate ordering procedures in a more timely fashion.

#### CONTROL OVER RECEIPTS AND ISSUES OF VACCINES AT MEDICAL CENTRES

21. There are no fixed procedures to control the receipt and issue of vaccine stocks at medical posts outside Lomé. Some centres use registers to record issues and deliveries, others use separate notebooks. We noted that in one instance these notebooks were retained by the different people to whom the vaccines were delivered.

22. As for Lomé there is no formal documentation either for requisitioning supplies of vaccine or for recording their receipt or delivery. We were informed that supplies were occasionally sent from Lomé with no accompanying documentation at all. Inventory procedures which allow project management to oversee the effectiveness of vaccine control are not in force.

23. Our recommendations to correct these weaknesses are the same as for Lomé (paragraph 20).

#### USAGE OF VACCINES

24. In the course of our visits to various medical centres we noted at least three different methods for recording the number of people vaccinated and consequently the number of doses used. These methods are:

- i) looking through the vaccination register and noting on a scrap of paper the number of times each type of vaccine appears for the day in question, and in the case of VAT and DTCoq, whether it was the 1st, 2nd, 3rd or 4th injection,
- ii) marking a scrap of paper (tally sheet) as and when each person is vaccinated. Distinction is made at this time as to which type of vaccine and which 'rappel' has been administered,

- iii) giving to each person to be vaccinated a piece of card (jeton) on which is marked the type of vaccination to be administered. At the time of vaccination these cards are surrendered to the nurse administering the vaccine. At the end of each day the cards are sorted by vaccine type and recorded.

25. It is certain that the method used to record the numbers and type of vaccine administered affects two parameters:

- i) the number of vaccinations administered in a given period of time,
- ii) the speed with which the daily report may be prepared.

26. After studying of the above three methods and discussion with the project managers we recommend adoption of method three, the jeton system. This method has the following main advantages:

- i) on the basis that the jetons are given out before the vaccinations are administered the vaccine bottles may be issued to the vaccinating nurse without her having to move. Properly operated this should help speed up the number of vaccinations administered in a period,
- ii) if a person has to have more than one vaccination he is less likely to leave after the first if he has a physical object in hand to indicate there is more to come,
- iii) a double control may be effected on the total vaccinations administered in a day if the person issuing the jetons records the total number issued. This number would be compared at the end of the day both with the number of jetons returned and the number recorded in the daily vaccination register,
- iv) its use may be extended where appropriate to control the issue of chloroquine tablets and oral rehydration salts.

27. We recommend also that the card jeton be replaced by a plastic one. Each type of vaccine and each rappel would be represented by a jeton of a particular colour, size or shape, which will significantly reduce sorting time at the end of the day.

#### VACCINE USAGE REPORTS

28. Vaccine usage reports are prepared:

- i) daily in a notebook of daily usage,
- ii) monthly from the summarized notebook of daily usage.

We examined these reports and conclude that:

- i) many medical centres are not submitting reports,
- ii) mistakes are frequently made in those reports which are sent in,
- iii) the procedures at both subdivision and divisional levels for following up late reports is inadequate,
- iv) reports are often not identified as to origin, period to which they relate, the person who prepared them or the date of preparation.

29. we would attribute the reason for the relatively poor performance in report production to:

- i) inadequate supervision,
- ii) inadequately defined responsibilities,
- iii) lack of motivation originating from poor understanding of the importance of the reports and how they will be used,
- iv) poorly reproduced report forms,

- v) inefficient methods of data collection making the report preparation a time consuming task which conflicts with other duties,
- vi) occasionally a lack of basic equipment (pencils, paper).

30. We recommend that:

- i) report forms be preprinted,
- ii) methods for recording daily usage data be revised and that standard formats be used in all medical centres,
- iii) job responsibilities within the medical centres be defined,
- iv) that supervision of the medical centres be evidenced by check lists to be completed at the time of the periodic rounds by both subdivisional and divisional managers.

#### CHLOROQUINE SUPPLIES

31. Chloroquine tablets are administered under the CCCD program, only on a prophylactic basis and only to two groups of people:

- i) pregnant women from the time of their first prenatal consultation,
- ii) women in the first two months after the birth of their child.

It is of note however that chloroquine tablets received from other donor sources (UNICEF, OMS) are used for therapeutic purposes. Although our findings and recommendations are directed to the prophylactic program of the CCCD, our recommendations apply equally to the control of chloroquine for both prophylactic and therapeutic purposes.

## STORAGE

32. Storage conditions for chloroquine supplies are very rudimentary. Cartons of chloroquine supplied by UNICEF, OMS, AGFUND and CCCD are all stored in a small storeroom at the offices of the National Malaria Service. The store room is also used for the storage of vehicles spare parts, other mechanical devices, plastic and glass containers of varying sorts and bits and pieces not connected with the CCCD program. The whole area was very dusty. The number of cartons of chloroquine tablets stocked at the time of our visit was small and there was little room, without removing some of the vehicle spares or other bric a brac to store the large quantities which will be required for the national therapeutic and prophylactic programs. We also noted that to gain physical access to the chloroquine it was necessary to avoid several obstructing items.

33. We recommend that the storage facilities for chloroquine supplies be improved either by:

- i) removing non-medical items from the present location to create more space, or by
- ii) obtaining other storage facilities.

In both cases we recommend that the storage area be kept as clean as is appropriate for the storage of chloroquine tablets.

## CONTROL OVER RECEIPTS AND ISSUES OF CHLOROQUINE AT LOME

34. In general the weaknesses in control over the receipts and issues of chloroquine are the same as for those we have found for vaccines and our recommendations for improvement are as set out at paragraph 20.

## CONTROL OVER RECEIPTS AND ISSUES OF CHLOROQUINE AT MEDICAL CENTRES

35. Again the weaknesses we noted at the level of the subdivisions sanitaires and medical centres we visited are similar to those we noted for vaccines: lack of formal documentation for recording receipts and deliveries; lack of stock records, uncontrolled registers and note books used to record stock in and stock out. The national director of the malaria activities of the CCCD program told us that the person responsible in the past for installing control procedures were the medecins chefs. The national director told us that he was unaware of the procedures actually employed at the centres. Our recommendations to correct these weaknesses are detailed at paragraph 20.

### USAGE OF CHLOROQUINE

36. Issues of chloroquine for prophylactic purposes in the medical centres we visited were recorded in a rather haphazard way on a scrap of paper as each patient was issued her quota of tablets. One sheet of paper is used for each of the two categories of patient (see paragraph 31). At the end of the day the number of checks on these pieces of paper is totalled and recorded in a note book of daily usage. At the end of the month a standard report is prepared from the information contained in the note book of daily usage. This report shows:

- i) the number of pills issued to each group of women,
- ii) stock movements and the opening and closing stock situations.

The reports are sent to the National Malaria Service in Lomé.

37. The method of recording issues of chloroquine is prone to error and, in the larger medical centres with high activity, is inefficient. We noted that in some centres the chloroquine pills are dispensed from a central pharmacy against presentation of a prescription. In other instances the administering nurse or doctor gives the chloroquine directly to the patient.

38. We recommend that a system of plastic jetons be introduced (as recommended for vaccine issue control at paragraphs 26 and 27). This system would enable the rapid sorting at the end of each day of the two different categories of women who were given prophylactic treatment. It is of note that the system could also be used for the control of chloroquine issued for therapeutic purposes under other programs.

#### CHLOROQUINE USAGE REPORTS

39. Chloroquine usage reports are prepared on a monthly basis for submission to the National Malaria Service at Lomé. The reports are required so that national managers may foresee supply requirements in the interior and so that they may use the information to monitor the effects of the program. Although one standard form is in use it is not always properly completed and many centres have not yet sent in a report since the prophylactic programme began in May 1985. In our opinion the poor response of the medical centres to the requirement to submit properly completed reports regularly will be largely corrected by:

- i) more frequent supervision by the subdivisions sanitaires,
- ii) more active follow up by national managers in Lomé,
- iii) easier methods of collecting daily data,
- iv) precise instructions as to the procedures to be followed.

40. Our recommendations to correct the shortcomings in the submission of chloroquine usage reports are as set out at paragraph 30.

#### ORAL REHYDRATION SALT SUPPLIES

41. The oral rehydration programme requires the distribution of oral rehydration salt (ORS) packages to all medical centres throughout the country for administering to patients who, for one reason or another, are suffering from dehydration, usually through diarrhea. ORS packages may be given to out-patients or to nurses for in-patients.

42. The general situation in respect of the storage, controls over receipts, distribution and usage, and reporting is similar to that which prevailed for vaccines and chloroquine. Consequently our recommendations for improvement are similar:

- i) use of standard preprinted and prenumbered documentation for requisition of ORS supplies by the medical centres,
- ii) use of stock cards to control ORS stocks,
- iii) use of jetons to facilitate daily recording of ORS usage,
- iv) use of preprinted report forms,
- v) increased supervision of medical centres by the subdivision sanitaires, and of the subdivisions sanitaires by the national directors.

#### GASOLENE COUPONS

43. The project has purchased several cars for use by the national and regional centres for project related activities. Gasolene for the vehicles is purchased in Lomé in the form of coupons by the national project management and distributed to the various centres. It is of note that fuel for the vaccine refrigerators (powered by kerosene) is also purchased as coupons in Lomé and distributed to the regional medical centres. The coupons for gasolene and kerosene are identical, are prenumbered for control purposes and are purchased from Shell. Each gasolene coupon is good for 10 (or 20) litres of super (cost 205 FCFA per litre). The coupons are issued in books of 100 i.e. sufficient for 1000 (or 2000) litres of fuel. The project vehicles are Peugeot 504 station wagons and 404 pick-ups, which have a fuel consumption of around 16 kilometers per litre. Thus one book of coupons is good for 16000 kilometers. It is of note that 15 gasolene coupons will purchase 228 litres of kerosene (135 FCFA per litre) which we understand is more than sufficient to power the vaccine refrigerators for a

year. We therefore recommend that the number of gasoline coupons per book be reduced to 15. This number will provide either sufficient fuel for the Peugeots to cover approximately 2400 kilometers (a month's average use), or sufficient kerosene for one year for the vaccine refrigerators (to be distributed monthly by the medicin chef). Although registers are maintained in Lomé by the project accountant (one to record receipts of gasoline coupons and a separate one to record distribution) they are insufficient to provide proper control over their usage.

44. The recording of the receipt and issue of gasoline coupons is not, in itself a valid method of controlling gasoline usage. This may only be achieved by controlling vehicle use, through regular maintenance of a vehicle log sheet. Log sheets have been introduced in Lomé but these are inadequate in that they do not allow enough detail to be recorded in respect of each trip made. We did not see vehicle logs in use in the other medical centres we visited.

45. We recommend the following:

- i) design and implementation of registers to control the receipt and issue of gasoline coupons,
- ii) redesign of the vehicle logs to permit sufficient detail to be recorded,
- iii) procedures to ensure that vehicle log sheets are reviewed by national project management to ensure that vehicles are only being used for project purposes.

## CONTROL OF EXPENDABLE COMMODITIES

46. Expendable commodities covers such items as lamps and wicks for vaccine refrigerators, syringes and needles, paper, pencils, files, bics, stencils, vaccination cards, accounting and report stationary. All these items will be requested at one time or another by the medical centres in the country. In the course of our visits to the centres we noted a variety of different types of documentation in use and, on more than one occasion, we were told of shortages of essential supplies. We found that in general, with the exception of vaccination cards, lamps and wicks, no arrangements had been made at the national level to stock and supply the medical centres with the various items they need to operate effectively. Certainly no written directives exist to explain how or from where such supplies should be obtained. In our view it is essential for the proper and efficient functioning of the project that each and every medical centre should properly equipped. For this to be possible the following conditions must pertain:

- i) each centre must know what supplies are available from the central supply point and where that supply point is located
- ii) each centre must constantly survey its stocks of general supplies so that requisitions for further supplies may be made in time to avoid shortages,
- iii) a speedy and efficient method of communicating requirements to the central supply point,
- iv) proper documentation and registers to expedite and control both requisition and subsequent delivery,
- v) adequate numbers of personnel at the various stages of the procedure to ensure timely execution,
- vi) sufficient supplies available at the central supply point (Lomé).

We understand that a location has yet to be identified which could conveniently serve as a storeroom for expendable commodities.

47. We recommend that:

- i) as a matter of urgency a secure location be identified to serve as a storeroom for expendable commodities. The storeroom must be under the direct control of one of the national divisions,
- ii) a stock recording system be set up at Lomé to control receipts, issues and consumption of expendable commodities,
- iii) procedures be developed to ensure the timely transfer of expendable commodities from Lomé to the medical centres as and when required.

#### OVERALL PROJECT COORDINATION

48. We noted that there was no dissemination of general project information either at the national or at the regional level. Although project managers at the national level, and medecins chefs or their adjoints at the regional level make periodic visits to medical centres, reports are not always produced. Where reports are produced they appear to be more for internal use at either national or regional level than as a method of providing feedback to the medical centres visited or of providing general information to all project managers in respect of project progress. It is of note that we were unable to ascertain how many times each medical centre had received a control visit from a national and regional manager.

49. We recommend that communication at all levels (between the national project managers themselves, between national project managers and regional managers, and between regional managers and those responsible at the medical centres) be improved. Specifically we recommend that consideration be given to:

- i) planning in advance how many visits should be made to the medical centres and by whom,

- ii) drawing up a standard combined check list and report of procedures to be followed during the visits. Such procedures would include test checking the proper operation of commodity controls, inspecting inventories and making test counts, and enquiring as to any practical problems being experienced. A copy of the completed check list would be left with the centre visited so that any shortcomings noted during the visit could be remedied,
- iii) arranging for all visit reports to be sent to Lomé, distributed to all national managers for comment and then discussed at a monthly meeting of national managers,
- iv) summarising the results of the visits and the national managers' meeting in a report which will be sent to the various medical centres.

We recommend that at the national level, in the interest of economy, managers making visits to medical centres should cover all aspects of the project and not just their own speciality.

#### TRANSPORTATION OF COMMODITIES

50. The present method of putting project commodities into the field (both medical and expendable general supplies) is inefficient: each subdivision sanitaire sends its own vehicle to Lomé as and when it needs to restock on certain supplies. This is costly both in terms of use human resources and in vehicle running costs.

51. We recommend that alternative procedures for putting commodities into the field be investigated. The alternative which we recommend would be delivery, direct from Lomé to the subdivision sanitaires, using a truck purchased specifically for this purpose.

52. This preliminary report has been discussed and agreed with Messrs. R. Thomas and K. Murphy. We would like to take this opportunity to thank your staff and the project personnel for their assistance and co-operation during this first phase of our mission.

Yours truly,

*Deloitte Henkin & Lee.*

ANNEXE 1DESCRIPTION DE TACHERESPONSABLES DES ACTIVITES CCCD  
AUX CENTRES FIXES ET DISPENSAIRES

- LIEU** Un agent dans chaque centre fixe sera désigné pour superviser l'exécution des différents volets du projet CCCD. Il s'occupera à la fois des trois composantes du projet, à savoir vaccinations, chloroquine et sel de rehydratation orale (SRO).
- HIERARCHIE** Il sera responsable devant les agents de la subdivision du bon déroulement de la réalisation du projet CCCD au niveau du centre.
- RESPONSABILITES** Ses responsabilités sont les suivantes:
- S'assurer tous les jours de la disponibilité des produits nécessaires à l'exécution du projet (chloroquines, vaccins, ORS).
  - En cas de besoin, faire une réquisition pour demander ou bien les produits manquants ou bien ceux qui risquent de manquer. (Voir si le seuil minimum défini est dépassé).
  - Faire des rappels en cas de réquisition sans suites.
  - S'occuper de la réception des produits (visa sur bordereau d'envoi/réception),

- Faire les enregistrements sur le registre des réceptions et les fiches de stock.
- Mettre les produits aux endroits appropriés en veillant aux conditions hygiéniques nécessaires à leur bonne conservation.
- Désigner la ou les personne(s) chargée(s) de l'exécution de la tâche principale.
  - a. distribution de comprimés de chloroquine chloroquines
  - b. vaccinations
  - c. distribution des sachets de SRO
- Superviser l'enregistrement:
  - a. dans le registre pré ou post natal des femmes qui reçoivent les chloroquines,
  - b. dans le registre des vaccinations en spécifiant les vaccins reçus des femmes et des enfants vaccinés
  - c. en encre rouge dans le registre des consultations des personnes qui reçoivent les sachets de SRO.
- Contrôler plusieurs fois dans la journée l'exactitude des enregistrements
- S'assurer par des contrôles fréquents dans la journée, de l'application des méthodes de travail préconisées (distribution de chloroquines, vaccinations, distribution des sachets SRO).
- Faire le décompte des jetons (chloroquines, vaccination, SRO) et inscrire les chiffres de la journée dans les cahiers spécifiques prévus à cet effet.

- S'assurer de l'exactitude des chiffres et faire viser par le responsable du centre.
- S'assurer tous les soirs du rangement, dans les conditions hygiéniques appropriées, de tous les produits et matériels employés pendant la journée (comprimés, SRO, seringues, registres, jetons),
- Etablir à la fin de chaque mois le rapport sur:
  - a. la distribution des comprimés de chloroquine,
  - b. les vaccinations,
  - c. la distribution des SRO.
- Faire viser les rapports mensuels par le responsable du centre.
- Envoyer, par les moyens les plus appropriés, les rapports établis à la subdivision dont relève le centre en respectant les délais fixés: (5 jours ouvrables au plus à la fin du mois).
- Faire, à la fin de chaque mois, un inventaire physique de tous les produits et matériels relatifs au projet.
- Etablir un rapprochement entre les résultats de l'inventaire physique et les soldes selon les rapports mensuels.
- Expliquer les écarts dans un rapport écrit dont une copie sera envoyée au responsable des subdivisions sanitaires avec le rapport mensuel.
- Faire tous les trois mois un rapport général d'activité au responsable de la subdivision.

ANNEXE 2DESCRIPTION DE TACHEMEDECIN-CHEF DE LA SUBDIVISION

- LIEU** Les médecins chefs sont installés dans la polyclinique la plus importante du chef lieu de chaque préfecture.
- HIERARCHIE** Le médecin chef de la subdivision est responsable vis à vis des quatres adjoints de Lomé (EPI, SNP, SRO, Education Nationale) du bon déroulement du programme dans chacune de ses trois composantes au niveau de la subdivision.
- RESPONSABILITES** Ses responsabilités sont les suivantes:
- Faire des tournées périodiques dans les centres fixes et dispensaires pour s'assurer que les responsables locaux assument pleinement les tâches qui leur incombent.
  - Mener, le cas échéant, les actions nécessaires pour corriger les défauts et lacunes constatés.
  - Rencontrer chaque semaine les responsables de la subdivision des différents volets du projet (EPI, SNP, SRO) pour faire le point de la semaine écoulée et planifier la semaine à venir. Les éventuels problèmes sont soulevés à cette concertation et des solutions sont trouvées.

- Avertir le responsable de Lomé tous les deux mois dans un rapport écrit du progrès du projet, des problèmes éventuels, et des solutions trouvées.
- Viser les rapports mensuels établis par les responsables de la subdivision (EPI, SNP, SRO).
- Viser les rapports des centres fixes dépendant de la subdivision (après vérification par le responsable de la subdivision).
- S'assurer auprès des responsables que les exemplaires qui doivent être expédiés à Lomé l'ont été dans les délais définis au préalable (10 jours ouvrables maximum après la fin du mois).
- Vérifier les sommaires mensuels établis par le responsable et le viser avant son envoi à Lomé.
- Faire des contrôles périodiques sur les lieux de vaccination, de distribution des comprimés de chloroquine et de distribution de SRO pour s'assurer de l'application des méthodes préconisées dans chaque domaine.
- Effectuer des vérifications surprises (au moins trois fois par mois) des registres, fiches de stock pour s'assurer de leur bonne tenue et de leur mise à jour. Cette vérification surprise est matérialisée par son paraphe et la mention de la date.
- S'assurer que les produits (vaccins, chloroquines, SRO) sont conservés selon les normes préconisées en la matière.
- Veiller à ce que les ruptures de stocks sont évitées.
- Fixer, en accord avec les responsables à Lomé, le seuil minimum de différents stocks (vaccins, chloroquine, SRO et fournitures générales).

- Elaborer une politique pour la destruction des produits dont la date de préemption est dépassée.
- Certifier à la fin de chaque mois la liste des vaccins périmés qui ont été détruits.
- Participer à certains inventaires physiques pour s'assurer que tous les produits sont comptés, qu'il sont comptés une fois seulement et que les stocks périmés sont bien marqués sur les feuilles d'inventaire.
- S'assurer du bon archivage de toutes les pièces relatives au projet (bordereau d'envoi/réception, réquisition, rapports mensuels, états de synthèse, PV des réunions.)
- Viser les carnets de bord des véhicules régulièrement pour s'assurer de la régularité des déplacements et de la bonne utilisation des bons d'essence.
- Approuver des déplacements de véhicules et distribuer les bons d'essence en conséquence.
- Faire un rapport sur l'utilisation du carburant et justifier les déplacements effectués.
- S'assurer de la disponibilité et de l'approvisionnement en bons de carburant (essence et pétrole).

ANNEXE 3DESCRIPTION DES TACHESRESPONSABLE DES DIFFERENTS VOLETS DU PROJET A LA SUBDIVISION

- LIEU** Un agent dans chaque subdivision sera désigné pour superviser la réalisation du programme palustre au niveau de la subdivision.
- HIERARCHIE** Cet agent est responsable devant le médecin-chef de la subdivision du bon déroulement du programme.
- RESPONSABILITES** Ses responsabilités sont les suivantes:
- Faire des tournées périodiques pour s'assurer que les responsables des centres assument normalement les responsabilités qui leur sont dévolues. (voir description des tâches du responsable des centres fixes et dispensaires).
  - Mener, le cas échéant les actions nécessaires pour corriger tout défaut constaté.
  - Faire un rapport des résultats de la tournée à l'attention du médecin-chef.
  - S'assurer tous les jours de la disponibilité suffisante des produits médicaux et générale pour alimenter la subdivision et les centres qui en dépendent.
  - Etablir le cas échéant les réquisitions sur Lomé pour alimenter le stock. Faire des relances pour les réquisitions qui restent sans suite.

- Réceptionner les produits à leur arrivée, viser.
- Faire les enregistrements dans le registre des réceptions et sur la fiche de stock.
- Ranger les produits reçus convenablement à l'endroit habituel.
- Répondre aux réquisitions envoyées par les centres fixes après analyse et justification de la demande.
- Veiller au classement des bordereaux de réquisitions.
- Tenir le registre des livraisons et les fiches de stock à jour au niveau des sorties.
- Au niveau de la subdivision, veiller à la bonne application des méthodes de travail préconisées concernant:
  - a. la distribution des produits par jetons,
  - b. l'enregistrement des femmes sur les registres pré ou post natal,
  - c. le décompte des jetons en fin de journée,
  - d. l'établissement de rapports d'usage de la journée sur les cahiers de distribution de produits.
- Viser les cahiers de distribution en fin de journée.
- Etablir les rapports mensuels chaque fin de mois et les faire viser par le médecin-chef.
- Vérifier les rapports mensuels envoyés par les centres fixes et s'assurer qu'il n'y a pas d'erreurs dans les opérations et dans la détermination du stock final.

- Faire viser les rapports des centres fixes par le médecin-chef.
- Etablir l'état de synthèse de tous les rapports mensuels de la subdivision.
- Envoyer un jeu de tous les rapports et de l'état de synthèse à Lomé dans les délais préalablement définis (10 jours ouvrables au plus à la fin du mois).
- Classer le deuxième jeu de rapports et de l'état de synthèse par groupe.
- Faire un inventaire physique des stocks des différents produits chaque fin de mois.
- Etablir un rapprochement entre les résultats de l'inventaire physique et l'état des stocks sur les fiches de stock.
- Expliquer les écarts dans un rapport dont une copie, visée par le médecin chef sera envoyée à Lomé.
- S'occuper de l'entretien et des réparations des véhicules CCCD qui sont affectés à la subdivision.
- Vérifier avant chaque déplacement la mise à jour du carnet de bord du véhicule.
- Faire un rapport sur tout dégât au médecin chef pour transmission à Lomé.

ANNEXE 4DESCRIPTION DES TACHESRESPONSABLES DES DIFFERENTS VOILETS DES PROJETS A LOME

Les responsables des Divisions Nationales, ayant en plus de leurs responsabilités dans le projet CCCD de nombreuses autres responsabilités il leur faut un adjoint au niveau national qui sera beaucoup plus proche du projet, et qui veillera à son bon fonctionnement dans les moindres détails.

LIEU Lomé - Direction de la division

HIERARCHIE Ils sont responsables devant les directeurs nationaux et leur feront des compte-rendus chaque fois que cela sera nécessaire.

RESPONSABILITES Les responsabilités sont les suivantes:

- Co-ordination et supervision générale du volet du projet, organisation générale, rencontre avec les représentants de l'AID pour la programmation générale, rencontre avec le directeur général du projet.
- S'assurer de la disponibilité suffisante de produits médicaux et généraux pour l'approvisionnement au niveau national.
- Faire faire les commandes auprès du représentant de l'AID en cas de besoin.
- S'assurer de la bonne réception des produits, de leur enregistrement correcte sur le registre de réceptions et sur les fiches de stocks.
- S'assurer du bon stockage des produits en veillant aux conditions d'hygiène en vigueur en la matière.

- S'assurer que les réquisitions envoyées par les subdivisions sont analysées (comparaison avec leur consommation moyenne normale et avec les quantités en stock selon les derniers rapports) et les produits envoyés dans les délais (5 jours ouvrables au plus).
- Liaison avec le co-ordinateur national du projet pour la planification des véhicules nécessaires à la distribution.
- Effectuer les analyses et états de synthèses trimestriels à partir des rapports reçus mensuellement.
- Faire des tournées périodiques dans les subdivisions (et parfois des centres) pour s'assurer du bon fonctionnement du programme et résoudre les problèmes éventuels.
- Faire un rapport détaillé des problèmes rencontrés dans les subdivisions au responsable général.
- Tenir tous les registres, le classement et archivage de toute la documentation relative au projet.
- Effectuer la prise d'inventaire mensuelle. Vérifier qu'il n'y a pas de produits périmés dans les stocks
- Effectuer le rapprochement de l'inventaire avec les fiches de stock.
- Fournir par écrit des explications sur les écarts éventuels au Directeur National du projet.
- Faire un rapport général d'activité tous les trois mois.
- Définir avec le Directeur National une fréquence de concertations périodiques pour suivre l'évolution du programme.
- Faire les rappels auprès des subdivisions qui n'envoient pas leur rapport.
- Fixer, en accord avec les médecins chefs des subdivisions sanitaires, le seuil minimum des différents stocks.

APPENDIX 5TRAINING OBJECTIVES, METHODOLOGY  
AND SKILLS NEEDS ANALYSIS

## OBJECTIVES

1. The objectives of the training course are:

- i) to impart to project personnel a working understanding of the new systems and procedures,
- ii) to ensure that national and regional management are able to implement the new procedures and to supervise implementation at the level of the medical centres,
- iii) to ensure as far as possible that staff from medical centres may implement the new procedures directly,
- iv) to ensure that each participant has a thorough understanding of the nature of the project and of where he fits into the overall picture,
- v) to emphasise the importance of the role of each person engaged on project activities to the success of the project as a whole,
- vi) to provide an initial stock of documentation to the various medical centres.

2. The training course cannot ensure the actual implementation of the new or revised procedures - this task must be left to the designated personnel with appropriate supervision from the regional centres and from the national co-ordinator.

3. A tentative list of the proposed subjects to be covered during the training sessions, and the staff who will attend the courses is as follows (SS = Subdivision Sanitaires ; MC = Medical Center)

|                                       | <u>NATIONAL</u> | <u>REGIONAL</u> | <u>MEDICAL CENTRES</u> |
|---------------------------------------|-----------------|-----------------|------------------------|
| <u>Accounting</u>                     |                 |                 |                        |
| Authorisation procedures              | v               | -               | -                      |
| Ordering                              | v               | -               | -                      |
| Maintenance of cash and bank books    | v               | -               | -                      |
| Preparation of reports on expenditure | v               | -               | -                      |
| Asset control                         | v               | -               | -                      |
| Filing                                | v               | -               | -                      |
| <u>General supplies</u>               |                 |                 |                        |
| Requisition by SS and MC              | -               | v               | v                      |
| Receipt and distribution              | -               | v               | v                      |
| Stock control                         | v               | -               | -                      |
| Overall control                       | v               | -               | -                      |
| <u>Petrol control</u>                 |                 |                 |                        |
| Requisition by SS                     | v               | v               | -                      |
| Coupon control                        | v               | v               | -                      |
| Vehicle log sheets                    | v               | v               | -                      |
| <u>Overall co-ordination</u>          |                 |                 |                        |
| Planning tournée                      | v               | v               | -                      |
| Tournée checklists                    | v               | v               | -                      |
| <u>Medical supplies</u>               |                 |                 |                        |
| Requisition by SS and MC              | v               | v               | v                      |
| Receipts and issues (Lomé)            | v               | -               | -                      |
| Receipts and issues by SS and MC      | v               | v               | v                      |
| Stock control                         | v               | v               | v                      |
| Vaccine supplies                      | v               | v               | v                      |
| Chloroquine supplies                  | v               | v               | v                      |
| ORS supplies                          | v               | v               | v                      |
| Report preparation                    | v               | v               | v                      |
| Use of reports                        | v               | v               | -                      |
| <u>General</u>                        |                 |                 |                        |
| Project overview                      | v               | v               | v                      |
| Control of accounting documentation   | v               | -               | -                      |
| Maintenance of stock levels           | v               | v               | v                      |

## METHODOLOGY

4. We have computed from various sources of information supplied to us, that the total maximum number of subdivisions sanitaires and medical centres in the five regions are as follows:

| <u>Région</u> | <u>Subdivisions<br/>sanitaires</u> | <u>Medical<br/>centres</u> |
|---------------|------------------------------------|----------------------------|
| Maritime      | 5                                  | 101                        |
| Plateau       | <u>5</u>                           | <u>109</u>                 |
|               | <u>10</u>                          | <u>210</u>                 |
| Centrale      | 3                                  | 34                         |
| Kara          | 6                                  | 74                         |
| Savanes       | <u>2</u>                           | <u>48</u>                  |
|               | <u>11</u>                          | <u>156</u>                 |
| Total         | <u>21</u>                          | <u>366</u>                 |

5. We have not been able to obtain from project management a list of names of the persons responsible at the various medical centres and subdivisions and so, for the purposes of planning the training exercise, we have assumed that one person will attend from each of the medical centres and two persons from the subdivisions sanitaires, one of whom must be the medecin chef. The total number of people to attend the courses would therefore be:

|                      | <u>Subdivisions<br/>sanitaires</u> | <u>Medical<br/>centres</u> |
|----------------------|------------------------------------|----------------------------|
| Maritime and plateau | 20                                 | 210                        |
| Other regions        | <u>22</u>                          | <u>156</u>                 |
|                      | <u>42</u>                          | <u>366</u>                 |

6. We plan to give the training to classes of not more than 20 participants. Because of differences in course content, the length of each course will not be the same. The following table shows where the course is planned to be held, the chronological order in which they will be given and the total number of work days (including three days travel and course set up):

| <u>Order</u> | <u>Personnel</u>                        | <u>Location</u> | <u>N° days per course</u> | <u>total N° work days</u> |
|--------------|---|-----------------|---------------------------|---------------------------|
| i)           | National managers                       | Lomé            | 3.0                       | 3                         |
| ii)          | Regional managers                       | Lomé            | 1.5                       | 3                         |
| iii)         | Medical centres in maritime and plateau | Lomé            | 1.5                       | 16                        |
| vi)          | Other medical centres                   | Kara            | 1.5                       | <u>12</u>                 |
|              |   |                 |                           | <u>34</u>                 |

7. It is planned that training will begin in the first week of October when the manuals have been finalised and all the new documentation and stationary has been printed.

#### NATURE OF THE COURSES

8. Each course participant will have course material (procedures and examples of documentation) relating to his particular area of responsibility. The training will consist of going through the various procedures and explaining them in detail. Where practicable worked examples will be presented. It is hoped to be able to use flip charts and overhead projection equipment to illustrate the various features of the system. The time we have allowed for each course will only allow for training in groups of 20. It will not allow for personal attention or supervision where individuals have difficulty in understanding basic theory.

9. We would expect to have a complete list of the names of all persons who will attend the training courses together with their official title, whether they are totally free to be occupied full time on project activities and, if not, a complete list of other activities in which they will be involved.

## SKILLS NEEDS ANALYSIS

### Project accountant

10. The project accountant requires training and instruction in order to be able to carry out the following daily and monthly asks:

- maintenance and monthly balancing of analysed bank and cash books,
- maintenance of an outstanding order register,
- maintenance of a supplier invoice register,
- preparation of bank reconciliations,
- preparation of the monthly reports to USAID,
- maintenance of an equipment register to record and control the location of project equipment,
- operation of the general supplies stock control system including the recording of receipt and disbursement of suppliers to medical centres,
- maintenance of a petty cash

### Project managers at all levels

11. The persons in charge of the CCCD operations at the medical centres and dispensaries will require training in the following:

- operation of the stock control system including receipt and disbursement of stocks of medical supplies,
- maintenance of control registers,

- basic inventory procedures;
- preparation of monthly reports,
- the use of commodity requisition forms.

National coordinator

12. In addition to the attributes described at paragraphs 10 and 11 above the national coordinator will require training in the maintenance of the petty cash control system.

APPENDIX 6OVERVIEW OF MODIFIED SYSTEMSFINANCIAL CONTROL

## INTRODUCTION

1. The project accounting will continue to be maintained at the Division d'Epidemiologie. All cheques and cash payments will originate from here and the accounting records will be maintained here. The accounting records will consist of:

cash book  
bank book

The accounting documentation to be used is:

request for approval of expenditure  
petty cash voucher  
cheque payment voucher

Accounting control documentation will include:

detailed budget  
bank reconciliation  
petty cash count forms  
monthly report on expenditure and committed funds  
registre de commande des biens et services  
registre des factures reçues mais non réglées  
justification of the balance of amounts advanced

## BUDGETS

2. USAID should prepare a detailed budget showing, for each line item, the amount of US \$ and the equivalent amount of FCFA at the prevailing exchange rate, available to the project for local currency expenditure. A copy of this budget should be distributed to each of the four national project managers and to the accountant. This detailed budget will be updated every month to take account of amounts expended in the month and changes in the exchange rate.

## OBTAINING FUNDS

3. When funds are required by the project managers a request for approval of expenditure will be completed and submitted to the national project coordinator and the directeur général de la santé publique for approval. Funds will then be drawn to pay for the expense. Cheques will be signed by the Directeur Général and by the Ministère de la Santé Publique.

## KEEPING TRACK OF COMMITTED FUNDS

4. Orders placed with supplies will be recorded in an order register. Suppliers invoices received but not due for payment until later will be recorded in a register of suppliers invoices. The order register will be cross referenced to the supplier register and the supplier register to the cash or bank book.

## RECORDING PAYMENTS FOR PROJECT EXPENDITURES

5. All payments for project expenditures, supported by a petty cash voucher or cheque payment voucher, together with approving documentation will be recorded immediately in the cash or bank book as appropriate. The cash and bank books will be analysed by budget line item.

## PREPARING REPORTS FOR GOT AND USAID

6. Each month the cash and bank books will be balanced and totalled and the total expenditure for each line item transferred to the Monthly Report on Expenditure and Committed Funds. Each month details of unpaid invoices and unfulfilled orders will be extracted from the registers of orders and invoices and also entered on this report. The report will be sent to USAID and each of the four national project managers. USAID will analyse the report, calculate the dollar equivalent of the expended and committed funds and ascertain remaining dollar funds. The figure of remaining dollar funds will be used to prepare the following month's detailed budgets.

7. Each month a further report, Justification of Amounts Advanced will be prepared by the project accountant for submission to USAID together with the vouchers, copies of the cash and bank book, bank reconciliation and bank statement.

APPENDIX 7OVERVIEW OF MODIFIED SYSTEMSCOMMODITY CONTROL - REQUISITION AND RECEIPT

1. Commodities comprise the following :

- Vaccines
- Chloroquine
- Oral rehydration salts
- General supplies
- Fuel (gasolene and kerosene)

2. Commodities will be stored at predetermined places. Each medical centre, dispensary and subdivision sanitaire will be advised of the location from which it will obtain the different supplies it needs.
3. When a medical centre needs supplies it will request them on a preprinted and prenumbered "Bon de Requisition". The bon de requisition will be sent to the supply centre. (Note that a separate bon de requisition will be raised for each different type of commodity). Procedures for the medical centres to follow up outstanding requisitions will be facilitated by using a stub copy of the requisition.
4. The supply centre will approve the bon de requisition and initiate the selection of the commodities required. A preprinted and prenumbered "Bordereau d'Envoi/Réception" will be made out by the supply centre to accompany the goods back to the medical centre.
5. At the supply centre details of the goods sent will be noted both in a goods delivered register and on stock cards.

6. Upon receipt of the commodities at the medical centre, details will be recorded in a register of goods received. Medical supplies (not general supplies) will also be recorded on stock cards.
7. Copies of the bordereau d'envoi/réception will be filed at both the supply centre and the receiving centre to evidence the transfer.
8. A copy of the bordereau d'envoi/réception at the supply centre will be filed in medical centre order and will allow the supply centre to monitor usage of commodities.

APPENDIX 8OVERVIEW OF MODIFIED SYSTEMSCOMMODITY CONTROL - USAGE AND REPORTS

1. Controls over usage of commodities will effected at:
  - the point of final use for vaccines, chloroquine, and ORS
  - the point of supply for general supplies and gasolene

## MEDICAL SUPPLIES

2. Usage of medical supplies at medical centres and subdivisions sanitaires will be recorded through the use of plastic jetons in preprinted daily usage books. The daily usage book totals will be used to update stock cards.
3. At the end of the month the daily usage book will be totalled for the month's usage. These totals will be used to prepare the monthly report. The monthly report forms will be preprinted in three copies.
4. At the end of the month a physical inventory of medical supplies will be taken. The results of this inventory will be compared with the stock cards. Any differences will be explained in a written report. Lomé will be kept informed of all differences and their explanation.

## GENERAL SUPPLIES

5. Control over use of general supplies will be effected at the point of supply (Lomé), where the file of requisitions for the particular centre will be reviewed to assess whether the immediate request is reasonable.

APPENDIX 9OVERVIEW OF MODIFIED SYSTEMSPETROL COUPON CONTROL

## POLICIES

1. Initially coupons will be issued only on the basis of budgetted kilometres according to a well defined program of "tournées".
2. Subsequently coupons will be issued on the basis of actual kilometres done for project purposes.
3. Coupons for gasolene will be issued for one month's projected consumption at a time.
4. Coupons for kerosene will be issued for the year in advance.

## CONTROL OF COUPON PURCHASE

5. Coupons will be purchased centrally in Lomé. The quantity purchased will equal the projected requirements of the project for the following two months.
6. Coupons receipts and issues will be recorded in Lomé in a manually ruled "Coupon purchased and distribution register".

## CONTROL OF COUPON USAGE

7. A register of coupon usage will be maintained by each centre (or division) which runs a car.
8. A vehicle log will be maintained for each journey undertaken by a project car. This register will enable gasolene consumption to be calculated.

9. Vehicle logs will be checked each week to ensure:
  - i) the vehicle is being used only for project purposes,
  - ii) gasoline consumption is reasonable
10. National managers will perform checks on the vehicle logs and coupon usage register at the time of their periodic "tournées".

APPENDIX 10OVERVIEW OF MODIFIED SYSTEMSASSET CONTROL

## PRINCIPALS

1. An asset is defined as any durable item with a life expectancy in excess of two years and whose cost exceeds 50.000 FCFA.
2. A register will be kept to record details of each asset purchased for the project.
3. Each asset will be accorded a unique identifying number.

## METHOD

4. The asset register, which will be manually ruled, will be maintained by the project accountant.
5. The register will be updated from the details recorded in the project cash and bank books and from advices received from USAID.
6. An inventory of fixed assets will be carried out each year and agreed with the asset register.