THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Audit of Global Fund Grants to the Republic of Burundi

GF-OIG-11-003
3 August 2012

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EXECUTIVE SUMMARY

Introduction

1. As part of its 2011 workplan, the Office of the Inspector General (OIG) carried out an audit of Global Fund grants to Burundi from April 11 to June 12, 2011. The audit covered all ten grants totaling USD 141.6 million, of which USD 113.9 million had been disbursed, from December 2003 (the inception date of the first grant) to 15 April 2011. The Principal Recipients (PRs) in Burundi were two public sector entities, viz. the Executive Secretariat of the National AIDS Control Commission (SEP-CNLS) and the National Tuberculosis Control Program (PNLT); and two civil society organizations viz. the Burundi Network of People Living with HIV/AIDS (RBP+) and CED-CARITAS.

2. This report presents 23 "High Priority" recommendations and 18 categorized as "Significant Priority"[1]. 11 other recommendations have been offered to management that "Require Attention" to address minor control weaknesses or non-compliance.

The Public Health Response

3. The HIV epidemic in Burundi has stabilized. Infection rates among groups at high risk are falling or have remained low. The documented increase in condom use among female sex workers was a contributory factor. Further, access to treatment for people living with HIV has expanded rapidly. The quality and follow-up of treatment and care was very good, as indicated by an 82 percent 24-month treatment adherence rate reported to UNGASS in 2011. However, there was scope for improvement in the following areas:

a) The Global Fund-supported health sector activities were managed as "projects" with insufficient attention to sustainability and to strengthening of the national health system;
b) There was a need to establish guidelines for treatment of opportunistic infections;
c) The supervision of clinical HIV services needed improvement. For example, HIV testing was continued by service providers despite the absence of confirmatory tests; and
d) There was a need to increase the utilization of Prevention of Mother to Child Transmission (PMTCT) services which was found to be low.

4. The tuberculosis control program was found to be performing well with steadily increasing case detection rates, high cure rates and low default rates. Clinics were well supervised and data were reliable. This was independently verified by an evaluation conducted by WHO in 2011. However, scope for improvement was noted in the diagnosis and treatment of MDR tuberculosis. The treatment regime was not approved and laboratory services were insufficient. The security of the MDR inpatient facility was in need of improvement.

5. Malaria treatment with ACT was standard throughout Burundi; the treatment was free of charge, and an increasing proportion of malaria diagnoses were confirmed by microscopy or RDT. Insecticide-treated bed-nets were distributed free of charge in ante-natal and immunization clinics, and a mass distribution campaign has achieved almost universal coverage.

[1] Recommendations are categorized as: "High Priority", "Significant Priority" and "Requires Attention". Definitions are at paragraph 55

6. However, the institutional ties of the Global Fund-supported program to the national malaria program were weak. Greater effort and resources needed to be allocated to developing and supporting the capacity of the national malaria program to exercise its role as technical leader in the national response to malaria. Further, the system of quality control for malaria microscopy had scope for improvement, as did the level of supervision provided by the provincial and district health teams.

Procurement and Supply Chain Management

7. There was a continuous flow of ARVs with no major stock-outs observed at the time of the OIG mission. However, there was scope to improve the following areas: (a) coordination of forecasting, procurement and distribution of HIV drugs and related supplies as well as condoms; (b) adoption of formal procedures for drug monitoring and drug management;
and (c) strengthening of controls over drugs for opportunistic infections and for sexually transmitted diseases.

8. Tuberculosis drugs were available and both quantification and procurement were well managed with assistance of the Global Drug Facility. The distribution system was working well with the support of the provincial tuberculosis coordinators.

9. There was continuous supply of ACTs without major shortages since 2004 through a partnership with the United Nations Children's Fund (UNICEF). However, in response to an increase in reported malaria cases in 2009 and 2010, the PR started to ration the supply of ACTs to health facilities, which led to local shortages and to substitution therapy with quinine.

Financial Management and Control

10. The OIG noted scope for improvement in financial management as well as control weaknesses that were common to all grant implementing organizations audited (PRs, SRs and implementing organizations). The underlying causes for these financial management and internal control weaknesses were (a) a lack of sufficiently qualified accounting staff in the country; and (b) insufficient supportive supervision of implementing entities by PRs.

11. This report includes tables in the Annexes that identify a total amount of USD 30,724 that should be recovered to the grants, largely due to over-payments on payment vouchers documented during the audit.

Governance and Program Oversight

12. The CCM had scope for improving the strategic direction and oversight it provided to ensure that Global Fund grants were implemented in a way that strengthened national systems and structures to promote sustainability.

13. There was scope for the CCM to ensure that there was a functional internal audit mechanism to provide effective assurance over the grants.

14. The Global Fund Secretariat needs to ensure that the Terms of Reference of external audits fully comply with the Audit Guidelines of the Global Fund, to provide effective oversight of the grants.

Overall Conclusion

15. The Global Fund-supported programs in Burundi have achieved significant positive results in all three disease areas. However, the health sector activities of the malaria and HIV program were insufficiently embedded in the national health system and were frequently implemented in parallel with the relevant institutions of the Ministry of Health without due attention to strengthening these institutions.

16. The OIG found that generally drugs were available for the treatment of HIV and TB. The rationing of ACTs to health facilities instituted in early 2011 led to incidences of stock-outs that point to a need to strengthen the quantification, monitoring and reporting systems for ACTs.

17. There is much scope for improvement in the financial management area. Addressing these weaknesses will contribute to enhancing the control environment within which the grants are implemented.

18. Based on the findings in this audit, the OIG is not able to provide the Global Fund Board with reasonable assurance over the effectiveness of controls in place to manage all the key risks impacting the Global Fund-supported programs and operations.

Events Subsequent to the Audit

19. After the OIG shared the report with the CCM and Principal Recipients, the PRs provided additional information and clarifications that could not be verified since the audit fieldwork on which this report was based took place twelve months ago. The OIG agreed with the PRs that the Global Fund Secretariat should request the LFA to verify further information and documentation provided; and amounts indicated to be refunded in Annexes 3 to 9 would be adjusted, if appropriate.

MESSAGE FROM THE GENERAL MANAGER

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

10 YEARS OF IMPACT

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Our ref: OGM/GJ/JK/2012.07.31-BURUNDI

31 July, 2012

MESSAGE FROM THE GENERAL MANAGER

I would like to thank the Office of the Inspector General for its thorough and insightful work on the audit of Global Fund grants to the Republic of Burundi.

The audit was carried out between April 11 and June 12, 2011 and covered all ten grants to Burundi, totalling at that time US$ 141.6 million - of which US$ 113.9 million had been disbursed from December 2003 (the inception date of the first grant) to April 15, 2011. Significant progress has been made in the fight against the three diseases, according to the audit report. Three successive Global Fund grants have contributed significantly to a rapid scale up of the HIV response in the last decade. The HIV epidemic in the country has stabilized and infection rates among groups at high risk are falling or have remained low. The tuberculosis control program was found to be performing well, with steadily increasing case detection rates, a 90.2 per cent treatment success rate, and a 4.7 per cent default rate. Malaria treatment free of charge with ACT was standard throughout Burundi; a mass distribution campaign of insecticide-treated bed nets achieved almost universal coverage.

The audit also found scope for improvement in financial management and in some programmatic aspects. Control weaknesses were identified in all grant implementing organizations audited by the Office of the Inspector General. The links between grant-funded activities and national systems are weak, and need to be strengthened by systematic integration of Global Fund supported activities. There is also a need to increase the use of HIV Prevention of Mother to Child Transmission services by the population and to improve the diagnosis and treatment of Multi-Drug Resistant tuberculosis. The audit report lists 53 recommendations to improve grants implementation in Burundi.

The report includes tables, in the Annexes, that identify a total amount of US$ 30,724 that should be recovered, largely due to over-payments on payment vouchers. Following the completion of the audit, the Country Coordinating Mechanism and the principal recipients provided additional information and clarifications that will be verified by the Secretariat.

Audit reports by the Office of the Inspector General are an essential form of quality control for the Global Fund. The Office of the Inspector General plays an indispensable role in helping us all achieve our mission of effectively investing the world's money to save lives.

Yours sincerely

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MESSAGE FROM THE COUNTRY COORDINATING MECHANISM*

REPUBLIQUE DU BURUNDI

Bujumbura, le... 18/7/.... /2012

UNITE - TRAVAIL - PROGRES

COMITE DE COORDINATION DES SUBVENTIONS DU FONDS MONDIAL DE LUTTE CONTRE LE SIDA, LA TUBERCULOSE ET LE PALUDISME AU BURUNDI.

CCM BURUNDI

Réf. : CCM BDI /...55.../ 2012

A Monsieur John Parsons, Inspecteur Général,
Le Fonds Mondial de lutte contre le sida, la tuberculose et le paludisme,
Chemin de Blandonnet 8.
1214 Vernier. Genève. Suisse

Objet : Accord rapport final de l'OIG

Monsieur l'Inspecteur Général,

Nous accusons bonne réception de la version finale du rapport d'audit des subventions du Fonds Mondial de lutte contre le sida, la tuberculose et le paludisme au Burundi, effectué durant la période d'avril à juin 2011 et vous en remercions profondément.

Ayant suivi avec attention les échanges de messages et les téléconférences entre le Bureau de l'OIG et les équipes PRs des subventions VIH (Round 1, Round 5 et Round 8) et paludisme (R2 RCC) relatifs aux observations formulées sur les annexes 3 à 9 et 11 du rapport préliminaire, le CCM Burundi a compris qu'il y aura un travail de vérification des informations et clarifications fournies par les PRs et les SRs des subventions concernées par le LFA, avant de confirmer les montants définitifs à rembourser.

Nous voudrions vous exprimer que nous sommes totalement d'accord avec le contenu de votre rapport d'audit des subventions du Fonds Mondial au Burundi effectué du 11 avril au 12 juin 2011.

Veuillez agréer, Monsieur l'Inspecteur Général, les assurances de notre haute considération.

REPUBLIQUE DU BURUNDI
GLOBAL FUND-CCM BURUNDI

La Ministre de la Santé Publique et de la Lutte contre le SIDA et Présidente du CCM Burundi

Hon. Dr Sabine NTAKARUTIMANA

Ndayi-agijé
Vice - Président

Copie pour information à :

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* English Translation on next page

MESSAGE FROM THE COUNTRY COORDINATING MECHANISM

Bujumbura, 18 July 2012

REPUBLIC OF BURUNDI

COMMITTEE FOR THE COORDINATION OF GRANTS FROM THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA IN BURUNDI

Mr John Parsons
Inspector General
The Global Fund to fight AIDS Tuberculosis and Malaria
Chemin de Blandonnet 8
1214 Vernier
Geneva
Switzerland

Subject: Agreement with Final Report from the OIG

Dear Inspector General,

We acknowledge receipt of the final version of the audit report on the grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria to Burundi, which took place from April to June 2011, and thank you profoundly.

Having carefully followed the exchange of messages and teleconferences between the Office of the OIG and the PR teams for the HIV grants (Round 1, Round 5 and Round 8) and malaria (R2 RCC) concerning the recommendations made in Annexes 3 to 9 and 11 of the draft report, the Burundi CCM understands that verifications will be carried out by the LFA regarding the information and clarifications provided by the PRs and the SRs about the funds in question before confirming the final amounts to be reimbursed. [2]

We would like to express our total agreement with the content of your audit report on Global Fund grants to Burundi, which took place from 11 April to 12 June 2011.

Please accept, Inspector General, the assurances of our highest consideration,

[signed]

The Honorable Dr Sabine NTAKARUTIMANA

The Minister of Public Health and the Fight against AIDS and
Chair of the Burundi CCM

cc: CCM Members (all)

[2] OIG clarification: Additional information and clarifications were provided on 29 March 2012.

BACKGROUND

20. From December 2003 to April 2011, the total funds committed by the Global Fund to HIV, Tuberculosis (TB) and Malaria programs in Burundi amounted to USD 141.6 million, of which USD 113.9 million had been disbursed as of April 15, 2011. The HIV program is the largest component of the Global Fund grant portfolio with 55 percent of committed funds. It is followed, respectively, by Malaria with 37 percent and TB with 8 percent. The Global Fund has a portfolio of ten grant agreements managed by four PRs, namely the Executive Secretariat of the National AIDS Control Commission (SEP-CNLS), the Burundi Network of People Living with HIV/AIDS (RBP+), the National Tuberculosis Control Program (PNLT), and CED-CARITAS.

21. SEP-CNLS is responsible for the public sector response to both HIV and Malaria, while RBP+ and CED-CARITAS are responsible for the civil society sector response to HIV and Malaria, respectively. PNLT is responsible for the national response to TB. The MOH's *Projet Santé Population II*, financed by the World Bank from 2003 through 2006, was the PR for the Round 2 Malaria grant program. When *Projet Santé Population II* ended in 2006, SEP-CNLS was given the responsibility for managing the Round 2 Malaria grant program because of inadequate capacity of the Ministry of Health Program on Transmissible and Deficiency Diseases (LMTC) in charge of malaria program activities at that time.

22. The Government of Burundi (GOB) established the CNLS in March 2002 to lead and provide a multisectoral response to the HIV epidemic. Since 2002, the World Bank has financed a USD 51 million Multisectoral AIDS Project (MAP) managed by the SEP-CNLS. This project is scheduled to end in June 2011. To show its political commitment in the fight against the HIV epidemic, the Government of Burundi established a Ministry of AIDS in the Office of the President in 2002. Administratively, SEP-CNLS was placed under the Ministry of AIDS. In August 2010, the Ministry of AIDS was merged with the Ministry of Public Health to establish a Ministry of Public Health and the Fight against AIDS (MSPLS).

23. Program activities and service delivery under the grant programs are carried out by public sector entities, civil society and faith-based organizations as well as private sector institutions in the 17 provinces and 45 districts of Burundi.

Country Context

24. Burundi suffered from a long civil war from 1993 to 2005 resulting in substantial loss of lives and migration abroad of the professional workforce. Consequently, this had adversely affected human resource capacity of public institutions including those in the public health system. Program officials said that staff retention is a challenge as there is strong competition amongst organizations for the few competent and experienced staff needed to implement the grant programs.

25. The integration of the Ministry of AIDS into the new Ministry of Public Health and AIDS had not been completed at the time of the audit fieldwork. In addition, SEP-CNLS, which is the PR for the HIV and malaria grants, is facing financial difficulties due to end of the World Bank MAP program that supports the Executive Secretariat's core staff salaries and operating costs.

Institutional Arrangements

The Ministry of Health and the Public Health System

26. There are 17 provinces in Burundi. Each province has a Provincial Health Service (BPS) responsible for public health management, monitoring and oversight of public health. The BPS are headed by a provincial health/medical director assisted by a team that includes a provincial TB coordinator paid through the grant and four provincial supervisors paid by the state who focus on reproductive health, health management information system, health promotion and hygiene etc.

27. To decentralize the management and oversight of public health services in the country, in 2010 the Government of Burundi started the process of establishing 45 District Health Services (BDS). To this end, the Government of Burundi is supported by Development Partners such as the European Union[3] to build the institutional capacity of selected District Health Services. The District Health Services (BDS) are led by a District Medical Director who is assisted by a team of supervisors who are responsible for supervision of health centers in the district.

28. The National Institute of Public Health (INSP), which is a public institution under the Ministry of Public Health, manages the National Reference Laboratory for HIV and TB. The INSP laboratory is responsible for quality control for TB and HIV including viral load tests. On the other hand, the PNILP has a laboratory for malaria quality control tests.

29. Health services for the three diseases are delivered at three levels of care in the country's health care system which include, four regional hospitals (third level of care), and 45 district hospitals (second level of care), and over 600 peripheral health centers (first level of care), as well HIV testing and treatment centers operated by Non-Governmental Organizations (NGOs), private and faith-based organizations. The OIG learned that by May 2011 there were 425 sites for HIV counseling and testing, 166 sites for PMTCT and 95 sites/centers for ART were operational. Approximately sixty percent of the sites are operated by faith-based and civil society organizations. Tuberculosis diagnosis and treatment is implemented in 167 centers offering diagnostic and treatment services as well as 138 centers offering only treatment services. Malaria diagnosis and treatment is carried out in all 600 health centers (CDS).

HIV Program: SEP-CNLS and RBP+

30. Since 2002 SEP-CNLS has been responsible for managing the World Bank financed Multisectoral AIDS Project (MAP). Administratively, SEP-CNLS operates under the supervision of the MSPLS. But the National AIDS Commission (CNLS) is chaired by the President of Burundi which shows political commitment at the highest level for the national response to the HIV epidemic.

31. To manage the first Global Fund Round 1 HIV grant SEP-CNLS established a Project Management Unit (PMU) headed by a National Project Coordinator. The National Project Coordinator for HIV is responsible for program implementation, management and supervision. He/she is supported by a multi-disciplinary team comprising technical, procurement and financial management staff.

[3] Projet Santé Plus

32. Under the World Bank financed Multisectoral AIDS Project (MAP), SEP-CNLS established provincial HIV committees (CPLS) and municipal HIV committees (COCOLS) as the governing, coordinating and oversight bodies for HIV program activities carried out at decentralized levels. To emphasize the importance the government places on HIV prevention, care and treatment program activities, the provincial and municipal HIV committees are presided by provincial governors and municipal administrators, respectively. SEP-CNLS funded the governance and oversight activities of the HIV committees from MAP funds.

33. From January 2010, the Burundi Network of PLWHA (RBP+) became the civil society PR for the Round 8 HIV grant focusing on the HIV prevention program activities, assistance to PLWHA and orphan and vulnerable children (OVC) affected by the disease.

Malaria Program: SEP-CNLS and CED-CARITAS

34. In 2005 the CCM selected SEP-CNLS as the PR for the Global Fund Round 2 malaria grant because of inadequate capacity of the entity responsible for malaria programs in the country. The National Malaria Control Program (PNILP) was established by the Ministry of Health in January 2009.

35. To facilitate management and implementation of the malaria grant program, the SEP-CNLS established a Project Management Unit (PMU) that is led by a National Project Coordinator for Malaria who reports to the Executive Secretary of SEP-CNLS. The Global Fund project coordinator for malaria is responsible for program implementation, management and supervision of malaria program activities carried out under the grant. The coordinator is supported by a multi-disciplinary team comprising technical, procurement and financial management staff.

36. CED-CARITAS is the civil society PR for malaria prevention. Likewise, it has a Project Management unit led by a Technical Project Coordinator assisted by a small team of technical and financial management staff. The Project Coordinator reports to the CARITAS' Director of Programs. It has five SRs. Between February and March 2011, it worked in close collaboration with local government institutions and 67 selected community based organizations to carry out a mass campaign of sensitization and distribution of 2.5 million LLINs, with the objective of achieving a universal coverage and use of bed nets in Burundi.

Tuberculosis Program: PNLT

37. To manage and implement the TB programs, the PNLT has a PMU headed by a National Project Coordinator who reports to the PNLT Director, the substantive PR. The National Project Coordinator is assisted by a small team of technical, procurement and financial management staff. Service delivery for Tuberculosis is carried out in the TB diagnostic and treatment centers.

PSM Arrangements

38. In Burundi each program is responsible for procurement of its medicines, health supplies, medical equipment and non-health related items approved in its PSM plan. To this end, each project management unit has one or two staff responsible for procurement. The role of Burundi's Central Medical Stores called CAMEBU is therefore limited to receipt, inventory management and issue of medicines, health and laboratory supplies on behalf of the programs. Since January 2010, CAMEBU has acquired SAGE inventory management software to manage

inventory of medicines and health supplies. DFID is providing technical assistance in PSM to CAMEBU.

39. Because of inadequate transportation facilities, CAMEBU does not deliver medicines and health supplies procured under the programs to the district pharmacies. The district pharmacies collect from CAMEBU ACTs, ARVs, anti-TB medicines, and drugs for opportunistic infections (OIs) that they have requisitioned and that have been approved by the PMUs. The service delivery centers in turn collect medicines and health supplies from the district pharmacies which likewise do not have the capacity to deliver to the health centers.

40. Procurement of LLINs under the Global Fund Round 9 malaria program was carried out by the malaria PMU through the Voluntary Pooled Procurement (VPP) mechanism. PSI was responsible for storage, logistics and supply management including transportation of the LLINs to distribution points at the municipal level.

41. Since 2005 the Global Drug Facility (GDF) has donated the first line anti-tuberculosis drugs. But from 2011 procurement of first line anti-tuberculosis drugs is budgeted under the Global Fund Round 7 TB grant. The procurement of second line TB drugs for MDR-TB has been funded by the Government of Burundi.

Principal Recipients' Financial Management

42. The four PRs audited, namely, the Executive Secretariat of the National AIDS Control Commission (SEP-CNLS), the Burundi Network of People Living with HIV/AIDS (RBP+), the National Tuberculosis Control Program (PNLT), and CED-CARITAS are responsible for maintaining adequate financial systems, processes and controls to assure sound financial management of grant funds.

Principal Recipients' Annual Independent Grant Audits

43. According to the grant agreements between the Global Fund and the PRs, each grant is subject to an annual audit to be performed by an independent auditor. The OIG reviewed the principal recipients' compliance with this requirement and the effectiveness of the audits performed by the external auditors.

The CCM

44. The CCM in Burundi was reconstituted in April 2010 with assistance from Grant Management Solutions (GMS). OIG assessed to what extent the Burundi CCM complied with Global Fund guidelines and how effectively it performed its oversight role. According to Global Fund guidelines, the CCM has ultimate responsibility for grant oversight and for all grant program activities. Since 2007, the CCM in Burundi has received direct Global Fund financial support amounting to USD 169,000. The GOB has also supported the CCM to acquire office furniture and equipment for its secretariat; and it financed a retreat for the CCM in 2010.

The Local Fund Agent

45. The LFA in Burundi has been PricewaterhouseCoopers (PWC) Mauritius since the inception of the grants in 2003. PWC Mauritius has no office in Burundi. It has a team of financial professionals and programmatic consultants who are based outside the country. LFA team members travel to the country to carry out specific LFA services according to a planned schedule agreed with the PRs. OIG reviewed the effectiveness of the oversight services provided by the LFA in Burundi. Key oversight

services provided by the LFA include initial and repeat PR capacity assessments before grant signature; verification of implementation which in the case of Burundi is semi-annual; assessment of PR after the initial two years of grant implementation; procurement reviews; assessment of sub-recipients; and on site data verification.

The Global Fund Secretariat

46. After inception of grants, the Global Fund Secretariat is responsible for ensuring that the grants are performing well through routine monitoring, periodic reviews and assessments as well as timely disbursements of funds to grant recipients. The OIG assessed how effective the Global Fund Secretariat performed this oversight role.

Development Partners

47. The national response to fight the three diseases is supported by other development partners, notably, UNICEF, WHO, USAID and its technical partners. The malaria program is supported principally by UNICEF (routine bed nets for pregnant women) and USAID through its technical partners (ACTs and malaria test kits for home-based treatment of malaria through community health workers). The Burundi Red Cross (Croix Rouge du Burundi) was closely involved in the mass distribution of LLINs.

OBJECTIVES, SCOPE AND METHODOLOGY

48. The objectives of the audit were to (a) assess the efficiency and effectiveness of the management and operations of the grants; (b) evaluate the soundness of existing systems, policies and procedures in safeguarding Global Fund resources; (c) confirm compliance of grant recipients with the Global Fund grant agreements and related policies and procedures, and the related laws of the country; (d) identify any other risks that the grants are exposed to and the adequacy of measures taken to mitigate such risks; and (e) make recommendations to strengthen the management of the grant-supported programs based on the above stated objectives.

49. The following five areas were covered: (i) programmatic management; (ii) procurement and supply chain management; (iii) fiduciary management; (iv) program oversight within Burundi; (v) program oversight by the Global Fund Secretariat. The OIG therefore deployed a multi-skill team comprising a public health specialist, a procurement and supply management specialist, and audit specialists.

50. The scope of the audit covered the following Global Fund grant programs.

Disease & Round	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
HIV Round 1	SEP-CNLS	BRN-102-G01-H	8,657,000	8,657,000
HIV Round 5	SEP-CNLS	BRN-506-G04-H	32,353,173	30,701,809
HIV Round 8	SEP-CNLS	BRN-809-G07-H	22,885,179	9,087,521
HIV Round 8	RBP+	BRN-809-G08-H	13,904,412	7,794,008
		Subtotal	***77,799,764***	***56,240,338***
Malaria Round 2	Project Santé Population II (MOH)	BRN-202-G02-M	16,568,331	16,568,331
Malaria Round 2	SEP-CNLS	BRN-202-G05-M	22,521,552	18,853,100
Malaria Round 9	SEP-CNLS	BRN-910-G09-M	11,947,329	11,947,329
Malaria Round 9	CED CARITAS	BRN-910-G10-M	1,709,069	2,321,672
		Subtotal	***52,746,281***	***49,690,432***
Tuberculosis Round 4	PNLT	BRN-405-G03-T	3,381,665	3,225,782
Tuberculosis Round 7	PNLT	BRN-708-G06-T	7,675,089	4,769.069
		Subtotal	***11,056,754***	***7,994,851***
Totals			**141,602,799**	**113,925,622**

Table 1: Global Fund *grants to Burundi audited by the OIG (Source: Global Fund website, April 2011)*

51. The audit covered the above-listed Global Fund grant programs being implemented by the four PRs and their selected SRs and implementing partners. The audit sampled transactions from the initiation of the grant programs in 2003 through 31 March 2011.

52. The four PRs were the Executive Secretariat of the National AIDS Control Commission (SEP-CNLS), the National Tuberculosis and Leprosy Program (PNLT), the Burundi Network of People Living with HIV (RBP+) and CED-CARITAS. SEP-CNLS is the PR for three HIV grants and two malaria grants. RBP+ is the civil society PR for one Round 8 HIV grant focusing on the HIV prevention program activities, assistance to PLWHA and orphan and vulnerable children (OVC) affected by the disease. CED-CARITAS is the PR for one malaria grant focusing on malaria prevention program activities such as distribution and usage of LLINs through community-based organizations. In addition, the audit covered selected sub-recipients (SRs) or implementing partners of the afore-mentioned entities such as the Central Medical Stores (CAMEBU) which is responsible for storage and distribution of medicines and health supplies, the National Malaria Control Program (PNLIP) as well as selected Regional Hospitals, District Hospitals, Health Centers and some Civil Society Organizations. Audit tests and program visits were carried out in seven provinces, namely, Gitega, Ngozi, Bujumbura-Mairie, Kayanza, Karusi, Mwaro and Muramvya.

53. The OIG used the following approaches to conduct its work: discussions with program and financial personnel of relevant grant recipients; review of grant program documents, monitoring/supervision reports, implementation and procurement plans, examination of supporting documents for grant expenditures as well as program and financial progress reports.

54. In addition to audit tests carried out at the national/central level, the OIG team visited program sites at provincial, district and peripheral levels in four provinces: During the field visits the OIG team carried out tests and made observations at provincial hospitals, district hospitals, district pharmacies and health center The OIG team also visited clinical, prevention and patient support programs managed by civil society and community-based organizations and conducted focus group discussions with program beneficiaries.

55. Audit recommendations have been prioritized so as to assist management in deciding on the order in which recommendations should be implemented. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. The categorization of recommendations is as follows:

i. High Priority: Material concern, fundamental control weakness or non-compliance, which if not effectively managed, present material risk and will be highly detrimental to the organization's interests, significantly erode internal controls, or jeopardize achievement of aims and objectives. They require immediate attention by senior management.

ii. Significant Priority: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

iii. Requires Attention: There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of best practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

PROGRAM QUALITY, MONITORING AND EVALUATION

HIV Program

The response to HIV in Burundi has evolved rapidly over the past decade. Three successive Global Fund grants have contributed significantly to this development. There are, however, concerns about the weak links of the grant-funded activities to national systems. There is now an urgent need for the PRs to focus on systemic integration of Global Fund supported activities, and on health and community systems strengthening.

HIV in Burundi

56. The history of the HIV epidemic in Burundi is marked by a rapid expansion in the 1980s reaching rates of infection above 20 percent in Bujumbura. A series of three national surveys conducted in 1989, 2002 and 2007 document a gradual decline of HIV infection rates in urban and peri-urban areas to levels of less than five percent in 2007, while the prevalence in rural areas increased three-fold to almost three percent. [4] Because the population of Burundi is primarily rural, these trends indicate that the number of people living with HIV continued to grow until the beginning of the century when it reached a plateau. The 2010 report of Burundi to UNGASS estimates the total number of people living with HIV at about 230,000. [5,6]

57. Behavioral and sero-prevalence surveys among people at high risk for HIV infection were conducted in 2007 and in 2011. The 2011 survey among female sex workers reported an HIV prevalence of 20 percent, a major decline from the 38 percent reported in 2007. A first survey among men who have sex with men in 2011 reported an HIV prevalence of 2.4 percent, a result that is within the range of the general HIV sero-prevalence in Burundi. A similar result (2.7%) was recorded among prisoners and a result of 1.4 percent among labor migrants. Uniformed personnel had a very low sero-prevalence of 0.25 percent. [7]

The National Response to HIV

58. The Conseil National de Lutte Contre le SIDA (CNLS) is working under its second HIV strategy while in the process of drafting the third. Under the first two strategies, 2002-2006 and 2007-2011, the response to HIV developed rapidly, driven by a very vibrant engagement of civil society. The main sources of international financial support for this development were two successive World Bank grants and Global Fund grants under Round 1, Round 5 and Round 8. The number of sites for HIV testing, prevention of peri-natal HIV transmission (PMTCT) and HIV treatment increased rapidly. By May 2011, 425 sites for HIV counseling and testing were functional, 166 for PMTCT and 95 for ART. At least half of the sites are in church-affiliated health facilities, the other half include public clinics and hospitals as well as civil society ambulatory clinics and testing sites. From 600 people on anti-retroviral

4 The results of the three surveys are not strictly comparable because each used a different age group. The decline in HIV prevalence is less than the statistics suggest. It Is, however, a real decline.
5 Gelmon et al. Synthèse sur l'épidémie du VIH et la réponse politique et programmatique. Sep/CNLS and World Bank; July 2010
6 Burundi UNGASS Report 2010
7 Arc Ingénierie. Enquête de séroprévalence et socio-comportementale du VIH focalisée sur les groupes a plus haut risque; Rapport de biologie (Draft) Avril 2011

therapy in 2002, the number grew to almost 23,000 by the end of 2010. [8] Although this growth is impressive, it represents only one third of people estimated in need of anti-retroviral treatment. Survival on treatment and treatment adherence after 24 months of starting ART is an impressive 82 percent indicating good quality of service provision and support. [9]

Service Delivery

General Findings

59. Services for HIV prevention, treatment and care have been supported by three successive Global Fund grants since 2003. In 2010, the budget overlap between the Round 5 and the Round 8 grants was shorter than planned because of delays in the signature of the Round 8 grant agreement. As a consequence, a number of critical services for people living with HIV remained un-funded for three months from December 2010 to March 2011. They included salary and operating costs of civil society clinics as well as the re-imbursement of medical care for people on ART in public and church-affiliated hospitals. By the end of May 2011, the facilities visited and the staff interviewed by the OIG had not received any payment since November 2010. Contribution agreements retroactive to April 1st were in preparation, and there was a public announcement that the Government would finance the gap, but there was no formal engagement.

60. The programmatic audit of the Round 8 Global Fund grant noted weak institutional and administrative links of health sector activities to the systems and structures of the Ministry of Public Health (MSPLS). To cite only three examples for the purpose of illustration:

a) The unit of the MSPLS charged with implementing the health sector response to HIV is the USLS of the MSPLS. Until 2009, the USLS, jointly with District personnel, conducted regular supervision missions of sites offering HIV services. In 2010, the CNLS shifted the supervision budget to Provincial and District offices. The OIG found no evidence (reports or register) of supervisions of clinical services conducted after 2009.

b) In 2006, Burundi introduced a system of performance based financing for health that is now covering the entire country. The quantity and quality of services delivered at all health facilities is closely monitored and facilities are financed accordingly. Systems and structures are in place to verify data down to the level of patient registers. Yet, the CNLS has adopted a parallel system of third party financing of services for people on ART through individual contracts with up to 400 health facilities. The "financing of a service package" described in the Global Fund proposal is different. The current implementation seems to result in a CNLS-administered health insurance scheme for people on ART that exists in parallel to the MSPLS Performance Based Financing system. The OIG found that the system of reimbursement of HIV treatment services to HIV treatment centers is inefficient and difficult to verify and control.

c) HIV services in the facilities visited by the OIG were to a major degree assured by a cadre of "Health Mediators" employed directly by the PR (formerly CNLS, now RBP+). There are currently 240 Health Mediators under contract. They are nurses, psychologists and other professionals. In most facilities, the Health

8 CNLS Database (provided to the OIG on 3/5/2011)
9 UNGASS Report Data – Draft March 2011

Mediators assured all aspects of HIV care, from counseling to laboratory work, drug dispensing, record keeping and electronic data entry. They have no ties to the public service and in several major hospitals (for instance the Military Hospital in Bujumbura) HIV services could not be maintained without the presence of the Health Mediators. This is not just a theoretical risk. At the time of the OIG mission, the Health Mediators had not received a salary for five months.

HIV Prevention

61. Prevention programs reviewed by the OIG included targeted programs for female sex workers, prisoners and men who have sex with men, as well as broad population-focused activities such as HIV awareness activities in schools and condom distribution through networks of community-based agents.

62. Preliminary results of the 2011 behavioral and sero-prevalence survey among groups at higher risk of infection indicate that the targeted prevention programs are effective in terms of increasing condom use and decreasing HIV prevalence. HIV-related information in the general population was collected in the 2010 Demographic and Health Survey. The results were not available at the end of the OIG audit in mid-June 2011.

HIV Testing and Counseling (HTC)

63. Burundi has national guidelines for HIV testing and counseling that were adopted in February 2011 but that have not yet been implemented. All health facilities visited by the OIG offered HTC. 14 out of 18 of these facilities had been out of stock of confirmatory HIV tests for a period of two to three months because the test approved in the national algorithm was phased out by the manufacturer. The CNLS was informed of this in December 2009. Only in May 2011, after most facilities had run out of test kits, was an expert committee convened to recommend a new test kit. By the end of May 2011, these test kits had not yet been procured.

64. With the exception of three facilities visited (Nouvelle Esperance, Ngozi Hospital and Kinama Health Center) all facilities continued testing without confirming positive screening results. Instructions to stop testing when confirmation is not possible can be found in the 2009 USLS supervision reports, but they are not adhered to by the majority of facilities.

65. All facilities had trained and qualified counselors, often Health Mediators who were professional psychologists. Most services adhered to national standards in terms of confidentiality and privacy of the counseling and testing process. Only three instances of non-adherence were observed by the OIG mission. [10]

Treatment of Sexually Transmitted Infections (STI)

66. The stated objective of the Round 8 proposal to the Global Fund was the provision of drugs for the treatment of STIs in all health facilities. The budget of the Round 8 grant has provisions for treating 15,000 patients each year. The procurement plan makes no reference to procuring STI drugs. These drugs are instead intermingled with the list of drugs for opportunistic infections.

67. Drugs for the treatment of STIs in all health facilities visited by the OIG are payable by patients. There is no national policy to exempt the treatment of STIs from

10 CHUK, Military Hospital and Muramvya Hospital

user-charges. There were no STI drugs financed by the Global Fund in any health center outpatient clinic visited.

68. Instead, the OIG observed large quantities of antibiotics for the treatment of STIs intermingled with drugs for the treatment of opportunistic infections in the pharmacies of HIV treatment centers. These drugs are dispensed free of charge for the exclusive use by patients on ART and women followed under a PMTCT protocol. For instance the Muramvya District Hospital HIV clinic had sufficient supplies of specific antibiotics to treat more than 100 cases of gonorrhea. The hospital has an active patient load of 218 patients on ART and reported 2 cases of STI in the first quarter of 2011. [11]

Prevention of Mother to Child Transmission (PMTCT)

69. According to national health information data, about 30 percent of women who attended ante-natal clinics were tested for HIV in 2010. [12] The CNLS reported that 2,662 HIV positive mothers gave birth under the protection of a PMTCT protocol in 2010. This is only about 16 percent of the estimated number of women in need of this service. This suggests that a significant number of HIV positive women who are tested and who know their result are not receiving PMTCT coverage at delivery.

70. Staff interviewed in the facilities visited by the OIG knew the national PMTCT protocol, provided good counseling and testing services (when tests were available), and provided follow-up for women after they had given birth. The acceptance of HIV testing and counseling by women in all ante-natal clinic visited was high, usually above 80 percent. According to observations by the OIG, a major loss of women who were tested and counseled in ante-natal care occurs at the time of admission to the labor and delivery wards.[13]

71. However, the maternity wards in the hospitals providing PMTCT services were not aware of the HIV status of the majority of women giving birth. ARV coverage was only provided to women who self-identified. A list of those women was kept in a separate register. Information about the testing status of all other women admitted for obstetric delivery was not available.

Medical Care for People Living with HIV

72. Medical care for people living with HIV is provided free of charge, but only after they have started anti-retroviral treatment. In all focus group discussions, participants complained about the high cost of medical care. Apparently they receive some drugs free of charge, but often end up with long prescriptions of additional drugs that they have to buy from the hospital pharmacy.

73. In the HIV treatment facilities visited by the OIG, first and second line anti-retroviral treatment was administered according to national standards. Although there were some stock-outs of fixed-dose combination ARVs, drugs were generally available. Cotrimoxazole prophylactic therapy was available everywhere. No results of viral load exams were found in any charts examined. Results of CD4 counts were found in the charts, but the interval between recorded results varied from 12 months

11 Report CPLS Muramvya 1st Quarter 2011
12 103,800/348,495 (CNLS report and EPISTAT Yearly Statistics 2010)
13 These observations are based on a small sample of hospitals that nevertheless manage a large number of obstetric deliveries.

to three years. The CD4 counters in the laboratories visited were all functioning and reagents were available.

74. Tuberculosis screening at the time of admission into HIV care is done by physicians. There is no systematic screening tool. All physicians stated that they use chest X-rays but no X-ray results or notes to this effect were found in any of the charts reviewed. At the time of the admission exam, X-rays have to be paid by patients because they are not yet on ART, and they are frequently unaffordable. A TB screening tool has been integrated in the new admission form that has not yet been introduced.

75. Charting was generally very weak. Patient charts were either a chaotic mess of loose papers (e.g. Gitega Hospital), or contained no information other than a partially completed admission sheet and a list of prescription renewals (e.g. Muramvya Hospital). This was already noted in supervision reports of the USLS in 2009.

76. There are no guidelines for the diagnosis and treatment of opportunistic infections (OIs). The responses to the question of what was reported as an OI and what qualified for treatment free of charge were contradictory in all cases. All HIV clinic pharmacies had unbalanced stocks of drugs identified as "OI drugs", e.g. stock-outs of drugs commonly used for OIs such as Acyclovir, but large amounts of one antibiotic or another. The most striking example was the Muramvya Hospital where the HIV clinic (catering for 218 patients) had a stock of 23,000 capsules of Cloxacillin 500 mg, enough to treat almost 600 bacterial skin infections. In Gitega Hospital and several other facilities the OIG observed large quantities of Ciprofloxacin, an antibiotic that is used primarily for intestinal infections and for the treatment of urethral discharge.

Psychological, Social and Nutritional Support for People Affected by HIV

77. The activities for psychological and social support are primarily provided under the PR agreement with RBP+, an agreement that also includes the objective of "Community Systems Strengthening" of the Round 8 HIV Global Fund grant. The OIG mission found that the systems, procedures and tools for supervision, monitoring and data collection by the PR were of good quality and were systematically applied.

78. The OIG visited the offices of eight community-based organizations involved in providing social support services and conducted six focus group discussions with people living with HIV or affected by HIV. The information received was consistent in all meetings.

79. The activities supported by the Global Fund are constrained by an excessively tight system of input rationing that is unresponsive to real needs and that negatively affects results. The OIG collected several examples of which we only present one for the purpose of illustration:

> *Income generation activities through the provision of livestock (goats and cows) are implemented by a competent agricultural development organization in Karusi. The organization has a staff of veterinarians and agricultural extension workers to support programs funded from other sources. However for the Global Fund program, the organization is restricted to providing a 3-day training seminar and then delivering the animals. Several beneficiaries reported that their animals had died, however the SR contract has no provision to provide follow-up or*

necessary veterinary services. The organization had the capacity, but not the means nor the mandate to respond.

80. The rationing system of inputs (food, training, etc.) is inefficient and negatively affects value for money. Portioning out, delivering and controlling small levels of service (e.g., individual food rations delivered by foot to far away hill-top houses[14]) has a very high cost in terms of human resources that is generally under-valued and under-budgeted. All implementing agencies interviewed by the OIG were struggling to meet their service delivery targets. Their grants left no margin for contribution to their own institutional development, i.e. for "community systems strengthening".

81. Food aid is provided to strictly controlled closed cohorts for defined periods. For instance a person newly placed on ART can receive nine month of food aid, an infant born to an HIV positive mother six months, etc. The implementing agencies are under performance pressure to fill their cohort quickly at the beginning of their annual contract. Performance is only measured in terms of completed cohorts. Any person with greater need who happens to fall ill after the cohort has been established is simply out of luck. It is incomprehensible why this system has been designed this way. Food aid is usually monitored in terms of person-months of services provided. In this case, an unusual monitoring indicator is distorting service delivery.

Monitoring and Evaluation

Performance Frameworks

82. The Performance Frameworks for the Round 8 HIV grant include five high level (impact/outcome) indicators, 13 output/process indicators for the government PR and 10 output/process indicators for the civil society PR. A detailed review of the frameworks, the reported results by December 2010, and the LFA assessment of these results is available. [15] The OIG identified several issues of which only the four that are most significant are detailed below:

a) The calculation of the impact indicator of mother-to-child HIV transmission (reported at 2.5%) is invalid because it is the results of all antigen tests on infants performed throughout the year. Since negative tests are repeated twice according to national protocol, there is a strong bias towards negative results.

b) The reported indicator on condom distribution tracks the movement of condoms from the central warehouse to storage at provincial level. This does not provide information on condom distribution.[16] OIG interviews with sex workers and community-based organization indicated that the use of female condoms is very low and that female condoms are stockpiling at the end of the distribution chain.

c) The indicator of HIV testing among pregnant women is meaningless (although it is being calculated as defined in the M&E plan). The measure of performance should be the proportion of pregnant women who are tested and received their result. The denominator should therefore be the number of women who registered for ante-natal care which was 348,495 in 2010 giving a performance of about 30 percent. The denominator that is used is the number of women who

14 Monthly food aid packages for people living with HIV are budgeted at BIF 19,200 (USD 16)
15 Working document 6: Review of PUDRs
16 The indicator is formulated as follows: "Number of condoms distributed". The OIG interprets this as meaning the number distributed to users and not the number shipped from one store to another.

have been tested. This provides some information about loss of clients after testing, but that information is only of marginal importance.

d) The three indicators on food subsidies are causing considerable confusion because there is no definition on how they should be calculated. Programs that provide monthly rations are usually monitored by following person-months of support. The insistence on reporting "person- 9 months" or "person- 6 months" results is difficult to understand and is affecting program quality.

Data Management and Quality

83. The Global Fund conducted a data quality audit for the Round 5 HIV grant in November 2009 and an on-site data verification mission for the Round 5 and Round 8 grants in October 2010. Neither report noted any major data quality issue. This was confirmed in the OIG site visits where we did not find any major difference between the numbers in registers and the numbers reported to the CNLS. OIG observations relate to systems and efficiency rather than to accuracy.

84. All HIV treatment and PMTCT facilities visited had one or more computers with the installed software of SIDA-Info. None of the sites had the habit of backing up data, and several of the computers were infected with viruses. In all sites, the names of new patients were entered at registration, and in several sites the data-base was used by pharmacists to calculate ARV requirements. Other information (clinical and laboratory) was not entered, and only at ANSS Gitega was the system used to retrieve patient information by the treating physician. Staff in all sites except ANSS Gitega, Gitega Hospital and Ngozi Hospital had major problems generating simple reports from SIDA-Info. They calculated the statistics to be reported to the CNLS manually, based on register information.

85. The findings related to SIDA-Info are in sharp contrast to the observations of the GESIS software used by the national health information system (EPISTAT). In all district offices visited, a trained data manager entered data from paper-based reports submitted by health facilities, and channeled the electronic files via the provincial data manager to the central level. Data quality checks were built in at several levels. All district and provincial offices visited were able to produce analytic reports on demand.

Capacity Building

86. The most critical observation on the issue of capacity building was noted above under "General Findings". Because the SEP-CNLS has created a semi-autonomous project implementing infrastructure for health services to people living with HIV, it contributes very little to the capacity of the national health system to take on this task.[17]

87. The 2011 training plan submitted by the SEP-CNLS (April-December) lists 34 distinct training activities for a total budget of USD 1.1M. Although training is clearly a key activity for capacity building, the OIG observed that many issues that are meant to be solved through training seminars persist because they are not related to knowledge but rather to attitudes and behaviors.

[17] Three examples illustrating the weak links of HIV care with general health services are cited under paragraph 59 above.

88. On questioning clinical staff on a number of technical issues, the OIG consistently received correct answers that were, however, not reflected in the practices followed. This is an issue of supervision rather than training. The absence of evidence of formative supervision since 2009 has already been noted.

89. The training plan of the civil society PR is of similar volume but the issues are different. Most training activities target volunteers or peers of people living with HIV, sex workers, etc. In this context, training can be seen as part of an effort for community building, an aspect that in general is under-represented in the overall program.

HIV: Programmatic Recommendations

Recommendation 1 (High)
The public sector PR (SEP-CNLS) should transfer responsibility and accountability for the implementation of Global Fund-supported health sector activities to existing institutions of the MSPLS at the central and decentralized level. This includes the USLS for technical issues and supervision of services.

Recommendation 2 (High)
SEP-CNLS should consider replacing the system of subsidizing medical care for people living with HIV through payments per service by a system of per capita payment controlled by the Performance-Based Financing Unit.

Recommendation 3 (High)
The cadre of PR-employed "Health Mediators" should be gradually absorbed into staff positions of the relevant health facilities.

Recommendation 4 (High)
The MSPLS should assure that all reagents required for HIV testing according to the national algorithm are available at all testing sites, and provide frequent and close supervision to assure that national directives on counseling, testing and record keeping are adhered to.

Recommendation 5 (High)
SEP-CNLS, the MSPLS and the Global Fund should re-examine the modalities of Global Fund support for STI treatment and agree on a mechanism to assure that these treatments are provided to people suffering from STIs. If no mechanism can be developed to deliver the STI drugs to health centers for the treatment of STIs free of charge, they should not be procured and the remaining stock should be absorbed in the stock of essential generic medicines of CAMEBU.

Recommendation 6 (High)
The MSPLS should develop guidelines for the treatment of opportunistic infections among people living with HIV, including a list of drugs authorized for the treatment of these conditions. Quantification, procurement and supply of these drugs to health facilities should be strictly based on this list.

Recommendation 7 (High)
If the policy of providing medical care free of charge for people living with HIV is maintained, then the essential generic drugs other than ARVs, Cotrimoxazole and drugs for identified opportunistic diseases should be provided by the health facilities and financed through the per-capita re-imbursement system that would need to be established.

Recommendation 8 (Significant)
The Global Fund Country Team, the CCM Burundi and the Principal Recipients should assure that the continuity of services for the treatment and care of people living with HIV is not disrupted by administrative delays in the negotiation and processing of PR and SR agreements.

Recommendation 9 (Significant)
The efforts to improve access to prevention of vertical HIV transmission should focus on maternity services in addition to the current focus on ante-natal clinics.

Recommendation 10 (Requires attention)
The MSPLS and SEP-CNLS should assure that during supervision of HIV treatment facilities, particular emphasis is placed on the quality and completeness of patient charts.

Recommendation 11 (Requires attention)
In the negotiation of the second phase of the Round 8 HIV grant, the civil society PR (RBP+) and the Global Fund should review and revise the modalities of providing social and nutritional support to people living with or affected by HIV. This review should be informed by the extensive documented experience on social protection programs in East Africa, including the experience of cash transfers [18] and the evidence on effective programs for children affected by HIV collected by the Joint Learning Initiative on Children and AIDS in Africa.[19]

Recommendation 12 (Requires attention)
The SEP-CNLS and the Global Fund should ensure that the HIV Round 8 grant performance frameworks are reviewed in the negotiation of Phase 2. At least the calculation methods and formulae for the indicators on vertical HIV transmission, on condom distribution, on HIV testing of ante-natal clients and on food subsidization should be revised.

Recommendation 13 (Requires attention)
For small HIV treatment and PMTCT centers, the SEP-CNLS should consider having dedicated data managers based at the district or provincial level who will be responsible for consolidating paper reports of these centers into the electronic format of SIDA-Info.

Recommendation 14 (Requires attention)
As part of the effort for capacity building, the SEP-CNLS should increase the support to formative supervision carried out by competent institutions of the MSPLS (i.e., the USLS, INSP, BDS, etc.) If necessary, planned training activities should be reduced to free up the necessary funds for supervision.

18 E.g., Miller C. The Evaluation of Cash Transfer Schemes in Africa; Center for Global Health and Development; Boston University School of Public Health; 2009

19 Home Truths: Facing the Facts on Children, AIDS, and Poverty; Final Report of the Joint Learning Initiative on Children and HIV/AIDS chaired by Agnès Binagwaho and Peter Bell; 2009

Tuberculosis Program

The tuberculosis program in Burundi is performing well, achieving results in terms of case finding and cure that are consistently above target. Management of MDR tuberculosis, however, is below acceptable standards.

Tuberculosis in Burundi

90. With an estimated tuberculosis incidence of 348/100,000,[20] Burundi is among the countries highly affected by the disease. There are doubts about the validity of this estimate which is not based on an epidemiological study. The tuberculosis prevalence in neighboring Rwanda may provide a benchmark for the review of the estimate.

The National Response to Tuberculosis

91. The PNLT was created in 1992 and it has received support from two successive Global Fund grants since 2005. It receives technical assistance from the Damian Foundation. Tuberculosis control is implemented through 167 treatment and diagnostic centers and 138 treatment centers.

92. The PNLT has an impressive record of achievements in terms of case detection and treatment success, confirmed by an independent evaluation conducted by WHO.[21] The case detection rate continues to increase, the reported treatment success rate of 90.2 percent is higher than the global average, and the default rate of 4.7 percent is a major improvement over the rate of 22 percent recorded in 2005. Contributing to this success is an active outreach program of community health workers (ASC). Referral by ASC accounted for one in five diagnoses of tuberculosis in 2010.

93. Since June 2010, the PNLT is piloting the practical approach to lung health (APSR) in Bubanza Province. Travel to this province was not possible during the OIG mission because of a security alert, and the program was therefore not reviewed.

94. In 2010, the HIV status of 71 percent of all tuberculosis patients (5,511) was known; about one in four (23%) was HIV positive. HIV testing is available at all tuberculosis treatment centers. Cotrimoxazole prophylaxis was provided systematically, but only 40 percent of tuberculosis patients were on ART. This is related to the fact that tuberculosis treatment is more decentralized than ART.

95. In February 2011 the PNLT received approval by the WHO Green Light Committee for the treatment of 84 patients with MDR tuberculosis. An MDR treatment program of acceptable standard has, however, not yet been established.

Service Delivery

Tuberculosis Diagnosis and Treatment

96. A site visit to seven tuberculosis clinics and interviews with five provincial tuberculosis coordinators confirmed that services are provided according to national standards, they are well supervised and well documented. The issues identified were minor and have already been noted in the WHO evaluation. They are being acted on

20 WHO World TB Report 2010
21 WHO Evaluation of the first phase of the Global Fund Round 7 grant, March 2011

by the PNLT. A new national tuberculosis treatment protocol has been developed and will be implemented in 2012, including the change from a trice weekly to a daily DOTS regime during the continuation phase. The only additional observation of the OIG mission is that the systematic examination of family contacts of people with pulmonary tuberculosis could be improved in order to increase case detection.

Tuberculosis and HIV Co-infection

97. HIV counseling and testing was systematic in all centers visited by the OIG. Confirmatory tests were out of stock in most clinics, but only one (Kinama) stopped testing. All patients who tested positive received Cotrimoxazole and were referred to the HIV clinic for assessment and initiation on ART. Program performance in this area may not improve this year because of the prolonged stock-out of confirmatory HIV tests.

Multi-drug Resistant Tuberculosis

98. Patients with chronic tuberculosis[22] are hospitalized at Kibumbu Hospital, a former tuberculosis sanatorium with a capacity of over 200 beds. At the time of the OIG mission, there were ten patients in the hospital which is well suited for MDR care, but lacks security arrangements to control contacts within and outside the hospital. Admission to the hospital is based on treatment history and the results of sputum cultures done at the INSP laboratory in Bujumbura. Sensitivity testing to confirm MDR tuberculosis is done by the Institute of Tropical Medicine in Antwerp. Results are not received for many months, usually not before the three month in-patient treatment phase is complete. Of the ten patients currently hospitalized only one has confirmed MDR tuberculosis. Six of the patients do not even have results of sputum cultures because of a breakdown of the culture facility at the INSP. Among the 25 patients admitted for treatment last year, only nine had results of drug sensitivity testing, one of whom was found not to have MDR tuberculosis. (about seven months after treatment initiation)

99. Drugs for the treatment of MDR-TB are procured under the national budget. The PNLT uses a 15-month treatment regime that is not approved by WHO. One of the key drugs in the regime, Ofloxazine, was out of stock at the time of the OIG visit. New treatment guidelines that conform to WHO recommendations have been developed and the OIG was told that they will be implemented in 2012.

100. After the 3-month hospitalization phase, patients are treated for 12 months as outpatients in their nearest tuberculosis clinic. There are currently 17 patients under treatment, most at the CATB in Bujumbura. Three regional treatment facilities have been built with Global Fund support and are almost completed. The facility in Gitega will be a major improvement over the current tuberculosis clinic which has problems of space and ventilation.

Monitoring and Evaluation

Performance Frameworks

101. The performance framework for the Round 7 Tuberculosis grant has three high level (outcome) indicators and 13 output/process indicators. All indicators are appropriate; there is only a minor issue that some indicators are defined for a three-

[22] The term “chronic tuberculosis” is used in this context because the majority of patients do not have confirmed resistant tuberculosis.

month period while the program update is submitted only every six months. In effect, this means that performance, for instance in terms of monthly supervision, is assessed only every second quarter.

Data Management and Quality

102. The Global Fund performed on-site data verification (OSDV) in 2009 and 2010. The 2009 report showed significant data problems, but it is also very difficult to understand. One indicator (case detection) appears to have been reviewed twice in different formulations; the other (cure rate) was reviewed on the basis of data from the national health information system (EPISTAT) rather than PNLT data. Since this requires a cohort analysis which is not possible with EPISTAT data, we are not able to understand the conclusions of this OSDV. A second OSDV was done in 2010. This verification was well done and reported no major data inconsistencies.

103. No data management problems or data inconsistencies were observed by the OIG in any of the clinics and provincial offices visited. The database for MDR tuberculosis was not well kept, the Excel format difficult to read, and different versions were kept at central level and at the Kibumbu hospital.

Capacity Building

104. The OIG did not identify any capacity issues for primary tuberculosis diagnosis and care and for the management of TB-HIV co-infection. There are, however, many shortcomings in the diagnosis and treatment of MDR TB which will also require a considerable effort of capacity building on many levels (tuberculosis clinics, MDR hospital, INSP).

Tuberculosis: Programmatic Recommendations

Recommendation 15 (High)
The PNLT should assure that the National Reference laboratory for culture and drug sensitivity testing becomes functional as soon as possible.

Recommendation 16 (High)
The PNLT should seek assistance from its technical partners to bring the clinical and laboratory services and the data management for MDR tuberculosis up to international standards.

Malaria Program

Burundi has experienced a massive increase in reported malaria incidence since 2008. Anecdotal information collected during the OIG audit indicates that the incidence may have started to fall following the bed-net campaign in February 2011. Observed diagnostic and treatment services vary in quality, primarily related to weak supervision and absence of quality control.

Malaria in Burundi

105. About 90 percent of malaria in Burundi is caused by Plasmodium falciparum, the remaining 10 percent by P. malariae and P. ovale. It is the most common cause of morbidity and mortality in Burundi. In 2010 it accounted for 44 percent of

consultations and 38 percent of deaths in health centers.[23] The country has three malaria transmission zones ranging from hyper-endemic to non-endemic. Communities located at intermediate altitude of 1,400 to 1,750 meters are at risk of epidemics. This stratification is currently being reviewed. Peak transmission periods of malaria are in May and in December.

106. Between 2008 and 2010 the number of malaria cases reported in hospitals and health centers doubled from 2.1 million to 4.2 million. This may in part have been driven by an increase in the number of health center consultations of about 2.5 million between 2009 and 2010.[24] A relatively high level of bed-net use by children under 5 (45 percent) and pregnant women, (50 percent)[25] and an emergency in-door spraying program in response to an epidemic in Ngozi district appeared to have had little impact. The number of malaria cases reported nationally in the first quarter of 2011 was identical to the number reported in the same period of 2010. There are, however, signs that the bed-net distribution of February 2011 is changing the trend. National data for April were not available, however in the health centers visited by the OIG, the number of consultations for malaria in April were considerably lower in 2011 than in 2010, often by more than 50 percent.

The National Response to Malaria

107. The National Malaria Program (PNILP) was created in 2009 with the development of the first malaria strategy (2008-2012). It has a work plan and budget of about USD 190M over four years, but it has only very limited access to funds. Until 2010 it has not played its role as a national coordinator of malaria activities, and there was considerable confusion and overlap between programs funded by different donors. This has recently improved and the first meeting of the Roll Back Malaria partners in Burundi was held in March 2011.

108. Despite the difficulties in the institutional development of the national malaria program, the country has made significant programmatic and policy advances. ACTs are the standard treatment for uncomplicated malaria everywhere. The drugs are provided free of charge in all public health facilities. Laboratory confirmation of malaria diagnosis is gradually increasing. Practically all health centers have microscopes. Insecticide-treated bed-nets are provided free of charge in ante-natal and immunization clinics, and a recent mass distribution campaign has succeeded in achieving near universal bed-net coverage.

Service Delivery

Malaria Diagnosis and Treatment

109. The OIG visits to eight health centers in six provinces revealed a mixed picture. Health center staff were generally well informed about national directives on diagnosis and treatment of malaria. They were aware of the need to obtain laboratory confirmation and of the policy of using ACT as the first line of treatment unless contraindicated. Monthly reports prepared for the national health information system often indicated conformity with these directives, although a review of patient registers sometimes revealed a different picture. For example, the April 2011 report of the CS Gitega stated that all cases of malaria, except for 10 pregnant women, were

23 MSPLS Annuaire Statistique 2010 (version provisoire)
24 New patients in Health Centers - 2009: 7,214,510; 2010: 9,751,851 (MSPLS 2009 and 2010-provisoire)
25 Demographic and Health Survey 2010 (preliminary results)

treated with ACT. However, a spot review of the register for a period of two days in the same month, found that 9 out of 25 children under 5 years of age were treated with Quinine. In the CS Makebuku, the staff stated that all cases of malaria were confirmed by microscopy. However, only about 20 percent of microscope exams were positive. We asked to see a negative slide, which on exam contained no red blood cells. The clinical staff were aware of the poor quality of microscopy and compensated by treating patients who had negative laboratory results with ACTs.

110. The conclusions drawn from these and other examples are that clinical staff know the directives, but this is not always reflected in their practice. Treatment of patients without laboratory confirmation or with negative laboratory exams is related to (a) lack of confidence in the microscopy or RDT results (sometimes justified), (b) stock-out of laboratory reagents (reported in several centers), and (c) inability of patients to pay for a microscopy exam (charges ranged from BIF 50 to BIF 500). Treatment with Quinine instead of ACT is related to (a) lack of confidence in the effectiveness of ACT and (b) stock-out of ACTs because of supply rationing (discussed in the PSM section).

111. Most of these issues can be addressed through close formative supervision. All health centers had supervision registers with monthly entries by District supervisors and by the provincial performance-based financing (PBF) data verification team. The only mention of malaria found in these registers was in the entries by the SEP-CNLS malaria project pharmacist. No record of laboratory quality control was found. All health centers visited were in the habit of washing and re-using malaria slides, preventing any systematic effort for quality control.

Bed-nets

112. The mass-distribution of bed-nets was concluded in February 2011. A review of health center malaria data by the OIG suggests the campaign was successful. In a meeting with a community association involved in the distribution and follow-up of bed-nets, a number of issues were raised. There were some gaps in the household census to be filled by a back-up campaign currently under preparation. Net size was cited as a frequent problem as the supplied nets were too small for large common beds used in rural areas. Color was also raised as an issue (the nets were white, but many people prefer colored nets). There was generally a sense of satisfaction and a positive assessment of the campaign results.

Monitoring and Evaluation

Performance Frameworks

113. The performance framework of the Round 2 RCC grant has seven high level (impact/outcome) indicators and nine output/process indicators. The OIG noted errors in the definition and calculation of the indicators for malaria mortality and for laboratory confirmation. Both were signaled to the Global Fund Secretariat and discussed with the PR. They have been corrected in the Phase 2 agreement.

114. The performance frameworks for the Round 9 grant have seven high level (impact/outcome) indicators. All but one await studies still to be conducted. The government PR reports on three output indicators, two related to supervision by provincial and district health teams. The supervision is generic, and the OIG found no evidence in the health centers visited that it addressed malaria diagnosis and treatment. The civil society PR reports on seven output indicators related to the bed-net mass distribution campaign and follow-up.

Data Management and Quality

115. An On-site Data Verification for the Round 2 RCC grant was done in October 2010. Significant data quality issues were identified for the indicator on laboratory confirmation and the indicator on ACT treatment. The OSDV report also noted problems with the measurability of the laboratory indicator but did not realize that this indicator was based on an invalid formula (it has been changed for Phase 2). The data accuracy problems for the ACT treatment indicator identified by the OSDV persists as confirmed in the spot-checks of the OIG mission.

116. Management of malaria data is fully integrated into the national health information system (EPISTAT). The quality of data is verified by the provincial PBF team. Improving the quality of data by frequent and systematic review of patient registers is a supervision task. It is currently not performed by the District and Provincial supervisors.

Capacity Building

117. By December 2010, the PR reported that 3,093 clinical and 393 laboratory staff had been trained. Yet, the OIG mission found issues in the quality of diagnosis and care in most health centers visited. We were not alone. In 2010, a USAID study reported a general lack of trained laboratory personnel in health centers. The study also commented on the absence of supervision and quality control. [26] This is not an issue to be addressed by more training, but rather by closer supervision that has to specifically focus on malaria diagnosis and treatment.

118. The PNILP is the mandated leader of the national response to malaria. The INSP has the mandate to develop the national laboratory network. Providing the necessary technical, financial and human resources to these institutions would go a long way towards building the capacity for malaria control in Burundi. Until now, this has been sadly neglected by the Global Fund-supported program.

119. The mobilization of community associations for bed-net campaigns is promising but it is also relatively recent. Community systems in Burundi have been weakened by years of conflict. Mobilizing these groups for “hang up” and “keep up” campaigns may help in strengthening them. But in discussions with one of the groups it became evident that they are not just a “service provider for bed-net services”. They are an emerging civil society institution at the community level. The current exclusive focus of the program on number of nets and number of home visits does not leave any margin for the type of community capacity building that may be required to sustain the results of the bed-net campaign.

Malaria: Programmatic Recommendations

Recommendation 17 (High)
The PR (SEP-CNLS) should increase supervision and quality control of clinical and laboratory services for malaria. This task should be guided by the PNILP (for clinical services) and the INSP (for laboratory services). Technical tasks should be gradually devolved to these institutions, while building their capacity to fully realize their mandate.

26 Improving Malaria Diagnostics – Evaluation Report; USAID 2010

Recommendation 18 (High)
The MSPLS should nominate staff within the decentralized teams to be specifically responsible for the formative supervision of clinical and laboratory services for malaria under the technical guidance of the PNILP and the INSP. The PR may consider financial support, but the positions should be fully within the public service for sustainability.

Recommendation 19 (Requires attention)
The MSPLS should consider making malaria microscopy in health centers free of charge.

Recommendation 20 (Requires attention)
In a future phase of the Round 9 malaria grant, CED-CARITAS and the Global Fund should jointly review the program design and seek technical advice on how to increase the community systems strengthening aspect of the program.

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

HIV

Quantification and Distribution

Pharmaceuticals

120. The SEP-CNLS is responsible for the quantification of ARVs, drugs for opportunistic infections (OI), and drugs for the treatment of sexually transmitted infections (STI). In order to coordinate the quantification of pharmaceuticals, a multi-partner committee was created by ministerial decree in April 2007, the "Comité national de gestion des ARV, I-O et fournitures médicales". However, the members of the committee have not met since 2008. Since then the task of quantification and forecasting is performed by the pharmacists of the SEP-CNLS, CAMEBU, and the HIV unit of the Ministry of Health (USLS).

121. Program officials informed the OIG of major stock-outs of ARVs in 2007. However, during the OIG audit in June 2011, the only ARVs that were out of stock in the facilities visited were fixed-dose combinations based on Emtricitabine. This did not result in treatment interruptions as these drugs were temporarily replaced with single molecule formulations.

122. The quantification of ARVs at national level is based on the mean monthly consumption reported by the central pharmacy (CAMEBU) rather than on the number of patients under treatment reported by the 95 ART sites. The paper-based reports submitted by these sites to the M&E coordinator of the SEP-CNLS are considered too unreliable and not timely enough. However as of June 2011, the SEP-CNLS plans to calculate quantities on the basis of electronic patient data collected with the SIDAINFO software at treatment sites. The software has been installed in all sites, but training of users is still on-going, and the user manual has not yet been distributed. The OIG observed that the capacity to work with SIDAINFO at peripheral level was highly variable. Only the larger sites were able to generate up-to-date reports.

123. The Phase One budget for OI and STI drugs in the Round 8 HIV grant is considerably higher than the budget for ARVs (USD 3.1 million versus USD 1.3 million) These drugs were procured without any quantification study. The quantities listed in the PSM plan were simply pasted into the tender files. The drugs are delivered to HIV treatment sites to be dispensed free of charge to patients on ART. There are, however, no guidelines for health professionals stating which medical conditions should be reported as OIs. There is no information about the incidence of these OIs, and the number of STIs treated at these sites is close to zero. The two consequences of this situation is that (a) large amounts of antibiotics are collecting in the pharmacies of the HIV treatment sites, and (b) the treatment sites complain of “stock-outs” of OI drugs because they are ordering drugs from CAMEBU that are not included in the PSM plan. The situation is complicated by OI drug donations to specific hospitals from other sources, for instance the Great Lakes Initiative on AIDS (GLIA).

a) The HIV clinic in Muramvya Hospital had 218 active patients on ART by the end of March 2011, 16 of them children. During the field visit, the OIG found, among the ARVs and many other drugs, the following antibiotics in the store room of the HIV clinic: (1) Cloxacillin Capsules 500 mg: 56 containers of 500 capsules each;

(2) Erythromycin Tablets 250 mg: 39 containers of 500 tablets each; (3) Amoxicillin Capsules 500 mg: 27 containers of 500 capsules each; (4) Spectinomycin injection 2g: 100 doses; (5) Amoxicillin & Clavulinic Acid 125 mg tablets (for children): 44 treatment doses (individually packed) (6) Amoxicillin & Clavulinic Acid 500 mg tablets (for adults): 50 treatment doses (individually packed). Most of these drugs had expiry dates of 2013, but the quantities are sufficient to last more than a decade even if the active patient load should double.

b) The HIV clinic in Kayanza Hospital had received a donation of OI drugs from GLIA. The clinic had enough Acetaminophen 500 mg to last at least four years. The drugs were expiring in November 2012. The clinic therefore adopted a practice of "lending" drugs to the hospital pharmacy where they were sold to patients, expecting reimbursement of drugs from the hospital at a later time.

124. Certain OI and STI drugs are also greatly overstocked at the central level at CAMEBU. The situation is chaotic and the PR does not have adequate tools or a functioning system to monitor the distribution of these drugs. The OIG was unable to obtain reliable information of drug quantities at different points in the chain once they had left CAMEBU. The risks of expiry of these drugs and of drug diversions are high.

125. The SEP-CNLS has no written procedures or tools for the quantification and tracking of ARVs. All processes are informal and very few are documented.

HIV Tests

126. The 15 health facilities providing HIV counseling and testing (HCT) visited by the OIG were well stocked with HIV screening tests (Determine®), but nine of them were out of stock of confirmatory tests, some since February 2011.

127. A new testing algorithm using three rapid tests was approved in February 2011 but had not yet been introduced. All facilities visited by the OIG were working according to the old algorithm, using a screening and a confirmatory test. Bio-Rad Laboratories, the manufacturer of the previously used Genie II® confirmatory test had informed the PR in December 2009 that it was replacing this test with a new product, Genie III®. A small quantity of this new test was procured and distributed. In October 2010 concerns were raised that the new test was not prequalified by WHO. No further tests were ordered, and only in May 2011, a technical committee was charged with choosing a new confirmatory test. At the time of completion of the audit mission in June 2011, the new test had not yet been procured.

Condoms

128. There are two main networks for condom distribution in Burundi. PSI operates a network of subsidized sales of its branded condom "Prudence Class". The National Reproductive Health Program (PNSR) operates a network of generic condoms distributed free of charge in health centers and by community-based distributors. The two main sources of condoms for the PNSR are the SEP-CNLS and UNFPA. The condoms managed by the PNSR are stored at CAMEBU and distributed via (a) the Health Districts and (b) the Provincial AIDS Committees (CPLS).

129. The PNSR monitors the distribution of condoms via the districts and health facilities, but it receives no information about condoms distributed via the CPLS. Once the condoms leave CAMEBU to the provincial CPLS offices, they are theoretically being monitored by the SEP-CNLS, although no monitoring system

exists. The PNSR therefore has no feedback on the flow of condoms to the community-based distributors.

130. This lack of coordination in the distribution chain is also seen at the stage of procurement. The main partners, PNSR, UNFPA, the SEP-CNLS and the USLS of the Ministry of Health have no formal agreement or coordinating mechanism. The coordination committee stipulated in the National Condom Policy of 2009, the "Comité de coordination et de gestion du préservative" was never convened. As a consequence, UNFPA and the SEP-CNLS procured large quantities of condoms simultaneously. At the time of the OIG mission, CAMEBU was overstocked with SEP-CNLS condoms while the PNSR had to rent an additional warehouse to stock the condoms procured by UNFPA. The condoms procured by the SEP-CNLS are currently not being distributed, waiting for the UNFPA-procured stock to diminish.

131. In April 2011, the PNSR and the SEP-CNLS organized their first joint supervision to 13 provinces. The report of this mission had not been issued and was not available to the OIG. In an interview with PNSR staff the OIG was told that the mission revealed considerable distribution imbalances, with some provinces overstocked and others close to stock-out.

Procurement

132. The OIG reviewed tender files for medical material, OI drugs, ARVs, condoms and laboratory supplies. The tendering process was generally well organized, resulting in transparent and equitable analysis and awards. However some weaknesses were noted in the areas of central coordination and internal control. For example, the lack of requisitions to formally initiate procurement actions. And inadequate coordination between the procurement unit and the program units in scheduling and monitoring procurements during implementation of the approved PSM plan.

Quality Control

133. The market for pharmaceuticals in Burundi is entirely deregulated as the National Drug Authority (DPML) is not able to register drugs entering the country. The quality control of drugs procured under Global Fund grants is therefore of special importance. Burundi is in the process of establishing a quality control laboratory but it is not yet operational. The SEP-CNLS therefore uses the services of a laboratory in South Africa, International Medical Solutions, for the quality control of drugs procured under the Round 5 and Round 8 HIV grants. The OIG did not find evidence that this laboratory has ISO 17025 certification, nor is it included in the WHO list of prequalified quality control laboratories (17th edition, January 2011).

HIV: PSM Recommendations

Recommendation 21 (High)
The SEP/CNLS should develop Standard Treatment Guidelines for Opportunistic Infections in order to ensure adequate management of patients and rational use of OI drugs

Recommendation 22 (High)
A physical stock-taking of all OI drugs should be conducted at the pharmacies of the HIV treatment sites with the view of identifying health facilities that have excess OI drugs beyond their need; and distributing them to facilities that need them.

Recommendation 23 (Significant)
The MSPLS should consider reactivating the multi-partner committee for coordinating the quantification of pharmaceuticals.

Recommendation 24 (Significant)
The SEP-CNLS should develop and adopt a manual of pharmaceutical management procedures with regards to quantification, procurement, stock management, drug distribution, monitoring systems, supervision and quality assurance.

Recommendation 25 (Significant)
The SEP CNLS should ensure that SIDA Info is fully functional and implemented in all treatment sites. SIDA Info data should be used by SEP CNLS together with the consumption data for forecasting and monitoring of consumption.

Recommendation 26 (Significant)
The MSPLS should consider reactivating the multi-partner committee for the management of condoms as specified in the 2009 national policy.

Tuberculosis

134. First line tuberculosis drugs are procured through the Global Drug Facility (GDF) which conducts annual missions to assist the PNLT with quantification. The process is working smoothly with only minor problems such as a stock-out of a pediatric formulation of INH/Rifampicin in 2010. The OIG did not identify any risks in this procurement process. Drugs for the treatment of MDR tuberculosis are procured with Government funds through Action Damien. The only pharmaceutical procurement done directly by the PNLT is for a small quantity of drugs required for the pilot project on comprehensive lung health (APSR - Approche Pratique de la Santé Respiratoire) in Bubanza Province.

135. Tuberculosis treatment facilities (CDTs and CTs) are supplied with tuberculosis drugs from the District Pharmacy. The resupply needs are determined during the quarterly provincial data verification meetings. The drugs are delivered by the Provincial Tuberculosis Coordinator from CAMEBU to the District Pharmacies. They are released to the treatment facilities against requisitions verified by the District Medical Officer and the Provincial Tuberculosis Coordinator. The process works efficiently. However the OIG noted that three of the five district pharmacies visited during the mission were not able to provide storage for the drugs according to an acceptable standard. The district pharmacies have only recently been included in the supply chain of tuberculosis drugs as part of the national health sector decentralization policy. A too rapid implementation of this policy risks to negatively affect the quality of tuberculosis control.

136. The PNLT does not have the capacity and the qualified personnel to manage procurement of pharmaceuticals on its own even though the actual volume of procurement it manages is very small. For example, the PNLT procured medical supplies and drugs for APSR under the Global Fund Round 7 grant. The review of procurement practices by the OIG revealed shortcomings in terms of procurement planning, tendering processes and record keeping. For example, the contract for the supply of APSR drugs (Tender No. AOO 011/2010) was awarded to a local supplier after an international open tender. The tender was only advertised in a local public announcement journal and was floated twice after cancellation of the initial tender. Both times the local supplier was the only bidder. The OIG found that the unit costs

for drugs in this contract were significantly higher than the prices of the same drugs sold by CAMEBU, and significantly higher than the costs estimated in the PSM plan.

Quality Control

137. The APSR drugs procured by the PNLT did not undergo any quality control procedure. The drugs were procured locally in a market that lacks regulation and controls.

Tuberculosis: PSM Recommendations

Recommendation 27 (High)
PNLT should refrain from purchasing drugs, reagents and medical supplies for APSR. This should be done by CAMEBU through a Memorandum of Understanding. An annual planning with a delivery by air should facilitate the process and avoid any delay in implementation of service delivery.

Recommendation 28 (Significant)
In the absence of a National Regulatory Authority to ensure quality of pharmaceuticals and diagnostics, the PR should work with technical experts on defining specifications for the procurement of health products.

Recommendation 29 (Significant)
An assessment of the district pharmacies should be performed in order to select those able to properly store and manage tuberculosis drugs. The districts that do not have adequate district pharmacies should not be considered as part of the tuberculosis supply chain. Drugs could then be distributed directly from CAMEBU to CDT sites.

Malaria

ACTs

138. The Principal Recipient of the two malaria grants, the SEP-CNLS, is responsible for the national quantification of ACTs and laboratory products for malaria, and for the procurement of ACTs and laboratory products based on (i) information about their distribution and availability and (ii) malaria morbidity data reported by health facilities. Monitoring the use of drugs and reagents at the level of health facilities is, however, not within the remit of the SEP-CNLS. This responsibility rests with the structures of the Ministry of Health, the National Malaria Program (PNILP) at the central level and the District Health Authorities at the peripheral level.

During the Round 2 Global Fund malaria grant, two different formulations of Artesunate and Amodiaquine combinations were procured by the SEP-CNLS through UNICEF:

a) From 2005 to 2008: A co-blistered formulation of Artesunate and Amodiaquine produced by CIPLA, IPCA Laboratories and Guilin Pharmaceuticals;
b) Since 2009: Co-formulated ASAQ produced by Sanofi-Aventis.

139. The SEP-CNLS malaria unit does not have a pharmaceutical procedures manual. One pharmacist (recruited since December 2010) is responsible for the

quantification, the national resupply calculation and the monitoring of distribution and stock management of ACTs. The distribution of ACTs is based on the mean monthly consumption as confirmed by a letter of the Minister of Health of May 2009.

140. Following the doubling of reported malaria cases and of ACT consumption between 2008 and 2010, as well as suggestions of over-use of ACTs and possible drug diversions in 2010, the SEP-CNLS started to ration ACT resupply to district pharmacies in the beginning of 2011. With endorsement of the PNILP, the SEP-CNLS reduced monthly resupply orders based on the number of confirmed malaria cases reported in the preceding month. In February 2011, the SEP-CNLS introduced a new method for the calculation of resupply quantities of ACTs based on the national incidence of malaria regardless of the age groups or the geographical situation. The two attempts of rationing the resupply of ACTs led to increased reports of stock-outs of ACTs and to an increased consumption of quinine for the treatment of malaria. In response, the Ministry of Health convened a meeting of the health partners with the PNILP and the SEP-CNLS on May 16th 2011. The participants agreed to return to the mean monthly consumption method of calculating resupply quantities.

141. The field visits to district pharmacies, health centers and hospitals by the OIG confirmed that the ACT rationing in 2011 severely disrupted stock management at the peripheral levels. Security stocks were degraded, stock-outs of ACT formulations for specific age groups increased in frequency and there was a massive increase in the use of quinine for malaria treatment. But the OIG also observed examples of supply-chain disruptions with the opposite effect. For example, the district pharmacy of Kayanza District had not been supplied with ACTs between January 2011 and the OIG visit in May 2011. But the pharmacy was holding more than 28 months stock of ASAQ 25/67.5 mg and more than 18 months stock of ASAQ 100/270 mg, both with expiry dates within the next 12 months. The mean monthly distribution of ACTs in the district had not been recalculated since April 2009.

142. National data on the consumption of ACTs for 2010 are within a few percentage points congruent with the reported incidence of malaria. A district level analysis showed that in 2010 there were seven out of 45 districts that had a significant overconsumption of one dosage formulation of ACTs. These instances require further analysis, reviewing the quality of data as well as adjusting for the possibility that lower dose formulations were doubled up to compensate for stock-outs of higher dose formulations. Some inconsistencies in ACT consumption at individual health facilities were reported by the SEP-CNLS to the LFA in 2010. According to the SEP-CNLS pharmacist they are being investigated by the police. The findings point to the need of a more robust system to monitor ACT flows, but they do not indicate that there has been any systemic diversion of ACTs.

Laboratory Supplies

143. There have been severe shortages of Giemsa stain for malaria microscopy throughout 2009 and 2010 and a shortage of vaccinostyles for taking blood samples for microscopy since the end of 2009. These items were never quantified in the PSM plan but simply included in a bulk amount for laboratory supplies. At the time of the OIG mission, vaccinostyles were still out of stock at central level but no order had been made.

Procurement

Procurement of ACTs

144. The SEP-CNLS has been procuring ACTs since 2004 via a direct contract with UNICEF. This approach has so far assured timely procurement without any periods of drug shortages. The OIG reviewed the procurement process from supplier to CAMEBU since 2004 and found it satisfactory in terms of procedures and security. Nevertheless, the question of strengthening the national health system has to be asked. CAMEBU is the institution within the health system responsible for the procurement and supply of essential medicines.

Procurement actions by PSI as Sub-Recipient of SEP-CNLS Malaria Program

145. Bed-nets for the 2011 mass distribution campaign under the Round 9 malaria grant were quantified by CED-CARITAS based on a household census in the eight targeted provinces carried out in 2010 by the SEP-CNLS. About 2.3 million bed-nets were procured through the VPP mechanism, to be stored and distributed by PSI under a Memorandum of Understanding signed with the SEP-CNLS in November 2010.

146. The OIG noted the following in the procurement by SEP-CNLS of the services of PSI to provide logistics and supply chain management support for the national distribution of LLINs.

a) The estimated cost of services was not stated in the agreement signed in November 2010 because the budget had not been finalized; and
b) An amendment to the agreement in February 2011 provided PSI/Washington with a nine percent overhead rate.

147. The OIG noted the following areas for improvement in procurement carried out by PSI to select suppliers to provide storage, security and transport services for the national LLINS distribution campaign. At the time of the audit, PSI officials ascribed these shortcomings in procurement to the short deadline given to them to provide the service of transporting the bed nets to distribution points in the communes. The contract with PSI was signed on 10 November 2010.

a) Short response time for suppliers to respond to invitation for bids for transport services;
b) Two of the three suppliers who submitted bids for security services received their invitations to bid a day before the opening of bids. In consequence, the losing bidders were not given sufficient time to prepare their bids and hence the bid was not competitive and fair. The cost for security services was BIF 95,488,946 (approximately USD 98,416);
c) Bids for the procurement of services for security, storage and transport were evaluated solely on the basis of technical submissions instead of both technical and cost in order to obtain value for money for those services. This is contrary to national procurement regulations; and
d) Additional costs for handling and gasoline amounting to BIF 22,585,404 (approximately USD 18,656) were added to the original contract of BIF 192,042,903 (approximately USD 158,713).

Quality Control

148. Although the chosen formulation of ASAQ is prequalified by WHO and is on the list of drugs approved by the Global Fund, the First Phase budget of the Round 2 RCC malaria grant included a line for quality control of ACTs, bed-nets, rapid diagnostic tests, and blades for blood sampling. Neither the Ministry of Health nor the SEP-CNLS have developed a policy and procedures for quality control and the entire budget remains as yet unspent.

Recommendation 30 (High)
The SEP-CNLS malaria program should establish an effective monitoring and reporting system for ACTs and laboratory supplies.

Recommendation 31 (High)
The SEP-CNLS should carry out a detailed independent review, agreed with the Global Fund Secretariat, of all expenditures incurred by PSI under its logistics and distribution service agreement for the mass distribution of bed nets. Any ineligible expenditure should be recovered from PSI.

Recommendation 32 (High)
The MSPLS and SEP-CNLS should develop policies and procedures for quality control of medicines and health products including ACTs, bednets, and rapid diagnostic tests.

Recommendation 33 (Significant)
Under the supervision of MSPLS, SEP-CNLS Malaria program should document, in a pharmaceutical procedures manual, the process and procedures for ACT quantification, procurement, distribution, monitoring, reporting and management. The manual should include standard tools for use by health facilities for ordering and reporting.

Recommendation 34 (Requires attention)
The MSPLS and SEP-CNLS should consider progressively assigning to CAMEBU, the procurement responsibility for malaria medicines and health products with a long-term objective of developing its capacity to fully assume its role as the central medical store for Burundi. Initially, CAMEBU should be given the responsibility currently handled by UNICEF of purchasing of ACTs for the malaria program.

Recommendation 35 (Requires attention)
After CAMEBU's procurement capacity has been duly assessed and found to be adequate, the SEP-CNLS should consider assigning to CAMEBU all tasks related to ACT procurement.

Procurement of non-health related goods and services

149. The OIG noted the following common findings for procurement of non-health related goods and services at grant implementing organizations audited (PRs, SRs and implementing organizations).

a) Lack of evidence of competitive bidding or price comparisons for purchase of goods/services; non-compliance with procurement regulations or procedures (shorter response times to suppliers to submit tenders; absence of technical specifications. Refer to Annex 9).

b) Penalty clauses in procurement contracts for late delivery of goods/services by suppliers were not applied as stated in the contracts

Recommendation 36 (Significant)
All PRs, SRs and grant implementing organizations need to show evidence that value for money is obtained for goods and services by ensuring that transparent competitive bidding takes place before goods and services are procured

Recommendation 37 (Significant)
To assure that program goods and services are delivered on time by suppliers, all PRs and SRs should ensure that penalty clauses for late delivery of goods by suppliers are applied to serve as a deterrent.

The Pharmaceutical Supply Chain

CAMEBU

150. CAMEBU is a state enterprise established by decree in March 2000. Although it has autonomous management and its own capital, it is under the direct authority of the Ministry of Health. Senior management is appointed by the Minister. Procurement and administrative procedures of CAMEBU are those of the public service. A manual of standard operating procedures is being developed with assistance of a DFID-funded technical assistance project. Stock areas are generally in good state and well maintained. The total stock area is about 2 500m² to 3 000m² organized in 6 storage areas in a single U shaped building. All warehouses are insured against fire and theft.

151. As a Sub Recipient of the SEP-CNLS and the PNLT, CAMEBU receives drugs and medical supplies, manages central level stocks and supplies health facilities with drugs and reagents procured with Global Fund support. These activities are guided by comprehensive memoranda of understanding signed with the PRs. These memoranda, however, do not reflect in detail the level of service that the SEP-CNLS HIV and malaria grant management units should expect from CAMEBU. Strengthening the operational relationship between CAMEBU and the PRs would be an important contribution to the goal of health systems strengthening. For instance CAMEBU could release a monthly "sales profile" of key pharmaceuticals to the PRs, replacing the current method of calculating mean monthly consumptions by the PRs themselves.

152. Storage space at CAMEBU is limited. It was quite difficult to store fast moving items such as Cotrimoxazole and Paracetamol. The stock is distributed among several buildings. Stock procured with Global Fund support is physically separated from other donated or procured stock. This has advantages but requires a lot of space. Because of space restrictions, identical drugs purchased with Global Fund support are stored in several buildings, complicating the inventory process. This problem is exacerbated by the practice of the PRs to launch annual tenders according to the PSM plans, requiring CAMEBU to store a whole year's supply. Since all HIV and malaria drugs are shipped by air, the deliveries could easily be spaced in six-monthly lots. This method has two main advantages: (i) rational management of storage space at CAMEBU (ii) better control over risk of expiry as the second consignment is delivered with longer shelf life than if it would have been delivered 6 months before.

153. Pharmaceuticals procured by other partners but used for Global Fund supported programs (e.g. donated OI drugs) are stored with pharmaceuticals procured by the PRs and maintained in the CAMEBU inventory list of Global Fund drugs. Since it is not known how these drugs have been procured and what quality control they have undergone, there is a risk that drugs of poor quality or even counterfeit drugs may be intermingled with drugs procured with Global Fund support.

154. The CAMEBU information system is organized vertically with four different databases, one for each major client. There are four different ways of coding clients, the same drugs may appear in each of the databases (for instance OI drugs procured by SEP-CNLS, OI drugs procured by CAMEBU, etc.), items are valued differently in each database, and in the case of donated drugs they may not be valued at all. There is considerable room for efficiency by creating a single database for all of CAMEBU's stock and by co-locating drugs according to type regardless of financing and provenance, considering that CAMEBU is holding the "national stock".

The District Pharmacies

155. The creation of District Pharmacies is part of the health sector decentralization process that started in 2007. The OIG visited five DPs and found large variations in capacity and performance. The DPs generally suffer from a severe shortage of qualified personnel. Most of them are managed by nurses with variable degree of training in pharmacy management. Each pharmacy manager used a different time period for the calculation of mean monthly consumption, a key variable to assure the resupply of ACTs, ARVs and other drugs. Standard operating procedures for the management of drugs at district level were released by the Ministry of Health in April 2011. This may result in some improvement, but the very high level of staff mobility is likely to temper success. Observations of very poor practices in handling pharmaceuticals such as drugs stored in a carton under a sink (Kayanza District Pharmacy) or pills kept in an open container that was surrounded by mouse excrement (Ngozi District Pharmacy) strongly suggest that there is insufficient supervision of the District Pharmacies.

Pharmaceutical Supply Chain: Recommendations

Recommendation 38 (Significant)
For the procurement of HIV and malaria health products, the PR should consider agreeing with the suppliers on a staggered delivery with a contractual clause specifying that quantities for the second delivery may be adjusted within certain percentage of the initial required quantities.

Recommendation 39 (Significant)
The MSPLS should involve pharmaceutical staff of the national programs for HIV, TB and malaria in the supportive supervision of the district pharmacies currently carried out by the District Health Offices.

Recommendation 40 (Requires attention)
SEP-CNLS should enter into an agreement with CAMEBU that specifies the level and types of service that it requires from CAMEBU for the HIV and malaria programs.

Recommendation 41 (Requires attention)
CAMEBU should create a single database for all of CAMEBU's stock and co-locate drugs according to type regardless of financing and provenance.

Recommendation 42 (Significant)
SEP-CNLS should strengthen the capacities of its pharmaceutical unit in regard to data collection, reporting and supervision, and ensure that the roles and responsibilities of the pharmaceutical unit are well aligned with program needs. The program may need to consider engaging technical assistance to implement this recommendation.

FINANCIAL MANAGEMENT AND CONTROL

The audit identified scope for improvement in financial management across all organizations audited (PRs, SRs and implementing organizations). These can be addressed by ensuring that (a) sufficiently qualified accounting staff are available and (b) supportive supervision of implementing entities by Principal Recipients takes place.

156. The OIG audited grant receipts, expenditures and financial reporting of four PRs, namely, SEP-CNLS, PNLT, RBP+ and CED-CARITAS. In addition, the OIG team audited grant expenditures and receipts of selected SRs and implementing partners of the above-mentioned PRs, namely, ANSS, PSI, SWAA, ABS, RBP+, selected Regional Hospitals, and some Civil Society Organizations.

Common Financial Management and Internal Control Weaknesses at all PRs and Sub-recipients audited

157. The OIG noted common financial management and control weaknesses at grant implementing organizations audited (PRs, SRs and implementing organizations. The underlying causes for these financial management and internal control weaknesses are (a) lack of sufficient qualified accounting staff in the country and (b) inadequate supportive supervision of implementing entities by principal recipients. The corresponding recommendations for the common findings can be found in Annex 2 of this report. In addition, examples/illustrations of the weaknesses in some of the grant implementing organizations audited can be found in Annexes 2 to 9 of this report. All PRs and lead SRs of Global Fund grants should issue management letters to all implementing organizations to prepare management action plans to address the following common findings.

Accounting, documentation and financial reporting

a) Grant expenditure on payment vouchers was not accurately coded according to Global Fund budget categories to facilitate budgetary control.
b) The OIG noted instances of weak control and monitoring of grant budgets that could result in grant recipients/implementers exceeding their approved budgets.
c) Advances of grant funds to organizations for program implementation activities were treated as expenditures and posted to expenditure accounts in the general ledger. The reasons for this are (a) inadequate professional skills of program accountants and (b) inadequate supportive supervision by the PRs.
d) SRs did not routinely correct errors in their financial reports noted by the PRs. The reason was that feedback to the SRs was often late. In addition, because of inadequate professional skills, some SR accountants did not place much importance in making these corrections/adjustments in their accounting books/software.
e) Payment of per diem to staff that exceeds rates established by the audited entities. The reason for this was that established rates paid by the PRs/SRs were inadequate to meet minimum reasonable costs of accommodation and food for program staff.
f) Payment vouchers and supporting documentation were not properly numbered sequentially and archived in a chronological manner to facilitate retrieval of accounting documents.
g) In some cases, the OIG could not verify that program managers have reviewed payment vouchers and accompanying invoices before payment due to absence of required signatures.

h) Financial reports submitted by grant recipients differed from financial data in their accounting software. The reports had been produced from bank statements because of backlog of financial transactions that had not been entered in the software.
i) Financial reports of SRs were not prepared according to grant program budget categories, which did not facilitate consolidation of grant financial reports by PRs.
j) The OIG noted that bank reconciliations were prepared quarterly during preparation of financial reports with the risk that errors and irregularities would not be detected on a timely basis; in addition, in some cases, there was no evidence of supervisory reviews of bank reconciliations by managers (absence of signatures).
k) Operations and Procedures Manuals have not been updated; and some SRs did not have financial and operations manuals that provide guidance for grant financial management and program implementation.
l) The OIG noted cases of inadequate supporting documentation for expenses relating to travel, training events because there were no clear policies in the Operations and Procedures Manual that specify supporting documents required for justification of these types of expenditures. Refer to Annexes 5 and 6.

Purchasing and contracts

m) Lack of evidence of competitive bidding or price comparisons for purchase of goods/services; non-compliance with procurement regulations or procedures (shorter response times to suppliers to submit tenders, and absence of technical specifications, etc.) Refer to Annex 9.
n) Penalty clauses in procurement contracts for late delivery of goods/services by suppliers were not applied as stated in the contracts.

VAT payment

o) VAT was paid for some goods/services purchased with grant funds and not subsequently refunded, contrary to the grant agreements. The OIG did not see evidence that VAT paid was being recovered in a timely manner from revenue authorities. Refer to Annex 3.

Staff contracts and statutory deductions

p) Statutory deductions, such as income tax and social security taxes, were not withheld from employee salaries. The OIG noted that deductions for income and social security taxes were not incorporated in employee contracts.

Fixed asset management

q) Fixed assets registers were not regularly updated to facilitate control and accounting of grant program assets; and in some cases, fixed asset registers were not maintained.
r) The OIG noted instances where delivery notes had not been prepared by the PR/SR and signed by final recipients of program goods (e.g. equipment and vehicles).

158. The OIG found some expenditure that should not be charged to the grants. These expenditures are detailed in Annexes 3, 4, 7 and 8. The Secretariat should consider seeking recoveries from the PRs.

Principal Recipients' Financial Management

PR Financial Management: SEP-CNLS HIV/AIDS Program

159. The OIG noted the following financial management and internal control weaknesses in the audit of SEP-CNLS:

a) Inadequate supporting documentation for expenses relating to travel, training events and gasoline because there were no clear policies in Operations and Procedures Manual that specify supporting documents required for justification of these types of expenditures. Refer to Annexes 5 and 6 for examples.
b) Other internal control weaknesses are detailed in Annex 2. The corresponding recommendations for the audit findings can also be found in Annex 2. The PR is required to address these weaknesses in its own organization and to issue management letters to all its SRs to prepare management action plans to address the common internal control findings.

PR Financial Management: SEP-CNLS Malaria Program

160. The OIG noted the following financial management weaknesses in its audit of SEP-CNLS as PR for the malaria program:

a) The agreement signed in November 2010 with PSI to provide logistics support for distribution of LLINs did not specify estimated cost of services, leaving room for cost increases;
b) Without an agreed cost of services, the above-mentioned agreement was modified in January 2011 to include nine percent management fees/overhead for PSI head office in Washington DC. The OIG could not verify the validity and reasonableness of the overhead costs charged to the grant by PSI;
c) An advance of USD 1.3 million was paid to PSI in February 2011 without an agreed contract amount with a budget breakdown;
d) A payment of BIF 108.1 million (USD 89,000) was made by the PR to PSI in January 2009 to implement program activities in anticipation of a Global Fund grant. The activities that PSI implemented were eventually not included in the approved Global Fund grant. The PR owes PSI an additional USD 299,000. PSI has referred the matter to the CCM for arbitration;
e) The big cash fund maintained to finance program activities of PNILP (due to the latter's lack of financial management capacity) had weak controls: individual cash payments from the fund have ranged from USD 10,000 and USD 30,000; and absence of periodic cash counts to monitor the fund;
f) Advances made by the PR to its SRs such as PNILP for implementation of program activities remain un-liquidated for up to four months beyond the deadlines established for justification of the advance; and
g) A review of purchase of 2000 liters of deltamethrin (used for spraying mosquitoes) for USD 21,915 confirmed the LFA findings that there was no transparent and fair competitive bidding as two related companies submitted bids. In addition, a review of an LFA finding for purchase of supplies in September 2010 totaling USD 23,028 indicated that prices paid exceeded prevailing market prices for these supplies.
h) Other internal control weaknesses are detailed in Annex 2. The corresponding recommendations for the audit findings can be found in Annex 2.

PR Financial Management: RBP+ Round 8 HIV/AIDS Program

161. RBP+ charges 80 percent of its office rent and 100 percent of the rental cost of its provincial offices to its HIV sub-grant with SEP-CNLS. The OIG noted that RBP+ operates other non-Global Fund grant activities in all its offices. In addition the OIG did not find an equitable cost-sharing formula for rental costs.

162. The OIG noted errors in payment of grant expenditures, which are detailed in Annex 7.

PR Financial Management: CED-CARITAS (Round 9 Malaria Program)

163. Since the program started in July 2010, the audit covered the six month period to 31 December 2010. There were no significant/material audit findings, but the OIG noted internal control weaknesses that are detailed in Annex 2. The corresponding recommendations for the audit findings can be found in Annex 2. The PR should address these weaknesses in its own organization, and it should issue management letters to all its SRs to prepare management action plans to address the common internal control findings.

PR Financial Management : PNLT (TB Program)

164. The OIG noted the following financial management weaknesses in its audit of PNLT. Please refer to the list of common financial management and internal control weaknesses in Annex 2.

a) Advances of grant funds to provincial health offices for program implementation activities were treated as expenditures and posted to expenditure accounts in the general ledger.
b) Bank reconciliations were prepared quarterly during preparation of financial reports with the risk that errors and irregularities would not be detected on a timely basis.
c) Payment vouchers and supporting documentation were not properly numbered sequentially and archived in a chronological manner to facilitate retrieval of accounting documents.
d) Payment vouchers were not coded according to Global Fund budget categories to facilitate budgetary control.

Sub-Recipient Financial Management

Sub-Recipients of SEP-CNLS (HIV/AIDS Program)

Sub-recipient: RBP+

165. The OIG noted the following financial management and internal control weaknesses at RBP+:

a) Weak control over invoices for treatment services for PLWHA has resulted in outstanding unpaid invoices of BIF 100,940,410 (approximately USD 83,421) which RBP+ did not have the budget for. Refer to Recommendation number 1.
b) RBP+ charges 80 percent of its office rent and 100 percent of the rental cost of its provincial offices to the HIV sub-grant received from SEP-CNLS. However, RBP+ operates other non-Global Fund grant activities in all its offices. Thus there was no equitable cost-sharing formula for rental costs.
c) Lack of evidence of competitive bidding or price comparison for some purchase of goods and services. Refer to Annex 9 for examples.

Sub-recipient: ANSS

166. The OIG noted the following financial management and internal control weaknesses at ANSS:

a) Weak control over invoices for treatment services for patients on ART. This issue has been discussed in detail in paragraph 59b. Also, refer to Recommendation number 2.

Sub-Recipients of RBP+ (HIV/AIDS Program)

Sub-recipients: ABS, GIPA and SWAA/Gitega

167. Financial management and internal control weaknesses at ABS, GIPA and SWAA/Gitega are similar to the common list of findings detailed in Annex 2.

Recommendation 43 (Significant)
All PRs should address the financial management and internal control weaknesses detailed in Annex 2. In addition, all PRs should prepare management action plans and issue management letters to their SRs and implementing organizations to address these weaknesses. The corresponding audit recommendations are in Annex 2.

Recommendation 44 (High)
The SEP-CNLS malaria program should review its contracting procedures and templates for agreements and memoranda of understanding in order to address the lapses found in its service agreement with PSI.

Recommendation 45 (High)
The SEP-CNLS malaria program should build the capacity of the PNILP to manage grant funds as a sub-recipient and phase-out the cash fund. In the interim, to mitigate the risk of theft or loss of cash, the PR should establish a maximum amount of cash to be held in the fund. In addition, a maximum amount should be established for individual cash payments from the fund. Surprise cash counts should be performed regularly and any difference should be investigated

Recommendation 46 (High)
The Global Fund Secretariat should request the LFA to calculate the total amount that was overcharged to the grant and the SEP-CNLS malaria program should reimburse the malaria grant account. Refer to paragraph 159g.

GOVERNANCE AND PROGRAM OVERSIGHT

CCM Oversight of Grant Programs

168. Burundi Global Fund financed grant programs for HIV and malaria have been implemented as separate projects. Hence, they have not been integrated into the national units/structures that have responsibility for program management and supervision of HIV and malaria program activities. The OIG found that the Ministry of Health's HIV unit (USLS/Santé) and the national malaria program (PNILP) have limited roles in the supervision of clinical services for HIV and malaria. A sub-agreement between the HIV PMU and USLS/Santé in June 2010 assigned the USLS/Santé, among other things, the responsibility of training supervisors of provincial and district health offices.[27] The CCM therefore needs to provide strategic direction and oversight to ensure that the Global Fund grants are implemented in a way that strengthens national systems and structures to promote sustainability.

169. Since April 2010, the CCM has been revitalized with election of new officers. The OIG established that all constituencies are represented on the CCM as per Global Fund guidelines. CCM meetings have been held regularly and CCM decisions have been documented in minutes of its meetings. Both national program and development partner officials OIG interviewed were satisfied with the improved effectiveness of the new CCM.

170. The OIG noted that a CCM sub-committee for monitoring and supervision that was established in mid-2010 has undertaken visits to program sites. But a program monitoring tool called the dashboard developed with technical assistance of Grant Management Solutions (GMS) is yet to be utilized because of inadequate mastery of the software by M&E officers of the PRs. Use of the software by the PRs would help the CCM Secretariat to produce analyses of grant recipients' programmatic reports to facilitate the CCM's program oversight role. To increase the use of the dashboard by M&E officers and the CCM M&E committee, OIG learned that UNAIDS has offered to support the costs of a consultant to provide refresher/additional training in the use of the software.

171. Since April 2007, the CCM has received funding from the Global Fund in addition to limited counterpart funding from the Government of Burundi to support the CCM Secretariat.

Financial Management: CCM Secretariat

172. The OIG noted the following financial management and internal control weaknesses at the CCM Secretariat:

a) There was no accounting system to manage funds. In addition the CCM Secretariat did not have an accountant/bookkeeper.
b) For details of other financial management and internal control weaknesses, refer to the common list at Annex 2.

Audit of the Grant Programs

173. Burundi has two young institutions, the Inspectorate General (*Inspection Générale d'état*) and the Special Anti-Corruption Brigade (SACB). Both entities were established in 2006 to promote good governance, transparency and to fight

[27] Convention entre SEP/CNLS et L'Unité Sectorielle de Lutte contre le SIDA du Ministère de la Santé Publique Phase I Juin 2010

corruption. However, they operate under the auspices of a ministry reporting to the Office of President. In 2008, the Inspectorate General carried out a financial and management review of the SEP-CNLS[28] but it was focused on the World Bank financed HIV program. The OIG learned that in April 2011 the Inspectorate General completed an audit of the PNLT, but a final report was not yet available for review by the OIG.

174. The Special Anti-Corruption (SACB) Brigade has the mandate to investigate and prosecute all cases of corruption involving misappropriation, management fraud, embezzlement and diversion of funds. The SACB collaborates with international partners such as the European Anti-fraud Office (OLAF) and it is a member of the International Association of Anti-Corruption Authorities (IAACA). The OIG learned that SACB had investigated and prosecuted people for the sale of expired drugs in the country.

175. The OIG confirmed that independent audits of the grants have been carried out regularly by audit firms selected through annual restricted tenders. The OIG learned that audit firms from Rwanda and Mauritius had audited the grant programs because of lack of capacity of local audit firms. For example, one audit firm has audited the HIV grants managed by SEP-CNLS from the inception of Global Fund grant programs through June 2011. There was no evidence that the restricted supplier list of audit firms resulted from an open advertised tender for prequalification of firms for audit services.

176. The OIG established that the terms of reference for the audits are reviewed and approved by the LFA. A review of the external audit reports for the HIV program managed by SEP-CNLS showed that, on the positive side, the audit covered many sub-recipients of the PR. But because of its wide scope, audit work focuses on desk reviews of payment vouchers and supporting documentation; and confirmation of receipt of services/goods by program beneficiaries is not within the scope of the external audits.

Principal Recipients' Oversight of Grant Programs

177. SEP-CNLS has one internal auditor for the World Bank financed MAP program. But SEP-CNLS, PNLT, CED-CARITAS and RBP+ do not have internal auditors providing audit oversight for the Global Fund financed programs. RBP+ is seeking funding to fill the position of internal auditor. There is no internal audit oversight for the Global Fund grant portfolio of USD 141 million.

178. The OIG noted that the only internal audits undertaken by SEP-CNLS from the inception of the Global Fund grant programs in 2003 took place between April and May in 2011. The OIG found that three reviews that were limited in scope were done by the MAP internal auditor. For the HIV program, a diagnostic review of the Round 8 HIV program[29] and a review of the controls surrounding management of gasoline by the PMU[30]. Regarding the malaria program, the MAP internal auditor reviewed a cash purchase of office supplies in October 2010.

[28] Rapport Définitif de Contrôle de la Gestion du SEP/CNLS pour la période 2004-2007, Septembre 2008.
[29] Rapport de l'Audit Interne pour l'Appui au Programme d'intensification de la Lutte contre le Sida et de Décentralisation.
[30] Rapport de l'Audit Interne Gestion de Carburant Projet PRIDE Année 2010, Mai 2011

179. The HIV PMU's accounting officer for SR financial monitoring verifies invoices submitted by HIV treatment centers. The PR's 2011 budget for reimbursement of treatment services for approximately 23,000 patients on ART, in 65 centers across the country, is USD 4.5 million. The OIG found that it is difficult and inefficient for one accounting officer to adequately review the documentation available to verify the invoices for various services provided such as consultation, hospitalization and laboratory tests etc. The accounting officer therefore conducts a limited review of supporting documentation for key treatment centers. To support its accounting officer, from January 2011, the PR has contracted the services of a local audit firm to verify each semester invoices from 20 out of the 65 HIV treatment centers at an annual cost USD 29,000. The audit firm is required to provide a four-person staff for 28 days in a year. Considering the volume of work and the level of effort that is necessary to do effective control of invoices for treatment services, the outsourcing arrangement is not cost-effective and value-for-money is not demonstrated. The PR should undertake a review of the current system with a view to introducing a simplified scheme which would reimburse treatment centers at an agreed standard or pre-determined uniform/average cost of treatment per patient. This would allow the PR to redirect its efforts in monitoring and supervising these treatment centers to providing good quality services according to an agreed package of services. Refer to Recommendation number 2.

180. The OIG found that the malaria PMU has not audited its largest SR, the Population Services International (PSI) that manages a budget of USD 3.4 million. The PMU hired an accounting officer for monitoring SRs in February 2011. But he has only focused on financial monitoring of small sub-recipients.

181. RBP+ has approximately 100 sub-recipients managing a total budget for 2010 of approximately USD 5.03 million. Program officials informed us that the position of internal auditor has not been filled because of lack of funds. RBP+ has an interim staff member who is currently responsible for financial control and monitoring of SRs. Given the program's number of SRs and the size of the budget managed by its sub-recipients, it is important for RBP+ to have an internal auditor.

Recommendation 47 (High)
The CCM needs to provide strategic direction and oversight to ensure that the Global Fund grants are implemented in a way that strengthens national systems and structures to promote sustainability.

Recommendation 48 (Significant)
The CCM should recruit an accountant/book-keeper for financial management of its grant funds.

Recommendation 49 (High)
The CCM should ensure a functional internal audit mechanism to provide effective assurance over the grants.

LFA Oversight of the Grant Programs

182. With four PRs and a portfolio of ten grants it was a challenge for PWC Mauritius to provide adequate oversight of the grants without an in-country office. The LFA has finance and programmatic personnel who have long been associated with the programs. The limited turnover appears to be an advantage since they possess valuable knowledge of the grants. However, interviews with PR officials showed that the absence of technical specialists on the LFA team that comes to Burundi to assess its programmatic results sometimes leads to incorrect assessments.

The LFA confirmed that it undertakes in-country PUDR reviews with only financial professionals and programmatic or technical specialists do desk reviews of PUDRs.

183. In 2010, the LFA allocated 31 days for a health specialist and an M&E specialist to review of program updates, and 20 days for on-site data verification.[31] Reviews of program updates by these specialists were, according to information from the LFA, done as desk reviews off-site.

184. The OIG reviewed all available OSDV reports. The three reports prepared in 2010 were well documented and methodologically sound, and the conclusions were supported by the findings. One report of a verification done in 2009, however, did not use a logical methodology and led to conclusions which were not replicable.

185. The OIG also reviewed the most recent set of six program updates submitted by the PRs, including the section completed by the LFA. The review raised a number of concerns about the validity and technical soundness of the LFA comments. The following three examples only serve for the purpose of illustration:

a) Throughout the first phase of the Round 2 RCC Malaria grant, the PR used invalid formulae to calculate and report the indicator on malaria mortality and on laboratory diagnosis. This was never commented on by the LFA.
b) The LFA endorsed the reported value on peri-natal HIV transmission although it is clearly derived by an invalid calculation. The LFA also stated that the "excellent result (on blood transfusion) was achieved as a result of the opening of the regional blood donation centers" while the OIG audit found that these centers exist in name only and nothing had changed in terms of staffing, infrastructure, equipment or procedures since the hospital laboratories had been renamed.
c) The LFA has extensively recalculated and readjusted the reported results of the nutritional support program based on the premise that the indicators should reflect the number of people receiving support over a fixed period. The technically more sound approach would have been to change the indicators and targets to reflect person-month of support, giving the programs more flexibility to respond to needs and greatly reducing the effort for monitoring and evaluation.

Global Fund Secretariat Oversight of the Grant Programs

186. As noted above, there were delays in the signing of the Round 8 grant agreement. As a consequence, a number of critical services for people living with HIV remained unfunded from December 2010 to March 2011. The Global Fund Country Program Team, the CCM Burundi and the Principal Recipients should assure that the continuity of services for the treatment and care of people living with HIV is not disrupted by administrative delays in the negotiation and processing of PR and SR agreements. Refer to Recommendation number 5.

Recommendation 50 (Significant)
The Global Fund Secretariat should ensure that the LFA improves its technical assessment of program updates submitted by PRs by assuring that the reported results are reviewed on-site by qualified professionals, and that the LFA comments are discussed with relevant PR professional staff before submitting them to the Global Fund Secretariat

31 PWC, LFA cost proposal 2010

Recommendation 51 (Significant)
The Global Fund Secretariat should ensure that the Terms of Reference of the audits fully comply with the Audit Guidelines.

Recommendation 52 (High)
The Global Fund Secretariat should request that the LFA confirm the amount of price inflation for the purchase of deltamethrin and supplies for the enumeration exercise and seek recovery from SEP-CNLS Malaria Program.

Recommendation 53 (Significant)
The Global Fund Secretariat should consider seeking recoveries from the PRs for the grant expenditures that OIG found to be ineligible. In addition, The Global Fund Secretariat should use its discretion in deciding whether to seek recovery of the USD 89,085 paid to PSI by the SEP-CNLS malaria program in January 2009 for implementation of non-grant related program activities.

ANNEXES

Annex 1: Abbreviations

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
ANSS	Association Nationale de Soutien aux Séropositifs et Malades
APSR	Approche Pratique de la Santé Respiratoire
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASAQ	Co-formulated Artesunate & Amodiaquine
BDS	Bureau du District Sanitaire
BIF	Burundian Franc
BPS	Bureau de Province Sanitaire
BSS	Behavioral Surveillance Survey
CAMEBU	Central d'Achat des Médicaments du Burundi
CATB	Centre Anti-Tuberculose de Burundi
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	US Centers for Disease Control and Prevention
CD4 Count	Immunological test to establish level of immune depression due to HIV
CDT	Centre de Dépistage et Traitement (Tuberculose)
CHUK	Centre Hospitalo-Universitaire de Kamenge
CHW	Community Health Worker
CNLS	Conseil National de Lutte Contre le SIDA
COCOLS	Comité Communale de Lutte Contre le SIDA
CPLS	Comité Provincial de Lutte Contre le Sida
CS	Centre de Santé
CT	Centre de Traitement (Tuberculose)
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short Course
EPISTAT	Service d'Epidémiologie et des Statistiques
GLC	Green Light Committee (of the Stop TB Partnership)
GLIA	Great Lakes Initiative on AIDS
GOB	Government of Burundi
HBM	Home-based management (of malaria)
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ICB	International Competitive Bidding
IEC	Information, Education and Communication
INSP	Institut National de la Santé Publique
IPT	Intermittent Preventive Treatment (for malaria)
LFA	Local Fund Agent
LLINs	Long-Lasting Insecticide-treated Nets
LMTC	Lutte Contre les Maladies Transmissibles et Carentielles
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MOH	Ministry of Health
MSPLS	Ministère de la Santé Publique et de la Lutte contre le Sida
NGO	Non-Governmental Organization
NRL	National Reference Laboratory
OI	Opportunistic Infection
OIG	Office of the Inspector General

OSDV	On-site data verification
OVC	Orphan and Vulnerable Child
PBF	Performance-based Funding
PCR	Polymerase Chain Reaction
PLWHA	Person Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PNILP	Programme National Intégré de Lutte Contre le Paludisme
PNLT	Programme National Lèpre et Tuberculose
PNSR	Programme National de la Santé de la Reproduction
PR	Principal Recipient
PSI	Population Services International
PSM	Procurement and Supply Management
PUDR	Progress Update and Disbursement Request
PWC	PricewaterhouseCoopers
RBP+	Réseau Burundais des Personnes Vivant avec le VIH et le Sida
RCC	Rolling Continuation Channel
RDT	Rapid Diagnostic Test (for malaria)
SEP-CNLS	Secrétariat Permanent du Conseil National de Lutte Contre le Sida
SR	Sub-Recipient
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	2001 United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USLS	Unité Sectorielle de Lutte contre le Sida
WHO	World Health Organization

Annex 2: Common financial management and internal control weaknesses at all PRs and SRs audited

Ref. No.	Audit Findings	Audit Recommendations
	Accounting, reporting and documentation	
a)	Grant expenditure on payment vouchers was not accurately coded according to Global Fund budget categories to facilitate budgetary control.	All payment vouchers should be coded according to grant budget categories to facilitate entry of transactions in the accounting system and to establish a good budgetary control. In addition accounting supervisors should verify the accuracy of the coding indicated on payment and journal vouchers.
b)	The OIG noted instances of weak control and monitoring of grant budgets that could result in grant recipients/implementers exceeding their approved budgets.	The PR/SRs should strengthen supportive supervision and coaching/oversight of grant implementing organizations to put in place a system of budgetary control.
c)	Advances of grant funds to organizations for program implementation activities were treated as expenditures and posted to expenditure accounts in the general ledger. The reasons for this are (a) inadequate professional skills of program accountants and (b) inadequate supportive supervision by the PRs.	Advances made to sub-recipients and implementing organizations should not be treated as expenditures until the program activities have been implemented and funds have been accounted for by the recipient of funds. Pending evidence of justification of the use of funds, these advances should be monitored in a control account.
d)	SRs did not routinely correct errors in their financial reports noted by the PRs. The reason was that feedback to the SRs were often late. In addition, because of inadequate professional skills, some SR accountants did not place much importance in making these corrections/adjustments in their accounting books/software.	The PRs and lead SRs need to ensure that SRs and grant implementing organizations have made necessary corrections/adjustments in their accounting records.
e)	Payment of per diem to staff that exceeds rates established by the audited entities. The reason for this was that established rates paid by the PRs/SRs were inadequate to meet minimum reasonable costs of accommodation and food for program staff.	The PRs should review and revise their per diem rates, subject to the approval of the CCM, if established rates are of per diem are found to be inadequate to meet minimum reasonable costs for accommodation and food.
f)	Payment vouchers and supporting documentation were not properly numbered sequentially and archived in a chronological manner to facilitate retrieval of accounting	All payment vouchers should be coded according to grant budget categories to facilitate entry of transactions in the accounting system and to establish a good budgetary control. In addition accounting

	documents.	supervisors should verify the accuracy of the coding indicated on payment and journal vouchers.
g)	In some cases, the OIG could not verify that program managers have reviewed payment vouchers and accompanying invoices before payment due to absence of required signatures.	To improve the audit trail, payment vouchers (PVs) should be numbered and supporting documents attached to the PVs. The PVs and their supporting documentation should be filed in a numerical sequence to facilitate retrieval.
h)	Financial reports submitted by grant recipients differed from financial data in their accounting software. The reports had been produced from bank statements because of backlog of financial transactions that had not been entered in the software.	PRs and SRs should ensure that transactions are entered in the accounting software on a daily basis. This would assure that accounting data verified and validated is used to prepare financial reports so that there is no difference between data from the accounting system and the financial reports.
i)	Financial reports of SRs were not prepared according to grant program budget categories, which did not facilitate consolidation of grant financial reports by PRs.	The PR/SRs should strengthen supportive supervision and coaching/oversight of grant implementing organizations to address this weakness in financial reporting.
j)	The OIG noted that bank reconciliations were prepared quarterly during preparation of financial reports with the risk that errors and irregularities would not be detected on a timely basis; in addition, in some cases, there was no evidence of supervisory reviews of bank reconciliations by managers (absence of signatures).	It is important that bank reconciliations are prepared, reviewed and approved on a monthly basis to ensure that errors, unusual movements or irregularities that could affect grant bank accounts/funds are detected and followed up on a timely basis.
k)	Operations and Procedures Manuals had not been updated; and some SRs did not have financial and operations manuals that provide guidance for grant financial management and program implementation.	PRs and SRs should ensure that grant implementing organizations have up-to-date financial and operations manuals that provide guidance for grant financial management and program implementation.
l)	The OIG noted cases of inadequate supporting documentation for expenses relating to travel, training events because there were no clear policies in the Operations and Procedures Manual that specify supporting documents required for justification of these types of expenditures. Refer to Annexes 5 and 6.	PR/SR Operations and Procedures Manual should be updated to specify in detail the type of supporting documentation required for justification of expenditures relating to travel, training events, purchase of gasoline etc.

	Purchasing and contracts	
m)	Lack of evidence of competitive bidding or price comparisons for purchase of goods/services; non-compliance with procurement regulations or procedures (shorter response times to suppliers to submit tenders, and absence of technical specifications. etc.)	The PR, SRs and grant implementing organizations need to show evidence that value for money is obtained for goods and services by ensuring that transparent competitive bidding takes place before goods and services are procured.
n)	Penalty clauses in procurement contracts for late delivery of goods/services by suppliers were not applied as stated in the contracts.	To assure that program goods and services are delivered on time by suppliers, penalty clauses for late delivery of goods by suppliers should be applied to serve as a deterrent.
	VAT payment	
o)	VAT was paid for some goods/services purchased with grant funds and not subsequently refunded, contrary to the grant agreements. The OIG did not see evidence that VAT paid was being recovered in a timely manner from revenue authorities. Refer to Annex 3.	The PRs should train program accountants to track/monitor VAT to be recovered either by setting up a paper-based monitoring system or VAT control accounts in the accounting software, as applicable.
	Staff contracts and statutory deductions	
p)	Statutory deductions, such as income tax and social security taxes, were not withheld from employee salaries. The OIG noted that deductions for income and social security taxes were not incorporated in employee contracts.	All employment contracts should comply with national laws particularly as it pertains to withholding and payment of statutory deductions.
	Fixed asset management	
q)	Fixed assets registers were not regularly updated to facilitate control and accounting of grant program assets; and in some cases, fixed asset registers were not maintained.	PRs and SRs should strengthen control over grant program assets by ensuring that fixed asset registers and records are updated at least annually.
r)	The OIG noted instances where delivery notes had not been prepared by the PR/SR and signed by final recipients of program goods (e.g. equipment and vehicles).	To improve accountability and transparency, PRs should ensure that SRs sign delivery notes as evidence of receipt of grant program goods including equipment and vehicles.

Annex 3: VAT charged to the grants:
(Source: Accounting records of implementing organizations)

PR/SR and Grant	Date	Voucher number	Amount (BIF)	Expenditure description
RBP+ HIV/AIDS Round 8	16/04/2010	110	295,221	VAT Paid
	14/09/2010	181	181,200	VAT Paid
	09/12/2010	224	684,000	VAT Paid
	31/12/2010	228	565,318	VAT Paid
		Subtotal	***1,725,739***	
ABS as SR HIV/AIDS Round 8	15/07/2010	02/10	29,185	VAT Paid
	15/07/2010	03/10	44,676	VAT Paid
	28/10/2010	16/10	73,901	VAT Paid
	03/12/2010	22/10	65,412	VAT Paid
	21/12/2010	23/10	71,608	VAT Paid
		Subtotal	**284,782**	
CCM	30/08/2010	***Subtotal***	450,000	VAT Paid
		Total BIF	2,460,521*	

*approximately USD 2,033

Annex 4: SEP-CNLS HIV grant expenditures over-paid to be refunded
(Source: SEP-CNLS HIV accounting software and records**)**

Grant / Financial Year	Date	Voucher Number	Amount USD	Expenditure Description	Comment
APRODIS 2006/07 HIV Round 5 SEP-CNLS	21/07/06	P14	1,848.07	Per diem for training in Tompro software 22 days @ USD 300	The per diem rate should be USD 250 and not USD 300. Actual per diem days is 20. In addition advance paid was not deducted from per diem paid.
	08/08/06	P37	1,050.00	Per diem for Toronto conference : 16 days @ USD 350	Over-payment of three days per diem.
	10/08/06	P42	4,959.00	Air ticket to Toronto for ANSS staff member	Double payment of same travel on voucher P44. No air ticket or boarding passes.
	30/08/06	P67	900.00	Per diem for seminar in Montreal PMTCT expert : 31 days @ USD 300 per day	Over-payment of three days per diem
	03/11/06	P165	600.00	Per diem training La Rochelle (Financial management expert) : 36 days @ USD 300 per day	Over-payment of two days per diem.
APRODIS 2007/08 HIV Round 5	29/11/07	P975	300.00	Training in Tompro software for the financial controller: 23 days @ USD 300 per day	Over-payment of one day per diem of USD 300.
	06/03/08	P1241	300.00	Training in care and treatment for PLWHA	Over-payment of one day per diem.
PRIDE 2010 HIV Round 8	09/07/10	AC63	1,050.00	Per diem for the CPLS accountant in Swaziland : 21 days @ USD 300	The per diem rate should be USD 250 and not USD 300. That is over payment of USD 50 for 21 days.
	16/07/10	AC72	650.00	Per diem training a staff member in Senegal : 13 days @ USD 300	The per diem rate should be USD 250 and not USD 300 i.e. is over payment of USD 50 for 13 days.
		Total USD	**11,657.07**		

Annex 5: Examples of SEP-CNLS HIV/AIDS Round 5 grant expenditures supported by photocopies only

(Source: SEP-CNLS HIV Round 5 accounting records)

Grant / Financial Year	Date	Voucher Number	Amount USD	Expenditure Description	Comment
APRODIS 2006/2007 HIV/AIDS Round 5	27/06/06	P3	6,199.23	Registration for a training workshop for Tompro accounting software.	Payment was supported by a photocopy of a proforma invoice.
	28/07/06	P15	8,000.00	Registration of the PMTCT expert for a seminar in Montreal.	Absence of original invoice. Photocopy of invoice used as supporting documentation.
	26/02/07	P389	11,335.63	Training of 46 participants in HIV counseling.	Absence of original invoices for workshop expenditures. Photocopies supported payment.
APRODIS 2007/2008 HIV/AIDS Round	14/05/08	IP23	11,718.58	Return air ticket Dakar-Brussels-Bujumbura for a consultant	Absence of original invoice and ticket stub.
APRODIS 2010 HIV/AIDS Round	11/05/10	AC1663	2,098,739.88	ARV medicines (CIPLA)	Absence of original invoices. Payment was supported by scanned invoices.

Annex 6: Examples of SEP-CNLS HIV/AIDS Round 1 and 5 grant expenditures with missing/inadequate supporting documents

(Source: SEP-CNLS HIV/AIDS accounting records)

Grant / Financial Year	Date	Voucher Number	Amount USD	Expenditure Description	Comment
HIV AIDS Round 1 (RIBUP) 2003/2006	28/11/03	P54	25,201.56	Computers and printers	No Goods Received note
	22/10/03	P35	2,747.35	Office Supplies	No Goods Received note
	30/06/05	P663	2,770.22	Air ticket UNAIDS conference Geneva	No travel authorization
	28/11/05	P867	6,776.22	Air tickets (4 participants)	No purchase order and travel authorization
	22/10/03	P39	2,747.35	Air tickets (2 participants)	No travel authorization
	09/12/03	P74	7,419.97	Air tickets (3 participants)	No travel authorization
	11/07/03	P6	9,500.00	Training in France (1 person)	No travel authorization
	20/10/03	P38	6,250.00	Training (1 person)	No travel authorization
APRODIS (HIV/AIDS Round 5 Grant 2006/2007	04/09/06	P68	2,544.51	Purchase of 2000 liters gas oil	No approved purchase and evidence of receipt
	20/12/06	P250	2,312.83	Purchase of 15 tires	No evidence of competitive bidding
	15/02/07	P366	2,599.03	Printer cartridges	No evidence of competitive bidding
	20/12/06	P262	4,180.00	Per diem consultant	No hotel receipt
	28/07/09	IP1046	6,170.65	Office supplies	No Goods Received note

Annex 7: RBP+ (PR) HIV/AIDS Round 8 grant expenditures overpaid to be refunded

(Source: Accounting records of RBP+ HIV/AIDS Round 8 grant)

PR/SR	Date	Voucher number	Amount to be Refunded (BIF)	Expenditure Description	Comments
RBP+ HIV/AIDS Round 8	17/06/2010	067	770,057	Antenna and internet subscription	Overpayment
	24/09/2010	117	364,622	Per diem training for accountants	Overpayment of per diem
	24/09/2010	117	364,622	Per diem training for accountants	Overpayment of per diem
	03/11/2010	136	1,663,114	Purchase of air ticket	Trip was cancelled. Amount should be refunded.
	Jan to May 2010	Various vouchers	3,027,245	Social security contribution January 2010 to May 2010	Amount already charged to Project PRIDE
		TOTAL BIF	6,189,660*		

*Approximately USD 5,114

Annex 8: RBP+ (SR) HIV/AIDS Round 5 sub-grant expenditures to be refunded (Sub-Recipient of the HIV/AIDS Round 5 Grant Managed by SEP-CNLS)

Source: RBP+ accounting records

Grant / Financial Year	Date	Voucher Number	Amount BIF	Expenditure Description	Comment
HIV/AIDS Round 5 (APRODIS)	19/11/2008		1,789,740	Air ticket ICASA conference in Senegal	This expenditure initially charged to the grant had been reimbursed by a development partner to RBP+.
HIV/AIDS Round 5 (APRODIS)	26/08/2008 and 27/10/2008	debit	2,638,257	Debit to grant bank account	Interest earned on time deposits in 2008 transferred to a non-grant bank account.
HIV/AIDS Round 5 (APRODIS)	6/5/2009	transfer	9,996,000	Operating costs for treatment of PLWHA not on ARVs	Un-supported transfer from grant bank account to a non-grant bank account.
		Total BIF	**14,423,997***		

*Approximately USD 11,920

Annex 9: Examples of RBP+ HIV/AIDS sub-grant expenditures without competitive bidding

(Source: RBP+ as SR of the SEP-CNLS HIV/AIDS Round 5 Grant)

Date	Amount BIF	Expenditure Description	Comment
1/2/2007	6,780,000	Duplication of books and cassettes	No evidence of competitive bidding.
1/7/2007	14,925,000	Film production concerning PLWHA	No evidence of competitive bidding.
21/3/2007 and 18/5/2007	2,776,950	Training in culinary art	No evidence of competitive bidding.
TOTAL BIF	24,481,950*		

*Approximately USD 20,233

Annex 10: Principal Recipients' and CCM Response to the Recommendations and Management Action Plan

Prioritization of recommendations

Audit recommendations have been prioritized so as to assist management in deciding on the order in which recommendations should be implemented. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. The categorization of recommendations is as follows:

i. High Priority: Material concern, fundamental control weakness or non-compliance, which if not effectively managed, present material risk and will be highly detrimental to the organization's interests, significantly erode internal controls, or jeopardize achievement of aims and objectives. They require immediate attention by senior management.

ii. Significant Priority: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

iii. Requires Attention: There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of best practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
HIV Program	Recommendation 1 (High) The public sector PR (SEP-CNLS) should transfer responsibility and accountability for the implementation of Global Fund-supported health sector activities to existing institutions of the MSPLS at the central and decentralized level. This	SEP-CNLS while remaining the principal beneficiary acts primarily as the national coordinating body in the fight against HIV and AIDS and not as an executing body. The implementation of interventions in the Round 8 grant is done by sub-recipients (SRs). The SRs and/or implementation partners are mainly the central, provincial and mid-level		

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	includes the USLS for technical issues and supervision of services.	institutions of the Ministry of Public Health and the Fight against AIDS (MSPLS). At a central level, it is primarily the PNLS/IST (ex-USLS/health), CAMEBU and INSP. At the decentralized level SEP-CNLS provides support for the strengthening of the health system at a district health level, through the provision of equipment to health facilities, funding for the training of service providers, financial and technical support for the supervision of services and the collection and quality control of data. Health facilities involved with caring for PLWHA, be they public, NGO, religious or private sector are funded through tripartite agreements signed by SEP-CNLS / PNLS/IST and the facility concerned. These agreements indicate the role of all concerned including PNLS/IST, regarding the monitoring and supervision of the implementation of the conventions.		
	Recommendation 2 (High) SEP-CNLS should consider replacing the system of subsidizing medical care for people living with HIV through	A technical team made up of members of the FBP implementation team and SEP-CNLS is in the process of analyzing the rates to be applied which will allow facilities to provide care to PLWHA free of	SEP-CNLS	With the phase II second disbursement

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	payments per service by a system of per capita payment controlled by the Performance-Based Financing Unit.	charge based on a study sponsored by the MSPLS of the costs of care in public health units in Burundi.		
	Recommendation 3 (High) The cadre of PR-employed "Health Mediators" should be gradually absorbed into staff positions of the relevant health facilities.	SEP-CNLS contributed to the initiation of mediation in the care of PLWHA and was responsible for the health mediators in the implementation of Round 1 and Round 5 grants (196 health mediators). Currently, health mediators report to the Burundi Network of People Living with HIV/AIDS (RBP +). Health mediators have proven the effectiveness of psychosocial support in monitoring and supporting patients and families in the observance and maintenance of dynamic prevention and the search for autonomy. This approach is much appreciated by anti-AIDS stakeholders, communities and the beneficiaries of the services themselves. The MSPLS recognizes that it is necessary to integrate health mediators as health professionals into the Burundi health pyramid to ensure the sustainability of the services they provide in the public and associative hospitals in the country's 17 provinces.		

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		However, given the limited financial resources available to the Burundi Government, it would be preferable that Community grant funds for the payment of health mediators' allowances and fees go to the Government PR that had previously made the case for their integration into the health system.		
	Recommendation 4 (High) The MSPLS should assure that all reagents required for HIV testing according to the national algorithm are available at all testing sites, and provide frequent and close supervision to assure that national directives on counseling, testing and record keeping are adhered to.	Efforts have already been made by the MSPLS to end inventory shortages of screening tests. Today tests purchased with GF grants are available. Other technical and financial partners were mobilized to make their contribution. Orders were passed, with both UNICEF, USAID through Family Health International (FHI) and ESTHER. Moreover, supervision missions were conducted at central and district health levels in all VSCs. They will continue to ensure that tests are available everywhere and that national guidelines on counseling and testing and the maintenance of records are met.	PNLS/IST	On going
	Recommendation 5 (High) SEP-CNLS, the MSPLS and the Global Fund should re-examine	The MSPLS will instruct the Medical Directors in the Health Districts to requisition and distribute free STI	PNLS/IST	April 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	the modalities of Global Fund support for STI treatment and agree on a mechanism to assure that these treatments are provided to people suffering from STIs. If no mechanism can be developed to deliver the STI drugs to health centers for the treatment of STIs free of charge, they should not be procured and the remaining stock should be absorbed in the stock of essential generic medicines of CAMEBU.	drugs not only to hospitals but also to Health Centers.		
	Recommendation 6 (High) The MSPLS should develop guidelines for the treatment of opportunistic infections among people living with HIV, including a list of drugs authorized for the treatment of these conditions. Quantification, procurement and supply of these drugs to health facilities should be strictly based on this list.	Two consultants are developing a user guide and algorithms for the diagnosis and management of opportunistic infections (OIs) in adults and children. A list of the drugs will be developed for the OIs to be treated. SEP-CNLS will quantify and purchase the OI drugs based on this list.	SEP-CNLS	April 2012
	Recommendation 7 (High) If the policy of providing	Agreed. For the per capita reimbursement system, see commentary to	SEP-CNLS	With the Phase II second disbursement

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	medical care free of charge for people living with HIV is maintained, then the essential generic drugs other than ARVs, Cotrimoxazole and drugs for identified opportunistic diseases should be provided by the health facilities and financed through the per-capita re-imbursement system that would need to be established.	recommendation n ° 2.		
	Recommendation 8 (Significant) The Global Fund Country Team, the CCM Burundi and the Principal Recipients should assure that the continuity of services for the treatment and care of people living with HIV is not disrupted by administrative delays in the negotiation and processing of PR and SR agreements.	For SEP-CNLS, since the beginning of HIV financing by the Global Fund (Round 1, Round 5 and Round 8), we have adopted the signing of tripartite agreements between the SR, the PNLS/IST, and PR as a method of financing. Upon signing of the agreements, the PR makes an advance payment equal to the first quarter budget to bank accounts opened by the SR exclusively for project financing. At the request of the SR, the PR disburses the next tranche upon presentation of a detailed report of the expenditure of an amount equal to at least 75% of the previous installment to allow the SR to continue to work with the 25% during the period of report analysis and whilst awaiting		

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		bank transfers.		
	Recommendation 9 (Significant) The efforts to improve access to prevention of vertical HIV transmission should focus on maternity services in addition to the current focus on ante-natal clinics.	The plan for scaling up Prevention of Mother to Child Transmission (PMTCT), during implementation, emphasizes the integration of PMTCT in maternal and child health including maternity services. The approach of offering testing by the service provider will be used in maternity hospitals so that all mothers know their HIV status and take advantage of PMTCT care as per the protocol.	PNLS/IST	On going
	Recommendation 10 (Requires attention) The MSPLS and SEP-CNLS should assure that during supervision of HIV treatment facilities, particular emphasis is placed on the quality and completeness of patient charts.	In working with the MSPLS, the SEP-CNLS and its partners have standardized patient records, data collection records and reporting forms. A guide for supervisors was developed to oversee the management and maintenance of records. The increase of supervisory missions under the 2012 supervision plan will help to solve several sub-recipient problems. The SEP-CNLS will continue to support the MSPLS district approach of leaving the prerogatives of supervision, training, procurement and evaluation to the operational and reporting level of the district health	SEP-CNLS	On going

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		offices. This will allow providers to be constantly supervised and provide services according to national guidelines.		
	Recommendation 11 (Requires attention) In the negotiation of the second phase of the Round 8 HIV grant, the civil society PR (RBP+) and the Global Fund should review and revise the modalities of providing social and nutritional support to people living with or affected by HIV. This review should be informed by the extensive documented experience on social protection programs in East Africa, including the experience of cash transfers and the evidence on effective programs for children affected by HIV collected by the Joint Learning Initiative on Children and AIDS in Africa.	RBP+ recognises the importance of a reflection and more up-to-date study on the approaches and conditions for social and nutritional support. RBP+ is prepared to work with the Secretariat of the Global Fund on the implementation of this reflection, taking into account the experiences of other countries. At the same time, RBP+ has worked on three documents which could be used for reference and comparison purposes in the definition of the new approach and implementation conditions for social and nutritional support activities Three guidance manuals are already available and concern assistance to orphans, socio-economic and psychological treatment as well as nutritional treatment These three documents describe the targets of the support, the approach and selection criteria, entry and exit criteria, the reference and cross-reference system, weaning support	RBP+	April 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		approaches for the autonomy of the beneficiaries etc. In collaboration with a team of consultants sent by the secretariat, RBP+ is preparing to implement this recommendation in April 2012		
	Recommendation 12 (Requires attention) The SEP-CNLS and the Global Fund should ensure that the HIV Round 8 grant performance frameworks are reviewed in the negotiation of Phase 2. At least the calculation methods and formulae for the indicators on vertical HIV transmission, on condom distribution, on HIV testing of ante-natal clients and on food subsidization should be revised.	The methods for calculating and reporting of these indicators are being negotiated with the Global Fund as part of Phase 2 of the grant.	SEP-CNLS	March 31, 2012
	Recommendation 13 (Requires attention) For small HIV treatment and PMTCT centers, the SEP-CNLS should consider having dedicated data managers based at the district or provincial level who will be responsible for	An aggregate database in the form of new data collection tools and report formats is being developed by the SEP-CNLS. This data synthesis can be used to capture and centralize paper data at the provincial or district level from sites that do not have AIDS-INFO. For sites that use AIDS-INFO, this database will be filled	SEP-CNLS	October 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	consolidating paper reports of these centers into the electronic format of SIDA-Info.	automatically using the information entered in AIDS-INFO. It may gradually replace paper data as electronic data transmission infrastructure is implemented.		
	Recommendation 14 (Requires attention) As part of the effort for capacity building, the SEP-CNLS should increase the support to formative supervision carried out by competent institutions of the MSPLS. (i.e. the USLS, INSP, BDS, etc.) If necessary, planned training activities should be reduced to free up the necessary funds for supervision.	In Phase 2 of Round 8, it is planned to further strengthen the ability of local structures to jointly perform the formative supervision with SEP-CNLS experts.	SEP-CNLS	With the first disbursement of phase II
Tuberculosis Program	Recommendation 15 (High) The PNLT should assure that the National Reference laboratory for culture and drug sensitivity testing becomes functional as soon as possible.	The recommendation has already been implemented.	PNILT	The recommendation has already been implemented
	Recommendation 16 (High) The PNLT should seek assistance from its technical partners to bring the clinical and laboratory services and the data management for MDR	The recommendation has already been implemented.	PNILT	The recommendation has already been implemented

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	tuberculosis up to international standards.			
Malaria Program	Recommendation 17 (High) The PR (SEP-CNLS) should increase supervision and quality control of clinical and laboratory services for malaria. This task should be guided by the PNILP (for clinical services) and the INSP (for laboratory services). Technical tasks should be gradually devolved to these institutions, while building their capacity to fully realize their mandate.	The PR agrees with the recommendation. The process of supervision of clinical and laboratory aspects by the PNILP and the INSP has already begun. New guidelines for the treatment of malaria on which the supervisions are based have just been approved and include clinical aspects and laboratory quality which are made jointly by the PNILP. Phase 2 of Round 9, which is in the process of being submitted, includes the logistical means which are seriously lacking in these two institutions to ensure their supervisory role.	SEP-CNLS/LMU Malaria Project, PNILP, INSP	Already begun and ongoing.
	Recommendation 18 (High) The MSPLS should nominate staff within the decentralized teams to be specifically responsible for the formative supervision of clinical and laboratory services for malaria under the technical guidance of the PNILP and the INSP. The PR may consider financial support, but the positions should be fully within the public service for sustainability.	The recommendation has already been implemented. In his letter #633/47/DG/PNILP/2012, dated February 17, 2012, the Executive Director for Public Health and the Fight against AIDS, instructed all Health District Medical Directors to designate a focal point within their management team who will be responsible for, in addition to his regular duties, monitoring daily activities in the fight against malaria. The PR will offer this unit logistical	DGSP	Already done.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		support for its operations (motorcycle, office equipment, computer equipment etc.) which has been ordered.		
	Recommendation 19 (Requires attention) The MSPLS should consider making malaria microscopy in health centers free of charge.	Free RDT microscopy is already available. The MSPLS must, in cooperation with the other partners in the fight against malaria, consider how to harmonize their prices.	MSPLS	December 2012
	Recommendation 20 (Requires attention) In a future phase of the Round 9 malaria grant, CED-CARITAS and the Global Fund should jointly review the program design and seek technical advice on how to increase the community systems strengthening aspect of the program.	CED-CARITAS Burundi will, in collaboration with the Global Fund Secretariat, contact WHO Burundi to mobilize technical assistance from WHO Africa to strengthen the community component of the Round 9 grant.	CED - CARITAS Burundi and the GF Secretariat	1st semester phase 2
PSM: HIV	Recommendation 21 (High) The SEP/CNLS should develop Standard Treatment Guidelines for Opportunistic Infections in order to ensure adequate management of patients and rational use of OI drugs	See comments on recommendation n°6.	SEP-CNLS	April 2012
	Recommendation 22 (High) A physical stock-taking of all OI	Drugs which are overstocked on a site are progressively redistributed to sites	MSPLS	April 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	drugs should be conducted at the pharmacies of the HIV treatment sites with the view of identifying health facilities that have excess OI drugs beyond their need; and distributing them to facilities that need them.	where they are needed.		
	Recommendation 23 (Significant) The MSPLS should consider reactivating the multi-partner committee for coordinating the quantification of pharmaceuticals.	The committee has been operational since November 2011.	MSPLS	On going
	Recommendation 24 (Significant) The SEP-CNLS should develop and adopt a manual of pharmaceutical management procedures with regards to quantification, procurement, stock management, drug distribution, monitoring systems, supervision and quality assurance.	The MSPLS made a request for technical assistance to the French Government to strengthen the management of the purchasing and supply of drugs, under the Global Fund 5% initiative. One of the terms of reference of this technical assistance focuses on the development of a procedures manual for the management of pharmaceutical products specific to projects funded by the Global Fund.	SEP-CNLS	9 months after the signing Phase 2 of Round 8 of the grant agreement
	Recommendation 25 (Significant) The SEP CNLS should ensure	AIDS-INFO is installed and functional in all treatment sites which have computerized access. A campaign of	SEP-CNLS	On going

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	that SIDA Info is fully functional and implemented in all treatment sites. SIDA Info data should be used by SEP CNLS together with the consumption data for forecasting and monitoring of consumption.	training / facilitating supervisions is underway at central, regional and provincial levels to ensure that updates to data are processed, in particular, for drug consumption. Training in the use of AIDS-INFO is provided during the months of March and April to ensure that sites have sufficient human resources to take advantage of this base.		
	Recommendation 26 (Significant) The MSPLS should consider reactivating the multi-partner committee for the management of condoms as specified in the 2009 national policy	A committee for coordination and management of condoms will be created that is inclusive, and whose members will come from the government, NGOs, technical and financial partners and key stakeholders in the distribution and social marketing of prophylactics. The mission of this committee is, among other things, to provide clear guidance in the management of male and female prophylactics.		
PSM: TB	Recommendation 27 (High) PNLT should refrain from purchasing drugs, reagents and medical supplies for APSR. This should be done by CAMEBU through a Memorandum of Understanding. An annual planning with a delivery by air	CAMEBU is currently finalising its Procedures Manual. A proposed change in CAMEBU's status was initiated to bypass the general Market Terms which apply uniformly to all products, which will facilitate the acquisition of sensitive products such as anti-tuberculosis drugs and	CAMEBU, MPLS	31 December 2013

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	should facilitate the process and avoid any delay in implementation of service delivery.	reagents for the detection of tuberculosis and related products. Pending the ongoing restructuring of CAMEBU, anti-tuberculosis drugs are purchased directly from GDF Geneva, who support PNILT via the donation of anti-tuberculosis drugs in paediatric forms.		
	Recommendation 28 (Significant) In the absence of a National Regulatory Authority to ensure quality of pharmaceuticals and diagnostics, the PR should work with technical experts on defining specifications for the procurement of health products.	The same recommendation was made by the Secretariat of the Global Fund. Pending accreditation of INSP's laboratory, the pharmacists of the three programmes are working on a call for tender dossier which complies with acceptable standards, in collaboration with experts of the Global Fund; this process will be completed by the end of April.	PNILT, PNILP and PNILS/IST	End of April 2012
	Recommendation 29 (Significant) An assessment of the district pharmacies should be performed in order to select those able to properly store and manage tuberculosis drugs. The districts that do not have adequate district pharmacies should not be considered as part of the tuberculosis supply chain. Drugs could then be	As the fight against tuberculosis is integrated into the health system, anti-tuberculosis drugs follow the same pattern as other medicines. As decentralisation across the districts is a recent process, the condition of district pharmacies will be evaluated via formative supervision. Should storage and management conditions not be fulfilled, the pharmacies of provincial health offices will be used or the medicines will be transported	DGR, DPML and PNILT	Continuous

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	distributed directly from CAMEBU to CDT sites.	directly to CDT sites until MSPLS is able to complete the construction or rehabilitation of the health district pharmacies, with the help of the different partners		
PSM: Malaria	Recommendation 30 (High) The SEP-CNLS malaria program should establish an effective monitoring and reporting system for ACTs and laboratory supplies.	The recommendation has already been implemented. A standard operating procedures document was developed with the support of Management Sciences for Health (MSH), the WHO and the PR's pharmacist. The CCM, Maxima and Minima Stocks, health centre alert stocks, average monthly distributions (DMM), Maxima Stocks and district alert stocks have been implemented and are reviewable semi-annually for ACTs and laboratory supplies, and a new reporting system has been developed and circulated.	SEP-CNLS, PNILP	Already completed and requires ongoing monitoring by management
	Recommendation 31 (High) The SEP-CNLS should carry out a detailed independent review, agreed with the Global Fund Secretariat, of all expenditures incurred by PSI under its logistics and distribution service agreement for the mass distribution of bed nets. Any ineligible expenditure should be recovered from PSI.	We agree with the recommendation. The SEP-CNLS malaria program is recruiting an external audit firm for Round 9 expenses for the period from 1 August 2010 to 31 December 2011 in consultation with the Secretariat of the Global Fund. According to the proposed calendar this audit should take place during the 2nd half of the month of May 2012. The CCM will require PSI to reimburse expenses this	SEP-CNLS Malaria, PSI	June 30, 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		audit deems ineligible. PSI Comments: PSI/Burundi welcomes the findings and observations made by the audit of the Inspector General of the Global Fund regarding weaknesses in procedures for the awarding of contracts for the of mass distribution campaign of mosquito nets to households under Round 9 of malaria funding. These observations are well understood and will be taken into account in the future. However, PSI would like to provide certain clarifications to explain the findings observed. • The purchase of the mosquito nets was carried out via the VPP mechanism and PSI/Burundi was responsible for the logistical support of the campaign: storage security and transport under an agreement signed between the PR and PSI in November 2010. • Among the anomalies found in the contracting process between the PR and SR, it is stated that (a) the amount is not mentioned in the		

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		agreement. (b) an amendment to the Agreement signed in February 2011 fixed a rate of 9% for administrative costs without indicating the estimated costs of these services: (a) the Agreement was signed before the end of budget negotiations, however, article 3 of the Agreement provides that "the amount of the Agreement will be specified in a separate query detailing activities and costs relating thereto, as set out by the campaign Steering Committee and in respect of the budget lines of Round 9 of the Global Fund Malaria Project. Funding requests may be made incrementally depending on the progress made." (b) the administrative costs allocated to PSI in this Agreement were the subject of specific negotiations. Before and during negotiations the PR received a letter with the topics covered by the administrative costs (9%) of PSI. • Weaknesses in procurement procedures.		

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
		All weaknesses in procurement procedures should be considered in the context of the lack of planning of the campaign. Contract signed with PSI on 10 November 2010, for the arrival of the mosquito netting announced for early December (of which the first batch was received on 09/12/2010) and the mass distribution originally scheduled for the week of 20-24 December see the minutes of the first meeting of the National Steering Committee (a, b, and c). It is clear that the three weeks between the signing of the agreement and the arrival of the netting, would not be sufficient to prepare a DAO (tender) or detailed specifications that would have allowed us to define the services and procedures required. Even if these procedures could have been developed in 3 weeks, we must recognize that its publication within a period of 30 days would have been almost impossible. Even though, PSI has launched, in the interests of efficiency, a public call for		

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		tenders, which we recognize presents limits. Also in the interests of transparency, we created a Contracting Committee made up of experts from the PR, the NMCP and PSI. (d) in the absence of a DAO (tender), certain services (such as the supply of fuel, and the payment of handling costs by the carrier) which were not mentioned in the tender documents, were subject to negotiations at the signing of the contract with the chosen service provider. The negotiations were based on the specifics in the field (such as the distance of the warehouse from the truck access point and the difficulty of access to outlying sites).		
	Recommendation 32 (High) The MSPLS and SEP-CNLS should develop policies and procedures for quality control of medicines and health products including ACTs, bednets, and rapid diagnostic tests.	We agree entirely with the recommendation. A joint call for tenders for HIV, TB and malaria by the Global Fund is being developed to ensure quality control of drugs and health products including RDTs, ACTs and mosquito nets, as recommended by the Global Fund Secretariat.	PMU HIV, TB, Malaria, CAMEBU	Ongoing.
	Recommendation 33 (Significant)	The recommendation is being implemented. A manual of standard	SEP-CNLS Malaria, PNILP	Ongoing and continuous.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	Under the supervision of MSPLS, SEP-CNLS Malaria program should document, in a pharmaceutical procedures manual, the process and procedures for ACT quantification, procurement, distribution, monitoring, reporting and management. The manual should include standard tools for use by health facilities for ordering and reporting.	operating procedures for the management of pharmaceutical products has been developed and includes the processes and procedures for quantifying, purchase, distribution, monitoring, reporting and management of ACTs. This manual also includes standard tools to be used by health centers for orders and reporting. This manual will be released in April 2012.		
	Recommendation 34 (Requires attention) The MSPLS and SEP-CNLS should consider progressively assigning to CAMEBU, the procurement responsibility for malaria medicines and health products with a long-term objective of developing its capacity to fully assume its role as the central medical store for Burundi. Initially, CAMEBU should be given the responsibility currently handled by UNICEF of purchasing of ACTs for the malaria program.	CAMEBU is finalizing its procedures manual. A proposal for a change in status of CAMEBU was initiated to circumvent the market terms that are the same for all products, which will facilitate the acquisition of sensitive products such as ACTs, ARVs and related products.	CAMEBU, MPLS	To 31 December 2013
	Recommendation 35 (Requires attention)	Idem as 34	CAMEBU, MSPLS	31 December 2013

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	After CAMEBU's procurement capacity has been duly assessed and found to be adequate, the SEP-CNLS should consider assigning to CAMEBU all tasks related to ACT procurement.			
Non-health related Goods and Services	Recommendation 36 (Significant) All PRs, SRs and grant implementing organizations need to show evidence that value for money is obtained for goods and services by ensuring that transparent competitive bidding takes place before goods and services are procured	We agree with the recommendation. Competitive tenders guaranteeing a good quality/price ratio are usually implemented by the PR. A new administrative and valid accounting procedures manual for HIV and malaria projects of which the SEP-CNLS is the PR is undergoing validation and includes these. All purchases will be made using the procedures described in this manual. In addition and in order to strengthen the internal control mechanisms ensuring the application of these procedures, two internal auditors shall be recruited with HIV Phase 2 of which two will be responsible for the malaria program (Round 2 RCCs and Round 9). With regard to procurement by SEP-CNLS, the tender process is competitive and transparent. Offers	SEP-CNLS	On-going

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		are analyzed by a technical sub-committee which reports to the Tender Committee for examination. A contract is only awarded upon agreement by the PR after its evaluation. Nevertheless, there are some materials (reagents) used specifically with particular makes of appliances, with which it is possible to enter into contracts by direct agreement. For purchases made at sub-recipient level, the agreements signed jointly between SEP-CNLS and said sub-recipient, stipulate that the recipient must respect the procedures of the PR and that they must involve them in the procurement procedures and awarding of contracts. To ensure good value for money, the CED - CARITAS Burundi will continue to ensure that the purchase of any goods and/or services is preceded by a competitive and transparent call for tenders.	CED-CARITAS Burundi	Upon receipt of the OIG report
	Recommendation 37 (Significant)	We agree with the recommendation and it has already been put into	SEP-CNLS	On going

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	To assure that program goods and services are delivered on time by suppliers, all PRs and SRs should ensure that penalty clauses for late delivery of goods by suppliers are applied to serve as a deterrent.	action. In fact, all tender and contract records contain a clause on delivery delay penalties. The PR will ensure the application of this clause in the event of delays, even at the level of sub-recipient except in cases of force majeure. CED-CARITAS Burundi, to ensure the delivery of goods and services in a timely manner, will continue to ensure that the provisions regarding penalties for delivery delays are applied.	CED-CARITAS Burundi	Upon receipt of the OIG report
Supply Chain	Recommendation 38 (Significant) For the procurement of HIV and malaria health products, the PR should consider agreeing with the suppliers on a staggered delivery with a contractual clause specifying that quantities for the second delivery may be adjusted within certain percentage of the initial required quantities.	The measure is partially applied with current markets. The clause will be incorporated in the DAO and purchase agreements if necessary.	SEP-CNLS	December 2012
	Recommendation 39 (Significant) The MSPLS should involve pharmaceutical staff of the national programs for HIV, TB	We agree with the recommendation. For the malaria program, training supervisions are held every quarter with all district pharmacies and health centers and involve the PR	SEP-CNLS, CAMEBU	31 December 2012

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	and malaria in the supportive supervision of the district pharmacies currently carried out by the District Health Offices.	pharmacist, the Department for Pharmaceuticals, Medicines and Laboratory supplies (DPML), and the PNILP.		
	Recommendation 40 (Requires attention) SEP-CNLS should enter into an agreement with CAMEBU that specifies the level and types of service that it requires from CAMEBU for the HIV and malaria programs.	CAMEBU has signed cooperation agreements in each of the 2 projects of which the SEP-CNLS is PR (HIV and malaria). SEP-CNLS will develop a single agreement in which the level and types of services that it requires of CAMEBU in the management of programs in the fight against AIDS and malaria will be specified.	SEP-CNLS CAMEBU	December 2012
	Recommendation 41 (Requires attention) CAMEBU should create a single database for all of CAMEBU's stock and co-locate drugs according to type regardless of financing and provenance.	This is already done: CAMEBU already merged the management of its own inventories and those belonging to partners, including programs to fight AIDS and malaria.	CAMEBU	
	Recommendation 42 (Significant) SEP-CNLS should strengthen the capacities of its pharmaceutical unit in regard to data collection, reporting and supervision, and ensure that the roles and responsibilities of the pharmaceutical unit are	For HIV the recommendation for technical assistance to improve the system for the management of the purchase and supply of drugs asked of the French government, will be implemented. (See comments in recommendation n ° 24) For malaria, the recommendation is implemented with the support of	SEP-CNLS HIV SEP-CNLS Malaria, DPML, PNILP	9 months after the signing of Phase 2 of Round 9 of the grant agreement

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	well aligned with program needs. The program may need to consider engaging technical assistance to implement this recommendation.	partners including MSH, HERA and WHO.		
Financial Management and Control	<u>Recommendation 43 (Significant)</u> All PRs should address the financial management and internal control weaknesses detailed in Annex 2. In addition, all PRs should prepare management action plans and issue management letters to their SRs and implementing organizations to address these weaknesses. The corresponding audit recommendations are in Annex 2.	For SEP-CNLS, a feedback letter with and an implementation plan indicating weaknesses identified, related recommendations and implementation delays will be addressed to all sub-recipients and entities involved in the implementation. The PR agrees with the recommendation. A report of monthly product consumption is already produced by CAMEBU and passed on to each PR (PNILP, Malaria, and HIV). Feedback on the report will be monthly. The PR shall address a letter to its beneficiaries at the end of each month with feedback on the weaknesses in the management of the funds for the period in question.	SEP-CNLS HIV SEP-CNLS Malaria TB Program	March 2012 On going
	<u>Recommendation 44 (High)</u> The SEP-CNLS malaria program should review its contracting procedures and templates for agreements and	We agree with the recommendation. Indeed, the agreement signed with PSI in November 2010 for the implementation of the logistics aspects the campaign did not mention		

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	memoranda of understanding in order to address the lapses found in its service agreement with PSI.	an amount. But it is stated in Article 3 that "the amount of the agreement will be specified in a separate request detailing the activities and related costs, as determined by the Campaign's Steering Committee and in conformity with the Round 9 budget. Requests for funds may be made by installment according to progress of the work." In fact, the amendment to the contract signed in February 2011 clearly states that amount and the administrative costs of 9% allocated to PSI would be subject to specific negotiations after agreeing on the overall budget of the grant. It should be noted that during the signing of the agreement in November 2010, the Campaign's Steering Committee led by MSPLS had not made progress in the organization of the campaign while the bed nets were about to arrive and would require storage. The next agreements to be signed with Sub-recipients will henceforth specify the amounts of the agreement.		
	Recommendation 45 (High) The SEP-CNLS malaria program should build the	The PR agrees with the recommendation. Five (5) actions planned and their	SEP-CNLS MSPLS PNILP	Current

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	capacity of the PNILP to manage grant funds as a sub-recipient and phase-out the cash fund. In the interim, to mitigate the risk of theft or loss of cash, the PR should establish a maximum amount of cash to be held in the fund. In addition, a maximum amount should be established for individual cash payments from the fund. Surprise cash counts should be performed regularly and any difference should be investigated.	progress: (1) The PNILP has already implemented new units to improve its financial management (A new financial manager has been in place since February 2012, with an established accounting department). (2) Checks are currently issued to PNILP fund managers or to the person mandated by him - instead of withdrawing funds from the PR account as before. (3) The PR has already ordered the TOMPRO management software for the PNILP to improve its management and training on the use of the program is planned after its installation. (4) A partnership agreement to gradually register the funds received from the project (based on the work plan drawn up by the PNILP) is already being finalized. (5) The PR will continue support the PNILP to develop its own procedures manual.		
	Recommendation 46 (High) The Global Fund Secretariat should request the LFA to calculate the total amount that was overcharged to the grant and the SEP-CNLS malaria program should reimburse the malaria grant account. Refer to	PR Response The purchase of the deltamethrin in question took place following a funding request by the national program because of an outbreak of malaria in the province of Ngozi. Based on this request, the PR, in consultation with the National	LFA and the PR team	As soon as the IGO responds

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	paragraph 159 g.	Program about the usual providers of this product, made a limited consultation of three companies, BOLENA, SOCOPHAR and ALCHEM and only BOLENA and ALCHEM responded to the ITT. The purchase respected the procurement procedures as determined by the PR and federal procedures manual (letter of limited consultation, appointment of a tender analysis commission, opening and analysis of offers by this commission, award of the contract by another procurement committee, product delivery, and payment of the invoice) and the various related documents were sent to the LFA. The main area of misunderstanding was that the two suppliers who tendered have the same name (RASQUINHA) and are brothers. The PR investigated and found that they are brothers, but that their pharmacy wholesalers were licensed separately by the MSPLS and the Ministry of Trade. We verified the prices obtained by the Swiss agency which co-financed the activity and bought the same product and found it to be BIF 15500 or BIF 1820 more expensive than what we paid. For the purchase of supplies in		

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		relation to the number of beneficiaries of mosquito nets from the campaign/countryside, it is in relation to a purchase which was part of a group of other activities and three pro-forma invoices are being searched as stipulated in the PR's procedure manual. If these explanations do not meet the approval of the OIG, the PR is willing to work with LFAs and provide any clarifications requested by them to produce a supplementary report. The PR will provide comments on the LFA report as soon as it has been produced. OIG Comment: The OIG agrees with the LFA that prices paid exceeded prevailing market prices.		
CCM Governance	Recommendation 47 (High) The CCM needs to provide strategic direction and oversight to ensure that the Global Fund grants are implemented in a way that strengthens national systems and structures to promote sustainability.	The CCM agrees with this recommendation and has included it in its 2011-2013 strategic plan.	CCM	In 2012
	Recommendation 48 (Significant)	The CCM agrees with this recommendation and will put the	CCM	In 2013

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	The CCM should recruit an accountant/book-keeper for financial management of its grant funds.	wheels in motion to hire an accountant.		
	Recommendation 49 (High) The CCM should ensure a functional internal audit mechanism to provide effective assurance over the grants.	This recommendation is accepted. The CCM will consider recruiting an internal auditor for the existing grants.	CCM	In 2013

Annex 11: Secretariat and LFA Oversight Recommendations and Management Action Plan

Prioritization of recommendations

Audit recommendations have been prioritized so as to assist management in deciding on the order in which recommendations should be implemented. The implementation of all audit recommendations is essential in mitigating risk and strengthening the internal control environment in which the programs operate. The categorization of recommendations is as follows:

i. High Priority: Material concern, fundamental control weakness or non-compliance, which if not effectively managed, present material risk and will be highly detrimental to the organization's interests, significantly erode internal controls, or jeopardize achievement of aims and objectives. They require immediate attention by senior management.

ii. Significant Priority: There is a control weakness or noncompliance within the system, which presents a significant risk. Management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal controls, or undermine achievement of aims and objectives.

iii. Requires Attention: There is a minor control weakness or noncompliance within the system, which requires remedial action within an appropriate timescale. The adoption of best practices would improve or enhance systems, procedures and risk management for the benefit of the grant programs.

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Global Fund Secretariat and LFA Oversight	Recommendation 50 (Significant) The Global Fund Secretariat should ensure that the LFA improves its technical assessment of program updates submitted by PRs by assuring that the reported results are reviewed on-site by qualified professionals, and that the LFA comments are discussed with the relevant PR professional staff before submitting them to	The Global Fund Secretariat has requested that the M&E expert of the LFA team be present in-country for the review of the six monthly progress updates. This practice has already started with the PUDR for the period ended 30 June 2011. The PSM and PHP experts are also expected to be in-country for the review of PUDRs as planning	Global Fund Secretariat	Continuous

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	the Global Fund Secretariat.	for other specific deliverables will be conducted taking into account PUDR review planning (procurement review and OSDV / RSQA). The LFA ensures that these two experts are present in-country for one PUDR per year and possibly both if procurement and programmatic issues are raised. The LFA formally debriefs relevant PR professional staff at the end of each PUDR review. This practice is consistently applied by the LFA for all its assignments.		
	Recommendation 51 (Significant) The Global Fund Secretariat should ensure that the Terms of Reference of the audits fully comply with the Audit Guidelines.	Terms of reference of all audit guidelines are reviewed by the Regional Team with support from a Program Finance staff. The LFA verifies that the finalized TORs take into account the feedback provided by the Global Fund Secretariat.	Global Fund Secretariat	Already fulfilled
	Recommendation 52 (High) The Global Fund Secretariat should request that the LFA confirm the amount of price inflation for the purchase of deltamethrin and supplies for the enumeration exercise and seek recovery from SEP-CNLS Malaria Program.	The LFA was requested to follow upon the purchase of deltamethrin to determine the nature and deviation from prevailing market prices at the time of the procurement. The Global Fund Secretariat will take the appropriate actions once the required clarifications are provided by the PR.	Global Fund Secretariat	30 September 2012