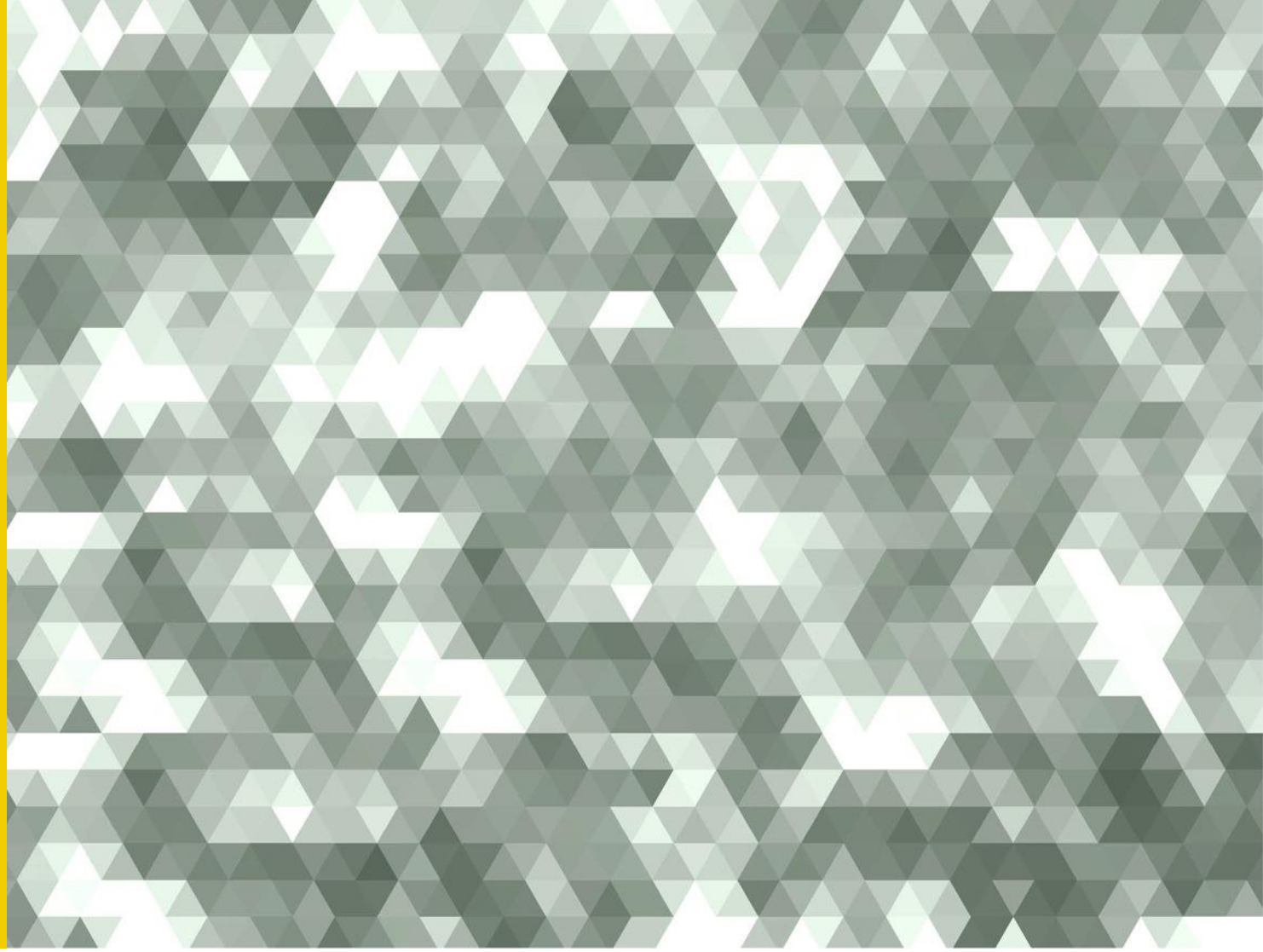

Audit Report

Global Fund Grants to Burkina Faso

GF-OIG-17-024
22 November 2017
Geneva, Switzerland

The Global Fund
Office of the Inspector General

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The Office of the Inspector General (OIG) safeguards the assets, investments, reputation and sustainability of the Global Fund by ensuring that it takes the right action to end the epidemics of AIDS, tuberculosis and malaria. Through audits, investigations and advisory work, it promotes good practice, reduces risk and reports fully and transparently on abuse.

Established in 2005, the OIG is an independent yet integral part of the Global Fund. It is accountable to the Board through its Audit and Finance Committee and serves the interests of all Global Fund stakeholders. Its work conforms to the International Standards for the Professional Practice of Internal Auditing and the Uniform Guidelines for Investigations of the Conference of International Investigators.

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Audit Report

OIG audits look at systems and processes, both at the Global Fund and in country, to identify the risks that could compromise the organization's mission to end the three epidemics. The OIG generally audits three main areas: risk management, governance and oversight. Overall, the objective of the audit is to improve the effectiveness of the Global Fund to ensure that it has the greatest impact using the funds with which it is entrusted.

Advisory Report

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OIG investigations examine either allegations received of actual wrongdoing or follow up on intelligence of fraud or abuse that could compromise the Global Fund's mission to end the three epidemics. The OIG conducts administrative, not criminal, investigations. Its findings are based on facts and related analysis, which may include drawing reasonable inferences based upon established facts.

Table of Contents

1. Executive Summary

1.1. Opinion

Global Fund grants to Burkina Faso are well-structured and contribute to reducing the burden of the three diseases in the country. Since the Global Fund first invested in the country in 2003, the malaria mortality rate has more than halved and the HIV prevalence rate has decreased significantly. The audit found that overall governance and control structures are established but improvements are still needed in some areas of Principal Recipient capacity.

Programme d'Appui au Développement Sanitaire du Burkina Faso (PADS), a project management unit established by the Ministry of Health in Burkina Faso, is one of three Global Fund Principal Recipients. It manages three out of five grants and almost 70% of total Global Fund grant funds. Given the importance of PADS for the Global Fund in Burkina Faso, the audit reviewed its structure and institutional arrangements. While the unit has functioning governance and control processes in place, the audit concluded that PADS institutional arrangements require improvements to be effective. Its program management and oversight capacity need improvement and overall financial management needs strengthening. Also, PADS could be more transparent towards donors regarding budgets and governance.

The design of the grant activities, including community-based activities and data systems, and the related implementation arrangements are adequate. The program has successfully recruited and trained 263 community-based organizations and trained more than 17,000 community health workers. The Government contributes 75% of the salaries for community health workers, ensuring sustainability of the system. The OIG noted weaknesses in the recruitment process of community-based organizations, which resulted in delays for several grant activities.

Internal controls for key expenditures such as travel and human resources are adequate for two Principal Recipients: *Secrétariat Permanent du Conseil National de Lutte contre le Sida et les IST du Burkina Faso* (SP/CNLS) and *Initiative Privée et Communautaire contre le VIH/SIDA au Burkina Faso* (IPC/BF). The Fiduciary Agent is effective in supporting the three Principal Recipients. However, controls need to be strengthened in PADS human resources management at the central level and expenditure at the regional and district levels**.** The regional/district expenditures represents 42% of total PADS expenditure.

1.2. Key Achievements and Good Practices

Decreasing malaria mortality despite high disease burden. Burkina Faso, with a population of just over 18 million, represents 2.84 % of the global malaria burden, or the eighth highest malaria disease burden in the world. The effectiveness of malaria prevention activities funded by the Global Fund has contributed to the reduction of the malaria mortality rate from 3.2% in 2003 to 1.5% in 2012.

Well-structured grant implementation arrangements. The grant implementation arrangements are clear and well-structured. The flow of funds and reporting lines, including roles and responsibilities, are adequately designed amongst private, public and community organizations/health worker implementers. The Principal Recipients represent both public and civil society sectors. The health system strengthening grant is well-designed with a focus on targeted activities that can contribute to long term impact in strengthening the health system such as improving quality assurance, data management and community activities.

Community health organizations and workers service all districts. The involvement of community health organizations and community health workers is key to achieving grant objectives. The system of supporting health in communities through working with community health organizations and workers is well-designed. The Government of Burkina Faso demonstrates

commitment in ensuring the sustainability of this approach by providing 75% of the funding for the community health workers' remuneration.

Adequate risk mitigation processes in place by the Global Fund Secretariat. The financial risk mitigation processes established by the Global Fund Secretariat are mainly effective. Expenditures paid by the grants are generally adequately supported. The Global Fund Secretariat has put in place various mitigation measures such as a Fiduciary Agent, a direct cash payment policy and a restricted cash policy. These measures have contributed to ensuring that program funds are used as per grant objectives. The Secretariat has also put in place an effective procurement risk mitigation process for both health and non-health high value procurements. This approach is also helping PADS avoid delays in the procurement process.

1.3. Key Issues and Risks

Gaps in PADS' institutional arrangements. As PADS manages a significant proportion of Global Fund grant funds, its effectiveness has a significant impact on overall quality of program implementation. The OIG noted the following gaps:

- PADS does not have a dedicated program management unit. Key grant oversight tasks are assumed by the monitoring and evaluation unit, which has limited staff with a substantial workload. This has resulted in ineffective monitoring and evaluation activities, which mainly focus on donor reporting and grant preparation rather than actual monitoring and supervision of grant activities. There is limited supervision of regions and districts. Follow-up and coordination mechanisms with other Principal Recipients and sub-recipients are also limited.
- PADS assumed direct responsibility for the implementation of the health systems strengthening grant, although it does not have adequate project management capacity, and no sub-recipient has been selected to implement related activities. This has contributed to underperformance of the health systems strengthening grant.
- An ineffective treasury system has resulted in delays in implementing grant activities. The audit also found weak control over regional/district expenditures, which represent 42% of total in-country expenditures. PADS does not have an adequate fraud identification, mitigation and reporting mechanism.
- There is limited transparency by PADS towards donors regarding governance mechanisms and budgeting. There is no cost sharing mechanism across donors to minimize the risk of double billing of salaries and expenses. Donors have limited insight into the PADS Steering Committee, its main governance body.

Gaps in design and effectiveness of grant activities. Significant delays have impacted the recruitment of community-based organizations as well as training and equipping the community health workers. As a result, community-based organizations and health workers are limited in their ability to follow up people with tuberculosis (TB) and people living with HIV on antiretroviral treatment. The country is still struggling with low retention rates of antiretroviral therapy after 12 months (70%), low HIV testing of infants (32%) and low TB case detection rate.

Weak controls over human resources management and regional expenditure. PADS and IPC do not have a salary allocation methodology across donors, which has resulted in some staff positions being funded by one donor although staff also worked for other donors. Staff salaries are not allocated based on the level of effort dedicated to each donor activity. The financial controls over regional and district level expenditure needs reinforcing.

1.4. Rating

	Objective 1. The institutional adequacy and effectiveness of PADS to manage the Global Fund grants for Malaria, Tuberculosis and Health System Strengthening OIG rating: **partially effective**, with need for improvements in the areas of strengthening project management for health system strengthening; ensuring adequate treasury system to ensure timely disbursement to implementers; revisiting the role of the internal auditor and establishing fraud prevention and reporting mechanisms; strengthening capacity of programmatic management in the area of monitoring and evaluation activities; and improving governance and transparency processes
	Objective 2. The design and effectiveness of grant activities to achieve grant objectives including the community based approach and data systems OIG rating: **partially effective** with areas of improvement needed in ensuring effective roles of community health organizations and workers.
	Objective 3. The adequacy of internal financial controls for travel related costs and Human Resources expenditures to ensure effective implementation of the Global Fund Grants OIG rating: **partially effective** with areas of improvement needed to improve control and oversight of regional/district expenditures and human resources management at PADS central level.

1.5. Summary of Agreed Management Actions

The Global Fund Secretariat has plans to address the weaknesses identified by the OIG through the following Agreed Management Actions:
A comprehensive capacity building plan for the main principal recipient (PADS) will be developed and implemented. This will address the following areas:

- program management, sub-recipient management, monitoring and evaluation;
- financial management and internal controls (including salary allocation, controls at regional/local levels and capacity building for regional accountants); and
- PADS budgeting and governance mechanisms.

Community-based activities will be improved as the new National Community Strategy will clarify how community-based organizations and health workers are involved/used to strengthen TB, HIV and malaria outcomes, including the follow-up of key programmatic indicators

2. Background and Context

2.1. Overall Context

Economic and political context

Burkina Faso is a landlocked West African country with a population of over 18 million people.[1] It is classified as a low income country with nearly half of the population living below the poverty line. The country is ranked 183th out of 188 in UNDP's Human Development Index.[2] Burkina Faso ranked 72th out of 176 in Transparency International's 2016 Corruption Perceptions Index.[3]

Burkina Faso has suffered from recurring droughts, military coups and power struggles, and has faced concern over the state of its economy.

Health sector structure

Burkina Faso's health care system is divided into three levels: central, intermediate/regional and peripheral levels. The central level is administratively under the authority of the cabinet and general secretariat of the Ministry of Health. The central level of the health care system directs and co-ordinates the national health care and health care development policies. The programs to fight TB, malaria and HIV are under the oversight of the *Direction de la Lutte contre la Maladie* [Disease Response Directorate] which is under the authority of the *Direction Générale de la Santé* [General Health Directorate].

The intermediate/regional level comprises of 13 *Directions Régionales de la Santé* [Regional Health Divisions] to implement the national health care and health care development policies at regional level. They include a *Service de Lutte contre la Maladie* [Disease Response Service], which coordinates the national response to TB and HIV. There are also four university hospitals and nine regional hospitals managing secondary and tertiary care.

The peripheral level consists of 70 health care districts. They are responsible for planning and implementing health care programs, including responses to malaria, TB and HIV. There are 1,716 health facilities conducting primary care interventions, numerous community-based organizations, including 263[4] that receive support from the Global Fund, and over 17,000 community health workers who support with communication, sensitization, treatment, referrals and patient monitoring and follow up.

2.2. Country Differentiation Category: Burkina Faso

The Global Fund has classified the countries in which it finances programs into three overall portfolio categories: focused, core and high impact. These categories are primarily defined by size of allocation amount, disease burden and impact on the Global Fund's mission to end the three epidemics.

Burkina Faso is classified as a Core country.

	Focused: (Smaller portfolios, lower disease burden, lower mission risk)
X	**Core: (Larger portfolios, higher disease burden, higher risk)**
	High Impact: (Very large portfolio, mission critical disease burden)

[1] World Bank 2015 - http://www.worldbank.org/en/country/burkinafaso

[2] UNDP Human Development Index 2016

[3] Transparency International Corruption Perception Index 2016

[4] 252 community based organizations were initially selected by the PADS and 11 specialized organizations were added after the initial selection.

2.3. Global Fund Grants in the Country

Burkina Faso received a 2014/2016 allocation of US$204.61 million.[5]

The Global Fund has invested over EUR341 million since 2003. There are currently five active grants in the country:

Table 1: Active Global Fund grants to Burkina Faso

Grant Number	Principal Recipient	Grant Components	Program Start Date	Program End Date	Signed Amount (in Euro)
BFA-C-IPC	Initiative Privée et Communautaire contre le VIH/SIDA au Burkina Faso (IPC/BF)	HIV/TB	01-Jul-2015	31-Dec-2017	7,876,000
BFA-H-SPCNLS	Secrétariat Permanent du Conseil National de Lutte contre le Sida et les IST du Burkina Faso (SP/CNLS)	HIV/AIDS	01-Jul-2015	31-Dec-2017	29,535,749
BFA-M-PADS	Programme d'Appui au Développement Sanitaire du Burkina Faso (PADS)	Malaria	01-Oct-2015	31-Dec-2017	59,286,922
BFA-S-PADS	Programme d'Appui au Développement Sanitaire du Burkina Faso (PADS)	Health Systems Strengthening	01-Oct-2015	31-Dec-2017	17,347,022
BFA-T-PADS	Programme d'Appui au Développement Sanitaire du Burkina Faso (PADS)	Tuberculosis	01-Jul-2015	31-Dec-2017	3,320,630
Total					**117,736,553**

PADS has allocated 63 % (EUR50 million) of the total grants to health procurement through the Pooled Procurement Mechanism (PPM) and 20 % or EUR16 million of total signed grant amount to two sub-recipients. These sub-recipients cover in aggregate 13 regional and 70 district activities, including the community-based organizations and community-based health workers.

SP/CNLS[6] is the Principal Recipient for the HIV and AIDS grant with a total amount of EUR30 million (25%) of total signed active grants. The SP/CNLS allocated 74.68% (EUR22 million) of its grant amounts to health procurement through PPM and 8.36% (EUR2.5 million) to two sub-recipients covering regional and district activities.

IPC/BF[7] is the Principal Recipient for the HIV/TB grant managing a total amount EUR7.8 million (7 %) of total signed active grants. IPC/BF allocated 75 % of its total budget (EUR5.9 million) to four sub-recipients, including 146 community-based organizations.

[5] 2015-2017 Burkina Faso Allocation Letter, 12 March 2014
[6] http://www.cnls.bf/

[7] http://ipcbf.org/

2.4. The Three Diseases in Burkina Faso

HIV: Burkina Faso has a general HIV epidemic. Investments into disease response have contributed to a decrease in the prevalence rate among the general population from 1.8 percent in 2003 to 1 percent in 2010.[8]

HIV-related deaths were estimated at 5,600 in 2013 and should decrease to 2,765 in 2020.[9]

Early infant diagnosis rate is 30%.

89% coverage of HIV positive pregnant women who receive anti-retroviral treatment.

110,000 People living with HIV[10]

Infection prevalence rate of 1%[11]

3600 AIDS related deaths in 2015[12]

Malaria: Burkina Faso is the Global Fund's eighth largest portfolio in terms of malaria disease burden.

Malaria is a priority health problem as it is the leading cause of consultation (46.5 percent), hospitalization (61.5 percent) and death (30.5 percent).[13]

The most vulnerable groups are children under the age of five and pregnant women.

In 2016, the Government introduced targeted gratuity, providing artemisinin-based combination therapy treatment free of charge to children under 5 and to pregnant women.

Transmission is high throughout the year but peaks during the rainy season (June-September).

7 million cases estimated annually[14]

15,000 deaths estimated annually[15]

2,9% of global malaria burden in Burkina Faso[16]

TB: The case notification rate for TB is 31/100,000 inhabitants. Given the estimated incidence of 52/100,000 inhabitants, this remains low despite significant improvements (from 21/100,000 in 2000).[17]

TB mortality is 11%, partly due to lack of case notification and cases diagnosed in late stages.

Multi-drug resistant tuberculosis (MDR-TB) remains a problem. In 2012, WHO estimated the proportion of MDR-TB cases among TB cases which had already been treated at 19 percent (75 cases) and the proportion of MDR-TB cases among new TB cases at 1.8 percent (79 cases).[18]

52/100,000 TB incidence[19]

5,808 TB cases detected in 2015[20]

60% TB treatment coverage[21]

81% treatment success rate for new and relapse cases in 2014[22]

[8] Global Fund Concept Note
[9] Global Fund Concept Note
[10] UNAIDS Aidsinfo
[11] UNAIDS Aidsinfo
[12] Global Fund Concept Note
[13] World Malaria Report 2016
[14] World Malaria Report 2016
[15] World Malaria Report 2016
[16] World Malaria Report 2016
[17] Global Fund Concept Note and Progress Update
[18] World Health Organization, Global Tuberculosis Report
[19] World Health Organization, Global Tuberculosis Report
[20] World Health Organization, Global Tuberculosis Report
[21] World Health Organization, Global Tuberculosis Report
[22] World Health Organization, Global Tuberculosis Report

3. The Audit at a Glance

3.1. Objectives

The audit sought to give the Global Fund Board reasonable assurance on whether the assurance and implementation arrangements of Global Fund grants to Burkina Faso are adequate, efficient and effective in achieving grant objectives. Through three specific objectives, the audit assessed:

(a) the institutional adequacy and effectiveness of PADS to manage the Global Fund grants for malaria, TB and health system strengthening;
(b) the design and effectiveness of grant activities to achieve grant objectives including community-based approach and data systems; and
(c) the adequacy of internal financial controls for the two main areas of administrative expenditures, travel and human resources costs, to ensure adequate use of funds.

3.2. Scope

The audit was performed in accordance with the methodology described in Annex B and covered the five active grants for the period from the start date of the current grants in 2015 to June 2017.

The review covered the ongoing grants implemented by the Principal Recipients and/or their sub-recipients:

(a) PADS: Grants BFA-S-PADS; BFA-M-PADS; and BFA-T-PADS;
(b) SP/CNLS: Grant BFA-H-SPCNLS; and
(c) IPC/BF: Grant BFA-C-IPC.

The audit did not cover the PPM procurement activities and the in-country supply chain. The exclusion of in-country supply chain was based on the Secretariat's plan to include Burkina Faso as one of the countries to be piloted for a supply chain diagnostic review.

The OIG also relied on the work done by the Fiduciary Agent who had reviewed significant expenditure transactions of 10 regions (including districts) in 2016. The auditors reviewed 20% of the 2015-2017 transactions to assess the effectiveness of the established financial controls.

3.3. Progress on Previously Identified Issues

An OIG investigation in Burkina Faso in 2015 found sub-standard and untreated counterfeit mosquito nets valued at EUR9.1 million, bought through local suppliers. The nets did not meet the requisite WHO recommendations, posing a significant public health risk. The Secretariat agreed to seek recovery of the full non-compliant amount of EUR9.1 million. The Government of Burkina Faso has already paid around EUR1.57 million and the remaining amount will be paid in annual installments through to September 2020. In addition to the ongoing recoveries, and to address the control gaps that were identified in this investigation, the Secretariat has also implemented additional mitigation measures. These include procurement of all health products through the PPM, local procurement of all major non-health products through independent third parties such as UNICEF and UNOPS, and the installation of a fiscal agent to verify and provide assurance on different program activities.

Previous relevant OIG work:

GF-OIG-15-019, Investigation of Global Fund Grants to Burkina Faso"Programme d'Appui au Développement Sanitaire"

GF-OIG-17-019 Investigation of Global Fund grant in Burkina Faso

Another OIG investigation concluded in September 2017 that a local supplier deceived a Principal Recipient of Global Fund grants in Burkina Faso when it delivered 35 counterfeit and low quality

motorbikes in June 2014. The bikes, valued at EUR73,366, were needed to provide community services to people with TB. The supplier, Sogedim-BTP Sarl, profited from the difference in value between the brand model it had promised in its bid proposal and those it actually delivered. The Principal Recipient, PAMAC (Programme d'Appui au Monde Associatif et Communautaire), did not make the terms and conditions of its purchase contract with Sogedim clear, which facilitated the irregular delivery. The Global Fund Secretariat will seek to recover the lost funds and take appropriate action against the supplier. The supplier has not been used for any other Global Fund grants in Burkina Faso.

The Global Fund Secretariat has implemented risk mitigation measures for the Burkina Faso portfolio following the investigation. For example, independent third parties like UNICEF and UNOPS now conduct local procurement of all major non-health products.

4. Findings

4.1. Gaps in PADS institutional capacity limit its effectiveness

PADS has the basic governance mechanisms in place in terms of the unit structure and overall control environment, but it needs improvements in project and programme management capacity, financial management and internal controls, as well as transparency.

Weaknesses in program management, sub-recipient management, monitoring, and evaluation

The PADS unit responsible for programmatic management and Monitoring and Evaluation (M&E) consists of one M&E officer and one assistant. In 2016, a specific position was created as a "Focal Point for Global Fund and Gavi grants". The focal point and the M&E team work closely together and all three staff members are collectively referred to in this report as the M&E unit.

The PADS Coordinator is formally responsible for programmatic management and oversight, but the daily work is conducted by the M&E unit.

The staff in the M&E unit have relevant academic credentials and adequate professional experience to carry out their work. Two out of the three grants were rated as B1 in December 2016, indicating "adequate performance", which indicates that PADS has successfully accompanied the implementing sub-recipients in achieving the programmatic objectives of the grants.

However, the following weaknesses exist in PADS' capacity to manage grant programs and M&E:

- In the absence of a dedicated program management unit, the M&E unit also has the role of ensuring programmatic advancement of all PADS grants. The unit's role is focused on preparing the implementation and reports for donors rather than monitoring programs through evaluation and supervisory visits. For example, the M&E work plan for 2017 focuses primarily on preparing progress reports for donors, participating in procurement processes for equipment and health products, and maintaining the PADS' website. There is only limited focus on project reviews, supervision and evaluations.

- PADS conducts only limited supervision missions to regional and districts level to ensure proper implementation of grant activities. PADS could not provide an overview of the supervisions that they had conducted for the ongoing grants. The 2016 PADS Annual Report states that supervision visits scheduled for 2016 did not take place. There is no specific M&E annual report detailing progresstowards achieving the plan. The PADS procedures manual does not outlines processes for conducting supervisions.

- PADS has limited formal mechanisms to coordinate activities and ensure progress with the sub-recipients and technical partners; meetings with the Principal Recipients, sub-recipients and technical partners are organized only twice per year. A Principal Recipient dashboard, a tool provided by the Global Fund to monitor grant progress and performance, is not maintained and updated.

These weaknesses are due to the lack of a dedicated unit responsible for accompanying the sub-recipients in their programmatic execution of the grants, submitting donor reporting and preparing the new grant periods. The M&E unit has a substantial workload with limited staff.

PADS' original mandate from 2005 focuses on its role in ensuring the distribution of funds and financial absorption of grant funding. However, it has limited references to ensuring programmatic

grant achievement. This has contributed to PADS limited internal structure for programmatic and M&E areas.

Weak project management capacity delayed the health systems strengthening grant activities

The health systems strengthening grant is well-designed and focuses on cross-cutting areas that have the potential to contribute to long term strengthening of the overall health system in Burkina Faso. This includes the strengthening of: i) data collection and management, ii) community-based service delivery, iii) the quality assurance of health products and laboratory testing, and iv) systems for procurement, distribution and management of health products. These are all core aspects of Burkina Faso's health system.

However, PADS' capacity to coordinate and implement the health systems strengthening grant activities is weak. The grant has several implementing partners and funds are distributed to ten different types of actors in the scope of the grant. Also, activities conducted under the health systems strengthening grant affect the implementation of other Global Fund grants in Burkina Faso. Thus, the coordination process of the grant is complex and needs to be carefully managed to ensure effective implementation.

PADS assumed the responsibility for the health systems strengthening grant without creating a dedicated project management unit to manage the coordination and implementation of the grant. The staff responsible for coordinating and implementing health systems strengthening activities are limited in number and have a significant workload from managing other projects in PADS' portfolio. PADS has not set up a governance structure for this grant, with a reporting mechanism and a coordination forum for implementing stakeholders. The recipient has not received support from the Global Fund Secretariat in setting up an appropriate governance structure to implement the grant.

Moreover, the implementation arrangements for the grant do not include a qualified sub-recipient to assist PADS in the actual implementation of the key health systems strengthening grant activities. Without a dedicated sub-recipient for the health systems strengthening grant, PADS takes on the day-to-day implementation responsibility while its primary mandate should be to focus on oversight and fund disbursement.

This has resulted in inefficiencies in the management of the grant and contributed to delays in implementation of the activities, resulting in a C rating ("unacceptable") in December 2016. Delays in the implementation of key health systems strengthening activities have affected the timely implementation of other activities from other grants. Examples include:

- *Delays in recruitment of community-based organizations:* The health systems strengthening grant is also responsible for recruiting 252 community-based organizations. These are civil society organizations working at the district level to provide awareness raising and prevention activities in communities. There were significant delays in the recruitment process (see section 4.2. for further information about the recruitment of the community-based organizations). It took over eight months from the start of the recruitment process until contracts with the community-based organizations were signed. The recruitment process initially did not adequately address the need for community-based organizations working with key populations. As a result, 11 additional community-based organizations focusing on providing services to key populations had to be recruited afterwards. The grant implemented by the Principal Recipient IPC includes providing services to key populations through community-based organizations. The delayed and contested recruitment process contributed to the grant receiving a "C" rating ("unacceptable") in December 2016.

- *No kits for community-based health workers:* The health systems strengthening grant is responsible for recruiting, training and equipping the community-based health workers to provide basic awareness-raising activities, prevention and care in all rural villages in Burkina

Faso. While the community-based health workers have been recruited and trained, at the time of the audit, they had not yet received the equipment kits that would allow them to provide services to the communities. Thus, the health workers could only conduct limited awareness-raising activities (see section 4.2. for further information about the community-based health workers). Therefore, only a few suspected cases of malaria were tested in the community, contributing to the low achievement (less than 10% compared to a target of 100%) of this indicator for the malaria grant as of December 2016.

The Country Coordinating Mechanism and the Global Fund Secretariat have already recognized the limitations in the current implementation arrangements of the current health systems strengthening grant. For the upcoming grant period starting in 2018, there are plans to merge it with the malaria grant and to recruit a specific sub-recipient for health systems strengthening.

Gaps in overall financial management and internal controls to ensure timely disbursements and proper safeguarding of grant funds.

PADS has an adequate accounting system, including a budget monitoring module, which monitors compliance with approved budgets. There are adequate controls to ensure that payments made are received by the intended beneficiary and that funds are not misused through direct mobile payments (in the case of community health workers), or bank transfers.

However, the OIG found weaknesses concerning treasury management, the effectiveness of the regional accountants and the internal control framework.

Treasury management: Disbursements to implementers were delayed due to late signing of various agreements with implementers but also due to weak treasury management, such as the absence of monitoring of cash flow and activity timelines. The funds for the first semester of 2016 were transferred to implementers only in June 2016. For the second semester, funds were transferred in December 2016. Weak treasury management has resulted in non-execution or delays in implementing activities, especially in 2016.

Regional accountants: PADS relies on 13 regional accountants (one for each regional department) to oversee all expenditures for activities at the regional and district levels. This represents 42 % of total PADS grant funding spent in country. There is no additional oversight of these expenditures at central level. The audit found weak quality of the verifications as detailed in section 4.3 and no control improvements were observed during the period of review. For example, from an analysis of 14 regional accountant reports, most findings are repeated from one quarter to the next and the reports are generic due to the absence of root causes analyses of the findings.

Fraud prevention, detection and reporting: The OIG noted inadequate fraud prevention (awareness), detection (controls) and reporting (hotline, escalation) mechanisms. Apart from the high level national guidelines to govern the fraud mechanism in the country, PADS does not have an internal procedure on how to prevent, detect and report cases of potential fraud.

Dual responsibilities of the internal audit function: In addition to the role as internal auditor, the PADS internal auditor also acted as internal comptroller to verify supporting documents for expenditures and financial reports after activities were undertaken. This has resulted in incompatible duties between operational and controlling roles.

Limited transparency for donors in PADS' budgeting and governance mechanisms

In 2016, PADS managed over EUR104 million for donors such as the Global Fund, the World Bank and Gavi. Donors continue to demonstrate confidence in PADS through continued request for PADS to manage new projects and grants.

However, there is a lack of transparency and coordination between PADS and donors, and amongst the donors regarding governance and budget allocation.

PADS does not share regularly detailed budgets to donors on which activities are funded by which donor. The Global Fund (and other donors) do not know which activities are funded by other donors in order to ensure that there are no duplications in salaries and expenditure. There is no agreement on common cost or salary allocation among donors. These expenses are allocated based on the donor's availability of funds rather than on level of effort (see section 4.3 for more information on salary allocation).

PADS produces an annual report on budget absorption and activity realization, but does not outline details about how donor contributions to common costs or salaries are allocated. There is no consolidated report among donors to share information about salary and common cost contributions.

Activities at the regional level are reported to the donor who funded the activity. However, there is no mechanism to ensure that the funding of the same activity has not been double-charged to more than one donor.

These weaknesses in funding and budget transparency result from a lack of clear reporting mechanisms and also a lack of coordination among the donors. The Global Fund, as main donor to PADS, is not a member of its Steering Committee, the main governance body. Limited donor insight and influence in PADS governance mechanisms increase the risk that the Principal Recipient is not managed optimally to achieve donor objectives.

Agreed Management Action 1

The Secretariat, together with PADS (and other main stakeholders as applicable), will develop a comprehensive capacity-building plan to address the weaknesses which have impacted on the efficiency of program implementation of the Global Fund grant funds:

- program management, sub-recipient management, monitoring and evaluation;
- financial management and internal controls (including in respect of salary allocation, controls at regional/local levels and capacity building for regional accountants); and
- PADS budgeting and governance mechanisms.

The plan should set out the key strengthening actions as well as establish timelines, responsible entities, indicators and budget needed to achieve such actions.

Owner: Head of Grant Management

Due date: 30 June 2018

4.2. Delays in setting up community-based activities affect the implementation of grants

The design and implementation arrangements of grant activities to achieve programmatic objectives are generally adequate. Delays in recruiting, training and oversight of the community-based organizations and health workers have negatively affected implementation of grant activities and disease interventions.

Weaknesses in recruitment and management of community-based organizations and health workers

Community-based organizations and health workers are cornerstones of Burkina Faso's health system at the local level. The community-based organizations are civil society organizations providing information, raising awareness and conducting prevention activities in collaboration with district and local health facilities and the community-based health workers. Community-based health workers serve all rural villages in Burkina Faso with awareness-raising, prevention and treatment activities.

Burkina Faso has a long tradition of working with community-based organizations and health workers. The community-based system is well designed and integrated with the clinical health care system. The Government of Burkina Faso demonstrates its commitment to ensuring sustainability of the community health workers by providing 75% of their remuneration (the Government pays XOF15,000 per month and Global Fund pays XOF5,000 per month and worker, totalling approximately EUR 30).

The community-based system has a key role in delivering last-mile health care and prevention, especially in rural areas. Delays or weaknesses in grant activities related to the management of community-based organizations and health workers can therefore also affect the implementation of other grant activities.

Delays in the recruitment of community-based organizations

Community-based organizations have long been in place in Burkina Faso. They were previously funded by other donors. When the Global Fund assumed the role of providing them with financial support, a decision was made to increase the number of organizations from around 180 to 252. This prompted a new recruitment process for all community-based organizations.

This process officially started in October 2015 when the health systems strengthening grant was signed. PADS had already taken steps to prepare the recruitment in anticipation of grant signature. It had defined the evaluation criteria and established the process together with the Principal Recipient IPC and the sub-recipient for the malaria grant, Progettomondo Mlal.

Some community-based organizations with years of experience, especially in working with key populations, were not retained in the recruitment process. This led to contestation of the recruitment results and ultimately to the decision that IPC should recruit 11 additional community-based organizations specifically for key populations (adding up to a total of 263 community-based organizations).

Contracts were eventually signed with the organizations. They received their first disbursement in June 2016, resulting in a process that took over eight months, a substantial delay in a three-year grant lifecycle.

The delays and contestation of the recruitment results were due to several factors: weak transparency at district level as the Principal Recipients (PADS and IPC) did not participate in the recruitment committees; sub-recipients were limited to an observer role; no independent verification of the

selected organizations' conformance with the selection criteria; the evaluation criteria did not sufficiently consider all key requirements, including experience working with key populations; the scoring process was not consistent across the regions; and applicant organizations were only given a five-day period for submitting their bid.

The delayed recruitment of the community-based organizations resulted in delays to implement grant activities for both PADS and IPC in the first semester of 2016. The delays also affected subsequent semesters that the grants are still catching up today.

Lack of coordination mechanism to manage the community-based organizations

There is no coordination mechanism for different implementers to manage the community-based organizations. These organizations receive funding from PADS for operational costs and from the sub-recipient Progettomondo Mlal for implementation of malaria-related activities. Organizations implementing activities related to key populations and HIV prevention also receive funding from the IPC sub-recipient AIDSETI for these activities. There is no mechanism to coordinate between the implementers to ensure synergies and to avoid duplications. Joint supervision missions have been planned but not yet conducted.

At the time of the audit, partners were working with the Minister of Health to establish the first universal package of service for the community-based organizations.

Lack of coordination may lead to inefficient use of the community-based organizations, leading to low value for money and low achievement of grant indicators.

Community-based health workers not yet functional to carry out their package of services

The health system strengthening grant is responsible for recruiting, training and equipping 17,790 community-based health workers to provide basic awareness-raising activities, prevention and care in all rural villages in Burkina Faso. While the community-based health workers have been recruited and trained, they have not yet received the necessary equipment kits that would allow them to provide services in the communities.

The kits were partly procured by PADS through UNICEF and partly by the Government of Burkina Faso. Components of the kits procured through UNICEF have been delivered to the UNICEF warehouse where they are waiting to be assembled and distributed. The Government-funded components have not been delivered yet and the status of the procurement process is not clear. Once all the components have arrived at the central warehouse, the kits will be composed and UNICEF will deliver them to the health workers.

As a result, the health workers can only carry out limited awareness-raising activities as they wait for their equipment kits to be able to conduct their complete package of prevention and treatment services.

The issues noted result from the lack of effective mechanisms to coordinate and manage the community-based organizations and community-based health workers and to ensure they are fully equipped to carry out their services. This is due to weaknesses in coordination and project management capacity of PADS as noted in the previous section.

Weaknesses in disease detection and treatment adherence for HIV and TB

Burkina Faso has made significant progress in dealing with the three diseases, with decreasing disease burden and new methods.

For 10 years, HIV prevalence has continuously decreased among women of childbearing age (from 2.7 percent in 2003 to 1.7 percent in 2012) and among the general population (from 1.8 percent in 2003 to 1 percent in 2010(.

In 2016, the Government of Burkina Faso introduced targeted gratuity, offering free-of-charge malaria treatment to pregnant women and children under five years old, the most at risk groups. The Government is also piloting additional initiatives together with other donors, such as seasonal malaria chemoprophylaxis for children under five.

There are, however, challenges related to case detection, testing and treatment adherence for HIV and TB.

The case detection rate for TB is currently 31/100,000 people. Although this rate has improved from 21/100,000 people in 2000, there is still significant progress to be made given the estimated incidence of 52/100,000 people.

For people living with HIV who are receiving antiretroviral medication, only 70% remain on treatment 12 months following initiation (compared to a target of reaching 90% treatment adherence in 2017). In the second half of 2016, only 35% of infants born from HIV positive mothers received an HIV test, compared to the target of 70%.

The limited effectiveness of case detection, testing and treatment adherence are due to the following reasons:

Community activities: The community-based organizations and health workers are not used efficiently to systematically follow up people affected by the HIV and TB. Nor do they search for potential new cases. Only 79 TB cases were refered in 2016 from all 252 community-based organizations.

Delays in task shifting: Burkina Faso has introduced the concept of task-shifting, where health care workers in primary health facilities are trained to assume certain responsibilities previously managed at higher levels, such as diagnosing and treating people living with HIV. Although initiated in 2014, the concept has still not been completely rolled out due to, among other reasons, delays in training-the-trainer sessions. Not all health care staff have received training to conduct HIV testing of infants, identify signs of TB, conduct TB testing and properly refer patients to specialist care.

Laboratory capacity: There are only four laboratories in Burkina Faso who can do the polymerase chain reaction test that is used for diagnosing HIV in infants. Three of them are located in the capital Ouagadougou and one in the second largest city, Bobo-Dioulasso. Samples sometimes have to travel a long way to reach the laboratories. The high workload in the laboratories adds to the time it takes for the sample to be analyzed. By the end of 2017, 13 additional laboratories that can test infants for HIV are planned in 11 regions which will help reduce travel times and work load.

Lack of gratuity for HIV follow-up testing: People living with HIV who take antiretroviral treatment have to pay parts of their follow-up testing themselves, which deters some from continuing their treatment.

Weaknesses in case detection, testing and ensuring treatment adherence can lead to increased infection rates, mortality rates and number of patients on second or third line treatments. Several of these weaknesses result from the identified limitations in the use of the community-based organizations and community health workers who play a key role in ensuring both case detection, testing and treatement adherence within their communities.

Weaknesses in data collection, management of data quality, and proper use of data to inform programme management.

Health information data is recorded manually at the primary health facility level and entered in a electronic health data recording and management system. The system used at the district level, Entrepôt de donnees sanitaires du Burkina Faso (ENDOS), is consolidated at the regional level and then sent to the central level for further consolidation. The ENDOS system is based on the DHIS2[23] system and has been implemented throughout Burkina Faso, enabling the country to record, consolidate and analyze health-related data electronically.

While rolling out ENDOS throughout the country is an achievement regarding health data management, weaknesses remain in the quality control of data and its use to inform programmatic management.

Inadequate process for quality control of data

A quality control process for data is in place at the regional level, but not at the primary health facility and district levels. The process of identifying and rectifying data inconsistencies when the data has already passed several levels is complicated and prone to errors. This is mainly due to lack of guidelines at lower levels; missing tools for data quality control; and insufficient training and system limitations.

Quality control guidelines: There are no formal guidelines describing the data quality control process at each level of the health pyramid. The task of data quality control is outlined in the individual terms of references for the person responsible for health data and epidemiological surveillance at regional and central levels in the Directorate for Sectorial Statistics, but not at primary health facility, district or hospital levels. More than half of the 70 districts do not have directives regarding data verification.

Missing quality control tools: Tools for verifying data quality exist at the central level in the Directorate for Sectorial Statistics. Other actors such as the Principal Recipients, sub-recipients, regional health departments or those at the health district level do not have access to tools to verify data quality and coherence. According to an audit of data quality conducted by the Directorate for Sectorial Statistics, the error rate between data reported in manual monthly reports and data reported in ENDOS is 35%.[24]

Limited review of data at lower levels: Data anomalies are not corrected at primary health facility or district levels, but are only reviewed at the central level. Although the ENDOS system checks for data coherence to spot anomalies when data is entered into the system, it does not prevent such data anomalies from being transmitted to higher levels in the system. Instead, data is transmitted with anomalies to the central level, where correcting the data becomes complicated. The data quality audit by the Directorate for Sectorial Statistics reported that at the national level, 63.8% of the submitted data had an error rate of over 10%.[25]

Insufficient training on data reporting: Currently, the staff responsible for health data and epidemiological surveillance at district and regional levels receive training in data recording and collection. However, the training has not been extended to primary health care facilities, where the input of the primary data takes place.

System limitations: The ENDOS system is dependent on a reliable and continuous internet connection in order to upload data. The system does not let the user input data offline which can

[23] DHIS2, is an electronic health management information system implemented in 47 countries
[24] Rapport de l'audit de la qualité de donnés de routine, Direction des Statistiques Sectorielles
[25] Rapport de l'audit de la qualité de donnés de routine, Direction des Statistiques Sectorielles

then be synchronized with the ENDOS system online. Given the instability of the internet connectivity throughout Burkina Faso, especially in rural areas, this poses a challenge for timely and complete data reporting. There is no local server in Burkina Faso to store data (the server is located at the University of Oslo), which means that a stable internet connection is even more important.

The health systems strengthening grant targets weaknesses in data management through the monitoring and evaluation module addressing data completeness in ENDOS and timeliness of reporting. The Global Fund Secretariat aims to further strengthen quality control of data through the health systems strengthening activities in the upcoming grant (starting January 2018). Planned activities include the introduction of routine data quality assessments, strengthening of data validation processes at regional and district level, including quality control of data before it is being entered into ENDOS, and an assessment by the Local Fund Agent on data quality relating to ENDOS.

Limited use of data to inform programme management

Data is used by the Principal Recipients and sub-recipients for quantification purposes, to elaborate progress reports and to inform grant-making processes. However, data is not used to inform daily programme management and supervisions. Nor was there any evidence that different types of data are cross-checked, for example, drug consumption data with patient registers to understand potential leakage of drugs. A Local Fund Agent Spot Check on the data system for logistics information and management conducted in November 2016 noted that, with the exception of the National Tuberculosis Programme, logistics data for malaria and HIV were not analyzed.

Limited use of data to inform program management leads to risks of inefficient program management and low achievement of grant objectives. Lack of mechanisms for quality control of data poses risks of data errors and inaccuracies not being detected, leading to incomplete and/or inaccurate data being used for quantifications and to inform future grant-making. This could lead to grants being less efficient.

Agreed Management Action 2

The Secretariat will work together with PADS to ensure that:

- a clear and transparent procedure for the recruitment and management of sub-recipients and sub sub-reicpients is established; and
- it is clarified in the National Community Strategy how community-based organizations and health workers are involved/used to strengthen TB, HIV and malaria outcomes including the follow up of key programmatic indicators

Owner: Head of Grant Management

Due date: 30 November 2018

4.3. Limited controls for expenditures at regional and district level and gaps in salary allocation internal controls

Controls over travel-related costs and human resources are adequate at Principal Recipients SPCNLS and IPC/BF. *PADS, however, needs to improve controls over regional expenditures, representing 42% of its total in-country expenditure, and its human resources costs.*

Limited financial controls at regional and district levels resulting in ineffective use of program funds and noncompliance with policies.

PADS has strengthened controls of payment processes through direct payments to implementers and suppliers. PADS is also able to release payments directly to 13 regional health departments, 70 districts, 263 community-based organizations, and more than 17,000 community health workers. This good practice ensures that the intended beneficiary receives the payment. Mobile payments are successfully carried out in collaboration with a private mobile phone company that pays directly over 14,000 community health workers. Following this success, the Global Fund Secretariat is currently assessing the possibility of extending this modality to seminars and other training activities to further reduce cash payments.

More than 42 % of PADS in-country expenditure is in the form of payments to regional and district levels and community-based organizations. The verification of this expenditure is assigned to 13 regional accountants hosted in each regional department. Supporting documents remain with each implementer but are verified on a monthly basis by the regional accountants. However, the quality of the controls performed need strengthening. For example, there no consistent and standardized verification approach and the monthly reports produced by regional accountants are inconsistent and do not identify root causes of anomalies. There has been no significant improvement over time in these controls. The regional accountants' salaries are paid by PADS but their reporting line is to the Regional Director, resulting in limited independence.

Gaps in internal financial controls regarding salary allocation and management

Human resources represent 4% of total in-country expenditures for all Principal Recipients. The expenditure is made up of Principal and sub-recipient staff salaries as well as monthly indemnities for community health organizations and volunteers.

All three Principal Recipients have well-trained and qualified staff to execute their roles and responsibilities. There are regular staff evaluations, leave monitoring and adequate controls over salary payments by the accounting units. The OIG, however, noted the following areas that need improvement:

Absence of salary allocation methodology: For PADS, staff salaries are charged to various donors including the Global Fund, depending on the availability of donor funding but not based on an agreed allocation methodology. The audit analysis shows that, for 2016, the Global Fund contributed 37% to total PADS salary costs, compared to the Global Fund grant budget that accounted for 63% of the total PADS budget. On the other hand, for 2017, the Global Fund contributed to almost 57% of total PADS staff costs compared to the grant budget that represented about 25% of the overall PADS budget.

Inconsistency of staff salary management: There is misalignment between the government salary scale applicable to PADS and salaries in staff contracts. For example, five out of 26 staff members have differences between salaries paid (based on contract) and the salary scale as per the applicable rule. The differences range from 10% to 90% and, in each case, the contract amount is higher than the current salary matrix.

For IPC, the OIG noted similar cases where the staff salary is funded by various donors but there is no defined method to allocate the salary across the donors. The current practice is that each staff member is paid by funds from a dedicated donor, which is mentioned in the staff contract. Due to the absence of a timesheet for each employee to track the level of effort dedicated for each donor activity, this poses the risk that donor funds are not equally shared across the donors based on staff actual level of effort.

Agreed Management Action 3

See Agreed Management Action 1

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
The Secretariat, together with PADS (and other main stakeholders as applicable), will develop a comprehensive capacity-building plan to address the weaknesses which have impacted on the efficiency of program implementation of the Global Fund grant funds: • program management, sub-recipient management, monitoring and evaluation; • financial management and internal controls (including in respect of salary allocation, controls at regional/local levels and capacity building for regional accountants); and • PADS budgeting and governance mechanisms. The plan should set out the key strengthening actions as well as establish / identify timelines, responsible entities, indicators and budget needed to achieve such actions.	30 June 2018	Head of Grant Management
The Secretariat will work together with PADS to ensure that: • a clear and transparent procedure for the recruitment and management of SRs and SSRs is established; and • it is clarified in the National Community Strategy how Community-based Organisations and Health Workers are involved/used to strengthen TB, HIV and malaria outcomes including the follow up of key programmatic indicators	30 November 2018	Head of Grant Management

Annex A: General Audit Rating Classification

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

Annex B: Methodology

The OIG audits in accordance with the global Institute of Internal Auditors' (IIA) definition of internal auditing, international standards for the professional practice of internal auditing (Standards) and code of ethics. These Standards help ensure the quality and professionalism of the OIG's work.

The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These help our auditors to provide high quality professional work, and to operate efficiently and effectively. They also help safeguard the independence of the OIG's auditors and the integrity of their work. The OIG's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

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

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

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