



Audit Report

Global Fund Grants in the Republic of the Union of Myanmar

GF-OIG-18-013
7 August 2018
Geneva, Switzerland

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Audit Report

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1. Executive Summary

1.1. Opinion

Myanmar has made significant progress in its efforts to tackle HIV, tuberculosis and malaria. The number of patients on antiretroviral treatment has increased by a factor of 3.7 in less than 8 years, HIV diagnosis among pregnant women is near universal and malaria cases declined by 64% between 2014 and 2017. TB treatment success rate is high at 87%. This programmatic success has been paired with increased financial commitments from the government to fight the three diseases and to widen health care coverage.

However, with this rapid expansion of services, concerns have increased about how best to plan for sustainability, optimize resources, and bridge gaps in service quality. Plans to transition HIV treatment services to government do not yet address critical components on supply chain and human resource requirements. Key populations, such as people who inject drugs, are still not yet effectively reached with services. Moreover, service delivery options and supply chain arrangements are siloed within the three disease programs and across implementers. This limits opportunities to leverage resources such as community health workers and to provide integrated services at health facilities. Finally, there are limitations in assurance and oversight by the Principal Recipients, Country Coordinating Mechanism and Local Fund Agent.

1.2. Key Achievements and Good Practices

Good programmatic performance: Myanmar has made good progress in addressing the HIV, TB and malaria epidemics in the last few years. The number of people on antiretroviral therapy increased from 40,128 in 2011 to 146,826 at the end of 2017. By the end of 2017, over 90% of pregnant women knew their HIV status. AIDS-related deaths fell by 52% between 2000 and 2016.¹ TB treatment coverage was 72% in 2016. Treatment success rates have remained relatively stable at 87% since 2013, and reached 80% among patients with multi-drug resistant TB (MDR-TB) at the end of 2014. A short-course treatment for MDR-TB is being piloted, which is expected to further improve treatment success rates when fully implemented. Myanmar has witnessed a 64% decline in malaria cases, from 205,568 in 2014 to 85,019 in 2017, and a significant decline in malaria-related deaths from 1,707 in 2005² to only 30 at the end of 2017. The country is making progress towards malaria elimination by 2030.³

Increased government financial commitment to the three diseases: The government supports the funding of methadone maintenance treatment and the procurement of antiretroviral medicines and other HIV-related commodities. It also supports the procurement of first and second line anti-TB medicines. The government's strong political commitment to accelerating progress towards universal health coverage will likely be reflected in increased financial support to combat the three diseases. Increased investments from the government will enable donors to focus resources on other aspects of the delivery of HIV, TB and malaria services.

Effective collaboration between government and other stakeholders in the planning and implementation of funded interventions: Ethnic health organizations and key affected populations are actively included in the planning and implementation of HIV, TB and malaria interventions. There is good engagement at the community level in the implementation of the programs, which ensures effective engagement with HIV/AIDS, TB and malaria patients. The country also receives coordinated HIV, TB and malaria related technical assistance from a number of bilateral and multilateral agencies including the United States Government, the Japan International Cooperation Agency, WHO, UNAIDS, UNFPA and UNICEF.

¹ UNAIDS Data 2017, http://www.unaids.org/en/resources/documents/2017/2017_data_book

² Myanmar Malaria National Strategic Plan, 2016-2020

³ Myanmar Malaria National Strategic Plan, 2016-2020

Improved financial controls through measures instituted by the Secretariat and Principal Recipients: The Global Fund instituted the zero cash policy which is implemented by UNOPS through the managed cash flow mechanism. This arrangement has safeguarded Global Fund resources and helped to improve absorption of the grants. In addition, the Principal Recipients have detailed policies and procedures for managing their sub-recipients.

1.3. Key Issues and Risks

Need to optimize resources to enhance impact and maximize effectiveness: There are opportunities to optimize service delivery at the community level. The Global Fund supports over 17,000 malaria health volunteers but this important network is not yet leveraged to support HIV or TB services. Moreover, none of the over 1,600 community outreach workers funded by the grants who provide HIV prevention services for key populations were undertaking HIV testing due to legislative barriers. As a consequence, there is a missed opportunity for task shifting where feasible in light of the shortage of health workers in the country. Only 22% of methadone maintenance treatment centers provide integrated HIV services, despite the high HIV prevalence among people who inject drugs in these sites. Fragmentation also affects supply management with different supply chains for implementers of each disease program. Nevertheless, in many cases, warehouses for all three programs are close to each other, and distribution routes substantially overlap. For example, in Yangon alone there are 13 central/regional warehouses covering the three disease programs within a 21km radius. This scenario may present opportunities to share resources. Efforts to develop an integrated logistics management information system amongst health partners and the government have seen limited movement.

Inadequate access to quality HIV services and limited infection control: 25%⁴ of facilities visited by the OIG had expired kits at the testing site at the time of the visit, which could have resulted in those kits being used. Furthermore, 38% of the facilities visited did not test in accordance with approved HIV testing guidelines. Coverage of key populations is not adequate. For example, less than 45% of people who inject drugs reached by prevention programs were tested for HIV, even though HIV prevalence among this population is 28.3%. Despite the dissemination of TB infection control guidelines for use in facilities offering both TB and HIV services, health workers were not screened for TB at least annually in 46% of the facilities visited.

Gaps in addressing institutional sustainability: Plans to transition treatment of over 26,000 patients on antiretroviral therapy from Non-Governmental Organizations (NGOs) to government providers have not yet addressed risks associated with service delivery and supply chain capability. The National AIDS Program is already facing storage constraints at the central level, and there is uncertainty about the ability of the current government supply system to absorb the increase in patient numbers. An assessment to understand the human resource requirements of this shift had not been done at the time of the audit. The transfer plan lacks description of patient tracking and tracing, which are necessary components of a successful transition. The current transfer practice includes transition of paper-based patient records to destination facilities and transfer forms to monitor patient transition.

Limitations in oversight and assurance: Supervision by Principal Recipients was not carried out consistently due to security challenges as well as grant making and the associated work load, which were appraised by the Secretariat. When supervisory visits to health facilities did take place, written feedback was not consistently provided to the visited sites. Of the recommendations that were provided by auditors and supervisors, a large proportion remain unaddressed. Oversight by the Country Coordinating Mechanism was limited with only one oversight visit conducted in 2016 and 2017. The Secretariat and Principal Recipients acknowledged the oversight gaps and committed to ensuring that the findings of the audit are considered in future oversight of the grants.

⁴ 8 out of 31 facilities providing HIV testing services

1.4. Rating

<p>Objective 1. Adequacy and effectiveness of the implementation arrangements in particular supply chain, use of community workers, data management, and provision of services to ensure efficient and sustainable achievement of grant objectives. OIG rating: Partially effective. The implementation arrangements have supported the delivery of HIV, TB and malaria medicines, commodities and other services to intended beneficiaries. Nevertheless, there is a need to optimize the utilization of resources to enhance impact and maximize cost efficiency.</p>
<p>Objective 2. Effectiveness of systems, processes and controls in place to ensure quality of service to intended beneficiaries. OIG rating: Partially effective. Despite conflicts in parts of the country, good progress has been made in addressing the HIV, TB and malaria epidemics in the last few years. Programmatic achievements include significant increase in antiretroviral therapy, relatively high TB treatment success rate, and material decline malaria cases. However, whilst investments made have supported the scale-up of interventions across all three diseases, access to quality services especially around HIV testing among key population, viral load monitoring and infection control at health facilities remain a challenge.</p>
<p>Objective 3. Adequacy and effectiveness of sub recipient management and assurance mechanisms in safeguarding Global Fund resources. OIG rating: Partially effective. The overall assurance framework has improved since the last OIG audit. There are defined procedures, controls and systems to ensure effective management of the Global Fund resources. However, oversight and assurance over programs require moderate improvements.</p>

1.5. Summary of Agreed Management Actions

The Global Fund Secretariat will work with the Principal Recipients, the MOHS and relevant partners to conduct supply chain assessment to identify key areas of fragmentation and define areas for potential integration. The Secretariat will also work with relevant stakeholders to finalize: an enterprise architecture blueprint for Health Information System Interoperability; and an integrated community case management policy/strategy to address integration and quality issues at the community level. A comprehensive ART transition plan which include all the relevant operational aspects including human resources needed, patients transition timeline, drugs supply chain and patients monitoring will also be developed.

2. Background and Context

2.1. Overall Context




With an estimated population of 55.1 million at the end of 2017, Myanmar is now seven years into a significant political and economic transition. Following 50 years of isolation under military rule, the country opened to the global market under a new administration that took office in 2011. Between 2011 and 2015, important economic reforms led to rapid growth, averaging 7.8%, in gross domestic product (GDP). Reforms unfolded within a stable macroeconomic environment and included exchange rate unification, telecom liberalization, fiscal adjustments, and the lifting of trade restrictions.⁵ The sustained economic growth over the last seven years has helped to lift a significant proportion of the population above the national poverty line, and the country attained lower middle-income status in 2015. Nevertheless, Myanmar remains one of the poorest countries in Southeast Asia.^{6,7} GDP per capita was US\$1,195 at the end of 2016, the lowest among the countries in the Greater Mekong region.⁸ The country is ranked 145th out of 188 countries in the UN Development Program's 2016 Human Development Index, and 130th out of 180 countries in the Transparency International 2017 Corruption Perceptions Index.⁹ Armed conflict, heightened sectarian tension, and vulnerability to natural disasters all present serious challenges for the sustainability of Myanmar's development agenda.¹⁰

Administratively, Myanmar has seven regions, seven states and the Naypyidaw Union Territory.¹¹ Naypyidaw is the country's administrative capital, and Yangon is the largest city and former capital. The country is divided into 73 districts, which are further divided into 330 townships.¹² Health expenditure as a percentage of GDP was 2.3% in 2014.¹³ Myanmar is one of 57 countries classified as having a critical shortage in its health workforce, with only 1.49 doctors, nurses, and midwives per 1000 people. The figure is below the 2.3 global benchmark level that would provide adequate coverage of essential health services.¹⁴

2.2. Differentiation Category for Country Audits

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. Countries can also be classified into two crosscutting categories: Challenging Operating Environments and those under the Additional Safeguard Policy. Challenging Operating Environments are countries or regions characterized by weak governance, poor access to health services, and man-made or natural crises. The Additional Safeguard Policy is a set of extra measures that the Global Fund can put in place to strengthen fiscal controls and oversight in a particularly risky environment.

The Global Fund classifies Myanmar as:

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

⁵ World Bank (2017)-Program Information Document (PID), Myanmar Development Policy Operation, Report AB789

⁶ <http://www.worldbank.org/en/country/myanmar/overview>

⁷ <https://www.adb.org/countries/myanmar/poverty>

⁸ <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MM>

⁹ https://www.transparency.org/news/feature/corruption_perceptions_index_2017

¹⁰ <http://www.worldbank.org/en/country/myanmar/overview>

¹¹ States have large ethnic minority populations and regions are mostly populated by the national majority Burmese.

¹² Thematic report on Labor force, Ministry of Labor, Immigration and Population, June 2017

¹³ <http://www.who.int/countries/mmr/en/>

¹⁴ Myanmar Health_Workforce_Strategic_plan_2012-2017

2.3. Global Fund Grants in Myanmar

The Global Fund has been a partner in Myanmar since 2003, with total grants of US\$781 million signed to date. Of this amount, US\$538 million has been disbursed. The Global Fund terminated investments in Myanmar in 2005 but resumed funding in 2011. In 2013, Myanmar was one of the first countries to apply for support under the New Funding Model¹⁵, which replaced the previous rounds-based funding system. For the 2017-2019 allocation period, the Global Fund allocated US\$206 million for HIV and TB interventions and for health systems building in Myanmar.

The country's malaria funding for this allocation period is managed under the Regional Artemisinin Resistance Initiative (RAI) grant, which covers five countries in the Greater Mekong Sub-region (Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam). Myanmar was allocated US\$97 million out of the total RAI grants of US\$242million. The country received catalytic funding of US\$19.3 million to support HIV prevention among key populations and to strengthen national health management information systems. Catalytic investments are also targeted at finding 50,000 missing TB cases.¹⁶

The United Nations Office for Project Services (UNOPS) and Save the Children Federation, Inc. have been the Principal Recipients for all Global Fund grants in Myanmar since 2011. Each Principal Recipient managed an HIV, a TB, and a malaria grant. The Ministry of Health and Sports, through the national programs for the three diseases, implements the grants as sub-recipients under UNOPS. The six grants that ended in December 2017 are:

NFM Grant Number	Principal Recipient	Grant Component	Grant period	Signed Amount (US\$)	Disbursed to date (US\$)
MMR-H-SCF	Save the Children	HIV/AIDS	Jan-2013 to Dec-2017	118,029,577	113,327,276
MMR-H-UNOPS	UNOPS	HIV/AIDS	Jan-2013 to Dec-2017	98,957,466	89,113,589
MMR-M-SCF	Save the Children	Malaria	Jan-2013 to Dec-2017	28,274,171	27,381,988
MMR-M-UNOPS	UNOPS	Malaria	Jan-2013 to Dec-2017	75,172,419	65,083,434
MMR-T-SCF	Save the Children	Tuberculosis	Jan-2013 to Dec-2017	24,437,385	23,793,102
MMR-T-UNOPS	UNOPS	Tuberculosis	Jan-2013 to Dec-2017	97,041,795	89,458,734
				441,912,813	408,158,123

¹⁵ https://www.theglobalfund.org/media/1467/replenishment_2013newfundingmodel_report_en.pdf?u=63648680736000000

¹⁶ Catalytic investments are for Global Fund-supported programs and activities that are not adequately covered by country allocations but that are essential to achieving strategic aims

2.4. The Three Diseases



HIV/AIDS: Myanmar is one of the 35 countries that account for 90% of new infections globally.¹⁷ It has the second highest number of people living with HIV in the Southeast Asia region.

Prevalence rates among key populations such as female sex workers (14.6%), people who inject drugs (28.5%) and men who have sex with men (11.6%) are higher than the prevalence rate in the general population.¹⁸ It has the highest recorded rate of prevalence for men who have sex with men in Southeast Asia. The country is one of the 30 highest burden TB/HIV co-infection countries in the world.

230,000 people living with HIV¹⁹

146,826 (55%) people currently on antiretroviral therapy²⁰

HIV prevalence among general population is 0.6%²¹



Malaria: Although significant progress has been made in recent years, Myanmar has the highest malaria incidence and burden in the Greater Mekong Region, accounting for 75% of the total malaria cases in the region.²² Malaria cases declined from 205,568 in 2014 to 85,019 in 2017, and malaria-related deaths also declined from 1,707 in 2005²³ to 30 at the end of 2017. The National Malaria Control Program estimates that 291 out of the total 330 townships are located in malaria endemic areas, and that approximately 85% of the population lives in areas where malaria transmission occurs.

11 million insecticide-treated nets distributed between 2014 and 2016²⁴

Annual Parasite Incidence (API): 1.39 in 2017²⁵ (2012: 8.09)



Tuberculosis: Myanmar is one of the 30 highest TB and MDR-TB burden countries in the world. Incidence of all forms of TB was estimated at 361 per 100,000 population in 2016. Multidrug-resistance/Rifampicin TB incidence is 25 per 100,000 population.

TB is the leading cause of death in the country among adults (15-49 years old), and accounts for more than 9% of all deaths. However, mortality due to TB decreased from 133/100,000 in 1990 to 53/100,000 in 2014.²⁶

139,625 TB cases notified in 2016²⁷ (2012: 142,162)

TB treatment success rate: 87% (2015)²⁸

MDR-TB treatment success rate: 80% (2014)

TB treatment coverage: 72% (2016)²⁹

Patients with known HIV status who are HIV positive: 9% (2016)³⁰

¹⁷ UNAIDS Fast Track Update on Investments, 2015

¹⁸ Myanmar HIV National Strategic Plan 2016 – 2020 (page 20)

¹⁹ <http://www.unaids.org/en/regionscountries/countries/myanmar/>

²⁰ Unverified HIV PUDR (UNOPS) July to December 2017

²¹ Strategic plan for HIV/AIDS and STI Prevention and Control in the Health Sector 2016-2020

²² PMI 2018 Burma country Operational Plan

²³ Myanmar Malaria National Strategic Plan, 2016-2020

²⁴ Global Malaria Report 2017 (page 7)

²⁵ Unverified PUDR July to December 2017 (UNOPS)

²⁶ Myanmar National TB Strategic Plan, 2016-2020

²⁷

https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=MM&outtyp e=PDF

²⁸ Ibid

²⁹ Ibid

³⁰ Ibid

3. The Audit at a Glance

3.1. Objectives

The audit sought to provide assurance that grants to Myanmar are effective in supporting the achievement of impact in the country. Specifically the audit assessed the:

- adequacy and effectiveness of the implementation arrangements, in particular supply chain, use of community workers, data management, and provision of services to ensure efficient and sustainable achievement of grant objectives;
- effectiveness of systems, processes and controls in place to ensure quality of service to intended beneficiaries; and
- adequacy and effectiveness of sub-recipient management and assurance mechanisms in safeguarding Global Fund resources.

3.2. Scope

The audit covered the period from January 2016 to December 2017. Where relevant, the period was extended to enable the auditors to assess progress made by the implementers in addressing identified issues. The audit covered both Principal Recipients of Global Fund grants in Myanmar. It focused on HIV/AIDS and tuberculosis supported interventions. The malaria grant was reviewed as part of the OIG's audit of the RAI grant. The malaria-related key findings will be reported in the audit of Global Fund Regional/Multi-country grants report, which will include the findings from the RAI audit.

Scope limitation

The United Nations General Assembly has adopted a series of resolutions and rules in a framework known as the "Single Audit Principle". Under this framework, third parties are not allowed to access books and records of the United Nations and its subsidiaries. All audits and investigations are conducted by the UN's own oversight bodies and the Global Fund accepts and relies on the resulting assurances. Accordingly, the OIG team did not audit the internal controls and processes (including expenditures) of the Principal Recipient, UNOPS. The audit included the sub-recipients of UNOPS. There was however limitation in the number of financial transactions of the three national disease programs that the OIG could test because UNOPS operate and manage their transactions under the "zero cash policy", and OIG is limited by the "20/130 Transaction Rule".³¹

The audit included site visits to selected health facilities, treatment centers, warehouses and stores. Due to travel restrictions and security concerns in parts of the country, site visits were limited to seven out of the 15 states/regions, which represent 59%, 63% and 32%, respectively, of HIV, TB and malaria patients in June 2017.

3.3. Progress on Previously Identified Issues

The last OIG audit of grants in Myanmar was conducted in 2014. The main weakness identified concerned financial management and supply chain management. The current audit noted improvements in financial management, largely due to the strengthening of internal financial controls at the sub-recipient level. However, oversight and assurance over the portfolio continue to be a challenge (see section 4.4).

Previous relevant OIG work
[Audit of Global Fund grants to Myanmar, 2014](#)

[Diagnostic Review of Global Fund Grants to the Republic of the Union of Myanmar, 2012](#)

There has been some improvement in the supply chain management of the portfolio including improvement in the storage conditions of commodities and significant reduction in stock-outs and

³¹ The "20/130" Transaction Rule" is a verification framework where up to twenty (20) individual expenditure transactions can be sampled from one hundred and thirty (130) transactions for verification.

expiries. However, there are still gaps in addressing the fragmentation in the supply chain arrangements (see section 4.1).

4. Findings

4.1. Service delivery arrangements need improvement in terms of operational efficiency and resource optimization

Despite conflicts and travel restrictions in parts of the country, the implementation arrangements have helped implementers to deliver HIV, TB and malaria medicines, commodities and other services to intended beneficiaries. Nevertheless, there is a need to optimize the utilization of resources to enhance impact and maximize cost efficiency.

Suboptimal integration of HIV, TB and malaria services: The potential of community workers and facilities to positively affect health outcomes is not fully leveraged:

- The more than 17,000 malaria health volunteers funded by the grants provide no HIV or TB services, even in high burden areas. The National Malaria Control Program is working on training the malaria health volunteers and transforming them into integrated community malaria volunteers to be able to provide TB, HIV, Leprosy and Dengue related services.
- Over 1,600 grant-funded community outreach workers provide HIV prevention services for key populations but do not conduct HIV testing. Until recently these outreach workers were not authorized by country regulations to undertake HIV screening testing.
- Over 3,800 community outreach workers test for TB but they only provide symptom-based TB screening services and do not collect sputum samples.
- 22% of the methadone maintenance treatment centers provide comprehensive HIV services despite the high HIV prevalence among people who inject drugs at these sites.
- 43% of facilities that diagnose multi-drug resistant TB do not initiate patients on treatment. The cost of traveling to treatment sites in other locations than where they are diagnosed limits access to treatment for multi-drug resistant TB patients.
- Although all antenatal care facilities in Myanmar offer HIV testing for pregnant women, only 301 of the over 5,000 health facilities provide antiretroviral therapy due to the differentiated service delivery model.

A contributing factor to the sub-optimal integration is that national partners implementing HIV, TB and malaria interventions have not undertaken an assessment to explore how utilization of community health workers across all three diseases can be optimized in the various townships, based on disease epidemiology and public health principles and approaches. In addition, there is also no national community health worker strategy and investment plan, although a literature review has recently been undertaken by the Ministry of Health and Sports with a view to inform the development of such a plan. The Government has also established a village-based health workers working group to ensure the development and implementation of this plan.

This has had consequences for treatment enrollment, which was delayed for 21% of patients diagnosed with multi-drug resistant TB in 2016. Among patients infected with both HIV and TB, 42% did not receive antiretroviral therapy that year. The figure rose to 45% in 2017. Also, 21% of HIV-positive pregnant women did not receive antiretroviral therapy in 2017.

Complex and fragmented supply chain arrangements: The Global Fund has been able to utilize the existing supply chains of implementers in recent years to distribute commodities to some of the hardest to reach communities in Myanmar. These supply chain arrangements have also helped the grants utilize increasing amounts of TB and HIV commodities, which have grown by 385% and 194% in value between 2013-2017, with no significant stock outs and expiries noted during the audit. This is despite widespread conflict and access challenges. However, supply chain arrangements, including warehousing, distribution and logistics management information systems (LMIS) under Global Fund supported programs, are along implementer and program funding lines (i.e. HIV, TB and malaria). This contributes to increasing the work load of an already overstretched and under resourced workforce, and may lead to duplication and inefficiencies in storage and distribution and

therefore drive up the overall operating cost of the supply chain. It also limits opportunities for supply chains to be optimally managed, especially considering the capacity challenges now being faced by the national disease programs at the central level.

The three national disease programs share a similar warehouse footprint and distribution network. For example 84% of central and regional warehouses of the National Malaria Control Program (NMCP) are in the same township as the National TB Program (NTP) and National AIDS Program (NAP) warehouses and 78% of NAP distribution routes mirror NMCP/NTP routes, representing opportunities to optimize going forward. For example, in Yangon there are 13 central/regional warehouses separately run by the three national disease programs within the same 21km radius. This includes three outsourced warehouses rented at a total cost to the grants of US\$0.5 million over the next 3 years. However, the current warehousing arrangements have not been informed by solid data points around utilization of space. Logistic Management Information Systems (LMIS) of health partners and Global Fund implementers are also fragmented. Table 1 illustrates the different LMIS used by partner organizations within Myanmar’s health sector. There have however been advancements in rolling out electronic LMIS, albeit fragmented. The electronic LMIS system, mSupply, has been rolled out to over 65 regional/state warehouses managed by the national programs, helping with improving reporting and stock analysis.

Table 1: LMIS in the health sector

Name of system	Funded by	Used for:
Zulu	MOHS	Essential Medicines at all levels
mSupply	3MDG	Essential Medicines at Township level in 3 states
Logisitimo	UNFPA	Reproductive Health at Township level
mSupply	DFID/BM GF	Regional warehouses for NAP/NMCP/NTP

This fragmentation is due in part to the fact that, despite the country developing a national supply chain strategy in 2015, there is still no operational plan to roll out and implement this strategy. The National Supply Chain Task Force, which was created to ensure the implementation of the strategy, was inactive in 2017, and the Myanmar Health Sector Coordination Committee Technical Strategic Group on Health System Strengthening only met twice during 2016 and 2017 and did not discuss supply chain integration. Limited partner coordination on health systems strengthening including supply chain, and the absence of a consolidated map of supply chain interventions also contributed to the fragmentation.

The Ministry of Health and Sports did not have a ministry-wide dedicated procurement and supply management (PSM) unit until the last quarter of 2017 and there are limited PSM human resources in place³². Both issues have contributed to the fragmented supply chain system. There has been no agreement by the Government on a preferred national LMIS system and timelines to roll it out, resulting in the roll out of different LMIS by various partners. Within the ministry, the Department of Public Health manages the supply chain for health facilities while the Department of Medical Services manages the supply chain for hospitals and clinics. This division of responsibility impacted the ability for crosscutting decisions to be made on PSM issues.

Agreed Management Action 1

The Global Fund Secretariat will work with the Principal Recipients, the MOHS and relevant partners to conduct a comprehensive supply chain assessment to identify key areas of fragmentation and define areas for potential integration.

Owner: Head, Grant Management Division

Due date: 31 December 2019

³² The PSM unit at the central level only had 13 staff members at the time of the audit but the requirement was 60

4.2. Access to services and infection control need improvements.

Global Fund investments in Myanmar have significantly contributed to the scaling-up of key interventions across the three disease programs. The interventions are strategically focused on relevant key populations and are informed by available epidemiological and programmatic data. For example with respect to HIV, the country is implementing a differentiated service delivery approach based on township HIV disease classification. This has resulted in a 266% increase in the number of people living with HIV on treatment between 2011 and 2017. However, ensuring that quality services are available and accessible remains a challenge.

Gaps in HIV testing coverage among key populations: Key populations include men who have sex with men, people who inject drugs, sex workers, and transgender people. Because these groups are often criminalized or otherwise marginalized, they face greater barriers to accessing HIV services than the general public. Despite these challenges, the provision of preventive services to key populations consistently increased over the audit period.³³ National actors including CSOs and partners have also engaged in advocacy efforts to strengthen an enabling environment for HIV programming among key populations. However, there have been challenges in translating this reach to an uptake in HIV testing for the various key populations reached in 2017. For example, implementers tested less than 44% of people who inject drugs reached, although the prevalence among this population is 26.3%. The low test ratio represents a missed opportunity for early diagnosis and timely initiation of antiretroviral therapy.

During the period under review, HIV testing could only be performed by trained health workers and not community outreach workers, which contributed to the low testing coverage. This situation is expected to change as community outreach workers have recently been authorized to undertake HIV screening.

Gaps in quality of HIV testing: Access to HIV testing services has expanded for key and vulnerable populations, and pregnant women: 988,773 people belonging to key and vulnerable populations were tested in 2016, and 1,208,830 were tested in 2017. However, HIV testing did not always comply with the national guidelines. Twenty-five percent³⁴ of facilities visited during the audit had expired test kits at the testing site at the time of the visit, which could have resulted in those kits being used. This practice increases the risk of incorrect diagnosis and treatment. Furthermore, 38% of the facilities visited did not perform HIV testing in accordance with approved HIV testing guidelines.

Some of the contributing factors include availability of HIV testing guidelines, limited external quality assurance (EQA) and inadequate supervision at the facilities. For example, 17% of the facilities visited did not have HIV testing guidelines, whilst 85% of the facilities visited that offered HIV testing services had not participated in the national EQA scheme for HIV testing. This is due to inadequate funding by implementers to enroll all of the facilities on the scheme as well as lack of capacity of the National Health Laboratory (NHL) to undertake EQA at the scale and coverage required. In addition, there is no national certification and proficiency testing for individual HIV testing providers. About 58% of the facilities visited that offered HIV testing services had not received HIV testing related supervision in the previous six months. Where supervision was conducted, no feedback was provided. Principal Recipients are collaborating with the Australia National Reference Lab (NRL), which is building the capacity of NHL with the support of US-CDC. The objective of this effort is to enroll HIV Testing and Counselling (HTC) sites of both principal recipients in their international EQA scheme, until NHL has sufficient capacity to provide EQA for all HTC sites in Myanmar.

³³ In 2017, the principal recipients reached 54,020 MSM, 58,486 FSW and 42,494 PWID

³⁴ 8 out of 31 facilities providing HIV testing services

Issues noted in monitoring of patients on HIV treatment: Viral load testing³⁵ is the standard for monitoring people living with HIV on treatment. Although viral load suppression is high (92%) for those tested, only 30% (38,220 out of an estimated 127,402) of those on treatment had a viral load test in 2016. Viral load monitoring coverage in 2017 was 35% in the 25 facilities that offered antiretroviral therapy services visited by the OIG. It was only in 2017 that the country transitioned from targeted to routine viral monitoring. This is due to inadequate human resource capacity, both in quantity and quality, for laboratory services to support viral load testing at all levels, from the National Health Laboratory at the central level to regional and township level laboratory personnel. Inadequate sample transportation arrangements also limit utilization of the existing viral load testing capacity. A comprehensive, costed and results-focused strategy for scaling up viral load monitoring was being developed at the time of the audit. This strategy is expected to address the gaps noted and optimize the use of available equipment.

Gaps in infection control in facilities that offer HIV and TB services: The TB/HIV co-infection rate in Myanmar is 9%, one of the highest in Southeast Asia. The National TB Program has distributed TB infection control guidelines for use in facilities offering TB & HIV services. The OIG assessment of 39 facilities offering HIV and/or TB services found that, contrary to these guidelines, 46% of the facilities did not systematically screen their health workers for TB at least annually, and 44% had not provided their health workers with refresher training in infection control in the past year. Over 48,500 people living with HIV on treatment and other immunity-compromised patients visited these facilities in 2017, and these gaps create an environment for TB to spread in health facilities among patients, health workers and the community. The gaps in infection control are attributable to unavailability of guidelines at the facilities as well as inadequate financing. For example, 28% of facilities visited did not have TB infection control guidelines, and infection control measures could not be consistently implemented due to unavailability of financing from the Government. The Principal Recipients are working with the National TB Program to continue the distribution of TB infection control guidelines to facilities offering TB & HIV services. Over time, this is expected to address the noted gaps in infection controls.

Inadequate monitoring of adverse drug reactions and medical waste disposal: Medicines and commodities financed by Global Fund grants are procured from WHO-prequalified suppliers. There are also in-country mechanisms to routinely monitor the quality of medicines across the supply chain in line with Global Fund requirements. However, Myanmar does not have systematic measures to detect, assess, understand, report and prevent adverse drug reactions (ADR) or other drug related problems for HIV, TB and malaria medicines. Although all 50 facilities visited identified HIV, TB and malaria ADR, only 6% had forms to monitor and report ADRs and 4% used these forms to report on ADR. Only 24% of the facilities visited had been trained on ADR. The Food and Drug Administration has no formal system in place at the central or regional level for monitoring ADR. It has a tool on ADR monitoring (on its website), but service providers have not been trained to use it. Due to the limited availability of grant resources, ADR monitoring has also not been prioritized. Although the TB grants included funds to monitor ADR, there are no funds for ADR in the HIV and malaria grants. The Secretariat is working with in-country stakeholders to conduct a pilot on ADR monitoring. Successful completion of the pilot and implementation of this monitoring would address this issue.

No national guidelines on medical and pharmaceutical waste management, including disposal, have been developed, leading to ad hoc disposal methods by health facilities. Save the Children has distributed WHO waste management guidelines to sub-recipients but these are not fully complied with. For example, 59% of facilities visited disposed waste on site. Sixty-three percent (63%) of health facilities visited had received no training on waste management and disposal, and 74% of facilities visited lacked tools for reporting waste management. The poor management of pharmaceutical and lab waste may expose health workers, waste handlers, patients and the community at large to

³⁵ A viral load test measures the number of HIV viral particles per millilitre of blood. A low viral load indicates that treatment is effective. A high viral load in a person on treatment indicates either that the medication is not being taken properly or that the virus is becoming resistant to the medication.

infection, toxic effects and injuries. This issue is being addressed as part of an initiative already undertaken by the Work Bank working with the Ministry of Health and Sports to develop national waste management guidelines.

Conflict affected areas in Myanmar: States with on-going conflicts in Myanmar pose a challenge for program implementation. Global Fund investments are expected to be tailored to the specific context, with flexibility to rapidly respond to changing environments. Countries facing humanitarian and other crises and emergencies are expected to work with in-country stakeholders and partners to identify potential suitable options to implement the grants when situations escalate in acute emergency and volatile settings. Some states with active conflicts such as Rakhine and Kachin face a high burden of malaria and of HIV. Since August 2017, the humanitarian crisis unfolding in Rakhine has displaced more than 0.7 million people (about 23% of the population in Rakhine state) to neighboring Bangladesh. Myanmar was considered and excluded from the Global Fund's list of Challenging Operating Environments for the 2017-2019 allocation period, as the Secretariat considers the policy to apply at the country level rather than to individual regions. Whilst a formal emergency response plan for North Rakhine was not deemed necessary or practical, the Secretariat did undertake various service delivery activities in neighboring Bangladesh in response to the crisis, including deployment of additional community workers, laboratory resources and malaria commodities.

Agreed Management Action 2

The Global Fund Secretariat will work with the Principal Recipients, the MOH and relevant partners to finalize an integrated community case management policy/strategy.

Owner: Head, Grant Management Division

Due date: 31 December 2018

4.3. Improvement needed to address institutional sustainability of the three disease programs

The government of Myanmar has progressively increased its investments in the national response to HIV, TB and malaria. These investments will likely increase further given the strong political commitment to accelerating progress towards universal health coverage.³⁶ The National Health Plan developed by the government, among others, also focuses on ensuring access to essential health services for the entire population. However, gaps in overall institutional capacity may affect the sustainability of the response.

Gaps in capacity building arrangements for the three national disease programs: The Global Fund's approach to sustainability and transition is based on the central premise that planning for sustainability should be inherent in program design and taken into account by all countries regardless of where they sit on the development continuum. The Secretariat is expected to align requirements to ensure that Global Fund financed programs can be implemented, as much as possible, through country systems in order to build resilient and sustainable systems for health.³⁷

Myanmar represents a good example of close collaboration between government and non-governmental organizations in the response to the three diseases. Despite the human resource challenges, the Principal Recipients have worked with the government to progress significantly against the three diseases in the country. Capacity at the national disease programs however remains a challenge. An overarching capacity development plan was developed by the Myanmar Health Sector Coordinating Committee (MHSCC) in February 2016 in response to a requirement in the grant agreement to build the capacity of national programs. This plan was not implemented by the Ministry of Health and Sports and the Principal Recipient, UNOPS. Another implementation capacity development plan for the national disease programs was developed by UNOPS, but it was not informed by an in-depth baseline assessment of the programs. A comprehensive assessment of the capacity of the national disease programs to administer the three programs has not been performed since 2010. Despite an investment of US\$1.2 million in 2016 and 2017 for capacity building, there is no mechanism for systematically tracking activities related to this goal.

UNOPS's efforts in this direction have been limited due to human resource gaps and turnover at the national disease programs. The 2018-2020 grants include over US\$0.6 million for capacity building activities. However, the activities themselves were not fully specified. In addition, roles and responsibilities over this funding between the key stakeholders including the Principal Recipient and the Ministry of Health and Sports are yet to be defined.

Inadequate transition arrangement to move HIV care, support and treatment services from NGO to government facilities: The transitioning of HIV treatment services from Non-Government Organizations to government facilities will enhance service sustainability. There is a quantitative plan (developed in 2017) that outlines the number of patients on treatment to be transitioned as well as the expected timelines for the transition. However, some programmatic and supply chain risks are yet to be addressed in the plan. The current plan does not yet address the tracking and tracing of patients to support treatment retention. In addition to the patients it already serves and its own targets going forward, the National AIDS Program will also absorb 26,000 patients formerly treated by NGOs. A full assessment to understand supply chain needs in view of this increase has not been completed despite the program already facing capacity constraints and utilizing outsourced space.

Under the new arrangement, public health facilities will provide antiretroviral therapy to large numbers of high-risk patients, including key populations. A correspondingly large number of health workers will therefore need specialized training to work with these and other patients. An assessment

³⁶ Myanmar National Health Plan, 2017-2021

³⁷ The Global Fund Sustainability, Transition and Co-financing Policy 2017 (GF/B35/04) –pages 4&5

of the number and types of staff required to meet the increased patient load had not been undertaken at the time of the audit.

Without effective planning, a transition on this scale could compromise the quality of services and increase the risk of treatment disruption and patients lost to follow-up. The delays in developing the plan to address these qualitative issues was due to a protracted grant making process where targets and resources for antiretroviral therapy were to be agreed. Until the grant making process was complete, with a funding envelope and commitment from both the government and the Global Fund, the plan could not be finalized.

Delayed development of strategic policies and plans for data management systems:

There has been significant investment³⁸ in health information systems but persistent issues around human resources continue to impact progress. The Global Fund is supporting the rollout of an array of health information platforms with a view to having a complete and interoperable network of systems to ensure seamless data management for health interventions. These systems include DHIS 2 for aggregate reporting, MS Access for malaria surveillance and OpenMRS for case based reporting in TB and HIV. DHIS 2 for essential health indicator reporting was rolled out nationwide in less than two years and over 96% of all townships were reporting essential health indicators at the end of 2017. Global Fund investments have also pushed forward innovative technological solutions like the ‘Malaria Case-based Reporting App’. This app is designed to improve adherence to treatment guidelines, reduce reliance on inefficient paper reporting and enable GPS mapping of malaria incidents to assist with elimination. These advancements are notable for a country where only 1% of the population used mobile phones and zero percent used the internet eight years ago.³⁹ However, despite ambitious investment in new systems, mechanisms to ensure their sustainability and interoperability are yet to be developed.

The Global Fund Technical Review Panel recommended the development of a sustainability plan with clear timelines and steps for the country to absorb recurrent operating costs⁴⁰ over time. This plan, which was to be completed during grant making (i.e. before December 2017), had not yet been developed at the time of the audit. The Global Fund investment in the system may not be sustainable without clarity on how the operational costs will be financed over time. Likewise, a ‘Blueprint for Interoperability’⁴¹ between the different systems, including those supported by the Global Fund, was to be completed by December 2017. This too has been delayed and there is no revised timeline on when it will be completed. Interoperability between the different systems is a key aspect of their effectiveness and sustainability.

Significant gaps in human resources for data management at the Ministry of Health and Sports contributed to the delays in the development of these key plans. There are only 28 people working in the HMIS Division of the ministry compared to the headcount of 204 as per the initial Ministry of Health and Sports needs assessment. Furthermore, roles and responsibilities over the various health systems, infrastructure, and data ownership are still fragmented across different programs and divisions within the Ministry of Health and Sports. This affected the necessary leadership needed at the national level to move forward with the development of these key plans, to ensure long term sustainability of the HMIS investments. At the time of the audit, the MOHS was undergoing a comprehensive restructure that would re-define roles and responsibilities of the divisions.

³⁸ US\$16m was budgeted for Health Information Systems and M&E in the Myanmar NFM grants from 2016-2017.

³⁹ Statistics on mobile phone and internet usage have been taken from World Bank Development Indicators for Myanmar for 2010.

⁴⁰ The recurrent operating cost include salaries of core staff, equipment, supplies, maintenance and operations including supportive supervisions.

⁴¹ The Blueprint would articulate the required IT landscape to ensure alignment and interoperability between all the different HMIS systems to keep to the requirements of the National Health Plan and Strategy for Health Information. It will also ensure that all investments were interoperable and thus are sustainable and ensure an efficient HMIS system.

Agreed Management Action 3

The Global Fund Secretariat will work with the Principal Recipients, the National AIDS program and partners to assess the current national ART treatment and supply chain capacities and needs for the transfer of ART patients from the civil sector providers to public health facilities. Based on the findings, a comprehensive ART management plan, which will include all the relevant operational aspects including; human resources needed, patients transition timeline, drugs supply chain and patients monitoring, will be developed.

Owner: Head, Grant Management Division

Due date: 31 December 2018

Agreed Management Action 4

The Global Fund Secretariat will work with the Myanmar Health Sector Coordinating Committee, Ministry of Health and Sports, WHO and Principal Recipients to finalize the 'Enterprise Architecture Blueprint for Health Information System Interoperability'.

Owner: Head, Grant Management Division

Due date: 31 December 2018

4.4. Improvement needed in program oversight and assurance

The Principal Recipients have instituted measures that have improved the financial and program management of the grants. There are defined procedures, controls and systems to ensure effective management of Global Fund resources. However, oversight and assurance over programs remain a challenge although, for all issues noted below, the Secretariat has already initiated corrective actions which, if implemented successfully, will remediate the noted gaps.

A. Gaps in supervision and oversight by Principal Recipients

Limited supervision of sub-recipients and facilities: Oversight functions closer to service delivery areas are essential for effective monitoring and proper implementation of programmatic activities. The Principal Recipients are providing supportive supervision and technical assistance to address capacity gaps at sub-recipient and facility levels, which has resulted in improved program performance. However, supervision visits and internal oversight are below the planned levels. Save the Children performed only 51% of the visits planned in 2016 and 2017; in hard-to-reach areas, only 41% of planned visits were carried out. In addition, 54% of facilities visited did not receive written feedback from Principal Recipients following their supervisory visits. Only one internal audit has been performed by Save the Children in the last three years and it did not include the sub-recipients of Global Fund grants.

Suboptimal supervision and oversight of sub-recipients and facilities contributed to some of the issues noted under section 4.2 of this report. The Principal Recipients' ability to conduct supervisory visits was affected by security concerns in parts of the country, which led to cancellation of some planned visits. Grant making work on the 2018-2020 grants and the RAI malaria regional grant also led to the Principal Recipients not undertaking some planned visits.

Delayed resolution of issues identified in audits and supervisory visits: Save the Children uses a Microsoft Access-based system to track implementation of recommendations from supervision visits, and their sub-recipients are required to give a biannual update on the resolution of recommendations. However, at the time of the audit, 52% of the recommendations following supervisory visits by Save the Children had not been addressed. Of those outstanding recommendations, 54% were rated high priority. In some cases recommendations were not implemented due to a lack of available funds in the budget. Other recommendations required changes in the sub-recipient's operational policy, for which they were awaiting approval from their respective head office. UNOPS did not apply a risk rating to their findings. This makes it more difficult to rank the resolutions in order of priority.

Significant delays in the submission of reports: Although the Principal Recipients sent the necessary reports required to the Secretariat, those reports including external audit reports and progress update and disbursement requests (PU/DRs) were submitted late. Submission of PU/DRs was delayed by an average of 110 days (up to a maximum of 158 days) and external audits reports were late by about 41 days on average by UNOPS. Late reporting affects timely identification and effective mitigation of risk in the portfolio. Changes in the UNOPS accounting software contributed to the delays, as did a change in the PU/DR reporting template.

The Secretariat acknowledged the above issues and committed to monitoring the supervision plans and management actions/recommendations from reviews/audits to ensure they are implemented as planned.

B. Limited oversight by the Country Coordinating Mechanism

The Country Coordinating Mechanisms (CCMs) are central to the Global Fund's commitment to local ownership and participatory decision-making. In addition to developing concept notes and overseeing grant implementation, CCMs play an active role in engaging stakeholders, aligning Global Fund grants with other national health programs, and contributing to national strategy

discussions.⁴² The Myanmar CCM (the MHSCC) is integrated into national structures, and has a broad mandate as a national coordinating body for all public health sector issues.⁴³ It is a good example of a well-designed CCM, with representatives from all key stakeholders including people living with the diseases. However, due to resource constraints the MHSCC played a limited role in on-site monitoring visits. It conducted only one oversight visit in 2016 and 2017. The Secretariat is working with partners and the Ministry of Health and Sports to support the MHSCC's activities including oversight. Oversight visit to facilities in hard-to-reach areas is planned in July 2018.

C. Limited oversight by the Local Fund Agent

Although the Myanmar portfolio is classified as high impact with significant risks, there were limited finance and supply chain spot checks by the LFA during 2016 and 2017. The LFA only performed a limited number of spot checks in 2016 & 2017, resulting in only 44% and 15% respectively of the relevant budget being utilized. In 2017, it took an average of 100 days (maximum of 223 days) between the expected and actual reporting dates of spot check reports to the Country Team. Submission of PU/DR reports to the Secretariat was delayed by 82 days on average, instead of the required timeline of two weeks.

The emphasis placed on grant making activities in 2016 and 2017 by the Country Team limited the LFA's ability to perform assurance activities. Lack of an in-country LFA team leader to coordinate LFA activities in 2016 was another factor. A team leader was appointed in 2017, and spot checks have been included in the 2018 LFA work plan. The Secretariat will continue to monitor the LFA's performance through the LFA performance evaluation tool.

An agreed management action was not deemed necessary because appropriate oversight arrangements including supervision plans are already in place. The Secretariat has committed to ensuring that the findings of the audit are considered in future oversight of the grants.

⁴² <http://www.theglobalfund.org/en/ccm>

⁴³ <http://www.myanmarhsc.org/>

5. Table of Agreed Actions

Agreed Management Action	Target date	Owner
The Global Fund Secretariat will work with the Principal Recipients, the MOHS and relevant partners to conduct a comprehensive supply chain assessment to identify key areas of fragmentation and define areas for potential integration.	31 December 2019	Head, Grant Management Division
The Global Fund Secretariat will work with the Principal Recipients, the MOH and relevant partners to finalize an integrated community case management policy/strategy.	31 December 2018	Head, Grant Management Division
The Global Fund Secretariat will work with the Principal Recipients, the National AIDS program and partners to assess the current national ART treatment and supply chain capacities and needs for transfer of ART patients from the civil sector providers to public health facilities. Based on the findings, a comprehensive ART management plan, which will include all the relevant operational aspects including; human resources needed, patients transition timeline, drugs supply chain and patients monitoring, will be developed.	31 December 2018	Head, Grant Management Division
The Global Fund Secretariat will work with the Myanmar Health Sector Coordinating Committee, Ministry of Health and Sports, WHO and Principal Recipients to finalize the 'Enterprise Architecture Blueprint for Health Information System Interoperability'.	31 December 2018	Head, Grant Management Division

Annex A: General Audit Rating Classification

<p>Effective</p>	<p>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.</p>
<p>Partially Effective</p>	<p>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.</p>
<p>Needs significant improvement</p>	<p>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.</p>
<p>Ineffective</p>	<p>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.</p>

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 documents 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 at the Global Fund as well as in country, 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.