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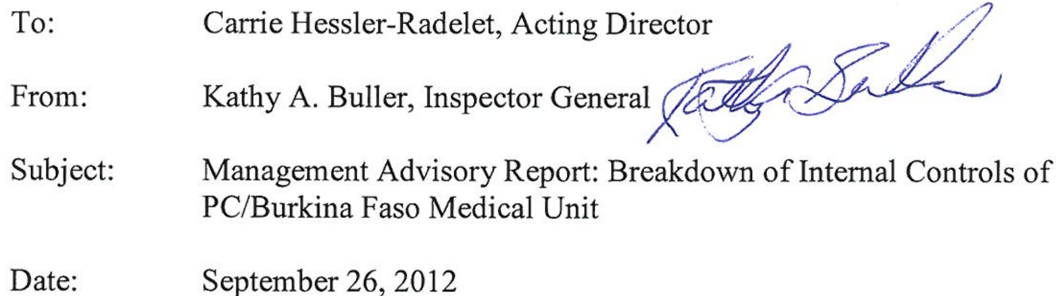

To: Carrie Hessler-Radelet, Acting Director

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Breakdown of Internal Controls of PC/Burkina Faso Medical Unit

Date: September 26, 2012

This purpose of this memorandum is to bring to your attention the serious consequences that can result from the lack of internal controls associated with Peace Corps business processes, specifically those surrounding medical supplies. The lack of internal controls over medical supplies has been a reoccurring issue identified in OIG audits from 2009 to 2011.[1]

OIG received information from the Peace Corps Office of Medical Services (OMS) that Peace Corps/Burkina Faso (hereafter, "the post") had a number of abnormalities associated with the operation of its medical unit. In a spot review OMS identified 14,065 individual unit differences for 31 unique medicines (including seven controlled substances) in the medical supply inventory submitted by the post's director of management and operations (DMO). In addition, the post had the fourth highest medical costs per Volunteer-year in the Africa region. These conclusions were based on a cumulative analysis of the four prior medical supply inventory submissions of by all posts.

Since it was difficult to determine the root cause of the discrepancies, our review was conducted by an interdisciplinary team, consisting of an auditor and the assistant inspector general for investigations (AIG/I). We were accompanied by a representative from OMS and benefited greatly from her expertise. We conducted a site visit from June 27 to July 10, 2012 to identify the cause of the discrepancies and to determine whether the post had effective controls over medical supplies. During our visit we attempted to perform a physical count of medical supplies, including controlled substances and specially designated items.[2] However, we discovered that a meaningful physical inventory was not possible given that the post failed to record an accurate beginning inventory of medical supplies and critical documentation was lacking. Instead, we focused on staff interviews, data analysis, and reviewing a selected sample of the physical inventory.

[1] Reoccurring Issues: Fiscal Years 2009 - 2011

[2] Specially designated items are items that are of high value, pilferable, or otherwise deserving of special attention.

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We found that the post's medical supplies inventory did not comply with basic Peace Corps policies. The post's noncompliance with essential controls resulted in waste and diversion of medical supplies and likely placed Volunteers at risk. The post's noncompliance with Peace Corps' medical supply policies described in *Peace Corps Manual* section (MS) 734 and *Medical Technical Guideline* 240 is particularly flagrant given OMS's medical training in May 2012 and OIG's recommendations from its October 2009 post audit. The audit highlighted concerns about a lack of separation of duties, inventory discrepancies, and no documented quarterly medical supply inventory. The post reportedly took corrective actions. However, our recent visit found that controls were still not in place and operating effectively.

We believe the discrepancies identified by OMS and the high cost of medical supplies in PC/Burkina Faso was the result of the CD's inadequate oversight, poor controls, and the disregard by PCMOs and other staff for essential Peace Corps policies. We noted that the post:

- Lacked an effective process of tracking medical supplies to prevent their misappropriation and improper dispensing. Without completing an accurate medical supply inventory workbook, the post did not have the information necessary to identify discrepancies during physical inventory count. Further, the post did not limit access to controlled and specially designated drugs. Post also failed to properly document controlled substances in the Drug Enforcement Agency (DEA) logbook.

- Permitted a non-medical staff member to dispense medical supplies, including specially designated items that require a medical prescription, and instituted a procedure whereby Volunteers freely requested and received such medical supplies without proper consultation with a medical doctor or checking of Volunteer medical charts and records. This increased the risk that Volunteers may not have received adequate medical care, and put their health in jeopardy.

- Did not fully document the transfer of medical supplies from PC/Niger and did not conduct a proper transfer of excess medical supplies to the U.S. Embassy. In doing so, the post circumvented controls by diverting medical supplies to a private entity as a donation and did not maintain accountability of over $165,000 of medical supplies transferred from PC/Niger.

A. Inaccurate Medical Supply Records

The post did not maintain accurate and complete medical supply records. We noted that the staff repeatedly failed to prepare the documentation required for receiving, dispensing, and disposing of medical supplies. According to the medical office staff, the workbook never matched the actual inventory on-hand, primarily due to the following issues.

The medical supply inventory control clerk (MSICC) had not updated the inventory workbook for over a month. The MSICC was also unclear on how to record the medical supply; for example, the MSICC did not know what the accurate "unit" of a drug was, or which generic drugs corresponded with their name-brand medicines. As a result, the inventory reconciliation clerk (IRC) could not reconcile the recorded inventory in the health office with the recorded inventory

in the workbook. Instead, the IRC witnessed the physical count of the medical supplies without comparing the workbook balance.

According to a PCMO, the post did not have a system to determine the quantity of medical supplies needed. The post did not allow adequate time to receive orders from headquarters before they were needed. As a result, the post procured medical supplies locally, often at higher costs.

In addition, the post had not designated an acceptance point clerk (APC) for almost two years. Even after assigning the role in March 2012, the APC did not verify the receipt of medical supplies procured locally; she only verified those received through the U.S. Embassy. Further, the post did not ensure that receipts of medical supplies were provided to the MSICC to enter into the workbook.

B. Unauthorized Access to the Medical Supplies

The post did not limit access to controlled and specially designated items. The medical secretary had the combination to, and frequently accessed, the controlled substances safe. This allowed her to dispense drugs to Volunteers in violation of Peace Corps policies and in some cases without proper consultation or the knowledge of the PCMOs. Additionally, we were informed that a custodial staff member and a maintenance staff member had unescorted access to the pharmacy, and would leave the key to the medical unit with the contract security guard.

Medical supplies, including some specially designated drugs designated for disposal, were left unsecured. According to the PCMO, many of the items had been returned from Volunteers. Further, the inventory listed for destruction did not match the quantity of medical supplies in boxes designated for disposal. Without adequate documentation we could not quantify the amount of excess medical supplies that were disposed of.

Figure 2. Unsecured Boxes of “Excess” Medical Supplies

C. Failure to Track Controlled and Specially Designated Medications

The post did not properly track controlled and specially designated medications. The post did not have a complete and accurate DEA logbook to record the dispensing of controlled drugs. Since March 2010, only one item had been recorded in the DEA logbook. When MS 734 was issued, the staff interpreted that the inventory workbook was a replacement of the DEA logbook, so the post stopped using it.

We attempted to calculate the book balance by starting with the post’s last inventory in March 2012, adding recorded purchases and subtracting amounts that were recorded as dispensed and disposed of. We compared the book balance of selected medical supplies to the actual count on

hand during our visit and found it unreliable. For example, a physical count for all of the five vaccines in our sample did not match the records in the workbook (see Table 1).

Table 1. Comparison of Vaccination Counts

Vaccine	Calculated Book Balance	Actual Amount on Hand
Typhim	1	30
Euvax (Hepatitis B)	189	100
Avaxim (Hepatitis A)	-1*	5
Menecevax	-31*	100
Rabies	29	25

*A negative book balance is the result of incomplete or inaccurate records.

Another example was a workbook balance of the controlled substance Alprazolam (Xanax) of 475 units. When we performed a physical count, we could not locate any of this product in the medicine safe. However, a few days later approximately 900 tablets appeared in the safe. No explanation was provided of how the item appeared in the office.

The inventory is an essential control to provide oversight and monitoring of the medical unit. Without an accurate inventory it is not possible to prevent and detect fraud or misuse of medical supplies. By not following policies and procedures for the receipt and dispensing of medical supplies, the medical secretary had an opportunity to misappropriate medical supplies. The medical supply inventory workbook was not reliable and could not be used to identify loss or theft, nor was it a valid tool to identify medical supply needs and analyze trends.

D. Unauthorized Dispensing of Medical Supplies

The post did not comply with Peace Corps policies and procedures for dispensing medical supplies. The medical dispensation records were unreliable and incomplete. OIG found that the medical secretary inappropriately dispensed medical supplies to Volunteers without required prescription forms. One of the PCMOs was fully aware of the medical secretary's improper role in dispensing to Volunteers and participated in the improper procedure. The post's process of issuing medical supplies circumvented the controls in place to ensure Volunteers receive proper medical care.

Figure 1. Stacks of Dispensing Forms Not Properly Filed in Volunteer Medical Charts

Based on our discussion with medical office staff we found that the medical secretary would receive text messages or medical supply request forms from Volunteers for drugs or medical supplies. In many instances, the medical secretary did not verify that the Volunteers' requests were based on the PCMO's prescriptions. The medical secretary sent the requested drugs or medical supplies to the Volunteers, prepared a "Record of Medical Supplies Dispensed" form for

the PCMO's signature, and left the unsigned form on the counter in the pharmacy. The PCMO would sign these forms after the drugs or medical supplies had already been dispensed. There were instances in which the PCMO did not verify the controlled substance logs, as the PCMO was busy and trusted the medical secretary. Further, Volunteers and trainees did not always sign the "Record of Medical Supplies Dispensed" form to confirm the receipt of controlled or specially designated medical supplies. In addition, the forms were not filed in the medical charts of the Volunteers.

Due to incomplete and unreliable information in the Volunteer medical charts, we could not conduct a thorough review of prescriptions dispensed to Volunteers. However, we reviewed a sample of medical charts with the OMS representative and identified highly questionable practices in the dispensing of drugs and specially designated medical supplies. In one instance, the PCMO dispensed a total of 1,500 tablets of Acyclovir 800 mg (an antiviral drug) between February 4, 2011 and May 16, 2011. Generally, an individual would be prescribed 160 tablets of Acyclovir 800 mg over a four-month period. Overuse of Acyclovir can cause serious medical complications, including kidney failure. OMS is following up with the Volunteer to assess the Volunteer's health and initiate appropriate actions.

E. Unaccounted-for Medical Supplies Transferred from PC/Niger

On March 8, 2011, PC/Niger transferred 328 medical supply items, including controlled substances and specially designated items, to the PC/Burkina Faso.[3] PC/Niger documented the transfer in a detailed spreadsheet, including item description, quantity transferred, and a column for the receiver to acknowledge receipt of the medical supplies. Using a conservative unit cost, a local pharmacy and the OMS representative estimated that the total cost of medical supplies transferred from PC/Niger was approximately $165,000.

The post dispatched two Peace Corps vehicles to accommodate the transfer of medical supplies from PC/Niger. However, there was no evidence to demonstrate the drivers verified that the medical supplies on the list matched the actual medical supplies received by them. When the medical supplies arrived at the post, the PCMO did not use the list prepared by PC/Niger to verify items and quantities actually received from PC/Niger. Instead, the PCMO prepared a separate list of the medical supplies received, which did not match the original list provided by PC/Niger. There was no explanation noted for the differences between the two lists.

MS 734 explicitly prohibits donating medical supplies to any entity except another Peace Corps post or the U.S. Embassy. OIG advised the post during its last audit that transferring medical supplies to private entities was prohibited. Post staff explained that the medical supplies were donated to the U.S. Embassy. However, the U.S. Embassy medical staff denied that the embassy received any medical supplies from the post, but only helped the post donate the supplies to private clinics.

We requested documentation from the PCMO and embassy medical staff to support the transfer of drugs from the post to the U.S. Embassy or private clinic in order to verify that the supplies were in fact received by private clinics. We did not find support for the transfer. Without

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[3] PC/Niger closed as a Peace Corps post in January 2011.

supporting documentation, we were unable to determine the exact nature of the transaction, the parties to whom the medical supplies were donated, and the ultimate disposition of the medical supplies transferred from PC/Niger. Based on correspondence between the post and the U.S. Embassy, it appears that the post circumvented the controls established in MS 734 by using the embassy to facilitate a donation to a private entity.

It is important to note post management took immediate action to correct the weaknesses we noted. The CD issued an interoffice memorandum on July 11, 2012 detailing the mandatory policies and procedures regarding the medical inventory, dispensing of medicines, and medical procurement. On July 20, 2012, the post conducted a full physical inventory of medical supplies and established beginning balances. We will continue to monitor the improvement in ordering, dispensing and disposing of medical supplies and will re-evaluate the post's compliance with procedures or conduct a follow-up audit or analysis if needed. However, given the state of medical supplies at Peace Corps posts worldwide, correcting the medical supply deficiencies at PC/Burkina Faso will not prevent the same issues from occurring at other posts.

Recommendation

We recommend that agency management take immediate action to ensure that all Peace Corps posts have adequate internal control over their medical supplies by fully implementing the requirements of *Peace Corps Manual* Section 734 and *Medical Technical Guideline* 240.

Cc: Dick Day, Regional Director, Africa
Brenda Goodman, Office of Medical Services