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OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/ZIMBABWE'S IMPLEMENTATION OF THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

AUDIT REPORT NO. 7-613-08-001-P
OCTOBER 24, 2007

DAKAR, SENEGAL

Office of Inspector General

October 24, 2007

MEMORANDUM

TO: USAID/Zimbabwe Director, Karen Freeman

FROM: Regional Inspector General/Dakar, Nancy Toolan /s/

SUBJECT: Audit of USAID/Zimbabwe's Implementation of the President's Emergency Plan for AIDS Relief (Report No. 7-613-08-001-P)

This memorandum is our final report on the subject audit. In finalizing this report, we considered management's comments on our draft report and included them in Appendix II.

This report contains two recommendations with which you concurred in your response to the draft report. Final action has been taken on all the recommendations and no further action is required of the Mission.

I appreciate the cooperation and courtesies extended to the members of our audit team during this audit.

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SUMMARY OF RESULTS

The Regional Inspector General/Dakar conducted this audit as part of a worldwide audit led by the Office of Inspector General's Performance Audit Division of USAID's implementation of the President's Emergency Plan for AIDS Relief (the Emergency Plan). The objective of this audit was to determine if USAID/Zimbabwe's Emergency Plan prevention, care and treatment activities achieved expected planned results in its grants, cooperative agreements and contracts (see page 4).

We found that USAID/Zimbabwe's Emergency Plan activities achieved almost 60 percent of its planned results for FY 2006. This level of overall achievement falls below the 90 percent threshold necessary to conclude that the program's planned outputs were achieved. The results that were achieved, however, are particularly noteworthy and have had an impact given the challenging operating environment in Zimbabwe. As a result, we are not making any recommendation regarding the outputs that the Mission did not achieve. Some internal control weaknesses at both the mission level and the partner level were noted, however, that, if addressed, will help the Mission improve its management of its partners (see pages 5-7).

According to USAID's Automated Directives System (ADS), missions are responsible for establishing performance management systems to measure the progress of activities from the lowest level—the output level—up to the higher-level results. USAID/Zimbabwe conducted two performance reviews during FY 2006, but the Mission did not review lower-level results. Our review of FY 2006 planned outputs revealed that the Mission did not perform some basic monitoring activities for three of its four partners. Mission management said that these monitoring problems occurred because the Mission was short-staffed. If the Mission were to drill down to the output level during portfolio reviews, internal control weaknesses such as those mentioned above could be discovered and corrected with a minimum of extra effort. This would allow the Mission to ensure that outputs identified in its grants, cooperative agreements and contracts are effectively monitored, providing the basis for sound performance management of higher-level results. Consequently, we recommend that the Mission revise the Mission Order on semi-annual portfolio reviews to include reviewing output-level data. Doing so would ensure that outputs in grants, cooperative agreements and contracts continue to be monitored in addition to higher-level results (see pages 7-9).

According to Agency guidance, measuring performance effectively means that missions must ensure that quality data are collected and available to inform management decisions. We performed spot-checks of the data reported to USAID by their four HIV/AIDS partners to verify the accuracy of information reported to USAID and to confirm that each partner had an effective data collection system. For three of four partners, there were problems with both the data collection system and the accuracy of data reported to USAID. Mission officials explained that in the current operating environment, partners find it difficult to hire, train and retain monitoring and evaluation specialists. This has proven to be an impediment to ensuring data quality and is further exacerbated by the increasingly severe humanitarian crisis in Zimbabwe, which often requires staff to focus on more urgent project needs. USAID/Zimbabwe staff was proactively involved with the partners but because of constraints on their time and resources, did not verify data at the partners' activity sites. Sound management decisions, however, require accurate, current, and reliable

information, and the benefits of this results-oriented approach substantially depend on the quality of the performance information available. To address this weakness, we are making one recommendation for USAID/Zimbabwe to develop procedures that define the roles and responsibilities of the Mission and partner staff in assuring the quality of Emergency Plan data. These procedures should address verifying reported data with source documentation, documenting key assumptions and maintaining documentation to support reported results (see pages 9-12).

USAID/Zimbabwe agreed with the findings and the two recommendations in the draft audit report. Final action has been taken on the recommendations and no further action is required of the Mission (see page 13).

BACKGROUND

Recognizing the global HIV/AIDS pandemic as one of the greatest challenges of our time, the Congress enacted legislation to fight HIV/AIDS internationally through the President's Emergency Plan for AIDS Relief (the Emergency Plan)--the largest international health initiative in history by one nation to address a single disease. The $15 billion, 5-year program provides $9 billion in new funding to speed up prevention, care, and treatment services in 15 focus countries. The Emergency Plan also devoted $5 billion over 5 years to bilateral programs in more than 100 non-focus countries and increased the U.S. pledge to the Global Fund [1]by $1 billion over 5 years. Of the non-focus countries that received increased funding for HIV/AIDS for fiscal year (FY) 2005, Zimbabwe received the second largest amount of the Emergency Plan funds.

To further the President’s goals for the Emergency Plan, the U.S. Government (USG) provided $20.5 million in FY 2005 to support the fight against HIV/AIDS. These funds were managed by USAID, Health and Human Services’ Centers for Disease Control and Prevention, the Department of Defense, and the Department of State’s Public Affairs Section. USAID/Zimbabwe received more than half of the total USG contribution ($11.5 million) and implemented its programs through four partners: John Snow Inc., Catholic Relief Services, Elizabeth Glazier Pediatric AIDS Foundation, and the Partnership Project. John Snow Inc. provided prevention, care and treatment activities; Catholic Relief Services was involved in care for orphans and vulnerable children (OVC); Elizabeth Glazier Pediatric AIDS Foundation provided Prevention of Mother-to-Child Transmission (PMTCT) activities; and the Partnership Project activities included other prevention and palliative care.

USAID/Zimbabwe’s 5-year strategic plan presents information on the social and economic situation in Zimbabwe and the fight against AIDS. With an HIV prevalence rate as high as 20.1 percent, 180,000 new infections each year, and 185,000 deaths each year from AIDS, Zimbabwe is at the epicenter of the HIV/ AIDS pandemic. It is reported that there are 1.63 million HIV-infected adults, 165,000 HIV-infected children, and 1.3 million OVCs in Zimbabwe. Life expectancy dropped from 61 years in 1990 to 34 years today, a 44 percent decline in less than two decades. Gender inequality, widespread practices of multiple and concurrent sexual relationships, and cross-generational sex fuel Zimbabwe’s epidemic, particularly among youth. Social norms, including stigma associated with HIV/AIDS, excessive alcohol consumption, and a reluctance to talk about HIV status or sexual relations also create barriers to behavior change.

Exacerbating the current HIV/AIDS pandemic is Zimbabwe’s political and economic climate. Zimbabwe continues to suffer a severe socioeconomic and political crisis, including unprecedented rates of inflation and severe “brain drain” of Zimbabwe’s health care professionals. Elements of a previously well-maintained health care infrastructure are crumbling. Zimbabwe’s HIV/AIDS crisis is further exacerbated by chronic food insecurity. Food insecurity is a contributing factor to sub-optimal nutrition, which increases the vulnerability of individuals with compromised immune systems to life-threatening opportunistic infections, such as tuberculosis.

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[1] The Global Fund is a public-private partnership that raises money to fight AIDS, tuberculosis and malaria.

To add to an already volatile situation, the country's shortage in foreign exchange, triple-digit inflation, and rapidly fluctuating exchange rate have created a recent critical shortage of anti-retroviral drugs (ARVs). Approximately 17,000 people are currently receiving ARV treatment provided through either the public or private sector, and a majority of those people have been receiving locally manufactured ARVs. More alarming, local manufacture has recently shut down because of the inability of the pharmaceutical company to access sufficient foreign exchange to import the necessary raw materials. Also because of the national lack of foreign exchange, imported ARVs are scarce and largely unaffordable. Zimbabwean dollar prices for ARVs at local pharmacies have more than tripled, making purchase unsustainable for a significant proportion of private sector patients. In fact, the exchange rate of the U.S. dollar to the Zimbabwe dollar more than doubled during the 3 weeks the audit team was conducting fieldwork. The current economic environment thus makes stable private sector access to ARVs increasingly untenable, placing pressures on the Government of Zimbabwe (GOZ) to either rapidly absorb private sector patients or face a looming threat of ARV resistance that could affect the entire public health profile. Additionally, with the declining value of the Zimbabwean dollar, the GOZ health budget alone is no longer sufficient to maintain those clients currently under treatment in the public sector.

In light of these seemingly insurmountable challenges, Zimbabwe's medical training programs continue to prepare cadres of Zimbabwean health professionals. It cannot keep abreast of the demand, however, particularly for medical doctors. The medical, nursing and laboratory programs, in particular, lose new graduates quickly to private sector, regional and international positions. As a result, most facilities have a greater than 50 percent vacancy rate for existing nursing and doctor posts. Shortages of trained personnel and limited laboratory capacity further constrain delivery of quality treatment.

Despite notable efforts to continue training for health care workers and a fairly well-established national culture and infrastructure for human capacity development, critical human resource needs persist. The continued exodus of skilled, trained people and excessive movement between organizations are driven by the economic crisis and short-term donor funding commitments. Other barriers--such as lack of performance-based incentives, labor laws that discourage employers from offering longer-term employment, weak management practices, and poor-quality working environments--are also contributing factors.

AUDIT OBJECTIVE

This audit was conducted as part of a worldwide audit led by the Office of Inspector General's Performance Audit Division of USAID's implementation of the President's Emergency Plan for AIDS Relief (the Emergency Plan). The Regional Inspector General/Dakar conducted this audit to answer the following audit objective:

- Did USAID/Zimbabwe's Emergency Plan prevention, care and treatment activities achieve expected planned results in its grants, cooperative agreements and contracts?

Appendix I contains a discussion of the scope and methodology of the audit.

AUDIT FINDINGS

USAID/Zimbabwe achieved 28 of 48 planned outputs (about 60 percent) associated with its Emergency Plan prevention, care, and treatment activities contained in its grants, cooperative agreements, and contracts[2]. Some outputs were achieved at levels lower-than-expected due to delays in getting activities started up in the first year of funding and because of the political and economic situation in Zimbabwe. The level of overall achievement is below the 90 percent threshold described in appendix I, but the results that were achieved are noteworthy and have had an impact, particularly given the challenging operating environment in Zimbabwe. However, some internal weaknesses related to the Mission's oversight of partners' performance and data verification were found, which, if addressed, would lead to improvements in the management of the program.

During fiscal year (FY) 2006,[3] USAID/Zimbabwe worked with four partners to implement HIV/AIDS care, prevention and treatment activities and the partners reported that many of these activities were achieved. For example, one of USAID/Zimbabwe's partners involved in treatment activities exceeded its target of providing 500 patients with antiretroviral therapy by providing treatment to 606 patients. Another partner involved in prevention activities reported training 777 health care workers in Prevention of Mother-to-Child Transmission (PMTCT), exceeding the annual target of 497. A third partner involved in care activities reported providing care and support to nearly 40,000 orphans and vulnerable children (OVCs) which exceeded the planned result by almost 10,000. In addition, the fourth partner's goal of providing 150,000 individuals with counseling and testing services was also exceeded by more than 50,000 individuals.

Achieving or exceeding many of these planned results is especially remarkable when viewed within the context of an unusually challenging operating environment, as discussed in the Background section. For example, one factor that made working in Zimbabwe particularly difficult for the Mission during FY 2006 was hyperinflation, which eroded purchasing power daily. As a result, budgeting and managing expenses for activities in local currency was nearly impossible. Similarly, hyperinflation also caused USAID's partners to lose professional staff at an alarming rate. Because Zimbabwean law required non-governmental organizations to pay salaries in local currency, many staff found that they were unable to support themselves because of the ever rising cost of necessities. According to the partners, in many cases, staff who had the means opted to leave the country.

Despite these and other conditions that steadily worsened throughout the year, the Mission's HIV/AIDS team managed to achieve some impressive higher-level results in addition to nearly 60 percent of their planned outputs. These higher level results included the successful leveraging of funding, the high sales and low stock-out rate of condoms and the development of an assessment tool to determine the skill capacity at clinics that was ultimately adopted by the Ministry of Health.

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[2] See appendix III on page 19 for detailed information on the planned and actual results for the 48 outputs.

[3] The scope of this audit covers FY 2005 funds, which were used for activities that were implemented during FY 2006.

Zimbabwe has one of the highest HIV/AIDS prevalence rates in the world, but it was not chosen as one of the 15 focus countries for the Emergency Plan, even though all of its surrounding neighbors are focus countries. As focus countries, Zimbabwe's neighbors receive an estimated 10 times as much assistance from the United States for HIV/AIDS as Zimbabwe. The Mission recognizes that this geographic situation makes Zimbabwe "the hole in the donut", putting its neighbors' Emergency Plan efforts at risk. To achieve a higher impact than its FY 2005 funding level would permit, the HIV/AIDS team collaborated with other donors to leverage substantial resources for their Emergency Plan activities. For example, USAID leveraged United Kingdom (UK) Department for International Development funds to augment the outreach of several care and prevention projects that were initially developed and implemented by USAID. In FY 2006, the UK contributed 80 percent of the overall funding for these projects, giving USAID/Zimbabwe's Emergency Plan activities a significant boost in capacity.

As the key condom distributor in Zimbabwe, the Mission is proud of the fact that its condom stock-out rate in public health facilities was less than 5 percent for FY 2006. In addition, USAID/Zimbabwe's social marketing program has been successful with high condom sales per capita. This was achieved in part through the innovative use of geographic information system (GIS) mapping. To strategically position distribution outlets, GIS mapping identified the areas where demand for condoms was the highest. In addition, USAID/Zimbabwe used GIS mapping to determine which areas of the country had the highest prevalence rates. In doing so, those communities could be targeted with outreach activities to promote awareness of the importance of using condoms. Greatly exceeding their own expectations of reaching 10,000 people, the Mission estimates that more than 93,000 individuals were reached through traveling community-based "road shows" that promoted HIV/AIDS prevention and other behavior change beyond abstinence or being faithful.

In conjunction with widely distributing condoms to the highest-risk areas, USAID/Zimbabwe's road shows have proven to be an effective way to convey important prevention information by engaging the community interactively to dispel misinformation about HIV/AIDS. In this photo, the facilitator is demonstrating the strength and capacity of a condom to counter the misconception that condoms break too easily and therefore are not worth using. Photo taken by a RIG/Dakar auditor in Chendambuya, Zimbabwe in May 2007.

Another impressive accomplishment is the site assessment tool developed by USAID/Zimbabwe. The Mission developed the tool to assess the capacity and capabilities of Zimbabwe's health facilities to determine which could provide antiretroviral therapy. The Government of Zimbabwe now assesses facilities using the same tool. Because of the critical loss of professional staff in Zimbabwe, this tool is essential for

determining which sites have the capacity to provide treatment effectively and responsibly.

Despite these positive achievements, approximately 40 percent of USAID/Zimbabwe's planned outputs for FY 2006 were not achieved. Although we did not verify reasons for lower-than-expected achievement for each of these outputs, delays related to the start-up of new activities in the first year as well as circumstances beyond the Mission's control affected the Mission's and partners' ability to achieve some of the planned results. For example, one partner said that a drug therapy sponsored by the U.S. government was slow in being provided at the clinics due to lack of information from the Ministry of Health on how to order the drug. However, this has been addressed and the provision of the drugs to patients has increased. Concerns from the clinics regarding the long-term availability of drugs from the U.S.-government supply chain also impacted the achievement of another output. According to the partner, the clinics have been assured that the treatments can be sustained.

Partners also discussed the impact of the political and economic situation in Zimbabwe on the achievement of their program goals and outputs. For example, one partner was not able to reach its target of providing almost 100,000 women with PMTCT services because of political events that displaced many people in the capital city from their homes. This displacement meant that fewer women than expected were able to access pretest counseling, which is the point-of-entry or prerequisite for four other PMTCT services. Therefore, when the partner did not achieve the planned result associated with the pretest counseling, achievement of the other four related results was not possible. In this particular case, the partner achieved only 44 percent of its planned outputs, which was the domino effect from not achieving that first planned result. The effect of the country's hyperinflation was also mentioned by the partners. The exchange rate for project funds into local currency was lower than expected, thus increasing project costs which eroded purchasing power. Staff shortages and high attrition were also cited by partners as impacting the implementation of their programs, with more time and funds spent on recruiting and re-training of staff. One partner viewed this as a major threat for the sustainability of current and future operations.

Because of the unusually challenging operating environment, we are not making any recommendation regarding the approximately 40 percent of planned outputs that had lower-than-expected achievement. However, some internal control weaknesses were noted at both the Mission and partner level that, if addressed, will improve the Mission's management of the partners' performance.

Performance Management Needs to Be Strengthened

Summary: According to USAID's Automated Directives System (ADS), missions are responsible for establishing performance management systems to measure the progress of activities from the lowest level—the output level—up to the higher level results. While USAID/Zimbabwe conducted two performance reviews during FY 2006, the Mission did not review lower-level results. When we conducted the review of FY 2006 planned outputs, we found that the Mission failed to perform some basic monitoring activities for three of its four partners. Mission management told us that these monitoring problems occurred because the Mission was short-staffed. If the Mission were to drill down to the

output level during portfolio reviews, internal control weaknesses such as those mentioned above could be discovered and corrected with a minimum of extra effort. This would allow the Mission to ensure that outputs identified in its grants, cooperative agreements and contracts are effectively monitored, providing the basis for sound performance management of higher-level results.

According to USAID's ADS, missions are responsible for establishing performance management systems to measure progress toward intended objectives. The ADS defines performance management as "the systematic process of monitoring the results of activities; collecting and analyzing performance information to track progress toward planned results; and using performance information to influence program decisions." Toward these ends, the ADS requires each mission to conduct at least one portfolio review each year. This systematic analysis of the progress of a strategic objective determines whether USAID-supported activities are leading to the results outlined in the approved results framework. The ADS suggests that during the portfolio review, the Mission review outputs—defined as "a tangible, immediate, and intended product or consequence of an activity within USAID's control"—and specifically address two questions: (1) Are the planned outputs being completed on schedule? (2) Are the planned outputs leading to the achievement of the desired results as anticipated?

During FY 2006, the Mission was responsible for monitoring 48 outputs identified in its cooperative agreements with four implementing partners. Examples of outputs included individuals receiving palliative care, number of orphaned or vulnerable children receiving assistance and number of health care workers trained in voluntary testing and counseling. Although USAID/Zimbabwe conducted two portfolio reviews during FY 2006, the Mission did not review the outputs included in its grants, cooperative agreements and contracts. These reviews address the fundamental questions pertaining to outputs that, like building blocks, are recommended for the Mission to assess overall progress towards accomplishing desired results.

As part of this audit, we conducted a review of outputs that was similar to that prescribed in the ADS for portfolio reviews, intending to compare the planned outputs with the year-end results reported by each partner. However, for three out of four partners, the audit team was unable to perform this simple analysis using documents readily available at the Mission.

For the first partner, the Mission provided us with a work plan that listed 15 planned outputs. However, the partner's year-end report included results for only one of the original outputs. When asked why the other 14 outputs were not tracked at year-end, the Mission explained that the focus had shifted during the year to monitoring a single Emergency Plan indicator that was composed of the original 15 indicators. According to its cooperative agreement with the partner, however, the Mission was still required to monitor the original indicators.

In the case of the second partner, USAID/Zimbabwe provided 20 percent of the funding for the partner's activities and the United Kingdom provided the other 80 percent. The work plan listed planned outputs for all of the activities funded by both donors and did not differentiate or allocate the planned results between the sources of funding. However, the year-end reported results attributed only 20 percent of the achieved outputs to USAID in an effort to assign results proportionate to donor funding levels. Because the work plan had not assigned 20 percent of the planned achievement to

USAID, and because the attribution methodology was inconsistently applied, it appeared that USAID had achieved only 20 percent of its planned outputs. When the audit team raised this issue with the partner and the Mission, management could not reach consensus on what the attribution methodology should have been for FY 2006 planned or achieved results or what methodology should be used in planning for and reporting on FY 2007 activities.

In the third case, the Mission did not ensure that a work plan developed for the partner included planned output targets. The partner said that targets were rolled out continually all year, in a piecemeal fashion, and were not documented in a single performance management document as the ADS requires. For example, the exact number of people to receive antiretroviral therapy was not determined until after the work plan was developed. The Mission explained that it and the partner were so familiar with the targets because of frequent meetings on the subject that the task of documenting these targets in an amendment to the work plan was never addressed. It appeared that both the Mission and the partner staff had a good understanding and recall of the targets for FY 2006, but both agreed that this information would be lost if the partner or Mission staff were to leave.

Mission management said that these monitoring problems occurred because the Mission was short-staffed. During FY 2006, the Mission attempted to hire a third Cognizant Technical Officer to share and alleviate the work load. Management explained that the position was advertised locally and internationally three times, but the Mission was not able to attract qualified candidates who were interested in the position. Mission management speculated the lack of interest was due to the current political and economic conditions in Zimbabwe. In addition, the Mission's monitoring and evaluation specialist left during the year.

Although the Mission appears to face a staffing shortage, if it were to drill down to the output level during the year-end portfolio review process, internal control weaknesses such as those mentioned above could be discovered and corrected with a minimum of extra effort. This would allow the Mission to ensure that outputs identified in its cooperative agreements are effectively monitored, providing the basis for sound performance management of higher level results.

Based on this conclusion, we make the following recommendation.

> *Recommendation No. 1: We recommend that USAID/Zimbabwe revise its Mission Order on semi-annual portfolio reviews to include reviewing output level data to ensure that outputs in grants, cooperative agreements and contracts continue to be monitored in addition to higher level results.*

The Mission and Its Partners Need to Verify Data

Summary: According to Agency guidance, measuring performance effectively means that missions must ensure that quality data are collected and available to inform management decisions. We performed spot-checks of the data reported to USAID by the Mission's four HIV/AIDS implementing partners to verify the accuracy of information reported to USAID and to confirm that each partner had an effective data collection

system. For three out of four partners, there were problems with both the data collection system and the accuracy of data reported to USAID. Mission officials explained that hiring, training and retaining monitoring and evaluation specialists in the current operating environment is difficult for the partners, which impacts the quality of data collected and reported. Although Mission staff was proactively involved with the partners and program activities, they had not performed data verification at the activity sites because of constraints on their time and resources. However, sound management decisions require accurate, current, and reliable information, and the benefits of this results-oriented approach depend substantially on the quality of the performance information available.

According to Agency guidance, measuring performance effectively means that missions must ensure that quality data are collected and available to inform management decisions. As part of the audit, we performed spot checks of the data reported to USAID by the Mission's four HIV/AIDS implementing partners to verify the accuracy of information and to confirm that each partner had an effective data collection system. For three out of four partners, problems were found with both the data collection system and the accuracy of data reported to USAID, affecting 6 of the 12 outputs checked.

For example, we visited a hospital supported by one of the partners where antiretroviral therapy (ART) treatment was provided in FY 2006. Each month the hospital reports to the partner on the patients who received various regimes of USG-provided ART. These reports are the basis data compiled and provided by the partner to USAID. We judgmentally selected one month and attempted to trace the number of patients shown in the hospital's report to the partner with a log that serves as the data source for the monthly report. After two failed attempts, and with the assistance of the partner staff, the hospital staff found a monthly report and log for the same month. However, the figures shown in the log did not reconcile with those in the monthly report. The report showed 27 and 120 patients receiving treatment for two different ART regimes but the log showed 89 and 83 respectively. The hospital staff member was unable to explain the methodology for the collection and compilation of the monthly data, however the partner explained that this staff member was not hired for this task but was filling in after the departure of the previous monitoring and evaluation specialist. The partner also mentioned that the hospital is generally short-staffed and the current staff is busy with many competing responsibilities, all of which affect the data collection and reporting system.

In the second case, we visited another partner's rural community orphans and vulnerable children (OVC) project. The partner had reported at year-end that it had provided 1,079 OVCs with education assistance and psychosocial counseling in FY 2006. When we asked to see the database, the partner staff was unable to show how they arrived at the 1,079 OVCs reported for FY 2006. The partner said that its monitoring and evaluation specialist had recently quit and the new monitoring and evaluation specialist had not yet been trained. The partner further explained that the database was not yet complete and a new reporting system for USAID was being developed because the current staff was not familiar with the old system.

In the third case, we visited a USAID-funded center that provides palliative care services to individuals who recently tested positive for HIV/AIDS. We judgmentally selected one month and asked to see the partner's records for the number of clients who received

services during that month. Although the number reported to USAID was 354, the partner's records showed only 244. This partner had difficulty explaining its data reporting system because the monitoring and evaluation specialist had recently been let go for poor performance.

Mission officials explained that with the current economically unstable operating environment, partners find it difficult to hire, train and retain monitoring and evaluation specialists. This has proven to be an impediment to ensuring data quality. Additionally, the increasingly severe humanitarian crisis in Zimbabwe often requires partner staff to direct their attention to other aspects of the project. As a result, the individuals who are responsible for data collection and reporting at the sub-partner level are often concerned with more urgent program implementation activities, sometimes at the expense of effective management of data quality for reporting purposes. The Mission said that unfortunately, it does not expect this situation to improve in the near future.

In terms of the Mission's efforts, the activity manager and CTO were proactive in monitoring program activities. Both said they had ongoing and frequent contact with the partners and made regular visits to the partners' offices. They also mentioned that they regularly reviewed the performance data submitted by the partners as part of their progress reports. However, both acknowledged that they had performed few site visits to partners' sites because of constraints on their time and have not performed verification of data at the program sites. As mentioned previously, the Mission attempted to hire an additional CTO to alleviate the workload but has been unable to fill the position. We also found the Mission had not performed a data quality assessment (DQA) on HIV/AIDS activity indicators as required by the ADS, and the Mission Order on monitoring and evaluation was out of date, with no revisions or updates since 1989.

We understand the severity of the economic and humanitarian crises in Zimbabwe, but reliable reporting remains key to USAID's results-oriented management approach. Agency guidance states that "sound management decisions require accurate, current, and reliable information, and the benefits of this results-oriented approach depend substantially on the quality of the performance information available." In addition, USAID's Center of Development Information and Evaluation Performance Monitoring and Evaluation Tips (TIPS Number 12), which summarizes the key references on performance measurement quality found in the ADS, indicates that while some errors in collecting data are to be expected, discrepancies can easily be avoided by cross-checking the data to the source document. Ensuring that the quality of data reported to the Mission by partners is reliable is an essential part of each mission's responsibility. The current operating environment in Zimbabwe heightens the need for USAID/Zimbabwe to verify the data reported by partners perhaps even more frequently than other missions because of high partner staff turnover.

We are making no recommendations related to the lack of a DQA or the out-of-date Mission order because the Mission had begun to address both of these weaknesses before we began our fieldwork. However, to help the Mission improve the accuracy and reliability of program data we make the following recommendation.

Recommendation No. 2: We recommend that USAID/Zimbabwe develop procedures that define the roles and responsibilities of Mission and partner staff in assuring the quality of Emergency Plan activity data. At a minimum, this would include procedures related to verifying reported data with source documentation,

documenting key assumptions and calculations, and maintaining documentation to support reported results.

EVALUATION OF MANAGEMENT COMMENTS

USAID/Zimbabwe agreed with the findings and the two recommendations in the draft audit report[4]. Final action has been taken on the recommendations and no further action is required of the Mission.

Recommendation No. 1 recommends that USAID/Zimbabwe revise its Mission Order on semi-annual portfolio reviews to include reviewing output level data in addition to higher level results. The Mission agreed and revised its Mission Order 203 in September 2007. The order now states that the fall session of the portfolio review will focus on ensuring that projects are progressing as planned and that targets and outputs are being achieved. In addition to this final action, the Mission is also requiring all partners to develop data quality plans by the end of fiscal year (FY) 2008.

Recommendation No. 2 recommends that USAID/Zimbabwe develop procedures that define the roles and responsibilities of Mission and partner staff in assuring the quality of Emergency Plan activity data. The Mission agreed and addressed this in its September 2007 revision of Mission Order 203. The order now directs partners to conduct quarterly spot checks of data and to also include verification of sub-partner data as part of those quarterly spot checks. The order also requires the Cognizant Technical Officers (CTOs) to perform data verification during site visits. The Mission also hired a Strategic Information Specialist in August 2007 who has responsibility for the monitoring and evaluation of Emergency Plan indicators. In addition to this final action, the Mission also has additional efforts underway which will be concluded by the end of FY 2008. These include developing a schedule of site visits, conducting a workshop for partners to highlight data quality issues, developing a data verification tool to be used by CTOs during site visits, and creating additional procedures related to Mission and partner responsibilities for data quality.

Management's comments are included in their entirety (without attachments) in Appendix II.

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[4] USAID/Zimbabwe's response refers to our preliminary report number 7-613-07-004-P. However, because this report is being issued in October 2007, it has been assigned a new number reflecting issuance in FY2008 (7-613-08-001-P).

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SCOPE AND METHODOLOGY

Scope

The Regional Office of Inspector General in Dakar conducted this audit in accordance with generally accepted government auditing standards. The audit was conducted as part of a worldwide audit led by the Office of Inspector General's Performance Audit Division of USAID's implementation of the President's Emergency Plan for AIDS Relief (the Emergency Plan). The audit objective was to determine if USAID/Zimbabwe Emergency Plan prevention, care and treatment activities achieved expected and planned outputs in its grants, cooperative agreements, and contracts for fiscal year (FY) 2005 funding. Fieldwork was conducted from May 7, 2007, through May 24, 2007, in Harare, and in the districts of Chiweshe, Chitungwiza, and Chendambuya.

In planning and performing the audit, we assessed the effectiveness of USAID/Zimbabwe's internal controls that could materially affect the audit objective. We identified internal controls such as USAID/Zimbabwe's process for monitoring its partners' progress and reporting, as well as USAID/Zimbabwe partners' process for validating and verifying data reported to the Mission.

For the period audited, three partners and a consortium of partners were engaged in HIV/AIDS prevention, care and treatment activities. We selected the activities of all three partners' and the consortium for review. These three partners and the consortium represented 100 percent of the total FY 2005 funding for prevention, care and treatment activities. We audited prevention, care and treatment activities completed no later than September 30, 2006 which were implemented with FY 2005 funding.

METHODOLOGY

To answer the audit objective, we met with USAID/Zimbabwe's staff. To gain an understanding of the subject matter, we reviewed prior Emergency Plan audits including a non-focus country audit. We reviewed the Mission Strategic Plan, Mission Order, cooperative agreements, work plans, result reports, and the Mission's annual self–assessment of management controls as required by the Federal Managers' Financial Integrity Act. We interviewed partners and reviewed their work plans, result reports. Two to four outputs on the result reports for each partner and the consortium were selected and we compared those output results to logs and other source documents at the partner's location. We then traced the two to four outputs as documented at the partners' location to sign-in logs and original documents at the local sites such as clinics, hospitals and counseling centers.

We compared each target on the partners' and the consortium's work plan against the results reported to determine the percentage of achievement for each target. We then analyzed the number of targets achieved per partner to determine the partner's level of achievement.

- If a partner achieved at least 90 percent of a planned output, the partner was deemed to have achieved that output.

- If a partner achieved less than 90 percent of a planned output, the partner was deemed to have not achieved the output.

To determine if USAID/Zimbabwe's planned outputs were achieved, we aggregated the targets for all three partners and the consortium and analyzed the percentage of the total targets using the audit threshold output criteria. The audit materiality threshold criteria were as follows:

> 1) If at least 90 percent of the outputs were achieved, the answer to the audit objective would be positive.
>
> 2) If at least 80 percent but less than 90 percent of the outputs were achieved, the answer to the audit objective would be qualified.
>
> 3) If less than 80 percent of the outputs were achieved, the answer to the audit objective would be negative.

We interviewed mission officials and in-country partners and reviewed results reports to determine progress towards planned outputs. In addition, we performed several site visits in Harare and in the districts of Chiweshe, Chitungwiza, and Chendambuya to observe operations meet with local implementing staff. We also reviewed documentation at clinics and other project implementation sites where we verified selected indicators to the prime partners' reports. Finally, we inquired about the challenges and impediments to implementing the Emergency Plan in Zimbabwe.

MANAGEMENT COMMENTS

USAID | ZIMBABWE
FROM THE AMERICAN PEOPLE

MEMORANDUM

Date: October 9, 2007

From: USAID/Zimbabwe Director, Karen Freeman /s/

To: Regional Inspector General (RIG)/Dakar, Nancy Toolan

Subject: USAID/Zimbabwe Comments on Draft Audit Report No. 7-613-07-004-P

USAID/Zimbabwe is in agreement with the findings of Audit Report No. 7-613-07-004-P and wishes to thank USAID RIG/Dakar for all its support and guidance in improving our monitoring capabilities.

Furthermore, USAID/Zimbabwe is in agreement with the recommendations offered in the report. Our plans for each recommendation with corrective actions are as follows:

Audit recommendation No. 1: We recommend that USAID/Zimbabwe revise its Mission Order on semi-annual portfolio reviews to include reviewing output level data to ensure that outputs in grants, cooperative agreements and contracts continue to be monitored in addition to higher level results.

Corrective Actions

a. USAID/Zimbabwe has revised Mission Order #203 (see attached) as of September 2007. It now states that portfolio reviews will take place semi-annually; the fall review will focus on performance issues to ensure that projects are progressing as planned and that targets and outputs are being achieved – Complete!

b. USAID/Zimbabwe is aligning all HIV/AIDS performance monitoring requirements for partner grants, cooperative agreements and contracts with the FY2007 PEPFAR indicators and will include a requirement that all partners develop data quality plans; Target completion date: end FY2008.

Audit recommendation No. 2: We recommend that USAID/Zimbabwe develop procedures that define the roles and responsibilities of Mission and partner staff in assuring the quality of data. At a minimum, this would include procedures related to verifying reported data with source documentation, documenting key assumptions and calculations, and maintaining documentation to support reported results.

Corrective Actions

a. USAID has revised Mission Order #203 as of September 2007. It now directs implementing partners to "conduct quarterly spot checks of data to ensure that accurate collection and reporting processes exist. This directive includes the need for partners to verify their sub-partners' data as part of the quarterly spot checks. Acquisition and assistance award mechanisms should explicitly include this directive. Furthermore, the Mission Order requires CTOs to perform data verification spot checks during site visits."

b. In August 2007, USAID/Zimbabwe hired a Strategic Information Specialist who has monitoring and evaluation responsibility for PEPFAR indicators.

c. A site visit schedule is being prepared for the Strategic Information Specialist for the last 3 quarters of FY2008.

d. A workshop will be held with our partners' monitoring and evaluation staff to highlight the importance of data verification, documenting assumptions and explaining results; Target completion date: mid FY2008.

e. USAID/Zimbabwe's Program Office is developing a data verification tool for use during site visits by CTOs; Target completion date: mid FY2008.

f. Procedures are being developed that define the roles and responsibilities of Mission and partner staff to ensure that quality PEPFAR activity data is obtained. These procedures will include more frequent and documented data verification spot checks of field sites; Target completion date: end FY2008.

Planned and Actual Results for Fiscal Year 2006

Outputs Achieved at 90 Percent Level or Higher

	Description	Target	Actual	Percent Achieved	Output Tested
1	Number of schools participating in resource exchange activities	2	149	7,450	No
2	Number of individuals reached through community outreach promoting behavior change beyond abstinence or being faithful	10,000	93,588	936	Yes
3	Number of individuals trained to promote HIV/AIDS prevention through behavior change beyond abstinence being faithful	100	763	763	No
4	Number of sound practices identified to support OVCs	1	3	300	No
5	Number of providers trained in opportunistic infection/Antiretroviral therapy management	100	170	170	No
6	Number of individuals provided with HIV related palliative care	8,500	13,941	164	Yes
7	Number of health care workers trained for PMTCT	497	777	156	Yes
8	Number of Basic Package PMTCT sites	118	180	153	No
9	Number of psycho social supportive interventions	10	15	150	No
10	Number of site readiness and follow-up assessments	30	42	140	No
11	Number of children receiving education assistance	21,000	28,181	134	Yes
12	Number of individuals who received counseling and testing for HIV and received their results	150,000	201,180	134	Yes
13	Number of targeted condom service outlets	10,000	13,373	134	No
14	Number of children receiving care and support OVCs	30,000	39,913	133	Yes
15	Number of children enrolled full year in school	22,500	28,181	125	No
16	Number of supportive package PMTCT sites	54	66	122	Yes
17	Number of patients on first- line alternative ARV drug sponsored by US Government	500	606	121	Yes
18	Number of individuals trained to promote HIV/AIDS prevention through abstinence or being faithful	200	205	103	Yes
19	Number of people trained in OVC activities	4,000	4,024	101	No
20	Percent of service delivery points having condoms in stock at point of delivery	95	95	100	No
21	Number of provincial site assessment teams trained	9	9	100	No
22	Number of organizations supporting community responses to OVCs	11	11	100	No
23	Number of community initiatives supporting OVCs	121	121	100	No
24	Number of daily meals served to OVCs	3	3	100	No
25	Number of education assistance interventions implemented	3	3	100	No
26	Number of women receiving results	46,058	45,353	98	Yes
27	Number of individuals trained in counseling and testing according to national and international standards	150	147	98	No
28	Number of service outlets providing counseling and testing according to national and international standards	21	20	95	No
Summary: 58 percent of outputs achieved at 90 percent level or higher (28 of 48 outputs)					

Outputs Achieved at Less Than 90 Percent Level

	Description	Target	Actual	Percent Achieved	Output Tested
1	Number of women HIV tested	55,664	47,448	85	No
2	Number of service outlets providing HIV related palliative care	6	5	83	No
3	Number of women pre-test counseled	79,408	66,139	83	No
4	Number of infants receiving ARV prophylaxis	5,718	4,558	80	No
5	Number of women accessing PMTCT services	98,076	69,485	71	No
6	Number of women receiving ARV prophylaxis	8,744	6,035	69	Yes
7	Number of first antenatal care visits	98,076	66,596	68	No
8	Number of individuals trained to provide HIV palliative care	120	81	68	No
9	Number children reached for psycho social support	42,000	25,369	60	No
10	Number of patients on second-line alternative ARV drug sponsored by U.S. Government	49	25	51	Yes
11	Number of patients on U.S. Government-sponsored Efavirenz	1,500	500	33	Yes
12	Number people living with HIV/AIDS receiving ART	150,000	46,000	31	No
13	Number of individuals trained in HIV-related institutional capacity building	44	10	23	No
14	Number of children benefiting of food security	14,000	3,025	22	No
15	Number of OVC enrolled for support services	150,000	28,181	19	No
16	Number of children benefiting from education assistance	150,000	28,181	19	No
17	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	22	4	18	No
18	Number of individuals reached with community outreach HIV/AIDS prevention through abstinence	14,000	826	6	No
19	Number of individuals reached with community outreach HIV/AIDS prevention through abstinence or being faithful	15,000	826	6	No
20	Number of individuals trained in HIV related stigma and discrimination reduction	20	0	0	No
Summary: 42 percent of outputs achieved at less than 90 percent level (20 of 48 outputs)					

Note: OVC: Orphans and Vulnerable Children; ARV: Antiretroviral; ART: Antiretroviral Therapy; PMTCT: Prevention of Mother-to-Child Transmission; NGO: Non-Governmental Organization; CBO: Church Based Organization

Funding Level

Funding by Accounts	FY 2005 Funding Amounts
Child Health and Survival	$9,900,000
Global HIV/AIDS Initiative	1,600,000
Total FY 2005 Funding	**$11,500,000**

FY 2005 Funding Received by Partners for FY 2006 Activities			
Prime Partners	**Activity period**	**Funding**	**Percentage of total funding**
John Snow Inc.	October 2005 to September 2006	$1,900,000	17 percent
Catholic Relief Services	October 2005 to September 2006	1,600,000	14 percent
Partnership Project	October 2005 to September 2006	3,350,000	29 percent
Elizabeth Glazier Pediatric Aids Foundation	October 2005 to September 2006	2,000,000	17 percent
Other and Admin Expenses	October 2005 to September 2006	2,650,000	23 percent
Total		**$11,500,000**	**100 percent**

Source: Mission data and Office of the Global AIDS Coordinator funding report (un-audited).

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