



USAID
FROM THE AMERICAN PEOPLE

OFFICE OF INSPECTOR GENERAL

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

AUDIT REPORT NO. 9-615-05-007-P
JULY 21, 2005

WASHINGTON, DC




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Office of Inspector General

July 21, 2005

MEMORANDUM

TO: USAID/Kenya Acting Director, Dwight Smith

FROM: IG/A/PA Director, Nathan S. Lokos 

SUBJECT: Audit of USAID/Kenya's Implementation of the President's
Emergency Plan for AIDS Relief (Report No. 9-615-05-007-P)

This memorandum transmits our final report on the subject audit. In finalizing our report, we considered your comments on our draft report and have included your response in its entirety in Appendix II.

The report includes recommendations that USAID/Kenya (1) develop a monitoring plan—including field site visits and milestones—based on a risk assessment of its partners and their activities, (2) place into action a plan to ensure more effective coordination and knowledge-sharing with and among its partners, (3) develop and implement a new procurement and distribution system for HIV test kits, (4) require that its partners develop strategies for the sustainability of their activities, and (5) coordinate with the U.S. Government country team to request Emergency Plan funding for nutritional assistance to be provided to malnourished patients receiving anti-retroviral treatment that are at greatest risk.

Management decisions have been reached for Recommendations No. 1 through No. 5. Please provide documentation supporting final action to USAID's Office of Management Planning and Innovation.

I want to express my sincere appreciation for the cooperation and courtesy extended to my staff during the audit.

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SUMMARY OF RESULTS

This audit, performed by the Office of Inspector General's Performance Audits Division, is part of a series of audits to be conducted by the Office of Inspector General. The objectives of this audit were to determine (1) how USAID/Kenya participated in the President's Emergency Plan for AIDS Relief activities, (2) whether USAID/Kenya's HIV/AIDS activities progressed as expected towards planned outputs in their agreements and contracts, and (3) whether USAID/Kenya's HIV/AIDS activities contributed to the overall U.S. Government's Emergency Plan targets. (See page 4.)

As a result of our audit, we concluded that USAID/Kenya has a principal role in the President's Emergency Plan for AIDS Relief activities in Kenya for HIV/AIDS prevention and care, as well as a major supporting role for HIV/AIDS treatment; its partners were progressing as expected towards meeting planned outputs in their agreements; and USAID/Kenya's HIV/AIDS activities are contributing significantly to the U.S. Government's Emergency Plan care and treatment targets for fiscal year 2004. (See pages 5, 8, and 17.)

This report includes recommendations that USAID/Kenya (1) develop a monitoring plan—including field site visits and milestones—based on a risk assessment of its partners and their activities, (2) place into action a plan to ensure more effective coordination and knowledge-sharing with and among its partners, (3) develop and implement a new procurement and distribution system for HIV test kits, (4) require that its partners develop strategies for the sustainability of their activities, and (5) coordinate with the U.S. Government country team to request Emergency Plan funding for nutritional assistance to be provided to malnourished patients receiving anti-retroviral treatment that are at greatest risk. (See pages 14, 15, 16, 20, and 23.) Management concurred with all five recommendations and management decisions have been reached on all five recommendations. See page 24 for our evaluation of management's comments.

Management's comments are included in their entirety in Appendix II.

BACKGROUND

Congress enacted legislation to fight HIV/AIDS internationally through the President's Emergency Plan for AIDS Relief (Emergency Plan). The \$15 billion, 5-year program provides \$9 billion in new funding to speed up prevention, care and treatment services in 15 focus countries.¹ The Emergency Plan also devotes \$5 billion over five years to bilateral programs in more than 100 countries and increases the U.S. pledge to the Global Fund² by \$1 billion over five years. The fiscal year 2004 budget for the Emergency Plan totaled \$2.4 billion. The Emergency Plan is directed by the Global AIDS Coordinator and implemented collaboratively by country teams made up of staff from USAID, the Department of State, the Department of Health and Human Services, and other agencies.

Kenya is one of the 15 focus countries. The U.S. Government Mission in Kenya (Emergency Plan Team) spent \$76 million during the Emergency Plan 2004 year,³ of which \$44.1 million was managed by USAID. Furthermore, in Emergency Plan year 2005, the Mission will operate the United States Government's (USG's) largest single country Emergency Plan program, with a budget of about \$82 million. The Bureau for Global Health has general responsibility for USAID's participation in the Emergency Plan. More specifically, the Director of Global Health's Office of HIV/AIDS provides the technical leadership for USAID's HIV/AIDS programs.

As of 2003, Kenya had a population of 32 million people, of which an estimated 1.2 to 1.6 million were infected with HIV. The adult prevalence rate⁴ was estimated to be 4.5 percent for men and 8.7 percent for women in 2003, with significant regional and urban/rural variations. Moreover, approximately 890,000 children⁵ in country have been orphaned due to HIV/AIDS.

¹ Twelve countries in Africa (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia); Guyana and Haiti in the Caribbean; and Vietnam in Asia.

² The Global Fund is a public-private partnership that raises money to fight AIDS, tuberculosis and malaria.

³ Kenya's Emergency Plan year 2004 ended May 20, 2005. The 2004 Emergency Plan year generally ended March 31, 2005. However, focus countries were given 12 months to spend their funds from the date each Country Operational Plan (see footnote number 38) was approved. Kenya's plan was approved on May 21, 2004.

⁴ The prevalence rate is defined as the number of cases of a disease during a particular interval of time, expressed as a rate.

⁵ Figures per UNAIDS 2002 Report.

The U.S. President and Congress have set aggressive goals for addressing the worldwide HIV/AIDS pandemic. The world-wide goal over 5 years is to provide treatment to 2 million HIV-infected people, prevent 7 million HIV infections and provide care to 10 million people infected and affected by HIV/AIDS, including patients and orphans. The Department of State's Office of the Global AIDS Coordinator (O/GAC)—which coordinates the USG's fight against HIV/AIDS internationally—divided these Emergency Plan targets among the 15 focus countries and allowed each country to determine its own methodology for achieving their portion of the assigned targets by the end of five years. The U.S. Government Mission in Kenya committed to achieving the following targets by May 20, 2005.

U.S. Government Emergency Plan Targets for Kenya

Total # of Infections Averted	Total # of People Receiving Care and Support	Total # of People Receiving Antiretroviral Therapy
30,000	180,000	Total 38,000 Directly 15,000 ⁶ Other 23,000

AUDIT OBJECTIVES

As part of the Office of Inspector General's fiscal year 2005 annual audit plan, this audit was conducted as one of a series of worldwide audits of USAID's implementation of the President's Emergency Plan for AIDS Relief to answer the following questions:

- How has USAID/Kenya participated in the President's Emergency Plan for AIDS Relief activities?
- Did USAID/Kenya's HIV/AIDS activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts?
- Are USAID/Kenya's HIV/AIDS activities contributing to the U.S. Government's overall Emergency Plan targets?

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

⁶ 15,000 is the number of people targeted to receive anti-retroviral treatment directly through USG Emergency Plan resources. An additional 23,000 HIV patients are targeted to benefit indirectly through USG investments in health infrastructure (commodity procurement, distribution and dispensing; facility-based and central reference laboratories, human capital, etc.), which will allow virtually all Kenyans supported by anti-retroviral treatment to be counted as supported by the Emergency Plan. For example, the strengthening of KEMSA (see page 8), an autonomous Government of Kenya supply agency, contributes towards the 23,000 target.

AUDIT FINDINGS

How has USAID/Kenya participated in the President's Emergency Plan for AIDS Relief activities?

The President's Emergency Plan work and targets are divided into three broad categories: prevention, care and treatment. USAID/Kenya has a significant role in all three areas. About 58 percent (\$44.1 out of \$76 million) of the United States Government's (USG's) funding for Kenya is managed by USAID. The Mission's efforts in these areas are detailed below.

Prevention

The Office of the Global AIDS Coordinator (O/GAC) published guidance dividing the broad category of prevention into the following initiatives. (The percentages in parentheses represent the USAID/Kenya fiscal year 2004 budget as a percentage of the USG country budget.)

1. Prevention of Mother-to-Child Transmission (PMTCT) (48 percent)
2. Abstinence/Be Faithful (65 percent)
3. Medical Transmission/Blood Safety (33 percent)⁷
4. Medical Transmission/Injection Safety (no USAID role)
5. Other Prevention (92 percent)

USAID/Kenya had a significant role in initiatives 1, 2, and 5, and a small role in initiative 3.

Prevention of Mother-to-Child Transmission (PMTCT) – HIV prevalence in pregnant women is estimated at 9.4 percent, and it is estimated that 39,000 newborns are infected with HIV through mother-to-child transmission annually. PMTCT activities are in transition, moving from pilot projects to a scaled-up national program. USAID and its partners provide nevirapine,⁸ train service providers, facilitate minor renovations in hospitals and health care centers, design and implement a logistics system for PMTCT commodities, and produce and air a mass media campaign concerning the prevention of mother-to-child transmission of HIV.

⁷ The USAID/Kenya fiscal year 2004 funding for this activity was \$150,000. Due to its small size (about a third of one percent of USAID/Kenya's \$44.1 million fiscal year 2004 Emergency Plan funding), we are not reporting on blood safety.

⁸ Nevirapine is an FDA-approved drug that significantly reduces the risk of transmission of the AIDS virus from mother to child.

A pregnant woman who tests positive for HIV/AIDS (refer to the Voluntary Counseling and Testing section) is provided counseling in how to reduce the risk of spreading the virus. The primary inducement for women to agree to testing is the opportunity to receive nevirapine. While the U.S. Government ramps up its other antiretroviral treatments, nevirapine has served as an important incentive for women—who otherwise would see little to no benefit in knowing their HIV/AIDS status—to get tested.⁹

Abstinence/Be Faithful – The goal of abstinence and faithfulness programs is to avoid new HIV infections by reducing high-risk behavior. USAID/Kenya’s prevention programming is based on the “ABC” model, where the “A” stands for abstinence, the “B” for “be faithful” and the “C” for condoms. The Emergency Plan legislation requires that one third of prevention funding be allocated to abstinence programs.

In Kenya, young women between the ages of 15 and 24, and young men 20 to 30 are at very high risk of HIV-infection. Accordingly, USAID/Kenya funds youth activities related to behavior change, delayed sexual debut and sustained abstinence. These activities include mass media campaigns, the printing and distribution of educational comic books, and the training of peer group educators, teachers and imams.¹⁰ Other prevention activities include outreach efforts to high-risk worksites and HIV/AIDS education during religious gatherings.

Other prevention – USAID/Kenya also has specific initiatives directed at high-risk groups. For example, one partner and its 14 sub-partners promote adoption of behavior to reduce the risk of infection among specific populations such as low-income women, sex workers, and boda boda drivers (bicycle taxis). Another partner has a condom social marketing program and also places condom dispensers in high-risk outlets such as bars.

Care

To establish consistency in reporting, the O/GAC published guidance dividing the broad category of care into the following initiatives. (The percentages in parentheses represent the USAID/Kenya fiscal year 2004 budget as a percentage of the USG country budget.)

- Voluntary counseling and testing (43 percent)
- Palliative care (89 percent)
- Care for orphans and vulnerable children (87 percent).

Voluntary Counseling and Testing (VCT) – Only 13 percent of adults in Kenya are aware of their HIV status, though most studies find 65 percent or more of those who do not know their status are interested in accessing HIV testing services. Existing VCT sites are unevenly distributed, and many rural areas have no access to VCT. Some

⁹ If the mother tests HIV-positive, the health facility will give nevirapine to the mother at the onset of labor and to the child soon after birth.

¹⁰ An imam is a prayer leader of a mosque.

sites operate sub-optimally due to shortages of VCT counselors, frequent test kit stock outs and inadequate space dedicated to VCT. There is a major effort to scale up VCT services using various models, including VCT services located within health facilities, stand-alone sites operated by partners and smaller community-based organizations, and mobile VCT.

VCT is a point of entry for HIV/AIDS prevention, care and treatment programming. Increasing the number of Kenyans who know their HIV status should promote behavior change and contribute to progress toward HIV prevention targets. Family Health International (FHI), with its nine sub-partners, has taken the lead in VCT. They are involved in activities such as providing counseling and testing, training health workers, conducting mobile VCT sites, renovating VCT clinics and providing quality assurance.

Palliative care – The Emergency Plan defines palliative care as the full range of care services from the time of diagnosis of HIV infection until death. These services include routine monitoring of disease progression and prophylaxis; treatment of opportunistic infections, tuberculosis and other AIDS-related diseases; symptom management; social and emotional support; and compassionate end-of-life care. USAID/Kenya’s partners train community home-based care workers, provide basic health care kits to the HIV-positive patients, and review food and nutrition implications for anti-retroviral treatment (ART).¹¹

Care and Support for Orphans and Vulnerable Children (OVC) - As a result of the high numbers of parents dying from HIV/AIDS, there are over 890,000 children orphaned by HIV/AIDS in Kenya.¹² These children need financial support to pay for food, housing, legal aid, and training and support for caregivers.

USAID/Kenya activities emphasize extended family and community-based responses to the needs of OVC. Sometimes, well-meaning individuals (in Kenya and abroad) have placed a disproportionate emphasis on orphanages. These are sometimes a useful option, but are cited by many child welfare experts as the least desirable or sustainable option for meeting OVC needs. USAID/Kenya activities identify vulnerable children and households, establish and strengthen community-based day care centers, train caregivers, provide psycho-social counseling, and train mature orphans in income-generating activities.

Treatment

USAID is playing a major supporting role in administering the Emergency Plan Team’s treatment programs in Kenya. Treatment reporting categories were divided into (1) antiretroviral (ARV) drugs, (2) ARV services, and (3) laboratory infrastructure.

¹¹ As discussed under the finding “ART Should Be Accompanied by Nutritional Supplements” (see page 23), nutritional assistance is essential for prolonging life and averting opportunistic infectious diseases.

¹² Figures per UNAIDS 2002 Report.

ARV drugs – USAID/Kenya is responsible for procuring ARVs for *all* USG agencies in Kenya. The major purchaser of ARVs is Mission for Essential Drugs and Supplies (MEDS), a non-profit, faith-based organization founded by the Christian Health Association of Kenya and the Roman Catholic Kenya Episcopal Conference. USAID/Kenya awarded MEDS a \$7,000,000 contract to procure and distribute ARVs and other essential commodities to more than 40 constituent health care facilities, including dozens of faith-based hospitals, private sector providers, and a limited number of public sector facilities.

Plans for ARV scale-up are coordinated with the Government of Kenya's National AIDS and STD¹³ Control Programme (NAS COP) to ensure that they are in accordance with the existing health care network in Kenya. Recipients of treatment include thousands of patients who were clinically eligible for antiretroviral therapy but had been unable to access or afford antiretroviral drugs.

ARV services – Distribution of the ARV drugs involves several steps that include storage, distribution, delivery and tracking. Kenya Medical Supplies Agency (KEMSA), an autonomous Government of Kenya (GOK) supply agency, has a program to strengthen the national logistics system. John Snow International (JSI) is providing technical assistance to help make KEMSA an efficient distribution center of essential drugs and other commodities with state-of-the-art inventory control, accounting, and logistics management information systems.

Laboratory infrastructure – JSI has a program to assess, refurbish and equip laboratories and to retrain staff and provide some consumables. Additionally, FHI has programs to purchase equipment and commodities and undertake laboratory renovations.

Did USAID/Kenya's HIV/AIDS activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts?

We found that USAID/Kenya's activities were progressing as expected towards meeting planned outputs contained in agreements and contracts with the Mission's partners. Those partners had until May 20, 2005¹⁴ to achieve planned outputs and were on track to do so. Nevertheless, we also determined that delays in the procurement of ARVs had temporarily threatened progress, that USAID/Kenya needs to strengthen both the monitoring of its partners and the coordination among its partners, and that shortages of HIV test kits have impeded the Mission's treatment program.

The following discussion provides examples of how the Mission's activities were progressing toward planned outputs and addresses the issues mentioned above.

¹³ STD is the acronym for sexually transmitted diseases.

¹⁴ For an explanation on how this date was determined, please refer to footnote number 3.

Prevention

USAID partners reported significant outputs in providing prevention under the categories of (1) Prevention of Mother-to-Child Transmission (PMTCT), (2) Abstinence/Be Faithful, and (3) Other Prevention Initiatives.

Prevention of Mother-to-Child Transmission – Two PMTCT partners, FHI and AMKENI¹⁵ (which means “awakening” in KiSwahili), reported problems in the receipt of nevirapine and HIV test kits (see the finding concerning HIV test kits on page 16). In a meeting at FHI's office, its staff reported that progress towards planned PMTCT outputs was initially limited due to the lack of nevirapine and HIV test kits, both of which were supposed to be supplied by the Kenyan government. FHI overcame this obstacle by procuring these items through a private company and reported that it exceeded its planned outputs.

In contrast, during the audit we visited a health center in Chwele supported by AMKENI. The center serves a population of 52,000 people. We inspected the health center's VCT and PMTCT log book, which showed that very little nevirapine had been administered. We were told that most of the women who were eligible did not receive nevirapine because of shortages. Center staff indicated that VCT kit shortages have held up the PMTCT programs. At their main office, AMKENI indicated that due to these shortages, they did not meet their intended outputs for the number of women visiting VCT centers, but that they exceeded their intended output in terms of numbers of VCT centers opened.

Abstinence/Be Faithful – One of USAID/Kenya's prevention partners, Population Services International (PSI), is involved in mass media advocacy for abstinence and in interpersonal advocacy programs for behavior change promotion in both schools and workplaces. Its mass media advocacy includes producing television ads targeted to youth, print ads, billboards, and posters placed in high-risk outlets. Interpersonal advocacy programs include conducting role-playing activities to promote abstinence in youth. We observed a TV commercial prepared by PSI targeting youth and were positively impressed by its professional quality.

We visited an activity by the Kenya Girl Guides¹⁶ Association, which receives funding via FHI. The funding pays for an assortment of literature, including printing and distributing comic books on HIV/AIDS featuring a young girl named “Sara.” The girls earn badges by performing activities such as caring for a person who needs palliative care or writing an essay about how HIV/AIDS is transmitted. We observed several detailed posters created by the Association which conveyed abstinence messages and watched the Association perform two skits that promoted abstention. The Association performs these skits in their community, as peer education for behavioral change.

¹⁵ AMKENI is a local umbrella organization involved in family planning, reproductive health, and child survival throughout Kenya, and is managed by EngenderHealth, an international nonprofit organization based in New York City.

¹⁶ Girl Guides are the British version of girl scouts.

In a busy market place, we also witnessed a drama presentation supported by PSI. A crowd of about 200 people assembled to watch the players dance and sing about HIV/AIDS. After the dancing, the group performed a drama about a girl who is kicked out of her family home when it becomes known that she is HIV-positive. Over time, her parents learn that they cannot catch the virus simply by touching her, so they allow her back in the house. After the drama, a person living with HIV/AIDS spoke to the group on his experiences living with the virus. The community drama seemed to be a very effective, low-cost way to reach people with information on HIV/AIDS and to demonstrate behavioral change.

Other prevention initiatives – PSI conducts social marketing of condoms. It procures condoms and distributes them through a supply chain management system to “high risk outlets,” such as brothels and bars. We visited a bar, a brothel and two kiosks in downtown Nairobi, and observed the condom dispensers prominently displayed. At both the brothel and the bar, packages of three condoms were sold for approximately 13 cents. As PSI believes that the Emergency Plan will no longer allow condom distribution,¹⁷ it notified us that it will continue to fund its condom program with British government funds.

Care

We found that USAID/Kenya’s care partners were progressing as expected towards meeting planned outputs in their agreements. USAID partners reported significant outputs in providing care under all U.S. Government categories of (1) voluntary testing and counseling (VCT), (2) palliative care, and (3) care for orphans and vulnerable children.

While USAID’s partners are, in general, making good progress towards achieving their planned outputs for care, we noticed the supply of VCT test kits was often not reliable.

Voluntary Counseling and Testing (VCT) – USAID maintained agreements with VCT partners to provide HIV/AIDS testing and counseling in urban and rural health centers. One such partner, AMKENI, reported problems in receiving supplies of HIV test kits and other commodities. We visited the health center in Chwele supported by AMKENI and were also told of the HIV test kit shortages (see related finding concerning HIV test kits on page 16). The health center conducts regional outreach services by going to funerals and schools in villages to encourage people to come in for testing.

Palliative care – USAID/Kenya provided funding to various partners for palliative care. Pathfinder International had 21 care and support groups in a small town, each with over 100 members. Depending on the physical condition of the HIV patient, the volunteer’s role can include bringing food, helping with the laundry and house cleaning, and assisting the patient with bathing. We visited a patient at her home, where a support group meets on a regular basis. The members were women, most widows who had lost

¹⁷ Another partner also told us that the Emergency Plan will no longer fund condom distribution. However, both the United States Mission to Kenya Five Year Strategy for the President’s Emergency Plan for AIDS Relief and the United States Mission to Kenya 2005 Country Operational Plan refer to the funding of condom distribution.

their husbands to HIV/AIDS. In this particular case, the hostess and visitors seemed to be still physically strong. They benefited from the social support provided by the group, as HIV-positive patients are often stigmatized by society and rejected by their own relatives.

Indiana University, through its Academic Model for the Prevention and Treatment for HIV/AIDS (AMPATH) activity, supports the HIV section of the Moi Teaching and Referral Hospital, one of the Kenyan hospitals with treatment centers for HIV patients. The hospital also provides HIV treatment training for Kenyan medical students who will provide HIV care in the latter years of the Emergency Plan, contributing to the sustainability of HIV efforts in Kenya. We visited the HIV section of the hospital, which provides basic care to HIV-infected individuals, where we saw a female patient being treated for Kaposi's sarcoma (KS) in her mouth, a skin cancer common in people with HIV/AIDS.

We also visited a "demo" farm in Mosoriot that serves as an "economic empowerment" activity for HIV patients. On this farm, HIV-infected individuals are taught small-scale agriculture, usage of compost, preparation of milk and cream, and condiment growing and usage, among other things. Nearby, we visited a larger farm that had only been purchased about a month before our visit and will become a large-scale "production" farm. The Emergency Plan paid for the start-up costs of these farms,¹⁸ which are both run by Indiana University.

Care for Orphans and Vulnerable Children (OVC) – USAID/Kenya activities for orphans are family and community-based. We visited a community center¹⁹ run by Pathfinder International. The center had a program to train HIV orphans in marketable skills. In this center, the students who receive training teach the subsequent class of students. We met an HIV/AIDS orphan who learned to sew through the first vocational training class (see following picture). His business has been very successful. He went on to train others to sew in the second training class. We also saw a group of HIV/AIDS orphan girls in their sewing workshop, who demonstrated how they have learned to sew school uniforms, dresses, sweaters, etc.

¹⁸ The land for the "demo" farm was donated by a local high school. The land for the "production" farm is owned by a British farmer who leases it to the Indiana University program for a nominal yearly fee. The farmer also works for the Indiana University program.

¹⁹ This community center was also a good example of sustainability, as described on page 20.



Photograph taken April 11, 2005 by an OIG auditor of a child orphaned by HIV/AIDS in Western province. He was taught sewing skills to provide a means of sustainable support.

Treatment

ARV drugs – USAID/Kenya's treatment partners were progressing as expected towards the planned outputs in their agreements. As of December 2004, the main USAID/Kenya treatment partner, MEDS, had procured 33 percent of the ARVs, which was adequate progress towards reaching 100 percent by March 31, 2005. However, in January 2005 the GOK imposed a 10 percent import tax on ARVs.²⁰ USAID refused to pay the tax, so MEDS did not procure the remaining ARVs by March 31, 2005, as planned. On April 18, 2005, the Mission received a waiver from the GOK allowing its partners to procure medical supplies without paying the import tax.²¹ As a result, MEDS expected to have 100 percent of the ARVs for fiscal year 2004 in its warehouse by the end of April 2005, ahead of the May 20, 2005 Emergency Plan deadline.

While visiting a MEDS warehouse, we observed that the locked area where they kept the Emergency Plan ARVs was full. We were told that the amount of stored ARVs was not even a third of the \$7 million contracted requirement because much had already been distributed. MEDS added that USAID/Kenya has provided the funding to reorganize their warehouses to accommodate new Emergency Plan ARVs in April 2005.

²⁰ The East African countries of Kenya, Tanzania and Uganda imposed a 10 percent import tax on all drugs manufactured outside of their countries.

²¹ Subsequently, in May 2005, Kenya temporarily suspended its 10 percent tax on drugs imported into the region.

ARV services – We visited two hospitals that had Emergency Plan ARV programs through FHI. At St. Mary’s Hospital, 76 patients were on ART. St. Mary’s has two doctors, including one shared with another hospital, as well as two medical assistants. We talked to the Medical Officer in Charge (a doctor), who was also the Emergency Plan project manager. The doctor told us that they have enough physicians to handle 76 ART patients, but when the number of patients increases, they will have a doctor shortage. All the 76 patients tested HIV-positive, but none were subsequently tested at the hospital to establish T-cell count baselines,²² as the hospital did not have the lab equipment to perform the tests. To obtain T-cell count baselines, the patients were referred to a larger hospital about 125 miles away. Because the other hospital is too far away to make regular testing practical, most of the 76 patients are not periodically monitored for T-cell counts. In these cases, patients are placed on ARVs based on symptoms, which the doctor indicated was not a good practice. (See related finding on page 22.) The hospital also provides nutritional information to its 76 ARV patients.

While St. Mary’s Hospital aims to have 250 patients on ARVs for the Emergency Plan year 2004 and 500 patients for Emergency Plan year 2005, the Medical Officer in Charge does not believe they can meet these outputs without additional lab equipment. JSI is expected to supply them with additional equipment, but hospital staff does not know when to expect it. We toured the laboratory, where the only HIV/AIDS-related equipment was a machine that confirms a patient’s HIV status in the event an initial test indicates an HIV-positive result. The hospital pharmacy was well stocked with ARVs. In the storage room, an upright fan was blowing on the drugs to keep them from getting too hot because heat might cause some drugs to lose their effectiveness.

We also visited Bungoma Hospital, which recently established its Emergency Plan treatment program. The Project Coordinator there told us that their planned output for fiscal year 2004 is to have 100 patients on ARVs. As of our visit, 10 patients were on ARVs. The Project Coordinator told us that they do not have the lab equipment necessary to monitor people on ARVs, so they send patients to a regional hospital in Kakamega for continuous monitoring. The coordinator told us that, due to transportation difficulties, patients on ARVs are not adequately monitored. We toured the hospital, in particular, a wing that USAID paid to renovate. We also visited the laboratory, which did not have any ARV monitoring equipment in it.

USAID/Kenya Should Strengthen the Monitoring of Its Partners' Progress

USAID/Kenya’s monitoring of its partners was not always sufficient, which could jeopardize the achievement of future outputs and targets. USAID/Kenya’s Cognizant Technical Officers are responsible for monitoring the progress of the partners’ activities. Yet, of the eight partners we met with, three had received little to no monitoring from

²² T-cell counts are also known as CD4 counts. T-cells are white blood cells, which play an important role in the immune system. The HIV virus infects and damages T-cells, and the T-cell count reflects how many functional T-cells are circulating in a patient’s blood. Periodic T-cell count monitoring is important as it provides an indication of the immune system’s strength, which a doctor takes into account when prescribing HIV medications and prophylactic antibiotics.

USAID.²³ Specifically, a prevention partner told us that there has been essentially no monitoring of their program by USAID and that they had contacted the Mission many times to request meetings, but that USAID staff did not have the time to meet with them. A second partner, involved in treatment, told us that there was no interaction with the Mission. Another treatment partner was not being monitored at all, was not submitting performance reports to USAID/Kenya, and was not aware that they were receiving Emergency Plan funds from USAID.²⁴ On the other hand, the remaining five partners reported that they received sufficient monitoring from the Mission.

According to Mission officials, the inconsistencies in monitoring are due to the heavy workload associated with the Emergency Plan and are exacerbated by not having sufficient staff. Moreover, USAID/Kenya officials themselves recognize that they have too many partners (36 Emergency Plan partners in fiscal year 2004, increasing to 72²⁵ in fiscal year 2005) to manage effectively.

In response to the workload issue, the Mission has initiated several actions to strengthen the monitoring of its partners' progress. For example, the Mission plans to reduce the number of partners it directly manages, both by placing new, small partners under umbrella organizations and by delivering some services through regional consortiums. The Mission has also taken steps to bring on additional personnel, including a person to direct major Emergency Plan activities, a New Entry Program employee and additional staff in the acquisition and legal offices. Mission officials further noted that its monitoring included the performance of pre-award assessments covering financial, administrative, personnel, procurement and travel issues, as well as other monitoring activities.

Nevertheless, based on the experience of the three partners which reported they had received little or no monitoring, we believe that the Mission's monitoring of its Emergency Plan activities could be strengthened. Accordingly, we are making the following recommendation.

Recommendation No. 1: We recommend that USAID/Kenya develop a monitoring plan—including field site visits and milestones—based on a risk assessment of its Emergency Plan partners and their activities.

²³ In general, partners that receive the most funds also had the most oversight. During fiscal year 2004, partners that received an average of \$4 million had more oversight than partners that received an average of \$2.3 million.

²⁴ This partner was a GOK entity that received funds through a managing agent.

²⁵ A USAID/Kenya official told us that for 2005, the effective number of partners that the Mission manages is 53, as 19 are managed by one entity. In our opinion, even 53 partners is a large number of partners to manage.

Coordination Among USAID/Kenya's Partners Should Be Strengthened

At the core of the implementation strategy of the Emergency Plan is a robust ongoing in-country planning effort to identify existing resources, needs, gaps, programs, objectives, performance measures, staffing and technical assistance requirements. An improved level of coordination increases the chances that objectives and performance measures will be achieved efficiently and effectively. While USAID/Kenya is facilitating coordination among most of its HIV/AIDS partners, of the eight partners we visited, three were working without effectively coordinating their activities with those of other partners.²⁶ Consequently, not all Emergency Plan resources have been used efficiently and effectively. For example, at one point PSI was creating demand for VCT and PMTCT services through mass media social marketing, not knowing that VCT clinics did not have HIV test kits. As a result, clinics had to turn away people who wanted to be tested for HIV. Although this specific situation was resolved, it demonstrates how inadequate coordination can jeopardize the efficient and effective use of Emergency Plan resources. In contrast, five other partners coordinated among themselves to the extent necessary. As a result, we concluded that although USAID/Kenya is coordinating five of its partners very well, three partners are receiving little or no coordination.

USAID/Kenya should manage resources efficiently and effectively, and this includes reducing potential programmatic inconsistencies or overlaps. We believe that USAID/Kenya and its partners will be able to achieve greater efficiency and magnify the impact of its funding by facilitating the exchange of information among HIV/AIDS partners. USAID/Kenya officials claimed that the lack of coordination reported by some partners is due to the heavy workload associated with the Emergency Plan and to not having sufficient staff. Nevertheless, the Mission needs to give coordination with and among partners the priority it deserves. The following recommendation, addressing the issue of coordination, will leverage the Mission's resources to help it meet its Emergency plan outputs.

Recommendation No. 2: We recommend that USAID/Kenya (a) formulate a strategy to ensure more effective coordination and knowledge-sharing with and among its partners, (b) develop an action plan—including targets and milestones—to enact its strategy, and (c) implement its action plan.

²⁶ These are the same three partners who also received insufficient monitoring from USAID/Kenya.

Shortages of HIV Test Kits Are Impeding USAID/Kenya's Treatment Program

As mentioned previously in this report, voluntary counseling and testing is a point of entry for HIV/AIDS prevention, care and treatment programming. Test kits are an important element of VCT because they provide the means to test for HIV/AIDS. The fiscal year 2004 HIV/AIDS test kits were procured by the World Bank and distributed to Kenya's VCT centers through the National AIDS and STD Control Program (NAS COP), under Kenya's Ministry of Health. However, a significant number of HIV test kits did not reach the intended VCT centers.²⁷

At their Nairobi offices, three Emergency Plan partners²⁸ cited HIV test kit shortages as impediments to reaching their planned outputs, and two of them are purchasing test kits using non-Emergency Plan funds. A clinic in Chwele advised us that HIV test kit shortages were holding up their VCT and PMTCT programs; they had a goal of 100 people tested a month and only accomplished it in one out of 15 months due to these shortages. The PSI example on page 15 also evidences these shortages. As a result of such shortages, testing sites are unable to meet demand, hindering other Emergency Plan programs (i.e., PMTCT, home-based care, treatment) that rely on VCT as the point of entry for their services and potentially impacting USAID/Kenya's progress in contributing to Emergency Plan targets.

USAID/Kenya should manage resources efficiently and effectively, and this includes devising and implementing a supply chain that provides test kits to all VCT sites in a timely and secure manner. USAID/Kenya officials stated that they were already considering alternative strategies for procurement and distribution of these commodities (see footnote number 27). We are making the following recommendation concerning this situation.

Recommendation No. 3: We recommend that USAID/Kenya (a) assess the current procurement and distribution system for HIV test kits, (b) devise a new procurement and distribution strategy that implements the controls necessary to ensure their timely distribution, (c) develop a plan for implementing that strategy, including targets and milestones, and (d) implement the plan.

²⁷ Allegedly, the fiscal year test kits were not arriving due to (1) the diversion of such kits and (2) the slow-moving GOK bureaucracy. The Mission stated that for fiscal year 2005, the Global Fund was supposed to procure these kits, but this has not yet happened. Therefore, in the interim, the Mission established a new system, by which JSI delivers the kits directly to district warehouses. The donor community is paying for the 2005 kits, including a \$300,000 contribution from USAID.

²⁸ These partners were FHI, Indiana University, and AMKENI.

Are USAID/Kenya's HIV/AIDS activities contributing to the U.S. Government's overall Emergency Plan targets?

USAID/Kenya's HIV/AIDS activities are contributing significantly to the USG's overall Emergency Plan care and treatment targets for fiscal year 2004. In the area of prevention, however, the O/GAC is reviewing its methodology for measuring the impact of prevention activities on non-PMTCT targets, which comprise 92 percent of the USG prevention targets. Accordingly, it was not possible to determine USAID's contribution to non-PMTCT targets. Nevertheless, for care, USAID/Kenya's activities contributed 51 percent of the Emergency Plan targets for palliative care and 51 percent of the OVC activities. In the area of treatment, USAID played a major supporting role by procuring the necessary ARV drugs needed for treating HIV/AIDS patients for *all* USG agencies in Kenya.

USAID/Kenya's important role in meeting Emergency Plan targets is also reflected in the fact that it received \$44.1 million (58 percent) of the \$76 million budgeted for the overall U.S. Government effort in Kenya. While we believe that the Emergency Plan Team should meet most of its fiscal year 2004 targets, there are potential impediments to achieving targets for future years.

Prevention

In the area of PMTCT prevention, USAID/Kenya's activities had contributed 13 percent of the Emergency Plan Team's progress towards its PMTCT target (see Table 1) and received approximately half (48 percent) of USG/Kenya's PMTCT budget.²⁹ For non-PMTCT prevention, USAID received 78 percent of the USG budget, but the figures for infections averted have not been computed. This is because the O/GAC is reviewing its methodology for measuring the impact of prevention activities on non-PMTCT targets, which comprise 92 percent of the USG prevention targets. As O/GAC has not yet completed its review and gathered enough data,³⁰ we could not determine USAID/Kenya's contribution to the USG's target of preventing 27,500 non-PMTCT infections. For fiscal year 2004 prevention activities, USAID received \$12.7 million (of which \$4.2 million was for providing PMTCT services) out of the \$19.6 million budgeted for the U.S. Government in Kenya.

In the future, meeting PMTCT targets might be increasingly challenging due to the rapid increase in targets and the unreliability of the HIV test kit supply chain (which we addressed on page 16). The PMTCT target triples from 2,500 in fiscal year 2004 to 7,500 in fiscal year 2006 and increases to a total of 12,500 (or 37,500 cumulatively) by 2008. Additionally, if the HIV test kit supply chain problems are not solved, the HIV

²⁹ The budget percentage is provided as an indication of USAID/Kenya's role within USG/Kenya and not as an indication of USAID/Kenya's progress toward achieving targets. The budget was for the year ending May 20, 2005, while the progress data was only reported as of September 30, 2004.

³⁰ O/GAC stated that the earliest date they can compute infections averted with sufficient data is at the end of calendar year 2005.

testing of pregnant women will be reduced—ultimately reducing the number of women to be offered a full course of nevirapine.

Table 1 - Prevention Targets and Contributions

	USG Target for FY 2004 (A)	USAID's Contribution 09/30/04 (B)	Total USG Progress 9/30/04 (C)	USAID's Contribution as a Percent of USG Target (B÷A)	USAID's Contribution as a Percent of USG Progress (B÷C)
PMTCT ³¹ Infections Averted	2,500	325	1,821	13 %	18%
Abstinence/ Faithfulness Infections Averted	Combined 27,500 ³²	Not computed	Not computed	N/A	N/A
Other Prevention Infections Averted		Not computed	Not computed	N/A	N/A

Note: These amounts were reported by the USG Kenya Emergency Plan Team and were not audited.

Care

USAID/Kenya's HIV/AIDS activities are making a major contribution to the U.S. Government's overall Emergency Plan targets for care. As the chart below indicates, USAID contributed 33 percent of the Emergency Plan results reported as of September 30, 2004, for VCT, 55 percent of the results under palliative care, and 100 percent of the OVC results. As of September 30, 2004, USAID had already achieved 51 percent of the U.S. Government yearly targets for palliative care and OVC activities, a very notable achievement given that 7½ months remained to achieve those results. The Mission also had a major role in all care areas: USAID/Kenya had 43 percent of the USG/Kenya VCT budget and a very high 89 percent and 87 percent for palliative care and OVC, respectively. In terms of funding for fiscal year 2004 care activities, USAID received \$9.6 million out of the \$16.7 million budgeted for the Emergency Plan Team in Kenya.

³¹ Per the Fiscal Year 2004 Country Operational Plan for Kenya, the number of PMTCT infections averted is calculated by multiplying the number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting by 20 percent. For example, 1,625 pregnant women received nevirapine through USAID/Kenya partners, resulting in an estimated 325 infections averted (1,625 times 20 percent).

³² This target includes 1,400 infections averted (including 200 due to USAID/Kenya's efforts) under the blood safety program mentioned on page 5.

Table 2 - Care Targets and Contributions

	USG Target for FY 2004 (A)	USAID's Contribution 09/30/04 (B)	Total USG Progress 9/30/04 (C)	USAID's Contribution as a Percent of USG Target (B÷A)	USAID's Contribution as a Percent of USG Progress (B÷C)
Individuals Receiving VCT	N/A ³³	90,754	275,772	N/A	33%
Individuals Receiving Palliative Care	60,000	30,575	55,675	51%	55%
OVCs Served by Program	112,000	56,816	56,816	51%	100%

Note: These amounts were reported by the USG Kenya Emergency Plan Team and were not audited.

While the U.S. Government appears to be on the way to achieving the fiscal year 2004 Emergency Plan care targets in Kenya, care targets are increasing substantially over the rest of the Emergency Plan. The palliative care target will increase to 90,000 for 2005 and to 120,000 for 2006. The OVC target will also increase to 190,000 for 2005 and to 287,000 for 2006.

Partners Should Develop Strategies For Sustainable Activities



The importance of sustainability is recognized in the O/GAC's 5-year strategy for the Emergency Plan. One of its strategic principles aims to develop sustainable HIV/AIDS health care networks. By definition, sustainable development activities continue providing benefits beyond the timeframe in which donor funding is received. On the other hand, the benefits of non-sustainable development activities do not necessarily continue beyond the 5 years covered by the plan.

Similarly, the importance of sustainability is also recognized in the 5-year strategy developed by the Emergency Plan Team in Kenya. In that plan, the US Mission in Kenya stated that it was reasonably confident that indigenous physical and human capacities will exist in 2008 to sustain the HIV/AIDS interventions initiated under the

³³ The Fiscal Year 2004 Country Operational Plan for Kenya provided no VCT targets.

Emergency Plan. However, it also noted that external financial support beyond the life of the Emergency Plan might be needed to provide ARV treatment to patients during the rest of their lives and to care for orphans. During our discussions, Mission officials told us that sustainability was harder to achieve with ARVs, but relatively easier to achieve with OVCs.

Despite the conceptual commitment to sustainability cited in the Emergency Plan strategy for Kenya, sustainability has not been deliberately planned into all of USAID/Kenya's Emergency Plan activities since O/GAC did not require partners to incorporate sustainability into their projects for FY 2004. This, however, is not to say that USAID/Kenya's programs do not incorporate sustainability in some cases. For example, a Community Center³⁴ in the Western Province had a program to teach HIV/AIDS orphans vocational skills so that they will be able to support themselves in the future. We met some orphans that had been taught to sew clothing such as school uniforms and boys' and girls' clothing. The leader of the program had also arranged to supply the municipality with school uniforms for the local school, guaranteeing a market for the orphans' products. As a result, these orphans will have a means of income and a foothold in the local market. While this was a good example of how sustainability had been built into an activity, other Emergency Plan activities lacked such features. As a result, the benefits of those activities may well not extend beyond the completion of the activities.

USAID is currently considering a draft policy addressing sustainability that would be included in its Emergency Plan contracts, grants and cooperative agreements. This policy—which requires the building of institutional capacity and the development of exit strategies—has already been approved by O/GAC and is awaiting USAID approval before being issued as a USAID Acquisition and Assistance Policy Directive. Pending the issuance of USAID's final policy concerning sustainability in Emergency Plan activities, we are making the following recommendation.

Recommendation No. 4: We recommend that USAID/Kenya require that its partners develop strategies for the sustainability of their Emergency Plan activities, including the incorporation of institutional capacity-building activities and the development of exit plans.

Treatment

USAID/Kenya's HIV/AIDS activities are playing a major supporting role in achieving the U.S. Government's overall Emergency Plan targets for treatment. As noted in the following table, USAID/Kenya had contributed 9 percent towards the achievement of the USG ART target for Kenya, and its contribution to the progress reported by the Emergency Plan Team as of September 30, 2004, was 17 percent. The USG target for HIV/AIDS treatment in Kenya is to directly provide 15,000 patients with Antiretroviral Therapy (ART) services by May 20, 2005. In terms of funding for fiscal year 2004 treatment activities, USAID/Kenya received \$15.5 million out of the \$23.3 million (66 percent) budgeted for the U.S. Government effort in Kenya, of which approximately \$7

³⁴ The report also mentions this Community Center on page 11.

million is for procurement of ARV drugs through MEDS, as discussed under objective number 1.

Table 3 - Treatment Targets and Contributions

	USG Target for FY 2004 (A)	USAID's Contribution 09/30/04 (B)	Total USG Progress 9/30/04 (C)	USAID's Contribution as a Percent of USG Target (B÷A)	USAID's Contribution as a Percent of USG Progress (B÷C)
Individuals Receiving ART	38,000 Direct 15,000 ³⁵ Other 23,000	1,353	7,864	9%	17%

Note: These amounts were reported by the USG Kenya Emergency Plan Team and were not audited.

The Emergency Plan Team's 5-year goal is to have 162,000 individuals receiving ARV treatment by 2008. Even though the USG partners are progressing towards meeting the Emergency Plan target for treatment, they face numerous challenges in meeting future targets. When the targets were set, the USG Mission relied on information from UNAIDS that stated that the HIV/AIDS prevalence rate in Kenya was 15 percent when in reality it is significantly lower.³⁶ Since the targets were based on an erroneously higher prevalence rate, the targets themselves were erroneously inflated and meeting them will likely present a challenge over the life of the Emergency Plan.

Another challenge to the treatment targets concerns the Emergency Plan's current requirement that only branded drugs be purchased as ART. Since branded drugs are priced higher than generics, this requirement effectively results in fewer people being treated than if generic drugs were used. We understand that the FDA is considering allowing World Health Organization (WHO)-approved generic drugs to be purchased with Emergency Plan funds, but such a determination has not been made as yet. Additionally, the reliance on branded drugs can place the achievement of future treatment targets in jeopardy if the manufacturers of those drugs are not able to meet the demand for ARVs. At least one pharmaceutical company that is experiencing shortages of branded ARVs recommended that available inventories be used to treat current patients and that enrollment of new patients be deferred until the supply capacity improves.

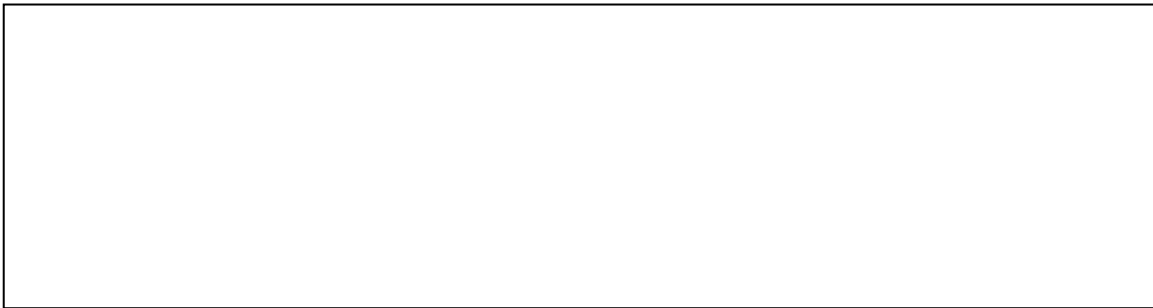
Other challenges include the reliability of the current system for monitoring patients on ARVs and the provision of proper nutrition as part of the treatment program. These

³⁵ 15,000 people are targeted to receive ARTs directly through USG Emergency Plan resources. For more details, refer to footnote number 6.

³⁶ According to the Fiscal Year 2004 Country Operational Plan for Kenya, the HIV/AIDS adult (age 15-49) prevalence rate by gender is 8.7 percent for women and 4.5 percent for men, per a 2003 Demographic and Health Survey in Kenya. However, earlier UNAIDS information cited a 15 percent rate, which became a basis for the country's high Emergency Plan targets.

issues are discussed in detail below.

Strategies for Monitoring Patients on ARVs Should Be Developed



We visited two district hospitals and a health center and noted that the facilities lacked laboratory equipment to properly monitor patients on ART. Mission officials told us that \$2 million in funding for laboratory equipment—which could begin to address this situation country-wide—was tied-up in a complicated procurement process. In the absence of necessary lab equipment, these facilities have placed patients on ARVs based on symptomology³⁷ as specified in WHO HIV/AIDS algorithms. The following picture shows the only HIV-specific medical equipment at one of the district hospitals that we visited.



Photograph taken April 11, 2005 of a doctor with a machine that confirms HIV test results at St. Mary's hospital in Western Province

³⁷ Symptomology is the study of the aggregate of the symptoms and signs of a disease.

Ideally, HIV/AIDS patients should not be placed on ARVs without periodic CD4, biochemistry and hematology tests as specified in the GOK National Protocols. However, some of the lower level health centers do not yet have the equipment necessary to properly monitor patients receiving ART and, therefore, need to rely on the Government of Kenya's networking approach. This approach links dispensaries to district hospitals to provincial general hospitals, and ultimately to the two national referral hospitals. In theory, an HIV/AIDS patient can go to a higher-level facility for testing if the local facility does not have the required equipment. However, in reality, the patient often does not receive the required testing because the alternative facility is too far away or expensive for the average Kenyan to reach. As a result, patients do not receive the necessary testing, and the quality of their HIV/AIDS treatment is compromised.

According to USAID/Kenya officials, the GOK Ministry of Health is developing a strategy to test and monitor patients at lower level district hospitals and health centers. Moreover, Mission officials anticipate that USAID and its partners will help the GOK implement that strategy. Consequently, we are not making a recommendation for further action at this time. However, we do intend to revisit this area in future audits of the Mission's Emergency Plan activities.

ART Should Be Accompanied by Nutritional Supplements

In the Emergency Plan legislation, Congress recognized the importance of good nutrition, noting that healthy and nutritious foods for individuals living with HIV/AIDS are an important complement to HIV/AIDS treatment. However, most of USAID/Kenya's partners in FY 2004 did not use Emergency Plan funds to combine nutritional supplementation with ARV treatment, given the emphasis on the provision of ARVs. To address this problem, USAID/Kenya, in conjunction with INSTA products, developed INSTA mix, a nutritional supplement designed specifically for adults with HIV/AIDS.

USAID/Kenya's fiscal year 2005 budget contains \$500,000 for INSTA mix, but this will only help approximately 6,500 people. Since USAID/Kenya estimates that 50 percent of ARV patients need nutritional supplementation, we calculate that approximately 22,500 adults will need nutritional supplements (half of the FY 2005 target)—leaving a 16,000-person shortfall. Without nutritional supplementation, malnourished patients will not fully benefit from treatment due to the toxicity of ARVs, compromising USAID's ability to meet the USG's treatment targets.

In April 2005, O/GAC released a draft policy on the use of Emergency Plan funds to address food and nutrition needs. Since this will allow USAID/Kenya the opportunity to request funding for such assistance, we are making the following recommendation to help the Mission find the resources to assist the remaining malnourished HIV/AIDS patients targeted to receive treatment.

Recommendation No. 5: We recommend that USAID/Kenya coordinate with the U.S Government country team to request Emergency Plan funding for nutritional assistance to be provided to malnourished patients receiving anti-retroviral treatment that are at greatest risk.

EVALUATION OF MANAGEMENT COMMENTS

In its response to our draft report, USAID/Kenya concurred with our draft Recommendation No. 1 through No. 4 and, with a minor modification, with draft Recommendation No. 6. It also addressed our concerns on draft Recommendation No. 5, which we have deleted from our final report. The Mission's comments—and our evaluation of those comments—are summarized below.

Recommendation No. 1 recommended that the mission develop a risk-based monitoring plan. In its comments, the Mission indicated that it will formally stratify its partners by risk and adjust its monitoring based on this stratification. We believe that a management decision has been reached on this recommendation.

Recommendation No. 2 recommended that USAID/Kenya develop a strategy and action plan for enhancing coordination and knowledge-sharing with and among its partners. The Mission reported that it will incorporate ongoing activities in a more comprehensive plan that includes an annual calendar of meetings and the distribution of meeting minutes for optimum information sharing and application of lessons learned. The Mission will also continuously track attendance at these meetings and will follow-up with partners if patterns of non-participation in these coordinating fora are found. We believe that a management decision has been reached on this recommendation.

Recommendation No. 3 recommended that USAID/Kenya assess the current procurement and distribution system for HIV test kits, devise a new strategy to ensure timely distribution of test kits, develop a plan for implementing that strategy, and execute the plan. The Mission noted that procurement was a cross-cutting area involving the GOK and all donors. However, the Mission also stated that while the national procurement and distribution systems are being developed, it will implement a system to ensure that the HIV kits are distributed based on a demand (stock inventory modeling system) approach. Based on this information, we believe that a management decision has been reached.

Recommendation No. 4 recommended that USAID/Kenya require that its partners develop strategies for sustainability of their Emergency Plan activities. The Mission agreed to ensure that appropriate language on sustainability is incorporated in all PEPFAR awards. We believe that a management decision has been reached on this recommendation.

Recommendation No. 5 recommended that USAID/Kenya develop strategies to test and monitor patients for anti-retroviral treatment at lower level district hospitals and health centers. The Mission noted that such a strategy is currently being developed by the GOK Ministry of Health, and that USAID and its partners will help implement such a strategy. Therefore, we have deleted this recommendation from the report.

Recommendation No. 6 (Recommendation No. 5 in the final report) recommended that USAID/Kenya coordinate with the U.S. Government team to request Emergency Plan

funding for nutritional assistance to be provided to all malnourished patients on anti-retroviral treatment. The Mission pointed out that while this could not be done given the limited resources available and the competing needs, it suggested that such assistance be provided to patients at greatest risk. We are modified our recommendation accordingly and believe that a management decision has been reached on this recommendation.

Management's comments are included in their entirety in Appendix II. (See page 28.)

SCOPE AND METHODOLOGY

Scope

The Performance Audit Division of the Office of Inspector General conducted this audit in accordance with generally accepted government auditing standards. Fieldwork for this audit was performed at the USAID Mission in Kenya and various Emergency Plan sites within Kenya between March 31 and April 20, 2005.

This audit is one of a series of worldwide audits to be conducted by the Office of Inspector General. The objectives of this audit were to determine (1) how USAID/Kenya participated in the President's Emergency Plan for AIDS Relief activities, (2) whether USAID/Kenya's HIV/AIDS activities progressed as expected towards planned outputs in their agreements and contracts, and (3) whether USAID/Kenya's HIV/AIDS activities contributed to the overall U.S. Government's Emergency Plan targets.

In conducting our audit, we assessed the effectiveness of USAID/Kenya's internal controls with respect to consolidating reporting data to the U.S. Government annual progress report of its activities through September 30, 2004. We identified internal controls such as:

- USAID/ Kenya's process for monitoring its partners' progress and reporting; and
- USAID/ Kenya's partners' process for compiling regional data to its country-level reports.

Methodology

To answer audit objective one, we reviewed USAID/Kenya's Country Operational Plan,³⁸ interviewed Mission and partner personnel, and reviewed other pertinent documentation. To answer audit objective two, we interviewed responsible Mission officials and in-country partners, and reviewed quarterly progress reports to determine progress towards outputs. To answer audit objective three, we reviewed the Emergency Plan Team's annual report and reported targets and compared these to individual partner reports to determine their role in achievement of these targets.

We conducted site visits to partners and beneficiaries involved in prevention, care and treatment, and observed facilities and operations. Of the Mission's 36 partners for fiscal year 2004, we selected eight for further review, representing 61 percent of the estimated funding for fiscal year 2004.

A materiality threshold was not established for this audit since it was not considered to be applicable given the qualitative nature of the audit objective, which focused on

³⁸ The Country Operational Plan is the USG-wide operational plan for a given country and year. It lists the country targets for 2004-2008 and identifies partners and their objectives, activities, agency and budget amounts.

USAID's participation, progression and contribution towards the U.S. Government's overall Emergency Plan targets.

MANAGEMENT COMMENTS

July 5, 2005

MEMORANDUM

TO: IG/A/PA Director, Nathan S. Lokos

FROM: USAID/Kenya Acting Director, Dwight A. Smith

SUBJECT: Audit of USAID Kenya's Implementation of the President's
Emergency Plan for AIDS Relief (Report Number 9-615-05-00X-P)

This memorandum transmits USAID/Kenya's responses to the Inspector General's Performance Audit Division report of our President's Emergency Plan for AIDS Relief (PEPFAR) program.

As requested in your memo, we have clearly stated our response to each recommendation. USAID/Kenya, and particularly the Office of Population and Health, would like to thank both Mr. Jimenez and Ms. Hughes for their time and interest in our program.

PEPFAR AUDIT RESPONSES

Recommendation No. 1:

We recommend that USAID/Kenya develop a monitoring plan—including field site visits and milestones—based on a risk assessment of its Emergency Plan partners and their activities.

Mission Comment:

USAID/Kenya agrees and appreciates the auditor's assessment that the Mission needs to strengthen its monitoring of Emergency Plan activities. In order to meet OGAC's stringent reporting requirements, the entire USG team in Kenya has improved its monitoring strategy, data collection methodology, and reporting procedures. Starting with the recently-completed Semi-Annual Progress report, we have used the MEASURE Evaluation project to assist with this process. The new system has worked well; we were able to complete this data-intensive report on time and without complaint from OGAC.

At present, we conduct risk assessment in three phases. First, small, high-risk new partners are usually placed under an umbrella organization that can give them organizational development assistance. Second, for direct grants the Controller's Office and the Regional Acquisition and Assistance Office conduct pre-award assessments before making an award. These include checks on financial, administrative, personnel, procurement, and travel policies and systems, and conflict of interest issues. Finally, once an award is made the Cognizant Technical Officer receives progress and financial reports and audits, holds quarterly meetings, conducts site visits, and periodically meets with or calls key project staff. These are discussed with the SO team and if necessary the Agreement or Contract Officer.

Proposed Corrective Action:

While we believe the ongoing measures adequately address the issue, we recognize that it may be useful to more formally stratify our partners by risk and adjust our involvement based on this stratification. This is already done informally; the partners complaining of a lack of monitoring were generally stronger, less risky partners than those getting more attention.

Proposed date of Completion:

If the IG believes that a more formal process would be beneficial, USAID/Kenya will implement immediately after the completion of the FY 2006 Country Operation Plan and apply for procurement actions scheduled for completion in the second quarter of FY 2006.

Recommendation No. 2:

We recommend that USAID/Kenya a) formulate a strategy to ensure more effective coordination and knowledge-sharing with and among its partners, b) develop an action plan-including targets and milestones-to enact its strategy, and c) implement its action plan.

Mission Comment:

USAID/Kenya welcomes this recommendation in the context of the previous recommendation to strengthen monitoring and interaction with its partners and will proceed to develop and forward the requested action plan. We would note that the following actions are already an integral part of our approach to work with and across partners:

- Quarterly one-on-one meetings with implementing partners between USAID personnel (including CTOs from the Office of Population and Health, the designated financial analyst, representatives of the Program Office, representatives of the regional legal and contracting offices, and interested OPH technical counterparts) for detailed review and discussion of progress and issues related to program and financial results;
- Joint semi-annual meetings with all implementing partners to present major programmatic and policy information from the USAID perspective and seek feedback from partners on common issues and challenges they may be encountering;
- Joint quarterly transitioning to semi-annual meetings, by technical area, of all Track 1 (i.e., HQ-awarded) partners and bilaterally-awarded partners active in programming for adults, orphans and vulnerable children or abstinence and being faithful change with youth;
- Quarterly meetings that bring together partners and agency technical area leaders across the USG team in critical program areas (e.g., ART, PMTCT, CT, etc.) to discuss lessons learned, challenges being encountered, and opportunities for greater synergies across partners and across USG agencies.

Proposed Corrective Action:

USAID/Kenya will incorporate these ongoing activities in a more comprehensive plan that includes an annual calendar of meetings to promote maximum attendance, and minuting of meetings and distribution of those minutes for optimum information sharing and application of lessons learned. We will also continuously track attendance at these meetings and will follow-up with partners if patterns of non-participation in these coordinating fora are found.

Proposed date of Completion:

September 30, 2005.

Recommendation No 3:

We recommend that USAID/Kenya a) assess the current procurement and distribution system for HIV test kits, b) devise a new procurement and distribution strategy that implements the controls necessary to ensure their timely distribution, c) develop a plan for implementing that strategy - including targets and milestones, and d) implement that plan.

Mission Comment:

We agree with the assessment of the problem. Procurement is a cross-cutting area in which the Government of Kenya and all donors are engaged. We therefore believe that since USAID/Kenya is only one element of a larger, national program, the recommendation is largely beyond the Mission's manageable interest. We do agree, however, that in the short-term we must assure that USAID procurement of commodities is effectively utilized, while national systems are being developed.

USAID is a member of the Ministry of Health's health systems strengthening task force. As part of this team USAID is working with the Ministry of Health's National HIV/Aids and STD Control Program (NAS COP) and other health donors to put in to place an effective procurement system to establish an effective in-country supply chain and delivery system. This procurement system and supply chain will be able to adapt quickly to unpredictable changes in client uptake of services, changes in testing and treatment protocols, and rapid scale up.

Due to the cost of HIV test kits and changes in distribution as we scale up, USAID together with the Ministry of Health has already developed a short-term strategy for better coordinating the distribution of test kits between different programs (e.g., MOH other donors, and outside foundations such as Gates, Clinton, etc.) This includes using the Deliver project well trained staff to distribute and monitor the delivery of test kits.

In the interim, until the Ministry of Health can take over, USAID/Kenya's partner (JSI/Deliver) along with other donors and the Government of Kenya have completed the design of a new monitoring system and taken over the procurement and distribution of HIV test kits for USG sites in coordination with NAS COP.

The Deliver project is procuring the test kits, distributing them to the district level warehouse, and monitoring through weekly visits the distribution from the district level to the actual testing sites. The Deliver project staff are recording the number of kits delivered to each site, and how many kits are used by each site resulting in the early detection and resolution of problems. Looking at the longer term, USAID is working with other international donors and the Ministry of Health to recognize the importance of commodity security for ensuring continuous supply of test kits and it is envisioned the Government of Kenya will eventually have its own well functioning procurement system and distribution system.

Proposed Corrective Action:

In the short-term, USAID will implement the system designed by JSI/Deliver, the GOK and other donors which ensures that HIV-Test kits for USAID/Kenya activities are distributed based on a demand (stock inventory modeling system) approach.

Expected Completion Date: July 5, 2005 (Completed)

In the longer-term, USAID will work the GOK and other partners to ensure that this system is a viable approach for the national system.

Expected Completion Date: TBD (September 2006)

Recommendation No. 4:

We recommend that USAID/Kenya require that its partners develop strategies for the sustainability of their Emergency Plan activities, including the incorporation of institutional capacity building activities and the development of exit plans.

Mission Comment:

We agree completely with the argument that we need to address sustainability. We note, however, that in the case of PEPFAR, sustainability of the total national system is much more relevant than the sustainability of individual activities. Individual activities are tools or instruments which should evolve as needs associated with the epidemic evolve. We therefore believe that trade-offs are likely and that an exclusive focus on the sustainability of any individual activity may not necessarily result in the sustainability of the program as a whole.

We also note that as of this date, USAID/Kenya has not received the Acquisition and Assistance Policy Directive (AAPD) referenced in the paragraph preceding this recommendation.

In the interim, we would observe the following:

- We assume the reference to “exit strategies” has a primary focus on US and international NGOs and the one to “institutional capacity building” to local partners;
- We have successfully used the FHI Impact Project to extend support – including institutional capacity building support – to over 40 Kenyan NGOs historically and have recently implemented a Leader with Associate Award to the Capable Partners Project to enhance our ability to strengthen local partners.
- We would welcome clarity regarding the language specifying that we “require that partners develop strategies for the sustainability of their Emergency Plan activities.” At the recent PEPFAR Annual Meeting in Addis Ababa, Ambassador Tobias clearly stated in front of an audience of over 300 people that the U.S. Government recognizes that it cannot start hundreds of thousands of people in the developing world on ART, and then walk away from that commitment. We

need guidance on reconciling OIG's recommendation with this statement by the Global AIDS Coordinator.

Proposed Corrective Action:

Once the Acquisition and Assistance Policy Directive (AAPD) is received, USAID/Kenya working with the REDSO/ESA/RAAO will ensure that appropriate language is incorporated in all PEPFAR awards.

Expected Completion Date:

NLT 12 months after the AAPD is received. (NB: We envision incorporating within annual agreements rather than unique procurement actions to incorporate this guidance)

More importantly, USAID/Kenya will work closely with the GOK and NGOs to ensure that indigenous capacity is developed and resourcing becomes sustainable as part of a longer-term PEPFAR exit strategy.

Expected Completion Date:

On-going with a formal exit strategy envisioned within the context of future guidance from Washington in terms of PEPFAR Completion dates.

Recommendation No. 5:

We recommend that USAID/Kenya develop strategies to test and monitor patients for anti-retroviral treatment at lower level district hospitals and health centers to compensate for the lack of laboratory equipment and the many challenges that patients face in accessing necessary care at higher level provincial and national hospitals.

Mission Comments:

While we agree with the thrust of the recommendation, we do not believe implementation is within the manageable interests of either USAID or the USG PEPFAR team. **We therefore suggest that the IG consider not including this recommendation.**

The recommended strategy is one that is actively being developed by the Ministry of Health and that USAID and its partners will help implement. Current MOH/NASCOP guidelines already define the level of care (and requisite training and laboratory equipment) that appropriate at health facilities at various levels.

In PEPFAR's Five Year Strategy we will work across sectors and program areas to build systems that promote sustainability. In the public sector, we will make strategic investments in Government of Kenya capacity to plan, secure resources for and implement the treatment, care and support, and prevention interventions that Kenyan citizens require.

In February of 2005 USAID/Kenya applied for and received PEPFAR additional funds to develop a network strengthening program that expands and improves existing networks

of care and treatment to include health centers, dispensaries and community centers. The activity will concentrate on rehabilitating, renovating and equipping these health centers and dispensaries and ensuring they have essential supplies; training personnel at these sites on ART follow-up care and management of WHO stage II patients including specifying referral criteria; and providing these sites with home-based care kits and nutritional supplements. It is intended that these clinics will act as the focal point of a palliative care network linking health facilities with community health workers, CBOs and NGOs specializing in community support and outreach. All of these planned activities will be implemented consistently with GOK/MOH strategies, guidelines and priorities.

Recommendation No. 6

We recommend that USAID/Kenya coordinate with the U.S. Government team to request Emergency Plan funding for nutritional assistance to be provided to all malnourished patients on anti-retroviral treatment.

Mission Comment:

While the Mission would very much like to have the resources to provide nutritional assistance to all malnourished patients on anti-retroviral treatment, we do not believe that such a recommendation is feasible given the limited resources available, and the competing needs. **We will, therefore, be happy to make the request that PEPFAR funding be provided, but would suggest that as a first option the recommendation be deleted or at a minimum the language of the recommendation be modified to focus on patients at greatest risk rather than “all”.**

In the FY 2005 Country Operational Plan USAID/Kenya requested funding for nutritional supplementation targeted specifically for patients on anti retroviral therapy. Along with other donors, USAID is trying to cover as many ARV patients as possible who are in desperate need of nutritional supplementation. USAID's program will reach at least 8,000 people by May 2006. During this initial period, product performance data will be collected and fed back optimizing products and creating sustainable supply systems. As these foods begin being distributed in the first quarter of the project, a simultaneous efficacy study will be commenced to validate product performance and provide direction for improvements.

The 2008 ARV Treatment Target for Kenya is 250,000. Conservatively, it is estimated, that 50% of people on treatment would benefit from nutritional supplementation, i.e. 125,000 beneficiaries. Based on written guidance and informal communication from the Office of the Global AIDS Coordinator, we do not believe that approval for a feeding program of this magnitude would be granted.

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