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Audit of USAID/Guyana's Progress in Implementing the President's Emergency Plan for AIDS Relief

AUDIT REPORT NO. 1-504-06-005-P

May 25, 2006

SAN SALVADOR, EL SALVADOR

Office of Inspector General

May 25, 2006

MEMORANDUM

TO: USAID/Guyana Director, Fenton Sands

FROM: Regional Inspector General/San Salvador, Timothy E. Cox "/s/"

SUBJECT: Audit of USAID/Guyana's Progress in Implementing the President's Emergency Plan for AIDS Relief (Report No. 1-504-06-005-P)

This memorandum transmits our final report on the subject audit. We have carefully considered your comments on the draft report in finalizing the audit report and have included your response in Appendix II of the report.

The report contains nine recommendations intended to improve implementation of the Emergency Program in Guyana. Based on your comments and documentation provided, final action has been taken on Recommendation No. 8 and management decisions have been reached for Recommendation Nos. 1, 2, 3, 4, 5 and 7. Management decisions for Recommendation Nos. 6 and 9 can be recorded when USAID/Guyana has developed a firm plan of action, with target dates, for implementing the recommendations. In this regard, please advise us in writing, within 30 days, of the actions planned to implement these recommendations. Determination of final action on the recommendations currently without final action will be made by the Audit Performance and Compliance Division (M/CFO/APC).

I appreciate the cooperation and courtesy extended to my staff throughout the audit.

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SUMMARY OF RESULTS

As part of a worldwide audit of certain USAID-financed activities under the President's Emergency Plan for AIDS Relief, the Regional Inspector General/San Salvador performed an audit of USAID/Guyana's progress in implementing the President's Emergency Plan for AIDS Relief to answer the following questions:

- Did USAID/Guyana's Emergency Plan prevention and care activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

- Did USAID/Guyana's Emergency Plan treatment activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

The Emergency Plan's goal in Guyana is to prevent 14,000 HIV infections, provide palliative care and support services to 9,000 persons infected or affected by HIV/AIDS, and provide treatment to 1,800 HIV-infected people. During fiscal year 2005, USAID/Guyana obligated $8.8 million and spent $6.3 million in support of the Emergency Plan for prevention, palliative care, and treatment activities.

With respect to prevention and care activities, of the 21 USAID-financed outputs listed in the FY 2005 country operational plan, the program achieved or exceeded 5 planned outputs, mostly in the areas of prevention of mother-to-child transmission and voluntary counseling and testing. These areas were a focus of attention during the first two years of the program, as was scaling up activities by bringing nine sub-grantees into the program in 2004 and bringing ten new sub-grantees into the program in 2005. However, 13 planned outputs were not achieved and progress toward achieving 3 outputs could not be fully evaluated because targets were not established or because sufficient information on actual accomplishments was not available. (See page 5 and Appendix III.)

The audit also disclosed that program performance targets were not consistently described in program documents (page 9), that reported information on actual achievements was inaccurate or unsupported (page 11), that delays in providing advances to sub-grantees impeded program activities (page 16), and that several sub-grantees suffered from weak financial management practices (page 19). In addition, while management attention to date has been focused on expanding program activities, progressively more attention needs to be placed on building a basis for sustaining program activities after the cessation of USAID funding (page 20).

Regarding treatment activities, the audit showed that activities had not progressed as expected due to delays in procuring antiretroviral drugs and establishing a supply chain management system that would forecast demand for ARV drugs and trigger procurement actions in time to meet the demand. (See page 22.)

The report contains nine recommendations to help USAID/Guyana improve program performance and the quality of services provided to program beneficiaries, more clearly communicate performance indicators and targets, better ensure the quality of reported information on program accomplishments, better ensure that sub-grantees have

sufficient liquidity to finance program activities, strengthen the financial management practices of sub-grantees participating in the program, and begin to build a basis for sustaining program activities after the cessation of USAID funding.

While USAID/Guyana agreed with most of the recommendations in our draft report, the Mission disagreed with some of the conclusions and requested some revisions to the report. We carefully considered USAID/Guyana's comments and made revisions where appropriate in finalizing the report. Our evaluation of management comments is provided after each finding and recommendation in the report. USAID/Guyana's comments in their entirety are included in Appendix II.

BACKGROUND

The President's Emergency Plan for AIDS Relief (Emergency Plan) is a $15 billion, five-year program that provides $9 billion in new funding to accelerate the delivery of HIV/AIDS-related prevention, care, and treatment services in 15 focus countries, including Guyana. The Emergency Plan also allocates $5 billion over five years to bilateral programs in more than 100 countries and increases the U.S. pledge to the Global Fund to Fight AIDS, Tuberculosis, and Malaria by $1 billion over five years. The Emergency Plan's five-year goal is to prevent 7 million HIV infections, provide palliative care to 10 million people affected by HIV/AIDS, and treat 2 million HIV-infected people. The Department of State's Global AIDS Coordinator directs the Emergency Plan.

Guyana has a population of 751,000 people of whom 18,000 are thought to be infected with HIV/AIDS. The United Nations Program on HIV/AIDS estimates a national HIV prevalence rate among adults of 2.5 percent and among pregnant women of 3.8 percent. However, higher HIV prevalence rates were reported for some high-risk groups such as commercial sex workers (31 percent) and gold miners (6 percent). More than half the population of Guyana is under the age of 24, and young people are especially vulnerable to infection. Almost 75 percent of reported cases of HIV/AIDS are among people 19-35 years old.

The Emergency Plan's goal in Guyana is to prevent 14,000 HIV infections, provide palliative care and support services to 9,000 persons infected or affected by HIV/AIDS, and provide treatment to 1,800 HIV-infected people. The strategy for achieving the goal focuses on strengthening the capacity of the national health care system, as well as non-governmental organizations interested in public health issues, to deliver effective and expanded HIV/AIDS prevention, palliative care, and treatment services. In Guyana, the Plan is implemented collaboratively by a country team that is lead by the Ambassador and includes representatives from USAID, the Centers for Disease Control and Prevention, the Peace Corps, the Department of Labor and the Department of Defense.

USAID/Guyana is one of the main U.S. Government agencies supporting the Emergency Plan. USAID/Guyana provides contracts, grants, and cooperative agreements totaling $9.5 million out of $15.8 million in funding provided by the program in fiscal year 2005. During fiscal year 2005, USAID/Guyana had obligated $8.8 million and spent $6.3 million in support of the Emergency Plan. USAID finances the following activities:

- Prevention (primarily prevention of mother-to-child transmission of the HIV virus, promotion of abstinence and faithfulness, and promotion of other prevention initiatives).

- Care (provision of voluntary counseling and testing services and palliative care services that help improve the quality of life of individuals suffering from HIV/AIDS, and their families and support for HIV/AIDS-affected orphans and vulnerable children).

- Treatment (procurement of pediatric and second-line[1] antiretroviral drugs for both children and adults and implementation of supply chain management system that will better ensure a reliable supply of antiretroviral drugs).

USAID/Guyana-funded Emergency Plan activities are implemented through a memorandum of understanding with the Government of Guyana's Ministry of Health and through two contracts:

- The first contract is with Family Health International (FHI). FHI, in collaboration with its subcontractors (Cicatelli Associates Inc., Howard Delafield International, Management Sciences for Health, and the Caribbean Conference of Churches), provides technical direction to a network of 19 local non-governmental organizations and faith-based organizations who provide services to program beneficiaries. Nine of these local organizations were involved in the Emergency Plan since 2004, and ten organizations started implementing Emergency Plan activities in July 2005. FHI also helps the Ministry of Health implement counseling and treatment activities. (Appendix IV lists the 19 local entities participating in the program and the activities they implement.)

- The second contract is with Maurice Solomon, a local accounting firm. Maurice Solomon entered into sub-grants with the 19 non-governmental organizations and faith-based organizations described above to formalize their participation in the Emergency Plan. Maurice Solomon advances USAID funds to the local organizations, obtains liquidations that show how USAID funds were used, and provides financial and administrative management assistance to the organizations.

The program began in October 2004, and is scheduled to end by September 30, 2008

AUDIT OBJECTIVES

As part of a worldwide audit directed by the Office of Inspector General's Performance Audits Division, the Regional Inspector General/San Salvador audited USAID/Guyana's progress in implementing the President's Emergency Plan for AIDS Relief to answer the following questions:

- Did USAID/Guyana's Emergency Plan prevention and care activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

- Did USAID/Guyana's Emergency Plan treatment activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

[1] Second line antiretroviral drugs are administered to patients who do not respond to treatment with less expensive first-line antiretroviral drugs.

AUDIT FINDINGS

Did USAID/Guyana's Emergency Plan prevention and care activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

Based on our review of 21 activities listed in the FY 2005 country operational plan,[2] USAID/Guyana's Emergency Plan activities did not progress as expected towards the planned outputs. Specifically, 5 activities achieved or exceeded planned outputs, 13 did not achieve planned outputs and 3 could not be evaluated because targets were not established or because sufficient information on actual accomplishments for FY 2005 was not available. (Appendix III lists the 21 activities, their reported accomplishments, and the accomplishments verified by our audit.)

The program achieved or exceeded five planned outputs, mostly in the areas of prevention of mother-to-child transmission and voluntary counseling and testing. These areas were a focus of attention during the first two years of the program, as was scaling up activities by bringing nine sub-grantees into the program in 2004 and bringing ten new sub-grantees into the program in 2005.

- Prevention of mother-to-child transmission (PMTCT) – Activities included training for health professionals, some light renovation of facilities, and support for operating costs. A considerable amount of effort was expended to expand the quantity and quality of PMTCT services and to make these services more widely available. During FY 2005, the program increased the number of assisted PMTCT sites from 8 to 43, surpassing the planned output target of 42. While these sites did not provide services to the planned number of women (see page 6), establishment of the sites themselves facilitated access to program services and help lay a basis for providing a higher level of services in the future.

- Number of voluntary counseling and testing outlets – Program activities included training for counselors and testers and support for operating costs. During FY 2005, the number of fixed-location counseling and testing sites increased from 0 to 15 and a mobile unit serviced an additional 26 sites. Thus, the program exceeded the planned output of providing voluntary counseling and testing services at 18 sites.

- Number of individuals who received counseling and testing for HIV – The program counseled and tested 10,546 individuals for HIV, which exceeded its target of 6,000.

- Number of individuals trained in providing voluntary counseling and testing services – Family Health International (FHI) substantially met its planned output of training

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[2] The FY 2005 Country Operational Plan listed 27 planned outputs, including six outputs related to mass media programs. In February 2006, the State Department's AIDS Coordinator announced indicators related to mass media programs should no longer be reported, as such estimates are not sufficiently reliable to be useful. Therefore, we excluded these six outputs from our report.

100 individuals on providing voluntary counseling and testing services by training 95 individuals.

- Number of individuals trained on providing palliative care – FHI and its sub-contractors trained 146 people to provide palliative care to HIV-infected individuals exceeding the expected output of 100 individuals.

However, as discussed below, 13 planned outputs were not met.

Many Planned Outputs Were Not Achieved

Summary: The FY 2005 country operational plan included 21 expected outputs related to prevention and care activities. However, 13 of these planned outputs were not achieved because FY 2005 funds were not received by the Mission until March 2005, because supporting media campaigns were not launched or communications materials were underutilized, because the local sub-grantees were less capable than expected, because USAID and FHI did not always provide needed guidance and oversight, because of insufficient funding, or because of other reasons. Consequently, the program did not deliver the expected level of prevention and care services to program beneficiaries.

The following sections describe factors that limited the effectiveness of seven of the most important prevention and care activities:

- Pregnant Women Receiving PMTCT Support – The FY 2005 planned output was to provide counseling and testing to 10,200 pregnant women. The program reported reaching 7,960 pregnant women but, because of inaccurate and unsupported reporting on actual achievements, the actual number of women reached is uncertain. The program did not meet its PMTCT target for several reasons. First, according to USAID officials, the target for pregnant women to be reached was based on the assumption that there would be 19,000 births during FY 2005, but later the estimate of births during FY 2005 was reduced to only 15,000. Second, the program did not receive FY 2005 funds until March 25, 2005, leaving only a half year to implement a full year of activities. Third, only one media campaign promoting PMTCT services was launched before December 2005 and no new communication materials on PMTCT services were produced. Finally, Georgetown Hospital (where a very significant portion of Guyanese women have their babies) did a poor job of referring its clients for PMTCT services: only 550 women were tested out of 3,810 women who gave birth at Georgetown Hospital from January through September 2005.

- Orphans and Vulnerable Children Served – The program did not meet its planned output of providing 560 orphans and vulnerable children with care and support. The program reported that 5,209 orphans and vulnerable children were served but our review of supporting documentation indicates that only 289 children, few of whom were directly affected by HIV/AIDS, were served. The sub-grantees were unaware that the program should be limited to children directly affected by HIV/AIDS and were given inaccurate guidance on the definition of orphans and vulnerable children. Finally, additional oversight and on-site mentoring by USAID and FHI would have helped sub-grantees achieve their targets.

- Palliative Care – According to mission officials, the expected output of 2,500 HIV/AIDS-infected persons provided with palliative care was not met because the capacity of sub-grantees to deliver palliative care was greatly overestimated. Therefore, implementation had to be limited to only a few sub-grantees. In addition, training on palliative care was not conducted until mid-2005. Prior to this, the sub-grantees did not have specific guidance on how to implement a palliative care program. Our visits to several sub-grantees in early 2006 indicated that they still did not know how to set up and deliver a home-based visitation program. For example, sub-grantees were unaware that the program should be limited to individuals infected with HIV/AIDS. Consequently, palliative care services were extended to not only persons directly infected by HIV/AIDS but also to individuals who were terminally ill with other illnesses. We encountered reporting problems as well: the reported number of people receiving palliative care, 742, was not supported by documentation and the reported number included persons not infected by HIV/AIDS.

- Mass Media HIV/AIDS Prevention Programs that Promote Abstinence and/or Being Faithful – During FY 2005, although the program planned to deliver 20 mass media programs, only three mass media programs promoting abstinence and be faithful were implemented. In addition, while Howard Delafield International developed a brochure and communication materials, distributing these materials received a low priority while FHI was preoccupied with opening new HIV counseling and testing sites.

- Individuals Reached with Community Outreach Program Promoting Abstinence – The planned output for FY 2005 was that this activity would reach 10,000 individuals but FHI only reported reaching 410 individuals. While FHI reported implementing 13 of 18 planned community outreach programs, the programs reached fewer people than planned. In addition, inadequate liquidity for financing activities by sub-grantees (as addressed in the section beginning on page 16 below) also contributed to poor results.

- Individuals Trained to Provide Prevention Programs – FHI had an expected output of training 400 individuals to promote abstinence and be faithful and other prevention measures. However, only 231 individuals were trained. Rapid expansion of HIV counseling and treatment sites drew FHI's attention from these planned prevention activities.

- Individuals Trained or Retrained on Delivering PMTCT Services – Only 75 persons out of an expected output of 100 were trained or retrained on how to provide PMTCT services. A shortage of health professionals in Guyana and the consequent difficulties that the MOH faced in finding people to staff their health facilities contributed to the shortfall.

The other activities that fell short of their planned outputs are listed in Appendix III.

One of the main reasons that some planned outputs were not achieved was that USAID/Guyana did not receive FY 2005 funding until March 25, 2005, about half way through the fiscal year. Because this problem was outside the control of the Mission, this issue will have to be addressed in the Office of Inspector General's Performance Audits Division overall report.

As a result of the problems described, the program was not as effective as planned in providing prevention and care-related services to at-risk populations and to people living with HIV/AIDS. In addition, as noted above in the discussion of support for orphans and vulnerable children and other palliate care activities, Emergency Plan funds were used to provide benefits to ineligible beneficiaries who were not directly affected by HIV/AIDS.

Recommendation No.1: We recommend that USAID/Guyana obtain from Family Health International an action plan that includes a timeline and steps needed to fully implement abstinence/be faithful activities, prevention of mother-to-child transmission mass media campaigns, palliative care, and orphan and vulnerable children programs.

Recommendation No. 2: We recommend that USAID/Guyana, in coordination with Family Health International, develop, disseminate, and support with on-site mentoring, detailed guidance on implementing the palliative care and orphan and vulnerable children program components for the benefit of participating sub-grantees.

Evaluation of Management Comments – In response to our draft report, the Mission stated that the Office of the U.S. Global AIDS Coordinator recently recognized the weaknesses in the indicators for mass media and thus all have been eliminated. Therefore, we excluded these six outputs from our report.

USAID/Guyana also believed that because it did not receive the FY 2005 funding until March 25, 2005, the date by which the program had to achieve the COP 2005 targets should be March 31, 2006, not September 30, 2005. USAID/Guyana mentioned that if the March 31, 2006 date was used, it would have achieved 13 of the 21 planned outputs.

While we acknowledge the Mission's viewpoint, the FY 2005 COP states that the targets included in the plan are the planned targets by the end of FY 2005. In addition, the FY 2005 Annual Program Results guidance states that results between October 1, 2004 and September 30, 2005 are to be reported against the FY 2005 targets and that results are to be reported regardless of whether they were achieved with FY 2004 or FY 2005 funding. We have mentioned in the finding that the long delay in receipt of funding was one of the main reasons for not achieving some of the targets. Because this funding delay is a systemic problem, and not unique to USAID/Guyana, this issue will need to be addressed in Washington. Even if we assumed that the Mission had until March 31, 2006 to meet the FY 2005 targets, our main conclusions concerning the progress of prevention and care activities would remain the same.

USAID/Guyana stated that it agrees with Recommendation No.1 and it has requested and received a draft work plan that outlines a timeline and implementation plan that includes the activities listed in the recommendation and will ensure that a finalized work plan sufficiently addresses these focus areas.

In response to Recommendation No. 2, the Mission stated that FHI, in collaboration with USAID and Maurice Solomon & Co., has already developed core teams that will support each sub-grantee with a focus given to monitoring and evaluating their programs and clarifying any misunderstandings as it relates to orphan and vulnerable children and palliative care. The Mission indicated that these core teams have completed the first

round of quarterly site visits to increase the level of mentoring, support, and technical guidance provided to the sub-grantees.

A management decision has been reached for Recommendation Nos. 1 and 2 and a determination of final action on these recommendations will be made by the Audit Performance and Compliance Division (M/CFO/APC).

Performance Targets Were Inconsistent

Summary: According to guidance in USAID's Automated Directives System (ADS), performance indicators and targets must be established so that program performance can be measured. However, the performance targets established for Emergency Plan activities in Guyana were inconsistent with one another. At the outset of the program, USAID/Guyana focused on rapidly scaling up Emergency Plan activities and did not devote sufficient effort to ensuring that program performance targets were expressed consistently. The large number of indicators established under the program also contributed to the problem. Inconsistencies in the performance targets reduced their usefulness and made it difficult to assess progress under the program.

ADS 203.3.3.4.5 states that each indicator "should include performance baselines and set performance targets that can optimistically but realistically be achieved within the stated timeframe and with the available resources." ADS Section 203.3.2.1.d notes that "more information is not necessarily better because it markedly increases the management burden and cost to collect and analyze. Operating units should also align their performance information needs with those of their partners, thereby lessening the reporting burden for partner organizations." Beyond what is specifically stated in the ADS, it is obviously important to the success of any program that program performance indicators and targets be unambiguous and expressed consistently.

However, there were numerous inconsistencies in the performance targets established for Emergency Plan activities in Guyana. While the country operational plan has 27 targets related to prevention and care activities, the FHI contract listed only 11 targets, and only 5 of them coincided with the targets in the country operational plan. Of these 5 targets, 4 exhibited inconsistencies as shown in the following table.

Table No. 1: Comparison of Performance Targets

Performance Indicator	Target in Country Operational Plan	Target in FHI contract	Target in Sub-Grantee Workplans
Orphans and Vulnerable Children Served by the Program	560	600	624
Individuals Provided with HIV-Related Palliative Care	2,500	2,700	480
Pregnant Women Provided with Prevention of Mother-to-Child Transmission Services, Including Counseling and Testing	10,200	15,200	No target

Performance Indicator	Target in Country Operational Plan	Target in FHI contract	Target in Sub-Grantee Workplans
Individuals Receiving Voluntary Counseling and Testing	6,000[3]	7,843	No target

Another problem noted was that the FHI workplan and two of the nine sub-grantee workplans reviewed (for Youth Challenge Guyana and Artistes in Direct Support) did not provide targets for either all or the majority of their activities.

At the outset of the program, USAID/Guyana focused on rapidly scaling up Emergency Plan activities and did not devote sufficient effort to ensuring that program performance indicators and targets were expressed consistently. The large number of prevention and care indicators established under the program also contributed to the problem. For example:

- 32 indicators were required by the Office of the Global AIDS Coordinator for its Annual Report to Congress,
- 27 indicators were included in the 2005 country operational plan,
- 27 strategic objective level indicators appeared in USAID/Guyana's 2005 Annual Report,
- 11 indicators were included in USAID/Guyana's contract with FHI,
- 107 indicators were included in FHI's work plan,
- 69 indicators were included in sub-grantees' monthly reports to FHI, and
- different numbers of indicators appeared in each of the 19 sub-grantees' work plans

While many of these indicators were similar to one another, there were numerous differences in the wording and definitions of the indicators.

Inconsistencies in program performance targets made it difficult for management to assess progress under the program. Further, the number of indicators created confusion, increased workload, and placed an unnecessary burden on USAID/Guyana, FHI, and the sub-grantees. It also reduced program efficiency and increased the risk of inaccurate and unsupported results.

Recommendation No. 3: We recommend that USAID/Guyana ensure that performance indicators and their corresponding targets are developed consistently among the various program documents.

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[3] This target was stated inconsistently (as 1,600 and 6,000) even within the country operational plan itself. However, both the Mission and FHI believed that the target was 6,000.

Recommendation No.4: We recommend that USAID/Guyana periodically evaluate performance indicators to ensure that all indicators are necessary, relevant and easily understood by all concerned.

Evaluation of Management Comments – In response to Recommendation No. 3, USAID/Guyana stated that it will include the indicators and their targets during the FY 2006 funding allocation process and that the Mission will then follow up with FHI and sub-grantees to ensure that there is consistency in the monitoring and evaluation plan, annual work plans, and monitoring and evaluation tools.

With regard to Recommendation No. 4, the Mission disagreed with part of the recommendation in our draft report, which was to reduce and simplify the number of indicators, stating that it is required to fulfill all applicable Emergency Plan indicators and has a strategic partnership to support the information needs of the host country government and international declarations made by them (including 36 core MOH indicators and 17 United Nations indicators). The Mission did agree to annually evaluate the number and purpose of collected indicators to ensure that all are necessary and relevant.

We continue to believe that the program has too many indicators and this has contributed to confusion and increased workload among the program implementers. Nevertheless, because considerable judgment is needed to decide how many indicators a program should have, and because the Mission is in the best position to make this judgment, we have deferred to the Mission's judgment and have eliminated this part of the recommendation.

A management decision has been reached for Recommendation Nos. 3 and 4 and a determination of final action on these recommendations will be made by the Audit Performance and Compliance Division (M/CFO/APC).

Results Reported by FHI and Sub-Grantees Were Inaccurate or Unsupported

Summary: According to ADS 203.3.5.1 and USAID TIPS 12, performance data should be accurate and reliable and missions should take steps to ensure that submitted data is adequately supported. In 50 of the 60 results we reviewed (83 percent), information on actual results reported by sub-grantees was inaccurate or unsupported. In addition, among three of eight Ministry of Health (MOH) health sites visited, we found a variation ranging between 21 and 33 percent, between the results reported and the corresponding information gleaned from supporting documentation. Central to the reasons why reported results were inaccurate was that USAID/Guyana and FHI did not always provide effective guidance to the sub-grantees or to the MOH and did not periodically validate reported results. As a result of inaccurate reporting by sub-grantees and the MOH, USAID/Guyana could not reliably determine if the program was achieving planned outputs and the Mission reported inaccurate information to the Office of the U.S. Global AIDS Coordinator and to the Congress.

In support of program reporting requirements, FHI requires all sub-grantees to submit monthly progress reports that include information on 69 performance indicators related to prevention and care activities. The monthly reports submitted by the sub-grantees are

provided to FHI. FHI then records the information received from the sub-grantees in a spreadsheet. FHI also collects data from the MOH facilities supported under the program and records the information in a spreadsheet as well. Subsequently, FHI produces quarterly, semi-annual and annual progress reports that are submitted to USAID/Guyana, which utilizes the information in fulfilling its reporting requirements to the Office of U.S. Global AIDS Coordinator (OGAC)[4] and to Congress.

In order to permit USAID staff to manage for results and produce credible reporting, ADS 203.3.5.1 requires performance data to be precise and reliable. ADS 203.3.5.1 also requires that missions perform effective data quality assessments and take steps to ensure that submitted data are of reasonable quality and adequately supported. USAID TIPS Number 12 emphasizes the importance of documentation, stating that proper documentation is a process that facilitates the maintenance of quality performance indicators and data. Such documentation should provide an opportunity for independent checks concerning the quality of the performance measurement system. USAID's contract with FHI states that "it is imperative to have well-developed and timely data from surveillance and program monitoring, supported by appropriate management information systems and other information technology." FHI's monitoring and evaluation plan states that the maintenance of data quality will be ensured through the training and supervision of sub-grantee staff and through tracking progress on achievement of activities. In addition, FHI's work plan states that FHI is responsible for conducting field visits that provide technical support ensuring the quality of data collected.

While visiting nine sub-grantee project sites, we compared information included in the progress reports to supporting documentation. We found errors and discrepancies in 50 out of 60 cases reviewed as shown below.

Table No. 2: Review of Results Reported by Sub-Grantees

Sub-Grantee	Results Tested	Results Inaccurate or Unsupported	Percent Inaccurate or Unsupported
Artistes in Direct Supports	7	7	100%
Comforting Hearts	7	4	57%
Guyana Responsible Parenthood Association	6	4	67%
Hope Foundation	11	9	82%
Lifeline Counseling Services	5	3	60%
Linden Care Foundation	4	3	75%
The Network of Guyanese Living with HIV/AIDS	5	5	100%
Volunteer Youth Corps	7	7	100%
Youth Challenge Guyana	8	8	100%
Total	*60*	*50*	*83%*

[4] The FY 2005 Emergency Plan Annual Program Results Guidance states that USG teams in country are responsible for ensuring that the data reported to OGAC are of good quality and accurately describe the USG program in country.

Several specific examples of inaccurate results and inadequate supporting documentation follow:

- The Hope Foundation did not have documentation supporting the number of printed materials reportedly distributed, individuals reached with community outreach, or the number of community outreach programs conducted. Also, in August 2005, Hope Foundation reported that they distributed 590 condoms; however, the supporting documentation indicated that 394 condoms were distributed.

- Artistes in Direct Support reported that 29 peer educators were trained in February 2005 and 36 peer educators were trained in March 2005. However, the organization only had documentation available to show that 11 peer educators were trained. Also, Artistes in Direct Support reported that they distributed 17,809 condoms during the months of December 2004, February 2005 and September 2005. However, we could only find documentation supporting the distribution of about 3,000 condoms.

- The Network of Guyanese Living with HIV/AIDS reported providing care to 34 persons living with HIV/AIDS during September 2005. However, we could only find documentation showing that 17 persons received palliative care. Also, the organization reported training 46 volunteers in home-based care in May 2005. This data could not be verified since the organization did not keep attendance records.

- Lifeline Counseling Services reported providing palliative care to 30 individuals in April 2005 but we only found documentation for 12 individuals receiving care.

- Volunteer Youth Corps reported serving 100 individuals with community outreach activities promoting behavior change and communication and reported training 55 persons on promoting abstinence and being faithful in February 2005. However, the organization could not provide documentation to support any of these accomplishments.

- Youth Challenge Guyana reported reaching 112 youths through peer educators and distributing 288 condoms in May 2005. However, the organization could not provide documentation to support these accomplishments.

In addition to the problems related to sub-grantees reporting results, FHI also did not accurately report accomplishments by the MOH and the sub-grantees. We noted the following problems:

- There were discrepancies ranging between 21 to 33 percent between the results reported by FHI and the documented results of the number of pregnant women tested for HIV/AIDS at three of the eight MOH sites we visited. For example, the site at Bartica Hospital recorded 266 pregnant women as having been tested for HIV while FHI reported 216 – a variance of 23 percent.

- FHI reported that 5,209 orphans and vulnerable children were reached during FY 2005 through 6 sub-grantees. However, this figure actually represents the number of services provided, not the number of children reached. Because each child can, and often does, receive more than one service, the reported figure is grossly overstated. We concluded that 289 children were reached, but most of these children did not

meet the definition of an orphan or vulnerable child provided by the Office of the U.S. Global AIDS Coordinator because they were not directly affected or infected with HIV/AIDS. For example, data from Lifeline indicated that out of 211 children reported, only 65 were directly affected by HIV/AIDS.

- FHI reported that Lifeline Counseling Services tested no individuals for HIV in February 2005. However, according to Lifeline's progress report and the voluntary counseling and testing register, 55 individuals were tested.

In addition to the specific problems outlined above, the reporting format provided by FHI only contained current period data. No cumulative results toward achieving planned outputs were captured. Including cumulative results would better help sub-grantees measure progress made towards achieving planned outputs.

The problems described above are symptomatic of the sub-grantees not having the capacity to measure and report on progress accurately. The sub-grantees were negatively impacted by a lack of effective guidance and on-site mentoring and by the fact that USAID/Guyana and FHI did not measure the validity of the reported results during field visits.

USAID/Guyana did not have a monitoring and evaluation officer so they relied, in part, on FHI to ensure the quality of reported results. However, FHI did not always provide effective guidance and on-site mentoring or make periodic visits to verify the accuracy of the progress reports. Although FHI provided a data collection tool to the sub-grantees, it was not properly utilized. Several sub-grantees did not understand some of the indicators listed in the tool – especially the ones related to orphans and vulnerable children and palliative care. The FHI data collection tool included 23 indicators related to the orphans and vulnerable children and palliative care program. These 23 indicators were further sub-divided by age, sex and new and existing cases. During our visits, most of the grantees reported that they did not know which category they should use to report results. While FHI provided training and conducted site visits, they did not make sure that training was properly understood and did not discover that the sub-grantees were reporting data that did not have supporting documentation. FHI's efforts with respect to data collection and reporting were less than adequate in large part because FHI was giving priority to expanding program operations, establishing 50 new counseling and testing sites and bringing 10 new sub-grantees into the program during fiscal year 2005.

Because the results reported by FHI, the MOH, and the sub-grantees were inaccurate or unsupported, USAID/Guyana could not reliably determine if program activities were meeting their objectives or make well-supported programmatic or funding decisions. In addition, publications such as the USAID Annual Report and the Emergency Plan's Report to Congress contained erroneous information. For example, the Second Annual Report to Congress states that 5,200 orphans and vulnerable children received support while in reality less than 300 received support.

To ensure that Mission managers have accurate and reliable data for reporting results to USAID/Washington, the Office of the U.S. Global AIDS Coordinator, the Congress, and the public, we are making the following recommendations:

Recommendation No. 5: We recommend that USAID/Guyana ensure that Family Health International provides the Ministry of Health and sub-grantees with training and guidance that ensures the submission of accurate, well-documented performance data on current and cumulative progress toward achieving targets.

Recommendation No. 6: We recommend that USAID/Guyana ensure that Family Health International implements a monitoring plan that regularly validates the quality of data, including supporting documentation, submitted by all sub-grantees.

Evaluation of Management Comments – In response to the draft report, the Mission disagreed with some of the information presented in the finding. For example, USAID/Guyana stated that sub-grantees were provided training and guidance on reporting and that site visits were made to provide technical assistance for reporting. USAID/Guyana also took exception to our conclusion that "As a result of inaccurate reporting by sub-grantees and the MOH, USAID/Guyana could not reliably determine if the program was achieving planned outputs and the Mission reported inaccurate information to the Office of the U.S. Global AIDS Coordinator and to the Congress."

As stated in the finding, we acknowledged that FHI provided training and conducted site visits. However, FHI did not make sure that training was properly understood and did not discover that the sub-grantees were reporting data that were either inaccurate or did not have supporting documentation. Hence, our testing revealed a high error rate (83 percent). Moreover, based on this high error rate, we believe that USAID/Guyana could not reliably determine if the program was achieving planned outputs and we also found cases where the Mission reported inaccurate information to the Office of the U.S. Global AIDS Coordinator, such as over reporting the number of orphan and vulnerable children assisted.

USAID/Guyana agreed with Recommendation No. 5 and stated that it will increase mentoring and guidance to the Ministry of Health and to the sub-grantees to ensure the submission of accurate, well-documented performance data on current and cumulative progress toward achieving targets. A management decision has been reached for Recommendation No. 5 and a determination of final action on this recommendation will be made by the Audit Performance and Compliance Division (M/CFO/APC).

In response to Recommendation No. 6, the Mission stated that it will ensure that FHI will continue to implement the monitoring plan that regularly validates the quality of data, including supporting documentation, submitted by all sub-grantees. In addition, FHI has already initiated quarterly site visits to each sub-grantee to perform this work. The Mission's response appears to state that FHI had been regularly validating the quality of results and that it will continue to do so. This is contrary to what was found during the audit. We found no evidence that FHI was periodically validating the results reported by sub-grantees. This lack of validation was confirmed by the high error rate and by discussions with various sub-grantee officials. A management decision for Recommendation No. 6 can be reached when USAID/Guyana provides details on how FHI will validate the quality of results reported, including supporting documentation, by all sub-grantees.

Delays in Providing Advances to Sub-Grantees Impeded Program Activities

USAID's contract with Maurice Solomon & Company (Maurice Solomon) states that "the contractor shall assure that funds are available as needed by partner organizations." However, sub-grantees typically did not receive advances from Maurice Solomon until 21 days into the month that the advances were intended to cover, leaving the sub-grantees chronically short of cash. This problem occurred primarily because the contract with Maurice Solomon was unclear on how funding to sub-grantees was to be provided. Lack of timely funding impeded the sub-grantees' efforts to achieve the goals and targets in their work plans and, in some cases, caused them to lose credibility with their clients.

Maurice Solomon signed a one-year contract with USAID on May 9, 2005 to provide $1.3 million to sub-grantees and provide them with financial and administrative management assistance. At that time, nine sub-grantees were already being financed by USAID/Guyana through sub-agreements with FHI. When these sub-agreements ended on September 30, 2005, the sub-grantees entered into new sub-agreements with Maurice Solomon to cover the next 12 months. In addition to these 9 existing sub-grantees, USAID/Guyana approved 10 new sub-grantees for financing from July 1, 2005 through June 30, 2006. Thus, as of December 31, 2005, a total of 19 sub-grantees were receiving funds from Maurice Solomon to implement the Emergency Plan related care and prevention activities.

USAID's contract with Maurice Solomon states that "the contractor shall assure that funds are available as needed by partner organizations and that funds will not be subject to administrative delays." However, the sub-grantees did not receive funds in a timely fashion from Maurice Solomon. Maurice Solomon required sub-grantees to liquidate the previous month's advance before approving a new advance for the following month. Because the sub-grantees needed time to prepare the liquidations, and because Maurice Solomon needed time to review the liquidations and process new advances, the sub-grantees did not receive advances until an average of 21 days into the following month, leaving them chronically short of funds.[5] The delays each sub-grantee experienced in receiving advances are detailed in the following table.

Table No. 3: Dates Funds Were Received by Sub-Grantees for July through December 2005

Sub-Grantee	Date Funds Were Received for Each Month						Average Days Late
	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	
Comforting Hearts	7/14	8/11	9/13	11/2	11/2	12/2	13
Linden Care Foundation	7/18	8/11	9/20	11/2	11/2	12/2	14

[5] Delays in approving sub-grantees' work plans also contributed to delays in providing advances. The ten new sub-grantees that entered the Emergency Plan program in July 2005 received no advances at all, or only minimal amounts for office expenses and salaries, until FHI approved their work plans beginning in October 2005. Finally, weak financial management by some sub-grantees contributed to funding problems since the sub-grantees submitted ineligible or misclassified costs to Maurice Solomon in their liquidations, leading to delays and disallowances.

Sub-Grantee	Date Funds Were Received for Each Month						Average Days Late
	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	
Ribbons of Life	NA	NA	NA	10/14	12/1	12/1	15
Youth Challenge Guyana	7/25	8/11	9/12	10/21	11/2	12/20	15
Hope Foundation	7/14	8/11	9/20	11/2	11/2	12/8	15
Guyana Responsible Parenthood Association	7/22	8/12	NA	11/2	11/2	12/9	16
Artistes in Direct Support	7/22	8/23	9/14	11/2	11/2	12/9	17
The Network of Guyanese Living with HIV/AIDS	7/27	8/10	9/12	11/2	11/2	12/20	17
RESLOCARE	8/5	8/26	9/13	10/14	11/10	12/8	18
Love & Faith Outreach	8/9	8/26	9/13	10/21	11/10	12/8	20
Lifeline Counseling Services	8/15	8/25	9/5	11/2	11/2	12/8	20
Hope for All	8/5	8/26	9/13	10/20	11/21	12/8	21
St. Francis Community Developers	8/9	8/26	9/13	10/14	12/5	12/5	22
Roadside Baptist Church	8/11	8/26	9/13	10/20	12/8	12/8	25
Mibicuri Youth Development Group	8/9	8/26	9/13	10/27	12/8	12/8	25
Swing Star/FACT	8/5	8/26	9/13	10/21	12/21	12/21	28
Volunteer Youth Corps	8/15	8/15	9/15	12/1	12/1	12/1	28
Central Islamic Organization of Guyana	NA	NA	NA	NA	11/10	1/24	33
Help & Shelter	8/8	8/26	9/13	12/21	12/21	12/21	39
Overall average for 19 sub-grantees							*21*

These delays occurred primarily because USAID/Guyana's contract with Maurice Solomon was unclear on how Maurice Solomon was to provide funding to sub-grantees. The contract indicated that Maurice Solomon was eligible to receive advances from USAID but did not clearly authorize Maurice Solomon to make advances to the sub-grantees. This ambiguity in the contract led Maurice Solomon to take a very conservative approach toward managing funding for the sub-grantees. USAID/Guyana staff were aware of the problem, although perhaps not its extent, and requested help in resolving the problem from USAID/Dominican Republic, the regional mission that services USAID/Guyana. Eventually, USAID/Dominican Republic clarified, through an e-mail to Maurice Solomon in January 2006, that the intent of the contract was that Maurice Solomon would provide 60-day rolling advances to the sub-grantees. Under this arrangement, sub-grantees will receive an initial advance for 30 days' cash needs, then receive a second advance for the next 30-day period, and then submit a liquidation of the first advance before receiving an advance for the third 30-day period.

Lack of timely funding impeded the sub-grantees' efforts to achieve the goals and targets in their work plans. As activities were canceled or postponed due to a lack of funding, staff became discouraged and, in some cases, the sub-grantees began to lose credibility with their clients. Some specific examples of the problems caused by a lack of funding follow:

- Voluntary Youth Corps was unable to make any payments between November 4, 2005 and December 1, 2005 since no funds were received for October or November 2005. As a result, its palliative care program suffered and clients left the program.

- Linden Care Foundation was unable to pay all of its staff on time and did not provide travel advances to staff in November. In addition, a workshop was postponed from January to February 2006.

- Comforting Hearts had a bank balance of less than $2, as of February 7, 2006, because it did not receive program funds in January 2006. To get by, it relied on additional assistance from staff and volunteers, holding a workshop, for example, in a staff member's home. It also made some purchases on credit. Still, it was unable to produce a scheduled TV program in January 2006.

- In January 2006, Lifeline Counseling Services had to postpone an educational tour for orphans and vulnerable children, hygiene kits for orphans and vulnerable children could not be purchased, home-based care training was canceled, and home-based care volunteers were not given their stipend.

- Artistes in Direct Support scheduled training for pastors in November 2005, but the training had to be postponed until January 2006. Outreach activities aimed at high risk groups and a drama workshop for religious youth leaders were also delayed.

As indicated above, USAID/Dominican Republic has informally clarified the intention that Maurice Solomon should provide 60-day rolling advances to sub-grantees. Still, there is no language in the contract authorizing advances to sub-grantees, and the contract needs to be amended to more clearly reflect its intent.

> *Recommendation No. 7: We recommend that USAID/Guyana arrange to modify the current contract and any subsequent contracts with Maurice Solomon & Company to better ensure that sub-grantees receive adequate funds in a timely manner.*

Evaluation of Management Comments – In response to the draft report, USAID/Guyana mentioned that weak financial management by some sub-grantees contributed to the funding delays. Also, the Mission disagreed with the statement that sub-grantees began to lose credibility with its clients. As stated in the finding, we mention that weak financial management by some sub-grantees contributed to the funding problem and a finding on this problem is included below. Moreover, based on interviews with sub-grantee officials, several indicated that as activities were canceled or postponed due to a lack of funding, staff became discouraged and, in some cases, the sub-grantees began to lose credibility with their clients.

USAID/Guyana agreed with Recommendation No. 7 and stated that it has already issued a travel authorization and request for assistance from its Regional Contracting and Controller Office in Santo Domingo, Dominican Republic. This site visit was planned for the second quarter of FY 2006. A management decision has been reached for Recommendation No. 7 and a determination of final action on these recommendations will be made by the Audit Performance and Compliance Division (M/CFO/APC).

Several Sub-Grantees Suffered from Weak Financial Management Practices

Summary: According to the sub-grants with Maurice Solomon, each sub-grantee shall maintain adequate internal accounting and administrative systems to properly account for the grant. Several sub-grantees did not have adequate financial management practices and were not able to complete monthly liquidations in a timely manner. This occurred primarily because the accountants were not qualified or properly trained to perform their duties. As a result, some sub-grantees received funds late, which impacted their scheduled activities. Poor financial management practices can also potentially lead to fraud, waste, and abuse.

According to the sub-grants with Maurice Solomon, each sub-grantee "shall maintain adequate internal accounting and administrative systems to properly account for the grant. The accounting system maintained shall provide necessary documentation to allow for the verification of transactions and facilitate timely preparation of acquittals/liquidations and reports." While the sub-grantees were required by their sub-grants to submit liquidations by the tenth day of the following month, several sub-grantees submitted liquidations late and included unsupported or misclassified costs in their liquidations.

Specific examples of financial management weaknesses follow:

- At Volunteer Youth Corps, Maurice Solomon noted that record keeping was poor, no general ledger was in place, supporting schedules for monthly liquidations were incorrect, and expenses were being allocated to the wrong budget line items.

- The Central Islamic Organization of Guyana wrote checks in November that had not been properly authorized by a second individual.

- Artistes in Direct Support made advance payments for items that were not in the approved budget, such as payments to television stations and improvements to its own offices. It should have obtained prior approval from Maurice Solomon or USAID prior to making these payments.

- St. Francis Community Developers failed to establish a separate bank account for managing the Emergency Plan funds and commingled the funds with other sources of funding.

Problems such as those described above have resulted in Central Islamic Organization of Guyana and three other sub-grantees being placed on a three-month probation period.[6] Sub-grantees on probation were subject to extra scrutiny by Maurice Solomon's financial analysts when they reviewed monthly liquidations. Weak financial management practices followed by sub-grantees can result in disallowances or delays in receiving

[6] The Central Islamic Organization of Guyana, Roadside Baptist Church, Reslocare, and Swingstar were placed on probation in October 2005. In January 2006, the Central Islamic Organization of Guyana and Roadside Baptist Church had their probationary periods extended for another three months.

funds that are needed for care and prevention activities. Weak financial management practices may also create vulnerabilities to fraud, waste, and abuse.

Sub-grantees were experiencing financial management weaknesses because their accountants were only marginally qualified to perform their duties or had not been properly trained. Maurice Solomon noted that only about two of the 19 sub-grantees had an accountant with three or more years of relevant experience. Because of this limitation, sub-grantees expressed a need for formal financial management training, in addition to the informal one-on-one training that occurs during the monthly liquidation process. In fact, Maurice Solomon's contract with USAID requires it to provide financial and administrative management assistance to sub-grantees, including annual training on financial management practices. This training was scheduled in July 2005 and again in January 2006; however, both sessions were postponed.

Recommendation No. 8: We recommend that USAID/Guyana obtain evidence that Maurice Solomon & Company has provided financial management training to sub-grantees so that the monthly liquidations can be completed accurately and on schedule.

Evaluation of Management Comments – USAID/Guyana agreed with Recommendation No. 8 and has provided documentation that Maurice Solomon trained 16 sub-grantee financial representatives on March 30, 2006. Based on the Mission's comments and the supporting documentation provided, final action has been taken on Recommendation No. 8.

Program Implementers Did Not Have Exit Strategies

Summary: The President's Emergency Plan aims to develop sustainable HIV/AIDS health care networks, but the main program implementers, FHI and Maurice Solomon had not developed exit strategies to develop the local sub-grantees carrying out the prevention and care activities. Furthermore, none of the 11 sub-grantees we visited had developed detailed plans to sustain prevention and care activities once USAID funds are no longer available. Sustainability and exit strategies have not yet been adequately addressed because a higher priority has been placed on expanding and scaling up activities during the first two years of Emergency Plan activities in Guyana. During the remainder of the program, progressively more attention needs to be devoted to sustainability to better ensure that these activities will continue after the cessation of U.S. Government funding.

The importance of sustainability is recognized in the Office of Global AIDS Coordinator's five-year strategy for the Emergency Plan. One of its strategic principles aims to develop sustainable HIV/AIDS health care networks. Sustainable development activities mean activities that continue providing benefits beyond the time donor funding ends. In addition, as outlined in guidance issued by the Office of the U.S. Global AIDS Coordinator,[7] grant language for international NGO partners will require them to take steps to build local capacity, and the Emergency Plan will begin to require such partners

7 The Emergency Plan's second annual report to Congress, page 96.

to develop exit strategies—plans for reducing their own role and devolving responsibility to local people and organizations on a reasonable time frame.

Nevertheless, the main program implementers, FHI and Maurice Solomon had not developed exit strategies to develop the local sub-grantees carrying out the prevention and care activities. Moreover, none of the 11 sub-grantees we visited had developed a detailed strategy for sustainability, although three organizations did have some plans to continue operations after USAID funding ends:

- In addition to relying on World Bank funds, Artistes in Direct Support plans to raise funds by charging the public for its theatrical productions and by charging for training it provides in workplaces. Recently, the organization has also taken steps to relocate and improve its office.

- Lifeline Counseling Services currently receives assistance from the World Bank and some corporate sponsors. It is continuing to develop relationships with additional partners.

- Linden Care Foundation plans to expand its on-site social pharmacy[8] by adding new products. It is also working closely with a government body in hopes of receiving additional assistance for its activities.

Program participants have not yet focused on sustainability and exit strategies because they have been consumed by other, more urgent concerns: namely, expanding and scaling up Emergency Plan activities in Guyana.

Now that the program is in its third year, and considerable progress in terms of expanding services has been achieved, progressively more emphasis should be placed on improving the quality of services and sustaining prevention and care activities after U.S. Government funding for the activities is completed.

> *Recommendation No. 9: We recommend that USAID/Guyana work with Family Health International and Maurice Solomon & Company to develop a clear exit strategy for the Emergency Program in Guyana.*

Evaluation of Management Comments – USAID/Guyana disagreed with the recommendation included in the draft report, pointing out that the recommendation was directed at the wrong level, i.e., sub-grantees, and suggested a recommendation that USAID work with FHI and Maurice Solomon to develop a clear exit strategy. We have accepted USAID/Guyana's suggestion and changed Recommendation No. 9. A management decision will be reached for Recommendation No. 9 when USAID/Guyana has developed a firm plan of action and a date for implementing the recommendation.

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[8] A social pharmacy provides medicines, contraceptives, and services at levels that are affordable to low-income individuals.

Did USAID/Guyana's Emergency Plan treatment activities progress as expected towards the planned outputs in its grants, cooperative agreements and contracts?

USAID/Guyana's Emergency Plan treatment activities did not progress as expected towards planned outputs. Although USAID/Guyana plays no role in clinical treatment, it finances some antiretroviral (ARV) drugs and strengthening of a drug management system. The following section discusses this issue.

Procurement of Antiretroviral Drugs Was Delayed

Summary: Family Health International (FHI) was responsible for procuring pediatric ARV drugs and adult second-line ARV drugs in 2004 and 2005. However, the pediatric ARV drugs did not arrive until May 2005 and there were delays in receiving additional shipments. The adult second-line ARV drugs did not arrive until February 2006. The delays in ordering and receiving drugs were due to a lengthy, complex procurement process and the lack of a supply chain management system. These delays could have serious effects since interruptions in the supply of ARV drugs can be life threatening.

According to the FY 2004 and 2005 Country Operational Plans, FHI was responsible for supply chain management and the procurement of pediatric and second-line ARV drugs.[9] FHI's FY 2005 work plan also states that it, along with the Management Sciences for Health (MSH), is responsible for strengthening the drug management system. During fiscal year 2005, it spent $650,000 on these drugs.

The Emergency Plan has the objective of providing an uninterrupted supply of high quality, low cost products that flow through an accountable system. According to a MSH official, the goal is to have a 3-4 month supply of ARV drugs on hand.

The first batch of pediatric ARV drugs was ordered on May 2, 2005 and was received on May 30, 2005. This was an emergency procurement to treat 15 children for one month and another 15 children for two months. Additional orders intended to treat 60 children were placed on June 30 and September 9, 2005. The September order was received between November 27, 2005 and January 21, 2006. The second line ARV drugs, intended to treat 78 people, were not ordered until January 13, 2006 and were not fully received until February 20, 2006. The May and June orders were from a U.S. source and origin and arrived within a month. Because U.S. source and origin drugs were deemed to be too costly,[10] the September and January orders originated from the Netherlands and took somewhat longer to arrive.

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9 First-line ARVs are financed by MOH through the World Bank and the Global Fund and have been available free of cost to HIV-infected persons since 2002. As mentioned in footnote 1 in the Background section of this audit report, second-line drugs are only provided to patients who do not respond to first-line ARV treatment.

10 "Source" refers to the country from which the goods are shipped. "Origin" refers to where the goods are made.

The delays in ordering and receiving the ARV drugs were due in part to the absence of a supply chain management system that would forecast demand for ARV drugs and trigger procurement actions in time to meet the demand. MSH was working to develop and implement such a system, but the system had not been completed by the end of our audit.

Delays were also caused by a lengthy and complex procurement process. Several meetings between numerous parties were required to clarify FHI's responsibilities. Before starting the process, FHI had to wait for the Ministry of Health's approval of national treatment guidelines for the drug regimens that could be used in Guyana. Approval of the guidelines for the second-line ARV drugs was not given until October 2005. The program then prepared a drug utilization forecast with several scenarios. Accurate forecasting was difficult due to the lack of information on current drug utilization. After a decision was made on what drugs to order, USAID had to prepare and obtain a required source and origin waiver. Additional time was needed to negotiate fees and prices with drug agents. Many of these agents viewed Guyana as a low priority relative to other countries that order substantially more ARV drugs and many agents were not interested in such a small order. Finally, the process of registering the ARV drugs for use in Guyana took a long time, partly because there were no written guidelines that clearly explained the procedure for registering drugs.

Interruptions in the supply of ARV drugs may literally be life threatening. To cope with the shortages caused by the procurement delays described above, the program borrowed pediatric ARV drugs from Mercy Hospital from October 25, 2005 to November 23, 2005. It borrowed second line ARV drugs from November 17, 2005 to March 13, 2006.

USAID/Washington has entered into a supply chain management services contract with numerous partners to provide ARV drugs and supply management support. To avoid the lengthy procurement process in the future, USAID/Guyana has bought into this mechanism and the partnership has assigned a procurement agent to backstop USAID/Guyana and has provided administrative oversight from MSH. According to USAID officials, this should enable USAID/Guyana to procure the needed drugs within a three-month timeframe and develop a supply chain system. Specifically, for FY 2006, USAID has set aside $2,775,000 for the supply chain management contract managed by USAID/Washington for the benefit of Guyana. Of this amount, $482,000 is specifically reserved for the purchase of pediatric drugs and related technical support. Because USAID has already taken action to prevent delays in procuring drugs in the future, no recommendation is needed.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/San Salvador conducted this audit in accordance with generally accepted government auditing standards. This audit is part of a worldwide audit of the President's Emergency Plan for AIDS Relief (Emergency Plan). The audit was designed to determine whether prevention, care, and treatment activities progressed as expected toward achieving planned outputs.

In planning and performing the audit, we reviewed and assessed the effectiveness of USAID/Guyana's management controls related to the Emergency Plan. The management controls assessed included the country operational plan, the Mission's performance monitoring plan, the Mission's semiannual portfolio reviews, and monitoring activities including staying abreast of program activities through meetings and telephone calls, site visits, and review of progress reports and other correspondence from the entities that are implementing the program.

During the audit, we interviewed USAID/Guyana officials, members of the U.S. Government country team in Guyana, and officials of the organizations implementing the program. We visited the two USAID/Guyana contractors, FHI and Maurice Solomon, and three of the four FHI sub-contractors. We also visited 11 of the 19 sub-grantees and 16 of 50 MOH facilities assisted by the Emergency Plan. Sub-grantees visited included all 9 sub-grantees that began implementing the program in FY 2004 as well as 2 of the 10 sub-grantees that joined the program in July 2005. To select the latter 2 sub-grantees, we judgmentally selected sub-grantees that had accessible, ongoing activities. With regard to the MOH prevention of mother to child transmission facilities, we visited 8 out of 43 facilities in six of the ten administrative regions of Guyana. Concerning the counseling and testing sites, we visited 12 out of 15 permanent counseling and testing sites (including 8 MOH and 4 sub-grantee facilities) in 5 administrative regions of Guyana, including one outreach facility served by the FHI counseling and testing mobile unit out of a total of 26 outreach sites. During fiscal year 2005, USAID/Guyana had obligated $8.8 million and spent $6.3 million in support of the Emergency Plan.

The audit fieldwork was performed in Guyana from January 31, 2006 through February 17, 2006, and the audit focused on activities implemented during FY 2005.

Methodology

To answer the audit objectives, we interviewed Mission officials and in-country partners and reviewed partner work plans and progress reports to confirm progress reported towards achieving planned outputs. We also conducted site visits at 11 sub-grantee offices, observed program operations, and tested data included in progress reports. We also tested data for eight MOH prevention of mother to child transmission facilities and eight MOH voluntary counseling and testing facilities. We judgmentally selected these facilities in an effort to maximize our coverage of the number of individuals tested and the geographic scope. Testing this data consisted of comparing the reported information to supporting documentation such as log books, patient records, and other

documentation for selected months for selected activities. We selected months for review judgmentally, trying to pick months that had reported data to review. In selecting results for review, we judgmentally selected important results that were most closely related to the Emergency Plan goals.

In answering the audit objectives, we used the following materiality thresholds:

- If at least 90 percent of the selected outputs were achieved, we would answer the audit objectives positively.

- If at least 80 percent, but not more than 90 percent of the selected outputs were achieved, we would answer the audit objectives positively, but with a qualification.

- If less than 80 percent of the selected outputs were achieved, we would answer the audit objectives negatively.

In judging the significance of variances found during the audit between reported accomplishments and supporting documentation, we considered variances of 10 percent or more to be significant and reportable.

MANAGEMENT COMMENTS

April 28, 2006

MEMORANDUM

TO: Regional Inspector General/San Salvador, Timothy E. Cox

FROM: USAID/Guyana Director, Fenton Sands

SUBJECT: Audit of USAID/Guyana's Progress in Implementing the President's Emergency Plan for AIDS Relief (Report No. 1-504-06-0XX-P)

This memorandum transmits our comments on the subject audit for your use in revision of the draft report and inclusion in the final submission. The Mission has responded to the nine recommendations as requested. Please find both the signed and unsigned copy as well as the necessary attachments.

The Mission more specifically, requests revision of the following critical components of the report:

1.) Revise the indicator evaluation table to take into consideration the March 30, 2006 deadline, and revise summary evaluation accordingly;
2.) Delete the six media-indicators that have been deleted by OGAC reporting given the weaknesses in the indicators and in collecting applicable data;
3.) Delete the reference made that MSH implemented treatment; and
4.) Revise the NGO funding allocation section given the responses.

Our office appreciates the efforts made by your team and feel confident that we will be able to build a stronger program given this critical analysis.

GUYANA MISSION COMMENTS

Did the prevention and care activities supported by USAID/Guyana through grants, cooperative agreements, and contracts progress as expected towards planned outputs?

Many Planned Outputs Were Not Achieved

The audit found that "Of the 27 USAID-financed activities listed in the FY 2005 country operational plan, 4 activities achieved or exceeded planned outputs, 17 did not achieve planned outputs and 6 could not be evaluated because targets were not established or because sufficient information on actual accomplishments for FY 2005 was not available."

The Office of the Global AIDS Coordinator recognized the weakness of 23 indicators which have been removed from reporting responsibility; 6 were directly applicable to this performance evaluation. The date by which the program had to achieve its results was March 30, 2006 (not September 30, 2005).[11] Taking this into consideration; of the 21 USAID-financed activities listed in the FY 2005 country operational plan 13 activities were fully achieved or exceeded planned outputs and 8 did not fully achieve planned outputs. But, of these 8 targets that were not met, five achieved between 70-98% and only three were achieved at levels less than 50%.[12] USAID recognizes that the targets set for the 2 indicators with the weakest performance within palliative care was a combination of setting targets too high, an over-estimation of the capacity of civil society to implement this program, and the fact that Palliative Care guidance was not finalized by OGAC until February 3, 2006.[13]

Recommendation No.1: We recommend that USAID/Guyana obtain from Family Health International an action plan that includes a timeline and steps needed to fully implement abstinence/be faithful activities, prevention of mother-to-child transmission mass media campaigns, palliative care, and orphan and vulnerable children programs.

The Mission agrees. USAID has requested and received a draft work plan that outlines a timeline and stepwise implementation plan that includes but is not limited to address A/B activity implementation, PMTCT communication programs, palliative care and OVC. USAID will ensure that the finalized work plan sufficiently addresses these focus areas.

Recommendation No. 2: We recommend that USAID/Guyana, in coordination with Family Health International, develop, disseminate, and support with on-site mentoring, detailed guidance on implementing the palliative care and orphan and

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11 Please refer to attached SI Guidance

12 Please refer to attached indicator table

13 HIV/AIDS Palliative Care Guidance #1: An Overview of Comprehensive HIV/AIDS Care Services in the President's Emergency Plan for AIDS Relief: February 3, 2006: US Department Of State Office of the Global AIDS Coordinator

vulnerable children program components for the benefit of participating sub-grantees.

The Mission agrees with the recommendation and will sufficiently address the capacity building needs of the implementing partners with specific focus given to monitoring and evaluating their programs and clarifying any misunderstandings as it relates to OVC and palliative care. FHI, in collaboration with USAID and Maurice Solomon & Co., has already developed core teams that will support each civil society organization and has completed the first round of site visits. Each core team has a programmatic technical officer, M&E officer, financial officer from MSC (and USAID representation on at least half of all visits). These core teams are permanently assigned to each organization and make quarterly site visits to increase the level of mentoring, support, and technical guidance that each organization receives on a continual basis and will visit NGOs throughout the quarter to address issues raised during the quarterly visits.[14]

Performance Targets Were Inconsistent

The audit team found that, "At the outset of the program, USAID/Guyana focused on rapidly scaling up Emergency Plan activities and did not devote sufficient effort to ensuring that program performance indicators and targets were expressed consistently." And that, "While many of these indicators were similar to one another, there were numerous differences in the wording and definitions of the indicators." The Mission does agree that its focus in FY05 was on rapidly scaling up service delivery which is at the heart of the PEPFAR initiative. The Mission also agrees that had it been able to fill its strategic information staff position, the program would have been stronger. Nonetheless, the Mission did ensure that it clearly and sufficiently expressed performance indicators and targets to FHI.[15]

The audit team found that, "Inconsistencies in program performance targets made it difficult for management to assess progress under the program. Further, the number of indicators created confusion, increased workload, and placed an unnecessary burden on USAID/Guyana, FHI, and the sub-grantees. It also reduced program efficiency and increased the risk of inaccurate and unsupported results." The Mission realizes that systems need strengthening in order to streamline the process, but disagrees that the monitoring and evaluation responsibilities have placed unnecessary burden on the program and undermined its efficiency. Further to this, the Mission wants to highlight the significance of many of the chosen indicators that lay outside of OGAC guidance. There are 36 core Ministry of Health Indicators and 17 UNGASS indicators to take into consideration. These indicators, along with the program level process indicators are all extremely valuable for tracking the progress of the program and providing our key partners with needed information. All of the applicable PEPFAR indicators are included in the FHI M&E plan, and it is accepted M&E principle that the number of indicators tracked by the sub-partners and FHI would be much greater than the number of core indicators reported for PEPFAR in order to better monitor implementation, capacity strengthening, and process-level indicators.

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14 Please refer to attached completed quarterly visits.

15 It should be noted that there were many revisions to targets, indicator definitions, and Strategic Information Guidance (Finalized June 6, 2005) from OGAC.

One critical issue that needs to be addressed relates to the audit finding that, "In addition, publications such as the USAID Annual Report and the Emergency Plan's Report to Congress contained erroneous information. For example, the Second Annual Report to Congress states that 5,200 orphans and vulnerable children received support while in reality less than 300 received support." USAID worked closely with its strategic information team at OGAC and with in-country partners to rectify this discrepancy which all partners involved had recognized. Hence, in the FY2006 country operational plan submitted in October 2006 a special reference to the matter was made and accepted by OGAC.

Recommendation No. 3: We recommend that USAID/Guyana ensure that performance indicators and their corresponding targets are developed consistently among the various program documents.

USAID agrees with the recommendation and will include the indicators and their targets in during the FY06 funding allocation process. USAID will then follow-up with FHI and supported civil society organizations to ensure that there is consistency in the M&E plan, annual program work plans, and M&E reporting tools.

Recommendation No.4: We recommend that USAID/Guyana reduce and simplify the number of indicators and periodically evaluate performance indicators to ensure that all indicators are necessary, relevant and easily understood by all concerned.

USAID strongly disagrees with this recommendation. USAID is required to fulfill all applicable PEPFAR indicators and has a strategic partnership to support the information needs of the host country government and international declarations made by them (36 core MOH indicators and 17 UNGASS). USAID does, however, agree to annually evaluate the number and purpose of collected performance, output, and capacity indicators to ensure that all are necessary and relevant.

Results Reported by FHI and Sub-Grantees Were Inaccurate or Unsupported

There are a great number of disagreements within the information the audit team reported in this section. USAID requests the methodology of determining data support so as to build the capacity of its partners to be able to respond to this level of scrutiny. As it relates to specific determinations, the Mission wishes to comment as follows:

1.) The audit team sited that, "Central to the reasons why reported results were inaccurate was that USAID/Guyana and FHI did not provide adequate guidance to the sub-grantees or to the MOH and did not periodically validate reported results."
   a. Response: This is not true. All of the NGOs were trained in M&E and provided with written guidance on reporting. Moreover, several follow up telephone calls and visits were made to the NGOs to provide TA for reporting. Please see attached visit schedule.

2.) The audit team sited that, "As a result of inaccurate reporting by sub-grantees and the MOH, USAID/Guyana could not reliably determine if the program was achieving planned outputs and the Mission reported inaccurate information to the Office of the U.S. Global AIDS Coordinator and to the Congress."

   a. Response: This statement reaches a conclusion that is not supported by the information provided—not being able to fully validate the reports does not necessarily means that the reports were inaccurate.

3.) The audit team sited, "There were discrepancies ranging between 21 to 33 percent between the results reported by FHI and the documented results of the number of pregnant women tested for HIV/AIDS at three of the eight MOH sites we visited. For example, the site at Bartica Hospital recorded 266 pregnant women as having been tested for HIV while FHI reported 216 – a variance of 23 percent.
   a. Response: The auditors reached this conclusion based on data from the lab register at Bartica which was not the source for PMTCT data which is actually the ANC register and the counselors' daily register. The lab register is likely to contain data on all HIV tests done for different purposes and will not necessarily give a true reflection of the number of persons tested;[16]

4.) The audit Cites, "USAID and FHI should have realized that the 5,209 orphans and vulnerable children reportedly reached was an error since the total estimated number in the entire country is only 4,000."
   a. Response: The Mission mistakenly reported the number of units of services (5209) that were given to OVCs. Later in FY05 the Mission along with our strategic information counterpart, corrected the error and reported the actual number (289) of OVCs reached during that six month period.

5.) The audit sites, "FHI did not consistently estimate the number of people reached by mass media. "
   a. All Indicators for Mass Media have been eliminated by OGAC given the weakness of the indicator.

6.) The audit sites, "In addition to the specific problems outlined above, the reporting format provided by FHI only contained current period data. No cumulative results toward achieving planned outputs were captured. Including cumulative results would better help sub-grantees measure progress made towards achieving planned outputs.
   a. Response: The is available in the FHI database.

7.) The audit sites, "USAID/Guyana did not have a monitoring and evaluation office so they relied, in part, on FHI to ensure the quality of reported results. However, FHI did not provide necessary guidance and on-site mentoring or make periodic visits to verify the accuracy of the progress reports."
   a. Response: Mentoring was provided through regular field visits and telephone contact. We agree that more time should have been spent on trying to validate the reports. Based on feedback that FHI received from the NGO we were led to believe that they understood all guidelines that were issued, but increased training and support has been integrated into our FY06 work plan.

Recommendation No. 5: We recommend that USAID/Guyana ensure that Family Health International provides the Ministry of Health and sub-grantees with

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16 Background information shared with team on February 24, 2006 by Navindra Persuad.

training and guidance that ensures the submission of accurate, well-documented performance data on current and cumulative progress toward achieving targets.

USAID/GUYANA agrees and will ensure that FHI continues to provide Ministry of Health and sub-contractors with training and will increase the mentoring and guidance of such partners to ensure the submission of accurate, well-documented performance data on current and cumulative progress toward achieving targets.

Recommendation No. 6: We recommend that USAID/Guyana ensure that Family Health International implements a monitoring plan that regularly validates the quality of data, including supporting documentation, submitted by all sub-grantees.

USAID agrees and will ensure that FHI updates their existing M&E plan and continues to implement the monitoring plan that regularly validates the quality of data, including supporting documentation, submitted by all sub-grantees. In addition, FHI has already initiated quarterly mentoring/site visits to each NGO/FBO partner whereby this process is conducted. FHI will also continue to work with the Ministry of Health regarding the validation of PMTCT data collection and necessary training.

Delays in Providing Advances to Sub-Grantees Impeded Program Activities

The audit sites, "Lack of timely funding impeded the sub-grantees' efforts to achieve the goals and targets in their work plans and caused them to lose credibility with their clients." The Mission disagrees in that the NGOs have not lost their credibility with their clients and that this speculation is incorrect as they continue to function in their communities, expand their coverage, and attract support from other donors and international partners.

The audit sites that "the contractor (Maurice Solomon) shall assure that funds are available as needed by partner organizations and that funds will not be subject to administrative delays. However, the sub-grantees did not receive funds in a timely fashion from Maurice Solomon. Maurice Solomon used an unreasonable method to provide funds to the sub-grantees." The Mission wishes only to highlight that the format /method used by the Accounting Firm was directed in their contract that was designed and developed by the Contracting Office, USAID/Dominican Republic. The failure of some NGOs to liquidate in a timely manner, despite numerous reminders caused submissions to the Dominican Republic to be delayed, resulting in the late receipt of funds. Thus, it is the defaulters in the liquidation process that adversely affected the entire liquidation process. The Mission had identified this problem early on in the contract and is working with the Regional Contracting Office to rectify the situation. It should be noted that some of the sited delays were not due to issues regarding the contract with MSC, but delays during the work plan approval process. The ten new sub-grantees that entered the Emergency Plan program in July 2005 received no advances at all, or only minimal amounts for office expenses and salaries, until FHI approved their work plans beginning in October 2005. Finally, weak financial management by some sub-grantees contributed to funding problems since the sub-grantees submitted ineligible or misclassified costs to MSC in their liquidations, leading to delays and disallowances.

The audit goes on to say that, "Voluntary Youth Corps was unable to make any payments between November 4, 2005 and December 1, 2005 since no funds were received for October or November 2005." It needs to be noted that this delay occurred because the NGO was required to adjust its proposed activities based on the technical review. The resubmission of the document by the NGO was submitted late, hence the receipt of funds in December 2005.

The audit sites another specific example, saying that, "Comforting Hearts had a bank balance of less than $2, as of February 7, 2006, because it did not receive program funds in January 2006." Comforting Hearts received program funds on February 8th in the amount of $1,228,200G. Such delays, however challenging, do not hinder the progress of the program entirely. Prior to this installment Comforting Hearts was able to continue working as a number of activities were conducted during the month of January, such as therapeutic sessions, sensitization sessions among pregnant women and employees, home based care (HBC) training, and OVC meetings with Regional officials in two districts.

> *Recommendation No. 7: We recommend that USAID/Guyana arrange to modify the contract with Maurice Solomon & Company to better ensure that sub-grantees receive adequate funds in a timely manner.*

USAID agrees and has already issued a travel authorization and request for assistance from our Regional Contracting and Control Office in Santo Domingo. This site visit is planned for the second quarter of FY2006.

Several Sub-Grantees Suffered from Weak Financial Management Practices

The mission agrees that there are indeed institutional weaknesses that need to be addressed, but asks that the audit also take into consideration the context and civil society environment in Guyana mentioned later on in the section regarding sustainability planning. One specific item the audit team sited was that, "Problems such as those described above have resulted in Central Islamic Organization of Guyana and three other sub-grantees being placed on a 3-month probation period." It is the practice of USAID to conduct a rolling assessment of the institutional capacity of the NGOs during the proposal review process and throughout the implementation cycle. Once it is determined that specific NGOs lack the requisite institutional capacity they are placed on diverse probationary periods. Such decisions are based on our knowledge of the NGOs, the accuracy and timeliness of their reporting, and the technical evaluation of their programs. Such decisions are made by a support team made up of key staff from USAID, GHARP, and MSC. Hence, the Central Islamic Organization of Guyana, Roadside Baptist Church, Reslocare, and Swingstar, were placed on probation in October 2005. In January 2006, the Central Islamic Organization of Guyana and Roadside Baptist Church had their probationary periods extended for another three months.

This process is set in place to prevent exactly the type of abuses the audit team sited (fraud, waste) and such a process of review, support, and resolution should be seen as a strong capacity-building and financial accountability strategy, not a negative activity as the audit team inferred when saying, "Sub-grantees on probation were subject to extra scrutiny by Maurice Solomon's financial analysts when they reviewed monthly liquidations." The Mission agrees that weak financial practices result in disallowance

and delays in receiving funds and the ability to implement the program, but the Mission strictly respects our responsibility to account for funds distributed and hence, strictly follows the contractual obligations while we strengthen the NGO financial management system in order to correct the weaknesses.

> *Recommendation No. 8: We recommend that USAID/Guyana obtain evidence that Maurice Solomon and Company has provided financial management training to sub-grantees so that the monthly liquidations can be completed accurately and on schedule.*

USAID agrees with the recommendation. MSC has since held training for 16 financial representatives from the NGOs on the March 30, 2006.[17] MSC will hold annual training, will continue onsite mentoring and support during the USAID/GHARP/MSC NGO quarterly visits, and will continue their monthly on-site NGO support.

Sub-Grantees Do Not Have Plans for Sustainability

The audit team found that, " The President's Emergency Plan aims to develop sustainable HIV/AIDS health care networks, but none of the 11 sub-grantees we visited had developed detailed plans to sustain prevention and care activities once USAID funds are no longer available. Sustainability has not yet been adequately addressed because a higher priority has been placed on expanding and scaling up activities during the first two years of Emergency Plan activities in Guyana. During the remainder of the program, progressively more attention needs to be devoted to sustainability to better ensure that these activities will continue after the cessation of U.S. Government funding."

USAID agrees with the principle that sustainability of these organizations is critical. This goal cannot be considered in isolation though as environment context is absolutely necessary in determining plans for sustainability. Three of the most significant contextual issues include:

- Indebted Poor Country (HIPC). Roughly 35% of the population lives below the poverty level.
- A new World Bank study has found that Guyana ranks the highest in the skilled emigration rate from developing countries, amounting to 89%. Guyana is followed by Jamaica, 85.1%; Haiti, 83.6%; Suriname, 47.9%; Ghana, 46.9%; Mozambique, 45.1%. These emigrants are from a diverse professional background, from entrepreneurs and financial experts to health care workers and teachers. Today, there are an estimated 700,000 Guyanese living abroad.
- Civil society organizations did not exist in Guyana until 1997 when political reform was instituted. The effectiveness of these organizations is frequently hampered by limited technical and organizational capacity.

The first, substantial funding that health-focused NGOs received was from USAID in 2001, and the largest award did not exceed $25,000USD. Over the last five years, USAID has worked to increase the capacity of these same NGOs, and through PEPFAR

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[17] Please refer attached training register

has taken on an additional eleven, but developing a loose group of very committed community members into trained service providers with basic institutional capacity is a long-term commitment, let alone developing them as self-sufficient institutions.

Given the focus of PEPFAR (USAID/Guyana's only health funding) being service delivery, and more specifically treatment and the services that lead to treatment, sufficient funding is not allocated within the program to adequately address all of the capacity building needs of the program implementers. Taking these factors into consideration, USAID continues to address institutional capacity issues, while continuing to work within the PEPFAR mandate.

> *Recommendation No. 9: We recommend that USAID/Guyana coordinate with Family Health International and Maurice Solomon and Company to ensure that its sub-grantees develop strategies for the sustainability of their Emergency Plan activities, including the incorporation of institutional capacity building activities and the development of exit plans.*

USAID disagrees with the recommendation, but suggests rather that USAID work with FHI and Maurice Solomon to develop a clear exit strategy for FHI/GHARP. As outlined by OGAC, "...grant language for international NGO partners will require them to take steps to build local capacity, and the Emergency Plan will begin to require such partners to develop "exit strategies" - plans for reducing their own role and devolving responsibility to local people and organizations on a reasonable time frame.[18]"

This strategy will be based on increasing the capacity of indigenous organizations to be sustainable implementers of the program with limited international technical assistance.

Did the treatment activities supported by USAID/Guyana through grants, cooperative agreements, and contracts progress as expected towards planned outputs?

Procurement of Antiretroviral Drugs Was Delayed

USAID wants to provide additional context and correction to the section of the audit report pertaining to the procurement of antiretroviral drugs given the critical nature of this responsibility. First, and foremost, it must be clarified, that USAID/Guyana plays no role in clinical treatment. USAID/Guyana's responsibility lies in the procurement of antiretroviral drugs. The entire procurement process is lengthy and includes a large number of actors and numerous activities including:

- government approval of HIV/AIDS treatment regimens
- quantification/forecasting
- verification of drug registration with the country regulatory authority
- negotiation of drug prices and selection of a procurement services agent
- preparation of source/origin waivers/purchase approval and purchase orders
- arranging procurement with the procurement services agent who in turn processes actual drug procurement with respective drug manufacturers and;

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[18] OGAC Guidance Annual Report 2006; pp 96-97.

- delivery of drugs to the country, customs clearance and delivery to the designated country drug distribution facility.

At any point in the process, delays are possible and are frequently encountered. It is not unusual for the entire process to take 6 months or more, particularly for a country's initial USAID HIV/AIDS procurement.

In the rapidly changing environment of AIDS drugs, changes in treatment protocols can and do occur. In Guyana, the MOH has not clearly articulated a process for changing protocols. Delays in the revisions to treatment guidelines have therefore delayed procurement activities since the list of drugs to be procured is determined by the protocols. Once the drugs are identified, consumption estimates for all drugs and all dosages must be calculated to develop forecasted national requirements. The HIV information system is virtually non-existent in Guyana and different sources report different data on the same variables. Thus, reaching agreement on important assumptions for scaling up and percentage of patients receiving the various treatment regimens was a time consuming activity. In the case of AIDS drugs it almost goes without saying that forecasts must be as accurate as possible. Under-estimation can result in interruptions in patient treatment: over-estimation estimating can result in waste of very costly medicines. Before any drugs can be imported into Guyana, they must be registered. The list of registered drugs in Guyana has not been updated in several years and special waiver letters from the MOH needed to be obtained before drugs could be ordered. The proper authorities were clarified and pursued and the waivers were obtained in a reasonable timeframe.

After drugs and dosages have been identified and the quantities forecasted, drug pricing, supplier(s) and estimated delivery dates are required. It is worth noting that Guyana is not classified as a least developed country (LDC) and as such LDC preferential pricing was not readily available. However, the program was able to negotiate LDC pricing for many of the drugs and favorable pricing for the remainder, thus maximizing the quantities of drugs procured with the available funds. The relatively tight global market for certain ARVs complicates timely procurement and this definitely has affected the Guyana procurement process. During the time period in question there was quite variable availability of some of the ARVs, particularly from the multinational "brand name" sources. The occasional gaps between demand and short term availability were aggravated by the lack of reliable data on actual global demand and the constantly changing situation with standard treatment protocols in PEPFAR focus countries including Guyana. GHARP was able to obtain products for Guyana in spite of these constraints. After suppliers and prices are identified, USAID requires source and origin waiver and/or purchase approval prior to expenditure of funds.

The audit sites, "Treatment activities supported by USAID/Guyana did not progress as expected due to delays in procuring ARV drugs." USAID disagrees with this conclusion since there were no treatment delays, scaling up of treatment, or interruption in treatment resulted from the procurement process. Previous to the arrival of pediatric ARVs procured by GHARP, no pediatric formulations were available. Children were treated with locally manufactured (New GPC) adult solid oral formulations that were suspended in measured amounts of water and withdrawn in syringes to obtain calculated dosages. Frustrated partners desiring pediatric formulations had highly distorted expectations of the process and timeframe needed to procure drugs under USAID contract, with the apparent belief that all drugs could be delivered to the clinics in

a matter of a few weeks despite the lack of treatment protocols, consumption information and quantification, waiver process or manufacturer availability of the needed ARVs. However, no patients were denied treatment as a result of any delays in the procurement process. We do recognize that frustration was created by this unavoidably time consuming process.

The audit sites, "The 2004 and 2005 country operational plans stated that MSH was responsible for procuring pediatric formulations of ARVs and second-line branded drugs for both HIV infected children and adults." It should be clarified that no money for the actual purchase of drugs passed through MSH as the purchase was made by FHI.

The audit sites, "*The first batch of pediatric ARV drugs was ordered on May 2, 2005 and was received on May 30, 2005. This was an emergency procurement to treat 15 children for one month and another 15 children for two months. Additional orders intended to treat 60 children were placed on June 30 and September 9, 2005. The September order was received between November 27, 2005 and January 21, 2006. The second line ARV drugs, intended to treat 78 people, were not ordered until January 13, 2006 and were not fully received until February 20, 2006. The May and June orders were from a U.S. source and origin and arrived within a month. Because U.S. source and origin drugs were deemed to be too costly, the September and January orders originated from the Netherlands and took somewhat longer to arrive.*"[19]

The audit sites, "*Interruptions in the supply of ARV drugs may literally be life threatening. To cope with the shortages caused by the procurement delays described above, MSH borrowed pediatric ARV drugs from Mercy Hospital from October 25, 2005 to November 23, 2005. It borrowed second line ARV drugs from November 17, 2005 to March 13, 2006. Prior to June 2005, MSH also gave children reduced dosages of adult ARV drugs, but this resulted in the children receiving incorrect dosages.*" It is critical to note that, MSH **has never had any role in treating children in Guyana at any time.** Prior to GHARP procurement of pediatric formulations, there were only adult formulations available in Guyana. The pediatric technical working group under OGAC presented the current gold standard in pediatric dosing in developing countries.[20] It recommends giving ½ tablets, what could be considered a 'reduced dosage of adult ARV drugs.' Many protease inhibitors are only available in tablet or capsule form. Even though MSH, nor any USAID program, is active in treatment programs, this practice is acceptable and even recommended in resource-constrained settings.

The need to borrow drugs was due to an inaccurate assumption provided by stakeholders during the quantification activity. There was an assumption that far more patients would be converted from liquid to solid formulation than actually occurred. This resulted in borrowing two liquid preparations. Utilization patterns are somewhat unpredictable and a system to share inventory between partners was developed for this reason. In this instance GHARP borrowed drugs from CRS. In early 2006, CRS borrowed other drugs from GHARP.

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19 Please refer to procurement process summary attached

20 Pediatric Antiretroviral and Cotrimoxazole Dosing, September 2004, CDC and Columbia School of Public Health.

Comparison of Planned, Reported, and Actual Prevention and Care Outputs for Fiscal Year 2005

Output	Country Operational Plan Target	Outputs Reported by FHI	Verified	Target Met?[21]
1. Community Outreach HIV/AIDS Prevention Programs that Promote Abstinence and/or Being Faithful	18	26	14	No
2. Individuals Reached through Community Outreach Prevention Programs that Promote Abstinence and/or being Faithful	10,000	3,306	Unsupported	No
3. Individuals Trained to promote HIV/AIDS Prevention Programs through Abstinence and/or Being Faithful	300	82	Unsupported	No
4. Community Outreach HIV/AIDS Prevention Programs that Promote Abstinence (A Subset of Abstinence and/or Being Faithful)	18	13	14	No
5. Individuals Reached through Community Outreach that Promote HIV/AIDS through Abstinence (A Subset of Abstinence and/or Being Faithful)	10,000	410	Unsupported	No
6. Individuals Trained to Promote HIV/AIDS Prevention through Abstinence (A Subset of Abstinence and/or Being Faithful)	300	91	Unsupported	No
7. Community Outreach HIV/AIDS Prevention Programs that are not Focused on Abstinence and Being Faithful	No defined target	16	12	Not determined
8. Individuals Reached with Community Outreach Prevention Programs that are not Focused on Abstinence and Being Faithful	No defined target	35,150	Unsupported	Not determined

[21] In cases where the reported amount was less than the planned target and the reported amount could not be verified (unsupported), we classified the target as not being met. Cases where the reported amount was greater than the planned target and the reported amount could not be verified were classified as "Not Determined."

Output	Country Operational Plan Target	Outputs Reported by FHI	Verified	Target Met?[21]
9. Individuals Trained in Other HIV/AIDS Prevention Services	100[22]	364	Unsupported	Not Determined
10. Pregnant Women provided with Prevention of Mother-To-Child Transmission (PMTCT) services, including counseling and testing	10,200	7,960	7,960[23]	No
11. Service Outlets Providing the Minimum Package of PMTCT Services	42	46	43	Yes
12. Health Care Workers Trained or Re-Trained in the Provision of PMTCT Services	100	75	75	No
13. Individuals Provided With HIV-Related Palliative Care [24]	2,500	742	80	No
14. Service Outlets Providing HIV-Related Palliative Care (excluding TB/HIV)	9	8	6	No
15. Individuals Trained to Provide HIV-Related Palliative Care (excluding TB/HIV)	100	127	146	Yes
16. Individuals Who Received Counseling and Testing for HIV [25]	6,000	10,546	10,546[26]	Yes
17. Service Outlets Providing Counseling and Testing Services	18	15	41	Yes

[22] Even though there was no target defined in the country operational plan, Mission officials and FHI believe that the target was 100.

[23] While testing at individual hospitals and clinics selected revealed large variances, the net variance for all eight hospital and clinics combined was one percent. We included some examples of the large variances at some of the hospitals and clinics in the report.

[24] This target was stated inconsistently (as 2,500 and 2,617) within the country operational plan.

[25] This target was stated inconsistently (as 1,600 and 6,000) within the country operational plan. However, both the Mission and FHI believed that the target was 6,000.

[26] While testing at individual hospitals and clinics selected revealed large variances, the net variance for all eight hospitals and clinics combined was two percent. We included some examples of the large variances at some of the hospitals and clinics in the report.

Output	Country Operational Plan Target	Outputs Reported by FHI	Verified	Target Met?[21]
18. Individuals Trained in Counseling and Testing	100	88	95	Yes
19. Orphans and Vulnerable Children (OVC) Served by the OVC Programs	560	5,209	289	No
20. Orphans and Vulnerable Children Programs	12	9	6	No
21. Providers/Caretakers Trained in Caring for Orphans and Vulnerable Children	100	92	57	No

Local Organizations Implementing Emergency Plan Activities in Guyana

Sub-Grantees	Emergency Plan Components
Artistes In Direct Support	Prevention (abstinence and/or being faithful), other prevention
Central Islamic Organization of Guyana	Prevention (abstinence and/or being faithful)
Comforting Hearts	Prevention (abstinence and/or being faithful), other prevention, palliative care, counseling and testing, and orphans and vulnerable children,
Guyana Responsible Parenthood Association	Prevention (abstinence and/or being faithful), other prevention, counseling and testing, and palliative care
Help and Shelter	Other prevention, and systems strengthening
Hope for All	Prevention (abstinence and/or being faithful), other prevention, and palliative care
Hope Foundation	Prevention (abstinence and/or being faithful), other prevention, palliative care, counseling and testing, and orphans and vulnerable children
Lifeline Counseling Services	Palliative care, counseling and testing, and orphans and vulnerable children
Linden Care Foundation	Prevention (abstinence and/or being faithful), palliative care, counseling and testing, and orphans and vulnerable children
Love & Faith Outreach	Prevention (abstinence and/or being faithful) and palliative care
Mibicuri Youth Development Group	Prevention (abstinence and/or being faithful) and other prevention
RESLOCARE	Prevention (abstinence and/or being faithful), other prevention, and orphans and vulnerable children
Ribbons of Life	Prevention (abstinence and/or being faithful) and other prevention
Roadside Baptist Church	Prevention (abstinence and/or being faithful) and orphans and vulnerable children
St. Francis Community Developers	Orphans and vulnerable children
Swing Star/FACT	Other prevention, and palliative care

Sub-Grantees	Emergency Plan Components
The Network of Guyanese Living with HIV/AIDS (G+)	Palliative care
Volunteer Youth Corps	Prevention (abstinence and/or being faithful), other prevention, palliative care, and orphans and vulnerable children.
Youth Challenge Guyana	Prevention (abstinence and/or being faithful), other prevention, counseling and testing, and orphans and vulnerable children.

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